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Brent

NHS

Brent Clinical Commissioning Group

Health and Wellbeing Board

Wednesday 24 January 2018 at 7.00 pm
Board Rooms 3, 4 & 5 - Brent Civic Centre

Membership:

Councillor Hirani (Chair)	Brent Council
Dr Ethie Kong (Vice-Chair)	Brent CCG
Councillor Butt	Brent Council
Councillor Colwill	Brent Council
Councillor McLennan	Brent Council
Councillor M Patel	Brent Council
Sheikh Auladin	Brent CCG
Dr Sarah Basham	Brent CCG
Rob Larkman	Brent CCG
Julie Pal	Healthwatch Brent
Carolyn Downs	Brent Council - Non Voting
Phil Porter	Brent Council - Non Voting
Dr Melanie Smith	Brent Council - Non-Voting
Gail Tolley	Brent Council - Non-Voting

Substitute Members (Brent Councillors)
Councillors:

Farah, Miller, Southwood and Tatler

Councillors:

Kansagra

For further information contact: Tom Welsh, Governance Officer
020 8937 6607; tom.welsh@brent.gov.uk

For electronic copies of minutes, reports and agendas, and to be alerted when the minutes of this meeting have been published visit: **www.brent.gov.uk/committees**

The press and public are welcome to attend this meeting

Notes for Members - Declarations of Interest:

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

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

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

***Disclosable Pecuniary Interests:**

(a) **Employment, etc. -** Any employment, office, trade, profession or vocation carried on for profit gain.
(b) **Sponsorship -** Any payment or other financial benefit in respect expenses in carrying out duties as a member, or of election; including from a trade union.
(c) **Contracts -** Any current contract for goods, services or works, between the Councillors or their partner (or a body in which one has a beneficial interest) and the council.
(d) **Land -** Any beneficial interest in land which is within the council's area.
(e) **Licences-** Any licence to occupy land in the council's area for a month or longer.
(f) **Corporate tenancies -** Any tenancy between the council and a body in which the Councillor or their partner have a beneficial interest.
(g) **Securities -** Any beneficial interest in securities of a body which has a place of business or land in the council's area, if the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body or of any one class of its issued share capital.

****Personal Interests:**

The business relates to or affects:

(a) Anybody of which you are a member or in a position of general control or management, and:
- To which you are appointed by the council;
- which exercises functions of a public nature;
- which is directed is to charitable purposes;
- whose principal purposes include the influence of public opinion or policy (including a political party of trade union).

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

or

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

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

Agenda

Introductions, if appropriate.

Item Page

1 Apologies for Absence and Clarification of Alternate Members

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

2 Declarations of Interest

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

3 Minutes of the Previous Meeting 1 - 8

To approve as a correct record, the attached minutes of the previous meeting held on 5 October 2017.

4 Matters Arising (If Any)

To consider any matters arising from the minutes of the previous meeting.

5 Focus on New Models of Care - Integrated Commissioning 9 - 92

Brent Council recently commissioned external consultants EY LLP to work with Brent Council and Brent Clinical Commissioning Group to: Develop a high-level framework for integrating commissioning functions; and Identify options for integrating commissioning in two specific areas, children's therapies and Continuing Health Care (CHC, brokerage element of the service). This report provides the proposals for integration of commissioning between the Council and CCG.

6 Brent Health and Care Plan Update: Focus on Prevention 93 - 96

The purpose of this report is to provide the Health and Wellbeing Board (HWB) with a further update on the progress of the delivery of the Prevention work stream, as part of Brent's Health and Care Plan.

7 Integrated Urgent and Emergency Care Developments 97 - 118

This Report provides the Health and Wellbeing Board with an update on

the latest development of Integrated Urgent Care (IUC) within Brent and more widely across North West London. This Programme is being developed and will be mobilised on a STP wide basis.

8 Improving the GP Extended Access Offer in Brent 119 - 148

This report provides the Health and Wellbeing Board with an update on the review of GP extended access in Brent. This report gives the Board an overview of the review process and the model being commissioned. It also reports the findings from our public engagement period which ran from 13 November 2017 until 9 January 2018.

9 Any Other Urgent Business

Notice of items to be raised under this heading must be given in writing to the Head of Executive and Member Services or his representative before the meeting in accordance with Standing Order 60 and paragraph 12 of the Council's Access to Information rules.

10 Date of Next Meeting

The next scheduled meeting of the Health and Wellbeing Board is on Tuesday 27 March 2018.

Please remember to ***SWITCH OFF*** your mobile phone during the meeting.

- The meeting room is accessible by lift and seats are provided for members of the public on a first come first served basis.

Brent

MINUTES OF THE HEALTH AND WELLBEING BOARD
Held on Thursday 5 October 2017 at 7.00 pm

MEMBERS PRESENT:

Councillor Hirani (Chair), Dr Ethie Kong (Vice-Chair of the Health and Wellbeing Board; Chair and Co-Clinical Director, Brent Clinical Commissioning Group), Sheikh Auladin (Interim Chief Operating Officer, Brent Clinical Commissioning Group), Dr Sarah Basham (Vice Chair and Co-Clinical Director of Brent Clinical Commissioning Group), Councillor Butt, Councillor Colwill, Carolyn Downs (Chief Executive, Brent Council), Julie Pal (Chief Executive, Healthwatch Brent), Councillor M Patel, Phil Porter (Strategic Director of Community Wellbeing, Brent Council), Dr Melanie Smith (Director of Public Health, Brent Council), Gail Tolley (Strategic Director of Children and Young People, Brent Council)

Also Present: Duncan Ambrose (Assistant Director, Brent Clinical Commissioning Group), Dr Arlene Boroda (Designated Doctor for Unexpected Child Deaths, Brent Clinical Commissioning Group), Helen Duncan-Turnbull (Head of Adults Services, Complex Care, Brent Council), Ralph Elias (Head of Planning and Programme Management Office, London North West NHS Trust), Ian Niven (Head of Healthwatch Brent), Councillor Shahzad

1. **Apologies for Absence**

   An apology for absence was received from Councillor McLennan.

2. **Declarations of Interests**

   There were no declarations of interest by Members.

3. **Minutes of the Previous Meeting**

   It was **RESOLVED** that the minutes of the previous meeting held on 14 June 2017 be approved as an accurate record of the meeting.

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

   There were no matters arising.

5. **Order of Business**

   The Chair outlined that there would be an alteration of the agenda order, which differed from the publication of the original agenda pack. It was **RESOLVED** that the agenda would be re-arranged so that the substantive items would be heard as follows:

   - Agenda Item 6 – Brent Child Death Overview Panel Annual Report;

- Agenda Item 7 – Brent Health and Care Plan – Learning Disabilities Update – Transforming Care;
- Agenda Item 8 – Overview and Scrutiny Task Group Report;
- Agenda Item 9 – Healthwatch Brent – From Words to Action 2016-2017 Annual Report;
- Agenda Item 10 – Health Inequalities Strategy – Mayor of London Consultation;
- Agenda Item 11 – Better Care Fund: 2017-2019 Plan; and
- Agenda Item 12 (items to be taken together) – Brent Children's Trust Update and Approval of draft written statement of action in response to the Ofsted/CQC joint local area Special Educational Needs and Disabilities (SEND) Inspection.

6. **Brent Child Death Overview Panel Annual Report: 01 April 2016 - 31 March 2017**

Dr Melanie Smith (Director of Public Health, Brent Council) introduced the report which analysed the Sudden Unexpected Deaths in Infancy (SUDI) since the commencement of the Child Death Overview Panel (CDOP) processes in 2008. She encouraged members of the board to consider how they could assist in promoting awareness of the need for infant safe sleeping in order to prevent accidents.

Dr Arlene Boroda (Designated Doctor for Unexpected Child Deaths, Brent Clinical Commissioning Group) added that the annual report had been brought to the Health and Wellbeing Board in order to spread the findings more widely. She said that there was a desire to develop a more holistic approach to tackling these problems and to link CDOP processes to other relevant organisations. She also drew Members' attention to the case studies within the report which detailed where a coroner had issued a 'Rule 28' (which provided coroners with the duty to make reports to a person, organisation, local authority, government department or agency where the coroner believed that action should be taken to prevent future deaths). She noted that it was important for all of the information and lessons learnt from Rule 28 cases, to be collated and disseminated effectively.

The Chair referenced paragraph 1.7 of the covering report and questioned whether the child death reviews spanned across different years, rather than solely looking at the deaths notified in 2016-2017. Dr Smith stated this was correct and that the reviews were not all from cases of the same year of notification. Dr Boroda added that time lags had often been caused because of the need to follow due process, particularly when coroner's inquests or police investigations needed to be completed before the review could begin.

(Dr Ethie Kong and Dr Sarah Basham joined the meeting at 7.08pm)

Questions were also raised on the steps which were being taken on a national level to address this issue, and whether there were any notable recent upwards or downwards trends on SUDI notifications within the findings. Dr Boroda stated that the Department of Education (DfE) were presently collating the statistics from across the country in this area and that the Department of Health (DH) would be taking over this function in the future. She also noted that at a London level Brent CDOP and Brent Local Children's Safeguarding Board (LSCB) had engaged with

the Healthy London Partnership and different voluntary agencies in order to network and ensure that the lessons learnt had been shared extensively. On trends, Dr Smith outlined that the total number of reported child deaths in Brent were largely on a downwards trend, but this could unfortunately change year-on-year. Dr Boroda stated that there also needed to be a focus on vulnerable adolescents in order to avoid preventable deaths in areas such as knife crime, road traffic accidents and gun crime.

Additional questioning arose on the statistics within the report, which included why St Mary's Hospital was the location with the highest number of recorded deaths, and why there appeared to be a high proportion of child deaths from Eastern European or Romanian ethnicities. Dr Boroda explained that St Mary's Hospital had an intensive care and trauma unit for children which could be attributed in part as to why the more deaths were recorded there. Dr Smith commented that health visiting centres had highlighted an emerging trend of Eastern European families with risk factors which related to SUDI, however she said that the overall reason for the high proportion of child deaths was not clear. She added that dedicated practitioners with translation skills across health and care settings would be beneficial to better understand these trends.

Dr Smith also outlined to the Board that an additional focus of Brent CDOP was on maternal health and the different risk factors (such as body-mass index, obesity, vitamin uptakes) which were thought to be associated with sudden unexpected child deaths. It was agreed that report which specifically considered maternity data and its possible correlation with unexpected child deaths be produced for consideration at a future meeting of the Health and Wellbeing Board. It was noted that this would need to be a closely collaborative piece of research between both the Council and Brent Clinical Commissioning Group (CCG), and that assistance with Healthwatch Brent would also be needed to assist with any community outreach work arising from this.

It was **RESOLVED** that:

(i) The Brent CDOP Annual Report be noted;

(ii) A report be produced by Officers which assessed the underlying causes of why there had been a higher proportion of Eastern European and Romanian child deaths;

(iii) A report be produced by Officers which assessed the maternity data from child death cases and whether there were any notable trends on early or late maternity or attendance at antenatal classes, and an analysis of how Brent's annual child death notifications compared to LSCBs in the Home Counties; and

(iv) In connection with resolution (iii), the Chair would write to any local NHS Trusts who refused to provide maternity data, to encourage them to do so in order to form part of the research; and

(v) Healthwatch Brent would assist with any community outreach work to raise awareness of SUDI in the borough.

7. **Brent Health and Care Plan - Learning Disabilities Update - Transforming Care**

Helen Duncan-Turnbull (Head of Adults Service, Complex Care, Brent Council) introduced the report which provided the Board with a progress update on the transforming care priorities within Brent's Health and Care Plan. She explained that, in light of the Winterbourne View Hospital scandal in 2011, there had been a national programme to transform care for people with learning disabilities based on individuals at risk of hospital admission being identified and services being transformed within the community. She gave an overview of the four work streams under the Brent Transforming Care Program (TCP) and outlined that there were now only seven in-patients in Brent who had a learning disability. She updated the Board on recent key areas of progress at the local level such as: the early intervention blue light protocol being implemented; a wrap-around discharge service being formulated; the planned establishment of a Brent Autism Board; and integrated team operating in shadow form from September 2018 and expected to be fully operational by April 2019. She also noted some of the challenges which related to: specialist commissioning; funding; and delays which related to the development of certain elements of the market management strategy.

Helen Duncan-Turnbull continued and highlighted some of the key priorities being pursued in this area at North West London (NWL) level (included in paragraph 3.4 of the report). She drew Members' attention to the Learning Disability and Autism Strategy 2017-2020 (attached as appendix 1 to the report) which had been agreed and signed off on the Council's side. She also ran through the four key 'enablers' which had been identified as essential elements to the strategy being successful. Duncan Ambrose (Assistant Director, Brent CCG) added that the progress of the work at NWL level had been beneficial and outlined that different provisions to meet the needs of adults with learning disabilities in a community setting at the Kingswood Centre was an example of this. He also said it would be useful to link with the Association of Directors of Adult Social Services (ADASS) on their learning disability work stream. He concluded by stating that, on the CCG's side, the Autism Strategy 2017-2020 was presently working its way through the CCG's own governance process before it could be signed off.

A question was asked on the plans for an integrated learning disability team and whether the time gap between the team operating in a shadow form (from September 2018) to being fully operational (April 2019) could be reduced. Duncan Ambrose responded and stated that there remained a need to understand the costs and benefits to a fully integrated team and that the shadow arrangements gave both the CCG and Council a suitable timetable to be able to consider the different operational options.

The Chair referenced the statistics contained within page 12, appendix 1, of the agenda pack (on the prevalence of learning disability nationally, and the statistics within Brent) and questioned whether the figures were precise or if they had been approximated. Dr Melanie Smith stated that the first set of figures were a direct application of what the percentage of national population known to have a learning disability would equate to in relation to Brent's population size. She also stated that the second set of figures, on the number of adults known to have learning disability in Brent, was an indication of the precise number of people known to the borough's health and social care services. Helen Duncan-Turnbull said that there were also people across the borough who accessed non-statutory support services and

therefore were not in direct contact with either the Council or CCG. She explained that this meant that the numbers of adults with a learning disability in Brent could actually be higher than presently recorded.

Discussions continued on the need to ensure that Brent's data for individuals with learning disabilities was as accurate and up-to-date as possible. A point was made that General Practices (GPs) kept a register of people with learning disabilities in accordance with data collected as part of the Quality and Outcomes Framework (QOF). The Board agreed that this data should be analysed against the figures included in the report: on both the adults registered by Brent CCG and those known to Brent Council as users of statutory funded services.

It was **RESOLVED** that:

(i) The progress report be noted;

(ii) The direction on travel of the Transforming Care Programme be agreed; and

(iii) That relevant Officers from both the CCG and the Council arrange to jointly assess the data on adults with learning disabilities known across health across social care settings in Brent, including a comparison of the register held by GP practices.

8. **Overview and Scrutiny Task Group Report: Brent's Child and Adolescent Mental Health Services**

The Chair explained that the task group report had recently been presented at both Cabinet (on 11 September 2017) and the Community and Wellbeing Scrutiny Committee (on 19 July 2017). He thanked Councillor Shahzad for being in attendance to answer the Board's questions on the task group report.

A Member of the Board asked whether the task group had found there to be one key factor which impacted upon young people's mental health. Councillor Shahzad indicated that there was no overriding factor but said that task group report had been very extensive and found that the issue of mental health for children and adolescents was much wider and deeper than was previously thought. He stated that he felt that the task group should continue its work on an annual basis to ensure that the issue is tackled effectively. He said that this was a national issue, but he was pleased that Cabinet had noted the task groups' recommendations for how this should be addressed at a local level.

It was **RESOLVED** that the recommendations and contents of the task group's report be noted.

9. **Healthwatch Brent - From words to action - 2016-2017 Annual Report**

It was **RESOLVED** that the progress Healthwatch Brent has made in delivering contract, as detailed within their annual report, be noted.

10. **Health Inequalities Strategy - Mayor of London Consultation**

The Chair stated that members of the Board had already had the chance to comment on the draft consultation response but any additional comments would be welcome.

Discussions ensued on how effective the Mayor's strategy would ultimately be in tackling health inequalities and what impact, if any, it would have on Brent at a local level. Several Members of the Board indicated that it was particularly positive that mental health had been identified as a priority within the 'healthy minds' scheme. The work of Thrive LDN was also praised as it was felt that their work could help change the way that mental health was discussed. It was also mentioned that Thrive had also undertaken similar work in New York which had been successful in raising awareness of mental health stigma, and had been pushed forward by a similar level of political support from the Mayor of New York. Members also felt it was significant that elements of the strategy were dedicated to addressing London's air quality and improving inequalities on respiratory conditions.

There were additional discussions on how the strategy would be funded and the Board felt that the Mayor would benefit by being more ambitious in seeking additional resource-raising powers from Central Government to support the plans.

It was **RESOLVED** that:

(i) The response to the consultation be agreed along the lines of Section 7 of the report subject to additional detail being added to propose that the Mayor call for further devolution and resource-raising powers from Central Government in order to fund the proposals; and

(ii) The draft consultation response be circulated to members of the Board for final comments prior to the final submission date on 30 November 2017.

11. **Better Care Fund: 2017-2019 Plan**

The Chair introduced the item and outlined that the full Better Care Fund (BCF) 2017-2019 plan had been submitted to NHS England (NHSE) after it was previously approved at a working meeting of the Board on 22 August 2017.

Zac Arif (Director of Integration, Community Wellbeing, Brent Council) added that the plan had been submitted on 11 September and that the initial response from NHSE outlined that they felt the plan was both strong and robust. He thanked colleagues for their support in constructing the document.

It was **RESOLVED** that the final Better Care Fund 2017-2019 Plan, which had been submitted to NHSE, be noted.

12. **Brent Children's Trust Update and Approval of draft written statement of action in response to the Ofsted/CQC joint local area Special Educational Needs and Disabilities (SEND) inspection**

Gail Tolley (Strategic Director of Children and Young People, Brent Council) outlined that it would be beneficial for the Board to discuss both the Brent Children's

Trust (BCT) Update and approval of the draft written statement of action at the same time. She outlined that this was in part because much of the work of the BCT had been to assist with preparations for the inspection by the Ofsted and Care Quality Commission (CQC) joint inspection team.

She firstly highlighted some of the other key BCT specific updates from the period between April 2017 and September 2017, as detailed within paragraph 3.4 of the report. These included: the substantive work undertaken on CAMHS transformation; establishing a better connection between the Troubled Families Programme and Working with Families Brent Partnership work; and facilitating meetings between midwives at Imperial, the Royal Free and Northwick Park to improve the links between midwives and health visitors.

Gail Tolley moved onto the local area joint Ofsted and CQC inspection of Special Educational Needs and Disabilities (SEND) services in Brent which took place between 15 May and 19 May 2017. She gave an overview of the inspection itself and outlined that Ofsted/CQC had identified a number of strengths in Brent's local service provisions. She outlined that partnership between the Council and schools had been identified as being extremely strong in particular. However, the Board heard that, regrettably, the Council had been asked to write a written statement of action due to a number of concerns which were identified as part of the inspection process (detailed in paragraph 3.2 of the report). She explained that the NHSE Region Lead for SEND and Department of Education SEND Advisor for Brent had reviewed the initial written statement of action on 26 September, and that their suggestions had been incorporated into the statement presented before the Board. Gail Tolley concluded that the final written statement submission would be made to the CQC/Ofsted by 23 October 2017, with the Health and Wellbeing Board's approval being required beforehand. She also mentioned that Brent would be subject to quarterly monitoring visits, and it was therefore essential that the actions contained within the written statement were put in practice at pace and that this would require substantial strategic leadership.

Members raised that there were ongoing problems with vacancies in Occupational Therapy (OT) Posts at London North West Healthcare NHS Trust which had contributed to some of the problems in this service area. It was noted that the Trust had been assessing different recruitment strategies in order to address this. Ralph Elias (Head of Planning and Programme Management Office, London North West NHS Trust) added that he couldn't answer specific questions on the timeline for completion of recruitment as this would depend on the market. However he outlined that OT vacancies were a problem nationally and that there were suggestions that the Trust should use its capabilities as a training organisation to address the issue in the long term. Duncan Ambrose added that recruitment problems affected waiting times and that the CCG were working alongside the Trust through weekly teleconferences and management meetings in order to find adequate solutions. Members noted that the recruitment problems on OT needed to be escalated to NHSE as it was a national issue and it be highlighted that Brent was not alone in the problems it faced.

There were final discussions on what the review of the terms of reference of the Brent Children's Trust would entail and whether the current membership should be expanded.

It was **RESOLVED** that:

(i) The work of the Brent Children's Trust for the period April 2017 to September 2017 be noted;

(ii) Subject to the inclusion of a specific recommendation that a senior representative from London North West Healthcare NHS Trust be included as part of the membership of the Brent Children's Trust, the written statement of action for submission to Ofsted and the CQC be approved; and

(iii) The Health and Wellbeing Board be frequently updated on the progress of the five key actions outlined within the Written Statement of Action.

13. **Exclusion of Press and Public**

There were no items on the agenda which required a resolution to exclude the press and public. The approval of draft written statement of action in response to the Ofsted/CQC joint local area Special Educational Needs and Disabilities (SEND) inspection, which was initially listed as part exempt on the agenda pack front sheet, contained no exempt information and was fully open to the press and public.

14. **Date of Next Meeting**

The date of the next meeting was noted as being 24 January 2018.

15. **Any Other Urgent Business**

There was no other urgent business to be transacted.

The meeting was declared closed at 8.00 pm

COUNCILLOR KRUPESH HIRANI
Chair

Brent NHS Brent Clinical Commissioning Group	**Health and Wellbeing Board** 24 January 2018
	Report from the Strategic Director of Community Wellbeing & Chief Operating Officer, NHS Brent CCG

Focus on New Models of Care – Integrated Commissioning

Wards Affected:	All
Key or Non-Key Decision:	N/A
Open or Part/Fully Exempt:	Open
No. of Appendices:	None
Background Papers:	EY Report – Integrated Commissioning in Brent, December 2017
Contact Officers:	Zac Arif Director Integration, Brent Council and NHS Brent CCG Tel: 020 8937 2298 zac.arif@brent.gov.uk

1.0 Introduction

1.1 Brent Council commissioned external consultants EY LLP to work with Brent Council and Brent CCG to:

- Develop a high-level framework for integrating commissioning functions; and;
- Identify options for integrating commissioning in two specific areas, children's therapies and Continuing Health Care (CHC, brokerage element of the service).

2.0 Recommendation

2.1 Note the report and comment on the proposals for integration of commissioning between the Council and CCG.

3.0 Summary

3.1 Strategically, Brent CCG and Brent Council believe that integrated commissioning is fundamental to the successful delivery of the Brent Health and Care Plan. There is a strong commitment to integrate commissioning functions where they achieve better outcomes for the citizens of Brent. It is recognised that the journey to achieve this is not an easy one and will need to take account of changes within North West London and deal with the complexities of commissioning and procurement. The Council and CCG agreed that external support was required to help define a Brent model and approach for integrated commissioning and to provide an implementation plan to support getting to that agreed state.

3.2 Two service areas were chosen for the first phase of integration; children's therapies and Continuing Healthcare (CHC) brokerage.

3.3 Brent local area was inspected between 15 May 2017 and 19 May 2017 by the Office for Standards in Education (OfSTED) and the Care Quality Commission (CQC), to gauge how effectively the area is delivering the Special Educational Needs and Disabilities (SEND) reforms contained within the Children and Families Act 2014. The inspection found significant strengths within the local system but also areas requiring improvement, one of which was joint commissioning of children's therapy services. Joint commissioning of children's therapies will ensure there are no gaps between services and will help ensure timely access to services, including for vulnerable groups of children and is an agreed priority for Brent Children's Trust and Health and Wellbeing Board.

3.4 Brent Council has a well-established brokerage and placements function serving the council's needs. Locally, work has been taking place to stream line systems and processes as well as better manage the residential and nursing market and associated costs. A single brokerage and placements function across the CCG and Council will enable better use of existing resources, obtain value for money in securing placements and overall improve the quality of outcomes. This is also one of the Better Care Fund (scheme 3) objectives.

3.5 Work was completed over a six-week period (November and December 2017) and overseen by a project board consisting of senior officers from both the Council and the CCG. The Board was chaired jointly by the Strategic Director Community Wellbeing Brent Council, the Strategic Director Children and Young People Brent Council and the Chief Operating Officer, Brent CCG.

3.6 A high-level goal for each area of work along with a set of suggested measures of progress were developed. The overall goal of this work was to help make improvements to outcomes through better alignment of commissioning in Brent, which would lead to:

- Improved outcomes achieved by commissioned services
- Greater alignment of services

- Improved value for money
- Improved satisfaction of service users/ patients and relatives
- More effective overall commissioning function.

The attached report is the outcome of this work and outlines detailed findings, and makes recommendations to implement these findings.

4.0 Next Steps

4.1 A high-level framework has been suggested and is intended to allow progress to be made in the medium to longer-term. This will require further discussion and consideration locally and comments are welcomed.

4.2 Specific recommendations have been made in the report on how integration within the two operational areas under review can be implemented. In the short term, two operational groups will be established drawing upon existing expertise from both the CCG and Council teams working together and across the existing governance arrangements.

CHC:

- Council and the CCG will integrate the brokerage, invoicing and contract management function under the management of the Council.
- Council and the CCG will create two additional posts under the Better Care Fund to help improve the quality of care provided in care homes and to link them to broader care pathways.

Children's therapies:

- Create integrated children's therapies commissioning team led by the Council.
- Agree memorandum of understanding (MoU) that will draw out what therapy services are provided on which contract to ensure alignment.
- Provide governance training and internal and external workshops on how integrated team can be effective, linked to specific goals.
- Develop a three-year plan, agreed by the Children's Trust Board.

4.3 A draft project plan has been prepared to guide this work in the short term (up to April 2018), medium term (2018/19) and longer term (2020/21).

5.0 Financial Implications

5.1 A high level overview of the resources required to take this work forward have been mapped out as part of this report and consideration has been given to;

- Time required from existing teams and senior management
- Project management support where required and,
- Specialist support (e.g. IT, HR Finance) as may be required.

In the main, resources will largely be sourced internally to ensure local implementation and ownership.

6.0 Legal Implications

6.1 None.

7.0 Equality Implications

7.1 Children with Special Educational Needs and Disability are a vulnerable group. The development of joint commissioning will improve the outcomes for these children.

8.0 Consultation with Ward Members and Stakeholders

8.1 Consultation with all relevant stakeholders remains ongoing.

9.0 Property / Human Resources Implications

9.1 None.

Report sign off:

PHIL PORTER
Strategic Director of Community Wellbeing

SHEIK AULADIN
Chief Operating Officer, Brent NHS CCG

Integrated commissioning in Brent

EY report

December 2017

Building a better working world

Contents

Executive summary

Scope and aims of this work

During the summer of 2017, Brent Council and Brent CCG undertook a review of the potential for integrated commissioning of health and care services in Brent. Further to the results of this review, the Council commissioned EY to work with the Council and the CCG to:

- Develop a high-level framework for integrating commissioning functions
- Identify options for integrating commissioning in two deep-dive areas:
  - Nursing and residential placements
  - Children's therapies.

This work was overseen by a project board consisting of senior officers from both the Council and the CCG. To guide this work, the board agreed a high-level goal for each area, along with a set of suggested measures of progress. This work was completed over a six-week period during November and December 2017.

Vision for integrated commissioning in Brent

There is a strong commitment within both the Council and CCG to integrate commissioning functions, with a view to achieving better outcomes for the citizens of Brent, albeit without a clear view of what this might ultimately mean for the two organisations concerned.

There are some differences as to whether and how to integrate governance structures, roles/teams and budgets, and also different views on the pace of integration. The complexity of commissioning and procurement arrangements across NW London is also a factor that needs further consideration.

This high-level framework is intended to allow progress to made in parallel with further work to address these factors and to make progress with deeper integration in the longer-term.

Executive summary

Vision for integrated commissioning in Brent, continued

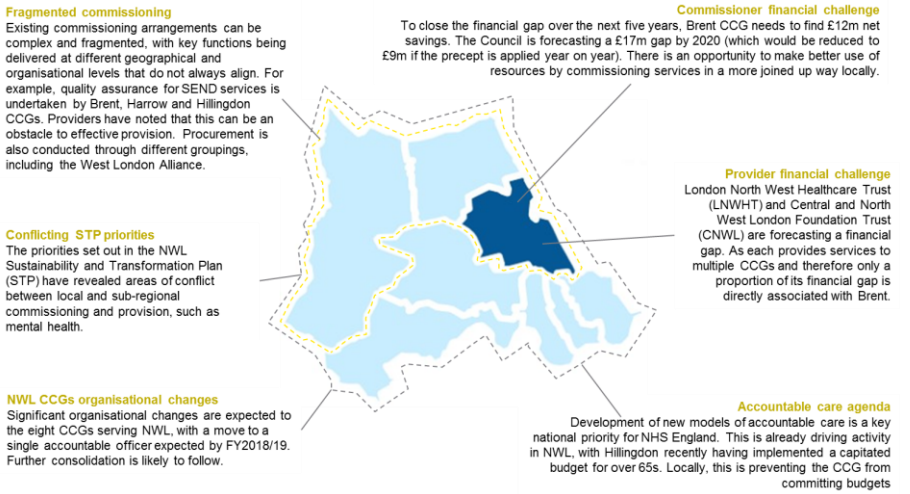
The high-level framework recognises that deeper integration of commissioning will need to take into account the complexities of both NW London and local considerations, in addition to responding to the priorities set out in the Brent Health and Care Plan.

There are barriers to achieving this, however, and the end-state for integrated commissioning is unclear.

A jointly commissioned, population-based model of care has the potential to drive behaviours that will overcome obstacles to better care which are inherent in current arrangements. The features of this model include a single budget allocated by commissioners (which could be aligned or pooled), a single provider or group of providers who collaborate to meet the needs of the defined population and a contract which specifies the outcomes and other objectives that should be achieved.

Such an arrangement would act as a catalyst for closer integration of commissioning. There would be flexibility as to which areas of commissioning such an arrangement would apply, and the pace with which it is implemented.

Complexities to be addressed across NWL



Priorities in the Brent Health and Care Plan

Your key priorities by 20/21		Risks to these priorities identified in our work	Mitigations
Health and wellbeing	**Holistic approach to wellbeing, services as joined up as possible**	• Current fragmented commissioning arrangements sometimes translate to fragmented services – as highlighted recently by LNWHT in a letter to commissioners.	• Stronger commissioner focus on patient-centrered models of care is needed deliver a step change in holistic provision of health and social care
	Focus on early intervention and prevention	• With the current commissioning approach providers are not incentivised to deliver proactive, joined up care	• Commissioners must encourage closer provider collaboration and communication to support more preventative and proactive care
Care and quality	**Highly skilled workforce working together across health and social care, increasingly integrated approach to commissioning**	• There are cultural differences between the Council and CCG which threaten further successful collaboration • Stakeholders have expressed views that gaps in competency may pose a risk to successful delivery under new structures	• Organisational development work is needed to support change • Competency mapping should be used to ensure new structures are supported by the right skill mix
	Provider joint accountability for quality and outcomes	• The existing commissioning approach does not support joint accountability amongst providers	• Alignment of provider contracts would increase joint accountability
Finance and efficiency	**Providers working together more efficiently and maintaining financial balance**	• The commissioning approach does not adequately encourage collaboration between providers to make the best use of resources and interventions	• Commissioners must incentivise providers to improve outcomes and efficiency
	Reduced demand for acute and residential care through better management of patients with complex needs	• A lack of a patient-centred approach reduces the effectiveness of care, particularly for those with complex needs	• Commissioners need to support increased focus on the patient in the design of future delivery models

Executive summary

Vision for integrated commissioning in Brent, continued

There are different approaches to delivering accountable care. A "multi-specialty community provider" (MCP) approach brings together primary, community, mental health and social care services. This approach is already being considered by Brent CCG, as part of the national direction of travel being set by NHS England. To implement an MCP model, a number of factors would need to be considered, including:

- The outcomes to be achieved
- Patient/service user groups
- Services to be included
- Duration of the contract
- Procurement approach
- Governance structure to be employed
- Payment and contracting mechanisms, including risk and reward.

Brent Council and CCG will explore the potential application of this approach further in the coming months. Notwithstanding the approach to be followed, a potential road-map for further integration is emerging further to this work:

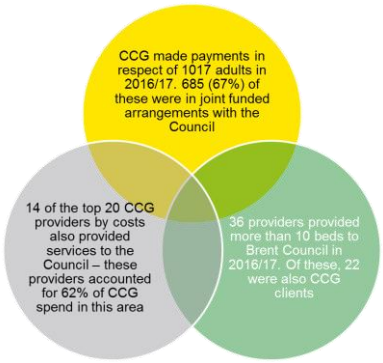
2017/18	2018/19	2020/21
• Steps towards integrated commissioning of residential and nursing and children's therapies services set out in implementation plan • Agree cohorts for next Wave 2 of expansion of integrated commissioning in adult social care which could include Community Mental Health, Learning Disabilities and frail elderly • Work to agree plans for further integration of commissioning for broader children's services and other areas • Assess models for new approaches to care and undertake organisational development review	• New integrated structures for CHC and SEND services effective April 2018 (Wave 1 areas) • Progress with wave 2 areas in adults and children's • Act on Organisational Development review • Progress towards models for new approaches to care	• Wave 3: Begin planning for multi-specialty community provider arrangements • Increasingly, provision of acute services at NWL level

Executive summary

Residential and nursing placements

Current state

Brent Council and CCG commission nursing and placement services separately, with different organisational structures and contractual frameworks. Nonetheless, there are significant overlaps in the population supported and the providers of services to this population. Combined Council and CCG spending on nursing and residential placements is £48.8m, with this budget facing significant funding pressure.



Across the two organisations, residential and nursing placements consists of seven core functions:

1. Strategic management
2. Contract alignment
3. Brokerage
4. Quality management
5. Budgets
6. Assessment of entitlement
7. Invoicing

Across these, there is a lack of alignment between the two organisations, with major differences in the contracting frameworks used, processes, systems and performance management of providers.

Proposals were developed for how to improve alignment across functions 1 to 4. Functions 5 to 7 (which are most closely related to funding) were out of scope of this review.

Executive summary

Residential and nursing placements, continued

Future state

For functions 1 to 4 the following proposals have been agreed between the Council and the CCG:

1. **Strategic management:** the Council and CCG will develop and take forward a shared strategic approach for the commissioning of nursing and residential care in line with the vision to improve outcomes through the greater alignment of commissioning in Brent
2. **Contract alignment:** the Council and the CCG will commission more services through contractual frameworks which support greater consistency in care provision, ideally through greater use of the AQP framework
3. **Brokerage:** the Council and the CCG will integrate the brokerage, invoicing and contract management function under the management of the Council
4. **Quality management:** the Council and the CCG will create two additional posts under the Better Care Fund to help improve the quality of care provided in care homes and to link them to wider care pathways.

Care will be taken to ensure that effective links remain to those functions that are out-of-scope. There remains the possibility that budgets could be pooled at a later date. A potential road-map for further development was also agreed and is set out below:

2017/18	2018/19	2020/21
• Creation of integrated CHC brokerage team, effective from April 2018 • Establishment of BCF 3 working group • Recruitment to new quality posts	• New ACP framework comes on stream • Alignment of contracts with integrated brokerage team deploying both AQP and DPS frameworks as appropriate • Move to shared database • Supply and demand analysis carried out at a West London level • Develop proposals for integration of services other areas (e.g. learning disabilities, Mental health and frail elderly) • Integrate nursing and residential providers into integrated care pathways	• Potential roll-out of integrated services to frail elderly population cohort

Executive summary

Children's therapies

Current state

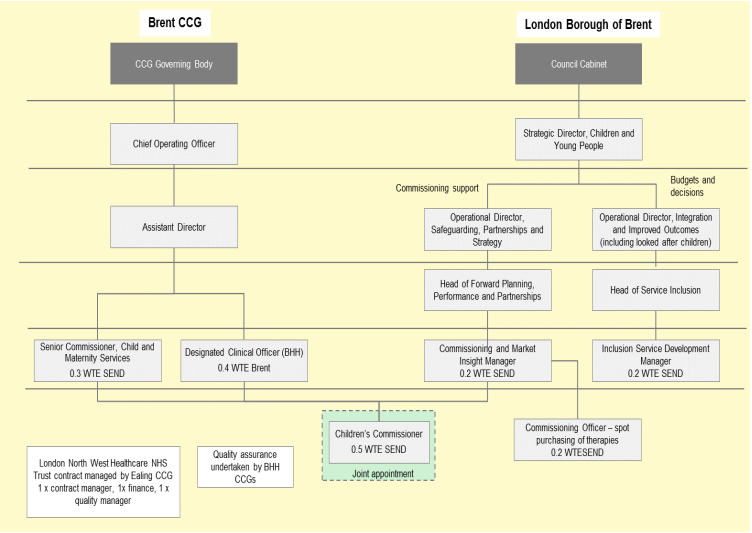
The commissioning of children's therapies was selected as a deep-dive area further to the CQC/Ofsted inspection and the subsequent Written Statement of Action (WSOA), dated 20 October 2017, which sets out a number of intentions regarding integrated commissioning arrangements.

The Children's Trust provides a joint governance arrangement for this work and shared goals have been set out in the WSOA. Formal processes are in place to involve NHS staff in the development of Education, Health and Care Plans.

Children's therapy services are commissioned via a small number of block contracts with London North West Healthcare NHS Trust and Central and North West London NHS Trust. There is some spot purchasing of support for out-of-area children.

Although the commissioning of these services is conducted by both the Council and the CCG, these services are commissioned separately at present, although there is one joint appointment between the two teams.

Current state commissioning structures



Executive summary

Children's therapies, continued

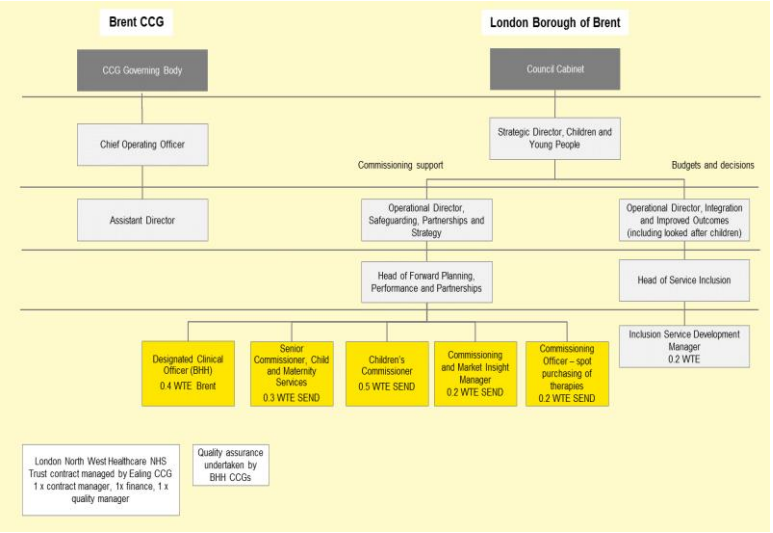
Future state

The Council and the CCG have agreed to a single integrated children's therapies team led by the Council. The Strategic Director for Children and Young People would be responsible for the performance of the team, would report periodically to the CCG and would be engaged in CCG Board discussions on relevant issues.

The integrated structure focuses on children's therapies in Brent, with child and adolescent mental health services (CAMHS) and other children's commissioning not included in the scope. This means that team members will spend some time as part of the integrated team and some time on other duties.

A memorandum of understanding would set out what will be commissioned under the different contracts for children's therapies to ensure alignment. The Council and the CCG are committed to closer alignment of commissioning of children's services, and have agreed to the development of a three-year plan to achieve this.

Future state commissioning structures



2017/18	2018/19	2020/21

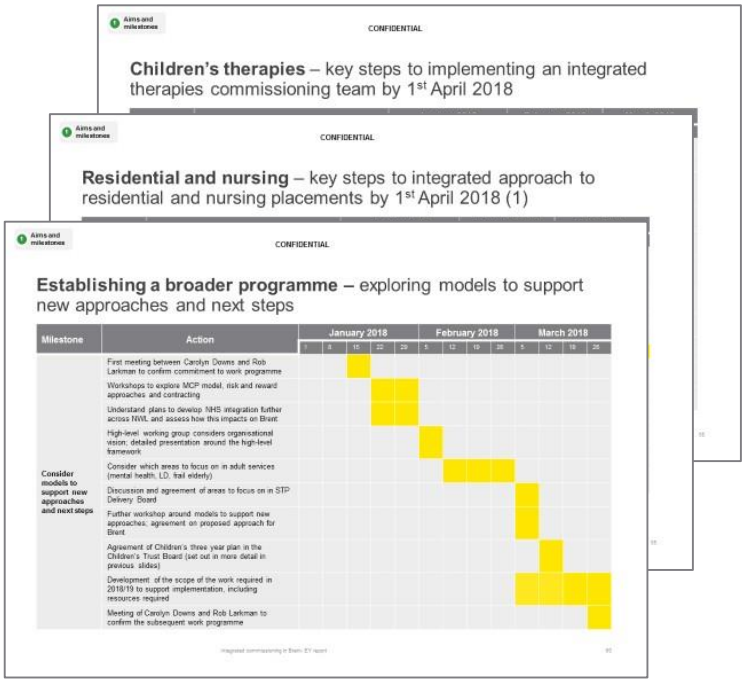
• Preparation for integrated children's therapies team:
  • Information governance training
  • Internal and external workshops on how the integrated team can be effective, linked to specific goals
• Development of three year plan, agreed in the Children's Trust Board
	• Consultation and engagement on the three year plan from April to August 2018
	• CCG gives commissioning intentions to providers by 30th September 2018
	• Disaggregation of children's therapies contract from CCG block contract with London North West by November/ December 2018
	• NWL-wide children's health commissioner network newly established, and Brent participation is expected. This will look as ASD, SEND, and CAMHS.
		• New commissioning arrangements come into place on 1st April 2019 in the new financial year

Executive summary

Establishing your integration plan

In order to maintain momentum with your work to integrate commissioning, proposals have been made for the following four key areas of implementation planning:

1. **Aims and milestones:** with supporting high-level plans, for the:
   - Implementation of the deep-dives by 1st April 2018
   - Development of a broader programme of integration during 2018/19 and beyond.
2. **Governance structures:** for the implementation of the deep-dives and the broader programme of integration
3. **Capacity and capability:** requirements for January to March 2018
4. **Risks and mitigations:** identified through this work, with potential mitigations to be carried out as part of the immediate next steps.



A major theme identified was the need to ensure greater cultural alignment between the Council and the CCG. To address this and support work around the above areas the project board agreed the following actions to be completed in January 2018:

1. Decision by both the Council and CCG to proceed with implementation of deep-dive recommendations
2. Meeting between chief executives of the Council and CCG to establish shared commitment to a broader work programme
3. Initial meetings between key Council and CCG senior managers to agree how to support integration in key areas – HR, IM&T and Finance

Section 1

Scope and aims

We have completed a six week engagement on integrated commissioning in Brent

Our work has focused on: i) the development of a high-level framework for integrated commissioning in Brent and ii) deep-dive analysis of integrated commissioning for residential and nursing placements and children's therapies. This version of the draft deliverable contains a new section on establishing your integration programme.

Week commencing	6th November	13th November	20th November	27th November	4th December	11th December
Governance/ Board meetings	Confirm scope	★		★ *Postponed as deep-dives taken forward in bilateral discussions*		★ ★
High-level framework	Develop and agree design criteria Develop draft high-level framework		Refine and agree high-level framework			
Deep-dives into SEND and CHC/ Placements	Draw together current state analysis		Develop options and carry out a clear process to identify the preferred option		Implementation planning and final handover	

Through discussion with key leads, we set the following goals and measures to guide this work

Overall goal: to make improvements to outcomes through the greater alignment of commissioning in Brent

How this could be measured:

- Improved outcomes achieved by commissioned services
- Greater alignment of services
- Improved value for money
- Improved satisfaction of service users/ patients and relatives
- More effective overall commissioning function

Children's therapies – to improve the quality of service co-ordination for children and parents

How this could be measured (taken from the Written Statement of Action):

- All children and young people with SEND including vulnerable groups receive timely support and access to services that help them maximise their potential
- Professionals feel more confident in identifying SEND, have the skills to assess need and develop SMART outcomes for children and young people
- Parents/carers are meaningfully participating in the design and delivery of services- 'do nothing about us without us'
- All parents/carers are actively engaged in the co-production of EHC Plans and agreeing outcomes for their child/ young person.
- More young people with SEND have access to employment and community activities to support them to lead independent lives
- The Council and the CCG jointly commission services for children and young people with SEND to ensure that the right provision is in place and children and young people have access to the services they need
- Children and young people with SEND make appropriate progress and outcomes are improved
- Waiting times for access to services are reduced in line with national guidelines
- Education Health and Care Plans are holistic in setting out all the needs of the child/young person, and are completed within required timescales
- Parents/Carers have access to support and services through the Local Offer, including a range of short breaks
- Parents/Carers report improved satisfaction with services that are better co-ordinated and reduce duplication – 'tell the story once'

Residential and Nursing – to improve the quality of care and the efficiency/ effectiveness of the commissioning process

How this could be measured:

- Improve quality of care for residents in care and nursing homes
  - Reduction in unplanned hospital admissions
  - Reduction in Delayed Transfers of Care
  - Reduction in incidents and subsequent inquiries
- Provide best value for money in Nursing and Residential commissioning

Section 2

Vision for integrated commissioning in Brent

Brent Council and CCG are committed to integrating commissioning functions but need to develop a programme of broader integration

There is a strong commitment by both the Council and CCG to integrate commissioning functions, with a view to achieving better outcomes for the citizens of Brent, albeit without a clear view of the what this might ultimately mean for the two organisations.

There are some differences as to whether and how to integrate governance structures, people/teams and budgets, and also different views on the pace of integration. The broader complexity of commissioning and procurement arrangements across NW London is also a factor that needs further consideration.

This high-level framework is intended to allow progress to made in parallel with further work to address these factors and to make progress with deeper integration in the longer-term.

As a starting point for this progress, it is essential to have a vision for integrated commissioning that sets out:

- The outcomes that the Council and CCG are seeking to achieve
- The broader context within which this work is taking place
- A road-map setting out the steps that can be taken in the next two years
- A basis for agreeing what the ultimate end-point is for the two organisations.

The deep-dives provide a basis for moving things forward in the short-term, and a basis for identifying some of the issues that will be faced in pursuing deeper and more extensive integration.

Deeper integration will need to take account of the complexities of NW London in addition to local considerations

Fragmented commissioning

Existing commissioning arrangements can be complex and fragmented, with key functions being delivered at different geographical and organisational levels that do not always align. For example, quality assurance for SEND services is undertaken by Brent, Harrow and Hillingdon CCGs. Providers have noted that this can be an obstacle to effective provision. Procurement is also conducted through different groupings, including the West London Alliance.

Conflicting STP priorities

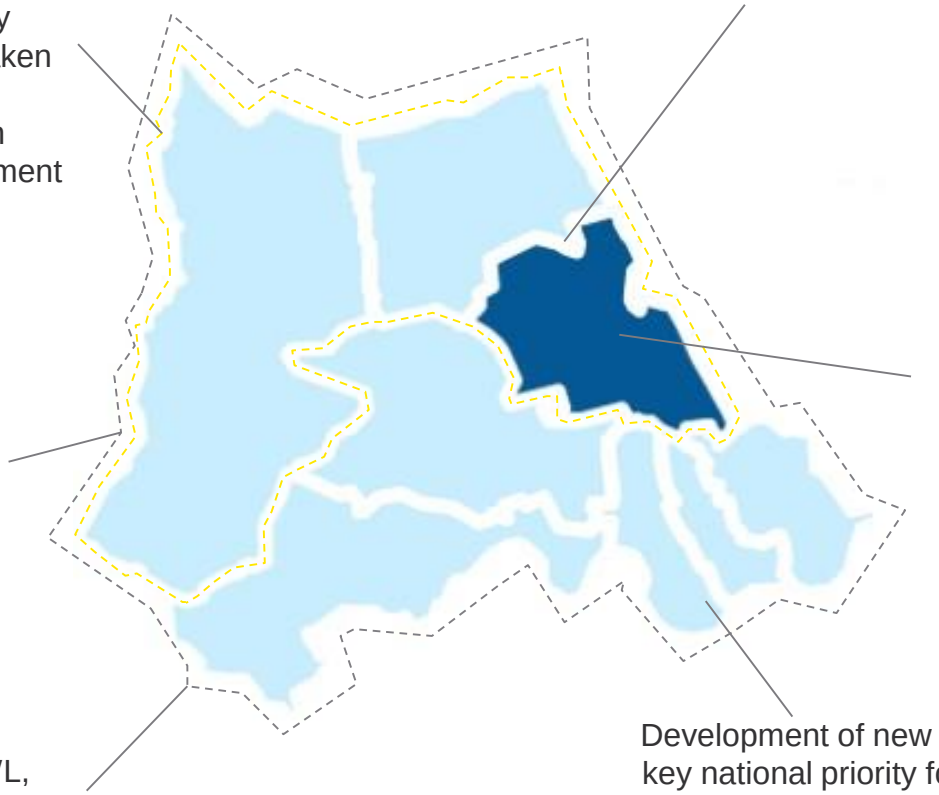
The priorities set out in the NWL Sustainability and Transformation Plan (STP) have revealed areas of conflict between local and sub-regional commissioning and provision, such as provision of mental health services.

NWL CCGs organisational changes

Significant organisational changes are expected to the eight CCGs serving NWL, with a move to a single accountable officer expected by FY2018/19. Further consolidation is likely to follow.

Commissioner financial challenge

To close the financial gap over the next five years, Brent CCG needs to find £12m net savings. The Council is forecasting a £17m gap by 2020 (which would be reduced to £9m if the precept is applied year on year). There is an opportunity to make better use of resources by commissioning services in a more joined up way locally.



Provider financial challenge

London North West Healthcare NHS Trust (LNWHT) and Central and North West London NHS Foundation Trust (CNWL) are forecasting a financial gap. Each provides services to multiple CCGs and therefore only a proportion of its financial gap is directly associated with Brent.

Accountable care agenda

Development of new models of accountable care is a key national priority for NHS England. This is already driving activity in NWL, with Hillingdon recently having implemented a capitated budget for over 65s. Locally, this is preventing the CCG from committing budgets

Integrated commissioning must respond to the priorities set out in the Brent health and care plan – but there are barriers to overcome

Your key priorities by 20/21		Risks to these priorities identified in our work in Brent	Mitigations
Health and wellbeing	**Holistic approach to wellbeing, services as joined up as possible**	• Fragmented commissioning arrangements sometimes translate to fragmented services – as highlighted recently by LNWHT in a letter to commissioners.	• Stronger commissioner focus on patient-centrered models of care is needed deliver a step change in holistic provision of health and social care
	Focus on early intervention and prevention	• With the current commissioning approach providers are not incentivised to deliver proactive, joined up care	• Closer provider collaboration and communication should be encouraged to support more preventative and proactive approaches to care
Care and quality	**Highly skilled workforce working together across health and social care, increasingly integrated approach to commissioning**	• Cultural differences between the Council and CCG threaten further successful collaboration • Stakeholders have expressed views that gaps in competency may pose a risk to successful delivery under new structures	• Organisational development work is needed to support change • Competency mapping should be used to ensure new structures are supported by the right skill mix
	Provider joint accountability for quality and outcomes	• The existing commissioning approach does not support joint accountability amongst providers	• Provider contracts should be aligned to support collective accountability for quality and outcomes
Finance and efficiency	**Providers working together more efficiently and maintaining financial balance**	• Brent commissioners do not adequately encourage collaboration between providers to make the best use of resources and interventions	• Commissioners must incentivise providers to collaborate more effectively to improve outcomes and efficiency
	Reduced demand for acute and residential care through better management of patients with complex needs	• A lack of a patient-centred approach reduces the effectiveness of care, particularly for those with complex needs	• Commissioners need to encourage increased focus on the patient in the design of future delivery models

A jointly commissioned, ‘population-based’ model of care could overcome obstacles to better care inherent in current arrangements

The current focus on closer commissioning of children’s therapies’ and residential and nursing placements demonstrates a clear intent to deliver high quality, joined up services to Brent residents.

However, as outlined on the previous slide, current commissioning arrangements present serious barriers – not only to achievement of the shared vision, but to delivery of high quality care now. A population-based model has the potential to address many of these by driving:

- Patient-centred care driving holistic provision
- Better use of the full range of local assets to serve the population
- Shared accountability and incentivisation driving providers to work together more effectively and efficiently

In addition, a move towards a population-based model would be in line with the national direction of travel, particularly from a health perspective, and would enable commissioners in Brent to strike the right balance between a local and sub-regional focus.

This would mean delivering local, patient-centred care to meet the unique needs of Brent residents while making the most of opportunities to deliver aspects of care across a broader footprint, ensuring high quality services and allowing commissioners to make the most of opportunities to realise economies of scale and leverage collective buying power.

Core components of a population-based care model

A population based model has three core characteristics:

1. **A single budget (aligned or pooled) allocated by commissioners to deliver a range of services to the defined population**
2. **A single provider or group of providers (accountable care organisation) that collaborates to meet the needs of a defined population**
3. **A contract specifying the outcomes and other objectives providers are required to achieve within the given budget**

There is no single structural model for an accountable care organisation (ACO). The two most well known models are:

- **multi-specialty, community based provider (MCP)** which provides primary, community, mental health and social care services
- **primary and acute care model (PACS)** which, in addition to the above services, provides most or all hospital services.

Adoption of population-based models of care is a key national priority for health and Brent CCG is being stewarded towards implementation of population based models in the short to medium term.

In Brent, the expectation is that the MCP model will be used, due to the increasingly sub-regional focus of acute services.

There is an opportunity for the Council to engage with this work now, working closely with the CCG to commission new MCP models for selected cohorts.

A move towards a population-based model could be implemented taking an incremental approach

There is recognition that the commissioners are in different places in terms of readiness to embrace an MCP model. There is also a reluctance locally, at this stage, to pursue further pooling of budgets.

There is no one size fits all approach of accountable care and areas are taking different approaches in line with their willingness and readiness to embrace change – we have included some examples below. Population-based models can be implemented on a cohort by cohort basis, by age group, condition and by age and condition. Commissioning budgets can also be aligned, rather than pooled.

The current focus in Brent on closer alignment of commissioning for residential and nursing placements and children's therapies is a strong foundation upon which to build towards a more ambitious model at the scale and pace that feels right locally.

Hillingdon accountable care partnership for over 65s

- In Hillingdon, the CCG and Council have jointly commissioned an Accountable Care Partnership (ACP) with a capitated budget to serve older people over the age of 65 in the borough
- Providers have pooled selected budgets in FY17/18 and the expectation is that a full capitated budget will be implemented by FY18/19

Wakefield multi-speciality community provider vanguard

- The Wakefield Vanguard is providing a wide range of health and social care services to people in their homes and communities with a focus on moving specialist care out of hospitals and redesigning care around the health of the population
- From April 2017, building on the successful pilot phase which started in 2015, Wakefield has started the process of rolling out a district-wide MCP model of care

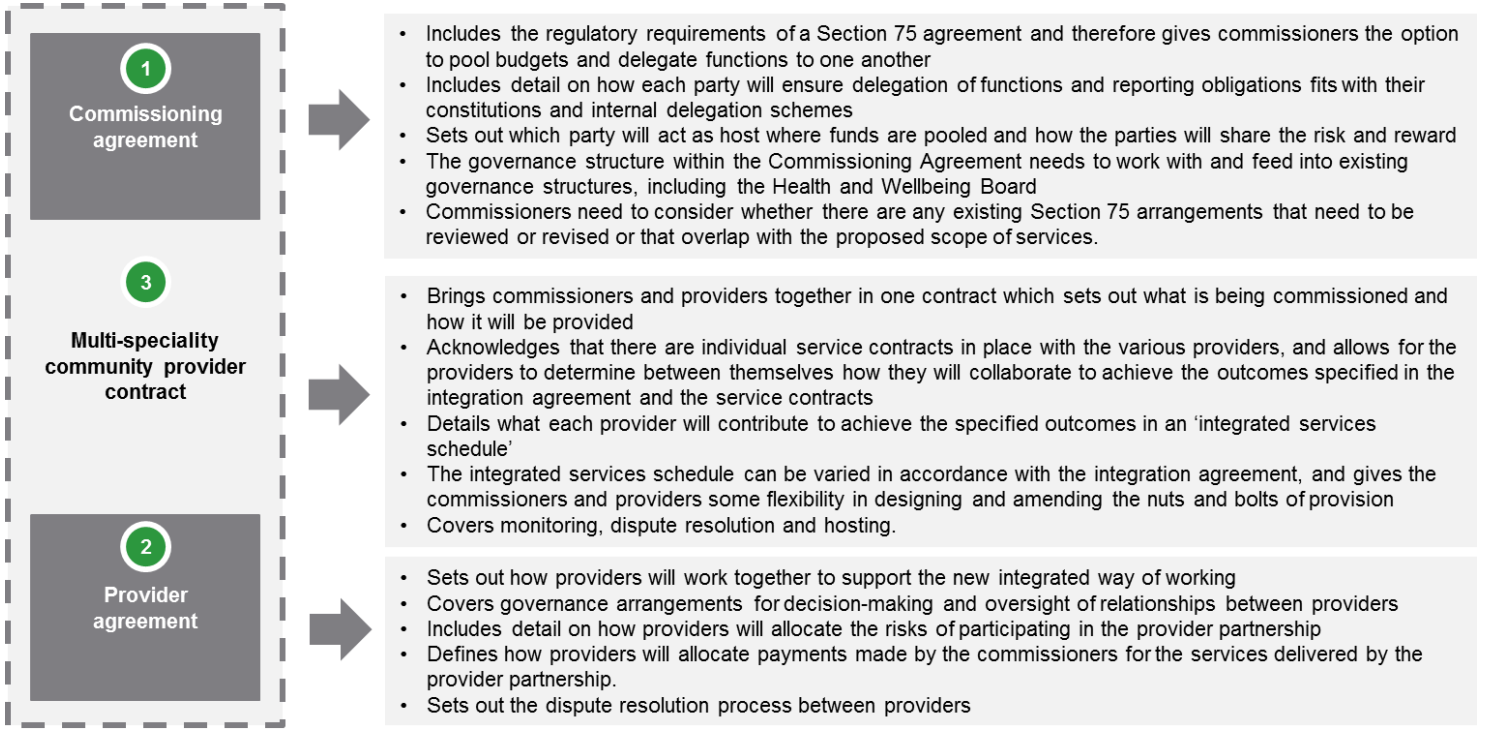
Doncaster ACS and integrated commissioning unit

- In Doncaster, the Council and CCG are working closely, together with local providers, to progress work towards an accountable care system.
- The work is starting with two focus areas, 'Complex Lives' and intermediate care, with a phased plan to upscale to strategic areas in 2018
- As part of the this work the Council and CCG plan to move to a single integrated commissioning unit

A framework of key agreements would be needed to support an accountable care model

Three types of agreement are needed to support a population-based accountable care model:

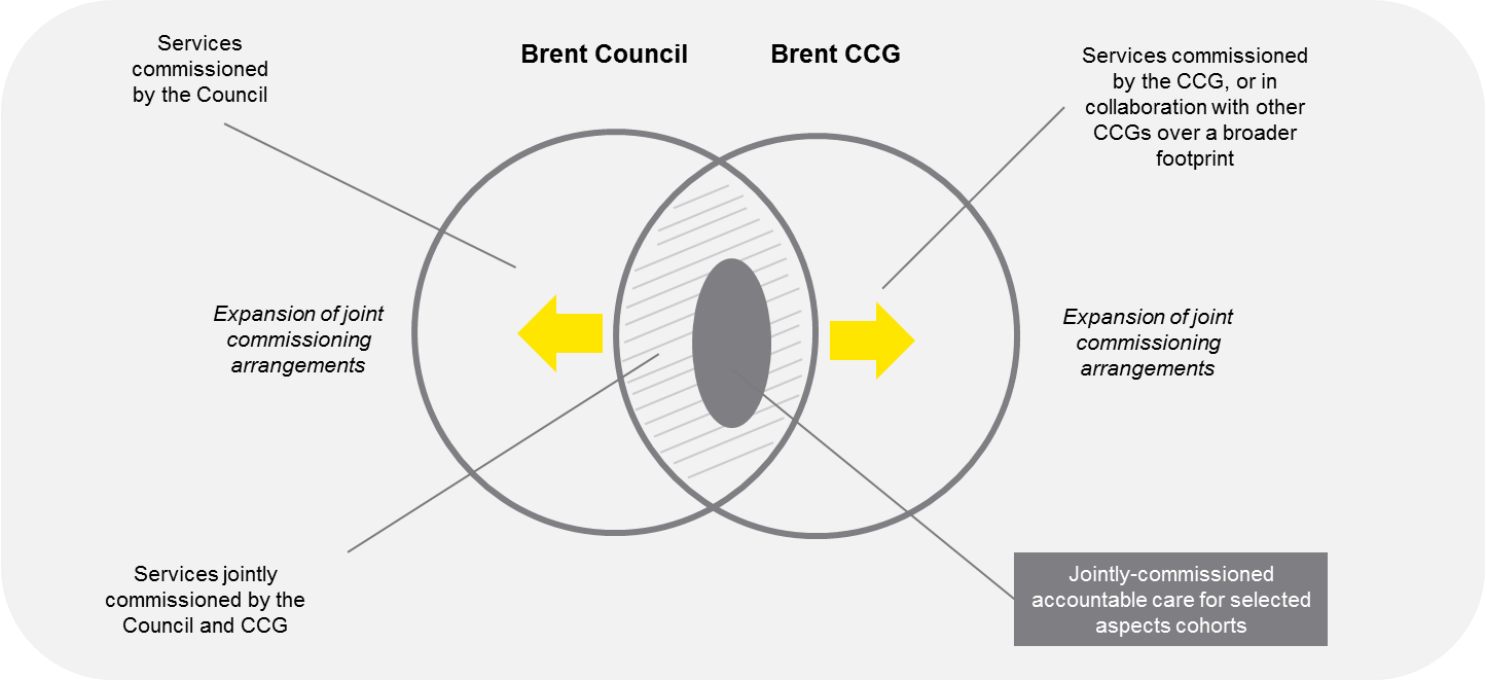
- an agreement between commissioners
- an agreement between providers
- an agreement between commissioners and providers.



An accountable model of care would act as a catalyst for closer integration of commissioning

By developing an accountable care model Brent commissioners could build on existing joint commissioning plans and further strengthen collaboration between the Council and CCG.

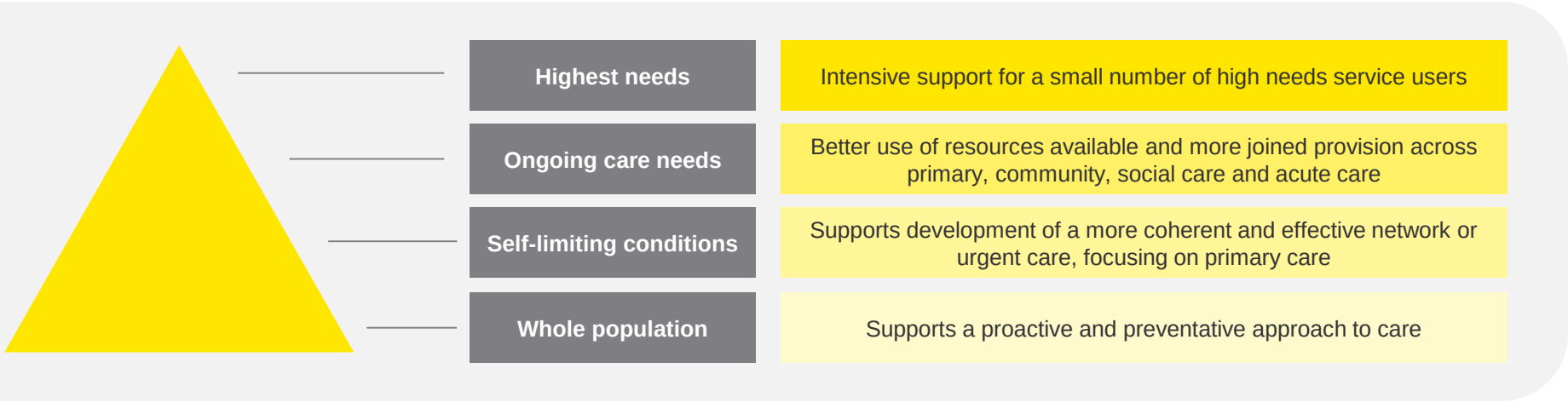
Accountable care would not necessarily apply to all jointly commissioned areas. This is illustrated in the diagram below, where accountable care cohorts sit within the shaded area which represents the full range of jointly commissioned services.



A multi-specialty, community based provider (MCP) model would be at the heart of a patient-centred, outcomes based strategy

An MCP is a relatively new provider structure to deliver place-based care, which can combine primary and community healthcare with social care and incorporate a range of specialists to best serve the designated population. This can include hospital services such as outpatients and day surgery and can also include mental health as well as physical health services.

An MCP is built around a hub or multiple hubs of integrated teams, depending on the size of the population it serves (typically, a hub will serve 30,000 – 50,000 people). In it's purest form an MCP holds a single budget for all the services it provides and has sufficient autotomy and incentivisation to reshape care to deliver the best possible outcomes for patients.



Based on our work, a roadmap is emerging for further integration over the next two years

2017/18

- Steps towards integrated commissioning of Residential and Nursing and children's therapies services as set out in the separate implementation plan
- Agree cohorts for next Wave 2 of expansion of integrated commissioning in adult social care which could include Community Mental Health, Learning Disabilities and frail elderly
- Work to agree plans for further integration of commissioning for broader Children's Services and other areas
- Assess models for new approaches to care and carry out Organisational Development review

2018/19

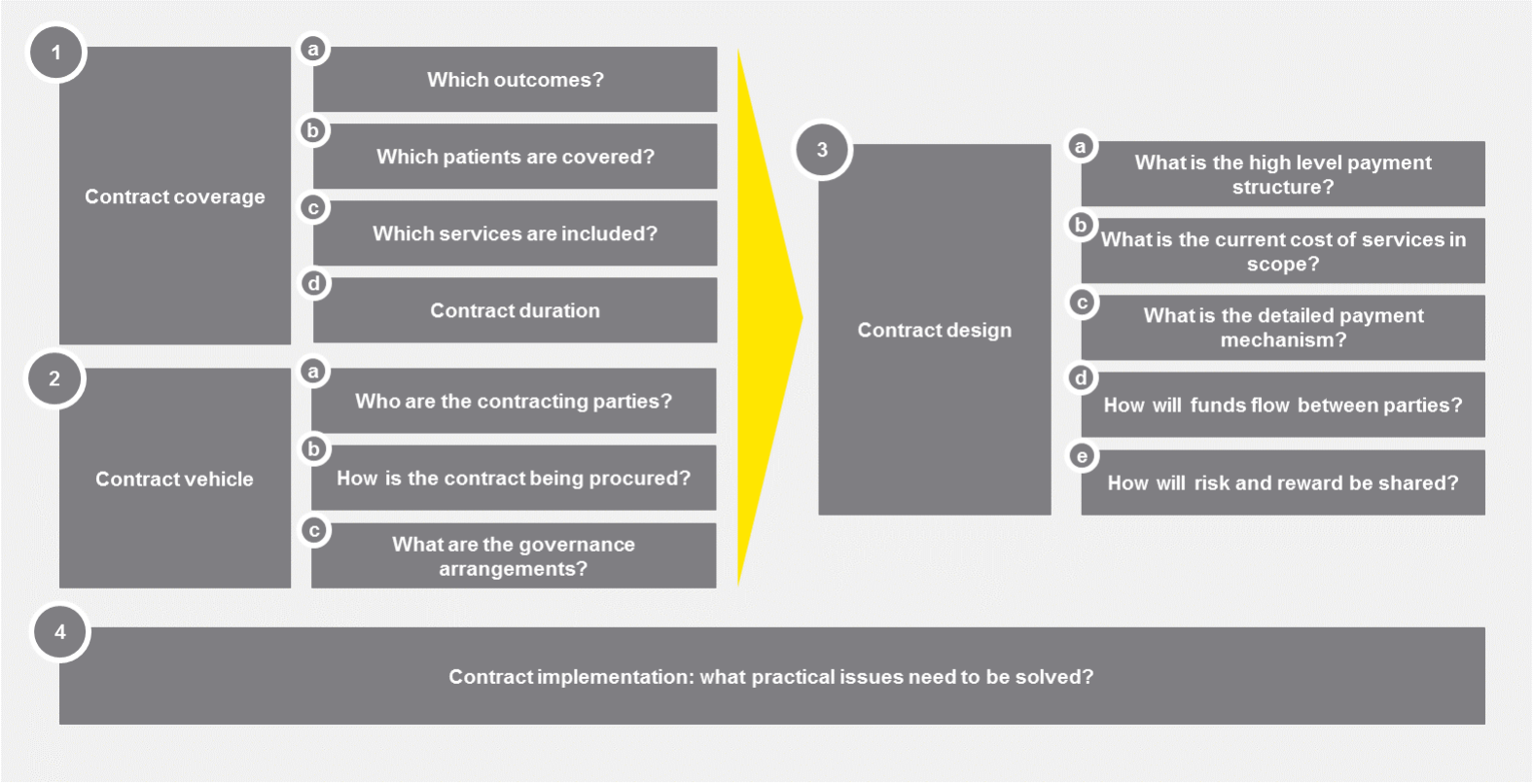
- New integrated structures for CHC and SEND services effective April 2018 (Wave 1 areas)
- Progress with wave 2 areas in adults and children's
- Act on Organisational Development review
- Progress towards models for new approaches to care

2019/20

- Wave 3: Begin planning for multi-specialty community provider arrangements
- Increasingly, provision of acute services at NWL level

Key steps towards contracting for an outcomes based model of care

The framework below sets out the key contracting steps towards an accountable care model. The Council and CCG would need to follow this process for each new cohort identified for a shift to accountable care. Further detail on each step is included in the following slides.



Key steps towards contracting for an outcomes based model of care (1 of 5)

Key question	Considerations
1a. Which outcomes do commissioners want to achieve as part of the contract?	► The outcomes framework is a key part of the overall contract structure and will be the main tool that commissioners use to hold the providers to account for delivery of quality for patients. ► Agreeing the outcomes to be delivered up-front is key. Each outcome will need to be supported by a metric (allowing commissioners to measure whether progress has been made) and a mutually agreed target (considered achievable by commissioners and providers).
1b. Which patients/service users will be covered by the contract?	► Deciding which patients will be covered by the contract needs to be one of the first steps in the contractual process. There are a number of different ways of segmenting the population. ► The contract will need to specify which segment is included in the contract and how those patients are defined. In the case of an age-segmented contract patients will be defined by age group, e.g. over-65s. ► Other options include identifying disease-specific cohorts such as cancer or other long term conditions. It is also possible to define a cohort by age and condition – for example, over 65s with one long term condition. Providers and commissioners need to ensure that the population is specified, unambiguous and identifiable. Some Vanguards are seeking to adopt a whole population budget.

Key steps towards contracting for an outcomes based model of care (2 of 5)

Key question	Considerations
1c. Which services are included in the contract?	► Defining which services the providers are responsible for delivering under the contract must be undertaken at an early stage so providers understand which of their current contractual flows will be absorbed into the new contract. This also allows providers to begin planning their service model for future care delivery. ► This will become particularly important when valuing the contract and paying providers to ensure that services are not paid for twice (i.e. once through the capitated payment and again through a payment for a specific service or treatment). Included services should be specified at as granular level a level of detail as possible (e.g. by HRG for acute providers). Other services are included in the contract by way of variation, over the course of the contract term.
1d. What is the duration of the contract?	► A longer contract length offers security of income for providers. This has the benefit of giving the providers greater certainty about future revenue streams for a longer period of time. This enables the providers to invest resources in activities that might improve outcomes for patients or reduce costs in serving the patient cohort over a longer payback period. ► However, a longer contract length locks the providers and the commissioners into greater financial risk. The pros and cons of this approach (for both commissioners and providers) should be considered and agreed up-front. Typically, contract durations are likely to be a minimum of 3 years and can extend to 7 or 8 years.

Key steps towards contracting for an outcomes based model of care (3 of 5)

Key question	Considerations
2a. Who are the contracting parties?	► Whilst new members may join the MCP over time, initial parties to the agreement will need to be agreed early on so that progress can be made with deciding relevant contractual issues.
2b. How is the contract being procured?	► Commissioners will need to decide on a procurement route, taking into account relevant NHS and EU procurement law.
2c. What are the governance arrangements?	► The governance arrangements must allow a provider partnership to run effectively, enable parties to be clear on their roles and responsibilities and allow decisions to be taken and disputes resolved. ► The governance arrangements, to a large extent, will be informed by the proposed legal form of the collaboration between organisations.

Key steps towards contracting for an outcomes based model of care (4 of 5)

Key question	Considerations
3a. What is the high level payment structure?	▸ There are a number of payment mechanisms to select from such as capitated budgets, block payments, PbR etc. ▸ The commissioners should determine whether a proportion of the contract value will be paid on achievement of outcomes. While the amount that should be linked to outcomes will need to be considered carefully, it is clear that it needs to be sufficiently material to ensure that it is impacts on the behaviour of the providers. In particular, it should be sufficiently high to counteract any potentially perverse incentives (for example to reduce cost at the expense of patient outcomes) that a block payment alone might create.
3b. What is the contract value?	▸ The contract value will be negotiated between the providers and the commissioners. The historical cost of included services can be used as a starting point, but other considerations must also be taken into account. For example, costs might be expected to increase over the course of the contract due to standard inflationary pressures or for epidemiological reasons anticipated with that specific cohort of the population. ▸ Equally, offsetting efficiency gains might be expected. Furthermore, a new model of delivery might be expected to reduce the overall costs of serving the population and, under certain circumstances, it might be deemed appropriate to claw back some of the cost saving over the duration of the contract itself.

Key steps towards contracting for an outcomes based model of care (5 of 5)

Key question	Considerations
3c. What is the detailed payment mechanism?	► The detailed payment mechanism will describe the full mechanics of payment flows under the contract under a range of different outcomes. For a capitated payment this needs to include how the outcomes element of the payment will be determined e.g. how is the outcomes payment element calculated? Are payments made for individual outcomes or for achievement of all outcomes? Is achievement greater than the outcomes target financially rewarded?
3d. How will funds flow between the MCP members, and any sub-contractors?	► This question relates to how the contract payment is shared between parties within the MCP. Although it is likely to vary on a case-by-case basis, a working assumption is that the overall payment structure (between the commissioner and the MCP) should, as far as possible, be replicated between the MCP members and also between the MCP and any subcontractors so as to ensure that all parties are equally signed up to the overall risks of the contract.
3e. How will risks and gains be shared?	► Agreeing and documenting how risks and gains will be shared is vital to the success of the agreement. This includes risk share between commissioners and providers and between providers within the MCP.
4. Contract implementation: what practical issues need to be solved?	► As well as the issues set out above, there will be a number of other points of detail that commissioners and providers will need to ensure are set out and documented before contract go-live. This typically includes: ► Ensuring that the new contractual arrangements operate effectively with other contracts that are already in place. In particular, it will be important that there are no gaps or overlaps with other contracts to mitigate against the risk of non or overpayment ► Ensuring that data capture protocols are in place to capture data for both activity and outcomes as this will feed into the payment and monitoring process for the contract ► Developing a framework to evaluate the effectiveness of the contract ► Defining performance thresholds that provide “step in” rights for the CCGs or some providers in the case of poor performance.

To support a longer term move to an accountable care strategy strong leadership would be needed to tackle cultural issues

- There are cultural differences between the Council and CCG. At a senior level there is a lack of alignment on the longer term direction of travel. It is also clear from interviews we have held that there is some mistrust between the two organisations.

- To address these issues we would suggest a programme of work with the leadership of both commissioning organisations to strengthen alignment on the future direction and to encourage the right behaviours.

Section 3

Residential and nursing care

Brent Council and Brent CCG commission residential and nursing care separately

The Council and CCG have statutory duties to commission residential and nursing care:

- The Council commissions support for people who require it under the terms of the 2014 Care Act. The 2014 Care Act sets out criteria for living independently, such as maintaining personal hygiene and being adequately clothed.
- The CCG commissions Continuing Health Care, where a patient requires 24/ 7 nursing provision and so a provider delivers that care on behalf of the NHS. In addition, the CCG pays for "Funded Nursing Care" in care homes and joint funds care packages with the Council.

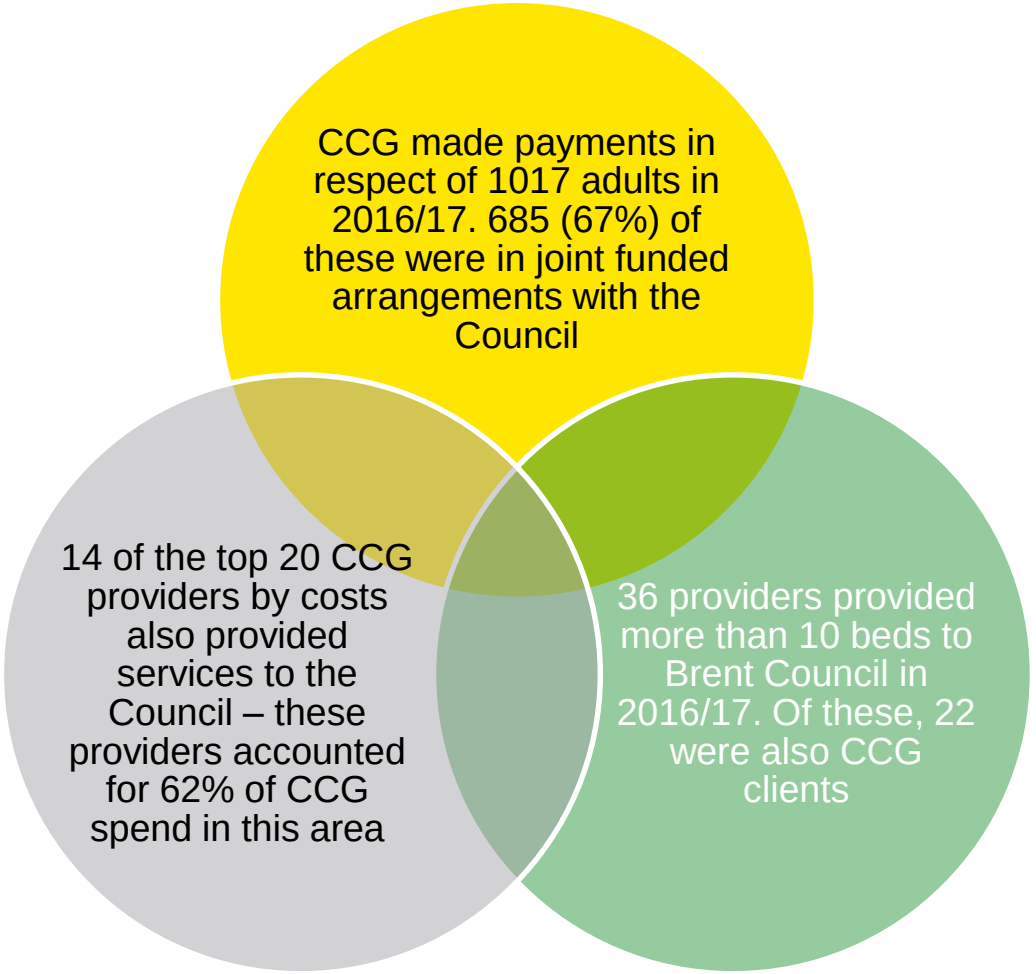
Different organisational approaches

- In organising its commissioning of CHC and placements, the CCG has joined together with Harrow CCG and Hillingdon CCG to create a shared BHH function. This function covers adults, including people with learning disabilities, and children. The services include nursing assessment of entitlement, brokerage and invoicing. The service is part of the BHH Quality and Safety Directorate. This Directorate has the broader remit to monitor the quality of all commissioned services, including residential and nursing care.
- Brent Council commissions residential and nursing support separately for adults and children, reflecting this conventional split in the organisation of Council services. Within adult social care, the Council is moving to new structures that commission at different levels of need; so a residential and nursing team, a supported living team and a community and preventative team.

Different frameworks

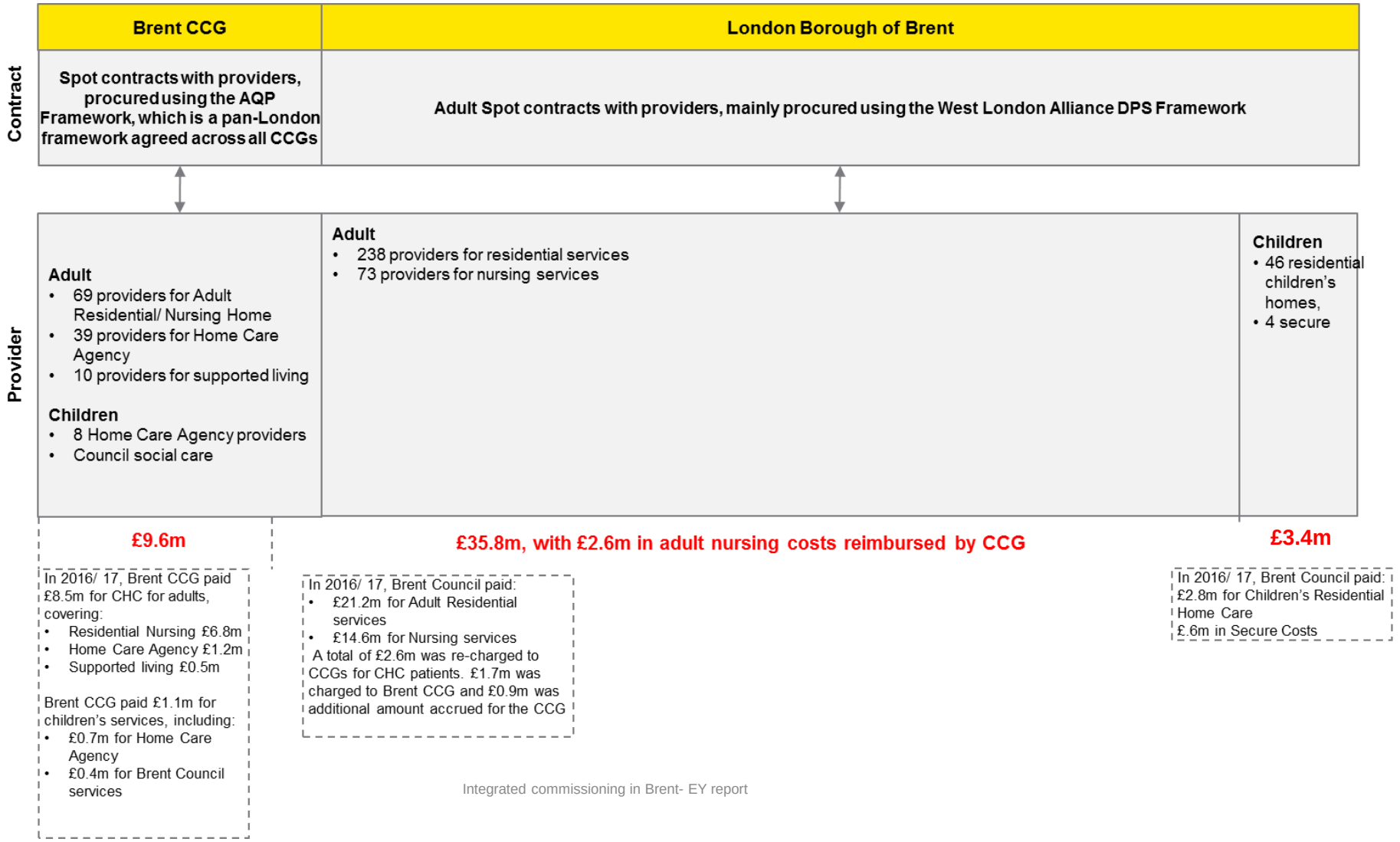
- BHH commissions CHC services through the pan-London AQP framework. All 32 CCGs are signatories. The framework sets out detailed quality criteria and a standard payment rate of £820 a week. BHH does not have frameworks in place specifically for nursing care outside CHC.
- Brent Council commissions residential care and supported living through the West London Alliance's DPS framework. The seven member boroughs of the West London Alliance are Barnet, Brent, Ealing, Hammersmith and Fulham, Harrow, Hounslow and Hillingdon. The West London Alliance is not coterminous with the North West London CCG collaborative who together have developed a Sustainability and Transformation Plan. The DPS framework sets out two categories of support for residential care and two categories of support for supported living.
- The DPS has identified Brent and Ealing as a distinct "Broad Market Area". The "Broad Market Area" rates for Brent and Ealing are lower than for most of the other boroughs but higher than Hillingdon.

There are significant overlaps in the population supported and the providers commissioned to provide services to them



Between them, Brent CCG and Council pay £48.8m for residential and nursing placements

Brent CCG commissions support through 24/ 7 nursing care (CHC), joint funding with the Council and funded nursing care provided in a home. The Council provides support to people in need as defined in the 2014 Care Act. This support is means-tested.



Looking ahead, there are significant funding pressures on the residential and nursing agenda

Changing demography in Brent means that demand for residential and nursing support is projected to increase significantly in the coming years.

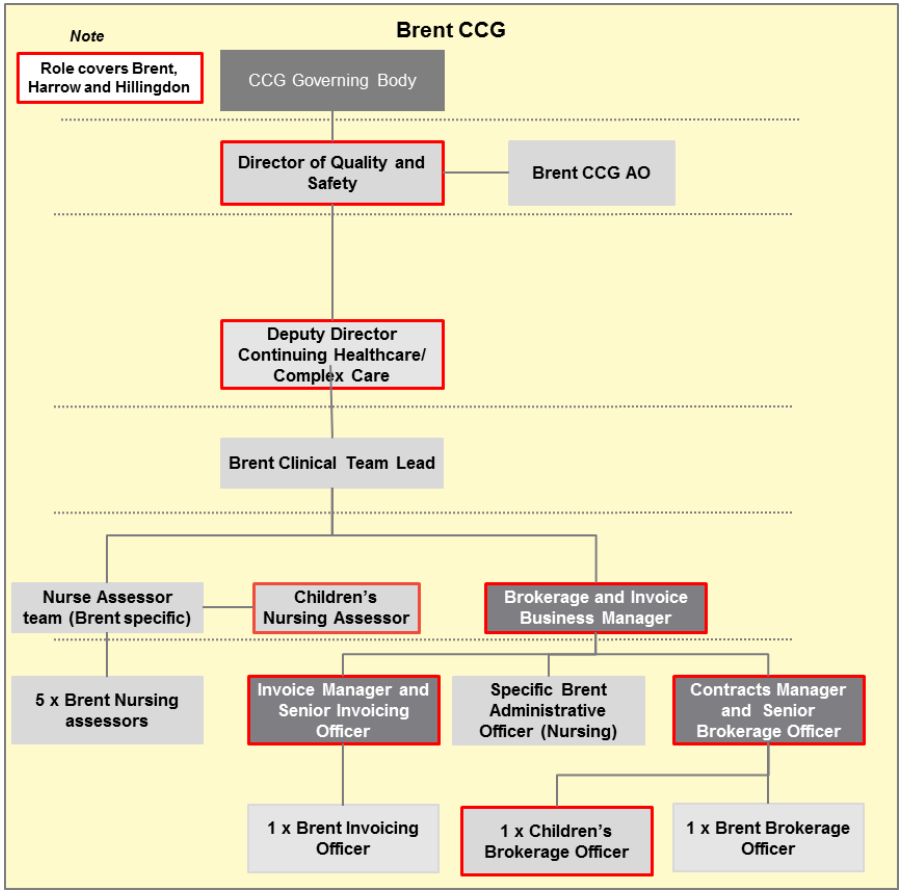
The Brent Joint Strategic Needs Assessment in 2015 projected that the population aged 65 and above will rise from 36,000 in 2015 to 52,900 in 2030, an increase of 47%. This population will have increasingly complex health needs. Between 2014 and 2030, the population of Brent estimated to have dementia is projected to increase from 2,369 to 3,857, an increase of 63% over the period. This will represent a significant demand on social care. The number of people over 65 living in Brent with or without nursing is projected to increase from 746 in 2015 to 1,189 in 2030, which represents an increase of nearly 60%.

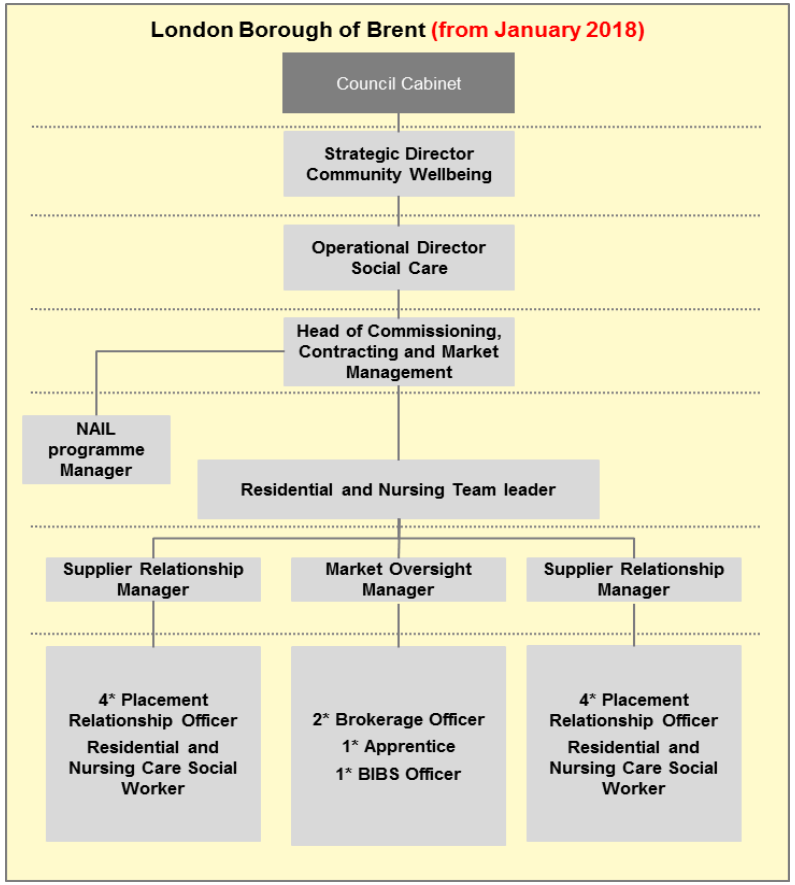
This increase in demand will be a significant cost pressure for Brent Council and the CCG. Between them, they paid £48.8m for residential and nursing care in 2016/17. Applying a crude measure of 60% increase in demand this would suggest that there is a potential £30m cost pressure. Further pressures include a lack of capacity in the residential and nursing home market, and this is beginning to have the impact of driving prices up. The West London Alliance has proposed a supply and demand analysis across West London. Providers are themselves under pressure, and one potential impact of Brexit is greater difficulty in recruiting and retaining appropriately qualified staff. In a constrained market, it is also essential that commissioners continue to set high expectations for providers so that vulnerable older people are not the victims of substandard care.

Brent Council and Brent Council recognise the strategic importance of this agenda, which is also highlighted in the North West London Sustainability and Transformation Plan.

- The North West London STP identifies a delivery area theme of achieving better outcomes and experience of care for older people. The actions include single seven day discharge approach across health, moving towards fully integrated health and social care discharge and training and support to care homes to manage people in their last phase of life.
- The Brent Health and Care Plan identifies joined-up services for older people as a big ticket item for 2016/ 17 and 2017/ 18.
- The Brent Better Care Fund has identified care home market changes as a priority.

Staffing structures CCG commissions across BHH and the Council is moving to a new structure





1. Brent CCG is part of an integrated team with Hillingdon and Harrow CCGs. There are three main tiers of provision; 24/ 7 nursing care (CHC), shared care funded with the Council and funded nursing care. The CCGs commission CHC using the pan-London AQP framework. Assessments are carried out by qualified nurses. The total cost of BHH continuing care staff is £1.8m p.a. (per annum). Brent CCG's share is £671k.
2. The Council commissions residential and nursing services through the West London Alliance DPS framework. The Council is developing a framework for supported living services. The cost of the team in the organigram, from the Head of Commissioning, Contracting and market management down, is £1.3m p.a.
3. Both organisations maintain separate brokerage and invoicing functions.

The two organisations operate essentially independently in commissioning residential and nursing care

Our work on the current state reviewed current activity against seven core functions:

Strategic functions

1

Strategic management

- BCF Steering Group brings together senior organisational leaders, but does not currently include BHH leaders who are responsible for CHC commissioning
- Care Homes identified as BCF shared priority but no integrated strategic view at present

2

Contract alignment

- Council commissions residential care through West London DPS Framework
- BHH CCGs commissions residential care through pan-London framework
- The main providers to both the Council and the CCG are on both frameworks

Provider management functions

3

Brokerage

- BHH CCGs has brokerage team which covers all CHC and nursing placements
- Council has brokerage teams and is moving to organise these around types of service being commissioned

4

Quality management

- BHH has distinct Quality and Safety Directorate which record quality information
- Council has separate performance monitoring system
- Providers complain that they have multiple contacts around similar information

Financial accountability

5

Budgets

- Complete separation of budgets for CHC/ Placements, bar pooling resource for some BCF roles
- Spending is triggered by assessment of entitlement against nationally defined criteria

6

Assessment of entitlement

- BHH CCGs have nurse assessors in place
- Council has distinct assessment procedures, including means testing
- Processes in place to work together

7

Invoicing

- BHH CCGs provide invoicing services for the CCG. Council has separate invoicing service
- Frequent links between the two teams where the cost of provision is shared

An assessment against the standard operating model framework identifies further issues around a lack of alignment

The following boxes set out an analysis of the current situation against a standard operating model framework. The provider market could be managed more effectively if the Council and CCG were to work together as aligned organisations.

Governance and Risk Management

- No structured arrangement in place to share intelligence and manage providers effectively
- Distinct CCG CHC Review Panel and Council Placement Review Panel in place. These are statutory bodies
- Individual CHC case assessments have social worker present
- Council present at Ratification Panel

Process

- At present, the two main framework contracts (AQP and DPS) operate independently
- Monthly meetings between Nicky Yiasoumi and Helen Duncan-Turnbull
- Existing Provider Forum, but providers approached separately by CCGs and LA and this causes duplication and confusion

Performance measurement

- Separate performance monitoring of providers through different contractual frameworks

Data and technology

- LA uses Mosaic system for brokerage and CCG uses Care Plan system
- Systems are incompatible
- Information Governance issues prevent sharing of data

Organisation

- Lack of resource put into effective scrutiny and challenge of providers and to integrate providers into broader care pathways

People

- Brent CCG commissions CHC as part of integrated team with Harrow CCG and Hillingdon CCG (BHH)
- Brent Council moving to new structures that place a greater emphasis on market management

Brent Council and CCG will share a strategic approach and manage providers together but financial accountability remains separate

Brent Council and Brent CCG recognise the need to work together to manage the residential and nursing market effectively. They will develop a strategic approach to managing nursing and residential care provision. They will share a brokerage function and pool resource to work with providers to improve the quality of care provided. However, we have had a firm steer that the organisations' financial management remains separate. Budgets will not be pooled and entitlement will be assessed separately.

Shared Strategy

1 **Strategic management:** Develop new governance forum to oversee shared approach, via a re-scoped BCF group. Agree shared performance indicators

2
- **Contract alignment:** Commitment to programme of work to align contracts

Integrated Provider Management functions

3
- **Brokerage:** Move to an integrated brokerage team, commissioning across health and social care. Migrate to shared brokerage data system

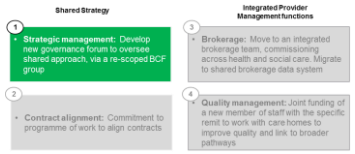
4
- **Quality management:** Joint funding of a new member of staff with the specific remit to work with care homes to improve quality and link to broader pathways

Financial Accountability- out of scope

5
- **Pooled budgets:** Brent CCG provided a clear steer that budgets would not be pooled

6 **Assessment of entitlement:** Separate teams to remain in place, albeit working together closely and with joint scrutiny. Distinct CHC and Council approval bodies are in place to authorise spending

7
- **Invoicing:** BHH proposed that distinct NHS and Council invoicing functions be retained, supporting accountability of spending



Brent Council and CCG will align around a shared strategy for commissioning residential and nursing care

Aspiration:

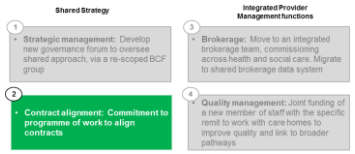
To develop and take forward a shared strategic approach for the commissioning of nursing and residential care in line with the vision to improve outcomes through the greater alignment of commissioning in Brent

Key Actions:

- Create a specific BCF 3 (Care home market) working group which will meet monthly from January 2018 and report to the BCF Steering Group. The working group will have the specific remit to:
  - Develop consistent messaging to the Brent Provider Forum from February 2018 onwards. At present, there is inconsistent messaging
  - Approve a shared approach to market management by March 2018; for example considering the development of block contracts to hold defined numbers of beds and hours of nursing for Brent. BHH are carrying out market analysis across NWL with CHC Delivery Group. The two organisations will also work with North West London CCGs and the West London Alliance. The West London Alliance is proposing a supply and demand analysis across West London, which will be an important input to a shared strategy moving forward.
  - Develop and agree clear indicators for performance of contracting residential and nursing provision by March 2018, as part of the shared approach to market management. This will take the form of a dashboard which integrates current indicators and agrees new indicators that reflect better shared priorities. Slide 40 sets out some initial proposals which could be developed further.
  - Oversee the work programme proposed in this package

Impact:

- More strategic and less ad hoc approach to market management
- Clear messaging to providers
- Common view of provider performance



Council and CCG will align contractual frameworks to improve consistency in market management

Aspiration:

To commission more services through contractual frameworks which support greater consistency in care provision

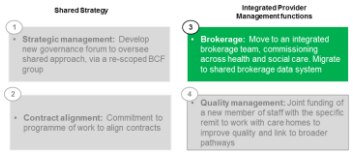
Key Actions

- There should be alignment between the terms of the AQP framework and the DPS framework; this initial analysis should be complete by January 2018
- BHH and the Council would like to explore whether the Council could use the AQP framework for its more complex cases; this will be decided by March 2018 as the framework goes live on 1st April 2018
- BHH and the Council should make a concerted effort to ensure that all providers align to the AQP and DPS frameworks; this will be a focus in February and March 2018 as both organisations set out their intentions for the next financial year
- Brent Council is developing a framework contract for domiciliary care and has invited Brent CCG to subscribe. The framework will be introduced through a staggered approach in 2019.

This work programme will be led by Nicky Yiasoumi of BHH CCGs and by Jenny Beasley of Brent Council.

Impact:

- More services procured on a framework basis
- Better value for money and quality of service offered by provider through framework



The Council and CCG have committed to the development of an integrated Brent brokerage team

Aspiration:

- To provide a seamless and integrated Council and CCG brokerage service
- To integrate brokerage more effectively with related Council and CCG services

Key Actions:

- The Council would take on brokerage, invoicing and contract management for Brent CCG within its residential and nursing team from April 2018. The senior Council officers in the structure would have responsibility for managing relationships with Council and health providers. **This implies a transfer of the specific Brent brokerage officer to the Council's residential and nursing team.** This brokerage officer will also commission homecare nursing support which aligns to the Council's supported living team
- There are two options for moving to the new structures:
  - The staff member will be transferred under TUPE to the Council. This would necessitate a 28 day consultation process launched by the end of January 2018.
  - A pilot for a period of six months where the staff work alongside the Council team but remain NHS employees. This is the approach being taken in Hillingdon.
- Our proposal would be to transfer the staff to the Council, as it would represent a clear statement of intent.
- Key performance indicators would be agreed between the Council and CCG for Council delivery of CCG brokerage services by March 2018 before go-live on 1st April 2018. These would be subject to a quarterly stocktake review between Nicky Yiasoumi and Jenny Beasley.

The Council and CCG have committed to the development of an integrated Brent brokerage team

- Brent CCG and Hillingdon CCG are moving to integrated brokerage arrangements with their local authorities. This then raises a question about the viability of the BHH brokerage manager (Band 6). Brent CCG's contribution to this roles equates to £17k per annum. This is a potential efficiency saving.
- The Council intends to develop a shared database for residential and nursing care. At present, BHH CCGs use the Care Plan system and Brent Council uses the Mosaic system. The CCG and Council will explore whether it is possible to migrate to a single system. This is a longer-term piece of work and would be complete by October 2018.
- Brent CCG commissions children's CHC provision as part of an integrated BHH Team, with one officer supporting all three CCGs. BHH would retain this discharge officer.

Impact:

- Greater consistency in placing Brent residents in CHC/ Placements
- Greater alignment between brokerage and related Council/ CCG services, so bringing both sets of organisational relationships into the new integrated team

Quality management will be addressed in the short-term via the BCF

Aspiration:

- Improve the quality of CHC/ Placement care provided to Brent residents

Key Actions:

- Two posts will be created under the Better Care Fund to help improve the quality of care provided in care homes and to link them to broader care pathways:
  - A Programme Manager will be appointed to lead and co-ordinate the planning, delivery and monitoring of the BCF 3 work stream to enable delivery of the specific objectives contained in the BCF 17-19 Plan. He or she will have a key role in developing the proposed BCF 3 working group. An interim will be appointed in January 2018.
  - A supporting project manager will work with a small number of care homes to identify potential barriers and issues faced by the homes in relation to health and social care and then to develop practical ideas and plans which can be implemented quickly leading to tangible improvements. An interim will be appointed in January 2018.
- In parallel, BHH CCGs are considering a proposal to recruit a Senior Accountable Nurse as part of its quality and safety directorate who would challenge poor quality provider performance from a clinical perspective. The job remit would cover all care provided, but with care home provision as an integral part. He or she would have a BHH remit, so operating across Harrow and Hillingdon. If approved, the Quality and Safety Directorate would aim to have the postholder in place by the end of April 2018.
- The potential introduction of three new roles represents a significant opportunity to work with providers to improve the quality of nursing and residential provision. It will be important to integrate the postholders into a broader team, working effectively with the BHH Quality and Satety Directorate, the BHH Nursing Assessors and the integrated brokerage team.

Impact:

- Providers improve quality of care or alternative providers identified where this is not possible

These changes have broader implications for the CHC/ Residential and nursing care operating model

The following boxes set out the description of the operating model following the proposed implementation of the changes. The actions in the box are intended to drive a collective change of culture to embed joint working between the Council and the CCG.

Governance and Risk Management

- Establishment of BCF 3 working group. Emphasis will be on bringing key actors together to drive through progress not as a governance consultation group
- BHH CCGs hold Council to account for delivery of brokerage service; Council to be explicit in its role as provider of service to CCG

Process

- Alignment of contracts
- Resolution on whether the Council can use the AQP framework
- Council and CCG to work together on Supported Living framework contract
- New integrated processes developed around quality assurance

Performance measurement

- Agree clear and consistent CCG/ Council performance measures for providers
- Benchmark performance and set improvement trajectories with action owners
- Monitor progress in the BCF3 working group

Data and technology

- Move to an integrated software system that enables brokerage officers to access both NHS and Council systems
- Resolve Information Governance issues relating to patient data

Organisation

- Commitment through BCF3 group to develop aligned team working across totality of BHH and Council commissioning
- Integrated brokerage team to make connections through both health and Council services
- Work programme to link care home providers to primary care to improve broader pathways of care

People

- Create integrated brokerage team where team members can manage both NHS and Council cases
- Set out broader matrix of how BHH, Brent CCG and Council staff contribute to integrated approach

It will be important to safeguard effective links between the integrated commissioning team and residual BHH functions

Financial accountability has remained out of scope with the clear need identified to retain separate budgets. Were the Council and CCG to pool budgets as part of a move to a new accountable care approach, then this would bring the potential to re-design services on a risk-reward basis. It will be important to ensure that a new separation does not develop between CCG assessment and invoicing teams on one side and the Council-based integrated brokerage team on the other.

Financial Accountability- out of scope

5	• **Pooled budgets:** Brent CCG provided a clear steer that budgets would not be pooled	Pooled budgets would be an area to consider if the CCG and Council moved to new models of care on a shared risk and reward basis. This additional step has the potential to drive radical changes in service provision but would need to be carefully worked through
6	**Assessment of entitlement:** Separate teams to remain in place, albeit working together closely and with joint scrutiny. Distinct CHC and Council approval bodies are in place to authorise spending	Formal processes are in place to work together on assessing entitlement, although separate accountability arrangements are in place . It will be important to maintain strong links between the BHH nurse assessor team and the integrated brokerage team based at the Council to ensure that patient needs are met effectively.
7	• **Invoicing:** BHH proposed that distinct NHS and Council invoicing functions be retained, supporting accountability of spending	Integrating invoicing would have the potential to streamline arrangements and is part of the overall relationship between the commissioners and providers. Effective communication between the integrated commissioning teams will be important

The changes would improve the quality and cost of care but action also needs to be taken to support people in their homes

The proposed initiatives focus on the effective and coordinated management of provider relationships. The proposals impact in two areas

Quality of care	RAG	Value for money	RAG
Service user and family satisfaction		Benchmarking costs to neighbouring Councils and CCGs This indicator can be developed to greater sophistication through focusing on particular service user or patient groups, for example the 20% most complex Council service users The impact will be in cost avoidance rather than reductions in programme spending	
Number of serious incidents			
Essential elimination of “never events” such as assault of care home residents			
Fewer delayed transfers of care			
Reduced emergency admissions			
Reduced number of deaths in hospital where a DNR order is in place			

The next stage in developing these indicators is to confirm what is currently being measured and by whom. The Council and CCG would then agree an objective view of baseline performance. A specific set of actions would then drive performance against those indicators. Progress would be reported to the proposed BCF 3 working group which will report to the BCF Steering Group.

Based on our work, a roadmap is emerging for further integration over the next two years

2017/18

- Creation of integrated CHC brokerage team, effective from April 2018
- Establishment of BCF 3 working group
- Recruitment to new quality posts

2018/19

- New ACP framework comes on stream
- Alignment of contracts with integrated brokerage team deploying both AQP and DPS frameworks as appropriate
- Move to shared database
- Supply and demand analysis carried out at a West London level
- Develop proposals for integration of services other areas (e.g. learning disabilities, Mental health and frail elderly)
- Integrate nursing and residential providers into integrated care pathways

2019/20

- Potential roll-out of integrated services to frail elderly population cohort

Section 4

Children’s therapies

SEND has been identified as a first focus for integrated commissioning in children's services

Brent is managing a significant growth in the number of young people. The 2015 Brent Borough Plan reported that the under five population increased by 37% between 2005 and 2015 and that the population aged five to 19 increased by 8 % over the same time frame. Council and CCG share a deep commitment to giving all its children and young people the best possible start in life.

SEND commissioning has been identified as a first focus for integrated commissioning. In May 2017, Ofsted and the CQC conducted a joint inspection of the local area of Brent. The report praised the strong commitment from senior leaders across Brent Council but noted that leadership of the SEN reforms within the CCG has been compromised by the lack of capacity at a senior level. It also noted that: "the joint commissioning of services is at an early stage of development. The local area does not have a cohesive strategy to ensure that all children and young people who have special educational needs and/ or disabilities and who need therapy services are assessed quickly and access treatment."

In response, the Written Statement of Action contains a number of actions specific to integrated commissioning of therapies.

- Brent Council and Brent CCG will align existing contracts with revised joint specifications in community paediatric therapies to address known gaps, particularly in speech and language therapy, in commissioned services and deliver a seamless service by 01 December 2017.
- Brent Council and CCG will implement a process for joint contract management by 31st December 2017. Brent Council and Brent CCG will also formally establish joint commissioning arrangements for integrated paediatric therapy services (Speech and Language Therapy, Occupational Therapy, Physiotherapy) and specialist nursing services from April 2018.
- Brent CCG will confirm the disaggregation of children's therapies' costs from current community paediatric contracts, in accordance with national contracting timeframes. The CCG Governing Body on 10th January 2018 will meet in public to take assurance and confirm the joint contracting arrangements necessary to jointly commission integrated SEND services from 1st September 2018.

Analysis against the operating model framework supports the CQC and Ofsted findings

This slide sets out analysis against the standard Operating Model framework. CCG and Council commission paediatric therapies separately. The Children's Trust provides a joint governance arrangement and shared goals have been set out in the Written Statement of Action. Formal processes are in place to involve NHS staff in the development of Education, Health and Care Plans.

Governance and Risk Management

- Children's Trust provides integrated governance with supporting working groups

Process

- Council has commissioned SaLT provision and has employed two Occupational Therapists
- CCG procures paediatric therapies services as part of a framework contract with London North West Healthcare
- Formal process agreed and in place for CCG to be part of development of Education, Health and Care Plans

Performance measurement

- Council and CCG have committed to clear goals in the Written Statement of Action
- Monitoring dashboard reviewed bimonthly by CT and six monthly by HWBB

Data and technology

- Commissioning staff work independently on CCG or Council systems

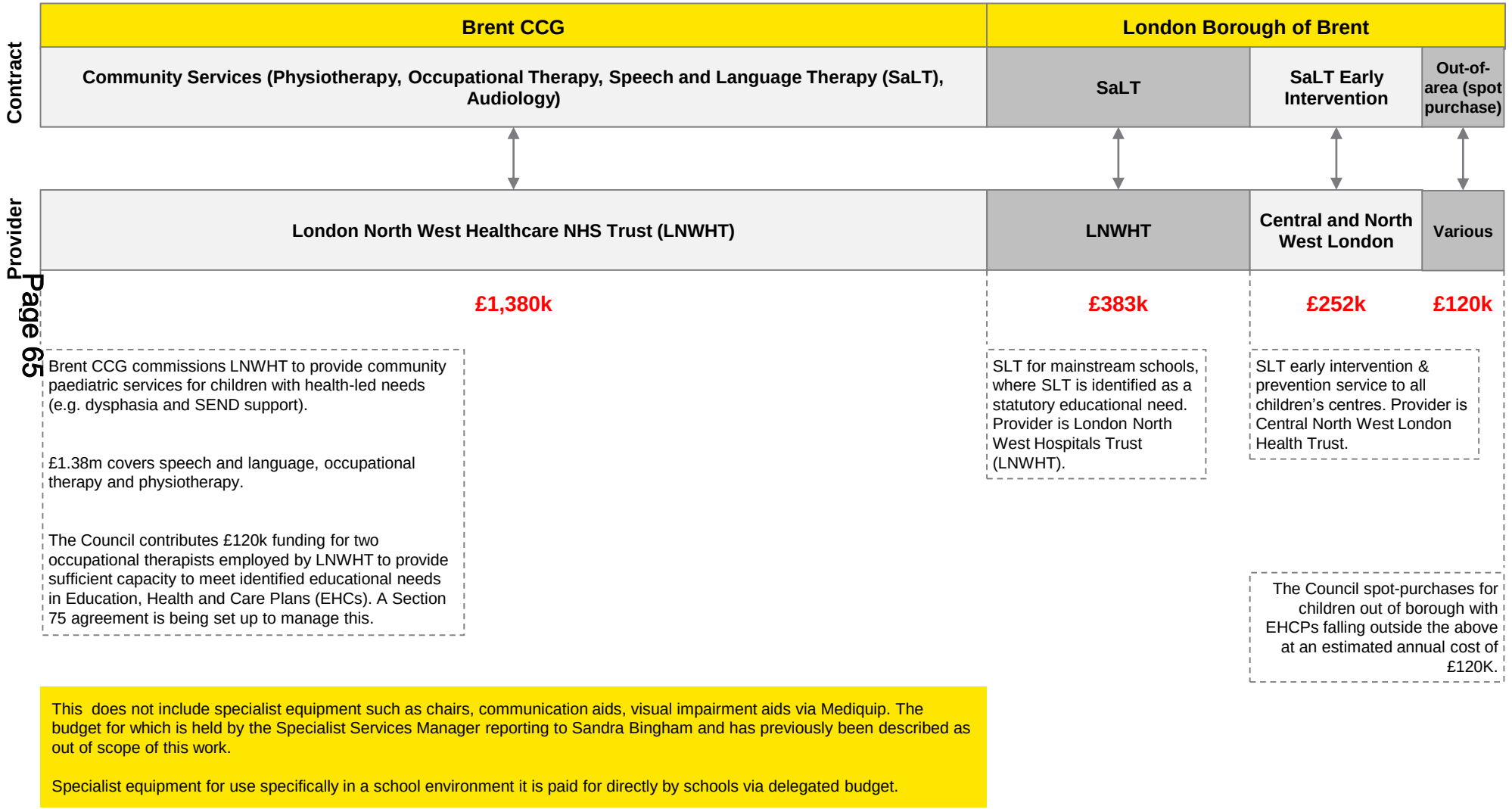
Organisation

- Commissioning team in Council links to the team which develops Education, Health and Care Plans
- CCG has specific Senior Children's Commissioner role whose remit covers all children's services

People

- Separate commissioning teams in place at CCG and in Council, commissioning related services from the same provider
- CCG has recruited Designated Children's Clinical Officer, working across BHH
- Joint CCG/ Council appointment of children's commissioner

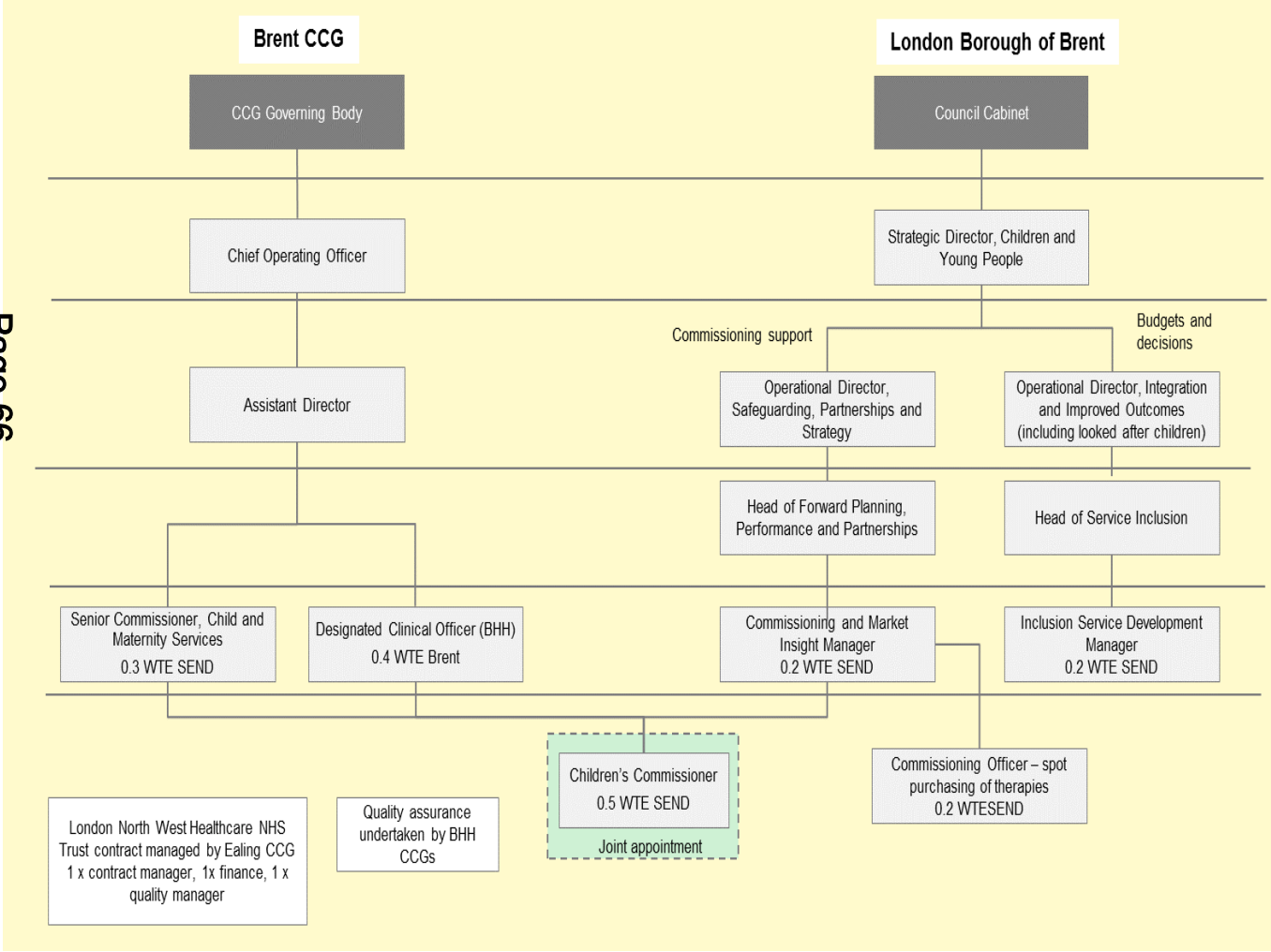
Brent CCG and Brent Council commission children's therapies support through block-contracts



This does not include specialist equipment such as chairs, communication aids, visual impairment aids via Mediquip. The budget for which is held by the Specialist Services Manager reporting to Sandra Bingham and has previously been described as out of scope of this work.

Specialist equipment for use specifically in a school environment it is paid for directly by schools via delegated budget.

In the current arrangements the CCG and Council commission activity children's therapies support separately



Under the current structure commissioning for SEND is shared by the Council and CCG.

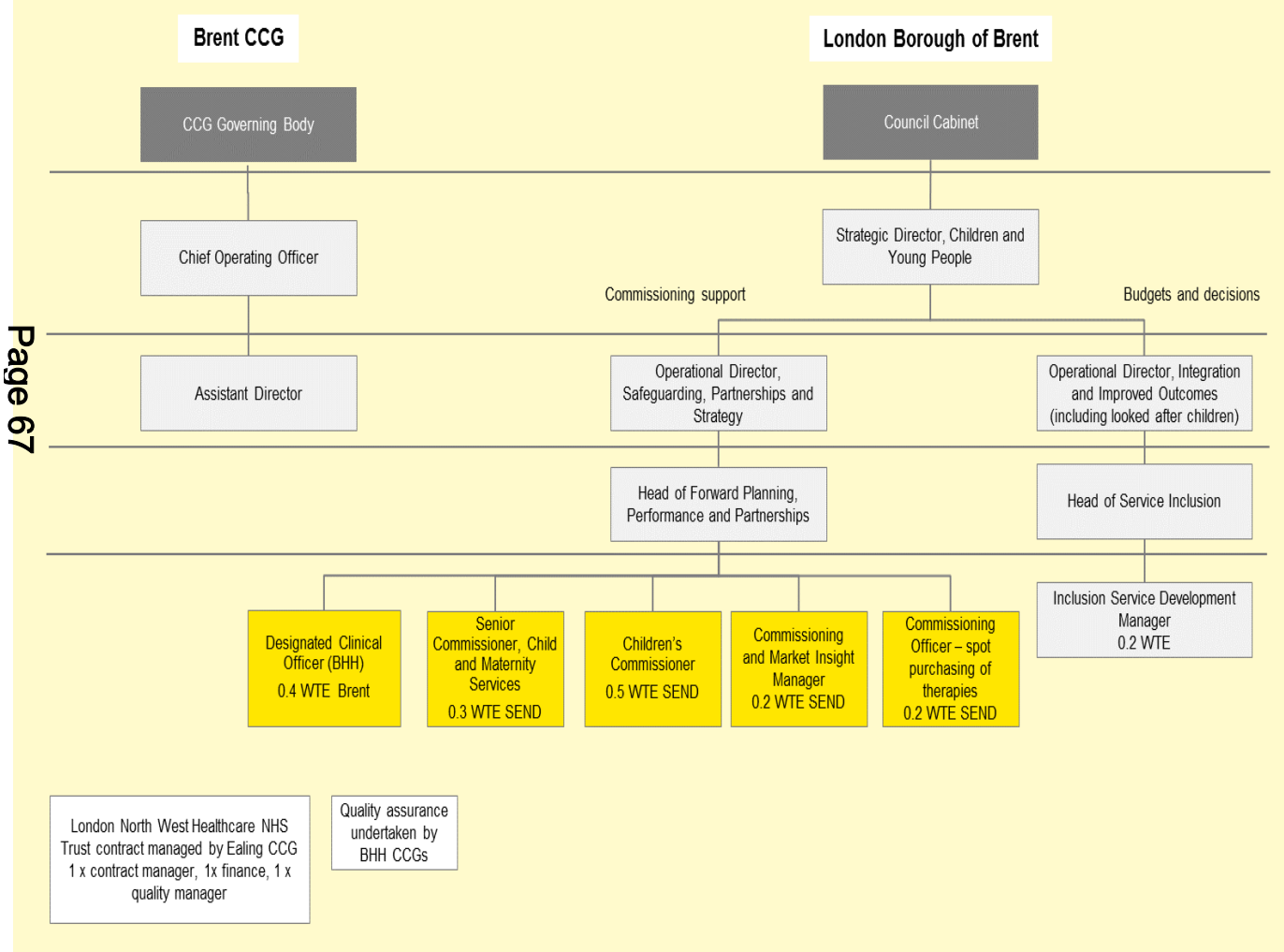
The Chief Operating Officer of the CCG has statutory responsibility to the CCG Governing Body for health.

The recently jointly-appointed Children's Commissioner reports to the Senior Commissioner of Child and Maternity Services at the CCG and Commissioning and Market Insight Manager at the Council.

A BHH Designated Clinical Officer spends two days a week at Brent.

Contracting, finance and quality assurance for provision by London North West Healthcare Trust is managed by BHH CCGs and Ealing CCG.

A integrated child therapy commissioning team will be established at the Council supported by a Memorandum of Understanding



In this proposed structure, a single integrated children's therapies team would be led from the Council.

The Strategic Director for Children and Young People would be responsible for the day-to-day performance of the integrated commissioning team. The Strategic Director would report to the CCG Governing Body at least every six months and would be engaged in CCG Board discussions on issues affecting children and young people.

The integrated structure focuses on children's therapies in Brent, with CAMHS and other children's commissioning not included in the scope. Some team members will spend time as part of the integrated team and some time on other duties.

In parallel, the CCG and Council will develop a memorandum of understanding. The memorandum of understanding will set out clearly what will be commissioned under the different contracts for children's therapies to ensure alignment.

Building on children's therapies, the Council and CCG commit to alignment of commissioning across children's services

The proposed changes will respond to the Ofsted and CQC inspection finding that integrated commissioning between Brent Council and Brent CCG should be strengthened. The Council and CCG agree this is but a first step in integrating children's commissioning.

The Council and CCG's senior leadership could work on a shared three-year plan agreed by the Children's Trust Board. This three-year plan would:

- confirm existing priorities based on the analysis of Brent children and families
- consider the totality of resources
- identify where there is a need to change services to improve outcomes for children and families
- draw out the timeline for reviewing contracts, for example the potential establishment of a single children's therapies contract once the CCG has disaggregated these elements from its block contract with London North West Healthcare

As the plan is developed, it supports broader discussions around the appropriate way to commission particular services, including:

- Health visitors and school nurses, provided by Central London Community Healthcare Trust (CLCH)
- CAMHS, where there is overlap between school and broader NHS commissioning. CAMHS covers ASD, LD commissioning and acute tier 4 specialist provision, (which would remain at a regional level)
- Troubled families initiatives, where there are overlaps between social care and NHS services
- While it may be appropriate to commission some aspects of children's services at a local i.e. Brent level, in other aspect it will be appropriate to commission health provision at a North West London level.

The commissioning discussion supports broader discussion around organisational form, including a specific Brent children's MCP.

While the integrated children's therapies team is a significant step forward, further progress can be made in aligning commissioning

The creation of the integrated children's therapies team is a first step in broader integration of children's commissioning. CCG members of the integrated team will have split roles, working on other tasks some of their time, so the commissioning of children's services will remain fractured to some degree.

Governance and Risk Management

- Integrated children's therapies team will report on progress to the Children's Trust Board
- Children's Trust Board will oversee development of medium-term plan

Process

- Memorandum of Understanding will set out what is to be delivered under the respective contracts to support alignment
- Separate contracting arrangements remain in place, although the CCG has given notice to London North West of its intention to disaggregate children's therapies from the block contract

Performance measurement

- Progress against the goals in the Written Statement of Action should be measured
- Current baseline needs to be established and then actions taken to show impact of integrated commissioning team

Data and technology

- Council will arrange for CCG staff in integrated team to have access to Council systems

Organisation

- Need for the integrated team to support improved care pathways for this group in line with the Written Statement of Action and to feed into Education, Health and Care Plans

People

- Integrated team around commissioning children's therapies
- Individuals in the team will spend some of their time working on children's therapies and some on other duties relating to children's services
- Some fracturing of commissioning children's services therefore remains and this will be addressed in the broader plan

The proposed changes will improve commissioning for children with SEND and be the first step in a broader transformation

The proposed changes will respond to some of the criticisms in the Ofsted/ CQC report. Integrated commissioning will prevent children from slipping between the gaps and improve parents' experience in accessing support. The Memorandum of Understanding will support a clear identification of the services that are being commissioned so that gaps in service provision are filled. This will contribute to the successful achievement of the objectives set out in the Written Statement of Action, particularly that:

- All children and young people with SEND including vulnerable groups receive timely support and access to services that help them maximise their potential.
- Children and young people with SEND make appropriate progress and outcomes are improved.

The development of specific goals to show the difference made by the integrated team will be part of the implementation of the new arrangements

Although limited in scope, the introduction of the integrated children's therapies team and the Memorandum of Understanding will be the first stage of a broader transformation.

The proposed three year plan would review existing commissioning of children's services in Brent and align objectives to these.

Based on our work, a roadmap is emerging for further integration over the next two years

2017/18

- Preparation for integrated children's therapies team:
  - Information governance training
  - Internal and external workshops on how the integrated team can be effective, linked to specific goals
- Development of three year plan, agreed in the Children's Trust Board

2018/19

- Consultation and engagement on the three year plan from April to August 2018
- CCG gives commissioning intentions to providers by 30th September 2018
- Disaggregation of children's therapies contract from CCG block contract with London North West by November/ December 2018
- NWL-wide children's health commissioner network newly established, and Brent participation is expected. This will look as ASD, SEND, and CAMHS.

2019/20

- New commissioning arrangements come into place on 1st April 2019 in the new financial year

Section 5

Establishing your implementation programme

Our suggestions for next steps cover four key areas of implementation planning, as agreed with the programme board

In order to take forward the recommendations in this report, we set out in this section our suggestions with regard to the following key areas of implementation, as agreed with the programme board on 11th December:

1. **Aims and milestones**
   - Confirming what you are seeking to achieve and by when
   - Key milestones to implement by 1st April 2018 the residential and nursing and children's therapies proposals

2. **Programme governance**
   - Confirming how you will maintain oversight of the work, and identifying those groups that need to take decisions on key next steps

3. **Capacity and capability**
   - A high-level view of the resources required to take this work further

4. **Risks and mitigations**
   - An overview of the risks identified in this work and how these may be mitigated in your next steps.

We conclude this section with our recommendations for key decisions that need to be taken in January in order to maintain momentum.

The **aims and milestones** provide a basis for implementing the deep-dives and establishing a programme of broader integration

In developing the aims and milestones, we have focused on what needs to be done between January and March 2018 to implement the deep-dives to drive further progress across the two organisations.

	January to March		*Output*
Implementing the deep-dives by 1st April 2018	**Adults residential and nursing** • Agree shared approach to market management, with supporting indicators • Align contractual frameworks • Create integrated brokerage team • Implement new approach to quality management	 **pp62-4**	**Integrated teams in place**
	Children's therapies • Create integrated children's therapies team • Agree MoU that will draw out what therapy services are provided on which contract	 **p65**	
Agree further deep-dive areas	**Adults** • Confirm next deep-dives, potentially mental health, learning disabilities and frail elderly • Further work is needed in January to develop the steps required to do this	***Covered as part of High-level Framework***	**Next wave of integration projects**
	Children's services three-year plan • Agree three year plan for children's commissioning further to discussions during this phase of work	 **p66**	
Establishing a programme of broader integration	**High-level Framework – organisational forms and ways of working** • Begin to progress discussions on risk/reward and contract mechanisms • Align proposals for Brent with NHS proposals for North West London • OD review, looking at capability gaps, organisational culture and governance • Developed approaches on workforce and information governance • What are the implications for new care model approaches?	 **pp67-8**	**Shared commitment a broader programme**

Residential and nursing – key steps to integrated approach to residential and nursing placements by 1st April 2018 (1)

Milestone	Action	January 2018					February 2018				March 2018			
		1	8	15	22	29	5	12	19	26	5	12	19	26
Completion of approvals	CCG Governing Body to confirm approval for work programme													
	STP Delivery Board confirms approach													
	STP Execs confirm SLA for brokerage services and proposed market strategy													
	CCG Governing Body confirms SLA													
Shared strategy agreed	Establish BCF3 working group													
	Fortnightly BCF3 meetings to drive implementation													
	Confirm key information for market management approach and baseline current performance indicators													
	Gain input to market management strategy from Provider Group													
	Develop proposed market strategy and indicators													
Alignment of contracts completed	Analyse scope for alignment between AQP and DPS frameworks													
	BHH to confirm whether the Council can apply the AQP framework for more complex cases													
	Development of approach to frameworks to feed into market management approach													

Residential and nursing – key steps to integrated approach to residential and nursing placements by 1st April 2018 (2)

Milestone	Action	January 2018					February 2018				March 2018			
		1	8	15	22	29	5	12	19	26	5	12	19	26
Integrated brokerage team in place	Prepare decision about whether to transfer BHH brokerage staff member (Brent specific role) on permanent basis or as a secondment on a pilot basis. Confirm in BCF3 group													
	HR to develop arrangements for transfer setting precedents for future changes. Issues will include salary, pension rights and changes to place of work **(in parallel with children's therapies)**													
	28 day consultation if transferring across													
	Resolve data security issues around access to personal data on NHS and Council systems **(in parallel with children's therapies)**													
	Confirm training needs around use of those systems by NHS and Council staff													
	Establish IT implementation needs; email addresses, laptops etc.													
	Resolve financial accounting issues with creation of integrated team **(in parallel with children's therapies)**													
	Develop Service Level Agreement between Council and CCG for brokerage team													
	Joint adult/ children's session on how integrated teams can work effectively													

Residential and nursing – key steps to integrated approach to residential and nursing placements by 1st April 2018 (3)

Milestone	Action	January 2018					February 2018				March 2018			
		1	8	15	22	29	5	12	19	26	5	12	19	26
Integrated brokerage team in place	Training of Council brokerage staff on brokering NHS services										■	■	■	
	Develop Service Level Agreement between Council and CCG for brokerage team						■	■	■					
	External workshop on how to make the integrated brokerage team work effectively **(in parallel with residential and nursing, potential joint session)**										■			
	Internal workshop on how to make the integrated brokerage team work effectively **(in parallel with residential and nursing, potential joint session)**											■		
	Detailed logistics around security pass, IT training etc for new joiner										■	■	■	■
Quality functions aligned	Interim Council Programme and Project Manager in place			■	■	■								
	BHH approval for recruitment of Senior Accountable Nurse- postholder to be in place from April			■	■	■								
	Introduce new postholders to the Provider group and secure provider input to new quality approach						■							
	Develop and agree new approach to working with care home providers to improve quality, confirming in BCF3 group. This should be an input to the overall market management strategy						■	■	■					

Children's therapies – key steps to implementing an integrated therapies commissioning team by 1st April 2018

Milestone	Action	January 2018					February 2018				March 2018			
		1	8	15	22	29	5	12	19	26	5	12	19	26
Completion of approvals	CCG Governing Body confirms agreement to proceed													
	Children's Trust Board confirms approach													
	CCG Governing Body approves MoU on contract alignment and agrees reporting approach with Gail Tolley													
Integrated therapies team in place	Confirm approach with team members who will be remaining on current employment terms													
	Develop HR approach to issues, developing precedents **(in parallel with residential and nursing)**													
	Confirm IT arrangements for CCG team members; data security, email addresses, access to systems **(in parallel with residential and nursing)**													
	Resolve any financial accountancy issues **(in parallel with residential and nursing)**													
	Develop Memoranda of Understanding for each of the CCG staff who will join integrated team													
	Develop proposals for reporting arrangements between Gail Tolley and CCG Governing Body													
	Develop Memorandum of Understanding around the scope of the different contracts													
	Joint adult/ children's workshop on how the integrated teams can work together effectively													

Children's therapies – key steps for developing a three-year plan for further integration

Milestone	Action	January 2018					February 2018				March 2018			
		1	8	15	22	29	5	12	19	26	5	12	19	26
Integrated therapies team in place	External workshop on how the integrated team be connect effectively across NHS and Council services **(in parallel with residential and nursing, potential joint session)**													
	Internal workshop on how integrated team can work effectively **(in parallel with residential and nursing, potential joint session)**													
	Detailed logistics around security pass, IT training etc for CCG staff													
Three-year children's plan agreed	Develop outline structure, confirm information requirements for the plan and prepare documents for Children's Trust Board													
	Children's Trust Board acts as a workshop to confirm the orientations for the three year children's plan													
	Development of detailed proposals													
	Discussion and iteration with senior stakeholders													
	Agreement in Children's Trust Board													

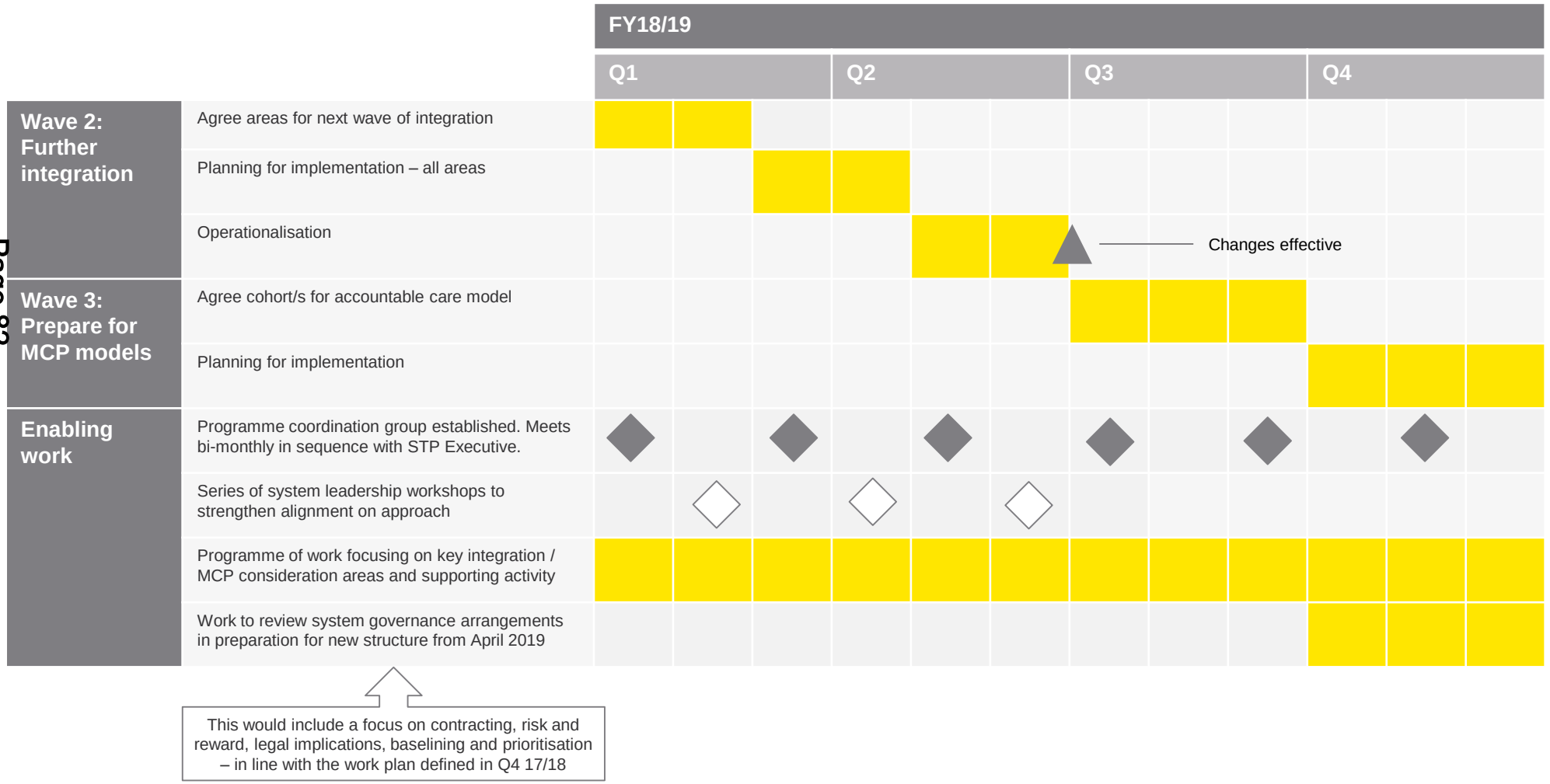
Establishing a broader programme – exploring models to support new approaches and next steps

Milestone	Action	January 2018					February 2018				March 2018			
		1	8	15	22	29	5	12	19	26	5	12	19	26
Consider models to support new approaches and next steps	First meeting between Carolyn Downs and Rob Larkman to confirm commitment to work programme													
	Workshops to explore MCP model, risk and reward approaches and contracting													
	Understand plans to develop NHS integration further across NWL and assess how this impacts on Brent													
	High-level working group considers organisational vision; detailed presentation around the high-level framework													
	Consider which areas to focus on in adult services (mental health, LD, frail elderly)													
	Discussion and agreement of areas to focus on in STP Delivery Board													
	Further workshop around models to support new approaches; agreement on proposed approach for Brent													
	Agreement of Children's three year plan in the Children's Trust Board (set out in more detail in previous slides)													
	Development of the scope of the work required in 2018/19 to support implementation, including resources required													
	Meeting of Carolyn Downs and Rob Larkman to confirm the subsequent work programme													

Establishing a broader programme – organisational development to support the Council and CCG in working together more effectively

Milestone	Action	January 2018					February 2018				March 2018			
		1	8	15	22	29	5	12	19	26	5	12	19	26
Organisational development	Develop shared HR policies around transfer of staff, using deep dives as case-study options													
	Confirm approaches to IT issues; data security, email addresses, access to systems													
	Interviews with key stakeholders on ways of working between Council and CCG, looking at culture													
	Review of lessons learned from implementing deep dives around residential and nursing and children's therapies													
	Review of governance against the planned next steps													
	High-level group considers Organisational Development approach and changes to ways of working													

Longer-term implementation – April 2018 to March 2019



In the short-term, implementation of the deep-dive proposals can be made through existing governance arrangements

Children's Therapies

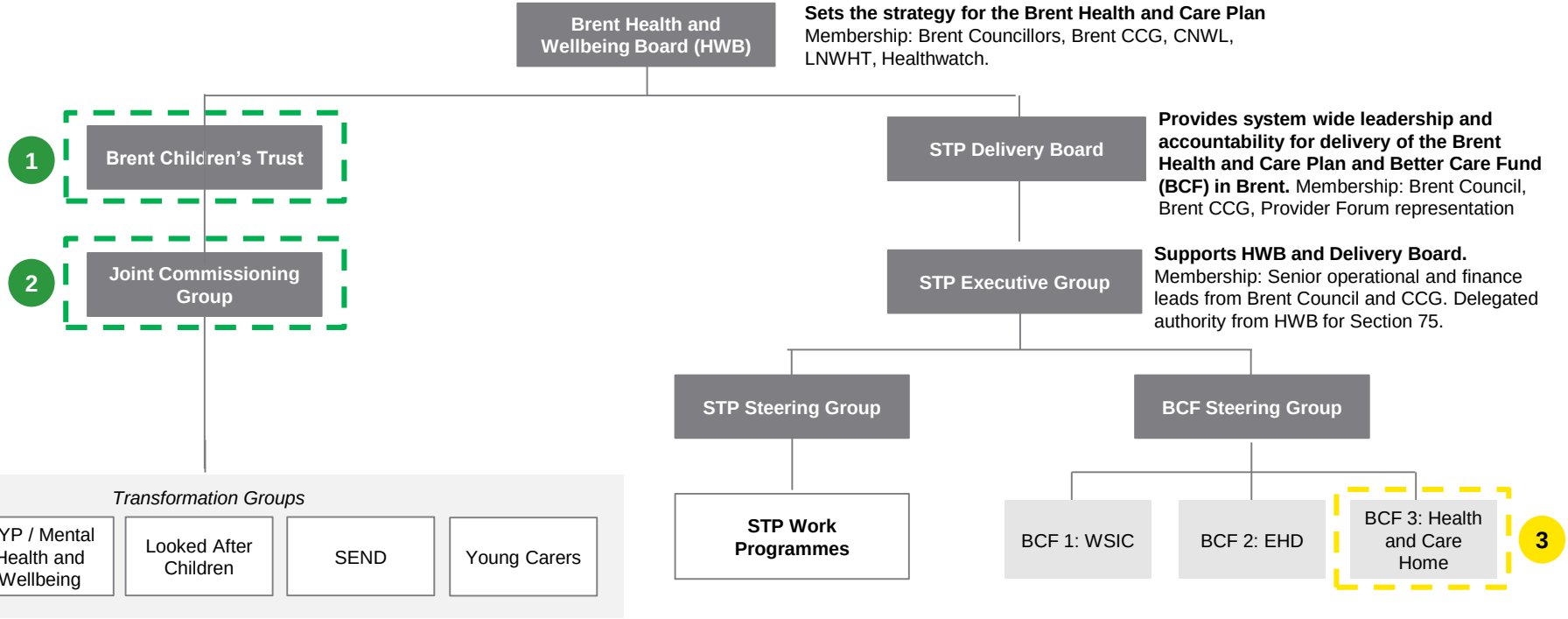
1. The Brent Children's Trust has been suggested as an appropriate forum to progress further detailed design work needed for Children's Therapies and the intention is to use the meeting on 23 January as a workshop to focus on this
2. Subsequently, the Joint Commissioning Group has been identified as a suitable forum to drive the work forward to operationalisation of changes in April 2018

Residential and nursing

3. The BCF3 sub-group, which has a remit covering the whole health and care home framework, would likely be an appropriate forum to drive the work around residential and nursing. BCF3 is not currently operational and the expectation is that this group will be up and running by the end of January (though at this stage a date has not been set). To prevent delay to the work we would strongly suggest expediting the first date. The scope and remit of the group would need to be reviewed to ensure that it can oversee this work and its BCF commitments..`

Broader programme

⚠ Within current governance arrangements there is no appropriate vehicle to take forward work set out in the broader vision for integration or to make the most of potential opportunities / manage risk



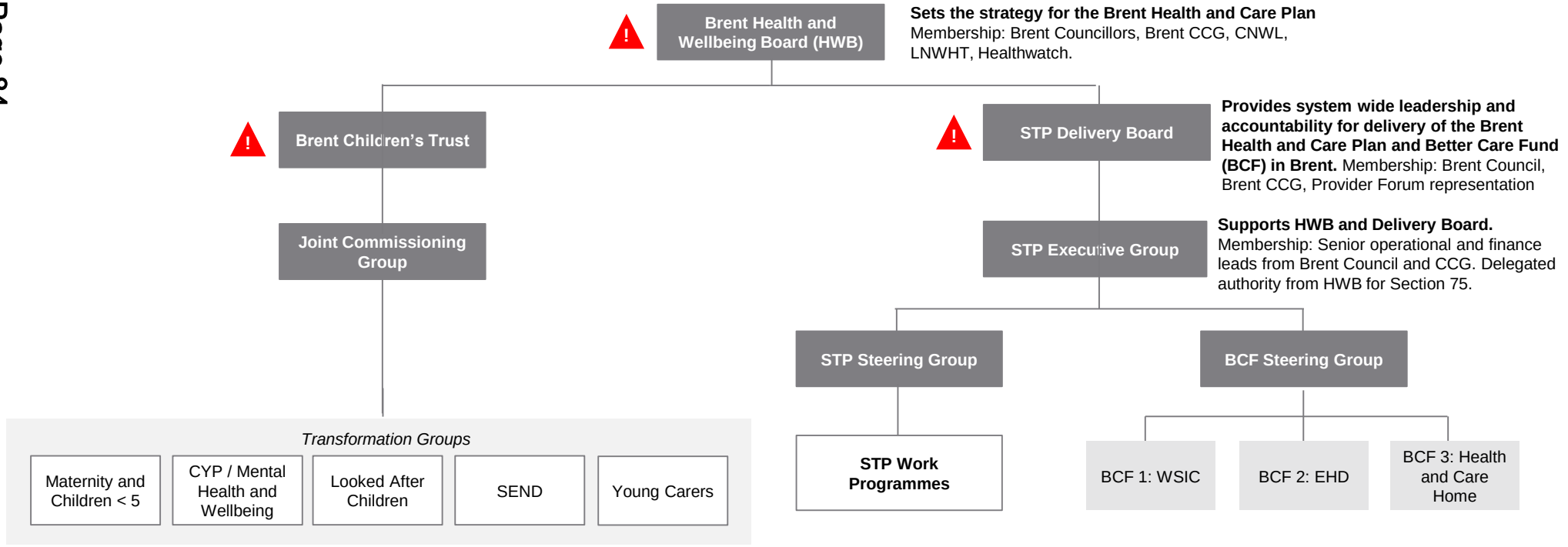
In the longer-term, the Council and CCG will need to consider whether existing governance structures are suitable

While existing governance structures can support the swift implementation of the proposals for residential and nursing placements and children's therapies, further integration of commissioning would require oversight of a much broader and deeper range of factors. It is not clear that existing structures could satisfactorily ensure that further integration in children's and adults' services do not diverge in material and unhelpful ways.

The Children's Trust does not report into the STP Executive or Delivery Board, creating a risk of isolation from broader work programme

Existing governance structures do not allow for the consideration of key enablers of integration, e.g. alignment of performance management, policies and support services and may have insufficient capacity

The Council and CCG may prefer to develop some proposals in groups that do not contain providers, before these are channelled into existing structures. We need to consider the things commissioners need to do, providers need to do, and commissioners and providers and commissioners need to do together.



We propose a broader review of governance in order to realise the longer-term vision for integrated commissioning

Immediate proposed changes in the deep dive areas can likely adequately be progressed within existing governance arrangements. However, the deep dive areas sit within a much broader vision for closer alignment and integration of commissioning which will include important work to:

- Agree cohorts for closer alignment of commissioning
- Identify opportunities to realise wider synergies: HR, systems, finance
- Develop thinking around risk and reward and other key areas of consideration linked to further alignment and integration
- Review organisational structures more broadly
- System leadership – work to ensure there is adequate alignment between stakeholder organisations
- Navigate and manage developments and interdependencies at sub-regional level
- Oversight of broader delivery of the strategy

We would suggest a review of current arrangements in Q4 2017/18 to ensure the planned work is adequately supported going forward, with a focus on:

- Bringing all health and social care together, reporting into one forum
- Providing increased perspective across the work programme
- Accountable care: dedicated resource to work through key areas and get to grips with the technicalities (work should start now)
- Stronger links into sub-regional governance and decision making
- Reducing duplication

The two high-level options for future governance are adapt existing structures or create a new one

1

Adapt the existing governance structure
Under this option, an existing group, most likely the Brent Health and Social Care Executive Group, would have oversight of the broader integration programme. This group also has delegated responsibility for Section 75 decisions.

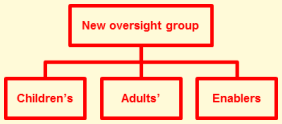
- ✓ This approach would minimise potential disruption
- — Terms of reference of this group would need to be amended to allow for oversight of enabling work (e.g. OD, HR, etc.)
- ✗ May not have the capacity required for a broader integration programme

2

Create a new governance structure
With existing governance structures likely to require considerable changes to existing terms of reference, it may be desirable to create a new structure.

- ✓ This would allow for better consideration of enabling activities and a broader integration programme.
- ✓ This would present an additional call on the time of key managers who are already involved in several other governance groups, and add complexity to the management of the existing structure.
- ✗ Stakeholders at the Council and CCG have clearly expressed that they are not ready for this level of change in the short term

Stakeholders at the CCG and Council have clearly expressed an intention to pursue a phased approach to development of governance to support the programme of work:

To April 2018	April 2018 – March 2019	April 2019
• Work within existing arrangements to deliver planned changes to residential and care homes and children's therapies	• Transitional arrangements: establish new programme coordination group, reporting into the STP Executive, to have sight of all of children's and adults' work plus enablers and make/recommend key decisions such as those relating to broader integration such as future areas for increased integration and  • Full review of system governance	• New structure: implement new system governance arrangements informed by review undertaken in 2018/19

High-level overview of capacity and capability required

	Children's Therapies	Residential and nursing	Broader programme of integration
Scope	Implementation of integrated children's therapies commissioning team. Supporting MoU to align contracts. Development of three year children's commissioning plan	Implementation of integrated brokerage team. Recruitment of two roles to work with providers on quality of care. Work programme to align contracts and shared strategic approach	Further exploration of population-based commissioning approaches, focusing on multi-specialty community provider model. OD programme to look at ways of working, culture and underlying governance
Time required from existing teams and senior management	► Regular meetings between CCG Assistant Director, Council Operational Director (Safeguarding, Partnerships and Strategy) and Senior Commissioner for Child and Maternity Services ► Oversight from Council Operational Director (Safeguarding, Partnerships and Strategy) ► Sponsorship from Strategic Director for Children and Young People, plus involvement in workshop on 23 January. Brent CCG COO to attend Children's Trust meetings in January and March 2018 ► Input from Council and CCG finance, HR and IM&T teams	► Regular meetings and oversight from CCG Head of Commissioning, Contracting and Market Management and Council Deputy Director of Quality & Safety (Head of CHC/ Complex Care) via BCF3 Group ► Sponsorship: Strategic Director of Community and Wellbeing, BHH (Brent, Harrow, Hillingdon) Director of Quality and Safety ► Regular reporting to BCF Steering Group ► Input from Council and CCG finance, HR and IM&T teams	► Senior leadership including BHH Accountable Officer and Brent Council CE agree on approach and timescale. ► Sponsorship and oversight from senior leaders Council Strategic Directors and Brent COO ► Regular workshops to work through issues and share practice and input into work to develop thinking around key consideration areas (e.g. risk/reward) ► Leaders of children's therapies and residential and nursing workstreams to contribute through lessons learned in practice ► Input from Council and CCG finance, HR and IM&T teams
Project management support required	► Project manager to support the development of the three-year plan. Could also support drafting of MoU on children's therapies contract alignment ► Current management to oversee move to integrated children's therapies team ► Ongoing management of project plan to April 2018	► Interim programme manager x 1 and interim project manager x 1 to drive the work forward already in recruitment process, with specific focus on quality agenda ► Potential need for PMO during initiation phase ► Additional project management support would be needed for further integration areas	► Project management support to design and manage the work programme, e.g. 1 x programme manager to scope and lead the work to develop the broader programme ► OD programme focused on system leadership / cultural alignment – series of Executive-level workshops ► Financial modelling support
Key knowledge/ skills required	► Commissioning expertise ► Finance, HR, IT	► Project management ► Finance, HR, IT	► Expert advice on key integration areas (e.g. payment models) ► Organisational development ► Finance, HR, IT ► Facilitation

We have identified a number of risks, and how these could be mitigated in your next steps (1)

We have identified a number of risks through our work, and categorised these using the operating model framework, in addition to a category on strategic or system-wide risks. For each, we propose mitigations that link to the implementation planning above.

Category	Risk	Description	How could the next steps mitigate this?
Strategic/system-wide risks	**Agreement of aims, structure and approach for integrated commissioning in the long-term**	There is no clear, agreed view of how integrated commissioning should be structured in Brent. Without this, there is a risk that individual functions will be integrated in a piecemeal and sub-optimal way, and without alignment of key supporting services and processes, e.g. those relating to HR and IT.	► Executive-level workshops in January to debate potential forms for integrated commissioning ► Establish a programme to identify and scope the requirements for successful integration (work plan for January to March 2018)
	Cultural alignment of the Council and CCG	The two organisations have very different cultures, which stem from long-standing differences in ways of working. This lack of cultural alignment inhibits joint working	► Executive-level meetings in January to agree shared vision and values for commissioning ► Focus on distributed leadership, alignment in other boroughs / areas and understanding the key factors driving behaviours locally ► Make commitment to look at harmonising structures and ways of working
Governance and risk management	**Alignment of existing governance structures**	Well-established governance structures are already in place for children's commissioning, while the STP has structures for a broad range of other services.	► Review governance structure during January to March 2018 and scope requirements for broader implementation ► Identify areas where existing structures may not be suitable (e.g. owing to scope or provider involvement)
Process	**Processes are based on organisational requirements**	Risk that long-established processes will inhibit integrated commissioning. These need to be re-designed with a system-wide focus in mind.	► Review and align processes as part of the deep-dive implementation in January to March 2018, and share lessons learned with other functional areas
Performance measurement	**Different performance management approaches and measures**	Performance management approaches and measures need to be aligned to support integrated commissioning. Need to encourage a system-wide focus	As part of deep-dive implementation in January to March: ► Agree shared market approach in residential and nursing ► Agree performance indicators to be used ► Assess whether current commissioning delivers objectives in three-year children's plan ► Establish HR group to explore alignment of policies, measures and approaches

We have identified a number of risks, and how these could be mitigated in your next steps (2)

Category	Risk	Description	How could the next steps mitigate this?
Data and technology	**The Council and CCG have different information, HR and finance systems**	Information sharing between the two organisations is inhibited by different information systems	▸ Establish an IM&T group to look at future information sharing, in accordance with the high-level framework, during January to March 2018 ▸ Use case-studies of brokerage and children's therapies teams to develop proposals ▸ Assess opportunities/benefits of linking in with interoperability work across WLA/BHH/ sub-regional footprint
Organisation	**Organisational structures**	Differences in structures will inhibit integrated commissioning	▸ As part of the work during January to March to identify further deep-dives, consideration to be given to harmonising structures. ▸ Groups to be established during January to March to look at broader organisational synergies, e.g. HR, finance and IM&T
	Support services	Misalignment of support services, e.g. HR, finance and IMT, will inhibit integrated commissioning – and we have heard from stakeholders we have interviewed that poor alignment of back office services has a negative impact on service delivery now	▸ Groups to be established during January to March to look at broader organisational synergies, and to help ensure that commissioners make the most of opportunities to deliver support services in a more joined-up way
People	**Cultural alignment and ways of working**	How to ensure cultural alignment on the ground – will require fundamental changes to ways of working	▸ Agree in January to establish a programme of OD support at Executive level to help drive constructive behaviours throughout stakeholder organisations
	Reporting structures for specific professionals	How to ensure continuity of professional reporting for certain groups	▸ As part of planning during January to March for further deep-dives during, review organisational reporting structures to ensure continuity of professional reporting

To maintain momentum, we recommend that the following decisions and actions are completed in January

1. Decision by both the Council and CCG to proceed with implementation of deep-dive recommendations:
   - Integrated brokerage team and aligned contractual frameworks for nursing and residential placements
   - Integrated children's therapies team and three-year plan for further integration

2. Meeting between chief executives of the Council and CCG to establish shared commitment to a broader work programme around:
   - Vision and aims for further integration
   - Exploration of a multi-specialty community provider (MCP) approach
   - Alignment of plans for North West London NHS integration with Council/ CCG integration in Brent
   - Review of governance structure for work post-April
   - Development of an organisational development plan to support deeper integration
   - Extended workshop in March to draw together these themes

3. Initial meetings between key Council and CCG senior managers to agree how to support integration in key areas – HR, IM&T and Finance

Planned engagement in January

		January 2018				
	W/c:	1	8	15	22	29
Key forums	CCG Governing Body		10th			
	Brent Health and Wellbeing Board				24th	
	Children's Trust					29th
Key engagement meetings	Caroyln Downs briefing		9th			
	Rob Larkman briefing		9th			

To support your agreement of next steps during January, we will provide:

- *A briefing to each Chief Executive on the findings from this phase of the work;*
- *A workshop on the characteristics and implications for integration commissioning of the MCP model.*

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Brent NHS Brent Clinical Commissioning Group	**Health and Wellbeing Board** 24 January 2018
	Report from the Director of Public Health

Brent Health and Care Plan Update: Focus on Prevention

Wards Affected:	All
Key or Non-Key Decision:	N/A
Open or Part/Fully Exempt:	Open
No. of Appendices:	None
Background Papers:	None
Contact Officer:	Dr Melanie Smith Director of Public Health Tel: 0208 937 6227 melanie.smith@brent.gov.uk

1.0 Purpose of the Report

1.1 The purpose of this report is to provide the Health and Wellbeing Board (HWB) with a further update on the progress of the delivery of the Prevention work stream, as part of Brent's Health and Care Plan.

2.0 Recommendation

2.1 The Health and Wellbeing Board are requested to note the progress report on the Prevention work stream

3.0 Detail

3.1 The Prevention work stream has five priority areas:

- reducing A&E attendances and hospital admissions due to alcohol
- addressing tobacco use
- exploring social prescribing as a means to address social isolation
- halting the increase of childhood obesity
- making every contact count (MECC).

3.2 The Prevention work stream has prioritised those areas where in Brent there is a significant opportunity to prevent future ill health.

3.3 Work to reducing A&E attendances and admissions due to alcohol has focussed on developing a seven day alcohol service within acute services drawing upon evidence from PHE as to the potential return on investment. A service model has been developed with clinical input from LNWHT, CNWL and alcohol treatment services as well as insight from service users. A business case was developed for a service in LNWHT serving Brent, Harrow and Ealing. However to date this has not been supported by the CCGs. The next steps are to explore a Brent and Harrow model at Northwick Park Hospital, modelling the potential impact with refreshed data from the last six months when a new way of identifying alcohol related admissions on the acute system was implemented.

3.4 As is the case nationally, the numbers of people accessing smoking cessation services are falling in Brent as smoking prevalence falls and e-products are widely available. In response Brent public health have joined the London Smoking Cessation Transformation Programme which is testing digital and telephone support for quitters. The digital campaign has had impressive reach and "click through" rates but this has not as yet yielded an increase in quitters. The Prevention Working Group will explore the potential to maximise the impact of the Preventing Ill Health – Tobacco and Alcohol CQUIN[1] which is to be implemented by LWNHT in 2018/19.

3.5 In Brent, social prescribing is being employed as a means to reduce social isolation and thereby reduce pressure on health and social care. Following the successful piloting of SIBI (social isolation in Brent initiative) and care navigation, discussions are underway between the Council and CCG to bring together the two services.

3.6 Halting the increase of childhood obesity is a clear priority for Brent given that more than a fifth of children start primary school overweight, and more than a third leave for secondary school overweight. Childhood obesity is also a national priority in the CCG Improvement and Assessment Framework 2017/18. Action to address childhood obesity includes

- Health Education England North West London (HEENWL) funded training for health and early years professionals in initiating conversations about healthy weight
- Achievement of Stage 1 Unicef Baby Friendly status for the Council, Children's Centres and health visiting service (stage 2 is on track to be achieved in 2018)
- The commissioning of a healthy weight service as part of the new 0-19 years public health contract
- Over 5000 children have received education on hidden sugars
- The Daily Mile has been promoted to Brent schools and taken up by 10
- Promotion of the Healthy Catering Commitment to fast food outlets in Harlesden

Future work planed includes:

[1] An incentive mechanism within the national NHS contract

- Further promotion of the Daily Mile and HCC
- Working towards the Dec*laration on sugar reduction and healthier food.*

3.7 Making every contact count (MECC) aims to equip front line staff with the knowledge and skills to employ brief health improving interventions during the course of their everyday interactions with residents, clients or patients. MECC was introduced into the Council in October 2016 following the successful bid to Health Education England North West London (HEENWL) to run a pilot. Since then, MECC has involved: creating briefing sessions based on a menu of health related topics, delivery of the first stage of MECC training to targeted teams (as defined in the HEENWL application as housing options, temporary accommodation and school nursing), rollout of training, and creating an easy access database of local specialist support services that will be made available via a web-app. Going forward, more MECC sessions will be created on different topics, sessions will be rolled out London Fire Brigade, London North West University Hospital Trust and other partners, and other options for publicising and delivery of MECC sessions, such as through videos, will be explored.

4.0 Financial Implications

4.1 There are no financial implications as a result of this report

5.0 Legal Implications

5.1 There are no legal implications as a result of this report

6.0 Equality Implications

6.1 There are no equality implications as a result of this report

7.0 Consultation with Ward Members and Stakeholders

7.1 The CCG, NHS providers and Healthwatch are all members of the Prevention Working Group and have been fully involved in the workstream. Third sector providers and service users were consulted in the development of the alcohol admission avoidance business case

8.0 Human Resources/Property Implications

8.1 There are no HR / property implications as a result of this report

Report sign off:

PHIL PORTER
Strategic Director of Community Wellbeing

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Brent NHS Brent Clinical Commissioning Group	**Health and Wellbeing Board** 24 January 2018
	Report from the Assistant Director - Integrated Urgent Care & Long Term Conditions, NHS Brent CCG

Integrated Urgent and Emergency Care Developments

Wards Affected:	All
Key or Non-Key Decision:	N/A
Open or Part/Fully Exempt:	Open
No. of Appendices:	3
Background Papers:	The Keogh Urgent and Emergency Care Review https://www.nhs.uk/NHSEngland/keogh-review/Pages/about-the-review.aspx
Contact Officer:	Shafeeq Tejani Assistant Director - Integrated Urgent Care & Long Term Conditions, NHS Brent CCG 020 8900 5384 s.tejani@nhs.net

1.0 Purpose of the Report

1.1 This Report provides the Health and Wellbeing Board with an update on the latest development of Integrated Urgent Care (IUC) within Brent and more widely across North West London. This Programme is being developed and will be mobilised on a STP wide basis.

2.0 Recommendation(s)

2.1 The Committee is asked to discuss and note the content of this report.

2.2 The Committee is asked in particular to note the wide ranging changes to access arrangements and service delivery the national and London approaches to Integrated Urgent Care will give rise to for all NHS unscheduled care users

3.0 Detail

Brent CCG together with the North West London (NWL) CCGs are working together to deliver an Integrated Urgent Care (IUC) service with NHS 111 as the Single Point of Access. The importance of a functionally IUC service to address the fragmented nature of out-of-hospital services was highlighted as part of the Five Year Forward

View Next Steps, the 2013 Keogh Review of Urgent and Emergency Care and the NHSE Commissioning Standards for Integrated Urgent Care (2015). The national service specification for the provision of integrated, 24/7 urgent care access, clinical advice, and treatment was introduced in August 2017.

This new pathway for the delivery of integrated urgent care services is designed to have the following attributes:

- Deliver 'Consult and Complete' by increasing clinical consultation to calls
- A Single call to get an appointment Out of Hours
- Data sent between providers
- The capacity for NHS 111 and OOHs is jointly planned
- The SCR is available
- Care plans and patient notes are shared
- Appointments made to in hours GPs
- Joint governance across urgent and emergency providers
- Clinical Hub containing GPs and other health care professionals

NHS England has mandated the following for all systems and are considered national priorities:

- IUC service coverage, 100% by April 2019
- 111 online, 100% available across NWL by Q4 17/18
- clinical contact, 50% by April 2018
- 111 booking into GP practice, 30% by April 2018
- booking appointments into OOH, 95% by April 2019
- extended hours coverage, 100% by April 2019
- enabler projects including: pharmacy lines, dental lines, mental health lines, special patient notes and ambulance re-triage

In September 2017, NWL CCG's approved a two year direct award pilot to the incumbent providers of NHS 111 and GP OOH services, to deliver an integrated Urgent Care service across the STP footprint of Northwest London.

The service is due to commence from Apr 2018 during which time a robust business case will be produced to support a full procurement and mobilisation in 2019/20. The key components for IUC are as follows:

- GP led service with other multidisciplinary clinical workforce
- Open for at least 12 hours a day seven days a week 365 days a year
- Direct booking from NHS 111 and other services
- Access to care records
- e-prescribing ability
- Access to simple diagnostics
- Access to x-ray facilities, with clear access protocols if not available on site

3.1 NHS 111

Brent patients account for approximately 50,500 contacts with NHS 111 annually. This is almost 25% of all contacts from patients in outer North West London boroughs.

The publication by NHS England in late August 2017 of the new national service specification for the provision of integrated 24/7 urgent care access, clinical advice and treatment incorporates the elements of NHS 111 service and GP Out of Hours (OOH) services.

The new NHS England Commissioning standards are more prescriptive than before and require fundamental changes within Integrated Urgent Care across the STP. Focusing on a 'Consult and Complete' model, the new standards require that 50% of calls will be spoken to by a clinician rather than only a health adviser and a GP available in the service 24/7, 365 days a year. This model has been shown to deliver better patient outcomes, reduce duplication of service and reduce demand at ED departments and on 999 Ambulance services.

This will be achieved through the NHS 111 number becoming the key co-ordinating function for all urgent care needs. Patients will access Urgent Care through their GP in hours, with access to NHS 111 via telephone and on-line 24/7.

We have recently implemented the *6 service which acts as a by-pass for care homes accessing clinical support from NHS 111. This will continue alongside a telemedicine service which will operate across all eight North West London CCGs from April 2018.

3.2 Clinical Assessment Service (CAS)

The model for an Integrated Urgent Care Clinical Assessment Service requires the following offer for patients:

- access to urgent care via NHS 111, either a free-to-call telephone number or online;
- triage by a Health Advisor;
- consultation with a clinician using a Clinical Decision Support System (CDSS) or an agreed clinical protocol to complete the episode on the telephone where possible;
- direct booking post clinical assessment into a face-to-face service where necessary;
- electronic prescription; and
- self-help information delivered to the patient.

The Future Clinical Assessment Service

Over time the CAS will continue to evolve, and will:

- Manage urgent appointment bookings, providing the access point for urgent care GP appointments, allowing GP surgeries to focus on scheduled and LTC care. It will be able to book patients 24/7 into Urgent Treatment Centres and Out of Hours Treatment Centres.

- Send a text message confirming appointment details and change or cancel appointments if necessary.
- Be *the key access point* for all urgent care services including the co-ordination of near-patient testing prior to clinical face-to-face (live or virtual) appointments, and enabling all prescriptions to be electronically prescribed and delivered to house bound patients.
- Develop into a single point of access for both urgent health and social care services, becoming the coordination and delivery centre for all clinical hospital discharge support services; community IV services, home visiting multidisciplinary clinical services, mental health and will integrate all specialist care clinicians.
- Use appropriate technology such as picture image sharing ability, video consultation technology and new patient wearable technology data sharing ability to maximise the number of consultations that can be completed within IUC.

3.3 Out of Hours Services

As noted above the out of hours landscape in North West London is complex. Across North West London there are 200 opted in practices, (53% of all practices) meaning that the GP practice has opted to provide the Out of Hours GP care to their patient population. They have mainly provided this by sub-contracting that care to in part or in whole to a 3rd party provider. Across NWL this is either London Central & West Unscheduled Care Collaborative or Care UK. These are individual contracts with the 3rd party provider and each practice has a different requirement and potentially a different charging mechanism.

3.4 Directory of Services

The Directory of Services (DOS) is a central directory - which is integrated with NHS Pathways – and provides the NHS 111 call handler with real time information about services available to support a particular patient.

For example, the clinical assessment within NHS Pathways gathers information that indicates the specific clinical skills needed by the patient. This information is used to perform a search on the directory to find a service local to the patient, which has all the clinical skills required.

3.5 Brent Urgent Care Services

In addition to the two year pilot, Brent CCG have been progressing with numerous additional service elements underpinning Integrated Urgent Care.

Northwick Park Hospital Urgent Treatment Centre

The Northwick Park Hospital Urgent Care Centre is co-located with the Northwick Park Hospital Accident and Emergency Department. Although the service is commissioned by NHS Harrow CCG, NHS Brent CCG is an associate commissioner. There is an even split in demand with Brent and Harrow patients each constituting almost 50% of total activity.

The service is delivered by Greenbrook Health in partnership with London Northwest Healthcare NHS Trust. The service manages in excess of 250 attendances per day which is circa 50% of overall attendances to the urgent and emergency service s on the site.

An important element of the service specification for the UCC is patient redirection. This is part of the developing approach seeking to ensure patients are able to access the service most appropriate for their particular needs at the time of presentation. Redirection entails, subject to patient choice, accessing a service more appropriate to the patient's clinical requirements. Examples of redirection include: dentist, GP Hub, own GP, pharmacy, sexual health, walk in centre, eye hospital, sent home with advice, and other speciality. In addition where patients are not registered with a GP, UCC staff facilitate registration.

Central Middlesex Hospital Urgent Treatment Centre

The Central Middlesex Hospital Urgent Care Centre has been a stand-alone unit since September 2014. The service has been the subject of a recent procurement resulting in a contract award to Greenbrook Healthcare with effect from April 2018.

In year 1 of the contract it is estimated that about 40,000 patients will attend the service. The contract is essentially a replica of that in operation at Northwick Park Hospital taking account of the fact that the service is not co-located with an accident and emergency service.

The contract is structured to ensure it has sufficient flexibility to be able to adapt to the requirements of the new national and London IUC service specifications.

Other Urgent Care Services

In addition to the Urgent Treatment Centres at Northwick Park and Central Middlesex Hospitals, Brent patients account for about 13%, of activity (approximately 8,000 attendances) at St. Mary's Hospital Urgent Treatment Centre services. In addition Brent patients account for almost 50% of activity in the Cricklewood Walk in Centre (approximately 10,000 attendances). There are other flows to services at St. Charles' Hospital and Edgware Community Hospital. These services will continue to be accessible to Brent patients.

GP Services

It has been agreed that GP extended access services will operate out of fewer but more consistent locations. There will be 5 locations, including Wembley Centre for Health & Care, Willesden Centre for Health & Care and Central Middlesex Hospital plus two further locations to be agreed, 1 in the north and 1 in the south. The GP Access Hubs would be joined up meaning that patients could access any of the hubs when appointments are available.

The Wembley GP Access Centre will convert to a GP Access Hub offering more pre-bookable appointments in both core and extended hours for the registered population in Brent and bookable through their own GP and by calling 111.

4.0 Financial Implications

4.1 Across North West London there is a very significant investment in unscheduled care services. Tied to this is a substantial level of activity which arises from the use of some services, and in particular, costly accident and emergency services, where suitable alternatives are underutilised. A case in point is the significant underutilisation of GP Extended Access Services with almost forty per cent of capacity unused

This is not a sustainable model and often delivers sub-optimal outcomes despite relatively high costs. It is envisaged that the proposed Consult and Complete' model, will facilitate both reduced costs and improved outcomes

5.0 Legal Implications

5.1 A number of key legal risks have been identified particularly in regard to the NHS 111 Direct Award. In order to mitigate against these legal risks and particularly the risk of potential challenge the Programme Board commissioned specialist procurement legal advice.

5.2 To mitigate this risk the IUC team continued to engage openly with the market and if no challenge was raised in 30 days then NWL would issue a contract to the incumbent providers. No challenge has been forthcoming and consequently a direct award has been made.

6.0 Equality Implications

6.1 An extensive Equality Impact Assessment has been undertaken across all North West London CCG (See Appendix 3). The EIA has been fully reviewed at individual CCG level to ensure full compliance with all local requirements as well as compliance with national requirements.

7.0 Consultation with Ward Members and Stakeholders

7.1 There has and will continue to be extensive pan North West London and local consultation and engagement with Ward Members and Stakeholders in the context of delivering the requirements of the Integrated Urgent Care Service Specification. This consultation and engagement process is to help facilitate the implementation of an integrated urgent care system that recognises local requirements but maintains compliance with outcomes from the Keogh Review and in particular ensures that regardless of where a patient may access urgent care services; there will be a recognisable core common across all local health economies.

8.0 Human Resources/Property Implications (if appropriate)

8.1 There is a risk that in the absence of a North West London wide approach, the CCGs will not be in a position to aggregate and utilise all clinical workforce where capacity may exist (Extended hours and UCCs) losing the ability to access this labour in an IUC model and funding a provider (essentially

overpaying). There is also the aligned risk of the market all chasing additional GP resource and having price inflation. This is also a key factor in the development of a London-wide service specification (Appendix 2) by Healthy London Partnership seeking to ensure that the particular requirements and demands are dealt with across London as a whole.

Report sign off:

SHEIK AULADIN
Brent CCG Chief Operating Officer

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The NHS Integrated Urgent Care Service Specification can be viewed electronically via: https://www.england.nhs.uk/urgent-emergency-care/nhs-111/resources/

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North West London (NWL) Integrated Urgent Care

Summary of current findings of Equality and Health Inequalities Analysis

Overview

This Equalities and Health Inequalities Analysis was undertaken in 2015 & 2016 and refreshed in 2017 to assess the extent to which the new integrated urgent care service, with NHS 111 as the front door, will meet the public sector duty set out in the Equality Act 2010 and the Health and Social Care Act 2012 to remove or minimise disadvantages suffered by people who fall under the `protected characteristics'; to propose recommendations and actions to meet their needs more fully; and to support the CCGs in meeting its separate legal duties on Equality and those on Health Inequalities. This analysis was undertaken using both quantitative and qualitative information from a range of sources.

The scope of the Equality and Health Inequalities Impact Assessment (EHIIA) covers Brent, Central London, West London, Hammersmith & Fulham, Harrow, Hillingdon, Hounslow and Ealing Clinical Commissioning Groups (CCGs). Appendix 1 details all NHS 111 engagement events held across the geographies of these CCGs. Further engagement across NWL will be carried out over the next two years of the pilot.

Objectives of the analysis and on-going programme through the two-year pilot:

1. Examine how services users that fall within the protected characteristic groupings access NHS 111, Urgent Treatment/Care Centres (UTC/UCC), GP Out of Hours (OOH), and other urgent care services using both NHS 111 data (telephony and on-line), continuing local engagement, current local and national patient surveys /pilots, other local STPs and other sources of information and intelligence;
2. Develop a set of recommendations that will be, where relevant and affordable, be included in the service specification for the procurement in 2019 and that the procurement documents to meet the Equality Duty.
3. Assess the impact of the new integrated urgent care service in reducing inequalities and advancing equality of opportunity for those service users that fall within the protected characteristic groupings through the Quality reporting of the two (2) year pilot and the service once commissioned

Analysis findings to date

The full North West London (NWL) Integrated Urgent care (IUC) Equality and Health Inequalities Analysis document has been developed and will continue to be populated throughout 2018. This work will be led by the Patient engagement sub-group of the NWL Integrated Urgent Care Board, supported by the eight (8) member CCGs and will draw on local and national pilots, other CCGs and patient engagement both locally and nationally.
Final recommendations will be included in the full business case, presented to the CWHHE investment committee and the each of the three (3) BHH procurement boards in Q4 2018/19, prior to the commencement of the procurement in Q1 2019/20.

Key themes from focus group's held and patient feedback

Access

- **Provide a one call service whenever possible**
- **Patients only have to give their information once**
- **Establish direct transfer to pharmacy and dental advice and assessment**
- Increase referral and rapid access to hospital specialists
- *Expand the different entry points including telephones, on-line, Skype, face time, text messaging, phone apps and chat line*
- *Confirm appointment times and location by text/email.*

Technology

- **Increase the number and use of special patient notes by all urgent and emergency care services**
- **Transfer of records from one service to another seamlessly**
- **Use cloud based platforms for record keeping and sharing**
- Keep records up to date
- Expand and continuously update the Directory of Services
- Design KPIs to measure outcomes as well as numbers of calls and outputs.
- *Information on callers to NHS 111 sent to their GP*

Workforce

- **Increase direct referral and access to professionals across the health and social care system.**
- Analyse data on the use of NHS 111 use and match predicted demand with staff rotas
- *Design the workforce based on skills, capability and capacity*
- *Provide continuous training, supervision, reflection and learning for all health and clinical advisers*
- *Staff could rotate between NHS 111, Out of Hours and Urgent Care Centres*

Communication

- *Promote NHS 111 wherever possible such as in pharmacies, GP practices, supermarkets, dentists, opticians, podiatrists, urgent care services*
- *Promote NHS 111 in public places, schools and universities, community centres, and entertainment outlets*
- *Include the NHS 111 number on all dispensing packaging*
- *Include the NHS 111 number on relevant correspondence with patients*
- *Notify patients about the NHS 111 service on discharge from hospital or an urgent care service.*

Service Integration

- **Develop joint commissioning across NHS 111, Out of Hours and Urgent Care**
- **Funding for services should be distributed in response to the new models of care**
- Provider networks should specify the role and expectations of NHS 111
- Integration can be driven through the GP networks and the development of new models of care i.e. diabetes management
- *Focus on patient-centred care with co-designed packages of care*

Bold = High or National Priority
No formatting = Medium or Local Priority
Italic = "Nice to Have"

Patient specific feedback on what they would like the service to deliver

1. Clarity, advertising and education efforts on the service and targeted advertising/engagement with minority cohorts who may face difficulties with access. (hearing impairment, English not 1st language, other disabilities, carer's)
2. Focus on direct access to clinicians and the ability to be booked into appointments where clinically appropriate.
3. Call handlers to have access to patient records, but with effective permission/confidentiality processes in place.
4. Healthcare problems addressed within a singular call.
5. No need to repeat information or answer unnecessary questions.
6. Direct access to mental health specialists, talking therapies and crisis management.
7. Patient transport services for access to urgent care where a face to face appointment is needed
8. To address language barriers.
9. Integration with pharmacy with the ability to receive and have prescriptions issued to a local pharmacy out of hours.
10. To keep local services such as GPs updated with patient progress.

11. Knowledge of local services and waiting times.
12. Increased access through other means (video messaging and apps).

Recommendations and how these will be addresses in the two (2) year pilot and in the service specification for the procurement

Equalities

Equality Data

1. The service specification, contract and the quality and key performance indicators to include that the provider has in place systems to capture data to obtain baseline information for the protected characteristic groups and to continue to evaluate the impact of the service in meeting the Equality Duty.

How will be addressed
This will be addressed through the KPI monitoring within the contract and as part of the monthly information schedule. The Patient Experience and Equalities engagement teams and the Patient reference group will review the service specification and the KPIs to ensure that this data collection is included. This will be reviewed at the Quality meetings with the provider

Disability

2. To include in the service specification, contract and key performance indicators for providers to develop and evaluate the effectiveness of existing and new technologies to improve access to the service for service users.

How will be addressed
This will be addressed through the contract as part of the quality data submittal with a quarterly reporting cycle. This is commonly referred to as "horizon planning" or "horizon review".
We will also be working closely with the local, London specific (HLP) and national team's, who are funding and developing pilots informed by the national patient questionaries' and reviewed by University of Sheffield.
An example of this is the national engagement with the British Sign Language services and a video relay (allowing video link into NHS 111 element of the service) information schedule.

3. Contracts, frameworks, and performance management arrangements with provider bodies enable and promote the Accessible Information Standard requirements. They must also receive assurance from providers that they are compliant with the standard.

How will be addressed
This will be addressed through the KPI monitoring within the contract and as part of the monthly information schedule. The Patient Experience and Equalities engagement teams and the Patient reference group will review the service specification and the KPIs to ensure that this data collection is included. This will be reviewed at the Quality meetings with the provider

Mental Health and other alternative care pathways (ACPs) and services

4. CCGs to ensure that the Directory of Services (DOS) reflects Mental Health local Crisis Concordat action plans.

   How will be addressed

   As part of the IUC programme the DOS is already being updated and there is a continual programme to ensure that the reference data within the DOS is kept up to date and the priority set as which services in which CCGs patients are booked into/directed to.

   Through the IVR (choice menu) there is an NWL/NCL mental health line already operational covering the tri-borough and there is an ONWL mental health line being used (in pilot phase at present with agreement from all parties). Therefore for pilot launch in 2018, we expect the IVR and patient choice to be the same across the 8 CCGs

   For Alternative Care Pathways (ACPs) The DOS and programme teams have already undertaken a review of all commissioned urgent care services that are across NWL, in order to understand fully the scope of what has been commissioned and to ensure that these services can be booked/patient transferred by the IUC service to the most appropriate care setting.

   Calls using these choices will be monitored through the contract management and quality meetings

5. Providers and CCGs' marketing of the IUC Service is advertised to make the service accessible for those with mental health problems and to emphasise that it is a service for both physical and mental health problems.

   How will be addressed
   This will be addressed through the patient reference group and through the central engagement teams. These messages are part of the co-ordinated campaigns led by the central communications team and includes all access (extended access, UCC/UTCs, NHS 111)

   There is on-going engagement with specific user groups through the CCG regular communication channels, which is reported through the NWL IUC board by the communications team membership of the board.

6. To improve the training and competency of call handlers to manage callers with a mental health need and/or experiencing a mental health crisis effectively through increasing awareness of mental health conditions and empathy. Working with the new IUC workforce models.

   How will be addressed
   This is being addressed through the national NHS 111 workforce model that has been developed in conjunction with Health education England. NWL bid for and were awarded additional funding to review the call handler (Health advisor) training across NWL, across both providers. This review is currently on-going and will continue through the pilot, as the national team continue to develop the NHS 111 workforce model

Ethnicity

7. For providers to evaluate the effectiveness of Language Line (the translation serviced used by NHS 111) and work to increase access and service user experience and uptake, for users for whom English is not their 1st language.

How will be addressed

This will be addressed through the specific collection of all service users, who utilise this functionality and through KPI monitoring within the contract and as part of the monthly information schedule.

The Patient Experience and Equalities engagement teams and the Patient reference group will be developing engagement strategies, across NWL and with especially for ONWL where the BAME are highest

Gender

8. CCGs and providers to undertake targeted communication and marketing of the NHS 111 service with male and older populations to increase uptake.

How will be addressed

This will be addressed through targeted campaigns and through the NHS 111 on-line capability. The collection of data and the age ranges are part of the standard data set available from the providers and the NWL data warehouse, which collects all activity data.

The Patient Experience and Equalities engagement teams and the Patient reference group will develop campaigns in conjunction with other STP messaging to ensure consistency in approach

Religion/Faith

9. For NHS 111 clinical staff to make use of care plans and end of life plans, and for training programmes to raise awareness of the different religious customs of service users that might impact these care plans.

How will be addressed

Through the Co-ordinate my Care (CMC) these plans are already available and are accessed by NHS 111 and the OOH/UTC services.
These will be further expanded to tag the callers main or regular numbers/ on line choices to automatically direct the call to a Clinician with access to that care plan, one the patient has made a choice early in the call/on line engagement, that they are contacting the service about. Where the call is about that condition and they have consented to those records be accessed. We have named this as "personalised IVR" choice, as the menu choices will be based on each callers plan.
Where the caller not calling from a known number, the same choice exists once the patient has undergone a patient demographic check (PDS) and their NHS number is known

Carers

10. NHS IUC staff to fully involve carers in care and treatment advice given to service users with the use of the Telemedicine pilot across the 8 CCGs.

How will be addressed

*This will be addressed through the telemedicine pilot, with initially carers using the ability to dial *6 at the start of the call, to be "warm transferred" or called back by a Clinician*

To reduce health inequalities

11. NHS IUC staff working in the 'Clinical Hub(s)' will maximise opportunities to provide health and where possible social care advice to help service users to self-manage their health conditions and provide health promotion information e.g. smoking cessation services, health screening, and drug and alcohol support.

How will be addressed

This will be addressed through the self-care options following a call/on line interaction with the service. The service will have access to the NWL patient literature (digitally and in paper format) and the service can arrange for that information to be made available to patients and carers.

After each call there is a post event message sent to the patient's registered GP surgery in other that the primary care provider is aware of the interaction and information supplied

12. The providers of the new integrated urgent care service will have education and training for staff that includes the health inequalities and priorities for NWL that impact on health promotion messages.

How will be addressed

This is being addressed through the national NHS 111 workforce model that has been developed in conjunction with Health education England. NWL bid for and were awarded additional funding to review the call handler (Health advisor) training across NWL, across both providers. This review is currently on-going and will continue through the pilot, as the national team continue to develop the NHS 111 workforce model

13. NWL CCG Commissioners to work with other CCGs to ensure that the clinical pathways and access to services for patients are the same for service users that live on CCG boundaries. How will be addressed

How will be addressed

As part of the IUC programme the DOS is already being updated and there is a continual programme to ensure that the reference data within the DOS is kept up to date and the priority set as which services in which CCGs patients are booked into/directed to.

Through the IVR (choice menu) there is an NWL/NCL mental health line already operational covering the tri-borough and there is an ONWL mental health line being used (in pilot phase at present with agreement from all parties). Therefore for pilot launch in 2018, we expect the IVR and patient choice to be the same across the 8 CCGs

For Alternative Care Pathways (ACPs) The DOS and programme teams have already undertaken a review of all commissioned urgent care services that are across NWL, in order to understand fully the scope of what has been commissioned and to ensure that these services can be booked/patient transferred by the IUC service to the most appropriate care setting.

Calls using these choices will be monitored through the contract management and quality meetings

14. CCGs to ensure that the Directory of Services is continually updated and includes a wide range of health, social care and voluntary sector services to ensure service users are able to maximise use of organisations that can support patients to manage their health and social care needs more fully.

    How will be addressed
    As part of the IUC programme the DOS is already being updated and there is a continual programme to ensure that the reference data within the DOS is kept up to date and the priority set as which services in which CCGs patients are booked into/directed to.

    This programme of regular update to the DOS has traditionally included healthcare services and will be expanded through the pilot to include voluntary sector and social care services data that the Health Advisors or the last person to talk the patient/carer can access the DOS to give this additional information. This service development will likely be subject to additional funding and any request will need to be approved the by CCGs F&P committees.

    For Alternative Care Pathways (ACPs) The DOS and programme teams have already undertaken a review of all commissioned urgent care services that are across NWL, in order to understand fully the scope of what has been commissioned and to ensure that these services can be booked/patient transferred by the IUC service to the most appropriate care setting.
    Calls using these choices will be monitored through the contract management and quality meetings

15. CCGs to undertake targeted marketing of the NHS 111 (IUC) and NHS 111 Online (IUC) service to those groups who will benefit most from a nonstandard route of access.

How will be addressed

This will be addressed through targeted campaigns to these user groups and through the NHS 111 on-line capability. The Patient Experience and Equalities engagement teams and the Patient reference group will develop campaigns in conjunction with other STP messaging to ensure consistency in approach

There will be specific and targeted campaigns to engage with the specific groups such as BSL, following the national pilots.

The collection of data and the age ranges are part of the standard data set available from the providers and the NWL data warehouse, which collects all activity data.

16. CCGs to evaluate language accessibility of NHS 111 Online triage pilot and if possible, introduce additional language options.

How will be addressed

This will be addressed through the specific monitoring of NHS 111 on-line capability and the access routes that users utilise. INWL has one provider and ONWL another provider for the two year initial contract. The services will be reviewed through the period and a separate procurement (possible across London) will then be reviewed by the 5 STPs to select a provider across London and review the requirement for multi-language capability for the NHS 111 online triage tool

The Patient Experience and Equalities engagement teams and the Patient reference group will review the NHSE questionnaires and user feedback.

17. CCGs to consider including 111 Online training as part of their provision for digitally excluded service users.

How will be addressed

There are no current plans for this, but NWL in conjunction with HLP could look to utilise the wide array of on-line training offered free by commercial entities (Barclays Digital Eagles, Lloyds training)

18. Access to patients notes in other that they do not repeat themselves

How will be addressed

Through the current system, the patients Summary care record (SCR) is available to the Clinician as are a number of special patient notes (SPNs such as Co-ordinate my Care (CMC) which are controlled by the patients GP and/or primary care provider)

There are a number of SPNs already available and are accessed by NHS 111 and the OOH/UTC services.
These will be further expanded to tag the callers main or regular numbers/ on line choices to automatically direct the call to a Clinician with access to that care plan, one the patient has made a choice early in the call/on line engagement, that they are contacting the service about. Where the call is about that condition and they have consented to those records be accessed. We have named this as "personalised IVR" choice, as the menu choices will be based on each callers plan.
Where the caller not calling from a known number, the same choice exists once the patient has undergone a patient demographic check (PDS) and their NHS number is known

At the end of a call, where the patient is booked for onward care (in a face to face setting) or for a call back, the record of the conversation and the questions answered (on the telephone or on line) is send electronically to the receiving organisation/Clinician, so that that are aware of the patient's condition and any relevant primary care notes or care plan that this in place.

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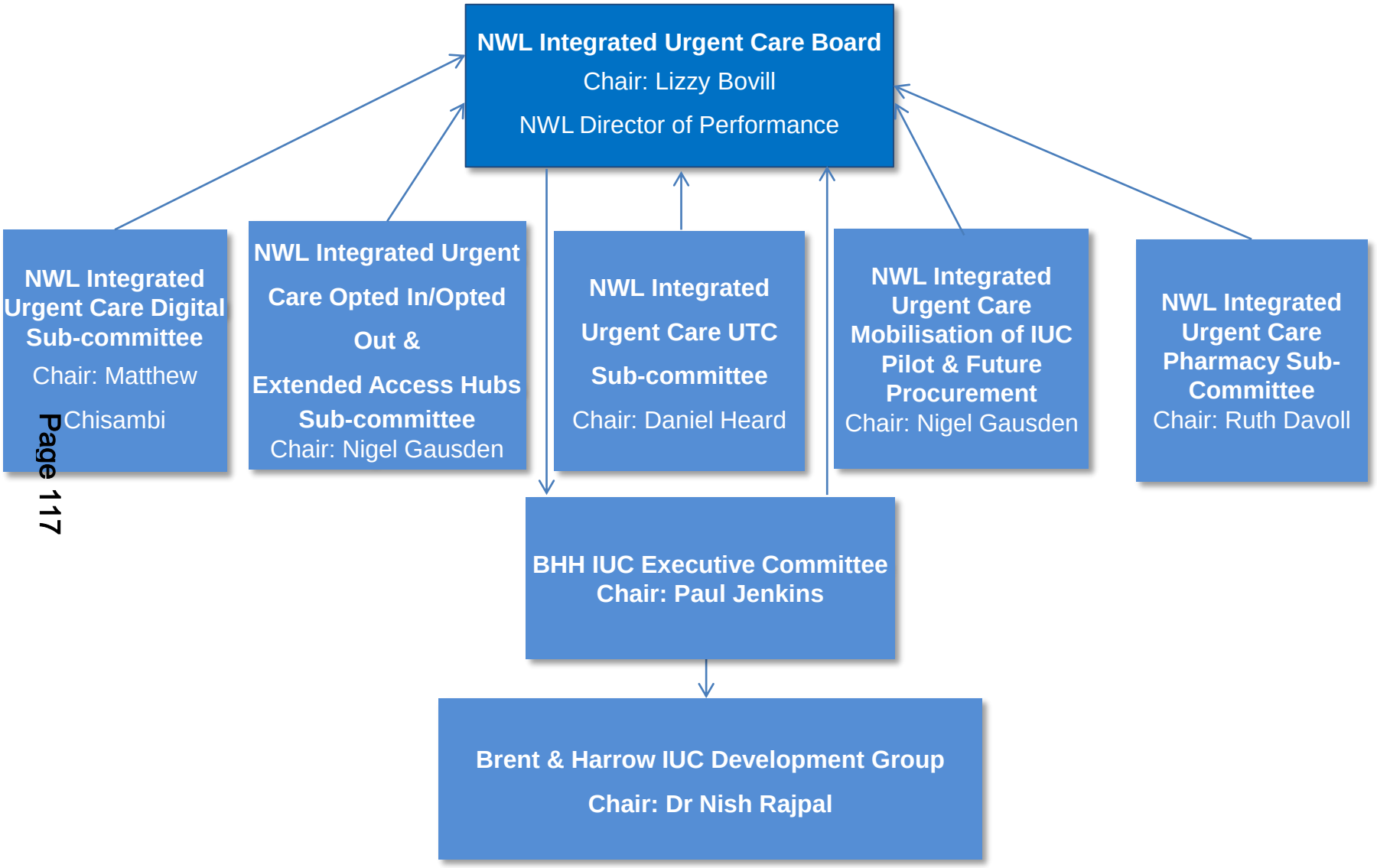
Brent Governance Structure



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Brent

NHS Brent Clinical Commissioning Group

Health and Wellbeing Board
24 January 2018

Report from Assistant Director of Primary Care, Brent NHS CCG

Improving the GP Extended Access Offer in Brent

Wards Affected:	All
Key or Non-Key Decision:	N/A
Open or Part/Fully Exempt:	Open
No. of Appendices:	5 (Appendices 1-4 are contained at the bottom of this report)
Background Papers:	GP Extended Access Information Booklet - http://brentccg.nhs.uk/en/review-of-brent-gp-access-services Community and Wellbeing Scrutiny Committee – Primary Care Transformation Report from Brent Clinical Commissioning Group (19 July 2017)
Contact Officer:	Fana Hussain Assistant Director Primary Care NHS Brent CCG fana.hussain@nhs.net

1.0 Purpose of the Report

1.1 This report provides the Health and Wellbeing Board with an update on the review of GP extended access in Brent. On 10 January 2018 the CCG approved a business case to improve the GP extended access offer across Brent. This approval was granted after the CCG completed a 8.5 week public engagement period. The engagement period was the route through which Brent patients, residents, GP providers and key stakeholders will shape and inform the final proposal for GP extended access locally.

1.2 This report gives the Board an overview of the review process and the model being commissioned. It also reports the findings from our public engagement period which ran from 13 November 2017 until 9 January 2018.

2.0 Recommendation(s)

2.1 The Board are asked to note the content of this report.

3.0 Detail

3.1 The Board will be familiar with the challenges around access to GP services. Brent has 62 GP practices serving a registered population of 371,405 people - growth of approximately 7.4% in the last 4 years. With demographic growth and local regeneration and housing projects the population needing primary care services, will continue to grow.

3.2 Extended access became a national priority over 3 years ago when the Prime Ministers Challenge Fund (PMCF) was put in place to improve access to general practice. This sought to provide additional hours of GP appointment time, improve patient and staff satisfaction with access to general practice, reduce demand elsewhere in the system and make use of emerging 'at scale' delivery models (partnership working between GP providers) to ensure extended access appointments were shared, staffed and managed.

3.3 Extended access has also been a local priority for some time; in 2015 a Brent Scrutiny Task Group considered primary care's ability to meet demand and provide fair and equitable access. It recommended investment in access, development of innovative ways to meet and manage demand, promotion of health and wellbeing and encouraging residents to support themselves wherever possible.

3.4 The model delivered locally (and seen nationally) is the Hub model; these generally take two forms - 'top up hubs' (a practice that provides a combination of routine core services and opens in the evenings and weekends) or through 'standalone hubs' (designated sites) which offer additional pre-bookable GP appointments 8am- 8pm, 7 days a week. Brent meets the requirement through top-up hubs which operate from GP practice sites in each of the Networks. Hubs provide pre-bookable appointments with GPs or Nurses outside 'core' or standard practice hours (for example in the evenings and at weekends).

3.5 In Brent we have two types of extended access service:

- GP Access Hubs
- GP Access Centre ('walk-in service').

There are currently 9 Hubs in Brent available to the registered population weekday evenings and weekends. Between them, the 9 hubs offer an additional 64,000 evening and weekend appointments annually, covering the hours Monday-Friday 6-9pm and weekends and Bank Holidays 8am-8pm. In addition the GP Access Centre offers approximately 37,000 GP or Nurse slots (attendances).

3.6 At present, the hubs operate different days/hours and are only open to patients whose practice is a member of the Network that runs that hub. This reflects the fact that – at the time the original contracts were commissioned – there was no single GP Federation and as such these services were commissioned through 5 separate contracts, reflecting the primary care provider landscape of the last few years.

3.7 Hub contracts expire 31st March 2018 and the Access Centre ('walk in service') contract expires 31st March 2018. So we are reviewing the service now to ensure any newly commissioned service preserves the best aspects of the local offer, respond to patient (and practice) feedback, offers an equitable service to all Brent patients, represents value for public money and delivers against national expectations and guidelines. We are also seeking to future-proof the model by ensuring it can support delivery of Integrated Urgent Care and has more effective links with the 111 service and with Urgent Care Centres.

3.8 The GP Access Centre (walk in service) was established in April 2009 and is at the Wembley Centre for Health and Care. The service provides a "see and treat" model; this means the clinician bases their treatment on the patients presentations at the appointment. Furthermore they are not commissioned to provide repeat prescriptions, order diagnostics or provide onward referrals to other services (except for urgent referrals to A&E and Cancer 2 week wait referrals).

3.9 There have been many improvements to the service since it was first designed. This includes:

- Extending opening hours to 8-8 /7 days a week
- Ensuring appointment availability available to every practice online so they can offer and book straight away when a patient contacts their practice.
- Ensuring online access for Hub GPs to the patients clinical record so they can offer a full service and better continuity of care
- Making use of the clinical system to directly share discharge and follow up information with the patient's own practice.
- Implementing text messaging so patients get a text from the Hub with their appointment and are able to cancel if they can no longer attend.
- Production of a short video raising awareness of the hub service as well as posters and leaflets.
- Linking the hubs to NHS 111 through the 'directory of services' used by 111 and now the trialling of technology to enable direct booking by 111 when a patient calls.
- Redirection of patients attending Urgent Care Centres where they might be better served by the GP access hubs.

3.10 Our review initially focused on identifying and implementing the improvements above, and the delivery of key objectives within the GP Forward View (GPFV). The *Access Task & Finish Group* (CCG officers and clinical directors, hub providers and Healthwatch) identified a number of areas where further work was needed:

- Underutilisation (especially at the weekend): there are more Hubs in Brent than in any other North West London borough and from April until August 2017 GP Access Hub utilisation across the 9 sites averaged 57%.
- Variation in the model of care delivered across the Hubs.
- Availability of Nurse appointments and dressing service at some hubs
- Variation in hours and days of opening which led to difficulty in promoting the Access Hubs
- Variation in way patients are booked into the Access Hubs and notification to patients
- Patient choice being limited to Network hubs

- The ability of the current Access Hub to deliver the national requirements on skill mix, direct booking by NHS 111 and patients etc
- Meeting standards and requirements: the GP Access Centre 'walk in' service is not compliant with national GP out of hours access requirements[1].

The review has culminate in a business case that the CCG Governing Body approved on 10 January 2018.

3.11 Our design for the new service has taken into account the key objectives and requirements for GP Extended Access and feedback from engagement with clinicians, patients, the public, providers and key stakeholders. We believe the improved design will mean:

- Brent patients are seen in the right place first time.
- Extended access services are a true extension/continuation of GP services (e.g. full access to clinical records, ability to view test results, full prescribing capability).
- There is a consistent service offering across Brent.
- Capacity and demand are better matched (with room for growth in the number of appointments available and booked).
- Appointments are pre-bookable in line with national requirements (with scope to also book same day).
- Pressure on the system is better managed (including at peak times)
- There is better alignment to and joint working with Urgent Care and 111.
- We are compliant with national out of hours standards.
- We are achieving better value for public money.

3.12 The proposed model will:

- Condense appointments at a smaller number of sites to enable longer and more consistent opening hours so appointments are available at times when people need them (like after-school/early evening).
- Ensure we have hubs at our 3 strategic sites - Wembley Centre for Health & Care, Willesden Centre for Health & Care and Central Middlesex Hospital.
- Convert the GP Access Centre into a pre-bookable stand-alone Hub open 8-8/7 days a week. This will help manage times of high demand in the individual practices and enable Brent to meet new national requirements including redirection of patients from Urgent Care Centres into practices during core hours. This would otherwise be difficult to manage for the 62 practices. We have mapped peak demand for appointments at UCC and will match this demand to availability of appointments at the Hub
- Provide more equitable access to the residents of Brent.
- Ensure patients can access any hub site.
- Commission Nurse and GP appointments across the borough consistently.

- Ensure when they do, their clinical records are available to the GP or Nurse and are subsequently updated so their own practice can see what support their patient has received.
- Ensure clinicians are not 'lone working'
- Support Brent residents (and those within the catchment area of a Brent GP practice) to register.

[1] Integrated Urgent Care Commissioning Standards Guidance (Amanda Doyle & Keith Willetts, September 2015)

- Encourage patients registered with a GP outside Brent to use services in the borough in which they are registered – this ensures better continuity of care and clinical record sharing is not enabled between practices in different boroughs.

3.13 One notable change to the future model is to move away from providing extended access services to unregistered and out of borough patients. The current 'walk in' service provides for people not registered and/or living in a different borough. If this is converted to a hub it will not do so.

3.14 The review has identified that 80% of people who use the current 'walk in' service are already registered with a Brent GP, 15% are registered with a GP in another borough, and only 5% are currently unregistered. Furthermore, 57% of attendances are from patients who are registered with a practice within 2 miles of the walk in service.

3.15 We have undertaken an Equality Impact Assessment and a Quality Impact Assessment. We have also met with other CCGs who have implemented similar changes. Our plan includes a commitment to:

- Support Brent residents to register
- Mitigate the risk of people redirecting themselves the A&E at Northwick Park by facilitating them to use the Access Hubs or to attend the Urgent Care Centre when appropriate
- Ensure Brent residents know the 'walk in' model for meeting urgent needs is still be available at our two Urgent Care Centres at Central Middlesex Hospital and Northwick Park Hospital by raising awareness of services as part of our mobilisation plan.

3.16 The exact locations will be agreed with the provider during mobilisation; however 3 locations are defined by our strategic estates plans (Wembley, Willesden and CMH) and the other 2 will be located in the areas of Brent that we expect to have the highest demand based on population growth and demographics. Appendix 1 and 2 provide the current operating hours for the nine hub sites and GP Access Centre[2] and the proposed operating hours.

3.17 The model will ensure there are enough appointments to meet demand based on 2016/17 data and there will be more appointments during GP practice 'core' hours (8.00am - 6:30pm) to address unmet demand during that time.

3.18 The total number of GP and Nurse appointments commissioned across the hubs and 'walk in' service in 16/17 was approximately 100,000. Of this 75,800 appointments were used. Our proposal is to commission approximately 89,000 Nurse and GP appointments from 18/19 onwards. This will provide room for growth in utilisation of 18.5% (or over 14,000 appointments). The new contract will include the option of increasing provision in line with demand to future proof growth as the new model should also increase awareness and improve uptake. Appendix 3 shows the current utilisation from April to November 2017 at an average of 59% across the hubs.

3.19 The proposal was taken to the CCG Executive Committee on 18 October 2017 and agreed subject to public engagement. A paper was taken to the Community and Wellbeing Scrutiny Committee (CWSC) – Special Meeting on

[2] Nine locations total as the Wembley Centre for Heath & Care houses a hub and the GP Access Centre

6 December 2017. The business case was updated based on the recommendations from the CWSC. The CCG Governing Body met in public on the 10 January 2018 and approved the business case.

3.20 The engagement period commenced on 7th November 2017 and ended at 9 January 2018. The engagement undertaken included:

- Produced a booklet outlining the proposals called “GP Access. Improving our GP access offer in Brent
- Produced an FAQ which provide more information on our proposals
- Produced an information pack outlining key facts and figures related to the GP Access Hubs and the GP Access Centre
- Launched a dedicated webpage on the CCG website at http://brentccg.nhs.uk/en/review-of-brent-gp-access-services
- Set up a dedicated email address for questions/suggestions/comments breccg.gpaccessengagement@nhs.net
- Launched a survey (online and paper)
- Pop-ups in public places including @ Brent Civic Centre, Central Middlesex Hospital, Willesden Sports Centre etc.
- Reached out to Children’s Centres and Sports Centres – as we know some of the highest users of the GP Access Centre are children and people between the age of 26-34.
- Held drop in sessions for Patient Participation Groups (PPGs) and other members of the public across Brent
- Planned workshops to engage the public in review of future locations for the Hubs (November and December)
- Conducted surveys and interviews at all 9 existing GP Access Hubs and at the GP Access Centre.
- Pop-up areas at popular locations in Brent (e.g. ASDA)

4.0 Financial Implications

4.1 Our proposal will not require any additional spend; indeed it will result in a potential cost saving to the NHS in the short term whilst appointment uptake improves. It is intended that any savings made through this proposal be reinvested in primary care services.

5.0 Legal Implications

5.1 A new specification for GP extended access is now being finalised.

5.2 As this is a primary care service the final decision on contract award will be taken by the Brent CCG Independent Procurement Panel (IPP) which includes senior management team members, an independent GP, the Londonwide Medical Committees (LMC), a Procurement advisor and is chaired by one of the Lay members on the CCG Governing Body.

5.3 The IPP will ensure the route to market complies with our statutory duties and regulations including adhering to the Public Contracts Regulations 2015 and NHS (Procurement, Patient Choice & Competition) Regulations (No2) 2013. We will ensure any ensuing contracting or procurement is undertaken in a way that manages conflict of interest and secures the highest quality and value. This panel has been established in accordance with, and shall be bound by, the CCG Constitution, Standing Orders and Scheme of Delegation.

6.0 Equality Implications

6.1 Delivery of our proposal for GP extended access should support delivery of our equality duty and positively contribute to a reduction in health inequalities and variation across Brent and its communities. Our duties will be reflected in the design of the services.

6.2 We have considered the potential impact of our proposal on different groups and how the service change may impact different groups of stakeholders in different ways. This is contained in our Equality Impact Assessment (EIA). The assessment highlights that no particular group will be negatively affected by our proposal. The EIA is available at the following link: http://brentccg.nhs.uk/en/publications/cat_view/1-publications/3-governing-body-meeting-papers/488-10-january-2018

6.3 The CCG will work with providers during the mobilisation period and throughout the duration of the contract to ensure that patient views, feedback and needs are taken into account in the commissioning and delivery of the service.

7.0 Consultation with Ward Members and Stakeholders

7.1 In October 2017, the CCG engaged Councillors Butt, Hirani, and Sheth to discuss the future GP extended access model for Brent. We have engaged the public and key stakeholders in November, December and January to gather views on our model. Information on the proposed changes and the evidence supporting them was and is still available on the CCG's website here http://brentccg.nhs.uk/en/review-of-brent-gp-access-services. Our engagement process and materials and reflected the Councillor's suggestions. Our detailed engagement plan is contained in Appendix 4.

7.2 We have also planned a series of in-person events that are listed below. Our engagement process included having a number of drop in sessions and stalls across. We also visited GP Access Hubs to conduct surveys.

NOVEMBER		
Tuesday	**7**	**Event/Activity**
		Willesden Centre for Health and Care - Stall from 9am-2pm
Wednesday	**15**	**Event/Activity**
		Wembley outlets - Surveys 2-5pm
Thursday	**16**	**Event/Activity**
		Survey at the Shaping Brent's Future Together event from 7-9pm at Brent Civic Centre
Friday	**17**	**Event/Activity**
		Surveys at Nail Salons in Wembley 2-4
Monday	**20**	**Event/Activity**
		Drop in session – 11-1pm – Mtg Rm 3 – Willesden Centre for Health and Care
		Brent Civic Centre stall
Tuesday	**21**	**Event/Activity**

		Stall at - Physical Play Session - At Alperton Children's Centre
		Drop in session - 12.30 – 2.30pm – Board Room - Wembley Centre for Health and Care
		Surveys at The Welford Centre - GP Access Hub from 7-8pm
Wednesday	**22**	**Event/Activity**
		GP and GP practice service design workshop - Sattavis Patidar Centre - 11:30-2:00
		Surveys at GP Access Hub - Kingsbury Health and Wellbeing - 6-7pm
		Willesden Market on Wednesday - hand out surveys and speak to public - Lunchtime
Thursday	**23**	**Event/Activity**
		Foyer of CMH to set up a stall to inform the general public and do surveys
		Brent Civic Centre stall
		Public Workshop providing more details about the review and determining future locations
		Stall with Brent Carers
Friday	**24**	**Event/Activity**
		Drop in session - 11-1pm – Board room – Hillside
Monday	**27**	**Event/Activity**
		Drop in session - 12-3pm – Rm 121 - Chalkhill/Welford centre
Tuesday	**28**	**Event/Activity**
		Surveys at Tube stations
Wednesday	**29**	**Event/Activity**
		Surveys at Tube stations
Thursday	**30**	**Event/Activity**
		Surveys at Tube stations

DECEMBER		
Friday	**1**	**Event/Activity**
		Wembley High Rd – Surveys at Barber Shops
Monday	**4**	**Event/Activity**
		Surveys at Tube stations
Tuesday	**5**	**Event/Activity**
		Stall/survey at the Shaping Brent's Future Together event from 7-9pm at Willesden Green Library
Wednesday	**6**	**Event/Activity**
		Special Scrutiny Meeting at BCC from 7-9pm
		Chalkill Mental Health Group
Thursday	**7**	**Event/Activity**
		Stall with Brent Carers - Drop in
Monday	**11**	**Event/Activity**
		Stall/survey at the GP Access Centre in WCHC - After 9:30
Thursday	**14**	**Event/Activity**

		GP and GP practice engagement - Willesden Library - 12pm to 14.30pm
Friday	**15**	**Event/Activity**
		Vale Farm Sports Centre 10 -12
Tuesday	**19**	**Event/Activity**
		Drop in session - Willesden Centre for Health and Care - Meeting room 1 from 2:30-4:30
Thursday	**21**	**Event/Activity**
		Detailed workshop about reviews and future locations – CVS Training Room - 3:00-5:00

January		
Tuesday	**9**	**Event/Activity**
		Drop in session – Tricycle Theatre -

8.0 Human Resources/Property Implications

8.1 The CCG will be engaging with the Strategic Estates Teams and any landlord or property owners to implement any necessary changes during the mobilisation period.

Report sign off:

SHEIK AULADIN
Chief Operating Officer

Appendix 1: Current locations and hours

Sites	Operating hours
1. Harness Wembley Health Centre	18.00-21:00 (M-F); 09.00-15:00 (Sa, Su)
2. Harness Harlesden Practice (*practice merging and moving to CMH in early 2018*)	18.00-21:00 (M, W-F); 09.00-15:00 (Sa)
3. Roundwood Park Medical Centre	18.00-21:00 (T); 09.00-13:00 (Sa)
4. Kilburn Park Medical Centre	18-21:00 (M-W)
5. Staverton practice	18-21:00 (Th-F); 9-15:00 (Sa); 9-13:00(Sun)
6. The Welford Centre	18-21:00 (M-F); 9-15:00 (Su)
7. Kingsbury Health & Wellbeing practice	18-21:00 (M, W); 9-12 (Sa)
8. Willesden Centre for Health & Care	8-21.00 (Sa, Su)
9. Sudbury	18-21:00 (M-F); 9-15:00 (Sa, Su)
Wembley GP Access Centre @ Wembley Centre for Health & Care	08.00-20:00 7 days/week

Appendix 2: Proposed locations (where known) and hours

Proposed sites	Weekday Hours	Weekend Hours
Strategic site – Wembley Centre For Health and Care	8am-8pm	8am-8pm Saturday and Sunday
Strategic site – Central Middlesex Hospital	4-8pm	9am-6.30pm Saturday Only
Strategic site – Willesden Centre for Health and Care	4-8pm	9am-6.30pm Saturday Only
Other location	4-8pm	9am-6.30pm Saturday Only
Other location	4-8pm	9am-6.30pm Saturday Only

Appendix 3: Current utilisation

	All Networks GP Access Hub utilisation per day (Apr- Nov 2017)			Brent wide GP Access Hub (Willesden) Utilisation per day (Apr to Nov 2017)		
Day	**Target appts per day**	**Actual patients seen**	**% Utilisation**	**Target appts per day**	**Actual patients seen**	**% Utilisation**
Monday	6,501	4751	73%	180	13	7%
Tuesday	5,426	3842	71%	0	0	
Wednesday	5,225	3761	72%	0	0	
Thursday	4,279	2975	70%	0	0	
Friday	4,324	2875	66%	36	5	14%
Saturday	8,808	3599	41%	1,260	291	23%
Sunday	4,645	1257	27%	2,520	154	6%
Total	**39,208**	**23060**	**59%**	**3,996**	**463**	**12%**

Appendix 4: Engagement plan

Stakeholder	Activities
GP Federation/Network leads	Letter and materials sent
Councillors	Letter and materials sent
Healthwatch	Letter and materials sent Newsletter copy for cascade to networks
GPs, Practice managers, GP practice staff	Letter sent to all 62 GP practices 2 workshops have been planned to gain input Leaflet and posters sent to all practices
Community and voluntary services	Letter sent Newsletter copy for cascade to their networks
Patient groups & lay member groups: PPGs,	Letter sent to GP practices to cascade to PPGs Newsletter copy for cascade to their networks
Patients and public Local schools Faith communities Local mother and baby groups Patient groups & lay members: PPGs,	CCG Website Stakeholder letter Social media Twitter PPG channels CCG engagement channels Local media releases Copy for GP websites Patient group channels Posters – digital copies Leaflet (digital copies)
Patients who use the walk in service and/or the Hubs	Local media releases SMS to patients using the walk in service and/or Hub services Council magazine editorial and advertising Newspaper editorial and advertising Posters in practices and pharmacies

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NHS
Brent
Clinical Commissioning Group

GP Extended Access Review

Outcomes from public engagement

Last updated January 2018

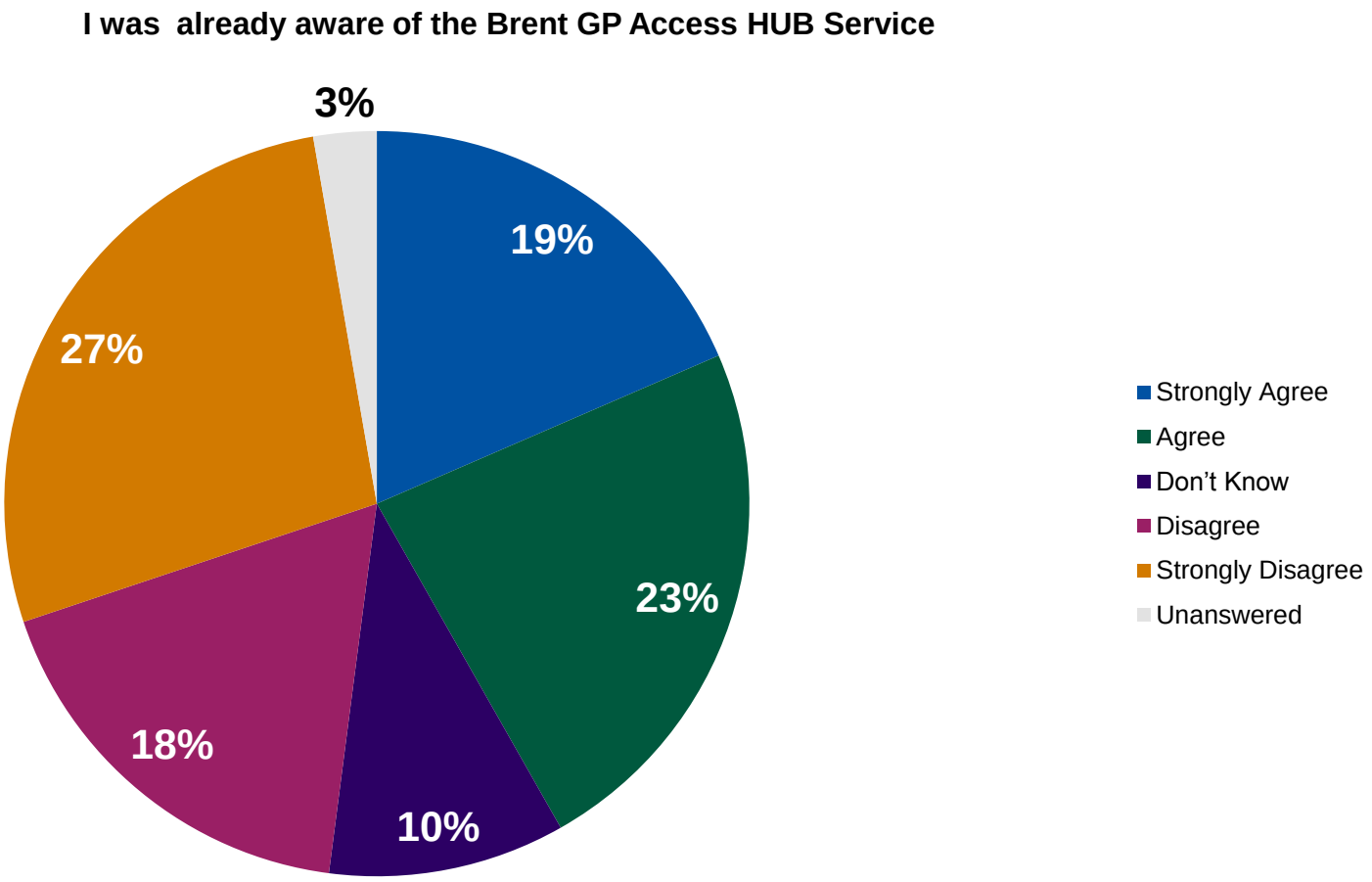
The survey results

- The data in this pack is gathered from 146 patient surveys completed either through the online survey or filled in a paper based survey between November 2017 – January 2018
- 92% of the respondents are Brent residents
- 59% of the respondents were female
- 35% of the respondents were male
- 90% of the respondent identified as being a local resident (as opposed to an Organisation Rep, Commissioner, or health care provider)

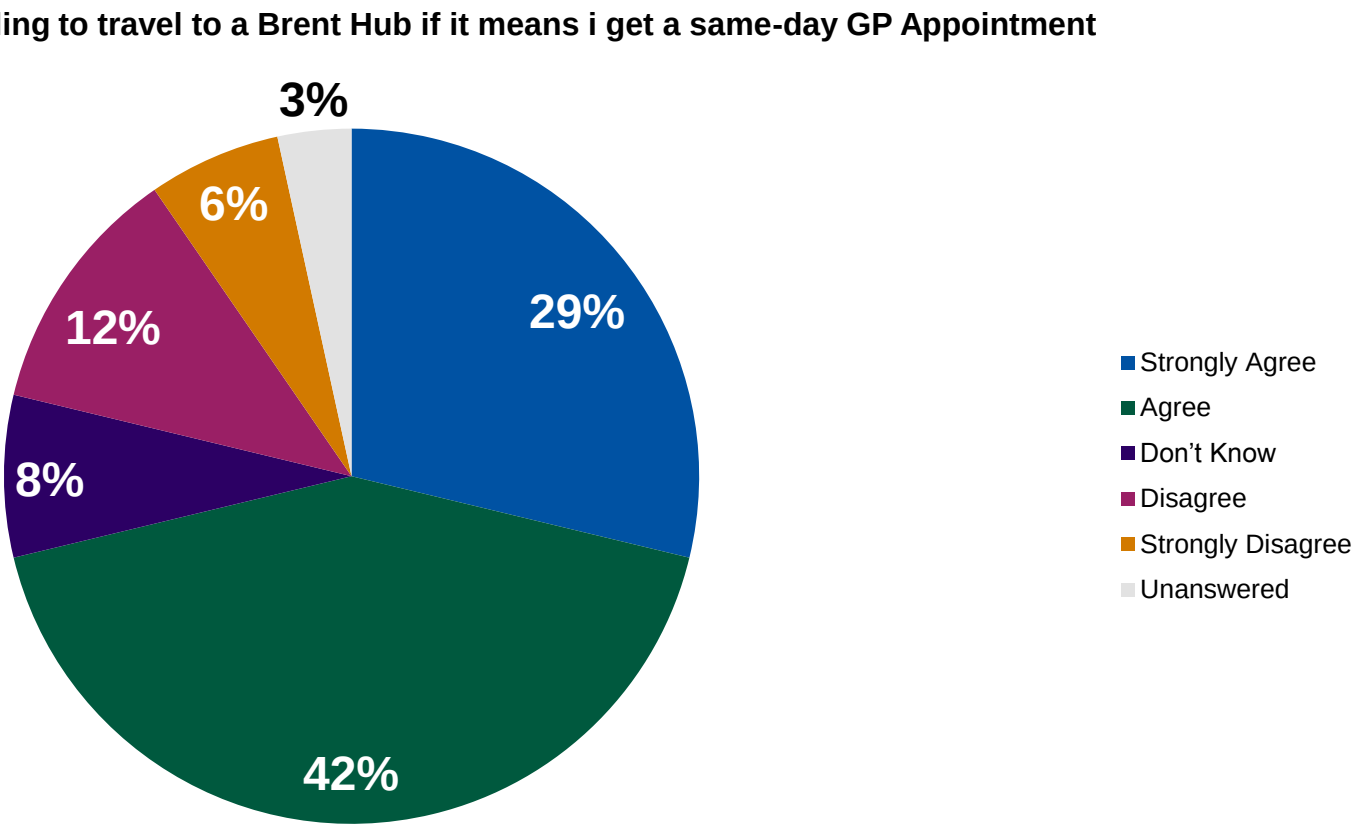
And wider engagement

- Over 2000 surveys were handed out to members of the public
- CCG team members attended over 30 events, drop in sessions and stalls and spoke to many members of the public to seek out views on the proposal
- The local councillors were engaged to seek their views on the proposal

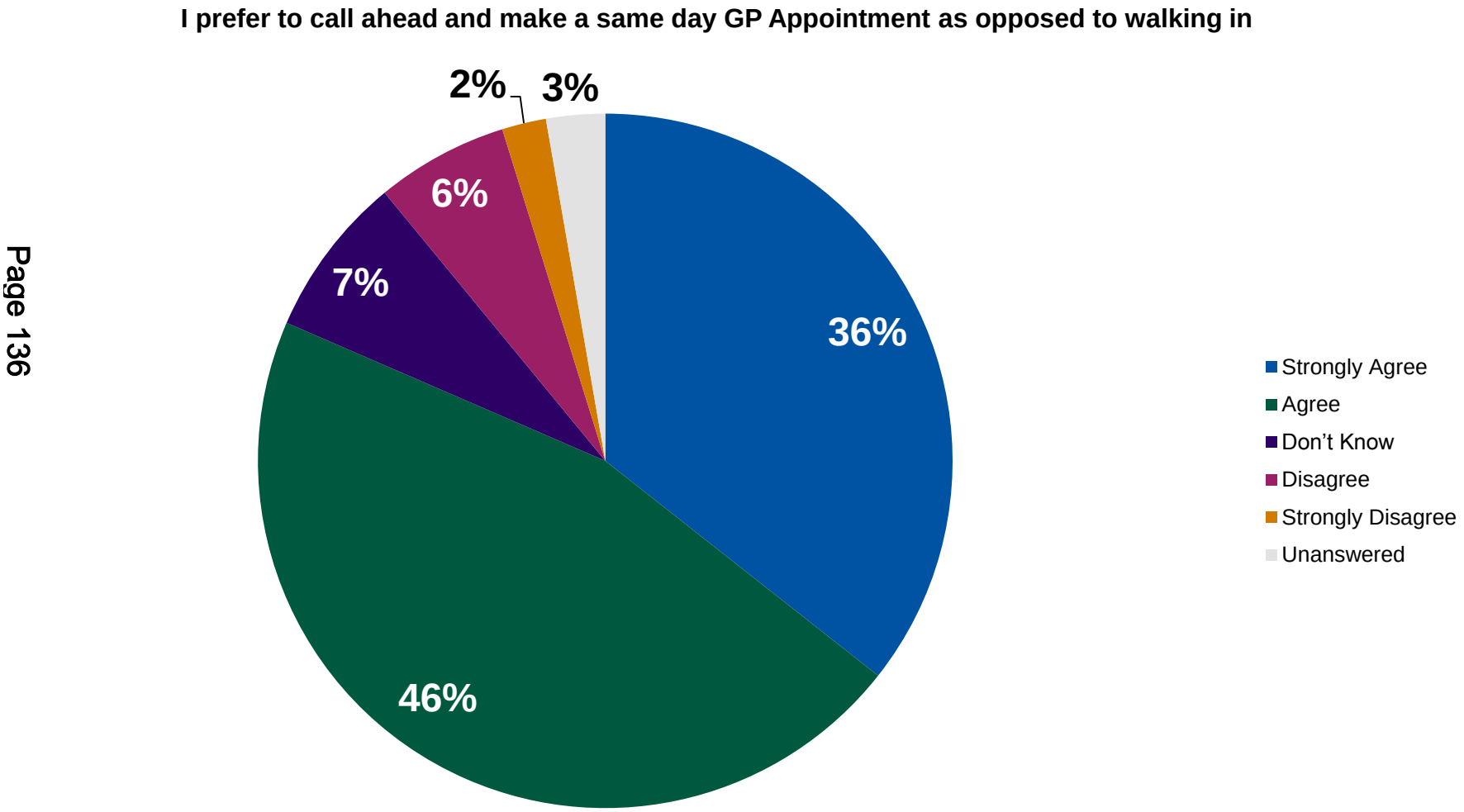
45% of people surveyed strongly disagreed or disagreed with the statement



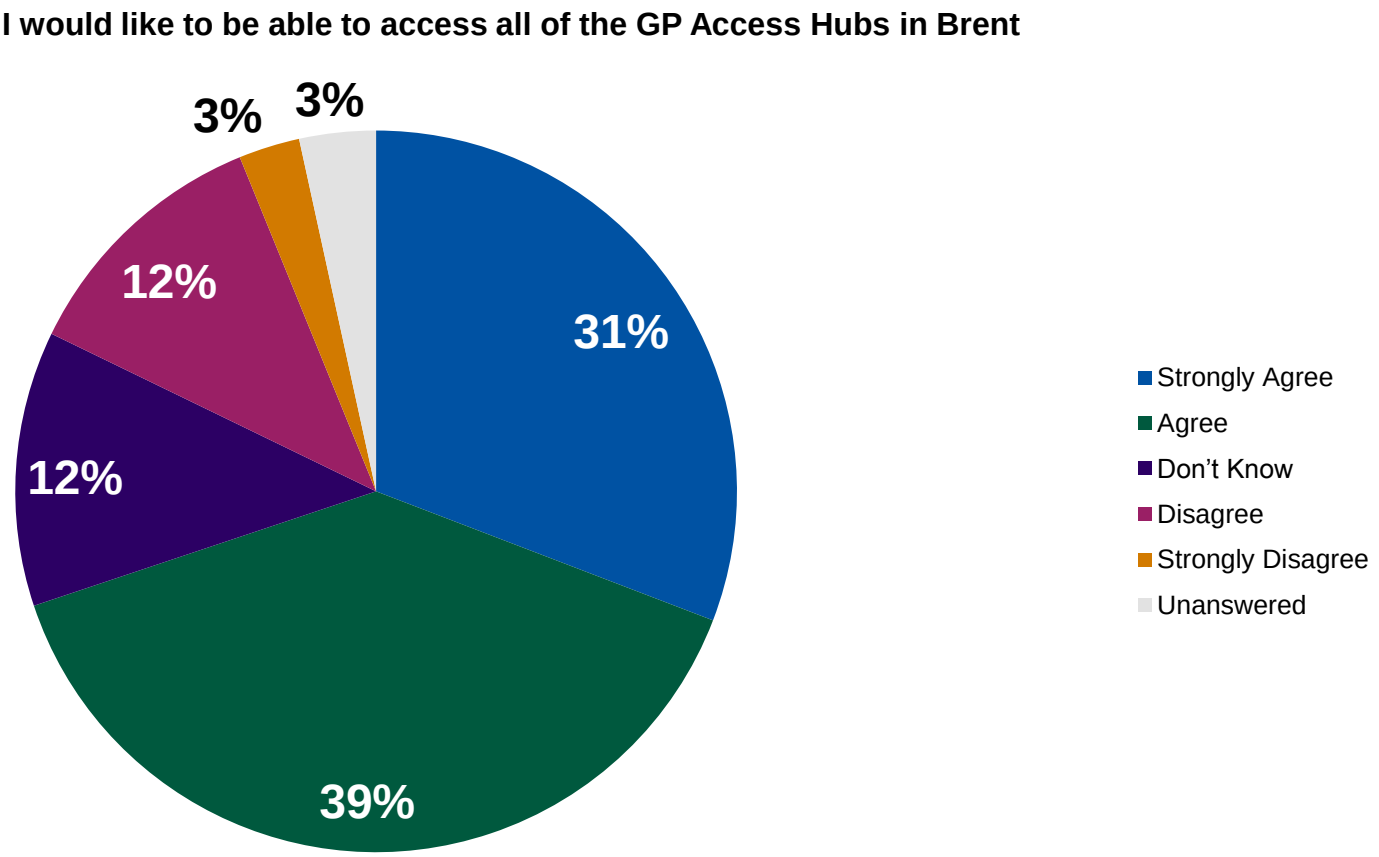
71% of people surveyed are willing to travel to a Brent Hub if they get a same date GP appointment



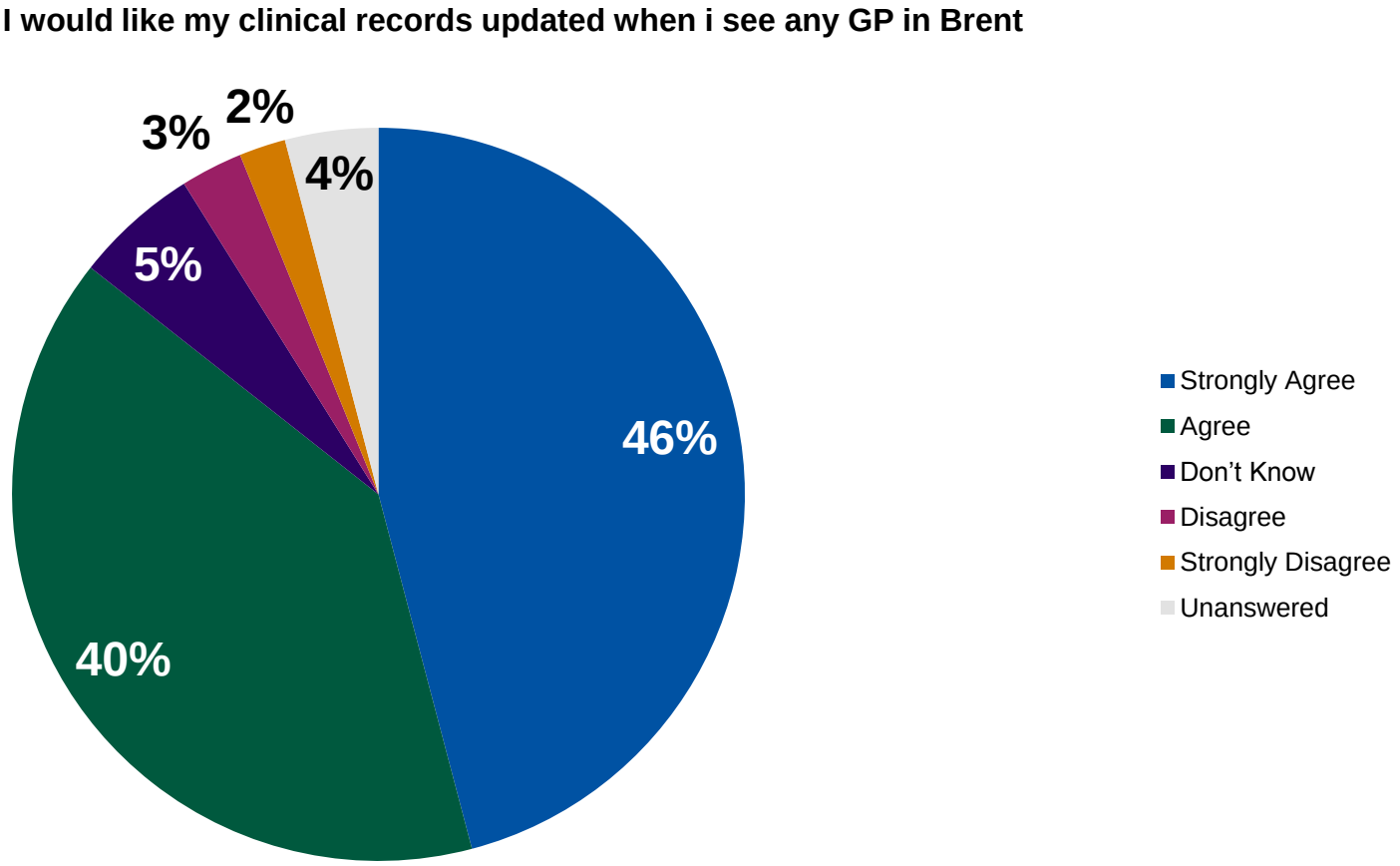
82% of people surveyed strongly agreed or agreed with preferring to call ahead to make a same day appointment



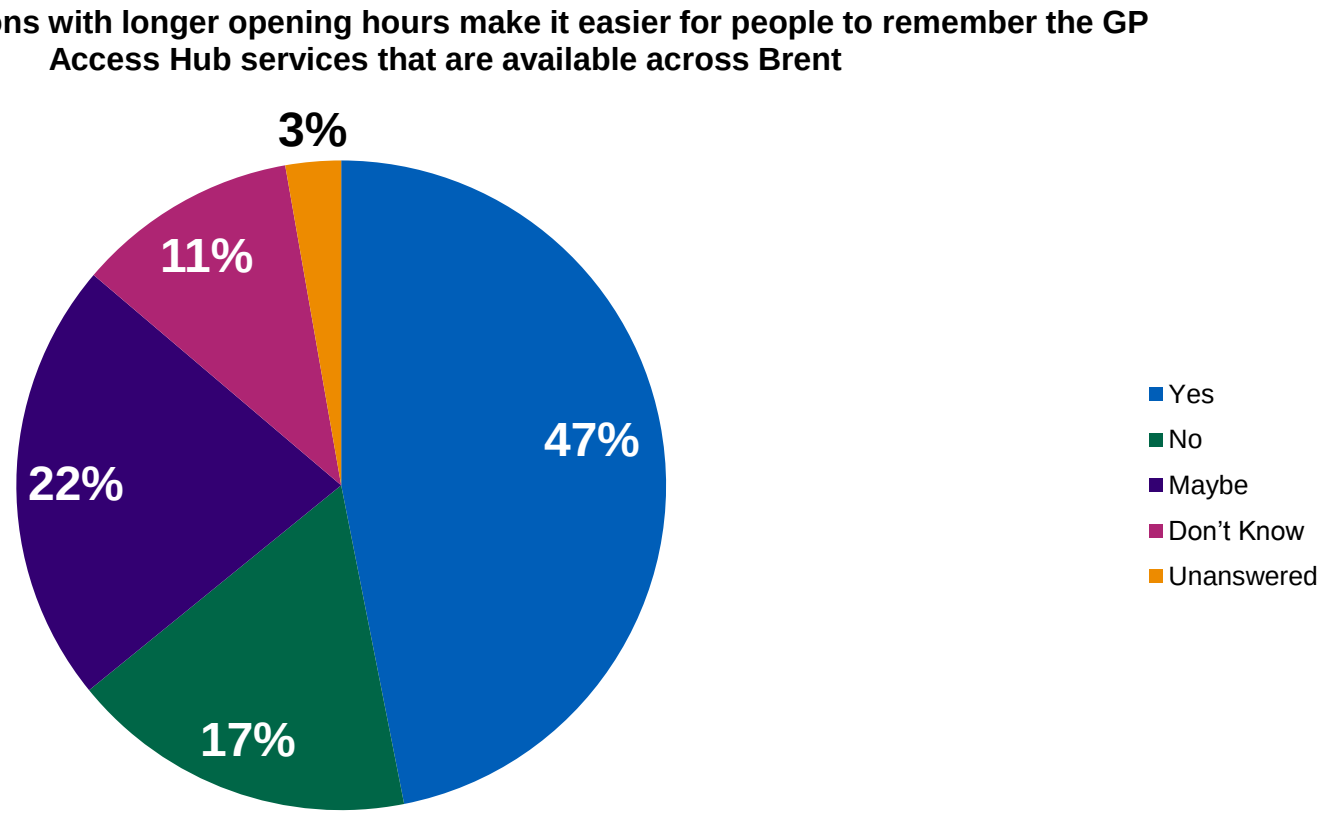
70% of people surveyed agreed that they would like to access all of the hubs in Brent



86% of people would like their clinical records updated when they see any GP in Brent

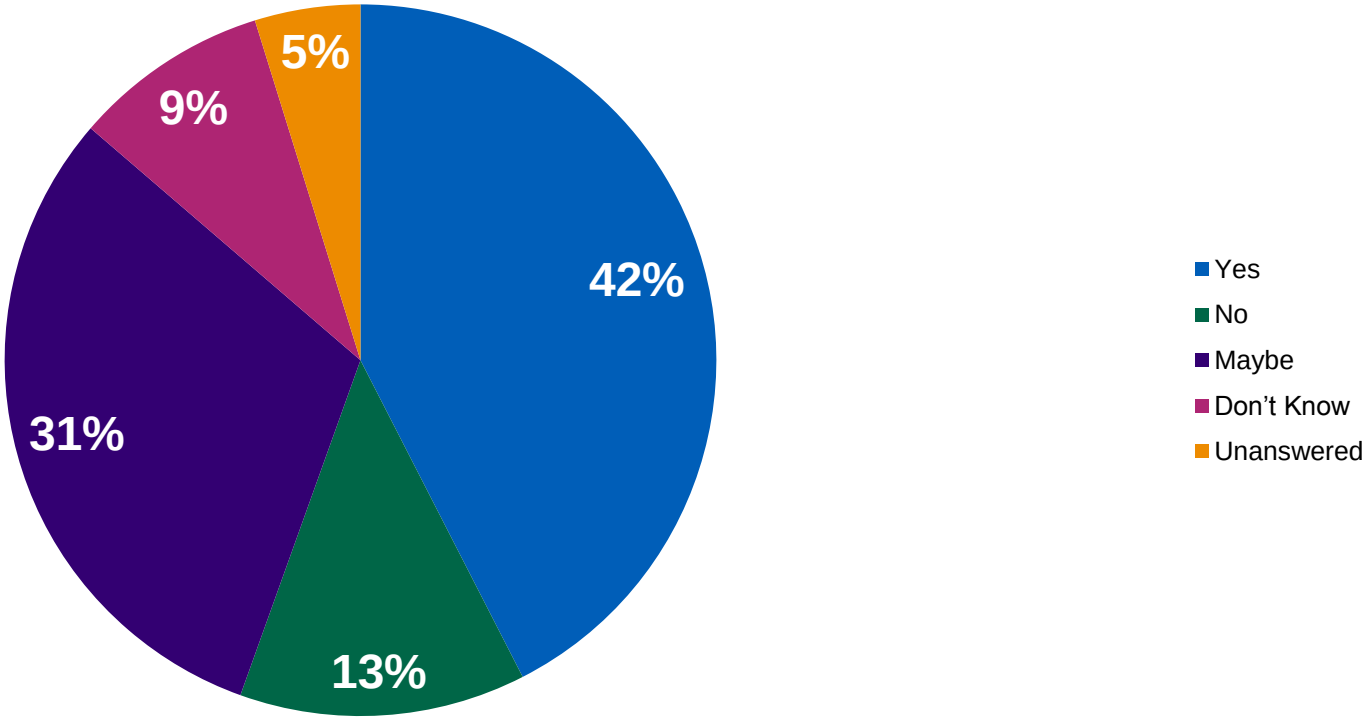


47% of people surveyed believe having fewer locations of hubs will make them easier for people to remember



42% of people surveyed believe our proposal to move away from a walk in service will improve care and experience

Having considered our proposal, will a move from a walk in service to a bookable service improve care and patient experience?



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Sample patient quotes from access engagement

December 2017

Will fewer locations with longer opening hours make it easier for people to remember the GP access Hub services that are available across Brent?

"More flexible for working parents"

"Need access Locally"

"Longer hours could be easier"

"Will be ok if it is well advertised"

"More locations make it easier to access"

"Less to remember"

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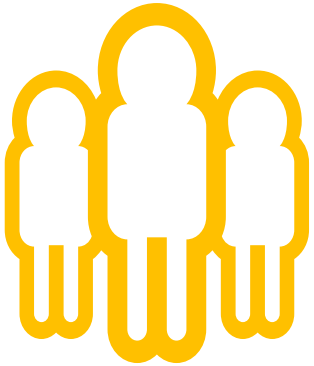
Having considered our proposal, will a move from a walk in service to a bookable service improve care and patient experience?

"If I cant see someone, I will go to A&E."

"Appointment is easier, wont have to waste time with waiting."

"It will be more organised."



"Walk in service currently has long wait times."

"It will be better planned and prepared for appointment."

"As long as you can actually get an appointment"

"Depends on how the appointment system works."

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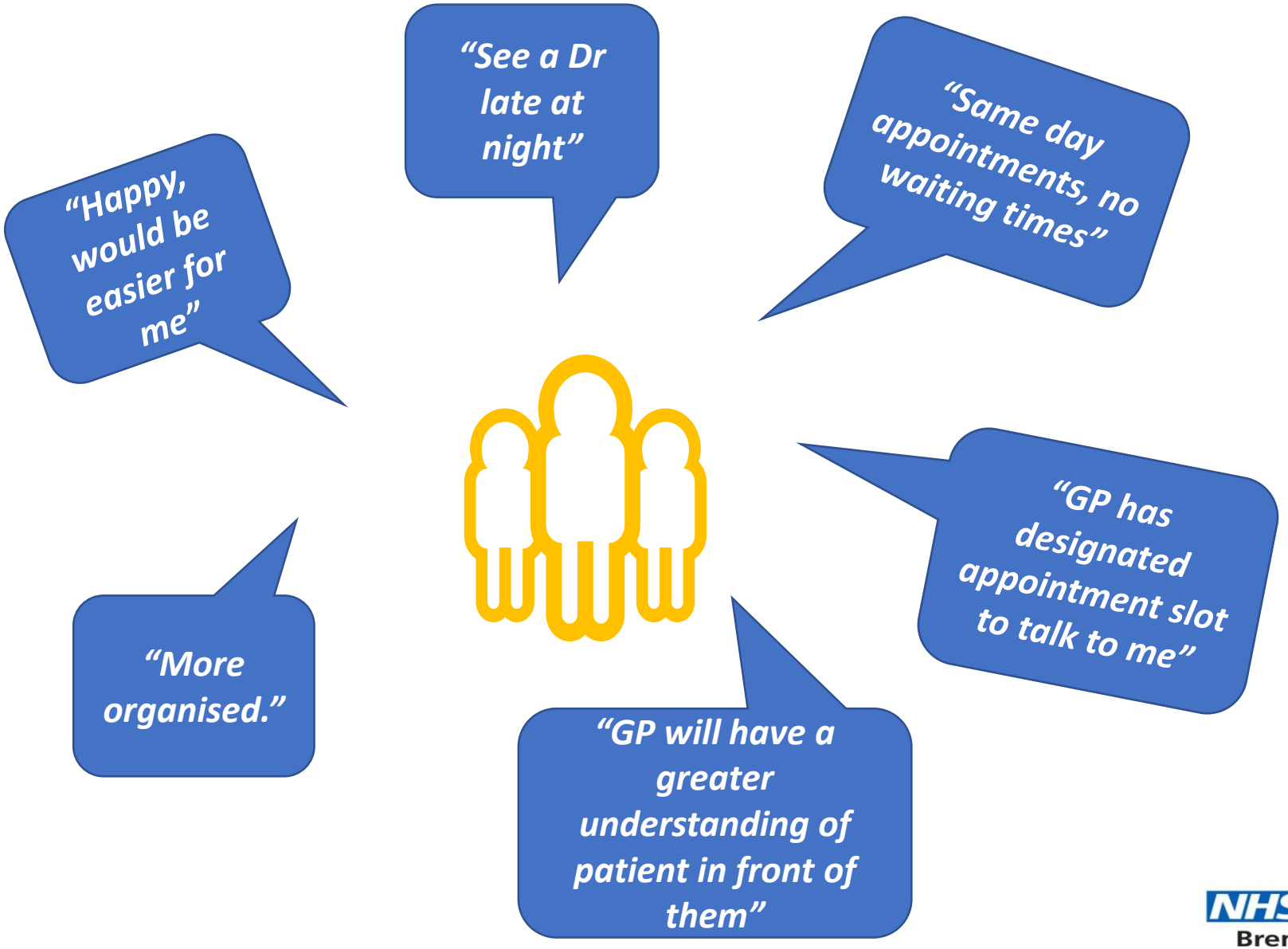
Please share your views on the potential benefits of the proposed model:



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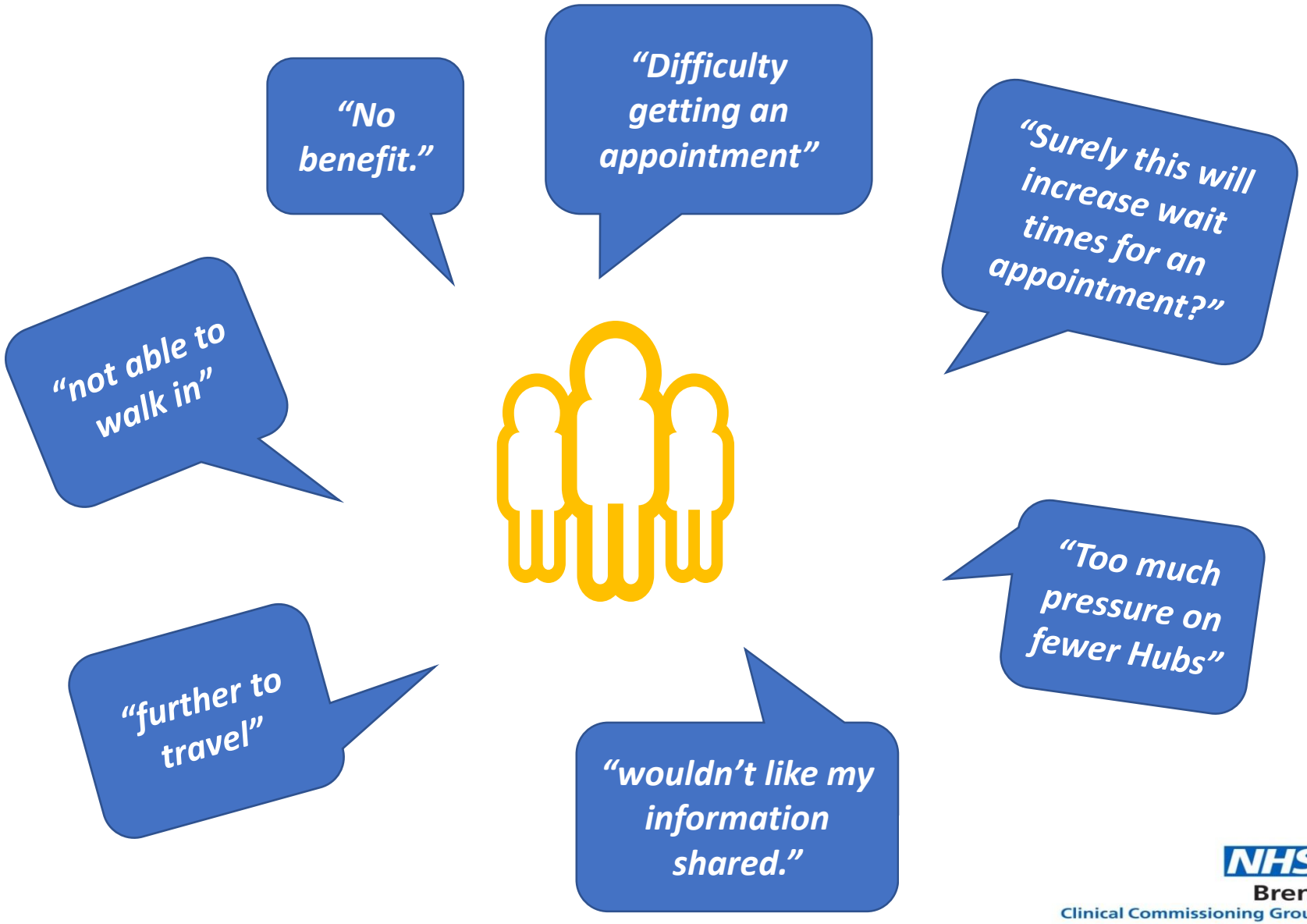
Is there anything you don't like about the proposed model:



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Please add any other comments or questions for us to consider

"promote access"

"Walk in should be available for babies"

"I would be interested to know how I can help save the CCG money"

"transport needs to be key in decision"

"advertise as much as possible"

"More location's would be better access"

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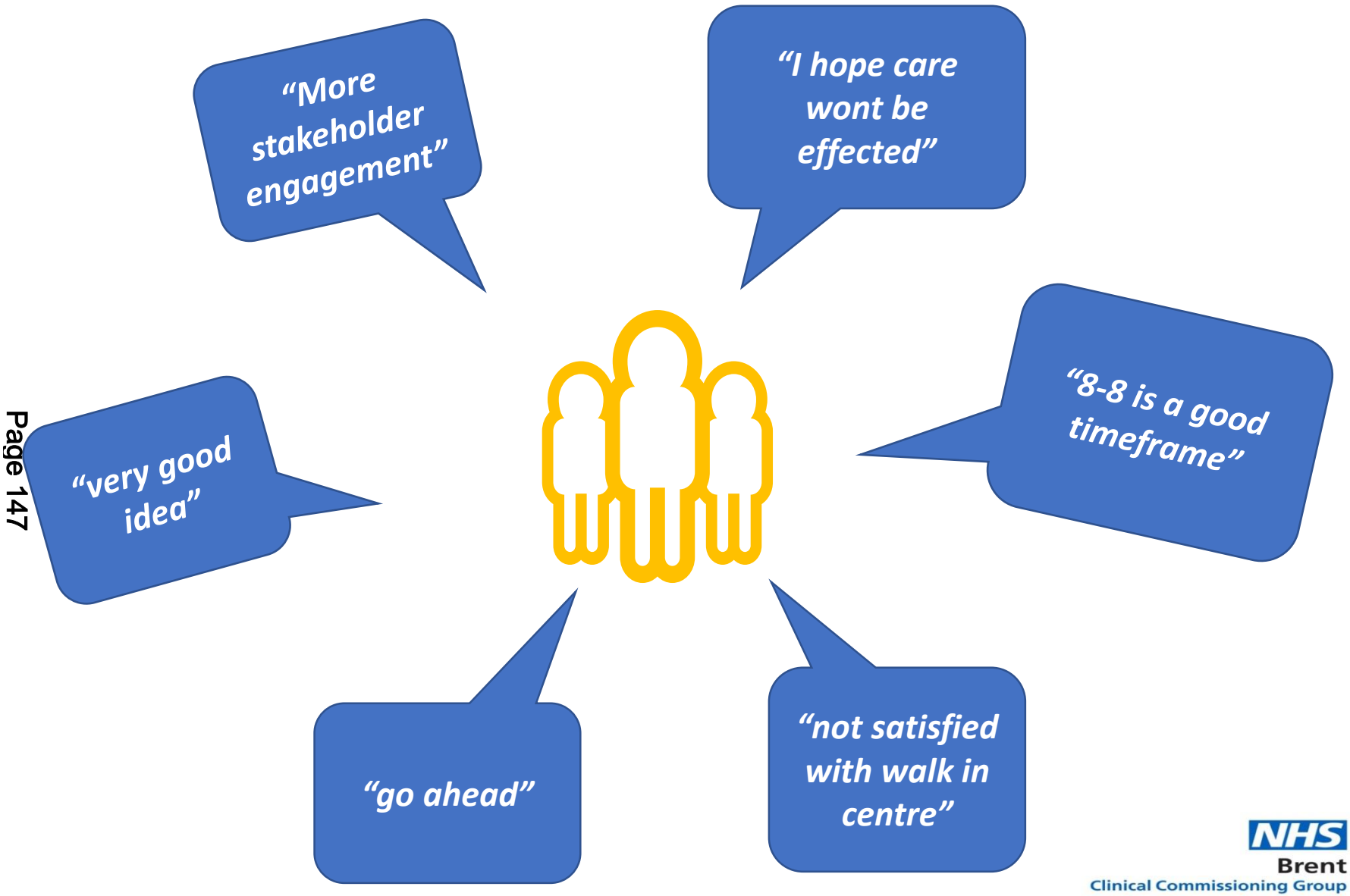
Is there anything else you would like to tell us about these proposals?



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