# NHS Brent Commissioning Strategy Plan

## Summary of Current Draft

**The material contained in these slides is based on the current draft of the CSP which is subject to further review and change and this summary has been produced to support that review process**

Finance & Information Strategy Group
November 25th 2009

# Vision

***Making a significant improvement to the health and wellbeing of the people of Brent***

NHS Brent retains its commitment to the vision and goals we set out in our CSP last year. We have amended these slightly to update them where relevant and to reflect ongoing feedback from stakeholders but the commitments we agreed with stakeholders last year are based on the same identified needs and remain fundamentally unchanged.

We recognise that achieving this vision requires us to focus on reducing the health inequalities in our borough by working with our partners, including local people, to commission high quality, accessible and value-for-money preventive and healthcare services and address deprivation – the top underlying cause of ill health in Brent. By engaging with our local community we will ensure the services available are responsive to the needs of the diverse and dynamic population we serve.

We are committed to making Healthcare for London a reality across North West London and see the significant changes that this will introduce and the renewed focus on disinvestment and decommissioning of lower priority services as opportunities to provide a greater focus on achieving our five goals.

# Case for change (1)

Brent is a borough which epitomises London's opportunities and its challenges. Its structure, history and demography mean that health and healthcare remain in need of urgent change and improvement. In the current political and financial environment the NHS in Brent stands on a burning platform where the need to change the way health services are commissioned and provided becomes ever more imperative.

**Reason 1 – the need to improve health in Brent**

Overall the health of people in Brent is similar to the rest of the country. For example Brent's mortality rate of 570 per 100,000 is lower than the England & Wales average of 628. However, Brent's mortality rate masks a range of specific health issues requiring urgent improvement.

**Reason 2 – the need to reduce health inequalities within Brent**

Equity of care is a founding principle of the NHS but Brent's residents do not experience equity in their health outcomes. Brent is a borough which suffers marked health inequalities, which are both a symptom and a cause of wider variance in deprivation.

**Reason 3 – the NHS in Brent is not meeting the public's expectations**

Understanding and meeting public expectations and ensuring good patient experience of care are integral to NHS Brent achieving its goals. However, too often there is a mismatch between expectations and experience.

# Case for change (2)

**Reason 4 – the way we deliver care is not working**

Healthcare policy from the Wanless review through Our health, our care, our say to Healthcare for London and the Next Stage Review has highlighted the importance of moving care from traditional acute settings to primary care and the community. In Brent whilst there has been progress there is still some distance to go in developing the requisite infrastructure, and in promoting the cultural shift for Brent residents and NHS staff that predicates success.

**Reason 5 – residents should benefit from cutting edge medicine**

London is in a unique position in the UK in terms of the quality and quantity of healthcare workforce on which it can draw. Innovative delivery of healthcare can be seen in the development of Healthcare for London pathways, and Academic Health Science Centres such as Imperial should promote world-class clinical innovation in north-west London.

**Reason 6 – making the best use of our resources**

A period of unprecedented NHS budgetary growth is at an end. In the new environment of constrained resources it is imperative that the NHS in Brent make its resources work harder and smarter to achieve our health goals for the population.

# Key insights from patients, public, clinicians and local partners

There is still a need to get the basics right

Patient experience across a range of our providers remains below acceptable standards

Patients continue to experience problems accessing healthcare services and current care pathways are complex & confusing

Our local case for change is strong but change is happening too slowly

The changes required can only happen with everyone working in equal partnership, including patients & carers

Any changes to acute care need to be supported by improvements in local primary & community services

NHS Brent needs to remain financially strong: to achieve this strength will require fundamental change to the ways that services are commissioned and delivered and that doing less of the same is not an option

# Existing Provider Landscape Across Brent (main providers)

| | | | |
|---|---|---|---|
| Acute hospital provision | North West London Hospitals Trust (CMH and NWP) | £104m | • Approx 96% of patients are treated within 18 weeks<br>• CQC Excellent Quality of Services<br>• Bottom 10% nationally on self-reported patient experience<br>• The trust is financially challenged and scored Weak for financial performance by the CQC in 2009 |
| | Imperial College Healthcare Trust | £62m | • Approx 93% of patients are treated within 18 weeks<br>• CQC Good Quality of Services<br>• Bottom 25% nationally on self-reported patient experience<br>• Scored Good for financial performance by the CQC in 2009 |
| Community services | Brent Community Services (Emerging APO) | £39m | • Approx 98% of patients are treated within 18 weeks.<br>• Limited ability to respond to developed services and clear specifications<br>• BCS is the sole provider with no choice options for patients<br>• 90% of patients are happy with the professional care they receive |
| Independent contractors | 71 GP Practices<br>Dentists<br>Pharmacies | £62m | • Brent ranked 135/150 nationally on ease of seeing a GP quickly<br>• Brent GPs scored on average 803 QOF points compared to an average of 938 across London and 954 Nationally (2008/9).<br>• Large number of small practices with poor infrastructure<br>• Brent ranked 149/152 nationally on patient satisfaction |
| Mental health | Central & North West London Mental Health Trust | £34m | • Brent is in the bottom quartile nationally with regards to the number of WTEs in crisis resolution and talking therapies<br>• Limited choice for service users<br>• CQC Good Quality of Services 2009 (from Excellent)<br>• Scored Excellent for financial performance by the CQC |

# Goals (1)

***Goal 1: Reduce premature mortality and therefore increase life expectancy by three years by 2013***

Average life expectancy in Brent is close to the national target of 78.5 years for men and 83.8 years for women but many people in Brent die young and miss the opportunity to live a full life. Over the last three years on average 698 people every year died prematurely (at or below the age of 75) in Brent.

***Goal 2: Reduce the gap in life expectancy by 6 months by 2013***

Brent performs well in many overall measures of health but there are stark inequalities in health linked to socio-economic status, gender, ethnicity, and geography. There is an 8.8 year gap in male life expectancy between the most deprived and least deprived 10% of areas in Brent and a 1.7 year gap for females.

***Goal 3: Promote good health and prevent ill-health***

Smoking rates are as high as 40% in some of our most deprived wards and smoking is both the single greatest cause of preventable illness and premature death in Brent, and a major factor in health inequalities. Another cause of concern is that more than half (56%) of Brent's adult population do not participate in any sport or physical activity: one of the lowest rates in England.

# Goals (2)

***Goal 4: To improve the quality and safety of services, so that by 2014 health and social care providers commissioned by NHS Brent receive a Care Quality Commission Regulatory Judgment at least equivalent to the existing Good rating in the Annual Health Check for acute services, and a "Fully Compliant" Registration Status for GP and Community Services***

*High Quality Care for All* sets out a vision of an NHS with quality of care at its heart – quality defined as clinically effective, personal and safe. NHS Brent aspires to make this vision a reality for all the care received by the residents of our borough.

***Goal 5: To improve the patient experience of services, so that by 2014 health and social care providers commissioned by NHS Brent will achieve patient experience scores at least as good as the London average***

For a number of reasons a significant number of providers commissioned by NHS Brent show levels of patient satisfaction below national and London benchmarks. For our main providers of acute services, we will ensure that over then next 5 years, their performance in achieving the national priority indicator "Experience of Patients" remains within or better than the national average. NHS Brent will strive to improve access to primary care services, and monitor its improvement via the relevant national priority indicator.

# Outcomes

| Outcome Description | 2008/09 | 2009/10 | 2010/11 | 2011/12 | 2012/13 | 2013/14 |
|---|---|---|---|---|---|---|
| Health inequalities in years (Males) | 7.9 | 8.80 | 9.97 | 11.07 | 12.17 | 13.11 |
| Health inequalities in years (Females) | 1.2 | 1.5 | 1.4 | 1.3 | 1.2 | 1.02 |
| Life expectancy in years (Males) | 78.2 | 78.5 | 78.34 | 78.69 | 79.04 | 79.44 |
| Life expectancy in years (Females) | 83.4 | 83.8 | 83.61 | 83.91 | 84.22 | 84.55 |
| Proportion of children completing MMR immunisation (1st & 2nd dose) by 5th Birthday | 41.8% | 72.7% | 90.7% | 94.4% | 95% | 95% |
| Smoking quitters (per 100,000) | 734 | 911 | 1,059 | 1,059 | 1,059 | 1,059 |
| Proportion of women aged 53-70 screened for breast cancer within the last three years | 44% | 49.66% | 59% | 71% | 75% | 78% |
| Self reported experience of patients & users | 70.3% | 72% | 74% | 76% | 78% | 80% |
| Delayed transfers of care (% of cases per 100,000 over 18) | 13.6% | 13% | 11% | 9% | 7% | 5% |
| CVD mortality (per 100,000 under 75) | 85.99 | 86.65 | 82.7 | 78.3 | 73.1 | 67 |
| Diabetes controlled blood sugar | 56.8% | 65% | 68% | 70% | 74.3% | 90% |
| Proportion of all deaths that occur at home | N/A | 19% | 20.5% | 22% | 23.5% | 25% |

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# Golden thread from Needs to Outcomes

| JSNA | Goals | Initiatives | WCC Outcome Measures |
|---|---|---|---|
| • Health inequalities | • Reduce the gap in life expectancy by 6 months by 2013 | • Staying Healthy<br>• Maternity and Newborn | • Reduce life expectancy gap<br>• Reduce IMD score |
| • Circulatory disease and cancer are biggest killers | • Reduce premature mortality and therefore increase life expectancy by three years by 2013 | • Staying Healthy<br>• Children and young people<br>• Long term Conditions | • Life expectancy<br>• Reduce CVD mortality rate<br>• Increase in smoking quitters<br>• Increase in breast cancer screening |
| • Mental health as largest cause of morbidity<br>• Smoking, diet and exercise<br>• High diabetes, TB and HIV<br>• Low uptake of preventive services | • Promote good health and prevent ill-health | • Mental Health<br>• Long Term Conditions<br>• Staying Healthy | • Increase in smoking quitters<br>• Increase in MMR coverage |
| • High delayed discharges<br>• Variation in performance across primary care | • Increase the proportion of activity commissioned from providers who perform at or above benchmarked performance standards | • Staying Healthy<br>• Acute Care<br>• Planned Care<br>• End of Life Care | • Increase in MMR coverage<br>• Reduce delayed transfers of care<br>• Increase in diabetes controlled blood sugar<br>• Proportion of all deaths that occur at home |
| • Low satisfaction with access to GPs | • Meet or exceed nationally–reported benchmarked patient satisfaction rates for all services commissioned | • Acute Care<br>• Planned Care<br>• End of Life Care | • Increase patient satisfaction with GP access |

# Maternity & Newborn initiative - Priority CSP Action Areas

## 1. IMPROVED PRE-CONCEPTION CARE AND ENCOURAGEMENT OF EARLY BOOKING

We will ensure that all GP practices, family planning clinics and sexual health clinics across Brent have access to the appropriate health education materials to support pro-active pre-conception care including tailored information for high-risk women.

Over the last year we have focussed considerable effort on segmenting the groups who book late for antenatal care. Whilst we will continue to work with the acute commissioning partnership to address capacity issues within local providers, we will also implement a range of initiatives aimed at increasing awareness amongst both health professionals and community groups about the importance of early booking and promote direct booking and improved community access.

## 2. CONTINUITY OF CARE THROUGHOUT THE MATERNITY PATHWAY

Due to workforce issues, NWLH has been unable to implement the agreed model of community midwifery. The model promotes NICE guidance with midwife-only care being provided within Children's Centres across Brent and postnatal care provided by the same team. However we recognise that this pathway is only available to women who book with NWLH and that the 49% of women who book elsewhere currently receive antenatal care from their chosen provider and postnatal care from NWLH.

In 2010/11 we will work with NWLH to implement the care pathway, including introducing joint midwife and consultant services in children's centres. In doing so we will review the amount of out block contract to ensure we are appropriately funding the care pathways as currently commissioned. In addition we will support wider work to introduce care pathways that ensure continuity of care for women booked at all of our main local providers.

# Children & Young People initiative - Priority CSP Action Areas

## 1. THE HEALTHY CHILD

Although we have had an agreed specification for health visiting for some time, it has not been implemented due to recruitment difficulties. We will be reviewing the specification and commissioning a care pathway that fully integrates the work of health visitors with children's centres with identified elements of the healthy child programme being commissioned directly from children's centres. The care pathway will ensure that all children access the healthy child programme and that children in need of protection are offered more intensive support.

With the local authority we will be exploring new models of working with families identified as requiring additional, more intensive parenting support. We will also be developing and implementing a new specification and care pathway for school-aged children integrating more fully the work of school nurses with the extended schools programme.

## 2. THE UNWELL CHILD

At present, too many young children are attending acute care (both A&E and outpatients) for services that should more appropriately be provided in community settings. At the same time as we implement improvements to the infrastructure for the healthy child, we will commission a support programme for primary care in relation to self-management; management within community support and management in primary care.

We will also develop care pathways for common conditions and commission multi-disciplinary teams to work within the polysystems to provide assessment and treatment, avoiding the need for hospital referral.

## 3. CHILDREN WITH COMPLEX COMMUNITY NEEDS

We will review our existing pathways for children with complex community needs and establish new care pathways to support improved access to specialist care at times of acute exacerbations, both to prevent admissions and to expedite discharge; access to specialist advice in community setting and ongoing support at home and school.

# Acute Care initiative - Priority CSP Action Areas

## 1. ACCESS TO PRIMARY CARE URGENT CARE SERVICES

Our polysystem implementation plans outline the establishment of two polyclinics providing 8-8 access to primary care urgent care consultations for both the registered and unregistered population. The third polyclinic, based on the CMH site, will provide a wider range of urgent care services and will be open 24/7. In addition, the UCC will provide the out of hours service for those GP practises across Brent who have delegated responsibility got out of hours cover to Brent.

Over time it is expected that with the planned improvements in GP availability through every GP practice in Brent (outlined in the Planned Care initiative) the demand for primary care consultations provided by other services will decrease.

## 2. ESTABLISHMENT OF SHORT TERM ASSESSMENT, REHABILITATION & REABLEMENT SERVICE

The STARRs service comprises a number of key elements; single point of access and brokerage; access to rapid response intensive health and social care response for people at risk of hospital admission; step-up and step-down health and social beds; rehabilitation and reablement in the community. The hub of the service will be based at CMH establishing integrated working with the UCC. The current Rapid Response service pilot is delivery early benefit with 108 referrals in October 2009, over 90% of which went on to avoid admission.

Procurement for the UCC and STARRs will commence in December 2009 and it is anticipated that both services will be in place by Spring 2010.

## 3. IMPLEMENTATION OF COMMUNITY-PATHWAY FOLLOWING STROKE

We are planning to use Clinicenta, in collaboration with NWLH, as the main provider of early supported discharge and stroke rehabilitation. We have agreed revised specifications for these services to ensure they meet the needs of our residents and balanced scorecard to ensure benefits realisation.

# Planned Care initiative - Priority CSP Action Areas (1)

## 1. PRIMARY CARE CONTRACTORS

List Validation

NHS Brent currently has the highest percentage difference between registered and resident population in London. The current intensive list validation exercise is due to complete in 2010/11.

Standardised Quality of General Practice

NHS Brent has made a commitment to standardise the core offering practices provide across the Borough and only to continue to commission services from those practices that meet the agreed standard metrics. We will agree implementation plans with all practices currently not offering the core services to the required standard.

Review of Contractual Frameworks

PMS Contracts will be reviewed to ensure that they offer value for money including the targeted use of growth money to support the priorities of NHS Brent as set out in the CSP.

Performance Management

We will be reviewing with clinical commissioners our existing balanced scorecard to ensure that it meets our current and future expectations for primary care. Practices and practitioners who are not meeting the required standards will be offered support to improve practise within agreed timescales.

Succession Planning

We will be agreeing with all single handed practitioners reaching or over retirement age a succession plan. This will include the need to meet the full requirements of the core offering to the required standards.

Estates Rationalisation

NHS Brent will only support the development of new sites where the revenue implications are cost neutral. We will work closely with Kingsbury and Kilburn clusters where the needs are greatest to see how new sites can be achieved through optimal use of sites.

Improving access to primary care

NHS Brent is funding a programme of support to practises that are providing poor access focussing on the 20 practices who achieved the poorest patient experience feedback in the 2008/09 study. This scheme will continue into 2010/2011 and will be extended to support additional practices improve access.

# Planned Care initiative - Priority CSP Action Areas (2)

## 2. CARE PATHWAYS

Through a phased programme of change we will implement an ambitious and innovative approach to the establishment of care pathways for identified specialties for elective care which supports care provided within the general practice without the need for onward referral; transforms community provision including multi-disciplinary team approach, reduces the need for onward referral to acute settings and decommissions all consultations which do not add clinical value for the patient.

Phase One (2010/11)

- Clinical prioritisation of specialities for inclusion in phase 1
- Agreement of consistent, protocol driven care pathways based upon Map of Medicine
- Agreement with clinical commissioners of Polysystem Improvement Plans with clear outcomes and expectations for practices within and across the cluster, linked to an agreed programme across all practices designed to ensure that all practices offer a high standard of quality care and advice.
- Introduction of Integrated Teams at polysystem level, comprising a designated consultant; nurse specialist and primary care specialist. Each specialty team will support the polysystem through tailored training and access to specialist advice
- Agreement of clear, measurable outcome measures including implementation of protocol-driven care, peer review and normalisation of referral rates
- Specification for community service based in polyclinics and procurement of new service to complete the primary and community transformation of elective care pathways (new services commencing 2011/12)

Phase 2

Phase 2 will commence in 2001/12 mirroring phase one with additional specialties and elective day care.

# Mental Health initiative - Priority CSP Action Areas

**1. RAISING PUBLIC AWARENESS, HEALTH PROMOTION & IMPROVING SERVICES IN PRIMARY CARE**

NHS Brent will support the pan-London asocial marketing campaigns planned to raise public awareness and promote health. Implementation of a compliant IAPT service is planned for the summer of 2010 and will be supported by awareness raising training for primary care clinicians.

**2. CO-ORDINATED COMMUNITY SPECIALIST INPUT**

Concerns have been raised by both users and primary care clinicians about the number of individual teams working within the community, potentially resulting in multiple handoffs for service users and fragmentation and duplication of care. We plan to work with CNWL to rationalise the number of teams; streamline the care pathways to improve user experience and simplify communication between health and social care professionals. The new model of coordinated community specialist input will be a central component of our polysystem model of care. We plan that this work will also reduce duplication (allowing for disinvestment) and improve productivity. In addition, we intend to undertake a similar exercise in relation to Community Learning Disabilities Teams.

**3. IN-PATIENT & SPECIALIST PATHWAYS**

We want to commission high-quality in-patient care which is outward focussed and working towards care outside of hospital wherever possible. We anticipate that the outcome from this work (together with the community work) will be a reduction in the number of people admitted as in-patients and reductions in length of stay for those admitted. In addition, we plan to review our commissioning arrangements for those in need of specialist services to ensure that we are getting the best value for money in the most appropriate location.

**4. IMPLEMENTATION OF INTEGRATED CARE PATHWAY FOR DEMENTIA**

We will be developing and implementing an integrated care pathway for dementia.

# Staying Healthy initiative - Priority CSP Action Areas

## 1. NHS HEALTH CHECKS

In 2008/09 we have undertaken detailed work to ensure successful implementation and will be commencing the phased programme from April 2010. Phasing supports the need to prioritise areas of maximum need rolling out across other polysystems across a four year period. Delivery will be commissioned from GP practices who meet the required quality specification under a Local Enhanced Scheme.

## 2. CHILDHOOD IMMUNISATIONS

Considerable focus in 2008/09 has been placed upon establishing the required infrastructure from which to accurately identify the current update rates and to ensure improvement both across Brent and within identified communities. Progress is now well underway to increase childhood immunisations aligned to best practice.

## 3. OBESITY

We will be building upon the success of our childhood obesity strategy to review our current adult obesity strategy. The launch for this work will happen in the New Year with our Physical Activity Summit with the expectation that the revised strategy, together with supporting plans for action, can be agreed by the Local Strategic Partnership in the summer of 2010.

## 4. SMOKING CESSATION

We are aware of the importance of smoking status to the achievement of our goals and we are disappointed that despite considerable focus the rate of improvement in our smoking cessation has not been as marked as we had planned. We will continue to work closely to identify new and more innovative ways of commissioning the service, diversifying the range of providers and incentivising providers to achieve improved outcomes.

## 5. BREAST, BOWEL AND CERVICAL SCREENING

We have improvement plans to ensure that we achieve trajectories for uptake for all screening programmes and across the whole of Brent.

# Long Term Conditions initiative - Priority CSP Action Areas (1)

**1. IMPROVED PATIENT EDUCATION AND EMPOWERMENT**

Using national best practice and local community expertise we will commission a range of resources including:

- Revitalised Expert Patient Programmes and carer support
- Education programmes including continuation of DAFNE and DESMOND
- Use of Media and Accessible information (formats and language)
- Focussed work taking account of language and cultural issues
- Increased focussed use of community pharmacists particularly in relation to self-care

**2. IMPROVED PRIMARY CARE MANAGEMENT (LEVEL 1 & 2 – SIMPLE & COMPLEX CARE)**

In line with our Primary and Community Strategy and polysystem development plans we will implement a programme across all practices designed to ensure that all practices offer a high standard of quality care and advice. Key components of the plan will be:

- Implementation, in conjunction with other PCTs of NW London, of a risk stratification tool together with consistent care pathways for LTC
- Agreement with clinical commissioners of Polysystem Improvement Plans with clear outcomes and expectations for practises within and across the cluster, linked to development of the commissioning budget for LTC across all settings of care to polysystem commissioners.
- Development and implementation of protocol-driven access to diagnostics to address underdiagnosis across Brent, together with active review of practice registers with plans for improvement to narrow the gap between expected and reported prevalence levels at practice level
- Introduction of Integrated LTC Teams at polysystem level, comprising a designated consultant; nurse specialist and primary care specialist.
- The work is being taken forward as a shared transformation initiative between NHS Brent and London Borough of Brent, building upon the shared intermediate care strategy (level 4 – acute exacerbation) which is described under our acute care initiative and further developing joint commissioning and integrated health and social care provision for people with long term conditions across all stages of the continuum.

# Long Term Conditions initiative - Priority CSP Action Areas (2)

**3. IMPROVED SPECIALIST ADVICE/COORDINATION ETC (LEVEL 3 – MULTI COMPLEX CARE)**

Specialist care and advice will be commissioned predominantly within polysystem settings including polyclinics. Models of commissioning will promote improved integration between GP practices and hospital specialists maximising the use of polyclinics as the appropriate setting of care and avoiding the need for attendance at acute hospitals unless specialist diagnostics or outpatient care is required.

**4. IMPROVED CASE MANAGEMENT (LEVEL 3 – MULTI COMPLEX CARE)**

Building upon the foundations already established through the ICCS, this workstream will mainstream care management and reablement as integral parts of LTC management within each polysystem health and social care system through;

- Early identification of people at risk using risk stratification and consistent application of the existing EARLI tool
- Integration of case management into every polysystem District Nursing Team widening the skillmix within the team to include district nurses, community matrons and social care co-ordinators, and ensuring rapid access to specialist support
- Agreed pathways/response between health and social care including enhanced reablement services supported by rehabilitation
- Appropriate use of assistive technology

The work is being taken forward as a shared transformation initiative between NHS Brent and London Borough of Brent, building upon the shared intermediate care strategy (level 4 – acute exacerbation) which is described under our acute care initiative and further developing joint commissioning and integrated health and social care provision for people with long term conditions across all stages of the continuum.

# End of Life Care initiative - Priority CSP Action Areas

## 1. DEVELOP END OF LIFE STRATEGY

An accelerated programme of development in place with expectation that an agreed End of Life Strategy will be agreed by April 2010. The strategy will be supported by a detailed action plan and will include reference to support that carers can expect through our carers' strategy.

## 2. IMPLEMENTATION OF GOLD STANDARD FRAMEWORK

We will support the full implementation of the Gold Standard Framework, a systematic approach to formalising best practise so that quality end of life care becomes standard for every patient by helping clinicians identify patients in the last years of life, assess their needs, symptoms and preferences and plan care on that basis enabling patients to lice and die where they choose. In addition, we will encourage our local care homes to become accredited with the Quality Hallmark Award.

## 3. IMPLEMENTATION OF LIVERPOOL CARE PATHWAY

The LCP is an integrated care pathway that is used at the bedside to drive up sustained quality of the dying in the last hours and days of life. It is recommended as a best practise model, most recently, by the Department of Health in the UK. We will put in place the leadership and structures to ensure that all of our providers, including care homes, implement the 10 step implementation plan.

# Polysystem Vision

Healthcare for London: Framework for Action set out polyclinics as a new model of care for transforming services across primary, community and secondary care. Polysystems are a clinically led model of care involving all partners in the network and supported by a primary care led polyclinic hub at its heart.

The polysystem will deliver transformed pathways in primary and community care through:

- Integrated multidisciplinary teams of primary, community and secondary care to improve the management of long term conditions
- Shift and redesign of pathways out of hospital into the community to provide one stop shop care including diagnostics
- Urgent care services integrated with primary care to better treat those patients who use A&E for primary care issues and to turn episodic care into planned care
- Closer working of primary care over a 50k to 80k populations to care manage the population and prevent unnecessary hospital visits and admissions
- Provide a more efficient structure for delivering care out of hospital through changes in skill mix and use of estate and overheads to support the transformational change in other parts of the health system

# Polysystem proposals (in discussion with PBC and PEC)

- Propose PBC as the locality commissioning body to commission the polysystem
- The number of localities may need to reduce in order to have fully functioning and affordable polysystems and adequate management infrastructure
- 2 Polysystems will share a polyclinic and 1 polysystem in base case will access a polyclinic in Barnet - Edgware
- We will have to bring in the 3 non PBC practices so their population is not excluded & Polysystems will need to be more co-terminous with their locality e.g. Wembley practices having CMH as their hub
- We will have to have a programme of improving primary care that is affordable and realistic which probably means fewer spokes providing better value for money than now (including dentists and pharmacies)
  - Extend the core offering at practice level and expand the settings of care in the polysystem
  - Proposed non recurrent investment in practice nursing and upskilling GPs in elective and long term conditions care
  - Some investment in premises – additional consulting space in up to 50 spokes and new centres for Kingsbury, Kilburn (South Kilburn & Mapesbury) and Willesden (Dollis Hill) in base case if self financing or in the better case if has a revenue cost



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# Proposed polyclinics and locality centres – likely preferred option

**Harness 76,000 population**

Polyclinic – CMH with urgent care centre & GP practice (relocate 2 existing practices)

Monks Park and Hillside Primary Care Centres

**Kilburn 83,000 population**

Polyclinic – Willesden with 8 to 8 GP led health centre (or Queen's Park)

South Kilburn locality centre (new) relocate five existing practices

**Kingsbury 62,000 population**

Polyclinic – Wembley with 8 to 8 GP led health centre or Edgware Community Hospital
Kingsbury locality centre (new) with six practices relocated
Chalkhill Primary Care Centre

**Wembley 66,000 population**

Polyclinic – Wembley with 8 to 8 GP led health centre with 6 practices

Monks Park (with 2 GP practices) and Sudbury Primary Care Centres (with 2 additional practices)

**Willesden 56,000 population**

Polyclinic – Willesden with 8 to 8 GP led health centre 2 practices and relocate a third GP practice



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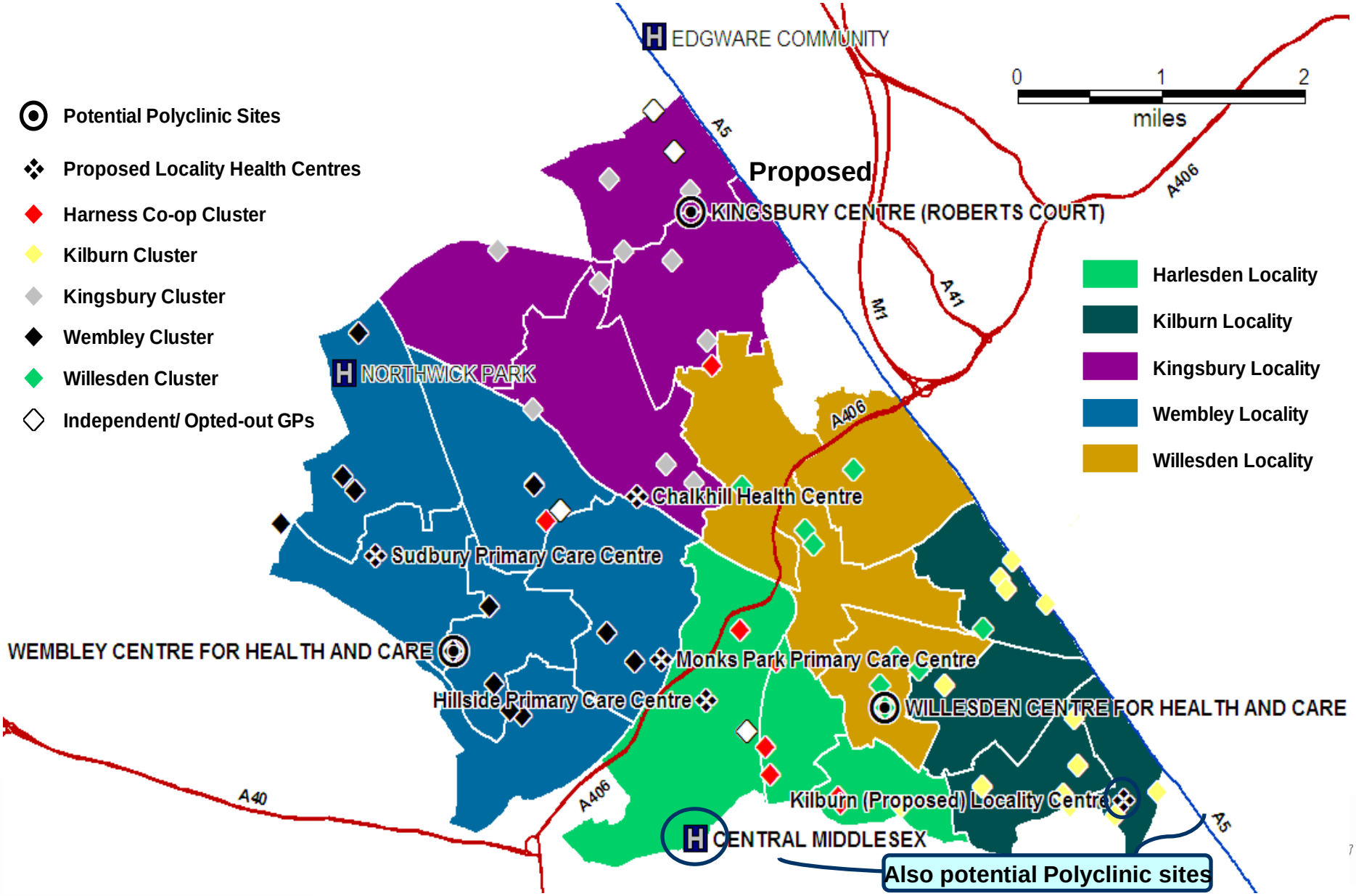
# NHS Brent Polysystem Modelling

## Map showing PCT Localities, PBC Clusters, possible future polyclinics and locality health centres



# Market Management

The combined effect of the planned care, acute care and LTC initiatives on activity transitioning out of acute into the polysystem is summarised below. The key actions we plan to take to develop the market to introduce the transformational changes required to support these shifts are primarily associated with the introduction of the polysystems and are set out in the table.

- 242,000 outpatients move into the polysystem setting (72%)
- 4,140 current emergency admissions treated in the polysystem (20%)
- 3,300 elective procedures move into the polysystem (11%)

| | |
|---|---|
| GPs | • Active contract management against a balanced scorecard agreed with PBC and PEC<br>• Access transformation programme to improve access to GPs<br>• Succession planning with practices where partners are approaching retirement.<br>• Entry of new providers<br>• Move towards a 'common tariff' for core GP services |
| Community services | • Work with BCS to determine future configuration based on the following options: Stand alone provider; Consolidation with local community provider; Merge with a foundation trust; Vertical integration with an acute trust |
| Acute Care | • Intermediate care – this will be contracted for the whole of Brent to achieve the required economies of scale. This service is planned to be operational from May 2010<br>• Urgent Care Centre – to be positioned at CMH to ensure primary care patients are treated in the appropriate setting. This service is planned to be operational from May 2010 |
| Elective – 3 Options | 1. Commission single service to provide all outpatients / elective procedures across whole of Brent (all polysystems)<br>2. Group similar specialities together and commission for the whole of Brent (all polysystems)<br>3. Group similar specialties together and commission for selective polysystems (appropriate for high volume specialties) |

# Past Delivery Performance

Over the course of the past year we have introduced a number of changes to improve our capability and capacity to deliver our strategic plans. We have further developed our Investment Panel process, aligning business case development and review to World Class Commissioning competencies and have also introduced a comprehensive Board performance report that monitors both the delivery of planned initiatives and their impact on key performance indicators.

We engaged an external consultancy to help implement the accelerated deployment of a best practice performance management methodology across our top 10 performance priorities. This provided a significant impetus to a number of our CSP initiatives and we have adopted this as our standard performance management methodology.

The most significant constraint to delivery over the last 12 months has been capacity. We recognise that aligning ambition to capacity is a critical success factor in delivery and we have therefore consciously focussed on delivering our Organisational Development Plan through 2009/10 to provide us with the capacity required to deliver even more ambitious plans.

# Delivery and In-Year Monoitoring

It is clear that the scale and pace required to deliver this plan is significantly greater than our CSP last year and this is reflected in the scale of the improvements we are making in terms of the programme management and collaborative working arrangements that we are putting in place. We recognise that these changes will be essential in order for us to work locally and as a sector to manage the following 3 interdependent transformational changes.

- Acute sector decommissioning and disinvestment with NWL sector partners
- Development of capacity in primary and community settings
- Behavioural change across clinicians and patients

The key changes we are making to our delivery arrangements include:

- Revising our existing Investment Panel process, extending its current focus on investment appraisal to cover the full strategic planning and delivery process. EMT will meet on a monthly basis to provide full assurance of the investment portfolio including the assessment of business cases and implementation plans, monitoring of delivery against the objectives, budget, milestones and benefits contained in the business cases and plans and ongoing monitoring of the overall progress against the portfolio's investment and disinvestment plans
- Aligning our business case approval process to a formal framework for benefits realisation to ensure that the realisation of benefits set out in approved business cases is monitored effectively and corrective action taken where there is any predicted slippage in terms of benefits realisation
- Enhancing our integrated monthly monitoring processes including the Board Assurance Framework and other performance reporting to the Board, Finance and Information Strategy Group and EMT to ensure these reporting arrangements are aligned to the process changes described above
- We will establish detailed working arrangements for monitoring and coordination of plans with the sector programme team

# Risk Management

| Risk Description | Actions we can take to reduce the risk |
|---|---|
| Polysystem alternative to acute provision is not delivered to timescales that align to the acute sector services reconfiguration | • Regular alignment of PCT and sector implementation plans<br>• Improve and integrate programme management arrangements within and across PCT and sector organisations |
| Primary care savings are not deliverable within existing GP contractual arrangements | • Tackle this as a sector to develop a coordinated approach and take advantage of cross-sector expertise |
| Capacity is created in polysystem settings but referrals and A&E attendances do not reduce or change sufficiently to make use of the new capacity and deliver required savings from the acute sector | • Coordinated and large-scale communications campaign in collaboration with the sector<br>• Significant focus on involving primary care clinicians in designing and embedding pathways that assure predictable referral patterns |
| Quality of GP practices to develop and respond to the scale and nature of proposed changes | • Plans to develop GP practices as set out in our OD Plan |
| PBC does not take ownership of transfers from acute settings | • Continued focus on PBC engagement in developing pathways and associated implementation plans |
| PCT lacks capability to deliver the savings targets within the required timeframe | • New senior staff are joining through Q3 2009/10 and will be inducted and deployed to prioritised activities to accelerate planning and delivery |
| Resulting instability in established providers impacts on provider performance | • Work through the sector and locally with other providers to engage them in the development of plans and provide support for any required reconfigurations |
| Investment and / or disinvestment figures change significantly at full business case stage | • Revised investment and disinvestment processes will provide early warning of any changes and maintain business cases as live documents providing a composite view of impacts on investment and disinvestment so deviations can be anticipated and pre-emptive corrective action can be taken<br>• Continue to look for further efficiency and disinvestment opportunities |

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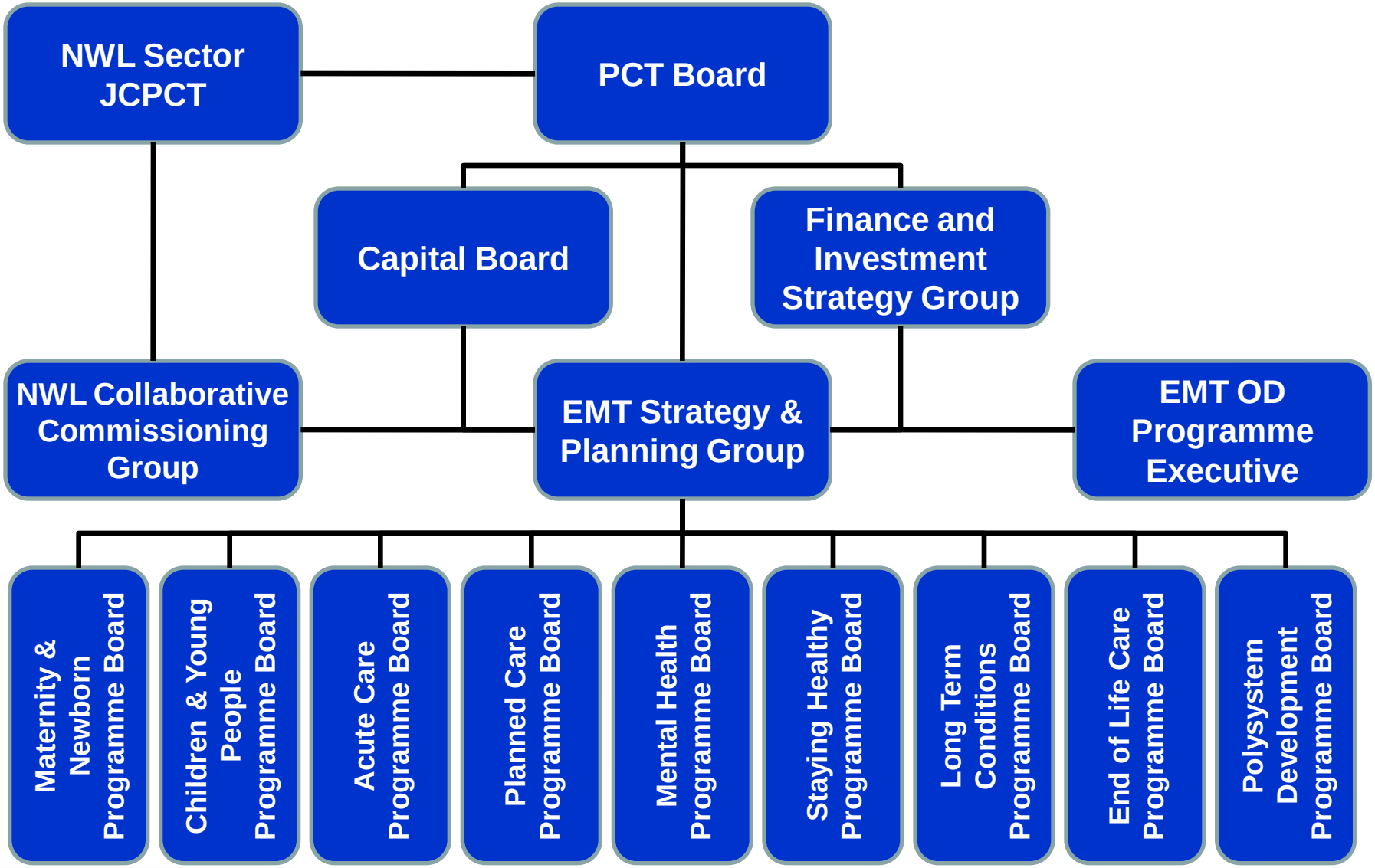
# Governance



# OD Plan – Overview

The Organisational Development Plan sets out NHS Brent's plan build on recent OD achievements and enable the deliver of the CSP, both in terms of our internal development as a commissioning organisation progressing towards world class commissioning status and also our role in developing the other organisations that are crucial to the successful delivery of the CSP.

We will need to work with a range of provider organisations to articulate, plan for and implement together the organisational transformations required to introduce the polysystems and thereby enable the delivery of healthcare in Brent and across North West London in the radically different ways set out in the CSP and ISP.

These other organisation include primary and community care providers as well as the acute providers whose development and reconfiguration we will seek to influence through the shared commissioning arrangements we have put in place as a sector.

# OD Plan – Summary of key workstreams

| | |
|---|---|
| Continuing our development as a commissioning organisation | • **New Ways of Working** - Developing the skills, culture, organisational systems and processes to become a more organic, adaptable, outward looking and responsive organisation.<br>• **Partnership and engagement** - Strengthening our commissioning arrangements, developing productive partnerships including PBC, and increased active engagement with the public and other stakeholder groups<br>• **Information and Analytics** – Advanced analytical skills and insights to support strategic commissioning decisions and drive performance. |
| Pathways into Polysystems | Supporting the creation of new service and organisational model including design, skills analysis, capability development and models of staffing and covering:<br>• **Governance and structure** – reviewing and introducing appropriate governance and structure arrangements to support the design, development and delivery of the polysystems model including the roles of PBC and PEC and collaborative working arrangement with the sector<br>• **Primary care development** – Developing PBC, general practice and other primary care providers to ensure they are ready to take on the roles required of them and have the required capability and capacity to respond to and absorb the planned shifts and changes<br>• **Market management –** focussing on the procurement and workforce development requirements<br>• **Benefits realisation** – ensuring that the implementation and monitoring plans are in place to assure the realisation of benefits |

# Completing and aligning the plans

The final submission date for our WCC strategic plans is December 18th . The key activities for completing, aligning, reviewing and approving the plans in each of the remaining 4 weeks are summarised below,.

| | |
|---|---|
| Week ending 27/11 | • Alignment of financial plan to CSP<br>• FISG review of draft summary of CSP<br>• PBC Review of draft summary of CSP<br>• Submission of draft CSP to NWL Sector team to support alignment to sector ISP<br>• Alignment of OD Plan to CSP |
| Week ending 4/12 | • PBC Workshop<br>• Submission of final drafts of CSP and OD Plan to Board for provisional approval |
| Week ending 11/12 | • Health Select Committee review of CSP Draft<br>• Pathways to Polysystems stakeholder event<br>• Board reviews and approves final drafts of CSP and OD Plan subject to further identified changes |
| Week ending 18/12 | • FISG approve self-assessment scores and any final significant changes to CSP and OD Plan<br>• Complete final draft incorporating feedback from Board<br>• Final submission of plans to NHS London as part of WCC assurance process |