NHS
Brent
Clinical Commissioning Group

Brent overview and scrutiny committee meeting – 6 August 2014

Brent CCG's transformational programmes for health services in Brent

Date: 28 July, 2014

Brent CCG's transformational programmes to improve healthcare in Brent

1. Introduction

Brent CCG has ambitious plans to transform the way care is provided in Brent so that the patient receives the best possible treatment through high quality integrated care.

The purpose of this report is to update the Overview and Scrutiny Committee on three major transformation programmes being pursued in Brent and involving local authorities and patients as partners. These plans are reflected in our five year draft strategy. These plans are designed and driven locally and with an increasing system leadership role from Brent's Health and Wellbeing Board. *The paper should be read in conjunction with the separate report on the assurance process for the closure of the A&E unit at Central Middlesex.*

The background for these transformation programmes is that we aim to provide care at a lower cost and to achieve better outcomes.

The three major transformational programmes are:

- Primary Care Transformation – making it easier to see your GP and making more treatments available in a community setting;
- Whole systems integrated care – joining together health and social services to provide person-centred care; and
- Shaping a healthier future – the reconfiguration of hospital services, and in particular developing the long term future of Central Middlesex Hospital.

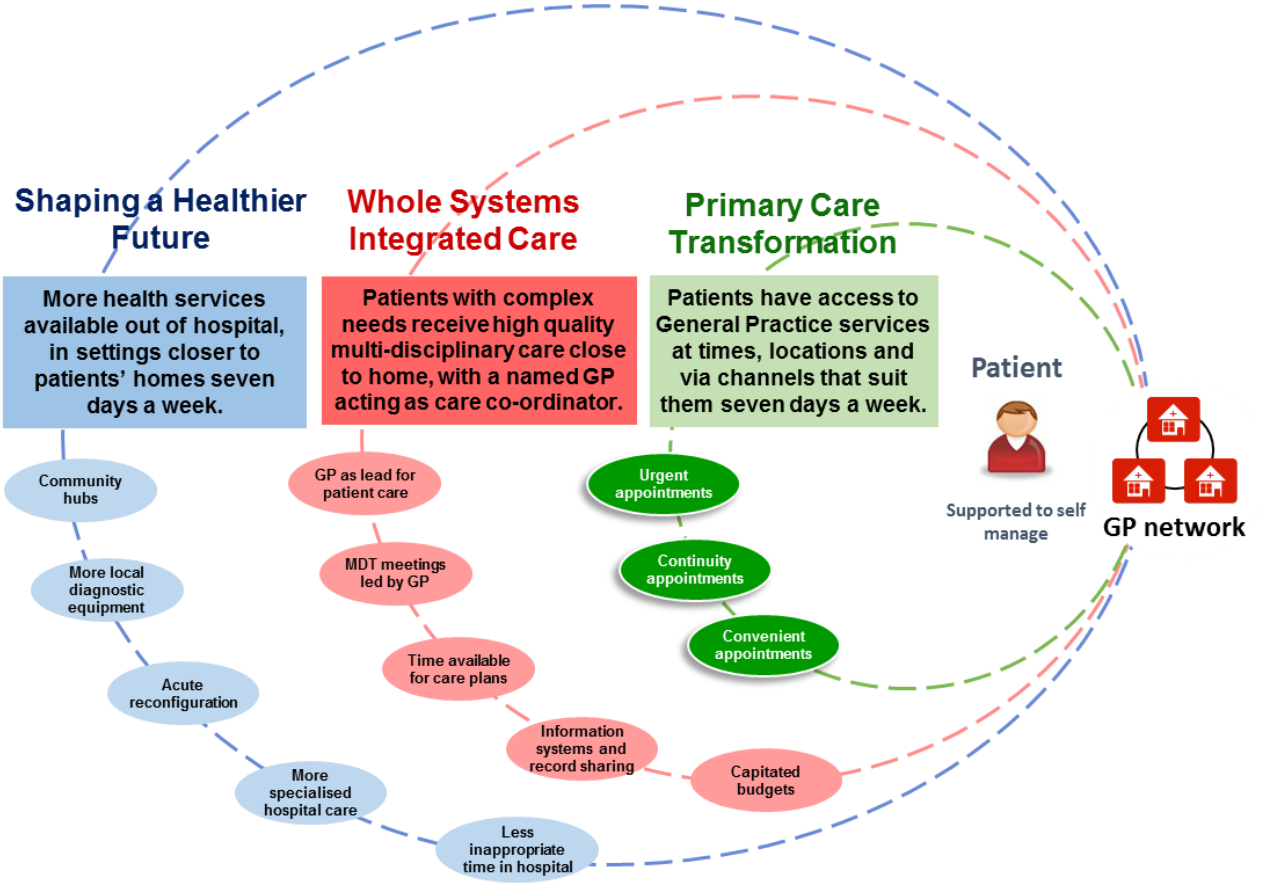
The three programmes are closely interlinked, with many interdependencies. We want hospitals to concentrate on providing their specialist services, other services provided in a community setting which will require expanding capacity in primary care, and a greater linkage between health and social to ensure patients receive a more integrated and coordinated service which meets their health and social needs.

The diagram below shows how the programmes covered in this paper fit together.

There are additional transformation programmes that are not covered in this paper:

(i) Mental health transformation - a whole system mental health and wellbeing strategic plan is currently under development

(ii) Planned care – community based outpatients for ophthalmology and cardiology starting in Autumn 2014 and musculoskeletal and gynaecology servcies starting in late 2015.



2. Transforming primary care

2.1 The role of primary care

Primary care, and in particular care delivered by general practitioners and practice nurses, is the cornerstone of the NHS healthcare system. Good quality primary care is considered an essential feature of all cost-effective healthcare systems delivering improved outcomes at lower cost and with higher patient satisfaction

Primary care provides universal and comprehensive access for all. It provides a holistic approach to an individual's care, diagnoses and manages disease, prevents illness and protects health by promoting healthy behaviours, having a whole population focus. It is the first element of the continuing healthcare process and supports patients to navigate across multiple care providers and settings.

As we reconfigure hospital services and look to provide more services in a community setting with more activity taking place outside of the hospital setting, primary care becomes increasingly important. Brent CCG wants to increase the effectiveness and capacity of primary care in the borough, in order to provide all patients with:

- Coordinated care – providing patient-centred, coordinated care and GP-patient continuity
- Accessible care – providing a responsive, timely and accessible service that responds to different patient preferences and access needs
- Proactive care – supporting the health and wellness of the population and keeping people healthy
- Convenient care – provided at a range of centres, including some local GP centres and community settings

Brent has 67 GP practices in the borough. Alongside but separate to the five localities that GPs work together in commissioning, the practices work in four networks on providing primary care. Moving towards delivering primary care in networks is best practice as:

- Practices are constrained on providing additional services through lack of staff and space
- Networks are more likely to be able to offer an extended range of services to patients that are high quality, cost effective and accessible.

2.2 The Prime Minister's Challenge Fund

In April 2014 all CCGs across North West London were awarded financial support from the Prime Minister's Challenge Fund to support schemes to make it easier for patients to see their GP. An additional £4m will come from GPs commissioning funds and money from Health Education North West London, making a total of £10m funding for the scheme.

The money will be used to help GPs develop their networks in order to provide extended opening hours, weekend opening and better use of technology so there will be more opportunities for people to see their GPs when they feel unwell. The fund will help networks plan to provide more diagnostics, clinics and services in GP practices and in partnership with other providers. The fund is only available for one year and does not fund additional services. It funds capacity for networks to plan their network and provide IT capability to work together.

Brent CCG has extended the hub network services until March 2017 that will allow patients to be seen within their practice or locality hub within 4 hours for urgent appointments and 48 hours for routine 7 days a week.

Improved IT capability within practices includes:

- Electronic prescriptions
- Online patient booking
- On line consultations and advice services
- Text message reminders
- Sharing clinical records for shared care plans and GP access services

2.3 What will this mean for patients?

The only service currently being provided within a network at this point are the GP locality hub services where patients can be seen by a nurse or GP within 24 hours. Improving access for an episode of illness at a linked centre provides speedy access to the patient and can also allow practices to free up time to look after more long term patients.

Providing services in a network either at another practice or in a centre e.g. Willesden, CMH or Wembley means that all patients can have access to such services as extended diabetic care.

2.4 What engagement has there been with patients?

The development of our primary care transformation programme had been informed by engagement across North West London and across the capital on what patients expect from primary care. We wish to co-design 7 day working through networks with patients. We will expect GP networks to develop mechanisms to ensure patient participation. Further work will be undertaken with patients and partners to publicise the availability and acceptability of GP appointments at the locality centres**.**

3. Whole Systems Integrated Care Brent Early Adopter Project

3.1 Introduction: why is integrated care important for Brent?

The Health and Wellbeing Board recently received an update on Brent's draft outline plan for whole system integration. The plan will be finalised by October 2014. This section provides a summary of the progress to date.

Integrated care is about joining up all health and social care services service users may receive to ensure they experience it as one seamless service, with their needs placed at the centre.

This will particularly make a big difference for people with long term conditions, who require regular treatment and support to better manage their conditions themselves. For the frail and elderly easy access to joined-up services is especially important, and being treated in their home and avoiding emergency admissions can have a significant impact on their quality of life as well as their health and wellbeing. It will also have important implications for the provision of services in increasingly challenging financial circumstances; as the elderly incur the majority of their lifetime health and social care costs in the last years of their life, avoiding admissions and introducing interventions so patients are less likely to require emergency care will deliver savings to the health and care system.

Brent CCG, Brent Council and Local Providers therefore want to create a health and social care system that is truly joined-up so that people receive the right care and support at the right time, and in the right place. Creating a more efficient and seamless system built around the individual will improve the outcomes and experience of care for people who use these services.

By better integrating care, patients and carers will:

- understand and know how to access services available to them
- be involved in developing and managing their own care plans
- have a single care plan that can be used by them and the professionals who look after them.

Integrating care is about helping patients have control over the care they receive, and ensuring services providers work together to provide it.

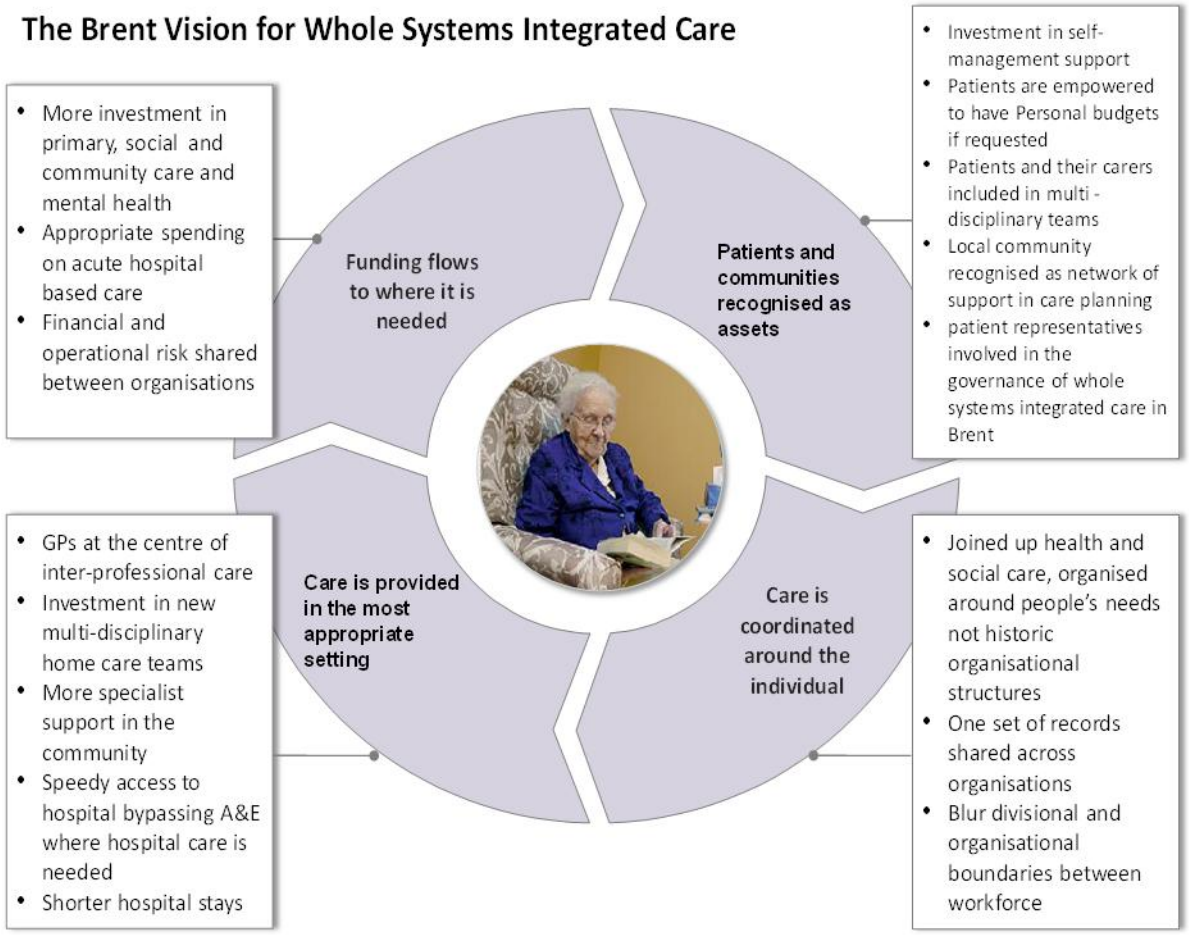
Brent CCG successfully applied with Brent Council, NWL CCGs, providers and other councils to become one of 14 Pioneer sites in England for whole system integrated care. An Integration Board reporting to the Health and Wellbeing Board has recently been established to work up the operational detail for the Better Care Fund plan, revised Integrated Care Pilot for all practices and Whole System Integrated Care plan. Whole systems integrated care will build on the Integrated Care Pilot 2 and the initiatives in Better Care Fund but will have the added components for those GP networks and providers.

The Outline Plan detailing the Brent WSIC Vision, built on the good practice modelled in the first phase of the WSIC, and was coproduced through a series of workshops involving a wide range service users, clinicians and lay partners.

3.2 Developing our vision for integrated care

The WSIC vision puts the patient's or service user's needs at the heart of the design and delivery of our health and social care services. Whole Systems Integrated Care will remove the barriers and obstacles to meeting the patient's needs and coordinate delivery of their care through multi-disciplinary teams and through the introduction of 'care coordinators'.

An overview of the Brent Vision is provided in the following diagram:



The patient or service user will be fundamentally central to the provision of services. Around the service user are arrayed four key overarching aspects to the WSIC Vision:

a. Self-Care Management,

b. Joined-up Seamless Services Coordinated around the Individual,

c. Provision of Care in the Most Appropriate Setting,

d. Fluid and Dynamic Resource Allocation to ensure investment is made where most appropriate for patient-centred care.

The Early Adopter project will initially focus on delivering whole systems integrated care for over 75s with one or more long-term conditions and are registered with a Harness or Kilburn GP. This equates to approximately 6500

registered patients, which experience suggests is the good number for an initial pilot.

Further work is underway to better understand the characteristics of this group; for example, analysis is being undertaken or is planned to be undertaken to evaluate the key care pathways currently used to navigate the provision of services. We are currently mapping the current landscape of services and support across all sectors to describe and understand their accessibility and settings.

Through this analysis of the current health and social care landscape we aim to better understand the gaps and challenges in services, and the potential obstacles and risks to developing whole systems integrated care services. This analysis will contribute to our understanding of the necessary interventions and levers required to deliver the WSIC vision. It will also deepen our understanding of the implications and impact of the WSIC Vision. This vision will develop and evolve as the detail of the Model of Care emerges and new patient pathways are developed to capitalise on innovations in self-care management, primary care services, and new treatments in community settings and in the patient's own home.

3.3 Developing our new model of care

The WSIC Vision will be updated and set out in greater clarity in the final draft of the Implementation Plan. It will provide the framework in which the new Model of Care will be described and navigated. Work is commencing to flesh out the Model of Care, plot the pathways and describe the interventions which will deliver the Vision. The Model of Care will embody key principles that together will govern the approach to delivering whole systems integration.

For example, where appropriate we will respond proactively so patients have the information, choice and control to manage their care to best meet their needs. Through the early adopter WSIC work patients will feel empowered and given the support to better manage their own treatment.

But where a patient requires treatment in a health setting we will respond reactively with rapid and timely interventions to deliver seamless patient-centred care; our aim is to keep people well, as long as possible in their homes and in their communities but be there to provide urgent care when they need this.

To deliver the above ambitions it has been determined that the Brent model of care should include 4 evidence based principles:

1. A Collaborative Multi-Disciplinary Team structure
2. Care Coordination
3. Self-Management by the Patient
4. A Single Shared Care Plan

In addition to this the Brent local vision has developed emerging principles to govern integrated care models that are developed. These include:

- Jointly commissioning for quality of life and independence outcomes

- Single point of access to health and social care services
- Single named coordinator/lead professional– who is best placed to care for patients
- Single care coordination approach that is holistic and person centred to empower and enable independence, dignity and quality of life
- Shared information and patient registration to maximize wellbeing and user experience
- Removal of professional and institutional barriers
- Network led to ensure equity of access and care
- Consistency and continuity of 24/7 across health and care
- Supporting carers to care and improve patient experience

To illustrate how the proposed changes will make things different for the patient, consider how in the current set-up your GP will not help patients with non-health issues, and instead is likely to direct you to social services or the voluntary sector. This leaves the patient with the job of finding out the relevant contact and help they need; a responsibility that not all patients are capable of fulfilling. In the future, adult social services and Age UK would be part of the multi-disciplinary Locality Team. They would all have joint responsibility and would be working together.

There would not only be better understanding of what is available (avoiding unnecessary referrals), but they could also make direct referrals, direct to another member of the Locality Team who would help immediately. All of these professionals would be working together on a daily basis and they would be identifying the gaps in services and support, and would work together to commission what was needed locally based on a shared understanding of the gaps, and a shared understanding of the impact – the impact it would have on the wellbeing of the people they support, and the impact it would have on the budget available to the locality team for its population.

A fundamental part of the Early Adopter process is the idea of a 'capitated budget'. This means the Locality would know how much money it has to spend on its population across all services, and could then make decisions about where to spend money, which services and support would make the greatest difference, rather than at the moment where different organisations are focus on their organization outcomes and spend money according to those organisational priorities.

In addition, the care coordinator role in the Locality Team would have a more explicit role in accessing support outside of the Locality Team that would have a significant impact on an individual's wellbeing. For example, there are no plans for Housing to be part of the Locality Team, but we know that Housing has a major impact on people's wellbeing. Therefore, there is an expectation that the Locality Team would have strong links with Housing and the Care Coordinators would help people to navigate the housing system to find solutions. They would help them to understand what may or may not be on

offer, and help them to access what is on offer, rather than just saying ‘you will need to speak to housing’.

The success of the Model of Care will be evaluated through the measurement of key outcomes and key performance indicators. Central to this evaluation will be quality of life outcomes. Measures of quality of life are the best indicators of service-user priorities; improvement in these outcomes will denote improvement in service-users' quality of life and as a result service-user satisfaction. Improvement will therefore demonstrate we have delivered the WSIC Vision and contributed towards the delivery of key Health and Well-being ambitions.

The ultimate aim of whole systems integration is to improve patient’s quality of life. Whilst we are planning further work to develop patient related outcomes, initial engagement shows that for over 75s quality of life means:

a. Living independently
b. Meeting personal goals
c. Being at home
d. Feeling safe
e. Having enough to eat
f. Opportunities to maintain choices
g. Feeling in control
h. Ability to direct support
i. Being listened to
j. Not feeling isolated

Success will also be measured by performance and professional related outcomes and in particular financial savings. Whole systems integrated care will provide patient-centred seamless care in settings convenient to the patient and which will deliver the best clinical outcomes. In practice this means planned care, reductions in expensive emergency admissions, reductions in avoidable admissions and readmissions, and the transfer of treatments from secondary care to primary care resulting in reduced bed-days and length of stay.

Whilst the primary objective of WSIC is improvement in patient related outcomes, the impact of the implementing the new Model of Care will be a reduction in costs for both health and social care services. Further work is required to evaluate costs associated with the new Model of Care and plan the realisation of benefits to the patient and to organisations along the care pathway. Once the Model of Care has been developed and costs associated with its interventions have been mapped, we will understand the relative affordability of the WSIC Early Adopter Project in comparison to the current care landscape for the target patient cohort.

3.4 Next steps and further engagement

The next phase of 'Implementation Planning' continues our journey of engagement and coproduction. We reiterate our local commitment to finding

and using representation from grassroots organisations and lay members, including the general public. We wish to engage a diverse wide range of people whose views are representative of all the local issues faced by service-users in Brent.

There will be a number of opportunities to engage with the coproduction of the Implementation Plan and particularly the development of the new Model of Care. We will be implementing the necessary structures and processes to ensure alignment of all Brent engagement work and to ensure adequate communication of progress, including regular updates on key programmes of work. This will include updates on WSIC Early Adopter Phase 2 Implementation Planning for the Overview and Scrutiny Committee where appropriate.

To ensure the Vision and Model of Care fit within the broader aims of the Health and Wellbeing Strategy and within the wider transformation agenda in Brent and NW London, including the Better Care Fund, it is proposed that a final draft of the WSIC Brent Early Adopter Implementation Plan will be submitted to the Health and Wellbeing Board to explain the Vision, the Model of Care and the outcomes chosen to measure success.

4. Shaping a healthier future – developing Central Middlesex Hospital

4.1 Background and Context

With the agreement to implement Shaping a Healthier Future (SaHF) and the change in services that sees Central Middlesex Hospital (CMH) become a Local and Elective hospital, we now have the opportunity to redefine and transform how care is provided on this important site for Brent residents.

As a local and elective hospital defined by SaHF, the services delivered at Central Middlesex Hospital are to include a 24/7 Urgent Care Centre (UCC), outpatients services, diagnostics, elective services and primary care.

We have done further work in how we can build on these services to offer a wider variety of services, ensuring that we are fully utilising what is some of our best NHS estate within North West London.

This additional work resulted in a Strategic Outline Case (SOC) being created for CMH which would offer additional services on site such as an; Elective orthopaedics centre, Mental health inpatient facility, primary care ‘hub’ and genetics laboratory (see section 2.3):

The SOC also considered which services may benefit by being co-located on the CMH site, which the rehabilitation beds currently located at Willesden have been considered.

We are currently developing an Outline Business Case (OBC) which builds much greater detail to scoping all of these services, including their layout within the site, how they would operate, staffing requirements and costs.

4.2 Proposals and Impact for Patients

The intention is that a range of additional services will be provided at the CMH site to fully utilise this facility for the benefit of Brent and the NWL wide population, ensuring the long term clinically viable and financially sustainable future of the CMH site.

A Strategic Outline Case (SOC) was developed during 2013 and subsequently approved by the required boards in 2014. A SOC is a very preliminary assessment of costs, benefits, risks and funding and affordability and this was the first and initial step that was taken to scope a range of services that could be provided at CMH.

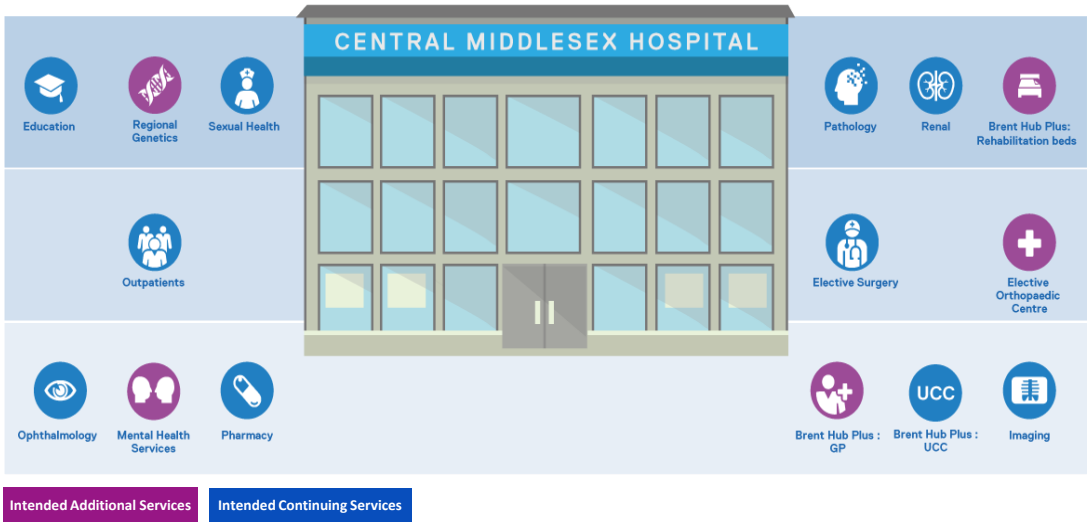
We are now developing an Outline Business Case (OBC) that builds upon the initial proposals and work undertaken in the SOC to further refine and develop the range of services at CMH. The OBC will provide more detailed development of the services than is contained in the SOC which will allow a more accurate costing of the services and ensuring clinical and financial viability.

During the SOC stage there were a range of stakeholder engagement activities including a workshop on 14 January and a public engagement meeting on 19 February.

As part of the SOC, travel analysis on affected patient/carer journeys was undertaken on the range of services affected. This analysis showed that there are no significant impacts that would prevent the inclusion of the range of services being considered for CMH. Similarly, equalities impact consideration highlighted no significant impacts that would prevent the range of services being progressed. Further equalities and travel impact analysis is now being undertaken for those services that are being progressed at the OBC stage.

4.3 Proposed range of additional services being developed:

- Hub Plus for Brent – providing an extended range of community based services for Brent residents including primary care (GP services), out-patient appointments, diagnostics, community services and the relocation of the rehabilitation beds from Willesden Centre for Health
- Elective Orthopaedic Centre for NWLHT, Ealing and Imperial Trusts
- Relocation of mental health services from Park Royal
- Relocation of regional genetics service from Northwick Park Hospital



4.4 Engagement/consultation considerations for services planned to be sited at CMH

Following patient and public engagement during development of the SOC, further appropriate patient and public engagement has been undertaken during June and July in developing the additional services at CMH.

The patient engagement element of this programme has been developed in collaboration with the patient representative members of the Partnership Board (which meets regularly to ensure this programme is appropriately governed and that key decision can be made to ensure it is making appropriate progress). An engagement matrix has been developed to ensure that appropriate engagement is being conducted for the key service developments. The matrix is being used to track and review the engagement activities undertaken during the OBC development and will be further used to specify any on going engagement and consultation requirements necessary on completion of the OBC to meet health and care legislation.

A public engagement event took place on 17th July in Brent which was well attended and gave patients and the public an opportunity to hear about the proposals being considered for CMH and to help us further develop and refine the options. These options will undergo further engagement until they are well enough defined for the OBC.

It is noted that the majority of the proposed changes have already been subject to formal stakeholder consultation as part of Shaping a Healthier Future (SaHF).

4.5 Details of the proposed additional services

(i) Brent Hub Plus providing an extended range of community based services for Brent residents

This was proposed within SaHF and therefore formal stakeholder consultation has already been undertaken. This included primary care (c. 7,500 list size), community and Out of Hospital services, including access to diagnostics that were intended to be sited at Central Middlesex Hospital, and the intention to work up these plans with appropriate patient and public engagement in the co-design to provide a positive impact.

This proposal includes up to c. 167,000 out-patient appointments being provided from CMH and would result in the majority of Brent residents attending CMH for their out-patient appointments. As services will be co-located this will provide patients with the opportunity to receive a wider range of services from a single site and having the opportunity to organise appointments as a one stop service, reducing the need for multiple visits.

The relocation of rehabilitation beds (c. 40) and community services from Willesden Centre for Health to CMH was not addressed within SaHF. The clinical review identified a positive impact for patients on co-locating the rehabilitation beds on the CMH site due to it being sited with a wider range of services and support. The relocation from Willesden to CMH is a distance of 2 miles.

Travel analysis on affected patient/carer journeys was undertaken at SOC stage and overall it suggested that there are no significant impacts that would prevent relocation of the rehabilitation beds from Willesden. It is however noted that this would provide both positive and negative travel impacts for some patients and their carers dependent on where they live in the borough. CMH has good public transport links and it also benefits from ample and increased parking facilities compared to Willesden (which has very limited availability of parking both on site and in the vicinity). Patients requiring rehabilitation services are usually transported to the service via hospital transport services so there would be little impact for the patients being transported to CMH instead of Willesden. The main travel impact would be on carers or family in visiting patients at the CMH site.

Brent CCG would welcome the view of Brent OSC on the possible relocation of the rehabilitation beds from Willesden Centre for Health to CMH so that should this option be assessed as viable and approved at OBC stage, that any further engagement and consultation requirements can be built into the development timeline.

The community services moving from Willesden relates to the staffing required to deliver the rehabilitation services as well as some other teams that provide outreach services to the population, for example; district nurses and health visitors who will continue to see patients in their usual care settings i.e.: at home/at GP practices and at health centres.

(ii) Elective Orthopaedic Centre for NWLHT, Ealing and Imperial Trusts (c. 5,000 procedures).

An Elective service was proposed within SaHF proposals. This included the intention to undertake elective activity at Central Middlesex Hospital and the intention to work up these plans with appropriate patient and public engagement in the co-design of such services to provide a positive impact. It is noted that this engagement will need to be as wide as possible to include

patients from further afield than Brent. The recent engagement event on 17th July included stakeholder and patient representatives from across Brent, Harrow, Ealing and Hammersmith & Fulham. The clinical review identified a positive impact for patients on setting up a dedicated centre for elective orthopaedic procedures that will bring about improved patient outcomes including reduced length of stay in hospital, lower infection and complication rates and higher patient satisfaction due to it being a single speciality service.

(iii) Transfer of local mental health services from adjacent Park Royal Site (4 Wards/all inpatient services excluding low secure services are considered as appropriate to be located at CMH and are being explored including mother and baby unit)

This option was not addressed within SaHF. However, the Park Royal site is adjacent to the Central Middlesex Hospital site. The Park Royal site estate requires significant redevelopment, and as a result investment to achieve current estates standards. Considering its relocation within the Central Middlesex Hospital site would bring improvements in its infrastructure and a respective benefit for patients and service providers working in updated facilities. Commissioners are supportive of its relocation. The relocation from an adjacent site would have no negative impact to the patient and in fact the clinical review identified a positive impact for patients in providing services from facilities that reach best standards, thus reducing risk and optimising care.

(iv) Relocation of genetics from Northwick Park Hospital

This option was not addressed within SaHF. However, this is a laboratory service. Patients are seen across multiple healthcare sites for their outpatient appointments and this will not change as a result of relocation of the laboratory services. The clinical review identified a positive impact in allowing Northwick Park Hospital to develop and expand other services at the Northwick Park Hospital site.

4.6 Patient Engagement and Consultation

A further public engagement event is planned and will be scheduled at the appropriate time. In the meantime, further patient and public engagement will continue during the refinement of the options and before any decisions are taken on the relocation of services.

4.7 Importance of Decisions

The relocation of rehabilitation beds from Willesden to CMH increases under-utilisation at Willesden Centre for Health and would result in increased costs to Brent CCG who holds the head lease for the site. The potential cost to Brent CCG of increasing empty space at Willesden and the requirement to subsidise rental costs for new services at both CMH and Willesden is high. The CMH site currently runs at an annual loss of £10.8M and the impact of moving services from Willesden adds a further c. £2m cost at Willesden to Brent CCG. Brent CCG is pursuing a number of initiatives to mitigate these potential increased costs, in partnership with NWL CCGs and providers as we expect the pressure to be absorbed across a number of organisations. The

future decisions on CMH and Willesden have major service and financial considerations for Brent CCG and residents for many years to come.

4.8 Next Steps

The OBC is being developed with stakeholder engagement across Brent and wider North West London for three elements of the OBC: Hub Plus for Brent, Elective Orthopaedic Centre and relocation of mental health services from Park Royal site.

Throughout the OBC process Brent CCG has and will engage with stakeholders and patients and public representatives to ensure that plans for services are tailored to the local population and an effective outcome for patients is achieved. **We would welcome views of Brent HOSC on the services being considered for CMH, and support and advice on engagement in this process. In particular, a view on the possible relocation of the rehabilitation beds from Willesden Centre for Health to CMH is sought so that should this option be assessed as viable, that any further engagement and consultation requirements can be built into the timeline**.

The OBC will go through a formal approvals process through the affected statutory organisations, in the same way as was undertaken for the SOC approvals process.

Timeline for completion of OBC