

Brent CCG

Commissioning Intentions

Brent Health & Wellbeing Board

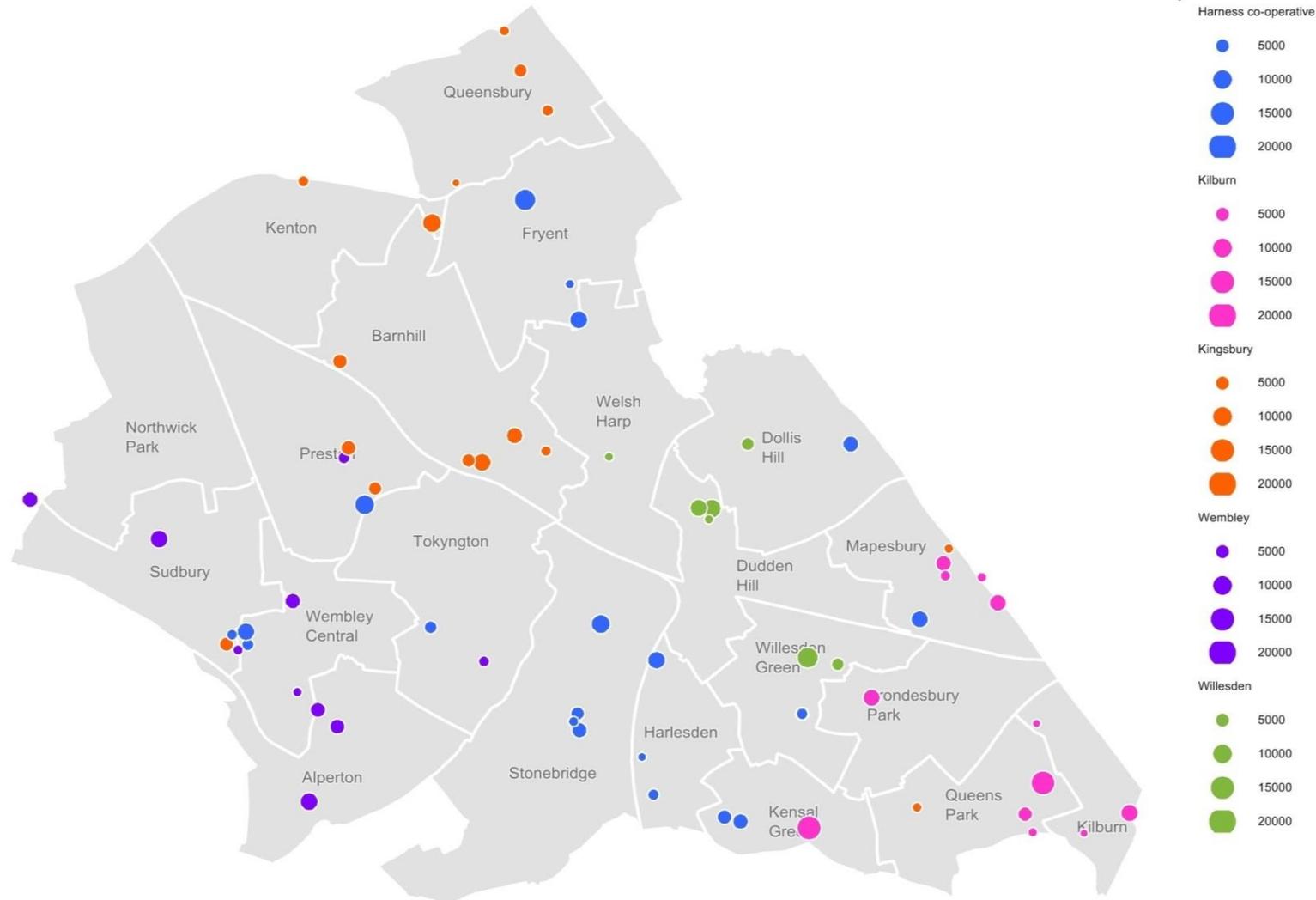
10th November 2015

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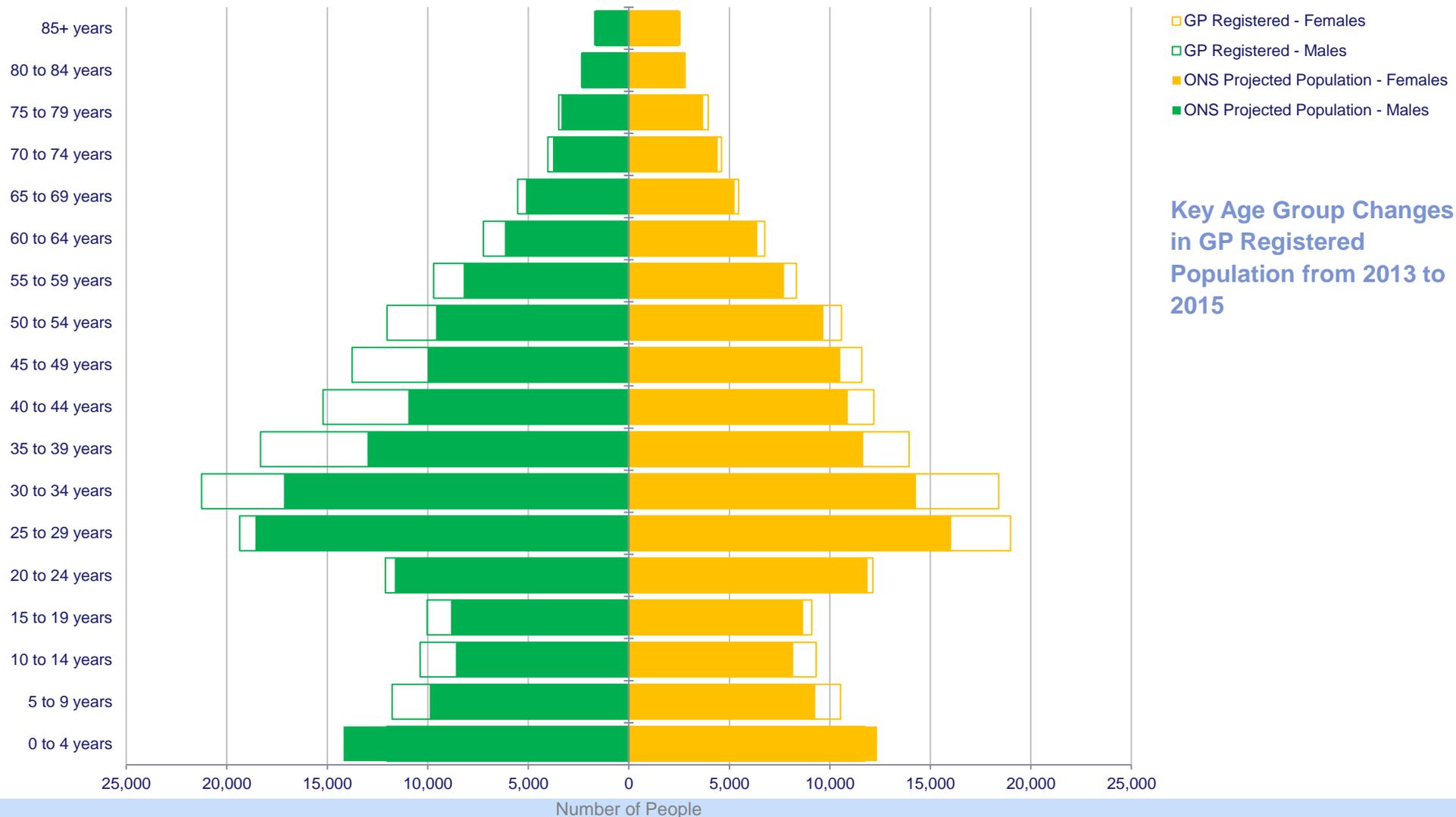
NHS Brent GP Practices and Localities

Brent is an outer London borough in north-west London (figure 1). It has a population of 321,009 and is the most densely populated outer London borough. Brent has 65 member practices which are all aligned to one of five locality based groups. Each has a Clinical Director. 18 practices have a registered list of fewer than 3,000 patients and 5 practices have a registered list of greater than 10,000 patients.



Brent's Resident and GP Population Profile

As of July 2015, there were 367,589 patients registered with Brent GPs. This is 15% higher than Brent's projected resident population of 321,009 in 2015.

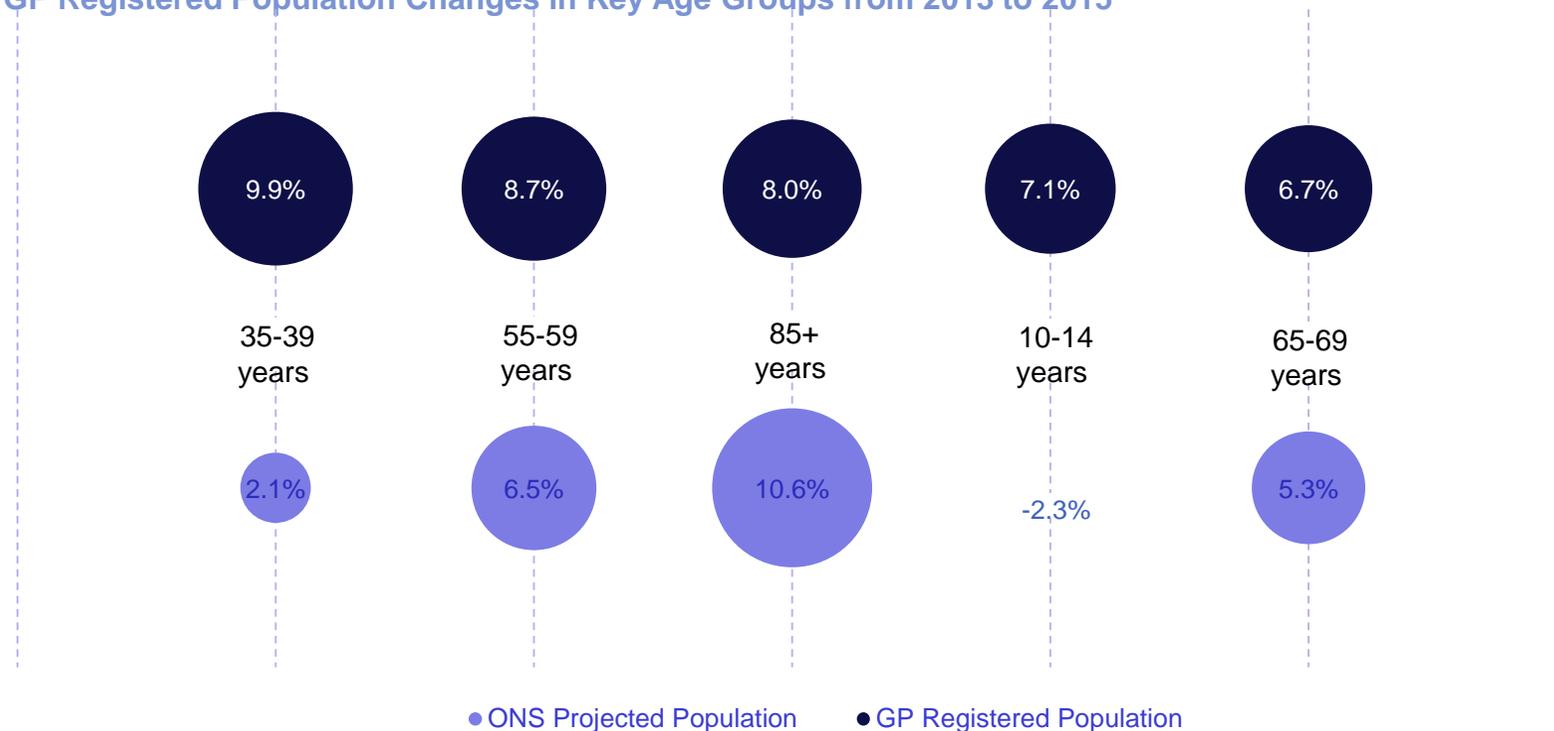


Key Age Group Changes in GP Registered Population from 2013 to 2015

Brent's Resident and GP Population Profile

The diagram below shows that there has been a significant increase in the population groups who are most likely to use healthcare services in Brent. It compares the GP registered population with the ONS figures. Both sets of figures confirm that there is a significant increase in the older age groups (55-85+) which will drive increasing demand for healthcare services. The biggest percentage increase is for patients aged 85+ (10.6%).

GP Registered Population Changes in Key Age Groups from 2013 to 2015



Commissioning Intentions 2016 – 2017

Our thinking so far

Our Shared Vision Across North West London

DRAFT

Our vision is centred on the needs of the NWL population (across 8 CCGs), developed from the patient views on their requirements of healthcare. These views then formed as the ambitions of our strategy and vision for the healthcare transformation in North West London.

Personalised



"I know how to lead a healthy lifestyle and can manage my own care"



"I feel in control over my care because decisions are taken with me and consider my lifestyle and individual choices"

Localised



"My care is now more convenient because the services closer to my home are more accessible"



"I know I will be provided with a wider range of high quality care within my community for all of my health and wellbeing needs"

Our vision allows us to achieve patient-centred care in all our care settings, across North West London, ensuring reduced inequality of care outcomes and delivery of services that are bespoke to the needs of the local population.



"I'm not treated 'in parts', but as a whole person in a coordinated way"



"Whoever I see, knows me and my preferences, and I no longer have to repeat my details each time"

Integrated



"I have a positive experience in a great hospital environment which helps me feel confident in the quality of care provided to me"



"I am in hospital no longer than I need to be, and am able to receive effective care sooner rather than later"



Centralised



- Reducing variation in clinical standards of primary care
- Developing GP networks to deliver more out of hospital care and enhancing GP access
- Shaping a Healthier Future - a major shift in care from within a hospital setting to an out-of-hospital setting so more people are treated closer to their homes;
- Developing integrated care through the Better Care Fund



Acute Reconfiguration aims to deliver:

- A major shift in care from within a hospital setting to an out-of-hospital setting so more people are treated closer to their homes;
- The concentration of acute hospital services in order to develop centres of excellence which are able to achieve higher clinical standards and provide a more economic approach to the delivery of care.

In 16/17 the focus will be to:

- Deliver a revised Implementation Business Case for approval by the NHS and HM Government, allowing for capital investments to be made to transform NHS estates in NWL;
- Improving the quality of healthcare in North West London
- Developing CMH as a local elective hospital to include:
 - A 24/7 urgent care centre
 - Outpatient services
 - Diagnostics
 - Planned operations
 - Primary care (GP practice)



STARRS

- Extend the rapid response element of STARRS to enable GPs and the STARRS team to care for more patients in the community without the need to an acute hospital admission via A&E
- The CCG and Council also wish to commission an integrated rehabilitation and re-ablement service to reduce duplication and provide enhanced re-ablement services for people to regain independence (through BCF)
- Analysis suggests that STARRS could do more to support a reversal of the current trend for increasing admissions through the Emergency Department particularly for the frail elderly



We will jointly review the activity plan for the service to ensure that it reflects the underlying demand for rapid response.

We will work with LNWHIT to revise the service specification and associated KPIs, as well as the contractual form and payment mechanism that is associated with this variation

Primary Care Led Urgent Care & 111

- Provide a GP-led and driven service, working in partnership with other provider to achieve improved long-term outcomes, reducing ED demand
- Review existing community-based service model to achieve a more integrated service and co-ordinated pathways for the benefit of patients
- Procure a safe, high quality NHS 111 service integrated with the Out of Hours Service, Urgent Care Provision and Emergency Care
- The new NHS 111 service will support our vision to deliver care closer to home, provide for a single point of access and allow for special patient notes & summary care records to be up to date.



Planned Care

- Improve the quality, responsiveness and cost effectiveness of community outpatient services to enable more patients with chronic and/or long-term conditions to be care for in community services
- Review of physiotherapy services to be undertaken – maximise clinical capacity, improve waiting times and value for money
- Stock take of community ophthalmology and cardiology contracts to understand potential to realise benefits and improve contractual performance
- Teledermatology pilot, providing rapid diagnosis for a range of dermatological conditions in GP practices by qualified specialists viewing high quality photographic images via a remote secure system.



- New DMARD care pathways for gastro patients, those with abnormal liver function tests and for those patients requiring an endoscopy.

Access to extended GP services and primary care in Brent-
A Scrutiny Task Group Report recommended:-

- NHS England, Brent CCG and local GP networks carry out a review of current GP opening hours across the borough and consider additional ways of accessing GP services, including Skype, telephone and email consultations where appropriate and within Information Governance principles.
- Brent CCG carries out a detailed review of GP Access Hubs following the initial six months and first full year of operation against the new service specification, providing a detailed evaluation on the level of take up, impact on patient satisfaction regarding access and impact on A&E and UCC attendances. Review includes public engagement to assess the extent to which the model reaches and benefits all residents in the borough.
- More services to be commissioned via GP networks e.g. Care Home & High Risk Housebound patient service



Better Care Fund

The Better Care Fund is a redesign programme delivered in partnership with organisations from across the Brent Health and Social Care economy. The objective is to bring together health and social care in order to transform local services, providing people with the right care, at the right place, at the right time tailored to their individual needs and to the highest possible standards. The schemes are described below:

BCF Scheme 1 – Keeping the most vulnerable well in the community (Whole Systems Integration)

BCF Scheme 2 – Avoiding unnecessary hospital admissions.

BCF Scheme 2.5 - Integrated rehabilitation and reablement.

BCF Scheme 3 – Efficient multi-agency hospital discharge and community bed provision.

BCF Scheme 4 – Improving Recovery From Mental Health Conditions

Outcome Measures

- Reduction in permanent residential care admissions
- Reduction in readmissions to hospital following period of reablement
- Reduction in delayed transfers of care
- Reduction in non-elective hospital admissions (general + acute)
- Improved patient experience and satisfaction



Mental Health

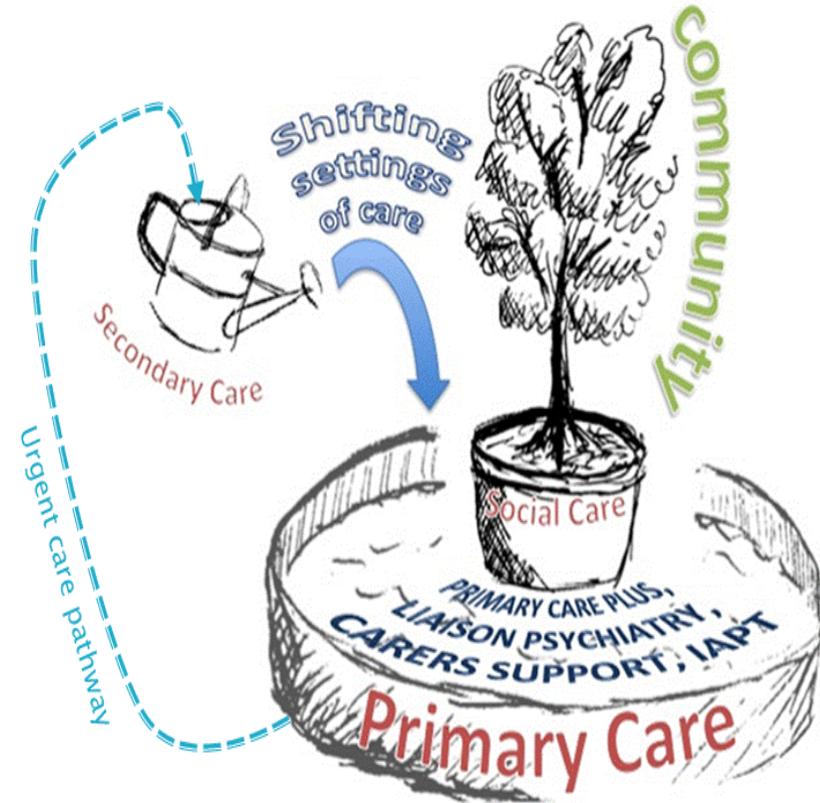
SELF-CARE: Move from 'opt in' to 'opt out' for attendance at the 'recovery college' for post-discharge advice and education about mental illness. This would reduce rates of relapse, and provide support to carers.

Primary care – Reshape peer support and specialist mental health nursing support to share learning in the recovery college, help people develop personal recovery plans, support social inclusion.

Community care – Continue development of crisis response at home, in the community, as well as in A&E. Establish a new model of community mental health teams with shorter waiting times, and fewer internal waiting lists. Increase the care available for post-traumatic stress disorder and personality disorder.

Crisis houses – Develop options for single-sex, short-stay accommodation, offered as an alternative to inpatient admission when treatment cannot be offered at home. Provide less medicalised care for people who would otherwise be admitted to a ward.

Inpatient care - Improve use of patient-rated clinical outcome measures in care-planning. Continued effort on improving the patient experience of care, ensuring the safety of the ward community. Reduce lengths of stay and readmission rates.



Questions

- Any questions?