Brent NHS Brent Clinical Commissioning Group	**Health and Wellbeing Board** 24 January 2017 **Report from the Chief Operating Officer, NHS Brent Clinical Commissioning Group**
	Wards affected: ALL

NHS Brent Clinical Commissioning Group (CCG) Commissioning Intentions 2017-19

1.0 Summary

1.1 This report details the commissioning intentions for NHS Brent CCG for the financial years 2017/18 and 2018/19. These are aligned with the North West London (NWL) Sustainability and Transformation Plan (STP).

1.2 The Health and Wellbeing Board (HWBB) has reviewed the Commissioning Intentions in depth and made a number of comments. These detailed comments provided by the HWBB have been considered and changes incorporated into the Commissioning Intentions as a result. This report provides an opportunity to discuss the CIs in person with the CCG.

2.0 Recommendation(s)

2.1 The HWBB are requested to note the changes made to the Commissioning Intentions which were approved by the CCG Governing Body on 11 January 2017.

2.2 The HWBB are requested to endorse the final Commissioning Intentions for Brent, which include health and care priorities for service development.

3.0 Detail

3.1 The purpose of these Commissioning Intentions is to inform health and care providers as well as partners about the priorities for Brent CCG as a commissioner. These commissioning intentions have been developed through a collaborative process, taking into consideration national and local policy drivers, demographics, as well as Brent CCG's commissioning principles and the Health and Wellbeing Board priorities.

3.2 The key national and local drivers for the commissioning intentions are the Five Year Forward View, the North West London Sustainability and Transformation Plan (STP) and the Brent chapter of the STP, including six 'Big Ticket Items'.

3.3 The Five Year Forward View was published in October 2014 and sets out 10 national priorities for the next five years. Our commissioning intentions implement these priorities at a local level. The ten priorities are:

- Improving quality of care and access to cancer treatment
- Upgrading quality of care and access to mental health and dementia services
- Transforming care for people with learning disabilities
- Tackling obesity and preventing diabetes
- Redesigning urgent and emergency care services
- Strengthening primary care services
- Timely access to high quality elective care
- Ensuring high quality and affordable specialised care
- Whole System change for future clinical and financial sustainability
- Foundations for Improvement

3.4 The North West London STP sets out ways to achieve the triple aim of closing the health and wellbeing gap, the care and quality gap and the financial sustainability gap. The table below sets out particular areas of concern for Brent relating to the first two gaps.

Brent's Health & Well-Being Gaps	Brent's Care & Quality Gaps
• **Common mental health disorders (CMD): in 2014, an estimated 33,959 people aged 18 to 64 years were thought to have a CMD** • **Severe and enduring mental illness:** affects 1.1% of the population • **Mental well-being: the percentage of people with depression, learning difficulties, mental health issues or other nervous disorders in employment is 23% also lower than both the England rate (36%)** • **Childhood obesity: Brent is in the worst quartile nationally for the % of children aged 10-11 classified as overweight or obese – 38%** • **Diabetes: by 2030 it is predicted 15% of adults in Brent will have diabetes**	• **Caring for an ageing population**: 35% of all emergency admissions in Brent are for those 65 and over; once admitted this group stays in hospital longer, using 55% of all bed days. • **EOLC**: Brent has one of the highest percentages of deaths taking place in hospital in the country. • **Primary care**: wide variation in clinical performance; Brent is in the worst quartile nationally for patient experience of GP services. • **LTC management:** Brent is in the worst quartile nationally for people with a long-term condition feeling supported to manage their condition. • **Cancer**: Brent is in the second lowest quartile nationally in terms

Brent's Health & Well-Being Gaps	Brent's Care & Quality Gaps
• **Long term conditions (LTCs): ~20% of people have a long term condition** • **Dementia: Over 2,225 people aged 65 years and over have dementia (2016)** • **STIs/HIV: 1,404 STIs per 100,000 population against 829 in England** • **Health-related behaviour: physical inactivity: worst in West London; nutrition: 47% get 5 a day; tobacco use; alcohol; take up of immunisations**	of GP referral to treatment for cancer and worst quartile in terms of cancer patient experience. • **Serious and long-term mental health needs:** people with serious and long term mental health needs have a life expectancy 20 years less than the average.

3.5 In order to close the financial sustainability gap, approximately £12m of net savings are required each year over the next five years. Allocation growth for 17/18 and 18/19 is lower than has been received in recent years. Therefore, with the expectation that demand will continue to increase in excess of funding growth, it is imperative that Brent CCG continues to make year-on-year savings and improvement in the value for money it obtains from its investments in order to maintain a sustainable financial position.

3.6 Closing all three of these identified gaps is the challenge addressed by the North West London STP, and the individual CCG chapters that support the overall strategy. Five delivery areas have been agreed that reflect where focus is needed to deliver at scale and pace to have the greatest impact. These five delivery areas are as follows:

- Radically upgrading prevention and wellbeing
- Eliminating unwarranted variation and improving the management of long term conditions
- Achieving better outcomes and experiences for older people
- Improving outcomes for children and adults with mental health needs
- Ensuring we have safe, high quality, sustainable acute services

3.7 The Big Ticket items identified in the Brent chapter of the STP are those items that will both have a significant impact on the triple aim and particularly benefit from being done as a collective locally. These items are:

- **Join up health promotion, self-care and non-statutory support across the continuum**. This covers a spectrum of activities, including making every contact count, workplace based health promotion programme, social isolation in Brent initiative and self-care as a part of Whole Systems of Integrated Care (WSIC)

- **New Models of Care** This build on the work done with primary care as part of the WSIC programme to fully integrate primary care with

community based acute prevention and discharge services, social care, housing and voluntary sector in a single pathway through an Accountable Care Partnership

- **Redesign Central Middlesex Hospital – One Public Estate** Redevelop the Central Middlesex Hospital site into a Brent Health and wellbeing Centre providing a range of local services including the Urgent Care Centre. This will take place as part of the wider NW London acute reconfiguration programme.

- **Unified Frailty Model** Span the services and pathways that address the needs of this cohort across Brent, concentrating and coordinating resources on a group of patients whose needs current drive a significant proportion of demand.

- **Improve outcomes and wellbeing for children and adults with mental health needs** Implement recovery focused mental health service provision across health and social care through integration of services and linking with housing and employment pathways with a strong peer support focus

- **Transforming care – supporting people with learning disabilities** Implement a borough wide Learning Disabilities Strategy across Brent and development of joint commissioning plans, including for children and young people

3.8 A brief summary of the commissioning intentions aligned to the STP delivery areas is set out below.

- **Delivery Area 1 – Radically upgrading prevention and wellbeing**

  Children's acute and community services: The aim is to commission high quality, effective, integrated services to reduce inequalities from childhood. The focus will be placed on parenting programmes, improving access to services for hard-to-reach groups and encouraging healthy behaviours in children's centres and nurseries

- **Delivery Area 2 – Eliminate variation and improve the management of long-term conditions:**

  - *Self-care:* Simple management of self-limiting conditions to support patients who are living with long-term conditions. The themes addressed include social isolation, self-care through the WSIC programme and programmes that are aimed at self-care and working with carers
  - *Long Term Conditions:* - Brent has one of the highest rates of people living with Long Term Conditions. Variations in the services that are available to patients exist in Brent we are developing programmes to address this.

- *RightCare programme*: This tool for identifying and addressing variation in outcomes will be used to identify improvements in diabetes, musculoskeletal diseases, cancer and respiratory conditions.
- *Review of Brent community services:* Reduce emergency department admissions to embed services and deliver training on their management.

- **Delivery Area 3 – Achieving better outcomes and experiences for older people**

  - *Primary care transformation:* GPs are central to health and care; working with patients and staff will help make the primary care model fit for purpose.
  - *End of Life care:* Commissioning and contracting changes to improve service access, while also managing quality and outcomes to improve links between end of life and primary care.
  - *Whole Systems Integrated Care (WSIC):* Developing proactive, coordinated and integrated care in Brent through partnerships between different providers to improve support of patients' care-pathways. It includes self-care, linking community teams with health service teams, GPs and other clinical services to address admissions and re-admissions.
  - *Care home and high risk housebound patients:* Improving the quality of medical support to patients, including use of support from pharmacy and medicines management teams.
  - *Unified frailty older people pathway:* Provision of 100% geriatric assessments, giving estimated discharge dates and reducing lengths of hospital stays.
  - *Rapid response service:* Reducing the proportions of non-elective emergency admissions and to increase care within community service environments.
  - *Integrating the transfers of health and social care:* Developing single access points, agreed data to be measured, targeting areas for improvement and through joint working across North West London to reduce the duplications of effort and by improving care and patient experience.
  - *Falls prevention and bone health:* A new service to reduce re-admissions for falls and hip fractures.

- **Delivery Area 4 – Improving outcomes for children and adults with mental health needs**

  - *The Likeminded strategy:* Addresses common mental health disorders, serious and long-term mental health needs, children and young peoples' mental health, wellbeing and prevention for conditions such as dementia and Learning Disabilities. Improved services are planned to

enable patients to live fuller and more healthier lives within their local communities

- *Perinatal mental health:* This is an important cause of maternal mortality; increased support is being planned during pre-conception and in postnatal periods of up to the first year of the baby's life
- *Early intervention in psychosis:* Expanding existing services and developing Black and Minority Ethnic (BME) support services are planned. Further expansion of BME peer support is considered during 2018 - 2019
- *Conduct disorder:* Children with long term physical illness are more likely to suffer emotional and/or conduct disorders. Early intervention and targeted mental health support for these conditions is planned to be delivered between 2017-2019. We aim to achieve reductions in referrals to specialist child and adolescent mental health services for such disorders
- *Dementia:* Brent has an estimated 2,513 patients living with dementia, of which only 68% are diagnosed. Bent CCG plans to develop a primary care dementia service to diagnose the condition early, where the right treatment and support can be offered to maintain good quality life for patients and their families, or for their carers
- *Learning disabilities:* Brent CCG is committed to transforming the care of people with learning disabilities and autism to avoid admissions into inpatient services. To achieve this, the integrated community learning disability team will deliver and implement transformation (prevention, wellbeing support and timely assessments), to achieve improved patient experiences. In 2018 -2019, we intend to re-model a local in-patient Learning Disabilities unit
- *Carers:* Brent CCG aims to increase the number of carers that are being supported, as well as the level of support that is provided for carers.

- **Delivery Area 5 – Ensuring we have safe, high quality and sustainable acute services**

  - *Urgent and Emergency Care:* We aim to develop an Integrated Urgent Care model across Brent, Harrow and Hillingdon. This involves the alignment of current GP Access Hubs, Out of Hours and Urgent Care Service at Northwick Park Hospital and at Central Middlesex Hospital. These changes will align the GP Access hubs with other urgent care services, enabling patients to access local services rather than needing to locate out of area service assistance
  - *Inpatient model of care:* Implementation of new care models in acute trusts where 90% of admissions receive consultant-directed reviews daily
  - *Radiology and diagnostics:* In 2017/18, we aim to have 90% of inpatient radiology diagnostics done and reported in 24 hours. This will

reduce the length of stay for patients and release inpatient beds. In 2018/19, a shared network will permit reporting to be partially shared across NWL trusts

- *Length of stay and transfers of care:* Our objective is to achieve an improved seven day emergency service; this is part of achieving the London Quality Standards. Improving the processes for transfer of care from a hospital setting is essential to this strategy. In addition we aim to reduce inappropriate referrals to community services and to limit duplications; for example – having to complete forms or making enquiries to accept referrals more than once
- *Maternity:* Working with NHS England to ensure immunisation requirements are met in provider practices, clinical pathways meet best practice guidelines and offer value for money and service models meet national specifications
- *Paediatric High Dependency Unit standards:* In 2017/18, we will provide holistic care, connected across primary and secondary services; maximising staff contributions to the way services are delivered and delivering advice and support between primary and secondary care
- *Referral Optimisation:* The system offers clinically led triage of referrals made by GPs and the CCG's main Trusts. Use of the system is expected to result in a 10% reduction in unnecessary referrals being made.
- *Community Gynaecology service:* The aim is to expand the number of patients seen and treated in community settings for gynaecological conditions. The plan for 2017/18 is to review the current gynaecology model with the aim of providing full coverage for a community services across the whole of Brent and including a wider range of conditions and diagnostics in a community setting.
- *Community dermatology services:* In 2017/18, we will review the current services, with the aim of reconfiguring the current community dermatology service including consultant support in the community and an expanded range of conditions seen in the community, reducing referral to treatment pressures in the acute dermatology service.
- *Redesign of Central Middlesex Hospital:* Central Middlesex Hospital will become a local hospital for elective treatments. This is part of the Shaping a Healthier Future (SaHF) programme. Our aim is to localise services required on a frequent or routine basis, centralising specialist emergency services and integrating them.

3.9 The following themes underpin activity across the delivery areas:

- Developing a digital environment - Digital advances will provide improved facilities for monitoring performance, sharing care records within the NHS in Brent and helping to deliver advice and support to patients and carers, for example through telehealth and telecare platforms.

- Estates - We intend to maximise the use of public sector land and premises, reducing recurrent premises costs by commissioning and creating additional capacity, minimising overheads and improving the access to primary care.

- Continuing Care and Personal Health Budgets - Continuing care (for adults and children) is based on a person's assessed needs. These packages of care are delivered outside hospitals in any setting; including a patient's own home or in a care home. Plans for 2017 – 2018 include enabling children with special needs (those with educational, health and care plans) to be supported with an option of a personalised health budget

- Medicines Optimisation - The objective is to achieve efficient use of medications, improve patient experiences with their medicines, based on national and local guidance and partnerships with relevant stakeholders to improve overall patient care.

3.10 Various bespoke engagement events have been undertaken in forming these Commissioning Intentions including the Brent Health Partners Forum. Brent Health and Wellbeing Board had the opportunity to comment on the intentions during December. All comments arising from this have been considered and amendments made to the final document. The Commissioning Intentions reflect the higher level STP plans and so engagement around the STP is synonymous with the CCG's commissioning intentions. A summary of all engagement on the STP and the Commissioning Intentions is below.

- 27 April: Health Partners Forum (120 patients)
- 1 June: Brent Governing Body Seminar
- 7 June: Brent Health and Wellbeing Board
- July: Adult Social Care Provider Forum update (150 providers)
- 13 July: Brent GP Forum
- 27 July: LNWHT AGM
- September: Bheard
- 13 September: Brent Adult Social Care's Annual Participation Day (150 residents)
- 21 September: Brent Overview and Scrutiny Committee
- 18 October: face to face meeting with Brent Patient Voice
- 19 October: Health Partners Forum (85 attendees)
- Ongoing online consultation on the STP – feedback summary included in the October submission
- 24 November: Mental Health Peer Support public event
- 25 November: Carers' Rights Day
- 30 November: On-line resident survey, specifically around the Commissioning Intentions co-ordinated by Brent Healthwatch closed.

4.0 Financial Implications

4.1 The detailed financial implications to the CCG and its providers will be worked through as part of the contracting negotiations for the financial years 2017/18 and 2018/19. The Commissioning Intentions are a high level plan only.

5.0 Legal Implications

5.1 The CCG is obliged under the Health and Social Care Act 2012 to engage the Health and Wellbeing Board in the development of the Commissioning Intentions.

5.2 CCGs must provide the Health and Wellbeing Board with a draft of the Commissioning Intentions and the Health and Wellbeing Board should review the plans to ensure that they take account of both the Joint Strategic Needs Assessment (JSNA) and the Joint Health and Wellbeing Strategy.

6.0 Equality Implications

6.1 The Commissioning Intentions aim to reduce health inequality overall. Individual proposals within the Commissioning Intentions impact on patients with the intention of improving patient care, making it more co-ordinated around the patient and maximising capacity within the system to improve referral to treatment times and waiting times for appointments.

6.2 Detailed Equality Assessments will be undertaken for each of the proposals contained within the Commissioning Intentions as an integral part of their implementation.

Background Papers

a) The full CCG Commissioning Intentions document, which is circulated with this paper
b) The North West London Sustainability and Transformation Plan accessed via https://www.healthiernorthwestlondon.nhs.uk/documents/sustainability-and-transformation-plans-stps
c) The NHS Five Year Forward View, accessed via https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

Contact Officers

a) Jonathan Turner – Assistant Director Planned Care and Service Transformation – NHS Brent CCG, Wembley Centre for Health and Care, 116 Chaplin Road, Wembley, HA0 4UZ, Tel: 0208 900 5423 Email: jonathanturner2@nhs.net

b) Sheik Auladin – Deputy Chief Operating Officer – NHS Brent CCG, Wembley Centre for Health and Care, 116 Chaplin Road, Wembley, HA0 4UZ, Tel: 0208 900 5422 Email: sauladin@nhs.net,