Commissioning Intentions

NHS Brent Clinical Commissioning Group

2017/18 & 2018/19

NHS Brent Clinical Commissioning Group

Content

Strategic Context

Strategic Context - Introduction

NHS Brent Clinical Commissioning Group

The CCG's strategic context is informed by national and local policy drivers, as well as Brent CCG's commissioning principles (which guide the CCG on *how* services should be commissioned as well as some of the key outcomes) and the Health and Wellbeing Board priorities. The key national and local drivers are:

- **Five Year Forward View**
- **The North West London Sustainability and Transformation Plan (STP)**
- **Brent's 'Big Ticket' Items**

These are explored in more detail on the following pages.

Strategic Context – 5 Year Forward View

The 5 Year Forward View was published in October 2014 and sets out 10 National Priorities for the next 5 years. Our commissioning intentions implement these priorities at local level.

- 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

Strategic Context – The Sustainability and Transformation Plan

The North West London health and social care economy has been developing a Sustainability and Transformation Plan (STP) over the last 5 months, designed to fulfil the aspirations outlined in the Five Year Forward View and setting 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 CCG's commissioning intentions are closely linked to the STP, and reflect how we will deliver the STP at local level. The Health and Wellbeing Gap and the Care & Quality gaps are set out in the table below:

Brent's Health & Well-Being gaps*	Brent's Care & Quality gaps*
Common mental health disorders (CMD): large numbers and projected to increase - 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 national quartile for % of children 10-11 classified as overweight or obese – 38% **Diabetes**: by 2030 it is predicted 15% of adults in Brent will have diabetes **Long Term Conditions (LTCs)**: ~20% of people have a LTC **Dementia**: prevalence of dementia in people aged 65 years and over is 2,225 (2016) (and 80% of prevalence is diagnosed) **STIs/HIV**: 1,404 STIs per 100,000 population compared to 829 in England **Health-related behaviour**: tobacco use; alcohol; take up of immunisations; physical inactivity: worst in West London; nutrition: 47% get 5 a day	**Caring for an ageing population**: 35% of all emergency admissions in Brent are for those aged 65 and over; once admitted this group stays in hospital longer, using 55% of all bed days. **End Of Life Care**: 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. **Long Term Condition (LTC) management:** Brent is in the worst quartile nationally in terms of people with a LTC feeling supported to manage their condition. **Cancer**: Brent is in the second lowest quartile nationally in terms 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.

**Sources: Brent JSNA; CCG Assessment & Improvement Framework*

Strategic Context – The Financial Gap

Approximately **£12m** of net savings ('QIPP') are required **each year** to close the CCG financial gap 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. The planning assumption in the 5-year STP is that the level of savings required for 17/18 and 18/19 is 3% (broadly £12m additional savings each year). This is due to be achieved through a mix of **transactional savings** and savings made by **transforming services** described in the five delivery areas in the North West London STP.

London North West Healthcare Trust (LNWHT) provides services to three key commissioners, and therefore only a proportion of its 'gap' is directly associated with Brent; similarly with Central North West London (CNWL). Brent also commissions services from other providers, e.g. Imperial Healthcare NHS Trust.

Organisation	'Do nothing' (including no 16/17 savings) by 2020/21	16/17 savings plans (CIP/QIPP)	Remaining financial challenge
LNWHT	£191.8m	£34.4m	£157.4m
CNWL	£52.9m	£14m	£38.9m
Brent CCG	£58.6m	£9.3m	£49.3m

Strategic Context - Our Duties to Maintain Financial Control

- The CCG is legally obliged to ensure that in each financial year it performs its functions so as to ensure that its expenditure which is attributable to the performance by it of its functions in that year does not exceed the amount allotted to it.

- In addition NHS England business rules under which CCGs should operate are:-

  - CCGs should achieve a 1% cumulative surplus
  - CCGs should hold a minimum of 0.5% contingency
  - CCGs should be in a position of underlying recurrent (i.e. normalised) balance
  - CCGs should operate within their running cost allowance
  - In-year surpluses/deficits would be carried forward into the next year

- We will continue to monitor the CCG's finances closely in 17/18 through the monthly Finance, QIPP and Performance Committee, the CCG Executive and the Governing Body

- We also have a significant QIPP programme (Quality, Innovation, Productivity & Prevention) which aims to make the system more streamlined and reduce unnecessary activity or duplication.

Strategic Context - STP Priorities and Delivery Areas

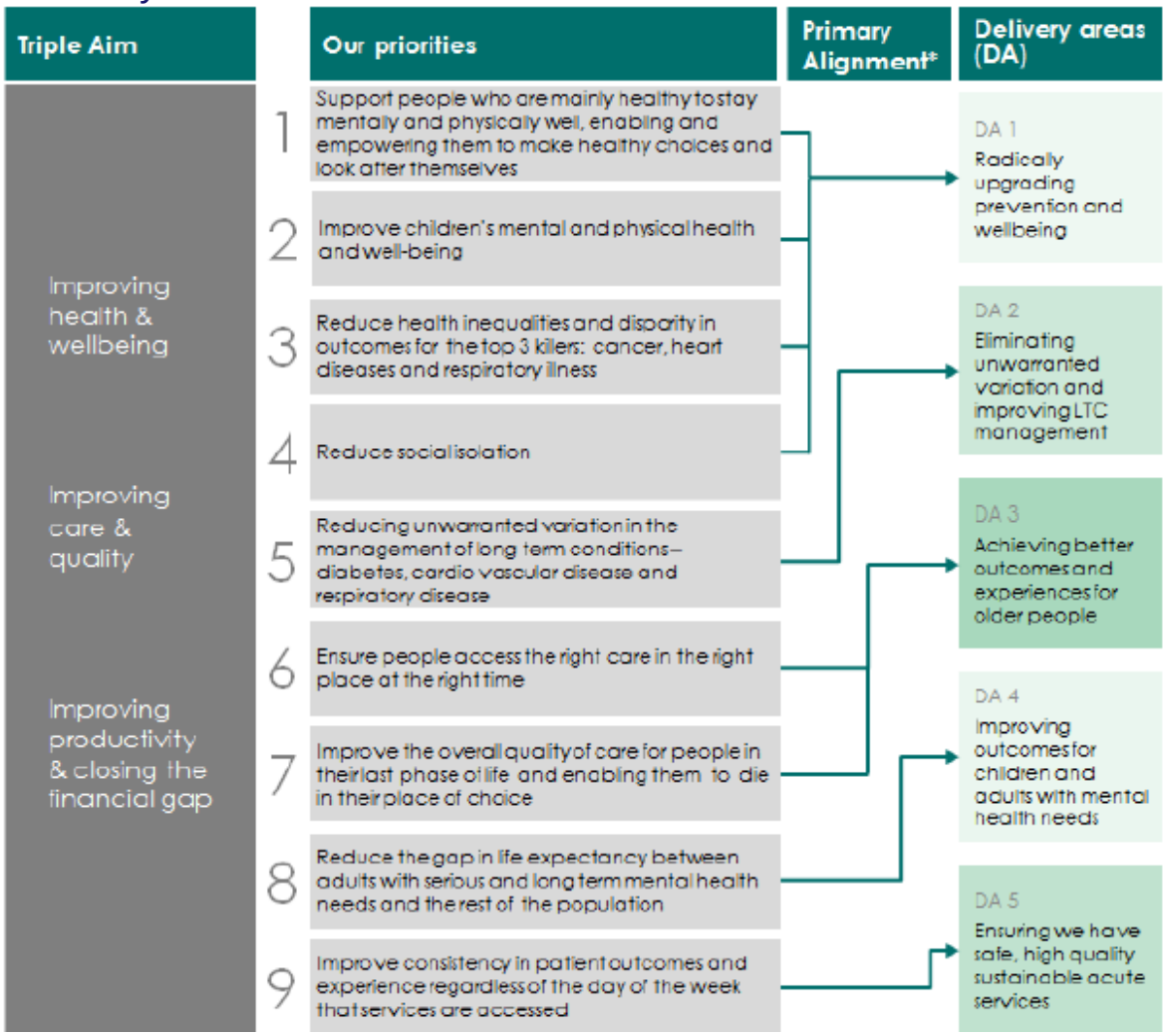
The NWL STP has organised the 9 NWL priorities into five High Impact Delivery Areas.

In order to achieve our vision, NWL has developed a set of nine priorities which have drawn on local place based planning, sub-regional strategies and plans and the views of the sub-regional health and local government NWL Strategic Planning Group.

Having mapped existing local and NWL activity, we can see that existing planned activity goes a long way to closing the triple gap. But we must go further to completely close these gaps. At NWL level 5 delivery areas have been agreed reflecting where we need to focus on to deliver at scale and pace.

At the NWL level we will set up or utilise an existing joint NWL programme for each delivery area, working across the system to agree the most effective model of delivery. We will build on previous successful system wide implementations to develop our standard improvement methodology, ensuring an appropriate balance between common standards and programme management and local priorities and implementation challenges.

Relationship of Triple Aim to 9 NWL priorities through to 5 NWL Delivery Areas



Strategic Context - Brent's 'Big Ticket' Items

Brent has identified the '**big ticket' items** that will both have a significant impact on the triple aim and particularly benefit from collective local work. Further development of these, collaborating pan-NW London where appropriate, will now be undertaken.

Title	Description	Impact
1. Join Up Health Promotion, Self-Care and Non-Statutory support across the Continuum	This covers a range of activities from simple management of self-limiting conditions to supporting patients with long term conditions. • ***Making Every Contact Count*** – use every opportunity to achieve health and wellbeing, and systematic promotion of benefits of healthy living (culture and environment) • ***Workplace based Health Promotion programme -*** adapted version of London Healthy Workplace Charter for small businesses in Brent; contracts issued with workplace health and wellbeing as a 'social value' requirement • ***Widen the scope of SIBI*** - re-align to support 1st tier (signposting, advice, links to existing services) & 3rd tier patients (intensive support for short periods) using multi-agency approach • ***Self-Care as part of Whole Systems Integrated Care (WSIC)*** - already a Brent plan • ***Alcohol related admissions -*** Addressing high levels of alcohol related admissions through 7 day alcohol care teams, increase in assertive outreach, screening, treatment and brief interventions • ***Smoking Cessation*** - improving the offer from mental health services for users who are more likely to smoke	• Improve outcomes by joining up services and preventing ill health • Reducing alcohol related admissions in Brent which are significantly above average • According to the Local Services Transformation paper, Brent could save ~£345k over five years through: (1) commissioning self-care programmes, e.g. social prescribing, peer support; (2) activating the workforce, e.g. motivational interviewing techniques; (3) improve provision of information; (4) use of PAM to tailor self-care; and (5) developing third sector infrastructure.
2. New Models of Care	Reconfirming the original vision for WSIC and building on work to date with Primary Care to take integration further with the GP-Patient relationship at the centre. This requires partnerships between Primary Care, Community services, Acute and discharge, Social Care, Housing and Voluntary Sector through an Accountable Care Partnership. The focus for the next two years is: • Models of Care that improve quality, experience & outcomes for patients with LTCs and their carers while reducing system costs. • New interventions & roles, multidisciplinary working to improve productivity and efficacy of teams	• Proactive care through planning, prevention and integrated care; • Move from professionally led care to a model of support to self-care and self-management • Achieve continuity of care through relationships between the patient their carers and their own GP • Deliver care at appropriate time & out of hospital where possible

Strategic Context - Brent's 'Big Ticket' Items

Title	Description	Impact
3. Redesign Central Middlesex Hospital – One Public Estate	• Redevelop the Central Middlesex Hospital (CMH) site into a Brent Health & Well-Being Centre providing a range of local services (including the Urgent Care Centre). • This work will take place as part of the wider NW London acute reconfiguration programme. • The redesign process will take account of the additional Extra Care Units that are being developed near CMH in 2016/17-2017/18.	• As a local Health & Well-Being Centre, support Brent's vision to improve the quality of care provided, empowering and supporting people to maintain independence and to lead full lives • Support financial viability of LNWHT & Brent CCG
4. Unified Frailty Model	Span the services and pathways that address the needs of this cohort across Brent, concentrating and coordinating resources on cohort whose needs currently drive a significant proportion of demand, including: • Common standards and specifications, and pooled, shared and rotated resources • Community-based networks – at scale • Single, universally accessible assessment • Cross-professional decision-making, e.g. to assess, treat, admit • Co-location of services, in particular for most vulnerable/complex, e.g. health & well-being villages This will require more complete development of the WSIC model and a pathway that cuts across WSIC, STARRS, Discharge and other services (e.g. GP-led urgent and emergency care model). This brings existing BCF schemes service models together in a single pathway.	• Significantly improve quality, timeliness, coordination of care and patient experience for older people in Brent, who are much more likely to be frail and have multiple LTCs. The higher proportion of non-elective admissions for people age 65 plus indicates that care could be better coordinated, more proactive and less fragmented. • Shift ratio of acute to out of hospital expenditure • Integrate care at every stage, e.g. use of Common Geriatric Assessment in-hospital, then shared with other providers – from Primary Care to Nursing Homes, with a focus on preventing deterioration through unnecessary time spent in hospital.

Strategic Context - Brent's 'Big Ticket' Items

Title	Description	Impact
5. Improve outcomes and wellbeing for children and adults with mental health needs	Implement a recovery focused mental health service provision across health and social care through integration of services and linking across housing and employment pathways with a strong peer support focus. Work streams include: • Community map and navigation, day service hub • Crisis care, extended GP appointments and primary MH care • Alternative to inpatient care & post discharge support • Improve dementia diagnosis, and community support Promote, protect and improve our children and young people's mental health and wellbeing through: • Prevention and early intervention • System without tiers • Care for the most vulnerable	• Bringing social care, education and health services together to improve outcomes for children and young people • Improved outcomes for adults and children with mental health needs: • Reduction in inpatient and residential care placements • Increased independent living and people with metal health needs supported into education and employment • Fewer children in care • Reduction in tier 4 placements
6. Transforming Care – Supporting People with Learning Disabilities	• Implement a borough-wide Learning Disabilities Strategy across Brent and develop of joint commissioning plans, including for children & young people • Integrate health and social care provision and improve the quality of the care offered to those who present with behaviours that is challenging and/or complex, including ensuring all those who meet criteria for Care Programme Approach are cared for within this framework • Provide suitable, local accommodation and support, continuing to take forward the Winterbourne work • Reduce reliance on inpatient care and increase support for people in primary care and community settings • Improve access to community and primary care support and to mainstream health services for people with a Learning Disability • Increase access and use of Personal Health Budgets and direct payments for individuals with a Learning Disability	• Reduce number of people in inpatient units and move people in to supported living and or mainstream housing as appropriate • Enhanced take up of personal budgets • Increase access to employment and education opportunities • Improved quality of care and wellbeing

Brent's Health Landscape & Challenges

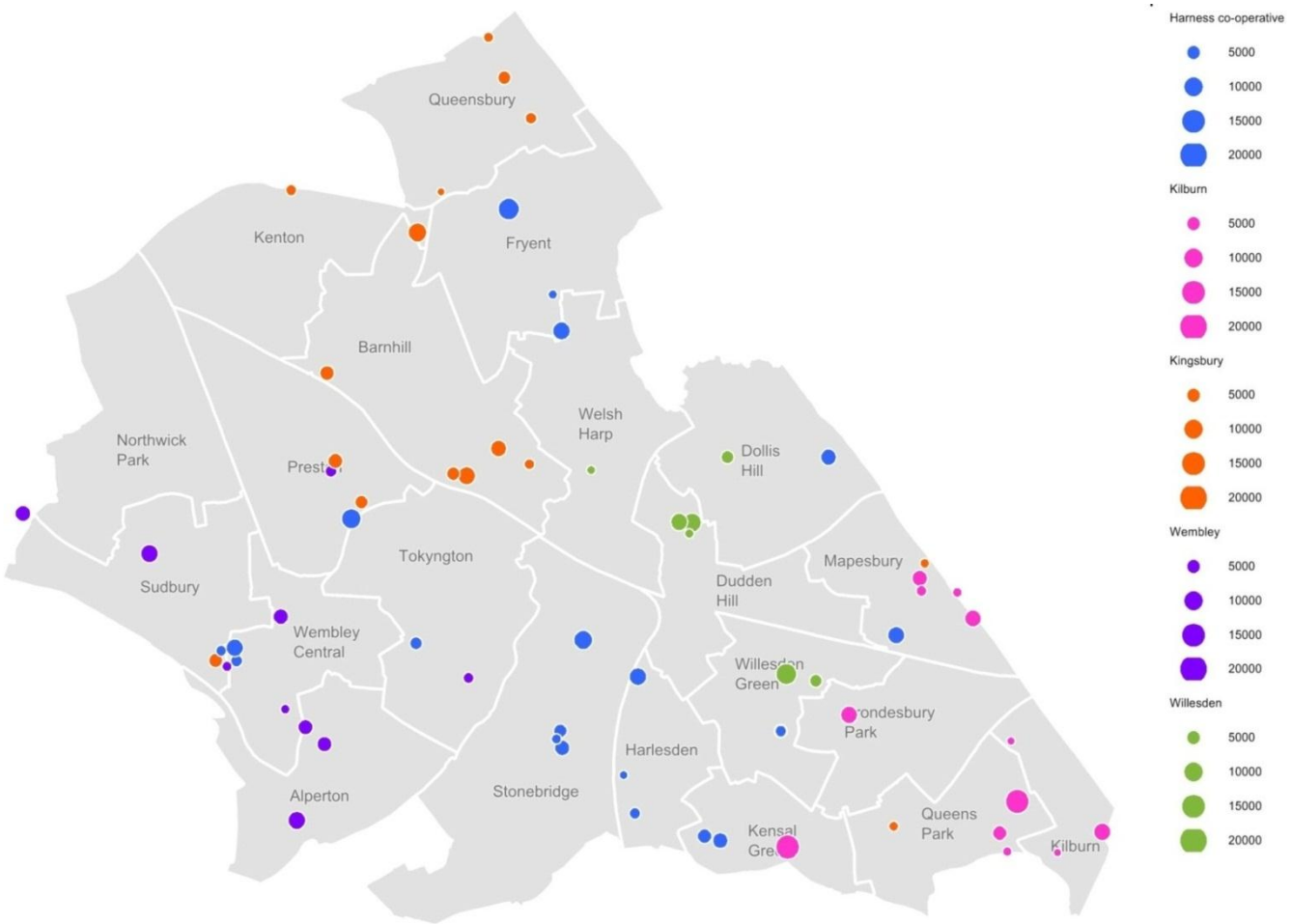
NHS Brent Clinical Commissioning Group

The following section summarises some of the features of Brent's local population and some of the specific issues highlighted by the JSNA:

- GP Practices and Localities
- Summary of Key Population Statistics
- Key Health Challenges
  - Premature Mortality
  - Physical Activity & Diet
  - Alcohol Use
  - Social Isolation
  - Type 2 Diabetes
  - Tuberculosis
  - Dementia
  - Common Mental Health Disorders
  - Child Health

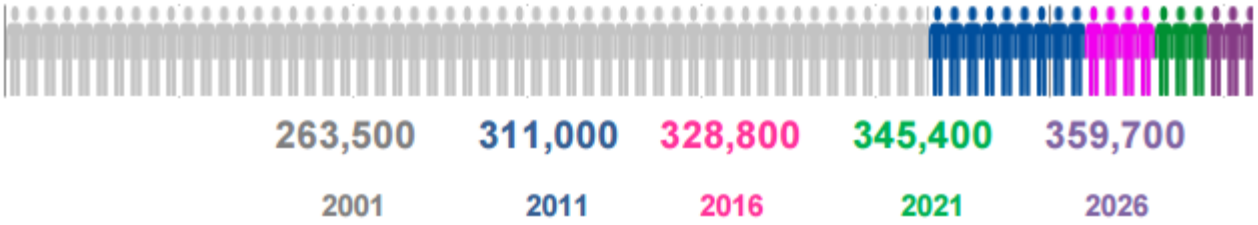
NHS Brent GP Practices and Localities

Brent is an outer London borough in north-west London. The number of patients registered with Brent GPs is 369,074. Brent has 62 member practices which are all aligned to one of five locality based groups. Each locality 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.



Key Population statistics – population and age

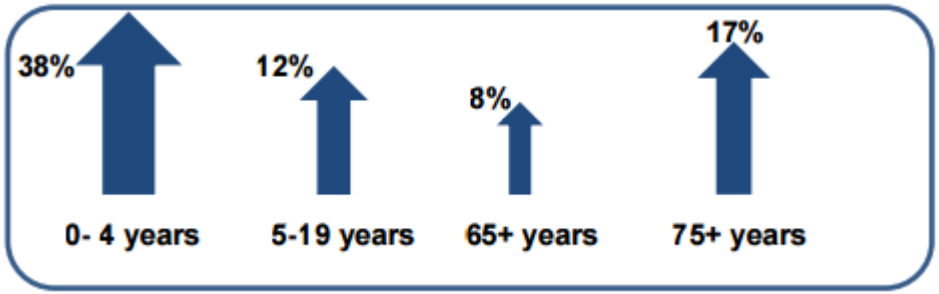
Brent borough has a population of 328,8001 (residents) and a population density of 75.2 people per hectare. The population has grown significantly since 2001 and is predicted to continue to grow.



Current and projected population growth in Brent. Source: GLA short term population projections, 2014 rnd

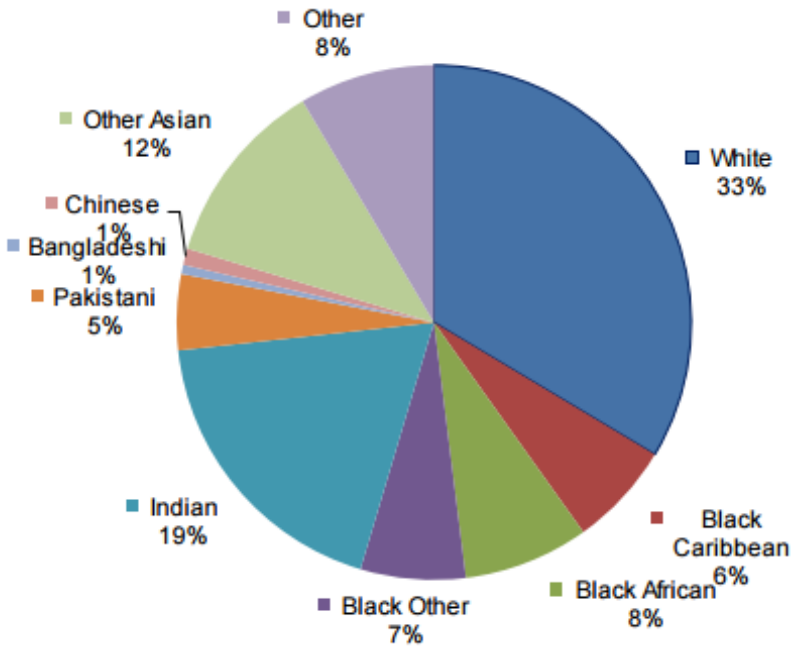
Brent has a young population with 35.1% aged between 20 and 39. The under 18 population makes up 22.9% of the population, the 16-64 (working age population) makes up 68.2% of the population and the 65 and over population makes up 11% of the population.

The older population is growing at a higher rate than the adult population:
Percentage changes between 2001 and 2011 for some of the key age groups in Brent 17%



Key Population statistics – ethnicity

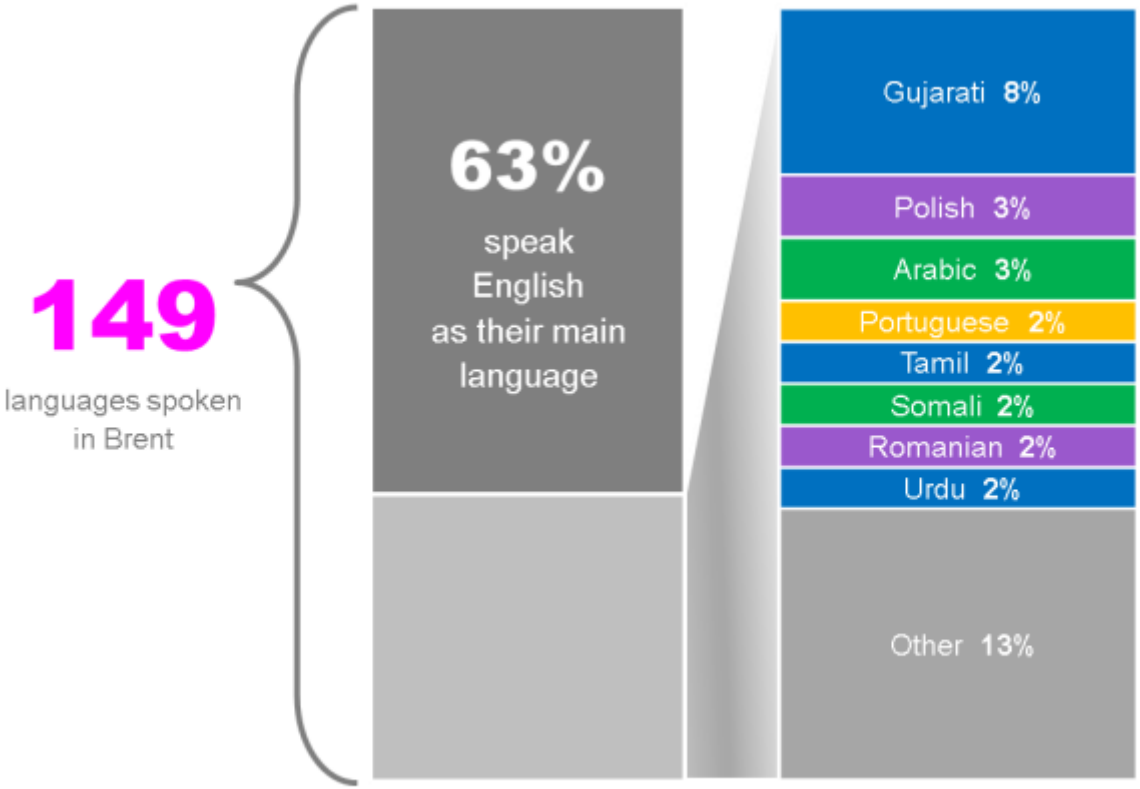
Brent is ethnically diverse: 66.4% of the population is Black, Asian or other minority ethnicity (BAME). This has increased since 2011, when BAME groups made up 63.7% of the population. The Indian ethnic group currently make up the highest proportion of BAME (19% of the population), followed by Other Asian (12%). The White group make up 33%.



Ethnic profile of Brent residents. Source: 2016 population from GLA SHLAA based population projections, 2013

Key Population statistics – language

There are many different languages spoken in Brent. English is the main language for 62.8% of the population. Gujarati is the main language for 7.9% of the population and Polish is the main language for 3.4% of the population. In one in five households, nobody speaks English as their main language.



Languages spoken in Brent. Source: ONS 2011 Census

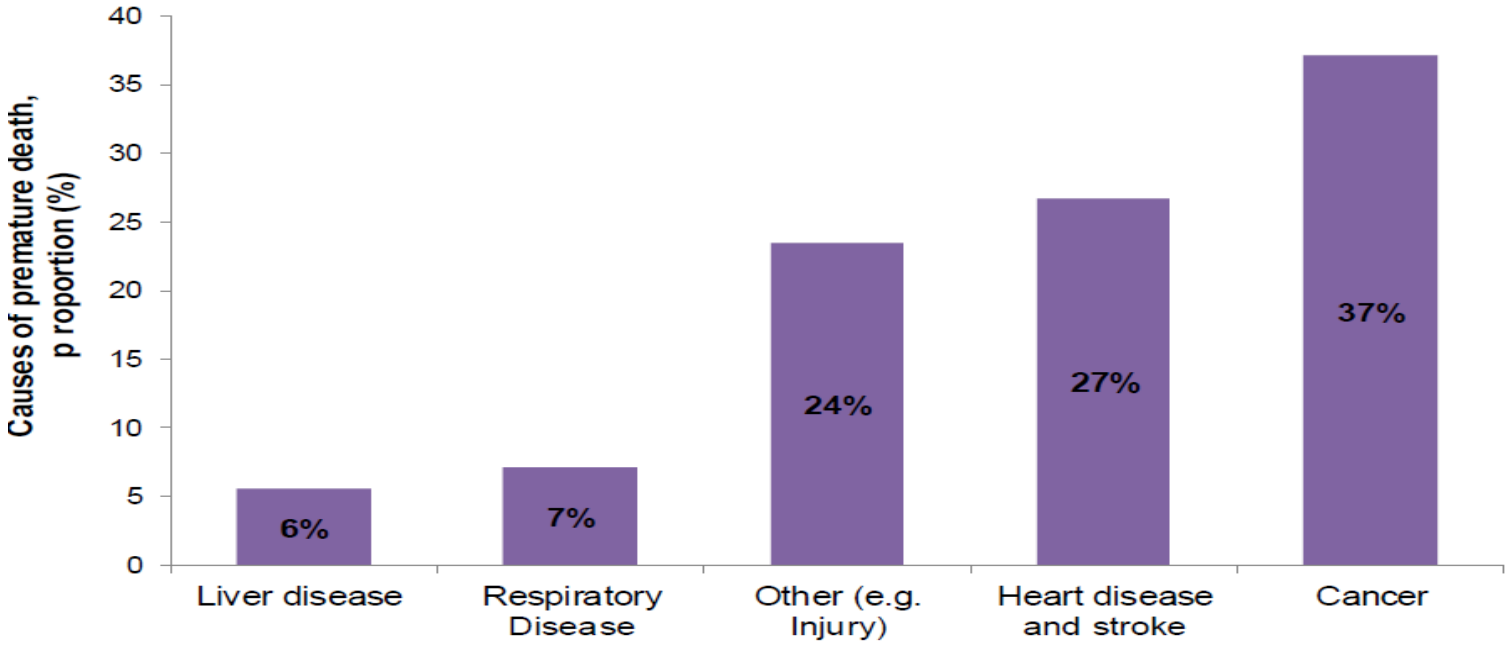
Key Health Challenges in Brent

Premature Mortality by Disease

The main causes of premature mortality (deaths before 75 years of age) in Brent are

- Cancer (37%)
- Cardiovascular Disease (coronary heart disease and stroke) (27%)
- Respiratory Disease (includes COPD and Asthma) (7%)

Although the mortality rate is better than in areas of similar levels of deprivation, there are still 650 premature deaths potentially preventable through early identification of risk and appropriate intervention programmes



Proportion of all premature deaths by cause in Brent, 2011-13. Source: Public Health England, 'Longer Lives'

Key Health Challenges in Brent

Physical Activity and Diet

Physical inactivity and an unhealthy diet are closely linked to excess weight and obesity. It is recommended that adults accumulate at least 150 minutes of moderate-intensity aerobic activity (e.g. cycling or fast walking) every week, and that children over five should engage in at least 60 minutes of moderate to vigorous intensity physical activity every day.

The Active People survey shows over half (51.6%) of Brent's adult population do not undertake sport or physical activity, the highest level of inactivity in West London and above the London average. The same survey shows only 18.5% of Brent's population are achieving the recommended level of moderate intensity sports or active recreation per week.

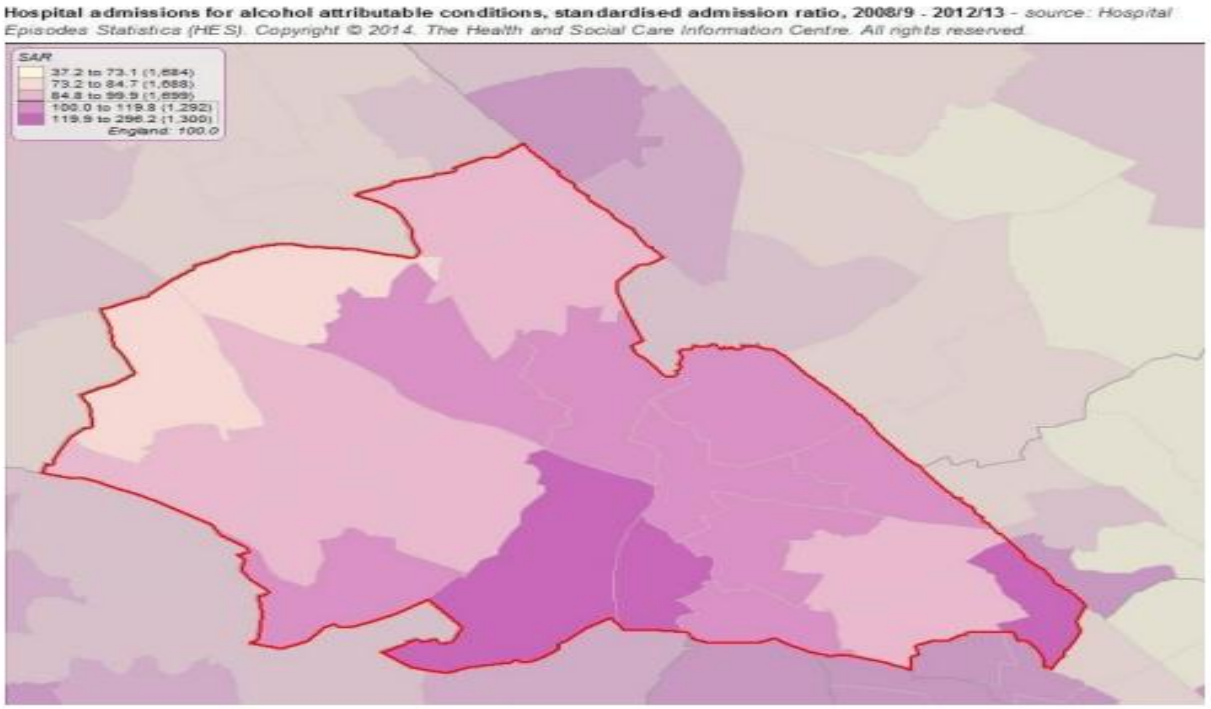
Only 47.1% of the population in Brent were meeting the recommended 5-a day fruit and vegetable intake in 2014. This was below the London (50.3%) and England (53.5%) averages.

Key Health Challenges in Brent

Alcohol Use

In Brent, 31.4% of the population aged 16 and over abstain from alcohol use, almost twice the national average of 16.5%. However the proportion of high risk drinkers in Brent at 7.1% is above the national average of 6.7%.

The diagram below shows where hospital stays for alcohol related harm were highest and lowest in Brent by ward.



Hospital admissions for alcohol attributable conditions. Source: HES.

Key Health Challenges in Brent

Social Isolation

Brent has 30,616 households with people living on their own according to the 2011 census. Of these, 29% (or 8,808 people) are aged 65 and over. Although social isolation is most common among the elderly, younger adults can still suffer.

Social isolation and loneliness have a detrimental effect on health and wellbeing. In 2013/14, only 39.3% of adult social care users in Brent reported that they have as much social contact as they would like. This was worse than the England average of 44.5%.

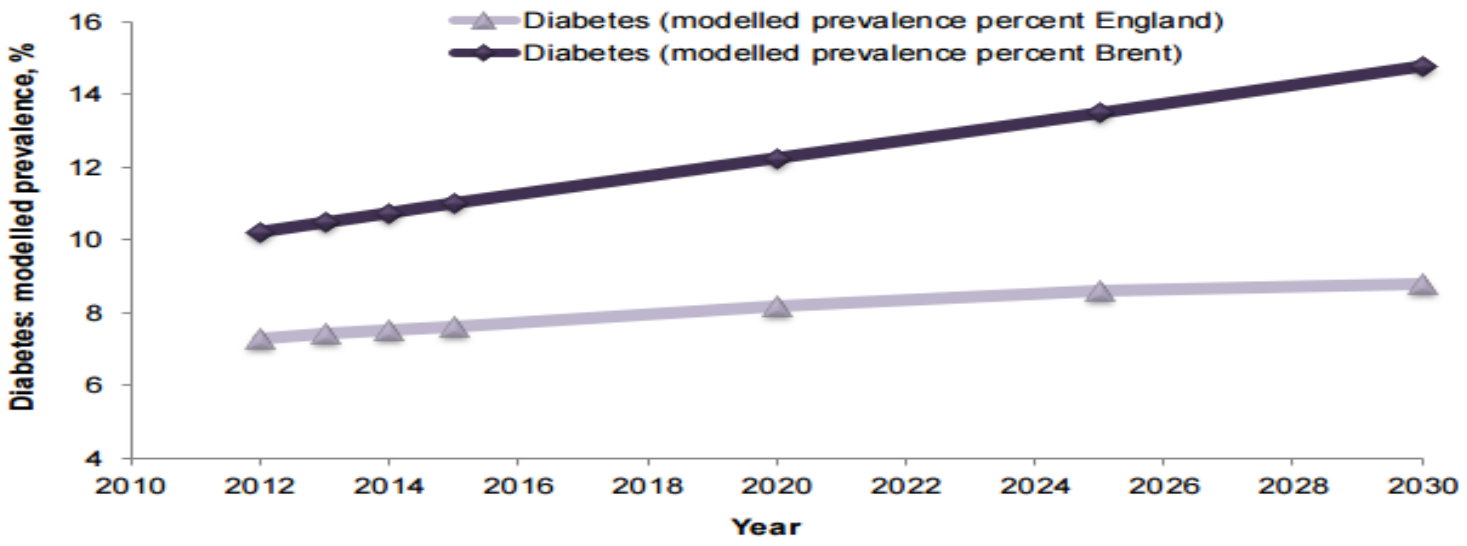
Social isolation is a key determinant of physical and mental health, whether older people, single parents, or people with mental health needs.

Key Challenges in Brent

Type 2 Diabetes

Rates of type 2 diabetes in Brent are particularly high compared to other parts of the country. At practice level, the recorded prevalence of diabetes varied across Brent CCG from 3.7% to 14.2%. It is forecast that by 2030 15% of adults in Brent will have diabetes.

Reflecting the ageing of the local population, the numbers of people who are obese and overweight and the large number of Black and South Asian people (who are at greater risk of developing diabetes) the prevalence of diabetes is predicted to rise in the future, as shown below.



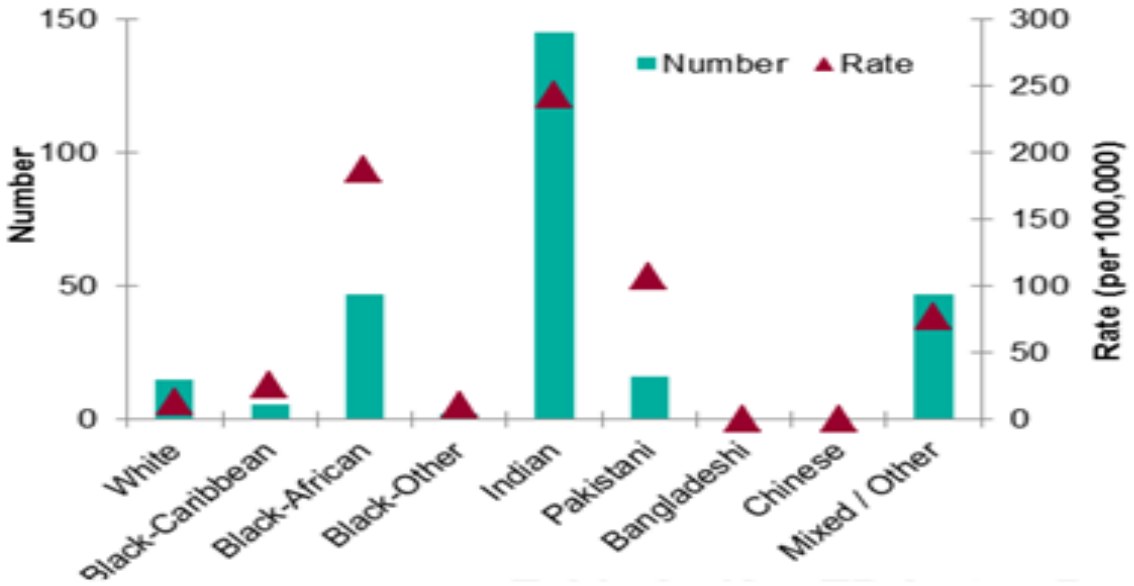
Modelled estimated prevalence of diabetes. Source: Public Health England (national cardiovascular intelligence network - NCVIN), Diabetes Prevalence Model for Local Authorities and CCGs 2012 to 2030

Key Health Challenges in Brent

Tuberculosis (TB)

In 2014, the highest numbers and rates of TB reported across London were in Newham and Brent. However, both areas saw rates decline by 25% compared with 2013. In Brent, the TB notification rate in 2014 was 64 per 100,000 (figure 17). This equates to 204 cases.

Over half of all TB patients in Brent in 2013 were Indian, most of who were born in India. Rates were next highest among the Black African population of whom approximately half were born in Somalia.



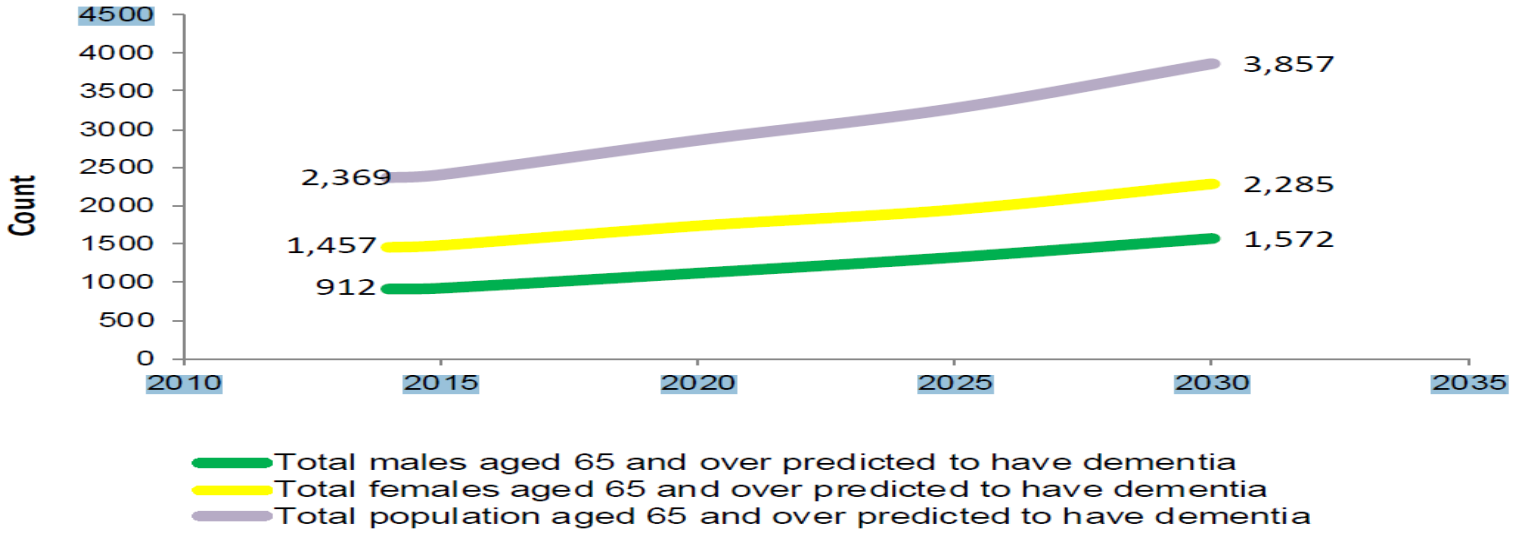
PHE, Brent TB Profile, 2013

Key Health Challenges in Brent

Dementia

In the UK, the estimated number of people living with dementia is estimated to be 850,000. In Brent in September 2015 the recorded (on GP practice registers) prevalence of dementia in people aged 65 years and over was 4.83%. This was higher than the England average of 4.27% which could reflect an actual higher rate or more complete diagnosis.

The number of people with dementia is increasing. Projections show that the number of people aged 65 and over with dementia will increase by 63% over the next 15 years in Brent.



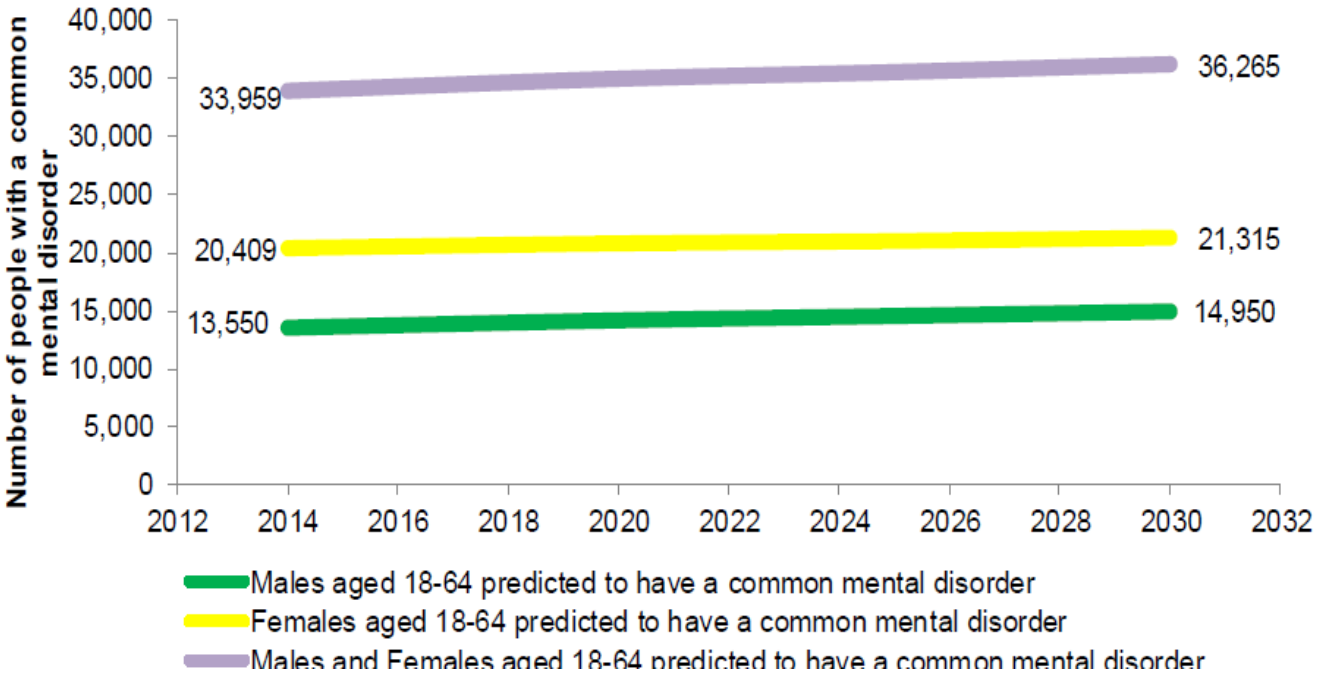
Brent Public Health Report 2015

Key Health Challenges in Brent

Common Mental Health Disorders (CMD)

Supporting service users, and providing people recovering from illness with meaningful employment and secure housing needs are important in ensuring people are able to recover from Mental Illness.

Estimates show that in Brent in 2014, 33,959 people aged 18 to 64 years were thought to have a CMD. By 2030, this is projected to increase to 36,265 people, an increase of 7%.



Brent Public Health Report 2015

Key Health Challenges in Brent

Child Health
In Brent, the proportion of live babies with low birth weight in 2014 was 3.6%, which was above England 2.9% and London 3.2%.

Childhood obesity in Brent is worse than Brent's average levels of obesity for adults. 23.8% of children in year 6 were classified as obese - higher than the average for England, 19.1%. In reception year, 10.2% of pupils were obese in Brent which was slightly higher than the England average of 9.1%.

- Asthma is the most common long-term condition in childhood nationally. In Brent, there were 207 emergency admissions of children (under 19 years) due to asthma in 2013/14. This equates to a rate of 271.5 per 100,000, which is higher than the average rate for England.

- Hospital admissions in Brent due to self-harm were lower than the England average in 2013/14 among individuals aged 10 to 24 years.

- The rate of young people aged under 18 years who were admitted to hospital as a result of a condition wholly related to alcohol (e.g. alcohol overdose) in 2011/12 - 2013/14 was 16.8 per 100,000. This was lower than the England average rate (40.1 per 100,000) of the population aged under 18 years.

Progress & Achievements Over the Last 12 months

NHS Brent Clinical Commissioning Group

- Procured and set up the new Referral Optimisation Scheme (ROS) providing a central hub for the whole of Brent through which referrals pass, supporting patients flows and care pathways within the local health economy. The new ROS model will manage approximately 116,000-147,000 clinical referrals per year across multiple specialities. It will provide a consistent level of primary care work-up before a referral is made and make sure that referrals get to the right place, first time.
- Embedded the Stroke ESD service which is now successfully avoiding readmissions and reducing the length of time people need to stay in hospital.
- Launched the Brent Health App to help people locate local services and check their symptoms online.
- The CCG has maintained a positive financial position, remaining in surplus as planned.
- Continued to evolve integrated care provision for adults with long term conditions through ensuring that the GP is supported by a multidisciplinary team to proactively manage patients care, reducing exacerbations through good long term condition management as well as empowering people to self-care and self-manage.
- Developed a model for providing responsive primary care to residents of nursing homes and better education to GPs.
- Progressed the reconfiguration of hospital based services through Shaping a Healthier Future to preserve clinical quality and to improve the quality of outcomes available 24/7 to patients.
- Developed a programme to improve diagnosis and case finding of atrial fibrillation. This will help patients to avoid developing a stroke in the future by treating the patients with anticoagulation therapy.
- Collaborated with Council and wider NHS providers to develop the Sustainability and Transformation Plans which comprises Better Care Fund initiatives.

Commissioning Intentions by STP delivery area

Part 2 - Index of Brent CCG Commissioning Priorities

Part 2 outlines our commissioning intentions by area in more detail. We have grouped the topics around the 5 delivery areas identified in the STP. The plans and areas covered in this section are:

Delivery Area 1 – Radically upgrading prevention and wellbeing
(a) Children's Acute & Community Services
(b) Digital

Delivery Area 2 – Eliminating unwarranted variation and improving management of long term conditions
(a) Long Term Conditions
(b) RightCare
(c) Community Services
(d) Digital

Delivery Area 3 – Achieving better outcomes and experiences for older people
(a) Primary Care Transformation
(b) End of Life Care
(c) Better Care Fund – Integrated Care Pathways
(d) Whole Systems Integrated Care
(e) Care Home & High Risk Housebound Patients
(f) Unified Frailty Older People
(g) Rapid Response Service
(h) Integrating Transfer of Care
(i) Falls Prevention & Bone Health
(j) Digital

Delivery Area 4 – Improving outcomes for children & adults with mental health needs
(a) Like Minded Strategy
(b) Perinatal Mental Health
(c) Early Intervention in Psychosis
(d) Conduct Disorder
(e) Dementia
(f) Learning Disorders
(g) Digital

Delivery Area 5 – Ensuring we have safe, high quality & sustainable acute services
(a) Urgent & Emergency Care
(b) Inpatient Model of Care
(c) Radiology & Diagnostics
(d) Length of Stay - Transfers of Care
(e) Maternity
(f) Paediatric High Dependency Unit Standards
(g) Referral Optimisation
(h) Community Gynaecology
(i) Community Dermatology
(j) Central Middlesex Hospital Redesign
(k) Digital

Other supporting areas
(a) Continuing Care & Personal Health Budgets
(b) Medicines Optimisation
(c) Carers
(d) Estates

Delivery Area 1 – Radically upgrading prevention and wellbeing

(a) Children's Acute & Community Services
(b) Digital

1a) Acute and Community Children's Services

Strategic Aim

To commission a range of high quality, effective, integrated acute and community children's service, embedding combined commissioning arrangements for children and young people and joint commissioning with key partners.

Rationale

Improving the health of children is essential to reducing inequalities, which needs to start in childhood. Children's Public Health in England was fundamentally redesigned by the introduction of the 2012 Health and Social Care Act and giving each child in Brent the best start in life and preparing them for school is one of the strategy's priority areas. The first years of life are crucial for the physical, intellectual and emotional development of individuals and have lifelong effects on many aspects of health and wellbeing. We intend to divert much of our energy to improving the quality of life for our youngest residents, focussing on key areas such as parenting programmes, improving access to services for hard-to-reach groups; and encouraging healthy behaviours through a range of settings including children's centres and nurseries.

	Commissioning/ Contracting Change	Impact
Maternity and Children 0-19	Improving the health and wellbeing of children in Brent and reduce inequalities in outcomes as part of an integrated multi-agency approach to supporting and empowering families. Working with Public Health to develop local action plans to reduce childhood obesity	• Reduced infant mortality • Improved parenting skills • Reduced accidents to pre-school children in the home
Children and Young People's Mental Health and Wellbeing	Mapping of community assets and needs locally to analysis children and young people's health requirements	• To enable us to improve the services we commission locally
Looked After Children	Promoting and improving health outcomes for children and young people in care	• Children and Young People are enabled to participate in decisions about their healthcare
SEND	A clearer focus on high aspirations and on improving outcomes for children and young people. Identify the gaps within the current provision. Improve the Education, Health and Care Planning process, and align the commissioning of therapy services, including Speech And Language Therapy.	• Ensure effective progression routes are in place so young people can achieve good outcomes. • More joint up care through Education, Health and Care Plans
Young Carers	Working with partners to improve the identification of young carers, and to update the joint Carers Strategy.	• More young carers identified and supported as Children in Need

1b) Digital

Description

- Transform primary care systems and processes to ensure efficient service delivery, giving them the knowledge and insight to be effective and sustainable businesses, with tools to report on patients, pathways and practice operations

Strategic Aim

This will enable the national 'Paperless by 2020' vision ad the digital golden thread of the STP

Rationale

- Empower the patient and carer to be informed about, and part of, the processes of managing their care, through technology
- Enhance early diagnosis and referrals pathways within the primary care setting, providing clinicians with the tools, methods and techniques to support consultations and healthcare, including templates and workflows for referrals, diagnostic test requests, prescribing, assessments and other protocols, and automated aids to clinical decision support.
- Integrate care between primary care and other settings of care, defining common standards for clinical communication to and from GPs

	Commissioning/ Contracting Change	Impact
Planned for Year 1	• Continued roll out of the Whole Systems Dash board in general practice • Start work on the **enhanced** Summary Care Record	• Improve children's mental and physical health and wellbeing through helping coordinate care for children and young people and identify vulnerable patients
Planned for Year 2	Taking forward the **enhanced** Summary Care Record and initiating the take-up through supporting patients with long-term conditions.	

Delivery Area 2 – Eliminating unwarranted variation and improving management of long term conditions

(a) Long Term Conditions
(b) RightCare
(c) Community Services
(d) Digital

2a) Long-Term Conditions (LTCs)

Description

75% of healthcare spend is on people with LTCs. Evidence also shows unwarranted clinical variations across all services; the CCG aim is to recognise and drive out unwarranted variation wherever it exists.

Strategic Aim

In the NHS Five Year Forward View, NHS England states that long term conditions are now a central task of the NHS; caring for these needs requires a partnership with patients over the long term rather than providing single, unconnected 'episodes' of care. The CCG will support people to understand and manage their own condition including how to access local services and to reduce the variation in outcomes for people with LTCs

Rationale

Brent has one of the highest prevalence rates of patients with Long Term Conditions (LTCs) in the country. There is also a wide variation in the range of community services available to patients in the borough. While in some areas there has been progress, such as the new community services for Diabetic and Stroke patients, there is still room for improvement. Without action, it is expected there will be rising health inequalities, poorer health outcomes for patients and greater demand on local acute/primary care services.

	Commissioning/ Contracting Change	Impact
Planned for Year 1	• Mobilisation of National Diabetes Treatment & Care Programme if application is successful • Extend diabetes dashboards to other LTCs, improving primary care awareness of variability and performance • Increasing COPD diagnosis/pick up rate through more proactive screening of symptomatic smokers and reducing variability in uptake of pulmonary rehabilitation • Explore tele-medicine to support the management of LTCs	• Reduction in progression from non-diabetic hyperglycaemia to Type 2 diabetes • Reduction in diabetes-related CVD outcomes: CHD, MI, stroke/TIA, blindness, ESRF, major and minor amputations • Improved COPD diagnosis rate
Planned for Year 2	• Development of Right Breathe respiratory portal – 'one-stop-shop' to support decision-making for professionals and patients for asthma and COPD • Technology to promote self-management and peer support for people with LTCs • Develop a strategy/clinical pathway for the management of hypertension ensuring alignment with Stroke services	• Patients receive timely, high quality and consistent care in line with best practice pathways • Increased patient awareness of self-care and • Reduction in hospital attendance

2b) Rightcare

Description
Undertake a number of service reviews across Diabetes, MSK, Cancer, Respiratory, CVD and Neurology to maximise value in population healthcare.

Strategic Aim
RightCare identifies variances between Brent and the best of the top 5 comparator CCGs with similar demographics. The aim is to manage out the variation to achieve higher quality at lower cost. The programme is in collaboration with a range of partners across health and social care along the whole care pathway.

Rationale
The aim is to standardise the quality and cost of care across areas with similar demographics and drive out unwarranted variation in quality and costs. Through clinical review and audit a programme is to be formed to optimise care pathways.

	Commissioning/ Contracting Change	Impact
Planned for Year 1	Mobilise plans for diabetes, MSK, cancer and respiratory.	• **Diabetes**: improvement in Hba1c management; reduction in elective spend • **MSK**: Improvement in EQ5D score for hip and knee replacement • **Respiratory**: Improvement in prevention & management of asthma and COPD
Planned for Year 2	Mobilise plans for CVD and neurology Continue plans for cancer	• **Cancer**: improve early detection & prevention • **CVD & Neurology**: Improvement in outcomes in line with findings of the reviews

2c) Review of Brent Community Services

Strategic Aim

To deliver a high quality responsive and cost effective and sustainable community health services to the Brent GP registered population to enable more patients to be cared for in the community. This will increase the capacity of secondary care for patients who have more complex needs and require more complex treatments. We will work and engage with faith communities and community groups to act as a conduit in taking health and social care messages back to local people.

Rationale

Brent CCG in collaboration with Ealing CCG have undertaken a review of community services (2016/17) to ensure that they are fit for the future and able to support the necessary transformation in out of hospital care. There are national and local drivers for changes and new approaches to deliver future health care as set out in the Five Year Forward View.

	Commissioning/ Contracting Change	Impact
Planned **for** Year 1	Working in collaboration with existing providers to agree and implement new specifications or service improvements Maximise opportunities in which providers can work together Jointly identify and agree ways in which prevention opportunities can be raised making every patient contact count We will work with community groups to take health messages back to local people which will support self management and prevention.	• Reducing Emergency Department attendance • Managing demand for acute services • Long term condition management, prevention & promotion of self care
Planned for Year 2	Year 2 will focus on developing an ACP model to be potentially rolled out by Brent CCG supported by health and local authority commissioners	

2d) Digital

Description

- Transform primary care systems and processes to ensure efficient service delivery, giving them the knowledge and insight to be effective and sustainable businesses, with tools to report on patients, pathways and practice operations

Strategic Aim

This will enable the national 'Paperless by 2020' vision ad the digital golden thread of the STP

Rationale

- Empower the patient and carer to be informed about, and part of, the processes of managing their care, through technology
- Enhance early diagnosis and referrals pathways within the primary care setting, providing clinicians with the tools, methods and techniques to support consultations and healthcare, including templates and workflows for referrals, diagnostic test requests, prescribing, assessments and other protocols, and automated aids to clinical decision support.
- Integrate care between primary care and other settings of care, defining common standards for clinical communication to and from GPs

	Commissioning/ Contracting Change	Impact
Planned for Year 1	• Working to deliver aspirational KPIs for use of technology to ensure easier access for patients in primary care including consultations by email and use of online prescription services • Further encourage the take-up of Patient Online and to work with NWL CCGs to look at online verification models to support patients and practices.	• Support people who are mainly healthy to stay mentally and physically well, enabling and empowering them to make healthier choices and look after themselves
Planned for Year 2	• Supporting hard to reach groups with the use of telehealth and telecare. • GP Federation to develop Information Governance arrangements (Caldicott Guardianship and Data Controller) to support collaborative working across practices. • GP Federations to support work with practices to use the 'data controller tool' (from NHSE London) to help manage Information Sharing Agreements.	• Reduce Social Isolation

2d) Digital continued

	Commissioning/ Contracting Change	Impact
Planned for Year 1	• Further roll out of Patient Activation Measure (PAM) within GP practices - a patient led measure of knowledge, skills and confidence in manage in their LTCs • Promotion of Anglia ICE for pathology and radiology requests and reports, building on pilot in Hillingdon and Hounslow	• Reduce unwarranted variation in the management of long term conditions
Planned for Year 2	• Advance the use Anglia ICE as the default tool to support ordering of diagnostics for primary care with a view to going paperless. • Majority of patients with an identified Long Term Condition receive a personalised care plan and named care professional by 2019.	• Reduce unwarranted variation in the management of long term conditions
Planned for Year 2	• Improve data reporting of unwarranted variation in order to target resources to reduce it. • Encourage general practice to keep an up-to-date register of people for the top disease areas • Improving care pathways and electronic communication between primary and secondary care to reduce unwarranted variation • Advance the use Anglia ICE as the default tool to support ordering of diagnostics for primary care with a view to going paperless • Increase the utilization of e-Referrals in line with the national average as the standard process for referrals. • All primary care practices to support receiving digital correspondence, documents and information as the preferred method from NHS and Care Organizations.	• Reduce health inequalities and disparity in outcomes for the top 3 killers: cancer, heart diseases and respiratory illness

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

(a) Primary Care Transformation
(b) End of Life Care
(c) Better Care Fund – Integrated Care Pathways
(d) Whole Systems Integrated Care
(e) Care Home & High Risk Housebound Patients
(f) Unified Frailty Older People
(g) Rapid Response Service
(h) Integrating Transfer of Care
(i) Falls Prevention & Bone Health
(j) Digital

3a) Primary Care Transformation

Strategic Aim

The General Practice Forward View (GPFV), NHS London Strategic Commissioning Framework (SCF) and STP provide the strategy and framework guiding the development of a fit for purpose and sustainable Primary Care system, working together, and with partners to deliver accessible, proactive and coordinated care.

Rationale

Our vision for health and care in Brent has GPs at the centre alongside patients and carers. We will work alongside Primary Care leaders, frontline staff and stakeholders to maintain and sustain the GP-patient relationship and to further develop the role of primary care so it is modern and fit for purpose.

	Commissioning/ Contracting Change	Impact
Planned for Year 1 & 2	**Patient Access** • Work with GP practices, NHSE and Estates to ensure areas of population growth can access GP services. • Review and re-launch the Brent GP Access Hubs to cover 8-8, over 7 days, tackle poor utilisation & high DNAs, ensure offer includes all local enhanced services, communicate this effectively to patients and carers. • Review use of technology to improve access eg online appointment booking, telephone consultations, e-consultations, e-prescriptions. **Provider Resilience** • Design & deliver a framework of support for practices in need/at risk. Focus on frontline practice solutions and include training/ OD support for those seeking to strengthen quality & the offer to patients. • Design & deliver a small number of 'at-scale' (Brent/NWL) schemes to tackle challenges such as staff recruitment/retention and efficient administration. • Work with Practices, Networks & the Federation to develop primary care infrastructure – eg new clinical roles (for example pharmacists in general practice), management capacity, shared systems & processes, **Quality & Outcomes** • Review delivery of locally enhanced services and out of hospital contracts– ensure patient access, maintain/improve quality and reduce variation. • Identify opportunities to further develop local enhanced services in line with local needs and the GPFV and STP.	• All 369,166 registered patients have better access to primary care 8am-8pm 7 days a week. • All 369,166 registered patients have access to enhanced services such as Phlebotomy at their own or a neighbouring GP practice. • GP practices feel equipped and supported to deliver frontline care. • Reduced variation in clinical outcomes and patient satisfaction between the 62 practices in Brent. • More care available closer to home and out of hospital.

3b) End of Life (EOL) Care

Description

Better support EOL patients so that they receive seamless services wherever they live in the borough and at whatever time of the day. Optimise patient pathway to increase the number of patients who die at their place of choice and help to avoid or reduce length of stay in acute hospital settings.

Strategic Aim

The aim of our commissioning intentions is to bring about a step change in access to high quality care for all people approaching the end of their life. Ensure that high quality care is available wherever the person may be; at home, in a care home; in hospital in a hospice or elsewhere. Implementation of this strategy should enhance choice, quality, equality and value for money.

Rationale

Over 80% of patients indicated a preference to die at home but only 22% actually did. Patients should be supported with compassion in their last phase of life according to their preferences through the provision high quality coordinated care enabling them to die in their place of choice.

	Commissioning/ Contracting Change	Impact
Planned for Year 1	Improve identification and planning for last phase of life through: • Identifying the 1% of the population who are at risk of death in the next 12 months by using advanced care plans • Identifying the frail elderly population using risk stratification and flagging patients to be offered advanced care planning. Improving interoperability of Coordinate my Care with other systems including primary care Review all contracting arrangement with a view to integrating service provision	• All patients in their last phase of life are identified • Patients identified as being in their last phase of life have an advanced care plan. • Reduction in non-elective admissions for this patient cohort. • Reduce the number of admissions from care homes
Planned for Year 2	Implement the findings of the contracts review as appropriate	• Every eligible person will have a care plan with a fully implemented workforce training plan • Meet the national upper quartile of people dying in the place of their choice

3d) Whole Systems Integrated Care (WSIC)

Description

Development of proactive, coordinated and integrated care in Brent and partnerships between providers to support joined up care and improved patient outcomes and experience on the journey towards accountable care

Strategic Aim

Improve the quality of care for individuals with long term condition and their families and carers. Empower and support people to maintain independence and to lead full lives as active participants in their community. Dissolve traditional boundaries between health, social care, mental health and the voluntary sector.

Rationale

Improve patient experience and quality of life, better manage long term conditions, reduce health inequalities, deliver accessible, proactive and coordinated care and support a reduction in unnecessary use of secondary care.

	Commissioning/ Contracting Change	Impact
Planned for Year 1 & 2	• **Self Care** – evaluate the impact of Care Navigators within the model of care; seek to increase the number of Care Navigators and align volunteer capacity. • **Aligning community based services** – engage community based teams and social care in the multidisciplinary complex patient management groups (CPMG) and formalise their alignment to these teams via implementation of the Community Services Review • **Proactively addressing the root cause of admissions/readmissions** – support providers to develop and make use of available data to target areas of greatest patient need within Brent. Ensure contract management processes evidence proactivity and improved outcomes. • **Training & OD –** align available resources to a shared training plan that develops frontline staff, operational managers and leaders to deliver modern Primary Care and integrated care. • **Development of an ACP/MCP –** progress the development of the Brent Care Provider Forum, aligned to STP delivery plan & governance, produce detailed scope and deliverables, embed in individual contracts through commissioning and contract variation, explore opportunities for joint approaches to assurance and for joint accountability for example through risk and reward share.	• All care planned patients who need it have access to a Care Navigator to support their self-care. • All parts of the health and care system are represented in the WSIC multidisciplinary teams, providing a doorway to wider teams and services in their parent organisation. • Reduced number of patients having 2 or more non-elective admissions including reduction in readmissions. • Staff survey demonstrates integrated working between frontline staff, operational managers and leaders

3e) Care Home & High Risk Housebound Patients

Description

The CCG commissioned a new service in 16/17 to deliver proactive care and improved outcomes for these patients. This service is designed to improve the quality of medical support to patients, provide pharmacist support and improved medicines management, reduce inappropriate LAS call outs and use of acute/secondary care and improve patient experience & satisfaction. The CCG will work with providers and partners to review the existing model of care and consider ways to align work across Brent to drive up the quality of care home and housebound provision and to reduce variation. This may require variation or re-commissioning

Strategic Aim

Align the existing service to wider strategic objectives for primary care out of hospital services and for this patient group. Contribute to the closing of the 'care and quality' gap under the STP. Improve key outcomes and patient experience.

Rationale

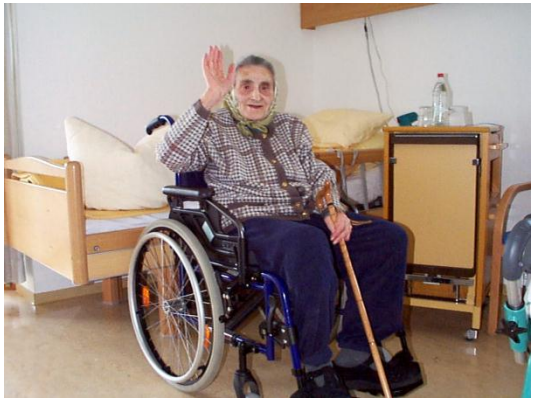
Opportunity to improve patient experience and quality of life and support a reduction in unnecessary use of London Ambulance Service, A&E attendances and non-elective admissions.

	Commissioning/ Contracting Change	Impact
Planned for Year 1 & 2	**Service development & improvement** – review work to date, align strategic objectives and key components of the model of care, improve quality, reduce variation in provision and improve key outcomes **Pharmacy Support** - consider the case for investment in additional pharmacy support and medicines management and develop links to Pharmacists working at practice or network level where relevant. **Integration** – consider the benefits of an integrated approach to commissioning and provision locally. Address key challenges and barriers to integrated working and coordinated care for example cross-border challenges. Include work with partners in the North West London STP 'footprint'. Consider alignment to development of an ACP/MCP where there would be benefits for this patient group.	• Reduction in LAS call outs and non-elective admissions from the 1,220 (approx) beds in Brent. • Integrated and coordinated care for housebound patients • Improved quality of care for patients in nursing and residential homes

3f) Unified Frailty Older People Pathway

Description

Increase in the older population poses a challenge to the health and care system due to their complex health and care needs. Patients who are over 65 years old are more likely to be frail and have multiple Long Term Conditions. As a result of this we are seeing a higher proportion of non-elective admissions into the acute trust. In order to manage this, care should be better coordinated, more proactive and less fragmented.



Strategic Aim

It is critical that the model of care needs to be integrated at every stage. At a NWL level, frailty services forms a key component of the 'intermediate and rapid response' workstream (as described on next slide).

Rationale

The frail elderly population will continue to increase in Brent and the services that we have commissioned both in and out of hospital need to manage this cohort of patients in the appropriate settings. If the acuity of the patient requires an attendance or an admission within the Emergency Department, the focus will be to ensure that our health and care system develops appropriate pathways of care which ensures a minimum amount of time within a hospital setting to get best outcomes for these patients. The CCG has commissioned a number of services which impact positively on frailty cohort of patients however their co-ordination and delivery needs to be seamless with the sharing of information at the heart of delivery.

	Commissioning/ Contracting Change	Impact
Planned for Year 1	• Comprehensive Geriatric Assessment on admission • Commissioning of Older Persons Assessment Liaison Service (OPALS) following sign off of a service specification • Developing a case for a dedicated frailty unit • Align services which support the frailty pathway (WSIC/Rapid Response /Care Home strategy)	• 100% of patients receive an assessment • 100% of patients have an Estimated Date of Discharge • Reduction in Length of Stay • Reduction in excess bed days
Planned for Year 2	• Opportunity to develop the ACP model for Care of Elderly • Commission a frailty unit • Improve the quality of services for patients, provide value for money by ensuring care is delivered in the most appropriate setting. Once patients have completed their Acute episode they are transitioned into the appropriate service as soon as possible.	• 100% of patients receive an assessment • 100% of patients have an Estimated Date of Discharge • Reduction in Length of Stay • Reduction in excess bed days

3g) Rapid Response Service

Description

The Rapid Response Service aims to reduce the high proportion of non-elective admissions and improve the current service to enable GPs and the Rapid Response team to care for more patients in the community without the need for an acute hospital admission.

Strategic Aim

To develop a fit for purpose model of care for intermediate care and rapid response service that is consistent across NWL to provide a consistent, high quality and efficient services to keep people well in the community.

Rationale

North West London CCGs are undertaking a review of Rapid Response Services which offers an opportunity to identify best practice and work in collaboration with stakeholders to improve the existing service in order to support more patients to remain independent and reduce the very short stay admissions for those people who don't need to go into hospital.

There are currently 8 models of rapid response services across NWL, with different costs and delivering differential levels of benefits. There is need to reduce variation and use best practice model creating standardisation wherever possible.

	Commissioning/ Contracting Change	Impact
Planned for Year 1	• Identifying the best parts of each model and move to a consistent specification as far as possible • Reducing non-elective admissions and reducing length of stay through early supported discharge • Enhancing integration with other service providers • Expanding the scope of the service to reduce the very short stay admissions (0-1 day)	• Increase in referrals into the service • Increase in the number of non-elective admissions and A&E attendances avoided • Reduction in short stay admissions.
Planned for Year 2	• Moving towards joint commissioning with local authority • Creating additional capacity to enable people to be cared for in less acute settings. • Operating as part of an integrated Accountable Care Partnership model	

3h) Integrating Transfer of Care (Health and Social Care)

Description

Transfer of Care processes will be consistent and streamlined across North West London ensuring timely referrals to appropriate place of care. Community, Social Care and Hospital teams will work together to enable an integrated needs based approach to packages of care. The pathway will be easier to navigate for patients and carers, with quality information provided along the pathway for staff and patients.

Strategic Aim

Delivery of an improved 7 day emergency service and therefore achievement of the London Quality Standards has been a key part of the strategy in North West London for several years. Improving processes for transfers of care from a hospital setting is key to our strategy to deliver care in the right place at the right time, as close to someone's own home as possible.

Rationale

There was a recognition across NWL CCGs that the current transfer of care pathways are fragmented, difficult to navigate for patients and staff and vary considerably across boroughs. The new model helps standardise pathways across NWL, build relationships between hospital and community based staff and improve the quality of information provided at discharge. A range of other benefits are also expected, including:

	Commissioning/ Contracting Change	Impact
Key deliverables in line with STP 5 year plan *Phased approach to implementation to be developed and agreed.*	• An agreed integrated acute and social care model of care • An integrated health and social care acute transfer of care team • A single point of access for transfer of care across NWL boroughs • A needs based assessment form • Agreed common dataset in relevant contracts to measure, target and identify improvement areas for transfer of care across NWL • Information sharing and joint working agreements • Shared IT platform to share information across health social care	• A reduction in inappropriate referrals to community services; • Reduced duplication of effort as staff will no longer need to complete different forms or chase hospital based staff for additional information in order to accept referrals into a service; • A reduction in Delayed Transfers of Care and Length of Stay • Improved quality of patient care and patient experience.

3i) Falls Prevention & Bone Health

Description
Set up and mobilise a new falls prevention and bone health service in the community

Strategic Aim
To reduce the number of readmissions to hospitals related to falls in the over 65s, thereby reducing the number of hip fractures, falls or fragility fractures that people suffer as a result.

Rationale
Falls are the most serious and frequent type of accident in the over 65 population. The number of referrals to the STARRS service for falls has been increasing year on year and we know that although Brent is a young borough, conversely our 85+ population is one of the fastest growing population segments as people live longer.

	Commissioning/ Contracting Change	Impact
Planned for Year 1	Create a robust pathway for patients who have fallen or at risk of falling. The new service will deliver 2 falls clinics per week and 4 falls classes across our locality areas.	• Reduce the number of readmissions for falls, reduce number of hip fractures from baseline.

3j) Digital

Description

- Transform primary care systems and processes to ensure efficient service delivery, giving them the knowledge and insight to be effective and sustainable businesses, with tools to report on patients, pathways and practice operations

Strategic Aim

This will enable the national 'Paperless by 2020' vision ad the digital golden thread of the STP

Rationale

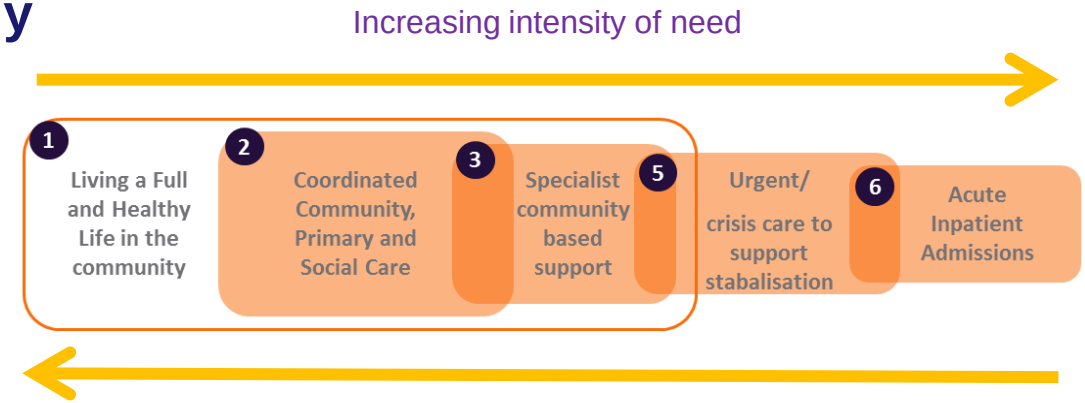
- Empower the patient and carer to be informed about, and part of, the processes of managing their care, through technology
- Enhance early diagnosis and referrals pathways within the primary care setting, providing clinicians with the tools, methods and techniques to support consultations and healthcare, including templates and workflows for referrals, diagnostic test requests, prescribing, assessments and other protocols, and automated aids to clinical decision support.
- Integrate care between primary care and other settings of care, defining common standards for clinical communication to and from GPs

	Commissioning/ Contracting Change	Impact
Planned for Year 1	• Improving access through a plan to implement 8am-8pm working in general practice including extended IT support • Increase the utilization of e-Referrals in line with the national average as the standard process for referrals. • Promotion of Anglia ICE for pathology and radiology requests and reports, building on pilot in Hillingdon and Hounslow	• Ensure people access the right support in the right place at the right time
Planned for Year 2	• All primary care practices to support receiving digital correspondence, documents and information as the preferred method from NHS and Care Organizations. • Advance the use Anglia ICE as the default tool to support ordering of diagnostics for primary care with a view to going paperless.	• Ensure people access the right support in the right place at the right time
Planned for Year 1 and 2	Increase the utilization of Co-ordinate My Care to support older people and enable sharing core information between urgent and emergency services and support End of Life Care.	• Improve the quality of care for people in their last phase of life and enable them to die in their place of choice

Delivery Area 4 – Improving outcomes for children & adults with mental health needs

(a) Like Minded Strategy
(b) Perinatal Mental Health
(c) Early Intervention in Psychosis
(d) Conduct Disorder
(e) Dementia
(f) Learning disorders
(g) Digital

4a) The Like Minded strategy



Five work streams

1 Common mental disorders
- Increasing the numbers of people using talking therapies
- Supporting people to maintain and regain employment

2 Serious and long-term mental health needs
- Increasing the numbers of people able to live independently
- Improving primary care support
- Improving evidence-based care in community teams
- Increasing the alternatives to inpatient care

3 Children and Young People's mental health and wellbeing
- Supporting children to stay in school
- Comprehensive needs analysis across NW London
- Open new community eating disorder services
- Improve mental health care for children with autism, learning disabilities, and neurodisabilities
- Improve crisis care
- Improve evidence-based care and early intervention

4 Wellbeing and prevention
- Build resilience in local communities and help people stay well after they recover from mental illness

5 Other projects:
- Crisis Concordat – Emergency response to mental illness crisis within 4 hours
- Dementia – Supporting early diagnosis and development of social networks
- Learning disabilities – Transforming Care Partnership, reducing the reliance on in-patent care a long way from home

4b) Perinatal mental health

Description
Perinatal mental health problems are an important cause of maternal mortality and the emotional development and well being of young people.

Strategic Aim
Recognising that mental ill health, complicating pregnancy and the postpartum year, is relatively common. In some cases this illness may be of a serious nature and may have long lasting effects, not only on maternal health, but also on child development and family relationships. Commission specialist community perinatal mental health services as recommended within best practice guidance. Ensure close integration of community perinatal mental health services, health visiting, and maternity based support.

Rationale
The need to improve local perinatal care through prevention, detection and treatment of perinatal mental health problems and prevent the long-term impact on both women and their families. The CCG will contribute to the North West London maternity Clinical Strategy, working with NHSE and Public Health to ensure the commissioning of antenatal and new-born screening programmes is appropriately integrated with that of maternity services. We will review the model and funding of perinatal mental health services and improve maternity care provision, linked with Shaping a Healthier Future, to ensure that every child has the best start in life

	Commissioning/ Contracting Change	Impact
Planned for Year 1	A stepped care approach to be adopted when managing women with mental ill health during pregnancy and the postnatal period, including health visiting support.	Increased capacity, increased support for prevention during the pre-conception and perinatal period and improved out of hospital mental health support for women and families in the postnatal period and first year of life.
Planned for Year 2	Improve perinatal mental health support to women who may experience a common mental illness during pregnancy as well as those with a known mental health problem or those who develop severe mental illness	Increased knowledge and awareness of mental health issues during pregnancy and post-natal. Improved care for women with mental health problems. Full compliance with NICE guidance

4c) Early Intervention in Psychosis

Description

- Early detection of pre-psychosis 'at risk mental states' can prevent or reduce the impairment from developing a psychotic illness. This scheme expands the existing service.
- Black people in Brent mental health services report wanting to have better support from their own community through peers, in particular people with lived experience of mental illness.

Strategic Aim

Recognising the impact on Black and Minority Ethnic communities is highly relevant to people in Brent. This theme reflects the NW London drive to improve prevention and early intervention within the Sustainability and Transformation Plan. It is a priority in the NHS England Five Year Forward View for Mental Health, with associated savings targets built in to CCG future funding allocations. It is a priority within the NW London 'Like Minded' strategy for mental health.

Rationale

Psychosis rates in Brent are high (around 3,490 people estimated to have a serious mental illness); Brent has a high number of under 18s. Aim to improve the quality of care and reduce cost of care after two years.

	Commissioning/ Contracting Change	Impact
Planned for Year 1	**Expansion of existing service, and development of BME peer support services** • Specific focus on under 18s detection • Culturally sensitive BME peer support alongside bio-social models of care, to develop support and challenge stigma within local communities • Development of talking therapies (Cognitive Behavioural Therapy) to help manage symptoms of psychosis	• Identification and awareness raising of 'at risk mental state' symptoms, and challenging stigma around mental illness. • Helping different communities develop their own positive emotional response to help people recover from acute episodes of psychosis and stay well.
Planned for Year 2	**Consider Primary Care Mental Health Service and peer support re-procurement** • Measure impact of service changes • Consider further expansion of BME peer support	More people from BME groups accessing talking therapies and gaining support in their local community to stay well

4d) Conduct disorder

Description
Children with a long term physical illness are twice as likely to suffer from emotional or conduct disorder problems

Strategic Aim
The aim is for early identification and appropriate support for children displaying significant behavioural difficulties who may have a conduct disorder

Rationale
Conduct disorders and associated antisocial behaviour, are the most common mental and behavioural problems in children and young people, and also the one which leads to the most referrals to specialist child and adolescent mental health services. We are working to ensure that more children and young people are supported to maintain good emotional wellbeing, difficulties are noticed earlier and appropriate services are available to support them.

	Commissioning/ Contracting Change	Impact
Planned for Year 1	We will work with our provider partners to develop integrated CAMHS pathways to support children with conduct disorders and their parents and carers and ensure that services delivered by local partners respond to NICE guidance relating to conduct disorders.	• Early identification of children and young people with conduct disorder • Early intervention and provision of targeted mental health support for children displaying significant behavioural difficulties and conduct disorder
Planned for Year 2	We will strengthen capacity and capability in Tier 2 provision predominantly around Primary Care Mental Health Workers	Reduction in referrals to specialist child and adolescent mental health services for conduct disorders and associated antisocial behaviour which will improve children and young people's life chances/opportunities.

4e) Dementia

Description

Brent has an estimated 2,513 patients living with dementia, of whom 1,713 (68%) are diagnosed on the QOF register. This leaves an estimated 800 (32%) undiagnosed patients living with dementia who would benefit from early diagnosis and follow up and support in the community.

Strategic Aim

The aim is to provide early interventions that support people with dementia to live longer in their own homes and delay and / or prevent the need for more costly care at a later stage. Our objectives are to work jointly with Brent Council and local communities to improve the quality of care and support that patients with dementia and their carers receive locally.

Rationale

With the prevalence of dementia continuing to rise, support for early diagnosis, appropriate services in the community following diagnosis, a preventative bio-psycho-social approach to admission avoidance to hospital, residential and nursing homes and early support and advice for carers of people with dementia is needed for dementia care locally.

	Commissioning/ Contracting Change	Impact
Planned for Year 1	Develop a primary care dementia service that includes: early diagnosis in a timely manner, communicating the diagnosis well to the person with dementia and their family, advising on appropriate treatment, information, care and support after diagnosis. To consider joint commissioning options with Brent Council.	• Reductions in residential, nursing and care home placements • Improved quality of life of people with dementia following early diagnosis and intervention • Positive effects on the quality of life of family carers following early diagnosis and intervention
Planned for Year 2	Remodelling of the Secondary Care Memory Assessment services to support more complex presentations	Early assessment and diagnosis in primary and secondary care settings. Early identifying of the right treatment and support to maintain a good quality of life

4f) Learning disabilities

Description
Transforming Care for people with learning disabilities and autism and focusing on avoiding admission to inpatient services and provision of community based infrastructures to meet the needs of the local population.

Strategic Aim
Improve integration and aligned commissioning with Brent Council of safe, appropriate, high quality services for people with learning disabilities to support prevention and self-care, admission avoidance and reduced lengths of stays when admitted for in-patient care.

Rationale
Following the Winterbourne view, transformation of health services for people with Learning Disabilities is required to ensure improved quality of care and quality of life, reduced reliance on in-patient, residential and nursing care provision, and provision of personalised care and support that focuses on positive experience of care for people with Learning Disabilities.

	Commissioning/ Contracting Change	Impact
Planned for Year 1	Jointly commissioned integrated community learning disability team (CTPLD) to deliver on and achieve transformation through prevention and wellbeing support, timely access to assessment and treatment and improved patient experience	Reduced reliance on in-patient care and facilitated early discharge from in-patient care
Planned for Year 2	Re-specifying and remodelling of the local in-patient Learning Disabilities unit	Improved quality of care, clinical effectiveness and outcomes for patients. Increased patient safety and improved patient experience. Reduced lengths of stay

4g) Digital

Description

- Transform primary care systems and processes to ensure efficient service delivery, giving them the knowledge and insight to be effective and sustainable businesses, with tools to report on patients, pathways and practice operations

Strategic Aim

This will enable the national 'Paperless by 2020' vision ad the digital golden thread of the STP

Rationale

- Empower the patient and carer to be informed about, and part of, the processes of managing their care, through technology
- Enhance early diagnosis and referrals pathways within the primary care setting, providing clinicians with the tools, methods and techniques to support consultations and healthcare, including templates and workflows for referrals, diagnostic test requests, prescribing, assessments and other protocols, and automated aids to clinical decision support.
- Integrate care between primary care and other settings of care, defining common standards for clinical communication to and from GPs

	Commissioning/ Contracting Change	Impact
Planned for Year 2	All patients with an identified Long Term Condition receive a personalised care plan and named care professional by 2019.	• Reduce the gap in life expectancy between adults with serious and long term mental health needs and the rest of the population

Delivery Area 5 – Ensuring we have safe, high quality & sustainable acute services

(a) Urgent & Emergency Care
(b) Inpatient Model of Care
(c) Radiology & Diagnostics
(d) Length of Stay - Transfers of Care
(e) Maternity
(f) Paediatric High Dependency Unit Standards
(g) Referral Optimisation
(h) Community Gynaecology
(i) Community Dermatology
(j) Central Middlesex Hospital Redesign
(k) Digital

5a) Urgent & Emergency Care

Description

The CCG will continue to review all current contracts for provision of unscheduled care and ensure that they align with our model for delivery of Integrated Urgent Care being developed across NWL.

Feedback from previous patient engagement is that there are several points of access for unscheduled care in Brent, however patients are not aware of these or when they should be accessed. There will need to be extensive public engagement for the new Integrated Urgent Care model.

Strategic Aim

Development of an Integrated Urgent Care model across Brent, Harrow & Hillingdon.

Rationale

The guidance published in November 2015 by NHSE on commissioning standards for delivery of Integrated Urgent Care requires that NHS 111 and Out Of Hours (OOH) services are aligned to facilitate the integration of all unscheduled services and a clinical hub is developed which manages the flow of patients form NHS 111. Currently approximately 60% of NHS 111 calls end with advise to the patient to attend A&E or Urgent Care Centre (UCC). In Brent there are several services commissioned for provision of unscheduled care, e.g. Walk In Centres, Access Hubs, UCCs, OOH service and Accident & Emergency, which all need to be integrated and streamlined so that patients do not need to visit multiple urgent care sites for the right care and get this the first time.

	Commissioning/ Contracting Change	Impact
Planned for Year 1	Continue development of the model for Integrated Urgent Care across Brent, Harrow & Hillingdon taking into account all the unscheduled services provided currently (local and out of area) and how these may need to redefined. Review and procure some elements of unscheduled care e.g. GP Access Hubs	Alignment of the current GP Access Hubs, Out of Hours and Urgent Care Service at NPH, CMH. An opportunity to ensure that patients access local services rather than accessing from out of area.
Planned for Year 2	Delivery of the new Integrated Urgent Care model across Brent, Harrow & Hillingdon which will include a new provider of NHS 111 services.	The Integrated Urgent Care model should result in patients being directed to the most appropriate local service in accordance with their needs, after having a locally led clinical assessment service.

5b) Inpatient Model of Care

Description

Delivering a new inpatient model of care that will deliver time to first Consultant review within 14 hours for all emergency admission via any route and a Consultant led, on-going twice daily, inpatient reviews for acute and high dependency units and daily 24 hour review for all other inpatients unless deemed it will not affect the patients pathway.

Strategic Aim

Delivery of an improved 7 day emergency service and therefore achievement of the London Quality Standards has been a key part of the strategy in North West London for several years. Delivery of the standards associated with increased consultant cover is specified explicitly within Delivery Area 5 of the STP.

Rationale

There is a national mandate for improving emergency hospital services and patient outcomes across the week, particularly in relation to increased consultant-led care. Benefits are being evaluated through the pilots being run in November 2016 across NWL but are expected to include reduced length of stay, improved patients & staff experience and reduced patient safety metrics (e.g. hospital acquired infection rates).

	Commissioning/ Contracting Change	Impact
Planned for Year 1	Implementation of new models of care in acute trusts. Models will be defined following pilots in November 2016.	• 90% of NEL admissions will receive consultant-directed reviews within the defined timelines every day of the week

5c) Radiology and Diagnostics

Description
Delivering the 7 day diagnostic standard which includes scanning and reporting of inpatient investigations in one hour for emergency, 12 hours for urgent and 24 hours for non urgent patients.

Strategic Aim
Delivery of an improved 7 day emergency service and therefore achievement of the London Quality Standards has been a key part of the strategy in North West London for several years. Delivery of the standards associated with improved and timely access to diagnostics is specified explicitly within Delivery Area 5 of the STP.

Rationale
There is a national mandate for improving emergency hospital services and patient outcomes across the week, particularly in relation to timely access to diagnostics. Data provided by LNWHT shows that average turn-around times for inpatients at Northwick Park are 68hrs for MRI and 51hrs for Ultrasound. Achieving the required 24hr turn-around times for these scans could release up to 30 inpatient beds for the hospital.

	Commissioning/ Contracting Change	Impact
Planned for Year 1	90% of inpatient radiology diagnostics undertaken & reported within 24hrs of request	• Reduction in length of stay for patients receiving a radiology diagnostic test by 0.5 days on average, leading to release of up to 30 inpatient beds
Planned for Year 2	Implementation of phase 1 of the NWL shared reporting network that permits reporting to be partially shared across NWL trusts	• Reduction in % reporting outsourced and efficiencies in reporting across NWL (OBC currently in development)

5d) Length of Stay - Transfers of Care

Description

Developing a consistent and streamlined North West London wide process covering the discharge of patients with a new or changed need for community healthcare support in their home on discharge from a hospital ward, including those that cross CCG boundaries. Introducing a standardised discharge referral form will improve the quality of information provided to community services, reducing paperwork and ensuring that patients are allocated to the appropriate service on discharge.

Strategic Aim

Delivery of an improved 7 day emergency service and achievement of the London Quality Standards has been a key part of the strategy in North West London for several years. Improving processes for transfers of care from a hospital setting is key to our strategy to deliver care in the right place at the right time, as close to someone's own home as possible.

Rationale

It is recognised across NWL CCGs that the current discharge pathways are fragmented, difficult to navigate for patients and staff and vary considerably across boroughs. The new model helps standardise discharge pathways across NWL, build relationships between hospital and community based staff and improve the quality of information provided at discharge.

	Commissioning/ Contracting Change	Impact
Planned for Year 1	• Deliver single points of access for non-bedded community services, with the potential to increase to wider community services in Year 2. • Deliver of an IT solution to allow electronic sharing of information between health and adult social care providers • To work in partnership with initiatives across the health and adult social care system to improve transfer of care and align approaches • Development of a system wide dataset to consistently measure effective Transfers of Care across the system	• A reduction in inappropriate referrals to community services • Reduced duplication of effort as staff will no longer need to complete different forms or chase hospital based staff for additional information in order to accept referrals into a service • A reduction in Delayed Transfers of Care and Lengths of Stay • Improved quality of patient care and patient experience
Planned for Year 2	TBD- potential to expand Single Point of Access to cover Bedded Community Services, Social Care, etc.	

5e) Maternity

Description

Providing women and their partners with advice, support and care from preconception, during pregnancy (antenatal care), child birth and after care (postnatal care).

Strategic Aim

To commission high quality, effective, maternity, services locally that support choice of a preferred pathway of care, in line with pregnant women's clinical needs and best practice and ensure that women have access to safe, high quality, nationally consistent, woman-centred maternity care.

Rationale

Provide a safe and accessible service for local women, babies and their families in planning pregnancy, during pregnancy and labour, and in the period following the baby's birth.

	Commissioning/ Contracting Change	Impact
Planned for Year 1 and 2	Work with NHS England to ensure that new immunisation requirements are embedded in all relevant provider practice. Work with Public Health to support the offer of universal BCG by maternity units as supplies become available Ensure that clinical pathways for pregnant women are appropriate, meet best practice guidelines (e.g. NICE, RCOG) and offer value for money. Develop new maternity service models in line with national specifications	Achieve national standards and targets Delivery of the London Quality Standards for maternity Established models of care that take account of national and local developments

5f) Paediatric High Dependency Unit (HDU) standards

Description
Paediatric HDU has been the term used to describe the provision of close observation, monitoring of specific therapies to critically ill children which is beyond the capability of the general Paediatric ward. Entry into HDU is governed by the degree of physiological instability as much as by diagnosis. A critically ill child requires close observation and monitoring and supervision from a specialist nursing team.

Strategic Aim
Level 1 Critical Care should be delivered in any hospital which admits acutely ill children and will focus on the commoner acute presentations and clinical scenarios that require an enhanced level of observation, monitoring and intervention than can be safely delivered on a normal ward.

Rationale
Patients who arrive via the A&E referral route with a detailed care plan will not be required to undergo a second clinical assessment. Children who are referred by other services will follow the standard assessment and screening criteria, and a care plan will be developed ahead of discharge home or to other clinical services (hospital, GP or community services).

	Commissioning/ Contracting Change	Impact
Planned for Year 1	Providing care that is holistically connected across primary and secondary care; developing a relationship between paediatric consultants and GPs	Maximise staff contribution to transforming the way services are delivered: • Transforming GP engagement in paediatric referrals • Advice and support network between primary and secondary care

5g) Referral Optimisation

Description
This is a system to clinically triage referrals that are made by GPs and internally generated referrals within the CCG's main Trusts.

Strategic Aim
This links to the aim of reducing unwarranted variation in levels of care in primary care and to make sure that people get the right care in the right place to a consistent standard.

Rationale
The CCG had seen high rates of increases in referrals over the past 18 months, beyond that of demographic growth. This scheme should make the system more financially sustainable and ensure that referral practice is standardised

	Commissioning/ Contracting Change	Impact
Planned for Year 1	Continue to develop Brent Referral Optimisation System (BROS) for GP referrals and commence optimisation for internally generated referrals within LNWHT, Imperial and RFL.	• Around 140,000 referrals per annum triaged, 10% reduction in unnecessary referrals • More consistent GP referral standards
Planned for Year 2	Continue to embed and evolve BROS to new specialties as clinical behaviour changes and training needs evolve.	• Reduction in the rate of referral growth • Consistent referral standards across Brent.

5h) Community Gynaecology Service

Description
Expand the current community gynaecology service to the whole of Brent and then procure the service based around an expanded range of conditions and appropriate diagnostics including ultrasound.

Strategic Aim
To expand the numbers of patients that can be seen and treated in community settings for gynaecology conditions, taking pressure off acute services and providing outpatients at lower cost.

Rationale
The CCG currently spends £3.7 million on gynaecology outpatients and procedures in Brent. There is national evidence from the Royal Society from the Royal Society for Gynaecology and Obstetrics that a community service can provide outpatient appointments and procedures for a wider range of conditions when supported appropriately by ultrasound.

	Commissioning/ Contracting Change	Impact
Planned for Year 1	Review current gynaecology model with a view to expanding the range and coverage of the service to further shift activity out of hospital. Implement recommendations of the review.	Reduction in the number of gynaecology outpatients and procedures taking place in hospital.

5i) Community Dermatology Services

Description
Review the community dermatology service and develop the model to ensure there is appropriate consultant support and an increased number of appointments.

Strategic Aim
To provide more outpatients in the community at lower cost, also reducing referral to treatment times in hospital.

Rationale
Referral to Treatment times are under pressure and an expanded community service can help to reduce waiting times in the acute service. Appropriate consultant supervision will also reduce the number of cases referred on from the community service into hospital

	Commissioning/ Contracting Change	Impact
Planned for Year 1	• Review current service with a view to mobilising a new dermatology service with appropriate consultant support in the community. • Review finance & contracting model	• Reduction in number of outpatient referrals into hospital • Reduction in number of onward referrals from community service to hospital

5j) Central Middlesex Hospital Redesign

Description
Transition of Central Middlesex Hospital into a Local Elective Hospital, as part of the Shaping a Healthier Future (SaHF) programme.

Strategic Aim
The main aim of the SaHF programme is to improve the provision of healthcare across NW London by:

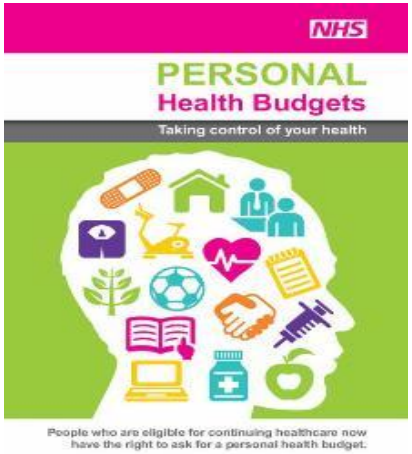
- Localising services that are required on a more frequent and routine basis
- Centralise specialist emergency services, and
- Integrate all of these services with other related services.

As part of the SaHF programme, Central Middlesex Hospital will become a Local Elective Hospital, offering a range of services including: Urgent Care Centre, Outpatients, a community hub, GP services, intermediate care beds, diagnostics and daycase & elective surgery.

Rationale
The main drivers behind the transition are to improve access to services for the local population, improve clinical outcomes, and improve financial stability of the health economy.

	Commissioning/ Contracting Change	Impact
Planned for Year 1 & 2	There will no, or little direct impact as in this period, business cases for the transition changes will be in the process of being developed.	The main impacts of the transition will be: greater range of services offered at Central Middlesex Hospital, an improvement in patient treatment and outcomes and improved financial stability.

5k) Digital



Description

- Transform primary care systems and processes to ensure efficient service delivery, giving them the knowledge and insight to be effective and sustainable businesses, with tools to report on patients, pathways and practice operations

Strategic Aim

This will enable the national 'Paperless by 2020' vision ad the digital golden thread of the STP

Rationale

- Empower the patient and carer to be informed about, and part of, the processes of managing their care, through technology
- Enhance early diagnosis and referrals pathways within the primary care setting, providing clinicians with the tools, methods and techniques to support consultations and healthcare, including templates and workflows for referrals, diagnostic test requests, prescribing, assessments and other protocols, and automated aids to clinical decision support.
- Integrate care between primary care and other settings of care, defining common standards for clinical communication to and from GPs

	Commissioning/ Contracting Change	Impact
Planned for Year 1	• Promotion of Anglia ICE for pathology and radiology requests and reports, building on pilot in Hillingdon and Hounslow • GP Federations to support work with practices to use the 'data controller tool' (from NHSE London) to help manage Information Sharing Agreements. • Increase the utilization of e-Referrals in line with the national average as the standard process for referrals. • Review benefits of patient apps and further development	• Improve consistency in patient outcomes and experience regardless of the day of the week that services are accessed

Other supporting areas

(a) Continuing Care & Personal Health Budgets
(b) Medicines Optimisation
(c) Carers
(d) Estates

Other a) Continuing Care and Personal Health Budgets

Description

Adult Continuing Healthcare is provided when an individual has been assessed by a multi-disciplinary team and been deemed to have a 'primary health need'. After this has been determined health will develop a package of care which is solely funded by health. The packages of care are delivered outside of hospital in any setting, including the patient's own home or a care home.

There is also Children and Young People's Continuing Care which is provided when an individual has been assessed by a multi-disciplinary team and been deemed to have a complex need which cannot be met by universal or specialist health services. The CCG has a legal responsibility for reasonably meeting the complex health care needs of the individual child or young person.

Since October 2014 the CCG has had to offer and provide for those individuals that are in receipt of Continuing Healthcare and wish to take up a Personal Health Budget. This budget is provided to deliver care as defined in the individual's personal plan which has to meet their health and wellbeing needs.

Strategic Aim

Eligibility for NHS Continuing Healthcare will be based on an individual's assessed needs and is not disease specific, nor determined by either the setting where the care is provided, or who delivers the care. Access for consideration and assessment is non-discriminatory; it is not based on age, condition or type of health diagnosis.

We aim to ensure that fair and consistent decisions are made for all individuals when they are being assessed for NHS Continuing Healthcare, Fast Track, Shared Care and Funded Nursing Care.

The Continuing Healthcare Service will assist the CCG's shaping of strategic commissioning arrangements, to ensure that the universal and specialist services can respond to the needs of adults, children and young people.

NHS England in 'Delivering the Forward View' has given CCGs a clear direction on the requirement to expand personal Health Budgets by 2021. The expansion will include Personal Health Budgets in Continuing Healthcare and Personal Health Budgets or Integrated Budgets for long term conditions, children with special educational needs, maternity, end of life and wheelchair service users.

Rationale

To deliver an effective and efficient Continuing Healthcare service that will enable to the CCG to deliver person centred care to those individuals in receipt of Continuing Healthcare, Fast Track, Shared Care, Funded Nursing Care and Personal Health Budgets.

Enable the effective administration of the Children's Continuing Care process in partnership with the Local Authority, Hospitals and the Children's Community Nursing Team

Other a) Continuing Care and Personal Health Budgets

	Commissioning/ Contracting Change
Planned for Year 1	Enable children who have special educational needs with an Educational, Health and Care Plan to have the option of a personal Health Budget Continuing Healthcare to expand the procurement of Nursing Homes and Home Care providers with the support from the NHS London Purchased Healthcare Team (AQP NHSE Contracts)
Planned for Year 2	Enable patients to be empowered to self-manage elements of their care with a Personal Health Budget or Integrated Budget with Social Care

Impact

There are 31 local Care Home Providers currently available to Brent CCG to use under the AQP Contract. All these providers submit monthly quality and patient safety data and the cost of care is fixed at a standard equitable rate. The plan is to encourage the remaining 14 Care Home providers to join the contract at the next NHS London Purchased Healthcare Team procurement phase.

The CCG currently commissions 27 local Home Care providers under the Continuing Healthcare local NHSE contract. The plan is to join the next NHS London Purchased Healthcare Team procurement phase for the Home Care AQP Contract. This will enable the CCG to obtain quality monitoring data and sets a standard for fair and equitable costs for commissioned care.

	Current Personal Health Budgets	Personal Health Budget targets numbers by 2021
Brent	25	359-717

Other b) Medicines Optimisation

Description

Brent CCG will continue to work with our GP members and local providers to support effective medicines optimisation and to develop the role of medicines management and pharmacy in primary care and models of integrated care. QIPP plans will build on existing work to drive improvement in quality and effective use of medicines.

Strategic Aim

To optimise medicines use to improve health outcomes by enabling timely, safe and cost-effective medicines related care, tailored to the needs of individual patients throughout the local health economy. This aim links in with the STP aim for Brent people to obtain the best possible outcomes from their medicines. In doing so this links in with the other STP aims to close the care and quality gap by reducing unwarranted variation in the management of long term conditions, supporting self care and understanding of medication regimes and improving care of nursing home residents.

Rationale

Medicines are the most common therapeutic intervention and evidence shows that only 16% of patients who are prescribed a new medicine take it as prescribed, experience no problems and receive as much information as they need; ten days after starting a medicine, almost a third of patients are already non-adherent– of these 55% don't realise they are not taking their medicines correctly, whilst 45% are intentionally non-adherent. To ensure that patients and the NHS get the best value from medicines, there must be a cross-sector wide commitment to medicines optimisation.

	Commissioning/ Contracting Change	Impact
Planned for Year 1 & 2	Develop and implement the 2 year prescribing QIPP plan to stay within budget and reduce wastage. Improve the quality and safety of medicines use and self-management by patients Consider the wider role to be played by pharmacy and medicines management in new models of care.	• Delivery of QIPP plan • Improved patient experience with their medicines; national and local guidance implemented • Partnership working with relevant stakeholders to improve patient care, new roles in primary care and improved multidisciplinary working.

Other c) Carers

Description
Using data from the past three years to offer carers support with greater impact.

Strategic Aim
The CCG needs to refresh and update its carers strategy which will focus on how health services can better support the health and wellbeing of carers. Young carers will be considered as part of this pathway clarification, and is a priority area for the Brent Children' Trust Board.

Rationale
Current CCG carers investments needs to be reviewed to ensure there is alignment to the updated strategy, ensuring that investment is matched to need, and that it is delivering greatest impact within the available funding.

	Commissioning/ Contracting Change	Impact
Planned for Year 1 & 2	Work with local communities and voluntary sector to develop peer-led social prescribing targeted at carers Increase the accessibility of advice on building mental and emotional resilience, and access to more talking therapies for carers Working with partners to improve the identification of young carers, and to update the joint Carers Strategy.	• Increase the number of carers supported • Increase the number of carers below the threshold for statutory support who feel confident to manage their own health and wellbeing • More young carers identified and supported as Children in Need

Other d) Estates

Description:
By 2020/21 we will be delivering an estate portfolio that meets the needs of our 2021 Vision for care and support in Brent.

Strategic Aim:
Delivery of this Enabling Theme will realise a service with the capacity and capability to meet the needs of our population and contribute towards social value across the borough.

Rationale:
Local services hubs will provide the physical location to support prevention and local service care. Investment in the primary care estate will provide locations where providers can deliver targeted programme to improve health outcomes. They will support implementation of new models of care and improved co-ordination of primary care multidisciplinary working and support for mental health needs. Social value is a way of thinking about how scarce resources are allocated and used. It involves looking beyond the cost of each individual estate locations and looking at the collective benefit to a community of using that site. This will be a key factor in shaping our estates strategy.

	Commissioning/ Contracting Change	Impact
Planned for Year 1	• Deliver Local Estate Strategy for Brent to support the delivery of the Five Year Forward View and 'One Public Estate' vision • Deliver a Primary Care Investment Plan which analyses the suitability of the current estate and sets out how the estate will need to change to meet the needs of the new model of care • Maximise use of existing estate and reduce void costs at Willesden Centre for Health and Care & Monks Park • Deliver primary care from CMH Hub +	• Realise substantial financial benefit by maximising use of land & premises. • Maximising capital receipts from land sales where one public estate projects offer joint opportunities. • Reduce recurrent premises costs through commissioning arrangements • Create additional capacity and improve primary care service offering for c10,000 patients in the CMH locality
Planned For Year 2	• Reducing HQ costs at Wembley Centre for Health and Care by consolidating the CCG space at Wembley to reduce the cost of the management accommodation, freeing up space for local service delivery • Delivery of Estates and Technology Transformation Fund (ETTF) schemes to improve access and delivery of Primary Care	• Minimise overhead costs of the CCG by implementing smarter working arrangements • Improve access to primary care by maximising investment via ETTF and improvement grant funding.

Engagement

Public Involvement and Engagement

The CCG has a legal duty under s14Z(11) 3 of the National Health Service Act 2006 which requires the CCG to describe how it intends to discharge its duties with regard to consultation and engagement of the annual commissioning plan (commissioning intentions).

Various bespoke engagement events have been undertaken in forming these commissioning intentions, and the document was released to the Health Partners Forum. The Commissioning Intentions reflect the higher level STP plans and so engagement around the STP is synonymous with the CCG's commissioning intentions.

To date in Brent we have already engaged with patients, the public and partners as follows:

- 27 April: Health Partners Forum (120 patients)
- 1 June: Brent Governing Body Seminar
- 7 June: Brent Health & Well-Being Board
- 5 July: Adult Social Care Provider Forum update (150 providers)
- 13 July: Brent GP Forum
- 27 July: LNWHT AGM
- 2 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
- To 30 November: On-line resident survey, specifically around the Commissioning Intentions coordinated by Brent Healthwatch

Additionally the Health and Wellbeing Board has discussed the Commissioning Intentions via e-governance between 18 November and 1 December.

Ongoing Consultation

In addition to the work that has already taken place, consultation and engagement regarding service design and on the STP will continue throughout the year. This is an iterative process rather than a 'hard' closure of a consultation deadline, with further opportunities to influence the CCG's thinking in an evolutionary way. Engagement activities will be targeted at specific service users or patient cohorts as part of the outreach function of patient and public involvement.

The Brent CCG Governing Body will approve the Commissioning Intentions for 2017-2019 at their meeting on 11th January 2017. All feedback received has been collated and considered as part of refreshing the plan for approval.

The CCG will feed back in more detail on how the commissioning intentions have changed as a result of the engagement at the next Health Partners Forum on 25th January 2016. A summary including representative comments from our engagement events and online consultations is provided on the next pages.

Upgrading Prevention & Well-being

You Said

- Important to get everyone to engage in what they can do for themselves with support as needed
- End the 'vicious circle' where people are conditioned to listen to what the GP tells them to do. Shift emphasis to self-care by the patient
- All agencies should work together to eliminate unwanted variation and improve outcomes for people with long term conditions
- Need to involve more community groups eg. faith groups
- Ensure people are aware of all the different support that is available

We did

- Person centred care and self care continues to be a major emphasis in our work
- We will increase the number of voluntary sector Care Navigators and align to other peer support services, eg mental health peer support workers and the Social Isolation in Brent Initiative
- Continue to work with mental health and primary care providers on models that promote independence and self-care as much as possible. Work jointly with Brent Council in planning the next two years of mental health care pathway improvement and carer support.
- Further discussions with Brent Council and carers in Brent to explore opportunities and benefits of social prescribing in improving health, confidence, and wellbeing.

Eliminating variations & improving long term conditions

You Said

- Patients with long term conditions do not know where to find joined up care and support
- We see that there is variation in care and services should be the same across Brent
- Self-care can be a big leap for people, you need to ask how do they need support and help them

We did

- Lack of awareness of services is a key theme identified through Rightcare workshops and increasing awareness of services available will be part of the ongoing Rightcare programme
- Support for elderly patients and those with long term conditions are key elements of our Commissioning Intentions
- One of the key aims of the Rightcare programme is to reduce variation both within Brent and compared with other similar CCG areas outside of Brent, working with other partner organisations.
- We will ensure that support for self-care is provided through care planning and case management. Those with the most complex needs should get proactive and coordinated support
- We need to develop new approaches to access and the introduction of new roles to free-up GP time to spend longer with the patients who need the most support

Achieving better outcomes and experiences for older people

You Said

- Living and dying at home is always the preferred course
- More resources need to be put into enabling elderly people and those with long term conditions to remain independent and stay well at home
- Better access for GPs is the top priority for the public in the STP consultation

We did

- The aim of our commissioning intentions is to bring about a step change in access to high quality care for all people approaching the end of their life.
- The frail elderly population will continue to increase in Brent and the services that we commission both in and out of hospital need to manage these patients in the appropriate settings.
- We will work with GP practices, NHSE and Estates to ensure areas of population growth can access GP services, and review and re-launch the Brent GP Access Hubs.
- Review use of technology to improve access eg online appointment booking, telephone consultations, e-consultations, e-prescriptions.

Improving outcomes for children and adults with mental health needs

You Said

- Quicker access to psychologists and psychiatrists is so important. My family suffer when I'm at those stages.
- Early intervention and prevention of mental health needs was a top priority for the public in the STP consultation
- Support the carers who care for the mental health patient by educating them and let them be involved in the care plan for the cared for person

We did

- Crisis Concordat is included in, which aims to provide an emergency response to mental illness crisis within 4 hours
- Early detection of pre-psychosis 'at risk mental states' can prevent or reduce the impairment from developing a psychotic illness. Our Commissioning Intentions expands the existing service.
- Our refreshed Carers Strategy will support those caring for all patients, including those with mental health needs

Improving Acute services & quality of life

You Said

- Help patients to be discharged at the right time and with the right support, coordinated with other services
- Need to provide integrated care
- Community workforce to share best practice 'right care'
- Feedback regarding plans for the gynaecology service

We did

- The new Integrated Rehabilitation and Reablement (IRRS) service is a collaborative approach between the LA, Health and other key partners including patients and carers. This will support integrated care across these different elements
- IRRS will also allocate patients to the appropriate lead professional who will coordinate every aspect of care.
- STARRS Rapid Response – we will aim to expand the existing service in order to support more patients to remain independent and reduce the very short stay admissions for those people who don't need to go into hospital
- Reconsidered approach to gynaecology service review to reflect feedback

Statement from the Brent Health and Wellbeing Board

The Brent Health and Wellbeing Board supports the priorities set out in Brent CCG's Commissioning Intentions 2016/17 especially their linkages with the Sustainability and Transformation Plan and their ability to address the real health needs of Brent residents. The Board will support the CCG in ensuring the delivery of these priorities results in high standards of care and enhanced access and that integrated care offers the best possible outcomes for Brent.

Cllr Krupesh Hirani, Chair of Brent Health and Wellbeing Board