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Brent

Brent Clinical Commissioning Group

Health and Wellbeing Board

Wednesday 26 February 2014 at 7.00 pm
Boardroom - Brent Civic Centre, Engineers Way, Wembley, HA9 0FJ

Membership:

Members :	representing
Dr Sarah Basham	Brent CCG
Councillor George Crane	Brent Council
Christine Gilbert	Brent Council
Sue Harper	Brent Council
Councillor Krupesh Hirani	Brent Council
Dr Ethie Kong	Brent CCG
Rob Larkman	Brent CCG
Councillor Ruth Moher (Chair)	Brent Council
Ann O'Neill	Brent Health Watch
Jo Ohlson	Brent CCG
Councillor Harshadbhai Patel	Brent Council
Councillor Michael Pavey	Brent Council
Phil Porter	Brent Council
Melanie Smith	Brent Council
Sara Williams	Brent Council

For further information contact: Lisa Weaver, Democratic Services Officer
0208 937 1358

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democracy.brent.gov.uk

The press and public are welcome to attend this meeting

Agenda

Introductions, if appropriate.

Apologies for absence and clarification of alternate members.

Item		Page
1	**Declarations of interests** Members are invited to declare at this stage of the meeting, any relevant financial or other interest in the items on this agenda.	
2	**Minutes of the previous meeting**	1 - 4
3	**Matters arising**	
4	**Brent Child Death Overview Panel Letter to Health and Wellbeing Board** Dr Arlene Baroda, chair of the Brent Child Death Overview Panel (CDOP), has written to the Brent Health and Wellbeing Board regarding two deaths in Brent that it has reviewed as preventable.	5 - 10
5	**Brent Better Care Fund Plan** The draft Better Care Fund Plan has been submitted to NHS London for comments and analysis. The Health and Wellbeing Board is asked to consider the plan and the schemes within it, ahead of its finalisation by 4th April 2014.	11 - 56
6	**NHS England's Draft Commissioning Intentions 2014/15** NHS England (London) has prepared a report for the Health and Well Being Board on its 2014/15 commissioning intentions.	57 - 66
7	**Health and Wellbeing Strategy and Action Plan** The Health and Wellbeing Board has asked Board members to develop an action plan for the Health and Wellbeing Strategy. The action plan takes account of discussions at previous Board meetings and includes details on key activities and outcomes as requested at the last meeting in December 2013.	67 - 96

8 Refresh of the Brent Joint Strategic Needs Assessment 97 - 100

This report provides a brief update on actions to refresh the Brent Joint Strategic Needs Assessment (JSNA).

9 Any other urgent business

Notice of items to be raised under this heading must be given in writing to the Democratic Services Manager or his representative before the meeting in accordance with Standing Order 64.

Date of the next meeting: Wednesday 9 April 2014

Please remember to ***SWITCH OFF*** your mobile phone during the meeting.

- The meeting room is accessible by lift and seats will be provided for members of the public.

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Brent

MINUTES OF THE HEALTH AND WELLBEING BOARD
Wednesday 11 December 2013 at 7.00 pm

PRESENT: Dr Ethie Kong (Vice Chair) Sarah Basham, Councillor Crane, Christine Gilbert, Sue Harper, Councillor Hirani, Jo Ohlson, Councillor HB Patel, Councillor Pavey, Phil Porter and Melanie Smith

Apologies were received from: Councillor R Moher, Rob Larkman and Sara Williams

1. **Declarations of interests**

Councillor Crane informed the Board that his wife was part of the healthy schools work taking place in Brent, which was included in the Health and Wellbeing Strategy Action Plan. However he did not feel this was a pecuniary interest and remained for the meeting.

2. **Minutes of the previous meeting**

RESOLVED:-

that the minutes of the previous meeting held on 30 October 2013 be approved as an accurate record of the meeting.

3. **Matters arising**

Andrew Davies (Policy and Performance Officer) informed the Board that voting rights for all Councillors, CCG and Healthwatch representatives had been approved at a recent meeting of Full Council.

4. **Health and Wellbeing Strategy and Action Plan**

a) Health and Wellbeing Strategy

Andrew Davies (Policy and Performance Officer) informed the Board of the amendments made to the strategy following the previous meeting including the revision of some priorities, principles and objectives. The Director of Public Health informed the Board that the strategy had been updated to reflect recent changes in legislation and up to date information such as the deterioration in obesity rates in the borough. It was noted that the Board needed to take ownership of the Strategy with work being undertaken across the Council to ensure the document was suitably publicised to the public.

RESOLVED:

Members approved the Health and Wellbeing Board Strategy.

b) Strategy Action Plan

Andrew Davies tabled a draft copy of the action plan with the intention of it being completed and signed off at the next meeting of the Health and Wellbeing Board in February 2014. He highlighted that members of the Board would be required to contribute to the action plan to ensure its competition and advised members to contact either himself or the lead member for the action direct.

RESOLVED:

Members noted the action plan

5. **Health and Social Care Integration**

Phil Porter (Acting Director Adult Social Care) showed a short video presented at pioneer events to demonstrate how a complex idea could be communicated effectively. The Acting Director of Adult Social Care informed the Board that the vision of the pioneer project was to put the patient at the centre of the care they receive, with organisations working around them and not being restricted by organisational boundaries in the way that they work to best meet the needs of the individual. To achieve this the Pioneer application made three commitments:

1. People and their carers and families will be empowered to exercise choice and control and to receive the care they need in their own homes or in their local community
2. GPs will be at the centre of coordinating care, working with others in integrated networks to support people to meet their individual goals
3. Systems will enable not hinder the provision of integrated care, we will focus on people, outcomes and align budgets to them.

Phil Porter informed the Board that the Pioneer bid was now called the Whole Systems Integrated Care Programme (WSIC) and consisted of four phases that would enable whole systems transform of care. The first phase created a toolkit and framework which would be used to deliver the second phase, which was to agree local priorities and plans to meet the long and short term vision. The third phase was the preparation to implement the wave one sites with phase four being a whole systems roll out. The Acting Director of Adult Social Services explained that they were currently in phase one which was due to be completed in January 2014 with stakeholders working to create a technical toolkit including analytical tools, a payment model, and organisational toolkit and a map of current integration programmes to aid integration. He continued to explain that six work streams underpinned the delivery of stage one including; population and outcomes, GP networks, provider networks, commissioning governance and finance, informatics and embedding partnerships.

Jo Ohlson highlighted that the paper set out ways of working together without allocated funding to enable the project. She explained that the integrated care pilot focussed on clinical conditions being treated outside of a hospital setting to identify areas to look at joined up working with primary and secondary care providers using existing resources. David Finch (NHS England) highlighted that the NHS recognised the challenge ahead and the problems currently faced by the NHS but were excited by the potential outcome that could be achieved through Pioneer and working together.

In response to queries regarding what outcomes would look like and how success would be measured, Phil Porter explained that this was dependent on the priorities set within phase two of the project. It was further explained that it was hoped to set up an integration board to enable greater communication of the project. Officers clarified that the toolkit would enable Brent to use what they felt was needed whilst balancing the needs of local residents and the priorities of North West London. Various stakeholders were involved including primary and secondary care providers, voluntary organisations, local authorities and a patients reference group. It was acknowledged that further engagement with patients needed to take place and to ensure that all engagement was formally recorded. Following discussion it was confirmed that the commitment from stakeholders was such that if Pioneer status was not granted the work streams would have still taken place, although through pioneer, greater flexibilities are granted to enable integration. It was intended that from February 2014 base line data would be available so outcomes could be measured. Christine Gilbert (Chief Executive Brent) expressed concern that the report was not accessible to most due to the terminology used and focus on the integration of services rather than the individual patient. The Chief Executive continued to highlight concerns that agencies may work in silos and that health care and social care could easily be segregated from other issues such as independence or resilience. The Acting Director of Adult Social Services acknowledged that the terminology used in the report was not user friendly however noted that the ethos of the project was based around the patient rather than services. He continued to explain that work was required outside of the health and social care remit to address issues such as loneliness and security which could affect a persons' health long term although it was unclear at this stage how this could be achieved. Brent Healthwatch noted that examples of best practice from the other boroughs forming part of the Pioneer bid needed to be fed in and utilised.

Phil Porter explained that the Integration Transformation Fund (ITF) was meant as a catalyst for integration with small amounts of funding being transferred from the NHS to local authorities for the purpose of adult social care and health care integration to act as a base budget to respond to issues. He continued to explain that the budget would increase over the next three years from £900m nationally to £3.8bn however the conditions in which the money can be used will also subsequently change and require a collaborative approach from all partners to ensure it would be paid.

RESOLVED:

The Health and Wellbeing Board:

(i) Noted the regional (Pioneer/Whole Systems Integrated Care) and national (Integration Transformation Fund) framework

(ii) approved the approach currently being developed to develop and deliver health and social care integration and the Integration Transformation Plan for Brent

(iii) agreed the Section 256 document for submission to NHS England as the first step in the Integration Transformation Fund process.

6. **Any other urgent business**

None.

The meeting closed at 8.00 pm

E KONG
Vice Chair

Brent	**Health and Wellbeing Board** **26th February 2014** **Report from the Assistant Chief Executive**
For Action	Wards Affected: ALL

Brent Child Death Overview Panel Letter to Health and Wellbeing Board

1. Summary

1.1 Dr Arlene Baroda, chair of the Brent Child Death Overview Panel (CDOP), has written to the Brent Health and Wellbeing Board regarding two deaths in Brent that it has reviewed as preventable. The CDOP wanted to draw the Board's attention to these cases and consider ways that the Board will be working to prevent suicide amongst young people, particularly teenagers, and road traffic accidents involving school age children. The letter from Dr Baroda, and a response from Cllr Ruth Moher are appended to this report.

1.2 Dr Baroda will be at the Health and Wellbeing Board to give an overview of the CDOP's concerns. The Board should listen to the panel's views and consider whether enough is being done in Brent to address the issues raised.

2. Recommendations

2.1 The Health and Wellbeing Board is recommended to:

(i). Consider the letter from Dr Arlene Baroda, chair of the Brent Child Death Overview Panel and how it wishes to take forward the issues it raises.

Contact Officer:

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NHS
Brent
Clinical Commissioning Group

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Wembley Centre for Health & Care
116 Chaplin Road
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Middlesex
HA0 4UZ
Tel: 020 8795 6399
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3 December 2013

To Cllr Ruth Moher and Dr Ethie Kong
Health and Wellbeing Board in Brent

Preventing Child Deaths – Linking: Brent Local Safeguarding Children Board (Child Death Overview Panel) and Brent Health and Wellbeing Board

The Brent Child Death Overview Panel, a subgroup of the LSCB, wish to partner the 'Brent Health and Wellbeing Board' in reducing child deaths and morbidity in our Borough, especially in the cases that have been reviewed as 'preventable'.

At the Child Death Overview panel meeting held on 6 November 2013 we reviewed two such cases:

The first was a 14 year old boy who died by hanging in April 2012.The coroner gave a verdict of *suicide* at the inquest. The case was also the subject of a Serious Case Review (as per Working Together to Safeguard Children 2010) and is available on the LSCB website[1]. The panel have endorsed the recommendations of the coroner and of the SCR. The public health recommendation from the health action plan is that:
Suicide prevention especially for teenagers should be part of the boroughs suicide prevention work that should be progressed by partner agencies, including health.

The second was a 11 year old boy who was killed in a road traffic accident in 2008 on a busy motorway in Brent. The panel spoke about bringing back 'the green cross code' and requests that the Boards prioritise *accident prevention work in school age children, especially in children with special needs.*

We await feedback from the Board.

Dr Arlene Boroda
Consultant Paediatrician
Acting Chair of Brent CDOP

[1] Brent SCR Child H:
http://www.brentlscb.org.uk/main/article.php?tag=serious_case&name=role&sector=Home

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HA0 4UZ

11th December 2013

Dear Dr Baroda

Preventing Child Deaths – Linking Brent Local Safeguarding Children Board (Child Death Overview Panel) and Brent Health and Wellbeing Board

I am responding to your letter dated 3rd December on the findings from the Child Death Overview Panel Meeting on the 6th November.

As chair of the Health and Wellbeing Board I am concerned that suicide prevention for young people is taken forward by the council and its partners in the health and voluntary sectors in Brent. One of the objectives in the borough's Health and Wellbeing Strategy is to focus on early identification and intervention for children with mental health problems. It is within this work stream that I would expect partners to be addressing suicide prevention for teenagers

With regards to the CDOP's second concern, that we prioritise accident prevention work in school age children, especially in children with special needs, I am reassured that the rate of children killed or seriously injured in road traffic accidents is significantly better in Brent than the England average as measured by analysis of road traffic collision statistics for Greater London and the UK. Brent remains one of the top performing boroughs with respect to reductions in total road casualties. Our Greater London target for reducing numbers of people killed or seriously injured by 50% was met some years ago and we are now revisiting our target to project a more challenging goal.

The council has a Safety and Travel Planning team who are responsible for road safety in Brent. The team aims to visit every school at least once a year to carry out a road safety presentation for pupils and to discuss road safety with school staff representatives. The team encourages schools to develop a school travel plan and works with them to continually improve their plan. If there are any concerns about safety outside the school the council can apply for funding from TfL to take action.

With regards to education the team promote many initiatives including children's traffic club with nurseries and some schools have Junior Road Safety Officers who carry out many activities throughout the year. They also run a programme of free cycle training for school children and adults and work towards ensuring that as many pupils as possible receive cycle training each year.

Despite Brent's strong record on accident prevention, I would like to draw your Panel's conclusions to the wider attention of the Health and Wellbeing Board (not least because they deal with two very important issues). Therefore I propose putting the letter on the Board agenda when it meets on the 26th February 2014. Officers will be in touch separately to confirm the arrangements for this.

Yours sincerely,

Councillor Ruth Moher
Deputy Leader of the Council
Labour Councillor for Fryent

Brent	**Health and Wellbeing Board** **26th February 2014** **Report from the Director of Adult Social Care**
For Action	Wards Affected: ALL

Brent Better Care Fund Plan

1. Summary

1.1 The draft Better Care Fund Plan has been submitted to NHS London for comments and analysis. The Health and Wellbeing Board is asked to consider the plan and the schemes within it, ahead of its finalisation by 4th April 2014.

2. Recommendations

2.1 The Health and Wellbeing Board is recommended to consider the draft Better Care Fund Plan and comment on the schemes proposed ahead of its finalisation by April 2014.

3 Report

3.1 The Health and Wellbeing Board has previously considered a report on Health and Social Care Integration and the Better Care Fund (previously known as the Integration Transformation Fund). Since December, when the Board last considered this issue, work has continued on the Better Care Fund Plan and a draft has been submitted to NHS London and local government teams for analysis and comment, prior to submission of the final document by 4th April.

3.2 The Board will be aware that the Better Care Fund is a single pooled budget to support health and social care services to work more closely together. In previous years the NHS has transferred funding to councils with the aim of protecting adult social care and promoting health and social care integration. Clear objectives were set nationally for the funding, but there was flexibility for local areas to determine how this investment is best used. In 2013/14 the rules for the transfer of this funding have changed. The focus for the funding is still the same, but instead of the funding being agreed by the council and the CCG, there is now a requirement for the Health and Well being Board to approve the approach and recommend sign off to NHS England, who will release the funds. At the meeting in December, the Board approved the Section 256 agreement for this purpose.

3.3 The Health and Wellbeing Board should see the agreement of the Section 256 agreement as the first step towards the implementation of the Better Care Fund, which goes fully live in 2015/16. The funding targeted at transforming health and social care to deliver genuine integration is increasing over the next three years from:

- 2013/14: £900m nationally - £4.8m in Brent
- 2014/15: £1.1bn nationally – local allocations to be issued in December
- 2015/16: £3.8bn

3.4 The Board will recall that the Better Care Fund is not new money. As already described the £900m nationally for 2013/14 (£4.8m in Brent) is part of the adult social care base budget. There is an additional £0.2bn nationally in 2014/15, but is expected that this will relate to current funding. In 2015/16 the £3.8bn nationally will be made up of: a range of existing funds that are added to the integration pot, including:

- £1.1bn which makes up the budget for 2014/15
- £130m carers breaks funds
- £354m capital funding to include £222m Disabled Facilities Grant
- £300m CCG Reablement monies
- £1.9bn nationally, which will be provided through a top slice of 3% of the CCG budget which equates to £15.8m for Brent (MTFS 25/9/13) by 2015/16 without a corresponding reduction in spend.

3.5 As the pot grows over the next two years, the rules for the use of the money change. The Better Care Fund provides a minimum set of indicators to provide focus and against which success will be measured:

- Permanent number of admissions to residential care
- Number of older people who receive reablement and rehabilitation services and are still at home after 91 days
- Numbers of delayed discharges from hospital
- Avoidable emergency admissions

3.6 However, these are system indicators, proxies for improvements in quality of life, but not necessarily recognised by service users. There also needs to be a clear focus on customer experience and perception. This will be done in three ways:

1. Embed outcomes in care plans and review progress to them
2. Put in place ongoing monitoring of experience – jointly across health and social care
3. Link to annual surveys: for example, Adult Social Care survey:
    - Percentage of people who are satisfied with the care and support they receive
    - The proportion of people who feel they have choice and control over their lives
    - Social care related quality of life index.

3.7 The draft Better Care Fund plan (which is appended to this report) sets out details of the schemes that have been developed that will enable the council, CCG and partners meet its objectives for the fund. In simple terms, there are two broad objectives that neatly summarise the ambitions for health and social care integration -

- To reduce the use of residential care and enable people to remain healthy and independent in the community.
- To reduce hospital admissions and the length of time people stay in hospital.

3.8 Three of the schemes in Better Care Fund Plan contribute directly to these objectives and form a whole system response aimed at reducing hospital admission, the length of time a patient has to stay in hospital if they are admitted, and more planned and proactive care, based in the community. Those schemes are:

- Keeping the most vulnerable well in the community
- Avoiding unnecessary hospital admissions
- Effective multi agency hospital discharge

3.9 The fourth scheme is Mental Health Improvement, which is a local priority and will contribute to the overarching aims and objectives. However, it is acknowledged that it doesn't neatly fit into a system approach as the other schemes do.

3.10 The fifth scheme is a range of enabling programmes that will help us deliver system change. We accept that organisations can't keep working in the same way under the BCP banner and expect improvements to happen. All of the participating organisations have to buy into the vision for health and social care and be prepared to adapt to make change happen. In Brent we believe that we are progressing in this regard and that partners are signed up to the integration agenda to improve health and social care services.

3.11 The Health and Wellbeing Board should considered the draft Better Care Fund Plan and comment on the objective and schemes. Ultimately the Board will have to approve a final version of the plan. The intention is to hold a development session on health and social care integration in March 2014 to assist with this.

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Project Manager
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Director:

Phil Porter, Director of Adult Social Care

Attached papers –

- Better Care Fund Presentation
- Draft Better Care Fund Plan
- Better Care Fund Plan finance templates

Health and Social Care Integration

Producing Brent's Better Care Fund Plan

Health and Wellbeing Board

26 February 2014

Phil Porter

Brent

www.brent.gov.uk

Objectives

Today's presentation

- Provide context – health and social care integration in NWL - Whole Systems Integrated Care (WSIC)
- Outline key features of the Better Care Fund plan: what it is/what it isn't
- Outline key schemes proposed to be part of the Better Care Plan
- Governance and next steps

NWL Whole Systems Integrated Care

Vision and Principles

Our shared vision of the WSIC programme …

> We want to improve the **quality of care** for individuals, carers and families, **empowering and supporting** people to maintain independence and to **lead full lives** as active participants in their community

… supported by 3 key principles

1. People will be empowered to direct their care and support and to receive the care they need in their homes or local community.
2. GPs will be at the centre of organising and coordinating people's care.
3. Our systems will enable and not hinder the provision of integrated care.

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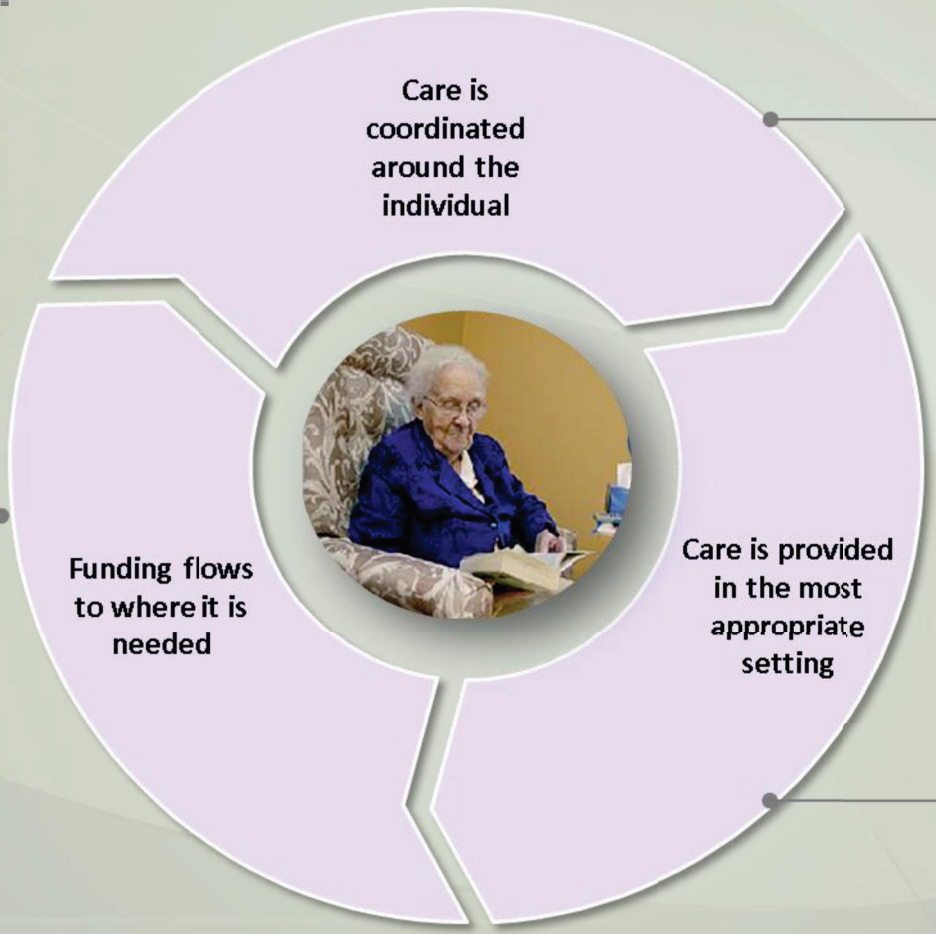
NWL Whole Systems Integrated Care

Achieving improved outcomes



- Joined up health and social care
- Organise around people's needs not historic organisational structures
- There is one set of records shared across organisations

- More investment in primary and community care
- Social care and mental health needs considered holistically with physical health and care needs
- Less spending on acute hospital based care and other institutional care (residential and nursing care)

- Multidisciplinary home care teams
- Fewer people are treated in hospital, and those that are leave sooner
- More specialist support in the community, so people can live independently in their own home

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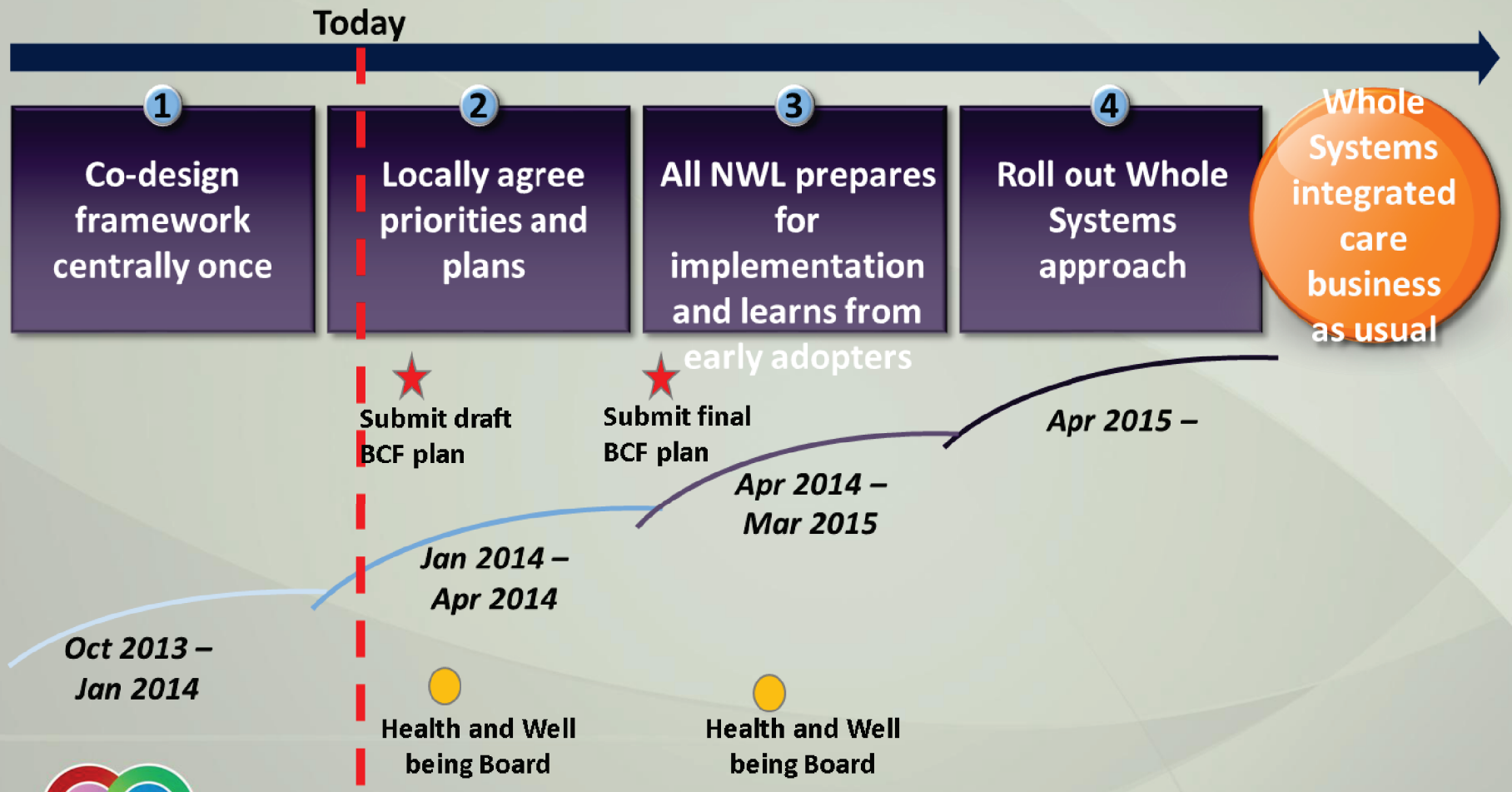
NWL Whole Systems Integrated Care

Timescales



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Brent's Better Care - overview

What it is / what it isn't

Department of Health/Department of Communities and Local Government letter on Better Care Fund Plan:

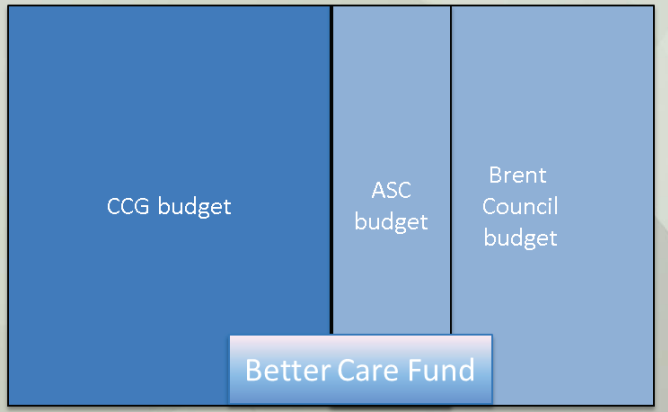
> ***"the biggest ever financial incentive for councils and local NHS organisations to jointly plan and deliver services, so that integrated care becomes the norm by 2018."***

What it is?

- Significant opportunity to drive health and social care integration (national deadlines)
- It is a significant amount of money: 2014/15 – in Brent £6.1m / 2015/16 - in Brent £19.9m
- Protect social care / continued focus on moving money from acute to community

What it isn't?

- It is not new money. It is in ASC, housing and CCG base. But we can incentivise efficiency (10%)
- It is only 5% of ASC and CCG budgets. How does it lever further efficiencies and change? Reduce residential
- It is not guaranteed funding: 25% is performance linked – 50% paid at the start of the year, 50% paid on achievement of targets.



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Better Care Fund - overview

How will we know we have delivered?

The Better Care Fund provides a minimum set of indicators to provide focus:

- Permanent number of admissions to residential care
- Number of older people who receive reablement and rehabilitation services and are still at home after 91 days
- Numbers of delayed discharges from hospital
- Avoidable emergency admissions

The DH has also produced the Statistical Significance Calculator which will set targets for us.

However, these are system indicators, at best proxies for improvement in quality of life. We also need to keep a clear focus on customer experience and perception. We are proposing to do this in 3 ways:

1. Embed outcomes in the care plan and review progress to them
2. Put in place ongoing monitoring of experience – jointly across health and social care
3. Link to annual surveys: for example, Adult Social Care survey:
    - Percentage of people who are satisfied with the care and support they receive
    - The proportion of people who feel they have choice and control over their lives
    - Social care related quality of life index.

Brent's Better Care Fund - Brent

Client group focus, not organisational focus

Age	Mostly healthy	Defined episode of care	Single LTC	Multiple LTC	Cancer	Serious and enduring mental illness	Learning disability	Advanced stage organic disorders	Socially excluded groups
0-15 (Children)	• The programme is currently not focused on integrated care for children • There may be innovative care models that we could trial, but that would be the focus of a future phase								
16-74	1 Mostly healthy adults		3 Adults with one or more long term conditions		5 Adults and elderly people with cancer	6 Adults and elderly people with SEMI	7 Adults and elderly people with learning disabilities	8 Adults and elderly people advanced stage organic disorders	9 Homeless people, alcohol and drug dependencies
75+	2 Mostly healthy elderly people		4 Elderly people (incl. frail) with one or more long term conditions						

Better Care Fund - Brent

Scheme 1: Keeping the most vulnerable well in the community

Support in the community is fragmented. This scheme would bring services together to deliver a shared goal.

Objective: help people to live in their own homes in the community and improve their quality of life.

Core components of the scheme:

- A focus on the 2-3% most vulnerable in the community (approximately 1800 people per GP network)
- Different levels of integrated case management resource across the 1800 to provide the whole person support
- GPs, social care, community nursing and voluntary sector – single care plan, shared goal
- Extended GP network out of hours provision, until 10pm, and homes visits, out of hours from the network.

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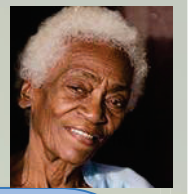
Tom is 61 and lives with, and cares for his mother, Jean, who is 84. They want to continue to live together, but Tom admits to be being depressed about his situation.

Over the last 12 months, Tom has been to A&E twice because he was 'out of breath' and was admitted once (Jean then had to go to respite care) and there has been a SGA alert against Tom because of his anger towards his mother.

In the future, Tom and Jean would each have an integrated care plan. Tom and Jean's social worker would take the lead as their health needs are being managed. The SW would have regular contact with them. They would liaise with the GP, but focus on ensuring the support is in place from the LA/voluntary sector, so Tom and Jean can continue to live safely together.

Better Care Fund- Brent

Scheme 2: Avoiding unnecessary hospital admissions



Even when care in the community is integrated there will be crises. This scheme is focused on managing the crises and responding proportionately.

Objective: to respond proportionately to crises, avoid A&E attendances and unnecessary hospital admissions.

Core components of the scheme:

- Effective referrals at time of crises from all parts of the system (particularly GPs and London Ambulance Service)
- 7 day integrated rapid response service including nurses, physios, OTs and social workers
- All staff able to put in place the right combination of support from health, social care and voluntary sector immediately.

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Alice is 76 years old. She suffers from multiple long-term conditions (LTCs) and lives alone. She doesn't get out and she has no family close by.

Over the last 12 months, Alice has had 5 A&E attendances, which resulted in 2 unnecessary emergency admissions. Despite fact she had 9 outpatient, 23 GP contacts, District Nurses twice a week and carers twice a day

In the future, the Integrated Rapid Response Service (IRRS) would be alerted by the London Ambulance Service. IRRS would have access to Alice's integrated care plan and they would be able to put in a range of services. Not only the nurse/physio 'bridging' service they currently provide, but also social and voluntary sector support that best meets Alice's need.

Better Care Fund - Brent

Scheme 3: Effective multi-agency hospital discharge

Even when care in the community is integrated, and there is effective admission avoidance, some people will still need to go to hospital, so it is important people get the right support when they are discharged from hospital.

Objective: Streamline the discharge process to reduce delays, and integrate it to ensure it links effectively back into the single care plan in the community

Core components of the scheme:

- 7 day discharge service – same quality of service 7 days a week
- Delivered by a single team made up of NWLHT hospital discharge co-ordinators, social care discharge team and CHC nurses
- Links straight back to the community and an integrated care plan with a lead professional if required, and wider support from family, community and voluntary sector

Brent

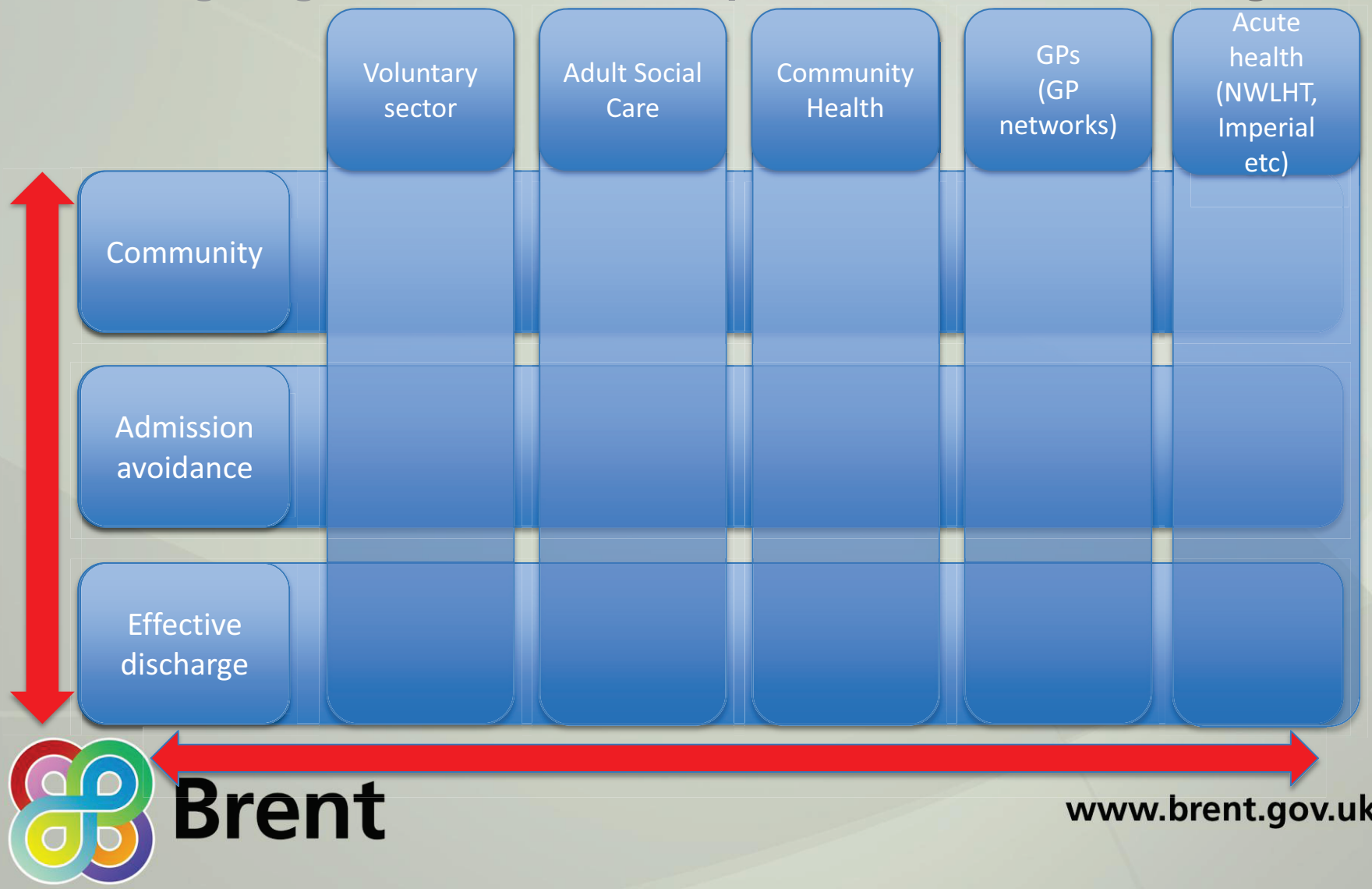
Anjali is 87 years old. She has family, but they do not provide day to day support.

Over the last 12 months, Anjali used to receive home carer used twice a day, DN once a week, as well as frequent GP appointments to manage her 3 LTCs. Anjali had 3 unnecessary emergency admissions all within a 2 month period. The final admission led to an increase in social care, additional nursing support to manage anxiety.

In the future, the Integrated Discharge Service would provide an integrated assessment of all of her needs, ensuring the full range of health, social care and voluntary sector support were in place for discharge. They would also prioritise her referral to the community network, so that a sustainable integrated care plan could be put in place.

Better Care Fund - Brent

Tackling fragmentation: across providers, across settings



Brent

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Better Care Fund - Brent

Scheme 4: Mental Health

This scheme links to the paper going to Executive on 17 February. Work has just begun on the detail of the next 12 months in anticipation of the decision at Executive, but the key planned features are…

Objective: Implement a health and social care 'Recovery Pathway', which supports people with a severe and ensuring mental health illness to lead independent lives in the community (and evidences a significant reduction in the use of institutional care)

Core components of the service:

- A consistent and comprehensive focus on recovery and independence (across social care and secondary health support)
- Joint commissioning (Brent Council and Brent Clinical Commissioning Group) of a local, Brent focused, health and social care service
- Redesign of JDs and teams in Brent to deliver the above

The long term aim is to extend and fully integrate this approach with primary care.

Brent

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Better Care Fund - Brent

Scheme 5: Key Enablers

This scheme recognises the scale of change that is required, and the range of wider changes that are necessary to underpin and deliver all of the previous schemes.:

1. It recognises that success is dependent on successful commissioning (market development) of a wider range of services and support to meet people's individual needs. For example, a range of integrated rehabilitation and reablement services (intensive step down after hospital, residential reablement and 6 week community bases, for example)

2. It recognises the need to have an IT strategy that supports integration rather than consolidating organisational boundaries.

3. And most importantly of all, it recognises the need for significant cultural change so that we build a single system of equals (professionals and customers) focused on delivering a shared goal as set out at the start of this presentation: improve the **quality of care** for individuals, carers and families, **empowering and supporting** people to maintain independence and to **lead full lives** as active participants in their community.

Brent

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Next steps

Ensuring an inclusive approach within tight timescales (1)

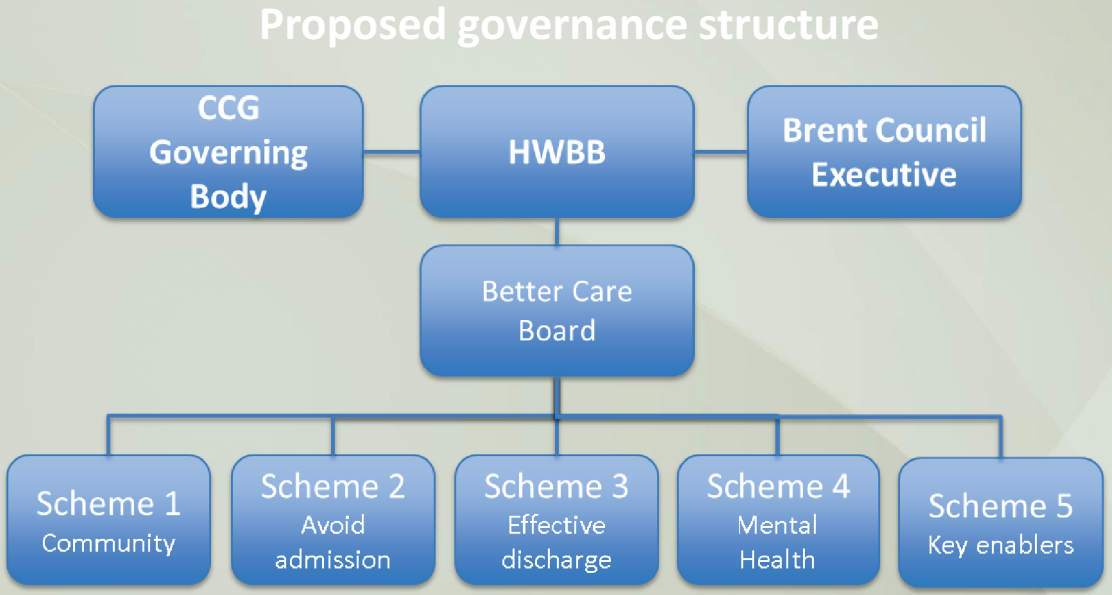
Governance:

Current co-production:

- Brent Integration Board has representatives from the CCG, council, health providers and voluntary sector
- Worked closely to develop the schemes.

Proposal for programme delivery:

- An overarching commissioner led strategic Better Care Board
- Individual scheme working groups
- Clear links back to HWBB and existing decision making bodies.



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Next steps

Ensuring an inclusive approach within tight timescales (2)

Next steps:

- Health Partners Forum (12 February)
- Draft BCF submitted to the Department of Health by 14 February (sign off within organisations)
- Detailed discussion at the HWBB on 26 February
- Re-scheduled HWBB at the end of March to sign off final submission
- Final plan, including timescales and an implementation programme, to be ready by 4th April.

Brent

Better Care Fund planning template – Part 1

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Brent Council**
Clinical Commissioning Groups	**Brent Clinical Commissioning Group**
Boundary Differences	**not applicable**
Date agreed at Health and Well-Being Board:	**Draft to be considered on 26/2. Final Plan to be approved on date tbc**
Minimum required value of BCF pooled budget: 2014/15	**£6,155,585**
2015/16	**£19,832,000**
Total agreed value of pooled budget: 2014/15	**£6,155,585**
2015/16	**£22,455,585**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	**Brent CCG**
By	**Jo Ohlson**
Position	**Chief Operating Officer**
Date	**<date>**

Signed on behalf of the Council	**Brent Council**
By	**Phil Porter**
Position	**Director of Adult Social Care**
Date	**<date>**

Signed on behalf of the Health and Wellbeing Board	**Brent Health and Well Being Board**
By Chair of Health and Wellbeing Board	**Cllr Ruth Moher**
Date	**<date>**

b). Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

This plan builds on a number of existing programmes within North West London which have included health and social care providers as well as our voluntary and community sector organisations as a collective.

Consultations shaping these programmes can be found in Shaping a Healthier Future, our Out of Hospital Strategy and Living Longer and Living Well, our application to become an Integrated Care Pioneer.

In Brent, this plan has been developed with extensive involvement of service providers and partners through the Brent Integration Board. Providers and commissioners have worked collaboratively through this forum to develop a shared vision and innovative service models aligned to the aims and outcomes of the Better Care Fund planning principles.

The Brent Integration Board is collectively accountable to the Brent Health and Wellbeing Board. Its main purpose is to provide local system wide leadership and accountability for delivery of integration within Brent's health and care economy. The Brent Integration Board's purpose is to design and implement the vision and direction for integrated care as set out by the Health and Well Being Board and in alignment with the principles of the Better Care Fund.

It will provide advice and recommendations to the Health and Wellbeing Board and seek its support in achieving rapid and dynamic change. It will be informed by Brent Health and Wellbeing Board, along with national priorities, local priorities, communities, users of services and clinical priorities.

The Integration Board's membership is diverse comprising a wide range of partners and providers:

- NHS Brent CCG
- Brent Council
- NWLH NHS Trust
- Central and Northwest London Foundation Trust
- Imperial NHS Trust
- Royal Free Hospital
- Ealing Integrated Care Organisation
- Brent Healthwatch
- Outer Integrated Care Pilot representatives
- NHS Brent CCG GP Member Practice representatives
- Brent Community and Voluntary Sector (CVS)

c) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

Our vision for whole system integrated care is based on what people have told us is most important to them.

Through patient and service user workshops, interviews and surveys across North West London (NWL) we know that people want choice and control. They want their care to be

planned with people working together across the statutory sector and with voluntary and community organisations, to help them reach their goals of living longer and living well and ensuring that quality of life is sustained and improved. They want their care to be delivered by people and organisations that show dignity, compassion and respect at all times.

Brent's aspiration is for all plans to be truly co-produced with the lived experience of service users and their carers. This will be central to the way that personalised health and social care services will be commissioned and delivered in the future, focussing on achieving individual outcomes in partnership with the community. To do this we have established a Patient and Public Representative Group comprising CCG Patient and Public Involvement lay members, representatives from Healthwatch, the voluntary and community sector and from service user and carer groups to ensure that the patient perspective is reflected within integrated care programmes, as they develop.

At a borough and CCG level, service users and carers are involved and engaged through a variety of regular engagement events:

- Joint Brent CCG, Brent Council and Council for Voluntary Service Brent (CVS Brent) Health Partners Forum are well attended with over a hundred representatives of patients, carers and voluntary and community sector organisations attending these events.
- On-going discussions between CVS Brent**,** the Council and CCG regarding how the voluntary and community sector engages with whole systems integrated care models being developed.
- Engagement with specific user groups in Brent, e.g. the Brent Council Adult Social Care Service Users Group, Pensioners Forum and Carers Group
- Engagement with Brent CCG's Equality, Diversity and Engagement Committee (EDEN) that includes representative from – most of the protected group as well as wider engagement at locality level patient participation groups via GP networks.

We are also considering a broader range of activities including building community capacity particularly in working closely with the voluntary sector and local enterprises to work in support of health and social care provision to vulnerable people within Brent. Working in partnership with Brent Healthwatch to deliver this will be central to our aims.

d) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

The following table lists the documents that underpin this submission, together with a brief summary of each.

Ref	Document	Synopsis
D1	*Joint Strategic Needs Assessment (JSNA)*	Joint local authority and CCG assessments of the health needs of the Brent population in order to improve the physical and mental health and well being of individuals and communities.
D2	*Joint Health and Wellbeing Strategy (JWBS)*	The Joint Health and Wellbeing Strategy sets out the priorities and actions which the Health and Wellbeing Board are planning to carry out in the period 2013 to 2016

Ref	Document	Synopsis
D3	*Out of Hospital Strategy*, Brent CCG, May 2012	The CCG's strategy to develop services in the community and focus on self-care, early diagnosis and high quality management of long term conditions, and the diagnosis and treatment of those with ambulatory emergency conditions in the community when appropriate. This would enable acute hospitals to focus on patients who are critically ill and those who require specialist investigations and interventions. At the heart of our vision is providing 'the right care, in the right place, with the right professional and at the right time'.
D4	*Commissioning Intentions 2014/15*, Brent CCG, January 2013	The CCG's commissioning intentions for 2014/15 which sets out the scope of commissioning improvements across a range of service areas.
D5	*Adult Social Care Local Account,* December 2013	The Local Account sets out details of the Adult Social Care Department's performance in 2012/13 and the Department's key challenges and achievements.
D6	*Adult Social Care Market Position Statement 2014,* Brent Council, January 2014	The MPS is for current providers of Accommodation based care and support services (ABCSS) who operate locally and for potential providers considering entering the market in Brent in an attempt to grow diversity in available service provision locally. The document sets out – • Current and predicted future demands on ABCSS locally. • A picture of current supply of ABCSS across Brent. What our strategic vision is, our commissioning intentions and models of service delivery we want to encourage in the local marketplace.
D7	*Living Longer, Living Well*, NWL Pioneer Application, June 2013	The vision for whole system integrated care in NWL, including that people, their carers and families will be empowered to exercise choice and control; GPs will be at the centre for organising and co-ordinating people's care; and systems will not hinder the provision of integrated care.
D8	*Shaping a Healthier Future*, NHS North West London, January 2012	The strategy for future healthcare services in NW London including how care will be brought nearer to people; how hospital provision will change, including centralising specialist hospital care onto specific sites so that more expertise is available more of the time; and how this will be incorporated into a co-ordinated system of care so that all the organisations and facilities involved in caring for the people of North West London can deliver high-quality care and an excellent experience.
D9	*Delivering Seven Day*	NW London's vision to be an early adopter for

Ref	Document	Synopsis
	Services, NHS North West London, November 2013	seven day services across health and care

2) VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

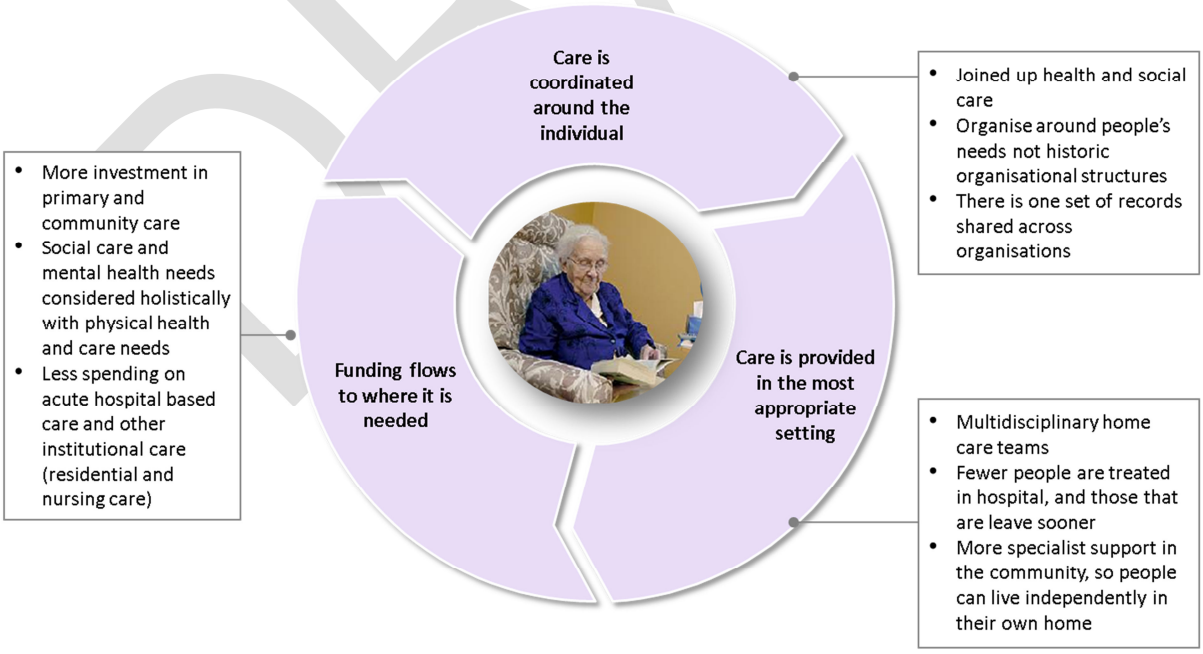
- *What changes will have been delivered in the pattern and configuration of services over the next five years?*
- *What difference will this make to patient and service user outcomes?*

In *Living Longer and Living Well*, our application for Pioneer status, we set out our strategy for developing person-centred, co-ordinated care in North West London. We want to improve the quality of care for individuals, carers and families, empowering and supporting people to maintain independence and to lead full lives as active participants in their community. This vision is supported by three key principles:

1. People will be empowered to direct their care and support and to receive the care they need in their homes or local community.

2. GPs will be at the centre of organising and coordinating people's care.

3. Our systems will enable and not hinder the provision of integrated care. Our providers will assume joint accountability for achieving a person's outcomes and goals and will be required to show how this delivers efficiencies across the system.



In developing the Better Care Fund Plan, we have considered what these principles mean for Brent and what we will change locally to improve the quality of care and empower people

to maintain independence. We have developed five schemes which considers the enablers required to help us achieve our vision.

In simple terms, there are two broad objectives that we are working towards which neatly summarise our ambitions for health and social care integration –

- To reduce the use of residential care and enable people to remain healthy and independent in the community.
- To reduce hospital admissions and the length of time people stay in hospital.

Three of the schemes in this plan contribute directly to these objectives and form a whole system response aimed at reducing hospital admission, the length of time a patient has to stay in hospital if they are admitted, and more planned and proactive care, based in the community. Those schemes are:

- Keeping the most vulnerable well in the community
- Avoiding unnecessary hospital admissions
- Effective multi agency hospital discharge

Our fourth scheme is Mental Health Improvement, which is a local priority and will contribute to the overarching aims and objectives. However, it is acknowledged that it doesn't neatly fit into a system approach as the other schemes do.

Our fifth scheme is a range of enabling programmes that will help us deliver system change. We accept that organisations can't keep working in the same way under the BCP banner and expect improvements to happen. All of the participating organisations have to buy into the vision for health and social care and be prepared to adapt to make change happen. In Brent we believe that we are progressing in this regard and that partners are signed up to the integration agenda to improve health and social care services.

We have developed a series of case studies to show how we expect our vision for health and care to services to improve services for patients –

Tom

Tom is 61 and lives with, and cares for his mother, Jean, who is 84. They want to continue to live together, but Tom admits to be being depressed about his situation.
Over the last 12 months, Tom has been to A&E twice because he was 'out of breath' and was admitted once (Jean then had to go to respite care) and there has been a SGA alert against Tom because of his anger towards his mother.

In the future, Tom and Jean would each have an integrated care plan. Tom and Jean's social worker would take the lead as their health needs are being managed. The SW would have regular contact with them. They would liaise with the GP, but focus on ensuring the support is in place from the LA/voluntary sector, so Tom and Jean can continue to live safely together.

Alice

Alice is 76 years old. She suffers from multiple long-term conditions (LTCs) and lives alone. She doesn't get out and she has no family close by. Over the last 12 months, Alice has had five A&E attendances, which resulted in two unnecessary emergency admissions. This is despite the fact she had nine outpatient appointments, 23 GP contacts, District Nurses support twice a week and carers twice a day.

In the future, the Integrated Rapid Response Service (IRRS) would be alerted by the London Ambulance Service. IRRS would have access to Alice's integrated care plan and they would be able to put in a range of services. Not only the nurse/physiotherapist "bridging" service they currently provide, but also social and voluntary sector support that best meets Alice's need.

Anjali

Anjali is 87 years old. She has family, but they do not provide day to day support.
Over the last 12 months, Anjali has received home carer support twice a day, District Nursing once a week, as well as frequent GP appointments to manage her three LTCs. Anjali had three unnecessary emergency admissions all within a two month period. The final admission led to an increase in social care and additional nursing support to manage anxiety.

In the future, the Integrated Discharge Service would provide an integrated assessment of all of her needs, ensuring the full range of health, social care and voluntary sector support were in place for discharge. They would also prioritise her referral to the community network, so that a sustainable integrated care plan could be put in place.

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- *What are the aims and objectives of your integrated system?*
- *How will you measure these aims and objectives?*
- *What measures of health gain will you apply to your population?*

Across NWL, we have identified the following aims and objectives for our integrated system:

- Care is coordinated with the service user and his or her social network at the centre, and avoids unnecessary duplication of services

- Care is provided in a way that empowers service users and helps them to manage their own care
- The service user experience of health and social care is seamless
- Service users get care that is uniquely tailored to their needs, and nobody feels that they have been given a "one size fits all" model that is unsuitable for them
- Providers communicate across organisational boundaries and share information about cases before it is specifically requested

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

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

In developing these principles, we are conscious of the overarching objectives in the borough's Health and Wellbeing Strategy, in particular –

- Empowering communities to take better care of themselves
- Improving mental wellbeing throughout life
- Working together to support the most vulnerable adults in the community

These objectives are an important influence on our approach to integrated health and social care and what we are seeking to achieve through the Better Care Fund.

The measures that we will use to measure impact of the changes to our service delivery models will be based on the Better Care Fund metrics and patient experience measures that are gained from the integrated services we will jointly commission:

- Permanent number of admissions to residential care
- Number of older people who receive reablement and rehabilitation services and are still at home after 91 days
- Numbers of delayed discharges from hospital
- Avoidable emergency admissions

These are system indicators which do not directly measure improvements in quality of life. We also need to keep a clear focus on customer experience and perception. We are proposing to do this in three ways:

1. Embed outcomes in the care plan and review progress to them
2. Put in place ongoing monitoring of experience – jointly across health and social care
3. Link to annual surveys in Health and Social Care. For example, the Friends and Family Test, which is used in acute hospitals and the Adult Social Care survey which measures:
    - Percentage of people who are satisfied with the care and support they receive

- The proportion of people who feel they have choice and control over their lives
- Social care related quality of life index.

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- *The key success factors including an outline of processes, end points and time frames for delivery*
- *How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care*

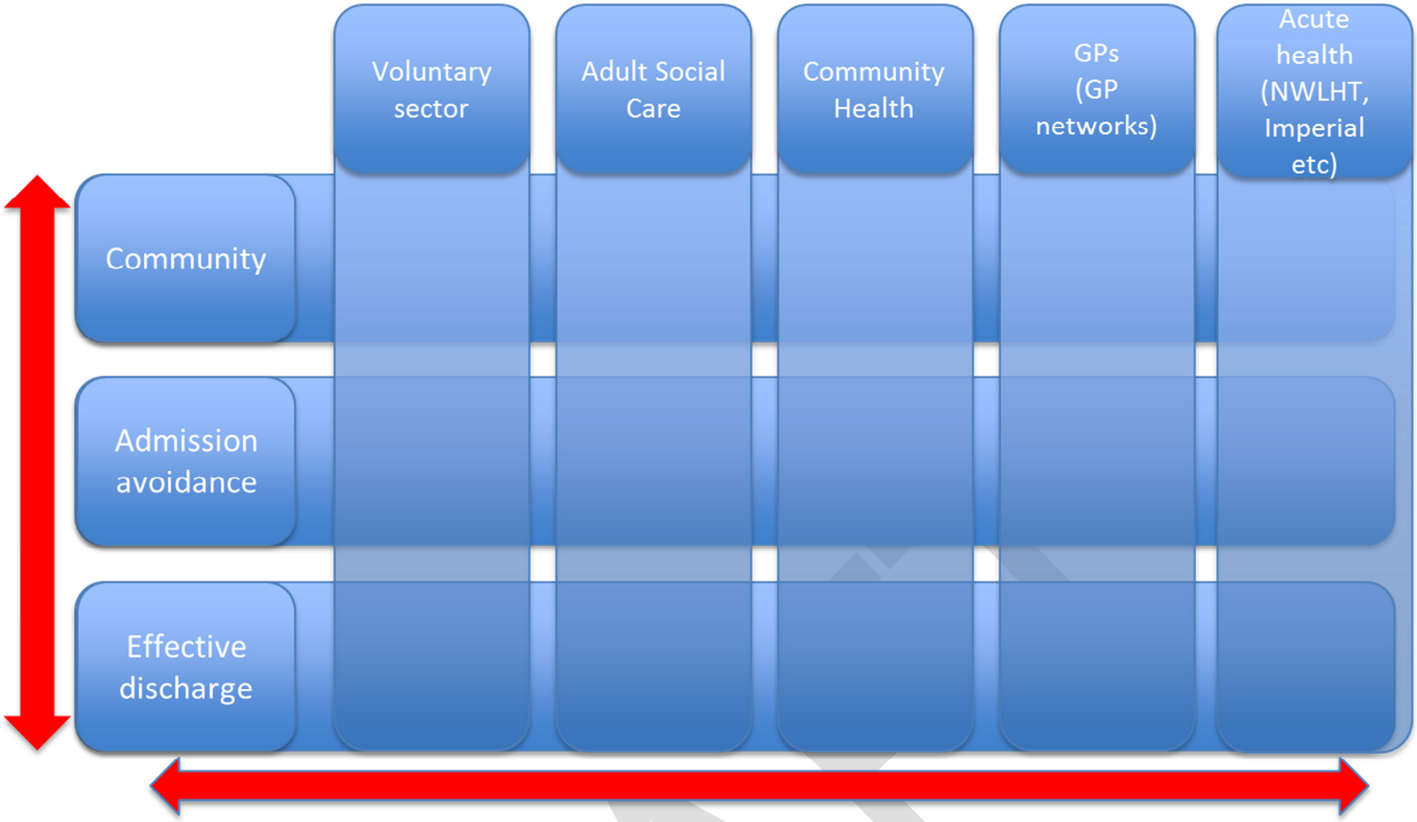
We recognise the scale and challenge of achieving our vision and that this will mean significant change across the range of health and care providers in Brent. Although GPs will play an instrumental role, all providers will need to deliver services differently. To this end, the CCG and Council commissioners are committed to working together to create and effect the required behavioural changes required across health and care sectors.

Brent Whole Systems is about developing anticipatory care management services and episodic care models across population groups, ensuring person centred and coordinated care for people who need:

- Complex health and care services, for example those over 75 and those with long term conditions requiring multidisciplinary configurations through GP networks.
- Episodic health and care services which will require redevelopment of primary and urgent care to provide high quality, rapid access to transactional care services.
- A coordinated and seamless access to health and care services which occurs at the same time to assess holistic needs and reduce unnecessary transfers of care.
- 24/7 provision of care that maintains continuity and provides assurances for carers and patients
- Support across traditional organisational boundaries, involving voluntary, community and private sector provider care models
- Support from carers to remain well in the community

There are a number of schemes that support the overall vision for Health and Social Care. Some of these are schemes that will result in specific changes to services, with tangible outcomes for service users. Others are enabling schemes, which will support us as we work to integrate health and social care.

Fundamentally, through these schemes we aspire to tackle fragmentation across providers and across settings to ensure the best outcomes and noticeable improvements to patient experience.



Service development schemes -

Scheme 1 - Keeping the most vulnerable well in the community

Scheme Objective – To help people to live in their own homes in the community and improve their quality of life

Key benefits -

- Performance: Reduced hospital admissions for a pre identified cohort of patients; reductions in the numbers of people in residential care
- Financial: cost of hospital admissions, reduced operational costs, reduced cost of community care
- Outcomes: better quality of life in the community

Core components of the scheme –

- A clear focus on the 2-3% most vulnerable in the GP network (approximately 1800 people per GP network)
- Different levels of integrated case management resource across the 1800 to provide the whole person support
- GPs, social care, community nursing and voluntary sector working to a single care plan and a shared goal for each patient
- MDGs (175 per year most complex) with a health and social care coordinator to monitor and ensure care plans are implemented

- Robust GP networks that are able to provide a single interface for multiple providers (social care, ICCS, community nursing) to agree a local model for delivering Brent wide outcomes
- Aligned case management and lead professional resources (from social work/community nursing/Integrated Care Co-ordination Service – ICCS) for next 325 most vulnerable
- Voluntary sector lead response for remaining 1300 to prevent or manage escalation
- Extended GP network out of hours provision, until 10pm, and homes visits, out of hours from the network.

Key changes –

- GP the accountable professional with support from hybrid workers
- Person centered - multi disciplinary Care Plans
- Health and Social Care Coordinators - development of a hybrid model of Health and Social Care Worker to case manage
- Each Network works with approximately 175 highly complex cases, 1800 complex cases - each patient has a Lead Professional and care coordination from a Health and Social Care Coordinator
- Single IT system / interoperability between systems
- Shared goals, shared culture, focus on the person (not the organisational priority)
- Social work staff embedded in the GP network
- Voluntary sector involvement that reflects the needs of the local community

Scheme 2 - Avoiding unnecessary hospital admissions

Scheme objective - To respond proportionately to crises, avoid A&E attendances and unnecessary hospital admissions.

Key benefits –

- Performance: metrics for reduced hospital admissions
- Financial: cost of hospital admissions – QIPP targets
- Outcomes: better quality of life at home

Core components of the scheme –

- Effective referrals at time of crises from all parts of the system (particularly GPs and London Ambulance Service)
- 7 day integrated rapid response service including nurses, physios, OTs and social workers
- All staff able to put in place the right combination of support from health, social care and voluntary sector immediately.

Key changes to services -

- Fully integrate social work into the Rapid Response service
- Direct access to community social care to avoid STARRS bridging
- Direct access to integrated short term rehabilitation and reablement services.

Scheme 3 - Effective multi agency hospital discharge

Scheme objective – Streamline the discharge process to reduce delays, and integrate it to ensure it links effectively back into the single care plan in the community

Key benefits -

- Performance: DTOCs, readmission rates
- Financial: lengths of stay (increased cost in the community)
- Outcomes:

Core components of the service -

- Social Care hospital discharge team
- Hospital discharge coordinators
- Continuing Healthcare assessors

Key changes to services -

- Single discharge worker and plan
- Faster discharge processes, which enable effective and efficient hospital discharge
- Better co-ordination of services, to care for service users in the community post discharge.

Scheme 4 - Mental Health Improvement

Scheme objective - Implement a health and social care 'Recovery Pathway', which supports people with a severe and ensuring mental health illness to lead independent lives in the community (and evidences a significant reduction in the use of institutional care)

Key benefits -

- Performance: Reduction in the use of residential care / reduction in the number of people using secondary mental health services
- Financial: Reduction in spend as a result of meeting 75% residential care target
- Outcomes: More service users recovering in community settings

Core components of the service -

- A consistent and comprehensive focus on recovery and independence (across social care and secondary health support)
- Joint commissioning (Brent Council and Brent Clinical Commissioning Group) of a local, Brent focused, health and social care service
- Redesign of JDs and teams in Brent to deliver the above

Key changes to services -

- Fewer service users in residential care

Scheme 5 - Key Enablers

These schemes recognise the scale of change that is required, and the range of wider changes that are necessary to underpin and deliver all of the previous schemes.

1. Enable care and support for carers and develop community capital, working with the community and voluntary sectors, to enable people to remain well in the community

2. It recognises that success is dependent on successful commissioning (market development) of a wider range of services and support to meet people's individual needs. For example, a range of integrated rehabilitation and reablement services (intensive step down after hospital, residential reablement and six week community bases, for example)

3. It recognises the need to have an IT strategy that supports integration rather than consolidating organisational boundaries.

4. And most importantly of all, it recognises the need for significant cultural change so that we build a single system of equals (professionals and customers) focused on delivering a shared goal as set out at the start of this presentation: improve the quality of care for individuals, carers and families, empowering and supporting people to maintain independence and to lead full lives as active participants in their community.

January – March 2014

- Develop locality integration plan, which sets out the scope of commissioners plans for integrated care, including target population, desired outcomes and budgets available, as well as providers responses
- Expression of Interest to become early adopter/accelerated learning site based on model of integrated anticipatory care via ICP II
- Develop expression of interest into outline business plan
- Confirming programme delivery governance
- Put in place programme implementation plan and project outline

March – April 2014

- Complete Whole Systems Expression of Interest application by April 2014

April 2014 – March 2015

- Complete Whole Systems Business Case by September 2014, including sign off by the Health and Wellbeing Board.
- Complete detailed planning to implement concepts developed during co-design phase to achieve our objectives
- Commence integrated care model as an accelerated learning site if successful or continue to plan implementation of model
- Monitor financial flows in shadow budgets to evaluate financial impact of possible models on different providers and on total cost to commissioners

From April 2015

- Use preparation from planning using co-designed materials and learning from accelerated learning sites to implement new models of care at scale with actual budgets attached

We will ensure other related activity is aligned by working in close collaboration with the seven other boroughs in northwest London (NWL) in co-designing approaches to integrating care. Our providers have a consistent approach from their different commissioners, and we are proactively sharing learning across boroughs.

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

Shaping a Healthier Future, and our Out of Hospital Strategy set out how we plan to reconfigure acute services to focus on the needs of our patients. These documents include analysis of the financial savings that will be delivered through improved out of hospital services reducing acute activity and a set of implementation plans up to 2018.

We have evaluated our proposed changes (together with other NWL boroughs) on the Value for Money criterion. This covered activity, capacity, estates and finance analyses, including commissioner forecasts, Trust forecasts, the out of hospital forecasts and the capital requirement to deliver the proposed changes. The analysis indicates that commissioner forecasts over the five years (across NWL) involve gross QIPP of £550m, with reinvestment in out of hospital services of £190m

The anticipated impact on NHS service delivery targets as a result of these changes will:

- reduce mortality through better access to senior doctors
- improve access to GPs and other services so patients can be seen more quickly and at a time convenient to them
- reduce complications and poor outcomes for people with long-term conditions by providing more coordinated care and specialist services in the community
- ensure less time is spent in hospital by providing services in a broader range of settings

Consequently, the impact on NHS service delivery targets in the scenario that we do not deliver activity reductions through improved out of hospital care, we expect most NWL sites to move into deficit, with no overall net surplus. In the downside scenario there would be an overall deficit of £89m, with all bar one acute site in deficit. Therefore the changes planned in NWL are critical to the future sustainability of this health and care economy.

Achieving this will require significant investment in primary and community care and reduced acute activity, as described in our Out of Hospital Strategy. In Shaping a Healthier Future, we set out major changes in how services will be configured in our health economy over the next 3-5 years, including:

- Central Middlesex becoming a local hospital and elective hospital
- Charing Cross becoming a local hospital
- Ealing becoming a local hospital

- Hammersmith becoming a specialist hospital with obstetric-led maternity unit and a local hospital
- St Mary's – a local hospital, a major hospital, a Hyper Acute Stroke Unit (moved from Charing Cross Hospital) and a specialist ophthalmology hospital (moving the Western Eye Hospital onto the site)

e) Governance

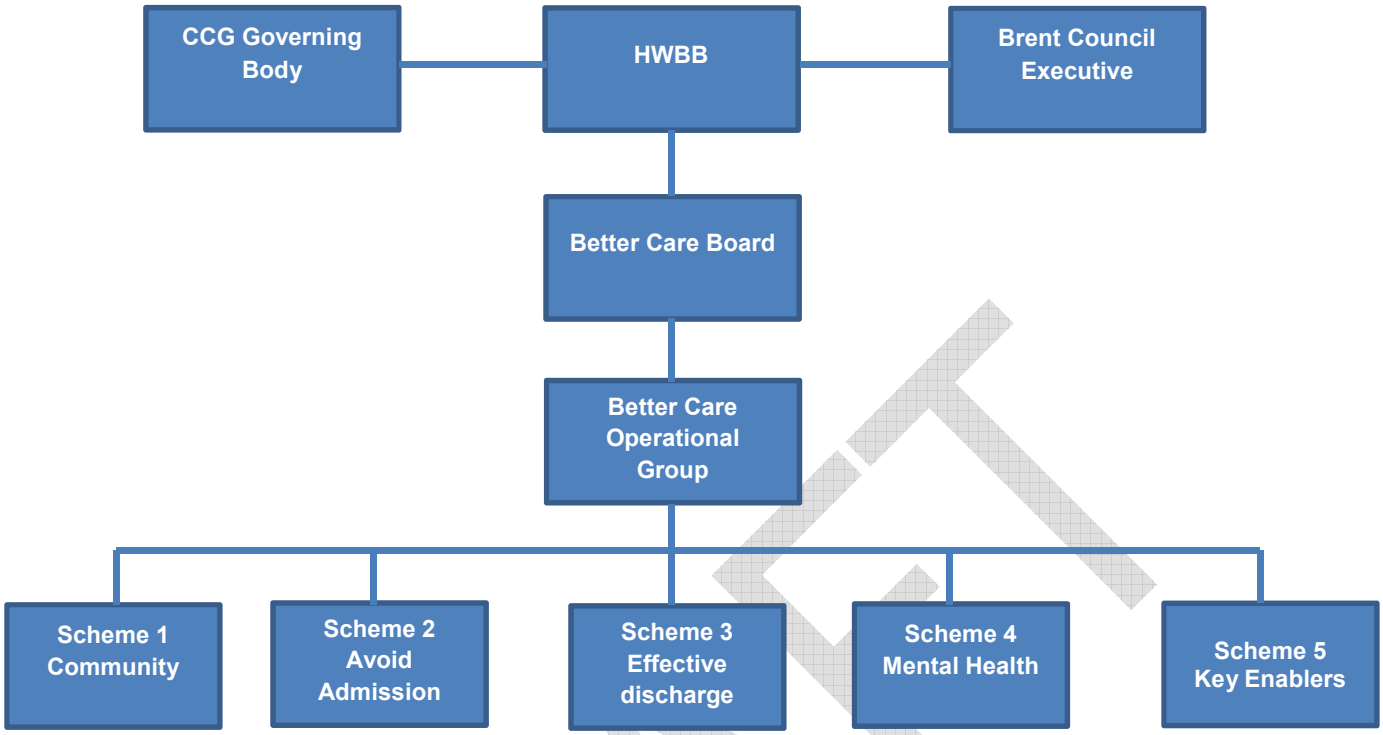
Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

There is a history of constructive partnership within Brent. The Brent Health and Wellbeing Board have been established in shadow form since November 2012. Since then, the Board have updated the JHWS and developed a corresponding action plan to support delivery. The JSNA is currently in the process of being updated and refreshed.

The BCF Plan and Pioneer Plan have benefited from senior leadership involvement across the CCG and Council with senior leaders being actively represented in work streams across the two. There are regular meetings between council members responsible for health related services and the CCG clinical leadership team. In parallel the council's director of adult social care and director of public health are members of the CCG Executive and Governing Body.

To deliver the ambition contained in our BCF, we recognise the need to develop further our strategic and operational governance arrangements. We will ensure that the leadership of the CCG and Local Authority have clear and shared visibility and accountability in relation to the management of all aspects of the joint fund. Our current proposal is to delegate specific functions between Local Authority and CCGs in areas that facilitate delivery of the BCF. We have already created the Brent Integration Transformation Board to lead this work. This is made up of representatives from the council, CCG, provider organisations and the voluntary sector. Whilst the balance between operational and strategic leadership on the group is emerging, it is driving the BCF and whole systems processes. The Integration Board reports to the Health and Wellbeing Board, and is in the process of establishing a work programme supported by workstream leads and work groups aligned to BCF schemes, to oversee operational implementation of key activity.

Our proposed governance structure is set out below –


CCG Governing Body
HWBB
Brent Council Executive
Better Care Board
Better Care Operational Group
Scheme 1 Community
Scheme 2 Avoid Admission
Scheme 3 Effective discharge
Scheme 4 Mental Health
Scheme 5 Key Enablers

3) NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services.

Protecting social care services in Brent means ensuring that those in need continue to receive the support they need, in a time of growing demand and budgetary pressures. Whilst maintaining current eligibility criteria is one aspect of this, our primary focus is on developing new forms of joined up care which help ensure that individuals remain healthy and well, and have maximum independence, with benefits to both themselves and their communities, and the local health and care economy as a whole. By proactively intervening to support people at the earliest opportunity and ensuring that they remain well, are engaged in the management of their own wellbeing, and wherever possible enabled to stay within their own homes, our focus is on protecting and enhancing the quality of care by tackling the causes of ill-health and poor quality of life, rather than simply focussing on the supply of services.

Please explain how local social care services will be protected within your plans.

Funding currently allocated under the Social Care to Benefit Health grant has been used to enable the local authority to sustain the current level of eligibility criteria and to provide timely assessment, care management and review and commissioned services to clients who have substantial or critical needs and information and signposting to those who are not FACS eligible.

This will need to be sustained, if not increased, within the funding allocations for 2014/15 and beyond if this level of offer is to be maintained, both in order to deliver 7 day services and in particular as the new Social Care Bill requires additional assessments to be undertaken for people who did not previously access Social Services.

It is proposed that additional resources will be invested in social care to deliver enhanced rehabilitation/reablement services which will reduce hospital readmissions and admissions to residential and nursing home care.

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy).

We are proposing to use the Integrated Care Programme II to help us deliver our commitment to providing seven-day health and social care services, supporting patients being discharged and prevent unnecessary admissions at weekends by identifying high-risk patient groups and introducing rapid response services.

Our JHWS identifies the need to prioritise vulnerable adults and will inform areas where integration and joint working will improve outcomes for Brent residents.

Our commitments will be overseen by an Integration Board, and we have the full support of our local Health & Wellbeing Board, as recognised in our successful Pioneer application.

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.

We will secure additional funding through the business planning for ICP II as an accelerated whole systems learning site to trial 7 day services in health and social care. This will enable partners to assess what additional capacity is required to develop an ongoing 7 day offer and to evaluate how successful the approach is to facilitating discharges and avoiding un-necessary admissions

Further work is also being undertaken to understand the Adult Social Care Customer Journey, including interfaces with health providers to enable timely assessment and transfer, with 7 day services in social care will be considered as part of this work.

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

All health services use the NHS number as the primary identifier in correspondence. Social services are in the process of adopting this, and we are committed to ensuring this occurs by April 2015.

Please confirm that you are committed to adopting systems that are based upon open APIs and Open Standards (i.e. secure email standards, interoperability standards (ITK))

We are committed to adopting systems based upon Open APIs and Open Standards. The majority of our practices will be using EMIS Web, a tool that allows primary, secondary and community healthcare practitioners to view and contribute to a service user's cradle to grave healthcare record.

To enable cross-boundary working, we will improve interfaces between systems. Further, we are creating a data warehouse that will aggregate data from different sources into a consistent format. This will provide one view over the whole systems of health and social care, and allow queries and analyses to take place across multiple, separate systems. Also, it will improve data quality by identifying gaps or inconsistent records.

Please confirm that you are committed to ensuring that the appropriate IG controls will be in place. These will need to cover NHS Standard Contract Requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Calidcott2.

All of this will take place within the Information Governance framework, and we are committed to maintaining five rules in health and social care to ensure than patient and service user confidentiality is maintained. The rules are:

- Confidential information about service users or patients should be treated confidentially and respectfully
- Members of a care team should share confidential information when it is needed for the safe and effective care of an individual
- Information that is shared for the benefit of the community should be anonymised
- An individual's right to object to the sharing of confidential information about them should be respected
- Organisations should put policies, procedures and systems in place to ensure the confidentiality rules are followed

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional.

NWL has been implemented an Integrated Care Programme (ICP) across local CCG areas which involves risk stratification of practice populations with care plans developed for these patients. Early implementation in Brent has focused only on the top 5% of the population identified at risk.

In 2014/15 this programme will:

- Extend the processes for identification – further risk stratification and more referrals from other agencies
- Ensure a comprehensive and holistic multidisciplinary care plan, with GPs as the accountable professional for the patients care
- Facilitate the use of EMIS Web to ensure electronica access across providers to the care plan for input and update
- Commission multidisciplinary groups focused around 4 emerging GP networks to develop wider provider networks making clear recommendations
- Require networks to provide self-management and prevention support/education
- Facilitate care planning coordination and case management around emerging GP networks, supported by a health and social care coordinator and/or lead professional depending on complexity and need
- Ensure patient involvement in developing the care plan so that they are empowered to self-direct their care
- Regular reviews to ensure care plan interventions are being delivered and recovery goals are being achieved
- Improve out of hours coordination through special flags for patients that are accessible to 111 and other out of hours providers

This is anticipated to increase the number of patients receiving this anticipatory integrated care model.

Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

Using the Kaiser Pyramid, we know that in all populations approximately 0.5% of the population are very high risk and the next 4.5% are high risk of hospital admission. Working on a population of 342,000 people in Brent, this would mean that there were 1,700 people at very high risk of admission and a further 15,390 people at high risk. Together this means that there are 17,090 people at high or very high risk.

The current numbers of care plans to date are 4,800 (estimate to January 2014) and this would represent 28% of the people at high or very high risk. The approach used to identify them has been based on disease pathways for those within diabetic, 75+, COPD or HF groups, starting with those at highest risk based on GP intelligence.

More recently, we have started using the local risk algorithm BIRT 2 and the frequent users of emergency services data to identify high risk services users. Moving forward, the

approach will be to use BIRT 2, the Frequent Users of Emergency Services data and GP intelligence. GP practices (or indeed other integration partners) will be able to select from any patient group and will use a more structured approach to patient selection, so that the population is identified at the start of the process.

4) RISKS

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

Ref	Risk	Risk rating	Mitigating Actions
R1	Shifting resources to fund new joint schemes will destabilise existing providers in the acute sector	High	▪ Our current plans are based on the agreed strategy for NWL, as set out in *Shaping a Healthier Future* ▪ The development of plans for 2014 to 2016 will be conducted within the framework of our Whole System Integrated Care Programme, allowing for transparency of impact across the provider landscape.
R2	Absence of robust baseline data and the need to make decisions based on assumptions may result in unachievable financial and performance targets for 2015/16	High	▪ The Whole Systems Integrated Care programme is undertaking a detailed mapping and consolidation of opportunities and costs which will be used to validate our plans. ▪ We are investing specifically in areas such as customer satisfaction surveying and data management to ensure that we have up-to-date information around which we will adapt and tailor our plans throughout the next 2 years.
R3	Operational pressures restricting the ability of our workforce to deliver the vision	High	▪ Need to include specific non recurrent investments into workforce development and organisational development
R4	Preventative, self management and improved quality of care fail to translate to reduced acute, nursing and care home expenditure, impacting the level of funding available in future years.	High	▪ Our assumptions are modelled on the best available evidence of impact, including metrics from other areas and support from the National Collaborative ▪ We will use 2014/15 to test and refine our assumptions with a focus on developing more financially robust business cases.
R5	The Care and Support Bill will result in an increase in the cost of care provision from April 2016 which is difficult to predict at this stage.	High	▪ Undertake an initial impact assessment with a view to refining assumptions as we develop our BCF plan. ▪ Explore opportunities and benefits arising from the introduction of this legislation that may help to offset negative financial consequences.

Association

Finance - Summary

For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actual contributions to the Better Care Fund pooled budget in 2015/16.

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15	Minimum contribution (15/16)	Actual contribution (15/16)
Brent Local Authority	Y	*6,155,585*	*6,155,585*	*6,155,585*
Brent Local Authority Disability Facilities Grant	Y	-	*1,852,000*	*1,852,000*
Brent Local Authority Social Care Capital Grant	Y	-	*748,000*	*748,000*
Brent CCG	N	*0*	*13,676,415*	*13,700,000*
BCF Total		*6,155,585*	*22,432,000*	*22,455,585*

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

Contingency plans will be developed by an Integration Board (that reports to the Health and Wellbeing Board) to be established.

Contingency plan:		2015/16	Ongoing
Outcome 1	Planned savings (if targets fully achieved)	TBC	TBC
	Maximum support needed for other services (if targets not achieved)	TBC	TBC
Outcome 2	Planned savings (if targets fully achieved)	TBC	TBC
	Maximum support needed for other services (if targets not achieved)	TBC	TBC

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Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please expand the table if necessary.

BCF Investment	Lead provider	2014/15 spend		2014/15 benefits		2015/16 spend		2015/16 benefits	
		Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent
Scheme 1: Keeping the most vulnerable well in the community	NWLHT	*2,319,585*	*0*	*0*	*0*	*9,454,585*	*0*	*0*	*0*
Scheme 2: Avoiding unnecessary hospital admissions	Various	*0*	*0*	*0*	*0*	*1,100,000*	*0*	*0*	*0*
Scheme 3: Effective multi agency hospital discharge	NWLHT	*1,926,000*	*0*	*0*	*0*	*3,426,000*	*0*	*0*	*0*
Scheme 4: Mental Health Improvement	CNWL	*762,000*	*0*	*0*	*0*	*2,362,000*	*0*	*0*	*0*
Scheme 5: Key Enablers	Various	*1,148,000*	*0*	*0*	*0*	*2,649,000*	*864,000*	*0*	*0*
Disability Facilities Grant	LA					*1,852,000*			
Social Care Capital Grant	LA						*748,000*		
Total		*6,155,585*	*0*	*0*	*0*	*20,843,585*	*1,612,000*	*0*	*0*

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Association England

Outcomes and metrics

For each metric other than patient experience, please provide details of the expected outcomes and benefits of the scheme and how these will be measured.

Residential and nursing home admissions
- To reduce the number of admissions to residential and nursing homes
- To enable people to live full and independent lives for longer in the community
- To put in place innovative service models to enable people to remain at home for longer
- To improve multidisciplinary working to identify people at risk in the community to work to prevent admission to a residential or nursing home
- To increase the number of service users receiving direct payments

Discharge

streamline the discharge process and reduce unnecessary duplicate assessments
- To reduce the amount of unnecessary days service users spend in hospital
- To enable people to receive appropriate support to meet their health and social care needs
- To review how the BICES contract could enable effective discharge
- To assess how the role of carers / home care can effect discharge
- Tracking readmission rates to ensure that discharge has been effective,

DTOC
- To streamline the discharge process and reduce unnecessary duplicate assessments
- To reduce the amount of unnecessary days service users spend in hospital
- To enable people to receive appropriate support to meet their health and social care needs
- To review how the BICES contract could enable effective discharge
- To assess how the role of carers / home care can effect discharge
- Tracking readmission rates to ensure that discharge has been effective,

Avoidable emergency admissions

Rapid response to support admission avoidance and A&E attendance
- Reduce hospital admissions and help reduce the length of stay of patients in hospital by continuing patient care at home
- Access to integrated short term rehabilitation and reablement services
- GPs remain clinically accountable for care

Care planning and case management to centre around GP, as the accountable professional with health and social care case co-ordination
- Care plans in place to prevent unnecessary hospital admissions, which will be monitored.
- Frequent attenders lists extracted from IT systems and shared with locality networks,

For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for October 2015 payment. Please see the technical guidance for further detail. If you are using a local metric please provide details of the expected outcomes and benefits and how these will be measured, and include the relevant details in the table below

To be confirmed

For each metric, please provide details of the assurance process underpinning the agreement of the performance plans

To be confirmed

If planning is being undertaken at multiple HWB level please include details of which HWBs this covers and submit a separate version of the metric template both for each HWB and for the multiple-HWB combined

Not applicable

Metrics		Current Baseline (as at January 2014)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	480.43	N/A	
	Numerator	162		
	Denominator	0.3372		
		(April 2012 - March 2013)		(April 2014 - March 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Metric Value*	81%	N/A	
	Numerator	655		
	Denominator	810		
		(April 2012 - March 2013)		(April 2014 - March 2015)
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*	9.31		
	Numerator	29.5		
	Denominator	3.17		
		(April 2013- Dec 2013)	(April - December 2014)	(January - June 2015)
Avoidable emergency admissions (composite measure)	*Metric Value*	40%		
	Numerator	10,372		
	Denominator	26,154		
		(forecast 13/14 admissions)	(April - September 2014)	(October 2014 - March 2015)
Patient / service user experience *• Acute sector Friends and Family Test* *• Percentage of people who are satisfied with the care and support they receive* *• The proportion of people who feel they have choice and control over their lives* *• Social care related quality of life index .*		32.9% 64.7% 17.6 (2012/13 ASC survey results)	N/A	*(insert time period)*
To be confirmed [local measure - please give full description]	*Metric Value*	TBC		
	Numerator	TBC		
	Denominator	TBC		
		(insert time period)	*(insert time period)*	*(insert time period)*

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Brent	**Health and Wellbeing Board** **26th February 2014** **Report from the Assistant Chief Executive**
For Action	Wards Affected: ALL

NHS England's Draft Commissioning Intentions 2014/15

1. Summary

1.1 NHS England (London) has prepared a report for the Health and Well Being Board on its 2014/15 commissioning intentions. Since April 2013 NHS England has had responsibility for commissioning services in the following areas: Primary Care, Specialised Services, Screening, Immunisations and Health in the Justice system.

1.2 To ensure that national commissioning plans are complimentary with local CCG plans, NHS England has required that Strategic Planning Groups (SPGs) are created. The report provided by NHS England sets out more detail on how it will ensure its plans compliment local developments, and also the planning process within the NHS over the next five years.

1.3 David Finch, the NW London Area Medical Director for NHS England will be at the Board to present the report and deal with questions from the Health and Wellbeing Board.

2. Recommendations

2.1 The Health and Wellbeing Board is recommended to consider the report provided by NHS England on its commissioning intentions and feedback its views on the plans.

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Report for: **ACTION**	
Item Number:	

Contains Confidential or Exempt Information	**NO**
Title	NHS England's Draft Commissioning Intentions 2014/5
Author(s)	Alex Gordon, Delivery Director NWL Area, NHS England
For Consideration By	**Brent Health & Well Being Board**

Purpose of Report:

- This brief report provides members of the Health and Well Being Board with the opportunity to consider the commissioning intentions developed by NHS England (London). Since April 2013 NHS England has had responsibility for commissioning services in the following areas: Primary care, Specialised Services, Screening, Immunisations and Health in the Justice system.

- To ensure that national plans are complimentary with local CCG plans, NHS England has required that Strategic Planning Groups (SPGs) are created. These groups should be large enough to ensure that system wide issues can be addressed and should include a wide range of stakeholders including Local Authority representatives, CCGs, NHS England direct commissioners and representatives of the voluntary sector and the public. North West London CCGs have agreed with NHS England (London) that the existing governance and planning arrangements that have been set up to deliver a number of NWL strategic objectives such as Integrated Care, 7 day working and Shaping a Healthier Future be used as the vehicle to develop NWL strategic Plans. The Collaborative board set up to oversee the delivery of the Integrated Care project, will act as the SPG and will drive and oversee the delivery of a NWL 5 year strategic plan by April 2014.

1. Recommendations

1.1 That the Board considers the draft commissioning intentions of NHS England, notes that NHS England would welcome feedback from the Board and determines what, if any, feedback the Board wishes to make.
1.2 That the Board notes the development of Strategic Planning Groups (SPG) to ensure that national plans are complimentary with local CCG plans.
1.3 That the Board endorses the proposal that the Collaborative board set up to oversee the delivery of the NWL Integrated Care project, will act as the SPG to drive and oversee the delivery of a NWL 5 year strategic plan by April 2014.

2. Introduction and Summary of Commissioning Intentions

Attached as appendices are the DRAFT commissioning intentions for directly commissioned services from NHS England (London region). The documents cover:

- Primary care
- Specialised services
- Screening
- Immunisations
- Health in the Justice system

These have been built to reflect the national commissioning intentions, which were published in October / November 2013. These can be accessed on: www.england.nhs.uk/2013/10/com.intentions

These commissioning intentions are draft currently, and are still being developed by the direct commissioning functions of NHS England (London). They are now being shared widely including with Health and Well Being Boards and any comments or feedback would be welcomed.

Set out below is a summary of the key messages from each set of commissioning intentions below:

Direct commissioning function	***Key points from direct commissioning intentions***
Primary care (GP, pharmacy, dental and optometry services)	The commissioning intentions include: • QIPP(savings) Requirement 14/15 • GP Information Technology (IT) Investment Criteria • Investment in Call 2 Action for Primary Care including Premises • Standard London wide approach in absence of National Single Operating Model • Extended Access Pilots • Fair Funding and Equalisation Policy • Working with CCQs on Improvements in Primary Care Quality • Working with CCGs on Out of Hospital Agenda
Specialised services; this includes a wide range of services e.g. Neonatal intensive care, paediatric intensive care, burns etc.	Key areas of focus are: • Use of data to support high quality services • Work with CCGs to commission along patient pathways to secure early intervention and prevention strategies that reduce the level of demand in specialised services • A systematic market review for all services to ensure the right capacity is available across services • Collaborative working with CCGs, local authorities and providers • Explore with CCGs innovative commissioning approaches to facilitate the transformation of CAMHS

	pathways • Review of all non-Payment by Results tariff payments • Contracting intentions – including single provider contracts and consistent contracting
Screening e.g. antenatal, breast and bowel screening	Key areas of focus are: • Service review and developments – including service redesign and review of back office functions • Service developments with co dependencies on CCGs, Public Health England, specialised commissioning, Primary care Commissioning, Local Authorities and other providers – including formalising co-commissioning arrangements with partners • Contracting intentions – including single provider contracts and consistent contracting • Supporting coverage – working with CCGs and other partners to increase coverage • CCG Information technology and IT developments - NHS England and CCGs will need to work cooperatively around IT developments within primary care, where there are often multiple interfaces with screening programmes. • Antenatal and new-born screening - NHS England needs to work closely with CCGs who commission maternity services
Immunisations and military health	Key areas of focus for 14/15 are: • Tightening key areas of the agreement. We have given further clarity to what NHS England is accountable for. More outcome measures are now set against numerical baselines – Further details are in relevant more detailed section of the attachments. • Beginning to deliver further ambitions NHS England inherited historic variations in contractual arrangements and local levels of service performance. The S7A sets out steps for NHS England to align contractual arrangements with national service specifications and, through focusing on low performers, to start reducing historic variations in local performance. • For immunisations and early years, this will include: o developing memorandum of understandings and public health action plans with CCGs, o developing an integrated governance framework with Local Authorities o an additional 621 Health Visitors over the next two years • For military health, this will include: o Better communication of the London Region's commitment to veterans
Health in the Justice system	Main strands of work are: • Direct procurement healthcare services (London) – commissioning of services • Procurement support (nationally)

	• Service review and developments – specifically with SARCs • Transfer of commissioning responsibility for healthcare in police custody suites by April 2015 • Develop liaison and diversion schemes – through developing service specifications and a national operating model • Promoting healthy prisons • Re-commissioning of non-direct healthcare services in prison • Information management and technology – procurement of IT for custody suites and roll out of prescribing model for prisons • Research and development – developing a framework for pathway review • Involving patients in the design and monitoring of services • Links with CCGs to develop continuity of care pathways, referral pathways with primary care and pathways to support those being released from custody / on bail • Links with PHE / CCGs / Specialist commissioning / MH Trusts to improve continuity of care

Attached as appendices are the more detailed draft plans for each of these service areas.

2.1 Inclusion of NHS England Commissioning Plans into CCG commissioning Plans

The new planning process (see below) requires CCGs and NHS England as co-commissioners to work together to deliver a 5 year strategic plan that will achieve a number of aims including improved outcomes for patients, better integrated care, and safe and sustainable services etc.

To achieve the delivery of a NWL 5 year strategic plan, NHS England and the 8 NW London CCGs are working together to agree the contents of their plan. For NWL CCGs this involves building on work in progress such as the work on integrated care, the work to support the implementation of Shaping a Healthier Future etc. From an NHS England perspective discussions need to take place on how CCG commissioners can help NHS England deliver its commissioning intentions e.g. through better commissioning of maternity services to deliver improved antenatal care or in terms of making changes to the Child and Adolescent Mental Health pathway. A series of meetings are scheduled and the output from each of these meetings will be part of what is included in the NWL final 5 year plan.

3. NHS England Planning Process and Planning Guidance

Until now NHS planning has been based on producing an annual plan. However, the NHS along with other partners is facing an unprecedented challenge in terms of funding and demands. NHS England is committed to transforming outcomes for patients and to playing its role in minimising inequalities within and between

communities. The Call to Action forecasts a financial gap of £30bn by 2020/21 and the affordability challenges in 2014/15 and 2015/16 are real and urgent. Therefore a different approach is required in planning terms to address these challenges.

CCGs and NHS England as co-commissioners are charged for the first time with producing both a 2 year operational plan and a 5 year strategic plan. For the first time financial allocations will be for two years allowing the agreement of longer contracts and providing a opportunity to plan on a longer times basis.

In terms of what is required

- each five year plan should include the first two years of operational delivery in detail so that patients, their carers and other key stakeholders can be satisfied that progress is being made against the longer term goals and the service transformation needed to realise them;
- plans must be explicit in dealing with the financial gap and risk and mitigation strategies;
- the planning process and timelines have been aligned with our national partners, including NHS commissioners, Monitor, the NHS Trust Development Agency (TDA) and the Local Government Association;
- CCGs have been asked to choose their own footprint for Health and Social Care planning. NHS England has asked each CCG to commit itself to a larger 'Unit of Planning' so that wider issues which affect more than one commissioner can be dealt with at scale. Brent CCG has agreed to be part of a North West London Strategic Planning group (SCG);

3.1 Timetable for Submissions

NHS England detailed planning guidance was published on 20th December 2013 been published on the NHS England website http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/ at the same time as financial allocations to commissioners. It is very challenging however it is aligned across organisations such as Monitor and The TDA which will help both providers and commissioners

Activity	**Deadline**
First submission of plans	14 February 2014
Contracts signed	28 February 2014
Refresh of plan post contract sign off	5 March 2014
Reconciliation process for with NHS TDA and Monitor	From 5 March 2014
Plans approved by Boards	31 March 2014
Submission of final 2 year operational plans and draft 5 year strategic plan	4 April 2014
Submission of final 5 year strategic plans	20 June 2014

4. Key Implications

The creation of a 5 year strategic plan will be very challenging given the NWL CCGs are very well developed in their planning whilst NHS England as co commissioners are less advanced. In addition the focus of planning attention is somewhat different in that NHS England commissioners are generally planning on the basis of a pan London

approach rather than on a specific area or borough basis. Therefore there is a need for careful coordination to ensure one set of commissioning plans do not contradict another. A process has been set in place to avoid this and to ensure that the NWL 5 year plan is consistent between all commissioners. In addition NHS England plans are necessarily very high level and broad at this stage so more detailed local discussions will be essential to be able to understand local ambitions and aspirations .The creation of SPGs allows all local partners to have the opportunity to discuss these issues and understand what they mean at both a borough and North West London planning level..

The new commissioning system is acknowledged as complex and this is reflected in the need to ensure alignment between the various NHS statutory organisations tasked with overseeing the system i.e. NHS England, TDA and Monitor. Alongside this Health and Well Being Boards have a key role to play in providing local oversight of commissioning plans to ensure their fit with the findings of local Joint Health Needs Assessment (JSNA) and other local health needs. In addition for NWL London CCGs the work being taken pan NWL CCGs i.e. developing Integrated care, supporting the delivery of Shaping a Healthier Future will provide the framework for the NWL plan. Central to all commissioning systems is a need to ensure engagement with the public and patients to be able to discuss and engage with the level of change that is required. The NHS England Call to Action and local work in London such as the recent launch of a case for Change for General Practice, are all potentially confusing. The challenge for the SPG will be to steer a clear path through all of these polices and publications and to develop a clear narrative for NWL that is in tune with the expectations of Health and Well Being boards s and which above all describes how health outcomes will be improved. The delivery of this key ambition is in danger of being lost in the plethora of initiates and changes that will need to be described and planned.

The financial challenge is as noted immense for both health and social care and delivery of the Better Care Fund, which sees existing funding being recycled into more preventative proactive care will be challenging although the Integrated Care Pilot in NWL does provide a good basis for discussion. NHS England has recognised this challenge and the publication of two year allocations will support discussions on making changes to contracts over a longer period which will be needed to deliver both the ambitions of local CCG commissioners and NHS England.

In summary Brent Health and Well Being Board will need to able to test and challenge the narrative emerging from the planning process to ensure that it is able to clearly describe how local health outcomes will be improved and how all of the plans will fit together and deliver the level of aspiration that all commissioners have for local residents in terms of health outcome improvements.

5. Value For Money

This is an underlying principle of the direct commissioning intensions and the new planning guidance**.**

6. Sustainability Impact Appraisal

Not applicable.

7. Risk Management

The challenge of agreeing and aligning planning over a number of co-commissioners including the Local Authority.

8. Community Safety

None.

9. Equalities, Human Rights and Community Cohesion

The commissioning intensions set out in this document will be subject to an impact assessment by NHS England and in line with meeting NHS England objectives. To advance equality, NHS England will refresh and roll out the Equality Delivery System across the NHS and develop and implement the Equality, Diversity and Inclusion in the Workplace Strategy.

10. Staffing/Workforce and Accommodation implications:

None specific.

11. Property and Assets

There are no immediate property implications.

12. Any other implications:

To be determined as part of work in progress in a number of joint areas such as Integrated Care, the use of the Better Care Fund etc.

13. Consultation

Draft NHS England directly Commissioned Services are being share widely with CCGs, H&WBB etc. and comments are invited on the proposals that are set out within the 5 attached appendices.

14. Timetable for Implementation

Set out in Section 2.1

15. Appendices

Health in the Justice System Commissioning Intentions 2014/5
Primary Care Commissioning Intensions 2014/5
Screening Commissioning Intentions 2014/15

Public Health, Immunisation and Military Health Commissioning Intentions 2014/5
Specialised Commissioning Intentions 2014/5

16. Background Information

NHS England ; A Call To Action ;*www.england.nhs.uk/2013/07/11/**call-to-action***

NHS England Planning Guidance : http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan

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Brent	**Health and Wellbeing Board** **26th February 2014** **Report from the Assistant Chief Executive**
For Action	Wards Affected: ALL

Health and Wellbeing Strategy and Action Plan

1. Summary

1.1 The Health and Wellbeing Board has asked Board members to develop an action plan for the Health and Wellbeing Strategy. The action plan takes account of discussions at previous Board meetings and includes details on key activities and outcomes as requested at the last meeting in December 2013.

2. Recommendations

2.1 The Health and Wellbeing Board is recommended to:

(i). Approve the Health and Wellbeing Strategy Action Plan

(ii). Consider how it wants to be updated on the objectives within the Plan, and whether there are any objectives it wishes to focus on in the immediate future.

3 Report

3.1 The Health and Wellbeing Board has spent time at previous meetings agreeing its Health and Wellbeing Strategy and the action plan that accompanies it. The action plan has been updated since the Board last met in December 2013, to include key activities over the next three years (where this is possible) and the outcomes expected from each objective. Where a baseline exists against which performance can be assessed, this has been included. For some objectives a baseline still needs to be set. For example, the objectives in the priority “working together to support the most vulnerable adults in the community” are based on the Better Care Fund, which is still being finalised. Once this is done, the baselines will be added to the Health and Wellbeing Strategy Action Plan. For other objectives setting a baseline is harder to do. So, outcomes could be assessed by considering inspection reports, or quality assurance audits so that the Board can be satisfied that services are performing as expected.

3.2 The Health and Wellbeing Board should consider the action plan and comment on the activities and outcomes that have been included. The Board should also consider whether there are any objectives it wishes to pay particular attention to in the coming months, so that agendas can be planned accordingly. It should be noted that Health and Social Care Integration and the Better Care Fund is going to feature significantly in the Board's work in the coming months, which means there will inevitably be a focus on the "working together to support the most vulnerable adults in the community" priority.

4. Conclusions

4.1 The Health and Wellbeing Board should consider the action plan that is appended to this report and confirm that it is happy with the plan, or suggest further amendments. Assuming the Board approves the action plan, thought should be given to the areas where the Board wishes to focus initially so that officers can work to plan themed meetings and work shops on the priority areas.

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Health and Wellbeing Strategy – Action Plan

Priorities:

1. Giving every child the best start in life
2. Helping vulnerable families
3. Empowering communities to take better care of themselves
4. Improving mental wellbeing throughout life
5. Working together to support the most vulnerable adults in the community

1. Giving every child the best start in life

Objective	Activity	Lead and partner	Progress Milestone	Outcomes
Evaluate our current parenting programmes with a focus on learning from best practice to inform the use of resources.	1. Rationalise programmes across the borough by locality. Engage other providers as facilitators and co-facilitators. 2. Follow up with attendees after six months to assess whether sustained change in parenting style 3. Train volunteers, parents and community champions to deliver programmes 4. Ensure peer support in place for practitioners (both staff	Sara Williams	Increased number of attendees and completion rates for programmes Increased number of trained facilitators to deliver accredited parenting programmes Programmes currently on offer include: • Incredible Babies • Incredible Years • Mellow Babies • Mellow Parenting • Strengthening Families, Strengthening Communities • Solihull Approach • Triple P Process in place following completion of parenting	Ensure that the percentage of parents completing programmes continues to improve Six monthly evaluation surveys return positive results – • Do parents feel they have benefited from the programme? • Parents scoring themselves against ten statements related to their learning • Positive feedback

	and volunteers). In particular to address complex issues.		programmes to identify outcomes for parents and positive outcomes identified Website regularly updated to promote parenting programmes across the LA	received from parents who completed courses Production of outcome reports setting out results of parent evaluation.
Agree and deliver a Child Oral Health Plan for Brent with NHS England	**1. Making every contact count:-** • Continue to use the Health Visiting team to promote oral health to every child in Brent at routine childhood reviews at; 6-months, 1-year and 2-years. • The Ealing ICO Community Dental Service will provide on-going training to the Health Visiting service to assure the quality of the advice given to parents which will include; substitution of sugary snacks and drinks, demonstration of tooth brushing to children, need for annual dental assessment, and distribution of Brush4Life packs. **2. Work with Early Years Settings to promote oral health -** • Work with child-minders, PVIs and Children Centres to promote oral health through Council's Healthy Early Years grant scheme. This work will include events for parents and training of oral health champions within each	Lead - Melanie Smith Partner – David Finch, NHS England	Completion of training for all of the Health Visiting team including Health visitors, community nurses and staff nurses {By April 2014} Completion of audit of oral health advice given by Health Visiting team {By August 2014}. Activity up to March 2014 will target 40 PVIs and all Children Centres. Review of scheme in March 2014 to plan activity for subsequent years Agreement and engagement from Local Dental Committee and NHS England on expected standard for dental assessment and the application of fluoride varnish {by April 2014} Agreement from partners to deliver targeted schools programme {by April 2014} Future plan for community awareness work to be developed by steering group {by April 2014}.	Increase the proportion of under-fives registered with Brent dentists by 5% in 2014/15 from 2013 baseline. Increase the number of fluoride varnish applications, in children aged 7 years and under, by 5% in 2014/15 from 2013 baseline*. Reduce the number of non-elective dental admissions for U5s by 5% in 2017/18 (from 2013/14 baseline)* * targets are only indicative at this stage particularly where baseline data is being collated

	setting.
	
	3. Work with local dentists and NHS England -
	
	• Explore with providers a common approach to improving the quality of care offered to young children especially
	  ○ Ensure that young children are offered regular dental assessments as early as possible i.e. once teeth appear
	  ○ Increase offer of fluoride varnish applications to children over the age of three
	
	• Explore arrangements for the collaborative commissioning of local dental teams to provide outreach dental assessment and fluoride varnish application in ten Brent primary schools.
	
	4. Targeted work with community groups -
	
	• Raise awareness of free NHS dental assessments for children including fluoride varnish applications - further work required by steering group to determine scope of this work.			

To expand partnership working with schools, nurseries,	**Early Years**		**Year 1, 2013-14**	Numbers of providers engaged and accredited

playgroups and other early years settings to improve the wellbeing of children.	**Year 1** 1. To promote health and wellbeing in the Early Years age group (0-5 years) by working with all Children's centres, PVIs and Child minders in Brent. Promote health in the following 7 areas: • Nutrition • Physical Activity • Oral Health • Immunisation • Breastfeeding • Smoking Cessation • Emotional wellbeing 2. To co-ordinate partnerships and key stakeholders: • All children's centres • Private, Voluntary and Independent settings (PVIs) • Child minders • Parents • Health professionals from Local Trusts NHS England and Council colleagues • Voluntary and community sector • Wider campaigns such as Change4life • School improvement and Early Years Advisory Teachers		**Healthy Early Years briefing and re-launch** All children's centres, PVIs and Child minders invited to attend a launch of the Healthy Early Years project and asked to register interest. **Number of parents engaged** Parent questionnaires given out to assess baseline activity for HEY award **Numbers of Early Years providers engaged and training sessions attended** • At least 70 engaged onto the Healthy Early Years project • Continue support to 22 settings already accredited with the Healthy Early Years award in 2012-13. **Set up a Healthy Early Years Delivery group** To meet at twice to monitor progress, report on activities in the 7 priority areas. **Increased awareness of Health and Wellbeing for Early Years** • More EY providers including Children's centres, PVIs and Child minders have knowledge of Health and Wellbeing in the 7 priority areas • Help with Ofsted for Early Years Foundation Stage requirements under Physical Development : Health and Self Care **Year 2, 2014-15** **Number of Early Years providers accredited with the Healthy Early Years award** • At least 40 to become accredited with the award by June 2014.	with HEY award • 70 engaged in year 1 • 40 accredited in year 2 which would involve at least 800 children Number of new Dentist registrations for 0-5 year olds target to be set once baseline established in year 1. Number of children with up to date red books Number of parents engaged through parent questionnaires • At least 200 questionnaires completed in year 1 Better Ofsted for Health and Self Care. Validated folders for HEY award

	Year 2 **1. As above in addition to:** Ensuring that each Early Years providers are kept informed and abreast of changes according to PH England for example Immunisations **Enhanced Healthy Schools** **Year 1** 1. Use a range of methods to communicate effectively with schools and promote public health local priorities and national health improvement campaigns. 2. Develop plans to support schools on the new 'School Food Plan'. Identify and coordinate the role of Brent Council in relation to free school meals for all infants and other school based entitlements and activities. 3. To audit provision and promote examples of good practice related to healthy weights, healthy lives activities including all elements identified in the School Food Plan. 4. To raise awareness of and encourage / support schools to gain Healthy Schools	Lead - Melanie Smith Partner - Sara Williams	• Target at a minimum of 800 children between the ages of 0-5 **Continue Healthy Early Years Delivery group** To meet at least 4 times a year to monitor progress, report on activities in the 7 priority areas to refresh knowledge and information sharing to Early years community **Year 1 by July 2014** Knowledge of health and wellbeing work in all schools is increased. Governance arrangements are secure through appropriate representation from schools, early years, health, education and voluntary sector. Terms of reference are agreed and updated. Monitoring of schools work can be reported. 50% schools receiving the EHS Grant return an evaluation questionnaire to support a coordinated report. Health promotion messages for schools are known by school staff, education staff and governors. **<u>Year 2</u>** Schools gain awards such as Children's Food Trust Awards and progressive Healthy Schools London Awards. Pupils have access to cookery sessions and evidenced through Ofsted reports	**Year 1** 30 schools register for Healthy Schools London 10 schools achieve Bronze level award 100% of schools of relevant primary schools are aware of the revised new school food standards. **Year 2** Increased uptake of 'school dinners' as defined through the School Food Plan Build on School Breakfast / Free milk survey carried out in 2013/14 – 59 surveys sent out, 34 returned. Of those: • 23 had breakfast clubs • 33 provided free milk to under 5s • 5 provided subsidised milk to over 5s

	London Awards as a mark of excellence. 5. To review annually the governance arrangements of the Healthy Schools and Early Years Partnership Board and ensure it is fit for purpose. 6. To evaluate the activities related to the Enhanced Healthy Schools Grant 2013/14. 7. To explore the possibility of and promote further funding or levered in resources to support school deliver health and wellbeing activities and gain Awards of excellence. **Year 2** 1. As above and in addition: • Plan to pilot and integrate the Early Years Healthy Award into schools. • Consider and respond to the work related to The School Food Plan and sustainability issues.			Number of schools with vegetable growing plots.
Review our approach to childhood obesity and agree a revised strategy	1. Other action plans for the Health and Wellbeing Strategy detail the work the Council is leading on: • Healthy early health settings and healthy schools which	Lead - Melanie Smith Partners – Sara Williams and Sue Harper	**2014/15 –** Effective stakeholder engagement with • Third sector • Faith Groups • Children, young people and families • Health services	Reverse the upward trend in childhood obesity in year 6 by 2014/15

	includes attention to increasing physical activity and promoting healthy eating. • Encouraging everyone to be physically active • Promoting healthy eating The Council is also working with NHSE to improve child oral health All of the above could contribute to addressing childhood obesity. However there is no agreed multiagency commitment to reducing childhood obesity as a priority, nor is there an evidence based multiagency plan		to produce a Brent Child Healthy Weight Strategy Review of the need for weight management interventions for children and their families in Brent Public Health Commissioning Intentions to reflect this review **2015/16 -** These milestones will be agreed with partners during the development of the Brent Child Healthy Weight Strategy	
Ensure that the council and partners are planning and ready for the transfer of health visitors and Family Nurse Partnership in 2015 to deliver our priorities for young people in Brent	1. Establish Family Nurse Partnership (FNP) in Brent 2. Prepare for responsibility for Health Visiting commissioning to transfer from NHS England to Brent Council in 2015/6 3. Prepare for responsibility for FNP commissioning to transfer from NSHE to Brent Council.	Melanie Smith / Sara Williams / NHS England	**2013/14 -** Reinvigorate Brent Maternal and Child Health Group, to include NHSE Establish governance arrangements for FNP Recruit staff to FNP **2014/15 -** Begin recruitment of mothers to FNP Brent participation in NHSE / London Councils work on “Improving Outcomes for London’s children through Early Years services” Agreed transition plan for HV including agreement of HV establishment and of funding to transfer to the Council Agreed transition plan for FNP contract to Council	Increase in HV numbers: NHSE to confirm trajectory for Brent Improvement in childhood immunisations: progress to be monitored quarterly towards 2020 target of 95% For FNP families: • smoking in pregnancy • breastfeeding • low birth weight • immunisations at age 2 *baseline data not yet available to inform target setting

			2015/16 - Successful transfer of budgets and contracts from NHSE to Brent Council October 2015	

2. Helping vulnerable families

Objective	Activity	Lead and partner	Progress Milestone	Outcome
Improve the identification and assessment of all vulnerable children underpinned by robust safeguarding procedures	1. Local Safeguarding Children's Board is leading this work but there is specific group leading the Brent Family Front Door (BFFD) work 2. Brent Family Front Door is up and running since July 2013 incorporating social care, health, police, probation and the Family Information Service 3. New e-CAF has been rolled out as common assessment tool, all schools are using it, plus other agencies 4. LSCB has multi-agency Business Plan, plus plans for BFFD 5. Success judged through Ofsted inspection and case audits	Sara Williams	All partner agencies are now engaged with the MASH Health and police have full network access to their own systems allowing full and rapid checks to be completed. Review of MASH to take place in March 2014 Progress against the Local Safeguarding Children's Board objectives are set out in the Board's annual report. The priorities are: • Quality, Audit and Outcomes • Vulnerable Groups • The Voice of the Child • Developing a Learning Culture • Governance, Accountability and Business Processes Local Children's Safeguarding Board has responsibility for children's safeguarding in Brent – Health and Wellbeing Board to agree partnership approach with LSCB. LSCB to demonstrate progress against each of the Future Challenges identified in 2012/13 Annual Report – 2013/14 Annual Report to be	Children will be protected though an improved front door (first point of contact), which makes decisions in a consistent manner with the benefit of access to full information from key partner agencies – Baseline required to assess the effectiveness of the Brent Family Front Door service. Health and Wellbeing Board to consider LSCB Annual Report, to consider Children's Safeguarding issues in the borough and reassure the Board that robust procedures are in place.

			published in early 2014. Challenges included: • Engagement of schools • Engagement with third sector and voluntary groups • Vulnerable groups	
Improve multidisciplinary working for children with additional or complex needs	1. Multi disciplinary approach operates at the level of individual children involving social care, education, health etc. 2. Multi-agency working on Special Educational Needs improvements, SEN Strategy and Action Plan, with multi agency project board 3. Need to improve strategic approach – will be done through 0-25 disabilities project and implementation of new 'Education, Health and Care Plans' 4. CAMHS service specifications have been reviewed and will be negotiated – social care involved 5. Success judged through Ofsted inspection and case audit	Sara Williams and Jo Ohlson	Multi disciplinary Task and Finish Group working on Safeguarding Disabled Children has been convened. TOR completed. Children with additionally complex health needs are presented at the Tripartite Panel where social care, health and education are represented and contribute to decision-making. Multi-agency working on SEND Reforms is under way with Social Care, Education and Health working jointly with Pathfinders to deliver the reforms in Brent according to national requirements. PID has been agreed for the Transformation project. Sub-groups have been established to work on developing: A joint Local Offer; Joint Commissioning systems; Personal Budgets; Design and Implement the joint EHC plans. Work is underway to consider opportunities of joint funding services to meet the SEND requirements Pathfinder conference took place in Brent on 1th December Parents Forum on SEND Reforms took place on 29th January. An initial scoping examining the costs/benefits of a 0-25yrs disability service is being undertaken. CAMHS services being jointly monitored for quality and access with LBB in term of outcomes and quality Parents conference / participation groups have	Disabled children and children with additional or complex needs are safeguarded and multi-agency working improved. Parents, carers and young people to have increased opportunities to participate in developing strategies and on-going evaluation of services. Integrated working between Education, Health and Care plan will lead to better outcomes for children with SEND. Stronger links with schools, education, social care, health and connexions with a team around child approach, CAMHS and other therapy support services. Better integrated assessments for CYP including those with disabilities and SEN Better communications and multiagency work through colocation of staff including record sharing

			enable us to strengthen our service specifications for CAMHS / therapies	Participation of parents/children in service design and delivery
Improve health outcomes for Looked after Children	1. An OFSTED/CQC inspection of Safeguarding and Looked after Children Services in Brent in October 2011 judged that the 'being healthy' standard for Looked after Children (LAC) was inadequate. A remedial action plan was agreed between the Ealing Hospitals Trust (Integrated Care Organisation Brent – *the Provider*), NHS Brent / Brent CCG and Brent Council from 1 April 2012. 2. Audit of LAC health files took place between April and May 2013 – 383 LAC files and a further 20 unaccompanied asylum seeking children). 3. All the health files audited with the exception of three were compliant with recognised good practice and complied with professional record keeping guidance and standards. 4. There is an overall trajectory of improvement in health assessments, both IHA and RHAs and their resulting action plans and the quality of health assessments is being sustained most notability those completed in	Sara Williams and Jo Ohlson	New LAC service to be commissioned from Ealing Hospital Trust – new service to begin in April 2014 Expectation that re-commissioned service will deliver LAC health assessments for out of borough children – this hasn't always been the case up to April 2014. Quality Assurance of LAC assessments will continue – • Monthly meetings between provider and commissioners to identify issues and address them at an early stage • Quality assurance audits to take place on a quarterly basis, to ensure provider quality is retained • A commitment to partnership working is maintained, with both social workers and nurse assessors working to ensure assessments are carried out within timescales.	Timescales for assessments are met by social care and LAC nurses – • New assessments are carried out within 20 days of a child being taken into care • Annual assessments are carried out for children in care • Six monthly assessments are carried out for under 5s in care • Social care pass details of new assessments to EHT within 5 days / annual assessments within 6 weeks of assessment being due. Quality assurance audits confirm assessments are of high quality and health needs of LAC are being addressed.

	the last 6 months prior to this audit. 5. There remain issues due to a lack of information sharing across the partnership and from the lead agency, which is adversely affecting the quality of assessments. 6. Immunisation rates, teeth checks and health assessments for LAC have all increased over the last three years.			
Helping families in Brent with complex needs through the delivery of the Working with Families (WwF) initiative.	1. WwF Phase 3 objectives have been identified, targeting the underlying structures, systems and processes that need to be in place, they are: • Objective 1: Delivering the Trouble Families (TF) target for Brent. • Objective 2: Embedding a sustainable multi-agency system for Brent. • Objective 3: Delivering Budget Savings 2. Completion of the WwF Phase 3 PID outlining Workstreams and approved by OC Board. 3. Phase 3 will be delivered through five main Workstreams along with activity targets:	Sara Williams	Workstream 1 – Delivering the Troubled Families agenda • Documented processes to meet TF targets. • Data on Lead Professional referrals and training attendance reported to Board on a regular basis. • Schedule of operational update and review meetings to measure progress Workstream 2 - Developing capacity to deliver WwF • Additional workers recruited & in posts. • Training plan and targets developed for Lead Professionals. • Lead Professional take-up monitored and evaluated. Workstream 3 – Performance and Payment • Monthly dashboard used by the Strategic and Operational Boards. • Documented process for making PbR claims and keeping stakeholders up to date on claims. • Documented system in place for monitoring	Objective 1: Delivering the Trouble Families (TF) target for Brent. Outcome - 810 families identified and worked with by March 2015 and 'turned around, achieving positive outcomes with at least 50% of those families. Objective 2: Embedding a sustainable multi-agency system for Brent. Outcome - Multi-agency working practice in place and embedded as core business practice; providing an integrated service that provides improved outcomes for families worked with. Objective 3: Delivering Budget Savings Outcome - Potential budget

	• Workstream 1 - Delivering the Troubled Families agenda • Workstream 2 - Developing capacity to deliver WwF • Workstream 3 - Performance and Payment • Workstream 4 - Stakeholder engagement • Workstream 5 - Future Multi Agency systems and structures		family outcomes • System in place to monitor budget savings and WwF costs Workstream 4 – Stakeholder Engagement • Internal and external communications and engagement plan in place • Use of case studies to highlight work. Workstream 5 - Future Multi Agency systems and structures • Feasibility study completed on the benefits and challenges of an integrated service with changes identified to take forward the WwF initiative. • Pilot' departmental and partner integration of processes and structures • Proposals for the 'business as usual' funding for BFFD and step-down work • Model for the assessment of the impact of the WwF	savings are identified across the WwF project and are implemented as part of the wider Council and Departmental savings targets.
Reduce the impact of poor quality housing on health and wellbeing	1. Improve the quality and safety of council properties 2. Use grants effectively and efficiently to support older and disabled people to live at home 3. Tackle fuel poverty and support affordable warmth across all housing sectors 4. Raise living standards in the private rented sector by working more closely with landlords to improve the quality and overall management of their properties	Andy Donald	**By December 2014** We will have spent £3 million to good effect upgrading and repairing Brent Housing Partnership properties 530 properties will have been improved to support both older and disabled people to live at home At least 500 properties will have been assessed for new energy measures and135 will have received energy saving measures. The improvement of 650 properties through enforcement action We will explore with private landlords the possibility of a licensing scheme and other innovative options to drive up standards in the sector	

	5. Ensure better management of houses deemed to be overcrowded 6. Clamp down on the number of illegal "beds in sheds"		40 additional shared properties will have been licensed to ensure they are fully safety checked, not overcrowded and in a good state of repair The closure of up to 80 illegally converted outbuildings between	

3. Empowering communities to take better care of themselves

Objective	Activity	Lead and partner	Progress Milestone	Outcome
Promoting independence and responsibility for our health and healthcare	1. Brent Clinical Commission Group is developing its self care strategy, supported by Adult Social Care and Public Health. A steering group is overseeing this work 2. Pump priming investment is available from the CCG for self care activity 3. The strategy will focus on – • Cardiovascular disease, chronic respiratory disease and cancers, which are the biggest killers in Brent and account for much of the inequalities in life expectancy within the borough. • High levels of many long-term chronic conditions which are often related to our poor lifestyles, relative deprivation and in some cases our ethnic make-up. For example,	Jo Ohlson	The Self Care Strategy is currently being updated and will be submitted to the CCG Executive in March 2014 for approval Educational Videos to be produced and video conferencing sessions teaching self care on a range of subjects including medicine management and dietary advice for people with long term conditions to be delivered. The use and development of expert patients to deliver generic chronic disease self-management courses to for people living with long term conditions to: • Increasing confidence • Improving the quality of their life • Helping them to manage their condition more effectively NHS Brent CCG will continue to commission pulmonary and cardiac rehabilitation, which has been demonstrated to have an impact on reducing admissions. Currently pulmonary rehabilitation is a six week course available for patients and can be accessed through a referral from primary or secondary care. The Clinical Commissioning	Outcomes will be linked to the Better Care Fund Plan – for example, reduction in the number of avoidable emergency admissions. Baseline to be established. Increase the number of patients attending pulmonary and cardiac rehabilitation from 130 a year to 800 (which modelling suggests Brent should be achieving) 144 people complete disease self management course in 2014/15

	diabetes • Production of self care leaflets/booklets on minor ailments, coughs, colds, burns, etc. 4. Address the rising levels of obesity Rising levels of obesity amongst children. 12% of under 5s and 22% of 12 year olds are obese. Almost 25% of adults in Brent are estimated to be obese		Group will work with Practices to improve referral rates providing simple referral tools to make it easier. Self Care Focus Group is being set up with CVS Brent, Somali Foundation, Registered Charities and with patient representatives from the Health Partners Forum who have volunteered to take part.	
Encouraging everyone to be physically active	1. Multi agency group in place to take forward this work (CSPAN) 2. The borough's Sport and Physical Activity Strategy is in place and includes a detailed action plan 3. There are performance indicators being used to assess service performance, which are monitored through CSPAN	Sue Harper	**Priorities from Theme 3 from the Brent Sport and Physical Activity Strategy, Get More People Active –** a) Reduce the percentage of people that are inactive, particularly those from low participation target groups b) Ensure opportunities for sports participation for all Brent's diverse communities c) Increase awareness of the opportunities available **Key actions:** Direct additional developmental work on the five target groups, concentrating on non and low participants to encourage them to become active. Develop activities within community settings to reduce transport as a barrier and enhance the likelihood of sustained participation Promote the use of Parks for informal physical activity Develop opportunities for 'family' participation in sport and physical activity	**Success measures and outcomes:** Reduction in zero participation in sport and moderate intensity physical activity. Increase in participation in sports and physical activity particularly by the five target groups. • Disabled people • Adults aged 35 to 54 • Black and ethnic minority people • Women and girls • Young people. Development plans written and implemented for three new priority sports

			Offer activity programmes that reflect the needs of Brent's diverse communities offering both inclusive and specific opportunities Implement key actions from Inclusive and Active, the sport and physical activity action plan for disabled people in London Proactively listen to local communities and develop activity programmes that are based on the needs of the individual, families and communities Use market segmentation and social marketing information to inform the provision of services and effective marketing techniques Develop and maintain a comprehensive web-based directory of sport and physical activities offered by all sporting providers: individuals, clubs, groups, organisations and private and public sector facilities Continue to use a range of different and exciting approaches to raise awareness of where, how and why people should and can take part in sport and physical activity Widely promote free activities, Brent's leisure discount scheme and the availability of pay and play opportunities at all Brent Council owned sports centres Work with stakeholders to produce sports specific development plans for the priority sports.	
Promoting healthy eating	1. Work with communities to run healthy eating 'classes', providing participants with information and skills on healthy eating. 2. Engage wider Brent community with benefits of	Leads - Melanie Smith and Sue Harper	Implement first community classes in 14/15 as pilot, use evaluation to extend scheme to 3 communities in 15/16. Planning implements policy changes in borough strategy to no new takeaways within 400m of secondary of further education establishments and proportion of takeaways in town centres not to	Completed and evaluated pilot in 14/15. A 33% increase in participants meeting national healthy eating guidelines post community programme.

	healthy eating, and ensure they have access to information and support where required. 3. Work with planning to provide evidence to support a decrease % saturation of high street takeaways in the borough, and implement a 400m restriction zone for new fast food take aways around secondary schools. 4. Engage the council and businesses in the borough, in healthy workplace programmes such as the London Workplace Charter and use the framework as a lever to ensure cafes at workplaces have a well promoted healthy option, and all other food is labelled appropriately. 5. Environmental health teams to promote the Healthy Catering Commitment Award to high street takeaways. 6. Ensure access to child weight management programmes for those who require them. 7. Work with schools and early years setting to ensure adequate provision, education and skills to enable healthy eating (as per actions in "giving every child best start in life")		exceed 7%. Brent council signs up to London Workplace Charter 12/13. Engage first "pilot" businesses in 14/15 and programme rolled out throughout the borough in 15/16 if appropriate. Pilot project completed in 14/15 and programme rolled out throughout the borough in 15/16. Commissioning strategy for weight management services agreed and commissioned 14/15,	Evidence of take away applications denied on basis of new planning policies. Food labelling and healthy eating options clearly signed in participating Brent organisations. Evidence of award displayed in Brent businesses Commissioned provider/s delivering services from 15/16.
Strengthening our tobacco	1. Link with schools in Brent	Melanie Smith	Peer led smoking cessation group up and running	Increase the number of

control partnership	and build links with local youth services to develop Peer led initiatives to increase awareness of the harms of tobacco among young people in Brent 2. Implement an annual programme to inspect and advise all Shisha cafes in the borough to ensure compliance with Smoke free and other relevant legislations 3. Support for clients with mental health issues 4. Public health campaign to address problem of smokeless tobacco. Brent stop smoking service to offer support for clients who wish to stop the use of chewing tobacco by offering specialist advice at core clinics 5. Increase families agreeing to sign up to a Smoke Free Homes and cars pledge. Offer a stop smoking clinic in a children's setting 6. Increase the number of routine and manual workers referred to the Stop Smoking Service. Provide support to employees of larger firms. 7. Work internally with council services to raise awareness of the stop smoking service	and Sue Harper	in a local secondary school Produce a quarterly report on the number shisha bars visited and the level of compliance with Health Act requirements Train professionals in Mental Health settings to level 1 in smoking cessation Train stop smoking specialists to engage with smokeless tobacco users Establish baseline of number of referrals to the stop smoking service Numbers of referrals of pregnant women to the stop smoking service Establish the referral pathway with secondary care – working closely with clinical and non-clinical staff.	schools engaged by 5% in 2014/15 One clinic to be set up in a mental health setting • 2013/14 – commence training of mental health professionals • 2014/15 – 10% increase on 13/14 baseline in mental health professionals trained • 2015/16 – 5% increase on 13/14 baseline in mental health professionals trained 2014/15 - Measurement of the number of families that sign up to the Smoke Free Homes pledge Year on year reduction in young (<19 years) pregnant smokers through work of Family Nurse Partnership Increase by 5% those from routine and manual occupations accessing smoking cessation services in 2015/16 Smoking cessation services to increase by 5% the number of service users they are working with that use smokeless tobacco.

	to support staff 8. Review and develop action plan for 2015/16			
Strengthening partnership work around alcohol	1. Develop Alcohol Harm Reduction Strategy and Action Plan 2014 – 17. The strategy has three objectives: • Improving Alcohol awareness, brief interventions, access to treatment and positive treatment outcomes • Tackling alcohol related crime and disorder • Working with communities and the alcohol related industry to tackle alcohol related harm 2. DAAT to develop cross partnership harm minimisation campaign 3. Health Check alcohol screening with GPs, Pharmacies, Custody / SNT, A&E, and outreach 4. Audit C programme maintained 5. Plan and deliver pilot 1 day alcohol awareness workshops 6. Through care and after care support provided through AA and other bodies	Melanie Smith	February 2014 - Alcohol Harm Reduction Strategy and Action Plan completed. Harm minimisation campaign planned May 2014 - Implemented June/July 2014 Audi C Programme planned May 2014 - Implemented August 2014 Monthly DAAT Monitoring of Alcohol Harm Reduction Strategy objectives Delivery of alcohol awareness workshops	Reduction in A&E admissions for - • Alcohol related conditions – 2012/13 figure was 2,148 per 100,000 population • Alcohol specific conditions – 2010/11 figure was 670.24 per 100,000 population Number of brief interventions with u40s and high risk groups including DV perpetrators and survivors – baseline to be established 500 alcohol awareness workshop attendees supported in 2014/2015 Increase new treatment by 10% Year on Year Reduction of those re-presenting to treatment Targeted response to alcohol related crime and disorder – • Reductions in alcohol related violent crime • Reductions in alcohol related anti-social behaviour

				• Reductions in alcohol related domestic violence • Reductions in under-age sales and drinking
Improve the health of young people through addressing risk-taking behaviour.	1. LBB is to re-commission young people's substance misuse and sexual health promotion services as an integrated service to address risk taking behaviours	Melanie Smith	To be developed as part of commissioning strategy in 2014/15	To be developed as part of commissioning strategy

4. Improving mental wellbeing throughout life

Objective	Activity	Lead and partner	Progress Milestone	Outcome
Promoting and maintaining good mental health	1. Develop a network of support services and activities to tackle social isolation 2. Explore potential of existing council services and local volunteer groups e.g. gardening and allotments, to contribute to mental health promotion. 3. Support and promote national programmes such as Books on Prescription (BOP) and Time to Change to encourage awareness around mental illness 4. Explore potential to incorporate mental health into	Lead - Melanie Smith Partner – Sue Harper / Phil Porter	Programme initiated 2014/15 Gardening pilot project implemented 2014/15 and evaluated Brent Council sign Time to Change pledge in 2013/14 and promote BOP scheme through launch, and community engagement work. Selected front line staff attend mental health first aid training 2013/14, use evaluated in 14/15 with intention to repeat training if beneficial. 5 ways to well being are incorporated into appropriate programmes and services in the borough, especially those promoting mental well being and health	No of residents participating in network and activities by 2015/16. Evaluation of programmes used to contribute to future borough strategies, or implement programmes in business as usual Halt decline in borrowing of Books on Prescription Trained staff have the confidence to sign post individuals to mental health services where appropriate.

	"make every contact count" initiative, and ensure appropriate front line staff are mental health first aid trained to recognise signs and symptoms of early mental distress 5. Work with Brent services, and communities to promote wellbeing and self-reliance through adoption of NEF '5 ways to wellbeing'			
Early identification and intervention for children with mental health problems	1. Commissioning of Clinical input to the Inclusion Support Team (Inclusion and Alternative Education Service) from the Anna Freud Centre to – • Undertake comprehensive assessment of pupils who have social, emotional and mental health difficulties and develop an action plan to address identified needs; • Work intensively with a small number of individual pupils with more severe and complex social, emotional and mental health difficulties through delivery of an education plan including evidence based approaches and multi-agency working as appropriate; • Contribute to the successful reintegration of pupils into mainstream settings; and • Strengthen skills and competencies in understanding the underlying needs of children and young	Sara Williams / Jo Ohlson	Implementation of clinical input to the Inclusion Support Team – service due to start on 1st April 2014. TaMHS service may continue beyond summer 2014, if schools continue to support provision Tier 2 CAMHS service to be re-commissioned from July 2014 to – • Work with foster carers and social workers to provide advice and support to assist children with emotional wellbeing needs retain their placements where possible. • Work with parents of disabled children with behavioural issues to give them the ability to manage and look after their children at home. Completion of SDQ questionnaires to assess the emotional wellbeing of children in care, aged 4-14.	Evaluate outcomes from the Commissioning of Clinical input to Inclusion Support Team. Performance Indicators are included in service specification and include: • Number of children receiving an intervention – target 170-250 per year • Mental Health of Service Users has improved – target 70% of young people seen (although indicator definition to be agreed) Number of SDQ questionnaires completed (12/13 has provided a baseline) Evaluation of children's emotional wellbeing as reported in SDQ questionnaires – using 12/13 as a baseline to

	people and in managing behaviour in mainstream schools/pupil referral units, including monitoring and assessing the quality of school interventions 2. The service will operate across all Brent schools and be targeted at children at risk of exclusion, including those with complex SEBD issues 3. Continuation of TaMHS service and Place to Be, with schools providing their own support for these services 4. Tier 2 CAMHS services re-commissioned from July 2014 **5.** FAIR and FAST teams to work with families with children on the edge of care, to provide support to prevent children going into care.			assess wellbeing in 13/14.
Improved multi agency approach to duel diagnosis for mental health and substance misuse and mental health and learning disabilities	1. DAAT Board oversees substance misuse sector and commissioning of substance misuse services 2. Substance misuse strategy is in place 3. PIs show strong performance in substance misuse sector, among the best performing partnerships in London 4. Access to mental health support within the substance	Phil Porter, Jo Ohlson and Melanie Smith	Review current provision with an aim to improve work around duel diagnosis – mental health and substance misuse to be taken forward by DAAT; Mental health and learning disabilities to take forward by LD Group.	Outcome of reviews to be reported to Health and Wellbeing Board.

	misuse sector is reasonable but LD and substance misuse issues can hinder access to mental health services			
Improving wellbeing for people with a serious mental illness	1. Project underway to work with CNWL to demonstrate improvements in five key areas of mental health service provision. Council and CCG are working collaboratively on this project. 2. There isn't a single commissioning plan or strategy in place between council and CCG for mental health 3. Services are commissioned separately which doesn't make best use of resources at a time where both council and CCG are under significant financial pressure 4. It is unclear what service users would expect or understand from "wellbeing", or how we measure success. 5. A commitment to joint commissioning will lead to service redesign. The Board is the vehicle to drive this ambition.	Phil Porter / Jo Ohlson	Phase 1 Mental Health Improvement Project to be completed and evaluated – by March 2014 Phase 2 Improvement Project to be set up, and work streams agreed. Focus will include – • Supporting people in the community and reducing the use of residential care services • Making best use of social care resources and integrated health and social care teams to deliver the Recovery Model • Delivery of the "Mental Health Challenge" • Better use of IT to support service delivery • The agreement of a joint commissioning framework with Brent CCG to commission integrated mental health services from 2015/16, moving towards whole systems from 2016 onwards.	A reduction in service users in residential care An increase in number of service users receiving direct payments Improvements in the % of service users assessed within 4 weeks of referral Completion of joint commissioning framework with CCG and a jointly commissioned, integrated mental health service
Early identification and intervention for dementia	1. Directed Enhanced Service (DES) for dementia (extended to 14/15): GPs identify patients at risk of dementia and refer to Memory Clinic. 2. CCG investing additional	Jo Ohlson	Brent Memory Clinic service specification signed off – end February ,2014 Dementia Performance Bond: • revisions to procedure communicated to GP practices – end February, 2014 • May, 2014: first wave of assessment claims	Forecast number of Dementia Cases* – 2014 – 2350 2015 – 2350 *The forecast number of cases is based on

	funds into the CNWL provided Brent Memory Clinic. 3. CCG and GP practices entered into a Dementia Performance Bond in October 2013: GPs carry out 6 month assessment on patients with dementia diagnosis discharged from Memory Clinic. 4. Well established multi-agency Dementia Steering Group, chaired by Dr Andy Tate (Clinical Lead). 5. Dementia Café opened 5 Feb, 2014 (jointly funded BCCG/LLB, operated by Alzheimer's Society).		Dementia Steering Group: monthly meetings (first Monday of the month) Dementia Café : progress review at 3 months (May, 2014); Shared care protocol finalised -March 2014 Dementia nurses: • Training: February, 2014 • Commence in 5 localities: March, 2014	calculations from the DoH Dementia Commissioning Toolkit, linked to population data. Diagnosis Rate - 2014 – 40% 2015 – 45% Resulting Dementia Register - 2014 – 940 2015 – 1058

5. Working together to support the most vulnerable adults in the community

Objective	Activity	Lead and partner	Progress Milestone	Outcome
Reduced A&E attendances	1. Brent CCG, North West London Hospitals Trust and Ealing Hospital Trust and other key partners are working together through the Urgent Care Board and working group to prevent all unnecessary admissions 2. The fully integrated Clinical Single Point of Access is	Jo Ohlson / Phil Porter	Production of the Better Care Fund Plan, including a range of projects to reduce A&E attendances and hospital admissions: • ICP 2 • Integrated STARRS Service • Effective hospital discharge • Mental Health Improvement Agreement of Better Care Fund performance metrics, including reducing A&E attendances. Metrics and baselines to be in place by April 2014.	Performance metrics to be agreed by April 2014 – plan will be updated with baseline information after that in order for the Board to monitor A&E attendance performance. The Better Care Fund provides a minimum set of indicators to provide focus:

	being piloted jointly with STARRS and social care as a strategic response to avoiding unnecessary admissions 3. Integrated care pilot (ICP) in place for diabetes and older people. ICP has been extended to any patient a member of the multi disciplinary team believes would benefit from a care plan, but uptake is not as extensive as expected or having as much impact as planned		Planning BCF schemes will take place up to April 2015 Implementation of new integrated ways of working from April 2015. BCF funding to be awarded in 2015/16, partly on performance metric achievement. 25% of funding is dependent on achieving performance targets.	• Permanent number of admissions to residential care • Number of older people who receive reablement and rehabilitation services and are still at home after 91 days • Numbers of delayed discharges from hospital • Avoidable emergency admissions
Reduced hospital admissions	1. STARRS is achieving reductions in hospital admissions but the ICP and CSPA are not achieving as planned. 2. There is a need for a shared analysis of the factors influencing unnecessary admissions	Jo Ohlson / Phil Porter	Production of the Better Care Fund Plan, including a range of projects to reduce A&E attendances and hospital admissions: • ICP 2 • Integrated STARRS Service • Effective hospital discharge • Mental Health Improvement Agreement of Better Care Fund performance metrics, including reducing A&E attendances. Metrics and baselines to be in place by April 2014. Planning BCF schemes will take place up to April 2015 Implementation of new integrated ways of working from April 2015. BCF funding to be awarded in 2015/16, partly on performance metric achievement. 25% of funding is dependent on achieving performance targets.	Performance metrics to be agreed by April 2014 – plan will be updated with baseline information after that in order for the Board to monitor hospital admission performance. The Better Care Fund provides a minimum set of indicators to provide focus: • Permanent number of admissions to residential care • Number of older people who receive reablement and rehabilitation services and are still at home after 91 days • Numbers of delayed discharges from hospital • Avoidable emergency admissions

Reduced delayed discharges	1. Operationally, Brent CCG, NWLHT, EHT and other key partners are working together to get rid of barriers to effective discharge. Failure to reduce delays from 2012/13 identifies this as a high joint priority 2. The good operational dialogue is not the same as a fully integrated system for discharges, which 'pulls' people from hospital back into the community ensuring the right mix of support across health and social care is in place for that discharge. Although there is support for this approach, there is not a detailed plan for how to achieve it 3. More can be done to ensure that the incentives put in place by national policy do not undermine local working, for example, shared dataset on delays that focuses on how we as a system can improve discharges, not which agencies is at fault	Jo Ohlson / Phil Porter	Production of the Better Care Fund Plan, including a scheme on effective hospital discharge. BCF Plan will include a range of enabling schemes to assist in reducing delayed discharges. Agreement of Better Care Fund performance metrics, including reducing delayed discharges. Metrics to be agreed by April 2014 and baselines identified. Planning BCF schemes will take place up to April 2015 Implementation of new integrated ways of working from April 2015. BCF funding to be awarded in 2015/16, partly on performance metric achievement. 25% of funding is dependent on achieving performance targets.	Performance metrics to be agreed by April 2014 – plan will be updated with baseline information after that in order for the Board to monitor delayed discharge performance. The Better Care Fund provides a minimum set of indicators to provide focus: • Permanent number of admissions to residential care • Number of older people who receive reablement and rehabilitation services and are still at home after 91 days • Numbers of delayed discharges from hospital • Avoidable emergency admissions
Improve support in the community to help people remain independent	1. Brent Council is starting a project to deliver more supported living and more extra care (potentially 300 units over the next 3-4 years), so people will have a more choice about where they want to live (at home, in housing that provides extra support, or is residential	Jo Ohlson / Phil Porter	Completion of the Better Care Fund Plan by April 2014, including measures to improve support in the community and ensure people remain independent for as long as possible. The BCF will contain performance metrics, including the number of people in residential care, which will help determine whether the actions being taken are leading to improvements in helping people to remain independent.	Performance metrics to be agreed with BCF by April 2014 and will be added to the Action Plan The Better Care Fund provides a minimum set of indicators to provide focus: • Permanent number of

	care). 2. As part of this work, Adult Social Care is focusing on assessment and care management and ensuring they are equipped to support people to identify more creative solutions than residential care that allow people to live at home in their community 3. Further work required to ensure that across health and social care there are no incentives in the system to push people into residential care and that everyone who supports vulnerable adults is able to support them to find the right support for them		Role out of BCF scheme – ICP2, which is focussed on keeping the most vulnerable well in the community. The core components of the scheme are: • Establishment of GP networks, with professionals from a variety of services working in an integrated network, and on a single care plan for each individual • Focus on 2-3% of the most vulnerable people in the community • Extended GP out of hours provision until 10pm, home visits and out of hours visit from within the network. Training will be taking place across Adult Social Care on good quality assessments and care planning. This will be happening throughout 2014, and will focus on older peoples' services, learning disabilities and mental health.	admissions to residential care • Number of older people who receive reablement and rehabilitation services and are still at home after 91 days • Numbers of delayed discharges from hospital • Avoidable emergency admissions Show ongoing improvement in potential years of life lost indicator – • 2012 baseline – 2512 per 100,000 population • 2014/15 target – 2431 per 100,000 population • 2015/16 target – 2353 per 100,000 population
Customer satisfaction with management and support of long term conditions	1. The Integrated Care Pathway project is up and running in Brent which provides multi-agency case conferences for the most complex cases. It has also provided a productive forum for multi-agency improvement and learning 2. This project will be evaluated in during 2013 3. Further work is required to build on this and deliver fundamental operational	Jo Ohlson / Phil Porter	Customer experience and customer satisfaction to form a key part of the Better Care Fund work and performance monitoring. There will be a clear focus on customer experience and perception. The proposal from an ASC perspective is to focus on the Adult Social Care Outcomes Framework (an area which required focus as set out in the Local Account and derived from the annual Adult Social Care Survey): • Percentage of people who are satisfied with the care and support they receive • The proportion of people who feel they have choice and control over their lives • Social care related quality of life index.	Percentage of people who are satisfied with the care and support they receive 2012/13 baseline – 32.9% The proportion of people who feel they have choice and control over their lives 2012/13 baseline – 64.7% Social care related quality of life index.

	change with community health and social care services being built around the GP to ensure a joined up approach for all 4. New initiative for diabetes will be in place by April 2014. Locality hubs and GP network development intended to increase capacity for long term conditions but not yet fully in place			2012/13 baseline – 17.6
Zero tolerance of abuse	1. Strong Safeguarding Adults Board with good attendance from all key partners 2. Clear priorities identified for this financial year 3. Improved outcomes in terms of screening SGA alerts and getting conclusive outcomes to investigations 4. Operational dialogue between the CCG, Brent Council and CQC to share intelligence and focus action 5. The Quality, Safety, Clinical Risk and Research Group reviews reports from the Adult Safeguarding Board including serious incidents and lessons learned from serious case reviews. It quality assures Brent CCG commissioned services in respect of adult safeguarding.	Jo Ohlson / Phil Porter	Safeguarding priorities for 2014 have been set and will be overseen by the Safeguarding Adults Board: • Reducing financial abuse and ensuring a more effective multi-agency response • Reducing avoidable pressure ulcer incidents • Improving processes and procedures to embed high quality standards • Improving multi-agency working, including Safeguarding Adults Board effectiveness • Changing culture - commissioning for quality	Continue to reduce the number of safeguarding investigations where the outcome is “not determined / inconclusive” – 2012/13 baseline – 20% of all investigations Increase the perceptions of safety as recorded in the safeguarding adults annual survey

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Brent	**Health and Wellbeing Board** **February 2014** Report from the Director of Public Health
For Action	Wards Affected: ALL

Refresh of the Brent Joint Strategic Needs Assessment

1. Summary

1.1 This report provides a brief update on actions to refresh the Brent Joint Strategic Needs Assessment (JSNA).

1.2 The intention is to complete the refresh of the local Brent JSNA by April 2014 prior to formal sign-off by the Health and Wellbeing Board.

2. Recommendations

The Board is asked:

2.1. To note and approve the scope and timetable of the JSNA Refresh.

2.2 To note and approve the collaborative involvement of Council and CCG officers and acknowledge the commitment by all sides to complete the Refresh by April 2014.

2.3 To browse through the current JSNA and provide:

a) Comments on the scope of the Refresh
b) Suggestions regarding the presentational style of the final JSNA summary report.

3. Report

3.1 It is a statutory obligation on the Council and the CCG to work collaboratively through the Health and Wellbeing Board to produce a local Joint Strategic Needs Assessment[i].

3.2 The purpose of the JSNA is to:

- Provide a comprehensive picture of local health and wellbeing needs

- Identify the major health inequalities and the key health issues for Brent and suggest what can be done to address them.

3.3 In turn, Health and Wellbeing Board should use the local JSNA to negotiate and agree overarching priorities on health and wellbeing when preparing the borough's Health and Wellbeing Strategy. This in turn will inform future health and social care commissioning plans.

3.4 The current Brent JSNA was produced in early 2012 and is publically available on the Council website at http://www.brent.gov.uk/your-council/partnerships/health-and-wellbeing-board/jsna/

3.5 The current JSNA was used to produce the initial version of the Health and Wellbeing Strategy produced in late 2012. However two years on, some of the data in JSNA requires updating, and it also needs to better align with both the recent refresh of the Health and Wellbeing Strategy and also recent policy developments in Health and Social Care.

3.6 A steering group has been formed with representation from the CCG, Public Health, Corporate Policy, Adult Social Care and Children and Families. The steering group is a task and finish group which will spend the next few months focusing on strengthening the current JSNA work.

3.7 The steering group is currently reviewing the JSNA which comprises of a number of briefs which analyse a range of health and wellbeing topics. There are 26 locally-produced briefs as well as a number of additional analysis from other agencies (e.g. the Public Health Observatory profile for Brent on tobacco control). The respective officers are identifying briefs which need updating or re-writing; for example the CCG are keen to re-write the briefs on primary and secondary care given the huge organisational changes that have occurred in recent years.

3.8 Council officers have already identified welfare reform, air pollution, transport and housing as key areas where new analysis is required. Discussions with Children and Families and Adult Social Care are on-going to identify other key areas which will require additional analysis.

3.9 In addition to updating the existing pieces of analysis in the JSNA, the other key aim of the Refresh will be to produce a summary document which will provide a powerful over-arching narrative of the current and future health and wellbeing needs of Brent. This summary/ highlight report will, it is hoped, provide a useful link between the large amount of analysis in the JSNA and the future commissioning intentions of the Council and the CCG.

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[i] Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies Department of Health http://webarchive.nationalarchives.gov.uk/20130805112926/https://s3-eu-west-1.amazonaws.com/media.dh.gov.uk/network/18/files/2013/03/Statutory-Guidance-on-Joint-Strategic-Needs-Assessments-and-Joint-Health-and-Wellbeing-Strategies-March-20131.pdf

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