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Brent

Brent Clinical Commissioning Group

Health and Wellbeing Board

Tuesday 18 November 2014 at 1.45 pm
Patidar House, 22 London Road, Wembley, Middlesex HA9 7EX

Membership:

Members		Substitute Members
Councillor Pavey (Chair)	Brent Council	Councillors:
Councillor Crane	Brent Council	Butt, Denselow, Mashari and McLennan
Councillor Hirani	Brent Council	
Councillor Moher	Brent Council	
Councillor Warren	Brent Council	
Christine Gilbert	Brent Council	
Sue Harper	Brent Council	
Phil Porter	Brent Council	
Melanie Smith	Brent Council	
Dr Sarah Basham	Brent CCG	
Jo Ohlson	Brent CCG	
Rob Larkman	Brent CCG	
Dr Ethie Kong	Brent CCG	
Ann O'Neill	Brent Health Watch	

For further information contact: Peter Goss, Democratic Services Manager
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democracy.brent.gov.uk

The press and public are welcome to attend part B of this meeting

Agenda

Introductions, if appropriate.

Apologies for absence and clarification of alternate members.

Item		Page
	PART A	
1	**Community Action on Dementia** Facilitated workshop	
	PART B	
2	**Membership** Councillor Perrin has stood down as Lead Member for Environment and Councillor Crane has been appointed in his place. The Leader of the Council has appointed Councillor Crane to the Board in place of Councillor Perrin. Sarah Mansuralli has been nominated to replace Jo Ohlson as a representative of the Brent CCG on the Board. This appointment will be made by Full Council on 8 December 2014.	
3	**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.	
4	**Minutes of the previous meeting** Minutes of 24 July 2014 attached for confirmation.	1 - 10
5	**Matters arising (if any)**	
6	**Better Care Fund** The purpose of this report is to update members on the progress made in respect of the health and social care integration in Brent and specifically 'Better Care Fund' (BCF) programme. **Ward Affected:** All Wards ***Contact Officer**:* Phil Porter, Strategic Director, Adult Social Services Tel: 020 8937 5937	11 - 90

phil.porter@brent.gov.uk

7 Annual report of the Director of Public Health for Brent 2014 91 - 116

The attached report considers the health of the people in Brent. It outlines the major causes of mortality and morbidity as well as describing health related behaviours in Brent. It contains a number of examples of how the Council and local people are responding to the health challenges in the borough.

Ward Affected: All Wards

Contact Officer: Melanie Smith, Director Public Health
Tel: 0208 937 6227
melanie.smith@brent.gov.uk

8 Joint Strategic Needs Assessment highlight report 2014 117 - 176

This refresh of Brent's JSNA provides a detailed analysis of the existing and projected health needs of the local population with the overall aim being to provide the intelligence to inform action to improve outcomes for Brent communities and residents.

Ward Affected: All Wards

Contact Officer: Melanie Smith, Director Public Health
Tel: 0208 937 6227
melanie.smith@brent.gov.uk

9 Tackling Violence against Women and Girls in Brent Action Plan 177 - 196

The Board is presented with the Action Plan from the Tackling Violence against Women and Girls in Brent Task Group.

10 Pharmaceutical Needs Assessment Consultation 197 - 202

The report outlines responsibilities for responding to consultation requests from neighbouring boroughs. The Board are asked to consider amendments to the PNA Steering Group terms of reference.

Ward Affected: All Wards

Contact Officer: Melanie Smith, Director Public Health
Tel: 0208 937 6227
melanie.smith@brent.gov.uk

11 Forward Plan

The Board are asked to agree future topics from a draft forward plan to follow.

Ward Affected: All Wards

Contact Officer: Phil Porter, Strategic Director, Adult Social Services

Tel: 020 8937 5937
phil.porter@brent.gov.uk

12 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: Thursday 22 January 2015

Please remember to switch your mobile phone to silent during the meeting.

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

Brent

MINUTES OF THE HEALTH AND WELLBEING BOARD
Thursday 24 July 2014 at 7.00 pm

PRESENT: Councillor Pavey (Chair and Deputy Leader of Brent Council) and Dr Sarah Basham (Co-Clinical Director, Brent Clinical Commissioning Group), Councillor Hirani (Lead Member for Adults, Health and Wellbeing, Brent Council), Sarah Mansuralli (Deputy Chief Operating Officer, Brent Clinical Commissioning Group), Councillor Moher (Lead Member for Children and Young People, Brent Council), Ann O'Neill (Healthwatch Brent), Jo Ohlson (Chief Operating Officer, Brent Clinical Commissioning Group), Councillor Perrin (Lead Member for Environment, Brent Council), Phil Porter (Strategic Director, Adult Social Services, Brent Council), Melanie Smith (Director of Public Health, Brent Council) and Gail Tolley (Strategic Director, Children and Young People, Brent Council)

Also Present: Councillor Harrison (Brent Council) and Ben Spinks (Assistant Chief Executive, Brent Council)

Apologies were received from: Christine Gilbert (Chief Executive, Brent Council), Sue Harper (Strategic Director, Environment and Neighbourhoods, Brent Council), Dr Ethie Kong (Chair, Brent Clinical Commissioning Group) and Rob Larkman (Chief Officer, Brent Clinical Commissioning Group)

1. **Declarations of interests**

Councillor Perrin declared that he was a member of the Equalities, Diversity and Engagement (EDEN) Committee, Chair of the Wembley Locality Patient Participation Group and Chair of Sudbury Surgery Patient Participation Group (also known as Intergrated Health) and by consequence, the patient representative on the board of Intergrated Health. However, he did not regard these as prejudicial interests and remained present to consider all items on the agenda.

2. **Minutes of the previous meeting held on 9 April 2014**

RESOLVED:-

that the minutes of the previous meeting held on 9 April 2014 be approved as an accurate record of the meeting, subject to the following amendment:

page 2, last paragraph, line 8 – add ‘and extended stays in hospital’ after ‘hospital admissions’.

3. **Matters arising**

Shaping a healthier future implementation update

Responding to a query from the Chair concerning the future of Central Middlesex Hospital (CMH), Jo Ohlson (Chief Operating Officer, Brent Clinical Commissioning

Group) advised that a thorough assurance process had been undertaken by Brent Clinical Commissioning Group (CCG), the Trust Board, NHSE and Trust Development Agency who were satisfied with arrangements that would lead to the closure of the Accident and Emergency Unit (A and E) on 10 September. She added that the Urgent Care Centre (UCC) at CMH would continue to operate on 24/7 basis and offer an enhanced specification as a standalone UCC. A high level, detailed information campaign informing the public of the changes to services at the UCC was to be launched in the week commencing 28 July. Members noted that the closure of the A and E at CMH was also to be discussed at the Scrutiny Committee on 6 August. In response to a query from Councillor Perrin, Jo Ohlson advised that the information campaign contained the header 'A and E is changing' because although the unit was closing, it could be misleading to the public to state this as a headline as in fact the UCC would continue to operate on a 24/7 basis.

In reply to the Chair's query concerning what the UCC at CMH could provide, Sarah Mansuralli (Deputy Chief Operating Officer, Brent Clinical Commissioning Group) advised that it would provide primary care for minor illnesses and accidents. There would also be signposting to relevant services for patients where treatment at the UCC was unnecessary.

Ann O'Neill (Healthwatch Brent) expressed surprise at there being no councillors present at a recent CMH consultation meeting and felt that it would be appropriate that they attend future such events.

In reply, The Chair acknowledged the importance of attending such events, explaining that some members had meetings clashing with the CMH consultation event. The Chair requested that there be a further update about the closure of the A and E at CMH at the next meeting.

Brent Better Care Fund Plan

Phil Porter (Strategic Director, Adult Social Services) updated the Board on the Brent Better Care Fund Plan, explaining that there was now greater clarity and that the Brent Integration Board was working with the new plan and template. He added that there would be greater focus on reducing hospital admissions whilst balancing medical and social care needs.

4. **Developing the Health and Wellbeing Board: new ways of working**

Ben Spinks (Assistant Chief Executive, Assistant Chief Executive's Service) introduced the report that set out a starting point for discussion for future ways of working for the Health and Wellbeing Board (HWBB). He explained that there were three types of items that the HWB to consider, these being:

- Nationally mandated issues, including statutory responsibilities
- System leadership
- Leadership on key issues in Brent

Ben Spinks advised that the HWBB had been successful in meeting its statutory responsibilities, such as developing and agreeing a Joint Strategic Needs Assessment (JSNA) and health and wellbeing strategy for the borough. The HWBB was also developing its system leadership role, an example of this was the

oversight role it played for the health and wellbeing action plan that brought together all the work being undertaken by the relevant organisations in delivering the health and wellbeing strategy. However, Ben Spinks advised that there was considerable scope for the HWBB to play a greater role in providing leadership on key issues and in view of this, the report was suggesting that the HWBB focus its development in this area over the next twelve months.

In order to strengthen its leadership on key issues in the borough, Ben Spinks suggested some ways in which this could be done, including:

- Facilitation of workshops by the council and through other organisations in Brent as appropriate
- External facilitation of workshops by a relevant expert
- Appoint a partner to lead the facilitation across all topics

Ben Spinks then referred members to the recommendations in the report.

Phil Porter added that the HWBB could look at issues across a number of areas and its work programme would be flexible to reflect any changes either at local or national level. He suggested that a more workshop like approach could be taken at meetings, with greater participation from a wider audience and providing a clear focus in achieving practical outcomes.

During discussion by Board members, Councillor Moher stated that it had been agreed by the Board last year that there would be a distinction between business meetings and other meetings and she sought clarification that both such types of items would be covered during meetings and whether there would be sufficient time to consider both. Councillor Hirani indicated his support for the proposals and members agreed to his suggestion that Board's work programme should be guided by the Joint Strategic Needs Assessment (JSNA) and the HWBB strategy. Councillor Hirani felt that a discussion about dementia would be a useful topic of discussion at a future meeting and the Board agreed that this be part of its future work programme. Ann O'Neill (Brent Health Watch) emphasised the need for the HWBB's work to relate to the public and for them to have faith in its effectiveness. She felt that there was a need for more community engagement and use of feedback from Brent Connect Forums and other local evidence should be used. Ann O'Neill felt that external facilitation of workshops was a good idea and it would be preferable that this was undertaken by a not for profit organisation, whilst the layout of the meeting should also be changed to a less formal one so as to encourage discussion amongst all who were present.

Jo Ohlson, in supporting the proposals, stated that the HWBB's role should be broad and there was a clear need to develop its system leadership role. There would also need to be a review after a period of time to see if the changes had made the HWBB more effective across its wider role. Jo Ohlson also supported external facilitation of workshops and she felt that this would help ensure wider views were heard. Sarah Mansurall also felt the proposals would make it easier to piece together information and feedback from a variety of sources to provide a broader picture and allow the HWBB to have a greater impact on a range of services and agencies. Dr Sarah Basham (Co-Clinical Director, Brent Clinical Commissioning Group) commented on the benefits of talking with other relevant agencies, especially as many issues involved a number of different organisations.

The Chair felt that the direction that the HWBB was taking was positive and he welcomed external facilitation of workshops. He added that the workshops would discuss key items and would take place in a setting relevant to the topic under discussion.

In reply to the issues raised, Ben Spinks confirmed the intention to include both workshop items, as part A of the agenda, and more formal items under part B of the agenda, at the same meetings. By taking a disciplined approach to each item and dividing the agenda into parts A and B, this would ensure that there was sufficient time to discuss and debate the items under part A. Ben Spinks advised that the proposals were designed to make HWBB meetings more inclusive and other forums, such as the Brent Connects Forums, could feed into this. He also advised that the Chief Executive was currently undertaking a review for restructuring Partners for Brent in order that the relevant organisations could work closer together.

Phil Porter advised that the Board could decide what items were most key and to allocate appropriate time at the meetings accordingly and people affected by a particular topic would be invited to that meeting. He informed members that the external provider appointed for the workshops would need to be capable of providing development of system leadership and opening up the HWBB to different ways of working and would either be appointed based on the particular issue for discussion or for the rest of the municipal year.

Melanie Smith (Director of Public Health) added that the workshops would benefit from subject matter experts as well as external facilitation.

The Chair then invited the Board to submit topics for discussion at future meetings and the following were put forward:

- Dementia
- Dental health/children's oral health
- Obesity
- Social isolation
- Mental health and well being
- Autism
- Housing and homelessness/rough sleepers
- Fuel poverty
- TB

The Chair added that other items may also be suggested to be added to the list above and following further discussion, a proposed schedule of topics would be circulated at the end of August.

Members agreed the recommendations in the report.

RESOLVED:

(i) that a trial of a number of changes to the format and focus of the Board's work be agreed as below:

- Focus on a priority list of key areas where a stronger partnership approach has the potential to drive change and improved outcomes.
- Develop a part A and B agenda in future, with part A comprising a limited number of items for detailed discussion and debate and part B items for noting and/or ratification.
- Agree the approach for facilitation of the part A discussions.
- Agree to hold meetings in venues related to the issue being discussed where relevant and appropriate;

(ii) that discussion and agreement of a provisional list of priority areas which will form the basis of the part A work programme over the coming months be agreed; and

(iii) that these changes starting from the October meeting of the Board be agreed, with dementia as the subject of part A of the agenda.

5. **Brent alcohol harm reduction strategy 2014 - 2017**

Melanie Smith introduced the report and advised that there had been wide input into producing the alcohol harm reduction strategy. The strategy aimed to reduce alcohol related harm through three desired outcomes, these being:

- A healthier community
- A safer community
- A more responsible community

Melanie Smith then drew the Board's attention to the recommendations as set out in the report. She added that work was already underway in developing the strategy's action plan.

During discussion, Councillor Moher noted the role the police had in respect of making representations for licensing applications and she queried whether higher fees could be set for certain kinds of licences. Councillor Perrin stated that there was a worrying increase in the number of counterfeit spirits and concerted efforts were being made in prosecuting retailers who sold alcohol to those who were under the legal age. Councillor Hirani felt there was a need for stronger licensing enforcement and consideration should be given to not approving licences in areas of the borough where alcohol misuse and its associated problems were at their highest.

Dr Sarah Basham emphasised the importance of outreach work and appropriate signposting for those affected by alcohol misuse. Sarah Mansuralli advised that there had been an increase in alcohol related admissions to hospitals and a number of such patients were frequent visitors which underlined the need to support intervention services. Jo Ohlson stated that there was a need for a broader risk assessment of those who may be at risk from alcohol misuse. Ann O' Neill felt that there was also a need to provide the relevant contacts for the public for those affected by others' drinking, such as street drinkers. Gail Tolley (Strategic Director, Children and Young People) enquired whether there were any current figures in respect of the desired outcomes.

The Chair noted and expressed concern about the increase in alcohol related crime and alcohol violent crime estimates in Brent compared to the London average which was decreasing, as set out in charts six and seven in the report. He enquired whether the HWBB would receive regular updates on the performance on achieving the strategy's outcomes.

In reply to the issues raised, Melanie Smith advised that the council had information for example on some of the businesses selling alcohol early in the morning. The licensing team were planning to review the council's Statement of Licensing Policy and there would be a focus on health. She felt that although the services provided to address alcohol misuse were good, they were not being used as much as they should and there needed to be better working between the relevant services and agencies to help reduce the number of hospital referrals. An early intervention alcohol service had been trialled without much success and so the service was currently being redesigned. Members noted that figures for the action plan were currently being populated and that there would be regular performance updates as part of the strategy.

RESOLVED:

(i) that the Brent alcohol harm reduction strategy 2014 – 2017 be approved; and

(ii) that the establishment of an Alcohol Harm Reduction Strategy Group with membership from public health, communications, licensing, community safety, the police and Brent Clinical Commissioning Group be supported to:

- Develop and implement an action plan to deliver the three objectives
- Monitor the impact of this plan.

6. **Whole systems integrated care**

Phil Porter presented the item and stated that Whole Systems Integrated Care (WSIC) Brent Early Adopter project was an ambitious programme that was a key part of the North West London Pioneer Project. He stated that the WSIC vision contained four main objectives, these being:

- Ensuring funding flows to where it is needed
- Patients and communities are recognised as assets
- Care is provided in the most appropriate setting
- Care is coordinated around the individual

Phil Porter then referred members to the WSIC approach to population grouping as set out in the report. Members heard that each GP locality had been given the opportunity to take part in the Early Adopter project, however it was the Harness and Kilburn GP networks that had volunteered to participate. The WSIC also sought to develop the model of care and this would include four evidence based principles, these being:

- A collaborative multi-disciplinary team structure

- Care coordination
- Self-management by the patient
- A single shared care plan

Phil Porter advised that there were also significant barriers to overcome as outlined in the report. In terms of measuring success and the impact on service users and providers, this would not just be measured in terms of reducing admissions and residential care, but also in improving quality and outcomes. Phil Porter confirmed that the deadline to finalise the business case for the programme was 31 October and the timetable of activities was also a challenging one.

Sarah Mansuralli added that a more collaborative approach with acute providers was being taken across the whole of North West London.

During members' discussion, Councillor Perrin enquired how patients would be supported to self-manage their health and wellbeing as mentioned in the report and he sought further comments in respect of one of the desired outcomes of over 75s patients to remain at home. Councillor Hirani enquired whether the programme would cover patients who received services from specialised commissioning. Ann O'Neill enquired what steps would be taken to inform the public about the programme and the reasons why it was being undertaken.

At the invitation of the Chair, Elcena Jeffers addressed the Board. Elcena Jeffers stressed that it was important for all stakeholders to work together to provide more effective care and she felt that another meeting should take place between them before the next HWBB meeting in October.

The Chair welcomed the report, however he enquired why it lacked any figures and asked how many patients would be affected by the programme and who would it impact upon most, whilst information on the budget was also sought. He suggested that by offering a simpler and more streamlined service, this was representing a positive message and he enquired whether anyone would be adversely affected by the proposals.

In reply to members' queries, Phil Porter advised that patients would self-manage to the extent that was practically possible and the proposals would be an improvement from the current system where decisions by different agencies were not necessarily joined up. With regard to the desired outcome of over 75s remaining at home, Phil Porter informed members that there needed to be an improvement in making patients feel safer in their homes and this is an area where efforts would be focused on. Phil Porter advised that budget details had not been finalised, however there would be no increase in cost, although some organisations may be contributing more than they currently were.

Sarah Mansuralli advised that around 6,000 patients would be involved in the pilot Early Adopter project. With regard to patients receiving specialised commissioning, she stated that the numbers involved were small, however information would be shared with NHS England to ensure all patients needing to be covered were. Frontline staff would be at the forefront of informing patients about the proposals, whilst workshops would be co-produced by the organisations involved with a view to testing these with individual community groups before preparing patient groups to help disseminate information.

Jo Ohlson added that Harness and Kilburn GP networks had been chosen for the Early Adopter project as it was felt that involving a relatively small number of patients was appropriate for a pilot project. The proposals would include the creation of a single team, with GPs providing coordinated care.

RESOLVED:

(i) that Brent's next phase planning activities, and in particular the deadline of 31 October 2014 for submission of the Implementation Plan and the emerging changes, challenges and opportunities in health and social care services that need to be overcome to deliver whole systems integration, be noted;

(ii) that the positive feedback from the Expert Panel for the process of co-production and the WSIC Outline Plan be noted;

(iii) that the forthcoming opportunities for engagement and co-production in the WSIC Brent Early Adopter Project and an opportunity to influence the development of the Early Adopter Implementation Plan, and specifically, the co-production of the vision for WSIC, the Model of Care and the outcomes for measuring success of whole systems integration for the target cohort of patients, be noted;

(iv) that following the development of the WSIC Implementation Plan for Brent's Early Adopter, that Brent's vision for Whole Systems Integrated Care and the Model of Care to deliver the vision be reviewed; and

(v) that the next review point, prior to formal approval at the October meeting of the Health and Wellbeing Board, be noted.

7. **Revision of the Brent pharmaceutical needs assessment**

Melanie Smith presented the report that detailed the requirement for a Pharmaceutical Needs Assessment (PNA) and how this would be carried out. She thanked Brent Clinical Commissioning Group and the Local Pharmacy Committee for their input into the work.

RESOLVED:

(i) that the establishment of a task and finish PNA Steering Group be agreed;

(ii) that the terms of reference for the PNA Steering Group which form appendix 1 to this report be agreed; and

(iii) that the PNA Steering Group be delegated the task of overseeing the conduct, consultation and publication of the revised Brent PNA.

8. **Medication incidents report**

Mark Eaton (Head of Delivery and Performance, Brent Clinical Commissioning Group) presented the report that set out Brent CCG's proposals to address Domain

5 of the CCG's 2014/15 Quality Premium. The main aim of Domain 5 was for CCGs to work more closely with key providers to increase the number of medically related incidents reported in order to capture the estimated 80% of medication incidents that go unreported. Mark Eaton confirmed that NHS England had accepted proposals for Brent CCG to work with Harrow CCG and Hillingdon CCG in delivering Domain 5. Agreement on the targets and the approach for Domain 5 had been agreed between NHS England and Brent, Harrow and Hillingdon CCGs and the providers. However, Mark Eaton advised that even if only one CCG failed to deliver its targets, then none of the three CCGs will be accredited with achieving Domain 5. The Board noted that three of the four providers were being asked to increase the rate of reported medication related incidents, whilst the other, Imperial Hospital, was being asked to maintain its figures.

During members' discussion, Ann O'Neill enquired why this item needed to be reported to the HWBB and how much the Domain 5 was worth to the CCGs. The Chair noted that the targets were set for December 2014, and in view that this was only a short while away, he sought further comments about the likelihood of these being delivered.

In reply, Mark Eaton advised that achieving Domain 5 was worth around £700,000 across all three CCGs and he felt that the targets were achievable by December. Jo Ohlson confirmed that Brent CCG's 2014/15 Quality Premium was statutorily required to be reported to the HWBB.

9. **Protocol agreement between Brent Local Safeguarding Children Board and the Health and Well Being Board**

Gail Tolley presented the report which sought members' approval for the protocol agreement between the Brent Local Safeguarding Children Board and the HWBB. She advised that Local Safeguarding Children's Boards were now to be reviewed, conducted under 15 (A) of the Children Act and there was an expectation clear governance protocols were in place.

In reply to a query from Jo Ohlson, Phil Porter confirmed that similar arrangements were being made with regard to the Brent Safeguarding Adults Board.

RESOLVED:

that the protocol agreement between the Brent Local Safeguarding Children Board and the Health and Wellbeing Board be agreed.

10. **North West London Five Year Strategic Plan (draft), 2014/15 - 2018/19**

Kate Lawrence (North West London Strategy and Transformation Team, NHS) presented the report and advised that the eight CCGs participating in the North West London Five Year Strategic plan were Brent, Central London, Ealing, Hammersmith and Fulham, Harrow, Hillingdon, Hounslow and West London CCGs. The eight CCGs had combined to produce a joint strategic plan as it was consistent with other strategic planning that they had been involved in, such as the Shaping a Healthier Future programme. Kate Lawrence drew members' attention to the process for developing the plan and what the plan meant to Brent as set out in the

report. She explained that the strategy was outcomes focused and referred to the desired outcomes listed in the report and the ways in the HWBB would be involved.

During members' discussion, Gail Tolley enquired if there was any children and young people representation on the North West London Strategic Planning Group. The Chair added that the proposals seemed quite adults focused and in noting the reference to giving every child the best start in life in the report, he felt there should also be more priorities involving children and young people.

With the invitation of the Chair, Elcena Jeffers addressed the Board and she requested that there be a sign in sheet at future HWBB meetings so there was a record of all who had attended, which the Chair agreed to.

In reply to the issues raised, Sarah Mansuralli acknowledged that there was a need to focus more on children and young people and efforts would be made to undertake this.

11. **Date of next meeting**

It was noted that the next meeting of the HWBB was scheduled to take place on Thursday, 30 October 2014 at 7.00 pm. Phil Porter advised that the next meeting would consider issues relating to dementia in Brent.

12. **Any other urgent business**

Jo Ohlson confirmed that she would be leaving Brent CCG to take up a position at NHS England. Sarah Mansuralli would take over her role as Chief Operating Officer of Brent CCG.

Phil Porter advised that a bid had been made with the endorsement of the HWBB to receive funds from the Integrated Technology Fund. If the bid was successful, Phil Porter stated that the funding would be of particular use in saving on unnecessary bureaucratic processes and he would inform members of the outcome of the bid.

The meeting closed at 9.10 pm

M. PAVEY
Chair

Brent	**Health and Wellbeing Board** 18 November 2014 **Report from the Director of Adult Social Services/Chief Operating Officer Brent CCG**
For Information	
Brent's Better Care Fund	

1. Summary

1. The purpose of this report is to update members on the progress made in respect of the health and social care integration in Brent and specifically 'Better Care Fund' (BCF) programme.

2. Recommendations

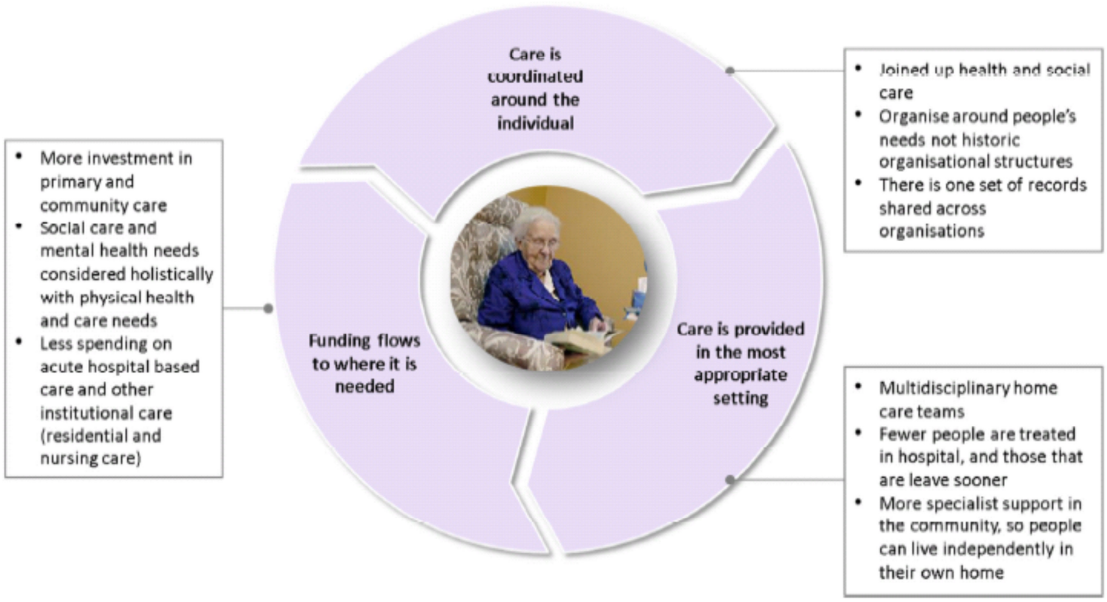
2.1 The Health and Well being Board is asked to:

- note and comment on the Better Care Fund submission, including:
  - the additional detail in the plans for further developing the schemes and delivery
  - the revised Mental Health scheme in the plan
  - the approach to implementation and in particular, the planned programme management office, the importance of service user and carer co-production and ongoing governance and oversight,
- note the assurance letter from NHS England.

3. Background – Better Care Fund

3.1. Brent Clinical Commissioning Group and Brent Council have been working closely with key partners including health providers and service users and carers over the last 9 months to develop a programme of health and social care integration which transforms services to improve the lives of people in Brent.

3.2. The Brent vision for this health and social care integration has not changed. It is clearly focused on putting the person at the centre of services, ensuring we respond to individual needs, moving beyond a medical model, to ensure all services and support reflect what is important to the people we serve. The diagram below (which has been presented to previous HWBB meetings) reflects that vision in more detail:



3.3. The Better Care Fund is a national programme that requires all localities to present local transformation programmes in a national template to secure funding. The original submission of Brent's Better care Fund was discussed in draft form at the February 2014 HWBB to steer the content, and then in final form after the submission at the April 2014 HWBB.

3.4. Since that time there has been a national review of the Better Care Fund programme, which challenged and revised both the process and the objectives of the programme. The key issues that were under revision are as follows:

- the performance metrics - there has been a renewed focus on reducing avoidable hospital admission,
- decisions about whether to make the funding performance related (this condition was removed, but brought back in so that £1.6m of the funding in the submission is now related to performance on avoidable hospital admissions
- protecting adult social care services – given the pressures on local council budgets, nationally, reassurance was sought that through this process support to the most vulnerable adults was protected
- delivering 7 day services, which is seen as a key transformation in delivering better outcomes for people and a more effective system.

3.5. As a result of these national changes, Brent was required to submit the Brent plan in September 2014. The key point to note here is that Brent had a clear vision in April, with core schemes of transformation underpinning that vision. Work has continued on those schemes and the document presented here today does not reflect a significant change in approach from that submitted and discussed at the HWBB earlier this year.

3.6. Since September, there has been a regional and national assurance process which has led to the receipt of the letter attached at Appendix A from NHS England. There are four categories of assurance: Approved, Approved with

Support, Approved with Conditions, Not Approved. Brent received an assurance rating of Approved with Support. This means there is confidence in the plan, but there is additional work to be done to meet a number of criteria set out in the national methodology.

3.7. This work is ongoing and support will be provided to help us address outstanding questions and risks raised by NHS England during review of our September submission. Brent has already provided an initial response to NHS England outlining how we will clarify our plans against each point raised, which was well received, and the final detailed responses will be addressed in a revised version of the Brent BCF resubmission due at the end of November, final date still to be confirmed.

3.8. The outstanding areas where NHS England wants to see more detail on are:

- Socio-demographic information
- Clearer articulation of the benefits to be derived from BCF
- Formal sign up by all local providers (Imperial Trust provided one response to all of the BCF plans across all of the CCGs they provide services to)
- The use of funds under BCF and the £1.6 million contingency fund (finance leads from the CCG and local authority will provide further input)
- How risks will be enacted through contracting arrangements with health providers.

3.9. However, the core message in this paper is that while this process of assurance with NHS England needs to be completed, the focus has to be on local work to continue to develop these schemes for implementation in April 2015 to deliver the benefit to local residents, and this should be the focus of the HWBB.

4. Implementing health and social care integration in Brent

4.1. As stated above the focus of the Brent BCF plan is largely unchanged from the last presentation to the HWBB the re-submission just provides more detail on what is in the schemes and how they will be delivered. The plan is made up of the following 'schemes':

- ***Scheme 1: Keeping the most vulnerable well in the community***, which is unchanged and focuses on developing proactive integrated care [planning which minimizes the number of crises. This is unchanged and work has continued on the two core components of this scheme:
  - *Integrated Care Pathway 2*, which brings together a range of professionals to develop care plans for those at the highest risk f hospital admission
  - *Whole Systems Integrated Care* – this is Brent's early adopter as part of the North West London health and social care Pioneer programme. An update on this project was provided to the last HWBB and a further paper which sets out the detail of the model of care will come to the next HWBB
- ***Scheme 2: Avoiding unnecessary hospital admissions***, which is unchanged and acknowledges that crises will still happen and focuses on building on the excellent work of the Short Term Assessment, Reablement

and rehabilitation Service (STARRS) to ensure we have all the services in place that people need in a time of crisis

- ***Scheme 3: Efficient multi-agency hospital discharge,*** which is unchanged recognizes that people will always be admitted to hospital and therefore we need to work in an integrated way across health an social care to ensure a sustainable discharge back into the community.
- ***Scheme 4: Improving urgent Mental Health care.*** This is a change from the initial submission in April 2014. The change in national criteria meant the original scheme did not fit the criteria. The work continues on the original scheme, through the Phase 2 Mental health transformation, but it is no longer in the Better Care Fund plan. The new scheme is focused on urgent care and avoiding hospital admissions which is the focus for the new BCF.

4.2. In addition, the original BCF plan had a fifth scheme – Key Enablers. This was focused on the key changes to systems, process and culture which would underpin delivery of the other four schemes. These included co-production with service users and carers, required changes in IT, workforce, and learning and development. Due to the changes in the national criteria and reporting these no longer make up a scheme in themselves, instead they have been integrated into the other four schemes.

4.3. Service user and carer engagement

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.

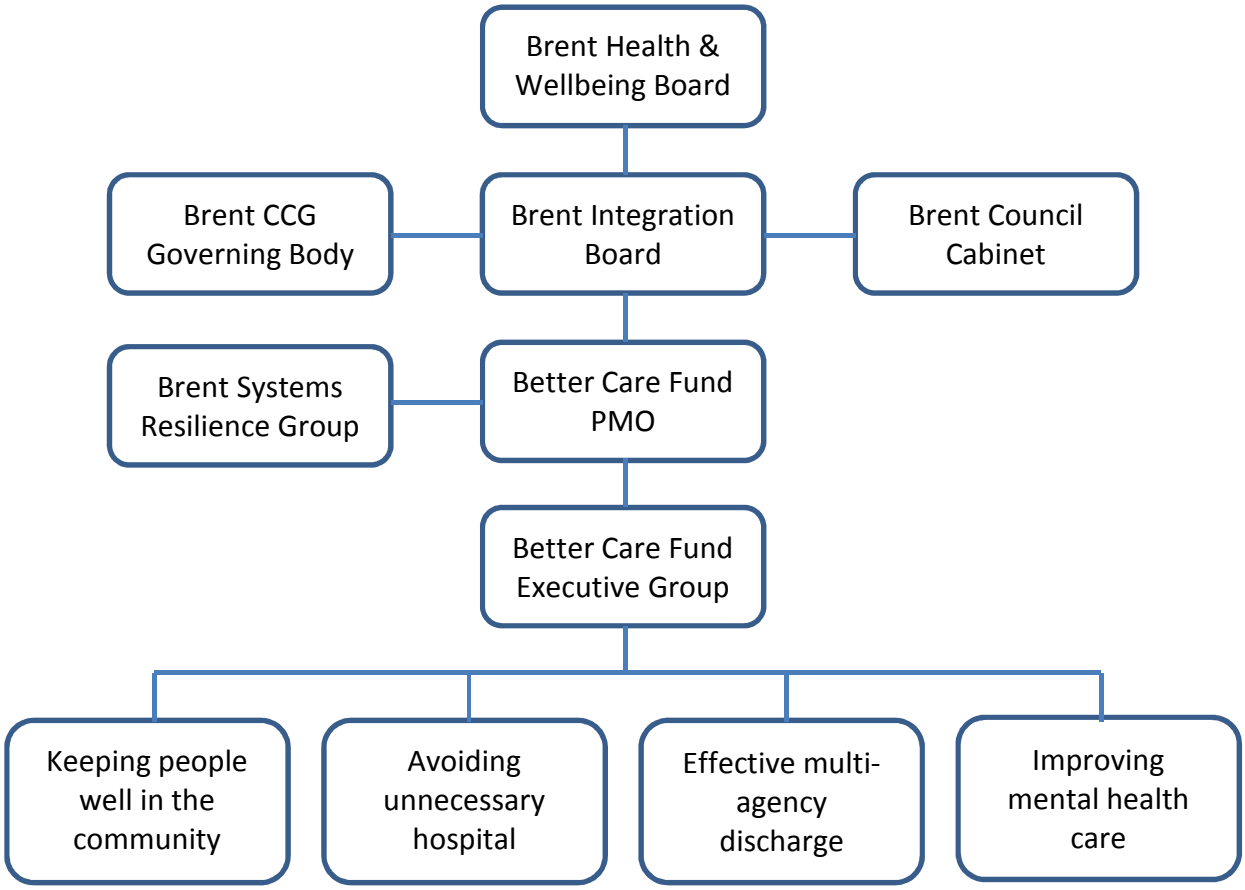
- On-going discussions between CVS Brent, the Council and CCG regarding how the voluntary and community sector engages with whole systems integrated care models being developed

- 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.

4.4. Governance

Our proposed governance arrangements are set out below:



4.5. Programme Management Office (PMO)

A PMO approach will be taken to the delivery of the various schemes that comprise the programme; supported by a joint team drawing on the resources from both health and social care. A programme manager has been appointed to oversee and drive forward the work to ensure the challenging timescales are achieved – see below. The programme manager and scheme leads will be supported by a small team funded from the joint fund.

5. Next steps - timescales

21 Nov 14	assemble Programme Management Office (PMO)
26 Dec 14	draft delivery plans completed
03 Apr 15	all schemes operational
01 Jan 16	3.5% reduction in non-elective admissions achieved

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To:
Brent Health and Wellbeing Board
NHS Brent CCG

Copy to:
Brent Council

29th October 2014

Dear colleague,

Thank you for submitting your revised Better Care Fund (BCF) plan. We know that the BCF is an ambitious programme and preparing the plans at pace has proved an immensely challenging task. However, your plan is now part of an ongoing process to transform local services and improve the lives of people in your community.

It is clear that your team and partners have worked very hard over the summer, testing out ways of working and finding innovative solutions to some of the challenges our services face in order to improve people's care.

NHS England is able to finally approve plans once the 2015/16 Mandate is published. I am pleased to let you know that, following the Nationally Consistent Assurance Review (NCAR) process, provided there is no material change in circumstance and the 15/16 Mandate is published as expected, your plan will be classified as **'Approved with Support'** once the 15/16 Mandate has been published. This recognises that whilst your plan is strong the review process identified a number of areas for improvement which once addressed will enable you to move to a fully approved status. This category means that your plan will be approved and your BCF funding will be made available to you subject to the following standard conditions which apply to all BCF plans:

- That you complete the agreed actions from the NCAR in the timescales agreed with NHS England;
- The Fund being used in accordance with your final approved plan and through a section 75 agreement;
- The full value of the element of the Fund linked to non-elective admissions reduction target will be paid over to CCGs at the start of the financial year. However, CCGs may only release the full value of this funding into the pool if the admissions reduction target is met as detailed in the BCF Technical Guidance[1]. If the target is not met, the CCG(s) may only release into the pool a part of that funding proportionate to the partial achievement of the target. Any part of this funding that is not released

into the pool due to the target not being met must be dealt with in accordance with NHS England requirements. Full details are set out in the BCF Technical Guidance.

The conditions are being imposed through NHS England's powers under sections 223G and 223GA of the NHS Act 2006 (as amended by the Care Act 2014). These allow NHS England to make payment of the BCF allocation subject to conditions. If the conditions are not complied with, NHS England is able to withhold or recover funding, or direct the CCG that it be spent in a particular way.

Appended to this letter is your NCAR Outcome Report which documents the agreed actions. Please work with your Area Team Lead Paul Bennett (paul.bennett8@nhs.net) to agree a timetable for when you will submit the additional information/evidence required on the back of the NCAR report.

We are confident that there were no areas of high risk in your plan and as such you should progress with your plans for implementation. Although the areas of support the review identified are essential to successful delivery in the medium term we do not consider them as material at this stage.

Any ongoing support and oversight with your BCF plan will be led by NHS England Regional/Area Team along with your Local Government Regional peer rather than the BCF Taskforce from this point onwards.

Non-elective (general and acute) admissions reductions ambition

As there is a considerable amount of time between the submission of BCF plans and their implementation from April 2015, we recognise that some areas may want to revisit their ambitions for the level of reduction of non-elective admissions, in light of their experience of actual performance over the winter, and as they become more confident of the 2014/15 outturn, and firm-up their plans to inform the 2015/16 contracting round. Any such review should include appropriate involvement from local authorities and be approved by HWBs. NHS England will assess the extent to which any proposed change has been locally agreed in line with BCF requirements, as well as the risk to delivery of the ambition, as part of its assurance of CCGs' operational plans.

Once again, thank you for your work and we look forward to the next stage.

Yours sincerely,

Dame Barbara Hakin
National Director: Commissioning Operations
NHS England

[1] http://www.england.nhs.uk/wp-content/uploads/2014/08/bcf-technical-guidance-v2.pdf

Better Care Fund planning template – Part 1

Please note, there are two parts to the Better Care Fund planning template. Both parts must be completed as part of your Better Care Fund Submission. Part 2 is in Excel and contains metrics and finance.

Both parts of the plans are to be submitted by 12 noon on 19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

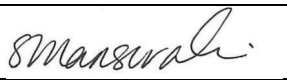
To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**London Borough of Brent**
Clinical Commissioning Groups	**Brent CCG**
Boundary Differences	**The Activity Plan takes into account other CCG plans where Brent residents are registered with GPS of bordering CCGs**
Date agreed at Health and Well-Being Board:	**26/03/2014** **Date at next HWB review – 30/10/14**
Date submitted:	**19/09/2014**
Minimum required value of BCF pooled budget: 2014/15	**£ 6,155,585**
2015/16	**£ 22,432,000**
Total agreed value of pooled budget: 2014/15	**£6,155,585**
2015/16	**£ 22,432,000**

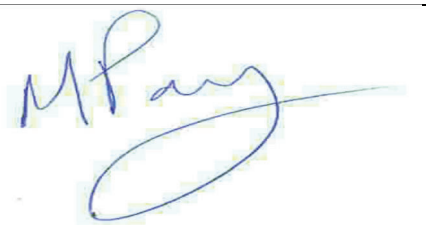
b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	
By	Sarah Mansuralli
Position	Acting Chief Operating Officer, Brent CCG
Date	19/09/2014

<Insert extra rows for additional CCGs as required>

Signed on behalf of the Council	
By	Phil Porter
Position	Strategic Director Adult Social Care Services, London Borough of Brent
Date	19/09/2014

<Insert extra rows for additional Councils as required>

Signed on behalf of the Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	Cllr Michael Pavey
Date	19/09/2014

<Insert extra rows for additional Health and Wellbeing Boards as required>

c) 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.

Document or information title	Synopsis and links
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.
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.
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

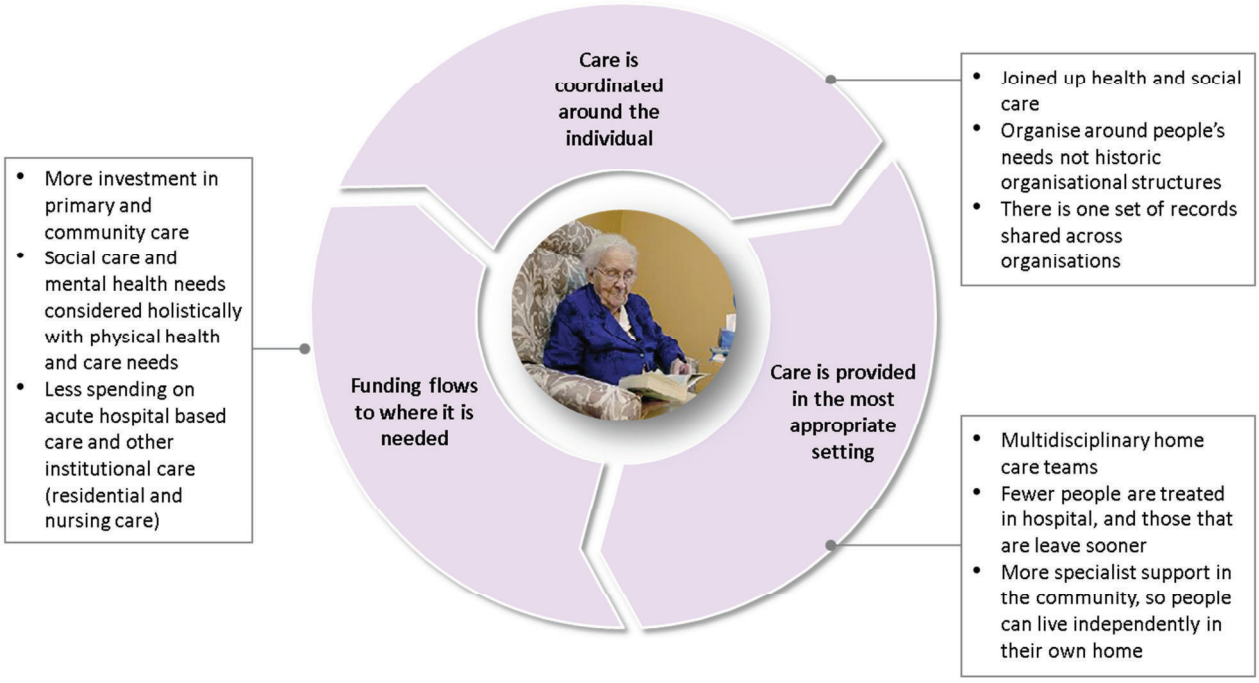
	emergency conditions in the community when appropriate. This would enable acute hospitals to focus on patients who are critically ill and those who require specialist investigations and interventions. At the heart of our vision is providing 'the right care, in the right place, with the right professional and at the right time'.
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.
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.
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. Current supply of ABCSS across Brent. Brent Adult Social Care Market position 2014 www.brent.gov.uk/media/9282655/asc-mps-app1.pdf What our strategic vision is, our commissioning intentions and models of service delivery we want to encourage in the local marketplace
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.
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.
Delivering Seven Day Services, NHS North West London, November 2013	NW London's vision to be an early adopter for seven day services across health and care

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

Brent CCG and Brent Council are partners in the North West London Pioneer programme for Integrated Care. 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. Our systems will enable and not hinder the provision of integrated care.
3. 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 four schemes which consider 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.

The Brent BCF schemes directly contribute to realising these aspirations and set out our approach to delivering 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. The schemes include:

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

Enabling these changes will require radical change in the way that organisations work. 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. Enablers span a continuum from organisational development about new ways of working to IT integration and implementation of 7 day working across health and social care.

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 which will have been developed with a team of professionals working from a GP network. In Tom and Jean's case, a social worker would take the lead as their health needs are being managed and their greatest need is for social work support. The SW would have regular contact with Tom and Jean. They would also liaise with the GP and other professionals in the network to ensure that the right support is in place so that Tom and Jean can continue to live together safely. The voluntary sector, working through the network will also be important providers of support.

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 should Alice call for emergency assistance. IRRS would have access to Alice's integrated care plan and they would be able to put in a range of services to prevent her admission to hospital and to support her at home. Not only the nurse/physiotherapist "bridging" service they currently provide, but 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 ahead of discharge. They would also prioritise her referral to the community network, so that a sustainable integrated care plan could be put in place and her needs can continue to be better managed in the community, preventing further admissions

Our Joint Strategic Needs Assessment has informed our vision and priorities to integrate care, reduce the high levels of health inequality which exist throughout Brent and improve the health and prosperity of those individuals and communities who experience high levels of social exclusion and disadvantages. This has ensured that we have a collaborative approach between the Local Authority, Health and other key partners. Brent's JSNA provides a detailed analysis of the current and future health needs of the local population with the overall aim being to provide the intelligence to inform the actions and plans to improve outcomes for Brent communities and residents.

Brent is ranked amongst the top 15% most deprived areas of the country. The Better Care Fund Plan has been developed with key stakeholders, to ensure that we continue to work towards improving health outcomes for our population. Fundamentally our aspiration is to tackle fragmentation across providers and across settings to ensure the best outcomes and measurable improvements to patient care and patient experience. We will do this by:

- Improving health and wellbeing in partnership with the Health & Wellbeing Board, patients, the wider community and commissioning services to address the key health issues within Brent, such as reducing health inequalities.
- Improving uptake of preventative services while reducing mortality and morbidity resulting from poor long-term condition management and keeping the most vulnerable well in the community
- Ensuring patients receive the right care, in the right setting by the most appropriately skilled clinician, which will improve the quality of care patients receive and reduce dependency on acute care and avoiding unnecessary hospital admissions through rapid response and in reach to A&E departments
- Develop an effective urgent care pathway for mental health working with local authority and other partners towards our aspiration of Whole Systems Integrated Care in Brent.
- Providing a proportion of outpatient appointments in community settings, rather than in acute settings, at lower cost and higher quality, where it is clinically safe and cost effective to do so.
- Providing services designed to minimise inappropriate A&E attendance and non-elective admission, e.g. urgent care centres, community beds and clinics for proactive long-term condition case management and crisis home treatment teams to support mental health service users.

In addition, the voices of our patients and communities have strongly influenced the direction of our schemes. From the development of proactive care plans which reflect the aspirations and wishes of our patients to choices about how care is provided.

It is on these foundations that our vision has been developed. These aspirations are reflected in our Better Care Fund schemes which will keep the most vulnerable well in the community, avoid unnecessary hospital admissions; effective multi agency hospital discharge and improve mental health.

b) What difference will this make to patient and service user outcomes?

As part of our Pioneer application, we have committed to principles that will differentiate care in the future from what it is today. We have committed to ensuring that:

- People will be empowered to direct their own care and support and to receive the care they need in their homes or local community.
- GPs will be at the centre of organising and coordinating people's care.
- 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.

Through the *Integrated care plan* the patient's perspectives will be at the centre of planning and care delivery for the patients and service users and this will make a difference by contributing to improved patient experiences, better care and support outcomes, service user satisfaction and potentially more cost effective care. Care planning will be co-ordinated and will bring together health, social care, well-being and enablement through a person centred approach that meets the full spectrum of the individual patient or service user's needs

The *Integrated Rapid Response Service (IRRS)* has access to integrated care plans to enable them to respond quickly and put a range of services in place that will prevent patients and service

user from being admitted to hospital settings where appropriate. Short-term multi-disciplinary care is delivered to support patients to remain in the community which in turn reduces hospital admissions and the length of time people stay in hospital but also enables a more proactive care approach to managing patients in the community

The *Integrated Discharge Service* works collaboratively to assess patients and service users to ensure that discharge planning and transfer of care to community settings is seamless and timely This service facilitates discharges, ensuring a reduction in the length of time a patient has to stay in hospital where appropriate, and more planned and proactive care, based in the community post discharge.

A *Recovery Focused Mental Health Service* providing care in an integrated and coordinated manner to extend the offer of early interventions for people with mental health problems and to improve the quality of care for individuals with serious mental illness; which includes the need to provide people recovering from illness with meaningful employment and secure housing.

We believe that this will ensure that we:

- Keep the most vulnerable well in the community
- Avoid unnecessary hospital admissions
- Reduce re-admissions and lengths of stay
- Ensure effective multi agency hospital discharge
- 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
- Promote patient and service user self-management
- Improve quality of life and patient/service user experience and patient satisfaction

c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

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 developing anticipatory care management services and episodic care models across our local 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 integrated health and social care which will result in specific changes to services, with tangible outcomes for service users.

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

The schemes aim to reduce reliance on acute and residential care, recognising that individuals have better quality of life when they are enabled and empowered to remain at home and in the community. We have agreed a common aim across health and social care for each of the schemes:

- Keeping vulnerable well in the community aims to ensure that there is proactive care to support better management of long term conditions and prevent acute exacerbations in health. Building on integrated care, operating in a virtual format, we are keen on the vision of a fully integrated local team.

  In this context we are testing a Whole Systems Model of Integrated Care for those aged 75 plus with one or more long term conditions, whilst continuing our virtual integrated care programme for the entire population. Our aspiration is to develop this model of care for each population segment, recognising that the multi-disciplinary team will need to be different for different population groups.

- Avoiding unnecessary hospital admissions aims to ensure that acute exacerbations don't necessarily result in an admission to hospital where care can be provided better at home. This will ensure rapid response through primary care networks as well as in reach into A&E departments to ensure unnecessary admissions are prevented.

- Effective multi-agency discharges aims to reduce the number of delayed bed days associated with complex discharges from 11 to 15 to 3-5. This scheme recognises the importance of ensuring our acute capacity is maintained through minimising the number of delayed transfers of care.

- Improving urgent mental health care focusses on admissions to physical care beds for people in mental disorder crisis related to self-inflicted physical harm (suicidal/ para-suicidal behaviour or serious deliberate self-harming behaviour). This scheme reflects the prevalence of mental health illness in Brent and will work to ensure a holistic approach to tackling the social contributory factors associated with suicide which will impact the rate of non elective admissions.

3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

Brent's Joint Strategic Needs Assessment reflects the needs that the Better Care Fund Plan will meet. The 2014/15 is divided into four individual domains as follows:

1. *Our people and place*
2. *The burden of ill health*
3. *Children and young people*
4. *Key health challenges in Brent*

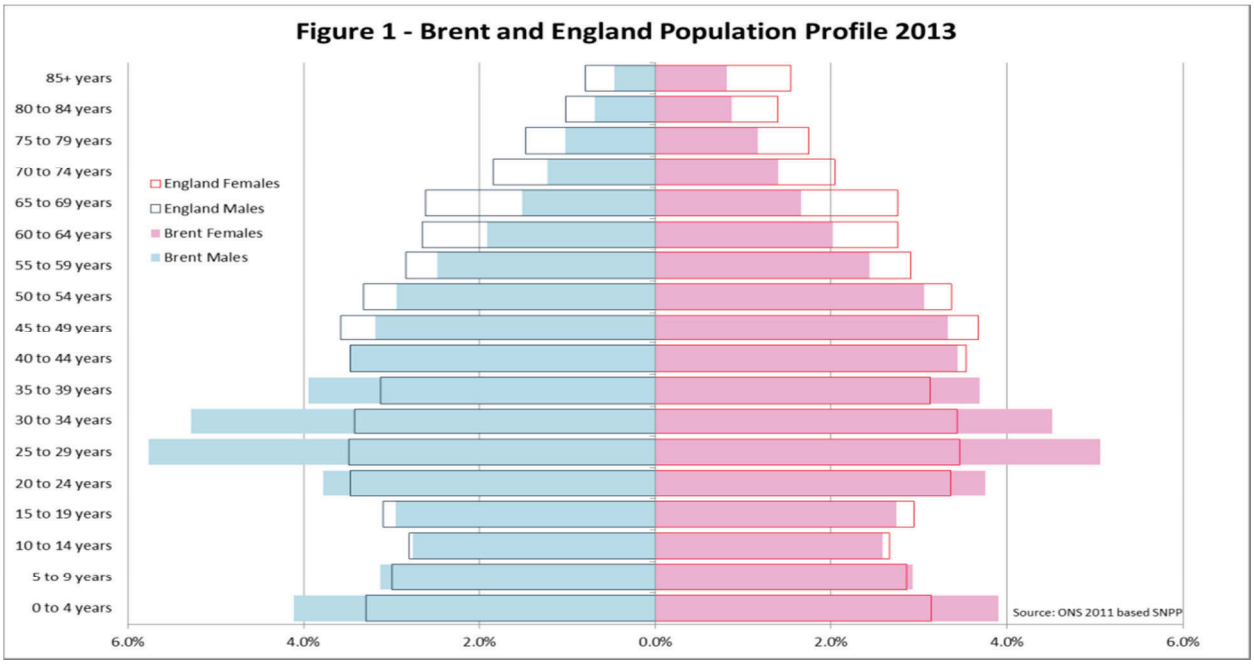
Each of these domains contains a series of briefs on a particular theme and explores how a range of underlying factors can influence the health and well-being of Brent's communities and residents with the associated health outcomes. The JSNA has identified particular social and

demography characteristics which have influenced our approach to integrated health and social care.

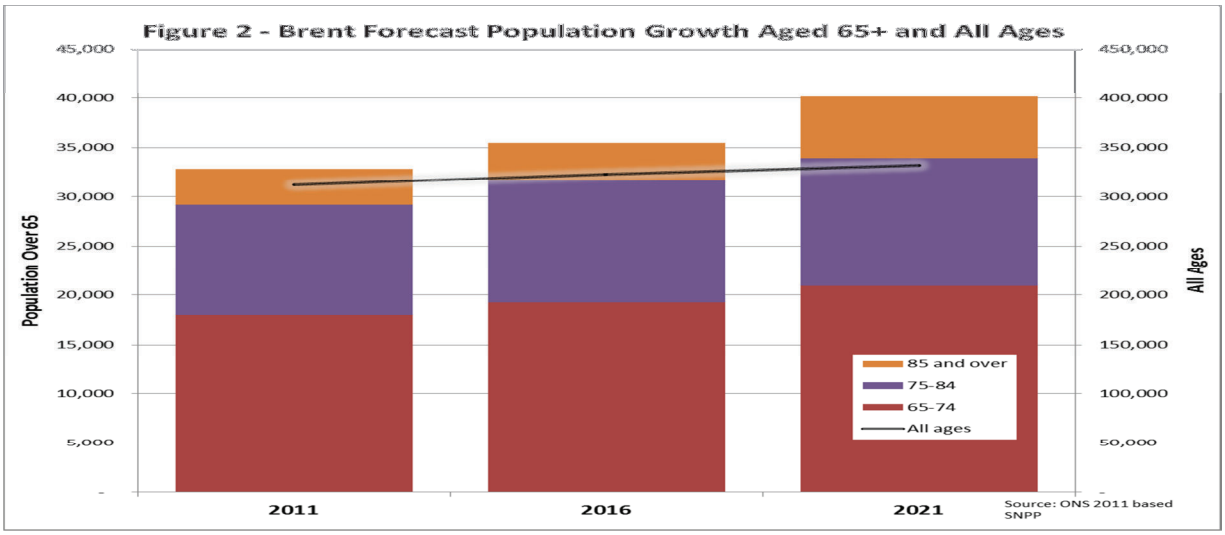
Population and demography

Brent is an outer London borough in north-west London. It has a population of 317,264 and is the most densely populated outer London borough, with a population density of 74.1 persons/ha. The population is young, with 35% aged between 20 and 39. Brent is ethnically diverse, with 65% of its population from black, Asian and minority ethnic (BAME) backgrounds.

The population of Brent is younger than England generally, as illustrated below, but the population aged 65 and above will grow at a faster pace than the population at large.

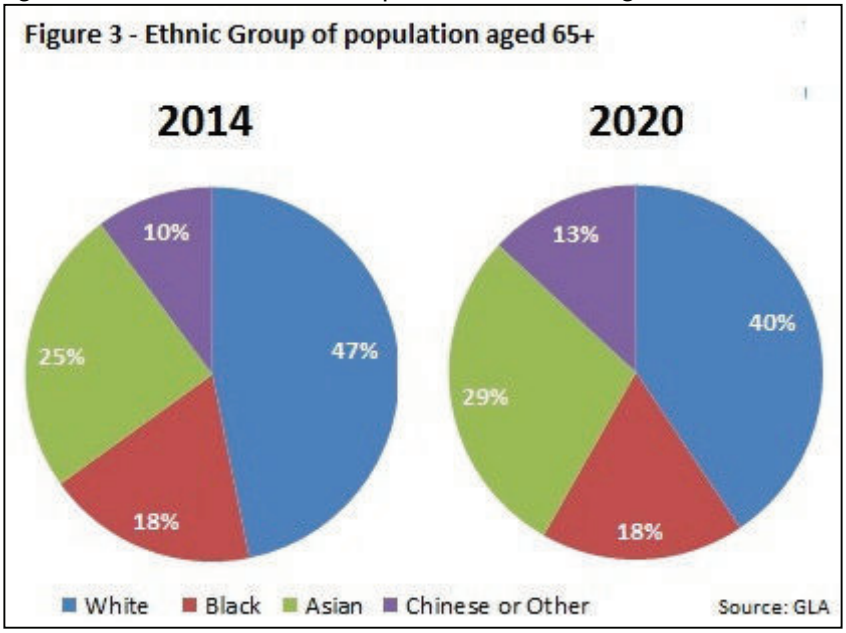


Between 2011 and 2021 the population aged between 65 and 74 is expected to grow by 16%, 75-84 by 16% and 85 + by 72% whilst the total population will only grow by 7%[1].



[1] ONS 2011 based population projections

As well as growing in number, the Ethnic composition of those aged 65 and over will change.



Age Related Morbidity

Growth in the number of people aged over 65 in Brent is in part the result of increasing life expectancy created by the reduction in premature death from the biggest causes of premature mortality such as Cancer and Cardiovascular Disease, but at the same time the prevalence of many conditions increases with age as the tables below illustrate.

Increase in prevalence with age of selected conditions[2]

People having 1 or more fall			Impaired Mobility			Dementia		
Age	**% male**	**% female**	**Age**	**% male**	**% female**	**Age**	**% male**	**% female**
65-69	18	23	65-69	8	9	65-69	2	1
70-74	20	27	70-74	10	16	70-74	3	2
75-79	19	27	75-79	12	21	75-79	5	7
80-84	31	34	80-84	18	29	80-85	10	13
85+	43	43	85+	35	50	85-89	17	22
						90+	28	31

Living Alone

As people age, the likelihood that they will live alone increases, bringing with an increased likelihood of social isolation and the need for support from others. Nationally 20% of men aged 65-74 live alone but for those aged 75+ this increases to 34%. For women the rate doubles from 30% to 61%[3].

[2] Source: http://www.poppi.org.uk. Impaired mobility means a person is unable to do at least one of the following: going out of doors and walking down the road; getting up and down stairs; getting around the house on the level; getting to the toilet; getting in and out of bed

[3] Source: http://www.poppi.org.uk ONS General Household Survey

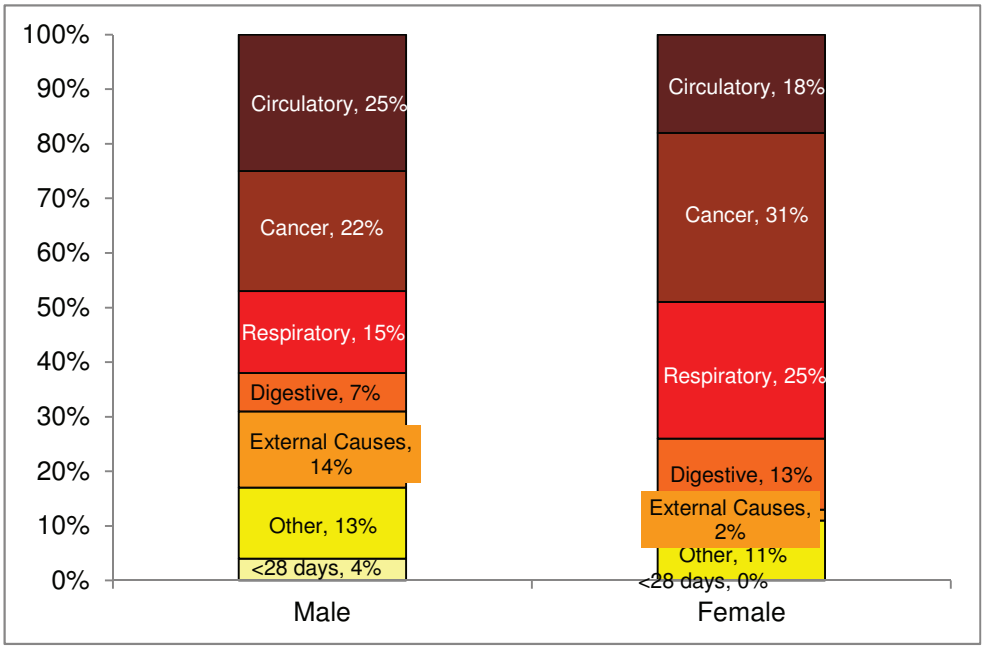
Brent Population aged 65+ living alone.	2014	2015	2020	2025
Males 65-74 predicted to live alone	1,780	1,820	2,060	2,400
Males 75 and over predicted to live alone	2,380	2,448	2,754	3,230
Females 65-74 predicted to live alone	2,970	3,060	3,420	3,900
Females 75 and over predicted to live alone	5,673	5,734	6,405	7,259
Total 65-74 predicted to live alone	4,750	4,880	5,480	6,300
Total 75 and over predicted to live alone	8,053	8,182	9,159	10,489

Life expectancy at birth

Life expectancy for both men and women in Brent is higher than the England average at 79.9 years for males and 84.5 years for females[4]. However, the overall life expectancy at borough level masks pronounced variation between the most deprived and least deprived parts of Brent.

Life expectancy for children born between 2010 and 2012 is 5.3 years lower for men in the most deprived parts of Brent than the least deprived parts. For females, the difference is less pronounced at 3.8 years.

A number of different diseases account for this gap: for men, circulatory disease accounts for 25% of the gap in life expectancy and cancer for 22%. For women, cancer was the largest contributor at 31%, with respiratory disease accounting for 25% of the gap[5], as shown below.



Life expectancy gaps in Brent by cause of death. Source: Public Health England

The Marmot Review, Fair Society, Healthy Lives (2010) recommendations included:

- Prioritise prevention and early detection of those conditions most strongly related to health inequalities;
- Increase availability of long term and sustainable funding in preventing ill health across the social gradient.

[4] 2010-2012
[5] 2009-2011

Cardiovascular disease (CVD)

Between 2009 and 2011, CVD accounted for 26% of deaths in Brent for people under 75years and 41% of deaths for people aged 75 and over. This is higher than England for both under 75s (24%) and for those aged 75 and over (35%).

Premature mortality rates from CVD in Brent have steadily decreased by 60% over the last 20 years. Despite this, rates of premature deaths from CVD in Brent remain worse than the England average, as shown in the graph below.

The estimated prevalence of diagnosed CHD varies between practices in Brent. The percentage of people on GPs' lists with a recorded diagnosis of CHD was 3.5% in Brent compared to 4.7% in England[6]. Given the higher death rates in Brent, this suggests possible under-diagnosis.

Respiratory disease

Respiratory diseases (which include COPD and asthma) account for approximately 15%[7] of all deaths in Brent and is the third major killer following circulatory disease and cancer. COPD alone accounts for around a quarter of deaths due to respiratory disease in Brent.
COPD includes two lung diseases: chronic bronchitis and emphysema. Smoking is the primary cause of COPD.

The premature mortality rate from respiratory disease in Brent in 2010-12 was 28.1 per 100,000 population. This represents 149 deaths. The England rate was slightly higher at 33.5 deaths per 100,000 population[8].

Prevalence of COPD varies across practices in Brent. The Brent average in 2012/13 was 0.8%. In comparison, the England average was 1.7%.

Mental ill health amongst adults

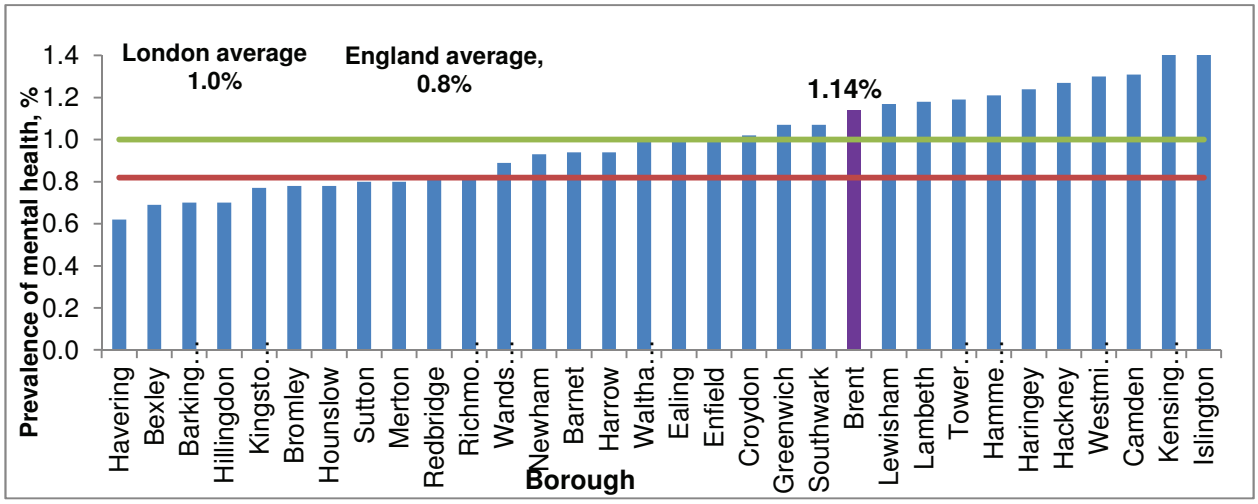
Estimates show that in a given week, 11% of Brent adults experience depression, higher than the England average of 8% and similar to the London average (11%)[9].

In 2010/11, 16,000 Brent adults were on a GP register for depression. Take up of talking therapies is lower in Brent in terms of the numbers of referrals who enter treatment: 53% in Brent compared to 60% in England. Supporting service users with other key requirements such as housing and employment needs are important in ensuring the effective treatment and recovery resulting from serious mental illness.

Levels of self-reported daily anxiety amongst Brent residents are comparable to the England average. Estimates show that 19.5% of Brent residents surveyed consider themselves to have high levels of daily anxiety compared to the England average of 21% and the London average 22.4%[10].

[6] Public Health England, National General Practice Profiles, NHS Brent CCG, 2011
[7] % of all respiratory deaths, 2008-2010 (NEoLCIN Profiles)
[8] Public Health England, Public Health Outcomes Framework (PHOF)
[9] London Health Observatory and Working for Wellness (2011), London Adult Mental Health Scorecard for Brent
[10] Based on 2012/13 results from the Annual Population Survey (ONS) self-reported well-being measure: % of respondents aged 16 and over scoring 6-10 to the question "Overall, how anxious did you feel yesterday?"

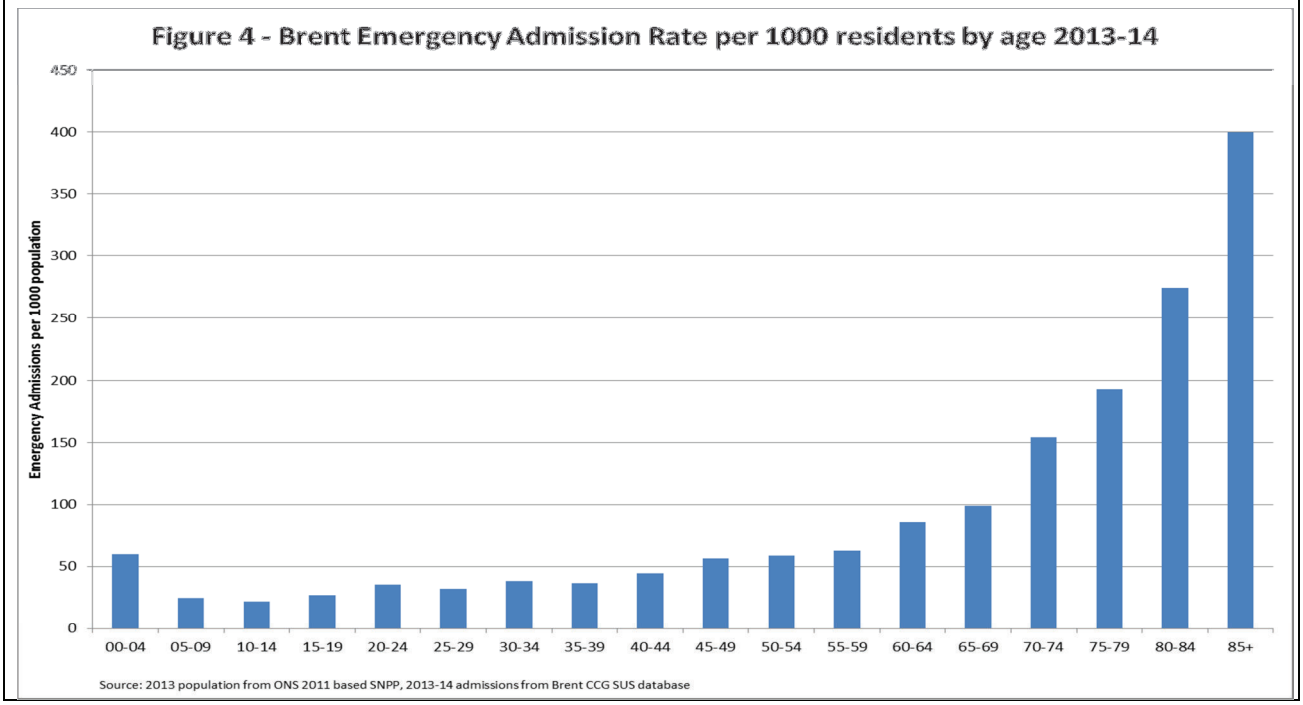
The prevalence of severe and enduring mental illness in Brent is 1.14% of the population which is above both the London and England averages. The graph below demonstrates the prevalence of severe and enduring mental illness between London boroughs for the period 2011/12 for severe and enduring mental illness (such as schizophrenia, bipolar disorder or other psychoses).



Mental illness prevalence (severe and enduring) among adults by London boroughs, 2011-2012. Source: London Health Programme HNA Toolkit 2012

Between 2011/12 and 2012/13, there was a 19% increase in the numbers of users of mental health services in Brent. GPs and specialist services report on-going pressures on services. Improving mental health is one of our Better Care Fund Schemes to reflect the needs of the local community as highlighted in our JSNA.

Whilst the population of Brent is young, age is a significant determinant of the likelihood of an unplanned admission to hospital as shown in the chart below. An 80 year old in Brent is almost 8 times more likely to be admitted as an Emergency than a 20 year old. An emergency admission is unsettling for the individual and their relatives and can expose patients to otherwise avoidable clinical risks such as health care acquired infections.



Once in hospital, patients aged 65 and over stay longer. In Brent, whilst 35% of Emergency Admissions are for patients ages 65 and over, 55% of bed days are used by this group[11]. This is caused by longer recovery times, infection and delays to the discharge of medically fit patients. In Brent, 13% of Emergency Admissions of patients over 65 are for conditions which can be better managed in a community, primary care or outpatient setting[12].

The interventions included in our schemes are designed to keep people out of hospital and residential care and prevent social isolation by providing intermediate care, re-ablement and rehabilitation, carer and service user support. The schemes have been designed in response to a risk stratification and segmentation of our population:

- Keeping those who are well, well in the community through healthy life style choice, support to remain independent and improve quality of life
- Ensuring those at most risk of deterioration receive more proactive support to manage their care
- Ensuring those who are at risk of institutional care receive the support to remain in the community and care at home should an admission occur
- Enabling those with mental health difficulties recover to lead fulfilling lives with support and assistance.

The partnership working between health, social care and the voluntary sector will provide integrated preventative and recovery strategies including support in times of crisis for frail elderly, those with long term conditions and those with mental health problems to live active lives for as long as possible. Care will be improved by identifying people at risk and intervening early, preventing hospital admissions or where people need to go into hospital, facilitating early discharges; supporting self-care to enable individuals to manage their own health and well-being.

The risks stratification exercises and evidence based used to develop the schemes in this plan includes the national evidence base extrapolated to Brent's population demographics including among others. We have four schemes as part of the Better Care Fund for improving care by integration in Brent and the risk stratification exercises we have undertaken as part of this include.

In addition, in 2013/14, Brent member practices have been using the BIRT2 risk stratification tool. The BIRT 2 tool has several different potential uses. Some of these relate to risk stratification for the purposes of analysing the health of a population ("risk stratification for commissioning") and others relate to targeting additional preventative care interventions, such as the Integrated Care Programme, to high-risks patients ("risk stratification for case finding").

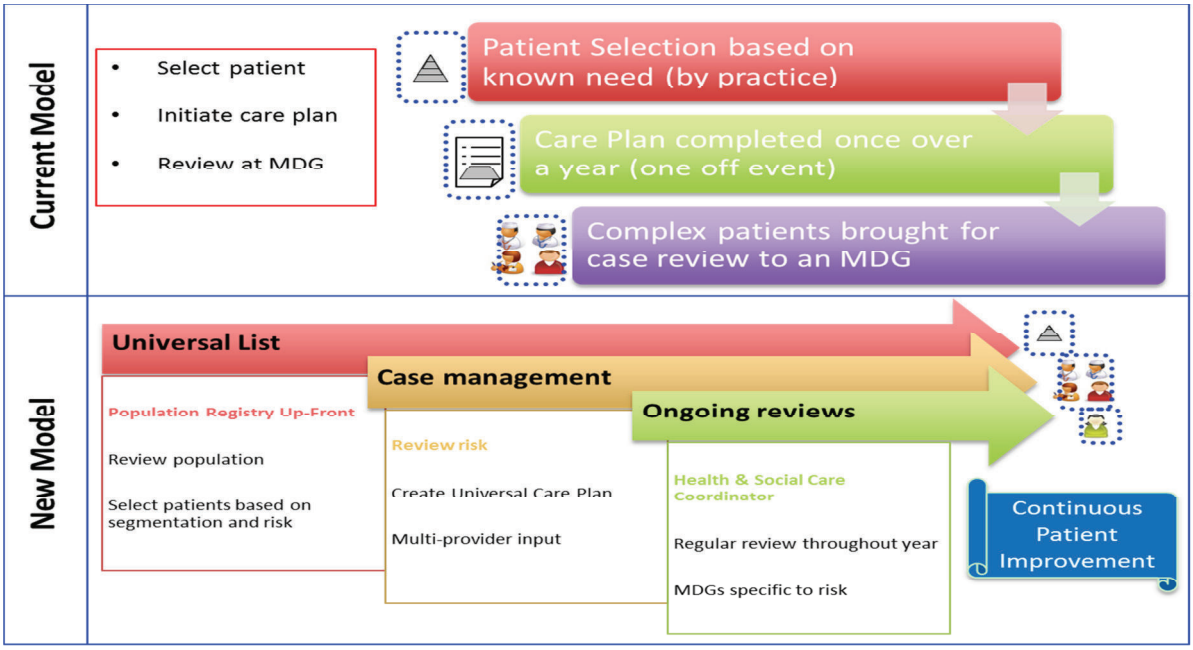
The tool works by risk scoring patients on a standardised scale. Clinicians are able to see the NHS numbers of patients so that they can contact them for an intervention.

Risk score models are equations which predict an output (risk) from a range of input variables (age, previous admissions etc). They are generated from a process called logistic regression. Risk score equations are built from large datasets, where factors most significantly associated with being admitted in the future can be identified. By 'plugging in' this input data for a patient, it is possible to calculate the likelihood that they may be admitted.

Risk score equations are not an exact science, so that some of those patients identified as 'high risk' may not in fact be admitted, and some not identified by the model will end up being admitted.

[11] Brent CCG SUS database 2013/14
[12] Admissions for ACS conditions, Brent CCG SUS database 2013/14

Our approach to risk stratification of the population is illustrated below.



Using GP Practice registers to risk stratify the local population and offer preventative and early intervention support to manage demand and reduce potential future need, care can be improved through integrated teams that work to:

- Reduce emergency admissions and readmissions
- Reduce reliance of and long term use of residential care and nursing homes
- Increase the proportion of elderly service users who are enabled and supported to self-care
- Increase the quality of life of vulnerable, frail elderly and those with long term conditions in Brent
- Promote carer and community support to support increased independence and resilience for this cohort of the population
- Development of dedicated integrated multi-disciplinary teams to support those most at risk in the community

From this risk stratification exercise we have identified that of patients who are at risk of admission:

- 2% are defined as high risk but stable requiring intensive proactive care management to reduce the risk of urgent care
- 48% are defined as being medium risk and stable requiring proactive care management to maintain stability
- 50% are defined as stable and low risk requiring regular reviews

4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

The BCF and its schemes has been in development throughout 2014/15 with the following activities taking place and planned. In 2014/15 scheme one was implemented and is starting to realise benefits.

For scheme 2 a Short Term Rehabilitation and Reablement Service is in place but will be reconfigured to achieve a reduction in unnecessary hospital admissions by extending and enhancing the provision into a 7 day Integrated Rapid Response Service.

For scheme 3 existing services will need reconfiguration to develop an Integrated Discharge Team to aid early and supported discharge of patients with complex needs who could be better cared for in the community.

For scheme 4 we will reconfigure existing assessment and brief intervention and crisis response services to offer an integrated and urgent care mental health pathway supported by recovery focused support to address social contributory factors.

A summary of progress and planned activities includes:

2014/15

- **Quarter 1 April to June 2014**

Brent Integration Board co-designed workshops with providers, commissioners, partners and lay member to agree common vision, schemes to deliver, identify areas for change and further development.

- **Quarter 2 July to September 2014**

Detailed work with providers to further develop new models of care and to identify provider impact was undertaken. This process has ensured that partners organisations are involved and in full sight of the direction of travel, benefits and risks.

BCF plan and governance has been reviewed and revised in the light of revised planning and technical guidance and support, for submission on 19th September 2014.

On-going engagement work with patients, service users and carers as described in more detail in section 8.

On-going work with providers to develop and agree the new models of care including the alignment of the planned changes to the revised BCF metrics. This will include all elements described within the local metric 'social care quality of life' such as food and nutrition, accommodation, dignity and social participation.

It is also recognised that work outside the schemes planned under the BCF will contribute to the non-elective admissions metric

- **Quarter 3 October to December 2014**

Receive feedback from NHS E /LGA on resubmitted plans making changes to the local plan if required.

Agree implementation process with providers and put enablers in place to achieve proposed 'go live' date 1st April 2015

Establish PMO and implementation groups

Implement revised governance arrangements with underpinning partnership arrangements.

- **Quarter 4 January to March 2015**

Implement transitional plan and contract strategy to deliver required changes from April 2015 Operational policies agreed

Agree performance dashboard and reporting mechanisms

- **Quarter 1 2015/16 April to June 2015**

Fully implement pooled budgets and associated services with governance structure embedded Integrated commissioning options appraisal

- **Quarter 2 2015/16 July to September 2015**

Identify and develop planned changes for 2016/17 with stakeholder engagement. Communicate outcomes to residents and local stakeholders

- **Quarter 3 2015/16 October to December 2015**

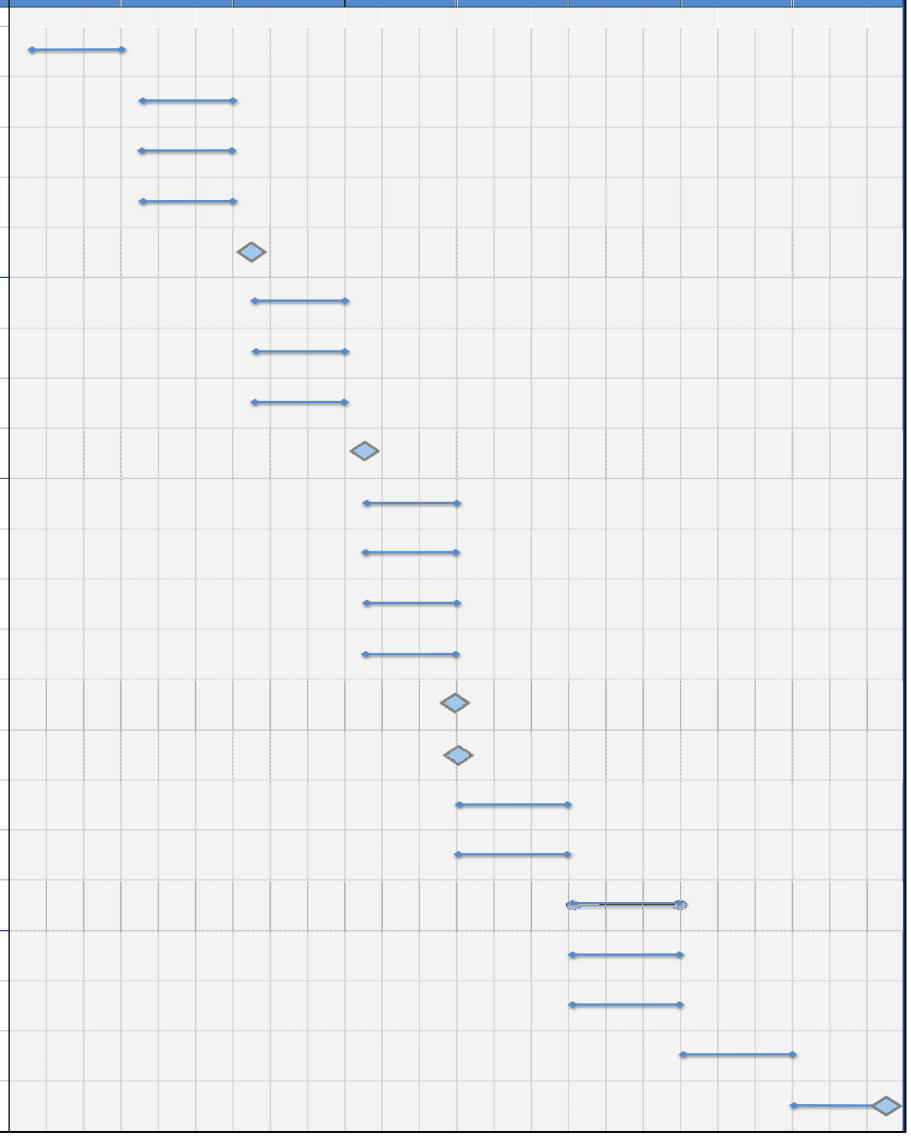
Develop implementation plans for to deliver next phase of changes

- **Quarter 4 2015/16 January to March 2016**

Agree implementation process with providers

Plan of Action

Item	Deliverables	Date
Plan of Action		
1	Brent Integration Board co-designed workshops with providers, commissioners, partners and lay member to agree common vision, schemes to deliver, identify areas for change and further development.	14/15 Q1
2	BCF plan and governance has been reviewed and revised in the light of revised planning and technical guidance and support, for submission on 19th September 2014.	14/15 Q2
3	On-going engagement work with patients, service users and carers as described in more detail in section 8.	14/15 Q2
4	On-going work with providers to develop and agree the new models of care including the alignment of the planned changes to the revised BCF metrics. This will include all elements described within the local metric 'social care quality of life' such as food and nutrition, accommodation, dignity and social participation.	14/15 Q2
5	Receive feedback from NHS E /LGA on resubmitted plans making changes to the local plan if required.	14/15 Q3
6	Agree implementation process with providers and put enablers in place to achieve proposed 'go live' date 1st April 2015	14/15 Q3
7	Establish PMO and implementation groups	14/15 Q3
8	Implement revised governance arrangements with underpinning partnership arrangements.	14/15 Q3
9	Implement transitional plan and contract strategy to deliver required changes from April 2015	14/15 Q4
10	Operational policies agreed	14/15 Q4
11	Agree performance dashboard and reporting mechanisms	14/15 Q4
12	IT integration solution in place	14/15 Q4
13	Consent to shared patient records	14/15 Q4
14	Scheme models of care agreed and commissioned	14/15 Q4
15	Agreement and development of Section 75 or Partnership Arrangements	14/15 Q4
16	Fully implement pooled budgets and associated services with governance structure embedded	15/16 Q1
17	Integrated commissioning options appraisal	15/16 Q1
18	Identify and develop planned changes for 2016/17 with stakeholder engagement.	15/16 Q2
19	Communicate outcomes to residents and local stakeholders	15/16 Q2
20	Operational and Strategic Governance Review	15/16 Q2
21	Develop implementation plans for to deliver next phase of changes	15/16 Q3
22	Agree implementation process with providers	15/16 Q4



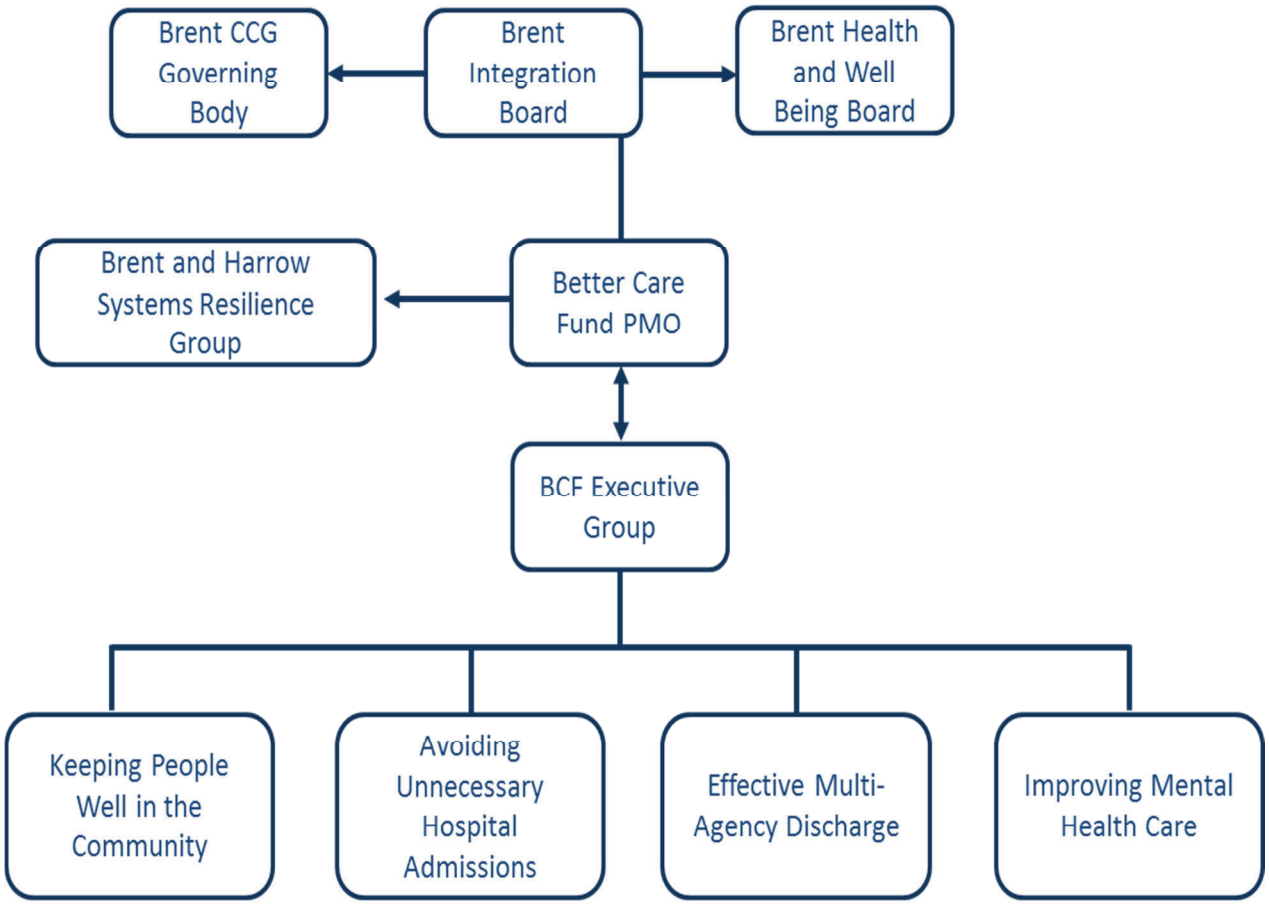
b) Please articulate the overarching governance arrangements for integrated care locally

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 for integrated care, 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 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.

We further recognise of importance of embedding the BCF in the local Systems Resilience Group (SRG) to ensure operational and strategic alignment between local non elective resilience arrangements including 7 day working and the BCF. Therefore, going forward, the Brent Integration Board will provide regular reports to the SRG on progress of BCF schemes and associated performance outcomes as well as to the Brent Health and Well Being Board.

Our proposed governance approach is set out below.



c) Please provide details of the management and oversight of the delivery of the Better care Fund plan, including management of any remedial actions should plans go off track

We have agreed that in order to maintain momentum we will use existing commissioning resources to deliver the changes required described in our BCF. However, we require additional support to ensure management and oversight of the schemes is required. Routine performance reviews and monitoring will also be a key component of delivery of the Plan.

To this end, we will be implementing a PMO specific to the BCF to ensure support, management and oversight as well as ensuring appropriate scheme resourcing to deliver the scale of change within the required timescales.

Through the PMO there will be a robust risk and issues log which will be monitored at all points in the governance structure shown above. Risks and issues will be escalated to ensure that controls and assurances are in place or being enacted.

The scheme implementation groups will be responsible for developing models of care, standard operating processes, KPIs to measure success/performance and working with providers through commissioning processes to ensure reconfiguration of existing services in line with scheme PIDs as set out in the appendices.

The PMO will be responsible for ensuring that scheme implementation groups deliver outputs on time, escalating issues and collating risks and issues relating to the scheme delivery. The PMO will also provide regular update on progress and performance to both the Better Care Fund Executive and the System Resilience Group.

The Better Care Fund Executive is responsible for operational oversight of scheme delivery and implementation of the Better Care Fund plan objectives. The Executive will routinely report progress, performance and/or escalate issues to the Brent Integration Board.

The Brent Integration Board is responsible for the strategic oversight of the plan and its outcomes. It will report progress against the plan and other integration initiatives to the CCG Governing Body and Health and Well Being Board. The Integration Board will be responsible for ensure that partner and provider organisations involved in the plan's development and implementation work collectively with a shared vision, working to unblock barriers and maximise opportunities across the health and care economy.

d) **List of planned BCF schemes**

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Ref no.	Scheme
1	Keeping the most vulnerable well in the community
2	Avoiding unnecessary hospital admissions
3	Effective multi agency hospital discharge
4	Improving urgent mental health care

5) RISKS AND CONTINGENCY

a) Risk log

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 and any financial risks for both the NHS and local government.

There is a risk that:	**How likely is the risk to materialise?** *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely*	**Potential impact** *Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact* *And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)*	**Overall risk factor** *(likelihood *potential impact)*	**Mitigating Actions**
Shifting resources to fund new joint schemes will destabilise existing providers in the acute sector	2	2	4	• 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. • The impact is on

				capacity and our ability to manage demand
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	3	4	12	• 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. • The impact is on the accuracy of the patients' health risk through the risk stratification tools
Operational pressures restricting the ability of our workforce to deliver the vision	4	3	12	• Need to include specific non recurrent investments into workforce development and organisational development • The workforce resources being used for the implementation of the BCF schemes and

				business as normal.
Preventative, self-care,/self-management and improved quality of care fail to translate to reduce acute, nursing and care home expenditure impacting the level of funding available in future years	3	4	12	• 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 2015/16 to test and refine our assumptions with a focus on developing more financially robust business cases. • Continued increase in individuals requiring acute in-patient support
The Care and Support Bill will result in an increase in demand and costs to the system from April 2016 which is difficult to predict at this stage.	5	3	15	• 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. • Continued increase in individuals requiring acute in-patient support
Managing patient flows	3	4	12	Continued work with the main provider trusts - Royal Free

				and Imperial Trusts to manage patient flows Ability and capacity of community provision to prevent patient flows to acute in-patient services

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

We have identified a savings target for non elective admissions, which equates to£1.62 million; and, we have enacted a contingency of equal value. The contingency has been agreed to be split 80% to Brent CCG and, 20% to Brent SSA.

If the risk materialise there will be reimbursements from the BCF for the cost of the non-elective admissions exceeding the target level. There is partnership working on the BCF schemes. Partners from acute Providers, Voluntary Sector Organisations, Service User and Care Groups have additionally been offered and have taken up 1:1 meetings. All partners have been consulted and are fully engaged in the Better Care Fund priorities.

If risk does not materialise, the funds will be available to the HWB to provide health related care in accordance with the HWB strategic priorities.

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

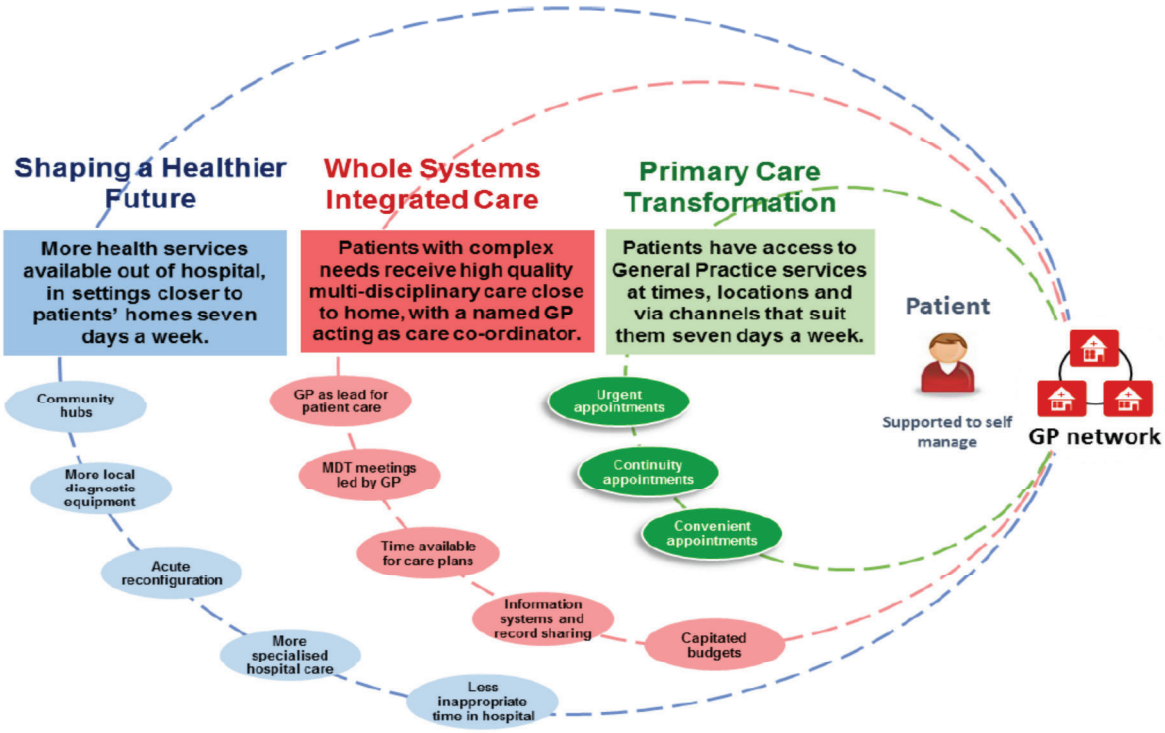
Brent CCG has ambitious plans to transform the way care is provided in Brent so that the patient receives the best possible treatment through high quality integrated care. These plans are reflected in our five year draft strategy. These plans are designed and driven locally and with an increasing system leadership role from Brent's Health and Wellbeing Board.

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

1. Primary Care Transformation –making it easier to see your GP and making more treatments available in a community setting;

2. Whole systems integrated care –joining together health and social services to provide person-centred care; and

3. Shaping a healthier future –the reconfiguration of hospital services, and in particular developing the long term future of Central Middlesex Hospital.



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

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

There is currently a broad alignment between the BCF and the 2year operating plan. The Brent 2-year operating plan produced a 2.9% reduction in NEL admissions in the 15/16 calendar year. The BCF 3.5% reduction therefore represents a stretch on this target.

Should any updates to activity plans on UNIFY2 be required, these will be refreshed at the next available opportunity.

d) Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

The Brent BCF plan aims to support improvement and access to primary care. We will do this through use of the Prime Ministers challenge fund, which enables GP practices to focus on improvements where specific gaps have been identified in BCF pathways and through primary care co-commissioning.

Brent CCG, along with the other 7 CCGs in North West London has submitted a shared expression of interest to NHS England to explore developing an approach to primary care co-commissioning.

Through the CCG's primary care transformation programme and approach to whole systems integrated care, GPs are at the centre of organising and co-ordinating care for their practice populations but the CCG is constrained in its ability to take this work further as it is unable to shift funding from other parts of the health system to primary care or to invest in enablers such as estates.

Developing primary care co-commissioning will mean that the CCG can further support the delivery of Better Care Fund projects by commissioning local services that meet the needs of the Brent population, investing in new ways of working within primary care which fosters more joint working with key partners and aligning incentives across providers by commissioning across whole systems.

We will develop plans about the role of primary care in the BCF and primary care co-commissioning in light of emerging guidance. Positive strides have been made with the unplanned admissions Directed Enhanced Service (DES) with the majority of Brent member practices having signed up to this and our Integrated Care Programme.

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

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.

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

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/re-ablement services which will reduce hospital readmissions and admissions to residential and nursing home care.

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

£9.2m which includes the £0.8m local proportion for the Care Act implementation funding

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

The Care Act, which is due to take effect in April 2015, presents implications for the adult social care workforce in local authorities in England.

Some of the key areas of responsibility which will apply to local authorities in April 2015 include:

- responsibilities including promoting people's wellbeing, focusing on prevention and providing information and advice;
- rights to support for carers, on an equivalent basis to the people they care for;
- responsibilities around transition, provider failure, supporting people who move between local authority areas and safeguarding.

For Brent council, the introduction of the Care Act means that opportunities will exist to further integrate health and social care support functions in alignment with other key partners.

The London Borough of Brent is working with partner agencies to ensure that the new duties from the care and support reform are met and that services have a stronger emphasis and ability to provide preventative support and early intervention. The new duties will ensure that the Council implements the assessment and eligibility criteria to include outcomes that are linked to the health and social care integration work. The areas of integration, professional roles and responsibility, assessment, personalisation, prevention and early intervention included in the full duties of the care and support reform as set out in the Care Act 2014 are a key component of the Better Care Fund Plan Schemes.

These will be met through closer care integration of health and social care, whilst enabling the Local authority and Health partners support vulnerable people to be cared for in their own homes and/or be assisted with self-care management skills. The provision within the Better Care Fund schemes, promotes the well-being of individuals in our locality by prioritising prevention and early intervention and support both of which are central to the Care Act.

v) Please specify the level of resource that will be dedicated to carer-specific support

The CCG will contribute £700k and SSA a further £200k to provide a total resource of £900k dedicated to carer-specific support

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

There is no change other than that the additional £776k will support the Care Act implementation

b) 7 day services to support discharge

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

NWL is an early adopter of the 7 day services programme. The aim of this programme is to ensure that urgent and emergency care providers develop plans for the delivery of 10 clinical standards, seven days a week. The ten clinical standards aim to improve quality and reduce variation in clinical outcomes (within hours from out of hours and weekends). The majority of standards relate to acute hospital care. However, two of these standards are directly interrelated to areas of development within Brent's BCF.

7 day working will be embedded in all BCF developments in order to ensure that there is consistency and alignment of the service standards required to improve quality and reduce variation in clinical outcomes.

The BCF will be the vehicle used to help with the delivery of Brent's commitment to providing seven-day health and social care services, supporting patients being discharged and preventing unnecessary admissions at weekends by identifying high-risk patient groups and introducing rapid response services.

The local Brent and Harrow health and care economy is working to implement the national clinical standards for seven day services (in urgent and emergency care) including 7-day inpatient diagnostics, consultant cover and access to key interventions.

The acute trust has established a multi-disciplinary and clinically led 7-Day Working Group to deliver 7 day priorities, reporting through the 'Improving Inpatient Care' and 7 Day Executive Group' that will agree the strategic direction.

The System Resilience Group will have particular oversight of clinical standard 9 i.e. that support services, both in the hospital and primary, community and mental health settings, must be available seven days a week to ensure that the next steps in the patients care pathway, as determined by the daily consultant–led review, can be taken.

c) Data sharing

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

Brent CCG and Brent Council are working in collaboration on a project to use the NHS Number as a safe and reliable way of uniquely identifying clients/patients across social and health care partners. Recently an application was made to the Integrated Digital Care Technology Fund for funding. The outcome of the application will be announced in October 2014.

Both the CCG and Local Authority are committed to rolling out the NHS number as a unique identifier and recognise that this project is a key priority to enabling a host of other integration pieces. A project plan to support the application has been completed and timelines and the initial project initiation phase has begun with key stakeholders. Key suppliers have already been engaged with to plan through the programme of work. Initial work for:-

Phase 1 - NHS Migration Analysis Cleansing Service (MACS), Frameworki Data Cleansing and Merging has begun and it is planned that this phase will be complete November/December 2014 and will be followed by

Phase 2 - Demographics Batch Service (DBS), Summary Care Record Application Matching (SCRa), FWi Data Cleansing & Merging. It is anticipated that the project will delivered in April 2015.

ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

As part of GPSoC mandate we expect our clinical providers to subscribe to the opens APIs. This expectation does not only apply to GP system suppliers but all suppliers that exist and supply our products. In procuring and contracting new products/suppliers open API and open source is a key requirement. Open APIs across all systems and suppliers and the agreement to deliver open APIs forms part of the CCG commissioning intentions for 2015-16.

As part of NWL Pioneers informatics group the CCG is not only committed to suppliers signing up to open APIs but will undertake a process to monitor and ensure that open APIs are delivered.
ITK standards and secure email standards have already been established across our systems health settings and providers.

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, and professional clinical practice and in particular requirements set out in Caldicott 2.

Our IM&T systems, Information Governance arrangements and processes all comply with Health Social Care Information Centre standards to ensure information flows efficiently and securely across the health and social care system, to improve patient outcomes.

We have a robust IG structure within the Federation (Brent Harrow and Hillingdon CCGs) that ensures all policies, procedures and controls are in place. These include the use of smart cards, the handling of patient identifiable information, patient consent, and the enforcement of Section 251.

We expect all our partners to have a Caldicott Guardian and to observe and comply with Caldicott requirements including those set out in Caldicott2 pertaining to the "Duty to Share". Organisations have regular IG reviews and mandated annual training.

To facilitate the secure sharing of information a NWL Information Sharing Protocol endorsed by the LMC is currently being signed by all partner organisations in Brent to facilitate the sharing of data. This overarching document sets out general principles, standards and governance agreed between the partner organisations. This ISP is also underpinned by individual Information Sharing Agreements (ISA) between partner organisations for specific purposes detailing what will be shared and how.

The IG toolkit requirements are well established across Brent with NHS organisations and partners undertaking the annual assessment. A majority of our practices have achieved Level 2 and there is a programme of work to help all practices achieve this level by March 2104.

NWL are making efforts to ensure that all systems have mechanism to records access to patients notes are there is a fully auditable record that will be viewable by the patient as required in Caldicott2.

d) Joint assessment and accountable lead professional for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

There are a number of international studies from medical journals which support the proposition that care planning and multi-disciplinary patient discussions reduce hospital activity for care planned patients.

Additionally, we have local evidence that the ICP is currently on track to deliver around £750k QIPP target by the end of the financial year on current projections.

For the Whole Systems Programme, there is also a range of evidence that the whole systems approach works from a range of international organisations such as:

- Kaiser Permanente (USA)
- Chen Med (USA)
- Alzira model (Spain)

IICP risk stratification has identified the top 2% of the practice population who are at high risk of admission to hospital. Based on a registered list size of 342,000 patients, this equates to approximately 6,500 people. The top 2% are identified using the BIRT 2 risk stratification tool, which rates risk from 1-100 based on secondary care utilisation, for example using non-elective admissions, outpatient appointments and A&E attendances using logistic regression theory. BIRT 2 is a local risk stratification tool developed by the CSU.

The local patient group has been risk stratified to establish criteria for agreeing a set of interventions for each group.

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

The lead professional role will be aligned with the development of GP based MDGs and emerging networks. The GP will be the responsible clinician, with health and social care coordinators working at MDG/MDT level to ensure those identified with risk factors have individual co-designed interventions and care plan initiated with multi provider input and regular review, making care planning a much more dynamic process. Complex people most at risk of admission will be supported by a community matron lead professional working within a primary care based (or community based) integrated service. Part of the planning for anticipated care needs involved in this process will include the definition of who the patient/service user or carer needs to get in contact with when they need to. This would include definition of who to get in contact with for routine needs and in a crisis situation. Who this individual is may vary dependent on the complexity of the needs of the person.

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

As of 18 September 2014, 2275 Brent patients have joint care plans which is 35% of the cohort target of 6500 care plans

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

Our vision for 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 Health-watch, 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 with regards to working closely with the voluntary sector and local enterprises to support health and social care provision. Continued working in partnership with Brent Health-watch and CVS will be central to our aims to deliver this plan.

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

Key Partners from NHS Foundation Trusts and Acute Trusts have been fully engaged with the Better Care Fund Plan. In addition, all community and voluntary sector providers have been actively engaged in shaping the schemes and its outcomes.

There have been extensive workshops which have been facilitated to co-produce, co-design and inform the process. There has been and will continue to be a number of workshops, forums, the Integration Board, the Health and Well-being Board, and various other Provider Engagement and participation forums to ensure full engagement of NHS Foundation Trusts and NHS Trusts in the planning and development, implementation, monitoring and reviewing of the Better Care Fund Plans.

NHS Foundation Trust and Acute Trust Partners were offered and took up 1:1 meetings as well as attending the Better Care Fund Integration Board. There have been follow-up meetings with different providers to enable full understanding of the priorities for the Better Care Fund and the impact on Acute provision.

We have consulted partners and delivered provider forums and workshops events with a diverse range of NHS stakeholders. We have shared high quality robust analysis of the Brent risk stratifications and information from other forums and workshops to ensure a joined up approach.

ii) primary care providers

We have regular GP member practice forums as well as Network meetings for all primary care providers. We have held additional GP Forum meetings and workshops specific to the Better Care Fund Plan to inform the plans, to comment on the plans and the lead and progress the schemes. The events to engage GPs have enabled in-depth discussion and co-design of the service improvements required for integrated care. Local GPS are fully signed up the Better Care Fund Plan and have been engaged as part of the Integration Board and in practice specific for a.

iii) social care and providers from the voluntary and community sector

There have been Provider Forums set up to consult and engage with social care, voluntary sector and community sector providers. These events have been used to get the views of key partners and consultation on the Better Care Fund Plan. We will continue to build upon our track record of meaningful engagement and involvement to demonstrate our commitment to work closely local providers and ensure that the interests of local organisations are included in our plans and reflect the strong working relationships and influences.

Social care and providers from the voluntary and community sector have been and continue to be involved and engaged in the design of services; implementation of plans and delivery of plans. Health and social care partners are committed to engaging and involving all local providers in the planning, development, delivery and monitoring of the Better Care Fund Plan to provide direct input and contribution.

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

The three main Providers – North West London Hospitals, Royal Free Hospital NHS Trust and Imperial College Hospitals, are engaged with the Better Care Fund Plan and are committed to working in partnership with the CCG to improve care and reduce non elective admissions – both general and acute.

Local acute providers are aware that the proposed BCF Schemes have a potential impact on activity, income and spending as resources are shifted to fund new joint schemes. The impact will be part of the 15/16 contract discussions, once an accurate activity plan baseline has been established across the acute providers.

Provider commentary is attached in Annexe 2 for 2 of the Providers. The 3rd Provider (Imperial College Health Car Trust) advised that they will provide their comments multi-laterally as opposed to singularly for one CCG as their activities cover a number of CCGs.

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Keeping the most Vulnerable well in the community

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
Scheme 1
Scheme name
Keeping the Most Vulnerable Well in the Community
What is the strategic objective of this scheme?

Integrated Care Programme II

The strategic objective is to keep people who are over 75 or have 2 or more long-term conditions healthier for longer. The model of care will be focussed on the right patients, with management and co-ordination of interventions through a new breed of worker – the health and social care co-ordinator.

The scheme also provides a strong platform for health and social care integration and is the foundation on which whole systems integration can be built. By focussing care on these patients, the system can provide more efficient care in a community setting and avoid expensive hospital admissions, as well as providing better quality care for patients.

The key principles behind the model are:

- Up-front identification of specific integration registry in each practice and MDG at the start of the year using segmentation guidance and a risk stratification tool;
- Changing the way care planning works so that it is no longer a static process and responds to changing patient needs;
- Creating the new role of the Health and Social Care Co-Ordinator to ensure that the patient is co-ordinated and that actions are followed up.

Whole Systems

During year 2 (2015/16), the current ICP II model will continue for all localities but will be supplemented by Whole Systems Integrated Care early adopter sites in Harness and Kilburn. Whole Systems is the next step in providing a truly integrated approach across a population group

The key principles behind the model of care for whole systems are:

1. **People will be empowered to direct their care and support and to receive the care they need in their homes or local community** – the system will be organised so that service users have more say over their care and when and how they receive it based on evidence and shared standards.

2. **GPs will be at the centre of organising and coordinating care so that it is accessible**

and provided in the most appropriate setting – this typically means convenient care close to home wherever possible and fewer urgent hospital stays.

3. **Our systems will enable and not hinder the provision of integrated care and ensure that funding flows to where it is needed most** – the system will enable care to be delivered quickly and effectively, saving time and money by avoiding duplication

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?
- What are the tangible and non tangible benefits/impact of each of the key enablers on this scheme:

The aim of this scheme is to reduce hospital admissions for those people identified as vulnerable or at risk of admission through a care planning approach and through discussing high risk patients with a range of professionals from across the health and social care economy at MDT and MDG meetings, encouraging consistency of approach across the different GP provider networks. The focus of the scheme is on people aged 75 and over and those with 2 or more long-term conditions over the age of 18. This can include mental health conditions.

The project will improve a range of patient outcomes including:

- Keeping healthier through a pro-active care planning approach with regular review, meaning that patients do not suffer exacerbations so regularly and are able to stay in their own homes rather than being admitted to hospital;
- An improved range of clinical metrics across some disease groups, for example HbA1c for people with diabetes, improved blood pressure and management of trigger points in people with COPD based on a 'gold standard' care pathway
- Reduced readmissions where patients do go to hospital, such as the number of people still at home 91 days after hospital discharge into a reablement programme
- Improvement in patient experience and having more time to discuss their concerns and goals in an extended care planning appointment
- More people achieving health and social care goals that improve their lifestyle
- Working more closely with social care to link with projects that reduce social isolation, which in turn is known to affect the risk of mortality and admissions to secondary care.

We will do this by delivering the following key deliverables:

- Care planning approx. 2% of the population from the top 20% at risk
- Using a dedicated risk stratification tool to care plan this proportion of the population
- Putting in place pro-active and patient centred care plans for patients which set goals and reflect patient concerns
- Responding to 'trigger' events throughout the course of the year of care
- Performance management review throughout the course of the year and regular audit.

<u>Whole Systems Interventions</u>

The Whole Systems cohort is focussed on those people who are aged 75 years or over with 1 or more long-term conditions and will be adopted in Kilburn and Harness localities.

The evidence gained through our workshops and engagement activities suggest that patients want to feel in control of their own health and wellbeing and that when support is required it is

tailored around their needs and not the requirements of organisations. In order to achieve this, organisations need to work closely together to design and adopt new ways of working.

In designing our model of care we have adopted the following 4 core principles:

1. Self-Management, Support and Empowerment
2. Care Co-ordination
3. Care Planning
4. Multi-Disciplinary Teams

The workshops are applying these principles across a range of settings, including (i) residential and inpatient (ii) ambulatory (iii) home-based care and (iv) empowerment and self-care.

Governance

The providers will come together to establish a joint governance framework for Whole Systems and to operate a shadow pooled budget during 2015/16 for this specific population group and to begin to redesign roles across health and social care to reduce unnecessary duplication and numbers of home visits undertaken by various different services.

Benefits & Impacts of the Key Enablers:

Rehab and Re-ablement

Rehabilitation and re-ablement has the potential to reduce length of stay by facilitating a stepped down pathway out of hospital. Scheme 1 should therefore build links with rehabilitation and reablement so that patients who attend GP practices for care plans or where a GP is notified of a trigger event could act as a referral route into rehabilitation and reablement. Factors associated with increased rates of admission include age, social deprivation, mobility levels, living in an urban area, ethnicity and environmental factors. A lack of alternative options frequently leads to patients being admitted to hospital when it is not clinically justified. It is therefore vital that there is capacity to offer rapid responses in the community that offer an alternative to a hospital stay, which supports the key objective of Scheme 1 to avoid unnecessary hospital admissions and keep people staying healthier for longer. The Health and Social Care Co-Ordinator workforce can build links with the rehabilitation teams in STARRS, the community rehabilitation team and the Social Care Re-ablement Team so that patients can be referred to these services by their GP and also act as a source of intelligence on patients who already have a care plan, for example alerting them to the fact that they are about to be discharged from hospital.

Information Technology

The scheme will utilise technology to improve the way that professionals and service users are able to communicate. We are bringing in videoconferencing to support the MDGs and allow case conferences to take place virtually. Patients can also attend the case conference virtually by attending at their practice. Videoconferencing would also facilitate virtual 1-1 appointment slots with their GP practice or allow 'mini-case conferences' so that a group of selected individuals could be brought together to discuss a patient's case without needing to leave their place of work. This will allow services to work more effectively together and more efficiently.

7 day working

NWL is an early adopter of the 7 day services programme. The aim of this programme is to ensure that urgent and emergency care providers develop plans for the delivery of 10 clinical standards, seven days a week. The ten clinical standards will improve quality and reduce

variation in clinical outcomes (within hours from out of hours and weekends).
The aim of the 7 day working project will seek to embed these standards into BCF developments in order to ensure there is consistency and alignment of service standards to improve quality and reduce variation in clinical outcomes.

Links to S*cheme 1* – *Keeping People Well in the Community*
Ensuring that individuals prone to acute exacerbations of long term conditions have a proactive care plan in place. This will enable people who have an urgent care admission to receive an MDT within the hospital setting that is informed by the primary and community records (part of standard 3 of 7 day working clinical standards).

7 day working means that people will be able to access services more appropriately, which compliments the aims of Scheme 1 to avoid unnecessary utilisation of urgent care services. Urgent care services may be more frequently utilised at weekends due to difficulty accessing other services. Therefore, increasing the availability of normal services may result in fewer people accessing urgent care unnecessarily.

Similarly, 7 day working in hospitals may mean that lengths of stay reduce, as medical staff are able to make more treatment decisions at weekends rather than waiting until Monday.

Social Isolation

London Borough of Brent's social isolation project will begin in September 2014. This is aimed at some groups of people who will overlap with the Scheme 1 cohort, including those with dementia, mental health problems, of frequent attendance of emergency services because of a pattern of behaviour that may be attributable to their social isolation. This is a key enabler because it is known that there is a section of the population that frequently accesses emergency services but do not necessarily attend their GP practice. These people may be picked up in the risk stratification tool, but others may be picked up by co-ordinators working in the social isolation project. A link should therefore be built between the social isolation project and GP practices to alert GPs where certain people would benefit from a care plan.

Perhaps the group suffering most frequently from social isolation is the older population group, whose friends, relatives or carers may have died or moved away from the area. Social isolation has been shown to increase mortality and illness and therefore the social isolation project would support the key aim of Scheme 1 of keeping people living healthier for longer in the community.

Scheme 1 could also refer patients to the social isolation project who would benefit from increased knowledge of healthy living patterns who may be able to self-care.

Public Engagement

Public engagement is essential to making Scheme 1 work. As part of planning the ICP public consultation was undertaken. For the Whole Systems work, this has been taken a stage further in that service users are directly involved in all the scoping meetings and co-design phase through the Whole Systems workshops. In this way, the ideas for the service model are developed with users rather than merely being consulted on them. Users have a vital role in testing whether a service model will work for them and the people they represent. Health watch is directly involved in the Whole Systems steering groups.

Carers/Self care

Many of the people within the cohort population for Scheme 1 will have carers and it is just as important to engage with them as it is with the person who is being cared for. If a person's carer becomes unwell or is unable to manage with the burden of caring, this may in itself cause a

hospital admission for social reasons if the person is unable to care for themselves. Therefore, supporting carers is an enabler for Scheme 1.

Self-care is important at the lower levels of the risk spectrum, and a key part of care planning is to allow people to take better care of themselves and to understand their condition better so that if they suffer an exacerbation they know what to do and who to contact.

Exploring new and innovative ways for patients to share information about how to keep healthy is important, and one way to do this is to encourage patients to connect with each other in social media forums, utilising new forms of technology.

Learning and Development/Workforce

Learning and development is a key enabler to Scheme 1.MDGs are an on-going forum for learning and development and help to share best practices and standardise clinical behaviour. The MDGs have included sessions on areas as diverse as motivational interviewing, or management of clinical conditions such as COPD or diabetes.

As part of the process of reviewing and auditing the care planning and case management process, areas for improvement may be highlighted and this should then be linked to learning and development for those MDGs or networks.

Health and Social Care Co-Ordinators are part of the new workforce, working in primary care to ensure that actions in care plans are delivered and taken forward. Having a fully developed workforce in primary care is crucial to delivering care outside of hospital and thereby keeping people healthier for longer, avoiding hospital admissions.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Care planning activity is primarily provided by GP practices who sign up to an agreement. GP practices schedule care planning sessions within their GP practice and are supported in setting up the administrative systems for this by the HSCCs.

MDT meetings are attended by the practice team with the support of the HSCC to discuss actions from the care plans that may need to be taken forward.

MDGs involve attendees from the acute sector (consultants), mental health specialists, social workers, community nursing team and GPs. Monthly meetings are scheduled in advance for the course of the year by MDG co-ordinators and dates sent out well in advance. The administrative side of the MDG and the recording of notes and actions is undertaken by the MDG Co-Ordinators.

A central team is in place to project and performance manage the scheme and to analyse data on its effectiveness.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

There are a number of international studies from medical journals which support the proposition that care planning and multi-disciplinary patient discussions reduce hospital activity for care planned patients. The studies are quoted below.

Integrated Care Programme for Chronically Ill Patients: A Review of Systematic Reviews
International Journal for Quality in Care 2005: Volume 17, number 2: pp.141-146.

Interventions to improve the management of diabetes in primary care, outpatient, and community settings: a systematic review.
Diabetes Care, 2001 Oct; 24(10): 1821-33

Specialist general practitioners and diabetes clinics in primary care: a qualitative and descriptive evaluation.
Diabetes Med, 2004 Jan; 21(1): 32-8

Long-Term Outcomes from the IMPACT randomised trial for depressed elderly patients in primary care
BMJ 2006; 322:259

Is Patient Activation Associated With Outcomes of Care for Adults With Chronic Conditions?
Journal of Ambulatory Care Management January/ March 2007 – Volume 30 – Issue 1 – p.21-29

Additionally, we have our own local evidence that the ICP is currently on track to deliver around £750k QIPP target by the end of the financial year on current projections.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan – included in Annexe 2

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Expected Benefit	Source of Data	Method of Measurement
Reduction in Non-elective admissions	SUS/NWL Data Warehouse	Expected versus observed
Reduction in A&E attendances	SUS/NWL Data Warehouse	Expected versus observed
Overall cost impact on care planned patients	SUS/ NWL Data Warehouse	Expected versus observed
Improved Clinical Metrics (e.g. HbA1c, BP, % COPD patients with yearly flu vaccinations etc.)	NWL Data Warehouse *(dependent on successful implementation of data warehouse)*	Monthly changes in metrics across care planned patient group
Improved Social care metrics (e.g. number of people still at home 91 days after hospital discharge into a reablement programme)	Brent Council databases (*subject to agreement with Brent Council):*	Trends over time
Improvement in patient experience.	Based on questions developed in Picker Institute "i-statements" contained in paper "*Developing Measures*	Patient/carer interviews and surveys.

	of People's Self-Reported Experiences of Integrated Care" (October 2013)	

The planned QIPP saving in 14/15 is 748K, which represents approximately 309 non-elective admissions saved and 296 A&E attendances saved. This is based on a monthly savings rate per care plan based on the order of savings from the international evidence.

For the Whole Systems aspect of the work, the model of care is still being scoped out and a plan to deliver and evaluate specific outcomes will be built up as part of this work. Key domain measures are likely to include: quality of life, quality of care, care utilisation and total cost, accessibility of care, service user experience and carer involvement.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Secondary care activity is being tracked by from SUS against care planned patients and against a list of ICD-10 codes specific to the scheme. This tracks activity before and after care planning. It also monitors the overall impact of the scheme on overall activity levels.

An audit programme is in place to track whether patients are being followed up in line with trigger events over time.

The audit programme looks at:

- Patient experience (survey)
- Whether patient goals are being achieved (as stated by the patient)
- Evidence that patients are being regularly reviewed in line with trigger events (or at 3 months if no trigger events)
- Evidence of multidisciplinary input into the care plan

There is a mechanism to feed back the findings of the audit and the activity monitoring to practices through the MDGs and through individual communications between the ICP team and the individual practices concerned (e.g. emails or letters addressing underperformance).

There is also regular monitoring of the scheme through the QIPP PMO management meetings and QIPP subcommittees.

What are the key success factors for implementation of this scheme?

The key success factors for implementation of the scheme are:

1. Clinical engagement from GP practices and other providers and a strong will to deliver the deliverables
2. Time and resource to develop and deliver the changed model.
3. A common vision across all participating providers on the Whole Systems model of care.
4. Patients/ service users understanding the care planning process and what to do if their condition exacerbates.
5. Strong performance management and feedback loop based on data, with learning and development programme for professionals to address areas of learning and standardise practice.

6. Strong supporting infrastructure in terms of data/analytics support and administration of the scheme including data warehouse and MIG.

. Avoiding unnecessary hospital admissions

Scheme ref no.

Scheme 2

Scheme name

Avoiding Unnecessary hospital admissions

What is the strategic objective of this scheme?

The strategic objective of this scheme is to ensure when a crisis happens the appropriate support is available to avoid unnecessary acute hospital admissions. The proposed model of care will need to ensure a flexible and responsive approach to meet the needs of the Brent's population.

The Short Term Assessment, Rehabilitation and Re-ablement Service (STARRS) provides a strong platform for health and social care integration and is the foundation on which this scheme can be built. STARRS aims to:

- Improve the transition for patients between acute hospital services and community services
- Reduce A&E attendances, unnecessary admission and reduce length of hospital stays
- Operate in an integrated way so improve services for patients and work flexibly across the Whole system
- Maximise independent living by treating people in their own homes where possible

There are 3 essential components of the service:

- The admission avoidance Rapid Response Teams (7 day service) which work directly in A&E Majors to avoid admissions, and accept direct GP and LAS referrals for patients at high risk of hospital admission to avoid A&E attendances
- The Early supported Discharge team (7 day service) which continues the treatment of patients at home following a hospital admission in order to reduce the time spent in hospital beds
- The Short Term Rehabilitation team (5 day service) which supports patients in the community providing on-going rehab and in collaboration with re-ablement to ensure patients can remain at home with appropriate support.

This scheme proposes to enhance the Rapid Response Service component of STARRS model but with greater focus on health and social care crisis management to provide more effective care in the community and avoid expensive hospital admissions.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?
- What are the tangible and non-tangible benefits/impact of each of the key enablers on this scheme:

The aim of this scheme is to support patients in need of short term intervention to mitigate the risk of hospital admission by providing an assessment and package of care in the home environment or referring the patient to the appropriate services. The cohorts of patients that will

be targeted are those who would normally have short stay admissions and adults requiring urgent social care intervention.

The current Rapid Response Service aims to:

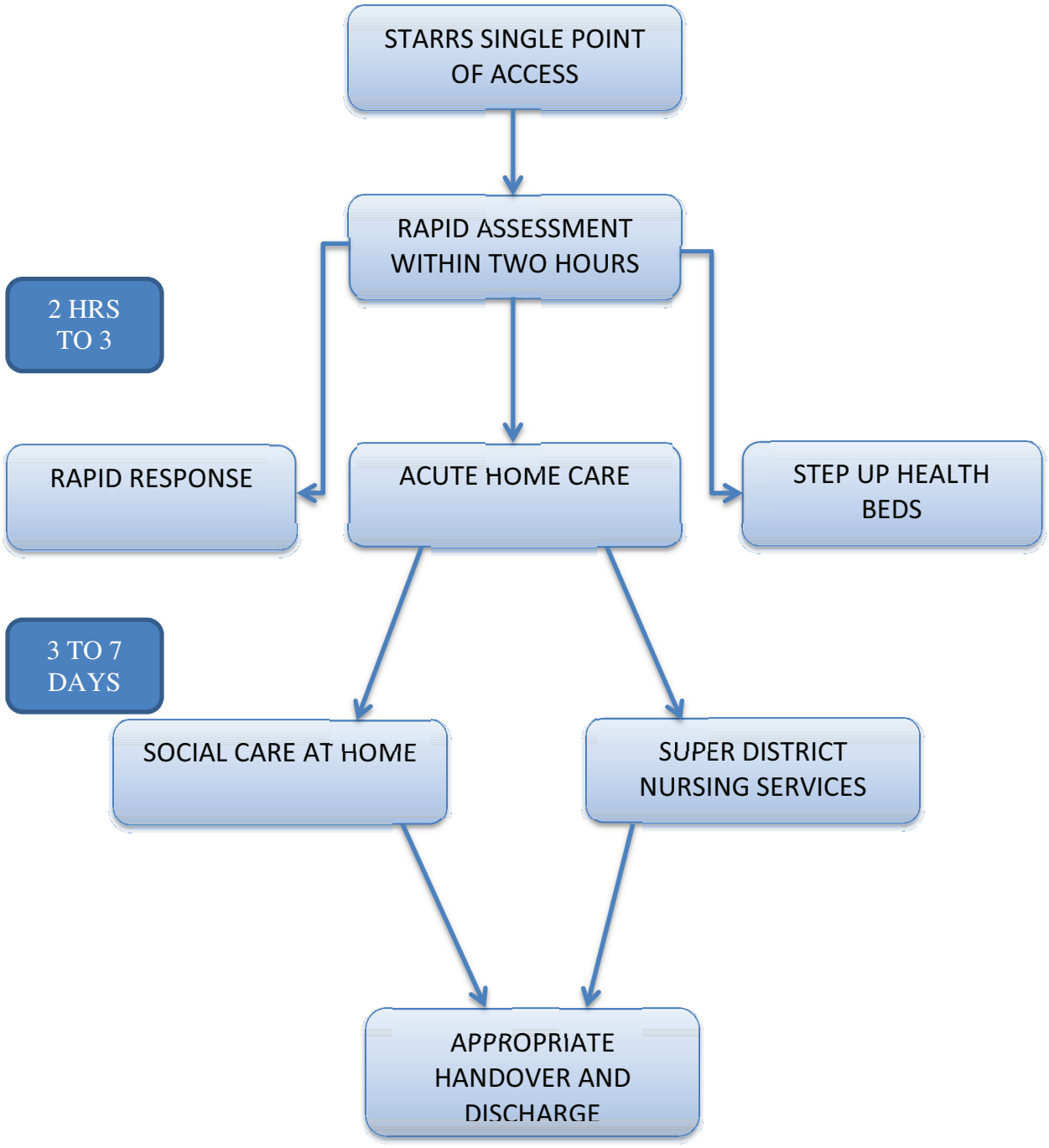
- Reduce hospital admissions by assessing patients with an acute exacerbation in the home environment
- Reduce hospital admissions by effectively treating patients in the home environment
- Provide an assessment and package of care in the home environment
- Refer to other appropriate services to support the patient/carers needs

The service achieves this by delivering the following:

- Provide a rapid assessment for patients in the community who are perceived to be at risk of admission within 2-hours of notification
- Assess patients attending A&E for suitability for care at home as an alternative to admission and ensure transfer within the 4-hour target
- Deliver associated care for up to 72 hours
- Ensure efficient and effective patient handovers at the time of discharge

Enhancement of the above service model will include:

- Extended hours of operation to support referrals from GPs/networks (referrals accepted until 7pm STARRS open until 9pm)
- social care working 7 days to avoid social admissions
- Social care - greater focus on health and social care integration to avoid admissions
- (Extend coverage to include Royal Free Hospital - focus on an outreach model
- GP with special interest input into service -expertise within service to provide links to GP networks - agree role and responsibilities
- Effective use of step-up beds and step down beds, Extra Care step downs and short term night support - align to Scheme 3 Effective multi-agency discharge planning
- Referral from 111 during hours of operation
- Better alignment with District Nursing service and Ambulatory Care Pathways, Continuing Health Care Service, and nursing homes ensuring clear referral mechanisms and clear communication when patients are transferred to their care e.g. District Nursing and vice versa to STARRS
- Develop an enhanced skills roving DN team (integrated with SW and other professionals). which is part of STARRS and can carry out cannulation; sub cut fluid hydration and other skills as part of an extended DN service which would need to be over 5-7 days.
- Agree and confirm interface with Ambulatory Care pathways such as DVT and Cellulitis
- Operational linkages to Mental Health Scheme for e.g. Psychiatric Liaison Interface
- Integration with voluntary sector services –explore models of third sector night sitting services and costs



7 Day Working Links to Scheme 2 – Avoiding unnecessary hospital admission. Ensuring that individuals receive the support to remain at home. A 7 day integrated rapid response service comprising nurses, physiotherapists, OTs and social workers are in place to put the right combination of support from health, social care and the voluntary sector in place.

Delivery of 7 day services in the hospital, primary, community and mental health settings coupled with effective case management should enable many patients to access the appropriate level of care 7 days a week. Consequently this should decrease the number of unnecessary hospital admissions as appropriate services will be available in the community including weekends. This should support patients to manage their conditions with less crisis interventions.

Furthermore operational links to Mental Health through the Psychiatric Liaison service will provide less restrictive alternatives to hospital admission for people experiencing mental health crisis or at risk of. Mental health is currently one of the top conditions for hospital admission. Having these links and alternative provisions will help decrease avoidable hospital admissions.

Brent will develop an Integrated Care model for prevention of admissions to hospitals which will work to:

- A whole systems model of working across health and social care to promote independence and prevent unnecessary hospital admissions.

- Improve outcomes for isolated and socially excluded people including those from hard-to reach black and minority ethnic groups

- Provide preventative services for people who are at risk of avoidable hospital admissions or premature admission to residential care, or are perceived to be at risk due to mental, physical, emotional or social problems and enabled them to be cared for at home.

7 day working will provide a holistic assessment of individuals' needs across all age and across all care groups and support them through primary and community care interventions to remain in their own home environment for as long as possible. The 7 day working will co-ordinate health and social care support and other required services from the private and voluntary sector providers including opticians, dentists, befriending services and others.

Avoiding unnecessary hospital admissions will include provision of:

- Integrated working between health and social care and pro-active management of the elderly frail, those with long term conditions,
- Self-care/self-management support
- Crisis Home Treatment support
- Hospital at Home support
- Falls Prevention services
- Intermediate care and community rehabilitation support
- Multi-disciplinary care management of frail elderly people and at risk individuals in the community
- Intensive follow-up after –discharge
- Reviews of medications

Key Enablers

Rehab and Reablement will facilitate a stepped down pathway out of hospital that GPs could also refer directly to if an issue arises where an unnecessary hospital admission could be avoided e.g. a fall that doesn't require surgery but the person lives on their own Currently a lack of appropriate care in the community can lead to unnecessary admissions e.g. people who live on their own

Information Technology will improve professionals and service users ability to share information and communicate directly more easily. Technology will increase patient's access to more appropriate consultation e.g. phone or skype and this could improve patients use of normal services thus enabling them to access medical attention earlier in order to prevent emergencies and have appropriate care plans in place.

Technology will also enable health and social care professionals to share records and therefore to know about a patient's history and on-going treatment in a timely fashion and without repeating

assessments. This will enable them to follow care plans in place and record any new issues and ensure the patient has continuity of care

Social Isolation will support a cohort of patients with conditions such as dementia, MH problems, and frequent users of emergency services. Having this type of support in place will contribute to a decrease in unnecessary hospital admissions as evidence reveals that social isolation and loneliness impact on quality of life and wellbeing, with demonstrable negative health effects. Loneliness is also associated with depression and higher rates of mortality. Such negative impact on individuals' health leads to higher health and social care service use, and lonely and socially isolated individuals are more likely to have early admission to residential or nursing care. Social isolation interventions will contribute to reducing unnecessary hospital admissions.

Public engagement and self-care will contribute to preventing unnecessary hospital admissions by increasing patients understanding of their own care and the role they can play in it. It can increase their sense of control and increase their awareness of when their condition is deteriorating and can seek support before it becomes an emergency.

Intelligent engagement will increase local communities' awareness of this services and their understanding of what services are provided and sign post people to the appropriate services. Going out to people in the community to hear what they have to say will help to make this services reflective of the community's needs.

Carers Supporting carers appropriately to maintain and protect their health could reduce unnecessary hospital admissions that result when a carer becomes unwell and the person they care for needs to be admitted to hospital for social reasons as there are no alternatives in place. A rapid response service could mean that this person is able to be cared for in the community.

Also focusing on carers and providing more services in the home at times of crisis will enable carers to provide care in the home for longer than they would have if these services didn't exist.

Learning and Development Learning and development that focuses on better alignment of professionals and services will support better communication and continuity of care. This can be supported by having joint training for rapid response team members and referrers.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The Rapid Response Service is accessed by a Single Point of Access. Referrals are received from a health or social care professional either from a community or acute setting. In each case, service delivery is divided into 'Rapid Assessment' and 'Rapid Response Care'. As part of the Rapid Assessment a care plan is created for the patient.

A single Key Worker is allocated to ensure a single point of care coordination, multi-agency facilitation and contact with the patient, the Key Worker can be either a health or social care professional.

A Virtual Ward Round takes place to discuss actions from the assessment and the care plans are created by the MDT; who allocate the on-going management of the patient,

NHS Brent Clinical Commissioning Group is the commissioner.

The providers are:

- North West London NHS Trust

- London Borough of Brent
- Ealing Integrated Care Organisation – NHS Brent Community Services

Milestones	Who	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16
Set up steering group	CCG	started					
Agree cohort from social care perspective	LA	started					
Establish interfaces with other schemes	CCG,LA	started					
Identify top conditions for emergency and no elective admissions	CCG, CSU	started					
Agree role and responsibility for GPsI	CCG, GPs,						
Develop new super DN team	STARRS						
Communicate and engage with internal and external stakeholders	All						
Revise service specification or business case	CCG						
Implement revised pathways	all						
Audit outcomes of revised rapid response service	STARRS Board						

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Since Department of Health Guidance and NSF for Older People (Standard 3) in 2001 there has been a steady increase in intermediate care services across the country. Approaches have varied in local content and resources included rapid response teams, community assessment and rehabilitation teams, residential re-ablement units, hospital-at-home schemes and community hospital services.

Greenwich Hospital Avoidance Scheme
Source: NHS England (2014). Safe Compassionate Care
The Kings Fund: Integrating Health & Social Care in Torbay

The National Audit of Intermediate Care (2013) demonstrates the cost effectiveness of intermediate care, as shown in the following details:

- Day hospital: 12 trials (n=2,867). Results suggest day hospitals are effective but expensive.
- Care homes: 1 trial (n=165). Results suggest that care homes shift costs to social care.
- Community hospitals: 2 trials (n=>700). Results suggest that community hospitals are cost-effective.
- Hospital At Home services: >40 trials (n= >6,000). Results suggest that HAH services are less expensive than inpatient care.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan – Included in Annexe 2

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below – Included in Annexe 2

Expected Benefit	Source of Data	Method of Measurement
Reduction in non-elective hospital admissions - NWLHT - Imperial - Royal Free	SUS/NWL Data Warehouse	Reduction in activity based on the agreed baseline
Reduction in A&E attendances - NWLHT - Imperial - Royal Free	SUS/NWL Data Warehouse	Reduction in activity based on the agreed baseline
Improved patient experience through coordinated care	Patient satisfaction response rate	Response rate measured as the number of patients completing the survey divided by the number of patients seen in the service

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

We need to look at activity and audit data, carry out analysis and then make agreed changes to services to improve outcomes. This needs to be jointly worked out as it is not sus service improvement but model change may be needed.

Monitoring - Secondary care activity will be used to monitor the impact of the scheme on overall activity levels.

Monthly performance and monitoring meetings will ensure that the service is monitored against its Key Performance Indicators and remedial actions plans are developed to mitigate any identified risks.

An agreed audit programme will be put in place to monitor the quality of services and evidence multi-agency care delivery. The findings from the audit will support continual service improvement and innovation within the service.

What are the key success factors for implementation of this scheme?

The key success factors for implementation of the scheme are:

- Clinical engagement with GP practices, other health and social care providers
- Clinical engagement with Acute Care clinicians to support higher levels of acuity in the community safely
- Time and resources to develop and deliver the enhanced model.
- Patients/ service users and carers engagement

- Robust performance and management mechanisms to monitor deliverables and support on-going development

- Finance and data/analytics support

Risks and Mitigations

- Failure to achieve the quantitative and qualitative benefits Mitigation we are building on established foundation of STARRS rapid response service which achieves current outcomes and is well thought of by GPs, patients and other stakeholders

- Lack of engagement from key stakeholders and providers –the steering group has been established with representation of key stakeholders and providers and all are in agreement re direction of travel

- Impact and interdependence upon other schemes for example Rehabilitation and Reablement the leads of all schemes meet regularly to ensure linkage and the lead for the Rehab and reablement is on the Brent BCF steering group

3. Effective Multi agency hospital discharge

Scheme ref no.
Scheme 3
Scheme name
Effective multi agency hospital discharge
What is the strategic objective of this scheme?
• To reduce delayed transfers of care (be specific by how many bed days) • To maintain minimum lengths of stays in hospital • To reduce readmissions to hospitals • To increase the number of people discharged to independent living in the community and reduce residential and nursing home admissions
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted? - What are the tangible and non tangible benefits/impact of each of the key enablers on this scheme:
The scheme will integrate the elements required to discharge people from hospital to form an integrated team that will discharge Brent customers and patients from all acute hospital stays and Willesden Community hospital. The aim of the scheme is to speed up the discharge process to reduce delayed transfers of care and ensure coordinated and safe discharges to reduce the risk of readmissions. The scheme will combine the functions of discharge coordination, social care assessment, continuing health care assessment, housing assessment and health, housing and

social care service provision for discharge to ensure that speedy decisions are made regarding discharge plans with the customer at the centre to enable safe and timely discharges and whole system coordination regarding community support on discharge. The scheme will promote trust of assessments between organisations and enable a whole health economy and systems approach to support on discharge to ensure the most appropriate support plan is in place which creates safety on discharge and maximises on the community support available.

The scheme will improve the safety of discharging to prevent readmissions and promote supporting people long term in the community. To enable this the scheme will need to have access to a number of key enablers and to manage a small number of services designed to bridge the gap and support the transition from institutional care such as hospital to home and community environments. These proposed discharge specific services are a small number of managed step down beds, residential reablement facilities, Extra Care step downs and short term night support in people's own home and hospital to home scheme for people who fall under statutory eligibility criteria but are socially isolated.

There were 57,206 hospital admissions in Brent last year with 41, 935 Brent residents and Brent CCG patients are admitted to hospital during the year. 90% of these are discharged directly from the ward with no other professional support (basic discharge). People that fall into the basic discharge category may require access to the low level scheme developments to further reduce readmissions but are not expected to need intense professional involvement from the discharge team.

10% of these admissions are referred to Social Care for assessment but only 5 % of these admissions require assessment and intervention from social care professionals and / or commissioned services. It is this cohort of people that we are targeting in the integrated discharge team which is predominantly older people (and largely 85 years and older) typically admitted to hospital due to a fall (usually resulting in a fracture), a CVA or TIA or UTI / confusion. The integrated scheme aims to work with people with 1 or more discharge planning requirements of simple or complex intensity via a care management / discharge coordination approach. Within our cohort and scheme we have formed 2 pathways (see below). Approximately 60 % of the target group will require simple discharge pathway, the other 40% will require more intense support from 1 and more professional in the team, although the time taken in assessment from the professionals is expected to reduce using this integrated / care coordination model.

The scheme aims to reduce the number of days people are in hospital unnecessarily by reducing the DTOC days by 8%. This aims to provide the right level of health and social care support at the right time and enable essential acute resource to be available to those who require this. In addition to targeting the complex discharges which caused delayed transfers of care, the scheme aims to reduce the Lengths of Stays by reducing the days on the pathway from 7-11 days currently to 4 days.

The scheme not only aims to improve on DTOC in Brent, it also aims to improve quality of discharges and thereby improve customer satisfaction, safety on discharge and reduce the readmission rate by 1%.

A key dependency on achieving these targets is the commitment of all organisations to the scheme and in the development of trusting assessments cross organisations and professions. The model is dependent on an integrated team under one management structure accountable to the joint integration transformation board to develop this organisational trust and promote confidence that wider targets and priorities specified by the board and incorporated in the BCF matrix are adhered to by the scheme.

The formation of the integrated discharge team will incorporate the following current positions. (the numbers are approximate requirements of working on the above model, further modelling will

be required within the next 2 months)
- 1 Team Manager
- 3 senior practitioner / team leads
- 7 social workers - 1 specialist nurse assessor
- 3 Discharge coordinators
- 4 Care Assessors - 1 housing officer
- 3 administrators / discharge assistants / liaison officers

The scheme requires a small number of discharge specific services to ensure safe outcomes for customers and a supportive pathway to community settings.

Hospital to home focused on customers falling under social care eligibility to reduce risk of readmission due to limited support on discharge. The service will use volunteers, with a home support manager maintaining an overarching managerial role to the Home Support Service Co-ordinator and trained volunteers. The focus of the service would be to provide task-orientated practical support at home (up to 4 weeks) to learn or relearn daily living skills and regain their independence.

- This service would require the following resources to include:

1 Manager - wte
2 Co-ordinators - wte
12 residential reablement beds to focus on promoting independence for customers with high needs on discharge to support a return to a community setting
1 Occupational Therapist - wte
1 Physio Therapist - wte
20 nursing step down beds for continuing health care patients not fit for rehab and other complex discharges with nursing needs
1 discharge nurse - wte
1 occupational therapist - wte
3 step down beds in Extra Care Sheltered Accommodation to support transition to community settings with expected length of stay 6-8 weeks
3 extra care flat rents
1 social worker to support move on
1Night support to bridge move from supportive environment back to own home where person is more isolated. The support would be to provide up to 3 nights support on discharge to meet social care needs, build confidence, establish routine and evaluate care needs during the night to inform on-going support package
1 social worker to support assessment immediately post discharge

- Housing incentives to enable planning for discharge to the most appropriate accommodation setting

- Blitz clean funds to ensure that people who are unable to access of fund this support independently have speedy access to support to enable a return to a safe environment in the community. In addition to these discharge specific schemes the following key enabling schemes will need to support the Effective Discharge Scheme

The enablers
Rehab and Re-ablement

The rehab and reablement scheme would be essential to the scheme which will need to have the capability to respond to the assessments and referrals from hospital discharges immediately on discharge. The rehab and reablement will need to ensure there is availability of intense short term community rehab and reablement support to ensure safe discharges and transition back to community based settings. The response required from the Rehab and Reablement team will be

setting up an appropriate package on same day referrals to enable the Effective Hospital Discharge Team to maintain the speed on discharges back to the community and to ensure that rehab is delivered to people being discharged from hospital at the right time to maximise potential.

Information Technology
IT enabling scheme will need to provide the scheme with the capability to access and share key information held in different organisation's records. There are also specific learning and development needs to enable the scheme to become operational in regards to the expanding role of professionals and understanding the legal roles and responsibility relating to organisations criteria for support and service provision.

7 day working
To enable the scheme to be most effective the team will need be operational 7 day, however in addition to the team assessing and discharging people over a 7 day period, the community resources will also need to have a facility to respond over a 7 day period.

Social Isolation
Another major key enabler is the social inclusion work stream, particularly around a service such as hospital to home for people (as described above) who live alone being discharged from hospital but who do not have eligible needs for a formal health and social care service. This will be key to ensure the scheme is able to meet the targets in relation so safe hospital discharges and prevention of readmissions.

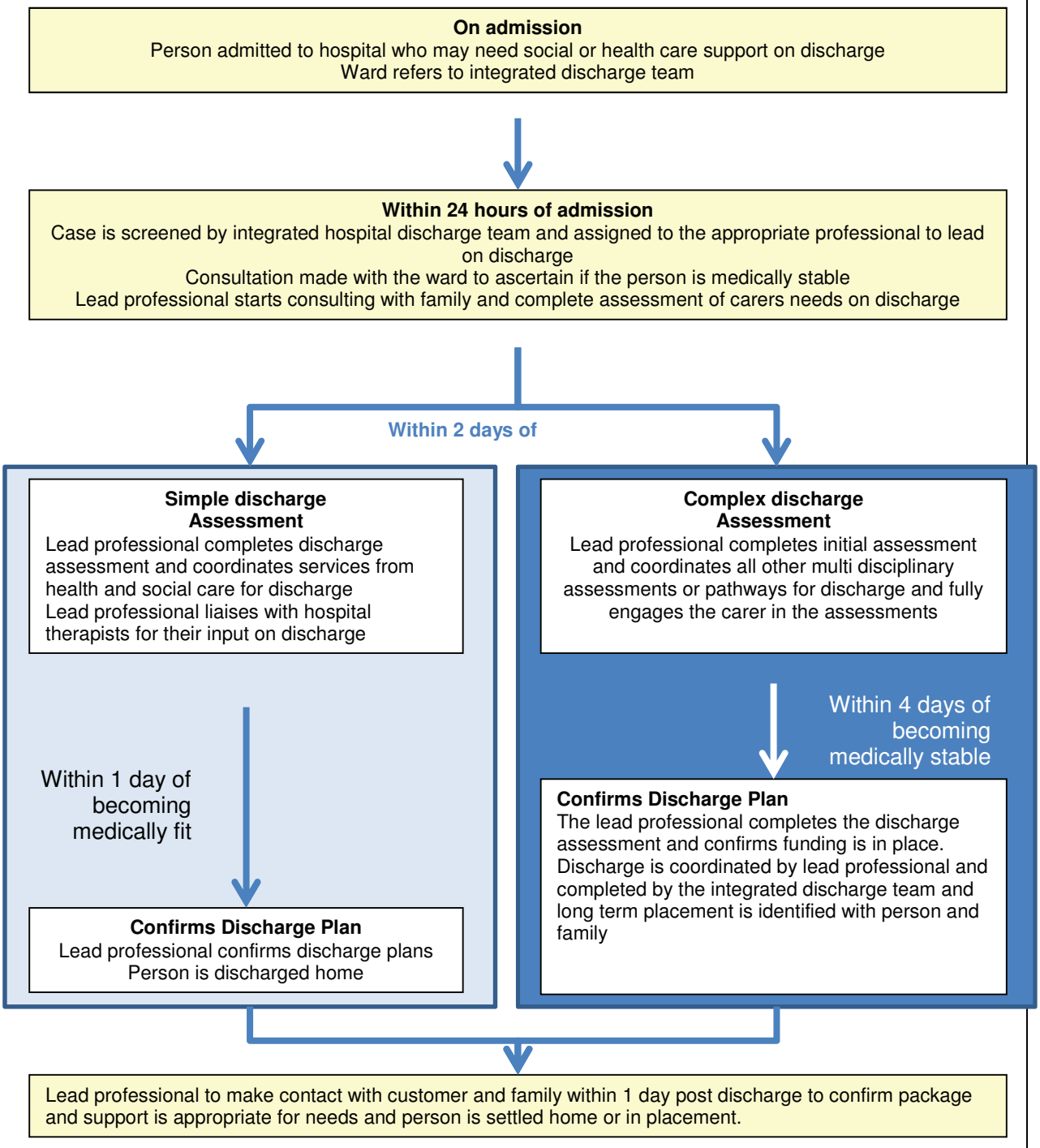
Public Engagement
Public will need to be engaged to inform the progress of the scheme and to be aware that the aim of the scheme is to ensure that people are discharged back to the community as soon as medically safe to do so. Public awareness of the expectation to 7 day discharges and a focus on providing health and social care need in the community away from an acute setting will be essential to enabling the success of the scheme to avoid customer disputes to discharges. Engagement with our target cohort is also essential in planning to ensure that the needs and requirements of this group are incorporated in the plan of the scheme.

Carers/Self care
The Effective Hospital Discharge Scheme will need to incorporate completing carers assessments and offering advice and guidance in relation to support to carers on discharge from hospital. The acknowledgement of carer's role in supporting safe discharges is required and a focus on how carers need to be supported to continue their role will enable safe discharges and continuity of service thereby reducing risks of readmissions.

Learning and Development/Work force
The professionals and workers across health and social care joining the team will need training to manage across their professional comfort zone as the expectation of the integrated team will be that they will take a key worker role and therefore take on basic tasks beyond their professional background.

On-going continual development will need to be factored in as the team evolves

Pathway for effective multi-agency hospital discharge



The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The team will require resources and skills of professionals and staff currently situated in a number of organisations across health and the local authority. These are primarily Adult Social Care, Northwest London Hospital Trust, BHH Continuing Health Care Team, Housing department.

The delivery chain will rely on the integrated approach within the team, organisational sign up and trust in cross organisational assessments. The key discharge resources outlined above and the key enabling schemes are also essential components for the delivery of this scheme. In addition to it is essential to define the hand over and interaction to other BCF schemes to ensure smooth transition through the customer's health and social care journey.

This scheme will largely focus on promoting safe discharge planning and intervention on discharge, the support and responsibility for the customer's health and care will need to then be handed over to the community network. The scheme will need to have direct access to referrals to the skills and intervention within the Keeping people safe in the community scheme and particularly case management in the community for complex discharges. The above model relies upon the success of the reducing hospital admission work scheme and has been resourced with the assumption that there will be an overall reduction on discharges with the success of this scheme.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The basis of this scheme has used data from both health and social care on hospital admissions, delayed discharges, readmissions within 90 days and health and social care services post discharge and incorporated the work completed by the local Systems Resilience Group (formerly the Urgent Care group).

The local data indicated that Brent has 57,206 hospital admissions in the last year and that professional support is only required in 5 -10 % of those discharges and that approximately 3% of the discharges are complex. The customers who are delayed transfer of care are all within the complex discharges as there are already joint agreements and services in place to provide solution for simple and basic discharges.

The evidence suggests that the readmissions rates are due to both complex and simple discharges. Therefore the multidisciplinary approach will enable more creative solutions for discharges with complex health needs. The hospital to home scheme and access to social isolation will improve safety on discharge to ensure that the person is discharged to a safe environment to reduce risk of readmission.

The Case for integrated and care coordination approach to discharge has been made in the following references - D Brand; (2003); Social and health care integration: (1) The individual dimension; Journal of Integrated Care

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan – Included in Annexe 2

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

- DTOC
- Readmissions
- Reducing residential / nursing care
- Customer satisfaction / outcomes

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- To collate the stats on the throughput of the team,
- Hospital admissions
- DTOC
- Outcomes for customers

What are the key success factors for implementation of this scheme?

- Sign up from all provider organisations and commitment to the aims of the scheme
- Trust in cross organisational assessments
- Development of a small number of resources to refer to on discharge
- Public awareness / agreement on the change of care provision and focus on community support
- Commitment to aims from other providers / referrers to the scheme
- Development and capabilities of other community based work schemes and key enablers

Mental Health Improvement

Scheme ref no.

Scheme 4

Scheme name

Mental Health Improvement

What is the strategic objective of this scheme?

This scheme improves the urgent care pathways for adults (18years and over) with a mental illness in or at risk of crisis.

This scheme includes Liaison Psychiatry Services in A&E and on the wards, and support for patients identified as suffering from dementia.

The model of care has been developed following the principles set out in 'Mental Health Crisis Care Concordat – Improving outcomes for people experiencing mental health crisis' (Department of Health and Concordat signatories, February 2014). In summary, these are:

- Access to support before crisis point
- Urgent and emergency access to crisis care
- The right quality of treatment and care when in crisis
- Recovery and staying well, and preventing future crises

In addition, model of care supports the Mandate from the Government to NHS England to delivery parity of esteem by making sure that people experiencing a mental health crisis get as responsive an emergency service as people needing urgent and emergency care for physical health conditions.

Overview of the scheme
Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?
- What are the tangible and non tangible benefits/impact of each of the key enablers on this scheme:

Vision
'To reduce the likelihood of avoidable emergency admissions to physical health wards, by empowering those people with a mental illness who are most at risk of a crisis to manage the health and social care factors in their lives that contribute most to keeping them safe'.

Objectives
In a one-year period, reduce the demand for non-elective admissions to physical care general acute beds in Brent, by a 14% (n111) reduction in the number of adults with a mental illness who present at A&E in a crisis.

To sustain this reduction, a system-wide change is needed in care-pathways and integration between the services commissioned by NHS Brent CCG, Brent Adult Social Services and Brent Public Health.

In particular, this scheme will focus on two patient cohorts:

- Reduce the number of A&E frequent attenders needing non-elective admission to physical care general acute beds due to injuries from suicidal/ para-suicidal behaviour or serious deliberate self-harming behaviour.
- Reducing emergency re-admissions within 30 days of people with dementia following discharge from physical care general acute beds.

This project will first identify the scale of the issue, both in terms of the number of patients with mental disorders frequently attending A&E, and in terms of the contributory factors of their crises. The project will then seek to review the patient pathway and to use existing or new resources to avoid admission and/or expedite patient discharge.

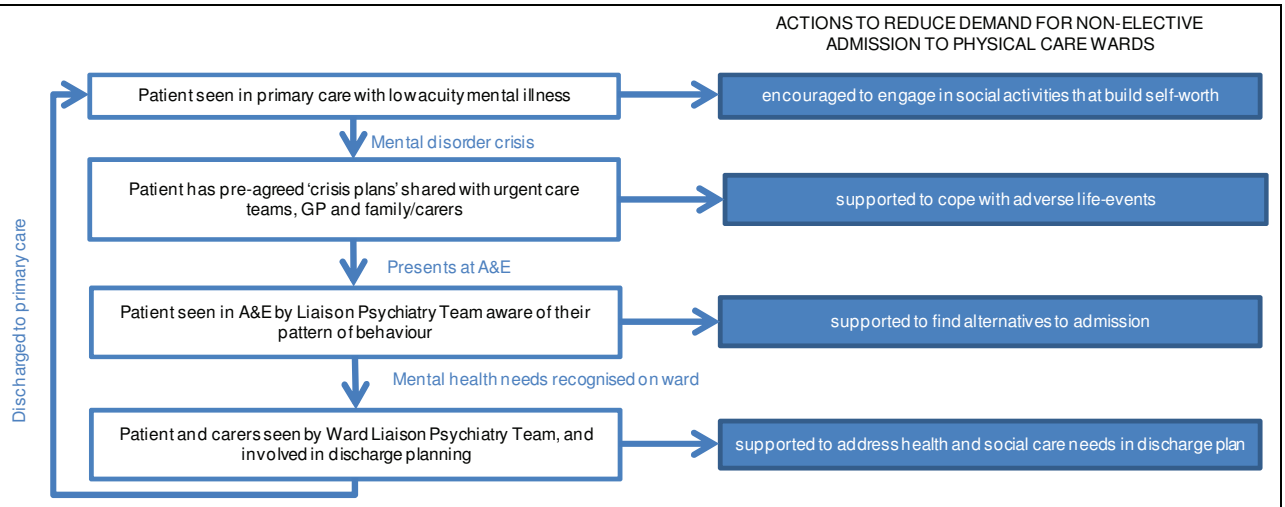
(Physical health emergency admissions for people with mental illness will be addressed within other schemes).

Key baseline data - 2013/14, four main categories of A&E presentations involving mental disorder (n780, this is likely to include frequent attenders):

Mental disorder	2013/14 A&E presentations	Reduction target	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
alcohol related mental disorder	423	*61*	12	15	16	18
dementia or delirium	165	*23*	4	6	6	7
depression and/or anxiety	157	*22*	4	6	6	6
schizophrenia	35	*5*	1	1	1	2
TOTAL	**780**	**111**	**21**	**28**	**29**	**33**

This scheme will identify the number of A&E frequent attenders with mental illness, and the number of non-elective re-admissions within 30 days for people with dementia. There is a need to explore the data and clinical practice to manage alcohol related mental disorders, and minimise admissions purely to sober up. This project will be particularly concerned with people with a mental illness and alcohol misuse problems.

Model of care



A system will be developed to identify people with mental disorders who frequently attend A&E, particularly for suicidal/ para-suicidal behaviour or serious deliberate self-harming behaviour. Health and social care teams will work with them to reduce the impact of social isolation and adverse life events.

Level of care	Provided by…
Primary care At a primary care and community level, these patients will be encouraged to engage in social activities that build self-worth and resilience, to find employment/ training, and to find and sustain suitable accommodation. Patients and their families/carers will be encouraged to anticipate and develop plans to cope with adverse life events that could trigger a crisis. Patients will be offered practical support to re-engage with relevant services where they have previously withdrawn.	This element of the model of care will be co-produced with service users and carers, and will draw on existing voluntary sector providers, befrienders, peer support, social care navigators and mental health specialists. This element represents a significant new development in integrated care.
Urgent mental health care At an urgent care-level, these patients will be supported to have pre-agreed 'crisis plans' shared with urgent care teams, GP and family/carers. Patients, GPs and family/carers will have access to 24/7 telephone advice from mental health clinicians, and a single point of access for referral. Where necessary, the patient will be supported to cope with adverse life-events that may be contributing to their crisis, including home visits where appropriate. This support may include a review of their medication and concordance, planned psychological interventions, and social support needs.	This element of the model of care will be co-designed with service users and carers, and will draw on existing mental health specialists and social care specialist staff. This element represents a significant new development in integrated care.
A&E Liaison Psychiatry At an A&E level, the A&E Liaison Psychiatry Team will	This element of the model of care will

be made aware of the patient's pattern of behaviour for frequent attenders, and will work with the patient to identify and address contributory factors leading to the crisis. For patients presenting with alcohol-related mental disorder, the A&E staff would look for alternatives to admission, including referral to community services where appropriate.	be reviewed in consultation with A&E frequent attenders, and provided by existing mental health specialists and social care specialist staff. This element represents a change to existing Liaison Psychiatry Team practice.
Ward-based Liaison Psychiatry At a physical healthcare ward level, the Ward Liaison Psychiatry Team will be made aware of the patient's pattern of behaviour. In addition, the Ward Liaison Psychiatry Team will be involved in discharge planning to minimise the risk of an emergency re-admission. In particular, the team will support people newly diagnosed with dementia, and their family/carers, to access support in the community.	This element of the model of care will be reviewed in consultation with service users, physical acute hospital staff, specialist mental health staff, people with dementia and their carers, and the Brent Dementia Action Alliance. This element represents a change to existing Liaison Psychiatry Team practice.

Rehab and Re-ablement
Home treatment teams and primary care teams will work with voluntary organisations (including faith-groups) to advise service users and carers how to access resources in their communities to help build resilience against a future crisis. Many of the community groups in Brent are interested in providing a wide range of advice and support, with the expectation that many people will prefer to seek help in non-medical mental health and wellbeing settings.

Brent offers a number of self-management and psycho-educational services for service users and carers, including low-level psychological therapies for those with anxiety and depression.

Information Technology
Telephone advice on mental health issues will be available 24/7 from mental health professionals to patients, family/carers and professionals. In addition, patients and family/carers will be made aware of other resources (in a range of media, including on-line) that may help them manage uncertainty with their accommodation, employment or social relationships.

7 day working
- 24/7 access to advice lines
- 24/7 operation of Crisis Resolution Home Treatment Teams
- 24/7 operation of A&E Liaison Psychiatry Teams
- 24/7 operation of Emergency Duty Teams
- Operation of Ward Liaison Psychiatry Teams 7 days per week
- Access to GP hubs 7 days per week
- Access to social care advice and support 7 days per week

Social Isolation
Patients in the cohort most at risk from social isolation will be identified and referred to befriending services, and support will be offered to family/carers to maintain their resilience. In addition, health and social care teams (including GPs) will share information on the level of supervision the patient receives, and coordinate when, where and how to increase or decrease this. These discussions will include options to encourage the service user and carers to re-

engage with the local community with the support of voluntary organisations.

Public Engagement

- The scheme will consider the needs of people with protected characteristic within the identified cohort.
- Voluntary organisations will be involved to engage with the diverse communities in Brent, many of whom are unknown to services until a crisis arises.
- A model of proportionate engagement will be used to inform, consult, co-design and co-produce services where appropriate.
- Carers will be recognised as a valuable resource that needs to be supported so they can help patients in crisis.

Carers/Self care

- Patients and their families/carers will be encouraged to anticipate and develop plans to cope with adverse life events that could trigger a crisis. GPs and mental health services will be encouraged to offer targeted self-care advice to patients in the cohort on how to reduce their risk of a future crisis.
- Patients and carers will be encouraged to self-refer to services that reduce social isolation, give support with accommodation and employment issues, and give psychological support.
- Patients and carers will also be encouraged to develop plans describing how they would like a crisis to be managed.

Learning and Development/Work force

- Primary care services will have access to advice on specialist mental health care, substance misuse management, accommodation, employment support and social isolation services.
- Dementia awareness training will be targeted on physical health ward staff involved in discharge planning.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Delivery of this approach will require better coordination and refocusing of existing teams: Crisis Resolution Home Treatment Teams, Older People's Home Treatment Teams, Liaison Psychiatry Services, Assertive Outreach Teams, Assessment and Brief Intervention Teams, Community Mental Health Teams, Primary Care Dementia Teams Substance Misuse Teams and Emergency Duty Teams.

Steering groups involving service users, carers will be established to co-design pathway changes. Voluntary organisations (such as Brent MIND, Mencap, Brent User Group, B3, BHeard, Age Concern) will be involved to engage with the diverse communities in Brent, many of whom are unknown to services until a crisis arises.

Mielstone	Who	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
A&E frequent attenders								
Develop business case for urgent care service re-design	CNWL, LA, CCG	Started (QIPP)	In progress	Y				
Develop business case for enhanced primary care support	CCG, GPs, CNWL, VolOrgs		Started	Y	Y			
Identify frequent A&E attenders with mental disorder	CCG		Started	Y				
Analyse contributory factors to crisis	NWL, CNWL, LA, CCG		Started	Y				
Audit alcohol misuse in A&E frequent attenders	NWL, CNWL, LA, CCG			Y				
Work with diverse communities to reduce reliance on emergency health care	CCG, LA, VolOrgs			Y	Y	Y	Y	
Develop business case for A&E Liaison Psychiatry Service re-design and funding model	NWL, CNWL, LA, CCG			Y	Y			
Establish steering group and engage frequent attenders in service re-design	NWL, CNWL, LA, CCG, carers, service users			Y	Y			
Work with GPs to ensure adequate crisis planning within 3 months of discharge from secondary mental health services (LIS)	CCG, GPs				Y	Y		
Implement revised pathways	CNWL, LA				Y	Y	Y	
Work with GPs to ensure adequate crisis planning for frequent attenders	CCG, GPs, LA, CNWL				Y	Y	Y	Y
Reduce dementia-related readmissions								
Formation of Brent Dementia Action Alliance	CCG, LA	Completed						
Primary Care Dementia Nurses in post	CCG, CNWL, GPs	Completed						
Older People's Home Treatment Team in post	CCG, CNWL	In progress	Y					
Work with GPs to ensure adequate care-planning 6 months after discharge (LIS).	CCG, GPs	In progress	Y	Y	Y	Y		
Analyse demand on Liaison Psychiatry Service and revise specification	NWL, CNWL	Started	In progress	Y	Y			
Audit non-elective re-admissions to physical care wards within 30 days for people with mental disorders	NWL, CNWL, CCG		Started	Y				
Work with GPs to ensure accurate recording of newly diagnosed patients (top 5 practices)	CNWL, CCG, GPs		Started	Y	Y	Y	Y	Y
Review dementia diagnosis pathway on physical care wards (linked to national CQUIN)	NWL, CNWL			Y				
Audit discharge plans for dementia social care support	NWL, CNWL, LA, CCG			Y		Y		Y
Work with Brent Dementia Action Alliance to develop steering group to improve links between hospital, primary care and social care	NWL, CNWL, LA, CCG, GPs, VolOrgs			Y	Y			
Audit Primary Care Dementia Nurse and HTT outcomes	CCG, GPs, CNWL					Y		

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Brent Health and Wellbeing Strategy and Joint Strategic Needs Assessment

Mental illness remains the single largest cause of morbidity within Brent affecting one quarter of all adults at some time in their lives.

Given the rise in local demand for health and social care, the NHS in Brent will only thrive if local people develop greater capacity to manage their own health and health care. We will work with our diverse resourceful communities to improve their capacity to take better care of themselves. This is vital across all aspects of health care, but is especially so for improving mental health.

We are keen to ensure that Brent commissions a comprehensive, recovery focused, mental health service, which will provide care in an integrated and coordinated manner. This will build on our commitment to expand the provision of early interventions for people with mental health problems and to improve the quality of care for individuals with serious mental illness; which includes the need to provide people recovering from illness with meaningful employment and secure housing.

Key assumptions

This scheme assumes that admissions to physical care beds for people in mental disorder crisis are related to self-inflicted physical harm (suicidal/ para-suicidal behaviour or serious deliberate self-harming behaviour). This scheme assumes that tackling the social care contributory factors

associated with suicide can reduce the non-elective demand for admissions.

Physical health emergency admissions for people with mental illness will be addressed within other schemes.

Key performance indicators to be developed
This scheme will develop measures for:

- A&E frequent attenders for suicidal/ para-suicidal behaviour or serious deliberate self-harming behaviour
- Number of people with dementia re-admitted non-electively within 30 days to physical care wards
- Number of unnecessary admissions to physical care beds prevented by the A&E Liaison Psychiatry Service (in development with NWLCSU).

Brent-wide 12 month estimates of demand

- Police estimated contacts with 584 adults in mental health-related crisis
- A&E assessments for mental illness estimated as 1,362
- CNWL mental health crisis line calls estimated as 711

Brent residents 2013/14 mental disorder related physical acute non-elective inpatient admissions (main categories, excluding those coded as tobacco-related mental disorders)

- 157 Mental and behavioural disorders due to use of alcohol: Withdrawal state
- 151 Mental and behavioural disorders due to use of alcohol: Acute intoxication
- 109 Depressive episode, unspecified
- 74 Unspecified dementia
- 64 Mental and behavioural disorders due to use of alcohol: Dependence syndrome
- 61 Delirium, unspecified
- 44 Mental and behavioural disorders due to use of alcohol: Harmful use
- 30 Vascular dementia, unspecified
- 25 Anxiety disorder, unspecified
- 22 Schizophrenia, unspecified
- 14 Panic disorder [episodic paroxysmal anxiety]
- 13 Paranoid schizophrenia
- 9 Mixed anxiety and depressive disorder

Brent Community Mental Health Profile 2012
Compared to the national average, Brent has a significantly higher level of emergency admissions for mental illness (particularly schizophrenia), and lower rates of contact with mental health services. These data support the views of community representatives (Multi-Faith Forum, July 2014; Health Partners Forum September 2014) that many people in Brent do not want to engage with traditional mental health services due to stigma in their community. This scheme needs to encourage frequent A&E attenders to engage with mental health and social care services at an earlier stage to reduce the risk of mental disorder crisis.

Treatment					
14	Directly standardised rate for emergency hospital admissions for mental health	266.29	216.93	664.19	60.45
15	Directly standardised rate for emergency hospital admissions for unipolar depressive disorders	33.96	34.22	176.83	2.78
16	Directly standardised rate for emergency hospital admissions for Alzheimer's and other related dementia	123.57	129.03	309.27	36.02
17	Directly standardised rate for emergency hospital admissions for schizophrenia, schizotypal and delusional disorders	96.94	44.09	213.75	1.63
22	Number of contacts with Community Psychiatric Nurse (CPN), rate per 1,000 population	120.45	168.53	3.21	584.44
23	Number of total contacts with mental health services, rate per 1,000 population	221.08	313.23	31.49	822.88

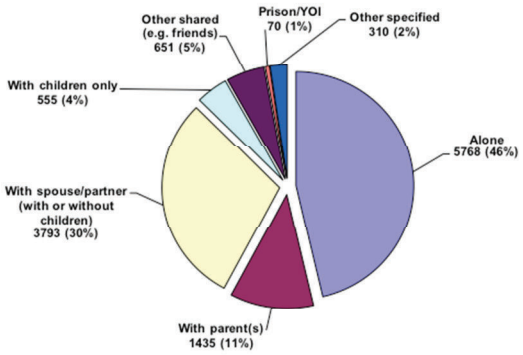
Contributory factors – national context
The scheme will tackle the underlying contributory factors that can lead adults with a mental illness to present in a crisis.

The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report July 2014 identified two key contributory factors to suicidal behaviour that are relevant to this scheme: social isolation, substance misuse, and adverse life events.

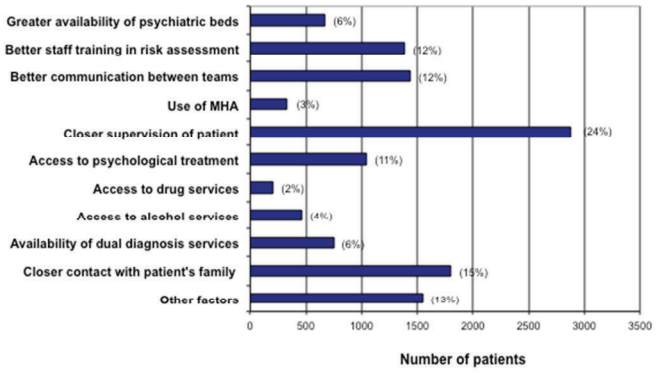
Social isolation
Suicide by patients receiving care under crisis resolution/home treatment teams (CR/HT) is now substantially more common than in in-patient care. In 2002-12 there were 1,943 patient suicides in the UK under CR/HT. CR/HT may not be suitable for patients at high risk or those who do not have adequate family or social support: services should review their criteria for its use.

Nationally, 37% of people who died by suicide (2002-12) had not seen their GP in the previous year. These 'non-attenders' were more likely to be male and younger than those who did consult their GP. In total, 4,310 were either non-adherent with medication treatment or missed their final service contact, meaning that 39% of patients were not in receipt of planned treatment before suicide.

Living circumstances: patient suicides



Mental health teams' views on preventability: patient suicides



Substance misuse
Between 2002 and 2011, the overall number of patient suicides with a history of alcohol misuse increased. The number with drug misuse did not change overall although there has been an increase since 2007.

- There were 5,999 suicides in patients with a history of alcohol misuse, 45% of the total sample, an average of 545 deaths per year.
- 4,201 had a history of drug misuse, 32% of the total sample, an average of 382 deaths per year
- 7,209 had a history of either alcohol or drug misuse or both, 54% of patient suicides, an average of 655 deaths per year.

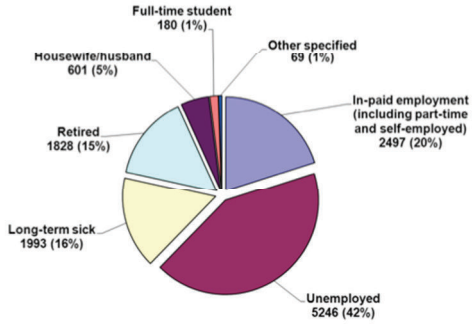
Adverse events
The first 3 months after discharge from psychiatric in-patient services remain a time of particularly high suicide risk – this is especially true in the first 1-2 weeks. Between 2002-12 there were 3,225 suicides in the UK by mental health patients in the post-discharge period, 18% of all patient suicides. Early follow up should be routine: suicide within 3 days of discharge should be considered as an NHS 'never event'. Adverse events that precede admission should have been addressed before discharge.

Adverse events would include:

- Loss of accommodation,
- Loss of employment,
- Loss of significant social relationships,
- Deterioration in physical health
- Aetiology of their mental illness.

In 2008-2011, a higher proportion of patients were unemployed (2,056, 45%) compared to the pre-recession years of 2004-2007 (1,906, 41%). 913 (7%) patients were homeless, living in bed and breakfast, or hostels, i.e. 'unstable housing'. This proportion did not change over the report period.

Employment status: patient suicides



Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

This scheme intends to reduce non-elective general and physical acute admissions.

Mental disorder	2013/14 A&E presentations	Reduction target	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
alcohol related mental disorder	423	*61*	12	15	16	18
dementia or delirium	165	*23*	4	6	6	7
depression and/or anxiety	157	*22*	4	6	6	6
schizophrenia	35	*5*	1	1	1	2
TOTAL	**780**	**111**	**21**	**28**	**29**	**33**

In addition, this scheme seeks to find culturally acceptable ways for the diverse communities in Brent to offer support to the people at risk of a mental disorder crisis. Service users and carers should feel more confident anticipating, responding and managing a future mental disorder crisis, with less risk of serious physical injury and less reliance on A&E services.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Key performance indicators to be developed

This scheme will develop measures for:

- A&E frequent attenders for suicidal/ para-suicidal behaviour or serious deliberate self-harming behaviour
- Number of people with dementia re-admitted non-electively within 30 days to physical care wards
- Number of unnecessary admissions to physical care beds prevented by the A&E Liaison Psychiatry Service (in development with NWLCSU).

Service user engagement

This scheme places greater emphasis on service users to use resources in their community to help them build resilience against a future crisis. Understanding the subjective experience of service users and carers

will be vital, particularly given the diverse communities in Brent, many of who are reluctant to engage with traditional mental health services. In addition, the services need to be responsive to people who are socially isolated. Service user views will be sought through surveys, interviews and advocacy groups.

Steering Groups
In addition to the monthly BCF monitoring group, service users and carers will be involved in steering groups to help make sense of the available evidence, and co-design the service developments.

Contract monitoring
KPIs and service user experience will be reflected in contract monitoring with service providers

Risks and mitigation
Steering groups will manage risk logs. For this scheme the key risks are:

Risk	Likelihood	Impact	Overall	Mitigation
Difficulty identifying cohort	2	4	8	GPs to check frequent attender data and mental health records
Admission avoidance hard to measure	4	4	16	Use history of frequent attenders to show change in admisson frequency
Operational team changes hard to coordinate across agencies	3	4	12	Multi-agency project team addressing operatonal team structure
Mental health financial benefits clouded by NHS mental health shadow tariff development	4	3	12	Project team to maintain dialogue with contract finance teams in the CCG and provider Trust
Changes to service may be slowed by NHS associate CCG contracting arrangements	2	5	10	Contracting team moving from CSU to lead CCG in 2014/15, allowing revisedworking arrangements
Local communities may not be accepting of people with alcohol misuse	3	3	9	Community leaders to be involved in mental health awareness, and in social care pathway development

What are the key success factors for implementation of this scheme?

- Improved coordination and pathway integration across specialist mental health services, public health, adult social care, physical acute hospitals and primary care.
- Sharing and joint interpretation of KPIs.
- Engagement of socially isolated, vulnerable service users.
- Adequate resources in local communities, and an acceptance by those communities of people with mental illness.

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

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PROVIDER

Name of Health & Wellbeing Board	NHS Brent
Name of Provider organisation	North West London Hospitals NHS Trust
Name of Provider CEO	Simon Crawford
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	17,372
	2014/15 Plan	16,920 (this figure is the plan submission to Unify and does not take into account the latest QIPP plan with the provider)
	2015/16 Plan	16,321 (this figure is the plan submission to Unify and does not take into account the latest QIPP plan with the provider)
	14/15 Change compared to 13/14 outturn	-2.6%
	15/16 Change compared to planned 14/15 outturn	-3.5%
	How many non-elective admissions is the BCF planned to prevent in 14-15?	1,449 (this is the latest QIPP plan with the provider excluding excess bed day admissions)
	How many non-elective admissions is the BCF planned to prevent in 15-16?	1,287 (this is based on the latest QIPP plan with the provider excluding excess bed day admissions)

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	Yes, NWLHT understands the methodology applied to the targeted reductions in NEL activity and understands that for 14/15 this is within the existing contract and for 15/16 this is subject to the annual contracting round discussions. NWLHT is committed to working in partnership with commissioners to develop the intermediate care and whole systems integrated care programme to support the delivery of care closer to home. This fits with the Trusts long term plan to work in partnerships with local commissioners to provide the best possible outcomes for our served population. The Trust believes that this model of care once fully implemented, will be part of the solution to a sustainable health and social care pathway in Brent
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	Yes as currently agreed in the long term financial plan. This will be discussed further for 15/16 as part of the annual contracting round

PROVIDER 2

Name of Health & Wellbeing Board	NHS Brent
Name of Provider organisation	Royal Free Hospital Trust
Name of Provider CEO	Kim Fleming
Signature (electronic or typed)	Kim Fleming

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	1937
	2014/15 Plan	1,965
	2015/16 Plan	1,896
	14/15 Change compared to 13/14 outturn	1.4%
	15/16 Change compared to planned 14/15 outturn	-3.5%
	How many non-elective admissions is the BCF planned to prevent in 14-15?	47
	How many non-elective admissions is the BCF planned to prevent in 15-16?	142

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	We are aware of Brent CCG plans and have been engaged in the Better Care Fund discussions. We are committed to working with Brent CCG both now and in the future on this plan, however we are not in a position to sign off these activity reductions as we need to understand how the individual schemes explicitly link to the reductions planned.
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	*As above*
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	As above

Signed off by off by Kim Fleming on behalf of the Royal Free Hospital NHS Trust

PROVIDER 3

Name of Health & Wellbeing Board	NHS Brent
Name of Provider organisation	Imperial College Healthcare NHS Trust
Name of Provider CEO	Bill Shields
Signature (electronic or typed)	Bill Shields

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	8,531
	2014/15 Plan	8,597
	2015/16 Plan	8,374
	14/15 Change compared to 13/14 outturn	0.8%
	15/16 Change compared to planned 14/15 outturn	-2.6%
	How many non-elective admissions is the BCF planned to prevent in 14-15?	305
	How many non-elective admissions is the BCF planned to prevent in 15-16?	53

For Provider to populate:

	Question	Response

1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	Provider has been fully involved in BCF plans and will send response multi-laterally as Provider covers a number of CCGS
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	*As above*
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	As above

Brent	**Health and Wellbeing Board** 18 November 2014 **Report from the Director of Public Health**
For discussion	Wards affected: ALL
Annual report of the Director of Public Health for Brent 2014	

1.0 Summary

1.1 The attached report considers the health of the people in Brent. It outlines the major causes of mortality and morbidity as well as describing health related behaviours in Brent. It contains a number of examples of how the Council and local people are responding to the health challenges in the borough.

1.2 The published report will be professionally designed and include the addition of photographic images.

2.0 Recommendation

2.1 The Health and Wellbeing Board is asked to receive the Annual Report of the Director of Public Health prior to publication. The Health and Wellbeing Board may wish to review its forward plan in the light of the Report.

3.0 Detail

3.1 The report considers:

The population of Brent
Health and wellbeing in Brent
Health related behaviour in Brent

3.2 The report notes the growth in the population of Brent and highlighting changes in the very young and very old age groups. The 0-4 years age group increased by thirty eight per cent between 2001 and 2011 while the 85 year and over age group is expected to grow by seventy two per cent by 2022.

3.3 The ethnic diversity of Brent's population is highlighted with examples of the opportunities for health this presents, high rates of breastfeeding, and challenges, notably high rates of tuberculosis in the Borough.

3.4 The section on health and wellbeing in Brent emphasises the association between deprivation and health, highlighting the difference in life expectancy in Brent of over five years for men and almost four years for women when comparing the least and most deprived areas.

3.5 When asked to describe their own health, people in Brent are positive with eighty one percent describing it as good or very good.

3.6 Premature mortality is defined as death before the age of 75 years. The main causes of premature mortality are cancer, cardiovascular disease (heart disease and stroke) and respiratory disease.

3.7 The report highlights the potential for Health Checks which the Council commission from GPs to prevent a range of diseases including heart disease and some forms of dementia.

3.8 Some particular health concerns for Brent are covered in the report. In particular the projected increases in the numbers of people with dementia, the high rates of sexually transmitted infection and HIV, childhood and adult obesity, diabetes and poor children's oral health. While rates of diabetes are high and projected to increase, the report notes that people with diabetes in Brent are less likely to suffer complications from the disease than people with diabetes elsewhere.

3.9 The health related behaviour section considers a number of behaviours which are detrimental to health and where too many people in Brent are making unhealthy choices, namely: tobacco use, drug and alcohol misuse, poor diet and physical inactivity. For each behaviour, an example of how the Council is working with local people to support positive choices or make negative choices less easy.

4.0 Financial Implications

None.

5.0 Legal Implications

5.1 The production and publication of the report is required under Section 31(5) and (6) of the Health and Social Care Act 2012.

6.0 Diversity implications

6.1 The influence of socio-economic and ethnic diversity on health is covered in the report.

Director
Dr Melanie Smith
Director of Public Health
Assistant Chief Executive's Office
Melanie.smith@brent.gov.uk

Annual report of the Director of Public Health for Brent

Foreword from the Leader of the Council

Brent Council is committed to helping local people protect their health and promoting wellbeing and independence.

As this report will show, working with partners and the community, the council has launched a number of initiatives which are making a real difference to the lives of many residents.

There are big challenges in Brent, not least the difference in health and life expectancy between our wealthiest and our poorest residents.

It is worth noting that Brent is healthier than you might expect given these high levels of deprivation and many people describe their health as good.

But the health of some children and young people is a concern. Oral health is poor and levels of obesity are too high. Through new projects such as The Healthy Early Years Scheme, we are working with hundreds of families with the aim of giving local children the best start in life.

Another priority is dementia, which is predicted to increase. With our partners, we have set up the Brent Dementia Action Alliance to raise awareness about the condition.

Diabetes rates are too high in the borough. But treatment here in Brent is good and together with Diabetes UK, we are informing the public how to prevent it.

Reducing tobacco use is another priority. Our Brent Stop Chewing Campaign aims to cut paan chewing among our South Asian communities.

And last year we opened green gyms in parks with the aim of raising levels of physical activity, which are lower in Brent than they should be.

With these kinds of innovative approaches, working closely with our partners and the community, I believe we can make a big difference to the health and wellbeing of Brent residents.

Signature

Photograph

Cllr Mohammed Butt

Leader of Brent Council

Contents list

List of figures

Brent's population

There are an estimated 317,264 people living in Brent. The population has grown dramatically over recent years: increasing by eighteen percent, or almost 50,000 people, between the 2001 and 2011 censuses. The growth in population in Brent has been particularly marked for young children, where the 0 – 4 years age group increased by thirty eight percent between 2001 and 2011.

The first years of life have a profound and lasting impact on later health and wellbeing. In Brent, the Council is working with early years settings and Brent parents to promote and protect the health of preschool children.

Healthy Early Years (HEY) Scheme

The HEY scheme is an accreditation and award scheme for early years settings in Brent including nurseries, child minders and children's centres. The scheme focuses on seven key health improvement areas for the under fives: healthy eating, oral health, physical activity, breastfeeding, immunisations, smoke free homes and emotional wellbeing.

In 2013/14, forty two settings achieved accreditation and five hundred parents were engaged. The scheme has been very positively evaluated through a parent survey which shows real behaviour change: for example, an increase in children registered with a dentist of almost a quarter at nurseries and children's centres and of a third at child minders.

Parent Champion Scheme

The Council has also teamed up with a national charity, the Family Childcare Trust, to recruit and train a group of Parent Champions to deliver positive messages on health and wellbeing to other parents in their communities. We have worked closely with the employment and enterprise team and the CVS to recruit people who are currently unemployed, as this experience could be a route into employment. There will be at least one parent champion working from each of our six children centre localities

Photograph of HEY activities

Brent's population is predicted to continue to increase in the future, albeit at a slower rate. The Office for National Statistics (ONS) predicts that between 2011 and 2012 the population of Brent will grow by seven percent. The increase is expected to be particularly marked for older age groups, with a predicted growth of sixteen percent in 65 to 74 years old, a similar increase in those aged 75 to 84 and a seventy two percent increase in those aged 85 and over. While population projection is not an exact science, these estimates highlight the need to promote healthy ageing in Brent.

Over 55s Physical Activity Programme

Levels of physical activity amongst those aged 55 and over are particularly low in Brent with nearly eighty percent of older people surveyed reporting that in the preceding month, there had been no days when they undertook physical activity.

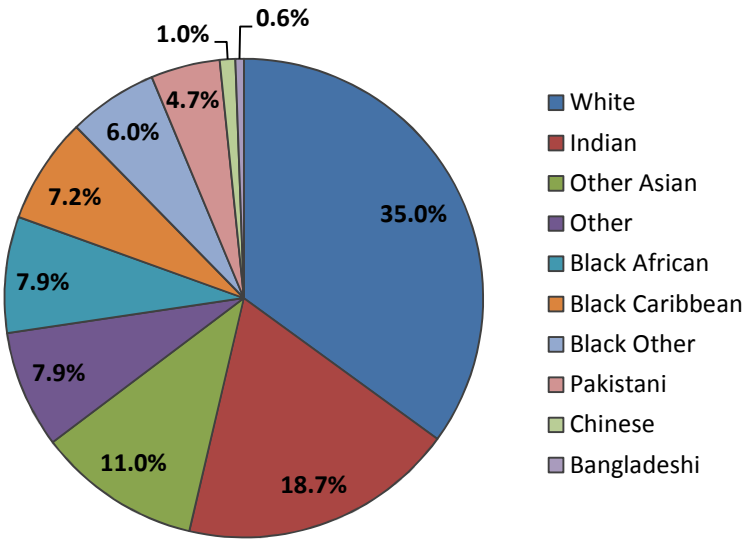
The Council has piloted a programme of physical activity in residential homes with qualified instructors leading weekly sessions of exercise appropriate to older participants. Fourteen homes and one hundred and eighty three people have already taken part. Four of the homes and their residents have already decided to continue the programme with their own funding.

Photograph of one of the exercise classes

Brent is one of the most ethnically diverse boroughs in the Country. According to the 2011 census, Black, Asian and Minority Ethnic (BAME) groups make up sixty four percent of Brent's population compared to forty two percent across London and fifteen percent nationally.

Forty six per cent of those aged 75 and over in Brent are from a BAME group (nationally this figure is four per cent). Ninety two per cent of school children in Brent are from a BAME group.

Figure 1 Brent's population by ethnic group



Source: GLA ethnic population projections 2013, based on ONS 2012 mid-year estimates

Brent has a high proportion of people born abroad including in countries with high rates of tuberculosis. This is reflected in the high rate of TB locally. Brent has the second highest rate of tuberculosis in the UK at 100 cases per 100,000 population, compared to a rate for England of 15 per 100,000. More than ninety percent of those diagnosed with TB in Brent were born abroad with twenty percent having entered the country in the last two years. This suggests the majority of disease seen in Brent was reactivation of infection acquired in high prevalence countries, in particular India.

Some cultural practices, such as breast feeding, which are common amongst Brent's communities are associated with health benefits. In Brent almost three quarters of new mothers are breastfeeding at the 6 to 8 week check compared to less than half of new mothers nationally.

Health and wellbeing in Brent

There is a strong relationship between deprivation and health. Brent is considerably more deprived than the England average. However, given the levels of deprivation in Brent, analysis by Public Health England shows that levels of mortality are better than might be expected.

Figure 2 Mortality rankings for local authorities with similar levels of deprivation

Rank		Local authority	Population	Premature deaths per 100,000
1		Brent	314,660	334
2		Greenwich	260,068	387
3		Lewisham	281,556	392
4		Walsall	270,924	399
5		Lambeth	310,200	402
6		Bradford	524,619	415
7		Wolverhampton	250,970	423
8		Leicester	331,606	431
9		Barking and Dagenham	190,560	435
10		Hartlepool	92,238	444
11		Blackburn with Darwen	147,713	450
12		Rochdale	212,020	459
13		Halton	125,692	462
14		Nottingham	308,735	466
15		Salford	237,085	493

Key	
	Best
	Better than average
	Worse than average
	Worst

Source: PHE Longer Lives

This analysis shows that for similar levels of deprivation, premature mortality between local authorities can vary by almost 150%. The relationship between deprivation and ill health is strong. But it is not immutable and it can be mitigated. Although we do not fully understand how this happens, individual and family behaviours and community resilience are both likely to play a part. Well London Chalkhill show how community resources can be mobilised to help people make healthier choices.

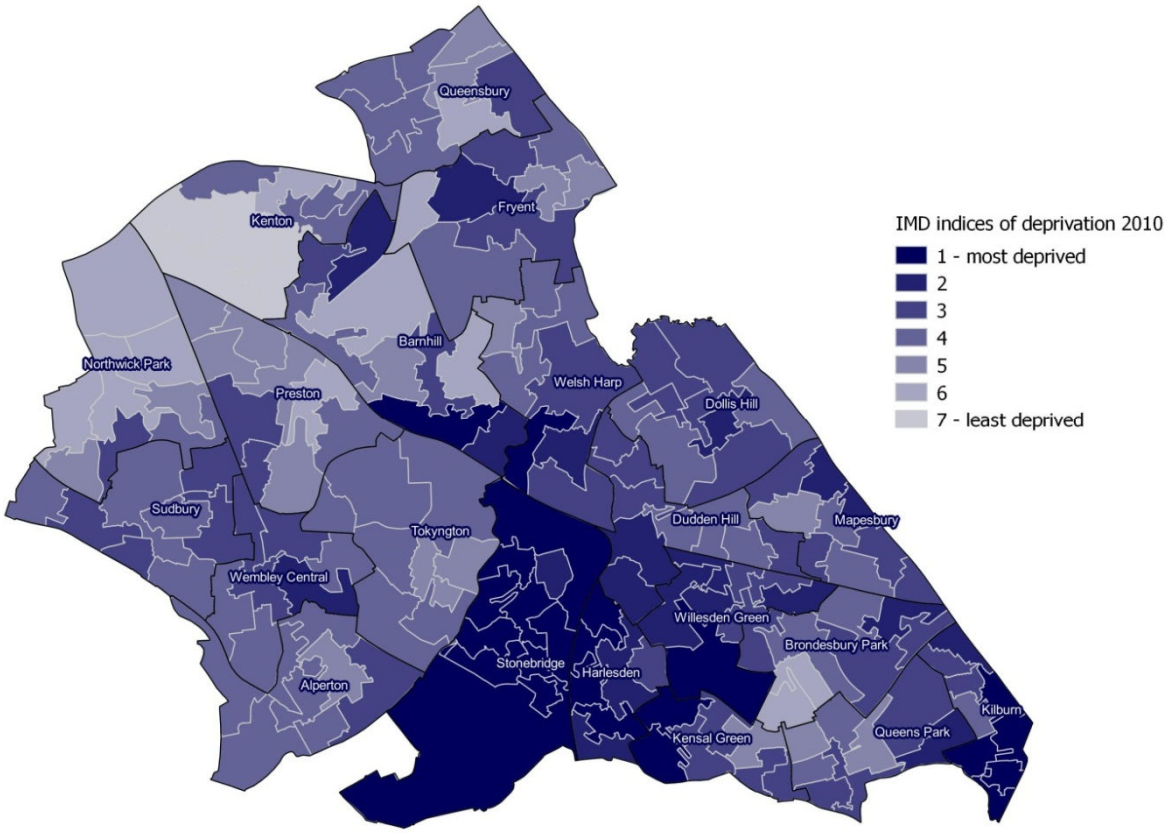
Well London Chalkhill

Funded by the Big Lottery and the GLA, the Well London Chalkhill programme has been running on the Chalkhill estate since August 2012. CVS Brent manage the programme which aims to improve the health and wellbeing of Chalkhill residents through mobilising local resident volunteers who host and promote healthy living programmes on the estate for local residents.

The programme includes cooking classes, an employment advisory service, a free internet café, a local running group, local allotments and a fruit and vegetable stall.

Within Brent there are marked variations in levels of deprivation between different parts of the Borough.

Figure 3 Levels of deprivation in Brent



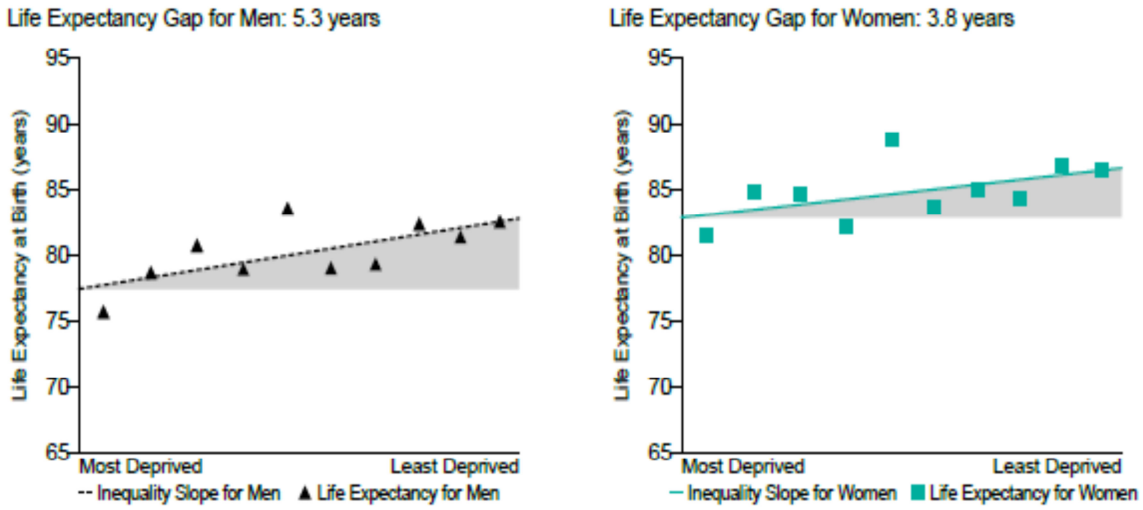
Source: Source: IMD 2010. data.gov.uk

Photographs contrasting different parts of the Borough

This pattern of deprivation is mirrored in the variation in life expectancy seen within the Borough.

Life expectancy in Brent is better than the England average at almost 80 years for men and 86 years for women. However, within the borough there is a gap in life expectancy between the most and least deprived areas of over 5 years for men and almost 4 years for women.

Figure 4 Life expectancy at different levels of deprivation in Brent: men and women

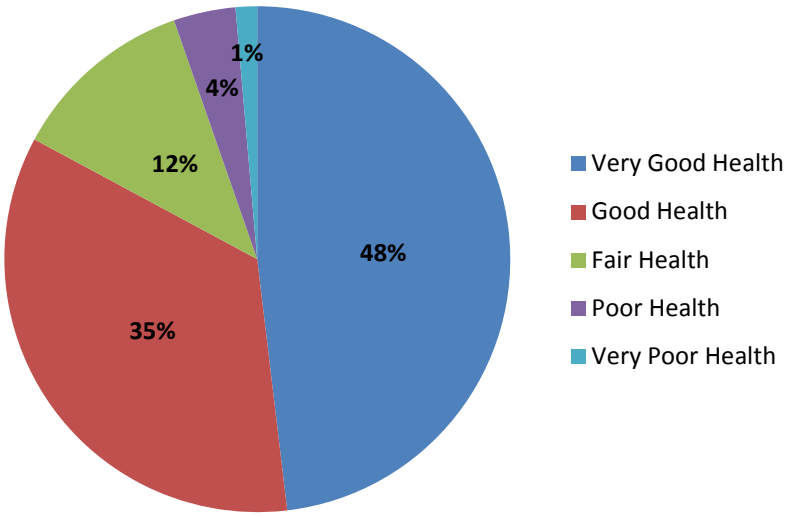


Source: PHE, Brent health profile, 2014

Life expectancy is an important measure of the health of the population but also important is healthy life expectancy, that is the length of time that someone born in Brent now could expect to live in good health. Healthy life expectancy in Brent is considerably less than life expectancy at 62 years for men and for women.

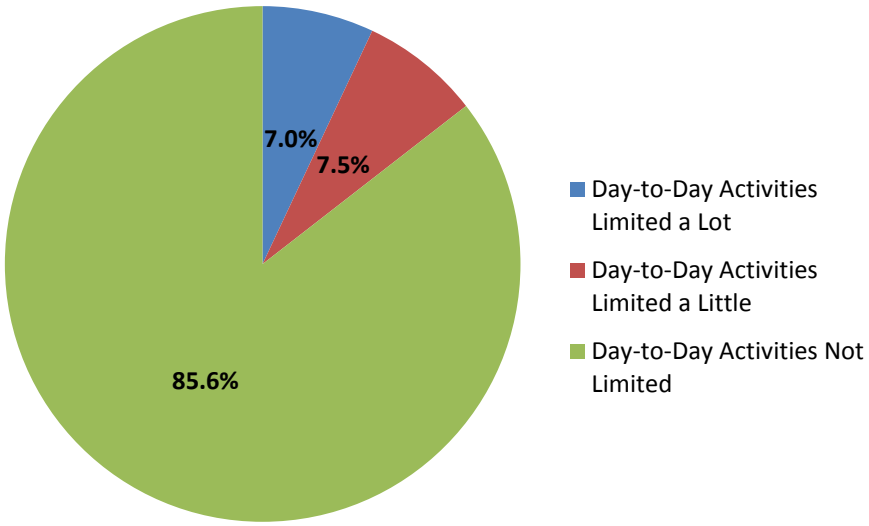
As important as any objective measure of health is the extent to which people feel healthy and the impact this has on their lives. In the 2011 Census, the vast majority of people in Brent described their health as good or very good (eighty one percent), only five percent of local people reported poor or very poor health.

Figure 5 How people describe their own health



Even those who do not view their health as good are not necessarily limited by it. Almost eighty six per cent of the population of Brent said their day-to-day activities were not limited at all in the 2011 Census. In contrast seven per cent felt their activities were limited a lot.

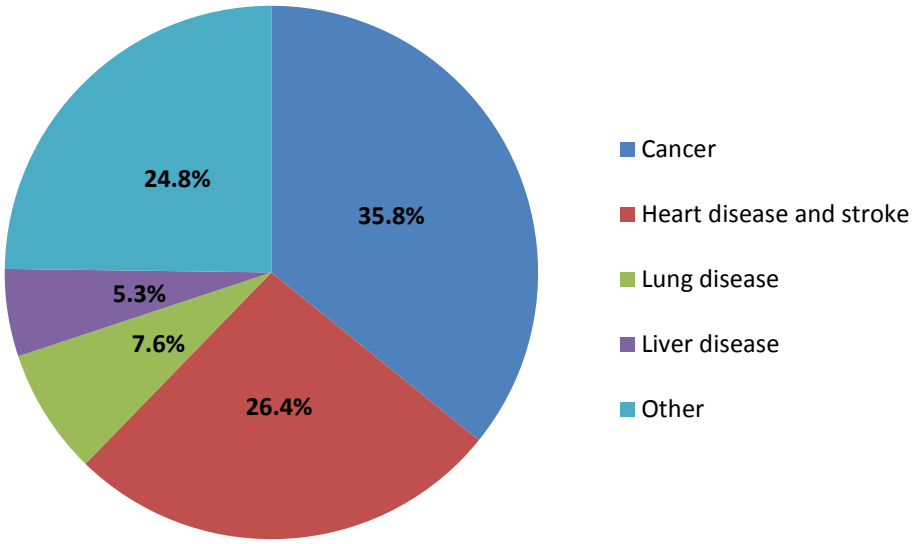
Figure 6 How people feel their health impacts on their day-to-day activities



Source: 2011 Census, ONS

Premature mortality is defined as death before the age of 75 years. Although the premature mortality rate in Brent, at 334 deaths per 100,000 population, is better than in areas with similar levels of deprivation, this still means there are on average 650 premature deaths each year in Brent. The main causes of premature deaths are cancer, cardiovascular disease (heart disease and stroke) and respiratory disease.

Figure 7 The main causes of death before 75 years in Brent



Source: ONS Mortality statistics, 2010-12

Many of these deaths are potentially preventable. The Council commissions the NHS Health Check Programme in Brent which aims to help prevent heart disease, stroke, diabetes, kidney disease and certain types of dementia.

NHS Health Checks

Local people aged between 40 and 74 years are invited every five years to attend their GP for a health check. The health check programme is a preventive programme. People who have already been identified as being at high risk of, or who already have, cardiovascular disease should be under regular review by their GP and will therefore not be invited to a health check.

A health check involves measurement of body mass index, blood pressure, pulse, cholesterol and a risk assessment for alcohol problems, diabetes and kidney disease.

The identification of cardiovascular risk is only worthwhile if that risk is reduced. For some people, their GP may prescribe medication to reduce blood pressure or cholesterol. But many people will need to change their lifestyle to reduce their risk. From April 2015, a new Council funded service will be in place, to which GPs can refer people found to be at high risk at their health check, and which will help people eat more healthily and become more active.

Infant mortality, children dying in the first year of life, in Brent is similar to the England average at almost 5 deaths per 1,000 live births. The child mortality rate measures deaths between 1 and 17 years and is worse for Brent than for England. Fortunately, the numbers of infant and child deaths in any one borough is very low. However, the Child Death Overview Panel (CDOP) reviews every death to identify any preventive actions which could be taken in future.

CDOP: Child death overview panel

The Brent CDOP brings together medical, nursing, midwifery, children's safeguarding, social work, police and public health expertise. Through a comprehensive and multidisciplinary review of child deaths, Brent CDOP aims to better understand how and why children in Brent die and use our findings to take action to prevent other deaths and improve the health and safety of our children

Co-sleeping and bed sharing is a risk factor for Sudden Infant Death Syndrome (SIDS). CDOP has provided training for health professions on these issues. It recommends that health professionals should share information with expectant mothers about safe sleeping for babies and recommends information produced by the Lullaby Trust be used to support these messages.

Surveys of Brent residents by ONS show that almost one in five Brent residents report high levels of daily anxiety and just over one in ten report low levels of happiness. These levels are similar to those seen nationally.

Levels of severe and enduring mental illness, such as schizophrenia and bipolar disorder, in Brent are higher than the England average: just over one percent of the population in Brent is living with severe and enduring mental illness.

Mental Health First Aid

Mental illness and distress is not uncommon, at least one in four of us will experience a mental health problem at some point in our life. Recognising that Brent Council front line staff will come into contact with people experiencing mental health problems, the Healthy Lifestyles team are piloting Mental Health First Aid training.

This training, developed in Australia in 2000 and now internationally recognised in twenty three countries, teaches people how to identify, understand and help a person who may be developing a mental health problem.

Staff from housing, benefits and adult social care attended the training, which they rated very positively: participants' confidence in their ability to support someone with a mental health problem markedly improved following training. An evaluation is now underway to ascertain the impact of the training and to determine if it should be rolled out more widely.

Community MARAC

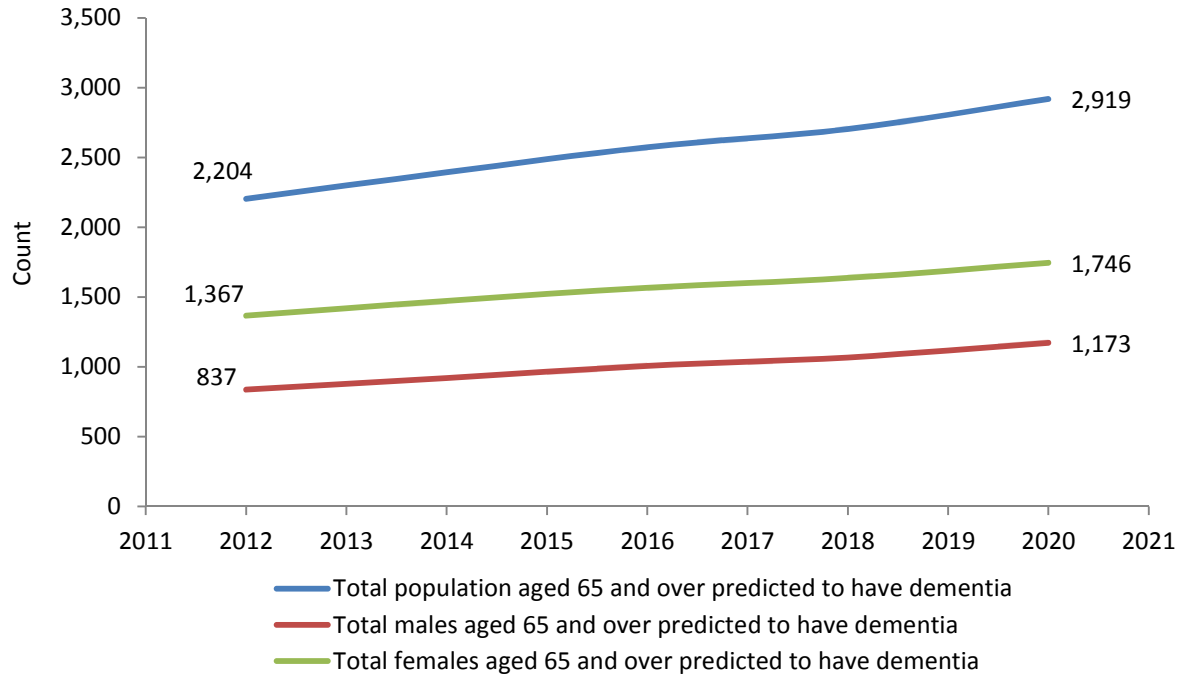
The Community Multi Agency Risk Assessment Conference brings together agencies to case manage those individuals deemed highly vulnerable, through being a victim of crime, social exclusion, disability, drug and alcohol problems or mental ill health.

The Council, the Police, Health, London Fire Brigade, the Clinical Commissioning Group and Social Landlords are all involved. The MARAC will work with people who do not met adult safeguarding thresholds and seeks to refer them into alternative service provision, for example voluntary sector, residents or community groups in order to reduce their risk and vulnerability.

Currently it is estimated that there are nearly 2,400 people aged 65 or over in Brent living with dementia. Around an additional 70 people in Brent aged less than 65 have early onset dementia. This is far less than the number of people affected by dementia, which includes the family, friends and neighbours of those with the condition.

It is projected that the number of people living with dementia in Brent will increase markedly, by thirty two per cent in those aged 65 and over.

Figure 8 Predictions for the Future Prevalence of Dementia in Brent and England



Source: Projecting Older People Population Information (POPPI)

Brent Dementia Action Alliance

Public services alone cannot meet the scale of the challenge of responding to the predicted increases in the numbers of people living with dementia nor can they deliver the improvements we want to see in the lives of people who are affected by dementia.

Prompted by a call to action by the voluntary sector, a Brent Dementia Action Alliance is forming with membership from the voluntary, community and private sectors as well as the Council, NHS, Police and Fire Service.

The challenge the Brent DAA has set itself is how can we ensure that:

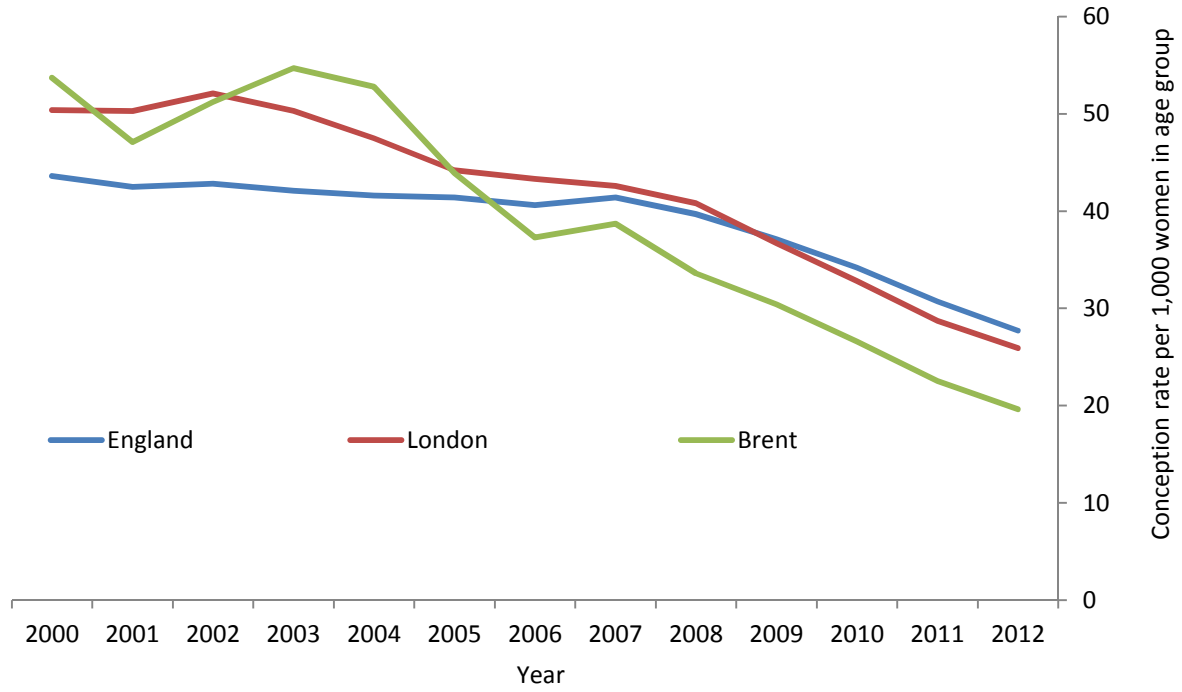
- Families are able to better support their loved ones
- Universal services support people, for example public transport responding to the needs of people with dementia through driver awareness training
- Inclusive public spaces are designed and signed to make them accessible to all
- Private companies know how to respond to the needs of people living with dementia, for example slow lanes in supermarkets

In common with most of London, Brent has high rates of sexually transmitted infections (STIs). The borough is ranked the 21st highest for diagnosed STIs. Our rates of gonorrhoea, syphilis and genital herpes are particularly high.

There are around 800 people diagnosed with HIV in Brent. Scientific advances have transformed the prognosis of HIV infection: diagnosed early and appropriately treated, HIV infection is compatible with normal lifespan. However too many people are diagnosed with HIV at a late stage of the disease when their immune system is already compromised. Currently fifty six per cent of HIV diagnoses in Brent are made at a “late stage” compared to fifty two per cent in London. Both of these figures are far too high and the promotion of earlier testing is a priority for the Council in it’s commissioning of sexual health services.

By way of contrast to STI rates and HIV late diagnosis, teenage pregnancy is a remarkable success story for Brent. Rates of teenage pregnancy have fallen below those in London and England and have more than halved since 2000.

Figure 9 Teenage pregnancy rates in Brent since 2000



Source: ONS, Conception Statistics

Family Nurse Partnership

Although rates of teenage pregnancy are falling, those teenagers who decide to proceed with their pregnancy face a higher risk of poor pregnancy outcomes, such as low birth weight; poorer mental health; and exclusion from education, training or employment.

The Family Nurse Partnership in Brent is funded by and licensed by NHS England. All teenage mothers to be are offered one to one support from a family nurse from early in their pregnancy to their child's second birthday

Childhood obesity rates in Brent are worryingly high and show no sign of improvement. Under the National Child Measurement Programme (NCMP) which the Council now commissions, all children in reception and year 6 are weighed and measured each year. The most recent figures show that over eleven percent of Brent children in reception are obese and twenty four percent of children in year 6. The proportion of children who are overweight or obese has remained disappointingly high over the past 3 years.

Figure 10 The percentage of children who are overweight and obese in Brent schools: Reception

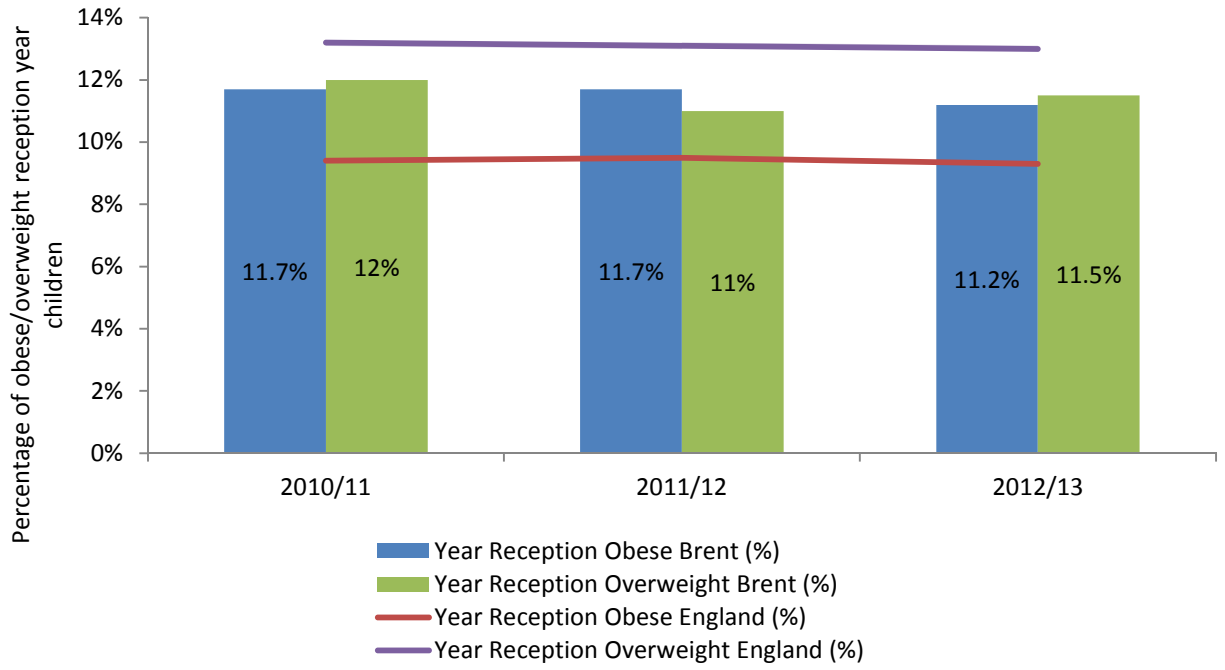
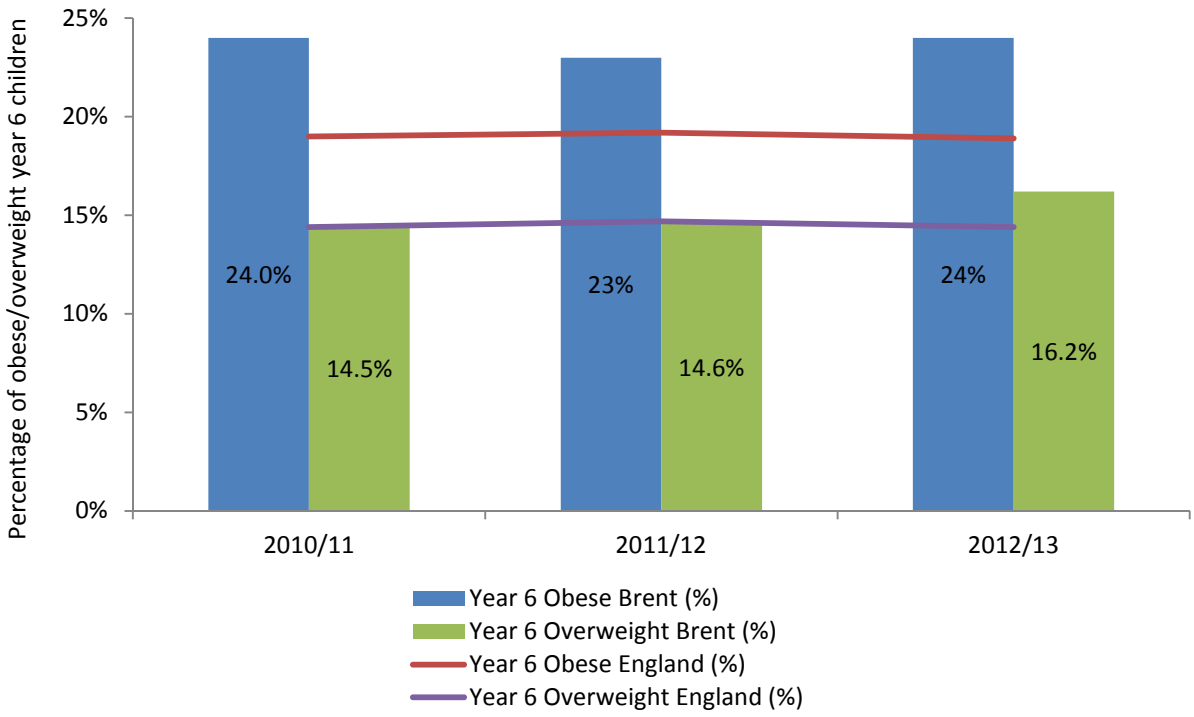


Figure 11 The percentage of children who are overweight and obese in Brent schools: Year 6



Source: NCMP, Health and Social Care Information Centre

Not only do many children start school carrying excess weight, the proportion who are overweight or obese increases during primary school years. Accordingly, healthy diet and physical exercise are a priority for many schools in the Healthy Schools Programme.

The Brent Healthy Schools Programme

The Brent Healthy Schools Programme is a voluntary scheme which schools in Brent can apply to join. In the academic year 2014/15, thirty eight schools have made applications. Of these twenty six schools have plans to promote healthy eating, cooking clubs, growing and eating clubs and the promotion of physical activity, including two outdoor gym trails for primary school children, walk to school programmes, taster sports sessions and a roller skating clubs for secondary pupils.

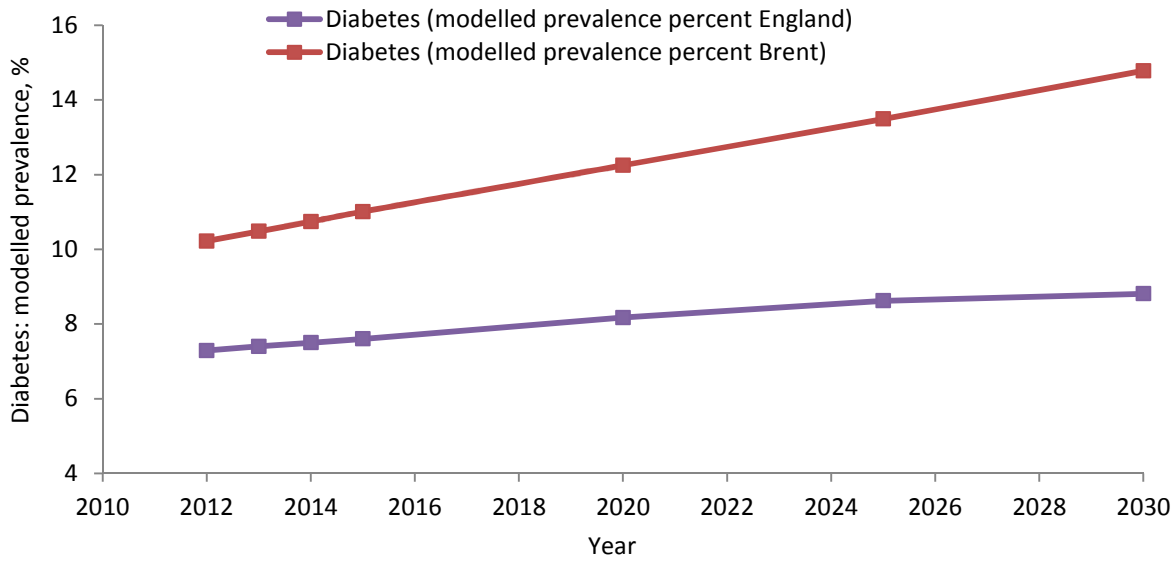
Many schools are working with their caterers to ensure the uptake of universal infant free school meals, including taster sessions for parents, and to promote healthy eating.

According to Public Health England, significantly fewer adults in Brent are overweight or obese than the average for England. However, national levels of obesity are so high that Brent can still perform well on a national league table when over half our population is overweight and an estimated one in five of our population is obese.

Rates of diabetes are high in Brent and expected to rise. Over twenty three thousand people are recorded as having a diagnosis of diabetes on GP registers. At nearly eight percent of the population this is well above the England average of six percent but, as it is estimated that one in four people with diabetes in London are undiagnosed, the true burden of disease is likely to be greater.

Reflecting the ageing of the local population, the numbers of people who are obese and overweight and the large numbers of Black and South Asian people locally (who are at greater risk of developing diabetes), the prevalence of diabetes in Brent is predicted to rise. By 2030, it is estimated that nearly fifteen percent of people aged 15 and over in Brent will have diabetes.

Figure 12 Predictions for the Future Prevalence of Diabetes in Brent and England



Source: Public Health England, Diabetes Prevalence Model for Local Authorities and CCGs

Diabetes increases the risk of a number of other conditions and complications. Early diagnosis, good diabetic care and self management can reduce these risks. While rates of diabetes in Brent are high, rates of heart disease, stroke, kidney disease and amputation are all considerably lower in people with diabetes in Brent than elsewhere in England, as are mortality rates.

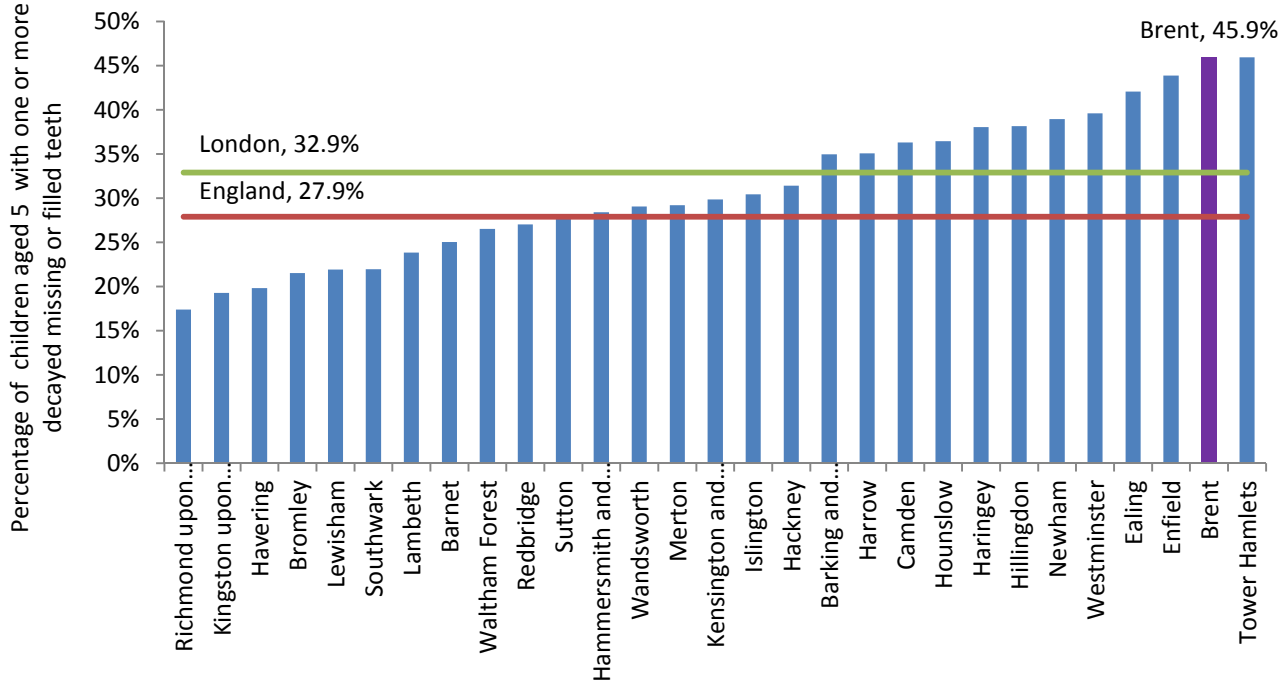
Diabetes Roadshows

The Council is developing a partnership with Diabetes UK to raise awareness of the risks of diabetes and how these can be reduced, as well as promoting early diagnosis. Diabetes UK delivered a Diabetes Roadshow as part of the Council's Week of Action in Tokynton Ward in August 2014.

Working from a customised trailer parked at Butlers Green, Diabetes UK professionals offered and undertook risk assessments to local people. These provide participants with an estimate of their risk of developing diabetes based upon factors including their age, ethnicity, BMI, waist measurement and family history.

Reflecting the high level of risk in the population in Brent, forty four per cent of people who took part were assessed as being at moderate or high risk and advised to consult their GP.

Children in Brent have very poor oral health. On starting school, forty six percent of children have at least one decayed, missing or filled tooth. Dental extraction is the commonest cause of planned hospital admission for children in Brent. Childhood tooth decay causes pain and school absence. It is associated with low self esteem and with adult ill health including oral cancer. But this is avoidable. Regular teeth brushing, healthy eating habits and regular attendance at an NHS dentist (free for children) could change this



Source: National Dental Epidemiology Programme for England, 2012

Healthy Smiles Brent

Healthy Smiles Brent is a joint initiative between the Council, Public Health England and NHS England. Ten primary schools and six dental practices in Brent are signed up.

Dentists and oral health promoters will visit local primary schools to promote oral hygiene and tooth brushing. Children will receive free packs with toothbrushes, toothpaste and brushing charts. Parents will be encouraged to join in the oral health days, meet the dental team and receive information on how to access local dentists – including the fact that dental care for children is free.

As well as health promotion, parents of children in nursery and infants will be asked to consent to their children receiving a free fluoride varnish treatment which will protect their teeth.

The project is a pilot to test the feasibility and acceptability of offering fluoride varnish in a school setting and aims to recruit a thousand children.

Health related behaviour in Brent

Tobacco Use

Smoking is the primary cause of preventable morbidity and mortality. It accounts for over one-third of respiratory deaths, over one-quarter of cancer deaths, and about one-seventh of cardiovascular disease deaths. In Brent, there are an estimated two hundred and forty one deaths related to smoking each year. Nicotine addiction is often acquired during childhood, nationally two thirds of smokers start before they are eighteen.

While rates of smoking are lower in Brent than national or regional averages at an estimated fifteen percent, there is a marked variation within the Borough from just under twelve percent of the population in the least deprived areas to almost twenty six percent in the most deprived neighbourhoods.

Cigarettes are not the only form of tobacco used in Brent. While official statistics are not available, it is evident that chewing or smokeless tobacco is widely used, particularly by the borough's South Asian communities. Furthermore, there are a growing number of shisha cafes and premises within the borough.

Unlike cigarettes, the health harm of chewing tobacco and of shisha is not necessarily widely recognised. Neither has been as extensively researched as smoking. However, smokeless tobacco use is associated with oral cancer, cardiovascular disease and dental disease, while preliminary research suggests waterpipe smoking is associated with many of the same risks as cigarette smoking.

Brent Stop Chewing Campaign

Alongside its stop smoking service, Brent Council now provides a stop chewing service for users of smokeless tobacco. Specialist advisors can provide the service across the Borough or by phone (020 8795 6669). A promotional campaign was carried out in the Wembley and Sudbury wards during the Weeks of Action, July 2014.

Working with a local oral surgeon and his team, who regularly see the effects of paan chewing, the Brent Tobacco Control Alliance is raising awareness of the health risks of chewing tobacco, particularly in South Asian communities and training healthcare professionals to conduct brief interventions with paan users.

Drugs and Alcohol

A range of illegal drugs is used in Brent and it is only possible to estimate the size and nature of the problem as, by its very nature, drug misuse is an activity which seeks to avoid attention. The most problematic drugs of misuse are generally held to

be opiates and crack cocaine and it is estimated that over one thousand eight hundred people are using opiates and / or crack cocaine in Brent. In the year ending March 2014 there were 1,367 drug users in treatment services and 367 alcohol users.

Alcohol use in Brent is polarised. The proportion of local residents who abstain from alcohol is, at thirty one per cent, almost twice as high as the national average. However, the proportion of the population who are estimated to be high risk drinkers is, at seven percent, slightly higher than the national average.

There is a strong drug and alcohol treatment and recovery sector in Brent. Nationally, Brent is ranked in the top quartile for the number of drug users that successfully completed their drug treatment. Forty percent of alcohol users in treatment services successfully completed their treatment. A cornerstone of this success is the involvement of our service users, not only in monitoring quality of services and shaping commissioning decisions but also in actually delivering services to support recovery.

Recovery champions and BSAFE

B3 is a service user led organisation which provides services to Brent Council to support recovery from substance misuse

Their Recovery Champions course runs for 2 days a week over 5 weeks for those who are completing their recovery and aftercare programmes. The course covers a range of opportunities for Champions to improve their skills and knowledge, such as peer support, service monitoring, volunteering and advocacy. Graduates act as peer mentors, undertake mystery shopping, participate in the DAAT and deliver the BSAFE weekend service.

In 2013/14, forty eight Recovery Champions graduated from the course. Public Health England have identified the programme as an example of good practice in not only sustaining individual recovery but encouraging others to lead drug and alcohol free lives.

BSAFE provides social support to service users and their families in Brent at weekends and is entirely run by ex service users

Eating well

While the nuances of what constitutes a healthy diet are debated in the popular and scientific literature, the benefits of five portions of fruit and vegetables a day are uncontested. Unfortunately, Public Health England estimate that only thirty seven per cent of people in Brent are achieving their 5-a-day.

Eating well depends upon knowledge, skills and opportunities. Set against this are the increasing opportunities to eat badly. These include the apparent saturation of our high streets with food takeaways.

Brent Students and Takeaway Food

To inform the Council's planning policies, the Council public health team undertook a survey of secondary school students to explore associations between the presence of fast food takeaways close to the school and students' use of takeaways and general food knowledge.

In the seven schools that participated, all year 7 and year 10 students were surveyed. Nearly two and a half thousand students responded resulting in a unique insight into student behaviour.

Students who attended schools less than 400m from a takeaway ate more takeaways at lunch, on the journey home from school and at home for their evening meal with their family.

The survey supports the policy of a buffer zone around schools which the Council is now implementing.

Physical activity

Too few people in Brent are sufficiently physically active to protect their health. Average levels of physical activity in Brent are considerably less than for England or for London.

It is recommended that adults should undertake muscle strengthening activities and at least two and a half hours of moderate intensity aerobic activity each week. Meeting these recommendations reduces the risk of heart disease, stroke and type 2 diabetes by up to 50%. However, over half the adult population of Brent undertake less than thirty minutes of moderate intensity activity each week.

Regular physical activity is also associated with improved mood and a reduction in the risk of dementia and depression.

Green gyms

In the summer of 2013, six outdoor gyms were installed in parks in Brent to encourage, facilitate and promote physical activity among residents. The gyms are located in Chalk Hill, Gibbons Recreational Ground, Roe Green Park, King Edward VII Park, Gladstone Park and Tiverton Park.

Eight hundred and seventy eight outdoor gym users took part in an evaluation of the gyms which showed very positive results. Forty one percent of users had increased their activity levels; twenty six percent of those using the green gyms had previously been active less than three times a month, and of those over eighty two percent are now active weekly;

Photograph of the Leader using the green gym

Map showing the location of the green gyms

Appendix 1

E09000005

Health Summary for Brent

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average

Regional average^ | England Average | England Worst | England Best | 25th Percentile | 75th Percentile | England Range

Domain		Indicator	Local No Per Year	Local value	Eng value	Eng worst	Eng best
Our communities	1	Deprivation	87,689	27.9	20.4	83.8	0.0
	2	Children in poverty (under 16s)	17,900	28.1	20.6	43.6	6.4
	3	Statutory homelessness	3,249	33.2	2.4	33.2	0.0
	4	GCSE achieved (5A*-C inc. Eng & Maths)	1,823	62.9	60.8	38.1	81.9
	5	Violent crime (violence offences)	4,993	16.0	10.6	27.1	3.3
	6	Long term unemployment	2,765	12.8	9.9	32.6	1.3
Children's and young people's health	7	Smoking status at time of delivery	220	4.3	12.7	30.8	2.3
	8	Breastfeeding initiation	4,322	84.8	73.9	40.8	94.7
	9	Obese children (Year 6)	716	23.7	18.9	27.3	10.1
	10	Alcohol-specific hospital stays (under 18)	12	17.5	44.9	126.7	11.9
	11	Under 18 conceptions	104	19.6	27.7	52.0	8.8
Adults' health and lifestyle	12	Smoking prevalence	n/a	15.2	19.5	30.1	8.4
	13	Percentage of physically active adults	n/a	52.3	56.0	43.8	68.5
	14	Obese adults	n/a	19.5	23.0	35.2	11.2
	15	Excess weight in adults	387	54.3	63.8	75.9	45.9
Disease and poor health	16	Incidence of malignant melanoma	13	4.7	14.8	31.8	3.6
	17	Hospital stays for self-harm	162	50.4	188.0	596.0	50.4
	18	Hospital stays for alcohol related harm	1,352	518	637	1,121	365
	19	Drug misuse	1,858	8.7	8.6	26.3	0.8
	20	Recorded diabetes	23,030	7.8	6.0	8.7	3.5
	21	Incidence of TB	102	98.3	15.1	112.3	0.0
	22	Acute sexually transmitted infections	4,413	1,413	804	3,210	162
	23	Hip fractures in people aged 65 and over	130	403	568	828	403
Life expectancy and causes of death	24	Excess winter deaths (three year)	70	14.4	16.5	32.1	-3.0
	25	Life expectancy at birth (Male)	n/a	79.9	79.2	74.0	82.9
	26	Life expectancy at birth (Female)	n/a	84.5	83.0	79.5	86.6
	27	Infant mortality	25	4.7	4.1	7.5	0.7
	28	Smoking related deaths	241	228	292	480	172
	29	Suicide rate	19	6.8	8.5		
	30	Under 75 mortality rate: cardiovascular	172	94.0	81.1	144.7	37.4
	31	Under 75 mortality rate: cancer	233	127	146	213	106
	32	Killed and seriously injured on roads	81	25.8	40.5	116.3	11.3

Indicator Notes

1 % people in this area living in 20% most deprived areas in England, 2010 2 % children (under 16) in families receiving means-tested benefits & low income, 2011 3 Crude rate per 1,000 households, 2012/13 4 % key stage 4, 2012/13 5 Recorded violence against the person crimes, crude rate per 1,000 population, 2012/13 6 Crude rate per 1,000 population aged 16-64, 2013 7 % of women who smoke at time of delivery, 2012/13 8 % of all mothers who breastfeed their babies in the first 48hrs after delivery, 2012/13 9 % school children in Year 6 (age 10-11), 2012/13 10 Persons under 18 admitted to hospital due to alcohol-specific conditions, crude rate per 100,000 population, 2010/11 to 2012/13 (pooled) 11 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2012 12 % adults aged 18 and over, 2012 13 % adults achieving at least 150 mins physical activity per week, 2012 14 % adults classified as obese, Active People Survey 2012 15 % adults classified as overweight or obese, Active People Survey 2012 16 Directly age standardised rate per 100,000 population, aged under 75, 2009-2011 17 Directly age sex standardised rate per 100,000 population, 2012/13 18 The number of admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause, directly age standardised rate per 100,000 population, 2012/13 19 Estimated users of opiate and/or crack cocaine aged 15-64, crude rate per 1,000 population, 2010/11 20 % people on GP registers with a recorded diagnosis of diabetes 2012/13 21 Crude rate per 100,000 population, 2010-2012 22 Crude rate per 100,000 population, 2012 (chlamydia screening coverage may influence rate) 23 Directly age and sex standardised rate of emergency admissions, per 100,000 population aged 65 and over, 2012/13 24 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.09-31.07.12 25 At birth, 2010-2012 26 At birth, 2010-2012 27 Rate per 1,000 live births, 2010-2012 28 Directly age standardised rate per 100,000 population aged 35 and over, 2010-2012 29 Directly age standardised mortality rate from suicide and injury of undetermined intent per 100,000 population, 2010-2012 30 Directly age standardised rate per 100,000 population aged under 75, 2010-2012 31 Directly age standardised rate per 100,000 population aged under 75, 2010-2012 32 Rate per 100,000 population, 2010-2012 ^ "Regional" refers to the former government regions.

More information is available at www.healthprofiles.info Please send any enquiries to healthprofiles@phe.gov.uk

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Brent	**Health and Wellbeing Board** 18 November 2014 **Report from Director of Public Health**
For approval	

Joint Strategic Needs Assessment (JSNA) highlight report 2014

1.0 Summary

1.1 This refresh of Brent's JSNA provides a detailed analysis of the existing and projected health needs of the local population with the overall aim being to provide the intelligence to inform action to improve outcomes for Brent communities and residents.

1.2 The refreshed JSNA highlight report has been divided into four overarching sections, which are:

1. *Our people and place*
2. *The burden of ill health*
3. *Children and young people*
4. *Key health challenges in Brent*

Each section contains further information on a particular theme which explores how a range of underlying factors can influence the health and well-being of Brent's communities and residents and the associated health outcomes.

The refresh of the JSNA has been overseen by a Steering Group with membership from all Council Departments and the CCG.

2.0 Recommendation

2.1 Health and Wellbeing Board to review and approve the JSNA prior to publication and dissemination.

3.0 Detail

3.1 The JSNA highlight report provides an analysis of the current Brent evidence base and identifies some of the key issues which lead to a range of health inequalities currently seen in Brent. These include issues such as premature mortality and borough wide disparities concerning life expectancy. Analysis of

the evidence base has provided an indication of some of the key health and social care concerns which are predicted to become increasingly prevalent in the future. These include dementia and loneliness.

3.2 A range of data sources have been used to inform the analysis contained within the JSNA. These include the Public Health Outcomes Framework developed by Public Health England, Public Health England's health report for Brent, and the ONS 2011 census. Comparisons are drawn with health indicators at both a national and regional level to ascertain whether Brent is performing better or worse than elsewhere.

3.3 This JSNA has a much wider scope than the previous version, in particular the wider determinants of health are now included, for example housing and employment

4.0 Financial Implications

N/A

5.0 Legal Implications

N/A

6.0 Diversity Implications

6.1 The report contains information on the age structure of the population in Brent, and changes predicted in this; on disability in Brent; on race; on religion; pregnancy and describes difference in female and male life expectancy.

7.0 Background papers

Background papers available on request.

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Brent Joint Strategic Needs Assessment (JSNA), 2014 Highlight summary report

Introduction

Reducing the high levels of health inequality which exist throughout Brent and improving the health and prosperity of those individuals and communities who experience high levels of social exclusion and disadvantage requires a collaborative approach between the council and its key partners. This refresh of Brent's JSNA provides an analysis of the current and future health needs of the local population. The overall aim of this refresh is to provide the intelligence to inform action to improve outcomes for Brent's communities and residents.

The refreshed Brent JSNA 2014/15 has been divided up into four sections, which are as follows:

1. ***Our people and place***
2. ***The burden of ill health***
3. ***Children and young people***
4. ***Key health challenges in Brent***

A series of information sheets have been produced to accompany this highlight report. These contain more detailed information on a particular theme and explore how a range of underlying factors can influence the health and well-being of Brent's communities and residents and the associated health outcomes. The information sheets are as follows:

1) **People and Place**
2) **Children's health**
3) **Housing**
4) **Diet, physical activity and obesity**
5) **Economy**
6) **Educational attainment**
7) **Female Genital Mutilation**
8) **Green spaces**
9) **Life expectancy and mortality**
10) **Older people**
11) **Smoking**
12) **Substance misuse**
13) **Sexual health**
14) **Transportation**
15) **Primary care**
16) **Secondary care**

As the population profile of Brent's communities can change quite dramatically over time, forecasting future rates of certain long term conditions is particularly challenging. To ensure that estimates of conditions including dementia and diabetes are accurate in such a diverse setting as Brent, a strong understanding of our communities is required both now and in the future.

A range of other supporting documents and data sources have been used to inform and shape the content of this JSNA. These documents are listed at the end of this report and provide an enhanced understanding of the different communities in Brent, the equality and diversity characteristics of the residents who live there, and the varying needs around which local service delivery is tailored.

1. OUR PEOPLE AND PLACE

Overview of LB Brent and its population characteristics

Brent is an outer London borough in north west London (figure 1). It has a population of 317,264 and is the most densely populated outer London borough, with a population density of 74.1 persons/ha. The population is young, with 35.1% aged between 20 and 39. Brent is ethnically diverse, with 65.0% of its population from black, Asian and minority ethnic (BAME) backgrounds. Life expectancy for females born between 2010 and 2012 is 84.5 years, higher than male life expectancy of 79.9 years. Conversely, healthy life expectancy for females born between 2009 and 2011 is 62.2 years, lower than the male healthy life expectancy of 64.2 years.

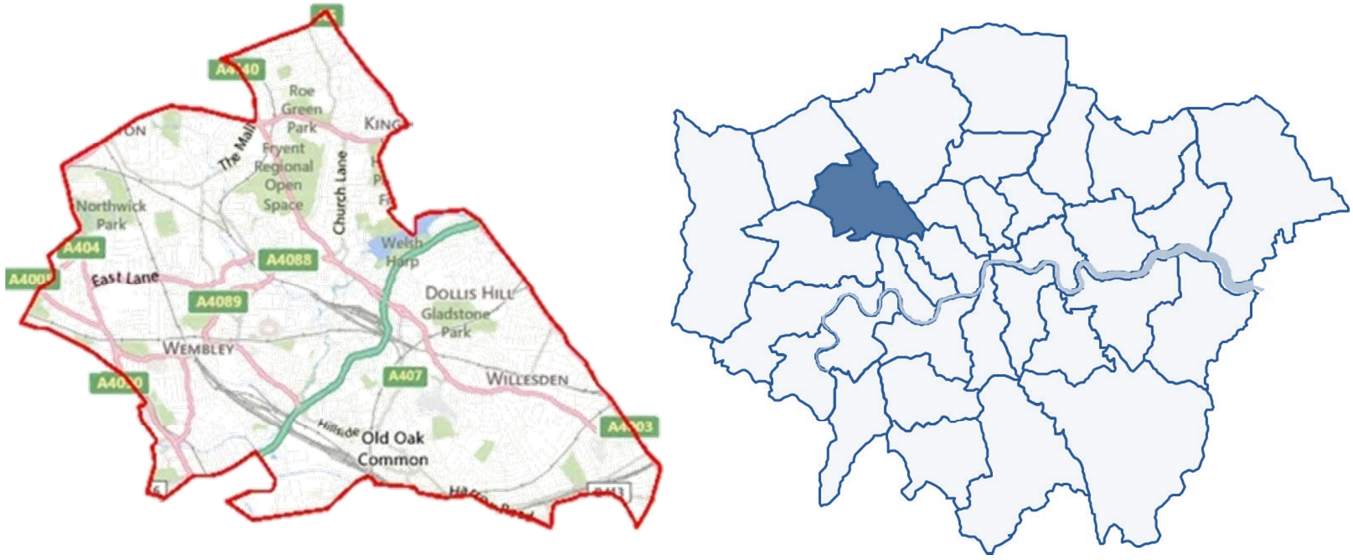


Figure 1: Brent in London and Brent map.

Brent: summary of key statistics	
Total resident population (2013)	**317,264**
Households in the borough(2013)	**114,319**
Average house price (June 2014)	**£382,076**
Percentage of people living in social rented housing	**24.1%**
Residents from black, Asian and minority ethnic groups (2013)	**65.0%**
Foreign born residents within the local population (2011)	**55.1%**
Main language is not English (2011)	**37.2%**
All Live births (2013)	**5,170**
Number of deaths (2013)	**1,633**
Gross weekly pay (2014)	**£538**
Job Seekers Allowance (JSA) claimants (2014)	**3.2%**
Unemployed 16-64 year olds(model based 2014)	**9.4%**
% of children in poverty (2014)	**28.8%**
Number of children aged 0-19 years (2013)	**79,789**

Population

The total population of Brent is 317,264, with 35.1% of residents (111,483) aged between 20 and 39, giving the borough a young overall age structure as illustrated in figure 2, which is similar to the age profile for London.

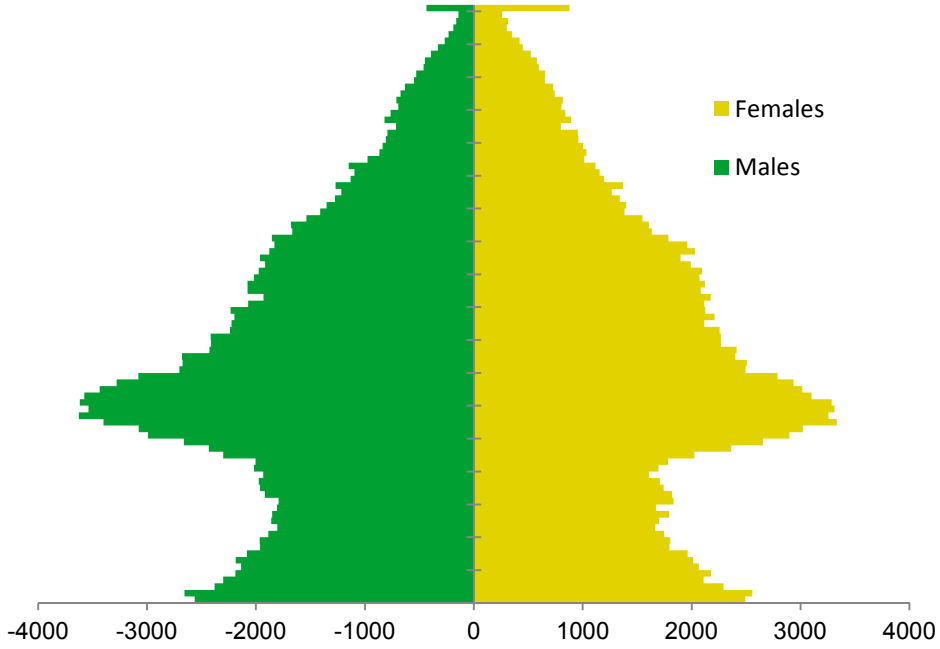
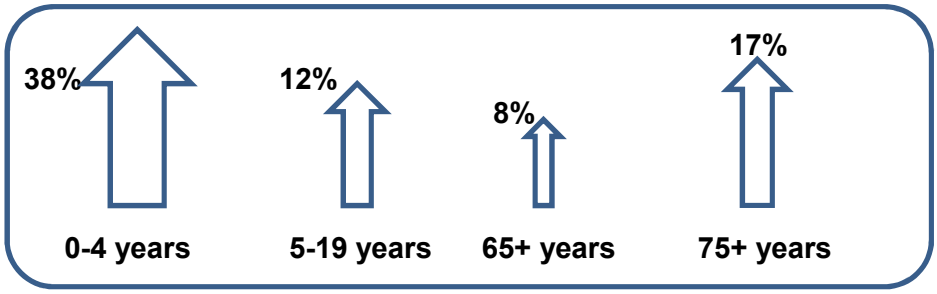


Figure 2: Brent's population by age and gender, 2013.
Source: ONS mid-year estimates 2013

Percentage changes between 2001 and 2011 for some of the key age groups in Brent



The CCG is responsible for its registered population. This is 353,372 and is the number of people registered with a Brent CCG GP practice. A patient does not necessarily have to live in Brent to be registered with a Brent GP.

Ethnicity

In Brent, the black, Asian and minority ethnic (BAME) groups make up 65.0% of the population, compared to 41.8% in London. This has increased since 2011, where BAME groups made up 63.7% of the population. About one third (36.0%) of the population are Asian; 35.0% white and 21.1% black1 (figure 3).

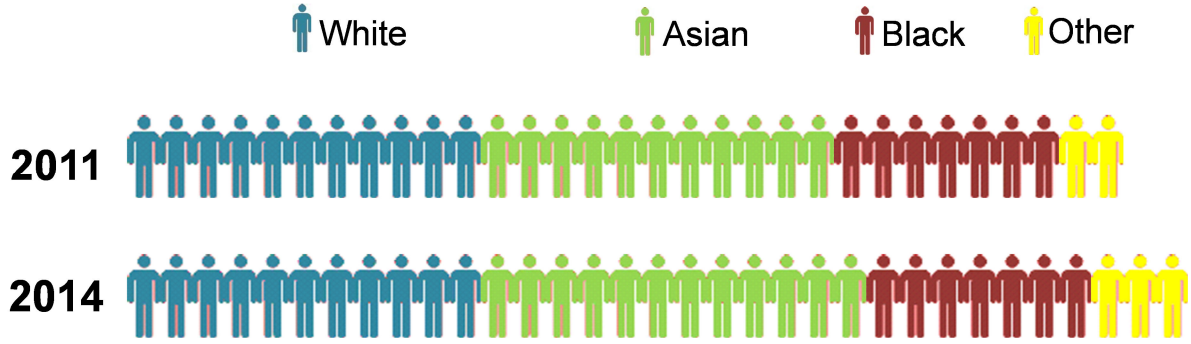


Figure 3: Population change in Brent 2011-2014
Source: 2011 Census, ONS mid-year estimates 2013

There is no information published at ward level about ethnicity after the 2011 Census. In 2011, at ward level:

- the largest white populations were in Mapesbury, Brondesbury Park, Queens Park and Kilburn wards (figure 4.a)
- the Asian population is largest in Alperton, Wembley Central and Kenton (figure 4.b)
- Stonebridge, Harlesden and Kensal Green wards have the highest black population (figure 4.c)

[1] GLA ethnicity trend based borough projections 2012

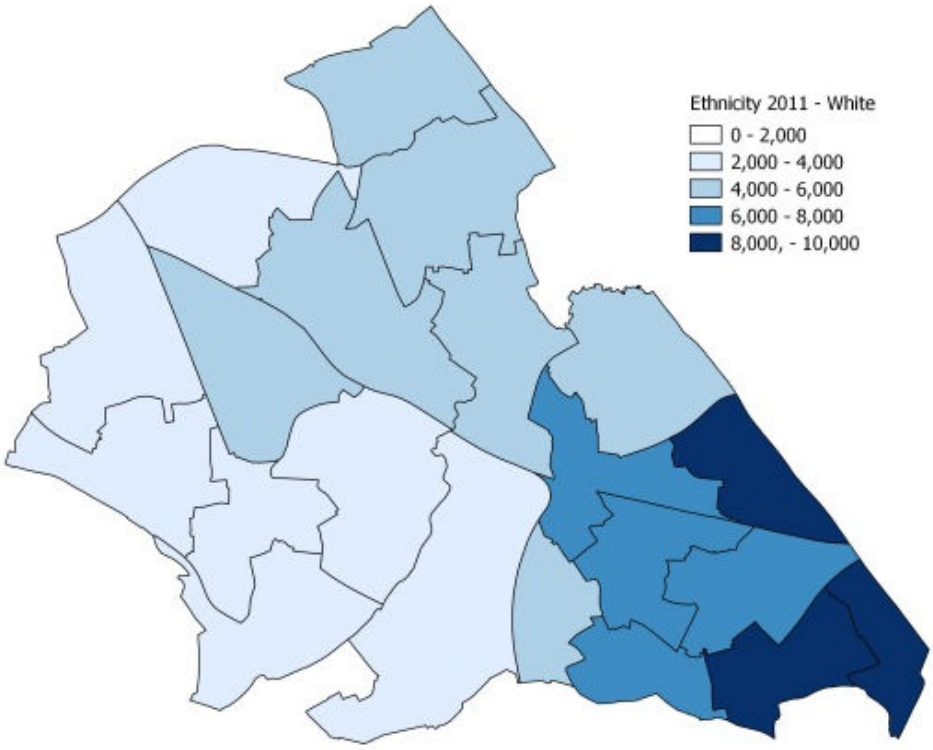


Figure 4.a

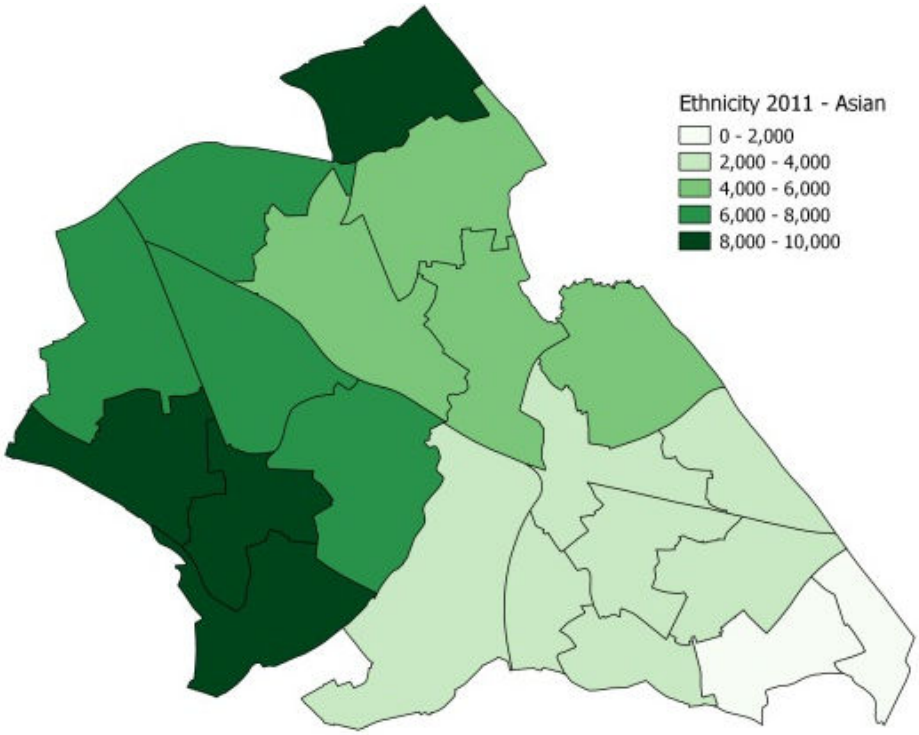


Figure 4.b

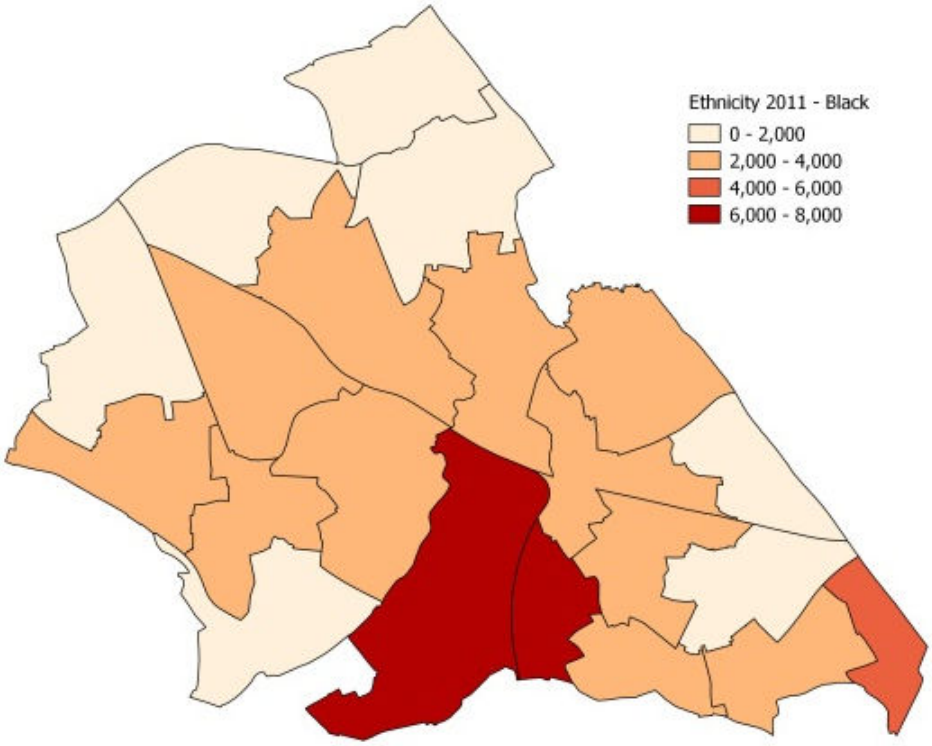


Figure 4.c

Figure 4 (a-c): Ethnic Groups by ward
Source: 2011 Census

The proportion of people belonging to the different ethnic groups in Brent varies with age. Figure 5 illustrates that among younger people (particularly 5-15 years olds); the white population is lower and black population higher than for the borough as a whole.

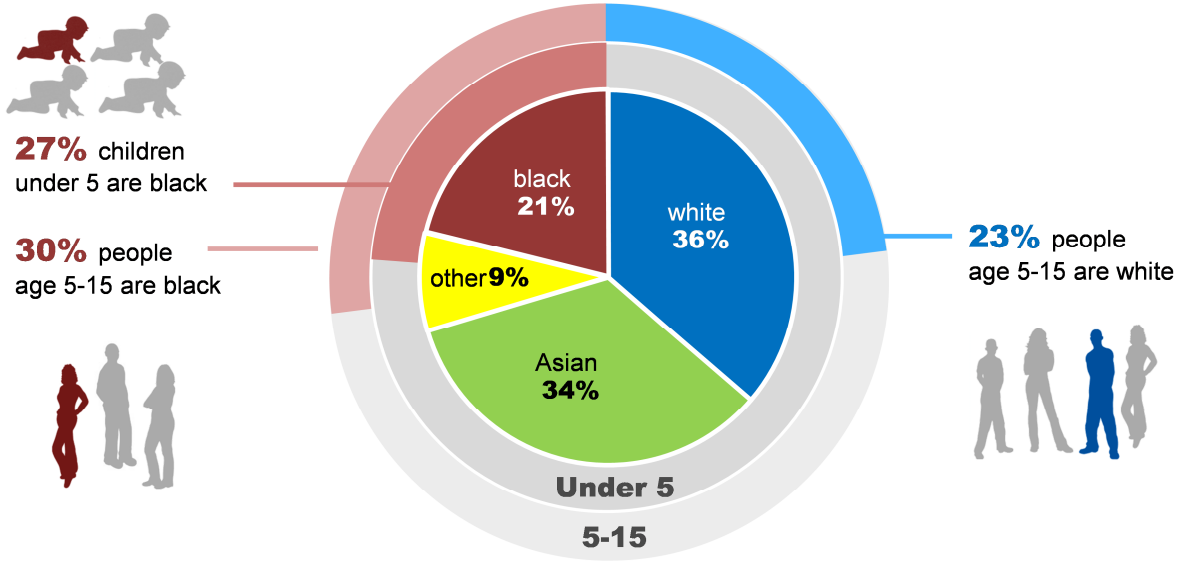


Figure 5: Ethnic Groups by age
Source: 2011 Census

Country of birth

Figure 6 shows the diverse range of countries where Brent residents were born, identifying the number of people born in a particular country.

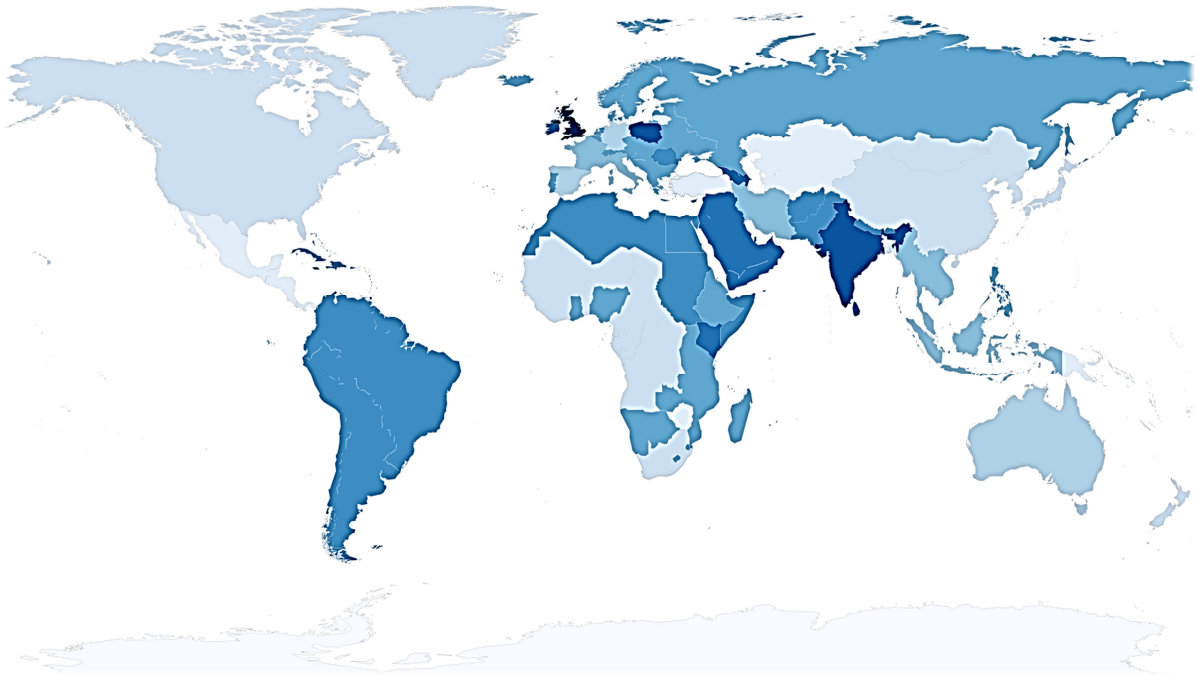


Figure 6: Country of Birth. Source: 2011 Census

Language

There are many different languages spoken in Brent. English is the main language for 62.8% or the population (figure 7). Gujarati is the main language for 7.9% of the population and Polish is the main language for 3.4% of the population.

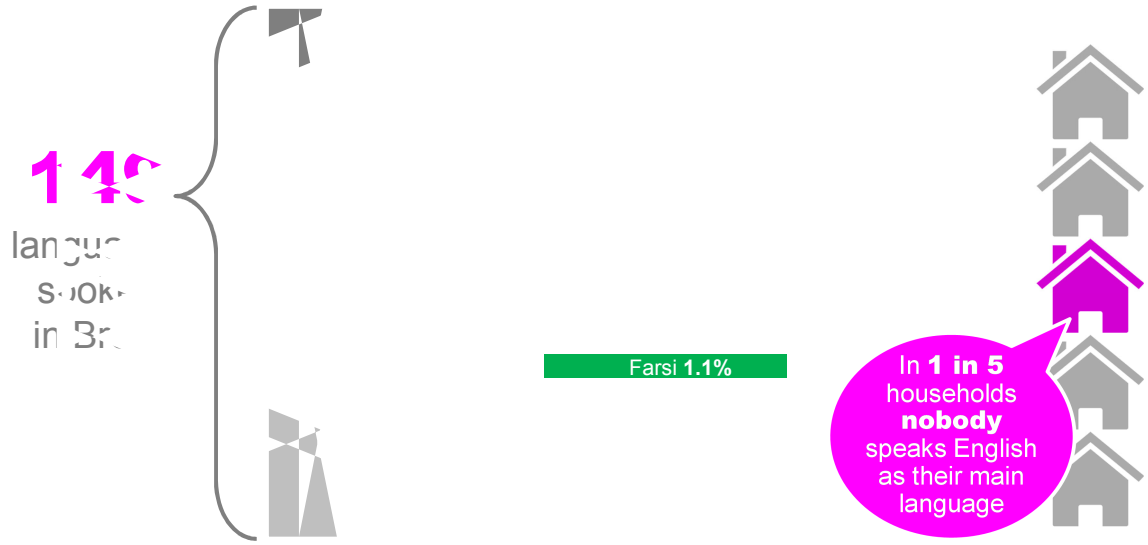


Figure 7: Languages spoken in Brent
Source: 2011 Census

Religion

Most people in Brent have a religion, 10.6% of the population said they did not have a religion. Christianity is the most popular religion in Brent, 41.5% or the population are Christian, 18.6% Muslim and 17.8% Hindu.

Since the 2001 census, Christianity has declined by around 7%, while Islam has increased by around 9%, nearly doubling since 2001 and becoming the second most popular religion in Brent (figure 8).

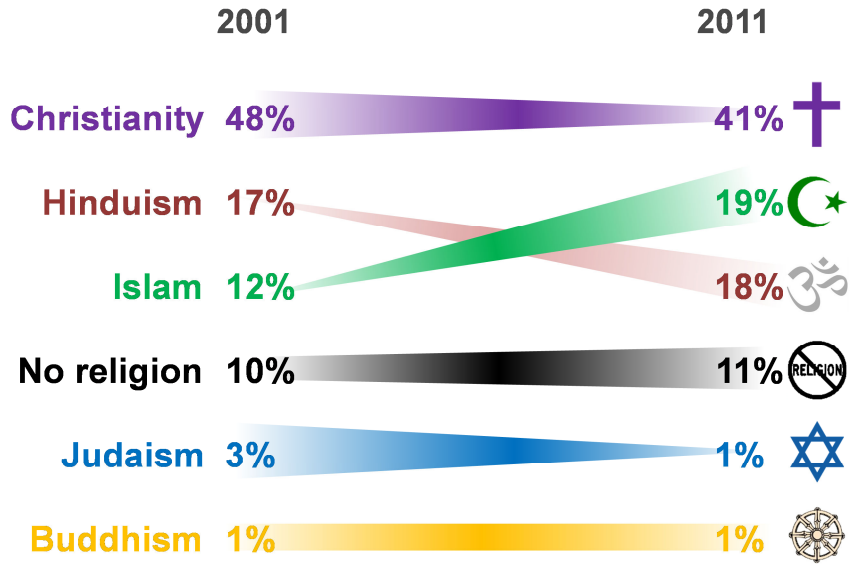


Figure 8: Change in Religions in Brent since 2001
Source: 2001 Census, 2011 Census

Lifestyle

Eating well

The benefits of healthy eating, and in particular of eating 5 portions of fruit and vegetables a day, are widely recognised and include a reduced risk of heart disease, stroke and cancer. Public Health England estimates that only 37% of the Brent population were achieving 5 a day during the period 2006/08[2].

Physical activity

Regular physical activity confers a range of health and well-being benefits. Levels of physical activity in Brent have been below the London and England averages since 2005/06[3]. Over half the adult population in Brent (52.8%) take part in no moderate intensity sport or physical activity for at least 30 minutes duration a week[4]. This compares to the London average of 44.5% and the England average of 44.4%.

Access to indoor sports facilities

Brent offers three public sports centres: Willesden Sports Centre, Vale Farm Sports Centre and Bridge Park Community Leisure Centre. Willesden and Vale Farm's facilities include the only two public swimming pools in the Borough. In 2013/14 there were just over 1.4 million visits[5] to these three centres, a number which is increasing annually. There are a small number of small private gym facilities in the Borough and some schools make their sports facilities available for the local community to hire.

Access to parks and open spaces

Brent has the lowest proportion of green space of all outer London boroughs. As cited by the Marmot Review, green spaces and green infrastructure improve mental and physical health and have been shown to reduce health inequalities. To help improve the mental and physical health of residents, the council faces a key challenge in making what space it does have as welcoming and accessible to all borough residents as possible. Between March 2012 and February 2013, only 8.8% of people in Brent aged 16 and over utilised outdoor space for either exercise or health reasons. This is lower than both the London (10.5%) and England (15.3%) averages[6].

Brent's 74 parks, ranging in size from Fryent County Park (115ha) to numerous small pocket parks throughout the borough, are used for many different activities. Outdoor gyms were installed in 6 parks in July 2013. These are free to use and have led to an increase in the physical activity levels of many users. Free guided health walks are another popular activity, with 119 people taking part in guided health walks in March 2014. Similarly, Park Run, a free-to-attend 5km run held every Saturday morning in Gladstone Park attracts around 100 weekly participants. Brent's parks and open space provide access to various other sporting facilities, including multi-use game areas, tennis courts, and football, rugby and cricket pitches. Brent's parks and open spaces also contain 23 allotment sites.

[2] Health Survey for England, 2006-2008
[3] Sport England, Active People's Survey (2005/06 to 2012/13)
[4] Sport England, Active People Survey, results from APS 7 (2012/13)
[5] Figure derived from LB Brent Sports and Parks service
[6] Natural England, 2012/13: Monitor of Engagement with the Natural Environment (MENE) survey. Respondents to the survey were asked to indicate how many visits they had taken to the natural environment in the last 7 days.

Wider determinants of health

As public health is influenced by many factors other than the healthcare received, opportunities exist to integrate public health priorities into some of the key wider determinants of health such as education, housing and transport. The model of health determinants (figure 9) illustrates the key roles local government could have in these particular areas.

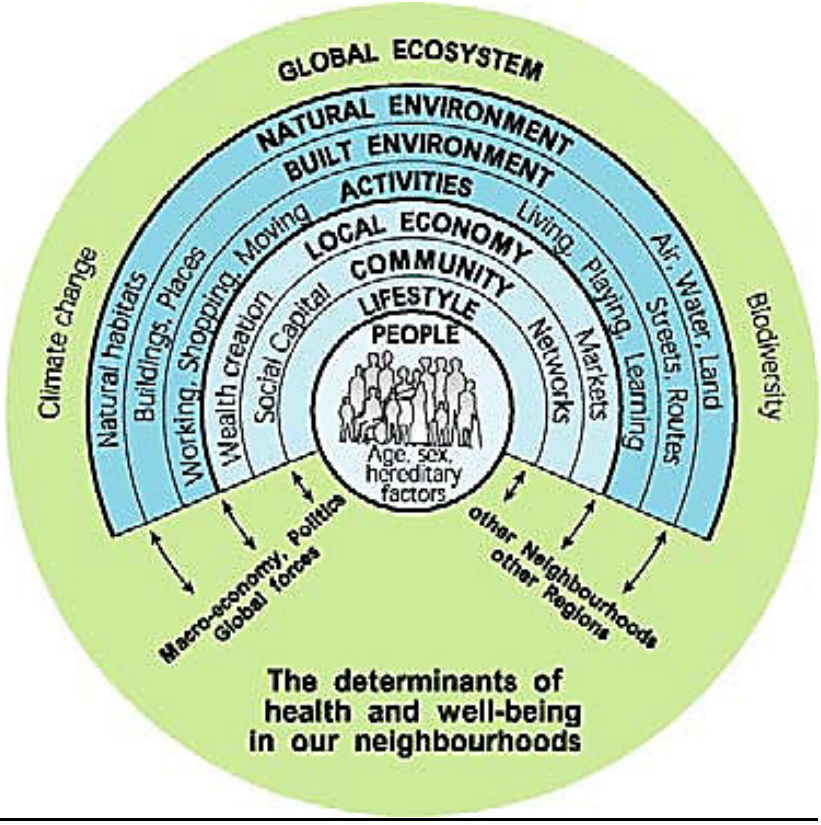


Figure 9: Health map of the wider determinants of health. Developed by Barton and Grant (2006) (based on Dahlgren and Whitehead, 1991))

Housing tenure

The total number of dwellings in Brent has increased by 8,016 (or 8%) since 2001. Of the 110,286 households in Brent in 2011, just under half of these (48%) were houses or bungalows (figure 10). Just over half (51%) were flats. Nearly 1% of Brent's accommodation was caravans or temporary structures. Other key points to note include:

- Social rented housing in Brent has increased from 23,881 in 2001 to 26,591 in 2011, a change of 11.4%; although as a proportion of the overall stock it has remained static. This trend is similar to London where the total number of dwellings increased by 9.9% between 2001 and 2011;

- Owner occupation now accounts for 44% of the borough's households. In 2001, owner occupation made up 56% of the borough's households; private rented makes up 32% of the households (compared to 18% in 2001);

- The mean household size went up from 2.6 in 2001 to 2.8 in 2011.

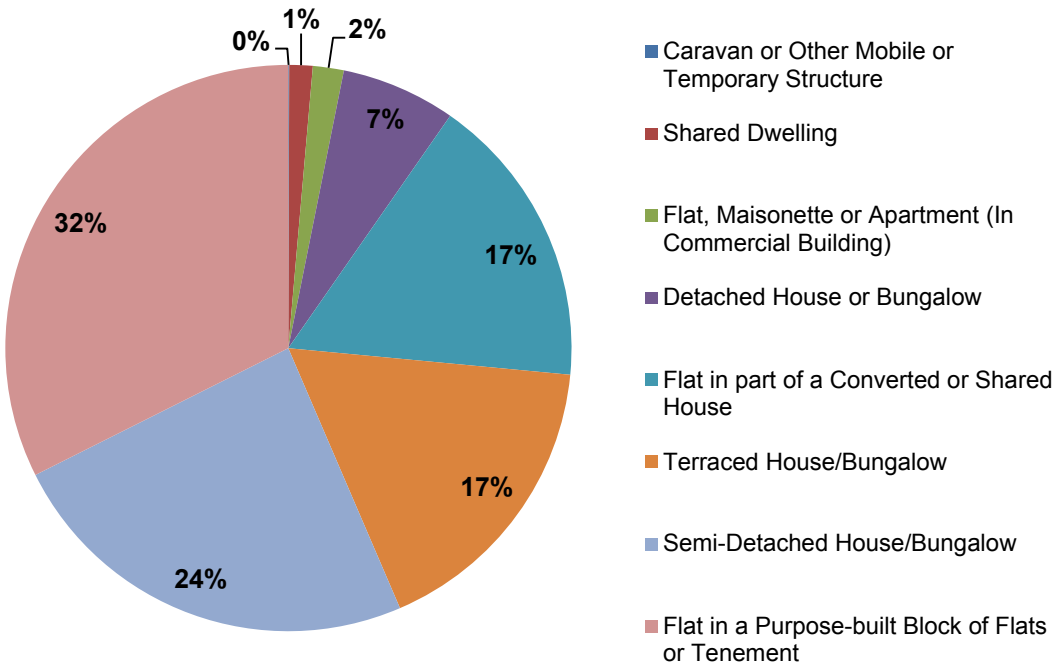


Figure 10: The main types of accommodation in Brent, Source: ONS 2011 census

Housing pressures in Brent

Since 2001, the population in Brent has expanded faster than predicted, causing a rise in the demand for affordable housing. Coupled with an increased demand for larger family-sized homes, there is a range of pressures to meet these needs.

Rising rents and house prices are some of the biggest challenges which residents in Brent are faced with. Approximately 30% of employees living in the borough are paid less than the London living wage. Finding affordable housing is therefore a particular challenge for many families[7]. These pressures have led to Brent (18%) having the second highest rate of overcrowding in London after Newham (25%). Overcrowded housing stock and a general lack of space and land available for housing development present a number of related concerns. Rates of respiratory disease and tuberculosis tend to be higher in overcrowded houses[8]. For children and young people, other issues include:

- Under achievement in school or college due to a lack of space to do homework;
- Anxiety, depression and stress[9].

Levels of statutory homelessness in 2012/13 are worse in Brent than the England average[10]. Factors such as our focus on regeneration, which prioritised households moving within large demolition and rebuilding schemes, and loss of stock due to right to buy schemes, are factors which have led to a large number of households residing in temporary

[7] New Policy Institute. London's Poverty Profile 2013, webpage: http://npi.org.uk/files/3313/8150/0123/Final_full_report.pdf
[8] Better Housing, briefing 20: Tackling the prevalence of Tuberculosis amongst poorly housed minority ethnic communities in London: www.better-housing.org.uk
[9] Shelter, 2005, Full house: how overcrowded housing affects families report
[10] Public Health England, Brent health profile 2014

accommodation. Additionally, a large proportion of private rented sector properties in Brent are seen as 'non decent[11].

Fuel poor households and excess winter mortality

The government considers households to be in 'fuel poverty' if they have to spend more than 10% of their household income on fuel to keep their home in a satisfactory condition. Poor quality housing stock (i.e. where houses lack energy efficiency measures or suitable insulation) coupled with high levels of deprivation and poverty can contribute to increased rates of excess winter mortalities (EWM).

The EWM index which the ONS uses to calculate the number of EWM against average non-winter deaths shows that there were around 22% more deaths in December to March 2011/12 than in non-winter months in Brent, a difference which is similar to what was seen nationally during that period. Nationally, the majority of these deaths were among individuals aged 75 and over of both sexes, with females aged 85 and over having the greatest number of EWM. Figure 11 shows the main causes of EWM by age in England and Wales in 2011/12. Respiratory disease accounts for the greatest proportion of EWM for all age groups, followed by circulatory disease. In Brent, older people who live in the most deprived parts of the borough and suffer from respiratory problems are likely to be most at risk of EWM.

Approaches to reduce EWM include increasing the uptake of flu vaccinations among older people. In 2012/13, 72.7% of eligible adults aged 65 and over in Brent received the flu vaccine. The England average was 73.4% and London average was 71.2%. In Brent, 57.1% of individuals aged between 6 months and 65 years old who were considered at risk of contracting the flu received the flu vaccine in 2012/13. This compares to 51.3% in England and 50.9% in London[12].

[11] The Poverty Site's definition of non decent homes: *'Non-decent' homes as those which do not meet the government's standard for 'decent homes' whereby housing should: be above a statutory minimum standard (i.e. be fit for habitation); provide a reasonable degree of thermal comfort; be in a reasonable state of repair; and provide reasonably modern facilities and services* http://www.poverty.org.uk/78/index.shtml#def

[12] Public Health England, Public Health Outcomes Framework

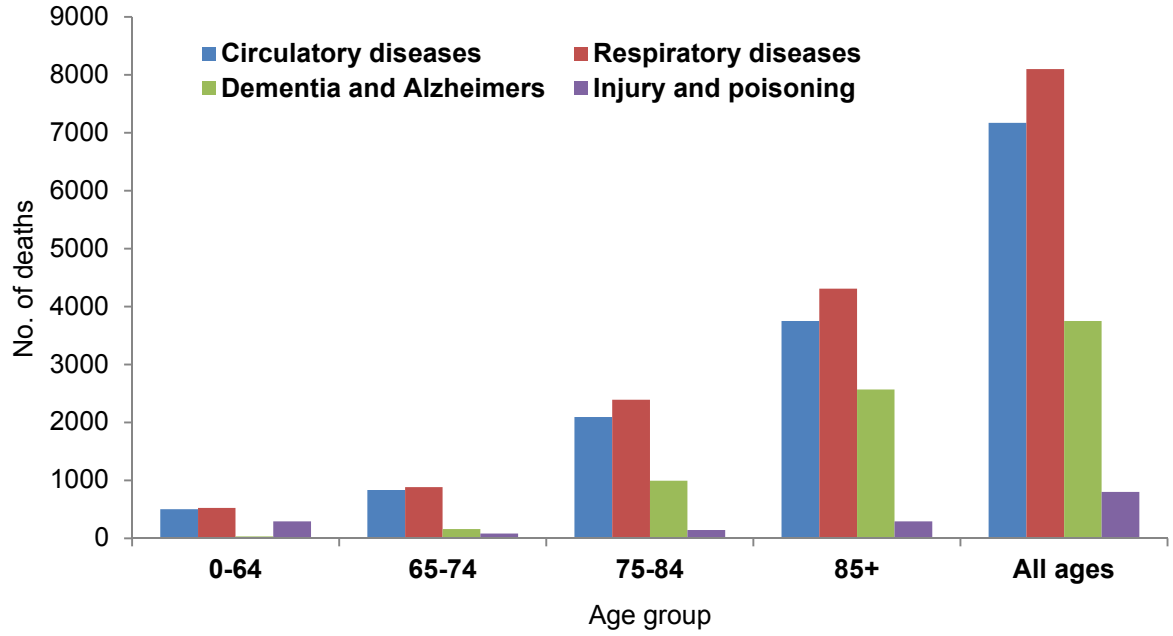


Figure 11: Causes of EWM in England and Wales, 2011/12

Living in a cold, damp home increases the risk of poor mental and physical health and may prolong the time taken for a person to recover from illness. Cold, damp houses encourage mould growth, which increases the risk of respiratory infection. The percentage of households estimated to be fuel-poor in 2012 in Brent (11.6%) was higher than both the London (8.9%) and England (10.7%) averages[13].

Welfare reforms

Recent national welfare reforms and changes to the benefit system have led to a range of associated issues for Brent residents. Among the provisions of the Welfare Reform Act 2012 are changes to housing benefit regime. Key changes have included the introduction of the under occupancy penalty. This reduces the amount of benefit paid to claimants who are deemed as having excessive amounts of living space in the property which they are renting.

Employment and unemployment

ONS mid-year 2012 population estimates show that 69% of Brent's population is of working age (i.e. aged between 16 and 64). During the period October 2012 to September 2013, 11% of the working age population were unemployed[14]. This compares to the London average of 8.7% and the national average of 7.7%.

High levels of unemployment in Brent coupled with people having less disposable income means that the living standards of many families in the borough are compromised. Issues such as food poverty are becoming an increasing concern for some families in the borough.

The employment rate varies by 16.9% for different ethnicities. Figure 12 illustrates that Indian people have the highest rate of employment (69.0%), and black people the lowest (52.1%).

[13] Department for Energy and Climate Change: fuel poverty indicator, 2012 (low income, high cost)
[14] ONS Annual population survey: model-based estimates (% is a proportion of economically active)

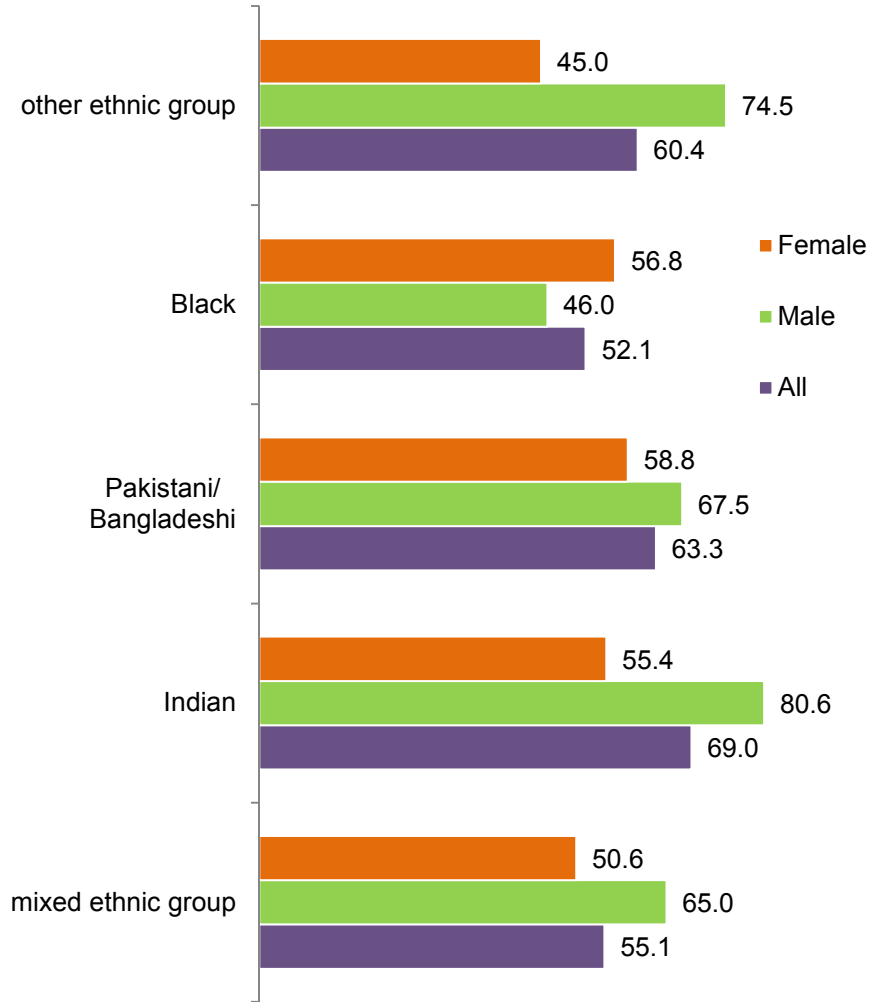


Figure 12: Employment rate by ethnicity and sex. Source: Annual Population Survey, 2014

There are 34,600 working age people in Brent with a long term illness or disability. Of these 16,800, (48.5%) are in employment. This is lower than both the London rate (59.8%) and the England rate (63.2%).

The percentage of people with depression, learning problems, mental problems or other nervous disorders in employment is 23% also lower than both the London rate (32.2%) and England rate (36.4%) as illustrated in figure 13.

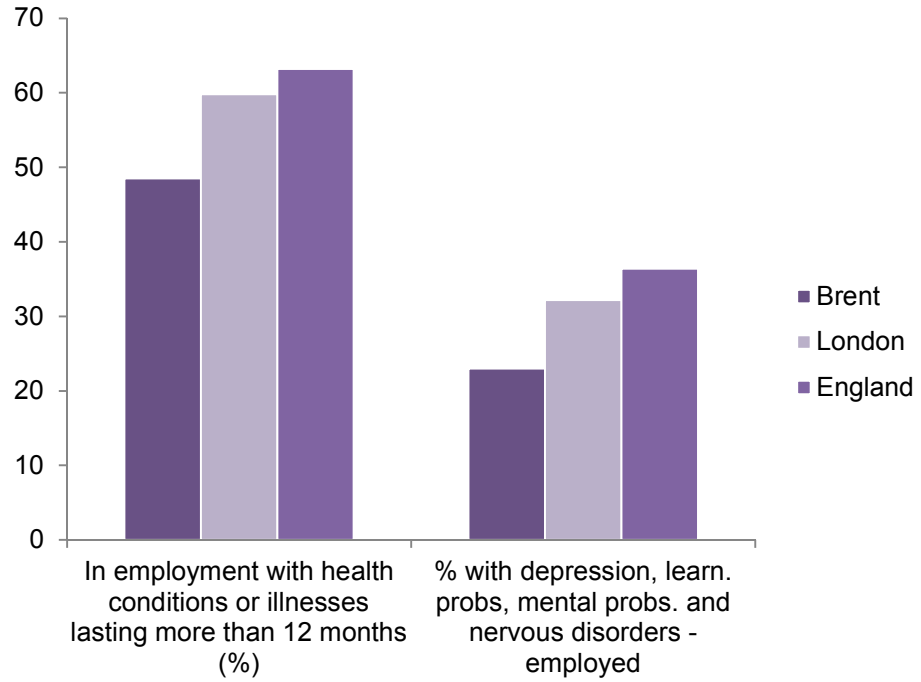


Figure 13: Percentage of people in employment with long term conditions.
Source: Annual Population Survey, 2014

Job Seekers Allowance (JSA) claimants

In May 2014, the Job Seekers Allowance (JSA) claimant rate in Brent was 3.3% (7,161 claimants) for people aged 16 to 64 years, which is higher than the London (2.7%) and Great Britain average (2.6%). Although this rate has fallen since 2012 in Brent, there are significant inequalities at ward level (figure 14).

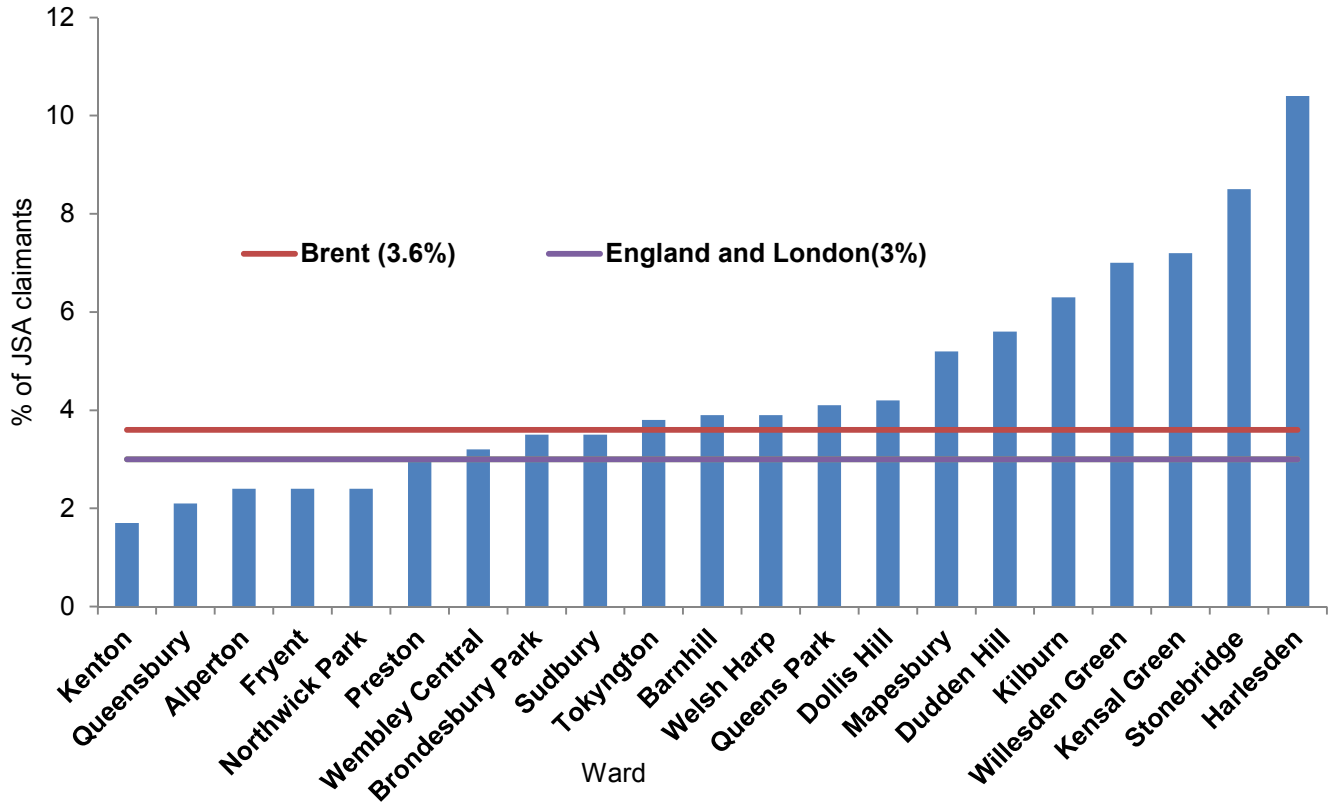


Figure 14: Percentage of JSA claimants in January 2014 for 16-64-year-olds by Brent wards. Source: ONS claimant count

Deprivation

Brent has areas of relative affluence and areas of deprivation. Deprivation is measured using the following seven indicators:

- income
- employment
- health deprivation and disability
- education, skills and training
- barriers to housing and services
- crime
- living environment

Deprivation is measured in deciles, a scale of one to ten, where one is the most deprived and ten is the least deprived. Measuring deprivation at lower super output area (LSOA - areas with between 1000 and 3000 residents) shows a variation across Brent from deprivation deciles one to seven (figure 15).

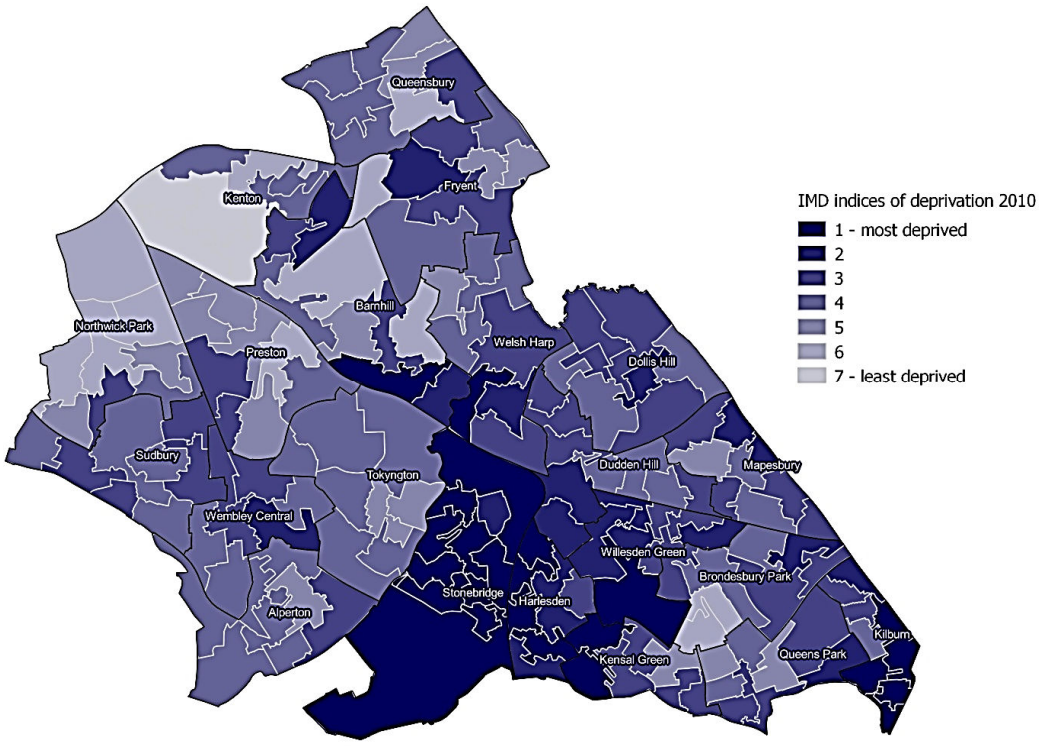


Figure 15: Indices of deprivation 2010. Source: IMD 2010 - data.gov.uk

Brent has high deprivation levels compared to neighbouring London boroughs with over a quarter of its LSOAs in deprivation deciles one or two.

Air quality

Poor air quality is a significant public health problem, particularly in larger cities such as London where high volumes of traffic and local industries or other pollutant sources contribute to increased concentrations of atmospheric pollutants. It is estimated that the burden of particulate air pollution in the UK in 2008 is equivalent to approximately 29,000 deaths. The presence of significant major routes running through the borough, notably the North Circular, leads to increased exposure to nitrogen oxides and particulate matter. As more people live in closer proximity to pollutant sources in the south of the borough, the impact of poor air quality tends to be worse here. However, air pollution is not necessarily restricted to certain parts of the borough and has an impact on every resident.

Long-term exposure to air pollution is known to exacerbate certain respiratory conditions such as Chronic Obstructive Pulmonary Disease (COPD). In Brent, emergency hospital admissions for COPD for the period 2006/07 to 2010/11 were mapped (figure 16). It was found that COPD admissions tended to be highest around the southern and central fringes of the borough. The extent to which air pollution in these localities has contributed to COPD admissions is difficult to quantify. Pre-existing respiratory conditions and smoking are known contributors which could cause COPD.

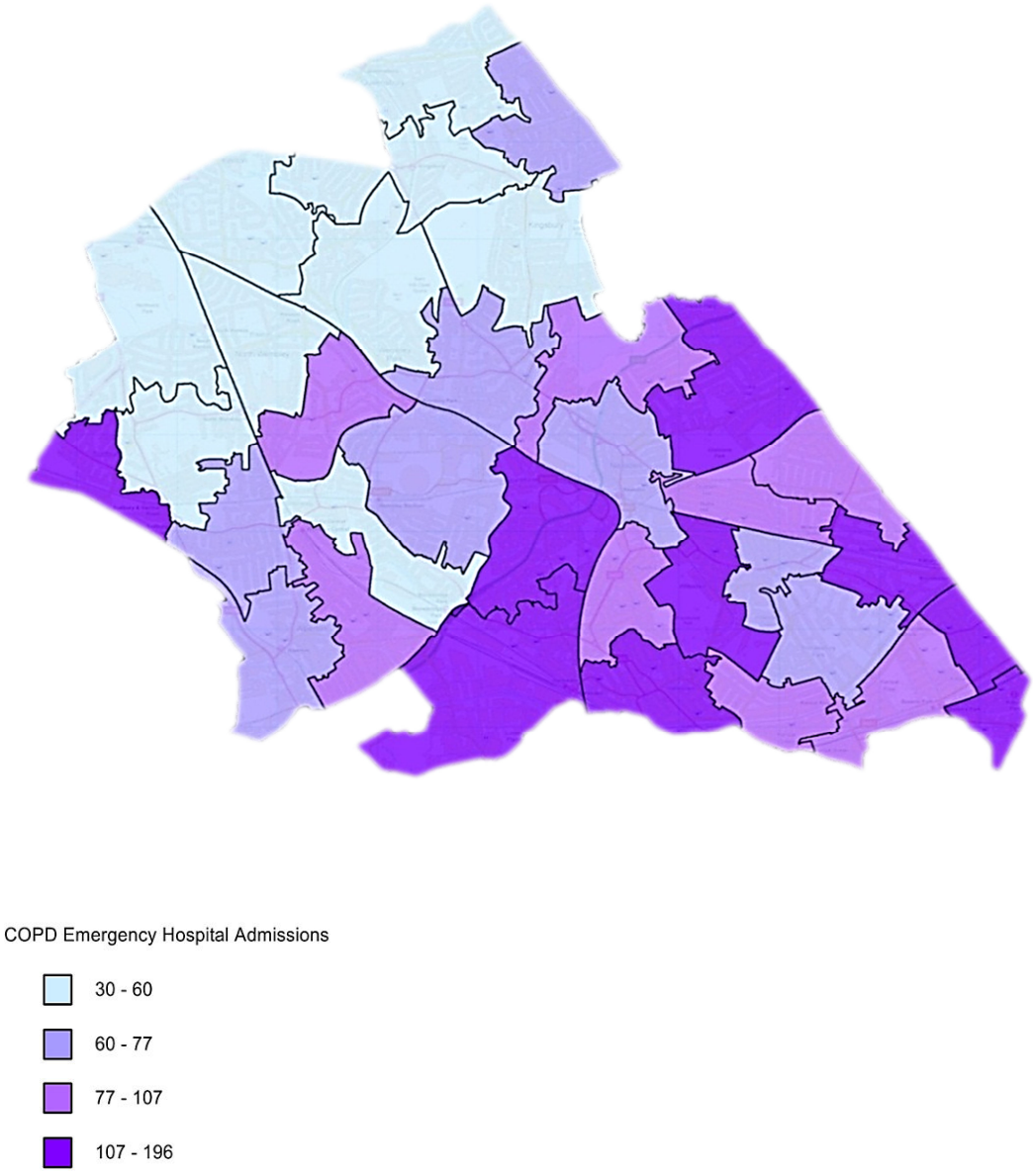


Figure 16: Emergency hospital admissions for COPD, standardised admissions ratio – 2006/07 to 2010/11. Source: Public Health England: produced from Hospital Episode Statistics (HES)

Transportation and road traffic accidents

Car ownership in Brent is relatively low, with 40% of Brent's households (or 2 in 5) having no access to a private motor vehicle. Kilburn (4,802) had the greatest number of households without access to a car or van, whereas Kenton (763) had the least. Overall, the total number of cars or vans in the borough in 2011 remained unchanged compared to 2001 with approximately 88,000 vehicles[15].

The rate of serious injury and deaths on Brent's roads is currently 25.8 per 100,000 of the population which is lower than the England average rate of 40.5 per 100,000 of the

[15] ONS 2011 Census

population. Between 2010 and 2012, 81 people were killed or seriously injured on Brent's roads. Of these, 8 were children aged 0-15 years[16].

The number of road casualties among children and young people in Brent aged under 16 years varies by ethnic group. Figure 17 provides a breakdown of child road casualties by ethnicity during the period 2009 to 2013. The Afro-Caribbean (31%) group had the highest proportion of road casualties during this period and the Oriental (1%) group had the lowest. During the five year period, there were 128 road casualties among Afro-Caribbean children and 4 casualties among the Oriental group.

In total, there were 411 child casualties between 2009 and 2013 among all ethnic groups with males comprising 58% of these casualties and females, 42%.

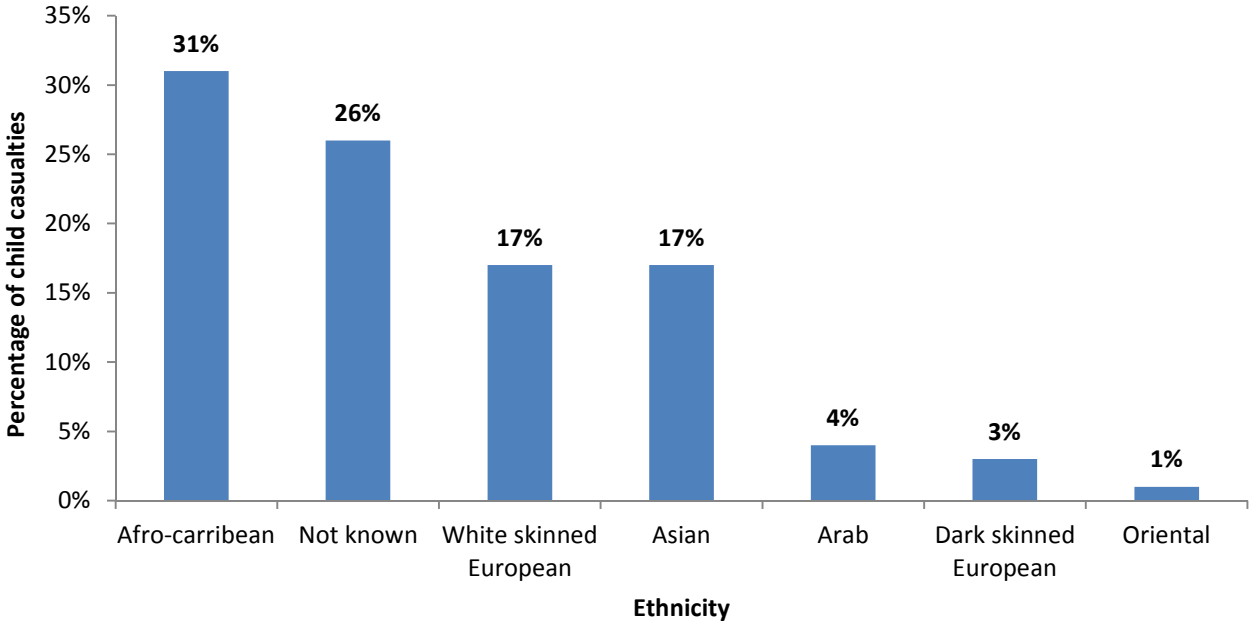


Figure 17: Percentage of child casualties by ethnicity*, 2009 to 2013. Source: LB Brent Transportation service. *Data originally collated by the Metropolitan Police Service (MPS). *ethnic groupings included in figure 17 based on MPS definitions.*

[16] Public Health England, Brent health profile 2014

2. THE BURDEN OF ILL HEALTH

Health inequalities in Brent

Life expectancy at birth

Life expectancy for both men and women born in 2010-12 in Brent is higher than the England average: 79.9 years for males and 84.5 years for females[17]. However, the overall life expectancy at borough level masks a pronounced variation between the most and least deprived parts of Brent. Life expectancy for children born between 2010 and 2012 is 5.3 years lower for men in the most deprived parts of Brent than the least deprived parts. For females, the difference is less pronounced at 3.8 years. This is reflected in figure 18, which illustrates the slope index of inequality and the life expectancy gap for males and females living in Brent.

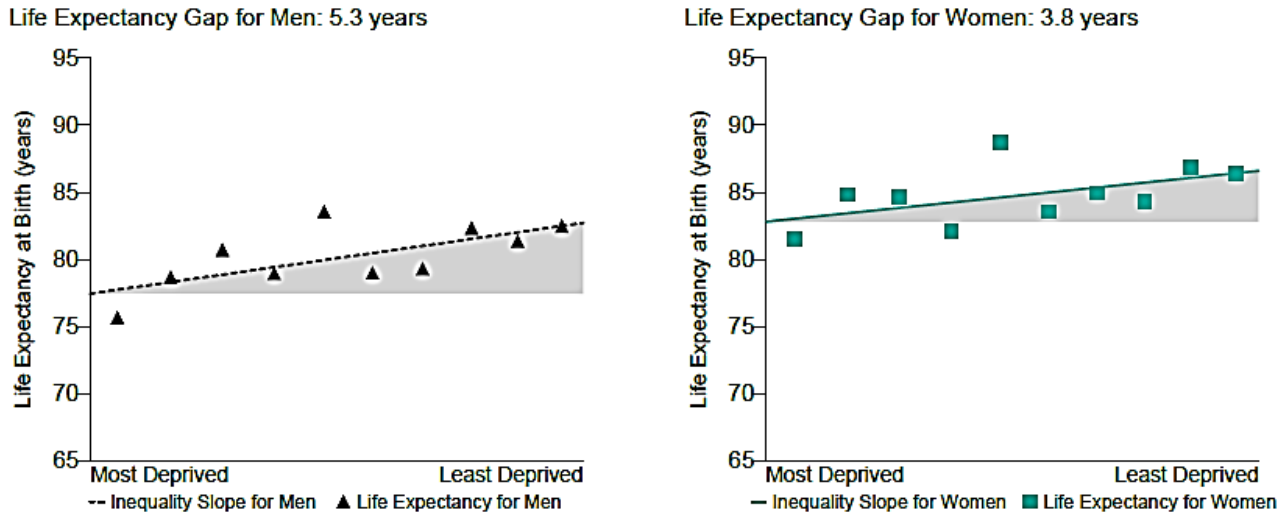


Figure 18: Slope Index of Inequality 2010-12. Source: Public Health England, Brent health profile 2014

A number of different diseases account for this gap: for men, circulatory disease accounts for 25% of the gap in life expectancy and cancer for 22%. For women, cancer was the largest contributor at 31%, with respiratory disease accounting for 25% of the gap[18] (figure 19).

[17] Public Health England, Public Health Outcomes Framework (PHOF) Overarching Indicators
[18] Public Health England, The Segment Tool for Brent (data for 2009-2011)

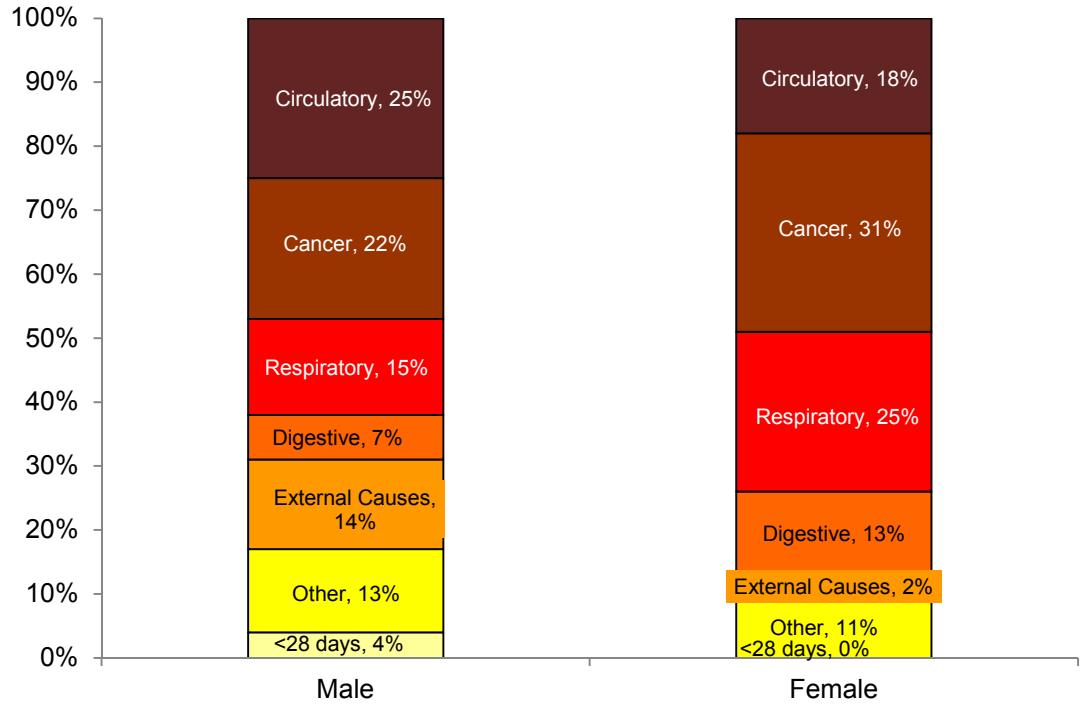


Figure 19: Life expectancy gaps in Brent by cause of death. Source: Public Health England, the Segment Tool: data for 2009-11

Figures 20 and 21 highlight the geographic variations in life expectancy at ward level for both males and females. Life expectancy for males born between 2008 and 2012 is lowest in Stonebridge (76 years) and highest in Dudden Hill (83 years). Female life expectancy is highest in Kenton (90.3 years) and lowest in Barnhill (80.6 years).

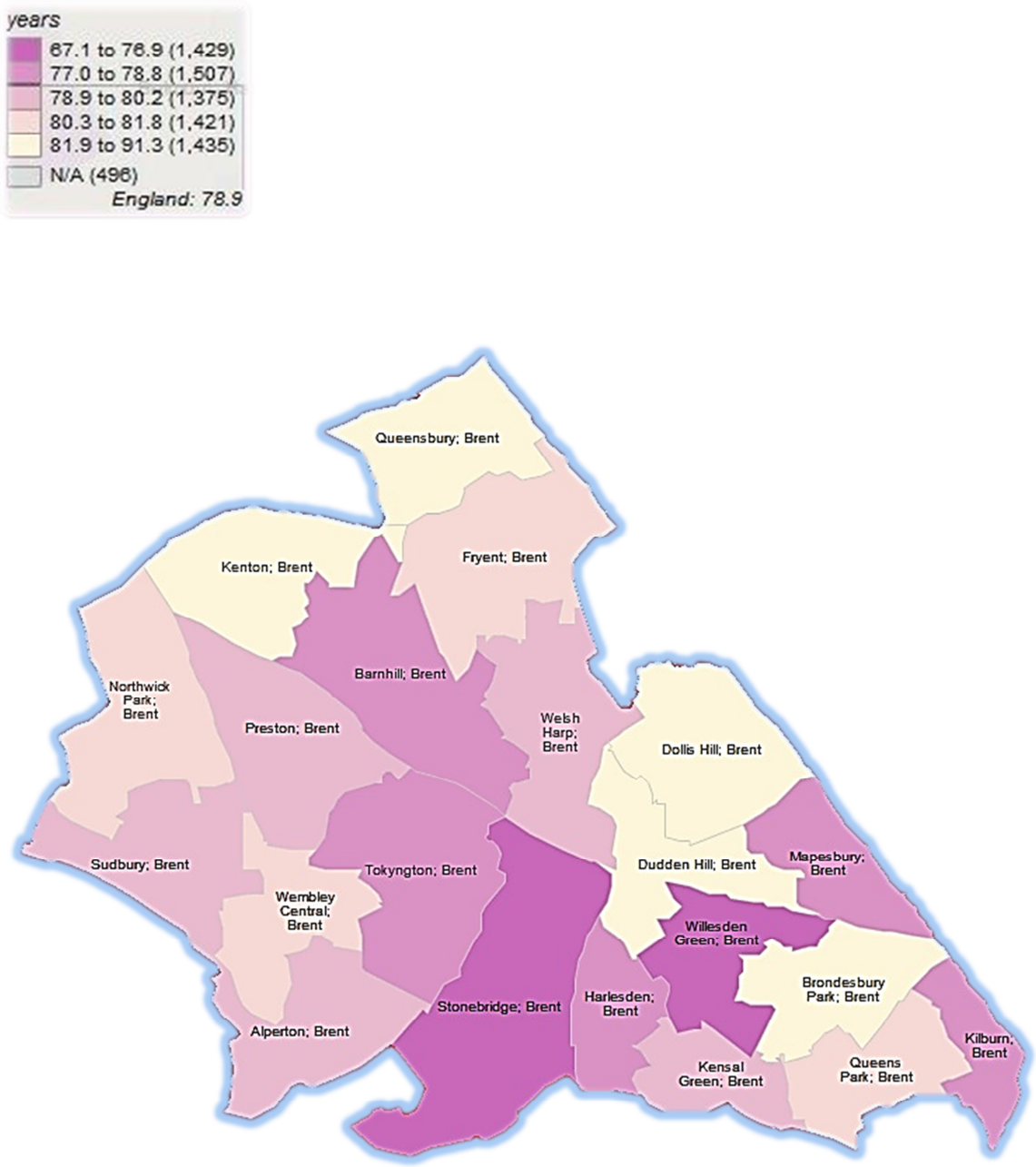


Figure 20: Life expectancy at birth for males born in 2008-2012, Source: ONS, PHE (Local Health mapping tool)

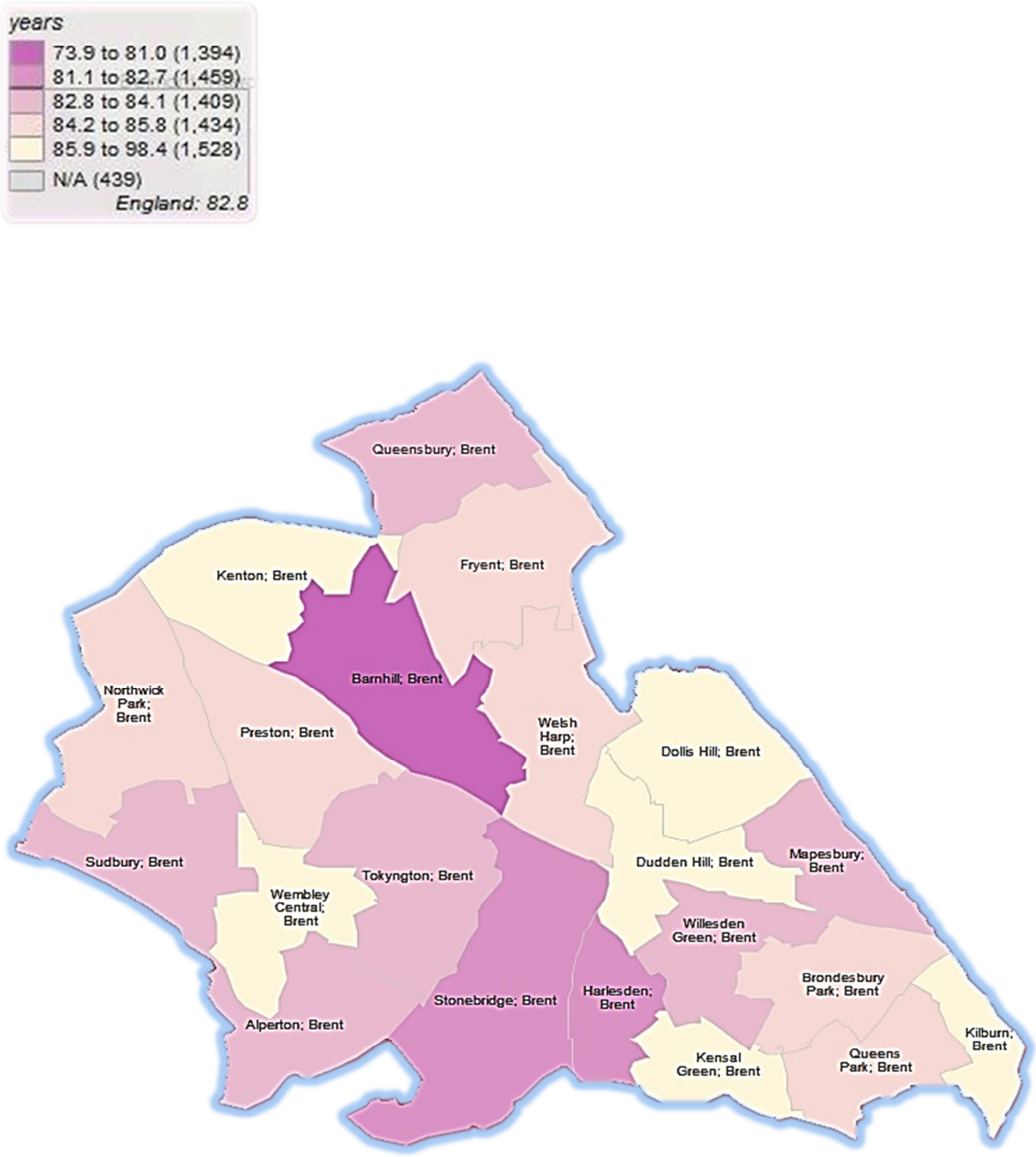


Figure 21: Life expectancy at birth for females born in 2008-2012, Source: ONS, PHE (Local Health mapping tool)

NB. Note that life expectancy data used in figures 18, 20 and 21 relates to different time periods.

Healthy life expectancy

As important, if not more so, as how long people can expect to live, is how long they can expect to live in good health, termed healthy life expectancy. On average, healthy life expectancy was 62 years compared to an overall life expectancy of 79.9 years for Brent males born in 2010-12. Females born over the same period can expect 62 years in good health compared to a total life expectancy of 84.5 years[19].

How people in Brent describe their own health

In the 2011 census, the vast majority of people in Brent (83%) described their health as "very good" or "good" (figure 22), a similar picture to England and Wales as a whole (81%). 5% described their health as "very bad" or "bad", with the remaining 12% as "fair".

At ward level, Kilburn had the highest number of residents who assessed their health as "very good" (8,448 residents), while Kenton had the lowest number of residents (5,502 residents) in "very good" health. Harlesden had the highest number of residents with both "good" health (5,815 residents) and those reporting "very bad" health (313 residents).

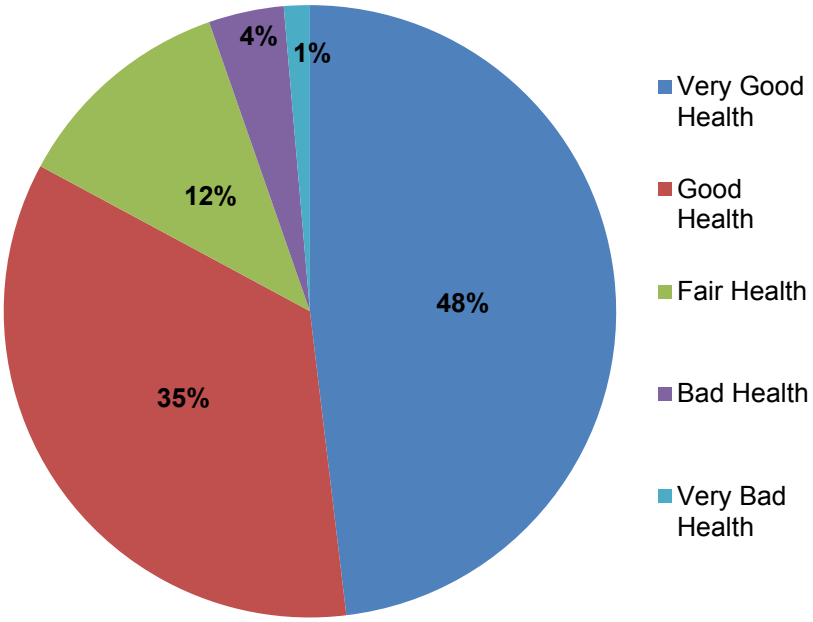


Figure 22: Percentage of residents describing their general health in relation to five categories (self-reported health) in Brent. Source: ONS 2011 census

Across the borough, there were only 4 wards where 6% to 7% of residents reported that they had bad or very bad health.

How people in Brent feel their health impacts on their day-to-day activities

In Brent, 7% of the total population (21,669 residents) reported in the 2011 census that their day-to-day activities were "limited a lot" (figure 23). This compares to the London average of 6.7% and the England average of 8.3%. By way of contrast, 85.6% of the total population

[19] ONS, Healthy Life Expectancy at Birth: Clinical Commissioning Groups (2010-12). Note: the proportion of life spent in 'good' health is a relative measure which divides HLE by LE, and can be expressed as a percentage.

feel that their day-to-day activities are “not limited at all”. This is similar to the London average of 85.8% and slightly better than the England average of 82.4%.

Nearly 8% of people in Brent feel that their day-to-day activities are “limited a little”. The comparable London figure is 7.4% and for England, 9.3%. The levels of self-reported disability vary throughout Brent. In the 2011 census, Harlesden had the greatest number of residents reporting they were *not* limited by health problems (14,574 residents in total) while Kenton had the lowest number (10,218 residents).

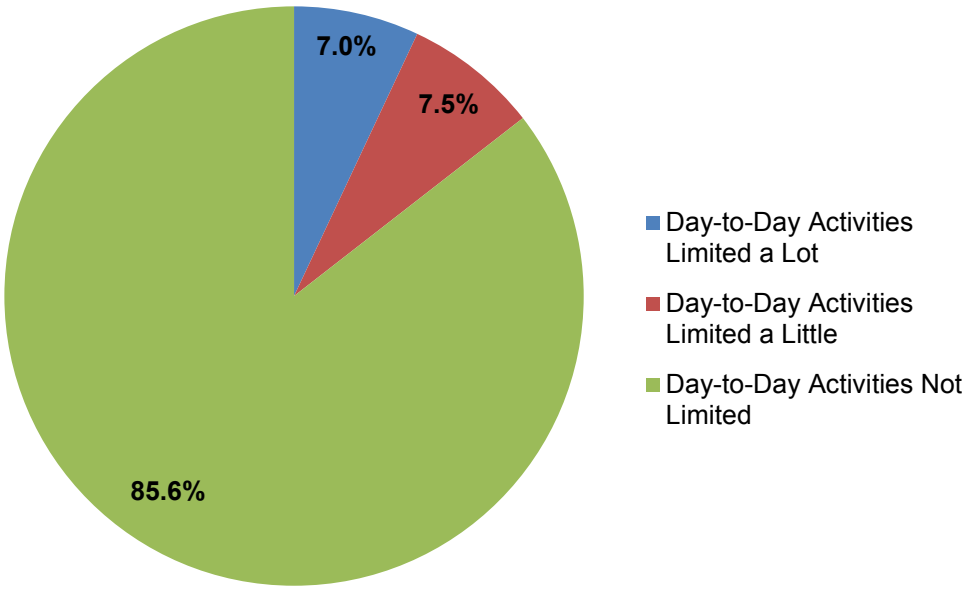


Figure 23: How people in Brent feel their health impacts on their day-to-day activities. Source: ONS 2011 census

Large parts of the borough reported that 7% to 8% of residents felt that their health ‘limited a lot’ their day to day activities as illustrated in figure 24.

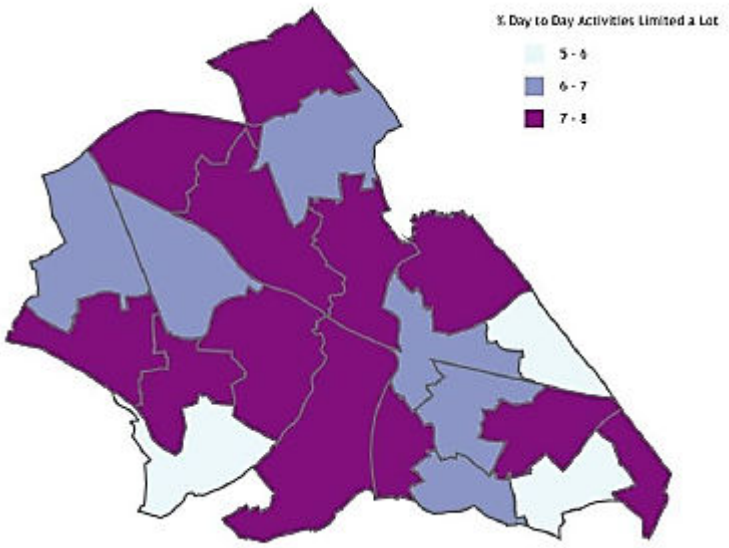


Figure 24: Percentage of day to day activities limited by health a lot by ward. Source: ONS 2011 Census.

Mortality and morbidity in Brent

Premature mortality relates to those deaths which occur under the age of 75 years.

Between 2010 and 2012, the rate of overall premature deaths in Brent was 334 people per 100,000 of the population[20]. Presently, the main causes of premature death in Brent are:

1) **Cancer**
2) **Cardiovascular disease**
3) **Respiratory disease**

Cancer

The premature mortality rate for cancer in Brent is significantly better than that for England and has fallen over the past 10 years (figure 25). It currently stands at 127 deaths per 100,000 people aged under 75 years, compared to the England figure of 146 per 100,000 aged under 75 years. This equates to 233 premature deaths in Brent between 2010 and 2012[21]. For males in Brent aged under 75 years, the mortality rate in 2010-12 due to cancer was 146 per 100,000 of the population. This was lower than the England rate of 164 per 100,000 of the population.

For females in Brent, the premature mortality rate due to cancer in 2010-12 was 111 per 100,000 of the population, which was lower than the England rate of 131 per 100,000 of the population[22].

[20] Public Health England, Longer Lives, 2010-2012
[21] Public Health England, Brent health profile 2014
[22] Public Health England, PHOF: Healthcare and premature mortality indicators

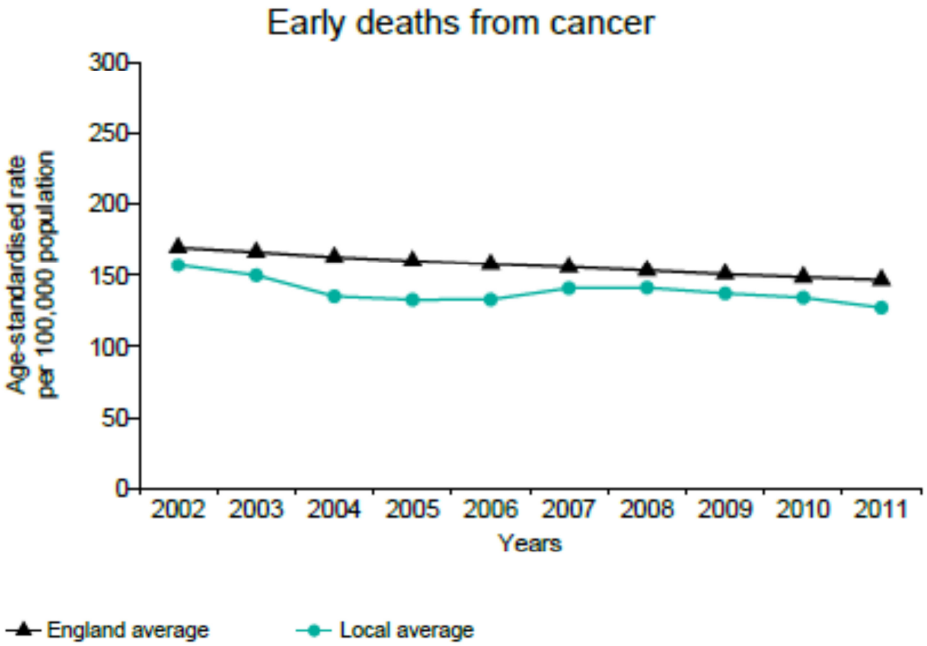


Figure 25: Source: Public Health England, Brent health profile 2014

Cardiovascular disease (CVD)

CVD includes coronary heart disease (CHD) and stroke. Age plays a key role in CVD mortality rates and the prevalence of CVD increases significantly beyond 40 years old[23].

Between 2009 and 2011, CVD accounted for 26% of deaths in Brent for people under 75 years and 41% of deaths for people aged 75 years and over. This is higher than the prevalence in England for both under 75s (24%) and for those aged 75 and over (35%).

Premature mortality rates from CVD in Brent have steadily decreased by 60% over the last 20 years. Despite this, rates of premature death from CVD in Brent remain worse than the England average (figure 26). The premature mortality rate from CVD between 2010 and 2012 in Brent was 94 per 100,000 of the population. The England rate was 81 per 100,000 of the population.

For males in Brent aged under 75 years, the mortality rate in 2010/12 due to CVD was 130 per 100,000 of the population. This was higher than the England rate, which was 114 per 100,000 of the population. The mortality rate due to CVD among the female population in Brent aged under 75 years was 61 per 100,000 of the population. The England rate was lower at 50 per 100,000 of the population[24].

The estimated prevalence of diagnosed CHD varies between practices in Brent. The percentage of people on GPs' lists with a recorded diagnosis of CHD was 3.5% in Brent compared to 4.7% in England[25]. Given the higher death rates in Brent, this suggests possible under-diagnosis.

[23] Public Health England, Cardiovascular disease health profile for Brent, 2013
[24] Public Health England, PHOF: Healthcare and premature mortality
[25] Public Health England, National General Practice Profiles for NHS Brent CCG, 2011

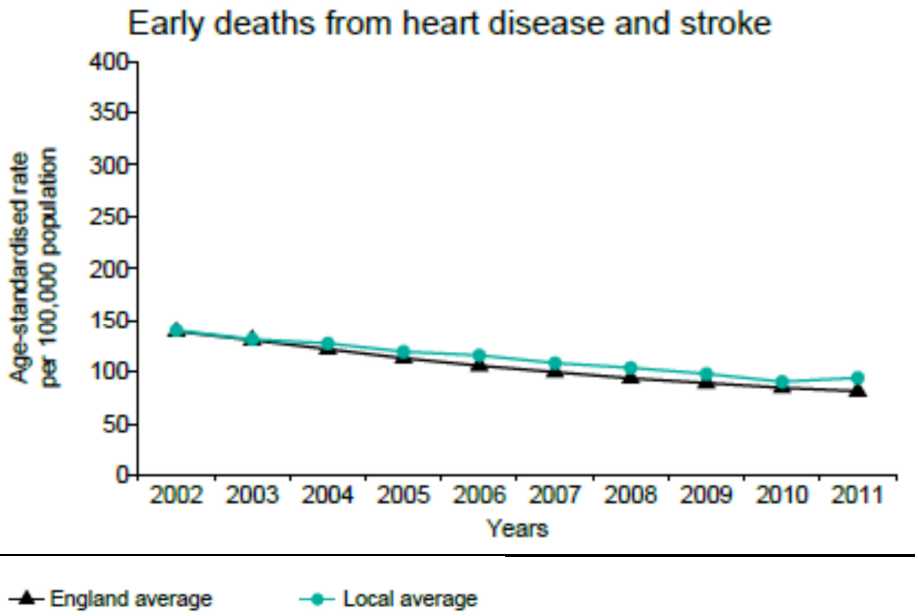


Figure 26: Source: Public Health England, Brent health profile 2014

Respiratory disease

Respiratory diseases (which include COPD and asthma) account for approximately 15%[26] of all deaths in Brent and are the third major killer following circulatory disease and cancer. COPD alone accounts for around a quarter of deaths due to respiratory disease in Brent. COPD includes two lung diseases: chronic bronchitis and emphysema. Although certain factors such as the presence of air pollution are known to exacerbate COPD, smoking is recognised as the primary cause.

The premature mortality rate from respiratory disease in Brent in 2010-12 was 28.1 per 100,000 of the population. This represents 149 deaths. The England rate was slightly higher at 33.5 deaths per 100,000 of the population[27].

For males in Brent, the rate of premature mortality due to respiratory disease in 2010-12 was 37 per 100,000 of the population, which was lower than the England rate of 40 per 100,000 of the population. For females in Brent, the rate of premature mortality due to respiratory disease in 2010-12 was 20 per 100,000 of the population, which was lower than the England rate of 28 per 100,000 of the population[28].

Other key causes of premature death

Other key causes of premature death in Brent include liver disease and suicide.

The rate of premature deaths due to liver disease in Brent between 2010 and 2012 was 17.3 per 100,000 of the population, which is below the England rate of 18 per 100,000 of the population.

[26] National End of Life Care Intelligence Network (NEoLCIN) profiles: Percentage of all respiratory deaths in 2008-2010 in Brent
[27] Public Health England, PHOF: Healthcare and premature mortality
[28] Public Health England, PHOF: Healthcare and premature mortality

Between 2010 and 2012, there were 19 suicides in Brent, a rate of 6.8 per 100,000 of the population. This is lower than the England average rate of 8.5 deaths per 100,000 of the population.

Health and provision of care

Provision of (unpaid) care

The 2011 census identified that there were 5.8 million carers in England and Wales. Since 2001 nearly 1,600 additional people are providing care between 20 and 49 hours a week and 1,312 are providing care of 50 or more hours a week in Brent (figure 27).

Key points to note include:

- Nearly 9% of Brent's residents provide some form of unpaid care;
- Around 26,600 residents of Brent provide one hour of care or more on a weekly basis according to the 2011 census.

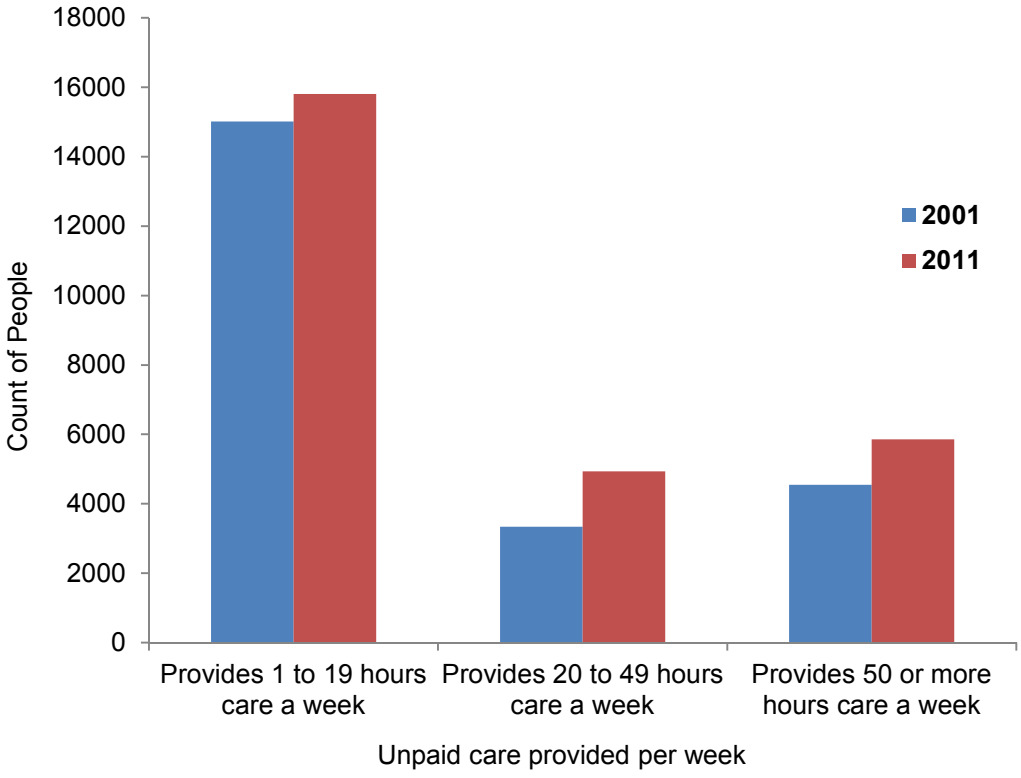


Figure 27: Number of residents (all ages) who provide unpaid care in Brent, 2001 versus 2011. Source: ONS 2001 and 2011 census

Figure 28 shows the number of people providing unpaid care in Brent by different age groups. It is apparent that the age group 25 to 49 years old have the highest number of people providing unpaid care (12,413) while those aged 0 to 24 have the lowest number (3,227) in 2011. As conditions such as mental illness and dementia are forecast to increase in Brent, the demand for more carers will increase.

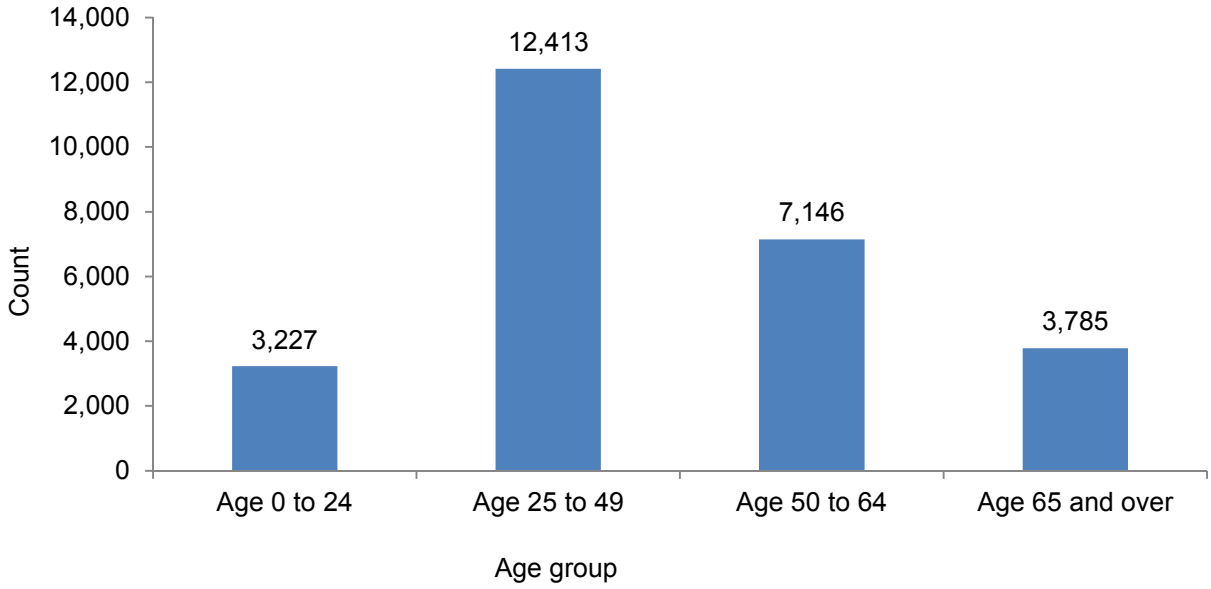


Figure 28: Total unpaid care provided by age groups in Brent. Source: ONS 2011 census

The 2011 census provides information on the provision of care by ethnic group (figure 29). It shows that the majority of ethnic groups provide a similar amount of care to the Brent average (9%). Some ethnic groups, including Asian/Asian British (10%), provide slightly more care than average while other groups, notably mixed/multiple (6%), provide slightly less.

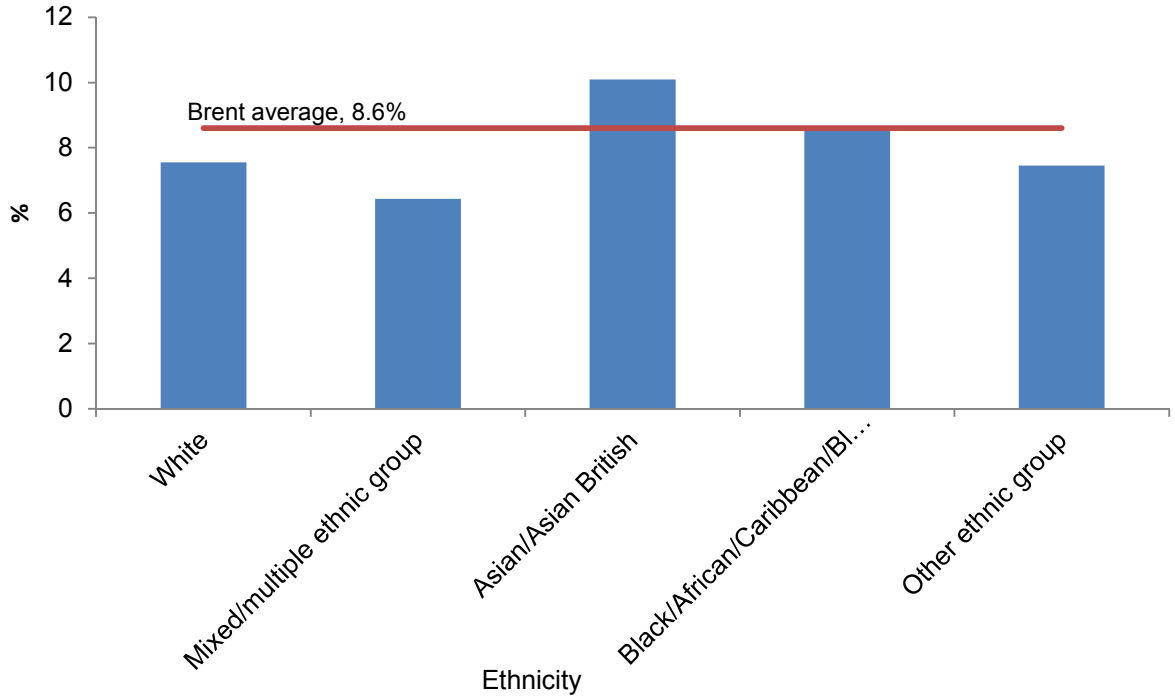


Figure 29: Provision of unpaid care in Brent by ethnic group (all ages). Source: 2011 census, ONS

A high proportion of adult carers in Brent experienced social isolation. In 2012/13, only 24% of adult carers reported that they had as much social contact as they would like. This is a

significant issue in Brent, as 41% of adult carers in England and 37% of adult carers in London reported that they did experience as much social contact as they would like[29].

The Care Act

The Care Act, which is due to take effect in April 2015, presents a range of implications for adult social care in local authorities in England.

Some of the new areas of responsibility which will apply to local authorities in April 2015 and beyond include:

- Carers' rights to support, on an equivalent basis to the people they care for;
- Responsibilities around transition, provider failure, supporting people who move between local authority areas and safeguarding.

For LB Brent, the introduction of the Care Act means that opportunities will exist to further integrate health and social care support functions in alignment with other key partners.

Poor mental health amongst adults

Prevalence of depression and anxiety

The Annual Population Survey undertaken by ONS provides estimates of subjective levels of wellbeing. The percentage of people in Brent reporting low levels of happiness were 11%. This is higher than the England average of 8% and the same as the London average[30].

In 2010/11, 16,000 Brent adults were on a GP register for depression. Take up of talking therapies is lower in Brent in terms of the numbers of referrals who enter treatment: 53% in Brent compared to 60% in England.

Levels of self-reported daily anxiety amongst Brent residents are comparable to the England average. Estimates show that 19.5% of Brent residents surveyed consider themselves to have high levels of daily anxiety compared to the England average of 21% and the London average of 22.4%[31].

Prevalence of severe and enduring mental illness

Supporting service users with other key requirements such as housing and employment needs are important in ensuring the effective treatment and recovery resulting from serious mental illness.

The prevalence of severe and enduring mental illness in Brent affects 1.1% of the population, which is above both the London and England averages. Figure 30 shows the prevalence of severe and enduring mental illness (such as schizophrenia, bipolar disorder or other psychoses) between London boroughs for the period 2011/12.

[29] Personal Social Services Survey of Adult Carers in England (HSCIC), 2012/13
[30] London Health Observatory and Working for Wellness (2011), London Adult Mental Health Scorecard for Brent
[31] Annual Population Survey (ONS), 2012/13. Self-reported well-being measure: % of respondents aged 16 and over scoring 6-10 to the question "Overall, how anxious did you feel yesterday?"

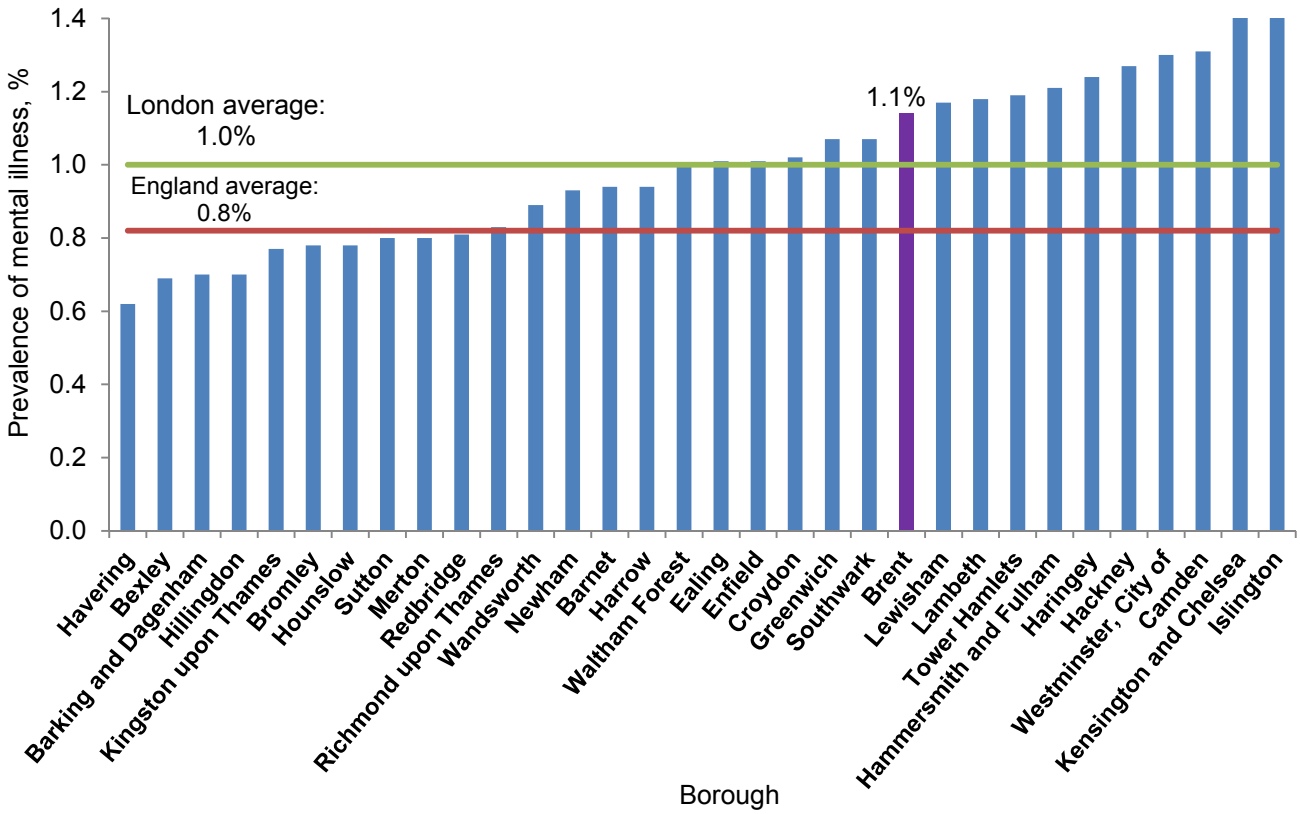


Figure 30: Mental illness prevalence (severe and enduring) among adults by London boroughs, 2011-2012. Source: NHS Information Centre.

Between 2011/12 and 2012/13, there was a 19% increase in the numbers of users of mental illness services in Brent. GPs and specialist services report on-going pressures on services.

Mental illness and incapacity benefit claimants

In May 2012, 44% of claims in Brent for Incapacity Benefit (IB) and Severe Disability Allowance (SDA) were due to a mental disorder, accounting for 2,950 of 6,710 claimants and forming the largest single category (figure 31). In England, mental disorder accounted for 43% of claims and in London, 47%.

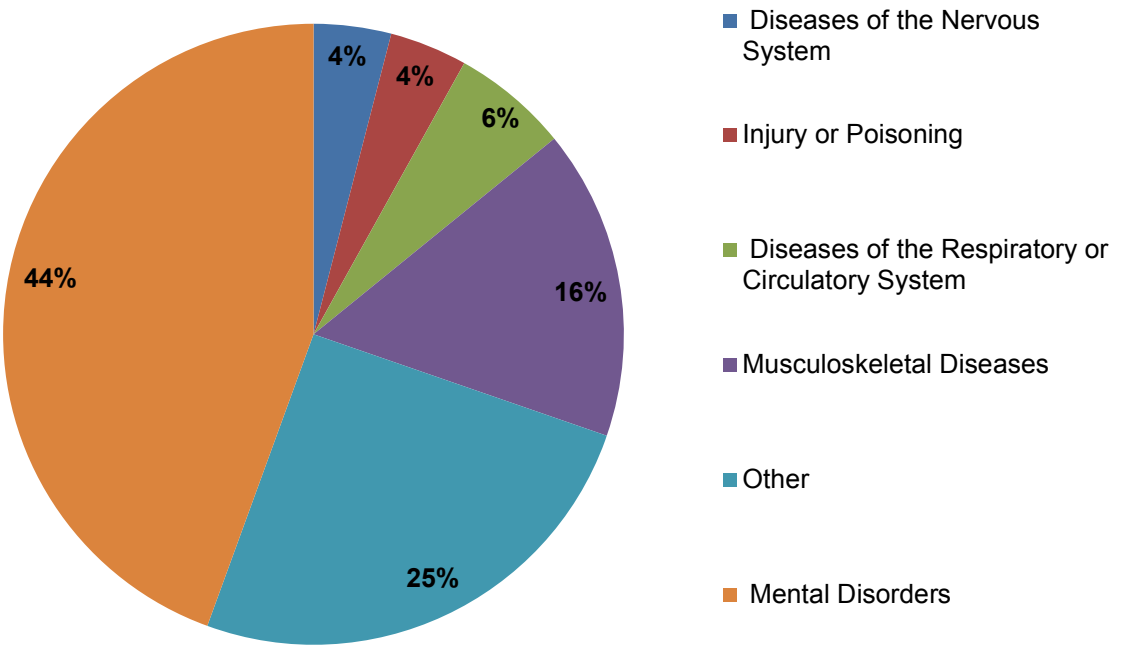


Figure 31: Medical reasons for claiming SDA/IB in Brent (data for May 2012). Source: Department for Work and Pensions (data for May 2012)

Future levels of mental illness

A steady increase, amounting to about 2%, in the number of people aged 18 to 64 with a common mental illness, principally depression and anxiety, is predicted in Brent from 2012 to 2020[32] (figure 32). This trend is not statistically different from the overall predictions for England (3%). In London, however, the prediction is for a more pronounced increase of 10%.

[32] Projecting Adult Needs and Service Information System (PANSI)

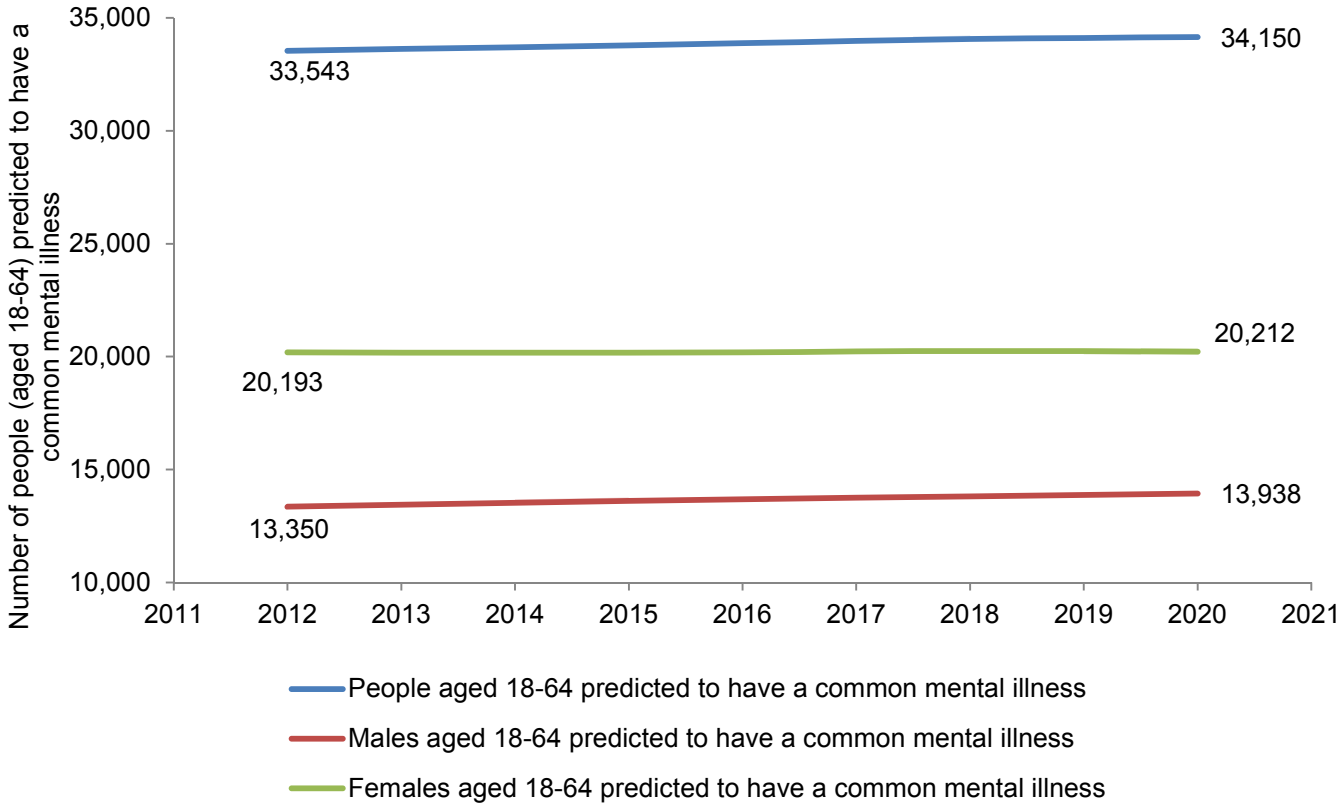


Figure 32: Mental ill health forecasts from 2012 to 2020. Source: Projecting Adult Needs and Service Information (PANSI)

Dementia

In the UK, there are 835,000 people living with dementia in 2014. By 2015, this will have increased to 850,000[33]. Some of the main symptoms associated with dementia include memory loss, communication problems and confusion. With time, these symptoms tend to become worse. As people are now living longer due to improvements in healthcare, the number of people with dementia is increasing.

Dementia can have a significant impact on those who live with the condition, their families, their carers and society more generally. Figure 33 identifies how many people are living with dementia in Brent compared to other London boroughs (CCGs). In Brent, 0.7% of the population were estimated to be living with dementia in 2012.

Twelve per cent of deaths in Brent had a contributory cause of Alzheimer's, dementia and senility in 2008-10. This is lower than the England average of 17%[34].

[33] Alzheimer's Society, Dementia 2014: Opportunity for change
[34] Public Health England, End of Life Care profile for Brent, 2012

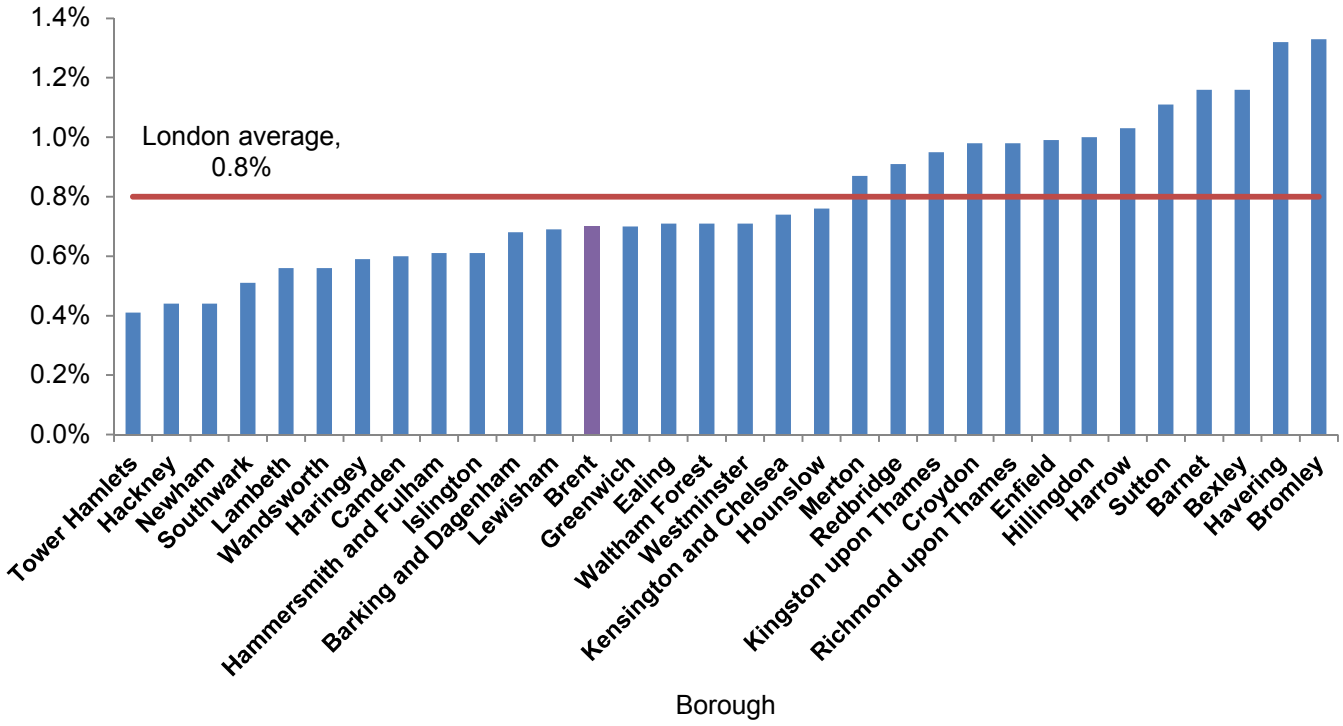


Figure 33: Prevalence of dementia by London local authorities, 2012. Source: Department of Health, Dementia Challenge. Webpage: http://dementiachallenge.dh.gov.uk/

The provision of appropriate support from social services will help to keep elderly residents independent rather than result in them being transferred to a care home setting. The quality of housing stock accessibility and adaptability are factors which influence whether older residents can remain independent for as long as possible.

The percentage of people aged over 65 in Brent who were living at home 3 months after a stay in hospital in 2012 (80.8%) was below both the England average (81.4%) and the London average of 85.3% (figure 34).

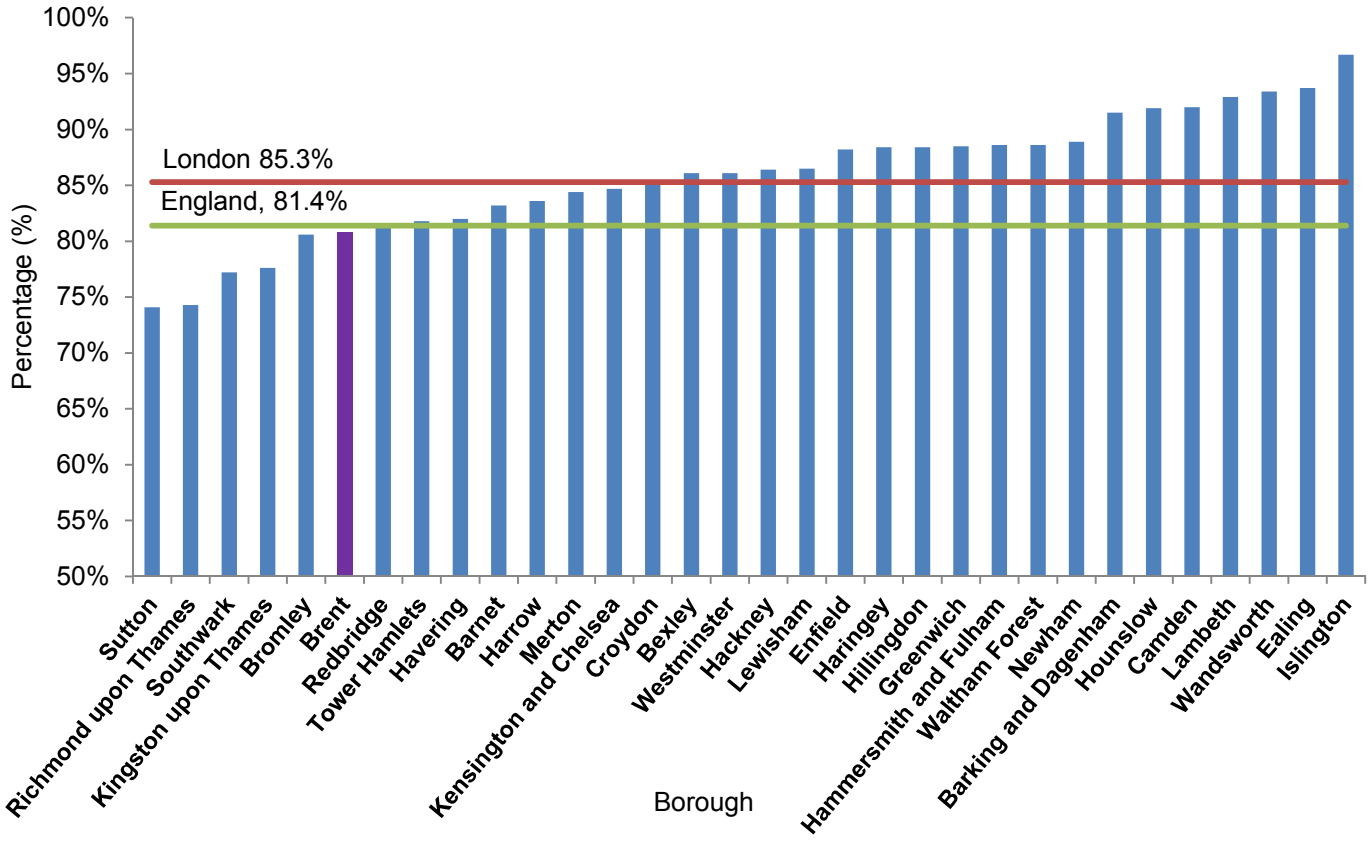


Figure 34: Percentage of older people (65 and over) who were living at home 3 months after a stay in hospital by borough (CCGs), 2012. Source: Social Care & Mental Health Indicators from the National Indicator Set, Health & Social Care Information Centre (HSCIC)

Dementia projections

Projections suggest that there will be a 32% increase in the total population aged 65 and over with dementia (figure 35).

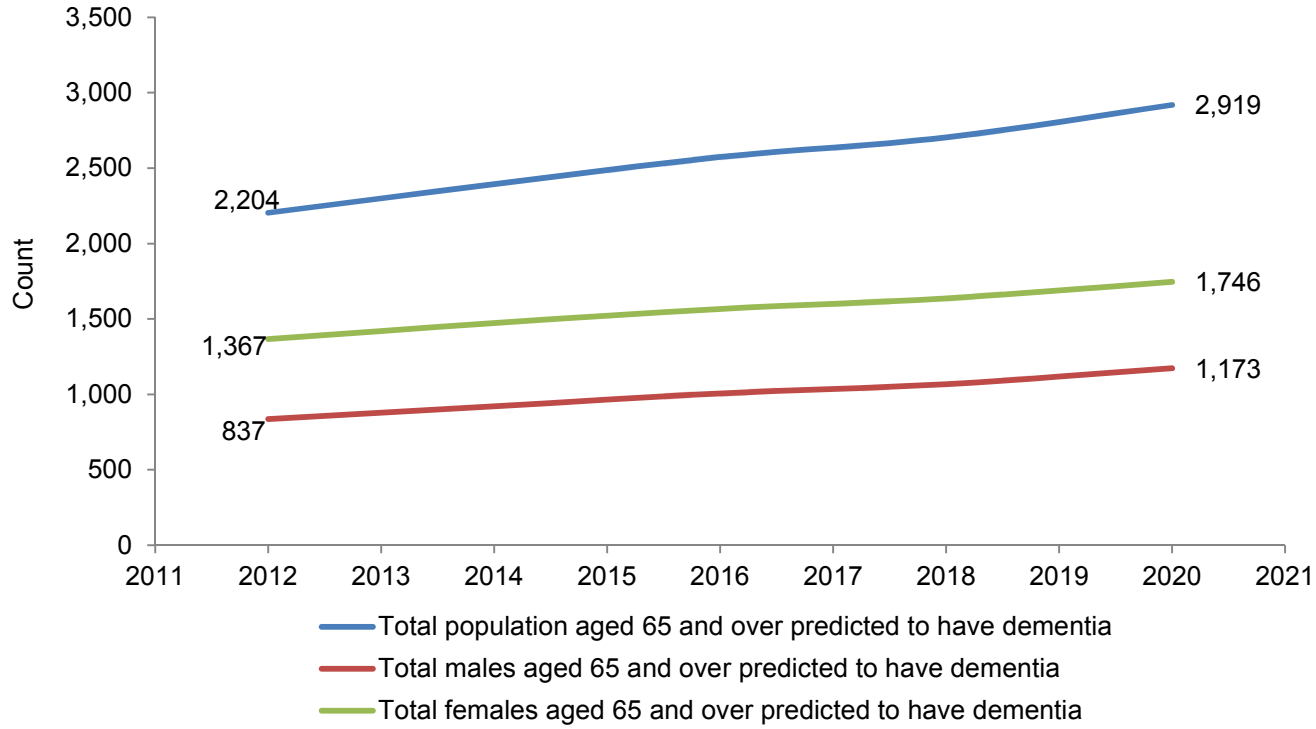


Figure 35: Dementia forecasts in Brent for people aged 65 years and over. Source: Projecting Older People Population Information (POPPI)

Dementia among people under the age of 65 is comparatively rare. There are over 17,000 younger people with dementia in the UK[35]. Figure 36 highlights the projected rise in people aged 30 to 64 predicted to have early onset dementia between 2014 and 2030 in Brent.

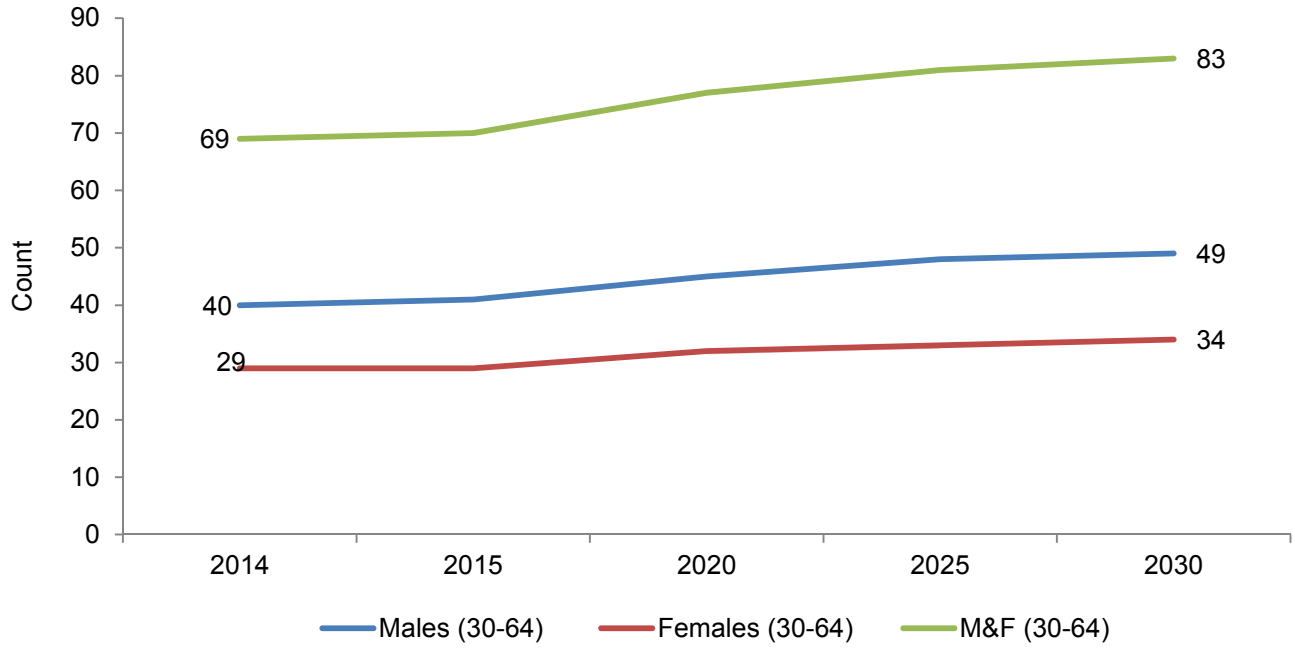


Figure 36: Early onset dementia. Source: Projecting Adult Needs and Service Information (PANSI)

[35] Alzheimer's society: Younger people with dementia factsheet

Adults with autism

National estimates are that approximately 1% of the adult population are regarded as having an autistic spectrum disorder (ASD)[36]. Currently estimates are that 2,158 adults aged 18 to 64 in Brent have an ASD. National rates of ASD are higher in adult males (1.8%) compared to females (0.2%)[37]. Forecasts show that between 2014 and 2030 the number of adults aged 18 to 64 with an ASD in Brent is predicted to rise by 10% overall (figure 37), with males accounting for the majority.

Years	2014	2015	2020	2025	2030
Total population aged 18 to 64 predicted to have autistic spectrum disorders	**2,158**	**2,175**	**2,254**	**2,310**	**2,369**
Total males aged 18-64 predicted to have autistic spectrum disorders	1,951	1,967	2,043	2,097	2,153
Total females aged 18-64 predicted to have autistic spectrum disorders	207	208	211	213	216

Figure 37: Adults aged 18 to 64 in Brent predicted to have an ASD. Source: PANSI

Overall, the total population aged 65 and over with an ASD in Brent is estimated to increase by 54% between 2014 and 2030 (figure 38). The number of people aged 75 and over predicted to have an ASD is projected to increase by 52%.

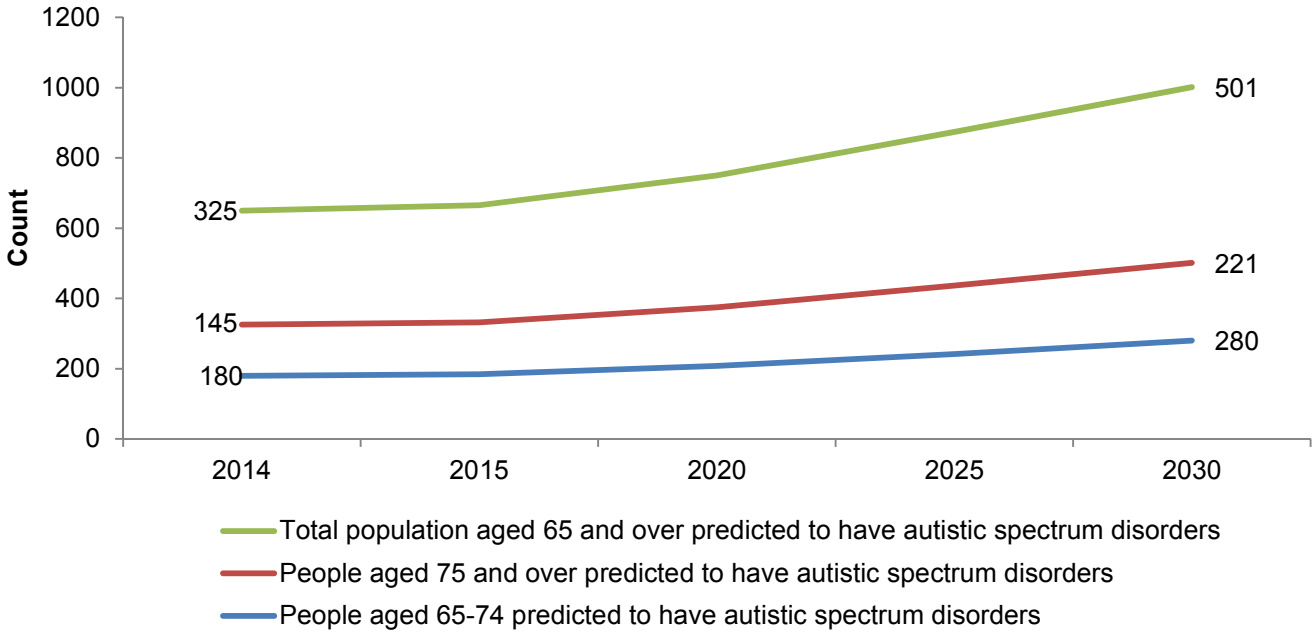


Figure 38: Adults aged 65 and over in Brent predicted to have an ASD. Source: POPPI

Although autism is a development disorder and not a learning disability, some people with autism may have an associated learning disability or mental health problem. It is estimated that 7.5% of adults with a learning disability may also be autistic[38].

[36] Emerson & Baines: The Estimated Prevalence of Autism among Adults with Learning Disabilities in England, 2010
[37] Autism Spectrum Disorders in adults living in households throughout England - report from the Adult Psychiatric Morbidity Survey 2007
[38] The Adult Psychiatric Morbidity Survey on autism and adulthood, 2007

Adults with learning disabilities

Between 2014 and 2030, the number of adults aged 18 to 64 with a learning disability is predicted to rise by 8%[39]. Furthermore, the number of adults aged 65 and over in Brent predicted to have a learning disability is projected to increase by 52% between 2014 and 2030[40].

Accommodation is a key factor for people with learning disabilities and settled accommodation can have a strong impact on quality of life, safety and social inclusion. In 2011/12, 73% of people aged 18 to 64 with a learning disability were living in settled accommodation in Brent (figure 39). This equates to 510 adults and is above the England average of 70% and the London average of 65.7%.

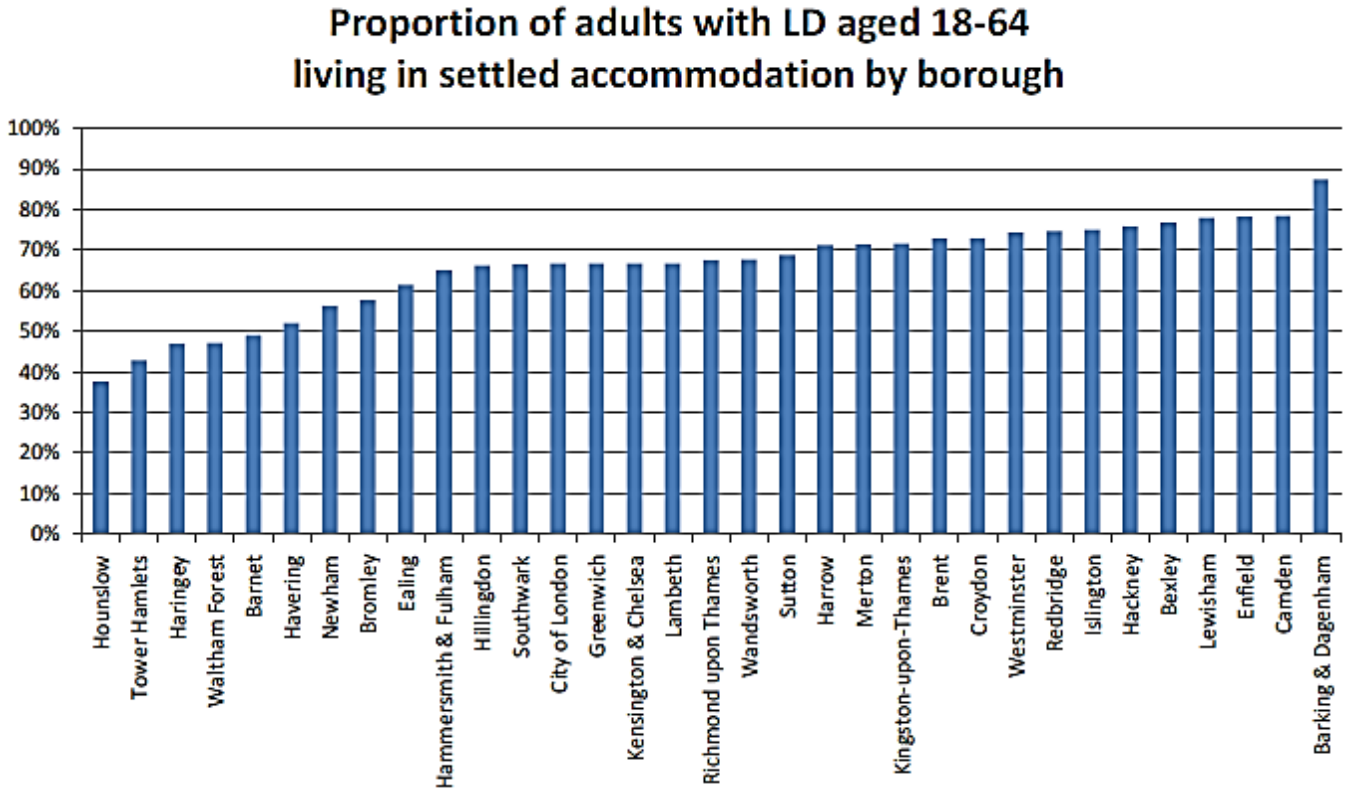


Figure 39: Source: NHS London Procurement Programme Purchased Healthcare Team: *Market Position Statement for Learning Disability Service Requirements and Provision in London* (April 2013). Data for 2011/12

Physical disability and sensory impairment

Level of need

Currently, 4% of residents in Brent regard themselves as being permanently sick or disabled[41].

[39] PANSI, 2014
[40] POPPI, 2014
[41] ONS 2011 census, the percentage of people aged 16 to 74 who were economically inactive and not working or seeking work as they were long-term sick or disabled

Estimates suggest that around 14,900 people in Brent aged between 18 and 64 years have a moderate physical disability[42]. This represents 7% of the total population who are aged between 18 and 64 years, which is similar to the England average of 8%.

Projections suggest that:

- By 2030, the number of people aged 18 to 64 in Brent who will have a moderate physical disability will be 16,725, an increase of 12% from 2014;
- By 2030, the number of people aged 18 to 64 who will have a severe disability will be 4,763, an increase of 16% from 2014;
- The number of people aged 65 and over who are unable to manage at least one self-care activity living on their own will rise to 17,590 in 2030, from 11,516 in 2014[43].

Incapacity benefit claimants and variations in Brent

There were 12,340 people in Brent claiming Incapacity Benefit (IB)/Severe Disablement Allowance (SDA) as of February 2014. This equates to 5.7% of the resident population aged 16 to 64 and is above the London average of 5.4% and below the Great Britain average of 6.2%[44].

Significant variations exist throughout the borough: the highest IB claimant rate was 12.3% in Harlesden, followed by 12.2% in Stonebridge. Kenton (3.7%) had the lowest proportion of claimants[45] (figure 40).

[42] PANSI, 2014 estimates
[43] PANSI and POPPI forecasts for 2030
[44] DWP benefit claimants - working age client group
[45] ONS benefit claimants - working age clients for small areas, February 2014

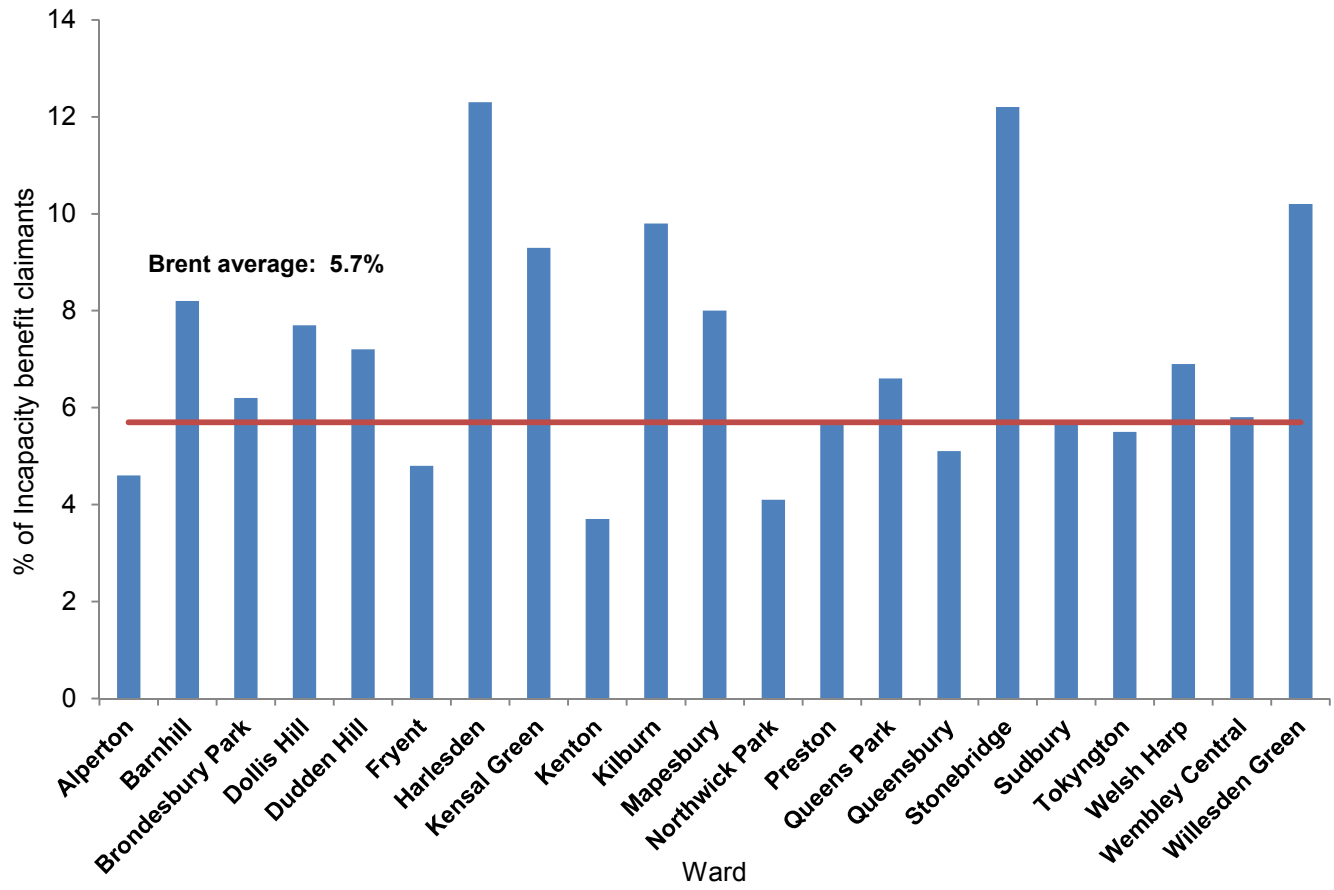


Figure 40: Incapacity benefit claimants for Brent wards (February 2014). Source: ONS benefit claimants

Hearing impairment

Current estimates suggest that 20% of people aged between 65 and 74 are living with a moderate or severe hearing impairment in Brent[46]. With age, the incidence of people with a hearing impairment increases in Brent. Estimates show that 11,065 people in the borough aged 75 and over have a moderate or severe hearing impairment[47].

Visual impairment and sight deterioration

As with hearing impairment, sight loss can affect people of all ages and can impact a person's independence. Older people are particularly at risk of sight loss. Around 2 million people in the UK live with sight loss and by 2050 this is predicted to double to 4 million.

Current estimates show that 2,021 people aged 75 years and over in Brent are predicted to have a moderate or severe visual impairment (figure 41). This represents 12% of the population aged 75 years and over in Brent.

By 2030, 3,001 people aged 75 and over are predicted to have a moderate or severe visual impairment. This equates to a 48% increase on current predictions.

[46] POPPI estimates for 2014
[47] POPPI estimates for 2014

Age range and level of visual impairment	2014
People aged 18-24 predicted to have a serious visual impairment	19
People aged 25-34 predicted to have a serious visual impairment	42
People aged 35-44 predicted to have a serious visual impairment	31
People aged 45-54 predicted to have a serious visual impairment	26
People aged 55-64 predicted to have a serious visual impairment	19
People aged 65-74 predicted to have a moderate or severe visual impairment	1,053
People aged 75 and over predicted to have a moderate or severe visual impairment	2,021
People aged 75 and over predicted to have registrable eye conditions	1,043

Figure 41: Levels of visual impairment among Brent residents aged 18 years and above. Source: PANSI

In Brent, the rate of sight loss due to glaucoma in those adults aged 40 and over was 13.8 per 100,000 of the population in 2012/13. This is above the England average of 12.5 per 100,000 of the population[48]. The risk of glaucoma is higher for the black African or black Caribbean population compared to the white population[49].

Other forms of visual impairment include diabetic eye disease, which relates to a series of eye problems that people with diabetes may be at risk of, as a complication of diabetes. In Brent, the rate of preventable sight loss due to diabetic eye disease in those individuals aged 12 and over was 4.5 per 100,000 of the population in 2012/13. This is above the England average of 3.5 per 100,000 of the population[50].

Research suggests that 50% of blindness and serious sight loss cases could be prevented if treated promptly[51]. In Brent, 1,530 people were registered blind as at 31 March 2014. Of these, 980 people (64%) are aged 75 and above[52].

Falls and hip fracture

Falls are a significant cause of disability and can contribute to mortality in people aged 75 and over in the UK. The rate of hip fractures among those people aged 65 and over in Brent is better than the England average in 2012/13. The Brent rate was 403 per 100,000 of the population aged 65 and over and the England rate was 568 per 100,000 of the population[53]. Between 2010 and 2013, the rate decreased by around 100 from 504.7 per 100,000 of the population to 403.1 per 100,000 of the population.

[48] Public Health England, PHOF: Healthcare and premature mortality indicators
[49] Bosanquet, N. (2010). *Libertaing the NHS: Making a reality of equity and excellence.* London: Imperial College
[49] Public Health England, Brent health profile 2014. Age-sex standardised rate of emergency admissions for fractured neck of femur in those aged 65 and over/100,000 of the population
[50] Public Health England, PHOF: Healthcare and premature mortality indicators
[51] Royal National Institute for Blind People (RNIB). Access Economics (2009), Future Sight Loss UK, Economic impact of Partial Sight and Blindness in the UK adult population
[52] HSCIC, Registered Blind and Partially Sighted People, year ending 31 March 2014 (published September 2014)
[53] Public Health England, PHOF

Older people's housing

Currently, 27% of people in Brent aged 65 and over live alone[54]. However, some significant variations exist across the borough (figure 42). In Wembley Central, only 16% (232 people) of the wards population aged 65 and over live alone whereas in Kilburn 40% (592 people) of the ward's population aged 65 and over live alone.

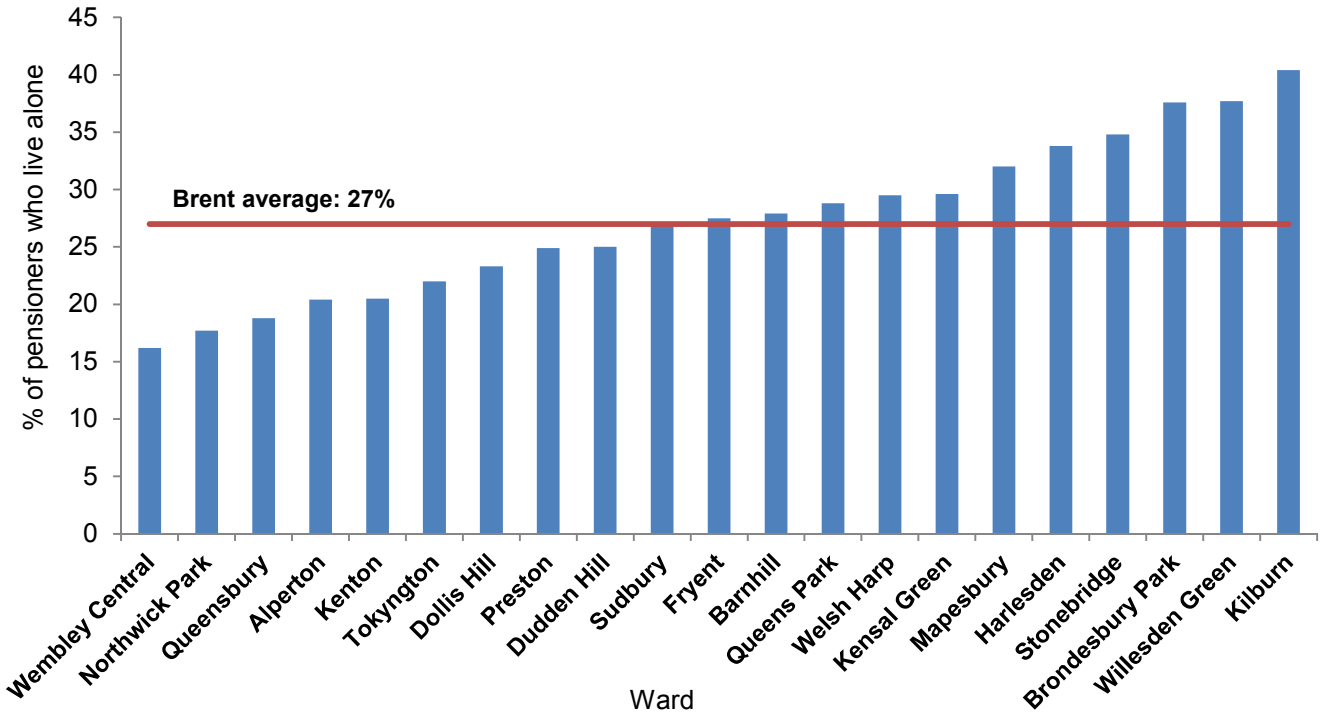


Figure 42: Pensioners (aged 65 and over) who live alone in Brent by ward. Source: ONS downloaded from NOMIS standard tables (QS114EW). Population aged 65 and over: ONS downloaded from NOMIS standard tables (KS102EW)

Estimates suggest that 721 people aged 65 and over were living in a care home either with or without nursing in 2014. By 2030, this is projected to rise to 1,189[55].

Figure 43 shows that the majority of the population in Brent aged 65 and over own a property.

Living status	People aged 65-74	People aged 75-84	People aged 85 and over
Owned	63.57%	66.78%	66.23%
Rented from council	11.91%	12.05%	11.07%
Other social rented	14.24%	12.53%	12.47%
Private rented or living rent free	10.28%	8.63%	10.23%

Figure 43: Living status of people aged 65 and over in Brent. Source: ONS 2011 census

[54] Pensioners living alone: ONS downloaded from NOMIS standard tables (QS114EW). Population aged 65 and over: ONS downloaded from NOMIS standard tables (KS102EW)
[55] POPPI, estimates for 2014 to 2030. ONS General Household Survey

Social isolation

In 2012/13, 39% of adult social care users in Brent experienced social isolation, which was below the England average of 43% and similar to the London average of 40%[56].

[56] Adult Social Care Users Survey, 2012/13 (based on responses to the survey question/indicator percentage of adult social care users who have as much social contact as they would like)

3. CHILDREN AND YOUNG PEOPLE

Population growth among children and young people

Children and young people under the age of 20 years constitute 25% of the population of Brent. The 'early years' of a child's life are particularly important in shaping future health outcomes. Key factors, such as income, housing, education and other socioeconomic issues can particularly affect young people during their earliest years of life. The underlying growth of the child population in Brent is a key factor which needs to be considered when designing and providing services to improve the health and well-being of children and tackling health inequalities. Between 2001 and 2011, in terms of broad age groups, the 0 to four-year-olds experienced a 38% increase, the 5 to 9s 16%, the 10 to 14s 9%, and the 15 to 19s 12%. The child population in Brent is predicted to increase over the next five years and beyond.

Projections show that there will be 83,400 children in Brent aged between 0 and 19 in 2020, which represents an increase of 6% based on current estimates[57]. Population projections show that the number of 0 to five-year-olds is due to peak in 2015 and 2016 in Brent at 29,000 children[58]. Of these, 15,000 are male and 14,000 are female. These changes are likely to impact on future schooling arrangements in Brent and should be considered alongside other related issues such as the projected availability of school places.

Children and young people in Brent: key statistics	
*Live births in Brent, 2012***	5,340
*Children (aged 0 to 4), 2012***	23,200
*Children (aged 0 to 19), 2012 ***	78,900
*School children from minority ethnic groups, 2013***	33,537
*Children living in poverty^ (aged under 16), 2011 ***	28%
*Percentage of live and still birth babies weighing less than 2,500g, i.e. a low birth weight, 2012***	9%
Number of first time entrants to the youth justice system, 2012**	210
*Hospital admissions for mental health conditions (0 to 17 years), 2012/13***	45
*Number of hospital admissions as a result of self-harm (10 to 24 years old), 2012/13***	65
*Number of children killed or seriously injured in a road traffic accident, 2010 to 2012***	8
*A&E attendances (0 to 4 years), 2011/12***	23,082
*Average number of looked after children being seen by Brent Child and Adolescent Mental Health Service (CAMHS), between April and June 2013****	93-74
*Number of looked after children in Brent, March 2014*****	349

^ denotes % of children aged under 16 living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income, 2011
**data sourced from Public Health England, child health profile for Brent 2014 (ChiMat)
***data sourced from Brent Child and Adolescent Mental Health Service (CAMHS)
**** figures obtained from LB Brent Children and Young People department

[57] Public Health England, child health profile for Brent 2014
[58] Greater London Authority (GLA): population projections for 0 to five-year-olds by local authority

Health improvement and prevention of ill health among children and young people

Low birth weight

Evidence shows that children who are born to mothers from low income and/or poor educational levels are increasingly likely to be premature or low birth weight babies. In these circumstances, a child is at a greater risk of infant mortality, morbidity and impaired cognitive development when compared to babies of normal birth weight. The percentage of live and stillbirths weighing less than 2,500 grams born in Brent in 2012 (9%) was worse than the national average (7.3%). Notably, the infant mortality rate in Brent is similar to the England average, whereas the child mortality rate is worse than the England average. Reported child mortalities in Brent have steadily increased over recent years from 26 deaths in 2009-2010 to 43 in 2012-2013[59].

Breastfeeding initiation

The percentage of mothers who initiate breastfeeding in Brent is higher when compared to the England average, with nearly 85% breastfeeding in Brent in 2012/13. The England average for the same period was 74%. At 6 to 8 weeks post-birth, the percentage of mothers in Brent (73%) who breastfed their babies remains significantly above the England average (47%).

Immunisation

In 2012/13, 92% of children received their initial dose of immunisation for measles mumps and rubella (MMR) by the age of two in Brent, which is similar to the England average (92.3%). At five years old, 88.4% of children received their second dose of MMR immunisation, which is similar to the England average (87.7%). Around 78% of children in care had an up-to-date immunisation record in 2013, which compares to the England average of 83%.

Oral health

Brent ranks among the poorest authorities in the country in oral health for children under five. In 2011/12, 45.9% of five-year-olds showed signs of dental decay, which is worse than the England average. Brent falls second after Enfield as having the highest tooth decay in London among five-year-olds[60]. It is recognised that a range of factors are associated with poor oral health among children in Brent. These include:

- Lack of frequent brushing
- Poor diet
- Poverty
- No fluoride treatment of tap water

Poor oral health among children under five in Brent presents a number of other associated concerns, which include higher rates of school absence and poor oral health going into adulthood. Furthermore, poor oral health can have other consequences to a child's overall well-being, resulting in reduced self-esteem and problems communicating with others. A number of oral diseases may result from poor dental hygiene, including gum disease and oral cancer. Tooth decay is the most common cause of non-urgent admission to hospital for children in Brent.

[59] Brent CCG Child Death Overview Panel, annual report: 2012-13
[60] Public Health England, PHOF, Healthcare and premature mortality indicators

Childhood obesity

Childhood obesity rates in Brent remain higher than the England average. In Brent, 11% of reception year pupils were obese in 2012/13 (figure 44) and 24% of year 6 pupils were measured as obese (figure 45). In England, the average rate of obese reception year pupils in 2012/13 was 9% and 19% for year 6 pupils. Childhood obesity is the single biggest predictor of adulthood obesity and can increase the risk factors for many clinical conditions throughout a person's whole life cycle. The percentage of overweight reception year and obese year 6 children in Brent has remained relatively steady since 2010/11.

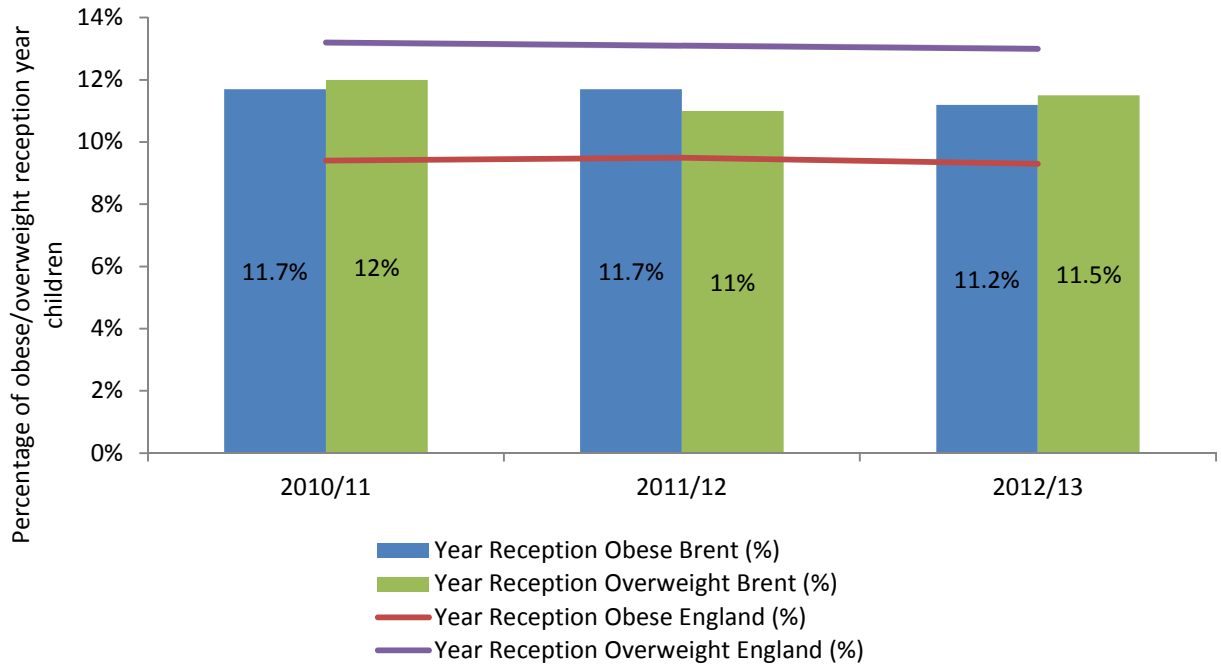


Figure 44: The percentage of children who are overweight and obese in Brent schools: Reception year

Figure 45: The percentage of children who are overweight and obese in Brent schools: Year 6

Source: NCMP, Health and Social Care Information Centre

Smoking in pregnancy

Smoking in pregnancy has well-known detrimental effects for the growth and development of a new born baby and can increase the risk of infant mortality by 40%[61]. Apart from reducing the risk of complications in labour, encouraging pregnant women to stop smoking during pregnancy may help them kick the habit for good, and thus provide long-lasting health benefits for both mother and child.

The prevalence of women who smoke at the time of delivery is much lower in Brent (4.3%) than the England average (12.7%) in 2012/13[62].

Children living in poverty

Approximately one third (28%) of children and young people (aged under 16 years) in Brent live in poverty. This is worse than the England average (20.6%) and also the London average (26.5%)[63]. In 2012, it was estimated that 42% of children lived in poverty in Stonebridge while in Kenton 10% of children are in poverty. Higher than average levels of child poverty are associated with a range of other closely related challenges. These include family homelessness, mental health problems and poor levels of concentration in school.

[61] Gardosi, J. et al. (2007). Stillbirth and infant mortality, West Midlands 1997-2005: Trends, factors, inequalities. West Midlands Perinatal Institute.
[62] Public Health England, health profile for Brent 2014
[63] Public Health England, child health profile for Brent 2014

Mental illness

Hospital admissions in Brent due to mental illness were lower than the England average in 2012/13 among individuals aged 0 to 17 years. Similarly, rates of hospital admissions due to self-harm amongst 10 to 24-year-olds were also lower than the England average in 2012/13.

Social Care

Child protection

At the end of March 2014 there were 230 children subject to a child protection plan, which was an increase on the figures from previous years, which were 213 (2011), 148 (2012) and 172 (2013). This figure is beneath the national average of 273 (2013) but above the London average (194 in 2013).

Looked after children

There were 349 looked after children in Brent at the end of March 2014. This compares to 385 in 2011, 360 in 2012 and 345 in 2013 and is indicative of an overall general decreasing number. This figure is beneath that of statistical neighbours, which was 367 at end of 2013[64].

Timeliness of adoption

There have been significant and consistent improvements in the time taken between a child becoming looked after and moving in with their adoptive family (for those children where adoption was the plan). At the end of 2011 it took an average of 827 days from becoming looked after to being placed with an adoptive family. By the end of 2014 this figure had reduced to 672 (based on three year average). The 2014 figure for the single year was 382 days.

Child sexual exploitation

Brent's high population mobility and highly diverse population would suggest risks in relation to child sexual exploitation activity. While there have been reported cases of child sexual exploitation, the police or the council are not currently aware of evidence of any systematic, organised abuse of boys or girls in Brent by groups or gangs of men of the kind that has been exposed in some towns in the north of England. However, during the period 2011 to 2014, 292 (29.6%) out of the 985 reports of sexual offences which occurred locally related to a victim under the age of 18.

There are concerns, however, that girls may be exploited within the gang culture in Brent. Addressing these concerns is a key part of Brent's overall strategy in regard to dealing with gangs.

[64] Figures obtained from LB Brent Children and Young People department

Education

Special Education Needs

As of August 2014, there were 1,721 children and young people in Brent identified as having a statement of special educational needs (SEN). These children have needs in any one or more areas related to learning, communication and sensory, physical or behavioural, social and emotional needs. A decreasing proportion of children with SEN receive a 'statement' (or from 1st September 2014 an Education, Health and Care plan (EHC plan)) because schools are resourced to meet all children's needs up to a threshold. The data on statements is however a helpful proxy for need in this area.

Number of pupils with SEN: 2011 to 2013

In 2013, 4% of the Brent school-age pupil population have a statement of SEN. The number of statutory assessments initiated for children under five following notification from the health authority increased from 45 in 2009 to 66 in 2013/14. This is partly due to better early identification but it is also an indication of more children being born with complex needs and having longer life spans due to improvements in medical science. Figure 46 shows that autism as a diagnosis is increasing.

SEN TYPE		TOTAL STATEMENTS				
		2010	**2011**	**2012**	**2013**	**2014**
ASD	*Autistic Spectrum Disorder*	262	240	298	302	347
MLD	*Moderate Learning Difficulty*	246	269	197	172	251
SLCN	*Speech, Language & Communication Needs*	191	221	244	248	234
SLD	*Severe Learning Difficulty*	149	173	176	209	148
BESD	*Behaviour, Emotional & Social Difficulty*	184	198	195	171	135
PD	*Physical Disability*	89	84	91	78	71
PMLD	*Profound & Multiple Learning Difficulty*	49	62	51	59	65
SPLD	*Specific Learning Difficulty*	53	61	66	59	49
HI	*Hearing Impairment*	28	25	29	36	30
VI	*Visual Impairment*	22	19	21	23	18
MSI	*Multi-Sensory Impairment*	3	4	6	8	5
OTH	*Other Need*	24	30	37	45	34
	OVERALL TOTAL	**1300**	**1386**	**1411**	**1410**	**1387**

Figure 46: 2010-14 SEN types of Brent resident pupils with statements at schools in Brent and neighbouring local authorities (Barnet, Camden, Ealing, Hammersmith and Fulham, Harrow, Kensington and Chelsea, and Westminster) by ethnic group. Only pupils with statements are counted, and only their primary SEN type is considered. Children attending independent schools and mainstream schools in other boroughs are not included. Source: All data is taken from the January school censuses (for the year specified) from Brent.

4. KEY HEALTH CHALLENGES IN BRENT

There are a number of particular health challenges in Brent, and some areas where the borough performs better than expected.

Tuberculosis

Brent has a high proportion of people born abroad including in countries with high rates of tuberculosis (TB). Rates of TB are amongst the highest in the country. Between 2010 and 2012, there were 102 cases of tuberculosis diagnosed in Brent. This represents a crude rate of 98.3 cases per 100,000 of the population compared to an England rate of 15.1 per 100,000 of the population and London rate of 41.4 per 100,000 of the population. More than 90% of those diagnosed with TB in Brent were born abroad with twenty percent having entered the country in the last 2 years. This suggests the majority of disease seen in Brent was reactivation of infection acquired in high prevalence countries, in particular India.

Studies from developed countries have shown worse (as opposed to neutral or improved) infectious disease outcomes following periods of economic crisis[65]. It is recognised that the economic downturn may have contributed to a recent increase in tuberculosis incidence in Brent. This may be due to poorer living conditions and lower treatment retention rates[66]. London has the highest TB rate of any capital city in western Europe and 21 boroughs have been rated 'high' by the World Health Organization in the past five years[67].

Adult obesity and type 2 diabetes

Obese and overweight adults put themselves at a greater risk of developing health conditions, such as type 2 diabetes.

In Brent, survey results suggest that 54% of adults are either overweight or obese[68]. Around 20% of Brent's adult population are obese, which is lower than the England average of 23%[69].

Type 2 diabetes rates in Brent are particularly high compared to other parts of the UK. The average recorded level of diagnosed diabetes on GP registers in England was 6% in 2012/13. Over the same period 7.8% of people on GP lists in Brent were recorded as having diabetes (23,030 people).

Brent saw a 38% increase in the prevalence of diabetes between 2008/09 and 2012/13. This is likely to be due to a combination of population growth, improved detection and recording on GP systems, as well as an increase in the actual prevalence. It is estimated that one in four people with diabetes in London are undiagnosed.

The prevalence of diabetes in Brent is projected to rise, fuelled by the ageing of the population, increasing numbers of people who are obese and overweight, and the high proportion of black and south Asian ethnic groups in the borough who are more susceptible to diabetes. By 2030, it is estimated that nearly 15% of people aged 16 and over in Brent will

[65] Suhrcke, M. and Stuckler, D. (2010). Will the recession be bad for our health? A review of past experiences. Report prepared for ECHAA
[66] Public Health England (Knowledge and Intelligence Team), Brent: A profile of socio economic determinants of health during the economic downturn (published 11 February 2014)
[67] London Health Programmes (2011) Case for change. TB services in London
[68] Sport England, 2012 Active People Survey
[69] Public Health England, Brent health profile 2014

have diabetes compared to the predicted England average of about 9%, as illustrated in figure 47.

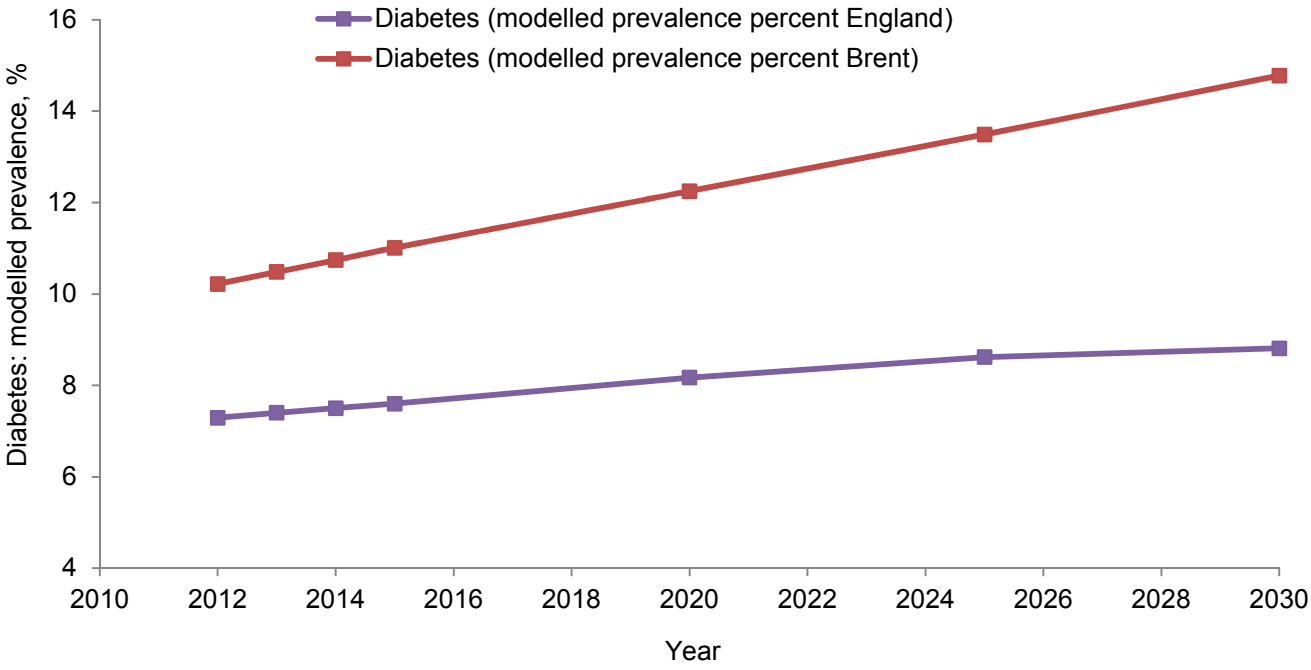


Figure 47: Modelled estimated prevalence of diabetes in Brent versus England, 2012-2030. Source of data: Public Health England (national cardiovascular intelligence network), Diabetes Prevalence Model for Local Authorities and CCGs

Estimates show that around 17% of all deaths in Brent are attributable to diabetes. People with diabetes are at risk of a range of complications, including heart disease, strokes, foot disease, which may necessitate amputation, kidney disease and loss of sight. Early diagnosis, good diabetic care and self-management can reduce the risk of complications. Rates of diabetes complications are low in Brent compared to the national picture.

Emergency hospital admissions by ethnicity

Hospital related admissions in 2012/13 that were regarded as emergencies varied quite significantly by ethnicity in Brent. Figure 48 identifies that the England average for all ethnic groups was 40.8%. Variations can be seen for each ethnic group in Brent with 'other' ethnic groups' (46%) and the black group (45%) reflecting the highest percentage of hospital admissions overall in Brent*.

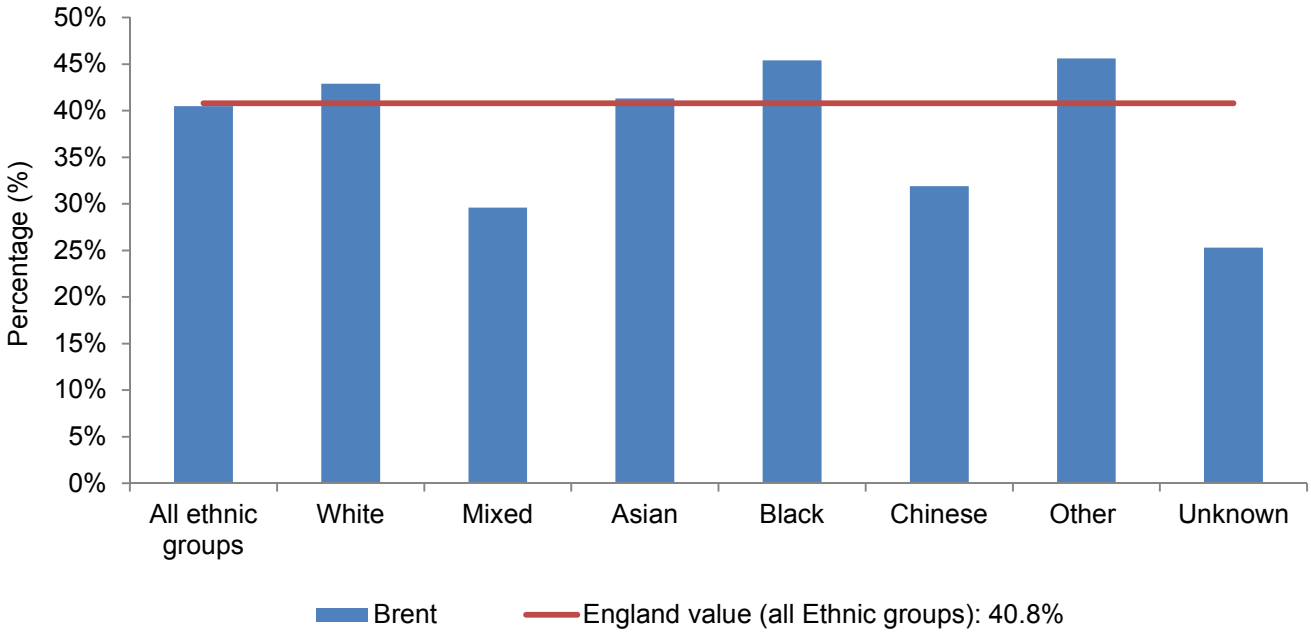


Figure 48: Percentage of hospital admissions by ethnicity, 2012/13. Source: Public Health England 2014 health profile. *Figures based on small numbers of admissions have been suppressed to avoid any potential disclosure of information about individuals.

Notably, a high proportion of emergency admissions may demonstrate that some patients are not accessing or receiving the care most appropriate to managing their condition effectively.

Domestic violence and violence against women and girls

In 2012/13, the rate of domestic abuse incidents recorded by the police in Brent was 18.6 per 1,000 of the population. This is higher than the London average of 18.5 per 1,000 of the population but lower than the England average of 18.8 per 1,000 of the population.

Notably, the number of domestic incidents[70] (non-criminal and criminal offences falling within the Home Office definition of domestic violence and abuse) in Brent as reported by the Metropolitan Police has gradually increased during the period 2005/06 to 2013/14. However, during this period domestic offences (criminal offences falling within the Home Office definition of domestic violence and abuse) have stayed reasonably consistent at around 2,000 offences annually (figure 49).

[70] Data from Home Office: Domestic violence and abuse (revised definition). The cross-government definition of domestic violence and abuse is as follows: *any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality*. *The abuse can encompass, but is not limited to psychological, physical, sexual, financial, and emotional.* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/142701/guide-on-definition-of-dv.pdf

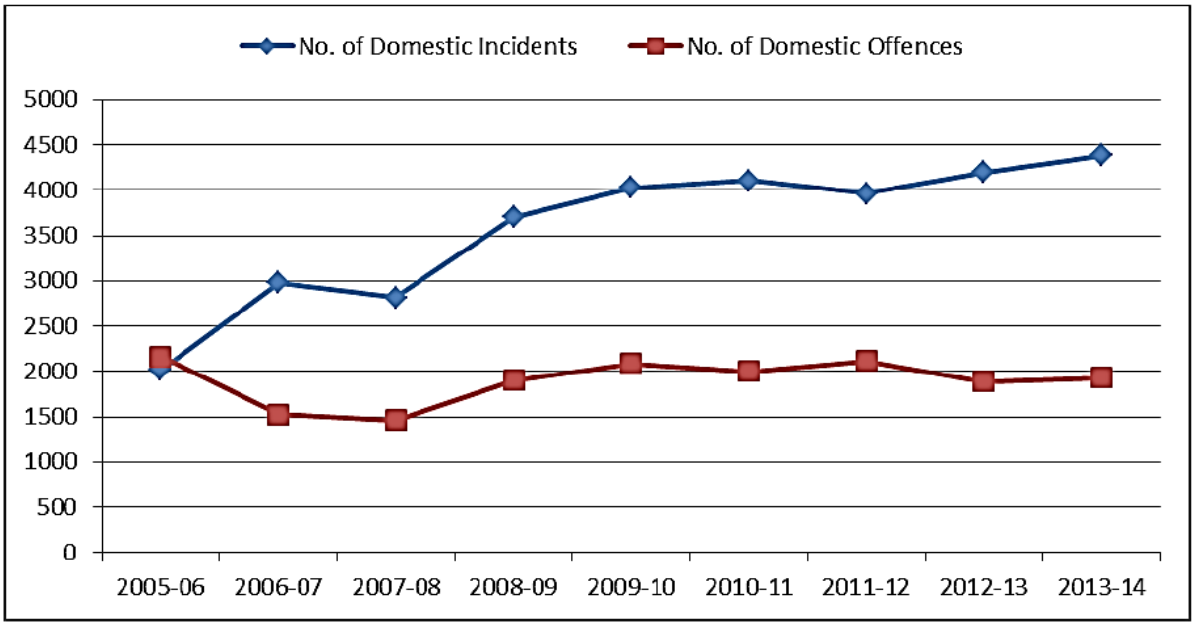


Figure 49: Number of Domestic Incidents and Offences per Financial Year (2005/06 to 2013/14). Source: LB Brent Community Safety Team

Violence against women and girls including Female Genital Mutilation (FGM), Honour-Based Violence (HBV) and Forced Marriages are a key priority for the Brent Safer Partnership. As some communities in the borough have strong links to other parts of the world, where such practices still prevail, it is recognised that these offences are considerably under reported locally. Research suggests that over 5,000 women and children in Brent are at risk of, or have already undergone, FGM[71]. As such, the council and its partners recognise the importance of mapping out the extent of these practices across the borough to ascertain a true picture of the total number of women and children at risk.

Forced marriage

A forced marriage is where one or both people do not consent to the marriage and pressure or abuse is used[72]. In 2013, the national Forced Marriage Unit advised 1,302 cases related to forced marriage[73]. Cases from London accounted for 24.9% of all cases; 15% of all calls involved cases under the age of 16. The countries of origin of those involved varied, with the highest percentage of cases from Pakistani (42.7%), Indian (10.9%) and Bangladeshi (9.8%) backgrounds, and a smaller number from Afghanistan (2.7%) and Somalia (2.5%). Brent has large Pakistani, Indian and Bangladeshi populations, with potential young girls at risk. In 2012/13 30 cases of forced marriage were identified in Brent by social services; the Asian Women's Resource Centre and Brent MET Police[74].

[71] Tackling violence against women and girls in Brent: An overview and scrutiny task group report, March 2014
[72] www.gov.uk/forced-marriage
[73] Forced Marriage Unit 2013 stats
[74] LB Brent Overview and Scrutiny Task Group Report: Tackling Violence against Women and Girls in Brent, March 2014

Smoking prevalence

The estimated prevalence of adults who smoked in Brent (15.2%) in 2012 is better than the England (19.5%) and London averages (18%)[75]. Estimates of smoking prevalence in Brent vary by ward from 11.7% in the least deprived neighbourhoods to 25.9% in some of the most deprived neighbourhoods[76]. In 2012, smoking prevalence among the routine and manual workforce aged 18 years and over in Brent (14.2%) was significantly lower than the England (29.7%) and London averages (25.7%)[77]. Evidence suggests that the number of shisha premises (licenced and un-licenced) is growing in Brent. Furthermore, the majority of these premises are not complying with the requirements of the Health Act (i.e. less than 50% enclosed)[78].

Smoking-related deaths

Rates for smoking-related deaths in Brent are lower than the England rate. The rate of smoking-related deaths in Brent for people aged 35 and over was 228 per 100,000 of the population, or 241 deaths between 2010 and 2012. In England the rate was 292 per 100,000 of the population aged 35 and over for the same period[79].

Alcohol use and abuse in Brent

In Brent, 31.4% of the population aged 16 and over abstain from alcohol use, almost twice the national average (16.5%). However, a larger proportion of the population in Brent are high-risk drinkers (7.1%) compared to the national average (6.7%)[80].
Out of a total of 326 Local Authorities in England, Brent is ranked 323 for alcohol-related recorded crimes and violent crimes and 253 for male alcohol-specific hospital admissions[81].
Alcohol-specific hospital admissions for women in Brent are comparable to those for England. However, the rate for males is significantly higher than the England average[82].
In 2012/13, there were 1,352 hospital stays for alcohol related harm in Brent, a rate of 518 per 100,000 of the population, which is better than the England average rate of 637 per 100,000 of the population[83].

Drug misuse

In 2010/11, there were an estimated 1,858 users of opiates and/or crack cocaine aged 15 to 64 in Brent. This equates to a crude rate of 8.7 users per 1,000 of the population, which is similar to the England rate of 8.6 per 1,000 of the population. The worst performing local authority area in England had a rate of 26.3 per 1,000 of the population and the best was 0.8 per 1,000 of the population[84].

[75] Public Health England, PHOF: Health improvement indicators
[76] LHO Practice Profile, 2008: Estimates of smoking prevalence by general practice
[77] Public Health England, PHOF, Local Tobacco Control Profiles for England
[78] Evidence from Regulatory Services, LB Brent
[79] Public Health England, Brent health profile 2014
[80] Public Health England, Alcohol Learning Resources (Alcohol Learning Centre website)
[81] Local Alcohol Profiles for England (LAPE). Note: rank 1 is the best Local Authority in England
[82] LAPE. Alcohol attributable hospital admission rate for males in Brent: 1,637 per 100,000 of the population;
London 1,423 per 100,000 2009/10
[83] Public Health England, Brent health profile 2014
[84] Public Health England, Brent health profile 2014

Sexually transmitted infections

In 2012, there were 4,413 sexually transmitted infections (STIs) diagnosed in Brent, a rate of 1,413 per 100,000 of the population, which is considerably higher than the England average of 804 per 100,000 of the population[85]. In particular, Brent currently has high rates of chlamydia, genital warts and gonorrhoea diagnoses (figure 50).

	Brent Rate: 2010	Brent Rate: 2011	Brent Rate: 2012	London Rate: 2012	England Rate: 2012	Rank within England 2012
All STIs	1523.6	1602.4	1413.3	1336,7	803.7	21
Chlamydia	537.5	421.5	464.7	512.2	371.6	55
Gonorrhoea	95.1	76.9	123.0	129.8	45.9	17
Syphilis	12.9	13.1	13.8	17	5.4	19
Genital Warts	157.5	151.5	141.2	167.9	134.6	90
Genital Herpes	113.0	102.8	104.1	91.4	58.4	12

Figure 50: Rates per 100,000 of the population of all ages of STIs in Brent: 2010-2012

HIV in Brent

In Brent, there were 886 people living with diagnosed HIV in 2013 (aged between 15 and 59)[86]. Late diagnosis of HIV is associated with a worse prognosis and an increased risk of onward transmission. In Brent, 56% of HIV diagnoses are at a late stage, compared to 52% in England and 50% in London.

There are a number of key groups who are most at risk of poor sexual health: young people aged 15 to 24 years, men who have sex with men (MSM), black and black British communities and sex workers. As elsewhere, STIs are more prevalent in those parts of the borough with high deprivation (70% of STIs in 2011 were in the borough's first and second most deprived LSOAs).

Teenage pregnancy

Brent had a lower teenage conception rate compared to the England and London averages in 2012 (figure 51). There were 104 conceptions among females in Brent who were aged between 15 and 17 years; a crude rate of around 20 conceptions for every 1,000 women aged between 15 and 17 years[87]. The England rate in 2012 was 27.7 per 1,000 females aged 15 to 17 and the London rate was 25.9 per 1,000 females aged 15 to 17. Notably, Brent has remained below the England and London averages since 2005.

[85] Public Health England, Brent health profile 2014
[86] Public Health England, data from the Survey of Prevalent HIV Infections Diagnosed (SOPHID)
[87] Public Health England, Brent health profile 2014

Figure 51: Conception rate per 1,000 women aged 15 to 17 years, 2000 to 2012.
A comparison between Brent, London and England. Source: ONS Conception Statistics, England and Wales 2012 (published February 2014)

FURTHER READING

NHS Brent CCG and LB Brent documents

The key supporting documents produced by NHS Brent CCG and LB Brent which were used to inform and develop the content of the JSNA and provide a detailed understanding of Brent's diverse population and its communities include the following:

The Brent Health and Wellbeing Strategy, 2014 to 2017. NHS Brent CCG and LB Brent http://brent.gov.uk/your-council/about-brent-council/council-structure-and-how-we-work/strategies-and-plans/health-and-wellbeing-strategy/

Brent Diversity Profile: Our population, July 2014. Compiled by LB Brent Research and Intelligence Team https://intelligence.brent.gov.uk/Pages/Search.aspx?k=diversity&cs=This%20Site&u=https%3A%2F%2Fintelligence.brent.gov.uk

The 2011 Census: A Profile of Brent. Compiled by LB Brent Research and Intelligence Team https://intelligence.brent.gov.uk/Pages/DocumentDisplayView.aspx?ItemID=289

Brent Sexual Health Needs Assessment and Service Review, 2013. Report compiled by Ottaway Strategic Management ltd

Brent CCG Child Death Overview Panel, annual report: 2012-13

Tackling violence against women and girls in Brent, an overview and scrutiny task group report March 2014

Other key data sources

Public Health Outcomes Framework: http://www.phoutcomes.info/

Evidence search: https://www.evidence.nhs.uk/

Public Health England: https://www.gov.uk/government/organisations/public-health-england

Health and Social Care Information Centre: http://www.hscic.gov.uk/

UCL Institute of Health Equity: http://www.instituteofhealthequity.org/

Local Alcohol Profiles for England (LAPE): http://www.lape.org.uk/

Office for National Statistics: http://www.ons.gov.uk/ons/index.html

Nomis: https://www.nomisweb.co.uk/

Brent	**Health and Wellbeing Board** 18 November 2014 **Report from the Assistant Chief Executive**
For Action	Wards Affected: ALL

Tackling Violence against Women and Girls in Brent - Action Plan Update

1.0 Summary

1.1 Between March 2013 and March 2014, a Scrutiny task group was convened to examine the issues of violence against women & girls in Brent, focusing on the issues of Female Genital Mutilation (FGM), Honour Based Violence (HBV) and Forced Marriages (FM).

1.2 The task group identified 12 recommendations, which were reported to the council's Cabinet in March 2014.

1.3 Recommendation 2 of the task group report states:

That work in relation to the implementation of the Harmful Practices Strategy is the responsibility of:

- The Local Children's Safeguarding Board
- The Health and Wellbeing Board
- Safer Brent Partnership
- The Assistant Chief Executive Department will take the overall lead responsibility

In accepting and welcoming the report, Cabinet asked that the Assistant Chief Executive's service co-ordinate the development of an action plan to tackle these issues identified in the scrutiny report.

2.0 Recommendations

2.1 The Health and Wellbeing Board acknowledges and agrees to the content of the action plan **(Appendix 1)** for implementation.

2.2 The Health and Wellbeing Board continues to support the work and activities taking place as part of the action plan.

2.3 The Health and Wellbeing Board encourages these actions to be imbedded in the future planning of services.

3.0 Detail

3.1 Discussion Group

In order to produce a multi-agency action plan, a discussion group was formed to identify and evaluate the actions required to implement the recommendations. The discussion group consisted of representatives from across the following partners:

- Brent Assistant Chief Executive Service
- Brent Adult Social Care
- Brent Children's Social Care
- Brent Local Children's safeguarding
- Brent Public Health
- Brent Community Safety
- Brent Equalities
- Brent Geographical Information Service
- Brent Police
- Brent Multi-Agency Front Door
- Brent CVS
- ADVANCE/Hestia Housing
- Clinical Commissioning Group
- North West London Hospital Trust

3.2 Developing the Action Plan

At the time that the task group's findings and report was presented to scrutiny, many good pieces of work were already happening within the borough. Brent and its partners were delivering pockets of excellent service and we needed to identify this work, and opportunities to build on it, across Brent. The action plan brings together and co-ordinates existing work already planned and being delivered across the borough and identifies a number of new priorities and actions, all designed to address the twelve recommendations made by the scrutiny task group.

The action plan reflects the priorities laid out in the Safer Brent Partnership Strategy Priority 6: Reducing Violence against Women's (VAWG); the action plan is also in alignment with the LSCB's Vulnerable Group's work.

Some actions within the plan require ongoing work and this is to be expected if we wish to successfully imbed these actions and processes into future service delivery and commissioning.

4.0 Financial Implications

4.1 None

5.0 Legal Implications

5.1 The council has a legal obligation to eliminate discrimination, to which this work focuses on reducing the unfair treatment of women and girls.

6.0 Diversity Implications

6.1 The work out lined in the action plan will have positive impacts on Brent's communities and drive services; which will improve the rights and outcomes for women and girls.

7.0 Staffing/Accommodation Implications

7.1 The following services have agreed to provide support to complete the actions laid out in the action plan:

- Brent Adult Social Care
- Brent Children's Social Care
- Brent Local Children's safeguarding
- Brent Public Health
- Brent Community Safety
- Brent Equalities
- Brent Communications
- Brent Community Engagement
- Brent Geographical Information Services
- Brent Schools Improvement Services
- Brent Police
- Brent Multi-Agency Front Door
- Brent Head Teachers Partnership
- Brent CVS
- ADVANCE/Hestia Housing
- Clinical Commissioning Group
- North West London Hospital Trust

Background Papers
Task Group Report – Tackling Violence against Women and Girls in Brent
http://brent.gov.uk/media/9338057/Tackling-VAWG-in-Brent-TG-Report.pdf

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APPENDIX 1

Tackling Violence against Women & Girls in Brent – Action Plan **Key: (L) Lead Office (P) Partner**

Recommendation And RAG Status	Actions	Lead and partner	Outcomes	Time-frame	Progress Milestones	Key Performance Indicators – how will progress be monitored?
1. **That tackling harmful practices becomes a high partnership priority within Brent and that a clear partnership strategy is developed within the context of the wider Violence against Women and Girls Strategy.**	• Extend the scope of Safer Brent's Violence Against Women and Girls Strategy to address FGM, HBV and FM • Establishing what London Councils' Ascent Ending Harmful Practices pays for in Brent. What the referral pathways look like, the service offer locally and how Community Safety can help publicise these through our planned communication products	Ben Spinks **(L)** Clare Brighton & Chris Williams **(P)** Police (Mike West?) **(P)** Schools (Stephen McMullan/ Allyson Moss)**(P)** Fiona Kivett – H&WBB **(P)**	Clear mapping of services & referral details Picture of current demand and any gaps Picture of how this relates to other commissioned prevention, or intervention services within the borough Clear mapping of services & referral details	June 13th	Email response from London Councils and project lead at Asian Women's Resource Centre – 12/05/14	**This rec will be monitored through updates to the Scrutiny Committee and:** • **LSCB** • **ASB** • **BSP** • **H&WBB** **As VAWAG is a borough priority it will also be monitored though the Brent Corporate Plan**
1.1 **Developing services to protect women and girls at risk**	HESTIA HOUSING – Working in Wembley Police Station, the Council's Locality and	HESTIA HOUSING Louise Bayston – **(L)** Public Health - Melanie Smith **(P)**	Reaching more women and girls who are at risk and require protection	**Ongoing**	Needs further discussion - Discussion group to consider	**This rec will be monitored via the community safety strategy KPI's**

Recommendation And RAG Status	Actions	Lead and partner	Outcomes	Time-frame	Progress Milestones	Key Performance Indicators – how will progress be monitored?
	Family solution teams Health – Update on new services in Brent for Women & girls (Tender) Discussions with CCG Working with schools to invite HESTIA HOUSING and ASCENT via, Forward & the Asian Women's Resource centre into schools to deliver training • Prevention • Protect • Provision Include FGM, FM & HBV awareness raising and signposting to support services in specification for non-mandated sexual health services	Police - Mike West **(P)** Schools Improvements - Stephen McMullan **(P)** Head Teachers – Allyson Moss**(P)**				
1.2 Developing services to support women and girls subjected to harmful practices **Please also refer to Recommendation 12**	Hestia Housing – Update on new services in Brent for Women & girls (Tender) Working with schools to invite ASCENT via Forward & the Asian Women's Resource	HESTIA HOUSING – Louise Bayston **(L)** Public Health - Melanie Smith **(P)** Police - Mike West **(P)** Schools Improvements - Stephen McMullan **(P)**	Increased awareness of FGM, HBV & FM and signposting to support services	**For procurement for 2015/2016**	As procurement plan	To be confirmed during procurements. Community Safety DV & VAWAG Strategy

Recommendation And RAG Status	Actions	Lead and partner	Outcomes	Time-frame	Progress Milestones	Key Performance Indicators – how will progress be monitored?
	centre into schools to deliver training	Head Teachers – Allyson Moss **(P)**				
1.3 Robust recording and better quality of data and sharing of data from all partners	Agree a key set of data that will be shared by all partners, in a robust manner and on a regular basis (quarterly) Who will maintain and co-ordinate this data? Should we be collecting data for the Voluntary sector? HESTIA HOUSING to investigate recording FGM data Data Hub identified as a possible place to upload and publish data Performance + is another possibility LSCB Data Set is another possibility	Gloria Rowland – NWL NHSE **(P)** Police - Mike West **(P)** Schools Improvements - Stephen McMullan **(P)** Head Teachers - Kay Charles **(P)** HESTIA HOUSING- Louise Bayston **(P)** GIS - Anne Kittappa **(P)** Sue Matthews **(P)**	**Brent partners along with voluntary organisation recommended by Brent CVS to collect and share data on a quarterly basis** **LSCB have agreed in principal (subject to LSCB agreeing) to report the collated data as part of their Dataset. Data will be submitted by the agreed partners** ***It has been decided that The Business Intelligence team will be best place to take responsibility for collating and analysing the data**	**Can we start from January?? Or do we begin in the new financial year. Oct/Nov 14**	Discussed approach needs confirmation and a decision on who will lead on this	**Quarterly reporting to Brent Hub/P+/LSCB Data Set of agreed data???**
1.4 Clear and consistent guidance for reporting risk, pathways for	Embed FGM and VAWG into CCG Safeguarding children training Embed FGM multiagency	Multi Agency Front Door – Mike West **(L)** HESTIA HOUSING –	Clear and consistent guidance for all staff across the Brent health community including	**Sept 14-Onwards**	• Multiagency Risk assessment tool in place,	LSCB/Community safety KPI's

Recommendation And RAG Status	Actions	Lead and partner	Outcomes	Time-frame	Progress Milestones	Key Performance Indicators – how will progress be monitored?
referrals and services* ***Note: The following Recommendations and outcomes are linked: 1.4 and 1.5 and 1.6. Focusing on signposting clients to agreed local and national services**	risk assessment tool 24 hour MAFD access, HESTIA HOUSING and NSPCC line (will promote through all relevant services)	Louise Bayston **(P)** Sue Matthews – LSCB **(P)** Mala Maru– Comm. Safety **(P)** Gloria Rowland - NHS **(P)** and Pauline Fletcher	multiagency risk assessment pathways		now signed of at LSCB P&P subgroup; LSCB to roll out across partners and imbed in practice's • Brent CCG staff aware of tools	
1.5 **Provide clear guidance to all key staff and the public on how to report a crime against a woman affected by these issues.**	Internet/intranet pages on harmful practices where to access additional support & services Update guidance using London Child Protection Procedures and make available to all services (web)	Sue Matthews – LSCB **(L)** Claire Solley – Adult SG **(P)** Mala Maru– Comm. Safety **(P)** HESTIA HOUSING – Louise Bayston (P)	**As above - linked to 1.4 1.6**	**Sept 14 - Onwards**	**As above - linked to 1.4 1.6**	**As above - linked to 1.4 1.6**
1.6. **A single point of contact is established for those affected**	24 hour MAFD access HESTIA HOUSING and NSPCC line (will promote through all relevant services)	Multi Agency Front Door – Mike West **(L)** Front Door/MASH for children, Adults PH? Solley – Adult SG **(P)** HESTIA HOUSING – Louise Bayston (P)	**As above - linked to 1.4 1.5**	**Sept 14 - Onwards**	**As above - linked to 1.4 1.5**	**As above - linked to 1.4 1.5**
1.7. **The adoption of good practice from elsewhere, health service, local**	Reach out to other organisations, partners and schools inside and outside of Brent, and establish best practices	**Kisi Smith-Charlemagne (L)**	A number of Schools have reached out to Stonebridge school (recommended in the task group report) and	**On going**		Approach/reach out to other organisations to review best practice in 6 month's time, to ensure they are

Recommendation And RAG Status	Actions	Lead and partner	Outcomes	Time-frame	Progress Milestones	Key Performance Indicators – how will progress be monitored?
authorities, voluntary sector organisations and educational institutions.	HESTIA HOUSING – Building closer partnership working with Health services, based on a successful model working in the LB Hammersmith& Fulham	HESTIA HOUSING – Louise Bayston **(P)**	have used their safeguarding policy to update their own and are following the steps used to approach the topics in their own schools. The policy team have been working with LB Islington on a number of items: • Developing mapping and data • Partnership working • Implementing changes into policy			learning from each other Best practices organisation approached: Bristol (FGM), Birmingham (FM, HBV)
2. **That work in relation to the implementation of the Harmful Practices Strategy is the responsibility of:** **• Local Safeguarding Children Board (LSCB)**	The Action Plan is being developed by a multiagency group, with the Assistant Chief Executive's Department co-ordinating all actions across the three main groups	Ben Spinks **(L)** Chris Williams **(P)** Sue Matthews **(P)** Fiona Kivett **(P)**	Action Plan 40% Completed	July/August	This has been agreed. Need a new representative from the Health and Wellbeing Board in the discussion group	The Assistant Chief Executive's Department will review all progress 6 months after the finalisation of the action plan

Recommendation And RAG Status	Actions	Lead and partner	Outcomes	Time-frame	Progress Milestones	Key Performance Indicators – how will progress be monitored?
• The Health and Wellbeing Board • Safer Brent Partnership •The Assistant Chief Executive Department will take the overall lead responsibility						
3. That mapping of practising communities is undertaken to establish the number of women and girls at risk and should be undertaken as part of the Safer Brent strategic assessment process. This work should be completed using tested methodologies, such as those used by Forward and in coordination with Brent's partners and specialist charities such as Forward, the Asian Women's Resource Centre, the Jan Trust and the Iranian and Kurdish Women's Rights Organisation (IKWRO).	• Establish what demographics are at risk of being harmed by FGM, HBV and FM. • Using schools data and 2011 Census data, identify the number of women and girls at risk, and geographically map them across the Borough. • Ward Mapping FGM is also being completed • New member of staff to start with the GIS Team who comes from Public Health, Will develop the FM and HBV mapping	Alisdair Maclean – GIS **(L)** Anne Kittappa– GIS **(P)**	The Council and relevant stakeholders would have a greater idea of the number at risk of harmful practices, and also the areas where they may be most prevalent, allowing awareness raising to be targeted for greater effectiveness. Current drafts for FGM mapping sent to discussion group, partners and rep form Brent Head Teachers Partnership Working with Islington Council to enhance mapping and use of data	FGM mapping to be completed by June 2014, HBV and FM mapping to follow in Mid-Sept/Oct	Draft Maps presented - Brent Head Teachers Conference and has been very successful in raising awareness of risk for FGM	**Production of map – may require annual updates**
4.	• Use partnership	Carol Allen – Comm.	• Better informed	Ongoing,	• July WoA	Evaluation forms from:

Recommendation And RAG Status	Actions	Lead and partner	Outcomes	Time-frame	Progress Milestones	Key Performance Indicators – how will progress be monitored?
That a programme of community engagement about violence against women focussing on harmful practices is developed which ensures that members of affected communities play a lead role. Awareness raising events should be aimed at all sections of the local community, partners, relevant staff and Council Members.	'Weeks of Action' events to promote and engage with communities about Violence Against Women agenda • Work with community partners to identify opportunities for partner agencies to get involved • Raise awareness about referral routes for safeguarding and protection issues at Brent Connects meeting and community events • Facilitate the showing of a theatre production on the subject of FGM called 'Little Stitches' in Wembley Library • FGM Community Awareness Sessions • HESTIA HOUSING - Prevention work with Women. • Adult SG basic awareness training now includes FGM, FM and HBV.	Engagement **(L)** Sarah Kaiser-Equalities **(P)** • **FORWARD UK (P)** • **By Us For Us. FGM Eliminated (P)** • Mike West – Police • HESTIA HOUSING – Louise Bayston	community regarding Violence Against Women agenda • Increase of partner agencies working with community organisations to deliver initiatives • Better informed community regarding Violence against Women agenda. Increase of referrals received. • Young people are aware that FGM is harmful and illegal • Young people are aware of where they can get support around FGM if they or someone they know is affected or at risk • Young people feel more confident talking about FGM with their peers • We run 20 awareness workshops amongst mothers in Brent about the illegal	though the play is scheduled to take place around October 2014 Once a week for 15-20 women engaged, seeking support and information.	• September WoA • Quarterly Overview and Scrutiny meetings • Quarterly Brent Connects meetings • Trained 8 women into NVQ Certificate in Community Volunteering Qualification	-Young people -Coordinators at SIYD Questions will be asked regarding: -Awareness of FGM -Awareness of support services -Actions you can take after the session (ex – talking to a friend) -Confidence speaking to peers about FGM Number of participants attendance and feedback evaluation questionnaire

Recommendation And RAG Status	Actions	Lead and partner	Outcomes	Time-frame	Progress Milestones	Key Performance Indicators – how will progress be monitored?
			practice of FGM and its negative • Implications. We started female group at St Raphael's Estate as hub point of information sharing. • Understanding of FGM and the current laws was key outcomes. • We have created partnerships with other Somali organizations and build women confident to speak about FGM. • We work with local Masjid in Church Road and Friday speech delivered in Somali to influential religious leaders. • Empowering women against DV including harmful practices, in conjunction with Help Somalia Foundation and Freedom. • Basic adults S.G awareness training	Ongoing Sept 14	• Women who have undergone the training are now training other women form within their communities	

Recommendation And RAG Status	Actions	Lead and partner	Outcomes	Time-frame	Progress Milestones	Key Performance Indicators – how will progress be monitored?
			programme to be rolled out from Sept 14			
5. That awareness raising resources, leaflets and posters are clearly displayed in medical and educational establishments particularly GP surgeries, clinics. Hospitals, schools and colleges. These should include a single point of contact for those affected by harmful practices.	• Existing materials on FGM, HBV and FM are to be updated to include a single point of contact. • These materials will be distributed most heavily among establishments in areas where those are most at risk of harmful practices • Increased awareness raising across the health economy • Increased awareness raising in CCG & GP member practices • Awareness raising in Youth Centre • IRIS – Develop partnership working with Health (HESTIA HOUSING) • Adult SG basic awareness training now includes FGM, FM and HBV. • GP DV training to be rolled out across Brent starts Sept 14	Sarah Mansuralli – CCG **(L)** Pauline Fletcher – NHS **(P)** Carol Allen – Comm. Engagement **(P)** Mala Maru Comm. Safety **(P)** Mike West **(P)** Louise Bayston – HESTIA HOUSING **(P)**	FGM resources leaflets and posters are clearly displayed in CCG buildings and GP member practices, clinics, hospitals and police stations. Self defences classes being offered to young women Basic adults SG awareness training programme to be rolled out from Sept 14 Sept & Oct 14	June 2014 Autumn 2014 Sept 14 Ongoing	Tackling VAWG in Brent presentation delivered at Brent GP member practice forum-done 30/4/2014	• CCG/Public health Lead to be confirmed • VAWG on Brent CCG and Council Maternity and child health partnership working group-Bi monthly work plan • Partners to monitors training content and numbers via feedback forms

Recommendation And RAG Status	Actions	Lead and partner	Outcomes	Time-frame	Progress Milestones	Key Performance Indicators – how will progress be monitored?
6. **That Brent Council and its partners work with local and national media, including community radio and television stations, to raise awareness and educate the public on harmful practices and the negative effect it has on women and girls in our society.**	The launch of the report generated significant coverage in local, regional and national print, digital and broadcast media. This culminated in an approach by ITV national Daybreak to discuss the issue and undertake a piece to camera and a double page spread in the Evening Standard. The Communications Department will continue to watch for proactive and reactive opportunities to promote the work of the council and partners in educating and informing residents of these harmful practices.	New Head of Communications **(L)** Mike West **(P)**	Somali TV (June) scheduled to go back in 6 months time Police – Live web chats Tweets, via Azure	**Ongoing**	The coverage on Brent tackling VAWAG has been received well ad as a result we have been receiving request to come and speak at national conferences	
7. **That a programme of training is developed for all key staff from all relevant agencies who are likely to have contact with affected women and girls that will ensure a better understanding of the issues, identification of those at risk and referral pathways. Funding is available to**	• Embed FGM, HBV and FM into multiagency safeguarding training • Continue to provide a rolling programme of half-day FGM meetings available for anyone. • Identify any training that has been developed already within in single	Sandy Youngson - LSCB (**L)** Katherine Bryans-LSCB **(P)** Claire Solley – Comm. Engagement **(P)** Mala Maru Comm. Engagement **(P)** HESTIA HOUSING – Louise Bayston (P)	• That every member of staff who comes into contact by those affected by harmful practices would be better equipped to respond to cases of FGM, HBV or FM. • Increased awareness of FGM in health professionals	Training for FGM is already available; HBV and FM training can realistically piloted in Summer 2014 and rolled out in Autumn. The FGM	• FGM training sessions and communications for primary care health professionals • Increased request for advice and support by GP member practices from DPs and	• Numbers of training sessions delivered, and the number of staff attending them. • Cases flagged in GP notes and maternity referrals

Recommendation And RAG Status	Actions	Lead and partner	Outcomes	Time-frame	Progress Milestones	Key Performance Indicators – how will progress be monitored?
the voluntary sector to assist Brent in delivering this training programme.	agencies that can be adapted for Brent multi-agency training • Develop a specific FGM e-learning course for Brent. • Ensure training is mandatory for all staff who are likely to have contact with victims of harmful practices • CFAB/Freedom FGM app is to be installed on all staff iPhones or iPads? • Commission as part of non mandated sexual health services local third sector organisations to deliver training to GPs on FGM • Embed FGM and VAWG into CCG Safeguarding children training • HESTIA HOUSING internal staff delivering MARAC training to Council teams and DV training in schools		• Stronger partnerships with CCG designated safeguarding lead to support their program on FGM training of health professionals for 2014 -15 • Increased accessibility to health staff of the online multiagency FGM Training host via brentlscb.learningpool.com • FGM case studies are included in the level 3 training pack for GPs (done Feb 2014) • Brent Police have agreed to take training provided by LSCB	e-learning course will be developed over Summer 2014.	increased referrals in the MASH • All CCG staff have a better understanding of the VAWG issues around identification, recording and reporting	
8. That all awareness	• Update current safeguarding training	Sandy Youngson **(L)** Mala Maru **(P)**		**The Jan Trust**		**Number of FGM & harmful practices**

Recommendation And RAG Status	Actions	Lead and partner	Outcomes	Time-frame	Progress Milestones	Key Performance Indicators – how will progress be monitored?
raising and training activities highlight the changes in the law which make these harmful practices criminal offences.	so that it includes not only FGM, but also HBV and FM, ensuring that changes in the law are highlighted. • The Jan Trust Charity will be delivering 1 days training for Adult Social Care Department			**Training will take place on 06/08/14**		**training sessions by 2015.**
9. **That joint working is undertaken with schools to ensure that all head teachers, school governors and those responsible for safeguarding receive training and that all year seven children receive information as part of Personal Social and Health Education (PSHE).**	• Link with all Designated Professionals in Schools to raise awareness of FGM, HBV and FM • Commission as part of non mandated sexual health services local third sector organisations to deliver training to school governors and parents on FGM • Schools work in partnership to share best practice • Attending Brent Head Teachers Conference to raise awareness and promote best practice • Attending Brent	Sandy Youngson – LSCB **(L)** Katherine Bryans – LSCB **(P)** Mala Maru **(P)** Allyson Moss **(P)** Kay Johnson – Head Teachers **(P)** Ann John- School Governor's **(P)** Helen Tulloch-School Improvement **(P)** Mike West **(P)** HESTIA HOUSING – Louise Bayston **(P)**	Increased awareness of FGM in school governors and parents Increased accessibility to school personnel of the online multiagency FGM Training host via brentlscb.learningpool.com Police agreed to send Safer School Officers on LSCB training Presentations given at : • Woodfield School • Brentfield school • Village School • Row Green	**During 2014/2015**	FGM specific briefings for School personnel via the commissioned provider Successful presentation at the Brent Head Teachers Conference	Number of FGM & harmful practices training sessions by 2015.

Recommendation And RAG Status	Actions	Lead and partner	Outcomes	Time-frame	Progress Milestones	Key Performance Indicators – how will progress be monitored?
	School Governors Annual Conference and delivering workshop. • HESTIA HOUSING attending College of NWL Welcome Week, where they will be training staff and holding workshops for young people					
10. **That Brent Council in conjunction with its partners, particularly Council for Voluntary Services (CVS) Brent, pursue all avenues for available funding and support specialist charities and local voluntary organisations to bid for money from government agencies such as the Forced Marriage unit and the European Union fund.**	CVS Brent will support this recommendation as well as assist specialist organisations with accessing relevant training. CVS Brent will also advertise any events via their newsletter and website CVS Brent will pursue all avenues for available funding and support specialist charities and local voluntary organisations to bid for money from government agencies such as the Forced Marriage unit and the European Union fund. To signpost any organisations that require assistance in this area.	Tessa Awe **(L)**		**Now - Ongoing**		**No. of organisations engaged/supported**

Recommendation And RAG Status	Actions	Lead and partner	Outcomes	Time-frame	Progress Milestones	Key Performance Indicators – how will progress be monitored?
	CVS Brent will assist organisations to work in consortium or partnership to be able to secure funding. Support and Encourage the Voluntary Sector to take part in Zero Tolerance Day To contact all CVs organisations (Approx. 15) to discuss sharing data and how they can support					
11.4 That Brent Council along with its partners annually take part in the International UN sponsored awareness day that takes place 6th February each year. Zero Tolerance of Female Genital Mutilation day is set up to make the world aware of Female Genital Mutilation and to promote its eradication.	2015 day has been agreed on, though no actions to implement it have been confirmed Support local activities taking place on the 6th February via CVS Brent, offer non financial support: • Event Management • Reduced Rates for Space • Advertising The council will fun other Harmful Practices Events throughout 2014/15 such	Sarah Kaiser **(L)** Mala Maru **(P)** Mike West **(P)** Maria Aden **(P)** HESTIA HOUSING – Louise Bayston **(P)**	Brent Police have agreed to be part of this event FORWARD have agreed to be part of this event	**Oct 2014-Mar 2015**	**Responses from voluntary organisations**	**Number of Attendees**

Recommendation And RAG Status	Actions	Lead and partner	Outcomes	Time-frame	Progress Milestones	Key Performance Indicators – how will progress be monitored?
	as: • White Ribbon Day • Little Stitched – Play • International Women's Day HESTIA HOUSING will support with planned activities					
12. **That Brent Clinical Commissioning Group (CCG) should commission services for women and girls affected by the harmful practices of Female Genital Mutilation, Honour Based Violence and Forced Marriages.**	Review the planning and commissioning services for women and girls who have been affected by harmful practices of FGM and require counselling services Some time ago there were discussions between LBB public health/CCG at looking at targeted services for this area of specialism. I am not aware if this has been agreed!!! We will investigate this further and look into identifying any gaps in services and adding to our list of commission intentions The discussion group has	Raj Pandya **(L)** Melanie Smith **(P)**	Clear referral pathways to access service provision Identify service gap and support with a range of services	**Ongoing-discussion**		**Still in discussion with CCG, Notes from CCG** - don't think we commission specific services However we would use our existing commissioned services to support this group of people including children and young people If there was a need we would spot purchase Our safeguarding teams provide training and support to all staff including GP's to raise awareness The CCG have published these issues and the impact at GP forums and other health promotion event

Recommendation And RAG Status	Actions	Lead and partner	Outcomes	Time-frame	Progress Milestones	Key Performance Indicators – how will progress be monitored?
	asked the CCG to focus on two areas: • IRIS GP referral system and • Counselling and empowerment services for survivor's					this is a part of the work they integrate in their service to ensure our safeguarding duties

Brent	**Health and Wellbeing Board** 18 November 2014 **Report from the Director of Public Health**
For decision	Wards Affected: ALL

Pharmaceutical Needs Assessment Consultation

1.0. Summary

1.1. The Health and Social Care Act 2012 conferred the duty for publishing and keeping up to date a statement of the population needs for pharmaceutical services in their area, referred to as a Pharmaceutical Needs Assessment (PNA) onto Health and Wellbeing Boards.

1.2. A paper proposing how this responsibility should be discharged was presented to the Health and Wellbeing Board on 24 July 2014. The establishment of a task and finish PNA Steering Group was agreed, with responsibility for the task of overseeing the conduct, consultation and publication of the revised Brent PNA.

1.3. The Regulations covering PNAs require consultation on the PNA. The Brent Health and Wellbeing Board has delegated this responsibility to the PNA Steering Group.

1.4 The required consultees for PNAs include neighbouring HWBs. In order for Brent to consider PNAs from neighbouring HWBs, this paper proposes an amendment to the PNA Steering Group terms of reference.

2.0. Recommendations

The Board is asked to

- Delegate to the PNA Steering Group the task of reviewing PNAs from neighbouring boroughs on behalf of the Health and Wellbeing Board and responding to consultation as required.
- Agree revisions to the terms of reference for the PNA Steering Group which form appendix 1 to this report.

3.0. Detail

3.1. From April 2013, Health and Wellbeing Board have been responsible for producing, consulting on and publishing the PNA for their area. A fully refreshed PNA must be produced before 1 April 2015.

3.2. PNAs are used by the NHS to make decisions on which NHS funded services need to be provided by local community pharmacies. PNAs are also used in decisions as to whether new pharmacies are needed in response to applications by businesses.

3.4. The PNA Steering Group will oversee the production of a revision of the Brent PNA in accordance with the 2013 Regulations.

3.5. All Health and Wellbeing Boards are required to undertake a 60 day consultation with named partners, including neighbouring boroughs, on a draft of their PNA.

3.6. To support engagement in the review of partners PNAs, it is proposed that the Health and Wellbeing Board delegates the responsibility for reviewing PNAs and responding to consultation to the PNA Steering Group.

Melanie Smith
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Brent Pharmaceutical Needs Assessment Steering Group

Terms of reference

Purpose

To direct and oversee the production of and consultation on a revision of the Brent Pharmaceutical Needs Assessment (PNA) in order to enable the Health and Wellbeing Board to approve this for publication by 1st April 2015.

Context

If a person wants to provide NHS pharmaceutical services, they are required to apply to the NHS to be included on a pharmaceutical list. Pharmaceutical lists are compiled and held by the NHS Commissioning Board, now known as NHS England. This is commonly known as the NHS "market entry" system.

Under the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations ("the 2013 Regulations"), a person who wishes to provide NHS pharmaceutical services must generally apply to NHS England to be included on a relevant list by proving they are able to meet a pharmaceutical need as set out in the relevant PNA.

The Health and Social Care Act 2012 established HWBs. The Act also transferred responsibility to develop and update PNAs from PCTs to HWBs. Responsibility for using PNAs as the basis for determining market entry to a pharmaceutical list transferred from PCTs to NHS England from 1 April 2013.

The NHS Act 2006 (the "2006" Act), amended by the Health and Social Care Act 2012, sets out the requirements for HWBs to develop and update PNAs and gives the Department of Health (DH) powers to make Regulations.

128A Pharmaceutical needs assessments

(1) Each Health and Well-being Board must in accordance with regulations:

(a) assess needs for pharmaceutical services in its area, and

(b) publish a statement of its first assessment and of any revised assessment.

(2) The regulations must make provision:

(a) as to information which must be contained in a statement;

(b) as to the extent to which an assessment must take account of likely future needs;

(c) specifying the date by which a Health and Well-being Board must publish the statement of its first assessment;

(d) as to the circumstances in which a Health and Well-being Board must make a new assessment.

(3) The regulations may in particular make provision:

(a) as to the pharmaceutical services to which an assessment must relate;

(b) requiring a Health and Well-being Board to consult specified persons about specified matters when making an assessment;

(c) as to the manner in which an assessment is to be made;

(d) as to matters to which a Health and Well-being Board must have regard when making an assessment.

"*Healthy lives, healthy people*", the public health strategy for England (2010) says: "Community pharmacies are a valuable and trusted public health resource. With millions of contacts with the public each day, there is real potential to use community pharmacy teams more effectively to improve health and wellbeing and to reduce health inequalities." This will be relevant to local authorities as they take on responsibility for public health in their communities.

Community pharmacy is an important investor in local communities through employment, supporting neighbourhood and high street economies, as a health asset and long term partner.

Responsibilities

- The Steering Group will oversee the production of a revision of the Brent PNA in accordance with the 2013 Regulations.

- The Group will ensure that the PNA is of high quality, specifically it will ensure that the PNA:
  - includes pharmacies and the services they already provide. These will include dispensing, providing advice on health, medicines reviews and local public health services, such as stop smoking, sexual health and support for drug users.
  - looks at other services, and services available in neighbouring HWB areas that might affect the need for services in its own area.
  - examines the demographics of Brent's population, across the area and in different localities, and their needs.
  - looks at whether there are gaps that could be met by providing more pharmacy services, or through opening more pharmacies. It should also take account of likely future needs.
  - contains relevant maps relating to the area and its pharmacies.
  - is aligned with other plans for local health and social care, including the Joint Strategic Needs Assessment (JSNA).

- The Group will ensure consultation in accordance with the Regulations.

- The Group will ensure the findings of the PNA are presented to the Health and Wellbeing Board once published.

- The Group will consider other PNAs from neighbouring boroughs on behalf of the Health and Wellbeing Board and respond to consultation as required.

Membership

Consultant in Public Health: Adults and Health Intelligence. Chair
Brent Council PH analyst: Ricky Geer
LPC nominee(s): Shabbir Panya

	Suraj Varia
CCG nominee(s):	medicines management, Theodora Michael
	primary care, Dr Sarah Basham
Healthwatch representative:	tbc
NHS E representative:	Albert Desouza
LMC:	tbc

To attend as required and provide advice:
Brent Council Senior Category Manager (Public Health Procurement): Zivio Mascerenas
Brent Council Consultation Officer: Bola Olatunde
Brent Council Communications link: David Green
Brent Council Head of Equalities: Sarah Kaiser
Brent Council Principal Planning Officer: Claire Jones

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