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Brent

Brent Clinical Commissioning Group

Health and Wellbeing Board

Tuesday 22 March 2016 at 7.00 pm
Boardrooms 5-6 - Brent Civic Centre

Membership:

Members		Substitute Members
Councillor Butt (Chair)	Brent Council	Councillors:
Councillor Carr	Brent Council	Denselow, Mashari, McLennan and Southwood
Councillor Pavey	Brent Council	
Councillor Hirani	Brent Council	
Councillor Moher	Brent Council	
Carolyn Downs	Brent Council	
Phil Porter	Brent Council	
Dr Melanie Smith	Brent Council	
Gail Tolley	Brent Council	
Dr Sarah Basham	Brent CCG	
Rob Larkman	Brent CCG	
Dr Ethie Kong	Brent CCG	
Sarah Mansuralli	Brent CCG	
Ian Niven	Healthwatch Brent	

For further information contact: Peter Goss, Democratic Services Manager
0208 937 1353 peter.goss@brent.gov.uk

For electronic copies of minutes, reports and agendas, and to be alerted when the minutes of this meeting have been published visit:
democracy.brent.gov.uk

The press and public are welcome to attend this meeting

Agenda

Introductions, if appropriate.

Apologies for absence and clarification of alternate members.

Item Page

1 Declarations of interests

Members are invited to declare at this stage of the meeting, any relevant financial or other interest in the items on this agenda.

2 Minutes of the previous meeting 1 - 6

3 Matters arising (if any)

4 Sustainability and Transformation Plan 2016-20 7 - 16

This report provides information on the requirements and timelines for producing the Sustainability and Transformation Plan (STP) as set out in the Shared Planning Guidance (December 2015).

A meeting of the Health and Wellbeing board members was held on 7 March to define the process for developing the STP.

Ward Affected:
All Wards

Contact Officer*:* Phil Porter, Strategic Director, Community Well-being, Tel: 020 8937 5937, phil.porter@brent.gov.uk,
Sarah Mansuralli, Chief Operating Officer, CCG sarah.mansuralli@nhs.net

5 Better Care Fund priorities 17 - 24

The Better Care Fund (BCF) is an important vehicle for driving forward health and social care integration at pace and scale. It creates a local single pooled budget to incentivise the NHS and local government to transform services and provide people with the right care, at the right place, sensitive to their specific needs and delivered in partnership to the highest standards. This report outlines the progress made on achieving this and seeking approval to the BCF submission.

Ward Affected:
All Wards

Contact Officer*:* Phil Porter, Strategic Director, Community Well-being
Tel: 020 8937 5937
phil.porter@brent.gov.uk
Sarah Mansuralli, Chief Operating Officer, CCG,
sarah.mansuralli@nhs.net,

6 Children and Young People's Mental Health and Wellbeing Transformation Plan implementation 25 - 30

This report outlines progress on the development of the Children and Young People's Mental Health and Wellbeing Local Transformation Plan.

Ward Affected:
All Wards

***Contact Officer**:* Gail Tolley, Strategic Director, Children and Young People
Tel: 020 8937 6422
gail.tolley@brent.gov.uk
Duncan Ambrose – Assistant Director
NHS Brent CCG

7 Primary Care Transformation 31 - 38

This paper provides an update on local work to deliver the objectives of Primary Care Transformation - a portfolio of work to develop effective and sustainable Primary Care in Brent.

Ward Affected:
All Wards

***Contact Officer**:* Phil Porter, Strategic Director, Community Well-being
Tel: 020 8937 5937
phil.porter@brent.gov.uk
Sarah Mansuralli, Chief Operating Officer, CCG,
sarah.mansuralli@nhs.net

8 2015/16 revision of the Joint Strategic Needs Assessment (JSNA) 39 - 146

This report outlines the requirements of the JSNA and the process and products of the 2015/16 revision.

Ward Affected:
All Wards

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

9 Any other urgent business

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

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.

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Brent

MINUTES OF THE HEALTH AND WELLBEING BOARD
Tuesday 26 January 2016 at 7.00 pm

PRESENT: Councillor Butt (Chair), Dr Ethie Kong (Vice Chair), Dr Sarah Basham (Assistant Chair, Brent Clinical Commissioning Group), Carolyn Downs (Chief Executive, Brent Council), Councillor Hirani (Lead Member for Adults, Health and Wellbeing, Brent Council), Sarah Mansuralli (Chief Operating Officer, Brent Clinical Commissioning Group), Councillor Moher (Lead Member for Children and Young People, Brent Council), Ian Niven (Director, Healthwatch Brent), Councillor Pavey (Deputy Leader, Brent Council), Phil Porter Strategic Director, Adults), Dr Melanie Smith (Director of Public Health, Brent Council) and Gail Tolley (Strategic Director, Children and Young People, Brent Council)

Apologies were received from: Councillor Carr (Brent Council) and Rob Larkman (Chief Officer, Brent, Harrow and Hillingdon Clinical Commissioning Groups),

Also Present: Duncan Ambrose (Assistant Director, NHS Brent CCG), Mike Howard (Chair, Brent Local Safeguarding Children Board) and Tina Benson (Director of Transformation, LNWHT)

1. **Declarations of interests**

None declared.

2. **Minutes of the previous meeting**

RESOLVED:-

that the minutes of the previous meeting held on 10 November 2015 be approved as an accurate record of the meeting.

3. **Matters arising**

None.

4. **Child Death Overview Panel Annual Report 2014/15**

Dr Melanie Smith (Director of Public Health) introduced the annual report of the Child Death Overview Panel presented to the Brent Local Safeguarding Children Board in June 2015. She introduced Dr Boroda, the Designated Doctor for Unexpected Child Deaths who was present for this item. Attention was drawn to paragraph 15 of the annual report which showed that since 2008 a number of sudden unexplained deaths in infancy were potentially linked to sleeping practices. There was a chance to take some action to publicise this during Safer Sleep week 14-20 March 2016. Dr Boroda stated that the work of the Child Death Overview Panel was an example of partnership working and that it was key to look carefully at

cases of preventable deaths and to stress the importance of good nutrition and engagement with parents. It was pointed out that the NW9 and NW10 postcodes featured the highest number of cases and that the ethnicity of child deaths was not reflective of the borough's ethnic breakdown. It was felt that a better understanding of these factors was needed.

Reference was made to vitamin D deficiency and the method by which supplements were either prescribed based on a recognised need or distributed based on a preventative approach. It was felt that a consequence of the welfare reforms was the potential for an increase in health risks and that the incidence vitamin D deficiency could increase. It was recognised that this would lead to a wider range of health issues.

RESOLVED:

(i) that the 2014/15 Child Death Overview Panel Annual Report be received;

(ii) that further consideration be given to promoting messages about safe sleeping;

(iii) that further consideration be given to the health issues arising from child death cases, such as vitamin D deficiency and how these can be addressed through preventative and treatment based approaches;

(iv) that further analysis of the data be undertaken, including matching with other parts of London, to determine an approach to seeking to reduce child deaths and improve children's health.

5. **Children's Trust and OFSTED**

The Board received the report which provided an overview of the findings of the Ofsted inspection of Brent services for children in need of help and protection, children looked after and care leavers. Gayle Tolley (Strategic Director, Children and Young People) introduced the report and highlighted the need identified as a result of the inspection for an appropriate strategic alignment between various boards and that work had already started on achieving this. It had also found that some improvements had been made but that further sustained improvement was needed before the service could be rated as Good.

Mike Howard (Chair of the Brent Local Safeguarding Children Board) was present and stated that there were opportunities for his board to have closer working relations with the Health and Wellbeing Board and other partnership groups in Brent.

It was pointed out that most of the work of the CCG was commissioned and issues were reported into joint commissioning groups. It was felt to be important that links were developed with the CCG's commissioning work. The Chair added that the inspection had found that the Health and Wellbeing Board was working together more effectively and that this needed to continue.

RESOLVED:

that the findings of the OFSTED inspection of Children's Services be received and the work being undertaken to improve services for children and young people be noted.

6. **Better Care Closer to Home - phase two**

The Board considered the report on the approach to reviewing and refreshing the Better Care Closer to Home Strategy. Sarah Mansuralli (Chief Operating Officer, Brent CCG) introduced the report by referencing the need to develop the framework by drawing on the North West London vision and identifying the priorities for local commissioning of care. Carolyn Downs (Chief Executive, Brent Council) submitted that there needed to be a better understanding of the local health economy and a facilitated discussion with health partners so that public expectation could be managed. Members of the Board recognised that the design stage of phase 2 of the strategy needed to formulate how residents were informed of the changing situation within the borough. It was felt that the profile of health related services and facilities needed to be increased in a bid to promote healthy lifestyles.

Phil Porter (Strategic Director, Community and Wellbeing) stated that consideration would have to be given to how the Health and Wellbeing Board could provide an oversight of the activities of the Sustainability and Transformation Plan, Better Care Fund and Better Care Closer to Home Strategy.

RESOLVED:

(i) that the approach to reviewing and refreshing the Better Care Closer to Home Strategy for phase 2 covering the period 2016-19 be noted and supported;

(ii) that the comments made during discussion of the item be incorporated into the approaches and priorities of the strategy.

7. **Outcome based reviews**

Phil Porter (Strategic Director, Community and Wellbeing) submitted a presentation to the Board outlining the Council's initiative to introduce design led outcome based reviews. He stated that three reviews were underway and that the Innovation Unit had been engaged to provide a fresh perspective to the work. The Chair stressed the need for a short, sharp approach to the work as identified in the presentation.

The Board endorsed the work being undertaken.

8. **London Health and Care Collaboration Agreement**

Carolyn Downs (Chief Executive, Brent Council) introduced the report which informed the Board of the progress of the collective agreement by London and National Partners to transform health and wellbeing outcomes. She expressed the view that the Council and partners should proceed towards as much integration as could be achieved whilst learning from the pilots as they tested different elements of integration, collaboration and devolution.

RESOLVED:

that the London Health and Care Collaboration Agreement be noted and supported on the basis that it supports continued closer working to improve outcomes for Brent residents, but implies no changes to Council or CCG governance or decision-making powers.

9. **Update on Winter pressures**

The Board considered the report updating it on the actions implemented in response to additional winter pressures. Phil Porter (Strategic Director, Community and Wellbeing) outlined a number of additional initiatives that were either in place or being planned for immediate implementation but stressed that more still needed to be done. The partnership approach remained strong and work continued on initiatives for coping with the winter pressures next year. Sarah Mansuralli (Chief Operating Officer, Brent CCG) agreed that there had been a marked improvement over the previous year. The board recognised that there were financial implications for the action being taken.

RESOLVED:

(i) that the report be noted and the Board assured that plans and governance mechanisms are in place to support NHS resilience over the winter so that patients get swift access to safe services;

(ii) that the strategic direction for 2016/17 be supported ahead of a report being submitted to the next meeting of the Board as part of the sign off of the 2016/17 Better Care Fund plan.

10. **Updates on Health and Wellbeing priorities**

10.1 **Giving every child the best start in life**

The Board considered the circulated update on the priority of giving every child the best start in life. Dr Sarah Basham (Co-Clinical Director, Brent CCG) elaborated on the work outlined in the briefing and referenced the connection with perinatal health.

NOTED

10.2 **Helping vulnerable families**

The Board considered the circulated update on the priority of helping vulnerable families. Dr Ethie Kong (Chair, Brent CCG) felt there was a need to agree a definition of what was considered a vulnerable family. Mike Howard (Chair of the Brent Local Safeguarding Children Board) suggested that the briefing could be added to by reference to the work being carried out by other groups involved with safeguarding issues.

NOTED

10.3 **Improving mental well being through life**

The Board considered the update on the priority of improving mental wellbeing throughout life. It was agreed that this priority needed to take account of the period of transition from child to adult.

NOTED

10.4 **Working together to support the most vulnerable adults**

The Board received the update on the priority of working together to support the most vulnerable adults.

NOTED

10.5 **Empowering communities to take better care of themselves**

The Board considered the update on the priority of empowering communities to take better care of themselves. The breadth of activity under this priority was acknowledged.

NOTED

11. **Any other urgent business**

None.

The meeting closed at 8.30 pm

M BUTT
Chair

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Brent

NHS Brent Clinical Commissioning Group

Brent Health and Wellbeing Board
22 March 2016

Report from the Chief Operating Officer of Brent Clinical Commissioning Group and the Strategic Director of Adults and Community Well Being Brent Council

Wards affected: ALL

Sustainability and Transformation Plan 2016-2020

1.0 Summary

1.1 The purpose of this report is to provide the Health and Wellbeing Board with information on the requirements and timelines for producing the Sustainability and Transformation Plan (STP) as set out in the Shared Planning Guidance (December 2015). The report further sets out the approach to developing the Sustainability and Transformation Plan in partnership across health and care organisations in North West London and locally in Brent.

2.0 Recommendation

2.1 The Health and Wellbeing Board are requested to note the requirements and timescales for producing the Sustainability and Transformation Plan. The Board are further requested to endorse the approach to developing the plan at a local and North West London level in conjunction with health and care partners.

3.0 Detail

3.1 The NHS Shared Planning Guidance asks every health and care system to come together to create their own ambitious local blueprint for accelerating implementation of the Five Year Forward View (5YFV). Sustainability and Transformation Plans (STPs) are intended to be place-based, multi-year plans built around the needs of local populations. They will help ensure that the investment secured in the Spending Review does not just prop up individual

institutions for another year, but is used to drive a genuine and sustainable transformation in patient experience and health outcomes over the longer-term. It is well recognised that STPs are not an end in themselves, but a means to build and strengthen local relationships, enabling a shared understanding of where we are now, our ambition for 2020 and the concrete steps needed to get us there.

3.2 The STP will be an umbrella plan and will bring together local place-based plans to address the health and care triple aim as set out in the Five Year Forward View:

- The health and wellbeing gap;
- The care and quality gap; and
- The finance and efficiency gap.

3.3 The key questions that STPs will need to respond to are set out in appendix 1. Timelines for development of STPs are set by NHS England and are ambitious. A final draft of the STP is due at the end of June, with submission of an STP base case on 11th April. It is anticipated that the 11th April STP submission will cover five components:

- Clinical base case which needs to describe how we will address the 'health and wellbeing' and 'care and quality' parts of the Five Year Forward View triple aims).
- Financial base case which needs to evaluate the current financial position and identify the financial drivers across the health and care system.
- Programme Plan which outlines the core tasks and major milestones in order to develop the full STP, based on three work streams (aligned to the triple aims)
- Governance Framework which sets out the senior leadership team responsible for the STP, Strategic Planning Group governance arrangements and engagement activities planned.
- Resources to deliver programme management functions, subject matter expertise, analytics and communications associated with the STP development.

3.4 North West London health and care organisations have already shown great commitment to local joint working to deliver better outcomes for our population through our transformational programmes such as the Better Care Fund (BCF) and Whole Systems Integrated Care (WISC). The STP development provides an opportunity to build on this work to improve services and address the wider determinants of health, such as housing, economic development and education, as a system locally. This will require improved collaboration between the NHS and local government, with patients and the public kept at the centre of everything we do.

3.5 For North West London, there is commitment to a five year plan that is based on the principle of subsidiarity, e.g. locally determined priorities will form the building blocks of the STP. The North West London STP will describe plans at different levels of 'place' – across the whole system in North West London, from

local to the sub regional, as appropriate. Local plans will form the basis of the wider STP and demonstrate our approach to delivering the new models of care in the Five Year Forward View to ensure a financially sustainable service that delivers person centred care and improves people's health and wellbeing.

3.6 There is agreement that the North West London STP must be seen as an opportunity to deliver shared ambitions for a healthier and happier population. A set of principles has been developed to underpin our approach to the STP which organisations need to agree to realise the opportunity that this collaboration is designed to achieve:

- Be bold, ambitious and strive to change things for the better;
- Commit to person centred services and outcomes, focussing on the needs of a populations rather than organisations;
- Work together to overcome obstacles and be prepared to have challenging conversations through trusting relationships and local partnerships;
- Commit to leading and owning the development of a joint STP and signing up to the principel of subsidiarity – decisions and implementation locally for locally based developments;
- Identify and where possible share opportunities, assets and risks through an open book approach;
- Engage widely and co-design with patients and the public during the STP development

3.7 The approach to developing the STP will need to take place at different levels. The clinical base case should focus on agreeing local priorities and closing the health and wellbeing gap and care and quality gap. The financial base case will be developed through a North West London Strategic Finance Group which comprises providers, commissioners and local authorities.

3.8 The next steps for developing the clinical base case will be for each borough to establish a local STP planning group to oversee this work locally. The local planning group should as a minimum comprise CCGs, local authorities, providers and patient/public representatives. This group will meet to:

- Define the local vision for delivering the health and wellbeing and care and quality themes
- Consider and agree the 'as is' and 'to be' position in 2020/2021 which includes validating a gap analysis with local authority and provider colleagues
- Determine the local governance arrangements that will review local content of the draft and final STP documents, e.g. Health and Well Being Boards
- Consider what local plans will need to be updated in line with the STP, for example Health and Wellbeing strategy and/or Joint Strategic Needs Assessment

3.9 In North West London a Strategic Planning Group (SPG) with local authority, provider organisations and CCGs has formed an STP planning group to

progress the STP development. This group met for the first time on 10th March. In Brent, an initial planning discussion was held with senior representatives from health, local authority, West London Alliance and HealthWatch to discuss our aspirations, vision and approach to the STP development. It was proposed that the Brent Health and Wellbeing Board would provide the overarching governance for the STP development and implementation. A local STP sub group to undertake the gap analysis and detailed planning work has been established and includes senior local authority, CCG, acute and mental health provider representatives and HealthWatch.

3.10 The first meeting of the local planning group will take place on 17th March and will focus on the gap analysis and potential priorities to address these. The outcome of this first meeting and suggested priorities will be presented to the Health and Wellbeing Board at its meeting on 22nd March.

3.11 Between now and 11th April the local STP Planning group will be responsible for:

- Collating and reviewing local inputs into the draft STP submission
- Prepare a draft of the local STP submission for local governance and SPG review (w/c 29th March)
- Update this draft to incorporate and local governance and SPG feedback for submission by 8th April.

4.0 Financial Implications

4.1 To be confirmed.

5.0 Legal Implications

5.1 To be confirmed.

6.0 Diversity implications

6.1 The STP aims to address the whole health and care system to enable a rebalancing towards prevention, early intervention; supporting independence and wellbeing. It aims to engage and empower the diverse communities of Brent and the wider health economy across North West London to deliver improved clinical outcomes and patient experiences.

7.0 Staffing/Accommodation Implications (if appropriate)

7.1 To be confirmed.

Appendix 1

STP 32 Questions to address the triple aims of the Five Year Forward View

Contact Officers

Name: Phil Porter
Job title: Strategic Director of Adults and Community Wellbeing
Brent Council

Name: Sarah Mansuralli
Job title: Chief Operating Officer
Brent Clinical Commissioning Group

Appendix 1

Give Year Forward View Gap	Proposed Strategic Themes	No.	Question / Theme
A: How will you close the health and wellbeing gap? "This section should include plans for a 'radical upgrade' in prevention, patient activation, choice and control, and community engagement"	**Delivering the Prevention Agenda**	H&WB - 1	How will you assess and address your most important and highest cost preventable causes of ill health, to reduce healthcare demand and tackle health inequalities working closely with local government?
		H&WB - 1a	How will we achieve full local implementation of the national Diabetes Prevention Programme?
		H&WB - 1b	What action will you take to address obesity, including childhood obesity?
	Empowering & Engaging Patients	H&WB - 1c	How will you achieve a step-change in patient activation and self-care? How will you embed the six principles of engagement and involvement of local patients, carers, and communities developed to help deliver the Five Year Forward View?
		H&WB - 2	How will you make real the aspiration to design person-centred coordinated care, including plans to ensure patients have access to named, accountable consultants?
		H&WB - 3	How will a major expansion of integrated personal health budgets and implementation of choice - particularly in maternity, end-of-life, and elective care - be an integral part of your programme to hand power to patients?
	Developing the Local Workforce	H&WB - 4	How are NHS and other employers in your area going to improve the health of their own workforce - for example by participating in the national roll out of the Healthy NHS programme?
B: How will you drive transformation to close the care and quality gap? "This section should include plans for new care model improvement, improving against clinical priorities, and rollout of digital healthcare"		C&Q - 18	What is your plan to develop, retrain and retain a workforce with the right skills, values and behaviours in sufficient numbers and in the right locations to deliver your vision for transformed care? How will you build the multidisciplinary teams to underpin new models of care? How ambitious are your plans to implement new workforce roles such as associate nurses, physician associates, community paramedics and pharmacists in general practice?
	Transforming Primary Care (This could possibly be merged with	C&Q - 1	What is your plan for sustainable general practice and wider primary care? How will you improve primary care infrastructure, supported in part through access to national primary care transformation funding?

Give Year Forward View Gap	Proposed Strategic Themes	No.	Question / Theme
	the theme below)	C&Q - 2	How rapidly can you implement enhanced access to primary care in evenings and weekends and using technology?
	Transforming The Local Provider & Commissioner Market	C&Q - 3	What are your plans to adopt new models of out-of-hospital care, e.g Multi-specialty Community Providers (MCPs) or Primary and Acute Care Systems (PACS)?
		C&Q - 4	How will you adopt new models of acute care collaboration (accountable clinical networks, specialty franchises, and Foundation Groups)? How will you work with organisations outside your area and learn from best practice from abroad, other sectors and industry?
		C&Q - 19	What is your plan to improve commissioning? How rapidly will the CCGs in your system move to place-based commissioning? If you are a devolution area, how will implementation delivery real improvements for patients? N.b. we expect to respond to this at a NWL level, but if there are specific local plans you would like us to include then please feel free to include
	Delivering The Constitutional & 'Mission Critical' Targets	C&Q - 5	What is your plan for transforming urgent and emergency care in your area? How will you simplify the current confusing array of entry points? What's your agreed recovery plan to achieve and maintain A&E and ambulance access standards?
		C&Q - 6	What's your plan to maintain the elective care referral to treatment standard? Are you buying sufficient activity, tackling unwarranted variation in demand, proactively offering patient choice of alternatives, and increasing provider productivity?
		C&Q - 7	How will you deliver a transformation in cancer prevention, diagnosis, treatment and aftercare in line with the cancer taskforce report?
		C&Q - 14	How will you achieve by 2020 the full-roll out of seven day services for the four priority clinical standards?
		C&Q - 15	How will you implement the forthcoming national maternity review, including progress towards new national ambitions for improving safety and increased personalisation and choice?

Give Year Forward View Gap	Proposed Strategic Themes	No.	Question / Theme
		C&Q - 13	What plans do you have in place to reduce antimicrobial resistance and ensure responsible prescribing of antibiotics in all care settings? How are you supporting prescribers to enable them issue the right drugs responsibly? At the same time, how rapidly will you achieve full implementation of good practice in reducing avoidable mortality from sepsis?
		C&Q - 17	How quickly will you implement your local digital roadmap, taking the steps needed to deliver a fully interoperable health and care system by 2020 that is paper-free at the point of care? How will you make sure that every patient has access to digital health records that they can share with their families, carers and clinical teams? How will you increase your online offer to patients beyond repeat prescriptions and GP appointments?
	Delivering on key Mental Health Challenges	C&Q - 8	How will you improve mental health services, in line with the forthcoming mental health taskforce report, to ensure measureable progress towards parity of esteem for mental health?
		C&Q - 9	What steps will your local area take to improve dementia services?
		C&Q - 10	As part of the Transforming Care programme, how will your area ensure that people with learning disabilities are, wherever possible, supported at home rather than in hospital? How far are you closing out-moded inpatient beds and reinvesting in continuing learning disability support?
		C&Q - 16	How will you put your Children and Young People Mental Health Plan into practice?
	Ensuring the provider market is safe and compliant	C&Q - 11	How fast are you aspiring to improve the quality of care and safety in your organisations as judged by the Care Quality Commission (CQC)? What is your trajectory for no NHS trust and no GP practice to have an overall inadequate rating from the Care Quality Commission (CQC)?
		C&Q - 12	What are you doing to embed an open, learning and safety culture locally that is ambitious enough? What steps are you taking to improving reporting, investigations and supporting patients, their families and carers, as well as staff who have been involved in an

Give Year Forward View Gap	Proposed Strategic Themes	No.	Question / Theme
			incident?
	Delivering the Research & Innovation Challenge	C&Q - 20	How will your system be at the forefront of science, research and innovation? How are you implementing combinatorial innovation, learning from the forthcoming test bed programme? How will services changes over the next five years embrace breakthroughs in genomics, precision medicine and diagnostics? N.b. we expect to respond to this at a NWL level, but if there are specific local plans you would like us to include then please feel free to include

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Brent

NHS Brent Clinical Commissioning Group

Brent Health and Wellbeing Board
22 March 2016

Report from Brent CCG Chief Operating Officer and Brent Council Strategic Director Community Wellbeing

For approval | Wards affected: ALL

- **Health and Social Care Integration Priorities for 16/17**
- **Brent's 16/17 Better Care Fund Submission**

1.0. Summary

1.1. The Better Care Fund (BCF) is an important vehicle for driving forward health and social care integration at pace and scale. It creates a local single pooled budget to incentivise the NHS and local government to transform services and provide people with the right care, at the right place, sensitive to their specific needs and delivered in partnership to the highest standards. As such it is an important part of the NHS and local governments present and future plans.

1.2. The Spending Review confirms that by 2020 health and social care are to be fully integrated across the UK and that each local authority and CCG will need have a plan in place on how they will achieve this by 2017. There is a continued requirement to ensure the BCF plans are aligned to other local areas of work including the STP plans, new models of care as set out in the NHS Five Year Forward View and delivery of 7-day services.

1.3. By working together across traditional boundaries, keeping people well, and supporting their recovery after periods of illness, we know we can improve individual quality of life whilst also reducing demands upon local services. The success of these changes will, from 2015/16 onwards, help drive reductions in emergency admissions to hospital, and the demand for nursing and residential home care, with benefits for individuals, the local authority and the CCG alike. This is about working together and working better, to put our health and social care systems on a steady footing, translating improved outcomes for individuals into long-term, sustainable support for our communities as a whole. Through the pooling of budgets and joining up commissioning activity across health (Brent CCG) and social care (Brent Council), Brent's Better Care Fund Programme is supporting the H&WB objectives; facilitating effective hospital discharge; reducing the number of DTOCs; supporting the early discharge of medically fit people from an acute setting.

2.0. Recommendations

The Brent Health and Wellbeing Board are asked to:

- Note the progress Brent has made on health and social care integration;

- Endorse the recommended 16/17 priority areas for health and social care integration;
- Agree delegated sign off of final plans and s75 to Brent CCG COO and Brent Strategic Director Community Wellbeing;
- Endorse the proposed programme approach to successful delivery;
- Agree to the proposed assurance sign off of Brent's Better Care Fund submission for 16/17.

3.0. Achievement to date

3.1. **BCF Scheme 1: Whole Systems Integrated Care - keeping the most vulnerable well in the community.** Whole Systems Integrated Care (WSIC) is a programme of work supporting integration in Brent alongside BCF. The objective is planned, proactive and integrated care for adults with long term conditions (LTCs). Work to design and contract services currently provided by Primary Care - risk stratification, care planning, multidisciplinary case management - formed BCF Scheme 1. In 15/16 codesign of the future model was completed with providers and lay partners, contracting models were reviewed, shaping of the market commenced and key enablers for example Integrated Care Records and dashboards were developed. The 16/17 Business Case was signed off early March and the route to market is currently being agreed. Changes to the model of care (including the launch of a self-care pilot) will be implemented and Q1 activity will commence from April 16.

3.2. **BCF Scheme 2: Avoiding unnecessary hospital admissions in line with out of hospital strategy (Rapid Response).** This focused on updating the Rapid Response elements of the STARRS contract. This scheme supported patients who are having a medical crisis to access nursing support in a community setting, ultimately preventing hospital attendance and hospital admission where appropriate. The aim is to maximize the number of appropriate referrals from GPs, LAS, A&E, and ensure the rapid response workforce is sized and skilled to meet any increased demand. Rapid response staff will continue to be trusted assessors for social care packages and are exploring the possibility of in-reaching into nursing homes in 16/17. The other part of this project is looking at the funding model for Early Supported Discharge at LNWHT. The specification and KPIs were completed in 15/16.

3.3. **Scheme 2.5: Avoiding unnecessary hospital admissions in line with out of hospital strategy (Rehab & Reablement).** This focused on updating the Rehab & Reablement elements of the STARRS contract. This scheme brings together the STARRS Rehab (provided by LNWHT) with Reablement and Enhanced Reablement (provided by the Council) into an integrated assessment and therapy service. The new service, based in LNWHT (with council staff seconded into LNWHT) has been co-designed with a broad range of partners. The new service will deliver intensive, short term (4-16 weeks) assessment and therapeutic support in the community to maximise independence in daily living skills and achieve rehab goals. All staff will be trusted assessors for social care packages and will work closely with homecare agencies as the lead professional. Expected outcomes are increasing independence and self-care in the community, decreasing readmission into hospital and admission into residential or nursing care homes, and decreasing duplication of assessment. The other part to this scheme is re-tendering the reablement home care market to improve quality and supplement the new assessment and therapy service. The detailed design of the model of care was completed in 15/16 and the business case for 16/17 developed. Work on implementation of the new model is underway, this includes transferring staff from the Council into the Trust, training staff in the new ways of working, ensuring the IT, estates, funding arrangements are in place to support successful go live and completing the retender of the home care market. Expected benefits will be realised in time for winter 2016.

3.4. **BCF Scheme 3 – The Brent Winter Plan for 15/16 (Efficient multi-agency winter resilience and reduction in DTOCs).** This focused on implementing the agreed integration plans to enable faster and supportive discharges from hospitals during the 15/16 winter period and take pressure off acute beds. The plans took into account wider system changes and initiatives in North West London and were based on practical ideas which will help both social care and the local NHS to work together to deliver realistic support during the busy winter period. These included;

- Daily DTOC dashboard and conference calls where stakeholders from across Brent and Harrow take part when the system is under pressure as per the surge and escalation process (Live from September 2015).
- Targeted support from housing colleagues at weekly housing surgery at Northwick Park and Willesden Community Hospital to review pipeline of patients approaching discharge and identify pathways out of hospital for those patients who do not meet the criteria for homelessness legislation and who do not have any social care needs (Live from December 2015).
- Joint commissioning of community residential and nursing step-down beds in the community to support DTOC patients once they are medically fit (live from December 2015).
- 7 day working by social care to support discharges at weekends (live from December 2015).
- DTOC analytic support to enable development of a robust dashboard and analysis to enable real time system learning (live from March 2016).

3.5. **BCF Scheme 4 - Improving the mental health urgent care pathway.** This focused on Brent CCG working with our Local Mental Health Provider (CNWL) to setup a liaison psychiatric service to support adults who have been referred to inpatients and present with the full range of mental health problems. The aim is to provide timely, brief interventions that can help to improve the patient's outcomes and prevent or reduce their length of in-patient hospital stay. The Liaison Psychiatry Service at Northwick Park Hospital operates an assessment lounge that works to divert people out of A&E. We have changed some of the ways in which this operates and this has resulted in changes to patient flow. A full sustainable service model has been agreed and went live in 2015/16. As part of this service line, we are scoping out alcohol related admissions to be included in this service model including frequent attenders of A&E to inform arrangements for managing these differently.

4.0. Challenges and Lessons Learned from 15/16

4.1. Acute providers (LNWHT and Imperial) have significant financial challenges. LNWHT also had a substantial change in executive management over the last 12 months. There are numerous initiatives underway to improve performance against NHS constitutional standards. Involvement of the right level of senior leadership from each organization, who actively support issue resolution and decision making, is key to successful delivery across multiple organisations. Having a single Integration milestone plan, which all sign up to, will help in managing the interdependencies with other change initiatives.

4.2. Approach to commissioning and implementing change is different between health and the local authority. Capacity for transformation across agencies is more difficult to obtain, as well as the complexities of working across health and social care. Continued investment of skilled programme and project change resource to drive the planning, coordination and delivery coupled with lead health commissioning resource (who understand the health environment) and lead council commissioning resource (who understand the council environment) is key. Having in place an agreed set of principles for working together and a gateway process for health and social care integration will also help this.

4.3. Brent has made excellent progress against plans for individual schemes and there have been significant developments in the wider programme of work required to achieve the outcomes and benefits of integrated care. The next step will require us to work across stakeholder groups to align these developments creating truly end-to-end pathways– from home to hospital and back again - coordinated around patient, carer and resident needs.

5.0. Proposed Integration Priorities for 16/17

5.1) Keeping the most vulnerable well in the community. Our priorities for the development of Whole Systems Integrated Care in 16/17 are the delivery of the 16/17 model of care and development of the Home Care market to deliver lower level district nursing tasks. Models of care delivery will include alignment of District Nurse Team Leaders and Social Work Team Leaders to the Network-based multidisciplinary teams. We will also embed and test the benefits of deliverables designed to support self-care including 3rd sector Care Navigators, staff training and a new Patient Activation Measure (PAM) which informs patient and carer goal setting, tailoring of care plans and referral to third sector services. Options for the development of the Home Care market to deliver lower level district nursing tasks require detailed design and sign-off. We hope to pilot this in 16/17.

What is the problem this scheme is trying to solve?

The model of care and provider model are designed to improve quality, experience and outcomes for patients with LTCs and their carers whilst reducing costs to the system. In 16/17 we need to improve the productivity and efficacy of the model, increase the capacity and capability within multidisciplinary teams, embed new interventions and roles, and overcome the barriers to integrated working between different professionals, teams and services.

The development of the Home Care market could help plug the capacity gap in the District Nursing workforce, enable DN teams to focus on more complex patients, help Brent make use of the Lot 5 Home Care providers who we believe could provide more complex health and social care support in the patient's own home, and provide a potential career pathway from Home Care into nursing. We hope to reduce multiple visits for patients and handovers between staff, improve coordination and integration and develop a model that engages Home Care providers in care planning, case management and the delivery of support to self-care.

What is the proposed solution to this problem?

The plan for services currently provided by Primary Care has been signed off in the 16/17 Business Case. We will move now to implement the improved model of care, the self-care pilot, market shaping and development of provider partnerships and roll out Integrated Care Records and dashboards from the Data Warehouse. Next steps in the development of the Home Care pilot will include development of a clinical model, co-design of plans with providers, patients and carers and confirmation of the options to train and accredit Home Care providers. It is likely this will be piloted in a defined area of Brent in 16/17 to support proof of concept.

5.2) The Brent Winter Plan for 16/17 (Efficient multi-agency winter resilience and reduction in DTOCs). Building on successes of 15/16, our proposed 16/17 priorities are to implement the following;

- **A.** Single integrated model of hospital discharge across North West London (referred to as the West London Alliance initiative)
- **B.** Additional social worker capacity and additional purchasing capacity
- **C.** Night sitting service
- **D.** Hospital at home service
- **E.** 7 day service (with inclusion of other services).

What is the problem this scheme is trying to solve?

To improve patient flow from hospital into the community and reduce delayed transfers of care designed to make a positive impact and contribution for the 16/17 winter period. To agree a DTOC target that is achievable, stretching and is reflected in CCG operating plans. The current hospital discharge system is for each local authority to be responsible for the discharge of their residents irrespective of whether the hospital is within the borough boundary. The result is confusion for hospitals to discharge via multiple borough procedures and difficulty for Brent council to resource discharge across a significant number of hospitals.

What is the proposed solution to this problem?

Building on the initiatives already implemented in 15/16, our proposal is to develop and implement the following;

A) The West London Alliance initiative is for a single local authority to be the lead for each hospital (for example Brent Council would be the lead local authority for Northwick Park Hospital and take on all discharges for Hounslow, Tri-borough and Ealing residents before the end of this winter) and follow a discharge to assess model. The discharge to assess model would mean hospitals only have to follow one procedure and each Borough minimises its risk as they get involved as soon as the person is out of hospital to put them into longer term care.

B) Night sitting service to spot purchase support as required at night to facilitate effective transition from hospital to home. This will reduce unnecessary hospital admissions due to night needs and to facilitate hospital discharges to the community where there is a high level of need for transition from hospital to home.

C) Hospital at Home service, designed to aid speedier recovery and greater independence for patients discharged from acute hospitals.

5.3) Nursing Care Home Review and Joint Re-Commission. Building on learning of the jointly commissioned step down beds for DTOC, our proposed 16/17 priority is to deliver an improved nursing care home offer in Brent.

What is the problem this scheme is trying to solve?

Complex needs (including dementia) continue to be a challenge for hospital discharge and through health and social care joint commissioning we want to support the system to develop the nursing home market to enable them to meet this growing need. The needs of people in Brent are increasing, with more residents requiring

support in nursing homes and other complex nursing input such as IVs or specialist 1:1 support to manage patient complex needs. Quality issues in our Nursing Care homes such as incidences of pressure ulcers and falls are on the increase. To further extend the early discharging of medically fit people from hospital to enable the market to manage more complex nursing needs in a more homely environment.
What is the proposed solution to this problem? There is much work underway in this area, but it is currently fragmented and unclear how it all fits together, for example (not an exhaustive list); • Health contract with GP's to in-reach into nursing care homes. • Health contract with Rapid Response to in-reach into nursing care homes. • Health BHH developing a health quality standard for nursing homes. • Health CHC placing patients in nursing care homes. • Council commissioning nursing care homes. • Council commissioned nursing bed DTOC step down beds. • Council placing patients directly in nursing care homes. There is a considerable amount of work to be done which will need further partner prioritisation. In 16/17 we will look to pull together all activity into a single Nursing care home plan and jointly manage Brent's bed based market in order to deliver an improved nursing care bed offer in Brent. This review and market engagement activity will likely result in jointly re-commissioning the nursing care home contract in Brent to improve quality, rectify service gaps, reduce A&E attendances and hospital admissions and manage social care and CHC placement costs.

6.0. Embedding and monitoring the benefits from 15/16

It is important to note the integration work started in 15/16 will require embedding and the development of a joint contract monitoring approach. These include;

- We hope to let the **16/17 WSIC contract** in Q1 of 16/17. The preferred route to market will be agreed and the process formally launched over the coming weeks. Delivery activity will continue with no break between 15/16 and 16/17. We will start to measure benefits from the end of Q1 and start to release outcomes based payments to providers from the end of Q2. We will monitor a range of KPIs and outcomes – focusing on non-elective admissions and patient experience. Providers will be performance managed against an agreed delivery and improvement plan.
- The **Integrated Rehab & Reablement Model**. Finalising the implementation of integrated Rehab & Reablement service. This includes putting in place joint commissioning monitoring arrangements to ensure we manage this in the future.
- The **Single Point of Access** proposal, as initiated by NWL CCG Strategy and Transformation Team, ensuring social care is included in the thinking for a community SPA model that will support 7 day discharge in Brent. This includes a redesign of the single point of access currently in the STARRS contract and have dependencies with Brent Customer Service.
- **Review of the 15/16 DTOC initiatives,** to help further shape our Winter Plans for 16/17.

7.0. Programme Approach and Enablers for 16/17

There are a number of enablers required for successful integration:

- **Integrated data and information sharing** - the development of information governance and information technology solutions that support integration is a key feature of any integration programme. All GP Practices and major providers in Brent (bar Royal Free) have signed the Whole Systems Information Sharing Agreement (WSIC ISA) which enables extraction and synthesis of specified data for patients aged 18 and over from GP, Acute, Community, Mental Health and Social Care into a linked dataset. The data is used to produce patient-level Integrated Care Records and a suite of dashboards for direct and indirect care purposes. These are governed by a system of role-based access and meet information governance requirements. Dashboards will be used to support direct care and also to understand flows and activity across a range of services, to review system performance and to track associated costs and benefits.

- **Training and OD for system leaders and for frontline teams** – one of the key enablers for integrated care is training and OD to support team development and team building for new integrated teams, training in new processes and operating procedures, and training in key competencies and behaviours for example structured problem-solving, influencing skills, difficult conversations and shared decision making with residents, patients and carers. Commissioners and providers will also need to consider the longer term impact of integration on the Brent workforce and opportunities to support recruitment, retention and career development.

- **Engagement and communications** - with patients, carers, residents, staff. The Brent integration programme has engaged stakeholders in the design of service improvements and new models of care. Work is also being undertaken to communicate the development of integrated data with materials and information to support communications produced and freely available via a multitude of channels (posters, leaflets, DVDs, online videos and SMS content).

These enablers all require input from subject matter experts across Brent's health and social care economy which requires ownership and coordination. In 16/17 we need to review our programme framework and confirm named leads for each of these enablers. This approach will increase the chances of successful implementation in Brent, while maximizing the use of existing resource. Other enabling workstreams likely to be required in 16/17 include workstreams to support the development of new provider models (Federations, Alliances, ACPs), the development of a digital roadmap for Brent and a review of estates.

8.0. Assurance Timeline

Final BCF plans need to be signed off by H&WB and submitted to NHS England by Monday April 25, 2016. The s75 agreement for 16/17 needs to be signed and in place by Thursday June 20, 2016. The proposal is to for the H&WB to approve the proposed priorities today and to agree delegated sign off of final plans and s75 to Brent CCG COO and Brent Strategic Director Community Wellbeing.

9.0. Financial Implications

For 16/17 in Brent, the minimum pooled funding is £23.7m (£20.101m from CCG, £3.599m from Council.

10.0. Legal Implications

The legal obligations on the Council changed with the passing of the Health and Social Care Act 2012 ("the Act"), which gave the Council new duties to:

- Improve the health of the people in its area; and
- Take steps to ensure that plan are in place to protect the health of the population.

The proposed approach of increased integration in relation to winter planning is in line with the Council's legal responsibilities, in particular in relation to public health. The role of promoting integration and joint working in health and social care services across Brent is delegated to the Health & Wellbeing Board and the Brent Integration Board.

11.0. Diversity implications

The Better Care Fund Plans support the H&WB Board to deliver in a fair and equitable way to the community.

Contact Officers

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NHS Brent Clinical Commissioning Group

Brent Health and Wellbeing Board
22 March 2016

Report from NHS Brent Clinical Commissioning Group Clinical Director and Brent Council Strategic Director - Children and Young People

For approval | Wards affected: ALL

- **Update on Children and Young People's Mental Health and Wellbeing Transformation Plan implementation**
- **Process and timeline for updating the joint plan**

Link to publicly available plan:
https://www.healthiernorthwestlondon.nhs.uk/documents/mental-health/children-and-young-peoples-mental-health-transformation-plan

1.0. Summary

1.1. *'Future in Mind'* was published in March 2015 following work by the Government-led Children and Young People's Mental Health and Wellbeing Taskforce, across education, health and social care. This provided a moral and economic case for change

1.2. In response, development of the Children and Young People's Mental Health and Wellbeing Local Transformation Plan (CYP-LTP) was led by the NHS Brent Clinical Commissioning Group (CCG) Clinical Director of Children and Mental Health, with input from Brent Council (Strategic Director - Children and Young Peoples Services, Director of Public Health, Director of Adult Social Care, and elected members involved in the Health and Well-being Board). Coordination and production of a combined plan across the eight boroughs in North West London was via the 'Like Minded' team. Every borough plan and the combined plan were signed off by the respective CCG Chair and Council Leader. The Brent plan was approved by the Leader of Brent Council on 14th October 2015, and by the Chair of the NHS Brent Clinical Commissioning Group on 15th of October 2015. Additional clarification information was provided on 30th November 2015.

1.3. In December 2015, NHS England agreed to support the plan, and to provide an additional £573,052 to NHS Brent CCG for each of the financial years 2015/16, 2016/17, 2017/18, and 2018/19.

1.4. The Bent plan was presented at the 09 February 2016 Brent Council Scrutiny Committee. The report provided a list of the existing commissioned services, and the total investment mental health services for children and young people in Brent.

1.5. Existing investment from schools, Brent Council, NHS Brent CCG, and NHS England is around £3.4m in 2015/16. NHS Brent CCG and Brent Council confirmed there are no plans to disinvest in mental health services for children and young people in Brent. The plan will review existing arrangements with the intention of reshaping and improving the use of resources.

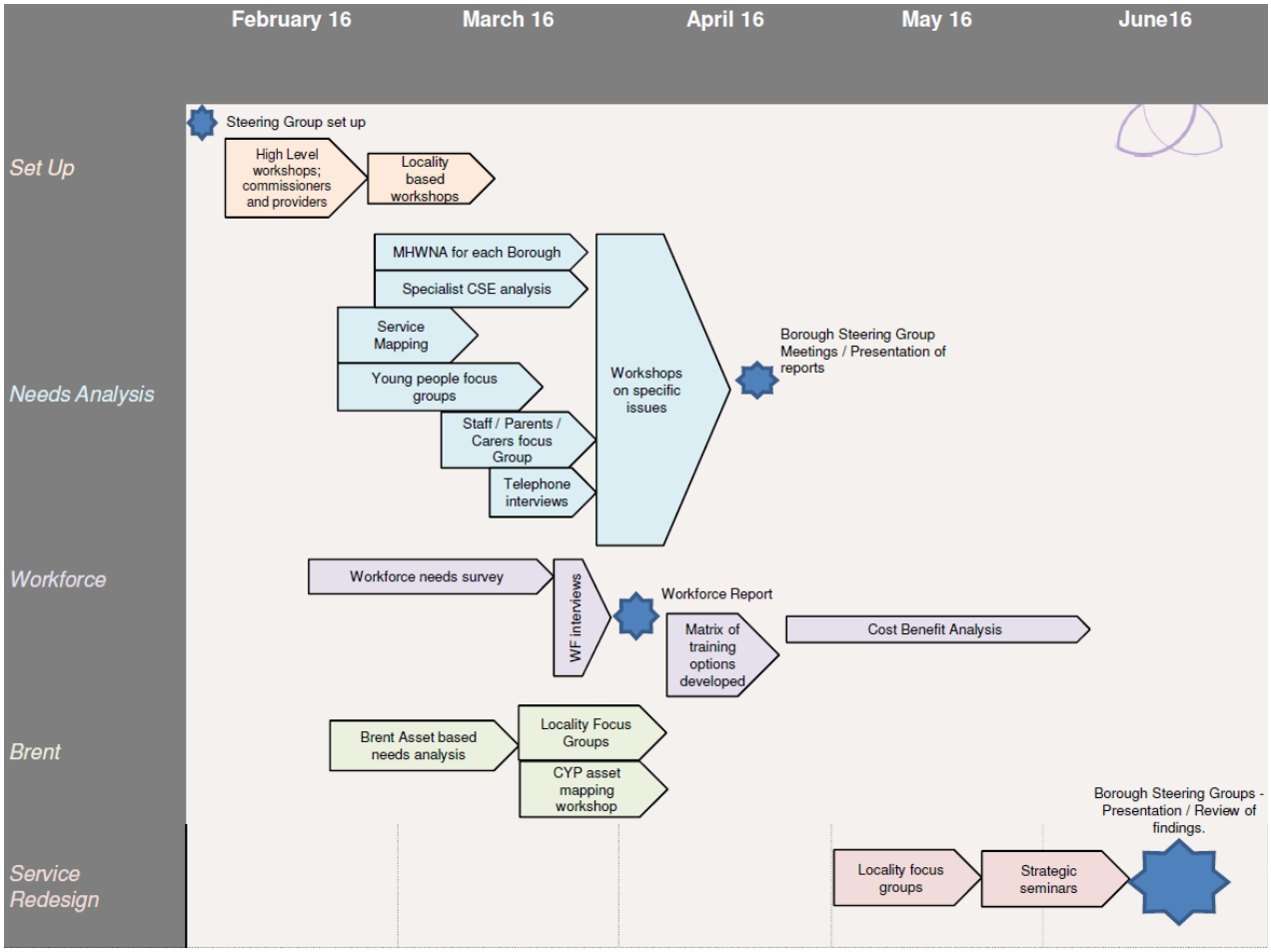
2.0. Recommendations

The Brent Health and Wellbeing Board are asked to:

- Note the progress to date on delivering the CYP-LTP;
- Endorse the principle that the additional funding from NHS England should be additional to the existing funding identified in the CYP-LTP;
- Agree to the proposed assurance sign off of CYP-LTP submission for 2016/17.

3.0. Achievement to date

3.1. **Priority 1: Needs assessment.** The Anna Freud Centre won a competitive tender to support the delivery of this priority. The specification included a bespoke 'asset based needs analysis' of Brent, to identify strengths within existing communities. The original proposal was to focus this effort in March and April 2016. A list of stakeholders is being developed so that the Anna Freud Centre can begin to make contact. As the Anna Freud Centre also provides direct support to some schools, Brent CCG and Brent Council are exploring ways to mitigate any potential conflict of interest by involving Brent HealthWatch in relevant aspects of work. The Anna Freud Centre will not be leading work on a local anti-stigma campaign, and alternative support is being considered to lead this.



Proposed timetable from the Anna Freud Centre for delivering the needs analysis (priority 1) and workforce development and training analysis (priority 2).

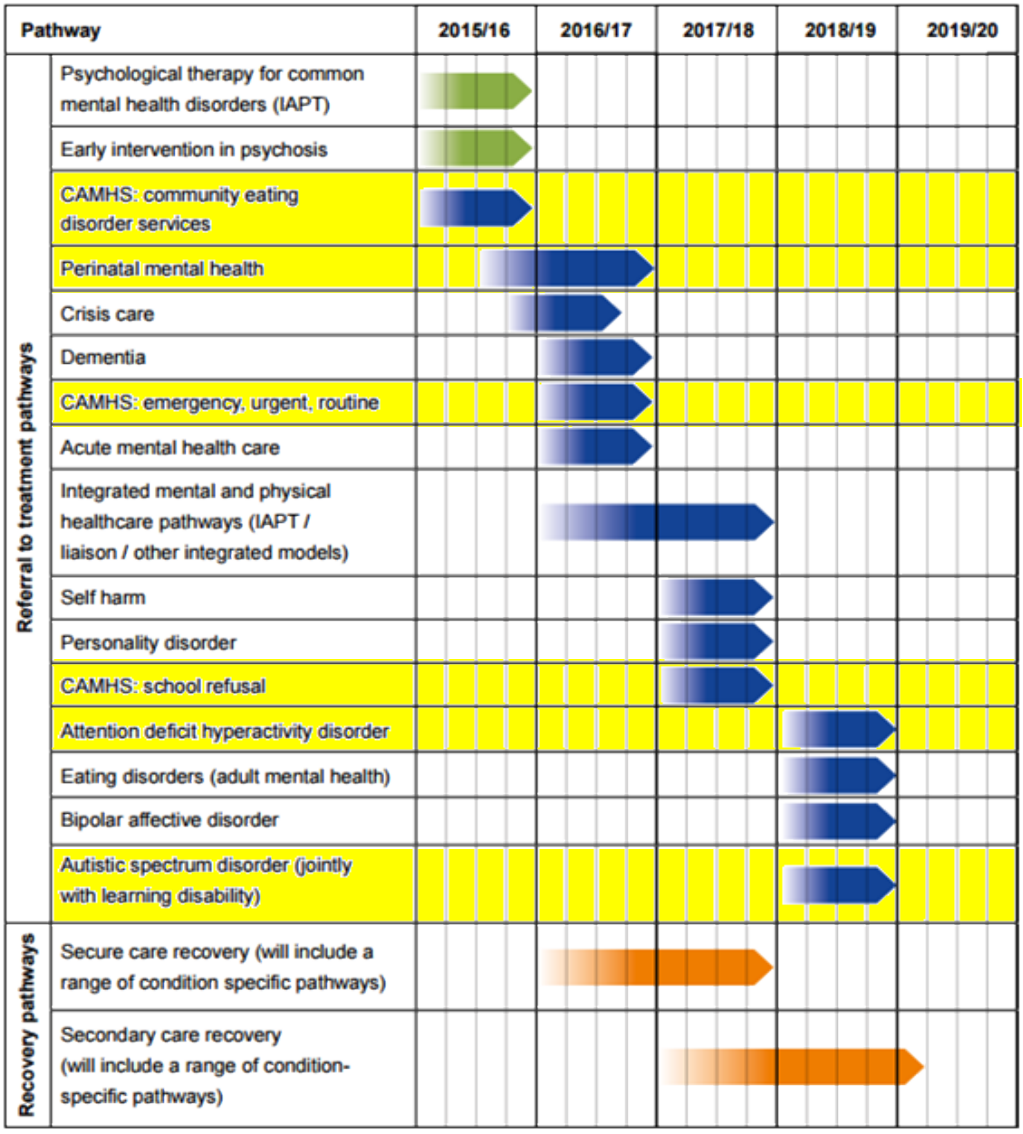
3.2. **Priority 2: Supporting co-production.** Existing engagement opportunities are being mapped. These will be supplemented throughout the delivery of the plan by targeted work to engage specific groups of children, young people, families, schools and wider communities. This work will build on existing approaches for Looked After children, and using the principles and workstreams being established by Brent CCG and Brent Council as part of the Brent Equality, Engagement and Self-care strategy.

3.3. **Priority 3: Workforce development and training.** The Anna Freud Centre won a competitive tender to support the delivery of this priority. A list of stakeholders is being developed so that the Anna Freud Centre can begin to make contact. As the Anna Freud Centre also provides direct support to some schools, Brent CCG and Brent Council are exploring ways to mitigate any potential conflict of interest by involving Brent HealthWatch in relevant aspects of work. The work will be coordinated alongside a training needs analysis of GPs, being led by Health Education England.

3.4. **Priority 4: Specialist Community Eating Disorder Service for children.** NHS England identified £163k to be directed by Brent CCG towards the establishment of North West London community eating disorder service for children as soon as possible. Currently, children with eating disorders are seen within mainstream specialist CAMHS, or by specialist inpatient services commissioned by NHS England. A service specification from NHS England has been locally adapted. The number of children who would be eligible has been established. An implementation plan for recruitment (including backfilling existing posts) is being developed. It is intended that an interim service is in place by the end of September 2016. Workforce issues may be a limiting factor in delivery, and a review is planned for September to determine

whether wider cooperation with other regions of London is required to deliver a viable service. NHS England will review progress in 2016/17 to determine whether the level of funding awarded in 2015/16 is justified going forward.

3.5. **Priority 5: Redesigning pathways – A tier free system.** This priority will be addressed after completing the needs assessment (Priority 1) and workforce review (Priority 3). It will be supported by ongoing community engagement and coproduction (Priority 2). Where possible, service redesign will be in line with the proposed national timescales in the Five Year Forward View for Mental Health (published February 2016). For 2015/16, non-recurrent funding has been provided to deliver increased capacity and reduce waiting lists ahead of any service redesign. Brent CCG is involved with the perinatal maternity pilot at Queen Charlotte's Hospital, and is working with the Strategic Clinical Networks for maternity and mental health, and the Health London Partnership for children, to take forward the learning from this pilot.



Proposed mental health pathway and infrastructure development from The Five Year Forward View for Mental Health (published February 2016, p36). Highlights in yellow added to show workstreams most relevant to children's mental health.

3.6. **Priority 6: Enhanced support for learning disabilities and neurodevelopmental disorders.** This priority will be addressed after completing the needs assessment (Priority 1) and workforce review (Priority 3). It will be supported by ongoing community engagement and coproduction (Priority 2). Where possible, service

redesign will be in line with the proposed national timescales in the Five Year Forward View for Mental Health (published February 2016). For 2015/16, non-recurrent funding has been provided to deliver increased capacity and reduce waiting lists ahead of any service redesign. The specialist workforce market for neurodevelopmental disorders is very limited, making it a challenge for the provider to increase the capacity of the service quickly.

3.7. **Priority 7: Crisis and urgent care pathways.** The existing pilot out-of-hours service agreed in 2014/15 went live in January 2016, providing a better resourced crisis response service. The pilot will help quantify and gather evidence of the frequency, complexity, and severity of demand. Between November 2015 and January 2016, there have been further developments in adult mental health urgent care pathways. The intention in the CYP-LTP is to explore opportunities to combine these pathways into a crisis response service capable of responding to people of all ages.

3.8. **Priority 8: Embedding 'Future in Mind'.** To improve frontline services, funding for a specialist worker post within the Youth Offending Service has been agreed from April 2016, as an extension of the existing specialist CAMHS service provided by CNWL. To improve joint commissioning, an interim CAMHS commissioner has been appointed to help formally establish the CAMHS subgroup of the Brent Children's Trust Board. This group will oversee delivery of the plan, and ensure a joined up approach with other areas of children's service commissioning. A job description for a fixed-term joint CAMHS Commissioner role is being developed jointly between Brent CCG and Brent Council.

4.0. Assurance Timeline

4.1. An updated implementation CYP-LTP needs to be incorporated into the Sustainability and Transformation Plan. Draft submission is due in April 2016, with final submission by June 2016.

4.2. The proposal is that the Health and Well-being Board endorse continuing to progress the existing priorities in the CYP-LTP, and delegate sign off of the updated plan to the Brent CCG Chief Operating Officer, and the Brent Council Strategic Director – Children and Young People.

5.0. Financial Implications

5.1. Existing investment from schools, Brent Council, NHS Brent CCG, and NHS England is around £3.4m in 2015/16. Current funding for children's mental health and well-being in Brent was detailed in the CYP-LTP submission to NHS England.

NHS Brent	NHS England	Brent Council
£2,471,000	£403,629	£370,751*

* In addition to this figure, 17 schools are paying a total of £161,600 in 2015/16 for the TAMHS (Targeted Mental Health in Schools) project, with the Local Authority funding £105,000 towards this service. Public Health also gave a one off grant of £30,000 for a Mental Health in Schools Programme for 2015/16 to include training for school staff and workshops for parents.

5.2. NHS England has supported the CYP-LTP and provided an additional £573,052 to NHS Brent CCG for each of the financial years 2015/16, 2016/17, 2017/18, and 2018/19. Of this, £409k has been included in the Brent CCG baseline allocation of

funding from 2016/17; a separate £163k for Community Eating Disorder Services for children, and is subject to further assurance by NHS England.

5.3. There are no plans to disinvest in children's mental health and well-being services in Brent. The CAMHS Local Transformation Plan will review existing arrangements with the intention of reshaping and improving the use of resources.

10.0. Legal Implications

The legal obligations on the Council changed with the passing of the Health and Social Care Act 2012 ("the Act"), which gave the Council new duties to:

- Improve the health of the people in its area; and
- Take steps to ensure that plan are in place to protect the health of the population.

The role of promoting integration and joint working in health and social care services across Brent is delegated to the Health & Wellbeing Board and the Brent Integration Board.

11.0. Diversity implications

The Children and Young People's Mental Health and Wellbeing Local Transformation Plan supports the Health and Well-being Board to deliver in a fair and equitable way to children and families in the community.

Named leads
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Brent	**Health and Wellbeing Board** 2016 **Report from NHS Brent Clinical Commissioning Group**
For information	
Report Title: ***Update on Brent Primary Care Transformation***	

1.0 Introduction

1.1 This paper updates the Brent Health and Wellbeing Board on local work to deliver the objectives of Primary Care Transformation - a portfolio of work to develop effective and sustainable Primary Care in Brent.

1.2 The aim of the paper is to give the Health and Wellbeing Board an opportunity to:

- Understand the current programme of work and approach to supporting Primary Care Transformation in Brent.
- Discuss the strategy for Brent – particularly in light of work being undertaken across North West London to develop the Sustainability & Transformation Plan 2016/17-2020/21
- Agree whether there are key messages that need communicating to Brent residents

2.0 Primary Care in Brent

2.1 There are 66 GP practices in Brent serving a registered population of 370,904 people (January 16). Each practice is a member of NHS Brent CCG which has 5 geographical localities. This gives practices a role in shaping local commissioning to achieve clinically effective, patient driven services. The CCG Chair, Clinical Directors and Clinical Leads are the clinical commissioning roles in the CCG.

2.2 The 66 GP practices are also providers – they provide some services as individual practices but also now work together in Networks to help them provide new functions and services for their patients where this cannot be provided at individual practice, due to skills, competencies and/or workforce. There are currently four networks in Brent; a Network is a legal entity with its own governance structure and is not part of the CCG.

Networks are accountable to commissioners where the Network is contracted to provide services.

2.3 As is the case nationally across the UK, Primary Care providers in Brent currently deliver core services (general medical services [GMS]) and enhanced services let through Personal Medical Services contracts (PMS) or Alternative Provider Medical Services (APMS) contracts. Primary Care providers also have a significant and emerging role in delivery of out of hospital services and integrated care in their role as coordinators of care for their patients.

2.4 Brent CCG currently has contracts in place with Primary Care for Out of Hospital services (OOH). The services commissioned at practice level include:

- *Cardiology* – 12 hour lead ECG, 24 hours BP monitoring
- *Carers* – identifying carers and including them on the carers register
- *Insulin Initiation*
- *Improved Access to Psychological Therapies (IAPT)*
- *Hormone Antagonist Injections*
- *Disease Modifying Anti-Rheumatic Drugs (DMARD)*

As these services are commissioned from individual practices not all GP practices offer them. To improve equity the CCG will review these schemes and seek ways to ensure these services are accessible to all patients in Brent - Networks may have a key role to play here as they can support individual practices to deliver at-scale, e.g. alternative practices within the network offering services on behalf of practices who are not able to offer a specific service. Services already commissioned at Network level include:

- *Phlebotomy* – blood tests and Glucose tolerance tests
- *GP Access Hubs* – routine GP appointments provided from Monday to Friday 6pm-9pm and also at weekends and bank holidays from 9am-3pm
- *Care Home and High Risk Housebound service* – provides enhanced GP access for Nursing Homes, Residential Homes and High Risk housebound patients with enhanced and dedicated GP access from 8am-8pm, out of hours service 6pm-8pm
- *Improving GP Clinical Outcomes across Networks* – aiming to improve indicator/triggers highlighted by NHS England within each practice and network

By commissioning at Network level we increase equity and access to these services for example any Brent registered patient can access Phlebotomy from any practice or walk-in service providing it within Brent – access is not limited by practice or Network boundaries.

2.5 Brent CCG also has contracts in place with the GP Networks for the delivery of services that form the building blocks of our vision for Whole Systems Integrated Care *(WSIC)*. This is a model of care planning and case management for adults with long term conditions. It first emerged as the Integrated Care Programme and transitioned to WSIC in 2015/16. The key change is greater ownership by Brent Networks, increased collaboration between providers and a multidisciplinary case management approach, coordinated by the GP as the accountable professional.

3.0 National and regional strategy for Primary Care

3.1 As an essential part of our health and care system, Primary Care must remain fit for purpose and able to provide safe, effective and high quality care. The objectives for Primary Care are reflected in national and regional strategies which we both shape and respond to locally.

3.2 In *London-A Call to Action* NHSE asked areas to develop joint Primary Care strategies that put general practice at the heart of a wider system of integrated out-of-hospital care. Population growth, widening health inequalities and complexity of need is driving up demand on general practice. There are also significant financial pressures.

3.3 The *Prime Ministers Challenge Fund* (PMCF)[1] followed this, with a message from the government that the traditional model of Primary Care - GP practices working in isolation of each other - is outdated and unsustainable. Practices need to work together in Networks in order to provide extended and more flexible access to patients.

3.4 The NHS Five Year Forward View followed stating clearly '*the foundation of NHS care will remain list-based primary care*'. It recognises the pressure Primary Care and GPs in particular are under and commits to investing more whilst stabilising the general practice funding model. Specific planned developments include:

- CCGs (and member practices) will have more control over the NHS budget as a whole helping shift investment from acute to primary and community services; this will require Primary Care to play a role in multiagency working, new care models and new delivery models (provider and payment models).
- Primary Care will play a significant role in development of proactive and preventative care (alongside Public Health).
- Primary Care will need to develop its operating model and upgrade infrastructure to support improved access, high quality care and effective use of technology to predict, diagnose and treat.
- Commissioners will need to work with Primary Care (and all other providers) to ensure patients receive an accessible and equitable service and reduced variation.
- Finally, we must support GP training, recruitment and retention and the development of the Primary Care workforce.

3.5 *Co-commissioning* is also a major element of the *Five Year Forward View*. Through this NHS England has committed to co-commissioning arrangements with CCGs which support development of integrated out-of-hospital services based around the needs of local people. This includes improved access to primary care and out-of-hospital services, with more services available closer to home. Services must be high quality, improve health outcomes, reduce health inequalities and improve patient experience through a more joined up approach. The model of Co-commissioning for NWL and Brent has been agreed and is being further developed.

[1] Now known as the Prime Ministers GP Access Fund, see https://www.england.nhs.uk/ourwork/futurenhs/pm-ext-access/

3.6 Transforming Primary Care in London: A Strategic Commissioning Framework specifies (at a high level) the capability and capacity that primary care in London should provide. Built on extensive patient engagement (including representatives from Brent) it seeks deliverables and outcomes resulting in accessible, proactive and coordinated primary care. Implementation requires GPs to work together and consider population health, whilst protecting local care, personalised care and continuity of care. Example of work to date to deliver against the framework includes:

- Improved access – GP Access hubs, routine GP appointments 7 days a week
- Workforce development – using Health Education North West London (HENWL) and Community Education Provider Networks (CPEN) funding
- Use of technology – e-consultations and video conferencing facilities.

4.0 Local strategy for Primary Care

4.1 Our work with Primary Care reflects the strong view in Brent that Primary Care is - and will remain - a fundamental provider and the foundation of the doctor-patient relationship.

4.2 Our vision for integrated care codesigned with local residents states this explicitly with the goal of commissioning and delivering models of care that have *'GPs at the centre of organising and coordinating care alongside patients and carers'.*

4.3 The foundations for this model of care need to be built in primary care and work to achieve this is being taken forward in NWL under the *Primary Care Transformation Programme.* This supports delivery against national expectations but also reflects objectives agreed at NWL and Brent level as featured in local strategies and plans including the CCG Commissioning Intentions. Colleagues are working on the following deliverables with national, regional and local partners:

- *PMCF Sustainability funding*
- *Co-commissioning* (working with NHSE)
- *Personal Medical Services (PMS) review* (working with NHSE)
- *Review of the Primary Care Estate* in Brent (working with NHSPS)
- *Primary Care – New Model of Care* (Brent with NWL partners)

4.4 *PMCF* - the CCG allocated PMCF resource to the development of the four Networks now established in Brent. PMCF funding has supported practices to deliver extended access, new technology, improvements to appointment booking and online services (for example prescription services). *PMCF Sustainability funding* will help drive through remaining deliverables and embed these improvements.

4.5 *Co-Commissioning* - Brent CCG has entered into joint arrangements with NHS England to shape and commission local Primary Care services. *Co-Commissioning* will enable the CCG to better influence development of local Primary Care and ensure it remains at the centre of ambitious plans to transform the health and care economy. NWL CCGs opted for *Level 2 Primary Care Co-commissioning*; this means decisions made regarding contracts for General Medical Services (GMS), Personal Medical Services (PMS) and Alternative Provider Medical Services (APMS) are made jointly with NHSE. This is via the *Local Primary Care Co-commissioning Committee*, which

includes representatives of the Health and Well Being Board (Chair) and Adult Social Care (Lead Member) (monthly). The Committee also reviews commissioning decisions for enhanced and out of hospital services based in Primary Care.

4.6 *PMS review* - Brent CCG is also engaged in the national Review of PMS Contracts. PMS agreements are locally agreed contracts between NHSE and a GP practice. They offer more flexibility than nationally negotiated GMS contracts offering variation in the range of services which may be provided by the practice, the financial arrangements and the provider structure. 2014/15 PMS funding for London totalled £90 million. 621 of the 1,405 practices have PMS (44% - slightly higher than the national average). In Brent 11 of 66 have PMS (17%). The review considers how far PMS expenditure is effectively paying for 'core' primary care services, paying for innovation and quality improvement in primary care and paying for 'enhanced' primary care services. It will agree how best to apply the principles of equitable funding and best value. In Brent the *PMS Task and Finish Group, which includes GMS and PMS GP practice representation and the LMC,* will oversee the review of existing allocations and develop recommendations for future commissioning. This feeds into the *Local Primary Care Co-commissioning Committee* and *North West London Steering Group* which:

- Ensures the process is undertaken in a robust and impartial manner with local and clinical engagement
- Will analyse the financial impact of a Mandatory London PMS offer and any proposed reduction in PMS support to practices (including any transitional funding arrangements)
- Ensure an impact assessment is completed
- Oversee the implementation of PMS plan.

Brent PMS commissioning intentions were submitted to NHS England on 19 February 2016 and the CCG are awaiting approval. Once approved, it will be communicated to practices and the public.

4.7 *Primary Care Estates review* - review of the Primary Care estate in Brent will be undertaken alongside NHSPS. Work to map the characteristics and quality of the existing estate has commenced. This will be followed by the development of a strategy and plan.

4.8 *Primary Care – New Models of Care* - early work to consider the vision and plan for a new model of care has been done at North West London level. Detailed local work is yet to begin in most areas including Brent. Local areas will review the range of services Primary Care could deliver and consider the most effective clinical and operational model. Delivery 'at-scale' e.g. across Brent supporting equitable access, will be key as will the development of approaches that support patients and carers to self-care and self-manage.

5.0 Next steps for Primary Care

5.1 Brent partners (commissioners, providers and local authorities) are required to submit a shared Sustainability and Transformation Plan (STP) in response to Shared

Planning Guidance covering the period 2016/17-2020/21. This will include plans for Primary Care and Primary Care's role in out of hospital care as outlined in this paper.

5.2 The detailed work to agree the Primary Care model of care and associated budgets will need to be completed and agreed and providers and residents will be engaged in this process.

5.3 To deliver the new model of care effectively Brent GP Networks need to further develop partnerships and joint working. The emerging partnership between the Networks is referred to in Brent as the 'federation'. PMCF sustainability funding may be allocated to this work. Healthy London Partnerships have also offered their support.

5.3 The Networks are currently considering the value of a Federation – a partnership or legal joint venture to underpin joint working and delivery of these services for Brent patients.

5.4 The 2016/17 contract for Whole Systems Integrated Care (WSIC) for adults with long term conditions presents one of the first opportunities for the Networks to come together in this way as it seeks to let a single contract to a group of providers to cover all elements of the model of care. The Business Case is published here.

5.5 This 'horizontal' integration between Primary Care is the foundation for 'vertical' integration with other providers e.g. Social Care (and other providers in the local authority marketplace), community services, mental health, acute and the third sector. Work to develop Primary Care Transformation and Whole Systems in Brent is considering opportunities offered by new contracting approaches. This represents as a step towards an Accountable Care Partnerships (ACP) – a group of providers jointly responsible for population health and care delivery, management and outcomes.

5.6 The expected benefits to patients, residents and the system are:

- Equity of access to services across Brent
- Continuity of service offer across Brent
- Economies of scale, efficiency and the sharing of risk and reward
- Delivery at scale - working across boundaries and in partnership with other providers
- Improved engagement –Primary Care able to speak with one voice to commissioners, to provider partners and to patients, carers and residents

5.7 Commissioners wish to retain the ability to commission services at Network and at Practice level; the decision will be based on the care model and pathway for the service being delivered and this will be evaluated on a case by case basis.

6.0 Engagement of Brent residents

6.1 The CCG has engaged patients and carers in the development of primary care services and integrated care models with primary care at the centre under Whole Systems. The input of Brent residents has played a significant part in the shaping of short and longer term plans and commissioning intentions. WSIC has been shaped by a Brent Lay Partners Forum and the wider vision for Primary Care has been shaped through

Health Partners Forums (September 2015, January 2016) and an open session for patients interested in primary care development in November 15.

6.2 The CCG will continue to engage and communicate via public events and more targeted engagement recognising patient views and experiences are essential to the design of safe, effective and high quality services and acknowledging the requirement for engagement where groups may be impacted by any proposed change. We will engage around PMS commissioning intentions and primary care KPIs and outcomes.

6.3 The Brent CCG AD for Primary Care attends the Brent Council Scrutiny Committee and there is regular communication with members of the HWWB who are also members of the Local Primary Care Co-commissioning Committee. At present there is no plan or timetable for any statutory public consultation however the CCG understands its duties and will of course engage appropriately.

7.0 Conclusion

The Brent Health and Wellbeing Board are asked to:

- Note the progress made in the development of Primary Care in Brent.
- Comment on the strategy for Brent and work that will be undertaken during the period covered by the Sustainability & Transformation Plan (2016/17-2020/21).
- Provide a steer on any key messages that need communicating to Brent residents.

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Brent	**Health and Wellbeing Board** 22 March 2016 **Report from the Director of Public Health**
For Decision	

2015/16 Revision of the JSNA

1.0 Summary

1.1 The Council and the CCG through the Health and Wellbeing Board have a duty to produce a Joint Strategic Needs Assessment of health and social care needs. The existing JSNA has been revised to include updated information and an expanded scope. This paper outlines the requirements of the JSNA and the process and products of the 2015/16 revision.

2.0 Recommendations

2.1 The Health and Wellbeing Board is asked to agree the publication of the JSNA Overview Document, attached.

2.2 The Health and Wellbeing Board is asked to note plans for the dissemination of the JSNA within the CCG, the Council and HealthWatch members.

2.3 The Health and Wellbeing Board is asked to consider how the JSNA can best be incorporated into future planning.

3.0 Detail

Requirements of the JSNA and process of revision for 2015/16

3.1 The Health and Social Care Act 2012 places a duty on the Health and Wellbeing Board to produce a Joint Strategic Needs Assessment (JSNA)[1]. JSNAs are assessments of health and social care needs, that is needs which could be met by the local authority, CCG or NHS England. There is no prescribed format or template for JSNAs. As well as describing health and

[1] Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies. Department of Health. 2013. Gateway 16630

care needs, there is an aspiration that JSNAs consider wider factors which may impact on health and wellbeing, for example housing or employment.

3.2 The requirement to produce a JSNA predates the Health and Social Care Act and the current JSNA is the latest in a series of products which have been produced over several years by the Council and firstly the PCT and latterly the CCG.

3.3 There is a current JSNA agreed by the Health and Wellbeing Board and published on the Council website. /www.brent.gov.uk/your-council/partnerships/health-and-wellbeing-board/jsna/

3.4 As health and social care needs are not static, there is an ongoing process of refreshing the JSNA. This has been delivered by a cross Council / CCG Working Group. The Group have developed two products. Firstly a series of information sheets which focus on specific areas. Secondly an overview JSNA which brings together the main messages from each information sheet into one place.

3.5 The information sheets have been through a sign off process by appropriate DMTs (and the CCG) with a view to ensuring both the accuracy of content but also that any departmental requirements of the JSNA are met; for example the expectations of Ofsted.

3.6 It is intended that the overview document and the suite of information sheets are jointly branded as 'the Brent JSNA'.

3.7 As the JSNA duties it jointly upon local authorities and CCGs, the JSNA products have been produced jointly by the Council and the CCG. The overview document was agreed by the CCG at its February formal Executive prior to presentation to the HWB.

3.8 The JSNA is a descriptive document, it should describe health and social care needs, the determinants of these, and how needs may differ between different groups. It is not intended to prescribe the response to those needs, rather the intention is that it should form the staring point for a range of plans. There is an expectation that CCG, NHS England and local authority commissioning is informed by the JSNA with the CCG being required to demonstrate that it's plans take account of the JSNA

Structure of the 15/16 Revision

3.9 The JSNA Information Sheets cover the following topics:

- Air Pollution
- Children and Young People
- Dementia
- Diabetes
- Domestic Abuse
- Economy and Employment
- Female Genital Mutilation
- Health and Lifestyle
- Housing, Homelessness and Health

- Learning disabilities
- Life expectancy and Mortality
- Liver disease
- Mental Illness
- Older People
- People and Place
- Physical disabilities
- Primary Care
- Secondary Care
- Sexual Health
- Smoking
- Social Isolation
- Substance Misuse
- TB
- Transportation

3.10 For the 2015/16 revision it was decided to present as much material as possible as infographics. The information sheets on People and Place, Life Expectancy and Transportation are included with this paper by way of example of this approach. Prior to publication on the Website, other Information Sheets are available on request from the Director of Public Health

3.11 The Overview Document is structured around five themes:

- Brent Priorities and Challenges: particular issues for Brent
- Adult Social Care
- Children and Young People
- Life expectancy and mortality
- Wider determinants of health: housing, employment etc.

4.0 Dissemination of the JSNA

4.1 The JSNA will be published on the Council website. As it contains a wealth of information which can be of value to the CCG and the Council but also to partners in particular the third sector, a communication plan has been developed. This includes dissemination across the CCG and the Council through informal staff learning and development activities, for example lunchtime presentations and an online quiz. Members of the JSNA Working Group have begun engagement with partners with presentations of the JSNA to groups including the LD partnership Board and the ASC Provider Market Engagement Forum. Following endorsement by the Health and Wellbeing Board, it is planned to use the JSNA as the basis of the next HealthWatch public meeting to inform their second year priorities. The revised JSNA will need to inform Brent aspects of the STP.

Background Papers
JSNA Information Sheets available on request

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Brent Joint Strategic Needs Assessment (JSNA)

Overview Report: 2015/16

Introduction

This refresh of Brent's JSNA provides an assessment of health and social care needs and their determinants. The JSNA refresh is based on an analysis of a range of datasets including demographic data, behavioural determinants of health (smoking, drinking and dietary habits), and epidemiology (life expectancy and the prevalence of diseases).

Comparisons are drawn against regional and national health outcomes to better understand whether the issues identified in Brent are similar to elsewhere.

The Overview Report is divided into five thematic areas. These are as follows:

1) Brent Priorities and Challenges
2) Adult Social Care
3) Children and Young People
4) Life Expectancy and Mortality
5) Wider Determinants of Health

To accompany the Overview Report, a series of Information Sheets have been developed. These sheets encapsulate some of the main health and care challenges in Brent.

The Information Sheets developed as part of this refresh are as follows:

- Air Pollution
- Children and Young People
- Dementia
- Diabetes
- Domestic Abuse
- Economy and Employment
- Female Genital Mutilation (FGM)
- Health and Lifestyle
- Housing, Homelessness and Health
- Learning Disability
- Life Expectancy and Mortality
- Liver Disease
- Mental Illness
- Older People
- People and Place
- Physical Disability
- Primary Care

- Secondary Care
- Sexual Health
- Smoking
- Social Isolation
- Substance Misuse
- Transportation
- Tuberculosis

OVERVIEW OF THE DEMOGRAPHIC PROFILE OF THE LB BRENT

Location of LB Brent

Brent is an outer London borough situated in North West London (figure 1).

Figure 1: Location of LB Brent. Source: Brent Council, Research and Intelligence team

Population

Brent has a population of 328,800[1] and a population density of 75.2 people per hectare. The population has grown significantly since 2001 and is predicted to continue to grow.

The population change in Brent between 2011 and 2016 varied significantly at ward level (figure 2). The largest population growth was in Alperton (17.1%). In Harlesden there was a population decrease of 4% between 2011 and 2016.

[1] GLA short term population projections, 2014

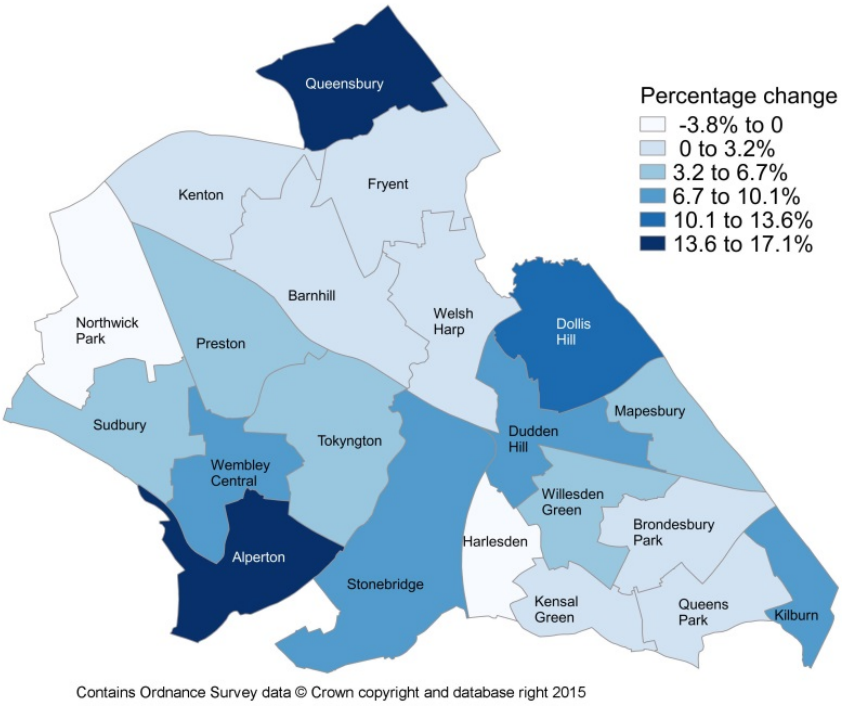


Figure 2: Population change from 2011 to 2016. Source: GLA short term population projections, 2014 rnd

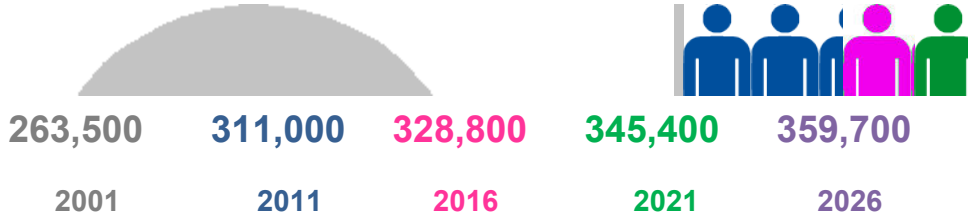


Figure 3: Current and projected population growth in Brent. Source: GLA short term population projections, 2014 rnd

The CCG registered population in July 2015 was 367,589. This is the number of people registered with a Brent CCG GP practice[2].

Age Profile

Brent has a young population with 35.1% aged between 20 and 39 (figure 4).

- The under 18 population makes up 22.9% of the population
- The 16-64 (working age population) makes up 68.2% of the population
- The 65 and over population makes up 11% of the population

[2] Health and Social Care Information Centre (Data extracted from GP Payments system for July 2015)

Figure 4: 2016 population. Source: GLA short term population projections, 2014

Gender

According to the 2011 census, there were 1,721 more males (156, 468) than females (154,747) in Brent, giving a gender ratio of 50.3 to 49.7.

Sexual identity

In 2013, 1.6% of adults aged 16 and over in the UK identified their sexual identity as lesbian, gay or bisexual[3]. In Brent, this equates to approximately 4,000 adults.

Ethnicity

Brent is ethnically diverse: 66.4% of the population is Black, Asian or other minority ethnicity (BAME) (figure 5). This has increased since 2011, when BAME groups made up 63.7% of the population.

The Indian ethnic group currently make up the highest proportion of BAME (19% of the population), followed by Other Asian (12%). The White group make up 33%.

[3] ONS, Integrated Household Survey, January to December 2013

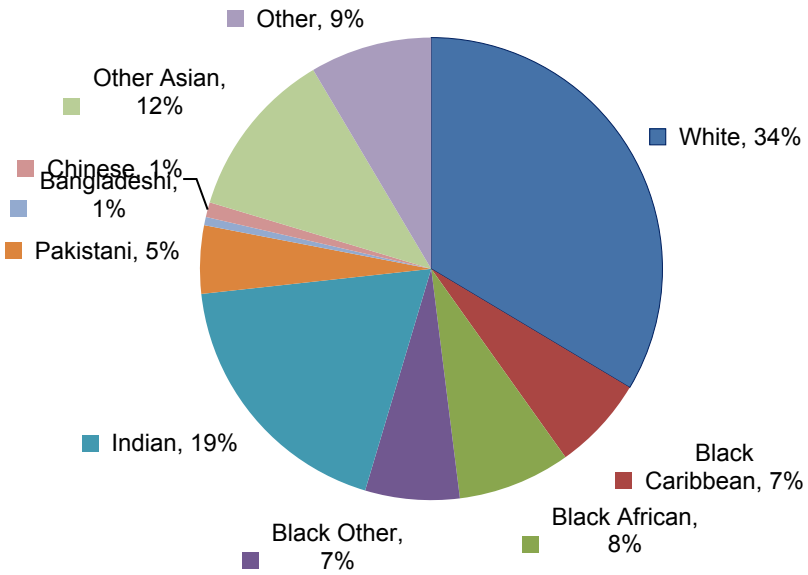


Figure 5: Ethnic profile of Brent residents. Source: 2016 population from GLA SHLAA based population projections, 2013

Language

There are many different languages spoken in Brent. English is the main language for 62.8% of the population. Gujarati is the main language for 7.9% of the population and Polish is the main language for 3.4% of the population[4]. In one in five households, nobody speaks English as their main language (figure 6).

[4] ONS 2011 Census

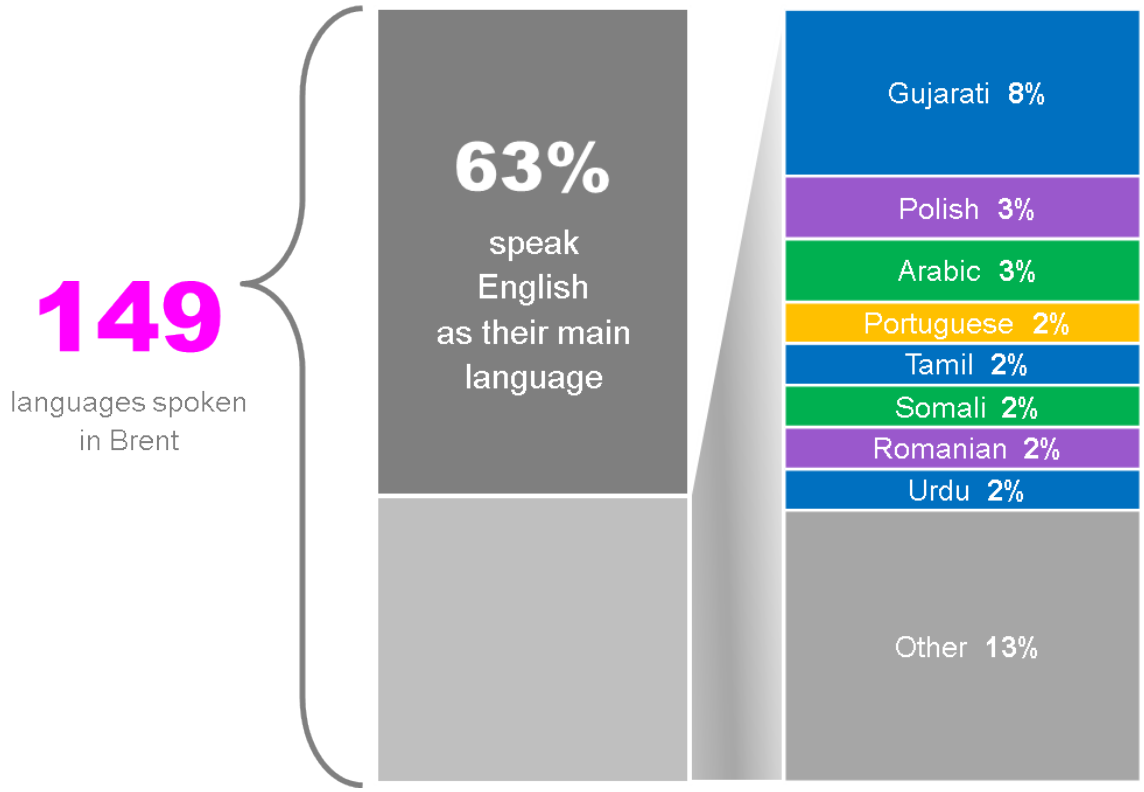
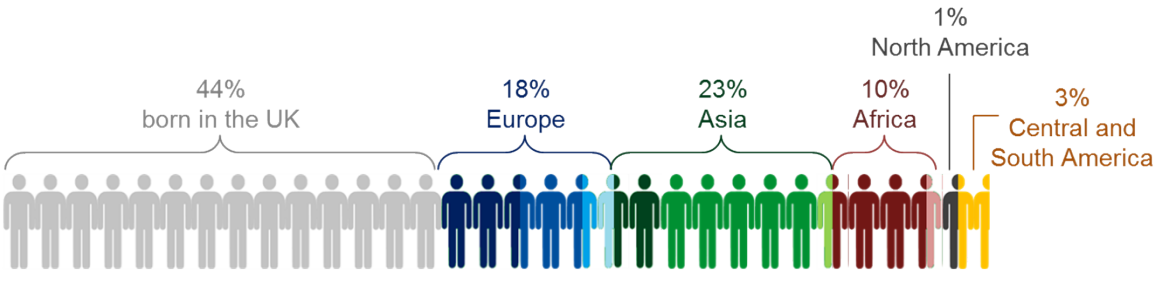


Figure 6: Languages spoken in Brent. Source: ONS 2011 Census

Place of Birth

Of all local authorities, Brent has the largest proportion of residents born abroad (55%) (figure 7). This ranges from Asia (23%), followed by Europe (18%) and Africa (10%) to Central and South America (3%) and North America (1%)



Old EU	7.2%	Middle East and Central Asia	5.0%	Sub-Saharan Africa	8.8%
Accession Countries	5.9%	East Asia	0.6%	North Africa	0.9%
Bulgaria and Romania	3.1%	South Asia	15.6%	Oceania	0.6%
Other Europe	2.1%	South East Asia	1.9%		

Figure 7: Place of birth of Brent residents. Source: ONS Annual passenger survey population estimates

Both EU born and non-EU born resident groups increased between 2004 and 2014. There was a sharp increase in the size of the non-EU born group between 2009 and 2011, (by 23,000, from 113,000 in 2009 to 136,000 in 2011): 16,000 of these were from South Asia (figure 8).

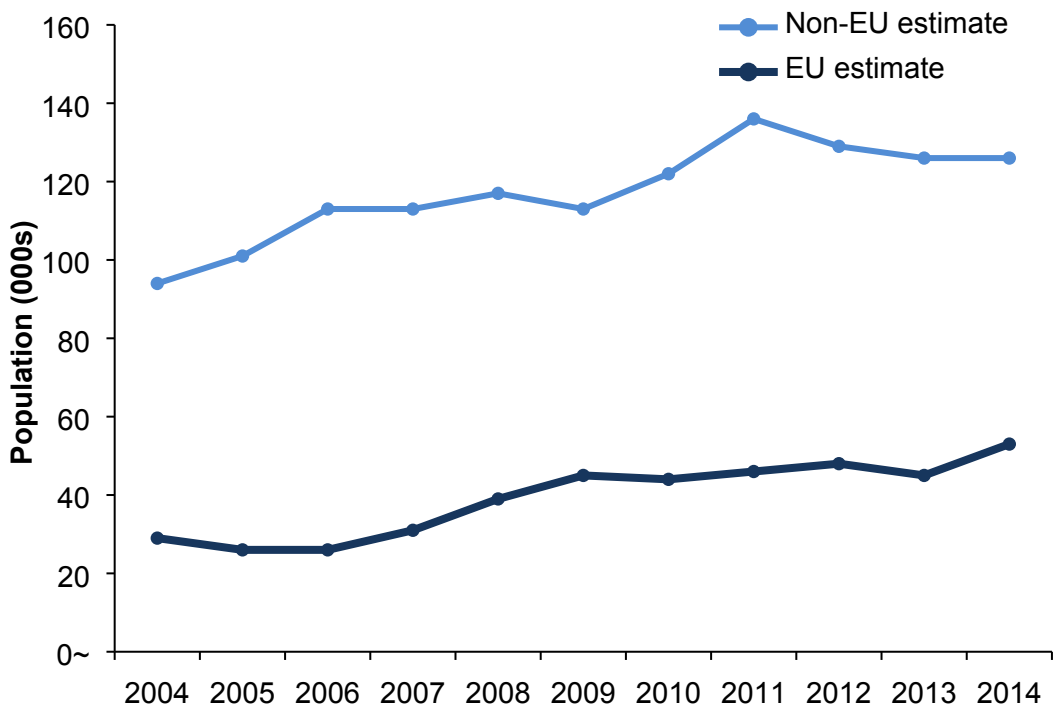


Figure 8: Brent's non-UK population over time (EU and non-EU). Source: ONS

1. BRENT PRIORITIES AND CHALLENGES

A number of priorities and challenges particular to Brent have been identified by the Council, Brent CCG and key partner organisations.

Physical activity and diet

Physical inactivity and an unhealthy diet are closely linked to excess weight and obesity. It is recommended that adults accumulate at least 150 minutes of moderate-intensity aerobic activity (e.g. cycling or fast walking) every week, and that children over five should engage in at least 60 minutes of moderate to vigorous intensity physical activity every day[5]. The Active People 8 survey shows over half (51.6%) of Brent's adult population do not undertake sport or physical activity, the highest level of inactivity in West London and above the London average. The same survey shows only 18.5% of Brent's population are achieving the recommended level of moderate intensity sports or active recreation per week.

Only 47.1% of the population in Brent were meeting the recommended 5-a day fruit and vegetable intake in 2014 (figure 9). This was below the London (50.3%) and England (53.5%) averages[6].

[5] The Department of Health
[6] Sport England, Active People Survey

Figure 9: Proportion of population meeting the recommended 5-a-day in 2014. Source: Sport England, Active People Survey.

Sexual Health

Sexually Transmitted Infections (STI's)

Young people aged 15-24 years, men who have sex with men (MSM), Black Africans, Black Caribbean and Black British communities and sex workers are particular at risk of poor sexual health. Rates of new STIs diagnosed in Brent were significantly higher than the England average.

Rate of STIs per 100,000	Brent 2013	Brent 2014	London 2014	England 2014
All new STI diagnoses*	**1,404**	**1,634**	**1534**	**829**
Syphilis	10.0	17.0	27.4	7.8
Gonorrhoea	121	151.6	190.5	63.3
Genital warts	143	140.6	161.3	128.4
Genital herpes	100	96.8	88.1	57.8

Figure 10: Diagnosis of STIs. Source: Public Health England
* With the exception of Chlamydia for age <25s

HIV

In Brent, there were 941 people living with HIV in 2014 aged 15 to 59 years. The diagnosed HIV prevalence rate was 4.5 per 1,000 of the population aged 15 to 59 years[7].

Late diagnosis of HIV increases the risk of transmission and reduces life expectancy. In Brent 37.9% of adults (aged 15 and above) had a late HIV diagnosis in 2012-2014. This was similar to the England average of 42.2% and London average of 36.6%[8]

Substance Misuse

Numbers in treatment

In Brent, the estimated prevalence of opiate and/or crack cocaine use was 8.3 per 1,000 of the population aged 15 to 64 in 2011/12. This was similar to the England average rate, 8.4 per 1,000 of the population.

The number of adults in treatment in Brent has risen slightly from 1,696 in 2013/14 to 1,739 in 2014/15, equating to an increase of 3% (figure 11).

Substance Category	Numbers in Treatment	%
Alcohol only	466	27%
Alcohol and non-opiate only	305	18%
Non-opiate only	252	14%
Opiate	716	41%
Total Clients	**1739**	100%

Figure 11. Source: NDTMS Adult Activity Report 2014/15

In Brent, 9.5% of opiate drug users left drug treatment successfully and did not re-present themselves to treatment within six months in 2014. This was better than the England average of 7.4%. In Brent, 43.7% of non-opiate drug users left drug treatment successfully and did not re-present to treatment within six months in 2014. This was better than the England average of 39.2%[9].

[7] Data sourced from Survey of Prevalent HIV Infections Diagnosed (SOPHID), Public Health England, 2014
[8] Webpage: https://www.gov.uk/government/collections/hiv-surveillance-data-and-management

[9] Calculated by Public Health England (Knowledge and Intelligence Team –NW) using data from National Drug Treatment Monitoring System (NDTMS)

Alcohol use

In Brent, 31.4% of the population aged 16 and over abstain from alcohol use, almost twice the national average of 16.5%. However the proportion of high risk drinkers in Brent at 7.1% is above the national average of 6.7%[10].

Figure 12 identifies where hospital stays for alcohol related harm were highest and lowest in Brent by ward.

Hospital admissions for alcohol attributable conditions, standardised admission ratio, 2008/9 - 2012/13 - *source: Hospital Episodes Statistics (HES). Copyright © 2014. The Health and Social Care Information Centre. All rights reserved.*

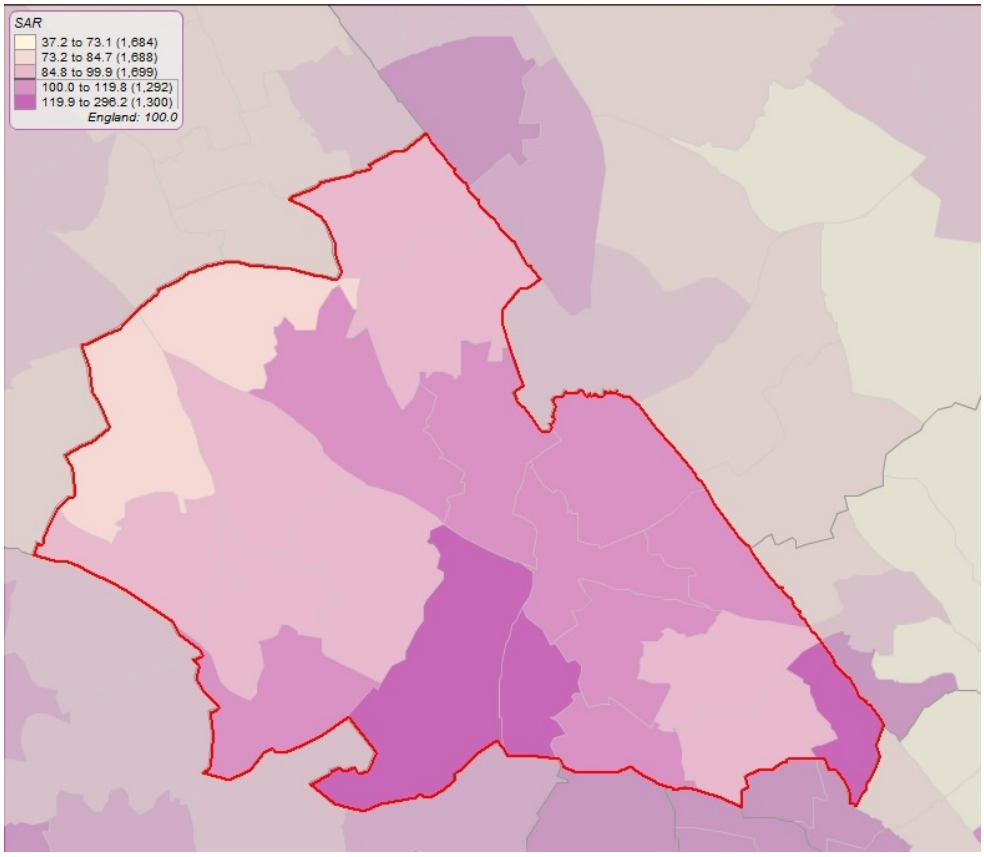


Figure 12 (above): Hospital admissions for alcohol attributable conditions. Source: HES, HSCIC

Social Isolation

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

Social isolation and loneliness have a detrimental effect on health and wellbeing. In 2013/14, 39.3% of adult social care users in Brent reported that they have as much social contact as they would like. This was worse than the England average of 44.5%[11].

[10] PHE, Local Alcohol Profiles for England (LAPE), 2009 Synthetic Estimates
[11] Adult Social Care Survey, England

Asylum Seekers

There has been a marked decrease in the number of asylum seekers in receipt of support over time, both in Brent and in the UK overall. In 2003/04, there were a total of 5,517 asylum seekers in Brent claiming support. This has decreased to 422 in 2014/15[12]. Unlike in Brent, the number of asylum seekers claiming support nationally has actually increased slightly since 2012/13 (figure 9). Many refugees are from war-torn countries and could be suffering from post-traumatic stress disorder (PTSD).

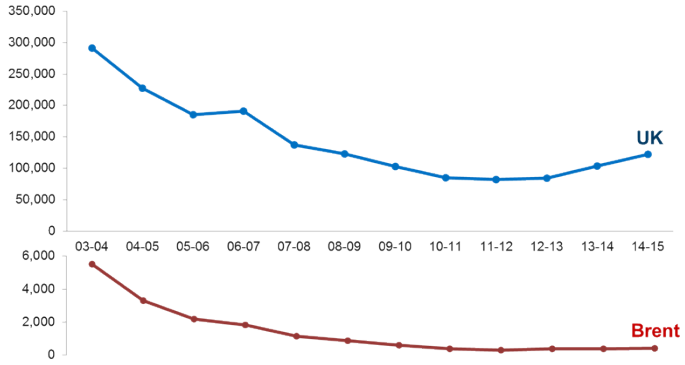


Figure 13: Supported asylum seekers (Brent and UK) 2003 to 2015

Forced Marriage

In 2012/13, 30 cases of forced marriage were identified in Brent by social services, the Asian Women's Resource Centre, and Metropolitan Police[13].

Female Genital Mutilation

Research conducted in 2013 found over 5,000 women and children in Brent are at increased risk of, or have already undergone FGM[14]. Research identified that Brent (9.4%) had the second highest percentage of girls born to women with FGM in 2015 (figure 14). This equates to 2,171 girls. In 2012/13, Northwick Park Hospital, which has a specific service for

[12] Home Office statistics

[13] LB Brent Overview and Scrutiny Task Group Report: Tackling Violence against Women and Girls in Brent, March 2014

[14] Scrutiny Report: Tackling Violence against women and girls in Brent, March 2014

women who have undergone FGM saw 236 Brent patients with FGM.

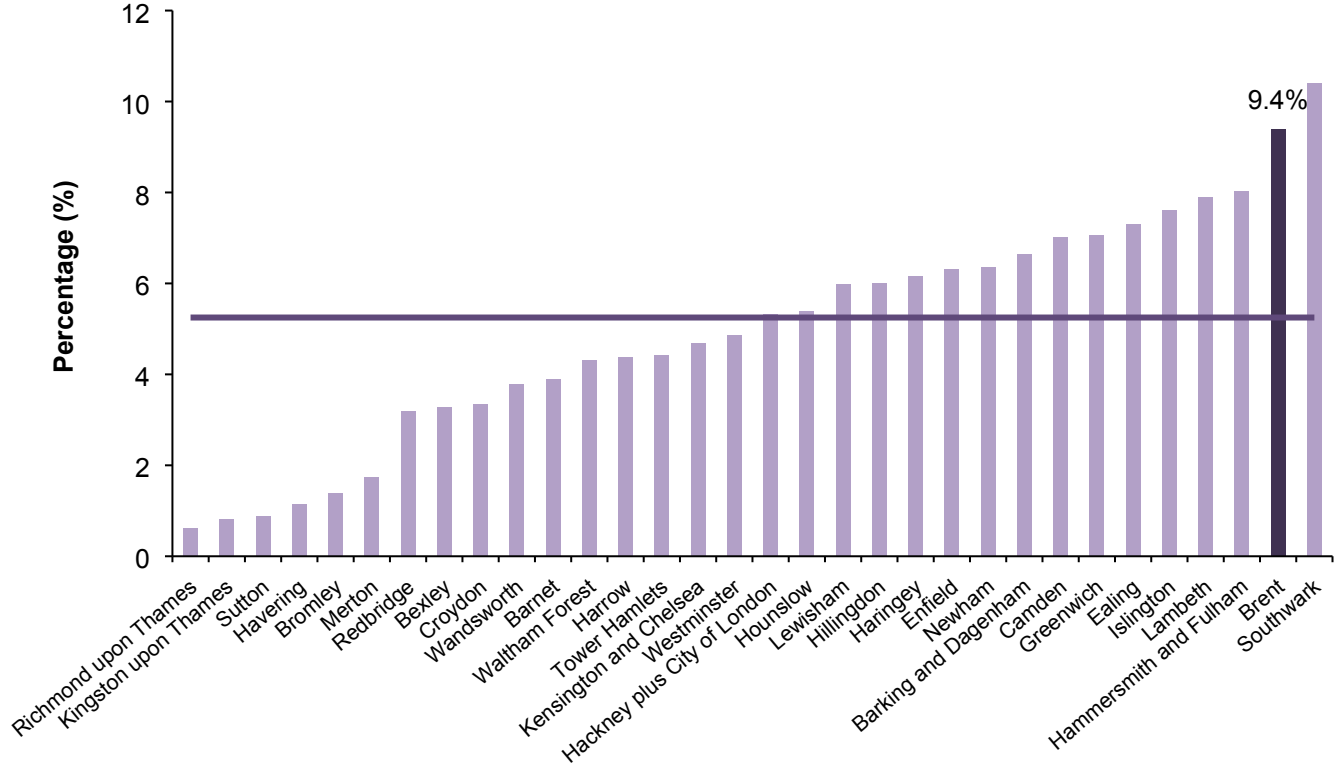


Figure 14: Estimated percentage of girls born to women with FGM in London, July 2015.
Source: Prevalence of FGM in England and Wales, City University London, 2015

Type 2 diabetes

Rates of type 2 diabetes in Brent are particularly high compared to other parts of the country. In 2013/14, 8.2% of people on GP lists in NHS Brent CCG were recorded as having diabetes. This equates to 23,079 recorded cases. Over the same period, the comparable figure for England was 6.2%[15]. At practise level, the recorded prevalence of diabetes varied across Brent CCG from 3.7% to 14.2%.

Reflecting the ageing of the local population, the numbers of people who are obese and overweight and the large number of Black and South Asian people (who are at greater risk of developing diabetes) the prevalence of diabetes is predicted to rise in the future (Figure 15)

[15] QOF

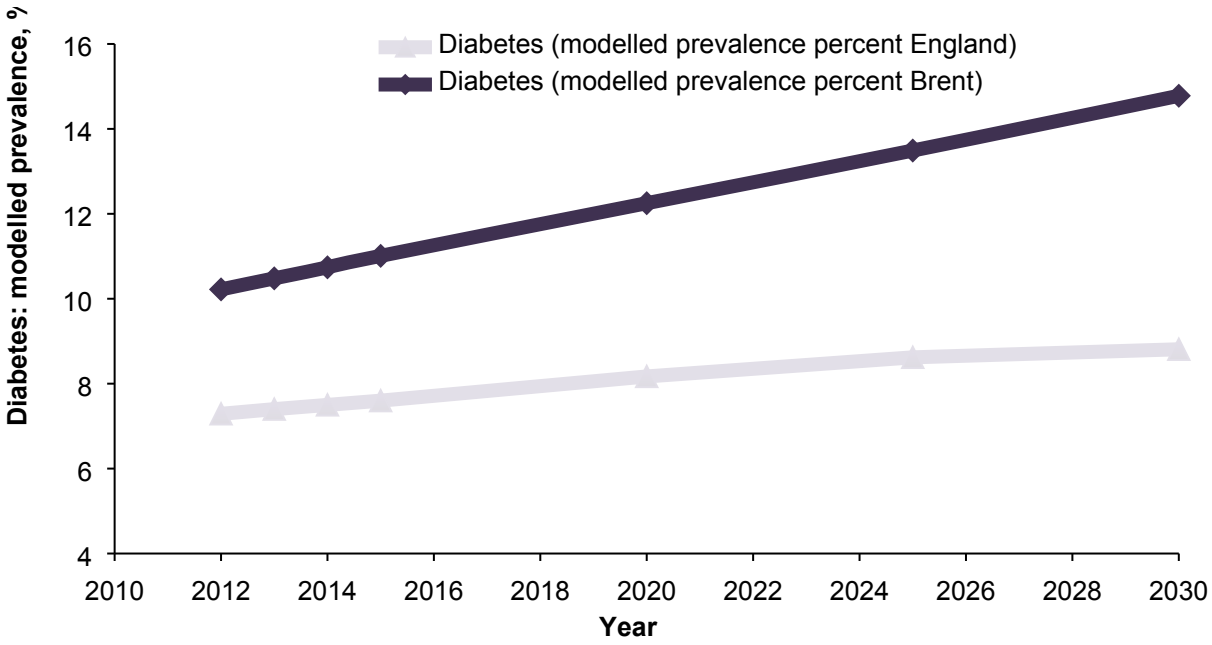


Figure 15: Modelled estimated prevalence of diabetes. Source: Public Health England (national cardiovascular intelligence network - NCVIN), Diabetes Prevalence Model for Local Authorities and CCGs 2012 to 2030

People with diabetes are at risk of developing a range of associated complications. Brent residents are less likely to have complications compared to people with diabetes in England (figure 16).

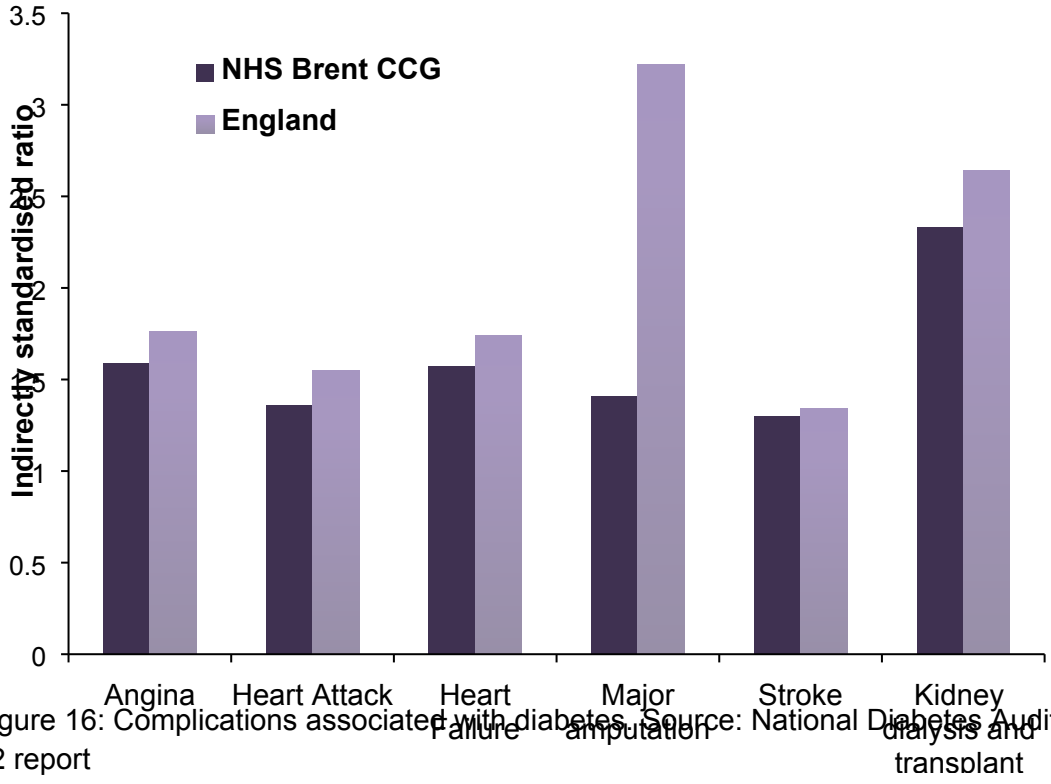


Figure 16: Complications associated with diabetes. Source: National Diabetes Audit, 2011-12 report

Tuberculosis

In 2014, the highest numbers and rates of TB reported across London were in Newham and Brent. However, both areas saw rates decline by 25% compared with 2013[16]. In Brent, the TB notification rate in 2014 was 64 per 100,000 (figure 17). This equates to 204 cases.

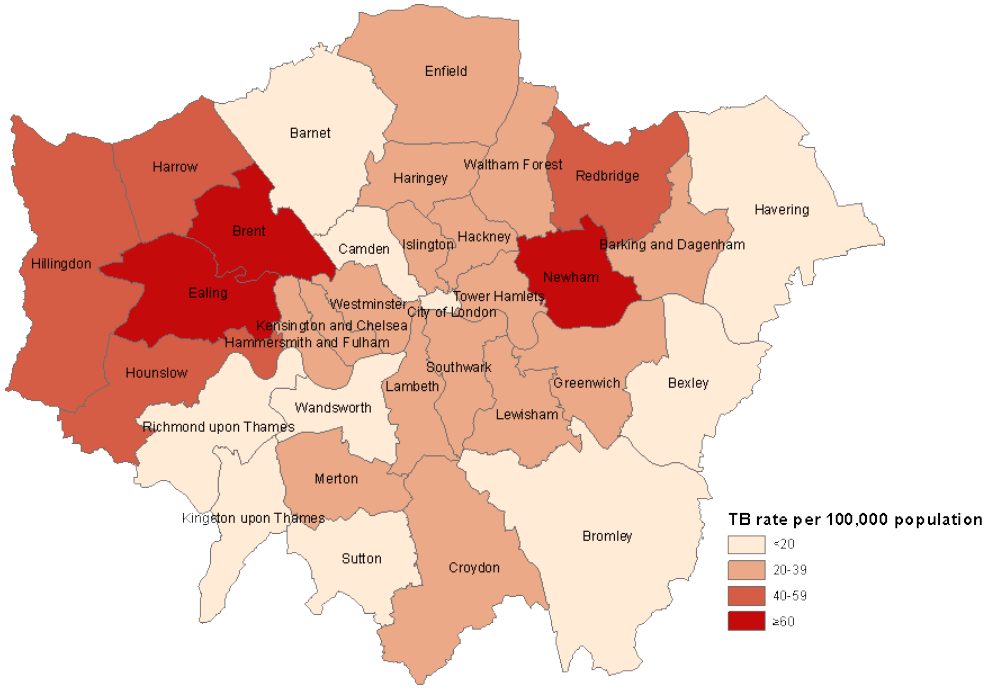


Figure 17: TB notification rates by local authority of residence in London in 2014. Source: Tuberculosis in London, Annual Review (2014 data)

In 2013, seven per cent of all TB cases were associated with 'social risk factors'. These include imprisonment, substance misuse and homelessness.

Over half of all TB patients in Brent in 2013 were Indian, most of who were born in India (figure 18). Rates were next highest among the Black African population of whom approximately half were born in Somalia.

[16] Public Health England, Tuberculosis in London: Annual Review (2014 data)

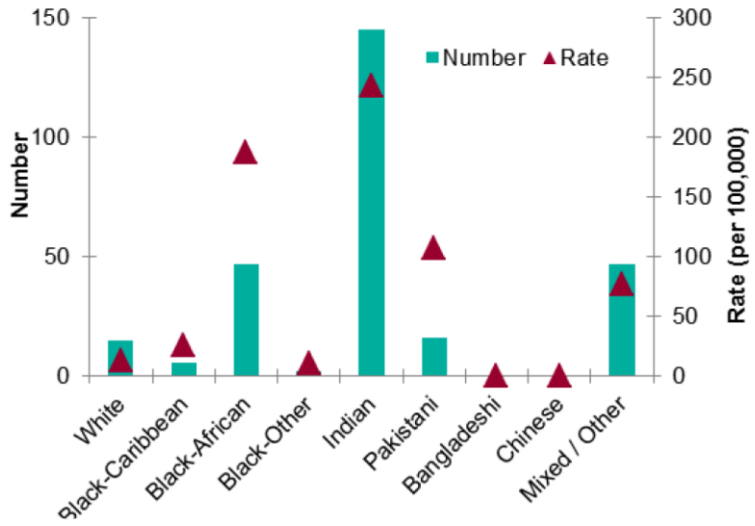


Figure 18: PHE, Brent TB Profile, 2013

2. ADULT SOCIAL CARE

Demography

Projected growth and ethnicity of older people

Figure 19 shows the projected increase in people aged 65 and over living in Brent between 2014 and 2030. Figure 20 identifies the ethnic breakdown of people aged 65 and over living in Brent.

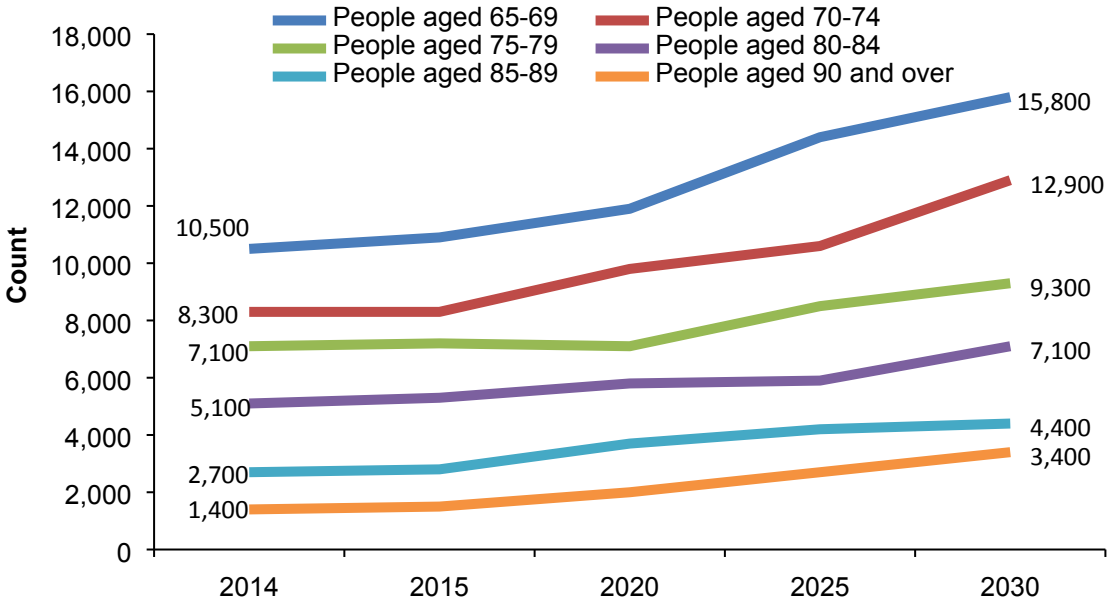


Figure 19: Projected growth of older people. Source: POPPI

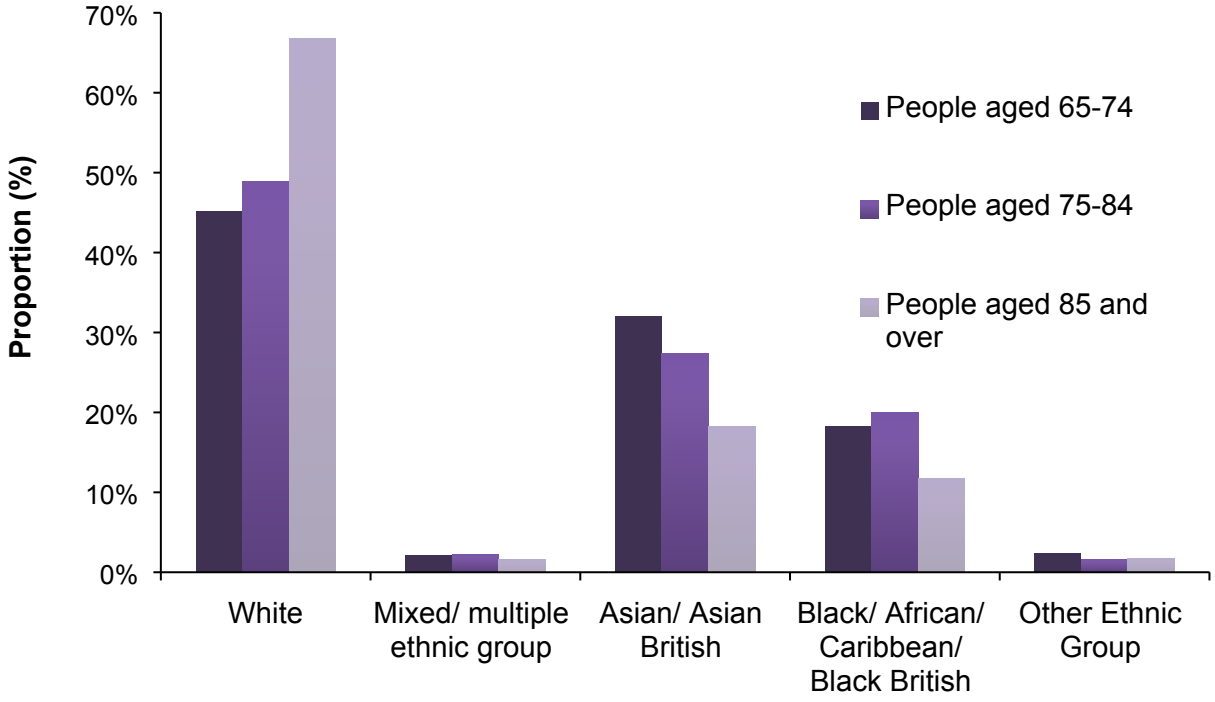


Figure 20: Ethnic breakdown of people aged 65 and over living in Brent. Source: ONS, 2011 Census

Mental Health

Dementia

In Brent in September 2015 the recorded (on GP practice registers) prevalence of dementia in people aged 65 years and over was 4.83%. This was higher than the England average of 4.27%[17] which could reflect an actual higher rate or more complete diagnosis.

Estimates show that around 730 people with dementia were undiagnosed in NHS Brent CCG and that of those with dementia in Brent 55.1% had mild dementia, 32.7% had dementia of moderate severity and 12.2% had severe dementia[18].

Projections show that the number of people aged 65 and over with dementia will increase by 63% over the next 15 years in Brent (figure 21).

[17] Health and Social Care Information Centre
[18] Primary Care Web Tool (PCWT), Dementia Prevalence Calculator.

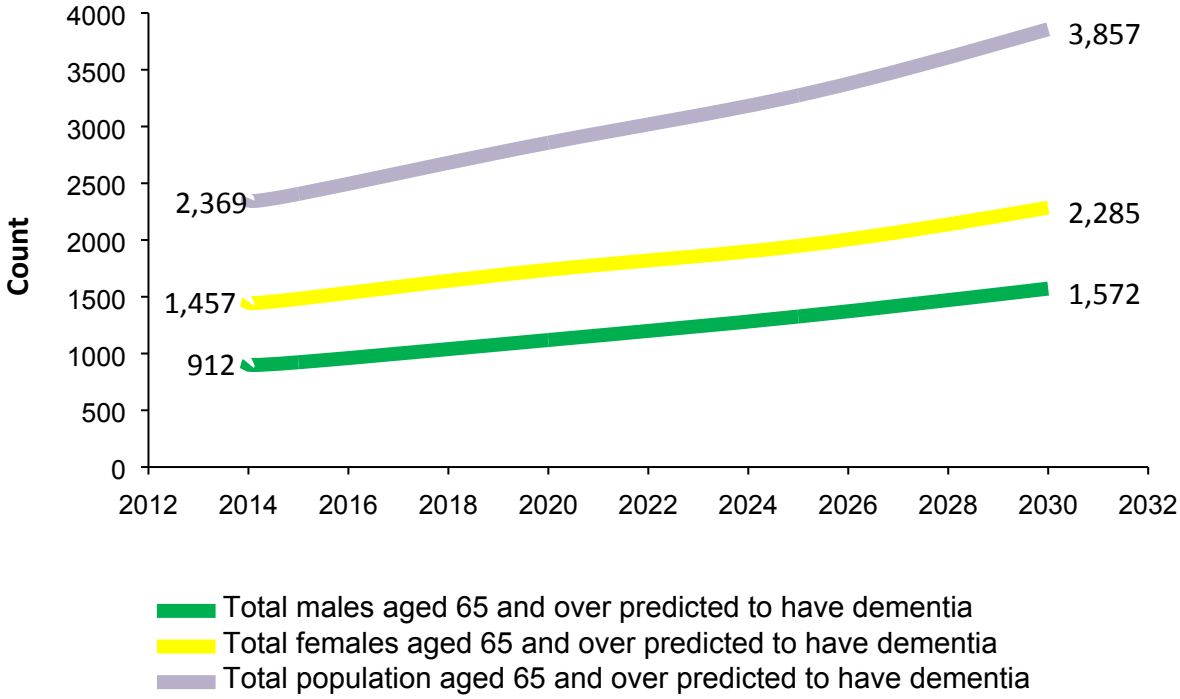


Figure 21: Dementia projections 2014 to 2030. Source: POPPI

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%[19].

Common Mental Health Disorders

One in four people in the UK will experience a mental health problem each year[20]. Common Mental Health Disorders (CMDs) include depression and anxiety.

In 2012/13, 3.4% of the population in Brent CCG aged 18 and over had a recorded diagnosis of depression[21]. This was below the England average which was 5.8%. Estimates of self-reported daily anxiety show that 18.8% of Brent residents consider themselves to have high levels of daily anxiety compared to the England average of 20% (2013/14).

Estimates show that in Brent in 2014, 33,959 people aged 18 to 64 years were thought to have a CMD. By 2030, this is projected to increase to 36,265 people, an increase of 7% (figure 22).

[19] Public Health England, End of Life Care profile for Brent, 2012
[20] Mind webpage: http://www.mind.org.uk/information-support/types-of-mental-health-problems/statistics-and-facts-about-mental-health/how-common-are-mental-health-problems/
[21] Quality and Outcomes Framework (QOF)

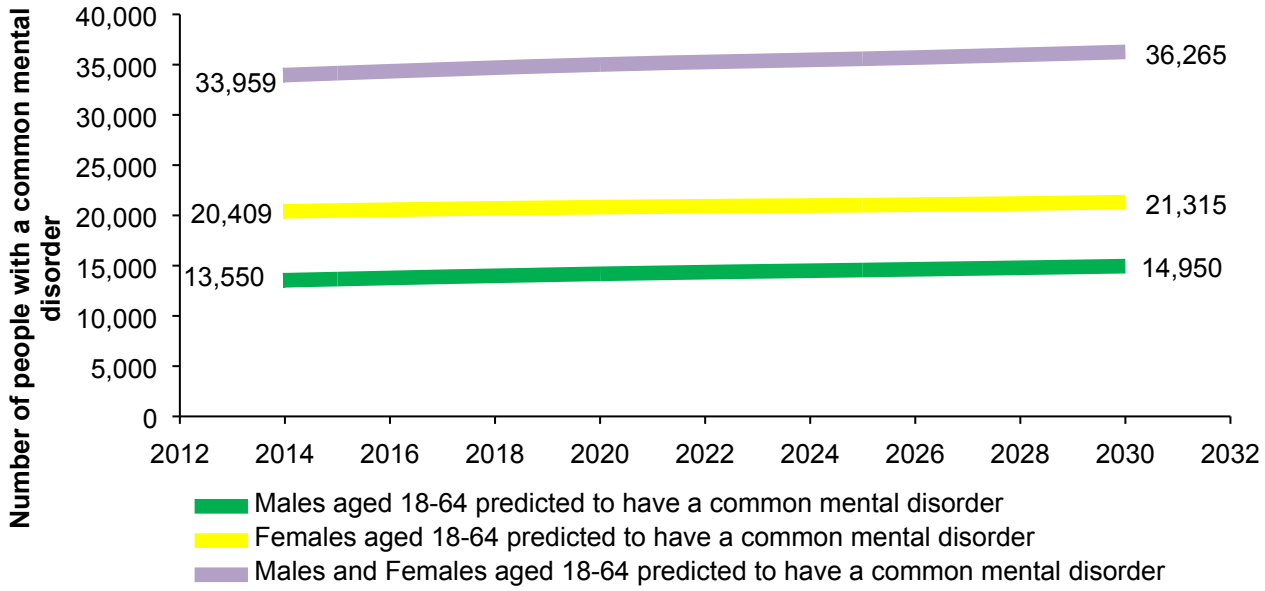


Figure 22: Count of the number of people with a common mental disorder. Source: PANSI

Dual Diagnosis (coexisting substance misuse and mental health problems.)

In Brent, the proportion of people who were in contact with mental health services when they were accessing services for drug misuse was 26.8% in 2013/14. This was higher than the England average of 17.5%. The proportion of people in Brent who were in contact with mental health services when they accessed services for alcohol misuse was higher at 24.2% than the England average of 21.2% in 2013/14.

Severe and Enduring Mental Illness

Severe and enduring mental health and conditions include long term illnesses such as schizophrenia, personality disorder, and bipolar disorder. In 2011/12, the prevalence of severe and enduring mental health conditions in Brent was 1.1% of the adult population, which is above both the London (1%) and England (0.8%) averages[22].

Premature Mortality and Mental Health

Nationally the premature mortality rate among those with mental health issues is 2.4 times higher than that of the general population[23]. However it varies across England as shown in figure 23.

[22] NHS Information Centre
[23] Open Public Services Network Review, 2015

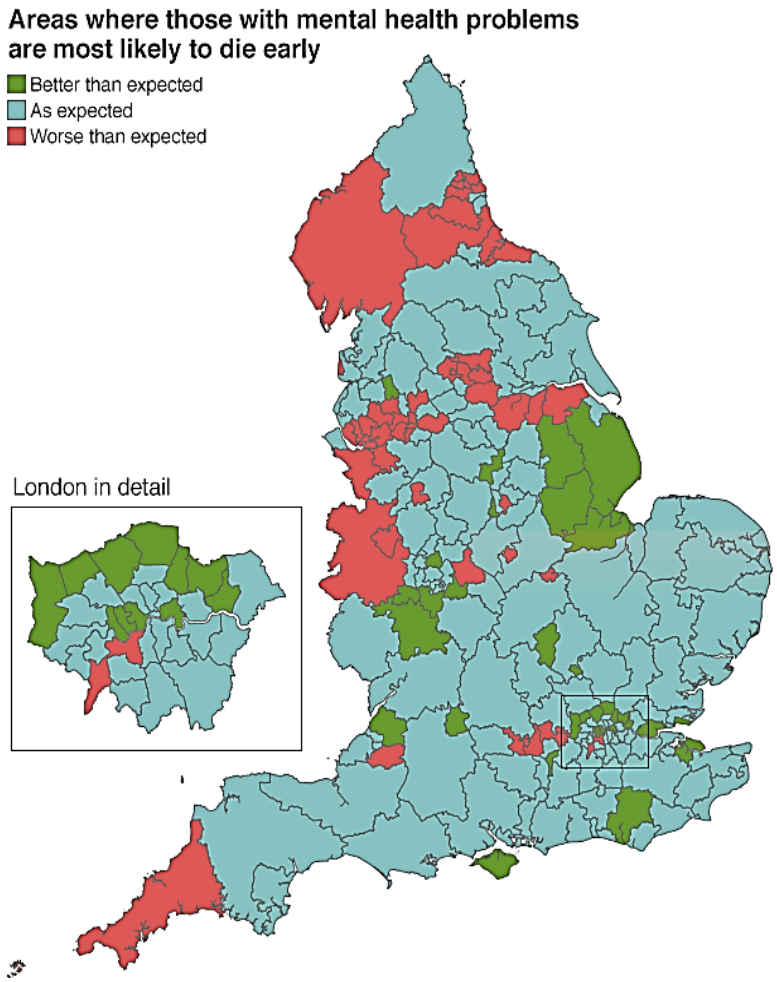


Figure 23: Premature mortality and mental illness. Source: Open Public Services Network, 2015

Talking Therapies

Take-up of talking therapies is relatively low in Brent in terms of the numbers of referrals who enter treatment: 53% in Brent compared to 60% in England. In Brent CCG, the proportion of people who are "moving to recovery" following completion of a period of talking therapy was 38% in 2012/13. This was below the England average which was 45.9%.

In Brent CCG, 74.5% (or 995 referrals) of referrals were from BAME groups (2014/15 quarter two)[24]. This was significantly above the England average of 16.4% and above the London average of 49.3%.

[24] Health and Social Care Information Centre, IAPT

Adults with Learning Disabilities

Prevalence

In 2014/15, 0.4% of Brent CCG's practice population aged 18 years and over had a learning disability, the same as the England average. At practice level the prevalence ranged from 0.09% to 1.14%[25].

Of those people who have a learning disability, generally around 20% will generally be known to specialist services, or will be registered as having a learning disability.

Health Needs

Evidence shows that people with learning disabilities suffer poorer health and are more likely to die at a younger age[26]. Regular GP health checks help to ensure that problems are diagnosed and treated. In 2013/14, in Brent CCG 72.6% of eligible adults with a learning disability were recorded as having had an annual GP health check. This was higher than the England average (44.2%) and London average (49.5%).

Accommodation

In Brent, 61.4% of adults (or 390 adults) with learning disabilities were living in settled accommodation in 2013/14. This was lower than the England average which was 74.9% and the London average, 68.6%[27].

Employment

Paid employment is generally associated with improved health outcomes amongst people with learning disabilities and an enhanced quality of life. In Brent, 2.4% of adults with a learning disability were in paid employment in 2013/14. This was significantly below the England average of 6.7% (figure 24).

[25] PHE, National General Practice Profiles, QOF Prevalence, 2014/15

[26] Hollins, S., Attard, M.T., von Fraunhofer, N. & Sedgwick, P. (1998). Mortality in people with learning disability: risks, causes, and death certification findings in London. Developmental Medicine & Child Neurology, 40, 50-56

[27] Health and Social Care Information Centre

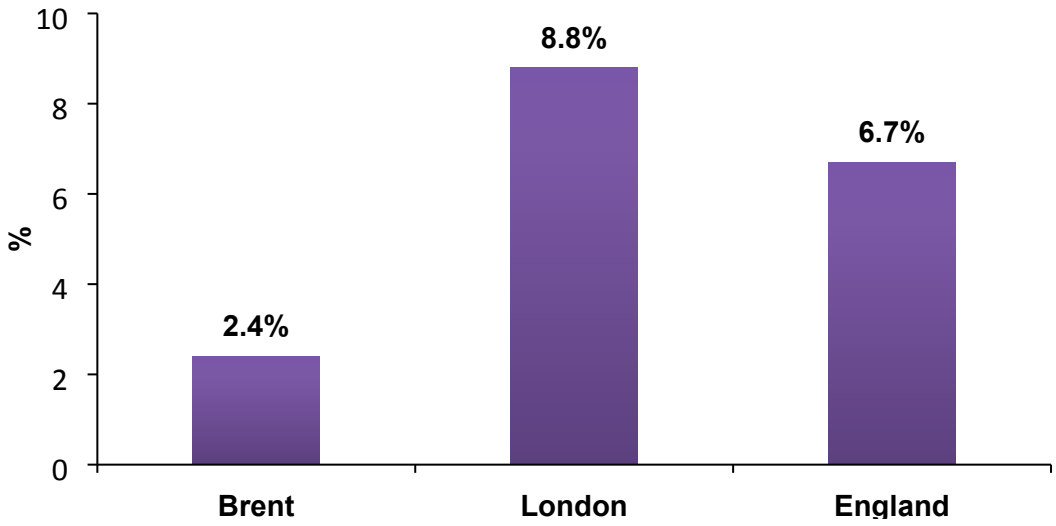


Figure 24: Adults with a Learning Disability in Employment in 2013/14. Source: Health and Social Care Information Centre, NASCIS Report, 2013/14

Physical Disability

In the 2011 Census, 14% of the population in Brent, or 44,882 people, reported a long-term health problem or disability which impacted on their day-to-day activities[28].

It is estimated that 15,057 people in Brent aged 18 to 64 years had a moderate physical disability in 2015 (figure 25). By 2030, this is estimated to increase to 16,725 people, an increase of 11%. In 2015, 4,164 people aged 18 to 64 were estimated to have a serious physical disability. By 2030, this is expected to rise to 4,763 people, an increase of 14%[29].

[28] ONS 2011 Census
[29] PANSI

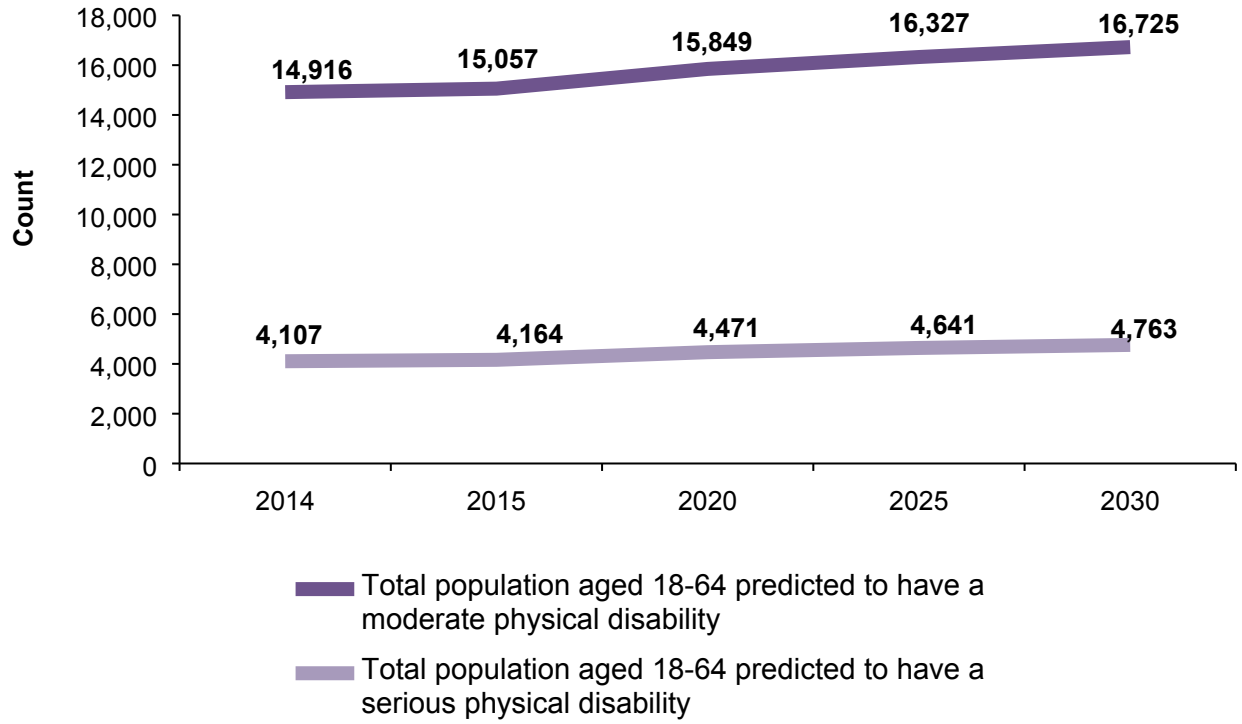


Figure 25: Moderate and Serious Physical Disability. Source: PANSI

Provision of Care and Support

Unpaid Care

According to the 2011 census, 8.6% of the borough's residents provide some form of unpaid care. This was slightly lower than the Outer London average of 9.2% and the same percentage of the population as in 2001. Around 26,600 residents of the borough provide care of more than 1 hour per week in 2011 (figure 26).

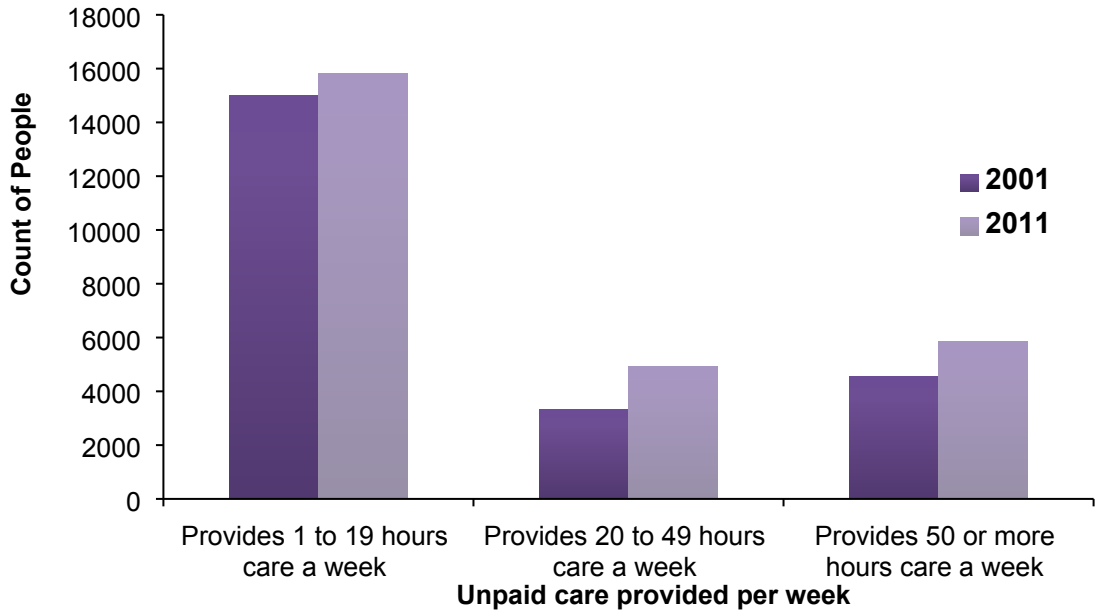


Figure 26: Number of residents providing unpaid care in Brent, broken down by hours. Source: ONS, 2001 Census and 2011 Census

Residential and Nursing Care Home Provision (aged 65 and over)

Figure 27 shows the rate of permanent admissions of older people (aged 65 years and over) to residential and nursing care homes per 100,000 of the population over the period 2010-11 to 2013/14 in Brent. In Brent, the rate of permanent admissions in 2013/14 was 425.8 per 100,000. This was below the national average rate of 625.8 per 100,000.

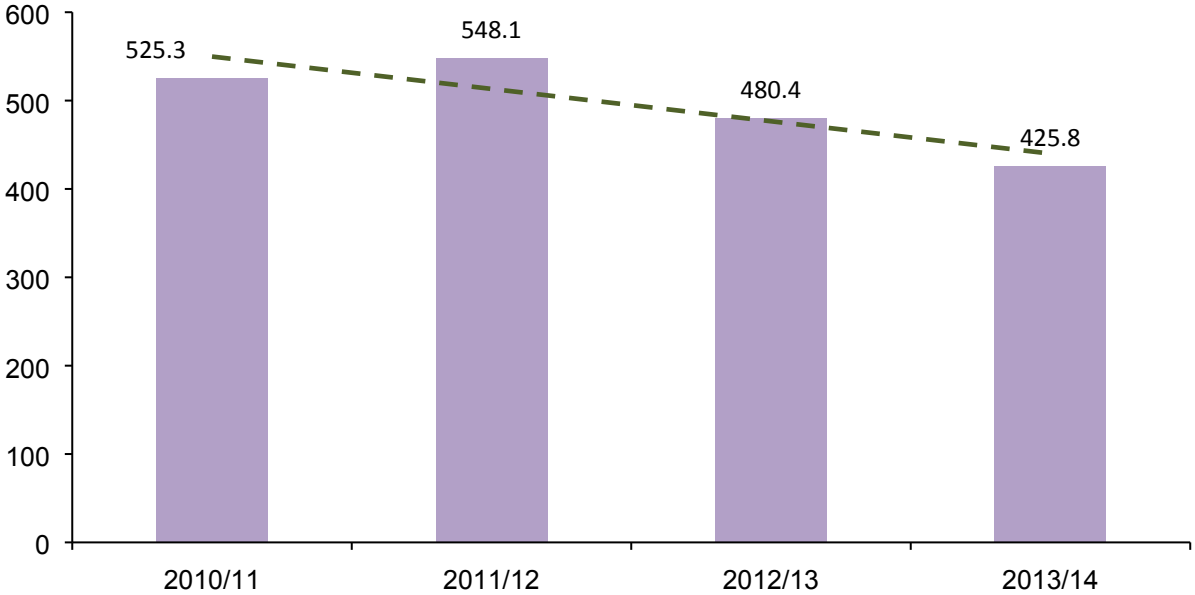


Figure 27: Source: Source: ASCOF Results 2010 – 2015 Published. Comparator Report of Brent with its CIPFA Group (from November 2014).

Figure 28 shows the long-term support needs of older adults (aged 65 and over) met by admission to residential and nursing care homes per 100,000 of the population. Brent performs favourably against the London and England averages.

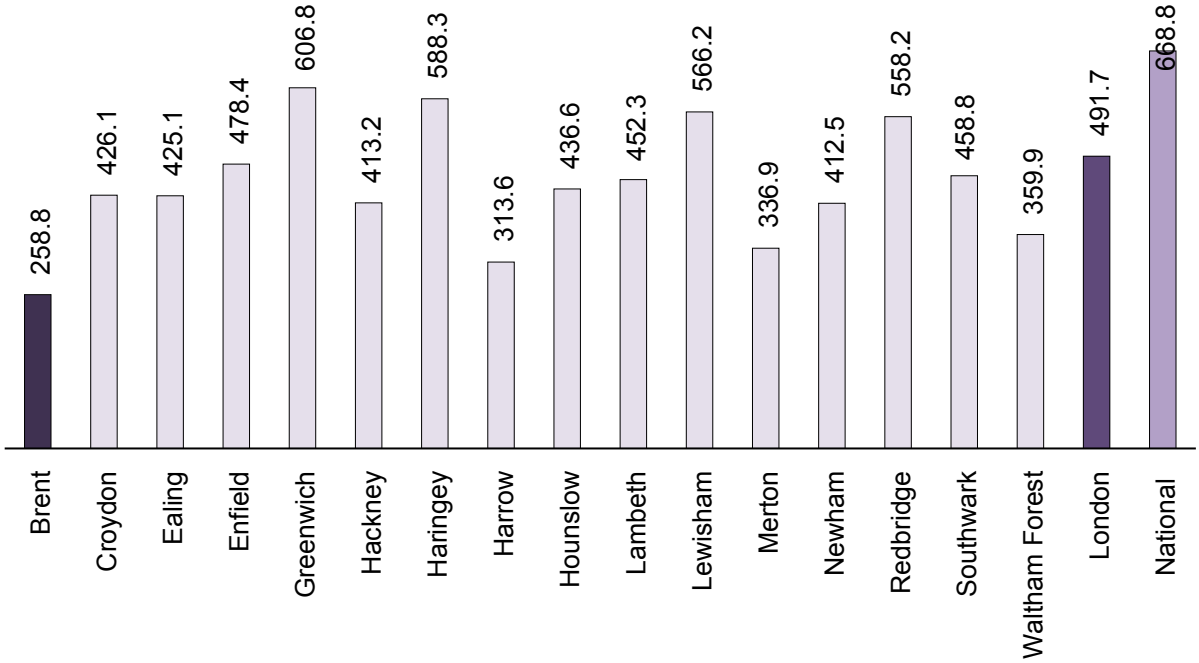


Figure 28. Source: ASCOF Results 2010 – 2015 Published. Comparator Report of Brent with its CIPFA Group (from November 2014).

3. CHILDREN AND YOUNG PEOPLE

Demography

Live Births

There were 5,078 babies born in Brent in 2014 (figure 29). This was a reduction from the previous year, a change in the steady upward trend in the number of live births over the previous nine years.

Figure 29: Live births: 2004 to 2014. Source: ONS

Under 5's Population

There are an estimated 24,600 children under 5 years living in Brent (comprising around 8% of the population). This number has increased by 2,500 since 2010 but the rate of increase is predicted to slow over coming years, as demonstrated in figure 30.

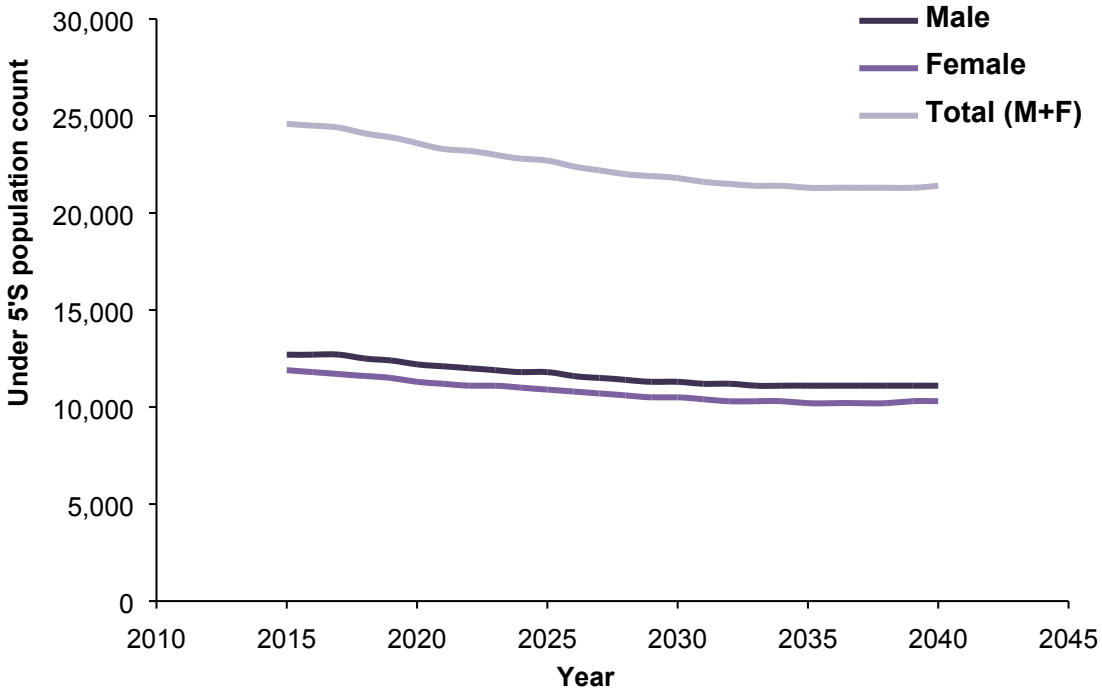


Figure 30: Source of data: GLA Population Projections 2013 Round SHLAA age range forecasts

Education

Demographic profile of pupils attending Brent schools

Ninety two per cent of pupils attending Brent schools are from minority ethnic groups, the national average is 29%.

Schools in Brent now draw pupils from an increasingly diverse range of cultural and linguistic backgrounds. One hundred and forty nine different languages are spoken in Brent. The five most common languages spoken are Gujarati, Somali, Arabic, Urdu and Tamil. This means that a majority of pupils are learning English as an additional language (64%).

School age population

In Brent, there has been a 9.53% increase in the school-age population from Reception to Year 11 in the last five years (figure 31). Brent has seen an unprecedented increase in the demand for primary school places over the past few years. The primary pupil population (Reception to Year 6) has grown from 21,427 in May 2008 to 26,028 in May 2015, an increase of 17.68%. A percentage of these children are likely to require support for their learning difficulties.

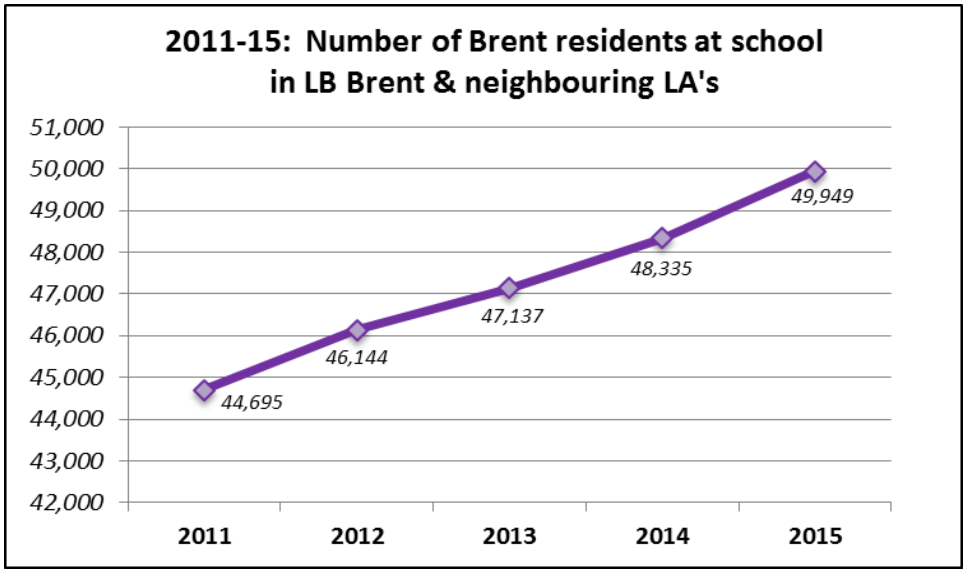


Figure 31. Source: Resident school age population data is from DFE SFRs 12/2011, 10/2012, 21/2013, 15/2014, 16/2015 and counts only pupils of official school age (Reception through to Year 11) residing in that LA regardless of where they are schooled.

Schools in Brent

At the start of this academic year, 2015-6, there were 85 schools (including academies) in Brent: four nursery schools; 60 primary schools; 15 secondary schools (including three all-through schools); four special schools and two pupil referral units. Of these schools, one secondary school and one primary school are free schools and 17 are academies: five primaries (three sponsored); 11 secondary (four sponsored); one special school. At the end of the last academic year, 86 per cent of Brent schools were classed as good or outstanding. This represents an increase of 8 per cent on the previous year's figure of 78 per cent.

Educational Attainment

The attainment of Brent's pupils at the end of the secondary and primary phases of education is above the national averages but just below the London averages.

In 2015, the proportion of Brent pupils attaining five GCSE grades A*-C including English and mathematics remained at 60 per cent compared to 2014. Brent was above the national average of 57 per cent and just below the London average of 61 per cent. Brent has been closing the gap with the London average. In 2015 the borough was one percentage point below London compared to 2 percentage points below in 2013.

The proportion of Brent's pupils leaving primary school in 2015 having attained Level 4 in reading, writing and mathematics was 83 per cent compared to the national average of 80 per cent and the London average of 84 per cent. The Brent average increased by three percentage points from 80% in 2014.

Social Care

Child protection

At the end of March 2015 there were 226 children subject to a child protection plan, which was an decrease on the previous year's figure, 229 (2014), but an increase from 172 in 2013 and148 in 2012 . In 2015 this figure is beneath our statistical neighbour average of 284.

Looked after children

There were 325 looked after children in Brent at the end of March 2015. This compares to 350 in 2014, 345 in 2013, and 360 in 2012 and is indicative of an overall general decreasing number. Brent have fewer looked after children than statistical neighbours which was 432 at end of March 2015.

Brent has seen a 100% increase in unaccompanied asylum seeking children looked after from March 2013 to March 2015. There were 50 unaccompanied asylum seeking children looked after at the end of March 2015 compared to 30 in 2014 and 25 in 2013. There are 2,630 unaccompanied asylum seeking children (UASC) looked after in England, which represents 4% of the total looked after children. At 31st March 2015, 14.7% of Brent looked after children were UASC.

Timeliness of adoption

There have been significant and consistent improvements in the time taken between a child becoming looked after and moving in with its 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 2015 this figure had reduced to 544 (based on three year average).

Domestic Abuse

Police recorded domestic abuse reports show that Brent has experienced a year on year increase in reported abuse, although such increases may be evidence of better reporting. In the reporting year 14/15 over 25% of child in need assessments had Domestic Violence as an identified factor.

Children in need and those with a disability

The number of children in need in Brent has increased by 40% since 2011, whilst the number with a disability has increased by 80%. The reasons for this are complicated, some of which relate to higher prevalence of incidence and some of which reflect better identification and recording.

Health Improvement

Low Birth Weight

Low birth weight includes those live births with a recorded birth weight of under 2,500g regardless of gestational age. Low birth weight increases the risk of childhood mortality and of developmental problems for the child. In Brent, 3.6% of live births were of low birth weight in 2014 which was above the England (2.9%) and London (3.2%) averages[30].

Breastfeeding

In Brent, the vast majority of women start breastfeeding their babies: 88.8% in 2014/15[31]. This was above the England (74.3%) and London (86.1%) averages.

Immunisation

Not all children in Brent who could be protected by immunisation are receiving the necessary vaccinations. When compared to the England average, a lower proportion of children in Brent (89.4%) received their first dose of immunisation by the age of two years. By five years old, 84.4% of children received their second dose of MMR immunisation, which was lower than the England average[32].

Childhood Obesity

In Year 6, 23.8% of children were measured as obese in 2014/15, worse than the average for England, 19.1%. In reception year, 10.2% of pupils were obese in Brent which was slightly higher than the England average of 9.1%[33].

Tooth Decay

A survey[34] in 2012 identified that 46% of five year old children in Brent had experienced tooth decay. As such, Brent ranks amongst the worst areas in the country for oral health for children under five years (figure 32). A range of factors contribute to poor oral health among children in Brent. These include:

[30] ONS
[31] NHS England derived data.
[32] HSCIC, PHE
[33] National Child Measurement Programme (NCMP), HSCIC
[34] National Dental Epidemiological Programme for England, Oral Health Survey of five year old children, 2012

- Lack of fluoride treatment of tap water
- Poor diet
- Poverty
- Lack of regular brushing

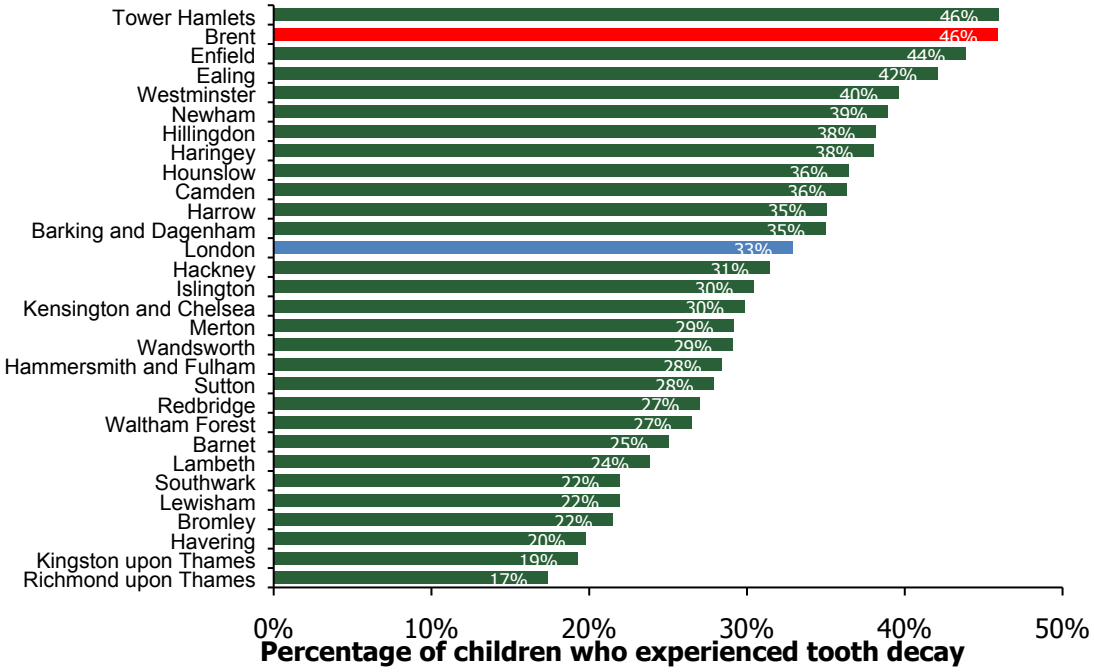


Figure 32. Percentage of children aged five who experienced tooth decay. Source: National Dental Epidemiological Programme for England, Oral Health Survey of five year old children, 2012.

Dental decay is the most common reason for non emergency admissions to hospital for children over 1 year in Brent, followed by viral infection (figure 33).

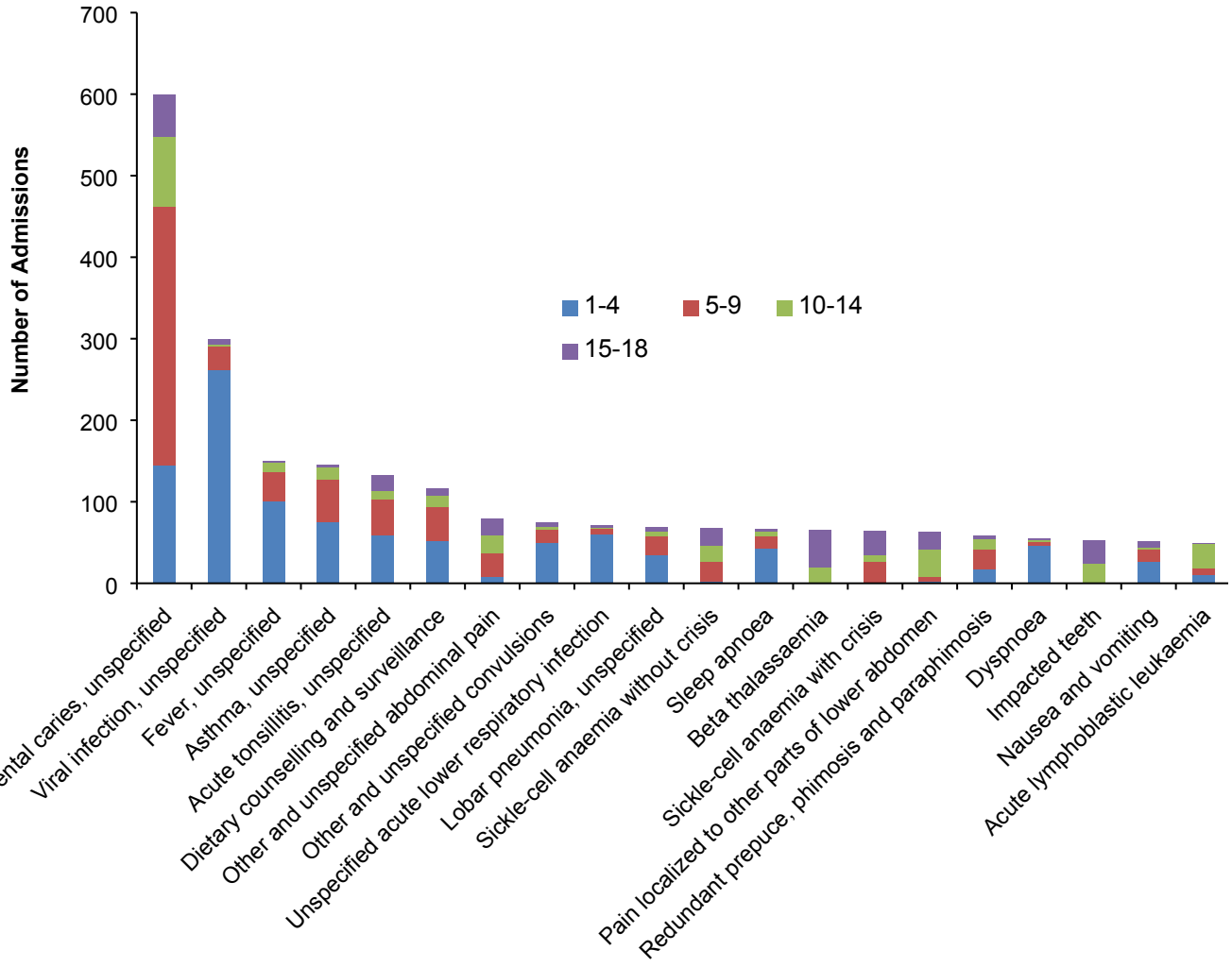


Figure 33: Top causes of childhood hospital admissions (1-18 years old) in Brent in 2012/13. Source: Secondary Uses Service (SUS)

Asthma

Asthma is the most common long-term condition in childhood nationally. In Brent, there were 207 emergency admissions of children (under 19 years) due to asthma in 2013/14. This equates to a rate of 271.5 per 100,000, which is higher than the average rate for England[35].

Self-harm

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

[35] PHE, Brent Child Health Profile, 2015

Alcohol misuse

The rate of young people aged under 18 years who were admitted to hospital as a result of a condition wholly related to alcohol (e.g. alcohol overdose) in 2011/12 - 2013/14 was 16.8 per 100,000. This was lower than the England average rate, which was 40.1 per 100,000 of the population aged under 18 years[36].

Teenage Pregnancy

Figure 34 shows live birth rates by age of mother in 2014. Of particular note are the low numbers of teenage girls giving birth. The under 18 conception rate in Brent was 18.2 per 1,000 females aged 15 to 17 years in 2013 (figure 35). This was better than the England rate (24.3 per 1,000) and London rate (21.8 per 1,000)[37].

The teenage pregnancy rate has fallen substantially over the last seven years and has been consistently below the London and England averages since 2006.

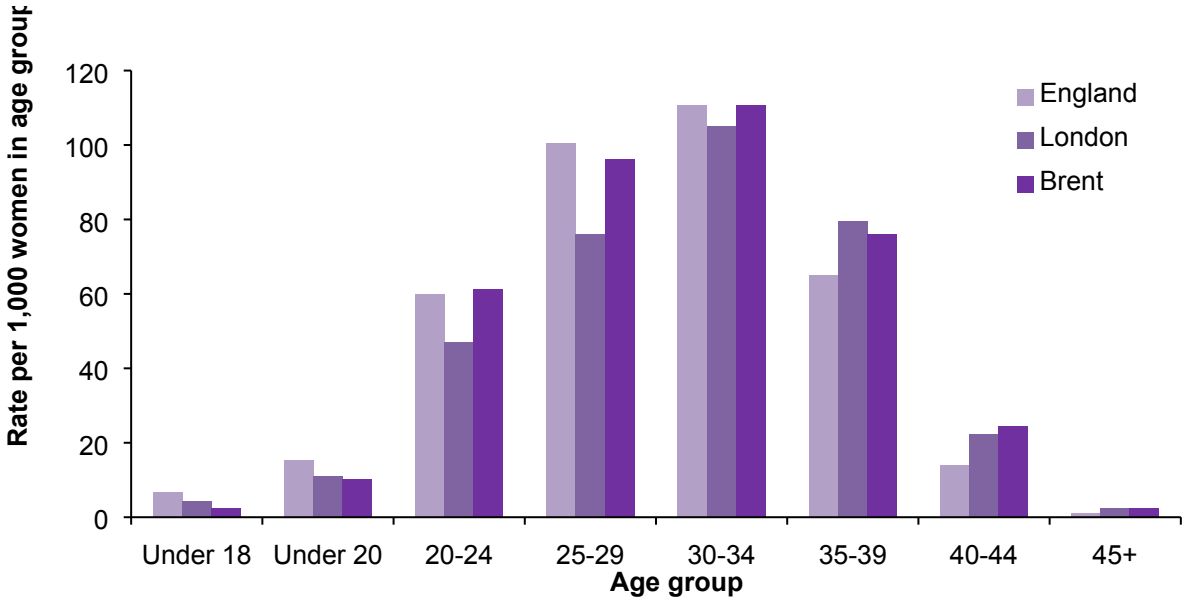


Figure 34: Live birth rate by age of mother in 2014. Source: ONS

[36] PHE, Child Health Profile, 2015
[37] ONS

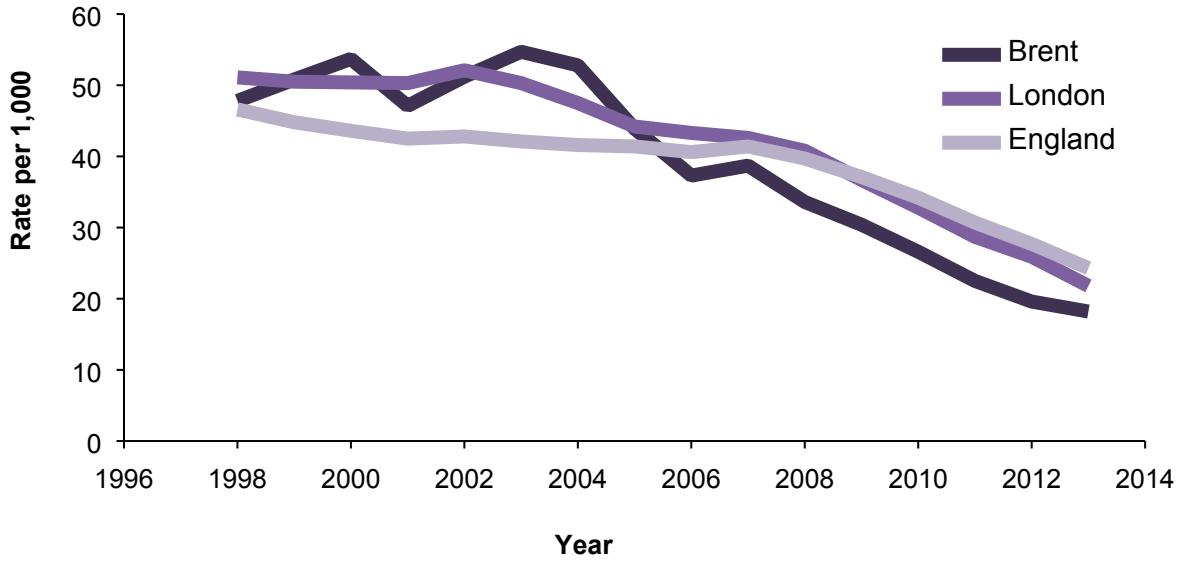


Figure 35: Teenage conceptions. Source: ONS

Smoking in pregnancy

In Brent, the proportion of women who were smoking at the time of delivery in 2013/14 was 3.2%, below the England average of 12% and lower than the London average of 5.1%.

4. LIFE EXPECTANCY AND MORTALITY

Life expectancy at birth is the most commonly used summary measure to describe population health. Self-reported health is a subjective measure that has been shown as a good predictor of hospitalization and mortality[38].

Self-reported health

In the 2011 Census, the vast majority of people in Brent (83%) described their health as "very good" or "good", a similar picture to England and Wales as a whole (81%). Five per cent described their health as "very bad" or "bad" (figure 36); with the remaining 12% saying it is "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 36 shows the proportion of residents with self reported bad health by ward.

[38] Righi, L et al (2015), Life expectancy and self-reported health: related factors in 36 countries. The European Journal of Public Health, Oxford University Press

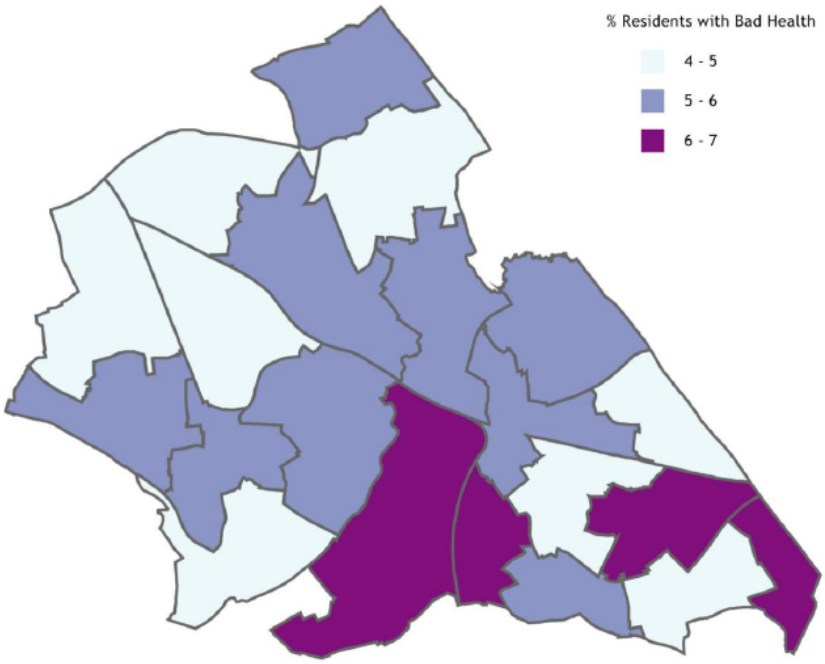


Figure 36: Percentage of residents with bad health in each ward. Source: ONS 2011 Census

Life Expectancy at Birth

In Brent, life expectancy for females born between 2011 and 2013 is 84.9 years. This was higher than the male life expectancy, 80 years (figure 37).

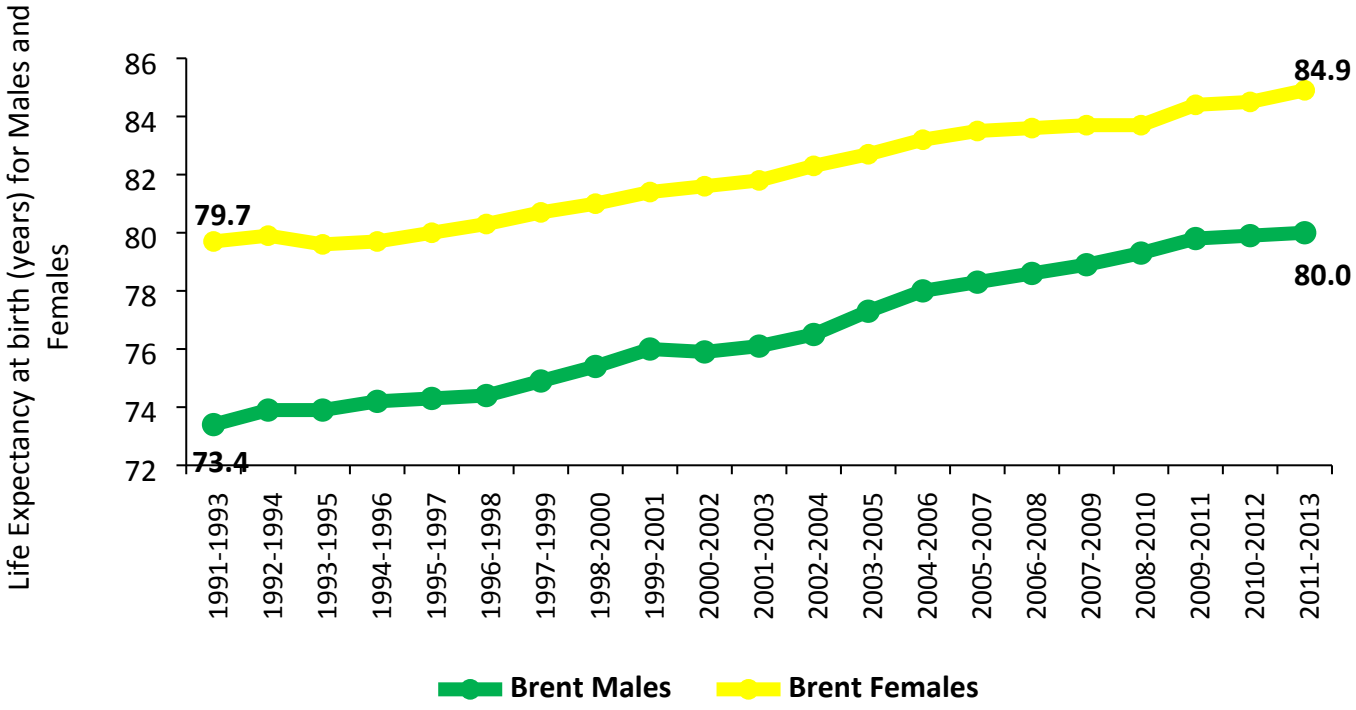


Figure 37: Life Expectancy at birth (years) for Males and Females. Source: ONS

Healthy Life Expectancy

Healthy life expectancy at birth is the average number of years a person would expect to live in good health based on contemporary mortality rates and prevalence of self-reported good health.

In Brent, healthy life expectancy for males in 2011 - 13 was 64.8 years (figure 38). This was similar to the England average which was 63.3 years. Healthy life expectancy for females in 2011-13 was 63.5 years, similar to the England average of 63.9 years[39].

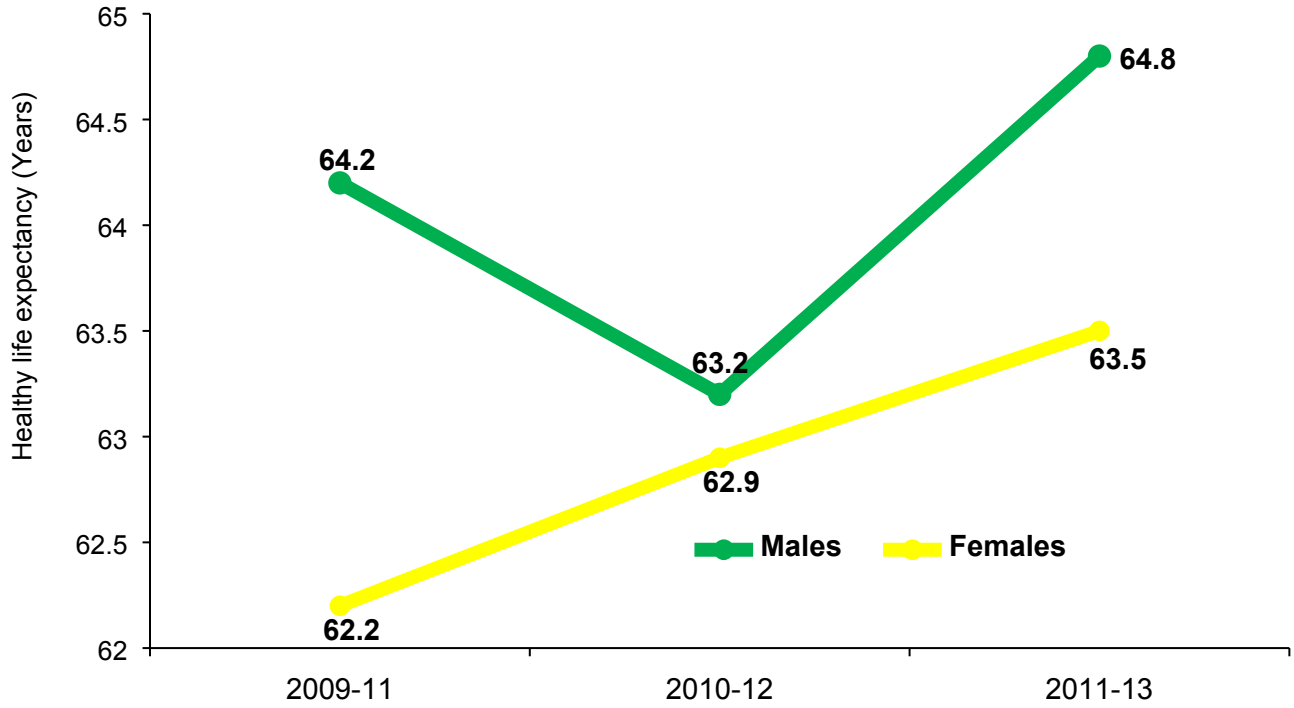


Figure 38: Healthy Life Expectancy: 2009-11 to 2011-13. Source: ONS

Figures 39 and 40 show variations in healthy life expectancy for males and females in 2009-13 in different parts of Brent.

[39] ONS

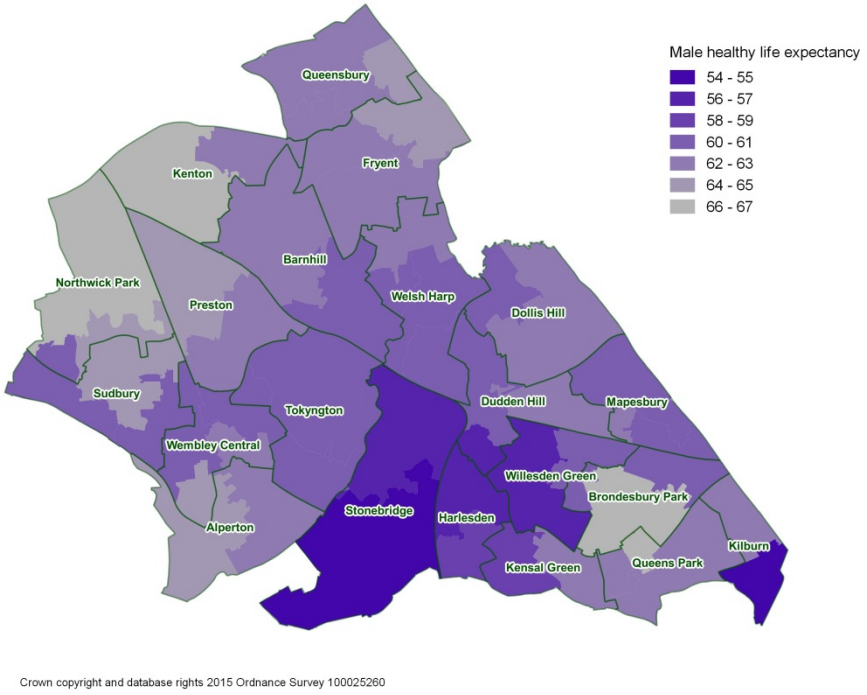


Figure 39: Male healthy life expectancy: 2009 to 2013. Source: ONS

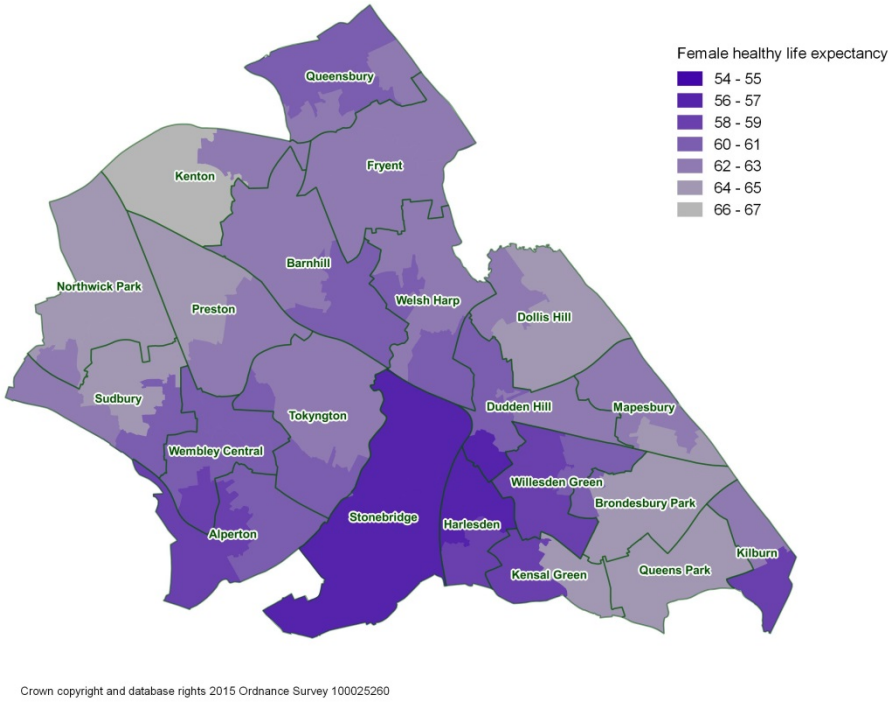


Figure 40: Female healthy life expectancy: 2009 to 2013. Source: ONS

Slope Index of Inequality

Life expectancy for males and females varies across Brent. Life expectancy is 4.7 years lower for men in the most deprived areas of Brent than in the least deprived areas: in the previous year the difference in life expectancy was 5.3 years for the same group. This reduced life expectancy gap is attributed to increased life expectancy for men in the most deprived areas. For women, the life expectancy gap is 4.4 years between the most deprived parts of Brent than in the least deprived parts: in the previous year, the difference in life expectancy was 3.8 years for the same groups (figure 41).

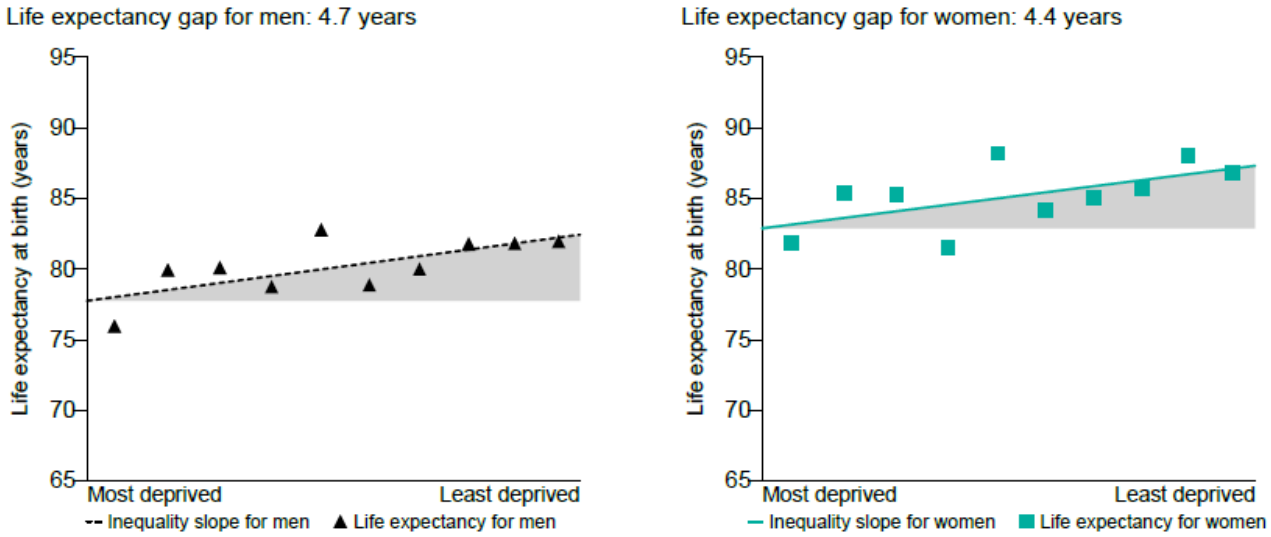


Figure 41: Slope Index of Inequality, 2011-13. Source: PHE, Brent Health Profile, 2015.

Causes of Premature Mortality

Figure 42 shows the main causes of premature mortality (deaths before 75 years of age) in Brent. The main three causes are:

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

The premature mortality rate in Brent is better than in areas of similar levels of deprivation. However, there were still around 650 premature deaths a year. Many of these deaths were potentially preventable through early identification of risk and appropriate intervention programmes.

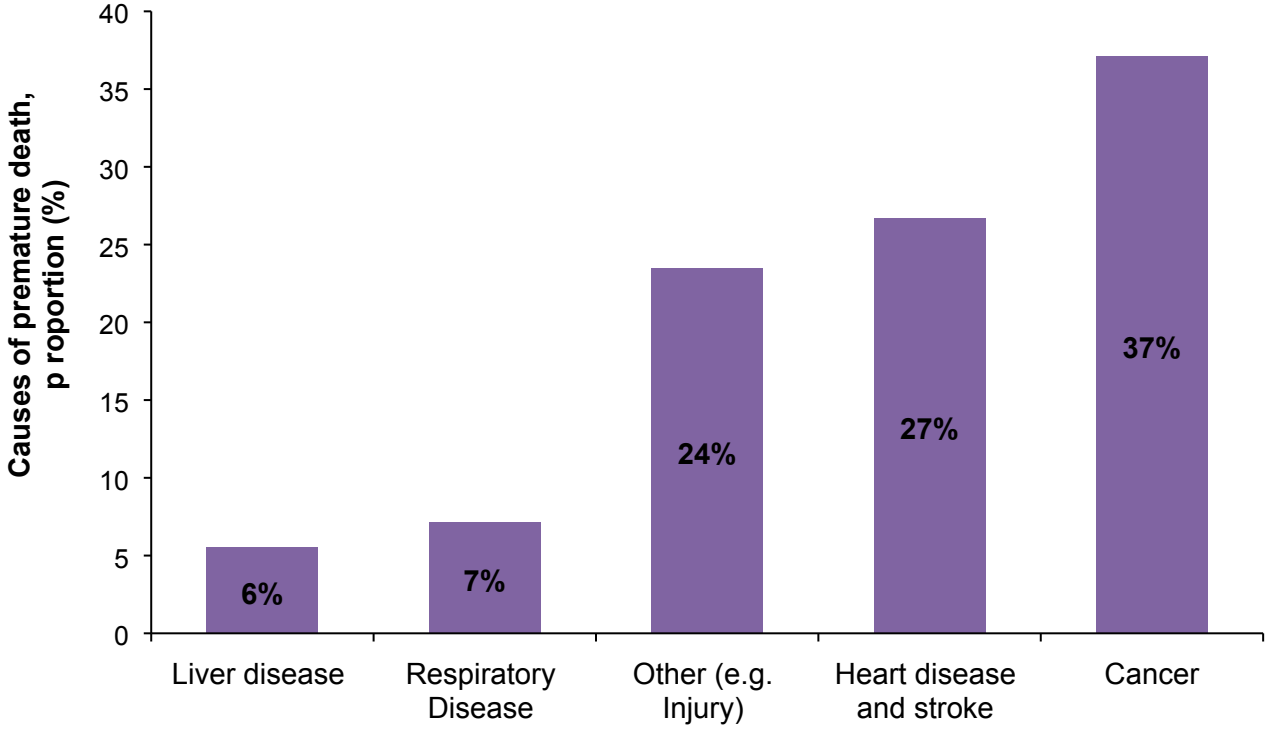


Figure 42: Proportion of all premature deaths by cause in Brent, 2011-13. Source: Public Health England, 'Longer Lives'

The causes of premature mortality in Brent are discussed in more detail below.

Cancer

The age standardised premature mortality rate in Brent from cancer is better than the London and England rates: in 2011-13 the premature mortality rate in Brent was 128.4 per 100,000, the London rate was 136.5 and the England rate, 144.4[40].

Cardiovascular Disease (CVD)

Age is a key factor in CVD mortality rates: the prevalence of CVD increases significantly beyond 40 years old[41]. Figure 43 shows the recorded prevalence of different cardiovascular conditions in Brent CCG and England in 2013/14. Hypertension is the most common CVD condition in Brent CCG, followed by coronary heart disease (CHD). This mirrors the national picture.

[40] Public Health England – based on ONS source data
[41] PHE, Cardiovascular Disease Health Profile for Brent, 2013

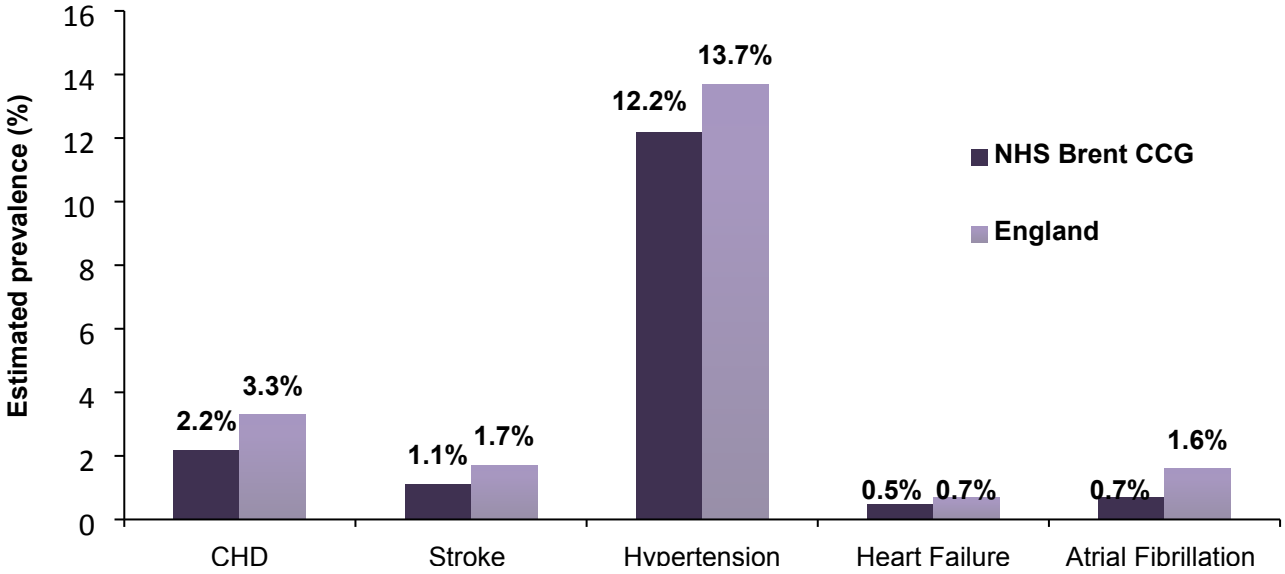


Figure 43: Prevalence of CVD. Source: HSCIC, Quality and Outcomes Framework (QOF), 2013/14

Since 2004-06, the under 75 age standardised mortality rate from CVD in Brent has remained consistently higher than both the London and England averages (figure 44). The 2011-13 under 75 CVD mortality rate in Brent was 93.5 per 100,000. The England rate was 78.2 per 100,000, and the London rate, 80.1 per 100,000[42].

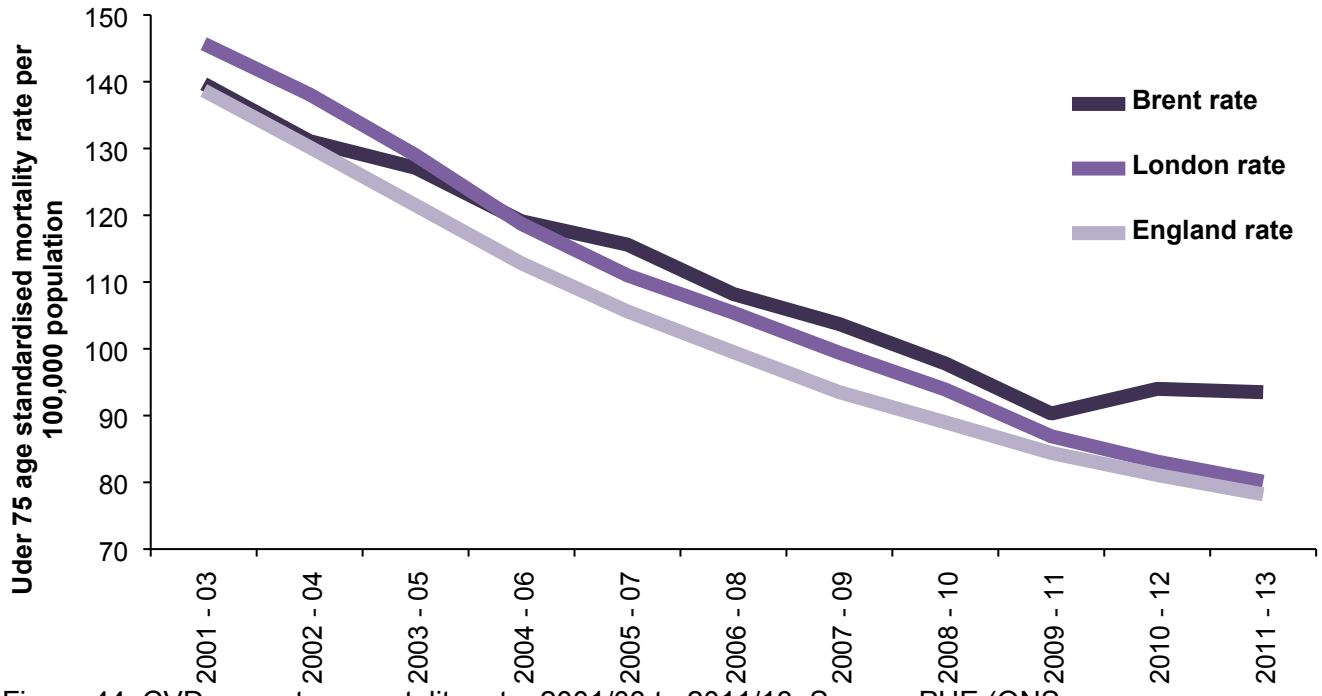
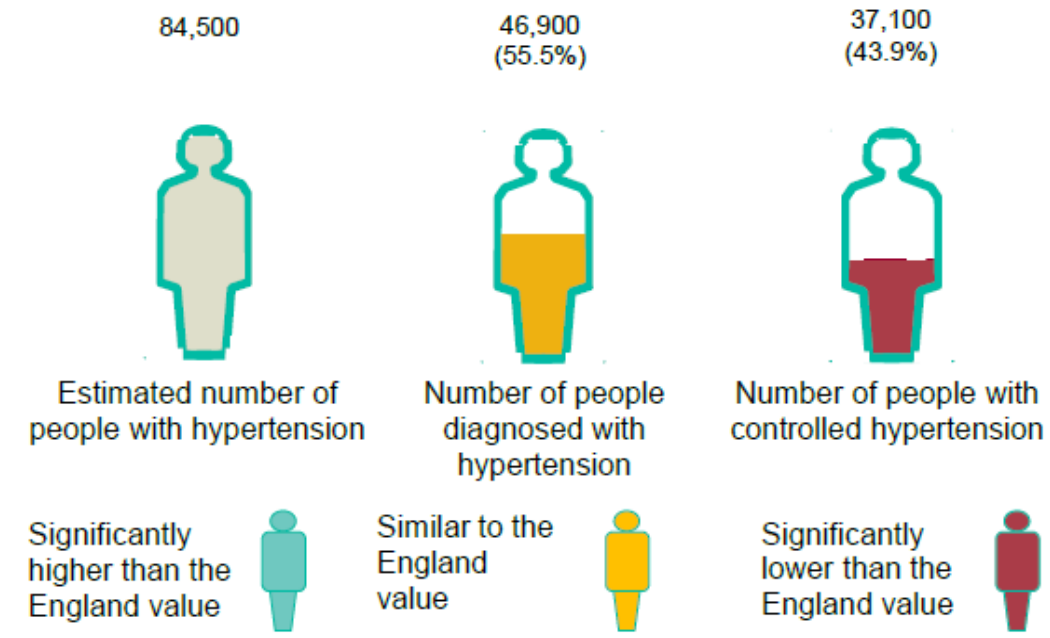


Figure 44: CVD premature mortality rate: 2001/03 to 2011/13. Source: PHE (ONS source data)

[42] Public Health England (based on ONS source data)

Figure 45 summarises diagnosis and control of hypertension in Brent based on GP registered population. Lifestyle risk factors associated with hypertension are: obesity, lack of exercise, and excessive alcohol intake. Evidence based advice[43] has been published which identifies how to effectively identify, treat, and prevent hypertension.



* based on the GP registered population

	Chosen local authority	ONS similar local authorities[2]	London Region	England
Proportion diagnosed with hypertension	55.5%	51.2%	51.3%	55.8%
Proportion with controlled hypertension	43.9%	41.3%	48.4%	44.9%

Figure 45: Diagnosis and control of hypertension in Brent. Source: PHE, Hypertension Profile 2016

[43] PHE, Tackling high blood pressure: from evidence into action: www.tinyurl.com/prk7drz

The London Borough of Brent commissions the NHS Health Checks programme, which aims to identify people who may be at risk of developing cardiovascular disease through blood pressure checks, measuring cholesterol etc.

In Brent in 2014/15 approximately 75,000 residents were eligible to be offered a health check. The percentage of people who were eligible for a health check in 2014/15 who were offered a health check was 22.3%, up 5.7% from 2013/14. The percentage for England was 19.7%. In Brent, the percentage of people who were offered a health check who took up the offer was 56%, up 4.6% from 2013/14. The England percentage was 48.8%[44].

Respiratory Disease

Respiratory disease, which includes Chronic Obstructive Pulmonary Disease (COPD) and asthma, accounts for approximately 15% of all deaths in Brent[45]. COPD alone accounts for around a quarter of deaths due to respiratory disease in Brent. There are likely to be large numbers of people with COPD who are undiagnosed.

Asthma is also a significant condition related to hospital admissions.

The under 75 mortality rate from respiratory disease considered preventable in Brent was 12.9 per 100,000 of the population in 2012-14. This was better than the England average rate of 17.8 per 100,000 of the population[46].

Smoking is seen as the primary cause of COPD. In 2013/14, the recorded prevalence of COPD in NHS Brent CCG was 0.8% (or 2,701 people). This was lower than the England (1.8%) and London (1.1%) averages[47].

Smoking

The prevalence of adults aged 18 years and over who smoked in Brent (13.6%) in 2014 was better than the England (18%) and London (17%) averages[48].

The age standardised rate of smoking related deaths in Brent was 229.3 per 100,000 of the population aged 35 and over in 2011-13. This equates to 248 deaths a year. The England rate was higher; 288.7 per 100,000 of the population[49].

Other Causes of premature mortality

Other causes of premature mortality in Brent include liver disease and injury.

The age standardised premature mortality rate due to liver disease in Brent was 17.8 per 100,000 of the population in 2012-14. The England rate was similar[50].

[44] PHE, Brent Hypertension Profile (2016)
[45] National End of Life Care Intelligence Network (NEoLCIN) profiles: Percentage of all respiratory deaths in 2008-2010 in Brent
[46] Public Health England (based on ONS source data)
[47] HSCIC, QOF
[48] Integrated Household Survey, Analysed by Public Health England
[49] Public Health England, Brent Health Profile, 2015
[50] Public Health England (based on ONS source data)

End of Life Care

Figure 46 summaises trends and variations in place of death in 2013.

Indicator	Period	Brent		Region	England	England		
		Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Hospital deaths, Persons, All Ages (%)	2013	911	56.3%	54.6%	48.3%	39.8%		65.9%
Hospital deaths, Persons, Aged 0 to 64 years (%)	2013	183	50.0%	51.7%	46.4%	25.0%		60.5%
Hospital deaths, Persons, Aged 65-74 (%)	2013	159	56.8%	53.7%	49.9%	39.4%		68.3%
Hospital deaths, Persons, Aged 75-84 (%)	2013	286	59.1%	57.8%	52.0%	41.7%		70.6%
Hospital deaths, Persons, Aged 85+ (%)	2013	283	58.0%	53.9%	45.6%	33.3%		68.5%
Home deaths, Persons, All Ages (%)	2013	383	23.7%	22.2%	22.4%	17.3%		28.0%
Home deaths, Persons, Aged 0 to 64 years (%)	2013	106	29.0%	29.2%	33.5%	22.9%		55.6%
Home deaths, Persons, Aged 65-74 (%)	2013	72	25.7%	28.3%	30.2%	19.4%		37.9%
Home deaths, Persons, Aged 75-84 (%)	2013	107	22.1%	20.2%	22.6%	15.9%		29.9%
Home deaths, Persons, Aged 85+ (%)	2013	98	20.1%	16.5%	14.8%	9.9%		28.4%
Care home deaths, Persons, All Ages (%)	2013	176	10.9%	14.8%	21.6%	5.3%		34.6%
Care home deaths, Persons, Aged 0 to 64 years (%)	2013	7	1.9%	2.4%	2.9%	0.0%		16.9%
Care home deaths, Persons, Aged 65-74 (%)	2013	24	8.6%	6.9%	8.1%	0.9%		18.8%
Care home deaths, Persons, Aged 75-84 (%)	2013	57	11.8%	13.6%	18.6%	5.9%		28.5%
Care home deaths, Persons, Aged 85+ (%)	2013	88	18.0%	25.8%	36.7%	11.4%		50.7%
Hospice deaths, Persons, All Ages (%)	2013	121	7.5%	6.1%	5.5%	0.0%		11.2%
Hospice deaths, Persons, Aged 0 to 64 years (%)	2013	50	13.7%	9.7%	10.3%	0.0%		18.5%
Hospice deaths, Persons, Aged 65-74 (%)	2013	24	8.6%	9.4%	9.9%	0.0%		22.6%
Hospice deaths, Persons, Aged 75-84 (%)	2013	31	6.4%	6.1%	5.5%	0.0%		12.9%
Hospice deaths, Persons, Aged 85+ (%)	2013	16	3.28%	2.68%	1.92%	0.00%		8.86%
Deaths in Other Places, Persons, All Ages (%)	2013	27	1.67%	2.35%	2.15%	1.11%		4.53%
Deaths in Other Places, Persons, Aged 0 to 64 years (%)	2013	20	5.5%	7.0%	7.0%	2.4%		12.4%
Deaths in Other Places, Persons aged 65-74 (%)	2013	1	0.4%	1.8%	1.9%	0.0%		7.5%
Deaths in Other Places, Persons, Aged 75-84 (%)	2013	3	0.62%	1.20%	1.28%	0.00%		2.73%
Deaths in Other Places, Persons, Aged 85+ (%)	2013	3	0.61%	1.06%	1.02%	0.00%		6.47%

Figure 46. End of Life Care Profile. Source: Public Health England

5. WIDER DETERMINANTS OF HEALTH

The wider determinants of health (see figure. 47) include:

- **Deprivation**
- **Poverty**
- **Homelessness and Housing**
- **Transport**
- **Air Quality**
- **Green Space**
- **Employment**
- **Crime and Disorder**

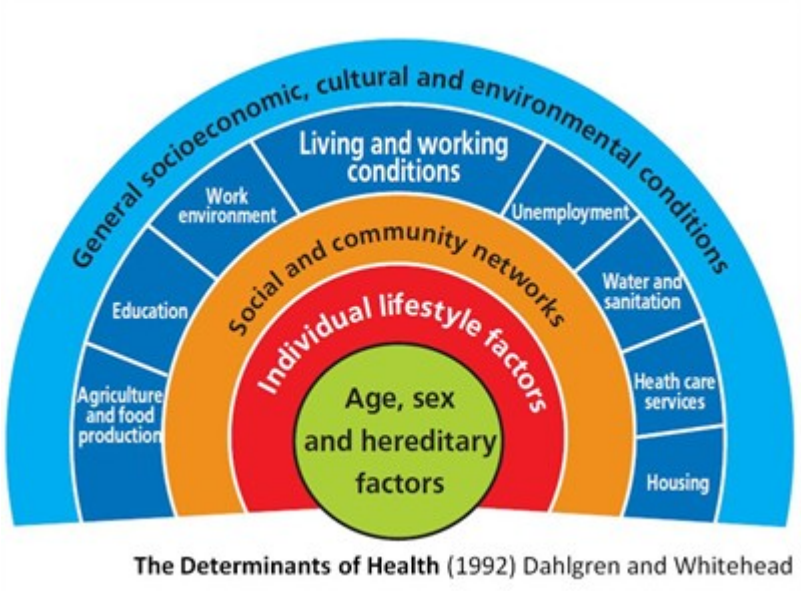


Figure 47: Wider Determinants of Health. Source Dahlgren and Whitehead, 1992

Deprivation

High levels of deprivation are associated with low economic activity, high levels of unemployment, unhealthy lifestyles, low life expectancy, poor educational attainment and poor quality housing.

Indices of Deprivation 2015[51] are prepared at Lower Super Output Area (LSOA) geographical level. There are 32,844 LSOA's in England. Deprivation scores are ranked from 1 (most deprived) to 32,844 (least deprived).

Nationally, Brent ranks 39 out of 326 local authorities in England (where 1 is the most deprived) on the 2015 IMD. However, the overall ranking masks some of the very high levels of deprivation which exist in parts of the borough (figure 48).

[51] Produced by Department for Communities and Local Government

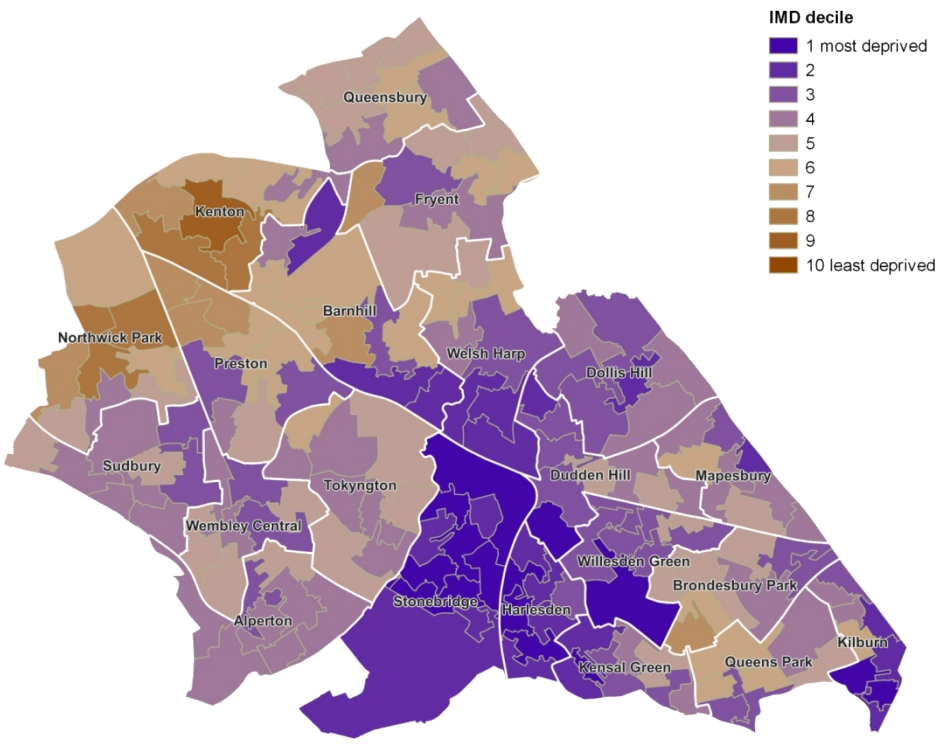


Figure 48: Indices of Deprivation 2015. Source: Department for Communities and Local Government

Poverty

In 2012, 24.8% of children and young people (aged under 16 years) live in poverty (figure 49). This is worse than the England (19.2%) and London averages (23.7%)[52].

[52] HM Revenue and Customs (Personal Tax Credits: Related Statistics – Child Poverty Statistics). Definition is based on children living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income for under 16s only

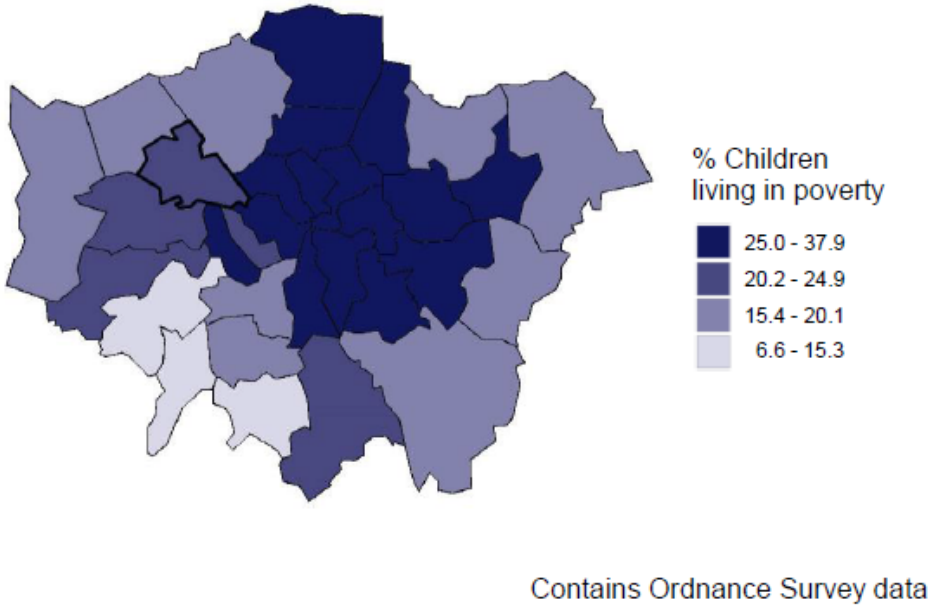


Figure 49: Child poverty in London in 2012. Source: Map produced by PHE, Brent Child Health Profile, June 2015. Data originally sourced from HM Revenue and Customs (Personal Tax Credits: Related Statistics – Child Poverty Statistics

Homelessness, Housing and Health

Homelessness

In March 2015, there were over 3,100 households in temporary accommodation and around 50 approaches a week[53]. Although temporary accommodation decreased by 5% decrease during 2014/15 (180 households), Brent Council still has the largest number of households in temporary accommodation in England and Wales.

Tenure

In common with the rest of London, there has been a significant tenure shift in Brent in the last 10 years, with the private rented sector now larger than the social sector, and with a decline in owner occupation. This trend has been more marked in Brent than in most London boroughs. Figure 50 shows the proportion of Tenure Type in Brent as reported in the 2011 census.

[53] Pie Return

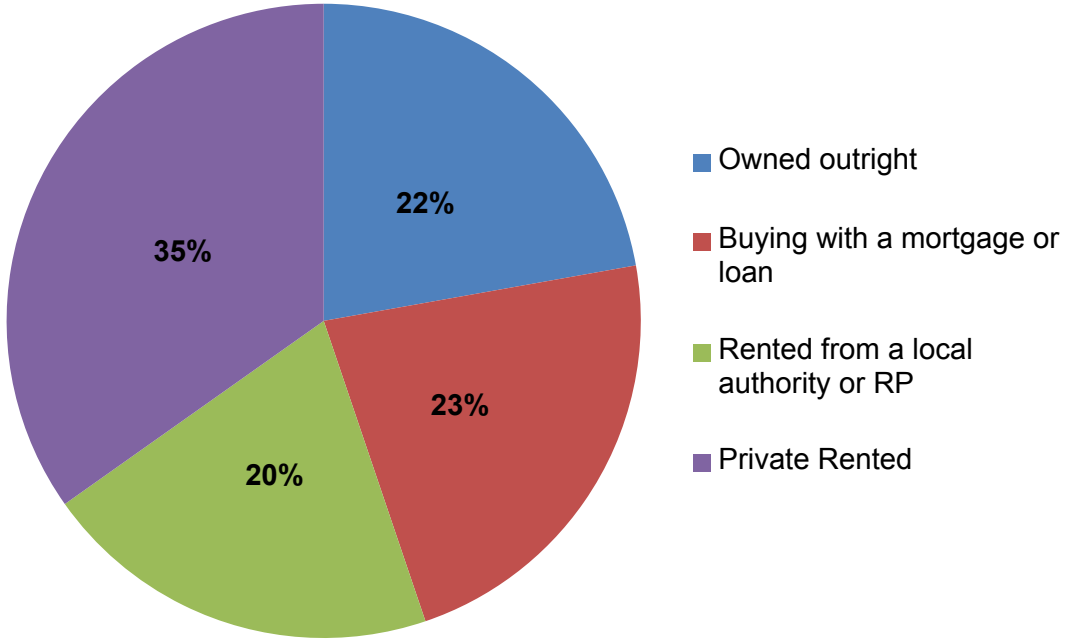


Figure 50: Tenure Type. Source: ONS 2011 Census

Fuel Poverty

Households are considered by the Government to be in fuel poverty if they would have to spend more than 10% of their household income on fuel to keep their home in 'satisfactory' condition[54].

According to the Department of Energy and Climate Change, there are three main factors which lead to fuel poverty:

1) Poor energy efficiency in the home
2) High energy prices
3) Low household income

Levels of fuel poverty in Brent are higher than the England average. In Brent, around 12% of households in 2013 experienced fuel poverty compared to 10.4% in England[55].
The elderly, children and those with a disability or long-term illness are particularly at risk of poor health outcomes as a result of living in a cold home. Evidence shows the significant impacts that cold housing can have on the population in terms of cardio-vascular and respiratory morbidity[56].

Excess Winter Deaths

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

[54] 'The Poverty Site' Webpage: http://www.poverty.org.uk/80/index.shtml

[55] Department of Energy and Climate Change (DECC)
[56] Marmot Review Team report (2011): The Impact of Cold Homes and Fuel Poverty

rates of excess winter deaths (EWD). In Brent, there were around 22% more deaths in December to March than in non winter months in 2011/12. However, this is not statistically different from London or England and Wales. It should be noted that factors such as influenza and indoor and outdoor temperature will contribute to a higher proportion of deaths during the winter months. As such, increasing the uptake of the influenza vaccination among older people is seen as an effective approach to reducing the number of EWD. In 2014/15, 68.6% of eligible adults aged 65 and over in Brent received the flu vaccine (figure 51). The England average was 72.7% and London average was 69.2%[57].

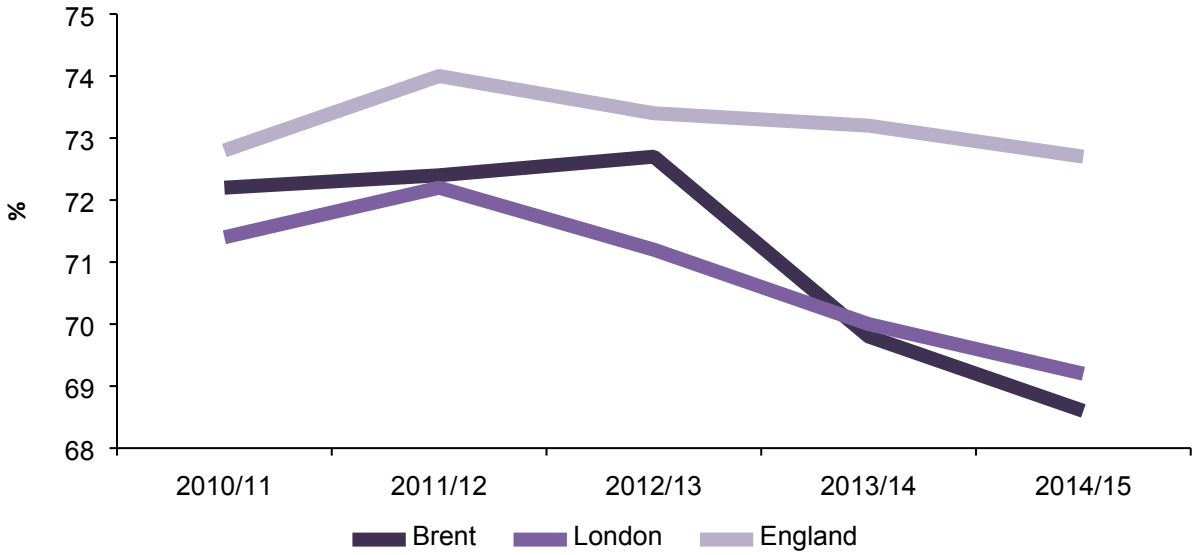


Figure 51: Flu vaccination coverage – aged 65. Source: ImmForm website

Transportation

Transport can influence and impact on health as a result of transport related accidents, active travel, air quality and public transport as discussed below.

Road Casualties

On Brent's roads in 2014:

- 1,067 people were injured: of these 2 resulted in the loss of life and 83 were serious injuries. This figure is higher than the London average.
- In the last 13 years the number of people killed or seriously injured has reduced from 204 to 83.
- There are more casualties amongst people travelling by car than other modes of transport.

[57] ImmForm website

Active Travel

Increasing levels of personal car ownership have contributed to people becoming less active. Approximately 2% of Brent residents cycle or walk to work. At ward level, Alperton had the highest number of people who walked to work and Kenton had the fewest[58].

People who walk or cycle to work or school on a regular basis will benefit from a healthier lifestyle as it helps reduce obesity and the risk of cardiovascular diseases. Research shows that the benefits of active travel outweigh the risks posed by hazards such as poor air quality and road traffic accidents[59].

Air Quality

Road transport and heating emissions are the main sources of oxides of nitrogen (NO_x) in London. Motorised traffic is a key source of air pollution and those that spend longer in traffic face a higher health risk. In parts of Brent where there are high volumes of traffic (such as the North Circular and Wembley High Road), the amount of nitrogen oxides emitted into the atmosphere are expected to be more significant. Populations that may be more sensitive to nitrogen oxides include people who suffer from asthma and those with COPD or heart disease. Although COPD is mainly attributed to smoking, long-term exposure to air pollutants and particles which can irritate the respiratory system can exacerbate the problem.

Green Spaces

Green space and natural environments can provide a range of health benefits to the local population. Green spaces and infrastructure improve both mental and physical health and have been shown to reduce health inequalities[60]. Between March 2013 and February 2014, 15.8% of people in Brent aged 16 and over utilised outdoor space for either exercise or health reasons. This is lower than the England average, 17.1%[61].

Employment

Fewer women are economically active than men. The employment rate for men in Brent (79%) is similar to both London (79%) and Great Britain (78%).

[58] ONS 2011 Census
[59] A benefit of shift from car to active transport. Transport Policy 19, Rabl and Nazelle, 2012
[60] Marmot Review, 'Fair Society Healthy Lives' 2010. UCL Institute of Health Equity
[61] Natural England: Monitor of Engagement with the Natural Environment (MENE) survey

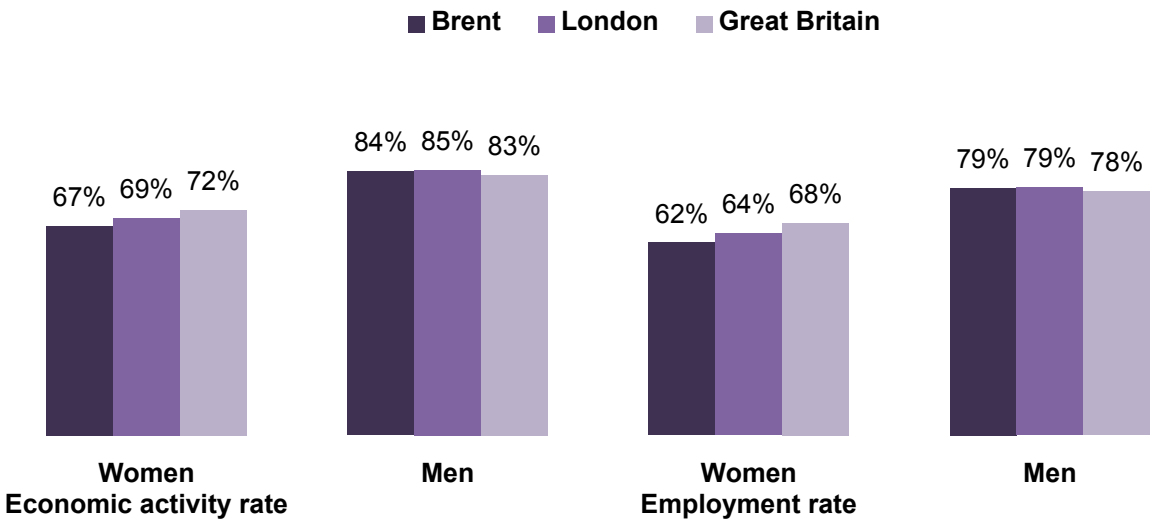


Figure 52. Economic activity and Employment rate (working age population, 16 to 64) – Brent, London and Great Britain. Source: Annual Population Survey

The relationship between health and low income exists across almost all health indicators[62]. Those in employment enjoy better levels of health than the unemployed. People who are unemployed are much more likely to experience poor mental and physical health compared to those in employment.

Crime and Disorder

Violent crime

In Brent, the rate of recorded violent crime (violent offences) against the person in 2013/14 was 16.7 per 1,000 population. This was significantly worse than the England average, 11.1 per 1,000 of the population.

Gangs

In Brent, there are currently between 15 and 19 active street gangs. Gang members in Brent have an average age of 24 years and are predominantly black males. A number of 'hotpots' for gang activities have been identified across the borough. These are located in some of the most historically deprived estates particularly in the south of the borough – Church End, Stonebridge, St Raphael's and South Kilburn.

Domestic Abuse

The number of domestic incidents[63] (non-criminal and criminal offences falling within the Home Office definition of domestic violence and abuse) in Brent as reported by the

[62] London Health Observatory, Determinants of Health

[63] Data from the 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*. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/142701/guide-on-

Metropolitan Police has steadily increased during the period 2005/06 to 2013/14. During this period, domestic offences (criminal offences falling within the Home Office definition of domestic abuse) have stayed reasonably consistent at around 2,000 offences annually (figure 53).

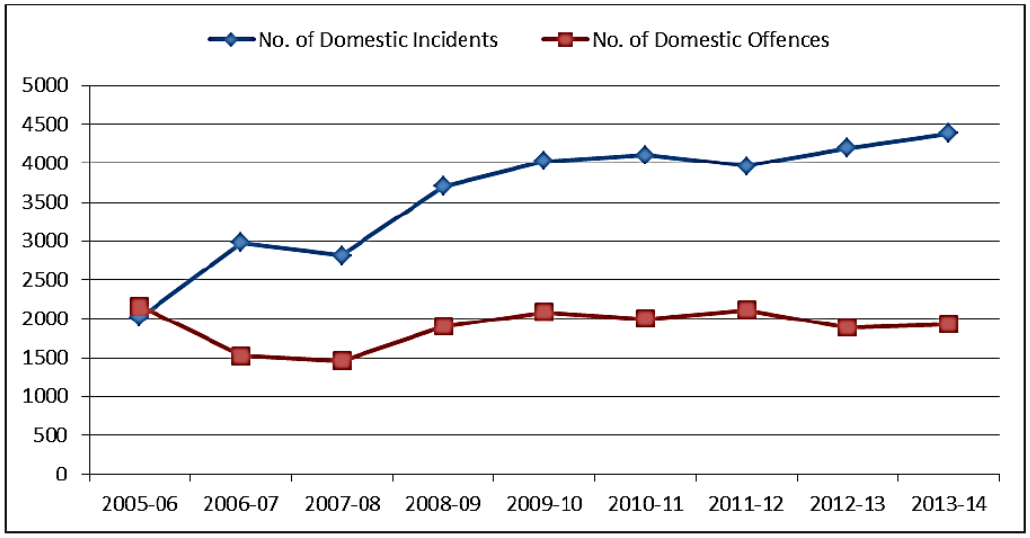


Figure 53: Number of domestic incidents and offences per financial year (2005/06 to 2013/14). Source: LB Brent Community Safety Team

definition-of-dv.pdf

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People and place

Brent JSNA
2015

Brent

NHS
Brent
Clinical Commissioning Group

Brent

Where Brent is in London

Wards

2016 Population	328,800
Area	4,232Ha
Population density (2015)	75.2 people per hectare

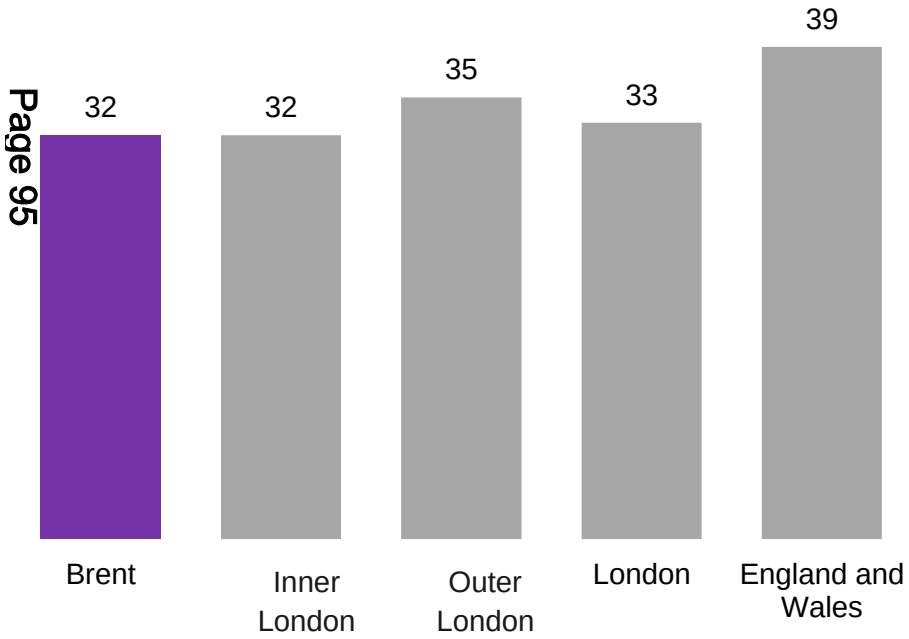
Source: GLA short term population projections, 2014 rnd

Summary

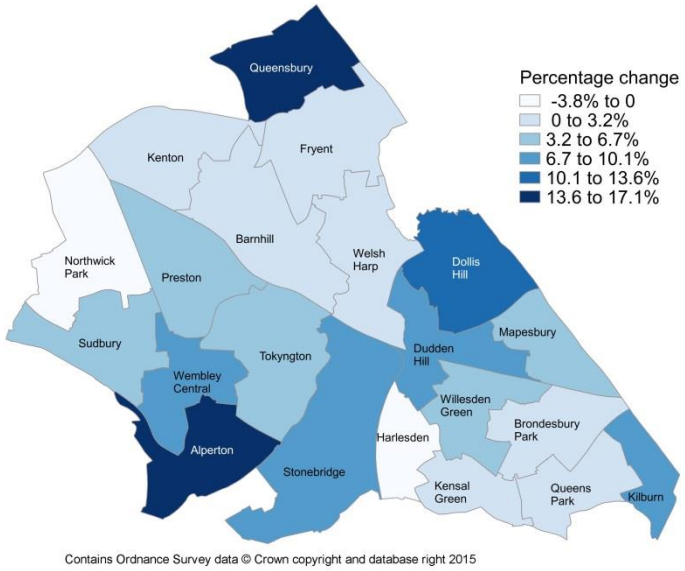
66.4% Brent is black, Asian or other minority ethnicity (BAME)

In **1 in 5** households **nobody** speaks English as their main language

Median age



Population increase from 2011 to 2016

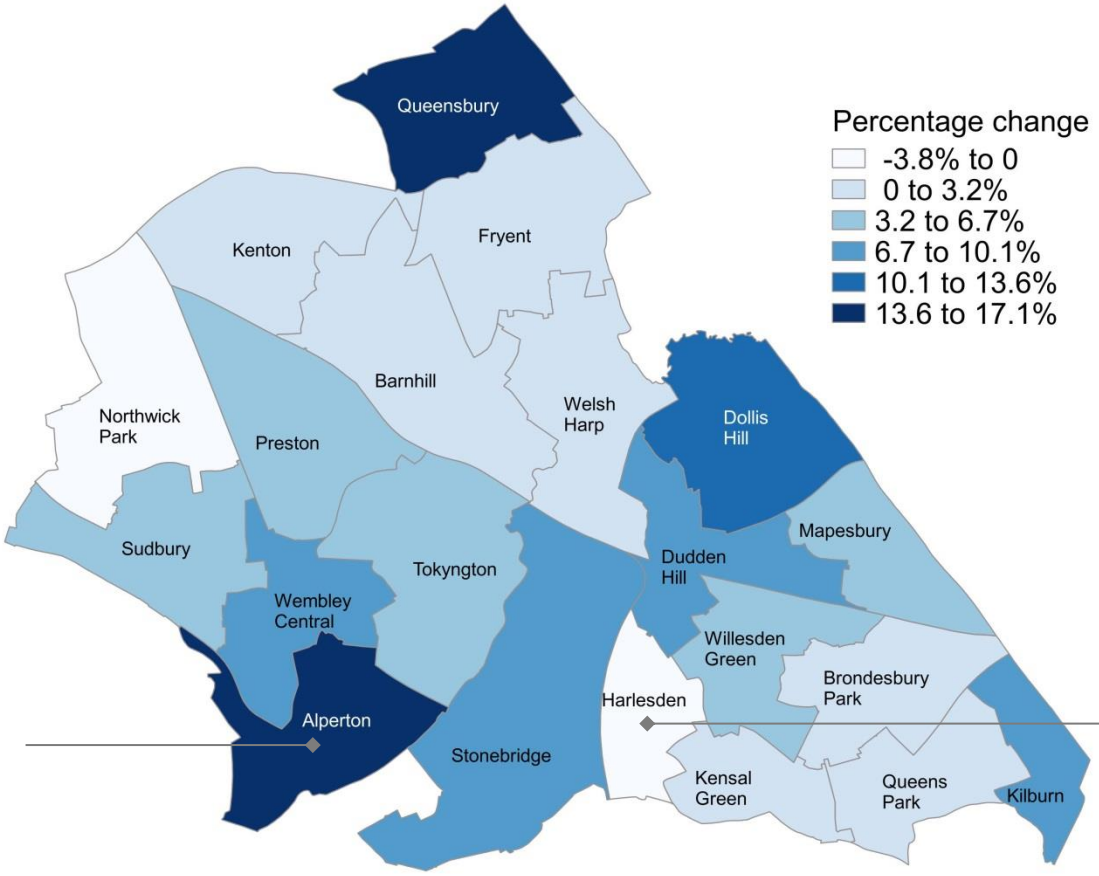


How many people live in Brent?

263,500	311,000	328,800	345,400	359,700
2001	**2011**	**2016**	**2021**	**2026**

Source: GLA short term population projections, 2014 rnd

Where was the population growth in Brent?



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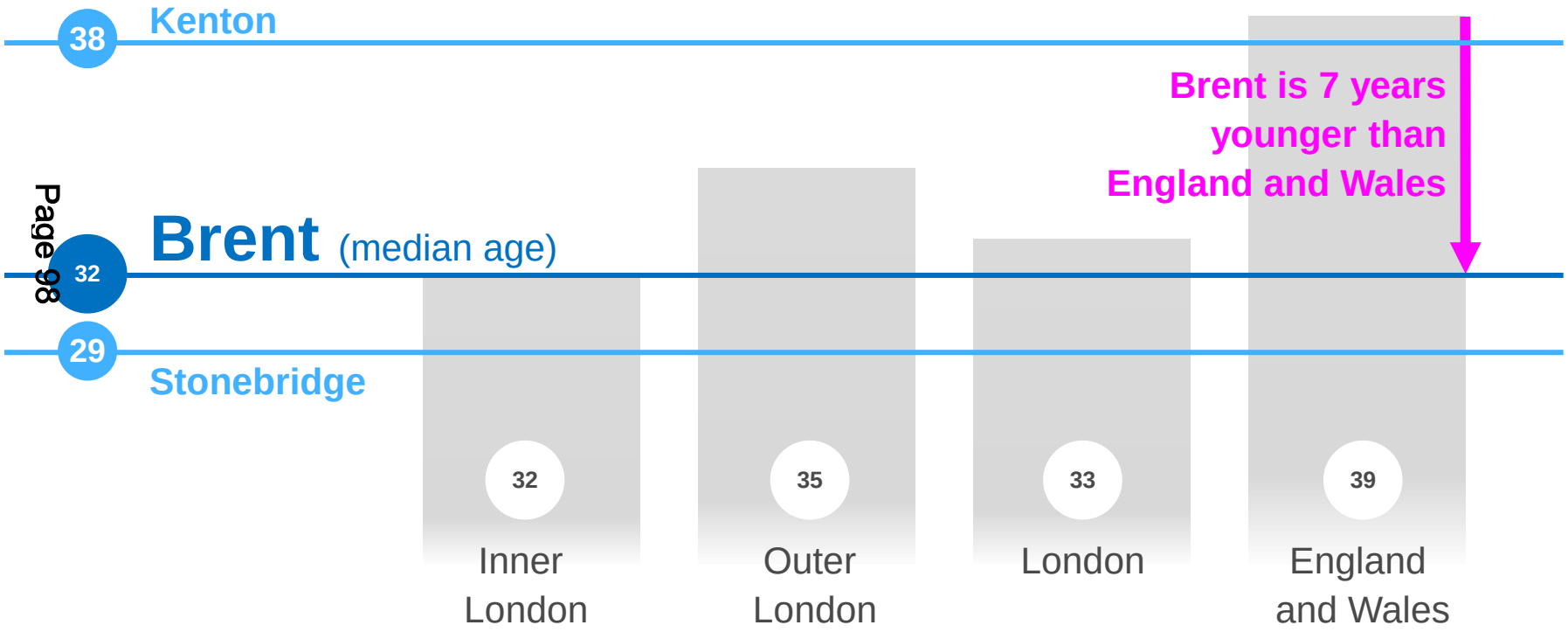
Largest growth (17.1%) in Alperton
The population increases by 2,411 people from 14,102 in 2011 to 16,513 in 2016.

There is a decrease in the population size in Harlesden of 655 people, from 17,277 in 2011 to 16,622 in 2016

Source: GLA short term population projections, 2014 rnd

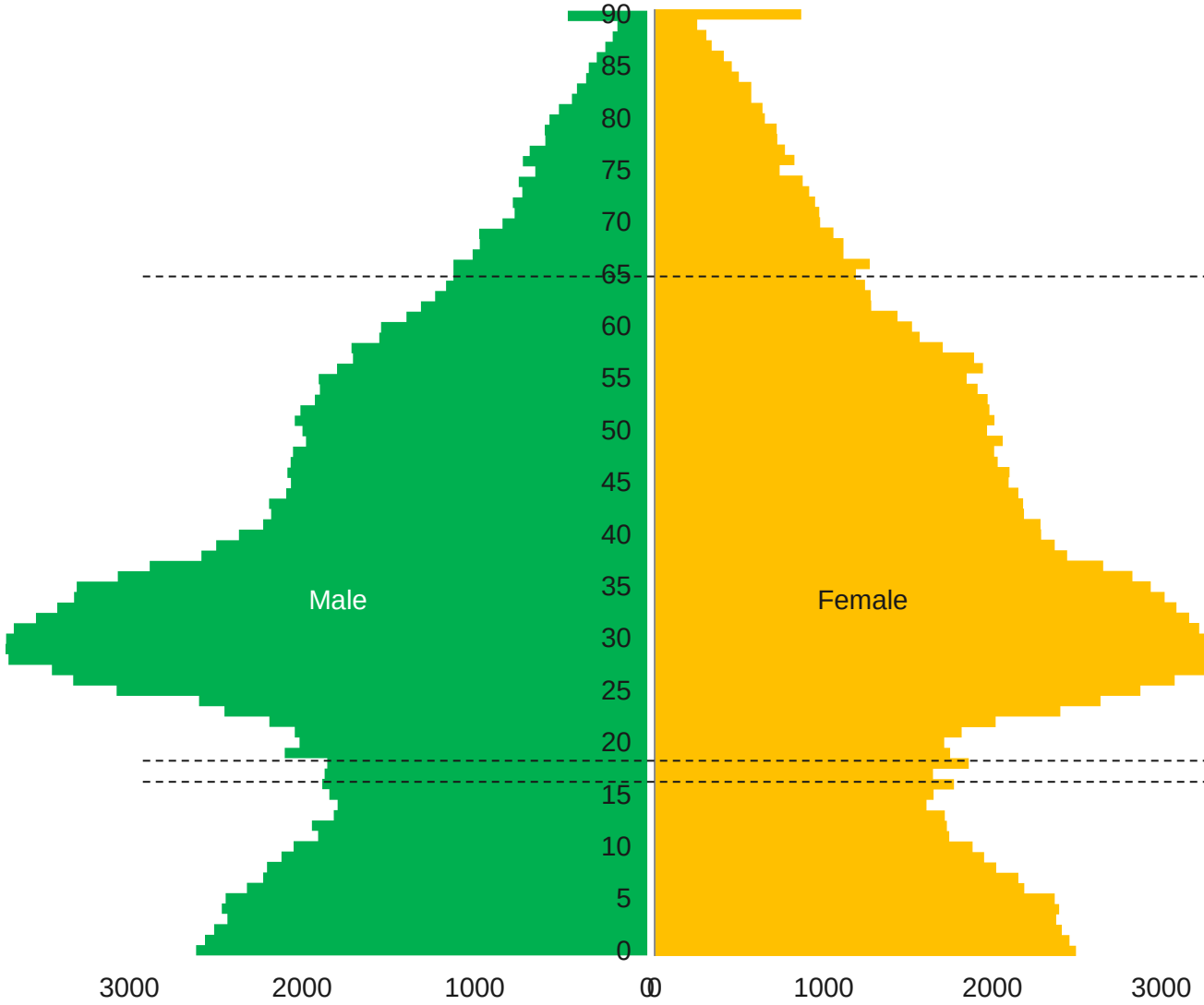
How old are the people in Brent?



Median age for Brent , London and England and Wales

Source: Census 2011

How old are the people in Brent?



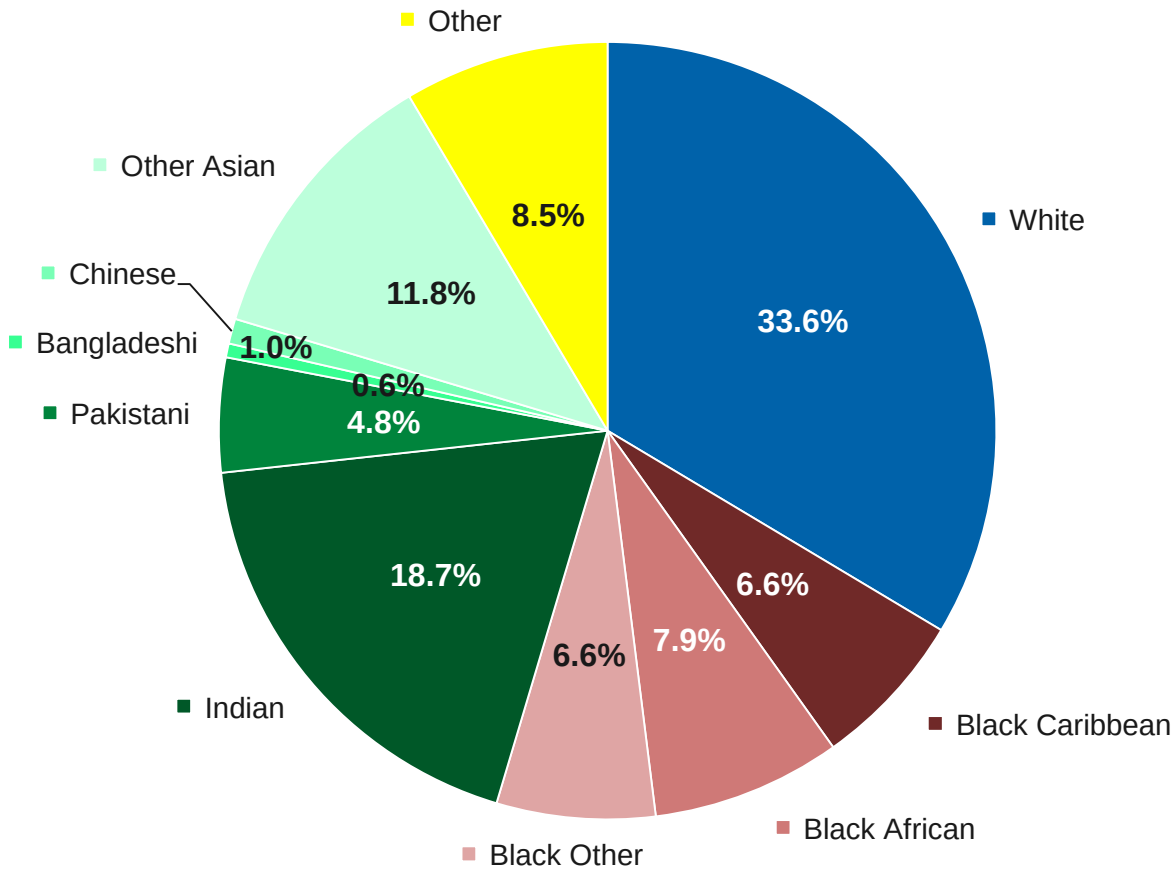
The **65 and over** population makes up **11.0%** of the population

The **16 to 64 (working age)** population makes up **68.2%** of the population

The **under 18** population makes up **22.9%** of the population

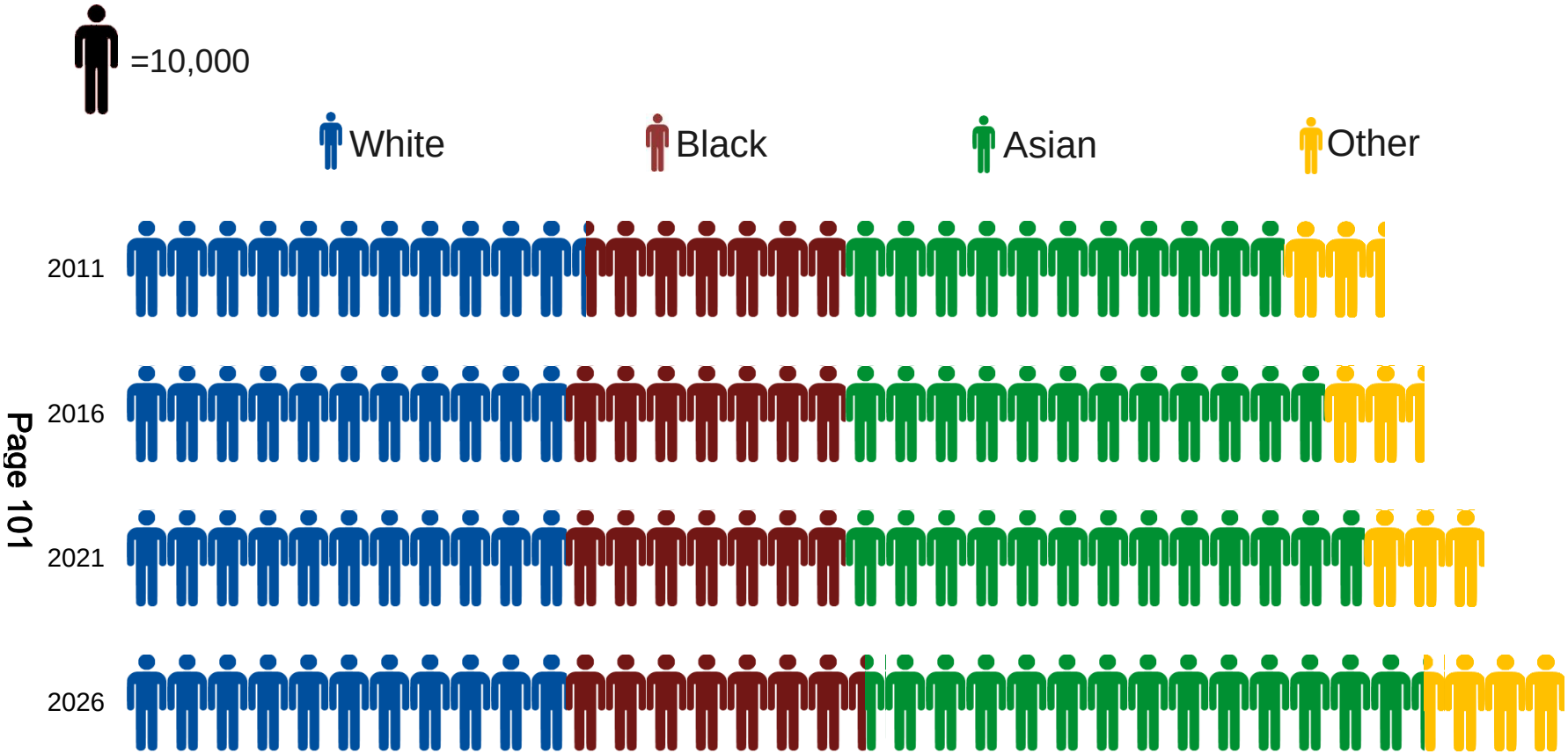
Source: 2016 population from GLA short term population projections, 2014 rnd

Ethnicity



Source: 2016 population from GLA SHLAA based population projections, 2013 rnd

Ethnicity over time

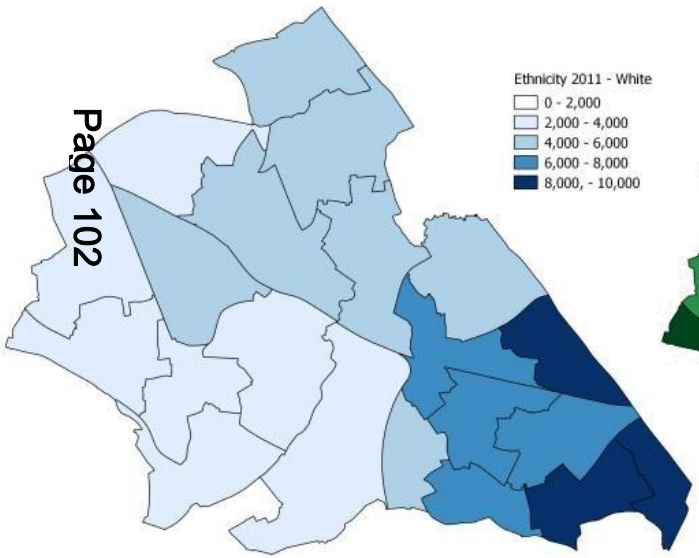


Mixed race people are included in black, Asian or other categories, e.g. white and black Caribbean people are included in black

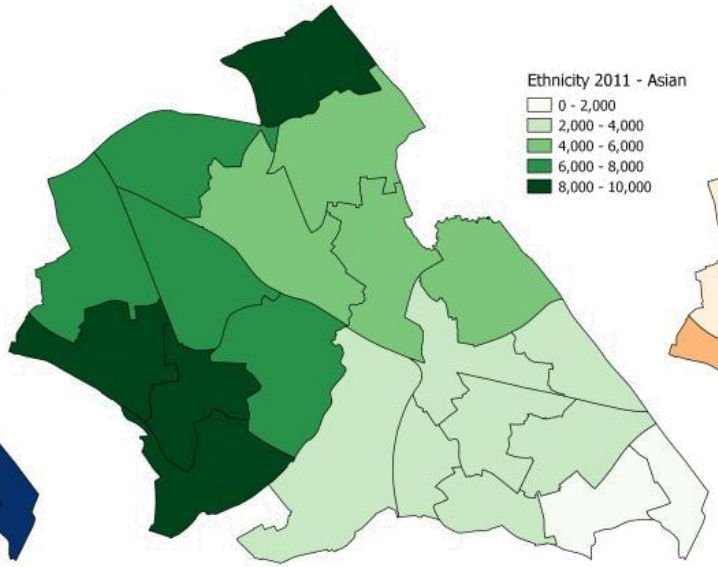
Source: GLA SHLAA based population projections, 2013 rnd

Ethnicity groups by ward

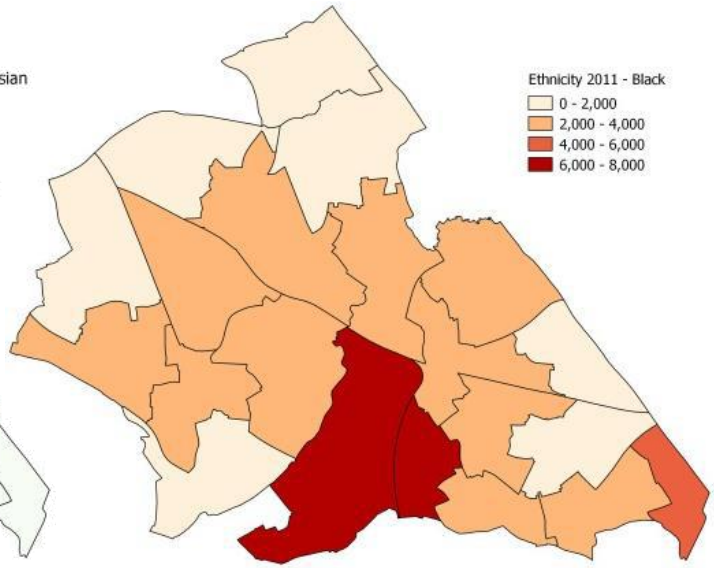
White



Asian



Black

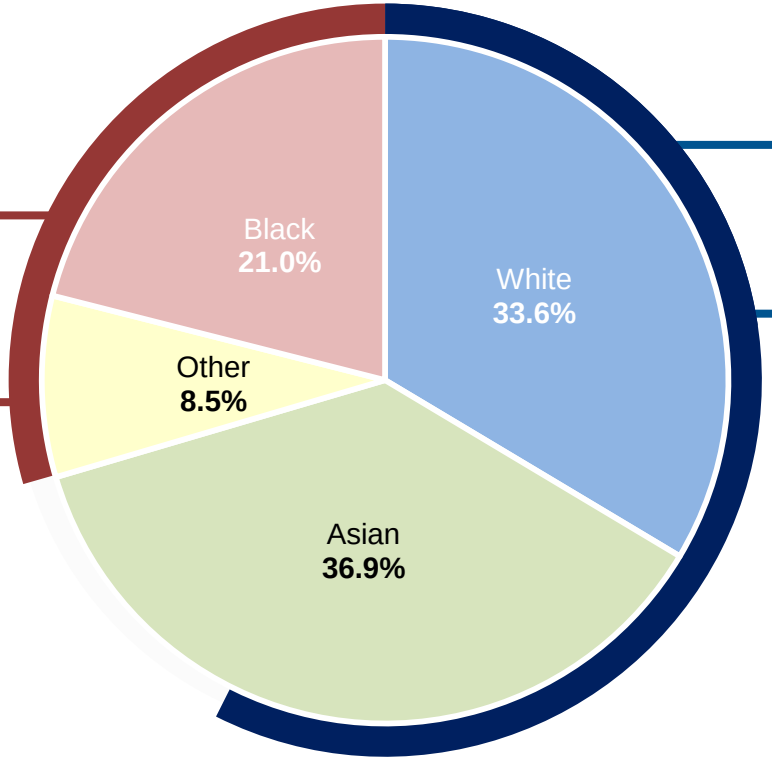


Source: 2011 Census

Ethnicity groups by age

30% people age 5 to15 are black

27% children under 5 are black



23% people age 5 to15 are white

57% people age 85 and over are white

Mixed race people are included in black, Asian or other categories, e.g. white and black Caribbean people are included in black

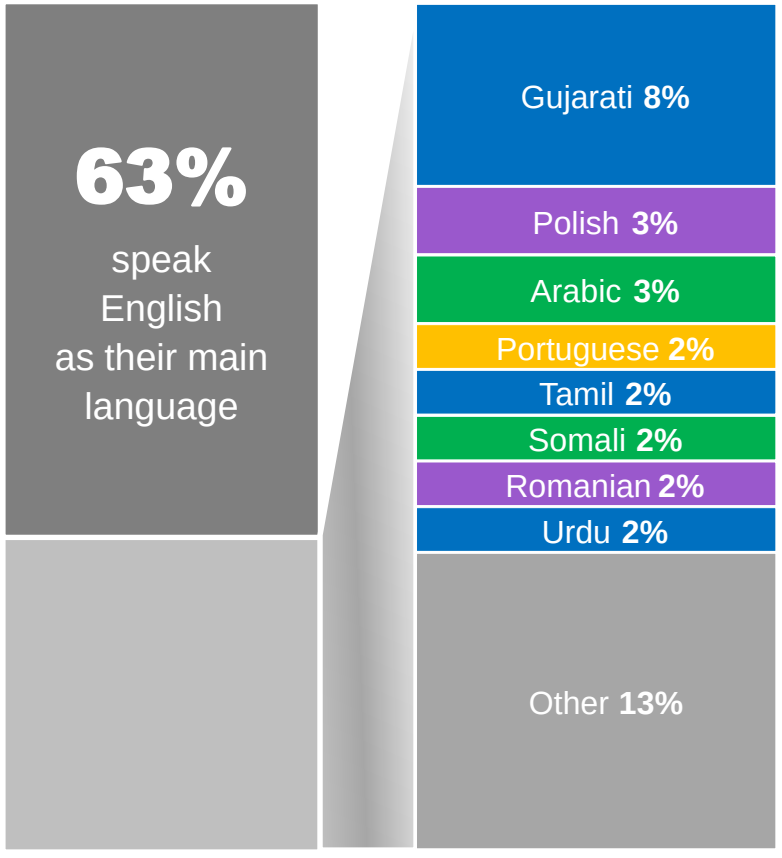
Source: GLA SHLAA based population projections, 2013 rnd

Include footnote about whatd included in other languages

Language

149

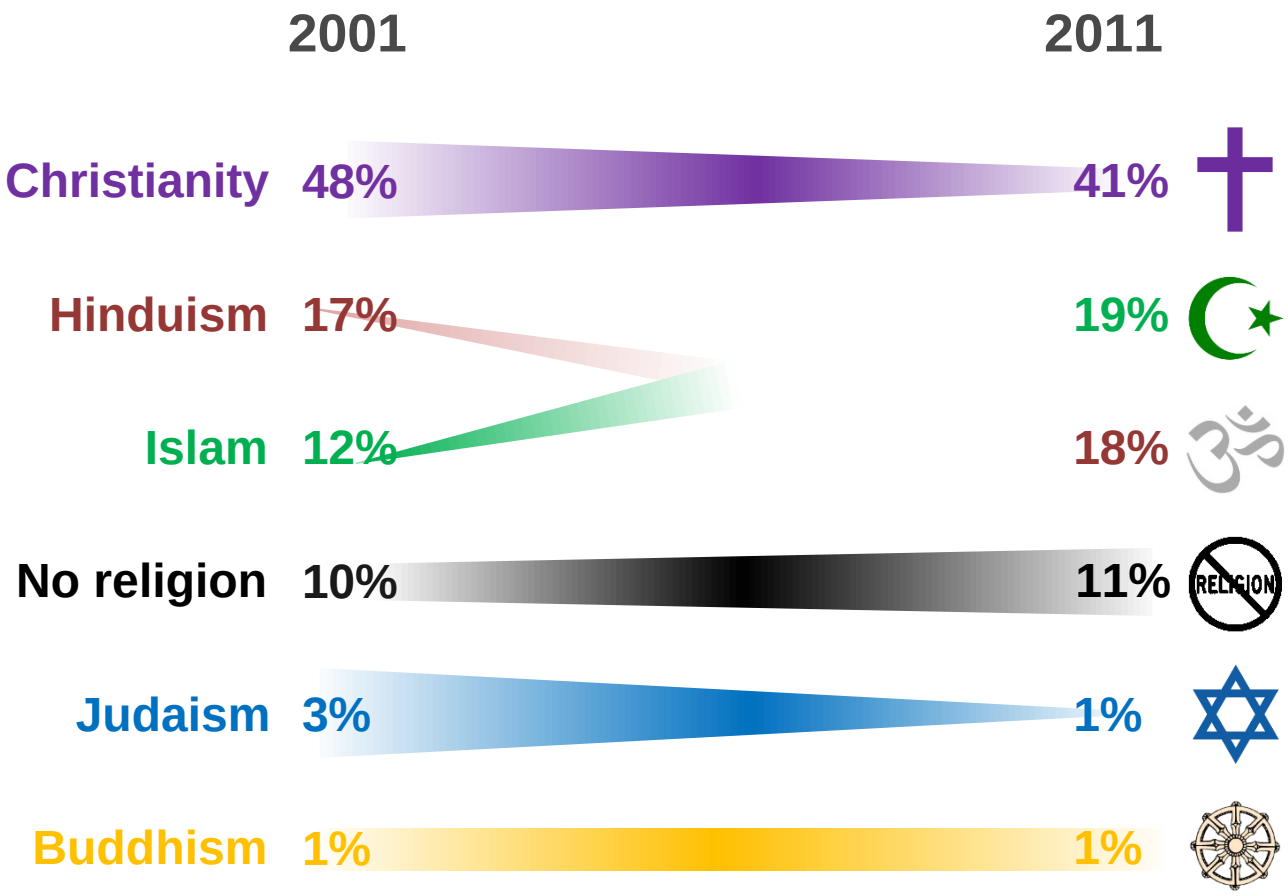
languages spoken in Brent



In **1 in 5** households **nobody** speaks English as their main language

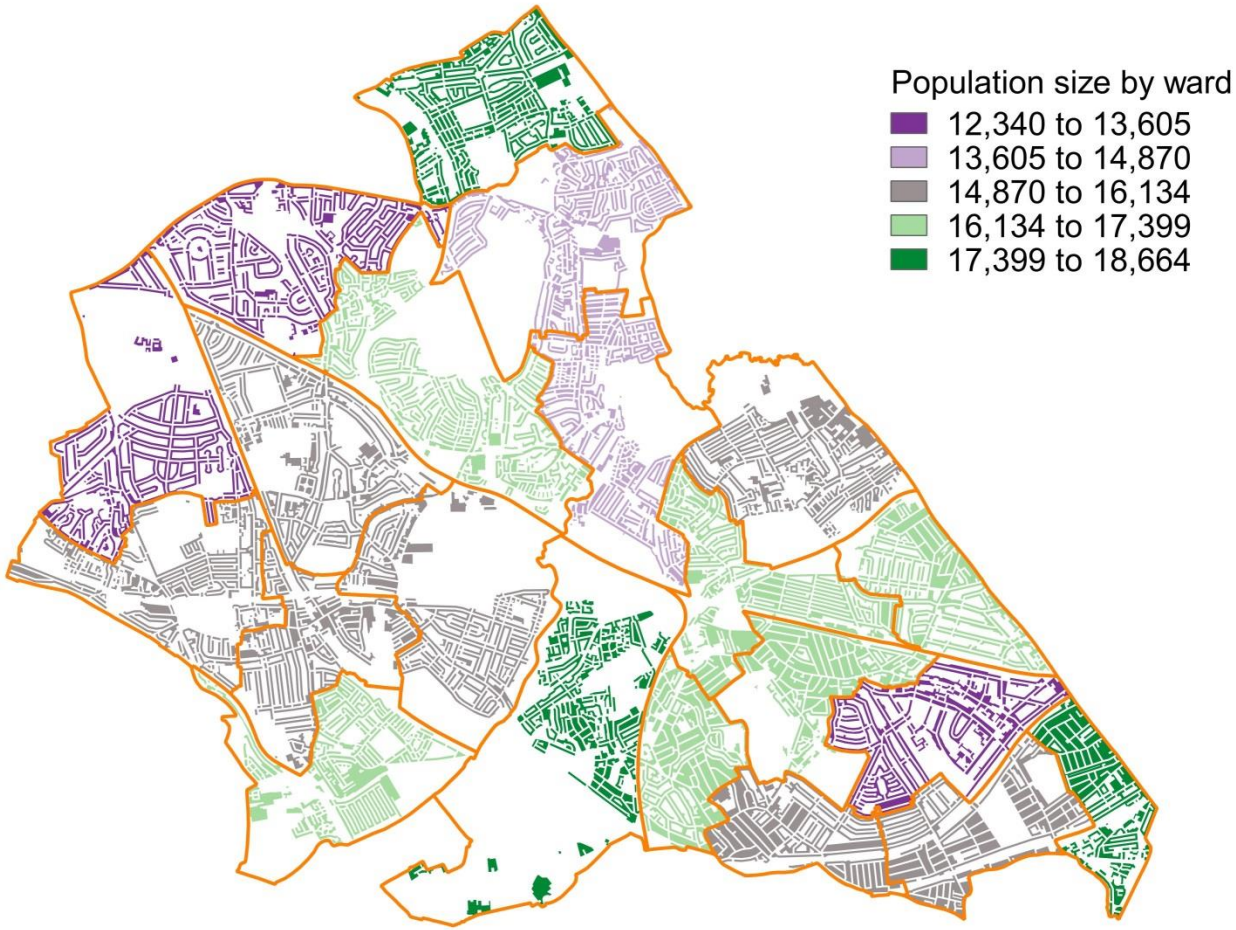
Source: 2011 Census

Religion



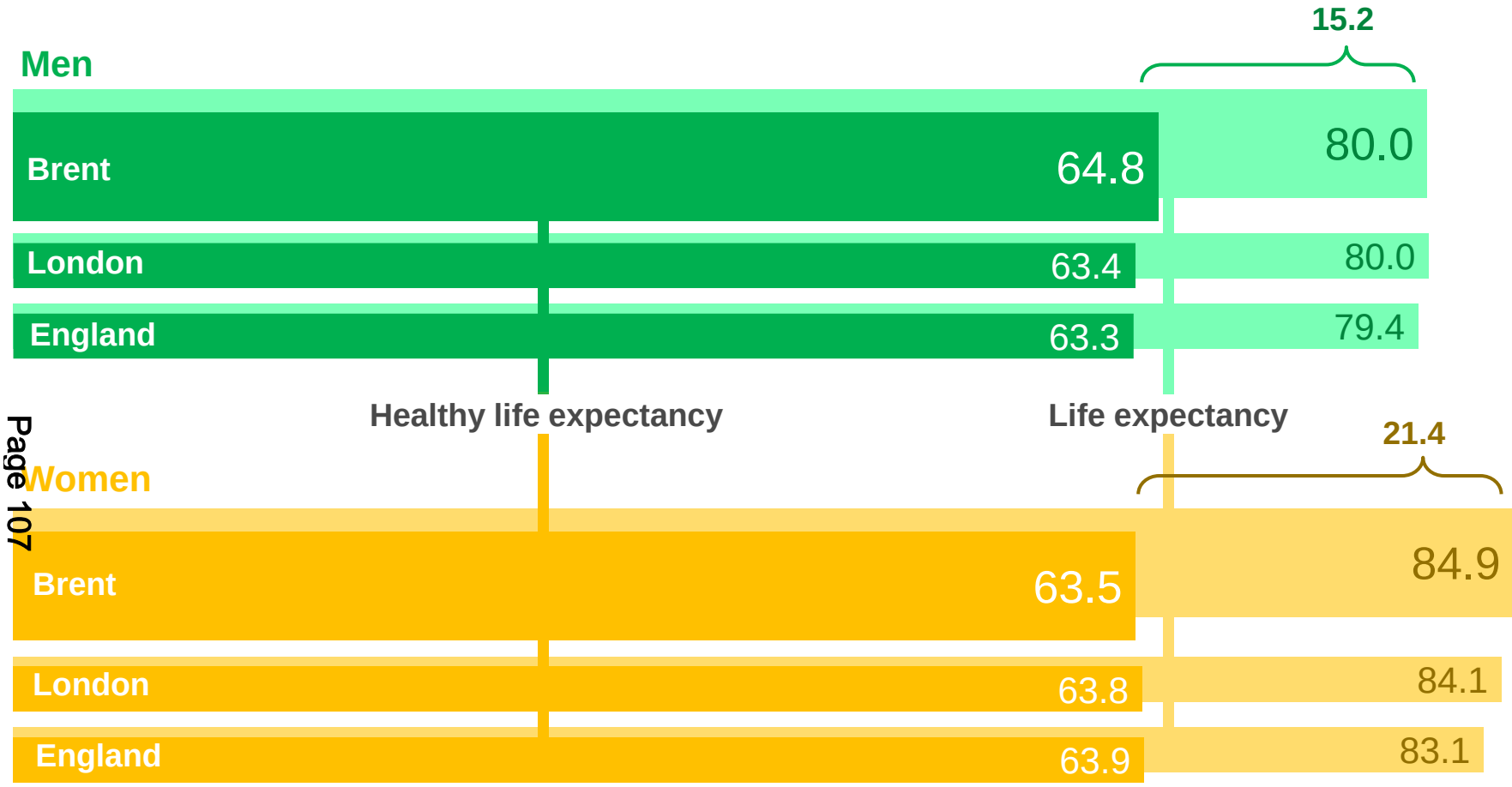
Source: 2011 Census

How many people live in each ward



Source: 2016 population from GLA short-term population projections 2014 rnd

Life expectancy and healthy life expectancy



Source: Public Health Outcomes Framework, for babies born between 2011 and 2013

Many factors contribute to making Brent a diverse and dynamic borough, with the same factors also bringing challenges, both to the council, and other organisations that seek to serve and meet the needs of the local community.

Perhaps one of the biggest challenges is around population size. In 2001, the total population of Brent was 263,500. By 2026, this is set to increase to 359,700 – a 27% increase over 25 years. This increase in population brings challenges in itself, such as increased pressure on housing, schools and health services.

Certain parts of the borough have seen more growth over recent years than others, such as Queensbury and Alperton, compared to Northwick Park and Harlesden, which have seen either negative or zero growth recently. Amongst different ethnic groups, there are further variations. The number of Asian residents is likely to increase, as too are the number of black residents, while the number of white residents is expected to decrease slightly over the coming years.

While the population profile of Brent is relatively young (68.2% of the population are of working age), there are key differences within this. For example, the black African population is young and growing (27% of children under five are black), while the black Caribbean population is ageing. This poses challenges at both ends of the spectrum, from demands on school places to adult social care and health. On average, men in Brent can expect to live 64.8 years in good health and have a life expectancy of 80. Women can expect 63.5 years of healthy life, with a total life expectancy of 84.9 years. This again poses many challenges on the health and social care system.

The north and west of the borough are characterised by higher proportions of Asian residents, while the south east of the borough has a larger proportion of white residents, and there are a higher proportion of black residents around Stonebridge and Harlesden. With these differences in ethnicity across the borough come further variations, notably the number of languages spoken and religion. A total of 149 languages are spoken in Brent. While 63% of residents speak English as their main language, in a fifth of households, nobody speaks English as their main language. Other key languages include Gujarati, Polish and Arabic.

Technical notes

Definitions

Life expectancy	The average number of years a person would expect to live based on contemporary mortality rates. For a particular area and time period, it is an estimate of the average number of years a newborn baby would survive if he or she experienced the age-specific mortality rates for that area and time period throughout his or her life.
Healthy life expectancy	the average number of years a person would expect to live in good health based on contemporary mortality rates and prevalence of self-reported good health.
Main language	Language spoken at home – this does not measure proficiency in English

Data sources

Public Health England, Public Health Outcomes Framework:
http://www.phoutcomes.info/search/life%20expectancy#gid/1/pat/6/ati/102/page/0/par/E12000007/are/E09000005

GLA population projections:
http://data.london.gov.uk/demography/population-projections/

2011 Census
http://www.nomisweb.co.uk/census/2011/data_finder

Other useful sites

GLA borough profile:
http://londondatastore-upload.s3.amazonaws.com/instant-atlas/borough-profiles/atlas.html

GLA LSOA atlas:
http://londondatastore-upload.s3.amazonaws.com/instant-atlas/lsoa-atlas1/atlas.html

GLA ward atlas:
http://londondatastore-upload.s3.amazonaws.com/instant-atlas/ward-profiles-html/atlas.html

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Life Expectancy and Mortality

Brent JSNA
2015

Brent

NHS
Brent
Clinical Commissioning Group

Summary

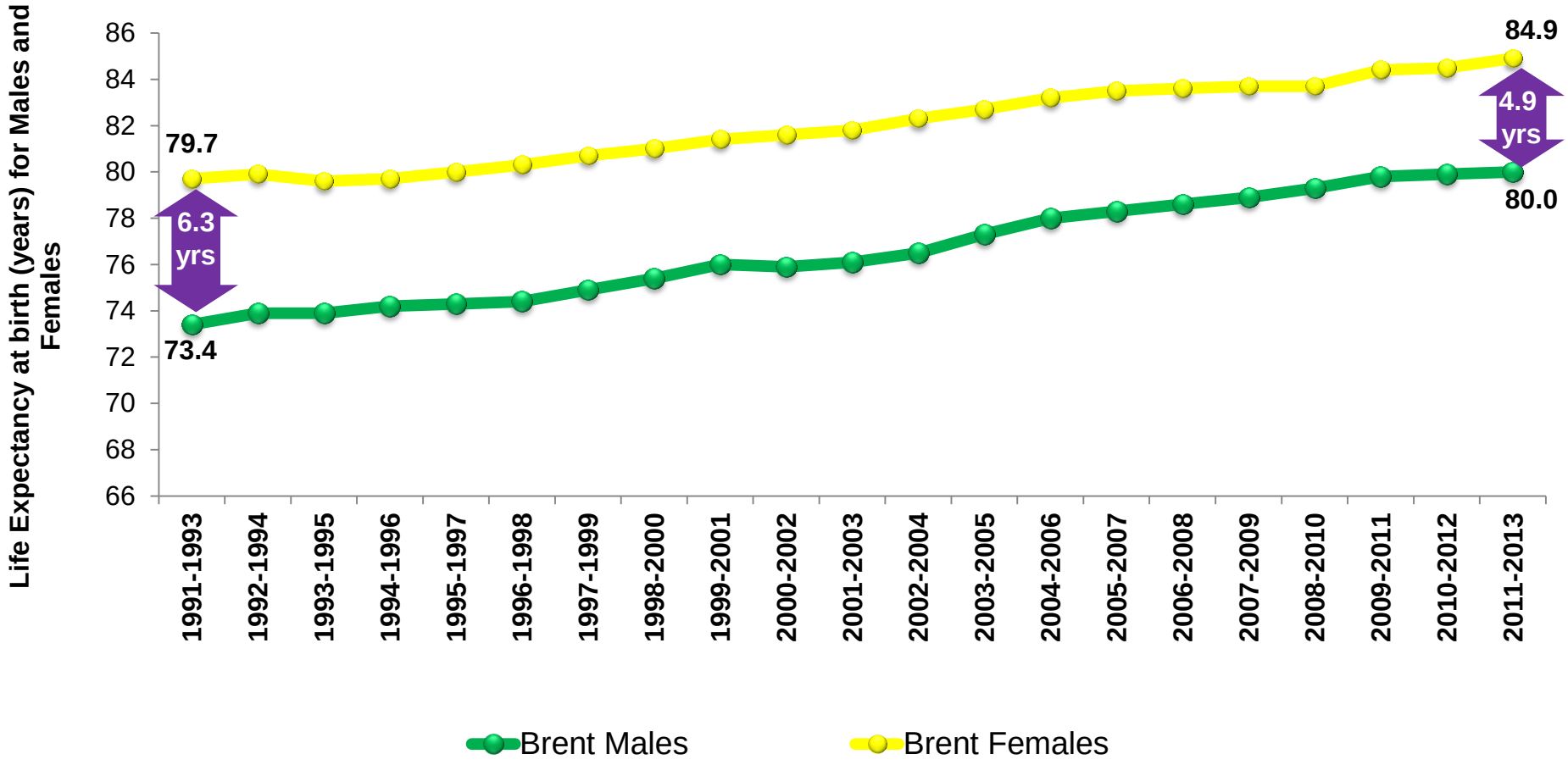
- Life expectancy for females born between 2011 and 2013 is 84.9 years which is higher than the male average of 80 years.
- Deprivation is a significant factor associated with life expectancy inequalities and premature death.
- Life expectancy for children born between 2011-13 is 4.7 years lower for men in the most deprived parts of the borough than the least deprived part. For females the difference is slightly less pronounced, 4.4 years.
- The main causes of premature mortality in Brent are: Cancer, Cardiovascular disease and Respiratory Disease.
- The premature mortality rate in Brent is better than in areas of similar levels of deprivation. However, there were still 1,952 premature deaths in Brent in 2011-13. Many of these deaths were potentially preventable through early identification of risk and appropriate intervention programmes.
- The overall age standardised premature mortality rate in Brent from cancer is better than the London and England rates; in 2011-13 the premature mortality rate in Brent was 128.4 per 100,000, the London rate was 136.5 and the England rate, 144.4.

Male and Female Life Expectancy

	Male	Female
Life expectancy at birth	80 years	84.9 years
Life expectancy at 65	19.3 years	22.8 years
Slope index of inequality	4.7	4.4
Life expectancy at birth most deprived quintile	76	81.9
Life expectancy at birth least deprived quintile	82	86.8

Source: Office for National Statistics (ONS), life expectancy at birth for local areas in England and Wales
Slope index of inequality: Public Health England (PHE), Public Health Outcomes Framework (PHOF)

Life Expectancy at Birth: Males and Females

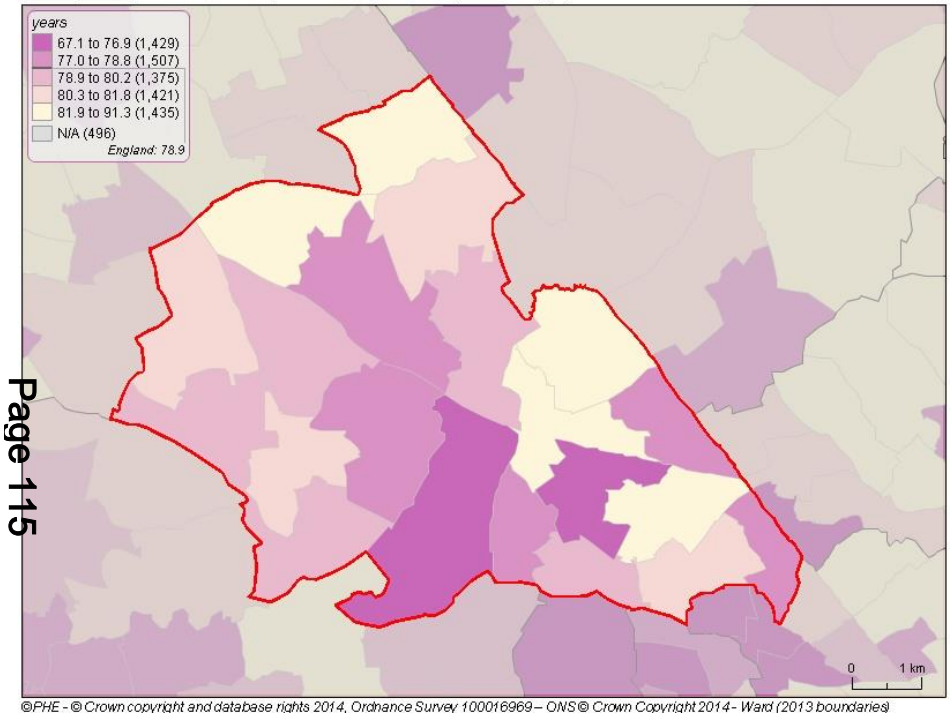


Source: Office for National Statistics (ONS), life expectancy at birth for local areas in England and Wales

Life Expectancy at Birth and Geography

Male life expectancy at birth

Life expectancy at birth for males, 2008-2012 - *source: ONS, PHE © Copyright 2013*



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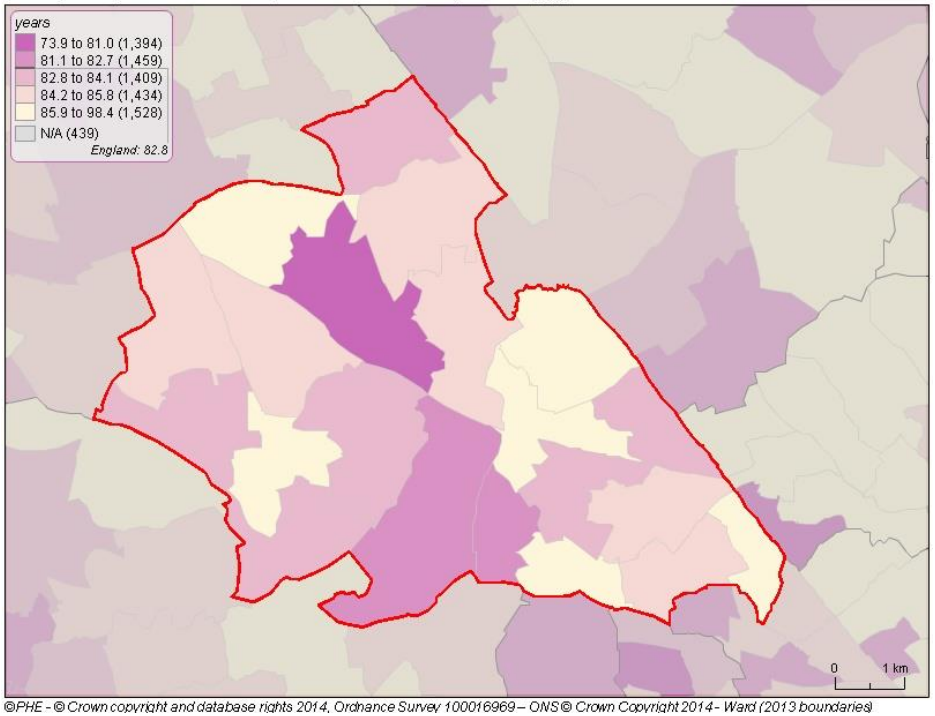
Female life expectancy at birth

Life expectancy at birth for females, 2008-2012 - *source: ONS, PHE © Copyright 2013*



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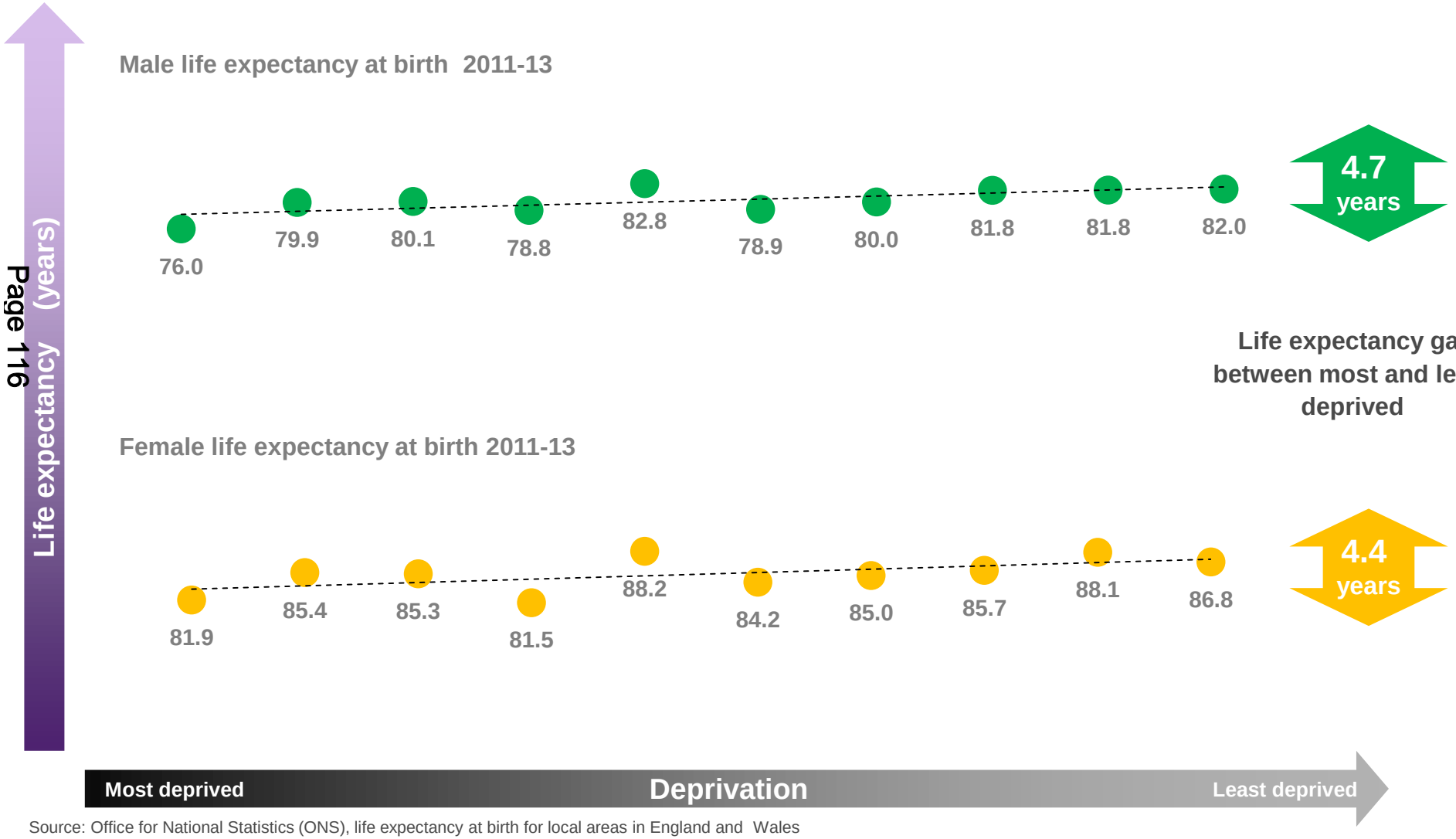
Source: Office for National Statistics (ONS), life expectancy at birth for local areas in England and Wales

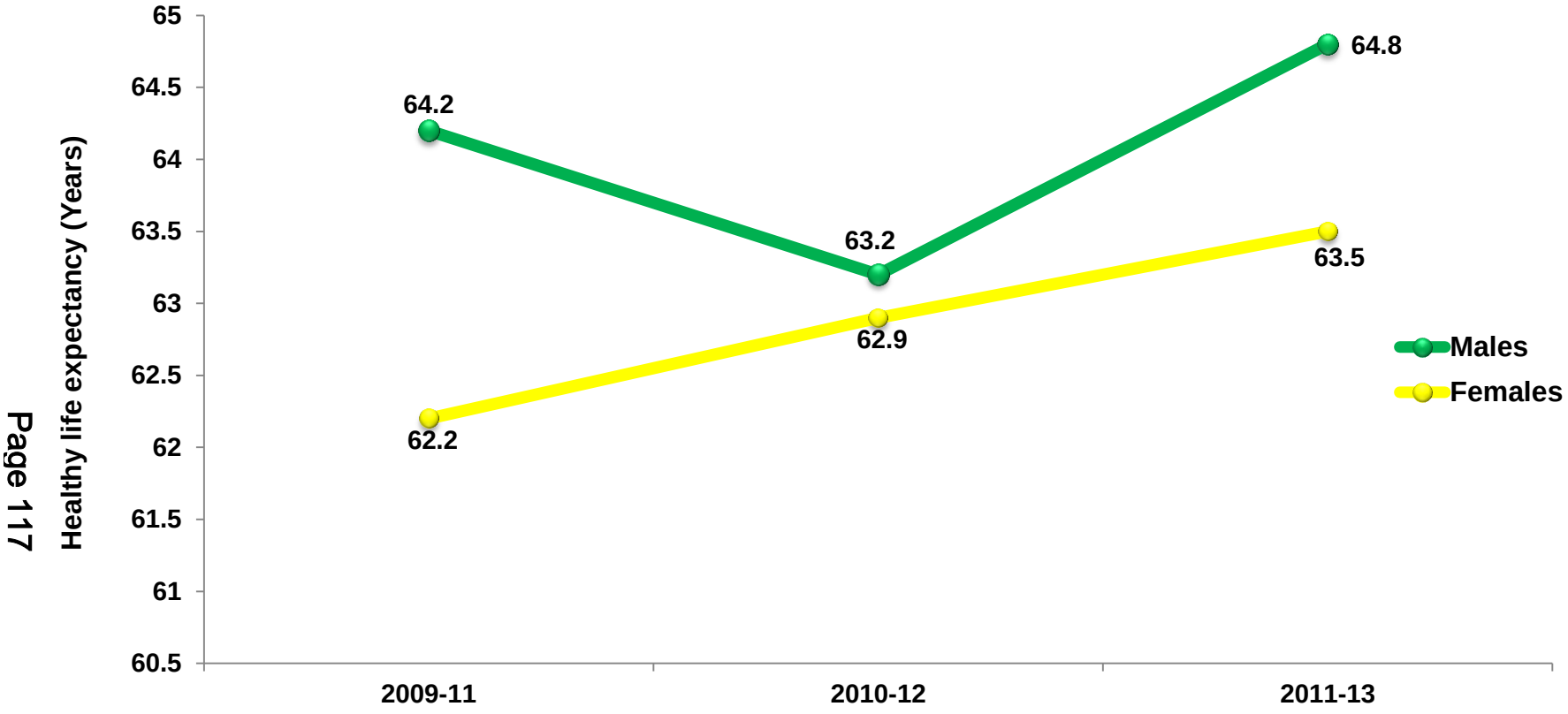
Slope Index of Inequality



Source: Office for National Statistics (ONS), life expectancy at birth for local areas in England and Wales

Healthy Life Expectancy

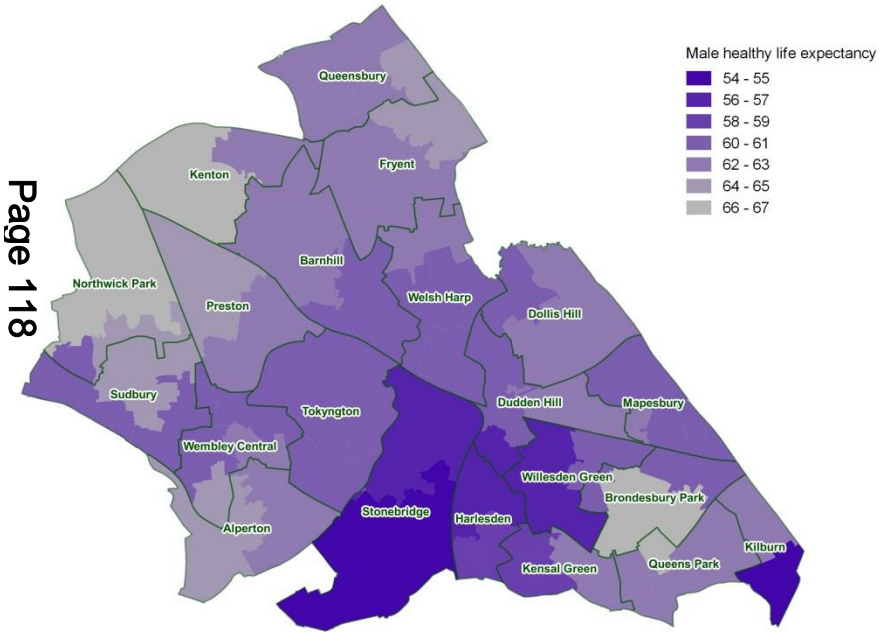
Healthy life expectancy at birth is the average number of years a person would expect to live in good health based on contemporary mortality rates and prevalence of self-reported good health.



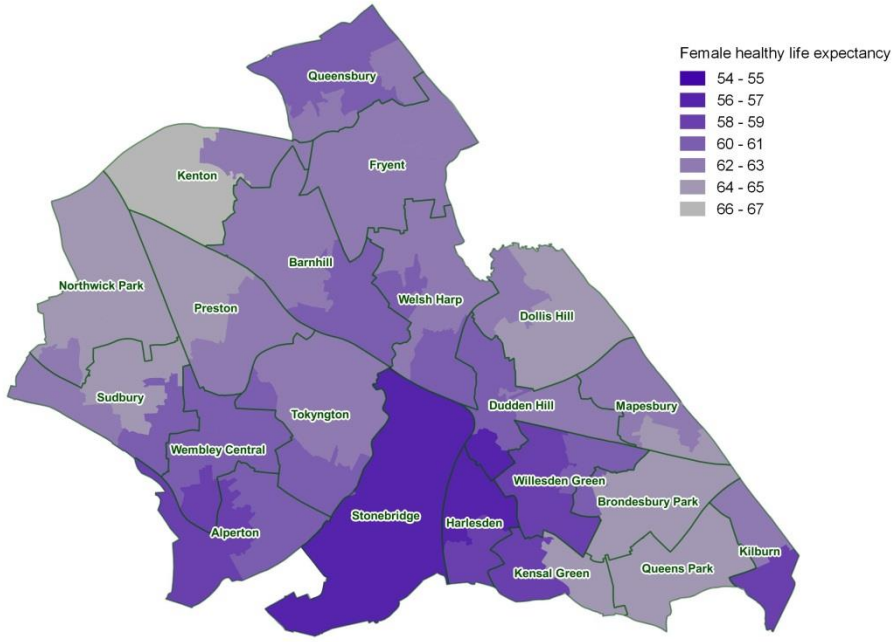
Source: Office for National Statistics (ONS), Healthy Life Expectancy

Healthy Life Expectancy and Geography

Male healthy life expectancy: 2009 to 2013

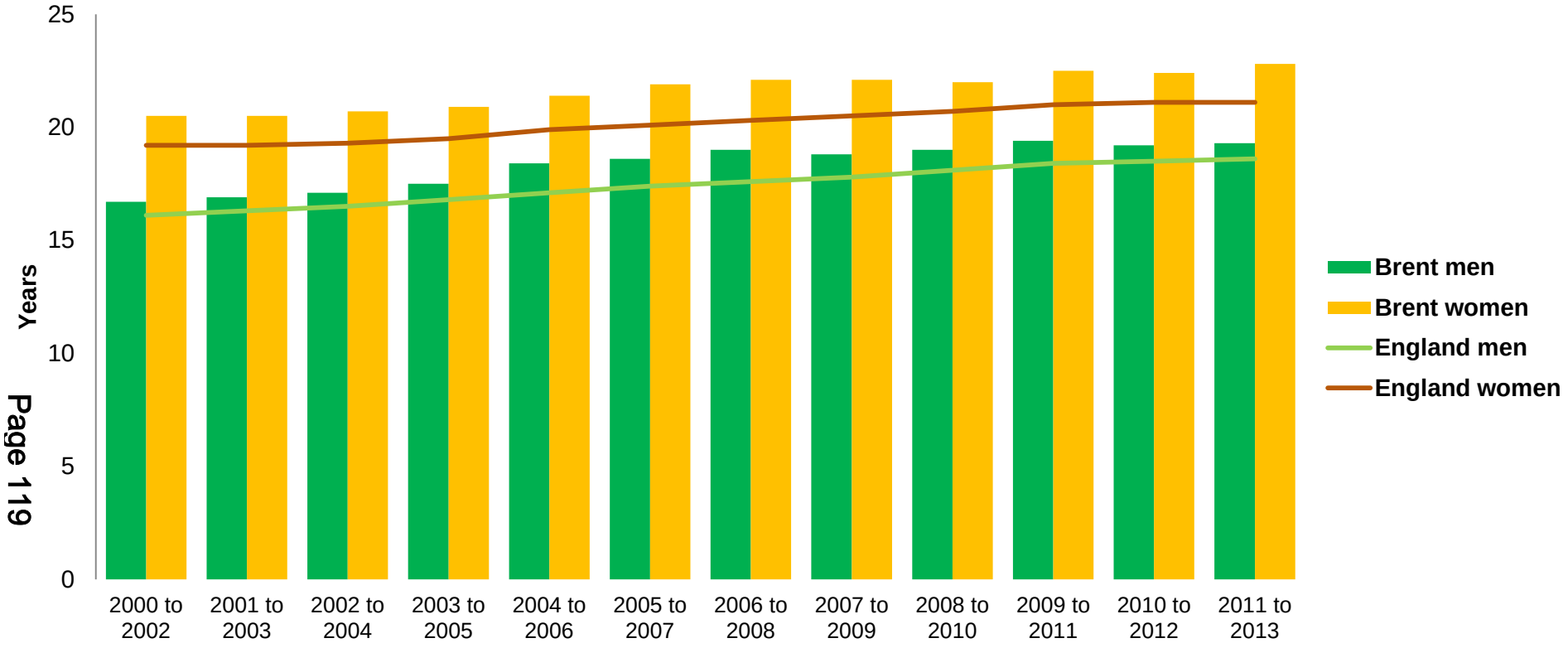


Female healthy life expectancy: 2009 to 2013



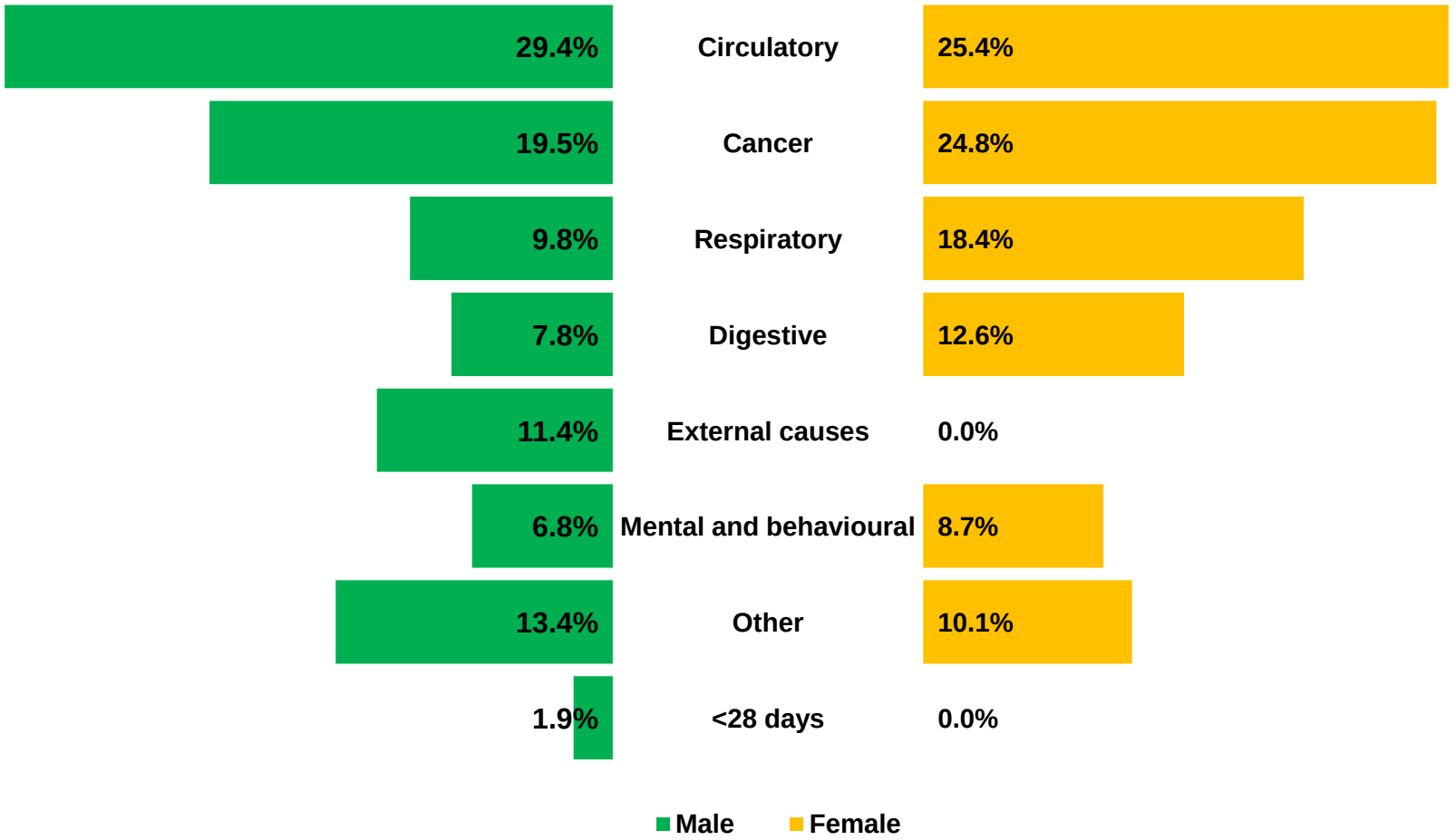
Source: Office for National Statistics (ONS), Healthy Life Expectancy

Life Expectancy at 65



Source: Office for National Statistics (ONS), life expectancy at birth for local areas in England and Wales

Causes of Death



Note. Circulatory diseases includes coronary heart disease and stroke. Digestive diseases includes alcohol related conditions such as chronic liver disease and cirrhosis. External causes includes deaths from injury, poisoning and suicide. 'Other' includes infectious and parasitic diseases, ill defined conditions and diabetes.

Source: Public Health England, The Segment Tool, 2010-12

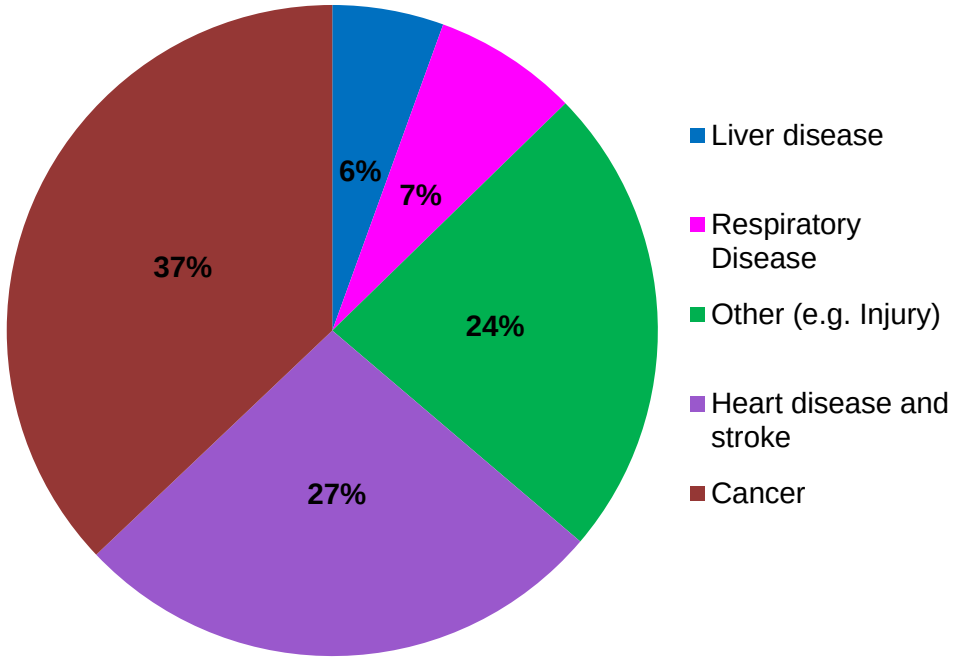
Premature Mortality

Rate of premature death (all causes) for 2011-13

Brent: **330** per 100,000

England average: **448** per 100,000

Proportion of all premature deaths by cause, 2011-13



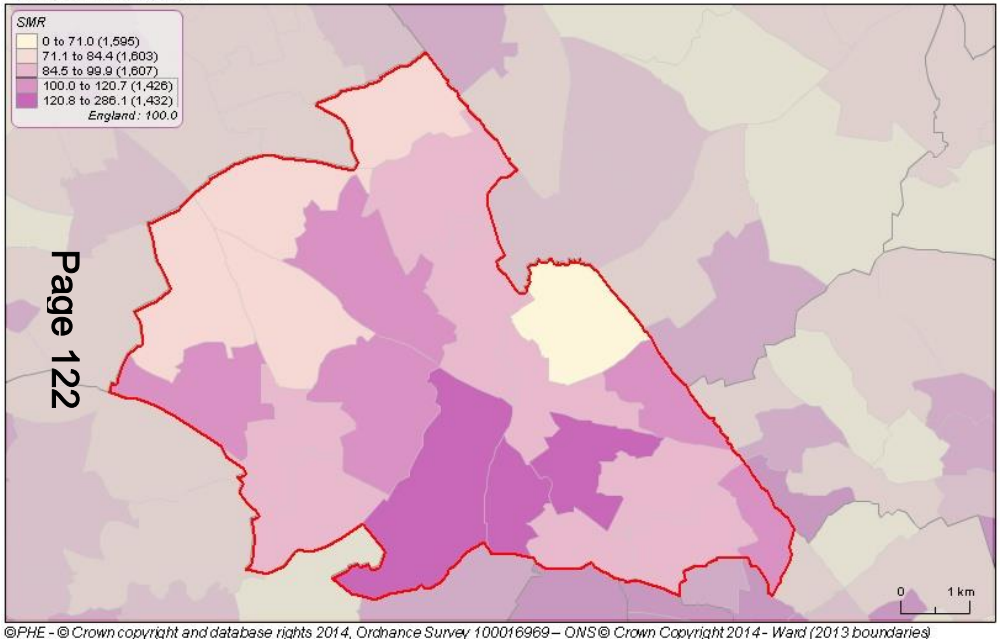
Source: Public Health England, Longer Lives

During the period 2011-13, there were 1,952 premature deaths in Brent. This equates to around 650 premature deaths per year. The main causes of premature deaths are cancer, heart disease and stroke (cardiovascular disease). Other contributors include respiratory disease, liver disease and injury.

Premature Mortality at Ward Level

Deaths from all causes, under 75 years

Deaths from all causes, under 75 years, standardised mortality ratio, 2008-2012 - *source: Public Health England, produced from ONS data © Copyright 2013*



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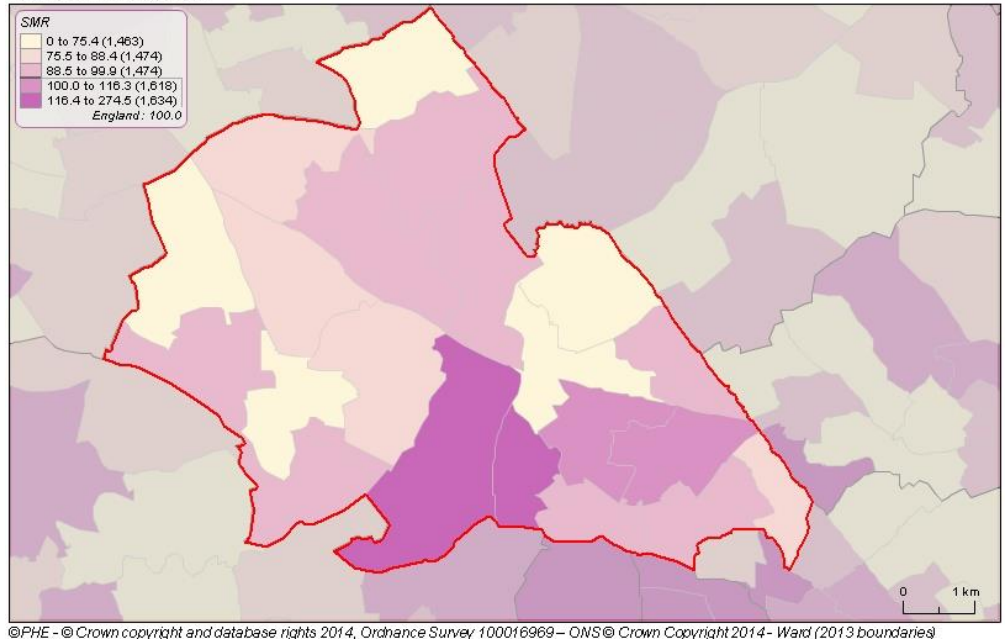
Deaths from all cancers, under 75 years

Deaths from all cancer, under 75 years, standardised mortality ratio, 2008-2012 - *source: Public Health England, produced from ONS data © Copyright 2013*



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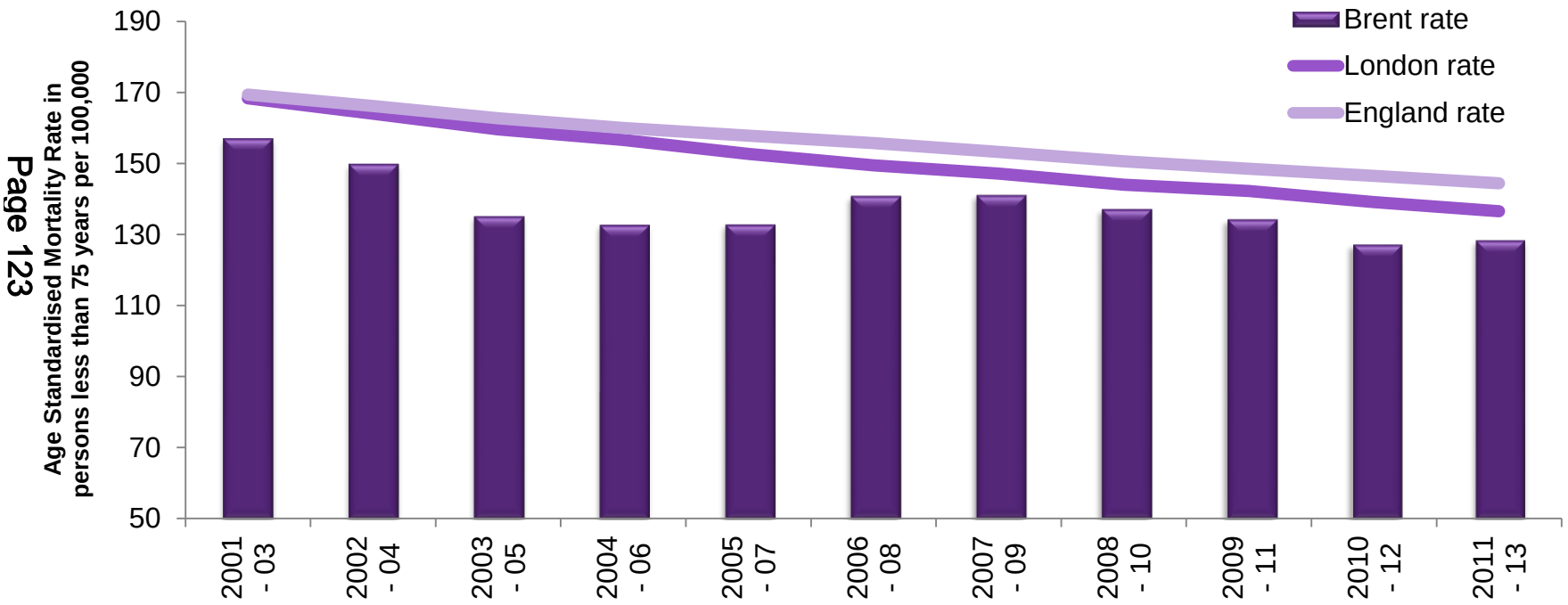
Source: Public Health England (data sourced from ONS)

Premature Mortality from Cancer

Deaths from cancer, under 75 years

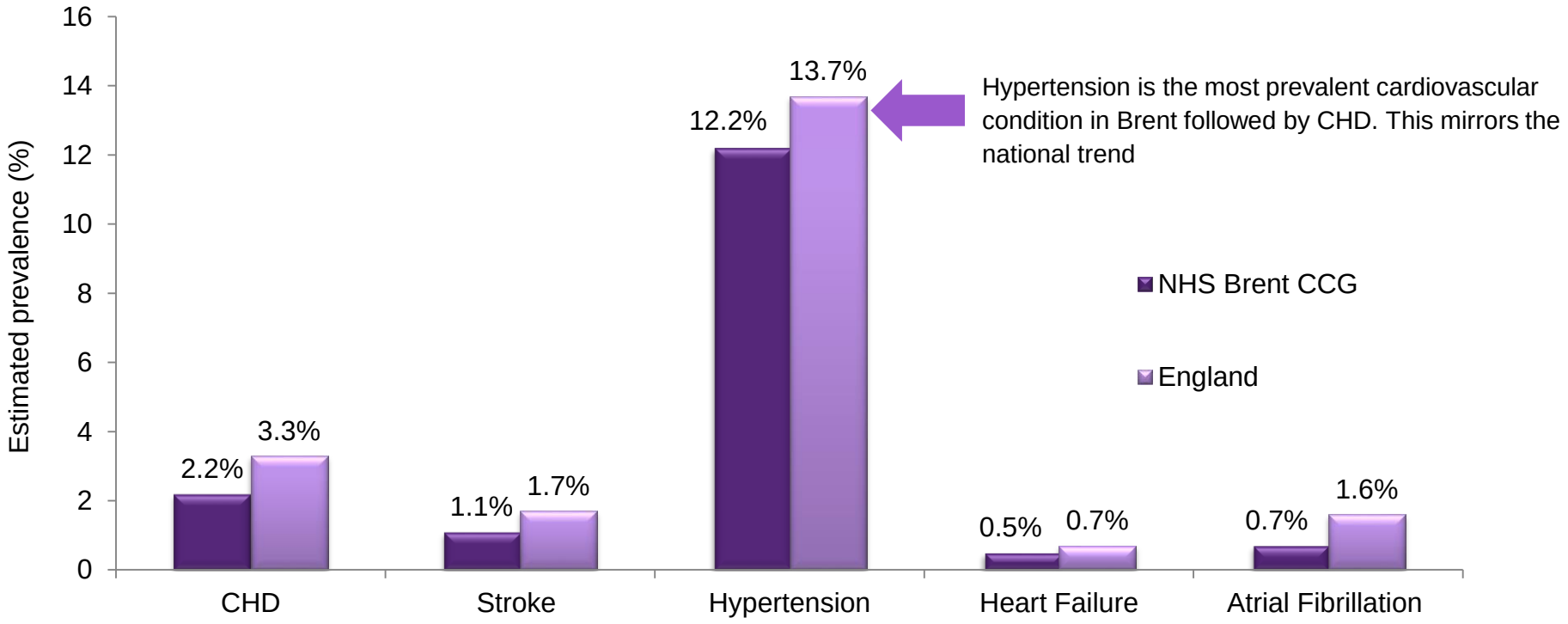
- The age standardised premature mortality rate in Brent from cancer is better than the London and England rates; in 2011-13 the premature mortality rate in Brent was 128.4 per 100,000, the London rate was 136.5 and the England rate, 144.4.
- Between 2011 and 2013, the age standardised rate of premature mortality due to cancer in males under 75 was 147.4 per 100,000 of the population in Brent. For females, the rate was 111.1 per 100,000 of the population.
- Between 2011-13, 72.1 in every 100,000 people aged less than 75 years in Brent died from cancer where their death was considered preventable. This figure is lower than both the London and England averages (PHE, based on ONS source data).



Source: Public Health England (based on ONS source data)

Prevalence and Premature Mortality from CVD

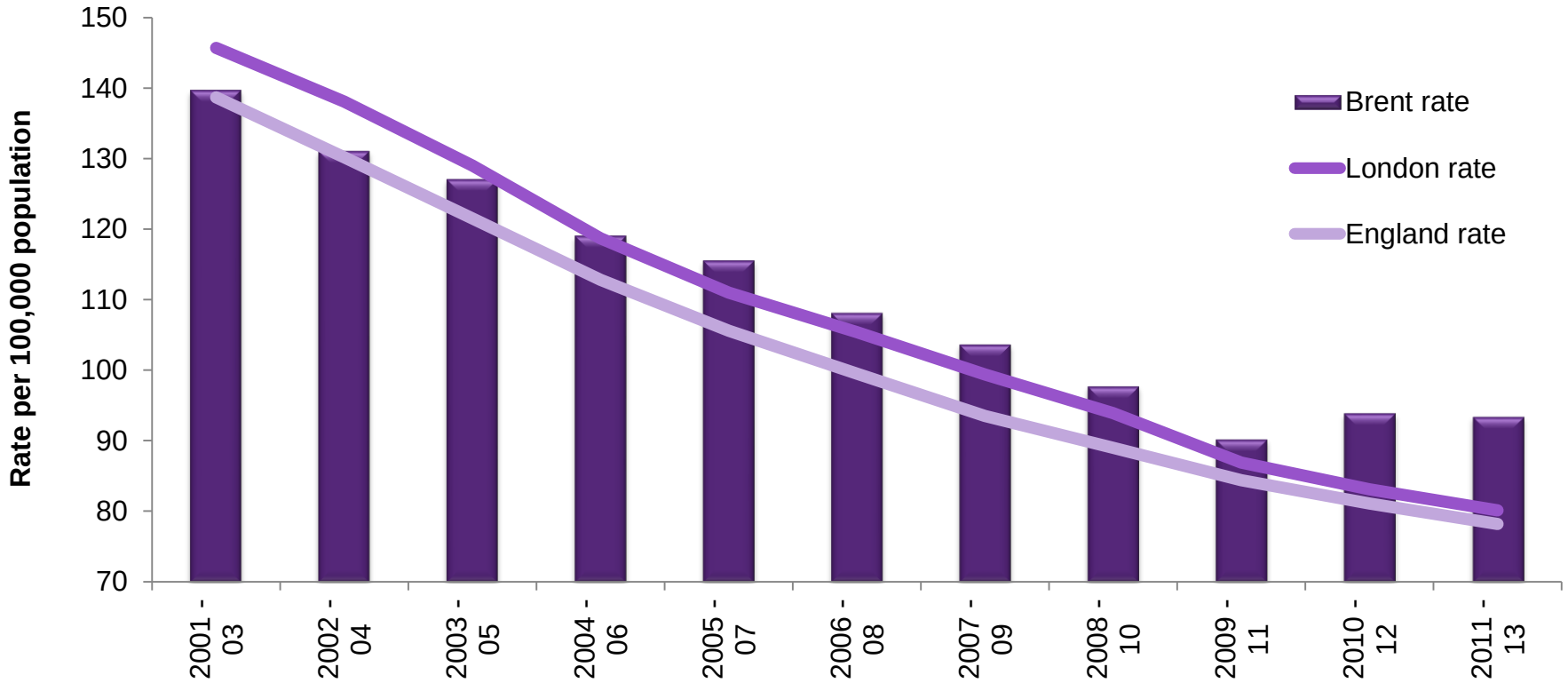
Recorded prevalence of cardiovascular disease in NHS Brent CCG, 2013/14



Source: HSCIC, Quality Outcomes Framework 2013/14

Under 75 Mortality Rate from CVD

- Since 2004-06, the under 75 mortality rate from all CVD in Brent has remained higher than both the London and England average rates.
- The 2011-13 under 75 CVD mortality rate in Brent is 93.5 per 100,000. The England rate is 78.2 per 100,000 and the London rate is 80.1 per 100,000
- The premature mortality rate in Brent for males is 129.1 per 100,00 and the premature mortality rate for females is 60.5 per 100,000.



Source: Public Health England (based on ONS source data)

NHS Health Checks Programme and CVD

LB Brent commission the NHS Health Checks programme which aims to prevent the main causes of premature mortality. The programme identifies people who are at risk of developing cardiovascular disease through measurement of blood pressure, cholesterol etc.

In Brent in 2014/15 approximately 75,000 residents were eligible to be offered a health check. The percentage of people who were eligible for a health check in 2014/15 who were offered a health check was 22.3%, up 5.7% from 2013/14. The percentage for England was 19.7%. In Brent, the percentage of people who were offered a health check who took up the offer was 56%, up 4.6% from 2013/14. The England percentage was 48.8% (PHE Hypertension Profile, 2016).

The ethnic mix of Brent's population and contrasting levels of poverty and deprivation which exist across the borough are some of the factors which influence the prevalence of CVD. The National Institute for Health and Care Excellence (NICE) Guidance PH 25 Preventing Cardiovascular Disease at a population level reported that:

i) Prevalence of CVD is related to ethnicity. Death rates from CVD are approximately 50% higher than average among South Asian groups.

ii) Premature deaths rates due to CVD are up to six times higher among lower socio-economic groups than more affluent group.

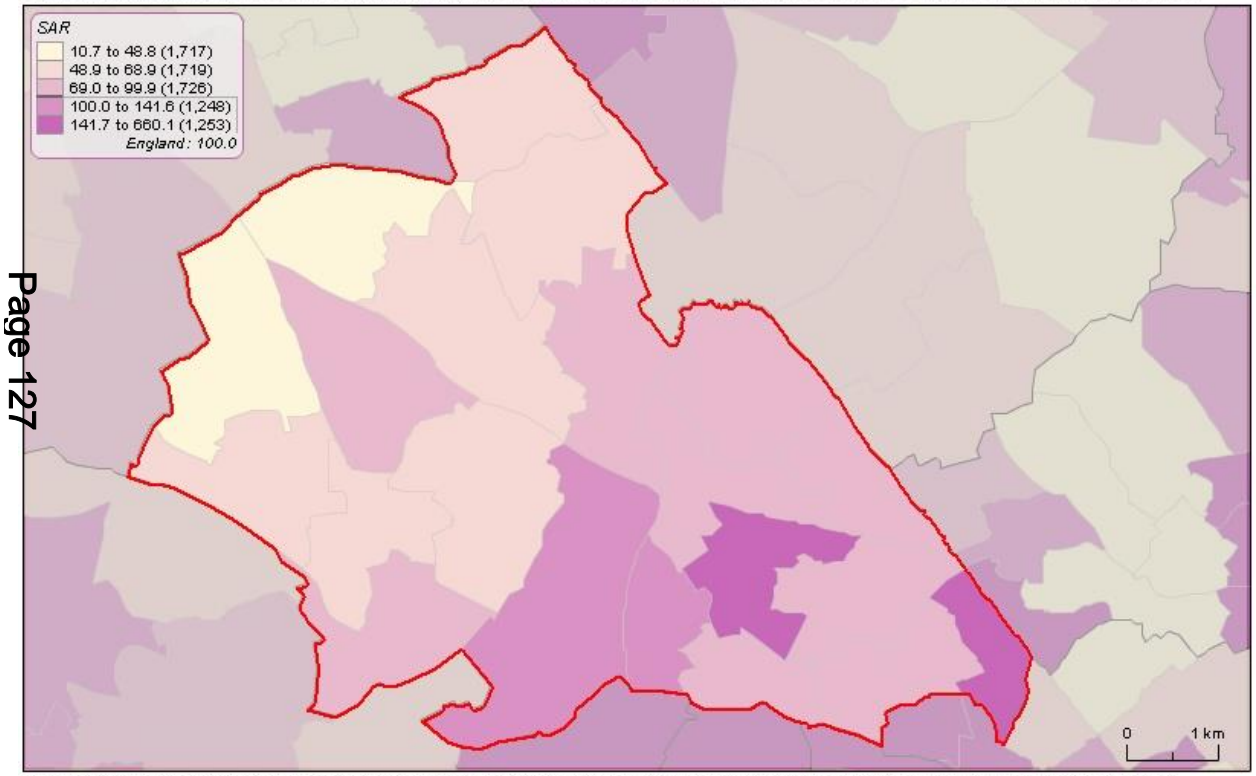
Although the NHS Health Checks programme is essential in reducing levels of mortality in Brent from CVD, lifestyle choices such as undertaking regular physical activity are seen as an important factors in contributing to further reductions in mortality due to CVD. At a national level, a fall in smoking prevalence is also seen as an important factor in driving a decline in CVD mortality in recent years.

Respiratory Disease

Emergency hospital admissions for Chronic Obstructive Pulmonary Disease (COPD), 2008/09 – 2012/13

Emergency hospital admissions for COPD tend to be highest towards the central and southern fringes of Brent, which coincides with those parts of the borough where levels of deprivation tend to be greatest. The northernmost parts of the borough have to lowest recorded admissions. It should be noted that COPD admissions will also be dependent on the age profile of a particular area.

Emergency hospital admissions for chronic obstructive pulmonary disease, standardised admission ratio, 2008/9 - 2012/13 -
source: Hospital Episodes Statistics (HES). Copyright © 2014. The Health and Social Care Information Centre. All rights reserved.



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Source: Hospital Episodes Statistics (HES), The Health and Social Care Information Centre

Sources of Information and Intelligence

Public Health England, Public Health Outcomes Framework:
http://www.phoutcomes.info/search/life%20expectancy#gid/1/pat/6/ati/102/page/0/par/E12000007/are/E09000005

Public Health England, The Segment Tool 2015 – Segmenting life expectancy gaps by cause of death:
http://www.lho.org.uk/LHO_Topics/Analytic_Tools/Segment/TheSegmentTool.aspx

Public Health England, Hypertension Profile (January 2016) http://www.yhpho.org.uk/hypertensionla/default.aspx

Office for National Statistics (Life expectancy data tables):
http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Life+Expectancies#tab-data-tables

National Institute for Health and Care Excellence (NICE) Guidance PH 25 Preventing Cardiovascular Disease

Technical notes

Definitions

Slope index of inequality	The Slope index of inequality is a measure of the difference in life expectancy between the most and least deprived sections of the local population.
Healthy life expectancy (HLE)	HLE is the average number of years a person would expect to live in good health based on contemporary mortality rates and prevalence of self-reported good health.
Premature mortality	Mortality under the age of 75 years of age.

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Transportation

Brent JSNA
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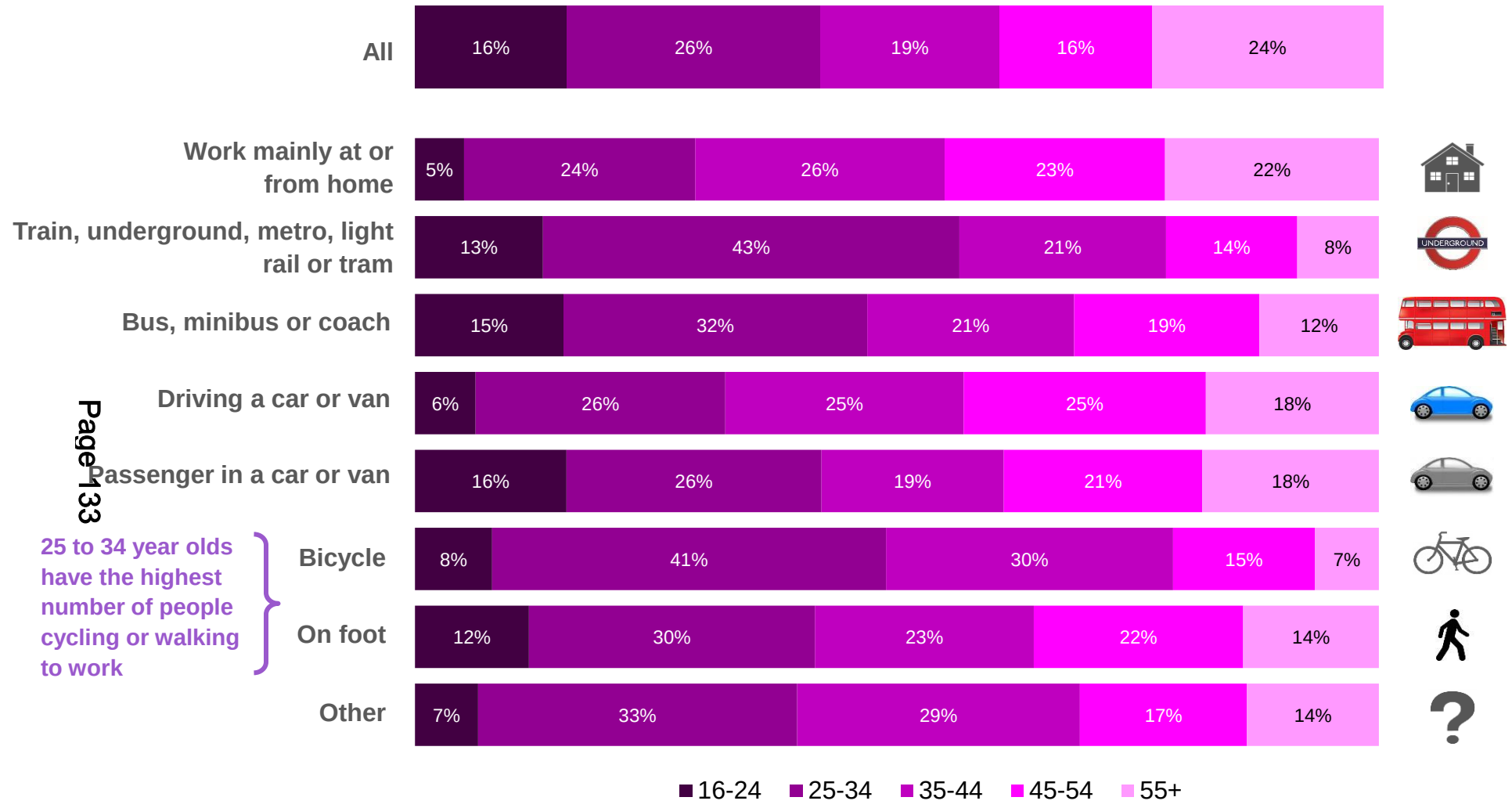
Brent
Clinical Commissioning Group

Summary

Key Messages

- Active travel includes walking, cycling and using public transport. More people are using this option and the number of vehicles per household has reduced to 0.80 (2011 census)
- This shift in travel behaviour helps improve air quality
- An increase in cycling and walking and a decrease in car use will help improve air quality in Brent
- Brent is well served with public transport including London Underground and Overground lines, National Rail and buses
- In 2014 1,067 people were injured on Brent's roads, of these 2 resulted in the loss of life and 83 were serious injuries. This figure is higher than the London average
- In the last 13 years the number of people killed or seriously injured has reduced from 204 to 83
- There are more casualties amongst people travelling by car than other modes of transport
- In all age groups there are more males than females being injured on Brent's roads
- In 2014 there were 89 children injured on Brent's roads, of these 6 were serious and 83 slight
- Most accidents happen on or near main roads

Method of travel to work by age

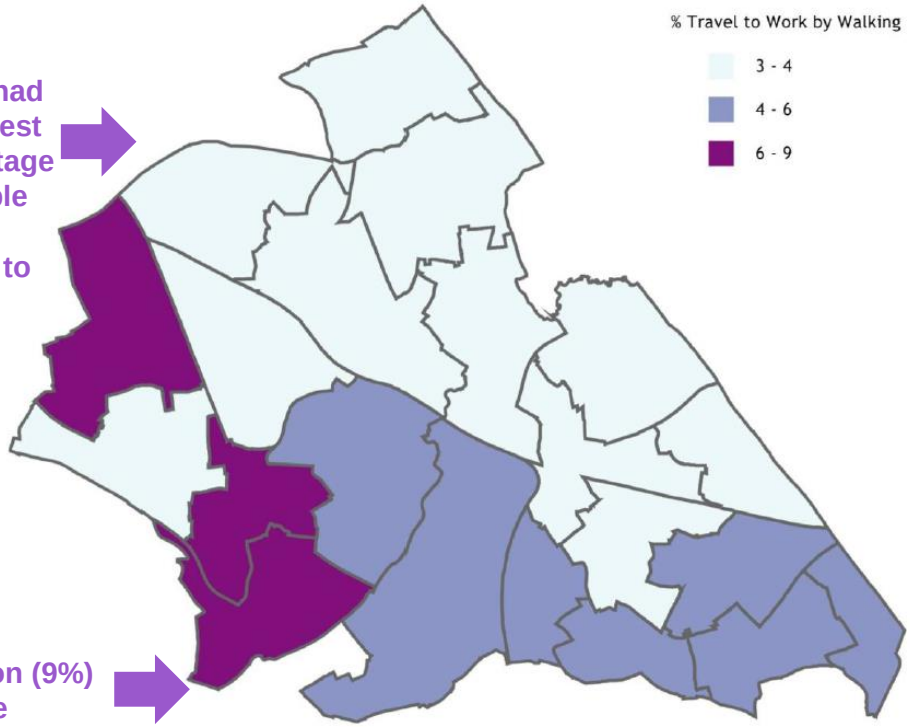


Source: ONS 2011 Census, Methods of Travel to Work

Active Travel to Work

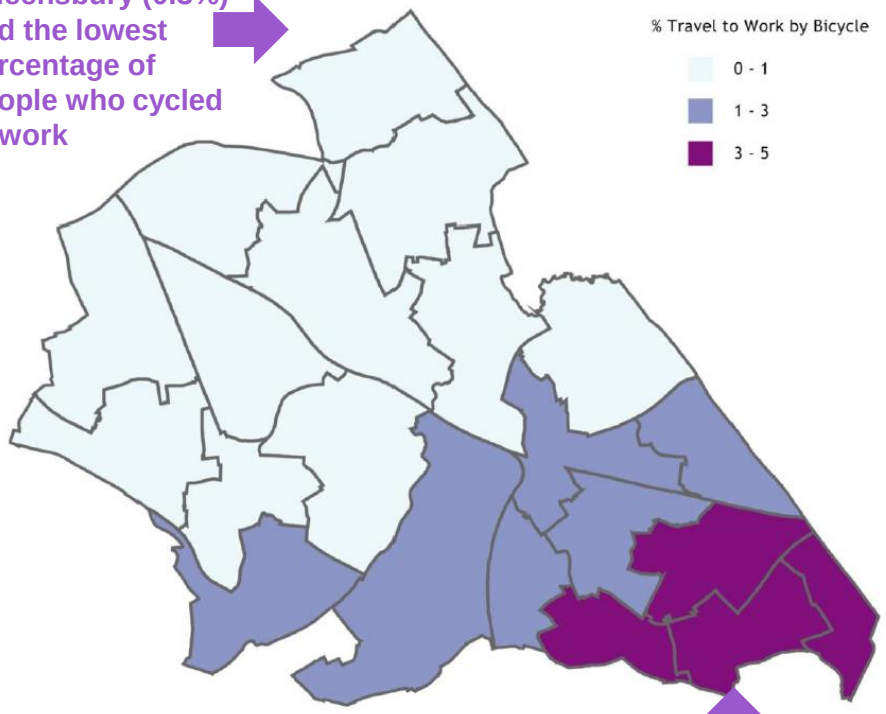
Percentage of residents that travel to work by walking or bike in each ward in Brent

Kenton (2.9%) had the lowest percentage of people who walked to work



Alperton (9%) had the highest percentage of people who walked to work

Queensbury (0.3%) had the lowest percentage of people who cycled to work



Queens Park (5.4%) had the highest percentage of people who cycled to work

Source: ONS 2011 Census, Methods of Travel to Work

Public transport

Brent is served by:

4 Underground lines

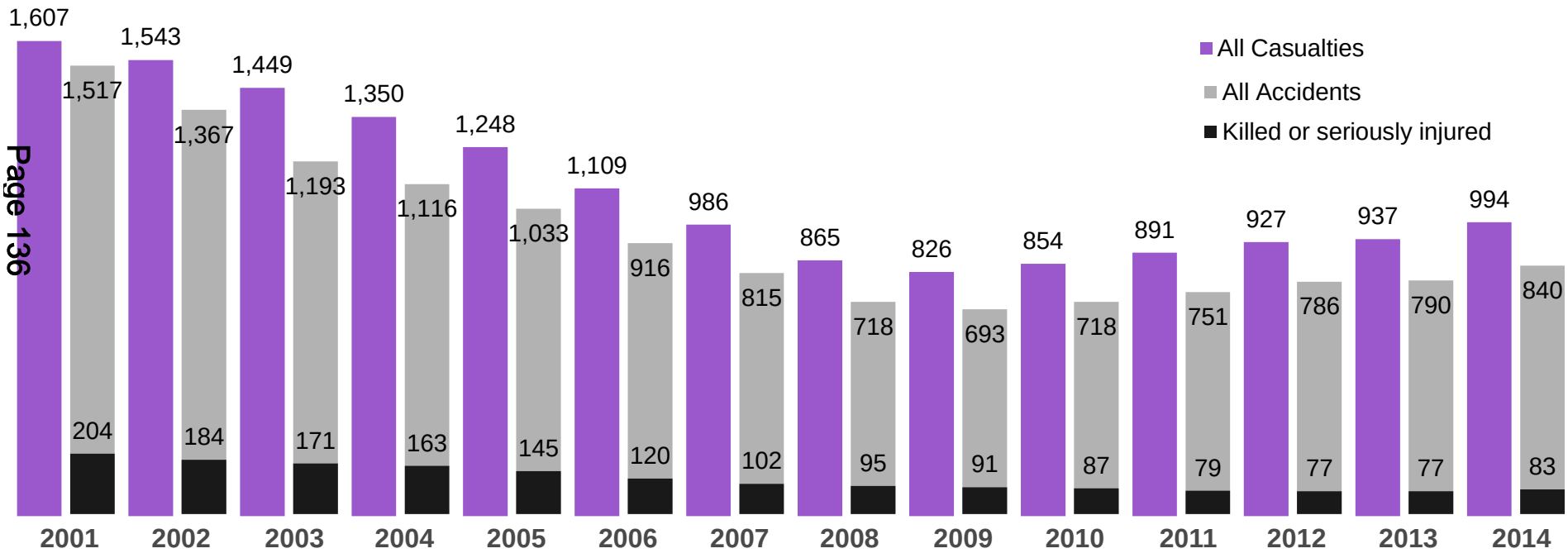
2 Overground routes

National Rail

60+ bus routes

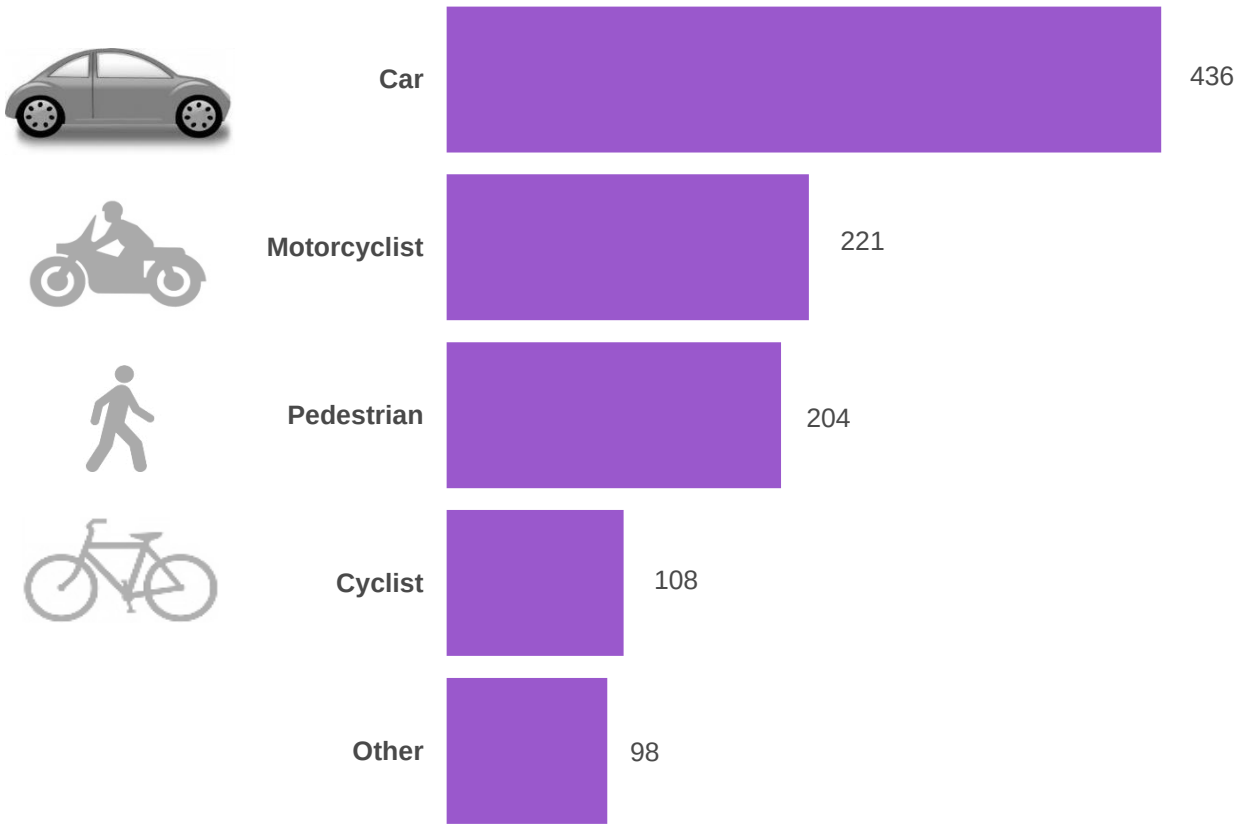
Accidents and casualties, three year rolling average

The chart below shows that whilst the number of casualties and accidents fluctuates on an annual basis, the severity in terms of those killed or seriously injured is reducing.



Source: TfL

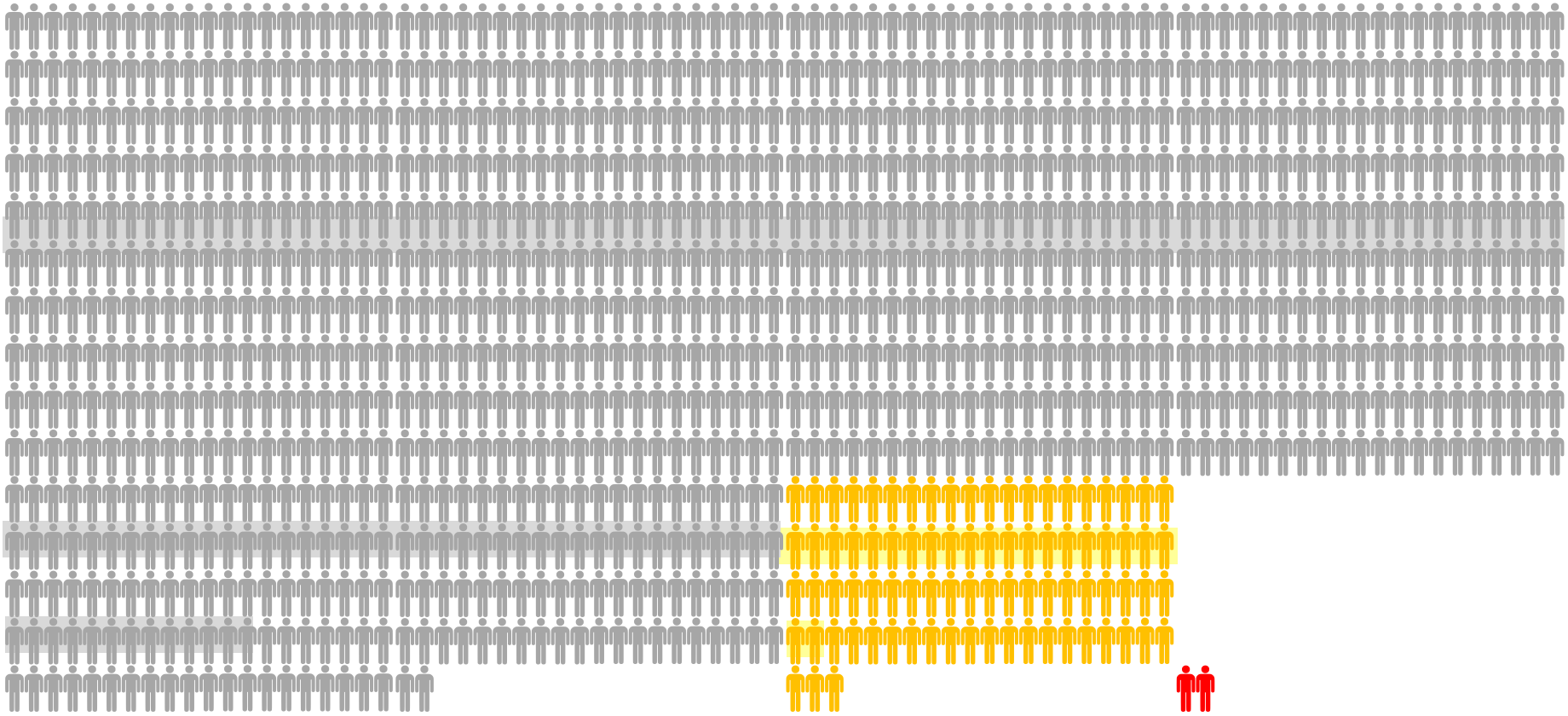
2014 - Casualties by mode of travel



Source: TfL

2014 - Casualties by severity

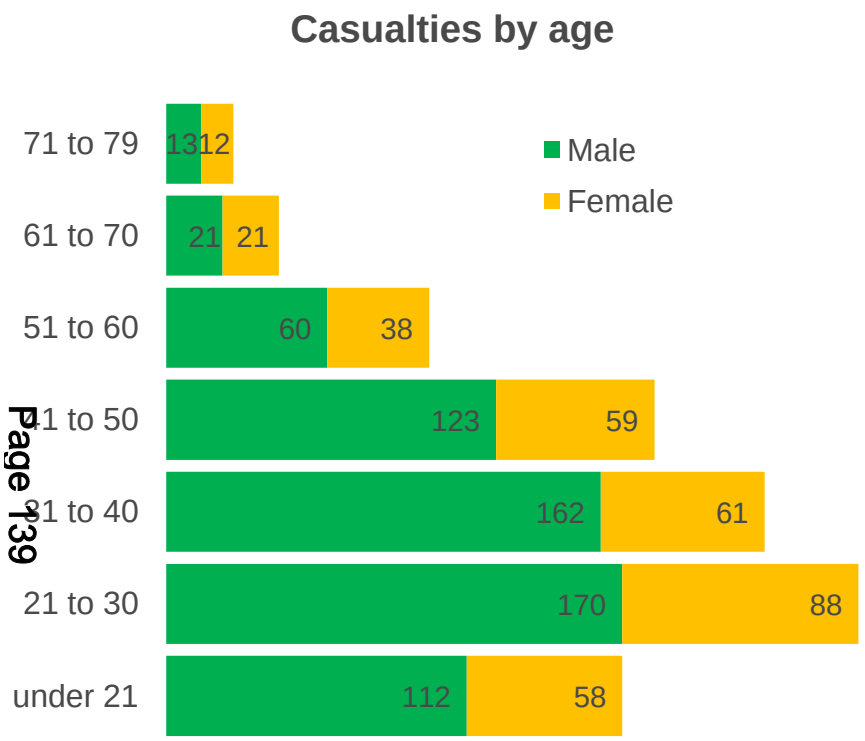
The diagram below show the number of casualties by severity and a comparison to the London average



	Slight	Serious	Fatal
Brent	982	83	2
London average	933	62	4

2014 - Casualties by demographics

The charts below show that in all age groups, the number of male casualties is higher than female.



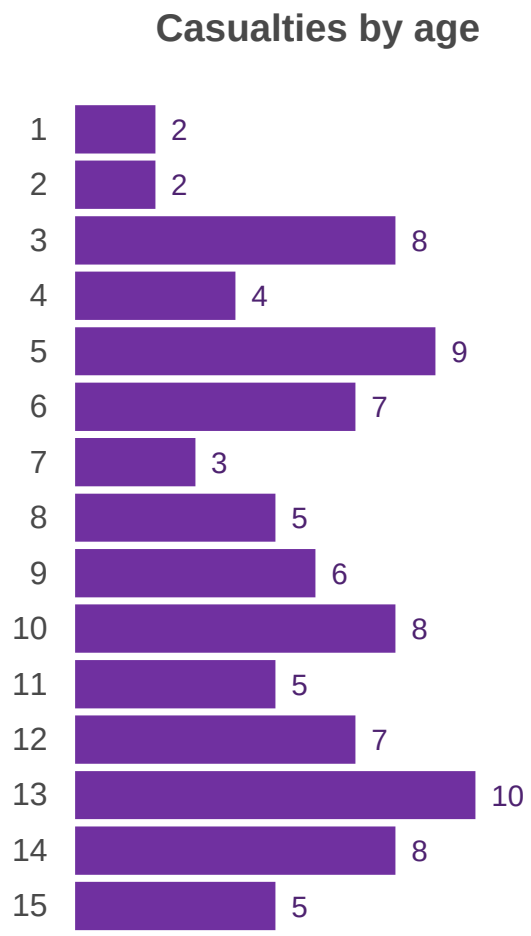
Source: TfL

2014 - Child casualties by severity

Slight	Serious	Fatal
83	6	0

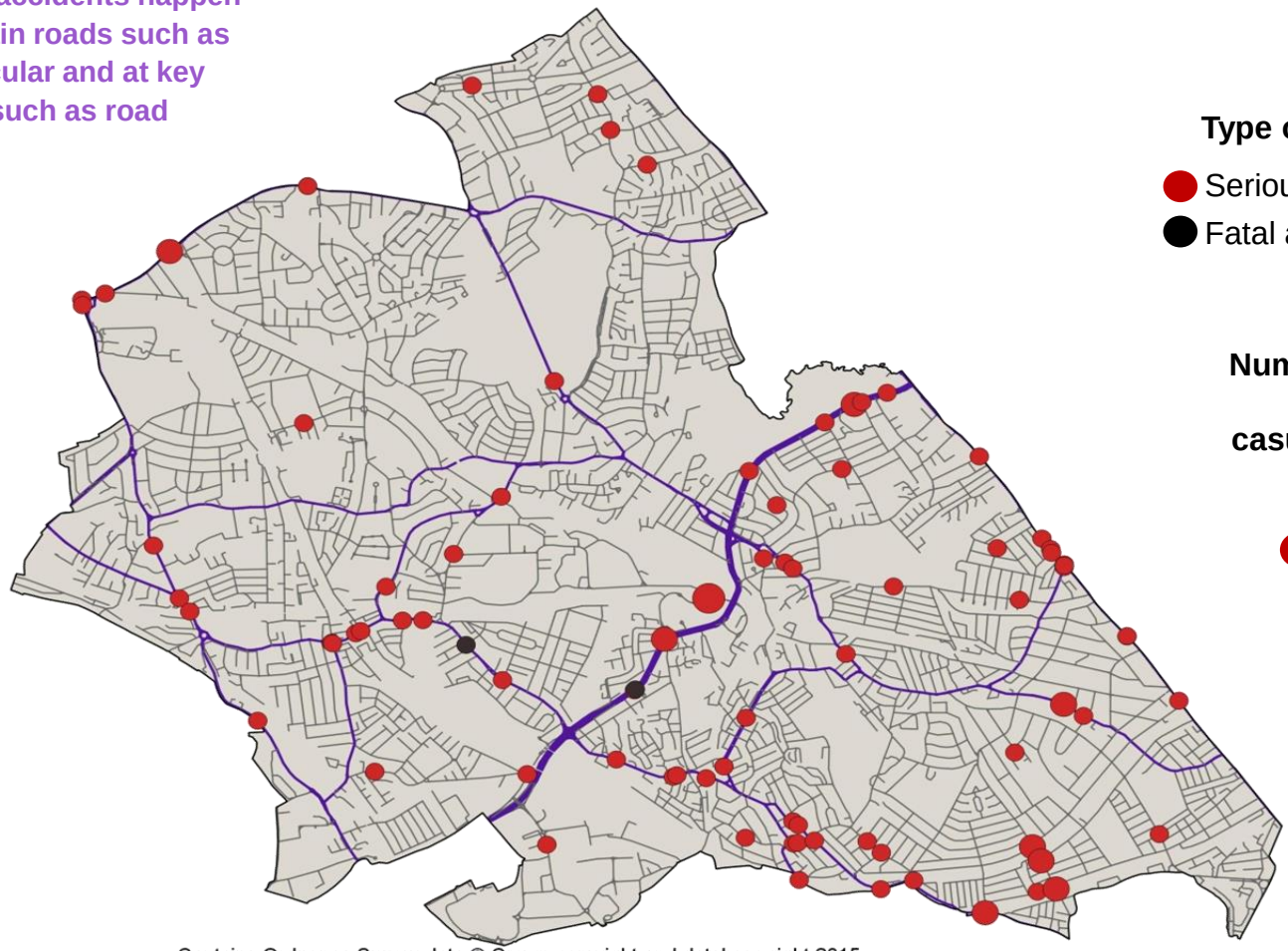
Source: TfL

2014 - Child casualties by demographics



2014 - Serious and fatal accidents

Most serious accidents happen on or near main roads such as the North Circular and at key nodal points such as road junctions.



Further information

Active Travel

- People who walk, cycle or use public transport on a regular basis will benefit from a healthier lifestyle as it helps reduce obesity and the risk of cardiovascular diseases.
- Motorised traffic is a key source of air pollution and those that spend longer in traffic face a higher health risk
- Brent Council has many activities to support this including free cycle training, a healthy walks programme, Bike it Plus in schools and the promotion of car clubs

Public Transport

- In addition to the Underground, Overground and National Rail lines indicated on the map Brent has a comprehensive bus network of over 60 routes
- Most residents can access this within 400m of their home

Road Casualties

- Fear of road traffic injury is one of the key reasons people choose not to travel actively.
- Although the total number of casualties travelling by car is much higher , the number of people seriously injured is higher amongst pedestrians, cyclists and motorcyclists.

Further information

Improving Road Safety

- An annual programme of engineering measures are introduced to improve safety on Brent's roads
- Education, training and publicity activities are targeted at groups with the highest number of casualties
- Road safety education is available to all schools in Brent and the following resources promoted during these visits:

- The London Childrens Traffic Club, pre-school https://www.trafficclub.london/

- Tales of the Road, primary school http://talesoftheroad.direct.gov.uk/

- Junior Travel Ambassadors, year 5 and 6 pupils https://tfl.gov.uk/info-for/schools-and-young-people/teaching-resources/junior-travel-ambassadors?intcmp=3364

- Youth Travel Ambassadors, https://tfl.gov.uk/info-for/schools-and-young-people/teaching-resources/youth-travel-ambassadors

- Transition resources for year 6 pupils to help with moving on to secondary school https://tfl.gov.uk/info-for/schools-and-young-people/safety-and-citizenship/primary-pre-transition

- Safe Drive Stay Alive, a roadshow with powerful messages for young drivers, Sixths forms and colleges https://www.facebook.com/SafeDriveStayAliveLondon
- Free BikeSafe riders skills days are available for motorcycle riders http://www.bikesafe-london.co.uk/

Commissioning implications

- Encouraging active travel work by assisting local businesses with information on public transport, walking and cycling routes
- Our cycling strategy will include a vision for new cycling routes in Brent which will be implemented as funding becomes available
- Where possible the planting of trees will be included in future highway schemes to help improve air quality
- Local safety schemes will be introduced in areas with the highest number of casualties to help make roads safer for all road users

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