



Health and Wellbeing Board

Tuesday 24 January 2017 at 7.00 pm

Boardrooms 7&8 - Brent Civic Centre, Engineers Way,
Wembley HA9 0FJ

Membership:

Members

Councillor Hirani (Chair)	Brent Council
Councillor Butt	Brent Council
Councillor Colwill	Brent Council
Councillor McLennan	Brent Council
Councillor W Mitchell Murray	Brent Council
Carolyn Downs	Brent Council
Phil Porter	Brent Council
Dr Melanie Smith	Brent Council
Gail Tolley	Brent Council
Dr Ethie Kong (Vice Chair)	Brent CCG
Dr Sarah Basham	Brent CCG
Rob Larkman	Brent CCG
Sarah Mansuralli	Brent CCG
Julie Pal	Healthwatch Brent

Substitute Members

Councillors:
Mashari, Denselow and
Southwood

For further information contact: Tom Welsh, Governance Officer
020 8937 6607 tom.welsh@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.

Item	Page
1 Apologies for Absence and Substitutions (where applicable)	
To receive any apologies for absence and substitutions from Members.	
2 Declarations of Interests	
In accordance with the Members' Code of Conduct, Councillors are invited to declare any disclosable pecuniary interests, or other interest, and the nature of it, in relation to any item on the agenda.	
3 Minutes of the Previous Meeting	1 - 6
To confirm as a correct record, the attached minutes of the meeting of the Health and Wellbeing Board, held on 6 October 2016.	
4 Matters Arising (If Any)	
5 Sustainability and Transformation Plan (STP) Update	7 - 18
The purpose of this report is to provide the Health and Wellbeing Board with an update on the progress of the delivery of Sustainability and Transformation Plan (STP) in Brent.	
6 Sustainability and Transformation Plan (STP): Update on Delivery Area One - Prevention	19 - 22
The purpose of this paper is to update the Health and Wellbeing Board (HWB) on the development of the North West London Sustainability and Transformation Plan (STP) and the Brent Plan, with a specific focus on prevention.	
7 Clinical Commissioning Group (CCG) GP Member Practices - Option to Move to Delegated Commissioning Arrangement	23 - 28
North West London (NWL) CCGs are now consulting member practices on the option of a move to 'level 3 - fully delegated' commissioning arrangements from 1 st April 2017. CCGs that move to fully delegated arrangements will be responsible for functions previously carried out by NHSE and their own statutory duties. The Health and Wellbeing Board is asked to note that Brent CCG Member Practices will take a vote on the	

option of moving to level 3 – delegated commissioning arrangements from 1st April 2017.

8 NHS Brent Clinical Commissioning Group (CCG) Commissioning Intentions 2017-19 29 - 122

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

9 Local Services Strategy

Report to follow.

10 Healthwatch Brent - Community Chest Update 123 - 136

This report outlines the work Healthwatch Brent is doing as part of its Community Chest programme.

11 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.

Date of the next meeting: Tuesday 28 March 2017



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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MINUTES OF THE HEALTH AND WELLBEING BOARD Held on Thursday 6 October 2016 at 7.00 pm

PRESENT:

Councillor Hirani (Chair), Dr Ethie Kong (Vice Chair; Co-Clinical Director, Brent Clinical Commissioning Group), Sheik Auladin (Deputy Chief Operating Officer, Brent Clinical Commissioning Group), Dr Sarah Basham (Assistant Chair, Brent Clinical Commissioning Group), Councillor Butt, Councillor Colwill, Carolyn Downs (Chief Executive, Brent Council), Rob Larkman (Chief Officer, Brent, Harrow and Hillingdon Clinical Commissioning Groups), Councillor McLennan, Councillor W Mitchell Murray, Julie Pal (Chief Executive, Healthwatch Brent), Phil Porter (Strategic Director Community Wellbeing, Brent Council), Dr Melanie Smith (Director of Public Health, Brent Council), Gail Tolley (Strategic Director Children and Young People, Brent Council).

Apologies for absence were received from Sarah Mansuralli (Chief Operating Officer, Brent Clinical Commissioning Group) with Sheik Auladin (Deputy Chief Operating Officer, Brent Clinical Commissioning Group) attending on her behalf.

1. **Declarations of Personal and Prejudicial Interests**

- (i) Councillor McLennan declared that she was a current employee of the London North West Healthcare NHS Trust;
- (ii) Dr Ethie Kong (Vice Chair; Co-Clinical Director Brent Clinical Commissioning Group) declared that she was a current working GP; and
- (iii) Dr Sarah Basham (Assistant Chair, Brent Clinical Commissioning Group) also declared that she was a current working GP.

2. **Minutes of the Previous Meeting**

RESOLVED that the minutes of the previous meeting held on 7 June 2016 be approved as an accurate record of the meeting, subject to the following amendments:

- (i) That the names listed in the apologies for absence be rearranged so it could not be construed that Carolyn Downs (Chief Executive, Brent Council) was listed as a Councillor; and
- (ii) That section 7.2, on page 4 of the minutes, be corrected to state that Gail Tolley (Strategic Director, Children and Young People) introduced the update on helping vulnerable families rather than Phil Porter (Strategic Director, Community Wellbeing).

3. **Matters Arising**

There were no matters arising.

4. **Sustainability and Transformation (STP) Plan Update: Brent & North West London**

Rob Larkman (Chief Officer, Brent Clinical Commissioning Group) introduced the report which updated the Health and Wellbeing Board on the development of the STPs at North West London level and locally in Brent. Mr Larkman gave some background on the introduction of STPs in January 2016 and how they were viewed as a method of building upon the opportunities identified by the NHS Five Year Forward View (FYFV), published in October 2014. He stated that the planning work for both North West London and Brent STPs, had been to address the 'triple aim' described in the FYFV and the wider challenges facing health and social care generally. As mentioned in the report, the triple aim included improving health and wellbeing; improving care and quality; and closing the financial and efficiency gap.

Mr Larkman said that there had been substantial progress at both North West London and Brent levels since the last update to the Health and Wellbeing Board. The Board heard that progress had been made in addressing the five big ticket items which drove the aims of the local Brent STP plan, and which were detailed in the report. In addition to local STP progress, he noted that a draft of the full North West London STP plan had been submitted to NHS England (NHSE) on 30 June. He stated that the full submission date to NHSE was 21 October and work was continuing to address the feedback from NHSE on the initial draft before submission of the final version of the plan.

Members agreed that progress was positive and it was a testament to what could be achieved when different organisations worked closely together. The Chair also mentioned successful recent local STP engagement work at four events across the Borough which had been very beneficial in gathering feedback from residents about the STP plans. He noted that there had been a lot of interesting feedback and suggestions relating to primary care, particularly GP waiting times; coordination between health and care organisations; the availability of equipment outside hospital settings; support for carers and proposals for self-care.

RESOLVED that:

- (i) The progress on the development of the Brent and North West London STPs be noted; and
- (ii) The five big ticket items contained in the Brent plan be endorsed whilst acknowledging that it was an evolving process and would be further adapted as the engagement and consultation process continued.

5. **Update on the Development of an Accountable Care Partnership**

Sarah McDonnell (Assistant Director of Primary Care, Brent Clinical Commissioning Group), introduced the report which was provided to update the Health and Wellbeing Board on the progress towards the development of an Accountable Care Partnership (ACP) in Brent and how it aligned to the local STP. She stated that the report gave an overview of the different versions of ACP models in use nationally, Multispeciality Community Provider (MCP) and Primary and Acute Care Systems (PACS), and how they related to the model of integrated care being developed in Brent.

Sarah McDonnell said that Brent's plan for an ACP model involved groups of providers coming together to plan and manage care delivery, with jointly accountable outcomes, all operating within a jointly managed budget. It was noted that the vision for patients was for multi-disciplinary teams to be 'wrapped around' them across both primary and community care settings, with a focus on end of life care pathways for those with long term conditions. Ms McDonnell mentioned that steps forward in providing coordinated care had been achieved through joint partnership working by Brent GP networks and also the closer alignment of teams and services between social care and primary care staff.

It was noted that whilst work on developing an ACP was moving forward, there still remained progress to be made, particularly in terms of establishing an approach which required joint commissioning across different organisations. Sarah McDonnell said that there would need to be agreements on scope, outcomes and processes before this could take place.

In the subsequent discussion, both Members and the representatives present recognised the need to continue to work closely together in the development of the ACP and that establishing the scope of the model was very important. Ralph Elias (Head of Planning & Programme Management Office, London North West NHS Trust) observed that some of the STP work that the Trust was undertaking, such as co-ordination of frailty services and improving acute services and quality of life at Central Middlesex Hospital could lend themselves to the development of the ACP model. Sarah McDonnell welcomed this suggestion and stated more generally that she felt providers were starting to re-invigorate plans on health and care pathways and look more widely at what different providers could do to bring elements within these pathways together.

In response to a specific question about savings generated by ACP models, Sarah McDonnell outlined that results were often mixed. She stated that there was definitive evidence that ACP models improved outcomes and patient experiences, and therefore plans needed to reflect a balance in achieving both of those two intentions.

RESOLVED that:

- (i) The progress on the development of an ACP in Brent be noted;
- (ii) The direction outlined in the report be confirmed as appropriate and organisational commitment be affirmed; and
- (iii) The need for development of a detailed scope and plan be agreed and ensure that it aligned with priorities within the Brent STP.

6. A Common Public Sector Estates Strategy in the London Borough of Brent

Phil Porter (Strategic Director, Community Wellbeing) introduced the item and stated that the aim for the development of a Common Public Sector Estates Strategy was to align the separate estates strategies of both the London Borough of Brent and Brent Clinical Commissioning Group (CCG). The Board heard that the overarching goal of the strategy was for both organisations to be able to both use

their assets more efficiently and reduce operating costs by working closely together, thereby allowing more money to be put back into services. Phil Porter directed Members to Appendix 1 (project brief) of the report where the five key objectives of the plan were set out in greater detail.

RESOLVED that:

- (i) The proposed project brief, be noted; and
- (ii) A tender exercise to commission the strategy, with a first phase project looking at both Brent and the local Health estate, be agreed.

7. STP Governance - Establishment of a Brent STP Delivery Board

Phil Porter (Strategic Director, Community Wellbeing) introduced the report which proposed the governance arrangements to be put in place in order to deliver the STP. The Committee heard that the purpose of the governance arrangements was to streamline the existing working groups within a proposed structure centred on the formation of an STP delivery board. Phil Porter stated that the membership of the STP delivery board would provide strategic direction to STP plans and the work of the proposed sub-groups within the governance structure. He noted that the work of these sub-groups would link back to the five big ticket items which were identified as priorities within the STP.

He drew the Board's attention to an error contained in the report which was the omission of Healthwatch Brent from the proposed membership. He continued that Healthwatch Brent had been heavily involved in the delivery board proposals up to this point and would continue to be so when they took effect. He noted that this was an oversight and that the report would be amended to include clarity on Brent Healthwatch Brent's role within the governance arrangements.

Following on from this point, the Chair addressed correspondence which had been received from Maurice Hoffman (Chair of the CMH Rheumatology Patient Support Group) relating to the proposed governance arrangements. It was noted that Mr Hoffman had raised concerns to the Board that the draft arrangements did not include lay members on the STP Delivery Board or working groups and this did not comply with NHSE guidance. The Chair responded to this by echoing Phil Porter's comments on the role of Healthwatch Brent in the arrangements, and how this had not been specified in the report. It was noted that the nature of Healthwatch Brent's organisational role ensured that it acted a conduit to representation of lay people from a variety of different patient groups across the Borough. The Board agreed that both point 4.5 of the report and draft terms of reference should be amended accordingly to address this.

RESOLVED that:

- (i) Subject to amendments being made to include the role of Brent Healthwatch Brent, the proposed STP governance arrangements, be agreed; and
- (ii) Subject to amendments being made to include the role of Brent Healthwatch, the Board the terms of reference for the proposed STP delivery board, be agreed.

8. **Brent Children's Trust Update**

Gail Tolley (Strategic Director, Children and Young People) gave a brief introduction to the report and stated that she hoped the detail of the update gave an assurance to the Board of the work of the Children's Trust currently taking place and work going forward.

A Member of the Board asked for clarification about when the Specialist Community Eating Disorder service for children in Northwick Park Hospital was due to open (bullet point 4, within 4.3 of the report). Dr Sarah Basham (Assistant Chair, Brent Clinical Commissioning Group) and Claire Murdoch (Chief Executive, Central and North West London NHS Foundation Trust) stated that the date of opening was unclear but that they would endeavour to find out and circulate details of this to the Board. Dr Sarah Basham added that although the service at the Northwick Park hospital site was not yet open, the Central North West Service had a fully staffed outreach team that would go out to anywhere in the Central North West area where required.

RESOLVED that:

- (i) The work of the Children's Trust from April to September 2016 be noted; and
- (ii) Details as to when the Specialist Community Eating Disorder Service will open at Northwick Park Hospital be circulated to members of the Health and Wellbeing Board.

9. **Healthwatch Brent Update: Patient Experience of Phlebotomy Services, and the Self-Directed Support of Residents Living with Mental Health Conditions**

Julie Pal (Chief Executive, Healthwatch Brent) provided a Healthwatch Brent update on two specific pieces of work on patient experience recently undertaken. It was noted, initially, that unfortunately two patients who were due to speak had not arrived but that Julie Pal would take away any more detailed questions and feed the answers back to the Board at a later date.

Julie Pal began by introducing a report on patient experience of phlebotomy (blood testing) services. She gave some background on how the work originated from a comment made last year by a member of the public on the challenges facing phlebotomy services in the Borough. The Board heard that the methodology of the research included interviews with 70 patients in Brent to ask them about their recent experiences of phlebotomy services alongside interviews with ten health professionals on the scope of phlebotomy services in the area. Julie Pal outlined that there had been some historical local challenges relating to phlebotomy, and it was significant to have found that Brent CCG had already completed a lot of patient engagement work in recent years to reconfigure how these types of services were provided. This included developing a de-centralised model and commissioning phlebotomy services in accessible community GP practices. Julie Pal stated that this had been a positive way of recognising the methods of the CCG in addressing an issue through its own patient engagement and re-shaping how the related services were provided accordingly.

Dr Ethie Kong (Vice Chair; Co-Clinical Director Brent Clinical Commissioning Group) elaborated further on the findings of the report stating that Brent CCG had invested in expanding out of hospital phlebotomy services because it had become difficult for patients to get appointments at smaller practices. She highlighted the importance of developing the Integrated Clinical Environment (ICE) system which allowed practitioners to access a patient's blood test results from across NHS settings in the North West London area. Dr Kong also drew attention to the issue of communication and that she felt messaging about the greater availability of phlebotomy services had struggled to reach residents and patients.

Members commented that the methodology and findings were interesting and a discussion ensued about how Healthwatch Brent disseminated this type of information. It was suggested that, in addition to Healthwatch's usual communication channels, a summary of the report findings be included in an upcoming YourBrent e-newsletter to expand reach to even higher numbers of residents and patients across the Borough.

Julie Pal also gave a brief overview of a Healthwatch Brent survey on self-directed support for service users with mental health issues in the Borough. It was noted that this was one of the first pieces of research to be funded by Healthwatch Brent's Community Chest.

RESOLVED that:

- (i) That Board note the work of Healthwatch Brent in delivering its contract and its recent research undertaken relating to phlebotomy services and self directed support for service users with mental health issues; and
- (ii) A suggestion be made that the summary of the report's findings be included and disseminated in an upcoming 'YourBrent' e-newsletter.

10. Any Other Urgent Business

There was no urgent business considered.

The meeting closed at 7.49 pm

COUNCILLOR KRUPESH HIRANI
Chair



NHS
Brent
Clinical Commissioning Group

Health and Wellbeing Board 24 January 2017

Report from the Chief Operating Officer of Brent Clinical Commissioning Group and the Strategic Director of Community Wellbeing, Brent Council

Wards Affected:
ALL

Sustainability and Transformation Plan (STP) Update

1.0. Summary

- 1.1. The purpose of this report is to provide the Health and Wellbeing Board with an update on the progress of the delivery of STP in Brent.
- 1.2. In Brent the delivery of STP is overseen by the Health and Wellbeing Board, (HWBB) which recently reviewed and extended its standing invites to include key partners such as London North West Healthcare Trust (LNWH) and Central and North West London Foundation Trust to ensure effective governance arrangements for delivery of the STP.
- 1.3. A task and finish local Brent STP Planning Group comprising of key stakeholders established to develop the STP has now transitioned to STP Delivery Board. The membership and terms of reference for this board were approved by the HWBB in October 2016.
- 1.4. The STP Delivery Board has the key responsibility of overseeing the delivery of the six STP work streams which are the Brent big ticket items. It provides strategic and operational direction and ensures appropriate links to NWL STP delivery areas.
- 1.5. The STP Delivery Board is accountable to HWBB and provides regular updates to the HWBB. Going forward, the aim is to focus in detail on one specific workstream at each meeting with a summary overview of the remaining workstreams.

2.0. Recommendations

- 2.1. The Health and Wellbeing Board are requested to note the progress report on delivery of the STP in Brent.

3.0. Detail

STP Governance

- 3.1 In order to deliver a plan as ambitious as the STP, it is essential that robust governance arrangements are in place to drive delivery. An STP Delivery Board in Brent has been established and mirrors the successful Children's Trust model of governance.
- 3.2 The Board reports to HWBB and oversees six subgroups responsible for delivery of the STP work streams and aligning with the five NWL Delivery Boards as required.
- 3.3 The STP Delivery Board has representation from Council, CCG, NHS provider organisations, Brent CVS, and HealthWatch Brent. It also includes representation from Council and CCG communications and engagement leads to facilitate on going communications and engagement throughout the process.
- 3.4 The STP governance structure chart is attached as Appendix one.

STP Management

- 3.5 The six STP work streams have designated Senior Responsible Officers (SRO) with responsibility for the delivery of the work streams.
- 3.6 The work streams are being supported by a joint CCG and Council STP Programme Team which is in the process of being established. The team is comprised of a director of integrated care which reports to both the Chief Operating Officer for the CCG and the Strategic Director for Community and Well Being. The Integrated Care Director will be supported by three programme managers to support the six work streams. The team will be supplemented by a programme officer to provide administration and co-ordination support for the STP workstreams and the Delivery Board.
- 3.7 Presently there are two interim project managers in place to provide support on Better Care Fund projects under the Frailty workstream. While the programme team is being established an additional interim manager will be recruited to support other work streams.
- 3.8 The STP programme team will be overseen by the STP Executive Group providing steer to the STP work streams, strategic support and influencing the delivery of the work streams
- 3.9 The STP Delivery Structure is attached as Appendix two.

STP Leadership Development

- 3.10 There is a strong commitment from leaders in Brent Health and Care system to implement the STP. The HWBB also has initiated an annual programme of seminars to address challenges and unblock barriers faced by individual work

streams. A successful seminar on Prevention was organised in December and the next one will be on Frailty in February.

- 3.11 However there is widespread acknowledgement that delivering STP is highly complex and requires system collaboration and leadership at every level and across range of organisations. It is recognised nationally that this will require a different set of skills, resources and approaches by local leaders.
- 3.12 Similar to other footprints, in Brent and NWL the focus until late last year has been on planning, moving into the delivery phase has identified a shared concern about the system's ability to implement the plans. This will require us as leaders and organisations to work together in different ways.
- 3.13 A key challenge faced by leaders is being asked to collaborate with other organisations while still being held to account as an individual organisation. Also in the absence of any formal authority to make decisions on behalf of the system, there is recognised need for adopting new approaches, to try to gain agreement and consensus between organisations.
- 3.14 To facilitate these new ways of working the STP Delivery Board has agreed to commission a System Leadership development programme for its members. This is being discussed with Kings Fund Leadership Development team in view of their experience in working with health and care leaders, who are developing a bespoke proposal appropriate for the Brent system. The NWL Strategy Team is also well placed to support with this and discussions are taking place to understand the potential offer.

STP Delivery Board Update

- 3.15 The STP Delivery Board with its newly constituted membership and terms of reference focused on delivery has met twice since transitioning from planning to delivery phase.
- 3.16 The focus of the board so far has been to ensure that the scope, outcomes and deliverables of the six workstreams are fully agreed across partner organisations and reflect the outcomes of various engagement events that were held in September and October 2016. All the six work streams have completed scoping documents which articulate key deliverables and outcomes.
- 3.17 The work streams are now developing a programme of work that will build on existing initiatives, using an incremental approach to transformation to further progress the outcomes specified.
- 3.18 It is becoming apparent that there is need for dedicated programme support to deliver on the work programme identified in each of the workstreams. While lead commissioners and operational managers are progressing the work, this is additional to their core roles and the scale of change and transformation required needs the additional resources identified above.

STP work streams update

Prevention

- 3.19 This work stream continues to build on the existing initiatives on workplace based health and wellbeing initiatives and making every contact count.
- 3.20 The main focus of this work stream is to link with Delivery Area one Programme Board which is developing a business case for Alcohol teams in acute settings and treatment interventions in primary care and community. There is a strong likelihood that this would be funded at sector level and once confirmed the intention is for Brent to be an early implementer site at Northwick Park Hospital.
- 3.21 In addition a proposal to develop the next phase of Social Isolation Brent Initiative (SIBI) is being worked up jointly by Adult Social Care, Public Health and Primary Care leads. This will be based on a social prescription model and be part of the Whole Systems Integrated Care model.

New Models of Care

- 3.22 This workstream has been in development over a number of years and builds on Whole Systems Integrated Care (WISC). Providers and commissioners co designed the first phase of WISC in 2015 as a precursor to an Accountable Care Partnership delivery model. However, this work is largely commissioner led in view of the need to develop the provider landscape to respond to the challenge of delivering care in this manner.
- 3.23 The aim is to create highly integrated teams working day to day with groups of GP practices, delivering proactive and reactive care, in and out of hospital settings for some of our most complex patients.
- 3.24 This would be provided by a new provider model which is delivery and performance led and managed by a partnership of providers who form an Accountable Care Partnership (ACP). The ACP would be responsible for planning and managing care within a defined budget and set of outcomes for which they are jointly accountable.
- 3.25 The CCG has worked with providers to fully align and develop the WISC care planning and case management model so that it is consistent and equitable across Brent. Recognising that 'horizontal' integration of Primary care is the foundation on which 'vertical integration between primary care and other providers (community, acute mental health, adult social care and third sector), the CCG awarded a single contract to Brent Care Ltd (comprising all Brent GP practices) for the provision of WISC.
- 3.26 The overarching objective of this contract is keeping vulnerable people well in the community. This is achieved through professional intervention and supporting people to better self-care and self-manage. Patients have the potential to benefit from proactive, coordinated and integrated care and support to self-care in line with one of two WSIC levels of support; enhanced mainstream care or intensive case management for up to 12 weeks and then stepped down, if appropriate, to enhanced mainstream care.

- 3.27 To provide this service Brent Care Ltd have employed nursing support and worked with CVS Brent to secure six care navigators. Throughout 2016/17, Brent Care has aligned adult social care services and talking therapy services (IAPT) provided by Central and North West London Foundation Trust to provide an integrated approach to the management of long term conditions.
- 3.28 Going forward, the Community Services review recently undertaken by the CCG in partnership with Ealing CCG should inform the approach to securing greater vertical integration with community services, with specific focus on district/community nursing services in 2017/18. In addition, the informal alignment with adult social care and talking therapy services will also be further developed in 2017/18.
- 3.29 Based on this incremental approach to vertical integration, Brent has always been most closely aligned to the Multi Community Provider (MCP) model from the Five Year Forward View. The MCP model is well suited to models of community based care for those with complex or chronic long term conditions. The MCP offers a framework through which to integrate a range of providers / services across health and social care. The 'whole systems' model of case management for adults with LTCs could evolve using the MCP framework.
- 3.30 The workstream will therefore continue to focus on the commissioner role in developing this new provider vehicle through identifying the challenges the partnership is being asked to overcome (and translate these into meaningful outcomes) and to consider how we might use contracting and payment mechanisms to incentivise joined up working and shared accountability, and ensure funding flows to where it is needed most in the system.

Frailty

- 3.31 This is priority work stream and two distinct but interlinked elements – acute frailty model and out of hospital community provision.
- 3.32 The out of hospital element relates to Better Care Fund (BCF) schemes and are the most progressed. These are integrated re-ablement and rehabilitation service and effective hospital discharge supported by multi-disciplinary proactive care planning for people with long term conditions (WISC). The work programme for next year will be incorporated in BCF plan for 17-18 and will focus on nursing homes (improving quality, reducing admissions to A&E, managing the market), improved complex discharge pathway, discharge to assess at home, and improving effectiveness of community beds provision.
- 3.33 The Acute Frailty Model led by LNWH is focusing on three main components:
- a) Early identification and assessment:** utilising a pro-active method of reducing unnecessary admissions to the acute settings through an ambulatory service (OPRAC) for rapid assessment and diagnosis with referral access from ED, community, nursing homes and GP and reducing length of stay in hospital through and working with community services

and aim to discharge within 48 to 72 hours, or at ED prior to any inpatient admission

- b) Acute Pathway:** a single point of access for all referrers to stream patients into the right service; comprehensive geriatric assessment by a multi-disciplinary team (MDT) including community and mental health practitioners (OPALS) at the earliest opportunity, interface with ED services to prevent older people with complex needs being admitted by default; early access to multi-speciality input and diagnostics.
- c) Integrated Discharge Service:** comprising of social workers, community health services and hospital discharge planners to facilitate a proactive timely discharge and transition from hospital to home or community services; progress on creating capacity by reducing duplication in assessments, enabling timely assessments thereby reducing delayed discharge.

Mental Health and Wellbeing

- 3.25. This work stream is in the scoping stage, although a scoping paper has been developed and presented to the board, more work is required to develop a focused and realistic work programme.
- 3.26. The main deliverables for this work stream is intended to be on reducing reliance on inpatient provision, reducing length of stay and occupancy rates; a focus on recovery with peer support, and enhanced primary care, which addresses wider determinants of health and supports people in the community.

Transforming Care for People with Learning Disabilities

- 3.27. This work stream has developed a work programme that has four components LD services integration – a comprehensive community learning disability/autism and challenging behaviour team and exploring the feasibility of a Section 75 agreement for the provision of an integrated service.
- 3.28. Market development – joint commissioning plans to ensure a full range of local services to enable people to remain with, or close to their families and communities; support workforce development across the health, social care, housing and voluntary sector workforce so that we have staff with the right skills in the right places.
- 3.29. Community support – make the best use of care and treatment reviews to ensure co-ordinated discharge care plans; ensure resources are used effectively to avoid admissions where possible; reduce our reliance on inpatient care and improve the quality of care.
- 3.30. Transitions – reduce waiting times for an assessment, develop and all age offer (across NWL) that provides the care and support needed during the transition period; strengthen the Education, health and care planning process.

Central Middlesex Hospital Hub Plus

- 3.31. This work stream identifies Central Middlesex Hospital (CMH) site as a major place-based opportunity, with the potential to accelerate integration and joint working for the benefit of local residents.
- 3.32. The work stream is still being scoped, emerging thinking is that there will be initially two broad strands of work; the first is estates-focused aimed at realising location and facility related opportunities and the second concentrates on service and service user driven opportunities, including the employment creation, learning opportunities as well as integrated models of support and care.
- 3.33. The Council and CCG submitted a One Public Estate (OPE) bid for the CMH site, which will provide seed funding for project management resource to develop the above mentioned strands of work.
- 3.34. In addition, the CCG has been successful with its application NHS England for Estates and Technology Transformation Funding (ETTF) for investment at Central Middlesex Hospital to create accommodation for a GP practice linked to a re-procurement that is of an APMS GP practice that is currently in progress.
- 3.35. In summary, each of the workstreams is at a different stage of implementation with initiatives that have been part of the Better Care Fund being most advanced at present. The HWBB will receive a further progress update on each workstream at its next meeting.

4.0 Finance Implications

- 4.1 There are no specific strategic financial implications in this update report.

5.0 Legal Implications

- 5.1 Whilst this document is an update on the ongoing project, from an adult social care perspective, it is important to ensure that throughout the project, the requirements of the Care Act 2014 in terms of promoting wellbeing, preventing, reducing or delaying needs are complied with so that we continue to meet our statutory obligations so that our actions do not leave the local authority open to legal challenge.

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 NW London to improve health and wellbeing outcomes and patient experiences.

6.2 Detailed Equality Assessments will be undertaken for each of the workstream plans to ensure that equalities issues are addressed or mitigated as part of the implementation process.

7.0 Staffing / Accommodation Implications (if appropriate)

N/A

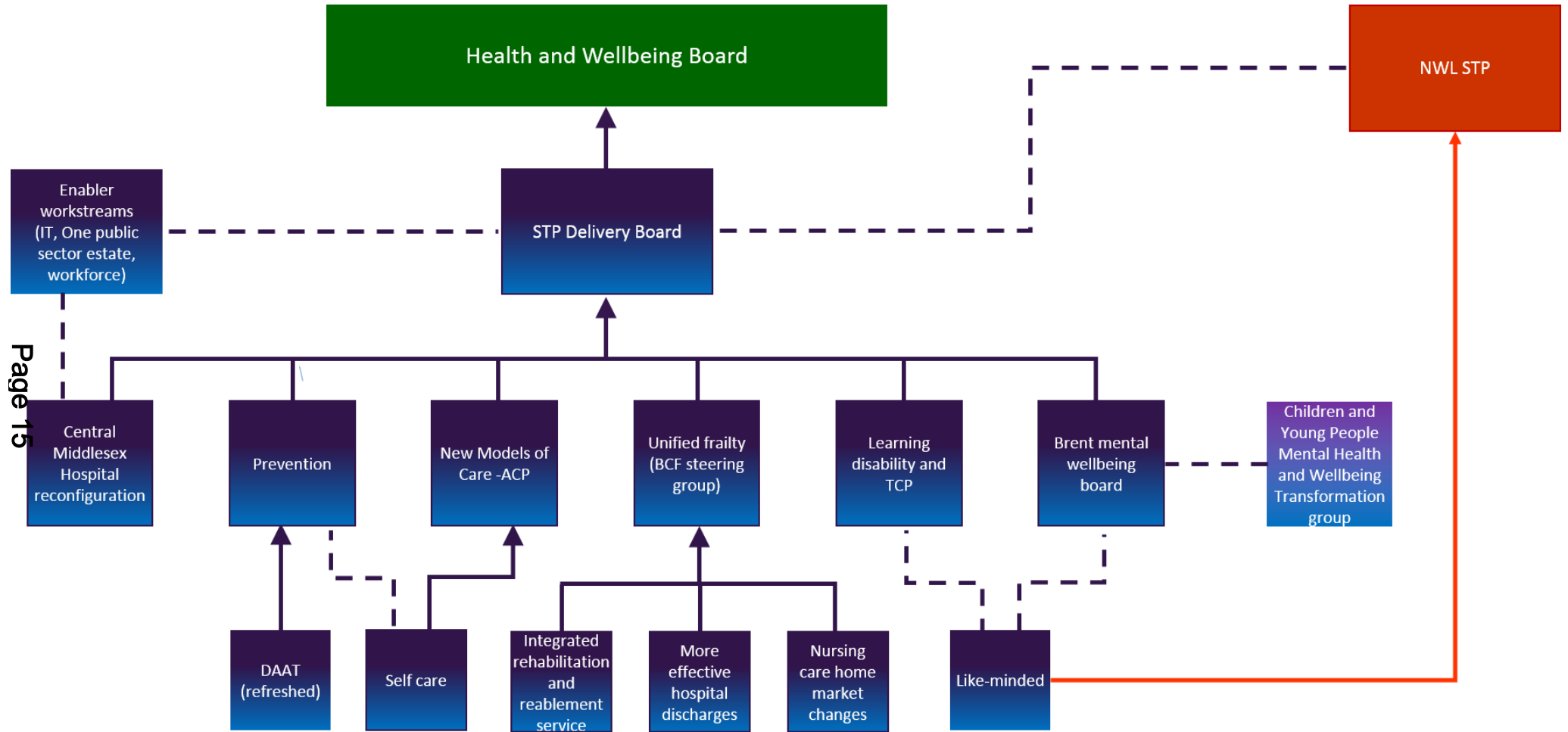
Background papers

- a) Brent Sustainability and Transformation Plan accessed via <https://www.brent.gov.uk/media/16405520/16-07-13-brent-stp-chapter-draft.pdf>
- b) The North West London Sustainability & Transformation Plan accessed via <https://www.healthiernorthwestlondon.nhs.uk/documents/sustainability-and-transformation-plans-stps>
- c) The NHS Five Year Forward View, accessed via <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

Contact Officers

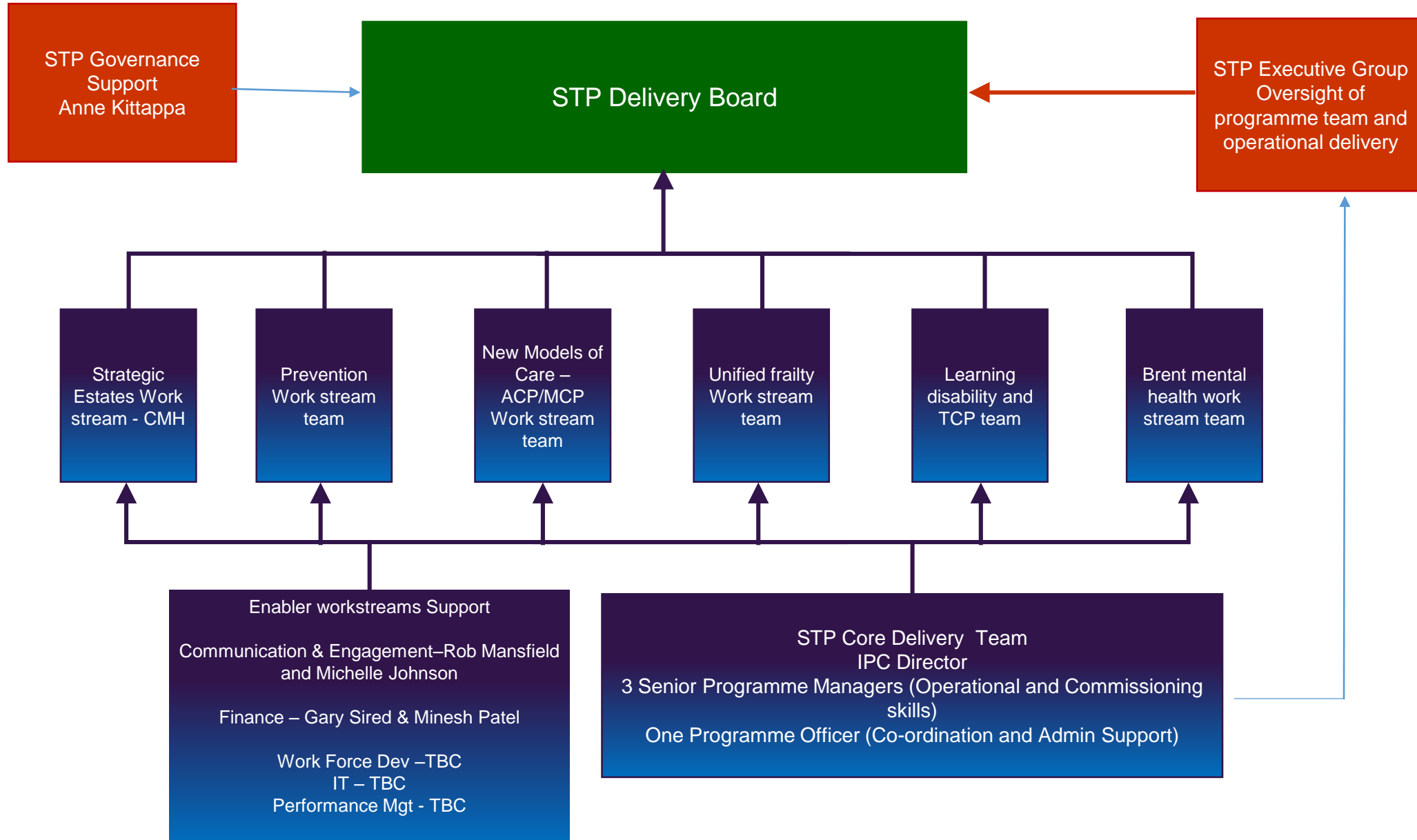
- a) Phil Porter - Strategic Director of Adults and Community Wellbeing, Brent Council, Civic Centre, Engineers Way, Wembley, HA9 0FJ. Tel: 020 8937 5937
Email: Phil.Porter@brent.gov.uk
- b) Sarah Mansuralli - Chief Operating Officer, NHS Brent CCG, Wembley Centre for Health & Care, 116 Chaplin Road, Wembley, HA0 4UZ, Tel: 020 8900 5367
Email: Sarah.Mansuralli@nhs.net

Appendix one





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Appendix two: STP Delivery Structure



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 <p>Brent Clinical Commissioning Group</p> 	<p>Health and Wellbeing Board 24 January 2017</p> <p>Report from the Director of Public Health</p>
<p>Wards affected: ALL</p>	
<p>Sustainability and Transformation Plan (STP): Update on Delivery Area One - Prevention</p>	

1.0 Summary

- 1.1 The purpose of this paper is to update the Health and Wellbeing Board (HWB) on the development of the North West London Sustainability and Transformation Plan (STP) and the Brent Plan, with a specific focus on prevention.

2.0 Recommendation

- 2.1 The Health and Wellbeing Board is invited to comment upon and note developments in the prevention priority of the Sustainability and Transformation Plan (STP).

3.0 Background

- 3.1 Sustainability and Transformation Plans (STPs) are being developed on geographic “footprints” which bring together a numbers of CCGs, local authorities and NHS providers (mental health, acute and community). The local STP covers North West London. Brent Health and Wellbeing Board (HWB) members are actively involved in the NWL STP but have also recognised the need for a local Brent focus. A Brent Plan which complements the NWL STP has therefore been developed.
- 3.2 At its October meeting the HWB endorsed five “big ticket” items for the Brent Plan, one of which was self-care and prevention, and the establishment of the Brent STP Delivery Board.
- 3.3 The HWB agreed that the Brent STP should focus upon those areas which address local need and where engaging a wider range of partners (than the

previous Health and Wellbeing Strategy) will enable more creative solutions. This led to the HWB agreeing that the prevention aspect of the Plan should be focused on: building on existing work on MECC (Making Every Contact Count), workplace health promotion and SIBI (Social Isolation in Brent Initiative). In addition the Board agreed to develop work on the prevention of alcohol- and tobacco-related harm

- 3.4 In parallel to the Brent work, the NWL STP includes a focus on prevention (as Delivery Area one) and is prioritising those areas which have the most potential return on investment during the lifetime of the STP.

4.0 Developments in the Brent Prevention work streams

- 4.1 The Brent STP prevention work stream originally included self-care. However the STP Delivery Board has determined that self care sits more comfortably with work stream two (New Models of Care), since this work stream aims to improve the management of and consistency of care for long-term conditions.
- 4.2 MECC seeks to maximise contacts between a professional (not necessarily a health or social care professional) and residents to identify opportunities to address health issues; for example early years staff promoting tooth brushing and dental registration with young families. The Brent Public Health team have piloted MECC with the council temporary accommodation team and with school nurses. Public health and housing or school nursing staff have jointly identified health issues and opportunities which may arise during contact with residents. Tailored training is being delivered by public health to these front line staff to enable them to identify these issues and to offer advice or signposting. For example temporary accommodation team have identified a need for training on identifying and responding to domestic abuse.
- 4.3 The HWB held a seminar in December to consider challenges and opportunities for the following STP prevention priorities:
- Alcohol
 - Tobacco use
 - Social isolation
- 4.2 The levels of alcohol related admissions in Brent are significantly above the national average. However there are few referrals to alcohol treatment services from health care professionals (the majority of people entering the treatment system are self or family referred). The HWB have identified that improving the pathway to treatment from health and social care should be a priority.
- 4.3 An outline business case has been submitted to the NWL STP Programme which demonstrates a potential return on investment, within the lifetime of the STP, for seven day alcohol care teams in acute settings, for an increase in assertive outreach and for a step change in screening and brief interventions (to address the very large numbers of people who while not dependent on alcohol, are drinking at levels which risk harming them). Research by Public Health England (PHE) suggests that investment in acute alcohol care teams

can show savings within two years by reducing alcohol related A&E attendance and admissions. However the Brent HWB seminar identified a risk that, given the current pressures on acute care, any reduction in alcohol related presentations could simply 'free up' capacity for other presentations. Public Health and the CCG have started to identify the metrics (using hospital activity recording) which would allow the impact of investment in alcohol prevention to be tracked.

- 4.3 While the NWL STP includes smoking cessation as a priority, the Brent HWB has broadened its focus to include other uses of tobacco, notably shisha and chewing tobacco, both of which the Board has identified as being particularly prevalent in Brent.
- 4.4 Smoking cessation services in Brent, as elsewhere in London and nationally, are seeing reduced demand and falling quit rates. It has been hypothesised that those smokers who wished to, or were more able to quit, have already accessed smoking cessation services – a hypothesis is supported by the falling prevalence of smoking. Alternatively, or additionally, there is a case that smokers are now using e products to quit or reduce their smoking in preference to using traditional smoking cessation.
- 4.5 With falling quit rates, existing local smoking cessation services represent decreasing value for money and Brent Public Health is reviewing the local offer. Alongside this, we are participating with the Association of Directors of Public Health (London) in collaboration with PHE to explore the potential for digital support and a London on line offer of support - with PHE sponsored "apps" a possibility for the future.
- 4.6 At the same time as traditional 'stand alone' smoking cessation services are seeing fewer clients, attention has focused on the potential for mainstream NHS services to better address smoking. For example through the routine monitoring of exhaled carbon monoxide ("would you like to know your level?") or through addressing by household smoking in the context of childhood ENT or respiratory illnesses ("does anyone smoke in the home?"). The London Clinical Senate is leading work in this area.
- 4.7 Mental health service users have particularly high levels of smoking – half of those admitted to mental health units are smokers. The HWB seminar heard how local mental health services have responded to this challenge with every smoker admitted being offered a nicotine substitute within 30 minutes and the Trust making its grounds completely smoke free. The STP Delivery Board will be exploring how the learning from implementing a smoke free policy could be shared with other health and social care settings.
- 4.8 PHE have focused attention on social isolation as a risk factor for early death as harmful as smoking 15 cigarettes a day. The Brent SIBI project has demonstrated success in identifying people who are currently socially isolated but whom have the potential to (re)engage with support: to date SIBI has reached 2700 people, of whom 272 socially isolated people were engaged - of

whom 79% moved out of social isolation with 27 becoming volunteers and 16 (re)entering employment.

4.9 The Council, CCG and Brent CVS are developing proposals to develop SIBI within a strategic approach to social prescribing

5.0 **Developments in the NWL Prevention work stream**

5.1 The NWL Prevention Board have agreed three thematic work streams within which a number of business cases are being developed to identify potential savings to the health and social care (and in some cases the wider public sector) economy. The current areas being developed are:

- Enabling and supporting healthier living for the population of NWL
 - Physical activity
 - Healthy workplace
 - Alcohol prevention
 - Long acting reversible contraception
 - Wellbeing charter
- Keeping people mentally well and avoiding social isolation
 - Work and health programme
 - Signing the LD Disability Employment Pledge
 - Social prescribing / isolation
 - Reducing the risk of homelessness
 - Health checks for people with LD
 - Targeted smoking cessation
- Radically Upgrading Prevention and Wellbeing- Helping Children to Get Best Start in Life
 - School Readiness/prevention of conduct disorder
 - Healthy weight

5.2 Of these, two have been prioritised for early intervention: alcohol and the work and health programme. As Brent have led on the development of the business case for the prevention of alcohol related harm, it has been proposed (but not yet agreed) that, should investment be forthcoming, an acute care alcohol team could be piloted at Northwick Park

Contact Officers



MELANIE SMITH

Director of Public Health

Brent Council

020 8937 6227

Melanie.smith@brent.gov.uk

 <p>Brent Clinical Commissioning Group</p> 	<p>Health and Wellbeing Board 24 January 2017</p> <p>Report from the Assistant Director - Primary Care, Brent Clinical Commissioning Group</p>
<p style="text-align: right;">Wards affected: ALL</p>	
<p>Clinical Commissioning Group (CCG) GP Member Practices – Option to Move to Delegated Commissioning Arrangement</p>	

1.0 Summary

- 1.1 North West London (NWL) CCGs are now consulting member practices on the option of a move to 'level 3 - fully delegated' commissioning arrangements from 1st April 2017. CCGs that move to fully delegated arrangements will be responsible for functions previously carried out by NHSE and their own statutory duties.
- 1.2 Newly delegated functions would include: management of GP core contracts, design of enhanced services and local schemes and financial management of the primary care budget. Functions retained by NHSE would include: management of the national performers list, management of the revalidation and appraisal process, capital expenditure, section 7A functions (e.g. screening and immunisation) and complaints.
- 1.3 The Health and Wellbeing Board is asked to note that Brent CCG Member Practices will take a vote on the option of moving to level 3 – delegated commissioning arrangements from 1st April 2017.

2.0 Recommendation

- 2.1 The Health and Wellbeing Board is asked to consider how we ensure we continue to commission effectively, and deliver our shared programme of transformation under the STP, with level 2 – joint commissioning arrangements, or with level 3 – delegated commissioning arrangements.

3.0 Detail

- 3.1 Currently NHS England (NHSE) has overall responsibility for commissioning and management of core primary medical services. They hold the 'core' GP contracts, commission 'enhanced' services, manage the primary care budget (primary medical allocations), manage patient communications, complaints, primary care estate and GP revalidation, appraisal and performance.
- 3.2 In 2015 CCG member practices voted in favour of a move to 'level 2 - joint commissioning' arrangements. At level 2, NHSE retain 51% decision making rights but the CCG are part of decision making processes.
- 3.3. North West London (NWL) CCGs are now consulting member practices on the option of a move to 'level 3 - fully delegated' commissioning arrangements from 1st April 2017. CCGs that move to fully delegated arrangements will be responsible for functions previously carried out by NHSE and their own statutory duties. Newly delegated functions would include: management of GP core contracts, design of enhanced services and local schemes and financial management of the primary care budget. Functions retained by NHSE would include: management of the national performers list, management of the revalidation and appraisal process, capital expenditure, section 7A functions (e.g. screening and immunisation) and complaints.
- 3.4 Nationally 114 of 209 CCGs are currently Level 3. NHSE are keen for CCG members to choose delegated commissioning. NHS Brent CCG remains impartial. It is possible, and even likely that some CCGs in NWL will choose to move to delegated commissioning and others will choose not to.
- 3.5 Brent member practices will vote on this option in line with the terms of the CCG Constitution. All member practices are given a vote (one vote per practice). 75% or more of member practices must vote in favour for the proposal to be carried. NWL CCGs submitted an initial application to NHS England on 5th December with the membership vote pending. The Brent vote will run 30th January – 13th February run by the Brent Council Electoral Services team. The result will be announced around 17th February 2017.
- 3.6 To facilitate an informed vote, the process of stakeholder engagement commenced early October 2016. There has been significant work to date to identify the opportunities and challenges with stakeholders; this has included engagement with GP member practices, CCG and NHSE colleagues, Brent local authority and some elected members: Cllr Butt, Cllr Hirani (Chair of the Health and Wellbeing Board), and Cllr Sheth (Chair of Community and Wellbeing Scrutiny Committee), Londonwide and Local Medical Committees and Healthwatch.
- 3.7 Some early engagement of lay members and patient representatives has taken place across NWL and more will follow the vote. GP practices have been urged to consult PPGs. This on-going process is helping identify the questions that need to be addressed as part of planning and due diligence.
- 3.8 NWL CCGs have commenced a process of due diligence. There are three key workstreams being led by leads from across the CCGs in NWL with input from

NHSE, practices and technical experts (lawyers, auditors). The three workstreams underway are as follows:

- **Governance:** governance leads from NWL have been reviewing the constitutional arrangements required for level 3, the revisions required to local committees (including what would be a transition from a local Joint CoCommissioning Committee to a local Primary Care Commissioning Committee), the lines of reporting and accountability and the approach to conflict of interest management. Draft documents have been produced and published for January Governing Body. Principles include ensuring the clinical voice is optimised whilst safeguarding GPs and CCGs from real or perceived conflicts of interest; ensuring local joint working is effective and transparent to all stakeholders and delivers the objectives in our STP and ensuring decision-making remains fully compliant with statutory guidance and reflects good governance.
- **Workforce (CCG and NHSE teams):** functions, processes, roles, skills and the structures in which these would be organised. This workstream is also looking at HR implications and developing an implementation plan taking into account the fact there would be an element of transition in the first year. It is likely elements of commissioning will be organised at NWL level, others locally (Brent or across the Federation of Brent, Harrow, Hillingdon CCGs).
- **Finance and legal:** understanding the financial risks and/or benefits associated with the proposed transfer of responsibilities from NHSE as at April 2017. CCG Finance leads are working with NHSE and RSM Tenon (auditors) to examine financial performance and any inherent risks. Key lines of enquiry include: likely final budget position at the end of 16/17, new budgets for 17/18 and beyond, requirements upon and issues that might impact these budgets and what room (if any) there might be to invest locally. Best efforts will be made to identify risks/disputes/ liabilities as at 31st March 2017 and a Memorandum of Understanding is being drafted between NWL CCGs and NHSE to indemnify CCGs against these legacy issues.

3.9 There are potential benefits in a move to delegated commissioning. Some of the key potential benefits are outlined below:

- Delegation could support delivery of the STP, in particular delivery area 2. It could make it easier to coordinate resources going into GP services so they better achieve local needs, priorities and outcomes.
- With fully delegated responsibility the CCG may have more ability to work with local authority teams (for example Public Health and Social Care) to (re)design and commission local enhanced services.
- Responsibility for all parts of the service provided by GPs could give local commissioners more scope to work with practices to refine contracts and

reporting and in turn to reduce the administrative burden on practices and free up more time for clinical delivery.

- The Primary Care Commissioning Committee would have direct and local control over primary care planning and decisions about how services are shaped. This would include greater ability to shape the future of primary care providers at all levels - practice, Network and Federation (Brent-wide).
- There would be greater emphasis on reducing variation in the services offered to and outcomes achieved for patients locally. The CCG would have better access to data on practice performance and outcomes and increased authority and responsibility to address challenges and seek equitable access for all registered patients, ultimately reducing health inequalities.

3.10 There are also potential risks in a move to delegated commissioning. Some of the key potential risks are outlined below:

- CCG capacity will be a challenge. Staff numbers significantly reduced with the dissolution of Primary Care Trusts (PCTs) and it is likely additional staff would be required to support primary care commissioning and contract management under level 3. The CCG currently has a capped staffing budget and whilst some existing NHSE staff would work at a NWL level, CCGs are unlikely to receive additional staffing resource from NHSE. We think there would be increased expectations around design and management of primary care services and contracts, reporting and governance, relationship management and administration.
- Currently the CCG is involved in shaping the primary care market, investing in primary care through locally enhanced services and out of hospital contracts, and in the development of provider joint working (for example through Whole Systems and delivery of the STP). Expectations would be raised with any move to level 3, and as delegated commissioners the CCG would have more control, but practices would remain independent providers and commissioners will have to work with them and their representatives to effect and deliver change over time.
- There will be an even greater requirement to manage conflict of interest. Whilst this is business as usual for CCGs with robust systems and processes in place, the governance structure and approach will need to be revised to take account of level 3 responsibilities and functions and it will need to be clear to external stakeholders (including practices) that this is being enacted effectively and appropriately. This is also a potential benefit as there will be even greater transparency and accountability for decisions locally.
- The demands on primary care are greater than ever and growing as the population grows and ages. Many practices can't meet patient demand for access, have staffing shortages, lack suitable premises, are seeing

increased running costs, professional fees (CQC, GMC) and individual and practice indemnity and insurance costs, and have GP Partners considering retirement. This means an increasing number of practices are vulnerable. The CCG will have to work within available resource to support practices. There will likely be a significant number of issues that arise locally over time and all will need to be managed as effectively as possible – recognising these constraints - in partnership with local stakeholders without negatively impacting wider relationships and joint working.

- 3.11 Once the outcome of the Brent member practice vote is known, it will be announced and the CCG and its partners will consider the implications at local and NWL level.

4.0 Financial and Legal Implications

- 4.1 The financial implications of this proposal are still work in progress and will be informed by the due diligence exercise being undertaken with a specific workstream on finance and legal implications
- 4.2 Should the member practices vote yes, any information that arises as part of ongoing due diligence (to end March 2017) that may impact the viability of a move to level 3 will be shared with CCG Governing Body and member practices.



5.0 Equality Implications

- 5.1 A potential benefit of delegated commissioning is better access to data on practice performance and outcomes with increased authority and responsibility to address challenges for the purpose of securing equitable access for all registered patients. This would result in improved quality, safety and patient experience that would contribute to a reduction in health inequalities.

Contact Officers

- a) Sarah McDonnell, Assistant Director – Primary Care, NHS Brent CCG, Wembley Centre for Health & Care, 116 Chaplin Road, Wembley, HA0 4UZ, Tel: 0208 900 5394 Email: Sarah.mcdonnell1@nhs.net
- b) Sarah Mansuralli, Chief Operating Officer, NHS Brent CCG, Wembley Centre for Health & Care, 116 Chaplin Road, Wembley, HA0 4UZ, Tel: 020 8900 5367 Email: Sarah.Mansuralli@nhs.net

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 <p>Brent Clinical Commissioning Group</p> 	<p>Health and Wellbeing Board 24 January 2017</p> <p>Report from the Chief Operating Officer, NHS Brent Clinical Commissioning Group</p>
<p>Wards affected: ALL</p>	
<p>NHS Brent Clinical Commissioning Group (CCG) Commissioning Intentions 2017-19</p>	

1.0 Summary

- 1.1 This report details the commissioning intentions for NHS Brent CCG for the financial years 2017/18 and 2018/19. These are aligned with the North West London (NWL) Sustainability and Transformation Plan (STP).
- 1.2 The Health and Wellbeing Board (HWBB) has reviewed the Commissioning Intentions in depth and made a number of comments. These detailed comments provided by the HWBB have been considered and changes incorporated into the Commissioning Intentions as a result. This report provides an opportunity to discuss the CIs in person with the CCG.

2.0 Recommendation(s)

- 2.1 The HWBB are requested to note the changes made to the Commissioning Intentions which were approved by the CCG Governing Body on 11 January 2017.
- 2.2 The HWBB are requested to endorse the final Commissioning Intentions for Brent, which include health and care priorities for service development.

3.0 Detail

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

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

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

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

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

Brent's Health & Well-Being Gaps	Brent's Care & Quality Gaps
<ul style="list-style-type: none"> • Common mental health disorders (CMD): in 2014, an estimated 33,959 people aged 18 to 64 years were thought to have a CMD • Severe and enduring mental illness: affects 1.1% of the population • Mental well-being: the percentage of people with depression, learning difficulties, mental health issues or other nervous disorders in employment is 23% also lower than both the England rate (36%) • Childhood obesity: Brent is in the worst quartile nationally for the % of children aged 10-11 classified as overweight or obese – 38% • Diabetes: by 2030 it is predicted 15% of adults in Brent will have diabetes 	<ul style="list-style-type: none"> • Caring for an ageing population: 35% of all emergency admissions in Brent are for those 65 and over; once admitted this group stays in hospital longer, using 55% of all bed days. • EOLC: Brent has one of the highest percentages of deaths taking place in hospital in the country. • Primary care: wide variation in clinical performance; Brent is in the worst quartile nationally for patient experience of GP services. • LTC management: Brent is in the worst quartile nationally for people with a long-term condition feeling supported to manage their condition. • Cancer: Brent is in the second lowest quartile nationally in terms

Brent's Health & Well-Being Gaps	Brent's Care & Quality Gaps
<ul style="list-style-type: none"> • Long term conditions (LTCs): ~20% of people have a long term condition • Dementia: Over 2,225 people aged 65 years and over have dementia (2016) • STIs/HIV: 1,404 STIs per 100,000 population against 829 in England • Health-related behaviour: physical inactivity: worst in West London; nutrition: 47% get 5 a day; tobacco use; alcohol; take up of immunisations 	<p>of GP referral to treatment for cancer and worst quartile in terms of cancer patient experience.</p> <ul style="list-style-type: none"> • Serious and long-term mental health needs: people with serious and long term mental health needs have a life expectancy 20 years less than the average.

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

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

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

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

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

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

- **Redesign Central Middlesex Hospital – One Public Estate** Redevelop the Central Middlesex Hospital site into a Brent Health and wellbeing Centre providing a range of local services including the Urgent Care Centre. This will take place as part of the wider NW London acute reconfiguration programme.
- **Unified Frailty Model** Span the services and pathways that address the needs of this cohort across Brent, concentrating and coordinating resources on a group of patients whose needs current drive a significant proportion of demand.
- **Improve outcomes and wellbeing for children and adults with mental health needs** Implement recovery focused mental health service provision across health and social care through integration of services and linking with housing and employment pathways with a strong peer support focus
- **Transforming care – supporting people with learning disabilities** Implement a borough wide Learning Disabilities Strategy across Brent and development of joint commissioning plans, including for children and young people

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

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

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

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

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

- *RightCare programme*: This tool for identifying and addressing variation in outcomes will be used to identify improvements in diabetes, musculoskeletal diseases, cancer and respiratory conditions.
 - *Review of Brent community services*: Reduce emergency department admissions to embed services and deliver training on their management.
- **Delivery Area 3 – Achieving better outcomes and experiences for older people**
 - *Primary care transformation*: GPs are central to health and care; working with patients and staff will help make the primary care model fit for purpose.
 - *End of Life care*: Commissioning and contracting changes to improve service access, while also managing quality and outcomes to improve links between end of life and primary care.
 - *Whole Systems Integrated Care (WSIC)*: Developing proactive, coordinated and integrated care in Brent through partnerships between different providers to improve support of patients' care-pathways. It includes self-care, linking community teams with health service teams, GPs and other clinical services to address admissions and re-admissions.
 - *Care home and high risk housebound patients*: Improving the quality of medical support to patients, including use of support from pharmacy and medicines management teams.
 - *Unified frailty older people pathway*: Provision of 100% geriatric assessments, giving estimated discharge dates and reducing lengths of hospital stays.
 - *Rapid response service*: Reducing the proportions of non-elective emergency admissions and to increase care within community service environments.
 - *Integrating the transfers of health and social care*: Developing single access points, agreed data to be measured, targeting areas for improvement and through joint working across North West London to reduce the duplications of effort and by improving care and patient experience.
 - *Falls prevention and bone health*: A new service to reduce re-admissions for falls and hip fractures.
 - **Delivery Area 4 – Improving outcomes for children and adults with mental health needs**
 - *The Likeminded strategy*: Addresses common mental health disorders, serious and long-term mental health needs, children and young peoples' mental health, wellbeing and prevention for conditions such as dementia and Learning Disabilities. Improved services are planned to

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

- *Perinatal mental health:* This is an important cause of maternal mortality; increased support is being planned during pre-conception and in postnatal periods of up to the first year of the baby's life
- *Early intervention in psychosis:* Expanding existing services and developing Black and Minority Ethnic (BME) support services are planned. Further expansion of BME peer support is considered during 2018 - 2019
- *Conduct disorder:* Children with long term physical illness are more likely to suffer emotional and/or conduct disorders. Early intervention and targeted mental health support for these conditions is planned to be delivered between 2017-2019. We aim to achieve reductions in referrals to specialist child and adolescent mental health services for such disorders
- *Dementia:* Brent has an estimated 2,513 patients living with dementia, of which only 68% are diagnosed. Brent CCG plans to develop a primary care dementia service to diagnose the condition early, where the right treatment and support can be offered to maintain good quality life for patients and their families, or for their carers
- *Learning disabilities:* Brent CCG is committed to transforming the care of people with learning disabilities and autism to avoid admissions into inpatient services. To achieve this, the integrated community learning disability team will deliver and implement transformation (prevention, wellbeing support and timely assessments), to achieve improved patient experiences. In 2018 -2019, we intend to re-model a local in-patient Learning Disabilities unit
- *Carers:* Brent CCG aims to increase the number of carers that are being supported, as well as the level of support that is provided for carers.
- **Delivery Area 5 – Ensuring we have safe, high quality and sustainable acute services**
 - *Urgent and Emergency Care:* We aim to develop an Integrated Urgent Care model across Brent, Harrow and Hillingdon. This involves the alignment of current GP Access Hubs, Out of Hours and Urgent Care Service at Northwick Park Hospital and at Central Middlesex Hospital. These changes will align the GP Access hubs with other urgent care services, enabling patients to access local services rather than needing to locate out of area service assistance
 - *Inpatient model of care:* Implementation of new care models in acute trusts where 90% of admissions receive consultant-directed reviews daily
 - *Radiology and diagnostics:* In 2017/18, we aim to have 90% of inpatient radiology diagnostics done and reported in 24 hours. This will

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

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

3.9 The following themes underpin activity across the delivery areas:

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

- Estates - We intend to maximise the use of public sector land and premises, reducing recurrent premises costs by commissioning and creating additional capacity, minimising overheads and improving the access to primary care.
- Continuing Care and Personal Health Budgets - Continuing care (for adults and children) is based on a person's assessed needs. These packages of care are delivered outside hospitals in any setting; including a patient's own home or in a care home. Plans for 2017 – 2018 include enabling children with special needs (those with educational, health and care plans) to be supported with an option of a personalised health budget
- Medicines Optimisation - The objective is to achieve efficient use of medications, improve patient experiences with their medicines, based on national and local guidance and partnerships with relevant stakeholders to improve overall patient care.

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

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

4.0 Financial Implications

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

5.0 Legal Implications

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

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

6.0 Equality Implications

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

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

Background Papers

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

Contact Officers

- a) Jonathan Turner – Assistant Director Planned Care and Service Transformation – NHS Brent CCG, Wembley Centre for Health and Care, 116 Chaplin Road, Wembley, HA0 4UZ, Tel: 0208 900 5423 Email: jonathanturner2@nhs.net
- b) Sheik Auladin – Deputy Chief Operating Officer – NHS Brent CCG, Wembley Centre for Health and Care, 116 Chaplin Road, Wembley, HA0 4UZ, Tel: 0208 900 5422 Email: sauladin@nhs.net,

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Commissioning Intentions

NHS Brent Clinical Commissioning Group
2017/18 & 2018/19

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2. Five Year Forward View
3. North West London Sustainability & Transformation Plan (STP)
4. Brent's 'Big Ticket' Items
5. Brent's Health Landscape & Challenges
6. Progress and Achievements Over the Last 12 Months

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Part 2 - Brent CCG Commissioning Intentions by STP delivery area

1. Radically upgrading prevention & wellbeing
2. Eliminating unwarranted variation & improving management of long term conditions
3. Achieving better outcomes and experiences for older people
4. Improving outcomes for children & adults with mental health needs
5. Ensuring we have safe, high quality & sustainable acute services
6. Other supporting areas

Part 3 – Engagement

1. Our Plan for Public Involvement and Engagement
2. Ongoing Consultation
3. Statement from the Health and Wellbeing Board.

Strategic Context

Strategic Context - Introduction

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

- **Five Year Forward View**

- **The North West London Sustainability and Transformation Plan (STP)**

- **Brent's 'Big Ticket' Items**

These are explored in more detail on the following pages.

Strategic Context – 5 Year Forward View

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

Improving quality of care and access to cancer treatment

Upgrading quality of care and access to mental health and dementia services

Transforming care for people with learning disabilities

Tackling obesity and preventing diabetes

Redesigning urgent and emergency care services

Strengthening primary care services

Timely access to high quality elective care

Ensuring high quality and affordable specialised care

Whole system change for future clinical and financial sustainability

Foundations for Improvement

Strategic Context – The Sustainability and Transformation Plan

The North West London health and social care economy has been developing a Sustainability and Transformation Plan (STP) over the last 5 months, designed to fulfil the aspirations outlined in the Five Year Forward View and setting out ways to achieve the triple aim of closing the health and wellbeing gap, the care and quality gap and

the financial sustainability gap. The CCG's commissioning intentions are closely linked to the STP, and reflect how we will deliver the STP at local level. The Health and Wellbeing Gap and the Care & Quality gaps are set out in the table below:

Brent's Health & Well-Being gaps*

Common mental health disorders (CMD): large numbers and projected to increase - in 2014, an estimated 33,959 people aged 18 to 64 years were thought to have a CMD

Severe and enduring mental illness: affects 1.1% of the population

Mental well-being: the percentage of people with depression, learning difficulties, mental health issues or other nervous disorders in employment is 23% also lower than both the England rate (36%)

Childhood obesity: Brent is in the worst national quartile for % of children 10-11 classified as overweight or obese – 38%

Diabetes: by 2030 it is predicted 15% of adults in Brent will have diabetes

Long Term Conditions (LTCs): ~20% of people have a LTC

Dementia: prevalence of dementia in people aged 65 years and over is 2,225 (2016) (and 80% of prevalence is diagnosed)

STIs/HIV: 1,404 STIs per 100,000 population compared to 829 in England

Health-related behaviour: tobacco use; alcohol; take up of immunisations; physical inactivity: worst in West London; nutrition: 47% get 5 a day

Brent's Care & Quality gaps*

Caring for an ageing population: 35% of all emergency admissions in Brent are for those aged 65 and over; once admitted this group stays in hospital longer, using 55% of all bed days.

End Of Life Care: Brent has one of the highest percentages of deaths taking place in hospital in the country.

Primary care: wide variation in clinical performance; Brent is in the worst quartile nationally for patient experience of GP services.

Long Term Condition (LTC) management: Brent is in the worst quartile nationally in terms of people with a LTC feeling supported to manage their condition.

Cancer: Brent is in the second lowest quartile nationally in terms of GP referral to treatment for cancer and worst quartile in terms of cancer patient experience.

Serious and long-term mental health needs: people with serious and long term mental health needs have a life expectancy 20 years less than the average.

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

Strategic Context – The Financial Gap

Approximately **£12m** of net savings ('QIPP') are required **each year** to close the CCG financial gap over the next five years.

Allocation growth for 17/18 and 18/19 is lower than has been received in recent years. Therefore, with the expectation that demand will continue to increase in excess of funding growth, it is imperative that Brent CCG continues to make year-on-year savings and improvement in the value for money it obtains from its investments in order to maintain a sustainable financial position. The planning assumption in the 5-year STP is that the level of savings required for 17/18 and 18/19 is 3% (broadly £12m additional savings each year). This is due to be achieved through a mix of **transactional savings** and savings made by **transforming services** described in the five delivery areas in the North West London STP.

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

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

Strategic Context - Our Duties to Maintain Financial Control

- The CCG is legally obliged to ensure that in each financial year it performs its functions so as to ensure that its expenditure which is attributable to the performance by it of its functions in that year does not exceed the amount allotted to it.
- In addition NHS England business rules under which CCGs should operate are:-
 - CCGs should achieve a 1% cumulative surplus
 - CCGs should hold a minimum of 0.5% contingency
 - CCGs should be in a position of underlying recurrent (i.e. normalised) balance
 - CCGs should operate within their running cost allowance
 - In-year surpluses/deficits would be carried forward into the next year
- We will continue to monitor the CCG's finances closely in 17/18 through the monthly Finance, QIPP and Performance Committee, the CCG Executive and the Governing Body
- We also have a significant QIPP programme (Quality, Innovation, Productivity & Prevention) which aims to make the system more streamlined and reduce unnecessary activity or duplication.

Strategic Context - STP Priorities and Delivery Areas

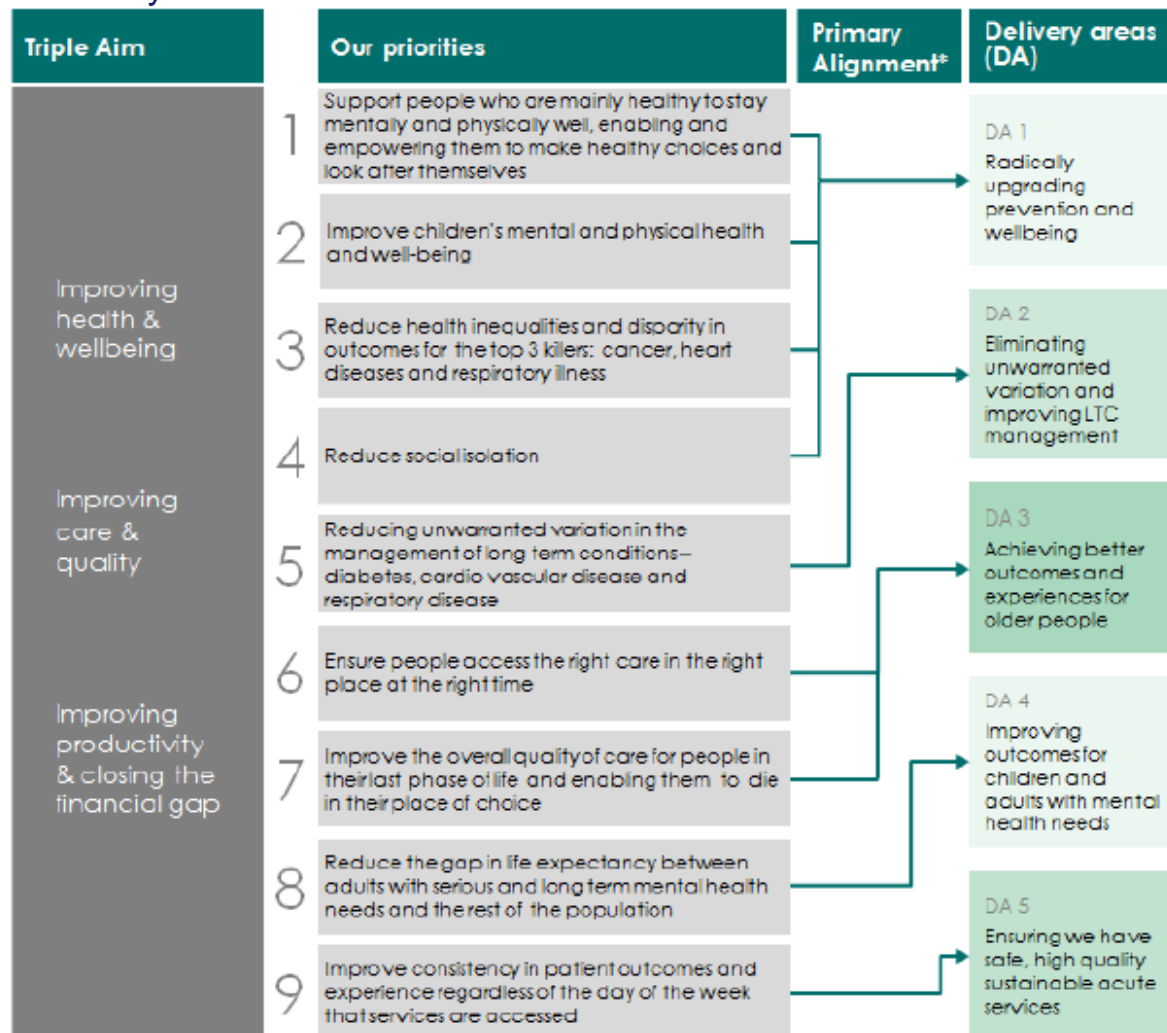
The NWL STP has organised the 9 NWL priorities into five High Impact Delivery Areas.

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

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

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

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



Strategic Context - Brent's 'Big Ticket' Items

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

Title	Description	Impact
<p>1. Join Up Health Promotion, Self-Care and Non-Statutory support across the Continuum</p>	<p>This covers a range of activities from simple management of self-limiting conditions to supporting patients with long term conditions.</p> <ul style="list-style-type: none"> • Making Every Contact Count – use every opportunity to achieve health and wellbeing, and systematic promotion of benefits of healthy living (culture and environment) • Workplace based Health Promotion programme - adapted version of London Healthy Workplace Charter for small businesses in Brent; contracts issued with workplace health and wellbeing as a 'social value' requirement • Widen the scope of SIBI - re-align to support 1st tier (signposting, advice, links to existing services) & 3rd tier patients (intensive support for short periods) using multi-agency approach • Self-Care as part of Whole Systems Integrated Care (WSIC) - already a Brent plan • Alcohol related admissions - Addressing high levels of alcohol related admissions through 7 day alcohol care teams, increase in assertive outreach, screening, treatment and brief interventions • Smoking Cessation - improving the offer from mental health services for users who are more likely to smoke 	<ul style="list-style-type: none"> • Improve outcomes by joining up services and preventing ill health • Reducing alcohol related admissions in Brent which are significantly above average • According to the Local Services Transformation paper, Brent could save ~£345k over five years through: (1) commissioning self-care programmes, e.g. social prescribing, peer support; (2) activating the workforce, e.g. motivational interviewing techniques; (3) improve provision of information; (4) use of PAM to tailor self-care; and (5) developing third sector infrastructure.
<p>2. New Models of Care</p>	<p>Reconfirming the original vision for WSIC and building on work to date with Primary Care to take integration further with the GP-Patient relationship at the centre. This requires partnerships between Primary Care, Community services, Acute and discharge, Social Care, Housing and Voluntary Sector through an Accountable Care Partnership. The focus for the next two years is:</p> <ul style="list-style-type: none"> • Models of Care that improve quality, experience & outcomes for patients with LTCs and their carers while reducing system costs. • New interventions & roles, multidisciplinary working to improve productivity and efficacy of teams 	<ul style="list-style-type: none"> • Proactive care through planning, prevention and integrated care; • Move from professionally led care to a model of support to self-care and self-management • Achieve continuity of care through relationships between the patient their carers and their own GP • Deliver care at appropriate time & out of hospital where possible

Strategic Context - Brent's 'Big Ticket' Items

Title	Description	Impact
<p>3. Redesign Central Middlesex Hospital – One Public Estate</p>	<ul style="list-style-type: none"> • Redevelop the Central Middlesex Hospital (CMH) site into a Brent Health & Well-Being Centre providing a range of local services (including the Urgent Care Centre). • This work will take place as part of the wider NW London acute reconfiguration programme. • The redesign process will take account of the additional Extra Care Units that are being developed near CMH in 2016/17-2017/18. 	<ul style="list-style-type: none"> • As a local Health & Well-Being Centre, support Brent's vision to improve the quality of care provided, empowering and supporting people to maintain independence and to lead full lives • Support financial viability of LNWHT & Brent CCG
<p style="writing-mode: vertical-rl; transform: rotate(180deg);">Page 49</p> <p>4. Unified Frailty Model</p>	<p>Span the services and pathways that address the needs of this cohort across Brent, concentrating and coordinating resources on cohort whose needs currently drive a significant proportion of demand, including:</p> <ul style="list-style-type: none"> • Common standards and specifications, and pooled, shared and rotated resources • Community-based networks – at scale • Single, universally accessible assessment • Cross-professional decision-making, e.g. to assess, treat, admit • Co-location of services, in particular for most vulnerable/complex, e.g. health & well-being villages <p>This will require more complete development of the WSIC model and a pathway that cuts across WSIC, STARRS, Discharge and other services (e.g. GP-led urgent and emergency care model). This brings existing BCF schemes service models together in a single pathway.</p>	<ul style="list-style-type: none"> • Significantly improve quality, timeliness, coordination of care and patient experience for older people in Brent, who are much more likely to be frail and have multiple LTCs. The higher proportion of non-elective admissions for people age 65 plus indicates that care could be better coordinated, more proactive and less fragmented. • Shift ratio of acute to out of hospital expenditure • Integrate care at every stage, e.g. use of Common Geriatric Assessment in-hospital, then shared with other providers – from Primary Care to Nursing Homes, with a focus on preventing deterioration through unnecessary time spent in hospital.

Strategic Context - Brent's 'Big Ticket' Items

Title	Description	Impact
<p>5. Improve outcomes and wellbeing for children and adults with mental health needs</p> <p>Page 50</p>	<p>Implement a recovery focused mental health service provision across health and social care through integration of services and linking across housing and employment pathways with a strong peer support focus. Work streams include:</p> <ul style="list-style-type: none"> • Community map and navigation, day service hub • Crisis care, extended GP appointments and primary MH care • Alternative to inpatient care & post discharge support • Improve dementia diagnosis, and community support <p>Promote, protect and improve our children and young people's mental health and wellbeing through:</p> <ul style="list-style-type: none"> • Prevention and early intervention • System without tiers • Care for the most vulnerable 	<ul style="list-style-type: none"> • Bringing social care, education and health services together to improve outcomes for children and young people • Improved outcomes for adults and children with mental health needs: • Reduction in inpatient and residential care placements • Increased independent living and people with metal health needs supported into education and employment • Fewer children in care • Reduction in tier 4 placements
<p>6. Transforming Care – Supporting People with Learning Disabilities</p>	<ul style="list-style-type: none"> • Implement a borough-wide Learning Disabilities Strategy across Brent and develop of joint commissioning plans, including for children & young people • Integrate health and social care provision and improve the quality of the care offered to those who present with behaviours that is challenging and/or complex, including ensuring all those who meet criteria for Care Programme Approach are cared for within this framework • Provide suitable, local accommodation and support, continuing to take forward the Winterbourne work • Reduce reliance on inpatient care and increase support for people in primary care and community settings • Improve access to community and primary care support and to mainstream health services for people with a Learning Disability • Increase access and use of Personal Health Budgets and direct payments for individuals with a Learning Disability 	<ul style="list-style-type: none"> • Reduce number of people in inpatient units and move people in to supported living and or mainstream housing as appropriate • Enhanced take up of personal budgets • Increase access to employment and education opportunities • Improved quality of care and wellbeing

Brent's Health Landscape & Challenges

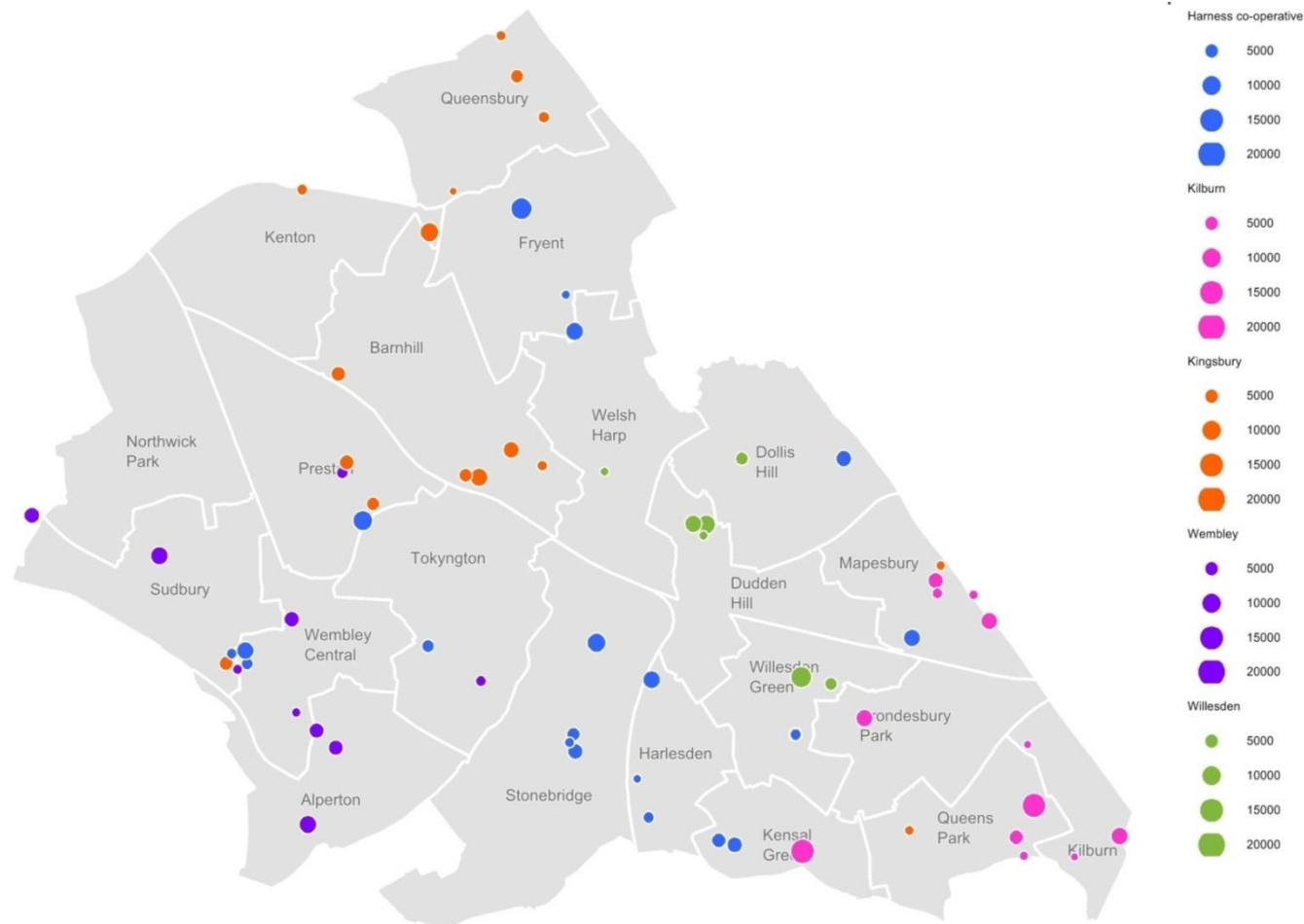
The following section summarises some of the features of Brent's local population and some of the specific issues highlighted by the JSNA:

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

NHS Brent GP Practices and Localities

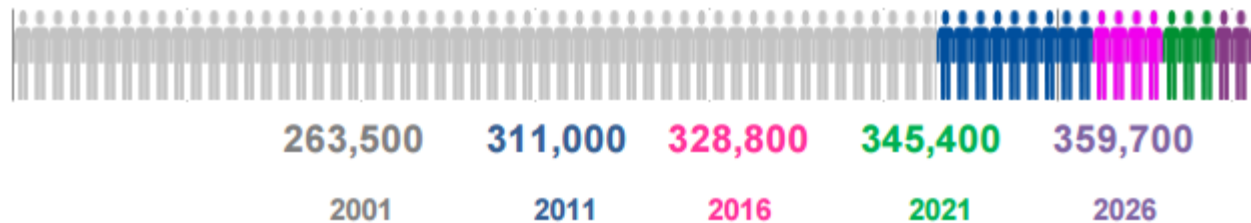
Brent is an outer London borough in north-west London. The number of patients registered with Brent GPs is 369,074. Brent has 62 member practices which are all aligned to one of five locality based groups. Each locality has a Clinical Director. 18 practices have a registered list of fewer than 3,000 patients and 5 practices have a registered list of greater than 10,000 patients.

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Key Population statistics – population and age

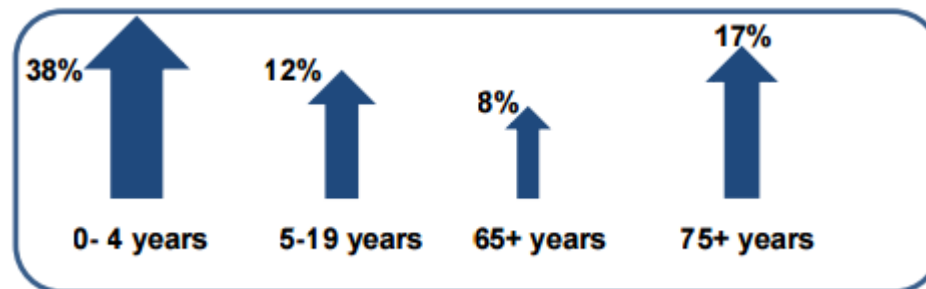
Brent borough has a population of 328,801 (residents) and a population density of 75.2 people per hectare. The population has grown significantly since 2001 and is predicted to continue to grow.



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

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

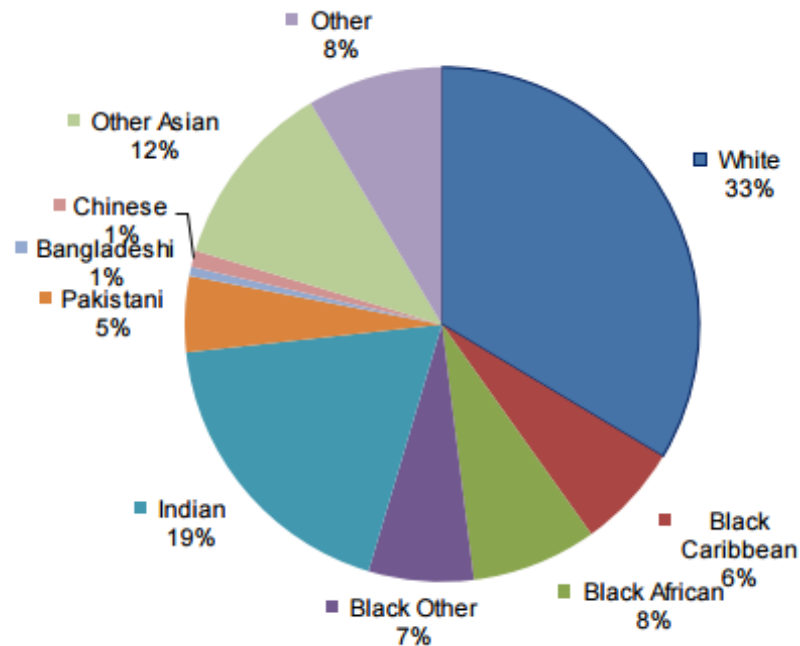
The older population is growing at a higher rate than the adult population:
Percentage changes between 2001 and 2011 for some of the key age groups in Brent 17%



Key Population statistics – ethnicity

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

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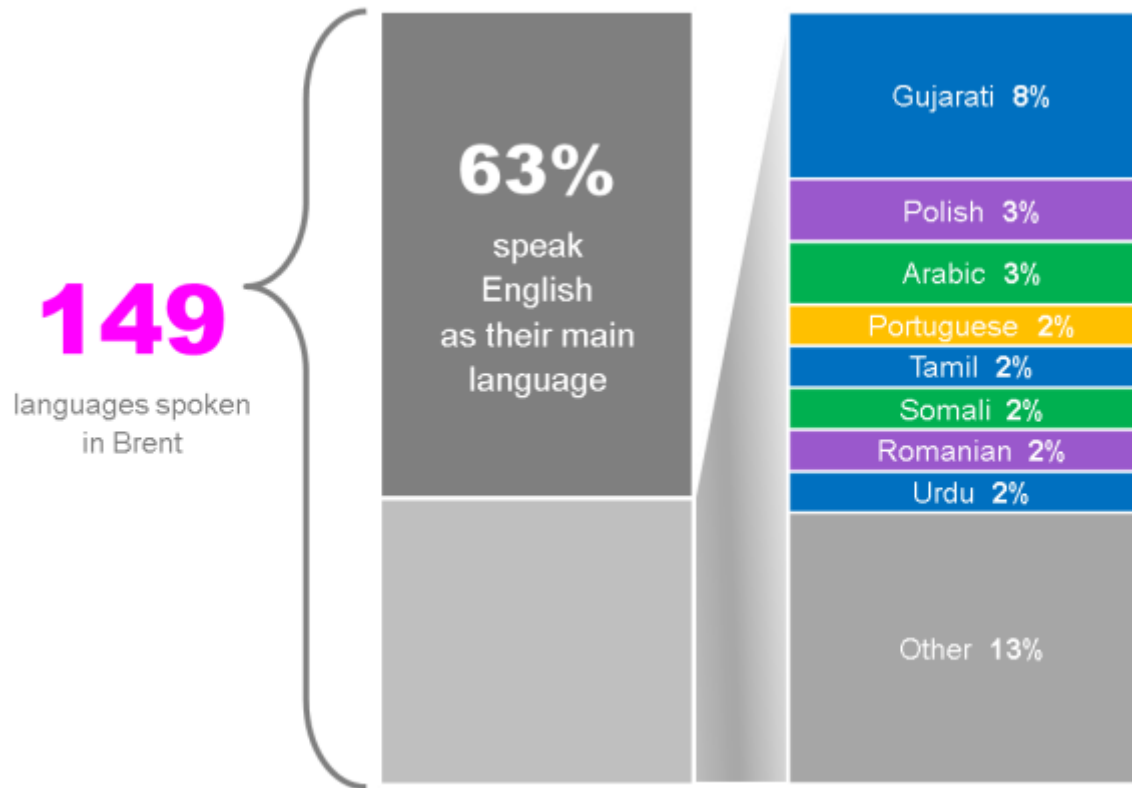


Ethnic profile of Brent residents. Source: 2016 population from GLA SHLAA based population projections, 2013

Key Population statistics – language

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

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Languages spoken in Brent. Source: ONS 2011 Census

Key Health Challenges in Brent

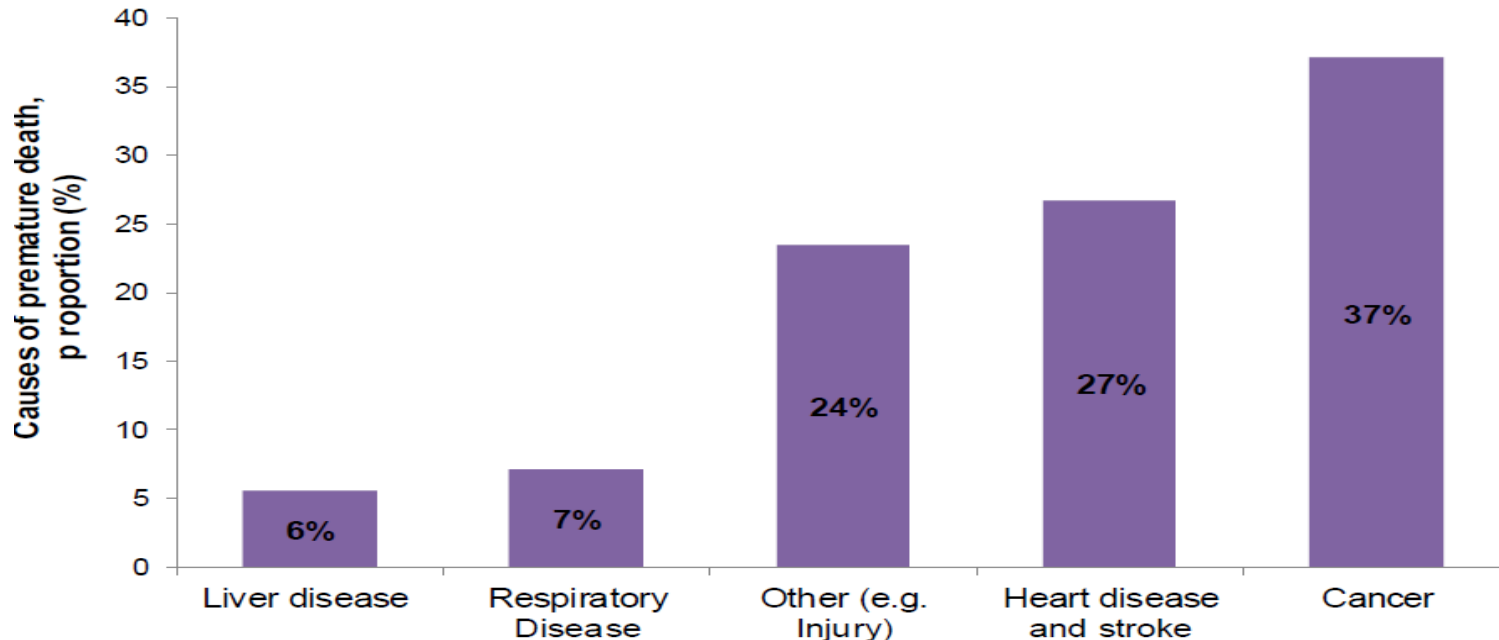
Premature Mortality by Disease

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

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

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

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

Key Health Challenges in Brent

Physical Activity and Diet

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

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

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

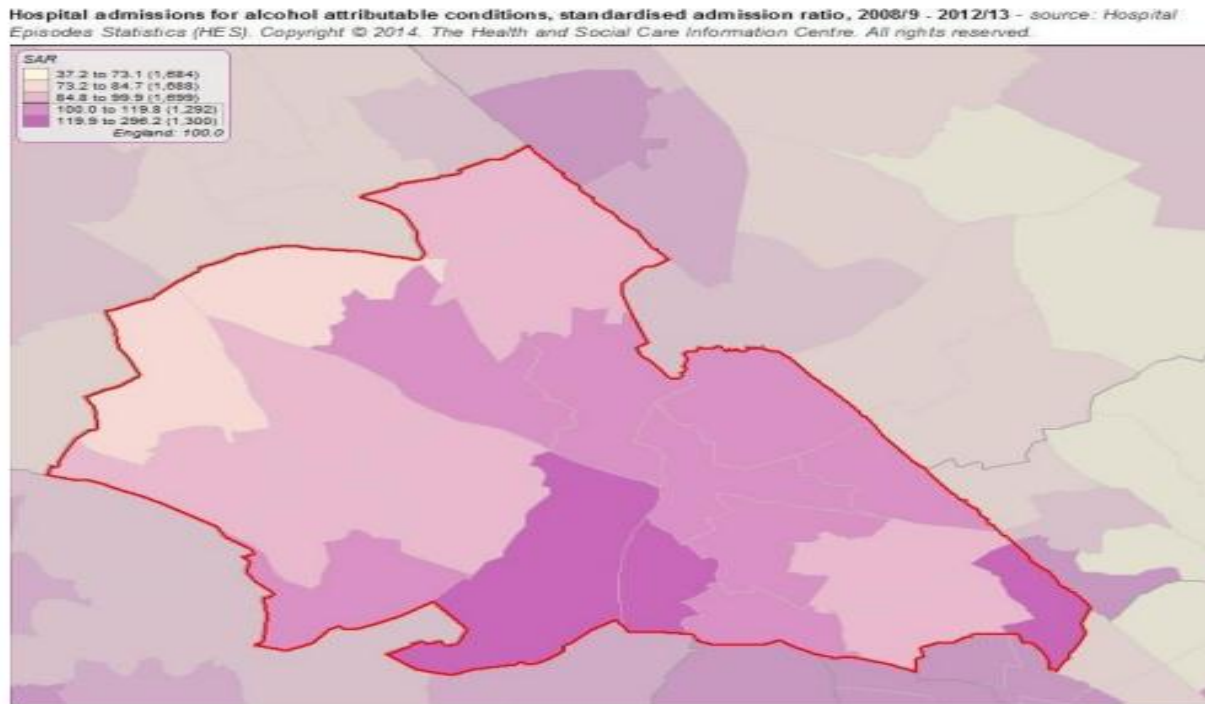
Key Health Challenges in Brent

Alcohol Use

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

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

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Hospital admissions for alcohol attributable conditions. Source: HES.

Key Health Challenges in Brent

Social Isolation

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

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

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

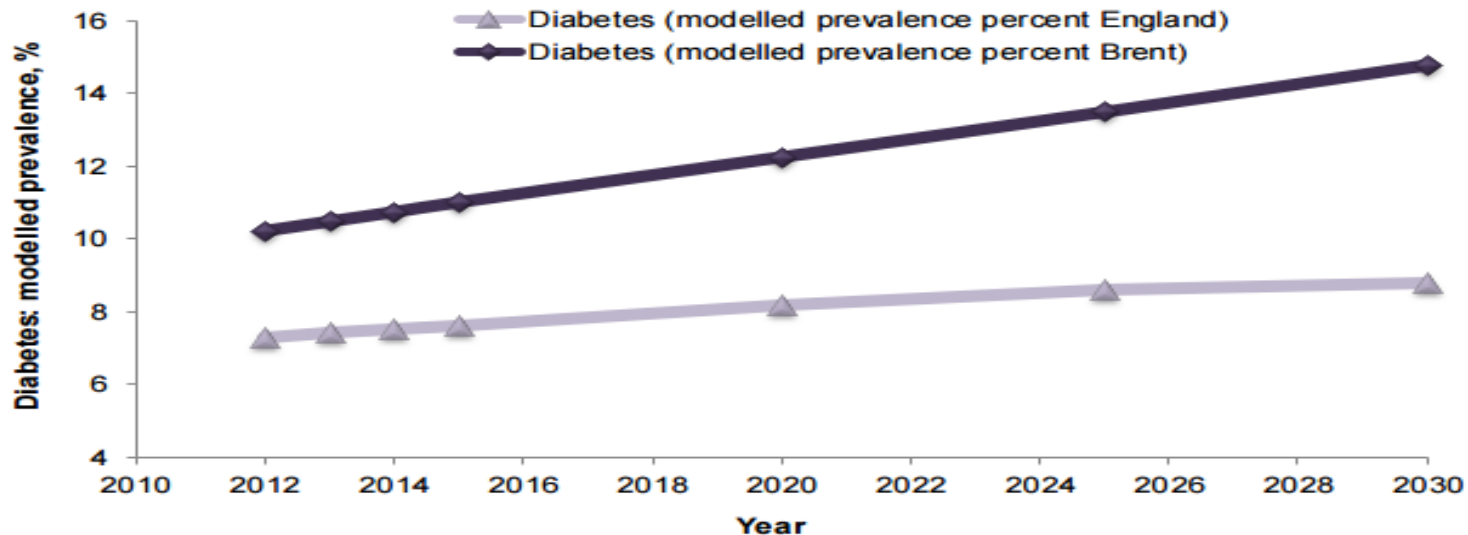
Key Challenges in Brent

Type 2 Diabetes

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

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

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

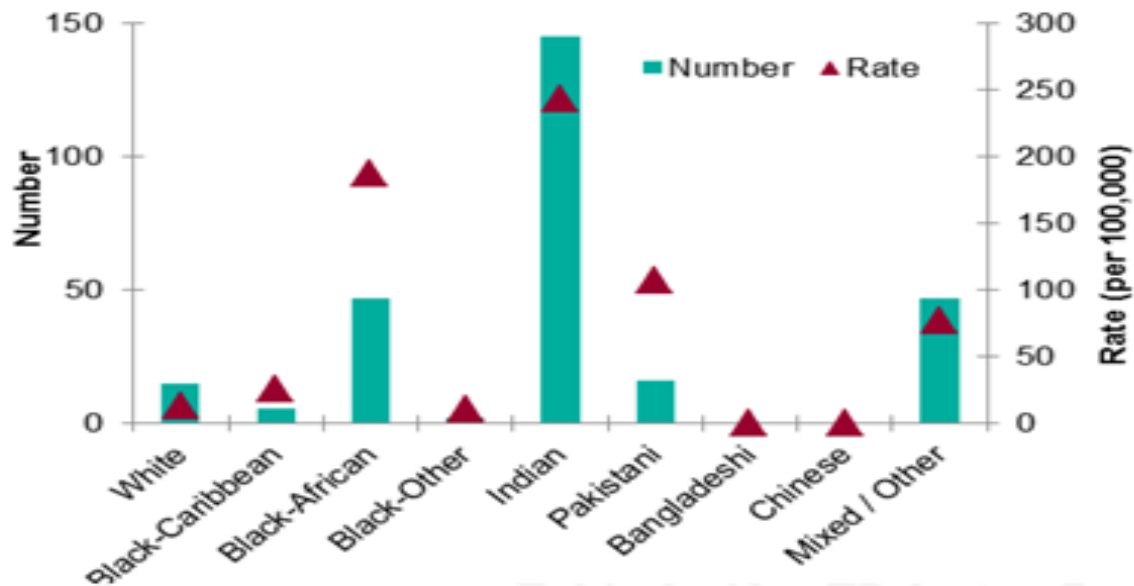
Key Health Challenges in Brent

Tuberculosis (TB)

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

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

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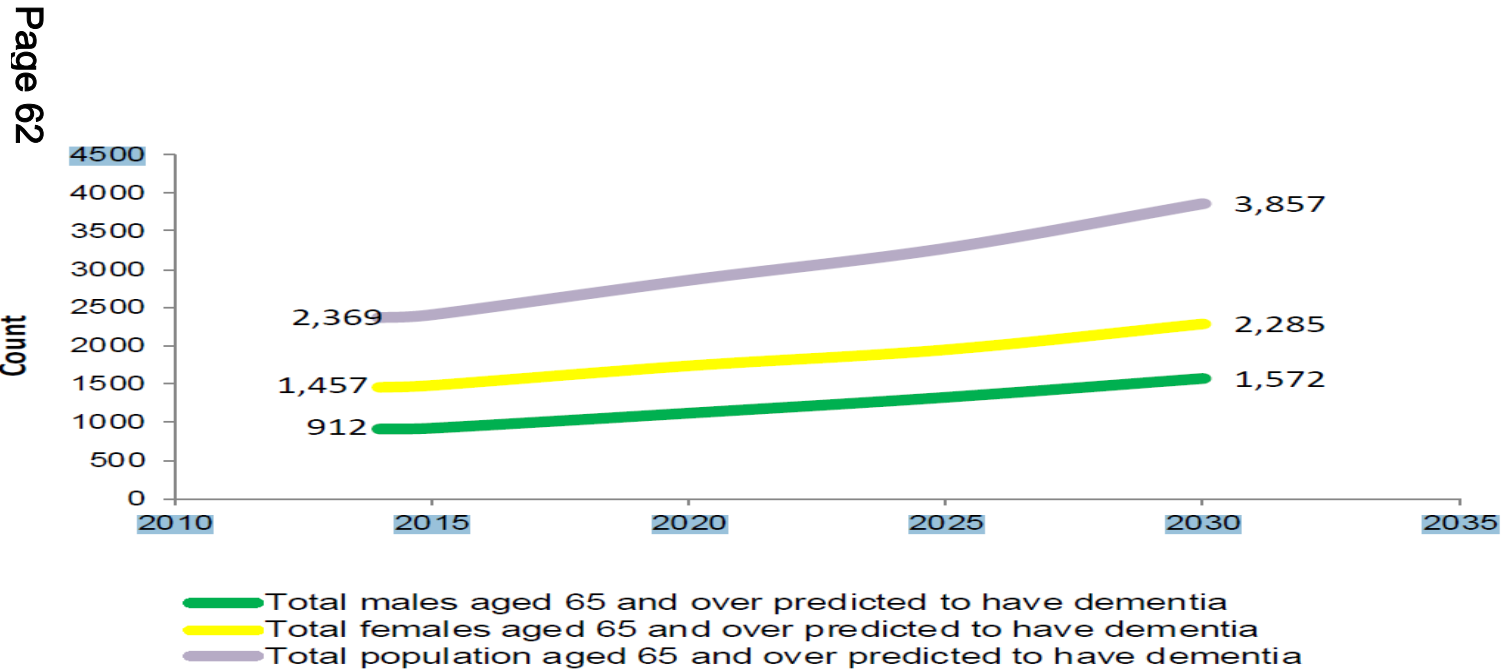
PHE, Brent TB Profile, 2013

Key Health Challenges in Brent

Dementia

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

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

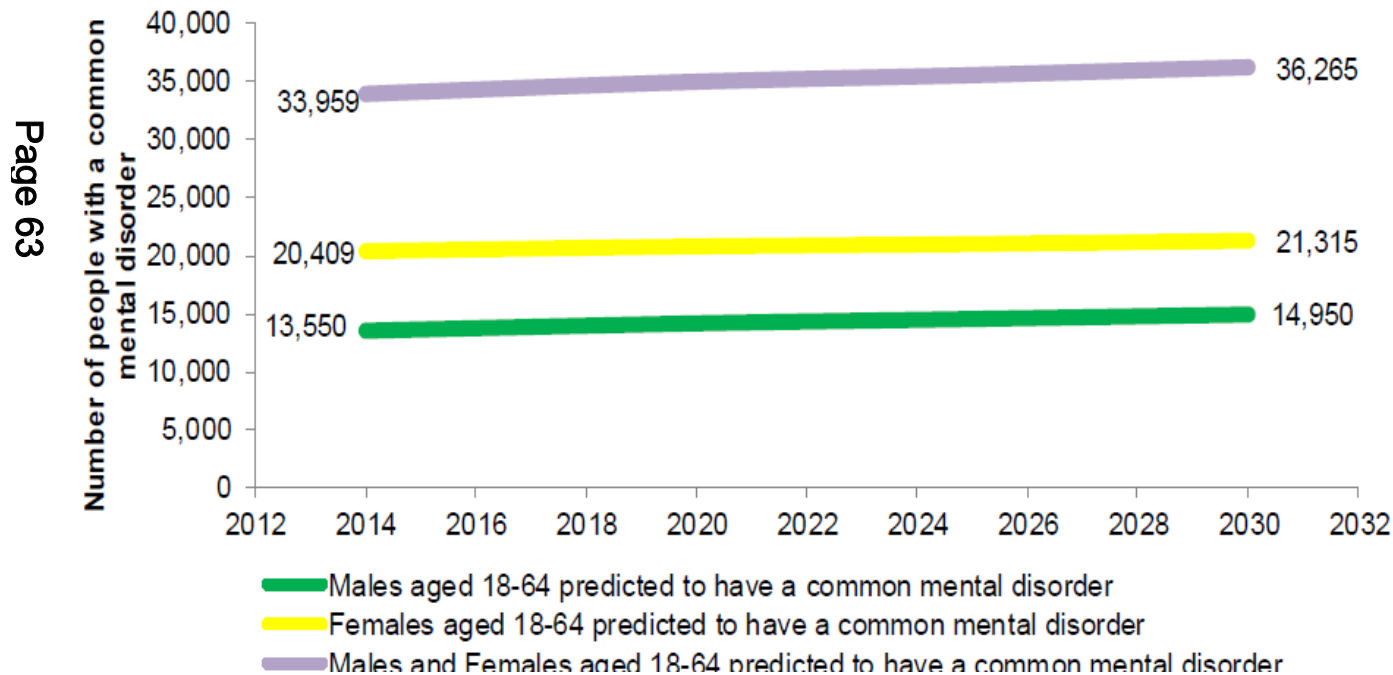


Key Health Challenges in Brent

Common Mental Health Disorders (CMD)

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

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



Key Health Challenges in Brent

Child Health

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

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

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

- Hospital admissions in Brent due to self-harm were lower than the England average in 2013/14 among individuals aged 10 to 24 years.
- The rate of young people aged under 18 years who were admitted to hospital as a result of a condition wholly related to alcohol (e.g. alcohol overdose) in 2011/12 - 2013/14 was 16.8 per 100,000. This was lower than the England average rate (40.1 per 100,000) of the population aged under 18 years.

Progress & Achievements Over the Last 12 months

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

Commissioning Intentions by STP delivery area

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Part 2 - Index of Brent CCG Commissioning Priorities

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

Delivery Area 1 – Radically upgrading prevention and wellbeing

- (a) Children’s Acute & Community Services
- (b) Digital

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

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

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

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

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

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

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

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

Other supporting areas

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

Delivery Area 1 – Radically upgrading prevention and wellbeing

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

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1a) Acute and Community Children's Services

Strategic Aim

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

Rationale

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

	Commissioning/ Contracting Change	Impact
Maternity and Children Page 69	<p>Improving the health and wellbeing of children in Brent and reduce inequalities in outcomes as part of an integrated multi-agency approach to supporting and empowering families.</p> <p>Working with Public Health to develop local action plans to reduce childhood obesity</p>	<ul style="list-style-type: none"> • Reduced infant mortality • Improved parenting skills • Reduced accidents to pre-school children in the home
Children and Young People's Mental Health and Wellbeing	Mapping of community assets and needs locally to analysis children and young people's health requirements	<ul style="list-style-type: none"> • To enable us to improve the services we commission locally
Looked After Children	Promoting and improving health outcomes for children and young people in care	<ul style="list-style-type: none"> • Children and Young People are enabled to participate in decisions about their healthcare
SEND	A clearer focus on high aspirations and on improving outcomes for children and young people. Identify the gaps within the current provision. Improve the Education, Health and Care Planning process, and align the commissioning of therapy services, including Speech And Language Therapy.	<ul style="list-style-type: none"> • Ensure effective progression routes are in place so young people can achieve good outcomes. • More joint up care through Education, Health and Care Plans
Young Carers	Working with partners to improve the identification of young carers, and to update the joint Carers Strategy.	<ul style="list-style-type: none"> • More young carers identified and supported as Children in Need

1b) Digital

Description

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

Strategic Aim

This will enable the national ‘Paperless by 2020’ vision and the digital golden thread of the STP

Rationale

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

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	Commissioning/ Contracting Change	Impact
Planned for Year 1	<ul style="list-style-type: none"> • Continued roll out of the Whole Systems Dash board in general practice • Start work on the enhanced Summary Care Record 	<ul style="list-style-type: none"> • Improve children’s mental and physical health and wellbeing through helping coordinate care for children and young people and identify vulnerable patients
Planned for Year 2	Taking forward the enhanced Summary Care Record and initiating the take-up through supporting patients with long-term conditions.	

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

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

2a) Long-Term Conditions (LTCs)

Description

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

Strategic Aim

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

Rationale

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

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	Commissioning/ Contracting Change	Impact
Planned for Year 1	<ul style="list-style-type: none"> Mobilisation of National Diabetes Treatment & Care Programme if application is successful Extend diabetes dashboards to other LTCs, improving primary care awareness of variability and performance Increasing COPD diagnosis/pick up rate through more proactive screening of symptomatic smokers and reducing variability in uptake of pulmonary rehabilitation Explore tele-medicine to support the management of LTCs 	<ul style="list-style-type: none"> Reduction in progression from non-diabetic hyperglycaemia to Type 2 diabetes Reduction in diabetes-related CVD outcomes: CHD, MI, stroke/TIA, blindness, ESRF, major and minor amputations Improved COPD diagnosis rate
Planned for Year 2	<ul style="list-style-type: none"> Development of Right Breathe respiratory portal – 'one-stop-shop' to support decision-making for professionals and patients for asthma and COPD Technology to promote self-management and peer support for people with LTCs Develop a strategy/clinical pathway for the management of hypertension ensuring alignment with Stroke services 	<ul style="list-style-type: none"> Patients receive timely, high quality and consistent care in line with best practice pathways Increased patient awareness of self-care and Reduction in hospital attendance

2b) Rightcare

Description

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

Strategic Aim

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

Rationale

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



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	Commissioning/ Contracting Change	Impact
Planned for Year 1	Mobilise plans for diabetes, MSK, cancer and respiratory.	<ul style="list-style-type: none"> • Diabetes: improvement in Hba1c management; reduction in elective spend • MSK: Improvement in EQ5D score for hip and knee replacement • Respiratory: Improvement in prevention & management of asthma and COPD
Planned for Year 2	Mobilise plans for CVD and neurology Continue plans for cancer	<ul style="list-style-type: none"> • Cancer: improve early detection & prevention • CVD & Neurology: Improvement in outcomes in line with findings of the reviews

2c) Review of Brent Community Services

Strategic Aim

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



Rationale

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

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	Commissioning/ Contracting Change	Impact
Planned for Year 1	<p>Working in collaboration with existing providers to agree and implement new specifications or service improvements</p> <p>Maximise opportunities in which providers can work together</p> <p>Jointly identify and agree ways in which prevention opportunities can be raised making every patient contact count</p> <p>We will work with community groups to take health messages back to local people which will support self management and prevention.</p>	<ul style="list-style-type: none"> Reducing Emergency Department attendance Managing demand for acute services Long term condition management, prevention & promotion of self care
Planned for Year 2	<p>Year 2 will focus on developing an ACP model to be potentially rolled out by Brent CCG supported by health and local authority commissioners</p>	

2d) Digital

Description

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

Strategic Aim

This will enable the national ‘Paperless by 2020’ vision and the digital golden thread of the STP

Rationale

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

Page 75	Commissioning/ Contracting Change	Impact
Planned for Year 1	<ul style="list-style-type: none"> • Working to deliver aspirational KPIs for use of technology to ensure easier access for patients in primary care including consultations by email and use of online prescription services • Further encourage the take-up of Patient Online and to work with NWL CCGs to look at online verification models to support patients and practices. 	<ul style="list-style-type: none"> • Support people who are mainly healthy to stay mentally and physically well, enabling and empowering them to make healthier choices and look after themselves
Planned for Year 2	<ul style="list-style-type: none"> • Supporting hard to reach groups with the use of telehealth and telecare. • GP Federation to develop Information Governance arrangements (Caldicott Guardianship and Data Controller) to support collaborative working across practices. • GP Federations to support work with practices to use the ‘data controller tool’ (from NHSE London) to help manage Information Sharing Agreements. 	<ul style="list-style-type: none"> • Reduce Social Isolation

2d) Digital continued

	Commissioning/ Contracting Change	Impact
Planned for Year 1	<ul style="list-style-type: none"> • Further roll out of Patient Activation Measure (PAM) within GP practices - a patient led measure of knowledge, skills and confidence in manage in their LTCs • Promotion of Anglia ICE for pathology and radiology requests and reports, building on pilot in Hillingdon and Hounslow 	<ul style="list-style-type: none"> • Reduce unwarranted variation in the management of long term conditions
Planned for Year 2 Page 76	<ul style="list-style-type: none"> • Advance the use Anglia ICE as the default tool to support ordering of diagnostics for primary care with a view to going paperless. • Majority of patients with an identified Long Term Condition receive a personalised care plan and named care professional by 2019. 	<ul style="list-style-type: none"> • Reduce unwarranted variation in the management of long term conditions
Planned for Year 2	<ul style="list-style-type: none"> • Improve data reporting of unwarranted variation in order to target resources to reduce it. • Encourage general practice to keep an up-to-date register of people for the top disease areas • Improving care pathways and electronic communication between primary and secondary care to reduce unwarranted variation • Advance the use Anglia ICE as the default tool to support ordering of diagnostics for primary care with a view to going paperless • Increase the utilization of e-Referrals in line with the national average as the standard process for referrals. • All primary care practices to support receiving digital correspondence, documents and information as the preferred method from NHS and Care Organizations. 	<ul style="list-style-type: none"> • Reduce health inequalities and disparity in outcomes for the top 3 killers: cancer, heart diseases and respiratory illness

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

- (a) Primary Care Transformation
- (b) End of Life Care
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- (d) Whole Systems Integrated Care
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- (f) Unified Frailty Older People
- (g) Rapid Response Service
- (h) Integrating Transfer of Care
- (i) Falls Prevention & Bone Health
- (j) Digital

3a) Primary Care Transformation

Strategic Aim

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

Rationale

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

	Commissioning/ Contracting Change	Impact
Planned for Year 1 Page 78	<p>Patient Access</p> <ul style="list-style-type: none"> • Work with GP practices, NHSE and Estates to ensure areas of population growth can access GP services. • Review and re-launch the Brent GP Access Hubs to cover 8-8, over 7 days, tackle poor utilisation & high DNAs, ensure offer includes all local enhanced services, communicate this effectively to patients and carers. • Review use of technology to improve access eg online appointment booking, telephone consultations, e-consultations, e-prescriptions. <p>Provider Resilience</p> <ul style="list-style-type: none"> • Design & deliver a framework of support for practices in need/at risk. Focus on frontline practice solutions and include training/ OD support for those seeking to strengthen quality & the offer to patients. • Design & deliver a small number of 'at-scale' (Brent/NWL) schemes to tackle challenges such as staff recruitment/retention and efficient administration. • Work with Practices, Networks & the Federation to develop primary care infrastructure – eg new clinical roles (for example pharmacists in general practice), management capacity, shared systems & processes, <p>Quality & Outcomes</p> <ul style="list-style-type: none"> • Review delivery of locally enhanced services and out of hospital contracts– ensure patient access, maintain/improve quality and reduce variation. • Identify opportunities to further develop local enhanced services in line with local needs and the GPFV and STP. 	<ul style="list-style-type: none"> • All 369,166 registered patients have better access to primary care 8am-8pm 7 days a week. • All 369,166 registered patients have access to enhanced services such as Phlebotomy at their own or a neighbouring GP practice. • GP practices feel equipped and supported to deliver frontline care. • Reduced variation in clinical outcomes and patient satisfaction between the 62 practices in Brent. • More care available closer to home and out of hospital.

3b) End of Life (EOL) Care

Description

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

Strategic Aim

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

Rationale

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



Page 79	Commissioning/ Contracting Change	Impact
Planned for Year 1	Improve identification and planning for last phase of life through: <ul style="list-style-type: none"> Identifying the 1% of the population who are at risk of death in the next 12 months by using advanced care plans Identifying the frail elderly population using risk stratification and flagging patients to be offered advanced care planning. Improving interoperability of Coordinate my Care with other systems including primary care Review all contracting arrangement with a view to integrating service provision	<ul style="list-style-type: none"> All patients in their last phase of life are identified Patients identified as being in their last phase of life have an advanced care plan. Reduction in non-elective admissions for this patient cohort. Reduce the number of admissions from care homes
Planned for Year 2	Implement the findings of the contracts review as appropriate	<ul style="list-style-type: none"> Every eligible person will have a care plan with a fully implemented workforce training plan Meet the national upper quartile of people dying in the place of their choice

3d) Whole Systems Integrated Care (WSIC)

Description

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

Strategic Aim

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

Rationale

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

	Commissioning/ Contracting Change	Impact
Page 80 Planned for Year 1 & 2	<ul style="list-style-type: none"> • Self Care – evaluate the impact of Care Navigators within the model of care; seek to increase the number of Care Navigators and align volunteer capacity. • Aligning community based services – engage community based teams and social care in the multidisciplinary complex patient management groups (CPMG) and formalise their alignment to these teams via implementation of the Community Services Review • Proactively addressing the root cause of admissions/readmissions – support providers to develop and make use of available data to target areas of greatest patient need within Brent. Ensure contract management processes evidence proactivity and improved outcomes. • Training & OD – align available resources to a shared training plan that develops frontline staff, operational managers and leaders to deliver modern Primary Care and integrated care. • Development of an ACP/MCP – progress the development of the Brent Care Provider Forum, aligned to STP delivery plan & governance, produce detailed scope and deliverables, embed in individual contracts through commissioning and contract variation, explore opportunities for joint approaches to assurance and for joint accountability for example through risk and reward share. 	<ul style="list-style-type: none"> • All care planned patients who need it have access to a Care Navigator to support their self-care. • All parts of the health and care system are represented in the WSIC multidisciplinary teams, providing a doorway to wider teams and services in their parent organisation. • Reduced number of patients having 2 or more non-elective admissions including reduction in readmissions. • Staff survey demonstrates integrated working between frontline staff, operational managers and leaders

3e) Care Home & High Risk Housebound Patients

Description

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



Strategic Aim

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

Rationale

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

	Commissioning/ Contracting Change	Impact
Planned for Year 1 & 2	<p>Service development & improvement – review work to date, align strategic objectives and key components of the model of care, improve quality, reduce variation in provision and improve key outcomes</p> <p>Pharmacy Support - consider the case for investment in additional pharmacy support and medicines management and develop links to Pharmacists working at practice or network level where relevant.</p> <p>Integration – consider the benefits of an integrated approach to commissioning and provision locally. Address key challenges and barriers to integrated working and coordinated care for example cross-border challenges. Include work with partners in the North West London STP ‘footprint’. Consider alignment to development of an ACP/MCP where there would be benefits for this patient group.</p>	<ul style="list-style-type: none"> • Reduction in LAS call outs and non-elective admissions from the 1,220 (approx) beds in Brent. • Integrated and coordinated care for housebound patients • Improved quality of care for patients in nursing and residential homes

3f) Unified Frailty Older People Pathway

Description

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

Strategic Aim

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

Rationale

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



	Commissioning/ Contracting Change	Impact
Planned for Year 1	<ul style="list-style-type: none"> Comprehensive Geriatric Assessment on admission Commissioning of Older Persons Assessment Liaison Service (OPALS) following sign off of a service specification Developing a case for a dedicated frailty unit Align services which support the frailty pathway (WSIC/Rapid Response /Care Home strategy) 	<ul style="list-style-type: none"> 100% of patients receive an assessment 100% of patients have an Estimated Date of Discharge Reduction in Length of Stay Reduction in excess bed days
Planned for Year 2	<ul style="list-style-type: none"> Opportunity to develop the ACP model for Care of Elderly Commission a frailty unit Improve the quality of services for patients, provide value for money by ensuring care is delivered in the most appropriate setting. Once patients have completed their Acute episode they are transitioned into the appropriate service as soon as possible. 	<ul style="list-style-type: none"> 100% of patients receive an assessment 100% of patients have an Estimated Date of Discharge Reduction in Length of Stay Reduction in excess bed days

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3g) Rapid Response Service

Description

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

Strategic Aim

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

Rationale

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

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

	Commissioning/ Contracting Change	Impact
Planned for Year 1	<ul style="list-style-type: none"> Identifying the best parts of each model and move to a consistent specification as far as possible Reducing non-elective admissions and reducing length of stay through early supported discharge Enhancing integration with other service providers Expanding the scope of the service to reduce the very short stay admissions (0-1 day) 	<ul style="list-style-type: none"> Increase in referrals into the service Increase in the number of non-elective admissions and A&E attendances avoided Reduction in short stay admissions.
Planned for Year 2	<ul style="list-style-type: none"> Moving towards joint commissioning with local authority Creating additional capacity to enable people to be cared for in less acute settings. Operating as part of an integrated Accountable Care Partnership model 	

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

Description

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

Strategic Aim

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

Rationale

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

	Commissioning/ Contracting Change	Impact
<p>Key deliverables in line with STP 5 year plan</p> <p><i>Phased approach to implementation to be developed and agreed.</i></p>	<ul style="list-style-type: none"> • An agreed integrated acute and social care model of care • An integrated health and social care acute transfer of care team • A single point of access for transfer of care across NWL boroughs • A needs based assessment form • Agreed common dataset in relevant contracts to measure, target and identify improvement areas for transfer of care across NWL • Information sharing and joint working agreements • Shared IT platform to share information across health social care 	<ul style="list-style-type: none"> • A reduction in inappropriate referrals to community services; • Reduced duplication of effort as staff will no longer need to complete different forms or chase hospital based staff for additional information in order to accept referrals into a service; • A reduction in Delayed Transfers of Care and Length of Stay • Improved quality of patient care and patient experience.

3i) Falls Prevention & Bone Health

Description

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

Strategic Aim

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

Rationale

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

	Commissioning/ Contracting Change	Impact
Planned for Year 1	Create a robust pathway for patients who have fallen or at risk of falling. The new service will deliver 2 falls clinics per week and 4 falls classes across our locality areas.	<ul style="list-style-type: none">Reduce the number of readmissions for falls, reduce number of hip fractures from baseline.

3j) Digital

Description

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

Strategic Aim

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

Rationale

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

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	Commissioning/ Contracting Change	Impact
Planned for Year 1	<ul style="list-style-type: none"> • Improving access through a plan to implement 8am-8pm working in general practice including extended IT support • Increase the utilization of e-Referrals in line with the national average as the standard process for referrals. • Promotion of Anglia ICE for pathology and radiology requests and reports, building on pilot in Hillingdon and Hounslow 	<ul style="list-style-type: none"> • Ensure people access the right support in the right place at the right time
Planned for Year 2	<ul style="list-style-type: none"> • All primary care practices to support receiving digital correspondence, documents and information as the preferred method from NHS and Care Organizations. • Advance the use Anglia ICE as the default tool to support ordering of diagnostics for primary care with a view to going paperless. 	<ul style="list-style-type: none"> • Ensure people access the right support in the right place at the right time
Planned for Year 1 and 2	<p>Increase the utilization of Co-ordinate My Care to support older people and enable sharing core information between urgent and emergency services and support End of Life Care.</p>	<ul style="list-style-type: none"> • Improve the quality of care for people in their last phase of life and enable them to die in their place of choice

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

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

4a) The Like Minded strategy

Increasing intensity of need



Five work streams

1 Common mental disorders

- Increasing the numbers of people using talking therapies
- Supporting people to maintain and regain employment

2 Serious and long-term mental health needs

- Increasing the numbers of people able to live independently
- Improving primary care support
- Improving evidence-based care in community teams
- Increasing the alternatives to inpatient care

3 Children and Young People's mental health and wellbeing

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

4 Wellbeing and prevention

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

5 Other projects:

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

Living well in the least restrictive setting

4b) Perinatal mental health

Description

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

Strategic Aim

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

Rationale

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

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

4c) Early Intervention in Psychosis

Description

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

Strategic Aim

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

Rationale

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

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	Commissioning/ Contracting Change	Impact
Planned for Year 1	<p>Expansion of existing service, and development of BME peer support services</p> <ul style="list-style-type: none"> • Specific focus on under 18s detection • Culturally sensitive BME peer support alongside bio-social models of care, to develop support and challenge stigma within local communities • Development of talking therapies (Cognitive Behavioural Therapy) to help manage symptoms of psychosis 	<ul style="list-style-type: none"> • Identification and awareness raising of 'at risk mental state' symptoms, and challenging stigma around mental illness. • Helping different communities develop their own positive emotional response to help people recover from acute episodes of psychosis and stay well.
Planned for Year 2	<p>Consider Primary Care Mental Health Service and peer support re-procurement</p> <ul style="list-style-type: none"> • Measure impact of service changes • Consider further expansion of BME peer support 	<p>More people from BME groups accessing talking therapies and gaining support in their local community to stay well</p>

4d) Conduct disorder

Description

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

Strategic Aim

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

Rationale

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

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	Commissioning/ Contracting Change	Impact
Planned for Year 1	We will work with our provider partners to develop integrated CAMHS pathways to support children with conduct disorders and their parents and carers and ensure that services delivered by local partners respond to NICE guidance relating to conduct disorders.	<ul style="list-style-type: none">• Early identification of children and young people with conduct disorder• Early intervention and provision of targeted mental health support for children displaying significant behavioural difficulties and conduct disorder
Planned for Year 2	We will strengthen capacity and capability in Tier 2 provision predominantly around Primary Care Mental Health Workers	Reduction in referrals to specialist child and adolescent mental health services for conduct disorders and associated antisocial behaviour which will improve children and young people's life chances/opportunities.

4e) Dementia

Description

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

Strategic Aim

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

Rationale

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

	Commissioning/ Contracting Change	Impact
Planned for Year 1	Develop a primary care dementia service that includes: early diagnosis in a timely manner, communicating the diagnosis well to the person with dementia and their family, advising on appropriate treatment, information, care and support after diagnosis. To consider joint commissioning options with Brent Council.	<ul style="list-style-type: none"> • Reductions in residential, nursing and care home placements • Improved quality of life of people with dementia following early diagnosis and intervention • Positive effects on the quality of life of family carers following early diagnosis and intervention
Planned for Year 2	Remodelling of the Secondary Care Memory Assessment services to support more complex presentations	Early assessment and diagnosis in primary and secondary care settings. Early identifying of the right treatment and support to maintain a good quality of life

4f) Learning disabilities

Description

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

Strategic Aim

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

Rationale

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

Page 53	Commissioning/ Contracting Change	Impact
Planned for Year 1	Jointly commissioned integrated community learning disability team (CTPLD) to deliver on and achieve transformation through prevention and wellbeing support, timely access to assessment and treatment and improved patient experience	Reduced reliance on in-patient care and facilitated early discharge from in-patient care
Planned for Year 2	Re-specifying and remodelling of the local in-patient Learning Disabilities unit	Improved quality of care, clinical effectiveness and outcomes for patients. Increased patient safety and improved patient experience. Reduced lengths of stay

4g) Digital

Description

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

Strategic Aim

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

Rationale

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

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	Commissioning/ Contracting Change	Impact
Planned for Year 2	All patients with an identified Long Term Condition receive a personalised care plan and named care professional by 2019.	<ul style="list-style-type: none">• Reduce the gap in life expectancy between adults with serious and long term mental health needs and the rest of the population

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

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

5a) Urgent & Emergency Care

Description

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

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

Strategic Aim

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

Rationale

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

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

5b) Inpatient Model of Care

Description

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

Strategic Aim

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

Rationale

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



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	Commissioning/ Contracting Change	Impact
Planned for Year 1	Implementation of new models of care in acute trusts. Models will be defined following pilots in November 2016.	<ul style="list-style-type: none"> 90% of NEL admissions will receive consultant-directed reviews within the defined timelines every day of the week

5c) Radiology and Diagnostics

Description

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

Strategic Aim

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

Rationale

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



	Commissioning/ Contracting Change	Impact
Planned for Year 1	90% of inpatient radiology diagnostics undertaken & reported within 24hrs of request	<ul style="list-style-type: none"> Reduction in length of stay for patients receiving a radiology diagnostic test by 0.5 days on average, leading to release of up to 30 inpatient beds
Planned for Year 2	Implementation of phase 1 of the NWL shared reporting network that permits reporting to be partially shared across NWL trusts	<ul style="list-style-type: none"> Reduction in % reporting outsourced and efficiencies in reporting across NWL (OBC currently in development)

5d) Length of Stay - Transfers of Care

Description

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

Strategic Aim

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

Rationale

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

Page 99	Commissioning/ Contracting Change	Impact
Planned for Year 1	<ul style="list-style-type: none"> • Deliver single points of access for non-bedded community services, with the potential to increase to wider community services in Year 2. • Deliver of an IT solution to allow electronic sharing of information between health and adult social care providers • To work in partnership with initiatives across the health and adult social care system to improve transfer of care and align approaches • Development of a system wide dataset to consistently measure effective Transfers of Care across the system 	<ul style="list-style-type: none"> • A reduction in inappropriate referrals to community services • Reduced duplication of effort as staff will no longer need to complete different forms or chase hospital based staff for additional information in order to accept referrals into a service • A reduction in Delayed Transfers of Care and Lengths of Stay • Improved quality of patient care and patient experience
Planned for Year 2	TBD- potential to expand Single Point of Access to cover Bedded Community Services, Social Care, etc.	

5e) Maternity

Description

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

Strategic Aim

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

Rationale

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



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

5f) Paediatric High Dependency Unit (HDU) standards

Description

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

Strategic Aim

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

Rationale

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

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	Commissioning/ Contracting Change	Impact
Planned for Year 1	Providing care that is holistically connected across primary and secondary care; developing a relationship between paediatric consultants and GPs	Maximise staff contribution to transforming the way services are delivered: <ul style="list-style-type: none">• Transforming GP engagement in paediatric referrals• Advice and support network between primary and secondary care

5g) Referral Optimisation

Description

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

Strategic Aim

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

Rationale

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



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	Commissioning/ Contracting Change	Impact
Planned for Year 1	Continue to develop Brent Referral Optimisation System (BROS) for GP referrals and commence optimisation for internally generated referrals within LNWHT, Imperial and RFL.	<ul style="list-style-type: none">• Around 140,000 referrals per annum triaged, 10% reduction in unnecessary referrals• More consistent GP referral standards
Planned for Year 2	Continue to embed and evolve BROS to new specialties as clinical behaviour changes and training needs evolve.	<ul style="list-style-type: none">• Reduction in the rate of referral growth• Consistent referral standards across Brent.

5h) Community Gynaecology Service

Description

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

Strategic Aim

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

Rationale

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

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

5i) Community Dermatology Services

Description

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

Strategic Aim

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

Rationale

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

	Commissioning/ Contracting Change	Impact
Planned for Year 1	<ul style="list-style-type: none">• Review current service with a view to mobilising a new dermatology service with appropriate consultant support in the community.• Review finance & contracting model	<ul style="list-style-type: none">• Reduction in number of outpatient referrals into hospital• Reduction in number of onward referrals from community service to hospital

5j) Central Middlesex Hospital Redesign

Description

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

Strategic Aim

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

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

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



Rationale

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

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

5k) Digital

Description

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

Strategic Aim

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

Rationale

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



	Commissioning/ Contracting Change	Impact
Planned for Year 1	<ul style="list-style-type: none"> • Promotion of Anglia ICE for pathology and radiology requests and reports, building on pilot in Hillingdon and Hounslow • GP Federations to support work with practices to use the 'data controller tool' (from NHSE London) to help manage Information Sharing Agreements. • Increase the utilization of e-Referrals in line with the national average as the standard process for referrals. • Review benefits of patient apps and further development 	<ul style="list-style-type: none"> • Improve consistency in patient outcomes and experience regardless of the day of the week that services are accessed

Other supporting areas

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

Other a) Continuing Care and Personal Health Budgets

Description

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

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

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

Strategic Aim

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

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

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

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

Rationale

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

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

Other a) Continuing Care and Personal Health Budgets

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

Impact

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

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

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

Other b) Medicines Optimisation

Description

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

Strategic Aim

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

Rationale

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



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	Commissioning/ Contracting Change	Impact
Planned for Year 1 & 2	<p>Develop and implement the 2 year prescribing QIPP plan to stay within budget and reduce wastage.</p> <p>Improve the quality and safety of medicines use and self-management by patients</p> <p>Consider the wider role to be played by pharmacy and medicines management in new models of care.</p>	<ul style="list-style-type: none">• Delivery of QIPP plan• Improved patient experience with their medicines; national and local guidance implemented• Partnership working with relevant stakeholders to improve patient care, new roles in primary care and improved multidisciplinary working.

Other c) Carers

Description

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

Strategic Aim

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

Rationale

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

Page 111	Commissioning/ Contracting Change	Impact
Planned for Year 1 & 2	<p>Work with local communities and voluntary sector to develop peer-led social prescribing targeted at carers</p> <p>Increase the accessibility of advice on building mental and emotional resilience, and access to more talking therapies for carers</p> <p>Working with partners to improve the identification of young carers, and to update the joint Carers Strategy.</p>	<ul style="list-style-type: none"> • Increase the number of carers supported • Increase the number of carers below the threshold for statutory support who feel confident to manage their own health and wellbeing • More young carers identified and supported as Children in Need

Other d) Estates

Description:

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

Strategic Aim:

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

Rationale:

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



	Commissioning/ Contracting Change	Impact
Planned for Year 1	<ul style="list-style-type: none"> Deliver Local Estate Strategy for Brent to support the delivery of the Five Year Forward View and 'One Public Estate' vision Deliver a Primary Care Investment Plan which analyses the suitability of the current estate and sets out how the estate will need to change to meet the needs of the new model of care Maximise use of existing estate and reduce void costs at Willesden Centre for Health and Care & Monks Park Deliver primary care from CMH Hub + 	<ul style="list-style-type: none"> Realise substantial financial benefit by maximising use of land & premises. Maximising capital receipts from land sales where one public estate projects offer joint opportunities. Reduce recurrent premises costs through commissioning arrangements Create additional capacity and improve primary care service offering for c10,000 patients in the CMH locality
Planned For Year 2	<ul style="list-style-type: none"> Reducing HQ costs at Wembley Centre for Health and Care by consolidating the CCG space at Wembley to reduce the cost of the management accommodation, freeing up space for local service delivery Delivery of Estates and Technology Transformation Fund (ETTF) schemes to improve access and delivery of Primary Care 	<ul style="list-style-type: none"> Minimise overhead costs of the CCG by implementing smarter working arrangements Improve access to primary care by maximising investment via ETTF and improvement grant funding.

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Engagement

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Public Involvement and Engagement

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

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

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

- Page 114
- 27 April: Health Partners Forum (120 patients)
 - 1 June: Brent Governing Body Seminar
 - 7 June: Brent Health & Well-Being Board
 - 5 July: Adult Social Care Provider Forum update (150 providers)
 - 13 July: Brent GP Forum
 - 27 July: LNWHT AGM
 - 2 September: Bheard
 - 13 September: Brent Adult Social Care's Annual Participation Day (150 residents)
 - 21 September: Brent Overview and Scrutiny Committee
 - 18 October: face to face meeting with Brent Patient Voice
 - 19 October: Health Partners Forum (85 attendees)
 - Ongoing online consultation on the STP – feedback summary included in the October submission
 - 24 November: Mental Health Peer Support public event
 - 25 November: Carers' Rights Day
 - To 30 November: On-line resident survey, specifically around the Commissioning Intentions coordinated by Brent Healthwatch

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

Ongoing Consultation

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

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

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

Upgrading Prevention & Well-being

You Said

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

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We did

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

Eliminating variations & improving long term conditions

You Said

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

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We did

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

Achieving better outcomes and experiences for older people

You Said

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

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We did

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

Improving outcomes for children and adults with mental health needs

You Said

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

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We did

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

Improving Acute services & quality of life

You Said

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

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We did



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

Statement from the Brent Health and Wellbeing Board

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

Cllr Krupesh Hirani, Chair of Brent Health and Wellbeing Board

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 <p>Brent Clinical Commissioning Group</p> 	<p>Health and Wellbeing Board 24 January 2017</p> <p>Report from Healthwatch Brent</p>
<p>For endorsement Wards Affected: ALL</p>	
<p>Healthwatch Brent Community Chest update</p>	

1.0. Summary

- 1.1. Healthwatch Brent is the independent voice through which Brent residents can share their experiences of using health and social care services.
- 1.2. CommUNITY Barnet is commissioned by the London Borough of Brent to deliver the local Healthwatch contract.
- 1.3. The contract commenced from 1 July 2015 for an initial period of 12 months and then extended for a further 12 months. This report presents a summary of the projects funded through the Community Chest prepared by the Healthwatch Team.
- 1.4. The report is attached as an appendix for reference.

2.0. Recommendations

2.1. The Health and Wellbeing Board is asked to:

- Note the progress Healthwatch Brent has made in delivering the contract
- Note the contents of the report for information.

3.0. Context

- 3.1. Healthwatch Brent works with 11 of Brent's charity, voluntary and community organisations.
- 3.2. It is delivered by a Brent-based central core team, a partnership of Brent based voluntary and community organisations and a team of volunteers.
- 3.3. The work programme of Healthwatch Brent aligns to all five priorities of the Brent Health and Wellbeing board namely:
 - Giving every child the best start in life
 - Helping vulnerable families
 - Empowering communities to take better care of themselves

- Improving mental wellbeing throughout life
 - Working together to support the most vulnerable adults in the community
- 3.4. Healthwatch Brent is delivered on a Hub and Spoke model. The Hub is the first point of public access and delivered by the core team located in Wembley. The Spokes consist of two groups – the Healthwatch Brent Advisory Board whose role is to support the core team and shape the work programme around the needs of Brent residents. Membership of the Healthwatch Brent Advisory Board includes Age UK Brent, Brent User Group, Brent Patient Voice, Mosaic LGBT Young People’s Group, Community Health Action Trust.
- 3.5. The Promotion and Reach Partners with their strong and vibrant networks are able to cascade messages from Healthwatch Brent to local residents. The partners include: Ashford Place, Brent Carers’ Centre, Elders’ Voice, Jewish Care, Brent Mencap.
- 3.6. Our strategic priorities for Healthwatch Brent include:
- Encouraging greater participation in health and social care
 - Collecting evidence of increasing engagement with those residents from under-represented communities
 - Demonstrating that Brent residents feel more able to express their views and to report they are listened to
 - Showing how Healthwatch Brent has been able to make a constructive contribution to support and enable informed decision making through the representation of the authentic voice
 - Healthwatch Brent offers value for money
 - That Healthwatch Brent service offers added value
- 3.7 As part of our delivery, Healthwatch Brent committed £20,000 to establish a Community Chest which aimed to increase the capacity of local organisations to provide evidence based reports from less heard communities, increasing public awareness of Healthwatch Brent and increasing the number and range of views we gather.

Healthwatch Brent reserved £20,000 to create a Community Chest providing grants to local groups and organisations to enable them to –

- Increase awareness of the role of Healthwatch Brent;
- Support our work of reaching and engaging more people;
- Ensure there is input from seldom heard voices on health and social care issues;
- Provide support to small community groups to allow them to host events;
- Increase the capacity of local organisations to provide clear evidence that support good practice or the needs of a service group;

- Recognise and harness the expertise of local organisations;
- Support local organisations, if required, to produce quality reports; and
- Produce evidence based reports to Brent statutory partners, including –
 - Health and Wellbeing Board;
 - Health and Wellbeing Scrutiny
 - NHS Brent CCG boards and committees;

3.8 We created two grant programmes:

Large Grant Programme (maximum £3,000) to fund activities to support good practice or identify the needs of a service group. These applications were required to provide clear evidence of need and had to be approved by the Advisory Board.

Small Grants Programme (maximum £600) would raise awareness of the role of Healthwatch Brent. Applications have been approved by the Healthwatch Brent team.

3.9 To date 18 organisations successfully received funding from the Community Chest.

3.10 The key achievements include:

- Through the reports, the Community Chest has relayed the experiences of 291 Brent residents to key Brent forums such as the Health and Wellbeing Board.
- The role and activities of HWB have been presented to 550 new people, including how they can use HWB as a route to their experiences being heard by key decision makers.
- These 550 people have directly benefited from the wellbeing work of our partner organisations.
- The capacity of 11 local organisations was expanded to allow them to use their specialist knowledge of difference sections of Brent's diverse communities.

4.0. Financial Implications

4.1. There are no financial implications as all costs are within the current agreed contract.

5.0. Legal Implications

5.1. Healthwatch Brent was established through the Health and Social Care Act 2012 to give users of health and social care a powerful voice both locally and nationally and formally launched in 2013 as an independent charity.

- 5.2 From 1 July 2015 its services have been delivered as an arms-length department of Community Barnet (CB) a charity and company limited by guarantee.
- 5.3 Financial and contract accountability remains with CommUNITY Barnet's Board of Trustees and delegated through the Chief Executive Officer to the Head of Healthwatch.
- 5.4 The contract is expected to run until 30 June 2017.

6.0. Diversity Implications

- 6.1. The reports presented reflect Healthwatch Brent's commitment to equalities and believes that they support Brent Council in meeting its Public Sector Equality Duty as defined in Section 148 of the Equality Act 2010.

7.0. Staffing / Accommodation Implications (if appropriate)

- 7.1. None for the purposes of this report.

Background Papers

Background papers are available on request.

Contact Officers

Julie Pal - CEO CommUNITY Barnet: Julie.pal@communitybarnet.org.uk

Community Chest update in Brent

Making your voice count



healthwatch

Healthwatch Brent Community Chest

Summary Report

July 2015 - December 2016

Authors:

Ian Niven, Healthwatch Brent
Selina Rodrigues – CommUNITY Barnet
Julie Pal, CEO, CommUNITY Barnet

Introduction

This paper sets out how Healthwatch Brent has implemented its Community Chest between July 2015 – December 2016 inclusive. Healthwatch Brent (HWB) is the independent voice for health and social care users living in the borough of Brent. Healthwatch Brent is part of a national network and part of its statutory function is to share the views of residents with health and social care providers to provide service feedback and to inform statutory commissioners of end-user feedback so that this information can be used to inform future commissioning decisions.

Keen to acknowledge and harness the expertise and knowledge of local communities, HWB established a Community Chest – essentially a funding pot through which local organisations could apply for financial assistance to deliver a range of activities. The Community Chest was divided into two funds – a small grants pot with a maximum limit of £600 and a large grants pot with a maximum limit of £3,000. A simple application form was designed by the HWB Team. The Small Grants Pot applications were assessed by the team, whilst applications to the Large Grants Pot were presented to the HWB Advisory Board for comment and approval. Due diligence checks were carried out on all the organisations applying for financial and governance probity. A key condition for approval was that Healthwatch Brent must be promoted to all the participants of the activities.

To date 18 organisations have successfully received funding from the Community Chest. One application was not approved by the Advisory Board and one application was withdrawn.

The key achievements include:

- Through the reports, the Community Chest has relayed the experiences of 291 Brent residents to key Brent forums such as the Health and Wellbeing Board.
- The role and activities of HWB have been presented to 550 new people, including how they can use HWB as a route to their experiences being heard by key decision makers.
- These 550 people have directly benefited from the wellbeing work of our partner organisations.

- The capacity of 11 local organisations was expanded to allow them to use their specialist knowledge of difference sections of Brent's diverse communities.

Purpose of the Community Chest

Healthwatch Brent reserved £20,000 to create a Community Chest providing grants to local groups and organisations to enable them to –

- Increase awareness of the role of Healthwatch Brent;
- Support our work of reaching and engaging more people;
- Ensure there is input from seldom heard voices on health and social care issues;
- Provide support to small community groups to allow them to host events;
- Increase the capacity of local organisations to provide clear evidence that support good practice or the needs of a service group;
- Recognise and harness the expertise of local organisations;
- Support local organisations, if required, to produce quality reports; and
- Produce evidence based reports to Brent statutory partners, including –
 - Health and Wellbeing Board;
 - Community and Wellbeing Scrutiny
 - NHS Brent CCG boards and committees;

The Community Chest is advertised in –

- HWBrent newsletter
- HWBrent website
- Via our 5 Promotion and Reach partners' newsletters
 - Brent Mencap, Brent Carers Centre, Jewish Care, Ashford Place, Elders Voice
- CVS Brent newsletter – funding section

Two types of applications are regularly invited –

- Small grants of up to £600 to support wellbeing events, raise awareness of HWB, and gather the experiences of a range of local people.
- Large grants of up to £3,000 to provide evidence based reports on a particular issue related to an identified part of our Brent community.

We offer support to organisations to complete thorough applications or we refer them to CVS Brent who offer more detailed support.

Applications are assessed against the core functions of Healthwatch Brent -

Outcome	Measure(s)
1. Residents are fully aware of Healthwatch Brent and it has a high profile across the borough.	<ul style="list-style-type: none"> • Number of enquiries / website visits / bulletins • Number of members • Clear communication strategy • Feedback from residents (public awareness survey)
2. Healthwatch Brent has clear systems and processes that ensure full engagement of the diverse community, including engagement with a targeted range of groups on issues of health and social care.	<ul style="list-style-type: none"> • Evidence of systems and processes in place – including engagement plan • Number of organisations part of HWB network • Number of outreach events and attendance • Demographics of members and volunteers
3. Residents feel and state that Healthwatch Brent has accurately reflected their views.	<ul style="list-style-type: none"> • Feedback from members and residents (survey) • Number of complaints received
4. Residents gain access to Healthwatch through a range of avenues and opportunities.	<ul style="list-style-type: none"> • Number of enquiries (by phone, email, in person) / website visits • Number of community engagement / outreach events held and attendance at events
5. Residents feel and state that the information, advice and signposting they receive is helpful, timely, appropriate and accessible.	<ul style="list-style-type: none"> • User satisfaction / experience survey
6. Healthwatch Brent secures patient and public involvement in health and social care, leading to improved patient and user experience.	<ul style="list-style-type: none"> • Number of volunteers trained in Enter and View • Evidence of reports and feedback submitted to HWE • Evidence that reports have led to service improvements
7. Healthwatch Brent fulfils the key functions of local Healthwatch.	<ol style="list-style-type: none"> 1. Gathering views 2. Making views known 3. Public involvement 4. Recommend HWE/CQC investigation 5. Provide Information and Signposting 6. 2 way flow of info with HWE / network
8. Healthwatch Brent has established constructive and open relationships with health and social care commissioners, providers and the Health and Wellbeing Board, influencing the policy, planning, commissioning and delivery of health and social care in Brent.	<ul style="list-style-type: none"> • Healthwatch Brent representation at key forums, including partnership boards • Evidence of reports and feedback submitted

Additionally, we assess larger grants according to:-

- The likely usability of the report and if will make a difference within the current focus of providers and commissioners.
- Whether the report will provide new information and not duplicate existing knowledge.
- Small grants are approved by two representatives of Healthwatch Brent.
- Large grants are approved in principle by two representatives of Healthwatch Brent with endorsement by a member of the Advisory Board.
- All applications to the Community Chest are reported to the Advisory Board for information.
- £6,000 of the £20,000 was reserved for commissioning specific pieces of work relating to Healthwatch Brent’s priority work areas.
- We would provide a grant to an organisation outside of Brent only in exceptional circumstances – e.g. where specialist knowledge lies only outside of Brent.

Between July 2015 and November 2016 the Community Chest provided the following grants –

We have agreed that all the reports and experiences will be shared with the CCG Head of Engagement who will advise on where to liaise on the recommendations. Feedback on residents’ experiences of health and social care services are collated and if emerging themes, issues or examples of good practice are identified, these will be presented to the CCG and statutory services leads for their information and comment/action.

Large grants			
Organisation	Purpose	Request / Award	Outcomes
ABi CIC	Collect patient experiences as case studies to start populating a Story Bank of resident experience as part of the Brent Equality and Engagement Sub-committee	£3,000 / £3,000 Fully funded	50 people relayed their experiences which were presented to- Brent Equality Engagement and Self-Care Committee, Brent Council Engagement Officer, and HWB team
Brent Centre for Adolescents	Mental Health needs assessment on young Irish travellers in Brent.	£3,000 / £3,000 Fully funded	Report and findings presented to the Children’s Trust November 2016 14 participants
BUG	Self-Directed Support for mental health service	£3,000 / £3,000	Report presented to the Health and Wellbeing Board – September 2016

Healthwatch Brent is managed by CommUNIY Barnet Registered charity 1071035

	users - an experiential guide for front line workers.	Fully funded	17 participants
Ashford Place	Dementia empowerment project with the aims of – Client led services Peer signposting Co-designing cheaper services with Commissioners by targeting support	£2,000 / £2,000 Partly funded	Commenced Nov 2016 Due date Apr 2017 50 participants
Help Somalia Foundation	Identifying Mental Health needs within the Somali community in Brent	£3,000 / £3,000 Fully funded	Commenced Nov 2016 70 people will provide their experiences
South Kilburn Ladies Sports Club	To run sessions and set up the club and its activities	£2,000 / £0	Suggested the group apply for a small grant application but approach Brent CVS for assistance.
CHAT	Promote HWB and gather residents views on health and social care	£2,000 / £0	Application received – HWB suggested a small grant application would better meet our funding criteria

Small grants

Organisation	Purpose	Requested / Awarded	Outcomes
CVS Brent	Commitment to Making Wembley Wonderful Project for match funding	£600 / £600 Part funded £0 supplied	Project did not go ahead due to competing priorities
Iraqi Welfare Association	Contribution towards breast cancer awareness event	£500 / £300 Part funded	The experiences of 30 people from the event were provided 150 people attended the event
South Kilburn Ladies Sports Club –	Equipment for new weekly women only community gym. This group reported feeling able to exercise due to the safety and support of the club – something that is not truly available elsewhere.	£500 / £500 Part funded	Equipment purchased which improved the effectiveness of gym sessions. A representative spoke at the March 2016 HWB public meeting – about the impact of the grant in promoting independence and managing long term conditions through simple exercise. 5 detailed case studies from group members were provided. 30 club members gained awareness of HWB.
Brent Advocacy Concern	Launch event for new BAC website giving	£250 / £250 Part funded	Website launched HWB's role and activity were presented to 30 new people. Experiences of health

	advice to Brent residents with disabilities.	60% paid	and care services were provided from some members of the group.
Stonebridge Boxing Club	Awards event supporting positive physical activity for young people	£600 / £600 Part funded	Successful event. Awaiting views of 25 participants
The African Family Works	Health and Social Care event targeting African and Caribbean communities in Brent. Dec 4 th event	£250 / £250 Payment for advert	HWB Advert on fliers and posters increased awareness – where did the fliers and posters go/newsletter? HWB stall at event collected individual experiences. HWB's role and activity were presented to 45 new people.
WISE	Wellbeing project to identify high blood pressure and diabetes in older people from Caribbean communities	£560 / £560 Fully funded	Postponed until spring 2017 to ensure maximum number of beneficiaries. 250 participants
Funding total		£27,260 / £16,960	

**Large grants in discussion / advertised / prioritised
All related to agreed HWB priorities for 2016-17**

Brent Carers Centre and Addaction –	Identifying Young Carers in Substance Misuse Households	Up to £3000	Approved 60 Participants
Abi Associates and a partner from an C&E European organisation	Central and East European organisations regarding their use of urgent care services	Up to £3,000	Approved in principle. Currently identifying the scale of this issue, reasons for behaviours, and whether these are distinct for any particular part of our community before committing any funds.
FORWARD	Further engagement on Female Genital Mutilation.	Up to £3,000	In-house work research and scoping work is on-going. Funds may be available should additional needs and benefits be identified.
Jewish Care and partner to be identified	The patient experience of hospital discharge	Up to £3,000	Approved in principle

Outcomes

- HWB's role and activity were presented to 550 people representing some of Brent's most vulnerable and marginalised communities.
- Almost 300 residents have shared their unique experience of using local health and social care services which they have never done before

- Communities whom we have reached include:
 - Muslim women
 - Young Irish Travellers
 - Users of mental health services
 - Young people
 - People living with dementia
 - Somalians
 - People with disabilities
 - Young black men
 - Older African and Caribbean people
 - Central and Eastern Europeans
 - Young Carers

Benefits to residents

People have a route to making their voice heard and experience helping to shape services and providing positive feedback where services are working well; The wellbeing of residents is improved. For example both the Stonebridge Boxing Club and the South Kilburn Women's Group) by the small organisations who have provided beneficial activities like the women only fitness group and Stonebridge Boxing Club.

Benefits to the local organisations

Both large and small grants allow local groups and organisations to use their skills and expertise to engage and consult with their communities and to improve the wellbeing of Brent residents.

The organisations were able to showcase their work to wider audiences at Health Watch Brent's public meeting, at the Health and Wellbeing and Scrutiny Committees and to the Health and Wellbeing Board (through this report)

Benefits to Brent

Increased skills and capacity within the voluntary sector which can lead to more effective delivery of services.

A steady flow of evidence-based reports to help guide decisions on provision, service improvement and feedback on where services are working well.

Case studies

Small grant

Al Bahdya (Happiness) Women's group are an inspiring example of community action. This organisation identifies the needs of women in South Kilburn. Through this project, the organisation employed a qualified female trainer to lead the fitness group and understood the specific needs for this community such as women only activity and appropriate dress. The Community Chest grant allowed the organisation to purchase essential equipment to ensure the exercise was effective and more broadly empowers these women in a safe environment by increasing their confidence and independence going around the borough.

Some of the women provided quite detailed information about their experience of healthcare and the role and activities of Healthwatch Brent were presented to over 40 local people.

Large grant

Brent Centre for Young People has a long history of providing therapy for young people with mental health problems. They have a history of high quality research and have produced reports which have been well received. Through their work they had made good links with the Irish Traveller Community in Brent and realised they were in a good position to learn more about this part of our community – one that others find very hard to engage with. One of Healthwatch Brent's priorities was on mental health, including the experience of people who are seldom heard.

The report presented to Brent Children's Trust summarised the following :

- The concerns found amongst the Irish Traveller community on Lynton Close have significant and high risk impacts. Young people have problems at school, and this often results in school absenteeism. Residents raised concerns about depression and a number of suicides have occurred onsite.
- Young women's concerns about Post Natal Depression indicate there could be an opportunity to provide Parental Support programmes for young mothers of young children.
- The desire amongst under 12s to have after school activities creates an opportunity for early preventative mental health programmes to be offered on site.
- Schools should be a key partner in delivering support for Travellers.

The next step for Community Chest -

The Community Chest will continue for the lifetime of the current contract and an update of the programme will be included in the contract summary report.

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