Better Care Fund planning template – Part 1

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Brent Council**
Clinical Commissioning Groups	**Brent Clinical Commissioning Group**
Boundary Differences	**not applicable**
Date agreed at Health and Well-Being Board:	**Draft to be considered on 26/2. Health and Wellbeing Plan Development meeting on 12/3. Final Plan to be approved on 9/4**
Minimum required value of BCF pooled budget: 2014/15	**£6,155,585**
2015/16	**£22,432,000**
Total agreed value of pooled budget: 2014/15	**£6,155,585**
2015/16	**£22,455,585**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	**Brent CCG**
By	**Jo Ohlson**
Position	**Chief Operating Officer**
Date	**4th April**

Signed on behalf of the Council	**Brent Council**
By	**Phil Porter**
Position	**Director of Adult Social Care**
Date	**4th April**

Signed on behalf of the Health and Wellbeing Board	**Brent Health and Well Being Board**
By Chair of Health and Wellbeing Board	**Cllr Ruth Moher**
Date	**4th April**

b). Service provider engagement

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

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

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

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

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

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

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

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

c) Patient, service user and public engagement

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

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

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

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

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

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

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

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

d) Related documentation

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

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

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

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

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

2) VISION AND SCHEMES

a) Vision for health and care services

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

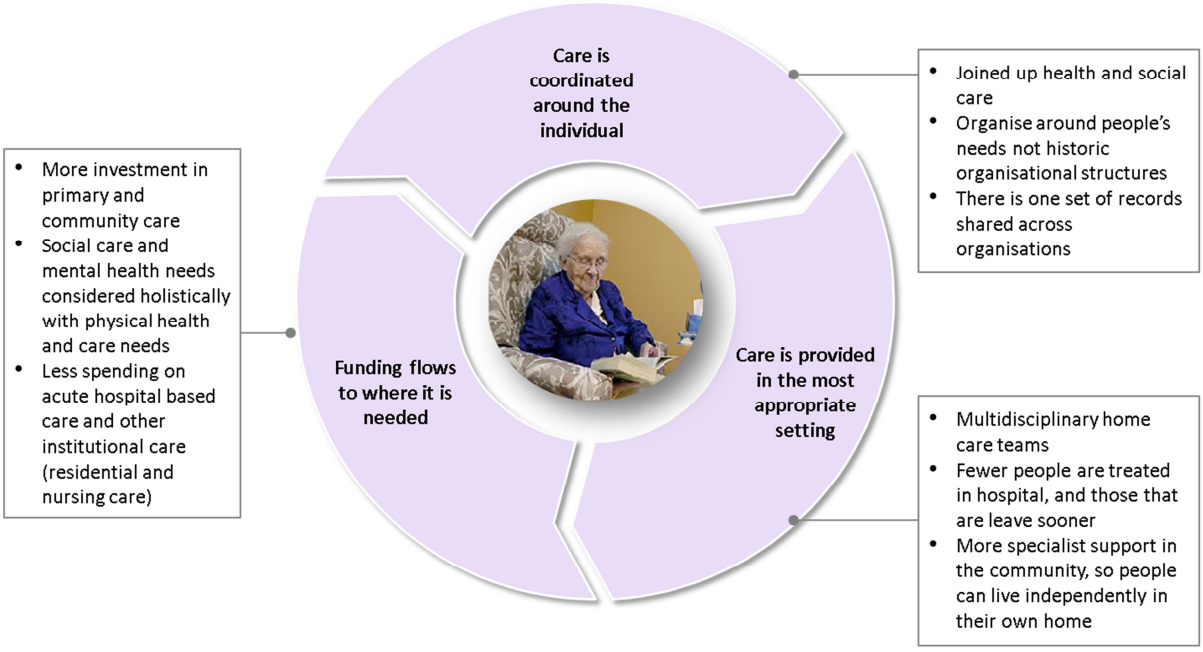
- *What changes will have been delivered in the pattern and configuration of services over the next five years?*
- *What difference will this make to patient and service user outcomes?*

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

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

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

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



In developing the Better Care Fund Plan, we have considered what these principles mean for Brent and what we will change locally to improve the quality of care and empower people to maintain independence. We have developed five schemes which considers the enablers required to help us achieve our vision.

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

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

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

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

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

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

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

Tom

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

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

The voluntary sector, working through the network will also be important providers of support.

Alice

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

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

Anjali

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

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

b) Aims and objectives

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

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

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

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

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

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

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

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

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

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

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

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

1. Embed outcomes in the care plan and review progress to them
2. Put in place ongoing monitoring of experience – jointly across health and social care

3. Link to annual surveys in Health and Social Care. For example, the Friends and Family Test, which is used in acute hospitals and the Adult Social Care survey which measures:
    - Percentage of people who are satisfied with the care and support they receive
    - The proportion of people who feel they have choice and control over their lives
    - Social care related quality of life index.

c) Description of planned changes

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

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

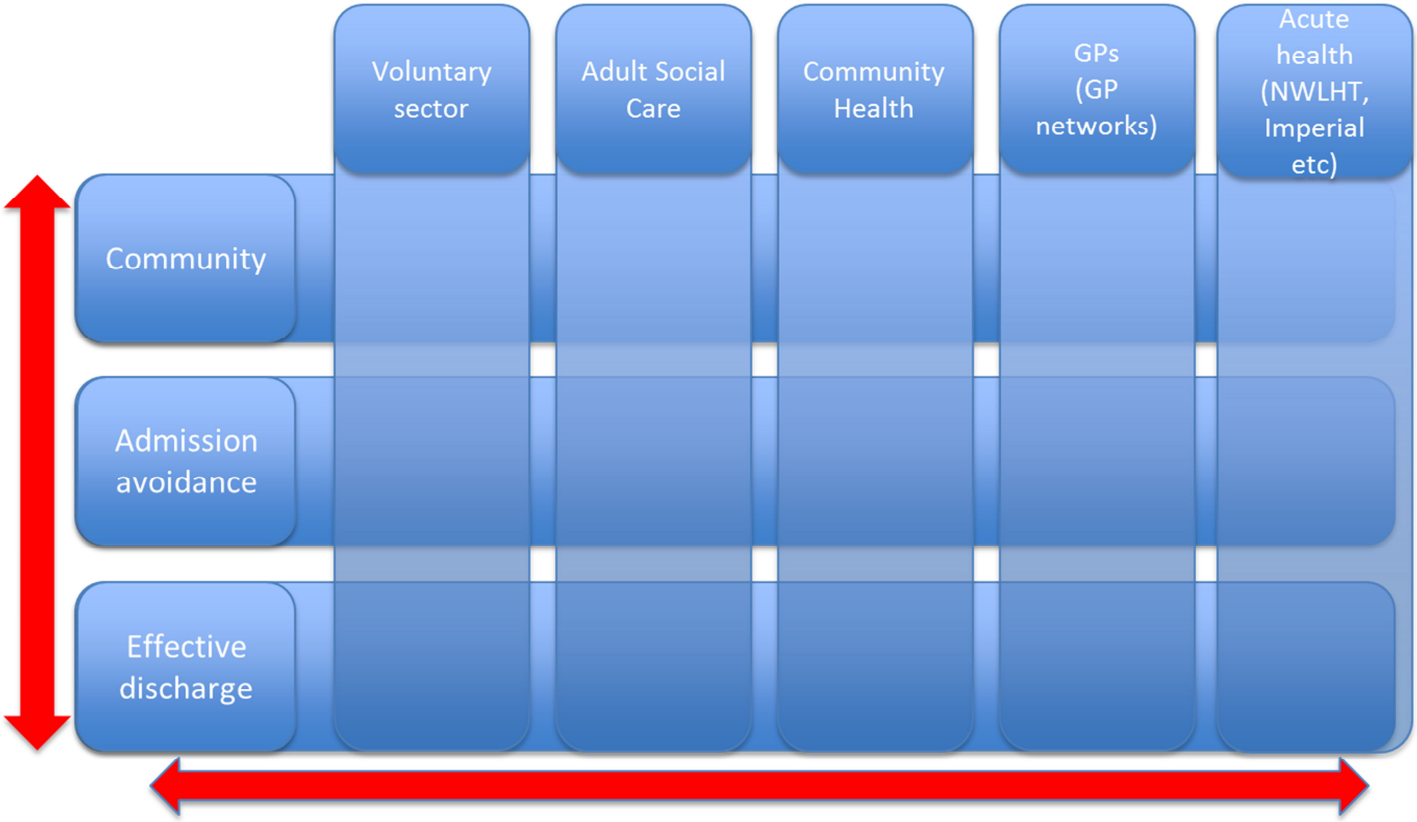
We recognise the scale and challenge of achieving our vision and that this will mean significant change across the range of health and care providers in Brent. Although GPs will play an instrumental role, all providers will need to deliver services differently. To this end, the CCG and Council commissioners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

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

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

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

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



Service development schemes -

Scheme 1 - Keeping the most vulnerable well in the community - Bringing services together to help people manage their health and remain healthy and active in the community.

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

Key benefits -

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

Core components of the scheme –

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

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

Key changes –

- GP the accountable professional with support from hybrid workers
- Person centered - multi disciplinary Care Plans
- Health and Social Care Coordinators - development of a hybrid model of Health and Social Care Worker to case manage
- Each Network works with approximately 175 highly complex cases, 1800 complex cases - each patient has a Lead Professional and care coordination from a Health and Social Care Coordinator
- Single IT system / interoperability between systems
- Shared goals, shared culture, focus on the person (not the organisational priority)
- Social work staff embedded in the GP network
- Voluntary sector involvement that reflects the needs of the local community
- Seven day working within GP networks, including community service and social care services. Defining what services will be available seven days a week is crucial for this scheme and is crucial for the delivery of improved services.
- Preparation for the move to whole systems integrated care, of which the aligned working in this model is the first stage.
- Referrals into the network from a range or providers, including Housing providers and the voluntary sector, who will be well placed to identify vulnerable people who may meet the cohort criteria.

Scheme 2 - Avoiding unnecessary hospital admissions - When a crisis happens we want to ensure the support available means people don't have to go into hospital.

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

Key benefits –

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

Core components of the scheme –

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

Key changes to services -

- Fully integrate social work into the Rapid Response service
- Direct access to community social care to avoid STARRS bridging
- Direct access to integrated short term rehabilitation and reablement services.
- Full engagement with GPs and LAS so that they are making referrals into the scheme to avoid admissions
- Prevention - identifying people before the crises happen, or when people are deteriorating or vulnerable. Other sectors, such as Housing providers can assist as they see people on a regular basis and they need to have connections to the Rapid Response service

Scheme 3 - Effective multi agency hospital discharge - We want to ensure that people are discharged as soon as possible and that support is available in the community or at home in order to continue their recovery.

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

Key benefits -

- Performance: reductions in the number of delayed transfers of care, lengths of stay and readmission rates
- Financial: lengths of stay (reduced acute bed day costs)
- Outcomes: better coordinated care between acute and community services for better patient care in the community

Core components of the service -

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

Key changes to services -

- Two discharge teams, one from health and one from social care, and the continuing health care teams all need to be brought together to create a multi agency discharge team.
- Single discharge worker and plan
- Faster discharge processes, which enable effective and efficient hospital discharge
- Better co-ordination of services, to care for service users in the community post discharge.
- Service users referred back to community networks, where their care is proactively managed.

Scheme 4 - Mental Health Improvement

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

Key benefits -

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

Core components of the service -

- A consistent and comprehensive focus on recovery and independence (across health and social care)
- Joint commissioning (Brent Council and Brent Clinical Commissioning Group) of a local, Brent focused, health and social care service
- Redesign of JDs and teams in Brent to deliver the above
- A focus on integrating with primary care to achieve a holistic response to maintaining mental and physical health

Key changes to services -

- Fewer service users in residential and complex care settings
- Better and more creative use of employment services, sports and leisure activities and social activities to enable service users to fulfill their aspirations in the community and continue their recovery.
- Involvement of service users in the design and delivery of new service models.

Scheme 5 - Key Enablers

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

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

2. Ensure high quality and accessible 7 day services so that the quality and responsiveness of health and care services are not compromised over weekends to enable people to avoid unnecessary hospital admissions and access appropriate crisis support in the community.

3. It recognises that success is dependent on successful commissioning (market development) of a wider range of services and support to meet people's individual needs. For example, a range of integrated rehabilitation and reablement services (intensive step down after hospital, residential reablement and six week community bases, for example). Rehab and reablement is crucial to the successful delivery of schemes 1, 2 and 3, and as such there will be strong interconnections between the schemes and the enabler.

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

5. And most importantly of all, it recognises the need for significant cultural change so that we build a single system of equals (professionals and customers) focused on delivering a shared goal as set out at the start of this presentation: improve the quality of care for individuals, carers and families, empowering and supporting people

to maintain independence and to lead full lives as active participants in their community.

Timetable

January – March 2014

- Develop locality integration plan, which sets out the scope of commissioners plans for integrated care, including target population, desired outcomes and budgets available, as well as providers responses
- Develop Whole Systems Integrated Care Expression of Interest to become early adopter/accelerated learning site based on model of integrated anticipatory care via ICP II

March – May 2014

- Complete Whole Systems Expression of Interest application by end of March and submit to NWL Whole Systems Integrated Care Programme team
- Develop Whole Systems Integrated Care Outline Business Plan for external review process at end of May

May – October 2014

- External review of NWL Outline Business Plan for early adopter proposal
- Put in place BCF programme governance and delivery plan and project outline
- Approval of programme delivery and governance plans
- Develop programme resourcing business case for CCG/Council approval
- Complete Whole Systems Business Case by October 2014, including sign off by the Health and Wellbeing

November 2014 to April 2015

- Commence implementation of integrated care model as an accelerated learning site
- Monitor financial flows in shadow budgets to evaluate financial impact of possible models on different providers and on total cost to commissioners

From April 2015

- Use learning from accelerated learning sites to implement new models of care at scale with actual budgets attached

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

d) Implications for the acute sector

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

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

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

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

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

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

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

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

e) Governance

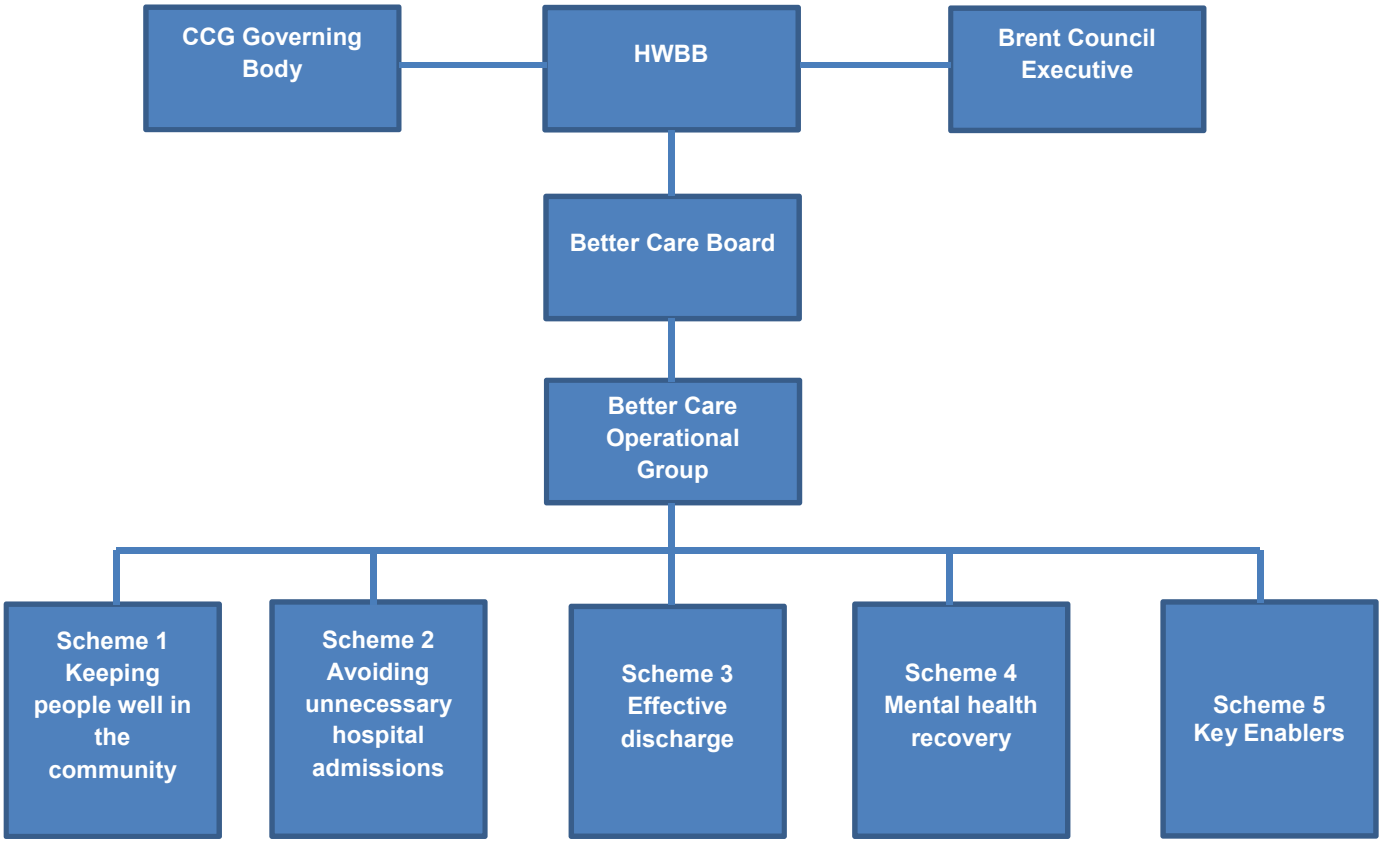
Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

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

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

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

Our proposed governance structure is set out below –



NATIONAL CONDITIONS

a) Protecting social care services

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

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

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

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

This will need to be sustained, if not increased, within the funding allocations for 2014/15 and beyond if this level of offer is to be maintained, both in order to deliver 7 day services and in particular as the new Social Care Bill requires additional assessments to be undertaken for people who did not previously access Social Services. Understanding the full implications of the Care Bill is crucial to both the council and CCG. Work will take place to model the financial impact of the Bill, and the pressures that it could bring to the pooled budget (and separate Adult Social Care and CCG budgets). Although the national funding models are useful, we think there is value in taking the time to work up our own local cost estimates to aid our understanding of the changes ahead.

The council and CCG also plan to make efficiency savings through the implementation of the BCF plan. A 10% savings target is set against the plan as a whole (the individual savings target for each scheme is to be worked up) to recognise the benefits that should be achieved through joint commissioning and using the BCF as a catalyst for savings across the health and social care system, such as in acute services (for the CCG) and in home care or residential care costs (for the local authority). It is proposed that additional resources will be invested in alternative care models which will reduce hospital readmissions and admissions to residential and nursing home care.

b) 7 day services to support discharge

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

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

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

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

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

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

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

c) Data sharing

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

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

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

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

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

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

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

- Confidential information about service users or patients should be treated confidentially and respectfully

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

d) Joint assessment and accountable lead professional

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

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

In 2014/15 this programme will:

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

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

As part of working with the North West London WISC Programme, Brent has submitted an expression of interest to become an early adopter/accelerated learning site for whole systems integrated care. Our approach to a whole systems approach is outlined above and will be tested with 2 of the four emerging Brent networks. The aim is to create a provider vehicle that combines primary, community, secondary mental health care providers together with the voluntary sector to provide a holistic and wrap around community services that are tailored to the elderly and adults with one or more long term conditions population group.

Our aim is to support this population needs through anticipatory health and social care and supported by 7 day services, GP out of hours and home visits to avoid admissions. We anticipate piloting this model and testing the value of this approach through developing a shadow capitated budget and monitoring the impact on this, patient outcomes and experiences.

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

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

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

More recently, we have started using the local risk algorithm BIRT 2 and the frequent users of emergency services data to identify high risk services users. Moving forward, the approach will be to use BIRT 2, the Frequent Users of Emergency Services data and GP intelligence. GP practices (or indeed other integration partners) will be able to select from any patient group and will use a more structured approach to patient selection, so that the population is identified at the start of the process.

3) RISKS

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

Ref	Risk	Risk rating	Mitigating Actions
R1	Shifting resources to fund new joint schemes will destabilise existing providers in the acute sector	High	▪ Our current plans are based on the agreed strategy for NWL, as set out in *Shaping a Healthier Future* ▪ The development of plans for 2014 to 2016 will be conducted within the framework of our Whole System Integrated Care Programme, allowing for transparency of impact across the provider landscape.
R2	Absence of robust baseline data and the need to make decisions based on assumptions may result in unachievable financial and performance targets for 2015/16	High	▪ The Whole Systems Integrated Care programme is undertaking a detailed mapping and consolidation of opportunities and costs which will be used to validate our plans. ▪ We are investing specifically in areas such as customer satisfaction surveying and data management to ensure that we have up-to-date information around which we will adapt and tailor our plans throughout the next 2 years.
R3	Operational pressures	High	▪ Need to include specific non recurrent

Ref	Risk	Risk rating	Mitigating Actions
	restricting the ability of our workforce to deliver the vision		investments into workforce development and organisational development
R4	Preventative, self management and improved quality of care fail to translate to reduced acute, nursing and care home expenditure, impacting the level of funding available in future years.	High	▪ Our assumptions are modelled on the best available evidence of impact, including metrics from other areas and support from the National Collaborative ▪ We will use 2014/15 to test and refine our assumptions with a focus on developing more financially robust business cases.
R5	The Care and Support Bill will increase costs from April 2015 with a further increase from April 2016 as implementation will take place in two phases. Both of which will bring the risk of increased costs, which is difficult to quantify and mitigate at this stage given the absence of draft guidance expected in May 2014.	High	▪ Undertake an initial impact assessment with a view to refining assumptions as we develop our BCF plan. ▪ Explore opportunities and benefits arising from the introduction of this legislation that may help to offset negative financial consequences. ▪ In the longer term, model through the impact of the Care Bill and the potential pressures on the council and CCG budgets as a result. ▪ Although both organisations will work with national funding models, it is important a shared understanding is developed locally. ▪ The draft guidance in May 2014 will inform the shared understanding and the final guidance, expected in November 2014 will be used to assess the impact on CCG and Council budgets.
R6	Managing patient flows in the south of Brent, where people may be registered with an out of borough GP, or use acute trust services outside of Brent, and ensuring they benefit from schemes	Medium	▪ Royal Free and Imperial Trusts are involved in Brent Integration Board and aware of discharge plans and the creation of GP networks ▪ Agreement to be reached at the start of project around eligibility for health and social care services provided through the BCF plan, which will effect those who use GP services outside of Brent.
R7	Different discharge arrangements develop with NWLH and other hospital trusts, meaning patients receive an inconsistent service	Medium	▪ Royal Free and Imperial Trusts are involved in Brent Integration Board and aware of discharge plans and the creation of GP networks ▪ Although focus of the work is discharge from NWLH, there is scope to involve discharge from other hospitals, and work with discharge teams from the trusts most commonly used by Brent patients.
R8	Ensuring that NWLH manage Brent and Harrow social care	Medium	▪ This is already a managed risk, as NWLH have to differentiate between Brent and Harrow service users currently

Ref	Risk	Risk rating	Mitigating Actions
	service users accordingly and manage discharge plans in line with borough specifications		▪ The eligibility for services will be reinforced and monitored by the multidisciplinary team to ensure appropriate referrals are being made to the team.
R9	Capacity within commissioner and provider organisations to deliver the transformational system changes is limited and prevents progress	High	▪ Specific business case to resource delivery of the BCF to be developed for CCG and Council to invest pump priming resources to support delivery and implementation of schemes/work streams.
R10	The council's financial position is becoming increasingly challenging and will require significant savings from all service areas in order to deliver a balanced budget in future years	H	▪ Work is already underway to identify savings opportunities in 2015/16. The BCF could be a catalyst to savings in other areas of council spending, particularly in Adult Social Care. As detailed above, the minimum expectations around the savings that the BCF will help to deliver are included in this plan.
R11	The CCGs budget position is relatively stable, but it is likely that there will be less growth in Brent in future years and budget stability is predicated on the delivery of 3% QIPP savings each year	L	▪ Plans are in place to deliver QIPP savings, and the BCF could be a catalyst to further savings in the system, particularly in spending on acute care and mental health.