Better Care Fund planning template – Part 1

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

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

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

1) PLAN DETAILS

a) Summary of Plan

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

b) Authorisation and signoff

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

<Insert extra rows for additional CCGs as required>

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

<Insert extra rows for additional Councils as required>

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

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

c) Related documentation

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

Document or information title	Synopsis and links
Joint Strategic Needs Assessment (JSNA)	Joint local authority and CCG assessments of the health needs of the Brent population in order to improve the physical and mental health and well-being of individuals and communities.
Joint Health and Wellbeing Strategy (JWBS	The Joint Health and Wellbeing Strategy sets out the priorities and actions which the Health and Wellbeing Board are planning to carry out in the period 2013 to 2016.
Out of Hospital Strategy, Brent CCG, May 2012	The CCG's strategy to develop services in the community and focus on self-care, early diagnosis and high quality management of long term conditions, and the diagnosis and treatment of those with ambulatory

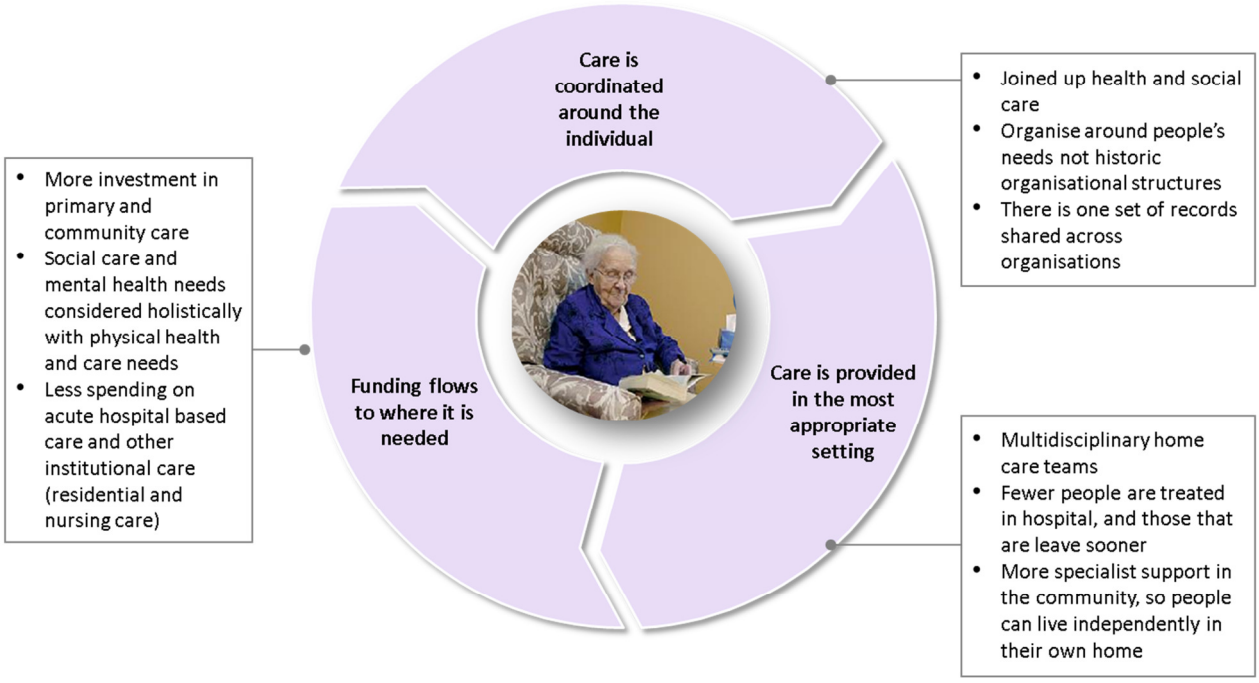
	emergency conditions in the community when appropriate. This would enable acute hospitals to focus on patients who are critically ill and those who require specialist investigations and interventions. At the heart of our vision is providing 'the right care, in the right place, with the right professional and at the right time'.
Commissioning Intentions 2014/15, Brent CCG, January 2013	The CCG's commissioning intentions for 2014/15 which sets out the scope of commissioning improvements across a range of service areas.
Adult Social Care Local Account, December 2013	The Local Account sets out details of the Adult Social Care Department's performance in 2012/13 and the Department's key challenges and achievements.
Adult Social Care Market Position Statement 2014, Brent Council, January 2014	The MPS is for current providers of Accommodation based care and support services (ABCSS) who operate locally and for potential providers considering entering the market in Brent in an attempt to grow diversity in available service provision locally. The document sets out – Current and predicted future demands on ABCSS locally. Current supply of ABCSS across Brent. Brent Adult Social Care Market position 2014 www.brent.gov.uk/media/9282655/asc-mps-app1.pdf What our strategic vision is, our commissioning intentions and models of service delivery we want to encourage in the local marketplace
Living Longer, Living Well, NWL Pioneer Application, June 2013	The vision for whole system integrated care in NWL, including that people, their carers and families will be empowered to exercise choice and control; GPs will be at the centre for organising and co-ordinating people's care; and systems will not hinder the provision of integrated care.
Shaping a Healthier Future, NHS North West London, January 2012	The strategy for future healthcare services in NW London including how care will be brought nearer to people; how hospital provision will change, including centralising specialist hospital care onto specific sites so that more expertise is available more of the time; and how this will be incorporated into a co-ordinated system of care so that all the organisations and facilities involved in caring for the people of North West London can deliver high-quality care and an excellent experience.
Delivering Seven Day Services, NHS North West London, November 2013	NW London's vision to be an early adopter for seven day services across health and care

2) VISION FOR HEALTH AND CARE SERVICES

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

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

1. People will be empowered to direct their care and support and to receive the care they need in their homes or local community.
2. GPs will be at the centre of organising and coordinating people's care. Our systems will enable and not hinder the provision of integrated care.
3. Our providers will assume joint accountability for achieving a person's outcomes and goals and will be required to show how this delivers efficiencies across the system.



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

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

- To reduce the use of residential care and enable people to remain healthy and independent in

the community.

- To reduce hospital admissions and the length of time people stay in hospital.

The Brent BCF schemes directly contribute to realising these aspirations and set out our approach to delivering a whole system response aimed at reducing hospital admission, the length of time a patient has to stay in hospital if they are admitted, and more planned and proactive care, based in the community. The schemes include:

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

Enabling these changes will require radical change in the way that organisations work. All of the participating organisations have to buy into the vision for health and social care and be prepared to adapt to make change happen. Enablers span a continuum from organisational development about new ways of working to IT integration and implementation of 7 day working across health and social care.

In Brent we believe that we are progressing in this regard and that partners are signed up to the integration agenda to improve health and social care services.

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

Tom

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

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

Alice

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

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

Anjali

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

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

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

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

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

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

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

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

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

- People will be empowered to direct their own care and support and to receive the care they need in their homes or local community.
- GPs will be at the centre of organising and coordinating people's care.
- Our systems will enable and not hinder the provision of integrated care.
- Our providers will assume joint accountability for achieving a person's outcomes and goals and will be required to show how this delivers efficiencies across the system.

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

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

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

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

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

We believe that this will ensure that we:

- Keep the most vulnerable well in the community
- Avoid unnecessary hospital admissions
- Reduce re-admissions and lengths of stay
- Ensure effective multi agency hospital discharge
- Reduce mortality through better access to senior doctors
- Improve access to GPs and other services so patients can be seen more quickly and at a time convenient to them
- Reduce complications and poor outcomes for people with long-term conditions by providing more coordinated care and specialist services in the community
- Ensure less time is spent in hospital by providing services in a broader range of settings
- Promote patient and service user self-management
- Improve quality of life and patient/service user experience and patient satisfaction

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

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

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

- Complex health and care services, for example those over 75 and those with long term conditions requiring multidisciplinary configurations through GP networks.
- Episodic health and care services which will require redevelopment of primary and urgent care to provide high quality, rapid access to transactional care services.
- A coordinated and seamless access to health and care services which occurs at the same

time to assess holistic needs and reduce unnecessary transfers of care.

- 24/7 provision of care that maintains continuity and provides assurances for carers and patients

- Support across traditional organisational boundaries, involving voluntary, community and private sector provider care models

- Support from carers to remain well in the community

There are a number of schemes that support the overall vision for integrated health and social care which will result in specific changes to services, with tangible outcomes for service users.

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

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

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

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

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

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

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

3) CASE FOR CHANGE

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

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

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

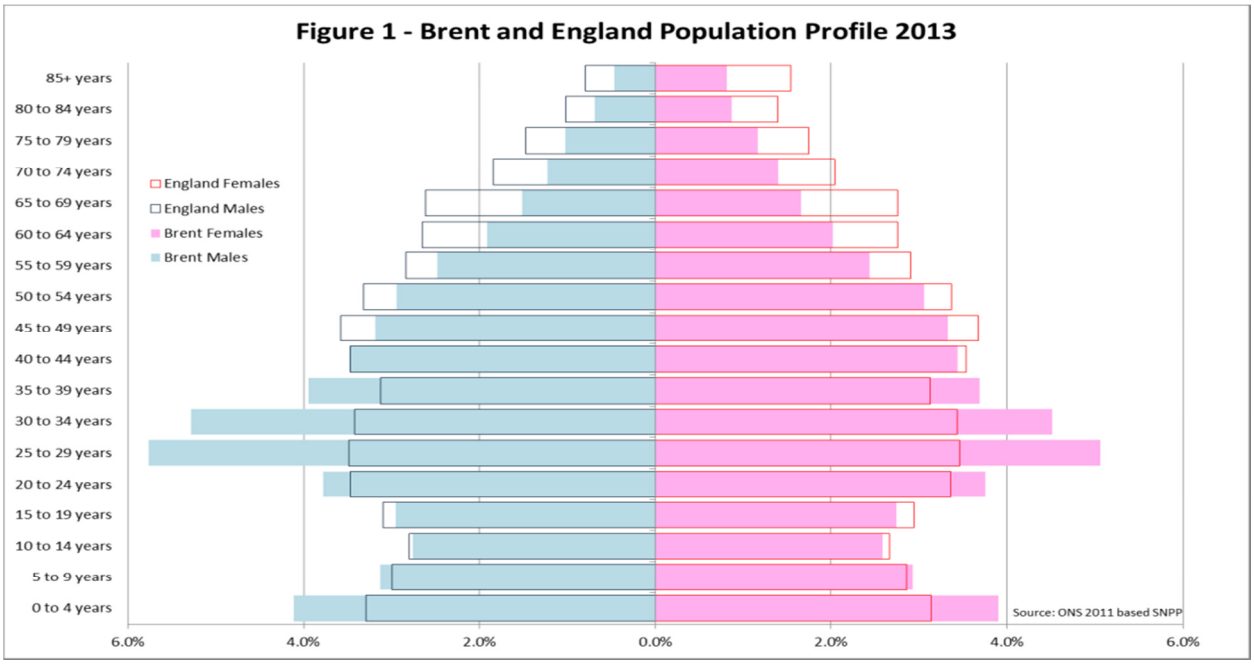
Each of these domains contains a series of briefs on a particular theme and explores how a range of underlying factors can influence the health and well-being of Brent's communities and residents with the associated health outcomes. The JSNA has identified particular social and

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

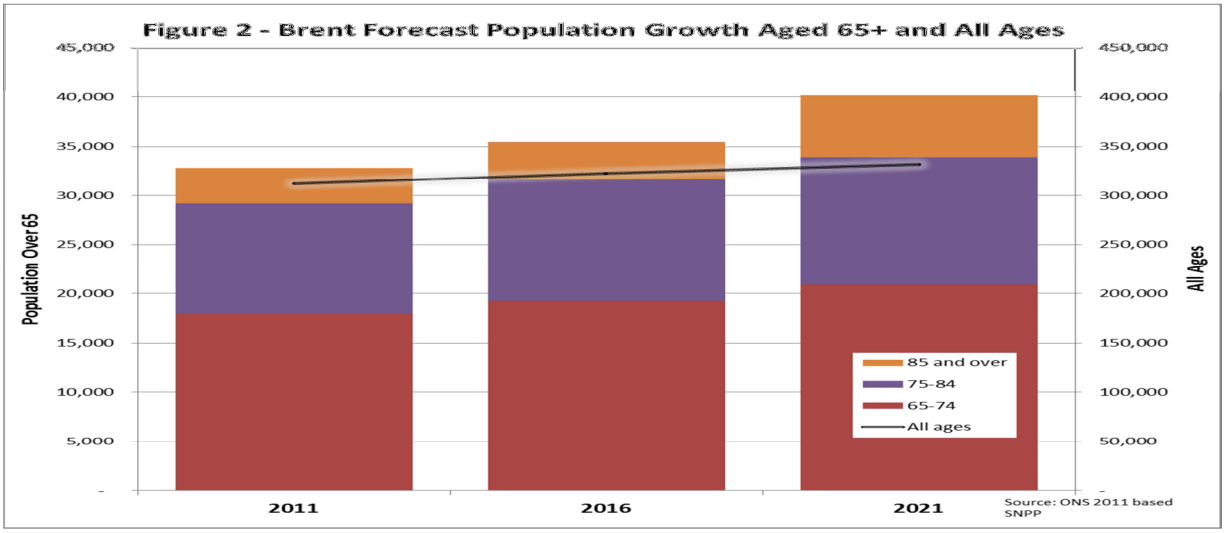
Population and demography

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

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

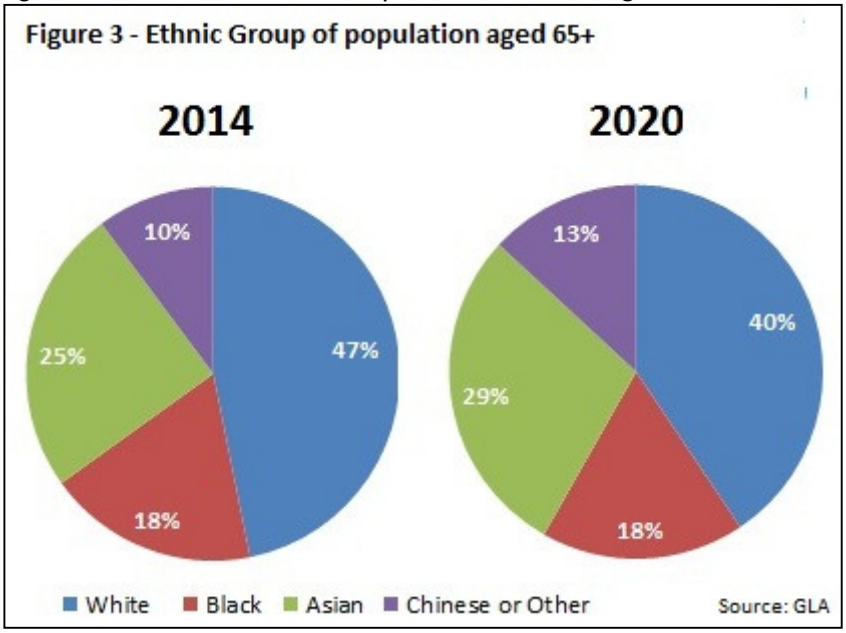


Between 2011 and 2021 the population aged between 65 and 74 is expected to grow by 16%, 75-84 by 16% and 85 + by 72% whilst the total population will only grow by 7%[1].



[1] ONS 2011 based population projections

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



Age Related Morbidity

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

Increase in prevalence with age of selected conditions[2]

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

Living Alone

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

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

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

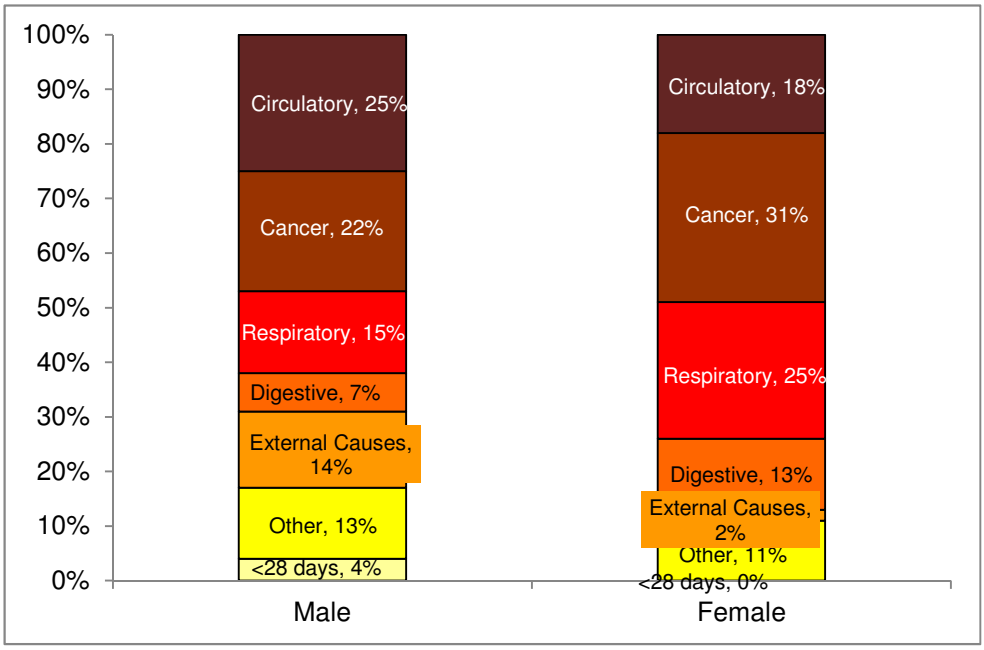
Brent Population aged 65+ living alone.	2014	2015	2020	2025
Males 65-74 predicted to live alone	1,780	1,820	2,060	2,400
Males 75 and over predicted to live alone	2,380	2,448	2,754	3,230
Females 65-74 predicted to live alone	2,970	3,060	3,420	3,900
Females 75 and over predicted to live alone	5,673	5,734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

Life expectancy at birth

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

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

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



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

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

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

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

Cardiovascular disease (CVD)

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

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

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

Respiratory disease

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

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

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

Mental ill health amongst adults

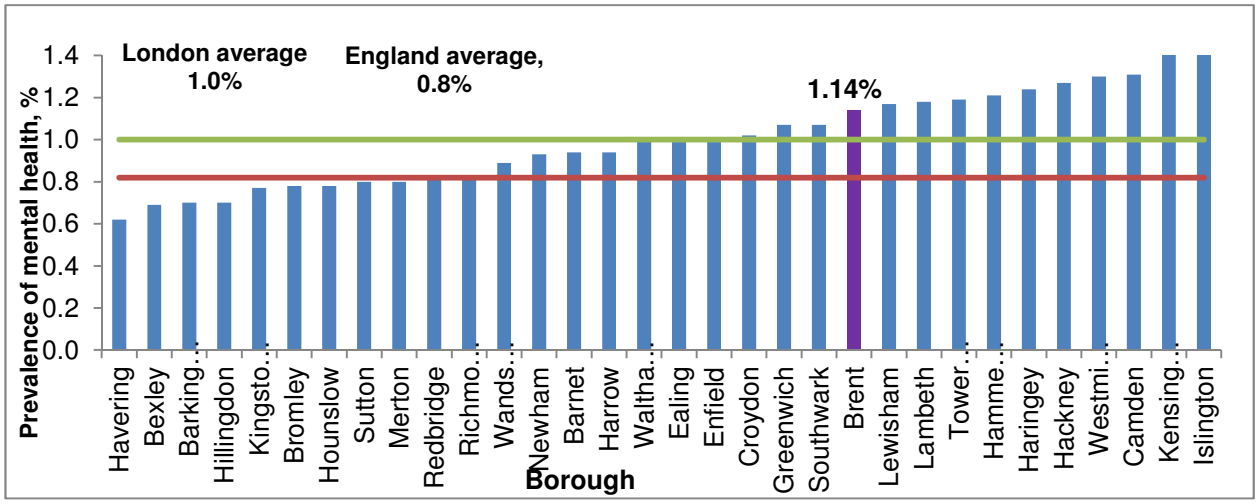
Estimates show that in a given week, 11% of Brent adults experience depression, higher than the England average of 8% and similar to the London average (11%)[9].

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

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

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

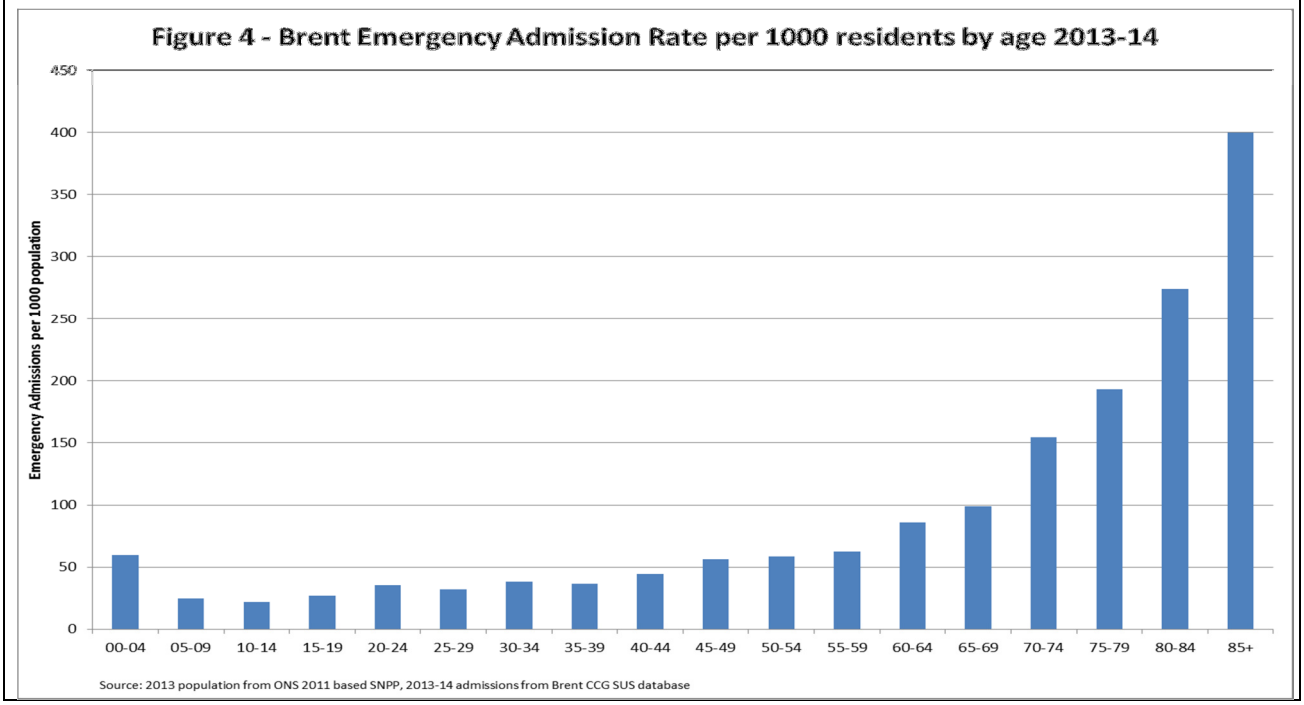
The prevalence of severe and enduring mental illness in Brent is 1.14% of the population which is above both the London and England averages. The graph below demonstrates the prevalence of severe and enduring mental illness between London boroughs for the period 2011/12 for severe and enduring mental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



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

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

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



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

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

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

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

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

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

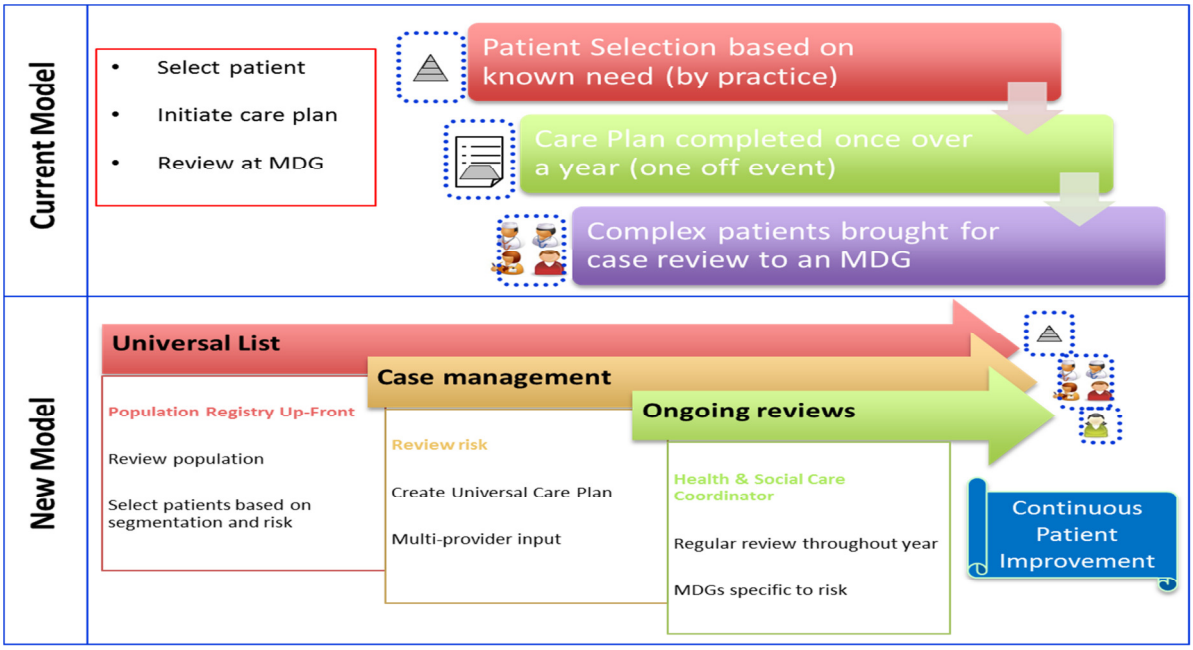
The tool works by risk scoring patients on a standardised scale. Clinicians are able to see the NHS numbers of patients so that they can contact them for an intervention.

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

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

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

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



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

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

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

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

4) PLAN OF ACTION

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

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

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

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

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

A summary of progress and planned activities includes:

2014/15

- **Quarter 1 April to June 2014**

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

- **Quarter 2 July to September 2014**

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

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

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

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

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

- **Quarter 3 October to December 2014**

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

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

Establish PMO and implementation groups

Implement revised governance arrangements with underpinning partnership arrangements.

- **Quarter 4 January to March 2015**

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

Agree performance dashboard and reporting mechanisms

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

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

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

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

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

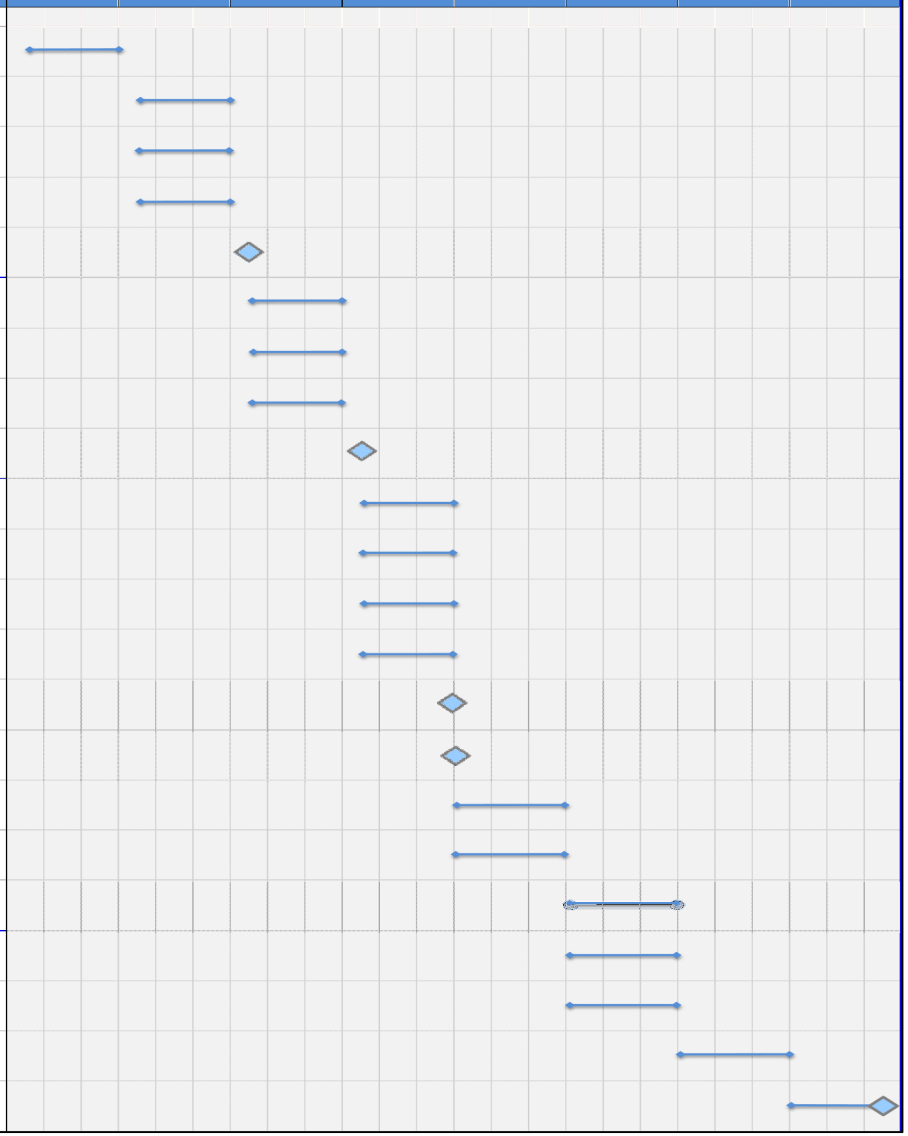
Develop implementation plans for to deliver next phase of changes

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

Agree implementation process with providers

Plan of Action

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



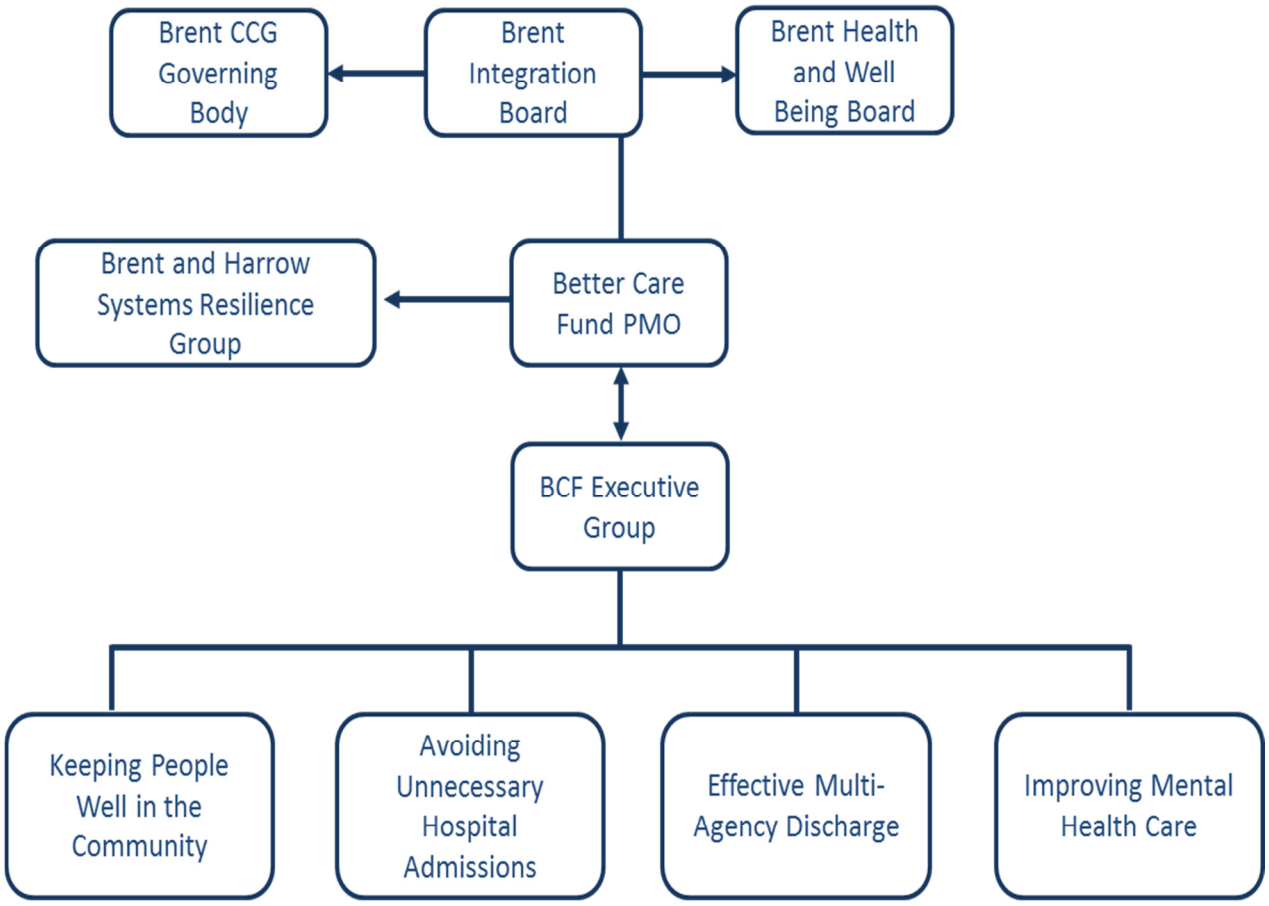
b) Please articulate the overarching governance arrangements for integrated care locally

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

To deliver the ambition for integrated care, we recognise the need to develop further our strategic and operational governance arrangements. We will ensure that the leadership of the CCG and Local Authority have clear and shared visibility and accountability in relation to the management of all aspects of the joint fund. Our current proposal is to delegate specific functions between Local Authority and CCGs in areas that facilitate delivery of the BCF. We have already created the Brent Integration Board to lead this work. This is made up of representatives from the council, CCG, provider organisations and the voluntary sector. Whilst the balance between operational and strategic leadership on the group is emerging, it is driving the BCF and whole systems processes.

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

Our proposed governance approach is set out below.



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

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

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

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

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

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

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

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

d) **List of planned BCF schemes**

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

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

5) RISKS AND CONTINGENCY

a) Risk log

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

There is a risk that:	**How likely is the risk to materialise?** *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely*	**Potential impact** *Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact* *And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)*	**Overall risk factor** *(likelihood *potential impact)*	**Mitigating Actions**
Shifting resources to fund new joint schemes will destabilise existing providers in the acute sector	2	2	4	• Our current plans are based on the agreed strategy for NWL, as set out in *Shaping a Healthier Future* • The development of plans for 2014 to 2016 will be conducted within the framework of our Whole System Integrated Care Programme, allowing for transparency of impact across the provider landscape. • The impact is on

				capacity and our ability to manage demand
Absence of robust baseline data and the need to make decisions based on assumptions may result in unachievable financial and performance targets for 2015/16	3	4	12	• The Whole Systems Integrated Care programme is undertaking a detailed mapping and consolidation of opportunities and costs which will be used to validate our plans. • We are investing specifically in areas such as customer satisfaction surveying and data management to ensure that we have up-to-date information around which we will adapt and tailor our plans throughout the next 2 years. • The impact is on the accuracy of the patients' health risk through the risk stratification tools
Operational pressures restricting the ability of our workforce to deliver the vision	4	3	12	• Need to include specific non recurrent investments into workforce development and organisational development • The workforce resources being used for the implementation of the BCF schemes and

				business as normal.
Preventative, self-care,/self-management and improved quality of care fail to translate to reduce acute, nursing and care home expenditure impacting the level of funding available in future years	3	4	12	• Our assumptions are modelled on the best available evidence of impact, including metrics from other areas and support from the National Collaborative • We will use 2015/16 to test and refine our assumptions with a focus on developing more financially robust business cases. • Continued increase in individuals requiring acute in-patient support
The Care and Support Bill will result in an increase in demand and costs to the system from April 2016 which is difficult to predict at this stage.	5	3	15	• Undertake an initial impact assessment with a view to refining assumptions as we develop our BCF plan. • Explore opportunities and benefits arising from the introduction of this legislation that may help to offset negative financial consequences. • Continued increase in individuals requiring acute in-patient support
Managing patient flows	3	4	12	Continued work with the main provider trusts - Royal Free

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

b) Contingency plan and risk sharing

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

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

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

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

6) ALIGNMENT

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

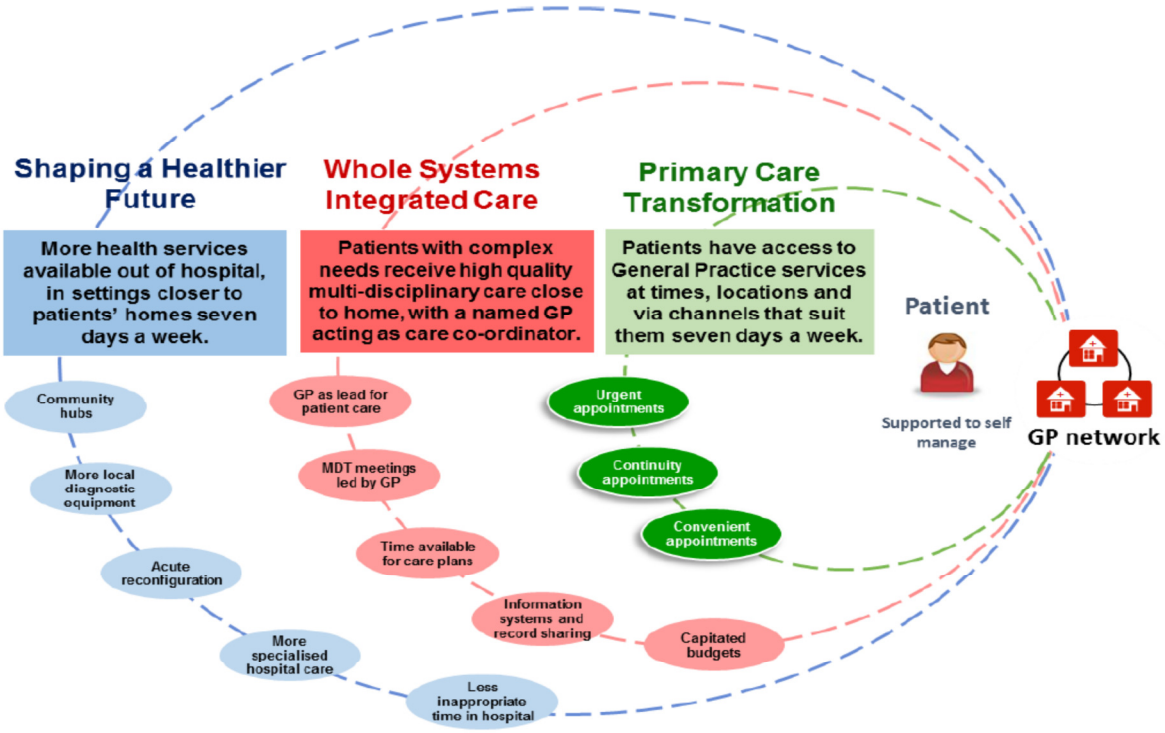
Brent CCG has ambitious plans to transform the way care is provided in Brent so that the patient receives the best possible treatment through high quality integrated care. These plans are reflected in our five year draft strategy. These plans are designed and driven locally and with an increasing system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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

7) NATIONAL CONDITIONS

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

a) Protecting social care services

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

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

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

Funding currently allocated under the Social Care to Benefit Health grant has been used to enable the local authority to sustain the current level of eligibility criteria and to provide timely assessment, care management and review and commissioned services to clients who have substantial or critical needs and information and signposting to those who are not FACS eligible. This will need to be sustained, if not increased, within the funding allocations for 2014/15 and beyond if this level of offer is to be maintained, both in order to deliver 7 day services and in particular as the new Social Care Bill requires additional assessments to be undertaken for people who did not previously access Social Services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

b) 7 day services to support discharge

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

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

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

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

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

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

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

c) Data sharing

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8) ENGAGEMENT

a) Patient, service user and public engagement

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

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

Through patient and service user workshops, interviews and surveys across North West London (NWL) we know that people want choice and control. They want their care to be planned with people working together across the statutory sector and with voluntary and community organisations, to help them reach their goals of living longer and living well and ensuring that quality of life is sustained and improved. They want their care to be delivered by people and organisations that show dignity, compassion and respect at all times.

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

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

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

We are also considering a broader range of activities including building community capacity particularly with regards to working closely with the voluntary sector and local enterprises to support health and social care provision. Continued working in partnership with Brent Health-watch and CVS will be central to our aims to deliver this plan.

b) Service provider engagement

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

i) NHS Foundation Trusts and NHS Trusts

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

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

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

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

ii) primary care providers

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

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

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

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

c) Implications for acute providers

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

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

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

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

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

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

ANNEX 1 – Detailed Scheme Description

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

Keeping the most Vulnerable well in the community

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

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

Integrated Care Programme II

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

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

The key principles behind the model are:

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

Whole Systems

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

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

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

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

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

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

Overview of the scheme

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

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

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

The project will improve a range of patient outcomes including:

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

We will do this by delivering the following key deliverables:

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

<u>Whole Systems Interventions</u>

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

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

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

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

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

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

Governance

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

Benefits & Impacts of the Key Enablers:

Rehab and Re-ablement

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

Information Technology

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

7 day working

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

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

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

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

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

Social Isolation

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

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

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

Public Engagement

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

Carers/Self care

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

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

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

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

Learning and Development/Workforce

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Feedback loop

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

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

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

The audit programme looks at:

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

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

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

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

The key success factors for implementation of the scheme are:

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

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

. Avoiding unnecessary hospital admissions

Scheme ref no.

Scheme 2

Scheme name

Avoiding Unnecessary hospital admissions

What is the strategic objective of this scheme?

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

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

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

There are 3 essential components of the service:

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

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

Overview of the scheme

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

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

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

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

The current Rapid Response Service aims to:

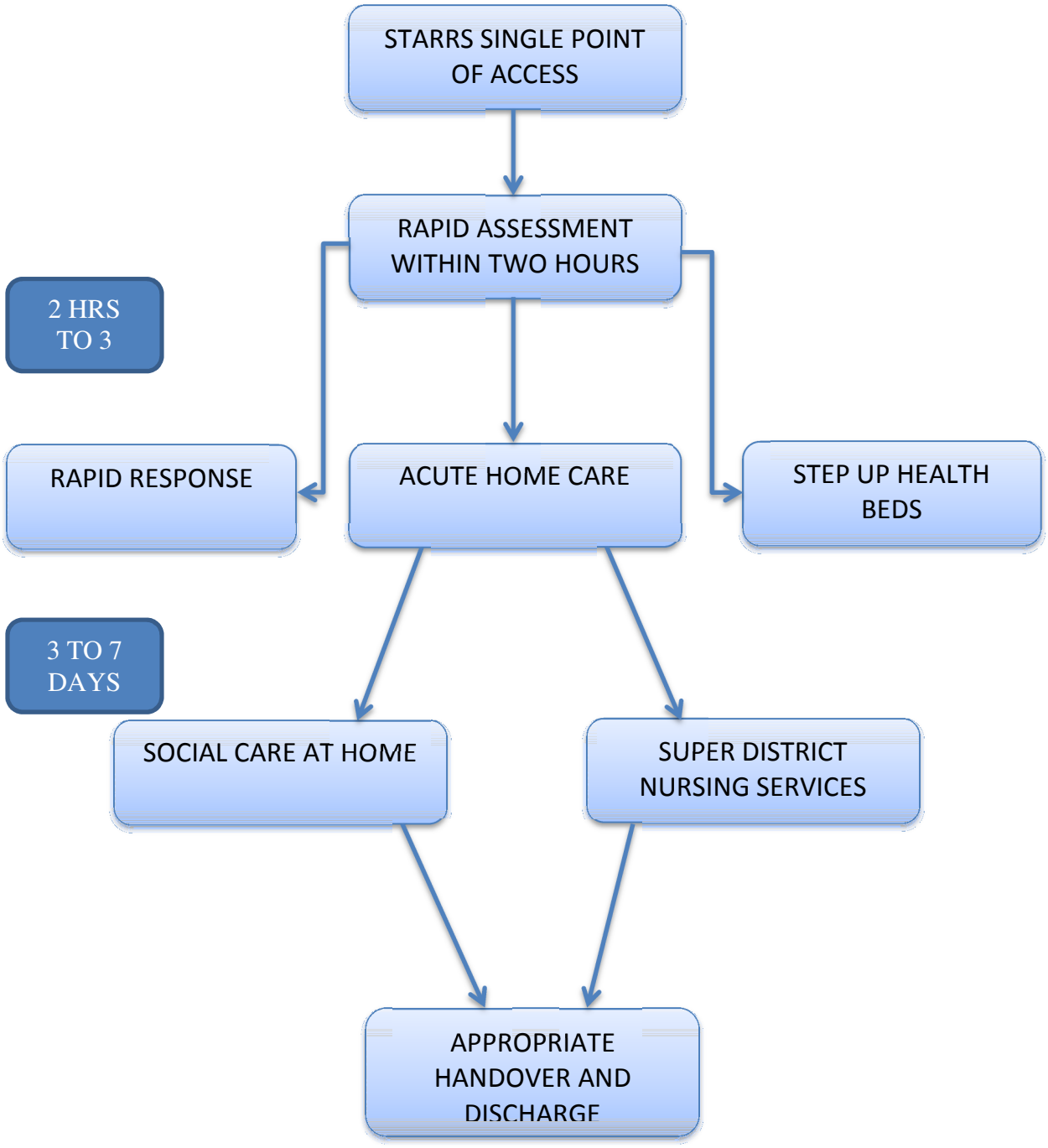
- Reduce hospital admissions by assessing patients with an acute exacerbation in the home environment
- Reduce hospital admissions by effectively treating patients in the home environment
- Provide an assessment and package of care in the home environment
- Refer to other appropriate services to support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

The service achieves this by delivering the following:

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

Enhancement of the above service model will include:

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



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

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

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

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

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

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

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

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

Avoiding unnecessary hospital admissions will include provision of:

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

Key Enablers

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

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

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

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

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

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

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

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

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

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

The delivery chain

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

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

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

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

NHS Brent Clinical Commissioning Group is the commissioner.

The providers are:

- North West London NHS Trust

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

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

The evidence base

Please reference the evidence base which you have drawn on

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

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

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

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

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

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

Impact of scheme

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

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

Feedback loop

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

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

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

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

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

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

The key success factors for implementation of the scheme are:

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

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

- Finance and data/analytics support

Risks and Mitigations

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

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

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

3. Effective Multi agency hospital discharge

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

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

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

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

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

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

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

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

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

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

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

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

- This service would require the following resources to include:

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

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

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

The enablers
Rehab and Re-ablement

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

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

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

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

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

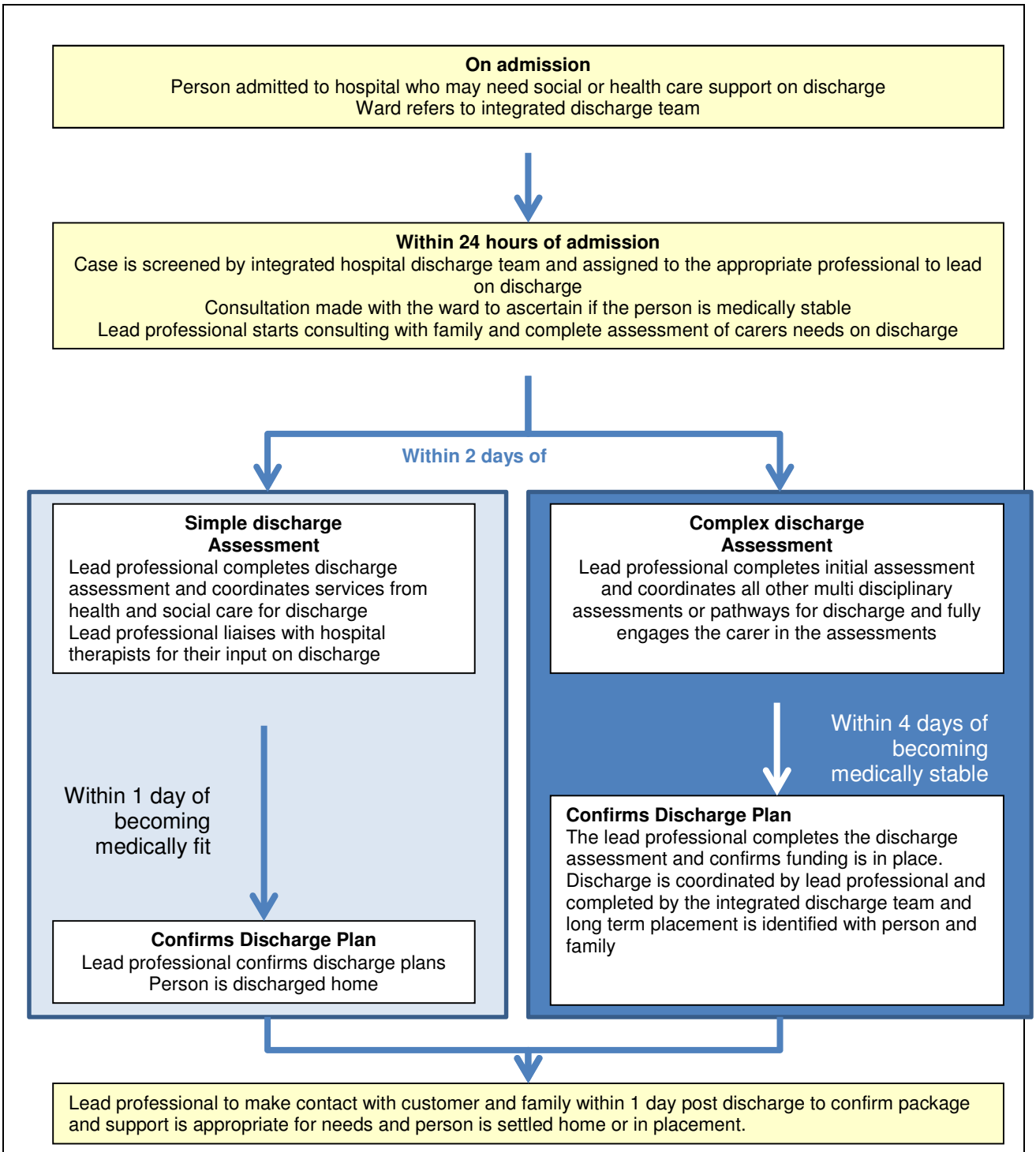
Public Engagement
Public will need to be engaged to inform the progress of the scheme and to be aware that the aim of the scheme is to ensure that people are discharged back to the community as soon as medically safe to do so. Public awareness of the expectation to 7 day discharges and a focus on providing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

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

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

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

Pathway for effective multi-agency hospital discharge



The delivery chain

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

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

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

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

The evidence base

Please reference the evidence base which you have drawn on

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

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

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

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

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

Investment requirements

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

Impact of scheme

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

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

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

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

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

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

Mental Health Improvement

Scheme ref no.

Scheme 4

Scheme name

Mental Health Improvement

What is the strategic objective of this scheme?

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

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

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

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

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

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

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

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

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

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

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

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

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

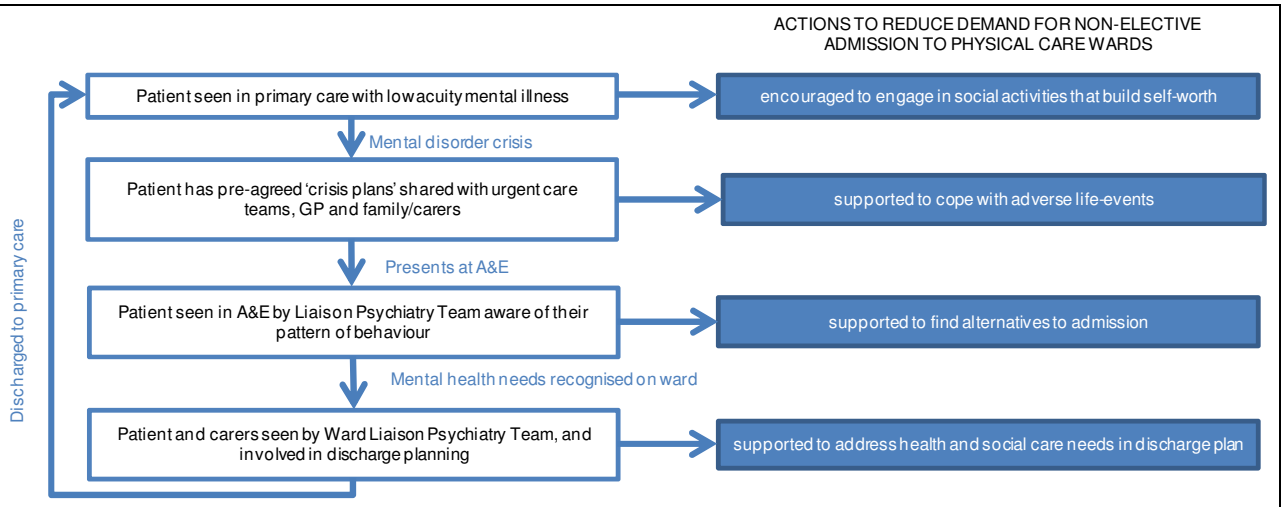
(Physical health emergency admissions for people with mental illness will be addressed within other schemes).

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

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

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

Model of care



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

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

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

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

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

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

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

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

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

Public Engagement

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

Carers/Self care

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

Learning and Development/Work force

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

The delivery chain

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

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

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

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

The evidence base

Please reference the evidence base which you have drawn on

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

Brent Health and Wellbeing Strategy and Joint Strategic Needs Assessment

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

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

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

Key assumptions

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

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

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

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

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

Brent-wide 12 month estimates of demand

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

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

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

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

Treatment

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

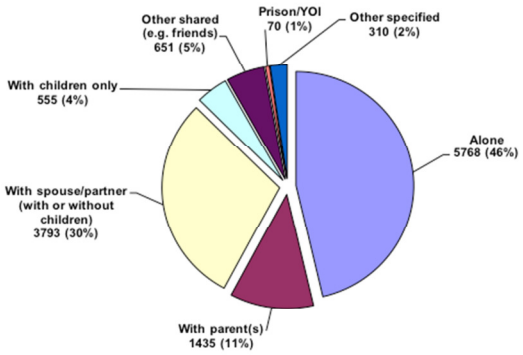
Contributory factors – national context
The scheme will tackle the underlying contributory factors that can lead adults with a mental illness to present in a crisis.

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

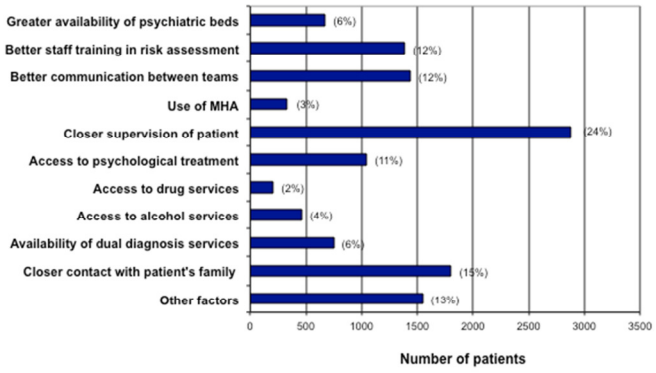
Social isolation
Suicide by patients receiving care under crisis resolution/home treatment teams (CR/HT) is now substantially more common than in in-patient care. In 2002-12 there were 1,943 patient suicides in the UK under CR/HT. CR/HT may not be suitable for patients at high risk or those who do not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

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

Living circumstances: patient suicides



Mental health teams' views on preventability: patient suicides



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

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

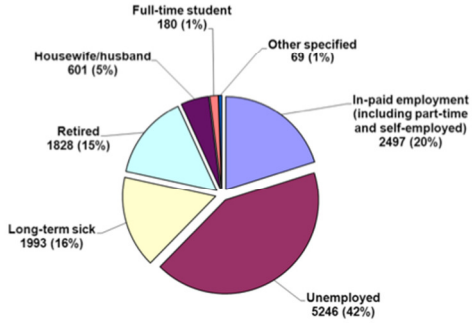
Adverse events
The first 3 months after discharge from psychiatric in-patient services remain a time of particularly high suicide risk – this is especially true in the first 1-2 weeks. Between 2002-12 there were 3,225 suicides in the UK by mental health patients in the post-discharge period, 18% of all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

Adverse events would include:

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

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

Employment status: patient suicides



Investment requirements

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

Impact of scheme

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

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

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

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

Feedback loop

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

Key performance indicators to be developed

This scheme will develop measures for:

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

Service user engagement

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

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

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

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

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

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

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

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

ANNEX 2 – Provider commentary

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

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PROVIDER

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

For HWB to populate:

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

For Provider to populate:

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

PROVIDER 2

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

For HWB to populate:

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

For Provider to populate:

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

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

PROVIDER 3

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

For HWB to populate:

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

For Provider to populate:

	Question	Response

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