Brent NHS Brent Clinical Commissioning Group	**Health and Wellbeing Board** 24 January 2017 **Report from the Chief Operating Officer of Brent Clinical Commissioning Group and the Strategic Director of Community Wellbeing, Brent Council**
	Wards Affected: ALL

Sustainability and Transformation Plan (STP) Update

1.0. Summary

1.1. The purpose of this report is to provide the Health and Wellbeing Board with an update on the progress of the delivery of STP in Brent.

1.2 In Brent the delivery of STP is overseen by the Health and Wellbeing Board, (HWBB) which recently reviewed and extended its standing invites to include key partners such as London North West Healthcare Trust (LNWH) and Central and North West London Foundation Trust to ensure effective governance arrangements for delivery of the STP.

1.3 A task and finish local Brent STP Planning Group comprising of key stakeholders established to develop the STP has now transitioned to STP Delivery Board. The membership and terms of reference for this board were approved by the HWBB in October 2016.

1.4 The STP Delivery Board has the key responsibility of overseeing the delivery of the six STP work streams which are the Brent big ticket items. It provides strategic and operational direction and ensures appropriate links to NWL STP delivery areas.

1.5 The STP Delivery Board is accountable to HWBB and provides regular updates to the HWBB. Going forward, the aim is to focus in detail on one specific workstream at each meeting with a summary overview of the remaining workstreams.

2.0. Recommendations

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

3.0. Detail

STP Governance

3.1 In order to deliver a plan as ambitious as the STP, it is essential that robust governance arrangements are in place to drive delivery. An STP Delivery Board in Brent has been established and mirrors the successful Children's Trust model of governance**.**

3.2 The Board reports to HWBB and oversees six subgroups responsible for delivery of the STP work streams and aligning with the five NWL Delivery Boards as required.

3.3 The STP Delivery Board has representation from Council, CCG, NHS provider organisations, Brent CVS, and HealthWatch Brent. It also includes representation from Council and CCG communications and engagement leads to facilitate on going communications and engagement throughout the process.

3.4 The STP governance structure chart is attached as Appendix one.

STP Management

3.5 The six STP work streams have designated Senior Responsible Officers (SRO) with responsibility for the delivery of the work streams.

3.6 The work streams are being supported by a joint CCG and Council STP Programme Team which is in the process of being established. The team is comprised of a director of integrated care which reports to both the Chief Operating Officer for the CCG and the Strategic Director for Community and Well Being. The Integrated Care Director will be supported by three programme managers to support the six work streams. The team will be supplemented by a programme officer to provide administration and co-ordination support for the STP workstreams and the Delivery Board.

3.7 Presently there are two interim project managers in place to provide support on Better Care Fund projects under the Frailty workstream. While the programme team is being established an additional interim manager will be recruited to support other work streams.

3.8 The STP programme team will be overseen by the STP Executive Group providing steer to the STP work streams, strategic support and influencing the delivery of the work streams

3.9 The STP Delivery Structure is attached as Appendix two.

STP Leadership Development

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

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

3.11 However there is widespread acknowledgement that delivering STP is highly complex and requires system collaboration and leadership at every level and across range of organisations. It is recognised nationally that this will require a different set of skills, resources and approaches by local leaders.

3.12 Similar to other footprints, in Brent and NWL the focus until late last year has been on planning, moving into the delivery phase has identified a shared concern about the system's ability to implement the plans. This will require us as leaders and organisations to work together in different ways.

3.13 A key challenge faced by leaders is being asked to collaborate with other organisations while still being held to account as an individual organisation. Also in the absence of any formal authority to make decisions on behalf of the system, there is recognised need for adopting new approaches, to try to gain agreement and consensus between organisations.

3.14 To facilitate these new ways of working the STP Delivery Board has agreed to commission a System Leadership development programme for its members. This is being discussed with Kings Fund Leadership Development team in view of their experience in working with health and care leaders, who are developing a bespoke proposal appropriate for the Brent system. The NWL Strategy Team is also well placed to support with this and discussions are taking place to understand the potential offer.

STP Delivery Board Update

3.15 The STP Delivery Board with its newly constituted membership and terms of reference focused on delivery has met twice since transitioning from planning to delivery phase.

3.16 The focus of the board so far has been to ensure that the scope, outcomes and deliverables of the six workstreams are fully agreed across partner organisations and reflect the outcomes of various engagement events that were held in September and October 2016. All the six work streams have completed scoping documents which articulate key deliverables and outcomes.

3.17 The work streams are now developing a programme of work that will build on existing initiatives, using an incremental approach to transformation to further progress the outcomes specified.

3.18 It is becoming apparent that there is need for dedicated programme support to deliver on the work programme identified in each of the workstreams. While lead commissioners and operational managers are progressing the work, this is additional to their core roles and the scale of change and transformation required needs the additional resources identified above.

STP work streams update

Prevention

3.19 This work stream continues to build on the existing initiatives on workplace based health and wellbeing initiatives and making every contact count.

3.20 The main focus of this work stream is to link with Delivery Area one Programme Board which is developing a business case for Alcohol teams in acute settings and treatment interventions in primary care and community. There is a strong likelihood that this would be funded at sector level and once confirmed the intention is for Brent to be an early implementer site at Northwick Park Hospital.

3.21 In addition a proposal to develop the next phase of Social Isolation Brent Initiative (SIBI) is being worked up jointly by Adult Social Care, Public Health and Primary Care leads. This will be based on a social prescription model and be part of the Whole Systems Integrated Care model.

New Models of Care

3.22 This workstream has been in development over a number of years and builds on Whole Systems Integrated Care (WISC). Providers and commissioners co designed the first phase of WISC in 2015 as a precursor to an Accountable Care Partnership delivery model. However, this work is largely commissioner led in view of the need to develop the provider landscape to respond to the challenge of delivering care in this manner.

3.23 The aim is to create highly integrated teams working day to day with groups of GP practices, delivering proactive and reactive care, in and out of hospital settings for some of our most complex patients.

3.24 This would be provided by a new provider model which is delivery and performance led and managed by a partnership of providers who form an Accountable Care Partnership (ACP). The ACP would be responsible for planning and managing care within a defined budget and set of outcomes for which they are jointly accountable.

3.25 The CCG has worked with providers to fully align and develop the WISC care planning and case management model so that it is consistent and equitable across Brent. Recognising that 'horizontal' integration of Primary care is the foundation on which 'vertical integration between primary care and other providers (community, acute mental health, adult social care and third sector), the CCG awarded a single contract to Brent Care Ltd (comprising all Brent GP practices) for the provision of WISC.

3.26 The overarching objective of this contract is keeping vulnerable people well in the community. This is achieved through professional intervention and supporting people to better self-care and self-manage. Patients have the potential to benefit from proactive, coordinated and integrated care and support to self-care in line with one of two WSIC levels of support; enhanced mainstream care or intensive case management for up to 12 weeks and then stepped down, if appropriate, to enhanced mainstream care.

3.27 To provide this service Brent Care Ltd have employed nursing support and worked with CVS Brent to secure six care navigators. Throughout 2016/17, Brent Care has aligned adult social care services and talking therapy services (IAPT) provided by Central and North West London Foundation Trust to provide an integrated approach to the management of long term conditions.

3.28 Going forward, the Community Services review recently undertaken by the CCG in partnership with Ealing CCG should inform the approach to securing greater vertical integration with community services, with specific focus on district/community nursing services in 2017/18. In addition, the informal alignment with adult social care and talking therapy services will also be further developed in 2017/18.

3.29 Based on this incremental approach to vertical integration, Brent has always been most closely aligned to the Multi Community Provider (MCP) model from the Five Year Forward View. The MCP model is well suited to models of community based care for those with complex or chronic long term conditions. The MCP offers a framework through which to integrate a range of providers / services across health and social care. The 'whole systems' model of case management for adults with LTCs could evolve using the MCP framework.

3.30 The workstream will therefore continue to focus on the commissioner role in developing this new provider vehicle through identifying the challenges the partnership is being asked to overcome (and translate these into meaningful outcomes) and to consider how we might use contracting and payment mechanisms to incentivise joined up working and shared accountability, and ensure funding flows to where it is needed most in the system.

Frailty

3.31 This is priority work stream and two distinct but interlinked elements – acute frailty model and out of hospital community provision.

3.32 The out of hospital element relates to Better Care Fund (BCF) schemes and are the most progressed. These are integrated re-ablement and rehabilitation service and effective hospital discharge supported by multi-disciplinary proactive care planning for people with long term conditions (WISC). The work programme for next year will be incorporated in BCF plan for 17-18 and will focus on nursing homes (improving quality, reducing admissions to A&E, managing the market), improved complex discharge pathway, discharge to assess at home, and improving effectiveness of community beds provision.

3.33 The Acute Frailty Model led by LNWH is focusing on three main components:

a) **Early identification and assessment**: utilising a pro-active method of reducing unnecessary admissions to the acute settings through an ambulatory service (OPRAC) for rapid assessment and diagnosis with referral access from ED, community, nursing homes and GP and reducing length of stay in hospital through and working with community services

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

b) **Acute Pathway**: a single point of access for all referrers to stream patients into the right service; comprehensive geriatric assessment by a multi-disciplinary team (MDT) including community and mental health practitioners (OPALS) at the earliest opportunity, interface with ED services to prevent older people with complex needs being admitted by default; early access to multi-speciality input and diagnostics.

c) **Integrated Discharge Service:** comprising of social workers, community health services and hospital discharge planners to facilitate a proactive timely discharge and transition from hospital to home or community services; progress on creating capacity by reducing duplication in assessments, enabling timely assessments thereby reducing delayed discharge.

Mental Health and Wellbeing

3.25. This work stream is in the scoping stage, although a scoping paper has been developed and presented to the board, more work is required to develop a focused and realistic work programme.

3.26. The main deliverables for this work stream is intended to be on reducing reliance on inpatient provision, reducing length of stay and occupancy rates; a focus on recovery with peer support, and enhanced primary care, which addresses wider determinants of health and supports people in the community.

Transforming Care for People with Learning Disabilities

3.27. This work stream has developed a work programme that has four components LD services integration – a comprehensive community learning disability/autism and challenging behaviour team and exploring the feasibility of a Section 75 agreement for the provision of an integrated service.

3.28. Market development – joint commissioning plans to ensure a full range of local services to enable people to remain with, or close to their families and communities; support workforce development across the health, social care, housing and voluntary sector workforce so that we have staff with the right skills in the right places.

3.29. Community support – make the best use of care and treatment reviews to ensure co-ordinated discharge care plans; ensure resources are used effectively to avoid admissions where possible; reduce our reliance on inpatient care and improve the quality of care.

3.30. Transitions – reduce waiting times for an assessment, develop and all age offer (across NWL) that provides the care and support needed during the transition period; strengthen the Education, health and care planning process.

Central Middlesex Hospital Hub Plus

3.31. This work stream identifies Central Middlesex Hospital (CMH) site as a major place-based opportunity, with the potential to accelerate integration and joint working for the benefit of local residents.

3.32. The work stream is still being scoped, emerging thinking is that there will be initially two broad strands of work; the first is estates-focused aimed at realising location and facility related opportunities and the second concentrates on service and service user driven opportunities, including the employment creation, learning opportunities as well as integrated models of support and care.

3.33. The Council and CCG submitted a One Public Estate (OPE) bid for the CMH site, which will provide seed funding for project management resource to develop the above mentioned strands of work.

3.34. In addition, the CCG has been successful with its application NHS England for Estates and Technology Transformation Funding (ETTF) for investment at Central Middlesex Hospital to create accommodation for a GP practice linked to a re-procurement that is of an APMS GP practice that is currently in progress.

3.35. In summary, each of the workstreams is at a different stage of implementation with initiatives that have been part of the Better Care Fund being most advanced at present. The HWBB will receive a further progress update on each workstream at its next meeting.

4.0 Finance Implications

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

5.0 Legal Implications

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

6.0 Diversity Implications

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

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

7.0 Staffing / Accommodation Implications (if appropriate)

N/A

Background papers

a) Brent Sustainability and Transformation Plan accessed via https://www.brent.gov.uk/media/16405520/16-07-13-brent-stp-chapter-draft.pdf

b) The North West London Sustainability & Transformation Plan accessed via https://www.healthiernorthwestlondon.nhs.uk/documents/sustainability-and-transformation-plans-stps

c) The NHS Five Year Forward View, accessed via https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

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