Healthcare for Brent

NHS Brent

Implementing 'Healthcare for London'

NHS Brent Strategic Planning

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Chief Executive
September 30th 2009

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- Emerging polysystem plans
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- Next steps

Introduction – Context

In 2008/09 NHS Brent developed a Commissioning Strategy Plan that set out a 5 year investment programme to deliver its vision of **making a significant improvement to the health and well-being of the people of Brent** with the following goals:

Goal 1: Reduce premature mortality and therefore increase life expectancy by three years by 2013

Goal 2: Reduce the gap in life expectancy by 6 months by 2013

Goal 3: Promote good health and prevent ill-health

Goal 4: To improve the quality and safety of services, so that by 2013 health and social care providers commissioned by NHS Brent receive a Care Quality Commission Review Standard at least equivalent to the existing Good rating in the Annual Health Check

Goal 5: To improve the patient experience of services, so that by 2013 health and social care providers commissioned by NHS Brent will achieve patient experience scores at least as good as the London average

Changing circumstances in the last year, and moving forward, require us to review our CSP to ensure that it both aligns with others across North West London and that it can continue to support progress towards delivering our goals and outcomes in the changing economic environment.

This presentation pack provides an initial statement of our progress and intentions as we review and realign our CSP.

Introduction – Alignment to Healthcare for London Care Pathways

We are redefining our CSP initiatives to align to the 8 Healthcare for London Care Pathways to provide a more robust and transparent platform for delivering Healthcare for London within Brent and the NWL sector.

9 Existing CSP Initiatives
Improve primary care services
Improve childhood immunisation rates
Improve vascular health
Reduce premature mortality from cancer
Improve intermediate care
Improve mental health and wellbeing
Improve maternity services
Give children and young people the best chance in life
Support healthy behaviours

8 Healthcare for London Pathways
Maternity and newborn
Children and young people
Acute care
Planned care
Mental health
Staying healthy
Long term conditions
End-of-life care

6 Healthcare for London Settings
Home
Polyclinic
Elective centre
Local hospital
Major acute
Specialist hospital

Introduction – Retaining commitment to our Goals

JSNA	Goals	Initiatives	WCC Outcome Measures
• Health inequalities	• Reduce the gap in life expectancy by 6 months by 2013	• Staying Healthy • Maternity and Newborn	• Reduce life expectancy gap • Reduce IMD score
• Circulatory disease and cancer are biggest killers	• Reduce premature mortality and therefore increase life expectancy by three years by 2013	• Staying Healthy • Children and young people • Long term Conditions	• Life expectancy • Reduce CVD mortality rate • Increase in smoking quitters • Increase in breast cancer screening
• Mental health as largest cause of morbidity • Smoking, diet and exercise • High diabetes, TB and HIV • Low uptake of preventive services	• Promote good health and prevent ill-health	• Mental Health • Long Term Conditions • Staying Healthy	• Increase in smoking quitters • Increase in MMR coverage
• High delayed discharges • Variation in performance across primary care	• Increase the proportion of activity commissioned from providers who perform at or above benchmarked performance standards	• Staying Healthy • Acute Care • Planned Care • End of Life Care	• Increase in MMR coverage • Reduce delayed transfers of care • Increase in diabetes controlled blood sugar
• Low satisfaction with access to GPs	• Meet or exceed nationally–reported benchmarked patient satisfaction rates for all services commissioned	• Acute Care • Planned Care • End of Life Care	• Increase patient satisfaction with GP access

Existing Provider Landscape Across Brent (top 6 providers)

Acute hospital provision	North West London Hospitals Trust	£104m	• Financially challenged trust • No clear route-map to clinically and financially stable future • Ongoing rationalisation across 2 sites, CMH and NWP
	Imperial College Healthcare Trust	£62m	• Academic Health Science Centre • Preferred specialist provider
	Royal Free Hampstead NHS Trust	£13m	• Local provider for south east of borough • Range of specialist maternity and paediatric care
Community services	Brent Community Services	£39m	• Emerging APO operating independently • Concerns over quality and productivity and ability to deliver some services
Independent contractors	71 GP Practices Dentists Pharmacies	£62m	• Large number of single and two-handed practices with poor infrastructure • Poor achievement for patient access / satisfaction • Variable quality and performance across practices
Mental health	Central & North West London Mental Health Trust	£34m	• Foundation trust • Modernisation programme required

All figures are 09/10 contract values

The Emerging Acute Provider Landscape Across Brent

North West London Hospital Acute Services Review

- In 2009 a health-economy wide review of North West London Hospitals (NWLHT) has been undertaken with involvement from the following:
  - Clinicians and managers from NHS Brent, NHS Harrow and North West London Hospitals
  - Representatives from both local authorities
  - Local patient participation groups
  - Review Board chaired by CEO, NHS Brent
  - Clinical Reference Group chaired by PEC Chair, NHS Brent
- Extensive scenario planning, with activity and financial modelling was undertaken using both PCTs' CSPs as a starting point and having identified fixed points of:
  - Maximising the use of Central Middlesex Hospital site – as a PFI build
  - Establishing primary care-led urgent care centres on both sites
  - Supporting the establishment of a HASU on Northwick Park site

The Emerging Acute Provider Landscape Across Brent (cont'd)

- Scenario planning workshops involving clinicians, managers, local patients and community representatives focused on care pathways relating to
  - Maternity and women's health
  - Children and young people
  - Urgent and emergency care
  - Planned care
  - Surgery
  - Intermediate care
- The overall outcome from the review concluded that NWLH's financial viability could not be ensured alone and needed to be considered within the wider North West London Transforming Acute Care Programme
- Two more immediate actions arose from the review
  - Further pre-consultation / deliberative work should be taken forward relating to the ongoing provision of in-patient paediatric beds on both sites
  - Relocation of emergency surgery from Central Middlesex Hospital to Northwick Park site

The Emerging Primary and Community Landscape Across Brent

- In April 2009 NHS Brent issued a discussion document " A Strategy for Improving and Developing Primary and Community Services for the Next Five Years"
- Clinical leadership for the document was provided by NHS Brent's Professional Executive Committee, who sponsored the programme. Clinical representatives from each of NHS Brent's five PBC clusters were on the Programme Steering Committee
- The document was developed with extensive involvement from the community of Brent including community forums, area forums, voluntary sector groups, Brent Youth Parliament, street canvassing, open meetings and wider scale media publicity
- The involvement culminated in a Deliberative Event involving 100 people representative of Brent's diverse population and demography - interactive voting yielded the following :
  - 47% participants felt that the current services did not meet their needs well
  - 93% participants agreed that there was a case for change
  - 75% participants felt that the proposed model would improve services
- The discussion document was widely consulted upon across the local Brent community, using a variety of methods for engagement. The feedback from the document was considered at the July meeting of the Board of NHS Brent and the strategy was adopted, noting the support for the direction of travel and improvements in quality required to deliver the outcomes

The Strategy underpins the Polysystem Proposals being taken forward

Polysystem Vision (1)

All patients will have access to care as close to home as possible, with care transferred from hospital that could be better provided close to home
1. Providing more specialist care close to home. This will include changes to some existing hospital out-patient appointments 2. Helping avoid admissions and helping people be discharged in a timely fashion 3. Providing minor procedures 4. Access to a rapid specialist opinion to support people's treatment being provided in the community

All Brent patients will have access to a standard range of practice based services:
These are expected to include: • minimum 45 hours opening each week • immunisation • child surveillance • level 1 long term conditions care • screening • level 1 health promotion • level 1 sexual health • diagnostics – ECG / phlebotomy / spirometry • choice of male / female GP • use of interpreting services • accepting patients for registration within a PCT agreed area • home visits • access to level 1 health visiting, district nursing and therapy services

All Brent patients will have access to practices that are:
• achieving national targets for preventative screening and quality • open sufficiently to see and manage their patients well • able to offer a range of services • able to recruit sufficient staff to meet their workload • located in suitable premises to meet their patients' needs • able to respond flexibly to change

Polysystem Vision (2) - All patients will have access to these services

GP:
- GP services
  - Consulting and procedure rooms
  - Dedicated child-friendly facilities
  - Core and extended GP services
  - Extended hours 8AM-8PM
- Practice Nurse services

Community services:
- District Nursing
- Health visitors & children's services
- Midwifery
- Specialised therapies
- Outreach services (TB/HIV)
- End-of-life care
- Dieticians
- Available 12 hours

Pharmacy:
- Medicines use review
- Medicines management services
- Anti-coagulation services
- Dispensing services
- Available 18 – 24 hours

Other healthcare professionals:
- Optician
- Dentist
- Other health professional
- Available 12 hours

Interactive Health Information Services:
- Smoking cessation
- Drug and alcohol information services
- Weight management
- Sexual health
- Dietary services
- Local services (e.g. social services, back to work services, and leisure facilities)
- Healthy living classes
- Available 18 – 24 hours

Minor procedures:
- Phlebotomy
- IUCD
- Suture removal
- Joint injections
- Minor surgical procedures
- Available 12 hours

Outpatient services:
- Management of chronic illness (e.g. COPD, asthma and diabetes)
- Community paediatrics
- Consultant or PwS
- Mental health
- Audiology
- Chemotherapy
- IV transfusions
- Access to pain management
- Available 12 hours

Urgent Care:
- Minor injuries unit
- Walk-in centre
- Urgent care centre
- Available out-of-hours

Diagnostics:
- ECG, Pulse Oximetry, Spirometry
- X-ray, U/S and Vascular Doppler
- CTG
- CT, MRI
- Colonoscopy
- Haematology, microbiology and pathology
- Available 18 – 24 hours

Long-term conditions:
- Detection of undiagnosed
- Screening & early detection
- Community matrons
- Management of disease registers
- Access to
  - Expert patient programme
  - Information prescriptions
  - Managers of complex needs
- Available 12 hours

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Polysystem Model System of Care

Model is based upon a network polysystem with spokes of practices, pharmacies, locality health centres, children's centres and a polyclinic

- Practice-based commissioning clusters geographically aligned to five polysystems
- Integrated Locality Partnership Boards for Children aligned to five polysystems
- Each cluster has produced a commissioning plan outlining implementation of its polysystem
- Core standards agreed for all GP practices and Neighbourhood Networks of practices
- Specifications for community nursing services based upon neighbourhood networks in polysystems
- Specifications for integrated teams based upon polysystem
- Infrastructure to deliver benefits being developed including
  - Clinical systems and patient records
  - Integrated care teams
  - Rationalised support functions

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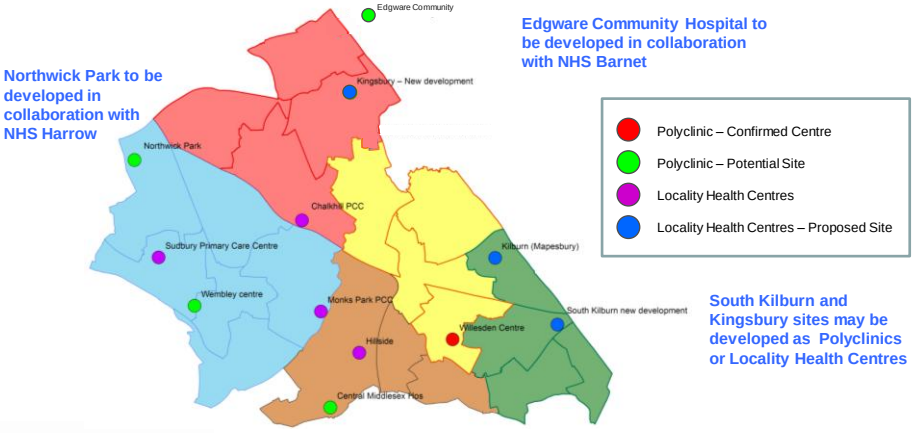
Emerging Polysystem Sites

Fixed points:

- GP Led Health Centre, Wembley Centre for Health and Care (June 2009)
- Urgent Care Centre, Central Middlesex Hospital (April 2010)
- Willesden Centre for Health and Care (PFI build)



Edgware Community Hospital to be developed in collaboration with NHS Barnet

Northwick Park to be developed in collaboration with NHS Harrow

South Kilburn and Kingsbury sites may be developed as Polyclinics or Locality Health Centres

Emerging Polysystems Plans

Progress to date and immediate next steps

- The development and agreement of the Primary and Community Services Strategy took longer than initially envisaged but resulted in strong and sustainable commitment from key partners, both to the case for change and to the polysystem as the framework for change
- All five Practice Based Commissioning clusters have developed supporting Commissioning Plans showing how they will work within practices, across networks of practices and within polyclinics to deliver the model of care and agreed quality outcomes
- These Commissioning Plans are the foundation for polysystem development and are currently being challenged and revisited to take account of
  - Healthcare for London Care Pathway developments
  - Revised scale of change / ambition to relocate acute services to polysystem settings of care (in line with the Healthcare for London Affordability Analysis)
  - Estates and workforce implications
  - Revised Market Management Strategy and commissioning / procurement options
  - Opportunities for improved integration and rationalisation with key partners including the local authority
- The overarching Polysystem Implementation Model together with plans for consultation and implementation will be included in our Commissioning Strategy Plan in December

Maternity Services – Case for change in Brent

- Brent is an outer London borough with a growing and dynamic population evidenced by a 3% average increase in birth rates since 2002
- Brent's score on the Index of Multiple Deprivation (IMD) has risen since 2004 and we are now one of the 15% most deprived areas in the country
- It is the most culturally diverse area in the country, and only one of two boroughs where black and minority ethnic groups are the majority (54.4%), with nearly 8% of our population classified as refugee or asylum seekers
- The infant mortality rate remains above the national average (2006 saw 6.6 infant deaths per 1000 births in Brent in comparison to the national average of 5.0 per 1000 births). An Infant Mortality National Support team visit to Brent in March 2009 made a number of strategic recommendations
- These factors contribute to the high ratio of complex or high risk pregnancies locally. This factor combined with a high vacancy factor at our local maternity provider (40% vacancy rate for community midwives) necessitates a continued focus on safety and quality of local maternity care

Maternity Services – Progress to date

The focus of progress to date has been a continued attention to improving the safety and quality of care following the Independent Review of Maternity Care provided by North West London Hospitals NHS Trust in 2008. Progress has also been achieved in relation to sector wide developments and implementation of Maternity Matters standards.

- **Safety and Quality**
  - Achievement of recommendations aimed at reducing risk for the large proportion of vulnerable and high risk women attending Northwick Park Hospital
  - Relocation of the stand-alone midwifery-led unit to be co-located with obstetric care at Northwick Park Hospital
- **North West Sector Maternity Project**
  - Implementation of the North West sector approved GP Antenatal Referral Form
  - Progressing and monitoring the implementation of the NWL sector Maternity Service Quality Specification 2009/10
- **Maternity Matters Standards**
  - Joint planning with stakeholders to improve on early access to antenatal care
  - Limited implementation of an integrated midwifery model of care which will offer access to antenatal and postnatal care within community settings i.e. children's centres
  - Audit of one to one care in established labour and development of patient survey to audit experiences and perception of care given
  - Research into characteristics of 'late bookers' in Brent to address barriers to early access
  - Revitalising of Maternity Services Liaison Committee to ensure more service user and Primary Care clinician engagement in service development and commissioning

Maternity Services – Plans for next stage

- **Safety and Quality of Care**
  - Ensure that one to one care in established labour is achieved and maintained
  - Ensure that 96 hours per week of consultant obstetric cover is achieved and maintained
  - Continued monitoring of workforce issues arising from high vacancy rates
  - Implementation of Infant Mortality National Support team recommendations
- **New model of Care which is aligned to integrated polysystem-based services in partnership with local authority children's services in Children's Centres deliver:**
  - Increased range of access points to maternity services for antenatal and postnatal care within community settings reducing dependence on hospital settings
  - Increased choice of units and types of birth focusing on accessible information to support using birth unit or home birth
  - Pathway re-design to ensure continuity of care for all service users
  - Full implementation of the North West London Primary Care Trusts' *Maternity Service Quality Specification 2009/10*
- **Improving the service user experience**
  - Greater engagement of Maternity Service Liaison Committee into pathway development and service re-design
  - Greater stakeholder engagement (clinicians service users) in service design and commissioning decisions

Children and Young People – Case for change in Brent

- Brent is an outer London borough with a growing and dynamic population with just over a quarter of residents being under 19
- The ethnic diversity of Brent's children and young people's population is greater than in the adult population. Over three quarters of Brent's school children are from black or minority ethnic heritage with over 130 languages spoken
- Brent's score on the Index of Multiple Deprivation (IMD) has risen since 2004 and we are now one of the 15% most deprived areas in the country
- Socio-economic deprivation is a known risk factor for poor outcomes in children
- Brent has a high proportion of children and young people living in single adult households which contributes further to the inequalities that exist
- There are significant workforce issues in Brent and this combined with the inequalities and increased demand has created severe capacity constraints in universal children's health services (health visiting and school nursing)
- Current patterns of care show an over-reliance on acute hospital settings for care that would more-appropriately be accessed in the community

Children and Young People – Progress to date

There has been good progress in strengthening local Children's Trust arrangements in Brent. This has enabled:

- A shared vision for the future of children's services in Brent contained in the local Children and Young People's Plan (2009-11)
- A robust strategic governance model which takes into consideration the provider and commissioner roles and contexts across the Children's Trust
- A focus on improving the safety and quality of safeguarding services for children and young people in partnership with the local authority
- Agreement of a new model of integrated and locality based service delivery in partnership with local authority children's services and in alignment with the polysystem network of care
- Establishment of Locality Partnership Boards for each polysystem involving clinicians, social and education professionals, other agencies and users / carers

Children and Young People – Plans for next stage

Brent Children's Trust has a shared vision for more integrated and locality-based service delivery. The next steps for achieving the vision are:

- Reviewing care pathways for universal, targeted and specialist services to ensure alignment with the polysystem network of care
- Improving capacity and access to universal services through community settings (closer integration of health visiting and school nursing to children's centres and schools)
- Improving access to targeted and specialist services providing care closer to home for children and young people with chronic and long term conditions
- Improving access to both planned and urgent care within the polysystem reducing the need for
  - Outpatient appointments at acute hospitals
  - A&E attendances
  - Unnecessary in-patient episodes (including pre-consultation work to determine bed base required across the two North West London Hospitals

Acute Care – Case for change in Brent

Access to Urgent Care services is inconsistent

- A & E attendances by Brent residents are high and rising at a rate of 8% per year
- 60% A & E attendances are for conditions that could/should be managed in Primary Care
- Emergency admissions are continuing to rise
- Patient satisfaction with access to GP services is poor and deteriorating

Stroke pathway

- Brent has a higher incidence of stroke than the London average
- Community rehabilitation services are often unable to respond to demand in a timely fashion
- An audit of stroke cases from July 07-June 08 showed that out of 343 cases of stroke, 24% receive no ongoing therapy on discharge into the community

Delayed Discharge from Acute environment

- Brent suffers from a high proportion of delayed discharges.
- A summary of 08/ 09 Delayed Bed Days recorded 1633 delayed days due to social care
- 60% of long term care decisions are being made by the LA from acute settings

Acute Care – Progress to date

- **A GP-led health centre opened in July 2009**, offering extended opening hours and a walk-in service, improving access to primary care
- **A detailed service specification for Urgent Care at Central Middlesex Hospital has been developed**, and a robust stakeholder engagement exercise conducted following DH guidelines for user engagement in urgent care services. The service is now ready to commence procurement with the new service being in place by Spring 2010
- **An integrated model for intermediate care (STARRs/Virtual Ward) has been created** in partnership with the local authority, involving significant investment in new and changed services to allow care currently delivered in the acute environment to be provided in a community setting. The model includes a Rapid Response service, for which a pilot is in progress, and an Acute Home Care service implemented in July 09. The model includes significant new investment in reablement services
- **The stakeholder consultation exercise regarding stroke and major trauma services received strong local support** with Brent achieving the 2nd highest response rate to the Healthcare for London consultation
- **Stroke early supported discharge and rehabilitation services have been developed** to support the Stroke Pathway. The stroke rehabilitation package was developed by NHS Brent in conjunction with the provider (Clinicenta). The specification is now being adopted by PCTs across North London. These services are in a position to go live, pending provider readiness

Acute Care – Plans for next stage

Improving Urgent access to Primary Care

- Implementation of the balanced scorecard/access improvements access all GP practices
- Implementation of strategy for urgent care including use of GP Led Health Centres; Urgent Care Centre and Out-of-Hours service
- Opening of UCC at CMH

Reducing unnecessary acute hospital admissions

- Implementation of Intermediate Care Strategy/Virtual Ward
- Improvements across all steps of the Brent NHS and Social Care LTC Model
- Integration of health and social care assessment/brokerage systems

Implementing the Health for London stroke pathway

- Implementation of Early Supported Discharge for stroke reducing LOS on Stroke Units
- Implementation of full Health for London Stroke Pathway

Planned Care – Case for Change in Brent

High-throughput procedures

- Community infrastructure underutilised
- Above-average day case rate achieved by local provider
- CMH model of care reflects good practice

Outpatients and diagnostic services

- GP referrals to acute care are increasing
- Variable referral rates between practices
- Lack of primary care pathways for elective care
- Variable timely access to diagnostic services
- Community infrastructure underutilised

Community-based supportive care

- Long waiting times for community therapy services
- Lack of primary care pathways for community supportive care
- Community-based nursing services require review and competence-development

Planned Care – Progress to date

- Practice-based commissioning clusters have agreed Commissioning Plans outlining priority planned care pathways for development, including need for consistent pathways across Brent
- PEC and PBC co-sponsors identified to provide clinical leadership to the programme
- Acute specialists identified to provide clinical expertise to the programme
- Healthcare for London Affordability Model applied to all outpatient and elective inpatient activity
- Agreed to use Map of Medicine as initial starting point for pathway development
- Priority pathways (in line with PBC Commissioning Plans) identified
  - Orthopaedics
  - Gynaecology
  - ENT
  - Urology
  - Dermatology
  - General Surgery
  - Gastroenterology

Planned Care – Plan for the next stage

Clinical Workshops at speciality level will determine :

- Optimum care pathways for priority areas
- Detailed specification requirements to support change within each setting of care
- Optimum activity changes within each setting of care

Polysystem Development

- Outputs from the clinical workshops will be modelled across the polysystem
- PBC clinicians will apply modelling to inform cluster configurations
- PBC / PEC clinicians will review other pathways based upon HfL assumptions
- Outputs will be included in polysystem implementation plan

Market Management Strategy

- Changing pathways will be included in the revised Market Management Strategy and Commissioning / Procurement Plan

Mental Health – Case for change in Brent

NHS Brent has a higher than national average proportion of mental health problems.

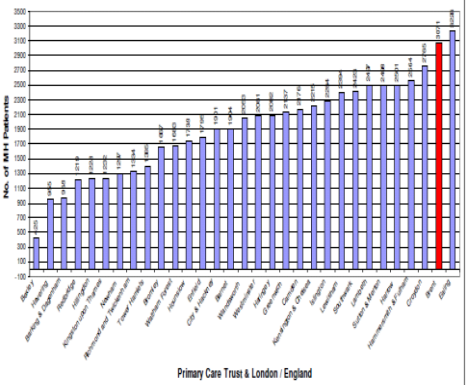
A patient experience survey was carried out across NHS Brent in 2007/8 for mental health. It highlighted "poor patient experience (lower than 80%) in: access and waiting, information and choice, safe, high quality and coordinated care".

The distribution of need varies greatly within the borough, the general needs being higher in the south of the borough with Carlton, Stonebridge, and Harlesden having the highest levels of mental illness, also indicated by the highest level of antidepressant prescribing.

44% of all acute admissions are Black African men compared to Harrow 14%, Westminster 25%, K&C 16% and the national average 9%.

Access to talking therapies is patchy. Currently the majority of spending for psychological therapies occurs within secondary care while the majority of need remains in primary care.

Figure MH3. Number of Patients with Mental Illness in London PCTs and England (2005/2006)



Source: QMAS Data - The Quality and Outcomes Framework (QOF) for April 2006 - March 2007)

Mental Health – Progress to date

- During 2009 NHS Brent made significant progress with their major provider CNWL and agreed a performance management framework including strong clinical leadership in the contract management process
- Planned programme of clinically-led review and development of care pathways across Brent including primary and secondary care clinicians and led by PEC chair
- Improved productivity and increased activity for Crisis Resolution agreed and implemented
- Enhanced Early Intervention Service in Psychosis commissioned
- Investment in a memory clinic to support implementation of the dementia strategy
- NHS Brent has submitted its bid to NHS London and are currently developing an IAPT model that will meet the needs of the local population
- Ongoing collaborative commissioning work with other PCTs to review the current contract arrangements, specifically looking at models of service which deliver efficiencies and improved outcomes in preparation for the implementation of the new NHS contract for Mental Health and Learning Disability services

Mental Health – Plans for next stage

Collaborative Commissioning
- Closer integration between NHS Brent and London Borough of Brent as commissioners of care
- Closer collaboration between main PCTs commissioning care from CNWL
- Robust contract negotiation

Review of mental health care pathways
- Strategic review of mental health care pathways (in collaboration with LBB) to ensure model of care is consistent with forward-looking, care out of hospital approach within established polysystem networks of care

Service Developments
- Ongoing development and implementation of IAPT
- Ongoing development of services in line with Dementia Strategy

Staying Healthy – Case for change in Brent

Circulatory disease and cancers
- Cardiovascular disease is the biggest killer in Brent accounting for 448 deaths in 2008 and disproportionately affects the most deprived areas

Smoking, diet and exercise
- One in six deaths (18%, 310 deaths) in Brent were caused by smoking
- Almost one fifth of Brent's Adult population are estimated to be obese
- Approximately 2/3rds of Brent's population are estimated as not eating the recommended amount of fruit and vegetables per week
- Over half of our population is not taking part in any form of physical exercise

High prevalence of diabetes TB and HIV
- More than 16,924 patients (4.8%) with diabetes are registered with a GP. This is amongst the highest prevalence in the country and the number is set to increase
- The TB notification rate (266.6 per 100,000) during 2005/2007 period was one of the highest in the country
- There are 726 people living with HIV/AIDS in Brent

Uptake of preventive services
- Low uptake of some preventative services, such as smoking cessation, breast and cervical screening, and immunisation and vaccination

Staying Healthy – Progress to date

- Established Tobacco Alliance with key local partners to provide a coordinated approach to tackling all tobacco-related issues
- Launched new incentive-based smoking cessation programme to reduce the number of smokers in Brent with significant increase in registrations through the first quarter of the year
- Developed operational policies and clinical pathways in conjunction with stakeholders for a borough-wide roll-out of NHS Healthchecks
- Child Obesity strategy completed
- Immunisation data quality issues have been identified and cleansing is in progress
- Chlamydia screening available from over 60 sites, including 80% of General Practices
- Cancer screening workshops to investigate low uptake

Staying Healthy – Plans for next stage

- Plans in place to commission stop smoking services from community groups, dentists and opticians in addition to the current providers
- Smoking cessation programme subject to intensive performance management over next two years to ensure targets are achieved
- Plans to offer an NHS Healthcheck to all 40 to 74 year-olds in Brent over the next 4 years
- Obesity, substance misuse and alcohol strategies under development
- An updated immunisations data mechanism is being established in order to manage performance on immunisation uptake
- An Organisation Development Strategy is being developed
- Community outreach strategy in development to support the achievement of the Chlamydia screening target
- Working in Partnership with the local authority to develop and implement London 2012 initiatives
- Cancer screening social marketing campaign

Long Term Conditions – Case for change in Brent

Circulatory disease and cancers

Cardiovascular disease is the biggest killer in Brent accounting for 448 deaths in 2008 and disproportionately affects the most deprived areas.

On our disease registers we have over 37,000 patients with hypertension, nearly 17,000 patients with diabetes and 18,000 patients with a respiratory condition. According to QMAS, Brent prevalence for diabetes is 5% but is probably nearer 8%. The prevalence is expected to increase further by 2012. We perform quite poorly on people having well controlled diabetes. We want to increase the % of people with a HbA1c of <=7 from 63% to 74% by 2012/03.

Pathway development in Brent

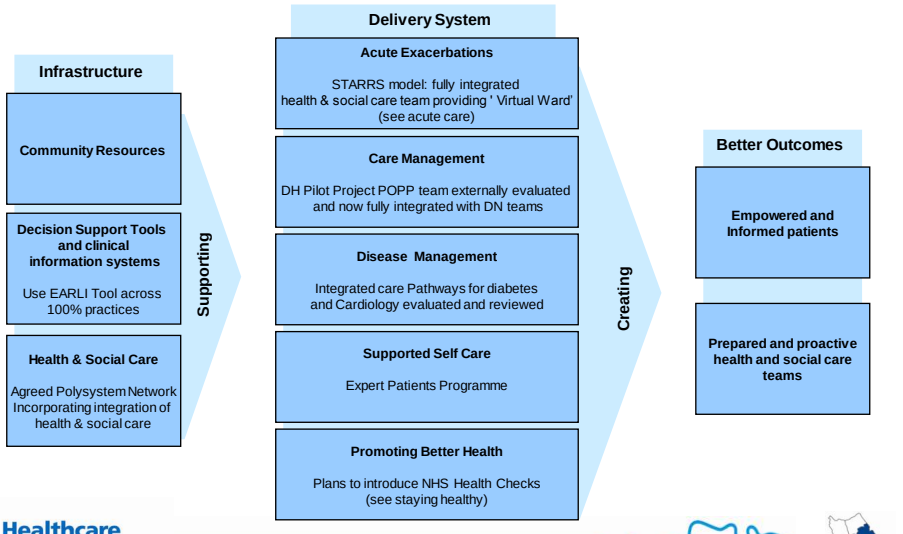
We have well established pathways for diabetes and cardiology with close working between specialist community services and acute care. Some practices provide good chronic disease management. More could be achieved in integrating services around the patient, providing a standard offering to all patients including greater support for self management, better outcomes for patients and improved value for money and the development of a personalised care plan for each patient with a long term condition.

Healthy lifestyles

We have nearly 24,000 adults who are recorded as obese in Brent and have the lowest uptake of recreational facilities in London. We need to identify early those at risk of vascular disease and offer them lifestyle interventions such as weight loss and exercise so they can delay the onset of diabetes and lower their risk of early death or disability. More deprived areas have lower uptake of healthy lifestyles and preventive services.

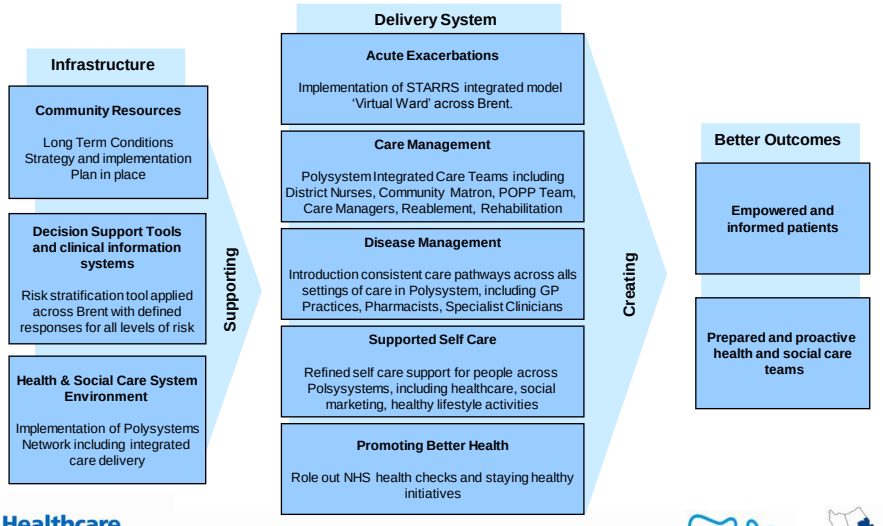
Long Term Conditions – Progress to date

Using an adaptation of the NHS and Social Care Conditions Model it is possible to map progress to date



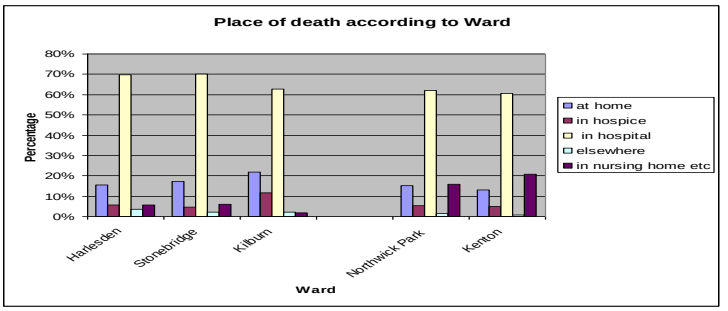
Long Term Conditions – Plan for the next stage

Using an adaptation of the NHS and Social Care Conditions Model it is possible to map future flow



End of Life – Case for change in Brent

- The majority of deaths in Brent are from Cancer and Ischemic Heart Disease
- Currently Brent has 65% of deaths occurring in a hospital setting and 16.1% at home and the majority of the rest are in nursing homes (the current average benchmarked performance for England being 10% at home)
- People living in the deprived wards of Brent are more likely to die in hospital



- Feedback from multi-disciplined stakeholder workshops cited insufficient information and confidence in current community infrastructure as the main barriers to patients and carers exercising real choice in terms of place of treatment and death

End of Life – Progress to date

Stakeholder Review

- Multi-disciplinary stakeholder workshops undertaken to review current service provision and scope local strategy development with the following feedback
  - Hospice at Home too limited
  - People don't know of services or how to access them
  - Pro-active visits by Night District Nurses not available
  - Quality of social services carers & continuity care – different person every day
  - Nursing home staff need training in EOL care
  - Differing response by the two out of hours GP Services within Brent

Service Review

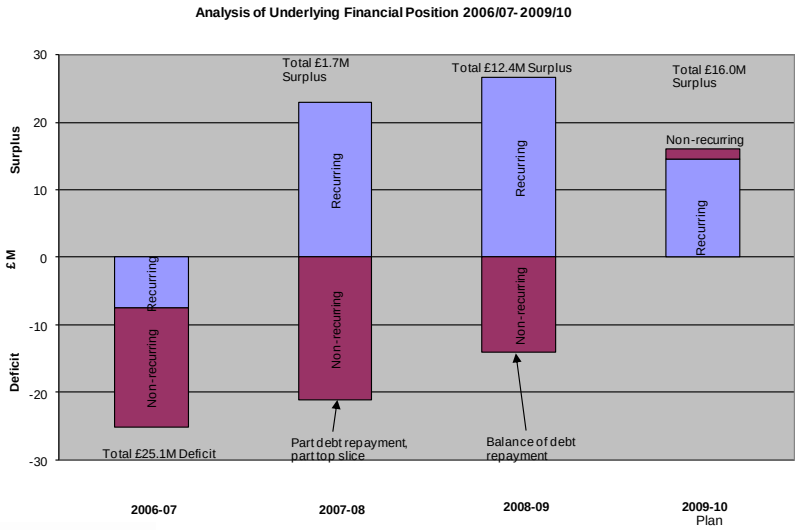
- Initial review of current contract portfolio for EOL suggests most commissioning expenditure in hospices – in-patients
- Difficult to quantify expenditure in acute or in primary and community care

End Of Life – Plans for next stage

End of Life Strategy

- Improved understanding of current services commissioned
- Improved understanding of all stakeholders' experiences
- Development of agreed End of Life Strategy
- Agreement of Business Case and phased implementation plan

Progress to date on activity and affordability modelling



Planning for 2010/11 onwards - Financial Context

The financial outlook for the PCT for 2010/11 onwards will be significantly tighter than projected in the CSP due to a combination of :-

- Tighter economic climate
- Changes in national resource allocation (NHS Brent is currently spending £37m above its weighted capitation target)
- Impact of revised Planning Assumptions 2010/11-2013/14 published by SHA
- Pressures in 09/10 on acute contracts

The medium term financial strategy has been reviewed to incorporate and address the issues above.

Key Financial Assumptions - Overview

Projections have been modelled under a number of key financial assumptions:-

The focus of the financial projections in the following slides is on the PCT's recurrent financial position

2009/10 full year financial outturn forecast has been modelled under the following 3 scenarios based on month 5:-

Planning Assumption Scenarios	Recurrent FY E Under/(Over)
	Rec
	£m
Base case	6.4
Upside	12.8
Downside	-0.2

Base case £6.4m reconciles to the forecast 2009/10 outturn at month 5 as follows:-

Reconciliation to full year effect baseline	£M
Forecast outturn at Month 5- 2009/10	13.5
deduct: Non Recurrent forecast outturn	-3.9
deduct: Full year effect in 2010/11	-3.2
Recurrent full year 2009/10 basecase	**6.4**

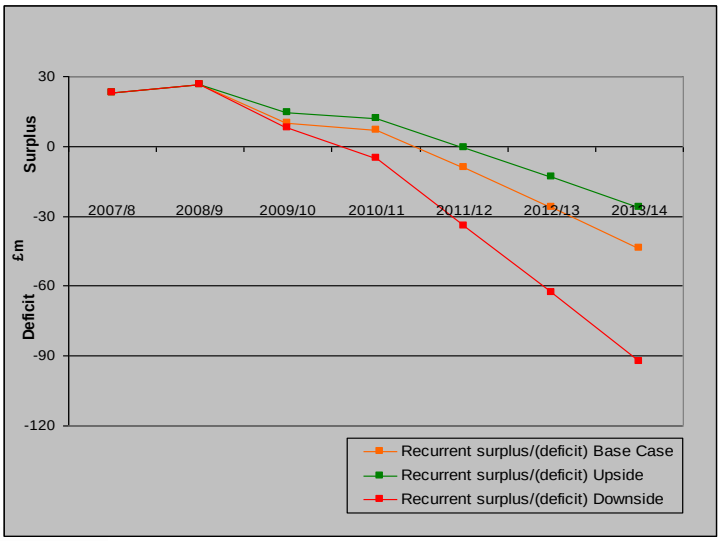
Assumptions for 2010/11-2013/14 reflect NHS London HfL affordability assumptions

All financial scenarios initially have been developed on a PCT 'do nothing' basis i.e. no further investment and, initially no savings after 2009/10

Financial Scenarios

- The financial impact of each scenario covering the period 2010/11-2013/14 is set out in the graph on the next slide
- The analysis reflects the PCT's recurrent financial position under each scenario
- This excludes both the potential mitigation of the PCT's financial position by the use of non-recurrent surpluses carried forward and also the additional pressure of any deficits on the total financial position as a consequence of the need to repay deficits
- All 3 scenarios have been built on a 'do nothing' basis from 2010/11 i.e. no further investment and no savings programme

Financial Scenarios – Recurrent Surplus / (Deficit) (Do Nothing)



Level of Savings / Disinvestment required to achieve sustainable financial position under all scenarios

- The Base case scenario demonstrates a requirement to save recurrently £60m (approx) over the three year period 2011/12 – 2013/14 in order to maintain a sustainable financial position and to allow investment in key priorities (equivalent to an average of £20m p.a.)

- The Upside scenario demonstrates a requirement to save recurrently £45m (approx) over the three year period 2011/12 – 2013/14 in order to maintain a sustainable financial position (equivalent to an average of £15m p.a.)

- The Downside case scenario demonstrates a requirement to save recurrently £105m (approx) over the three year period 2011/12 – 2013/14 in order to maintain a sustainable financial position (equivalent to an average of £35m p.a.)

HFL - Three broad actions for commissioners to take

		Description
1	Shift to lower cost setting	• Reduce unit price for those services that can be safely and more cost effectively provided through a different pathway out of the hospital and closer to home
2	LTC and case management	• Provide care proactively for people outside of hospital to prevent use of hospital services
2	Prevention	• Reduce demand for healthcare services by addressing health behaviours to reduce risk of ill-health and by improving screening to detect ill health at an earlier stage
2	De-commissioning	• Stop commissioning and providing low value added interventions (e.g., grommets, some joint replacements, some OP follow-ups)
3	Reduced unit costs in the non acute sector	• Reduce unit price of non-acute services to be delivered within a polysystem setting (which will also deliver activity shifted from acute, as well as activity from LTC and prevention) • Eliminate unnecessary and costly service overlaps (e.g., out-of-hours, extended hours, urgent care, A&E)

Source : PCT CEs 18/6/09

HFL initiatives - NHS Brent specific modelling – summary of potential savings

Themes 1, 2a and 2c are based on the application of the HfL methodology to Brent specific 2008/09 actual activity at specialty level

Themes 2b and 3 based on Brent (3.8%) of total London costs

Theme	Savings Initiatives	Core Scenario			Aggressive Scenario		
		Gross Red'n £m	Increased Non-acute £m	Net Reduction £m	Gross Red'n £m	Increased Non-acute £m	Net Reduction £m
1and 2a	**Shift to Lower Cost Settings/ LTC management:-**						
	Out patients	21.8	16.7	5.1	30.6	22.2	8.4
	Admitted patients - elective and day cases	5.4	0.4	5.0	5.4	0.4	5.0
	Admitted patients - non-elective	4.5	0.2	4.3	11.2	0.5	10.7
	A&E	3.8	3.4	0.4	4.6	3.3	1.3
	Community	4.5	2.5	2.0	14.7	5.8	8.9
	Sub total Themes 1 and 2a	40.0	23.2	16.8	66.5	32.2	34.3
2b	**Prevention**	0.0	0.0	0.0	2.7	0.4	2.3
2c	**Decommissioning:-**						
	Out patients (note)	8.6	0.0	8.6	3.4	0.0	3.4
	Admitted patients - elective and day cases	2.0	0.0	2.0	2.3	0.0	2.3
	Sub total Themes 2c	10.6	0.0	10.6	5.7	0.0	5.7
3	**Reduced Unit Costs in Non Acute Sector**	30.1	0.0	30.1	76.3	0.0	76.3
	Grand Total	**80.7**	**23.2**	**57.5**	**151.2**	**32.6**	**118.6**
	Savings target			**60.0**			**105.0**

Note:
The Aggressive savings in relation to 2c (Decommissioning outpatients) are less than the Core savings because of 100% shifts to lower cost setting (1 & 2a) in a number of specialties leaving no residual balance for Decommissioning

HFL Lower cost setting and LTC (1 & 2a) – Analysis of activity and cost

PODs	Brent CSP 2008-09		HFL Core		HFL Aggressive	
	Activity No's	£ 000s	Activity No's	£ 000s	Activity No's	£ 000s
Savings from Shift to Lower Cost Settings:-						
Elective Medicine			(1,900)	(2,876)	(1,900)	(2,876)
Non Elective Medicine (Primary and Intermediate Care)	(2,865)	(4,351)	(1,894)	(4,521)	(4,388)	(11,202)
Elective Surgery	(600)	(360)	(1,411)	(2,547)	(1,411)	(2,547)
Non Elective Surgery			-	-	-	-
Total Inpatient	(3,465)	(4,711)	(5,205)	(9,944)	(7,699)	(16,625)
Outpatient	(57,323)	(7,910)	(172,787)	(21,781)	(241,739)	(30,554)
A&E	(43,008)	(2,408)	(62,908)	(3,837)	(75,489)	(4,605)
Community Services			(33,800)	(4,462)	(111,540)	(14,723)
Total Shift to Lower Cost Settings	**(103,796)**	**(15,029)**	**(274,700)**	**(40,024)**	**(436,467)**	**(66,507)**
Cost of Reprovision in Lower Cost Settings:-						
Elective Medicine			1,900	217	1,900	217
Non Elective Medicine (Including Intermediate Care)	2,526	388	1,894	216	4,388	500
Elective Surgery	600	252	1,411	161	1,411	161
Non Elective Surgery			-	-	-	-
Sub Total Inpatient	3,126	640	5,205	594	7,699	878
Outpatient	57,392	5,670	172,787	16,760	241,739	22,240
A&E	43,278	2,408	62,908	3,397	75,489	3,322
Community Services			33,800	2,467	111,540	5,800
Total Cost of Reprovision	**103,796**	**8,718**	**274,700**	**23,218**	**436,467**	**32,240**
Net Savings		**(6,311)**		**(16,806)**		**(34,267)**

Notes:
HFL Core and Aggressive excludes Decommissioning and Productivity
Community services transfer is assumed at 50% into Home environment and 50% into Polyclinic setting

HFL Decommissioning (2c) – Analysis of activity and cost

POINT OF DELIVERY	HFL CORE		HFL AGGRESSIVE	
	Activity	Cost £ 000s	Activity	Cost £ 000s
Outpatients				
Medical Specialties	39,038	5,514	27,184	3,048
Surgical Specialties	28,560	3,091	2,850	332
Total Outpatients	67,598	8,605	30,034	3,380
Elective & Daycase				
Medical Specialties	61	89	-	-
Surgical Specialties	1,058	1,910	1,270	2,292
Total Elective & Daycase	1,119	1,999	1,270	2,292
Grand Total	**68,717**	**10,604**	**31,304**	**5,672**

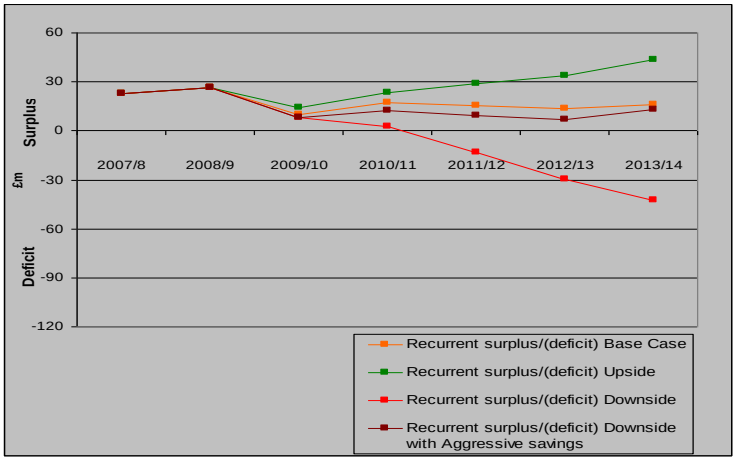
HFL % Activity Transfers (1, 2a & 2c)

POINT OF DELIVERY	Core			Aggressive		
	Transfer to polysystem	Decommissioning	Residual activity in acute	Transfer to polysystem	Decommissioning	Residual activity in acute
	%	%	%	%	%	%
Outpatients						
Medical	38	20	42	53	14	33
Surgical	69	20	11	97	2	1
Total Outpatients	51	20	29	72	10	18
A&E	50	0	50	60	0	40
Elective and Daycase						
Medical	16	0	84	16	0	84
Surgical	8	6	86	8	7	85
Total Elective and Daycase	11	4	85	11	4	85
Non Elective						
Medical	7	0	93	16	0	84
Surgical	0	0	100	0	0	100
Total Non Elective	6	0	94	14	0	86

HFL Reduced Costs in Non-Acute Sector (3)

Reduced Costs in Non-Acute Sector	Core		Aggressive	
Categories	Pan London (£ M)	Brent (£ M)	Pan London (£ M)	Brent (£ M)
Staff Productivity				
GP/ Nurse Practitioner	269	10	593	23
Primary Care skill mix	64	2	65	2
District Nursing	110	4	150	6
Community skill mix	75	3	225	9
Polysystem staff consolidation	47	2	140	5
Reduced appointment times	138	5	570	22
Space Utilisation				
Polysystem consolidation	18	1	55	2
Drug Expenditure				
Reduction in branded prices	30	1	90	3
Reduction in prescribing variability	40	2	120	5
Total	**791**	**30**	**2,008**	**76**

Impact of HFL core savings on underlying recurrent position



- The base case and upside scenarios provide surplus for sustainable investment
- The downside scenario requires additional savings to ensure a sustainable position. This is shown in the downside with aggressive savings line

Current status of plans

Volume of activity change for which there are **definite plans**	5% (Interm. care)
Volume of activity change for which there are **plans in principle**	0%
Volume of activity change for which there are **no definite plans yet**	95% (All other)

Issues and risks to delivery

- Basis for projections of transfers of activity out of acute settings (themes 1, 2a and 2c)
- Ownership by PBC of transfers from acute settings
- Compatibility of acute activity shifts with acute sector services reconfiguration
- Implications for enablers (estates, workforce, IT) not yet assessed
- Delivery of polysystem alternative to acute provision in appropriate timescale and at affordable cost
- Deliverability of primary care savings within existing GP contractual arrangements
- Basis for other savings target in non acute sector, particularly under aggressive scenario
- Capability of PCT to deliver the savings targets within the required timeframe
- Resulting instability in established providers

Other potential savings areas under review

In order to mitigate the risks to delivery set out in the previous slide, a number of additional potential savings initiatives are currently being reviewed as summarised below.

- Acute Claims validation – targets for ACV and CSL
- Primary Care
  - QOF payments validation
  - List size validation
  - Dental contract prices
- HQ
- Continuing care procurement
- Mental Health
  - CNWL productivity
  - Whole system review

Next steps – Overall timeline