Brent NHS Brent Clinical Commissioning Group	**Health and Wellbeing Board** 9 October 2018
	Report from the Managing Director, Brent Clinical Commissioning Group

Brent Clinical Commissioning Group Commissioning Intentions 2019-2021

Wards Affected:	ALL
Key or Non-Key Decision:	N/A
Open or Part/Fully Exempt: (If exempt, please highlight relevant paragraph of Part 1, Schedule 12A of 1972 Local Government Act)	Open
No. of Appendices:	One: • Draft Commissioning Intentions Presentation
Background Papers:	None
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1.0 Purpose of the Report

1.1 This report details the commissioning intentions for NHS Brent Clinical Commissioning Group (CCG) for the financial years 2019/20 and 2020/21. These are aligned with the North West London (NWL) Sustainability and Transformation Plan (STP).

1.2 All Clinical Commissioning Groups (CCGs) develop and publish their commissioning intentions on an annual basis. Brent CCG has taken a proactive and inclusive approach to the development of its commissioning intentions for 2019-21, with a number of different consultation events having taken place over the last 2 months, including the Health Partners Forum held at the Sattavis Centre on 29th August 2018.

1.3 Following agreement of the CCG Governing Body to these commissioning intentions, the CCG teams will then move into the contracting cycle to embed these intentions within service contracts and contract monitoring during the course of the 2019-21 year.

1.4 The Health & Wellbeing Board should comment and provide a statement to the CCG on the Commissioning Intentions.

2.0 Recommendation

2.1 It is recommended that the HWB provide comments to the CCG on the Commissioning Intentions which can be included as a statement in the Commissioning Intentions document.

3.0 Detail

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

3.2 The key national and local drivers for the commissioning intentions are the Five Year Forward View, the North West London Sustainability & Transformation Plan (STP) and the Brent Health and Care Transformation Board priorities.

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

Brent's Health & Well-Being Gaps	Brent's Care & Quality Gaps
• **Common mental health disorders (CMD):** large numbers and projected to increase - in 2017, an estimated 35,082 people aged 18 to 64 years were thought to have a CMD • **Severe and enduring mental illness:** affects 1.1% of the population • **Mental well-being:** the percentage of people with depression, learning difficulties, mental health issues or other nervous disorders in employment is 23% also lower than both the England rate (36%) • **Childhood obesity:** Brent is in the worst national quartile for % of children 10-11 classified as overweight or obese – 43.9% • **Diabetes:** by 2030 it is predicted 15% of adults in Brent will have diabetes • **Long Term Conditions (LTCs):** ~20% of people have a LTC • **Dementia:** prevalence of dementia in people aged 65 years and over is 2,624 (2017) (and 80% of prevalence is diagnosed) • **STIs/HIV:** 1,404 STIs per 100,000	• .**Health-related behaviour**: tobacco use; alcohol; take up of immunisations; physical inactivity: worst in West London; nutrition: 47% get 5 a day • **Caring for an ageing population**: 35% of all emergency admissions in Brent are for those aged 65 and over; once admitted this group stays in hospital longer, using 55% of all bed days. • **End Of Life Care**: Brent has one of the highest percentages of deaths taking place in hospital in the country. • **Primary care**: wide variation in clinical performance; Brent is in the worst quartile nationally for patient experience of GP services. • **Long Term Condition (LTC) management:** Brent is in the worst quartile nationally in terms of people with a LTC feeling supported to manage their condition. • **Cancer**: Brent is in the second lowest quartile nationally in terms of GP referral to treatment for cancer and worst quartile in terms

Brent's Health & Well-Being Gaps	Brent's Care & Quality Gaps
population compared to 829 in England	of cancer patient experience. • **Serious and long-term mental health needs:** people with serious and long term mental health needs have a life expectancy 20 years less than the average

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

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

3.5 The Brent Health and Care Transformation Board has identified that the following programmes will be particularly effective in delivering care that is more closely integrated across health and social care, and these are included in our Commissioning Intentions:

- **Integrated Older People's Pathway (including hospital discharge)** – commissioning a review of further opportunities to streamline older people's pathway and Mainstream Home First into the Hospital Discharge model.

- **Integrated Commissioning and Market Management** – continue to refine and deliver plans for market management and integrated commissioning with a special emphasis on Continuing Healthcare

- **Enhanced Care in Care Homes** – develop and refine the ECCH programme and scope and cost training programme, map and stocktake on existing activity.

3.6 A brief summary of the commissioning intentions organised by STP delivery areas is set out below.

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

  Children's acute & community services: Work as part of the Brent Children's Trust to commission a range of high quality, effect and integrated children's services. Building on the Thrive Model, continue transformation of CAMHS locally, supported by CCG recurrent funding, and working with schools, social care and local communities. Local Transformation Plan to be updated and published in October 2018.

  Please note that other areas of the Commissioning Intentions that are referred to within other delivery areas also incorporate upgrading prevention and wellbeing.

For example the introduction of new types of screening tests for bowel cancer in Delivery Area 2 are a notable example of the increased focus upon prevention and early detection of cancers, so that treatment can be given at an earlier stage. This comes in conjunction with the introduction of national NICE guidelines which lower the threshold for referral for some cancers in primary care. More people will be screened for cancer, and more people will live longer with a diagnosis of cancer.

Additionally, the work of the care co-ordinators within the WSIC programme is also focussed on prevention, whereby care co-ordinators co-ordinate disparate health and care services for vulnerable older people, with a focus on joining up support from health care services, charities and volunteers. This approach focuses on the overall wellbeing of the person and addressing social determinants of health such as social isolation, and is intended to reach the outcome of reducing non-elective hospital admissions. . This is contained within Delivery Area 3.

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

    - *Long Term Conditions:* - Brent has one of the highest rates of people living with Long Term Conditions. Variations in the services that are available to patients exist in Brent we are developing programmes to address this. This includes implementation of the National Diabetes Transformation Programme in Brent, including establishment of an NWL self-care education hub, more support for practices to diagnose and treat patients and improved foot care. Additionally, developing a strategy and clinical pathway for the management of hypertension, ensuring alignment with stroke services.
    - *RightCare programme*: Using Rightcare data packs and methodology undertake a number of service reviews across Cancer, Respiratory, CVD, and Neurology to maximise value in population healthcare.
    - *Cancer:* Increase the rates of early detection of cancer, increasing the likelihood of long-term survival and avoiding people presenting with cancer symptoms at A&E in an unplanned way. For example by implementing the FIT test.
    - *North West London Outpatient Programme:* Implementing NWL referral guidelines for dermatology, gynaecology, ENT and cardiology. Implementation of teledermatology within our newly procured community dermatology service and allow GPs to send in photos of lesions with referrals. In year 2 we will mobilise plans for respiratory, paediatrics, CVD and neurology.
    - *Dermatology*: Procure, implement and embed a new community dermatology service within a community setting
    - *Gynaecology:* Set up and implement a new community gynaecology service in Brent based around an expanded range of conditions and appropriate diagnostics including ultrasound.

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

    - *Primary care transformation:* Re-aligning our GP Access Hubs to ensure that they meet our local population needs. Introducing alternate forms of patient consultation including on-line and video consultations over seven days per week. Improve patients' awareness and utilisation of on-line services
    - *End of Life care:* Improve identification and planning for the last phase of life through identifying the 1% of the population who are at risk of death in the next 12 months by using advanced care plans. Improving the interoperability of the Co-Ordinate my Care IT system with other IT systems including primary care.
    - *Whole Systems Integrated Care (WSIC):* Implement centralised case finding, set clear expectations about the care planning process, redesign the Complex Patient Management Group and expand the service to include a Recovery Model of care in collaboration with Rapid Response.
    - *Care home and high risk housebound patients:* Support pro-active management of patient care to improve patient experience and quality of life for this patient group. Contribute to the closing of the care and quality gap under the STP. Improve key outcomes and patient experience
    - *Integrated Care System:* Launch Primary Care Home pilots following completion of an Expression of Interest period. Develop a Multi-Disciplinary Community Provider model of care including key partner organisations including our acute and social care partners, including a new contracting structure.
    - *Integrated Care at Home Service:* Improve or maintain health status through co-ordinated delivery of high quality care in the most appropriate setting. Expansion of the STARRS team to provide pro-active support linked to the WSIC programme for up to 6 weeks
    - *Unified Frailty Older People's Pathway:* Comprehensive Geriatric Assessment on admission; strengthening of the acute frailty model to ensure that discharge pathways are fully embedded
    - *MSK workstream and fracture liaison service:* Mobilise the new MSK physiotherapy service and associated care pathways, incorporating triage by Extended Scope Physiotherapists and a pathway for patients to self-refer. Implement the new Planned Procedure with Threshold (PPwT) pathways for diagnostic imaging. In collaboration with NWL and LNWHUT, launch the new fracture liaison service

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

    - *Mental Health and Physical Wellbeing:* Culturally sensitive BME support alongside bio-social models of care, to develop support and challenge stigma within local communities. Specific focus on under 18s psychosis risk factors.
    - *Talking Therapies:* Increased capacity and capability of the IAPT service and improved quality of people's experience of services. Alignment of

IAPT with general acute in-patient services, with a greater focus on people with long-term conditions.

- *Psychology and Psychotherapy:* Development and design of care pathways that offer evidence based interventions tailored to meet the needs of individuals with Personality Disorder and Post-Traumatic Stress Disorder who access mental health services
- *Dementia:* Reflect new NICE guidance in commissioned services. Continue remodelling of the Secondary Care Memory Assessment services to support more complex presentations and up-skilling of primary care, peer support and carers to support.
- *Learning disabilities:* Monitor effectiveness and outcomes from the jointly commissioned integrated community learning disability team (CTPLD)

- *Carers:* Work with local communities and voluntary sector to develop peer-led social prescribing targeted at carers. Increase the accessibility of advice on building mental and emotional resilience, and access to more talking therapies for carers.

- **Delivery Area 5 – Ensuring we have safe, high quality and sustainable acute services**

  - *Urgent & Emergency Care:* Continue existing pilot model for Integrated Urgent Care across NWL taking into account all the unscheduled services provided. Delivery of the new Integrated Urgent Care model across NWL in Year 2.
  - *Inpatient model of care:* Delivering a new inpatient model of care that will deliver time to first Consultant review within 4 hours for all emergency admissions (type 1) via any route and a consultant led, ongoing twice daily inpatient reviews for acute and high dependency units and daily 24 hour review for all other inpatients
  - *Radiology and diagnostics:* Reducing unnecessary usage of direct access diagnostics in primary care through implementing best practice protocols embedded within diagnostic ordering systems.
  - *Length of stay and transfers of care:* Deliver single points of access for non-bedded community services, with the potential to increase to wider community services in Year 2.
  - *Atrial Fibrillation:* Recruit pharmacist into medicines management team to work with GP practices to identify new patients and treat them with DOAC drugs or anticoagulation therapy (warfarin)

- **Enabling Area – Estates**

  - *Deliver Local Estates Strategy* – support the delivery of the Five Year Forward View and 'One Public Estate' vision
  - Deliver a Primary Care Investment Plan which analyses the suitability of the current estate and sets out how the estate will need to change to meet the needs of the new model of care

- Maximise use of existing estate and reduce void costs at Willesden Centre for Health and Care, Wembley Centre for Health and Care, Sudbury Primary Care Centre and Monk's Park
- Reducing HQ costs at Wembley Centre for Health and Care by consolidating CCG space at Wembley to reduce the cost of the management accommodation
- Address the needs of the new populations in Wembley, South Kilburn and Alperton Housing zones by supporting new primary care provision within these development areas.

4.0 Financial Implications

4.1 The detailed financial implications to the CCG and its providers will be worked through as part of the contracting negotiations for the financial years 2019/20 and 2020/21. The Commissioning Intentions are a high level plan only and further work to develop detailed plans and financial modelling follows later.

5.0 Legal Implications

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

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

6.0 Equality Implications

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

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

7.0 Consultation with Ward Members and Stakeholders

7.1 Various bespoke engagement events have been undertaken in forming these Commissioning Intentions including the Brent Health Partners Forum which took place last month. The current document is in draft form so that comments from the Health and Wellbeing Board may be incorporated into it, or amendments made following the suggestion of amendments. The Commissioning Intentions will then be presented to the CCG Governing Body in November 2018 and a final version can then be shared with the Health and Wellbeing Board.

The draft document has been published on the CCG's website and we are currently inviting comments from members of the general public via an online survey.

This is available at the following web address: https://brentccg.nhs.uk/en/news/600-find-out-more-about-our-commissioning-intentions-and-take-our-survey

To date we have already engaged with patients and public at the following venues:

- 17 August 2018 – Hilltop Medical Practice
- 29 August 2018 – Wembley Centre for Health and Care (Brent Carer's Centre)
- 29 August 2018 – Health Partners Forum (Sattavis Centre, Wembley Park)
- 30 August 2018 – Central Middlesex Hospital Foyer – service users
- 30 August 2018 – Asian People's Disability Association
- 1 September 2018 – Black Cancer Care
- 12 September 2018 – Dementia Support Group

8.0 Human Resources/Property Implications (if appropriate)

8.1 The Report covers a wide range of programmes and areas. Some may require staff to work in a different way to implement the project and some involve the hiring of new staff (e.g. within STARRS) to deliver care in a more pro-active way in the community. Some of the projects have TUPE implications for NHS providers (e.g. dermatology/ gynaecology where services have been decommissioned and new services are being recommissioned to replace them).

8.2 The Estates Strategy has implications for property as some of the CCG's rented estate portfolio may be rationalised and the HQ programme involves joint working with the Council as part of the 'One Public Estate' programme.

Report sign off:

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