NHS
Brent
Clinical Commissioning Group

Draft Commissioning Intentions 2019-2021

DRAFT




Draft Version 6 Prior to Engagement

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Strategic Context

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Strategic Context - Introduction

The CCG's strategic context is informed by national and local policy drivers, as well as Brent CCG's commissioning principles (which guide the CCG on *how* services should be commissioned as well as some of the key outcomes) and the Health and Wellbeing Board priorities. The key national and local drivers are:

- **The North West London Sustainability and Transformation Plan (STP)**
- **Brent's Local STP Priorities (Health and Social Care working together)**

These are explored in more detail on the following pages.

Strategic Context – The Sustainability and Transformation Plan

In 2016, NHS England organised England into 44 STP geographical areas. Brent is part of the North West London STP area. The STP includes NHS Trusts, Local Authorities and Clinical Commissioning Groups. The STPs work across organisational boundaries to help build a consensus for transformation and the practical steps to deliver it. These collaborative arrangements are designed to address health and care 'gaps' and to reduce health inequalities. In February 2018 it was announced that the STPs would evolve in the future to become integrated care systems (source NHSE 18/19 Planning Guidance)**

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	**Health-related behaviour**: tobacco use; alcohol; take up of immunisations; physical inactivity: worst in West London; nutrition: 47% get 5 a day
Severe and enduring mental illness: affects 1.1% of the population	**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.
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%)	**End Of Life Care**: Brent has one of the highest percentages of deaths taking place in hospital in the country.
Childhood obesity: Brent is in the worst national quartile for % of children 10-11 classified as overweight or obese – 43.9%	**Primary care**: wide variation in clinical performance; Brent is in the worst quartile nationally for patient experience of GP services.
Diabetes: by 2030 it is predicted 15% of adults in Brent will have diabetes	**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.
Long Term Conditions (LTCs): ~20% of people have a LTC	**Cancer**: Brent is in the second lowest quartile nationally in terms of GP referral to treatment for cancer and worst quartile in terms of cancer patient experience.
Dementia: prevalence of dementia in people aged 65 years and over is 2,624 (2017) (and 80% of prevalence is diagnosed)	**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.
STIs/HIV: 1,404 STIs per 100,000 population compared to 829 in England	

**Sources: Brent JSNA; CCG Assessment & Improvement Framework*

***https://www.england.nhs.uk/wp-content/uploads/2018/02/planning-guidance-18-19.pdf*

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Strategic Context – The Financial Gap

The NHS is under increasing financial challenge nationally. This is no different in Brent, and having enjoyed a long period of financial sustainability, the CCG is only just managing to break even.

Allocation growth in 17/18 and 18/19 was lower than in previous years and demand has risen at a rate that exceeds the growth in financial allocations. In 19/20 and 20/21 the financial environment is uncertain. The Prime Minister's speech on 18th June 2018 announced an average increase of 3.4% growth in real terms for the NHS from 19/20. However, the detail of how this will be funded is yet to be worked through, and as yet it is unclear how much of this funding will be allocated to the provider sector and how much will go to commissioners. At the time of writing, there has been no increase to commissioner budgets.

It is therefore essential that we focus on **transforming services** described in the five delivery areas in the North West London STP so that we are able to make the funding available go as far as possible and achieve the best value possible with limited resources. Brent CCG has a statutory duty to maintain financial control and to achieve its financial control total.

Strategic Context – North West London STP Priorities and Delivery Areas

- Each Delivery Area contains a core area of focus.
- Under each Delivery Area a number of different programmes sit.
- Some of these programmes are delivered by a team at a North West London level
- In most programme areas, the project is led by an NWL team, but delivered and rolled out locally by a team within the CCG
- Each programme is designed and structured so as to ensure an appropriate balance between common standards and programme management, and local priorities and implementation challenges.
- The diagram on the next 2 pages sets out the STP Delivery Areas and the key programme areas that we are working on to deliver.
- Many of these are reflected in the content of our local CCG commissioning intentions

Strategic Context – North West London STP Priorities and Delivery Areas

Triple Aims	DA Number	Delivery Areas & Projects
Improving Health & Wellbeing		**Improving Health and Wellbeing** Childhood Obesity •Smoking and Alcohol •Homelessness
	2	**Better Care for People with Long-Term Conditions** •GP Extended Access •Online Consultations •Primary Care Provider Development •Diabetes Transformation Programme •Digital Health Apps •Improving Access to Psychological Therapies – (Long Term Conditions)
Improving Care & Quality	3	**Improving Care for Older People** • Enhanced Care in Care Homes • Last Phase of Life (Telemedicine) • Response in a Time of Crisis • Home First • Transforming Care Programme • Crisis Care • CAMHS
Improving Productivity and Closing the Financial Gap	4	**Improving Mental Health Services** •Transforming Care Programme •Crisis Care •CAMHS Remodelling •Serious and Long-Term Mental Health Needs - Individual Placement Support

Strategic Context - STP Priorities and Delivery Areas (continued)

Triple Aims	DA Number	Delivery Areas & Projects
Improving Productivity & Closing the Financial Gap	5	**Safe, High Quality Sustainable Acute Services** •Outpatient Transformation Programme •Inpatient model of care (reducing length of stay) • Radiology and diagnostics programmes • Clinical Decision Support
	6	**Acute Reconfiguration** Capital Business Case for Shaping a Healthier Future •Improvements to Women's Services

Our Local STP Priorities

- Brent CCG operates its own local-level Health and Care Transformation Board, which oversees prioritised STP programmes, delivered at local level;
- The objective of this Board is that it drives forward health and social care integration at local level and at team level, making change real;
- The Board includes representation from the CCG, London Borough of Brent and LNWHUT;
- The priority programmes were reviewed and refreshed at the May Board;
- The refreshed priorities are shown on the pages set out below; we also show the governance structure

Recommended priorities 18/19

Programme	Whats new/changed for 18/19	Proposed lead/s
Strategic priorities		
1) Integrated older people's pathway (including hospital discharge)	a. Define and agree plan to integrate STARRS/Hospital Discharge Team/Integrated Rehabilitation and Reablement Service and single point of access (SPA) b. Commission review of further opportunities to streamline older peoples pathway c. Mainstream Home First into new discharge model d. Develop costed options paper and action plan for improving volume and quality in step down care e. Oversee alignment between priority programmes f. Undertake analysis of Winter pressures preparation and high impact changes	LA - Helen Woodland Provider – James Walters/Philippa Galligan CCG – Jonathan Turner
2) Integrated commissioning and market management	a. Continue to refine and deliver plans for market management and integrated commissioning with special emphasis on Continuing Healthcare b. Develop joint and integrated monitoring framework c. Further develop integrated brokerage function d. Scope and cost virtual proactive performance team	LA – Phil Porter CCG – Isha Coombes/Sue Grose
3) Enhanced Care in Care Homes	a. Develop and refine ECCH programme b. Develop Care Home Forum c. Scope and cost training programme d. Map and stocktake existing activity	CCG – Sheik Auladin LA – Helen Woodland

Recommended priorities 18/19

Programme	Whats new/changed for 18/19	Proposed lead/s
Scoping/testing		
4) Self care	a. Develop costed options paper and action plan for integration of SIBI and community co-ordinators, aligned to WSIC b. Develop scoping paper to support development of a wider preventative self care programme (link to prevention lead)	CCG – Jonathan Turner LA – Jon Liquorice/Helen Duncan-Turnbull
5) Integration development	a. Immediate opportunity to scope pilot to expand telemedicine and integrated commissioning into extra care facilities b. Develop action plan for wave 2 integrated commissioning development c. Test the development of a fully integrated care system, including alignment of ICS and WSIC, with focus on system incentives and investment, building on Primary Care Home/MCP and integrated commissioning	CCG – Jonathan Turner LA – Phil Porter
6) Dementia	a. Develop options paper and action plan to develop appropriate care and support for people with dementia, linked to wider programme	Philippa Galligan

Proposed governance

Governance:

Council Cabinet

HWB Board

CCG Governing body

Health and Care Care Transformation Board (HCTB)

HCTB Exec

Priority programmes:

Project Delivery Board
Chair – HW – GT/JW/CCG

Project Delivery Board
Chair Phil Porter – HoC/Pauline Collins/Brian Rogers/Isha Coombes

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Strategic priorities:

Brent Older People's Pathway

Integrated Discharge and community services – IRRS/HDT/STARRS

MM and IC– Structure

MM and IC– data & information

MM and IC– Quality frameworks and Team

Enhanced Care in Care Homes

Scoping:

Dementia

Self care

Integration development

Key Board interdependencies:

A&E Board

Home First Operational Delivery Group

Children's Trust Board

Key Task and Finish groups for delegated leadership:

Childhood obesity

Thrive

Mental health

Transforming Care

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Why greater collaboration is so important…

There is a difference of 17 years in life expectancy depending on where you live in NW London

Although low, **there is a difference in Hospital Standardised Mortality Rates** depending on which hospital you go to – varying from 0.76 to 0.90

Service provision varies **– the average length of stay can be 4.3 days or 7.5 days for the same procedure** depending on which hospital you go to

People with long term mental health needs have a life expectancy 20 years less than the average NW London population; the number of people with long term mental health needs in NW London **is double the national average**

In order to achieve health equality and harness system capacity by moving towards more joint working, we are improving our governance arrangements

The proposed governance arrangements we are discussing tonight are part of the collaboration development programme which has been established in response to agreements reached by all eight Governing Bodies in September 2017.

We agreed to:

- ✓ Develop and launch a Joint Committee which will have delegated decision making authority over an agreed range of responsibilities
- ✓ Make changes to sub-committee arrangements within and across CCGs
- ✓ Develop a new financial framework that supports and enables greater collaboration
- ✓ Establish & appoint a single Accountable Officer and single Chief Financial Officer across the eight CCGs
- ✓ Develop new senior leadership structures to support new ways of working
- ✓ Develop new processes and operating models that support and enable greater collaboration

Governance arrangements that support joint working will enable us to achieve our vision

- We have been working with our membership and stakeholders to develop a Joint Committee, standardise our CCG constitutions and review all sub-committee arrangements
- We have been running the joint committee in shadow form since January 2018 to test and further develop new governance arrangements
- All this work has culminated in a set of recommendations that will be considered by Governing Bodies in September 2018

Brent's Health Landscape & Challenges

The following section summarises some of the features of Brent's local population and some of the specific issues highlighted by the JSNA:

- GP Practices and Localities
- Summary of Key Population Statistics
- Key Health Challenges
  - Premature Mortality
  - Physical Activity & Diet
  - Alcohol Use
  - Tobacco Use and the NHS
  - Social Isolation
  - Type 2 Diabetes
  - Tuberculosis
  - Dementia
  - Common Mental Health Disorders
  - Child Health
  - Child Obesity

Key Population statistics – population and age

The London Borough of Brent has a population of 336,659 and a population density of 76.8 persons per hectare. The population has grown significantly since 2001 and is predicted to continue to grow.

Brent Population Growth
Source ; Source: 2017 GLA housing led population projection short term

2001	2011	2018	2021	2026
263,500	311,000	336, 659	346, 437	363, 285

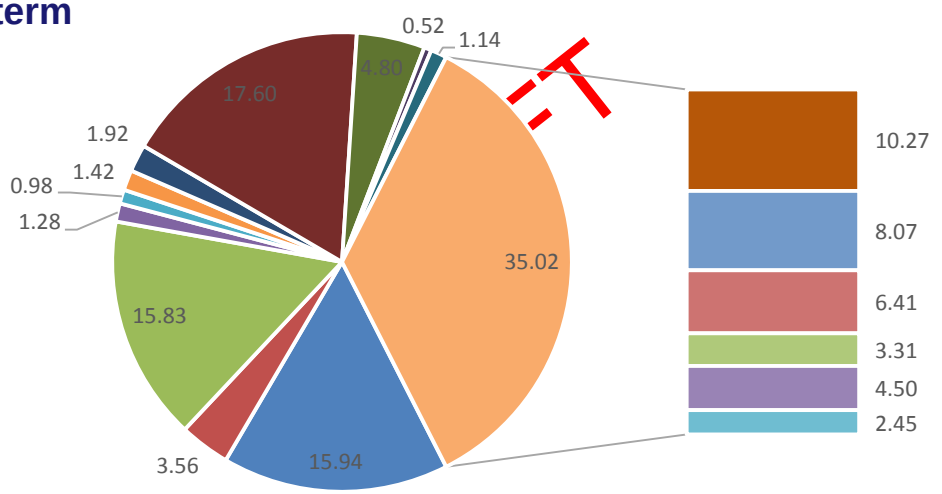
Brent has a young population with the population between 0 – 15 years comprising 20.9% of the total population. The 16-64, working age population makes up 67.8% of the population and the 65 and over population makes up 11.3% of the population.

The older population is growing at a higher rate than the adult population.

Key Population statistics – ethnicity

Brent is ethnically diverse: 64.7% of the population is Black, Asian or other minority ethnicity (BAME).. The Indian ethnic group currently make up the largest ethnic group with 17.6% of the population+, followed by Other Asian (12%). The White group make up 33%.

Ethnic profile of Brent residents
Source: 2017 GLA housing led population projection short term



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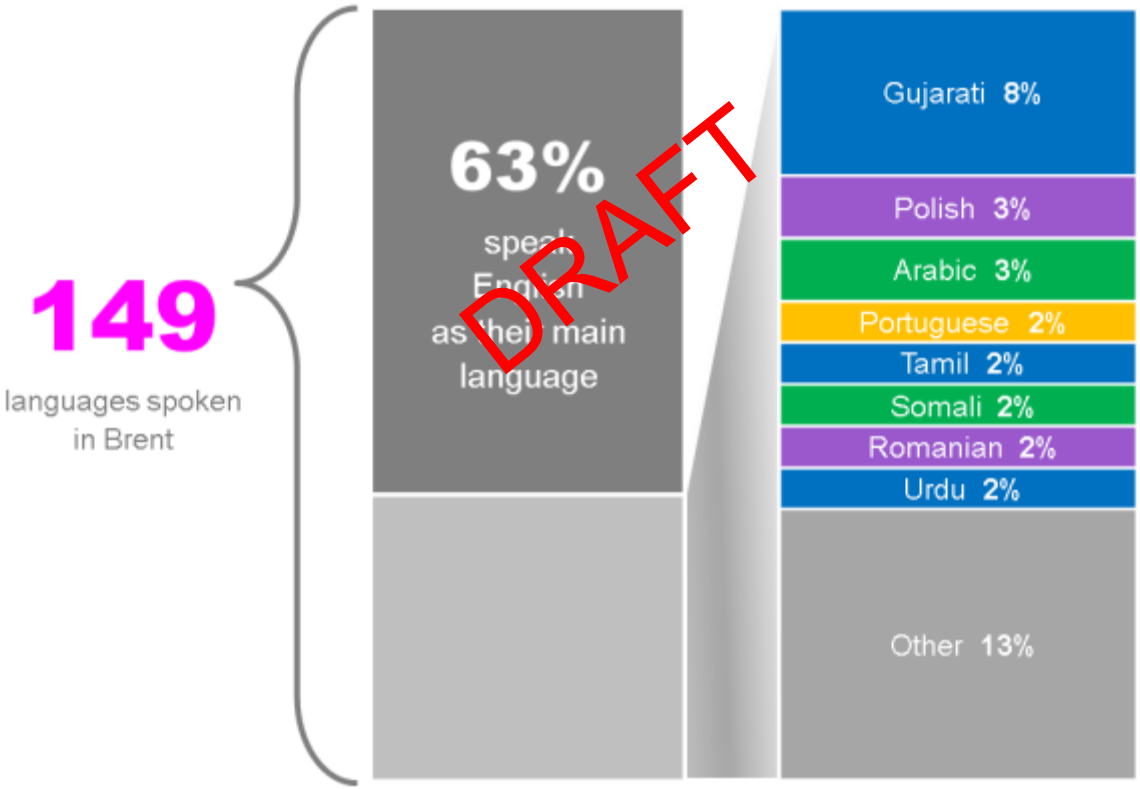
Key Population statistics – language

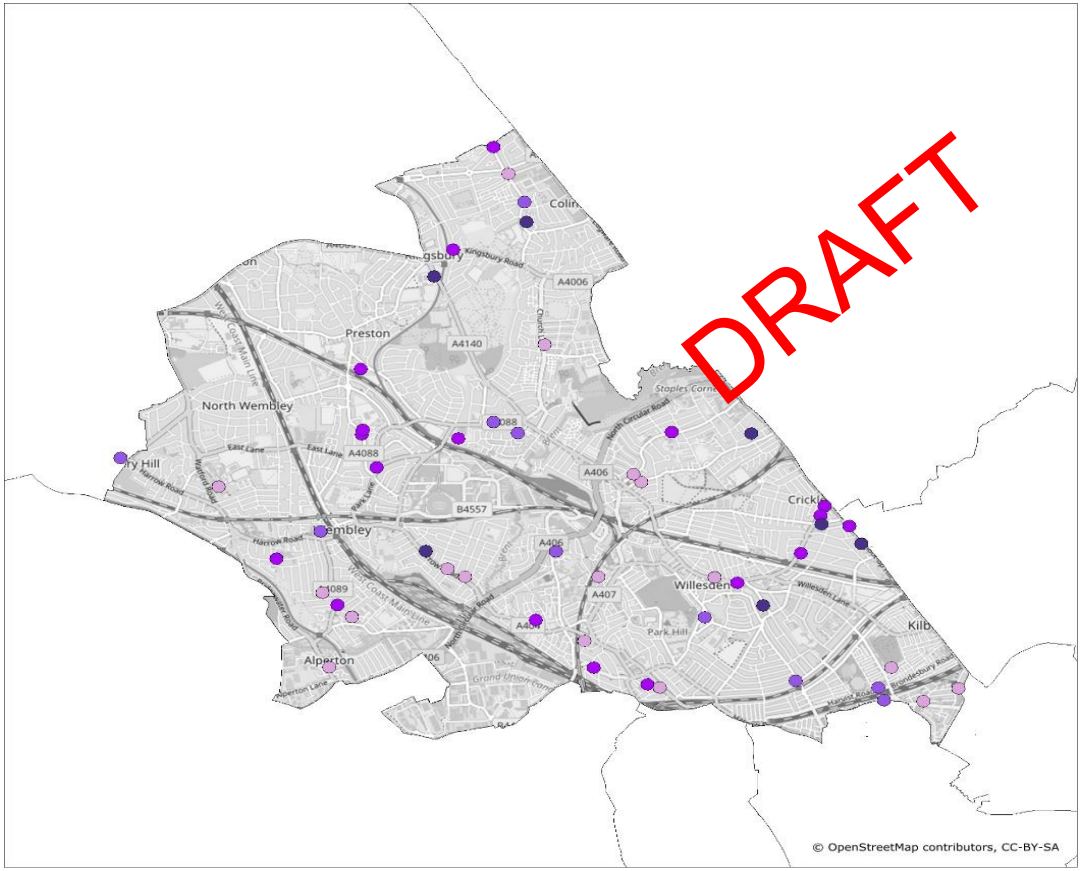
There are many different languages spoken in Brent. English is the main language for 62.8% of the population. Gujarati is the main language for 7.9% of the population and Polish is the main language for 3.4% of the population. In one in five households, nobody speaks English as their main language.



Languages spoken in Brent. Source: ONS 2011 Census

NHS Brent GP Practices and Localities

Brent is an outer London borough in north-west London. The number of patients registered with Brent GPs is 382,192 (May 2018). Brent has 56 member practices which are all aligned to one of five locality based groups. Each locality has a Clinical Director. 18 practices have a registered list of fewer than 3,000 patients and 5 practices have a registered list of greater than 10,000 patients.



Overall Experience of GP practice

- 92.5 up to 100.0
- 88.1 up to 92.5
- 83.2 up to 88.1
- 76.0 up to 83.2
- 35.0 up to 76.0

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Key Health Challenges in Brent

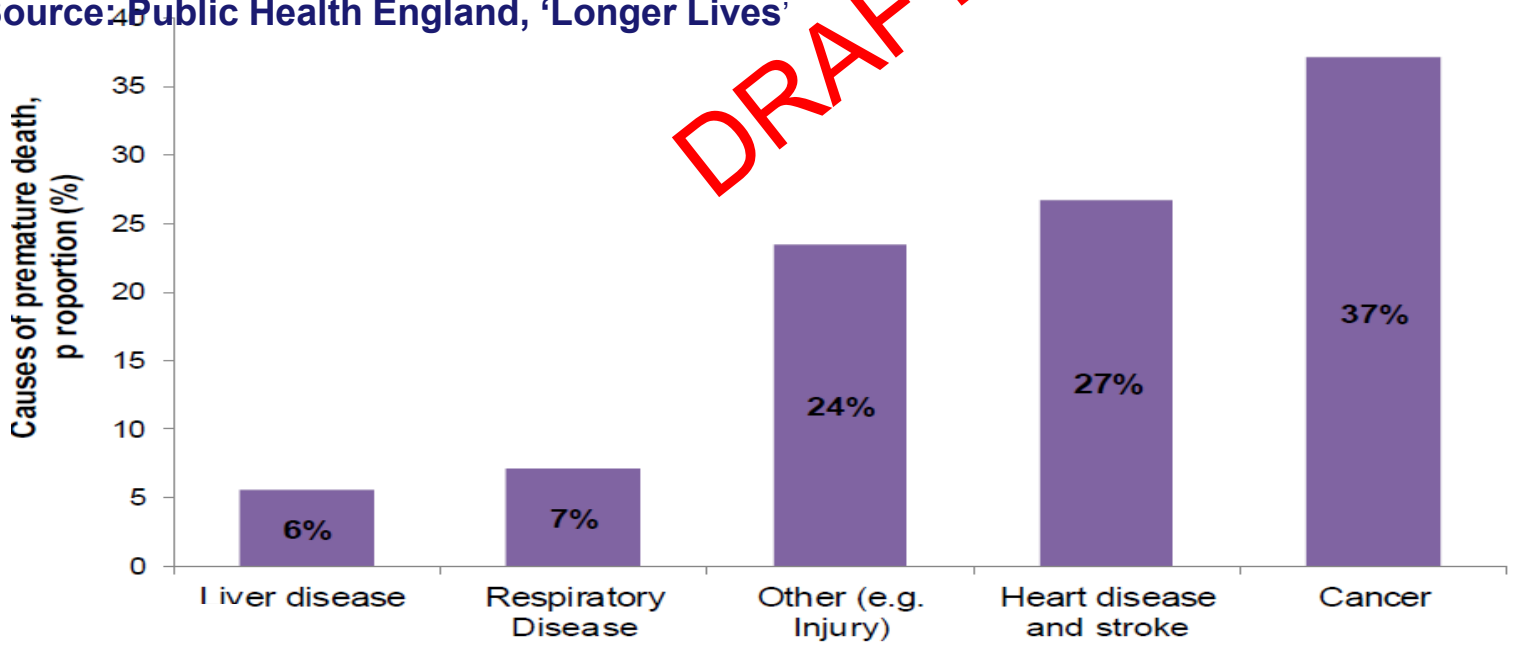
Premature Mortality by Disease

The main causes of premature mortality (deaths before 75 years of age) in Brent are

- Cancer (37%)
- Cardiovascular Disease (coronary heart disease and stroke) (27%)
- Respiratory Disease (includes COPD and Asthma) (7%)

Although the mortality rate is better than in areas of similar levels of deprivation, there are still 650 premature deaths potentially preventable through early identification of risk and appropriate intervention programmes

Proportion of all premature deaths by cause in Brent, 2014-16.
Source: Public Health England, 'Longer Lives'



Key Health Challenges in Brent

Physical Activity and Diet
Source: Fingertips

Physical inactivity and an unhealthy diet are closely linked to excess weight and obesity. It is recommended that adults accumulate at least 150 minutes of moderate-intensity aerobic activity (e.g. cycling or fast walking) every week, and that children over five should engage in at least 60 minutes of moderate to vigorous intensity physical activity every day.

In Brent 49.4% of individuals aged 16 + achieved this level of activity this is less than the level for England 57% and London 57.8%

It is recommended that individuals consume five portions of fruit and vegetables
.
55.7 % of the population in Brent were meeting the recommended 5-a day fruit and vegetable intake in 2014. This was higher than the London (50.3%) and England (53.5%) averages.

In Brent 58.1% of individuals aged 18+ were either overweight or obese compared to 55.2% in London and 61.3% in England

Key Health Challenges in Brent

Alcohol Use
Source: Fingertips

- In Brent in 2016/17 there were 6587 admission episodes for alcohol related ill. This equates to a rate of 2669 per 100, 000.
- This compares to a rate of 2254 per 100,000 in London and 2185 per 100,000 in England
- There were also 91 deaths from alcohol related conditions
- In 2016 42.9% of clients alcohol successfully completed alcohol treatment
- In 2016/17 there were 400 people in treatment at specialist services

Key Health Challenges in Brent

Tobacco Use and the NHS
Source: Fingertips & Annual Population Survey

- In 2016/17 smoking prevalence in Brent was estimated at 15.6 % of the adult population. This compares with 14.8% in England and 14.6 % in London
- There were 176 Brent mothers smoking at delivery in 2016/17
- Smoking attributable mortality was 195.6 per 100, 000
- In Brent in 2016/17 there were 1847 individuals in Brent who set a quit rate

Key Health Challenges in Brent

Tobacco Use and the NHS
Source: Fingertips & London Clinical Senate: Helping Smokers Quit

The NHS London Clinical Senate has advised the NHS IN London

- **Tobacco Dependence is a Major Problem for the NHS and is the main cause of cancers and the three main reasons for hospital admissions under 25 years, CHD, COPD and Cancer.**
- **Helping people stop smoke is the single highest value contribution a clinician can make**
- **Effective diagnosis and treatment of tobacco dependence requires an urgent improvement in clinical training, use of carbon monoxide monitoring as an essential near-patient test, and medicines optimization**

There were 176 Brent mothers smoking at delivery in 2016/17

Referrals from antenatal services to specialist services need to be increased

In Brent in 2016/17 there were 1847 individuals in Brent who set a quit rate

There is a need to embed smoking cessation in all new value based programmes

Secondary care providers need to increase prescribing for smoking cessation

Key Health Challenges in Brent

Social Isolation
Source: Fingertips

Brent has 30,616 households with people living on their own according to the 2011 census. Of these, 29% (or 8,808 people) are aged 65 and over. Although social isolation is most common among the elderly, younger adults can still suffer.

Social isolation is a key determinant of physical and mental health, whether older people, single parents, or people with mental health needs

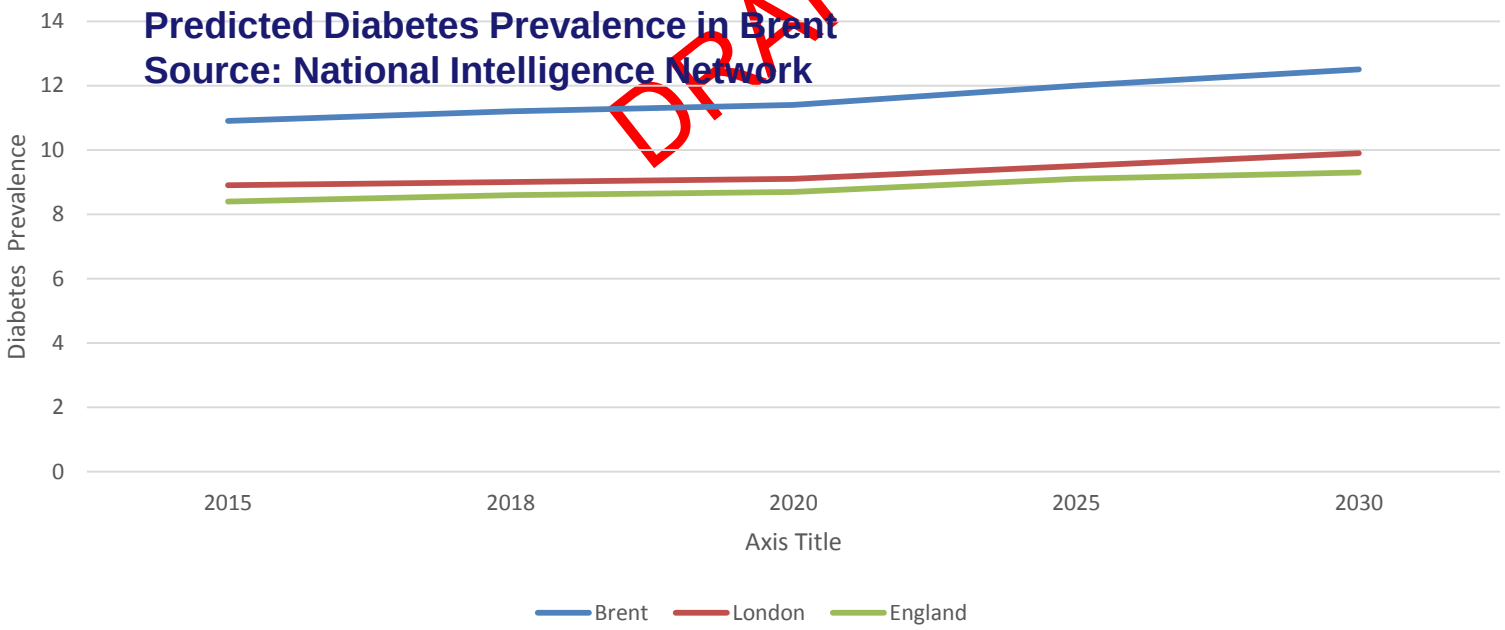
Social isolation and loneliness have a detrimental effect on health and wellbeing. In 2016/17, only 32.5% of adult social care users in Brent reported that they have as much social contact as they would like. This was worse than the England average of 35.5 % and London 35.6%.

Key Challenges in Brent

Type 2 Diabetes

Rates of type 2 diabetes in Brent are particularly high compared to other parts of the country.. It is estimated that 2018 in the Brent CCG responsible population there are 34, 283 persons living with Diabetes representing 11.2% of the population. By comparison the prevalence is 9% in London and 8.6% in England. It is forecast that by 2030 12.5% of adults in Brent will have diabetes.

Reflecting the ageing of the local population, the numbers of people who are obese and overweight and the large number of Black and South Asian people ,who are at greater risk of developing diabetes the prevalence of diabetes is predicted to rise *in the future*, as shown below.



Key Health Challenges in Brent

Tuberculosis (TB)
Source: Brent TB Profile
In 2016, 192 cases were notified in Brent residents , this equates to a rate of 58 per 100,000

Six deaths were reported in Brent residents

The age group with the greatest number of cases was 20 – 29.

Social factors were associated with 10 % of cases a similar proportion to the rest of London

The majority of cases were in non- UK born individuals

TB Cases by most common country of birth
Source: PHE Enhanced TB Surveillance

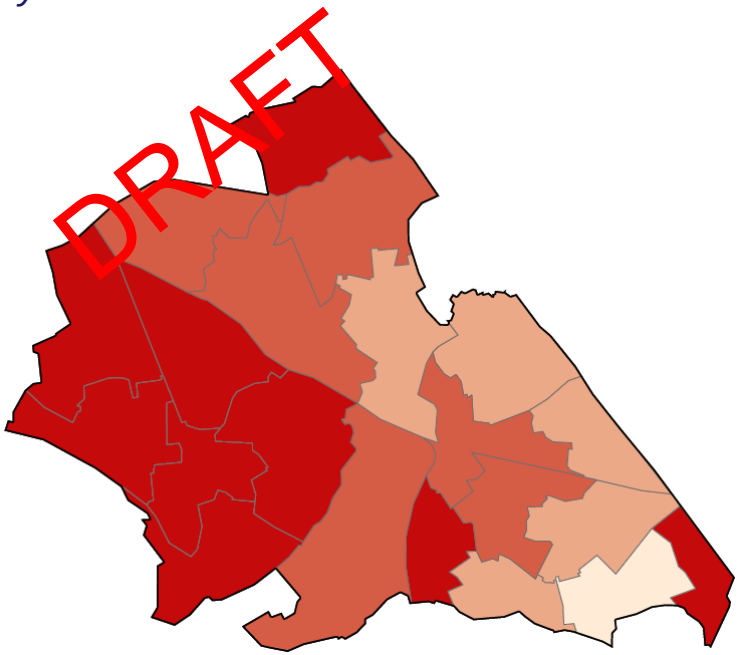
Country of Birth	Number of Cases	Percentage
India	73	39
UK	22	11.8
Somalia	20	10.7
Romania	12	6.4
Pakistan	8	4.3
Kenya	7	3.7

Key Health Challenges in Brent

Tuberculosis

The rates of Tuberculosis are highest in the wards of the North and South West

Map showing three year average rate of Tuberculosis incidence by electoral ward in Brent



Three year average rates 2013-2015

- No TB
- 1-19/100,000
- 20-39/100,000
- 40-59/100,000
- >=60/100,000

Source: Brent TB profile 2016

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Key Health Challenges in Brent

Dementia

In Brent in 2017 it is predicted that 2, 624 were living with Dementia. It is estimated that by 2035 this will have increased by 79%.

	2017	2020	2025	2030	2035
Total males aged 65 and over predicted to have dementia	1,022	1,130	1,367	1,633	1,933
Total females aged 65 and over predicted to have dementia	1,602	1,764	2,003	2,345	2,757
Total individuals aged 65 and over predicted to have dementia	2,624	2,894	3,371	3,978	4,690

Source: POPPI

Key Health Challenges in Brent

Common Mental Health Disorders (CMD)

Supporting service users, and providing people recovering from illness with meaningful employment and secure housing needs are important in ensuring people are able to recover from Mental Illness.

Estimates show that in Brent in 2017, 35,082 people aged 18 to 64 years were thought to have a CMD. By 2035, this is projected to increase to 37,966 individuals people, an increase of 8%.

	2017	2020	2025	2030	2035
People aged 18-64 predicted to have a common mental disorder	35,082	35,790	36,450	37,181	37,966
People aged 18-64 predicted to have a borderline personality disorder	977	996	1,013	1,032	1,053
People aged 18-64 predicted to have an antisocial personality disorder	788	809	832	856	880
People aged 18-64 predicted to have psychotic disorder	871	888	904	922	942
People aged 18-64 predicted to have two or more psychiatric disorders	15,788	16,129	16,459	16,819	17,195

Source: PANSI

Key Health Challenges in Brent

Child Health

- In Brent in 2016/17 the infant mortality rate was 3.0 per 100,000 which was lower than the rate for London 3,2 per 100,000 and England 3.9 per 100,000.

- In Brent, the proportion of live babies with low birth weight in 2016 was 3.07% which showed a decrease from 2014 from 3.6%, This figure for 2016 is still above that of England 2.79% and London 3.01%.

- In Brent in 2017 only 71.7 % the children in care were up to date with their immunisations. This was lower than the rate for London 81.8% and England 84.6%.

- The child mortality rate in 2016/17 was 12 per 100,000 which was higher than the rates for London and England which was 11.6 per 100, 000 in both cases.

- Seasonal Flu Uptake for 2017/18 in 2yr old in General Practice was 29.7% compared to the figure for London 33.2% and England 42.8%

- Seasonal Flu Uptake for 2017/18 in 3yr old in General Practice was 31.2% compared to the figure for London 33.3% and England 44.2%.

Sources; Brent Child Health Profile, https://www.gov.uk/government/collections/vaccine-uptake

Key Health Challenges in Brent

Child Health
Childhood Emergency Admissions
Source: Fingertips

- Asthma is the most common long-term condition in childhood nationally.
  In Brent, there were 181 emergency admissions in individuals under 19 years due to asthma in 2016/17. This equates to a rate of 225.4 per 100,000, which is higher than the average rate for London 200.9 per 100, 00 and England 202.8 per 100,000
- In Brent in 2016/17 there were 21, 255 A& E attendances in the 0- 4 age group. This equates to a rate of attendance of 840.4 per 100,000 which is higher than the rate for London of 695 per 100,000 and the rate for England of 601.8 per 100, 000. The rate is the 4th highest of the London Boroughs.
- In Brent , the rate of hospital admissions in Brent due to self-harm in individuals aged 10 - 24 was 111.7 per 100, 000 which is lower than the rate for London 197. 2 per 100, 000 were lower than the England average 404.6 per 100,00 in n 2016/17 among individuals aged 10 to 24 years.
- The rate of young people aged under 18 years who were admitted to hospital as a result of a condition wholly related to alcohol in 2014/15 - 2016/17 was 9.3 per 100,000. This was lower than the London average, 19.4 per 100, 000 and the England average rate, 34.2 per 100,000 in the same time period.

Key Health Challenges in Brent

Childhood Obesity

- The proportion of children with obesity is the highest in any London borough in reception year and second highest in year 6 in 2016/2017.
- In 2016/17 28.0 % of children in year 6 were classified as obese compared to the equivalent figures for London and England, 23.6 % and 20 % respectively.
- When one considers the proportion of those obese and those overweight together in year 6, the figure was 43.9% compared to London 38.5 % and England 34.2%
- In the reception year in 2016/17 13.3% of pupils were obese in Brent compared to the London average of 10.3% and the England average of 9.6%.
- When one considers the proportion of those obese and those overweight together in reception, the figure was 27.6% compared to London 22.3% and England 22.6%.

Source: Brent NCMP and Child Obesity Profile

Progress & Achievements Over the Last 12 months

- We approved and launched a business case to reprocure our MSK physiotherapy service under an enhanced model with Extended Scope Practitioners, investing an additional £500k into the new service. This procurement is underway at the time of writing;
- Following a CQC/ OFSTED inspection of services for children with special educational needs, we worked with Brent Council to integrate services and to ensure that they are joined up for patients, aligning operational processes;
- Launched the Health Help Now app to help people to self-care and to signpost them to appropriate services, as well as providing them with a portal to book online GP services
- The CCG has maintained a positive financial position, achieving its control total in challenging financial times.
- Launched the Diabetes Transformation Programme in Brent, employing two GP leads to visit GP practices to optimise care and improve treatment targets relating to HbA1c, blood pressure and cholesterol.
- Launched and invested into a frailty proof of concept service at LNHWUT. This is part of the Winter Resilience Programme and supports Brent and Harrow
- Commissioned an additional 70,000 GP appointment slots to increase primary care access and take pressure of A&E
- Appointed an additional learning disabilities nurse, with the help and support of a panel of people with learning disabilities
- Appointed a Parkinson's Disease Nurse, supported by Parkinson's UK, to provide an enhanced level of support for people with Parkinson's Disease in the community.

Commissioning Intentions by STP delivery area

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Part 2 - Index of Brent CCG Commissioning Priorities

Part 2 outlines our commissioning intentions by area in more detail. We have grouped the topics around the 5 delivery areas identified in the STP. The plans and areas covered in this section are:

Delivery Area 1 – Radically upgrading prevention and wellbeing

(a) Children's Services
(b) Child & Adolescent Mental Health Services

1 (a) Children's Services

Strategic Aim
Work as part of Brent Children's Trust to commission a range of high quality, effective, integrated children's services.

Rationale
Improving the health of children is essential to reducing inequalities, which needs to start in childhood. The first years of life are crucial for the physical, intellectual and emotional development of individuals and have lifelong effects on many aspects of health and wellbeing. We need to help families be as independent as possible, helping those with complex needs take charge of their care and reduce their reliance on statutory services.

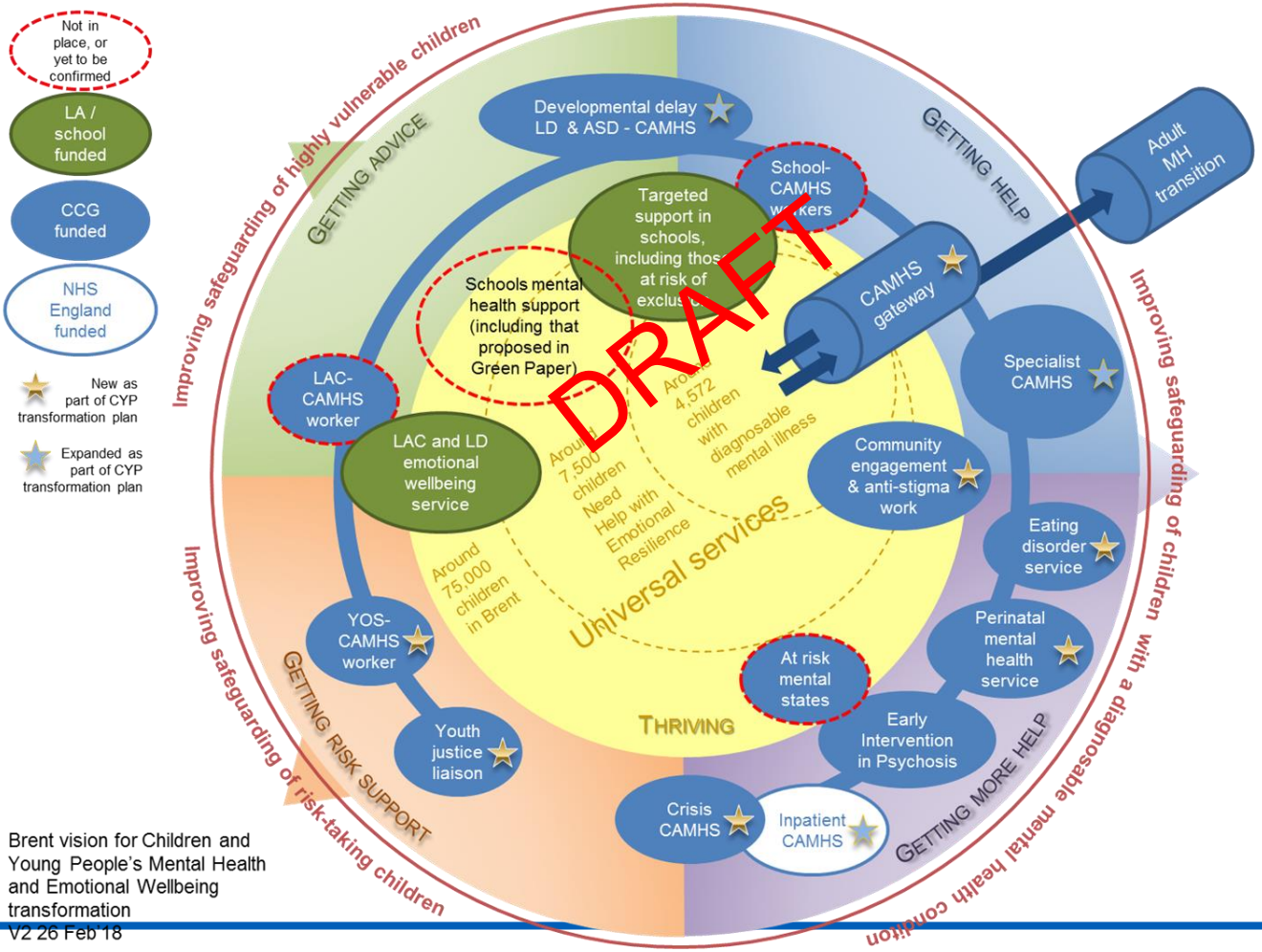
	Commissioning/ Contracting Change	Impact
Maternity and Children 0-19	Continue working with Public Health to develop local action plans to reduce childhood obesity smoking cessation, and to align special school nursing with their public health nursing service. Expand the mental health support available during pregnancy and for new parents.	• More children maintain a healthy weight • More parents with a mental illness are confident in their parenting skills
Children and Young People's Mental Health and Wellbeing	Implement redesigned care-pathways with a common gateway for mental health support across schools, youth offending, Looked After Children's services, and early help services.	• More children with mental health needs can access timely, high quality support. • Local ways of staying mentally well are recognised and valued, and local sources of stigma are challenged.
Looked After Children (LAC)	Help to reduce the variation in service quality by introducing the national standard specification and tariff for LAC health assessments. Improve access to specialist mental health care and advice for LAC and their professional carers.	• Ensure LAC get timely access to high quality health care
Special Educational Needs and Disabilities (SEND)	Improve the Education, Health and Care Planning process. Jointly commission paediatric therapy services, including Speech And Language Therapy.	• More joined-up care through Education, Health and Care Plans • Focused support for all children with SEND for the period of time they need it • More parents aware of the Local Offer and how to influence its development
Itchy, Wheezy, Sneezey	Use multi-agency information to identify children with long-term health conditions who would benefit for targeted relapse-prevention support.	• More children are confident managing their asthma and reducing the frequency of an asthma attack.

1 (b) Child and Adolescent Mental Health Services

Strategic Aim

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 Oct'18.

Monitor impact of new crisis service, community eating disorder service, local inpatient service, and better links to schools.



Brent vision for Children and Young People's Mental Health and Emotional Wellbeing transformation
V2 26 Feb'18

NHS Brent Clinical Commissioning Group

Delivery Area 2 – Eliminating unwarranted variation and improving management of long term conditions

(a) Long Term Conditions
(b) Cancer
(c) RightCare
(d) North West London Outpatient Transformation Programme
(e) Community Gynaecology Service
(f) Community Dermatology Service

2a) Long-Term Conditions (LTCs)

Description

A very high proportion of the NHS budget is spent on patients with LTCs. With an ageing population, this is set to rise in the future.

Our aim is therefore to support people to understand and manage their own condition and to reduce the variation in outcomes for people with LTCs by standardising the management of LTCs, particularly in primary care.

Strategic Aim

One of the CCG's strategic objectives for 2018/19 is to provide better proactive and coordinated care for people with long term conditions with a focus on patient education and the promotion of self-care.

Rationale

Brent has one of the highest prevalence rates of patients with Long Term Conditions (LTCs) in the country. For example the JSNA estimated that by 2030 nearly 15% of people aged 16 and over in Brent will have diabetes compared to the England average of about 9%. There is a marked variation in the outcomes for patients across NW London – our residents have a right to expect the quality of care should not vary depending on where they live. The CCG is committed to reduce health inequalities and improve experience and outcomes for patients

	Commissioning/ Contracting Change	Impact
Planned for Year 1	• Implementation of the National Diabetes Transformation Programme in Brent including establishment of a NWL self-care education hub, more support for practices to diagnose and treat patients, and improved foot care. • Successful delivery of National Diabetes Prevention Programme for pre-diabetic patients in Brent • If evaluated to be successful, mainstreaming of the Parkinson's Disease Nurse pilot. • Commissioning of an enhanced Community Respiratory Service for Brent patients including an admission avoidance programme for COPD/Asthma patients	• 30% of diabetic patients have structured education by 2021 • 52% of diabetic patients achieve 3 Treatment Targets by 2021 • Reduction in progression from non-diabetic hyperglycaemia to Type 2 diabetes • Reduction in acute care admissions for LTC patients
Planned for Year 2	• Continue to review and improve access and outcomes of existing LTC services • Providing extra support for primary care clinicians in the diagnosis and treatment of patients with atrial fibrillation • Develop a strategy/clinical pathway for the management of hypertension ensuring alignment with Stroke services	• Reduction in the number of AF patients who have strokes • Increased patient awareness of self-care and • Reduction in A&E attendance

2b) Cancer

Description

To improve patient experience of cancer services and increase the number of cancers detected at an early stage

Strategic Aim

To increase the rates of early detection of cancers, increasing the likelihood of long-term survival and avoiding people presenting with cancer symptoms at A&E in an unplanned way.

Rationale

Reported patient experience of cancer care in Brent is lower than the national average. England as a whole has lower cancer survival rates than some other advanced European countries and it is therefore a national and local priority to improve cancer care and long-term survival rates.

	Commissioning/ Contracting Change	Impact
Planned for Year 1	•To introduce a service in collaboriation with RM Partners, who have procured an organisation called Community Links to call patients who have not completed their FOBt kit • Introduce safety netting processes at GP practice level	• Increased numbers of patients participating in cancer screening, increased numbers of bowel cancer patients diagnosed at an earlier stage.
Planned for Year 2	• Working with NHSE, introduce the FIT test for bowel screening, which has better compliance rates than the current FOBt test	• Increased compliance rate for sending back bowel screening kit, increased numbers of bowel cancer patients diagnosed at an earlier stage.

2(c) Rightcare

Description

Using RightCare data packs and methodology, undertake a number of service reviews across Cancer, Respiratory, CVD and Neurology to maximise value in population healthcare. Continue implementing the outcomes of previous RightCare reviews into MSK and Diabetes

Strategic Aim

RightCare identifies variances between Brent and the best of the top 5 comparator CCGs with similar demographics. The aim is to manage out the variation to achieve higher quality at lower cost. The programme is in collaboration with a range of partners across health and social care along the whole care pathway.

Rationale

The aim is to standardise the quality and cost of care across areas with similar demographics and drive out unwarranted variation in quality and costs. Through clinical review and audit a programme is to be formed to optimise care pathways.

	Commissioning/ Contracting Change	Impact
Planned for Year 1	Continue to mobilise plans for diabetes and MSK including supporting GPs to manage patients with these conditions and introduce improvements to community services. Continue initial work relating to atrial fibrillation (AF) and respiratory Undertake reviews and develop approaches relating to Respiratory, Paediatrics, CVD, Cancer and Neurology	• **Diabetes**: improvement in Hba1c management; reduction in elective spend • **MSK**: Improvement in EQ5D score for hip and knee replacement, reduction in unnecessary diagnostics, improvement in outcomes from physiotherapy • **AF**: Improvement proportion of patients with AF who are appropriately treated, reduction in numbers of strokes
Planned for Year 2	Mobilise plans for Respiratory, Paediatrics, CVD, Cancer and Neurology	• **Cancer**: improve early detection & prevention • **Respiratory, CVD & Neurology**: Improvement in outcomes in line with findings of the reviews including reduced emergency admissions for related conditions.

2(d) North West London Outpatient Programme

Description

An Outpatient Transformation Programme has been running across NWL and has made a number of recommendations. During 19/20 we intend to implement the recommendations.

Strategic Aim

To embrace new ways of working to make the traditional outpatient and follow-up model more efficient, releasing finite clinical resources to see more patients within the time available.

Rationale

A large proportion of consultant and junior doctor time is spent in outpatient appointments. In some cases, the patients do not always need to be attending these appointments in person, and a decision could be made more quickly by using newer technology and ways of working, instead of waiting for an appointment in person.

	Commissioning/ Contracting Change	Impact
Planned for Year 1	Implement NWL referral guidelines for dermatology, gynaecology, gastroenterology, ENT and cardiology. Implement teledermatology within our newly procured community dermatology service and allow GPs to send in photos of lesions with referrals. Hospital trusts to implement recommendations on triage	• Reduction in number of unnecessary outpatient appointment, increase in number of patients being treated within 18 weeks (RTT)
Planned for Year 2	Mobilise plans for Respiratory, Paediatrics, CVD, Cancer and Neurology	• **Cancer**: improve early detection & prevention • **Respiratory, CVD & Neurology**: Improvement in outcomes in line with findings of the reviews including reduced emergency admissions for related conditions.

Key design principles underpinning outpatient pathways

Referral

How can we get the right referral to the right specialist?

Guidelines for appropriate referrals

1. Are there consistent, specific and agreed guidelines between GPs and specialists for when a referral should take place?
2. Do the guidelines cover all diagnostics and clinical information required pre referral? (incl. fitness for surgery)
3. Are the guidelines easily connected into IT systems

Advice & Guidance (A&G)

1. Can GPs access specialist advice through the eRS system without making a referral?
2. Is the standard eRS functionality sufficient ? If not, what other support is required?
3. Is there an agreed protocol of advice and feedback between primary care and specialists?
4. Are systems in place to assure timely action for part time GPs?

Triage

When a referral is made, how is it triaged?

Triage

1. Is there a system of triage to ensure:
   - adherence to guidelines,
   - pre referral tests/investigations are ordered and reported,
   - all information, including images, available easily to specialist in the referral letter ?
2. Would a different triage system give greater value?
3. Should patients being referred via the 2 week cancer pathway be triaged?

Good triage should ensure that all 1st appointments are value added with the right patients, with all appropriate information available.

First appointment

When a referral reaches secondary care, how is it managed?

Who sees the patient?

1. Could any first appointment be appropriately managed by non-consultant grade staff?
2. Should there be guidelines to cover consultant: consultant referrals

How does this take place?

1. Could patients be assessed virtually, by telephone or video link?
2. Would a system for virtual patient review between GP and specialist be appropriate or feasible?

Efficiencies in Hospital Outpatients

1. Are DNA rates and fluctuations in DNAs causing waste and are there plans to reduce these?

Follow-up

How should the patient's care be managed after the first appointment?

Follow-up

1. Could all follow up appointments be determined by real-time clinical need rather than at fixed periods of time? Could it be via a patient activated portal with a clinically designed algorithm to assess the need to see specialist.
2. Could follow up combine with other scheduled appointments ?
3. Could any follow-up appointments be appropriately managed by non-consultant grade staff?
4. Could follow-up or monitoring take place remotely or virtually?

Discharge

1. Is an appropriate care plan provided (electronically) to GPs and patients when discharged?
2. Discharge and care plans should assume that the baseline for all GP practices are those required by the NHS standard contract.

Feedback and support to GPs

1. How do the GPs know their comparative patterns of referral?
2. What are we measuring to test adherence to clinical guidelines and use of A&G?
3. How do we support Primary Care to develop any additional skills required?

Feedback and support to patients across the whole pathway

1. Is there sufficient information for patients to make informed choices (shared decision making) e.g. whether to have surgery?
2. Do care plans cover self-management and prevention ?
3. Should peer support for self-management or group sessions be designed into the pathway?

2(e) Community Gynaecology Service

Description
Set up and implement a new community gynaecology service in Brent based around an expanded range of conditions and appropriate diagnostics including ultrasound.

Strategic Aim
To expand the numbers of patients that can be seen and treated in community settings for gynaecology conditions, taking pressure off acute services and providing outpatients at lower cost.

Rationale
The CCG currently spends £3.7 million on gynaecology outpatients and procedures in Brent. There is national evidence from the Royal Society from the Royal Society for Gynaecology and Obstetrics that a community service can provide outpatient appointments and procedures for a wider range of conditions when supported appropriately by ultrasound. This allows a more efficient service to be provided in a variety of different venues closer to people's homes. Work has taken place throughout 17/18 to define the scope of the new service, which has been undertaken jointly with Harrow CCG. A specification has been developed with patient engagement input, and a procurement is about to commence. We aim to have the new service in place by February 2019

	Commissioning/ Contracting Change	Impact
Planned for Year 1	Procure and mobilise community gynaecology service across Brent. Decommission current pilot in Harness & Willesden. Embed and promote the service with local patients and GPs.	Reduction in the number of gynaecology outpatients and procedures taking place in hospital. Reduction in tariff for community gynaecology outpatients

2(f) Community Dermatology Services

Description
Procure, implement and embed a new community dermatology service within a community setting

Strategic Aim
To provide more outpatients in the community at lower cost, also reducing referral to treatment times in hospital.

Rationale
Referral to Treatment times are under pressure and an expanded community service can help to reduce waiting times in the acute service. Appropriate consultant supervision will also reduce the number of cases referred on from the community service into hospital. The current community service run by LNWHT has been reviewed and a new specification has been developed with clinical input and patient engagement. At the time of writing, the CCG is about to commence a procurement process, the review having been flagged in previous commissioning intentions. Market engagement has taken place.

	Commissioning/ Contracting Change	Impact
Planned for Year 1 (19/20)	• Procure and mobilise the new community dermatology service • Embed contract monitoring process and promote to local patients and GPs	• Reduction in number of outpatient referrals into hospital • Reduction in number of onward referrals from community service to hospital • Improved clinical outcomes for dermatology patients

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

(a) Primary Care Transformation
(b) End of Life Care
(c) Whole Systems Integrated Care
(d) Integrated Care System
(e) Care Home & High Risk Housebound Patients
(f) Integrated Care at Home Service
(g) Unified Frailty Older Person's Pathway
(h) Integrating Transfers of Care
(i) MSK Workstream and Fracture Liaison Service

3a) Primary Care Transformation

Strategic Aim

The General Practice Forward View (GPFV), NHS London Strategic Commissioning Framework (SCF) and STP provide the strategy and framework guiding the development of a fit for purpose and sustainable Primary Care system, working together, and with partners to deliver accessible, proactive and coordinated care.

Rationale

The Brent Primary Care Strategy sets out our vision for developing primary care, with GPs remaining at the centre of the new model of care. We will work with GPs, patients, Networks/Federations and other stakeholders to ensure primary care continues to develop to meet local patients needs and remains fit for purpose.

	Commissioning/ Contracting Change	Impact
Planned for Year 1 & 2	**Improving Access to Primary Care** • Re-align our GP Access Hubs to ensure they meet our local population needs. Introduce alternate forms of patient consultation including on-line and video consultations, over seven days a week. Improve patients awareness and utilisation of on line services. • Support general practice to adopt new technological advances including the electronic referral service (E-RS), new fit for purpose GP websites, a GP intranet service. **Developing Resilience** • Develop an integrated mode of care with primary care working closely with community, social care, voluntary sector, out of hours service providers and secondary care to ensure patients are seen in the right setting first time. Support co-ordination of care and joined up approach across providers. • Support development of Networks and Federation and deliver of patient care 'at scale' with practices working together to share skills, knowledge and expertise to assist patients in living independent lives. • Further development of new roles in primary care, including clinical pharmacists, new nurse mentors, train new nurses and introduce Apprenticeship programmes **Quality & Outcomes** • Ensure all patients have access to the same services irrespective of where they may be registered. • Reduce variation – ensure all enhanced services are delivered against agreed targets and performance indicators.	• Ensure a fit for purpose Extended Access Service which meets the needs of our registered population, including development of the digital platform • Ensure continued development of GP practices / Networks and Federation to share resources and skills to reduce unnecessary hospital attendances • Reduced variation in clinical outcomes and ensure all patients have access to the same services to the agreed quality standards.

3b) End of Life (EOL) Care

Description

Provide better support to EOL patients so that they receive seamless services wherever they live in the borough and at whatever time of the day. Optimise patient pathway to increase the number of patients who die at their place of choice and help to avoid or reduce length of stay in acute hospital settings where appropriate.

Strategic Aim

The aim of our commissioning intentions is to bring about a step change in access to high quality care for all people approaching the end of their life. Ensure that high quality care is available wherever the person may be; at home, in a care home; in hospital in a hospice or elsewhere. Implementation of this strategy should enhance choice, quality, equality and value for money.

Rationale

Over 80% of patients indicated a preference to die at home but only 22% actually did. Patients should be supported with compassion in their last phase of life according to their preferences through the provision high quality coordinated care enabling them to die in their place of choice.

	Commissioning/ Contracting Change	Impact
Planned for Year 1	Improve identification and planning for 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 • Identifying the frail elderly population using risk stratification and flagging patients to be offered advanced care planning. Improving interoperability of Coordinate my Care IT system with other IT systems including primary care Review all contracting arrangement with a view to integrating service provision	• All patients in their last phase of life are identified • Patients identified as being in their last phase of life have an advanced care plan. • Reduction in avoidable non-elective admissions for this patient cohort. • Reduce the number of avoidable admissions and A&E attendances from care homes
Planned for Year 2	Implement the findings of the contracts review as appropriate	• Every eligible person will have a care plan with a fully implemented workforce training plan • Support people dying in the place of their choice

3(c) Whole Systems Integrated Care (WSIC)

Description

Development of proactive, coordinated and integrated care in Brent and partnerships between providers to support joined up care and improved patient outcomes and experience on the journey towards the development of integrated care system

Strategic Aim

Improve the quality of care for individuals with long term condition and their families and carers. Empower and support people to maintain independence and to lead full lives as active participants in their community. Foster joined up collaborative working between health, social care, mental health and the voluntary sector.

Rationale

Improve patient experience and quality of life, better manage long term conditions, reduce health inequalities, deliver accessible, proactive and coordinated care and support a reduction in unnecessary use of secondary care.

	Commissioning/ Contracting Change	Impact
Planned for Year 1 & 2	**To close the care and quality gap as well as the financial gap, the following service improvement initiatives are prioritised:** • **Centralised Case Finding - s**implify GP access to case-finding lists and support the case-finding process • **Care Planning Development and Sharing - s**et clear expectations for the care planning process, the content and the distribution of the care plan • **Redesign of the Complex Patient Management Group (CPMG) Operating Model - a**n improved CPMG model will facilitate the CPMG care pathway from start to finish • **Expanding the service to include a Recovery Model of care - in collaboration with the Rapid Response provide** additional support to a define group of patients until they have fully recovered will reduce their risk of readmission.	• Streamlined care planning process through a reduction in redundant data entry • Simplified and more efficient compact care planning process • Successful sharing of care plan across health and social care partners • Live documents across the system • CPMG is able to provide better and more personalised care for a wider cohort of service users with more complex needs • Shared system learning of available services which can support service users to stay at home

3(d) Integrated Care System (ICS)

Description

Development of proactive, coordinated and integrated care in Brent through service co-ordination and collaboration within and across sectors to support joined up care and improved patient outcomes and experience.

Strategic Aim

To improve the health and wellbeing for patients by turning a reactive, increasingly acute-based model on its head, to one where patients take more control, supported by an integrated system which proactively manages care closer to people's homes, where possible.

Rationale

To (re)design health and care systems that are aligned to the 'quadruple aim' of providing equitable, high quality and financially sustainable care; with the aim of improving patient experience and quality of life, reducing health inequalities, delivering accessible, proactive and coordinated care and supporting a reduction in unnecessary use of secondary care

	Commissioning/ Contracting Change	Impact
Planned for Year 1 & 2	• Revise the strategy for the CCG's vision for integrated care and develop a project plan to move towards an ICS. • Enhance the model of care and the operating model of WSIC and Rapid Response Service (with additional functions as part of the PCH/Hub based model. • Work with stakeholders to develop and clarify the detail required to articulate the agreed strategic approach to primary care homes, in line with the integrated care road map and related transformational objectives. • Launch Primary Care Home pilots following completion of Expression of Interest period. • Develop the model of care with the pilot PCHs to ensure that the care interventions selected are the most effective in improving the desired outcomes for patients. • Review lessons learned and develop plan for commissioning framework for a single ICS via chosen contracting option.	• Opportunities to tackle variation in outcomes through consistent practices • Enhanced collaboration between providers with reduced fragmentation • Reduced waiting times (including increased access to same day appointments) for patients. • Reduced growth rate in A&E attendances/admissions • Improved staff recruitment and retention with the opportunity to explore sharing back office functions to save money for practices.

3(e) Care Home & High Risk Housebound Patients

Description
The CCG commissioned a new service in 16/17 to deliver proactive care and improved outcomes for these patients. This service is designed to improve the quality of medical support to patients, improved medicines management, reduce inappropriate LAS call outs and use of acute/secondary care and improve patient experience & satisfaction. The CCG will continue to work with existing providers and stakeholders to pro-actively support patients to remain well and residing in their on homes.

Strategic Aim
Align the existing service to wider strategic objectives for primary care out of hospital services and for this patient group. Contribute to the closing of the 'care and quality' gap under the STP. Improve key outcomes and patient experience.

Rationale
Support pro-actvie management of patient care to improve patient experience and quality of life and support a reduction in unnecessary use of London Ambulance Service, A&E attendances and non-elective admissions.

	Commissioning/ Contracting Change	Impact
Planned for Year 1 & 2	**Service development & improvement** – review existing service delivery model to re-define and re-align to best meet the intended outcomes. Including review of Key Performance indicators **Pharmacy Support** – secure funding for dedicated Clinical pharmacists to support Care Home contract and pro-active patient management. **Integration** – Review and re-align the Care Home contract to the developing Primary Care Home model and 'at scale' delivery of services. **Utilisation of technology** advances to support better managment of patient care through remote technology e.g. video conferencing	• Reduction in LAS call outs and non-elective admissions from the 1,220 (approx) beds in Brent. • Integrated and coordinated care for housebound patients • Improved quality of care for patients in nursing and residential homes

3(f) Integrated Care at Home Service

Description

The Integrated Care at Home service developed and aims to to achieve a new integrated pathway that bridges the gap between Rapid Response (RR) and Whole Systems Integrated Care (WSIC) models. The new Integrated service model develops the capacity and capabilities of the RR service to provide proactive and reactive care pathways that are joined up to prevent those people most at risk of unnecessary A&E attendance and hospital admission

Strategic Aim

The Service supports the ambition of the North West London system to treat and manage patients proactively in their own homes and communities, with acute hospital based care used only when necessary. The aim is to have joined up care plans which is shared with all health and care professionals involved in the patient's care support with clear communication mechanisms.

Rationale

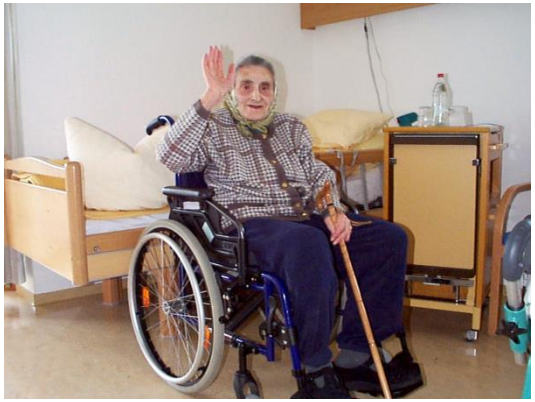
As the population ages and long term conditions (LTCs) increase in prevalence, providers and commissioners are being asked to do more with less. In this context providers and commissioners have come together to develop a long-term model of care that focusses on providing high quality pro-active and preventative action to stop older people becoming unwell in the first place.

	Commissioning/ Contracting Change	Impact
Planned for Year 1	• Improved and or maintained health status through coordinated delivery of high quality care in the most appropriate setting • Reducing A& E attendances & non-elective admissions and reducing length of stay in acute & community hospitals • Streamlined & coordinated access to appropriate Health & Social Care services in the community • Enhancing integration with other service providers • Expanding the scope of the service to reduce the very short stay admissions (0-1 day)	• Enhanced Quality of life for people with complex conditions • Increase in referrals into the service • Reduction in unplanned hospital admissions, length of stay and inappropriate use of A&E • Reduction in short stay admissions.
Planned for Year 2	• Creating additional capacity to enable people to be cared for in less acute settings. • Operating as part of the Primary Care at home direction of travel	

3(g) Unified Frailty Older People Pathway

Description

Increase in the older population poses a challenge to the health and care system due to their complex health and care needs. Patients who are over 65 years old are more likely to be frail and have multiple Long Term Conditions. As a result of this we are seeing a higher proportion of non-elective admissions and avoidable A&E attendances.



Strategic Aim

It is critical that the model of care needs to be integrated at every stage, the CCG in collaboration with stakeholders will commission care that is better coordinated, more proactive and less fragmented.

Rationale

The frail elderly population will continue to increase in Brent and the services that we have commissioned both in and out of hospital need to manage this cohort of patients in the appropriate settings. If the acuity of the patient requires an attendance or an admission within the Emergency Department, the focus will be to ensure that our health and care system develops appropriate pathways of care which ensures a minimum amount of time within a hospital setting to get best outcomes for these patients. The CCG has commissioned a number of services which impact positively on frailty cohort of patients however their co-ordination and delivery needs to be seamless with the sharing of information at the heart of delivery.

	Commissioning/ Contracting Change	Impact
Planned for Year 1	• Comprehensive Geriatric Assessment (CGA) on admission • Acute Frailty Service model in place • Align services which support the frailty pathway (WSIC/Rapid Response /D2A Homefirst/Care Home)	• 95% of patients with Rockwood score of 4 & above will be screened and receive rapid assessment & treatment • Reduction in the number of patients with a hospital stay over 21 days
Planned for Year 2	• Strengthen Acute Frailty Service ensure discharge pathways are fully embedded • Improve the quality of services for patients and provide value for money by ensuring care is delivered in the most appropriate setting. • Ensure better links and collaborative relationships with a wide range of stakeholders – health, social care and voluntary sector • Ensure the service benefits from system-wide Information & Communications Technology improvement in terms of information sharing and its interoperability	• 100% of appropriate patients receive CGA at an earliest opportunity • Reduction in the number of patients with a hospital stay over 7 and 21 days • Front line staff will have real-time access to patient information from community

3(h) Integrating Transfer of Care (Health and Social Care)

Description

Transfer of Care processes will be consistent and streamlined across North West London ensuring timely referrals to appropriate place of care. Community, Social Care and Hospital teams will work together to enable an integrated needs based approach to packages of care. The pathway will be easier to navigate for patients and carers, with quality information provided along the pathway for staff and patients.

Strategic Aim

Delivery of an improved 7 day emergency service and therefore achievement of the London Quality Standards has been a key part of the strategy in North West London for several years. Improving processes for transfers of care from a hospital setting is key to our strategy to deliver care in the right place at the right time, as close to someone's own home as possible.

Rationale

There was a recognition across NWL CCGs that the current transfer of care pathways are fragmented, difficult to navigate for patients and staff and vary considerably across boroughs. The new model helps standardise pathways across NWL, build relationships between hospital and community based staff and improve the quality of information provided at discharge. A range of other benefits are also expected, including:

	Commissioning/ Contracting Change	Impact
Key deliverables in line with STP 5 year plan *Phased approach to implementation to be developed and agreed.*	• An agreed integrated acute and social care model of care • An integrated health and social care acute transfer of care team • A single point of access for transfer of care across NWL boroughs • A needs based assessment form • Agreed common dataset in relevant contracts to measure, target and identify improvement areas for transfer of care across NWL • Information sharing and joint working agreements • Shared IT platform to share information across health social care	• A reduction in inappropriate referrals to community services; • Reduced duplication of effort as staff will no longer need to complete different forms or chase hospital based staff for additional information in order to accept referrals into a service; • A reduction in Delayed Transfers of Care and Length of Stay • Improved quality of patient care and patient experience.

3(i) MSK workstream and Fracture Liaison Service

Description

Procure and mobilise a new MSK Physiotherapy service and implement new pathways for pain management and diagnostics associated with MSK

Strategic Aim

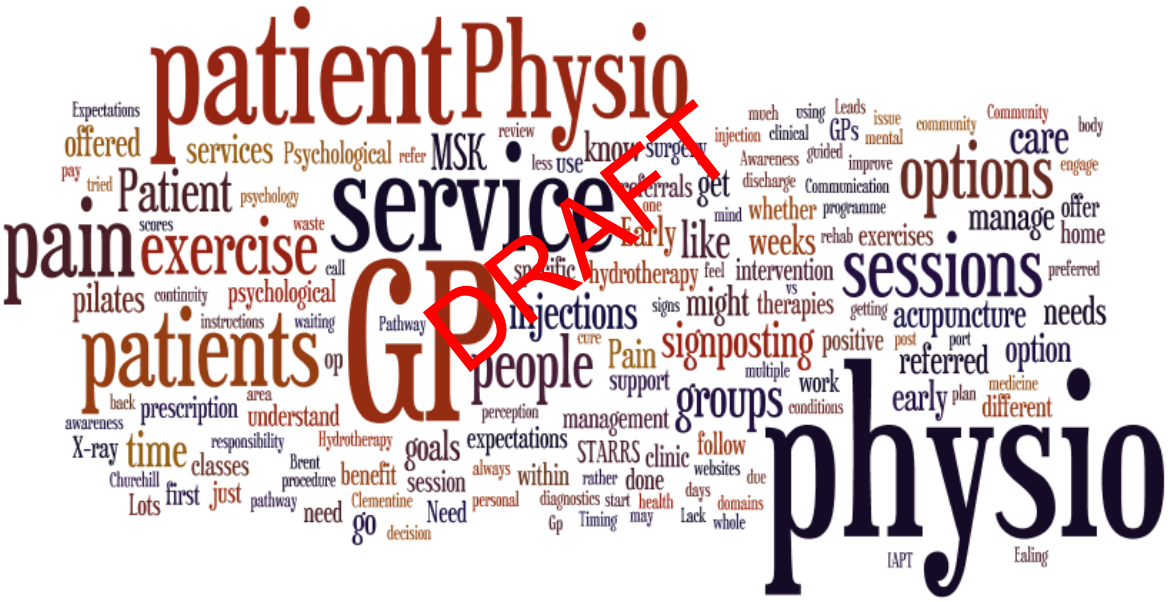
To improve waiting times and quality of care in our community MSK physiotherapy services and to reduce unnecessary MSK-related outpatient appointments that could be avoided through better physiotherapy services. To reduce reliance on unnecessary diagnostic imaging when it does not influence treatment options. Increase the number of patients with risk factors for fractures from orthopaedic to our falls service.

Rationale

Waiting times in our existing physiotherapy service (excluding Kilburn) are high. At our Rightcare MSK workshop, held with patients and MSK professionals, it was considered that the MSK care pathways were unclear and that people 'bounced around' the system, going from consultant-led orthopaedic outpatient appointments, back to the GP and into physiotherapy without a clear pathway. It has also been evidenced that large amounts of diagnostic imaging is being undertaken which has often has no influence over the treatment options (i.e. the treatment option would be the same regardless of whether an MRI is undertaken or not).

	Commissioning/ Contracting Change	Impact
Planned for Year 1	Mobilise the new MSK physiotherapy service and associated care pathways, incorporating triage by Extended Scope Physios and a pathway for patients to self-refer. Implement the new PPwT pathways for diagnostic imaging. In collaboration with NWL and LNWHUT, launch the new fracture liaison service.	• Reduce waiting times in MSK Physiotherapy • Reduce unnecessary diagnostics and outpatient appointments • Increase in number of patients identified in trust orthopaedic department and refer into our falls prevention and bone health service

Word Shower From our MSK 'Rightcare' Event



NHS Brent Clinical Commissioning Group

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

(a) Mental and Physical Wellbeing
(b) Talking Therapies
(c) Psychology and Psychotherapy – Personality Disorder & Post Traumatic Stress Disorder
(d) Dementia
(e) Learning disorders
(f) Carers

4 (a) Mental health and physical wellbeing

Description

- We have an opportunity to remodel the 'Recovery College' approach to better support local community wellbeing.
- We need to improve physical health access for people with serious mental illness, and psychological support for people with physical long-term illness.

Strategic Aim

Many people with mental illness experience difficultly accessing wellbeing services, or developing their own self-care support in local communities. Recognising the impact on Black and Minority Ethnic communities is highly relevant to people in Brent. Reducing the risk of physical illness (respiratory disease, cardiovascular disease, and diabetes), and psychosis (associated with cannabis use and family risk factors) is a priority in the NHS England Five Year Forward View for Mental Health, with associated savings targets built in to CCG future funding allocations.

Rationale

- Mortality rates from physical illness are more than three-times higher for people with serious mental illness that the general population.
- BAME groups in Brent mental health services report wanting to have better support from their own community through peers, in particular people with lived experience of mental illness.

Commissioning/ Contracting Change	Impact
Culturally sensitive BME peer support alongside bio-social models of care, to develop support and challenge stigma within local communities. Specific focus on under 18s psychosis risk factors Better access to physical health care for people with Serious Mental Illness Better psychological support for people with long-term physical health disorders	• Helping different communities develop their own positive emotional response to help people recover from acute episodes of psychosis and stay well. • More people from BME groups accessing talking therapies and gaining support in their local community to stay well • More impact from annual health checks for people with serious mental illness • Integration of talking therapies and physical long-term condition services

4(b) Talking therapies

Description

One in ten people would benefit from support to help them learn new ways to cope with stress, depression, and anxiety. In Brent over 6,000 people a year use talking therapy services (part of Improving Access to Psychological Therapies, IAPT). National targets have been set to increase the number of people accessing these services.

Strategic Aim

From April 2018, CCGs were required to ensure that talking services are integrated with physical healthcare pathways. Additionally in line with the Five Year Forward View, there is an expectation for increased numbers of adults accessing care each year by 2020/21 moving from targets of 15% access of all people with anxiety and depression each year to 25%. The focus is on people with long term conditions, supporting people to find or stay in work and improving quality and people's experience of services. This also supports improvements in the numbers of people who recover, reducing geographic variation between services, and reducing inequalities in access and outcomes for particular population groups.

Rationale

- Talking therapy services in Brent to see c9,500 people a year by 2020, with 75% accessing care within 6 weeks and 95% within 18 weeks
- Improvements in access for people from black and minority ethnic groups, people with a learning disability, older people, and women in the perinatal period.

Commissioning/ Contracting Change	Impact
Increased capacity and capability of the IAPT service and improved quality of people's experience of services Alignment of the IAPT service with general acute in-patient services, with a greater focus on people with long term conditions An integrated IAPT and employment approach	Increased numbers of people accessing IAPT services including those from black and minority ethnic communities. Reduction in unplanned admissions and less reliance on in-patient care More support for people to find and keep work. Reduction in health-related job loss, increased likelihood of an earlier return to work following health-related absence

4(c)Psychology and Psychotherapy - Personality Disorders and Post Traumatic Stress Disorder

Description
To offer individuals with personality disorders, post-traumatic stress disorders, and long term psychological problems the most appropriate assessment and treatment for their needs. To ensure appropriate support to primary and secondary care to provide effective interventions for people with Personality Disorders and those with Post Traumatic Stress Disorders

Strategic Aim
Re-specify and remodel psychology and psychotherapy provision for individuals with Personality Disorders and those with Post Traumatic Stress Disorders and ensure more effective management and treatment approaches for them. Increase alternatives to hospital admissions and minimise length of stay for those who have an admission. Improve information on Personality disorders and Post Traumatic Stress Disorders, treatments and support available.

Rationale
People with a primary diagnosis of personality disorder are frequently unable to access the care they need from secondary mental health services. Historically Brent has never had dedicated commissioned services for people with Personality Disorders and those with Post Traumatic Stress Disorders. The majority of people with Personality Disorders and those with Post Traumatic Stress Disorders therefore depend on generic Adult psychiatric services for routine and crisis input placing these services under immense pressure.

Commissioning/ Contracting Change	Impact
Development and design of care pathways that offer evidence based interventions tailored to meet the needs of individuals with Personality Disorders and those with Post Traumatic Stress Disorders who access mental health services.	Improved long term care for people with Personality Disorders and those with Post Traumatic Stress Disorders.
Provision of more effective management and treatment approaches for individuals with Personality Disorders and those with Post Traumatic Stress Disorders	Focus on recovery and empowering individuals with Personality Disorders and those with Post Traumatic Stress Disorders to live meaningful lives with or without on-going symptoms of their condition.

4 (d) Dementia

Description
Brent has a high rate of dementia identification and support (latest data Jun'18).
Estimated prevalence >65yrs 2,451 people; diagnosis rate 75.6%.

Strategic Aim
The CCG intends to Implement new NICE guidance, and provide early interventions that support people with dementia to live longer in their own homes and delay and / or prevent the need for more costly care at a later stage. We will continue to work jointly with Brent Council and local communities to improve the quality of care and support that patients living with dementia and their carers receive locally.

Rationale
The prevalence of dementia is continuing to rise. Early diagnosis is important as is early support and advice for patients and for carers of people with dementia. This advice can also help family members reduce their risk of dementia.

Commissioning/ Contracting Change	Impact
Reflect new NICE guidance in commissioned services Continue developing our primary care dementia service, including: early diagnosis in a timely manner, communicating the diagnosis well to the person with dementia and their family, advising on appropriate treatment, information, care and support after diagnosis. 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	• Early assessment and diagnosis in primary and secondary care settings. Early identifying of the right treatment and support to maintain a good quality of life • Improved quality of life of people with dementia following early diagnosis and intervention • Positive effects on the quality of life of family carers following early diagnosis and intervention

4 (e) Learning disabilities

Description
Jointly commissioned integrated community learning disability team (CTPLD) implemented in 2018/19.
Local risk registers in place to reduce reliance on inpatient care.
Building provision of community based infrastructures to meet the needs of the local population.

Strategic Aim
Improve integration and aligned commissioning with Brent Council of safe, appropriate, high quality services for people with learning disabilities to support prevention and self-care, admission avoidance and reduced lengths of stays when admitted for in-patient care.

Rationale
Following the Winterbourne view, transformation of health services for people with Learning Disabilities is required to ensure improved quality of care and quality of life, reduced reliance on in-patient, residential and nursing care provision, and provision of personalised care and support that focuses on positive experience of care for people with Learning Disabilities.

Commissioning/ Contracting Change	Impact
Monitor effectiveness and outcomes from the jointly commissioned integrated community learning disability team (CTPLD)	Reduced reliance on in-patient care and facilitated early discharge from in-patient care Deliver wellbeing support, timely access to assessment and treatment and improved patient experience
Remodel local in-patient Learning Disabilities unit, including the establishment of a specialist unit for children.	Improved quality of care, clinical effectiveness and outcomes for patients. Increased patient safety and improved patient experience. Reduced lengths of stay. Fewer children placed out of area for specialist mental health provision.

4 (f) Carers

Description
Work with Brent Council to ensure carers are able to access an assessment, and get support in staying well.

Strategic Aim
The CCG to continue to work with Brent Council and local residents to update the joint strategy, including support for young carers.

Rationale
Carers are entitled to a statutory assessment that is proportionate to their circumstances. They should be supported to develop a plan to stay well.

Commissioning/ Contracting Change	Impact
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 Working with partners to improve the identification of young carers, and to update the joint Carers Strategy.	• Increase the number of carers identified and supported • More young carers identified and supported

Delivery Area 5 – Ensuring we have safe, high quality & sustainable acute services

(a) Urgent & Emergency Care
(b) Inpatient Model of Care
(c) Radiology & Diagnostics
(d) Length of Stay - Transfers of Care
(e) Referral Optimisation
(f) Atrial Fibrillation
(g) Park Royal Masterplan
(h) Central Middlesex Hospital Redesign

5 (a) Urgent & Emergency Care

Description

The CCG will continue to review all for provision of unscheduled care and ensure that they align with the Integrated Urgent Care model being developed across NWL. Feedback from patient engagement is that there are several points of access for unscheduled care in Brent, however patients are not aware of these or when they should be accessed. There will need to be extensive public engagement for the new Integrated Urgent Care model.

Strategic Aim

Development of an Integrated Urgent Care model across Brent, Harrow & Hillingdon.

Rationale

The guidance published in November 2015 by NHSE on commissioning standards for delivery of Integrated Urgent Care requires that NHS 111 and Out Of Hours (OOH) services are aligned to facilitate the integration of all unscheduled services and a clinical hub is developed which manages the flow of patients from NHS 111. There is a need to integrate and streamline NHS 111,Urgent Treatment Centres, GP Access Hubs and GP out of hours services, so that patients do not need to visit multiple urgent care sites for their right care and to get this right the first time.

	Commissioning/ Contracting Change	Impact
Planned for Year 1	• Continue existing pilot model for Integrated Urgent Care across NWL taking into account all the unscheduled services provided (local and out of area) and how these may need to be re-defined. • Support the NWL review and procurement of the elements of unscheduled care e.g. GP Access Hubs, Telemedicine for care homes.	• Alignment of the current GP Access Hubs, Out of Hours and Urgent Care Services. • An opportunity to ensure that patients access local services rather than accessing from out of area.
Planned for Year 2	• Delivery of the new Integrated Urgent Care model across NWL to ensure equity of service provision	The Integrated Urgent Care model should result in patients being directed to the most appropriate local service in accordance with their needs, after having a locally led clinical assessment service or via NHS 111.

5 (b) Inpatient Model of Care

Description

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, on-going twice daily, inpatient reviews for acute and high dependency units and daily 24 hour review for all other inpatients unless deemed it will not affect patient outcome.

Strategic Aim

Delivery of an improved 7 day emergency service and therefore achievement of the London Quality Standards has been a key part of the strategy in North West London for several years. Delivery of the standards associated with increased consultant cover is specified explicitly within Delivery Area 5 of the STP.

Rationale

There is a national mandate for improving emergency hospital services and patient outcomes across the week, particularly in relation to increased consultant-led care. Benefits are being evaluated through the pilots being run in November 2016 across NWL but are expected to include reduced length of stay, improved patients & staff experience and reduced patient safety metrics (e.g. hospital acquired infection rates).

	Commissioning/ Contracting Change	Impact
Planned for Year 1	Implementation of new models of care in an emergency departments of the acute trusts.	• 90% of NEL admissions will receive consultant-directed reviews within the defined timelines every day of the week
Planned for Year 2	Implementation of new models of care in the acute hospital wards / units to facilitate effective hospital flow using ECIP SAFER bundle	• Reduction NEL • Reduction in LOS • Seamless transfer of care • Reduced HAIs

5 (c) Radiology and Diagnostics

Description
Implementing best practice practice for direct access diagnostics to make the care pathway as efficient as possible

Strategic Aim
Ensuring that best practice is adhered to for radiology and diagnostics requests from GPs to ensure that the care pathway is as efficient as possible. Reducing unnecessary spend on direct access diagnostics which may then be repeated in a hospital setting.

Rationale
GPs are able to request direct access diagnostics such as MRI scans and X rays in their practice. Sometimes these are then repeated in the acute hospital setting, which is unnecessary and costly. The latest NICE guidance clarifies when it is appropriate for these diagnostics to be undertaken and when it is not (e.g. for lower back pain). In some cases, the diagnostics makes no difference to the treatment options. Adhering to this guidance will save unnecessary expenditure on expensive diagnostic procedures and will not waste the patient's time attending an appointment for a diagnostic test that they do not need to have. Brent's direct access MRI procedures are currently very high compared with other NWL CCGs

	Commissioning/ Contracting Change	Impact
Planned for Year 1	Best practice protocols embedded within ICE diagnostic test ordering system and referral forms to independent sector diagnostic companies. Triage through BROS of MRI and diagnostic tests.	• Reduction in unnecessary MRI tests and other types of diagnostic

5(d) Length of Stay - Transfers of Care

Description

Developing a consistent and streamlined North West London wide process for the discharge of patients with a new or changed need for community health or care support on discharge from a hospital, including those that cross CCG boundaries. Introducing a standardised single discharge referral form that will improve the quality and flow of information provided to community services, reducing paperwork and ensuring that patients are allocated to the appropriate service on discharge.

Strategic Aim

Delivery of an improved 7 day emergency service and achievement of the London Quality Standards has been a key part of the strategy in North West London for several years. Improving processes for transfers of care from a hospital setting is key to our strategy to deliver care in the right place at the right time, as close to someone's own home as possible.

Rationale

It is recognised across NWL CCGs that the current discharge pathways are fragmented, difficult to navigate for patients and staff and vary considerably across boroughs. The new model helps standardise discharge pathways across NWL, build relationships between hospital and community based staff and improve the quality of information provided on discharge.

	Commissioning/ Contracting Change	Impact
Planned for Year 1	• Deliver single points of access for non-bedded community services, with the potential to increase to wider community services in Year 2. • Deliver of an IT solution to allow electronic sharing of information between health and adult social care providers, hospital, community and voluntary sector where appropriate • To work in partnership with initiatives across the health and adult social care system to improve transfer of care • Development of a system wide dataset to consistently measure Transfers of Care across the system	• A reduction in inappropriate referrals to community services • Reduced duplication of effort as staff will no longer need to complete different forms or chase hospital based staff for additional information in order to accept referrals into a service • A reduction in Delayed Transfers of Care and Lengths of Stay • Improved quality of patient care and patient experience • Timely flow of information across health and care economy
Planned for Year 2	To expand Single Point of Access to cover Bedded Community Services, Social Care and cross boundary services	

5(e) Referral Optimisation

Description
This is a system to clinically triage referrals that are made by GPs and internally generated referrals within the CCG's main Trusts.

Strategic Aim
This links to the aim of reducing unwarranted variation in levels of care in primary care and to make sure that people get the right care in the right place to a consistent standard.

Rationale
Since the inception of the service in September 2016, the CCG has seen a more controlled rate of growth in GP first outpatient attendances. However, we need to ensure that this continues. Rates of consultant to consultant referrals have increased at rates in excess of 10%, beyond that rate of demographic growth. We aim to extend the function of the GP BROS into our local acute trusts for non-emergency internally generated referrals.

	Commissioning/ Contracting Change	Impact
Planned for Year 1 (2019/20)	Extend the BROS into internally generated referrals at LNWHT, Imperial and RFL	• 10% reduction in unnecessary IGR referrals • Maintain low rates of referral growth in GP referrals
Planned for Year (2020/21)	Continue to embed and evolve BROS to new specialties as clinical behaviour changes and training needs evolve.	• Reduction in the rate of referral growth • Consistent referral standards across Brent.

5(h) Atrial Fibrillation

Description
Increase the case finding of patients who have undiagnosed atrial fibrillation and treat them, to avoid future risk of having a stroke

Strategic Aim
To prevent people from having an avoidable stroke in the future – patient benefit. To avoid cost of treating avoidable strokes in hospital – system benefit.

Rationale
Brent has a higher expected rate of atrial fibrillation compared with the rate actually diagnosed (taken from GP clinical systems). This suggests that there are people with undiagnosed atrial fibrillation, so if we target people with risk factors for atrial fibrillation, we can treat them and prevent them from having strokes in the future. A business case has been approved and we are in the process of recruiting a pharmacist to help identify patients.

	Commissioning/ Contracting Change	Impact
Planned for Year 1 (19/20)	• Recruit pharmacist into medicines management team to work with GP practices to identify new patients and treat them with DOACs or Warfarin (anticoagulation therapy)	• Increase in diagnosed prevalence of AF in Brent • Reduction in strokes related to Atrial fibrillation in the future. • Reduction in death rates due to stroke

5(i) Park Royal Masterplan

Description

Central Middlesex Hospital and Care Village workstream is one of the priorities contained in Brent's Health and Care Plan. In October 2017, Executives from Brent CCG and the London Borough of Brent agreed to commission a masterplan for the CMH site. This masterplan would help to identify how CMH can be transformed into a space that people will use (e.g. by identifying how existing spaces could be used differently), and help realise the vision of CMH becoming a health and care village.

Strategic Aim

The site offers a major opportunity to:

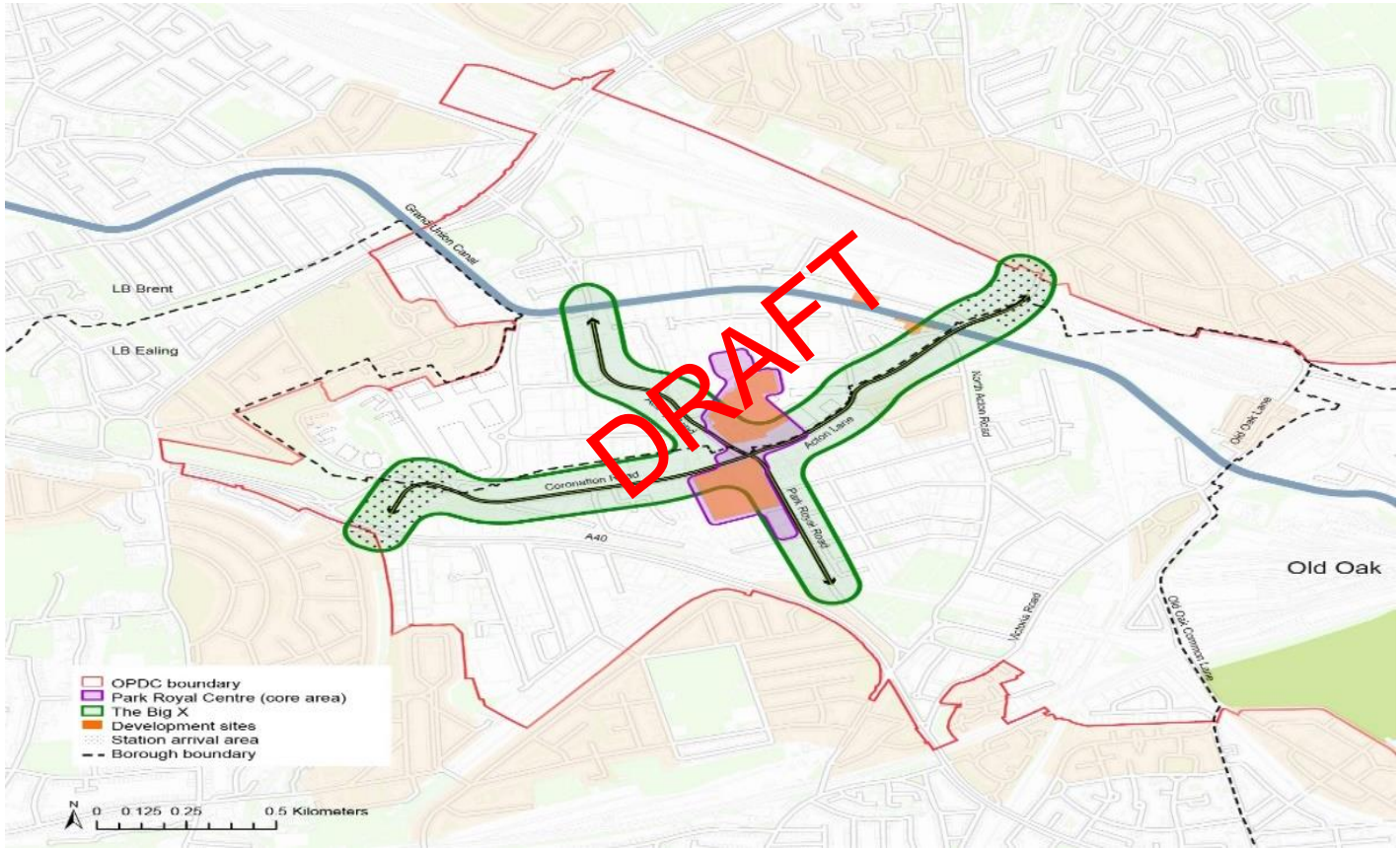
- Create a sense of place that strengthens the community in Park Royal, and improve the local environment.
- Accelerate joint-working to deliver support and care services that are truly integrated.
- Engage local residents and service users in being well and living well.

Rationale

Old Oak redevelopment is part of the Mayor of London's strategic plan and has been targeted for regeneration. It is also the single largest area of Strategic Industrial Land in London. In line with the direction of travel set within the NWL strategic healthcare landscape, London North West Healthcare NHS Trust is seeking to improve the utilisation of the Central Middlesex Hospital site. The objective being the creation of a "Community Hub Plus" that reinvigorates the hospital's role at the heart of the local community

	Commissioning/ Contracting Change	Impact
	• TBC – from Park Royal Masterplan - Old Oak Development Corporation.	

Map Showing Park Royal Development Area



NHS Brent Clinical Commissioning Group

Other supporting areas

(a) Digital Innovation and Technology
(b) Medicines Optimisation
(c) Estates

Digital Technology and Innovation

Description

The London Digital Roadmap aims to enable the objectives of the STP and the NHS's Five Year Forward View – to become 'paper free at the point of care', support the delivery of integrated health and care services and also stretch the ambition to harness the digital revolution.

Strategic Aim

At the core of NWL's STP and LDR is the vision of a fully integrated, inter-operative and digitally transformed health and social care delivery system, enabling new models of care that better meet the needs of the population and can deliver better outcomes at a lower cost, including delivering services in new and creative ways through digital channels.

Rationale

The NHS needs to harness the power of technology to streamline its clinical processes and interactions with patients, freeing up time for patient facing activities and ensuring that clinicians can have the right information to hand quickly and easily when treating them.

	Commissioning/ Contracting Change
Planned for Year 1	**Automate clinical workflows and records**, particularly in secondary care settings; to support transfers of care through interoperability (including fully digital ordering and reporting of diagnostics), thus removing the reliance on paper and improving quality; whilst also progressing digital opportunities to support back office functions i.e. HR and Finance. **Build a shared care record** across all care settings to enable integration of health and care services, including the transition away from hospital. **Enable Patient Access** through new channels and extending patient records to patients and carers to help them become more involved in their own care – including novel ways to access care such as virtual consultations. This includes Health Help Now and **Provide people with tools for self-management and self-care**, enabling them to take an active role in their care and wellbeing; and also look at consumer technologies (e.g. wearables) to inform local care provision. **Use dynamic data analytics** to inform care decisions and support integrated health and social care, both across the population and at patient level, reducing unwarranted variation, through whole systems population health intelligence.

Other b) Medicines Optimisation

Description

Medicines are the most common intervention used in the NHS, playing a crucial role in treating disease, preventing illness and managing long term conditions. Effective medicines optimisation will enable prescribers and patients make treatment choices together using evidence –based medicine and national guidance to get the best value and health outcomes from medicines. Pharmacy professionals in CCGs, hospitals, GP practices and community pharmacy all play a role in supporting this as well as the implementation of a self-care approach to enhance the management of minor ailments.

Strategic Aim

The aim of medicines optimisation is to help patients to take their medicines correctly, avoid taking unnecessary medicines, reduce wastage of medicines, improve medicines safety, promote self-care and ultimately improve their health outcomes.
The CCG works with prescribers (GPs, practice nurses, practice pharmacists) and our providers to deliver medicines optimisation to support the challenged health economy and align this with the development of primary care.
In doing so this links in with the other STP aims to close the care and quality gap by reducing unwarranted variation in the management of long term conditions, supporting self care and understanding of medication regimes and improving care of nursing home residents.

Rationale

Medicines play a fundamental role in health care delivery and in the environment of economic, demographic and technological challenges and changes it is crucial that patients receive the best quality outcomes from medicines. National issues with medicines have been identified including:

- Approximately 30-50% of medicines are not taken as intended by the prescriber.
- Between 5-8% of unplanned hospital admissions are due to medication issues
- Problematic polypharmacy
- Medication waste is a significant issue (nationally reported as £300million in primary and community care per year)
- Increasing antimicrobial resistance and the importance of judicious prescribing of antibiotics

This evidence of suboptimal medicines use requires a cohesive, cross sector strategy to support patients to get the best possible outcomes from their medicines.
Working collaboratively across NWL to deliver medicines optimisation including the NWL Integrated Formulary Panel for the managed entry of new drugs that have a clear benefit over existing therapies and are cost effective to improve health outcomes for the population of NWL.

Other b) Medicines Optimisation (continued)

	Commissioning/ Contracting Change	Impact
Planned for Year 1 & 2	• Continue to develop and implement QIPP Plans that improve the quality and safety of prescribing and identify opportunities for medicines related savings • Improve medicines management and optimisation in care homes including a medication review service • Provide support to GP practice pharmacists to deliver medicines optimisation • Review the prescribing support decision tool, OptimiseRx, contract ends August 2019 • Continue to implement antimicrobial stewardship and work towards the national targets • Implement NHS England guidance on reducing prescribing of low priority medicines • Implement the NWL Prescribing Wisely programme to reduce wastage in repeat prescriptions and prescribing of OTC medicines with promotion of self-care • Implement a community education and engagement strategy on medicines optimisation • Monitor community nurse wound care prescribing and investigate better ways to provide dressings for patients.	• Improved patient experience with their medicines • Improved health outcomes from medicines • Evidence-based, cost effective and safe prescribing embedded in primary care with reduced variation in prescribing practices • Implementation of national and local guidance • Delivery of QIPP plan and financial balance • Improved partnership working with relevant stakeholders to improve patient care, new roles in primary care and improved multidisciplinary working.

Other d) Estates

Description:

By 2020/21 we will be delivering an estate portfolio that meets the needs of our 2021 Vision for care and support in Brent.

Strategic Aim:

Estates will deliver Local Services Hubs to enable more services to be delivered in a community setting and support the delivery of primary care at scale, will increase the use of advanced technology to reduce the reliance on physical estate, maintain and further develop a clear estates strategy and Borough-based shared visions to maximise use of space and proactively work towards 'One Public Estate' and deliver improvements to the condition and sustainability of the Primary Care Estate through an investment fund of up to £100m and Minor Improvement Grants

Rationale:

The estates strategy will support the clinical service model with a progressive transformation of the estate to provide facilities that are modern, fit for purpose and which enable a range of services to be delivered in a flexible environment. Poor quality estate will be addressed through a programme of rationalisation and investment that will transform the primary, community and acute estate to reflect patient needs now and in the future. Investment in the development of local hubs will enable the provision of integrated, co-located health care, social care and voluntary support, reducing A&E and UCC attendances and providing accessible, pro-active and coordinated care..

	Commissioning/ Contracting Change	Impact
Planned for Year 1	• Deliver Local Estate Strategy for Brent to 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 & Monks Park	• Realise substantial financial benefit by maximising use of land & premises. • Maximising capital receipts from land sales where one public estate projects offer joint opportunities. • Reduce recurrent premises costs through commissioning arrangements • Create additional capacity and improve primary care service offering for c10,000 patients in the CMH locality (programme complete)
Planned For Year 2	• Reducing HQ costs at Wembley Centre for Health and Care by consolidating the CCG space at Wembley to reduce the cost of the management accommodation, freeing up space for local service delivery • Delivery of Estates and Technology Transformation Fund (ETTF) schemes to improve access and delivery of Primary Care • Address the needs of the new populations in the Wembley, South Kilburn and Alperton Housing zones by supporting new primary care provision within these development areas	• Minimise overhead costs of the CCG by implementing smarter working arrangements • Improve access to primary care by maximising investment via ETTF and improvement grant funding. • Increased primary care capacity to meet new population needs from fit for purpose premises

Engagement

DRAFT

Public Involvement and Engagement

The CCG has a legal duty under s14Z(11) 3 of the National Health Service Act 2006 which requires the CCG to describe how it intends to discharge its duties with regard to consultation and engagement of the annual commissioning plan (commissioning intentions).

Various bespoke engagement events have been undertaken in forming these commissioning intentions, and the document was released to the Health Partners Forum. The Commissioning Intentions reflect the higher level STP plans and so engagement around the STP is synonymous with the CCG's commissioning intentions.

To date in Brent we have already engaged with patients, the public and partners as follows:

- 17th August 2018 – Hilltop Medical Practice
- 29th August 2018 – Wembley Centre for Health and Care (Brent Carer's Centre)
- 29th August 2018 – Health Partners Forum
- 30th August 2018 – Central Middlesex Hospital Foyer – service users
- 30th August 2018 – Asian People's Disability Association

Up and coming engagements include:

- 1st September 2018 – Black Cancer Care
- 12th September 2018 – Dementia Support Group
- 17th October 2018 – Mental Health Support Group

Additionally the Health and Wellbeing Board will discuss the Commissioning Intentions at its next meeting on 9 October 2018

Ongoing Consultation

In addition to the work that has already taken place, consultation and engagement regarding service design will continue throughout the year. This is an iterative process rather than a 'hard' closure of a consultation deadline, with further opportunities to influence the CCG's thinking in an evolutionary way. Engagement activities will be targeted at specific service users or patient cohorts as part of the outreach function of patient and public involvement.

The Brent CCG Governing Body will approve the Commissioning Intentions for 2019-2021 at their meeting, currently planned for 7th November 2018. All feedback received will be collated and considered as part of refreshing the plan for approval.

The CCG will feed back in more detail on how the commissioning intentions have changed as a result of the engagement at the next Health Partners Forum in January 2019. A summary including representative comments from our engagement events and online consultations is provided on the next pages. (TO BE ADDED ONCE FEEDBACK COLLATED AND RECEIVED)