Better Care, Closer to Home

Our strategy for co-ordinated, high quality out of hospital care

May 2012

NHS Brent

Foreword

Growing up in Brent and being a local GP for 25 years, I am aware that we need to change the way we deliver and receive care. We need to ensure we preserve what we have done well and develop with our residents, partners from secondary care, local council and voluntary sectors, improved care for our patients.

We recognise demand for health care services is increasing as our population is living longer (which is good!), with increased long term conditions and lifestyle diseases, and available interventions are complex, expensive and require high level specialist skills. To respond to these challenges we need to improve our delivery of care in a more co-ordinated integrated approach, without compromising quality, delivering care in settings closer to home. This needs to be done by utilising people's skills and the buildings around us, in a cost effective manner. We also believe that we need to comply with good standards of care to bring about equity in health, quality and access.

Our ultimate goal is to maintain a healthy population with the ability to self-care, supported by healthy lifestyle choices, and the ability to get appropriate health and social care advice and care with ease and in a joined up manner, avoiding layers of duplication.

Brent residents have experienced the positive changes we have already made towards achieving this goal – such as the ability to be cared for at home (through our Short-Term Assessment, Rehabilitation and Reablement Service) and more proactive care (through Case Management). This is supported by practices working in established Locality networks, sharing extended services between practices, ensuring access of services is fair disregarding which practice one is registered with.

This strategy sets out how we will continue to improve care out of hospital, including:

- Our vision for future- our level of ambition and the out of hospital standards we will adhere to
- What we will do to make this change happen, how we will organise and the key enablers for success
- The financial investment we will make and the time frames for implementation

Brent CCG's vision "Our Health is in our Hands" signifies health is everyone's business. Let's work together to make our plans a reality!

Dr. Etheldreda (Ethie) Kong, CCG Chair, Brent.

Executive summary

This strategy sets out how Brent CCG will commission and deliver better care for people, closer to home. It focuses on care provided out of hospital and follows the launch earlier this year by NHS North West London of Shaping a Healthier Future.

1. The case for improving out of hospital services

There are three main challenges for Brent that mean how health care in the borough is delivered needs to change.

1. The residents of Brent have changing health needs, as people live longer and live with more chronic and lifestyle diseases – putting pressure on social and community care
2. Under our current model of care, we cannot afford to meet future demand. We need to have more planned care, provided earlier to our population in settings outside of hospital. This should provide better outcomes for patients, at lower cost
3. However, this needs a **transformation of primary, community and social care**. Currently there is variation in both **quality and access** and standards must improve.

2. How care will be different for patients in future

We have a clear vision for delivering better care, closer to home in Brent and have started to commission new services that are allowing people to receive the care they need in their homes. At the heart of our vision is providing the right care, in the right place, at the right time to reduce reactive, unscheduled care and do more planned care earlier. There are 5 main areas where we will take action to achieve our vision:

A. **There will be easy access to high quality, responsive primary care** to make out of hospital care first point of call for people. GPs and primary care teams will be at the heart of ensuring everyone who provides care does so to consistently high standards of care.

B. **There will be clearly understood planned care pathways** that ensure wherever possible care is delivered outside of a hospital setting. Patients will have access to services closer to home.

C. **There will be rapid response to urgent needs** so that fewer patients need to access hospital emergency care. If a patient has an urgent need, a clinical response will be provided within 4 hours.

D. **Providers (social and health) will work together**, with the patient at the centre, to proactively manage people with long term conditions, the elderly and end of life care out of hospital.

E. **Patients will spend an appropriate time in hospital** when they are admitted, with **early supported discharge** into well organised community care.

Health and Social Care commissioners are considering how they can work closer together to achieve this vision.

3. Delivering better care, closer to home

We will implement a number of key initiatives in each of these five areas. These will include:

- The new 111 phone number throughout North West London to provide a single point of access to health and care services
- A new referral facilitation and peer review system to support GPs making referrals on from primary care
- Providing some outpatient appointments in the community
- Establishing rapid response teams to deliver care in patient homes when appropriate
- Redesigning our pathways of care, encouraging providers to increase productivity by employing new ways of working
- Implementing a new model of care so that different providers work together in multi-disciplinary groups to provide seamless, integrated care for patient
- Investing and developing in primary care capacity so our existing gp practices can support more care outside hospital

4. How we will work together

To achieve our vision and implement these ambitious new initiatives will mean we need to change the way we work to deliver care in Brent.

Ensuring more care is delivered in the right setting and out of hospital means we need to change the way we do things. We have agreed on some organising principles as the basis for this change. Primary, community, social and mental health providers in the localities need to work together in networks to ensure care is coordinated and effective. We have **5** established localities, which will continue to function as existing networks, sensitive to locality needs of Brent's residents and working collectively to address pan Brent needs. The five Locality networks will consolidate their inter-practice relationships, ensuring there is an enhanced level of care in community settings and effective co-ordination of care across providers.

As we take activity into the community, we need to allocate both clinical and office space to this increased level of activity. We propose **four** Locality Health Centres, **two** Standard Hubs and **one** Hub+, based on our existing sites.

Out of hospital care will be organised and coordinated on three levels:

- **69 individual GP practices** will be responsible for routine primary care and have overall responsibility for patient health in their area.

- **Five locality networks**, based on the current locality structures, will manage services like rapid response, case management, integrated care, specialist primary care, community nursing, community outpatients and end of life care.
- **The Borough/CCG** will be responsible for commissioning the new 111 phone service, rapid response out of hours care, diagnostics, community beds and acute care, including accident and emergency care.

5. Enabling improved healthcare

We will invest in better information systems, put in place stronger governance structures to hold providers to account and make sure patients have easy ways to tell us what is not working at every stage of care

We will invest in 5 key enablers to support better care, closer to home:

1. We will step up **patient, user and carer engagement** and improve our patient education and information. We will utilise the existing 5 Locality Patient Participation Groups to enable us to deliver on this commitment.
2. We will put in place clear **locality governance** and a system of support and **performance management** so that the benefits set out in this strategy are delivered.
3. We will put in place the right **information systems** and tools to support networks.
4. We will ensure that we have the right **contracts and incentives** to improve care and to underpin the new ways of working we need.
5. We will provide **training to localities** to support professional and organisational development, in particular in leadership, governance, culture and teamwork, IT skills and patient engagement. We will work closely with the NWL Local Education and Training Board (LETB) and Health Education and Innovation Committee (HEIC) and our practices to train and develop a **multi-disciplinary workforce**.

6. Next steps

The strategy set out here will form the basis of further, detailed discussions in the next few weeks with GPs, patients and families, other clinicians, partners in social care and public health, health and well-being board and others, leading to full public consultation in June. A detailed implementation plan for the strategy is outlined in this document.

Contents

1. The case for improving out of hospital services

In this strategy, we are setting out our plans to transform out of hospital care and provide better care, closer to home. Excellent out of hospital services are essential if Brent is to maintain quality of care in the face of increasing demand and limited resources. If we hope to maintain and improve standards in the face of these challenges, we must dramatically change the way we deliver primary, community and social care. In particular, in order to provide better care out of hospital, we will need to improve the quality of and access to primary care. The challenges we face are laid out in Exhibit 1:

EXHIBIT 1

This section has described why out of hospital care in Brent needs to change so that we respond to these challenges urgently. The next section describes our vision for out of hospital care in Brent and what these changes will mean for patients.

2. Our vision for how care will be different for patients

We have a clear vision for how out of hospital care in Brent will look in future:

Brent CCG will provide an integrated preventative model of health and social care services across intermediate care. Building on existing work by the Short-Term Assessment, Rehabilitation and Reablement Service (STARRS) and case management, we will broaden the preventative model by targeting a wider cohort of patients, removing duplication and improving productivity across the health and social care economy. The scope of primary care will be expanded to be central to co-ordination of multidisciplinary services. This may also involve integrating community reablement services provided by Brent social services, with the rehabilitation service provided by Brent Community Services

At the heart of our vision is providing the right care, in the right place, at the right time to reduce reactive, unscheduled care and provide more planned care earlier in the patient's journey. We will achieve our vision by improving patient care in 5 areas as shown on Exhibit 2.

EXHIBIT 2

We will achieve our vision by improving patient care in 5 areas

		Specifically, this means
	▪ **Easy access** to **high quality, responsive primary care** to make out of hospital care first point of call for people	▪ GPs and primary care teams will be at the heart of ensuring everyone who provides care does so to consistently high standards of care
	▪ **Clearly understood planned care pathways** that ensure out of hospital care is not delivered in a hospital setting	▪ Whenever possible, patients will have access to services closer to home
	▪ **Rapid response to urgent needs** so that fewer patients need to access hospital emergency care	▪ If a patient has an urgent need, a rapid clinical response will be provided
	▪ **Providers (social and health) working together**, with the patient at the centre to proactively manage **LTCs**, the **elderly and end of life care** out-of hospital	▪ Patients will have a named coordinator who will make sure they have all the services they need. If a patient's condition becomes more complex, GPs will be able to direct to a clinician with specialist skills close to home
	▪ **Appropriate time in hospital** when admitted, with **early supported dis-charge** into well organised community care	▪ Care providers will know when an individual patient is in hospital and will manage discharge into planned, supportive out of hospital care

2.1 EASY ACCESS TO HIGH QUALITY, RESPONSIVE PRIMARY CARE

We are committed to expanding and improving primary care so it meets patients' expectations and is fit for the future. We will provide recurrent investment in more GPs and nurses so that practices and networks so that we can offer the following:

- Improved access through all practices being open from 0830hrs to 1830hrs Monday to Friday and extended hours access at some locality practices, and at our GP Access Centre, Wembley and Urgent Care Centres (at Central Middlesex Hospital, Northwick Park, and St Mary's).
- Bookable GP sessions across both mornings and afternoons.
- Access to a health care professional within 24 hours for urgent care and 48 hours for routine care
- 100 bookable clinical appointments per 1,000 weighted population as well as appointments being bookable up to 4 weeks in advance.
- At least one FTE nurse per 3,000 patients (e.g. for wound care)
- Choice of male or female GP
- Better Outcomes for patients as set out in our Commissioning Plans.

This will be supported by providing individuals with up-to-date, evidence-based and accessible information to support them in taking personal responsibility when making decisions about their own health, care and well-being.

This will mean that our patients' experience of primary care will improve (as outlined in Exhibit 3).

EXHIBIT 3

Easy access to high quality, responsive primary care

Claire is 36. She is a working mother who struggles to manage her work and home life. She has a young son, Jason who is 4 years old and has a fever and rash.

Primary care has been difficult for some patients to access, putting pressure on other parts of the health system…

Claire comes home form work at 6pm to find her son has come back from nursery with a fever and rash	Claire rings her GP but cannot get through. After several attempts decides to take Jason to her local A&E	A&E is crowded and there is long wait. The conditions are stressful and Jason's condition worsens.	Treatment is transactional. Jason misses out on opportunity for broader child welfare e.g., staff do not make sure jabs up to date, check Claire is coping
Claire uncertain what best course of action is and who to contact	Stressful and time consuming process for Claire to find a solution	A&E staff feel overwhelmed by flow of unscheduled patients	Claire grateful for treatment and idea of A&E as place to get care is reinforced

In future, patients will have better access to primary care and know how to get it . . .

Claire comes home form work at 6pm to find her son has come back from nursery with a fever and rash and calls 111	111 gives her an appointment in a local practice which is running extended hours on that day.	An appropriate member of the Primary Health Care (PHC) team accesses and examines the child having access to the child & family's health records. A diagnosis of viral rash is made and they are sent home.	If it was something more serious (e.g. rash with query meningitis), then the member of the PHC would administer antibiotic and dial 999 and alert the appropriate Paediatric team
Claire understands that 111 can direct her to the most appropriate care	She is relieved and reassured, feeling confident in the system	Claire is reassured and feels confident to see episode through	A complete record of the event is communicated to the family's GP by the next morning

2.2 CLEARLY UNDERSTOOD PLANNED CARE PATHWAYS

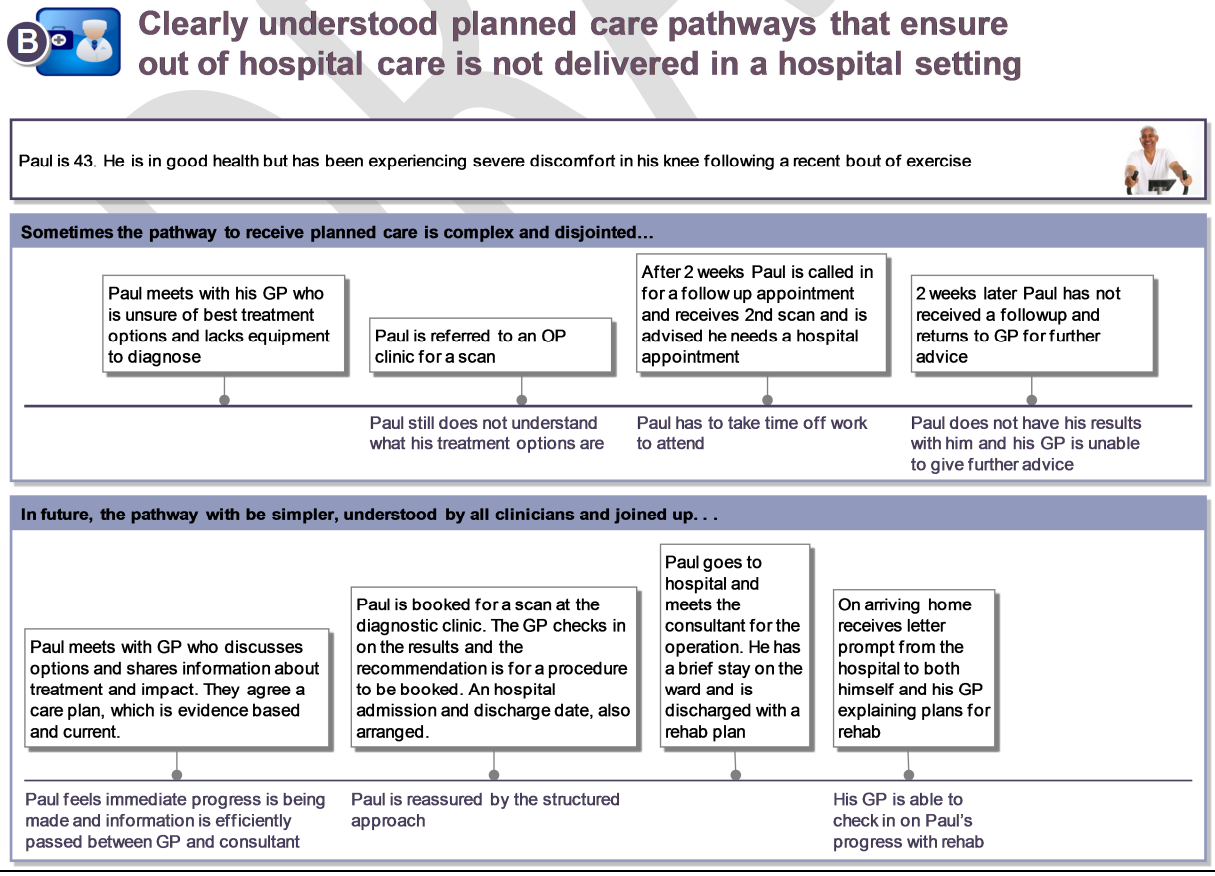
We will put in place more specialist services in the community so that out of hospital care is delivered in a more appropriate setting:

- Out of hospital care will be a seven days a week service.
- Community health and care services will be accessible, understandable, effective and tailored to meet local needs. Service access arrangements will include face-to-face, telephone, email, SMS texting and video consultation.
- To ensure that care pathways are effective, with an individual's consent, relevant parts of their health and social care record will be shared between care providers improving the way we work together.
- Monitoring of patients by health professionals will identify any changing needs so that care plans can be reviewed.
- The intention is that by 2015, all patients will have online access to their health records.

As part of our process of pathway re-design, we have re-designed our diabetes pathway, with a Local Enhanced Service in place on provision of diabetic care up to insulin management and support, either at one's own practices or within the setting of the localities.

This will mean that our patients' experience of planned care will improve (as outlined in Exhibit 4).

EXHIBIT 4



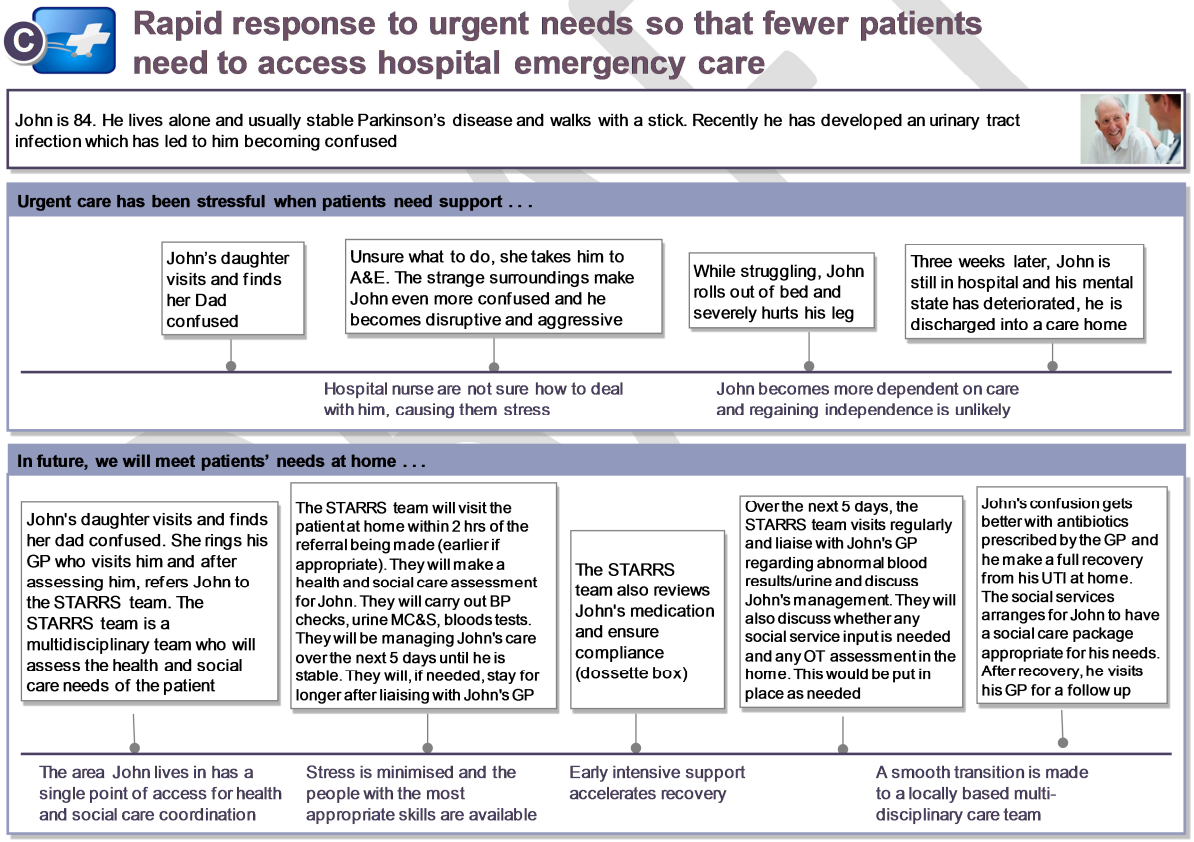
2.3 RAPID RESPONSE TO URGENT NEEDS

Hospital admissions should be appropriately prevented wherever possible. We know at present people are admitted to hospital when a rapid community response could keep them in their own homes. To support this, we have set up multi-disciplinary rapid response team, who will go to the patient's home where they have been assessed as being at risk of admission to hospital. We will aim to avoid unnecessary admission by providing expert advice, services, diagnostics or the supply of equipment. Patients will access the service by calling the 111 number and a response will be made within two hours.

The rapid response team and other out of hospital care initiatives are expected to prevent 2,000 emergency admissions a year in Brent.

This will mean that our patients will be able to receive rapid care when their need is urgent (as outlined in Exhibit 5).

EXHIBIT 5



2.4 INTEGRATED CARE FOR PEOPLE WITH LONG TERM CONDITIONS AND THE ELDERLY

We will ensure that there is more effective working between social and health teams to support people with long term conditions, the elderly and people nearing the end of their lives to stay out of hospital and have the support they need.

Patients and their carers tell us that they sometimes fall between the gaps in services. In future, we will ensure that patients and their families in Brent who need community health and social care will experience coordinated, seamless and integrated services using evidence-based care pathways, case management and personalised care planning.

This will be facilitated by 5 multidisciplinary groups (MDGs), based on our current locality structures, working across Brent as part of the Outer North West London Integrated Care Pilot. The MDGs will be made up of local GP practices and other providers from community health, mental health, acute hospitals and social care for those patients most at risk of a hospital admission They will work together to identify and review patients at risk of becoming ill. Initially these groups in Brent will focus on the over 75s. Additionally, case management systems currently piloted at 2 localities will be rolled out to all 5 localities. Such integrated care will be better for patients as they will receive proactive care to keep them well, will not suffer from gaps in provision between services and will not have to constantly repeat their story. It will also be better for professionals as they will have access to full patient information and will be able to learn from colleagues with different expertise developing shared priorities for patients. Integrated care should be better value for taxpayers by reducing costly emergency admissions and visits to hospital, making preventative care across health and social care settings a reality.

Some of the benefits of integrated and proactive care we will have for our patients are outlined in Exhibit 6.

EXHIBIT 6

Providers (social and health) working together, with the patient at the centre

Laura, 75 years old smoker has recently been diagnosed with COPD and lives at home with her husband Jim.

Urgent care has been stressful when patients need support . . .

- After visiting her GP, Laura is diagnosed with having a Stage 2 COPD and is put on an inhaler. After a period of no improvement Laura's GP prescribes her a stronger dose
- After a series of complications, Laura is referred to a Chest physician. Laura's visit is extended as the specialist does not have access to Laura's records, and has no indication about the progression of Laura's condition.
- Unexpectedly, Laura is admitted to A&E and inpatient care for one week later with breathlessness
- Laura is discharged to home, but her records and history are not available to either social care works or district nurses during their follow up visits.

In future, we will meet patients' needs at home . . .

- Laura is indentified as a patient in need of an integrated care plan by her GP. Her care plan and results of investigations is made available to all health care professional involved in her care
- Laura is discussed by her GP at a case conference with a specialist Chest physician and other members of the community and hospital respiratory team . They identify that Laura needs education on how to use her inhaler properly, rather than a stronger dose prescription.
- Nonetheless, Laura experiences complications, however on referral, her Chest physician has access to Laura's care records both at primary and secondary care so that a full assessment can be made of her condition and progress
- Admissions to A&E or interaction with social care are also supported by having her care plan accessible to all. Upon discharge the care plan recommends multi-disciplinary pulmonary rehab and self management and would be followed up with a visit at home by a specialist team

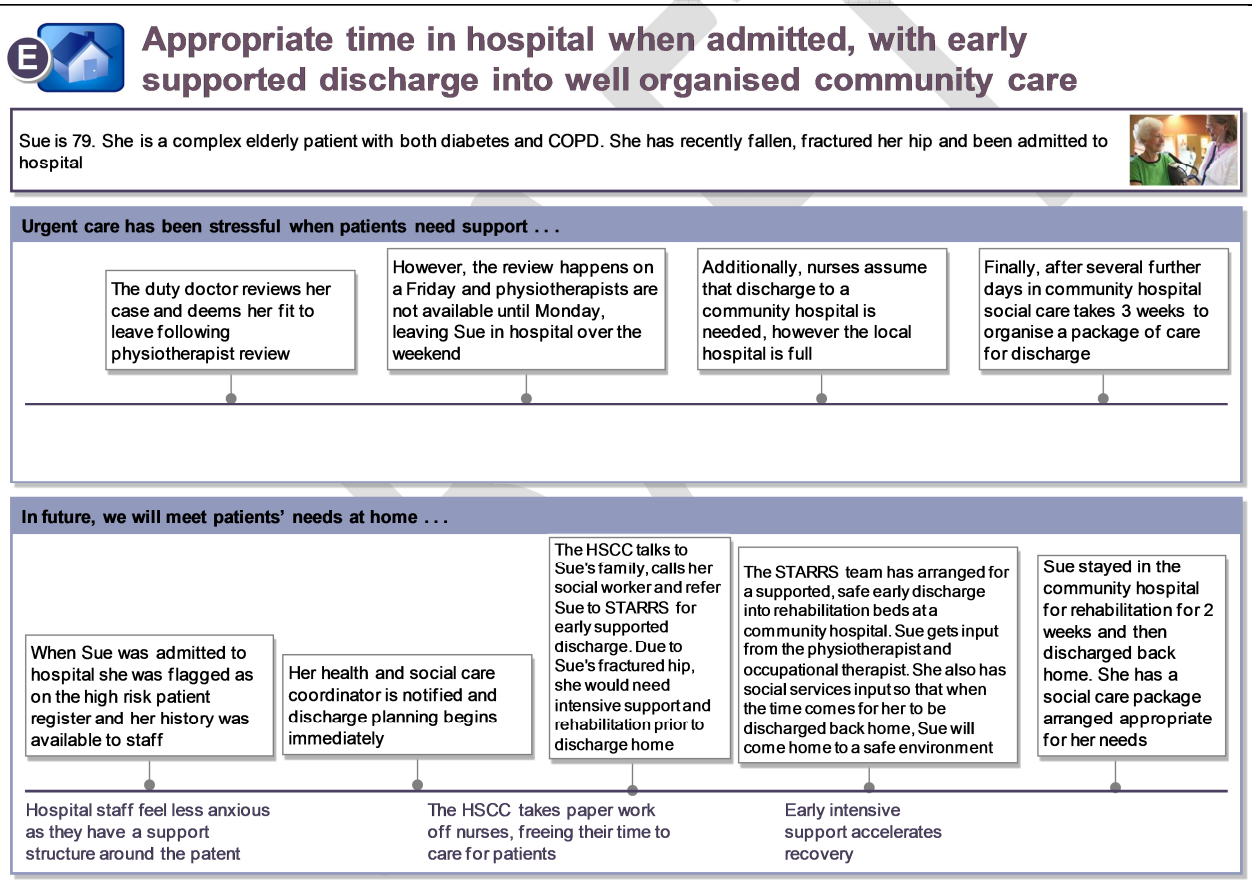
2.5 APPROPRIATE LENGTH OF TIME IN HOSPITAL AND SUPPORTED DISCHARGE

We will put in place properly planned discharge and support for patients who can be discharged from hospital so that they avoid longer stays than they need. The patient's GP and other providers of health and social care will be involved in coordinating an individual's discharge plan (including intermediate care and reablement) as well as continuing care needs.

There will be more joined-up discharge support, with an appropriate step-down in care (e.g. step-down beds in a community hospital), prompt communication to other providers and clear advice and information for patients.

This will mean that our patients will not stay in hospital when it is not best for their care (as outlined in Exhibit 7).

EXHIBIT 7



2.6 STANDARDS TO MAINTAIN THE QUALITY OF CARE

Patients and the public need to be confident that as we change where and how patients are cared for, we will hold ourselves to high clinical standards of care in the community. Therefore, we have agreed standards that set our aspirations for the future. They emphasise the central role of the GP in the coordination and delivery of out of hospital care. The standards encompass both core primary care delivered by GP practices and, more broadly, care delivered outside of hospital. They aim to shift care delivery from more reactive unplanned care to proactive planned care.

EXHIBIT 8

Domains	The standards are covered in four key domains
Individual Empowerment & Self Care	▪ Individuals will be provided with up-to-date, evidence-based and accessible information to support them in taking personal responsibility when making decisions about their own health, care and wellbeing
Access convenience and responsiveness	▪ Individuals will have access to telephone advice and triage provided 24 hours a day, seven days a week. As a result of this triage: ▪ Cases assessed as urgent will be given a timed appointment or visit within 4 hours of the time of calling ▪ For cases assessed as not urgent and that cannot be resolved by phone, individuals will be offered the choice of an appointment within 24 hours or an appointment to see a GP in their own practice within 48 hour
Care planning and multi-disciplinary care delivery	▪ All individuals who would benefit from a care plan will have one. ▪ Everyone who has a care plan will have a named 'care coordinator' who will work with them to coordinate care across health and social care ▪ GPs will work within multi-disciplinary groups to manage care delivery, incorporating input from primary, community, social care, mental health and specialists
Information and communications	▪ With the individual's consent, relevant information will be visible to health and care professionals involved in providing care ▪ Any previous or planned contact with a healthcare professional should be visible to all relevant community health and care providers, ▪ Following admission to hospital, the patient's GP and relevant providers will be actively involved in coordinating an individual's discharge plan

3. How we will deliver better care, closer to home

This section sets out the key initiatives we will take to deliver improved care out of hospital in each of the six areas described previously. Some of these initiatives are new and specific to Brent, while others are part of broader work such as the 111 service. Exhibit 9 outlines the out of hospital initiatives we will be implementing.

EXHIBIT 9

Theme	Initiative description
A Easy access to high quality, responsive care	A1 Primary care development
	A2 Rolling out of **111** across NWL
	A3 Shifting mental health patients to a **less intensive model of care** supported by a **primary care plus system**
B Simplified planned care pathways	B1 Reducing variation in GP referral rates through **Referral management**
	B2 Shifting a proportion of **elective procedures** into enhanced community clinics
	B3 Reducing cost of outpatients through shifting a proportion of acute **outpatient services** to community settings
	B4 Carrying out a proportion of **pre-op assesments** in GP clinics
C Rapid response to urgent needs	C1 Treating patients that are part of the **"STARRS" cohort** in alternative care settings in the community
	C2 Expansion of **urgent care centres** reducing A&E admissions
D Integrated care for LTC and elderly	D1 Outer sub-cluster **integrated care** to reduce NEL admissions (including mental health)[1]
	D2 **Proactively managing the care provided** to a proportion of our residents who are high users of our acute services
	D3 Integrate consideration of **mental health co-morbidities** in the Integrated Care Pilot
	D4 Ensuring patients are able to choose their **end of life** care
E Appropriate time in hospital	E1 **Discharge support** reducing patients stay in hospitals when not required
	E2 Establish a **psychiatric liaison** service

3.1 EASY ACCESS TO HIGH QUALITY RESPONSIVE PRIMARY CARE

Initiative A1: Primary care development

We have established a programme to expand and improve the quality of primary care in Brent in four key areas: clinical outcomes, service, enhanced primary care, patients and the public. The programme will have an incentive scheme with ten indicators taken from the London Outcomes Framework (LOF). Each practice will be supported to develop a practice plan for how they will achieve the indicators and how that will improve services. The programme will strengthen working relationships between practices, encourage the development of Clinical Commissioning Group, and will enable primary care to be better placed to deliver more services in the context of current NHS changes.

Improved quality of primary care will be supported by an expansion in primary care capacity. We will agree capacity and delivery plans with practices to support them in meeting the out of hospital standards through funding additional healthcare professional capacity.

For patients, this will mean improvements in quality, consistency and access so that their choice of GP will be based on location and convenience. This will also mean that patients have a choice of a male or female GP.

Initiative A2: Single point of access through the new 111 phone number

The roll out of the new 111 phone number across NHS North West London will provide a single point of access for patients, carers and clinicians to the appropriate level of care. The free to call 111 number is available 24 hours a day, 7 days a week, 365 days a year. Patients will call 111 when:

- They need medical help fast, but it is not a 999 emergency
- They do not know who to call for medical help or do not have a GP to call
- They think they need to go to A&E or another NHS urgent care service
- They require local health information or reassurance about what to do next

The NHS 111 service will provides management information to commissioners on the demand for and usage of services to enable the commissioning of more effective and productive services that are designed to meet people's needs.

Call handlers will be highly trained and supported by experienced clinicians. They will follow agreed clinical pathways and will have access to a local directory of services, with escalation to clinical support as appropriate. Agreed service standards will mean that urgent cases will be dealt with within 4 hours, and those whose needs are not urgent will be seen within 24 hours, or 48 hours if they want to go to their own GP practice.

For patients, this will mean quick and easy direction to the right level of care.

Initiative A3: Shifting mental health patients to a less intensive model of care supported by a primary care plus system.

For people who are being treated by a mental health provider, there is an opportunity to provide more care from primary care. As many as 10% of patients currently under the care of mental health trusts have low level needs that could be met in primary care.

Having GPs responsible for more patients with non-complex mental health needs will require a structured approach. It is proposed that an agreed pathway is adopted for the transfer of responsibility for care from community mental health teams to GP practices. This will include setting criteria for the transfer of responsibility, a case review to confirm criteria have been met and joint work between the community mental health team, the GP and the patient to develop a care plan. Primary care will also have access to ongoing support in the form of a "primary care plus system" outlined in Exhibit 10.

EXHIBIT 10

Ongoing CPN support for more complex patients

CPN

Psychiatrist

Care support workers

- CPNs provide low level step down care to patients transferred from secondary care into primary care
- Average 2-3 contacts per patient in first 6 months step down
- Annual assessment
- 2-3 appointments per patient per year
- Follow up aid from care support worker
- CPN work overseen by 1 psychiatrist in each borough
- Patient care remains the overall responsibility of the GP at all other times

Mental health training for GPs

GP

- Dedicated course aimed at providing education in basic mental health care, for example:
  - 4-6 week course, 1 evening per week
  - Run by experienced mental health experts
  - Each practice nominates 1 members to participate
- Courses run annually to ensure continual training

Expert mental health advice for GPs

Psychiatrist

- Telephone and e-mail support from mental health consultant:
  - Part of "on call" duties for consultant
  - 5 hour per week per CCG dedicated to answering GP mental health questions (e.g., advice on medication, care plans etc.)
- Informal coaching of GPs as part of involvement in ICP MDG meetings

Mental health induction for GP surgeries

Community psychiatric nurse

- Annual session run by CPN in each GP surgery to provide overview of care for mental health patients, including:
  - Discussion of unique care requirements of mental health patients
  - Introduction to patient care pathway
  - Provision of information on further support for mental health patients (e.g., voluntary sector)

SOURCE: Working group

3.2 CLEARLY UNDERSTOOD PLANNED CARE PATHWAYS

Initiative B1: Referral facilitation

We will launch a new referral facilitation and peer review system to support GPs in the decision making process when they make referrals on from primary care. In this way, we will not only reduce the number and costs of referrals but also improve the quality of decision making by GPs.

The system will involve continuous professional development, peer review, implementation of best practice and increased use of benchmarking and current data.

GPs will take part in skills development sessions, undertake regular and frequent peer review and will attend referral panels with GP clinical champions.

This will mean that patients will only be referred for further investigation or treatment when it is really necessary.

Initiative B2: Move some elective procedures from secondary to primary care

Brent CCG has identified procedures that could be performed outside a hospital setting by GPs and specialist providers in enhanced community clinics. This project will be carried out in full discussion with GPs and potential specialist providers. Primary care services will, as a result, be able to identify potential specialist procedures they are able to provide though clinical networks. Those procedures that cannot be provided in primary care can be opened up to other potential providers on the basis of quality and cost.

For patients, this will mean having services delivered closer to home.

Initiative B3: Move a proportion of acute outpatient services to community settings

Similarly, we will take a two-tier approach to plan outpatient care. Some services will be provided by GP networks as a Local Enhanced Service. Where services can be provided by a specialist provider, including networks, this will be done through competitive dialogue (developing specifications in collaboration with potential providers). In Brent, this is already the case for ophthalmology and cardiology outpatient services.

Services will be commissioned on the basis of outcomes, with providers expected to deliver on a set of clearly defined clinical and patient reported measures. Bids will be assessed on three criteria: quality of service, cost effectiveness and capacity and resilience.

For patients, this will mean high quality outpatient services and better value for money.

3.3 RAPID RESPONSE TO URGENT NEEDS

Initiative C1: Treating patients that are part of the "STARRS" cohort in alternative care settings in the community

Brent CCG has already begun to implement the STARRS program which involves short-term, intensive interventions which prevent hospital admissions and enable patients to reach their rehabilitation potential before moving on to their ultimate care destination. This includes both time-bound rehabilitation (health therapy care) and reablement (social care, with therapy management).

The key operational elements of the service are a Rapid Response team and a short-term service. The rapid response team will carry out urgent assessment and intervention to stabilise a patient for a maximum of 72 hours as an alternative to A&E attendance or short term hospital admission, whilst the short-term service will include temporary beds (health step-up and step-down beds and social care beds) and time-bound reablement/rehabilitations services. To ensure the continued success of our rapid response service we will focus on improving awareness of the service among patients and carers.

For certain patients, the STARRS programme will mean they will not have to go to hospital to receive rapid assessment and medical support but will receive this promptly in their own home.

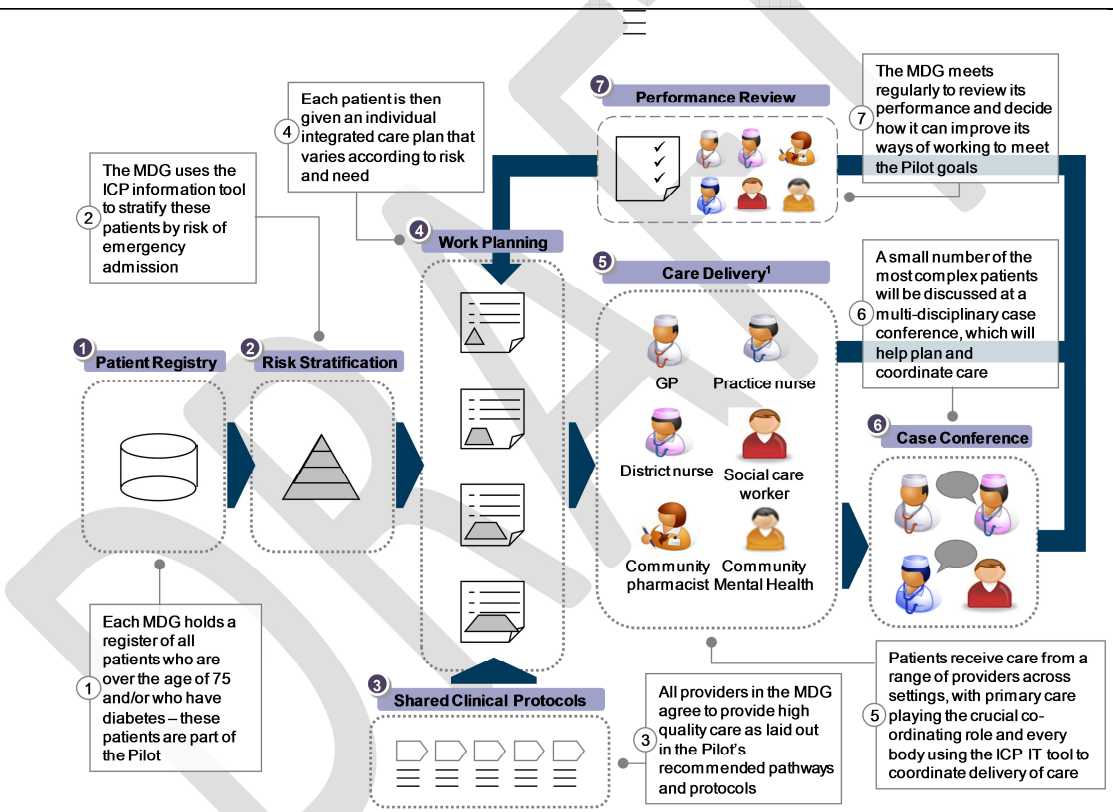
3.4 INTEGRATED CARE FOR PEOPLE WITH LONG TERM CONDITIONS AND THE ELDERLY

Initiative D1: Integrated care pilot

Brent will implement a model of integrated care with other CCGs in outer North West London. Integrated care is an internationally proven system of bringing health and social care services together to work in a model of care that supports and develops multidisciplinary working between local GP practices and other providers from community health, mental health, acute hospitals and social care for those patients most at risk of a hospital admission.

We will establish five multidisciplinary groups across Brent who will work together to identify and review patients at risk of becoming ill. Initially their focus in Brent will be on the over 75s. Exhibit 11 outlines how the integrated care model will work in practice.

EXHIBIT 11



1 Icons are illustrative only: any number of other professionals may be involved in a patient's care, a case conference or performance review

Aligned services will

- Enhance patient, user and career involvement
- Share joint governance through the integrated management board and borough-based management groups with a shared performance framework
- Align incentives through an innovative financial model (e.g, innovation fund to pump-prime investment into services)
- Have access to timely data analysis and information sharing

- Develop a strong organisational culture (through holding each other to account in performance review discussions)
- Deliver substantial financial savings
- Improve professional experience via joint governance, aligned incentives and transparent information sharing

For patients, integrated care by multi-disciplinary groups will mean seamless, preventive care, which will reduce the likelihood of unplanned admission to hospital.

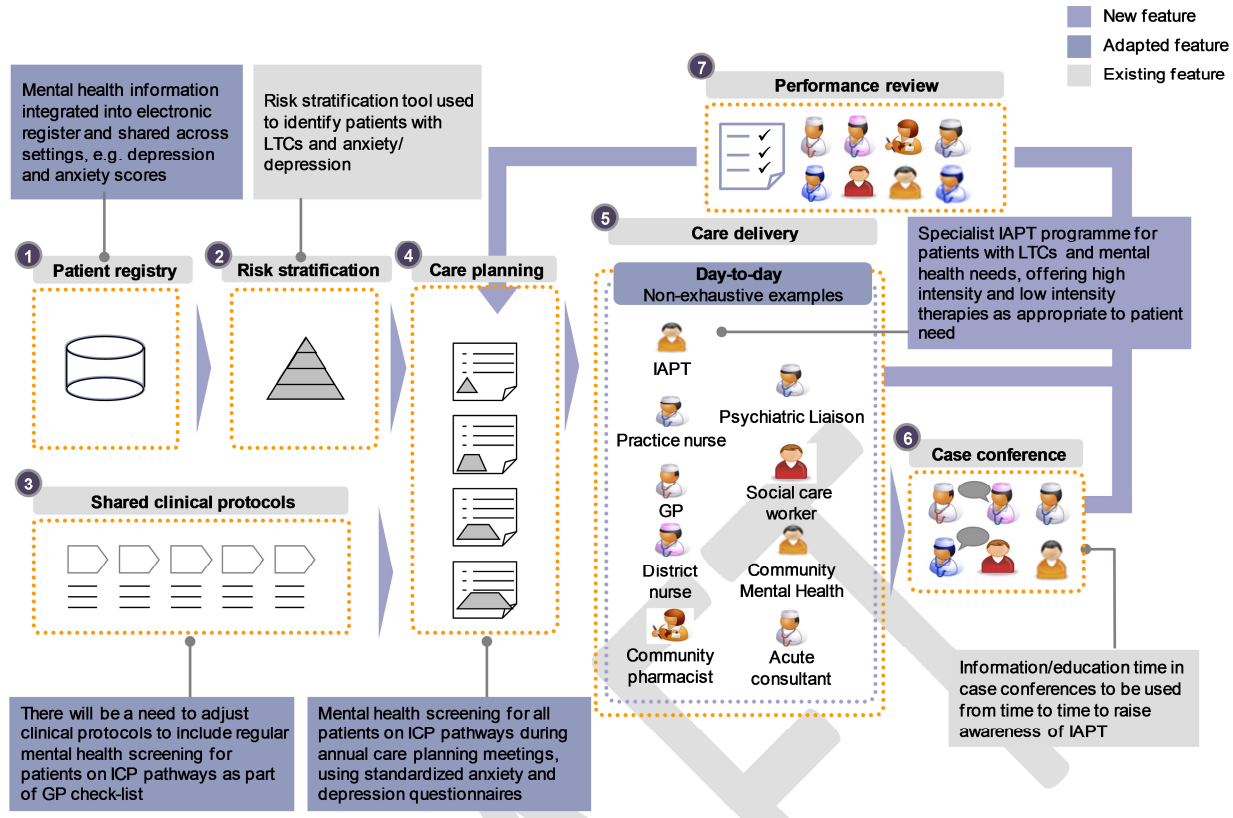
Initiative D2: Integrate consideration of mental health co-morbidities in the integrated care pilot

People who have a physical long term health need, such as diabetes, are also more likely to have mental health problems. And where these mental health "co-morbidities" exist, care can be between 45-75% more expensive than for patients with just the physical ailment[1].

Therefore, it is crucial that the Integrated Care Pilot consider mental health needs. For patients this will include mental health screening as part of annual reviews and specially tailored psychological therapy sessions when necessary. Exhibit 12 below outlines how mental health will be considered at each stage from patient registry through to case conference discussions.

[1] "Long-term conditions and mental health: the cost of co-morbidities," Chris Naylor et al., February 2012, King's Fund and Centre for Mental Health.

EXHIBIT 12



Source: ICP; Mental Health model of intervention

Initiative D3: Proactive case management for frequent users of hospital services

All patients who have had three or more emergency admissions in the previous year or who are identified as being at significantly increased risk of emergency admissions will be referred for case management by experienced community nurses. These patients will have care plans and support in primary care to reduce their need for hospital admissions, which will be better for patients and better for the health system. The community nurses will work closely with GPs to ensure these patients have appropriate proactive care in place.

Initiative D4 : Ensuring patients are able to choose their end of life care

Patients who have expressed a wish to remain in their own homes as they approach the end of their lives frequently end up being admitted to hospital. The Brent end of life strategy seeks to move the place of death for 70% of people on the end of life pathway out of hospital and back into the community, preferably their own homes. For this group of patients, we also aim to reduce by 70% the number of spells in hospital for unplanned care.

We will achieve this by using the London-wide end of life register in Brent which records patients' wishes on their place of death; raising skills of staff and standards of care by greater use of the Gold Standards Framework and the Liverpool Care Pathway; and by providing incentives for practices to ensure staff time for training on these tools. We will increase our capacity to provide care outside hospital and this will include 24/7 support for hospice at home.

3.5 APPROPRIATE LENGTH OF TIME IN HOSPITAL AND SUPPORTED DISCHARGE

Initiative E1: Reducing patients stay in hospitals with our discharge team

One function of our STARRS team is to facilitate the safe early discharge of patients from acute hospital wards

The service is designed for patients who would benefit from a short-term crisis intervention in a community setting. The team will be accessed by a single point of contact. Staff will undertake a full assessment of patient needs within 2 hours. The team will draw up a care plan with clear goals for the patient to work towards that is responsive to their needs. Each patient will be allocated a single case manager to coordinate the care for that patient across the health and social care economies as part of the virtual team. Where appropriate, the patient will receive a package of care over a 24 hour period, 7 days a week. The case manager will monitor the patient's progress throughout the intervention. Referrals will be made by the case manager in consultation with the patient and directed to appropriate health and social care agencies.

This will mean patients who are medically fit for discharge but require continued support will be able to receive this in their own home, avoiding unnecessarily lengthy hospital stays.

Initiative E2: Establish a psychiatric liaison service

A psychiatric liaison service will be set up. The liaison team will be multidisciplinary as outlined in Exhibit 13. These teams are a flexible resource within the hospital that can be deployed anywhere to support patients with mental health problems. This may prevent unnecessary admission into hospital or for existing inpatients it should mean quicker discharge (more often to a patient's own home) and overall improved outcomes.

EXHIBIT 13

Summary of Optimal Standard Liaison Model for a NWL hospital of ~500 beds

What is it?

- The 'Optimal Standard' is a high quality liaison psychiatry service designed to operate in acute general hospitals in NWL, providing the following services:
  - Care for patients with significant mental health needs (outside specialist MH units)
  - Training for other hospital staff to enable them to support patients' mental health needs
  - Integration with other parts of the health system e.g., GPs, specialist mental health teams

Who delivers the service?

- 2 Consultant Psychiatrists
- 1 Team Manager
- 12 Team Nurses (Bands 6 and 7)
- 1 Alcohol Nurse
- 2 Specialist Registrars
- 1 Generic Therapist
- 1 Occupational Therapist
- 1 Social Worker
- 1 Administrative support
- 1 Research/Business Support Officer

What does the service look like?

- Highly **visible multi-disciplinary** mental health team fully **integrated** into the hospital
- **Single point of contact** for all patients (16+) in hospital with diagnosed or suspected mental health conditions of any severity
- **Rapid response** for patients requiring mental health support and 24/7 support in A&E and wards
- **Training experts** on mental health problems and related issues for non-mental health clinicians
- **Coordination with out-of-hospital** care providers and housing services
- **Integrated** with broader health and social care system
- **Single management** structure

Having the psychiatric liaison team in place should help all clinicians by ensuring better mental health care in acute hospitals with improved risk management. One of the roles of the liaison team will be to train staff members in mental health care. For the whole health and social care system, there should be benefits in terms of fewer admissions, reduced length of stay and lower accommodation costs for local authorities (with more patients discharged directly home).

For patients psychiatric liaison will mean their mental health needs are treated earlier.

Conclusion

The new services that we have described in this section will mean that we need to put in place new ways of working. The next section sets out how we will do this so that patients, carers, users and professionals are well informed and have confidence in the success of the new services and so that the changes are handled well.

4. How we will work together

To achieve our vision and implement these ambitious new initiatives will mean we need to change the way we work to deliver care in Brent. Exhibit 14 outlines the 6 aspects to this:

EXHIBIT 14

1. We need to change the way we do things – and we have agreed some **organising principles** we need to stick to as we change
2. Primary, community, social and mental health providers in the localities need to work together in **networks** to ensure care is coordinated and effective
3. As we take activity into the community, we need to allocate both **clinical and office space** to this increased level of activity – we are proposing making use of our existing sites to support this
4. There are three distinct **'levels' of care** where it makes sense to co-ordinate **services** locally vs. Borough level – and have therefore organised how services are managed and delivered outside the GP and acute setting
5. To deliver care effectively in networks requires new ways of working, including care coordinators, and network coordinators

The following sections look at these 6 aspects in more detail.

4.1 ORGANISING PRINCIPLES

The strategy we are proposing for Brent involves big changes in how and where care is delivered: it includes integrated care, case management and rapid response; beds in the community; and some outpatient appointments and some elective procedures taking place in the community. To deliver these significant changes, **providers need to work more closely together to ensure care is organised around the patient and to extend the range of services offered in the community.**

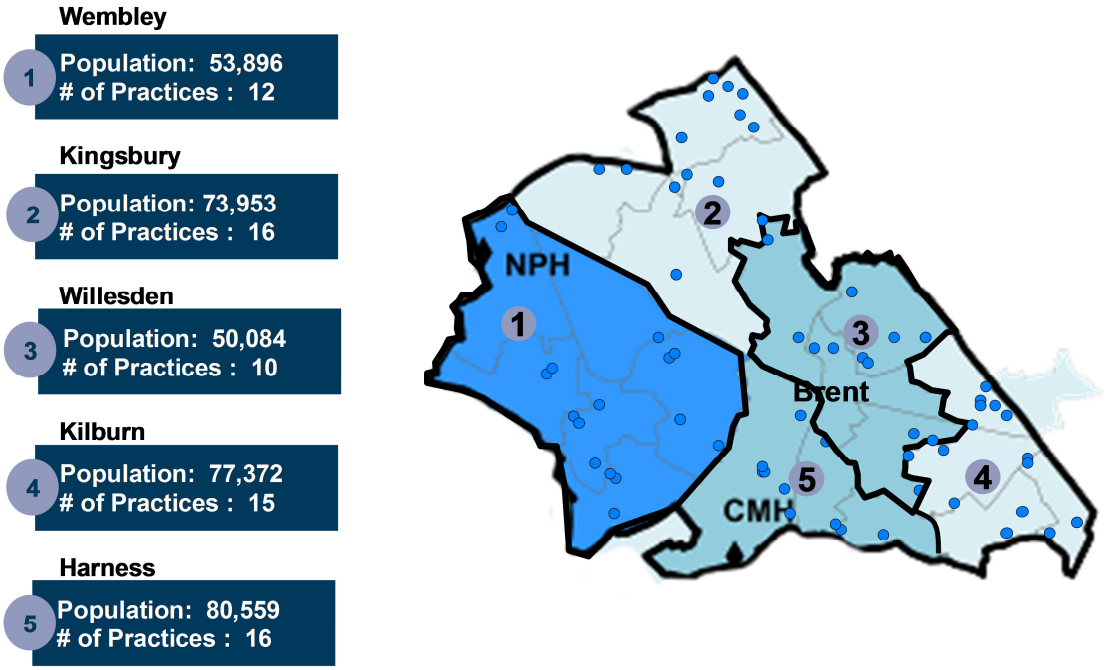
To guide this closer working, we have developed some organising principles:

- We need to organise in a way that enables **collaboration and co-ordination** of care across Brent
- We must **avoid duplication** of activity
- Activity should be delivered at most efficient point **financially**, equally balanced with where it is **most effective** for the patient
- **Care will be GP-led, with primary care teams** remaining central to patient care
- We should design our care around Locality **network practice population** which broadly reflects geographical boundaries
- **Existing contracting arrangements** should not constrain the design.
- **Workforce, training and planning should support these organising principles.**

4.2 PRIMARY, COMMUNITY, SOCIAL AND MENTAL HEALTH PROVIDERS IN THE LOCALITIES NEED TO WORK TOGETHER IN NETWORKS

In Brent we have established GP networks working together to improve outcomes for patients, we have already successfully worked together to deliver effective immunisation, health risk checks, and stop smoking campaigns. We will continue to organise ourselves as 5 Locality networks based on our current localities/multi-disciplinary groups. The five Locality networks will provide an enhanced level of care in community settings and will also collaborate with other providers to provide integrated primary and secondary care services.[2] Exhibit 15 shows the location and sizes of the 5 Locality networks in Brent.

EXHIBIT 15



3 out of 5 of our localities already have established social enterprise bodies for provision of care as networks.

4.3 WORKING WITH OUR PARTNERS TO PROVIDE COORDINATED CARE

In order to provide seamless and well-co-ordinated care in Brent, the CCG is committed to working very closely with its partners.

One of the important ways in which we will improve the way we work together is by establishing five multidisciplinary groups across Brent who will work together to identify and review patients at risk of becoming ill. The role of multidisciplinary groups is outlined below in Exhibit 16:

EXHIBIT 16

The role of multidisciplinary groups:

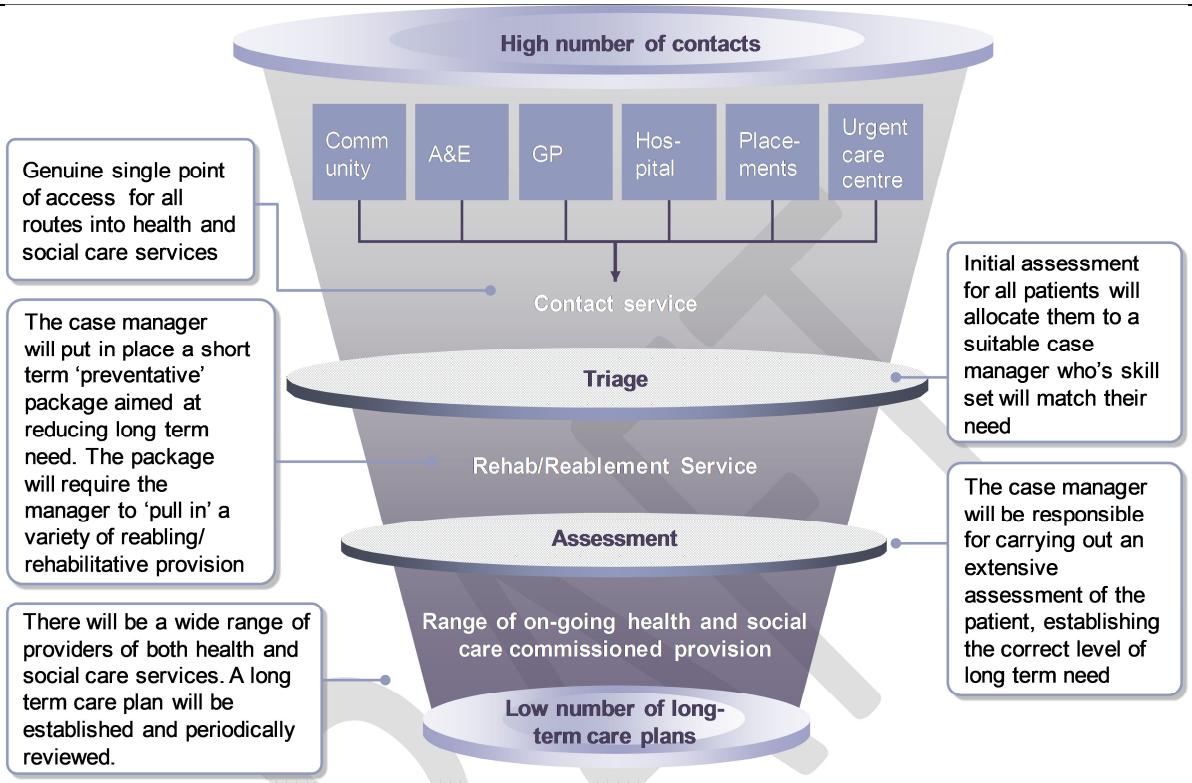
Multidisciplinary groups are made up of primary care, social care and mental health staff. They share a database of patients which they can utilise to identify the patients most at risk of hospital admission (known as "risk stratification"). The multidisciplinary group has agreed clinical pathways of proactive interventions to keep people out of hospital and through a regular process of work planning, each patient will have an integrated care plan, developed in consultation with them.

High risk patient cases are discussed at monthly case conferences by the members of the multidisciplinary group. There will also be regular performance review meetings to hold different providers to account, evaluate the effectiveness of local care pathways and propose key investments to close gaps in care delivery. An IT tool is being procured which will automate much of the data for the ICP, including risk assessment, work planning and messaging between providers. Providers will be reimbursed for the care coordination activities (work planning, case conferences and performance reviews) done to deliver integrated care. Exhibit 5 shows the working arrangements of the multidisciplinary groups.

In addition to MDGs, Brent CCG and social care are exploring the benefits and risks of integrated commissioning. If this was pursued health and social care budgets could be pooled to support earlier intervention.

To improve coordination amongst providers, we will put in place a genuine single point of access to coordinate patient referrals from multiple providers. This will be supported by a case manager who will put in place care packages (for those patients who it is deemed necessary) aimed at reducing long term need of patients. The structure of our integrated, preventative model of care is outlined below in Exhibit 17.

EXHIBIT 17



4.4 ALLOCATING SPACE TO SUPPORT THIS INCREASED LEVEL OF ACTIVITY

As we take activity into the community, we need to allocate both clinical and office space to this increased level of activity. There will be three tiers where services are provided: **the Hub+, Standard Hubs** and **Locality Health Centres**.

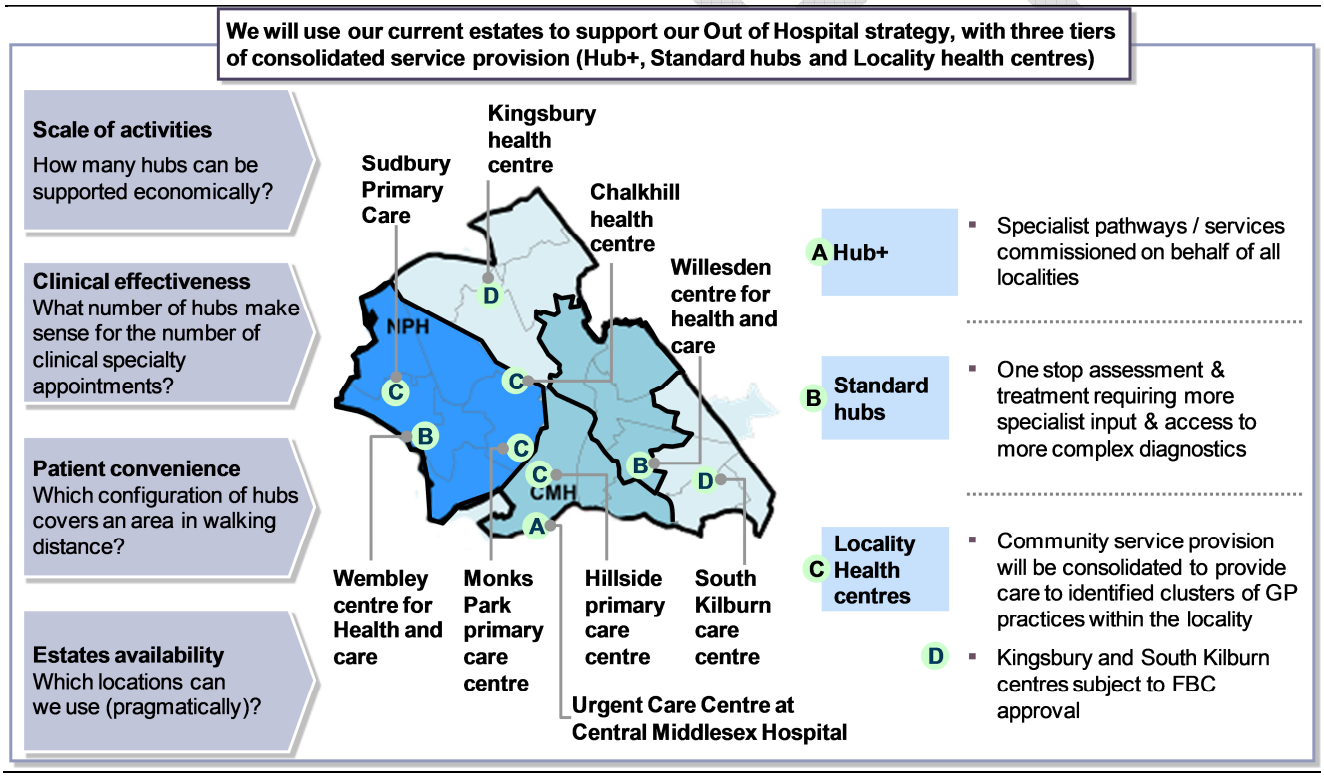
The Hub+ will provide specialist pathways and services commissioned on behalf of all localities.

Standard Hubs will provide one-stop assessment and treatment that requires more specialist input or access to more complex diagnostics.

Locality Health Centres will provide community services. They will be consolidated to provide care to identified groups of GP practices within the locality.

We can make use of existing sites to deliver our out of hospital strategy in Brent. We propose **six** Locality Health Centres, two Standard Hubs and one Hub+. Exhibit 18 shows the proposed locations based on existing sites.

EXHIBIT 18



4.5 THREE LEVELS FOR THE CO-ORDINATION OF CARE IN BRENT

In future, out of hospital care will be organised and co-ordinated on three levels.

The 69 individual GP practices will be responsible for routine primary care and navigating patients through the health system. They will have overall responsibility for patient health in their area. GPs, nurse practitioners, practice nurses and district nurses will deliver care at this level.

We will retain our current locality structure as Locality networks. These will manage the following services:

- Rapid response – admission avoidance, discharge support
- Social services reablement and rehabilitation
- Walk-in centres
- District nursing – case management
- Integrated care – multi-disciplinary groups for elderly patients
- Specialist primary care
- Community outpatients
- End of life care
- Referral management

At this level, care will be delivered by community mental health representatives, social care representative, community matrons and district nurses.

The Borough/CCG level will be responsible for:

- 111 phone service
- Rapid response out of hours care
- Community beds
- Acute care including accident and emergency care.

At this level, care will be delivered by acute specialists, mental health specialists and social care specialists.

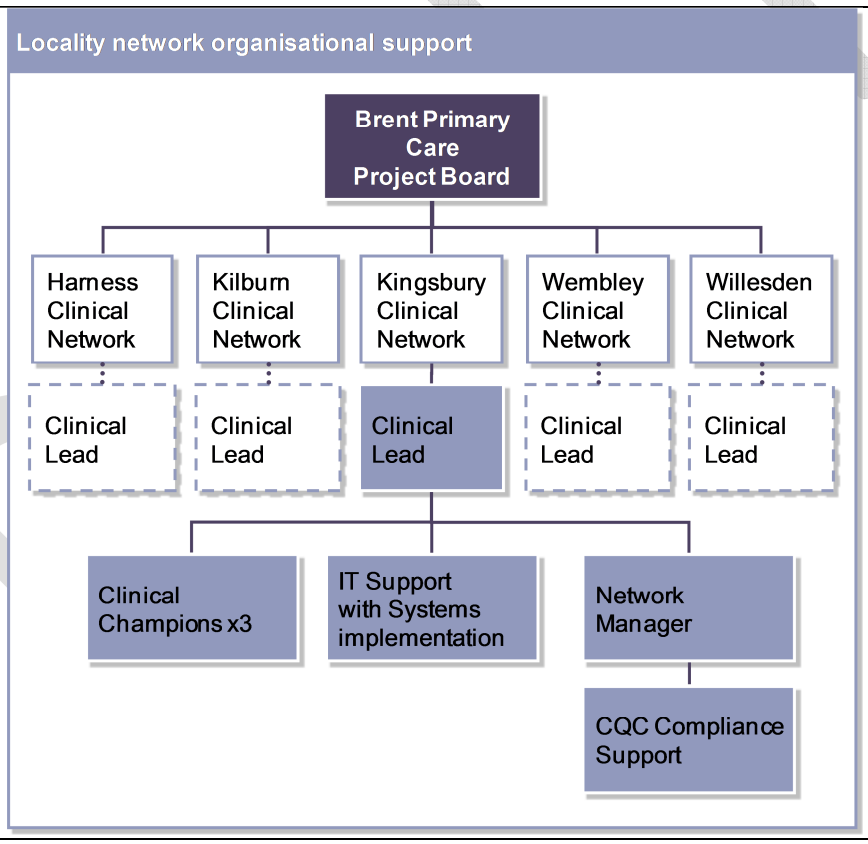
4.6 NEW ROLES TO SUPPORT LOCALITY NETWORKS

In each of the 5 Locality networks, we will create new roles to enable them to deliver care effectively. Each Locality network will have:

- 1 clinical lead responsible for overseeing clinical governance (1 session per week)
- 3 clinical champions responsible for being champions of new clinical pathways (2 sessions per month)
- 1 Locality network manager responsible for network coordination including organizing network meetings and providing materials for performance conversations (full-time equivalent)
- IT support for systems implementation.

Exhibit 19 shows the additional support we will put in place for our networks.

EXHIBIT 19



Conclusion

This part of the report has outlined new ways of working together to deliver the strategy. The next section builds on this further by examining the enablers that will facilitate the changes needed in this strategy.

5. Supporting improved out of hospital care for Brent

We have identified 5 key enablers to support better care, closer to home. These are summarised in Exhibit 20 below.

EXHIBIT 20

	We will…
A Patient, user and carer engagement 	▪ Identify and target frequent flyers, carrying out patient education specifically focused on these issues ▪ Carry out patient education through the use of multiple media ▪ Provide access to information so we have the same information in all areas of the NHS (e.g., practice, 111, UCC)
B Network governance 	▪ Networks to have clear management structures and reporting lines in place ▪ Use a common assessment process across health and social care
C Information and tools to support networks 	▪ Put in place a macro level information system for commissioning (significant work to progress this underway) ▪ Purchase a real time patient information system, based on a scoping on available systems ▪ Develop and implement information sharing agreements across health and social care ▪ Develop specific contract support and specifications
D Contracts and incentives 	▪ Put in place standards to ensure practices meet a minimum level of quality/productivity in order to bid for provision of other services ▪ Develop mechanisms to provide up-front investment for care ▪ Set consistent standards for care ▪ Standardise investment across primary care for the core
E Professional and organisational development 	▪ Baseline current workforce and understand current skill-mix carry out gap analysis ▪ Increase utilisation of GPwSIs ▪ Invest in upskilling and training of clinical staff. "Repurpose" existing staff to deliver more care in the OOH setting

The following sections describe the actions we will take around each of these areas.

5.1 PATIENT, USER AND CARER ENGAGEMENT

We will build on the plans we already have in place to increase patient, user and carer engagement, which is essential for success as we make the changes outlined in this strategy.

In addition to the engagement already taking place through Patient Participation Groups in localities, we will build on our existing Borough-wide equality, diversity and engagement strategy.

We will carry out patient education using a variety of different media. Focussing on supporting our diverse population with multilingual access guides, engaging with community structures (e.g. religious and community centres) and identifying the key segments of our population who can benefit from increased engagement (e.g., young mothers, those with long term conditions).

We will identify people who have frequent contact with the health system and carry out patient education specifically aimed at their needs.

Exhibit 21 sets out the specific commitments we are making to patients, users and carers in Brent about how they will be involved.

EXHIBIT 21

Our commitment	How we'll deliver
You'll be involved	▪ Ensure patient representation on key committees and decision making bodies, including CCG Board ▪ Work with LINk and other partners to ensure as broad a range of service users as possible are consulted
You'll be informed	▪ Be pro-active in explaining services changes and the reasons for decisions to the public through regular communication ▪ Use clear concise language in all communication to ensure it is meaningful ▪ Work with partners, such as the Council to ensure consistent use of language
Your feedback will shape services	▪ Use nationally and locally collected patient experience data to inform decision making ▪ Commission services which provide evidence of listening to service users' views ▪ Run patient events to get more detailed input on existing services and future plans
We'll respond to your concerns	▪ Explain how patient input has influenced decisions ▪ Commission services to demonstrate that they have reacted to service users' views

5.2 LOCALITY NETWORK GOVERNANCE

In Brent CCG, we recognise the potential conflict of GPs as both commissioners and providers. Our arrangements for managing this will be embedded in our CCG constitution. We will have a separation of practice and locality commissioning and provision roles so that a locality is not commissioning from itself. The CCG as a commissioning body will be responsible for placing contracts with networks and monitoring performance in addition to the networks' governance arrangements. Our governance arrangements for GP networks are emerging. While there will be a separation of commissioning and provision responsibilities to manage conflict, GP networks will be integral to our Clinical Commissioning Group. The GP network and networks for the ICP will overlap. However, as the ICP is a provider network with social care and other providers, the governance structures for the ICP and the GP networks will be distinct.

As part of our development of GP networks and as a Clinical Commissioning Group, we will strengthen arrangements for supporting improvements in outcomes for our patients.

Data on organisational performance will be reviewed at 3 levels:

- By GP practices, daily and in real time
- By localities, fortnightly, reviewing clinical performance and benchmarking against others
- By a performance sub-group, monthly looking at priority areas, such as prescribing.

Robust performance metrics need to be developed. These could include key areas of a practice's work, such as the number of patients with long term conditions or at end of life who have care plans; Quality and Outcomes Framework scores and MORI access poll results; and response times for community services and social care. Indicators could also include whether practices are reducing outpatient referral rates, emergency admissions rates and accident and emergency rates of admission.

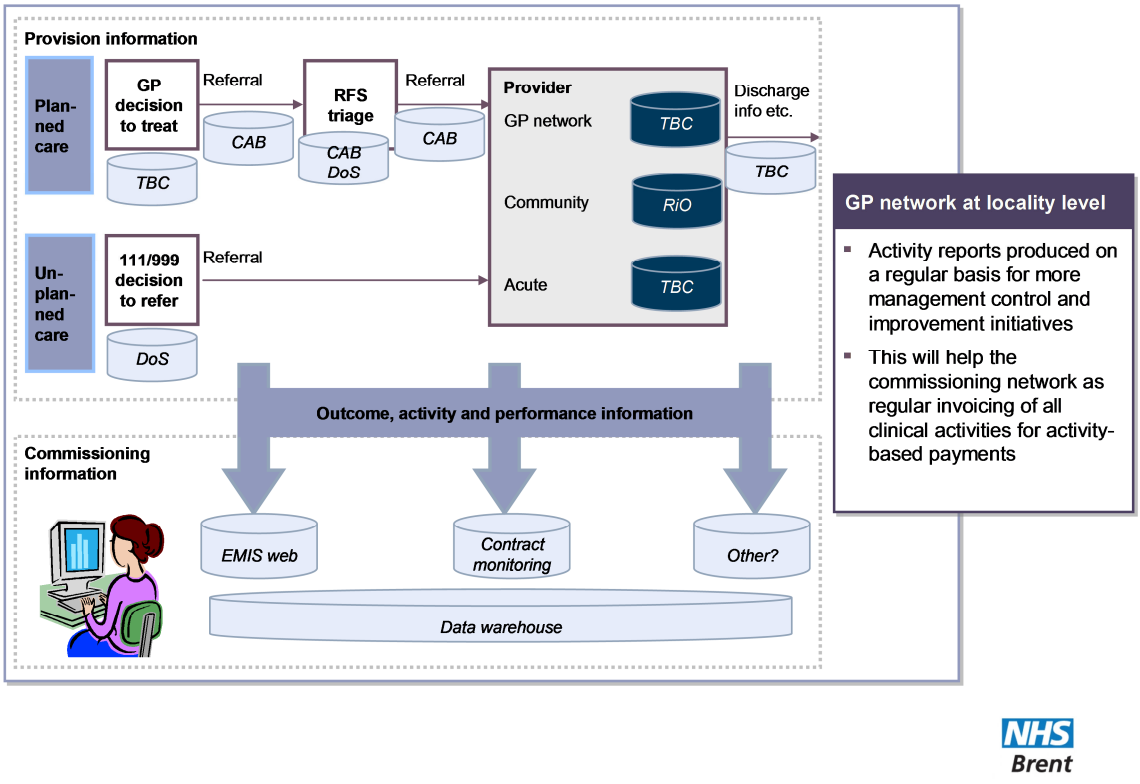
5.3 INFORMATION AND TOOLS TO SUPPORT LOCALITY NETWORKS

Better sharing of information will be central to achieving our vision. It will achieve the following:

1. Real-time shared records will inform health care providers and link GPs, community, acute and mental health teams. Duplication will be reduced.
2. Transparency of information gathered will help us drive up standards and deliver equality of care across Brent.
3. Planned care will become more streamlined as referrals follow precisely defined pathways and GPs have access to granular reporting on referrals.
4. Urgent care will become better informed as information input by the GP is visible to staff at the UCC and care is visible to GPs and prompts are given for follow-up actions
5. Long term care will become more proactive as a result of risk stratification of patients by GPs, care plans being put in place and regular check ups and early intervention based on these.

Exhibit 22 shows the key information flows and IT systems that enable an integrated approach.

EXHIBIT 22



5.4 CONTRACTS AND INCENTIVES

We need to create the right contracts and incentives to improve care and to ensure that they underpin the new ways of working that are needed to deliver better care, closer to home.

We have already developed, working closely with Brent LMC, specific incentives to bring about change and will invest in these so that GPs can deliver change effectively. These include:

1. **Improvement plans for primary care: practices will develop individual improvement plans.** We will reward practices that achieve better outcomes. We will also reward practices that participate in the Locality GP network. We will fund protected time for practices to develop their improvement plan and network plan.
2. **Moving towards a common core specification and more equitable funding for primary care**: we will make funding available to practices each year so that they can increase their capacity for care outside of hospital in a sustainable and planned way
3. **Support for GP networks to establish their business model for delivery of out of hospital services**: funding will support the development of business models, including governance arrangements, implementation plans, inter-practice payment mechanisms and new infrastructure.

In future, we will go further. Exhibit 23 summarizes how targets, contracts and incentives could be aligned to support each of the five goals of our better care, closer to home strategy.

EXHIBIT 23

	Target	How we can achieve this	Re-imbursement to support this
Easy access to high quality, responsive care	▪ Improve access ▪ Improve satisfaction	▪ Meeting minimum primary care requirements	▪ Incentives for delivery ▪ Penalties for failing to meet requirements
Simplified planned care pathways	▪ Reduce Outpatient attendances ▪ Elective admissions	▪ Peer review/referral management system ▪ Inter-practice referrals	▪ Referral incentive scheme ▪ Activity-based reimbursement ▪ Shared incentives across network to reach targets
Rapid response to urgent needs	▪ Reduce A&E attendances ▪ Improve reliability	▪ 111, UCC, extended hours ▪ Walk-in centres	▪ Shared budget allocation for urgent care split across UCC, A&E, OOH ▪ Shared incentives across network to reach targets
Integrated care for LTC and elderly	▪ Reduce NEL admissions ▪ Increase Integration ▪ Increase proactive care	▪ Coordination ratings ▪ Care plans	▪ Payments for care plans ▪ Payments for clinicians to attend case conference ▪ Shared incentives across providers to reach targets
Appropriate time in hospital	▪ Reduce length of stay	▪ Discharge coordinator ▪ HSCC ▪ Rapid response	▪ Contracting HSCC, Discharge coordinator and rapid response teams

5.5 PROFESSIONAL AND ORGANISATIONAL DEVELOPMENT

The Government's ambition for the NHS to deliver health outcomes among the best in the world is rooted in the three principles of giving patients more information and choice, focusing on healthcare outcomes and quality standards, and empowering frontline professionals with a strong leadership role. At the heart of these proposals are clinical commissioning groups (CCGs).

CCGs will be different from any predecessor NHS organisation. Whilst statutory NHS bodies, they will be built on the GP practices that together make up the membership of a CCG. CCGs must ensure that they are led and governed in an open and transparent way which allows them to serve their patients and population effectively.

It will be vitally important that CCGs are clinically led, with the full ownership and engagement of their member practices, so that they can bring together advice from the broadest range of health and care professional to influence patterns of care and focus on patients' needs. At the same time they will need to demonstrate probity and governance commensurate with their considerable responsibilities for their patients healthcare and taxpayers money.

NHS Brent CCG will build on its experience to date, through Professional Executive Committees, Practice Based Commissioning and now as a shadow CCG, to further develop leadership and governance to deliver Brent's Out of Hospital Strategy.

This will mean:

- Practices will work together in localities to provide services and work in integrated care networks with other providers to provide joined up services for patients.

- Practices will work together in the CCG to hold each other to relevant on improving primary care services and to hold other providers to account for senior delivery through contracts the CCG holds.

- NHS Brent CCG will adopt a constitution that clearly sets out our governance arrangements for undertaking our statutory duties.

1. Governance

In order to ensure that Locality networks engage in decision making on their structures, that working groups meet regularly and that board structures are formalised, we will focus on outlining roles and responsibilities, decision making, resource sharing, legal issues and performance management.

2. IT skills

We will provide training for all relevant staff to ensure that they have the necessary IT skills to deliver the changes we are putting in place, such as care packages, which will rely on IT support to be fully effective.

3. Patient engagement

We will provide training for clinical leaders to ensure that we reach out to communicate more effectively with the diverse communities that make up Brent. This will help to ensure that we engage patients and the wider public in planning.

4. Professional Training

We will work closely with the NWL Local Education and Training Board (LETB) and Health Education and Innovation Committee (HEIC) and our practices to train and develop a multi-disciplinary workforce, fit for purpose, with the ability to implement the out of hospital work plans with innovative technology. We will add to the training set out above with development for particular professional groups:

- We will support GPs to specialise where appropriate, increasing the number of GPs with a special interest
- We will up skill our practice nurses so that they are able to carry out tasks that GPs have traditionally carried out (e.g. chronic disease management)
- We will build the capabilities of our healthcare assistants so that they are able to carry out technical procedures (e.g. ECG scans, ear syringing and audiometry)
- We will develop the skills of our managers so that they are effective at coordinating Locality networks, monitoring outcomes and developing strong relationships with CSS.

6. Investing for the future

This strategy has started to lay out our vision for a fundamentally different model of care. To deliver our vision, we will make significant investments in staff and estates across different settings of care. Exhibit 24 broadly outlines the investment we will aim to make in services delivered at home, in GP practices and community health centres over the next three years as investment shifts from hospital to out of hospital sector.

These investments will be subject to approval of full business cases that are likely to be investment led and include disinvestments in other services and will have measureable benefits that will be performance managed.

EXHIBIT 24

Investment by 2015[1,2]

Where you will receive care[3]	Services offered	Additional Investment	Additional space	Additional workforce
At Home[2]	▪ Community care ▪ Elderly care ▪ Postnatal care ▪ Rapid Response	▪ £0.5-1.0m	▪ Access to consulting rooms/team room	▪ 20 – 25 WTE
At a GP Practice[3]	▪ nGMS plus extended hours ▪ Core primary care services	▪ £3.5-4.0m	▪ 150-200 m^2 ▪ <3 consulting rooms ▪ Team room	▪ 10 – 15 WTE
In a Local hub	▪ ECG, possibly ultrasound ▪ Rapid access to blood tests ▪ Rapid access referral to hub/ hospital	▪ £6.0-6.5m	▪ 1,300-1,350 m^2 ▪ <18 consulting rooms ▪ Team rooms ▪ <5 beds	▪ 60 – 70 WTE
TOTAL		£ 10-12m		

1 Based on bottom up calculation of saving initiatives. Each initiative build on granular assumptions: e.g. "Outpatient at lower cost" initiative assumes re-provision cost of 0.8 GP appointment of 12 minutes & 0.2 Consultant appointment of 30 minutes per patient per year for 5% of total outpatient cohort
2 Assumptions based on pilots outcome of Brent Intermediate Care 2009 and BRENT Unplanned Care Initiatives 2011, QIPP 11/12 business cases, Healthcare for London, CCG input and expert interviews
3 Initiatives includes: "At Home"- e.g. Rapid Response (Nursing), Case Management, ICP; "AT a GP Practice"- e.g. Outpatient at lower cost, Outpatient at lower cost (telephone advice), ICP; "In a community health centre"-e.g. Rapid Response (Bed), Outpatient at lower cost, Outpatient at lower cost (telephone advice), ICP

SOURCE: NHS NWL Team; Commissioning Service Plan, 1st December 2011, QIPP plans 15th December 2011, QIPP revision, Healthcare for London; HES; CCG input and expert interviews

21

The staffing and investment identified in the figure above is indicative based on CCG strategic plans and is dependent on the release of funding from acute providers as activity transfers from acute settings to community settings. Specific investments will be agreed through the normal planning and governance processes of the CCG and as such the production and agreement of robust business cases demonstrating both value for money and affordability to the CCG.

The reductions in acute activity planned by the CCG are consistent with and reflected in the acute PCBC base case modelling.

7. Next steps

The strategy set out here will form the basis of further, detailed discussions in the next few weeks with GPs, patients and families, other clinicians, partners in social care and public health, health and well-being board and others, leading to full public consultation in June.

In order to ensure the success of the strategy, we need to take the following critical steps outlined below in Exhibit 25.

EXHIBIT 25

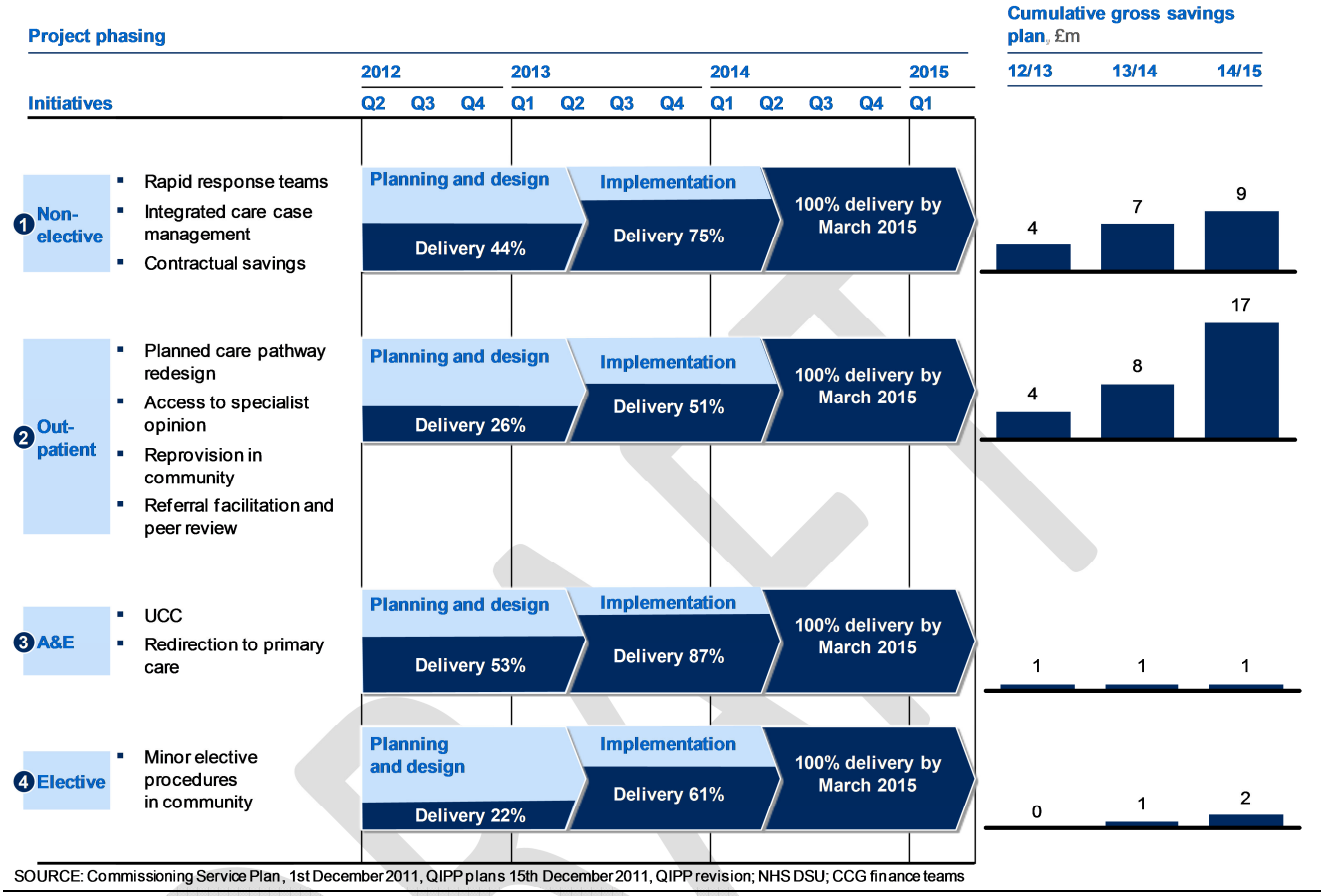
Five immediate steps critical to success of strategy

Crucial step	Status
1 **12/13 budget is set** in line with strategy	☑
2 **Strategy is endorsed** by: – Health and Wellbeing board – CCG board – All practices	☐
3 **Performance framework is agreed** by CCG (including metrics, targets, thresholds and escalation process)	☐
4 Appropriate **governance structures** in place for **managing performance**	☐
5 **Capabilities are in place** to deliver strategy including: – Management support in CCG – CSS support – New workforce required to deliver service	☐

7.1 INITIATIVE IMPLEMENTATION PLAN

Implementation of many of our initiatives is already underway. Exhibit 26 outlines our implementation plan and benefits realisation for our key initiatives.

EXHIBIT 26



SOURCE: Commissioning Service Plan, 1st December 2011, QIPP plans 15th December 2011, QIPP revision; NHS DSU; CCG finance teams

7.2 ENABLES TO DELIVER

Successful delivery of our initiatives will rely on our successful implementation of enablers identified in section 5. The delivery plan for these is outlined in Exhibit 27.

EXHIBIT 27

Improved picture under construction by DSU to be shared with Brent