Reminder: STPs are not an end in themselves, but a means to build and strengthen local relationships, enabling a shared understanding of where we are now, our ambition for 2020 and the concrete steps needed to get us there.
Executive Summary

1. Introduction
   a) Introduction
   b) Big ticket items

2. Closing the Health & Well-Being Gap:
   a) Wider Determinants of Health (Mental Well-Being)
   b) Prevention
   c) Self-Care
   d) Children’s Services
   e) Summary

3. Closing the Care & Quality Gap:
   a) Primary Care
   b) Long-Term Conditions (LTCs) & Community
   c) Mental Health
   d) Urgent & Emergency Care
   e) Acute Care
   f) Continuing Care
   g) Integrated Care:
      i. Whole Systems Integrated Care
      ii. Health & social care integration
      iii. Length of stay
      iv. Accommodation-based care
   h) Enablers:
      a) Workforce

b) Digital
   i) Summary

4. Closing the Financial Gap

5. Core Brent STP Outcome Indicators

6. Governance, Implementation and Next Steps

7. Discussion and Conclusion

8. Appendix
   A: Brent STP Engagement
   B: NW London and Brent priorities
   C: Principles for working together
BACKGROUND AND PURPOSE:

NHS England has published the Five Year Forward View (FYFV), setting out a vision for the future of the NHS. Local areas have been asked to develop a Sustainability and Transformation Plan (STP) to help local organisations plan how to deliver a better health service that will address the FYFV ‘Triple Aims’ of improving people’s health and well being, address the quality of care which people receive and to address the financial gap. This is a new approach across health and social care to ensure that health and care services are planned over the next 5 years and focus on the needs of the place where people live, rather than individual organisations.

While Brent is part of the North West London footprint and formal STP submission to NHS England, Brent has also developed its own local version of the STP, focusing on how Brent will achieve the triple aim locally. The Brent STP therefore represents Brent's overarching 5-year strategy and implementation plans to improve health and well-being, the quality of services provided, and achieve financial sustainability. It is a triangulation of existing plans, plus new initiatives where gaps in existing plans have been identified. New initiatives will be subject to further public and patient engagement. It provides:

- A clear shared view of the big priorities for the next 5 years
- A mechanism for the CCG and Council to track the delivery of Brent's key programmes

The financial situation in Brent

Approximately £12m of net savings (‘QIPP’) are required each year to close the CCG financial gap over the next five years.

Council will have a £17m gap by 2020 without applying the Council tax precept and £9m if Brent applied the precept year on year up to 2020.

LNWHT provides services to three key commissioners, and therefore only a proportion of its 'gap' is directly associated with Brent; similarly with CNWL.

Brent's financial gap by organisation

<table>
<thead>
<tr>
<th>Organisation</th>
<th>'Do nothing' (including no 16/17 savings) by 2020/21</th>
<th>16/17 savings plans (CIP/QIPP)</th>
<th>Remaining financial challenge</th>
</tr>
</thead>
<tbody>
<tr>
<td>LNWHT</td>
<td>£191.8m</td>
<td>£34.4m</td>
<td>£157.4m</td>
</tr>
<tr>
<td>CNWL</td>
<td>£52.9m</td>
<td>£14m</td>
<td>£38.9m</td>
</tr>
<tr>
<td>Brent CCG</td>
<td>£58.6m</td>
<td>£9.3m</td>
<td>£49.3m</td>
</tr>
</tbody>
</table>

1. Introduction

1.1 The local picture

The Brent Sustainability and Transformation Plan (STP) brings together providers and commissioners of care (both local government and NHS) to deliver a genuine place based plan for the borough.

**The financial situation in Brent**

- 328,568 Brent residents
- 369,166 GP-registered population
- £406,569k - 2016/17 CCG allocation
- 66 GP Practices
- 14 Nursing Homes

**Key Provider Trusts:**
- London Northwest Healthcare NHS Trust
- Central and North West London NHS Foundation Trust

1: GLA Population Estimate 2016
2: HSCIC, April 2016
3: Excludes running costs and carry forward surplus from 15/16

Working draft
1.1 Brent has identified its key gaps with regards to the ‘Triple Aim’

Home of the iconic Wembley Stadium, Wembley Arena and the spectacular Swaminarayan Hindu Temple, Brent is the destination for thousands of British and international visitors every year. Our population is young, dynamic and growing. Our long history of ethnic and cultural diversity has created a place that is truly unique and valued by those who live and work here.

Key demographics

- 328,568 Brent residents
- 64.9% of the population from BAME groups (2013)
- Amongst the top 15% most-deprived areas in the country
- Life expectancy is significantly better than national average

Brent’s Health & Well-Being gaps

**Common mental health disorders (CMD):** large numbers and projected to increase - in 2014, an estimated 33,959 people aged 18 to 64 years were thought to have a CMD

**Severe and enduring mental illness:** affects 1.1% of the population

**Mental well-being:** the percentage of people with depression, learning difficulties, mental health issues or other nervous disorders in employment is 23% also lower than both the England rate (36%)

**Childhood obesity:** Brent is in the worst quartile nationally in terms of the % of children aged 10-11 classified as overweight or obese – 38%

**Diabetes:** by 2030 it is predicted 15% of adults in Brent will have diabetes

**LTCs:** 20% of people have a long term condition

**Dementia:** prevalence of dementia in people aged 65 years and over is 2,225 (2016) (and 80% of prevalence is diagnosed)

**STIs/HIV:** 1,404 STIs per 100,000 population compared to 829 in England

**Health-related behaviour:** physical inactivity: worst in West London; nutrition: 47% get 5 a day; tobacco use; alcohol; take up of immunisations

Brent’s Care & Quality gaps

**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.

**EOLC:** Brent has one of the highest percentages of deaths taking place in hospital in the country.

**Primary care:** wide variation in clinical performance; Brent is in the worst quartile nationally for patient experience of GP services.

**LTC management:** Brent is in the worst quartile nationally in terms of people with a long-term condition feeling supported to manage their condition.

**Cancer:** Brent is in the second lowest quartile nationally in terms of GP referral to treatment for cancer and worst quartile in terms of cancer patient experience.

**Serious and long-term mental health needs:** people with serious and long term mental health needs have a life expectancy 20 years less than the average.

Note: the financial gap in Brent is set out on slide 3

Sources: Brent JSNA; CCG Assessment & Improvement Framework
1.1 How the Brent Sustainability & Transformation Plan is organised

Brent’s vision: “We want to improve the quality of care for individuals, carers and families, empowering and supporting people to maintain independence and to lead full lives as active participants in their community”

- In Brent and North West London there is significant pressure on the whole system. Both the NHS and local government need to find ways of providing care for an ageing population and managing increasing demand with fewer resources. Over the next five years, the growth in volume and complexity of activity will out-strip funding increases.
- This challenge also gives us an opportunity. We know that our services are siloed and don’t treat people holistically. We have duplication and gaps; we have inefficiencies that mean patients often have poor experiences and that their time is not necessarily valued. We are focused on helping to get people well, but do not spend enough time stopping them from becoming ill in the first place. The STP gives us the opportunity to do things much better.
- Our plan involves ‘flipping’ the historic approach to managing care. We will turn 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 with the default position being to provide this care as close to, or in people’s homes, wherever possible. Through better targeting of resources to make the biggest difference, it will also improve the finances and efficiency of our system, with the more expensive hospital estate and skills used far more effectively. This will also allow more investment into the associated elements of social care and the wider determinants of health such as housing and skills, to improve the broader health & wellbeing of our residents.
- In order to address the challenges set out in the Triple Aim, we have developed a set of nine shared priorities at the NW London level, as well as five local Brent priorities (see Appendix A). Plans to support these priority areas, along with other key health workstreams to improve care and quality, are described in the following sections of Brent’s STP. The associated financial opportunities are then summarised in the ‘Closing the Financial Gap’ section.
- The NWL STP has organised the 9 NWL priorities into five High Impact Delivery Areas for NWL, and these are marked as appropriate throughout the Brent STP.
- Brent has also identified the ‘big ticket’ items that will both have a significant impact on the triple aim and particularly benefit from doing as a collective. Further work to develop these areas, collaborating on a pan-NW London where appropriate, will now be undertaken.
- The final section of the Brent STP sets out how it will be implemented and how progress will be monitored. It is anticipated that the Brent and NW London STP plans will benefit from investment through the Sustainability and Transformation Fund (STF), but specifics about how this funding will be allocated have yet to be provided.
1. Introduction

1.1 Link to High Impact Delivery Areas

As per the previous page the NW London STP has organised the 9 NWL priorities into five High Impact Delivery Areas for NW London.

In order to achieve our vision, NW London has developed a set of nine priorities which have drawn on local place based planning, sub-regional strategies and plans and the views of the sub-regional health and local government Strategic Planning Group.

Having mapped existing local and NWL activity, we can see that existing planned activity goes a long way to closing the triple gap. But we must go further to completely close these gaps. At a NW London level we 5 delivery areas have been agreed reflecting where we need to focus on to deliver at scale and pace. The five areas are designed to reflect our vision with DA1 focusing on improving health and wellbeing and addressing the wider determinants of health; DA2 focusing on preventing the escalation of risk factors through better management of long term conditions; and DA3 focusing on a better model of care for older people, keeping them out of hospital where appropriate and enabling them to die in the place of their choice. DA4 and DA5 focus on those people whose needs are most acute, whether mental or physical health needs.

At the NW London level we will set up or utilise an existing joint NW London programme for each delivery area, working across the system to agree the most effective model of delivery. We will build on previous successful system wide implementations to develop our standard improvement methodology, ensuring an appropriate balance between common standards and programme management and local priorities and implementation challenges.
1.2 Brent ‘big ticket’ items, i.e. those which will have the most significant impact on closing the gaps in Brent and that will most benefit from working collaboratively

AT the Brent level, Brent has identified the ‘big ticket’ items that will both have a significant impact on the triple aim and particularly benefit from doing as a collective locally. Further work to develop these areas, collaborating on a pan-NW London where appropriate, will now be undertaken.

**Brent’s big ticket items:**

| Title: 1. Join Up Health Promotion, Self-Care and Non-Statutory support across the Continuum |
| Description:  |
| Self–Care covers a spectrum of activities from simple management of self-limiting conditions to those designed to support patients living with long term conditions – to include: |
| - **Making Every Contact Count (MECC)** – i.e. use every opportunity to achieve health and wellbeing, and involve systematic promotion of benefits of healthy living (culture and environment) |
| - **Workplace based Health Promotion programme** - i.e. adapted version of London Healthy Workplace Charter for small businesses in Brent; contracts issued with workplace health and wellbeing as a ‘social value’ requirement |
| - **Widen the scope of SIBI** - SIBI currently delivers a 2nd tier service, but the service can be re-aligned to support 1st (signposting and advice, with links to existing services) and 3rd tier patients (intensive support for short periods (6wks to 3 mo) using multi-agency approach |
| - **Self-Care as part of WSIC** - already a Brent plan |

| Impact: |
| - According to the Local Services Transformation paper, Brent could save ~£345k over five years through: |
| (1) commissioning a menu of self-care programmes, e.g. social prescribing, peer support; (2) activating the workforce, e.g. motivational interviewing techniques; (3) improve provision of information; (4) use of PAM to tailor self-care; and (5) developing third sector infrastructure. |
| - According to NESTA, people-powered health could save CCGs from £12m - £21m. |

| Why work together: |
| - Effective health promotion and self-care programmes require collaboration and coordination across all partners in Brent, including third sector. |

| Next steps: |
| - Develop project scoping document for presentation at the 6th October Brent Health & Well-Being Board |

| Title: 2. Nursing Care Homes |
| Description: |
| Build on existing 16/17 BCF Scheme #4 in terms of: |
| - Market management |
| - Joint commissioning, including pooled and/or aligned purchasing budgets and integrated brokerage and monitoring resources |
| - Workforce development |
| - New models of care |
| - Co-production |

| Impact: |
| - Increased capacity and quality in the local marketplace |
| - Reduced A&E attendances, NEL admissions, LOS and DTOC |
| - New extra care nursing provision |
| - Better value for money |
| - New models of care to meet increasing demographic demand and increasing acuity of need |

| Why work together: |
| - A part of system of affects all partners, with considerable opportunity to improve quality and efficiency |

| Next steps: |
| - Develop through 16/17 BCF and beyond |
1.2 Brent ‘big ticket’ items, i.e. those which will have the most significant impact on closing the gaps in Brent and that will most benefit from working collaboratively (cont.)

<table>
<thead>
<tr>
<th>Title: 3. Redesign Central Middlesex Hospital – One Public Estate</th>
<th>Description:</th>
<th>Impact:</th>
<th>Why work together:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Redevelop the Central Middlesex Hospital (CMH) site into a Brent Health &amp; Well-Being Centre providing a range of local services (including the Urgent Care Care).</td>
<td>• Support financial viability of LNWHT</td>
<td><strong>To ensure a whole system approach is taken to the redesign process.</strong></td>
<td><strong>Why work together:</strong> To ensure a whole system approach is taken to the redesign process.</td>
</tr>
<tr>
<td>• This work will take place as part of the wider NW London acute reconfiguration programme.</td>
<td>• Support financial sustainability of Brent CCG</td>
<td><strong>Next steps:</strong></td>
<td><strong>Next steps:</strong> Develop project scoping document for presentation at the 6th October Brent Health &amp; Well-Being Board</td>
</tr>
<tr>
<td>• The redesign process will take account of the additional Extra Care Units that are being developed near CMH in 2016/17-2017/18.</td>
<td>• As a local Health &amp; Well-Being Centre, support Brent’s vision to improve the quality of care provided, empowering and supporting people to maintain independence and to lead full lives as active participants in their community”</td>
<td></td>
<td><strong>Why work together:</strong> Models of care need to be integrated at every stage, e.g. use of Common Geriatric Assessment in-hospital then shared with other providers – from Primary Care to Nursing Homes, with a focus on preventing deterioration through unnecessary time spent in hospital.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Title: 4. Unified Frailty Model</th>
<th>Description:</th>
<th>Impact:</th>
<th>Why work together:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Span the services and pathways that address the needs of this cohort across Brent, concentrating and coordinating resources on cohort whose needs currently drive a significant proportion of demand, incl.:</td>
<td>• The increase in the older population in Brent poses a challenge to the health and care system as this population cohort has more complex health and care needs. The over 65 population is much more likely to be frail and have multiple LTCs. The higher proportion of non-elective admissions for this age group indicates that care could be better coordinated, more proactive and less fragmented.</td>
<td><strong>To ensure a whole system approach is taken to the redesign process.</strong></td>
<td><strong>Why work together:</strong> Models of care need to be integrated at every stage, e.g. use of Common Geriatric Assessment in-hospital then shared with other providers – from Primary Care to Nursing Homes, with a focus on preventing deterioration through unnecessary time spent in hospital.</td>
</tr>
<tr>
<td>• Common standards and specifications, and pooled, shared and rotated resources</td>
<td>• Shift ratio of acute to out of hospital expenditure</td>
<td></td>
<td><strong>Next steps:</strong> Develop project scoping document for presentation at the 6th October Brent Health &amp; Well-Being Board</td>
</tr>
<tr>
<td>• Community-based networks – at scale</td>
<td>• Significantly improve the quality, timeliness and coordination of care provided to older people in Brent</td>
<td></td>
<td><strong>Next steps:</strong> Develop project scoping document for presentation at the 6th October Brent Health &amp; Well-Being Board</td>
</tr>
<tr>
<td>• Single, universally accessible assessment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Cross-professional decision-making, e.g. to assess, treat, admit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Co-location of services, in particular for most vulnerable/complex, e.g. health &amp; well-being villages</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>This will require more complete development of the WSIC model and a pathway that cuts across WSIC + Primary Care Transformation + STARRS + discharge + other (e.g. GP-led urgent and emergency care model), stitching together the existing BCF scheme services/models into a single pathway.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
1.2 Brent ‘big ticket’ items, i.e. those which will have the most significant impact on closing the gaps in Brent and that will most benefit from working collaboratively (cont.)

<table>
<thead>
<tr>
<th>Title</th>
<th>Description</th>
<th>Impact</th>
<th>Why work together:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enabler - Workforce</td>
<td>• Develop proposed shared Workforce vision and plan for Brent including:</td>
<td>• Fewer shortages of key staff groups</td>
<td>To create economies of scale in developing the workforce and benefit from the</td>
</tr>
<tr>
<td></td>
<td>o Skills</td>
<td>• Reduced agency and bank spend</td>
<td>opportunity for staff to work across care settings, strengthening pathways and</td>
</tr>
<tr>
<td></td>
<td>o Flexible use of staff across settings of care</td>
<td>• Improved quality of care provided</td>
<td>MDT working</td>
</tr>
<tr>
<td></td>
<td>o Workforce planning and career path;</td>
<td>• Increased employment for Brent</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Multi-disciplinary workforce; and</td>
<td>residents</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Recruitment/retention</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The Brent ‘big ticket’ items, as set out in this section, have been identified as those initiatives that will have the greatest impact on addressing Brent’s triple aim and that will most benefit from a collaborative approach across the health and social care economy.

Most of the initiatives are new, or go considerably beyond existing workstreams – the next step for each of these is to develop a detailed Project Scoping document for presentation at the next Brent Health & Well-Being Board (6th October 2016).
Section 2 sets out all of the key workstreams through which Brent will close its Health & Well-Being Gap. These include NW London priorities, Brent’s additional local priorities, and Brent ‘big ticket’ items, as well as the remaining set of key Brent workstreams.

Health & Well-Being chapter sub-sections

Legend:
- Yellow text identifies a ‘Priority’
- Yellow star indicates a ‘big ticket’ item

Working draft
2.1 Wider Determinants of Health (mental well-being)

Brent STP priority: employment and housing to support mental well-being

Our to-be:
- Opportunities are maximised and the adverse impacts of Welfare Reform minimised for Brent residents
- Improved independence and wellbeing and reduced revenue costs through improved availability, accessibility and suitability of accommodation for vulnerable people

5 Year Plan for Wider Determinants of Health

As public health is influenced by many factors other than the healthcare received, opportunities exist to integrate public health priorities into some of the key wider determinants of health such as education, housing and transport.

An Outcome Based Review (OBR) is a way of looking at specific problems across multiple providers and organisation and understanding different points of view through involvement of a wide range of partners. It puts the voice of the customer at the centre, seeks to understand current demand, customer patterns and systems / procedures, and engages a wide stakeholder group in discussing the issues.

Key workstream: OBR for Housing for Vulnerable People

Current housing processes are subject to multiple assessment processes and internal competition (across housing, children’s, adults) for the same accommodation. There is a need for a shared approach in dealing with cross-cutting issues and to understand the scale of the problem, the whole cost and the impact.

Undertake an OBR of Housing to establish evidence as to what changes are required, by testing the suitability and availability of accommodation for vulnerable people based on findings of the Discovery phase, design, develop and deliver changes to address three key themes:
- Preventing loss of tenancy
- Pathways into services and looking at eligibility criteria
- Adaptations – maintaining independence & well-being

Key workstream: Individual Placement Scheme

Brent Council is investing £1 million in 16/17 to support people with Common Mental Illness, on the premise that having a regular routine, including work, supports people’s mental well-being.

The IPS scheme will invest in work placements for those with common mental illness, as part of a trailblazer across the WLA, and linked to IAPT services. Twinings has won the contract for IPS in each borough and is partnering with CNWL in Brent.

NWL DA Area 1: Radically upgrading prevention & well-being
## 2. Health & Well-Being

Sent to Peter, Dawn & Jon Cartwright for review

### 2.1 Wider Determinants of Health (mental well-being) (cont.)

<table>
<thead>
<tr>
<th>Key changes (deliverables) by workstream / area of work</th>
<th>16/17</th>
<th>17/18</th>
<th>2018/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Housing for Vulnerable People</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OBR:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Discover more about what is actually being delivered and define a vision for the service</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Develop detailed plans setting out the service and commissioning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Test new service model(s) to inform implementation in delivering agreed outcomes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Employment Support &amp; Welfare Reform</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OBR:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Discover more about what is actually being delivered and define a vision for the service</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Develop detailed plans setting out the service and commissioning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Test new service model(s) to inform implementation in delivering agreed outcomes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IPS:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Invest £1 million in work placements for those with common mental illness, linked to IAPT services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>OBR</strong>: improve the assessment process – joining up across different services, but also ensuring assessments respond to people’s ability and motivation to engage, rather than just their statutory need</td>
<td></td>
<td></td>
<td>Implement agreed solutions</td>
</tr>
<tr>
<td>• Adapt assessment processes to better reflect needs of those coming from institutional settings (prison, hospitals)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Build on/accelerate the work Private Housing Services already do to develop our role with private sector landlords to improve availability and standards</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Commission more short-term accommodation to help flow in the system, but with a stronger evidence base of need, and with the right front line resource</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Reference strategy/plan documents: implementation plans will be developed at the completion of the Discovery phases of the OBR process |

**Key outcome indicators/targets**

**Housing:**
- Improved independence and wellbeing
- Reduced revenue costs

**Employment:**
- Employment rates are at least as good as London average.
- % of people with depression, learning difficulties, mental health issues or other nervous disorders in employment

**Delivery mechanism / reporting structure**

**Employment OBR:**
- Leads: Phil Porter (Council), with Dawn Bailey & Fiona Kivett

**Housing OBR:**
- Leads: Phil Porter (Council), with Dawn Bailey & Fiona Kivett

Note: IPS governance not shown
2.2 Prevention

Introduction
The Five Year Forward View sets out that a 'radical upgrade in prevention' is needed to improve people's lives and achieve financial sustainability of the health and care system. The NHS spends more than £15.5 billion per annum treating illness which directly results from alcohol and tobacco consumption, obesity, hypertension, falls, and unhealthy levels of physical activity. Most of this treatment is avoidable.

Key workstream – Public Health & Health & Well-Being Strategy 2012-2015, Empowering communities to take better care of themselves

Key prevention services in place in Brent include:
- NHS Health Checks, which aim to prevent the main causes of premature mortality by identifying people at risk of developing CVD through measurement of BP, cholesterol, etc. in primary care
- Diabetes Champions
- Parent Champions
- Maternal and childhood immunisation programmes (NHS England)
- Screening (commissioned by NHS England)
- Local & pan London HIV prevention programmes

Key strategies and future plans include:
- Introduction of latent TB checks screening (CCG-led workstream) - NHSE and PH England are implementing Latent TB screening of new immigrants from identifies 20 high prevalence countries. The new migrant Latent TB Testing and Treatment (LTBI) screening program is part of the delivery

5 year plan for Prevention

NWL STP priority: support people who are mainly healthy to stay mentally and physically well, enabling and empowering them to make healthy choices and look after themselves

Our to-be: people live healthy lives and are supported to maintain their independence and wellbeing with increased levels of activation, through targeted patient communications – reducing hospital admissions and reducing demand on care and support services

“the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health” - Five Year Forward View (2014)

- Review of Smoking Cessation Service (Public Health service Plan) – note that smoking is still the single biggest identifiable risk factor for poor birth outcomes
- Implement Healthy Workplace Agenda – see Workforce section
- Physical Activity Strategy, a 5 year strategy with a 1 year action plan

Brent recognises that existing prevention plans are not sufficient to close the Health & Well-Being gap in Brent, and would like to co-produce a strengthened, scaled up and shared approach to prevention with patients & the public.

Brent expects to collaborate with the Healthy London Partnerships prevention programme, which will include improving workplace health, within and beyond the health and care system; and taking innovative action to reduce smoking and obesity and promote wellbeing.

Key workstream – Transport & Cycling Strategies

The benefits of increasing the uptake of cycling in London are significant in terms of improved air quality, less congestion and a fitter and healthier population. To ensure Brent residents benefit from the wider positive outcomes, Brent Council has developed a Cycle Strategy to support achieving an average 5% mode share for cycling across London. The Transport Strategy strategic objectives include to increase the uptake of sustainable modes, in particular active modes of travel and reduce the exposure of Brent residents to Particulate Matter (PM) and Nitrogen Dioxide (NO2) generated by the transport network. It also references other strategies, including Brent Walking Strategy and Brent Air Quality Strategy.
## 2.2 Prevention (cont.)

### Key changes by workstream / area of work

<table>
<thead>
<tr>
<th>Public Health</th>
<th>16/17</th>
<th>17/18</th>
<th>2018/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Brent CCG Latent TB (LTBI) Local Incentive Scheme (LIS) Screening Program go live (May) – plan to test 1741 patients for latent TB, resulting in an estimated 338 patients requiring treatment (3% of 1741 tested)</td>
<td>• Implement agreed changes to the Smoking Cessation Service</td>
<td>• Implement agreed solutions</td>
<td></td>
</tr>
<tr>
<td>• Review Smoking Cessation Service</td>
<td>• Co-produce a strengthened, scaled up and shared approach to prevention (may start in 16/17)</td>
<td>• Implement Years 3-5 action plans of the Physical Activity Strategy</td>
<td></td>
</tr>
<tr>
<td>• Monitor NHSE progress in implementing the Immunisation Improvement Action Plan</td>
<td>• Implement Year 2 action plan of the Physical Activity Strategy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Implement Year 1 action plan of the Physical Activity Strategy</td>
<td>• Develop plans to address premature CVD mortality</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Develop plans to strengthen hypertension management</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Transport &amp; Air Quality</th>
<th>16/17</th>
<th>17/18</th>
<th>2018/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Year 1 of Cycling Strategy, including network of cycle routes developed, and strong brand and communication strategy for ‘Cycling in Brent’ developed to promote cycling</td>
<td>• Year 2 of Cycling Strategy</td>
<td>• Achieve objectives of Cycling Strategy</td>
<td></td>
</tr>
<tr>
<td>• Implement Transport Strategy</td>
<td></td>
<td>• Achieve 2021 Transport Strategy objectives, e.g. increase cycling mode share to 3% from 1%</td>
<td></td>
</tr>
</tbody>
</table>

### Key outcome indicators/targets

- **Smoking prevalence:**
  - **Baseline:** 13.6% (2014, Public Outcomes Framework)

- **Diabetes prevalence:**
  - **Baseline:** 11.5% (2015, modelled prevalence, PH)

- **Percentage of physically active and inactive adults, inactive adults:**
  - **Baseline:** 30.3% (2014, Public Outcomes Framework)

- **Number of people tested for latent TB in 16/17:**
  - **Target:** 1,741 people

### Reference strategy/plan documents:

- Health & Well-Being Strategy 2014-17
- Brent Cycle Strategy (2016-2021)
- Brent Long-Term Transport Strategy (2015-2035)

---

**Sent to Melanie, John & Duncan for review**

**Leads:** Dr Melanie Smith (Council) & Duncan Ambrose (CCG)

**NWL DA Area 1:** Radically upgrading prevention & well-being

---

**Working draft**

---

**NWL TB steering group**

**NHSE & Public Health England**

**Brent Health & Well-Being Board**

**Brent & Harrow TB Steering Group**

**Public Health Service Plans**

Note: Transport & Air Quality governance not shown
2.3 Self-Care

NWL STP priority: support people who are mainly healthy to stay mentally and physically well, enabling and empowering them to make healthy choices and look after themselves

Our to-be: people live healthy lives and are supported to maintain their independence and wellbeing with increased levels of activation, through targeted patient communications – reducing hospital admissions and reducing demand on care and support services

NWL STP priority: reduce social isolation

Our to-be: people are empowered and supported to lead full lives as active participants in their communities

5 year plan for Self-Care: Joining Up Health Promotion, Self-Care & Non-Statutory Support Across the Continuum

The NHS Five Year Forward View set out a central ambition for the NHS to become better at helping people to manage their own health. Self-Care covers a spectrum of activities from simple management of self-limiting conditions to those designed to support patients living with long term conditions. It includes giving people the knowledge to take independent decisions and share in decisions about prevention, treatment & recovery.

Key workstreams – Social Isolation in Brent Initiative (SIBI)

Social isolation and loneliness have a detrimental effect on health and wellbeing. SIBI is a cross department project from Brent Council and Brent CCG, to tackle social isolation in Brent adults. Outreach activities are planned to target socially isolated individuals and raise awareness of SIBI. Referrals to SIBI are made from Brent Council and NHS, although SIBI outreach will establish direct contact. Social activities on Care Place are advertised and isolated individuals referred/signposted to SIBI are “brokered” onto these activities, which is expected to improve well-being. To date 600 activities have been identified as suitable for SIBI patients, and there are 200 patients on SIBI records. The service has high patient satisfaction levels, with patients being brokered onto activities they want to do based on follow ups and discussions.

Brent has also commissioned a range of Mental Health Advocacy and Peer Support Services, including peer support, for 2016/17.

Key workstreams – Self-Care through WSIC (section 3.10)

Self-Care is embedded within our Whole Systems Integrated Care (WSIC) model. The three self-care deliverables are: (1) ‘Care Navigators’, voluntary sector staff working within multidisciplinary teams; (2) staff training, including techniques such as Coaching for Health and Motivational Interviewing, and the Patient Activation Measure (PAM), which identifies knowledge, skills and confidence within individuals and supports the tailoring of interventions. It is expected that 6,000 patients in 2016/17 will receive a PAM score, and that this will expand rapidly.

There is also a self-care CQUIN in the LNWHT contract for 16/17.

Key workstreams - Join up Self-Care Across the Continuum

Brent has identified joining up Health Promotion, Self-Care and Non-Statutory support across the continuum as a ‘big ticket’ item on which Brent partners will collaborate over the next five years – these are expected to include:

- Implement ‘Making Every Contact Count’ MECC
- Widen SIBI (Social Isolation Brent Initiative)
- Workplace self-care initiatives, e.g. in small businesses/employers
- Establish Primary Care Mental Health team
- Self-care initiatives through Whole Systems Integrated Care

Brent will refresh the Brent Equality, Engagement and Self-Care Strategy, including revision of the work plan for 2016/17 – through this work the additional aspects across the continuum will be scoped for further development. The first step is to develop a scoping document for HWBB.

Key workstreams – Carers (leads: Amy Jones (Council), Sarah McDonnell (CCG) & Dr Sarah Basham (CCG))

Brent will refresh its Carers’ Strategy in 2016/17 – this will be jointly developed by CCG and LA, and ultimately endorsed by the HWB.
### Self-Care (cont.)

#### Key changes by workstream / area of work

<table>
<thead>
<tr>
<th>16/17</th>
<th>17/18</th>
<th>2018/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self-Care &amp; Social Isolation</strong></td>
<td><strong>Carers</strong></td>
<td><strong>Carers</strong></td>
</tr>
<tr>
<td>• Refresh the Brent Equality, Engagement and Self-Care Strategy (including Social Isolation) – Joining Up Health Promotion, Self-Care &amp; Non-Statutory Support across the Continuum</td>
<td>• Develop a new Carers’ Strategy</td>
<td>• Continue implementation of the Carers’ Strategy</td>
</tr>
<tr>
<td>• Implement PAM (6,000 licences – one for each care planned patient through WSIC)</td>
<td>• Continue implementation of the Carers’ Strategy</td>
<td>• Continue implementation of the Carers’ Strategy</td>
</tr>
<tr>
<td>• Commission a range of Mental Health Advocacy and Peer Support Services, including peer support</td>
<td>• Implement PAM (6,000 licences in use)</td>
<td>• Implement further elements of the Joined Up Self-Care Strategy</td>
</tr>
<tr>
<td>• Monitor achievement of the LNWHT self-care CQUIN</td>
<td>• Implement further elements of the Joined Up Self-Care Strategy</td>
<td></td>
</tr>
</tbody>
</table>

#### Key outcome indicators/targets

- People with a long-term condition feeling supported to manage their condition:
  - Baseline position: 56% (2014/15, NWL STP Data pack)
- Quality of life of carers – health status score (EQ-5D):
  - Baseline: 0.82 (Mar-15, NWL STP Data pack)

#### Delivery mechanism / reporting structure

Through WSIC:  
- Brent Integration structure  
- BCF Scheme #1 Steering Group  
- WSIC Self-Care Steering Group  

**Carers:**  
- Brent HWBB  
- Internal CCG & Council governance

2.4 Children’s Services

Brent Children’s Trust vision

Developing and implementing services that meet the needs of every child and family in Brent.

5 year plan for Children’s Services

Introduction

Brent Children’s Trust (BCT) is a strategic body that encompasses a local partnership of all commissioners and key partners. The primary function of the BCT relates to commissioning, joint planning and collaborative working, in ensuring that resources are allocated and utilised to deliver the maximum benefits for children and young people.

In terms of health and well-being, ‘Giving every child the best start in life’ is a priority area within the Brent Health & Well-Being Strategy.

Key areas of work – Health & Well-Being Strategy: Giving children the best start in life

Objectives include:

- Review our approach to childhood obesity and agree a revised strategy
- Evaluate our current parenting programmes with a focus on learning from best practice to inform the use of resources
- To expand partnership working with schools, nurseries, playgroups and other early years settings to improve the wellbeing of children

In addition, funding has been secured from HENWL to support the development of a high quality child obesity service in General Practice, including training (and train the trainer) for Primary care nurses and HCAs. The service will focus on and support the promotion of behavioural change

Key areas of work – Brent Children & Young People’s Joint Commissioning Group

The trust has developed a clear framework for strategic planning and commissioning which is being delivered through five transformational groups for the following priority areas (led by the Brent Children and Young People’s Joint Commissioning Group):

1. Maternity and Children under 5
2. Children and Young People’s Mental Health and Wellbeing (CAMHS): to support improved mental health and wellbeing for children and young people in Brent. A CYP Mental Health & Well-Being Strategy has been developed, with the following workstreams:
   - Needs Assessment; Supporting Co-Production; Workforce and Training; Community Eating Disorder Service; Transforming Pathways – a Tier Free Service; Enhanced support for Learning Disabilities and Neuro Development Disorders; Crisis and Urgent Care Pathways; & Embedding Future in Mind Locally
3. Children Looked After
4. Children and Young People with SEND
5. Young Carers: to champion and be an advocate for Young Carers (YC) to help ensure every young carer has the right to: a childhood; an education; be healthy; be heard, listened to, and believed; be protected from physical and psychological harm; be consulted and fully involved in discussions which affect their lives; have privacy and respect.

NWL STP priority: improving children’s physical and mental well-being

Our to-be: children and young people have a healthy start to life and their parents or carers are supported – reducing admissions to hospital and demands on wider local services

NWL DA Area 1: Radically upgrading prevention & well-being

Working draft
### 2.4 Children’s Services (cont.)

#### Key changes by workstream / area of work

<table>
<thead>
<tr>
<th>16/17</th>
<th>17/18</th>
<th>2018/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CYP MH &amp; Well-Being Transformation</strong></td>
<td>• Needs and workforce assessment completed</td>
<td>• Implement workforce plans and new pathways</td>
</tr>
<tr>
<td></td>
<td>• New NWL community eating disorder service in place</td>
<td>• Enhance capacity for ASD, ADHD and support to schools and ARPs</td>
</tr>
<tr>
<td></td>
<td>• Waiting lists reduced and pathways redesigned</td>
<td>• Ensure sufficient capacity for joint paediatric and CAMHS case-management, &amp; processes and systems to support Transitions</td>
</tr>
<tr>
<td></td>
<td>• Out of hours crisis and urgent care pathways in place</td>
<td></td>
</tr>
<tr>
<td><strong>Other BCT workstreams</strong></td>
<td>• Achieve outcomes of the Young Carer plan on a page, e.g. YC will have opportunities to take a break from their caring responsibilities</td>
<td></td>
</tr>
<tr>
<td><strong>HWBB Strategy – Giving children best start in life</strong></td>
<td>• Develop Brent Child Obesity Strategy</td>
<td>• Implement Child Obesity Strategy</td>
</tr>
<tr>
<td></td>
<td>• Develop Practice Nurses and HCAs to extend roles and provide a childhood obesity service in General Practice</td>
<td>• New Community Dental services in place from 04/17</td>
</tr>
<tr>
<td></td>
<td>• Implement Public Health initiatives, incl. engaging primary schools to deliver daily mile, progress a 400m ‘exclusion’ zone for new fast food outlets near schools, &amp; promote healthy catering commitment to businesses</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Co-commission Oral Health with NHSE to ensure improved oral health promotion offer in new Community Dental Services, and support</td>
<td></td>
</tr>
</tbody>
</table>

#### Key outcome indicators/targets

- Prevalence of child obesity:
  - Baseline: 38% of children aged 10-11 classified as overweight or obese (14/15, NWL STP Data Pack)

#### Delivery mechanism / reporting structure

- **BCT:** Brent H&WBB
- **HWBB Strategy:**
  - Brent Children’s Trust
  - CYP Joint Commissioning Group
  - Public Health Service plans

**Reference strategy/plan documents:** Children and Young People’s Mental Health and Wellbeing Local Transformation Plan (CYP-LTP); Brent Children’s Trust ‘Plans on a Page’; HENWL Child Obesity proposal 12th Oct 2015; Public Health Services Plan; Brent Health & Well-Being Strategy (2014-2017)
How Brent will tackle the Health & Well-Being gap

Brent will close its health and well-being gap over the next five years, including the incidence and prevalence of common mental health disorders, diabetes, and childhood obesity, through:

- Tackling proven key determinants of health and mental well-being, i.e. employment and housing
- Improving health related behaviour through a co-produced strengthened, scaled up and shared approach to prevention with patients & the public
- Joining up self-care along the continuum – a phased approach over 5 years including health promotion in everyday patient and service user contacts, workplace health, and incorporating support for self-care into all care pathways
- Implementation of agreed strategies, e.g. Brent Children’s Trust workstreams and Child Obesity Strategy

This will lay the foundation not only for 2020/21, but also for the next ten to fifteen year, helping to make Brent a great place to live and work, and where people feel that they have opportunities to changes their lives for the better.

Brent’s vision for Health & Well-Being in 2021:

- Wellbeing is seen in its widest sense. It is not just about healthcare but wider factors such as employment, housing, and lifestyle. Brent will be a Dementia-Friendly Borough.
- Mental and physical health are given equal importance and will be considered holistically at the point of care.
- A significantly strengthened approach to prevention will improve the health status of Brent on a medium to long-term basis.
- **Joining up health promotion, self-care and non-statutory support across the continuum** enables people, including those with Long Term Conditions, to make decisions, take actions & manage a broad range of factors that contribute to their health & wellbeing on a day-to-day basis

Brent’s current challenges or gaps in terms of achieving its vision for Health & Well-Being in 2021 and the steps that will be taken to close them are:

- Existing prevention plans are not sufficient to close the H&WB gap – Brent would like to co-produce a strengthened, scaled up and shared approach to prevention with patients & the public
- Self-care initiatives are patchy, with lack of take-up and ownership – Brent will refresh its Self-Care Strategy to reflect its Big Ticket item, Join Up Health Promotion, Self Care & Non-Statutory Support Across Continuum

[SUMMARY]
Section 3 sets out the key workstreams through which Brent will close its Care & Quality Gap, including specific Brent and NW London priority areas.

3. Closing the Care and Quality Gap in Brent

Section 3 sets out all of the key workstreams through which Brent will close its Care & Quality Gap. These include NW London priorities, Brent’s additional local priorities, and Brent ‘big ticket’ items, as well as the remaining set of key Brent workstreams.

Care & Quality chapter sub-sections:

Primary Care
- Primary Care Transformation, incl. GP Access
- Medicines Optimisation
- Other

LTC & Community
- LTCs, including Right Care
- EOLC
- Other

Mental Health
- Mental Health, including SMI life expectancy
- Dementia
- Learning Disabilities

Urgent Care
- Urgent & Emergency Care
- 7DS
- Other

Acute Care
- Acute Care
- Redesign CMH

Continuing Care
- Continuing Care
- BCF – Integrated Pathways
- WSIC – new models of care, including Frailty
- Health & social care integration
- Length of stay
- Nursing Homes (Accommodation-based care)

Legend:
• Yellow text identifies a ‘Priority’
• Yellow star indicates a ‘big ticket’ item
• Purple box indicates a BCF scheme

Working draft
3.1 Primary Care:

3.1.1 Primary Care Transformation

NWL STP Priority: ensure people have access to the right care at the right place at the right time

Our to-be: GP, community and social care is a high quality and easily accessible, including through NHS 111, and in line with the Urgent Care Strategy

Brent’s strategic objectives for Primary Care

- Defining a primary care model of care for Brent – drawing on existing plans (e.g. SCF), evidence/best practice and stakeholder views and linked to strategic plans (for example for local services/out of hospital).
- Agreeing a commissioning strategy – identifying key commissioning intentions to 2020, agreeing a framework that supports transparent decision making, moving towards commissioning for outcomes.
- Provider development and market shaping - to ensure primary care remains at the centre of emerging provider partnerships and that providers are geared up for working together so that partnerships are delivering at scale.
- Workforce sustainability & development - making sure Brent is the destination of choice for primary care professionals and colleagues from across health and care, which lends itself to coproducing a value-add programme of organisational development for the workforce.
- Financial sustainability - ensuring CCG spend on primary care and out of hospital services is efficient and effective, identifying opportunities for economy of scale, ensuring we have a stable, sustainable and diverse primary care provider market.

5 year plan for Primary Care

Primary Care has a central role in new models of care and provision, and will support this journey by providing Brent with a platform for engagement with stakeholders across primary care; a foundation for a multi-provider model underpinned by shared objectives; and a clear link between our 5 year strategy and our commissioning, contracting, market shaping and performance management. We will develop primary care at scale in Brent.

Key areas of work – Primary Care Transformation/PMCF

As part of the Prime Minister Challenge’s Fund (PMCF), Brent will implement the following in 16/17:

- Activities required to further develop a single provider entity across the Networks to deliver both proactive and reactive new models of care.
- Work on how the single provider form will develop to provide, at scale, the urgent and integrated primary care led model of care which conforms to the national urgent care clinical standards.
- Continue to provide the WISC model of care, working towards a single provider form that will be in a position to provide the WISC contract by July 2016 and bid provision of the new Urgent Care Model.
- Networks will work with practices to increase the number of practices offering telephone consultations, and to commit to the delivery of patient online access to records, repeat prescribing and appointments.

The above will all contribute to meeting Brent’s Primary Care objectives.

Key areas of work – PMS Review

Brent will commission a range of KPIs from PMS practices in 16/17, and will roll out to GMS practices over 3 years. The KPIs include breast and cervical screening, and childhood, flu and pneumococcal immunisations.

Key areas of work – GP Access Hubs

GP Access Hubs were developed to free up capacity, manage demand differently and provide access to out of hours care through the delivery of seven day care provision. It is dependent on practices working together in networks in order to provide extended access to routine GP appointments. The current configuration of GP Access hubs will be rationalised to up to three primary-care led urgent scheduled care facilities, integrated with the BHH-wide urgent care configuration.

Key areas of work – Out of Hospital

See Community section x.x for further detail.
### 3.1 Primary Care:
#### 3.1.1 Primary Care Transformation (cont.)

#### Key changes by workstream / area of work

<table>
<thead>
<tr>
<th>Workstream / Area of Work</th>
<th>16/17</th>
<th>17/18</th>
<th>2018/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Care Transformation/PMCF</strong></td>
<td>Components of the new MoC for primary care are identified and prioritised.</td>
<td>Commissioning for outcomes becomes a reality across a GP Federation that consists of the Brent GP networks.</td>
<td>New MoC for primary care is fully implemented.</td>
</tr>
<tr>
<td></td>
<td>GP Federation is organised and begins.</td>
<td>Based on detailed baseline develop and implement plans to expand on-line booking of GP appts and provision of alternatives forms of appointments.</td>
<td>GP Federation has a strong and organised voice and is operating as part of an ACP.</td>
</tr>
<tr>
<td></td>
<td>OD work is in progress for federation/partnership.</td>
<td></td>
<td>Commissioning is outcomes based.</td>
</tr>
<tr>
<td></td>
<td>Contracts are created to commission for new MoC for primary care.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Vision of primary care reset to deliver specifications outlined in the SCF and align to WSIC.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CCG defines provider expectations to deliver joined up care.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Networks come together to provide care – first through delivering the 16/17 WSIC MoC contract.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Establish a detailed baseline of the on-line booking of GP appointments and the provision of alternative forms of appointments (e.g. phone, e-mail).</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Roll out the NHS Brent Health App.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>PMS Review &amp; GP Access Hubs</strong></td>
<td>Rationalise the current configuration of GP Access hubs to up to three PC-led urgent scheduled care facilities.</td>
<td>Initiate roll out of the commissioning of screening and immunisation KPIs from GMS practices.</td>
<td>Complete roll out commissioning of screening and immunisation KPIs from GMS practices.</td>
</tr>
<tr>
<td></td>
<td>Commission screening and immunisation KPIs from PMS practices.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Outcome measures / targets
- Patient experience of GP services:
  - Baseline: 66.5% *(July 2015, NWL STP Data pack)*
- UCC/WIC/A&E activity
- GP practice screening and immunisation KPIs
- Audits of LIS schemes

#### Delivery mechanism / reporting structure

**Reference strategy documents:** Brent CCG – Primary Care Transformation WBS v8 (April 2016); 150213_HUB_ACCESS_OOH_Service_Spec_v6.14; Brent NHS Mobile App – Business Case – September 2015 v1;
3. Primary Care:

3.1 Medicines Optimisation

Our to-be: Brent people to obtain the best possible outcomes from their medicines

Vision

To optimise medicines use to improve health outcomes by enabling timely, safe and cost-effective medicines related care, tailored to the needs of individual patients throughout the local health economy.

5 year plan for Medicines Optimisation

Introduction

Medicines use is the most common health intervention accounting for approximately 10% of the total healthcare budget. There is a need to optimise medicines use to get the greatest possible health gain for patients from the available resources. Brent CCG GP prescribing costs were over £36 million in 2015/16 and it is imperative that with this significant investment, Brent people are able to derive the best possible outcomes from their prescribed treatments.

Key areas of work – GP Practices

To support GP practices implement cost-effective, evidence based prescribing by:

- Holding regular meetings with GP practices and Localities to discuss prescribing benchmarking data and agree audits and actions to support the aspiration that all medicines are prescribed in line with best practice guidance and local formularies
- Ensuring medicines use is as safe as possible
- Communicating medicines advice to GP practices via the newsletters and Medicines Optimisation educational events
- Ensuring integration of Medicines Optimisation into local development of care pathways
- Providing a medicines optimisation service to care homes to implement cost effective medicines management processes in care homes and support clinical medication reviews for care home residents
- Support prescribing to be in line with NICE guidelines for the management of long term conditions and reducing unwarranted variation in the prescribing patterns

- Improving medicines management processes in care homes and provide a medication review service to care home residents.

Key areas of work- Work with Providers (Commissioning)

- To ensure medicine optimisation is included within all commissioning arrangements to deliver subsequent assurance of safe, high quality and cost-effective use of medicines across Brent CCG providers.
- Work with our providers via the Brent Medicines Management Subcommittee and the provider Drug and Therapeutic Committees.
- Via the NWL Integrated Formulary ensure that effective arrangements are in place between all providers and the CCG for local decision making on new medicines where prescribing is transferred to primary care.
- Working with the NWL PbR Excluded High Cost Drugs Lead at North West London Collaboration of Clinical Commissioning Groups and other relevant providers to ensure cost effective use of PbR excluded drugs.

In 2016/17, Brent will also develop a Brent Medicines Optimisation Strategy and work with local providers for a strategy across the local health economy.

Key areas of work – Prescribing QIPP Plan

- Develop and implement an annual Prescribing QIPP Plan to deliver financial balance.
- Use of Prescribing Decision Support tool in GP practices to deliver cost-effective tips and quality and safety messages at the point of prescribing in GP practices.
### 3.1 Primary Care:

#### 3.1.2 Medicines Optimisation (cont.)

<table>
<thead>
<tr>
<th>Key changes by workstream / area of work</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>16/17</strong></td>
</tr>
<tr>
<td><strong>17/18</strong></td>
</tr>
<tr>
<td><strong>2018/2021</strong></td>
</tr>
<tr>
<td><strong>GP Prescribing</strong></td>
</tr>
<tr>
<td>• Prescribing data information at practice level, monthly reporting system (with plan to upload onto WHYSE)</td>
</tr>
<tr>
<td>• Send monthly newsletter to all GPs</td>
</tr>
<tr>
<td>• Responsive medicines information service to GP practices</td>
</tr>
<tr>
<td>• Procurement of Prescribing Decision Support tool for GP practices completed</td>
</tr>
<tr>
<td>• Medicines management and medication review service to the nursing homes with planned expansion to the larger residential homes</td>
</tr>
<tr>
<td><strong>Commissioning</strong></td>
</tr>
<tr>
<td>• Work with providers to ensure discharge information regarding medicines to communicated effectively.</td>
</tr>
<tr>
<td>• Integration of Medicines Optimisation into local development of care pathways</td>
</tr>
<tr>
<td>• Develop a Brent Medicines Optimisation Strategy and work with local providers for a strategy across the local health economy</td>
</tr>
<tr>
<td><strong>Prescribing QIPP Plan</strong></td>
</tr>
<tr>
<td>• GP Prescribing QIPP Plan developed and in process of implementation</td>
</tr>
<tr>
<td>• Primary care rebate schemes explored to increase value for money for drugs prescribed in primary care</td>
</tr>
<tr>
<td>• Implement the Brent Medicines Optimisation Strategy across the local health economy</td>
</tr>
<tr>
<td>• Continue implementation of the Brent Medicines Optimisation Strategy across the local health economy</td>
</tr>
<tr>
<td>• Implement 17/18 GP Prescribing QIPP Plan</td>
</tr>
<tr>
<td>• Develop 18/18 GP Prescribing QIPP Plan</td>
</tr>
<tr>
<td>• Develop and implement annual GP Prescribing QIPP Plans</td>
</tr>
</tbody>
</table>

### Key outcome indicators (including targets)

- Prescribing QIPP Plan delivered

### Delivery mechanism / reporting structure

- Brent CCG Governing Body/Executive
- Provider Drug & Therapeutic Committees
- Brent Medicines Management Committee

**Reference strategy/plan documents:** Prescribing QIPP Plans
### 3.2 LTCs and Community:

#### 3.2.1 Long-Term Condition Management

**NWL STP Priority:** reduce unwarranted variation in the management of LTCs – diabetes, cardiovascular and respiratory disease

**Our to-be:** Care for people with long term conditions is proactive and coordinated and people are supported to care for themselves

<table>
<thead>
<tr>
<th>5 year plan for Long Term Condition Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-care/self-management will be integral to all pathways, and mental health will be embedded with physical health in all pathways. Note that IAPT is working with LTC physical health providers to ensure patients and carers are aware of mental health support.</td>
</tr>
</tbody>
</table>

**Key workstream – Diabetes pathway**

In 2013/14, 8.2% of people on GP lists in Brent CCG were recorded as having diabetes (23,079 recorded cases). Over the same period, the comparable figure for England was 6.2%15. The prevalence of diabetes is predicted to rise in the future, due to ageing of the 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).

Health and social care will collaborate with patients, carers, voluntary and 3rd sector organisations to support self-care and self-management for people with diabetes (including more service provision in different languages). Brent will develop an integrated care pathway across community and acute services, spanning health and social care provision. This will build on the re-launched Community Diabetes pathway (from 15/16), which Brent would now like to, working collaboratively with providers, integrate with the acute Diabetes pathway.

**Key workstream – Atrial Fibrillation management**

The CCG will improve the identification and management of patients with AF – the ultimate approach may include a screening programme – in order to reduce variation and improve the identification and management of patients with AF at high risk of stroke, and thereby reduce stroke and stroke-related mortality.

**Key workstream – Enhanced Community Respiratory Service**

Brent CCG will introduce a new enhanced service better able to meet the needs of the population of Brent by providing care in a community network setting, with less reliance on secondary care and ultimately providing a safe service for patients initiated on high risk drugs. The enhanced service will involve closer links to primary care networks, as well as a great emphasis on training and supporting practices in the diagnosis and treatment of COPD within an overall enhanced service. In addition, awareness initiatives targeting populations identified as most at risk of COPD, which focus on early diagnosis and intervention, could have a significant impact.

**Key workstream – Personal Health Budgets (see section 3.8)**

Patients living with one or more long-term conditions and also children with special educational needs will have the opportunity to have a PHB. A local offer for PHBs is under development by the Brent, Harrow and Hillingdon Continuing HealthCare team which with plans for implementation also underway. During 2016/17 a three year plan to expand the take-up of PHBs will be developed and this will include joint PHBs and Direct Payments.

**Key workstream – WSIC (see section 3.10, New models of care)**

The Whole Systems Integrated Care (WSIC) project oversees GP-led care planning and case management of adults with LTCs. See section 10 for further detail.

**Key workstream – Right Care**

The aim of the RightCare movement is to maximise the value that the patient derives from their own care and treatment and that the whole population derives from the investment in their healthcare. The BHH CCGs have agreed to work together to realise opportunities identified within the RightCare Programme and will selectively use the tools and approaches proposed by RightCare. Brent has been selected as part of Wave 1 of the NHS RightCare Programme. The areas that BHH will progress in the ‘First Wave’ will be Diabetes and MSK, with a particular focus on the NHS Prevention Agenda. It is planned that Respiratory and Cancer will be progressed as a ‘Second Wave’ in the near future.
### Key changes by workstream / area of work

<table>
<thead>
<tr>
<th>Long Term Conditions</th>
<th>16/17</th>
<th>17/18</th>
<th>2018/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Integrate community and acute diabetes pathways into a single health &amp; care diabetes pathway</td>
<td>• Develop a strategy/clinical pathway for the management of hypertension ensuring alignment with Stroke services</td>
<td>• Right Care: implement identified opportunities for Cancer and Respiratory Care</td>
</tr>
<tr>
<td></td>
<td>• Increase AF training for Primary Care practitioners, and review &amp; treatment of existing AF patients</td>
<td>• Right Care: implement identified opportunities for Diabetes and MSK. Identify opportunities for Cancer and Respiratory Care</td>
<td>• PHBs: 359 – 717 new PHBs will be achieved by 2020</td>
</tr>
<tr>
<td></td>
<td>• Explore the use of tele-medicine to support the management of LTCs – complete an impact analysis</td>
<td></td>
<td>• WSIC: ACP delivering at scale to standardise management of LTCs</td>
</tr>
<tr>
<td></td>
<td>• Commission new Respiratory Service, including Home Care, a comprehensive Pulmonary Rehab service, a Home Oxygen and Review Service, and up-skilling in Primary Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Right Care: identify whole system QIPP Efficiency &amp; Quality programmes for 17/18 and beyond, with a specific focus on the NHS Prevention Agenda.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Personal Health Budgets (PHBs): develop a three year plan to expand the take-up of PHBs, including joint PHBs and Direct Payments.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Key outcome indicators/targets

- A reported improvement on the applicable treatment target achievement rates from 2013-2015 reported by National Diabetes audit – i.e. diabetes patients that have achieved all the NICE-recommended treatment targets: 3(HbA1c, cholesterol and blood pressure) for adults and 1 (HbA1c) for children (based on NDA)
  - Baseline: 39.8% (2014/15, NWL STP Data pack)
- Number of Personal Health Budgets (PHBs) in use: 359 – 717 new PHBs will be achieved by 2020
- Premature mortality from stroke:
  - Baseline: 22.4 (2014, NWL STP Data pack)

### Delivery mechanism / reporting structure

- CCG Executive/GB
- Diabetes Working Group
- BHH Right Care

Steering Groups will be set up for the various clinical work-streams for e.g. Respiratory, Diabetes

### Reference strategy/plan documents

- CCG Portfolio Roadmap (Dec 2015); Enhanced Respiratory Service Business Case (2016)
3.2 LTCs and Community:

3.2.2 End of Life Care

**NWL STP Priority:** improve the overall quality of life for people in their last phase of life and enable them to die in their place of choice  
**Our to-be:** People are supported with compassion in their last phase of life

### 5 year plan for End of Life Care

#### Introduction

Phase 1 of the Local Services Last Phase of Life programme will focus on the following interventions for the NW London system on 16/17:

- Improve identification of patients entering their last phase of life
- Increase care planning for patients in the last phase of life, to include all aspects of care, medical, social, religious
- Facilitate access to advice (generalist and specialist), 24 hours a day
- Commission and provide Training and Education – consistent and sustained, for care home and other health care professionals
- Enhance nursing support in the community
- Extending the role of pharmacy in care homes

The majority of these are being implemented in Brent through the Clinical Services for Care Home and High Risk Housebound and the Acute CQUIN.

#### Key workstream – Integrated Care Pathway & Acute CQUIN

Develop and implement an integrated care pathway, i.e. one in which a single provider is responsible for delivery of services across the pathway. The delivery of this pathway may be supported through a range of commissioning options, depending on the outcomes of design discussions with providers. This lead provider approach will support patients and their families to access care and to die in the preferred place, and to receive a more seamless service across providers. In the future this Lead Provider model may include the implementation of a single point of access for EOL care.

The acute CQUIN in 2016/17 asks that where a patient is admitted and is identified as being an End of Life patient and is not on an End of Life pathway, the Trust will:

- Put the patient on an End of Life pathway

#### Key workstream – develop shared EOLC strategy

In 16/17 the STARRS Nursing Home support team 3 month pilot project led by STARRS Brent will target the two Nursing Homes who have had the most ambulance call outs, providing them with intensive support, in order to reduce LAS call outs and hospital admissions. Learning from this pilot will support future EOLC strategy development.

#### Key workstream – Clinical Service for Care Home and High Risk Housebound

One of the aims of the service is to deliver the Gold Standards Framework Care Homes (GSFCH) for End of Life. The provider will carry out a fortnightly review of patients in the last phase of life. The provider will ensure that patients are supported to die in a dignified manner in a setting of their choice. In a small number of cases Subcutaneous Hydration may be considered for patients on an end of life pathway. Advance Care Planning (ACP) is of particular relevance in care homes as half of care home residents die within approximately 1.5 years after admission.
### 3.2 LTCs and Community:
#### 3.2.2 End of Life Care (cont.)

#### Key changes by workstream / area of work

<table>
<thead>
<tr>
<th>16/17</th>
<th>17/18</th>
<th>2018/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EOLC</strong></td>
<td><strong>Update Brent's EOLC strategy, including localising the national EOLC strategy - may include a single point of access for EOLC</strong></td>
<td><strong>Continue implementation of the Brent EOLC Strategy</strong></td>
</tr>
<tr>
<td>• Develop and implement integrated Lead Provider EOLC pathway</td>
<td>• Review Year 1 outcomes of Clinical Service to Care Homes and revise approach as required</td>
<td></td>
</tr>
<tr>
<td>• Develop an Information and Advice Strategy around End of Life Care (Council)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Roll out newly commissioned Care Home &amp; High Risk Housebound service through networks for all NH, RH and housebound patients registered with Brent GP practices</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Monitor progress against Acute EOLC CQUIN</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Key outcome indicators/targets

<table>
<thead>
<tr>
<th>% of deaths which take place in hospital:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Baseline: 58.2% (Q1 2015/16, NWL STP Data pack)</td>
</tr>
</tbody>
</table>

#### Delivery mechanism / reporting structure

<table>
<thead>
<tr>
<th>EOLC:</th>
<th>Clinical Service to Care Homes &amp; Housebound:</th>
</tr>
</thead>
<tbody>
<tr>
<td>NWL Local Services Programme Executive</td>
<td>Primary Care Transformation Board</td>
</tr>
<tr>
<td>Brent EOLC Working Group</td>
<td></td>
</tr>
</tbody>
</table>

*The existing Brent CCG working group membership will be extended to include providers & Council*

---

**Reference strategy/plan documents:** *Care Home specification (November 2015); NHS_Brent_EOL_Strategy Final 2010 – 2014; CQUIN documentation*
3.2 LTCs and Community:

3.2.3 Cancer

NWL STP Priority: reduce health inequalities and disparity in outcomes for the top 3 killers: cancer, heart disease and respiratory illness

Our to-be: people with cancer, heart disease or respiratory illness consistently experience high quality care with great clinical outcomes, in line with Achieving World-Class Cancer Outcomes

Healthy London Partnerships – vision for cancer

All Londoners should be able to access the best cancer care in the world

Our vision: We want to make more Londoners more aware of signs and symptoms of cancer. We strive for early diagnosis, subsequent care and treatment, delivered promptly and locally where clinically appropriate and consolidated into centres of excellence where this will improve outcomes. Experience will be positive throughout a patient’s journey including optimal support to live well following active treatment, and patients will receive support in line with their choices at the end of life.

5 year plan for Cancer

Introduction

Cancer remains the leading cause of premature death across the capital. A thousand lives could be saved every year if London’s cancer survival rates matched the best in Europe. Earlier diagnosis is key to improving survival rates but there is also variation in access to and outcomes from the capital’s cancer services. The Five Year Forward View calls for improved survival through early diagnosis and high quality treatment in centres of excellence.

While a London Cancer Commissioning Strategy is in place, along with a local Acute improvement plan, the NW London and Brent Cancer strategies and/or implementation plans are not yet developed. Effective links between Brent and the London Transforming Cancer Services programme are not yet in place.

Key workstream – Five Year Cancer Commissioning Strategy for London

The Transforming Cancer Services programme was set up in April 2014 and will support accelerated delivery of the Five Year Cancer Commissioning Strategy for London and focusses on four key areas:

1. Improving early detection and awareness
2. Developing centres of excellence and reducing variations in quality and experience
3. Living with and beyond cancer
4. Supporting commissioning and contracting

Brent will work with local partners and NW London to develop a cancer strategy and implementation plan, building on the Five Year Cancer Commissioning Strategy for London.

Key workstream – LNWHT Cancer Services Improvement Plan

Clarify issues with the non-compliance with the 62 day performance standard and develop a recovery plan to support sustainable delivery in 16/17, including:

- Establish substantive for cancer services across merged Trust
- Establish an effective structure of the MDT administration team
- Introduce an effective cancer management database
- Ensure there is timely access and reporting of investigations.
- Reduce administrative delays - PTL tracking
- Standardise and strengthen pathways across Brain, Skin, Head & Neck, Lung, Urology, Haematology, Gynaecology, Endoscopy, Colorectal.
### Key changes by workstream / area of work

<table>
<thead>
<tr>
<th>16/17</th>
<th>17/18</th>
<th>2018/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cancer (acute)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implement the LNWHT Cancer Services Improvement Plan 2016/7, including:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Introduce an effective cancer management database</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Ensure there is timely access and reporting of investigations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Reduce administrative delays - PTL tracking</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Standardise and strengthen pathways</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cancer (whole system)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Develop a Brent cancer strategy and implementation plan, building on the Five Year Cancer Commissioning Strategy for London</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Implement the Brent Cancer Strategy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Right Care: identify opportunities for Cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Implement the Brent Cancer Strategy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Right Care: implement identified opportunities for Cancer</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Key outcome indicators/targets

- People with urgent referral having 1st definitive treatment for cancer within 62 days of referral:
  - Baseline: 81.5% (2015/16 Q3, NWL STP Data pack)
- One-year survival from all cancers:
  - Baseline: 71% (2013, NWL STP Data pack)
- Cancer patient experience:
  - Baseline: 0.81 (2014, NWL STP Data pack)

### Delivery mechanism / reporting structure

**LNWHT Cancer Services Improvement Plan:**

- LNWHT Performance & Contracting Exec
- LNWHT Clinical Quality Group (CQG)

**Reference strategy/plan documents:**

*Five Year Cancer Commissioning Strategy for London (April 2014); LNWHT Cancer Services Improvement Plan 2016/17*
3.2 LTCs and Community:

3.2.4 Other

Our to-be – Vision for 2020 (Community): **Patients hold own notes; Urgent care – better solution in Primary Care; LTC - you will be looked after better to avoid hospital – you look after yourself; better more, coordinated care closer to home; GP is not the only port of care for navigation**

<table>
<thead>
<tr>
<th>5 year plan for Community Services</th>
</tr>
</thead>
</table>

**Key workstream – Falls Prevention & Bone Health Service**

Falls are the most frequent and serious type of accident in the over 65’s, and Brent has a large and growing population of over 65s. These falls result from a combination of risk factors, many of which can be reduced. Brent will create a robust pathway for patients who have fallen or are at risk of a fall, reducing the number of hip fracture, fall or fragility fracture operations. The objective is to implement a new falls management service to patients registered with a Brent practice to deliver falls clinics, classes, education and bone health advice to prevent further increases in the number of falls and fractures that occur in the borough. The new service will expand a community offer to deliver 2 falls clinics per week in Brent and 4 falls classes across our locality areas.

**Key workstream – Falls Care Bundle Pilot**

The pilot will strategically focus on older adults and those with long term conditions (LTC’s), a defined cohort of individuals that evidence based research suggests are at a higher risk of suffering a fall. To support and maintain their health and well-being in their own home environment it is proposed to use interventions such as self-care, risk stratification, falls avoidance techniques and an educational program. Using LWNHT’s experience of delivering falls prevention within the acute setting (including the reporting techniques already developed) an opportunity exists to leverage this knowledge and pilot a care bundle within the community to ensure a quality Falls provision. The Falls prevention pilot aims to reduce falls and falls-related injuries in the older population of Brent by targeting those at high risk. The CCG and LWNHT are currently mobilising the pilot in three nursing homes to commence in the coming months.

**Key workstream – Early Supported Discharge**

Brent CCG commissioned an Early Supported Discharge (ESD) service for Brent registered patients that began operations on 1 September 2015. The purpose of this new 7-day a week service is to provide bespoke therapy and treatment by a multi-disciplinary team in patient’s homes rather than in the hospital setting. The Stroke ESD service provides proactive case management for stroke patients, delivering coordinated care immediately after discharge from hospital up to a period of 6 weeks. It includes physiotherapy, speech and language therapy, occupational therapy, nursing, dietetics advice and psychological support.

**Key workstream – Community Services Review**

Strong community health services are essential to ensuring system sustainability and the most effective use of health and social care resources. In 2016/17 Brent will review current community service provision and compete an options appraisal to determine how to secure integration within our community services provision over the next five years.

**Key workstream – Out of Hospital Strategy**

The CCG commissioned a community Cardiology service and Ophthalmology service that commenced operations in 2015 , as part of Brent’s Out of Hospital Strategy. Consolidation of these services in 2016/17 will include: delivery of full contract volumes; reconciliation of community activity with identifiable areas of acute outpatients, including diagnostics; impact of LNWHT Direct Access Service (Cardiology); move to direct listing for both Moorfields and LNWHT (CMH (Ophthalmology); and implementation of Brent Referral Optimisation Scheme (ROS). Brent is also developing a Consultant-led community-based Dermatology service.

**Key workstream – Out of Hospital LIS**

At the beginning of 2014 the previous Local Enhanced Schemes for Out of Hospital care were transferred to Local Improvement Schemes (LIS) in line with the changes to regulations. Remaining LIS schemes in Brent are: Carers (maintaining a register of Carers); Zoladex administration; Insulin initiation; and Cardiology. The effectiveness of these will be reviewed, and opportunities to provide on a network basis (rather than individual GP practices) will be explored. The network based Phlebotomy service is commissioned for three years until 31 October 2017, which allows a patient registered at any GP practice in Brent to access this service across Brent, which is not restricted to a particular network.
### 3.2 LTCs and Community:
#### 3.2.4 Other (cont.)

#### Key changes by workstream / area of work

<table>
<thead>
<tr>
<th>16/17</th>
<th>17/18</th>
<th>2018/2021</th>
</tr>
</thead>
</table>
| **Falls Prevention & Early Supported Discharge** | • Implement a Falls Prevention & Bone Health Service  
• Pilot a care bundle within the community to ensure a quality Falls provision (in 3 nursing homes)  
• Complete the Stroke ESD pilot | • Review outcomes and learning from 16/17 and strengthen Falls services accordingly  
• Review outcomes and learning from 16/17 and strengthen the Stroke ESD services accordingly |  |
| **Out of Hospital** | • Develop and implement a Consultant-led community based Dermatology service at LNWHT  
• Implement Pathology service changes  
• Move to full contract delivery for the Community Cardiology and the Community Ophthalmology services  
• Review remaining 4 LIS scheme effectiveness and update as required | • Review outcomes of Phlebotomy service and take decision regarding the future of the service |  |
| **Community Services Review** | • Undertake an options appraisal and develop business cases to secure more integrated models of care | • Implement preferred option for community services arising from the review |  |

#### Key outcome indicators/targets

- Number of falls in nursing homes:
  - Baseline: 85 (2015/16, LAS data)
- Number of readmissions for stroke patients within 90 days of discharge from hospital/rehab units
- Referrals to acute providers for Cardiology & Ophthalmology care

#### Delivery mechanism / reporting structure

- **Out of Hospital:**
  - LNWHT Clinical Quality Group (CQG)
  - LNWHT Performance & Contracting Exec
  - Primary Care Transformation Board
  - As required

- **Falls:**
  - As required

---

**Reference strategy/plan documents:** Community Falls Prevention – Procurement Briefing; Falls Management Service – Delivery Plan v6; OOH scheme review June 2016; Scope of Community Nursing Review

---

**Working draft**
3.3 Mental Health:

3.3.1 Mental Health & Dementia

Brent will commission a comprehensive, cradle to grave, mental health service which will provide care in an integrated and coordinated manner. This will includes providing early interventions for those with mental health problems, and providing people recovering from illness with meaningful employment and secure housing.

Key areas of work – ‘Like Minded’

Brent has worked with NWL colleagues to develop a Mental Health strategy for working age adults, ‘Like Minded’, which has four key workstreams:

1. Well-being and prevention (links to section 2.1)
2. Serious and Long Term mental health needs: implement a new model of care to improve physical and mental health, and increase life expectancy
3. Common mental health needs (the focus of this workstream is still being scoped)
4. Children and Young People (see section 2.4) - CAMHS

Additional areas of joint work include:

- Implementation of the new Urgent Care and Assessment pathway, including the CNWL SPA, to deliver the ‘Crisis Care Concordat’
- Perinatal service redesign (as part of the CYP Mental Health Transformation Plan)

Key areas of work – local to Brent

Brent’s strategy to improve patient experience, quality of care and cost-effectiveness also includes:

- Shifting Settings of Care: shifting patients, where appropriate from inpatient to community services, and other patients from community to primary care services.

5 year plan for Mental Health & Dementia

Key areas of work – Dementia

Brent intends to become a ‘Dementia-friendly borough’. In 16/17, Community Action on Dementia (CAD) Brent is running two pilot projects with the Innovation Unit: Peer Support and ‘A whole street of support’ approach – focussing on a small area initially to test ideas (prototypes) for engaging with and mobilising the community to take action to make their community more dementia friendly. Review of the CAD-Brent pilots will inform future plans for improving support for those living with dementia.

The recognition process for dementia-friendly communities is designed to enable communities to be publicly recognised for their work towards becoming dementia-friendly. The foundation stage of the process was built around seven foundation criteria which were developed around what is important to people affected by dementia and their carers.

Working draft
3.3 Mental Health:
3.3.1 Mental Health & Dementia (cont.)

**Key changes by workstream / area of work**

**Like-Minded**
- Establish SPA (telephone advice & referral)
- Implement Rapid Response Team for out of hours assessment & treatment
- Community Psychology: reshape psychology and psychotherapy care for personality disorder & psychosis
- Improve experience and safety on ward; reduce LoS
- Expand reach of mental health resilience & self-care support through IAPT; move to sustainable provision
- Improve and sustain mental health input in A&E

**Shifting Settings of Care**
- Reduce reliance on inpatient care for triage
- Depot: implement primary-care based psychosis care
- Commission peer support
- Direct payments - easier payment system & devt. of personal care assistant small business market
- Incorporate access to IAPT into WSIC
- Increase step-down accommodation

**Dementia**
- Primary-care based dementia care as part of WSIC
- CNWL looking at team redesign following changes to Memory Clinic in 2016/17
- Community Action Dementia and Innovation Unit pilots in 2016/17 (Dementia Friendly Streets; Peer Supporters)

**Outcome measures / targets**
- ‘No health without mental health’ Mental Health Dashboard
- Life expectancy of people with serious and long term mental health needs have a life expectancy 20 years less than the average and the number of people in this group in NW London is double the national average.

**Delivery mechanism / reporting structure**

- NWL Mental Health & Well-Being Transformation Board
- Brent Health & Well-Being Board
- Brent Mental Health Board
- Brent Adult Mental Health & LD Strategy Planning Group
- Community Action on Dementia

Reference strategy/plan documents: CCG Portfolio Roadmap (Dec 2015); Brent Health & Well-Being Strategy (2015-2017); Liked-Minded strategy
3.3 Mental Health:

3.3.2 Learning Disabilities

North West London’s vision

Our vision is that in NWL, people with a learning disability and/or autism and their families will be able to say:

- “I manage my health with the level and quality of support that I need”
- “I have choice and control”
- “I am part of a community”
- “I direct my care”
- “I have a home I can call my own”

5 year plan for Learning Disabilities

Key areas of work – NWL Transforming Care Partnership (TCP)

An all ages plan to address the needs of people who have a learning disability (LD) and/or autism spectrum disorder - workstreams include:

- Pathways and protocols: develop clear service user pathways and protocols for transfer between services to reduce hand offs, share information (with consent) and provide a seamless journey
- Estates: address the challenges with limited estate and high costs unique to London
- Specification of existing services: update specifications to ensure clarity of existing offer and that this meets the needs of service users
- Workforce and market development
- Green Light: ensure that people with a learning disability and/or autism are able to access mainstream mental health services
- Blue Light protocol: register for people with learning disabilities/autism at risk of inpatient admission. Help to identify barriers to supporting the individual to remain in the community.

Key areas of work – Brent TCP Plan (aspirations for 18/19)

Improved Quality of Care

- To implement a borough-wide Learning Disabilities Strategy across Brent and development of joint commissioning plans, including for CYP
- To integrate health and social care provision and improve the quality of the care offered to those who present with behaviours that is challenging and/or complex, including ensuring all those who meet criteria for CPA are cared for within this framework
- To increase Health Actions Plans and support people with a Learning Disability to have Annual Health Checks

Improved quality of life

- To roll out self-care management strategies
- To provide suitable, local accommodation and support, continuing to take forward the Winterbourne work
- To support individuals to remain in their own homes with care and support packages as far as possible
- To increase access and use of Personal Health Budgets and direct payments for individuals with a Learning Disability
- Enable people to be part of a community with increased access to employment, volunteering opportunities and leisure activities

Reduced reliance on inpatient services

- To reduce reliance on inpatient care and increase support for people in primary care and community settings
- To improve access to community and primary care support and to mainstream health services for people with a Learning Disability

Reduced reliance on residential and nursing care provision - see NAIL.

Key areas of work – NAIL

The LA NAIL (New Accommodation for Independent Living) programme has a target to develop 172 new supported living placements in Brent for people with a learning disability. The aim is to divert people who may have previously been placed in a care home in new accommodation with tailored support to meet their individual needs in the community. We are also working with people who are currently in a care home environment both in borough and out of borough to return to Brent in accommodation that meet their needs in the community.
### 3.3 Mental Health:

#### 3.3.2 Learning Disabilities (cont.)

<table>
<thead>
<tr>
<th>Key changes by workstream / area of work</th>
<th>16/17</th>
<th>17/18</th>
<th>2018/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Brent TCP and NAIL</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Integrate the health &amp; social care Community Learning Disability teams</td>
<td></td>
<td></td>
<td>Learning disability integrated team – Integration scope and age range to be agreed. Look for new model in place by 2018/19.</td>
</tr>
<tr>
<td>• Develop crisis provision and community forensic services for people with learning disabilities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Explore feasibility of s75 partnership agreement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Develop a joint strategic plan for Learning Disabilities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Deregister some care home provision and remodel the service as supported living provision</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Develop an all-ages learning disability register – Blue light protocol</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Developing a transitioning protocol with the Transitions Team who currently sits in ASC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>NWL TCP</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Single CTR process in place across NWL</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Green List toolkit rolled out to mainstream providers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Kingswood Service spec updated</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Community LD service core spec developed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Consistent transition protocol developed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Workforce education and devt. plan developed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Kingswood Service specification rolled out</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Community LD Service specification rolled out</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Consistent transition protocol rolled out</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Workforce education &amp; devt. plan implemented</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Outcome measures / targets

- To monitor quality of care: we are supporting the development of a basket of indicators; exploring how to measure progress in uptake of personal budgets (including direct payments), personal health budgets and, where appropriate, integrated budgets; and strongly support the use of quality checker schemes and Always Events
- To monitor quality of life: Health Equality Framework
- To monitor reduced reliance on inpatient services: Assuring Transformation data set

### Delivery mechanism / reporting structure

#### Brent:

- Learning Disabilities Partnership Board (BLDPB)
- Health Action Group
- Transforming Care Task & Finish Group

#### NWL London:

- NWL MH & Well-Being Transformation Board
- NWL Transforming Care Partnership Board

---

Reference strategy documents: *Transforming Care Planning NWL March 2016 04 01; TCP Local Annex BRENT – 7th April 2016; A Strategy for Adults with Autism in Brent 2011-2014; Brent Market Position Paper*
3.4 Urgent and Emergency Care:

3.4.1 Urgent Care

NWL STP Priority: ensure people have access to the right care at the right place at the right time

Our to-be: GP, community and social care is a high quality and easily accessible, including through NHS 111, and in line with the Urgent Care Strategy

Brent Integrated Urgent Care Working Group – Terms of Reference

Develop an improved configuration of services, to maximise potential for:

- An improved experience for patients
- Greater integration of services, where recommended
- Avoidance of duplication
- Improved communication between services
- Greater mutual responsibility and accountability between services

5 year plan for Urgent Care

Through the NWL Acute Reconfiguration programme, those with more serious or life-threatening emergency care needs, will receive treatment in centres with the best expertise and facilities to maximise the chances of survival and good recovery (i.e. at one of 5 Major Hospitals in NWL). For Brent, the most significant Major Hospital will be Northwick Park Hospital.

Key workstream – shape of face-to-face services

Brent’s further plans for face-to-face urgent care services include:

- The Urgent Care Centre at CMH to remain a 24/7 open access facility
- The GP Access Walk-in Centre at Chaplin Road, Wembley will be re-specified and commissioned as an urgent scheduled primary care facility, but with a remaining capability to treat walk-in patients
- The current configuration of GP Access hubs will be rationalised to up to three primary-care led urgent scheduled care facilities, integrated with the BHH-wide urgent care configuration
- The number and location of the primary-care urgent unscheduled care facilities will be determined by the IUC working group

St Mary’s UCC Procurement is also taking place in 2016/17.

Key workstream – NHS 111 and CAATS procurement

Brent is working on a pan-NWL basis to re-procure its NHS 111 contract. In the future contract, NHS 111 will do the call-handling, but a local ‘CAAT’ service, a clinician-led assessment and triage service that bypasses 111 from 2017/18 onwards, will do the assessment, triage and sign-posting. This will provide a single entry point for patients with an urgent care need – through NHS 111 – to be able to access to network system of integrated care services where organisations collaborate to deliver high quality, clinical assessment, advice and treatment. The service will also be accessible by health professionals in the community and within the acute sector (if required) so that no decision needs to be taken in isolation. Patients requiring urgent help will access this through their GP but when their practice is closed, NHS 111 will be the primary route to UC services.

Key workstream – London Ambulance Service (LAS)

A joint London wide strategy for the ambulance service will be developed on behalf of UEC networks, LAS commissioners and LAS provider. Like STPs, this will be a five-year view of transformation that also includes immediate actions. It will be based on the following key transformation themes:

- Collective responsibility across UEC Networks and LAS
- Better integration with 111 (integrated urgent care) and 999
- Consistency across London
- Incentivising out-of-hospital care
- Digital transformation
- The right staff in place and empowered
- Public and staff understanding

Working draft
3.4 Urgent and Emergency Care:

### 3.4.1 Urgent Care (cont.)

#### Key changes by workstream / area of work

<table>
<thead>
<tr>
<th>Workstream/Area of Work</th>
<th>16/17</th>
<th>17/18</th>
<th>2018/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Face-to-face services</strong></td>
<td>Implement the integrated urgent care system face-to-face service changes, including:</td>
<td>• Implement agreed plans for primary care urgent unscheduled care facilities</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• UCC at CMH remains 24/7 open access facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• The GP Access Walk-in Centre at Chaplin Road, Wembley is re-commissioned as an urgent scheduled primary care facility, with a remaining capability to treat walk-in patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Establish future number and location of the primary care urgent unscheduled care facilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• St. Mary's UCC procurement</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>NHS 111 &amp; CAATS</strong></td>
<td>• Current NHS111 contracts expires (end of 2017)</td>
<td>• New NHS 111 service in place across NWL</td>
<td>• Develop a joint London wide strategy for the ambulance service will be developed on behalf of UEC networks, LAS commissioners and LAS provider</td>
</tr>
<tr>
<td></td>
<td>• Establish a Brent-based clinician-led assessment and triage service (CAAT service)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>LAS</strong></td>
<td></td>
<td>• Implement London-wide strategy for the ambulance service locally</td>
<td>• Implement London-wide LAS strategy locally</td>
</tr>
</tbody>
</table>

#### Key outcome indicators/targets

- Ambulance call-outs from:
  - GP Practices
  - Nursing Homes
  - Overall

- Ambulance conveyance rates

- A&E attendances (leading to fewer NEL admissions)

#### Delivery mechanism / reporting structure

<table>
<thead>
<tr>
<th>Workstream/Area of Work</th>
<th>Face-to-face:</th>
<th>NHS 111 &amp; CAATS:</th>
<th>LAS:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>BHH Integrated Care Working Group</td>
<td>NHS 111 Programme Board</td>
<td>LAS Strategic Commissioning Board</td>
</tr>
</tbody>
</table>

**Reference strategy/plan documents:** SaHF DMBC (year); ImBC SOC1 (summer 2016); North West London Integrated Urgent Care Service Specification 2017-2020; LAS Commissioning Strategy Workshop – Draft Report – 23 June 2016; 111 Programme Plan – 11_05_16

**Leads:** Isha Coombes (CCG) & Dr Sami Ansari (CCG)
3.4 Urgent and Emergency Care:

3.4.2 Seven Day Services

Introduction

People who are admitted to hospital in an emergency should receive the same high quality care 7 days a week. Currently, lower staffing levels over the weekend contributes to increases in waiting times and disrupted patient flow.

By 2020, Brent will roll out 7 day hospital services to 100% of the population, so that patients receive the same standards of care in hospitals, seven days a week.

There are three distinct challenges under the banner of seven day services:

• Reducing excess deaths by increasing the level of consultant cover and diagnostic services available in hospitals at weekends. During 16/17, a quarter of the country must be offering four of the ten standards, rising to half of the country by 2018 and complete coverage by 2020;

• Improving access to out of hours care by achieving better integration and redesign of 111 (see Urgent Care section);

• Minor injuries units, urgent care centres and GP out of hours services to enhance the patient offer and flows into hospital (see Urgent Care section); and

• Improving access to primary care at weekends and evenings where patients need it by increasing the capacity and resilience of primary care over the next few years (see Urgent Care & Primary Care sections).

Key workstream – NW London 7 Day Services programme: clinical standards

NW London was awarded “Early Adopter” status by the NHS England/NHSIQ Seven Day Services Improvement Programme in November 2013. In October 2015 NWL then accepted the opportunity as a sector to be a national First Wave Delivery Site for the refreshed 7 day services programme (as launched by the PM at the Conservative Party conference). Workstreams are underway to support all acute providers to meet the 4 priority standards for 16/17. Approaches include the creation of Clinical Implementation Groups (CIGs) within LNHWT.

5 year plan for 7 Day Services

LNWHT and Brent CCG have agreed a Service Development & Improvement Plan (SDIP) to enable the Trust to progress the following standards:

- ** Time to First Consultant Review
- Multi-Disciplinary Assessment
- Shift Handovers
- ** Diagnostics
- ** Interventions
- ** On-Going Review

Note that ** indicates a standard that will be fully met by end of 16/17

The NWL 7 Day Services programme has its own programme plan to support implementation of the required 7 day clinical standards within 16/17. The programme is also supporting the implementation of a single point of access into community health services from 1st May 2016 to facilitate the single needs based assessment process.

NWL STP Priority: improve consistency in patient outcomes and experience regardless of the day of the week that services are accessed

Our to-be: People receive equally high quality and safety care on any day of the week, we save 130 lives per year.
### 3.4 Urgent and Emergency Care:

#### 3.4.2 Seven Day Services (cont.)

**Key changes by workstream / area of work**

<table>
<thead>
<tr>
<th>16/17</th>
<th>17/18</th>
<th>2018/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>10 clinical standards</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Achieve national clinical 7 day standards #2, 5, 6, and 8 at LNWHT:</td>
<td>• Achieve required national clinical 7 day standards for 17/18</td>
<td>• All 7 day standards in place</td>
</tr>
<tr>
<td>o Consultant assessment within 14 hours of admission</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o 7-day access to diagnostics, including reporting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o 7-day access to interventions/key services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Ongoing review (twice daily or daily)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Implementation of a single point of access into community health services from 1st May 2016 to facilitate the single needs based assessment process</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Key outcome indicators/targets**

Outcome indicators are in discussion at the national level – NW London is currently tracking the following metrics associated with 7 day services (at an Acute Trust level):

- LOS by day of admission
- LOS by day of discharge
- # discharges by day of discharge
- Mortality
- Readmission
- Patient Experience (F&F)
- Staff satisfaction

**Reference strategy/plan documents:** *LNWHT (Acute) SDIP 2016-2017 (Final) v.3; 160407 7DS Programme Brief v4.0; 15-12-16 7 Day Services for CCG Governing Bodies draft v2*

**Delivery mechanism / reporting structure**

At Brent level, the 7DS governance is provided by the LNWHT SRG.
3.5 Acute Care:

### 3.5.1 General

**London Northwest Healthcare NHS Trust (LNWHT) vision**

Our vision is to provide excellent clinical care in the right setting by being: Compassionate; Responsive; Innovative

**5 year plan for Acute Care**

These are rolling plans that are regularly updated and reviewed via the LNWHT Systems Resilience Group (SRG).

**Key workstream – Quality Improvement**

The Care Quality Commission (CQC) published its report in June 2016, following a routine inspection of LNWHT, giving the Trust a ‘Requires Improvement’ rating – this will form the basis for developing and implementing an affordable plan to make improvements in quality, including in Critical Care. These areas will be reviewed via the contractual Clinical Quality Group (CQG). Providers, including LNWHT, will participate in the annual publication of avoidable mortality rates by individual trusts.

**Key workstream – Maternity Services**

Maternity services in England must become safer, more personalised, kinder, professional and more family-friendly. The 2016 National Maternity Review recommends seven key priorities to drive improvement including more personalised care (personalised care plan, and trialling an NHS Personal Maternity Care Budget); increased continuity of carer; better postnatal and perinatal mental health care; safer care, with professionals working together across boundaries to ensure rapid referral, and access to the right care in the right place; multi-professional working, breaking down barriers between midwives, obstetricians and other professionals; and new payment mechanism. The Maternity Review also recommends implementation of new guidance to reduce stillbirth rates from 4.7 per thousand to 2.3 per thousand by 2030.

Brent will work with partners in NWL and London (pan-London Maternity Network) to strengthen its maternity pathways, with regular reporting across NWL through a single maternity performance framework and dashboard. This will build on the changes implemented as part of the Acute Reconfiguration.
### 3.5 Acute Care:
#### 3.5.1 General (cont.)

#### Key changes by workstream / area of work

<table>
<thead>
<tr>
<th>Performance &amp; Quality</th>
<th>16/17</th>
<th>17/18</th>
<th>2018/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Establish Brent Referral Optimisation Service (ROS)</td>
<td>• Implement LNWHT transformation programme workstream deliverables</td>
<td>• Implement LNWHT transformation programme workstream deliverables</td>
<td>• Implement LNWHT transformation programme workstream deliverables</td>
</tr>
<tr>
<td>• Implement LNWHT transformation programme workstream deliverables</td>
<td>• Implement Access Target improvement plans</td>
<td>• Implement rolling Access Target improvement plans</td>
<td>• Implement rolling Access Target improvement plans</td>
</tr>
<tr>
<td>• Implement Access Target improvement plans</td>
<td>• Develop Trust Quality improvement plans</td>
<td>• Establish joint QIPP/CIP Delivery Group</td>
<td>• Establish joint QIPP/CIP Delivery Group</td>
</tr>
<tr>
<td>• Establish joint QIPP/CIP Delivery Group</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Maternity

- Strengthen local Maternity pathways and improve performance framework

#### Key outcome indicators/targets

- **Achievement against national access targets:**
  - Referral to Treatment (RTT)
  - Cancer GP 62 Day Referral to Treatment
  - 4 hour A&E standard
  - Diagnostic 6 Week Wait

- **Quality measures: avoidable mortality rates**

- **Women's experience of maternity services:**
  - Baseline: 78.3 (2015, NWL STP Data pack)

- Neonatal & stillbirth per 1,000 births:
  - Baseline: 7.7 (2013, NWL STP Data pack)

Maternity: as per new single NWL Maternity performance framework

#### Delivery mechanism / reporting structure

**Contractual:**
- Performance & Contract Executive (PCE)
- Clinical Quality Group (CQG)
- Finance & Information Group (FIG)
- Joint QIPP/CIPP Delivery Group

**Non-contractual:**
- LNWHT Systems Resilience Group (SRG)
- Elective Operations Group
- NEL Operations Group

### Reference strategy/plan documents
- LNWHT (Acute) SDIP – STF Trajectories; LNWHT (Acute) SDIP 2016-2017 (Final) v.3

---

**Notes:**
- Leads: Huw Wilson-Jones (CCG) and Dr Sami Ansari (CCG)
- NWL DA Area 5: Ensuring we have safe, high quality, sustainable acute services

---

**Working draft**
3.5 Acute Care:

3.5.2 NWL Acute Reconfiguration - redesign of CMH

NWL STP Priority: ensure people have access to the right care at the right place at the right time

Our to-be: GP, community and social care is a high quality and easily accessible, including through NHS 111, and in line with the Urgent Care Strategy

Brent Health & Well-Being Centre at CMH

The clinical principles for the Brent Health & Well-Being Centre at CMH aim to provide:

- A prevention oriented service which enables self-management, providing clear guidance and access to education whenever possible.
- Fast, convenient access to services and treatments, delivered closer to home.
- Responsiveness to long & short term needs with a continuity of care, which manages complex needs and multiple conditions.
- Quality care that addresses the health and disease profile of the population – e.g. higher levels of diabetes, obesity, lung disease and cardiovascular diseases.
- Safe and holistic care through joined-up services: patients know who to contact for help and information is universally accessible.

Introduction

Shaping a Healthier Future (SaHF) is a programme to reshape hospital and out of hospital health and care services in NWL. NWL has a growing and ageing population, and at present, specialist care is too thinly spread over too many sites and some facilities are inadequate. SaHF will require a major shift in care from within a hospital setting to an out-of-hospital setting so more people are treated closer to their homes.

Key workstream – Central Middlesex Hospital (CMH)

Central Middlesex Hospital is a small district general hospital located in Brent in North West London. The hospital site currently operates at an £11.0m deficit each year (forecast to rise to £15.3m) and is a major contributor to the overall deficit for LNWHT.

The services provided at CMH will be redesigned so that Northwick Park becomes the specialised provider of acute services, while CMH is converted to a Local/Elective Hospital, accommodating existing Trust residual services plus receiving the transfer of some elective services from Ealing. These will include outpatient, elective and day case activity; Care of the Elderly/Fractured Neck of Femur; Renal; Phlebotomy; Pathology; and Sexual Health GUM.

In addition, CMH will develop a Health and Well-Being Centre including a GP practice, community outpatients, plus community beds relocated from Willesden and the Regional Genetics Service from Northwick Park Hospital.

The Health & Well-Being Centre will include: Brent re-provisioned Outpatients; Urgent Care Centre; Diagnostics; GP practice; STARRS; Willesden Rehabilitation Beds; Therapies; Community Nursing; Respiratory service; Diabetic eye screening; Podiatry; Diabetic Walk In Centre; Psychiatric liaison service; Social care coordinator; Neuro rehabilitation beds; and Regional rehabilitation unit (RRU).

Responding to the local demography which has resulted in a large care home development in close proximity to the CMH site, consideration is being given to co-locating social care and Frailty Services on the CMH site.

Due to the major financial and quality impact of the redesign of CMH, it is identified as a ‘big ticket’ item for Brent.

5 year plan for the Redesign of CMH – One Public Estate

Working draft
3.5 Acute Care:

3.5.2 NWL Acute Reconfiguration - redesign of CMH (cont.)

### Key changes by workstream / area of work

<table>
<thead>
<tr>
<th></th>
<th>16/17</th>
<th>17/18</th>
<th>2018/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Redesign CMH</td>
<td>• Complete detailed space utilisation of the CMH site</td>
<td>• Progress redesign of CMH</td>
<td>• CMH SaHF must conclude by Nov 2022</td>
</tr>
<tr>
<td></td>
<td>• Progress redesign of CMH</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Complete Outer NWL Strategic Outline Case (SoC)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**NOTE:** while current timescales see the CMH changes concluding by Nov 2022, it is now recognised that this is too slow, as the financial and quality issues associated with the status quo need to be resolved as soon as possible (e.g. to reduce the operating deficit and support the new build for Critical Care required at the Northwick Park site). The SaHF programme has always delineated a central role for the CMH site for Brent patients. The timescales question has been raised with NHS England and will continue to be prioritised.

### Key outcome indicators/targets

- CMH operating deficit:
  - Baseline: £11m per year

### Delivery mechanism / reporting structure

- NWL Hospital Transformation Programme Board
- CMH Local Hospital Transformation Workstream Steering Group
- CMH Elective Transition Workstream Steering Group
- CMH Partnership Board

**Reference strategy/plan documents:** 20141031 Draft CMH Outline Business Case v0.2
3.6 Continuing Care

Core values and principles - NHS Continuing Healthcare Framework

The process of assessment and decision-making should be person-centred. This means placing the individual, their perception of their support needs, and their preferred models of support at the heart of the assessment and care-planning process. When deciding on how their needs are met, the individual's wishes and expectations of how and where the care is delivered, and how their personal information is shared, should be documented and taken into account, along with the risks of different types of provision and fairness of access to resources.

5 year plan for Continuing Care

Introduction

NHS Continuing Healthcare (CHC) is the name given to a package of care that is arranged and funded solely by the NHS for individuals who are not in hospital but have complex ongoing healthcare needs.

If one is eligible for NHS Continuing Healthcare, one can receive NHS continuing healthcare in any setting, for example:

- In one's own home – the NHS will pay for healthcare, such as services from a community nurse or specialist therapist, and personal care, such as help with bathing, dressing and laundry
- In a care home – as well as healthcare and personal care, the NHS will pay for your care home fees, including board and accommodation

Children’s NHS Continuing HealthCare is a process for assessing, deciding and agreeing bespoke continuing care packages for children and young people whose needs cannot be met by existing universal and specialist children's services.

Key areas of work – Retrospective Claims

Previous Un-assessed Packages of Care (PUPoC) and retrospective claims and Appeals.

Key areas of work – Reviews

Reviews of Continuing HealthCare and Funded Nursing Care eligibility at 3 and 12 months. Assessments of eligibility for NHS continuing healthcare and NHS-funded nursing care should be organised so that the individual being assessed and their representative understand the process, and receive advice and information that will maximise their ability to participate in informed decision-making about their future care. Decisions and rationales that relate to eligibility should be transparent from the outset for individuals, carers, family and staff alike.

Key areas of work – Resource management and recovery

Monthly analysis and recovery planning with monthly governance reports to Finance and QIPP Committee and the Quality and Safety Committee (Business as Usual).

Personal Health Budgets and EHC (Education, Health and Care) Plans. Personalisation of healthcare embodies co production. It means individuals working in partnership with their family, carers and professionals to plan, develop and procure the services and support that are appropriate for them. Their development will include ensuring that a patient:

- Is able to choose the health and wellbeing outcomes they want to achieve, in agreement with a health care professional.
- Knows how much money they have for their health care and support.
- Is enabled to create their own care plan, with support if they want it.
- Is able to choose how their budget is held and managed, including the right to ask for a direct payment.
- Is able to spend the money in ways and at times that make sense to them, as agreed in their plan.
## 3.6 Continuing Care (cont.)

### Key changes by workstream / area of work

<table>
<thead>
<tr>
<th>16/17</th>
<th>17/18</th>
<th>2018/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Previous Un-assessed Packages of Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• PUPoC to achieve the NHSE close down trajectory of 30/09/2016</td>
<td>• Monitor guidance from NHSE of any further close down periods for Retrospective Claims</td>
<td>• Monitor guidance from NHSE of any further close down periods for Retrospective Claims</td>
</tr>
<tr>
<td>• Appeals cases to be processed through Local Resolution within 4 weeks on Appeal</td>
<td>• Appeals cases to be processed through Local Resolution within 4 weeks on Appeal</td>
<td>• Appeals cases to be processed through Local Resolution within 4 weeks on Appeal</td>
</tr>
</tbody>
</table>

| **Reviews & Resource management and recovery** | | |
| • Report monitoring of reviews as part of the resource management and recovery plan | • Continue to monitor and report on review activity | • Continue to monitor and report on review activity |
| • Develop business case for resource allocation | | |

| **Personal Health Budgets** | | |
| • My Support Broker pilot implementation and feedback | • Development of a PHB and Integrated Budget Local Offer | • Development of PHB & Integrated Budget Local Offer |
| • Develop a 3 year plan for the expansion of integrated personal health budgets that will ensure the implementation of choice - particularly in maternity, end-of-life, and elective care with the overall aim to empower the patients | | • Achieve Brent aspiration in terms of people in receipt of PHB or Integrated Budget |

### Key outcome indicators (including targets)

- London PHB aspirations for 2020 – Brent aspiration for national objective is a range of 359 – 717 people in receipt of a PHB or Integrated Budget
- No. of PUPoC cases remaining versus trajectory
- Eligibility review KPIs

### Delivery mechanism / reporting structure

- QIPP & Finance Committee
- Quality & Safety Committee

**Reference strategy/plan documents:** n/a but note national guidance and legislation including NHSE Continuing HealthCare Framework 2012 (revised); Care Act 2014; Children and Families Act 2014; Children’s Continuing HealthCare Framework 2016; The NHS Mandate
3.7 New models of care (Brent Better Care Fund)

By 2020… local models of integrated care will be fully implemented and scaled for all population segments and accountable care partnerships will be in place across NWL, accountable for the health of the whole population through outcome based capitated contracts

5 year plan for New Models of Care

Since 2013, NWL has been a national pioneer of integrated care through its Whole Systems programme.

Key workstream – Whole Systems Integrated Care (WSIC)

The WSIC model of care and provider model are designed to improve quality, experience and outcomes for patients with LTCs and their carers whilst reducing costs to the system. The model is designed to support people aged 18 or over with one or more long term conditions who are at risk, in need or unstable. Full implementation of WSIC will require a multi-year transition. In 2016/17 Brent will improve the productivity and efficacy of the WSIC model, increase the capacity and capability within multidisciplinary teams, embed new interventions and roles, and overcome the barriers to integrated working between different professionals, teams and services.

BCF Scheme 1 will build on the work to develop LTC case management with a new contract in 16/17 that focuses on three things:

- Model of care: including dynamic risk stratification and case finding; enhanced care planning, MDT development; and case management
- Effective operating model, including new tools to support assessment of a patient’s ability to self-care and self-manage (PAM).
- Development of provider partnerships: ‘horizontal’ integration across Primary Care and ‘vertical’ integration with other health and care providers as part of a journey towards new provider models.

In 16/17 Brent will move towards an Alliance Agreement, as a step towards the development of fully formed ACPs (capable of holding capitated budgets). In 17/18, Brent will implement an Accountable Care Partnership (ACP) that is built around a registered population, commissioned for outcomes and inclusive of the functions required to deliver those outcomes, and accountable for end-to-end care of the population group. Three data health and social care sharing dashboards have been developed to support the integration of services.

Key workstream – Unified Frailty Model

Brent has identified that the increase in the older population poses a challenge to the health and care system as this population cohort has more complex health and care needs. It has therefore identified the development and implementation of a Unified Frailty Model as a ‘big ticket’ item for Brent over the next five years. This will span the services and pathways that address the needs of this cohort across Brent, including:

- Common standards and specifications, and pooled, shared and rotated resources
- Community-based networks – at scale
- Single, universally accessible assessment
- Cross-professional decision-making, e.g. to assess, treat, admit
- Co-location of services, in particular for most vulnerable/complex, e.g. health & well-being villages

This will require further development of the WSIC model and development of a pathway that cuts across WSIC, Primary Care Transformation, STARRS Rapid Response, provision of acute care (may include the development of a Frailty Unit), and discharge services, amongst others. The next step is to develop a more detailed scoping document for review at the Health & Well-Being Board.
3.7 New models of care *(Brent Better Care Fund)* (cont.)

**Key changes by workstream / area of work**

<table>
<thead>
<tr>
<th>Workstream</th>
<th>16/17</th>
<th>17/18</th>
<th>2018/2021</th>
</tr>
</thead>
</table>
| Whole Systems Integrated Care | • Award a new contract for the case management of people aged 18 or over with one or more long term conditions who are at risk, in need or unstable  
• Develop provider partnerships  
• Move towards an Alliance Agreement  
• Implement PAM (6,000 licenses)  
• Establish Care Navigator role  
• Develop and review 6,000 care plans  
• Support 800-900 patients to be actively case managed  
• Align Adult Social Care and District Nursing teams to GP networks or localities  
• Release and use three data sharing dashboards | • Implement an Accountable Care Partnership |           |
| Unified Frailty Model | • Develop project scoping document |                                                                                   |           |

**Key outcome indicators/targets**

- Non-elective admissions:
  - Target: **109** NEL admissions to be avoided in 16/17 through WSIC
  - ICP/User Satisfaction Survey – positive response to the question “Are you more confident to manage your own health?”
    - Baseline: **72%** in 2014/15

**Delivery mechanism / reporting structure**

- Brent HWBB
- CCG Governing Body
- Brent Integration structure
- Primary Care Transformation Board
- BCF Scheme #1 Steering Group

**Reference strategy/plan documents:** *WSIC-Summary Design_16/17 (Feb 2016); Brent BCF Submission (10 June 2016)*
3.8 Health and social care integration *(Brent Better Care Fund)*

**Brent STP priority: health and social care integration**

**Our to-be:** our systems will enable (and not hinder) the provision of integrated care and funding will flow where it is

---

**Introduction**

There are opportunities to reduce duplication, improve continuity of care, and generally improve the effectiveness and cost-effectiveness of services through the integration of existing but separate health and social care teams that perform similar functions.

Integration and transformation of our system will help us achieve two key objectives: (1) reduce the use of residential care and enable people to remain healthy and independent in the community; and (2) reduce hospital admissions and the length of time people stay in hospital.

**Key workstream – Integrated Rehab & Reablement (BCF 16/17)**

In the current state, if a patient/service user is assessed for a community based reablement service it will be provided by one of over twenty home care providers. There have been recurring issues with providers, and Brent is essentially spending more for services which do not deliver more than is provided by many standard home care providers.

BCF Scheme 2 (16/17) will bring the STARRS reablement team and the Council reablement team together to form one assessment and therapy function. The assessment and therapy service will be a multi-disciplinary team of lead professionals, including social workers, therapists and junior support staff, who will all work with patients to set goals and lead the process. The objective of this integration is to streamline the services that clients receive when exiting hospital and/or while being supported within a community setting. Improved rehab and reablement services will reduce use of residential care and enable people to remain healthy and independent in the community.

**Key workstream – integrated health and social care discharge teams**

*See Length of Stay for further detail.*

**Key workstream – further integration of health and social care teams**

Over the next five years, further opportunities to integrate health and social care teams, processes and funding will be identified, assessed, and implemented. Key examples included:

- Joint Learning Disability commissioning
- Integrate Community Nursing, Social Care and Home Care services, including through single assessment and single care package

The STARRS Rapid Response service will also be expanded in 2016/17.
### 3.8 Health and social care integration (Brent Better Care Fund) (cont.)

#### Key changes by workstream / area of work

<table>
<thead>
<tr>
<th>16/17</th>
<th>17/18</th>
<th>2018/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health &amp; social care integration</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Bring the STARRS reablement team and the Council reablement team together to form one assessment and therapy function</td>
<td>• Review outcomes of the rehab and reablement integration and revise approach as required</td>
<td>• Adopt and implement the learning from Vanguard sites</td>
</tr>
<tr>
<td>• Expand STARRS Rapid Response service</td>
<td>• Develop and test an approach that sees Home Care staff trained and procured to perform some DN tasks, working with a sub-set of Home Care providers from Lot 5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Review the scope of STARRS to include other at risk cohort of patients for e.g. alcohol /substance misuse (where does Rapid Response best fit)</td>
<td></td>
</tr>
</tbody>
</table>

#### Key outcome indicators/targets

- Proportion of older people (65 and over) who are still at home 91 days after discharge from hospital into reablement / rehab services
  - Baseline: 88.6% (2015/16, Brent 2016/17 BCF Submission Planning Template)
  - Target: 92% in 2016/17, and 90% by 2017/18

#### Delivery mechanism / reporting structure

- HWBB
- Brent Integration structure
- BCF Scheme #2 Steering Group

**Reference strategy/plan documents:** Brent BCF Submission (10 June 2016)
3.9 Length of stay (Brent Better Care Fund)

**Brent STP priority: reducing unnecessary time in hospital**

**Our to-be: patients admitted to hospital stay only as long as clinically necessary and do not require unplanned re-admission**

Brent will enable faster and more supportive discharges from hospitals both during and out of the winter period, in order to take the pressure off acute beds. Brent’s Health Partners Forum has emphasised the importance of providing effective support to those discharged to community settings.

**Key workstream – LNWHT initiatives**

LNWHT is implementing a range of initiatives to reduce hospital length of stay, including:

- Expansion of Ambulatory Emergency Care services
- Emergency Pathway: modernisation of planned care service including optimisation of patient flows, standardisation of processes and quality improvement
- Length of Stay (Medicine & Surgery): reduction in LOS through optimisation of care pathways and service models to increase efficiency and productivity
- Frailty model/pathway, including in the Acute

Brent is currently working to localise an NHSE template, ‘Supporting Patients choices to avoid long hospital stays’ for LNWHT - this will be the operational document for all patients regardless of which CCG they belong to. The Trust is also holding weekly multi-agency review sessions for all patients who have stayed 14 days or longer.

**Key workstream – BCF Scheme #3: More effective discharges**

This BCF theme will reduce the negative impacts of the winter period in the Brent health and social care economy by joint commissioning appropriate support in the community and by improving patient flow from hospital into the community and reducing delayed transfers of care. Community based integration initiatives: that will support effective hospital discharge and reduced DTOCs include:

- Step down Beds and supporting team
- Night Sitting Service
- Home from Hospital Service

Hospital-based integration initiatives to facilitate discharge include:

- Support from Housing
- Multi-disciplinary 7 day working, including discharge
- West London Alliance (WLA) integrated discharge initiative (see below)

This set of solutions will enable faster and more supportive discharges from hospitals both during and out of the winter period. Brent will undertake further horizon scanning identify implement further best practice.

**Key workstream – WLA Integrated Discharge Initiative**

Through West London Alliance integrated discharge initiative a single LA will be the lead for each hospital, taking on all discharges for peer borough and following a Discharge to Assess model. The Discharge to Assess model will mean hospitals only have to follow one procedure and each Borough minimises its risk as they get involved as soon as the person is out of hospital to put them into longer term care. Brent will pilot reciprocal social work assessments for hospital discharge in Northwick Park Hospital for Ealing and Tri-borough to support a single approach, one model for Adult Social Care hospital discharge that will be aligned to hospitals across NWL. This will include the co-location of appropriate hospital discharge functions within the hospital setting.

**Key workstream – Out-of-borough discharges (may be part of BCF from 17/18)**

Almost 50% of non-elective admissions are to out-of-borough hospitals; however, the average Length of Stay for out-of-borough NEL admissions is 7.8 days compared to 5.9 days for in-borough discharges. Brent will review in further detail and will sit down with partners to understand constraints and to develop plans to address them. This may also include extending the WLA initiative to non-NWL hospitals, e.g. Royal Free Hospital.

**Key workstream – 7 day Services (see section 3.4.2)**
### 3.9 Length of stay (Brent Better Care Fund) (cont.)

#### Key changes by workstream / area of work

<table>
<thead>
<tr>
<th>Workstream/Area of Work</th>
<th>16/17</th>
<th>17/18</th>
<th>2018/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out of hospital</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Review joint commissioning of community residential and nursing step-down beds and strengthen</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Implement Home from Hospital &amp; Night Sitting Service</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Scope project to reduce out of borough LoS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Year 1 of WLA Integrated D/C initiative</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-hospital</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• LNWHT Emergency Pathway project</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• LNWHT LoS projects (Medicine and Surgery)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Expand Ambulatory Emergency Care services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Localise NHSE template ‘Supporting Patients choices to avoid long hospital stays’ for LNWHT and adopt</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Hold multi-agency ‘multi-agency review for all long stayers’ - weekly review of those with LoS &gt;14 days</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Hospital-based integration initiatives – e.g. extend housing support worker</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Key outcome indicators/targets

- **Delayed Transfers of Care from hospital:**
  - Baseline: 10,085 (BCF submission, 15/16 Q1 – Q3 actual & forecast Q4)
- **Emergency bed days per 1,000 population:**
  - Baseline: 1.02 (Q2 2015/16, NWL STP Data pack)
- **Non-Elective (NEL) Admissions:**
  - Baseline: 36,302 (Total Non-Elective Admissions (Spells) (Total Activity) – CCG 15/16 Forecast outturn)
- **Length of Stay of out-of-borough NEL admissions:**
  - Baseline: 7.8 days
  - Target: 5.9 days

#### Delivery mechanism / reporting structure

- **BCF:** Brent HWBB
- **WLA:** NWL Local Services Executive
  - WLA Partnership Board
  - BCF Scheme #3 Steering Group
  - Hospital Discharge Steering Group
  - LNWHT Systems Resilience Group
  - LNWHT NEL SRG Operations Group

### Reference strategy/plan documents

- Brent Better Care Fund Submission (10 June 2016)
- WLA Hospital Discharge – Overall Programme Tracker – June 2016
- TEMPLATE POLICY (Replacing Discharge Protocol) - v.02
## 3.10 Accommodation-based care (Brent Better Care Fund)

### Brent STP priority: better use of care homes
**Our to-be:** sufficient capacity at a sustainable price delivering high quality proactive care

### Introduction
There are 13 nursing homes with a capacity of approximately 672 nursing beds (January 2015) and 64 homes with a capacity of 623 residential beds in the London Borough of Brent, providing care for people with a range of physical, mental or emotional needs (although only 12 nursing homes provides services to Brent residents).

The nursing care home market does not currently deliver what is required locally in Brent to meet current needs, with issues in terms of nursing home placement availability; the quality of placements available; the cost of placements; lack of appropriately skilled and experienced nurses in the workforce; and a joined up approach to identifying new models of care for the future. Brent CCG also identified significant acute hospital related activity from care homes for conditions which could have been avoided, if good case management, appropriate nursing skills, medicines management and adequate policies, systems and protocols were in place.

**Key workstream – BCF Scheme #4: Better use of Nursing Care Homes**

Brent will establish the following work streams as part of a wider programme of work to develop an integrated approach to commissioning services locally, development of new models, pooled and/or aligned purchasing budgets and integrated brokerage and monitoring resources, ultimately leading to increased user and carer satisfaction with the quality of services:

- Market management
- Joint commissioning – operational and strategic
- Workforce development
- New models of care
- Co-production

### Housebound (over 75’s business case)
Brent is rolling out a newly commissioned Ce Home & High Risk Housebound service through networks for all NH, RH and housebound patients registered with Brent GP practices. It will provide enhanced and dedicated access from 8am-8pm, out of hours service 6pm-8pm. The service will include:

- Development and regular review of care plans jointly with care homes
- Identification of training needs including:
  - Wound care assessment
  - Nutritional support (include kitchen staff)
  - Managing medicines
- Regular meetings with network providers, care homes and Continuing Health care team to help identify issues and monitor progress
- Support from dedicated CCG care home pharmacist to review policies and procedures, standardise medicines management processes, storage and security of medicines and help identify training requirement.

Care homes will be connected to the health and care system, reducing unnecessary hospital admission.

**Key workstream – STARRS Nursing Home support pilot**

In 16/17 the STARRS Nursing Home support team, a 3 month pilot project led by STARRS Brent, will target the two Nursing Homes who have had the most ambulance call outs, providing them with intensive support, in order to reduce LAS call outs and hospital admissions.

Learning from this pilot will also support future EOLC strategy development.

---

**5 year plan for Care Homes**

<table>
<thead>
<tr>
<th>Brent STP priority: better use of care homes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Our to-be:</strong> sufficient capacity at a sustainable price delivering high quality proactive care</td>
</tr>
</tbody>
</table>

**Introduction**

There are 13 nursing homes with a capacity of approximately 672 nursing beds (January 2015) and 64 homes with a capacity of 623 residential beds in the London Borough of Brent, providing care for people with a range of physical, mental or emotional needs (although only 12 nursing homes provides services to Brent residents).

The nursing care home market does not currently deliver what is required locally in Brent to meet current needs, with issues in terms of nursing home placement availability; the quality of placements available; the cost of placements; lack of appropriately skilled and experienced nurses in the workforce; and a joined up approach to identifying new models of care for the future. Brent CCG also identified significant acute hospital related activity from care homes for conditions which could have been avoided, if good case management, appropriate nursing skills, medicines management and adequate policies, systems and protocols were in place.

**Key workstream – BCF Scheme #4: Better use of Nursing Care Homes**

Brent will establish the following work streams as part of a wider programme of work to develop an integrated approach to commissioning services locally, development of new models, pooled and/or aligned purchasing budgets and integrated brokerage and monitoring resources, ultimately leading to increased user and carer satisfaction with the quality of services:

- Market management
- Joint commissioning – operational and strategic
- Workforce development
- New models of care
- Co-production

**Housebound (over 75’s business case)**

Brent is rolling out a newly commissioned Ce Home & High Risk Housebound service through networks for all NH, RH and housebound patients registered with Brent GP practices. It will provide enhanced and dedicated access from 8am-8pm, out of hours service 6pm-8pm. The service will include:

- Development and regular review of care plans jointly with care homes
- Identification of training needs including:
  - Wound care assessment
  - Nutritional support (include kitchen staff)
  - Managing medicines
- Regular meetings with network providers, care homes and Continuing Health care team to help identify issues and monitor progress
- Support from dedicated CCG care home pharmacist to review policies and procedures, standardise medicines management processes, storage and security of medicines and help identify training requirement.

Care homes will be connected to the health and care system, reducing unnecessary hospital admission.

**Key workstream – STARRS Nursing Home support pilot**

In 16/17 the STARRS Nursing Home support team, a 3 month pilot project led by STARRS Brent, will target the two Nursing Homes who have had the most ambulance call outs, providing them with intensive support, in order to reduce LAS call outs and hospital admissions.

Learning from this pilot will also support future EOLC strategy development.
### 3.10 Accommodation-based care (Brent Better Care Fund) (cont.)

#### Key changes by workstream / area of work

<table>
<thead>
<tr>
<th>BCF Scheme #4</th>
<th>16/17</th>
<th>17/18</th>
<th>2018/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Develop a joint market management plan across all partners, including acute and community providers</td>
<td>• Establish an Integrated Quality and Safeguarding Team, focused on developing the quality of care</td>
<td>Implement new models of care, e.g.</td>
<td></td>
</tr>
<tr>
<td>• Develop a joint workforce development plan to identify workforce needs and how best to meet them</td>
<td>• Establish a single discharge &amp; nursing home brokerage function across CCG, Council &amp; LNWHT (scope may be expanded), build on dynamic purchasing system</td>
<td>• Hospital at Home packages integrated with home care</td>
<td></td>
</tr>
<tr>
<td>• Review current services provided to nursing homes across partners</td>
<td>• Implement integrated plan to increase the use of Assistive technology in nursing care settings</td>
<td>• Jointly commissioned nursing care within Extra Care Sheltered Housing</td>
<td></td>
</tr>
<tr>
<td>• Pilot the (increased) use of Assistive technology in nursing homes</td>
<td>• Undertake a feasibility and consultation exercise in relation to building a nursing home locally in Brent and partnering with the market to deliver the service</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clinical Service to Care Home and High Risk Housebound &amp; STARRS pilot</th>
<th>16/17</th>
<th>17/18</th>
<th>2018/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Roll out newly commissioned Care Home &amp; High Risk Housebound service through networks for all NH, RH and housebound patients registered with Brent GP practices</td>
<td>• Review Year 1 outcome and revise approach as required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Pilot intensive support provision from STARRS team to two Nursing Homes &amp; review of outcomes</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Key outcome indicators/targets

- A&E attendances from nursing homes
- NEL admissions from nursing homes
- LAS call-outs from nursing homes
- Number of pressure ulcers developed in nursing placements

### Delivery mechanism / reporting structure

- **BCF:**
  - Brent HWBB
  - Brent Integration structure
  - BCF Scheme #4 Steering Group

- **Care Home Service:**
  - Primary Care Transformation Board

- **STARRS pilot:**
  - LNWHT Performance & Contracting Exec
  - STARRS Steering Implementation Group

#### Reference strategy/plan documents:
- Brent Better Care Fund Submission (10 June 2016)
- Care Home and High Risk Housebound Service Specification (Nov 2015)
- STARRS Brent Nursing Home Support team pilot
3. Care and Quality

3.11 Enablers:

3.11.1 Workforce

Our to-be:
- A growing workforce to meet patient needs; comprised of new staff and a retained and developed existing workforce; whose valuable skills and expertise will be key to delivery of quality improvement in care settings that are closer to home.

5 year plan for Workforce

Workforce is fundamental to the delivery of high quality care and services. Key challenges for Brent and NWL include staff shortages across care settings (including district nursing), and enabling the workforce to deliver new models of care. In addition to local workstreams below, Brent is part of the wider BHH and NWL workforce plans to address workforce shortages, invest in the primary care workforce, and strengthen leadership and organisational development.

Key workstream – Community Practice Education Network (CEPN)

CEPNs are networks of education and service providers based in the community. They are tasked with increasing capacity for future workforce training in the community, and the development of the current and future workforce across Primary and Community Care. 2016/17 plans include: supporting Whole Systems Integrated Care implementation and GP federation development (e.g. through Action Learning Sets for Care Navigators and federation development); expanding the HCA workforce and training to receive Care Certificates; clinical updates and development (e.g. COPD and spirometry workshops); primary care nurse development; management and leadership development; and reception/admin development.

It's not known what HENWL funding will be available for CEPNs after 16/17.

Key workstream – Workforce Planning

A Workforce (WF) Tool has been developed to help understand the current GP workforce and what its needs are, in order to support workforce planning and training and development planning in primary care. Findings from the WT Tool will be used to support the development of Brent’s Workforce & Transformation Plan by early 2017.

Key workstream – Healthy Workplace Charter

The London Healthy Workplace Charter provides a free self-assessment framework. It can be used as a tool to enable employers to benchmark their workplace health and wellbeing initiatives against a set of national standards. Brent Council and CNWL are already signed up to the London Healthy Workplace Charter, while LNHWT has started implementation. Following Commitment-level accreditation in 16/17, the NWL CCGs OD Team will work with individual CCGs to ascertain next steps. Depending on appetite, readiness and capacity, CCGs may start work on their applications for “Achievement” and/or “Excellence” level accreditation.

Key workstream – other partners

LNWHT’s workforce workstreams from 16/17 include Nursing and AHP Modernisation, i.e. the design of new roles and ways of working to support integrated care and new models of care; and an organisational development programme to support post-merger integration and the delivery of the Trust’s strategic priorities.

Key workstream – shared Workforce vision & plan

Brent’s partner organisations currently address workforce challenges individually, but a shared Workforce vision and plan for Brent has been identified as a ‘big ticket’ enabler for the health and care economy. This would be anticipated to include: skills; flexible use of staff across settings of care; workforce planning and career path; multi-disciplinary workforce; and recruitment/retention.

Working together across settings is an ambitious vision and will require significant commitment and will from partner organisations.

Leads: Patricia Whelan-Moss (CCG) & Phil Porter (Council) (tbc)
### 3.11 Enablers:

#### 3.11.1 Workforce (cont.)

**Key changes by workstream / area of work**

<table>
<thead>
<tr>
<th>Training &amp; OD (CEPN &amp; LWNHT workstreams)</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>All HCAs to be trained to level of a Care Certificate for HCAs</td>
<td>Implement 16/17 CEPN investment plan</td>
<td>Continue implementation of the Brent WF &amp; Transformation Plan</td>
<td>Continue development of the GP federation</td>
</tr>
<tr>
<td></td>
<td>LNWHT Nursing &amp; AHP Modernisation workstream</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>LNWHT OD &amp; Workplace development workstream</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Workforce planning</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pilot GP Workforce Tool with one network (3 months)</td>
<td>Roll out GP Workforce Tool</td>
<td>Complete roll out of GP Workforce Tool</td>
<td>Develop a Brent workforce plan based on findings of the workforce tool</td>
</tr>
<tr>
<td></td>
<td>Complete Day of Care audit in general practice</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Healthy Workplace Charter</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CCG to Submit Commitment-level application under the GLA’s London Healthy Workplace Charter framework</td>
<td>Develop CCG, Council &amp; provider workplace health and wellbeing initiatives</td>
<td>Achieve ‘Achievement’ or ‘Excellence’ level accreditation (CCG)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Workforce Strategy</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Develop Brent Workforce &amp; Transformation Plan (by Jan 2017) – start implementation</td>
<td></td>
<td>Develop shared Workforce Vision and Plan for Brent</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Implement actions from Brent Workforce &amp; Transformation Plan</td>
<td></td>
</tr>
</tbody>
</table>

#### Key outcome indicators/targets

- Primary care workforce - GPs and practice nurses per 1,000 population:
  - Baseline: 0.58 (2015, NWL STP Data pack)
- Sickness absence rate:
  - LNWHT: 3% (15/16, NWL STP Data pack)
- Vacancy levels:
  - NHS Trusts
  - Social care organisations
  - Adult nursing

#### Delivery mechanism / reporting structure

- CCG Primary Care Transformation Board (PCTB): Shares learning – every 6 weeks
- BHH Education Forum: Includes education leads from each network
- Brent Community Practice Educator Network

**Reference strategy/plan documents:**

- CEPN Investment Plan 2016 – 2017 Final
- Workplace Health & Well-Being Charter Paper – FINAL
- BHH Workforce Action Plan 2015-17

*Reviewed by Patricia & Cilla*

*Leads: Patricia Whelan-Moss (CCG) & Phil Porter (Council) (tbc)*

**Working draft**
3.11 Enablers:

3.11.2 Local Digital Roadmap

Our to-be:
- Fully digital care and support, integrated health and social care information, right information available in the right place at the right time, paperless services:
  - Integrated health and social care through shared data and whole systems intelligence
  - Remove reliance on paper
  - Involve citizens in their own health through digital empowerment

5 year plan for Digital

The Five Year Forward View made a commitment that, by 2020, there would be "fully interoperable electronic health records so that patients’ records are paperless".

CCGs are charged with leading local health and care systems to produce Local Digital Roadmaps (LDRs), setting out how they will achieve the national ambition of operating Paper-free at the Point of Care by 2020, and also support local strategic objectives. Brent is part of the NWL Local Digital Roadmap.

Strategic NWL Local Digital Roadmap Vision in response to the STP:
- Automate clinical workflows and records, particularly in secondary care settings, and support transfers of care through interoperability, removing the reliance on paper, improving quality
- Build a shared care record across all care settings to deliver the integration of health and care records required to support new models of care, including the transition away from hospital
- Extend patient records to patients and carers, provide them with tools for self-management and self-care, delivering digital empowerment and supporting the shift to new channels of care
- Use real-time data analytics to inform care decisions, and support integrated health and social care across the system through whole systems intelligence.

In addition, the following enabling work streams have been identified:
- IT Infrastructure requirements of new models of care, such as mobile data and wireless networking, and extending the reach of clinical systems to new locations such as care homes
- Completion of the Information Governance mechanisms required to underpin shared care records, building on the existing NW London Information Sharing Protocol and associated Information Sharing Agreements which support direct care, enable new care models and govern patient access, as well as pioneering the secondary use of data.
- Building a Digital Community across the citizens and care professionals of NW London, through communication and education

The most urgent area for investment and transformation through digital technology in NWL is within care organisations, particularly in secondary care (primary care is already largely paper-light) - to replace paper records with digital ones, and achieve the key STP goal to remove reliance on paper. This is the main way in which IT can address the Finance and Efficiency Gap identified in the Five Year Forward View, improving the speed and quality of clinical workflows and reducing duplication of processes.

At a pan-London level, the Healthy London Partnership has created the London Digital Programme - a programme of work which focuses on connecting Londoners and health and care providers to allow for real time access to records and information. According to its vision, this will be achieved by establishing interoperability standards that allow service providers to seamlessly exchange information across a diverse systems landscape: it will develop universal services such as ‘consent’, ‘identify management’ and ‘role-based access controls’ allowing service providers to overcome common issues that have historically acted as a barrier to true interoperability. All 32 CCGs across London have signed up to the London Digital Programme and the NWL footprint intends to link in to the significant capabilities when feasible.
3.11 Enablers:

3.11.2 Local Digital Roadmap (cont.)

Key changes by workstream / area of work

<table>
<thead>
<tr>
<th>Local Digital Roadmap</th>
<th>16/17</th>
<th>17/18</th>
<th>2018/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>All GP orders and results for pathology &amp; radiology diagnostics to be transmitted and read electronically, with a seamless interface to the GP system - LNWHT to deploy ICE for GP radiology requesting in 2016/17</td>
<td>• Continuation Local Authorities likely to implement automated interfaces to CMC once critical mass gained in local CCGs subject to receipt of funding during FY</td>
<td>• Achieve Local Digital Roadmap in Brent, including provider Capability Groups</td>
<td></td>
</tr>
<tr>
<td>Co-design of Integrated Care Planning and shared care records across each care community (Digital CQUIN)</td>
<td>• Implement shared care records and integrated care plans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work with primary and community IT suppliers to start implementation of open interfaces for shared care records</td>
<td>• Enable citizens (patients and other service users, carers) to have access to their care records</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continue work on NHS numbers, shared care records and Adult safeguarding</td>
<td>• Social care able to share patient records to and from healthcare provider</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Commence work on acute transfers</td>
<td>• Data repository and analytical tools to meet the requirements of planning and delivering New Models of Care</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Key outcome indicators/targets

<table>
<thead>
<tr>
<th>Capability Group</th>
<th>Baseline score (Feb 2016)</th>
<th>Target (end 18/19)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Records, assessments &amp; plans</td>
<td>43.4</td>
<td>82.3</td>
</tr>
<tr>
<td>Transfers of care</td>
<td>47.4</td>
<td>84.1</td>
</tr>
<tr>
<td>Orders and results management</td>
<td>56.7</td>
<td>87.6</td>
</tr>
<tr>
<td>Medicines management &amp; optimisation</td>
<td>29.1</td>
<td>70.7</td>
</tr>
<tr>
<td>Decision support</td>
<td>34.9</td>
<td>75.7</td>
</tr>
<tr>
<td>Remote care</td>
<td>35.7</td>
<td>68.3</td>
</tr>
<tr>
<td>Asset and resource optimisation</td>
<td>38.6</td>
<td>77.9</td>
</tr>
</tbody>
</table>

Reference strategy/plan documents: Local Digital Roadmap for NW London
High-level clear narrative on how to tackle the Care & Quality gap

Brent will close its care and quality gap over the next five years, improving the quality of care provided to service users and patients, through its key transformation programmes and service portfolios, including:

- Primary Care Transformation, a key foundation to other changes,
- Brent’s Integration programme (Better Care Fund) – more integrated models of care, centred around GP networks and localities, including community district nursing and social care
- Mental Health and Well-Being Transformation

These and other key plans are reflected in Brent’s vision for Care & Quality in 2021.

Brent’s vision for Care and Quality in 2021:

- An integrated workforce plan is in place to develop skills, enable flexible use of staff across settings of care, improve workforce planning, and support local recruitment and retention, including of local Brent residents.
- Primary care providers are better equipped through a new federation and model of care to provide more care in the community.
- An Accountable Care Partnership will be accountable for the end-to-end care and outcomes of a population group, i.e. people aged 18 or over with one or more long term conditions who are at risk, in need or unstable.
- There will be a concentration of acute hospital services to develop centres of excellence. These will achieve higher clinical standards, including 7 day services, and more efficient care delivery. Central Middlesex will be redesigned as a Health and Well-Being Centre, including urgent care.
- Expanded provision of early interventions for people with mental health problems and reduced reliance on inpatient care.
- An integrated approach to commissioning (and providing) services locally, including Nursing Care Homes, improving quality.
- A unified Frailty and Older People’s Care model will stitch together existing services and models into a single pathway that ensure older people receive high quality and timely acute care and active support to maintain independence.
- Best practice is implemented across all clinical pathways, including the management of long-term conditions.

Brent’s current gaps in terms of achieving its vision for Care & Quality in 2021 and the steps that will be taken to close them include:

- Lack of integrated community nursing & social care plan and packages – Brent will address as part of its Better Care Fund (Health & Social Care Integration theme) in 17/18 onwards
- Lack of joined up approach to End of Life Care (EOLC) strategies locally – Brent will develop a shared EOLC strategy, working with both local and NWL partners
- Lack of plans to address premature CVD mortality and hypertension management – Brent will develop these plans in 2017/18
- Lack of clear shared plan for improving cancer outcomes – Brent will work with London Healthy Partnerships, NW London CCGs, LNWHT, and Primary Care to develop its cancer plan
- Need to ensure that CMH redesign plans will best meet full range of local needs, including of new Extra Care Units – Brent will review membership of the CMH Working Group and adapt as required
- Lack of shared Council, provider and CCG Workforce vision and plan – Brent will develop its shared Workforce vision and plan, line with NW London workforce plans
Section 4 describes how Brent will close its Finance & Efficiency Gap, i.e. the financial impact of the set of planned Health & Well-Being and Care & Quality changes described in the Brent STP.

The approach to achieving financial sustainability will differ for each partner organisation, including:

- Brent CCG
- Brent Council
- Providers

**Sustainability and Transformation Fund (STF):**

NW London have been notified of their indicative recurrent allocations of additional funding from the Sustainability and Transformation Fund (STF) in 2020/21 - this is £147m for NW London. Note that these indicative figures represent the full amount of funding expected to be available to local health systems from all sources in 20/21. They include an indicative fair share of the sustainability funding, primary care access and transformation funds, and other transformation funding, including technology. Potentially there are additional costs relating to the 5YFV policy initiatives for which the NHSE STP template requires estimated quantification. Given the uncertainty, the potential benefit to closing the gap from the STF funding could be within the range of £0m and £147m.

Despite this uncertainty, proposed phasing of funding over the next 5 years in the NW London STP shows a mix of transformation funding and deficit support, with an increasing proportion to transformation funding over time.
A number of analyses have been undertaken to support Brent and NW London to establish the scale of the opportunity to close the finance and efficiency gap through a number of the planned and other changes within the STP. These papers are:

- North West London (Strategy & Transformation) Local Services Transformation (May 2016)
- West London Alliance (WLA) – STP Scale of the Opportunity paper (May 2016)
- Healthy London Partnerships paper – Commissioning for Prevention:
  - North West London SPG (May 2016)
  - NWL ImBC Handover Pack – Brent CCG (NWL QIPP paper with Brent figures) (Jan 2016)

The suggested savings opportunities across all potential schemes have been organised based on the Brent STP sections, and five year savings across each are summarised in the table below (Health & Well-being) and on the following pages (Care & Quality). See Appendix X for available detail in terms of sources, assumptions, etc.

The full range of opportunities suggested by the source documents totals £25.3m over five years (some of which, particularly in the Prevention category, are gross savings), while the CCG’s financial gap is £49.3m. Therefore even if the CCG were to fully realise these opportunities there would remain a gap of £24m.

The CCG has further financial saving opportunities to realise, including:

- Other QIPP schemes (e.g. building on existing schemes)
- The redesign of CMH, which should set the facility on a sustainable financial footing and eliminate the additional payments required to maintain viability

In summary, the CCG will close its financial gap through the effective realisation of existing opportunities through the implementation of the Brent STP. However, additional opportunities will also be required over time.
4. Closing the financial gap – Brent Council

The following section of the NWL STP sets out how social care finances will be supported across NW London – essentially it suggests the level of savings that will be realised by Local Government through the range of opportunities set out in the papers named on page 61. It also assumes that the residual gap will be closed through the recurrent £147m sustainability funding for NW London.

Local government has faced unprecedented reductions in their budget through the last two comprehensive spending reviews, and the impact of the reductions in social care funding in particular has had a significant impact on NHS services. To ensure that the NHS can be sustainable long term we need to protect and invest in social care, and in preventative services, to reduce demand on the NHS and to support the shift towards more proactive, out of hospital care. This includes addressing the existing gap, and ensuring that the costs of increased social care that will result from the delivery areas set out in this plan are fully funded.

The actions set out below describe how the existing gap will be addressed. Benefits for health savings are assumed to be shared on the basis of performance.

### Table: Benefits for Health Savings

<table>
<thead>
<tr>
<th>Theme</th>
<th>STP delivery area</th>
<th>Benefit for ASC (£m)</th>
<th>Benefit for LG / PH (£m)</th>
<th>Benefit for Health (£m)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Health &amp; prevention</td>
<td>DA1</td>
<td>-</td>
<td>2.0</td>
<td>2.2</td>
</tr>
<tr>
<td>Demand management &amp; community resilience</td>
<td>DA2</td>
<td>-</td>
<td>-</td>
<td>6.1</td>
</tr>
<tr>
<td>Caring for people with complex needs</td>
<td>DA3</td>
<td>-</td>
<td>-</td>
<td>5.1</td>
</tr>
<tr>
<td>Accommodation based care</td>
<td>DA3</td>
<td>7.7</td>
<td>-</td>
<td>2.0</td>
</tr>
<tr>
<td>Discharge</td>
<td>DA3</td>
<td>3.4</td>
<td>-</td>
<td>9.6</td>
</tr>
<tr>
<td>Mental Health</td>
<td>DA4</td>
<td>3.5</td>
<td>2.9</td>
<td>5.0</td>
</tr>
<tr>
<td>Vulnerable</td>
<td>DA1</td>
<td>3.0</td>
<td>3.0</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total savings through STP investments</strong></td>
<td></td>
<td><strong>17.6</strong></td>
<td><strong>7.9</strong></td>
<td><strong>30.0</strong></td>
</tr>
<tr>
<td><strong>Joint commissioning</strong></td>
<td>DA3</td>
<td>22.0</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total savings through joint commissioning</strong></td>
<td></td>
<td>22.0</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

To deliver the savings requires investment of £21m in 17/18, rising to £34m by 20/21. The investment generates £55.5m savings recurrently. The residual gap of £19.5m in 20/21 is assumed to be addressed through the recurrent £147m sustainability funding for North West London on the basis that health and social care budgets will be fully pooled by then.
4. Closing the financial gap - Acute Provider and Summary

Closing the financial gap – LNWHT:

London Northwest Healthcare NHS Trust (LNWHT) has one of the greatest financial challenges of the NW London providers, and is pursuing a three-phase process to secure long-term sustainability:

- **Phase 1: Immediate term** - stabilising the Trust’s financial position in the current financial year
- **Phase 2: Next three years** - driving significant improvements in service and administrative efficiency and productivity; and strengthening the financial health.
- **Phase 3**: Three to Five Years – resolving the structural deficits at Ealing and Central Middlesex Hospitals (including through the redesign of CMH, a Brent ‘big ticket’ item)

Key areas of opportunity identified include: bank and agency, Elective Orthopaedics, and End of Life care.

Lord Carter’s 2015 review of efficiency in hospitals shows how large savings can be made by reducing unwarranted variation across key resource areas, including clinical staff, pharmacy and medicines, diagnostics and imaging, procurement, back-office functions, and estates and facilities, and Trusts across NW London will be reviewing their services in light of the Carter Review.

Closing the financial gap – summary for Brent:

The transformation required to close the Health & Well-Being and Care & Quality gap in Brent will also directly support closing the Finance & Efficiency gap. Several attempts to quantify the level of financial opportunity they present have been developed (see page X), and one of the next steps for all partners will be to review these opportunities in more detail at the local level and to build these opportunities into future financial plans.

In summary, Brent will close the finance and efficiency gap over the next five years as follows:

- Brent CCG and Council will minimise the impact of changing demographics through the cumulative impact of the initiatives outlined in the Brent STP, and ensuring that **best practice** is achieved across all service areas in Brent.
- **Reduced acute and residential care demand** will be achieved through a range of initiatives, including: new EOLC pathways; effective case management of people with complex needs; reduced variation in the management of LTCs (including Right Care); enhanced care in Nursing Homes; implementation of ‘discharge to assess’ models as part of the WLA integrated discharge initiative; and implementation of a unified Frailty and Older People’s Care model.
- Providers will achieve and maintain financial balance by implementing internal financial recovery plans, including the **redesign of CMH, reductions in Length of Stay**, reduced reliance on agency staff, and **Carter Review** recommendations.
- **A strong delivery focus** will be required to ensure the Brent STP is fully implemented on time.

There remain residual gaps for both CCG and Council, and therefore (a) existing opportunities must be maximised, and (b) further opportunities will be required in order to ensure that the CCG and Council continue to provide high quality services to a growing Brent population.
### 5. Core Brent STP Outcome Measures

A core set of key outcome measures for Brent have been identified to track overall progress across the Brent STP in achieving its Triple Aim. These are the key indicators that should improve as Brent implements its STP. Progress against baseline will be monitored on an annual basis (at a minimum).

**Brent’s Core STP Outcomes Measures:**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Percentage of people with depression, learning disabilities, mental health issues or other nervous disorders in employment</td>
<td>23% (tbc)</td>
<td>LA Information Team / No health without mental health – Mental Health Dashboard (<em>Employment of people with mental illness</em>, Labour Force &amp; ONS)</td>
</tr>
<tr>
<td>2. Patient experience of GP services</td>
<td>66.5%</td>
<td>July 2015</td>
</tr>
<tr>
<td>3. People with a long-term condition feeling supported to manage their condition</td>
<td>56%</td>
<td>2014/15</td>
</tr>
<tr>
<td>4. % of people with Diabetes receiving all 3 NICE recommended treatments</td>
<td>39.8%</td>
<td>2014/15</td>
</tr>
<tr>
<td>5. Premature mortality from stroke</td>
<td>22.4</td>
<td>2014</td>
</tr>
<tr>
<td>6. Emergency bed days per 1,000 population</td>
<td>1.02</td>
<td>Q2 2015/16</td>
</tr>
<tr>
<td>7. Non-elective admissions (NEL)</td>
<td>36,302</td>
<td>Brent 16/17 BCF submission (Planning Template): Total Non-Elective Admissions (Spells) (Total Activity) – CCG 15/16 <em>Forecast outturn</em></td>
</tr>
<tr>
<td>8. Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 1,000 population</td>
<td>271.9 (98/36,047)</td>
<td>Brent 16/17 BCF submission (Planning Template): <em>Forecast 15/16</em></td>
</tr>
<tr>
<td>9. % of deaths taking place in hospital</td>
<td>58.2%</td>
<td>Q1 2015/16</td>
</tr>
<tr>
<td>10. <em>Prevention/Public Health or Housing indicator - tbc</em></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
6. Governance and Implementation

Brent’s ability to achieve its Triple Aim will depend not only on having a robust STP plan, but equally on its ability to effectively implement its plan. The following approach in terms of governance and implementation has been agreed to date:

• The Brent Health & Well-Being Board (HWBB) has ultimate oversight of the Brent STP and will receive an annual progress report, including on the core STP outcome measures.

• Existing bodies will continue to be accountable for the delivery of existing plans, e.g. health & social care integration components (BCF) will continue to be overseen through Integration governance structure, and health-specific workstreams (e.g. Urgent Care) by the CCG Exec/Governing Body.

• It is anticipated that Health & Well-Being components will be monitored through the HW&BB governance structure – however, this may ultimately take the form of the Brent STP Planning Group evolving into the STP Working Group (and the Health & Well-Being remit). This approach is reflected the diagram to the left.

Health & Well-Being Board and working groups (proposed)

- Health and Wellbeing Board
- Brent Better Care Fund Implementation Board
- Sustainability and Transformation Plan Working Group
- Brent Mental Wellbeing Board
- Young Carers Transformation group
- SEND Transformation group
- Children Looked After Transformation group
- Children and Young People Mental Health and Wellbeing Transformation group
- Maternity and Children Under 5 Transformation group
- Children’s Trust
- Joint Commissioning Group
- Family Nurse Partnership Advisory Board
- Local Safeguarding Adults Board
- Local Safeguarding Children Board
- Safer Brent Partnership

Implementation:

• New big ticket items, including Workforce and Self-Care, will require effective oversight and governance – those leads responsible for developing project scoping documents will be asked to identify their preferred governance mechanism. It is therefore anticipated that by the end of September, i.e. once the project scoping documents are complete and have been reviewed by the STP Planning Group, that complete governance of the Brent STP is confirmed.

• A key implementation challenge for Brent will be to ensure the sufficient local resource to implement the improvement and transformation plans are in place, alongside maintenance of business as usual activities.

• The Brent STP Delivery Plan, which supports this document, tracks the existence of a delivery plan and sufficient project resource for each workstream in the Brent STP. A strong delivery focus will be required to ensure the Brent STP is fully implemented on time.

• At the NW London level, a joint implementation plan for each of the 5 high impact delivery areas will be developed – Brent will participate actively in order to achieve its priorities locally.
Summary:

- The Brent Sustainability & Transformation Plan (STP) builds on the NW London STP to provide a detailed local perspective of how Brent will achieve the Triple Aim locally.
- The Brent STP represents Brent’s overarching 5-year strategy and implementation plans to improve the health and well-being of Brent residents, the quality of services and care provided, and to achieve financial sustainability in the context of a growing population and constrained resources.
- The Brent STP is a triangulation of existing plans, plus new initiatives where gaps in existing plans have been identified. New initiatives will be subject to further public and patient engagement.
- The Brent STP provides:
  - A clear shared view of the big priorities for the next 5 years, particularly the Brent ‘big ticket’ items
  - A mechanism for the CCG and Council to track the delivery of Brent’s key programmes, including through the associated Delivery Plan
  - The planning horizon dictates that Brent’s plans for 2016/17 and 2017/18 are the naturally the most fully developed, while detailed planning work for following years will be required over time, building on the foundations laid through the early transformations achieved.
  - The following slide depicts the range of inter-dependencies across priority areas and illustrates how Brent will continue to adopt a joined up approach across the continuum of care in order to improve outcomes.

Next steps:

- A number of next steps have been identified to support further development of new initiatives, the overall governance and monitoring of the STP, and more detailed financial planning. These include:
  - Development of project scoping documentation for newly identified (or substantively updated) ‘big ticket’ items – for October 2016 Health & Well-Being Board
  - Confirmation of governance required to ensure effective delivery of the Brent STP, particularly the Health & Well-Being initiatives and new ‘big ticket’ items – for October 2016 Health & Well-Being Board
  - Detailed review and analysis of the suggested financial opportunities in the Brent context (including in the context of newly developing initiatives)
  - Continued engagement with Brent residents and other stakeholders
  - Collaboration with NW London colleagues on the development of pan-NWL implementation plans for the five NW London Delivery Areas
- Brent will continue to build and strengthen local relationships, as throughout the STP development process, supported by a shared understanding of strengths and challenges faced, a clear ambition for 2020, and a set of concrete steps to get there.
While the NW London and Brent priorities have been described within specific sections of the STP, it is recognised that there are interdependencies across the continuum of care, as demonstrated in the figure below. Brent will pursue a joined up approach to achieving its priorities.

**How Brent will deliver the priorities across service areas:**

<table>
<thead>
<tr>
<th>NWL Priority #1:</th>
<th>Brent Priority: Employment &amp; housing to support mental well-being</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support people are who are mainly healthy to stay well, enabling them to make healthy choices and look after themselves (and the people they care for)</td>
<td>NWL Priority #2: Reduce health inequalities and disparity in outcomes for the top 3 killers: cancer, heart diseases and respiratory illness</td>
</tr>
<tr>
<td>NWL Priority #3: Reduce social isolation</td>
<td>NWL Priority #4: Reduce unwarranted variation in the management of long-term conditions</td>
</tr>
<tr>
<td>NWL Priority #5: Ensure people access the right support in the right place at the right time</td>
<td>NWL Priority #6: Improve the overall quality of care for people...</td>
</tr>
<tr>
<td>NWL Priority #7: Reduce the gap in life expectancy between adults with serious and long term mental health needs and the rest of the population</td>
<td>NWL Priority #8: Improve children’s mental and physical health and wellbeing</td>
</tr>
<tr>
<td>NWL Priority #9: Improve consistency in patient outcomes and experience regardless of the day of the week that services are accessed</td>
<td>Cont...</td>
</tr>
</tbody>
</table>

**Brent Priority:**

**4 themes of the Brent BCF Programme**
Appendix

Appendix A: Brent STP Engagement
Appendix B: NW London and Brent priorities
Appendix C: Principles for working together
Community Wellbeing Directorate

**Adult Social Care**
- Assess needs
- Self-referral or referred by other services
- Design care plans

**Public Health**
- Joint Strategic Needs Assessment
- Public Health advice
- Health Protection duties
- Health Intelligence
- Work across Council

**Housing**
- Social Housing
- Preventing and resolving homelessness
- Private Housing
- Partnerships

**Services we commission or provide**
- Day care or day opportunities
- Residential or nursing care home placements
- Community and preventative support
- Extra Care Sheltered Housing
- Safeguarding
- Day care or day opportunities
- Information, advice and guidance and signposting
- Home care
- Substance Misuse Services
- Sexual Health
- School Nursing
- Health Visiting
- Behaviour change services
- Providing library and leisure services and supporting cultural activities in Brent
- Floating support
- Supported or independent living placements
North West London principles:

1. Be bold, ambitious and strive to change things for the better;
2. Commit to person-centered services and outcomes, focusing on the needs of the population rather than organisation;
3. Work together to overcome obstacles and be prepared to have challenging conversations through trusting relationships and local partnerships;
4. Commit to leading and owning the development of a joint STP and sign up to the principle of subsidiarity – where things can be decided and done locally they will be;
5. Identify and where possible, share opportunities, assets and risks through an open book approach; and
6. Engage widely and co-design with lay partners with every stage of the STP process.

Additional Brent principles:

1. Make decisions based on a system view (rather than an organisation view)
2. Maintain trust and transparency, and raise any issues that may be encountered
3. Recognise that the Brent STP Planning Group has both Brent deliverables and deliverables as part of the NWL footprint
4. Recognise that work will go on between meetings in order to progress within timescales, and commit to making best efforts to attend all meetings
5. Each member is responsible both for representing their respective organisation view and for cascading back outcomes from the Planning Group