Shaping a healthier future

NHS
Brent
Clinical Commissioning Group

BRENT

Summary of progress under Shaping a healthier future

February 2015
www.brentccg.nhs.uk

Shaping a healthier future

SHAPING A HEALTHIER FUTURE

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Shaping a Healthier Future (SaHF) will transform services for 2 million people across North West London

Why the system needs to change

- We have a growing and ageing population with more long-term conditions
- One in four patients find it difficult to see a GP when they need to and many end up in A&E
- We have more A&E departments per person than other parts of the country
- There are too few specialists in hospitals to provide high-quality round-the-clock care
- We are working from inadequate NHS facilities
- We are working within an increasingly tight budget

North West London's five year plan

- Design a system which better supports patients and gives them more control and input over their own care
- Prevent people from dying prematurely
- Enhance quality of life for people with long-term conditions
- Help people to recover from episodes of ill health or following injury
- Ensure that people have a positive experience of care
- Treat and care for people in a safe environment and protecting them from avoidable harm

Five year plan to date

2012-2014
- Consultation and decision making

2014 - 2019
- Year 1 of implementation

Mental health and wellbeing

Improving mental and physical health through integrated services.

- Transformation of services to be responsive to patients needs and easy to access and navigate.
- Care provision as close to home as possible, with GPs at the heart of care, where and when it is needed.
- Improves the lives of users and cares, promoting recovery and delivering excellent health and social care outcomes, including employment, housing and education.

Whole systems integrated care

Coordinating care across commissioning bodies and providers

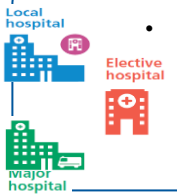
- People will be empowered to direct their care and support and to receive the care they need in their homes or local community.
- GPs will be at the centre of organising and coordinating people's care.
- Our systems and processes will enable and not hinder the provision of integrated care.

Primary and community care

Transforming out-of-hospital services and improving access to GPs

- Provides more local input into primary care commissioning; improves access to GPs whilst being able to move money around the health economy more quickly.
- Puts the right support in place to nurture and grow GP networks so they are able to deliver sustainability in the long term.
- Develops a primary care estates strategy that takes into account hub and GP estate requirements and support implementation of plans to deliver the required estates changes of need.

Hospital reconfiguration



- Delivers 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. The concentration of acute hospital services in order to develop centres of excellence which are able to achieve higher clinical standards and provide a more economic approach to the delivery of care.

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INTRODUCTION TO BRENT

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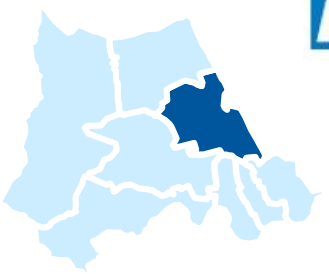
Brent is a London borough with a growing population.
Brent is ranked amongst the top 15% most-deprived areas in the country, and is the 11th most deprived borough in London.



Population demographics

- Brent is the most densely populated London Borough. The population density is 74.1 persons/hectare.
- The population is relatively young with 43% of residents under 30 years old, however more than 30,000 residents are aged 65 or over.
- Between 2011 and 2021 the population aged between 65 and 74 is expected to grow by 16%, 75-84 by 16% and 85+ by 72% whilst the total population will only grow by 7%.

- Brent is ethnically diverse with 65% from black, Asian and minority ethnic (BAME) backgrounds.
- Over 130 different languages are spoken in schools in Brent.

- Brent is ranked amongst the top 15% most-deprived areas in the country.
- Children and young people are most affected with a third of children in Brent living in a low income household.
- The gap in life expectancy for men varies between the most affluent and the most deprived parts of the borough by 8.8 years.

Overview

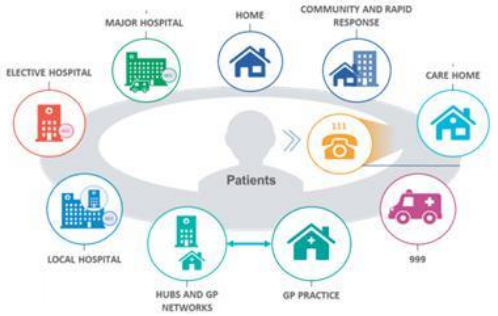
325,000
Local resident population

£415m for 2014/15
£422m for 2015/16
Health commissioning budget

£18m investment in community and integrated services

Care provision

- **67 GP** practices
- **66 dental** practices
- **75 pharmacies**
- **16 nursing homes**



- London North West Healthcare NHS Trust and Imperial College Healthcare NHS Trust are the main providers of acute and specialist care.
- London North West Healthcare NHS Trust also provides community nursing and therapies.
- Central North West London (CNWL) Foundation Trust is the main provider of mental health services.
- 4 networks have been set up (made up of Brent GP practices) to deliver extended primary care and Out of Hospital Services for the Brent population.

Health challenges

- Chronic disease and Long Term Conditions (LTCs) are endemic in Brent. There was a 38% increase in the prevalence of diabetes between 2008/09 and 2012/13.
- Hypertension, chronic heart disease and lung disease are all set to increase over the next five years.
- The prevalence of severe and enduring mental illness in Brent is 1.14% of the population which is above both the London and England averages.
- Brent children have worse than average levels of obesity – 11% of children aged 4-5, 24% of children aged 10-11 years
- In Brent 46% of five year olds had one or more decayed, missing or filled teeth. This is worse than the England average of 28%.

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CURRENT OUT OF HOSPITAL CARE

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Brent CCG has invested £18m[1] in 13/14 and 14/15 on increasing the number of community services and joining up health and social care.

Whole systems integrated care

- **Short Term Assessment Rehabilitation and Re-ablement service (STARRS):** The fundamental driver is to provide care closer to home and in the patient's home to avoid hospital stays and speed up discharge from hospital. The service is made up of a team of nurses, physiotherapists, consultant physician, social workers, speech and language therapists and healthcare support workers. In 2014/15 the service has prevented over 2,700 hospital admissions.
- **Integrated Care Planning**: Giving patients with long term conditions a care plan that considered all their health and social care needs; keeping people healthier for longer and reducing the need for hospital care. Unmanaged long-term conditions are a major cause of emergency admissions to hospital; so better support through care plans is an essential part of reducing pressure on hospital services. Since care plans were introduced in 2012 we have supported over 8,500 patients. Comparing LTC related admissions between 2013/14 and 2014/15 shows a reduction in admissions of nearly 400.

Community Out of Hospital services

- **Ophthalmology & Cardiology** have been redesigned and commissioned as consultant-led community clinics. Also investing in cardiology diagnostic equipment (ECG) in GP surgeries.
- **Diabetes**: In October 2014 an improved service for diabetics was launched; offering multi disciplinary diabetes care in GP and community health centres including extra self management & education courses and podiatry capacity. The service will reduce the number of emergency admissions for diabetic patients through better support for patients to effectively self manage their diabetes
- **Patients on medication** for arthritis and heart conditions now being monitored in primary care rather than hospital clinics providing support which is more co-ordinated with their wider health needs and helping to prevent conditions reaching crisis point and needed hospital admission.
- **More tests available from GPs** for conditions including heart failure and inflammatory bowel disease.

Additional one off investments

New primary care IT system: Moving all GP practices onto a single IT system to improve information sharing to support networks of practices offering more support to patients across their area.

Mental health and wellbeing

- Increased investment to **improve access to psychology therapy** to support patients with mild to moderate mental health illnesses
- **Older Adults**: investment in crisis resolution home treatment team to support more elderly individuals in the community and prevent emergency admissions.
- Established **Primary Care Dementia Nurses** for each locality within Brent, which has been in place since May 2014, to increase capacity for early diagnosis and provide early intervention as well as an effective interface between primary care and secondary care services for patients with dementia. The CCG and Brent Council also jointly commission a Dementia Café for patients and carers with dementia.
- **Primary Care Plus** has been rolled out, offering greater support for mental health conditions from within general practice. GPs are able to offer more holistic support with their knowledge of patient's physical health record. In addition the service provides care from a more relaxing environment; reducing the need for people to visit specialist mental health units for outpatient appointments.

Primary care transformation (including OOH hubs)

- **Prime Ministers Challenge Fund (PMCF)**: is helping all 67 GP practices in Brent to deliver better support to patients for urgent, continuous and convenient care.
- **Weekend & evening GP appointments:** *GP Access Hubs* offer extended access to patients for all 67 practices in Brent. Appointments are available in the evening Mondays to Fridays, and daytime at weekends. This is being extended to include bank holidays from March 2015. There is a GP hub in place in each of our five localities.
- **Efficient appointments:** 59 practices now offer telephone consultations and 55 practices offer online appointment bookings. 55 also offer longer appointments to those that need them.
- **Elderly care:** GP networks to provide those in nursing homes and housebound patients with proactive care management to prevent deterioration and enable carers to better manage acute exacerbations leading to reduced demand for urgent care/hospital admission.
- **Improved estates:** Brent is investing in the estate needed to deliver more services in out of hospital settings. As well as developing GP hubs in each locality, three 'out of hospital hubs' at Central Middlesex Hospital, Willesden and Wembley are being developed to deliver access to an extended range of integrated care for patients across Brent.

Investment note: Additional expenditure on 'out of hospital' services and infrastructure, spent since the start of SaHF. This is expenditure on primary and community care services, provided outside of acute, intended to reduce demand on the acute sector, i.e. to reduce non-elective or elective admissions, in-hospital outpatient appointments, and A&E attendances. Also includes investment in supporting infrastructure. Project costs are excluded.

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FUTURE OUT OF HOSPITAL PLANS

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Whole systems integrated care

- **Improve management of Long Term Conditions** by supplementing the current Integrated Care Programme model with Whole Systems Integrated Care early adopter sites in Harness and Kilburn, which will 'go live' during 2015. Early adopters will work with patients aged 65+ with one or more long term condition to proactive care management by the GP and supported by a team to deliver a range of interventions to promote better management of long term conditions and access to crisis response support
- **Enhance current STARRS service** by reconfiguring and extending into a 7 day **Integrated Rapid Response Service**. The service demonstrates year on year improvement in admission avoidance. An increased focus on rapid response will address a known capacity gap. The changes will also bring integration with social care and help speed up hand-offs at an earlier point in the patient's recovery
- Reconfigure existing discharge services to develop an **Integrated Discharge Team** to aid early and supported discharge of patients with complex needs who could be better cared for in the community.
- Establish an **Integrated Rehabilitation and Reablement Service** with a single point of access to enhanced reablement support at home, preventing readmissions and improving clinical outcomes.

Primary care including hubs

- **Improving access to Primary Care and strengthening GP networks** capability to manage more services within the community.
- **London Ambulance call out audit:** the CCG is undertaking an audit of ambulance call outs by GPs to see if there is anything that can be done to further reduce pressure on London Ambulance Service and A&E.

Mental health and wellbeing

- **Offer an urgent care mental health pathway** integrated with adult social care**,** with recovery focused support to address social factors (social isolation, unstable accommodation, and unstable employment) that increase the risk of a mental illness crisis.
- Reconfigure existing services to provide **more rapid crisis response, briefer and more intensive treatment, and transition support back to primary care** (GP-led). Currently, GPs have few mental health resources, and over 53% of adult community mental health patients have been in secondary care services for 5 years or more).
- Brent CCG, in partnership with the North West London CCGs Collaboration, has recognised the need to **improve out-of-hours Child and Adolescent Mental Health Services (CAMHS) provision** and has agreed to invest an additional £140k as part of a £1.1m pilot which is aimed at improving the urgent care response to children and young people with a mental health crisis. The pilot will be undertaken during a comprehensive review of CAMHS in 2015/16 to inform the future service developments required.

Community Out of Hospital services

- **Increasing access to services for the youngest in our community** including further provision for CAMHS Tier 3 support (severe, complex and persistent needs), Children's Integrated Nursing Team, and paediatric occupational therapy.
- **Develop Diabetes Insulin Initiation service within general** practice to further strengthen GP and community based support for diabetic patients.
- **End of Life support, roll out *Co-ordinate My Care*:** A tool for patients with terminal illnesses that allows them to share decisions and wishes about their care with all health and care services supporting them. The tool supports patient choice, helps avoid hospital admissions and supports people to have a comfortable death.
- **Redesign new community based services in 2015**, including ear nose & throat, paediatric phlebotomy, falls clinic & fracture liaison services.
- **Sickle Cell**: We are investing in a pilot from March 2015 to improve sickle cell care through a patient education and support programme with the aim of helping patients manage their condition and avoid crisis leading to emergency admissions.