

REACH

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NHS Brent
Commissioning Strategy Plan
2009 to 2014



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NHS
Brent

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1. Chair / Chief Executive's foreword

In 2008/09 NHS Brent developed a Commissioning Strategy Plan that set out a five year investment programme to deliver our vision of making a significant improvement to the health and wellbeing of the people of Brent and to establish ourselves as the local leader of the NHS, a commissioner of health and wellbeing very much rooted in the community we serve.

We are making good progress towards these objectives and, having increased our scores from "weak-weak" to "good" for quality of financial management and "fair" for quality of services, we are one of the two fastest improving PCTs in the country based on the CQC Performance Ratings for 2008/09.

We are developing rapidly towards becoming a highly skilled commissioning organisation and strengthening the partnerships we need to confront the challenges that lie ahead and convert Healthcare for London into a reality across North West London.

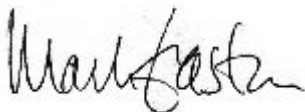
We recognise that we still need to deliver significant improvements across a number of services and we have retained the same outcomes as last year to reflect our commitment to achieving these health gains for the people of Brent. We believe that the considerable gains we have made over the last year against our Organisational Development goals have provided a stable foundation upon which to deliver these outcomes.

Over the course of the year we have worked with our partners, providers and other stakeholders to undertake a thorough review of our CSP both as an overarching programme and at individual project level to ensure that as a whole it remains coherent, realistic and deliverable and aligns with our North West London Integrated Strategic Plan to deliver Healthcare for London.

This is our key challenge: to deliver the eight Healthcare for London Pathways and work with clinicians to implement a polysystem model that enables us to commission affordable health care in more appropriate settings.

We have also responded to the changing economic climate by ensuring that our plans are focussed on achieving value for money, providing sufficient disinvestment and decommissioning savings to maintain our recent robust financial position.

We believe that this revised CSP sets out how we will achieve all these things while still maintaining our commitment to deliver the goals and outcomes we agreed with all our stakeholders last year.



Mark Easton
Chief Executive



Marcia Saunders
Chair

2. Vision

Making a significant improvement to the health and wellbeing of the people of Brent

The people of Brent suffer more ill health than in most locations in England. Our commitment is to work with our partners to reduce that experience and ensure that when they are unwell the services that we commission are responsive to their diverse needs. Our commitment to these outcomes is broadly unchanged from last year.

To achieve this we have five specific goals

1. Increasing the life expectancy of our population by 2.8 years amongst males and 2.2 years amongst females by 2013/14
2. Reducing the projected gap in life expectancy by 6 months amongst males and 4 months amongst females by 2013/14
3. Promoting good health and preventing ill health, to improve the health and wellbeing of our population with a significant impact on a number of outcomes
4. By working with partners we will improve the quality and safety of services commissioned to at least the equivalent of the existing Good CQC rating
5. By 2014 providers commissioned by us will achieve patient experience scores at least as good as the London average

Principles

The core principles which continue to underpin everything we do are set out below.

1. Evidence-based care – the PCT will draw on the available evidence to take good decisions about which health issues should be the highest priority, and which interventions will be most effective in addressing those issues. Where the evidence base does not exist, or is weak, we will contribute to strengthening it
2. Health outcomes – the PCT will look beyond process targets to focus on achieving health outcomes for our population, ensuring we understand the health benefits of every new initiative
3. Value for money – the PCT will test the efficiency and effectiveness of all investments, commissioning and decommissioning care services to maximise value for money
4. Public engagement – the PCT will ensure that all members of our community, including those who often have the poorest health and are hardest to reach, are genuinely involved, helping to shape service changes and not simply consulted on them

3. Context

Brent is an outer London borough in the north west of the city, home to Wembley Stadium, the Neasden Temple and a diverse and growing population. NHS Brent forms part of the North West London sector comprising eight PCTs.

3.1a Population demographics

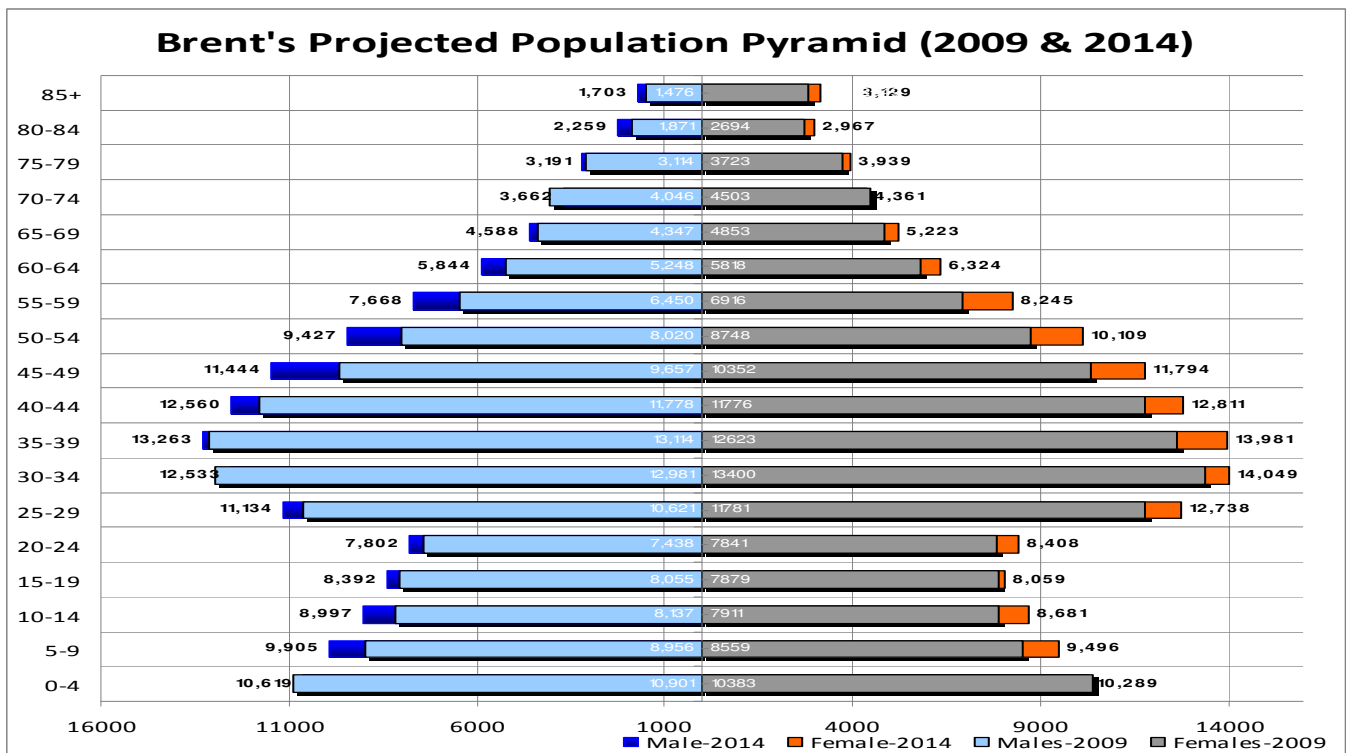
1. Brent's population

- 278,800 resident population, 351,000 registered population
- 55% of residents are from black and minority ethnic communities
- Over 130 different languages are now spoken in our schools
- The population is relatively young with 43% of residents under 30 years of age
- Over 30,000 people are over the age of 65
- Brent is the 53rd most deprived borough in England and is becoming more deprived

NHS Brent commissions health improvement and health care based on a comprehensive and nuanced understanding of the population and its unique characteristics. A joint strategic needs assessment (JSNA) undertaken in collaboration with local partners forms the basis of this approach. This has informed this strategic plan and our local area agreement priority action areas. This section highlights some of the key characteristics of Brent at a summary level; for more detail please refer to the JSNA.

2. Demography

- Brent's resident population is 278,800, although this figure could be over 5% higher and is growing steadily with the population predicted to increase to 305,575 by 2018
- Our population is dynamic – the significant numbers of people moving into the borough are creating new emerging communities, and we have significant numbers of transient people
- Almost a quarter of residents are under 19 years old, but our elderly population is growing too

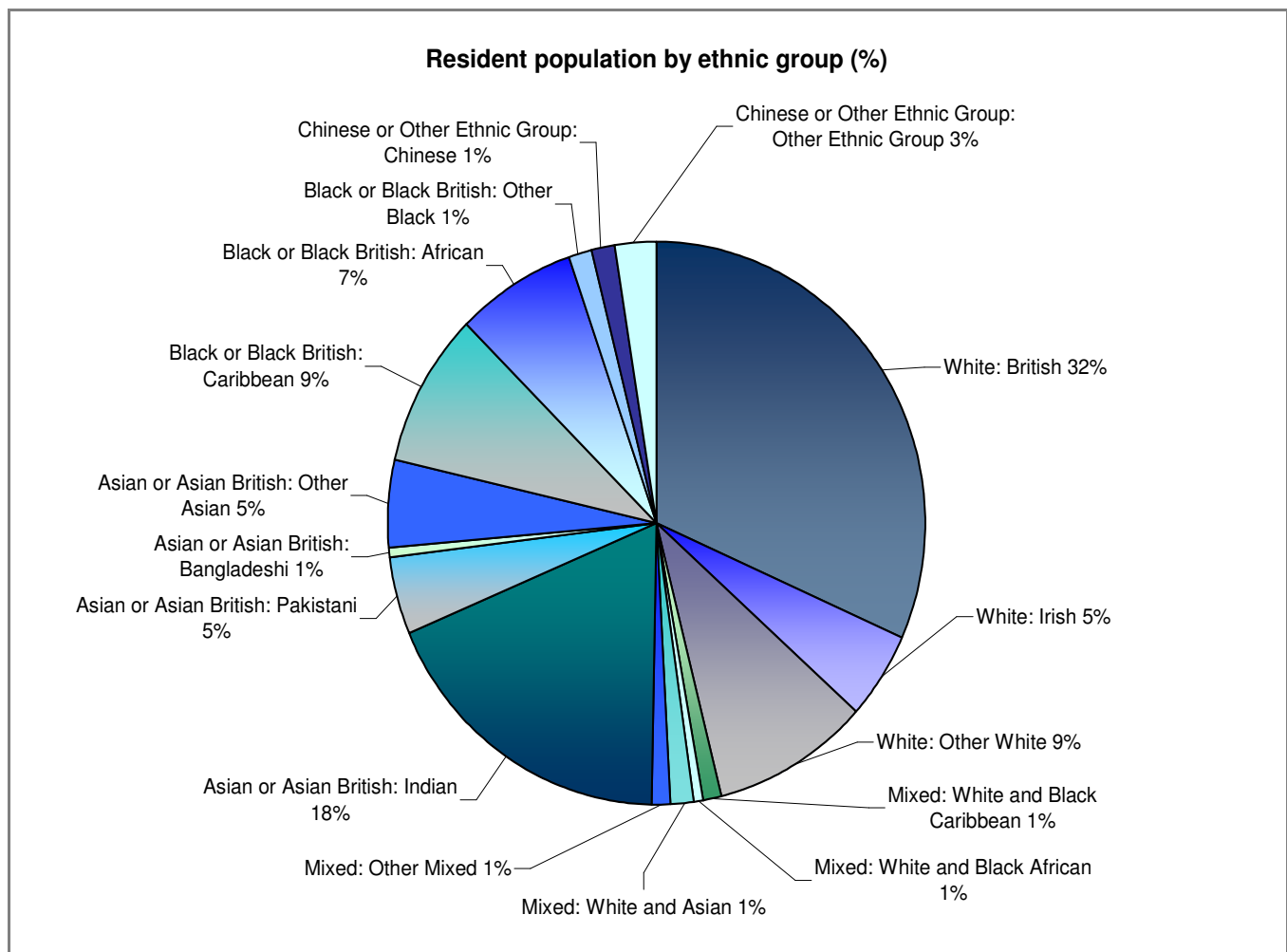


3. Diversity

- Brent is the most ethnically heterogeneous borough in the country
- The chances of 2 people in Brent being from different ethnic groups are higher than anywhere else in the country
- It has the highest proportion of people born outside the EU in England and Wales

Different ethnic groups are concentrated in distinct parts of the borough.

- The highest concentrations of black residents are in Stonebridge and Harlesden wards
- Asian residents tend to be located towards the west of the borough
- The white population concentrates towards the east of the borough
- Kilburn, Mapesbury and Dollis Hill wards have the highest numbers of white Irish residents



This diversity has a direct impact upon the different health needs of the population and a failure to understand those differences is not just a moral matter but is an issue of medical efficacy. For example our Asian groups have higher rates of diabetes and heart disease and develop these diseases about 10 years earlier than white groups, whilst black groups have higher rates of diabetes, hypertension and stroke and also develop these diseases earlier.

4. Deprivation

Brent is the most deprived borough in North West London despite having some areas which are relatively affluent. We have areas which experience high levels of deprivation, particularly in the south of the borough, although pockets of deprivation have also emerged in some areas to the north. Our most deprived

3.1b Case for change

Many of the deaths in Brent are preventable – cardiovascular diseases and cancers are Brent's biggest killers, accounting for 448 and 330 deaths in 2008 respectively. Healthy lifestyles and early intervention can have a major impact on these deaths but:

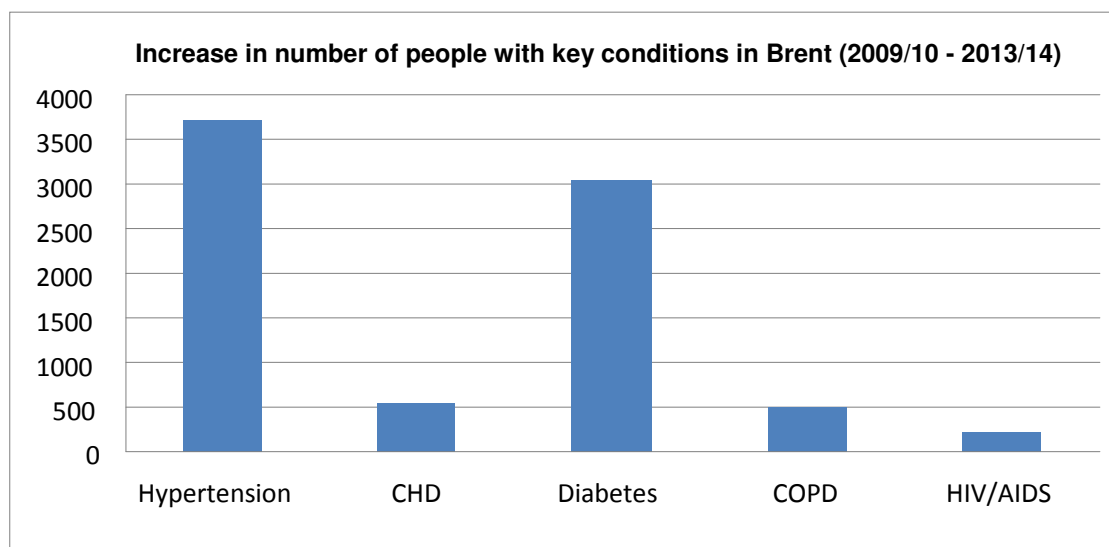
- 18.6% of Brent's residents smoke and 18% of deaths are caused by smoking. However rates of quitters are the second worst in England
- Chronic disease and Long Term Conditions (LTCs) are endemic in Brent. For example diabetes prevalence is amongst the highest in the country (and second highest in London) at 5.61% of the population diagnosed and additional undiagnosed cases of circa 2%
- Use of preventive services is patchy. For example uptake of breast and cervical screening services is one of the lowest in both London and England
- Almost one quarter of Brent's adult population are estimated to be obese

Children are inheriting health problems that will leave a lasting adult legacy of chronic ill-health:

- By the age of 5 over 10% of children are obese, rising to over 22% by age 12 (within the worst decile in England). Obesity levels are likely to increase further in the future – in Brent over half the population do no physical exercise and two-thirds don't eat the recommended amounts of fruit and vegetables
- Immunisation rates for childhood diseases have historically been amongst the worst in England and far below recommended levels for true effectiveness. For example in 08/09 only 32% of children were immunised against measles, mumps and rubella by age 5 (first and second dose). Although rates have now improved they are still far below recommended levels, meaning many children are still at risk

Prevalence estimates for key conditions highlight that many issues with which Brent is currently grappling are set to increase in scale in the coming years. For example:

- The prevalence of diabetes is expected to increase to around 8.5% of the adult population by 2014
- There are 726 people living with HIV/AIDS in Brent and this will increase by 25% by 2014 if current trends continue
- Prevalence of key diseases such as hypertension, CHD and COPD will increase over the next 5 years
- Health needs for Brent's ageing population will increase. The number of people over 75 with dementia is expected to increase from 2,027 to 2,226 between 2009 and 2014.



A much more effective intervention from NHS Brent in these areas will make a real difference to the health of the people of Brent, for example better uptake of screening services could save at least 11 deaths from cancer per year.

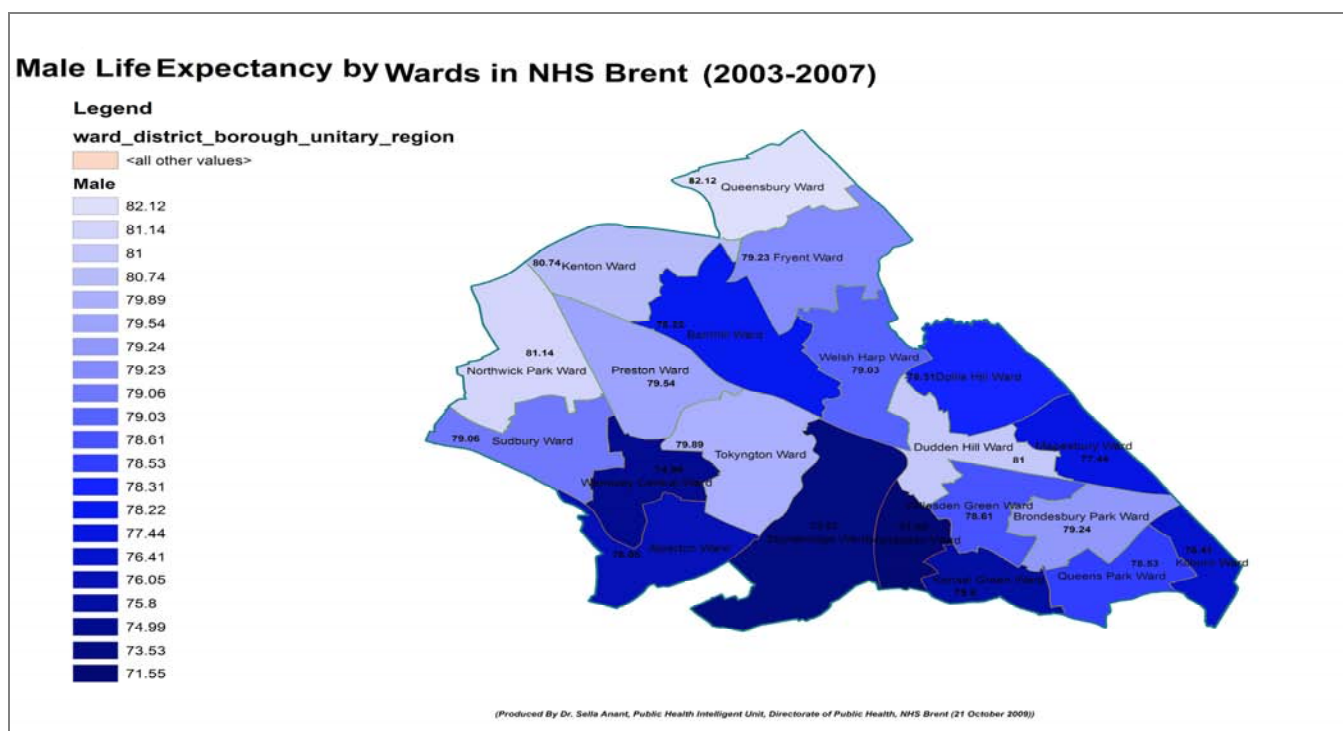
Reason 2 – the need to reduce health inequalities within Brent

Equity of care is a founding principle of the NHS but Brent's residents do not experience equity in their health outcomes. Brent is a borough which suffers marked health inequalities, which are both a symptom and a cause of the wider variance in deprivation we highlighted earlier.

There is a stark contrast between the deprived south of the borough and the more affluent north, for example:

- A male living in the northern ward of Northwick Park can expect to live 9 years longer than a male in the southern ward of Harlesden. The gap in life expectancy for men is increasing rapidly and is expected to increase over 13 years by 2014 if the current rate of increase continues
- Determinants of health and lifestyle choices are reinforcing health inequalities. For example smoking prevalence in the southern ward of Stonebridge is at 40%, more than double that of the northern ward of Kenton (16%)
- Mental health problems affect one in six people in Brent and have a differential impact upon the black population, our southern wards of Harlesden and Stonebridge have high black populations reflected in the fact that 44% of acute admissions are Black African men

Our task is to target healthcare interventions to make a real difference to closing the gap in health inequalities. Since we know that of the gap in life expectancy in males 35% can be attributed to circulatory disease, 18% to cancer and 15% to respiratory diseases we need to target these diseases in those most deprived areas.



Reason 3 – the NHS in Brent is not meeting the public's expectations

Understanding and meeting public expectations and ensuring good patient experience of care are integral to NHS Brent achieving its goals. However, too often in Brent there is a mismatch between the public's higher expectations of health care and their actual experience.

Primary care is an area where Brent's residents have made their expectations clear – improvement is necessary. Significant attention is being given to this but public dissatisfaction remains. For example:

- A recent local deliberative event saw 47% of attendees claim that current primary care and community services in Brent did not meet their needs well
- Brent ranks 149th in England (out of 152) for patient experience of GP practices

3.1b Case for change

- The most recent CQC GP survey revealed that Brent residents were less satisfied than the national average for overall satisfaction, opening times, cleanliness, courtesy of reception staff, waiting at the surgery and their experience whilst with the doctor

Similarly experience at our main acute provider North West London Hospitals NHS Trust is not meeting public expectations. The most recent CQC inpatient survey revealed that patients were less satisfied than the national average for overall experience, cleanliness and food, their experience with nurses, pain control and getting help, and involvement in decisions.

All Brent's residents should expect delivery of defined national standards in healthcare. We do not achieve this at the moment. NHS Brent has had a recent impact on quality of services, achieving a 'Fair' rating in the 2008/09 Annual Health Check. However current performance against some key targets emphasises the fact that Brent's delivery model is unsustainable and that public expectations are not being met – for example primary care access, immunisation, breast screening, cervical screening, smoking quitters and access to maternity services have all been identified as at a high risk of failure in 2009/10.

Stakeholder engagement over the past year has highlighted some clear messages from patients and the public, for example:

- Community infrastructure for maternity and children's services is poor
- It is difficult to access services, particularly in primary care
- Pathways for acute care and mental health are fragmented and confusing

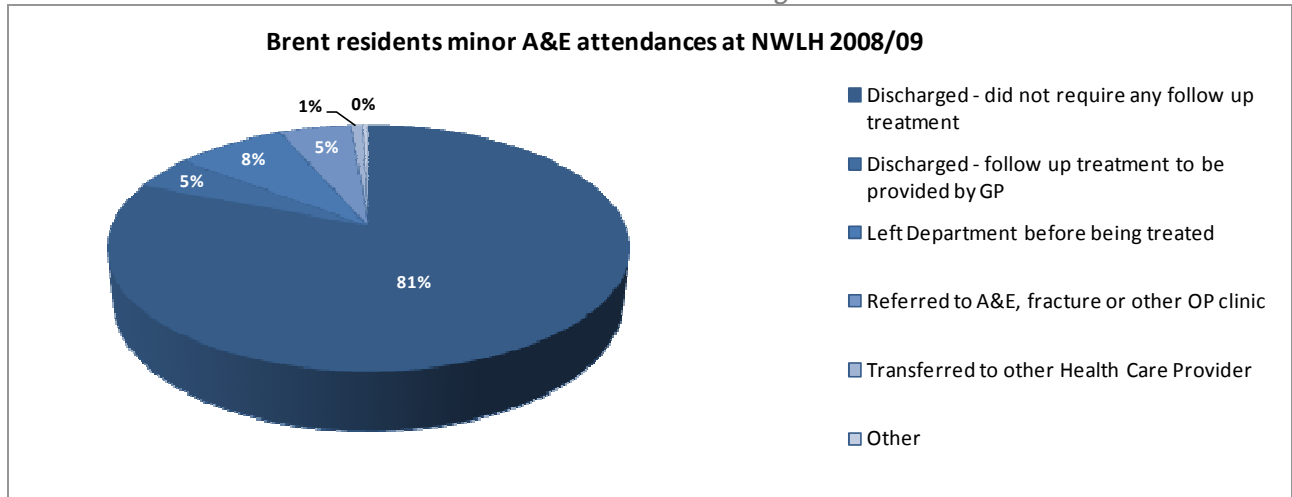
Whilst NHS Brent is taking steps to address these issues this gap between expectation and experience means that the pace of change must be quickened.

Reason 4 – the way we deliver care is not working

Healthcare policy for the last five years has highlighted the importance of moving care from traditional acute settings to primary care and the community. In Brent whilst there has been progress there is still some distance to go in developing the requisite infrastructure, and in promoting the cultural shift for Brent residents and NHS staff that predicates success.

The way we are using hospitals in Brent is inefficient, expensive and promotes poor patient experience and outcomes. For example:

- A&E is used in Brent as an alternative to primary care, levels of activity are high and continue to rise at an unsustainable rate of 8% a year
- An estimated 60% of A&E attendances are for conditions that could be managed in primary care
- Ambulatory care conditions that could be managed in primary care account for almost 12% of hospital admissions (amongst the worst five PCTs in London). Analysis of the 19 most common conditions suggests that a productivity saving of £1.46m could be achieved if these admissions were avoided
- Those that are admitted are often dealt with inefficiently, with historically high levels of delayed transfers of care compared to London or national average (at least 25% worse)
- The vast majority of outpatient and diagnostic appointments still take place in an acute hospital far from residents' homes
- Only 18% of people die at home, with 68% dying in hospital



If we are to move these trends then we need to rejuvenate the primary and community care that will provide these services. This means changing the current situation where:

- The number of single or two handed practices (70%) is not sustainable with the greater range of services and opening hours required against a likely background of falling income (Minimum Practice Income Guarantee)
- There is considerable variation in quality between GP practices – the best performing practices achieve three times the number of QOF points than the worst
- The unit costs per patient paid to GP practices range from £52 to £120
- Access to primary care in terms of geography and opening hours varies across the borough and is inversely linked to deprivation
- Within community services the ratio of district nurses and health visitors per population is amongst the lowest in England, with low average contact levels

We also need to ensure that North-West London realises the benefits that the HfL centralisation of specialist care such as acute stroke, cardiac and major trauma will bring.

Reason 5 – residents should benefit from cutting edge healthcare

London is in a unique position in the UK in terms of the quality and quantity of healthcare workforce on which it can draw. Innovative delivery of healthcare can be seen in the development of HfL pathways, and Academic Health Science Centres such as Imperial should promote world-class clinical innovation in north-west London.

Innovation needs to take place not just in a number of different medical interventions but needs to be systemic. Brent needs to ensure that it draws maximum benefit from these developments. Brent must also ensure that it is in the vanguard in terms of developing and employing cutting-edge innovation in primary care in the coming years, most notably in the implementation of the polysystem model.

Reason 6 – making the best use of our resources

A period of unprecedented NHS budgetary growth is at an end. In the new environment of constrained resources it is imperative that the NHS in Brent make its resources work harder and smarter to achieve our health goals for the population.

NHS Brent is an organisation that has come out of turnaround to achieve financial stability and has therefore had to look closely at all expenditure. It is essential that this rigour is carried forward. NHS Brent commissions in a health economy that is not working.

Brent's main acute provider North West London Hospitals Trust (NWLHT) was rated 'Weak' in 2008/09 for financial management, as it was for the past three years. The new financial environment is a compelling motivator to deliver a leaner and more productive health economy in Brent.

3.2 Insights from patients, public, clinicians and local partners

Best use of resources includes smart utilisation of NHS estates. This is a particular challenge for Brent, where NHS Brent has inherited considerable LIFT estate and a PFI at Willesden Hospital. This estate is currently underutilised. The acute trust also has a PFI building at Central Middlesex Hospital (CMH). NHS Brent must find a way to best exploit these fixed capital points financially and to drive forward improvement in health outcomes.

Conclusion

These six reasons make a compelling case for changing healthcare in Brent. The goals and initiatives within this strategic plan show how we intend to make this change. In formulating the strategy we have maintained the clear link between our population's needs, this case for change, our vision for the future, our goals and the initiatives we have developed to deliver the changes needed.

To formalise this link we have aligned the metrics in the case for change to those used to track delivery of goals and initiatives against trajectories and against national and local benchmarks.

3.2 Insights from patients, public, clinicians and local partners

Key Messages

- There is still a need to get the basics right
- Patient experience across a range of our providers remains below acceptable standards
- Patients continue to experience problems accessing healthcare services and current care pathways are complex and confusing
- Our local case for change is strong but improvement is happening too slowly
- The changes required can only happen with everyone working in equal partnership, including patients and carers
- Any changes to acute care need to be supported by improvements in local primary and community services
- NHS Brent needs to remain financially strong: this will require fundamental change to the ways that services are commissioned and delivered. Doing less of the same is not an option

In developing our Commissioning Strategy Plan last year we focussed attention on establishing our vision, goals and outcomes with our partners, most notably our patients and our local community. We recognised that we were at an early stage of the process and needed to adopt a more systematic approach to making sure that we were listening, understanding and responding to patients. In establishing this systematic approach we have ensured that patients, the community, clinicians and partners are involved at every stage of the commissioning cycle.

Clinicians

Clinical Commissioners and leaders have been central to the service redesign initiatives undertaken this year across all of the 8 HfL pathways. This has been supported by the DH funded Practice Based Commissioning Development Project, which has focussed upon our transforming care programme.

Partners

This year we have improved system alignments and enhanced integrated governance with the London Borough of Brent (LBB) and this has helped to create the shared priorities that underpin our CSP. Care pathway redesign and monitoring of delivery are increasingly being undertaken as shared priorities.

Community

We have developed a close working relationship with Brent Local Involvement Networks (LINKs), using their infrastructure to engage with people including the seldom-heard communities of Brent. Brent LINKs have also developed their role in influencing and scrutinising the planning and delivery of NHS services and can demonstrate where real changes have happened as a result of their interventions. Our stakeholder engagement plans demonstrate a more systematic approach to ensuring that we reach all sections of our diverse community using a variety of tools and techniques.

Local Leaders

Health Select (Overview and Scrutiny) has continued to play an active role in holding NHS Brent to account through formal meetings, challenge sessions and in-depth reviews. Area Forums, which are aligned with the five developing polysystems of Brent, play an increasing role for local scrutiny.

Key themes by pathway

Although the areas of engagement and consultation have been varied and diverse over the last year, there have continued to be a number of key themes providing valuable insight into the continuing priorities for health and social care in Brent, including support for more rapid introduction of HfL care pathways.

The table below summarises the key feedback we have received against each pathway.

Who we spoke to	What they told us
Maternity & newborn	
User groups Clinical forums	<ul style="list-style-type: none"> Lack of Community infrastructure Need system alignment with children's centres Capacity issues reducing choice
Children & young people	
Deliberative Events Brent Youth Parliament Clinical forums User Groups Co-production workshops Focussed Media engagement	<ul style="list-style-type: none"> Lack of community infrastructure Rationale for in-patient centralisation accepted but needs of parents must be met Need system alignment with children's centres Pace of change too slow
Staying healthy	
Health & wellbeing consultation Co-production workshops	<ul style="list-style-type: none"> Need to focus on areas of greatest deprivation Need to work with local people Needs to be part of wider regeneration strategy Achievement of screening targets critical but rate of improvement too slow
Mental health	
User groups Focussed media engagement	<ul style="list-style-type: none"> Must recognise the needs of seldom-heard groups Model of care too acute focussed Current pathways / teams confusing Opportunity to increase use of 3rd sector
Acute care	
Deliberative event Stroke & trauma consultation Urgent Care co-production workshops Clinical forums and User groups Focussed Media engagement Primary care survey	<ul style="list-style-type: none"> New stroke pathway strongly supported Access to GP appointments is difficult Current pathways to avoid hospital admissions are fragmented Need to remember the needs of carers
Planned care	
Deliberative event Clinical forums and User Groups Co-production workshops Focussed Media engagement Primary care survey	<ul style="list-style-type: none"> GPs are very busy Need to be more diagnostic services to prevent referrals Community services are depleted Support primary and community strategy and make it simple to navigate
LTCs	
User Groups Clinical forums Co-production workshops	<ul style="list-style-type: none"> Patients and their carers need to be listened to Too many separate appointments Access to specialists is critical Need to use 3rd sector more
End of life care	
User Groups Co-production workshops	<ul style="list-style-type: none"> Too many people are dying in hospital Community services are fragmented, under-resourced and of variable quality

Having recently emerged from financial turnaround there has been strong agreement from all stakeholders that NHS Brent needs to remain financially strong. Stakeholders agree that achieving this strength will require fundamental change to the ways that services are commissioned and delivered; that doing less of the same is not an option and that this change can only be achieved through working in partnership. Therefore we have been honest with stakeholders about the challenge of making significant savings by finding innovative ways to boost the quality, efficiency and productivity of services.

The insights we have gained from our patients, public, clinicians and local partners have shown that the case for change in Brent is recognised and supported. However, it has also shown us that progress to date has been slow and that stakeholders expect us to be more ambitious and to drive forward improvements in a more transformational and less incremental way.

3.3 Provider landscape

Overview of current provider landscape

For 2009/10 the commissioning spend across the various settings of care is approximately £500m. In reviewing the current provider landscape we have concentrated on the major local providers within each of the following settings of care: independent contractors (focussing upon primary medical services provision); existing community / out of hospital services (BCS), acute (NWLH & Imperial) and mental health (CNWL). Together these account for approximately £300m of the total spend in 2009/10. They are also the existing providers who will be most affected by, and will need to respond to, the ongoing implementation of HfL locally. In reviewing the existing range, capacity and economics of these providers we have focussed upon the performance domains of access, choice, outcomes, patient experience and value for money.

Independent contractors

Expenditure on independent contractor services and prescriptions in 2009/10 is a total of £82m (GPs £45m and prescribing £37m). Pharmacy provision is commissioned from 74 pharmacies and dental provision is commissioned from 63 dental practices.

NHS Brent holds 71 GP contracts. The majority of contracts are for core primary medical services. 13 of the 71 are Personal Medical Services (PMS) contractors who receive additional funding to provide a range of services 'over and above' the core contract. A GP Led Health Centre opened in the summer of 2009 in Wembley and is commissioned to provide both primary medical services and walk-in services.

Measure	Performance
Access	<ul style="list-style-type: none"> Under 50% of practices are open more than 45 hours a week Brent ranked 135/150 nationally on ease of seeing a GP quickly Brent ranked 150/150 nationally on ease of seeing a practice nurse
Choice	<ul style="list-style-type: none"> 97% of Brent residents have a choice of GP practice (compared to 92% nationally) Out of all GPs reporting DDA compliance, only 13% were compliant
Outcomes	<ul style="list-style-type: none"> Brent GPs scored on average 803 QOF points compared to an average of 938 across London and 954 nationally (2008/9). (Total points available = 1000) All bar 3 Practices across Brent record above 50% achievement for managing patients at or below 7.5 Hba1c levels, however 52 practices record exception reporting levels of over 5% 63.7% of women aged 25-49 years received cervical screening in the last 3.5 years and 74.9% of women aged 50-64 years received screening in the last five years (2008/09)
Patient Experience	<ul style="list-style-type: none"> Brent ranked 149/152 nationally on patient satisfaction
Value for Money	<ul style="list-style-type: none"> The total list size in Brent was 352,000 in 2008/09 compared to ONS population projections of only 271,000, indicating a significant element of list inflation Unit costs for GPs on GMS contracts ranged from £52 to £87 and for PMS contracts from £74 to £120 Brent has 0.57 GPs per 1,000 population similar to the national median of 0.58. Non-GP clinical staff per 1,000 of 1.1 is significantly below the national median of 1.45 GP availability in Brent is below countrywide benchmarks. Only 83% of patients were able to get an appointment within 48 hours compared to 87% nationally

3.3 Provider landscape

The aggregated benchmarks for Brent mask variation across practices. This is reflected in Brent's Quality and Outcomes Framework (QoF) scores. While average QoF scores in Brent lag behind those achieved across London, there is also a significant number of practices (45%) that exceed the London average. The discrepancies also become apparent when looking at the achievement of a range of GP targets, including the achievement and exception reporting on a range of chronic conditions, A&E attendances and first outpatient appointments.

The overall provider landscape for primary medical services is not meeting current performance expectations. If unaddressed this, combined with the known workforce issues (30% of Brent GPs are over 60), will have serious implications for the ability of NHS Brent to improve the health and healthcare of the people of Brent.

Brent Community Services (BCS)

NHS Brent commissioned £38m of services from Brent Community Services in 2009/10. BCS achieved Autonomous Provider Organisation (APO) status in May 2009 and Business Readiness Status in October 2009. BCS provides a wide range of services encompassing 31 service lines grouped into six directorates ranging in size from £2.3m for Learning Disabilities to £12.3m for Therapies & Adult Inpatient Services.

Measure	Performance
Access	<ul style="list-style-type: none"> Breaches have occurred in diagnostics and audiology Waiting times are long for some non-consultant services e.g. dentistry and physiotherapy 100% of admitted Neuro-rehabilitation patients and 97.4% of non-admitted patients across six major pathways are treated within 18 weeks
Choice	<ul style="list-style-type: none"> Across all 31 service lines BCS is the sole provider with no choice options for patients / referrers living within Brent Community services to Brent GP registered populations living outside the borough boundary are provided by other NHS community services
Outcomes	<ul style="list-style-type: none"> A GP survey indicates that community services often fail to meet patient needs and that quality is low (however, this is based on a small number of responses) Key services have shown limited ability to respond to developed services and clear specifications Quality standards are not in place for key services
Patient Experience	<ul style="list-style-type: none"> Over 90% of patients are happy with the professional care they receive Over 90% of patients agreed that they were treated with dignity and respect and listened to by the healthcare professional (internal survey 2008)
Value for Money	<ul style="list-style-type: none"> An independent pan-London review of community services identified significant performance opportunities in District Nursing and Health Visiting with opportunity to improve by at least 20% (Meridian Productivity Ltd) An external review of both Brent Rehabilitation Services and Willesden rehabilitation beds was performed indicating significant opportunities in improving efficiency both in staff productivity and use of beds (The Health Works Ltd) Staff sickness rates varied across services but were high for some of the largest services, including: <ul style="list-style-type: none"> Children's Medical: 12% District Nursing: 10% Health Visiting: 10% Rehab and Intermediate Care Inpatient Services: 11%

In achieving business readiness, BCS has established a more robust management infrastructure, better prepared to respond to the challenges ahead. However, the current provider landscape for community services is not meeting current performance expectations. If unaddressed this will have serious implications for the ability of NHS Brent to implement the HfL care pathways and model of care required to deliver our strategic vision and goals.

Major and specialist acute services

In the major and specialist acute settings, NHS Brent has forecast spend of £267m of services in 2009/10 with the top two providers delivering approximately 83% of all activity and the top five providers around 91%. A total of 53% of all acute activity provided to NHS Brent is from NWLH and 30% from Imperial. Currently, due to their market share of Brent activity, their performance is of particular significance to the quality of acute healthcare experienced by the people of Brent. NWLH provides services from two hospital sites: Northwick Park Hospital (NPH) in the west of the borough on the boundary with Harrow and CMH in the south of the borough. Imperial was formed in 2007 through the merger of Hammersmith, Charing Cross and St Mary's Hospitals and continues to provide services from all three sites. Brent residents in the south of the borough access services predominantly from the St Mary's Hospital site. Together NWLH and Imperial account for £176m of spend.

Measure	NWLH	Imperial
Access	<ul style="list-style-type: none"> 95.5% of admitted patients and 97.5% of non-admitted patients are treated within 18 weeks The A&E target was achieved with 98.1 % of patients being seen within four hours 100% of patients are able to access a sexual health clinic within 48 hours Designated HASU (NPH) 	<ul style="list-style-type: none"> 90% of admitted patients and 95% of non-admitted patients are seen within 18 weeks The A&E target was achieved with 98.4% of patients being seen within four hours The two-week wait from urgent referrals for suspected cancer target was rated as 'Excellent'. Designated HASU (Hyper Acute Stroke Unit) at St Mary's
Choice	<ul style="list-style-type: none"> 61% of clinics were available on Choose and Book in August 2009 	
Outcomes	<ul style="list-style-type: none"> CQC Excellent Quality of Services Trust performance was average for C-Difficile infections and fell short of national outcomes for MRSA-infections 	<ul style="list-style-type: none"> CQC Good Quality of Services The trust underperformed on safety indicators with the number of MRSA and C-Difficile infections being well above the national median
Patient experience	<ul style="list-style-type: none"> The trust is in the bottom 10% nationally on self-reported patient experience and user involvement with decisions about their own care (CQC, 2008/09) 	<ul style="list-style-type: none"> The trust is in the bottom 25% nationally on self-reported patient experience. Its outcomes are average with national performance on user involvement with decisions about their own care (CQC, 2008/09) The trust was in the top 20% on four indicators relating to patient experience in emergency departments (CQC, HCC, 2008)
Value for Money	<ul style="list-style-type: none"> The trust is financially challenged and was scored Weak for financial performance by the CQC in 2009 Performance on key operational metrics is mixed CMH is a brand-new PFI build while NPH has poor estate fabric & utilisation 	<ul style="list-style-type: none"> The trust was rated Good for financial performance by the CQC in 2009 Performance on key operational metrics is mixed

Over the past year NHS Brent has worked closely with NHS Harrow and NWLH to undertake a review of local acute services provision. The review involved clinicians, members of the local community, partners including local authorities and senior managers from all three organisations. The review, together with the implementation of both PCTs' Commissioning Strategy Plans and the implementation following consultation of HfL care pathways relating to stroke and trauma have had a number of impacts on the designation of both sites with the CMH site being designated as a local hospital and NPH as a major acute hospital.

The impact of the key changes on the designation of CMH and NPH are summarised below.

3.3 Provider landscape

	Central Middlesex	Northwick Park
Hyperacute stroke unit (new designation)	N	Y
Stroke unit (HfL designation)	N	Y
Trauma (HfL designation)	N	Y
Emergency surgery	N	Y
UCC	Y	Y
Unselected medical take	Y	Y
Gynaecology Direct Referrals	N	Y
Paediatric In Patient Beds	**	**

** Currently out to consultation regarding the establishment of a Paediatric Assessment Unit at CMH and centralisation of in-patient paediatric beds at NPH.

The acute services review also demonstrated the continuing uncertainty of NWLH's underlying financial position. With the continuing and accelerated implementation of HfL care pathways across North West London there will be substantial impacts to the provider landscape. Determination of the future options for the acute provider landscape across the sector, as fully outlined in our Integrated Strategic Plan for North West London, will take account of the needs of Brent residents to be able to access high quality healthcare.

Mental health provision

NHS Brent is forecasting spend of approximately £43m on mental health provision. Of that spend approximately £35m is with Central and North-West London Hospital Trust. Less than 2% of Brent's spend is currently with the independent or third sector.

Measure	Performance
Access	<ul style="list-style-type: none"> Brent scored 4 out of 4 on appropriate access for children with learning disabilities exceeding the London average of 3 Brent is in the bottom quartile nationally with regards to the number of WTEs in crisis resolution and talking therapies
Choice	<ul style="list-style-type: none"> Limited choice for service users 85% spend with CNWL
Outcomes	<ul style="list-style-type: none"> CQC Good Quality of Services 2009 (from Excellent)
Patient Experience	<ul style="list-style-type: none"> CNWL is currently among the 20% least well performing trusts nationally with regards to patients' experience of care (CQC 2009) CNWL performed worse than the average trust on patient experience in community services (CQC, 2008)
Value for Money	<ul style="list-style-type: none"> CNWL performed strongly financially as it met all its financial targets being awarded 'Excellent' for use of resources by the Healthcare Commission Performance on key operational metrics is mixed. High DNA rates in some service areas (CAMHs 22%)

CNWL achieves good performance in relation to the main indicators, although the downward trajectory in relation to quality of services and poor patient experience of in-patient services requires active management to ensure improvement in line with the action plans established by the trust. The opportunities for NHS Brent in implementing the HfL care pathways and model of care required to deliver our strategic vision and goals, relate to the need to open up the market to other providers including the independent and third sector. This will be in line with our desire to offer improved choice and value for money.

Ability of providers to respond to case for change

Over the past year NHS Brent has taken a number of steps to actively manage the local provider market using all four market levers of competition, cooperation, contract / pricing structure and regulatory as appropriate.

However, the strength of the case for change within Brent, coupled with both the continuing fragility of current providers across all settings of care and the need to accelerate the pace of change, requires a more transformational market management strategy. This strategy needs to align the requirements for polysystem development across Brent with the requirement to establish quality acute services across North

West London and pan London. These requirements are identified at HfL care pathway level across both the CSP (and supporting Market Management Strategy) and the North West London Integrated Strategic Plan, as well as across settings of care within polysystems and the acute landscape.

3.4 Finance and activity context

Introduction

We have developed a Medium Term Financial Strategy (MTFS) which is available as a supporting document to the CSP. This section, along with section 4.5, summarises the key features of the MTFS. Further details are included in the supporting document and the WCC finance and activity template.

Planning for the downside – NHS Brent approach

All PCTs are required in the WCC submission and template to submit financial projections under three scenarios (best, base, downside) and NHS London issued allocation uplift assumptions for each. The advice from the SHA was that working through the implications of the base case, together with the downside case or 'flat cash' scenario should be the main focus for PCTs in their WCC submissions.

Having considered the assumptions, our weighted capitation position (currently £37m above target), and the difficulties and risks of developing and implementing significant efficiency and disinvestment plans without sufficient planning, the PCT's approach has been to explicitly assume the downside allocation scenario within our 'base case' and plan accordingly.

We have modelled potential changes to our assumptions in our scenario planning.

Our approach has therefore been to:

- Assume the downside allocation scenario and plan accordingly (i.e., the downside allocation scenario of 'flat cash' is NHS Brent's base case)
- Develop a credible efficiency and disinvestment plan to meet the above
- Undertake a rigorous risk assessment of our base case plan including the risk of delivering the efficiency/disinvestment plan but also including risks to other key variables
- Develop other scenarios and outline how we would respond to these
- Stress test our plans to ensure that financial sustainability can be maintained

This approach was felt to be both the most prudent and also in the best interests of the local health economy, as it is preferable to develop plans now for the downside, with headroom for further investment should the downside not happen, rather than respond to the downside at a later date.

This approach was endorsed by the Executive Management Team, the Finance and Investment Strategy Group (FISG), and the Board as a whole.

Engagement with stakeholders has been undertaken as part of the wider CSP engagement processes (see section 3.2).

Modelling phases

The financial and activity modelling has involved five distinct phases as set out below.

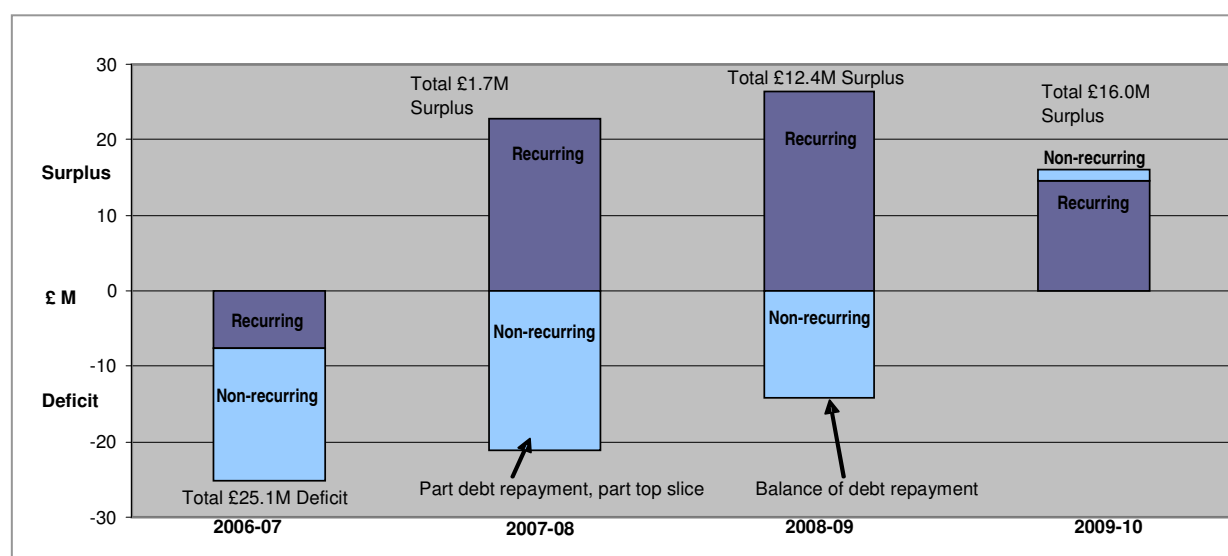
- Analysis of baseline spend and benchmarking
- Construct a forecast for 10/11 – 13/14 based on a PCT 'do-nothing' scenario
- Overlay the impact of the PCT initiatives, after a rigorous risk assessment
- Undertake a further risk assessment of the overall plan
- Conduct scenario modelling

Underlying recurrent financial position

In order to understand and monitor the PCT's financial position and ensure ongoing financial sustainability, it is essential to distinguish between recurrent and non-recurrent income and expenditure. A summary of the PCT's underlying financial position over the 4 years 2006/07 – 2009/10 is summarised below.

Year	2006/07 £m	2007/08 £m	2008/09 £m	2009/10 FOT £m
Recurring	(7.5)	22.8	21.6	10.0
Non-recurring	(17.6)	(21.1)	(9.0)	6.0
Total	(25.1)	1.7	12.6	16.0

The table illustrates the movement from the £25m bottom-line deficit in 2006/07 to the surplus forecast for 2009/10 of £16m. The recurrent position has been similarly transformed, with the forecast closing position for 2009/10 being an underlying surplus of £10m.



The improvement in financial standing has been accompanied by an improvement in underpinning financial management. The PCT's historic weakness in financial management was reflected in the lowest possible ALE score (weak) in both 2006/07 and 2007/08. The PCT's Use of Resources rating in 2008/09 reflected the significant improvements made. In particular, in respect of 'quality of financial management', the PCT has moved from 'weak' in 07/08 to 'good' in 08/09. The improvement was also evidenced by the SHA finance risk rating which increased from a level 2 (amber) at the end of 07/08 to level 4 (green) at the end of 08/09.

Activity summary

The table below summarises the 2009/10 forecast outturn activity.

Care setting	Currency	09/10 Forecast Outturn	
Primary and Community	GPs	Attendances	1,215,719
	Prescribing	No. of prescriptions	3,951,296
	Dentistry	UDAs	527,402
	Community	Spells	356
		Outpatients attendances	30,056
		Contacts	350,299
	GP Led Health Ctr	Attendances	22,092
Mental Health and Learning Disabilities	Mental Health	IP bed days	66,529
	Learning Disabilities	Other Contacts	78,145
Continuing Care	Continuing care	Contacts	1,582
		No. of patients	593

3.4 Finance and activity context

Care setting		Currency	09/10 Forecast Outturn
Secondary / Tertiary Care	NHS / FT	Elective spells	8,216
		Planned Same Day procedures	25,814
		Non-elective spells	34,711
		Outpatient attendances	339,523
		A & E attendances	137,066
	Ambulance	No. of calls	53,104
		No. of journeys	52,188

Financial projections (pre-initiatives)

This section sets out the key income and cost driver assumptions under a PCT 'do nothing' scenario, in order to identify the scale of the challenges facing the PCT under the 'base case'. In accordance with the planning approach set out above, the following allocation cash uplifts have been assumed.

2010/11	2011/12	2012/13	2013/14
5.1%	0.0%	0.0%	0.0%

The zero growth for 2011/12 – 2013/14 reflects the NHS London downside assumption. In accordance with NHS London guidance, we have assumed that carry forward of surpluses continues to apply. For 2010/11 we included the second (and final) non-recurrent contribution to the London Challenged Trust process. The main activity and cost drivers have been identified and assessed using a combination of advice from NHS London (e.g. tariff uplifts) and local analysis. An assessment of the specific impact of individual cost drivers on the PCT expenditure position has been made as follows:

1) **Tariff uplift** – the following tariff uplifts assumptions have been provided by NHS London:

YEAR	2010/11	2011/12	2012/13	2013/14
Tariff(excl. CQUIN)	3.5	3.5	3.5	3.5
Efficiency	(3.5)	(3.5)	(3.5)	(3.5)
Tariff (net)	0.0	(0.0)	(0.0)	(0.0)
Increase in CQUIN	1.0	-	-	-

For services not subject to tariff, the following has been assumed:

- non-PbR services provided by NHS Trusts/FTs (including community services, mental health, etc) – as above
- primary care – 1.0% inflation uplift per annum
- non – NHS (ISTC, continuing care, etc) – 1.0% inflation uplift per annum
- prescribing – 4% price growth per annum (volume growth of 3% also included – see below)

The overall weighted impact of the above tariff/price changes per annum is shown in the table below.

YEAR	10/11	11/12	12/13	13/14
% weighted increase	1.3	0.5	0.5	0.5

2) Population drivers

The assessments of both total and age mix population changes have been derived from the latest GLA estimates. The total Brent population is estimated to grow by approximately 5% across the next four years.

Within the overall growth position, higher than average increases in relation to the under 14 and over 75 age groups, both high consumers of health care resources are forecast. As outlined in section 3.1, Brent is the most ethnically heterogeneous borough in the country and Brent's diverse communities have specific health needs associated with them.

3) Other activity drivers

Much of the historic increases in activity have been driven by factors over and above demographic changes such as: Legal changes, policy changes, national operating framework targets, impact of deprivation/

3.4 Finance and activity context

lifestyle trends, impact of patient choice/expectations, increase in survival rates and technological developments.

As data has not been available to assess the individual impacts of each of the above, we have used a combination of NHS Brent historical trends and London/national data sources to calculate activity and cost growth rates for each major expenditure heading.

The results of above analysis is summarised below, with the % changes in cost and activity shown separately. In some areas, increases in activity do not translate into proportionate cost increases due to a combination of marginal cost rates applying and/or productivity in service provision.

Expenditure Category	Cost %	Activity %
Primary Care	1.0	3.0
Prescribing	3.0	3.0
Dental	1.0	3.0
Community	1.0	3.0
Mental Health	1.0	3.0
Continuing Care	3.0	3.0
Acute	4.5	4.5
TOTAL (WEIGHTED INCREASE)	3.0	

Clearly there is no 'correct' answer to the issue of assessing the future impact of individual activity and cost drivers. It is important therefore to attempt to validate our estimates with other external credible sources of data.

The % uplifts derived from the internal PCT modelling have been compared with the projected increases for the period 2008/9 to 2012/13 identified within the Wanless report of 2002. We have also reviewed the HfL modelling undertaken by NHS London.

The compound annual growth rate in cost is set out in the table below and compared with the HfL affordability assumptions.

	Brent	HfL		
	Base	Lower	Base	Upper
Overall spend weighted %	3.0	1.1	2.6	3.9

Overall, our assessment of the underlying growth rate is approx 15% above the 'base' rate assessed by HfL. We have modelled variations in our projections in our risk/opportunity assessment.

The forecast financial position for 2010/11, as well as taking account of the above, also needs to include the balance to full year effect of 2009/10 (both investments and non-recurrent in-year recovery measures).

The total impact of the all the above factors are summarised below.

	2010/11	2011/12	2012/13	2013/14
Cost/tariff	1.3%	0.5%	0.5%	0.5%
Activity/volume	3.0%	3.0%	3.0%	3.0%
FYE of 09/10	1.4%	-	-	-
Total	5.7%	3.5%	3.5%	3.5%

Summary of financial position (pre-initiatives)

The financial modelling (pre-initiatives) summarised below indicates that the underlying recurrent position would progressively worsen as expenditure growth outstrips allocation growth. Whilst the PCT has a significantly strong underlying position to withstand this deterioration in 10/11, by 11/12 the PCT would move into recurrent deficit.

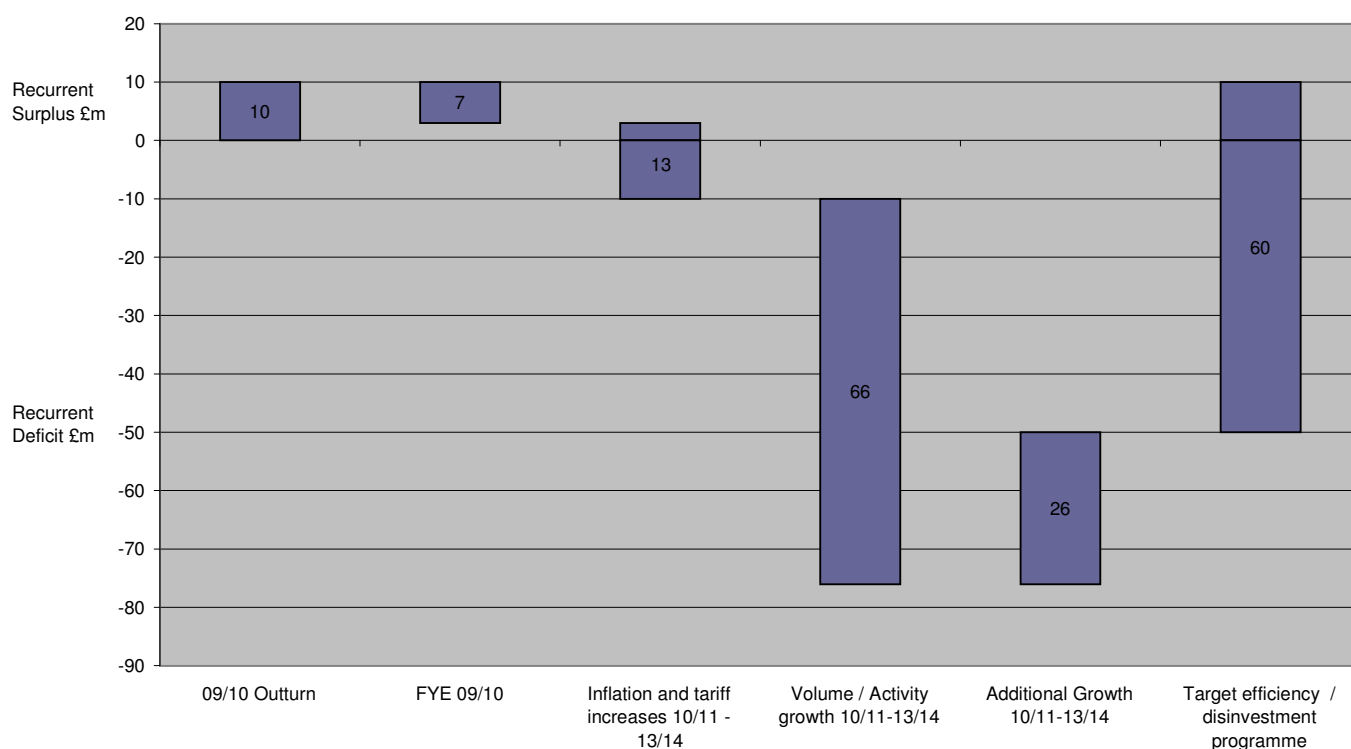
	09/10 £m	10/11 £m	11/12 £m	12/13 £m	13/14 £m
Income - recurrent	524.2	550.5	550.5	550.5	550.5
Expenditure - recurrent	514.2	544.0	561.7	580.2	599.5
Surplus / (Deficit) - recurrent	10.0	6.5	(11.2)	(29.7)	(49.0)

The above excludes the non-recurrent carry forward and other non-recurrent income/expenditure items. Under the surplus/deficit carry forward rules, the PCT would enter a cycle of increasing deficits once a sustainable recurrent position is lost as income would be reduced to reflect the previous year's deficit. It is therefore critical that the recurrent surplus position is maintained. In order to maintain a 2% recurrent surplus in accordance with the 2010/11 national Operating Framework, the PCT will therefore need to deliver a recurrent efficiency/disinvestment programme of approx. £60m, as illustrated below.

Scale and timing of the challenge

This graph below illustrates the movement in the recurrent surplus. The recurrent surplus starts at £10m at 2009/10 Outturn and is reduced by £86m for Full Year Effects, price increases and volume growth and improved by £26m for additional growth. The target efficiency and disinvestment programme therefore needs to be £60m, resulting in a £10m recurrent surplus by the end of 2013/14.

Movement in recurrent surplus 09/10-13/14



Based on the 'do-nothing profile of income and expenditure above, the PCT could aim to deliver the £60m in years 2011/12 – 2013/14. However, as realising efficiency gains of this scale will require complex change, we believe that a more prudent and realistic approach would be to engage in a four year programme and a target profile has therefore been established as below.

Year	10/11	11/12	12/13	13/14
In-year (£m)	6	18	18	18
Cumulative (£m)	6	24	42	60

Summary of activity (pre-initiatives)

If we compare the savings necessary above with the likely growth in the activity that we commission care for we can begin to gauge the size of the gap. The activity growth under a PCT 'do nothing' scenario reflects the growth rates above. The ongoing increase in acute care would lead to the activity levels set out in the table below.

Acute Care	2009/10	2013/14
Elective spells	8,216	9,776
Planned same-day	25,814	30,902
Non-elective spells	34,711	40,995
Out-patient attendances	339,523	401,268
A&E attendances	137,066	163,713

The challenge for the PCT is to both limit the increase through decommissioning low value added interventions and to secure benefits from changes to the location and model of care to lower cost settings.

4. Strategy

We do not underestimate the magnitude of the challenge as set out in the Context section above. Activity and expenditure in acute settings are rapidly increasing and whilst we recognise that the changing profile of our population means that health needs will continue to rise, our plans as set out in the remainder of this document seek to ensure that these interactions will be shifted to more appropriate settings that offer better value for money.

We will also deliver improvement through better case management, prevention, decommissioning and productivity gains that will provide sufficient disinvestment and efficiencies to maintain financial stability as well as invest in driving up quality. Commissioning of preventative and people-centred services that are better for patients but also more productive is central to achievement of our plan. Meeting the productivity challenge is critical to success.

Successfully realising these shifts and changes to the required extent can only be delivered through coordinated transformational changes within Brent and sector-wide on an unprecedented scale. This section sets out our strategy for achieving this transformation across each of the eight HfL pathways and how we are establishing a polysystem model across Brent to support these changes.

4.1 Goals

Goal 1: Reduce premature mortality and therefore increase life expectancy by 2.8 years amongst males to 81 years and 2.2 years amongst females to 85.6 years by 2013/14

Average life expectancy in Brent is 78.2 years for men and 83.4 years for women but many people in Brent die young and miss the opportunity to live a full life. Over the last three years on average 698 people every year died prematurely (at or below the age of 75) in Brent. We will measure the successful achievement of this goal against the WCC outcomes of Life Expectancy, CVD Mortality, Breast Cancer Screening Uptake and Diabetes Controlled Blood Sugar.

Goal 2: Reduce the projected gap in life expectancy by 6 months amongst males and 4 months amongst females by 2013/14

Brent performs well in many overall measures of health but there are stark inequalities in health linked to socio-economic status, gender, ethnicity, and geography. There is an 8.6 year gap in male life expectancy between the most deprived and least deprived 10% of areas in Brent (the slope index of inequality) and a gap of 2 years for females. The gap in male life expectancy is increasing rapidly and is expected to reach 13.2 years by 2014 if the current rate of increase continues. We aim to reduce the gap in life expectancy against this baseline by 6 months amongst males and 4 months amongst females by 2014. We will measure the successful achievement of this goal primarily against the WCC Health Inequalities outcome.

Goal 3: Promote good health and prevent ill-health

Smoking rates are as high as 40% in some of our most deprived wards and smoking is both the single greatest cause of preventable illness and premature death in Brent, and a major factor in health inequalities. Another cause of concern is that 56% of Brent's adult population do not participate in any sport or physical activity; one of the lowest rates in England. Increasing participation will be crucial if we are to achieve our ambition of reducing the number of people suffering from cardio-vascular disease, diabetes and poor mental health in the borough, all of which have higher rates in the wards with the most deprived and ethnically diverse populations. We will measure the successful achievement of this goal primarily against the WCC outcomes of Smoking Quitters, and MMR Completion.

Goal 4: To improve the quality and safety of services, so that by 2014 health and social care providers commissioned by NHS Brent receive a CQC Regulatory Judgment at least equivalent to the existing Good rating in the Annual Health Check for acute services, and a "Fully Compliant" Registration Status for GP and Community Services

NHS Brent aspires to make quality services (defined as clinically effective, personal and safe) a reality for all the care received by the residents of our borough. To do so, we will continue to commission acute and mental health services from providers that maintain their performance to a level assessed as "Good" or "Excellent" by the Care Quality Commission.

Our acute providers have been performing satisfactorily and we expect the North West London Acute Commissioning Vehicle to continue to hold them to account and to drive further improvements. As a borough-based commissioning organisation we will focus on driving improvements in out-of-hospital services. NHS Brent will work with GPs and Brent Community Services to ensure that the services they provide meet the new CQC essential standards of quality and safety, resulting in a regulatory judgment by the CQC of "Fully Compliant" by 2013/14. NHS Brent will also ensure that there are no "Major Concerns" attached to the Registration status of Brent Community Services from the first year, reaching a status of "Fully Compliant" by 2012/13.

Goal 5: To improve the patient experience of services, so that by 2014 health and social care providers commissioned by NHS Brent will achieve patient experience scores at least as good as the London average

For a number of reasons a significant number of providers commissioned by NHS Brent show levels of patient satisfaction below national and London benchmarks. For our main provider of acute services, we will ensure that over the next 5 years, their performance reported by the Vital Sign "Self reported experience of patients / users", as measured by the annual inpatient survey, improves steadily and surpasses the current London as well as national average.

Self reported experience of patients & users

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Target	70.3%	72.0%	74.0%	76.0%	78.0%	80.0%
% Change vs. baseline	0.0%	2.4%	5.3%	8.1%	11.0%	13.8%

NHS Brent will also strive to improve access to primary care services, and monitor its improvement via the relevant GP Patient Survey - derived indicator.

% of patients reporting satisfaction with GP Access

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Target	65.7%	69.3%	71.2%	73%	74.9%	76.8%
% Change vs. baseline	0.0%	5.5%	8.4%	11.1%	14.0%	16.9%

NHS Brent will be further developing a suite of metrics to monitor and measure patient and user experience, particularly as the polysystem model will require the performance measurement of a wider scope of community care services.

Outcomes

We have set tangible objectives for these goals and to monitor our progress against achieving them as described above. These include our selected WCC Outcomes.

We have retained 9 of the 10 outcomes agreed with stakeholders last year as they continue to represent the key outcomes we are committed to achieving for our population and we confirmed these with stakeholders at an engagement workshop in October 2009. The tenth outcome last year was a locally defined outcome to better measure health inequalities but this has effectively been duplicated in 2009/10 with the revision of the mandatory Health Inequalities indicator. We have therefore added a further outcome to set and track performance for End of Life care. This addition means that our outcomes now cover 6 of the 8 HfL outcomes with Maternity & Newborn and Mental Health being the exceptions.

Our rationale for selecting “Proportion of all deaths that occur at home” as our tenth outcome is that this is a key outcome for End of Life Care which is a more emerging priority for us and is not well covered by other performance frameworks at this point. Maternity & Newborn is increasingly being delivered at a sector level and is also well covered by other performance frameworks. There is no single Mental Health outcome that would provide a reasonably comprehensive measure for our Mental Health initiative and this is also an area that is well covered by other performance frameworks.

We have set aspirations for all these outcomes as set out in the table below.

Outcome Description	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Health inequalities in years (Males)	9.7	10.39	10.76	11.29	11.87	12.38
Health inequalities in years (Females)	1.9	1.98	1.90	1.90	1.90	1.90
Life expectancy in years (Males)	78.20	78.69	79.04	79.50	79.96	80.96
Life expectancy in years (Females)	83.40	83.92	84.22	84.53	84.83	85.13
Proportion of children completing MMR immunisation (1st & 2nd dose) by 5th Birthday	41.8%	72.7%	90.7%	94.4%	95%	95%
Smoking quitters (per 100,000)	332	911	1,059	1,059	1,059	1,059
Proportion of women aged 53-70 screened for breast cancer within the last three years	44%	49.7%	59%	71%	75%	78%
Self reported experience of patients & users	70.3%	72%	74%	76%	78%	80%
Delayed transfers of care (% of cases per 100,000 over 18)	13.6%	13%	11%	9%	7%	5%
CVD mortality (per 100,000 > 75)	86.65	78.81	75.43	70.84	64.75	58.16
Diabetes controlled blood sugar (at Hba1c 7.5)	56.8%	65%	68%	70%	74.3	75
Proportion of all deaths that occur at home	N/A	19%	20.5%	22%	23.5%	25%

Health Inequalities

The CSP goal is to reduce the health inequalities gap against the projected baseline by six months which will be achieved through the phased rollout of NHS Health Checks starting in our most deprived boroughs. This is against a trend where the gap in male inequalities is increasing rapidly by 0.7 years per annum, reaching 13.15 by 2014. Overall therefore there will still be a significant net increase in Health Inequalities.

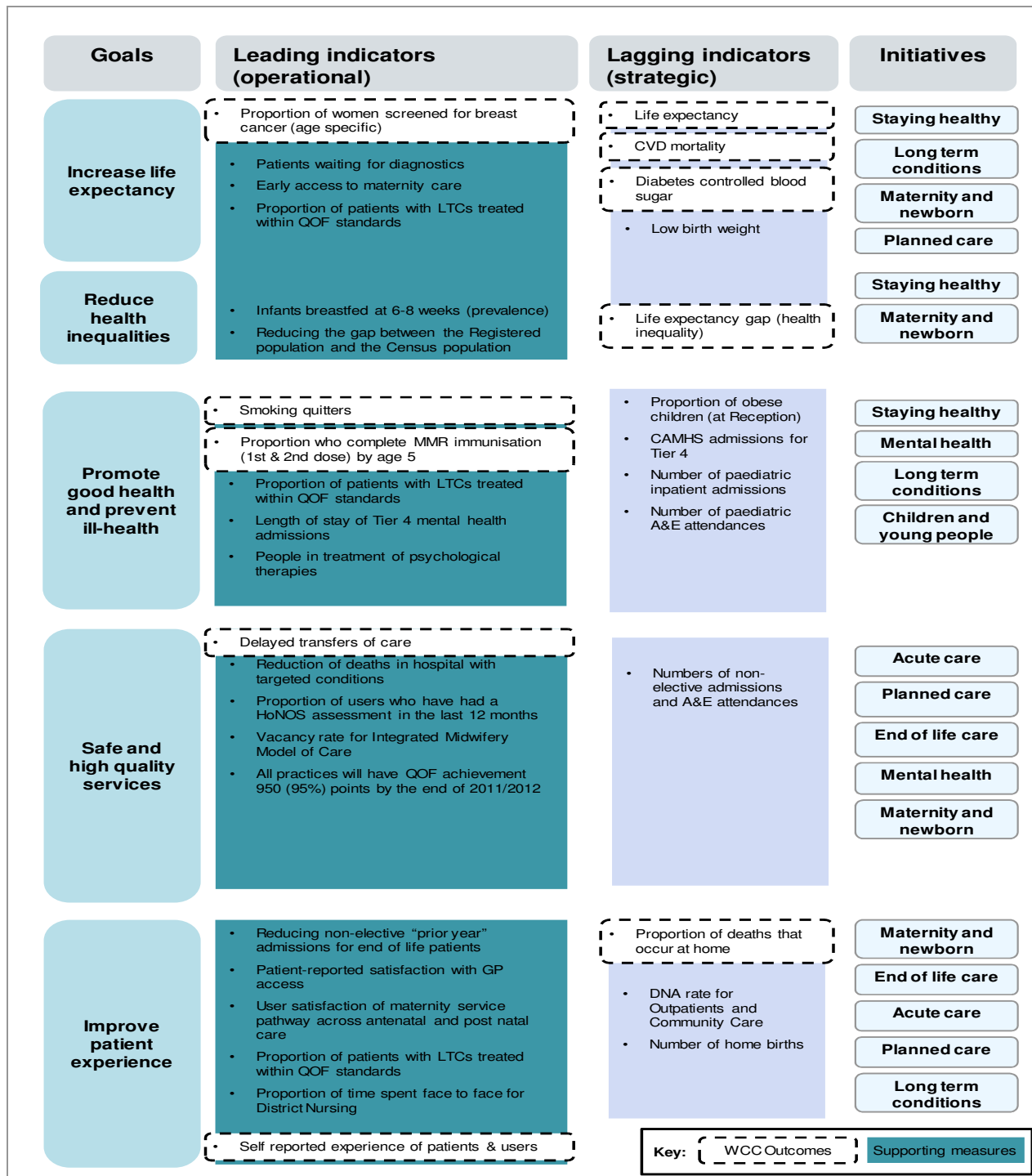
We have adopted a cautious approach to both the calculation of the baseline trajectories and the modelling of the impact of our initiatives on the trajectories. In terms of the baseline trajectories we have taken the LHO data for 4 data points (01-05, 02-06, 03-07 and 04-08) and extrapolated the trend but we believe it is unlikely that the trend would continue to rise at the same rate even without any intervention. We would expect to revise the trajectory as more data becomes available in future years.

4.1 Goals

At this stage we have only modelled the impact of the NHS Health Checks on the baseline trajectories. In practice it is not just the NHS Health Checks that will have an impact on health inequalities. Improving access to antenatal care, tackling infant mortality, improving access to psychological therapies, and reducing smoking prevalence will also address health inequalities. In addition the PCT has developed a health and wellbeing strategy jointly with the Local Authority that sets out joint actions to improve health and reduce health inequalities in Brent and we have a jointly appointed Director of Public Health and Regeneration. However it will take a number of years for these programmes to have an impact on health inequalities and NHS Health Checks is the only programme where we have been able to identify an immediate, quantifiable and significant impact on health inequalities at this stage.

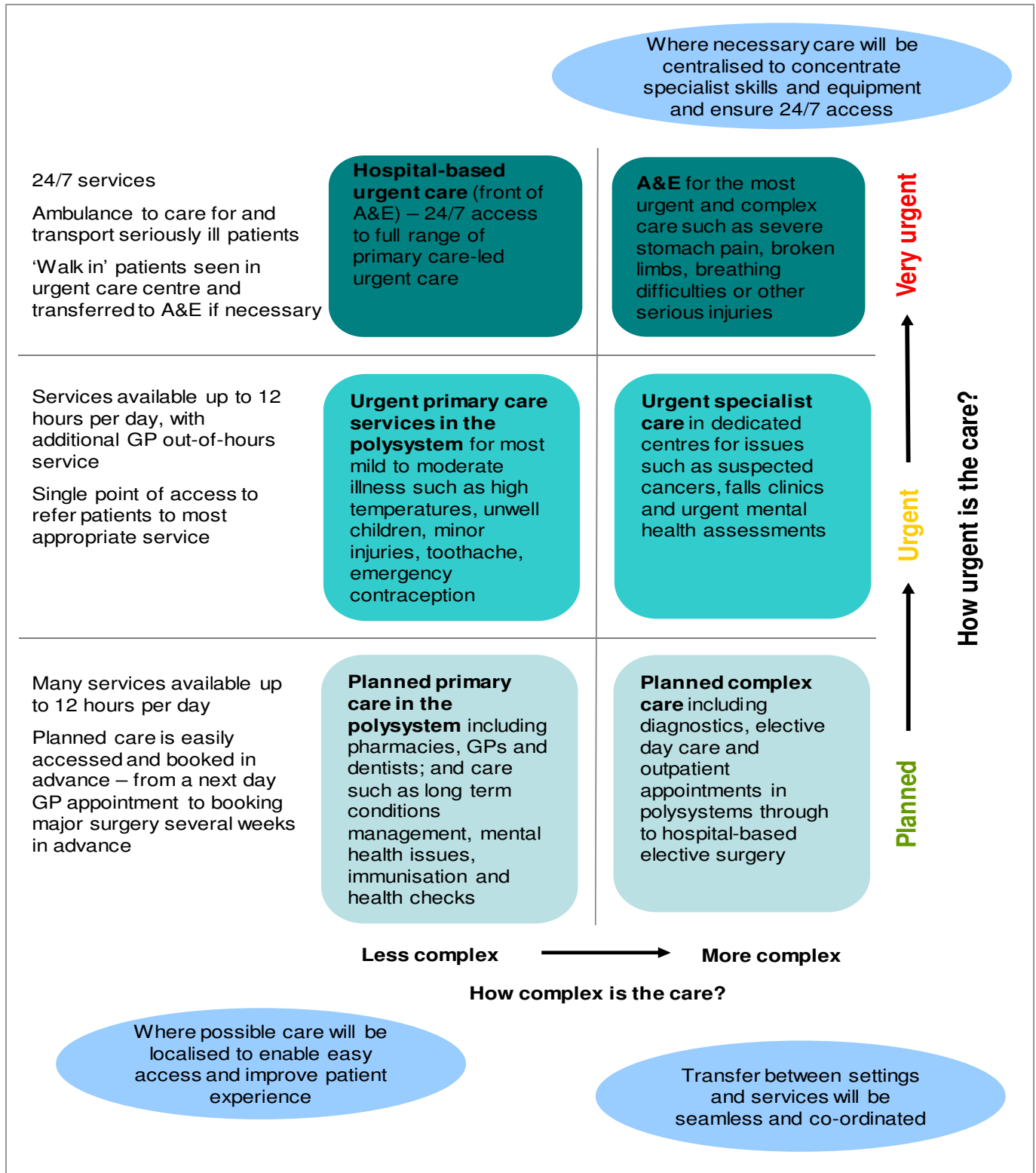
Goals, Outcomes and Initiatives

The diagram below illustrates the links between our goals, outcomes (and other metrics) and initiatives.



Future End State

If we are to achieve our goals we need to commission differently – changing the models of healthcare delivery and transforming the ways in which care is accessed. Detailed information on our plans for polysystems can be found in section 4.3 and information on changes to the acute sector in the sector-level integrated strategic plan. The diagram below summarises the changes we will make to transform healthcare and achieve our goals in Brent by 2014.



4.2 Initiatives

The impact of each of the PCT initiatives has been assessed in terms of both activity and financial implications, with analysis being undertaken at HRG/specialty level as appropriate. Both investment and disinvestment implications have been considered and a clear distinction has been drawn between recurrent and non recurrent impacts (all non-recurrent enabling costs have been drawn together in our OD Plan). In addition to the efficiency and disinvestment plans and figures included in the eight initiatives set out below, we also plan to deliver £2.1m of management cost savings and this is included as a separate initiative in the finance template. Also it should be noted that all financial projections in this section are pre risk-assessment. The impact of the risk assessment and reconciliation to the World Class Commissioning (WCC) finance template is included in section 4.5 below.

Initiative one – Maternity and newborn

- Birth rates in Brent are increasing at approximately 8% per annum
- There is a high ratio of complex or high risk pregnancies, and significant late presentation
- The infant mortality rate at 5.4 per 1000 live births is higher than London and national averages, and there is also a high number of low birth weight babies
- Vacancy rates at our local provider stand at 40% for community midwives and 26% for hospital midwives

HfL recommendations for improving maternity services focus on the need to ensure choice regarding place of delivery, improve the way antenatal care is provided, ensure continuity of care through the pathway, and deliver a step change in the quality of care during labour.

Maternity has been a key priority for NHS Brent for some time, with recent focus being on improving quality and safety of care, especially during labour, at NWLH the main provider for Brent women. This has led to a number of key achievements including:

- Relocation of the Brent Birthing Unit from CMH to NPH
- Improved stratification of risk during pregnancy ensuring active management during pregnancy and labour of high risk women

A range of stakeholders have been engaged in the development of this initiative. This has enabled us to encapsulate the views of clinicians, GPs and service users in shaping the service improvements required to improve care. Considerable progress has been made with regard to strengthening the Maternity Services Liaison Committee with the appointment of an independent lay chair and the development of a work plan to ensure service users, clinicians and stakeholders are actively involved in service improvement work.

High quality care during labour will now be the main focus of the North-West London sector team, whilst NHS Brent will concentrate on developing two main areas:

- Improved pre-conception care and encouragement of early booking
- Continuity of care throughout the maternity pathway and in line with the Children's Centres pathways of care

PCT AREAS OF FOCUS ALONG THE PATHWAY (sector focus areas in *italic*)



PRIORITY CSP ACTION AREAS

1. IMPROVED PRE-CONCEPTION CARE AND ENCOURAGEMENT OF EARLY BOOKING

We will ensure that all GP practices, family planning clinics and sexual health clinics across Brent have access to the appropriate health education materials to support pro-active pre-conception care including tailored information for high-risk women.

Over the last year we have focussed considerable effort on segmenting the groups who book late for antenatal care. Whilst we will continue to work with the acute commissioning partnership to address capacity issues within local providers, we will also commission a range of initiatives aimed at increasing awareness amongst both health professionals and community groups about the importance of early booking and promote direct booking and improved community access. ***In 2011 we will achieve the DH performance measure.***

2. CHOICE & CONTINUITY OF CARE THROUGHOUT THE MATERNITY PATHWAY

Due to recruitment issues, NWLH has been unable to implement the agreed model of community midwifery. NWLH has been working actively with NHS London to improve the current vacancy levels and expects to be shortly in a position to implement the agreed model. The model promotes NICE guidance with midwife-only care being provided within Children's Centres across Brent and postnatal care provided by the same team. However we recognise that this pathway is only available to women who book with NWLH and that the 49% of women who book elsewhere will currently receive antenatal care from their chosen provider and postnatal care from NWLH.

Whilst supporting the wider work being undertaken across London to ensure continuity of care for women, locally we will work with NWLH to implement the care pathway, including introducing joint midwife and consultant services in our Children's Centres. Through setting standards of good practice we will ensure that we have agreed clear expectations of service providers, including GPs continuing to be involved in shared care. Through more active commissioning and contract management, including achievement of agreed productivity improvements from our community midwifery provider, we will eradicate the current inefficiencies we have due to duplication of commissioning. This will result in a reduction in contract pricing for community midwifery and payments for shared care only being made to practices actively participating in the antenatal care pathway. ***By October 2010 we will have introduced polysystem-based care pathways with supporting commissioning arrangements.***

IMPACT

We have identified a suite of priority metrics attached to this initiative. These metrics are directly aligned to the realisation of our CSP goals, and have been chosen as those metrics which will have most impact on our priority areas of focus within the initiative. We will measure success and drive delivery through monitoring of these metrics against locally defined improvement, and by benchmarking against national, London and comparator group performance. These metrics will include:

Early access to maternity care

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Target:	50.0%	80.0%	90.0%	95.0%	95.0%	95.0%
% Change vs. baseline*	0.0%	60.0%	80.0%	90.0%	90.0%	90.0%

Number of home births

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Target:	0.9%	1.3%	1.7%	2.2%	2.6%	3.0%
% Change vs. baseline*	0%	47%	93%	140%	187%	233%

User satisfaction of maternity service pathway across antenatal and post natal care

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Target:	73.0%	77.4%	81.8%	86.2%	90.6%	95.0%
% Change vs. baseline*	0.0%	13.8%	29.8%	48.6%	70.9%	97.9%

Vacancy rate for Integrated Midwifery Model of Care

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Target:	26.5%	23.0%	19.5%	16.0%	12.5%	9.0%
% Change vs. baseline*	0%	-13.2%	-26.4%	-39.6%	-52.8%	-66.0%

Proportion of births that are caesarean sections

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Target:	27.0%	26.3%	25.6%	24.9%	24.2%	23.5%
% Change vs. baseline*	0.0%	-2.6%	-5.2%	-7.8%	-10.4%	-13.0%

Low birth weight

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Target:	9.3%	8.9%	8.6%	8.2%	7.9%	7.5%
% Change vs. baseline*	0.0%	-10.1%	-18.1%	-26.1%	-32.5%	-39.0%

*The baseline, per year, is the forecasted performance for that year if the initiative was not in place, against which we are measuring progress.

As well as these quantifiable impacts on health outcomes the successful implementation of this initiative will also contribute in general to healthier pregnancies and babies across Brent and especially in areas of greatest need, and to increasing service quality and patient satisfaction. Overall this initiative will therefore contribute directly to our stated CSP goals, and to creating a more efficient and streamlined NHS maternity service within Brent.

FINANCIAL IMPACT

	2010/11	2011/12	2012/13	2013/14	Total
	£000	£000	£000	£000	£000
New investment					
Disinvestment	(250)	(687)	(873)	(873)	(873)
Net total disinvestment	(250)	(687)	(873)	(873)	(873)

Initiative two – Children and young people

- Children and young people make up 25% of our population, with an 8.7% increase from 2005-2007
- Over 75% of the youth population are from BaME populations
- Levels of childhood obesity & teenage pregnancy are higher than both national and London rates
- A higher proportion of Brent children attend hospital as outpatients (Brent 33.7%, London 27.5%) and are admitted following A&E attendance (Brent 9.6%, London 6.5%)
- Children's workforce issues, particularly in universal services have exacerbated this trend

The recent guidance from HfL promotes a model of care that aims to provide a seamless journey for children and young people by creating more appropriate access points for unplanned care; more appropriate facilities in all hospitals for observation without the need for admission; multi-disciplinary teams who work across traditional care settings; moving care closer to home and by developing community teams to provide care for children who are ill, have LTCs or complex health needs.

In the past year NHS Brent has focussed attention on improving health and promoting healthy behaviours for children and young people and on undertaking extensive pre-consultation work in relation to the current acute paediatric bed configuration in the context of the development of the Urgent Care Centre (UCC) at CMH and the need to ensure more appropriate care in the community settings. This has led to a number of achievements including:

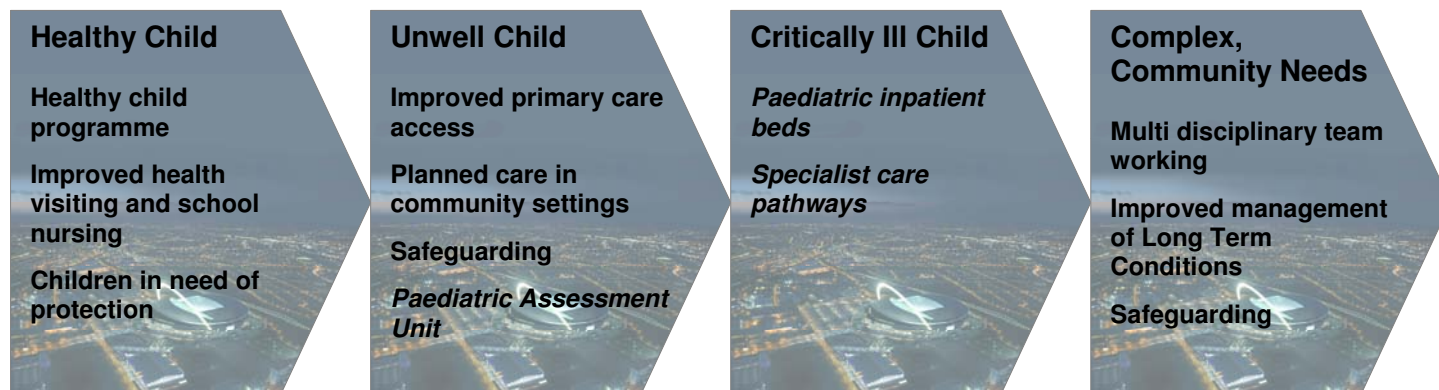
- Successful implementation of jointly commissioned services relating to childhood obesity, breast feeding and risk-taking behaviour amongst young people
- Establishment of integrated locality boards co-terminus with the five polysystems and involving all partner agencies

4.2 Initiatives

- Review and strengthening of safeguarding arrangements including integration of some arrangements with the LBB
- Agreement of the Children and Young Peoples Strategy and establishment of Joint Commissioning Board to take forward the strategy and HfL pathway

All of this work, together with the extensive pre-consultation work relating to the development of a Paediatric Assessment Unit has been undertaken with extensive stakeholder engagement. This has included primary care clinical leadership, co-design of the pathways between primary and acute clinicians, active involvement of the partners in Children's Trust, parents and carers and young people themselves. A wide variety of methods have been employed including deliberative events, focus groups and interviews. It will be important to continue with this level of stakeholder engagement as the initiative develops.

PCT AREAS OF FOCUS ALONG THE PATHWAY (sector focus areas in italic)



PRIORITY CSP ACTION AREAS

1. THE HEALTHY CHILD

Although we have had an agreed specification for health visiting and school nursing for some time, it has not been implemented due to recruitment difficulties. We will be reviewing the specification and commissioning a care pathway that fully integrates the work of health visitors with children's centres with identified elements of the healthy child programme being commissioned directly from the Children's Centres. The introduction of new providers together with agreed productivity improvements for health visiting will enable full implementation of the pathway. Once implemented, the care pathway will ensure that all children access the healthy child programme and that children in need of protection are offered more intensive support. We will also be developing and implementing a new specification and care pathway for school-aged children integrating more fully the work of school nurses with the extended schools programme. We believe that this model of implementation will both help address the current workforce risks to the quality, capacity and capability to deliver, and also better support the impact the healthy child and extended schools programme can also have on parents' lifestyles. ***By October 2010 we will have introduced a comprehensive Healthy Child Programme, fully integrated with Children's Centres & Extended Schools.***

2. THE UNWELL CHILD

Too many young children are attending acute care (both A&E and outpatients) for services that should more appropriately be provided in community settings. We will commission a support programme for primary care in relation to self-management; management within community support and management in primary care. Implementation of this programme will be a key success factor for polysystem commissioners and will result in significant decommissioning of current acute activity.

We will also develop care pathways for common conditions and commission, at a negotiated local tariff rate, multi-disciplinary teams including consultants, primary care specialist doctors, nurses and therapists, to work within the polysystems to provide assessment and treatment, avoiding the need for hospital referral. ***By the end of 2011/12 up to 50% of current outpatient care for children will take place in polysystem settings.***

3. CHILDREN WITH COMPLEX COMMUNITY NEEDS

We will review our existing pathways for children with complex community needs and establish new care pathways to support improved access to specialist care at times of acute exacerbations (both to prevent admissions and to expedite discharge); provide access to specialist advice in community settings and provide ongoing support at home and school. We will review our current commissioning arrangements to ensure we have the most efficient and effective arrangements, ensuring we avoid duplication or fragmentation of care. **By the end of October 2010 we will have in place new pathways and models of care.**

IMPACT

We have identified a suite of priority metrics attached to this initiative. These metrics are directly aligned to the realisation of our CSP goals, and have been chosen as those metrics which will have most impact on our priority areas of focus within the initiative. We will measure success and drive delivery through monitoring of these metrics against locally defined improvement, and by benchmarking against national, London and comparator group performance. These metrics will include:

Number of paediatric inpatient admissions (per 1000)

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Target	12.50	10.50	8.50	7.50	7.00	6.50
% Change vs. baseline*	0.0%	-16.0%	-32.0%	-40.0%	-44.0%	-48.0%

Number of paediatric A&E attendances (per 1000)

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Target	9.60	8.60	7.50	6.40	5.90	5.40
% Change vs. baseline*	0.0%	-10.4%	-21.9%	-33.3%	-38.5%	-43.8%

Proportion of time spent face to face for Health Visiting

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Target	38.0%	38.0%	50.0%	65.0%	65.0%	65.0%
% Change vs. baseline*	0.0%	0.0%	31.6%	71.1%	71.1%	71.1%

Proportion of infants breastfed at 6-8 weeks (prevalence)

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Target	53.4%	72.1%	76.2%	79.3%	81.0%	82.0%
% Change vs. baseline*	0.0%	35.0%	42.7%	48.5%	51.7%	53.5%

Proportion of obesity in Reception children

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Target[†]	10.8%	10.9%	11.0%	11.0%	10.9%	10.9%
% Change vs. baseline*	-4.4%	-7.6%	-10.6%	-14.1%	-18.0%	-21.0%

*The baseline, per year, is the forecasted performance for that year if the initiative was not in place, against which we are measuring progress.

[†]The Target for 2008/09 had been agreed previously in the Local Area Agreement based on the 2007/08 baseline data; therefore, the % Change versus baseline is already assuming a negative trend, rather than No Change.

ACTIVITY IMPACT

Description	2010/11	2011/12	2012/13	2013/14
Shift to Lower Cost Setting - Paediatric outpatients		4,420	4,420	4,420
Decommissioning paediatric outpatient activity (follow up care)		2,652	2,652	2,652
CCN - Preventing avoidable admissions		281	281	281
Total activity shift		7,353	7,353	7,353

FINANCIAL IMPACT

	2010/11	2011/12	2012/13	2013/14	Total
	£000	£000	£000	£000	£000
New investment	300	346	761	761	761
Disinvestment	(250)	(668)	(2,184)	(2,184)	(2,184)
Net total disinvestment	50	(322)	(1,423)	(1,423)	(1,423)

Initiative three – Acute care

- A&E is used in Brent as an alternative to primary care and rates are rising at 8% a year
- 60% of A&E attendances are for conditions that could be managed in primary care
- Cardiovascular disease is Brent's biggest killer and disproportionately affects the most deprived areas
- North West London Hospitals averaged 78 delayed bed days per week for Brent patients, with the main cause of delay being a wait for a community intermediate care bed
- 65% of all Local Authority long term placements into residential and nursing care are made directly from the acute setting due to a lack of community intermediate care

The key HfL recommendations around acute care relate to significantly improving access through the establishment of UCCs; centralisation and networks for major trauma, heart attack and stroke and providing accessible care which meets the needs of the population in the most appropriate setting.

In the past year NHS Brent has participated in the development of pathways for stroke and trauma and the consultation which concluded in the designation of major trauma centres and hyperacute stroke units across London, including on the NPH and St Mary's site. Locally we have focussed on three main areas of acute care; the undertaking across the health economy of a review of the acute services provided by NWLH; improving access for people with primary care urgent needs and improving intermediate care services (including stroke) to prevent unnecessary hospital admissions and to expedite hospital discharges. This has led to a number of key developments including:

- Centralisation of emergency surgery on Northwick Park site with agreed specification and benefits realisation plan
- Opening in July 2009 of a GP Led Health Centre at Wembley, offering extended opening hours and a walk-in service
- Agreement of the specification for the establishment of a Primary Care Led UCC as the 'front door' to CMH
- Agreement of a joint Intermediate Care Strategy with the LBB and joint commissioning of a fully integrated Short Term Assessment, Rehabilitation and Reablement Service (STARRs)
- Agreement with key partners of an Early Supported Discharge Pathway for stroke to complement the planned improvements in acute pathway

These projects have all been driven forward with strong leadership across a range of stakeholders including acute and primary care clinicians involved in leading the acute services review and development of the new acute and community pathways for acute and urgent care locally. The LBB have shared leadership of the intermediate care and stroke work, including joint commissioning of new service models. Patients and carers have been involved in all pathway redesign work and the wider community have participated in the extensive co-production initiatives undertaken for each project, using a wide range of methods including deliberative events.

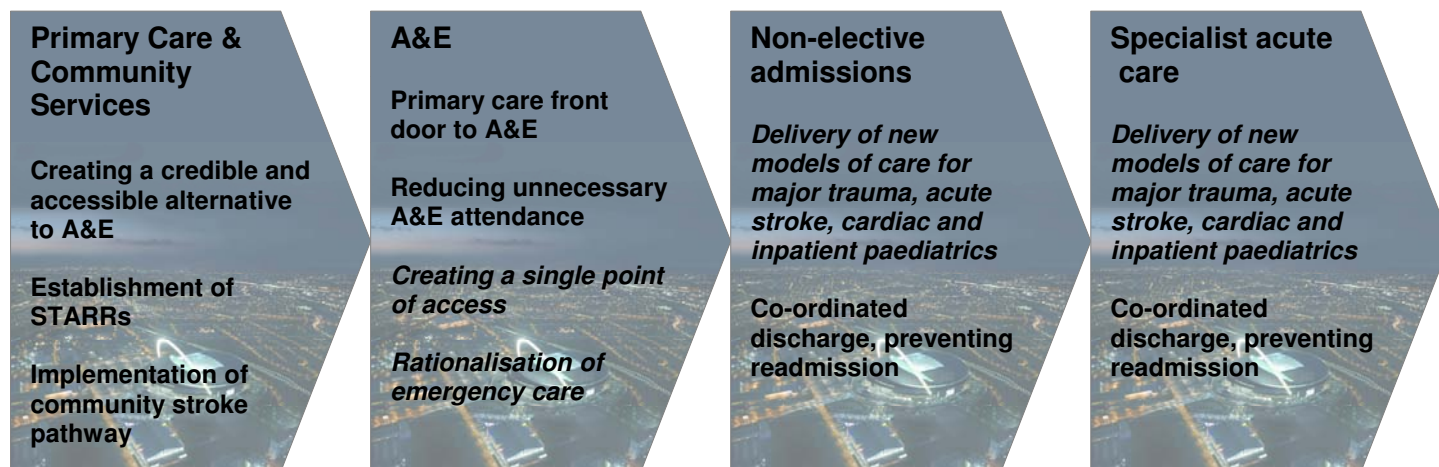
This level of stakeholder involvement and clinical leadership remains critical as the projects move towards full implementation, developing Central Middlesex Polyclinic as the gateway for urgent care access.

Further development of acute specialist pathways will be undertaken through the sector arrangement, with the focus of this CSP initiative being upon ensuring access to appropriate care for people with

4.2 Initiatives

urgent primary care needs and jointly commissioning the pathway services required to manage people with acute exacerbations of care in the most appropriate setting.

PCT AREAS OF FOCUS ALONG THE PATHWAY (sector focus areas in italicic)



PRIORITY CSP ACTION AREAS

We recognise the importance of a co-ordinated approach to the care of people with urgent and acute care needs. The CSP action areas are being co-designed to ensure the required coordination. The overall delivery model for urgent and acute care is more fully described in the Polysystems section of this document, using CMH/Polyclinic as the focus point across Brent.

1. ACCESS TO PRIMARY CARE URGENT CARE SERVICES

Our polysystem implementation plans outline the establishment of two polyclinics providing 8-8 access to primary care urgent care consultations for both the registered and unregistered population. The third polyclinic, based on the CMH site, will provide a wider range of urgent care services and will be open 24/7. In addition, we will commission the UCC to provide the out of hours service for those GP practices across Brent who have delegated responsibility for out of hours cover to NHS Brent.

Over time it is expected that with the planned improvements in GP availability through every GP practice in Brent (outlined in the Planned Care initiative) the demand for primary care consultations provided by other services will decrease. **By the end of 2011/12 every Brent resident will be registered with a GP practice that meets access standards and there will be 8-8 GP Access Centres open in every polyclinic**

2. ESTABLISHMENT OF SHORT TERM ASSESSMENT, REHABILITATION & REABLEMENT SERVICE (STARRs)

The STARRs service comprises a number of key elements; single point of access and brokerage; access to rapid response intensive health and social care response for people at risk of hospital admission; step-up and step-down health and social beds; rehabilitation and reablement in the community. The hub of the service will be based at CMH establishing integrated working with the UCC. The current Rapid Response service pilot is delivering early benefits with 108 referrals in October 2009, over 90% of which went on to avoid admission.

Procurement for the UCC and STARRs will commence in December 2009 and it is anticipated that both services will be in place by quarter 2 of 2010. **By July 2010 all people with acute exacerbations will be cared for in polysystem settings of care if medically appropriate.**

3. IMPLEMENTATION OF COMMUNITY-PATHWAY FOLLOWING STROKE

We are planning to use Clinicenta, in collaboration with NWLH, as the main provider of early supported discharge and stroke rehabilitation. We have agreed revised specifications for these services to ensure they meet the needs of our residents and a balanced scorecard to ensure benefits

4.2 Initiatives

realisation. **By April 2010 the HfL rehabilitation pathway for stroke will be fully implemented across Brent.**

In addition to these priority areas, we will seek to drive out significant savings through the Acute Commissioning Vehicle, London Ambulance Service utilisation and other specialist commissioning savings as well as further cost reductions and decommissioning opportunities at A&E.

IMPACT

We have identified a suite of priority metrics attached to this initiative. These metrics are directly aligned to the realisation of our CSP goals, and have been chosen as those metrics which will have most impact on our priority areas of focus within the initiative. We will measure success and drive delivery through monitoring of these metrics against locally defined improvement, and by benchmarking against national, London and comparator group performance. These metrics will include:

Impact on non-elective admissions

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Target	22,160	21,759	20,020	18,200	18,200	18,200
% Change vs. baseline*	0%	-3%	-10%	-19%	-19%	-19%

Assumptions:

1. Underlying trend remains constant based on 2009/10 estimated year end position
2. 10/11 benefits of reablement are 50% of estimated end-state effect

Impact on A&E attendances

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Target	49,343	49,343	21,463	13,782	13,782	13,782
% Change vs. baseline*	0%	0%	-57%	-72%	-72%	-72%

Assumptions:

1. Underlying trend remains constant based on 2008/09 actuals
2. UCC will treat all minors and 50% of standards
3. UCC commences after 20% of 2010/11 has passed (approx June 10)

Impact on Delayed transfers of care

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Target †	13.6%	13.0%	11.0%	9.0%	7.0%	5.0%
% Change vs. baseline*	-9.0%	-13.0%	-27.0%	-40.0%	-53.0%	-67.0%

*The baseline, per year, is the forecasted performance for that year if the initiative was not in place, against which we are measuring progress.

†The Target for 2008/09 had been agreed previously based on the 2007/08 baseline data; therefore, the % Change versus baseline is already assuming an Improvement trend, rather than No Change.

ACTIVITY IMPACT

Description	2010/11	2011/12	2012/13	2013/14
Emergency admissions avoided through delivery of Intermediate Care	1,383	2,265	2,265	2,265
A&E attendances avoided	1,831	3,000	3,000	3,000
Reduced A&E attendance from GP Led Health Centre and UCC at CMH	18,218	24,290	24,290	24,290
A&E cost reduction / decommissioning	10,000	10,000	10,000	10,000
Total	31,431	39,555	39,555	39,555

FINANCIAL IMPACT

	2010/11	2011/12	2012/13	2013/14	Total
	£000	£000	£000	£000	£000
New investment	2,286	3,083	3,083	3,083	3,083
Disinvestment	(8,302)	(14,029)	(17,978)	(21,495)	(21,495)
Net total disinvestment	(6,016)	(10,946)	(14,896)	(18,413)	(18,413)

Initiative four – Planned care

- In 2008/09 Brent GPs scored on average 803 QOF points compared to the London average of 938
- Brent ranks 149 (out of 152) for patient experience of GP practices
- There are variable referral rates to acute care in some specialties & community pathways for elective care are under-developed
- Some pathways for elective care are fragmented across providers resulting in duplication
- The unit costs paid to GP practices range from £52 to £120
- NHS Brent has the highest recorded difference between census population levels and registered population levels in London

HfL recommendations for improving planned care include improving access to routine GP appointments; shifting routine diagnostics and outpatients out of larger hospitals; increasing day case provision; centralising specialist care and standardising care through use of care bundles.

NHS Brent's recent focus has been upon establishing the Primary and Community Strategy to support the improvements required within primary care settings, addressing under-performance in relation to the delivery of quality services and achievement of targets at individual practice, polysystems and cross-Brent levels and introducing contract management arrangements with Brent Community Services as the main provider of community services. This has led to a number of key achievements including:

- Agreement of a Primary and Community Strategy which clearly articulates the quality and model of care all people in Brent can expect
- Improvements in primary care access with the majority of practices offering extended hours and implementation of a Primary Care Access scheme to support practices
- Introduction of a Balanced Scorecard for Primary Care

The development of the Primary and Community Strategy was clinically led by the Professional Executive Committee and by the clinical leaders in each of the five PBC Clusters (polysystems). The outcomes and commitment made within the strategy were heavily influenced by user feedback following an extensive engagement campaign which employed a range of methodologies including deliberative events, surveys, focus groups and groups within our community. Key partners including the local authority were involved in the development of the strategy. It is recognised that the scale of the change required in primary and community settings requires transformational rather than incremental change if the improvements required to implement HfL across Brent are to be fully realised. Ongoing stakeholder engagement in the implementation of the changes will be critical.

PCT AREAS OF FOCUS ALONG THE PATHWAY (sector focus areas in *italic*)



PRIORITY CSP ACTION AREAS

1. PRIMARY CARE CONTRACTORS

We recognise that GP practices are central to delivery of our CSP and that transformational change is required to achieve the improvements required. The actions detailed below will, when taken together, lead to such change. The overall outcome will be that people in Brent will have choice of GP practice based upon geographical convenience and personal preference, not quality. Quality will be of a consistent high standard across all practices.

By the end of 2011/12:

All practices will be CQC registered (with fully compliant registration in 2014)

All practices will be providing core services to agreed quality standards

All practices will be achieving national outcome measures (screening & prevention)

All practices will show improved patient experience with 74% of Brent patients reporting overall high/good experience

100% of practices will be achieving over 95% QOF with both prevalence and exception reporting status meeting normal levels

List validation: NHS Brent currently has the highest percentage difference between registered and resident population in London. The current intensive list validation exercise is due to complete in 2010/11. Practices completing the intensive programme will automatically be incorporated into the ongoing rolling programme undertaken either after a fixed period or triggered by unexpected variations.

Standardised quality of General Practice: NHS Brent has made a commitment to standardise the core offering practices provide across the borough and only to continue to commission services from those practices that meet the agreed standard metrics. We will agree implementation plans with all practices currently not offering the core services to the required standard. The implementation plans may include a transitional period where local practices work together to provide core services, prior to formal consolidation on one site or full implementation on each site.

Review of contractual frameworks: PMS contracts will be reviewed to ensure that they offer value for money including the targeted use of growth money to support the priorities of NHS Brent as set out in the CSP. Over time we would wish to review contractual arrangements with all primary medical service contractors to ensure the equalisation of payments in relation to the core service provision and agreement of additional services provided with additional funding within the contract value.

Performance management: We will be reviewing with clinical commissioners our existing balanced scorecard to ensure that it meets our current and future expectations for primary care. Practices and practitioners who are not meeting the required standards will be offered support to improve practice within agreed timescales. Contractual and performance measures will be implemented where necessary.

Succession planning: We will be agreeing with all single handed practitioners reaching or over retirement age a succession plan. This will include the need to meet the full requirements of the core offering to the required standards.

Estates rationalisation: In the base case, NHS Brent will only support the development of new sites where the revenue implications are cost neutral. We will work closely with Kingsbury and Kilburn clusters where the needs are greatest for two new locality centres to see how these can be achieved through the consolidation of practices, joining up of functions across practices and using sites optimally, both across primary care and with other agencies.

Improving access to primary care: NHS Brent is funding a programme of support to practices that are providing poor access focussing on the 20 practices who achieved the poorest patient experience feedback in the 2008/09 study. This scheme will continue into 2010/2011 and will be extended to support additional practices improve access.

The changes outlined above will require active commissioning and contract management including regulatory management; re-negotiation and management of contracts, active encouragement of cooperation between practices and the introduction competition. Similar commissioning initiatives will be put into place for other independent contractors to ensure value for money, utilising all four contractual levers as appropriate.

2. CARE PATHWAYS – ELECTIVE CARE

Through a phased programme of change we will implement an ambitious and innovative approach to the establishment of care pathways for identified specialties for elective care which supports care provided

4.2 Initiatives

within general practice without the need for onward referral; transforms community provision including a multi-disciplinary team approach; reduces the need for onward referral to acute settings and decommissions all consultations which do not add clinical value for the patient.

Phase One (2010/11)

- Agreement of consistent, protocol driven care pathways based upon Map of Medicine
- Agreement with clinical commissioners of Polysystem Improvement Plans with clear outcomes and expectations for practices within and across the cluster, linked to an agreed programme across all practices designed to ensure that all practices offer a high standard of quality care and advice
- Introduction of Integrated Teams at polysystem level, comprising a designated consultant, nurse specialist and primary care specialist. Each specialty team will support the polysystem through tailored training and access to specialist advice
- Agreement of clear, measurable outcome measures including implementation of protocol-driven care, peer review and normalisation of referral rates
- Specification for community services based in polyclinics and procurement of new services, at negotiated local tariff price, to complete the primary and community transformation of elective care pathways (new services commencing 2011/12)

Phase 2 will commence in 2011/12 mirroring phase one with additional specialties and elective day care. Successful delivery of this workstream requires improved management of care within general practice (including access to the appropriate diagnostics), the decommissioning of elective care from acute providers, payable under PBR tariff, and the commissioning of polysystem care, payable at a local tariff. Adherence to the agreed protocol-driven pathways will be critical to success and will form both a key success factor for polysystem commissioners and a contractual requirement for new providers of polysystem care. **By the end of 2013/14 up to 100% of current outpatient care in a number of specialities will take place in polysystem settings.**

3. COMMUNITY SERVICES

The changes in both acute and planned care, together with the introduction of polysystems, will require significant changes from all of the community services commissioned, predominantly from Brent Community Services. These changes will be agreed as the relevant care pathways are both specified and then commissioned. In advance of these changes, we will require significant productivity gains from our existing community providers (based upon work already undertaken through the Meridian studies) and we will be rationalising our commitments with neighbouring PCTs. Through infrastructure changes we expect a significant reduction in the contract / pricing structure for BCS. In addition we will also be optimising our shared service arrangements.

IMPACT

We have identified a suite of priority metrics attached to this initiative. These metrics are directly aligned to the realisation of our CSP goals, and have been chosen as those metrics which will have most impact on our priority areas of focus within the initiative. We will measure success and drive delivery through monitoring of these metrics against locally defined improvement, and by benchmarking against national, London and comparator group performance. These metrics will include:

Proportion of patients reporting satisfaction with GP Access

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Target	65.7	69.3	71.2	73.0	74.9	76.8
% Change vs. baseline*	0.0%	5.5%	8.4%	11.1%	14.0%	16.9%

All practices will have QOF achievement 950 (95%) points by the end of 2011/2012

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Target (no. of practices)	29	40	60	71	71	71
% of all Practices (Baseline)*	40.8%	56.3%	84.5%	100.0%	100.0%	100.0%

4.2 Initiatives

Reducing the gap between the registered population and the Census population

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Target	340,000	330,000	306,000	300,000	295,000	289,000
% Change vs. baseline*	0.0%	-2.9%	-7.3%	-9.1%	-10.6%	-12.4%

An independent study of the current Brent Community Services District Nursing Team showed that productivity can be increased by changing and modernising the current ways of working.

The study reported that the overall direct face to face contacts by service was 53% with a large variation in performance indicating an opportunity for improving performance and the lack of consistency across the service. By increasing the overall % direct face to face time to 70%, up to 50,000 additional appointments will be released to the service.

Proportion of time spent face to face for District Nursing

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Target	53.0%	53.0%	65.0%	70.0%	70.0%	70.0%
% Change vs. baseline*	0.0%	0.0%	22.6%	32.1%	32.1%	32.1%

Proportion of patients waiting 2 weeks for Diagnostics

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Target	58.0%	60.0%	65.00%	75.00%	85.00%	100.0%
% Change vs. baseline*	0.0%	3.4%	12.1%	29.3%	46.6%	72.4%

Proportion of all appointments that are missed as DNAs (Outpatients & Community)

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Target	14.0%	13.0%	12.0%	11.0%	9.50%	8.50%
% Change vs. baseline*	0.0%	-7.1%	-14.3%	-21.4%	-32.1%	-39.3%

*The baseline, per year, is the forecasted performance for that year if the initiative was not in place, against which we are measuring progress.

ACTIVITY IMPACT

Description	2010/11	2011/12	2012/13	2013/14
Shift to Lower Cost Setting - outpatients	0	18,823	56,469	188,229
Decommissioning outpatient activity	0	2,738	8,215	27,382
Shift to Lower Cost Setting - electives	0	327	980	3,266
Decommissioning electives activity	0	127	381	1,270
Prevention of emergency admissions through enhanced reablement packages	469	1,875	1,875	1,875
Total	469	23,890	67,919	222,022

FINANCIAL IMPACT

	2010/11	2011/12	2012/13	2013/14	Total
	£000	£000	£000	£000	£000
New investment	550	2,508	6,523	20,576	20,576
Disinvestment	(5,265)	(15,636)	(26,930)	(53,312)	(53,312)
Net total disinvestment	(4,715)	(13,129)	(20,408)	(32,736)	(32,736)

Initiative five – Mental health

- Mental health problems affect one in six people in Brent
- There were 3,254 people on GPs serious mental illness registers in Brent in 2007
- The number of people over 75 with dementia is expected to increase from 2,027 to 2,226 between 2009 and 2014
- 44% of acute admissions are Black African men
- In 2007/08, 18% of 16-74 year olds in Brent had a neurosis such as anxiety and depression, and phobias, compared to 16% in London

4.2 Initiatives

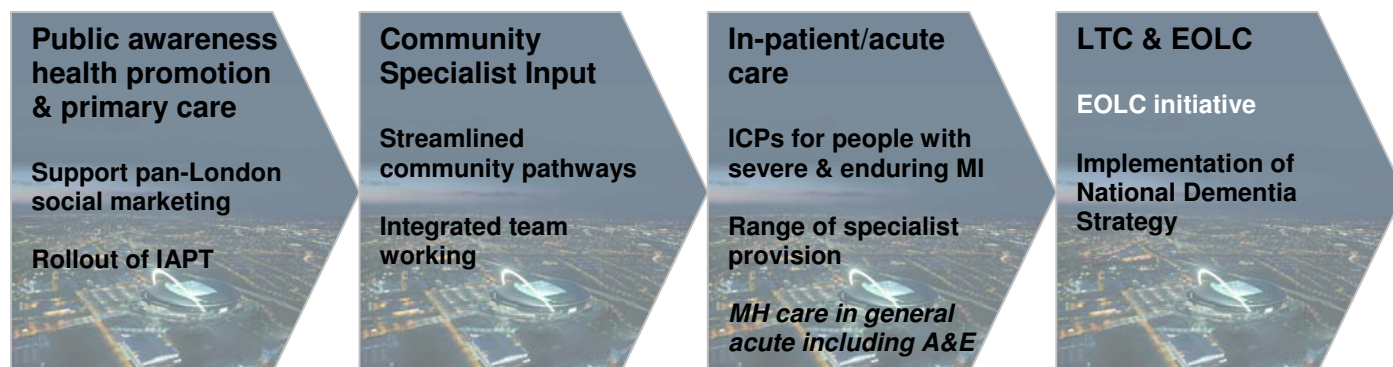
The key HfL objectives for mental health (from the original National Service Framework) include: local treatment should be provided for most people with a mental health problem, with specialist inpatient care for the few who need it; more use should be made of 'talking' therapies in the community; early intervention services need to be improved; there should be a clear pathway for care so that service users and partner organisations know what to expect and how to be involved; community mental health teams should have a more focussed remit.

NHS Brent's focus in the last year has been upon effective commissioning based on these objectives. In particular commissioning has concentrated on some of the core services identified in last year's CSP as being absent or fragmented and establishing the performance management and contractual framework required to more appropriately take forward the transformation agenda across mental health services. This has resulted in a number of key achievements including:

- Development of contracting and performance management arrangements with Central North West London, resulting in achievement of performance targets and significant productivity gains
- Commissioning of a successful Early Intervention in Psychosis Service and Crisis Resolution Health Teams aligned to polysystems
- Development of an Improving Access to Psychological Therapies specification

Stakeholder engagement has been critical to the success of the developments to date and will be of continuing importance moving forward with the development of the initiative. Primary care clinicians have played a leading role in performance improvements and have worked with mental health consultants to redesign pathways for the new services commissioned. Modernisation work is a shared strategic objective with the LBB and moving towards more aligned commissioning arrangements. Users, carers and community groups have been actively involved in contract management and service development.

PCT AREAS OF FOCUS ALONG THE PATHWAY (sector focus areas in *italic*)



PRIORITY CSP ACTION AREAS

NHS Brent and the LBB have established a Modernisation Board to take forward the review of the Brent Mental Health Strategy. The strategy and resulting implementation plan will be influenced by the 'New Horizons strategy' which is due to be published shortly.

1. RAISING PUBLIC AWARENESS, HEALTH PROMOTION AND IMPROVING SERVICES IN PRIMARY CARE

NHS Brent will support the pan-London social marketing campaigns planned to raise public awareness and promote health with targeted local initiatives. Initially we will focus on those within Brent in greatest need, including Afro-Caribbean, Irish and South Asian communities. More explicit links will be made with the Staying Healthy Initiative, recognising the role physical activity can play in improving wellbeing and reducing depression and with Children and Young People, in relation to early intervention and mental wellbeing through work such as anti-bullying strategies. Commissioning of a compliant IAPT service is planned for the summer of 2010 and will be supported by awareness raising training for primary care clinicians. ***By September 2010 talking therapies (IAPT) will be available across Brent.***

2. CO-ORDINATED COMMUNITY SPECIALIST INPUT

Concerns have been raised by both users and primary care clinicians about the number of individual teams working within the community, potentially resulting in multiple handoffs for service users and fragmentation and duplication of care. We plan to work with CNWL and Brent Community Services to rationalise the number of teams; streamline the care pathways to improve user experience and simplify communication between health and social care professionals. The new model of coordinated community specialist input will be a central component of our polysystem model of care. We plan that this work will also reduce duplication (allowing for disinvestment) and improve productivity as well as reducing the length of stay within acute wards. **By the end of 2010 new, streamlined care pathways will be in place with more integrated team working utilising settings of care across the polysystem.**

3. IN-PATIENT AND SPECIALIST PATHWAYS

We want to commission high-quality in-patient care which is outward focussed and working towards care outside of hospital wherever possible. We anticipate that the outcome from this work (together with the community work) will be a reduction in the number of people admitted as in-patients and reductions in length of stay for those admitted. We plan to review our commissioning arrangements for those in need of specialist services to ensure that we are getting the best value for money in the most appropriate location. **By the end of 2010 we will have improved specialist pathways in place.**

4. IMPLEMENTATION OF INTEGRATED CARE PATHWAY FOR DEMENTIA

We will be developing and implementing an integrated care pathway for dementia. **By June 2010 we will have agreed a joint strategy and implementation plan with the LBB.**

IMPACT

We have identified a suite of priority metrics attached to this initiative. These metrics are directly aligned to the realisation of our CSP goals, and have been chosen as those metrics which will have most impact on our priority areas of focus within the initiative. We will measure success and drive delivery through monitoring of these metrics against locally defined improvement, and by benchmarking against national, London and comparator group performance. These metrics will include:

CAMHS Admissions for Tier 4

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Target	4	4	4	4	3	3
% Change vs. baseline*	0.0%	0.0%	-20.0%	-20.0%	-40.0%	-40.0%

Length of stay of Tier 4 Admissions with length of stay 31-90 days

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Target	54	50	47	42	34	28
% Change vs. baseline*	0.0%	-7.4%	-13.0%	-22.2%	-37.0%	-48.1%

People in treatment of psychological therapies

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Target	1093	1126	1500	2500	3200	3200
% Change vs. baseline*	0%	0%	29%	109%	160%	156%

Proportion of patients (cared for by GPs) with schizophrenia, bipolar affective disorder & other psychoses with a review recorded in the preceding 15 months

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Target	86.5%	87.5%	88.5%	89.5%	90.5%	91.5%
% Change vs. baseline*	0.0%	1.2%	2.3%	3.5%	4.6%	5.8%

Proportion of users on new Care Programme Approach who have had a HoNOS assessment in the last 12 months

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Target	15.0%	15.0%	25.0%	40.0%	60.0%	80.0%
% Change vs. baseline*	0.0%	0.0%	66.7%	166.7%	300.0%	433.3%

*The baseline, per year, is the forecasted performance for that year if the initiative was not in place, against which we are measuring progress.

FINANCIAL IMPACT

	2010/11	2011/12	2012/13	2013/14	Total
	£000	£000	£000	£000	£000
New investment					
Disinvestment	(2,748)	(5,757)	(8,315)	(9,940)	(9,940)
Net total disinvestment	(2,748)	(5,757)	(8,315)	(9,940)	(9,940)

Initiative six – Staying healthy

- Prevalence of diabetes and TB are amongst the highest in the country and is set to increase
- The highest rates of TB are in males aged 20-40 of Indian or Black African origin, who have been in the UK less than 5 years; and in the homeless population
- Uptake of preventative services such as screening and immunisation are amongst the lowest in the country
- Healthy behaviours in Brent are low and obesity is becoming endemic
- These issues disproportionately affect the most deprived areas of Brent
- Some conditions impact disproportionately on BaME communities
- Wembley Stadium will be a focal point of the 2012 Olympics and can be used as a big motivator

HfL recommendations for Staying Healthy focus on the importance of collaborative working and delivery, a need for the NHS to focus on health improvement and protection, and maximising the opportunity of the 2012 Olympics.

Staying Healthy remains a key initiative for NHS Brent and our partners. All partners recognise and support the need to focus upon health and wellness if we are to reduce the current burden of preventable health and social care needs that occur further downstream within the system and to address the health inequalities that currently exist within Brent. The work is being driven by the Local Strategic Partnership and underpinned by our joint Health and Wellbeing Strategy which promotes both the coordinated approach required and the need to continue to seek new and innovative ways of working with local communities. The partnership is currently seeking to maximise the opportunities presented through Wembley Stadium as the focal point for promoting physical activity linked with the 2012 Olympics.

This initiative comprises a number of discrete projects led by health within the strategy. The key focus for all work remains the need to identify innovative approaches to engaging hard-to-reach groups and Brent's transient or unregistered population, accompanied by targeted intervention in those areas identified as in most need. Clinical leadership has been central to the development of all of the projects that underpin this initiative and clinicians have both driven the development of the plans and promoted their implementation with colleagues. This is of significance as polysystem commissioning will be one of the main drivers of change in the future, with each polysystem developing its own Staying Healthy Implementation Strategy with its local stakeholders, including the local community.

The below pathway summaries areas of focus and highlights links to areas further along the healthcare pathway (in white):

PCT AREAS OF FOCUS ALONG THE PATHWAY

PRIORITY CSP ACTION AREAS

This initiative includes a range of topic-specific projects. Prioritisation of projects was agreed with stakeholders to focus upon those areas where there was greatest scope for improvements as we are not already reaching required performance targets and where improvement would make the most significant impact upon achievement of our outcomes and goals.

1. NHS HEALTH CHECKS

The outcomes that will be achieved through the successful introduction of NHS Health Checks will impact significantly on our goals and vision. In 2008/09 we have undertaken detailed work to ensure successful implementation and will be commencing the phased programme from April 2010. Phasing supports the need to prioritise areas of maximum need and will commence in Harness polysystem (Harlesden) rolling out across other polysystems across a four year period.

Delivery will be commissioned from GP practices who meet the required quality specification under a Local Enhanced Scheme. For those populations not covered by a LES, including the unregistered, alternative commissioning routes will be established. Recognising the difficulties some individuals experience making changes to their lifestyles until the later stages of their illness, we will ensure that we work with local community and faith groups to support the lifestyle changes required. **By 2013/14 all adults within the identified ages range will have been invited for an NHS Health Check and offered support tailored to their identified needs.**

2. CHILDHOOD IMMUNISATIONS

Considerable focus in 2009/10 has been placed upon establishing the required infrastructure from which to accurately identify the current uptake rates and to ensure improvement both across Brent and within identified communities such as well educated parents with low uptake or the Irish community in Kilburn and Cricklewood. Progress is now well underway to increase childhood immunisations aligned to best practice. **By Q3 2011/12 we will have achieved the required DH uptake rates for all childhood immunisations.**

3. OBESITY

We will be building upon the success of our childhood obesity strategy to review our current adult obesity strategy. The launch for this work will happen in early 2010 with our Physical Activity Summit with the expectation that the revised strategy, together with supporting plans for action, can be agreed by the Local Strategic Partnership in the summer of 2010. **By September 2010 we will have an agreed strategy and implementation plan.**

4. SMOKING CESSATION

We are aware of the importance of smoking cessation to the achievement of our goals and we are pleased that the considerable focus the PCT has given this issue has resulted in a promising rate of improvement. We will continue to work to identify new and innovative ways of commissioning the service for target populations such as smokers from routine and manual socio-economic groups and BaME groups with high smoking rates. We will diversify the range of providers to include workplaces and community groups, and incentivise and performance manage providers to achieve improved outcomes. We are aware that some approaches will be more effective than others and will be applying good use of metrics across the service provider landscape to identify which providers are more effective, efficient and productive. We will use this information to regularly review and decommission non-effective services as appropriate. **By Q4 2010/11 we will have achieved the annual target for smoking cessation as set by DH.**

5. BREAST, BOWEL AND CERVICAL SCREENING

Early detection and access to treatment for cancer remains a high priority but continues to be an area where uptake in Brent is significantly below London levels. The overall poor uptake masks even more significant variations across Brent which impact significantly upon the health inequalities – screening levels are lower in deprived areas and within BaME groups. In the last year the focus has been upon ensuring that screening service providers are prepared to deliver the improvements required, including incentivising coverage through the introduction of a split local tariff for breast screening. Moving forward, we have improvement plans to ensure that we achieve trajectories for uptake for all screening programmes and

4.2 Initiatives

across the whole of Brent. **By Q2 2012/13 we will have achieved the DH standard for breast screening uptake with plans to exceed the DH target moving forwards.**

6. COMMUNICABLE DISEASES

We are developing implementation plans to meet the requirements for both Tuberculosis and HIV DH performance standards. Work is planned to promote earlier diagnosis, reduce stigma and increase awareness; particularly through effective use of primary care.

IMPACT

We have identified a suite of priority metrics attached to this initiative. These metrics are directly aligned to the realisation of our CSP goals, and have been chosen as those metrics which will have most impact on our priority areas of focus within the initiative. We will measure success and drive delivery through monitoring of these metrics against locally defined improvement, and by benchmarking against national, London and comparator group performance. These metrics will include:

CVD mortality (per 100,000 under 75)

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Target	86.7	78.8	75.4	70.8	64.8	58.2
% Change vs. baseline*	0.0%	-9.0%	-12.9%	-18.2%	-25.3%	-32.9%

MMR immunisation by 5 years (%)

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Target	41.8%	72.7%	90.7%	94.4%	95%	95%
% Change vs. baseline*	0.0%	73.9%	117.0%	125.8%	127.3%	127.3%

Breast Screening uptake (%)

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Target	44.0%	49.7%	59.0%	71.0%	75.0%	78.0%
% Change vs. baseline*	0.0%	13.0%	34.1%	61.4%	70.5%	77.3%

Smoking quitters

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Target	332	911	1059	1059	1059	1059
% Change vs. baseline*	0.0%	174.4%	219.0%	219.0%	219.0%	219.0%

*The baseline, per year, is the forecasted performance for that year if the initiative was not in place, against which we are measuring progress.

Overall this initiative will make significant contributions to Brent's goals of increasing life expectancy by reducing premature mortality (goal 1), addressing health inequalities (goal 2) and improving health and wellbeing (goal 3).

ACTIVITY IMPACT

Description	2010/11	2011/12	2012/13	2013/14
Reduced volume of CVD events	99	212	230	254

FINANCIAL IMPACT

	2010/11	2011/12	2012/13	2013/14	Total
	£000	£000	£000	£000	£000
New investment	1,706	2,000	2,245	2,634	2,634
Disinvestment	(341)	(841)	(1,039)	(1,117)	(1,117)
Net total disinvestment	1,365	1,159	1,206	1,517	1,517

Initiative seven – Long Term Conditions

- Long term conditions (LTCs) are endemic in Brent with diabetes prevalence being amongst the highest in the country at 5.61% of the population with undiagnosed cases around a further 2%
- Cardiovascular disease is the biggest killer in Brent and disproportionately affects the most deprived areas
- QOF data demonstrates variability across practices in relation to the quality of outcomes for people with LTC including diabetes
- The current model of care is fragmented and not centred around the patient
- The emergency admission spends for ambulatory sensitive conditions are in Diabetes, Angina, Chronic Obstructive Pulmonary Disease (COPD) and Congestive Heart Failure

HfL recommendations for meeting the needs of people with LTC outline a model of care that puts patients at the centre of care provision, feeling empowered to self-manage and with easy access to high quality support provided across agencies and in a coordinated way.

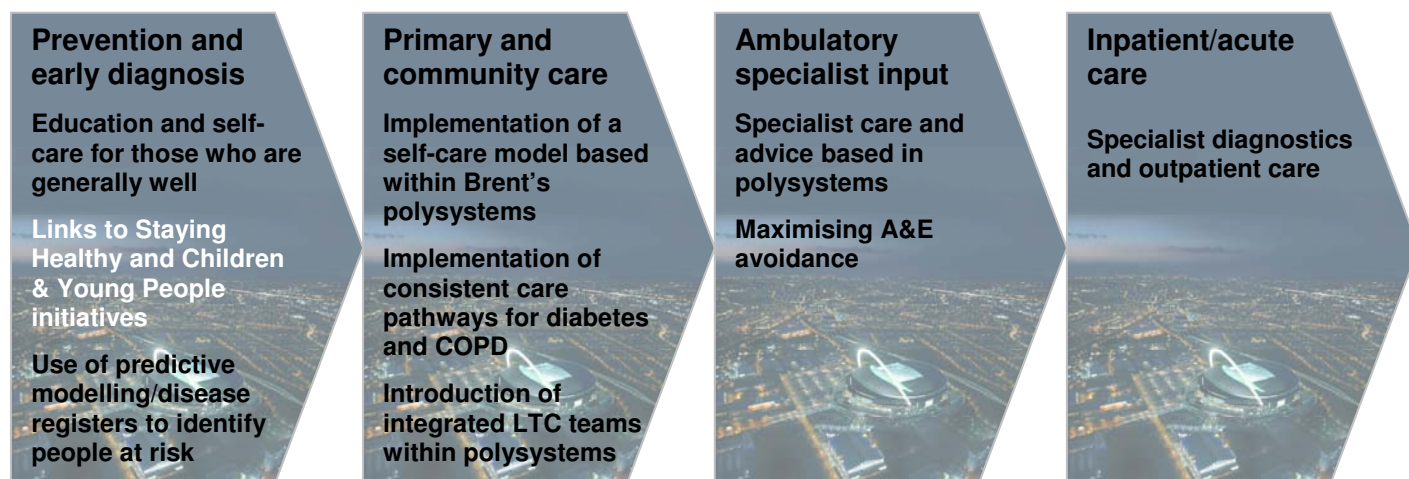
NHS Brent's recent focus has been on improving the experience and outcomes for people during and following acute exacerbations and those at risk of hospital admission. This has led to a number of key achievements including:

- Integrated Care Coordination Service: initially set up under the Partnerships for Older People Projects Scheme in collaboration with the LBB with external evaluation showing impact in relation to both saved bed days and A&E attendances
- Agreement of joint NHS Brent and LBB Intermediate Care Strategy and joint commissioning of a STARRs
- Renewing current community pathways for LTCs and ensuring they support upskilling of primary care

The initiative seeks to establish a more comprehensive and coordinated approach to the management of LTC across all of the levels of care, establishing a strong and effective web of care for patients. Establishment of the polysystem model of managed care delivery is a key enabler to delivery of this initiative. Each polysystem will be configured to implement the generic model of care and pathway that can be applied to any long term condition. Individual condition-specific elements of the pathway will be introduced in a phased and planned way. The initial focus will be diabetes due to its prevalence in Brent, particularly amongst our most deprived and BME populations; the existing variable quality of care experienced by people with diabetes in Brent and the impact improvements will make on achievement of our goals and vision. Learning from development of the diabetes pathway will inform the generic model which will then be rolled out to other priority conditions including COPD, asthma, CHD and hypertension.

The following overall pathway summarises areas of future focus in managing LTCs and provides a framework for the future LTC model.

PCT AREAS OF FOCUS ALONG THE PATHWAY



PRIORITY CSP ACTION AREAS**1. IMPROVED PATIENT EDUCATION AND EMPOWERMENT**

In line with the phased programme of improvement across condition specific care pathways, we will introduce a coordinated programme to support improved patient education and empowerment. Using both national best practice and local community expertise we will commission a range of resources to promote self care including using innovative approaches such as telecoaching as well as revitalising existing schemes such as the Expert Patient Programme. We will link this closely with each polysystem's health and wellbeing strategy and healthy neighbourhoods as well as ensuring access to talking therapies. We anticipate an increasingly focussed use of community pharmacists in relation to self management.

2. IMPROVED PRIMARY CARE MANAGEMENT (LEVEL 1 & 2 – SIMPLE & COMPLEX CARE)

In line with our Primary and Community Strategy and polysystem development plans we will implement a programme across all practices designed to ensure that all practices offer a high standard of quality care and advice. Key components of the plan will be:

- Implementation, in conjunction with other PCTs in NW London, of a risk stratification and predictive modelling tool together with consistent care pathways for LTC. We will support this through the continuing improvements planned to our data quality systems
- Agreement with clinical commissioners of Polysystem Improvement Plans with clear outcomes and expectations for practices within and across the cluster, linked to development of the commissioning budget for LTC across all settings of care to polysystem commissioners
- Development and implementation of protocol-driven access to diagnostics to address underdiagnosis across Brent, together with active review of practice registers with plans for improvement to narrow the gap between expected and reported prevalence levels at practice level and reductions in levels of exception reporting
- Introduction of Integrated LTC Teams at polysystem level, comprising a designated consultant; nurse specialist and primary care specialist. Each LTC Team will support the polysystem through tailored training and access to specialist advice

3. IMPROVED SPECIALIST ADVICE/COORDINATION ETC (LEVEL 3 – MULTI COMPLEX CARE)

Specialist care and advice will be commissioned predominantly within polysystem settings including polyclinics. Models of commissioning will promote improved integration between GP practices and hospital specialists maximising the use of polyclinics as the appropriate setting of care and avoiding the need for attendance at acute hospitals unless specialist diagnostics or outpatient care is required. ***By 2013/14 up to 100% outpatient care for people with LTC will be provided in polysystem settings of care.***

4. IMPROVED CASE MANAGEMENT (LEVEL 3 – MULTI COMPLEX CARE)

This workstream will mainstream care management and reablement as integral parts of LTC management within each polysystem health and social care system through:

- Early identification of people using risk stratification and consistent application of the existing EARLI tool
- Integration of case management into every polysystem District Nursing Team widening the skill mix within the team to include district nurses, community matrons and social care co-ordinators, and ensuring rapid access to specialist support
- Agreed pathways/response between health and social care including enhanced reablement services supported by rehabilitation
- Appropriate use of assistive technology, using telehealth to open up greater caseload coverage by each case manager, impacting on both efficiency and productivity

The work is being taken forward as a shared transformation initiative between NHS Brent and LBB, building upon the shared intermediate care strategy (level 4 – acute exacerbation) which is described under our acute care initiative and further developing joint commissioning and integrated health and social care provision for people with LTCs across all stages of the continuum. ***From January 2011 onwards 30 emergency admissions a month will be avoided through improved case management and reablement.***

IMPACT

We have identified a suite of priority metrics attached to this initiative. These metrics are directly aligned to the realisation of our CSP goals, and have been chosen as those metrics which will have most impact on our priority areas of focus within the initiative. We will measure success and drive delivery through monitoring of these metrics against locally defined improvement, and by benchmarking against national, London and comparator group performance.

The achievement scores are only meaningful against the exception reporting scores. We have quite high levels of exception reporting which falsely displays good achievement in some areas. During the next year we will have agreed targets for exception reporting levels. This will have to be agreed per indicator and will be agreed at clinical working groups.

The percentage of patients with hypertension in whom the last blood pressure (measured in the previous 9 months) is 150/90 or less - with exception reporting reduced to clinical agreed minimum (BP 5)

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Target	77.1%	77.1%	77.1%	86.0%	88.0%	90.0%
% Change vs. baseline*	0.0%	0.0%	0.0%	11.5%	14.1%	16.7%

The percentage of patients with diabetes in whom the last HbA1c is 7.5 or less (or equivalent test/reference range depending on local laboratory) in the previous 15 months - with exception reporting reduced to clinical agreed minimum (DM23)

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Target	56.8%	65.0%	68.0%	70.0%	74.3%	75.0%
% Change vs. baseline*	0.0%	14.4%	19.7%	23.2%	30.8%	32.0%

The percentage of patients with COPD with a record of FeV1 in the previous 15 months - with exception reporting reduced to clinical agreed minimum (COPD10)

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Target	79.0%	79.0%	79.0%	82.0%	85.0%	88.0%
% Change vs. baseline*	0.0%	0.0%	0.0%	3.8%	7.6%	11.4%

The percentage of patients with asthma who have had an asthma review in the previous 15 months - with exception reporting reduced to clinical agreed minimum (ASTHMA 6).

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Target	80.0%	80.0%	80.0%	85.0%	87.0%	90.0%
% Change vs. baseline*	0.0%	0.0%	0.0%	6.3%	8.8%	12.5%

The percentage of patients with coronary heart disease whose last measured total cholesterol (measured in the previous 15 months) is 5 mmol/l or less - with exception reporting reduced to clinical agreed minimum (CHD8)

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Target	81.0%	81.0%	81.0%	84.0%	87.0%	90.0%
% Change vs. baseline*	0.0%	0.0%	0.0%	3.7%	7.4%	11.1%

*The baseline, per year, is the forecasted performance for that year if the initiative was not in place, against which we are measuring progress.

ACTIVITY IMPACT

Activity moved to community & home settings	2010/11	2011/12	2012/13	2013/14
Outpatients (first and follow-up)	0	4,909	14,727	49,090
Respiratory	0	76	227	758
Diabetes	0	307	922	3,072
Cardiology	0	342	1,025	3,418
Total	0	5,634	16,901	56,338

FINANCIAL IMPACT

	2010/11	2011/12	2012/13	2013/14	Total
	£000	£000	£000	£000	£000
New investment	250	773	1,318	3,228	3,228
Disinvestment		(827)	(2,481)	(8,270)	(8,270)
Net total disinvestment	250	(54)	(1,163)	(5,042)	(5,042)

Initiative eight – End of life care

- In Brent 68% of people die in hospital
- People from our most deprived wards are more likely to die in hospital & few of them access hospice services
- A wide range of community-based services are delivered separately and in isolation
- Links and communication between services is patchy and there are multiple points of assessment along the pathway

HfL recommendations for improving end of life care (EoLC) focus on the individual needs of people and the need to have personalised care plans and choice in setting of care. This should be delivered through integrated and co-ordinated services and meet existing best practice guidelines

Services in Brent do not currently adhere to these principles. In order to address this NHS Brent is developing a strategy and pathway for end of life in line with national best practice and developing HfL care pathways. Development of this strategy is at an early stage but an accelerated programme of improvement is planned. This strategy will give people meaningful choice in where they receive care as they approach the end of their lives, backed up by healthcare support and advice. As more people have expressed a wish not to die in hospital we aim to reduce the numbers of deaths that occur in hospital.

PCT AREAS OF FOCUS ALONG THE PATHWAY (sector focus areas in italicic)**PRIORITY CSP ACTION AREAS**

An accelerated programme of development is in place and an End of Life Strategy will be agreed by April 2010. The co-ordination and integration of services will be driven through an end of life care Project Board / Network. **By April 2010 the EOLC strategy will be agreed.**

1. CHOICE

We will work with all our partners to promote awareness and understanding of EOL care services and ensure that plans are agreed to reduce the gaps through better integration and coordination of services across all settings to be able to offer choice to patients. We will also ensure through social marketing and communication that choice is fully understood by all including the hard to reach groups.

2. NATIONAL STANDARDS

We will ensure that all practices have registers of palliative care patients. Data will be gathered to evaluate EOLC services to support the commissioning of appropriate services. We will ensure that baseline national standards including the Gold Standard Framework, Liverpool Care Pathway and Preferred Priorities of Care initiatives are implemented.

3. ACCESS TO 24/7 CARE

We will work to achieve better co-ordinated care on a 24/7 basis across Brent through better integration of current care provision in the first instance including the development of a standardised palliative and end of life care model. This will be achieved through awareness of the services available, improved understanding of the roles and responsibilities across all professionals and care providers and access to specialist care and advice 24 hours a day and 7 days a week. To support this we will undertake a comprehensive and targeted education and training programme to promote the pathway and ensure the trigger points to accessing services are understood.

4. OPTIMISING CARE ACROSS THE PATHWAY

We will undertake a comprehensive review of services across Brent to identify the capacity available, the gaps in services and understand the current constraints in the system. We will introduce the advance care planning tool and ensure that all partners in care provision including the London Ambulance Service, social care and Out of Hours GP services work to deliver care in accordance with the plans. To support this we will ensure that there is rapid access to equipment and medication as well as specialist advice and support. **By 2013/14, 25% of deaths will occur at home.**

IMPACT

We have identified a suite of priority metrics attached to this initiative. These metrics are directly aligned to the realisation of our CSP goals, and have been chosen as those metrics which will have most impact on our priority areas of focus within the initiative. We will measure success and drive delivery through monitoring of these metrics against locally defined improvement, and by benchmarking against national, London and comparator group performance. These metrics will include:

Proportion of all deaths that occur at home

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Target	N/A	19%	20.5%	22%	23.5%	25%
% Change vs. baseline*	N/A	0.0%	7.9%	15.8%	23.7%	31.6%

Number of deaths in hospital with targeted conditions

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Target	N/A	321	289	231	162	89
% Change vs. baseline*	N/A	0.0%	-10.0%	-28.0%	-49.5%	-72.3%

Number of non-elective "prior year" admissions for end of life patients

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Target	N/A	328	295	236	167	94
% Change vs. baseline*	N/A	0.0%	-10.1%	-28.0%	-49.1%	-71.3%

*The baseline, per year, is the forecasted performance for that year if the initiative was not in place, against which we are measuring progress.

ACTIVITY IMPACT

Description	2010/11	2011/12	2012/13	2013/14
Reduction of end of life spells in hospital	32	90	159	232
Reducing non-elective "prior year" admissions for end of life patients	33	92	161	234
Total activity shift (spells)	65	182	320	466

FINANCIAL IMPACT

	2010/11	2011/12	2012/13	2013/14	Total
	£000	£000	£000	£000	£000
New investment		176	176	176	176
Disinvestment	(194)	(543)	(954)	(1,390)	(1,390)
Net total disinvestment	(194)	(367)	(778)	(1,214)	(1,214)

4.3 Developing the polysystem

Vision

Our Commissioning Strategy Plan describes our plans for transformational change across the eight HfL care pathways. Achievement of our agreed outcomes, goals and vision for Brent cannot be delivered without a corresponding change to the ways that care is provided in primary and community settings. Neither can change be achieved by health professionals working in isolation, rather they need to work in a more integrated and coordinated way with each other, with colleagues in partner agencies, with the voluntary sector, and most importantly, with the people and communities of Brent. We plan to deliver this change through the effective establishment of polysystems covering the five localities of Brent.

The Brent polysystem model of care has been developed and is owned and supported locally. The model was conceived and developed as an integral part of our Primary and Community Strategy, using as its starting point the cooperative ways of working already in place within each of our five Practice Based Commissioning Clusters. The configuration is also supported by the LBB who have reconfigured their children and young peoples' services to match the polysystems and local politicians who appreciate the alignment of the polysystems with Area Consultative Forums, promoting local decision-making and accountability.

The public have been actively involved in developing the polysystems, in relation to the quality standards expected from all providers; support for more integrated ways of working and the requirement that ease of navigation must be an integral part of the new ways of working to be established.

Every polysystem will deliver transformed pathways in primary and community care as set out in the box below.

- General practitioners will be central to polysystem commissioning with the identified practice populations forming each polysystem locality
- Coordinated response to care management (with identification using a shared risk assessment tool) within and across practices, in line with agreed care pathways
- Integrated multidisciplinary teams of primary, community and social care staff to improve the management of people with LTCs, including immediate access to specialist support
- Improved access to primary care for people with urgent care needs including social marketing to support self management; use of polysystem community pharmacists; extended hours in GP practices and access to 8-8 GP access centres
- Implementation of redesigned pathways for elective care including direct access to diagnostics; integrated community services within polysystems and one stop care including access to specialist advice and treatment
- Integrated teams for children's services, using the polysystem Children's Centres as a setting of care for midwifery, healthy child and intensive parenting support programmes
- Use of settings of care within the polysystem for mental health care delivery
- Use of settings of care within the polysystem for social care delivery, voluntary services and health and wellbeing activities
- Publicised quality standards for all providers in all care settings across the polysystem
- Maximisation of existing infrastructure including estate and workforce to support value for money, promote integrated working and enable transformational change across the provider landscape

4.3 *Developing the polysystem*

The changes to the ways of working required to implement the Brent polysystem vision have already started but now need to accelerate to ensure delivery of the transformed care pathways. These changes are being supported through our development of clinically-driven commissioning, moving beyond the current practice based commissioning arrangements, a key component of our organisational development plan.

Implementation of the polysystem model of care

Clinical commissioning

The Professional Executive Committee (PEC) together with Practice based commissioners led the development of the Primary and Community Strategy that underpins our model of polysystem delivery. The practices within each of the five PBC clusters have demonstrated a willingness and ability to work together to drive improvements in primary and community services and each cluster has already produced a commissioning plan that details how they would take implementation of the strategy forward in their area. With the refresh of these plans to meet the accelerated delivery timescales, it is an opportune time to review the current practice based commissioning arrangements to ensure they are robust and appropriately supported to take forward implementation of the care pathways within polysystem settings of care and to influence and clinically lead the wider changes across the acute provider landscape.

It is proposed that PBC Locality / Polysystem Commissioning Boards drive the implementation of the polysystems, with the clinical chairs from each polysystem joining with the chairs of the PEC and Executive Directors of NHS Brent to form the Clinical Commissioning Executive. Clinical commissioning is at the centre of polysystems and the proposed model for phased delegation of commissioning responsibilities to polysystem commissioners is being actively developed as part of the DH Transformation Programme.

Primary care services

Polysystem Commissioning Boards will continue to play an active role in the development of primary care services within their polysystem and across Brent. This will include providing clinical leadership to the development of quality indicators and thresholds for the Balanced Scorecard, both at PCT and sector level; supporting practices to agree and implement improvement plans, including clinical approval for transition plans; active involvement to ensure delivery of agreed improvements and succession planning.

Improved management of Long Term Conditions

Polysystems will be the commissioning vehicle for driving improvements in the coordinated and integrated management of people with LTCs. Moving forward this will involve delegated authority for all commissioning budgets, across all providers, for the service provision across the continuum of care. Initially, the polysystems will focus upon the development of the required infrastructure in primary care, the implementation of best-practice care pathways (focussing initially on diabetes as the highest health need for Brent and the LTC with the greatest scope for improvement) and the establishment of a managed care network at polysystem level, using an agreed risk stratification tool. Community providers will be reconfigured to align their teams to polysystem networks.

Pathways for elective care

Polysystems will be the main delivery vehicle for driving the changes in pathways for planned care, including working at board level and across the sector to agree protocol-driven pathways; developing and agreeing learning and development plans at practice and polysystem level; participating in procurement exercises and ensuring polysystem compliance with agreed pathways.

Coordination of urgent care

Each polysystem will be responsible for ensuring appropriate access to primary care for people with urgent care needs, this will include establishing a self-management strategy including maximising the use of community pharmacists; ensuring all practices meet the required access and availability standards, including offering extended hours and further enhancing access through the commissioning of 8-8 GP practice provision (appointments and walk-ins) in all polyclinics. These access points for urgent / unplanned care within each polysystem will be supported through the commissioning of the UCC as the entry-point to CMH A&E department, which will include as part of its specification the provision of out-of-hours GP care

4.3 Developing the polysystem

(attendance & home visiting service) for Brent. In addition, the UCC at CMH will provide the single point of contact for referral to the STARRS service, commissioned cross-Brent to prevent emergency admissions and reduce the length of time people need to spend in acute hospital. Co-locating rapid response, urgent care and out of hours care together provides the opportunity to ensure a single point of access for people, ensuring that identified needs are met in the most coordinated and efficient way, within community settings wherever possible. CMH will therefore act as a Polyclinic+ for Brent, as well as being the polyclinic for Harness polysystem.

Promoting health and wellbeing

Although the initial focus of the polysystems will be upon pathway implementation, they will also play a lead role in the implementation of the Health and Wellbeing strategy for Brent.

Polysystem coverage

The five polysystems offer 100% practice coverage.

Harness	16 practices	77,862 population
Willesden	10 practices	56,013 population
Kilburn	15 practices	83,111 population
Wembley	15 practices	65,517 population
Kingsbury	15 practices	70,247 population

As polysystems develop as commissioning units, commissioning on behalf of their local communities, we anticipate that some minor geographical re-alignments of practices between polysystems will occur. One of the benefits realisation outcomes for polysystems will be to ensure that they are of sufficient size to commission pathways at polysystem level. The current configuration allows full implementation of polysystem long term condition pathway commissioning.

Settings of care within the polysystem

Care will be provided from a range of settings of care within each polysystem.

Community	Level One	Level Two	Level Three	Level Three +
Community settings	All GP practices and pharmacies will be spokes within the polysystem network of care	Locality health centres; Children's Centres; Cluster GP practices; Cluster pharmacies	All Polyclinics	Polyclinic + (CMH)
Each polysystem will implement a Health & Wellbeing Strategy to localise where appropriate delivery of the Brent strategy Each polysystem will implement a PPI strategy to ensure appropriate community engagement	All GP practices and pharmacies will provide core and enhanced services in line with contractual requirements and to agreed standards of quality and access It is anticipated that over the time of the strategy the number of GP practice spokes will reduce as practices consolidate onto fewer sites	Community service provision will be consolidated to provide care to identified clusters of GP practices within the polysystem Enhanced levels of short-term care will be commissioned on behalf of clusters	One stop assessment & treatment requiring more specialist input & access to more complex diagnostics Case management and LTC multidisciplinary teams covering the polysystem Extended hours GP practice from 8am to 8pm Polyclinics may provide services for 2 polysystems Polyclinic provision may be commissioned from settings outside of Brent borders	Specialist pathways / services commissioned on behalf of all polysystems <i>Urgent care pathways</i> UCC & OOH / STARRS / Community beds <i>Planned care pathways</i> Specialist diagnostics Low volume, high specialism consultant care

Locations for settings of care across Brent

NHS Brent has a portfolio of new community buildings commissioned either under LIFT or as PFI builds. We are contractually obligated to rent these buildings for at least 20 years and therefore, in determining our need for community space from which to deliver our CSP and polysystem model, we have considered these 'fixed points' that must be fully utilised. In addition, CMH within Brent is also a PFI build, the costs for which are incurred by the local health economy. To ensure value for money, CMH must also be fully utilised.

In determining the capacity available within each location we have modelled the increased requirements for consultations being provided outside of acute hospital sites; the consolidation of practices into established buildings; the rationalisation of use of estate by Brent Community Services and the requirement to use space more flexibly, across longer working days to ensure maximum efficiency of space utilisation.

We commissioned external consultants to undertake the capacity modelling. Three options were modelled and appraised using the following criteria:

- Quality – potential to improve quality
- Transformation – potential to support HfL care pathway implementation
- Productivity – potential to promote new ways of integrated working
- Efficient use of resources – maximum utilisation of existing good quality assets
- Health inequalities – coverage meeting the needs of the most deprived areas
- Geographical coverage – appropriate geographical coverage
- Affordability – within differing funding scenarios

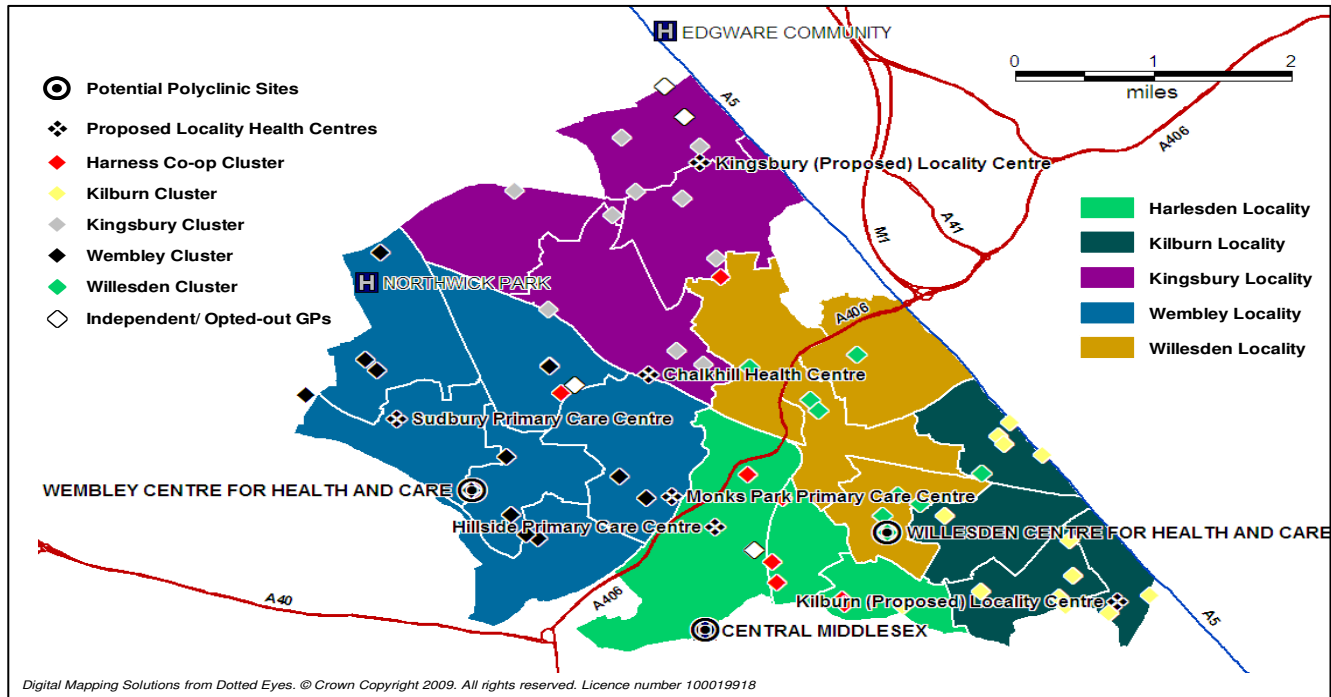
<p>Option One</p> <ul style="list-style-type: none"> • One polyclinic in each polysystem • Full utilisation of existing LIFT / PFI buildings • Two new polyclinic builds 	<p>Option excluded</p> <ul style="list-style-type: none"> • Capacity utilisation would be below 50% • Option would not offer value for money
<p>Option Two</p> <ul style="list-style-type: none"> • Full utilisation of existing LIFT / PFI buildings • 3 polyclinics at Wembley; Willesden; CMH • Polyclinic+ at CMH • 2 polysystems commission services at Willesden Polyclinic • 1 polysystem commissions services from Edgware • 2 new locality health centres developed at Kingsbury and Kilburn (only if cost neutral) 	<p>Likely case</p> <ul style="list-style-type: none"> • Option would fully utilise existing estate with flexibility for growth • Option would provide good geographical coverage • Option would support both primary care transformation & polysystem development • Option would offer value for money • Risk that if Edgware is not commissioned it would be necessary to extend Kingsbury to become a polyclinic
<p>Option Three</p> <ul style="list-style-type: none"> • As option two but with Kingsbury and Kilburn being developed even if they are not cost neutral • In addition the business cases for new locality health centres at Mapesbury and Dollis Hill to support further consolidation of practices would be considered 	<p>Best case</p> <ul style="list-style-type: none"> • This option would support primary care transformation and polysystem development but could only be pursued incrementally under the best case financial scenario

Of the two viable options, option two is currently being taken forward as the preferred option. Development of this option includes active clinical and managerial discussions with NHS Barnet in relation to the use of Edgware as the polyclinic for Kingsbury Polysystem and with NHS Ealing in relation to the use of CMH as a polyclinic / polyclinic+. The decision regarding the viability of option three will be made by the end of March 2010.

4.3 Developing the polysystem

All three options include some consolidation of primary care contractors into both locality health centres and polyclinics.

Map showing Polysystems coverage under options 2 and 3



Polysystem	Polyclinic	Locality Health Centre	GP Practice Consolidation
Harness	CMH	Monks Park Hillside	Relocate up to 2 practices to CMH
Willesden	Willesden	(Dollis Hill)	Relocate 1 practice to Willesden
Kilburn	Willesden	South Kilburn (Mapesbury)	Relocate up to 6 practices to Kilburn
Wembley	Wembley	Sudbury	Relocate up to 4 practices to Sudbury
Kingsbury	Edgware (Kingsbury)	Kingsbury Chalkhill	Relocate up to 6 practices to Kingsbury

Full implementation of option two would reduce the number of locations from which primary medical services are provided across Brent from 71 to 58. Together with other changes anticipated over the period, it is anticipated that by the end of the strategic planning period primary medical services will be provided from 50 locations (including all polyclinic hubs and locality health centre spokes).

Wembley polysystem

An outline of the plans for Wembley is provided below to demonstrate the depth of information and plans that we have.

Demographics

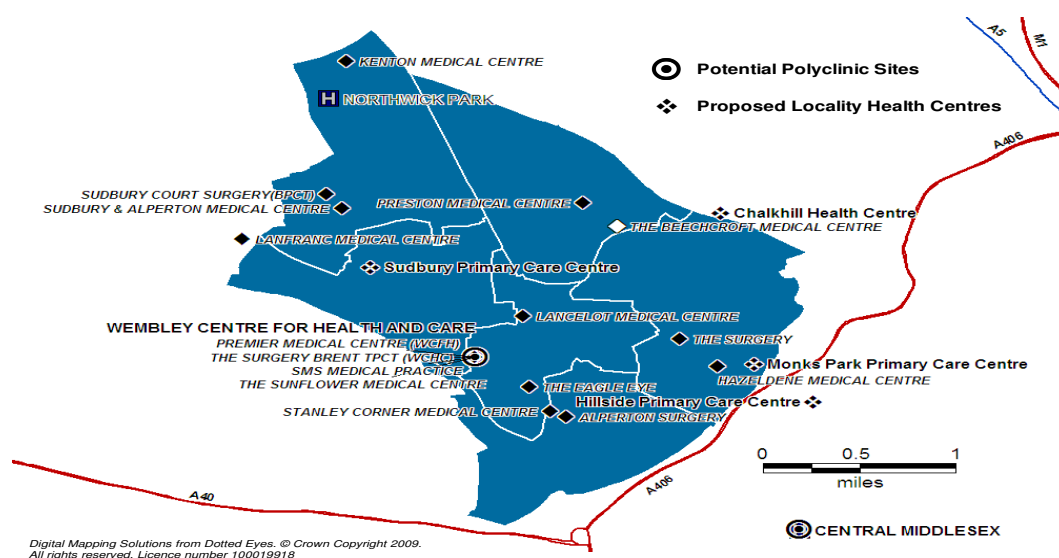
- Wembley has a population of 65,517; this is projected to increase, particularly in southern wards (for map of wards please see below and the Context section of the CSP)
- Tokyngham is projected to have the highest population growth of any ward in Brent as a result of the Wembley stadium development (10,000 increase by 2031)
- Very mobile and transient population with high patient turnover
- Ethnically diverse (significant Asian population) and young population (43% under 30 years of age)

Health needs

- Wembley contains the ward with highest male life expectancy in Brent (Northwick Park) and the third lowest (Wembley Central)
- Nearly half of Wembley's residents smoke
- Wembley polysystem has the second highest prevalence within Brent for diabetes, CHD and hypertension; with all wards' prevalence notably higher than Brent and England average
- Most TB cases in Brent are found in the Wembley wards of Wembley Central and Alperton
- Lower rate of cancer mortality than Brent, London or England averages

Use and organisation of healthcare services

- Rising rates of A&E attendance and high variation between practices in Wembley (a lowest practice-level rate of 182/1000 versus a highest of 396/1000)
- High rates of outpatient attendances across Brent for ophthalmology, gynae, ENT, gastro and urology
- Underutilised estate at Wembley Centre for Health & Care and Sudbury Primary Care Centre
- 16 GP practices across the polysystem at a range of locations (see map below)



Wembley Centre for Health & Care is the Wembley polysystem hub delivering level 3 services.

Sudbury Primary Care Centre is our locality health centre with plans for up to four GP practices to potentially relocate to the site and deliver level 2 services.

Remaining GP practices will operate as polysystem spokes providing level 1 care to required quality and accessibility standards.

Level 3 plus services such as STARRs and 24/7 urgent care from **CMH**

Viability and affordability analysis

Underutilised NHS estate in Wembley means we can develop our polysystem without the need for new premises or significant capital investment. Detailed capacity analysis has highlighted the underutilisation of estate at Wembley Centre for Health & Care (60% utilisation) and Sudbury Primary Care Centre (25% utilisation).

We have calculated increased future capacity at these sites and changes to demand from our CSP initiatives and the associated shift to polysystems; following which these sites have been modelled to run at 67% and 40% utilisation respectively. These sites are geographically well-positioned to serve the polysystem's catchment population.

Affordability analysis underpinning our plans shows levels of projected savings and reinvestment for Wembley by 2013/14; and the overall levels of activity transferred to the polysystem:

4.3 Developing the polysystem

Wembley polysystem	Savings (£000)	Reinvestment (£000)	Activity
Elective spells/PSD	(1,433)	70	607
Non-elective spells	(1,581)	421	821
Outpatients	(6,337)	4,135	44,899
A&E	(496)	251	4,511

Capital estimated to improve sites for polysystem delivery:

- Wembley Centre for Health & Care - £1m to refurbish and accommodate diagnostics and outpatients
- Sudbury Primary Care Centre – share of £0.5m for refurbishment of 2 locality health centres

Current and future services

Existing services already in operation from our polysystem hub at Wembley Centre for Health & Care include GP practices, a GP-led Health Centre, Children's Centre, pharmacy, physiotherapy, podiatry and phlebotomy services. Both Wembley Centre for Health & Care and Sudbury Primary Care Centre provide a well-established and well-known base from which to build the full polysystem model of care within Wembley, tailored to the local population's needs. For example the GP-led Health Centre with its capacity for walk-in attendance sees large volumes of patients from Wembley's transient population.

Additional services will transition to the polysystem in preparation for the hub to become fully operational from Q4 2010/11 as per the summary table which maps polysystem development to our CSP initiatives.

Capital requirements and investment plans

The capital requirements relate to the need to improve quality and capacity at every care setting across the polysystem:

GP Practices Meeting DDA compliance and ensuring capacity	Non-recurrent, small scale capital funding to practices who meet agreed quality criteria. Priority will be given to practices commissioned meet level 1 & 2
Existing Locality Health Centre Sites	Capital will be required to refurbish Sudbury and Monk's Park to enable them to accommodate relocated practices and outpatients
Existing Polyclinic Sites	Capital will be required to refurbish the facilities at Wembley and Willesden to enable them to accommodate diagnostics and outpatients
New Locality Health Centres	Funded through GP premises reimbursement (revenue)

The total estimated capital spend for the PCT as a whole is included in the financial template at £2.5m for 2010/11 and 2011/12 and £1.5m for 2012/13 and 2013/14.

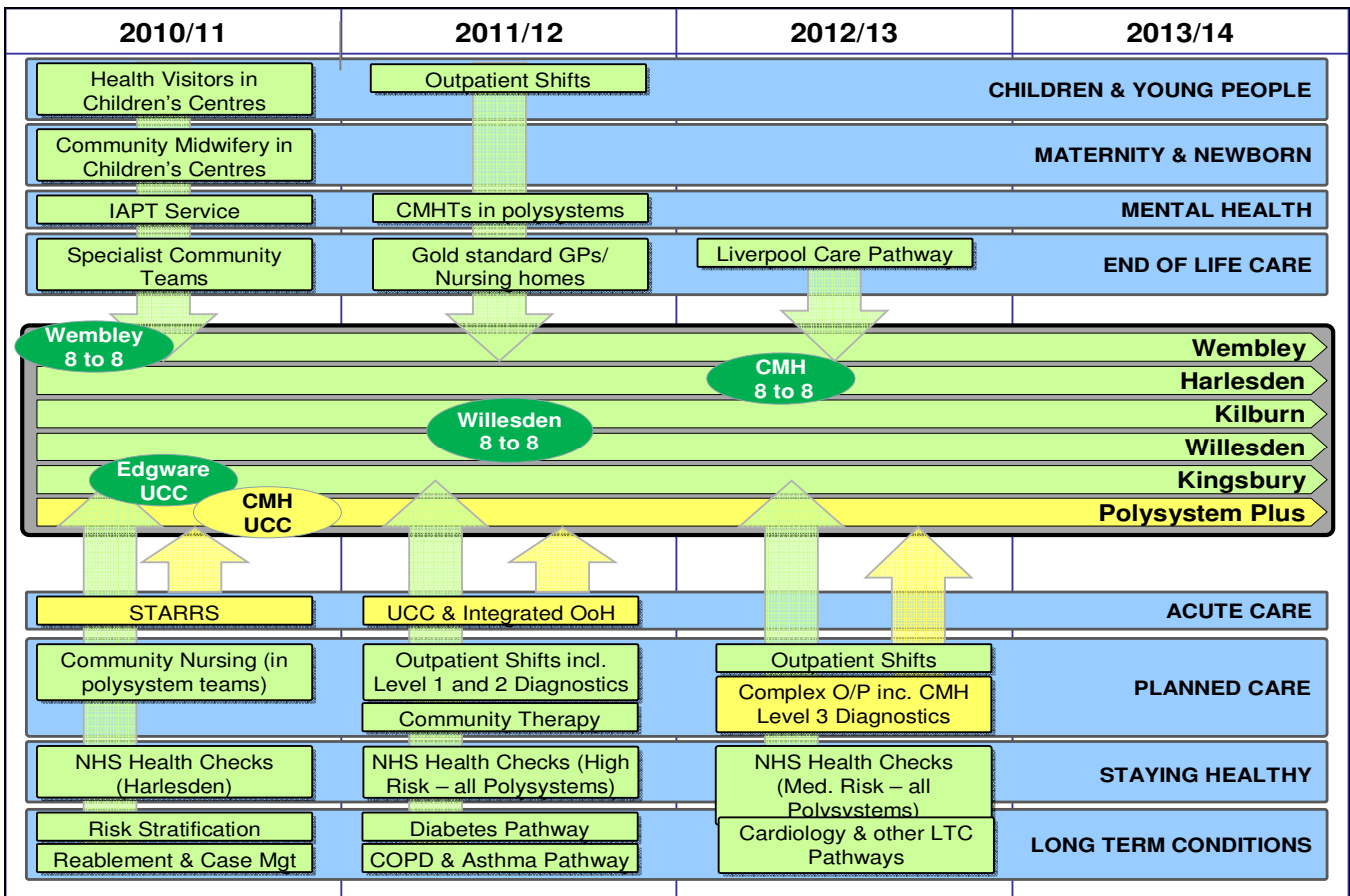
Pathways into Polysystems

Successful implementation of the Polysystem model of care will provide improved quality, closer to home, more efficiently. The building blocks to this change relate to: Development of clinically-driven polysystem commissioning, efficient infrastructure, new ways of working including IT, efficient use of staff and estates and application of lean methodology throughout each polysystem

Achieving the transformational change required to make polysystems a success is the cornerstone of our Organisational Development Plan.

Our Commissioning Strategy Plan is based upon implementation of the eight HfL care pathways, accelerating the implementation of clinically-driven commissioning at polysystem level, and working across the polysystems of Brent, to realise these transformational changes. The strength of the clinical leadership towards these changes, together with the high-quality buildings available for use, means that we can be ambitious in terms of our plans for delivery.

For a number of the projects within each of the pathways, implementation will occur across all five polysystems at the same time. The phasing of projects relates more to the opening of 8-8 GP practices as urgent care hubs. Implementation of the pathways into polysystems, showing the changes in settings of care is shown below, with the programme overview shown in the delivery section. The realisation of the benefits of using polysystems as the networks of care will therefore be implemented incrementally in relation to pathways but not to polysystems.



4.4 Market management strategy

Scale of the change

The scale of change required across Brent to redesign our provider landscape to meet, through implementation of HfL, our vision and goals, is substantial. We clearly need to ensure that we can commission the right quality of care at the best value for money for our population's needs.

Within our Market Management Strategy we have reviewed the scale and pace of change required across all of the eight pathways, and within the context of implementing five polysystems across the borough. The outcome from this work clearly shows the need to prioritise those pathways with the largest shift in activity from acute into polysystem settings of care: planned care; acute care and LTCs. The combined effect this has on activity transitioning out of the acute into the polysystem is up to:

- 242,000 outpatients move into the polysystem setting (59%)
- 5,000 current emergency admissions treated in the polysystem/decommissioned (12%)
- 3,300 elective procedures move into the polysystem (8%)
- 37,000 A&E attendances move into the polysystem/decommissioned (23%)

Implications for current providers

The scale of change is significant. The move to providing these services within the polysystem to achieve improved quality and outcomes in settings closer to home and at a lower cost setting represents a substantial challenge for Brent. The providers most impacted can be seen in the following table.

4.4 Market management strategy

Prioritised pathways	Initiatives	Care setting Providers							
		High intensity Secondary Care Sector	GPs	Community Services	Independent Sector	Mental Health Sector	Social sector	Voluntary Sector	Pharmacies
Acute Care	Intermediate care	-	+	+	+		+		
	Urgent care centre	-	+						
Long term conditions	Improved case and self-management	-	+	+	+	+	+	+	+
	Enhanced reablement			+			+		
Planned Care	OP shifts	-	+	+	+				
	Electives shifts	-	+	+	+				

Pressure areas – highlights providers that are key to achieving transformation

Key:
- Activity decrease
+ Activity increase

As shown in our review of the current provider landscape the community providers affected are already challenged in relation to all aspects of performance and our market management, organisational development and procurement strategies seek to address these deficiencies in addition to driving forward change and innovation.

Changes required within primary care

Both our GP services and community based services will have to improve their service substantially for polysystems to be effective within Brent.

GPs

Our provider landscape details the challenges we have with our current GP provision. In summary we have many practices with limited opening hours, with generally below average performance operating out of buildings which are not DDA compliant. These types of practices do not support the ideals of a polysystem which requires consistent quality, delivered by appropriate staff mix to ensure activity is kept in the community. We will actively manage this market through:

- Active contract management against a balanced scorecard derived from the quality markers agreed with our PBC and PEC
- Practice CQC registration / GP accreditation
- Providing an access transformation programme to improve access to GPs
- Networking of local practices to deliver core services for a limited period until every practice achieves core standards in their own right
- Succession planning with small practices where partners are approaching retirement
- Entry of new providers
- Move towards a 'common tariff' for core GP services

Community provision

Our community provider also has variable service quality and some inefficiently operated services which impact their value for money. They are also currently provided by a relatively small organisation with high management costs and we need to have strong sustainable community providers. The future configuration to support our provider's stability requires a recommended decision in early 2010. The options open to our provider are:

- Stand alone provider (not considered a viable option)
- Consolidation with local community provider
- Consolidation with an integrated care provider
- Merge with a foundation trust
- Vertical integration with an acute trust

Decisions regarding the most optimal future configuration are critical as over the next two years we will be decommissioning some of the services currently provided, developing new specifications and market testing existing services against the new specifications and outcomes. In addition, community services will be required to meet the productivity challenges critical to success of the CSP.

Market testing of services has commenced and in 2010/11 this will impact upon the following services currently provided by Brent Community Services:

Children & Young People	Healthy Child Programme (Health visiting)		
Acute Care	STARRs (Brent Rehabilitation Service)	UCC at CMH (Front of House / CMH)	
Planned Care	Community Drugs Service	Community Dental Service	Community Phlebotomy

Market management options

Clinical commissioning is at the heart of our market management strategy. The improvements that we are planning in relation to commissioning high quality primary medical services will not just improve patient care and experience at practice level but will also enhance the role of GPs as clinical commissioners of care both at micro / patient level through application of evidence-based, protocol-driven pathways and at polysystem level, commissioning and managing contracts to ensure delivery of the changes required.

Our market management options are primarily associated with the introduction of the polysystems. Our polysystems will be aligned to the existing Practice Based Commissioning clusters that are developing a clinical governance structure and the capability to manage local performance. It is an imperative that we manage our market so that the transition of care is undertaken in a planned and achievable way and to the required quality. This includes ensuring that the options offered to the market are attractive and achievable so that we have choices when commissioning. For the activity we plan to transition out of the acute we have identified options for grouping activity for it to be attractive to the market.

Elective options

- Option 1: Commission single service to provide all outpatients / elective procedures across whole of Brent (all polysystems)

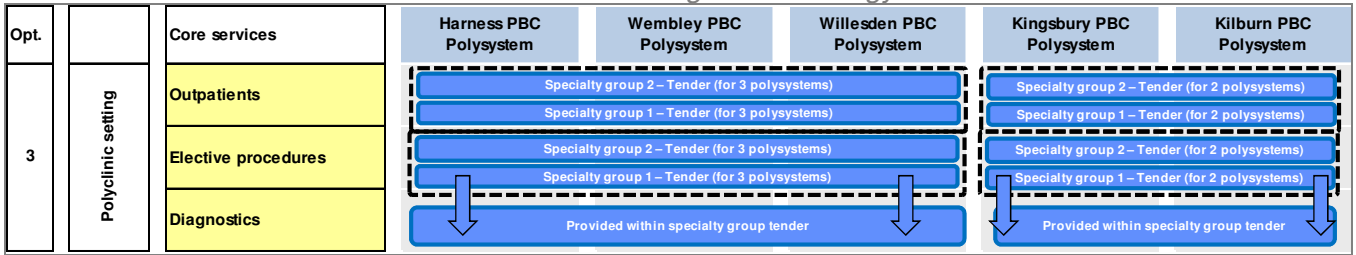
Opt.		Core services	Harness PBC Polysystem	Wembley PBC Polysystem	Willesden PBC Polysystem	Kingsbury PBC Polysystem	Kilburn PBC Polysystem	
1	Polyclinic setting	Outpatients	Tender (for all polysystems)					
		Elective procedures	Tender (for all polysystems)					
		Diagnostics	Tender (single polysystem)	Tender (single polysystem)	Tender (single polysystem)	Tender (single polysystem)	Tender (single polysystem)	

- Option 2: Group similar specialities together and commission for the whole of Brent (all polysystems)

Opt.		Core services	Harness PBC Polysystem	Wembley PBC Polysystem	Willesden PBC Polysystem	Kingsbury PBC Polysystem	Kilburn PBC Polysystem	
2	Polyclinic setting	Outpatients	Specialty group 2 – Tender (for all polysystems)					
			Specialty group 1 – Tender (for all polysystems)					
		Elective procedures	Specialty group 2 – Tender (for all polysystems)					
		Diagnostics	Specialty group 1 – Tender (for all polysystems)					
			Tender (single polysystem)	Tender (single polysystem)	Tender (single polysystem)	Tender (single polysystem)	Tender (single polysystem)	

- Option 3: Group similar specialities together and commission for selective polysystems (appropriate for high volume specialities)

4.4 Market management strategy



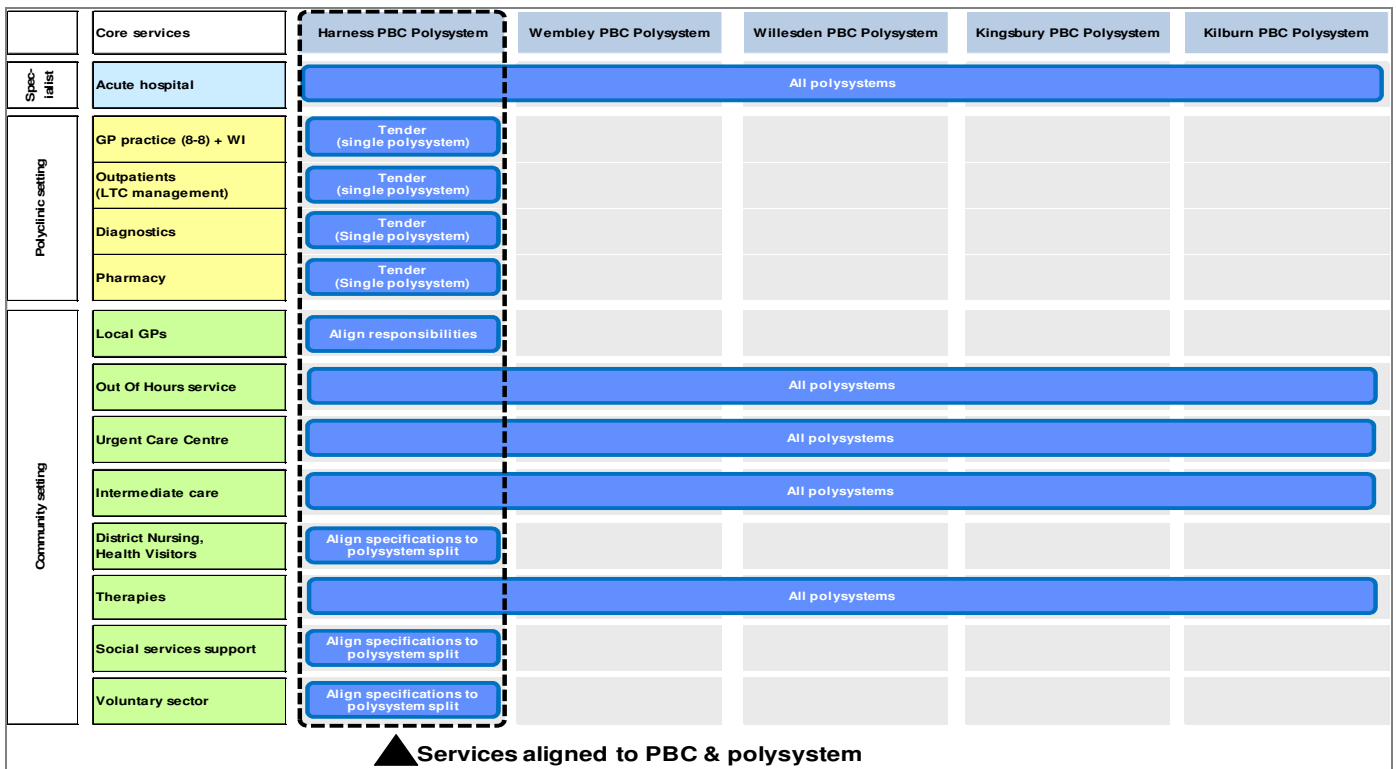
Decisions regarding the most appropriate bundling of specialities will be made at the appropriate stage of business case development. However, a number of principles will underpin any option chosen:

- Decommissioning of care under PBR tariff for care now commissioned in polysystems
- Adherence by polysystem commissioners to agreed evidence-based pathways with this forming a critical key performance indicator for polysystem autonomy
- Contractual requirement from both all providers to comply with the agreed pathways
- Agreement of a local tariff reflecting optimum use of skill mix, productivity and quality targets

Long Term Conditions option

Management of these conditions must be performed well in the community to reduce our requirement on acute services. To ensure we have the right alignment of accountability and performance management all of our existing community services will be aligned to a polysystem where this care will be delivered. Initially this alignment will be through updating specifications and in a later phase we will market test these services.

GPs and their PBC cluster will be responsible for monitoring patient performance and usage of services within the polysystem. It is expected that a poorly performing primary care service, not meeting the needs of their patients early enough, will make greater use of acute care services as the care is not managed efficiently along the pathway. Closely monitoring both our patients’ pathway and the use of services will provide peer pressure within the clusters to help improve quality and use of community services.



Successful implementation of this devolved model of long term condition commissioning will also rely upon a number of contractual requirements being met at all stages of the LTC care continuum:

- Achievement of consistent standards of high quality care across all GP practices (as outlined in both LTC and Planned care initiatives)

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- Decommissioning of acute care under PBR tariff for care now commissioned in polysystems
- Adherence by polysystem commissioners to agreed evidence-based pathways with this forming a critical key performance indicator for polysystem autonomy
- Contractual requirement from acute and polysystem providers to comply with the agreed pathways
- Agreement of a local tariff reflecting optimum use of skill mix, productivity and quality targets

Acute care

Polysystem commissioners will be required to work together across Brent, and in partnership with the LBB, to commission the services required to support people with urgent and acute care needs within community settings and avoiding the need for acute hospital admission. These include:

- Intermediate care (STARRs) – this will be contracted for the whole of Brent to achieve the required economies of scale. This service is planned to be operational from Q2 2010/11
- UCC – to be positioned at CMH to ensure primary care patients are treated in the appropriate setting. This service is planned to be operational from May 2010 and to include the out of hours GP services from April 2011

Successful implementation of this model of acute / urgent care is dependent upon a number of factors:

- Achievement of required changes in the management of people with LTC in primary / community care (LTC initiative) and improvements in urgent care access at practice level (Planned care initiative)
- Decommissioning of acute care under PBR tariff for care now commissioned in polysystems
- Commissioning of holistic, rapid-response services, integrated with social care and located at the front-end of CMH and with strong links to Northwick Park and St Mary's
- Adherence by polysystem commissioners to agreed evidence-based pathways with this forming a critical key performance indicator for polysystem autonomy
- Contractual requirement from both acute and polysystem providers to comply with the agreed pathways

4.5 Financial summary, including scenario modelling

Impact assessment

The aggregated recurrent financial and activity impacts of the initiatives by 2013/14 (pre-risk assessment) are summarised in the tables below.

Finance impact (all figures at 2013/14) - Pre-risk assessment

	Initiative	Savings £000	Investment £000	Net £000
1	Maternity	(873)		(873)
2	Children & Young People	(2,184)	761	(1,423)
3	Acute Care:			
	Intermediate and urgent care reprovision	(7,427)	3,083	(4,345)
	Acute Commissioning Vehicle benefits realisation and other commissioning efficiencies	(14,068)		(14,068)
4	Planned Care:			
	Acute shifts/decommissioning	(36,117)	20,576	(15,541)
	Primary and Community Services Efficiencies	(17,195)		(17,195)
5	Mental Health	(9,940)		(9,940)
6	Staying Healthy	(1,117)	2,634	1,517
7	LTCs	(8,270)	3,228	(5,042)
8	End of Life Care	(1,390)	176	(1,214)
9	Other (mgt.costs)	(2,100)		(2,100)
	TOTAL	(100,682)	30,457	(70,224)

Activity impact (all figures as at 2013/14) - Pre-risk assessment

Acute Care	Pre-initiatives		Post-initiatives					
			Shift to polysystem		Decommissioned		Remain in acute	
	No	%	No	%	No	%	No	%
Elective Spells/Planned Same Day	40,737	100%	3,266	8%	1,270	3%	36,201	89%
Non-elective Spells	41,346	100%	4,421	11%	720	2%	36,205	88%
Outpatient attendances	406,437	100%	241,739	59%	30,034	7%	134,664	33%
A&E Attendances	164,079	100%	24,290	15%	13,000	8%	126,789	77%

Risk assessment of initiatives

We have recognised that:

- Our plans to deliver a total net efficiency and disinvestment programme are of a scale and complexity that they inherently have a high degree of risk, and
- Whilst the PCT has a recent track record both of delivering savings (turnaround) and strong financial management, it does not have demonstrable evidence of achieving clinical and service transformation on the scale now being proposed

We have therefore undertaken a rigorous financial risk assessment of our initiatives (both the savings and the associated investments). This was undertaken by the finance team in conjunction with the SROs and risk factors were applied across all initiatives in each year.

The approach taken is outlined below.

Stage 1	Profile of savings & spend by year forecast at sub-initiative level	→ Overarching CSP risks (section 5.2 of CSP)
Stage 2	Risks identified and scored using 5 x 5 matrix of likelihood and impact plus Mitigating actions identified for each initiative	
Stage 3	Assessment of stage 2 risks and mitigating actions to calculate overall financial risk factor for each initiative, by year, for savings and spend separately	
Stage 4	Overall financial risk factor applied to stage 1 values	

Overall, the risk assessment results in a reduced net recurrent savings projection by 2013/14 of £42m (60%) as shown in the table below. This reflects the fact that a number of the initiatives (particularly for the later years) need more work before we can have the required level of confidence in delivery, and with the measures we have in place to develop our plans and monitor delivery (see below), we expect the projected delivery % to increase.

The above four items account for £22m of the total reduction of £28m (i.e. £70m to £42m).

The risk assessment undertaken has enabled a risk prioritisation exercise with the associated development of mitigations by the Executive Management Team (EMT). 12 key risks to the delivery of the CSP as a whole have been identified and these cross-cutting risks will form part of the Board Assurance Framework and will therefore be monitored on a monthly basis by the EMT. These risks, together with the mitigating actions, are set out in section 5.2.

Finance Impact (all figures as at 2013/14) - Post-risk assessment

	Initiative	Savings £000	Investment £000	Net £000	% estimated achievement	Finance Template Ref
1	Maternity	(655)		(655)	75%	E
2	Children & Young People	(1,604)	761	(843)	59%	A
3	Acute Care: Intermediate and urgent care reprovision	(6,685)	3,170	(3,515)	81%	B

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	(ACV) benefits realisation and other commissioning efficiencies	(7,034)		(7,034)	50%	
4	Planned Care: Acute shifts/decommissioning	(24,145)	20,601	(3,544)	23%	C, D & K
	Primary and Community Services (inc. prescribing and estates)	(14,480)		(14,480)	84%	
5	Mental Health	(8,201)		(8,201)	83%	F
6	Staying Healthy	(1,005)	2,634	1,628	n/a	G
7	LTCs	(5,789)	3,228	(2,561)	51%	H
8	End of Life Care	(973)	185	(788)	65%	I
9.	Other	(1,890)		(1,890)	90%	P
	TOTAL	(72,460)	30,578	(41,883)	60%	

Activity impact (all figures as at 2013/14) - Post-risk assessment

Acute Care	Pre-initiatives				Post-initiatives			
			Shift to polysystem		Decommissioned		Remain in acute	
	No	%	No	%	No	No	No	%
Elective Spells/Planned Same Day	40,737	100%	1,633	4%	635	2%	38,469	94%
Non-elective Spells	41,346	100%	3,924	9%	555	1%	36,867	89%
Outpatient attendances	406,437	100%	169,217	42%	21,024	5%	216,196	53%
A&E Attendances	164,079	100%	21,861	13%	11,700	7%	130,518	80%

Achieving the target level

As explained, we have set ourselves the target of delivering approx. £60m over the period. A comparison of the phasing of the £42m with the target level shows that, whilst 2010/11 exceeds our target, we will need to increase the delivery in years 2011/12-13/14 as set out in the table below.

	Finance Template ref	2010/11 £m	2011/12 £m	2012/13 £m	2013/14 £m	Total £m
Risk assessed level		8	13	11	10	42
Additional	J	(2)	5	7	8	18
PCT Target		6	18	18	18	60

This is a level we believe we can achieve, through a combination of:

- Increasing delivery of our current initiatives from 60% to 75% - through the measures we are putting in place as detailed in the table below
- pursuing all other opportunities, including:
 - the maximisation of Sector-wide and pan-London collaboration – for example we have included a conservative estimate of the impact of the NW London Acute Commissioning Vehicle, compared with the agreed Business Case
 - developing the elements of the Healthcare for London affordability analysis that we have not yet fully included in our plan
 - continuing to explore other opportunities identified locally, including the maximisation of the recurrent surplus at the end of 09/10 and further back office savings
 - nationally facilitated contractual changes signalled in the 10/11 Operating Framework
 - expanding our joint working arrangements with LBB, including reviewing the learning from the Total Place pilots

Based on the above, we have reflected in our base case the target level of £60m. In order to maintain transparency, we have identified the £18m separately in the F & A template (reference – initiative J) with an additional £10.5m to be delivered from increasing the delivery of existing initiatives from 60% to 75%,

4.5 Financial summary, including scenario modelling

and £7.5m from additional opportunities. Of the latter, as at month 8, we have identified a £2.5m improvement in the 09/10 outturn from the month 6 position.

Action plan to ensure delivery

In addition to taking actions to specifically support the achievement of the efficiency/disinvestment programme, there are also a number of wider actions that we are taking to underpin delivery of the financial plan as a whole. These actions have been consolidated into the following 15 point action plan:

		ACTION	DATE	COMMENTS
INITIATIVES	1	Develop detailed project plans and Business Cases for all initiatives, prioritising those due to deliver in 10/11 – 11/12	31/3/10	Programme office leadership
	2	Ensure alignment with 10/11 budget – setting and Operating Plan timetable processes	31/3/10	
	3	Ensure that detailed plans for years 2-4 are in place	30/6/10	
	4	Ensure 'best practice' programme and project management arrangements are in place	31/3/10	Overseen by Strategy EMT. Supported by use of performance accelerator software
	5	Ensure that all investments/disinvestments are subject to robust Business Cases that meet WCC competency 11 levels	Ongoing	Development of current processes
	6	Ensure that robust mitigation plans in place to address the 12 cross-cutting risks identified (section 5.2 of CSP)	Monthly	Board Assurance Framework reviewed by EMT, Audit Committee and Board
	7	Develop lead financial and activity indicators to monitor impact of initiatives	31/3/10, then monthly	Link to actions 11 – 13 below
	8	Ensure that our plans are implemented through clinical commissioning and procurement arrangements that underpin and incentivise delivery	Ongoing	See sections 4.3 and 4.4 of CSP
	9	Pursue all other additional opportunities	Ongoing	
OVERALL FINANCIAL PLAN	10	Target our non-recurrent investment plans to support key enabling and transition measures, including those set out in the OD plan	Ongoing	See section 7.7 of MTFS
	11	Ensure level of contingency is set at a level that recognises risks to delivery and reviewed regularly	Quarterly	See section 7.8 of MTFS
	12	Ensure rigorous and continuous and review testing of risks/opportunities, scenario plans and adopt overall plans accordingly	Quarterly	See sections 10 and 11 of MTFS
	13	Continue to strengthen our financial monitoring, forecasting and predictive modelling processes	Quarterly	See section 13 of MTFS
	14	Continue to strengthen our ongoing financial management and governance arrangements	31/3/10	See section 14 and appendix 3 of MTFS
	15	Subject our plans to an external review and strengthen our plans accordingly	28/2/10	See appendix 2 of MTFS for ToR

Non-recurrent analysis and contingency

The enabling measures we need to take to support the changes set out in the Strategic Plan are set out fully in our Organisational Development (OD) plan.

Explicit allowance has been made for non-recurrent enabling and transition costs in implementing the initiatives. The areas specifically highlighted in the HfL affordability analysis were the set-up and transitional costs of polysystems.

We have reviewed the above and also taken into account estimated project and procurement costs of the initiatives, as well as other OD costs and critical enablers, such as IT and Information management.

As with all other investments/disinvestments, all non-recurrent investments will be subject to a robust Business Case process. Also an element is being held as a contingency to allow for spend levels to be reviewed if our downside scenario arises.

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Given the inherent risks we have identified in delivering the £60m programme, the level of contingency has been increased beyond the minimum 0.5% advised in the planning guidance. The contingency has been set at 1.0% in 2010/11 and 1.5% in 2011/12-2013/14. This is the level we feel is required to cover both the initiative risks identified above, together with other risks. The level will be kept under review (both in-year and across years), and, if, as we expect, the full £60m is delivered, the contingency will be released to support further non-recurrent investment in the areas outlined in our OD plan.

The total transition costs and contingency are summarised below:

	10/11	11/12	12/13	13/14
Transition Costs	4.1	4.85	5.35	5.35
Contingency	5.5	8.25	8.25	8.25
Total	9.6	13.1	13.6	13.6

Overall financial position

The summary financial position (recurrent plus non-recurrent) for the plan is as follows:

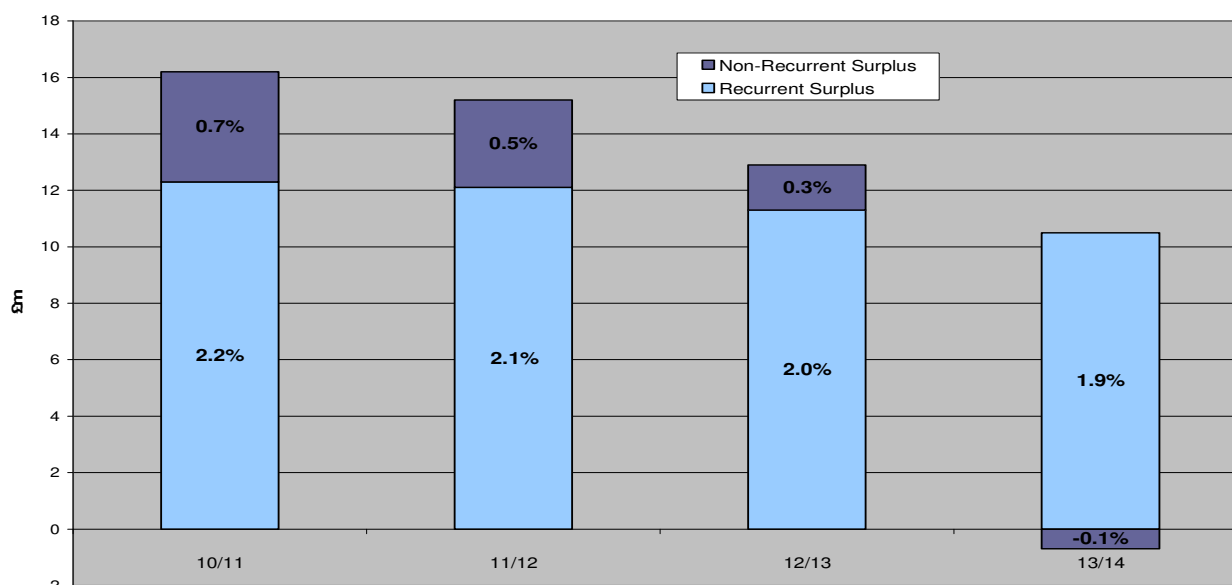
All figures are £m	2010/11	2011/12	2012/13	2013/14
Recurrent Income	550.5	550.5	550.5	550.5
Recurrent Expenditure	538.2	538.4	539.2	540.0
Total surplus (Rec)	12.3	12.1	11.3	10.5
Non Recurrent Income	13.5 (1)	16.2	15.2	12.9
Non Recurrent Expenditure (2)	9.6	13.1	13.6	13.6
Total Surplus (Non Rec)	3.9	3.1	1.6	(0.7)
Total	16.2	15.2	12.9	9.8

(1) £2.5m of 09/10 carry forward of £16m will be provided in 2010/11 to NHS London as second and final contribution to the Challenged Trust process. This will be actioned as an allocation reduction, reducing the non-recurrent carry forward to £13.5m.

(2) Including contingency (see above).

The above projections are shown below, including as a % of total income. The PCT's underlying financial position is maintained throughout the planning period at 2%, with the large step-down in income growth between 2010/11 and 2011/12 absorbed in a managed way.

Recurrent and Non-Recurrent Surplus showing % Surplus of Total Income



The projections assume that the contingency covers the in-year risk to delivery and that the recurrent efficiency/disinvestment programme of £60m is achieved by 2013/14. A lower level of achievement is modelled in our downside scenario.

Assessment of risks and opportunities

The risk assessment undertaken of the efficiency/disinvestment programme was described above. The programme, together with four other key variables have been assessed. Of the five variables tested, the potential impact of each have been assessed (five risks, four opportunities), together with a likelihood percentage, to derive the adjusted risk/opportunity.

Variable	Impact Tested		Likelihood		Adjusted	
	Risk	Opportunity	Risk	Opportunity	Risk	Opportunity
1. 09/10 outturn (recurrent)	0.5% lower surplus (£2.5m)	0.5% higher surplus (£2.5m)	10%	80%	£250k (per annum)	£2m (per annum)
2. Impact of population growth/mix and other activity drivers (per annum)	0.9% higher i.e. HfL downside (£5m)	0.5% lower (£2.5m)	20%	20%	£1.0m (per annum)	£500k (per annum)
3. Impact of PCT initiatives	£20m not delivered	Additional £10m delivered	50%	10%	£10m (total)	£1m (total)
4. Impact of tariff changes	0.5% higher (£2.5m)	0.5% lower (£2.5m)	20%	20%	£500k (per annum)	£500k (per annum)
5. Other risks	Unexpected costs per annum (0.5%)	N/A	50%	N/A	£1.25m (per annum)	N/A
				TOTAL(£m)	22.0	13.0

The risk/opportunity from changes to the allocation uplift is not included here; rather this is reflected in the scenario analysis.

A description of each of the five variables, together with the rationale for the likelihood percentages is as follows:

Variable	Description	Likelihood Rationale
1. 09/10 outturn (recurrent)	The movement from the month 6 forecast	Improvement identified at month 8 reflected in 90% opportunity
2. Population and other activity growth	The movement from the weighted average of 3% per annum assumed	Equal likelihood of risk/opportunity
3. PCT savings programme	Extent of under/over achievement	50% risk likelihood reflects risk of under achievement
4. Tariff inflation changes	Higher or lower than level assumed	Equal likelihood of risk/opportunity
5. Other risks	Other cost pressures	50% likelihood based on experience

The table below summaries the total adjusted impact (i.e., impact multiplied by likelihood) of the risks and opportunities, by year, and compares this with the level of contingency.

All figures £m	10/11	11/12	12/13	13/14	Total
Risks					
- initiatives	0.8	2.6	3.0	3.6	10.0
- other	2.7	2.8	3.3	3.3	12.1
Total risk adjusted impact	3.5	5.4	6.3	6.9	22.1
Contingency	5.5	8.25	8.25	8.25	30.25
Risk as % of contingency	64%	65%	76%	84%	73%
Opportunities	3.0	3.3	3.3	3.4	13.0
Risk minus opps	0.5	2.1	3.0	3.5	9.1
Risk minus opps as % of contingency	9%	25%	36%	42%	30%

Overall, the level of adjusted risk is 73% of the contingency, reducing to 30% when opportunities are taken into consideration, which indicates that the base case plan has 'headroom' for further risks to be absorbed, particularly as the plan also delivers a 2% surplus after inclusion of £20m of non-recurrent investment.

The key to managing the position will be the implementation of the 15 point action plan. This sets out how we will monitor the development and implementation of our initiatives (the largest risk), together with how we will keep track of the overall financial position, ensuring that our strategy can be amended as appropriate.

Other scenarios

As explained above, the PCT's 'base case' plans have been developed to respond to the downside allocation assumptions for 2011/12 – 2013/14 and the assessment of risks and opportunities tests the robustness of the base case plan to changes in other key assumptions. This section develops two other scenarios (best and downside). The best case outlines the impact on our plans of improved allocation uplifts and our downside scenario explores how the PCT could respond to a scenario in which our full efficiency plans are not delivered. We have also undertaken a downside headroom analysis to test the combination of factors that would cause the PCT to move from a surplus to a deficit position.

Best case

a) Assumptions

The table below illustrates the differences between our base and best case projections.

	Base Case	Best Case
Allocation uplift	5.1% 10/11 0% 11/12-13/14	5.1% 10/11 2.5% 11/12-13/14
Inflation & activity uplifts	5.7% 2010/11 3.5% 2011/12-13/14	As base case
Initiatives (net efficiency/disinvestment)	£60m with £10m included in risk analysis	£60m with £5m included in risk analysis
Contingency	£5.5m 2010/11 £8.5m 2011/12-13/14	£5.5m 2010/11 £6.25m 2011/12-13/14

b) Implications

Under the best case, the PCT would continue with its efficiency and disinvestment initiatives with the aim of delivering the levels set out in the base case. This would allow further investment opportunities equivalent to the increased allocation.

c) PCT response

The further investment potential would not be committed until the delivery of the efficiency/ disinvestment initiatives had been assured. As a result, the level of risk to the initiatives would be offset and the level of contingency required reduced, resulting in increased non-recurrent investment headroom.

All additional investments would be subject to business case approval. NHS Brent has a well developed model for business case approval and this is being extended to include a prioritisation matrix that will assess and weight new investments against the following considerations:

- Impact on life expectancy and health inequalities
- Degree of fit with CSP targets including polysystem development
- Impact on national and local targets
- Stakeholder views
- Value for money (our existing approach to assessment of VFM is set out below)
- Capacity and capability of the PCT and providers to implement

The maximum level of investment, assuming full delivery of the £60m efficiency programme, is set out below.

Year	Recurrent £m	Non-recurrent £m
2010/11	-	-
2011/12	13.8	2.0
2012/13	14.1	2.0
2013/14	14.5	2.0

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The areas identified for investment in the best case would further support the initiatives within the CSP providing additional benefits to those already identified. For example, intensive lifestyle interventions would be considered to identify patients with impaired glucose tolerance as part of the NHS Health Checks and offer them an intensive lifestyle intervention comprising dietician support and twice weekly supervised physical activity sessions. Investment to support the delivery of the obesity strategy would be considered including increasing funding for the existing programme provided to children in Brent and funding weight management programmes for obese adults in Brent. Other priority areas would be likely to include further non-recurrent investment in primary care capacity development, including premises development.

d) Revised projections

The revised projections taking into account the above are summarised below:

All figures are £m	2010/11	2011/12	2012/13	2013/14
Recurrent Income	550.5	564.3	578.4	592.9
Recurrent Expenditure	538.2	552.2	567.1	582.4
Surplus	12.3	12.1	11.3	10.5
Non-recurrent Income	13.5	16.2	15.2	12.9
Non-recurrent Expenditure (1)	9.6	13.1	13.6	13.6
Surplus	3.9	3.1	1.6	(0.7)
TOTAL SURPLUS	16.2	15.2	12.9	9.8

(1) includes both non-recurrent spend plus contingency

e) Risk analysis

The analysis of risks, opportunities and contingency under this scenario are as follows:

All figures are £m	2010/11	2011/12	2012/13	2013/14	TOTAL
Risks					
- initiatives (1)	0.8	1.3	1.5	1.8	5.4
- other (2)	2.7	2.8	3.3	3.3	12.1
Total risk	3.5	4.1	4.8	5.1	17.5
Contingency (3)	5.5	6.25	6.25	6.25	24.25
Risk as % of contingency	64%	66%	77%	82%	72%
Opportunities (4)	3.0	3.3	3.3	3.4	13.0
Risk minus opps	0.5	0.8	1.5	1.7	4.5
Risk minus opps as % of contingency	9%	13%	24%	27%	19%

(1) Risk of initiatives in base case in 11/12-13/14 reduced by 50% due to discretionary investment headroom

(2) As base case (3) Reduced from base case (4) As base case

Overall the level of adjusted risk is 72%, reducing to 19% after taking account of opportunities, again demonstrating a robust plan under this scenario.

Downside case

a) Assumptions

The table below illustrates the difference between our base and downside projections:

	Base case	Downside
Allocation uplift	5.1% to 10/11 0% 11/12-13/14	As base case, plus further tested in downside headroom analysis (see section 11.5)
Inflation and activity uplifts	5.7% 2010/11 3.5% 2011/12-13/14	As base case, plus v further tested in downside headroom analysis (see section 11.5)
Initiatives (net efficiency/disinvestment)	£60m, with £10m included in risk analysis (i.e. net £50m)	£51m, with £10m included in risk analysis (i.e. net £41m)
Contingency	£5.5m 2010/11 £8.25m 2011/12-13/14	As base case

Having already taken on board the potential downside allocation uplifts in our base case, for our downside case we have used the same allocation and tariff/activity growth assumptions. Changes to these factors are taken into account in both the risk analysis plus the downside head room analysis – see f) below.

b) Implications

We have assumed in this scenario that of the £60m efficiency programme, £9m is not achieved (50% of the £18m). This leads to a resultant reduction in the level of surplus (before remedying actions) as outlined in the table below.

All figures are £m	2010/11	2011/12	2012/13	2013/14
Recurrent Income	550.5	550.5	550.5	550.5
Recurrent Expenditure (1)	538.2	541.4	545.2	549.0
Surplus	12.3	9.1	5.3	1.5
Non-recurrent Income	13.5	16.2	12.2	3.9
Non-recurrent Expenditure (2)	9.6	13.1	13.6	13.6
Surplus	3.9	3.1	(1.4)	(9.7)
TOTAL	16.2	12.2	3.9	(8.2)

(1) As per base case plus £9m, spread over 11/12-13/14

(2) Level of non-recurrent expenditure unchanged, including contingency which is kept at base case levels

The reduced level of recurrent savings has the impact of:

- reducing the recurrent surplus in 13/14 from £10.5m in the base case by £9m to £1.5m
- a knock-on impact on the non-recurrent position due to the reduced surplus carry forward
- an overall deficit in 13/14 of £8.2m

c) PCT response

Given the timeline we have established to work up detailed plans for 11/12-13/14 (i.e. 30 June 2010), and the strength of our monitoring and forecasting processes, we will be in a position to respond promptly to the downside.

Faced with this position the PCT would:

- Reduce the level of recurrent expenditure by £4m (from £30m in the base case to £26m). The specific areas we would target are the staying healthy initiative (net cost of £1.6m) and the planned care initiative (total cost of £20m)
- Reduce the level of non-recurrent expenditure from £20m in the base case to £12m and the specific areas we would target is the unallocated sum.

Whilst these reductions would be stretching to deliver, they would not fundamentally prejudice the delivery of the overall programme.

d) Revised projections

The summary position after these actions is summarised below:

All figures are £m	2010/11	2011/12	2012/13	2013/14
Recurrent Income	550.5	550.5	550.5	550.5
Recurrent Expenditure (1)	538.2	540.4	543.2	545.0
Surplus	12.3	10.1	7.3	5.5
Non-recurrent Income	13.5	16.2	15.2	11.9
Non-recurrent Expenditure (2)(3)	9.6	11.1	10.6	10.6
Surplus	3.9	5.1	4.6	1.3
TOTAL	16.2	15.2	11.9	6.8

(1) £4m reduction in recurrent expenditure - £1m per annum 11/12 – 12/13, £2m 13/14

(2) £8m reduction in non-recurrent expenditure - £2m 11/12, £3m per annum 12/13 -13/14.

(3) Contingency unchanged from base case.

e) Risk analysis

For our downside scenario, we have also modelled all of the base case risk plus an increased level of risk to reflect the risk of delivering the mitigations. The revised risk assessment for the downside scenario is set out in the table below:

All figures £m	2010/11	2011/12	2012/13	2013/14	TOTAL
Expenditure risk (additional) (1)	-	0.5	0.5	1.0	2.0
Base case risk (2)	3.5	5.4	6.3	6.9	22.1

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Total adjusted risk	3.5	5.9	6.8	7.9	24.1
Contingency (3)	5.5	8.25	8.25	8.25	30.25
As % of contingency	64%	72%	82%	96%	80%
Opp from base case (3)	3.0	3.3	3.3	3.4	13.0
Adjusted risk less opportunities	0.5	2.6	3.5	4.5	11.1
As % of contingency	9%	32%	42%	55%	37%

1) 50% of the proposed recurrent expenditure reduction above (2) As base case (3) As base case

The level of contingency is sufficient to cover the total risk (i.e. incremental risk plus base case risks), with increased headroom available if the opportunities are able to be realised.

f) Downside headroom

This section tests the 'headroom' available to absorb the worsening of the key assumptions from the downside scenario and tests the combination of assumptions that would need to change for the PCT to move to a deficit position. The headroom available in the downside comprises three elements:

- i) The level of surplus
- ii) The contingency less the adjusted risks/opportunities and;
- iii) The level of non-recurrent investment

The headroom available in the downside scenario is summarised below:

	£m
Surplus 13/14	6.8
Risk/contingency (total)	19.15
Non-recurrent investment	11.65
TOTAL	37.60

'Downside plus' scenarios have been modelled to test the extent to which changes could be absorbed whilst still maintaining a balanced financial position. The variables tested are:

- i) Exclusion of all opportunities
- ii) Increase in risks beyond the downside i.e. £41m delivery of initiatives and £14m if expenditure above base case projections in respect of tariff, activity growth and other pressures. An increase of 0.5% - 1.0% p.a. has been modelled
- iii) A reductions to the flat cash uplift for 2011/12-13/14 of 0.5% - 1% p.a. has been modelled

This is illustrated below:

Scenarios	Impact (£m)	
Zero opportunities	13.0	13.0
Plus increased risks 2011/12 – 13/14: - 0.5% p.a. - 1.0% p.a.	8.0	16.0
Reduction in allocation 2011/12 – 13/14: - 0.5% - 1%	16.0	8.0
TOTAL	37.0	37.0

The above demonstrates that, after excluding all opportunities from the position, some £24m of headroom remains, which equates to approx. 1.5% per annum for 11/12-13/14. It is considered unlikely that a combination of zero opportunities, allocation reductions and activity/tariff increases would reach or exceed this level.

Conclusion

The above analysis shows that:

- A recurrent surplus position of 2% is maintained in each year, under all scenarios, with the exception of the downside in 12/13-13/14, when the recurrent surplus is 1%
- The risk to contingency ratio is 73% (base), 72% (best) and 80% (downside)
- Once opportunities are taken into account, these ratios reduce to 30% (base), 19% (best) and 37% (downside)

4.6 CSP development

Notwithstanding the robustness of the financial plan, given the inherent risks and uncertainties involved in planning both income and expenditure over the coming years, the PCT will need to be focussed on ensuring that it is able to respond to changes in key assumptions and projections in a flexible and optimum manner. This is enabled by

- our solid foundation and recent track record providing a strong platform on which to build
- the strength of our planning process including our base case assumptions, our identification and assessment of risks and opportunities, our scenario planning, and the levels of contingency and non-recurrent investment
- our 15 point action plan to ensure that we have capacity, capability and focus to maintain a firm grip on our position and the flexibility and speed of response to risk and volatility to maintain a sustainable financial position under all scenarios.

4.6 CSP development

NHS Brent developed a CSP in 2008/09 which informs this document to a large extent, particularly in terms of our priorities and the way we identified these. What is different about this CSP is the wider scope and our desire to fully articulate and plan the way in which we will deliver HfL (HfL) in Brent.

Last year the starting point for the selection of our outcome measures, and the development of our goals was our existing knowledge, including our JSNA and Health & Wellbeing Strategy. The CSP development process began last year with a review of Brent's key health needs, gathering of stakeholder views, and identification of performance issues and policy commitments by our executive team. Our executive team then conducted a SWOT analysis. A list of key priorities was generated, which formed the basis of a new vision for healthcare in Brent. Five key goals emerged, closely aligned to HfL and the Next Stage Review:

Goal 1: Increase life expectancy

Goal 2: Reduce health inequalities

Goal 3: Health improvement and wellbeing

Goal 4: Safe and high quality services

Goal 5: Improve patient experience

Our vision and goals were discussed, refined and agreed by the Board. These now form a fundamental part of our organisational culture and remain our vision and goals for this plan. Prioritisation criteria for selection of initiatives in 2008/09 were developed based on the health needs of the community, preferences of local users, impact on addressing gaps, clinical effectiveness, implementation challenges and financial impact. The final prioritisation criteria selected were as follows:

1. Mandatory and statutory work	4. Savings
2. Contribution to Vision and Goals	5. "Implementability"
3. Cost	6. Stakeholder Ranking

Forty people (partners, patient and carers' organisations, PEC and PBC clinicians, providers and PCT staff) attended a stakeholder event to refine the vision, goals and initiatives and rank the potential initiatives. The results were considered by an "expert panel" of Executive Directors and local clinical leaders. This process established the final list of initiatives that were included in our 2008/09 CSP.

Recognising the importance of delivering HfL this year we have widened the scope of initiatives and aligned them directly to HfL pathways. In doing so we are not discarding the work of last year but reflecting the full ambition of our plans for local implementation of HfL. HfL gives NHS Brent a strong local mandate for change and clear framework for prioritisation of action based on its clinical evidence base, clinical engagement and extensive public engagement and consultation.

In September 2009 we convened a similar group of stakeholders to those outlined above, secured their support for aligning our initiatives to the eight HfL pathways and gathered views on what this specifically means for Brent.

5.1 Past delivery performance

We have developed our priority areas of focus within initiatives by identifying the gaps between our current state and the key areas for improvement and future state identified by HfL, as well as considering stakeholder feedback and public health analysis. We have also been clear about which priority areas for improvement will form the main area of PCT focus and those for which we will delegate responsibility for delivery to the NWL sector vehicle.

In developing our CSP aligned to the HfL pathways each initiative has involved considerable stakeholder and clinical engagement. This is outlined in individual initiative sections. A draft CSP has also been shared with our PBC clusters and amended to reflect their views.

Our Board has been heavily involved and provided active leadership to the development of this CSP. In addition to the activities outlined above there have been several Board seminars, executive team checkpoint meetings and brainstorming sessions to secure engagement and feedback and work through specific issues such as the identification of risks.

The CSP development process as described above has resulted in a robust strategy which prioritises actions founded in clinical evidence and best practice and reflects the views of a wide range of Brent's stakeholders both internal and external.

5. Delivery

5.1 Past delivery performance

Over the past year we have started the challenging process of turning around performance with a number of key successes. Our progress and current position against both our financial and performance improvement plans have been recognised in our CQC scoring of Good from Weak in Quality of Financial Management and Fair from Weak in Quality of Services.

The most significant constraint to delivery over the last 12 months has been capacity. We recognise that aligning ambition to capacity is a critical success factor in delivery and we have therefore consciously focussed on delivering our Organisational Development Plan through 2009/10 to provide us with the capacity required to deliver even more ambitious plans.

Over the course of the past year we have introduced a number of changes to improve our capability and capacity to deliver our strategic plans and have made over 30 new permanent appointments. Details of these and a summary of our successful progress are contained in our OD Plan.

In addition to these major organisational changes, we have further developed our Investment Panel process, aligning business case development and review to WCC competencies and this process has been managed and assured by a dedicated programme office. We have also continued to develop our Board performance report that monitors both the delivery of planned initiatives and their impact on key performance indicators.

We engaged an external consultancy to help implement the accelerated deployment of a best practice performance management methodology across our top 10 performance priorities. This provided a significant impetus to a number of our CSP initiatives and we have adopted this as our standard performance management methodology.

In terms of our performance across each initiative, we conducted a structured, mid-year progress review of all our CSP initiatives in August and a summary of this analysis is provided below.

5.1 Past delivery performance

Initiative	Progress and Performance	Initiative Improvements
Improve primary care services	<ul style="list-style-type: none"> • Primary and Community Care Strategy agreed • GP Led Health Centre opened • UCC business case approved by PCT Board • GP access improvements 	<ul style="list-style-type: none"> • Polysystem Strategy aligned to Primary & Community Strategy • Alignment of polysystem strategy with LBB locality developments
Improve childhood immunisation rates	<ul style="list-style-type: none"> • Performance in 2009/10 has been significantly down in part due to the impact of more accurate calculations and the current programme focus on data and establishing the key enablers. This is a long-term programme targeting the resolution of entrenched and complex issue and performance is now on an upward trajectory • The data cleansing activity has commenced and over 5,000 records (over 78 %) have been cleansed 	<ul style="list-style-type: none"> • Lead role of GPs clearly articulated with full engagement in immunisation scheme. • Implementation of database with clear KPIs to ensure ongoing integrity of data • Population segmentation and social marketing
Improve vascular health	<ul style="list-style-type: none"> • Full business case has been developed defining options for delivery based on a sliding scale of investment and an assessment of the impact on health inequalities • Specification and operational policies developed 	<ul style="list-style-type: none"> • Targeted and phased approach agreed to address health inequalities • Involvement of faith & community groups to support lifestyle changes • Need to set expectations with stakeholders based on the level of investment available
Reduce premature mortality from cancer	<ul style="list-style-type: none"> • Root cause analysis of poor uptake of breast screening services identified a lack of communication at all stages of the process • Patient focus groups across a broad range of ethnic groups have highlighted key themes around health promotion, access and quality of information • Strengthened commissioning framework with provider for breast screening 	<ul style="list-style-type: none"> • Support transition to incentivised cost per case contract for breast screening to replace block contract • Endorsement and local involvement of General Practices • Locally sensitive health promotion and social marketing
Improve Intermediate Care	<ul style="list-style-type: none"> • Overall performance on Delayed Transfers of Care is exceeding targets set. Recent work to reduce bed days delayed is having a consistent impact • Pilot of Rapid Response services was commissioned in January, which continues to deliver successfully whilst providing valuable insight into the commissioning requirements for the end-state Intermediate Care model • Year 1 has focussed on the development of the strategy and business case jointly with the council. The business case is now approved • Brent was amongst the earliest PCTs to go live with Clinicienta Acute Home Care • Re-commissioning plans are at an advanced stage of development 	<ul style="list-style-type: none"> • Full Intermediate Care model needs to be implemented before the commitment to save 2,265 admissions per annum can be achieved • There is a need to continue to focus on strategies to reduce delays • Clear related opportunities exist around social care reablement services, and in understanding how they are delivered in tandem with community rehabilitation to reduce dependency on long-term care • Activity monitoring of the Rapid Response service pilot suggests that a significant number of admissions are being successfully avoided. However, total admissions overall are not reducing in line with this, suggesting other factors are involved which need to be investigated
Improve mental health and wellbeing	<ul style="list-style-type: none"> • Increased capacity in Early Intervention in Psychosis service – currently exceeding target of 65 cases • Focus on working with largest provider of mental health services, CNWL to agree a performance 	<ul style="list-style-type: none"> • Need to focus on ensuring that the right models of service are in place in preparation for the implementation of the new NHS contract for Mental Health • A system review of all Mental Health

5.1 Past delivery performance

Initiative	Progress and Performance	Initiative Improvements
	management framework and with 4 other PCTs on reviewing the current contract arrangements , looking at models of service which will deliver efficiencies and improved outcomes	<p>service provision is to be undertaken to improve efficiency</p> <ul style="list-style-type: none"> IAPT compliant service to be commissioned from Summer 2010
Improve maternity services	<ul style="list-style-type: none"> Improvements at NPH have been progressed with 72% complete and 28% in progress and being reviewed in relation to current sector wide priorities and deliverables Improved involvement of women in the planning and contract management of services 	<ul style="list-style-type: none"> Implementation of community-based antenatal pathway including clear specifications and contract management Innovative plans to enhance early booking rates
Give children and young people the best chance in life	<ul style="list-style-type: none"> Initial figures show that there has been a significant reduction in under 18's conceptions for Q1 of 2008 and we have reported a 20.92% change in conceptions against the 1998 baseline Improved access to sexual health and substance misuse services for young people in and outside of the school setting Midwives and health visitors engaged in the emphasis on improving breastfeeding rates TAMHs pilot, targeting Mental Health support is underway in 6 primary care and 2 secondary care settings 	<ul style="list-style-type: none"> Continue to collate information about breastfeeding experience, perceptions, initiation and prevalence across 5 localities in order to gain a comprehensive understanding of factors impacting breastfeeding prevalence Continue to develop support systems at key maternity units used by Brent women to encourage breastfeeding initiation and maintenance using the CHPP good practice guide Develop and implement a social marketing campaign with positive images and role models for breastfeeding
Support healthy behaviours	<ul style="list-style-type: none"> Progress against Smoking Quitters target sits at 56% of target trajectory up until July 2009. This is an increase from 08/09 when 37% of target was achieved. Since May the number of registrations has risen significantly and progress towards the quit target is expected to rise Sport and Physical Activity strategy out for consultation 	<ul style="list-style-type: none"> Strategy building for Obesity, physical activity summit, alcohol and substance misuse Stakeholder engagement will continue to be a key activity Development of health and wellbeing plans within each polysystem

5.2 Risk management

Risk management is a central part of our project management methodology which has been developed by our Programme Office team and is applied across all our strategic initiatives. The Risk Log below represents the key risks to the delivery of the CSP as a whole, as identified by our Executive Management Team. Individual project level risks will be managed and escalated through standardised processes and are ultimately managed by the SRO for each initiative. The cross-cutting and significant risks outlined below will form part of the Board Assurance Framework and will be monitored on a monthly basis by the Executive Management Team.

Key: O = likelihood of Occurrence (1 – 5); C = most likely Consequence (1-5); R = overall risk Rating (O x C) with 25 as the highest risk score

Risk Description	O	C	R	Actions we can take to mitigate the risk
Unable to procure new services at projected price and quality	4	4	16	<ul style="list-style-type: none"> Early engagement with potential market entrants Enhanced commissioning capabilities Seek savings in other areas to cover shortfall
Speed of implementing our change agenda is constrained by organisational capacity and capability	4	4	16	<ul style="list-style-type: none"> CSP phases implementation over 4 years Organisational capacity grown in 2009/10 OD plan actions Provision of non-recurrent programme resource
Providers' workforce capacity	4	4	16	<ul style="list-style-type: none"> Workforce transition programme

5.3 Delivery schedule and in-year monitoring for initiatives

Risk Description	O	C	R	Actions we can take to mitigate the risk
and capability cannot deliver change in the timescales needed				<ul style="list-style-type: none"> Collaborative working with current and potential providers Joint health and social care workforce programme Primary care development programme included in OD plan
Scale of change is too challenging at GP practice level	4	4	16	<ul style="list-style-type: none"> Primary care development programme included in OD plan Continuing clinical engagement and ownership Use of incentives and levers
Brent's population doesn't change behaviour in the way they access healthcare services	4	4	16	<ul style="list-style-type: none"> Effective decommissioning and pathway redesign Maximise role of primary care clinicians Use of communications and social marketing linked to sector and pan-London
Lack of alignment and accuracy of modelling (accurate and cost) assumptions contained within the CSP	4	4	16	<ul style="list-style-type: none"> Comprehensive review of initiative business cases Detailed implementation planning and monitoring of progress Co-ordination of plans and effective matrix working across the PCT and sector
Plans are not supported by stakeholders such as the local authority and politicians	4	4	16	<ul style="list-style-type: none"> Continued engagement Clear demonstration of clinical evidence base
Lack of an integrated and effective IT infrastructure across the health economy	5	3	15	<ul style="list-style-type: none"> OD plan includes actions for IT development Implement London wide initiatives Use of the national spine
Low levels of clinical engagement hamper benefits realisation	3	5	15	<ul style="list-style-type: none"> Ensure clinicians understand the nature and benefits of the proposed model of delivery Clinical engagement in the development and localisation of care pathways and polysystem development Identification and promotion of examples of good practice and benefits amongst early implementers
Changes lead to serious destabilisation of the provider landscape and compromise integrity of the health economy	4	3	12	<ul style="list-style-type: none"> Robust reconfiguration plans for acute sector developed in partnership with sector and pan-London Clear local plans for future configuration and potential new entrants to the market
Changes do not deliver the projected impact on health outcomes	3	4	12	<ul style="list-style-type: none"> Monitoring of metrics throughout implementation period and take corrective action as required Outcome-based specifications built into contracts Robust contract monitoring and performance management against outcome measures
External partners cannot deliver their role in CSP implementation	3	4	12	<ul style="list-style-type: none"> Ensure alignment with pan-London, sector and local authority work Support for and scrutiny of sector development and delivery

5.3 Delivery schedule and in-year monitoring for initiatives

It is clear that the scale and pace required to deliver this plan is significantly greater than our CSP last year and this is reflected in the scale of the improvements we are making in terms of the programme management and collaborative working arrangements that we are putting in place and which are set out in section 5.4. We recognise that these changes will be essential in order for us to work locally and as a sector to manage the following 3 interdependent transformational changes.

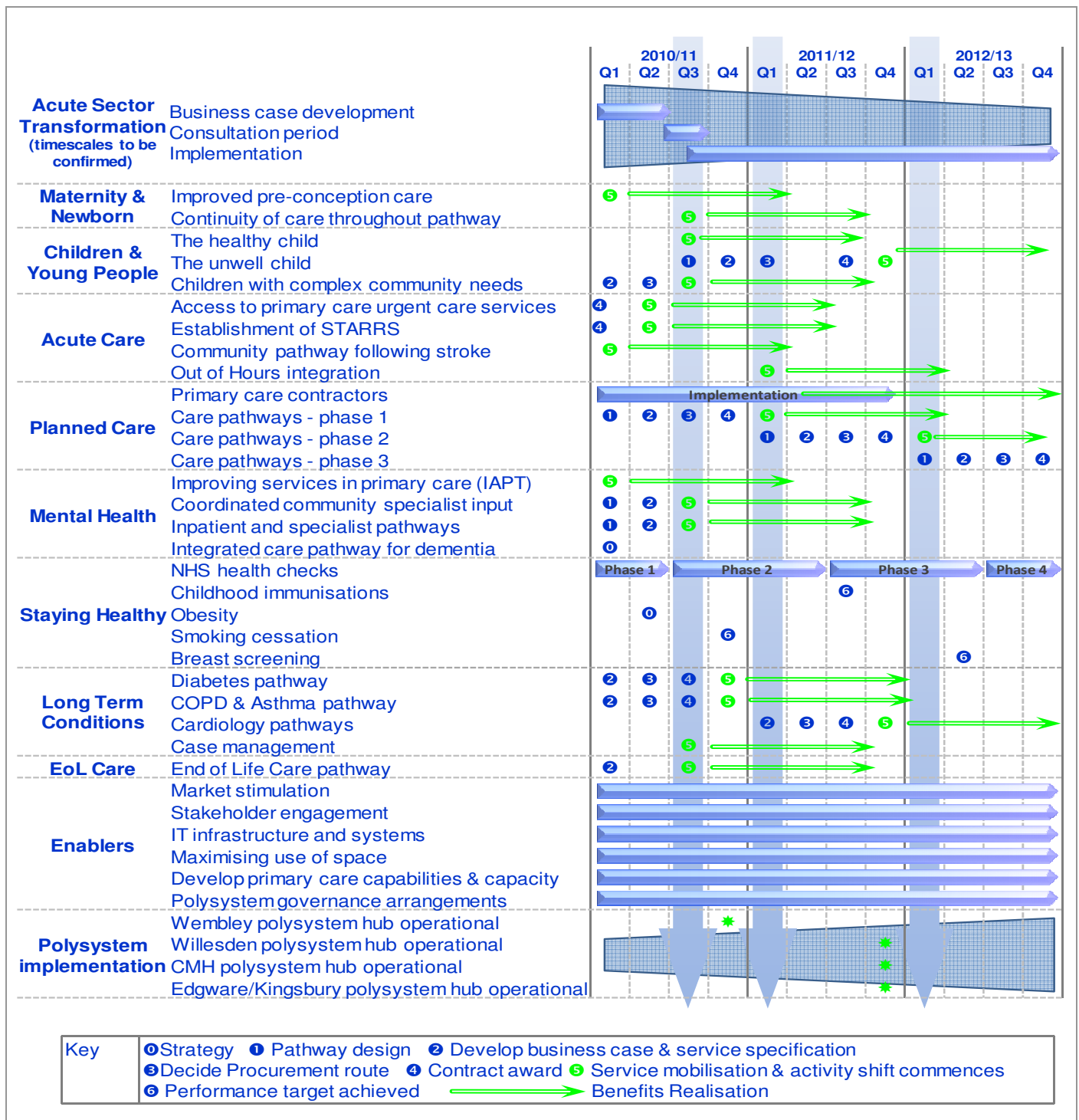
1. Acute sector decommissioning and disinvestment with NWL sector partners
2. Development of capacity in primary and community settings
3. Behavioural change across clinicians and patients

Delivery Schedule

The programme overview in this section summarises the timelines and phasing for the shifts in activity described in this CSP and illustrates the dependencies across the acute sector transformation, new pathway development and the implementation of polysystems.

5.3 Delivery schedule and in-year monitoring for initiatives

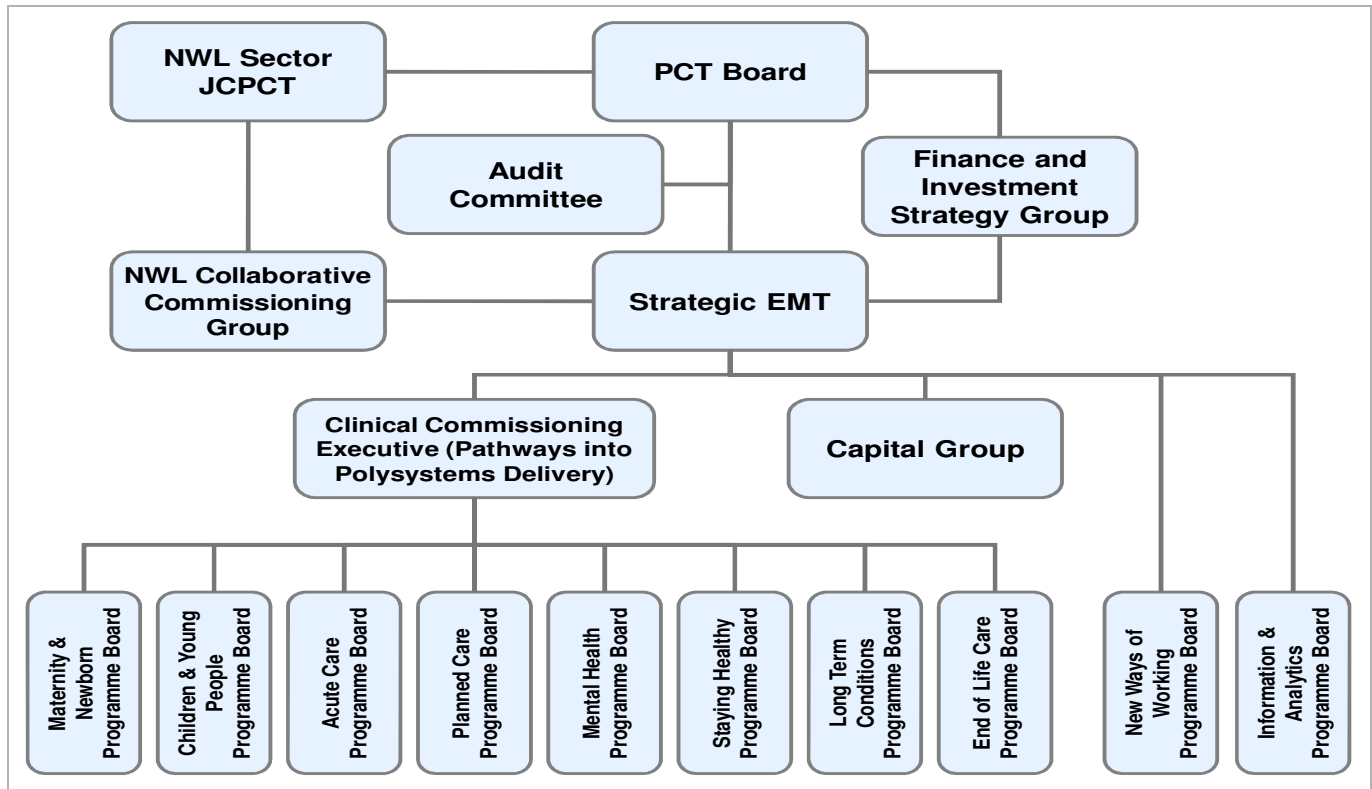
This CSP contains other activities which will deliver significant financial benefits such as the use of the acute commissioning vehicle and these are fundamental to the delivery of this plan. These activities are summarised within individual initiatives, the finance sections of this plan and our MTFS.



Governance

The diagram below summarises our current governance arrangements for assuring delivery of our CSP initiatives and how these align to our OD delivery and sector governance arrangements. As clinically-driven commissioning develops the governance arrangements will be reviewed and amended to ensure that they support both the delegation of further responsibilities to Polysystem Commissioning Boards, and the requirement that the PCT has appropriate scrutiny and accountability arrangements in place. The current phase of the development programme is planned to report by March 2010, with the expectation that any

shadow arrangements can be put in place in 2010/11 in preparation for full implementation of Local Clinical Partnerships in 2011/12.



In-year monitoring

Please note that the key metrics for in-year monitoring of each initiative are covered in the initiative chapters in section 4.2. In addition to the organisational changes outlined in section 5.4 and the substantially increased capacity that our recent recruitment campaign has provided, we are also introducing the following process changes to improve in-year monitoring.

- We are revising our existing Investment Panel process, extending its current focus on investment appraisal to cover the full strategic planning, delivery and monitoring process. Strategic EMT will meet on a monthly basis to provide full assurance of the investment and disinvestment portfolio including the assessment of business cases and implementation plans, monitoring of delivery against the objectives, budget, milestones and benefits contained in the business cases and plans and ongoing monitoring of the overall progress against the portfolio's investment and disinvestment plans
- A Clinical Commissioning Executive will be established including membership from PBC and PEC and will provide overall clinical assurance of our pathway programmes and integration of these programmes into the Pathways into Polysystems programme
- Our business case approval process is being aligned to a formal framework for benefits realisation to ensure that the realisation of both financial and non-financial benefits set out in approved business cases is monitored effectively and corrective action taken where there is any predicted slippage in terms of benefits realisation
- We are enhancing our integrated monthly monitoring processes including the Board Assurance Framework and other performance reporting to the Board, Finance and Investment Strategy Group (a Board sub-committee) and EMT to ensure these reporting arrangements are aligned to the process changes described above
- We will establish working arrangements for monitoring and coordination of plans with the NWL sector programme team

We are continually looking at areas to develop our financial monitoring, forecasting and predictive modelling processes. This is included as a specific objective within our Use of Resources Financial Management Improvement Plan. The key areas that we will be developing include:

5.4 Organisational requirements and enablers

- extending our current monthly finance report to enable a structured and systematic tracking of the MTFS.
- development of our quarterly forecasting process to explicitly include review of MTFS risks and opportunities
- continued development of predictive modelling techniques for major areas of spend
- integration with overall CSP governance, monitoring and risk management processes, as set out in sections 5.2 and 5.3 of the CSP

In respect of initiative development, we have recognised that our initiatives are at varying stages of development and this is reflected in the financial risk assessment.

As part of our planning processes, the initiatives will be subject to ongoing development, including further financial challenge and risk assessment (see below).

The process will ensure that our financial projections are regularly updated and reflect realistic assessments of delivery.

5.4 Organisational requirements and enablers

The Organisational Development Plan contains a comprehensive view of our delivery goals, capabilities and gaps to improve the strategic initiatives. Our strengths to enable delivery and our critical gaps with solutions are illustrated in the tables below. Timelines for actions are contained in the Project Plan section of the Organisational Development Plan.

Organisational strengths to enable delivery

<p>Leadership and Direction</p>	<p>Board and Executive Management Team</p> <p>NHS Brent has robust Board arrangements in place. The Board members have clear roles and responsibilities, appropriate to their skills and experience and regularly reviewed and a clear understanding of the role of a Board in a commissioning organisation. The Board have a strong quality assurance process in place and a commitment to self assessment and continuous improvement. In addition to regular board meetings we hold board seminars which provide the opportunity to gain deeper understanding of emerging issues and horizon scan. Each Non Executive Director has access to personal coaching and regular appraisal.</p> <p>The Executive Management Team, newly formed last year, are now firmly established and working cohesively. There has been stability in the team with no vacancies or turnover. There is strong commitment to our vision, and driving better performance. There is a clear strategy with shared ownership.</p>
<p>Accountability</p>	<p>Systems have been implemented to ensure accountability to the Executive Management Team and to the Board for our performance against key targets.</p> <p>The Audit Committee are integral to our structures and performance management and regularly scrutinise our organisational performance. The Audit Committee has submitted itself to evaluation from the Executive Management Team.</p> <p>The Board and key corporate Committees undertake self assessment at the end of each meeting.</p> <p>We have developed a new framework for appraisals and performance reviews, supported by training.</p> <p>Our quality of financial management has improved from weak in 2007/08 to good in 2008/09 (as measured by the Use of Resources).</p>
<p>Co-ordination and control</p>	<p>The organisation has re-built its governance and financial and risk management systems and processes following the recommendations of the Taylor report. In his follow up report of November 2008, Michael Taylor acknowledged the considerable progress made and commended the PCT for their achievements.</p> <p>These improvements have been recognised by being shortlisted for the HFMA award for “the</p>

5.4 Organisational requirements and enablers

	<p>most innovative and efficient accounts team of the year”</p> <p>We have robust investment and disinvestment processes in place enabling informed decision making and greater control over our initiatives.</p>
Capability and Motivation	<p>Our new structures and recent recruitment means that we now are better provided with the skills and talent we need to support our strategic plans. Retention and development of talent becomes key to ensuring delivery of our goals. Staff turnover continues to be on a downward trajectory, vacancies are reduced and significant investment in development has been committed.</p>
External orientation	<p>A key area of focus over the past two years with much closer working with the LBB (supported by joint posts) and close engagement with the establishment of the Acute Commissioning Partnership.</p> <p>The implementation of our community engagement strategy is now well established and has resulted in stronger links with the community, support agencies and the people of Brent.</p>

Gaps to delivery of plans

Gap identified	Solution
Programme Management and Project Management capacity and capability	Build/Grow/Procure Design and implement “best practice” programme/project management model. Identify skills required for each role and resource with a combination of internal and external specialist resources. Continue knowledge transfer sessions currently in place.
Benefits Management expertise	Procure/Grow Buy specialist external resource to develop benefits management strategy and monitoring processes. Grow Programme Office role to implement processes.
Capacity and capability to deliver complex new models of care (polysystems)	Grow/Share/Procure Access bespoke programmes on polysystem development. Share expertise with other PCTs. Procure consultancy support.
Informatics – Robust data and expertise	Grow/Share Deliver improvements through the Information and Analytics development goal. Work closely with the Acute Commissioning Vehicle to utilise skills and resources.
Procurement expertise	Procure/Share Buy in specialist resource for specific procurement activities. Share procurement activities across the sector.
Sufficient providers	Build Implement Market Management strategy.
Sufficient Learning and Development resources/ expertise to deliver WCC competency improvements programme	Share Establish programme with North West London sector to share experts and deliver a sector wide programme.
Sufficient communications resource to deliver a sustained programme of communications for staff engagement	Grow Formalise communications arrangements within the programme governance.
Skills to develop a comprehensive talent management system	Share Develop a programme across NWL sector. Achieve economies of scale through procurement of providers.
Formal arrangements for sector working across OD priorities	Share Establish forum and identify priority areas to work on collaboratively.
Culture and systems to work effectively across organisational boundaries	Grow Align cultural development programme to take account of emerging structures and changed ways of working.
Capabilities in producing evidence based pathways	Grow Ensure that multi functional project teams are developed with significant input from Public Health.
Effective cross discipline cross directorate working	Grow Team building programme and matrix working development.

6. Declaration of Board approval

As a Board, we have been engaged in ongoing strategic planning as well as the assurance of delivery throughout the year. The publication of our WCC scores and the feedback we received in February 2009 represented a key milestone for us as it provided us with an opportunity to consider how to respond to the feedback and embed planning to WCC standards in the business of the Board. This was discussed and actions agreed at a board seminar.

This also coincided with the publication of the second Taylor Report which gave the Board and other stakeholders the confidence that a stable and effective executive team was in place and well prepared to plan for and deliver the further improvements required to provide the high quality services our population expects. We have captured below some of the key areas where the Board has played its part in establishing the environment for delivering these improvements, in helping support and assure the delivery and in shaping and challenging the strategy. The following are examples taken from board meetings, sub-committee meetings and at the regular and very successful board seminars.

- The strategic plan in terms of the approach, the challenge and the response was discussed at a series of board seminars over the summer with the Chair and the Chair of the Audit Committee taking lead roles in this activity and with responsibility for maximising NED input
- The Board Assurance Framework includes quality measures such as HCAs and is presented and challenged at every board meeting with further detailed scrutiny at the Audit Committee
- The Performance Report includes tracking of the delivery and impact of CSP initiatives and is presented and challenged at all Board meetings
- There has been specific challenge and shaping of the high value investment initiatives that are core to our strategic goals including Smoking Cessation and the Vascular Risk Assessment programme
- Significant quality issues have been discussed in detail including NWLHT and Brent Community Services, specifically a post Mid-Staffordshire hospital enquiry assessment of risks in respect of NWLHT at the request of the SHA and an external review of health visiting and school nursing.
- Cover sheets for all board papers include a requirement to demonstrate how any proposals align to the WCC competencies

In addition, outside of formal board meetings and board seminars, board members have also performed the following roles.

- The Board has actively participated with NHS Harrow in the acute services review of NWLHT which has resulted in the centralisation of emergency surgery on the Northwick Park site and the possible transfer of inpatient paediatrics to Northwick Park, and the growth of elective, diagnostic and outpatient services at CMH
- The Chair and CEO are in discussions with other sector organisations to determine how to maximise the influence of the Academic Health Sciences Centre and the Health Innovation and Education Cluster on the quality of services and the workforce
- The Board has agreed sector governance arrangements and the Chair and Chief Executive attend NWL JCPCT (joint committee of North-West London PCTs) meetings and report back to board members
- The Director of Finance and Performance is a member of the London Challenged Trust Board

As described above, the Board has been engaged throughout the strategic planning process that has led to the production of this plan and endorses and approves the plans that NHS Brent have set out for the next five years.