Health and Social Care Integration

Producing Brent's Better Care Fund Plan

Health and Wellbeing Board

26 February 2014

Phil Porter

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Objectives

Today's presentation

- Provide context – health and social care integration in NWL - Whole Systems Integrated Care (WSIC)
- Outline key features of the Better Care Fund plan: what it is/what it isn't
- Outline key schemes proposed to be part of the Better Care Plan
- Governance and next steps

NWL Whole Systems Integrated Care

Vision and Principles

Our shared vision of the WSIC programme …

> We want to improve the **quality of care** for individuals, carers and families, **empowering and supporting** people to maintain independence and to **lead full lives** as active participants in their community

… supported by 3 key principles

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

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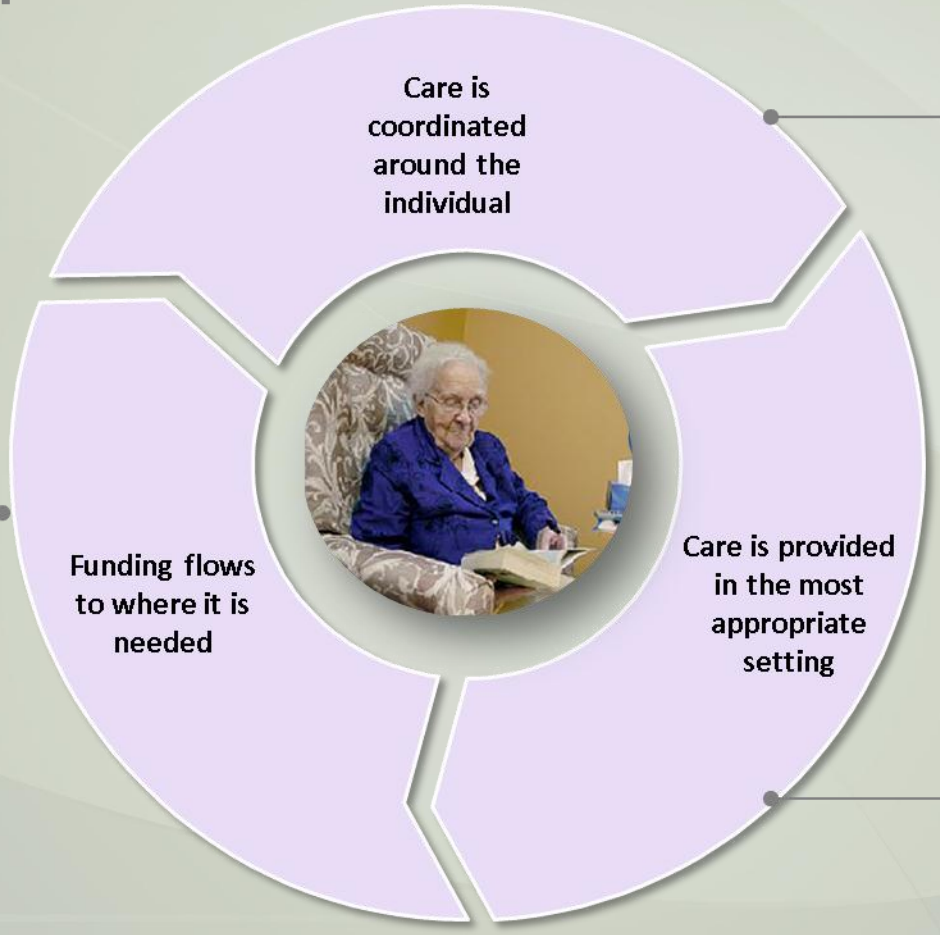
NWL Whole Systems Integrated Care

Achieving improved outcomes



- Joined up health and social care
- Organise around people's needs not historic organisational structures
- There is one set of records shared across organisations

- More investment in primary and community care
- Social care and mental health needs considered holistically with physical health and care needs
- Less spending on acute hospital based care and other institutional care (residential and nursing care)

- Multidisciplinary home care teams
- Fewer people are treated in hospital, and those that are leave sooner
- More specialist support in the community, so people can live independently in their own home

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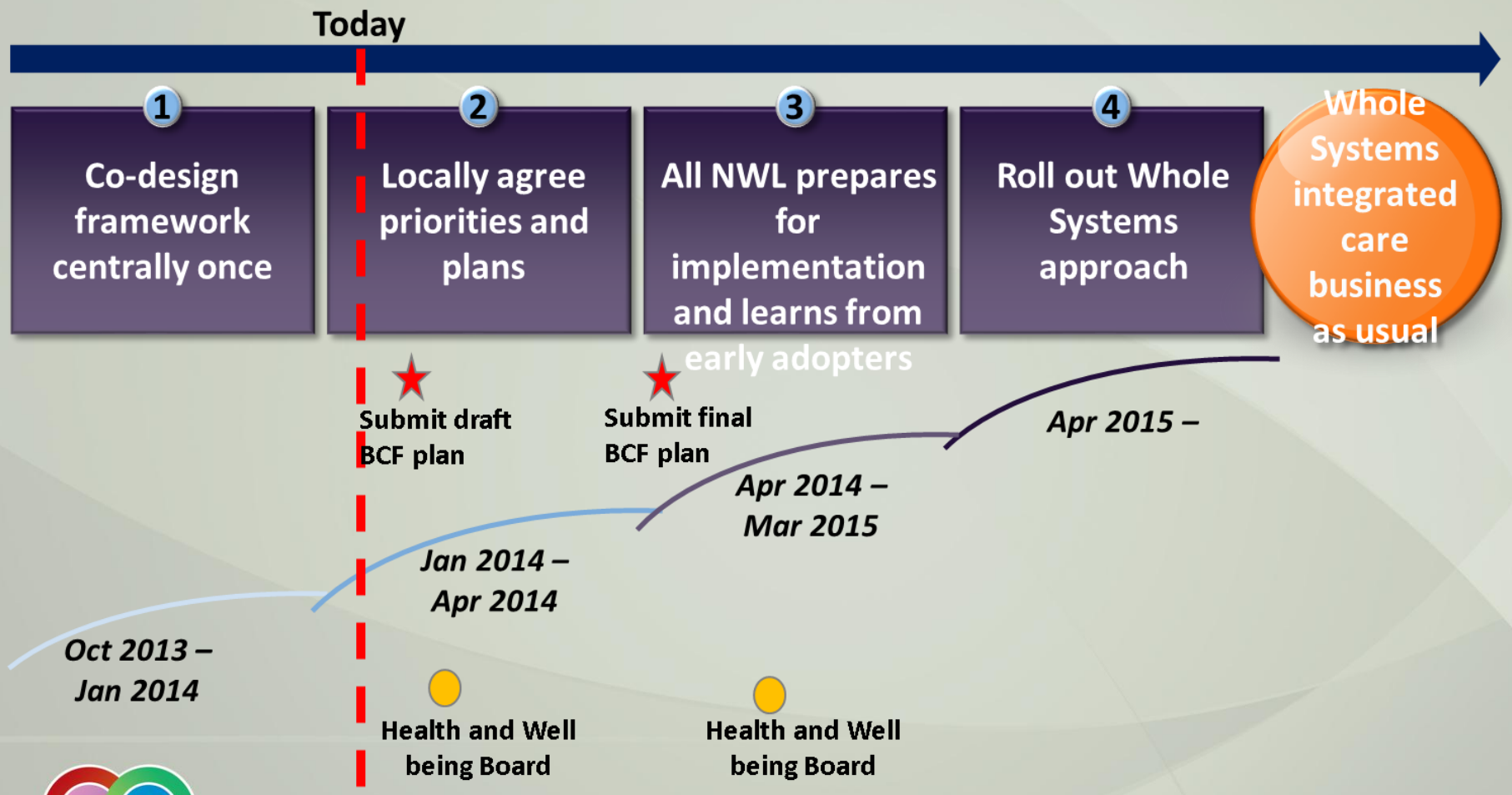
NWL Whole Systems Integrated Care

Timescales



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Brent's Better Care - overview

What it is / what it isn't

Department of Health/Department of Communities and Local Government letter on Better Care Fund Plan:

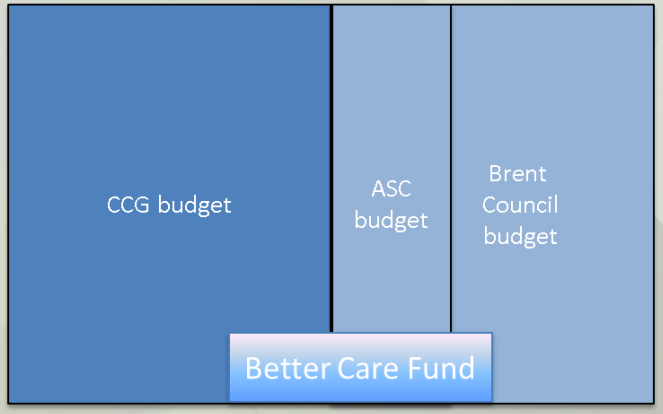
> ***"the biggest ever financial incentive for councils and local NHS organisations to jointly plan and deliver services, so that integrated care becomes the norm by 2018."***

What it is?

- Significant opportunity to drive health and social care integration (national deadlines)
- It is a significant amount of money: 2014/15 – in Brent £6.1m / 2015/16 - in Brent £19.9m
- Protect social care / continued focus on moving money from acute to community

What it isn't?

- It is not new money. It is in ASC, housing and CCG base. But we can incentivise efficiency (10%)
- It is only 5% of ASC and CCG budgets. How does it lever further efficiencies and change? Reduce residential
- It is not guaranteed funding: 25% is performance linked – 50% paid at the start of the year, 50% paid on achievement of targets.



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Better Care Fund - overview

How will we know we have delivered?

The Better Care Fund provides a minimum set of indicators to provide focus:

- Permanent number of admissions to residential care
- Number of older people who receive reablement and rehabilitation services and are still at home after 91 days
- Numbers of delayed discharges from hospital
- Avoidable emergency admissions

The DH has also produced the Statistical Significance Calculator which will set targets for us.

However, these are system indicators, at best proxies for improvement in quality of life. We also need to keep a clear focus on customer experience and perception. We are proposing to do this in 3 ways:

1. Embed outcomes in the care plan and review progress to them
2. Put in place ongoing monitoring of experience – jointly across health and social care
3. Link to annual surveys: for example, Adult Social Care survey:
    - Percentage of people who are satisfied with the care and support they receive
    - The proportion of people who feel they have choice and control over their lives
    - Social care related quality of life index.

Brent's Better Care Fund - Brent

Client group focus, not organisational focus

Age	Mostly healthy	Defined episode of care	Single LTC	Multiple LTC	Cancer	Serious and enduring mental illness	Learning disability	Advanced stage organic disorders	Socially excluded groups
0-15 (Children)	• The programme is currently not focused on integrated care for children • There may be innovative care models that we could trial, but that would be the focus of a future phase								
16-74	1 Mostly healthy adults		3 Adults with one or more long term conditions		5 Adults and elderly people with cancer	6 Adults and elderly people with SEMI	7 Adults and elderly people with learning disabilities	8 Adults and elderly people advanced stage organic disorders	9 Homeless people, alcohol and drug dependencies
75+	2 Mostly healthy elderly people		4 Elderly people (incl. frail) with one or more long term conditions						

Better Care Fund - Brent

Scheme 1: Keeping the most vulnerable well in the community

Support in the community is fragmented. This scheme would bring services together to deliver a shared goal.

Objective: help people to live in their own homes in the community and improve their quality of life.

Core components of the scheme:

- A focus on the 2-3% most vulnerable in the community (approximately 1800 people per GP network)
- Different levels of integrated case management resource across the 1800 to provide the whole person support
- GPs, social care, community nursing and voluntary sector – single care plan, shared goal
- Extended GP network out of hours provision, until 10pm, and homes visits, out of hours from the network.

Tom is 61 and lives with, and cares for his mother, Jean, who is 84. They want to continue to live together, but Tom admits to be being depressed about his situation.

Over the last 12 months, Tom has been to A&E twice because he was 'out of breath' and was admitted once (Jean then had to go to respite care) and there has been a SGA alert against Tom because of his anger towards his mother.

In the future, Tom and Jean would each have an integrated care plan. Tom and Jean's social worker would take the lead as their health needs are being managed. The SW would have regular contact with them. They would liaise with the GP, but focus on ensuring the support is in place from the LA/voluntary sector, so Tom and Jean can continue to live safely together.

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Scheme 2: Avoiding unnecessary hospital admissions

Even when care in the community is integrated there will be crises. This scheme is focused on managing the crises and responding proportionately.

Objective: to respond proportionately to crises, avoid A&E attendances and unnecessary hospital admissions.

Core components of the scheme:

- Effective referrals at time of crises from all parts of the system (particularly GPs and London Ambulance Service)
- 7 day integrated rapid response service including nurses, physios, OTs and social workers
- All staff able to put in place the right combination of support from health, social care and voluntary sector immediately.

Alice is 76 years old. She suffers from multiple long-term conditions (LTCs) and lives alone. She doesn't get out and she has no family close by.

Over the last 12 months, Alice has had 5 A&E attendances, which resulted in 2 unnecessary emergency admissions. Despite fact she had 9 outpatient, 23 GP contacts, District Nurses twice a week and carers twice a day

In the future, the Integrated Rapid Response Service (IRRS) would be alerted by the London Ambulance Service. IRRS would have access to Alice's integrated care plan and they would be able to put in a range of services. Not only the nurse/physio 'bridging' service they currently provide, but also social and voluntary sector support that best meets Alice's need.

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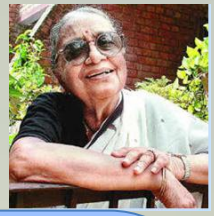
Scheme 3: Effective multi-agency hospital discharge



Even when care in the community is integrated, and there is effective admission avoidance, some people will still need to go to hospital, so it is important people get the right support when they are discharged from hospital.

Objective: Streamline the discharge process to reduce delays, and integrate it to ensure it links effectively back into the single care plan in the community

Core components of the scheme:

- 7 day discharge service – same quality of service 7 days a week
- Delivered by a single team made up of NWLHT hospital discharge co-ordinators, social care discharge team and CHC nurses
- Links straight back to the community and an integrated care plan with a lead professional if required, and wider support from family, community and voluntary sector

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Anjali is 87 years old. She has family, but they do not provide day to day support.

Over the last 12 months, Anjali used to receive home carer used twice a day, DN once a week, as well as frequent GP appointments to manage her 3 LTCs. Anjali had 3 unnecessary emergency admissions all within a 2 month period. The final admission led to an increase in social care, additional nursing support to manage anxiety.

In the future, the Integrated Discharge Service would provide an integrated assessment of all of her needs, ensuring the full range of health, social care and voluntary sector support were in place for discharge. They would also prioritise her referral to the community network, so that a sustainable integrated care plan could be put in place.

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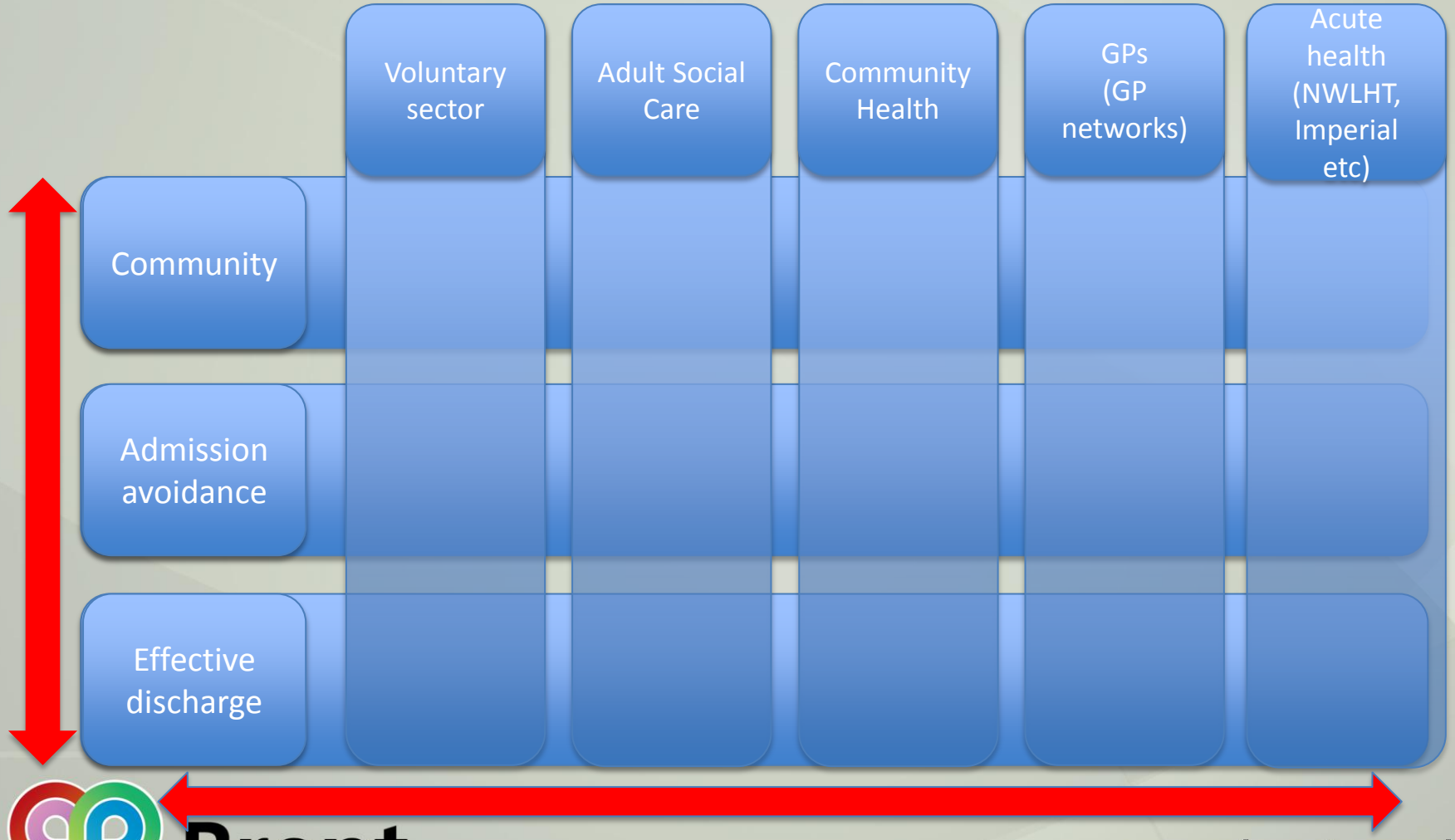
Tackling fragmentation: across providers, across settings



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Scheme 4: Mental Health

This scheme links to the paper going to Executive on 17 February. Work has just begun on the detail of the next 12 months in anticipation of the decision at Executive, but the key planned features are…

Objective: Implement a health and social care 'Recovery Pathway', which supports people with a severe and ensuring mental health illness to lead independent lives in the community (and evidences a significant reduction in the use of institutional care)

Core components of the service:

- A consistent and comprehensive focus on recovery and independence (across social care and secondary health support)
- Joint commissioning (Brent Council and Brent Clinical Commissioning Group) of a local, Brent focused, health and social care service
- Redesign of JDs and teams in Brent to deliver the above

The long term aim is to extend and fully integrate this approach with primary care.

Better Care Fund - Brent

Scheme 5: Key Enablers

This scheme recognises the scale of change that is required, and the range of wider changes that are necessary to underpin and deliver all of the previous schemes.:

1. It recognises that success is dependent on successful commissioning (market development) of a wider range of services and support to meet people's individual needs. For example, a range of integrated rehabilitation and reablement services (intensive step down after hospital, residential reablement and 6 week community bases, for example)

2. It recognises the need to have an IT strategy that supports integration rather than consolidating organisational boundaries.

3. And most importantly of all, it recognises the need for significant cultural change so that we build a single system of equals (professionals and customers) focused on delivering a shared goal as set out at the start of this presentation: improve the **quality of care** for individuals, carers and families, **empowering and supporting** people to maintain independence and to **lead full lives** as active participants in their community.

Next steps

Ensuring an inclusive approach within tight timescales (1)

Governance:

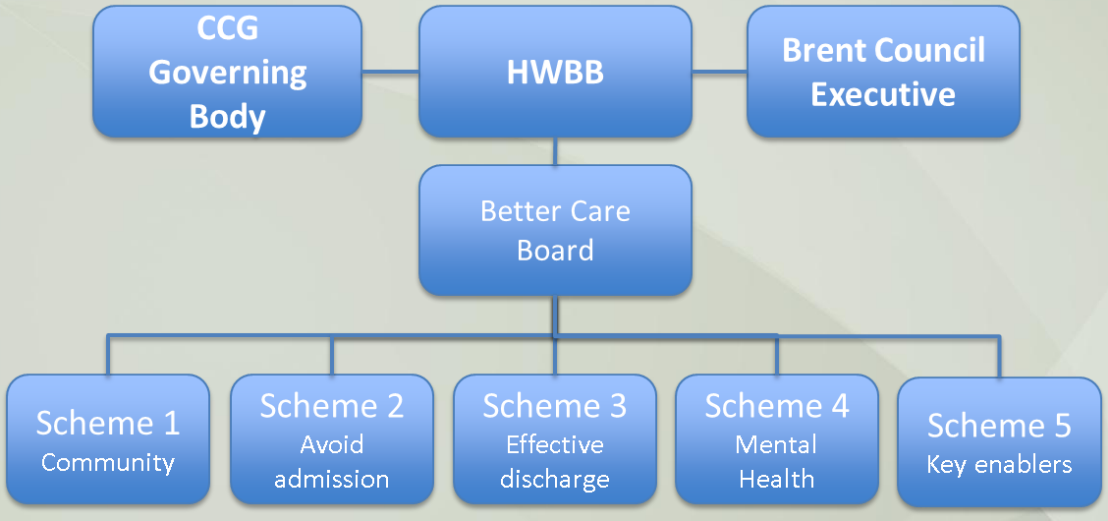
Current co-production:

- Brent Integration Board has representatives from the CCG, council, health providers and voluntary sector
- Worked closely to develop the schemes.

Proposal for programme delivery:

- An overarching commissioner led strategic Better Care Board
- Individual scheme working groups
- Clear links back to HWBB and existing decision making bodies.

Proposed governance structure



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Next steps

Ensuring an inclusive approach within tight timescales (2)

Next steps:

- Health Partners Forum (12 February)
- Draft BCF submitted to the Department of Health by 14 February (sign off within organisations)
- Detailed discussion at the HWBB on 26 February
- Re-scheduled HWBB at the end of March to sign off final submission
- Final plan, including timescales and an implementation programme, to be ready by 4th April.

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NHS Brent Clinical Commissioning Group

The Brent Health Partners Forum

6pm to 8pm Wednesday 12th February
Registration and refreshments from 5.30pm

Come and find out more about better integrated care in Brent.

We will be focusing on the integration of social care and health services.

- What is integrated care?
- Why is it important?
- What does it mean for all of us?

You will have the opportunity to ask questions and share your ideas on how we can progress integrated care in Brent.

Venue: Sattavis Patidar Centre
Forty Avenue j/w The Avenue
Wembley, Middlesex HA9 9PE

Parking at rear of venue.

Wembley Park

83,182, 206 and 245

EMBEDDING

Shaping a healthier future

Integrated care pilot

NWL whole systems integrated care programme

Out of hospital planning

PARTNERSHIPS

Primary care transformation

To RSVP or for more information, please email:
brentccg.engagement@brent-harrowpcts.nhs.uk or call 020 8795 6107 / 6122.
Refreshments will be provided.

Please advise of any specific accessibility issues and special dietary requirements.

Please provide own translators if required.

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