Brent

NHS Brent Clinical Commissioning Group

Brent Health and Wellbeing Board
22 March 2016

Report from Brent CCG Chief Operating Officer and Brent Council Strategic Director Community Wellbeing

For approval | Wards affected: ALL

- **Health and Social Care Integration Priorities for 16/17**
- **Brent's 16/17 Better Care Fund Submission**

1.0. Summary

1.1. The Better Care Fund (BCF) is an important vehicle for driving forward health and social care integration at pace and scale. It creates a local single pooled budget to incentivise the NHS and local government to transform services and provide people with the right care, at the right place, sensitive to their specific needs and delivered in partnership to the highest standards. As such it is an important part of the NHS and local governments present and future plans.

1.2. The Spending Review confirms that by 2020 health and social care are to be fully integrated across the UK and that each local authority and CCG will need have a plan in place on how they will achieve this by 2017. There is a continued requirement to ensure the BCF plans are aligned to other local areas of work including the STP plans, new models of care as set out in the NHS Five Year Forward View and delivery of 7-day services.

1.3. By working together across traditional boundaries, keeping people well, and supporting their recovery after periods of illness, we know we can improve individual quality of life whilst also reducing demands upon local services. The success of these changes will, from 2015/16 onwards, help drive reductions in emergency admissions to hospital, and the demand for nursing and residential home care, with benefits for individuals, the local authority and the CCG alike. This is about working together and working better, to put our health and social care systems on a steady footing, translating improved outcomes for individuals into long-term, sustainable support for our communities as a whole. Through the pooling of budgets and joining up commissioning activity across health (Brent CCG) and social care (Brent Council), Brent's Better Care Fund Programme is supporting the H&WB objectives; facilitating effective hospital discharge; reducing the number of DTOCs; supporting the early discharge of medically fit people from an acute setting.

2.0. Recommendations

The Brent Health and Wellbeing Board are asked to:

- Note the progress Brent has made on health and social care integration;

- Endorse the recommended 16/17 priority areas for health and social care integration;
- Agree delegated sign off of final plans and s75 to Brent CCG COO and Brent Strategic Director Community Wellbeing;
- Endorse the proposed programme approach to successful delivery;
- Agree to the proposed assurance sign off of Brent's Better Care Fund submission for 16/17.

3.0. Achievement to date

3.1. **BCF Scheme 1: Whole Systems Integrated Care - keeping the most vulnerable well in the community.** Whole Systems Integrated Care (WSIC) is a programme of work supporting integration in Brent alongside BCF. The objective is planned, proactive and integrated care for adults with long term conditions (LTCs). Work to design and contract services currently provided by Primary Care - risk stratification, care planning, multidisciplinary case management - formed BCF Scheme 1. In 15/16 codesign of the future model was completed with providers and lay partners, contracting models were reviewed, shaping of the market commenced and key enablers for example Integrated Care Records and dashboards were developed. The 16/17 Business Case was signed off early March and the route to market is currently being agreed. Changes to the model of care (including the launch of a self-care pilot) will be implemented and Q1 activity will commence from April 16.

3.2. **BCF Scheme 2: Avoiding unnecessary hospital admissions in line with out of hospital strategy (Rapid Response).** This focused on updating the Rapid Response elements of the STARRS contract. This scheme supported patients who are having a medical crisis to access nursing support in a community setting, ultimately preventing hospital attendance and hospital admission where appropriate. The aim is to maximize the number of appropriate referrals from GPs, LAS, A&E, and ensure the rapid response workforce is sized and skilled to meet any increased demand. Rapid response staff will continue to be trusted assessors for social care packages and are exploring the possibility of in-reaching into nursing homes in 16/17. The other part of this project is looking at the funding model for Early Supported Discharge at LNWHT. The specification and KPIs were completed in 15/16.

3.3. **Scheme 2.5: Avoiding unnecessary hospital admissions in line with out of hospital strategy (Rehab & Reablement).** This focused on updating the Rehab & Reablement elements of the STARRS contract. This scheme brings together the STARRS Rehab (provided by LNWHT) with Reablement and Enhanced Reablement (provided by the Council) into an integrated assessment and therapy service. The new service, based in LNWHT (with council staff seconded into LNWHT) has been co-designed with a broad range of partners. The new service will deliver intensive, short term (4-16 weeks) assessment and therapeutic support in the community to maximise independence in daily living skills and achieve rehab goals. All staff will be trusted assessors for social care packages and will work closely with homecare agencies as the lead professional. Expected outcomes are increasing independence and self-care in the community, decreasing readmission into hospital and admission into residential or nursing care homes, and decreasing duplication of assessment. The other part to this scheme is re-tendering the reablement home care market to improve quality and supplement the new assessment and therapy service. The detailed design of the model of care was completed in 15/16 and the business case for 16/17 developed. Work on implementation of the new model is underway, this includes transferring staff from the Council into the Trust, training staff in the new ways of working, ensuring the IT, estates, funding arrangements are in place to support successful go live and completing the retender of the home care market. Expected benefits will be realised in time for winter 2016.

3.4. **BCF Scheme 3 – The Brent Winter Plan for 15/16 (Efficient multi-agency winter resilience and reduction in DTOCs).** This focused on implementing the agreed integration plans to enable faster and supportive discharges from hospitals during the 15/16 winter period and take pressure off acute beds. The plans took into account wider system changes and initiatives in North West London and were based on practical ideas which will help both social care and the local NHS to work together to deliver realistic support during the busy winter period. These included;

- Daily DTOC dashboard and conference calls where stakeholders from across Brent and Harrow take part when the system is under pressure as per the surge and escalation process (Live from September 2015).
- Targeted support from housing colleagues at weekly housing surgery at Northwick Park and Willesden Community Hospital to review pipeline of patients approaching discharge and identify pathways out of hospital for those patients who do not meet the criteria for homelessness legislation and who do not have any social care needs (Live from December 2015).
- Joint commissioning of community residential and nursing step-down beds in the community to support DTOC patients once they are medically fit (live from December 2015).
- 7 day working by social care to support discharges at weekends (live from December 2015).
- DTOC analytic support to enable development of a robust dashboard and analysis to enable real time system learning (live from March 2016).

3.5. **BCF Scheme 4 - Improving the mental health urgent care pathway.** This focused on Brent CCG working with our Local Mental Health Provider (CNWL) to setup a liaison psychiatric service to support adults who have been referred to inpatients and present with the full range of mental health problems. The aim is to provide timely, brief interventions that can help to improve the patient's outcomes and prevent or reduce their length of in-patient hospital stay. The Liaison Psychiatry Service at Northwick Park Hospital operates an assessment lounge that works to divert people out of A&E. We have changed some of the ways in which this operates and this has resulted in changes to patient flow. A full sustainable service model has been agreed and went live in 2015/16. As part of this service line, we are scoping out alcohol related admissions to be included in this service model including frequent attenders of A&E to inform arrangements for managing these differently.

4.0. Challenges and Lessons Learned from 15/16

4.1. Acute providers (LNWHT and Imperial) have significant financial challenges. LNWHT also had a substantial change in executive management over the last 12 months. There are numerous initiatives underway to improve performance against NHS constitutional standards. Involvement of the right level of senior leadership from each organization, who actively support issue resolution and decision making, is key to successful delivery across multiple organisations. Having a single Integration milestone plan, which all sign up to, will help in managing the interdependencies with other change initiatives.

4.2. Approach to commissioning and implementing change is different between health and the local authority. Capacity for transformation across agencies is more difficult to obtain, as well as the complexities of working across health and social care. Continued investment of skilled programme and project change resource to drive the planning, coordination and delivery coupled with lead health commissioning resource (who understand the health environment) and lead council commissioning resource (who understand the council environment) is key. Having in place an agreed set of principles for working together and a gateway process for health and social care integration will also help this.

4.3. Brent has made excellent progress against plans for individual schemes and there have been significant developments in the wider programme of work required to achieve the outcomes and benefits of integrated care. The next step will require us to work across stakeholder groups to align these developments creating truly end-to-end pathways– from home to hospital and back again - coordinated around patient, carer and resident needs.

5.0. Proposed Integration Priorities for 16/17

5.1) Keeping the most vulnerable well in the community. Our priorities for the development of Whole Systems Integrated Care in 16/17 are the delivery of the 16/17 model of care and development of the Home Care market to deliver lower level district nursing tasks. Models of care delivery will include alignment of District Nurse Team Leaders and Social Work Team Leaders to the Network-based multidisciplinary teams. We will also embed and test the benefits of deliverables designed to support self-care including 3rd sector Care Navigators, staff training and a new Patient Activation Measure (PAM) which informs patient and carer goal setting, tailoring of care plans and referral to third sector services. Options for the development of the Home Care market to deliver lower level district nursing tasks require detailed design and sign-off. We hope to pilot this in 16/17.

What is the problem this scheme is trying to solve?

The model of care and provider model are designed to improve quality, experience and outcomes for patients with LTCs and their carers whilst reducing costs to the system. In 16/17 we need to improve the productivity and efficacy of the model, increase the capacity and capability within multidisciplinary teams, embed new interventions and roles, and overcome the barriers to integrated working between different professionals, teams and services.

The development of the Home Care market could help plug the capacity gap in the District Nursing workforce, enable DN teams to focus on more complex patients, help Brent make use of the Lot 5 Home Care providers who we believe could provide more complex health and social care support in the patient's own home, and provide a potential career pathway from Home Care into nursing. We hope to reduce multiple visits for patients and handovers between staff, improve coordination and integration and develop a model that engages Home Care providers in care planning, case management and the delivery of support to self-care.

What is the proposed solution to this problem?

The plan for services currently provided by Primary Care has been signed off in the 16/17 Business Case. We will move now to implement the improved model of care, the self-care pilot, market shaping and development of provider partnerships and roll out Integrated Care Records and dashboards from the Data Warehouse. Next steps in the development of the Home Care pilot will include development of a clinical model, co-design of plans with providers, patients and carers and confirmation of the options to train and accredit Home Care providers. It is likely this will be piloted in a defined area of Brent in 16/17 to support proof of concept.

5.2) The Brent Winter Plan for 16/17 (Efficient multi-agency winter resilience and reduction in DTOCs). Building on successes of 15/16, our proposed 16/17 priorities are to implement the following;

- **A.** Single integrated model of hospital discharge across North West London (referred to as the West London Alliance initiative)
- **B.** Additional social worker capacity and additional purchasing capacity
- **C.** Night sitting service
- **D.** Hospital at home service
- **E.** 7 day service (with inclusion of other services).

What is the problem this scheme is trying to solve?

To improve patient flow from hospital into the community and reduce delayed transfers of care designed to make a positive impact and contribution for the 16/17 winter period. To agree a DTOC target that is achievable, stretching and is reflected in CCG operating plans. The current hospital discharge system is for each local authority to be responsible for the discharge of their residents irrespective of whether the hospital is within the borough boundary. The result is confusion for hospitals to discharge via multiple borough procedures and difficulty for Brent council to resource discharge across a significant number of hospitals.

What is the proposed solution to this problem?

Building on the initiatives already implemented in 15/16, our proposal is to develop and implement the following;

A) The West London Alliance initiative is for a single local authority to be the lead for each hospital (for example Brent Council would be the lead local authority for Northwick Park Hospital and take on all discharges for Hounslow, Tri-borough and Ealing residents before the end of this winter) and follow a discharge to assess model. The discharge to assess model would mean hospitals only have to follow one procedure and each Borough minimises its risk as they get involved as soon as the person is out of hospital to put them into longer term care.

B) Night sitting service to spot purchase support as required at night to facilitate effective transition from hospital to home. This will reduce unnecessary hospital admissions due to night needs and to facilitate hospital discharges to the community where there is a high level of need for transition from hospital to home.

C) Hospital at Home service, designed to aid speedier recovery and greater independence for patients discharged from acute hospitals.

5.3) Nursing Care Home Review and Joint Re-Commission. Building on learning of the jointly commissioned step down beds for DTOC, our proposed 16/17 priority is to deliver an improved nursing care home offer in Brent.

What is the problem this scheme is trying to solve?

Complex needs (including dementia) continue to be a challenge for hospital discharge and through health and social care joint commissioning we want to support the system to develop the nursing home market to enable them to meet this growing need. The needs of people in Brent are increasing, with more residents requiring

support in nursing homes and other complex nursing input such as IVs or specialist 1:1 support to manage patient complex needs. Quality issues in our Nursing Care homes such as incidences of pressure ulcers and falls are on the increase. To further extend the early discharging of medically fit people from hospital to enable the market to manage more complex nursing needs in a more homely environment.
What is the proposed solution to this problem? There is much work underway in this area, but it is currently fragmented and unclear how it all fits together, for example (not an exhaustive list); • Health contract with GP's to in-reach into nursing care homes. • Health contract with Rapid Response to in-reach into nursing care homes. • Health BHH developing a health quality standard for nursing homes. • Health CHC placing patients in nursing care homes. • Council commissioning nursing care homes. • Council commissioned nursing bed DTOC step down beds. • Council placing patients directly in nursing care homes. There is a considerable amount of work to be done which will need further partner prioritisation. In 16/17 we will look to pull together all activity into a single Nursing care home plan and jointly manage Brent's bed based market in order to deliver an improved nursing care bed offer in Brent. This review and market engagement activity will likely result in jointly re-commissioning the nursing care home contract in Brent to improve quality, rectify service gaps, reduce A&E attendances and hospital admissions and manage social care and CHC placement costs.

6.0. Embedding and monitoring the benefits from 15/16

It is important to note the integration work started in 15/16 will require embedding and the development of a joint contract monitoring approach. These include;

- We hope to let the **16/17 WSIC contract** in Q1 of 16/17. The preferred route to market will be agreed and the process formally launched over the coming weeks. Delivery activity will continue with no break between 15/16 and 16/17. We will start to measure benefits from the end of Q1 and start to release outcomes based payments to providers from the end of Q2. We will monitor a range of KPIs and outcomes – focusing on non-elective admissions and patient experience. Providers will be performance managed against an agreed delivery and improvement plan.
- The **Integrated Rehab & Reablement Model**. Finalising the implementation of integrated Rehab & Reablement service. This includes putting in place joint commissioning monitoring arrangements to ensure we manage this in the future.
- The **Single Point of Access** proposal, as initiated by NWL CCG Strategy and Transformation Team, ensuring social care is included in the thinking for a community SPA model that will support 7 day discharge in Brent. This includes a redesign of the single point of access currently in the STARRS contract and have dependencies with Brent Customer Service.
- **Review of the 15/16 DTOC initiatives,** to help further shape our Winter Plans for 16/17.

7.0. Programme Approach and Enablers for 16/17

There are a number of enablers required for successful integration:

- **Integrated data and information sharing** - the development of information governance and information technology solutions that support integration is a key feature of any integration programme. All GP Practices and major providers in Brent (bar Royal Free) have signed the Whole Systems Information Sharing Agreement (WSIC ISA) which enables extraction and synthesis of specified data for patients aged 18 and over from GP, Acute, Community, Mental Health and Social Care into a linked dataset. The data is used to produce patient-level Integrated Care Records and a suite of dashboards for direct and indirect care purposes. These are governed by a system of role-based access and meet information governance requirements. Dashboards will be used to support direct care and also to understand flows and activity across a range of services, to review system performance and to track associated costs and benefits.

- **Training and OD for system leaders and for frontline teams** – one of the key enablers for integrated care is training and OD to support team development and team building for new integrated teams, training in new processes and operating procedures, and training in key competencies and behaviours for example structured problem-solving, influencing skills, difficult conversations and shared decision making with residents, patients and carers. Commissioners and providers will also need to consider the longer term impact of integration on the Brent workforce and opportunities to support recruitment, retention and career development.

- **Engagement and communications** - with patients, carers, residents, staff. The Brent integration programme has engaged stakeholders in the design of service improvements and new models of care. Work is also being undertaken to communicate the development of integrated data with materials and information to support communications produced and freely available via a multitude of channels (posters, leaflets, DVDs, online videos and SMS content).

These enablers all require input from subject matter experts across Brent's health and social care economy which requires ownership and coordination. In 16/17 we need to review our programme framework and confirm named leads for each of these enablers. This approach will increase the chances of successful implementation in Brent, while maximizing the use of existing resource. Other enabling workstreams likely to be required in 16/17 include workstreams to support the development of new provider models (Federations, Alliances, ACPs), the development of a digital roadmap for Brent and a review of estates.

8.0. Assurance Timeline

Final BCF plans need to be signed off by H&WB and submitted to NHS England by Monday April 25, 2016. The s75 agreement for 16/17 needs to be signed and in place by Thursday June 20, 2016. The proposal is to for the H&WB to approve the proposed priorities today and to agree delegated sign off of final plans and s75 to Brent CCG COO and Brent Strategic Director Community Wellbeing.

9.0. Financial Implications

For 16/17 in Brent, the minimum pooled funding is £23.7m (£20.101m from CCG, £3.599m from Council.

10.0. Legal Implications

The legal obligations on the Council changed with the passing of the Health and Social Care Act 2012 ("the Act"), which gave the Council new duties to:

- Improve the health of the people in its area; and
- Take steps to ensure that plan are in place to protect the health of the population.

The proposed approach of increased integration in relation to winter planning is in line with the Council's legal responsibilities, in particular in relation to public health. The role of promoting integration and joint working in health and social care services across Brent is delegated to the Health & Wellbeing Board and the Brent Integration Board.

11.0. Diversity implications

The Better Care Fund Plans support the H&WB Board to deliver in a fair and equitable way to the community.

Contact Officers

Phil Porter - Strategic Director Community Wellbeing
Brent Council

Sarah Mansuralli – Chief Operating Officer
NHS Brent CCG