Brent

NHS Brent Clinical Commissioning Group

Scrutiny Committee

5 April 2016

Report from

Brent Council Strategic Director of Adults and Community Wellbeing

and

NHS Brent Clinical Commissioning Group Chief Operating Officer

Brent and Harrow Systems Resilience Group Update on Winter 2015/16 and Planning for 2016/17

1.0 Summary

1.1 The purpose of this paper is to provide the Brent Scrutiny Committee with an update on the progress to date made by the Brent and Harrow Systems Resilience Group (SRG) with regard to managing winter pressures in 2015/16 and the impact that this has had on performance.

1.2 The paper provides details about developing winter plans for 2016/17 which build on lessons learned from initiatives commenced in 2015/16 as well as detail about performance against the Delayed Transfers of Care (DTOC) performance standard, which is a key performance target of the Better Care Fund plan.

1.3 Over the past winter, there have been cautious signs of improvement which suggest that the internal process and flow work that LNWHT have undertaken combined with the efforts of the wider system partners through the SRG and winter plans have made a positive impact on performance.

2.0 Recommendations

2.1 The Scrutiny Committee are requested to:

- Review the progress made with managing winter demand
- Note the factors that need to be addressed to improve DTOC performance
- Note the plans being developed for 2016/17, building on successful initiatives in 2015/16

3.0 Detail

Introduction

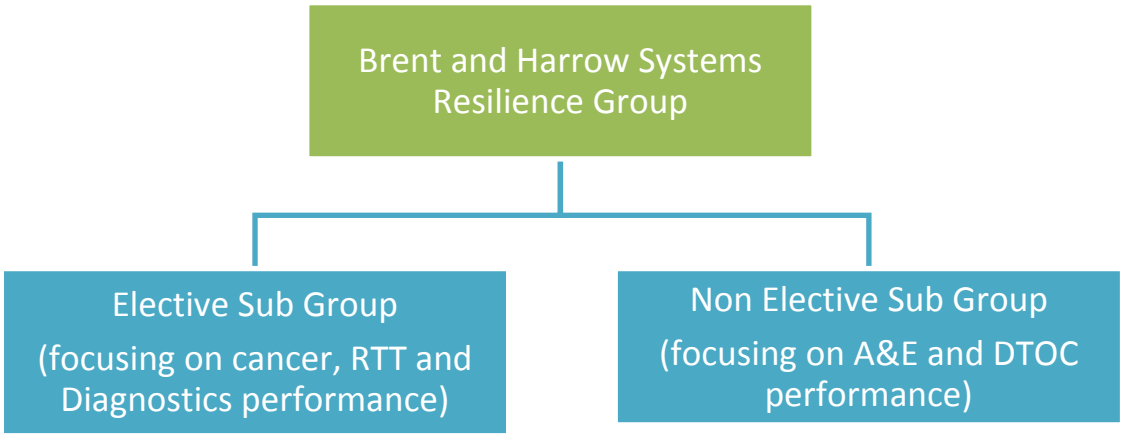
3.1 SRGs are the forum where all the partners across the health and social care system come together to undertake the regular planning of service delivery. SRGs plan for the capacity required to ensure delivery of the key NHS constitutional standards, which include:

- Referral to Treatment Time (RTT) is within 18 weeks
- Cancer diagnosis and treatment within 32 and 62 days of referral
- A&E waits no longer than 4 hours
- Diagnostic waits no longer than 6 weeks

3.2 SRGs offer a powerful opportunity to improve care for patients by, for example, fully integrating emergency healthcare development with primary care (where most unscheduled care takes place). SRGs have helped to establish more patient-centred care and are encouraging shared learning across health and social care communities by working in partnership.

3.3 The introduction of the Better Care Fund also brought additional opportunities for working across health and social care. The presence of all health providers and commissioners, as well as local authorities and social care partners, on these groups was crucial to delivering an integrated approach.

System Resilience Group overview



3.4 The Elective Sub Group of the SRG oversees the delivery of elective projects that have been clinically agreed by members of the SRG. The group also oversees the performance management and quality assurance of the schemes. In doing so, the elective subgroup identifies gaps in the delivery of target outcomes and initiates collaborative task and finish groups. Risks are managed collaboratively through an agreed risk mitigation plan, and significant risks are escalated to the SRG.

3.5 The Non Elective Sub Group oversees the delivery of non-elective projects that have been clinically agreed by members of the SRG. Following on from the paper submitted in February 2014 the non-elective group focused on projects such as support for internal flow review, continuing care assessment and nursing home beds to support outflow from Northwick Park. There is substantial focus on implementation and monitoring of winter plan initiatives and performance of Delayed Transfers of Care (DTOC).

Winter Plans

3.6 Brent's Better Care Fund Scheme 3 is the Brent Winter Plan, which comprises all of the integration solutions being implemented in Brent that will support reduction in DTOC and improve hospital discharge for complex patients by delivering higher quality more streamlined discharge from hospital. This scheme is looking at changing the way health and social care professionals work together in the hospital setting, as well as commissioning possible community services that could support hospital discharge more effectively. For example through developing the bed based care home market to support complex patients within the community.

3.7 The hospital based initiatives that were implemented as part of the Brent Winter Plan this year and which will continue to be progressed in 2016/17 are integrated solutions to enable faster and more supportive discharges during the winter period, taking pressure off acute beds. The plans consider the wider system changes and initiatives in North West London and are based on practical ideas that would aid both social care and the local NHS to work together to deliver realistic support during the busy winter period. The 16/17 plans will build on the learning from 15/16 and include:

- Colocation of social workers on the hospital site to improve communications between health and social care (four Hospital Discharge Social Workers moved to Northwick Park Hospital in December 2015, further work is required to move the remainder of the team)
- 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)
- Opening of 43 new modular beds on the Northwick Park Site (live 18th February 2016)
- Targeted support from housing colleagues at a weekly "housing surgery" at Northwick Park and Willesden Community Hospitals to review the 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)
- 7 day working by social care to support discharges at weekends (live from December 2015)

3.8 In 2016/17, the **West London Alliance** is progressing plans to implement an initiative where a single local authority will 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 for next winter) and follow a discharge to assess model. The lead authority model will mean that hospitals only have to follow one procedure and each Borough minimises its risk as they are involved earlier in planning a person's discharge, thus allowing for the identification of the most appropriate form of ongoing care and likely reducing the number of people in residential and nursing care.

3.9 The discharge to assess model will allow for the earlier, safer discharge of people who require ongoing support and time for further assessment, but who do not have to

stay in an acute setting for this to be achieved. Discharge to assess is the process whereby assessments post hospital admission and decisions regarding long term care needs or appropriate services post discharge are made in the person's pre admission place of residence. Brent partners have confirmed that this is an ambitious move and will require a culture shift in all agencies in addition to community resources to enable this model.

3.10 At present, work is underway to pilot reciprocal social work assessments in Northwick Park Hospital for Ealing and Tri-borough. It is anticipated that this model will form the basis of a single approach, one model for Adult Social Care hospital discharge that will be aligned to hospitals across NWL. This will include colocation of appropriate hospital discharge functions within the hospital setting. A task and finish group made up of local CCG, Acute, Council and WLA staff have been working together to progress this work over the past couple of months.

3.11 As part of the broader strategic view there is a need to integrate the functions necessary to support complex hospital discharges and implement new ways of integrated working. A phased approach is being implemented in Brent, initially co-locating the Council's social work discharge team into Brent hospitals and supporting them to develop new /different ways of integrated working with the other discharge teams. Some social workers are already co-located and are working in different ways (e.g. ward rounds, MDTs, proactively picking up referrals, educating ward staff), with accommodation to house the remainder of the team being actively pursued with a view to full colocation by end of April. Space is very limited but some options have been identified and currently are awaiting decision by LNWHT senior management.

3.12 Brent has already put in place a small number of community based initiatives in 15/16. It is now planning to develop these as well as bring on line new ideas, designed to make a positive impact and contribution to DTOC and to support discharge of complex patients for the 16/17-winter period.

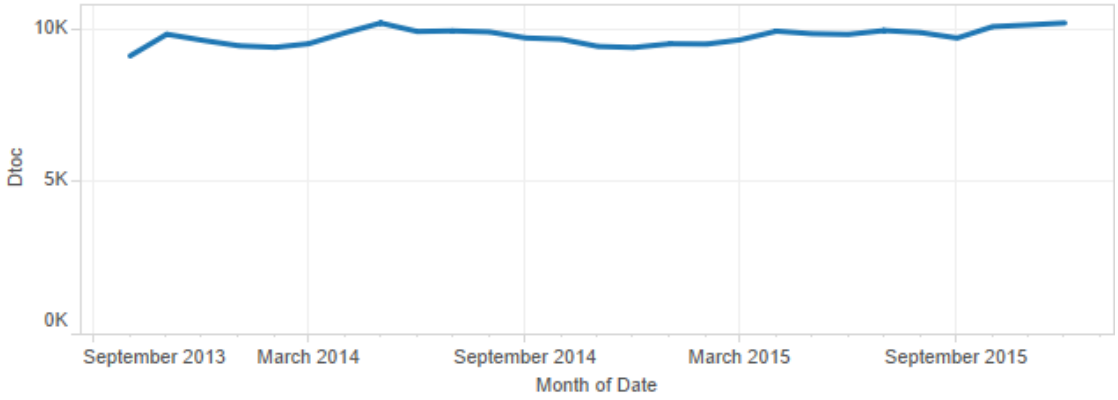
3.13 To date the following community based initiatives have been implemented, and are jointly commissioned between Health and Social Care. This together with the hospital based initiatives is designed to enable faster and more supported discharge from hospital during the winter.

- Additional social worker capacity and additional purchasing capacity to provide faster searching, identifying, arranging and managing placements for complex cases has been put in place and is likely to be repeated in 16/17.
- Night sitting service - Night sitting service to spot purchase support as required at night to facilitate effective transition from hospital to home is in the planning stage for 16/17. This will help 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.
- Home from hospital service - is being planned for the 16/17-winter period. This will aid speedier recovery and greater independence for patients discharged from acute hospitals.
- Additional step down beds have been jointly commissioned between Health and Social Care to improve the flow of patient back in to the community from the hospital.

Delayed Transfers of Care (DTOC)

3.14 Nationally and locally there is a focus on health and care economies, led by the SRG, effectively managing delayed transfers of care. An article analysing the best and worst regions for delayed transfers of across the UK published by the Health Service

Journal (16th February 2016) indicated that LB Brent, along with most of NHSE London area, performed better than the national average. However, there is an increasing trend for LB Brent over the period September 2013 to September 2015 as illustrated in the graph below:



Source: Health Service Journal (16th February 2016)

3.15 Whilst it is encouraging that local performance is better than UK averages, there is still scope for improvement and the SRG Group have identified the following trends that need to be addressed if performance is to be maintained (in the context of growth) and/or improved.

3.16 Market capacity, particularly related to EMI nursing and Continuing Care placements is a contributing factor in DTOCs. As people's needs become more complex, and as we keep people at home for longer, when a residential or nursing placement is required then it can be difficult to find an appropriate placement that can manage a higher level of complexity and/or challenging behaviour. The increasing incidence of people with dementia has made this issue more acute. Quality within the market is also a concern, and the available capacity can be impacted when there are concerns about a provider, if a provider has a formal embargo in place or if a provider has had a poor CQC inspection. Recently, capacity issues in North West London have been compounded by increased referrals from Central London to Outer London residential and care homes. BCF scheme 5 will focus on addressing quality and capacity in the market.

3.17 An emerging trend is the number of non-Brent & Harrow DTOCs at Northwick Park Hospital (NWP) which has risen significantly compared to last year; and, that in the last week they have constituted more than 50% of DTOCs on the NWP site. Ealing, Barnet and Hillingdon patients now appear regularly on the DTOCs list for both NWP and CMH sites.

3.18 The Housing assessment process is complex and lengthy but required to determine eligibility and appropriateness of proposed housing solutions. There is a need to identify opportunities where health and housing might be able to work differently to streamline the process and/or assess the potential for an intermediate solution.

Conclusion

3.19 The health and care system partners across Brent and Harrow have created a robust System Resilience Group, which continues to provide constructive challenge and leadership to partners whilst working collaboratively to address identified areas for improvement. An article in the Brent and Kilburn Times on 10th December highlighted that the performance at LNWHT marks an improvement of patients being seen within the 4 hour waiting time. The November figures demonstrated that 85.5

% of patients at LNWHT received care within the four-hour waiting time in the last week of November in comparison to the same time period last year when the figure dropped below 68%.

3.20 Since February 2016, performance has been maintained and there have been days where the performance has met the 95% national standard. These cautious signs of improvement suggest that the internal process and flow work that LNWHT have undertaken combined with the efforts of the wider system partners through the SRG and winter plans have made a positive impact.

3.21 The challenge for the SRG going forward is to ensure that there is a proactive approach to system resilience throughout the year, ensuring that systems and processes that are effective are embedded into core business and integrated structures, where appropriate. The intelligence and lessons learned from ongoing monitoring and evaluation of initiatives needs to inform future planning and developments.

4.0 Financial Implications

4.1 The financial implications of implementing winter plans and initiatives have been met through the Better Care Fund plan, the CCG's winter resilience budget and the Council's Adult Social Care budget.

5.0 Legal Implications

5.1 There are no legal implications of note.

6.0 Diversity Implications

6.1 The winter plan and Better Care Fund plans aim to engage and empower the diverse communities of Brent and the wider health economy across London to deliver improved outcomes and service user experiences.

7.0 Staffing/Accommodation Implications (if appropriate)

7.1 Not applicable

Contact Officers

Name: Phil Porter

Job title: Strategic Director of Adults and Community Well Being, Brent Council

Name: Sarah Mansuralli

Job title: Chief Operating Officer, NHS Brent Clinical Commissioning Group