APPENDIX A
Better Care Fund – Description of services

The Better Care Fund Schemes are as follows:

1. Whole System Integrated Care (WSIC)

The WSIC 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 plan to improve the productivity and efficacy of the model, increasing the capacity and capability within multidisciplinary teams, embedding new interventions and roles, and overcome barriers to integrated working between different professionals, teams and services. The scheme supports adults with LTCs with goals of:

- Move from reactive care to proactive care though better planning, prevention and management
- Move from fragmented care to coordinated and integrated care
- Moving from professionally led care to a model of support to self-care and self-management - with personal goal-based care plans
- Continuity of care is achieved through the relationship between the patient, their carer(s) and their own GP
- Care is delivered at the appropriate time and in the appropriate setting - out of hospital wherever possible

In the community Brent has a significant capacity gap within its District Nursing (DN) workforce. DN's are sometimes supported by a Home Care provider to provide domiciliary care. We plan to develop this Home Care market to help maximise the effectiveness of available resource and plug the capacity gap in the District Nursing workforce by providing support for the simpler DN tasks.

2. Integrated Rehabilitation and Reablement

In the current state, if a patient or service user is assessed for a community based reablement service, this service may be provided by one of over twenty home care providers. There have been recurring issues with these providers in relation to: service continuity and missed calls; following the instruction of the health professionals; and effective communication between the providers and the health professionals. This has served to reduce service quality and impact on the time of health professionals and the contract manager. In essence, this means that we are spending more for services which do not deliver more than is provided by many standard home care providers. The *Integrated Rehabilitation and Reablement* scheme will bring together the STARRS Rehab service (provided by LNWHT) with Reablement and Enhanced Reablement (provided by the Council) into an integrated assessment and therapy service which delivers intensive, short term (4-16 weeks) assessment and therapeutic support in the community to maximise independence in daily living skills and achieve rehab goals. The scheme will streamline the services clients receive when exiting hospital and/ or while being supported within a community setting.

3. More effective hospital discharges

A primary goal for this scheme is to reduce the negative impacts of the winter period in the Brent health and social care economy by joint commissioning appropriate support in the community. We plan 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 2016/17 winter period.

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. This creates confusion for hospitals to discharge via multiple borough procedures and difficulty for Brent council to resource discharge across a significant number of hospitals. A key goal for this work is to move towards a common approach to discharging irrespective of which of the eight London Borough Councils (as members of the West London Alliance) are involved.

4. Nursing Care Home Market changes

The Nursing Care home market does not currently deliver what is required locally in Brent to meet current needs in relation to capability, quality, capacity and price. The CCG and LA commissioners plan to develop an integrated approach to commissioning from the market and to develop new models to ensure we can improve quality and capacity as well as manage the price of nursing home provision more effectively.

APPENDIX B

Brent Integrated Community Equipment Services

1 Service Description

1.1 The aim of the Service is to supply, deliver, fit, adjust, service, collect, refurbish, recycle or dispose of items of equipment requisitioned by authorised Prescribers on behalf of Service Users.

1.2 The Service is predominantly provided to adults, when a need has been identified for equipment to assist care. A limited range of equipment may be used for children.

1.3 The Service Provider is required to:-

1.3.1 procure, supply, deliver and install equipment (in compliance with the standards set out in CECOPS Code Standards 11 and 20) for daily living or nursing equipment to Service Users on either a short term or indefinite loan basis; and

1.3.2 maintain, collect and refurbish equipment (examination and inspection in accordance with the standards)

1.3.3 store a range of equipment to assist with personal care, mobility and independent living for people in a community setting.

1.3.4 respond to service referrals in an efficient and appropriate manner;

1.3.5 ensure all equipment supplied to Service Users is in a clean and safe condition and in good working order;

1.3.6 maintain and repair all items of equipment on issue at no cost to the Service User or their carer;

1.3.7 collect all items of equipment from the Service User's home when no longer required; and

1.3.8 offer advice regarding equipment to Service Users as requested.

1.3.9 provide suitable storage facilities for the purposes of providing the service;

1.3.10 provide on-site technical advice, working with clinicians [e.g. Occupational Therapists, District Nurses, Physiotherapists], attending joint visits and advising clinicians on all aspects of

1.3.11 provide a procurement service for special purchases and one off items including paediatric equipment;

1.3.12 deliver to Service User equipment specified by the Prescriber within the timescale instructed by the Prescriber;

1.3.13 in accordance with the manufacturer's instructions, allow sufficient time to install, fit, and/or adjust the equipment;

1.3.14 provide the Service User with all necessary instructions on the cleaning and use of the equipment provided and fitting if appropriate;

1.3.15 service and maintain the equipment supplied in accordance with the manufacturers recommendations, including regular service of hoists and any other equipment specified by the Prescriber while the equipment is on issue to the Service User, in the warehouse and before re-issue;

1.3.16 on request from the Prescriber, Service User, or persons acting for the Service User, collect equipment from the Service User's address;

1.3.17 where cost effective clean, and where appropriate, decontaminate equipment collected from or returned by Service User's to enable its re-

use as quickly as reasonably practicable;

1.3.18 where cost effective, undertake minor repairs to equipment collected from or returned by Service Users to enable its re-use;

1.3.19 safely dispose of all items of equipment collected from or returned by Service Users where the equipment is unsuitable for re-use and beyond economic repair;

1.3.20 retain all items designated for disposal for a period of seven calendar days and make them available to the Authorised Officer for inspection;

1.3.21 deliver equipment to Hospitals, Therapist/District Nurse bases, Health Centres, General Practitioners, Schools and Day Centres where instructed by the Prescriber;

1.3.22 adhere to the Prescriber's right to require that equipment be delivered to or collected from any address in each (any of the) Contracting Authority boundaries adjacent of 5 miles;

1.3.23 at the request of a Prescriber accept back into storage equipment currently issued to Service User;

1.3.24 Prescribers can request a Trusted Assessor (TA) Service when they have completed a clinical assessment of the client's needs, but have not seen or assessed the environment. Trusted Assessors must be accredited as a minimum at Level 2 by the National Qualification Framework, Open College Network (OCN) or similar equivalent and certified as competent to assess, use and fit daily living equipment.

1.3.25 The TA will visit a Service User at home, to assess the environment and select and install (during the same visit as the trusted assessment) the appropriate equipment item(s) of the type(s) identified by a Prescriber. The TA will demonstrate how to use the equipment and ensure the Service User's safety. The TA will make decisions about the position and height of equipment, including any folding support rails, grab rails or banister rails and will install these during the visit. A pre-agreed range of Equipment can be provided where the person has already been assessed by the relevant Prescriber as meeting the requirements of the Care Act 2014 and CES Joint Eligibility Criteria. (For the avoidance of doubt other equipment, including complex items, can also be delivered and/or collected as part of the same trusted assessor visit.)

1.3.26 The Service Provider's TA service shall provide items which shall include, but shall not be limited to:

- Grab rails
- Furniture raisers
- Raised toilet seats and toilet frames
- Straight stair rails
- Commodes
- Bathboards
- Key safes
- Bed/Chair sensors

1.3.27 obtain and provide equipment for trial use with Service User's and for assessment purposes and provide a schedule of charges for provision of equipment for this purpose;

1.3.28 immediately notify the Prescriber should equipment issued to the Service User be misused, abused or removed from any property to which it has been delivered without their express consent;

1.3.29 deliver all items of equipment to the Service User or the Prescriber in a clean, safe condition and in good working order and have waterproof labels bearing the name, address and telephone number of the vice;

1.3.30 where appropriate, cleaning of all equipment before delivery;

1.3.31 notify the originating Prescriber (or Prescriber Team Manager) if a Service User has refused to accept equipment. Notification shall be given within 24 hours or one working day whichever is sooner;

1.3.32 establish close working links with Clinicians, Prescribers and other stakeholders; and have in place systems, including IT infrastructure, to enable Prescribers to incorporate the service within their respective care management systems.

2 Hours of Service

2.1 The Service Provider shall provide two levels of Service, namely: -

2.1.1 Normal Working Hours Service; and

2.1.2 Out of Hours Service.

2.2 During Normal Working Hours Service the Service Provider is to provide the full range of activities, including delivery and collection.

2.3 Out of Hours Service relates to the supply and repair of essential Equipment at all other times. The Out of Hours Service may include collection of Equipment where it is not reasonably practical to collect at any other time.

APPENDIX C

Brent Mental Health Services

The overarching aim of the agreement tis to ensure the integrated provision of high quality, cost effective mental health services which meet local health and social care needs and delivers personalised, recovery focused care and choice to individuals and their Carers.

The service will focus on a period of personalised intervention (for up to two years) whilst the individual recovers and is then enabled to move on from receiving secondary care services when that level of support is no longer required.

The services included in Section 75 agreement are:

- Community Mental Health Team – North
- Community Mental Health Team – South
- Early Intervention Team
- Mental Health Act Team

Key objectives for service improvement:

- Clear pathways for individuals to 'step down' from residential and supported living provision when this level of support is no longer required.

- All individuals identified as subject to S117 to have a care plan identifying S117 needs which are reviewed regularly and individuals discharged as appropriate.

- Clear and monitored care pathways for all individuals, including those transitioning from adolescence to adulthood, which ensure safety, equality, quality and consistency of care.

- A health and social care needs assessment, risk assessment and carer's assessment will be carried out following referral from the Single Point of Access (SPA).

- An outcome based care and support plan will be put in place for each individual, with progress reviewed against this plan on a regular basis by the care coordinator.

- The service will enable individuals to become as independent as possible thus facilitating a return to support from primary care services as soon as possible.

- Improved health and social care support at point of access to services and better liaison with services within primary care. Partners will work together to ensure the Transformation agenda of Shifting Settings of Care is implemented and that individuals identified as being able to be supported by primary care are discharged safely following the agreed protocols with General Practitioners ("GPs").

- The service will engage with people to ensure they are involved with employment support services, training and other activities designed to promote independence and recovery and to avoid social isolation.

- A co worker / buddy system will be implemented so that there is continuity of service for individuals and their carers if a member of staff is unavailable for a period of time, another member of the team will be available to provide support.

- Improved Information Technology ("IT") systems and an integrated approach to data collection, which reduces duplication of data entry and data collection. All staff will have greater accessibility to the Council's IT resources to ensure more effective communication between the Partners.

- Improved workforce planning which ensures a strategic and joint response to recruitment and improved staff development and career progression.

- Improved delivery of personalised care, individual budgets and social inclusion, including support to maintain and find employment, maximising individual's potential and engagement with the local community.

- Harmonisation of all clinical and non-clinical practices for staff to avoid duplication and increase efficiency.