Brent NHS Brent Clinical Commissioning Group	**Health and Wellbeing Board** 14 June 2017 **Report from Operational Director Adult Social Care and Deputy Chief Operating Officer London North West Healthcare NHS Trust**
	Wards Affected: ALL

Unified Frailty Pathway/ OPALS Business Case

1.0. Summary

1.1. The purpose of this report is to provide the Health and Wellbeing Board (HWB) with an update on progress on the Older People's Acute Liaison Service (OPALS) business case for Northwick Park Hospital.

This is one component of the Unified Frailty Pathway and part of Delivery Area (DA) 3 - the Older People's services workstream of the Northwest London Sustainability and Transformation Plan (NWL STP). It also forms a key workstream of the Brent Health and Care Plan (the Brent Plan).

The business case additionally forms part of the recovery action plan for the A&E performance targets, with phasing for breach reduction to begin from September 2017.

2.0. Recommendations

2.1 The Health and Wellbeing Board is invited to comment on the programme of work and note progress.

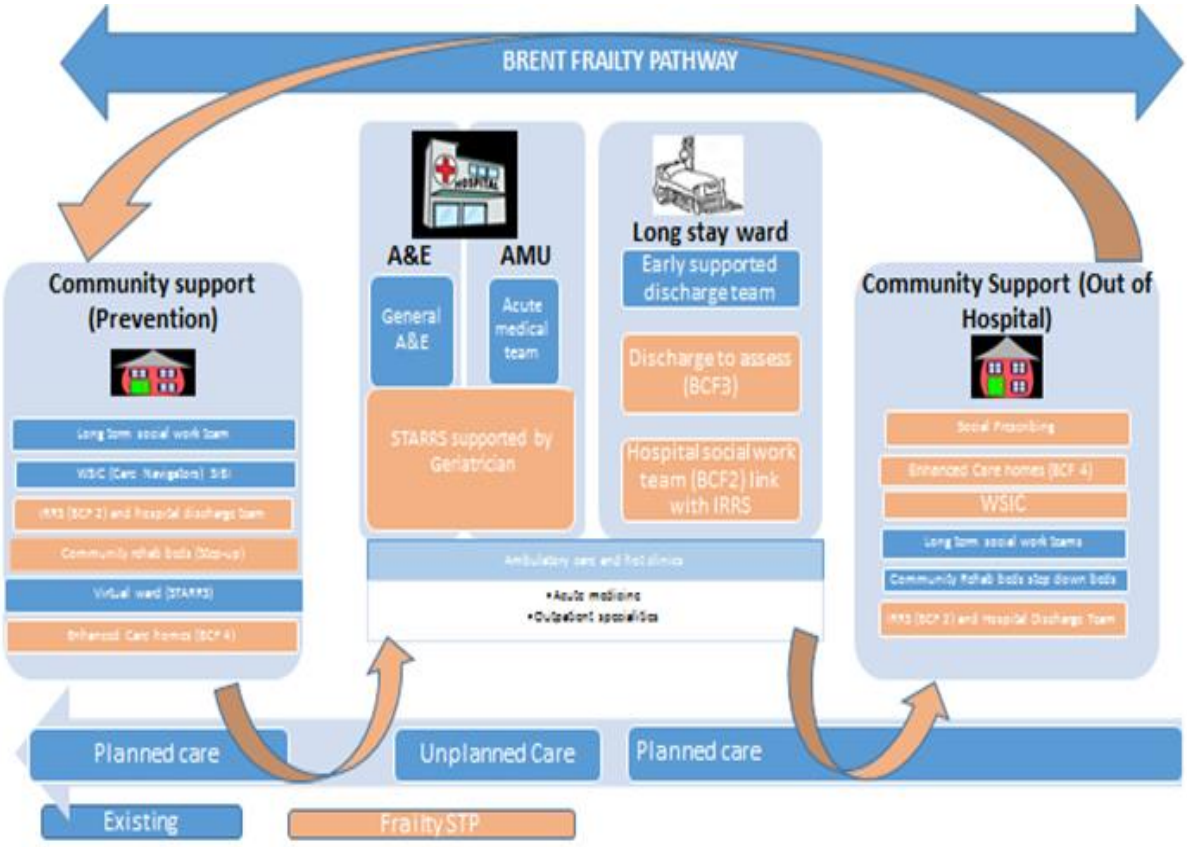
3.0 Background

3.1 Sustainable Transformation Plans (STP) are being developed on geographic "footprints" which bring together a number of CCGs, local authorities and NHS providers (mental health, acute and community). Brent is part of the North West London (NWL) STP footprint. Brent HWB members are actively involved in the NWL STP, but the board has also recognised the need for a local Brent focus. The Brent Health and Care Plan, which localises the NWL STP, has therefore been developed.

3.2 At its March meeting, the HWB endorsed the high level plan for the Older People's Workstream and requested ongoing updates to include costs and benefits for the different elements of the Older People's Service workstream, acknowledging that this workstream was particularly complex and wide ranging, and that different elements of the overarching pathway were at different stages of development.

3.3 Improving outcomes for Older People is one of the six big ticket items and a key priority of the Brent Plan, and also one of the five Delivery Areas of the NWL STP.

3.4 The Frailty pathway agreed by the Brent STP Board is illustrated below:



3.5 Due to the scale of the work required to deliver the whole frailty pathway, work has been separated into four workstream to deliver meaningful change across in and out of hospital services. This approach will not create silo working but it is expected to be concurrent ensuring that key planks of STP, BCF, A&E breach reduction and business as usual plans deliver the transformational change required so a fully functioning frailty pathway is in place in Brent by 2020. The four workstreams are summarised below:

3.5.1 Workstream 1 – Long Stay Wards & Improved Discharge

For this phase of work the assumption is made that patients with frailty have moved through the emergency system from A&E, assessment units and transferred into the general wards.

The Better Care Fund 16/17 & the revised 17/18 schemes are at the heart of delivering changes within this phase of work. Brent CCG/LA and LNWHT went live with an 8 week pilot (May 2017) to deliver a 'discharge to assess' model of care which aims to reduce the length of stay and the number of DTOC's on the Northwick Park site.

Patients under this model will be transferred home with a rapid OT assessment and an immediate package of care in place to support the necessary needs. Any equipment requirements will be dealt with rapidly so that care is wrapped around the patient at home whilst they wait for their relevant assessments.

The cohort of patients that this model will impact on will be older people (65+) of which some will have frailty.

The Brent system already has an Integrated Rehabilitation and Reablement Service (IRRS) in place which supports transfer of patients home and if patients still need to remain under the care of a medical team we have Early Supported Discharge which is under the remit of STARRS.

The elements under this scheme have been delivered and the focus is to ensure that they are embedded and expanded where appropriate and feasible.

3.5.2 Workstream 2 – A&E and AMU

This aspect of the frailty model is the focus of the OPALS business case and specifically on quicker, more multi-disciplinary assessment at the 'front-door' of the hospital (Emergency Department). The OPALS pilot run in 2015/16 tested the initial case for change and highlighted the financial opportunity (length of stay reduction).

The CCG has already commission a Rapid Response service through STARRS which is expected to manage a range of patients at home, some of which would be patients with frailty. This is expected to accelerate during 2017/18 along with the presence they have in A&E to ensure patients are identified and managed accordingly.

The OPALS service proposed in the business case is expected to span across A&E and the short stay assessment units.

3.5.3 Workstream 3 – Community Support (Prevention)

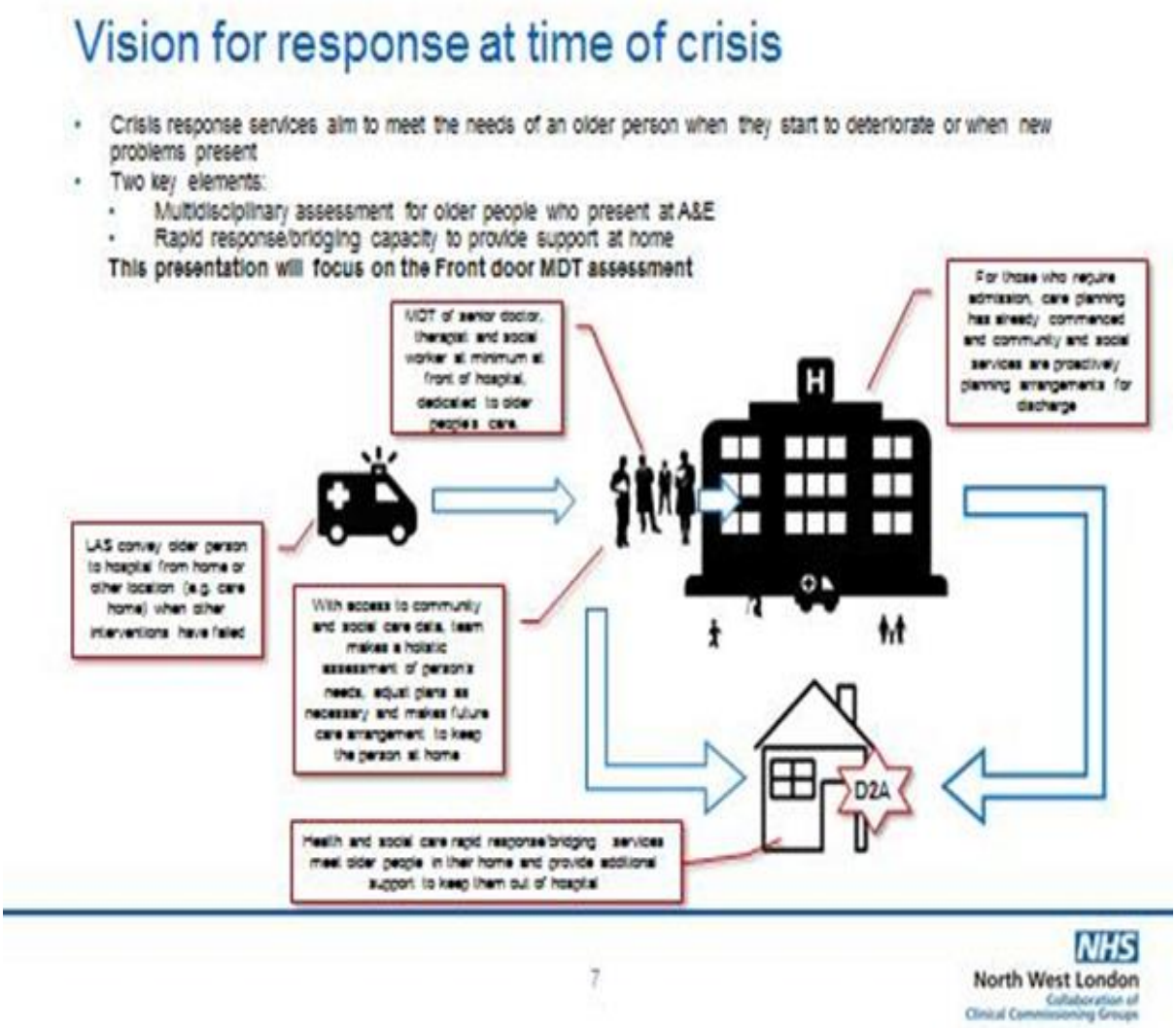
This is a critical area to ensure that we are doing everything we can to avoid patients moving upstream into the urgent and emergency care system. Whole

Systems Integrated Care (WISC) and the Enhanced model for care homes are the key components within this workstream.

3.5.4 Workstream 4 – Community Support (Out of Hospital)

Once patients have had an unplanned episode of care in the hospital this phase aims to ensure that the infrastructure in the community can maintain patients as there is a risk that as a result of a change in baseline they are likely to be readmitted in the future.
Services which impact on other phases within this pathway are included here such as IRRS, Early Supported Discharge and Community nursing, all of which will deliver a service to manage patients in the community.

3.6 This report concentrates on developments around the Workstream 2 – A&E and AMU aspects of the pathway, specifically the business case that has been developed in relation to the development of the OPALS service for Northwick Park Hospital. The diagram below sets out how the pathway will interact with existing services:



4 Background to OPALS business case

4.1 Despite the numerous initiatives delivered as part of an overarching out of hospital strategy, an increasing number of older people are attending hospital through an urgent and emergency route, accessing urgent health and social care services.

Over the past 12 months LNWHT (London Northwest Hospitals Trust) has reported a 6% increase in admissions for 65+ and a 10% growth in admissions for 85+. Evidence at a local level suggests that older people who attend an emergency department are;

I. more likely to be admitted into an acute bed
II. have a longer length of stay and occupy more bed days compared to the other patient groups.

A patient who is 85+ has a length of stay of 9.9 days at LNWHT compared with a 4.5 day average across all age groups.

4.2 Based on Brent CCG SUS data (Secondary User Data), the cost of non-elective emergency admissions for older patients at LNWHT during 2015/16 was £15.6m and in 2016/17 the cost had increased to £16.7m (all providers). At LNWHT the activity has remained relatively flat with total non-elective admissions 3661 for 16/17 compared with 3538 in 15/16.

4.3 Doing nothing is no longer an option and large scale transformation within the short term has a number of challenges. Therefore, as part of this frailty business case the transformational change is articulated as a phased approach to address the local requirements. By 2020/21 the expectation is for the Brent system to have completed the necessary deliverables to achieve the overarching ambition of a ‘unified frailty model’.

4.4 For the LNWHT recovery of the A&E performance trajectory, a fully operational frailty model within the acute trust by Sept 2017 is critical to ensure that breaches are reduced. The submission to NHS England and NHS Improvement committed to a reduction of 1302 A&E breaches over a six month period from September 2017.

4.5 The focus of this business case at Northwick Park, will address the issue of older people with frailty once they have entered the Emergency Department and who are likely to end up in a bed for a period of time which can cause unnecessary harm and deterioration, should a prolonged length of stay materialise for whatever reason.

4.6 The aim of this business case is approval for an enhanced model of care for the Northwick Park site which will ensure that there is a focus on assessment and treatment of frail elderly patients in the full Emergency patient flow. The design of this model is based on the OPALS pilot which included patient

feedback. NWL also have an Older Peoples Reference Group which has informed this business case.

5 Detail of the proposed model

5.1 The proposal is to create both an OPALS mutli-disciplinary team and a frailty pathway that will allow for early identification and assessment of people who would benefit from earlier, targeted assessment and a dedicated team to co-ordinate and manage their care. Evidence suggests that this will support frail elderly people to avoid admission to long stay wards and to be supported back home with a better chance of avoiding re-admission.

5.2 In order to successfully establish a team for NWP site which will aim to cover all frailty patients on site it is anticipated that the following staff will be required to deliver the initial 5 day service:

- 1.4 x WTE consultants
- 1 x Band 7 therapy team leader (team needs dedicated leadership) and 1 x band 6 and 1 band 5 therapists
- 4 x Junior Drs - 1 x registrar, 2 x SHOs/clinical fellows and 1 x F1 (required to cover annual and study leave)
- 1.5 x discharge co-ordinator (this role was central in ensuring success of pilot and needs to have leave cover built in)
- 1.5 advanced nurse practitioners (ideally 3 x WTE working across acute wards and Emergency Pathway)
- 1.5 x Social Worker (holiday and sickness cover can be provided through the existing Hospital Discharge Team)
- 1 x Occupational Therapist (cover to be provided by IRRS)
- 0.5 x Housing/adaptations advisor.

Whilst some elements of the workforce can be made available through internal reconfiguration of staff it is expected that a number of these roles will require recruitment.

5.3 Further discussion is taking place regarding whether there is a need for input from a pharmacist and a transport co-ordinator.

5.4 The OPAL team will aim to assess patients within 24 hours of admission and discharge/transfer 75% of those patients within 48 hours. The aim will be to move this model to a 7 day service within 12 months.

5.5 ED department at NPH will establish a frailty area on Carroll Ward to facilitate comprehensive geriatric assessment and admission avoidance for the frail elderly identified using the frailty screening tool.

5.6 The OPAL team will interface and in-reach into this area aiming to see patients within 2 hours of referral to avoid admission if appropriate, overall management

of patients in this area will remain the responsibility of the ED team led by a consultant and advanced nurse practitioner (Leicester model).

5.7 If the OPAL team deem that the patient requires admission then they will be referred via the acute medical team and then triaged to the appropriate clinical team for ongoing treatment.

5.8 The team will work to the agreed complex discharge planning process with shared responsibility between the acute trust, community services and social care:

- Older people should only be discharged from hospital with adequate support and respect for their preferences
- Information must be shared between the relevant services whenever there is a transfer of care between individuals of services
- An expected discharge date should be set within 2 hours (14 hours overnight) following admission into a bedded unit
- Sharing of information on local voluntary sector organisations, accessing financial support and reablemenent services.

6 Finance Implications

6.1 The resource implications will need to be fully worked through prior to business case approval for Jun 2017. The cost of this service is estimated at £397k per annum with identified savings of c. £550k. However, there remains significant opportunity to increase this level of savings through this model of care.

Sign-off will also be required by the contract and finance teams to ensure that the assumptions made on Payment by Results activity shifts are valid.

7 Legal Implications

7.1 No implications have been identified at this stage. This will be reviewed as work progresses towards implementation.

8 Diversity Implications

8.1 The Brent and Health Care plan aims to address the whole health and care system to enable a rebalancing towards prevention, early intervention, supporting independence and wellbeing. It aims to engage and empower the diverse communities of Brent to improve health and wellbeing outcomes and patient experience.

8.2 Detailed Equality Assessments will be undertaken for each of the workstreams to ensure that equalities issues are addressed and or mitigated as part of the implementation process.

9 Staffing / Accommodation Implications (if appropriate)

9.1 Staffing implications are listed as above. Further implications will be assessed once work is completed to identify what existing resource can be contributed towards the team.

Contact Officers

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