Vision for integration in Brent

June 2019

Background/Summary

- Partnership working - Longstanding commitment to work in partnership. Brent Council signed up to the STP and was an active partner at a NW London level to co-design priority programmes of transformation. Brent used the NW London STP as a template for joint working across health and care at a borough level
- Integrated services – Brent already has several integrated services (although not integrated commissioning), including:
  - Adult community mental health team
  - Community Learning disability service
  - Community integrated rehabilitation and reablement service (IRRS)
- Transformation – Brent council and CCG jointly contribute to a joint programme of transformation to improve health and care outcomes across the system using BCF funding. The priorities for 19/20 are:
  - An integrated hospital discharge pathway
  - An enhanced health and care in care home service
  - Integrated commissioning and market management
  - Development of integrated pathways for self care and social prescribing
  - Implementation of an assistive tech strategy
- Key successes from the programme in 18/19 include:
  - Increase from 7 to between 30 and 45 people discharged through Home First within 3 months
  - Reduce DTOC levels to low levels
  - Pilot a ‘placement premium’ to support faster assessment and discharge from hospital
  - Pilot expansion of Home First to more complex patients (pathway 2/3)

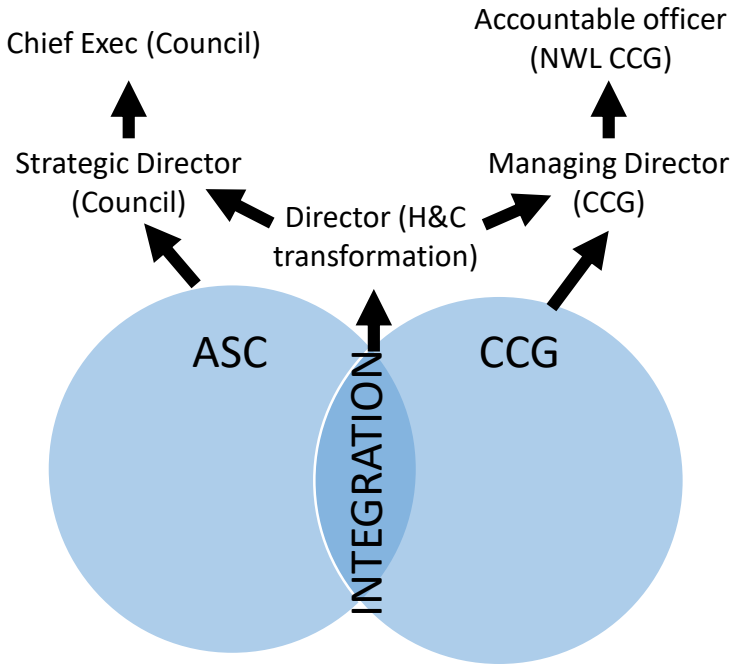
Opportunity: integrated commissioning

Whilst Brent has worked together to design an integrated service model for a number of key services for people in Brent (as outlined above), the commissioning of those services are not currently integrated. There is an opportunity to develop an integrated commissioning function for all existing integrated services, and any future integrated services. The **advantages to health partners** of such an approach include:

- NHS access to financial flexibilities available to the council.
- Greater strategic operational control over whole service to ensure it is delivering outcomes and addresses operational issues
- Ability to provide long term planning and stability to services
- Maximise opportunities for savings to the system

Proposed approach

Now…



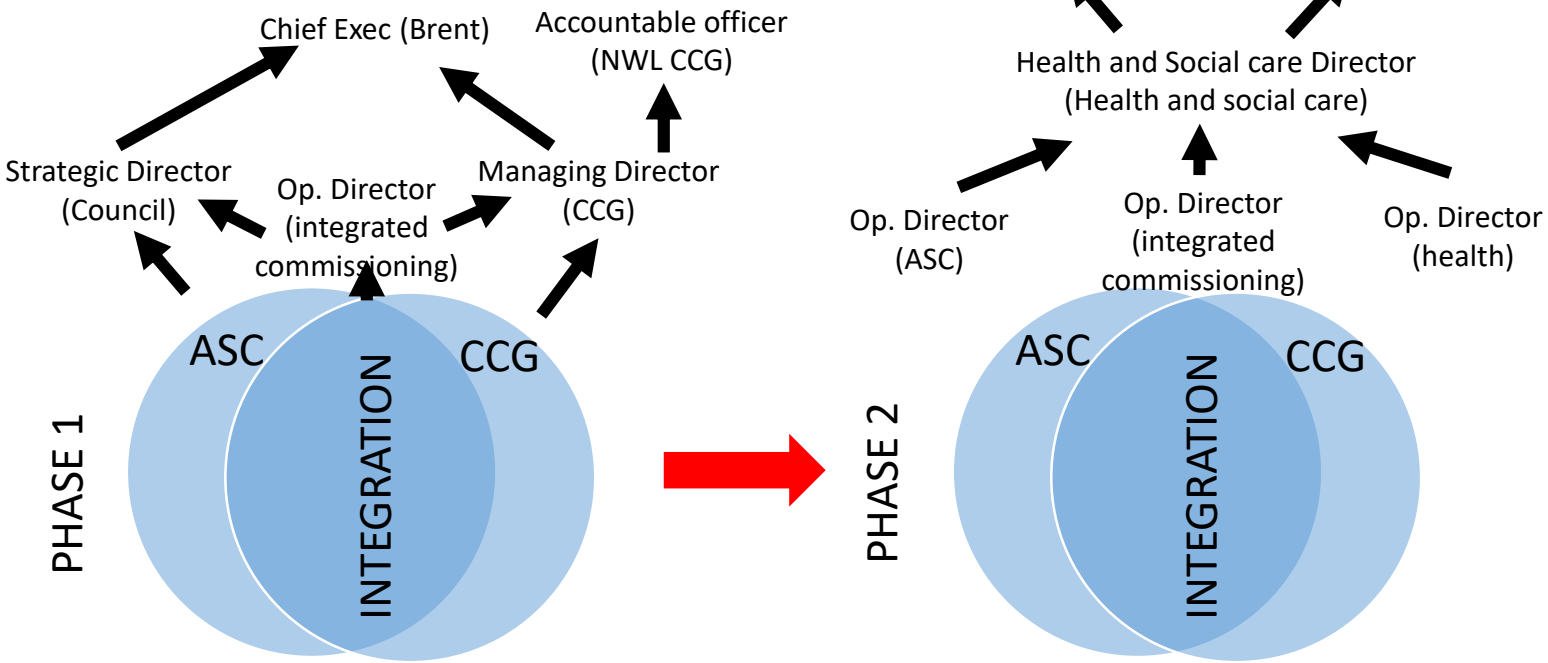
What is integrated?

- Adult community mental health team
- Community Learning disability service
- Community integrated rehabilitation and reablement service (IRRS)
- Transformation team

What is excluded?

- All other services
- Joint commissioning of all existing integrated services

Next…?



What is integrated (Phase 1)?

- Joint commissioning of all integrated services
- Care home placements (CHC and ASC)
- Integrated care partnership
- Integrated discharge pathway
- Adult community mental health team
- Community Learning disability service
- Community integrated rehabilitation and reablement service (IRRS)
- Home care
- Transformation team

What is integrated (phase 2)?

- Mental health
- Estates
- Community services

What is under review (phase 3)?

- Public health and children's health
- Primary care
- Joint commissioning of children's therapies and CAMHS

What remains separate (NWL)?

- Anything not explicitly agreed through phases 1-3
- Acute commissioning
- Specialist commissioning
- Enabler support – digital, workforce and estates
- Other core health or ASC functions

Integrated care partnership: working at different spatial levels

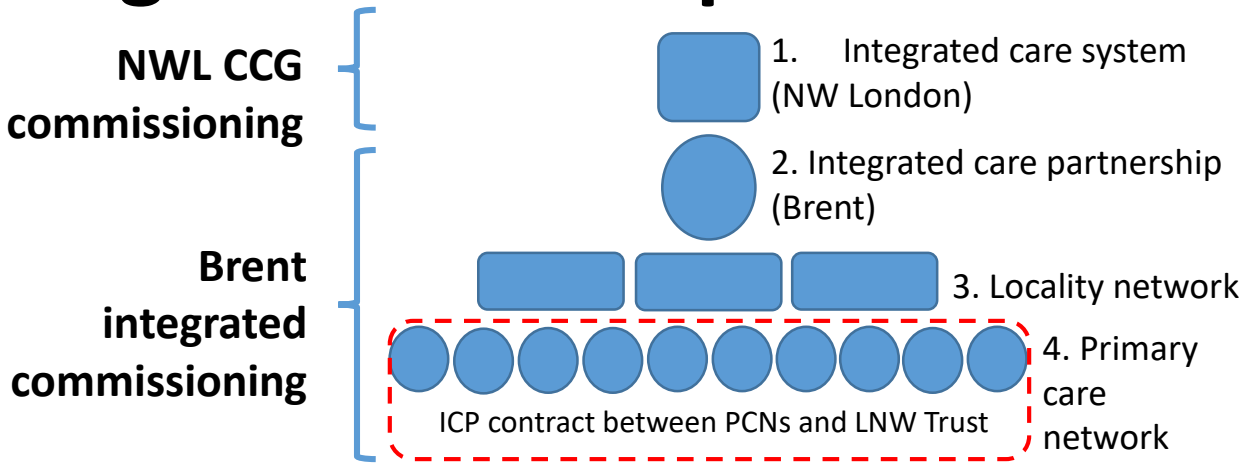
What will happen at what level?

1. Integrated care system (ICS) (NW London)
- Commission acute care, specialist services and acute mental health services
- Provide a range of support services to CCGs (IT, data, strategy advice)
- Provide strategic market management support for care homes

2. Integrated care partnership (ICP) (Brent)
- Commission all community health and mental health services
- Commission and manage PCNs and primary care contract
- Manage ICP contract between PCNs and Trust

3. Locality network (x3)
- Provide a range of support services to PCNs (IT, HR etc)

4. Primary care network (x10)
- Provide primary care and community health services



IRRS - Example of opportunity

The integrated rehabilitation and reablement service (IRRS) is a jointly designed and funded fully integrated service delivered by LNWHT, with Brent Council staff seconded into it under a S75 agreement. The service assesses and reviews rehabilitation and reablement support (usually provided over a 6 week period), including access to equipment for support in people's homes.

Key challenges with current service	Proposed changes to improve	Key benefits
Culture - various handoffs between services and a linear focus to care rather than a whole system approach	**Single line of accountability** - to improve operational grip and respond quickly to operational issues. Clear linear governance routes to ensure	**Efficiencies** – reduced time wasted between services and teams as a result of improved communication
Referrals - different services referring same people with different timescales and needs	**Single set of service metrics and service standards** – to ensure clear responsibility and accountability for delivery	**Improved system performance** – improvements in effectiveness of support and timeliness of support and patient flow
IT - not fit for purpose and health and care systems do not talk to each other	**Pooled budget** – to ensure funding is managed coherently as a single service and deliver best value for money	**Improved patient experience**– service users receive more seamless service as a result of clear processes and referral routes
Mixed lines of accountability/governance - reporting to organisations with different expectations	**Shared systems** – single IT system and HR support/processes to reduce bureaucracy	
HR processes - bureaucracy and time wasted	**Co-location** – to ensure synergies with other key teams and develop joint working with other teams and address culture issues	

Adult community mental health - Example of opportunity

This is a fully integrated service delivered by a single service in CNWL, with Brent Council staff seconded into it under a S75 agreement. The service provides a joined up health and care service to people diagnosed with a severe and enduring mental illness to help them live independently and manage their condition. It was reviewed and co-designed in a collaborative project, but it is contract managed through individual commissioning relationships. It is based on a recovery model, which is grounded in the local community and excels when the links are made from this service to core council services such as employment and housing. There are 40 Brent Council staff in the service and 110 health staff.

Key challenges with current service	Proposed changes to improve	Key benefits
IT - not fit for purpose and health and care systems do not talk to each other despite having shared care records	**Single line of accountability** – single panel and improved operational grip and respond quickly to operational issues. Clear linear governance	**Efficiencies** – resulting from a single focus on clearly defined population and service standards as well as clearer commissioning oversight
Multiple panels – duplication and mixed messages resulting	**Single front door/triage** – older people with working adults	**Improved system performance** – improvements in effectiveness of support and timeliness of support and patient flow
Lack of alignment – especially between different services and referral routes between working adults and older people	**Single set of service metrics and service standards** – to ensure clear responsibility and accountability for delivery	**Improved patient experience**– service users receive more seamless service as a result of clear processes and referral routes
Mixed lines of accountability/governance - reporting to organisations with different expectations	**Shared systems** – single IT system and HR support/processes to reduce bureaucracy	

ASC and CHC placements - Example of opportunity

Brent CCG's combined CHC and Adult Social Care (residential and nursing placements) services commissioned some external consultancy work in 2017. A joint model has been co-designed, and some progress has been made on the establishment of an integrated brokerage function. However, the current CHC service is commissioned by 3 CCGs and there is a significant opportunity to deliver greater collective control over the market working at a Brent level, delivering better value to the system supported by formally integrated teams and an integrated commissioning function.

Key challenges with current service	Proposed changes to improve	Key benefits
Lack of operational control – with a CHC service spanning multiple boroughs, there is limited capacity or appetite to integrate with ASC	**Single line of accountability** - to improve operational grip and respond quickly to operational issues. Clear linear governance	**Lower assessment costs** – optimised staffing levels to reduce duplication of assessment
Misaligned visions – wider system vision to expand Home First, but a rigid focus on organisational targets limits more ambitious approaches	**Formally establish integrated teams** – focussed on integrated brokerage, assessment, quality	**Greater market control and price**– basic economic theory of greater bulk purchasing power
Funding disputes – significant disputes over health or social care responsibility for funding, leading to increased mistrust	**Integrated approach to strategic market management** – to drive up quality and value from the market	**Reduced DTOC** – resulting from aligned vision and supporting processes
Limited control over market – by operating separately, commissioners are missing out on potential enhanced purchasing power with care homes	**Single set of service metrics and service standards** – to ensure clear responsibility and accountability for delivery	**Better patient experience** – single assessment, reduced duplication, clearer communication, reduced delays
Duplicating processes – currently duplicating assessments as well as reviews, with no joint approach to quality	**Pooled budget** – to ensure funding is managed coherently as a single service and deliver best value for money	**Efficiency** – reduced duplication and potential efficiency savings

Next steps

1. Agree model/approach
2. Commission external support to support practical action towards phase 1 in 19/20