Brent NHS Brent Clinical Commissioning Group	**Health and Wellbeing Board** 20 October 2020
	Report from the Director of Integrated Care

Health and Care Transformation Programme Update

Wards Affected:	All
Key or Non-Key Decision:	N/A
Open or Part/Fully Exempt: (If exempt, please highlight relevant paragraph of Part 1, Schedule 12A of 1972 Local Government Act)	Open
No. of Appendices:	None
Background Papers:	None
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1.0 Purpose of the Report

1.1 To provide a progress report on key activities of the joint Health and Care Transformation programme

2.0 Recommendation(s)

2.1 To note progress against the plan agreed in 2019/20 and provide strategic steer and advice to support the delivery of the updated priorities and approach

3.0 Background

3.1 In October 2019 the Board received a full progress report on the programme of work that was agreed the March 2019. The full breakdown of priority areas that were agreed were::

- A patient centred older people's care pathway, reducing delays in hospital discharge and improving patient experience
- A joint commissioning and brokerage function for nursing, residential and home care, reducing delays and duplication and creating a catalyst for the development of a fully integrated care system.
- A joint market management approach, including support to care home networks and training and development support.

- Self care, with a focus on connections between social prescribing link workers and the council and wider statutory services
- Technology enabled care strategy, to improve access to new equipment to support people to remain independent and at home
- Integrated care partnership, with a focus on supporting people at 'rising risk' in the community, and setting the groundwork for further integration

3.2 This was followed by a detailed update on the work with care homes to the Board in January 2020.

3.3 It was subsequently agreed at the Health and Care Transformation Board that the work to bring the provision of reablement support back into council control would sit with this programme, given the critical synergies between rehabilitation and reablement across both health and social care service users.

3.4 During the first wave of Covid 19 in Brent, the Health and Care Transformation Team were re-deployed to support operational priorities, in particular support to care homes to help to mitigate and manage any outbreaks, as well as establishing the monthly care home forum as a weekly forum. This provided an invaluable opportunity for care homes to learn from others, and ensure they were up to speed with the latest advice and guidance

3.5 As a result of this, a number of the deliverables slipped against the planned timescales. At the same time changes in the national, regional and local arrangements that were put in place during this period have had a material impact on the programme and the priority areas. The notable contextual changes are:

- The establishment of a single Hub at Northwick Park to manage all hospital discharges on behalf of Brent and Harrow patients
- National guidance that NHS partners should manage all discharges and placements from hospital into nursing homes, with funding to be provided through NHS funding steams (subject to agreement at London level)
- The realignment of services at London North West NHS Trust to provide 'hot' and 'cold' sites, resulting in 35 general rehabilitation beds at Central Middlesex hospital needing to be reprocured outside of the hospital setting
- Outbreaks of Covid-19 across care homes in Brent, requiring careful management and infection control procedures within care home settings, including additional government funding to support this, as well as support to limit physical interactions of services and staff within care home settings, requiring new ways of working to address shared priorities
- Funding pressures across the system, resulting in a decision by Members to pause work to bring reablement provision back under council control, whilst looking at alternative approaches
- The disproportionate impact of Covid-19 on different communities in Brent, and the need for a joined up approach to health inequalities to

address underlying causes

4.0 Programme update

4.1 The focus of the programme has changed in response to this changing landscape and priorities of the system. The key additions and changes to the programme, as well as the existing areas of work are set out below

4.2 Care home quality and support

4.2.1 In response to the increasing prevalence of Covid-19 within care home settings, the Health and Care Transformation Team shifted its focus to working with the system in the following ways:

- Establishing a weekly care home forum (from monthly), to provide peer support, advice and guidance to homes as well as an opportunity for homes to raise any risks or issues directly to senior representatives from across the system
- Working closely with ASC commissioning team and the local NHS Enhanced care home, CCG, public health and NW London teams to provide daily points of contact and to support responses to any issues, and rollout of PPE, testing and infection control training and general support
- In one instance, where there were serious leadership as well as quality and safeguarding concerns, arrangements were made to move residents to other care home settings, helping to ensure that there was no reduction in the quality of care received

4.2.2 The impact of this support during the first wave of Covid-19 shows a positive impact for Brent. In particular:

- A relatively low infection and death rate within care homes, relative to the overall case numbers for the borough, as compared to other London boroughs
- A short survey of care home managers following the first wave showed a unanimously positive response to Brent Council and the health and care transformation team. In particular, the extent and speed of PPE distribution, the weekly care home forum meetings, training and responsiveness of staff to live issues

4.2.3 Following the first wave, the support to care homes was adjusted to reflect the new landscape. The key changes were as follows:

- Following the resignation of Mark Bird as the Care Home Forum Chair, a new Chair was appointed. Basu Lamichhane, Manager at Victoria Care Centre took on the post in August, and will replace Mark Bird as the care home representative on the Health and Wellbeing Board
- Following a concerted push to get all homes signed up to NHS Mail, a new video consultation platform was procured and tablets have begun to be distributed to care homes to enable NHS and social care consultations to take place remotely
- Training for care homes has continued throughout the first wave, but

has now been broadened from infection control to a range of other themes, as prioritized by care home managers

- In response to the quality and safeguarding concerns during the first wave, the Forum have agreed to piloting a new approach to improving quality ensuring that more homes within Brent are CQC rated as either Good or Outstanding. This will be a peer led approach, with a registered manager supporting 6-12 homes directly. The post has now been appointed and will start on 9 November.
- The development of a new Enhanced Health in Care Homes Service through the new GP contract (Direct Enhanced Service – DES). This will rollout the existing service provided to 11 older people's care home in Brent to all homes, including learning difficulties and mental health
- Operational support is still being provided in response to Covid-19, in particular support to complete Capacity Tracker and monitoring testing take up

4.3 Hospital discharge Hub

4.3.1 Prior to March 2020, there was an extensive programme of work to establish a single point of access, and improve hospital discharge decision making and the timeliness of discharge. This work had started to have an impact, evidenced by a measurable reduction in delayed transfers of care (DTOC) for both NHS and social care, as well as a significant increase in 'Home First' referrals.

4.3.2 During the Covid-19 period, NHS partners were mandated to create a single discharge hub for each major acute hospital site, and be responsible for all hospital discharge placements into nursing homes. The principle of the Hub was in line with the work that had already been started within Brent prior to Covid, but the pace of change, combined with the wider changes within London Northwest Trust, the fact that the Hub was required to span multiple boroughs and the nature of the way that this was implemented had some perverse consequences, notably:

- An increase in the number of nursing home placements at a higher cost than would usually be expected
- An increase in failed discharges to 'Home First', creating significant operational issues and reduced capacity where it was most needed
- Uncertainty of the process and pathways and the role and make up of the MDT team as part of the Hub, resulting in an increase in operational administrative work

4.3.3 Following the experiences (both positive and negative) resulting from the establishment of the Hub, a small task and finish team was established across key organisations to design clear pathways and improvements to the operational implementation of the hub. This review is nearing completion and will be moving into implementation following agreement at the operational Health and Care Transformation Board. The principles of the new model have been agreed operationally, and are now subject to formal agreement by the leadership of organisations. The key principles for Brent are as follows:

- A single point of referral for all patients within London Northwest for both Brent and Harrow
- All Brent residents located in other hospitals will be referred to the Northwick Park Hub
- The MDT process will result in decision making that shifts more people from pathway's 2 and 3 into pathway's 0 and 1
- Processes will be developed to ensure that social worker capacity within the trust is focused on the most complex cases requiring placement, as well as more streamlined administrative processes and governance
- There will be clear points of escalation for the system, should there be no clear agreement on any individual cases

4.3.4 A full delivery plan is being developed in line with the proposed pathways, and further updates and reporting of KPIs will be brought to future Health and Wellbeing Board meetings to monitor progress

4.4 Rehabilitation and reablement

4.4.1 Rehabilitation beds reprovision – following the end of the 35 general rehabilitation beds within Central Middlesex hospital, provided by London NW Trust, a decision was made to reprovide the equivalent service within the community. A business case was developed that provided improved quality of provision at approximately £1million reduced cost. The principle was that people should receive rehab at home wherever possible, and there should be a clear pathway to support people in the community. The key elements of the model that were agreed were:

- 20 general rehabilitation beds provided within an 'outstanding' nursing home setting, with facilities and nursing support provided by the home. This service will be procured by the council on behalf of the CCG
- A dedicated clinical team of 16.5 people supporting both the beds and to support at least the equivilant of 15 beds rehab support at home. The team will be aligned to the ICP team, remaining under the employment of LNW Trust
- Procurement of double-up packages of care for up to 5 people per week in receipt of rehabilitation at home for an average of 3 weeks, procured by the council on behalf of the CCG

4.4.2 Significant progress has been made in all aspects of the service, and the beds and dedicated team are due to go live from 1 November.

4.4.3 Reablement in house service - Following a decision by Councillors to bring the provision of reablement back under council control, the Health and Care Transformation Team were instructed to develop a costed model of care and deliver the new service, in line with the existing Integrated Rehabilitation and Reablement Service. A plan was developed, and scheduled for implementation on 1 October.

4.4.4 However, as a result of the significant financial pressures faced by the

council, it was decided in early October that the additional cost for the in-house service could not be afforded at the current time. A new proposal is therefore being developed that should be able to deliver some of the benefits of the in-house model, working with the independent sector. The key objectives will be:

- Improve the effectiveness of goals-oriented reablement, reducing the length of time that people need reablement, and reducing readmissions to hospital
- Improving the quality of reablement provision across the borough
- Developing clear pathways for people with wider enablement needs, including for people with mental health and learning disabilities support needs, as well as other service and support requirements
- Strengthening the oversight and processes for the integarted rehabilitation and reablement service (IRRS) and connections to rabblement providers
- Strengthening the synergies and pathways between rehabilitation and reablement in the community

4.4.5 Further updates and reporting of KPIS will be provided at future Health and Wellbeing Board meetings, if required

4.5 Health inequalities

4.5.1 Following a discussion at the previous Health and Wellbeing Board, a decision was made to develop some dedicated work with communities that have been most significantly impacted by Covid-19. A separate report on the progress of this work has been produced as a separate discussion item

4.6 Integrated commissioning, market management, Integarted Care Partnership (ICP) and Integrated Care System (ICS)

4.6.1 Progress in this area has been significantly disrupted by Covid-19, however, key components of the work still remain:

- Discharge to assess protocol and beds – the protocol remains in place and the 10 beds or equivalent value of support is available for Brent residents to support timely discharge and assessment outside of a hospital setting between adult social care and continuing heathcare. This process is working well, and prior to Covid-19 had resulted in a significant reduction of DTOC for NHS patients
- Placement Premium – the pilot scheme was launched in February 2019 to incentivize timely assessment and placement by care homes, with the aim of reducing delayed transfers of care from hospital. The model works on the basis that care homes receive £50 for assessment completed within 24hrs of referral, and an additional £50 if this results in a placement within 48hrs, and £500 for a nursing placement. The take-up of this offer has significantly reduced during Covid, but is intended to continue to make a positive difference once the system returns to business as usual
- Integrated commissioning – it was agreed that a CHC broker be co-located with adult social care brokers for nursing and residential care homes from

2018, following recommendations by consultants Ernst and Young in late 2017. The integrated brokerage function went live in June 2018, and the feedback from brokerage staff involved was positive, and fostered joint working and a shared understanding of the market and prices paid. Unfortunately, the commitment to the joint brokerage role was rescinded due to pressures on the CHC service. As a result of this, the integrated commissioning steering group and programme board have reviewed joint working, and agreed to work on the following alternative areas where there is agreement to do so. Work is ongoing in each of these areas to develop and implement a work programme:

- Joint Quality Framework/Approach - A comprehensive and joined up approach to assess quality and contract monitor services in a holistic way across partners.
- Integrated Pricing Strategy – a joint pricing strategy to ensure consistent message to the market. Specific proposals would be agreed and developed jointly, including a review of the placement premium for CHC placements
- Joint Approach to Assessment/review - A shared assessment process, including: MDT assessment of patients; An integrated panel process to follow strength based approach; An assessment document that is proportionate to the request for help (linked to checklist), to capture core data set requirements agreed between the Local Authority and Health to complete an assessment of their needs, resources and desired outcomes. This would include a joint review of requests for 1:1 support.
- Discharge to assess for CHC and complex care – as outlined in section
- Home first for complex patients - Expand number of patients discharged home who are complex or CHC eligible, where there is a clear financial case that support at home will be more cost effective than residential or nursing placement. Specific proposal to put intensive support in for first 7 days (including night sitting), with ongoing care plan developed at home during this period

4.7 Better Care Fund and Winter pressures

4.7.1 The guidance has not yet been published for the production and publication of the 2020/21 BCF and winter pressures plan. However, discussions about the BCF plan have been progressing, and proposals have been developed at an officer level which will need to be formally agreed at the next meeting of the Board. The approach that is proposed is to continue in line with previous years, including the new schemes that were developed and delivered last year in response to Winter pressures. In addition there is an inflationary uplift in the BCF values. The CCG allocation for this funding has not yet been agreed by officers, but discussions have progressed in relation to how the ASc share of the uplift will be allocated.

4.7.2 The key elements of last years BCF and Winter pressures plan are summarized as:

- Handyman service, supporting settlement back home and reduce delays in hospital discharge
- Positive behavioral management in care homes pilot, supporting people with dementia and avoid hospital admissions and improved outcomes for patients
- Additional social workers to support the expansion of Home First
- Overnight care to support expansion of Home First for more complex patients
- Assistive technology pilots for key patient cohorts to improve outcomes for people and enable people to remain at home and independent for longer
- Nurse assessor, to support a reduction in NHS delayed transfers of care through effective management of discharge to assess beds
- Backfill to support the design teams implementing the changes identified for the integrated discharge pathways
- Training for reablement providers to improve the effectiveness of reablement

4.7.3 Further details of the impact of these schemes and the proposed BCF plan for 2020/21 will be shared at the next meeting for formal approval

5.0 Financial Implications

5.1 A number of the schemes outlined are funded through Better Care Fund, as outlined in the Better Care Fund Plan. This includes the funding of a joint Health and Care Transformation Team, with a dedicated programme manager and project officer to support work with care homes.

6.0 Legal Implications

6.1 None

7.0 Equality Implications

7.1 None directly

8.0 Consultation with Ward Members and Stakeholders

8.1 Ongoing

9.0 Human Resources/Property Implications (if appropriate)

9.1 None

Report sign off:

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