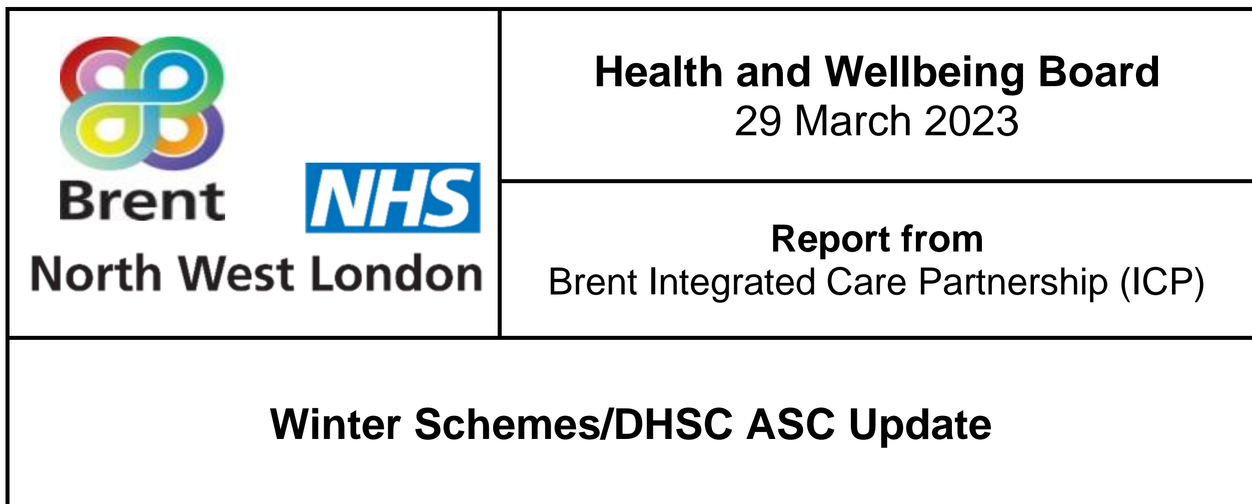


Health and Wellbeing Board
29 March 2023

Report from
Brent Integrated Care Partnership (ICP)

Winter Schemes/DHSC ASC Update

Wards Affected:	All Brent
Key or Non-Key Decision:	N/A
Open or Part/Fully Exempt:	N/A
No. of Appendices:	N/A
Background Papers	N/A
Contact Officer(s): (Name, Title, Contact Details)	Tom Shakespeare Managing Director Brent Integrated Care Partnership (ICP) Tom.Shakespeare@brent.gov.uk Steve Vo Assistant Director of Integration and Delivery, NWL ICB Brent Borough Antoinette Jones Head of Delivery Brent and Harrow Borough's

1.0 Purpose of the Report

1.1 This report provides an update on the joint health and local authority delivery of Winter Planning and Department of Health and Social Care (DHSC) funded schemes. The report outlines the progress and key headlines of winter planning schemes and additional discharge funding.

2.0 Recommendation(s)

2.1 The NHS and Brent Local Authority (LA) continue to deliver and support part of business as usual, working to reduce hospital delays, including a dedicated hospital discharge team, step-down beds, Home First and several schemes supporting our Mental Health Service users. We continue to provide through the DHSC funding additional capacity for complex discharges, including care home placements and domiciliary care.

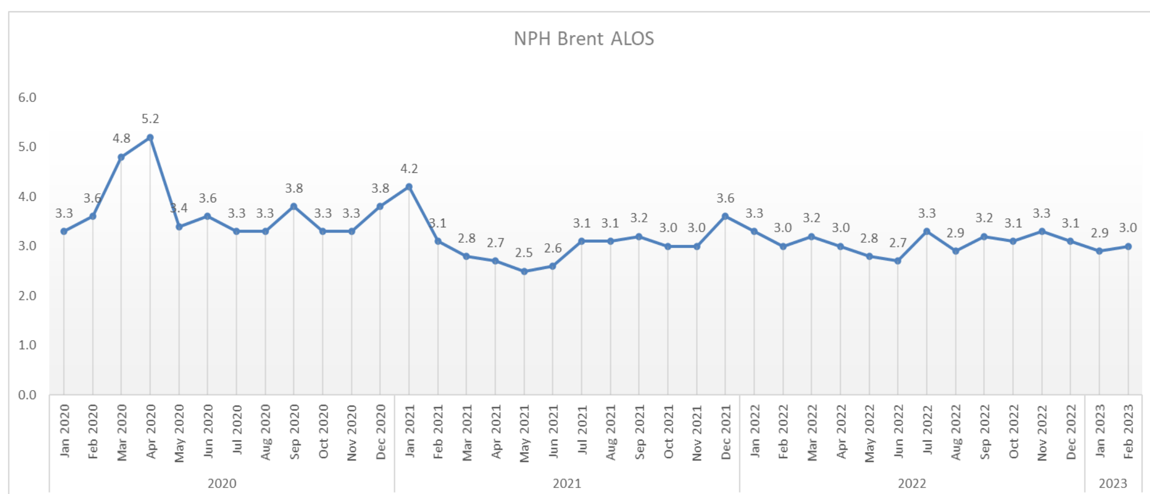
3.0 Detail

3.1 A total of **£3.35m** has been secured across the system. The breakdown of the funding streams, spending to date, and likely year-end position is set out in table 1 below: An underspend of **£298k** is likely at the end of March 2023, and this is mainly due to two schemes (1) Step down beds £**162k**, following agreements of alternative arrangements agreed for patients. (2) PCN Primary Care redirections **£135k** due to NWL ICB directly funding schemes that impact direct patient care.

Table 1: Spend by Funding Stream.

Funding Stream	Allocation	Spend to Date	FOT (March 23)	Variance (Underspend)
NWL ICB Funded Schemes	£562k	£438k	£562k	£0
LA Section 256	£517k	£219k	£219k	-£298k
DHSC Funding				
LA Allocation	£1.119m	£741k	£1.119m	£0
NWL ICB Allocation	£1.153m	£1.112k	£1.153m	£0
Total Sets Funds	**£3.351m**	**£2.510m**	**£3.053m**	**-£298k**

3.1.1 Evidently, challenges still exist in the system, with recorded increases in A&E and NEL attendance and admissions. However, we saw a sharp improvement in delayed discharges and average Length of Stay (LOS) in the run-up to Christmas and January 2023, and this has somewhat slowed in early February 2023. The charts below illustrate current performance and trends.



NEL Admissions continue to increase year on year; however, there's a slight improvement in the LOS. December 22 and February 23 have remained stable at an average of 3 days compared to previous years.

3.2 Several partnerships implemented schemes accept patients and referrals. This in turn, is having a positive impact on our acute hospitals.

3.2.1 Discharges from the hospital: This metric below is reported by Brent Local Authority and NWL Integrated Care Board (ICB)as part of governance for monitoring via fortnightly returns to the Department of Health via the Better Care fund, with the first submission having taken place on 6th January 2023.

3.2.2 Most of the discharges were for patients on Pathway 1, both in terms of the discharges from the hospital and the use of home care, domiciliary and reablement hours. Staff overtime and additional staff secured via agency and bank have helped the LA process discharge cases more quickly. Table 2a and 2b below show weekly performance, which illustrates the number of discharges and care packages (DHSC Funding) by pathway.

Table 2a - Number of Discharges from Hospital

Reporting Period	**No 1**	**No 2**	**No 3**	**No 4**	**No 5**
Dates	06/01/23	20/01/23	3/02/23	17/02/23	03/03/23
Pathway 1 = homecare, home first, Daycare, community care	63	75	60	57	53
Pathway 2 = Rehabilitation	0	0	0	0	5
Pathway 3 = Residential and Nursing	2	2	4	6	2
Other pathway one support (meals on wheels)		2	1	1	
Number of intermediate (reablement) care beds			0	0	11
Total	**65**	**79**	**65**	**64**	**71**

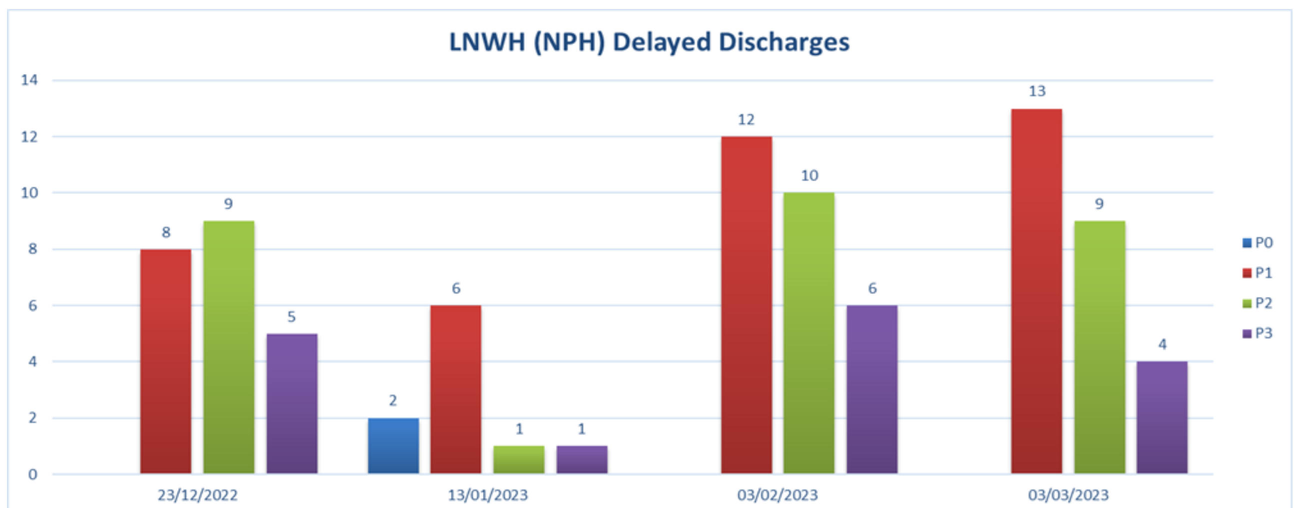
Table 2b - Home or Domiciliary Care and Reablement Hours

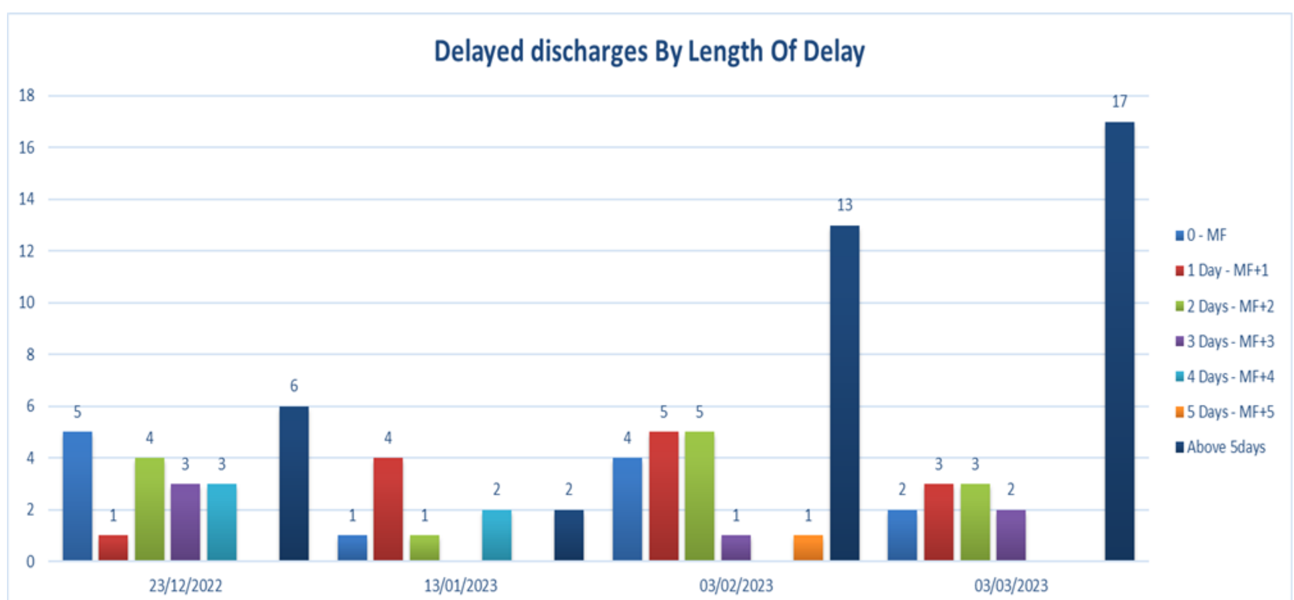
Reporting Period	**No 1**	**No 2**	**No 3**	**No 4**	**No 5**
Dates	06/01/23	20/01/23	03/02/23	17/02/23	03/03/23
Pathway 1 = homecare, home first, Daycare, community care	570	463	740	970	738
Pathway 2 = Rehabilitation	144	48	0	0	72

Pathway 3 = Residential and Nursing	11	2	4	6	2
Total	**725**	**513**	**744**	**976**	**812**

3.2.3 Although there has been much effort in reducing LOS and increasing numbers of discharges, there is an increase in delayed discharges particularly for patients with over 5-day LOS in the reporting period of 3rd March**.** There has been an increase in referrals with patients with complex needs and also an increase of requests for care home placements although care homes have limited availability for patients with complex care needs. Furthermore, there have been reported delays to the supply of community equipment needed to facilitate patient discharges.

Table 3a&3b: Delayed Discharges by pathway and LOS.

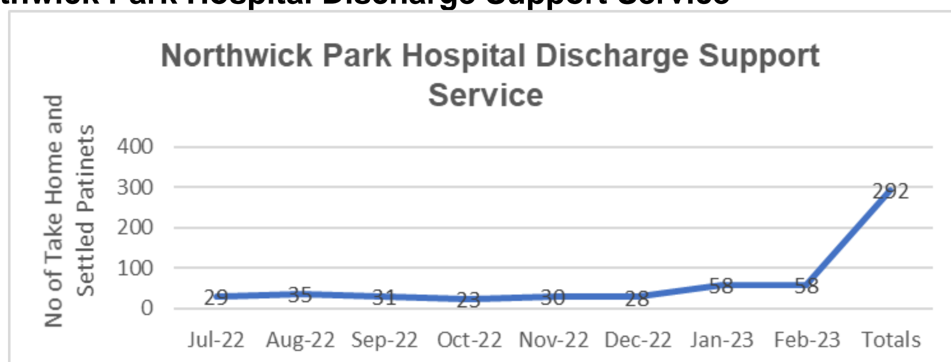




3.2.4 D2A Local Mitigation Plan (due to discontinuation of D2A funding): Ten step-down beds were commissioned for the winter period. Six beds, especially for those with complex needs and who are challenging to place, and four beds for people with lesser complex needs. The four beds have been fully occupied since mid-December 2022

3.2.5 Take Home and Settle Service Monday – Friday: This is a reactive discharge service that supports the discharge of patients predominantly aged 50 and older across the hospital. The service supports to get the patients home, settle them back at home, ensure appropriate follow-ups are in place, and signposting patients or their carers to relevant third-sector organisations for long term comprehensive support. The table below illustrates the scheme's impact following our formal contribution and buy-in as part of Winter Planning.

Table 4 Northwick Park Hospital Discharge Support Service



3.2.6 Urgent Response Care Team: This service provides additional capacity in the system to provide social care in patients' homes for a short period to allow full social care assessment.
The team is operating at full capacity; the initial plan was to offer support to **8** patients per day. Due to increasing demand, the team has been expanded, and there are now **19** patients supported through home care agency workers.

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3.3 Supporting Mental Health Service Users: The following are schemes dedicated to supporting Mental Health service users.

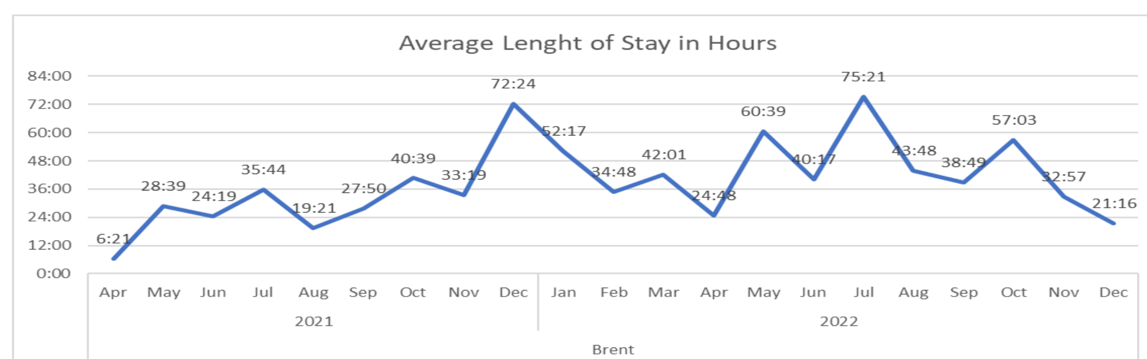
3.3.1. Holistic Support and Wellbeing: Community response and support for urgent Mental Health Crisis Support. The service was commenced at Ashford Place, supporting early interventions for patients at higher risk of experiencing a mental health crisis.
The service provides bereavement support by providing group and individual counselling to improve emotional and mental wellbeing for those experiencing loss and grief. As of the end of January 2023, **148** assessments have been delivered against an indicative baseline of 100 to be delivered from December to March 2023.

3.3.2 Northwick Park Hospital Adult Mental Health Emergency Centre (MHEC) 7-day working: The Mental Health Emergency Centre is funded on a 7-day working basis, staffed by three Mental Health workers and two outreach workers who will work to offer contact at the point of admission. The outcome of this scheme is to reduce avoidable hospital admission and facilitate earlier discharge from A&E. Table 3 below illustrates that between November and January 2023, **24** patients from Brent were admitted to the Northwick Park MHEC from A&E for further treatment or review. Of the 24, only four were admitted to the hospital. The rest were signposted to appropriate services and discharged from the MHEC.

Table 5 MHEC Activity December 22

Discharge Reason – Brent	**Nov**	**Dec**	**Jan**	**Total**
Admitted to Hospital	1	1	2	4
Discharged - Moved out of the area				0
Discharged - Referred for MHA Assessment				0
Discharged - Referred to other speciality/Service	1	4	5	10
Discharged - Service no longer required	1	1	2	4
Discharged - to GP				0
Discharged - Treatment completed				0
Finished by Patient's Non-attendance				0
Finished by Patient's Non-engagement				0
Inappropriate Referral				0
Please Select Reason	1	2	1	4
Transferred to Primary Care Mental Health Team				0
Transferred to Secondary Care MH Service		1	1	2
Total	**4**	**9**	**11**	**24**

Table 6 MHEC Average LOS (Hours)



The chart above illustrates improvements in average LOS for patients.

3.3.3 Community Places for People with Mental Health Issues and at Risk of Homelessness: This scheme stabilises patients in step-down beds, works closely with community outreach workers and supports patients towards living as independently as possible. The aim is to prevent

patients from using A&E as the only place of safety, preventing avoidable Urgent and Emergency Care (UEC) admissions. Based on the admission criteria, seven patients have been admitted to the facility, and five patients have since been found a place and discharged.

3.4 Increasing Capacity in Reablement and Rehabilitation through the Extension of the D2A Pilot: More people are discharged directly home from the hospital. This would help prevent admissions and support discharge. Service users should rely less on ASC provision with targeted reablement support at home. The service is up and running. Eighteen therapy sessions are now delivered weekly. In January, there were 13 referrals from acute and seven from the reablement team to the service. At the end of February 23, 47% of Patients had greater control of daily life and had achieved their goals against a target of 50%. In addition, 52% of people did not require ongoing home care services post 6-week reablement.

4.0 Financial Implications

4.1 Underspend is reported on two schemes (1) Step down beds **£163k**, due to alternative arrangements agreed for patients. (2) PCN Primary Care redirections **£135k** due to NWL ICB directly funding schemes that impact direct patient care.

5.0 Legal Implications

5.1 N/A

6.0 Equality Implications

6.1 N/A

6.2. N/A

7.0 Consultation with Ward Members and Stakeholders

7.1 All Winter Planning and ASC Discharge Planning Schemes have been worked through and agreed upon by all Brent key partners.

8.0 Human Resources/Property Implications (if appropriate)

8.1 N/A

<u>Report sign-off:</u>

Tom Shakespeare
Managing Director
Brent Integrated Care Partnership