Brent

NHS Brent Clinical Commissioning Group

Brent Health and Wellbeing Board
10 November 2015

Report from the CCG Chief Operating Officer and Strategic Director Adults

For approval

Wards affected: ALL

Brent Winter Plan and Better Care Fund Report

1.0. Summary

1.1. Every winter across the UK we see an increase in demand, particularly in our hospitals. The resulting winter pressures place an increased strain on every part of the health and social care economy. This winter, we are predicting similar spikes in demand, however the changes being driven by the Better Care Fund (BCF) are designed to reduce some of the strain across the health and social care economy for winter 15/16 and winter 16/17.

1.2. Bringing together both elements of Health and Social Care within one planning process underlines the importance of whole- system resilience and that both parts need to be addressed simultaneously in order for local health and care systems to operate as effectively as possible in delivering year-round services for patients.

1.3. Whilst winter is clearly a period of increased pressure, establishing sustainable year-round delivery requires capacity planning to be ongoing and robust. This will put the NHS, working with its partners in local authorities, in a position to move away from a reactive approach to managing operational problems, and towards a proactive system of year round operational resilience.

1.4. The following paper provides a summary of the work underway across the Brent health and social care economy.

2.0 Recommendations

2.1. The Brent Health and Well Board are asked to:

- approve the overall approach; and

- receive assurance that plans are in place to support NHS resilience over the winter so that patients get swift access to safe services in line with the NHS constitution.

3.0 Brent Winter Plan 15/16

3.1. We also understand that the scale of change required for our Winter Plan will not happen without significant and joined-up investment between health and social care. Our BCF plans explicitly build upon progress to-date and we have already agreed to pool our resources across the identified BCF areas joining together under a section 75 agreement. By working together across traditional public sector boundaries, keeping people well, and supporting their recovery after periods of illness, we know we can improve individual quality of life whilst also reducing demands upon local services.

3.2. The success of these changes will, from 2015/16 onwards, help drive reductions in emergency admissions to hospital, and the demand for nursing and residential home care, with benefits for individuals, the local authority and the CCG alike. This is about working together and working better, to put our health and social care systems on a steady footing, translating improved outcomes for individuals into long-term, sustainable support for our communities as a whole. Examples of these change program are highlighted below:

3.2.1. Colocation of hospital discharge teams and new ways of working for this winter

We will co-locate the LNWHT Complex Discharge Team and Brent Council's Hospital Discharge Team in November 2015, supporting joint working and streamlining of the discharge process. Initially 4 x social workers will move out of the Brent Civic center and be based within the hospital setting (once space is made available by LNWHT we expect an additional 10 x social workers to join them). Some of the agreed changes to the ways of working include social workers allocated to specific wards, attending MDTs, earlier involvement in discharge planning, educating ward staff on appropriate social care referrals (reducing the current 40% inappropriate referral rate). We anticipate these changes will result in patients experiencing a more coordinated service, able to leave hospital in a more timely way with the right services in place, while reducing both DTOC and nursing/residential care admissions.

3.2.2. Joint commissioning of community residential and nursing step-down beds

Brent BCF plans set out how we will secure increased capacity in the care home market through joint commissioning beds to support more effective and more timely 'step down' from the acute hospital setting. In order to achieve significant improvement on DTOCs and improve the flow in and out of the beds in the system, we are proposing to secure this bed capacity in the community through the volume purchasing of beds for a period of 12 months. By taking this planned, strategic approach we will reduce crisis spot purchasing of beds which commend a significantly higher rate. The access criteria has been agreed and signed off by all partners to ensure there is confidence that the commissioned community provision will deliver the required reduction of DTOCs and deliver the proposed improvements to previous systems. The beds will be supported by a small team (social worker

and nurse) to manage access and exit from the beds and ensure quality standards are being adhered to. Based on demand analysis we have established that 25 beds needed to be commissioned within the community to meet demand in 2015/16.

3.2.3 Dealing with Housing Issues

Delays as a result of Housing issues in 15/16 will be supported by a housing officer for 2 days a week. This officer would attend a weekly surgery at Northwick Park Hospital and Willesden Community Hospital to review the pipeline of patients approaching discharge- identify any housing issues and deal with them before the actual date of discharge. This dedicated input from the housing team would also identify pathways out of the hospital for those patients who do not meet the criteria for homelessness legislation and do not have any social care needs.

3.2.4 West London Alliance hospital discharge proposal

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. The result is confusion for hospitals to discharge via multiple borough procedures and difficulty for Brent council to resource discharge across a significant number of hospitals. The aspiration of the West London Alliance is for a single local authority to be the lead for each hospital (for example Brent Council would be the lead local authority for Northwick Park and take on all discharges for Hounslow, Tri-borough and Ealing residents before the end of this winter) and follow a discharge to assess model. The discharge to assess model would mean hospitals only have to follow one procedure and each Borough minimises its risk as they get involved as soon as the person is out of hospital to put them into longer term care.

3.2.5 Mechanisms in place for managing the health and social care system this winter

3.2.5.1. Daily call: Starting in September 2015, a Brent and Harrow system wide conference call was established. All local stakeholders take part in this call and if/when necessary this call will take place multiple times per day when the system is under pressure as per the surge and escalation process. Each provider within the system has their own operational escalation policies, which include alert status triggers related to bed capacity. Within individual escalation policies there are actions identified alongside alert levels specific to the providers concerned. Managing Directors (through their designated leads) will manage all winter pressures in their respective CCG and Local Authority areas. In the event that further escalation may be necessary, i.e. support from other areas may be needed, the CCGs will escalate issues to NHS England / Area Teams via established communication routes both in and out of hours.

3.2.5.2 Systems Resilience Group (SRG): Strategic planning group across Brent and Harrow, made up of leaders from across health and social care, who meet on a regular basis to identify and manage pressures across the system. Their particular focus is managing the pathway in and out of hospital, including reducing unnecessary admissions and improving hospital discharges. The SRG had developed a comprehensive action plan.

3.5.2.3 Brent Integration Board: Senior representatives for those organizations directly involved in the integration of health and social care in Brent.

Responsible for oversight and issue resolution in relation to the Brent Better Care Fund plans to integrated health and social care.

4.0. Brent Winter Plan for 16/17

4.1. The Better Care Fund (BCF) is a government sponsored initiative driving the integration of health and social care to deliver more effective, preventative, community services which reduce pressures on hospital and other institutional care settings. Through the pooling of budgets and joining up commissioning activity across health (Brent CCG) and social are (Brent Council), Brent's Better Care Fund Programme is supporting the SRG with their objectives across Brent; facilitating effective hospital discharge; reducing the number of DTOCs; supporting the early discharge of medically fit people from an acute setting.

The Brent BCF Change Programme is responsible for implementation of the long term changes necessary to achieve health and social care integration. The schemes are outlined below;

4.2. *Effective multi-agency discharge - Integrated Hospital Discharge*

There is work underway at a regional level (lead by WLA and NWL) to implement changes to the way we discharge patients from hospital. Some of these changes include developing a single discharge process, simplifying paperwork, improving the single point of access (SPA) model, and arranging for a lead local authority to assess and commission all packages of care irrespective of where the patient lives.

We recognize the benefit this work will bring to Brent; however these changes are unlikely to be place for this winter. In order to realize some benefits in time for this winter, the decision was taken by the Brent Integration Board in July 2015 to proceed with a phased approach towards an integrated hospital discharge service.

This decision was considered the most pragmatic option to progress towards an integrated model, while achieving some benefits this winter. The coordination of this change will be managed by the Brent BCF Programme.

4.3. *Market shaping of our community bed based offer in specialist rehabilitation and nursing care*

In 16/17 we will look to manage Brent's bed based market to deliver an improved nursing care and rehabilitation bed offer. We acknowledge that the needs of people in Brent are increasing, with more residents requiring CHC support in nursing homes and other complex nursing input such as IVs or specialist 1:1 support to manage behaviour. This work will establish a strategic, long term approach to managing all health and social care placements in the residential and nursing care market.

In order to develop the current care home market to be able to deliver the service models we need, for access by winter 2016/17, planning and development work needs to begin now. Market testing and development take time to ensure it is successful and allows engagement with current providers to develop services and to establish the support mechanisms required to deliver these service models in the community.

The aim of these beds will be to further extend the early discharging of medically fit people from hospital to enable the market to manage more complex nursing needs in a more homely environment. The complex needs continue to be a challenge for hospital discharge and through health and social care joint commissioning we want to support the system to develop the nursing home market to enable them to meet this growing need.

4.4. *Sustaining independence in the community - Integrated Rehabilitation and Reablement*

In April 2016 we will go live with an integrated rehab and reablement service designed to maximize independence and self care in the community and prevent both readmission into hospital and nursing/residential care admissions. This has been jointly commissioned by Brent CCG and Brent Council. The multi-disciplinary team consists of physiotherapists, occupational therapists, social workers, speech and language therapists, dieticians, psychologists, and rehab assistants who will support patients to achieve independence in daily living skills and rehab goals in their own home.

The staff will change the way they work, following a lead professional / trusted assessor model and will aim to work closely with the rehab and re ablement home care providers. We have successfully completed workforce modelling and will focus the rest of 15/16 on moving staff from the Council into Trust, training staff in the new ways of working, developing the home care market to support both rehab and reablement, and ensuring the IT, estates, funding arrangements are in place to support successful go live in April of 16/17. We expect to see benefits from these changes over winter 2016/17.

5.0. Financial Implications

5.1 Core funding for services underpins everything, but additional demand needs to be resourced and this additional demand can only be predicted to a degree. The Winter pressures funding has now been mainstreamed into the CCG budgets. If further monies become available the mechanisms outlined in section 3.5 of this paper will determine where and how best to spend any additional funding.

6.0. Legal Implications

6.1. The legal obligations on the Council changed with the passing of the Health and Social Care Act 2012 ("the Act"), which gave the Council new duties to:

- Improve the health of the people in its area; and
- Take steps to ensure that plan are in place to protect the health of the population.

6.2. The proposed approach of increased integration in relation to winter planning is in line with the Council's legal responsibilities, in particular in relation to public health. The role of promoting integration and joint working in health and social care services across Brent is delegated to the Health & Wellbeing Board and the Integration Board.

7.0. Diversity implications

7.1. All those identified as member organisations for the SRG have committed to ensuring all decisions and actions in response to winter issues are respectful and considerate of the diverse needs of the community. The Brent Winter

Plan and BCF supports the SRG and the H&WB Board to deliver in a fair and equitable way to the community.

Contact Officers:

Phil Porter - Strategic Director of Adults
Brent Council

Sarah Mansuralli - COO
NHS Brent CCG

Sheik Auladin - Deputy COO
NHS Brent CCG

Sean Girty
Programme Director Better Care Fund
Brent Council and NHS Brent CCG