Health and Wellbeing Board

28th March 2017

Report from Operational Director Adult Social Care and Deputy Chief Operating Officer London North West Healthcare NHS Trust

For information

Wards Affected: ALL

Brent Health and Care Plan: Older People's Services Update

1.0. Summary

1.1. The purpose of this report is to provide the Health and Wellbeing Board (HWB) with an update on the development of the Brent Health and Care Plan (the Brent Plan), with a specific focus on Older People's services. It also makes reference to the sector level development for Older People Services through Delivery Area 3 of the North West London Sustainable Transformation Plan (NWL STP).

2.0. Recommendations

2.1 The Health and Wellbeing Board is invited to comment on the programme of work and note progress in the Older People's Services work stream of the Brent Health and Care Plan.

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 October meeting, the HWB endorsed six "big ticket items" for the Brent Plan, and the establishment of a local STP delivery board to oversee its delivery.

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

3.4 The priorities for the Older People's services work stream of the NWL STP are being developed by the DA3 board and informed by the needs and gaps identified by local systems including Brent. The Brent Older People's work stream, whilst aligned to the DA3 priorities, has a very strong local focus and builds on the existing pathways and services available for Older People.

4.0 Developments in the Brent Older People's Services Work stream

4.1 The Brent Older People's work streams main objectives is to join up the existing services across the health and care system, identify the gaps and build a proactive, preventative service pathway that enables Older People to enhance their independence and wellbeing, maintain their dignity and access support closer to home, and wherever possible to support older people to remain in their own communities.

4.2 This work stream entails a complex programme of work across a continuum of settings including; primary and community care, social care and acute services.

It aims to develop and support the operational processes and services, working with both out of hospital care and improving patient flow within a hospital setting to deliver better outcomes and more admission avoidances.

It also incorporates the schemes under the Better Care Fund (BCF) programme which aim to reduce emergency hospital admissions, reduce delays in discharges from health services, and reduce residential and nursing care placements.

4.3 A diagram on Brent Older People Services Pathway attached as Appendix 1 depicts the existing service provision and pathways and the areas for further development to be progressed through this work stream.

4.4 The programme of work has several components but can be categorised into three main areas of work:

- Community (out of hospital) services;
- Acute services and
- Pathway development to link the existing services together to build an integrated, holistic service pathway for older people.

4.5 The main developments so far in 16/17 have been related to out of hospital services and delivering on the BCF schemes. A summary of achievements so far is listed below:

4.5.1 Whole Systems Integrated Care – this builds on existing work to integrate health and social care in Brent through proactive identification of need, risk

and instability. Multi-disciplinary working led by GPs with other services and involvement of patients, carers and the voluntary and community sector is now in place. Since September 2016, Adult Social Care staff are also part of the multi-disciplinary care planning process and information and data sharing protocols are in place. This initiative is a major step towards providing proactive, integrated care to people with long term conditions and supporting them to better manage their own conditions (self-care) and reduce unnecessary admissions to hospital. During the period of April 16 to Jan 17 133 non-elective admissions have been avoided, delivering savings of £316,378.

4.5.2 Integrated Reablement and Rehabilitation Service (IRRS)- This scheme brought together the reablement team from Adult Social Care and the rehabilitation team from London North West Healthcare NHS Trust (LNWHT) to form one assessment and therapy service. The integrated service, which went live in Oct 2016, is a multi-disciplinary team of lead professionals including occupational and physiotherapists, social workers, and other support staff who work with service users to set and help achieve their independence goals. This team works in partnership with private sector home care providers who provide reablement workers for day to day support to users under the guidance of lead professional.

The service is hosted by LNWHT and the integration of health and care teams is enabled through section 75 agreement between LNWHT and Brent Council (Adult Social Care). IRRS is yet another progressive step towards our vision of providing a joined up front line service. The service has so far delivered £436,913 of avoidable costs, supported 226 people to remain at home rather than in a residential or nursing home setting and 88% people who are still at home 91 days after discharge from hospital.

4.5.3 Effective Hospital Discharge – this scheme aims to improve patient flow from hospital into the community and contribute to reducing delayed transfer of care, improve the quality and speed of hospital discharges, and developing greater staff understanding and better communications through colocation and collaborative working.

These objectives are being achieved through various initiatives, both in the community and within the hospital:

Joint commissioning of community residential and nursing step down beds and reablement beds to support Delayed Transfer of Care of patients once medically fit. These beds have allowed for 57 discharges from hospital where patients would otherwise have needed to be discharged into residential or nursing care, and have contributed to reduced averaged length of stay in hospital.

A highly effective multidisciplinary team is in place to ensure effective flow and discharge through the step down beds. This team have considerably improved the through put in the step down beds, supporting 27 people (between Oct 16 – JaN17) people thereby reducing the number of delayed discharges considerably for this winter.

Agreement to the design and implementation of a discharge to assess (D2A) model- to support people to be discharged home with appropriate wrap around health and social care support to assess for longer term care needs. Brent is an early adopter of this model, and in conjunction with ECIP an outline model and pathways have already been co-produced by a wide range of health and social care partners, as well as with the support of the voluntary and community sector and our provider market, ready to be piloted. The pilot is intended to be implemented by April 17.

- West London Alliance (WLA) integrated discharge initiative – Brent is now the lead local authority for Northwick Park hospital, meaning that Brent ASC staff carry out all discharges for Hounslow, Tri-borough and Ealing residents. Reciprocal arrangements are being developed with other boroughs in WLA to support discharge for Brent residents in other hospital trusts. The Brent Hospital Discharge Team (HDT) are now co-located with the discharge team at Northwick Park Hospital, and having a presence on site within the hospital has already facilitated better communication and joint working between hospital and social care staff. 7 day working – ASC have implemented 7 day working, meaning HDT staff are available to support discharges at weekends. This scheme was implemented in April 16 and between April 16 to Dec 16 has supported 93 patients to be discharged on weekends.

  Housing Worker support – a jointly funded housing support worker is now working with the HDT team to review and provide advice for patients approaching discharge and to identify pathways out of hospital for those patients who do not meet the criteria for homelessness legislation and who do not have any social care needs. This post has already achieved a reduction of 214 bed days in the period Oct/Nov/Dec 2016 (compared to the same period last year) and there has been a steady decline in the number of housing related delays across Brent for those patients not covered by the Care Act with 265 delays in the winter of 2015 reducing to 50 in 2016 (Oct to Dec).

5.0 Future Work Programme

5.1 The work programme for Older People services for 17-18 will build on the existing pathways and successes as detailed below.

5.2. Interface with Whole Systems Integrated Care – this work strand will map the clinical and operational pathway(s) linking WSIC to other existing/developing out of hospital pathways and acute pathways. By joining up different services

the system will be more effective in preventing people from reaching crisis and attending A&E. Better pathways will also allow for more effective support for people once discharged from hospital. Better joined up services and pathways will also decrease length of stay, improve and facilitate discharge into community and increase the number of people supported through reablement and self-care routes.

5.3 Care Homes Project – This work is aligned to DA3 Enhanced Care and aims to bring together various initiatives already in place into a single, coherent offer for care homes in Brent. A project board is being set up which will oversee a work programme that focuses on models of care, training needs and workforce development, market management, achieving consistency in quality and pricing and building the capacity of the market to support people with complex needs. The main objective is to improve the quality of care in care homes, reduce London Ambulance Conveyances, reduce emergency admissions and improve the capacity of the market to meet the needs of older people.

5.4 Front door admission avoidance and Acute Frailty Model – aligned with the DA3 work stream, Response in times of crisis, this work stream addresses the current gap in the Brent acute frailty “response in times of crisis” service pathway. This will involve designing a model that will make better use of existing resources to manage older people who are attending A&E more proactively. For older people who do have to attend hospital, a more comprehensive consultant lead, multi-disciplinary assessment and management service at the ‘front door’ will support older people to be assessed more quickly and to be supported back home or to an out of hospital care setting more quickly, thus reducing the average length of stay. The model is likely to be based around an expansion of existing services, for example, the STARRS service or IRRS and will include developing operational links to community support such as, WSIC, Early Supported Discharge and step down beds. The objective of this work strand is to reduce the conversion rate of A&E attendances to admissions through the acute medical assessment unit and short stay wards and to reduce the length of stay in older people’s wards.

5.5 IRRS and hospital discharge –aligns with DA3 Care at Home and WLA Integrated Discharge initiative. This work strand involves building on the work done to develop an integrated reablement and rehabilitation service. It aims to build a comprehensive operational service model to create an integrated discharge response for people who are medically fit to leave the acute setting. The objective of this work strand is to enable a comprehensive integrated response to discharge, enable more people to be supported through the

reablement and rehabilitation service, reduce long term care provision and reduce permanent placements to care homes.

5.6 Discharge to Assess (D2A) – aligns with DA3 Discharge to Assess.

This work strand supports the national direction of travel endorsed by Nice Guidelines (Dec 15) of supporting patients to have assessments for longer term needs outside the acute setting.

The main focus will be to enable a cultural and operational shift in the acute and community service pathway to discharge patients safely home with the necessary health, care and wellbeing wrap around support, following which their longer term needs can be assessed in an environment more conducive to gathering a holistic picture of the person and their wants and needs. Brent is developing a business case for implementing this model and a six month pilot to establish learning and assess outcomes.

The main objective of this work strand is to improve outcomes for people, facilitate appropriate discharge, and enable people to regain independence and an opportunity to assess needs outside the acute settings. It will reduce length of stay and reduce long term packages of care for Adult Social Care and Continuing Healthcare, as well as delivering better outcomes for older people.

5.7 All of the planned work streams as set out above are interdependent, and a key aim of the Older People's programme will be to identify, map and improve the pathways and interdependencies between the various services. This will ensure that Brent has a coherent, efficient, proactive and seamless pathway for older people.

6.0 Finance Implications

6.1 Each of the work strand as set out above will require a detailed business case to identify the costs and benefits to the health and care economy. These will be developed by each of the lead as work progresses.

7.0 Legal Implications

7.1 Whilst this document is an update for information purposes only, from and Adult Social Care perspective, it is important to ensure that throughout the project, the requirements of the Care Act 2014, in terms of promoting wellbeing, preventing, reducing or delaying needs are complied with so that we continue to meet our statutory obligations so that our actions do not leave the local authority open to legal challenge.

8.0 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 work streams to ensure that equalities issues are addressed and or mitigated as part of the implementation process.

9.0 Staffing / Accommodation Implications (if appropriate)

9.1 Each work stand will need to identify the staffing and accommodation implications for that particular scheme as part of the business case development.

Contact Officers

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