Brent Better Care Fund Plan 2017-2019

BRENT COUNCIL AND NHS BRENT CCG (V1.0 FINAL)

Contents

Brent Better Care Fund Plan 2017-19

1. Introduction

The Better Care Fund (BCF) is an important change vehicle for driving forward health and social care integration at pace and scale. It creates a local single pooled budget to incentivise the NHS and local government to transform services and provide people with the right care, at the right place, first time and to deliver care that is sensitive to people's specific needs and delivered in partnership to the highest standards. As such it is an important part of the NHS and local government's present and future plans.

The following document is the joint 2017-19 Better Care Fund Plan for the London Borough of Brent (LBB) and NHS Brent Clinical Commissioning Group (CCG).

Local Authority	London Borough of Brent
Clinical Commissioning Group (CCG)	NHS Brent CCG
Value of BCF pooled budget: 2017/18	£31.4m
Date submitted to HWBB	22nd August 2017
Date submitted to NHS England	11th September 2017

2. Case for Change

The refreshed local Joint Strategic Needs Assessment (JSNA), provides a clear evidence base for the prioritisation of schemes under our local BCF programme.

Brent's population is young, with 35.1% aged between 20 and 39; the 65 and over population makes up 11% of the population. Brent is ethnically diverse: 66.4% of the population is Black, Asian or other minority ethnicity (BAME). This has increased since 2011, when BAME groups made up 63.7% of the population. The Indian ethnic group currently make up the highest proportion of BAME (19% of the population), followed by Other Asian (12%). The White group make up 33%.

Nationally, Brent ranks 39 out of 326 local authorities in England (where 1 is the most deprived) on the 2015 Indices of Deprivation. However, the overall ranking masks some of the very high levels of deprivation that exist in parts of the borough. In 2012, 24.8% of children and young people (aged less than 16 years) live in poverty - this is worse than the England (19.2%) and London averages (23.7%).

In Brent, life expectancy for females born between 2011 and 2013 is 84.9 years. This is higher than the male life expectancy, which is 80 years. In Brent, healthy life expectancy for males in 2011 - 13 was 64.8 years. This was similar to the England average which was 63.3 years. It is noted the life expectancy has increased in Brent from previous JSNA assessments.

Key facts	**Local Providers**
• 328, 600 Brent residents • 369,166 GP registered population • 14 Nursing Homes	• London Northwest Healthcare NHS Trust • Central and North West London NHS Foundation Trust (community & acute) • Imperial College Healthcare Trust • Royal Free Hospital Trust

	• 62 GP Practices • 3 GP Networks forming 1 GP Federation • London Ambulance Service • Brent Community and Voluntary Sector • Nursing and Care Home sector

Five-Year Forward View

NHS England (NHSE) published (2015) the Five Year Forward View setting out a national requirement for all local health and care systems to be integrated by 2020. In December 2015 it was announced that local areas would need to deliver this vision through local Sustainability and Transformation Plans (STPs). This plan will help local organisations to deliver better, joined up care which will help improve people's health and wellbeing and the quality of care people receive. In addition, it will help Brent to reduce the gap between available funding and the actual costs of meeting increasing demand. Fundamentally it is about focussing on the needs of people at or in the place they live rather than individual organisations.

Sustainability and Transformation Plans

The NWL STP (October 2016) sets out five delivery areas:

1. Radically upgrading prevention and wellbeing.
2. Eliminating unwarranted variation and improving long term condition management.
3. Achieving better outcomes and experiences for older people.
4. Improving outcomes for children and adults with mental health needs.
5. Ensuring we have safe, high quality and sustainable acute services.

Brent has developed local delivery plans contained in the Brent Health and Care Plan, which take into account these priorities with the triple aim of:

- Improving health and wellbeing
- Improving quality of services
- Meeting the financial challenges.

In Brent – and across North West London (NWL) - there are significant pressures (including financial pressures) on the whole system. NHS Brent CCG will have to find approximately £17.5m net savings in 2017/18 and the requirement is expected to increase slightly each year in order to close the gap over the next five years. Brent Council will have a £17m gap without applying the Council tax precept and £9m if precept is applied each year up to 2020. Both the NHS and local government need to find ways of providing care for an ageing population, and managing increasing demand, with fewer resources. So, we need a clear understanding of the needs of the local community, a clear plan for integrating service provision where possible, and a commitment to reducing overlaps and inefficiencies in the local system. We are seeking a

health and care system that is highly productive and able to support the growing needs of our population, whilst improving patient experience and outcomes.

Meeting local needs - challenges and opportunities

There is collective understanding between the CCG and Council of the shared challenges we need to address to meet the needs of our local population.

Need	Description
Improve Mental Health & Wellbeing	• 1.1% of population have severe or enduring mental illness • 34,000 (2014) thought to have common mental health disorder • Pressures relating to housing and or employment can have negative impact on people's mental health and wellbeing
Tackle childhood obesity	• 38% of children 10-11 classified as overweight / obese
Reduce Smoking	• 17% smoking prevalence with 14% amongst 18+
Increase exercise	• 53% of population do not take part in moderate or intensive exercise
Reduce Social Isolation	• Only 39% (2013-14) of adult social care users report that they have as much social contact as they would like
Tackle Diabetes	• 15% of the Brent population will have Diabetes by 2030 (England average 9%)
Support people to better manage their long term conditions	• Only 56% of those with an LTC feel supported to manage their own condition

These challenges are significant, but there are also real opportunities to tackle them in a more integrated way. Service inefficiencies can mean patients often have less than ideal experiences, people's own time and ability to manage their own health and care is not always valued and services can be overly focused on

treatment and helping people get well, rather than preventing them from becoming ill or vulnerable in the first place or enabling individuals to be in control of their own wellbeing.

The STP and Brent Health and Care Plan are focused on meaningful change so by 2020 we will have in place:

- Improved health and wellbeing – including health, employment, housing and lifestyle.
- Improved care and quality – through a joined up workforce with the right tools and support to deliver better care.
- Improved efficiency and use of finances – to help reduce the financial gaps

3. Brent's vision for health and care

Brent CCG and the Council will continue to work towards increased integration and better-coordinated care for the communities of Brent. All participating organisations in Brent's BCF Plan are committed to our local vision for and are prepared to adapt and play a proactive role to facilitate local change.

Our **vision** is:

"We want to improve the quality of care for individuals, carers and families, empowering and supporting people to maintain independence and to lead full lives as active participants in their community"

4. Better Care Fund and the Improved Better Care Fund

The strategic plans for Brent will be delivered through the Better Care Fund (BCF) to provide better and more integrated health and social care. The BCF is an ambitious programme to encourage integration where CCGs and the Council enter into pooled budget arrangements, (s.75 of the NHS Act 2006) which supports an integrated spending plan.

In 2016/17, £23.7m was pooled in the BCF. A number of joint initiatives have and are continuing to be implemented across Brent and are described in this plan. These have started to deliver real improvements through collaborative working and have highlighted further areas of work to better align with the priorities in both the STP and Brent Health and Care Plan.

From 2017/18 a new funding element has been added to the Better Care Fund - the Improved BCF (IBCF). This new funding has been paid directly to Brent as a local authority grant and is part of the IBCF. The allocation for Brent is £6.9m for the 2017/18 financial year.

The funding is granted on the condition that it is pooled under the BCF and can only be used for purposes of:

- Meeting adult social care needs;
- Reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready;

- Ensuring that the local social care provider market is supported.

The Government has made clear that part of this funding is intended to enable councils to provide stability and additional capacity in the local care system. Councils will therefore be able to spend the grant, including on the commissioning of care, provided the conditions set are met and spend has been locally agreed with the CCG in line with the BCF plan.

The IBCF also recognises the pressures on the NHS and the investment will contribute to meeting the goal to reduce delayed transfers of care to occupying no more than 3.5% of hospital bed days by September 2017 (in the 2017-18 NHS England Mandate for NHS organisations)**.** The BCF in Brent has been running for two years and evidence (July 2017) shows that we have started to meet these targets; however we are not complacent and will continue to manage and monitor the situation in line with expectations.

Funding can be allocated across any or all of the purposes outlined above and the Council and CCG will jointly determine how they will manage local pressures. The IBCF is subject to a joint NHS England and local government assurance process and a time table has been set, including submission of the Brent BCF Plan by 11th September 2017.

IBCF investment

In Brent the IBCF funding through the BCF Plan will enable us to invest in transformation of our system to deliver integrated care. Specific areas where we will invest to support this strategic objective include:

- **Home First (Discharge to Assess)** – investment in the hospital discharge team and expansion of the Home First programme currently being piloted.
- **Provider market stability** – including block purchasing of nursing/EMI/residential beds across Brent to provide additional capacity, commissioning of home care on a patch basis to increase capacity and responsiveness and implementation of key elements of the Enhanced Care Home model.
- **Preventative programmes** – joint investment in prevention and demand management programmes (Self Care, SIBI and assistive technology) and early discharge planning such as continuance of the step down beds, investment in reablement provision and increase in Occupational Therapy staffing.
- **Increased capacity for hospital discharge** – through investment in multiagency teams (OPALS, STARRS, WSIC teams, OT capacity), and a performance and brokerage post to support timely monitoring of patient flow and activity.
- **Increase capacity in the market place** – through block purchasing of reablement provision to support discharge to asses and provision of same day packages at home and provision of extra care sheltered housing as an alternative to residential and nursing care to be used for reablement provision.

These strategic work areas will be incorporated as part of the scheme work plans described later.

Funding Summary	£m's	
	2017/18	2018/19
Scheme 1: Whole system integrated care	3.188	3.247
Scheme 2: Effective Hospital Discharge	9.983	10.090
Scheme 3: Enhanced Health in Care Homes and Joint Commissioning	6.691	6.912
IBCF	6.973	9.440
Disability Facilities grant	3.971	4.343
BCF and STP Project Management	0.600	0.600
Total BCF pooled budget	**31.406**	**34.632**

5. BCF 2016-17 programme progress and plans for 2017-19

Three main schemes have been running since 2015-16 which collectively support more effective joined up acute, community, primary and social care working, supported by a vibrant voluntary, community and provider market. Furthermore, these schemes support the wider STP programme such as Home First, implementation of the frailty model, SIBI, transforming care and Like Minded initiatives. As such it is an enabler for the whole Brent Health and Care Plan. In this section progress made to date and plans for 2017-19 are described.

Scheme 1: Whole System Integrated Care (WSIC)

The WSIC model of care and provider model (Appendix 1) has been in place for the last two years. Its development continues as it is the flagship model for integrated and multidisciplinary out of hospital care in Brent. The scheme supports adults with one or more long term condition (LTC) and a range of bio-psycho-social needs. The overarching objective is to empower patients to self-care and self-manage and – where required - to provide timely intervention in primary and community settings to manage down levels of complexity, need and risk.

It seeks to achieve the following key outcomes:

- People will be empowered to direct their care and support and to receive the care they need in their homes and local community.
- GPs will be at the centre of organising and coordinating peoples care – which will be coordinated around the individual and delivered in the most appropriate setting
- Our systems will enable (and not hinder) the provision of integrated care and funding will flow to where it is needed most
- Patients and communities will be recognised as assets.

Progress to date

In 2016/17 the model took a number of major steps forward with the development of a WSIC Data Warehouse containing integrated health and social care data, the addition of voluntary sector Care Navigators to the multidisciplinary teams, and a new provider and operating model to bring more consistency to the offer to patient and patient pathways and an independent review to identify and close remaining design and delivery gaps and to maximise the impact of the WSIC model. The model has significant potential and is a platform for care planning, complex case management and self-care. It is an integral part of our 2017/19 plans.

High quality Care Plans include a focus on proactive planning, optimised support, crisis planning (including information that services can access in the case of exacerbation), development of self-care goals and objectives and a review of all aspects of health and wellbeing (social and psychological as well as the medical). As such it is an integral feature of WSIC where patients and carers come together with their GP to make decisions about how best to manage their LTC.

In 2016/17 a consistent Care Plan template was rolled out for all Brent Practices/Network to use. The template also included the Patient Activation Measure (PAM) score and trend – the tool we are using to identify the level of knowledge, skills and confidence an individual has to manage their own conditions. In 16/17 approximately 7,500 patients were invited to develop a Care Plan with their GP. This has enabled a direct reduction in non-elective admission to the hospitals as shown in the table below.

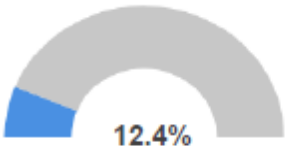
2016/17

Baseline Cost (15/16)	Actual Cost (16/17)	Savings Cost	Baseline Activity	Actual Activity	Non-elective admissions
£7,573,686	£6,989,372	£584,314	2712	2446	-266

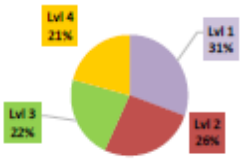
- A **Complex Patient Management Group (CPMG)** meets weekly and reviews the complex cases of individuals who are referred for Case Management support by their GP. They focus on caseload management and the development of a delivery plan for Case Managed patients scheduled over that quarter (0-12 weeks). Tasks are allocated to members of the Core Team – initially there was an increase in number of patients referred and managed at CPMG but this number has fallen recently with patients instead being managed at practice level. The CPMG team also refers complex patients from residential and nursing homes. Data shows that there was an improvement in the number of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services.

- Monthly **Multi-disciplinary Group (MDG)** meetings are hosted by the GP Network that meets with the Network Core Team, with additional representation from individual GP practices, partners and specialists as required. This group reviews exceptionally complex cases, sharing skills and best practice, training and development needs and also sharing information on services available to Brent patients and carers. Both CPMG and MDGs are multi agency in their membership.

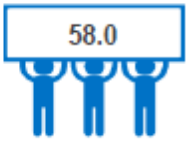
- **Patient Activation Measures (PAM)** were introduced in 2016 to improve the confidence of patients to self-care, and in partnership with our voluntary sector five care navigators were recruited to support patients and carers to set goals and access support in the community. PAM enables moving patients from being passive recipients to a more collaborative relationship where they are active partners in their own health and wellbeing. Now that PAM is established, there will be a drive to increase the uptake of the licenses in 2017/18. As at quarter 1, 598 (10%) of the 6000 licenses applied for have been used.



742 Licences in Use



Level Breakdown



Average Score

PAM 2016/17 activity

- **Care Navigators** support other professionals in the Core Team (working with patients requiring further support through Case Management) to develop individual Care Plans that capture an individual's ability to manage their own health and care. Input from the Care navigators are valued by the professionals and feedback received shows that there has been a positive impact on patients in enabling them to self-care and self-manage their condition in the community.

WSIC focus for 2016/17

Plans for 2017/19

WSIC is now embedded in Brent and as such provides further opportunities to develop the Integrated Operating Model by focussing on specific areas such as hospital discharges and care homes. There are plans

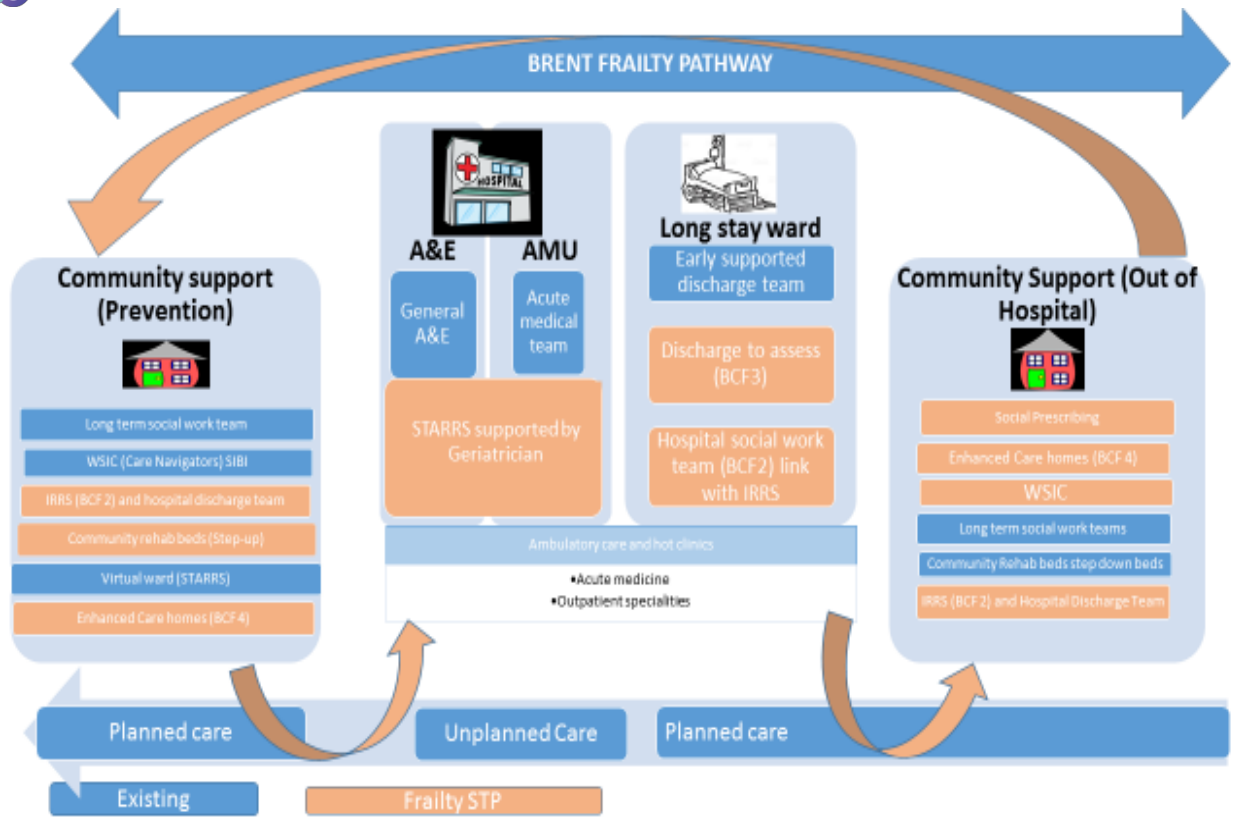
to work towards establishing integrated pathways and processes across all providers and aligning these with the priorities contained within the STP and Brent Health and Care Plan. To enable this we will specifically focus on a number of areas to further develop this ambition.

We will:

- Align and strengthen the Integrated Operating Model by developing integrated care pathways for elective discharge planning and integrate this into existing discharge processes and pathways working closely with the CPMG / GP Network and multi-disciplinary teams.
- Explore Community Matron role in GP Networks to follow patients in and out of hospitals, link admission avoidance and discharge to GP Networks with access to "step up" services.
- Improve data intelligence capacity by reviewing health and social care data over the past two years to ensure that networks are aligned to need rather than just registered population, and work towards shared performance indicators utilising existing system dashboards.
- Further integrating and aligning social work staff and community nursing with the localities model to provide improved access and working of the MDGs.
- Extend and enhance integrated working through the work of the newly established Provider Forum.
- Improve the case finding and care planning process to ensure that the case finding process identifies people who have the highest needs.
- Agree the most effective way of providing a holistic social prescription service that targets social isolation and reduces inappropriate use of primary care, statutory social care services, A&E and LAS, and one that supports carers and those who might otherwise slip into dependence.
- Development and implement the Older People's Assessment and Liaison Service at A&E (Northwick Park Hospital) to assess and decide quickly the most appropriate pathway for health and care.
- Extend the role of the Care Navigators to support the SIBI programme.
- Further strengthen the assurance model across the system by reviewing the programme governance structure and updating the performance management criteria.
- Explore accountable care models to enable better alignment of incentives across care providers to develop a stronger outcomes focus enabling and sustaining service transformation.

Scheme 2: Effective Hospital Discharges

Our 2016/17 BCF plan placed an emphasis on improving discharges and accompanying processes from the acute hospitals, which resulted in successfully bringing together disparate teams from partner organisations and removing structural barriers to effective collaborative working towards a single goal, that of enabling patients to return back to their home or place of residence as soon as is possible. This programme of work forms an essential part of the Brent Frailty Pathway (below) providing a co-ordinated approach to return people back home from hospital. This approach will continue into 2017/19.



Brent Frailty Pathway

The **objectives of this scheme** are to:

- Support more integrated, effective and streamlined hospital discharge arrangements based on a discharge to assess model (D2A) for Brent residents.
- Deliver hospital discharge as part of the continuum of care as set out in Brent's Frailty Pathway with clear pathways in and out of Brent's WSIC model as described above.
- Deliver discharge pathways that are organised around the person, focusing on individual need and empowering independence wherever possible.
- Work towards developing fully integrated health and social care services which support effective hospital discharge.

Progress to date

This scheme builds on the 2016/17 BCF scheme 2 and the scheme formerly known as Scheme 2.5. Through these schemes, we **successfully integrated the reablement team** from Adult Social Care and the STARRS community rehabilitation team from London North West Healthcare NHS Trust (LNWHT) to form an Integrated Rehab and Reablement service. It is a multi-disciplinary team made up of lead professionals including occupational therapists and physiotherapists, social workers, care assessors and other support staff who work with service users to set and help achieve their independence goals. The team works in partnership with private sector home care providers who provide reablement home care packages to service users under the guidance of the lead professional. The scheme has streamlined the services clients receive when exiting hospital and / or while being supported within a community setting.

Through scheme 3, in 2016-17 we implemented a range of community and hospital based initiatives to facilitate effective hospital discharge as detailed below:

- A **discharge to asses** (**D2A) pilot Home First,** has been established at LNWHT (April 2017). At the time of writing, a total of 83 appropriate referrals for the Brent Home first team have been received. These are medically fit patients who have facilitated discharges safely home with the team often responding within the day. At present 5-7 patients are being discharged earlier per week as part of the pilot phase saving a total of 166 bed days. A six month risk and benefit report will be produced and planning is well underway to ramp up the complexity and number of patients in preparation for the seasonal increase in activity and demand with the team aiming to achieve 13 discharges a week through this process by the end of September 2017.
- **Joint commissioning of community residential and nursing step down beds and reablement beds** to facilitate timely transfer of care of patients once ready for discharge. These beds, supported by a highly effective multidisciplinary team, ensures effective flow and discharge through the step down beds. The team has considerably improved the throughput in the step down beds, thereby reducing the number of delayed discharges for the 2016 winter.
- **West London Alliance (WLA) integrated discharge initiative** where Brent is now the lead local authority for Northwick Park hospital, which enables Brent Adult Social Care (ASC) staff to 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. This reduces areas of overlap and improves access for patients to professional staff.
- We **co-located our Adult Social Care Hospital Discharge Team (HDT) with the acute discharge team at Northwick Park Hospital**, and having a presence on site within the hospital has already facilitated better communication and joint working between social care and hospital staff with many issues being dealt with speedily through joint working and has facilitated joint learning of each other's roles.
- **Implementation of 7 day working**, HDT staff being available to support discharges at weekends. A dedicated housing support worker, to work 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 has resulted in substantial reduction of housing related delays in 2016/17 (from 265 in Oct – Dec 2015 to 50 in Oct – Dec 2016).

Plans for 2017/19

Going forward our plan is to build on the work done to date, extending or developing more integrated teams and services, and ensuring discharge pathways support people seamlessly.

We will:

- Design a comprehensive service model building on work done to date in integrating the rehab and reablement service, which will enable more people to be supported through the service, reduce long term provision and reduce permanent placements to care homes.
- The service would also look to model a rapid response service and integrate with the existing health rapid response service. This would enable rapid and holistic assessment of a person's needs and allow intervention at an earlier point, possibly keeping individuals at home longer.
- Enhance the model through offering tele-health and telecare which will both support and facilitate discharge home from hospital but also prevent hospital admissions. Whilst this is already in place through Brent's Integrated Community Equipment Service the intention is to work towards ensuring

that Social Care staff and LNWHT therapists are able to effectively assess and prescribe the necessary equipment required thereby further reducing unnecessary delays.

- Explore earlier housing and voluntary service input into admission avoidance and discharge planning processes for signposting/advice and guidance around housing (including adaptations and repairs, access to Telecare services), support with benefits, and connecting people with universal services to reduce risks of re-attendance.
- Make the *Home First* initiative the default pathway by September 2017, and develop a programme plan to increase the complexity and number of patients (13 per week) receiving a facilitated discharge in support of the DTOC target. This will enable a cultural and operational shift in the acute and community service pathway to discharge patients safely home within an integrated service and pathway led by professionals, where the assessment of clients' needs is undertaken in their home environment. This is more conducive to gathering a more holistic picture of needs and then facilitating the timely provision of health and social care support and or reablement services.
- Develop an Integrated Complex Discharge Team bringing together health, social care, housing and the voluntary sector with in-reach from community services such as community nursing and GP networks to improve the handover of patient's information across community and hospital services.
- Look at ideas to develop a voluntary led service to support vulnerable patients where there may be no statutory requirement on Adult Social Care to provide services but without support there is the risk of deteriorating health and social resilience and readmission to hospital.
- Review 7 day working and identify benefits and actions required to streamline further.
- Establish a clear D2A model in Brent linked to the work of the MDGs, a key priority across the NWL STP footprint.
- Identify development and training needs to enable cross sector learning through the Change Academy.

Scheme 3: Care home market changes

This work is aligned to STP DA3 Enhanced Care in Care Homes and aims to bring together various initiatives already in place into a single, coherent offer for care homes in Brent.

The **objectives of this scheme** are to:

- Develop the care home market capacity to meet on-going and future demand.
- Reduce London Ambulance Service call outs and emergency admissions from poorer performing homes through supporting enhanced care in Care Homes.
- Improve the process for complex discharges from hospitals to support the market and thereby reducing delayed discharge.
- Ensure residents in these settings of care receive an integrated core and enhanced service offer from primary care and other community based services.
- Ensure that care received in care homes is of the highest quality and supports residents to be as independent as possible.

Progress to date

In 2016/17 a **stakeholder project board** focusing solely on care homes in Brent was established. The board

has focused on programmes in support of joint information and intelligence sharing, 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.

To date the board has overseen and supported the achievement of:

- **Joint Intelligence & Performance Monitoring** – agreement on terms of reference to establish a joint intelligence & performance group for Brent. Bringing together relevant provider representatives across health and social care to review data on activity and quality to address quality and safety and capacity within the care home market.
- **Integrated training** – a training framework offering needs identification and integrated health and social care training in support of mandatory and recommended training to meet CQC standards and local monitoring requirements.

Plans for 2017/19

We will:

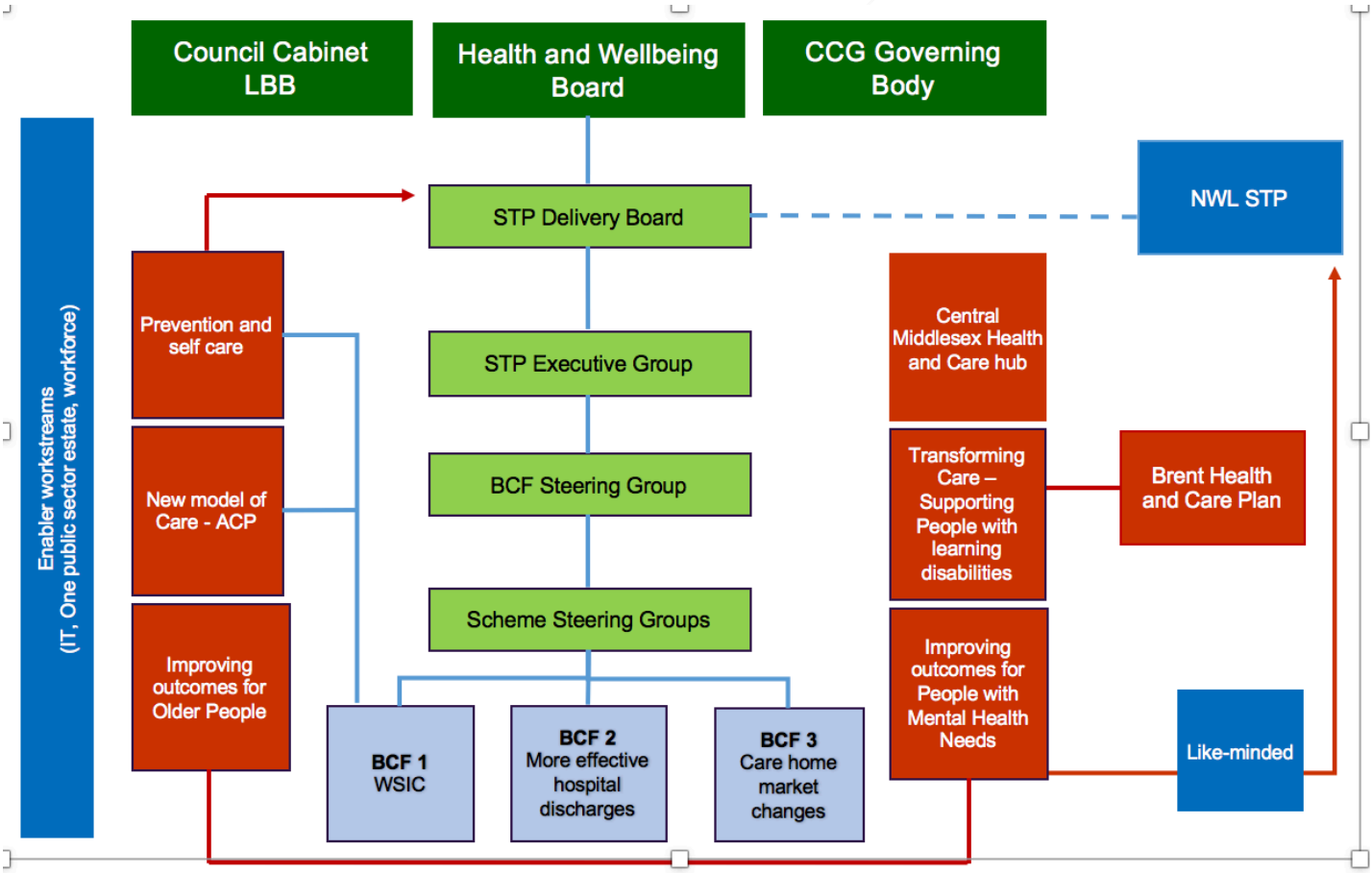
- Working with the local care homes forum, develop an enhanced model of health and social care to support frail elderly patients and those with multiple complex long term conditions in a planned, proactive and preventative way. A series of initiatives to support this include;
    - Develop a comprehensive medicines optimisation programme working with the CCG medicines management team (a part of the primary care team) to ensure patients have access to medication review and optimisation advice, are supported to take medications appropriately and avoid unnecessary polypharmacy.
    - Introduce impartial trusted assessors to carry out assessments of elderly patients in hospital on behalf of multiple homes. This will assist in improving the quality and speeding up the two way transition between discharges from the hospital and the care home.
    - Explore development of a Brent Early Intervention Vehicle where a dedicated community based ambulance staffed by a Paramedic or Emergency Care Practitioner and Health and Social care professional respond to triaged 999 calls to prevent avoidable A&E attendances.
    - Implement the "Red Bag" in Brent which helps to keep important information about a care home resident's health medication which is easily accessible to ambulance and hospital staff to help determine the treatment a resident needs quickly.
    - Further develop the enhanced service provided by the local GP Networks which provides a multidisciplinary support to nursing, residential and housebound patients from 8am-8pm over 7 days. The service provides proactive care through care planning, case management, ‘ward rounds’ and medicines management and reactive care with the homes and patients able to contact the service when they need access to a GP.
- Develop a complex care quality and development framework to help shift the focus towards prevention and early intervention, to reduce, or delay, people becoming frail or developing complex needs. This includes identifying appropriate training as well as explore incentives for enhanced rates paid to those homes who can offer quality care for complex patients.
- Appoint a joint commissioner for nursing and residential care to aid joint or reciprocal

commissioning and contracting with care homes and to reduce inefficiency and make better use of resources.

- To develop a joint Quality Improvement Team to take a proactive approach to improving quality of care in care homes. This team will work with homes to support them to improve the quality of care, supporting them to develop and deliver improvement plans and providing training and support across the sector.
- To develop a single brokerage and placements function across the CCG and Local Authority for all people requiring residential, nursing or community care, regardless of whether they are council or CCG funded.
- Use the intelligence provided by the Care Analytics annual review of nursing and care homes and the WSIC Data Warehouse and incorporate this with learning from vanguard sites to inform and refine our planned actions.

6. Delivery and Governance structure

The BCF plan overall is accountable to the Health and Wellbeing Board through the STP Delivery Board and the following diagram illustrates the reporting and governance structure.



Roles and responsibilities of each body within the delivery structure is described further below:

Health and Well-Being Board sets the strategy for Brent Health and Care Plan and delegate's authority to the STP Delivery Board. Approves the BCF plan and section 75 agreements and remains accountable for

integration.

STP Delivery Board provides system wide leadership for the delivery of STP work streams in Brent. It is made up of commissioner and provider strategic leaders who are accountable for the delivery of STP work streams in Brent. The board will provide strategic oversight, both support and challenge to the delivery of the six work streams including the three BCF schemes. Members will act as the Integration champion within their host organisations to help manage and resolve issues and risks (both political and clinical). They will make strategic links to other transformation activities impacting the Health and Social Care Economy in Brent, monitoring interdependencies. They will report progress against the STP work streams and other integration initiatives to the Health and Well Being. The Board is co-chaired by the Strategic Director of Community Wellbeing Brent Council and the Chief Operating Officer Brent CCG and supported by the Director of Integration.

STP Executive Group is made up of the CCG and Council leads who are responsible for providing senior operational oversight, financial scrutiny, and validation. This includes financial management of s75 and supporting financial decision making for the implementation of integration.

BCF Steering Group is responsible for development of the BCF plan and implementation of individual schemes. The group is made up of the project managers and scheme SROs from both the CCG and Council who are responsible for analysis, planning, coordination and realisation of benefits from integration in Brent. The meeting is chaired by Operational Director Adult Social Care, Brent Council and Deputy Chief Operating Officer Brent CCG and supported by Director of Integration.

Scheme Steering Groups are made up of appropriate commissioner and wider provider representatives responsible for operational viability and operational delivery of the changes necessary to achieve the integration outcomes. The scheme Steering Groups are responsible for developing models of care, standard operating processes, KPIs to measure success / performance and working with providers through commissioning processes to ensure reconfiguration of existing services in line with plans. This also includes engagement, communication, risk & issue management, and dependency management. Joint Chaired by Health Scheme SRO & Council Scheme SRO; supported by Project Managers; and attended by Director of Integration as required.

BCF Programme Management

The BCF steering groups will ensure operational delivery of the 2017/19 BCF plan, including establishing appropriate scheme resourcing to deliver the scale of change within the required timescales.

The Interim Director of Integration is responsible for ensuring that the overall plan for BCF is delivered and that scheme steering groups deliver outputs, escalating issues and collating risks and issues relating to scheme delivery.

A high level BCF implementation plan incorporating all the actions from other related pieces of work such as actions arising from the high impact change models self-assessment, STP plans and specific BCF scheme plans are being developed and will be in place by October 2017. This will include scheme specific dashboards and a benefits realisation plan to enable local monitoring. A risk and issues log for each scheme will be further refined and monitored through a central BCF PMO function. This will help to ensure that all actions identified in various work streams are collated and centralised to enable effective management of all projects. Regular communications with all stakeholders on progress being made will also continue using existing channels.

It is recognised that these are cultural change projects and there will be a need to establish learning networks and workshops where issues can be tackled and resolved. This includes actively taking part in established NWL learning networks but also developing relationships with other specialist forums and organisations to ensure sharing and learning across the BCF family.

Project management arrangements for BCF are currently being reviewed to ensure that adequate support is provided to scheme leads and management of work plans.

Brent Integration Programme Risk Log

The Brent Integration Programme risk log is used to manage risks at scheme and programme level and to ensure they are regularly reviewed and escalated as appropriate.

In addition, a scheme risk register will be maintained and updated by each Scheme Steering Group. Reports will be presented to the STP Executive Group, STP Delivery Board and ultimately to the Health and Wellbeing Board. This will enable risks at each level to be highlighted and managed.

The **main high level programme level risks** include:

- Shifting resources to fund new joint schemes may destabilise existing providers in the acute sector.
- Absence of robust baseline data and the need to make decisions based on assumptions may result in unachievable financial and performance targets for 2017/18.
- Operational pressures restricting the ability of the workforce to deliver the vision may reduce the rate of change (or the scale of change).
- Any possible misalignment between the Council and the CCG may reduce the focus on delivery, as these differences are resolved.

However, there is confidence amongst partners that any risks to the programme can be identified and dealt with in a timely manner.

Effective joint working arrangements in place

There is a good history of collaboration in Brent. We recognise the value in working together both across NWL and locally to deliver our collective aims of achieving improvements in health and wellbeing, care and quality, and finance and sustainability. NW London has one of the most established whole system partnerships in the country, with a strong history of pan-borough working through the long-established West London Alliance, NHS NW London and individual commissioners and providers as well as academic and workforce institutions. Lay partners are represented across the system and leadership. We are working together on a number of work streams both at a strategic and operational level such as, STP, BCF, mental health, transforming learning disability services and discharge to asses.

At each level within the BCF governance arrangements both Council and CCG staff are matched with their equivalent counterpart, i.e. each BCF scheme has two SROs, one from the Council and one from the CCG as well as membership drawn from a wider group of partners ensuring a multi-agency approach. There is a jointly appointed project manager, acting on behalf of both SROs. These SROs meet monthly to review progress at Steering Group meetings and ultimately report into the STP Delivery Board.

We have also embedded the BCF in the work of the local A&E Delivery Board to ensure operational and strategic alignment. The Board is chaired by the Brent, Harrow and Hillingdon CCGs Accountable Officer and CEO of the LNWHT and includes membership from the Brent COO, and Brent Director of Adult Services. The six work stream areas include;

- Care Homes
- 111 & LAS Diversion
- Intermediate Care & Rapid Response
- ED Improvements
- Frailty Pathways
- Discharge to Assess (D2A).

Brent leads from the CCG and Council provide regular updates on progress of BCF schemes and on performance outcomes.

7. Meeting National Conditions

BCF plans will need to be formally submitted by 11th September 2017. The plans will need to respond to the priorities of all the BCF partners as well as meet four core national conditions:

1. Plan is jointly agreed between the Local Authority and CCG;
2. NHS contribution to social care maintained in line with inflation;
3. Plan contains agreement to invest in NHS commissioned out-of-hospital services;
4. High Impact Change Model for Managing Transfers of Care is implemented.

National condition 1: Plan to be jointly agreed

Brent CCG and Council CCG have worked jointly and have actively engaged providers in the development of the BCF plan since January 2017 both at an operational and scheme level within the Steering Groups, and at senior leadership level through the Brent Steering Group and STP Older People's work stream. The Older People's work stream is jointly led by the Adult Social Care Operation Director, Brent Council and Deputy Chief Operating Officer, London North West Healthcare NHS Trust. The direction of travel for this work stream was agreed at the March Health and Wellbeing Board meeting.

Local acute providers recognise the service change consequences of the BCF Plan, i.e. on activity and income, as these, particularly the targeted reduction in Non-Elective Admissions (NEL), have been discussed as part of local contract negotiations for 2017/18. BCF metrics also align with those within the Brent CCG Operating Plan for 2017/18.

In addition, community and voluntary sector providers have been actively engaged in shaping the schemes and their outcomes.

With Scheme 1, Whole Systems Integrated Care (WSIC), the key providers are GP provider networks. They continue to work collaboratively to be in a position to assure the CCG of their ability to bid for and hold the

contract delivering the outcomes and benefits of integrated care to their patient populations. In addition, it is now established practice that the team leader /deputy team leader from Adult Social Care is in attendance at weekly Complex Patient Management Group meetings to support multi-disciplinary case management. Initial discussions have commenced with the Council's housing service to involve them in the care planning process to enable supporting people with housing related needs.

The Voluntary and Community Sector are also actively engaged in the Care Navigator initiative and host the care navigators, who support people with case management and link them into a wide range of community services.

LNWHT is one of the providers participating in the newly established integrated rehab and reablement teams to be implemented as part of Scheme 2, and is actively involved in the development of the individual initiatives within Scheme 3, *More Effective Hospital Discharge*, including the local DTOC action plan. Any fundamental changes agreed in how nursing homes operate as part of Scheme 3 will be reflected in changed contractual terms and conditions where appropriate. Key messages have been shared with the Nursing Home Market (PIV – Private, Independent and Voluntary providers) at a broad level around the work we wish to do to support them to improve quality, build the right capacity, and manage a fair price for care. As this scheme moves into the design phase, much more detailed planning will be shared with providers and we will fully engage providers at various levels via forums, working groups and implementation of pilots alongside our usual forms of engagement. Any fundamental changes agreed to how other social care providers, including home care providers, operate, will be shared and communicated through the appropriate scheme as we move into the design phase, although voluntary and community sector providers have been consistently engaged in STP governance processes and have a good level of understanding and involvement. This will continue to increase going forward.

The STP Delivery Board chair from the Council is the Strategic Director for Community Wellbeing – this role includes oversight of housing, public health and adult social care, ensuring a joined up approach to improving outcomes across health, social care and housing. This is particularly reflected in the initiatives established through Scheme 3. For example, targeted support from housing colleagues at weekly housing surgery at Northwick Park and Willesden Community Hospital has been live since December 2015, in order to review pipeline of patients approaching discharge and 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.

Disability Facilities Grant

The Disability Facilities Grant (DFG) is available from Local Authorities to pay for essential housing adaptations to help disabled people stay in their own homes. The DFG will continue to be allocated through the BCF and is one of the three main sources of funding for the BCF. For Brent the grant equates to £3.971 for 2017/18 and £4.343 for 2018/19.

Use of this grant will assist work streams to look at use of assistive technologies and home adaptations to support people to live independently in their own homes for as long as is possible. In year, there are plans to develop a Handy Person Service primarily supporting BCF Scheme 2. This will enable faster and appropriate discharges from the hospital back to the persons own place of residence. In addition, the means testing applied for those who are not eligible or are self-funders, will be reviewed to enable faster discharges.

Stakeholder engagement

Effective engagement is something we take seriously. For example, with the STP engagement events with members of the public were held at a number of locations across Brent (Central Middlesex Hospital, Kingsbury tube station and Asda Wembley). Representatives from Healthwatch, NHS Brent CCG and Brent Council, shared the plans and explained what they meant for Brent. Based on our experience we will continue to look at the most appropriate way of ensuring effective engagement about the BCF Plan.

In addition, there are opportunities to do the same with regular attendance and discussions at:

- Health and Wellbeing Board
- CCG Governing Body
- Health Partner Forum
- Provider Forums
- Outreach events with local community groups
- Partnership Boards.
- Carers Forum
- STP work streams
- BCF work streams

These are useful forums and provide an opportunity to share and test BCF implementation, monitoring and review of the Brent BCF Plan.

National condition 2: NHS contribution to adult social care is maintained in line with inflation

Maintaining provision of social care services in Brent means ensuring that those in need continue to receive the support they need, in a time of growing demand and budgetary pressures. Our primary focus is on developing new forms of joined-up care which help ensure that individuals remain healthy and well, and have maximum independence, with benefits to both themselves and their communities, and to the local health and care economy as a whole. By proactively intervening to support people at the earliest opportunity and ensuring that they remain well, are engaged in the management of their own wellbeing, and wherever possible enabled to stay within their own homes, our focus is on protecting and enhancing the quality of care by tackling the causes of ill-health and poor quality of life, rather than simply focussing on the supply of services.

Funding currently allocated under the Social Care to Benefit Health grant has been used to enable the Local Authority to sustain the current level of eligibility criteria and to provide timely assessment, care management and review and commissioned services to clients who have substantial or critical needs and information and signposting to those who are not eligible. This will be sustained, within the funding allocations for 2017/18 and beyond if this level of offer is to be maintained.

The Care Act element within the Better Care Fund is linked to a range of duties for local authorities in 2017/18. This should provide for duties included in the Care Act that commenced in 2015/16, focussing on support for carers. The funding also includes provision for Independent Mental Health Advocacy and the disregard for Guaranteed Income Payments for veterans, and money to offset financial pressures on the care and support system that may be created by changes to the pensions and benefit systems.

It is proposed that additional resources via the IBCF will be invested in social care to deliver the discharge to assess pathway which will help reduce delayed discharges and admissions to residential and nursing home care.

This national condition will be met through the funding allocated for the protection of adult social care services. The level of protection for social care has increased to reflect demographic pressures and ensure that the system is not destabilised.

Description	2016/17 (£000)	2017/18 (£000)
RNF for Social Care	£6.200	£6.374
Care Act	£0.786	£0.800

National condition 3: Agreement to invest in NHS commissioned out-of-hospital services, which may include 7 day services and adult social care

The Brent strategy is to use its IBCF resources to invest in out of hospital care. A number of specific areas have already been identified such as Home First (discharge to asses), looking at practical ways of providing greater market stability in the purchasing of nursing and residential beds, joint investment in preventative programmes and increasing capacity for both hospital discharge and increasing capacity through block purchasing reablement provision. The BCF provides an opportunity to work across the different programmes to help reduce pressure on the local system.

Risk share and contingency arrangements:

Brent reviewed the potential for agreeing a local risk sharing arrangement, supported by analysis of the likely risk of unplanned activity. However, it was agreed that a risk sharing arrangement was not appropriate for 2017/18, as the CCG and Council work very well together and a risk sharing agreement was not perceived to add any additional value to the effectiveness of this collaboration or to increase the likelihood of a positive impact from the implementation of the BCF plans.

The programmes within the BCF are enablers to reduce secondary care admissions and costs. The acute and mental health inpatient contracts are not held in the BCF.

There are also a number of non-financial risks (operational and quality risks) associated with not meeting BCF targets in 2017/18, including increased pressure on acute providers and further challenge to meeting NHS constitutional standards. Non-financial risk sharing arrangements include ensuring that everyone involved in the BCF Plans (including the providers who will help deliver them) have a shared view of the risks to the plan, that key indicators are in place to highlight when an identified risk is becoming more likely (as part of the wider BCF KPI framework), and regular monitoring and communication with all parties so that any emerging problems can be dealt with.

Long term trend in admissions and the success of schemes implemented to date

Brent has been reasonably successful in preventing any growth in non-elective admissions over the past six years, particularly since 2013/14, from when admission levels have decreased year on year in real terms given projections based on demographic and non-demographic growth. The figure below illustrates this trend in non-elective general and acute admissions over time – over the entire period from 2009/10 to 2015/16 there has been an increase in 7% in NEL admissions. There has been slight over performance in the first three quarter of 2016-17 because of unplanned short stay beds implemented by one of the major acute trust.

Non–elective General and Acute admissions over time

Year	Admissions	Change
2009/10	25,896	
2010/11	25,335	5.6%
2011/12	26,590	-2.7%
2012/13	26,793	0.8%
2013/14	27,346	2.1%
2014/15	26,992	-1.3%

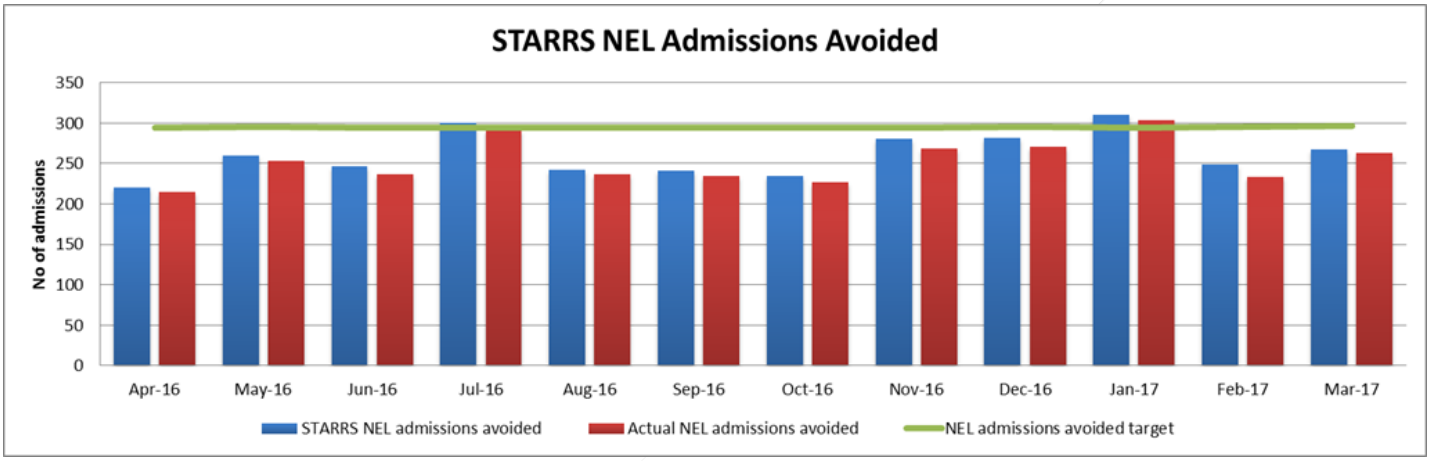
2015/16	27,019	0.1%
2016/17	26,994	- 0.1%

Source: Brent CCG Information team/SUS, BHH CCGs

Brent's success in maintaining stable NEL activity levels, despite growth, is attributed in part to the effectiveness of BCF schemes in previous years, particularly Scheme 1 (i.e. WSIC, GP-based case management for adults with long-term conditions) and Scheme 2 (which in previous years focused on the expansion of the 'STARRS' rapid response and admission avoidance service).

For example, the figure below illustrates both avoided admissions reported by the STARRS service (blue bars) and avoided admissions validated against SUS data (red bar), both of which show that the STARRS service was effective in avoiding NEL admissions in 2016/17.

STARRS NEL Admissions Avoided – 2016/17



Source: Brent CCG Information Team

With regards to WSIC, 2015/16 was a transition year and performance was complex: while non- elective activity reduced against baseline for the population group, the cost of these non-elective admissions increased. Potential reasons for this have been analysed and reviewed. Investment for 2016/17 therefore does present a risk should the contract fail to perform from a financial perspective. The model of care, commissioning framework and payment model for 2016/17 seek to mitigate this risk to commissioners.

Brent is continuing to commission out-of-hospital services in 2016/17 to support the reduction of non-elective admissions, including Rapid Response services ('STARRS') and Whole Systems Integrated Care (Scheme 1).

Managing Transfers of Care

Brent Council, Brent CCG and local acute partners have actively been working together to reduce levels of Delayed Transfers of Care (DTOC) in the system. A system wide response has been developed in relation to the high impact changes to manage transfer of care. A plan consisting of a number of schemes has been in place to reduce the negative impacts of winter during 2016/17, and the scheme Steering Group has been building on this to plan for the 2017/18 schemes. The BCF Scheme 2 focuses on effective hospital discharge and improving pathways and services to support safe and timely discharges and prevent readmissions.

The overall reduction target for DTOC is based on the national trajectory as shown in the table below. There

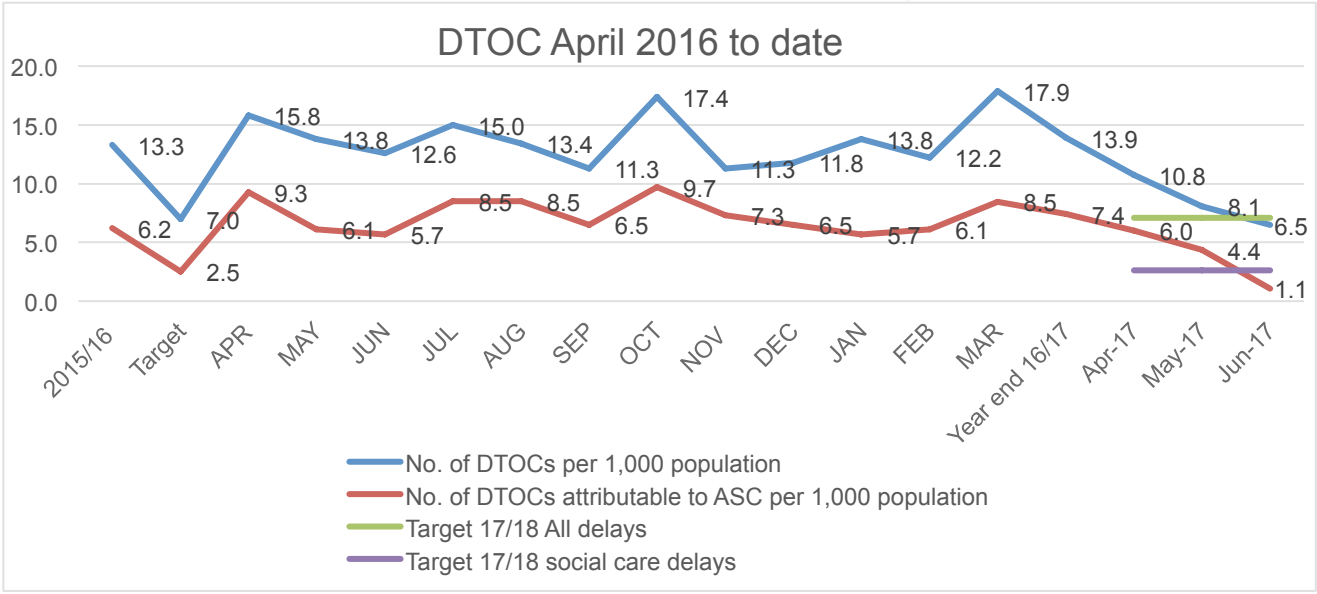
is a requirement for the NHS to reduce DTOCs to achieve fewer daily delays by the end of September 2017 by reducing both NHS and social care attributable delays. The Government has set out indicative expectations for reductions in daily delays on a local authority footprint. These included expectations for total, NHS and social care attributable delays. This would deliver an equal share of the required reduction in daily delays from the NHS and social care. Local Authority performance by November will help inform consideration of a review in that month of 2018-19 funding.

Performance to date

Each area had to submit agreed DTOC targets by 21 July 2017, showing at Local Authority level the planned reduction in social care-attributable delays, and at individual CCG level, the planned reduction in NHS-attributable delays that will be achieved.

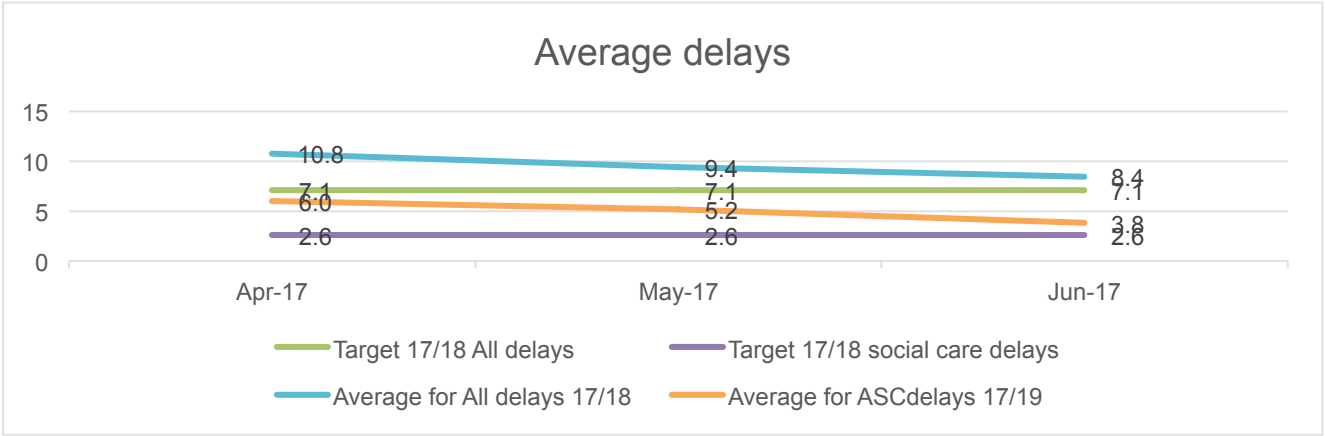
The Brent monthly DTOC has continued its improvements since April 2017 and the target was achieved in June for All and Social care delays. The **outturn for June 2017** was:

- 6.5 for all delays (NHS, ASC & Both) against the target of 7.1 – Brent ranked 10th out of 33 London Boroughs (previously it was 32nd).
- 1.1 for ASC related delays against the target of 2.6 – Brent ranked 8th out of 33 London Boroughs



At the **end of quarter 1** our average *(April to June)* DTOC statistics are:

- 8.4 for all delays – Brent ranked 16th out of 33 London Boroughs
- 1.1 for ASC delays against the target of 2.6 – Brent ranked 17th out of 33 London Boroughs



National condition 4: Alignment of the BCF Plan with high impact changes and A&E board governance structure

The high impact change model is a practical approach to supporting local health and care systems to manage patient flow and discharge. The model identifies eight system changes which can have the greatest impact on reducing delayed discharge and includes:

- early discharge planning
- systems to monitor patient flow
- multi-disciplinary/multi-agency discharge teams, including the voluntary and community sector
- home first/discharge to assess
- seven-day services
- trusted assessors
- focus on choice
- enhancing health in care homes.

Brent has used this model to self-assess itself against how care and health systems are working now, and to reflect on, and plan for action that can be taken to reduce delays throughout the year. The BCF Plan incorporates a number of actions arising out of the self-assessment and some have been included to develop further by the relevant BCF scheme. An overall and integrated implementation approach will be used by scheme Steering Groups and presented for sign off by the STP Executive Group and the STP Delivery Board.

8. Appendices

Appendix 1 – Brent co-designed model of care – adults with LTCs.

Appendix 2 – BCF Scheme 1 - Whole Systems Integrated Care (working papers).

Appendix 3 – BCF Scheme 2 - Effective Hospital Discharge (working papers).

Appendix 4 – BCF Scheme 3 - Care Home Market Changes (working papers).