Brent NHS Brent Clinical Commissioning Group	**Health and Wellbeing Board** 27 March 2018
	Report from the Strategic Director of Community Wellbeing

Older People and Frailty

Wards Affected:	All
Key or Non-Key Decision:	N/A
Open or Part/Fully Exempt:	Open
No. of Appendices:	None
Background Papers:	None
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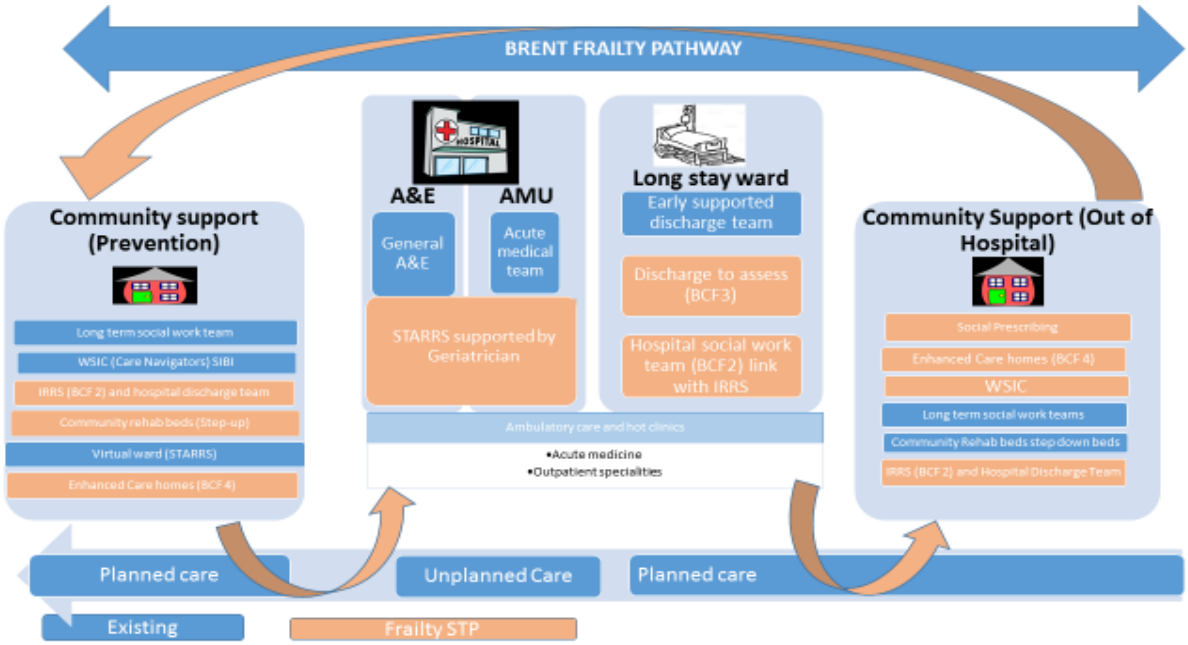
1.0 Purpose of the Report

1.1 The purpose of this report is to provide the Health and Wellbeing Board (HWB) with a summary of progress on the delivery of the Older People's workstream, identifies challenges and priorities for 2018/19. This major workstream forms part of Brent's Health and Care Plan.

1.2 There are 4 main workstreams within the Older People's Big Ticket Item that support delivery of Brent's frailty pathway (see pathway below). These are:

1. Community Support (Prevention) – includes Whole Systems Integrated Care (WISC) and Enhanced Health in Care Homes (EHCH) programmes.
2. Effective Hospital Discharges – includes Home First and Step Down Beds schemes which aim to reduce the length of stay, and number of delayed transfers of care (DTOC):
3. Integrated Rehabilitation and Reablement (Out of Hospital) services
4. Acute Frailty Service



1.3 The Older People's workstream is significant and work is extensive. This report will focus on providing a strategic overview of the key achievements of the entire workstream over 2017/18, issues emerging, and priorities going forward.

2.0 Recommendation(s)

2.1 The Health and Wellbeing Board is invited to note progress to date, discuss the findings and identified issues from 2017/18.

2.2 The Health and Wellbeing Board is asked to note and discuss the recommended projects for 2018/19 and to provide direction to the Integration Team and partner organisations regarding which projects should be prioritised for the coming year.

3.0 Detail

3.1 Improving outcomes for Older People is one of the six Big Ticket items of the Brent Health and Care Plan, and is also one of the five Delivery Areas of the North West London Sustainability and Transformation Plan.

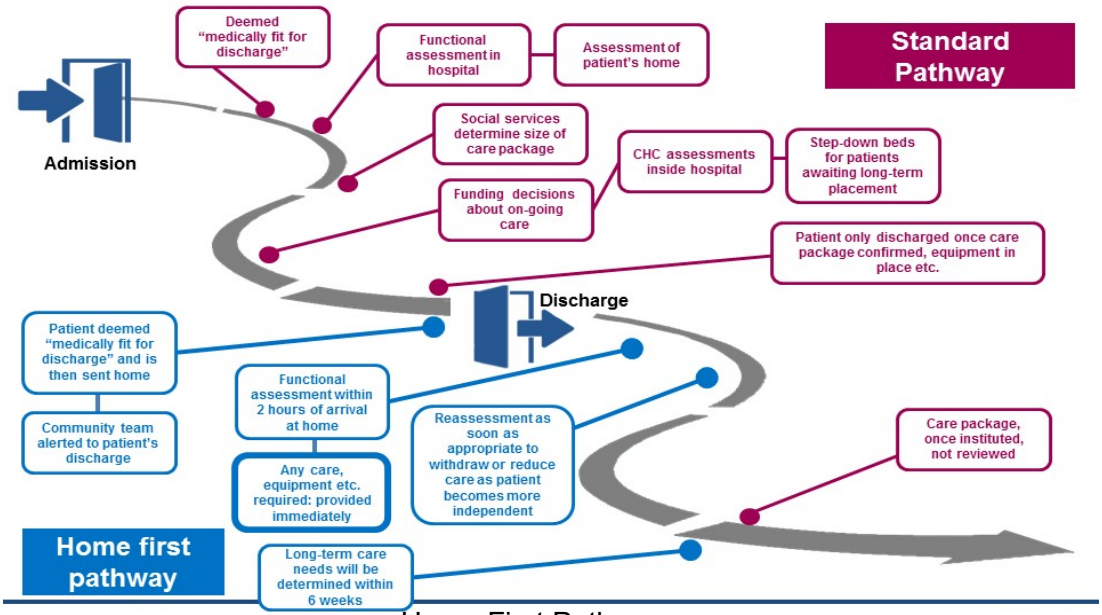
3.2 Brent's plans for older people consist of those which we believe will have the biggest impact locally in supporting reduction in unnecessary A&E attendances, reduce the length of time that patients stay in hospital and improve the overall client experience through an integrated service delivery approach. We want to make supporting people at home and within their own communities the norm. This is delivered through close working between partners' and utilising available resources in the most effective and timely way. This is important as some resources such as iBCF are time limited and partner contribution and commitment to funding is required to maximise investment and ensure that outcomes are delivered.

4.0 Achievements 2017/18

This section provides an update on some of the major achievements in this workstream to date.

Home First

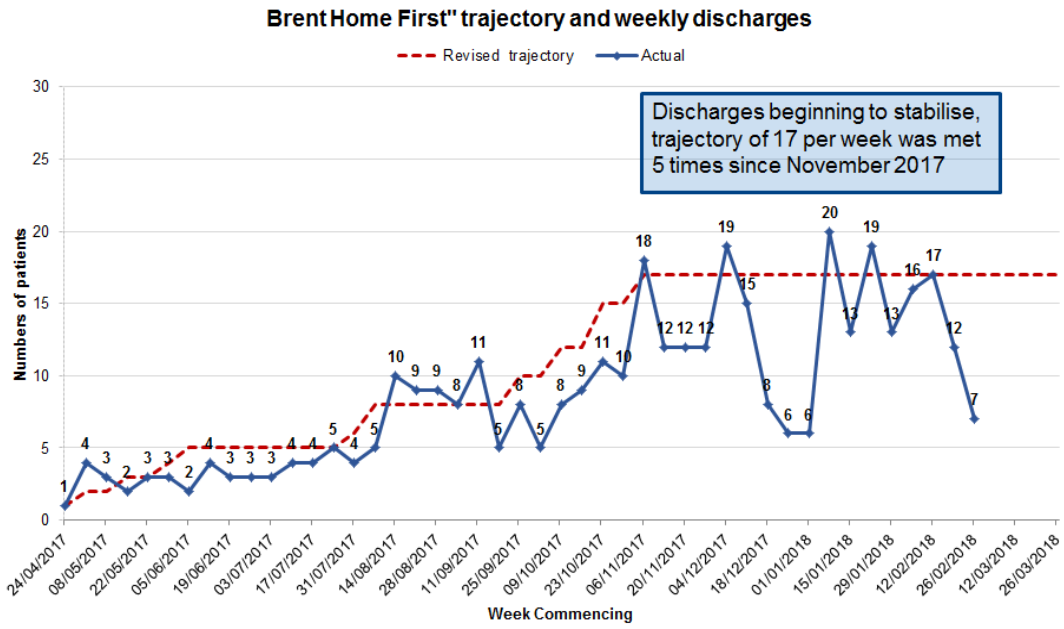
4.1 Home First is a discharge to assess model of care whereby the assessment of a patient's ability to successfully function and carry out normal daily activities is performed in their own home and not in a hospital bed. This means that as soon as patients are medically fit for discharge they are discharged directly to their place of care where a member of the team offers them an assessment of need. The Home First versus the Standard Discharge pathway is illustrated below



Home First Pathway

Since May 2017:

- 362 patients have been referred using the Home first pathway.
- Referral trajectories of 17 referrals per week set by the A&E Delivery Board have been met five times since November. The A&E Delivery Board trajectory and weekly discharges recorded is illustrated below.
- 2.2 days reduction in time spent by patient in hospital referred to Home First.
- 4% readmission rate compared to the NWL average of 9%.
- Brent is leading the way in implementing Home First and has been an "early adopter" of the Home First model of care and is sharing good practice with neighbouring boroughs and CCGs.



Patient story

- Mr HT is 90 years old.
- Admitted to Northwick Park due to lower respiratory tract infection.
- Mr HT lived with his brother and they were moderately independent and received no formal care service or package.
- While in hospital, Mr HT's brother passed away unexpectedly in their home, alone.
- Mr HT was referred to Home First late afternoon for an Interim package to support with personal care and meal preparation.
- He was discharged the following afternoon and the care package commenced that evening.
- A home visit/ community assessment took place the following day, which showed Mr HT was independent with dressing and could manage his meal preparations and medications independently.
- However, due to the loss of his brother Mr HT was now very anxious living alone and completing activities of daily living himself.
- The Home First team agreed that Mr HT would benefit from a welfare call each morning to encourage him to complete his personal care and meal preparation and increase his confidence with doing tasks alone.
- Mr HT has now been transferred to the reablement team who will review his progression in the community.

Step-down beds

4.2 24 nursing and residential step-down beds and 3 extra care step-down beds are in place offering an alternative form of care when a patient cannot be supported at home, but are not unwell enough to stay in hospital. These beds help reduce the overall length of stay in hospital for patients and help to reduce Delayed Transfer of Care (DTOCs). It should be noted that due to the increased flexibility and responsiveness required from providers regarding

these beds, they are significantly higher cost than other forms of residential and nursing care.

Step-down beds are jointly funded by the Council and CCG (70:30 split). To date:

- Average Length of Stay in a step down bed is 43 days compared with local target of 42 days.
- Patients are usually admitted to step-down within 24 hours of being assessed by the provider.
- 83% (167/202) of admissions to step-down beds have been for individuals awaiting further assessment (35), extra care (31), housing (27), blitz cleaning (26), care placements (26) or have been non-weight bearing (22). In the majority of these cases, the patients concerned would have had to remain in hospital despite not requiring a hospital bed if we did not have an alternative form of care available for them.
- 49% (99/202) of admissions come from Northwick Park (64) and Central Middlesex Hospitals (35).
- 52% (106/202) of people return either to their home address (61), or to accommodation with a new tenancy (45) following a period in step down. It is likely that if the step down beds were not available, the majority of these patients would have had to go into some form of residential or nursing care on a long term basis, and we would not have been able to support them to return to their own homes or communities.

Delayed Transfers of Care (DTOC)

4.3 A 'delayed transfer of care' occurs when a patient is ready to leave a hospital, or similar care provider, but is still occupying a bed. Delays can occur due to factors including, but not limited to, the patient waiting for assessment or care packages, awaiting residential or nursing home placements, and patient or family choice.

NHSE report DTOCs by dividing the number of delayed days during the month by the number of calendar days in the month. Locally, we then take this DTOC number and calculate the DTOC rate based on per 100,000 population (DTOC rate = number of delays/population * 100,000).

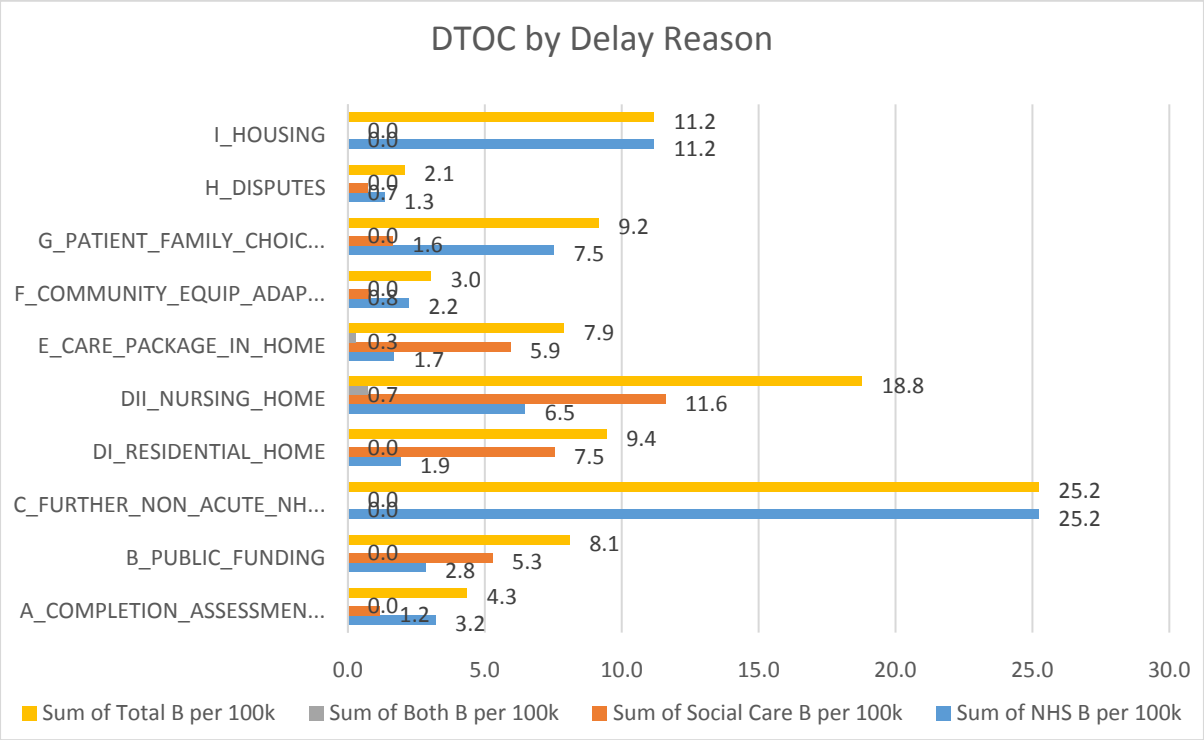
DTOC targets are set by the NHS Executive and is jointly owned by the CCG and the local authority. This means that both organisations are jointly responsible for the delivery of the overarching target despite being monitored separately. The iBCF funding is linked to the achievement of the overall target.

At the end of 2016/17 there were 13.9 delays per 100,000 people, and by January 2018 this figure has decreased to 9.91 delays, which is a significant improvement. However, this is still short of the 7.1 delays target per 100,000

people. The table below breaks down Brent's DTOC performance and details delays attributable to each agency.

	2016/17 rates	2017/18 target	2017/18 average
All delays (per 100,000 people)	**13.9**	**7.1**	**9.91**
Adult Social care delays	**7.4**	**2.6**	**3.46**
NHS delays	**n/a**	**4.0**	**6.34**
Both delays	**n/a**	**0.5**	**0.1**

All hospitals are required to collect delayed transfer data for adults (aged over 18 years) and provide it to NHS England, together with the reasons for these delays. The graph below shows the reasons for DTOCs by each month across 2017/18.



4.4 The current biggest cause of delay (excluding the Further Non Acute NHS delays) is people due to people awaiting a care home placement (nursing and/or residential care). The biggest area of reduction in delays is in completion of assessments. Since Home First was first introduced in May 2017, we have been able to demonstrate a 70% decrease in delays in this category.

Delays related to patients awaiting nursing home or residential home placements are often due to increased accuity of need and/or capacity in the market. Current issue include the length of time it takes for care homes to assess an individual whilst in hospital. This can mean that an additional 5-10 days delay can be added to a

patient's stay if multiple homes assess the individual, particularly if these assessment need to be arranged around family or friend availability. The Enhance Care in Care Homes project is aiming to address this in the coming year through the development of a 'trusted assessor' post to be based in the hospital, and who can assess once on behalf of multiple care homes.

Acute Frailty Service (AFS)

4.5 The AFS "proof of concept pilot" was established in October 2017. This service aims to provide older people with a comprehensive geriatric assessment and intervention once they enter the Emergency Department to ensure that breaches are reduced. The service assumes that if an older person has reached the ED, then all other preventative interventions have failed, and they do need to be at the hospital. The aim of the service is therefore to prevent older people being admitted to long stay beds, or to reduce the amount of time a person will stay in a long stay ward if admission is unavoidable. The service is open to Brent and Harrow residents even though Harrow at present does not contribute financially to the service. To date:

- 507 patients had been referred (Brent, 31%, Harrow, 48%, Others 21%).
- 372 (73%) of the referrals were appropriate for comprehensive geriatric assessment offered by the AFS.
- The outcomes of those seen by the AFS were:
    - 34% avoided admission from ED
    - Of the 66% admitted:
        - 12% transferred to CMH
        - 38% admission to short stay wards
        - 9% admission to Care of Elderly wards
        - 7% admission to other wards.

Integrated Rehab and Reablement Service (IRRS)

4.6 The Integrated Rehab and Reablement Service is a short term community based service which assists to identify and set goals aimed at achieving independence, self-resilience and reduce the need for ongoing community packages of care from Social Care. IRRS receives referrals from Hospital Discharge incorporating Home First; Community Health Services and GPs; and Brent Social Care. Rehab and Reablement is an integrated service comprising of a multi-disciplinary team made up of Occupational Therapists, Physiotherapists, Psychologist and Dietician from what was previously the intermediate care community rehab team, working with Social Workers and Care Assessors from Brent Adult Social Care Reablement team.

The staff are co-located, they operate a Lead Professional role with the individuals they see which has the benefit of them having just one key worker

and point of contact. The team have developed and now implemented a core assessment and are able to pull together their professional skill bases to maximise the effect the service has with the individuals referred to the team as demonstrated the data for 2017/18.

- 95% people who receive support from the IRRS team remain at home after 91 days.
- 81% people using the service complete reablement without requiring an on-going service.
- 91% people fully achieve their rehabilitation goals.
- A provisional estimate of savings (based on the cost difference per annum on the package patients started with versus the outcome (minus any self-funders/ deceased / transferred to other services) for 2017 equated to approximately £2m per annum.

5.0 Emerging issues

Whilst there have been significant achievements in the above workstreams, a number of issues have emerged which moving forward need to / or are being addressed.

Workforce Development

5.1 Sufficient staffing capacity in the system has been an ongoing problem with all the workstreams. There are particular challenges in recruiting skilled staff especially Social Workers and Occupational Therapists (OT). This has necessitated front line staff being used wherever possible to support the workstreams and then attempting to back fill with more expensive agency or contracted staff.

AFS

5.2 Currently there is only one Consultant Geriatrician working across the AFS. At present there is no cover for annual or unscheduled leave, which poses a significant risk to service delivery and causes disruption when it does occur. A locum is currently filling this post, as recruitment to the substantive post has been unsuccessful. This is likely to be due to the nature of the short-term contract, but nevertheless is a priority for LNWUHT to resolve.

Home First

5.3 Until now Home First has been operating alongside normal discharge processes. This means the system is bearing the cost of double running the programme and needs to be mainstreamed. Brent ASC hospital discharge staff have been dedicated to the programme and their substantive positions backfilled with agency staff. However, LNWUHT staff have retained their substantive roles and the Home First programme has been staffed through agency workers. This has meant a high turnover of staff, without the required

upskilling of permanent staff and without the skills and knowledge transfer being embedded in the team delivering the programme. This is currently being discussed with LNWUHT management in order to resolve the issue.

Recruitment of OTs

5.4 Many of the out of hospital pathways and programmes rely on qualified and experienced Occupational Therapists to successfully deliver the outcomes required (IRRS, Home First and the Step Down Beds). There is a national shortage of qualified and experienced OTs and we struggle to recruit them across the Brent health and care economy. No new national programmes to develop OTs are in the pipeline, therefore Brent as a system will need to think about how best to recruit, attract and retain these staff.

Investing in staff

5.5 Staff being supported to develop and deliver new pathways require time and space to participate in development work. Experience shows that new and integrated services are more successful where time is invested up front to allow them to be involved in co-designing and co-producing the service. This increases costs due to the need to backfill staff, and additionally it can be challenging to release staff in a system that is under pressure.

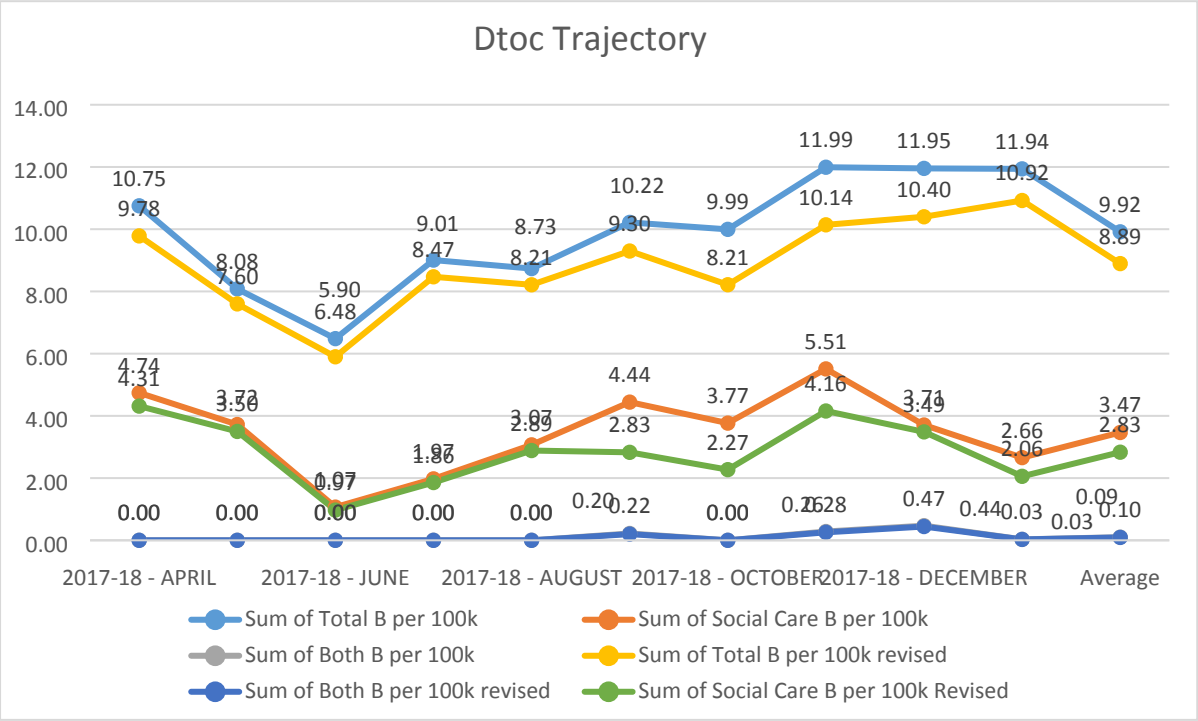
5.6 As part of service planning for 2019-20 consideration needs to be given to longer term contracts to attract and retain staff, combined with a more innovative approach to recruit these essential staff. This will not only reduce the risk of service interruption but also help minimise operational difficulties for services. Organisations need to consider how to commit to releasing operational staff when the system in under intense pressure.

Data quality

5.7 There is an issue concerning DTOC data quality and validation. The main problem has been that validated data submitted by Brent Local Authority and Brent CCG does not match the reported data on situation reports (“sitrep”), causing inaccuracies and difficulties in local resource planning. In addition, there have been delays in reporting by West London Mental Health Trust who started to report delays in September 2017, which has increased the Brent DTOC rates by 4.

5.8 In order to monitor, track and challenge the data, Brent Local Authority have had to employ a full time officer to carry out this process. In addition, the Hospital Discharge Team Manager and performance team validate and challenge data weekly, and the Head of Service – Urgent Care (ASC) meets with the Assistant Director of Urgent Care (CCG) every two weeks to take stock, examine emerging issues and develop plans to deal with these. The interim Director of Integration also attends to ensure alignment with the Brent Plan. The CCG and ASC work together to ensure that risks are minimised. Regular reports are provided to the ASC, CCG and A&E Delivery Board.

5.9 Additionally, there are a number of delays being attributed to Brent that actually relate to other boroughs and based on our local validations report there is approximately a 10% difference between the reported delays and our validated delays.



Graphic showing trajectory of DTOC since April 2017 to January 2018

for Sitrep data and Brent validated data

5.10 However, published data, combined with our own data indicates that the biggest improvements were made in reducing social care delays which went down from 7.4 for 2016/17 to 3.46. We also expect that revision to data will see a further decrease to 2.83 a drop of 61%.

5.11 The 2017/18 DTOC for all NHS and Social care is averaging at 9.92 as per sitrep whereas our calculations show that this figure should be around 8.89 which shows a variance of 1.03. The 2017/18 current DTOC for Social care is averaging at 3.47 as per sitrep where our calculations show that this figure should be around 2.83, a variance of 0.64.

5.12 Discussions to correct this data are ongoing. But these discussions are time consuming and do not make best use of scarce capacity. A new data validation processes for the reporting of DTOC was established between LNWUHT and Brent CCG in January 2018, which is expected to minimise any future data quality issues from this provider. However, discussions are continuing with other providers to help minimise future data quality and validation issues.

Resource planning

5.13 The Better Care Fund (BCF) is the national programme, through which local areas agree how to spend a local pooled budget in accordance with the programme's national requirements. The pooled budget is made up of CCG funding as well as local government grants, of which one is the improved Better Care Fund (iBCF). The iBCF was first announced in the 2015 Spending Review, and was increased in the 2017 Spring Budget. IBCF is paid directly to the Council to spend against national priorities.

5.14 Brent's allocation of iBCF funding is £6.9m for 2017/18 and estimated as £9.3m for 2018/19 and £11.4m for 2019/20. In 2017, iBCF funding has been used by the Council to support a number of work areas which benefit the local health economy, including, expansion of Home First, providing market stability, including block purchasing of nursing / EMI / residential beds to provide additional capacity to allow for faster discharges, joint investment in prevention programmes, early discharge initiatives, block purchasing of reablement provision supporting discharge to assess and provision of same day packages at home.

5.15 The iBCF grant represents substantial investment in the short term, but when they were announced government explicitly did not build them into the long-term funding baseline. So funding remains a risk to the long-term viability of Older Peoples work stream as many elements are funded via the iBCF. There is a need to collectively plan during 2018/19 for when these resources end and partners will have to make some difficult decisions in terms of contributions to sustain this workstream.

System Complexity

5.16 Learning from this year and previous years of activity relating to the Older People's workstream is clear that whilst the Brent health and care economy are undertaking a range of innovative and progressive projects that are delivering tangible improved outcomes for individuals, the system is overly complex and inefficient.

5.17 As different teams and projects develop, it has become clear that there is significant overlap and duplication in what these teams and services deliver. This is not just inefficient; it makes the system difficult to navigate both for residents and for professionals across the health and care economy. This complexity is increased exponentially in a hospital setting, where different local authorities and CCGs are running similar initiatives and programmes, but often with different designs and pathways. For example, LNWUTH has 3 different versions of the Home First programme running out of Northwick Park hospital, one for Brent, one for Harrow and one for Ealing. None of these pathways and programmes align.

5.18 Similarly, the natural evolution of different teams and services has meant that there is now significant overlap between what these teams provide. For example, the IRRS service is supporting people to be discharged via the Home First pathway, as are the local authority Hospital discharge team and the discharge co-ordinators employed through LNWUHT.

5.19 Learning from this year has shown that particularly when the system in under stress, practitioners across the system revert to old pathways and relationships they trust and know, for example when Northwick Park Hospital was operating under a black alert, referrals to home first decreased by 10 (w/c 5th March) compared to the previous week. This indicates both that there is work to do to fully embed new pathways, and that they complexity in the system needs to be addressed for it to be fully effective.

6.0 Priorities for 2018/20 - review and realign service plans

6.1 During 2018/19 there is a need to review and refine our service plans and priorities in light of the lessons learnt and available resources. Highlights of actions include;

Home First

- Mainstream Home First as a sustainable model of care. Develop Business Case.
- Include and mainstream Mental Health into the Home First model.
- Expand Home First with the Royal Free NHS Trust and Imperial NHS Trust sites.
- With LNWUHT and neighbouring boroughs consolidate and simplify the number of discharge pathways (particularly aligning the different Home First models operating out of a single hospital site).
- Evaluate the impact of Home First on all system partners, acute, community and social care supported by NWL S&T Team.

Step-down beds

- Review step down beds and pathway to develop a step down team to improve support and flow.
- Ensure suitable number of step-down beds are available to support flow and reduce DTOCs in the system.
- Urgently explore ways of recruiting OTs including how the STARRS and IRRS OT's can support step-down beds.
- Identify how other teams, such as Housing and Commissioning, and care home providers can support smoother and timelier discharge into the step-down beds, and help plan the move on from the step-down beds.

IRRS and HDT service

- Review the IRRS and HDT to align, and potentially restructure and merge them to respond to current demands and future challenges including workforce requirements.
- Expand the review of IRRS and HDT to incorporate other hospital discharge related teams and functions, for example the hospital discharge co-ordinators, STARRS and Rapid Response.

AFS

- Evaluate the AFS service to develop a sustainable model including feasibility of service provided in evenings and at weekends. Discuss funding with Harrow.
- LNWUHT to reconfigure and provide dedicated space near A&E for Consultant Geriatric Assessment.

WSIC

- Review and strengthen the WSIC operating model.
- Expand scope of service to include 'recovery model'.
- Improve case finding of patients and care planning.

Enhanced Care in Care Homes and Integrated Commissioning

- Expand telemedicine to include video links to care homes.
- Development and delivery of targeted training for care homes.
- Delivery of in-reach training.
- Roll out of Coordinate my Care (CMC), online care planning tool.
- Explore Trusted Assessors.
- Appoint dedicated Project Manager to work with care homes.
- Design and implement an integrated brokerage function for residential, nursing home and home care placements funded by the Council and CCG building on the strategic framework already developed in January 2018.

System leadership

7.0 In implementing the Brent plan for 2018 /20, there is a need to support local leaders in leading change across organisational and professional boundaries. This collective leadership at all levels will increasingly be needed to handle many of the complex and difficult issues facing services in Brent that cannot be resolved by any one partner alone.

7.1 What is required is working with our local neighbouring partners such as Harrow and Ealing councils and CCGs and wider partners to resolve some of the system issues we all face and attempt to resolve these. Learning from exemplar sites can also assist. A local plan based on this intention will be developed with partners.

8.0 Financial Implications

8.1 None for 2018/19.

9.0 Legal Implications

9.1 None.

10.0 Equality Implications

10.1 None directly.

11.0 Consultation with Ward Members and Stakeholders

11.1 On going.

12.0 Human Resources/Property Implications (if appropriate)

12.1 Look at NWL wide recruitment strategies and learn from others who may have / are facing similar issues.

Report sign off:

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