Brent NHS Brent Clinical Commissioning Group	**Health and Wellbeing Board** 23 April 2019
	Report from the Director of Integrated Care

Health and Care Transformation Programme Review

Wards Affected:	All
Key or Non-Key Decision:	N/A
Open or Part/Fully Exempt: (If exempt, please highlight relevant paragraph of Part 1, Schedule 12A of 1972 Local Government Act)	Open
No. of Appendices:	None
Background Papers:	None
Contact Officer(s): (Name, Title, Contact Details)	Tom Shakespeare, Director of Integrated Care, tom.shakespeare@brent.gov.uk

1.0 Purpose of the Report

1.1 To provide an update to the Board regarding progress of key activities of the joint Health and Care Transformation programme during 2018/19, and to seek comment and endorsement for the priorities for 2019/20.

2.0 Recommendation(s)

2.1 To note progress against the plan during 2018/19, and to provide comment and advice in relation to priority areas where progress has been slower.

2.2 To comment on and endorse the proposed additional priorities for 2019/20

3.0 Background

3.1 In October 2018 the Board agreed to a revised set of priorities for health and care transformation, with three core priorities for implementation, and three areas for scoping and development. These areas were as follows:

3.2 A patient centred older people's care pathway, reducing delays in hospital discharge and improving patient experience. This includes:

- Development and implementation of a system resilience plan and operational working group to reduce delayed transfers of care
- Development and implementation of a plan to sustain Home First at scale, reducing handoffs, inefficiencies and duplication within the existing pathway

3.3 A joint commissioning and brokerage function for nursing, residential and home care, reducing delays and duplication and creating a catalyst for the development of a fully integrated care system. This includes delivery of the following objectives:

- Harmonisation of price paid in and out of borough for spot purchases for equivalent levels of care
- Reduce DTOC due to nursing and residential placements and CHC assessment
- Reduction in funding disputes between CHC and social care
- 'One system' approach to market management with care homes to improve quality and value
- Improved service user experience

3.4 A joint market management approach, including care home networks and training and development support. This includes delivery of the following objectives:

- Development of a shared approach with the care home market to respond to the big strategic challenges and opportunities facing the system
- Prioritisation of support that will have the biggest impact on key system performance indicators across the system (LAS callouts/non conveyances, NEL, DTOC etc)
- A focussed approach to working directly with individual care homes where there are the biggest performance challenges, working closely with the integrated commissioning and market management programme

3.5 In addition, by April 2020 the Board will have overseen:

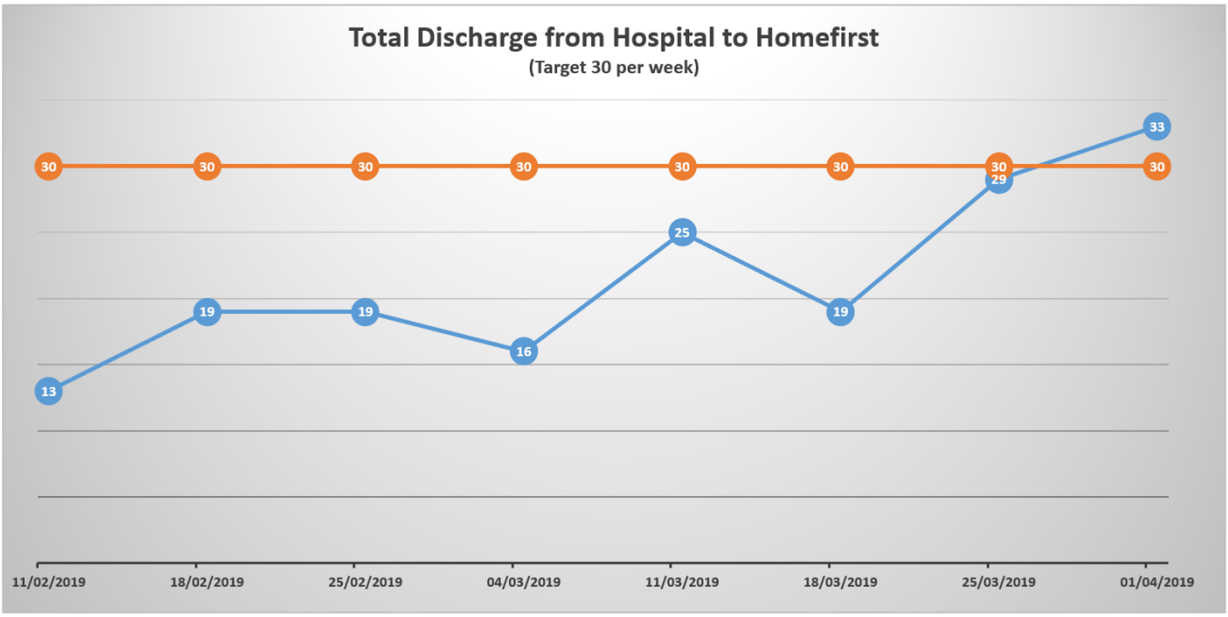
- Development of our integrated care system, building on integrated commissioning, to take a whole system approach to incentives, investment and benefit realisation, enabling a greater focus on prevention and community services to keep people well and in their own homes
- Development of new approaches to promote prevention and self care in the community
- An integrated service or support for people with dementia

4.0 Progress to date

4.1 Older people's pathway

4.1.1 Integrated discharge pathway – Consultants, Newton Europe, were commissioned at the end of 2018 to provide specialist knowledge and support to redesign and deliver the integrated discharge pathway. The aim of this work is to streamline the discharge process through the Discharge to Assess (D2A) framework. The analysis is now nearing completion, and work is moving into the design phase, with system workshops. Implementation will start from May 2019, and a full report will be brought to the next Health and Wellbeing Board.

4.1.2 Home First – In January 2019 Brent's existing model of Home First (discharge home to assess) was expanded to Imperial and Royal Free Trusts, and re-launched at Willesden and Central Middlesex Hospitals. The refreshed model includes assessment at home, and relies on Trusts to push referrals. It is currently focussed on simple discharges (pathway 1), but there is an opportunity to expand to more complex patients (pathway 2 and 3) as part of the integrated discharge pathway work. The current target for accepted referrals is 30 people per week, and numbers have increased steadily since launch towards this target, as shown below:



4.1.3 Step down and short term beds – Brent has 19 step down beds in addition to extra care facilities to support timely discharge out of hospital. Work has been completed to tighten step down criteria, improve throughput and secure commitment from the CHC team to complete assessment out of hospital within 15 days

4.1.4 System resilience plan – In late 2019, partners worked together to develop a plan across health and social care for use of £1.3m non-recurrent funding over the Winter period. The plan included Home First expansion, a handyman service, a placement premium pilot and additional short term bedded placements. All aspects of the plan are now operational, and the plan was highlighted as an exemplar plan at the A&E Delivery Board

4.2 Integrated commissioning and market management

4.2.1 Placement Premium – the pilot scheme was launched in February 2019 to incentivize timely assessment and placement by care homes, with the aim of reducing delayed transfers of care from hospital. The model works on the basis that care homes receive £50 for assessment completed within 24hrs of referral, and an additional £50 if this results in a placement within 48hrs. The evaluation is to be completed in April, but initial indications suggest that there has been an impact on the speed of assessment, but it is early days to know whether there is any significant impact on the increased timeliness of placements

4.2.2 Integrated brokerage (and commissioning) – it was agreed that a CHC broker be co-located with adult social care brokers for nursing and residential care homes from 2018, following recommendations by consultants Ernst and Young in late 2017. The integrated brokerage function went live in June 2018, and the feedback from brokerage staff involved was positive, and fostered joint working and a shared understanding of the market and prices paid. Unfortunately work has since paused due to numerous staffing issues within Brent, Harrow and Hillingdon CHC team. At this point there does not seem to be a sustainable resolution to this issue. This is causing significant delay to the delivery of this priority area

4.2.3 Aligned pricing strategy – an analysis has been commissioned to inform market management opportunities across health and social care, recognizing that there are a significant number of complex placements across both health and social care. The output from this work will inform integrated commissioning priorities

for 19/20, and provide a clear pricing strategy for integrated brokerage.

4.3 Enhanced health in care homes

4.3.1 Care Home Forum – Forum established with provider chair (Mark Bird, Birchwood Grange Care Home), with a re-focussed agenda based on delivery and joint ownership of shared system priorities. Attendance and feedback significantly improved, and the input and leadership has enabled significant progress on key priorities, including the development of the Placement Premium.

4.3.2 Training – four focussed training programmes to support care home staff including 'My Home Life' training programme. There has been positive feedback from homes. Wave 2 from April 2019 with 3-4 Brent care homes and 7 homecare providers.

4.3.3 Red bag – this is a scheme to ensure key information follows a patient between hospital and home. It was launched in Brent but beset by operational issues. The opportunity for 2019/20 is to tie into Older People's pathway redesign

4.3.4 GP Enhanced Care – provides MDT link through primary care into care homes 8-8, 7 days a week. This service has been well received by homes

4.3.5 NHS 111 *6 – 24/7 assessment and advice line to reduce hospital admissions from homes. IT has been well received but beset with operational issues, which now appear to be stabilising. Review to be completed through Care Home Forum in 2019/20

4.3.6 Medicines optimisation – pharmacist team supporting homes and providing training to optimise medicines

4.4 Scoping priorities

4.4.1 Self care – improved referral pathway developed to align Brent's Social Isolation in Brent Initiative (SIBI) service (now part of Gateway) to the care navigators and care co-ordinators, based within primary care.

4.4.2 Integrated care system development – development of proposed new model to establish primary care networks and increase support to people who are at medium-high risk of hospital admission through enhanced focused support in the community. Work ongoing to link together with social care and with the new referral pathway for self care

4.4.3 Dementia and challenging behaviours – completed analysis of key causes of delay discharging patients home, and work is ongoing through to 2019/20 to establish support to homes to keep people at home and as independent as possible.

5.0 Proposed priorities for 2019/20

5.1 It is proposed that the priorities remain the same for 2019/20, with the following additions and changes:

5.1.1 Enhanced health in care homes – review of priorities based on discussions with local system partners, care homes and resourcing and guidance from national

and NW London partners. Will include addition of support to care homes for people with dementia and challenging behaviours

5.1.2 Integrated commissioning and market management – fully integrate operational teams for continuing health care and auly social care nursing and residential placements, with an aligned pricing strategy and shared operating guidance for teams. (NB subject to resolution to current operational issues)

5.1.3 Older people's pathway – implementation of recommendations from consultancy report. Will include enhanced offer to homecare and reablement service to enable timely discharge of more complex patients.

5.1.4 Self care – implementation of new referral pathways between health and social care

5.1.5 Assistive technology – development of strategy to support cost-effective assistive technology solutions in peoples homes and extra care to keep people independent and at home for as long as possible

5.1.6 Integrated care development – work directly with health networks to support increased alignment between social care and health

6.0 Financial Implications

6.1 Continue to review

7.0 Legal Implications

7.1 None

8.0 Equality Implications

8.1 None directly

9.0 Consultation with Ward Members and Stakeholders

9.1 Ongoing

8.0 Human Resources/Property Implications (if appropriate)

10.1 Continue to review

Report sign off:

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