Brent NHS Brent Clinical Commissioning Group	**Health and Wellbeing Board** 7 October 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 a six month progress report on key activities of the joint Health and Care Transformation programme

2.0 Recommendation(s)

2.1 To note progress against the plan for 19/20, and provide strategic steer and advice to support the delivery of the shared priorities

3.0 Background

3.1 In March 2019 the Health and Wellbeing Board approved a refreshed set of priorities for health and care transformation, building on the existing priorities agreed in October 2018. These areas were as follows:

3.1.1 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 an integrated discharge pathway, including a plan to sustain Home First at scale, reducing handoffs, inefficiencies and duplication within the existing pathway

3.1.2 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

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

- Development and implementation of support initiatives to care homes to impact on key system performance indicators across the system (LAS callouts/non conveyances, NEL, DTOC etc)
- Development of a shared approach with the care home market to respond to the big strategic challenges and opportunities facing the system
- 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

3.1.4 Self care, with a focus on the following objectives:

- Development of a Brent-wide model of self care through use of link workers connected to primary care networks, with a focus on reducing GP appointments for non-health reasons

3.1.5 Technology enabled care, with a focus on the following objectives:

- 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

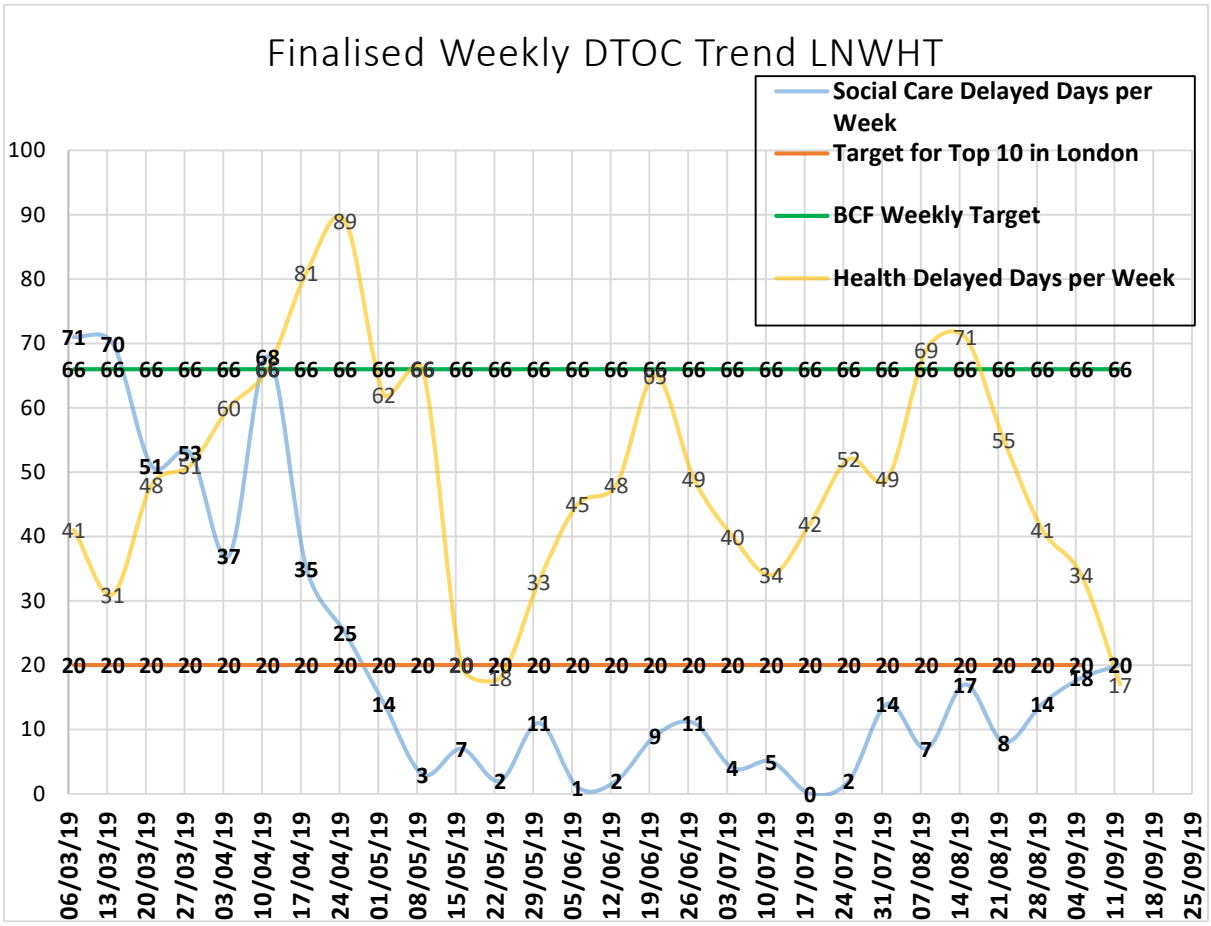
3.1.6 Integrated care partnership development, with a focus on the following objectives:

- Establishment of multi-disciplinary team, including social care, to proactively find and case manage patients identified as 'rising risk' of health needs
- Alignment of other new or existing services to the development of ICP
- Development of more formal integrated commissioning arrangements between the CCG and council

4.0 **Progress to date**

4.1 **Older people's pathway**

4.1.1 System performance – there has been a dramatic improvement in Brent's adult social care delayed transfers of care (DTOC) performance over recent months driven by a combination of service changes, moving Brent into the top ten performing London boroughs. Unfortunately, NHS delays have remained variable and high. Work is now progressing to address this ahead of Winter, including through the establishment of a new discharge to assess protocol, and we expect to see an improvement in performance over the coming months.



4.1.2 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.

a. The key findings from the work were:

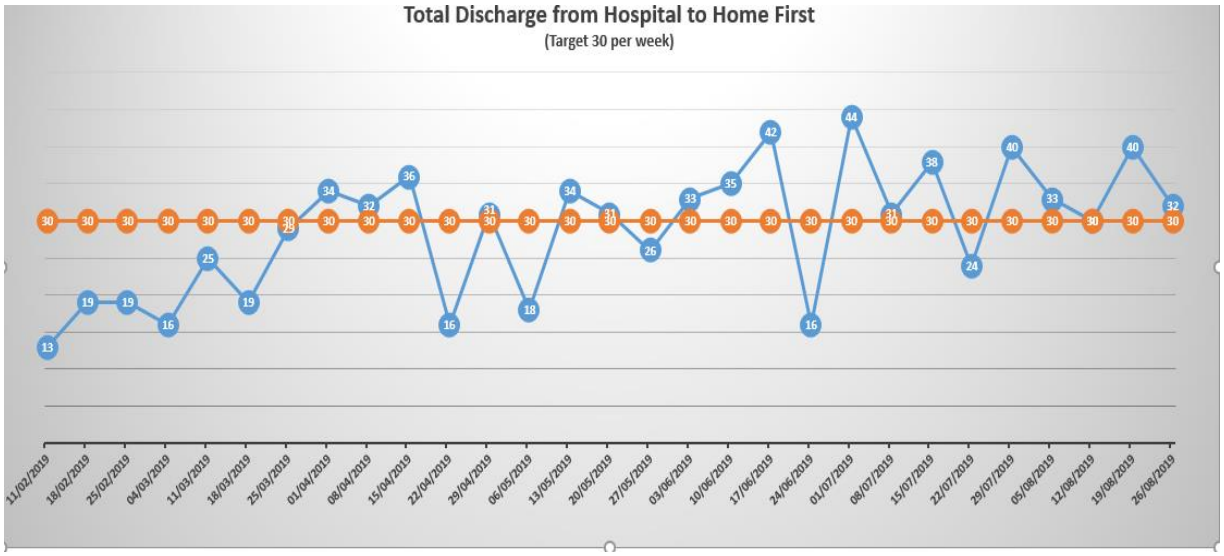
- Length of stay in hospital – There is significant room to reduce length of stay in hospital through improved MDT working and early discharge planning
- Discharge destination decisions – Despite comparatively low placement figures, there is still further opportunity for more people to be supported at home or with reablement. This would also impact on length of stay
- Reablement – there is significant scope to improve the effectiveness of reablement, and also reduce the length of time that reablement is provided. There is also potential to link this work to the Home First pathway, and look to expand the rollout of Home First for more complex patients

b. Work has now moved into the implementation phase. Design groups have been established, and delivery plans developed based on a pilot/rollout model, focused on the following key interventions:

- Establishment of a single point of access within hospital to improve discharge destination deision making
- Development of streamlined discharge processes in hospital with MDTs on wards to develop early discharge planning processes
- Establishment of a single Home First, reablement and rehabilitation team to manage more complex patients and improve the effectiveness and length of reablement provision to reduce long term support needs

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 work ongoing 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 and are now regularly exceeding the target, as shown below:



4.1.3 Discharge to assess protocol and beds – a new protocol has been agreed to support discharge of patients with complex needs or assessment for NHS continuing healthcare (CHC) support. Ten beds have been procured to support this process in addition to the recruitment of a CHC nurse assessor to support patient flow through the Winter period. The beds are funded through existing CCG and local authority contributions to the Better Care Fund, and additional funding has been allocated through the adult social care winter funding to recruit the nurse assessor. Adult social care will continue to make spot purchased placements into care homes or extra care facilities where required.

4.1.4 Winter pressures plan – Winter pressure plan priorities for allocation of the £1.3m Brent allocation have been implemented during 2018/19, and a new plan has been developed, subject to agreement from the Health and Wellbeing Board for spend in 2019/20. The enhanced Winter plan forms part of the 2019/20 BCF plan, and builds on the key initiatives from the 2018/19 plan. This includes the following new and existing schemes:

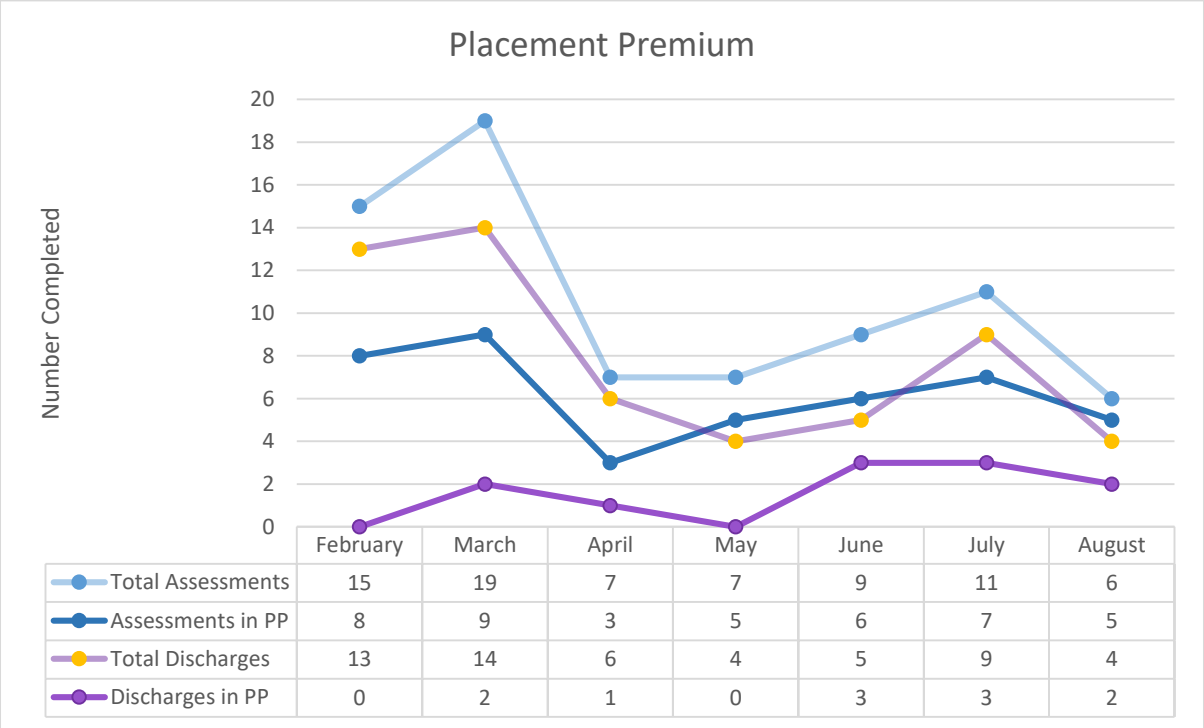
- Handyman service, supporting settlement back home and reduce delays in hospital discharge
- Positive behavioral management in care homes pilot, supporting people with dementia and avoid hospital admissions and improved outcomes for patients
- Additional social workers to support the expansion of Home First
- Overnight care to support expansion of Home First for more complex patients
- Assistive technology pilots for key patient cohorts to improve outcomes for people and enable people to remain at home and independent for longer
- Nurse assessor, to support a reduction in NHS delayed transfers of care through effective management of discharge to assess beds
- Backfill to support the design teams implementing the changes identified for the integrated discharge pathways
- Training for reablement providers to improve the effectiveness of

reablement
- Expansion of pilot to incentivise improvement to the timeliness of care home assessments and placements

4.2 Integrated commissioning and market management

4.2.1 Placement Premium – the pilot scheme was launched in February 2019 to incentivise 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.

a. The data shows an improvement in the proportion of assessments and placements completed in the required timescales. This performance improves significantly further to 80% when reviewed against a 72 hour period.



	February	March	April	May	June	July	August
Total Assessments	15	19	7	7	9	11	6
Assessments in PP	8	9	3	5	6	7	5
Total Discharges	13	14	6	4	5	9	4
Discharges in PP	0	2	1	0	3	3	2

b. For 19/20, it is proposed to expand this pilot to provide an enhanced incentive to nursing homes for a £500 one off payment in recognition of the challenges that a number of homes face with settlement. The aim of this should be to further improve care home assessment and placement timescales, whilst also increasing the number of placements within borough and reduce the need for ongoing higher intensity support. The pilot will start on 1 October, and will be reviewed after 6 months

4.2.2 Integrated 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, the commitment to the joint brokerage role was rescinded due to pressures on the CHC service. As a result of this, the integrated commissioning steering group and programme board have reviewed joint working, and agreed to work on the following alternative areas where there is

agreement to do so. Work is ongoing in each of these areas to develop and implement a work programme:

- Joint Quality Framework/Approach - A comprehensive and joined up approach to assess quality and contract monitor services in a holistic way across partners.
- Integrated Pricing Strategy – a joint pricing strategy to ensure consistent message to the market. Specific proposals would be agreed and developed jointly, including a review of the placement premium for CHC placements
- Joint Approach to Assessment/review - A shared assessment process, including: MDT assessment of patients; An integrated panel process to follow strength based approach; An assessment document that is proportionate to the request for help (linked to checklist), to capture core data set requirements agreed between the Local Authority and Health to complete an assessment of their needs, resources and desired outcomes. This would include a joint review of requests for 1:1 support.
- Discharge to assess for CHC and complex care – as outlined in section 4.1.3
- Home first for complex patients - Expand number of patients discharged home who are complex or CHC eligible, where there is a clear financial case that support at home will be more cost effective than residential or nursing placement. Specific proposal to put intensive support in for first 7 days (including night sitting), with ongoing care plan developed at home during this period
- Homecare - Joint approach to procure homecare and reablement providers to drive up quality and enable providers to support more complex patients. Potential opportunity to develop shared brokerage of homecare support

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 Dementia and challenging behaviours – In 2018/19 an analysis of key causes of delay discharging patients home was completed, identifying dementia and challenging behaviours as a key driver of these delays. A transformation programme was developed with 3 key strands, and progress has been made against all three areas:

a. Dementia awareness in homes without specialist dementia capacity – training sessions scoped and delivered across Brent homes
b. Quality of dementia support in care homes – workshops to train and develop care home staff on improved ways to identify and support people with dementia
c. Dementia in reach service - A new pilot service model has been developed and agreed with partners to provide specialist support to dementia care homes. The funding for this is included as part of the 2019/20 BCF plan. The next step is to implement the pilot and agree how the model will be rolled out and become business as usual

4.3.3 GP Enhanced Care Support – Throughout 2018/9 there has an established MDT service through primary care into care homes 8-8, 7 days a week. This service provides support to homes with the aim of supporting people and reducing unnecessary hospital admissions. The service has to a large extent been successful and has been well received by homes. However, due to financial pressures on the CCG, the service has been reviewed, and a new service specification developed and agreed through CCG Exec. This new services focusses on homes with the highest hospital admissions, and looks to reduce duplication with existing GP responsibilities and provide MDT support linked to the development of the new Integrated Care Partnership service.

4.3.4 Other schemes – there are also a number of additional support schemes homes which are being taken forward as part of the enhanced care home support programme:

- Additional care home 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.
- Development of a directory of service to support improved referrals between services and from care homes
- 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
- MOTITEK bikes – bikes to support wellbeing for residents in Brent. Pilot completed, and rollout expected through 2019-21
- NHS Mail – encouraging and support care homes to sign up and use NHS mail to enable greater information sharing with NHS partners
- Telehealth – a pilot scheme including video conferencing run by the NW London transformation team
- Red bag scheme – currently on hold

4.4 Self care

4.4.1 Self care – improved referral pathway developed to align Brent's Social Isolation in Brent Initiative (SIBI) service (to be part of Gateway) to the new Link Worker roles within the primary care networks (PCNs). A steering group with PCNs to develop a Brent wide model has been developed, and work will be ongoing throughout 2019/20 to deliver this.

4.5 Technology Enabled Care/Assistive Technology

4.5.1 A Technology Enabled Care (TEC) Strategy is being developed, and will be brought for discussion at a future Board meeting. This will include a proposal for investment in new technology to support key cohorts of patients to remain independent and at home for longer.

4.6 Integrated care

4.6.1 Integrated care partnership (ICP) - Progress has been made on the development of a 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. A new service is now operational across most of Brent and will cover the whole of Brent from

December 2019. The model includes an MDT, including social care, and is focused on a proactive model of care for people identified as 'rising risk'. The new ICP service will involve a partnership approach between London NW Trust and the primary care networks, and the intention is that existing services such as district nursing will be aligned to this.

4.6.2 Existing integrated arrangements – There are a number of existing pooled budgets and integrated service arrangements between adult social care and NHS organisations. The council has entered into two formal partnership agreements under Section 31 of the Health Act 1999, one with NHS Brent CCG for provision of occupational therapy equipment and the other with Central and North West London NHS Foundation Trust for provision of mental health services. Additionally, there is a pooled fund agreement under Section 75 of the NHS Act 2006 between the council and CCG to administer the Government's Better Care Fund. Partnerships and spend for 2018/19 is shown in the table below

	Mental Health	Occupational Therapy	The Better Care Fund	Integrated Rehabilitation & Reablement Service
	£m	£m	£m	£m
Funding: LB of Brent	(0.2)	(0.5)	(13.5)	(0.9)
NHS Brent CCG	0.0	(0.6)	(21.1)	0.0
LNWUNT	0.0	0.0	0.0	(1.1)
CNWLNFT	(0.2)	0.0	0.0	0.0
Total Funding	**(0.4)**	**(1.1)**	**(34.6)**	**(2.0)**
Expenditure	0.4	1.7	34.6	1.9
2018/19 Net Overspend/(Underspend)	**0.0**	**0.6**	**0**	**(0.1)**
2017/18 Net Overspend/(Underspend)	**0**	**0.5**	**(0.2)**	**(0.2)**

4.6.3 Future integrated commission arrangements - Further to the agreement at the July 2019 meeting of the Health and Wellbeing Board to develop integrated commissioning arrangements between health and social care, a more detailed paper will be provided to the Board for steer

5.0 Financial Implications

5.1 Continue to review

6.0 Legal Implications

6.1 None

7.0 Equality Implications

7.1 None directly

8.0 Consultation with Ward Members and Stakeholders

8.1 Ongoing

9.0 Human Resources/Property Implications (if appropriate)

9.1 Continue to review

Report sign off:

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