City of Westminster

Westminster Health & Wellbeing Board

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Title:	**Better Care Fund Update**
Report of:	**WCC and Central and West London CCGs**
Wards Involved:	**All**
Policy Context:	**Health and Social Care Integration**
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1. Executive Summary

1.1 This paper is the regular update requested by the Health & Wellbeing Board on progress with development of the Better Care Fund (BCF).

1.2 After a reminder of the national context for the BCF, a brief progress update on BCF schemes in the Triborough is provided. The progress update starts with the most significant scheme, the new integrated Community Independence Service (CIS). There is also a specific update on the pilot that has now commenced to test a new approach to hospital discharge. Following these, there is a broader update on the other schemes that form the Triborough BCF plan.

2. Key Matters for the Board

2.1 The Health and Wellbeing Board is asked to note the progress made with the BCF schemes.

3. Background

3.1 The BCF is a single pooled budget for health and social care services to work closer in local areas, based on a plan agreed between the NHS and local authorities. A national fund of at least £3.8bn was announced in the summer of 2013.

3.2 The BCF is a national initiative to improve health and social care outcomes and cost-effectiveness, with an emphasis on more care at and near home. Every Health and Wellbeing Board has been tasked with developing a plan, and the Westminster BCF plan has been approved by NHS England. The BCF did not come into full effect until 2015/16, but a significant amount of planning and preparatory work was required in 2014/15. Regular updates on the progress to date have been provided to the Health and Wellbeing Board.

4. Progress Update

Community Independence Service

4.1 The new, integrated CIS will provide consistent rapid response, hospital in-reach, and rehabilitation and reablement services. This is the most significant scheme in terms of anticipated benefits.

4.2 Each borough currently has a CIS, but the services in each of the three boroughs work in different ways and are provided by a range of different organisations. In autumn 2014, Triborough CCGs and local authority Cabinets agreed a business case for investment in a single, integrated CIS, serving all three boroughs. It is not possible in 2015/16 to create one organisation to provide the whole of CIS. Instead, the BCF plan aims to invest in improvements in front-line services through two lead provider roles, one for health services and the other for social services. This goes a considerable way to simplifying existing arrangements.

4.3 Following selection of Imperial College Healthcare Trust (ICHT) and partners as lead health provider, joint working has been established with Triborough Adult Social Care to develop and implement the service changes needed. Joint mobilisation, investment and communication plans have been developed, and at the end of March, health and social care commissioners reviewed and approved the plans against a set of pre-agreed requirements.

4.4 The new service led by ICHT and Triborough Adult Social Care therefore commenced as planned at the beginning of April 2015. Contractual arrangements, including performance indicators and measures, have been developed and agreed to monitor and manage the new service. A joint governance structure across health and social care has also been developed, which includes a clinical reference group to review and approve detailed service design. Patients and residents will be involved in design and scrutiny through this governance structure.

4.5 Lead providers are working together to plan and deliver communications to increase awareness, firstly amongst health and social care professionals and then the wider public. This includes briefings for GPs to build their confidence in the CIS changes and additional capacity, encouraging more referrals from them into the service. In-depth patient communications are scheduled for July.

Piloting Enhancements to Hospital Discharge Processes

4.6 Plans were developed in 2014/15 for hospital social work teams to pilot improvements in the support for people leaving hospital. The pilot started in March and will evaluate process changes against a range of criteria, including patient and carer experience, reductions in length of stay in hospital, and the interface with CIS.

4.7 In the pilot, assigned social workers are responsible for all Triborough residents on selected wards across Imperial and Chelsea and Westminster hospitals. For example, on the Manvers and Witherow wards at St Mary's Hospital, social workers involved in the pilot are working closely with medical and nursing teams to provide social care input into multi-disciplinary decision making; and are seeing residents and their carers earlier to provide support. Feedback to date from St. Mary's has been very positive. Links between the discharge process and WCC housing colleagues are being strengthened to help support smooth transition back home from hospital.

4.8 The pilot is scheduled to run until mid-June, with subsequent evaluation to provide recommendations and options for wider roll-out. A briefing paper on the pilot is provided at Appendix 1.

Other BCF Schemes

4.9 Work is also continuing to improve other operational services as part of the BCF plan. These include commissioning of the new homecare service to help more people remain independent in their own homes. Providers for the new service are being procured, and more ways to support joint working between health and social care are being established. Work is also progressing on the business case to increase capacity for neuro rehabilitation in the Triborough, helping to reduce Delayed Transfers of Care in acute hospitals.

4.10 In the BCF schemes focusing on patient and customer experience, a model of care for self-management has been developed through public engagement workshops in each borough and a review of national best practice. An approach to testing the model is now being developed with Whole Systems leads. A review of personal budgets for patients with Continuing Healthcare needs has informed development of a business case, now approved, to increase CCG investment in support provided by Triborough Adult Social Care.

4.11 In the schemes focusing on integrated commissioning and contracting, finance and commissioning leads across health and adult social care are meeting regularly to review opportunities for greater effectiveness and efficiency in services included in existing pooled budgets; and a business case has been developed to assess the benefits of establishing a joint health and social care placements and review team for nursing and residential care.

4.12 In the schemes supporting programme delivery, work is continuing to enable consistent use of the NHS number as the primary identifier of individuals across health and social care. Complementary work on information governance has led to accreditation against the Department of Health's self-assessment toolkit, which measures compliance with legal requirements and central government guidance on information governance. BCF investment is also continuing to support a range of tasks to support Care Act implementation.

5. BCF Ownership

5.1 The BCF plan is owned by the Health and Wellbeing Board and overseen by the BCF Board. Delivery is led by the executive teams for health and social care, which regularly meet jointly and are supported in between meetings by a steering group of the officers responsible for BCF schemes.

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Appendix 1: Update on Hospital Discharge Pilot

1. Purpose of Paper

1.1 This paper provides an update on the hospital discharge scheme that is part of BCF Group A.

2. Background

What is the objective of the pilot?

2.1 The pilot is about testing a new approach to hospital discharge. The Better Care Fund Programme and Customer Journey Programme are supporting the three ASC borough hospital teams to prepare a pilot that will test a new approach to Adult Social Care hospital discharge, and alignment to hospital discharge and in-reach functions. The new approach will enhance the timeliness and quality of hospital discharge, and prepare the ground for reform of the wider hospital discharge process (including the CIS and discharge services of the acute trusts).

2.2 The pilot will test (and evaluate) the following areas:

- **Improving multi-disciplinary teams and integrated working** – are staff members more satisfied working together and sharing information/knowledge – and more effective?
- **Patient and carer experience** – is this really improving outcomes for people? Or impacting on patient safety and quality?
- **Improving discharge process** – are we finding a reduction in length of stay and more effective transfer into CIS?
- **Improving quality of post-discharge** – are their less re-admissions due to holistic care planning? Is there less usage of long-term care arrangements, and specifically placements directly from hospitals?
- **What care needs are not being met currently** – how are we addressing these needs differently?
- **Staffing and skills** – what is the best way to deliver an integrated discharge?
- **Wider recommendations** – what staff resources are needed? What is the business case (quality, finance) based on the activity/outcomes of the pilot wards?
- **Reciprocal arrangements between authorities** – what are the operational requirements on the ground?

What is in scope?

2.3 The pilot will run for three months (16 March to 15 June 2015) across the three borough footprint across Imperial and Chelsea & Westminster hospitals.

2.4 The pilot will only affect the three borough residents that are being discharged from the following 8 wards:

- Imperial – St Mary's Hospital: Witherow and Manvers
- Chelsea & Westminster: Edgar Horne and David Erskine
- Imperial – Hammersmith Hospital: Fraser Gamble and Christopher Booth
- Imperial – Charing Cross Hospital: 8 West and 8 South.

2.5 The primary aim of the pilot is to test redesign of social care and in-reach discharge related functions and workforce – and will directly affect:

- RKBC, H&F and WCC ASC hospital teams
- CLCH in-reach assessment functions across the patch.

2.6 The secondary aim of the pilot is to engage and align to the following services – to ensure improved integration between health and social care:

- Imperial and Chelsea & Westminster medical, nursing, therapy and discharge teams
- The pilot will measure the effect of these changes on demand for other services and make recommendations to optimise the service pathway. Specifically it will look at the referral volumes and demand for the following services:
    - Current CIS and other service provision teams delivering short term care
    - ASC long term assessment teams and provision across the three boroughs
    - Information and advice – potentially access teams and voluntary sector.

What are the desired outcomes?

2.7 The pilot seeks to demonstrate a new approach that will enhance the timeliness and quality of hospital discharge, and provide increased alignment between CIS and the discharge services of the acute trusts; and contribute to the MTFP savings in the Customer Journey programme.

2.8 It will produce evidence-based recommendations and options for wider roll-out across the three boroughs (and potentially with neighbouring authorities across NW London) and inform a business case for integrated 7 day working across the health and social care discharge model for residents of the three boroughs.

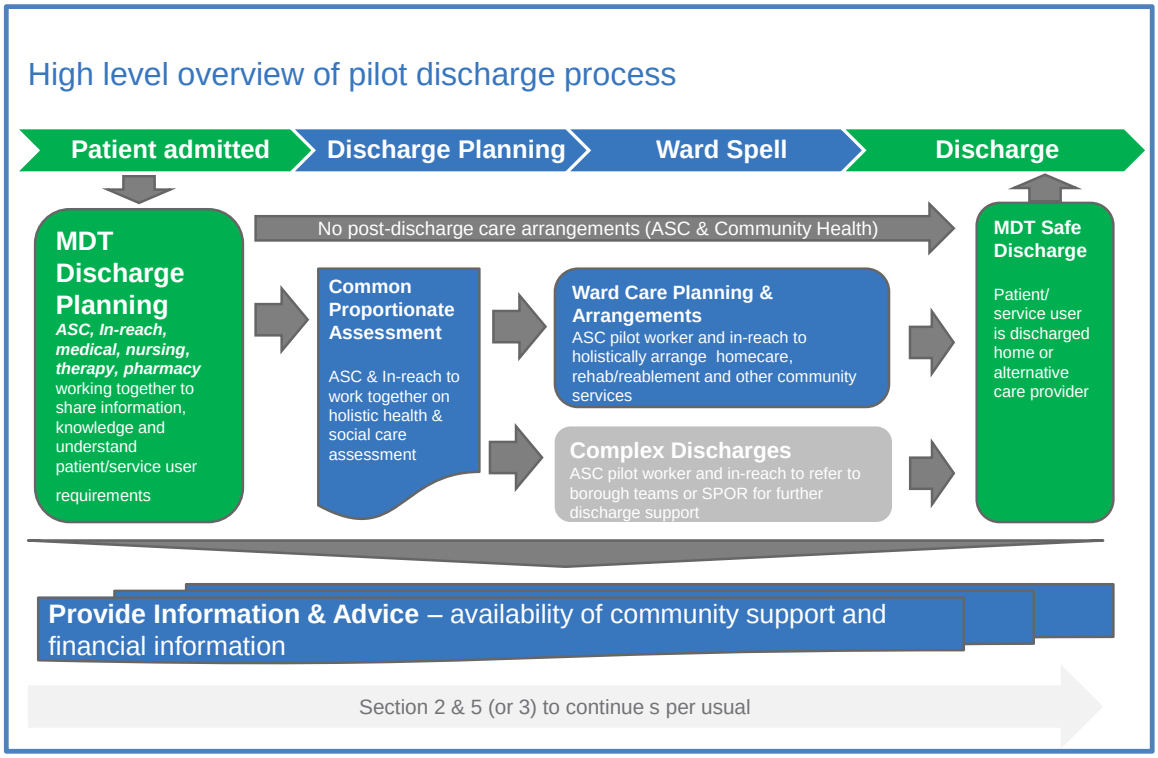
How does it work?

2.9 Starting on Monday 16th March an assigned ward social worker is responsible for all patients/residents from LBHF, RBKC and WCC on selected wards (8 altogether) across Imperial and Chelsea & Westminster hospitals. They are working as one team with the CIS in-reach assessors.

2.10 They will be attending the multi-disciplinary meetings and board rounds, and be available to provide information and advice for and about patients, carers, hospital discharge, nursing, medical and therapy staff. They are also trialling a common proportionate assessment between social care and in-reach, which will help reduce any duplication and delays in discharge planning.

2.11 Figure 1 depicts the overall process of the pilot.

Figure 1: Overview of hospital discharge pilot process for all patients from the three boroughs:



What are the key features of the discharge process?

2.12 Immediate benefits of the pilot include:

- Information and advice for patients and carers in the ward, to improve transition of care to community services
- Named social care and in-reach staff working with one MDT on the wards
- One access point to social care and in-reach for H and F, K and C and Westminster, with common assessment across both teams for all three boroughs
- Access to information from social care records (Frameworki) as part of MDT meetings and board rounds
- More integrated working between Hospital Discharge and Hospital Adult Social Care

- Easy access to knowledgeable professionals and resources around social care and community health provision including CIS (Rapid Response, Reablement, Rehabilitation), voluntary sector and long-term care options
- Streamlined referral processes for CIS and community services
- Reduced duplication and delays between current ward teams and adult social care
- Managed as part of BCF Group A to ensure consistency with development of the new CIS.

Method: co-production

2.13 Taking a pilot approach has been highly beneficial as we can develop and test a different model. The staff who deliver the service, and who know what does and doesn't work on the ground. We have been able to engage with staff, managers and wider stakeholders to shape the approach and gain real buy-in from staff in ASC, in the acute and community NHS trusts.

2.14 A co-production and "test and implement" approach has been taken to designing, developing and implementing this pilot. The co-production consists of:

- Running a weekly working group involving front-line managers and staff across ASC, in-reach and hospitals, to inform design and day-to-day management
- Monthly pilot staff development workshops to listen to and engage with staff
- Direct input and support from:
  - The wider ASC hospital team, including support functions
  - ASC teams including extended hours, long-term care, Frameworki and performance teams
  - Acute medical, nursing, therapy, performance and IT teams
  - CIS project implementation team
- Survey and other feedback from a wide range of customers, patients and ward hospital staff to inform the design of the pilot, and for planning evaluation.

2.15 This approach has been very well received. Operational staff and managers are feeling engaged and working in a safe environment to provide both feedback and develop their own solutions – and they know what works best.

How is this being funded?

2.16 This pilot is being funded by the BCF programme. The staffing costs have been funded through current staffing budgets in addition to Winter Resilience funding which will continue to give us operational capacity to continue with this pilot and keep the service running during such a busy period for the acute system.

3. Progress to Date

What are the key achievements to date?

Pre Go-Live

3.1 Managers and front-line staff from ASC hospital and in-reach teams have developed and agreed a joint assessment and support planning process that is streamlined across the 3 boroughs.

3.2 A joint health and social care assessment has been developed, and is to be tested by both ASC and in-reach staff during the pilot. The pilot design and process has been very well received by the Imperial medical team: “It’s great that we are removing silos and bringing the right staff together to manage discharges”.

3.3 There has been excellent buy-in and contribution from acute teams, including a successful push for Wifi access on pilot wards for ASC and in-reach staff members. This is allowing MDT teams to access Frameworki information live on the ward for the first time. Overall, there is good enthusiasm and momentum from both managers and staff. Induction and training have been completed and well received.

Post Go-Live

3.4 The pilot went live on 16th March, with all pilot workers (including ASC and In-Reach), management and support teams. Since then, there has been a robust issue-resolution process in-place. It has been possible to resolve 90% of issues, with emphasis on front-line support by operational managers across ASC, CLCH, Imperial and Chelsea & Westminster hospitals and the project team.

3.5 Work is continuing to embed new processes, and refine based on staff, support and managerial feedback. This is contributing to continual improvement of the hospital discharge process across the three boroughs, taking good practice from each borough.

3.6 An evaluation approach and plan has been developed by the working group, and there will be further exploration of how the approach could be scaled across hospitals in the three boroughs. This includes “front-door” acute units and out-of-borough hospitals (e.g. UCLH/St. Thomas etc).

What is the early feedback so far?

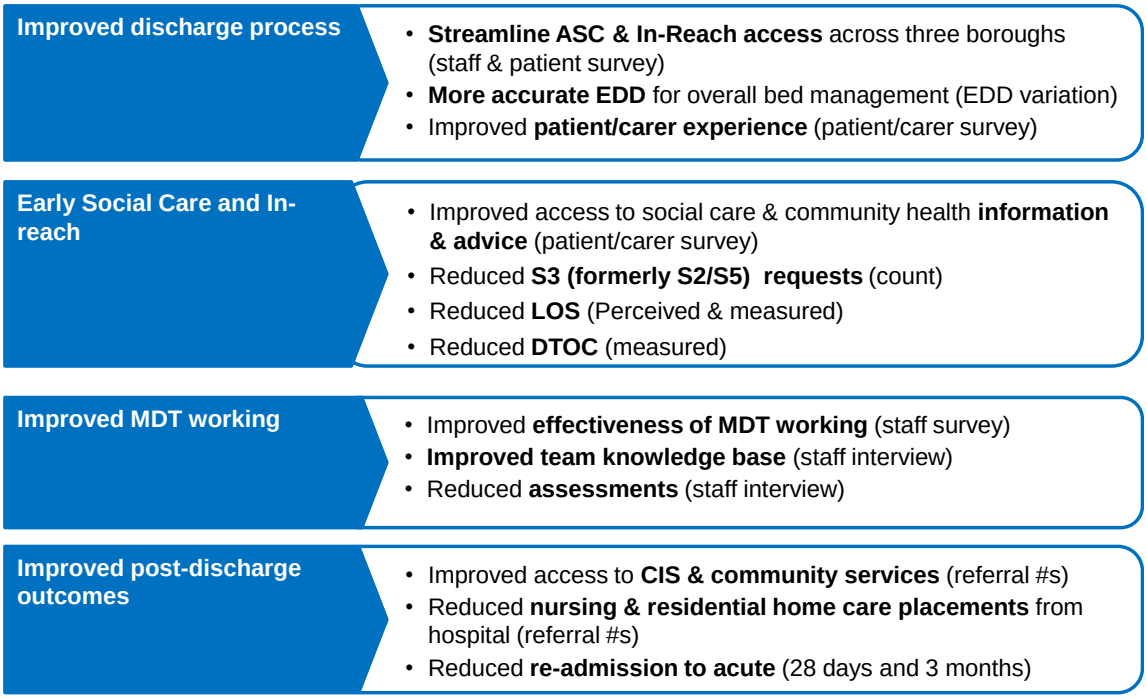
3.7 Over the first 3 weeks of the pilot, early feedback has been obtained from carers, ASC, CIS In-Reach and hospital staff on how the pilot is shaping:

*Early **successes** to date…* • Ability to assess **holistic needs** of patients and in particular for carers – early wins of identifying alternative and cost-effective options • Staff involved have highlighted is **reduced duplication** between different professionals – e.g. assessments, administration, referrals • **'One-stop' access** for patients, carers and professionals on community assessment, service planning and information and advice • Building relationship and **breaking down traditional cultural barriers** between health and social care and acute and community care • **Locally tailored** pilot discharge design to different ward and patient-population type • Ward Consultants feedback **"Why have you not done this before?"**	*Key **issues/challenges** to date…* • **Information governance** between multiple organisations (LA, CLCH, Imperial, Chelsea & Westminster) – having to develop "workarounds" (e.g. joint assessments – storage issue of information) • Effective discharge may potentially **increase demand on 'downstream' services** – long-term ASC, CIS, home care – this is being measured as part of the evaluation to better understand impact for wider recommendations and to ensure appropriate resourcing. Demand for CIS is high and increasing, so resourcing is needed to meet this demand. Clinical support will be crucial in order to satisfactorily change the practices of supporting people at home. • Running a **hybrid environment** of pilot vs. non-pilot wards – we have developed operational processes to enable this and reviewed on a weekly basis
***Opportunities** to further explore…* • Further develop **whole team' approach** - Front-line management and staff have recognised that different teams (i.e. hospital discharge, therapist, CIS, in-reach, ASC hospital teams) using this pilot as an opportunity to test an integrated discharge model • Pilot should expand to **7 day MDT approach** on emergency and acute wards (e.g. AAU and medical units) – where pilot approach and 'turn-around' outcomes • Enhance current **care coordination/arrangement** processes – e.g. enhanced carer support in tandem with CHC packages • **Reduce duplication and handover** between hospital and community teams for both social care and health – e.g. looking at in-reach assessment as a function of CIS rather than a separate team. A discharge role, encompassing both aspects could reduce duplication and provide economies of scale.	***Risks and barriers** to mitigate/ overcome…* • Further explore **clinical responsibility** – who is accountable for what decisions – and what functions can be shared between professionals (e.g. joint assessments to inform **workforce recommendations)** • Continue to develop and implement **CIS** service to enable smooth discharge and transition into community

4. Next Steps

Focus on evaluation and data collection

4.1 An evaluation framework has been developed (with an associated data collection process) based on the original pilot objectives and areas we want to test:



4.2 Next steps and considerations will include how to:

- Further 'operationalise' and embed pilot processes across pilot, hospital and wider ASC borough hospital and in-reach teams
- Develop recommendations and an options paper for wider implementation, informed by evaluation and stakeholder input/feedback
- Implement automated data collection across adult social care in the three boroughs, and in Imperial and Chelsea & Westminster performance teams.

4.3 After the completion of the pilot, an evaluation report will be produced, including feedback from staff, patients and carers.