

# HEALTH AND WELLBEING BOARD

10 FEBRUARY 2014

<b>Title:</b>	<b>Section 75 agreement for the Joint Assessment and Discharge Service</b>
<b>Report of the Corporate Director of Adult and Community Services</b>	
<b>Open Report</b>	<b>For Decision</b>
<b>Wards Affected: All</b>	<b>Key Decision:</b>
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<b>Sponsor:</b> Anne Bristow, Corporate Director, Adult and Community Services	
<b>Summary:</b> <p>The Board has received previous reports regarding the establishment of a Joint Assessment and Discharge Service (JAD) intended to provide an integrated approach to supporting the discharge of patients from BHRUT.</p> <p>The contributing partners are, BHRUT, NELFT, London Boroughs of Barking and Dagenham and London Borough of Havering, and the 3 CCGs covering the local health and social care economy. The JAD does not currently include the London Borough of Redbridge. The London Borough of Barking &amp; Dagenham is the host for the service and has led the implementation programme.</p> <p>The service is now fully operational and a S.75 agreement is required to formalise the partnership arrangements. The agreement requires formal approval from all partners and the Board is recommended to agree to enter into the partnership arrangements described in Appendix 2.</p> <p>This report also describes the services performance to date against agreed measures and, its role in winter planning, and supporting our broader social care and health system at a period of increased demand over the winter period. Performance measures are provided within Appendix 1.</p> <p>In parallel with consideration by the Health and Well Being Board, the relevant Clinical Commissioning Groups Governing Bodies are considering the partnership arrangement so that this can be agreed; and London Borough of Havering is progressing the agreement through its own formal processes.</p>	
<b>Recommendation(s)</b> <p>The Health and Wellbeing Board is recommended to:</p> <p>(i) Agree the proposed S75 agreement (as provided within Appendix 2) and to note the successful implementation of the Joint Assessment and Discharge Service.</p>	

- (ii) To note the positive performance of the service and its contribution to winter planning and operational resilience across health and social care. (Appendix 1).

### **Reason(s)**

The report supports the Council priority 'enabling social responsibility' and more specifically protecting the most vulnerable, keeping adults and children healthy and safe and ensuring everyone can access good quality healthcare when they need it.

## **1. Background and Introduction**

- 1.1 The Joint Assessment and Discharge Service (JAD) Service went live on the 9th June 2014 and consists of around 50 health and social care staff, with a staffing budget of c.£2m. The Service has completed recruitment of permanent staff, with the exception of 3 of 5 nursing vacancies.
- 1.2 The service is arranged into Ward Groups covering Queen's and King George Hospital. The JAD is the single point of contact for all referrals of people who may require health and/or social care support on discharge with a named worker allocated to each ward. In addition the service covers the intermediate care beds and provides a service for patients placed in hospitals out of the area.
- 1.3 The service has been effectively implemented and is now embedded across both Queens and King Georges Hospitals.
- 1.4 Progress is being made in resolving the IT issues within Queens hospital that were key to implementation in the efficient delivery of the service. However staff are still required to input information to different systems and further development of Health Analytics is required to ease some of the difficulties. An integrated IT system is an aspiration which may be realised at some point in the future.
- 1.5 A training and development plan has now been developed for the service following a Training Needs Assessment involving both ward based and JAD staff. This is aligned to BHRUTs improvement plan. LBBB is providing Care Act briefings for BHRUT for ward based staff to dovetail with training for JAD, as well as briefings on the implications for senior staff.
- 1.6 The CCGs have provided additional nursing capacity to help progress continuing Health Care assessments to reduce such delays.

## **2. Operational Resilience**

- 2.1 The service has formed a key element of the Operational Resilience plans across health and social care, supporting both improved flow through the hospital and providing a service in Accident and Emergency departments to support both admission avoidance and diversion to other more appropriate services. This has involved Social Work support working across the 7 days and at peak periods of demand, commissioning increased community based support packages, interim placements and a 'take home and settle service' provided via Age UK.
- 2.2 In key areas such as in the provision of community based crisis response, planned activity levels and the intensity of support to individuals was anticipated to increase,

and this would have been unsustainable without the availability of additional Operational Resilience funding. However it is clear that demand during December and January has been significantly higher than planned with the hospitals under acute pressure and discussion is underway with the CCG to ensure the local authorities are able to continue to fund these pressures in 2014/15.

- 2.3 The JADs contribution to Operational Resilience (winter pressures) planning is to reduce the pressure upon acute bed stock by 15 which along with community based provision contributes to the 25 beds saved for the JAD, and the 3 local authorities. For the JAD and LBB community, 24 beds were saved in December 2014 against an operational resilience plan requirement of 15.

### **3. Other programmes**

- 3.1 The service is fully operational across 7 days – supporting a Better Care Fund national outcome for the provision of 7 day working. It is however, noticeable that discharges are reduced at weekends due to the reduced levels of clinical staff with whom discharge planning is necessary.

### **4. Governance**

- 4.1 Whilst the development and implementation of the JAD has been overseen by the Integrated Care Coalition and the Urgent Care Board regular Executive Steering Group meetings with senior representation from each participating organisation have been established chaired by LBB.
- 4.2 The Steering Group has played a crucial role in reviewing progress against milestones established within the individual work streams in the original project plan, providing oversight of performance and acting as a point of resolution of key issues. The Steering Group has closely supported the development of our S.75 agreement, considering in turn each partner organisations requirements and our overall vision for this integrated service.
- 4.3 Following the formal sign off of the partnership agreement the Steering Group will for a formal executive function in governing the service.

### **5. Performance**

- 5.1 The latest performance against agreed metrics is provided with Appendix 2. These were considered and steered by the JAD Steering Group as the agreed point of governance for the JAD Service.
- 5.2 Performance to date evidences that despite high and sustained numbers of S.2's (referrals) and S.5's, DTOC numbers of days delayed via responsibility shows a marked decline (improvement). For example, there has been a 35% reduction in Delayed Transfers of Care (attributable to social care) for the first six months of the JAD.
- 5.3 However it is also evident that commitment to service support hours has markedly increased as we approach the winter period. For example for LBB we have seen numbers of new support packages increase from 262 in August to 530 in October with this increase sustained across November with 680 support packages in November. Spend is significantly supported via the availability of additional funding

via Operational Resilience and would otherwise be unable (within resources available to the council) to be sustained.

- 5.4 Whilst work is underway to develop a robust methodology for establishing user experience, there has been significant feedback from service users and their carers identifying their positive experiences of support via the JAD. Examples have included, the benefits of families being able to come in at weekends and talk to a worker, and earlier discussion about how an individuals support needs might best be met ahead of any discharge.
- 5.5 The indicators provided within the Appendix 2 confirm a surge in activity, notably packages of care and support at home which both avoid unnecessary admissions and support people to remain at home after a period in hospital. Performance in this respect remains within top quartile and is a significant contributory factor in supporting system demand and shifting our reliance upon bed based services to those based closer to home.
- 5.6 The Service has now won an award sponsored by Health Education- North Central East London 'Quality Awards' for training under the category of 'Collaboration and Partnership Education'.



## 6. Discharge Workshop

- 6.1 The Urgent Care Board has committed LBBB to lead a workshop to consider in more detail some of the issues that have come to light in the discharge pathway and allow a broader consideration of contributing processes and services. It is proposed to combine this with learning from the Operational Resilience experience which has been marked by significant culture shift in working together at an operational level, particularly with BHRUT and NELFT staff.
- 6.2 This workshop is planned to be held in May when the pressures subside and will include both operational and commissioning staff from:
- The CSU and CCGs
  - BHRUT – clinicians and managers
  - NELFT – CTT, IRS and CHC teams
  - LB Havering
  - LB Redbridge

- GPs and primary care and
- Joint Assessment and Discharge service

## **7. Implications**

### **7.1 Health and Wellbeing Strategy**

The service has been developed and implemented to positively impact upon the health and well being of people who have received acute care and require support, information and advice to leave hospital in a timely and safe way.

The Service is supported by a range of performance outcomes for the service which both align to existing measures – such as the number of people remaining at home after 91 days of discharge, number of discharges and numbers entering long term bed based care. We are also critically developing a measure that will provide the service with direct feedback from service users and their families determining both their experience of support and the extent to which they consider that their individual outcomes have been met.

### **7.2 Joint Strategic Needs Assessment**

At this time there is the necessity, the motivation and momentum to transform the entire organisation and delivery of health and care services to the extent that has not existed throughout the existence of the NHS. The Joint Assessment and Discharge service is part of the transformation agenda providing a single point of access. Its creation was underpinned by the JSNA. The JSNA recommends that this need encompasses primary, community, hospital and social care services and is driven by the need to ensure that meeting the needs of the population goes hand in hand with services that are of high quality, sustainable and affordable.

### **7.3 Integration**

The delivery of the Joint Assessment and Discharge has successfully delivered a single, integrated discharge function across BHRUT involving hospital discharge staff, LBBB SW staff, LB Havering hospital SW team and staffing resources from NELFT.

### **7.4 Financial Implications**

Implications completed by: Roger Hampson, Group Manager Finance

The service has been modelled on existing staffing budgets and operational commissioning budgets and there are no financial issues. The pooled implementation pot is considered sufficient at this stage, and partners are continuing to manage additional one-off implementation costs from within their own budgets.

The S.75 provides for delegated authority to the service in respect to social care budgets and processes related to Continuing Health Care. Further work has been completed from finance teams to ensure there are simplified approaches to funding flowing between organisations and satisfactory reporting mechanisms and draft monitoring and reporting arrangements receive consideration by the Steering Group on a monthly basis.

## 7.5 Legal Implications

Implications completed by: Allan Donovan, Legal Services

The delivery of the JAD requires a formal S.75 to be in place to properly support the arrangements, allowing staffing and resources to be managed within the service. We have developed a S.75 which has been subject to support from the Councils legal services and in turn partner organisations contributing to the JAD seeking parallel input from their legal representatives. The agreed S.75 is now provided with Appendix 2.

## 7.6 Risk Management

The S.75 provides for the management of risk between the partners to the JAD and includes provisions in the event of exit from the service by the partners.

## 7.7 Customer/ Patient/ service user Impact

The provision of the JAD is supporting improvements in collaborative working with decisions moved closer to the service user and their families as planning for discharge is begun within the wards at the point of admission.

Alongside a range of performance measures the conclusion of our approach to gaining direct feedback from individuals and their families will provide further steer in the development of the service continues.

## Public Background Papers Used in the Preparation of the Report:

Previous reports to the HWBB:

04 June 2013 <http://moderngov.barking-dagenham.gov.uk/ieListDocuments.aspx?CId=669&MId=7074&Ver=4>

17 June 2014 <http://moderngov.barking-dagenham.gov.uk/ieListDocuments.aspx?CId=669&MId=7551&Ver=4>

17 Sept 2013 <http://moderngov.barking-dagenham.gov.uk/ieListDocuments.aspx?CId=669&MId=7076&Ver=4>

## Appendices:

Appendix 1: Performance measures

Appendix 2: JAD Section 75 Agreement