ISLINGTON

In partnership with

Whittington Health NHS

Report on Section 75 (National Health Service Act 2006) Partnership Working between

London Borough of Islington and Whittington Health NHS Trust

1. INTRODUCTION

This report covers the main achievements of during the financial year of 2016/17 in the provision of integrated services for adults and older people, and identifies the key priorities for 2017/18.

2. KEY AREAS OF ACHIEVEMENT 2016-17

2.1 Integrated Locality Team Working - Where we are now

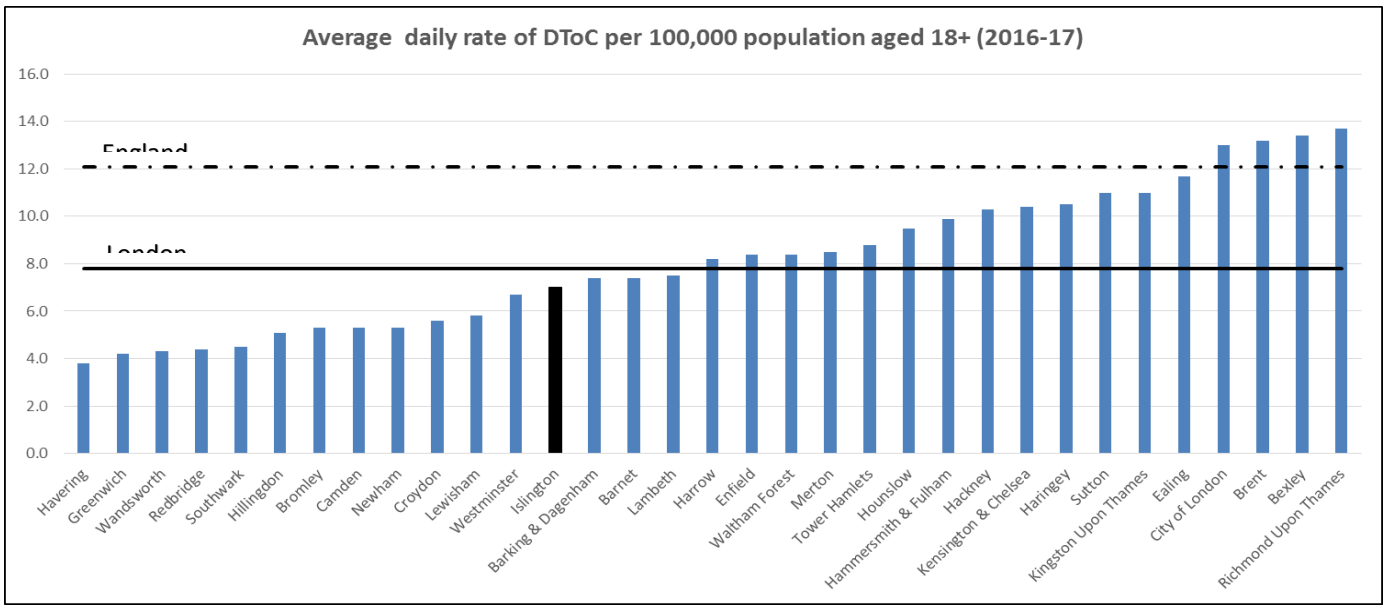
The service has updated its name to 'Integrated Community Services'. This is as a result of the implementation of the integrated GP networks and to prevent any confusion around referral pathways. The North and South integrated community teams continue to be co-located with the REACH services. The teams continue to work together to ensure that the services are delivered in partnership and are sustainable and able to respond to the increasing number of people being supported to remain in their own homes and independent for as long as possible.

Collaboration between Whittington Health and Islington continues in the following areas:

- Integration in line with healthcare priorities
- Development of discharge to assess pathways
- Retain co-location between health and social care staff in the community setting
- Integrate team meetings across community health and social care
- Ongoing work on admissions avoidance
- Growth in the use of Enhanced Telecare services

2.2 Care Closer to Home – reducing the time people have to spend in hospital

Delayed Transfers of Care



Islington continues to perform well in maintaining a low number of Delayed Transfers of Care (delays to people leaving hospital). This has been supported by: -

- Daily teleconferencing to discuss people with complex needs, and to agree actions across hospital and community teams towards discharge day and social work service over the winter period.
- The development of a "virtual ward" which enables patients to be discharged with reablement packages of care over the weekend.

- Prompt access to necessary equipment via TCES (community equipment service)
- A support worker (employed by Age UK) continues to carry out practical tasks necessary for hospital discharge, in a timely way e.g. getting keys cut, enabling essential work to prepare people's home for them to return to being carried out whilst they are still in hospital.
- Links to the voluntary sector, particularly Age UK, to support people on return home, for example following an attendance at accident and emergency.
- Continue review of whole system concerns with the Discharge Lead to monitor Delayed Transfers of Care for Islington residents and to escalate issues around delays.

Islington perform well when benchmarked with other providers and have consistently been a highly performing authority in London for the past 5 years. Performance has improved slightly in 2016-17 from 7.2 to 7.0 delayed transfers of care per 100,000 of the population. It is worth noting however that Islington rates of delay are still significantly lower than the London average of 7.8 delays per 100,000 of the population, and the England average of 12.1 delays per 100,000 of the population.

2.3 Avoiding Hospital Admission

Evidence shows that older people 'decompensate' and lose their independence during an extended hospital stay. Hospitals are an unfamiliar environment and patients lose their routine impacting on their ability to keep active and maintain muscle strength. There is a continued focus on supporting and caring for people at home in line with current clinical best evidence if they do not need an admission for acute medical care.

The **Facilitating Early Discharge Service (FEDs)** team changed their name this year to the **Specialised Therapy and Rapid Treatment Team (START)** to better reflect their role in admission avoidance in the Emergency Department, Clinical Decision Unit, Acute Assessment Units and Ambulatory Care. The service is covered every day from 08.30 to 20.30.

The aim of the team is to screen all patients who require therapy intervention as part of a full MDT assessment within 12 hours of admission. The assessment will determine the needs of the person and if they can be supported to return home safely thus avoiding admission to hospital. Early intervention and rapid assessment can also significantly reduce the time the person is in hospital for reducing the risk of decompensation and hospital acquired infection.

The team work closely with the Virtual Ward service, Social Services and Reablement to ensure a seamless link from hospital to home. Equipment that is required to promote independence, maintain function or improve safely can be rapidly accessed through a loan provider or via local pharmacies using a prescription system.

The team also includes a technician who can undertake further assessment in the home environment immediately post discharge, for example, to complete a home safety check, practice with new equipment in the home setting, assess for non-urgent equipment such as bathing aids or outdoor mobility equipment and make onward referrals to both statutory and voluntary sector services when required.

A social worker is linked to the team on weekdays to provide assistance and support with assessing the more complex patients who present for example with, a higher level need or safeguarding concerns. At the weekends the team link closely with the duty social worker based in EDT for the same purpose.

These initiatives are successfully minimising the time people spend in hospital, supporting them to remain as independent as possible and providing the support they need to remain in their own homes.

Currently we are progressing to the Discharge to Assess Pathway working with colleagues in

Social care and Reablement to ensure when people are medically optimised they can leave the acute setting with the appropriate care and therapy provision they require to continue their recovery at home.

The work of **the Lead Nurse for Quality and Assurance**; a jointly funded post that sits in the Older Adults Commissioning Team within the Council, continues to improve the quality of care and clinical competency within the care homes, to prevent hospital admissions and to support reductions in hospital lengths of stay.

Currently, all of the homes have permanent home managers in post and for the exception of one home, good clinical leads, this has enabled effective working relationship with the GP and the wider MDT to manage the increasingly frail and complex residents and support the sustainability of the training and input being provided into the homes.

A number of actions identified in the 2015 -16 report have been completed whilst others remain in development. The achievements for the year includes:-

- Engagement of care home staff in cross sector training, in particular the Health Education England funded Care Certificate training.
- The development of the nursing audit tools.
- Embedding the process and systems for care home management of residents requiring PEG feeding.
- The move from the use of blister packs on care home nursing floors.
- Engagement of ICAT pharmacist to improved medicine management.
- The introduction of defibrillators into the care homes in support of London Ambulance Service response time.
- With the support of a Darzi fellow, the introduction of Treatment Escalation Plan guidance and template
- Full implementation of the pan London based Quality Performance Monitoring (QPM).

There is ongoing work required around the introduction of the 'Standard Operating Procedure for the management of deteriorating residents. This is being progressed in 2017 -18.

The Home Managers Clinical Care Improvement Group (HMCCIG)

This group set up in 2014 continue to meet bimonthly and work collaboratively to sustain clinical changes that have been implemented as well as those being proposed by specialist groups. The group is represented by a broad spectrum representation and include community based specialist teams (SALT, Dietician, OT, Physiotherapist Team), TVN, SAMH, DN, and other relevant resources. It remains the forum through which clinical concerns are highlighted and clinical improvements progressed.

The Lead Nurse continue to provide a monthly update of current and potential clinical risks and concerns to the RADAR group, which monitors the quality of care or service provided within the care homes and other care providers. The purpose of the group is to monitor areas of concern as well, engaged the wider MDT and share intelligence. The group is made up of operational and commissioning leads from both Health and Social Care including both the Council and CCG Safeguarding leads and key members of the HMCCIG i.e., SALT.

This collaborative approach has ensured that safeguarding concerns or investigations following complaints or feedback from the wider MDT with a clinical practice component are addressed quickly and effectively.

As a result of the quality monitoring, a number of quality improvement initiatives have been implemented during 2015 -16. These initiatives have been developed in part to address gaps in the delivery of effective and safe care, hospital avoidance and primarily to continue to improve the experience of residents in the homes.

The 2016-17 focus of the HMCCIG, in support of the relevant Sustainability Transformation Plans (STP), whole system thinking and approach is to sustain previous initiatives as well as develop the following:

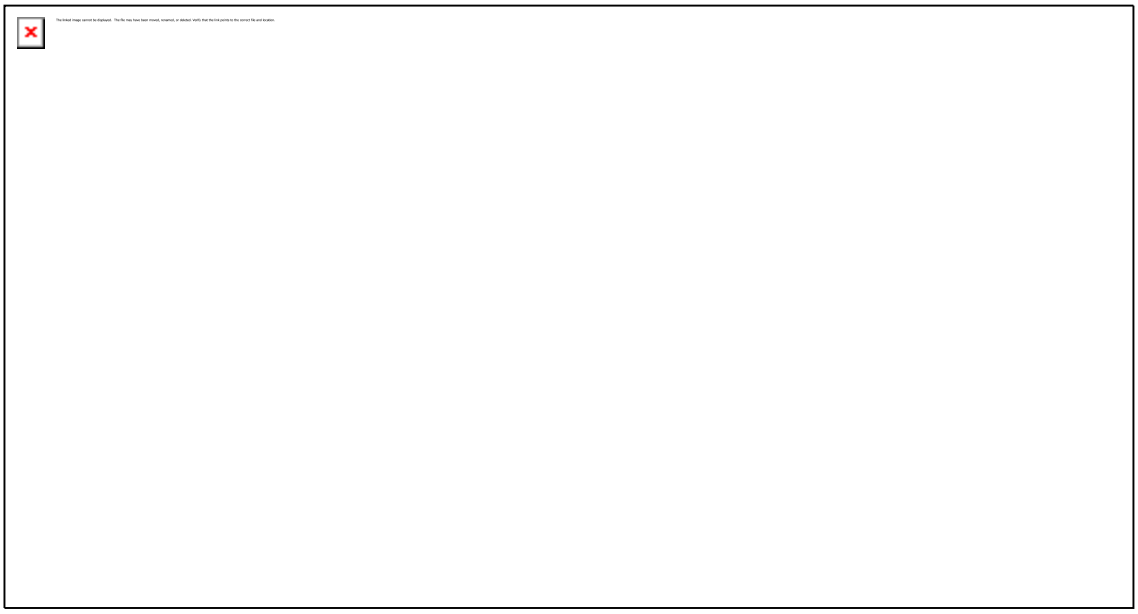
- A more skilled qualified and unqualified workforce in care homes who are well able to utilise the resources available to manage long term conditions within the home.
- Inclusion of care homes in integrated workforce planning within the local health and social care system
- With representation from the Lead Nurse, the Community Provide Education Network (CPEN) continues to engage care homes in cross sector training.
- Through recent transformation plan funding, the care homes will be in the position to access secondary sector training to gain extended clinical skills in support of Advance Care Planning and Treatment Escalation Plan e.g., management of syringe drivers and catheterisation.
- Three Islington care homes, Bridgeside Lodge, Highbury New Park and Muriel Street will be supporting the UCLP pilot of the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT). The pilot will start in September 2017 and is expected to add to achievements made to date around hospital avoidance.
- There is ongoing commitment to engage the care home providers in the various initiatives and projects designed to prevent unnecessary hospital admissions and improve experience of care within the care homes. Two of the home managers were invited and have made successful applications to take part in the Capital Nurse Senior Leadership programme. Alongside the Lead Nurse, the home managers will be focussing their project on 'Care homes internal infrastructure which will in turn support the 'Trusted Assessor' and secondary sector care clinical training objectives. There will also be the potential to develop clinical pathways that extends to care within the care home setting.

2.4 Telecare

The Enhanced Telecare team continue to provide support focussed on keeping Islington residents safer and more independent at home, as well as delaying admission into care homes and preventing hospital admissions. Telecare is available to residents in private dwellings as well as to people living in supported accommodations and sheltered schemes to assist onsite staff in managing their residents' needs and keeping people independent for longer.

In 2017/18 Islington is committed to further cementing telecare as a central part of our universal preventive offer. We have streamlined the referral process for enhanced telecare services, removing the requirement for a full social care assessment to trigger access to the service in line with the principles of the Care Act. To support and embed this process change, a mainstreaming training programme will be delivered in Autumn 2017 to ensure staff across adult social services are confident in using this new referral process and understand telecare's role as a universal preventive service for all residents who stand to benefit from the support it offers.

As a result of this shift, we expect to see a continued upward trend in the number of people receiving the service and we will be monitoring this closely.



3 PLANNED DEVELOPMENTS

3.1 Developing the locality-based model with GPs

There is a commitment to participation in the locality-based multi-disciplinary team working within GP localities. The participation of staff from both social services, and community health teams, e.g. therapists, district nurses and community matrons, and hospital consultant geriatricians, in a fortnightly primary care led teleconference brings together information and expertise from a wide range of professionals, and from acute and community care. This supports development of a coordinated care plan to support better management of people's well-being within a community setting. Whittington operationally manages the integrated networks (multiagency teams wrapped around primary care) through the Integrated Network Coordination (INC) infrastructure.

The development of locality based teams of health and social care staff will support effective links with the primary care localities, and development of multidisciplinary work to support management of patients most at risk of hospital admission or premature entry in to long term care.

Whittington Health has been a central part to the implementation of the Integrated Networks across Islington so far. The roll out of the programme began in February 2016 and Whittington Health have operationally managed and provided the ongoing infrastructure for the Integrated Networks. There are now 12 Integrated Networks running across Islington with 97% of GP practices part of a Network as of July 2017. In 2016/17, a total of 1440 patients were discussed via the Integrated Networks.

The relationships and ways of working that have been developed across health and social care organisations across Islington will be key to the successful delivery of the CHIN's as part of the STP. The Integrated Networks will be the foundation of the CHIN model and the Whittington Health admin, management and community matron teams involved will continue to work with partners to support the development. There will be a focus this year in strengthening links between the Integrated Networks and secondary care to ensure that they are embedded into business as usual and the relationships already created will be extended to acute clinical teams.

3.2 Discharge to assess

3.2.1 The approach

'Discharge to assess' is a new approach to hospital discharge which supports people who are medically ready to be discharged from hospital to get home more quickly by having their social care needs assessed at home rather than on the ward. This approach to discharge will help to improve patient flow through the hospital, ease demand on hospital beds and staff, and make better use of our community services and deliver better outcomes for patients.

Patient outcomes the approach supports include the following examples:

- They will have a much lower risk of getting a hospital acquired infection;
- They will keep their independence for longer
- They will rely less on long term care and receive care that is most appropriate to their needs
- They are likely to live longer.

3.2.2 The pilot

Discharge to assess has been piloted on a small scale to date for residents living in Islington through a partnership with The Whittington Hospital, University College London Hospital (UCLH) and Islington Adult Social Services. As of July 2017, a pilot pathway has been developed based on the Medway model for patients in pathway 1 (those who have additional care needs but can have these safely met at home).

The pilot has facilitated 3 discharges from the Whittington to date and 1 from UCLH. A further 6 discharges (5 from each hospital) will be delivered through the pilot, each building on learning from the previous example to ensure continued improvements.

Upon completion of the pilot, evaluation data will be reviewed and overall learnings considered ensuring the delivery of a sustainable pathway using discharge to assess as the primary discharge route for pathway 1 discharges going forward. Work is underway to scope requirements to deliver a pilot for pathway 2 and 3 patients in the coming months.

3.2.3 Upcoming priorities for delivery

Delivering effective discharge to assess pathways relies on safe and effective community services which are able to respond to referrals rapidly to facilitate same day discharge for medically fit patients. In particular, a strong therapeutic and reablement offer in the community is essential.

Priorities development areas for delivering these requirements in the coming months include;

- Ensuring accurate data is available from both acute and community partners to support well informed understanding of capacity requirements of the discharge pathways
- Delivering improvements in the efficiency, flexibility and capacity of our reablement service to support same day discharges as standard
- Developing a sustainable and robust single point of access for acute referrals to adult social care
- Securing additional resources required to fully staff this single point of access
- Developing a coherent admissions avoidance strategy which supports the discharge to assess approach.
- Ensure services are embedded for Winter 2017/18.
- Implementation timetable includes CHC beds from September 2017.

4 CONCLUSION

The strong partnership working between Islington Social Services and the health services within Whittington Health NHS Trust continues to move in a positive direction. Ongoing work such as Discharge to Assess will further develop local and locality services that are truly 'joined up' and delivered in a way that offers integrated care and support, to the benefit of Islington residents.

It is important to preserve the benefits of integrated working, and to use the opportunities to develop further integration of front-line teams over the coming year, as this will provide a better coordinated service to vulnerable people, and ensures that opportunities to share expertise and specialist knowledge are maximised, and that any duplication of work is minimised.

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