ISLINGTON

In partnership with

Whittington Health NHS

Appendix 1

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 the last year in the provision of integrated services for adults and older people, and identifies the key priorities for 2016/17.

2. KEY AREAS OF ACHIEVEMENT 2015-16

2.1 Developing Integrated Locality Team Working

2.1.1 Service Review and the recommendations

In September 2015, the council commissioned a review of the Integrated Locality Working Model. The purpose of the review was to look at the recent restructure of community health and social care services to identify how we could make the best use of available resources to achieve a more integrated and effective service and ensure that the service delivers more personalised and integrated support to service users.

The new model required significant changes to social care structures in order to ensure that duplication was minimised, outcomes improved and statutory obligations related to changes in legislation met. The implementation of the Care Act 2014 had significant operational implications for adult social care with an anticipated increase in demand from those requesting assessments, new duties to provide additional support (e.g. to self-funders) and an increased focus on providing information, advice and guidance to all.

The purpose of the review was to identify what was or wasn't working and ways of addressing concerns and how to further improve the model. We also wanted to check how we have responded to the additional duties introduced by the Care Act which necessitated operational changes to the service and contributes to the health and social care efficiency targets.

The Review made recommendations that can be summarised into three areas:

People

- Work with staff to support them to work to the principles of the new operating model
- Develop clear guidance on remit and role of each team and how they work together

Process

- Embed ownership of hospital work within community teams and define core social work tasks for discharge process
- Review the rotation system for staff across the front door teams
- Ensure effective contingency for staff cover across the service
- Implement a number of quick win operational decisions to facilitate day to day working
- Review caseloads across all teams to ensure these are equal

Systems

- Streamline interface between community teams and GP locality networks
- Decrease number of dropped calls between front door and community teams
- Streamline case closure and authorisation processes

2.1.2 The approach taken to resolve issues identified in the review

The review of the model gave Senior Management the opportunity to consider all staff feedback and make the required adjustments to the model.

Whilst the review identified that the number of incoming cases had not increased, the review identified that there were significant pressures on different parts of the system that are causing capacity issues. As a short term measure, 10 additional staff were brought into the

North and South Community and Social Care Rehabilitation teams to provide additional support.

Following the review and staff briefings, a number of business process mapping workshops were carried out with the following areas of the service:

- Access & Advice/Screening
- Urgent Response
- Assessment and Support Planning
- Enablement and Home Support Service
- Reviews
- Carers Assessments
- Direct Payments
- Hospital Discharges

The sessions were set up to test the business processes and systems to see if they were working in practice. This provided an opportunity to directly address some of the problems which staff reported in the review. Following this further work was done to:

- Finalise updated business processes for each area of the service to provide further clarity to staff about how they should be working
- Carry out targeted communications with staff to promote the new business processes
- Review aspects of integration which were not working and separate out responsibilities across health and social care Partners
- Develop the integrated networks to increase joint working where it was working successfully and include housing
- Progress the development on integrated health and social care record
- Develop fast track access to social care services through Rapid Homecare service

2.1.3 Where we are now

The 'Moving Forward' programme plan continues to focus on developing the integrated model between community rehabilitation, intermediate care and social care which seeks 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 to work with:

- Progress with integration in line with healthcare priorities
- Consider how both organisations can integrate work happening in clinics across community health and social care
- Retain colocation between health and social care staff in the community setting
- Integrate team meetings across community health and social care
- Consider linking up front door services across community health and social care through an updating of the Islington Directory (formerly Links for Living)
- Benefits realisation of co-located between North and South teams.

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

Delayed Transfers of Care

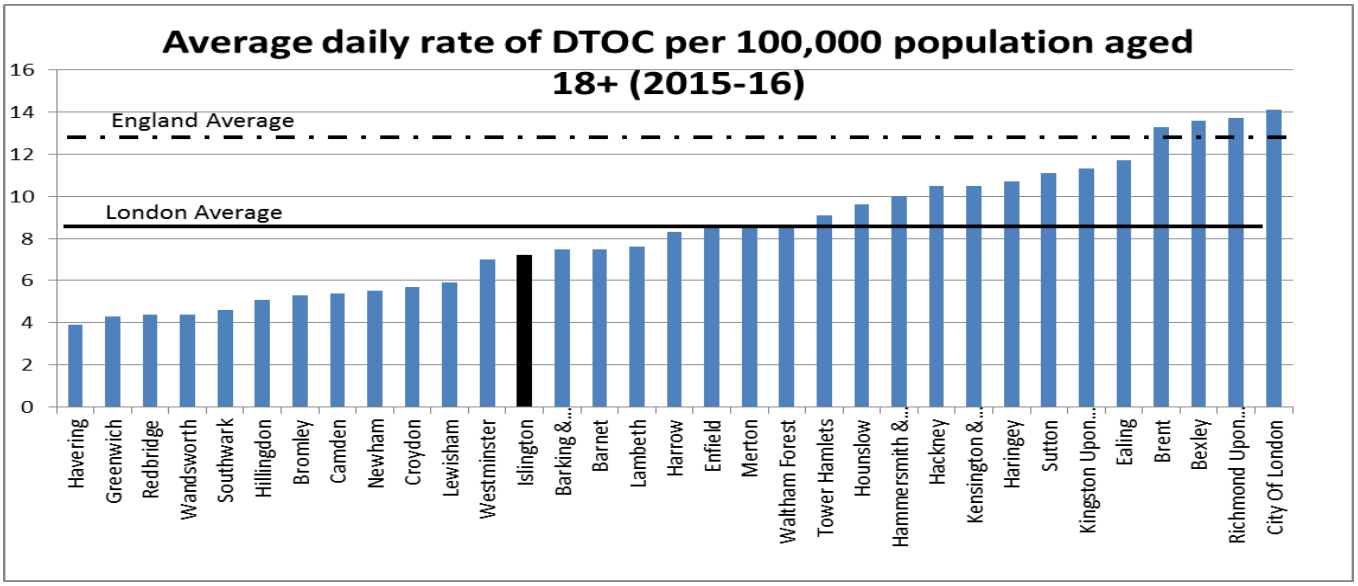
Islington continues to perform well in maintaining a low number of Delayed Transfers of Care (delays to people leaving hospital). This has been supported by: -

- 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)
- 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.
- The appointment of a whole system 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 4 years. Performance has declined slightly in 2015-16 to 7.2 delayed transfers of care per 100,000 of the population compared to 6.2 per 100,000 in 2014-15. It is worth noting however that Islington rates of delay are still significantly lower than the London average of 8.3 delays per 100,000 of the population, and the England average of 12.3 delays per 100,000 of the population.



2.3 Avoiding Hospital Admission

Evidence shows that older people often 'decompensate' and lose their ability to keep independent in hospital, due to being in an unfamiliar environment, not keeping active to maintain muscle strength, and losing confidence. In the past year there has been an increased emphasis on supporting and caring for people at home if they do not need an admission for acute medical care.

The **Facilitating Early Discharge Service** (FEDS) is a team of therapists who see patients 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, practise 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.

Key next steps are to progress with Discharge to Assess for home care and reablement which will further reduce duplications and length of stay by 1 to 2 days.

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.

During 2015-16 work continued on the following streams:

- Development of the nursing audit tool
- Quality performance reporting
- Support for residents with PEG
- Medicine management
- Hospital avoidance SOP for deteriorating patients
- Training and workforce development

Majority of the streams above are now concluded with the exception of the 'Standard Operating Procedure for the management of deteriorating residents. To be progressed in 2017.

The Home Managers Clinical Care Improvement Group (HMCCIG)
This group was set up in 2014 and continue to meet bi monthly with a key focus to agree systems and process and drive actions to improve and sustain clinical change proposed by specialist groups. The group have a broad spectrum representation and include community based specialist teams (SALT, Dietician, OT, Physio Team), TVN, SAMH, DN, and other relevant resources. It remains the forum through which clinical concerns are highlighted and clinical improvement progressed.

The Lead Nurse also provides a monthly update of current and potential clinical risks and concerns to the RADAR group, which monitors the quality of clinical care provided within the care homes. 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.

Current measures in place in support of hospital avoidance include the following:

- Access to a named GP and named GP/ICAT input and rounds in care homes
- On-going implementation of treatment escalation plans

- ICAT input during hospital admissions for care homes residents
- Access to the ambulatory care unit
- Regular input from wider MDT services e.g. Palliative / End of Life clinical nurse specialist

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.

Quality improvement initiatives in support of clinical care
The quality monitoring initiated and built on throughout 2015-16 includes:

- Cavendish Care Certificate Training
- Clinical Supervision in Care Homes Project
- The SALT Dysphagia 'Train the Trainer' project
- Sharing Information & Good Practice
- Continuing Professional Development for care homes workforce
- Teaching Care Homes – Student Nurse Placements Middlesex University
- Care closer to home for residents e.g. Advanced Care planning sessions

These initiatives have been developed in part to promote links and address gaps in the delivery of effective and safe care and support the vision for hospital avoidance. The SALT Dysphagia 'Train the Trainer' project in its approach to provide input for sustaining good practice in the home is highlighted as one of the key contributors.

The incidence of hospital admission from Care Homes remained comparable to previous years. The majority of these were reported as unavoidable by the care homes, due to significant changes in the resident's condition; e.g. the resident became unwell during an outpatient appointment. In the cases where hospital admissions were deemed to be avoidable there was evidence that escalation plans had not been fully utilised. A key action is therefore for the Lead Nurse to work with Care Homes to ensure that these plans are fully utilised.

The Islington's model of support to Care Homes compares well with care homes in the national Vanguard sites in that each Care Home has a named GP and receives on-going and regular input from a specialist multi-disciplinary team.

However there are considerable concerns with the internal infrastructure and performance of the key care homes within Islington currently i.e., Cheverton, Lennox, Muriel Street and to a low degree Highbury New Park. Muriel Street has a 'Suspended Placement' in place following significant concerns about the home.

A pressing focus for the Lead Nurse is therefore to work in close conjunction with all stakeholders including the care home managers and senior management of the organisations to address issues identified and to minimise risk of avoidable hospital admissions and delayed discharge.

The 2016-17 focus of the HMCCIG is on developing 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.
- A more integrated workforce in the local health and social care system
- Consideration for extended clinical skills e.g. management of syringe drivers
- Potential to update clinical pathways that include care within care homes

2.4 Integrated Community Equipment Service

The Transforming Community Equipment Services project (TCES) has now been 'live' since

February 2011, when the retail model for simple aids to daily living, and joining the London Consortium for Complex Aids to Daily Living, were introduced in Islington.

In 2015-16 between 196-278 service users a month were issued with prescriptions and the redemption rates have averaged 85%, which is above the national average.

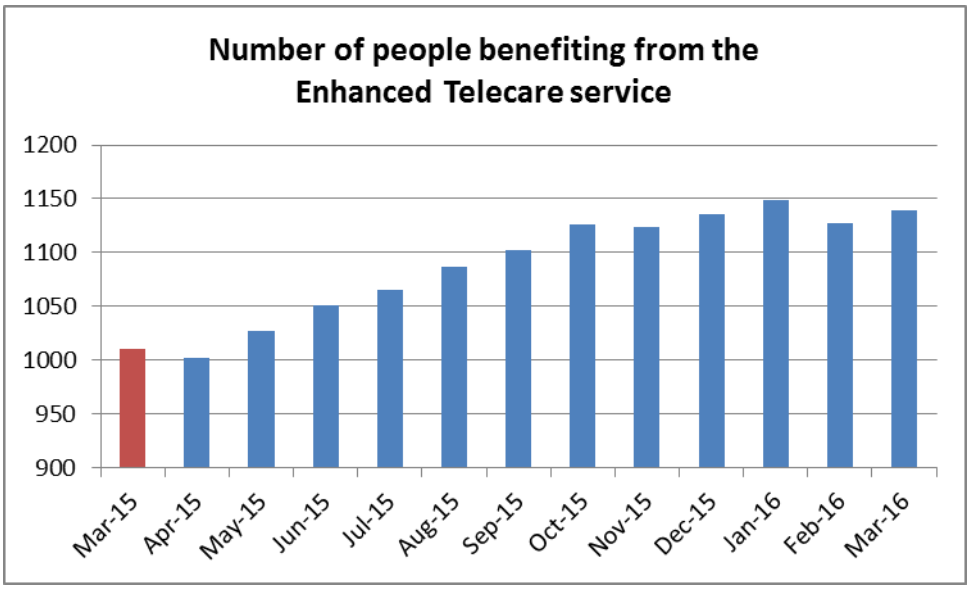
Trends in prescriptions are monitored jointly, and processes in place to ensure appropriate and consistent prescribing of equipment.

2.5 Expansion of the use of Telecare

The Enhanced Telecare team has expanded due to the increased demand to keep Islington residents safer and more independent at home, as well as delaying admission into care homes and preventing hospital admissions. This demand is also reflected by the number of people receiving the service steadily increasing as hospitals, community and social care teams continue to make referrals for residents.

In addition to private dwellings, Enhanced Telecare have also continued to work with Islington's Learning Disability Partnership, supported accommodations and sheltered schemes to assist onsite staff in managing their residents' needs and keeping people in their homes for longer.

The use of Telecare will continue to expand with the advancement of assistive technology and as knowledge of available equipment grows amongst professionals. Current Telecare projects are exploring the potential use of SIM card-operated alarms to facilitate hospital discharges for those without a telephone landline and GPS tracker devices (for those at risk of wandering/becoming lost) in Islington.



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.

Since February 2016, the Integrated Network initiative has been rolling out across Islington. Each Integrated Network is centred round a small group of GP surgeries that have agreed to work together. Integrated Networks meet face to face regularly to discuss the specific issues that are affecting individual patients/clients who are registered at that group of GP surgeries. Health and care issues are discussed systematically and the team create a coordinated plan that makes the best use of local services to ensure patients and service users benefit from the highest standard of care. This plan may reduce the likelihood of someone having an unplanned admission to hospital; support their existing community care or create a new approach to solving a long term problem. The progress of each plan is reviewed regularly.

Each Integrated Network consists of

- 1-4 GP's,
- a senior social work practitioner dual trained in Housing from LBI
- a locality navigator from Age UK
- a mental health practitioner from C&I
- a Whittington Health community matron
- Whittington Health senior administrator.

Referrals into the service can be via any organisation and this referral process is managed by Whittington Health's Integrated Network Coordination (INC) admin team.

Since February 2016 (until 14th October 2016), 815 patients have been discussed via the Integrated Networks. As of Autumn 2016, over 95% of Islington GP's will be attached to a Network. The next step will be looking at embedding these Networks into the health and social care systems to ensure benefit across the patch for all patients.

4 CONCLUSION

The strong history of partnership working between Islington Social Services and the health services within Whittington Health NHS Trust continues to provides a solid platform to 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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October 2016