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 2015/16.

2. KEY AREAS OF ACHIEVEMENT 2014-15

2.1 Developing Integrated Locality Team Working

The 'Moving Forward' programme plan for 2014/15 included developing a new integrated model between community rehabilitation, intermediate care and social care which sought to ensure that the services that were delivered in partnership were 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.

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 Care Act 2014 has 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.

It also required changes to the Whittington Health Community Rehabilitation Team (CRT) and REACH team in order to deliver a model of care that supported the delivery of community intermediate care and rehabilitation as part of an integrated service with social services, with co-located teams, a single point of access for referrals and advice and shared screening of new referrals.

Using the learning from the N19 pilot that ran from June 2013 – March 2014, a project group was set up to develop and agree the operational aspects of the model which included work streams for:

- A single point of referral and advice for social care and REACH/CRT teams (Access and Advice Team)
- Streamlining assessments and reviews including a review of forms
- Review of discharge services
- Agreeing the locality team bases and team staffing structures
- Review of reablement service and home care
- Review and update the Links for Living website
- Review of urgent response provision in social care and links to development of rapid response team with Islington CCG (ICCG).
- Training and development programme for staff

The Access and Advice service will support Islington to fulfil its duties in Care Act 2014, this requires health and social services to provide advice and information, guarantee preventative services which could help reduce or delay the development of care and support needs, and inter-professional working. Staff working in this service have been trained to quickly identify how best to meet people's needs, offer advice or suggestions as to where they can find services or solutions for their needs, or quickly route them to screening and services that they require.

The 'Links for Living' pages have been redesigned to offer an effective and attractive way to support people to find information about a range of health and social care services, and to enable them to consider what they need, with advice how to access this.

Consultations were held with staff on the proposed reorganisation during October &

November 2014 with a go live date proposed for April 2015. The purpose of the reorganisation was to:

- Ensure that the service delivers more personalised, integrated support
- Ensure that all service users have the best opportunity to achieve their maximum level of independence with the required level of support tailored towards their needs
- Ensure that the service is configured to provide a high quality and cost effective service by removing multiple handoffs and duplication of work between Health and Social Care teams
  Respond to the additional duties introduced by the Care Act which necessitate operational changes to the service Contribute to the health and social care efficiency targets.

2.2 Keeping Independent at Home

The past year has seen continued improvement and innovation in the Reablement service.

The 'In reach' services continue to work with the Whittington and UCLH, linking strongly to the hospital teams with a focus on delivering faster discharges, over 7 days.

A successful pilot to base a physiotherapist within the Reablement service, with the dual aims of providing timely physiotherapy intervention, and providing training and advice for the enablers to gain competencies in helping people mobilise and prescribing simple mobility aids, continued in 2014-15 and a bid submitted to commissioning to continue the funding in 2015/16.

- 188 people were referred for physiotherapy as part of their Reablement during April – December 2014.
- 66% of service users either achieved or partly achieved their goals during their 6 week involvement with reablement, with the option of continued physiotherapy via the REACH community team.

The Enhanced Reablement service has continued to provide intensive support packages to people who would otherwise be at high risk of admission to residential or nursing home (typically due to dementia). During 2014/15 Enhanced Reablement had a total of 57 referrals of which 43 were accepted for a service.

Outcomes for these people were: -

- 7 transferred to a period of standard reablement at home
- 16 transferred to ongoing support and remained at home
- 12 needed further medical or therapy services
- 7 required no further services

Mainstream reablement has provided free care and rehabilitation at home for 543 Islington residents in 2014/15. Reablement continues to deliver good results in terms of independence for service users; outcomes following reablement intervention show that 67.4% of service users have no ongoing care needs and the proportion of older people who were at home 91 days after their discharge from reablement services was 83.9%

The **Intermediate Care Team** coordinate and provide the therapy and social work support to people using the 12 intermediate care beds that were provided at Mildmay (within extra supported housing) and to ensure that services are coordinated to support people to return home if possible.

55 people were admitted to the Mildmay intermediate care beds in 2014-15.

The discharge destinations from these services are: -

Discharge Destination from Intermediate Care Beds (Mildmay)	% Service Users
Home	58.1%
Extra Care Sheltered / Supported Housing	7%
Hospital	14.5%
Residential / Nursing Home	7%
Other	12.7%

The contract for the intermediate care beds at Cheverton Lodge (Barchester Healthcare) ended at the end of March 2014. The review of Intermediate Care continued during 2014/15 which included finding a new provider for intermediate care beds in Islington. 40 Spot placements were required in 2014/15, funded by the intermediate care pooled budget, due to the lack of available intermediate care beds during this time.

ICCG approached Whittington Health with regards to creating additional inpatient intermediate care and rehabilitation capacity given the lack of capacity. Two rehabilitation beds and four intermediate care beds opened temporarily on the Cavell Rehabilitation Unit at Whittington Hospital from 17th November 2014 – 1st May 2015. This was a very positive pilot with 17 patients admitted during this period with an average length for stay of 40 days and a positive change in Barthel scores i.e. they were more independent on discharge. 60% of the patients were able to return home at discharge. The location of these beds within an acute facility appeared to have resulted in an earlier move from an acute bed than would otherwise have been possible and/or facilitated on-going investigations in a less acute setting.

Ten intermediate care beds opened at St Anne's Nursing Home in February 2015 which has improved the availability of bed based care in the community and facilitated discharges from acute Trusts. No further Spots placements have been required for intermediate care since these beds opened. The Intermediate Care Team (WH/LBI) provide the therapy and social work support to people in these beds, as with Mildmay intermediate care unit & this additional capacity will relieve some of the pressure on demand for intermediate care rehabilitation over the winter months..

The Intermediate Care teams (REACH and Reablement) again participated in the National Audit of Intermediate Care.
The national average for people over 65 years of age admitted into Reablement is 2.1% (2010). Islington has consistently admitted over 3.5% since 2010, and also scored highly for numbers of people leaving Reablement with no ongoing homecare need.

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

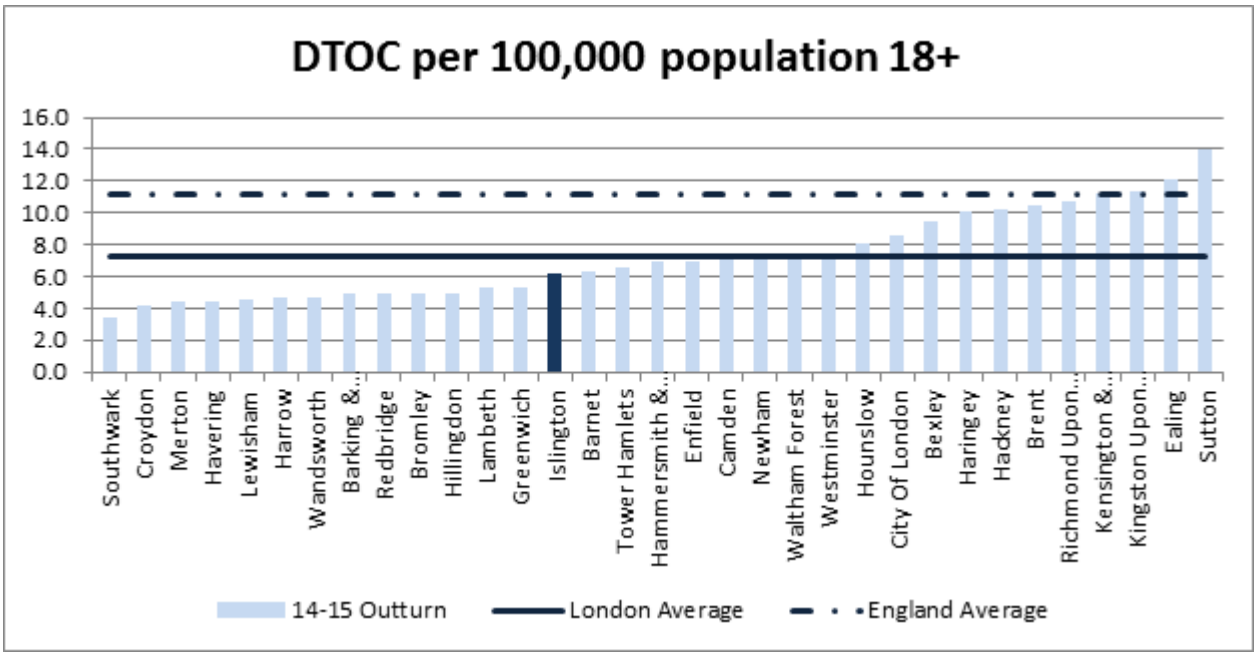
2.3.1 Delayed Transfers of Care

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: -

- In-reach to both local acute Trusts by the Reablement Service
- Daily teleconferencing to discuss people with complex needs, and to agree actions across hospital and community teams towards discharge
- Social workers attending daily 'board rounds' on the wards, and 7 day social work over the winter period.
- Access to Reablement at weekends
- Prompt access to necessary equipment via TCES (community equipment)
- Use of the Integrated Pooled budget to fund 'spot placements' so that people can move out of hospital for further assessment of their needs

- A new support worker (employed by Age UK) 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 e.g. following an attendance at accident and emergency.

Islington perform well in terms of our benchmarking position and have consistently been a highly performing authority in London for the past 4 years. Performance has declined slightly in 2014-15 to 6.2 delayed transfers of care per 100,000 of the population compared to 4.8 per 100,000 in 2013 -14. It is worth noting however that Islington rates of delay are still significantly lower than the London average of 7.0 delays per 100,000 of the population, and the England average of 11.2 delays per 100,000 of the population.



2.3.2 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 made up of therapists working 8.30am-8.30pm, 7 days a week in the 'front of hospital' assessment team, and provides rapid assessment of people's ability to go straight home safely, with any essential equipment, and with a seamless link to community services from both health and social care. FEDS aim to screen all patients who require a therapy assessment as part of a full MDT assessment within 12 hours as per the Emergency Care standards.

The team also includes a technician who can provide a bridge between hospital at home and can for example, complete home safety checks, practice with new equipment in the home setting immediately post discharge, assess for non-essential equipment and arrange provision, e.g. bathing, practice exercises etc.

A linked social worker is involved in assessing the more complex patients, and the team also refer direct to Age UK for follow up contact and social support. The week-end social worker funded by winter resilience money also worked closely with this team.

An additional service provided by Camden Carelink was commissioned with winter resilience funds, and this provides a very fast response to provide short-term enabling care to support earlier hospital discharge over extended hours.

These initiatives are successfully minimising the time people spend in hospital, and supporting them to remain independent where possible.
As Ambulatory Care has developed the FEDS team also link with the team there to provide a rapid assessment and access to services for people who are receiving medical intervention in the new centre, and thereby avoiding a hospital admission.

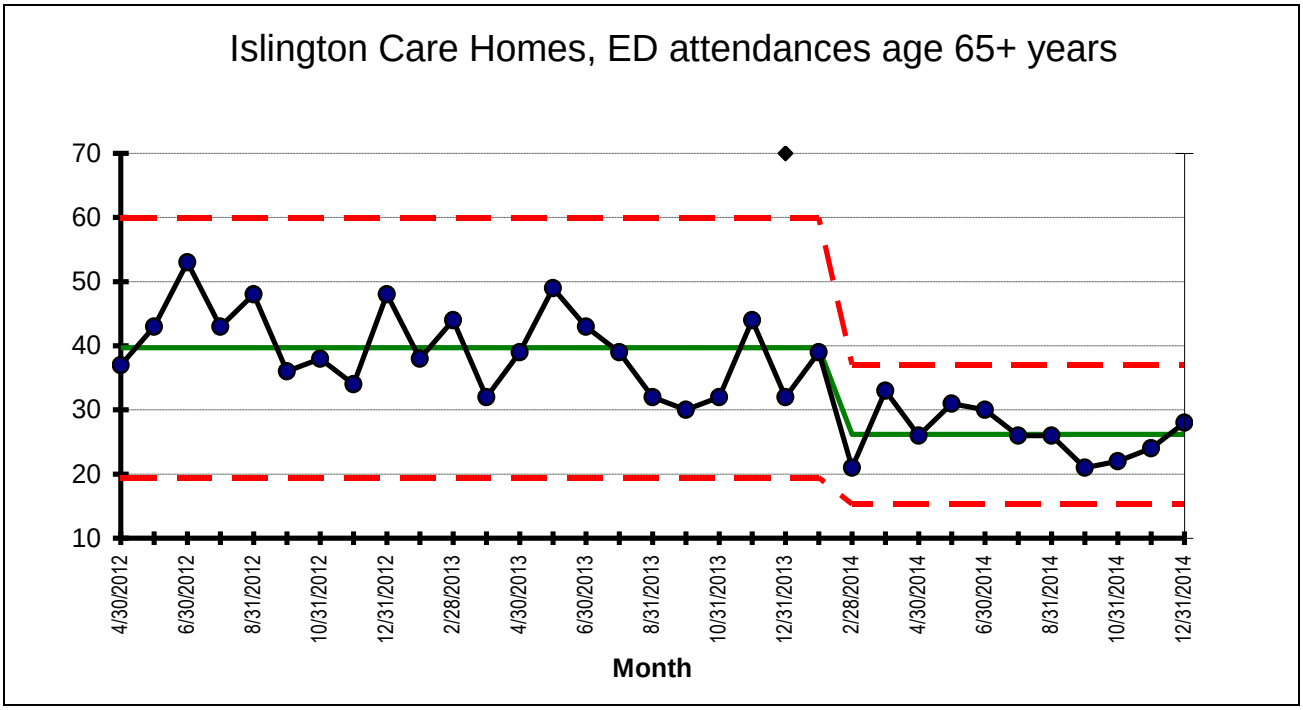
The Integrated Community Ageing Team (ICAT -previously known as the Community Geriatrician service) started in April 2014, with recurrent funding of £200k p/a from the Strategic Investment Fund.

The service provides clinical support to care homes and, through the locality MDT's, to the wider population of older adults in Islington. ICAT has been proactive in developing additional pathways as set out below

- Telephone line at Whittington Health or UCLH for clinical advice, 9-5, Monday to Friday
- In-reach assessment, flagging all patients from care homes admitted to UCLH and Whittington to ensure continuity of senior medical care
- Regular visits to care homes providing consultant level medical assessment
- Education and training
- Co-ordinating wider input to care homes
- 'Hot' clinics in Ambulatory care unit Geriatrician input to ambulatory care

The service is provided by consultant geriatrician at the Whittington (Dr Ruth Law) providing 7 sessions, a GPwSI (Dr Philly O'Riordan) providing 2 sessions and the UCLH consultant geriatrician (Dr Nadia Raja) providing 3 sessions.

To date, the ICAT service has focussed on Care Homes. The care home population represents some of the most vulnerable people with the highest health needs outside of acute hospitals. In 2013-14, prior to the start of ICAT, there were 607 London Ambulance Service call-outs from the Islington care homes, 85% of which were conveyed to hospital, with an average length of stay in the hospital of 15 days for these residents. As a result of various initiatives into the Care Home sector, this trend of ED attendances is decreasing.



A report from Healthwatch Islington has been commissioned to examine the qualitative impact of ICAT. We were keen to demonstrate qualitative impact for a population that would otherwise be difficult to reach. The report is attached below but feedback included

"The ICAT service has made an obvious difference to his overall health and wellbeing. The doctor has reduced the number of hospital admissions by reviewing medication and carrying out procedures that a GP may have previously referred to hospital. He used to be admitted regularly so this has made a positive difference to his physical and psychological wellbeing" (Interview with staff about service user)

"With (ICAT doctor) I felt extremely well handled and very engaged and she knows all about geriatrics and strokes. She has a wonderful attitude and so well organised. The service is more than good, it's excellent"

To maintain impact in care homes and move the team beyond this setting to work in the community, ICAT were successful in bidding to expand the team further in 2015/16 which will include recruiting a multidisciplinary skills-mix of specialist Nurses and 2 physiotherapists/ occupational therapists to work within ICAT. The key initiative would be the delivery of Comprehensive Geriatric Assessments into the community. This is a process of care involving a holistic, multidimensional, interdisciplinary assessment of an individual by a number of specialists. The British Geriatric Society have demonstrated it to be associated with improved outcomes in a variety of settings, and a University of Oxford Cochrane review identified

- High quality evidence that CGA improves care of frail older patients admitted to hospital, including a 30% higher chance that patients would be in their own home 6 months later
- High quality evidence that CGA decreases the number of patients admitted to residential care.

An update on progress of the team will be included in the 2015-16 report.

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 2014-15 the action plan included the following work 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

2.4 Integrated Community Equipment Service

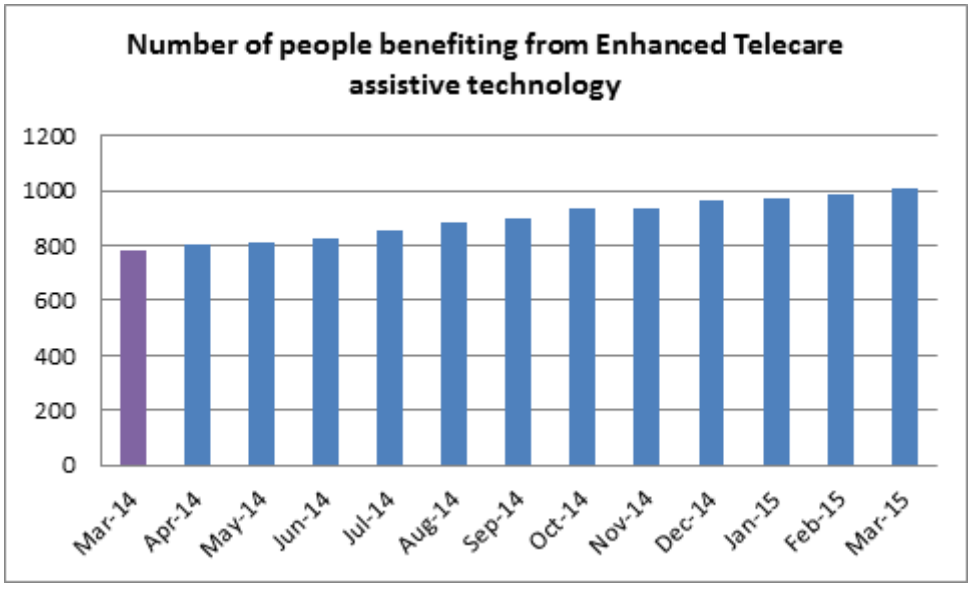
The Transforming Community Equipment Services project (TCES) has now been 'live' since February 2011, when the retail model for simple aids to daily living, and joining the London Consortium for Complex Aids to Daily Living, were introduced in Islington.

In 2014-15 between 186-273 service users a month were issued with prescriptions and the redemption rates have averaged 84%, 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 number of people issued with Telecare equipment has been steadily growing, with a range of health and social care services making referrals to Telecare for residents. The project to assess for and provide complex Telecare equipment is still continuing with the new locality teams, and aims to increase knowledge of the range of equipment available across health and social care teams, and how it can be used to keep people safe and independent at home.

In the last year, Telecare has also been successfully installed as part of the development of new independent living units for people with learning disabilities, and used in sheltered and supported accommodation schemes.



3. PLANNED DEVELOPMENTS

3.1 Embedding the Integrated Locality Teams

The new integrated social care and rehabilitation teams, based at Vorley Road in the North of the borough and at Calshot Street in the south, went live on 30th March 2015. Teams comprise both health staff (physiotherapists, occupational therapists and rehab assistants) and social care staff (social workers, OTs and case managers). Referrals are now managed by the new Access and Advice Team based at 222 Upper Street.
Since go live date, support has been given by the service leads and team managers to embed the new ways of working with frontline staff, addressing operational issues as they arise.
The new model is being formally evaluated in September 2015, with the final report due at the end of October 2015. The purpose of this review is to examine how well the model is bedding down and recommend actions to address any deficient areas in order to realise the primary anticipated benefit of improved customer experience through integrated working.

3.2 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 weekly 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 Health has been asked by ICCG to operationally manage the integrated networks (multiagency teams wrapped around primary care) by developing and managing the Integrated Liaison (ILS) 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.

3.3 Pooled Budget for Intermediate Care

There is a Commissioning intention to further extend the existing pooled budget for Intermediate Care, in order to strengthen the opportunities to provide Islington residents with high quality rehabilitation and recovery services by providing a unified pathway, incorporating Readmission Prevention projects at UCLH and Whittington Hospital. The partnership is responding to this by engaging strongly with work to further improve the services offered, and to make them as timely and seamless as possible.

In the immediate future the following projects are continuing: -

- Weekend access to the Reablement Service
- Supporting weekend working linked to admission avoidance or earlier discharge at the acute hospitals (UCLH and Whittington)
- A pharmacist that Reablement can access to check that people understand and are taking their medication correctly, as this can prevent readmissions
- Outreach by the REACH team to Islington residents temporarily placed out of borough
- A support worker to support earlier discharge from both acute hospitals (Age UK post, funded by the pooled budget)

4. CONCLUSION

The strong history of partnership working between Islington Social Services and the health services that are now within Whittington Health NHS Trust 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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September
2015