Whittington Health NHS

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Whittington Health Trust Board meeting

24th July 2013

Title:	**Annual Partnership Report with London Borough of Islington**		
Agenda item:	**13/107**	**Paper**	**7**
Action requested:	To note this annual report (Appendix 1) and endorse the achievements of the S75 partnership working between London Borough of Islington Adult Social Services and Whittington Health for adults and older people.		
Executive Summary:	Islington has a long history of successful partnership working, with the first S31 (now S75) Partnership Agreement signed by the newly formed PCT and the Council in 2002. There has been significant structural change within the NHS and the S75 Partnership Agreements were updated in 2011. That agreement, together with the Intermediate Care Integrated Provider Agreement, continues to have the following aims : • Support people to live independently for as long as possible • Improve the services received by vulnerable people in the community, by integrating the service delivery and provider arrangements between health and social care. This will allow client focussed care to be developed and delivered to individuals in order to meet their needs in a more seamless and efficient manner • Enhance opportunities available to provide services to local people which meet their needs in an integrated, coordinated, sensitive and efficient manner • Provide services to clients with fewer gaps and overlaps between different providers • Provide communities with a single response from health and social care about how best to meet their needs • Provide a richer pool of knowledge and experience for staff working within the partnership arrangements from which to draw upon in developing and delivering services • Offer an improved infra-structure and management support for all staff working within the partnership arrangements • Ensure policy, strategy and decision making takes place in whole system context • Support the development of the joint strategic needs assessment and priority setting • Support the development of the Local Area Agreement and partnership activities to improve health and wellbeing outcomes for local people • Achieve efficiency savings.		
Fit with WH strategy:	Improving population health		

Reference to related / other documents:							
Date paper completed:		16/07/2013					
Author name and title:		**Carol Gillen Director of Operations, ICAM**		**Director name and title:**		**Lee Martin Chief Operating Officer**	
Date paper seen by EC	**n/a**	**Equality Impact Assessment complete?**	**Yes**	**Risk assessment undertaken?**	**No**	**Legal advice received?**	**No**

Housing & Adult Social Services
5 Highbury Crescent, London N5 1RN

Report of: Executive Member for Health and Wellbeing

Meeting of:	Date	Agenda item	Ward(s)
Executive	11 July 2013	D2	All

Delete as appropriate	~~Exempt~~	Non-exempt

SUBJECT: ANNUAL PARTNERSHIP REPORT WITH WHITTINGTON HEALTH

1. Synopsis

1.1 The London Borough of Islington and Whittington Health have an existing Section 75 (National Health Service Act 2006) Partnership Agreement, which supports effective partnership working.

1.2 There are three main drivers for partnership working to deliver health and social care:

- It makes sense for users – most vulnerable residents need elements of both, and the more integrated the response the better for them
- It makes sense for staff – better understanding of, and access to, a wide range of health and social care services and advice enables them to provide a better service
- It delivers better value for money – combining budgets and avoiding duplication makes for more effective use of public funds.

2. Recommendation

2.1 To note this annual report (Appendix 1) and endorse the achievements of the S75 Partnership working between London Borough of Islington Adult Social Services and Whittington Health for adults and older people.

3. Background

3.1 Islington has a long history of successful partnership working, with the first S31 (now S75) Partnership Agreement signed by the newly formed PCT and the Council in 2002. There has been significant structural change within the NHS and the S75 Partnership Agreements were updated in 2011 and that agreement, together with the Intermediate Care Integrated Provider Agreement, continues to have the following aims :

- Support people to live independently for as long as possible

- Improve the services received by vulnerable people in the community, by integrating the service delivery and provider arrangements between health and social care. This will allow client focussed care to be developed and delivered to individuals in order to meet their needs in a more seamless and efficient manner
- Enhance opportunities available to provide services to local people which meet their needs in an integrated, coordinated, sensitive and efficient manner
- Provide services to clients with fewer gaps and overlaps between different providers
- Provide communities with a single response from health and social care about how best to meet their needs
- Provide a richer pool of knowledge and experience for staff working within the partnership arrangements from which to draw upon in developing and delivering services
- Offer an improved infra-structure and management support for all staff working within the partnership arrangements
- Ensure policy, strategy and decision making takes place in whole system context
- Support the development of the joint strategic needs assessment and priority setting based in this
- Support the development of the Local Area Agreement and partnership activities to improve health and wellbeing outcomes for local people
- Achieve efficiency savings.

4. Implications

4.1 **Financial implications**

The Council and Whittington Health have a S75 partnership agreement that was set up in 2004 to assist with the access and delivery of equipment in the community. The total budget was £900k for 2011/12 and is the same for 2012/13. The Council and Whittington Health both make an equal contribution of £450k. At this time there are no additional expected pressures on these budgets for 2013/14 and it came in on target for 2012/13. Any risks arising should be managed down in year in accordance with the agreements set out.

Please note that the Intermediate Care Pooled budget is held with Islington CCG.

4.2 **Legal Implications**

The Health and Social Care Act 2012 sets out obligations on the health service in respect of its relationship with care and support services, including making it easier for health and social care services to work together. The new Care Bill gives the Council a duty to promote integrated services. The relevant agreement between Whittington Health and the Council, made under section 75 of the National Health Services Act 2006, includes arrangements for pooling resources and delegating certain NHS and Council health-related functions to the other partner, where this leads to an improvement in the way those functions are exercised.

4.3 **Environmental Implications**

It will be important to ensure that a robust process is put in place to ensure that environmental issues are considered within future partnership arrangements between Whittington Health and Islington Council. Whittington Health and Islington Council will work together to ensure that this is fully facilitated.

4.4 **Equality Impact Assessment**

The council must, in the exercise of its functions, have due regard to the need to eliminate discrimination, harassment and victimisation, and to advance equality of opportunity, and foster good relations, between those who share a relevant protected characteristic and those who do not share it (section 149 Equality Act 2010). The council has a duty to have due regard to the need to remove or minimise disadvantages, take steps to meet needs, in particular steps to take account of disabled persons' disabilities, and encourage people to participate in public life. The council must have due regard to the need to tackle prejudice and promote understanding.

Vulnerable people often require both health and social care services; the partnership between the Council and Whittington Health to ensure services can be delivered and commissioned in a co-ordinated way to meet local needs.

5. Conclusion and reasons for recommendations

5.1 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. This has been effective to:

- Support people to stay in their own homes and be as independent as possible
- Avoid unnecessary stays in hospital
- Receive all necessary equipment that enables them to be safely cared for at home in a timely fashion
- Support integrated working with primary care to manage the care of people with complex needs or frailties more effectively.

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 ensure that opportunities to share expertise and specialist knowledge are maximised, and that any duplication of work is minimised.

The attached report details some of the key achievements and developments over the last year and outlines planned future developments.

Appendices

- Report on Section 75 (National Health Service Act 2006) Partnership Working between London Borough of Islington and Whittington Health NHS Trust

Final report clearance:

Janet Burgess

Signed by: **Executive Member for Health and Wellbeing** **Date:** 11 June 2013

Received by: **Head of Democratic Services** **Date:**

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Appendix 1

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 the last year in the provision of integrated services for adults and older people, and identifies the key priorities for 2013/14.

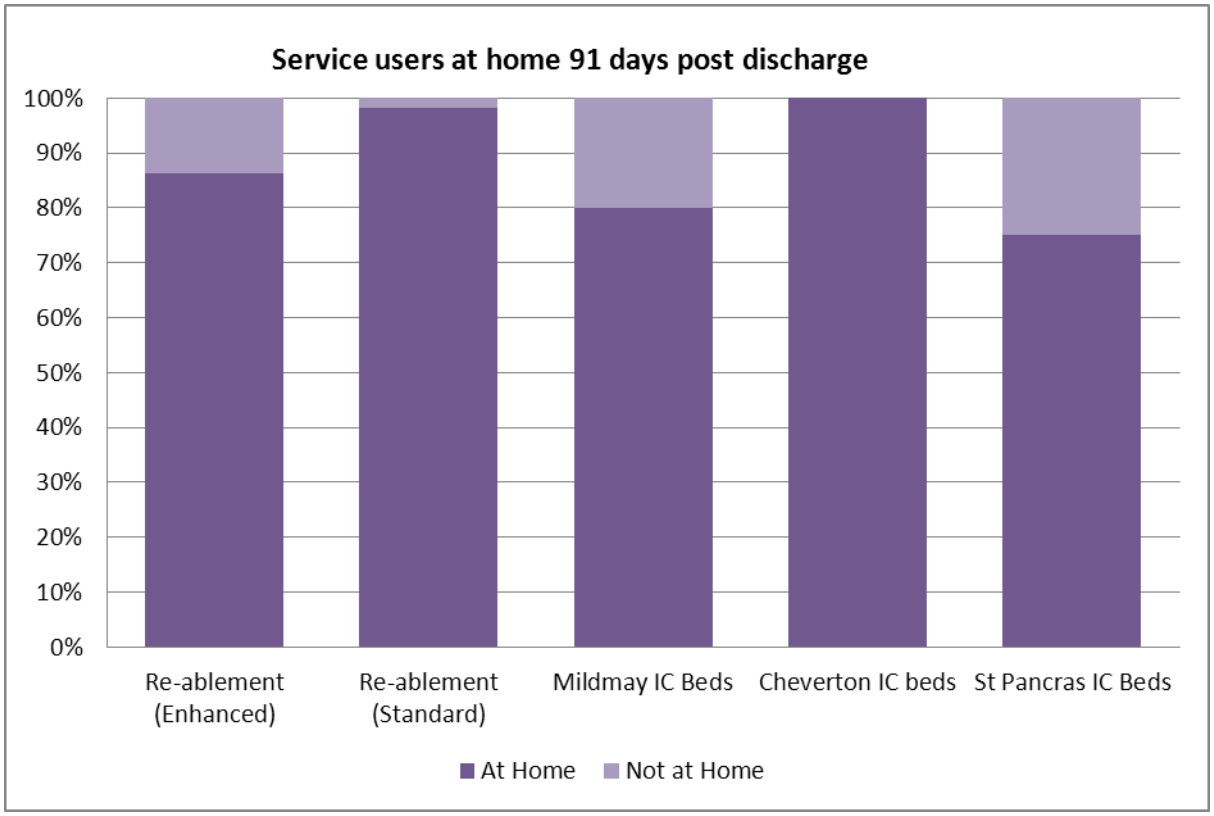
2. KEY AREAS OF ACHIEVEMENT 2012-13

2.1 Keeping Independent at Home

The past year has seen continued improvement and innovation in the Reablement service. 'Inreach' services are operational at the Whittington and UCLH, linking strongly to the hospital teams that focus on delivering faster discharges, including over the weekend.

The Enhanced Reablement service has provided intensive support packages to people who would otherwise be at high risk of admission to residential or nursing home (typically due to dementia). A total of seventy five people received this service in 2012-13, an increase from of 56% from forty eight people in 2011-12, with 86.4% remaining at home for 91 days post discharge. This service was initially run as a pilot project to fill a gap in the ability of the Reablement Service to support people with dementia and will now be continued as part of the integrated services.

Mainstream reablement has provided free care and rehabilitation at home for more Islington residents; 710 service users in 2011-12 increased to 881 people in 2012-13, an increase of 24%. Reablement continues to deliver good results in terms of independence for service users; outcomes following reablement intervention show that 69% of service users have no on-going care needs and a further 18% have reduced care needs. 98.3% of service users are still at home 91 days after being discharged from the service.



The way in which the service works in an integrated way with a range of services is shown in this example:

Mr A was referred from the acute hospital, recovering from a chest infection, and because of his dementia and concerns for his safety, he was provided with a very intensive Enhanced Reablement package, with input from a mental health nurse, occupational therapist and senior enabler, as well as monitoring from the district nursing service. After five days of intensive assessment and support to avoid a readmission to hospital, he was transferred to the standard reablement service, with additional input from physiotherapy due to his very high risk of falling, and the installation of telecare (a falls detector). During the period immediately following discharge a safeguarding alert was raised due to concerns about financial abuse, at which point a social worker was allocated. The client's choice was to remain at home, which was enabled by the combination of services. The GP was kept informed of the situation. Additionally his family, who lived out of borough, were provided with information and advice about community support in Islington.

The Intermediate Care Team coordinate and provide the therapy and social work support to people using the intermediate care beds at Cheverton Lodge (nursing care) and Mildmay (extra supported housing) and ensure that services are coordinated to support people to return home if possible. The discharge destinations from these services are: -

Discharge Destination from Intermediate Care	% Service Users
Home	67%
Extra Care Sheltered / Supported Housing	9.7%
Hospital	9.7%
Residential / Nursing Home	9.7%
Other	3.9%

Last year the above teams participated in the first National Audit of Intermediate Care, and this will be repeated in 2013-14 to see how we perform against other Intermediate Care Services. Islington scored highly in the range of the multidisciplinary professions available last year.

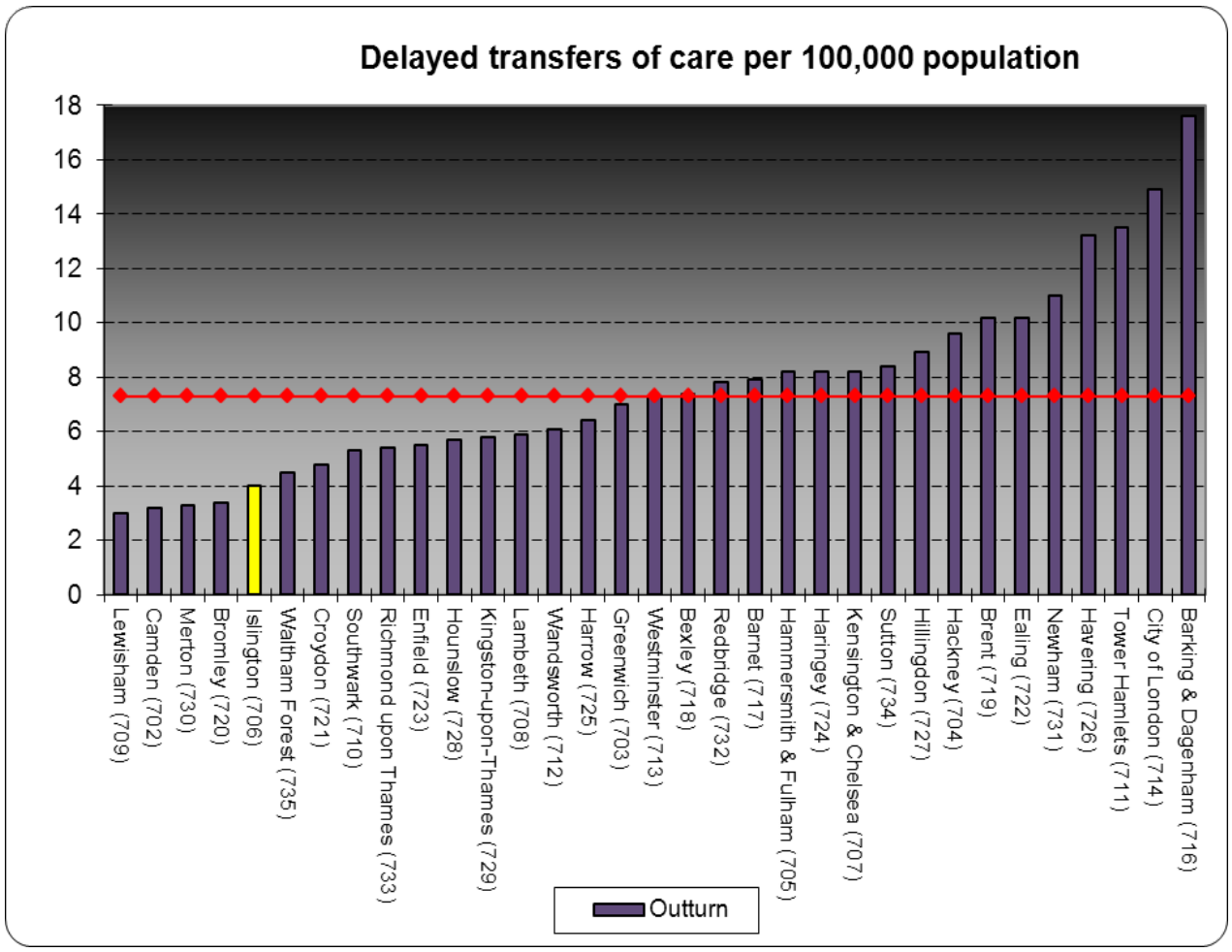
2.2 Care Closer to Home – reducing the time people have to spend in hospital

Delayed Transfers of Care

The improvement in reducing the number of Delayed Transfers of Care (delays to people leaving hospital) has been maintained. 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
- Social worker attending daily 'board rounds' on the wards
- Access to Reablement at weekends
- Prompt access to necessary equipment via TCES
- Use of the Integrated Pooled budget to fund 'spot placements' so that people can move out of hospital for further assessment of their needs

We perform well in terms of our benchmarking position and have consistently been a top performing authority in London for the past 2 years. In addition to this our rate of delays is significantly lower than the London average of 7.3 delays per 100,000 of the population.



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.

Additional therapist input to the 'front of hospital' assessment team, has enabled 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. To support this the Whittington Hospital FEDS (Facilitated Early Discharge Service) carry out the community assessment for social care and enter this directly onto IAS, avoiding duplication of assessment by the Reablement team, and ensuring that the care that people need is in place swiftly. Community matrons in-reach to the hospital to support identification of suitable patients, and can offer next day visits. Social workers are involved in assessing the more complex patients, and the team also refer direct to Age UK for follow up contact and social support.

2.3 Integrated Community Equipment Service

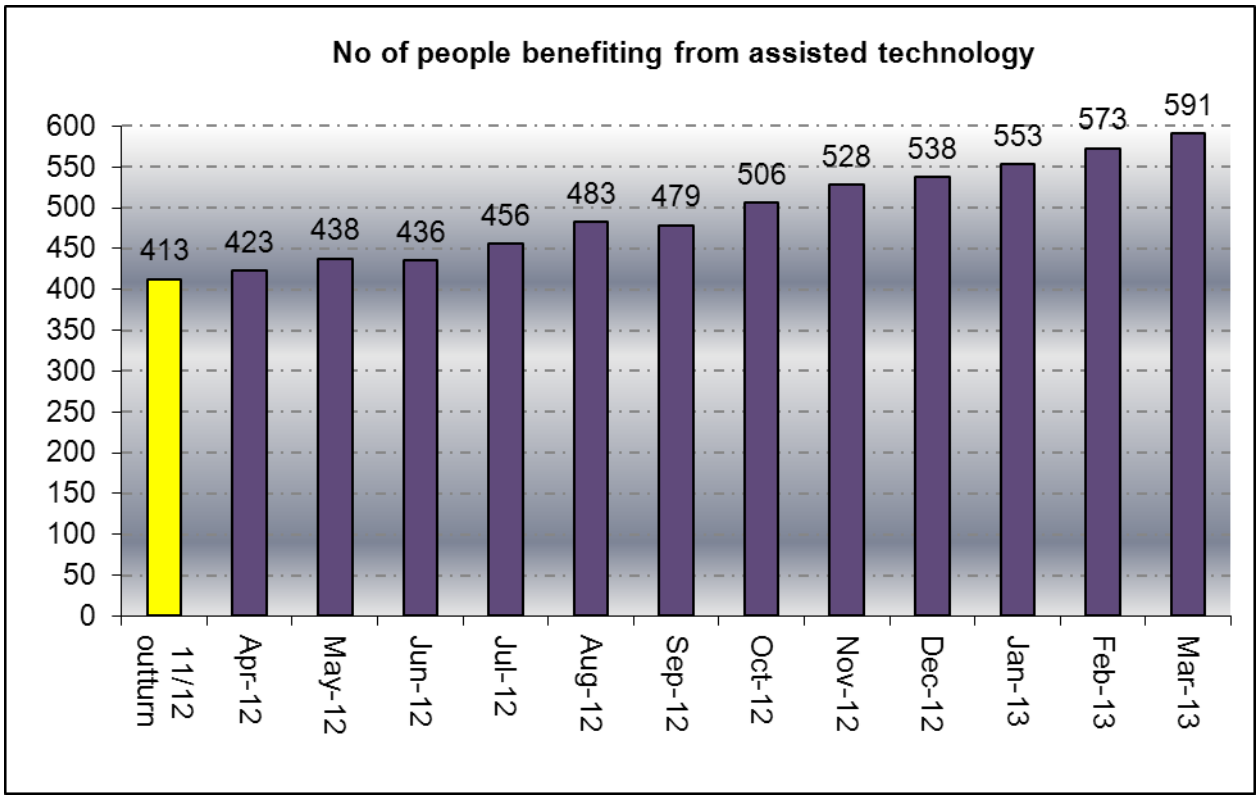
The Transforming Community Equipment Services project (TCES) has now been 'live' since February 2011, when the retail model for simple aids to daily living and joining the London Consortium for Complex Aids to Daily Living were introduced in Islington.

In 2012-13 between 202 – 257 service users a month were prescriptions were issued with prescriptions (an increase from the previous year of between 176 - 239 prescriptions per month) and the redemption rates have averaged 85%, which is above the national average.

The budget was re-set in 2012-13, largely as a result of increased usage of health related equipment such as pressure care mattresses and cushions, hospital beds and other complex equipment for people being cared for in the community rather than in acute care or hospices. Trends in equipment use continue to be monitored jointly.

2.4 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 for telecare for residents. The project to assess for, and provide, more complex telecare equipment is based with the Reablement Service, and part of this project has been to increase knowledge across health and social care teams, of the range of equipment available, and how it can be used to keep people safe and independent at home. This project has also worked with the mental health services to pilot GPS trackers for older people who wander. This is done with appropriate consent, with the aim of enabling people to remain in their own home for longer.



3. PLANNED DEVELOPMENTS

3.1 Single point of access

Priorities for 2013-14 include a programme of Integration to create a single point of access for health and social care services in Islington.

Where people's health and social care needs are relatively straightforward, and can be met by the wide range of preventative services on offer in Islington, we will help people to quickly find the right solution for them through the new Single Point of Access. Wherever possible,

we will seek to do this before people end up in a crisis situation, and require more intensive support. This will support keeping people independent for longer, and reduce or delay the need for more intensive services that are more expensive to deliver.

3.2 Integration of services

Integration of services across health and social care to create locality based teams that provide assessment and recovery services (rehabilitation and reablement) as a single coordinated service, pulling in additional therapy or specialist input as necessary, is underway. A pilot of this new way of working, which has had excellent staff engagement, is due to start in the N19 area from 3rd June 2013.

During the pilot the most appropriate worker from a multidisciplinary team will carry out an assessment, and develop one set of goals in partnership with the service user, that the team will then work to achieve. People will have one key 'recovery coordinator' throughout their recovery, coordinating the input to help them reach their goals, and to ensure a timely transition to independence or a personal budget for on-going support. The aim is to ensure that people are not waiting for one of the services they need, and that all the input is delivered to the same time frame, thereby maximising the effectiveness of intervention.

A range of measures will ensure that learning from the pilot can be used to further refine and determine a more seamless model that will support people's recovery from an event that has led to deterioration in their ability to remain safe and/or independent.

Another example of integrated working is the commitment by both Islington Adult Social Services and Whittington Health staff 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.

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 progressing:

- Continued weekend access to the Reablement Service
- Supporting weekend working linked to admission avoidance or earlier discharge at the acute hospitals
- Mainstreaming of the Enhanced Reablement Service
- Dedicated pharmacist input to check that people understand and are taking their medication correctly, as this can prevent readmissions
- Physiotherapy within the Reablement Service, supporting return to independence
- Outreach by the REACH team to Islington residents temporarily placed out of borough
- A support worker to support earlier discharge from both acute hospitals
- Timely access to rehabilitation in the community

4. CONCLUSION

4.1 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.

4.2 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 ensure that opportunities to share expertise and specialist knowledge are maximised, and that any duplication of work is minimised.

Carol Gillen
Director of Operations, Integrated Care and Acute Medicine
May 2013