Whittington Health NHS

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The Whittington Hospital NHS Trust
Magdala Avenue
London N19 5NF

Whittington Health Trust Board

1st October 2014

Title:	Annual Report on Partnership working with the London Borough of Islington		
Agenda item:	**14/150**	**Paper**	**10 i**
Action requested:	To note this annual report and endorse the achievements.		
Executive Summary:	Whittington Health and the London Borough of Islington have an existing Section 75 Partnership Agreement which, together with the Intermediate Care Integrated Provider Agreement, supports effective partnership working to provide a better coordinated service to vulnerable people; ensure that opportunities to share expertise and specialist knowledge are maximised; and minimise duplication of work. The attached report details some of the key achievements and over the last year and outlines planned future developments. 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.		
Summary of recommendations:			
Fit with WH strategy:	Integrate models of care, deliver efficient, effective services that improve outcomes, innovate and improve.		
Reference to related / other documents:	The Care Act 2014 http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted		
Reference to areas of risk and corporate risks on the Board Assurance Framework:			
Date paper completed:	1.9.14		

Author name and title:		**Carol Gillen Deputy COO, Director of Operations, ICAM**		**Director name and title:**			
Date paper seen by EC		**Equality Impact Assessment complete?**		**Quality Impact Assessment complete?**		**Financial Impact Assessment complete?**	

Housing & Adult Social Services
7 Newington Barrow Way, London N7 7EP

Report of: Executive Member for Health and Wellbeing

Meeting of:	Date	Agenda item	Ward(s)
Executive	23 October 2014		All

Delete as appropriate	~~Exempt~~	Non-exempt

SUBJECT: SECTION 75 ANNUAL PARTNERSHIP REPORT – ISLINGTON COUNCIL AND 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 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 arrangments

- 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 2013/14 and is the same for 2014/15. The Council and Whittington Health both make an equal contribution of £450k.

In 2013/14 the ICES pooled budget final position £194k overspent which was then split on a 50/50 basis. At this time there are no additional expected pressures on these budgets for 2014/15. 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 between Islington CCG and Islington Council.

4.2 **Legal Implications**

The Health and Social Care Act 2012 sets out the 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 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.

The Council has a duty under Section 3 of the Care Act 2014 to integrate care and support with those provided by the NHS and other health-related services. The duty will apply where the Council considers that integration of services would promote the wellbeing of adults with care and support needs (including carers), contribute to the prevention or delay of developing care needs, or improve the quality of care in Islington.

4.3 **Environmental Implications**

Islington Social Services has a relatively minor environmental impact, which is largely limited to travel (emissions and congestion) and office usage (energy and paper use). Joint working projects such as this partnership with Whittington Health have the potential to have a positive environmental impact, due to a reduction in the duplication of work. The increasing use of telecare also has a positive environmental impact, as it reduces travel demand.

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.

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 unneccessary 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:** 22 September 2014

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ISLINGTON

In partnership with

Whittington Health NHS

Report on Section 75 (National Health Service Act 2006) partnership working between the

London Borough of Islington and Whittington Health

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 2014/15.

2. KEY AREAS OF ACHIEVEMENT 2013/14

2.1 Integrated Locality Team Working

A pilot of integrated and co-located team working by health and social services staff, under a single team leader ran from June 2013 – March 2014. The N19 Pilot brought together staff from Islington Social Services (social workers, support advisors, senior enablers, occupational therapists) with staff from Whittington Health (physiotherapist, occupational therapist, rehabilitation assistant, administrator) to work as a single team for all referrals of people living in the N19 area of Islington.

Joint screening by health and social care staff was used to identify a care-coordinator, who would be the person who worked with the person throughout their time with the service, would support them to identify what they wanted to get from the service, and then coordinate the input to achieve this. This included carrying out joint assessments, and bringing in specialist advice or input from other team members as required. After an initial 10 weeks, the pilot district nurses also joined the team, as did a mental health nurse from Camden and Islington Foundation Trust. The team built strong links with other agencies and teams, such as Age UK, Housing, a pharmacist, and community matrons and invited them to weekly meetings to discuss joint working on specific cases.

The aim was to reduce the current 'handoffs' that happen between different parts of the services, for example, from hospital social work team to reablement, to ongoing support and review teams, and also to avoid duplication of referrals to different services that would each respond in their own time, often asking the person for the same information to be repeated for each service.

The three aims were to: -

- Improve people's experience of the services
- Improve outcomes
- Reduce unneccessary emergency admissions

The team worked with 909 people over the nine months, of which 70 per cent were aged 65 years and over (31 per cent were aged between 75 and 84 years).

2.1.1 Improved experience of the services

The feedback from service users was very positive: -

- 81 per cent were very or fairly satisfied with the service, compared to 59 per cent
- 75 per cent were very or fairly satisfied with how quickly they were seen, compared to 58 per cent
- 56 per cent said they felt in complete control of how they wanted things, compared with 48 per cent
- 48 per cent knew the name of the person coordinating their care, compared with only seven per cent in the control group.

Quotes from a service users/families included: -

“Hopefully the pilot will roll out. It did benefit my mother. People were occasionally not singing from the same hymn sheet, but the social worker pulled it together nicely and acted as coordinator for the others, such as OT.”

“We had a say in everything. She always asked what we want.”

Reduction in duplication of work and assessments appears to have been achieved. Of the 350 people referred through social services, 82 per cent had one keyworker who carried out all assessments, 14.6 per cent saw two people for assessment, and 2.6 per cent saw three people for assessments.

There was a drop of eight days in the average time people in the pilot waited for a social care assessment, from 27 days to 19 days. Staff in the team were very positive about co-location and the ability to get an immediate response from a colleague e.g. OT or physiotherapist.

2.1.2 Improved outcomes

There was a reduction in the number of people requiring on-going support from social services compared to the control group.

N19 pilot service users – 17 per cent needed ongoing support
Control group – 25 per cent needed ongoing support

It is not clear how significant this reduction is, and as the model rolls out we need to continue to monitor this to see if improved outcomes are achieved.

2.1.3 Reduction in hospital admissions

It was not possible to evaluate whether this was achieved due to difficulties sharing data or getting the necessary data across different organisations.

It is probable that without a robust rapid response function, integrated across primary care, community services and with the hospitals and London Ambulance Service, this was not achieved.

Work is underway, led by the Clinical Commissioning Group (CCG), to develop an integrated rapid response function for Islington.

2.1.4 Benefits – staff feedback

Staff liked the way of working, they felt it began to reduce handoffs, that they started to expand their roles to take on aspects of care coordination or assessment that they would previously have referred to another service, and they could see the benefits for people using the service. The co-location and ability to ask questions of colleagues, get advice and support, was particularly valued. The weekly multidisciplinary meetings, with a wider team, such as the pharmacist and Age UK were very useful.

2.1.5 Challenges

The lack of a shared IT system, which led to duplication of entering information, with information being held on three different systems, was a major frustration.

It was difficult to build strong communication and links with GPs. This is something that became easier when district nurses joined the team, as they have strong links with primary care and GP practices, but is something that will need to be developed more strongly in a future model. The current work to develop GP networks, and to develop coordinated care plans for the top two per cent of patients at risk of admission, will support better development of locality working and communication with GP practices. We are working closely with the CCG to ensure that future models work effectively together to integrate care for Islington residents.

Balancing the workload and caseloads was a challenge. With a wide variety of work coming in to the team, from safeguarding alerts to hospital discharges and GP referrals, balancing priorities and keeping on top of the workload was not easy. Good team leadership and staff engaging with working differently was essential to keep motivated and to ensure a timely response.

The amount of paperwork and bureaucracy was a challenge and work is currently underway to review business processes to see where streamlining and simplification can be achieved.

2.2 Keeping independent at home

The past year has seen continued improvement and innovation in the Reablement Service. The service was recognised as an exemplar of good practice by the National Audit of Intermediate Care (NAIC) with the managers being invited to speak at a national conference.

The 'Inreach' services continue to work with Whittington Health and University College London Hospitals NHS Foundation Trust (UCLH), linking strongly to the hospital teams with a focus on delivering faster discharges, including over the weekend.

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, will be continued for a further year in 2014/15.

- 237 people were referred for physiotherapy as part of their reablement during April – December 2013.
- 67 per cent of service users either achieved or partly achieved their goals during their six week involvement with reablement, with the option of continued physiotherapy via the REACH community team for others.
- Waiting times for community physiotherapy reduced over this period, from 35 days to 25 days.

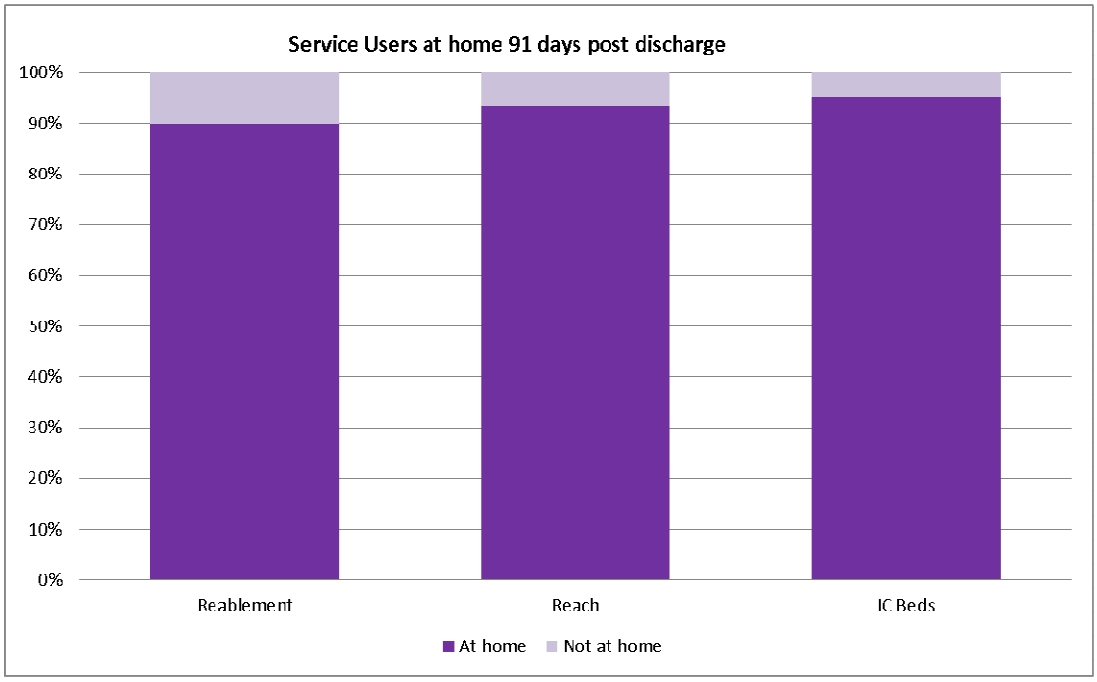
The Enhanced Reablement service has continued to provide intensive support packages to people who would otherwise be at high risk of admission to residential or nursing home (typically due to dementia). During 2013/14 enhanced reablement had a total of 68 referrals of which 45 were accepted for a service.

Outcomes for these people were: -

- 16 transferred to a period of standard reablement at home
- 14 transferred to ongoing support and remained at home
- 6 needed further medical or therapy services
- 4 required no further services
- 1 required 24 hour care (care home)

Mainstream reablement has provided free care and rehabilitation at home for fewer Islington residents. 658 compared to 969 people in 2012/13. However, the percentage of people aged over 65 going through reablement is still higher than the national average (National Audit of Intermediate Care).

Reablement continues to deliver good results in terms of independence for service users; outcomes following reablement intervention show that 60 per cent of service users have no ongoing care needs and a further 30 per cent have reduced care needs. 90 per cent of service users are still at home 91 days after being discharged from the service.



The Intermediate Care Team coordinate and provide the therapy and social work support to people using the intermediate care beds that were provided at Cheverton Lodge (nursing care) and Mildmay (extra supported housing) and to ensure that services are coordinated to support people to return home if possible.
111 people were admitted to the intermediate care beds in 2013-14.

The discharge destinations from these services are: -

Discharge Destination from Intermediate Care Beds (Cheverton and Mildmay)	% Service Users
Home	58.3%
Extra Care Sheltered / Supported Housing	8.7%
Hospital	21.4%
Residential / Nursing Home	7.8%
Other	3.9%

The contract for the intermediate care beds at Cheverton Lodge ended at the end of March 2014, and they are no longer available. Commissioners are reviewing Intermediate Care, and looking for an alternative provider of beds locally.

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 per cent (2010). Islington has consistently admitted over 3.5 per cent since 2010, and also scored highly for numbers of people leaving reablement with no ongoing homecare need.

The Islington Reablement Service was identified as an exemplar of good practice, with an excellent multidisciplinary mix of staff in the team, good outcomes and innovative practice, and the managers presented the work of the service at a national conference.

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

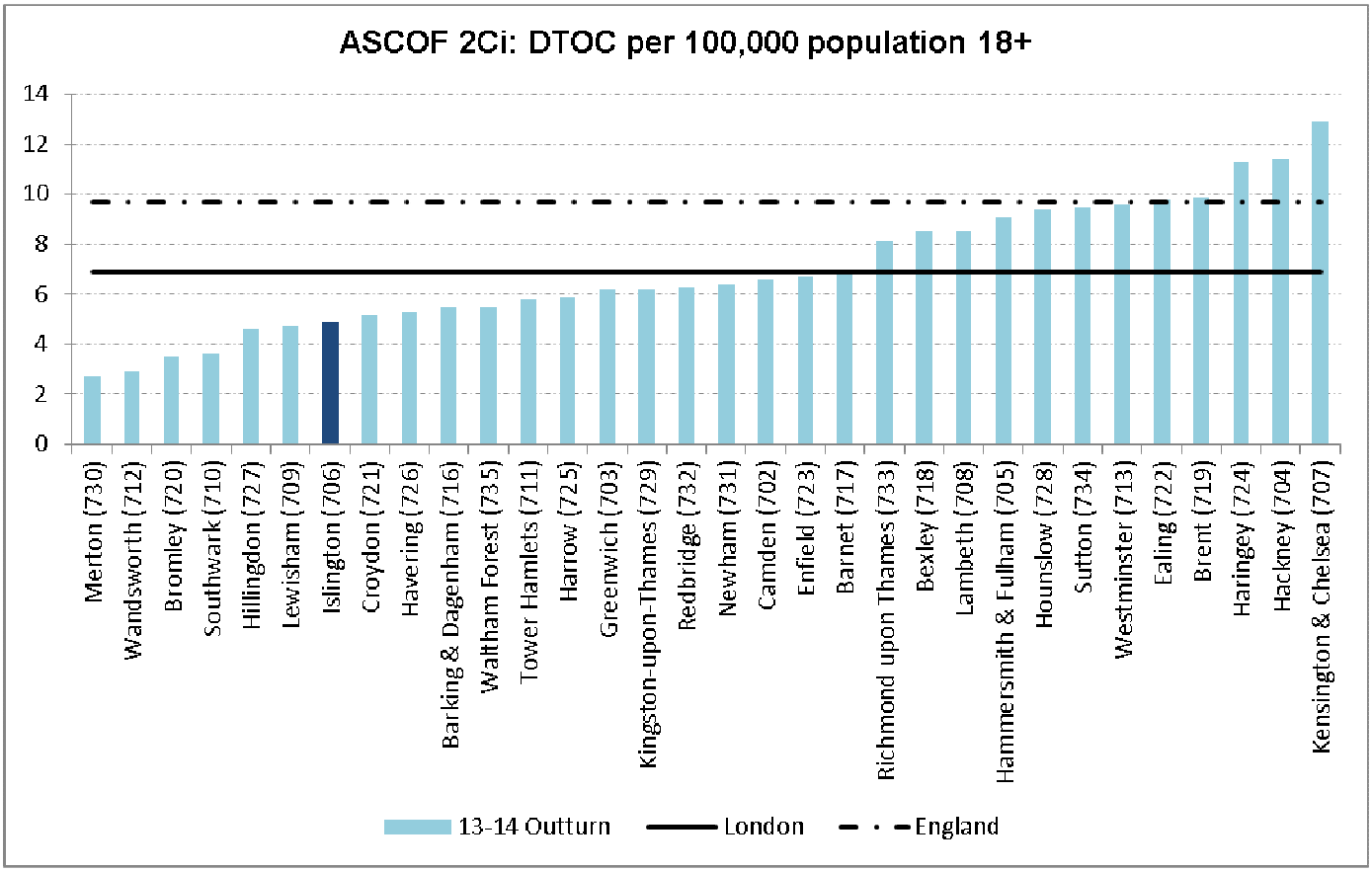
2.2.1 Delayed Transfers of Care

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 seven 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.

We perform well in terms of our benchmarking position and have consistently been a top performing authority in London for the past four years. Our performance has declined slightly in 2013-14 to 4.9 per 100,000 of the population compared to 2.8 per 100,000 in 2012-13. It is worth noting however

our rate of delays is still significantly lower than the London average of 6.9 delays per 100,000 of the population, and the England average of 9.7 delays per 100,000 of the population.



2.2.2 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 8am-8pm, seven 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. To support this the team can carry out the community assessments for social care and enter this directly onto the social services database, avoiding duplication of assessment by the Reablement team, and ensuring that the care that people need is in place swiftly.

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. 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.

A new community geriatrician and GP with a special interest in older people were commissioned and recruited in 2013/14, funded by the Pooled Budget for Older People, and with the aim of avoiding hospital admissions through more specialist advice and support. Initially they are focussing on the care homes in Islington, which have a population of increasingly frail residents, who have a high risk of hospital admission, and they will also provide rapid access advice and specialist support to GPs to manage care of complex older people as effectively as possible. They will use the facilities and multidisciplinary team within the Ambulatory Care centre when more diagnostic tests or assessments are needed.

The work of the Lead Nurse for Care Homes, also a joint funded post, has been instrumental in supporting care homes to improve the quality of care provided to residents, and to develop the knowledge and skills for care home staff to manage long-term conditions, recognise deterioration in residents, and take appropriate early action. This work was commended by the Chief Nurse, NHS England (London) who visited the service during 2013/14.

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.

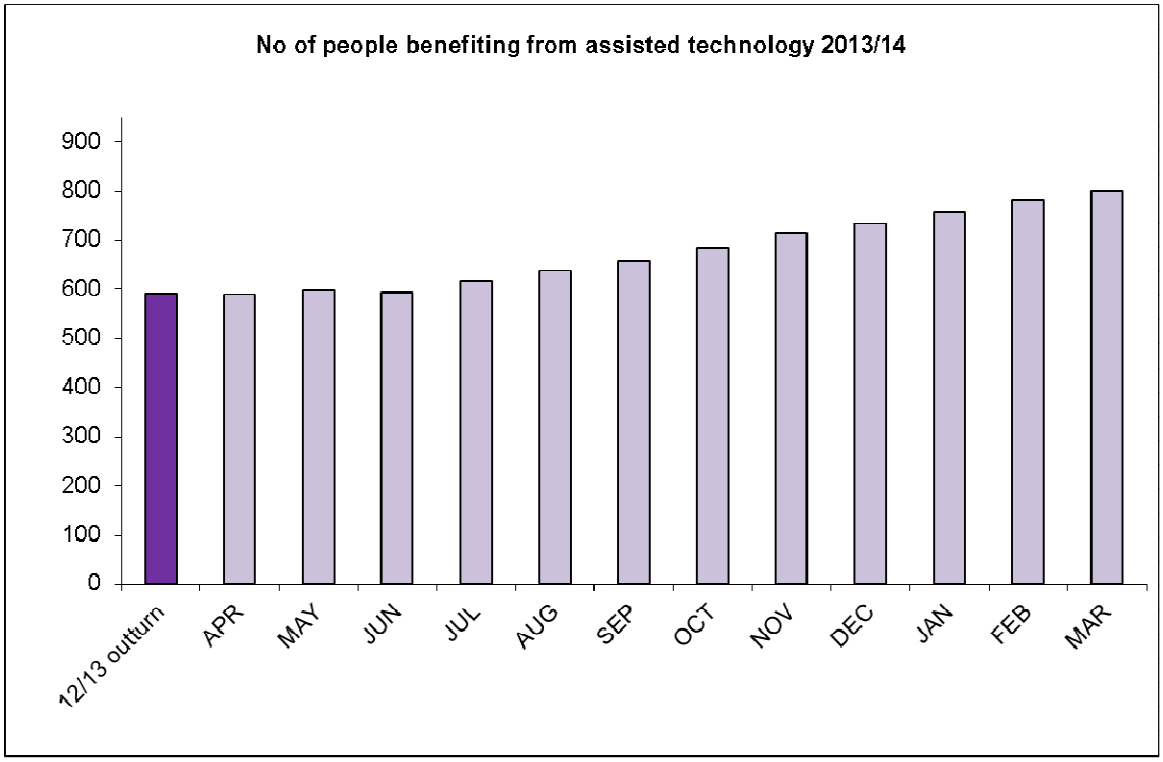
In 2013/14 between 202 – 303 service users a month were issued with prescriptions (an increase from the previous year of between 202 - 257 prescriptions per month) and the redemption rates have averaged 85 per cent, which is above the national average.

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

2.4 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 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 and used in sheltered accommodation units, and is being installed as part of the development of new independent living units for people with a learning disability.



3. PLANNED DEVELOPMENTS

3.1 Single point of access

Joint screening of all referrals to social services or therapies was piloted as part of the N19 Project. This worked very well to identify duplicate referrals, to identify the most appropriate professional to respond, and to provide a timely response.

Work has been underway to develop a single point of contact to provide access to services and advice, and this will be shared between social services and relevant community health services.

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 Access and Advice service. Staff working in this service will be 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.

The Access and Advice Service will support Islington to fulfil its duties Care Act 2014, which require health and social services to 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.

Wherever possible, we will seek to provide advice and access to services 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

Learning from the success of the N19 pilot has been used to support development of a model for co-located and integrated teams of health and social care staff across Islington, with the aim or providing a more seamless and timely service for residents and service users, and achieving cost savings by cutting out duplication. The new model is planned to be in place by April 2015.

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.

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 with complex needs.

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 The 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 Hospital)
- 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 in Whittington Health 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 ensure that opportunities to share expertise and specialist knowledge are maximised, and that any duplication of work is minimised.

Carol Gillen
Deputy COO, Director of Operations, Integrated Care and Acute Medicine

August 2014

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The Whittington Hospital NHS Trust
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London N19 5NF

Whittington Health Trust Board

1st October 2014

Title:	Update Report- Progress in Integrated Working- Haringey Integrated Learning Disabilities Partnership.		
Agenda item:	**14/150**	**Paper**	**10 iv**
Action requested:	For Information		
Executive Summary:	The Report outlines the progress made by the Haringey Learning Disability Partnership over the last 18 months and describes how this progress has been achieved by the high degree of integrated working between the 4 health and social care bodies in Haringey. The Key Achievements have been 1. Development of an integrated assessment pathway 2. Strong cohesive service culture developed over many years 3. Joint risk and need assessment tools 4. No emergency hospital admissions through strong MDT working 5. Innovative Health Action Plan utilising the 'My Purple Folder' initiative 6. Good performance overall against key performance measures. The report also highlights the ongoing nature of the developmental journey and the need for more work to truly develop processes which deliver better joint outcomes and measures which robustly capture the benefits of integrated working.		
Summary of recommendations:	The report is for Information/Discussion		
Fit with WH strategy:	The report is an update on the formal Section 75 Agreement between Whittington Health NHS Trust, Barnet, Enfield and Haringey Mental Health NHS Trust, Haringey CCG and Haringey Council.		

	Integrated working is a cornerstone of Government Policy across Health and Social Care and is at the heart of the Care Act 2014,
Reference to related / other documents:	Haringey Learning Disabilities Partnership Service -Section 75 Partnership Agreement 2013-2016
Reference to areas of risk and corporate risks on the Board Assurance Framework:	
Date paper completed:	**22/09/2014**

Author name and title:		**Carol Gillen/Beverley Tarka**		**Director name and title:**		Carol Gillen, Director of Operations, Integrated Care & Acute Medicine/Deputy COO	
Date paper seen by EC		**Equality Impact Assessment complete?**	**N/a**	**Quality Impact Assessment complete?**	**N/a**	**Financial Impact Assessment complete?**	**N/a**

Appendix 1

Haringey Learning Disabilities Partnership Service
Update Report
Progress in Integrated Working
September 2014

A partnership between Haringey Council, Haringey Clinical Commissioning Group (CCG), Whittington Health and Barnet, Enfield and Haringey Mental Health NHS Trust). Haringey Council is the lead partner.

1. Introduction

This report covers the main achievements of the last year in the provision of integrated services for people with a learning disability by Haringey Learning Disability Partnership (HLDP).

2. Background to the partnership

The integration of health and social care services for people with learning disabilities has been the policy of successive governments and local partners, and remains a key driver for future improvements in the delivery of health and social care services, nationally and locally.

The HLDP was established in October 2003 and further developed through a series of Partnership Agreements established via Section 75 of the National Health Service Act 2006. Section 75 Agreements make provision for prescribed NHS bodies and prescribed local authorities to enter into prescribed arrangements in relation to the exercise of prescribed functions of the NHS bodies, and prescribed health-related functions of the local authorities.

The current core partners are the two commissioning and funding bodies (Haringey Council and Haringey CCG) and the service provider/ delivery bodies (Haringey Council; Whittington Health NHS Trust; and Barnet, Enfield and Haringey Mental Health NHS Trust). Haringey Council is the lead partner in the HLDP.

3. What does the Haringey Disability Partnership provide?

HLDP provides health and social care services to adults with learning disabilities resident in Haringey. The main interface is between health and social care and is delivered through the community service. This is an integrated service consisting of health and social care professionals working together to improve outcomes and reduce inequalities.

The partnership focuses on:

- Improving access to mainstream health services, enabling those with the most complex health needs to remain in their own home or continue with care and support packages;
- Following referral and screening, ensuring that people referred to the service are notified of acceptance within two working days, are allocated a ‘named worker’ within five working days, that a ‘single’ assessment is started within seven working days and completed within eight weeks (40 working days);
- Working with GP surgeries, hospitals and other health services, ensure that the particular needs of people with a learning disability are taken into account in their services, for example, by providing longer appointment times and appropriate signage;

- Ensuring that all adults with a learning disability have the opportunity to have a Health Action Plan (HAP) completed, with assistance from a health facilitator if required;
- Supporting eligible adults who have learning disabilities to have an annual health check provided by their general practice;
- Ensuring that there is a clear pathway and appropriate support for people with a learning disability with profound multiple learning disabilities (PMLD); similarly for those with an autism spectrum diagnosis; and that there are robust arrangements in place for young people with learning disabilities transferred from the children's service ('Transition' for people with a learning disability);
- Ensuring timely access into mainstream mental health services for adults with a learning disability and concurrent mental health problems;
- Providing support to those adults who have learning disabilities who require pre-planned hospital admission (such as referrals to ATUs – Assessment & Treatment Units);
- Facilitating access to mainstream services whilst in hospital and appropriate 'in-reach' or 'out-reach' services to facilitate discharge;
- Equally that those who are admitted to acute hospitals (generally unplanned) do not remain in hospital without appropriate support and discharge plans in place, which might include referral to the local authority re-ablement service;
- Increasing the range of health promotion/ disease prevention programmes are in place (tailored to the needs of people who have learning disabilities);
- Ensuring that the wider primary care community (dentists, pharmacists, physiotherapists, podiatrists, optometrists, sexual health etc.) is demonstrably addressing and promoting the better health of people with a learning disability;
- Ensuring that people who have learning disabilities and their families/carers are supported to contribute fully to, and participate in, discussion as well as in the planning prioritisation and delivery of services generally;
- Providing an appropriate service response to support people with early onset dementia;

4. The benefits of an integrated team

In addition the multidisciplinary team which comprises the range of health and social care professionals have identified the following benefits from the joint team:-

Person Centred Planning (PCP)– at the centre of any service delivery is a patient/service user. If we really want to embrace person centred planning, we do need to take both health and social care aspects in to consideration. Having a different health and social care service/approach fails to deliver PCP in a true sense. The health service on its own will not be able to achieve PCP and same is true for social care. Having integrated team facilitates PCP through joint single care plan that is person centred.

Health and wellbeing– to achieve good health and wellbeing, we need to consider both health and social care. Again, having an integrated team helps with achieving holistic health and wellbeing goals.

Patient/service user experience – health outcomes are quite integrated with and are dependent on both health and social care input. Pulling resources together meant achievinghealth outcomes through both health and social care input. These include

preventative aspects as well as recovery aspects.

No health without mental health–again outcomes on mental health could not be achieved without meaningful input on social care side. This is not about just having a social worker in the team but thinking more strategically at the commissioning levels by developing appropriate health and social care resources in the community to improve quality of life for individuals and to improve outcomes on mental health.

Delivering quality – Integration allows strategic preventative approach to health care but it also allows effective recovery from ill health. Apart from recovery from ill health, there is also a need to consider rehabilitation pathways to promote independence and to reduce need for care. Again, these issues could not be considered as separate health and social care issues but require integrated/joined up commissioning intentions. This would reduce the need for reliance on non-commissioned services. To ensure choice and independence, it would need both social and healthcare intervention.

Learning organisation – integration allows pulling resources together but also brings different organisations with different cultures together. It has a positive benefit of learning from each other and improving practices. It also allows access to development structures of partner organisations.

Risks – Integration would allow better management of risks; both for patients/service users through PCP and for organisation by sharing responsibility to deliver high quality service.

Effective use of resources – Integration will not necessarily equate to savings. However, an effectively integrated service is more likely to provide a better quality services. This would translate into achieving better health outcomes over a longer term. Better health outcomes over longer term would eventually lead to financial efficiency by proactively reducing need for care and dependency. It allows a joined-up strategic thinking to deliver better outcomes through care planning and market development.

5. What has the partnership achieved in the last 18 months?

Development of single integrated care pathway and development of NICE guideline based protocols

Over the last 18 months, we have actively worked on streamlining our care pathways in order to enhance efficiency and service user. We have established multi-disciplinary and integrated comprehensive initial assessment framework, streamlined allocation process and have developed number of protocols as per NICE guidelines. These include protocols for complex physical health care, end of life care, obesity and weight management, autism, complex mental health and challenging behaviour, dementia etc.

The team has developed a ‘person-centred’ care pathway for all people with a learning disability and is working to introduce a completely integrated assessment and planning process *on one IT system* (Appendix 1)

Initial allocation, transition planning and interdisciplinary allocation are all managed as a common multidisciplinary process

The team has developed a completely integrated risk assessment tool and process, which ensures that there is a common sense of urgency across all disciplines.

Speedy and appropriate allocation on referral

Following referral to the Partnership Team, contact and confirmation of acceptance/ rejection, are made with new/ prospective service user within two working days and are allocated a named worker within five working days of new service user being accepted;

100 per cent of referrals have been assessed via a single assessment process.

54 people who are allocated to the team have services co-ordinated via the CPA.

Review of the partnership management structure

We have worked on streamlining the management structure that would help deliver the outcomes and KPIs. We have embarked on the pathway of continuous innovation and development. In order to support it, we have created a clinical leadership and operational group represented by senior managers and clinicians. CLOG reports to the Learning Disability executive and sets the strategic framework for the partnership work. We have also created implementation group consisting of lead professionals who oversee all the developmental initiatives within the partnership. Governance is ensured through practice governance framework.

Reducing admissions to hospitals

The role of the Acute Liaison Learning Disability Nurse, based at The Whittington Hospital has been well established. This nurse works in partnership with healthcare professionals from the acute care services and takes lead responsibility on enabling people with learning disabilities to access local acute health services (including emergency, elective and outpatients). The post supports the functioning of primary care services and facilitates access to acute health services, so that these are both accessible and appropriate for people with learning disabilities.

There have been no admissions to specialist hospitals, in the 15 months from 1st April 13 and the end of August 2014.

Winterbourne View review

Following the Winterbourne View review, similar to other boroughs, Haringey was presented with challenging tasks of reviewing and discharge planning of patient with learning disabilities in the out of borough hospital placement. As a partnership, we provided and integrated response with a team of health and social care professionals working together in actively reviewing admissions in long stay hospitals. Due to the integrated nature of the partnership, we were able to bring in the expertise of various health and social care professionals in the review process. The team carried out comprehensive reviews with clear plans for discharge or step down services. We formed a Winterbourne project board

with representation from partner organisations and have successfully managed the process. Since this process began, we have successfully enabled the discharge of eight people with learning disabilities back into community placements.

There have been no new inpatient admissions during this period.

Providing alternatives to/reducing reliance on Residential and Nursing Care Placements

The team achieved the social care target for reducing the rate of admissions to permanent residential care for 2013/14.

Autism service developments

The team has developed 'in borough' autistic specific provision – both day opportunities and housing; and recently submitted an innovative proposal to the Government's Autism Innovation Fund, which, if successful, will in combination with a capital allocation enable us to establish a dedicated user/carer led advice and support service.

General Practice link

To support primary care providers in Haringey, the Learning Disability Nurses provide a liaison role with each of the collaborative. Their role currently is:

- To provide a names point of contact from the Haringey Learning Disability Partnership for GPs and primary health care staff
- To update GPs on issues related to meeting the health needs and ensuring the best health outcomes for people who have learning disabilities and their families
- To provide advice on health issues related to people who have learning disabilities and advise on specialist support available
- To provide support and advice in relation to the implementation of the LD DES, annual health checks and health action planning.
- To provide advice on mental capacity, best interests and safeguarding.

Health Action Plans

HLDP have been offering training on and subsequently distributing 'purple folders' across the borough. This innovative document is designed to help deliver person centred care and contains information that will be needed for treatment plans and risk assessments across all health settings. Within the purple folder is the Health Action Plan (HAP) – which is used to provide an overview of the current treatment and proposed follow-up care. The purple folder belongs to the person with a learning disability/carer and so far over 250 have been allocated in Haringey. The total number of people known to the team is 620.

Clinical Team excellence

The team was successful in winning Whittington Health's Clinical Team of the Year Award in 2014.

Palliative care

The team’s palliative care/end of life Care protocol was recognised as a benchmark of good practice by Public Health England in their document*Making Reasonable Adjustments to End of Life Care for People with Learning Disabilities.*

Productive community service
In order to improve quality of our service provision, efficiency and to enhance service user experience, we decided to incorporate principles of the Productive CommunityServices (PCS).

6. Key challenges for the next year

Despite the high level of joint working and creation of integrated solutions, the team still needs to develop/improve systems to both maximise and also record the benefits of integrated working. This will be particularly true given the financial pressures that public bodies are currently under.

These challenges include:-

Outcome focussed – service is not currently geared up for measuring outcomes. Service delivery is also not outcome based or outcome focussed. We should be using NHS and social care outcome framework to define our core business and activities should be towards achieving those outcomes

Efficiency and cost effectiveness through innovation and performance management – ensuring innovation to achieve desired outcomes in available resources. For this to happen, it would be important to incorporate culture of PCS and performance management.

Management structure that supports delivery of the care pathway – Instead of trying to fit available resources in the existent management structure, we should re-structure management roles to support delivery of the care pathways.

Carol Gillen
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