North Somerset Council

REPORT TO THE ADULT SERVICES AND HOUSING POLICY AND SCRUTINY PANEL

DATE OF MEETING: 16 JANUARY 2015

SUBJECT OF REPORT: INTEGRATED CARE TEAMS

TOWN OR PARISH: ALL

OFFICER/MEMBER PRESENTING: CLAIRE LEANDRO, ASSISTANT DIRECTOR, PEOPLE AND COMMUNITIES

KEY DECISION: NO

RECOMMENDATIONS

Scrutiny Panel is asked to note the contents of the report and provide comment on the work to integrate health and social care services.

1. SUMMARY OF REPORT

1.1 This report provides Scrutiny Panel with an update on progress with a key shared initiative to deliver integrated locality working within North Somerset. Members are asked to note this report and provide comment. There is a strong commitment within the workforce to deliver the national drive towards integration; it is recognised that there remains a lot of work ahead, but significant steps have been made towards the joint goal.

2. POLICY

2.1 This joint service development, with health, ensures that North Somerset is able to deliver the strategic direction set out for health and social care in the publication 'Integrated care and support: our shared commitment' (May 2013). This was published by the National Collaboration for Integrated Care and Support, a group of major stakeholders in the delivery of integration.

2.2 This publication was endorsed by Local Government Association and NHS England in their 'Statement on the health and social care Integration Transformation Fund' (August 2013). It states that the strategic direction within England is to 'move toward fuller integration of health and social care for the benefit of the individual'.

2.3 Within the North Somerset Clinical Commissioning Group and North Somerset Council Better Care Fund submission of September 2014 we set out:-

> *Our ambition for integration of health and social care services - advanced arrangements for joint working is to ensure that there is high quality coordination of care. In order to achieve the vision for the integration of health and social care within*

North Somerset, it is essential that a model for integration continues to build on the existing good work that will achieve greater joint working across health and social care, delivering personalised care and support in locality settings across the area.

Consequently integrated health and social care teams are a key element in the Better Care Fund Delivery Plan to meet this ambition.

2.4 The council's Corporate Plan has as one of its key aims to 'enhance health and well-being' and one of the priorities for delivery by 2015 is to 'promote greater integration of health and social care'. The developments this paper reports on demonstrate how the council and partners are progressing this work.

3. DETAILS

3.1 North Somerset is facing increasing pressures across the health and social care system, with predicted population growth of 40% by 2033, especially within the over 65 group. Alongside this are the significant budget challenges facing both local government and the local health economy

3.2 To address this increasing demand and financial situation the joint health and social care community in North Somerset decided to expand upon the already well established integrated services, such as the Single Point of Access, Community Learning Disability Service and Integrated Mental Health service, putting in place integrated locality health and social care teams, consisting of staff from social care and community health with strong links with GPs, the acute sector and mental health services.

3.3 The partners in the delivery of this new approach are North Somerset Clinical Commissioning Group (CCG), North Somerset Council (NSC), North Somerset Community Partnership (NSCP), Weston Area Heath Trust (WAHT) and Avon and Wiltshire Mental Health Partnership Trust (AWP). Alongside these partners we are linking with the voluntary and community sector.

Design of the teams

3.4 The integrated teams:-

- Promote independence
- Improve the ease and speed of access to health and social care services
- Focus on the needs of the most vulnerable in our communities
- Deliver as much care locally as is safe and good value
- Shift the pattern of care towards domiciliary and community settings
- Provide a sustainable pattern of integrated care pathways across social, community, mental health acute and primary care services
- Commit the maximum spend on services, and the minimum spend on overhead
- Support the North Somerset Health and Social Care System to be in financial balance, with increased emphasis on efficiency and productivity.

3.5 There will be four teams, each covering a geographical location linking with GP practices serving a population of approximately 50,000, each with a single manager. The first team was set up in the summer of 2013. From this we are building and developing a model to be rolled out across the authority. It is important to recognise that for each team the majority of people will only need input from community nurses/health staff, a significant number of people will only require social care support and there will be a small but complex minority who require a multi-disciplinary/integrated approach.

3.6 In June 2013 the Weston Integrated Care Team was established; its main base is the Town Hall with a satellite at Worle Health Centre, servicing 9 GP surgeries. The team consists of approximately 19.4 fte NSC social care staff and 44 NSCP health staff, with input from mental health staff in Avon and Wiltshire Mental Health Trust. In July 2014 the second team – Worle was established. This team covers 6 GP surgeries and has approximately 14 NSC social care staff and 18.5 NSCP health staff. This team also has input from Avon and Wiltshire Mental Health Trust. The teams are developing links with GP surgeries and through working in partnership with NSCP's Teams also has close links with Weston General Hospital. Each team has one manager with responsibility for the service.

3.7 The project deliberately prioritised co-location of staff as the key enabler of integration. This allows closer worker relationships, better planning and driving forward a culture of shared responsibility and identity.

Progress

3.8 Since the March 2014 report to ASSH the following has been achieved:-

- Establishment of second ICT for Worle.
- Appointment of the manager for each team. One manager is employed by NSCP and one is employed by NSC.
- Weekly Multi-Disciplinary Team (MDT) meetings for both teams – these are held in partnership with GPs and AWP, and identify high risk residents/patients and allocate a key worker to oversee the care required for that person. As at November 2014, since April, 99 people had been allocated a key worker to ensure the delivery of the multi-disciplinary care plan.
- UWE provided an evaluation of staff views of integration to date.
- Begun multi-disciplinary meetings for two final localities in preparation for formally forming these two teams.
- Occupational Therapy staff are developing joint working approaches and shared pathways.
- Administrative staff are being trained on both NSC and NSCP information technology systems to facilitate shared working. There are now internal referral systems in place to speed up services for patients/service users
- Work with GPs is progressing, staff can attend meetings at surgeries, where possible, to assist in identifying patients for the MDT approach.

Issues

3.9 ICT – the two principle organisations (NSC and NSCP) within the team have separate IT systems. This makes information sharing and reduction of duplication complicated. While the North Somerset system, including both organisations, is signed up to the BNSSG Connecting Care project, this does not negate the need to double enter information onto different systems.

3.10 Re-procurement of community health services – this is a major procurement and has consumed significant resources of both the CCG and NSCP, as well as officer time from NSC. This inevitably has had an impact on the ability of all three organisations to continue this work at pace. Although the procurement is hard work it is providing an opportunity to redesign services and consider how integration will work in to the future.

3.11 NSC Transformation programme – this major initiative across the council requires concerted staff commitment and time. While the programme offers key positive opportunities, elements of it impact on the integrated care teams and this must be built in to the programme both for transformation and integration. Within the specification for the Agilisys business support offer is a commitment to only reshape these services for integrated teams in discussion and negotiation with both NSC and NSCP.

3.12 Accommodation – obtaining appropriate cost effective office space for these teams is challenging. These are significant staff numbers and accommodation is required to facilitate frequent and timely nursing and therapy care across the whole of the council area, as well as meet the needs to provide office accommodation for the ICTs.

Case Studies

3.13 These two case studies explain how the integrated care teams improve the pathway and experience for residents and staff in North Somerset.

Case Study 1

GP requested community nurses visit a newly diagnosed terminally ill man as a matter of urgency. He had moved into to live with his family and wants die at home with his family around him. Nurses visited and identified that social care needs at this stage were more urgent that his health needs. Social worker picked up case. Following discussion with nurses about the urgency, a same day visit arranged and personal care was provided. Referral for carers support was also made.

<u>Prior to Integrated Care Team</u>

There would have been a slower response time for the man and his family. Nurses would have had to make a referral through SPA. This would have diverted staff time of both referrer and receiving teams away from their other work. Also there could have been a delay in social care team receiving referral, due in part to number of referrals received in SPA and need to prioritise.

<u>Integrated Care Team Approach</u>

Having organised his personal care, social worker was able to withdraw from case, while nurses kept an overview of his health needs. As he was still known to the ICT, the team was able to respond swiftly to any changes. The team achieved its aim of acting appropriately to ensure provision of care and equipment to support both him and his family with his wish to die in his family home.

Case Study 2

Safeguarding alert regarding a pressure sore reported. The service user was living in a residential care home. The social worker, lead for safeguarding, discussed case with community nurse who gave them advice about investigating concerns and care provided by the care home staff. A safeguarding meeting was arranged to include social worker, care home and nurses at a suitable time. There was co-ordinated liaison with contracts compliance team.

<u>Prior to Integrated Care Team</u>

The social worker may not have known the appropriate questions to ask in relation to pressure area care. A lot of time would have been spent trying to co-ordinate meeting at a time and place to suit all parties. Community nurses would have worked separately to provide training to the care home on pressure area care. Social worker

would have separately liaised with contracts compliance team to ensure that learning is put into practice by home providing the care.

Integrated Care Team Approach
The new teams enabled a shared response from both health and social care staff to support the safeguarding investigation. The team facilitates mutual learning within team about health needs and the safeguarding process.

Final two integrated care teams

3.14 We are in the process of setting up the remaining 2 teams, one to cover Clevedon and Portishead and another to cover Nailsea and the more rural areas of North Somerset. Early thinking is in hand to identify where the office locations might be. There will be challenges to ensure the service is responsive to the needs and geography of the populations in these parts of North Somerset and we are considering whether a 'hub and spoke' model will be most appropriate.

Governance

3.15 There is a group, made up of chief executive officers, or their delegates, from NSC, NSCP, AWP, WAHT, and CCG which provides strategic direction for this work. Alongside this sits the Joint Management Team, chaired by NSC Director of People and Communities which manages the implementation of the intiative.

Evaluation

3.16 The Centre for Employment Studies Research at the University of the West of England delivered an evaluation to the Joint Management Board (JMT) in September 2014. Their work concentrated on perceptions and experiences of health care and social care staff. They produced a lengthy report with detailed commentary on their findings. However no summary was produced and the second team had only just been established. Their principal findings were that 'overall interviewees embraced positively the idea of care service provision that was effectively coordinated in the interested of patients/service users'. However, while staff, in the main, had a broad-brush shared understanding of integration and its aims, there were mixed views on how embedded and mature the two teams were. Further evaluation is planned for early 2015 and will ensure there is feedback from the second ICT at Worle.

3.17 Following on from this the JMT acknowledged that there needed to be follow up on the initial Healthwatch work which concentrated on the views of patients, one of the most important markers of effectiveness of ICTs.

3.18 The Avon Primary Care Collaborative are taking an overview of the evaluation work for the project and will report back to JMT.

3.19 In addition to this there is regular reporting of Quality and Effectiveness Framework Indicators for the teams, these are compared with performance for the areas which are not yet integrated. See Appendix A

4. CONSULTATION

4.1 There has been ongoing engagement with all relevant organisations in relation to integrated working. The NSCCLG has received reports, Staff have been engaged with and have contributed to the baseline evaluation and will be included as the project progresses.

4.2 Residents and patients have been involved through Healthwatch undertaken a survey of their views and as noted above this needs to be followed up.

5. FINANCIAL IMPLICATIONS

5.1 This work is being delivered within current staffing budgets for NSCP and NSC, although this is challenging. Joint health and social care funding is meeting some of the implementation costs. There are likely to be some accommodation set up costs and potentially ICT commitments in order to deliver this work and the value of these is currently being determined covering a two year timeframe. The CCG and the council are committed to utilising the Better Care Fund, which is designed to support the delivery of 'integrated care and support', to support costs identified.

6. RISK MANAGEMENT

6.1 There are a range of risks and issues for this work, identified in paragraphs 3.9 to 3.12. It is also important to note that this service redesign is expected to deliver efficiencies but is less likely to release cashable financial savings in the short term. The risks are monitored and managed through both the Chief Executives' Group and the Joint Management Team.

7. EQUALITY IMPLICATIONS

7.1 There are no equality implications of this development. It should improve access to services for all sections of the community, particularly those with long term conditions or problems associated with aging.

AUTHORS

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BACKGROUND PAPERS

LGA and NHS England – Statement on the health and social care Integration Transformation Fund, NHS England Publications Gateway Ref 00314 – 8 August 2013

NHS England – Planning a sustainable NHS: responding to the 'call to action', NHS England Publications Gateway Ref 00542 – 10 October 2013

LGA and NHS England – Next Steps on implementing the Integration Transformation Fund, NHS England Publications Gateway Ref 00535 – 17 October 2013

Department of Health and Department for Communities and Local Government – Better Care Fund 20 December 2013

Integrated Care Teams – Performance 2014 Appendix 1

Weston ICT	April	May	June	July	August	September	October	November	Total
Numbers of multi-disciplinary team cases with MD care plans - each month	7	12	11	6	10	9	9	8	72
Numbers of admissions – cumulative	9	13	23	25	32	40	41	54	54
Carers referrals for assessment to Crossroads – cumulative	0	1	3	9	16	19	22	27	27
Telecare – as at month end	92	94	95	97	99	97	100	99	99

Worle ICT	April	May	June	July	August	September	October	November	Total
Numbers of multi-disciplinary team cases with MD care plans - each month					9	6	9	3	27
Numbers of admissions – cumulative	1	2	8	12	17	20	23	26	26
Carers referrals for assessment to Crossroads – cumulative					Awaiting ratification of data				
Telecare – as at month end	96	98	102	101	99	97	99	102	102

NSC Adult Care Teams and NSCP Managed Care Teams - Performance 2014

Nailsea (NSC) Tyntesfield and Strawberry Line (NSCP)	April	May	June	July	August	September	October	November	Total
Numbers of multi-disciplinary team cases with MD care plans - each month							4	TBC	4
Numbers of admissions – cumulative	3	5	7	8	13	18	28	30	30
Carers referrals for assessment to Crossroads – cumulative					2	7	11	14	14
Telecare – as at month end	89	90	91	95	96	101	106	102	102

Clevedon (NSC) Clevedon & Portishead (NSCP)	April	May	June	July	August	September	October	November	Total
Numbers of multi-disciplinary team cases with MD care plans - each month								2	2
Numbers of admissions – cumulative	2	6	12	14	20	25	29	32	32
Carers referrals for assessment to			2	2	7	8	10	14	14

Crossroads – cumulative									
Telecare – as at month end	71	74	71	76	79	79	82	82	82