Havering
LONDON BOROUGH

INDIVIDUALS OVERVIEW AND SCRUTINY SUB-COMMITTEE

Subject Heading:	Integrated Social Care Teams
CMT Lead:	Isobel Cattermole, Director Children, Adults and Housing
Report Author and contact details:	Barbara Nicholls Assistant Director, Adults and Commissioning
Policy context:	

SUMMARY

There are a number of key forms of integration; this paper will focus upon the progress in Havering around multidisciplinary service integration.

RECOMMENDATIONS

This report is for information only.

REPORT DETAIL

Integrated Care

The idea of Integrated Care is not new – the concern about lack of integrated care dates back to before the start of the NHS. This concern has been about fractures in systems and delivery that allow individuals to 'fall through the gaps' in care.

People benefit from care that is person-centred and co-ordinated within healthcare settings, across mental and physical health and across health and social care. For care to be integrated, organisations and care professionals need to bring together all of the different elements of care that a person needs.

A person's care may be provided by several different health and social care professionals, across different providers. As a result people can experience health and social care services that are fragmented, difficult to access and not based around their (or their carers') needs. Approaches that seek to address fragmentation of care are common across many health systems, and the need to do so is increasing as more people live longer and with complex co-morbidities.

Integrated care may be judged successful if it contributes to better care experiences; improved care outcomes; and the delivery of more cost effective services.

As financial and service pressures facing the NHS and local government intensify, the need for integrated care to improve people's experience of health and care, the outcomes achieved and the

efficient use of resources has never been greater. The Better Care Fund (formerly the Integration Transformation Fund) was announced by the Government to ensure a transformation in integrated health and social care. The Better Care Fund (BCF) is one of the most ambitious ever programmes across the NHS and Local Government. It creates a local single pooled budget to incentivise the NHS and local government to work more closely together around people, placing their well-being as the focus of health and care services. This not new or additional money; however, it comes from clinical commissioning group (CCG) allocations and NHS money already transferred to social care. Guidance makes clear that the Better Care Fund will entail a substantial shift of activity and resource from hospitals to the community.

Work in Havering

The Barking Havering and Redbridge CCG Integrated Care Coalition '*Case for Change*' sets out the plans for the shift of resources from acute to community and to provide better care and services closer to peoples' homes.

There is a developing joint commissioning approach with the CCG, governed by a joint commissioning management forum, working towards a vision for how health and social care services work together to provide better support at home and earlier treatment in the community to prevent people needing emergency care in hospital or care homes.

The priorities for our integrated care system include developing further the integrated locality model. Our design principles underpin this by stating: '*Localities will be central to organising and co-ordinating peoples' care*'.

Our BCF 2015/16 plan states: The strategic objective will deliver by 2019: '*A locality based integrated health and social care workforce comprising multi- disciplinary workforce across six GP cluster-based localities. Remaining sensitive to practice list profiles, the service will incorporate adult social care eligibility criteria in its risk profiling. It will include voluntary sector provision of local information and advice and integrate mental health professionals. This will ensure a smooth pathway between locality and specialist provision and to provide support to GPs and their patients in a similar way to physical health specialists. 'Individuals will have a named care professional who will be responsible for ensuring their care is appropriately coordinated for their needs.'*

This will build on the successes of Integrated Case Management (ICM and ICM+) the Community Treatment Team (CTT), the Joint Assessment and Discharge (JAD) team and the recently launched Health and Social Care Service (HSCS) and integrate fully the social work function across the services.

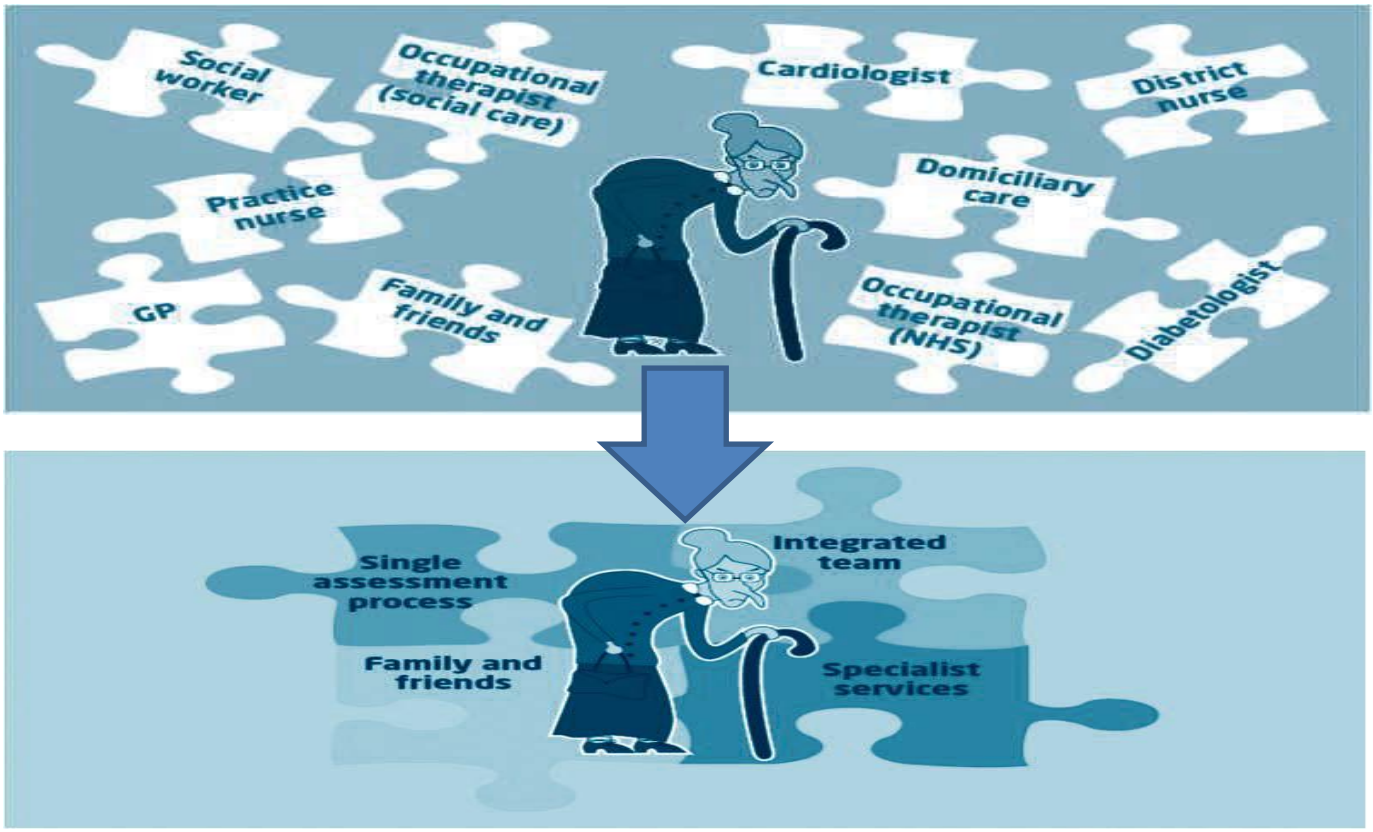
This approach aims to remove organisational barriers so care can be joined up around individuals. By increasing co-ordination, collaboration and integration the service aims to:

- Improve the service user experience, they *'tell their story once'*
- Eliminate duplication
- Streamline care pathways
- Intervene earlier and adopt and preventative approach; and
- Improve safeguarding.

The locality model will be based on six clusters of GP practices co-locating health and social care staff wherever possible, to ensure that multi-disciplinary working is embedded in daily practice and as well as through multi-disciplinary meetings. The approach will be targeted and proactive with joined up assessment, care planning and care co-ordination.

The patient cohort being targeted by the locality working model are frail elderly people, mostly over the age of 65 with one or more long term conditions. The cohort also includes patients with dementia, End of Life patients, those at risk of hospital admission / re-admission, and those being discharged from hospital.

It is our intention to expand integrated locality working in the future to include paediatrics/vulnerable children, once the adult focused approach has been piloted, evaluated and adjusted to deliver the intended benefits.



Progress to date and next steps

Co-located teams are now in place in Cranham and Harold Hill, with two more locations in Romford and Rainham/Elm Park to be co-located by April 2016. The locations house social work and health (NELFT) teams.

Once the four teams are co-located, the service delivery model will be reviewed to agree how we can then progress towards full integration with NELFT partners. The key aim will be to have a joint approach to assessments and care planning and, where funding is used for integrated packages of care.

Performance measures are in place to track the benefits and impact of the move to co-location. There is a joint governance framework in place as well as an operational group.

It is expected that we will be able to respond more quickly and effectively at earlier points in the pathway to a non-elective admission, managing the increase in demand that is likely to occur with Havering's specific demographic.

Early intervention and the provision of the right services at the right time will have the impact of enabling people to stay at home rather than move to a residential setting. The patient and service user experience is expected to be positively impacted as a more joined up approach will be in place to enable better information sharing and more timely decision making as we move towards full integration. Pathway mapping will improve as the model develops further.

Information Communications Technology has been and will continue to be key focus area as integration in joint localities continues. Work is already underway to ensure better data sharing between health and social care, based on the NHS number and secure scanning at each location is also being developed further.

IMPLICATIONS AND RISKS

Financial implications and risks:

It is anticipated that budgetary pressures related to providing care services through greater integrated social and health care activities routed to a community based approach will be funded through the Better Care Fund.

Legal implications and risks:

There are no apparent legal implications from noting this report.

Human Resources implications and risks:

There are no direct HR implications, or risks to the Council or its workforce, that can be identified from the contents of this report or the recommendation made.

Equalities implications and risks:

The proposals contained within the report will support and maintain a number of services which protect individuals and ensure that they are targeted to those in most need. No adverse impact upon patients or service users is anticipated as a result of the information contained within this report

BACKGROUND PAPERS

No background information papers used.