# Committee: Health and Wellbeing Board

# Date: 4 October 2016

Wards: All

# Subject: Local integration of health and social care

Lead officer: Simon Williams Director of Community and Housing, Adam Doyle Chief Officer Merton CCG

Lead member: Tobin Byers Cabinet Member for Adult Social Care and Health, Andrew Murray Chair of Merton CCG

Contact officer: Murrae Tolson, Merton CCG

---

**Recommendations:**

A. To note the progress made with local integration between health and social care

---

## 1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

- To provide an update to the HWBB regarding the progress of health and social care integration

## 2. BACKGROUND

Merton has a rich history of integration between health and social care. Since 2014/15 integration has been further supported through the NHS funded Better Care fund programme and a £12,5m pooled health and social care budget. This budget is constituted of a Local Authority held lead fund of £5.5m and NHS community services to the value of £7m.

The key priority for integration in 2016/17 BCF is to strengthen the relationships and collaboration between multiple providers in Merton with the aim of reducing:

1. Permanent admissions to residential care homes

2. Unscheduled admission of vulnerable people to hospital.

3. Delayed transfers of care

## 3. DETAILS

### 3.1 Performance

| Metric | Q1 Performance | Commentary |
|---|---|---|
| **Non-elective admissions** | During Q1 2016/17 Merton experienced 537 more admissions than the same | This is 261 more admissions than forecast. The over activity is mainly driven by |

| | | |
|---|---|---|
| | period last year. | short stay admissions at St. Georges hospital. |
| **Permanent admissions to residential care** | There were 22 new permanent admissions to residential/nursing care homes in Q1. | Should this trend continue, the end of year ambition of less than 105 admissions will be achieved**.** |
| **Reablement activity** | There were 118 reablement packages provided in Q1 against a target of 93. | This is currently only counting social care provided reablement and does not include health provided intermediate care or community rehabilitation. If this activity were included the numbers would be significantly higher. |
| **Delayed Transfers of care** | There were 904 bed days occupied due to delayed transfers of care from Acute hospitals across health and social care | Whilst this is in line with planning assumptions, it is 437 more beds days than the same period last year. The number of delays that have been attributed to social care have reduced significantly from last year. |
| **Length of stay of intermediate care** | The average length of stay for community intermediate care was 30 days. | This is driven by a small number of people with complex discharge needs, particularly those who are non-weightbearing, not ready for rehabilitation or where responsibility for payment by either health funded continuing care or social care is being clarified. |

### 3.2. Programme progress

The integration work to date in 2016/17 has focussed on creating a shared vision of integrated health and social care provision between social care teams, community health services, voluntary services and the Merton GP federation. This vision is illustrated in Appendix 1.

Three workshops have been facilitated and a joint health and social care operational implementation plan has been developed by the Director of Merton Community Services, The LA Head of Access and Assessment and the Chair of the Merton GP Federation. (Appendix 2). The following has been achieved:

#### 3.2.1. Case finding pilot

The Merton GP federation is piloting using a tool called e-Frailty to identify people who are susceptible to a rapid increase in vulnerability to hospital admission or increased care needs.

To date, 100 patients have been identified as potentially having a high level of frailty. Practices are in the process of gaining consent from these patients to participate in the pilot. The federation are working in partnership with 2 newly appointed community case managers, 2 care navigators, health liaison social workers and the voluntary service sector thereby constituting a co-ordinated multi-disciplinary team (MDT).

Once consent has been gained, relevant people from the MDT will work with the people identified to assess their needs, work with them to identify their priorities and offer supported self-care or agree an holistic care plan as appropriate. 100 reviews are scheduled for completion by the end of October 2016.

The pilot is running from 1st September to the 30th November and will be evaluated in December. The evaluation will inform how to improve the way of working and scale the pilot up to a bigger group of people.

### 3.2.2. Co-location of health and social care teams.

The BCF plan identified co-location as an enabler to better integration and closer working between health and social care in order to support joint assessment, care planning and service delivery as well as supporting joint training and team building. CLCH have welcomed the opportunity to move their operational base from 120 The Broadway in Wimbledon to the Civic Centre in Morden, thereby achieving co-location of clinical locality teams (including community nurses and therapists) and management support posts alongside council staff.

The move is progressing as planned for Q4 2016/17, subject to agreement of Heads of Terms from London Borough of Merton and the installation of the IT infrastructure.

In the interim, the rapid and intermediate care health service teams have developed closer working with social care by attending weekly reablement meetings. Improved relationships are facilitating reduced overlaps of care provision, bridging gaps in care provision to prevent unnecessary hospital admission and facilitating a reduction of hospital length of stay.

### 3.2.3. Integrated health and social care response.

The LA Head of Access and Assessment and the Director of Community services have agreed the principles around joint working opportunities to create an integrated health and social care response. In preparation for this, all local authority teams (hospital to home, first response and Reablement) and the community services rapid response teams (MERIT) are currently streamlining their individual processes. However, operational discussions about joint processes between health and social care have not yet been begun. These will be developed in partnership with the teams to ensure that they maximise opportunities for joint working whilst not creating additional unintended pressures for either organisation. Work on mapping the movement of demand will need to be part of this work to ensure that investment follows the activity.

Reablement is now prioritising hospital discharge and prevention of admission. However, referral to this team is still restricted to social work teams. This creates some access barriers for people who require a joint health and social care response to increase people's functional ability with the aim of reducing their longer term support needs and is an area that will be further explored.

The CCG are tightening operational processes for ratifying decisions regarding continuing health care eligibility. This has highlighted inconsistent provision of evidence to support continuing health care funding applications. For a small number of people with complex health and social care needs, or those that would benefit from a period of recuperation, this is causing a delay to the decision making process, sometimes translating to a delay to discharge from hospital or intermediate care.

To address these issues, a workshop has been arranged for late September for service managers from CLCH and LBM to map the preferred operational processes to expedite joint health and social care assessment and the role of interim packages of care for people where an extended assessment period is required. Initial discussions have begun to explore how this can be better managed in particular for people with a learning disability, who may not impact on the acute sector but for whom there may be a high level of financial commitment.

### 3.2.4 Data Sharing

Merton CCG's Information Management and Technology (IM&T) Strategy identifies the importance of ensuring the capacity and capability of information sharing across providers in the SW London STP area. The Strategy sets out the technical solutions that need to be procured or aligned in order to deliver the objectives and is supported by a series of inter-related technical projects both at a Merton and at a SW London level. In order to deliver these projects, a robust data sharing framework needs to be in place that will provide an over-arching information-sharing protocol covering a series of peer-to-peer sharing agreements. A group has been set up to progress this comprising commissioners and all the providers working within Merton. Consideration is being given to using an existing over-arching agreement, most likely the one currently managed by Kingston Hospital, following which the 'Tier 2' peer-to-peer agreements will be developed and implemented. The timescales are for the principal agreements to be in place by 31 March 2017 with full implementation by 30 September 2017. This will enable full exchange of patient-consented information between care settings in Merton.

## 4. ALTERNATIVE OPTIONS

Not applicable

## 5. CONSULTATION UNDERTAKEN OR PROPOSED

Not required.

## 6. TIMETABLE

As per operational implementation plan – appendix 3.

## 7. FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

The NHS contributes £5.5m towards BCF pooled fund with the LA currently the Lead fund holder. There is a risk share agreement in place for the value of the CCG QIPP savings target of £1,014k. The transfer to the LA will be reduced as a proportion of non-achievement of the QIPP up to a maximum of £687k should this savings target not be achieved.

## 8. LEGAL AND STATUTORY IMPLICATIONS

There is a signed section 75 in place between the CCG and the LA setting out the terms of the BCF pooled fund.

## 9. HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

The Integration programme is sensitive to human rights, equalities and community cohesion and is governed under current service management arrangements.

## 10. CRIME AND DISORDER IMPLICATIONS

None

## 11. RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

Risk management and health and safety is managed by current service management arrangements.

## 12. APPENDICES – THE FOLLOWING DOCUMENTS ARE TO BE PUBLISHED WITH THIS REPORT AND FORM PART OF THE REPORT

Appendix 1: Health and social care approach to integrated care planning.

Appendix 2: Health and social care operational implementation plan.

## 13. BACKGROUND PAPERS

**BCF PLAN 2016/17**

## APPENDIX 1: HEALTH AND SOCIAL CARE APPROACH TO INTEGRATED CARE PLANNING