London Borough of Hammersmith & Fulham

Health, Adult Social Care and Social Inclusion Policy and Accountability Committee

Agenda

Tuesday 12 September 2017
7.00 pm
Courtyard Room - Hammersmith Town Hall

MEMBERSHIP

Administration:	**Opposition**
Councillor Rory Vaughan (Chair) Councillor David Morton Councillor Mercy Umeh	Councillor Andrew Brown Councillor Joe Carlebach
Co-optees	
Debbie Domb, Disabilities Campaigner Patrick McVeigh, Action on Disability Bryan Naylor, Age UK Jim Grealy, Save Our Hospitals	

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Date Issued: 04 September 2017

London Borough of Hammersmith & Fulham

Health, Adult Social Care and Social Inclusion Policy and Accountability Committee

Agenda

12 September 2017

To approve the minutes of the meeting held on 13 June 2017.

2. APOLOGIES FOR ABSENCE

3. DECLARATIONS OF INTEREST

If a Councillor has a disclosable pecuniary interest in a particular item, whether or not it is entered in the Authority's register of interests, or any other significant interest which they consider should be declared in the public interest, they should declare the existence and, unless it is a sensitive interest as defined in the Member Code of Conduct, the nature of the interest at the commencement of the consideration of that item or as soon as it becomes apparent.

At meetings where members of the public are allowed to be in attendance and speak, any Councillor with a disclosable pecuniary interest or other significant interest may also make representations, give evidence or answer questions about the matter. The Councillor must then withdraw immediately from the meeting before the matter is discussed and any vote taken.

Where Members of the public are not allowed to be in attendance and speak, then the Councillor with a disclosable pecuniary interest should withdraw from the meeting whilst the matter is under consideration. Councillors who have declared other significant interests should also withdraw from the meeting if they consider their continued participation in the matter would not be reasonable in the circumstances and may give rise to a perception of a conflict of interest.

Councillors are not obliged to withdraw from the meeting where a dispensation to that effect has been obtained from the Audit, Pensions and Standards Committee.

4. HEALTHWATCH

Verbal update – a regular update provided by Healthwatch on local, Hammersmith and Fulham related health concerns and issues.

5. ADULT INPATIENT DISCHARGE 9 - 16

This report outlines plans to reduce delayed transfers of care to improve the patient experience, reduce length of stay, and improve flow through our hospitals.

6. SEASONAL INFLUENZA VACCINATION UPTAKE 17 - 29

This report provides an update on the uptake and coverage of seasonal influenza vaccinations during the winter of 2016/17.

7. COMMUNITY INDEPENDENCE SERVICE - PROGRESS REPORT 30 - 40

The following report provides an update on progress made by the Community Independence Service, which helps to support residents in their own homes or community.

8. WORK PROGRAMME 41 - 42

The Committee is asked to consider its work programme for the remainder of the municipal year.

9. DATES OF FUTURE MEETINGS

- Tuesday, 14th November 2017
- Tuesday, 12th December 2017
- Tuesday, 30th January 2018
- Tuesday, 13th March 2018
- Tuesday, 24th April 2018

London Borough of Hammersmith & Fulham

Health, Adult Social Care and Social Inclusion Policy and Accountability Committee

Minutes

Tuesday 13 June 2017

PRESENT

Committee members: Councillors Daryl Brown, Mercy Umeh, Joe Carlebach and Rory Vaughan (Chair)

Co-opted members: Patrick McVeigh (Action on Disability) and Bryan Naylor (Age UK)

Other Councillors: Ben Coleman

Officers: Craig Williams, Head of Health Partnerships; Helen Mann, Healthwatch Programme Manager; Prof. Julian Redhead, Medical Director; Prof. Tim Orchard, Divisional Director, Medicine and Integrated Care; and Shona Maxwell, Chief of Staff to the Medical Director

134. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Andrew Brown, and, co-optees Debbie Domb, Patrick McVeigh and Jim Grealy.

135. MINUTES

The minutes of the previous meeting were agreed as an accurate record.

136. DECLARATION OF INTEREST

Councillor Joe Carlebach declared an interest as the Vice-Chair of the Board of Trustees for the Royal National Orthopaedic NHS Hospital Trust, and, a link to Newcastle University, in respect of Agenda Item 7.

137. COMMITTEE MEMBERSHIP 2017/18: APPOINTMENT OF VICE CHAIR AND TERMS OF REFERENCE

The Chair, Councillor Rory Vaughan invited nominations for the appointment of Vice-Chair. Councillor Mercy Umeh was nominated by the Chair, seconded by Councillor Daryl Brown:

RESOLVED:

Councillor Mercy Umeh be appointed Vice-Chair of the Committee for the municipal year 2017/18.

138. APPOINTMENT OF CO-OPTED MEMBERS

The following co-opted members be re-appointed for the municipal year 2017/18:

Debbie Domb, Disabilities Campaigner
Patrick McVeigh, Action on Disability
Bryan Naylor, Age UK

A new co-option, Jim Grealy, Save Our Hospitals, was also agreed.

139. HEALTHWATCH

The Chair welcomed Helen Mann, Programme Manager for Healthwatch, who presented an update detailing recent activities and current areas of work. A welcome was also extended to Olivia Clymer, recently appointed Chief Executive Officer for Healthwatch. Summarising the key points, Helen Mann reported that the organisation had reset priorities, was continuing to collate background information and evidence.

Healthwatch was actively pressing the CCG with regards to a newly launched consultation "Choosing Wisely", and indicated that they would be challenging the short timeframe of the consultation, due to end on 30th June. A key concern was that the consultation allowed for sufficiently broad and robust consultation and engagement. Changes to prescription charges were being sought to help reduce costs through avoiding the need for a prescription for medication that was easily available over the counter.

Obtaining feedback about mental health issues was another priority area of work for Healthwatch. They had been working to further develop relationships with voluntary organisations commissioners, providers and users. In response to a query from Bryan Naylor, it was noted that a carers event had recently been held in White City. It was explained that this was a priority area, particularly in terms of addressing the needs of young carers. Councillor Carlebach indicated his support for this, and acknowledged that while the remit of the Committee did not cover children's services, paediatric health services did. Councillor Coleman commented that there were approximately 6 million carers in the UK and emphasised the importance ensuring that they were properly supported. He confirmed that he would be

meeting with Healthwatch to explore this issue further. Craig Williams reported that the Health and Wellbeing Board had identified a gap in support for carers and that the development of a carers strategy was planned.

Following a comment from a member of the public regarding the issue of homecare service continuity when provision was sub-contracted, Helen Mann confirmed that they were undertaking work on this. Ben Gladstone confirmed that user feedback was helpful, as a way of monitoring existing provision and for shaping future commissioning intentions. There followed a brief discussion which acknowledged the invaluable commitment and support offered by unpaid cares, balanced against the provision of homecare services. Craig Williams recognised that a significant portion of carers did not contact the Council, which had important implications for the way in which the Council Communicated with carers and how support for Carers could be managed.

Action: Report to be prepared on Homecare

RESOLVED

That the report be noted.

140. IMPERIAL COLLEGE HEALTHCARE NHS TRUST: QUALITY ACCOUNT 2016/17

The Chair welcomed NHS colleagues from Imperial College, presenting the Quality Account 2016/17. Professor Julian Redhead, Medical Director explained that the Trust's Quality Strategy 2015/18 was the vehicle by which they hoped to achieve quality goals, supported by annual targets and a number of improvement programmes. They had incorporated an extended timeframe in order to ensure that there were opportunities for the document to be publicly reviewed and consulted upon, with the first draft circulated on 4th April 2017. The report was shorter and easier to read and presented an overall picture of what was one of the safest hospitals. While there was a high rate of reported incidents, there was by comparison a low harm rate.

With reference to the Referral To Treatment (RTT) rates, Councillor Carlebach understood the pressure that the Trust was operating under but observed that while some rates were good, 62.62% for Dementia was poor. 'Access to Cancer Services, 62 day wait for first treatment from urgent GP referral', was in Q4, 74.7%, having progressively decreased from earlier quartile performances. Professor Redhead accepted that the Trust had struggled to meet standards for specific reasons including late referrals from tertiary providers, despite their intent to be patient-centric. They had put in place measures that would improve patient pathways, however, the key was to have in place effective preventative measures and earlier diagnosis to ensure that patients received the best treatment.

With reference to End of Life care, Councillor Carlebach enquired about what steps had been undertaken to address this particular need. Professor Redhead acknowledged that there was a need to bring together all sectors

from primary to acute trusts, wanting to ensure that patients where not unduly distressed. Councillor Carlebach expressed his thanks to health colleagues for the commitment and performance of staff at Imperial.

In response to a query from Bryan Naylor, it was explained that the Trust was in the same position as many organisations, responding to the uncertainties and difficulties of Brexit, and they were doing their best to reassure staff about this. In terms of recruitment, the Trust was also trying to ensure minimum standards for staff to communicate clearly and effectively with patients. The hospital was a multicultural environment, with multi-lingual staff which was helpful in terms of understanding cultural differences and having effective communication.

The discussion continued, focusing on the education and training provided to health staff, to ensure that they were able to access career pathways, upgrade their skills and develop relevant expertise in areas that offer them job satisfaction. It was noted that this was a long term programme of on-going development, which could take up to three years for the benefits to materialise.

Bryan Naylor highlighted concerns reported by Age UK members about discharge protocols for patients, their carers' and families and allegations of "bed blocking". Prof. Tim Orchard responded that this was an important issue for the Trust. Patients were admitted from a range of different areas, for example, Adult Social Care, district nurse or GP referrals. This potentially required them to liaise with a number of different groups. The West London Alliance pilot project meant that a social worker was directly accessible on site, so that the process of putting in place support services in preparation for discharge could commence far more quickly and effectively. Craig Williams confirmed that the Council had worked collaboratively with the Trust, with social workers taking on specific responsibility for residents in LBHF, and similar, reciprocal arrangements operated with the other partner councils such as Ealing.

It was reported that there had been improvements, with the achievement of a reasonable level of discharges. However, it was important to be able to measure or assess the time taken for the discharge process, in order to obtain a clear picture. The Community Independence Service was a key component of the discharge protocol and the Council worked closely with Imperial on this. It was important people were assessed properly prior to discharge. A member of the public expressed concern about premature discharge from the Charing Cross site, undertaken late at night. Professor Redhead confirmed that they would normally discharge vulnerable patients during daylight hours only and offered apologies on behalf of the Trust. A member of the public added that the experience of having access to a social worker on site had been extremely helpful and positive.

Councillor Vaughan made reference to patient transport (page 45 of the Quality Account document) and the FFT (Friends and Families Test) results which had been reported as "consistently below target", noting the measures put in place by the Trust to address this. Professor Redhead acknowledged

the significant difficulties that they had experienced in monitoring the key performance indicators (KPIs) for a service which had been contracted out. Councillor Vaughan indicated that it would be useful to come back to the issue, once the new service protocols had been embedded. Acknowledging a point made by Councillor Coleman, Professor Redhead accepted that the Trust would be ultimately responsible for the activities of failing contractor.

Action: Update on patient transport services, Imperial

A member of the public commented that Charing Cross hospital was a busy site and suggested that another urgent care centre similar to one in Parsons Green be opened, alleviating the need to visit a GP and to stop people from having to visit the hospital. Professor Redhead responded that part of the issue was the lack of resources and funding for Adult Social Care and the need for improved patient pathways. In response to a query from Councillor Coleman, Professor Redhead confirmed that the cost of keeping a person in hospital was approximately £500 per day, varying according to the extent of the illness and treatment required, rising to £2500 per day, on a rising scale for an intensive care bed depending on the treatment.

Continuing the discussion on financial implications Councillor Vaughan enquired in particular about changes to charges for non-European patients. Councillor Coleman also enquired about the current vacancy rates, broken down by hospital site. Professor Redhead reported that the vacancy rate was more or less similar across the whole organisation, with rates specialities finding it particularly challenging to fill roles.

Focusing on the issue of training, Professor Redhead asserted that the Trust as an employer had a responsibility to put in place measures to improve work based training opportunities. It was reported that since Brexit, there had been a 96% fall in applications for nursing posts, although he speculated that in part this could also be attributed to short term planning. He suggested that the way to address this was to establish a system of statutory, national training, incorporating appraisal protocols, work based training, prioritising student recruitment and retention and work closely with nursing colleges. Professor Redhead stated that up to a quarter of nursing students were unsatisfied with training and that there was a challenge to striking the right balance between the needs of students in training and of patients.

Professor Tim Orchard, continued the discussion, observing that with medical student training, there was now a move to increasingly greater classroom and bedside training, provided by dedicated teaching fellows. He anticipated that this would temper the experience of students on initially entering the hospital environment. Advocating the need for statutory mandatory training, he stated that this was an important issue for the Trust, with ward based training offered as support for student training and development.

With reference to earlier discussions on RTT, it was noted that there were government penalties for missing the 52 week waiting list target. Councillor Vaughan speculated that there was a broader issue here linked to internal target monitoring, with a lack of incentives.

A member of the public reported an on-going situation at the warden controlled housing in which they lived. This was noted as a safeguarding issue, to be addressed directly by officers outside the meeting.

Councillor Vaughan enquired if the Trust had been affected by the recent cyber-attack experienced by recently by a number of NHS bodies and the implications for maintaining future cyber security. Professor Redhead confirmed that they had not been directly affected. The virus had affected older operating systems and that the Trust had (prior to the incident) invested in upgrading their operating system. In terms of future defences, it was reported that it would be very difficult to anticipate, predict and prevent the impact of any similar occurrences. Although the IT department of the Trust operated strong firewall protocols, it was difficult to maintain robust security in an open system.

With reference to CQC Councillor Vaughan enquired about the digital elements of outpatient booking appointment system. It was noted that the choose and book system was available through most GP surgeries and the Trust confirmed that they had recently introduced a more efficient electronic data retrieval system which made it easier to find old medical records and letters.

With reference to page 43 of the Quality Account, Councillor Vaughan enquired about patient safety issues, in particular, pressure ulcers. Additionally, he asked about “never events” (defined as serious incidents that were entirely preventable, if recommended protocols and guidance are followed) and the targets set out in page 63 of the Quality Account. It was noted that while staff reporting rates had improved and that the rates of “never events” had reduced. Shona Maxwell explained that the target figures continued to reduce by 10%, with a reduction of 26% evidenced during 2016. It was noted that this was a ‘stretch’ target.

Professor Redhead clarified that the learning obtained from “never events” had been utilised within the surgical department, with core themes around patient safety protocols being developed. He acknowledged that previous surgical checklist protocols had not been robust. In response, the Trust had in November 2016 undertaken proactively safety improvement work in theatres, from which point, he reported that there had been no further “never events” recorded, to date.

With reference to page 55 of the Quality Account and the section on Well-led quality highlights, Councillor Vaughan asked about the low scores related to staff experiences and reporting of violence at work. 31% of staff surveyed had experienced harassment, bullying or abuse, against an average of 25% nationally. Professor Redhead explained that work was being undertaken to address this such as more training for managers and promoting general awareness of dignity and respect at work, improving general engagement with staff. The Trust took its legal duty to ensure a safe working environment for its staff very seriously. While violent behaviour or abuse in some environments, such as A&E was not condoned, it was anticipated, usually

with underlying mitigating factors. There was a need to ensure that staff are not placed in any danger and do not put themselves at risk. Work had been undertaken so that staff were able to respond to security alerts and that emergency and contingency planning was sufficiently robust, given recent events. In response to a query from Councillor Coleman, Professor Redhead explained that they had established that incidences of staff bullying by colleagues largely related to emotional bullying.

Referring to an earlier point on the FFT, Councillor Vaughan sought an assurance that the qualitative data available from the survey could offer robust evidence. Professor Orchard explained that the data was taken on a monthly basis, ward by ward, and triangulated with patient responses from a detailed questionnaire to see if there was any correlation between satisfaction levels and the recording of serious incidences such as pressure sores. Each individual was invited to complete a scorecard and scorecards were taken from each directorate. Professor Orchard reported that they would go through the findings on the scorecards and that this also offered a robust metrics system. Identified problems were routinely escalated outside this framework and much of the development work undertaken to address behaviour concerns was through training and education. This was a complex area, requiring a structured programme of change within the organisation, ensuring that the Trusts' values and ethos regarding respect and valuing diversity, were shared by staff. It was noted that many of the reported incidents took place during transfers or the handover of patients to staff and Professor Redhead acknowledged that this an area in which they would need to work much harder.

While it was noted that patients were not discharged unless post-medical care was in place, Councillor Coleman enquired how the Trust measured patient discharges and the level of post-medical care required. Professor Redhead acknowledged that this was a good point but confirmed that there were no performance indicators in place to measure this. He explained that it was difficult and could not commit to putting in place any such measures but would be happy to discuss this in more detail.

A member of the public commented that if everyone contributed £5 per person, this may help address the financial difficulties currently faced by the NHS. She offered to donate her recent £100 lottery ticket win. Both Imperial and Council colleagues, were touched by this warm gesture and thanked her for a very generous and kind donation.

It was noted that the earlier publication of the draft Quality Accounts had provided an opportunity for sufficient to time to provide feedback. The Quality Accounts covered all areas of the Trusts work and Councillor Vaughan thanked the Trust for a candid and open report, despite the fact that it had missed a number of targets. He asked that the Trust bring back the following areas for more detailed discussion:

- Patient discharges - measures for evidencing satisfaction;
- Workforce satisfaction - details of the improvement programme, impact and outcomes; and

- Further updates on the Trusts digital strategy, progress on development and implementation.

On behalf of the Committee and the residents of Hammersmith and Fulham, Councillor Vaughan expressed his thanks to the Trust, for the invaluable work and support undertaken by their dedicated and hard-working staff.

141. WORK PROGRAMME

Following a brief discussion, it was agreed that the following topics be added to the long work programme:

- Community Independence Service
- Patient discharges
- Workforce staff satisfaction – health / Imperial
- Homecare update

RESOLVED

That the Work Programme be noted.

142. DATES OF FUTURE MEETINGS

The date of the next meeting will be Tuesday, 12th September 2017.

Meeting started: 7pm
Meeting ended: 9.35pm

Chair .....

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London Borough of Hammersmith & Fulham **HEALTH, ADULT SOCIAL CARE & SOCIAL INCLUSION POLICY & ACCOUNTABILITY** **12 SEPTEMBER 2017**	
ADULT INPATIENT DISCHARGE	
Report of Imperial College Healthcare NHS Trust	
Open Report	
Classification - For Policy & Accountability Review & Comment **Key Decision: No**	
Wards Affected: All	
Accountable Executive Director: n/a	
Report Author: Mick Fisher, head of public affairs, Imperial College Healthcare NHS Trust	**Contact Details:** E-mail: mick.fisher@imperial.nhs.uk

1. EXECUTIVE SUMMARY

1.1. This report to the Health, Adult Social Care and Social Inclusion Policy and Accountability Committee from Imperial College Healthcare NHS Trust (the Trust), covers the current picture of delayed transfers of care and plans to reduce delays in partnership with stakeholders across the sector.

2. RECOMMENDATION

2.1. The Committee is asked to review and comment upon the report.

3. BACKGROUND

3.1. Imperial College Healthcare NHS Trust provides acute and specialist healthcare for a population of nearly two million people in North West London, and more beyond. It comprises of five hospitals – Charing Cross, Hammersmith, Queen Charlotte's & Chelsea (all located in the London Borough of Hammersmith &

Fulham), St Mary's and Western Eye – as well as a growing number of community services.

4. LIST OF APPENDICES

Appendix 1: Adult Inpatient Discharge

Imperial College Healthcare NHS Trust

Adult Inpatient Discharge

Report from Imperial College Healthcare NHS Trust to the London Borough of Hammersmith & Fulham Health Adult Social Care and Social Inclusion Policy and Accountability Committee

1. Summary

This report to the Health, Adult Social Care and Social Inclusion Policy and Accountability Committee from Imperial College Healthcare NHS Trust (the Trust) covers the current picture of delayed transfers of care and plans to reduce delays in partnership with stakeholders across the sector.

2. Imperial College Healthcare NHS Trust overview

The Trust provides acute and specialist healthcare for a population of nearly two million people in North West London, and more beyond. We have five hospitals – Charing Cross, Hammersmith, Queen Charlotte's & Chelsea, St Mary's and Western Eye – as well as a growing number of community services.

With our academic partner, Imperial College London, we are a founding member of one of the UK's six academic health science centres (now expanded to include Royal Brompton & Harefield NHS Foundation Trust and the Royal Marsden NHS Foundation Trust), working to ensure the rapid translation of research into better patient care and excellence in education. We are also part of Imperial College Health Partners, the academic health science network for North West London, spreading innovation and best practice in healthcare more widely across our region.

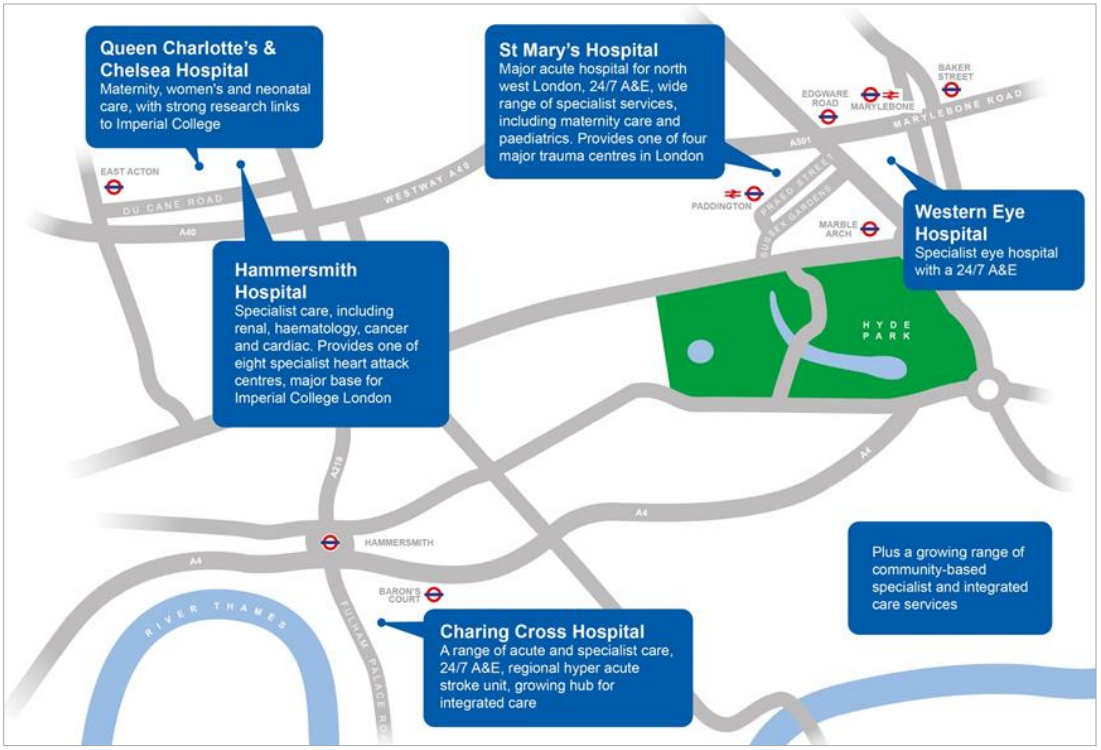


Figure 1 – Map of hospitals in Imperial College Healthcare NHS Trust

3. Discharge Services

The discharge team provide a Trust-wide service of specialist nurses and administrative staff that support pathways for patients with complex needs across all five Imperial College Healthcare NHS Trust sites. The service works in collaboration with Adult Social Care, North West London Collaboration of Clinical Commissioning Groups (CCGs), Community Health Care partners including the Community Independence Service (CIS), and the Voluntary Sector providers to facilitate discharge. The team are responsible for the management of the medically fit pathway for patients and for delayed transfers of care.

4. Performance and activity

Figure 2 shows the reasons for delayed transfers of care (DTOC) across West London, Hammersmith & Fulham and Central London CCGs at Imperial College Healthcare NHS Trust for the period April 2016 to March 2017.

NHS England defines the term 'delayed transfer of care' as follows:

"A delayed transfer of care from acute or non-acute (including community and mental health) care occurs when a patient is ready to depart from such care and is still occupying a bed. Delayed transfers of care can occur for a range of reasons."

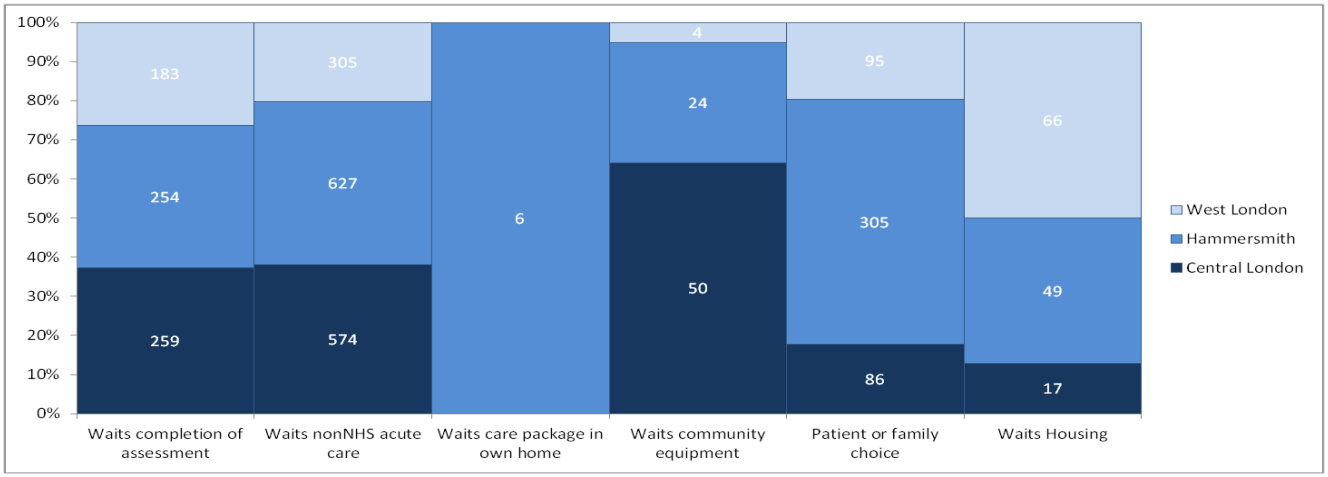
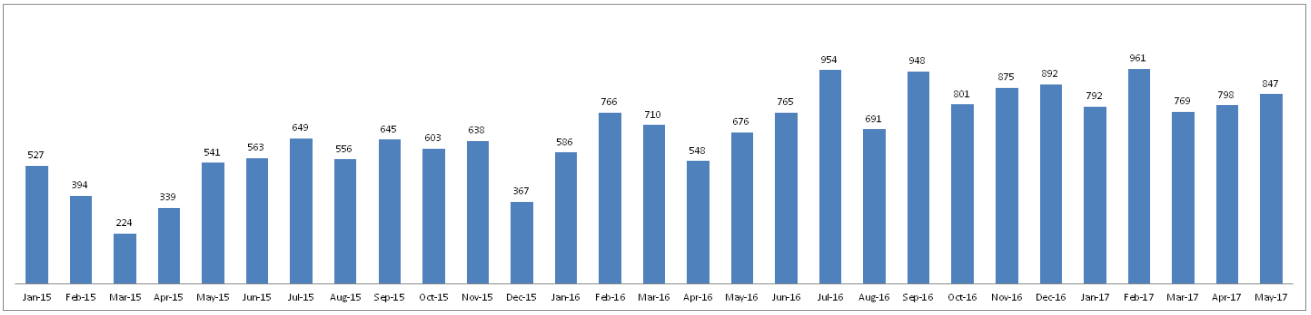
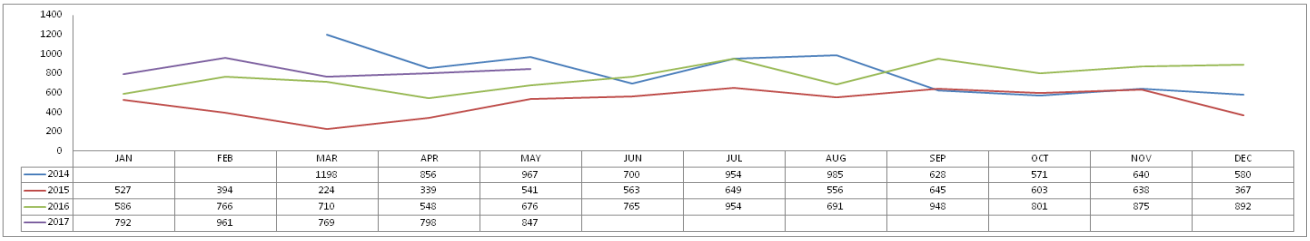


Figure 2 – DTOC days lost per category by CCG – West London, Hammersmith, and Central London

The impact of the delays is seen across the Trust and in all specialties. Delays have an impact on patient experience, length of stay and flow through our hospitals.

As Figures 3 and 4 show, the number of delayed transfers of care (DTOC) has increased significantly in 2017/18 compared with the two previous years. Since January 2015, the Trust has seen an average of 96 patients experiencing DTOC each month, with numbers steadily rising. This increase has continued even though the Trust moved to a seven-day model for complex discharge services during 2016/17.

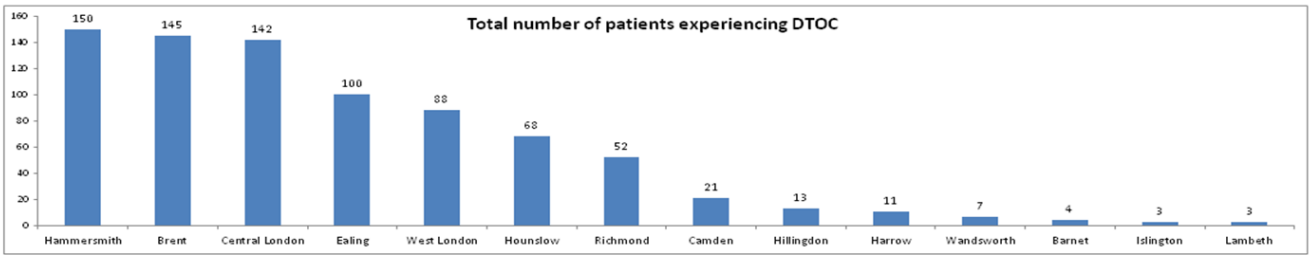


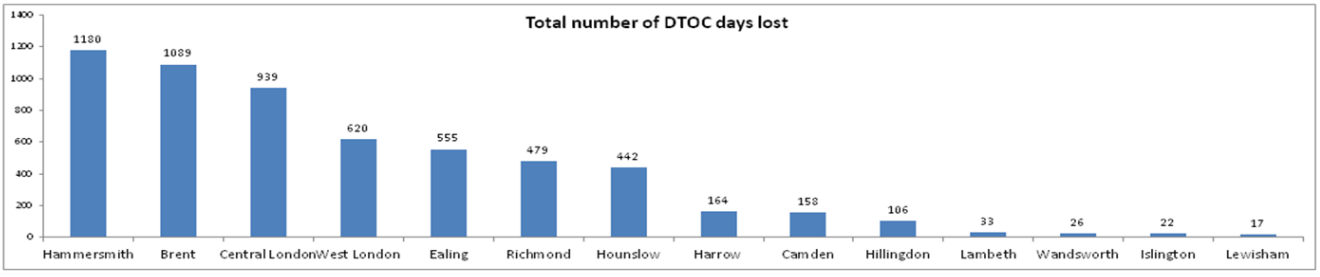


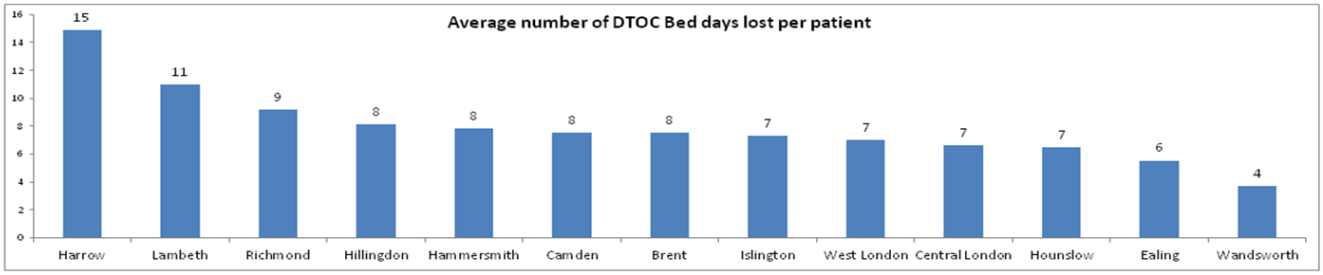
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
2014			1198	856	967	700	954	985	628	571	640	580
2015	527	394	224	339	541	563	649	556	645	603	638	367
2016	586	766	710	548	676	765	954	691	948	801	875	892
2017	792	961	769	798	847							

Figures 3 and 4 – Overall number of DTOC lost bed days across Imperial College Healthcare NHS Trust January 2015 – May 2017

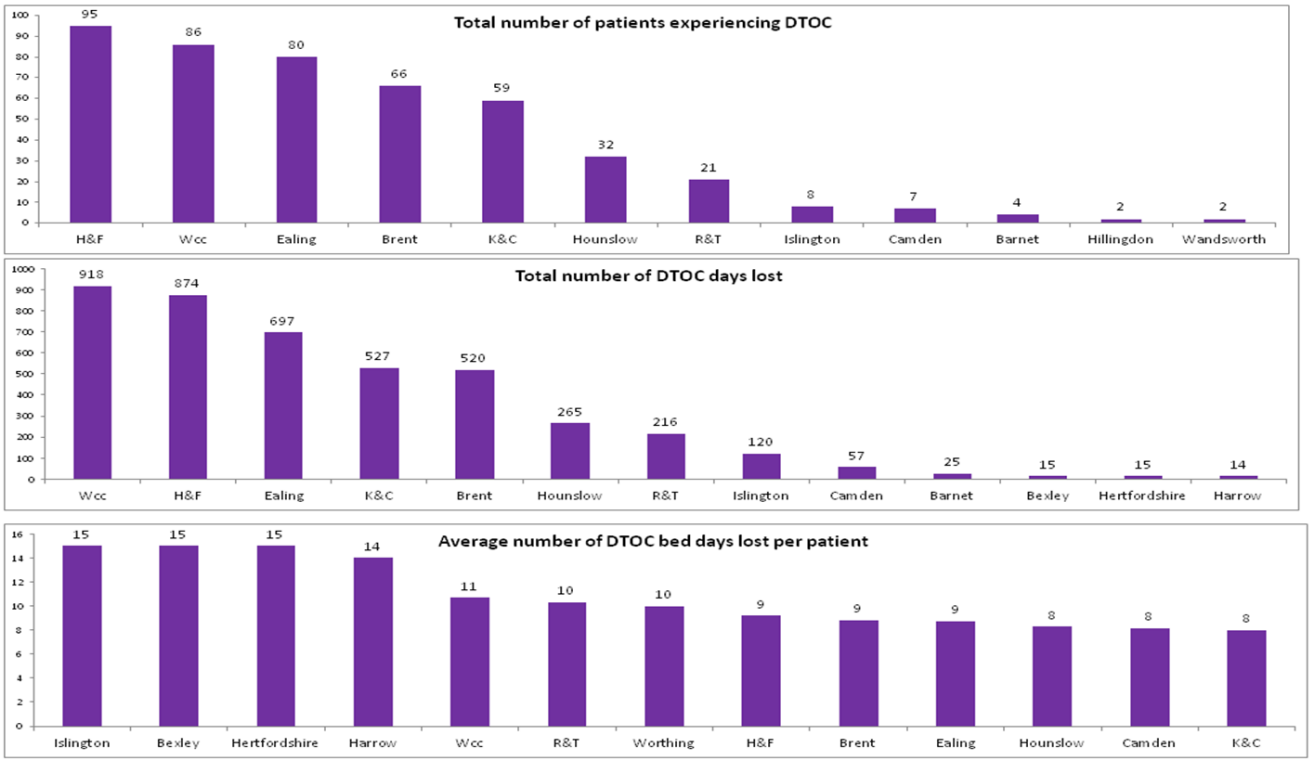
An analysis by borough of residence of patients shows that the London Borough of Hammersmith & Fulham (H&F) lost the most bed days during 2016/17 due to DTOCs. This is shown in Figures 5 to 10.







Figures 5, 6 and 7 – Health and Social Care DTOCs by borough 2016/17



Figures 8, 9 and 10 – Social Care DTOCs by borough 2016/17

An analysis of health DTOCs by category shows that for H&F residents, the majority of days lost were due to waiting for non-acute NHS care e.g. a rehabilitation placement or continuing care home placement. The delays in this category are primarily for NHS Continuing Care assessment and access for Care at Home or Placements. This is followed by waits for assessment for interim nursing or permanent placement – particularly Dementia Nursing. It is anticipated that delays for these categories will be reduced through the implementation of Trusted Assessment (see below). Delays experienced due to community equipment, such as beds, mattresses or hoists, will be improved through the implementation of Integrated Discharge Teams (see below).

37 per cent of delays for Adult Social Care relate to residential and nursing placements represents. It is anticipated that these delays will be reduced through a combination of Integrated Case Management and Integrated Discharge teams (see below). However, capacity and access to assessment for care homes poses a risk to DTOC reduction plans. There are plans to recruit two Nursing Home Nurse Assessors as part of the better care plans to support hospital discharges to facilitate access to nursing home assessment and placements.

5. DTOC reduction plans

The Trust has committed to reducing DTOCs by 50 per cent in H&F as part of an improvement plan to include the following:

- Early discharge planning – discharge planning commenced early in the pathway, with multidisciplinary board rounds, ward allocated Social Workers and assessment of need from admission or pre admission if possible.
- Multi-agency discharge teams – teams that are co-located where possible and include specialist discharge nurses/CHC assessors, British Red Cross, specialist homeless workers and therapy teams. The teams will work together, reducing duplicate assessments and referrals, streamlining processes and handovers of care needs.

- Home First – this is a pathway whereby people who are clinically optimised[1] and do not require an acute hospital bed, but may still require care services are provided with short term, funded support to be discharged to their own home (where appropriate) or another community setting. Assessment for longer-term care and support needs is then undertaken in the most appropriate setting and at the right time for the person.
- 7 day service – providing a service for patients and access to clinical review and senior decision making 7 days a week, resulting in access to care requirements and discharge from hospital when they are medically fit to leave. Services provided across the Trust 7 days a week include the specialist discharge team, social services and CIS.
- Trusted assessor roles – delays in patient discharge can be harmful to patients but most can be avoided, particularly if the delay is caused by waiting for a care provider to assess and accept a patient into their service. A trusted assessor carrying out the assessment − someone acting on behalf of and with permission of the provider − is an effective way of dealing with these delays.
- Focus on choice – partnership working to support where feasible choice of care provision and ensuring patients and families are given information on options available. Where first choice options and provision are not available ensuring a joint approach across health and social care to provide alternative care arrangements. Early discharge planning and information will aid the choice discussion and ensure all of the multidisciplinary team understand expectations and limitations.

This is being addressed through three interlinked strategies:

i. <u>Home First (Discharge to Assess)</u>
A Home First pilot commenced in July on four wards across the St Mary's and Charing Cross Hospital sites. This model has demonstrated significant benefit in reducing delays in other areas of North West London, although it has been more challenging than anticipated to identify suitable patients for discharge using this pathway in our hospitals. These challenges are being addressed through dedicated medical and nursing leadership and targeted communications to wards teams.

ii. <u>Trusted Assessor</u>
The Trust now has six trained trusted assessors in place to establish and the process for trusted assessment will be implemented by the newly established Integrated Care Management Team. The team is hosted by the Trust and works across the Imperial College Healthcare NHS Trust and Chelsea & Westminster NHS Foundation Trust sites. Since its establishment, and in the last two months, the team has supported increased occupancy and reduced length of stay at the Farm Lane bedded community rehabilitation unit thereby freeing up acute capacity.

iii. <u>Integrated Discharge Team</u>
The Integrated Discharge Team includes hospital-based specialist discharge nurses and co-ordinators working collaboratively with hospital-based social workers to address issues of complex social care. A pilot has been running on three wards across the Trust since June with positive feedback received from acute teams. Information technology and governance issues are delaying the reduction in duplicated health and social care assessments. The pilot was extended to include a further three wards from July.

In addition, the Trust is in the process of scoping the potential for establishing a winter ward in a local care home, potentially providing 10 beds for medically optimised patients awaiting

[1] Clinically optimised is described as the point at which care and assessment can safely be continued in a non-acute setting. This is also known as 'medically fit for discharge' 'medically optimised.' NHS England (2015).

placement in residential care. This would be focused on a cohort of patients for whom the Home First model would not be appropriate. The Integrated Care Management Team would be responsible for managing the flow of patients from acute beds to the winter ward. The scoping exercise will be completed and a decision on whether to proceed with this plan taken by the Trust by the end of September.

6. Risks to delivery

The enablers are key in delivering a sustainable and partnership based model of care for patients discharged from the acute setting. There has been significant work and focus on the enablers and success to date, however there are still potential risks to achieving a 50 per cent reduction in the delayed transfers of care for H&F. These include:

- Recruitment and retention – shortages of staff with the skills required to support the work is evident. There is a significant vacancy factor in specialist discharge services currently and work is continuing to evolve rotational posts and develop roles for alternative trained professions and non-clinical staff. Training staff to undertake what can be a complex and challenging role in the NHS takes time and resource also impact on delivery.
- Contractual arrangements – current contracting arrangements require amendment to deliver change that better supports patient criteria and care needs.
- Choice issues – ensuring all staff have the same focus and understanding of choice and communicating with patients/families early in the pathway. Poor communication and lack of patient / family involvement increases what can be a complex situation to navigate causing distress and anxiety and impacting on length of stay. A wide reaching approach to train and support staff in the management of discharge options and provision is required to ensure patients have the required information at hand to be involved in the decisions made.
- Capacity within adult social care – constraints on the availability of social workers to support assessment and expedite panel decisions can further increase delays to discharge.
- Community capacity – with limited options and capacity across local care providers the availability of both care homes and homecare impact on access to choice. Utilising independent care providers and private care sourcing agencies at Imperial has supported access to capacity.

7. Summary

The number of DTOCs has shown a significant increase in 2017/18 compared with the two previous years. To address this, the Trust has put a plan into place working in collaboration with partner organisations that will also improve patient experience, reduce length of stay and improve flow through our hospitals.

In order to deliver this plan it will be essential to maintain close working relationships with adult social care, community care providers and the voluntary sector and for these organisations to ensure that there is sufficient capacity across the system for patients to receive care in the most appropriate setting.

London Borough of Hammersmith & Fulham **THE HEALTH, ADULT SOCIAL CARE AND SOCIAL INCLUSION POLICY AND ACCOUNTABILITY COMMITTEE** **12 SEPTEMBER 2017**	
SEASONAL INFLUENZA VACCINATION UPTAKE	
Report of the Executive Director of Adult Social Care and Health – Liz Bruce	
Open Report	
Classification: For Policy and Accountability Review and Comment **Key Decision:** No	
Wards Affected: All	
Accountable Director: Liz Bruce, Executive Director of Adult Social Care and Health	
Report Author: Sophie Ruiz, Primary Care Lead, Hammersmith and Fulham CCG, and Lucy Rumbellow NHS England (London), Commissioning Lead - Immunisations	**Contact Details:** Tel: 0203 350 4159 Email: sophie.ruiz@nw.london.nhs.uk

1. EXECUTIVE SUMMARY

1.1 To provide the Hammersmith and Fulham Health, Adult Social Care and Social Inclusion Policy and Accountability Committee with an update on uptake and coverage of seasonal influenza vaccinations during the Winter 2016/17.

1.2 To provide the Hammersmith and Fulham Health, Adult Social Care and Social Inclusion Policy and Accountability Committee with an overview of proposed actions being undertaken to improve influenza vaccination coverage in the London borough of Hammersmith and Fulham.

2. RECOMMENDATION

2.1 That the Committee reviews and comment on the report.

3. INFORMATION AND BACKGROUND

3.1 As attached in Appendix 1.

4. LIST OF APPENDICES

Appendix 1: Seasonal Influenza Vaccination Uptake for London Borough of Hammersmith and Fulham Winter 2016/17 and planning for 2017/18

NHS England

Appendix 1

Seasonal Influenza Vaccination Uptake for London Borough of Hammersmith and Fulham Winter 2016/17 and planning for 2017/18

Seasonal Influenza Vaccination Uptake in Hammersmith and Fulham

Prepared by: Lucy Rumbellow, Immunisation Commissioning Manager for North West London, NHS England (London Region).

Signed off by: Dr Catherine Heffernan, Principal Advisor for Commissioning Early Years, Immunisations and Vaccination Services.

Classification: OFFICIAL

Contents

1 Aim

- To provide the Hammersmith and Fulham Health, Adult Social Care and Social Inclusion Policy and Accountability Committee with an update on uptake and coverage of seasonal influenza vaccinations during the Winter 2016/17.

- To provide the Hammersmith and Fulham Health, Adult Social Care and Social Inclusion Policy and Accountability Committee with an overview of proposed actions being undertaken to improve influenza vaccination coverage in the London borough of Hammersmith and Fulham.

2 Seasonal influenza vaccination uptake 2016/17

- The seasonal influenza vaccine (also known as 'flu vaccine) is an annual vaccine which is offered to three identified 'at risk' groups - over 65s, clinically at risk groups aged 6 months to 64 and pregnant women. The vaccine is also offered to all children aged between 2 and 8 years old.
- The vaccine is given for direct or individual protection. There is no level for herd immunity, although there is an aspiration to reach 75% uptake nationally for 'at risk' groups.
- The seasonal influenza vaccination is offered to Health Care Workers (HCW) to prevent transmission of flu to vulnerable people and to minimise staff absences.
- London's overall uptake increased on last year's rates across the adult 'at risk' groups and healthy child groups.
- London achieved its highest uptake ever amongst Health Care Workers working in NHS Trusts - 55.4% were vaccinated and another 8% accessed the vaccine via a pharmacy.
- A total of 189,642 vaccines had been given in community pharmacy – up from 151,792 in 2015/16 and surpassing London's 20% improvement target. In addition, 9,111 were given to carers.
- Similarly to the national trend, uptake in the over 65s is decreasing but it is very likely that they were vaccinated in community pharmacies and these numbers are not captured in the reported rates.
- Whilst London performs lower than national rates it is worth noting that London vaccinates twice as many people than the next largest region (Yorkshire).
- The purpose of vaccinating healthy children is to provide herd immunity thereby reducing the need to vaccinate older at risk groups in the future. We have an aspirational target of between 40 and 60% to ensure this herd immunity.

2.1 At Risk Groups

Table 1 shows the uptake rates for seasonal influenza vaccinations in at risk cohorts. Overall there was an increase in vaccination rates compared to winter 2015/16, with rates showing an increase nationally, regionally and at a local level.

<u>Key points for Hammersmith and Fulham</u>

- Hammersmith and Fulham achieved 57.6% uptake for the over 65 year olds cohort in 2016/17. It can be seen that similar to national and London declines, the uptake in over 65s decreased (this could be due to increased usage of pharmacy that is not recorded here - 94,574 over 65s accessed pharmacy, 50% of the total pharmacy usage in 16/17)
- In the under-65 year olds in clinical 'risk groups', Hammersmith and Fulham achieved 36.2% uptake up from 32.8% in 2015/16.
- Hammersmith and Fulham achieved 35.4% uptake for pregnant women, again an increase of 3% from 2015/16's 32.4%

Table 1 – Seasonal influenza vaccination uptake rate for 'at risk' groups for winters 2015/16 and 2016/17 in primary care

	% of uptake 65 +			% of at risk patients (6 months - 64 years)			% of pregnant women		
CCG	**14/15**	**15/16**	**16/17**	**14/15**	**15/16**	**16/17**	**14/15**	**15/16**	**16/17**
Brent	68.9	67.4	65.6	53.0	49.3	50.4	36.6	36.9	36
Central (Westminster)	64.8	57.3	59.4	43.1	27.1	40.4	34.0	36	37.4
Ealing	65.2	63	63.2	46.7	42.1	46.8	35.7	33.1	35.3
H&F	61.7	57.3	57.6	38.4	32.8	36.2	31.1	32.4	35.4
Harrow	70.2	68.8	68.7	50.5	45.7	47.9	34.6	34.7	36.5
Hillingdon	70.6	68.3	68	52.6	47.8	50.7	39.7	39.6	40.5
Hounslow	66.7	63.8	63.1	45.1	39.3	44.7	34.5	33.2	28.7
West London (Hammersmith and Fulham)	64.1	59.8	59.2	41.7	35.9	41	31.7	31.3	38.4
London	**69.2**	**66.2**	**65.1**	**49.8**	**43.6**	**47.1**	**39.9**	**38.5**	**39.6**
England	**72.7**	**71**	**70.4**	**50.3**	**45.1**	**48.7**	**44.1**	**42.3**	**44.8**

Source: PHE (2017)

2.2 Healthcare Workers

Frontline health and social care workers have a duty of care to protect their patients and service users from infection. This includes getting vaccinated against flu. The impact of flu on frail and vulnerable people in communities, care homes, and in hospitals can be fatal. In addition, immunisation against influenza should form part of the organisations' policy for the prevention of transmission of influenza to protect patients, residents, service users, staff and visitors. Table 2 shows the uptake of local NHS trust uptake, where residents from Hammersmith and Fulham may receive treatment or access services from.

Table 2 – Seasonal influenza vaccination uptake rate in Healthcare Workers for winters 2015/16 and 2016/17

	2015/16			2016/17		
Organisation Name	All HCWs involved in direct patient care			All HCWs involved in direct patient care		
	Number involved	doses given	%	Number involved	doses given	%
London Ambulance Service NHS Trust	3295	1691	51.3	3282	2153	65.6
Central and North West London NHS Foundation NHS Trust	5056	1470	29.1	4040	1760	43.6
Central London Community Healthcare NHS Trust	2182	1003	46	2526	1075	42.6
Chelsea and Westminster Hospital NHS Foundation Trust	4269	23.01	53.9	4319	2771	64.2
Imperial College Healthcare NHS Trust	8935	2716	30.4	8574	2661	31
King's College Hospital NHS Foundation Trust	7869	3194	40.6	8175	3999	48.9
London North West Healthcare NHS Trust	7628	2752	36.1	8462	3612	42.7
West London Mental Health NHS Trust	3090	698	22.6	3069	670	21.8

Source: PHE (2017)

2.3 Childhood Influenza vaccinations for 2, 3 and 4 year olds

Table 3 shows the uptake rates for seasonal influenza vaccinations in 2, 3 and 4 year olds, given in general practice. There were increases in uptake in these age groups nationally, regionally and at a local level.

Key points for Hammersmith and Fulham

- Hammersmith and Fulham achieved 31.9% uptake rate for 2 year olds, an increase of 7.2% from 15/16.
- Hammersmith and Fulham achieved 28.9% uptake rate in 3 year olds, an increase of 2.7% from 15/16.
- Hammersmith and Fulham achieved 25.2% uptake rates in 4 year olds, an increase of 5.8% from 15/16.

Table 3 –Seasonal influenza vaccination uptake rate for 2, 3 and 4 year olds for winters 2015/16 and 2016/17

	% of 2 year olds			% of 3 year olds			% of 4 year olds		
CCG	**14/15**	**15/16**	**16/17**	**14/15**	**15/16**	**16/17**	**14/15**	**15/16**	**16/17**
Brent	29.5	27.3	28.1	32.6	30	30.9	25.1	23.4	23.8
Central (Westminster)	21.1	22	23.2	25.1	21.8	22.7	18.9	17.8	17.8
Ealing	29.6	28.1	35	31.1	28.8	35.5	21.9	22.3	28.8
H&F	26.2	24.7	31.9	22.7	26.2	28.9	19.6	19.4	25.2
Harrow	30.7	21.8	27.4	30.6	23.7	29.5	21.0	18.3	21.6
Hillingdon	26.9	25	31.2	29.0	29.5	33.4	21.8	23.4	27.5
Hounslow	30.5	23.2	29.1	32.8	25.5	30.4	22.3	17.7	23.6
West London (Hammersmith and Fulham)	18.6	16.5	21.8	19.5	15.3	21	14.8	12.6	17.2
London	**30.3**	**26.5**	**30.3**	**32.7**	**28.8**	**32.6**	**23.6**	**21.8**	**24.9**
England	**38.5**	**35.4**	**38.9**	**41.3**	**37.3**	**41.5**	**32.9**	**30.1**	**33.9**

Source: PHE (2017)

2.4 School based childhood influenza vaccination programme

For the 2015/16 winter influenza season all school years 1-3 were invited to receive the influenza vaccination. In Hammersmith and Fulham, year 1 achieved 37.8%, an increase of 2.9% from the previous year, year 2 achieved 33.4%, an increase of 0.8% from the previous year. Year 3 was a new age group and achieved 33.4%.

Table 4 –Influenza vaccination uptake rates in North West London for children aged 5 - 8 years old in 2016/17 compared to 2015/16.

	Flu Season 2015/16		Flu Season 2016/17		
CCG	% of year 1	% of year 2	% of year 1	% of year 2	% of year 3
Brent	16.7	17.2	36.6	31.7	32.9
Central (Westminster)	31	30.7	34	30	29.3
Ealing	33.4	26.4	42.5	38.8	38.5
H&F	34.9	32.6	37.8	33.4	33.4
Harrow	43.3	39.5	54	47.6	46.2
Hillingdon	48.2	48.2	52.6	51.4	49.5
Hounslow	44.9	42.9	52	48.7	50.2
West London (K&C)	30	24.8	34.4	32.3	26.7
London	**42.4**	**39.9**	**45.8**	**43.6**	**42**
England	**55.6**	**54.3**	**57.6**	**55.3**	**53.3**

Source: PHE (2017)

2.5 Pharmacy Provision

Across Hammersmith and Fulham, 29 pharmacies delivered 4,295 seasonal influenza vaccines. These were the following results for each cohort:

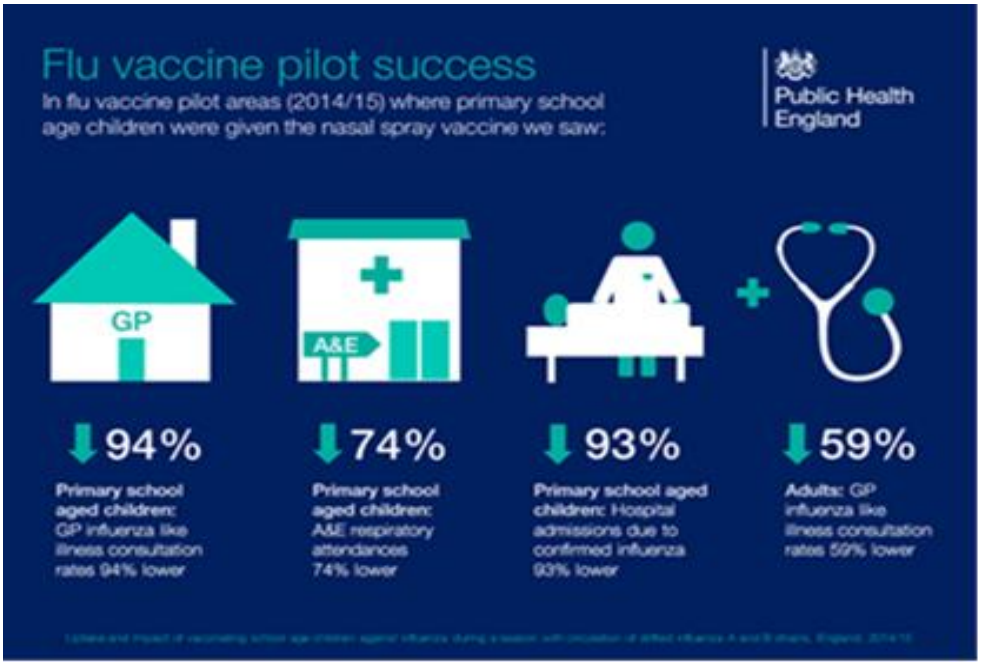
- Pregnant women = 102
- Under 65's At Risk = 1,022
- Carers = 139
- 65 's and over = 1,398
- Healthcare Workers = 1,552
- Other = 82

Community pharmacies have been recommissioned to continue to deliver seasonal influenza in 2017/18.

3 London Childhood influenza vaccination evaluation of 2016/17

Seasonal influenza vaccination for children is a vital component of the Annual Flu Vaccination Programme and a routine part of the National Childhood Immunisation Programme. Children are known to be super-spreaders of seasonal influenza because they mix very closely with one another. If we can stop outbreaks of seasonal influenza amongst children, then we can protect the wider community including older people, pregnant women, and those with long term health conditions who may be hit harder by the effects of seasonal influenza. As such there is great potential to reduce morbidity and mortality in the general population. Diagram 1 illustrates the direct and indirect benefits observed in general practice and A&E services in the school flu vaccine pilot areas in 2014/15.

Diagram 1. Flu vaccine pilot success



Source: PHE (2015)

In light of the 2015/16 performance, a decision was made to focus on how we could raise seasonal influenza vaccination uptake rates in 2, 3 and 4 year olds, children in school years 1 and 2 and children clinical risk groups in 2016/17. Not only was uptake very low in 2015/16 in this cohort but the benefits offered to the wider community in ensuring higher vaccination in this cohort (in terms of reducing the spread of infection within the community) suggests that this is an important group to improve uptake in. A summary of activities undertaken to improve child flu vaccinations is shown below:

- Increasing uptake of child flu vaccine to 40% minimum for 2, 3 and 4 years in GP practices was a key objective for our London Immunisation action plan 2016/17
- This objective was reflected in all borough level plans across London to ensure that local partnership working highlighted and supported the importance of annual child flu vaccine
- We undertook an audit of GP practice performance across London. 500 practices across London were identified as having had low uptake rates in their 2, 3 and 4 year olds (those below 15%), 9 of which were in Hammersmith and Fulham and they completed an improvement plan for their child flu programme. 150 of those practices identified as having very low uptake (10% or lower) received an NHS England assurance visit to discuss performance and how they can improve uptake for the coming influenza season. 3 of these were in Hammersmith and Fulham. All practices visited showed an increase in uptake of child flu vaccine.

4 Next Steps

- The national flu letter was published on the 10th March 2017, providing detailed information on the 2017/18 national seasonal influenza programme. In 2017/18, the following individuals are advised to receive flu vaccination:

    - All children aged two to eight (but not nine years or older) on 31 August 2017 (with LAIV)
    - All primary school-aged children in former primary school pilot areas (with LAIV)
    - Those aged six months to under 65 years in clinical risk groups
    - Pregnant women
    - Those aged 65 years and over
    - Those in long-stay residential care homes
    - Carers
    - In addition, frontline health and social care workers should be provided flu vaccination by their employer. This includes general practice staff.

Table 5 – Vaccine uptake ambitions 2017/18

Category	Ambition
Children (2, 3 and 4 year olds and schools based programmes)	40-65%

Clinical risk groups	55%
Pregnant women	55%
Aged 65 years and older	75%
Healthcare workers (Trust staff)	75%

Source: PHE, 2017. The national flu immunisation programme 2017/18

The London Immunisation Board and NHSE (London) are keen to continue to build upon the success of 2016/17 London Immunisation Plan and replicate the impact for the coming 2017/18 winter season. Similarly to last year, NHSE is currently auditing and evaluating the impact of 2016/17 flu vaccination plan with the view to produce a flu plan for July 2017. This has included:

- A 'wash up' session with stakeholders focusing on improving uptake in mental health workers (the lowest uptake amongst health workers were in mental health trusts) and care homes
- An audit of uptake of child flu vaccine in GP Practices
- Audits of Health Care Trusts and GP practices where uptake increased to enable the sharing of learning across London
- Building upon the work with carers and community pharmacies in promoting uptake in informal caregivers (our work in 2016/17 won a Flu Fighter Award)
- Continuation of partnership work with PHE (London) in rolling out immunisation training to increase numbers of vaccinators in London

4.1 Next steps for Hammersmith and Fulham

- Community pharmacy: Community Pharmacies have once again been commissioned to offer seasonal influenza to those over the age of 65 and people in clinical 'risk groups', to increase access to seasonal influenza vaccinations. 29 pharmacies in Hammersmith and Fulham have signed up to provide free NHS flu vaccinations.
- Trust Health Care Workers: Flu fighters will be working with NHS England to support London Trusts to improve their staff uptake rates. Trusts will be invited to attend events and webinars and good practice guides and resources have been shared and published on the Flu fighters website. In addition, NHS England commissioners will be attending Trust System Resilience Groups across London to seek assurance and offer support on their flu vaccination programme.
- Carers: NHS England has engaged with a charity called Reachingcarers.org, who specialise in supporting communities to identify carers who might not consider themselves carers and therefore are not registered as a carer or do not engage with local carer organisations.
- Pregnant women: Imperial NHS trust is now offering flu and pertussis vaccinations by the maternity unit in addition to primary care, to improve access to pregnancy immunisations. These are offered to all women booked in with them.
- School aged vaccinations: The roll out of the primary school vaccination programme will continue meaning that in 2017/18 all school children in reception and years 1 - 4 will be offered a seasonal influenza vaccination. In additional all children and staff in SEND schools will be offered seasonal

influenza vaccinations. The school-aged vaccination provider has been commissioned to visit every school twice, for a primary immunisation visit and a mop-up visit, as well as providing community catch up clinics for those who missed the two opportunities in school.

- 2 and 3 year olds: As part of the London-wide initiative to continue to improve uptake rates for children aged 2 and 3 years old, the practice visits completed in 2016/17 will be repeated for the lowest performing practices. Of the Hammersmith and Fulham practices, 2 have been identified for a performance review visit by NHS England's immunisation team. Visits will be carried out over August and September in readiness for the beginning of the flu vaccination season.
- Housebound patients: Hammersmith and Fulham CCG have drafted a Housebound Local Enhanced Service for Primary Care staff to vaccinate their housebound patients with seasonal influenza, and also to offer shingles vaccinations if patients are eligible.
- Initial analysis of reasons for poor uptake in GP practices revealed that practice nurses felt that the delayed supply of Fluenz meant that they couldn't adequately plan for clinics, some practices were not aware that this was a routine programme and thought it was only available in schools, instances showed a shortage of staff to give the vaccine whilst doing the other flu clinics, parents expressed a lack of convenience in taking toddlers to the practices for vaccination (requires time off work) and lack of knowledge expressed about the vaccine amongst parents and GP practice staff.
- As part of our Immunisation plan 2016/17, we picked 5 vaccines to actively promote in partnership between PHE, NHSE, CCGs and local authorities - MMR, Shingles, PPV/PCV, HPV, Men ACWY and child 'flu. This is likely to be repeated and a concerted effort will be made to promote child flu vaccinations, including regular teleconferences with providers to ensure they are up-to-date with the information on child flu.
- Joint Hammersmith and Fulham, Westminster and Kensington and Chelsea flu steering group formed with local partners including the CCG's, NHSE, PHE, school provider team and the local authority. The first meeting is to be held on the 30th August 2017. All partners will meet fortnightly throughout the flu season.

London Borough of Hammersmith & Fulham **HEALTH, ADULT SOCIAL CARE & SOCIAL INCLUSION POLICY AND ACCOUNTABILITY COMMITTEE** **12 SEPTEMBER 2017**	
COMMUNITY INDEPENDENCE SERVICE – A JOINT ADULT SOCIAL CARE AND HAMMERSMITH AND FULHAM CLINICAL COMMISSIONING GROUP PROGRESS REPORT	
Open Report/ All Exempt	
Classification - For Policy & Accountability Review and Comment **Key Decision: NO**	
Wards Affected: All	
Accountable Executive Director: SUE REDMOND	
Report Author: Toby Hyde, Head of Strategy, H&FCCG Frank Hamilton, Strategic Commissioner, ASC Commissioning	**Contact Details:** Toby.Hyde@nhs.net Frank.hamilton@lbhf.gov.uk

1. EXECUTIVE SUMMARY

1.1 On behalf of the London Borough of Hammersmith and Fulham and Hammersmith and Fulham Clinical Commissioning Group, the following report provides an update on progress made by the Community Independence Service (CIS). The focus of the CIS is the delivery of unplanned care supporting residents in their own homes or community, where they experience ill health or require short term care, reablement or rehabilitation. The total contract value for the CIS is £15.9m for a duration of 21-months, with an annual associated cost to Hammersmith & Fulham CCG and the Council of £3.6m.

1.2 Delivered by Central North West London NHS Foundation Trust, the Community Independence Service works across three clinical care pathways:

- Nurse-led Rapid Response – for urgent help to support people with an acute illness in the community when it is safe and appropriate to do so (response within 2 hours where required with input ordinarily for up to 5 days).
- Community Rehabilitation and Reablement – offered for up to 6 weeks. Rehabilitation provides physical and occupational therapies for

housebound people to enable them to achieve functional goals and improve their independence. Reablement services are provided in the home to help a person gain confidence and re-learn the skills to carry out daily activities and practical tasks.

- Community Independence Service liaison, Early Supported Discharge – identifying those suitable, with provision of care coordination and planning, to receive care and support in their own home or place of residence.

1.3 The Community Independence Service aims to enable the health and social care economy to achieve the following goals:

1. Reduce the number and likelihood of urgent hospital attendances and admissions.
2. Reduce the length of stay in hospital when admission is necessary.
3. Reduce the premature use of long-term residential care and requirement for long term care packages.
4. Reduce readmission rates.
5. Deliver within existing financial envelope and delivery of agreed productivity savings.

The above goals will only be achieved through providing a service that:

- Ensures that at all times service users receive the right care, in the right place, at the right time - first time.
- Provides a rapid and responsive service with a strong clinical skillset and experienced practitioners able to support patients with exacerbations of conditions and/or in need of crisis intervention.
- Integrates health and social care and improves the co-ordination of all intermediate care services inclusive of supported discharge, community rehabilitation and reablement.
- Reduces hand-offs between the different parts of pathways to ensure the smoothest and safest flow for patients.
- Actively promotes independent living and improves the self-care skills of service users and develops their resilience and that of their carers and families in the community.

1.4 The Policy and Accountability Committee is asked to note and consider the progress made to date on the Community Independence Service to improve local residents' lives through:

- Greater integration of health and social care support
- More rapid deployment of the right type of support when it is needed
- High levels of resident satisfaction with the support provided

2. RECOMMENDATIONS

2.1. That the committee notes the contents in this progress report for this work programme.

3. INTRODUCTION AND BACKGROUND

3.1. The Community Independence Service was first developed in 2013 as a pilot partnership between Hammersmith & Fulham CCG, the London Borough of Hammersmith & Fulham and Central London Community Healthcare.

3.2. Due to the success of the initial pilot, the Better Care Fund Board agreed in December 2014 to expand the service to provide support to residents in Westminster and Kensington & Chelsea. The expanded service was led by Imperial College Healthcare Trust as lead healthcare provider, working alongside the Local Authorities as lead social care providers to deliver a consistent model of care to residents across all three boroughs as part of a pilot from 1st April 2015 to 31st October 2016.

3.3 In Autumn 2015, the Clinical Commissioning Groups - Central London, Hammersmith and Fulham and West London - as lead commissioners, alongside Adult Social Care as associate commissioners, made the decision to consolidate and improve on current service delivery by procuring an integrated health and social care Community Independence Service under a single contract with a partnership of providers.

3.4 The procurement process included engagement with residents across all three boroughs (including an event held on 9th August 2016), which was particularly focused on the outcomes that would be most important to residents. These outcomes were then embedded within the specification and service contract awarded through the procurement.

3.5 On 27th May 2016, Central and North West London NHS Trust, as a Lead Provider Organisation, with West London Mental Health NHS Trust, London Medical Association, Central London Healthcare and London Central and West Unscheduled Care Collaborative were successfully awarded the contract following a competitive procurement process.

3.6 The service partnership led by Central North West London NHS Trust began operating on the 1st November 2016. Section 5 of this paper focuses on the progress made to date and provides an updated overview of performance during Q1 of 2017/18.

3.7 Within the partnership led by Central North West London NHS Trust, West London Mental Health NHS Trust are responsible for providing services within Hammersmith and Fulham. London Central and West Unscheduled Care Collaborative provide the Single Point of Referral for all three boroughs. GP engagement is via the Hammersmith & Fulham GP Federation, who provide the GP input into the service. Adult Social Care in Hammersmith & Fulham provides the reablement service. All parties have worked together to design and implement the service and continue to meet under a partnership board arrangement.

4. CURRENT PROVISION

The Community Independence Service	
Rapid Response	A nursing and therapy service that provides support within 2 hours of referral to avoid admission to A&E. Nurses mainly manage the team, which has access to CIS GP and Geriatricians and Pharmacist as required.
CIS Liaison	Based in A&E and downstream wards, the liaison service helps to avoid (where appropriate) admissions to hospital, and enables timely and safe discharges by providing support at home, rapid equipment, assessment, and physical care. Intervention is limited to 5 days post discharge, at which point the team then hands over to the appropriate team for longer term support. The liaison team is comprised of Occupational Therapists (OTs), Health Care Assistants and has access to nursing as and when needed.
Rehabilitation	The team supports residents to gain their maximum ability to remain in their own homes, and to reduce dependency on services. This team mainly consists of Physiotherapists and OTs.
Reablement	This is a care and support service, for up to 6 weeks, based on people's needs and goals, working to improve residents daily living skills (i.e. Cooking, washing dressing, confidence building) to enable independence and avoid unnecessary access to long term care. The Team consists of Community Independence Assistants (CIAs), coordinators, and Independent Living Assessors (ILAs) whose role is to assess, set goals, and measure improvements.

4.1 In Hammersmith & Fulham, the Community Independence Service also incorporates a 'Virtual Ward' function. This helps to provide a single point of contact for patients and carers and for the patient's registered GP throughout the interaction with the service, and supports the transition into longer term services where required by initiating appropriate referrals.
Specifically, the Virtual Ward:

- Works alongside GP practices to increase appropriate referrals and proactively target support to those patients in greatest need.
- Provides more intensive support to patients who people who are particularly unwell as part of a multidisciplinary team
- Helps to coordinates this support by liaising with families, carers, GPs, community and hospital provider partners etc.

4.2 Case Study

An 84 year old lady was referred following discharge because she had abnormal blood results, was dehydrated and had a query infection. Her past medical history included diabetes, rheumatoid arthritis, chronic kidney disease, high blood pressure. Some of her chronic diseases were quite poorly controlled. Overall she was quite frail and vulnerable because she lived alone. Her immune system was quite compromised.

Her inpatient stay had been on the Clinical Decision Unit (short stay ward) and she had been admitted via her GP because she was generally deteriorating, her admission was for a full work up and investigation including imaging etc. She was

referred to the Community Independence Service Rapid Response and Case Management Service.

On acceptance onto the Community Independence Service caseload she was kept on our virtual ward as a 'red' bed as she was quite dehydrated, the Multi Disciplinary Team monitored her for renal and heart failure due to dehydration. She also had more than five medications plus a new prescription so she needed pharmacy input. The Rapid Response pharmacists provided medicine teaching, medication review and re-administration of her medication (including setting up of a dossett box). She received therapy input as she had reduced mobility and had become more frail. She was monitored for a couple of days.

On a follow up visits general 'top to toes' observations identified inflamed lymph nodes and so a referral was made back to Older Persons Rapid Access Clinic at Charing Cross Hospital for a two week referral on the cancer pathway. She later received a cancer diagnosis.

In terms of Community Independence Service involvement, after the initial Rapid Response intervention she was moved into the Case Management/ 'amber beds' (provided for up to a further 6 weeks). This was to ensure that all the aspects of her care plan were followed up: therapy, medication concordance, liaison with the hospital to ensure 2 week referral and subsequent treatment was followed through. The Case Management Service set up Medequip and a Care Line Response Alarm was installed for her. The Social Worker was involved during the red/amber bed to set up a package of care for ongoing care and support.

5. PROGRESS REPORT

5.1 Considerable progress has been made to mobilise and to deliver the requirements of the service specification, given the complexity and different inter-related aspects of the service.

5.2 For Hammersmith and Fulham residents, based on the performance during Apr-July 2017, the early signs on patient and resident satisfaction are extremely positive. 96% of Hammersmith and Fulham residents would recommend the service to a friend or family, using the Friends and Family Test. In addition, patients and residents feel that they are treated with dignity and respect (92%), as well as being involved in decisions about them (82%).

5.3 During the same period (Apr-July 2017), the service in Hammersmith & Fulham received 1262 referrals, 336 for rapid response support, 544 for rehabilitation or reablement and 382 referrals to support discharge from hospital (described as liaison services). The majority of these referrals came from general practice, community providers and acute hospitals.

5.4 Further detail is provided within Appendix A regarding the activity against targets set by commissioners, breakdown of referral sources and the demographics of the patients referred into the service.

5.5 Hammersmith & Fulham Clinical Commissioning Group and associate commissioners in Adult Social Care colleagues meet with the lead provider on a monthly basis to review activity, emerging risks and mitigations and to discuss contractual issues. All parties are working constructively together on a number of areas where we think we can improve. For example, two particular challenges in Hammersmith & Fulham are in improving referral rates in practices with higher rates of hospital admissions and in working with referring organisations to ensure we are using the Community Independence Service to support the residents that would benefit the most from the support offered.

5.6 There have been some positive achievements over the duration of the service contract, specifically:

- The establishment of a single of point referral for all three boroughs
- The introduction of an Integrated Patient Record in Hammersmith & Fulham, which establishes a shared record across health, including primary care and social care
- Establishment of a robust triage and referral management processes for rehabilitation services
- Recruitment to address previous 70% vacancy rates which are now at 30%
- Exceeding targets for the proportion of patients discharged from the service who have achieved their goals set at assessment at 84%

5.7 One of the anticipated outcomes of the Community Independence Service is to reduce Accident & Emergency and unplanned, often urgent, admissions into acute hospitals; and where appropriate, reablement should support a reduction in long-term services costs for Adult Social Care. In 17/18 it is anticipated that in Hammersmith & Fulham there will be a reduction of approximately 823 unplanned hospital admissions. However, although the service is reporting numbers of avoided admissions that would enable the achievement of this ambition, other factors such as increasing patient complexity, changes to other services and demographic shifts mean this is not necessarily reflected in the secondary care activity we are seeing in our hospitals.

6. KEY CONSIDERATIONS

6.1 The existing contract for the Community Independence Service is due to expire in July 2018. The Clinical Commissioning Groups are working in partnership with Adult Social Care to explore the procurement options that best enable this important integrated service to continue to deliver high quality care and support to Hammersmith & Fulham residents and maximise the value of our joint investment and ensure the best outcomes for service users. This programme of work is currently being developed including timescales to reach the necessary agreements during Q4 of 2017/18.

6.2 The Community Independence Service has clearly demonstrated the benefits of partnership working between the NHS and the Local Authority for our residents in Hammersmith & Fulham. The future contracting model for the Community Independence Service should seek to build on this partnership and act as a template for the wider integration of health and social care in the borough.

7. EQUALITY IMPLICATIONS

7.1. The service is available to any residents or registered patients in Hammersmith & Fulham aged over 18, including those groups with protected characteristics.

8. LEGAL IMPLICATIONS

8.1 The successful development of the Community Independence Service is an illustration of compliance with the duty imposed upon all Local Authorities through their Health and Wellbeing Boards under s195 Health and Social Care Act 2012.

8.2 Section 195(1) of the Health and Social Care Act 2012 requires as follows:

(1) A Health and Wellbeing Board must, for the purpose of advancing the health and wellbeing of the people in its area, encourage persons who arrange for the provision of any health or social care services in that area to work in an integrated manner.

8.3 Implications verified/completed by: Kevin Beale, Senior corporate lawyer Tel:0208 753 2740

9. FINANCIAL AND RESOURCES IMPLICATIONS

9.1 There are no financial implications as this is a strategy / progress update report on the CIS service. Implications verified/completed by: David Hore, ASC Finance Manager, Ext: 4498.

9.2 The Integration and Better Care Fund plan for 2017-19 will be agreed via the Health and Well Being Board and Clinical Commissioning Group Chairs. The ongoing financial monitoring is via the Joint Finance Oversight Group and Clinical Commissioning Group Finance and Performance Committees. As part of the assurance and reporting process the Joint Funding and deliverables of the Community Independence Service are reported to NHS England, Department of Health and Local Government Association on a quarterly basis.

LOCAL GOVERNMENT ACT 2000
LIST OF BACKGROUND PAPERS USED IN PREPARING THIS REPORT

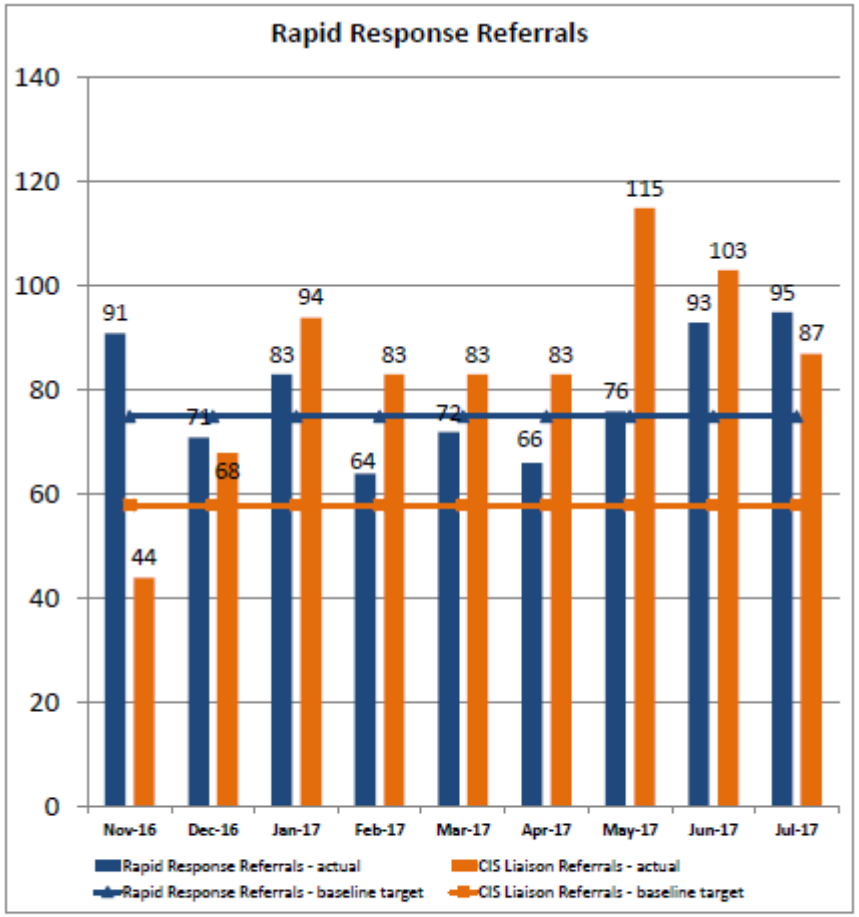
No.	Description of Background Papers	Name/Ext of holder of file/copy	Department/ Location
1.			

*[**Note:** Please list only those that are not already in the public domain, i.e. you do not need to include Government publications, previous public reports etc.] Do not list exempt documents. Background Papers must be retained for public inspection for four years after the date of the meeting.*

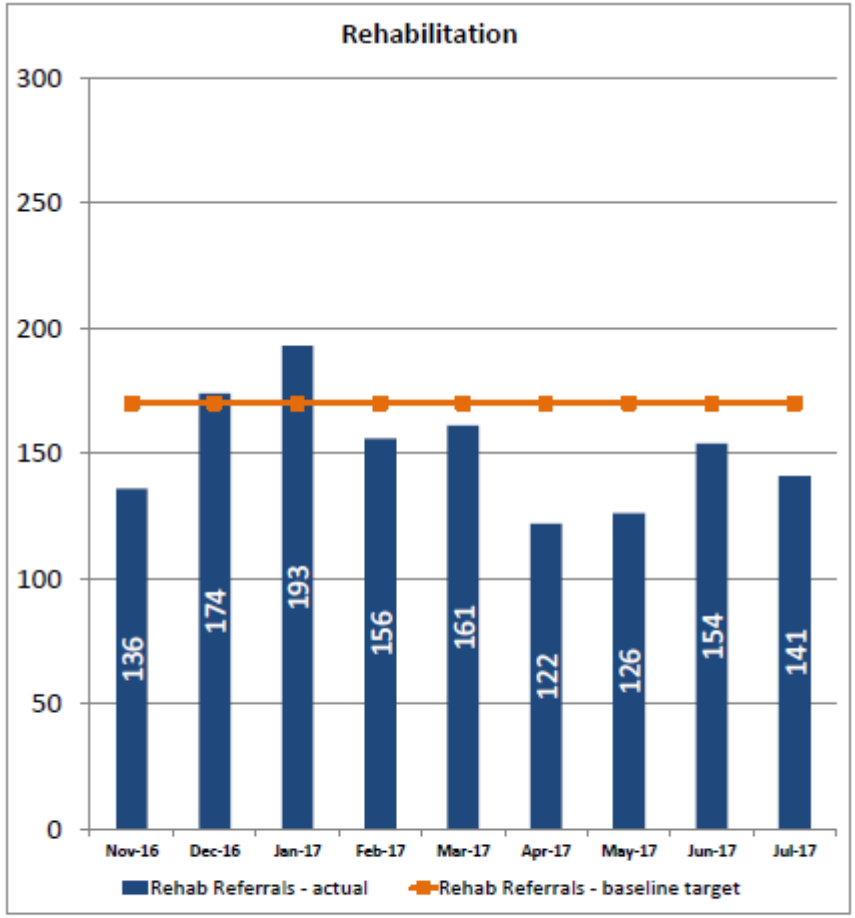
LIST OF APPENDICES:

Appendix A **Community Independence Service activity, referral sources and age breakdowns**

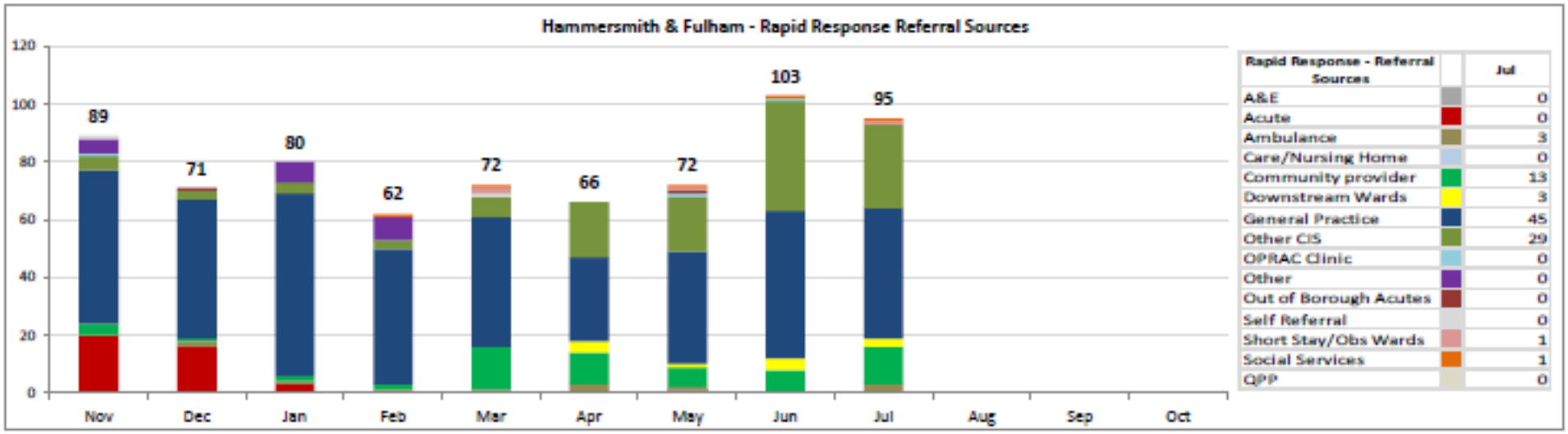
Appendix A – Hammersmith & Fulham – CIS activity, referral sources and age breakdowns

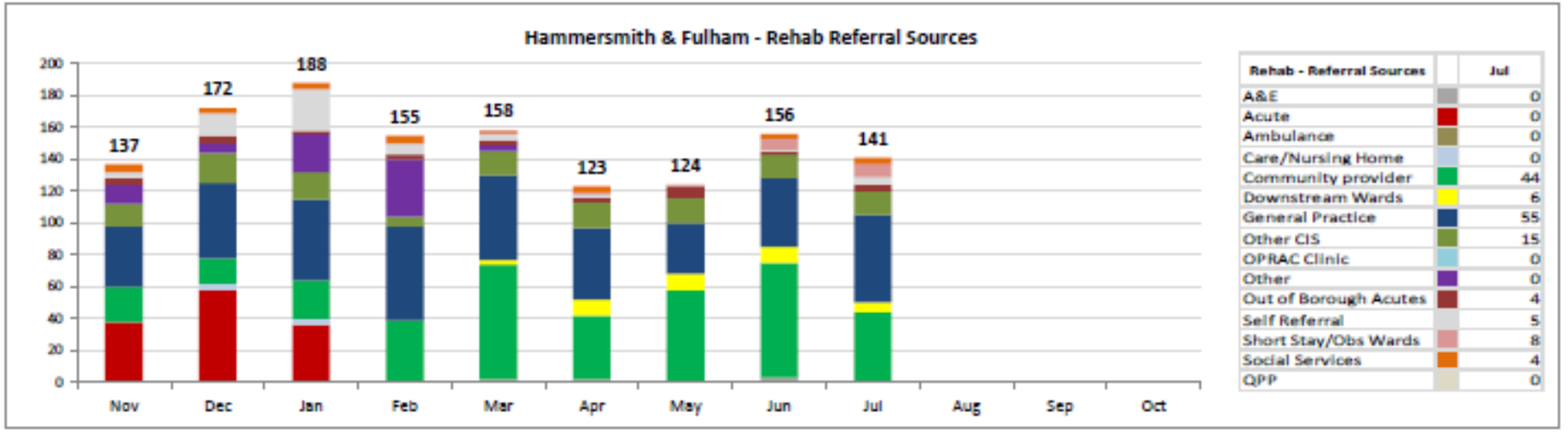


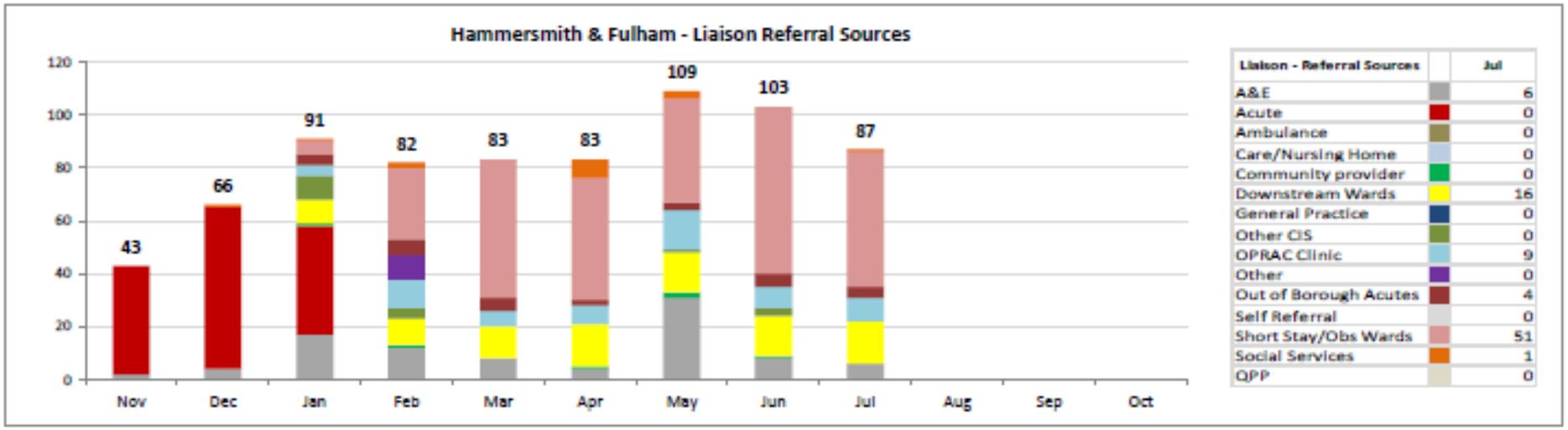
Year to Date	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17
Rapid Referrals - cumulative	91	162	245	309	381	447	523	616	711
CIS Liaison Referrals - cumulative	44	112	206	289	372	455	570	673	760

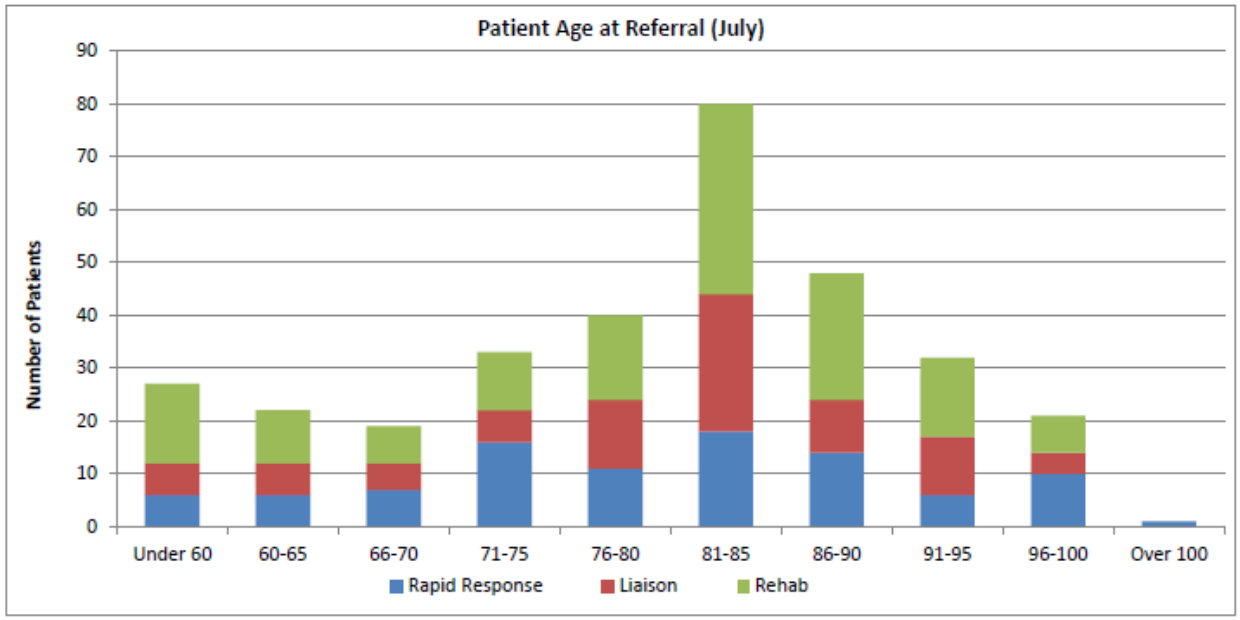


Year to Date	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17
Rehabilitation Referrals - cumulative	136	136	503	659	820	942	1068	1222	1363


Hammersmith & Fulham - Rapid Response Referral Sources
120
100
80
60
40
20
0
89
71
80
62
72
66
72
103
95
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Rapid Response - Referral Sources
Jul
A&E 0
Acute 0
Ambulance 3
Care/Nursing Home 0
Community provider 13
Downstream Wards 3
General Practice 45
Other CIS 29
OPRAC Clinic 0
Other 0
Out of Borough Acutes 0
Self Referral 0
Short Stay/Obs Wards 1
Social Services 1
QPP 0


Hammersmith & Fulham - Rehab Referral Sources
200
180
160
140
120
100
80
60
40
20
0
137
172
188
155
158
123
124
156
141
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Rehab - Referral Sources
Jul
A&E 0
Acute 0
Ambulance 0
Care/Nursing Home 0
Community provider 44
Downstream Wards 6
General Practice 55
Other CIS 15
OPRAC Clinic 0
Other 0
Out of Borough Acutes 4
Self Referral 5
Short Stay/Obs Wards 8
Social Services 4
QPP 0


Hammersmith & Fulham - Liaison Referral Sources
120
100
80
60
40
20
0
43
66
91
82
83
83
109
103
87
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Liaison - Referral Sources
Jul
A&E 6
Acute 0
Ambulance 0
Care/Nursing Home 0
Community provider 0
Downstream Wards 16
General Practice 0
Other CIS 0
OPRAC Clinic 9
Other 0
Out of Borough Acutes 4
Self Referral 0
Short Stay/Obs Wards 51
Social Services 1
QPP 0


Patient Age at Referral (July)
Number of Patients
90
80
70
60
50
40
30
20
10
0
Under 60
60-65
66-70
71-75
76-80
81-85
86-90
91-95
96-100
Over 100
Rapid Response
Liaison
Rehab

London Borough of Hammersmith & Fulham **HEALTH, ADULT SOCIAL CARE AND SOCIAL INCLUSION POLICY & ACCOUNTABILITY COMMITTEE** **12 September 2017**	
WORK PROGRAMME 2017-18	
Report of the Chair – Councillor Rory Vaughan	
Open Report	
Classification: For review and comment **Key Decision:** No	
Wards Affected: None	
Accountable Executive Director: Sarah Thomas, Director for Delivery and Value	
Report Author: Bathsheba Mall, Committee Coordinator	**Contact Details:** Tel: 020 87535758 E-mail: bathsheba.mall@lbhf.gov.uk

1. EXECUTIVE SUMMARY

1.1 The Committee is asked to give consideration to its work programme for the municipal year 2017/18.

2. RECOMMENDATIONS

2.1 The Committee is asked to consider the proposed work programme and suggest further items for consideration.

LOCAL GOVERNMENT ACT 2000
LIST OF BACKGROUND PAPERS USED IN PREPARING THIS REPORT

None.

LIST OF APPENDICES:

Appendix 1 – Work Programme 2017/18

Appendix 1

Health, Social Care and Social Inclusion Policy and Accountability Committee

Item – Report Title	Report Author / service	Status
12th September 2017		
Immunisations update – 2017*	Public Health / NHS England	Expected
Community Independence Service - Update	LBHF / CCG	Expected
Hospital Discharges	Imperial NHS Trust	Expected
14th November 2017		
Report of the Disabled Peoples Commission	Disabled Peoples Commission	TBC
Transitions Task Group		Also being considered at CEPAC (11th Sept)

(*suggested items)

Items for future agenda planning:

Suggested items for November:

Podiatry
GP prescribing*

- Meal Agenda
- Commissioning Strategy: Providers
- Customer Journey: Update
- Equality and Diversity Programmes and Support for Vulnerable Groups
- H&F CCG Performance
- *Immunisation: Report from the HWB Task and Finish Group
- Integration of Healthcare, Social Care and Public Health
- Listening to and Supporting Carers
- Self-directed Support: Progress Update
- Anti-biotic prescriptions*
- Tuberculosis
- CAMHS update (at CEPAC, 11th Sept)