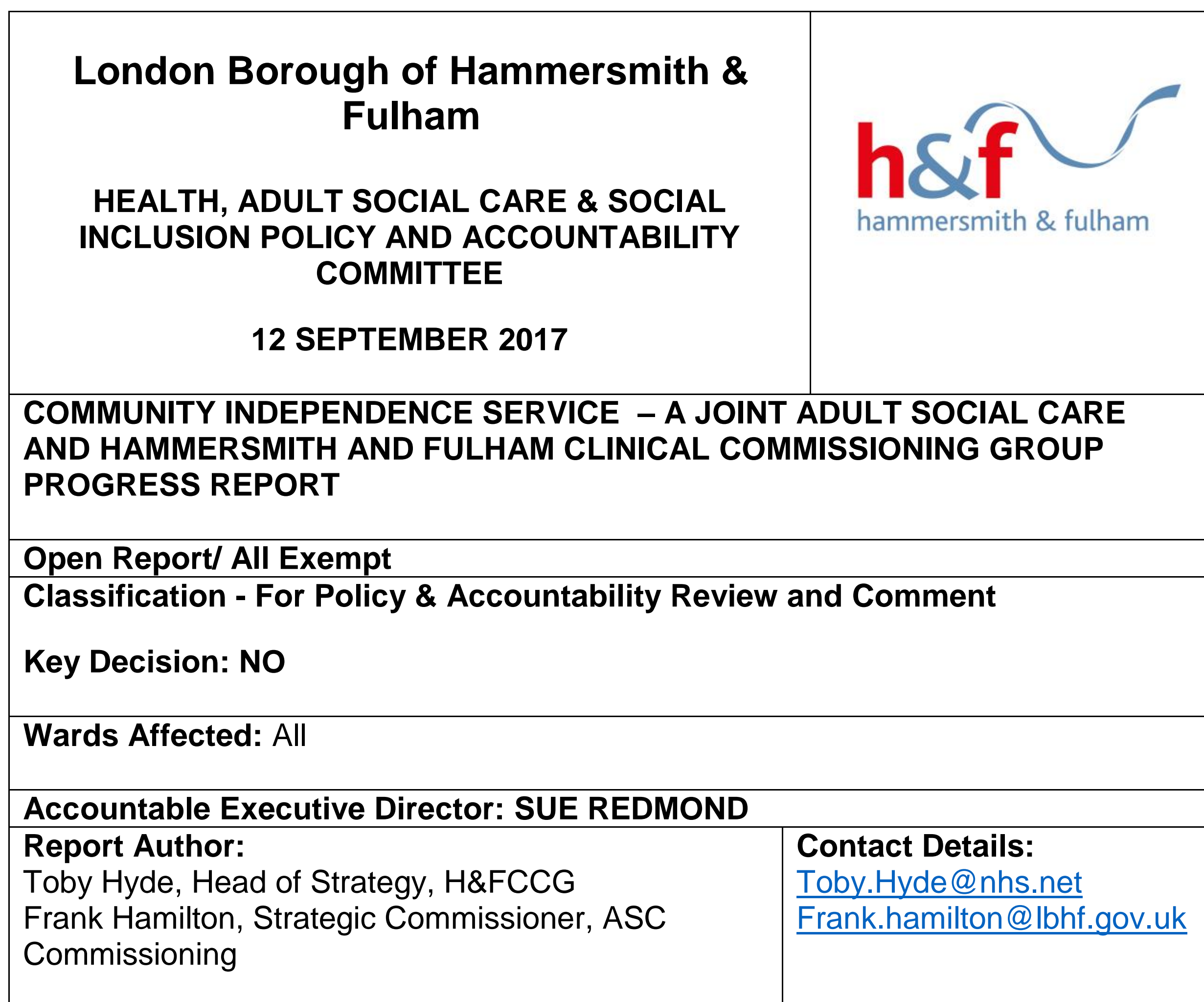


London Borough of Hammersmith & Fulham HEALTH, ADULT SOCIAL CARE & SOCIAL INCLUSION POLICY AND ACCOUNTABILITY COMMITTEE 12 SEPTEMBER 2017	h&f hammersmith & fulham
COMMUNITY INDEPENDENCE SERVICE – A JOINT ADULT SOCIAL CARE AND HAMMERSMITH AND FULHAM CLINICAL COMMISSIONING GROUP PROGRESS REPORT	
Open Report/ 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

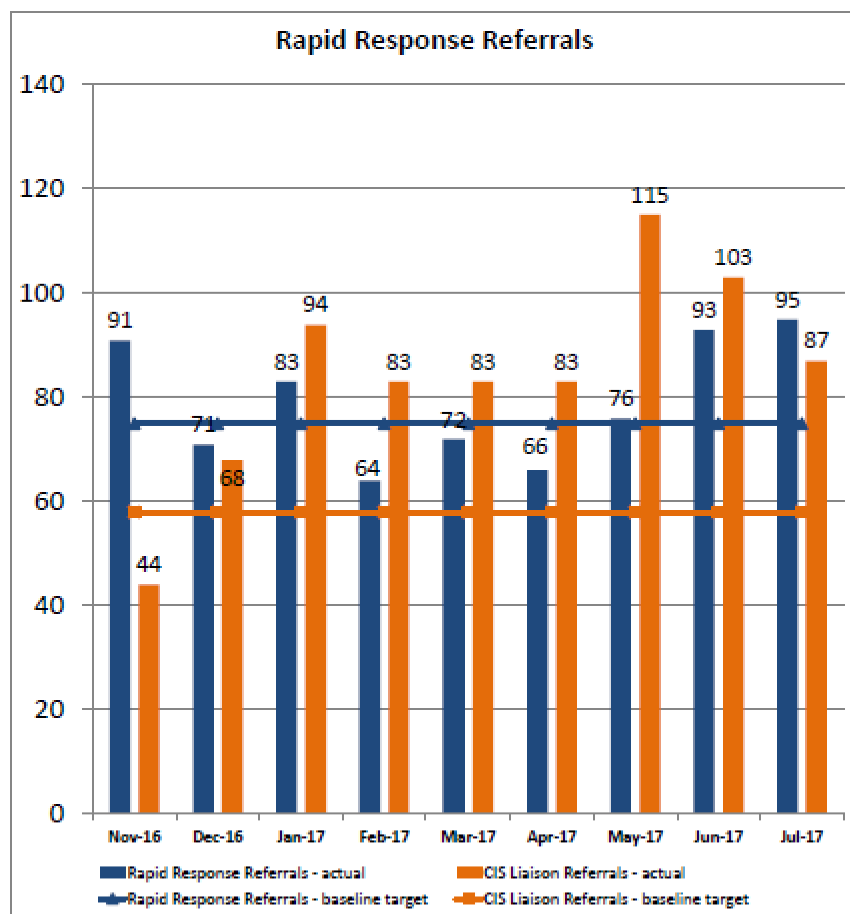
No.	Description of Background Papers	Name/Ext of holder of file/copy	Department/ Location
1.			

*[**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.*

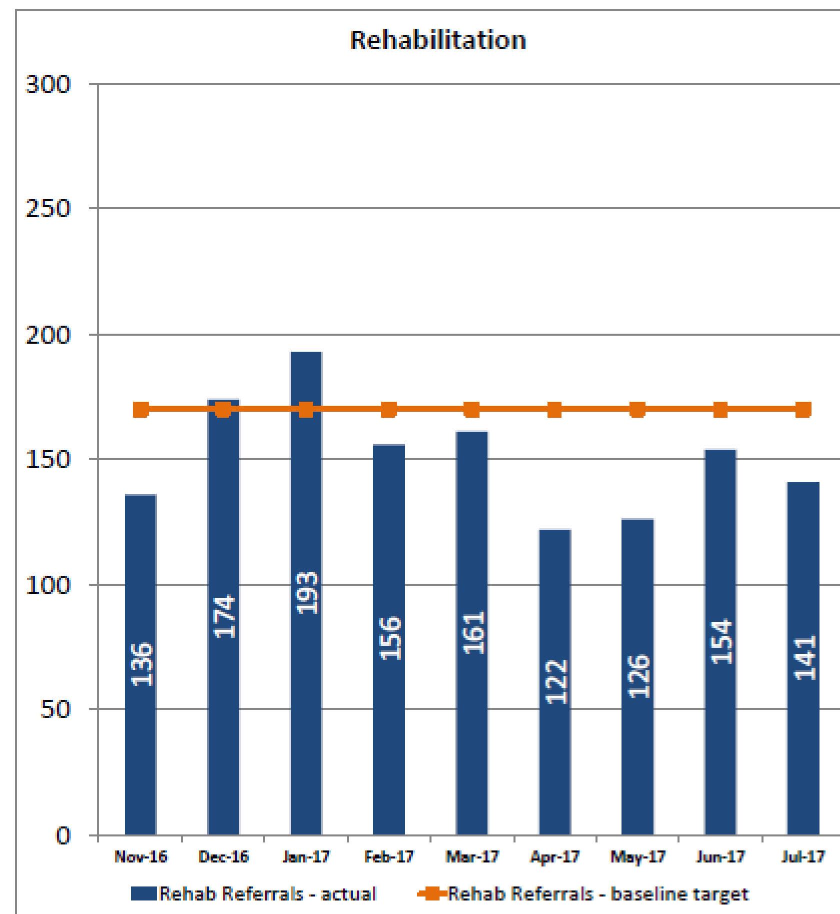
LIST OF APPENDICES:

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

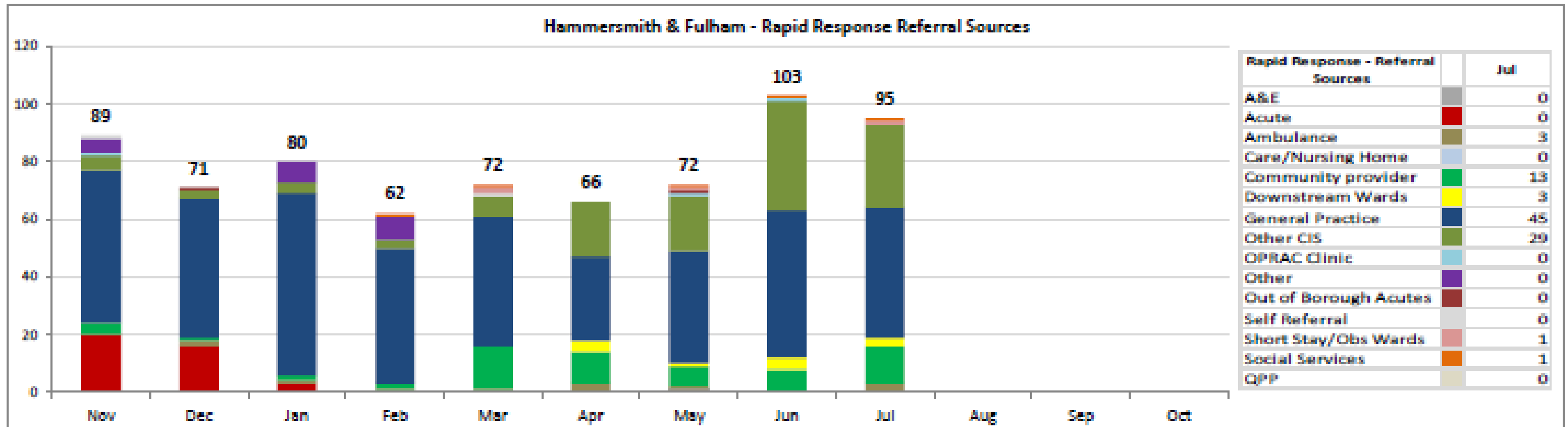
Appendix A – Hammersmith & Fulham – CIS activity, referral sources and age breakdowns



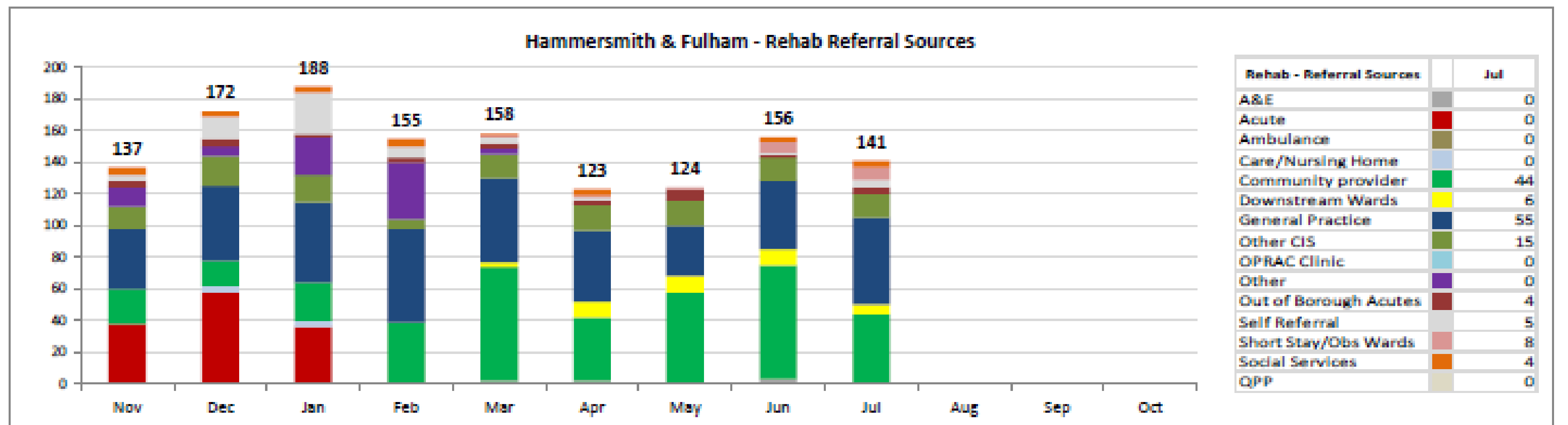
Year to Date	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17
Rapid Referrals - cumulative	91	162	245	309	381	447	523	616	711
CIS Liaison Referrals - cumulative	44	112	206	289	372	455	570	673	760



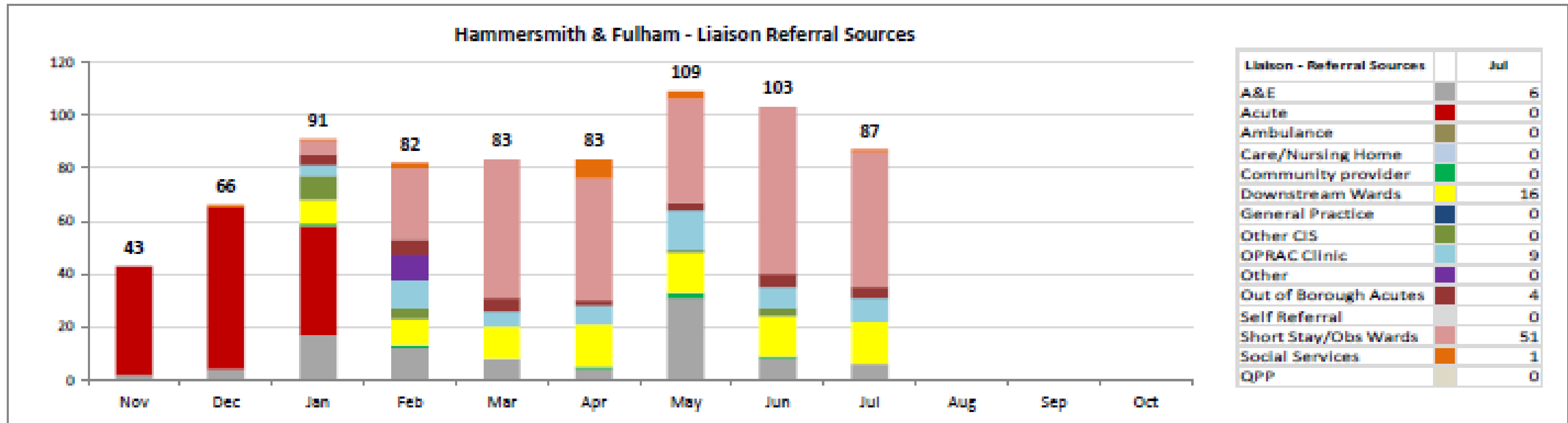
Year to Date	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17
Rehabilitation Referrals - cumulative	136	136	503	659	820	942	1068	1222	1363



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



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