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Health Scrutiny Committee
Wednesday 17th September 2014

First Community Health and Care: Integration of Community Services with the Wider Health and Social Care System

Purpose of the report: Scrutiny of Services

This report is for the Health Scrutiny Committee to investigate the integration of community services with the wider health and social care system, particularly focusing on technology and how it can be used to further integration and improve services.

Introduction

1. This report focuses on integration of health and social care services in Surrey. The report outlines the history of integration between health and social care in East Surrey with particular reference to the Rapid Response Service Model which was a particular example of good integrated practice. It intends to outline the vision for the future of integrated health and social care services, as well as the anticipated challenges and learnings from past joint working.

History of Integrated Services

2. In East Surrey in 2006, Health and Social Care had a partnership agreement where a director, nurses, social workers etc. had joint positions, working for (and being paid by) both Surrey County Council and the health organisation.

3. One joint Health and Social Care Service that was very successful was the Rapid Response Service. The team was based together at East Surrey Hospital and comprised of 120 whole time equivalent health and social care employees including nurses, social workers, occupational therapists, physiotherapists, advisory officers, mental health practitioners and admin. This fully integrated health and social care service provided a multidisciplinary approach through

continuous assessment, management by a programme of care agreed with the user and their carer. Training was provided to all staff from both organisations and the service was provided 24/7.

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4. Integrated Service Model – Rapid Response service:

4.1. The health and social care leads agreed to use the social care IT system (SWIFT) as health records were manual. Referrals from all health and social care professionals were made through a single point of access. The advisory officer completed a Fair Access to Care Assessment (FACS). There was no charge for users receiving the Rapid Response Service in the short term (6 weeks). All long term services provided via the social care team would be financially assessed under the Fairer Charging guidance.

4.2. This joint service used basic personal information and a generic assessment. The user had integrated home notes that were completed by the team members. The user's story was accessible, comprehensive and clear. Fully integrated documentation was held at base on SWIFT and in the profile notes.

5. Governance:

5.1. Statutory and mandatory joint training was provided.

5.2. Social Service procedures for safeguarding (SCC).

5.3. Joint complaints procedures, reporting to each organisation.

5.4. Joint Equipment.

6. Data:

6.1. N1125 forms sent to DoH.

6.2. Situation Reporting (SITREP) figures sent to DoH.

6.3. Monthly figures sent to each organisation.

6.4. Monthly analysis of data.

7. End of the Service:

   7.1. In 2010, RiO, the IT system for health was procured. Separating the data was impossible. Double counting began and this was not acceptable for either organisation. This led to the separation of services. In 2011, job descriptions and contracts were changed and the integrated service ended.

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Vision for the Future and Anticipated Challenges

8. It is envisaged that within 5 years, services currently provided in the East Surrey CCG locality by the community health provider (FCHC), local authority (Surrey County Council) and a range of voluntary sector agencies will be working together as one provider team, enhanced through the support of the Better Care Fund (BCF). Part of the BCF from East Surrey CCG is being provided to enhance and align services to meet identified need. The broad vision is:

   8.1. Prevent hospital admissions and re-admissions through early needs assessment, increased access to the reablement and home therapy services, improved risk and falls assessment.

   8.2. Improve hospital discharge through, increased access to the reablement service, implementation of the discharge to assess model, streamlining the assessment model to a single assessment, psychiatric liaison in acute and community settings, improved use of health passports for people with learning difficulties.

   8.3. Support people to remain at home.

   8.4. Provide integrated “in reach” services to acute and community hospitals.

   8.5. Have fully developed out of hospital care, including early intervention, admission avoidance and early hospital discharge through: engagement with providers, co-design and co-delivery with patients, service users and the public, investment in social care, primary care and community health services.

   8.6. Have effective arrangements for integrated working with shared staff, information, finances and risk management centred around the patient.

   8.7. Have accountable lead professionals across health and social care with a joint process to assess risk, plan and co-ordinate care.

   8.8. Deliver 7 day health and social care services.

8.9. Use new technologies to give people more control of their care.

8.10. Dementia friendly communities that support people to live in their own community.

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9. Our vision for working jointly with SCC is:

9.1. Integration will allow a multi-disciplinary assessment at the point of discharge, so the patient's transition can be monitored for 24-48 hours. It will enable the teams to review all East Surrey bed stock and put patients in the best place to meet their needs whether this is a nursing home, a residential home or community hospital.

9.2. Partnership agreement between organisations to ensure continued integration and commitment.

9.3. FCHC provide occupational therapists and physiotherapists to support SCC – recruit Occupational Therapists to a standard contract (neither health or social care), rotation of current staff to gain skills and knowledge of each others roles.

9.4. FCHC to gain read-only access for social services IT system. Adult Integrated System (AIS) this will be a reciprocal agreement as social care will be able to read FCHC.

9.5. Standardise patient journey pathways, ensuring high quality services and preventing duplication. This should include the flow of information following the patient through pathways, especially where there are hand offs in the journey.

9.6. Multi-disciplinary team meetings set up weekly/fortnightly.

9.7. Aligning with the voluntary services to avoid duplication.

9.8. Innovation – proactive care model.

9.9. Community hubs.

9.10. Integration of appropriate patient information where relevant across care settings.

10. Anticipated Challenges:

10.1. Compatibility of IT systems – AIS (SCC) and RiO (FCHC). However, FCHC are currently procuring a new clinical information system, so there is an opportunity for this to be integrated with AIS, or subsequent SCC IT systems.

10.2. Joint / standardisation of contracts/job descriptions.

10.3. Governance – need agreed governance processes.

10.3. Aligned processes – need trust in other provider's assessments.

10.4. Data reporting and KPI's – this needs to be locally defined to avoid double counting and the past problems separating data. Sharing of information and systems integration will help to negate this challenge.

10.5. Financial implications of integrating IT systems.

10.6. Information Governance implications of integrating patient information between systems, even if only in a Read Only format.

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Conclusions:

11. Health and social care have successfully worked together in East Surrey as recently as 2011. Present challenges include differing IT systems, data reporting and governance processes. Full commitment from all parties is required in order to fully integrate health and social care processes.

12. There is a unique opportunity currently due to FCHC procuring a new clinical IT system, which is looking at integration across care settings as one of its primary objectives. The involvement of SCC in this work should therefore be considered.

Recommendations:

13. SCC should be involved within the procurement of a new IT system for FCHC to ensure that future integration between systems is possible.

14. The integration of SCC and FCHC IT systems should also become an integral part of FCHC's IM&T strategy and the wider programme of service developments within both organisations.

15. The Community HUB model aims to better share appropriate patient information such as assessments or diagnostics. This should involve SCC to form part of the vision of this joint work, alongside other possible benefits. The IM&T workstream within this will be a key enabler to the greater integration of IT systems across the local health economy, and SCC's AIS system should be considered within this.

16. Joint budgets, joint data collection, joint management structure and partnership agreements between commissioners.

Next steps:

Identify future actions and dates.

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Sources/background papers: N/A