Islington Patient Group meeting

Wednesday 7th November 2018 2.30pm to 4.30pm

Lift, 45 White Lion Street, London, N1 9PW
www.healthwatchislington.co.uk/

Islington Clinical Commissioning Group (CCG) Update from last meeting - Walk in centre: Phil Wrigley, Primary and Urgent Care Manager

- The current contract has been extended from March 2019 to September 2019.
- Since the last Islington Patient Group Meeting, the CCG have been engaging with Patient Participation Groups and have found that a surprising number of people were unaware of the service.
- The CCG wishes to maintain the current level of investment and is looking at options to increase the number of in-hours appointments in Primary Care
- Option 1: do nothing (not feasible as funding would not then be reinvested back into primary care).
- Option 2: recommission the same service (the current service has a number of limitations and the budget couldn't fund the same level of service)
- Option 3: Allocate the money across all GP Practices (based on list size) to provide extra in-hours appointments
- Option 4: Funding would be allocated to a single provider to offer in-hours appointments in Hubs (similar to current Extended Access out-of-hours service at iHubs based in Laycock Street, Ritchie Street and the Andover estate).
  If this option is approved, then it would be aligned to the re-procurement of the whole Extended Access service, which is due for contract renewal in March 2020.
- In order to reach a decision the CCG has undertaken considerable engagement.
  1. Exploring the impact on GP services, have engaged once and will do so again.

2. Exploring the impact on patients – Healthwatch Islington (HWI) have undertaken a big program of engagement focusing on specific cohorts of patients.

- Phil is in the process of visiting as many Patient Participation Groups as possible by the end of January, currently having visited 6, with further 4 arranged (out of 31 practices). The aim is to gather feedback around the options.
- At the end of February 2019 there will be a big event involving stakeholders to appraise the options. (Stakeholders are first and foremost the patients, then voluntary sector organisations, public health, primary care and the finance team).
- After this event the CCG will come out with a decision. The CCG will be feeding back to everyone who's been involved in the engagement process.

By our next meeting on Wednesday June 19th 2019 the CCG will give us an update about what decision has been reached.

Questions:

1. Our Patient Participation Group is only meeting once before the end of January and that meeting will be a Christmas celebration.

   - How will you ensure you engage all patient groups?

   - Could you provide an info sheet to be shared with PPG's you are unable to meet with?

   A. Phil is currently drafting something that will go to GP's to share with their PPG's and mailing lists.

2. In another borough there was a process similar to this that was steered by a multidisciplinary group. It was made up of the local Healthwatch, other voluntary sector organisations, patients (about 10 people in all) and it provided a space for the CCG to share more detail with and it serviced as a check mechanism.

   A. That is a good idea, we could host 2 meetings between now and the end of January. **Phil to talk to HWI about this.**

Presentation by Islington CCG on Intermediate Care: Dan Windross, Integrated Care Commissioning Manager

Intermediate Care across Haringey & Is

- Intermediate Care covers services from physiotherapy at home, reablement, nurses at home… it is often seen as the link between hospital and home and generally is provided in people's homes.
- Unlike social care services, these services are free and short term (up to 6 weeks).

Question: What does reablement mean?

- A service provided by the council but funded via the NHS that helps individuals with the 'tasks of daily living'; getting washed, dressed and so on. The team are not just there to do things for someone, but to help them regain independence.
- There are lots of organisations which work together to deliver intermediate care.
- The CCG are proposing a new model for integrating Intermediate Care:
  - 1 point of access
  - 1st tier – Rapid response care within 2 hours, 7 days a week between 8am and 8pm
  - 2nd tier – bed based units. 3 sites in Islington (43 beds), 3 sites in Haringey (30 beds). For up to a 6 week stay as needed.
  - 3rd tier – Reablement and longer term care for people at home.
- The service currently costs around £8 million per year and cares for 1000's of patients through reablement, 1000's through therapeutic services and 100's through bed based care.

<u>Questions:</u>

1. A few years ago I was helping an elderly neighbour who had had a 10 day stay in UCH. She was transferred to Mildmay for a 2 week stay for rehab and I was impressed with how quickly the service responded and she began to recover. However, once she was home

the problems started. The day to day care was too sporadic and not long enough. In the end she paid privately for care which was much more suitable. How can you ensure that handover from Intermediate Care to longer term social care will be thought through?

A. We think by bringing care together and making it more joined up, we should be able to improve these experiences. It is also an opportunity to work more closely with social care.

2. Align and co-ordinate always sound like good things, but what might be lost in this process?

   A. A practical example: if you leave hospital now and go home you would be referred to the council's reablement service. You would be visited either that day or the next day for an assessment for reablement and they might make a referral to the Whittington for you to have some physiotherapy in your home too. The physiotherapy would be likely to start in a few weeks which might be after the reablement service has ended.

   If we put these services together, these services could be better combined to offer better care through a broader care team. Eg. Physiotherapists may lead care teams. This change is not about reducing budgets, but reducing hospital stays.

3. Why did Islington choose to partner with Haringey and not Camden?

   A. Islington is part of North Central London along with 4 other boroughs (Camden, Haringey, Barnet and Enfield). With Haringey we share the Whittington Hospital and the community health services it provides. Although we still work closely with Camden, Barnet and Enfield.

4. Would patients be able to self-refer into this service?

   A. Yes, from GP's NHS 111 and self-refer. It's currently quite complicated and we want to make it easier to access directly.

5. How will you ensure that the necessary equipment is available when needed?

A. We need to remember to ensure that we don't just focus on buildings and staff, but also on equipment. We have services that provide equipment but we need to bring them into this model.

6. Regarding bed based intervention – how much pressure would be placed upon the patient to take a bed in Haringey if they'd rather wait and be placed in Islington?

   A. Rehabilitation and reablement only works when people want to engage. Most patients do want to engage, but it's a matter of choice. We can't make someone accept something they don't want. If someone is moved whilst in the community, it's a matter of personal choice. However, if you're coming out of hospital it's different. Patients can't stay in a hospital bed if they no longer need it, you would then have less choice about where you're placed.

7. (Patient explained a personal experience of this service where there had been many gaps) When you assess people are you using age related criteria?

   A. I'm sorry you had to go through that. We would like to broaden the reach of these services, and a larger team should help with this. We also need to stop assuming these are services for older people and promote this better among a broader population. Referrals from once service to another does not cost the referring party anything.

8. This service is needs led and not service led. Part of a person's ability to be independent depends on how easy it is to access the service. It's important for patients that they maintain access with their initial contact (perhaps assessor), provide support through support groups and any of this care provided closest to home is best.

   A. We agree that staying independent depends on what each individual needs. That's a good point about group support. We need to make sure that with the referral, this keeps coming back/ being shared with primary care. We hope that this new model will have better digital services that link things up more closely.

9. How will this be coordinated? By the hospital or by a central unit?

A. We don't know or mind which service is the one single team, we're not at that point yet. We would welcome your views on what you think is best and why. We're working with providers so they own this model and take responsibility, otherwise we risk a fragmentation. We hope that by bringing teams together we will avoid this.

Further Questions:

1. How are you going to make sure that this model is actually clearer?

   A. Today's a big part of that. We need to talk to people in the community to make sure it's clearer. Instead of there being 5 or 6 services in each borough there will just be one. We also want to ensure that our language is clearer too.

2. If the St Pancras site is going to be redeveloped, what impact will that have on the intermediate bed availability?

   A. 90% of the care provided through this service is delivered at home. In terms of the St Pancras consultation, the bed unit is outside the scope of the redevelopment. Occupancy rates are high 90 to 95%, there are never lots of empty beds.

3. If people already have a carer employed would they still access Intermediate Care?

   A. Reablement is a top up to existing care, through this process we are hoping to work better with informal carers too.

4. Does a patient have an overall care plan?

   A. Currently, no. The Whittington will do one, the nurses will do one, reablement will do one. We want to have one team and one plan. There are technical challenges to overcome, but that's the plan.

5. Is the integration you're talking about within each borough or across the two boroughs?

   A. It's across the two. One service, two boroughs.

6. Is there the expectation that different packages will be offered and that some people might want to self-fund some of their care?

   A. Everyone brings variation in needs and care to these services. We need to understand this and set goals that are meaningful for each patient. This will involve using patient language eg. Instead of 'ambulate for 20 meters unaided', 'take the dog for a walk'.

7. Can you assure us that carers will be well paid across the service?

   A. We are not talking about care agencies here. All the staff are directly employed by the local authority or local trust and therefore are all on council or NHS pay structures which pay at least the London Living Wage. (Islington, Haringey and Whittington).

Table discussion Summary:

- Tables discussed wanting speed of services versus location, however patient choice should not be compromised
- One of the most prevalent issues raised around the current service provision was how patients too easily fall through gaps. This needs to be avoided in any future model.
- It was felt that the deciding factor for patients about location of service is access to public transport to services
- It seemed most important to those on the tables that the services were caring and that services were co-ordinated.
- It felt important that services were linked up, being person centred rather than budget focused
- It was highlighted that there doesn't seem to currently be a standard assessment process
- It was important that there is better liaison including GP practices that are left out of patient care /plan.

2019 meetings

Wednesday 19th June 2019 from 5.30 to 7pm at St Lukes Community Centre

Wednesday 13th November 2019, from 2.30 to 4.30pm