Integrated Localities

Previously referred to as ILS

My life a full life

The Objective

- What is Integrated localities (IL)
- What is the purpose and aim of IL
- What difference will it make to you as a practitioner
- Criteria and Referral process

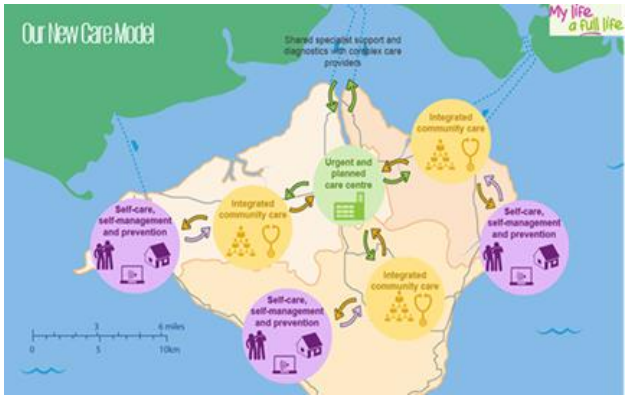
What is IL?

(Integrated Localities)

- The Integrated Locality model has been developed in collaboration with Health, Social Care and Voluntary organisations.
- These organisations have committed to the locality model and developed “integrated Locality working” to bring community based services together
- Integrated locality working is not an unnecessary structural change; it is about developing ways of doing things differently and enhances ways of working.
- Integration on the island has been built on good practices that are already in place and aims to provide a more streamlined access route to services for people who use them and staff.
- The model of integrated locality working on the Isle of Wight has been developed using best practice models from around the country.

What is the aim of the IL?

- People will receive improved, appropriate and holistic care. As part of ‘business as usual’ for community services.
- People will remain independent in their day-to-day lives.
- People will have greater involvement in planning their own care.
- People will no longer have to repeat information with multiple services.
- People will remain in their own home for longer.

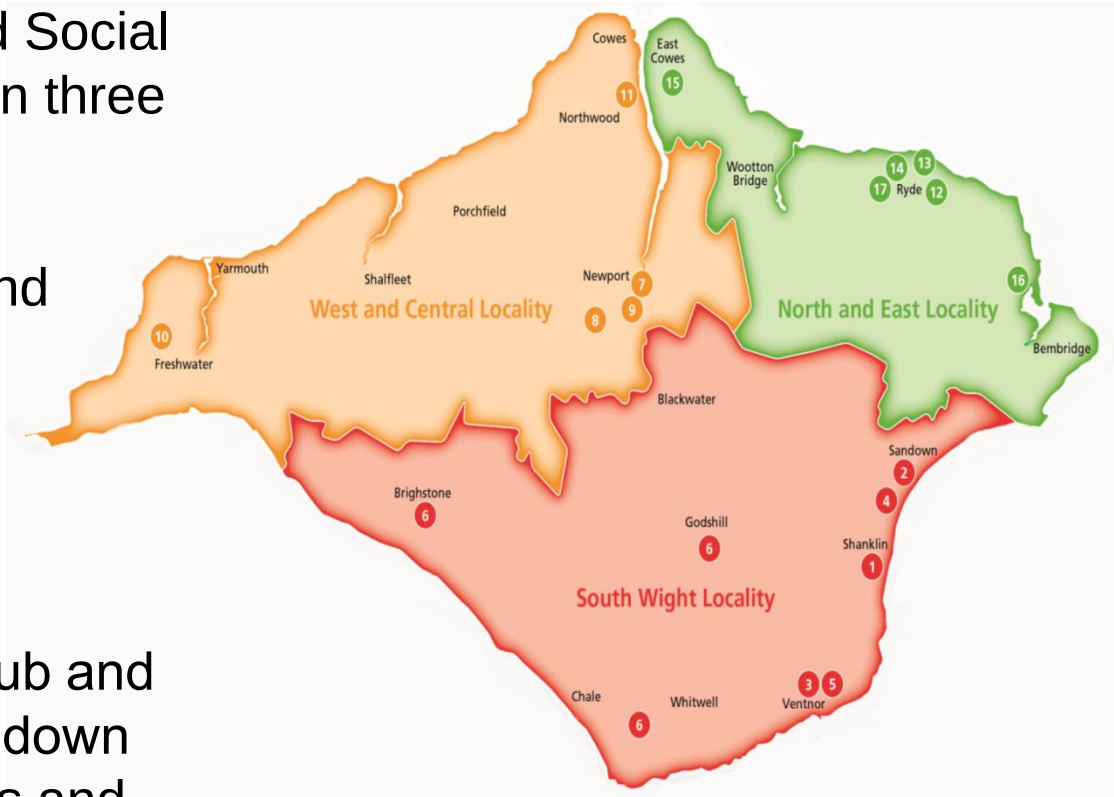


How could IL help to support?

- IL is able to provide multi agency coordinated support to a person with complex needs.
- IL can provide new support or offer additional support, when involvement already occurring from several different community teams.
- IL can support an individuals issues or outcomes, that are unable to be explored within the context of normal referrals or criteria's of health and social care.

Integrated Localities on the Isle of Wight

- The integration of Health and Social care teams has taken place in three main localities.
- **The North & East**
  - based at Ryde Health and Wellbeing Centre.
- **The South**
  - based at The Barracks , Sandown
- **The West & Central**
  - Aims to operate as a “Hub and Spoke” model with touchdown points in Newport, Cowes and Freshwater. This remains in current development.



Who does IL involve?

- The Person
- Their networks – Informal and Professional
- Their community

How does IL affect me, as a practitioner?

Legal Obligation

<u>Prevention</u> is now a statutory duty for Local Authorities to provide. The Care Act provides a 'rubber stamp' to put prevention into practice. (The Guardian, 2015)

The Care Act 2014 states that a local authority must arrange **care and support systems that work to actively to promote wellbeing and independence, and does not just wait to respond when people reach a crisis point.**

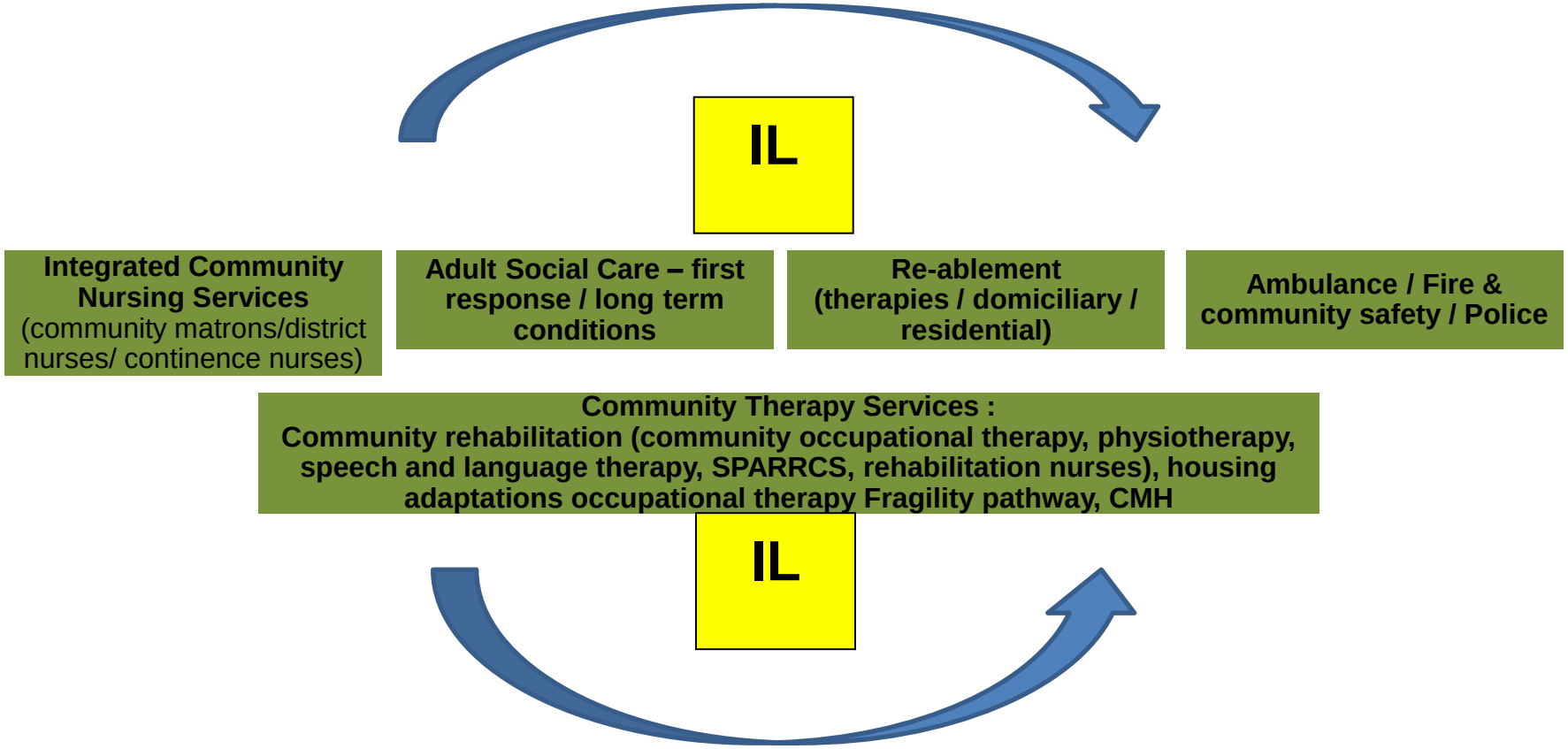
To meet the challenges of the future, it will be vital that the care and support system intervenes early to support individuals. The LA must help people retain or regain their skills and confidence and work towards reducing the need for support, delays or deterioration wherever possible.
(DH 2016 section 2.1)

Legal Obligation

Health and Social Care Act 2012

The Health and Social Care Act 2012 **placed duty on NHS England** to make it easier to work together with social care (RIPFA, 2015) **.**

IL within Adult Social Care Structure



- **IL is an <u>ADDITIONAL</u> service.**
- **IL is <u>NOT</u> a means to bypass the <u>FRONT DOOR</u> of services**

The Process

- Criteria
- Consent
- Referral
- Weekly Case Review meetings
- Response/ Feedback

Criteria

For referral to IL

Needs to meet the following three factors:

- Minimum 18 years of age.
- Requiring input from 2 or more services. This can be Adult Social care, Voluntary Sector, Community services and Health.
- Resident on the Isle of Wight and GP registered.

AND.....

One of the following criteria:

- Frequent A and E/ hospital admissions or emergency activity within the community.

- Prevention work where it is has been identified preventative work would reduce the risk for in-depth need for health and social care.

- Anticipated or recent carer breakdown

- Step-down service from hospital discharge or a community rehab bed. ILS to be considered to follow up, readjustment and monitor an individual's wellbeing to prevent readmission or further breakdown.

- Joint working alongside the case worker; co-ordinate/ support with multi-agency partnerships in order meet a targeted outcome, for the individual.

The Referral

The identified individual can then be referred to the integrated localities by one of the following points:

- Referral form - Via the locality nhs.net email
- Discussed referral with appropriate locality team member
- Presented in person

Consent written or verbal should be sought wherever possible. However for people who are hard to engage or may lack capacity implied consent is acceptable.

Benefits to practitioners

- Simple referral process.
- One referral to IL to access a wide range of services and support
- Follow up to hospital discharge, to help prevent readmission.
- Aim to reduce crisis and provide preventative measures.

What Happens Next?

Once the locality receives a referral .The referral will be triaged and you may be contacted to discuss the referral further.

The locality manager is responsible to ensure this goes to the next case review meeting .

The meeting will discuss the referral and professionals in attendance will decide the appropriate action to take and who will be responsible for co-ordinating the care.

Process Map for Adult Social Care and the Integrated Localities

1) Adult Social Care identifies potential person who meets IL criteria.

2) Adult Social Care Worker ascertains consent and completes referral to relevant Integrated Locality

3) Integrated Locality team receives referral.

ILT triages the referral. More information gathered, if required.

ILT notifies referrer, within three working days, the referral has been received.

4) Referral is presented to weekly integrated locality case review meeting.

IL considers appropriate steps to take.

IL accepts referral:

NO

5) Integrated Locality Team declines referral.

IL responsible to notify refer.

Referral is closed to the team.

yes

5) Integrated locality team accepts referral

IL will decide who the most appropriate lead professional is.

6.1) Not open to Adult Social Care

If the lead professional is identified by ILS as social care worker, referral on PARIS opened to IL and put in social care workers name.

If Lead Professional is an alternative professional, then the referral is only opened to the IL

6.2) Open to Hospital Social Work team

Integrated Locality Team added as an involvement to PARIS tab.

Integrated Locality Team liaises with Hospital team.

Once individual discharged from hospital, Integrated Locality Team follow 6.1 processes.

6.3) Open to Adult Social Care

Integrated Locality Team added as an involvement to PARIS tab.

IL notify allocated worker on PARIS of the intended action and involvement of Integrated Locality Team.

Who is at the case review meeting

- Locality Manager
- District Nursing lead
- Adult Social Care lead
- Safeguarding lead
- Case Coordinator
- Community Matron
- Occupational Therapist
- Advanced clinical practitioner
- SPARRCS
- Wellbeing advisor
- Continence nurse
- Local Area Coordinator
- Care Navigator
- Fire & Rescue Service
- Police and Community Support Officers.

Case review Meetings

New referrals: presented by locality manager or referrer

- Discuss the referral.
- Consider if referral is appropriate for the integrated locality team.
- Discuss the individuals' outcomes and any risks identified.
- Planned actions.
- Lead worker to be identified.
- Feedback to referrer, if not present at meeting.

Open referrals

- At the weekly meeting, updates and feedback discussed.
- Review of individuals outcomes

- When outcomes are met the referral is closed.
- If outcomes remain unresolved, identify appropriate referral and steps.

Some examples IL been involved in ...

Mr HB

Was referred to IL by a care navigator.

- The care navigator had become involved with Mr HB, following is regular attendance to GP practice and growing concerns about his wellbeing.

-Meeting with Care Navigator highlighted many issues including Isolation, undisclosed continence issues, poor diet and nutrition, issues around bereavement and concerns regarding growing vulnerability which had been previously highlighted by Police, poor living conditions, home hard to access and fire risks in home environment.

Following a referral to the integrated locality the following was achieved .....

-**Fire and rescue** visited to ensure fireplaces and fire alarms were being used appropriately. Several actions taken to improve safety, secure the property and advice given regarding electrics check.

-**Continence Nurse** visited to discuss issues and provide necessary products resulting in improvement in overall health and wellbeing.

-**Police** visited to discuss concerns of vulnerability in the community and how to keep himself safe leading to Mr HB feeling more comfortable in his own home.

-Informal visit from **Locality Social Worker jointly with Care Navigator**.

-**Local Area Coordinator** visited and discussed social groups/interest. Love for poetry identified and work being completed towards publishing poetry in the Beacon Magazine.

-Joint visit conducted with **Care Navigator and Local Area coordinator** to discuss works required to the property.

-**Closed to IL but work remains ongoing with Local Area Coordinator. Avoided AFR, Hospital admission, crisis in the community.**

Some examples ILS been involved in ...

Ms SD

Ms SD lives in a run down building on the edge of a cliff. Does not engage with services and has a history of mental & physical health issues, self neglect and risky behaviours.

Frequent referrals are being made to Adult Safeguarding, Police, Fire and Ambulance services. Previously heard at vulnerable adults panel and MARM (multi – agency risk management) completed.

Referral to integrated locality, as an action from MARM.

Following a referral to the integrated locality the following has been achieved:

- **Safeguarding and IL social worker** have been able to complete regular visits to monitor
- known to **local area co-ordinator**
- **Fire safety** have attempted a fire safety check. Now a known high risk property, due to hazardous living conditions.
- Regular visits and monitoring by the **integrated locality team.**
- **Police** have knowledge of the lady and named contact in the police has been provided to IL, to contact if there are concerns regarding Ms SD.

Ms SD currently remains open to the relevant integrated locality team. All professionals continue to monitor with action plans in place to support if needed.

Some examples IL been involved in ...

Ms PD

Is a 78 year old lady with a moderate learning disability. PD was referred to IL by the community Matron who visited weekly.

There were concerns about PD's ability to maintain her personal hygiene which had lead to skin infections and risk of cellulites and hospital admission.

PD was a frequent caller to GP, 111, IDoc and Ambulance services due to the high levels of anxiety she experiences.

Paris has history of a period of reablement and frequent referrals to First response for social care support – not progressed due to PD declining social care assessment. When contacted.

Following a referral to the integrated locality the following was achieved .....

-**Locality Social Worker jointly with Community Matron**. Informal visit which revealed a range of issues involving capacity, self neglect, finances and support network. High risk of support breakdown resulting in need to crisis intervention.

-Locality Social Worker & Safeguarding lead. Looked into safeguarding concerns re informal arrangements, undertook mental capacity assessments resulting in need for Court of Protection application for Isle of Wight Council deputyship and increase of care agency support.

-**Local Area Coordinator.** Visit and explore social groups/interest.

-Fire Safety. Visit to check smoke detectors in place and working.

Learning Disability Nurse. Referral for support completed- awaiting assessment

-**ongoing with IL**
Avoided further AFR, Hospital admission, crisis in the community, reduction in OOH calls.

Joining the meetings in January 2018

- Living Well Advisors
- Mental Health
- Housing
- Ambulance

Links and Cross-Overs with IL

- Vulnerable Adults Panel
- Community Watch
- MARMs (multi-agency risk management)

Could the Integrated Locality Teams help support an individual your working with ?

Locality Contacts

West and Central Locality
Locality manager: Lucy Abel
Lead Social Worker: Rachael Millmore
Lead Nurse: Kathleen Suitor

Email:
iow.WestandCentralILS@nhs.net

South Locality
Locality manager: Pete Smith
Lead Social Worker: Janina Frame
Lead Nurse: Mark Rawlinson

Email: iow.SouthILS@nhs.net

North East Locality
Locality manager: Charlise Cuthbert
Lead Social Worker: Amy Cato
Lead Nurse: Emma Maher

Email:
iow.NorthEastILS@nhs.net

Questions?

References

ADASS: Care Act Guide for Occupational Therapists- Prevention
Accessed 25/09/2017

Department of Health: Care and Support Statutory Guidance Issued under the Care Act 2014:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/315993/Care-Act-Guidance.pdf
Accessed 25/09/2017

The Guardian, 2017. The Care Act Makes Prevention A Duty.
https://www.theguardian.com/social-care-network/2015/apr/29/the-care-act-makes-prevention-a-duty-but-how-will-councils-make-it-work
Accessed: 25/09/2017

RIPFA, 2015 Supporting Successful Integration: Improving Outcomes in Social Care and Health; Frontline Briefing, Dartington.

Brief outline of the role of a .....

Local Area Co-ordination (LAC)

Local Area Co-ordination supports people (adults and children) with disabilities, mental health needs and older people to:

- Achieve what the person wants out of their life. ·
- Spend time talking to people to identify what could improve their life.
- Support people to identify their own strengths and skills.
- Support to develop old and new relationships support with practical steps to make changes
- Support people to source local activities and opportunities.
- No limit to length of support.

Brief outline of the role of a …

Care Navigator

Care Navigators provide Short term support up to 6 weeks for people,
over 50, carers and families. They support people to:

- Build confidence
- Be an emotional support through challenging times
- Engage in social and community activities
- Access domestic support and help around the house
- Advice on falls prevention
- Home safety, including fitting minor aids and equipment
- Welfare and Benefits (including ensuring you're accessing all of the support to which you're entitled)
- Housing and Care issues
- Support through other challenges personal to you

Brief outline of the role of the .....

Living well Approach

Partnership organisations:
Carers UK

- Carers lounge
- 48 hour follow up from hospital for carer
- Training for carers

People Matter IW
- Brokerage support
-Information and advice on guidance to all types of care.

Age UK
-Link to services
-Support with paperwork
-Help with temporary meal and shopping support

Learning disability Support

- Partnership to the Way forward programme
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