Housing Learning & Improvement Network

The Health and Social Care Change Agent Team (CAT) was created by the Department of Health to improve hospital and social care associated arrangements. The Housing Learning & Improvement Network, a section of the CAT in the newly formed Care Services Improvement Partnership, is devoted to housing based models of care and support for adults.

Department of Health

Care Services Improvement Partnership CSIP

Durham Integrated Team

A practical guide to help managers in social care, health (primary care) and housing to develop integrated teams and improve services. This document draws on the experience of County Durham Social Care and Health, Sedgefield Primary Care Trust and Sedgefield Borough Council to develop a partnership and deliver 5 integrated and co-located teams to improve services for adults in their locality.

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Introduction

This paper describes the approach taken by Sedgefield Primary Care Trust, Sedgefield Borough Council and Durham County Council Social Services & Health to develop and sustain a partnership to deliver integration. It sets out why they decided to take this approach, the structures they put in place to take the work forward, their joint vision, the contribution of service users and carers and the results.

Background

In 1994 the three organisations formed a 'Health Alliance'. Its aim was to improve services for vulnerable adults. In 2003 they established the Sedgefield Adult Community Partnership – a fully constituted voluntary body.

Involving Users and Carers

Service users and carers have been involved in designing the model for integration and the change process itself. Early consultation established some key principles:

- Provide a single point of access to services
- Avoid duplication of assessment
- Provide services that are locally based and focussed
- Incorporate health promotion and prevention

A Strategic Approach

Integration and the needs of service users and carers are included and embedded in the following:

- Community Strategy
- Primary Care Trust Local Delivery Plan
- County Council's Operational Plan
- Borough's Corporate Plan and Business Plans

Sedgefield Adult Community Partnership

The aim of the partnership is to implement integrated working between health, social services and the local Council in the:

- Prevention of illness
- Provision of care
- Promotion of health

to local people and the communities they live in.

Membership of the partnership Board is senior executives and non executives from the primary care trust, borough council and county council, together with service users and carers. There is an agreement to operate in an integrated way. There is no care trust.

The Design Team

The role of the design team was to project manage the process of implementation. The team had a dedicated project manager and they met every Thursday morning to review progress on each of the work streams. An important role for this team was sorting out which services would be integrated and how to work with services outside the integrated teams such as OT's and mental health. They reported progress to the partnership board.

Work Streams

- Human resources
- Information management and technology
- Legal
- Finance
- Accommodation
- Business support
- Communications
- Performance management
- Training
- Policy & procedures
- OT services
- Primary care
- Single assessment
- Trade unions

The Model

The model provides for 5 integrated teams each based within and responsible for a centre of population within Sedgefield Borough. Each team is managed by a jointly appointed Community Partnership Manager. Managers have been appointed from each of the professional disciplines of housing, health and social care. They manage staff from each of the three agencies including:

- District nurses
- Social workers and social work assistants
- Housing support officers
- Business support officers
- Aligned social care OT's

The Pathfinder

One integrated team was established initially during which time the design team completed the detailed design of the community teams, tested pathways, systems and procedures and consulted and involved users and carers. The learning from this informed the design of the remaining 4 teams. All 5 teams are now up and running

The Housing Perspective

Integration supports housing to deliver its strategies, specifically around homelessness and prevention. It enables housing resources such as the Disabled Facilities Grant and money from the Housing Revenue Account to be available to the integrated teams. It prevents hospital discharge into unsuitable accommodation. It enables health and social care staff to discuss housing options with patients and clients. It makes better use of adapted accommodation and sheltered and supported housing. It allows integrated teams to prescribe technology to prevent falls, remind people to take medication, provide remote continuous assessment and even telemedicine. It provides integrated solutions to complex problems, targets limited funding to those in greatest need and increases customer satisfaction. A practical example of this is that Single Assessment includes a trigger for technology to see if these services can be used to assist.

The manager of the Pathfinder team commented that one of the best things to come from integration was the contribution that housing and housing related services can make to improving people's lives.

Sedgefield Borough Carelink wardens are not part of the integrated teams there are strong links and they are looking at options to develop and strengthen such arrangements.

Evaluation

Professor Bob Hudson at the School of Applied Social Sciences at Durham University has evaluated the Sedgefield programme to see how well integration has worked. His conclusions are that integration has been successful across the eight dimensions he used for evaluation. Service users are appreciative of the support they receive, some of the GP's who had reservations are now supporters of integration and new ways of working. Staff are supportive of one another and deliver a flexible, creative and speedy service.

An integrated Solution – Case Study

Mrs. B is an 81 year old widow, who had been living independently and alone for several years. She had no history of involvement with social services and remarkably had never even been in hospital. She has no children of her own but has a close relationship with her niece who lives in the area. Mrs B fell when out shopping near her home and suffered a broken hip

The first involvement of the integrated team resulted from a discharge referral from the acute hospital after Mrs. B was thought sufficiently recovered from her fall. The immediate issue was the unsuitable nature of her accommodation. Everyone including Mrs. B acknowledged that this was no longer a viable option since it had a coal fire and an outside toilet as well as stairs and steps. Mrs. B expressed a wish to live near her niece.

Before a permanent solution to her accommodation could be addressed, temporary accommodation had to be found once Mrs. B was well enough to be discharged from hospital. This took the form of short term care aimed at expediting the discharge. The social worker, carer and client agreed with this idea. At the same time explorations commenced for a permanent solution.

At this point the social worker and housing officer made a joint visit to Mrs. B. The options examined included the possibility of modernising her own property through a Disabled Facilities Grant. However her preference was for a bungalow. The housing support office checked with the local housing office at the Borough Council on the availability of a bungalow in Mrs. B's preferred area. This revealed the waiting list to be relatively short. During the course of the visit application forms were completed and the process of re-housing was begun. The Housing Support Officer continued to liaise with the local housing office and within a week a suitable adapted bungalow with Care Link warden services became available. Although it might simply have been fortuitous that a suitable bungalow came a long so quickly, equally it was fortunate that the Housing Support Officer was available to liaise so effectively with the housing office.

continued

Mrs. B's niece began to decorate the bungalow and organise the removal. However, in the meantime Mrs. B suffered a second fall whilst in temporary accommodation and broke her other hip. Although this set back the plans she did recover well and was eventually able to move in. In the meantime her niece expressed concern about the level of care Mrs. B might need and her inability to provide it unaided. This resulted in the social worker putting in a care package to provide daily help with washing, dressing and food preparation. As she became more independent Mrs. B phased out this care and she now lives independently in her bungalow.

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Other Housing LIN publications available in this format:

Case Study no.1:	**Extra Care Strategic Developments in North Yorkshire**
Case Study no.2:	**Extra Care Strategic Developments in East Sussex**
Case Study no.3:	**'Least-use' Assistive Technology in Dementia Extra Care**
Case Study no.4:	**Tenancy Issues - Surviving Partners in Extra Care Housing**
Case Study no.5:	**Village People: A Mixed Tenure Retirement Community**
Case Study no.6:	**How to get an Extra Care Programme in Practice**
Case Study no.7:	**Sonali Gardens - An Extra Care Scheme for Bangladeshi and Asian Elders**
Case Study no.8:	**The Kent Health & Affordable Warmth Strategy**
Case Study no.9:	**Supporting People with Dementia in Sheltered Housing**
Case Study no.10:	**Direct Payments for Personal Assistance in Hampshire**
Case Study no.11:	**Housing for Older People from the Chinese Community in Middlesbrough**
Case Study no.12:	**Shared ownership for People with Disabilities**
Case Study no.13:	**Home Care Service for People with Dementia in Poole**
Case Study no.14:	**Intermediate Care Services within Extra Care Sheltered Housing in Maidenhead**
Case Study no.15:	**Sheltered Housing Contributes to Regeneration in Gainsborough**
Case Study no.16:	**Charging for Extra Care Sheltered Housing Services in Salford**
Case Study no.17:	**A Virtual Care Village Model**
Case Study no.18:	**Community Involvement in Planning Extra Care: the Larchwood User's Group**

The Housing LIN welcomes contributions on a range of issues pertinent to Extra Care housing. If there is a subject that you feel should be addressed, please contact us.

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