Committee	Date:
Health and Social Care Scrutiny Committee	10 May 2016
Subject: City of London Care Navigator	**Public**
Report of: Director of Community and Children's Services	**For Information**
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Summary

This report updates Members on the Care Navigator role in the City of London, the impact it has had and plans for the future.

The City of London Corporation has commissioned a Care Navigator service which is designed to help ensure safe hospital discharge for any City resident who requires it. The service began in January 2015 and has had considerable impact. Building on the success of the role, funding has been secured for a continuation of the service for a further year. Funding is also being sought for an additional service to support City of London residents in Accident and Emergency who are not admitted but need some support to return home safely.

Recommendation

Members are asked to note the report.

Main Report

Background

1. The City of London has complex care pathways with 75 per cent of patients registered at the Neaman Practice (the City's one GP practice and part of City and Hackney Clinical Commissioning Group) and the remaining mainly registered with GPs who are part of Tower Hamlets Clinical Commissioning Group (CCG).

2. These two CCGs commission hospitals for their registered patients and for City and Hackney CCG this is normally the Homerton hospital. However, when any City of London resident is admitted to hospital as an acute or emergency case then they are usually taken either to The Royal London Hospital or University College London Hospital. Very few City residents are admitted to Homerton Hospital.

3. As a result of these complexities, there is an increased risk of City of London residents not being linked up with the correct follow on services and that the Adult Social Care Team is not being made aware of residents being discharged back into the community who may need support.

4. This creates potential safety issues and a risk of a delayed transfer of care from hospital to the community. Ensuring that those being discharged from hospital get the right services and support they require helps to promote independence, good health and wellbeing and prevent hospital readmission.

5. In response to this, the City of London Corporation developed a one year pilot of a Care Navigator service to provide support to City residents who required it to ensure a safe hospital discharge.

Current Position

6. The Care Navigator service has been operational in the City of London since January 2015 and is provided by Age UK East London. The role was originally funded through Section 256 funding (health money given to social care to deliver services which have a health benefit) and some additional funding came from the Better Care Fund (BCF) in 2015/16. The Better Care Fund is a national fund which aims to integrate health and social care services at a local level. The total budget for the Care Navigator service is £50,000 per year.

7. Between March 2015 and March 2016, the Care Navigator service has had contact with 60 City residents in hospital with some of these being recurrent admissions.

8. As a result of the Care Navigators work, the number of delayed discharges of care has been reduced thus saving money on the potential fines that hospitals can charge if beds are blocked for social care reasons when a person is considered to be medically fit to go home. The links between Care Navigators and the reablement team mean that reablement has been able to target people more quickly thus making their goals for independence more achievable.

9. Care Navigators have also been able to make early intervention and prevention referrals direct from hospital wards to commissioned services such as shopping, befriending (to avoid social isolation), the carers group, memory group and the 50+ support group.

10. A qualitative survey has also been undertaken with residents who have received the service. The main themes from the survey included the beneficial nature of the service but that a follow up home visit after discharge may have been useful and that although some clients did not have much direct contact with Care Navigators, they were aware that they were able to receive other services that they needed as a result of contact with the navigators.

Proposals

11. Given the impact of the Care Navigator service, the Health and Wellbeing Board agreed that the service should be continued for another year. Further funding from the BCF 2016/17 City proposal is set aside for this. It is recognised that long term sustainable funding needs to be secured and this is being explored as part of the integrated care model that is being developed by City and Hackney CCG as part of One Hackney and the City.

12. It is also proposed that a new service is developed to support City residents who are conveyed to Accident and Emergency but not admitted and need support to return home safely during unsociable hours. City and Hackney CCG have allocated some non-recurring funding to help address delayed transfers of care and emergency admissions in the City of London and it is proposed that part of this funding could be used to fund a pilot service. This is currently being discussed with City and Hackney CCG.

Corporate & Strategic Implications

13. With pressures on health and social care systems nationally, and a drive towards more person centred care, integrated care has become a key mechanism for achieving efficient, effective and holistic services which are delivered at the right time and in the right place. Integration is therefore a key driver in a number of national strategic documents and plans such as the NHS five year forward view.

14. The Better Care Fund 2016/17 includes a national condition around addressing Delayed Transfers of Care in order to access the funding.

15. Integration is a priority in the refreshed City of London Joint Health and Wellbeing Strategy and delivering the Better Care Fund is a key action in the Department of Community and Children's Services Business Plan.

Implications

16. The Care Navigator service and the proposed additional service are currently being provided from non-recurrent funding. Therefore if the service is to be sustained in the longer term further funding will need to be identified. Our long term aspiration would be to secure mainstream funding for these services.

17. For any additional services, City of London Corporation procurement process will need to be followed.

Conclusion

18. The City of London Care Navigator service plays a key role in supporting safe hospital discharge for City residents and reducing potential delayed transfers of care.

Appendices

- None

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