Dashboard – Integration focus

Southwark's Health and Wellbeing Board 22 October 2013

A: Profile of older people in Southwark

Older people's needs in Southwark

- There are around 22,300 people aged 65 or over, with another 5,000 predicted by 2025; nearly half, around 10,000, receive pension credits
- About 80% of the borough's older population is of white ethnicity, with black/black British making up the next largest group at 13%
- One in eight non-decent homes are occupied by over-60s, about 60% of older households rent and around 9,200 are thought to live alone
- A man living in the most deprived 20% of the population dies on average 9.5 years before one in the least deprived 20% (6.9 years for women); the five council wards with proportionally the most 65+ are Camberwell Green, Livesey, The Lane, Brunswick Park and East Walworth
- At least 10,000 older people need help at home with simple daily tasks, and nearly 5,000 have problems with at least one aspect of their mobility
- Around 4,200 over-65s have BMIs greater than 30, although this is likely to be an underestimate
- Nationally around a quarter of adults in manual households smoke, compared to around 16% of non-manual households; it is also estimated that around one in seven over-65s smoke
- The Royal College of Physicians estimates that around 60% of older people admitted to hospital because of confusion, repeated falls at home, recurrent chest infections and heart failure may have unrecognised alcohol problems
- It is estimated that around 6,600 people over 65 will fall during the year, resulting in around 800 admissions to hospital; this is above expected admissions for the local population, which predicts around 540; nearly half the admissions are for people aged over 85
- An estimated 2,500 over-65s provide unpaid care to others
- There are estimated to be some 2,200 older people with moderate to severe sight impairment, and some 11,000 have a moderate to severe hearing impairment; around 4,800 over-65s are registered as podiatry service users

Long term conditions

- Some 12,500 over-65s have a limiting long-term illness, and nearly half of these are estimated to live alone
- There are around 1,500 over-65s with coronary heart disease and nearly 2,500 with diabetes but as many as half of sufferers go undetected; similarly nearly 6,000 with hypertension but this is thought to be around 80% of anticipated levels
- Over 65s make up less than 8% of registered GP patients but account for half to three-quarters of long term condition disease registers
- There are an estimated 1,800 older people with dementia, although around 70% of care home residents are thought to have some form

C: Services and provision supporting older people

Adult social care services

- Nearly 3,000 over-65s receive a full community care package, with nearly all in receipt of a personal budget
- The council arranged over 750,000 hours of homecare, for just over 1,000 clients
- Some 1,400 adults receive community reablement or intermediate care services after being in hospital, while nearly 1,200 are supported in residential or nursing care, and nearly 1,300 mental health service users receive professional support through the care programme approach
- Around 600 receive telecare, around 2,700 have alarms and nearly 400 receive meals on wheels
- There are nearly 100 'Extra Care' housing places, 2,900 people receive Supporting People supported accommodation and floating support in their own home, and over 1,303 carers were assessed in 2012/13, with 545 leading to a service and 808 getting advice and information
- There are 521 day services clients as part of care package

Dementia Centre of Excellence

This will open in a purpose-redesigned building at Cator Street in 2015; co-produced with users, families and practitioners, the innovative model will increase capacity and access to a wider range of specialist therapeutic activity and other support. It will also include a greater selection of 'in-reach' and outreach support for users and carers including with the voluntary sector seven day a week access.

A+E and emergency admissions

- Although A+E attendance volumes have remained fairly stable over recent years, the number of over-65s has risen by around 10% over the three years to 2012/13, although over-65s account for 8% of population and 13% of A+E attendances, but under 5s account for 7% of population and 13.5% of attendances
- Southwark is in the upper quartile nationally for over-65 emergency admissions
- Some two-thirds of the over-65s admitted to A+E are for a single episode, and a third of elderly A+E admissions last a day or less, but about 350 attend A+E five times or more a year

Southwark and Lambeth Integrated Care

- Established in May 2012 to provide integrated care to older people across both boroughs; covers over three-quarters of over-65s in Southwark, and around a third of GP practices have signed up
- Holistic health assessment are beginning to be undertaken in participating GPs, with 60-70 undertaken a month
- Support services include a GP-referral 'fast track' assessment for a geriatrician or therapist on same/next day; and the rapid response and nursing-led home ward services which provide nursing care, therapy and social care in the home to help people stay out of hospital

- The cost of A+E attendances by over-65s in 2009/10 was nearly £1.3m, while emergency admissions for the same period cost £21.3m
- An ambulance is called some 2,500 times for someone who had fallen, with nearly 1,700 taken to hospital and some 700 admitted, which is higher than national expectations
- The number of admissions for lung diseases, diabetes complications and heart failure are significantly higher than the England average
- About 20% of emergency admissions are for long term conditions, a further 18% for infections, and 13% for trauma or falls with senility; cardiovascular events accounts for 10% and cancer 7%
- The length of stay over 50 days is rising, with proportionally a 2% rise from 2010/11 to 2012/13, although there has been a 4% fall in the proportion of over-65s staying 21-49 days over the same period
- No evidence that 'winter demand' is overloading local A+Es, with peaks occurring at other times of the year depending on the age group

B: Views from older people and practitioners

"Early intervention is important so people do not reach their lowest point and find it difficult to recover. It is important we are be able to identify early warning signs so people could be given a bit of help, rather than a lot of help."

"I can manage with basic support but there is no help out there. It's difficult to know who to get support from."

"Elderly patients require a more targeted and personalised standard of care and the existing system does not cater effectively for vulnerable groups who require care at home."

"When I first started with the line dancing group, I hadn't done any exercise but then I realised that I could and that it was enjoyable. I've got arthritis now but I dread to think what I would been like if I didn't exercise."

"We all meet in Morrisons in Peckham – it's a regular thing."

"I make myself part of the community – and go out to meet people."

"OAP groups are essential so that those living alone can meet friends – and also for transport."

"It's important to provide social activities, for example Christmas dinners. Without that some people would be isolated."

Huda

Huda is Somali and in her 60s. She has a number of long term conditions including for her heart, liver and stomach, which have developed over the past ten years. Speaking very limited English and without a good English speaker in the household, she struggles to explain her symptoms to her GP, often going to A+E. She finds A+E very stressful and avoids going until she feels she has no option. She attends about every three weeks. She only goes when she is worried her symptoms could be life threatening, such as blurred vision or headaches, and worries that her existing medication is not working. She usually leaves with a new prescription though occasionally is kept in overnight, such as to monitor her heart. She feels her conditions complicate everything as she needs to see a GP or consultant for even minor concerns.

"Patient X is feeling in limbo. They don't know where they stand with all the changes – urgent care centre, walk in centre, A&E. They feel it is so difficult to get to see the GP."

In developing the Southwark and Lambeth Integrated Care programme, local older people told us:
- They wanted all their needs looked at, with physical and mental health and social care needs all taken into consideration
- They wanted more time to talk to a professional at their GP practice, who understood their needs
- They wanted support to stay fit and healthy for as long as possible
- They wanted to stay out of a care home or hospital as long as possible; if they had to go to hospital, they wanted to be assessed and treated as quickly as possible and return home
- They wanted their care to be coordinated better, particularly when living at home in the community or being discharged from hospital

Vera

Vera is nearly 70. She likes to keep positive, particularly in the face of life's regular challenges. She has some mobility issues and is physically frailer than she was, but she says she just 'gets up and goes' to overcome life's barriers. She values a personal and polite approach, and is cynical about the complexity of the 'system'. She has an active social circle, and volunteers at her local church. She would like to do more, but cost is a barrier. She has had small adaptations to her council flat, which have helped.

Mrs M

A local GP recently referred Mrs M to the Rapid Response service. She had suffered falls as a result of confusion following an infection. The team assessed Mrs M and agreed a care plan including some mobility exercises to improve her strength and balance and short term assistance with her personal care. Both Mrs M and her granddaughter said they felt the team was utterly professional – treating them with respect and listening carefully to their concerns. They both felt actively involved in the arrangement of the care plan, which the GP believes is the hallmark of a high-quality, integrated service.

Consultation on reorganisation proposals for primary care in Dulwich area

- The CCG found strong support from respondents for delivering services locally and out of hospital – 89% were in favour, with over-65s even more in support at 94%
- Strong wish for GPs, hospitals, any new health centre, pharmacists and social services to have access to current medical records; although there was concern by some respondents that implementing this effectively would be problematic and therefore worried that the hub model could cause further fragmentation of the care an individual receives
- "The proposals have the effect of placing the patient and his or her needs at the forefront of healthcare professionals' thinking, and will reduce the tendency for the condition to be separated, as it were, from the patient. Medicine and therapies will be more holistic."
- "For some, ie middle class, mobile, a hub may improve their access to healthcare. I am concerned that for more vulnerable and deprived people this may not be the case. Also for people who typically fail to engage with services, I feel there are huge benefits for services being delivered in local surgeries by a team who works closely with regular meetings and detailed knowledge of vulnerable patients."
- "There is a huge variation in the quality of GPs and care, centralising the resources and specialism will help improve quality and cost effectiveness."

Martin

Martin, who is deaf and blind, attends Southwark Resource Centre three days a week. Born deaf, he lost his vision gradually. He had never learned to speak or to use any formal sign language and he has a moderate learning disability. He has attended day services for approximately 20 years. Over the past year, support staff have helped him become more independent, such as using the toilet, feeding himself or developing her memory and recognition of objects. He is now much more engaged, independent and active while at the centre than previously. He has a "communication passport" which was developed by the support staff, containing pictures of familiar signs he uses to communicate. He has now begun to learn new signs and to communicate pro-actively with other people.

D: Adult social care outcomes framework

	2011/12 (final) Southwark	2012/13 (provisional) Southwark	2012/13 (provisional) London
1a Social care related quality of life (composite measure from user survey)	17.7	18.1	18.2
1b The proportion of people who use services who have control over their daily life (user survey)	67.7%	66.6%	70.7
1c.1 The proportion of people using social care who receive self-directed support (part 1)	60%	74.2%	63.5%
1c.2 The proportion of people using social care who receive self-directed support via direct payments (part 2)	31%	30.4%	19.3%
1d Carers reported quality of life (composite measure from carers survey)	n/a	7.4	7.5
1e Proportion of adults with learning disabilities in paid employment	9.7%	5.6%	9.4%
1f Proportion of adults in contract with secondary mental health services in paid employment	4.0%	4.5%	6.1%
1g Proportion of adults with learning disabilities who live in their own home or with their family	66.3%	73.1%	67.7%
1h Proportion of adults in contact with secondary mental health services living independently, with or without support	60.8%	71.4%	80.4%
1Ia Social isolation new measure from 2013/14): a) % users who "have as much social contact as I want with people I like"	-	72%	72%
1Ib Social isolation (new measure from 2013/14): a) % carers who "have as much social contact as I want with people I like"	-	29%	35%
2a.1 Permanent admissions to residential and nursing care homes per 100,000 population - part 1 younger people	6.8	9.6	10.8
2a.2 Permanent admissions to residential and nursing care homes per 100,000 population - part 2 older people	665	790	495
***2x** Effectiveness of prevention/ preventative services – placeholder to be developed*			
2b.1 Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services (part 1)	90.7%	77.2%	85.9%
2b.2 Coverage of reablement: Proportion of older people discharged from hospital receiving reablement	2.8%	3.6%	4.0%
2c.1 Delayed transfers of care from hospital (all) per 100,000 ppn. (part 1)	5.3	4.4	7.1
2c.2 Delayed transfers of care from hospital attributable to social care or both NHS and social care per 100,000ppn (part 2)	1.9	1.6	2.7
***2d** New for 2014/15: The outcomes of short terms services: sequel to services*			
2e *Effectiveness of reablement - placeholder to be developed*			
***2f** A measure of the effectiveness of post diagnosis care in sustaining independence and improving quality of life – placeholder (dementia)*			
3a Overall satisfaction of people who use services with their care and support (User survey results received)	49.4%	53.1%	58.2%
3b Overall satisfaction of carers with social services (carers survey)	n/a	44.4	34.6
3c The proportion of carers who report that they have been included or consulted in discussion about the person they care for	n/a	65.5%	65.9%
3d The proportion of people who use services and carers who find it easy to find information about services (user survey and carers survey)	71.2%	69.7%	68.2%
***3e** Placeholder: Improving people's experience of integrated care*			
4a The proportion of people who use services who feel safe (user survey)	51.6%	58.5%	60.2%
4b The proportion of people who use services who say that those services have made them feel safe and secure (user survey)	64.7%	73.4%	73.1%
***4c** Effectiveness of safeguarding – placeholder to be developed*			

E: Public health outcomes framework (selected)

Health improvement	Period	Local value	Eng. value	Eng. lowest	Range	Eng. highest
2.24i Injuries due to falls in people aged 65 and over (Persons)	2011/12	2,283	1,665	1,070		2,985
2.24i Injuries due to falls in people aged 65 and over (males/females) - Male	2011/12	1,982	1,302	704		2,535
2.24i Injuries due to falls in people aged 65 and over (males/females) - Female	2011/12	2,584	2,028	1,298		3,713
2.24ii Injuries due to falls in people aged 65 and over - aged 65-79	2011/12	1,346	941	545		1,726
2.24iii Injuries due to falls in people aged 65 and over - aged 80+	2011/12	6,496	4,924	2,892		8,965

Healthcare and premature mortality	Period	Local value	Eng. value	Eng. lowest	Range	Eng. highest
4.01 Infant mortality	2009 - 11	4.11	4.29	2.28		8.02
4.03 Mortality rate from causes considered preventable (provisional)	2009 - 11	174.9	146.1	100.7		264.2
4.04i Under 75 mortality rate from all cardiovascular diseases (provisional)	2009 - 11	72.9	60.9	39.5		113.3
4.04ii Under 75 mortality rate from cardiovascular diseases considered preventable (provisional)	2009 - 11	47.0	40.6	23.0		75.1
4.05i Under 75 mortality rate from cancer (provisional)	2009 - 11	117.3	108.1	84.0		153.2
4.05ii Under 75 mortality rate from cancer considered preventable (provisional)	2009 - 11	71.3	61.9	45.2		98.1
4.06i Under 75 mortality rate from liver disease (provisional)	2009 - 11	20.7	14.4	8.7		39.3
4.06ii Under 75 mortality rate from liver disease considered preventable (provisional)	2009 - 11	19.0	12.7	7.5		37.0
4.07i Under 75 mortality rate from respiratory disease (provisional)	2009 - 11	33.1	23.4	13.7		62.0
4.07ii Under 75 mortality rate from respiratory disease considered preventable (provisional)	2009 - 11	21.8	11.6	5.3		28.6
4.08 Mortality from communicable diseases (provisional)	2009 - 11	35.4	29.9	22.0		54.9
4.10 Suicide rate (provisional)	2009 - 11	7.4	7.9	4.3		13.9
4.11 Emergency readmissions within 30 days of discharge from hospital	2010/11	12.4	11.8	8.1		13.8
4.11 Emergency readmissions within 30 days of discharge from hospital - Male	2010/11	13.8	12.1	8.6		14.8
4.11 Emergency readmissions within 30 days of discharge from hospital - Female	2010/11	11.1	11.4	7.2		13.2
4.12i Preventable sight loss - age related macular degeneration (AMD)	2011/12	75.8	110.5	12.8		225.2
4.12ii Preventable sight loss - glaucoma	2011/12	13.7	12.8	3.0		34.5
4.12iii Preventable sight loss - diabetic eye disease	2011/12	4.1	3.8	0.9		15.8
4.12iv Preventable sight loss - sight loss certifications	2011/12	25.3	44.5	5.1		82.5
4.14i Hip fractures in people aged 65 and over	2011/12	433.8	457.2	337.9		599.5
4.14ii Hip fractures in people aged 65 and over - aged 65-79	2011/12	216.8	222.2	135.7		346.7
4.14iii Hip fractures in people aged 65 and over - aged 80+	2011/12	1,410	1,515	993		2,021

F: Statutory and regulatory frameworks

National shared commitment to integrated care and support

- Integrated care to be the 'norm' by 2018
- Adoption of National Voices' definition and narrative on integration
- Appoint 10 'pioneer' localities to test new models of integration; expectation that further pioneer waves will follow
- Develop, with pioneer localities, a new way of measuring people's experience of integrated care and support; will be basis of performance measures for Integration Transformation Fund

Integration Transformation Fund

- June Spending Round announced creation of Integrated Transformation Fund to support health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and LAs
- Fund totals £3.8bn in 2015/16
- To access funding, CCGs and LAs must develop joint two-year plans of how pooled funding will be used and the ways in which the national and local targets attached to the performance-related £1 billion will be met
- National and local targets under development; so far the LGA and NHS England have indicated that local plans must meet the following conditions:
  - Be jointly agreed and for the protection for social care services (not spending)
  - Enable seven-day working in health and social care to support patients being discharged and prevent unnecessary admissions at weekends
  - Better data sharing between health and social care, based on the NHS number
  - A joint approach to assessments and care planning
  - Where funding is used for integrated packages of care, there will be an accountable professional
  - Risk-sharing principles and contingency plans if targets are not met – including redeployment of funding if local agreement is not reached
  - Agreement on the consequential impact of changes in the acute sector

Care Bill

- Redraws entitlement to assessment for service users and carers based on need
- Duty to prevent, reduce or delay need for support
- Duty to provide preventative advice and guidance, including to those not eligible for support, and to consider what support would delay need for support
- Duty to provide all adults with eligible care needs with a personal budget
- Stronger entitlements for carers, and scope for adults' assessment frameworks to be applied to under 18s
- Duty to ensure sufficiency of provision
- Places safeguarding adults boards on statutory footing