Item No.	Classification: Open	Date: 27th January 2014	Meeting Name: Health, Adult Social Care, Communities & Citizenship Scrutiny Sub-Committee
Report title:		Access to Health Services in Southwark – call for evidence - submission from Director of Adult Care	
Ward(s) or groups affected:		All	
From:		Sarah McClinton, Director of Adult Care, Children's and Adults Department	

RECOMMENDATION(S)

1. The Health, Adult Social Care, Communities & Citizenship Scrutiny Sub-Committee note this report.

BACKGROUND INFORMATION

2. The Health, Adult Social Care, Communities & Citizenship Scrutiny Sub-Committee is undertaking a review on the subject of Access to Health Services. This is covering issues around out of hours services (especially the 111 service), GP access, implications of the TSA and KHP merger, and understanding the reasons for increased pressures on A&E over winter and how this may be reduced where appropriate.

3. The Director of Adult Care has been invited to provide evidence for the review with a focus on the pressure on A&E arising from the following groups that have been identified as key sources of pressure:

   - older people with high needs
   - people with mental health problems

4. This report sets out the issues from an adult care perspective, with a focus on how social care plays a role in preventing avoidable A&E attendance, and assists in reducing pressure on the overall urgent care system by assisting discharge from hospital.

FACTORS FOR CONSIDERATION

Social Services Users at risk of A&E admission

5. People who are eligible for adult social care services have substantial social care needs, and also frequently have health problems such as long term conditions, dementia or mental health issues and/or may be highly frail older people. Risk of hospital admission is a key factor in assessing eligibility for social care, and services are put in place to minimise the risk. As such social care users are a population at high risk of needing to use urgent care services, including A&E.

This is particularly so in the winter when there are additional risk factors associated with the cold, and the prevalence of viral infections.

6. Our experience of demand pressure confirms that with the ageing population there are increasingly high levels of need, in particular arising from people with dementia. With a 38.5% increase in the over 90's age group forecast between 2014 and 2020 in Southwark this pressure will continue to grow. Dementia is now a key factor in most care home admissions for older people.

Increases in A&E attendances by Southwark residents at Kings

7. Data provided by the CCG indicates that whilst there was an overall increase in A&E attendances of 6% at Kings between Quarter 3 (i.e. Oct-Dec) 2012/13 and 2013/14, there was actually a reduction of 6% in the numbers of Southwark residents attending A&E over the same period. This is important context, and is encouraging insofar as it indicates that the system wide efforts to prevent avoidable A&E attendances are having an impact in Southwark. There is a similar picture with regards to emergency admissions to hospital which have decreased 4% over the same period.

8. It is also important to note that for the Southwark Mental Health Liaison Team, which supports people presenting at Kings A&E with mental health problems, only 37% of the cases are Southwark residents (December 2013).

Social Services objectives and A&E demand reduction – integrated approach

9. A key objective of all our social services is to provide support that prevents, delays or avoids the need for people to access more intensive health and care services including A&E, by helping people to live safely and independently in the community. Also, when people are admitted to hospital our services have a key role in supporting the hospital discharge process and providing appropriate community support such as intermediate care and reablement to reduce the risk of re-admission through attendance at A&E or other routes.

10. To work effectively with people with health and social care needs at risk of hospital admission we recognise that integrated working with health and other agencies (including housing) is essential, hence the integration agenda we have with health, including through Southwark and Lambeth Integrated Care and through integrated community mental health teams with SLAM. This is particularly so given the reduction in resources available to health and social services, which means services need to be targeted and well co-ordinated.

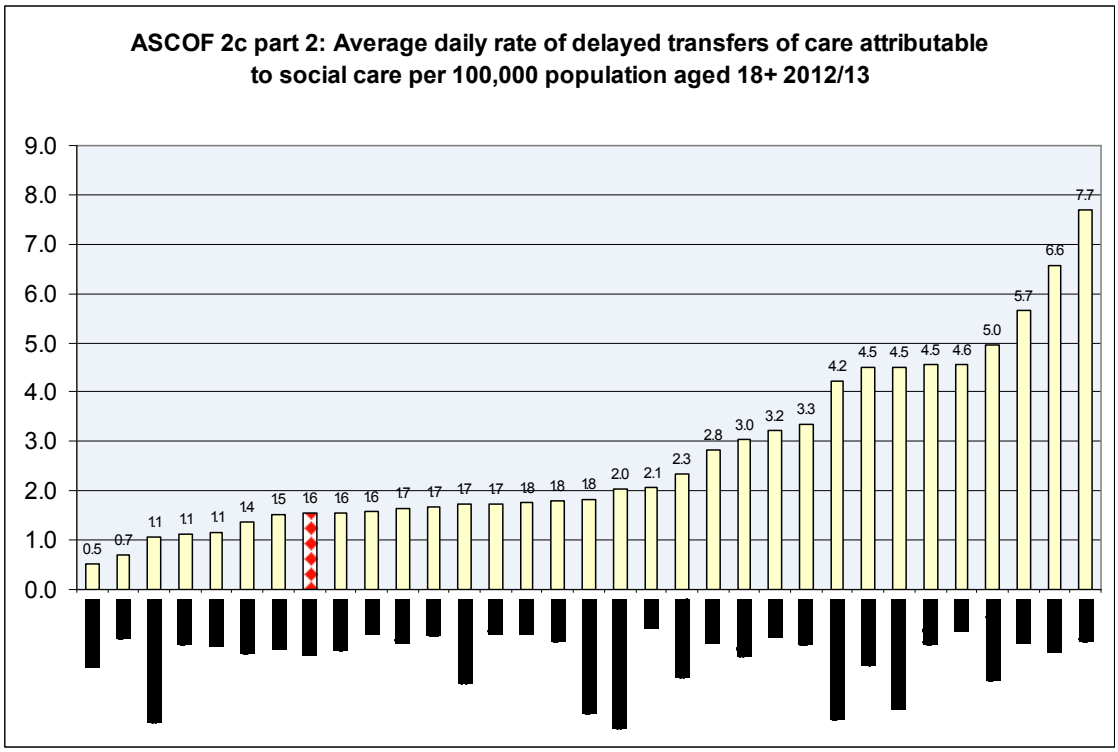
11. For older people identified as at risk of admission we take a multi-disciplinary team approach with a single lead professional co-ordinating support from different agencies that should help prevent avoidable admissions through A&E. This priority is recognised nationally and will be taken forward in 2014/15 onwards through the Better Care Fund which necessitates pooled funding and joint working in areas that will reduce pressure on health and care services, in particular non-elective care. This approach will build upon the existing arrangements where services are part funded by NHS funding transfers specifically to reduce pressure on health (e.g. re-ablement, discharges services, intermediate care).

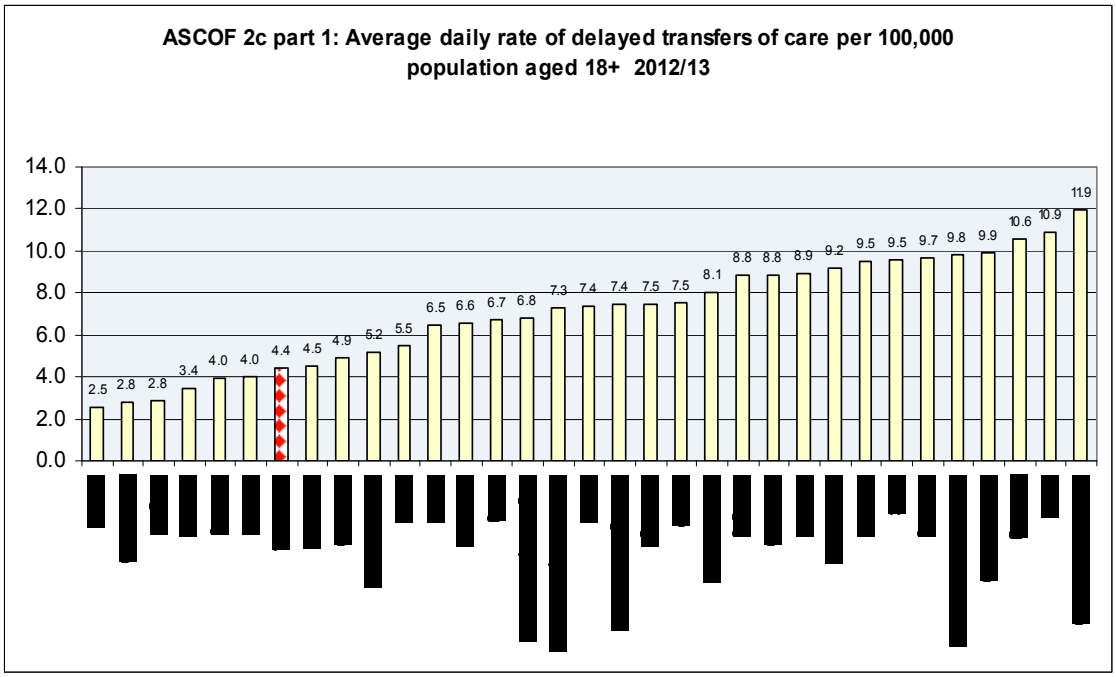
12. Health services lead on the overall admissions avoidance plan, and social care contributes where appropriate through the multi-disciplinary team approach. This includes the provision of the "Night Owls" enhanced homecare service operating between 10.00pm and 7.00am providing higher levels of care that reduce deterioration and avoid re-admission. The enhanced rapid response team and home ward services have enhanced social work input. Southwark social services are active members of the Urgent Care Board which leads on the development of health plans that cover A&E pressures.

13. Re-ablement is a key area that has been expanded in line with our strategy, with 1,400 people benefitting from short term services that restore people's independence after a period of disablement in 2012/13. Recent figures show that around 85% of people discharged from hospital into a re-ablement service were found to be still at home, without a hospital re-admission, 3 months later.

Minimising Delayed Transfers of Care

14. A key measure of the success of local systems in facilitating smooth hospital discharge is the national Delayed Transfers of Care (Adult Social Care Outcome Framework measure). This differentiates between all delayed transfers of care and those delays attributable to social care. On both measures Southwark is a strong performer, in the top quartile as the charts below show. This is a key measure that impacts on A&E because it reduces the risk of there being a shortage of acute beds in which to admit people from A&E, and so reduces the risk of lengthy waits in A&E which in turn block up the A&E system for new arrivals.





Further relevant issues re social care and reducing A&E pressure

- Southwark operates a 24 hour 7 day social care service. The emergency duty team system operates out of hours, reducing risk of avoidable A&E attendance or admission by people requiring social care support.

- The Carers Strategy will enhance the focus on supporting people in looking after the people they care for. The breakdown of informal care arrangements is frequently a factor in A&E attendance.

- Telecare is a resource that can help people live independently at home, for example sensors that detect wandering by people with dementia. Around 3,000 people benefit from alarm systems that can connect them to family or sheltered housing support services rather than escalating this to emergency services.

- As set out previously to the committee in our report on Care Home quality (My Home Life), homes are supported to manage the health of residents in a way that reduces unnecessary ambulance call outs, which place a particular pressure on the A&E system. Quality home care provision is a vital resource for keeping people safe and well, and subject to similar quality improvement initiatives.

- People who are not eligible for a full social care package can still benefit from contacting services in other ways. For example, our information line provides advice on how to access a range of appropriate universally accessible services, including health services and our council funded community support services which provide advice and support including to services such as befriending support for people who are suffering due to social isolation.

- Occupational Therapy Services and Community Equipment Services work specifically with people to reduce the risk of household accidents in older people, making a key contribution to the falls prevention strategy.

- For people requiring dementia care, day services provide a range of support, and through the proposed centre of excellence in Peckham due to open in 2015 we wish to further develop and improve this offer, reducing the risk of hospital attendance.

- Social Services play an active role in promoting the flu immunisation programme, in particular for front line staff.

- Southwark Council also promotes the winter "Keep Warm" campaigns.

Focus 1: Hospital Social Work Teams

At an operational level, work undertaken by the Hospital Discharge Teams to maintain patient flow through the hospital includes;

- Close partnership working with the ward Multidisciplinary teams and discharge coordinators to facilitate safe and timely discharges for patients.

- Close linking with Kings A&E social worker for early identification of most complex patients being admitted to the hospital.

- Southwark have recently implemented a new operating system in which all cases which are referred from the wards are allocated on the same day with the aim of providing a more proactive response to assessment.

- Priority and integrated referral to the Re-ablement and Intermediate Care teams for hospital inpatients.

- Implementation of a new care package restart pathway which accelerates discharge for patients who do not require a change in existing services to go home Wards are able to restart care packages directly with our brokerage services rather than having to complete the existing 3 day referral process via the social work teams.

This has contributed to the strong performance referred to above.

Focus 2: Mental Health Services

Features of our mental services relevant to preventing and responding to A&E attendance are set out below:

- Mental health services in Southwark are provided by integrated health and social care teams – under the auspices of SLaM. Integration enables there to be a seamless service between health and social care that uses an MDT approach (multi-disciplinary team approach – social workers, nurses, OT's, Doctors, psychologists, therapists etc) that is holistic and enables teams to support all health and social care needs under one service (holistic assessments and care plans – which are recovery orientated with good crisis

and contingency plans). These teams also "in-reach" on to wards to enable earlier discharges. Over the past year in particular rates of delayed transfers from mental health setting have reduced and are now significantly below many neighbouring boroughs.

- HTT (Home Treatment Teams) provide 24/7 care to service users in a crisis in their own homes rather than them having to either be admitted to hospital or attend A&E. The teams are multi-disciplinary and provide a range of treatments and care to enable residents to stay in their own homes when unwell. They also provide 'early intervention' to enable residents to leave wards earlier (earlier discharge) with daily support from the HTT.

- HTT accept out of hours referrals from GP's – rather than GP's having to refer residents to A&E

- Peer support is also provided for people in leaving HTT and / or in the community. A randomised control trial is to be set up soon to research the effectiveness of peer support for those that have been in crisis.

- PLN (Psychiatric Liaison Nurses) – are based in A&E and provide a 24/7 mental health triage in A&E to enable a rapid assessment and care planning for those that come to A&E. They also assess for HTT – so a speedy discharge can be accommodated.

- Reablement is a social care team that provides up to 13 weeks support to enable residents to be supported in any social care needs – i.e. feeling isolated, money management, housing etc. This is a new team, and relatively rare in mental health services. After re-ablement is completed people are subject to a Recovery and Support Plan aimed at avoiding any future mental ill-health episode leading to a crisis situation.

- Maudsley's "place of safety" (sometimes known as the 136 suite) – a dedicated unit open 24/7. Residents who may have an mental illness and who are picked up by the police are taken to this unit rather than A&E.

- AMHP service – a dedicated team who are able to respond immediately to undertake assessment under the Mental Health Act – these assessments may take place in A&E or the Maudsley's place of safety.

- Social care provides an EDT (emergency duty worker – social worker/AMHP) for out of hours. They provide rapid assessment (including AMHP work – Mental Health Act assessments) as well as care planning. EDT and HTT work closely together. There is no evidence that significant numbers of A&E breaches are created by lack of – or response time of – EDT/AMHP.

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