Item No.	Classification: Open	Date: 11 November 2014	Meeting Name: Healthy Communities Scrutiny Sub-Committee
Report title:		Response to recommendations in Access to Health Services in Southwark	
Ward(s) or groups affected:		All	
Cabinet Member:		Councillor Dora Dixon-Fyle, Adult Care, Arts and Culture and Councilor Barrie Hargrove, Public Health, Parks and Leisure	

RECOMMENDATION

Recommendations for the Healthy Communities Scrutiny Sub-Committee

1. That the Healthy Communities Scrutiny Sub-Committee receives this report and notes the evidence in response to recommendations agreed at Cabinet on 16 September 2014

BACKGROUND INFORMATION

2. This supplementary paper is for Cabinet and in response to two recommendations arising from a Cabinet Report of 16 September 2014 namely Response to recommendations in Access to Health Services in Southwark (Health, Adult Social Care, Communities and Citizenship Scrutiny Sub-Committee)

   Its specifically responds to the following recommendations :

   Recommendation 10
   This sub-committee commends the work of the Clinical Commissioning Group (CCG), jointly with the local authority and community services to help people stay home for longer. We would like to see further evidence of the work being done on the frail elderly pathway to ensure that we are offering our residents the best care services.

   Recommendation 11
   The director of adult social care would be happy to arrange a further report for the sub-committee providing more evidence on the work being undertaken across health and social care on the frail elderly pathway. A meeting to discuss the required scope of this report can be arranged by the chair of the sub-committee.

RESPONSE TO RECOMMENDATION 10

3. In Southwark we value older people and recognise the contribution they make to the community. Our policy dictates that we treat every resident as if a part of our family and our Southwark Fairer Futures Promise 10 is to make Southwark “an age friendly borough”. Older people in Southwark are vital to our community, they are the largest group of people that give up their time to volunteer and

assist elderly neighbours, libraries, meals on wheels and local centres. Older people share a vast amount of experience and have a unique opinion on how best we can assist them and they us.

4. Southwark Adult Social Care developed a customer journey for adults to support effective delivery of a range of interventions to support older people in Southwark. The journey had been clearly process mapped and is linked to forms/systems that services use in providing support to people in Southwark. It demonstrates how older people engage with our services (Please see appendix 1).

5. **The Adult Social Care Customer Journey –** The first point of contact for a person will be either the Contact Adult Social Care Team (CASC) based in the community or the hospital team. Our community based team record initial contacts, provide information and advice, small pieces of equipment and take referrals for the Reablement Team and Community Support and Review teams. If appropriate the person calling in is referred to our Reablement team for an assessment of their needs. If eligible the person will receive an up to six week free service to maximise their independence and regain skills that may have been lost. If the person needs further support after this period they will be provided with an indicative budget and will begin support planning. The final support plan once implemented will be reviewed on a regular basis and adjustments made when needed. Please see Appendix 1 for a representation of the journey for an older person.

6. **Statistics**

- 25,000 people aged 65 or over live in Southwark (approx 9% of the population) a smaller proportion compared to London (11.4%) and England (16%).
- By 2025 an additional 5,000 more residents aged 65 and over are projected to live in Southwark, with a larger proportion of people aged 85 and over.
- Currently, 81% of older people living in Southwark are of White ethnicity. The second largest group is Black/Black British (13%). In the future there will be increasing numbers of and an increasing proportion of older people from BAME groups.
- 61% of older people are in social housing
- 43% of older people live alone which creates a challenge around social isolation
- Life expectancy at age 65 for both men and women is higher in Southwark than London or England.
- In March 2014, 934 patients of our local GPs had a formal dementia diagnosis which is thought to be approximately just over 50% of the total number of people who are living with the condition in Southwark.

7. The range of opportunities aimed to support Southwark's frail elderly population include:-

- **Telecare –** Assistive technology within the home to reduce the reliance upon formal services in the community.
- **Centre of Excellence** – a new development is underway as an alternative to current Day Services specialising in dementia support and for those with complex needs. This will be based at Cator Street and will have an extra care facility as part of the same complex.
- **Carers Strategy** – includes supporting carers to have the confidence to support people with long term conditions and frail elderly self care at home. Southwark are providing a multidisciplinary assessment to include the Southwark Resident and their family or carer, and ensuring that the carers needs are met as well as the cared for.
- **Age UK** – Funded by Southwark Council to provide advice and also a number

of one off projects that are preventative in focus i.e SAIL (Safer And Independent Living). They also run a day service that is funded by residents who have a Personal Budget.

- **Metropolitan** – Funded through the BCF (Better Care Fund – NHS monies to support social care to shift provision away from hospitals into the community) to provide a hospital prevention service supporting with support in own home with respect to advocacy and supporting administrative tasks in the home.
- **Riverside** – run a Community and Voluntary Sector service to provide advice and information on all services available within the community.

- **Alzheimer's Society** - are funded by Southwark to provide Dementia Advice and Support Workers that support people with dementia and their families with both practical advise, referral and support.
- **Dulwich helpline -** run a dementia programme and have recently been awarded some additional funding from City Bridge Trust to help promote Southwark as a dementia friendly environment.
- **Dementia Capital Grant -Tower Bridge Care Home** - improving the physical environment of the Tower Bridge care home to make it more dementia friendly. the works were completed in March 2014.
- **Age UK "Stones End" day centre** - renovation to the building to make it a dementia friendly environment.
- **Southwark Dementia Action Alliance –** partnership between the Voluntary Sector, statutory sector, commercial and arts projects in Southwark (includes organisations such as Globe, Milwall as well as CCG, Age UK, Kings, SLAM)
- **Alzheimer's Society** also provide a number of other non commissioned groups, such as singing for the brain. There is also nationally co-ordinated activity going on locally, most notably the roll out of the dementia friends programme.
- **Age UK Southwark –** through their community partnerships initiative are co-ordinating dementia friends sessions through out the borough.
- **Culture and arts** - Dulwich Picture Gallery **-** run a dementia arts group weekly that is being expanded outwards through their arts bus initiative.

RESPONSE TO RECOMMENDATION 11

8. In Southwark, as part of the Health & Wellbeing Strategy to keep people healthy, living at home and away from hospital, Primary Health, Adult Social Care and NHS/CCG are working closely to make access to community and health services as easy and integrated as possible in order to effectively support our frail elderly population.
9. By working together we are providing a responsive service that works to maximize independence and to support people to only use services for as long as they require them.
10. Initiatives are designed to support people in the community, to prevent admissions to hospital and if admitted, then to facilitate safe discharges to reduce length of stay.
11. In Southwark Adult Social Care one key initiative to enable integration with health is SLIC (Southwark and Lambeth Integrated Care). The SLIC program has facilitated a significant amount of integration and joint working between Health and Social care and enables an integrated approach to providing care to the residents of Southwark. We jointly work to identify initiatives and provide integrated services to be proactive and preventative. These initiatives work to support people to be discharged from acute care safely in a timely, and support the frail elderly to maintain their preferred environment for as long as possible. (Please see Appendix 2 for SLIC overview).

12. Southwark Adult Social Care and the CCG are developing a joint policy for the implementation of the National Framework for Continuing Health Care (CHC) in Southwark to ensure older people have access to appropriate health services at the right time.
13. By providing integrated community support (ICS), we are working jointly to ensure that high acuity patients and those complex health population are able to maintain independent living, as opposed to moving into, or receiving ongoing treatment, whether in an institutional or hospital setting.
14. Ways in which this is being provided in a joint approach with health and social care to prevent unnecessary hospital admissions include:
    - **GSTT @Home** – The GSTT @Home service is a multidisciplinary team working within Southwark and Lambeth to provide acute clinical care to residents in their home environment.
    - **Red Cross** – The Red Cross are providing a supported discharge for all those patients that do not have family close by or need extra support in order to go home safely. Nurses and social workers are working together to refer patients to the Red Cross who will assist the patient by providing basic shopping, turn on the heating before they get home, organise key safes and assist the person to settle back into their home life for up to six weeks.
    - **Enhanced Rapid Response** – Provides therapists, nursing and social care support to clients in the community who are at risk of admission to hospital, support consists of hands on care and provision of equipment to avoid unnecessary hospital admissions.
    - **7 day working** – Utilising the Better Care Fund and "Operational Winter Resilience" funding from the NHS, Southwark are currently employing social workers to work within A&E and with the Multidisciplinary teams to provide early intervention, provide admission avoidance and information and advice to Southwark residents and their carers.
    - **Reablement** – Reablement works with people to promote independence in their home environment and can be accessed within the community, or via A&E or if admitted to either acute hospital. The service that provides enhanced care workers who work closely with social workers and occupational therapists to set goals and improve outcomes with the provision of equipment and personalised goals.
    - **Supported Discharge Team** – the Supported Discharge Team is the Southwark Intermediate Care Service that provides rehabilitation in the home environment, to improve independence.
        1. **Double handed care project** – Using Winter Resilience funding, a project to facilitate discharges for those in patients who require double handed therapy and care in their own homes.
15. Other initiatives available in the community for all residents, which enables people to remain at home longer include
    - **Community MDT** – Community based multidisciplinary meeting to discuss residents who require a joined up approach and ensuring sharing of information to provide best outcomes.
    - **Care Home Support Team** – Social Workers working with the GPs and care homes to ensure that those admitted to long term care are supported, and provide a better experience in the home, and reduce hospital admissions.
    - **Step-down Capacity** – using CCG Slippage monies to consider alternatives to remaining in hospital, and providing support required before discharge home.

APPENDICES

No.	Title
Appendix 1	Pictorial representation of customer journey
Appendix 2	SLIC Overview

AUDIT TRAIL

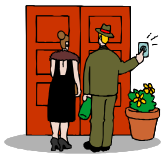
Cabinet Member	Councillor Dora Dixon-Fyle, Adult Care, Arts and Culture and Councilor Barrie Hargrove, Public Health, Parks and Leisure	
Lead Officer	Jay Stickland, Director of Adult Social Care, Children's and Adult's Services	
Report Author	Vanessa Pugh, Interim Head of Older People Services, Children's and Adult's Services	
Version	Final	
Dated	5 November 2014	
Key Decision?	No	
CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer Title	**Comments Sought**	**Comments Included**
Director of Legal Services	No	No
Strategic Director of Finance and Corporate Services	No	No
Cabinet Member	Yes	Yes
Date final report sent to Constitutional Team		5 November 2014

Appendix 1 - Adult Customer Journey

IN

One number to call

Write, Fax or email



Visit our office

Health services

Other services

Children to Adults

Contact Adult Social Care

Initial contacts received,
Equipment issued
Safeguarding
Information and advice
Referrals completed to OT, LD, Community Support
Referral to voluntary sector

Reablement

Maximise independence
Service up to 6 weeks
Equipment provision
Goal Plans
Complete assessments
Provide Indicative budget
Referral for support planning

Community Support And Review

Support planning, personal Budgets
Ongoing management of Support
Review of existing support
Safeguarding

OUT (comes)

Equipment and Support

Keeping people safe

Information and advice

Information and advice

Independence

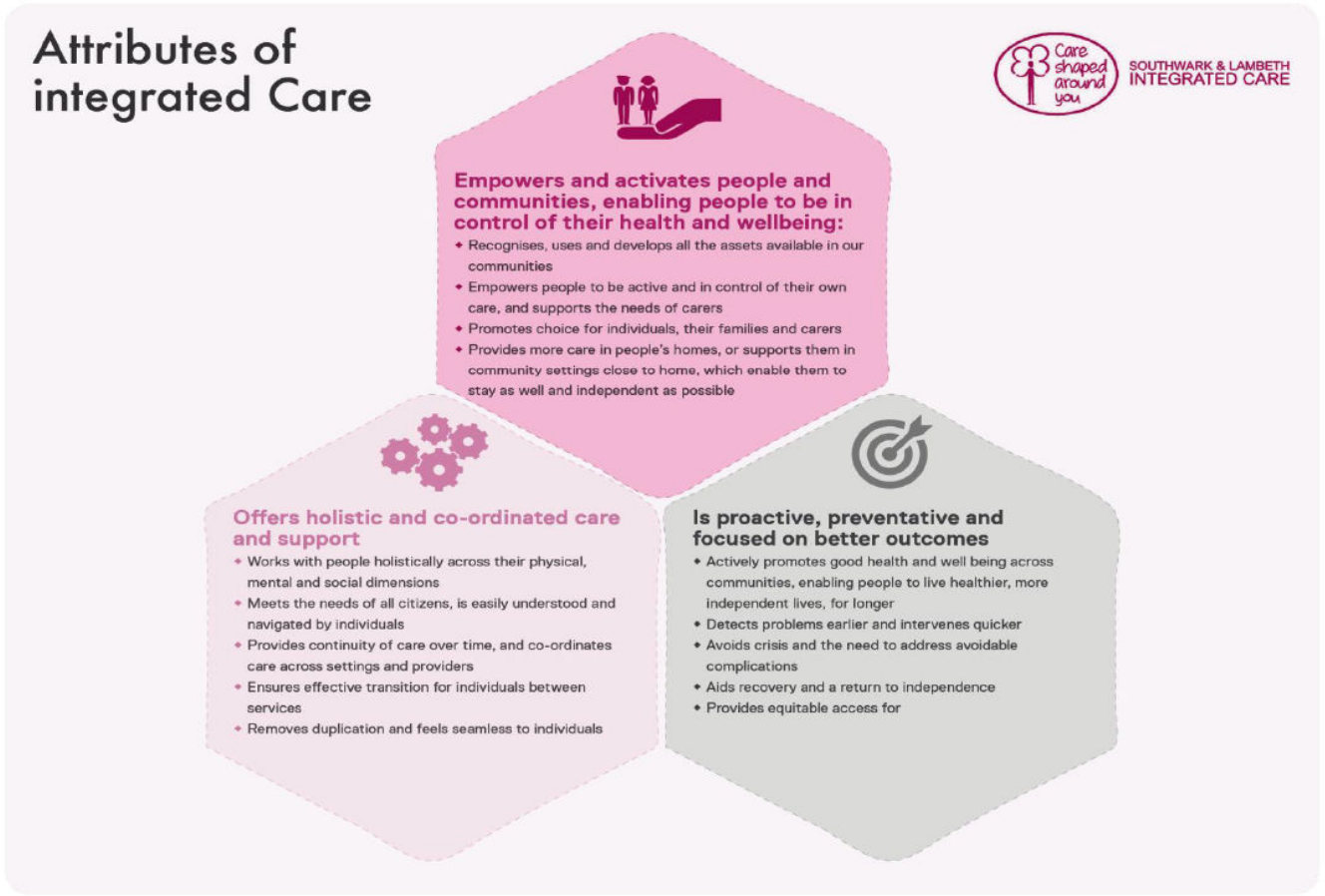
Equipment

Support

Personal Budgets

Appendix 2 – SLIC overview

New services should feel different: people should experience services that are empowering, holistic and preventative



We are all working together to increase the value of care we provide for the people of Lambeth and Southwark

Objectives of high value care

Issues in our current system

Quality

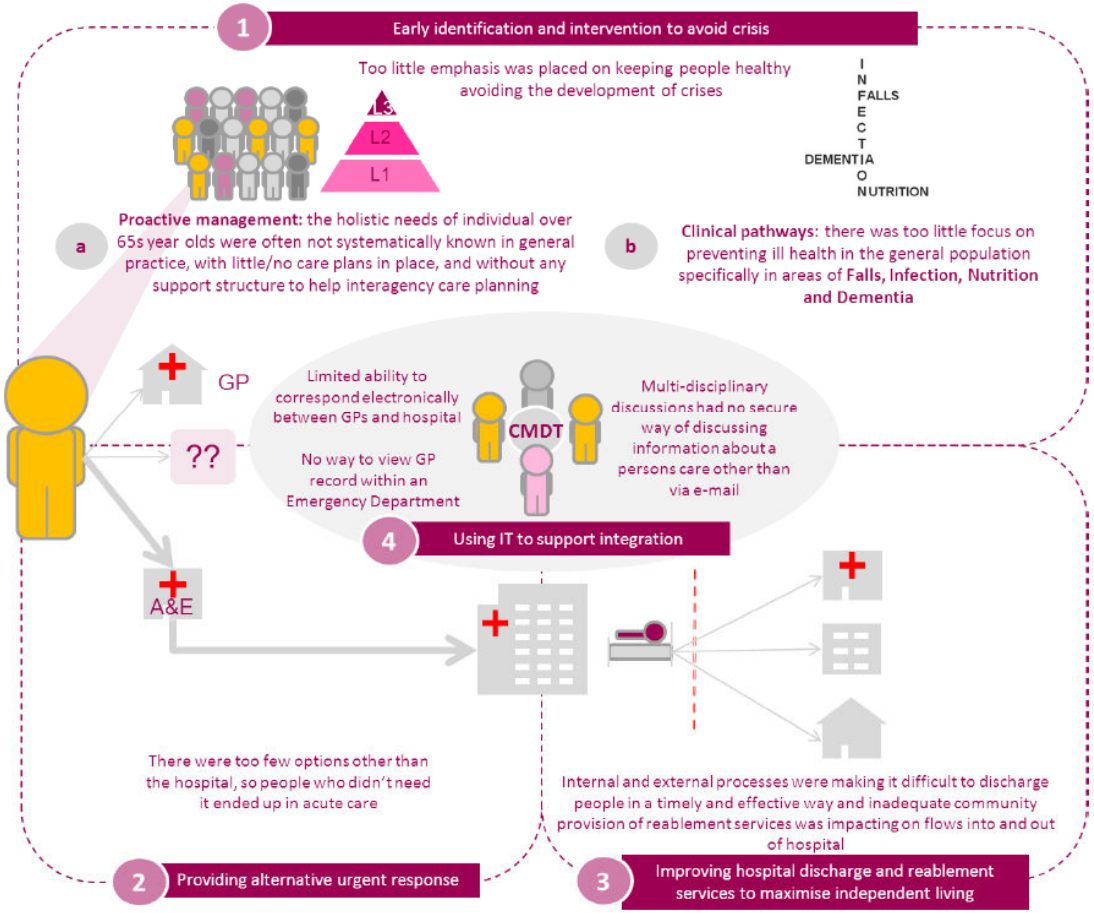
- The care people experience could and should be improved
- Commissioners are now looking to providers to focus on co-producing outcomes with patients through services that feel very different with an emphasis on being preventative, holistic and empowering

Cost

- If we carry on without change they system will go broke
- By working together to deliver preventative and coordinated care we can significantly reduce the gap
- But this will requires a fundamental shift in the way we work both clinically and operationally, underpinned by a new way of contracting with commissioners

Note: details about the analysis of costs is contained within Appendix 3

Our initial focus has been with the frail and elderly: our programme focuses on resolving real challenges for the system…



Anticipated benefits

By 2015/16:

Bed Reduction
(through reduced admissions & LOS)

- 23,500 bed days saved
- Equates to 32 beds for each acute

Social Care Reduction

- 20% reduction in residential packages
- Equates to 133 less packages of care

Improved patient experience

.....Working together for healthier and happier lives