Committee: Healthier Communities and Older People overview and scrutiny panel

Date: 25th June 2018

Wards: All

Subject: Adult Social Care - Department update and current priorities

Lead officer: John Morgan, Assistant Director – Adult Social Care; Community & Housing

Lead member: Cllr Tobin Byers – Cabinet Member for Adult Social Care and Health

Contact officer: Phil Howell – Interim Head of Adult Social Care; Community & Housing

Recommendations:

1. That members discuss and comment on the report and the progress made against key strategic and operational priorities in Adult Social Care

1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1. The purpose of the report is to provide the panel with an overview of Adult Social Care in Merton, including an overview of the work of the department and key issues, challenges and priorities for the year ahead.

1.2. This report provides an update on key activities of the department including:

- Merton Health and Care Together
- Delayed Transfer of Care performance
- ADASS Peer Review

2 DETAILS

The national and local context & challenges

2.1. The challenges for our department, in the context of integration and the sustained restraint on public sector spending, the ongoing parallel pressures on health services, the fragility of the market and pressure on market providers are well documented and recognised nationally. The numbers of Merton residents with risk factors for long term conditions, and the inequalities in health risks and health outcomes; the pressures in providing adult social care to an ageing population with more complex needs; the increased complexity and cost of meeting the needs of disabled adults; the rising cost of property and rent; the shortage of suitable and affordable homes; the availability of suitable temporary accommodation for homeless households in borough; and the impact of welfare reform impacting on homelessness, are all significant challenges to our operating model.

2.2. Long term demographics have two complementary trends at work:

- The demographic bulge of the ‘baby boomer’ generation, who are now reaching retirement in the first decades of the 21st Century; and

- The increasing longevity of that population, with life expectancy at birth now 79.5 years for men and 83.1 for women.

2.3. As a consequence, the population aged 75 and over is projected to double in the next 30 years and the number of people over 85 in the UK is predicted to more than double in the next 23 years. As the population ages, it is predicted that by 2030 there will be:

- 45% more people living with diabetes
- 50% more people living with arthritis, coronary heart disease or stroke
- 80% more people living with dementia

2.4. These population trends have important, well-reported, impacts on health and care demand as well as adding complexities to public space, housing and service design. They have been exacerbated by related trends in working-age disability, with more disabled people surviving longer and the costs of their support increasing. As a result, social care for people of working age now costs local authorities as much as that of older people. In addition, these trends increase the demands on the health & care workforces. With the working age population shrinking relative to the older population, there is a significant workforce supply risk.

2.5. These trends have played out at a time of public spending austerity, with falling real-terms public spending on social care in particular; 11% in real terms between 2009/10 and 2015/16.

2.6. Our three strategic priorities are

- **Demand management** – making best use of the available resource to manage demand. Ensuring prevention and early intervention is at the heart of what we do; delaying, avoiding and reducing the need for more intensive interventions. Integrating with health through the Merton Health & Care Together programme. Managing demand through better use of digital channels, self-service and self-management. Ensuring our pathways are defined and there is ease of access for borough residents. For services where we are seeking to increase demand (e.g. libraries and adult learning) we will work collectively to promote prevention and wellbeing to try and minimise residents from requiring high cost support.

- **Market capacity & capability** – ensuring we have a well-managed, sustainable and capable health and care market in all our commissioned services. That the market has both sufficiency of supply (including workforce) and the diversity of service provision to meet with people's expectations for community based leisure, training, learning, volunteering and employment. That there is a range of suitable and decent accommodation available in the borough. Ensuring we work with statutory partners and regulators to ensure Merton has safe services and high performing providers serving our residents; and we work collaboratively with other boroughs and partners to maximise our procurement strength.

- **Commissioning** – developing our departmental commissioning function to ensure that we have the internal capacity and capability to work effectively with external partners and ensure an appropriate, sufficient and diverse supply of

good quality services, ensure that we proactively quality assure and performance monitor providers and that we manage provider failure procedures effectively. Our commissioning activity will be well planned, based on available evidence and data and outcomes focused. Our commissioning activity will make best use of all the available resources, across the whole system, to achieve the best outcomes for residents of Merton and ensure we have skilled teams who deliver excellent outcomes through contract management processes.

2.7. The Care Act's (2014) ambition of integration is supported by legislation that asks local authorities to work closely with health partners wherever sensible to do so. The Care Act combined, replaced and overhauled substantial amounts of previous legislation and with it, brought a range of new duties. New duties in relation to assessment against national eligibility criteria, irrespective of the person's ability to pay and their current care and support situation means the threshold for assessment is substantially lowered, as it is for carers, who are no longer identified as someone providing 'substantial' care to another. There are a range of duties in relation to wellbeing and prevention and new duties for commissioning with regards Market Shaping and sustainability.

2.8. The department, in line with the rest of the council, has a challenging set of savings targets to achieve over the next four years in order to balance the budget as the money the council received from central Government continues to decrease. This means we having to take difficult decisions. The principles we will apply to this task are:

- maintaining focus on delivery of our statutory functions;
- seeking longer term sustainable solutions, rather than pursuing short term savings that generate longer term costs;
- community and Housing working together to deliver safe and effective services that meet the needs of residents of the borough.

2.9. The future funding of Adult Social Care is under review. The timing of the future funding of Adult Social Care is tied to the upcoming Green Paper (due in July), the Government's integration agenda and potentially the future funding of the NHS. In the mean time we have to plan on the basis of what is known, and assume that that there will be no additional resources for Adult Social Care.

Overview of department activity and performance

2.10. Figures from our annual statutory return show that during 2017/18 Merton provided 2,385 people in Long Term Support. This included 423 aged 18-64 with a learning disability, 288 aged 18-64 with a physical disability, 76 aged 18-64 with Mental Health or Substance Misuse support, 20 aged 18-64 with other support reasons and 1,578 older people. Overall 75% of our customers aged 18+ were supported in the community.

2.11. Merton offered 3,122 long term services to customers aged 18+ during 2017-18. 259 were supported in long term Nursing Care, and 355 in long term Residential Care, 1,200 received domiciliary care services and 551 were in receipt of a Direct Payment. A further 757 received other types of community based services.

2.12. The reablement outcome monitoring trend data for April to March 2018 showed that on average around 73% were reabled and 27% went onto receive long term support. In July 2017 we analysed the reablement outcome data manually and it suggested that of those customers who went onto receive long term support their reablement episode had been partially successful in maintaining or increasing independence.

Merton Health & Care Together Programme

2.13. In 2014, the NHS published its Five Year Forward View. This document promoted integrated care, describing how the delivery of NHS services was to be redesigned through new models of care that dismantled traditional organisational boundaries – such as those between the NHS and social care, or between community care and hospital services. These models of care provide a way of improving quality while making the whole system more efficient. How this will work in practice will vary across the country. Merton is pursuing the Multispecialty Community Provider (MCP) model, in which GPs, social care and other community based health practitioners (e.g. district nurses, pharmacists) work together to provide most out-of-hospital care for a registered list of patients, with a delegated responsibility for managing the health service budget for their registered patients. This programme of work is progressing as the Merton Health & Care Together Programme.

2.14. The vision of the programme of work is "*working together, to provide a truly joined up, high quality, sustainable, modern and accessible wellbeing system for all people and partners of Merton, enabling them to start well, live well and age well"*. A programme board has been established with a representation across health and social care and further details of the programme of work will emerge through reports to the Health and Wellbeing Board and overview and scrutiny routes.

2.15. There are specific work streams that involve Adult Social Care and these predominantly focus on delivering more joined up front line care and support to individuals. We are involved in the development of Integrated Locality Teams based around 4 newly formed clusters of GP surgeries across the borough. The teams will focus on a defined population of patients and coordinate better care and support that works proactively with the individual in order to avoid unnecessary attendance at and admission to hospitals. It also aims to support and maintain independent living at home.

2.16. Adult Social Care will also be playing a key role in the work around integrated intermediate care. This supports timely discharge from hospital and supports people to remain at home successfully, following a stay in hospital. This work is about putting the right services in place and coordinating the response across health, social care and housing. We trialled some of this work in the winter months of 2017/18 and it proved hugely successful. We now have further work to join up our services with community health rehabilitation and therapies and focus on avoidable admission by supporting people in their community and at the hospital Emergency Department.

Delayed Transfer of Care performance

2.17. The Care Act updates and re-enacts the provisions of the Community Care (Delayed Discharges etc.) Act 2003, which set out how the NHS and local authorities should work together to minimise delayed discharges of NHS hospital patients from acute care. The NHS is still required to notify relevant

local authorities of a patient's likely need for care and support and (where appropriate) carer's support, where the patient is unlikely to be safely discharged from hospital without arrangements for such support being put in place first (an assessment notice). The NHS also has to give at least 24 hours' notice of when it intends to discharge the patient (a discharge notice).

2.18. A delayed transfer of care (DToC) from acute or non-acute (including community and mental health) care occurs when a patient is ready to depart from such care and is still occupying a bed.

2.19. A patient is ready for transfer when:

a. A clinical decision has been made that patient is ready for transfer and;
b. A multi-disciplinary team decision has been made that the patient is ready for transfer and;
c. The patient is safe to discharge/transfer.

2.20. A multi-disciplinary team (MTD) in this context is made up of people from different professions, including social workers where appropriate, with the skills and expertise to address the patient's on-going health and social care needs. If there is any concern that a delay has been caused by the actions or inactions of a local authority, they should be represented in the MDT. Delayed discharge can occur for a number of reasons. Waits for appropriate support can be for helath, social care and housing reasons. The way that the team is organised and functions is fundamental to timely discharge and to the patient's wellbeing.

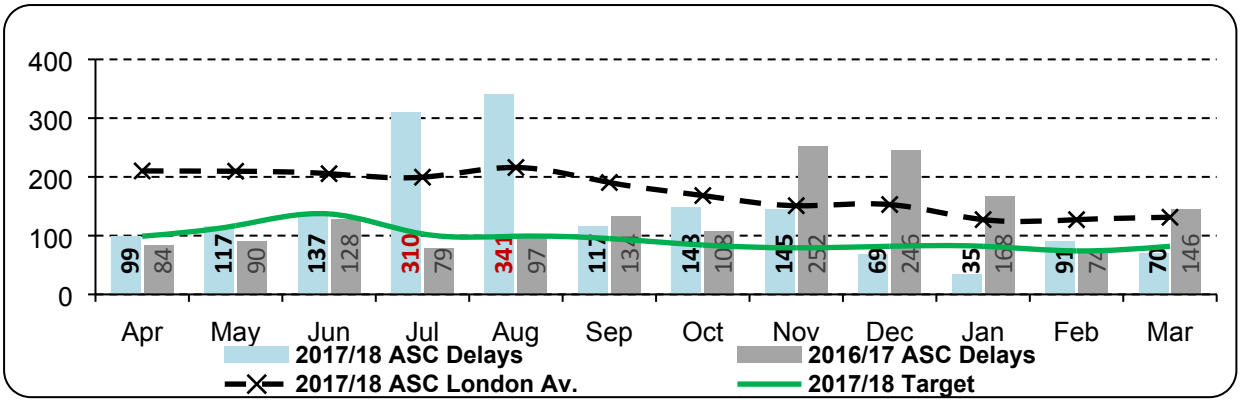
2.21. 'Medical optimisation' is the point at which care and assessment can safely be continued in a non-acute setting. It is a decision that balances the acute care requirements of the patient, the typical desire of individuals to return to their home environment at the earliest opportunity, the potential harm associated with staying in hospital and the needs of other more acutely ill patients.

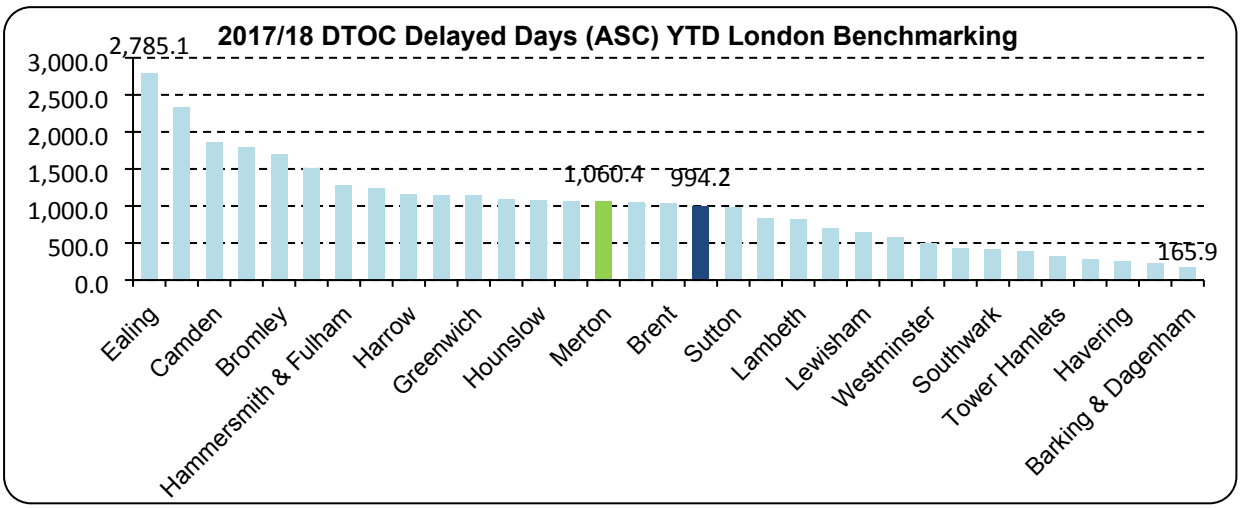
2.22. Too often, early discharge is seen as 'freeing up a bed' rather than acting in a patient's best interests to move them swiftly to a safer, more familiar environment that will encourage supported self-management, speed recuperation and recovery, and have them feel better.

2.23. Individuals may still have on-going care and assessment needs (e.g. therapy or social care assessment), but these needs can often be and should be met in the community.

2.24. The following graph shows Merton's' performance over the last financial year, and benchmarks our performance against the London average.

2.25. Tables 1&2: 2017/18 Monthly snapshot - DTOC (ASC) Total Delayed Days & London Benchmarking





2.26. It is worth noting that, although the annual average for Merton was above the London average, this is due to having to recover a position of comparatively poor performance in the second quarter of 2017/18. The Council did seek clarity on the data submitted by the acute trusts for these months. It is worth noting that DToC is counted in terms of days, rather than people, meaning that one or two complex discharge processes can cause a spike in the data. In the Final quarter of the year the department had managed to turn that performance around to being the best performing council in London. This pattern of performance has continued into the first months of 2018/19 and we continue to show very few DToC days that are attributable to Adult Social Care.

2.27. Ahead of the winter period we worked hard with health colleagues in the community and the acute trust to develop our relationships and joint working. Daily and weekly meetings of clinicians and professionals were initiated to help facilitate better discharge. We also initiated discharge to assess processes which meant that the person could return home or to an alternative community based bed and assessments are undertaken in this setting, rather than the hospital, to determine the longer term care and support needs of the individual.

2.28. A ‘handy person’ service was also commissioned to ensure minor aids, home adaptations, telecare equipment and key safes could all be installed quickly and in a timely manner. They also made manual adjustments for example, relocating bedroom furniture to the downstairs; meaning that, often, a person could return home where before the environment may have been deemed unsuitable or presented substantial risk.

2.29. Maintaining and continuing to improve our DToC performance is a key target and measure in several programmes of work including the Better Care Fund and Improved Better Care Fund delivery and the Merton Health and Care Together Programme.

ADASS Peer Review

2.30. In February 2018 Community and Housing hosted a peer review of Commissioning. This process is a chance to stop & reflect and forms part of London ADASS Quality Assurance process and acts as an alternative to inspection, as Adult Social Care departments are not subject to statutory regulation in the way that Children's' services are with Ofsted and CQC. The process gives a choice of 3 themes: safeguarding, Commissioning and Use of Resources.

2.31. The process involves an onsite visit by a team of reviewers, formed by colleagues from other local authorities who have significant experience and expertise in the chosen field for review, in Merton's case: Commissioning.

2.32. Commissioning is the strategic planning and delivery of services that make best use of our resources and the focus will be about how we work better with our partners including public health, the CCG and other agencies within a 'whole system' to plan for the future and utilise our resources to improve outcomes for our customers.

2.33. Good commissioning starts from an understanding that people using services, and their carers and communities, are experts in their own lives and are therefore essential partners in the design and development of services. Good commissioning creates meaningful opportunities for the leadership and engagement of people, including carers and the wider community, in decisions that impact on the use of resources and the shape of local services

2.34. The 'exam question' we set ourselves, and that we asked the peers to review was '"How well placed is community & housing to meet its statutory duties and the challenges ahead through its approach to commissioning services?"

2.35. The review team spent two days examining our processes, partnerships, funding and engagement arrangements through direct observation, meetings with key stakeholders and partners and by attending meetings that we hold as part of our business as usual. On the third day of the review the reviewers coordinate their observations into feedback and presented this to senior managers within the Council, elected members and our partners.

2.36. This is a summary of their findings:

- The team found Merton and partners open and welcoming
- Staff teams are working hard, are well intentioned, knowledgeable and committed
- There is insight into most issues providing a platform to build on and we hope this review will help Merton move forward

- There is effective Member and partner engagement which is a great opportunity to co-produce the Merton Way for the wellbeing of residents
- In the spirit of self directed improvement the team attempted to identify good practice as well as areas for reflection which may suggest ways for improvement
- Partners and stakeholders praised staff
- There are examples of joint working: Joint Intelligence Group with CQC, CCG and Merton Seniors Forum where provider issues are shared; Inclusion of voluntary sector in quality monitoring; Volunteering – strong recruitment & retention

2.37. The review team also identified areas for development and we are considering these in developing our options for a Community & Housing Commissioning Function, which includes Adult Social Care, moving forward:

2.38. The opportunity to develop a clear commissioning vision, strategy and action plan based on a thorough understanding of demand and need. Bringing together commissioning resources to work across the Directorate, with a close interface with corporate procurement, so that the commissioning team are able to continue to fulfil market shaping duties;

2.39. Using resources across the Directorate with a focus on prevention & wellbeing. Develop a shared narrative for Merton, leading to an outcomes framework for population groups and marrying up intentions and resources with the CCG; and

2.40. Continue to develop consistent and structured engagement with providers and stakeholders, including regular provider forum(s). Encourage providers to be active in maturing the market. Further developing our proactive approaches to quality and contract monitoring.

3 ALTERNATIVE OPTIONS

3.1. n/a

4 CONSULTATION UNDERTAKEN OR PROPOSED

4.1. There will be a full communications and engagement plan drawn up for the Merton Health & Care Together Programme and this will define the strategy for involving stakeholders throughout the programme of work.

4.2. In redesigning processes and pathways, Adult Social Care will look to engage where necessary with stakeholders and will also undertake an consultation, statutory or otherwise, where ever it is deemed necessary.

5 TIMETABLE

5.1. n/a

6 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

6.1. Adult Services ended 2017/18 with a £656k overspend, compared to a £909k overspend forecast in December 2017. At time of writing, we do not

have the results of the first budget monitoring round, but the draft view looks like a stable position.

6.2. ASC has £1.5m of savings to make in 2018/19. These are previously agreed savings and no new savings have been added to 2018/19 requirements. As at the end of May, £575k had already been achieved, and so the service is on track. One saving in relation to day service transport requires more work and is unlikely to be achieved this year.

6.3. The future funding off Adult Social Care is under review nationally and we are expecting a Green Paper in the summer. Equally the Better Care Fund is coming to an end in 28/19 and as yet future arrangements are unclear.

7 LEGAL AND STATUTORY IMPLICATIONS

7.1 The services of the department are covered by a wide range of specific and general legislation and regulations. The primary responsibilities are set out below. However, there are a myriad of additional regulations, such as the Choice Directive which sets out the right of people going into residential care to have a choice about where they live.

7.2 Adult Social Care core legislation is the Care Act 2014, which sets out a number of core duties in relation to people 18 years and older who have an eligible social care need. These include:

- Assessing need, producing support plans and commissioning or providing services to adults over 18 years old
- Promoting people's wellbeing
- Safeguarding vulnerable adults
- Providing advice and information to everyone;
- Ensuring that people have access to financial advice and to advocacy;
- Overseeing the local care market including mitigating any provider failure

7.3 In regulations, national policy and some funding streams there is a presumption of increasing integration with health services where possible. Although there is no prescribed model, there are three forms being pursued nationally. Merton is pursuing a Merton Care & Health model that meets local needs.

7.4 Other key legislation includes the Mental Capacity Act 2005, which sets out people's rights to make decisions for themselves and the process to be followed when a person lacks capacity to make a particular decision. The Act importantly sets out that a person's capacity relates to each decision and cannot be a generic assessment. The Deprivation of Liberty Safeguards (2010) set out the rules around restrictions placed on people in health or care settings.

7.5 Direct Provision is subject to regulation and inspection by the Care Quality Commission, as are the integrated Learning Disability, the Reablement team and Mental Health teams. Other ASC functions can be subject to CQC inspection, but this is now by exception.

8 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

8.1. There are no direct implications of this report as it is intended as an update paper. In general terms, Adult Social Care services are provided to and meet the needs of adults who would be considered protected under the protected characteristics of the equalities act, in the main – disabilities and age related. Several other protected characteristics would also be considered dependent on the decisions being taken.

8.2. As a department we are committed to upholding the human rights of our residents and to considering the impact on community cohesion with regards the delivery of our statutory functions.

9 CRIME AND DISORDER IMPLICATIONS

9.1. n/a

10 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

10.1. n/a

11 APPENDICES – THE FOLLOWING DOCUMENTS ARE TO BE PUBLISHED WITH THIS REPORT AND FORM PART OF THE REPORT

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12 BACKGROUND PAPERS

12.1.