Committee: Healthier Communities and Older People overview and scrutiny panel

Date:

Wards: All

Subject: Enabling Older People to live independently at home.

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

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

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Recommendations:

1. That members note the report and the range of programmes that support older people to live independently at home.

1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1. This paper sets out the strategic approach taken by Community & Housing and the role it plays as a Council department in helping people maintain independence. The paper is in response to the scrutiny panel's recognition that 'many people prefer to receive support in their own home rather than be placed in residential care when they become vulnerable'.

1.2. The paper sets out the philosophy and strategic intent that the department has in relation to its statutory duties for prevention and wellbeing. It sets out how maintaining and maximising individual independence is supported by a range of departmental activity and services provided by or commissioned by the council. The paper also sets out how the department works with its statutory partners to further the aim and ambition that all vulnerable adults should be able to lead independent lives in Merton for as long as possible, and to the extent they are able to and want to.

1.3. The paper is for information. There are no formal recommendations.

2 DETAILS

2.1. National and local legislation and policy context

2.1.1 In recent years a wide range of new legislation and policy has shaped the departments' service development and its wider partnership working with the health, care and housing system locally. The Care Act 2014, The Homelessness Reduction Act 2017, The NHS 10 year forward view have all focused on prevention, early intervention and joint working to reduce demand on statutory services. It is expected that the anticipated Green Paper on Adult Social Care long term funding will also refer to the prevention agenda, in the context that with increased demographic pressure comes growing demand for

services and to provide the same model of support to more people will not be possible in the challenging financial climate the system operates within.

2.1.2 Collectively the ambition of our newly refreshed Target Operating Model is that we will; work together to provide leadership and vision for our services, enabling our customers to live better, healthier and more independent lives, enabling improved life chances, whether through learning and information, having a place to live, or for older / disabled people living as independent a life as possible.

2.1.3 Through the services the department provides, we aim to increase our service users best possible life chances from transitioning young adults in to our services, through to older residents, enabling them to help themselves where possible to build their capacity, resilience and independence. We will also maximise our use of libraries and our learning services to assist people to live as independently as possible and to improve their life chances. This means, where an adult is identified as vulnerable or has potential to be, we aim to prevent this from arising or reduce the risk associated with vulnerability.

2.1.4 The department is responsible for commissioning, providing and discharging a range of statutory functions that contribute to the health and physical, mental and economic wellbeing of the residents of Merton. We commission public health services including those that support older people to lead healthy lifestyles living and work with colleagues in Merton CCG on programmes such as social prescribing which aims to connect residents to preventive services. We also commission adult learning programmes, housing, housing related support, supported and temporary accommodation, accommodation with care and support and community based care and support services for vulnerable adults.

2.1.5 We commission and provide information advice and guidance, signposting and early intervention, services that prevent, delay and reduce further need for statutory services and services aimed at rehabilitating and returning people to independent living in the tenure of their choice. We provide community facilities, libraries, social spaces and dedicated accessible spaces for people to live, learn, contribute to their community, develop skills and maximise their independence. We provide statutory assessment, support planning and service delivery functions across housing and adult social care and in partnership with local health services.

2.1.6 The Care Act 2014 introduced statutory duties in relation to prevention and wellbeing and made it explicit that these duties were relevant to the whole local population, not just those with a need for adult social care. The Act describes the local authority duty in relation to prevention as follows: ‘a local authority must provide or arrange for services, facilities or resources, which would prevent, delay or reduce an individual’s need for care and support or the need for support of carers’.

2.1.7 Following the statutory guidance, we facilitate a whole community approach across Merton to improving wellbeing, maximising independence and helping people live the fullest life possible. Creative and innovative solutions, which draw upon family and community networks, enable people to stay independent for longer. The department as a whole can draw upon many assets and services to support this.

2.1.8 The community libraries are an example of a place where people can find out more about what is going on in their community, they can engage in social activities and research their own support requirements. In December 2016 the DCMS published, 'Libraries Deliver: Ambition for Public Libraries in England 2016 – 2021' that sets out the government's 5-year strategy to public libraries. Key to this is the term 'Libraries First' that urges local authorities to maximise how they use their libraries to address cross cutting issues.

2.1.9 Housing services commissions Housing Related Support, which aims to help people maintain their tenancy independently. Typically, this can include how to maximize benefits, some of which may be specifically aimed at independence, for example mobility allowances. It also includes advice on how to manage a household budget and maintain the home. In April 2018 the Homelessness Reduction Act became law. This puts additional responsibilities on councils to prevent statutory homelessness. It is known that issues of tenancy sustainment can lead to a higher likelihood of social care needs and can impact on and limit the ability to live independently in the community.

2.1.10 Occupational Therapy, sometimes in conjunction with the Disability Facilities Grant application process, can advise on aids and adaptations that make everyday living more manageable and enable people to do things for themselves instead of reliance on others. There is a broad spectrum of equipment, aids and adaptations available from a simple grab rail to enable someone to get in and out of the bath, to the installation of a wet room shower facility where someone is unable to use the bath in their upstairs bathroom.

2.1.11 The department has just completed its recommissioning of the Wellbeing Programme of community grants. These grants, previously known as the Ageing Well Programme, now have an extended remit across all age groups and needs. They ensure valuable community and voluntary resources in relation to information, advice, guidance and early intervention for people who need that little bit of support to live their life, be it from time to time or on a more regular basis. Funding has also been granted to several organisations in the borough who provide lunch clubs. These extremely valuable, community based activities bring people together on a regular weekly basis to socialize, engage with other services and their community generally. They currently provide over 2000 meals collectively every week. Community and Housing is currently undertaking a comprehensive review of lunch clubs to ensure their long-term sustainability in the borough.

2.2. <u>The economic value of maintaining and maximizing independence</u>

2.2.1 To prevent, reduce or delay the need for formal services makes economic sense to the department as this means that, over the life course, individuals rely less on formal, often costlier, care services. By focusing on enabling people to do things for themselves by building new and strengthening existing networks and partnerships across the community. Providing a greater focus on prevention, early intervention and support for self-care; through promoting and encouraging self-management at the earliest opportunity; prevents social care needs from escalating wherever possible, ensuring a financially sustainable service.

2.2.2 It is not only Community & Housing specifically and the Council generally that benefits from this approach, there are cost savings to the wider 'whole system' of health and social care in Merton. People who are able to live independently, manage their own long-term conditions and rely on strong networks of community, friends and family will generally rely less on the NHS and Adult Social Care. This means fewer GP visits, less input from primary and secondary care, fewer attendances and admissions at acute hospital services. As well as better physical health, there is also a likelihood of better mental health that also brings whole system cost savings.

2.2.3 Merton Health and Care Together is a programme of work jointly agreed between the Council and Merton CCG. It aims to use the vehicle of health and social care integration to achieve better outcomes for residents of Merton. Cutting across the three work streams of Start Well, Live Well & Age Well is the philosophy of prevention and early intervention. The programme will build on the respective work of partners to bring about a more coordinated prevention offer that focuses the whole system on independent living, in good health. It also aims to develop the models of community based health and social care that mean more people are able to live in their own homes, for longer, with the right support wrapped around them. The economic argument is that providing joined up holistic, person centred health and social care services through primary and secondary care in the community is more cost effective than the current reactive system of disjointed working in response to over demand for acute, hospital-based care.

2.3. <u>Preventing or recovering from a crisis</u>

2.3.1 As a department, we recognise that decline in independence is not always a predictable, progressive process. It is often the case that people experience crisis which temporarily impacts on or limits their ability to continue to live an independent life. A period of ill health, non-elective admission to hospital for example following a stroke, a fall at home or other such sudden changes in a person's circumstances can have an instant impact.

2.3.2 In these situations, is it in everyone's interests to wrap support around an individual with the aim of maintaining and regaining independence. This is known as rehabilitation and reablement. Adult social care directly provides a reablement service to people who have reduced, limited or lost some of their independent living skills with the sole aim of supporting them to regain and recover these. The service supports up to 50 people at any one time and demonstrates significant results with over 65% of individuals referred requiring no further care and support upon discharge from the service. A further 25% of people will require less care and support on completion of reablement, compared with when they started with the service.

2.3.3 The service works closely with health colleagues who provide rehabilitation services, such as physiotherapists, nurses and occupational therapists. This means the individual gets a holistic service that addresses all aspects of their functioning and their ability to remain living at home and independently in the community. We are currently undertaking work, through the Merton Health and Care Together Age Well work stream, to integrate rehab and reablement into a single pathway and service. This will require joint working and development with our community health provider colleagues, Central London

Community Healthcare NHS Trust (CLCH). The services will aim to ensure joined up support to people being discharged from hospital, so that they can go home in a timely way and get back to their normal way of life. The services will also work closely with GP practices and what are known as 'Integrated Locality Teams', teams of different professional disciplines who work together to manage complex care and support needs in the community and avoid unnecessary or avoidable attendance and admission at hospitals.

2.4. Providing formal care at home

2.4.1 Prevention, early and crisis intervention services are all aimed at reducing, delaying or removing the need for more formal care and support. Under the Care Act assessment begins when we begin discussing an individual's needs. However, the process of assessment allows us to 'pause' to consider these options before continuing to formally assess, using the national eligibility criteria. Where an individual meets this criteria, they are entitled to a personal budget to address needs that cannot be addressed through other informal arrangements, services or supports. It is very often the case that the individual wish is to remain living at home. This is also the preference of the department, though we recognise there are always cases where the individual circumstances, complexity of care need and general safety of an individual would compromise the ability to remain living at home. It is these cases that decisions; whether made by those with capacity or made on behalf of them as a best interest decision under the Mental Capacity Act; are made in relation to admission to residential and nursing care homes.

2.4.2 There are well developed alternatives to care homes in Merton. Many are well served and have sufficient supply and others are under development or expanding. Domiciliary care is the provision of care and support for personal care and other aspects of daily living, in a person's own home. In a similar way to care homes, it is an activity regulated by the CQC, provided in the community. In Merton there are over 30 providers providing in excess of 7100 hours a week to 580 individuals on behalf of the local authority. Extra Care Housing is a model of accommodation with support where there is a general separation between the landlord and the care provider. Someone who lives in Extra Care Housing typically will have an amount of care and support need when they move there. The person owns a self-contained flat or rents the property from the scheme landlord. The care and support is provided by a CQC registered provider who is onsite 24/7. There are often additional services available to the individual, provided by the landlord. These may include day time activities, restaurants and coffee shops and support to maintain the home and garden. In Merton, we have two Extra Care Housing schemes where the council has nomination rights to offer people a tenancy. This often proves to be a long term alternative to residential care, due to the ability of the care and support package to develop alongside any deterioration in the individual's functioning, whilst ensuring they do not need to move home or consider selling their home and move into a care home.

2.4.3 The number of older people in residential and nursing care has gradually decreased over a number of years. In the last year this has shown further reductions as more people choose to and are supported to live at home with support to retain as much independence as possible.

Other related services

2.5. Falls Prevention and 'Active Ageing'.

2.5.1 Falls can seriously impact an older person's quality of life, such as reducing mobility or the ability to maintain independence in the family home. They can also reduce an older person's confidence, such as the ability to go to the shops or to meet up with friends, potentially creating issues around loneliness and social isolation. Serious falls can also have significant economic impact to both health and social care budgets, for example if a person needs to move into a care home after a fall.

2.5.2 Public Health part funds a Falls Prevention Service with Merton Clinical Commissioning Group, that supports people who have fallen or are at risk of falls. Public Health also support an innovative London Fire Brigade pilot in Merton, 'Fire, safe and well' which provides health interventions as part of fire safety visits to people's homes. Fire Service personnel will ask residents a number of questions regarding risk of falls and can then, if appropriate, make a forward referral to the Falls Prevention Service.

2.5.3 Being physically active, including regular strength and balance activities is an important element to keep people independent in their own homes for longer. Recent work has included research to understand perceptions, existing provision, barriers and opportunities around active ageing in Merton with an aim to encourage a step change in the number of older people engaged in physical activity.

2.6. Merton's Dementia Hub and Community Dementia services

2.6.1 Public Health have also worked collaboratively with Adult Social Care to commission community dementia services. Based at Merton's Dementia Hub in Mitcham this provides a range of health, care and community and leisure services in one location. The aim of the hub is to bring together health and social care services, advice, information & support and a wide range of activities that support people with dementia and their carers, all in one space.

2.6.2 Wider engagement and services are also provided across the Borough, including through a network of monthly 'dementia cafés'. Community dementia services aims to keep people with dementia and their carers living in their own homes and independent for longer. The hub offers a range of services to people with dementia and their carers/families. Of note is the START programme, an educational and therapeutic training programme for carers of people with dementia, which aims to address the challenges they face. University College London has evaluated the programme finding it reduced depression and anxiety in family carers and improved quality of life both in the short term (8 months) and long term (2 years).

2.7. Dementia Friendly Merton

2.7.1 In July 2018 Merton became a 'dementia friendly community', receiving 'working towards' status from the Alzheimer's Society. This award

acknowledges the work that local partners have taken to improve the quality of life of people with dementia and their carers in Merton whilst recognising there is always more to do. Creating a dementia friendly community can be seen as part of our wider prevention model as it is about supporting people with dementia and their carers to live independent lives for as long as possible.

2.7.2 We know that two thirds of people in Merton with dementia live in their own homes, a third of whom live on their own. Where our local shops, banks or services are 'dementia friendly' they allow people with dementia and their carers to better navigate their communities, gain the support they need or continue to do the day to day things that allow them to live independently. A GP surgery may make sure reminder phone calls are provided to people with dementia who forgot their appointment, the local supermarket may have a 'slow lane' that allows people to take their time at a checkout whilst the local sport centre may offer dementia inclusive swimming sessions.

2.8. Tackling isolation and loneliness

2.8.1 Feeling socially connected to others is just as important to our health and wellbeing as a well-balanced diet or exercise and older people are at greater risk of loneliness and isolation.

Public Health commission a befriending service for older people who are isolated; those who live alone, are recently bereaved, are housebound or have a long-term condition. The service, delivered by Age UK Merton, matches volunteers to clients to provide weekly befriending based on shared interests. Weekly befriending work further encourages greater connectivity, such as attending group events as well as appropriate physical activity, such as walking.

3 ALTERNATIVE OPTIONS

3.1. n/a

4 CONSULTATION UNDERTAKEN OR PROPOSED

5 TIMETABLE

5.1. n/a

6 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

7 LEGAL AND STATUTORY IMPLICATIONS

7.1

7.2

8 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

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.