Committee: Council

Date: 15 April 2015

Agenda item:

Wards: All

Subject: Strategic Objective Review - Older People

Lead officer: Simon Williams

Lead member: Cllr Caroline Cooper-Marbiah

Forward Plan reference number: N/A

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Recommendations:

A That Council consider the content of the report

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 To provide a strategic overview of the council's progress in meeting the needs of older people in Merton.

1.2 The report details the changes brought in through the Care Act, the opportunities and challenges this poses to Merton and discusses local progress in providing services for older people.

Financial Context and Challenges

2.1 Any discussion about older people's services takes place against the backdrop of:

- The introduction of the Care Act and the additional opportunities and burdens this places on the Local Authority (*2.4 - 2.5*)
- The challenge of integration between health and social care – both practically to achieve improved outcomes for individuals and in terms of the differing funding mechanisms between the council and the NHS (*2.7 – 2.9*)
- Reduced funding faced by all council services and specifically by social care services (*2.12*). This is reflected in the £9.103m of savings that Adult Social Care needed to find as part of the recent 2015-16 and 2018-19 MTFS; of which just over £3m is still to be identified and agreed.
- The constrained opportunity for savings within the provider market limiting the options from where to find savings (*2.12*)
- The changing demographics of Merton's population – which project an increase in population of older people of 9% and of those with dementia of 13% from 2015-20.

2.2 This is the wider context in which the rest of the report is set.

National context

2.3 The Care Act came into force on 1 April 2015. This is the biggest change in social care legislation affecting older people for 60 years, and consolidates all previous legislation.

2.4 The major elements are:

- An overall duty to promote people's wellbeing and to prevent the need for more intensive services, a duty which extends to people before they may be eligible for services
- A duty to offer information and advice to everyone including those who fund their own support, including signposting access to financial advice
- Greater national consistency, through national eligibility criteria set at "Substantial", and through measures to ensure continuity of support if people move between local authorities
- A duty of oversight of the whole local care market, whether or not the local authority directly commissions from it, and specifically a duty to intervene to ensure continuity of support for people in the event of a provider ceasing to operate
- Setting safeguarding of adults on a statutory basis
- Offering personal budgets and direct payments where desired and appropriate
- Rights for carers to assessments and services in their own right
- Offering advocacy to those who need it
- A duty for local authorities to offer Deferred Payment Arrangements for those who request it, in order to prevent people having to enact rapid sales of their properties if they go into care homes

2.5 The Care Act also contains provisions for funding reform, on which the Department of Health is currently out to consultation and which are intended to be implemented as from 1 April 2016 subject to the guidance following this consultation. The main elements of this reform are:

- The threshold, in terms of assets, at which people may first become financially eligible for local authority support moves from £23,000 to £118,000
- A cap on what anyone may have to pay for support out of their own means set at £72,000, with any spending towards this cap starting to be counted as from 1 April 2016.
- Monitoring of this spending towards the cap through a Care Account
- A duty for local authorities to manage this process, in terms of determining whether someone is eligible to have their spend counted in this way and whether the arrangements made by the person offer reasonable value for money in terms of progress towards this cap.
- A right of appeal against decisions made by a local authority in this respect

2.6 Alongside this change in legislation, the emphasis on personalisation continues with everyone expected to have a personal budget and a right to exercise this

through a direct payment under their own control if they so choose. This is beginning to extend into healthcare, with an intention that people with long term conditions can have personal health budgets.

2.7 There is all party consensus that greater integration between health and social care is desirable, though divergence in the detail. In 2014 all local authorities and health bodies were required to establish Better Care Funds, funded direct from the Department of Health and via Clinical Commissioning Groups, albeit without the provision of 'new' money, and intended to promote integrated services in the community to reduce usage of acute hospitals, including some protection of social care with this objective.

2.8 In the winter of 2014/15 integration was also supported by local Systems Resilience Groups, made up of all partners in the catchment area of acute Trusts, and again with the explicit aim of managing the pressures on acute care.

2.9 Such integration is now overseen locally by Health and Wellbeing Boards, established in 2013 and with a duty to oversee and promote good integrated services, along with specific duties to produce needs assessments and a health and wellbeing strategy.

2.10 There has been growing concern about the quality of care offered to people, both in care homes and through home care agencies. The Care Quality Commission has restructured itself into three functions of acute hospital, primary and social care in order to offer greater regulatory expertise, and is re-introducing overall quality ratings of Outstanding/Good/Requires Improvement/Inadequate in order to make this more transparent, along with a clear process for what happens if a provider is found to be inadequate. There is greater focus on staffing arrangements and whether recruitment, deployment and payment practices enable quality care to be delivered. There have been challenges to certain local authority commissioning practices such as 15 minute visits. There is debate about whether what local authorities pay providers enables them to offer a quality service, and an upward pressure on fees partly arising from this factor and partly arising from general market forces of supply and demand.

2.11 In response to the need to offer people more choice and control, and to move away from micro managing people's support arrangements through "time and task" ordering of support, local authorities are being urged to move towards commissioning for outcomes rather than focussing on inputs, with learning going on across the country about how to do this while at the same time keeping control of costs.

2.12 Finally, all this takes place against a background of a reduction in the funding for social care, 26% in real terms between 2010-2014, and some concerns from independent reports such as the National Audit Office and Barker Commission about whether such continuing reductions can be sustained, while also recognising that local authorities have no choice but to make these reductions when adult social care forms on average 35% of controllable budgets. As there is greatly diminished scope to make any further savings through reduced fees to providers, there is increased emphasis on arranging less expensive support packages and seeking wherever possible to reduce reliance on statutory services through a "promoting independence" approach

Local progress

2.13 In 2010 Merton pioneered an approach to using resources in a value based way. This approach has informed national work in this area including a self-assessment framework on whether local authorities are doing everything possible to use money to best effect.

2.14 The framework has six key statements on how value is offered to the customer and to the taxpayer:

- *I am not forced into using health and social care earlier than I need to. I am enabled to live an active life as a citizen for as long as possible and I am supported to manage any risks* (Prevention).
- *When I initially need health or social care, I am enabled to achieve as full a recovery as possible and any crises are managed in a way which maximises my chances of staying at home* (Recovery)
- *If I still need continued support, I am able to choose how this is done. I can choose from a range of services which offer value for money. The resources made available to me are kept under review* (Long Term Support)
- *The processes to deliver these outcomes are designed to minimise waste, which is anything that does not add value to what I need* (Process)
- *The organisations that support me work together to achieve these outcomes. These organisations include health and social care, other functions in statutory bodies such as councils or government agencies, and the independent sector* (Partnership)
- *I and others who support me are expected and enabled to make a fair contribution to this support. These contributions may be financial according to my means, informal care and support from those close to me or from volunteers, or from me playing my own part in achieving these outcomes* (Contributions)

2.15 This framework has proved locally to be an effective way of designing services, and has been broadly supported by local service users and carers. The headings in the framework will be used to describe local initiatives.

Prevention

2.16 The continuation of Celebrating Age, a festival every September where older people are encouraged to remain physically and mentally active through being able to try out a range of activities.

2.17 Commissioning of Merton-i, an interactive information and advice portal, jointly managed with the voluntary sector, and designed to enable people to find information and arrange their own support where appropriate.

2.18 A re-focussing of prevention for older people through Ageing Well, a programme involving around 30 local authorities in which Merton participated. This re-focussing was based on achievement of outcomes for which there is evidence that they prevent or delay the need to use formal care. The needs on which these outcomes have been designed to address are falls, incontinence, dementia, depression, and social isolation. It also involves a more personalised

approach to each older person on what would best achieve these outcomes for that individual. Examples include an incontinence advisory service offered by Age UK, a befriending service offered by several voluntary organisations working together, people spending time with professional groups in which they used to work, and the use of technology to facilitate visual communication with loved ones.

2.19 New initiatives for people with dementia. Merton has commissioned the Dementia Hub with the Alzheimers Society as its provider partner, with a significantly improved environment largely funded by the Department of Health and offering immediate access to support for those with a diagnosis of dementia. The Hub has attracted national attention. Merton has also formed a Dementia Action Alliance for every organisation which wishes to improve the lives of people with dementia, and recognising that such improvement goes well beyond health and social care and includes for example transport, retail and access to leisure.

2.20 Recognition that people are affected by the temperature of their homes. Merton Seniors Forum arranges an annual event on fuel poverty and on measures which people can take to heat their homes cost effectively. Merton's telecare service MASCOT has installed temperature sensors in hundreds of local homes so that should temperatures fall or rise to dangerous levels there can be an intervention.

2.21 The launch of Disabled Go, a guide to local public spaces for disabled people.

Recovery

2.22 MASCOT continues to reach a growing number of people (1,300), and equipment is increasingly offered as a solution to promote independence. Examples are Just Checking, a cost effective way of assessing the level of someone's mobility within their own home, and devices to manage gas and water in the event of taps being left on.

2.23 Merton's in house re-ablement service MILES has been restructured to offer a clearer focus on recovery programmes for those who can most benefit, and led by occupational and physiotherapists.

2.24 Equipment and adaptations for people in their own homes continues to play a vital role. Equipment is largely procured from the Croydon equipment store and has offered reductions in cost and faster delivery times.

Long term support

2.25 Personal budgets are made available to everyone needing long term support, and 35% of these people currently exercise this through direct payments. Merton has pioneered the use of pre-paid cards as a cost effective and efficient way of managing this area, along with Merton Managed Accounts to offer money management for those requiring it: this area won the Local Government Chronicle award for Innovation in 2014, and the service is being used as a platform by the local NHS for personal health budgets.

2.26 In 2012 Merton awarded contracts to preferred home care providers through a framework contract, which remains in place despite the pressure on fees referred to above. Merton is now working with providers to move to a more outcome based approach.

2.27 Merton's use of residential care homes has declined, whereas use of nursing homes has slightly increased. Accessing local nursing home care has become an increasing challenge. Quality of care in these homes remains a focus, and Merton Seniors Forum has led an important initiative in this area, through recruiting and training volunteers to act as Dignity in Care Champions in local homes.

2.28 Circle Homes Merton Priory have completed the complete re-provision of three sheltered housing complexes at Gresham Court, The Oaks and Doliffe Close, all offering significantly improved accommodation.

Process

2.29 The brokerage service was launched in 2012, offering a way of accessing the market in a way that secures best available value for money at acceptable quality. This change to process has been all the more essential as it has become harder to find care at the prices which Merton pays and as the pressures have increased especially in terms of the dependency levels of those being discharged from hospital. We are considering how this can be best positioned for those who fund their own care.

2.30 Merton's safeguarding function has managed significantly increased volumes of referrals in recent years, although a slight decrease in 14/15, as people become more aware of the issue. In order to ensure a degree of independent oversight, the directors for adult social care for Kingston and Merton chair each other's Safeguarding Adult Boards on a reciprocal basis.

2.31 A major development in this area has been an increased recognition of self-neglect as a safeguarding issue, which in Merton was accepted as a criterion for a safeguarding intervention before this was enshrined in stature under the Care Act. In this area there has been some specific work in the area of hoarding, where people may put themselves and others at significant risk: Merton with its partners has developed a shared protocol which has enabled successful interventions to take place and which has attracted national attention for its pioneering nature.

2.32 The information system in use forms a significant proportion of process time, and Merton is in the process of changing to a new system for both childrens and adult social care. The system is called Mosaic and is due to go live in September 2015. Changing systems is a very significant change process, but we expect as a result to see reduced time spent on data inputting and therefore more time available to be spent with customers, which will in turn support more flexible working.

2.33 Merton continues to perform very well in terms of enabling discharge from hospitals in a timely way, and due to the pressure in this area needs to continue to adapt its processes. Alongside the remodelling of re-ablement referred to above, the hospital based service is also being remodelled to a "Home from Hospital" service with core objectives of facilitating timely discharge, ensuring that support packages are set at an appropriate level promoting independence, discharging to the least institutional alternative available, and ensuring that multi-disciplinary assessments for NHS continuing care are effective.

Partnerships

2.34 In February 2013 Merton hosted an event for all local NHS organisations (CCG, 3 acute Trusts, the community provider Trust, and the mental health Trust) where the integration programme for older people and people with long term conditions was launched. 4 strategic outcomes were agreed:

- An improvement in satisfaction levels among customers
- A reduction in emergency admissions to acute hospitals
- A reduction in lengths of stay in acute hospitals
- A reduction in admissions to care homes

2.35 This programme is based on two main areas:

- Proactive care management, where social care workers, community health workers and primary care workers work together in three geographical locality teams, offering integrated assessments and case management.
- Reactive response services, especially focussed around avoiding hospital admissions and facilitating hospital discharge.

2.36 The programme turned out to anticipate the central government initiative of the Better Care Fund, where across England local partners were required to produce a plan to use a pooled budget to achieve similar outcomes and especially a reduction in admissions to hospitals. Merton's plan was judged one of the five best in the country, and the local arrangements have been praised by visiting senior civil servants and government ministers. We are achieving the fourth outcome, have reduced the level of increase in acute admissions, and are reducing lengths of stay where under the control of the partnership. We are awaiting a national metric on satisfaction levels among customers.

2.37 At the same time our pre-existing partnership arrangements for learning disabilities and mental health have remained effective and been refreshed through a formal review of the Section 75 agreements.

2.38 Partnership working with the voluntary sector has remained strong and a number of outcomes initially envisaged with the voluntary sector task group are being achieved:

- A transfer of management of small grants for carers to Carers Support Merton, which has levered in external funding to supplement what the council spends
- A change in the pathway for those who get a visual impairment diagnosis, so that they get more rapid support from the voluntary sector
- The launch of the community fund to support local voluntary group endeavours
- Transfer of management of certain assets to the voluntary sector
- The ageing well programme for prevention
- A reduction in transport costs

2.39 There is also a regular forum with independent sector providers to discuss matters of quality and finance.

Contributions

2.40 The council's charging policy has remained relatively unchanged, recognising that in comparison with many councils Merton already receives a comparatively high contribution level through charges. The charging consultation group has continued to meet in order to listen to customer experience and make changes where required.

2.41 There has been a re-launch of the volunteering strategy, with Merton Voluntary Service Council taking lead responsibility for implementation, which has included a merger with Volunteer Centre Merton in order to offer one place to support volunteering. The strategy has been the subject of regular reports to the Overview and Scrutiny Commission. Volunteering is playing an increasingly effective role in areas such as day opportunities, befriending, working with people on a short term basis in order to help them work out the right support for them, and informal get-togethers.

2.42 The contribution of carers continues to be seen as vital, and more investment went into Carers Support Merton under Ageing Well in order to promote a single place for carers to get information and support, supplemented by more specialist support in certain key areas.

Quality and performance

2.43 A revised quality framework was launched in 2014, with seven key domains and overseen by a quality board. The domains are:

- Enhancing quality of life with care and support needs
- Delaying and reducing the need for care and support
- Ensuring that people have a positive experience of care and support
- Safeguarding adults at risk
- Prevention
- Local measures
- Workforce development

2.44 The aspiration is to get more feedback in real time from customers about their experience of support, alongside the usual performance metrics.

2.45 Merton has published a Local Account since 2011: this is not a duty for councils but is encouraged as it sets out local performance in a transparent way for local people. It can be found on the council's website. The one for 2013/14 has been delayed by the lateness of getting validated comparator data, the intention is to publish in the summer 2015 and include core data for 2014/15 as well.

2.46 Merton has welcomed opportunities for external challenge. It was part of the pilot programme for peer reviews for Health and Wellbeing Boards in 2013. It had a peer review for commissioning, as part of the London wide review programme, in 2013. It has had an externally supported self- assessment on its use of resources in 2013. As it becomes harder to find the savings needed to deliver quality services with less money, such external challenge and learning from best practice is increasingly important.

2.47 Benchmarked performance data for 2013/14 (the most recent year for which this is available) shows:

- Below average and reducing use of residential care homes
- Below average use of nursing homes
- Comparatively low spend per head of population
- Lower than average unit costs from commissioned services
- Slightly above average levels of satisfaction overall among customers
- Average rates of supporting people of working age into employment
- Below average numbers of people in the system overall
- Well below average rates of delayed discharge from hospital attributable to social care

Input from Overview and Scrutiny

Preventing Excess winter deaths

2.48 In June 2011 the Association of Public Health Observatories Health Profile for Merton reported that between 2006-2009 Excess Winter Deaths in the borough were higher than the England average.

2.49 The Panel held a special meeting to discuss this issue on 2nd November 2011 with partners including the Director of Public Health, Merton Seniors Forum, the Environmental Health officer, Age UK Merton. A reference was made to cabinet asking for the council and partners to produce a joint publication with consistent messages around keeping warm during cold weather. Also that the council and agencies identify and support the most vulnerable people in the borough and ensure they are alerted when cold spells of weather are expected, and advised how to keep warm and given relevant helpline numbers. The Panel also asked for energy saving schemes to be rolled out across the whole of Merton.

2.50 The Panel also invited EDF energy to a meeting in April 2012 to highlight local concerns and discuss their role in alleviating fuel poverty.

Safeguarding Older People Task Group

2.51 In 2011/12 the Panel held a task group review on Safeguarding Older People, focussing in particular on those living in their own homes, given that this was the highest levels of reported abuse in Merton. As a result of the review the following recommendations have been implemented:

- Information leaflets on safeguarding adults were updated,
- More work was done to use Preventing Elder abuse day to highlight important issues including an article in My Merton in December 2012 as well as a stall in Merton Link.
- Information and advice was made available to those who pay for their own care through Merton Eye in November 2012.
- A Dignity in Care conference was held in September 2013 to bring all the relevant partners together to discuss this issue.
- Lifting and handling training is provided for carers

Incontinence services – March 2014

2.52 The Panel conducted a review looked at the services available to people suffering from incontinence. The task group decided to focus on women of child

bearing age as it was felt that if services can be improved for this age group, there will be a direct knock on effect on older age groups where incontinence is more prevalent. This review also looked at how to raise awareness of incontinence and tackle the stigma that prevents people seeking help. Recommendations included developing a clear pathway for incontinence services, more work to raise the profile of continence services, more support and information to pregnant women about incontinence issues. Merton Clinical Group has developed an action plan as a result of the review; and a progress report will go the Panel in later this year.

End of life Care Services

2.53 The Panel asked for an update on end of life services and Merton Clinical Commissioning Group attended the meeting in November 2014. Panel members asked a number of questions around partnership working and learning from best practice. It was also suggested by a panel member that the terminology should be changed from 'A Good Death' to 'A Peaceful Death'. Merton Clinical Commissioning Group agreed to take the feedback on board.

Adult Social Care

2.54 The Panel receives regular updates on Adult Social Care; in September 2014 the Director of Community Housing attended the meeting to discuss the new opportunities and challenges raised by the Care Act and the increasing demand for services due to the ageing population. The panel were keen that the council maintain high standards in domiciliary care and were reassured that this takes place through monitoring contracts and feedback from customers.

2.55 This year the Panel were required to consider a number of savings across Adult Social Care. Panel members expressed concern about the impact on vulnerable people but many felt they were faced with no choice given that the service had been protected thus far but the council needed to make considerable savings. Some members felt that the savings should be taken from elsewhere in the council's budget. The Panel reluctantly agreed to accept the savings and asked Cabinet to ask officers to look again at the equality impact assessment of all the savings taking into consideration those all those who will be affected and particularly looking at the knock on effects on the voluntary sector.

2.56 In February 2015, The Panel considered the responses to the council's consultation on changes to Adult Social Care. The Panel provided an important opportunity for local residents to come along and share their views and concerns on these issues. The Panel recognised the need to make savings but expressed concern about the impact the proposals may have on disabled people, including social isolation, increased burden on carers and entry to residential care at an earlier stage.

Visit to Merton Dementia Hub

2.57 Following an invitation from the Cabinet Member for Adult Social Care and Health, a number of panel members visited Merton Dementia Hub in October 2014. The Panel were very impressed with the facility and will consider further work on dementia as part of their topic selection and work programming process for 2015/16.

The Panel also considered the following issues in relation to Older People:

- Integrated care
- Safeguarding Adults Annual Report
- Merton Joint Strategic Needs Assessment
- Health and Wellbeing Strategy
- Improving the working relationship between Care Quality Commission and Healthier Communities and Older People Overview and Scrutiny Panel
- Adult Social Care local Account
- Adult Social Care Performance Indicators

2 CONSULTATION UNDERTAKEN OR PROPOSED

Not applicable for the purpose of this report

3 TIMETABLE

Not applicable for the purpose of this report

4 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

Not applicable for the purpose of this report

6 LEGAL AND STATUTORY IMPLICATIONS

Adult social care is a statutory service now largely governed by the care act 2014

7 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

Not applicable for the purpose of this report

8 CRIME AND DISORDER IMPLICATIONS

Not applicable for the purpose of this report

9 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

Not applicable for the purpose of this report

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

None

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