Nottinghamshire County Council

Report to Adult Social Care and Public Health Committee

7th October 2019

Agenda Item: 9

REPORT OF THE SERVICE DIRECTOR, AGEING WELL SERVICES

AGEING WELL SERVICES – PROGRESS AND FUTURE PRIORITIES

Purpose of the Report

1. This report provides an update on progress with the development of services for older adults aged 65 years and above and seeks approval of the future strategy and key priorities.

2. The report also seeks approval for a joint publicity initiative on the opening of Priory Court Housing with Care scheme, in partnership with Bassetlaw District Council.

Information

The health and social care needs of older people

3. The national success story of how improved technology and health interventions has led to people living longer is well documented. In turn this is resulting in an increasingly ageing population. The population is growing and more people are living longer, with needs that can be complex and expensive to provide for. Deaths from cancer and heart disease are falling, but more people are experiencing chronic illness for longer periods of their life. People aged 75 years and over, for example, are highly likely to have at least two long term conditions ('co-morbidity'). The incidence of dementia and frailty in later life is also rising. 4. Increasingly, many more people will live for longer with a mixture of needs to do with physical health, mental health, and perhaps difficulty in making decisions for themselves. Local Integrated Care Systems and Partnerships are developing and implementing plans to support key national objectives to have speedier discharge from hospital and also to support more people with complex needs for longer in their own homes, rather than in acute or institutional health services. This provides better outcomes for people, but it also equates to potential increased demand for either short or longer term social care.

5. 21% (170,200) of Nottinghamshire County Council's total population of 858,300 (Office of National Statistics 2018 mid-year estimates) are aged over 65 years old. Overall the age structure of Nottinghamshire is slightly older than the national average, with 20% of the population aged 65+ years in 2016 compared with 18% in England. Nottinghamshire's population is predicted to continue to age over the next 10 years, with the number of 75-84 year olds increasing by 44% and 85+ year olds by 39% with the largest increases in the Districts of Ashfield, Bassetlaw and Newark & Sherwood. The majority of carers who

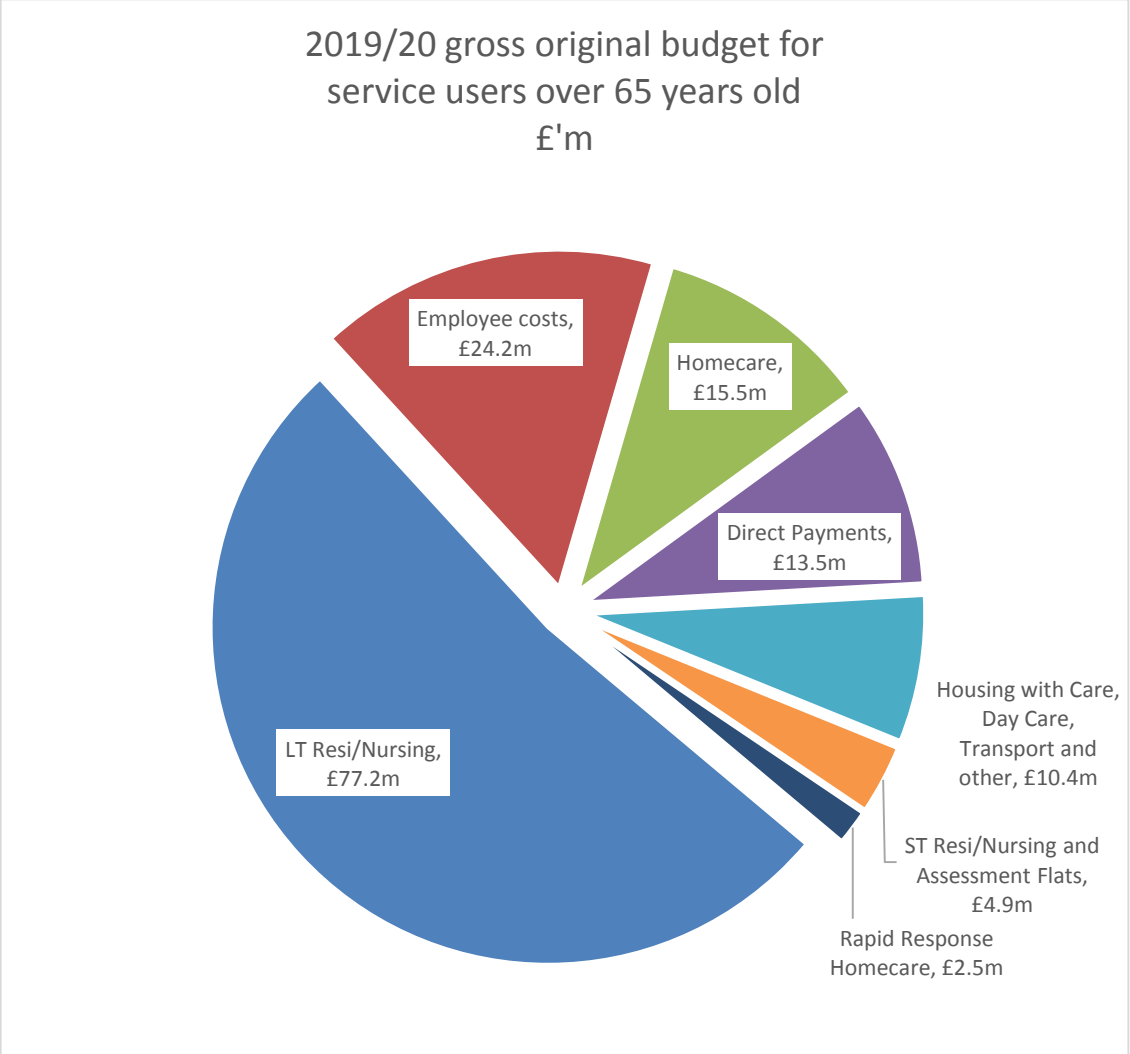
provide 50 or more hours of care per week are aged 65+ years, often caring for a partner. Those carers themselves are more likely to experience poorer health than those of a similar age who do not provide care.

6. It is anticipated that, increasingly, older people in Nottinghamshire will live alone (increasing by 21% between 2017 and 2026). Older people living alone and without access to a car in the more rural areas of Nottinghamshire, which also have poorer access to public transport (notably Newark & Sherwood and Bassetlaw), are particularly likely to become isolated and find it difficult to access support. All these factors have implications for future planning and delivery of services in order to meet their health and wellbeing needs.

Current adult social budget and provision for people aged 65 years and above

7. The chart below shows the current broad areas of spend on services and packages of care for people aged over 65 years which shows that the costs of residential and nursing care placements accounts for the significant majority of the money.

8. In 2018/19 the Council supported 2,349 older adults in residential or nursing care and 3,090 with packages of support in their own homes.



The employee costs shown include START Reablement Service costs (£4.6m).

9. Over recent years, adult social care services for older adults have been shaped by a number of successful initiatives and improvement projects. These have been based on local and national evidence and learning about how to best support people to age well and to lead as healthy and independent lives as possible. In turn, this focus on independence, as set out in the Departmental Adult Social Care Strategy, has also delivered savings because people have then required less or smaller formal packages of care and support funded by the Council.

Future strategy

10. Key future objectives for older adult services are:

A. Implementation of the new workforce model will provide the right structure, functions, staff roles and skills to:

i) maximise the number of older people who can have their issues and needs successfully resolved at the earliest point

ii) maximise the number of older people with the potential to benefit from a short term preventative intervention, including re-ablement, before a new or increased package of care at home is put in place.

B. Strategic commissioning with partners will:

i) develop a joint plan and commission the right type and volume of short term re-ablement and intermediate care services that will help people regain their independence after a period of ill-health, often involving a hospital stay, and also proactively avoid residential care and hospital admissions.

ii) develop a greater range of housing options for older people that maximise their independence and ability to remain in their own home and delay the need for residential/nursing care

iii) build on the work in the two Integrated Care Systems to develop a joint dementia strategy and deliver the adult social care aspects of the Dementia Declaration Action Plan.

11. Key areas of work over the past two years have focused on strengthening the three core aims of the customer journey:

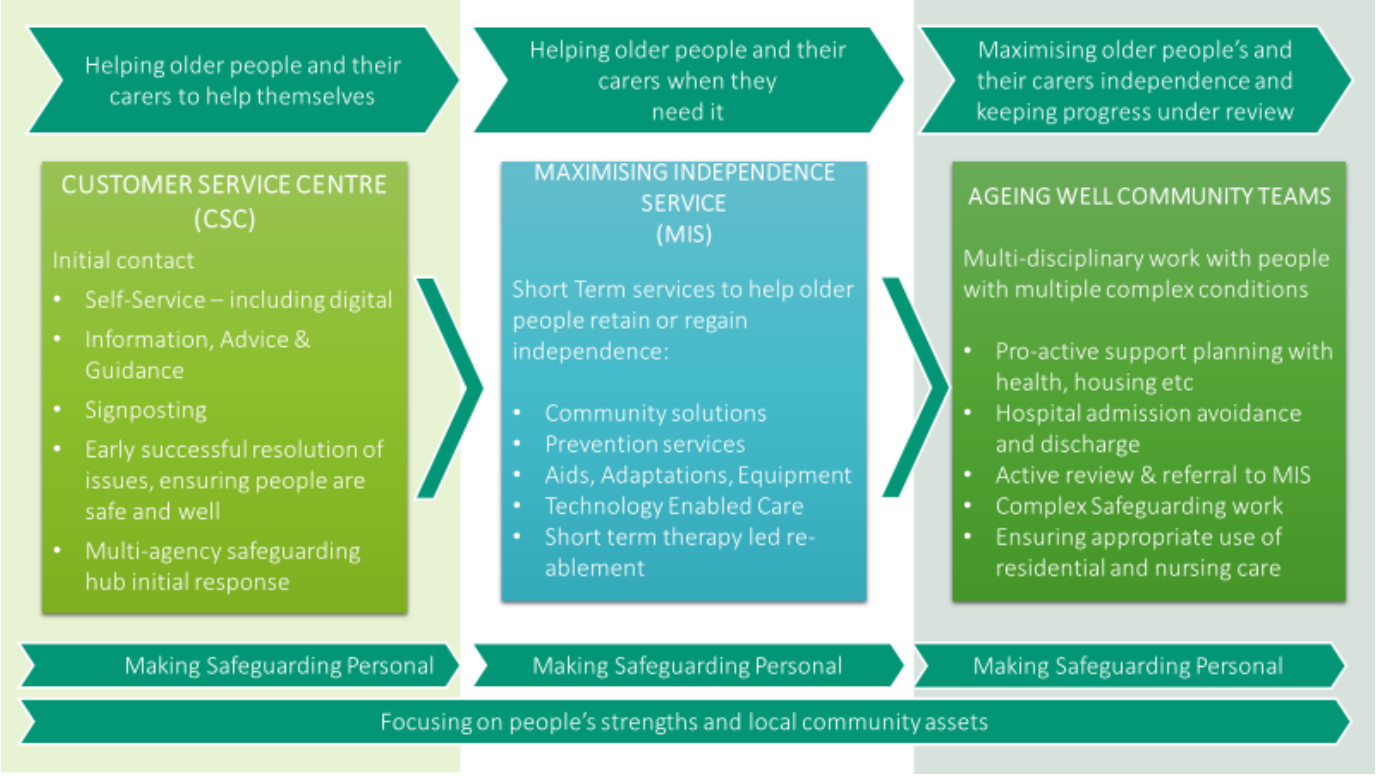
- **Helping Older People and their Carers to Help Themselves** – improving the Council's offer for information, advice, guidance and signposting, as well as having different conversations that support people to resolve their issues at the earliest point.

- **Helping Older People and their Carers When They Need It** – a range of short term support options have been expanded or developed to help people retain or regain their independence: preventative services such as Connect, aids, adaptations, equipment, technology, community solutions, and re-ablement.

- **Maximising Older People's and their Carer's Independence and Keeping Progress Under Review** – multi- disciplinary work (across Health, District Councils, Housing and provider services), with people with multiple complex conditions, Housing with Care and short term assessment and re-ablement apartments to provide alternatives to residential care, more creative support planning, and work within integrated discharge teams to get people home as soon as they are well enough with the right short term support.

12. The next phase of work needs to ensure that what has been tested and works well is fully maximised and embedded through the Department's new operating and workforce models. On 9th September 2019 Adult Social Care and Public Health Committee approved the new Senior Leadership structure for Adult Social Care. This set out clear leadership roles with one Service Director having oversight for the range of support and services provided for older adults from first contact through to management of complex multi-disciplinary casework.

13. The new senior management workforce structure also brings together under one Group Manager the Adult Access Service and re-ablement provision for everyone aged over 18 years (Short Term Assessment and Re-ablement Service (START) and Notts Enabling Service (NES)). This creates the opportunity to develop a Maximising Independence Service (MIS) that will bring together the Department's preventative and short term services offer, enabling the route in and access to these to be simplified. The diagram below illustrates how the new workforce model aligns to supporting and strengthening delivery of the three key aims of the social care offer within the customer journey for older adults.



14. The next part of the report gives further detail about progress in these areas to date. The Department provides a wide range of services for older adults and it is beyond the scope of this paper to detail them all. They are all included with further detail in the Department's Market Position Statement which can be accessed at:

http://home.nottscc.gov.uk/working/policies-performance/policy/policy-library/adult-social-care-market-position-statement-2019-2021

Early resolution and the three tier model

15. In 2018-19 the Customer Service Centre successfully resolved 73% of those new contacts it received for social care. The service has embedded a continuous improvement approach and aims to maintain and wherever possible build on this positive delivery. Work also comes directly into social care teams from the integrated hospital discharge arrangements, local multi-disciplinary integrate care teams for older adults and Safeguarding referrals from the Multi-Agency Safeguarding Hub (MASH).

16. The three tier model is the term used in the Department for a different way of having conversations with people requesting support, that brings out their strengths and ability to identify their own solutions rather than rushing immediately into a full assessment and service provision. It can be used at all stages and is equally applicable for people with complex needs as those with fewer. For example, a request comes into the Adult Access Service for an assessment for homecare. Information and advice have already been given by the Customer Services Centre on how to self purchase a small piece of equipment. Rather than immediately starting an assessment for eligibility for social care, short term support is provided by Home First Rapid Response Service. A social worker from the local community team meets with the person, their family and friends to discuss support needs and they agree between them to provide the support with a review agreed in two weeks with the worker to see how the plan is working.

Short term prevention and re-ablement services

17. The Department currently has a range of short term prevention services for older people and their carers, including Connect, Assistive Technology, Meals at Home and the Short Term Assessment and Re-ablement Team (START). Increasing numbers of older people are now accessing and experiencing positive outcomes from these. Data analysis, however, has shown that there is variation across and in teams as to the level of referral into these services. The Maximising Independence Service will provide a one stop shop approach to improve consistent and simpler access into these services for older people, whether they are new to social care or already receive a service.

18. A total of 1,920 people completed reablement with START during 2018/19 which equates to a 22% increase on the numbers completing in 2017/18. The service is in its second year of a project to transform the way that it works and is on track to deliver enough capacity, within the same budget, to work with 581 more people a year by March 2020. Of the people completing re-ablement in 2018/19, 75% of people required no ongoing homecare, 12% required a reduced level of support, 12% required a maintained level of support and only 1% required an increased level of support. Regaining independence is a good outcome for people which in turn will deliver an anticipated saving of £1,289,000 in 2019/20. There is not enough capacity in START however, to currently offer a service to all people who could benefit from it according to national research, therefore work is underway to analyse what is required with the aim of addressing this within the new workforce model.

19. A typical case study for START involved an older woman who had been discharged home from hospital after a two week stay due to falls and ill health. She initially required four daily calls for support with personal care and meals. START worked with her and she quickly regained her confidence and independence with washing and dressing. This was despite a temporary setback when she had another fall after developing a Urinary Tract Infection. A START Occupational Therapist worked with her to set goals for preparing hot drinks and food and provided her with equipment to help her to regain more independence, such as a dining trolley for transporting food and drinks. START worked alongside her until she felt confident to do this herself. She was thrilled with the trolley, which she also uses to help transport her washing to where she hangs it on the drier. Initially START had used her key safe to let themselves in, but as she progressed she asked them not to so she could answer the door herself. She regained her full independence after three weeks and was full of praise for the help of the Council's Reablement service.

Multi-disciplinary work and services for people with multiple complex conditions

20. **Residential and nursing care –** the Department remains committed to ensuring that people only need to move into a care home when they really need it. Positively, over recent years the age people have been admitted has risen and also the length of time that they spend in residential care has decreased. There has also been a shift towards funding a greater proportion of residential nursing placements, which indicates different options are being provided for people where possible. At the end of March 2019 the Council was funding 2,349 older adults in residential or nursing care placements and the target for March 2020 is to further reduce this to 2,309. This will be challenging and will require managers and staff to continue to peer review new admission requests to ensure all alternative options have been considered, alongside continuing to work with partners to develop more creative support planning that promotes alternatives, as well as commissioning alternative pathways and services.

21. **Hospital Discharge** - the Council has held its excellent performance at avoiding delays to people being discharged home from hospital (DToCS) over the last year. Reducing how long older patients stay in hospital has benefits for patients, hospitals, and also for reducing demand for social care services. Evidence shows that longer hospital stays for older patients can lead to worse health outcomes and an increase in their care needs on discharge. Research has shown that older people can lose their mobility quickly if not active and their ability to perform daily living tasks can reduce considerably whilst in hospital:

- Monitor's 2015 review highlighted a study which showed that, for healthy older adults, 10 days of bed rest led to a 14% reduction in leg and hip muscle strength and a 12% reduction in aerobic capacity: the equivalent of 10 years of life. Other studies have found a reduction in muscle strength of as much as 5% per day.

- A further study found that 12% of patients aged 70 years and over saw a decline in their ability to undertake key daily activities (bathing, dressing, eating, moving around and toileting) between admission and discharge from hospital, and the extent of decline increased with age.

22. Better Care Fund Grants have been used to provide additional Social Work and Occupational Therapy staff to support the work of the integrated discharge teams in all the County's acute hospitals. This funding has also been used to commission the Homefirst

Rapid Response Service (HFRRS) which provides care at home for up to 14 days. HFRRS has run a trial in Bassetlaw, working more closely alongside the START re-ablement service and community health teams to ensure people get the right therapy support when returning home. In the south of the County, increasing numbers of people are now having their assessment for longer term needs completed when they are back in their own homes rather than when in hospital.

23. For people needing additional support whilst they have a period of re-ablement the Council is developing short term assessment and re-ablement apartments in Housing with Care schemes. This means that people are in an environment that is more like their own home which makes it easier to support them to regain their confidence and independent living skills than in a residential care home setting. Because of this it is the intention to only spot purchase individual residential care beds for short term assessment and re-ablement at times of high pressure in the system.

24. The following case study provides an example of how the short term assessment and re-ablement beds can help people regain their independence and remain living in their own home:

Mrs M was already receiving four daily homecare visits, requiring two staff for each call. Following a health crisis Mrs M was returned home with the same package of support. The family had concerns about her frequent admissions to hospital and her ability to manage at home and were requested that she move into residential care. It was agreed with the family that she have a short stay in an assessment and re-ablement apartment, where staff could see how she managed at night as well as during the day. An Occupational Therapist worked with Mrs M and arranged for equipment and technology to be installed at Mrs M's home which reduced both Mrs M's and the family's worries. It also enabled one carer to support her at each visit rather than two and reduce the calls from four a day to three.

25. Future work on short term re-ablement and intermediate care services aims to ensure that the right amount of the right type of services are available so that people can access these at the time they need them, this includes:

- streamlining and simplifying referral processes into services
- further alignment of social care and health services
- joint work on data to fully understand the need for short term services and develop these, with the aim of people being able have the right service at the right time when discharged.

26. **Developing strength based practice and local community development** – services for older adults are increasingly aligning with those of other key partners such as health and housing. The development of the three Integrated Care Partnerships and local Primary Care Networks provides an opportunity for better place based working with local citizens. This applies to how local multi-disciplinary teams work and also to local work that increasingly focuses on people's strengths and the development of more resilient communities that are able to support people as they age, an example being how health's social prescribing can complement existing approaches in Nottinghamshire County and the District Councils.

27. **Housing pathway and options for older people -** are important to enable people to remain living in their own homes and local communities for as long as possible and in turn delay the need for residential/nursing care. A key factor in maintaining independence for older people is having in place a robust housing pathway that enables people to live in housing that best meets their needs. This incorporates the availability of a range of accommodation designed to adapt to ageing populations, the provision of minor and major adaptations through the Integrated Community Equipment Loan Services and the Disabled Facilities Grants, Technology Enabled Care, home-based care, and a variety of Housing with Care options including: managed accommodation, retirement villages and Extra Care. Key to the success of Housing with Care options is good information that is easy to find and the timely identification of need that supports effective and sustained transition.

28. Up until now, work has focused on Nottinghamshire County Council's Extra Care/Housing with Care Strategy in the absence of a wider partnership vision, pathway or plan. Work has now started in the Better Care Fund Partnership to develop this. However, Housing with Care is just one component of the range of alternatives that need to be in place. An independent review and recommendations have been undertaken which partners are currently considering in their respective agencies, prior to agreeing a joint plan of action.

29. As part of a regional and local project, advice was also sought on sustainable financial models of Housing with Care, from experts in the field: the Housing and Learning Improvement Network (LIN). Their recommendation was that the best approach and benefits arise from the broader housing approach and partnership. Getting this right can affect the amount and type of specialist Housing with Care schemes required. Following this, alongside the opening of Priory Court in November 2019 and planning for the Ollerton Housing with Care scheme, the Department is developing a plan to better consolidate and utilise existing provision and establish a more consistent model for good practice. Going forward, new schemes will be planned and delivered in the context of a plan with partners for the broader mix of housing options that older people need.

30. Priory Court is a newly refurbished Housing with Care scheme in Worksop, Nottinghamshire, which will provide 52 homes for older people on a social rent basis. This housing development was jointly funded between Bassetlaw District Council, Nottinghamshire County Council and Homes England. Nottinghamshire County Council will have nomination rights to 37 flats, 10 of which will be short term assessment and re-ablement apartments. The scheme was formerly Abbey Grove, an Extra Care/sheltered scheme which closed in April 2017 for refurbishment.

31. Priory Court offers communal facilities including a communal lounge, dining area, laundry, gym, hair salon and library. It also offers a scooter store and accessible landscaped gardens. Provision has been made for local health services to offer clinics onsite. The scheme is designed to promote health and wellbeing through social inclusion. The scheme is due to open in winter 2019 with a proposed launch date to be agreed with Bassetlaw District Council. Committee is requested to approve a joint publicity plan once the scheme opens.

32. **People living with dementia** – the Council is working with partners within the two Integrated Care Services to develop joint strategies for people with dementia, which incorporates Nottinghamshire County Council's Dementia Declaration Action Plan 2019-

2022. There are three priority areas emerging that social care is currently exploring with partners:

- improving how the Council and partners identify people living with dementia and their carers at an earlier point. The aim is to be able to start to work with people when they have greater potential to benefit from preventative services and strength based approaches. This will include, for example, close working relationships with Memory Assessment Services and reviewing the advice given by the Council's Customer Service Centre/Adult Access Service.

- exploring the potential to make more use of social care's existing range of preventative and re-ablement services to support people with dementia and their carers at an earlier point. This is based on research that has shown that implementing new skills, for example use of technology, at an earlier stage of dementia means that people are more likely to have these skills form part of long term memory processes and be able therefore to benefit from them as their condition progresses.

- ensuring health and social care short term Intermediate Care/Re-ablement Services can meet the needs of the growing cohort of people with dementia requiring these services. This changing demographic has been highlighted by the early work Professor John Bolton is supporting in the south of the County at Queen's Medical Centre (QMC) to analyse which services older adults need when they are discharged from hospital, but will likely have shared learning points across the County.

Next actions

33. The next key pieces of work over the following six months to progress this work are:

- by March 2020, complete the two year START Re-ablement project that will enable the service to work with 530 more people every year
- complete the adult social care workforce remodelling which will create a structure to shift resources into services that will maximise early resolution, prevention and re-ablement. Implementation to start from 1st April 2020
- complete a joint needs assessment with health partners on the volume and type of short term re-ablement/intermediate care services required
- simplify processes and routes into short term social care services at point of hospital discharge
- develop a housing strategy and housing options pathways with Better Care Fund partners.

Other Options Considered

34. Other options have been considered; the ones proposed have the strongest evidence based linked to delivery of the objectives of the Departmental Plan and Adult Social Care Strategy.

Reason/s for Recommendation/s

35. A number of successful initiatives and projects have been delivered in older adults services and it is now timely to fully embed and maximise the benefits of these.

Statutory and Policy Implications

36. This report has been compiled after consideration of implications in respect of crime and disorder, data protection and information governance, finance, human resources, human rights, the NHS Constitution (public health services), the public sector equality duty, safeguarding of children and adults at risk, service users, smarter working, sustainability and the environment and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Financial Implications

37. There are no financial implications arising from this report. As the work is taken forward, any issues requiring Committee approval will be the subject of further reports as appropriate.

Implications for Service Users

38. The aim is to be able to work with more older adults to improve their health and independence, by rolling out an embedding initiatives and projects that have provided better outcomes for people.

RECOMMENDATION/S

That Committee:

1) approves the future strategy and key priorities for the development of Ageing Well services for older adults aged 65 years and above.

2) approves a joint publicity initiative on the opening of Priory Court Housing with Care Scheme, in partnership with Bassetlaw District Council.

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Constitutional Comments (LW 25/09/19)

39. Adult Social Care and Public Health Committee is the appropriate body to consider the content of the report.

Financial Comments (AGW 25/09/19)

40. The recommendations in this report do not have any direct financial implications. Any implementation of these recommendations which will have financial implications will need to be brought back to Committee for separate consideration.

Background Papers and Published Documents

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

Adult Social Care Strategy

Adult Social Care and Health – senior management structure: report to Adult Social Care and Public Health Committee on 9th September 2019

Electoral Division(s) and Member(s) Affected

All.

ASCPH680 final