Meeting: Adult Social Care, Health and Wellbeing Sub-Committee

Date: 4 October 2018

Title: Sustaining Older People in their own Homes

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Wards affected:	All	

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1. Purpose of Report

To provide the committee with an overview of the Council's aim to sustain older people in their homes and how successful this has been, including information on the new Extra Care Homes and how successful they have been in helping to sustain people at home for longer.

2. Recommendations

2.1 To note the content of the report: for the Committee members to be kept informed regarding the process that Adult Social Care has in place to maintain people in their own homes. This includes:

- Reconfiguration of social work teams into localities
- All people receiving a service to have an allocated worker
- Accessing a range of services for example Universal Services, Extra Sheltered Care and equipment to provide support to people

3. Details

3.1 Background information

The aim of promoting keeping people in their own homes means that they will continue to be as independent for as long as possible which in turn is hoped to promote their general wellbeing. This has been a focus for Adult Social Care and the Council for a number of years and is also linked in with national strategy and policy direction. This is also supported by the Council's Target Operating Model of supporting people across the borough to remain independent and not reliant on Council services.

A whole system review of the Customer Journey was carried out which lead to a subsequent reorganisation of the social work teams was carried out in Adult Social Care in June 2017 to change the way the teams are configured, with the aim of keeping people as independent as possible for as long as possible.

It had been identified that the processes that were previously in place in Adult Social Care meant that too many people were being assessed too often; this frequently would lead to increases in services. This was because their cases were closed for an annual review and so when a minor issue occurred, they would go back to Gateway, be allocated to a different worker who was not aware of their situation and often receive another assessment. This was not felt to be an effective use of resources, nor a positive experience, with people often having to tell their story many times over.

3.2 Assessment and Care Management

The introduction of The Care Act 2014 promoted the importance of ensuring that Wellbeing and Prevention is at the centre of all work.

The overall aim was to carry out more personalised assessments and offer more solutions to meet need based on existing community resources and an individual's own family and community networks.

The focus of this work was to:

- Use an asset based approach to identify develop and use an individual's own social assets (and that of the community) to meet needs in an outcome focused way.
- Undertake proportionate assessments that focus on outcomes rather than process and make best use of universal services
- Work in partnership with the NHS to provide a multidisciplinary and integrated approach to reablement services for older people
- Promote customers (including other professionals) to self-serve
- Ensure customers with Personal Budgets remain with a team, thus reducing traffic to Gateway.

3.3 How the Teams are Organised

We have four locality teams in the North West, South West, Coast and Central. The workers hold cases of between 60-70 with about 30 active cases and 30-40 inactive cases at any one time. Over the course of the past year workers have got to know the people they work with and have focused on maintaining people in their homes and keeping them as independent as possible for as long as possible.

Gateway and Care Point are the two points of entry into the Adult Social Care system for new people.

The Gateway team keep cases for longer with the aim of resolving issues raised by signposting people to universal services and reduce the number of referrals into the locality teams.

Care Point aims to use reablement, as often as possible, to enable an individual to reach their full potential after discharge from hospital.

3.4 Services to Support Independence

It must be recognised that for some people 24 hours care will continue to be required to meet their needs. This is because there is a point for people where they are at too high a risk to remain living independently in their own homes. This is based on the social work assessment process in consultation with other professionals, the individual and their families.

However for a vast majority of individuals care and support in the home and / or in the community will be used and put in place to support independence and for individuals to live in their own homes.

There are a range of services and options available for individuals and, where appropriate, a personal budget from Adult Social Care will be identified as part of the assessment and planning process to help access these. These include:

- **Advice and Information** – there are two main strategies supporting this, My Care and SIGN North Tyneside

  My Care North Tyneside is an information and advice website about care and support options for residents in North Tyneside. My Care offers information and advice on a range of care and support options for individuals, their carer or their family members. It will ensure individuals are informed, can make choices and remain independent in life. It will also help to identify support needs and the cost involved in paying for support.

  SIGN North Tyneside brings together information about activities, events and services for residents living within North Tyneside. It can help individuals find out what's happening in their local area. There is also information about support and equipment for the home, activities within your community, and services to meet care and support needs.

- **Care and Connect** – this function has a small number of Community Navigator posts and the aim here is to connect people to local groups and other individuals or low level community based services. The service has worked well and is able to divert people from "traditional care services" and think more laterally and uniquely about what a person is interested in and what groups / services exist in the locality. The service has also been able to link like-minded individuals together.

- **Select and Direct –** Gateway has access to the Select and Direct service where a dedicated member of staff will discuss an individual's issues and support them to identify small pieces of equipment and minor adaptions which can help to resolve something they have been struggling with. This can negate the need for any on-going support or other intervention. For example a lady recently contacted the team because she had a level access shower in the property she had moved into; it had a drop down and drop down handle, which were not helpful to her in accessing the shower. Select and Direct arranged for the seat removed as she did not need it and a grab rail put in place of the drop handle. This meant she was able to access the shower independently and stated that "all of her Christmases had come at once."

  Other situations occur when people are struggling on the stairs but don't want to move house. Select and Direct staff will discuss the issues and often find that a second bannister rail can make all the difference in supporting them to continue accessing the stairs and therefore the upstairs in the property.

- **Reablement** – this is an internally delivered Adult Social Care service that supports individuals for up to six weeks and generally as part of hospital discharge arrangements.

The team's approach and focus is to maximise independence and to get people back to where they were prior to hospital admission. For some people they will be "re-abled" and not need any longer term services or support and for some people they will need longer term support, the information from the Reablement Team will feed into the assessment for longer term support where this is needed.

- **Social Prescribing** – Social Prescribing is a mechanism for linking people with non-medical resources and support in the community. Social Prescribing has been recognised as an effective means of meeting the needs of people, due to an enhanced recognition of the social, economic and cultural factors which impact on residents' health and well-being. Social Prescribing is all about engaging and re-engaging people with interactions and opportunities that break the downward cycle and intervene before significant mental health or physical deterioration develop.

  North Tyneside is fortunate to have a wide range of activities, services and support options that are available within the community. There are some people that have low level needs associated with their physical or mental health, which mean they often experience additional barriers to accessing activities in the community and need additional support to do so. Over the last year North Tyneside Council, has been conducting a pilot within the existing social prescribing service to establish what 'the new preventative offer' should look like.

  The Social Prescribing Service supports people to access opportunities in the community in the following categories:

    - Social
    - Physical
    - Creative
    - Learning
    - Holistic

  There is a plan to re-tender the service in November 2018, for a new service to be in place from April 2018.

- **North Shields Live at Home Scheme** – aims to provide support, encouragement and companionship to socially isolated older people living in their own homes to:

    - Enable older people to continue and remain in their own home
    - Retain an individual's level of independence
    - Reduce social isolation by supporting people to play an active role within their community

  There are volunteers in place to support paid staff to deliver the service.

  The criteria for accessing the service is to be aged sixty or over and to be living alone in their own home, (including sheltered housing), or to be living in a family home but with significant time spent alone, leading to social isolation/ The service currently supports approximately 150 older people.

- **North Tyneside Living** – across North Tyneside there are sheltered accommodation properties offering individuals their own tenancy in purpose built accommodation which meets many individual's needs. There are housing officers providing oversight and general support to the residents. They also have the benefit of communal living areas which can prevent isolation and loneliness.

- **Loan Equipment and Adaptations –** a range of equipment is available to support people in their own homes from the Loan Equipment Service, details of this are out in a separate report to this Sub-Committee (4 October 2018).

- **Home care services** – there are a number of commissioned home care providers that operate across the borough and they are used to provide a range of practical and personal care tasks to individuals. This will follow a social work assessment and plan.

- **Day services** – there are a number of commissioned day care services across the borough that people can access, this is following a social work assessment and plan. The focus here will be to provide practical support and activity and also to support issues of social isolation. Support may be in place because of a level of cognitive impairment and / or dementia and may be linked to carer relief.

- **Support for Carers** – North Tyneside Carers Centre supports carers to have:

    - Improved access to advice and information;
    - increased choice and control over their own health and wellbeing; and
    - a life outside of caring.

  Trained professionals provide emotional support by providing someone for carers to talk to when they most need it. There are also a wide range of peer support groups; training and social activities carers can access free of charge. Support and advice for carers of people with dementia remains the highest requested service in the centre.

3.4 Extra Care Sheltered

There are nine Extra Care Sheltered Schemes currently operational across the Borough. In these services the Council works with a housing provider that operates as the landlord and also with an identified care provider that delivers the on-site care and support to individuals living there.

Details of the current extra care schemes are as follows:

Extra Care Scheme	Location	Number of Apartments	Vacancy Level
Homeside Lodge	Wallsend	45	6
Rowan Croft	Killingworth	45	2
Linskill Park	North Shields	63	0
Sandringham	Longbenton	40	5
Fontburn	North Shields	31	0
Thomas Ferguson	North Shields	29	0
Weetslade	Wideopen	49	3
Crossgates	Wallsend	45	1
Edith Moffatt	North Shields	24	5
Totals		**371**	**22**

Rowan Croft, Linskill and Weetslade also offer shared ownership apartments in each of their schemes (28 units in total).

Each scheme operates with a number of self-contained apartments and communal areas. Adult Social Care commissions the care and support provision within each scheme. Extra care enables people to have a tenancy and live in their own self-contained property. They have the

benefits of communal living, with communal areas available for them to use and a package of care which is tailored to their individual needs. Extra care sheltered schemes also have staffing available 24 hours who can respond if there is an emergency.

They offer a real alternative to residential care.

The most recent extra care scheme is operated by North Tyneside Living. Crossgates is an Extra Care scheme which has been open for just over a year. Crossgates in in a building operated by North Tyneside living and also has two North Tyneside Reablement members of staff embedded in the scheme so that individuals are supported to maximise their independence when they move there. This has resulted in reducing people's care packages, maintaining independence for longer and increasing individual's wellbeing. A care provider is commissioned separately to deliver

The Council's Market Position Statement for housing for vulnerable adults supports the development of extra care provision across the borough and having at least one extra care scheme in each of the borough's four locality areas. We need to develop an extra care service in the Whitley Bay area but this has proved difficult due to availability of suitable land and land values to make the scheme economically viable.

Also there is a gap in provision around extra care for dementia and we are working with the housing and care markets to see how this gap can be filled.

See the Case Studies highlighted in the Appendix in Section 4 below.

3.5 Pressures in the system

Demographic changes mean that there is potential for significant increasing demand on the Council from the aging population and from the numbers of people with disabilities and mental health issues.

At this stage we are seeing a small but consistent net increase in the number of people (approx. 100 per annum) supported with Personal Budgets under the Care Act 2014. However, the cost of individual care packages is rising dramatically from the increasing level of need people present with and the sharp rising cost of care, through factors such as the National Living Wage.

Our goal is to ensure that 80% of new clients that approach us as a direct result of the Care Act 2014, receive general advice and support and/or simple services such as equipment, without the need for a full home-based assessment.

To support this we've implemented a comprehensive on-line digital offer for advice information and mobile working has been rolled out across all front line teams.

A lack of community providers means that it can be very difficult to access community services to keep people in their own homes.

It must be recognised that for some people, 24 hours care will continue to be required to meet their needs. This is because there is a point for people where they are at too high a risk to remain living independently in their own homes. This is based on the social work assessment process in consultation with other professionals, the individual and their families.

3.6. Performance data

- **Home Care and Extra Care Sheltered**
  In 2018-19 there are currently 975 clients receiving Homecare and 186 receiving Extra Care. This equates to 1145 clients currently receiving Homecare or extra care.

  Year to date 1371 people have received these services in 2018-19. In 2017-18, 1422 clients were supported during the same time period.

  This is a reduction of 51 people receiving a service.

- **Short Term placements**
  There are 53 current short term placements. Year to date 162 people have received this support. During the same period in 2017-18, 176 were supported in short term placements.

  This is a reduction of 14 placements year on year.

- **Long Term placements**
  There are 817 people currently in long term placements.

  Year to date for 2018-19, 954 people have been in long term placements. During the same period in 2017/2018, 1013 clients being supported.

  This is a reduction of 59 placements year on year.

4. Appendices

Case studies

Mrs G

Ms G, a bariatric lady, was in a community hospital. Physiotherapists and occupational therapy completed moving handling and reported she needed the assistance of 3 staff to hoist as she could not weight bare

Ms G's existing property was unsuitable for equipment and she was referred to the Extra Sheltered panel.

A decision was made by the Panel for reablement workers to visit Ms G in hospital and for them to work alongside the physio and OT in hospital for a few days.

Following this reablement worked alongside Ms G for a further 7 days to help her gain confidence doing transfers, Ms G moved into Extra Sheltered and they worked with her for a further 2 weeks building confidence with transfers.

Ms G now has the support of one staff on 3 of her 4 calls and 2 staff to support to lift her legs into bed at night.

Ms G lives a full enjoyable life; she holds an arts and crafts morning within the scheme and takes part in organising other activities. She is part of the Salvation Army and they also visit the scheme and hold organised events for the tenants.

Ms M

Ms M lived in the community she was self-neglecting, drinking excessively and was being exploited by her son and his friends. Ms M needed to move into a short term residential placement to keep her safe. (Ms M has capacity and agreed with support her).

Ms M's case was presented at Extra Sheltered panel and she was allocated a flat.

Reablement workers worked with Ms M rehabilitating her to self-care and better manage nutrition.

Ms M now lives a full life, she no longer drinks alcohol, her presentation and diet has improved she is on the committee at the scheme and takes part in and organising a lot of the activities held there. Ms M moved into Extra Sheltered care with 17hrs - 45min care per week she now has a package of 6hrs – 45min per week. This is a reduction of 11 hours per week.