TRAFFORD COUNCIL
CHILDREN, FAMILIES & WELLBEING

Report to:	**Health & Wellbeing Board**
Date:	**22/11/13**
Report for:	**NHS Support for Social Care 2013/2014**
Report author:	**Finance Manager**
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Report Title

Joint Report of Trafford Council and Trafford CCG
NHS Support for Social Care 2013/2014

Summary

The report outlines the additional monies allocated to Trafford Clinical Commissioning Group (CCG) for NHS support for social care covering the period 2013/2014. The report indicates where the additional monies are allocated, the resultant increased activity and outcomes and outlines the reporting responsibilities attached to the monies.

Recommendation(s)

That the Health and Wellbeing Board
agrees to:

- the allocation of the NHS Support for Social Care monies 2013/14
- the outlined monitoring arrangements

Contact person for access to background papers and further information

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Introduction

Additional monies have been allocated from the Department of Health to provide support for Local Authority Adult Social Care. NHS England will enter into an agreement with each Local Authority and individual arrangements will be administered by the NHS England Area Teams (and not Primary Care Trusts as in previous years). These funds will be transferred under a Section 256 agreement of the 2006 NHS Act.

The funding must be used to support Adult Social Care services in each local authority, which also have a health benefit. However, beyond this broad condition, NHS England will provide flexibility for local areas to determine how this investment in social care services is best used.

The joint local leadership of Clinical Commissioning Groups (CCGs) and Local Authorities, through the Health and Wellbeing Board, is at the heart of the new health and social care system. NHS England will require the Local Authority to agree with its local health partners about how the funding is best used within social care, and the outcomes expected from this investment. Health and Wellbeing Boards will be the forum for discussions between the Area Teams, CCGs and local authorities on how the funding should be spent.

Allocation

The allocation for Trafford is:

Year	£000's
2010/2011	649
2011/2012	2,595
2012/2013	2,478
2013/2014	3,385

Reporting Requirements

The Area Teams will ensure that the CCG and local authority take a joint report to the Health and Wellbeing Board to agree what the funding will be used for, identified outcomes and the agreed monitoring arrangements in each local authority area.

The report will be:

- presented to the Health and Wellbeing Board who will sign it off as an appropriate investment plan,
- agreed by the NHS Area Team who will recommend release of the monies due
- on receipt of the recommendation of the NHS Area Team, NHS England will pass over the money due after the signature of the Section 256 agreement.

Funding Areas

The funding must be used to support adult social care services in each local authority, which also has a health benefit. However, beyond this broad condition, NHS England wants to provide flexibility for local areas to determine how this investment in social care services is best used.

The funding can be used to support existing services or transformation programmes, where such services or programmes are of benefit to the wider health and care system, provide good outcomes for service users, and would be reduced due to budget pressures in local authorities without this investment. The funding can also support new services or transformation programmes, again where joint benefit with the health system and positive outcomes for service users have been identified.

In Trafford funding in previous years has been spent on:

- Additional short-term residential care places, or respite and intermediate care;
- More capacity for home care support, investment in equipment, adaptations and telecare;
- Investment in crisis response teams and other preventative services to avoid unnecessary admission to hospital; and
- Further investment in reablement services, to help people regain their independence and reduce the need for ongoing care.

The funding provided for 2013/2014 is intended to develop;

- Older Peoples Rapid Response – to support urgent and enhanced care
- Short Term Beds – Ascot House
- Residential and nursing care
- Personal Budget capacity
- Reablement
- ICES
- Telecare

With the objective to;

- Improve and promote independence and quality of life
- Support integrated care, in the right place at the right time
- Prevent unnecessary hospital admissions
- Prevent unnecessary residential and nursing care admissions
- Prevent delayed discharges

Again this is a local decision, between the Council, CCG through the Health and Wellbeing Board as to how this funding will be spent.

Trafford Position
2013/2014 Allocation £3,385k

Funding Allocated	2013/2014 £000's
Older Peoples Rapid Response	412
Night Service	200
Short Term Beds – Ascot House	477
Residential and nursing care	477
Personal Budget capacity	406
Reablement	706
Equipment and Adaptations	270
Telecare	437
Total	**3,385**

Approval of the final allocation of this is required.

Increased Activity and Outcomes

Telecare

Indicator	12/13 out-turn	13/14 Q2 position	13/14 end year projection
Number of people receiving Telecare in Year	1,792	1,851	2,400 – 33% increase on 12/13 end year
Number of new people aged 65+ receiving Telecare	664	489	980 – 48% increase on 12/13 end year
Number of new people aged 18-64 receiving Telecare	82	90	105 – 28% increase on 12/13 end year

Outcomes

680 new people have benefitted from Telecare installations from April – end October 2013. The table below lists the outcomes that were expected at assessment. The overall total is more than 680 as more than one outcome could be identified for each individual.

As can be seen below, Telecare installation was intended to;

- Facilitate Hospital Discharge in 23.5% of cases
- Minimise risk of falls in 65% of people
- Reduce the likelihood of admission to hospital in 56% of cases
- Improve health and emotional wellbeing in 54% of cases

The expected outcomes are highlighted when a referral is made to the telecare provider (Trafford Housing Trust). The intention is that, on review, these outcomes would be discussed with the user to assess whether they felt they were met.

For example, the outcome “Facilitate hospital discharge” – these people would have been in hospital when referral to telecare was made so 23.5% of referrals (160 / 680) can be said to have facilitated hospital discharge.

Outcome Expected	Number	% of people
Minimise risk of falls	445	65.4%
Manage the effects of dementia	104	15.3%
Enable independent living	525	77.2%
Support carer	340	50.0%
Facilitate Hospital discharge	160	23.5%
Living safely in own home	574	84.4%
Reduced likelihood of admission to Residential/Nursing Care	273	40.1%
Overall improved health and emotional wellbeing	366	53.8%
Reduced likelihood of admission to hospital	379	55.7%
Reduction/change to Home Support package	64	9.4%

Below is case study evidencing the effectiveness of Telecare

Telecare in Action

Mr P was admitted into hospital due to increased confusion and falls, he was discharged from hospital to Ascot House.

Although Mr P had advanced dementia, he had a very good daily routine. Mr P was discharged from Ascot House back home with a falls alarm and “Just Checking”.

Mr P went to the local Newsagent every day at 10.00a.m.; his son monitored the “Just Checking” around this time as his father had fallen once before when going out for his newspaper. Mr P’s son phoned central control as he had not returned home. Mr P again had fallen while outside. Central control phoned the carers who were supporting Mr P at home, and they found him on the floor close to home and called an ambulance.

Mr P returned home that same day as he suffered no serious injury, but he and his family agreed that it would be better for the newspaper to be delivered from now on. Day care support was then arranged for Mr P as Mr P could soon begin to feel isolated.

“Just Checking” not only proved that Mr P had an excellent daily routine at home and slept well at night, it also identified instantly that he had not returned home from buying his newspaper and provided emergency care to minimise length of stay in hospital

Equipment and Adaptations

Indicator	12/13 out-turn	13/14 Q2 position	13/14 end year projection
Total number of equipment / minor adaptations provided	13,950	9,485	18,800 – 38% increase on 12 / 13 end year

In 2012 / 13 we were able meet 85.1% of our target for urgent waiting times (within 7 days to delivery) and 64.8% for those clients classed as 'non-urgent' (within 8 weeks to delivery).

In the year 2013 / 14, we have improved our waiting times for clients to 100% within agreed delivery times for both urgent and non-urgent clients.

Effective delivery of equipment and adaptations ensure the following outcomes:

- People able to remain living independently in their own homes
- Reduction in residential admission
- Reduction in hospital admission
- Timely discharge
- Diversion from more expensive and on-going health and social care services

A sample survey of people who had received equipment / adaptations in the last six months of 2012 / 13 was carried out in April 2013.

- 380 people were surveyed, from which we received 145 responses.
- 96% of respondents reported that receiving equipment / adaptations "had made their life better"

In relation to outcomes:

- 26% reported that it had reduced the likelihood of admission to hospital.
- 35% reported that it had reduced the amount of time they need help from people supporting them.
- 70% reported that it made them feel safer.

Below is an One Stop Resource Centre case study that was included within the Local Account for 2012 / 13

Integrated Care in Action – One Stop Resource Centre

Mrs X needed both equipment and adaptations in order to keep her safe in her own home. Joint assessments took place between Occupational Therapists and Adaptation Officers in order to identify and agree a plan of action. Both had to work closely with Social Workers and the Fire Service to meet Mrs X's needs.

Through this 'integrated' work which involved Occupational Therapists, Manual Handling and Nurses from Health, Majors / Building Control / Social Workers from the Council, Stakeholders including Trafford Housing Trust, Fire Service, Ambulance Service and Equipment Suppliers, we were able to ensure Mrs X was able to remain in her own home to receive very specialist and complex care

Reablement

Indicator	12/13 out-turn	13/14 Q2 position	13/14 end year projection
Total number of community reablement episodes provided in year	1,647	959	1918 – 12% increase on 12 / 13 end year
Total number of days community reablement provided in year	49,619	31,087	62,174 - 25% increase on 12 / 13 end year

Outcomes

We have 2 local indicators that monitor the outcomes from community reablement provision;

- Average % reduction in service hours following reablement intervention in year – as at Q2 (13 /14) this stood at 60% (against a target of 60%)

- % people receiving no on-going service following community reablement intervention - as at Q2 (13 /14) this stood at 46% (against a target of 50%)

Savings analysis of community reablement.

The table below provides an analysis of the potential savings that are being made via community reablement provision based on 2012 / 13 information.

Number of people successfully completing an episode of community reablement	789
Total hours received at the **start of reablement** for the 789 episodes	8,642
Average weekly hours at the **start of reablement** for the 789 episodes	10.95 / week
Total hours received at the **end of reablement** for the 789 episodes	1,809
Average weekly hours at the **end of reablement** for the 789 episodes	2.29 / week
Total hours saved per week for the 789	(6,833)
Average hours saved per person per week	(8.65)
Total cost of hours saved per week @ £12.62 / hour	£(86,230) / week
Potential Full year effect of the reduction in hours (hours saved / week X 52)	£(4,483,920)
Taking the above: Based on a normal distribution of people entering and leaving the service in a year the saving arising from the hours saved is estimated at	£(2,033,000)

Taking the above: Based on an assumption of 50% of people requiring an increase in services due to needs changing the notional saving is in the region of:	**£(1,016,500)**

For every person that successfully completes an episode of reablement, the reduction in their care package cost equates to £(109.29) / week or £(5,683) / year before adjusting for changes in needs after reablement.

The work of the reablement team in benefiting the whole health and social care economy is demonstrated through the following improvements in health related indicators

Information within the AQUA / ADASS report evidences clear improvement across a range of indicators that are intended to support the development and monitoring of integrated health and social care working with a particular focus on frail elderly.

The information below is based on a "rolling year" and compares the 2 most recent reporting periods; April 2012 – March 2013 and June 2012 - July 2013

Indicator	April 2012 – March 2013	July 2012 – June 2013	Improvement
Non-elective admissions aged 65+ per 1000 pop 65+	258	255	1.2%
Non-elective bed days aged 65+ per head of 1000 pop 65+	3092	2962	4.2%
Non-elective readmission rate within 30 days aged 65 and over	16.8%	15.8%	6%
Non-elective readmission rate within 90 days aged 65 and over	27.9%	24.9%	11%

The information below compares the Delayed Transfers of Care bed day's figures from March 2013 to September 2013.

Indicator	April 2012 – March 2013	July 2012 – June 2013	Improvement
Delayed transfers of care (Bed Days) per 100,000 population 18+	255	146	43%

The National ASCOF indicators relating to Delayed Transfers of Care have also seen a significant improvement since 2012 / 13 year end as evidenced below;

Indicator	April 2012 – March 2013	April – Sept 2013	Improvement
Delayed transfers of care (all) per 100,000 population 18+	7.6	6.2	18%
Delayed transfers of care (Adult Social Care responsible) per 100,000 population 18+	4.1	2.1	49%

Below is a reablement case study that was included within the Local Account for 2012 / 13

Promoting Independence in Action – Community Reablement

Mr A was referred to the Reablement team by Trafford General Hospital, for an assessment of his needs. Mr A had suffered from a stroke which had affected his mobility and speech. Prior to his stroke he was an independent man who was retired and lived with his wife. He didn't live in the local area but was planning to move here, to be near other family members.

Necessary arrangements were made, and he was registered with the local doctor. The hospital sent information Mr A had shared to the Reablement team. When he was discharged a member of the team met Mr A at his home. The Occupational Therapist in the hospital had assessed Mr A would require a range of equipment; these were in place and ready for him when he got home.
At this stage the Reablement team provided four calls a day with two carers to support Mr A with all his personal care needs.

The team continued to support Mr A in his new surroundings and helped him regain his confidence. Mr A was recovering well from his stroke and his abilities increased. Consequently a referral was made for an OT assessment for new equipment relative to his improved mobility.

New equipment was provided, which Mr A was supported to use. Again, as he grew more comfortable with these, and his strength and mobility increased, the Reablement workers reassessed him. Mr A's was now able and comfortable to use the equipment with minimal assistance from one carer.

The Reablement team worked with both Mr A and his wife, as Mr A's mobility improved both he and his wife grew more confident to manage certain aspects more independently. With the A's agreement, visits were staggered to allow them to try to things on their own, gradually, at their pace, services were reduced to one visit in a morning by one carer.

A Social Care Assessor (SCA) reviewed the assessment and long term options were discussed with Mr and Mrs A. They chose a commissioned service and Trafford Council arranged this support. When the SCA carried out the six week review, Mr and Mrs A felt confident that they could manage independently but were concerned that Mr A's needs might change in the future and they wouldn't have any support.

The SCA reassured Mr and Mrs A that they could refer themselves at any time for a reassessment through the screening team. With this information Mr and Mrs A felt comfortable to cancel the care completely, returning their independence and control over their lives.

LD Reablement

In 2012 / 13, we expanded our reablement provision to cover people with Learning Disabilities. Development of the service in 2013 /14 is evidenced by the information below.

Indicator	April 2012 – March 2013	13/14 Q2 position	13/14 end year projection
Number of episodes of community reablement (LD specific)	57	50	100 – 75% increase on 12/13 end year
Number of days LD specific reablement provided	4604	3169	6338 - 38% increase on 12/13 end year

The role of the Learning Disability Reablement Service is to increase individuals functioning, independence and social capital and reduce reliance on formal health and social care services.

Short Term Beds - Ascot House

Indicator	12/13 out-turn	13/14 Q2 position	13/14 end year projection
Number of episodes of residential reablement provided	197	110	220 – 12% increase on 12/13 end year
% of people returning home following assessment unit intervention	42.7%	47.1%	48% - 12% improvement on 12 / 13 end year

The unit at Ascot House has also incorporated 5 health funded beds since April 2013. In this period, 33 people have completed a period of reablement with 30 (91%) returning to their home address.

Savings analysis of residential reablement.

The table below provides an analysis of the potential savings that are being made via residential reablement provision based on 2012 / 13 information.

Number of people **accessing** the assessment unit	192
Number of people **returning home** following assessment unit intervention	82
Average **estimated cost of a care package** for those returning home (10 / hours / week)	£126.20
Average **cost of a residential / nursing care placement** / week	£400
Average **cost saving per week** for those diverted from residential / nursing care.	£(273.80)

Total weekly savings for those 82 people diverted from residential / nursing care in 2012 / 13.	£(22,452)
Potential full year effect of savings for those people diverted from residential / nursing care (weekly savings 52)	**£(1,167,483)**
Based on a normal distribution of people entering and leaving the service in a year the saving arising from people diverted from residential/nursing care is estimated at	**£(478,600)**

For every person that returns home from the assessment unit having been diverted from long term residential / nursing care, the reduction in their care package cost equates to £273.80 / week or £14,237.60 / year before adjusting for changes in need after leaving Ascot House.

Integrated Care in Action – Ascot House

Mr G was admitted to Ascot House for a six week assessment. When he arrived at Ascot House Mr G required maximum support in all areas of daily living. Mr G was determined to return home and worked with a range of health and social care staff, including Physiotherapists, Occupational therapists and Carers to improve his mobility. The social care assessor arranged a package of care and Telecare equipment including falls detector, bed sensor, pendent alarm and key safe.
Due to the progress he made and the improvement in his confidence and mobility Mr G was able to return home after four weeks. This case shows how joint working with partners can have a positive and successful outcome enabling individuals to return home maintaining independence and preventing the need for 24hr residential care/nursing care and reducing hospital admission

Rapid Response

Indicator	12/13 out-turn	13/14 Q2 position	13/14 end year projection
Number of episodes of Rapid Response provided	511	287	575 – 12% increase on 12/13 end year

The following case studies provide examples of the effectiveness of the Rapid Response service;

Rapid Response in Action

1. Mr L

Referred from Wythenshawe Hospital as palliative care, this gentleman had been given a poor prognosis and he and his family wished for him to return home to spend his last days. Hospital occupational therapist had organised the necessary equipment before discharge home. Senior Support worker visited on the first day with a support worker to carry out personal care needs and complete the risk assessments. Senior discussed with Mr L and his wife the service and confirmed the visits would meet his needs. During visit Senior noticed that the armchair that had been raised was too high as there was a pressure cushion on it. Mr L was then referred to our Occupational Therapists to rectify the problem. Over the subsequent few days Mr L deteriorated and was unable to mobilise and needed to be cared for in bed which meant the support staff needed to be increased from one to two carers. Mr L was at home for a total of 6 days when he passed away in the comfort of his own home which was his and his families wish.

2. Mrs N

Referral received direct from District Nurses as Mrs N was not coping at home. She was on the reablement waiting list but was now no longer able to wait for support. Mrs N had severe arthritis and had been experiencing falls due to restricted mobility. Senior visited to complete risk assessments with family also present. It was noted that Mrs N was struggling to get up from the chair and bed due to arthritis in her hips and had poor dexterity in her hands making the simple tasks such as wringing a cloth or dispensing her medication very difficult. Referral was made to the Occupational therapist to look at raising the bed and chair to a manageable height and provide a perch stool in both kitchen and bathroom so that Mrs N could sit while completing tasks. Advice was given to purchase either a sponge or lighter flannel that Mrs N could wring out. Blister pack was discussed and following agreement by Mrs N ordered with GP so that she could manage her medication independently. Mrs N was on our service for approximately 3 weeks when she cancelled all support as she felt she had regained her independence which our records also confirmed.

Waking Nights Service

The waking nights' team consist of 7 members of staff that each work 3 nights a week - 30 hours. They work from 10 pm – 8 am over 7 days.

The service started in October 2011 and was set up with the aim of reducing the number of admissions to Hospitals and, where possible, assisting service users to return back to their home within the community in the Trafford area. The team work alongside the district nurses and when they are not assisting service users in the community they are based in Ascot House Sale. The District Nurses contact the staff if they receive a call that a service user requires assistance in the community and the staff attend in two's.

Staff also pick up from referrals from A & E Departments at Trafford General and Wythenshawe Hospitals and assist with a "meet and greet" at the service user's home if they require assistance once back home. The team also assist with night sits that can be pre booked through the Rapid Response team if a service user requires an assessment of night time needs. Staff also assist with night sits for palliative care end of life service users or emergencies that might happen when on duty with the District Nurses. Night sits are a maximum of 3 nights.

The number of visits that the staff have made from the 1st April 2013 – 30th September is 414.

Outcomes include

- Diversion from A+E
- Prevention of hospital admission
- Support to carers
- Promoting independence and quality of life

Monitoring Arrangements

NHS England will require expenditure plans by local authority to be categorised into the following service areas (Table 1) as agreed with the Department of Health. This will ensure that NHS England can report on a consolidated position on adult social care expenditure.

Table 1:

Analysis of the adult social care funding in 2013-14 for transfer to local authorities

Service Areas- 'Purchase of social care'	***£000's***
Community equipment and adaptations	270
Telecare	437
Integrated crisis and rapid response services	412
Maintaining eligibility criteria	0
Re-ablement services	706
Bed-based intermediate care services	0
Early supported hospital discharge schemes	477
Mental health services	0
Other preventative services	0
Other social care: Personal budget capacity	406
Other social care: Residential and nursing care placements	477
Other social care: Night service	200
Total	**3,385**

Furthermore, as part of the agreement with local authorities, NHS England will require access to timely information (via Health & Wellbeing Boards) on how the funding is being used locally against the overall programme of adult social care expenditure and

the overall outcomes against the plan, in order to assure itself that the conditions for each funding transfer are being met.

Conclusion

The 13/14 funding allocation is intended to be invested in services that benefit the Trafford Health and Social Care economy and support our shared journey towards integrated care. The funding transfer will make a positive difference to Social Care Services, and outcomes for service users, compared to service plans in the absence of the funding transfer

The plan provides a robust foundation for the development of Integration Transformation Fund plans as it focuses on the five outcomes already identified as ITF priorities:

- Delayed transfers of care
- Emergency admissions
- Patient and service user experience
- Effectiveness of reablement
- Admissions to residential & nursing care

Recommendations

It is proposed that;

- Final allocations for the use of this money, as outlined above are agreed by the Health and Wellbeing Board
- Agreement of NHS England for the release of this money as outlined above is sought.