REPORT TO:	**HEALTH & WELLBEING BOARD (CROYDON)** **11 September 2013**
AGENDA ITEM:	**8**
SUBJECT:	**Reablement and Hospital Discharge Programme – Funding Allocations 2013/14**
BOARD SPONSOR:	**Hannah Miller, Executive Director – Department of Adults Services, Health and Housing, Croydon Council**

CORPORATE PRIORITY/POLICY CONTEXT:

At national level, the government, through the Department of Health, sets the strategic direction of adult social care and NHS in England and provides the legal and policy framework to both local authorities and NHS Clinical Commissioning Groups.

The reablement and hospital discharge services detailed below are being delivered at a time of extreme financial challenges. Councils are being asked to reduce their budgets year on year and NHS organisations are working hard to improve their financial position and reduce deficits.

The Reablement and Hospital Discharge programme is using monies allocated by NHS England and has been designed to reduce unnecessary use of costly acute hospital beds, improve people's ability to continue to live in their own homes and prevent or delay entry to long term residential and nursing care, using increased spending on social care to improve health outcomes.

This payment is made via agreement under section 256 of the 2006 NHS Act and will be administered by the NHS England Area Team. The Area Team require the local authority and Clinical Commissioning Group (CCG) to take a joint report to the Health and Wellbeing Board to agree what the funding will be used for, any measureable outcomes, and agreed monitoring arrangements.

FINANCIAL IMPACT:

The NHS monies referred to in this report have enabled the Council to continue providing services to older people and people with long term conditions, and to deliver low hospital discharge delays (see appendix 1 section 12) despite continued demographic demand coupled with reductions in local authority funding; a 29% reduction over the life of the last spending review.

All services detailed in this report are funded from these NHS monies.

1. RECOMMENDATIONS

This report recommends that the Health and Wellbeing Board:

- Notes the achievements made through the Reablement and Hospital Discharge programme during 2012/13 detailed in Appendix 1 to this report;

- Approves the allocation of the Reablement and Hospital Discharge programme funding for 2013/14 as proposed by the Reablement and Discharge Board and detailed in Appendices 2 and 3 to the report.
- Agrees for the Executive Director for Adult Services, Health and Housing to have delegated responsibility for the allocation of any unallocated 2013/14 programme funding.

2. EXECUTIVE SUMMARY

2.1 In 2010 the Reablement and Discharge Board (the Board) was set up by Croydon Council to work with health partners to develop a number of social care initiatives and look at how the investment in social care services provided by the Department of Health could be used to deliver real benefits to health services in Croydon. The Board is made up from representatives from Croydon Council's Department of Adult Services, Health and Housing (DASHH), Croydon Clinical Commissioning Group (CCG), Croydon Health Services (including Croydon University Hospital), G.P.s, and the voluntary sector.

2.2 This investment from central government acknowledged the important role social care plays in enabling acute health services to deal with the demand pressures, and recognised the additional pressures on social care budgets in enabling timely hospital discharge.

2.3 The Board established a number of principles in order to support its work in delivering social care investment to support the delivery of health outcomes:

- ***Prevention is better than cure***

The best treatment and best service is one that is able not only to treat someone early but also increase the delay in the person having to come back for further help. Important to this approach is in enabling a person or someone close to them to take preventative action at an earlier stage.

- ***Let's deal with this right now***

For many minor illnesses, living alone, minor accidents and other life changing events can destroy the confidence and competence of many adults, including having to use expensive acute and secondary health services and equally having a "life time career in care". The use of mixed social care and health services, supporting people to get their confidence back and to learn or re-learn activities of daily living, will provide a better long term solution. Moving away from using day time opportunities in some of the day care centres to providing "treatment" and recovery particularly for older people with mental health illness, will enable better long term living at home in their own community/area.

- ***I don't need to go to hospital***

The overall aim is to avoid hospital admission and to make use of community health and social care budgets to support people to use other alternatives.

- ***Not one more hour***

Inevitably, some people will have to access short term acute care in a hospital setting. This has to be managed to ensure emergency admissions are planning discharge and post hospital care using shared information and data. Better use of services in A&E will continue to reduce waiting times and reduce admissions as social and health care interventions will enable return home wherever that is after treatment.

- ***No quick returns***

Getting people home and out of hospital is a key part of reducing costs and meeting the needs of individuals who in the main prefer not to be in hospital. Preventing people from returning is a difficult balance and relies on follow on services being available and easily accessible. Most importantly it is keeping in touch with people who have left without a great deal of support to ensure they do not re-emerge in A&E.

2.4 The delivery of health and social care is currently going through a stage of significant national change and transformation. This is against a background of increased national scrutiny of health care services, increasing drive for efficient service delivery and value for money within strict financial envelopes.

2.5 Increasing pressure has been felt within social care in Croydon, where continued reductions in base budget alongside increasing demographic pressure, as a result of an ageing population, has created a challenge in supporting the ongoing work with health to reduce pressure on acute and primary health services.

2.6 The Reablement and Hospital Discharge Programme for 2013/14 (the Programme) has recognised that the delivery of earlier hospital discharge leads to additional demand and cost pressures on social care. Recent analysis presented to the Board has shown that there has been a 23% increase in council brokered domiciliary care packages between April 2011 and March 2013, which translates to a structural financial pressure of circa £2.5 million on the DASHH budget. The overall growth is largely explainable by a 58% increase in new hospital discharge care packages over the same time frame.

2.7 The early evidence suggests that earlier hospital discharge is leading to an increasing number of people requiring long-term support. It is therefore expected that the 23% structural growth will continue to grow over the next 12 to 18 months as the recent increase in hospital discharge care packages works its way through the system. This has been built into the Board's consideration of funding allocation of the 2013/14 Department of Health monies to social care.

3. DETAIL

3.1 Based on the principles developed by the Reablement and Discharge Board, the reablement programme funded 24 workstreams with the Department of Health allocated social care funding to Croydon. These are detailed in appendix 1.

4. FINANCIAL AND RISK ASSESSMENT CONSIDERATIONS

4.1 The funding for all reablement initiatives detailed above is provided from the Department of Health via the NHS England.

4.2 The Department of Health allocation for 2013/14 to Croydon Council is £5.015 million.

4.3 From this allocation the Board has identified continuation funding for a number of existing projects and initiatives that will see sustainable support in adult social care services that will enable better health outcomes. These are listed in Appendix 2.

4.4 In addition a number of new projects have received funding approval from the Reablement Board. These are detailed in Appendix 3.

4.5 A summary of the total allocation for 2013/14 recommended to the Health and Well-Being Board is contained in the table below:

Revenue and Capital consequences of report recommendations

2013/14 Department of Health allocation to social care in Croydon	**5,015,000**
2013/14 Reablement monies for Continuation of projects and services (appendix 1)	3,957,000
2013/14 New Projects (Appendix 2)	763,926
Monies to be allocated (see para 4.6)	294,074
Total	5,015,000

4.6 Usage of the balance of the 2013/4 allocation is still to be finalised by Board, however discussions to date have highlighted the need for funding to be available to support the Croydon dementia strategy. It is recommended that this money be held pending development of a suitable business case with delegated responsibility for the final allocation being given to the Executive Director for Adult Services, Health and Housing, Croydon Council.

4.7 An allocation of £400K has been made to Children, Families and Learners in financial years 2011/12 and 2012/13 to support a three year programme that underpins the integration of commissioning of health and children's services for under 5's in readiness for embedding the local authority's new health visiting commissioning role that starts in 2015. Due to the delay in implementing this project funding is not required for 2013/14.

4.8 There has been careful consideration given to developing initiatives that align with Croydon Clinical Commissioning Group Transformation Plan (2013-17). This has included ensuring social care capacity is in place to support the ongoing development of multi-disciplinary teams in the GP clusters, the development of a single point of assessment and Rapid Response Service, whilst continuing to support a range of initiatives that seek to:

- alleviate pressure on urgent and emergency care services through a range of early intervention and care support initiatives;
- support timely and safe hospital discharge;
- provide post discharge reablement services to enable people to regain functional, practical and social skills with a view to preventing early and unplanned re-admission to hospital.

4.9 In order to achieve the above health focused outcomes, the Board also recognises that the delivery of early intervention and earlier hospital discharge can lead to additional demand and cost pressures on social care. These translate both in terms of demands placed on existing staffing resources, and pressure on care package budgets within Croydon adult social services which if not met would lead to social care services not being in place and as a consequence would increase the pressure on hospital resources.

4.10 Funding for future years is expected at an increased level to support the implementation of the Care Bill but at present figures have not been confirmed by the Department of Health.

4.11 The effect of the decision

The Department of Health 2013/14 allocation to social care will enable DASHH to continue to provide services to help prevent unplanned admissions to hospital and enable timely and safe discharge from hospital. The monies will help alleviate some of the demographic pressures facing the Department as a result of an aging population which is placing demand pressure on health and social care services.

4.12 Risks

The programme risks, along with potential mitigating actions, are set out below:

Risks	Mitigation
Department of Health does not allocate winter pressures grant as per previous years, or the amount allocated is less than required to meet additional demand and as a consequence places pressure on social care budgets.	• Unallocated monies from the Department of Health for Social Care 2013/14 allocation, or monies held in reserve as a result of late start projects could be used to cover any shortfall and alleviate social care revenue pressure.
Projects or initiatives funded do not meet objectives in supporting the avoidance of unplanned hospital admissions and timely and safe discharge.	• Reablement Board reviews all projects in order to ensure monies are targeted appropriately and effectively.
Projects or initiatives funded exceed budget allocations	• Reablement Board reviews all projects and any projected overspends can be reviewed and appropriate action taken.

4.13 (Approved by: Paul Heynes, Head of Finance (DASHH) on behalf of the Director of Financial Services)

5. CONSULTATION

5.1 There have been a number of events where there has been engagement with G.Ps, Croydon Health Services, Croydon University Hospital, S.W London Commissioning Support Unit (CSU) and Croydon CCG. These have been to gain feedback on specific areas of development sponsored through the Reablement Programme, or to enable the tie in of the programme to key strategic developments within the Croydon health economy.

6. SERVICE INTEGRATION

6.1 The programme reports to the Reablement Board whose membership is made up from the local authority, Croydon CCG, Croydon Health Services, and the voluntary sector.

6.2 There is also close liaison with the Urgent Care Network where updates are provided and issues raised are fed back to the Reablement Board.

6.3 The programme is also working to develop a partnership with S.W Commissioning Support Unit (CSU) on the development of the health and social care dashboard (see appendix 1, item 18).

7. LEGAL CONSIDERATIONS

7.1 The Council Solicitor comments that under s.256 of the National Health Service Act 2006 payments may be made to a local social services authority towards expenditure incurred or to be incurred by it in connection with any social services functions.

7.2 (Approved by: Gabriel MacGregor, Head of Corporate Law on behalf of the Council Solicitor & Monitoring Officer)

8. HUMAN RESOURCES IMPACT

8.1 There are no immediate H.R issues that arise from the recommendations of this report for London Borough of Croydon staff.

8.2 (Approved by: Michael Pichamuthu. On behalf of Heather Daley, Interim Director of Workforce)

9. EQUALITIES IMPACT

9.1 There is an overarching equalities impact assessment for the reablement programme.

10. ENVIRONMENTAL IMPACT

10.1 There are no environmental impact issues that arise from the recommendations of this report

11. CRIME AND DISORDER REDUCTION IMPACT

11.1 There are no crime and disorder impacts arising from the recommendations of this report

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Appendix 1

2012/13 Reablement Funded Projects and Initiatives

1. GP access to Home care hours using simple process of call off from providers

The aim of this project was to enable G.P.s to arrange for domiciliary care support to be put in place quickly in order to prevent unnecessary admissions to hospital.

This service had been operational since April 2012 and was able to provide up to 4 social care visits per day of up to one hour per visit, for up to 72 hours to allow time for a full social care assessment by London Borough of Croydon staff. Take up of this service continued to be low despite further promotion of the service by Careline Plus with only 12 appropriate referrals being received from the start of the project to March 2013.

Reablement Board made the decision to close this project as the ongoing costs of the service could not be justified with such low demand.

2. Easy access to equipment using 'prescriptions' from GPs from local suppliers and the LATC

To enable people at home to manage health conditions, mobility and other related problems by the speedy provision of simple aids to daily living.

This service has been operational since March 2012 and enables all Croydon GPs to order the following pieces of equipment for London Borough of Croydon residents, 24 hours a day, 365 days a year, as part of any package to avoid a hospital admission:

- Standard commode
- Ordinary bedpan
- Slipper bedpan

This service continues to be used by GPs with steady demand per month and a total of 63 pieces of equipment delivered between April 2012 and March 2013. These interventions enabled those individuals to remain at home rather than face a hospital admission with consequent savings to health services.

3. Enabling family carers to be able to get access to health care on an emergency and planned basis. This will involve a mixture of community and institutional respite for the cared for.

The aim of this initiative is to reduce the number of unplanned admissions to hospital and emergency placements in care homes by having community based and care home based respite and other services.

Extra carers respite and emergency respite were commissioned from current providers including Crossroads. From the funding provided in 2012/13 358 short breaks were enabled, providing 10,760 respite hours.

4. **The provision of increased community pharmacy capacity to enable better management of drugs for people living at home, in care homes, and in special sheltered housing as part of the wider approach to raising standards and reducing admissions to hospital.**

The aim is to reduce the number of admissions to acute care, increase the health and well-being of patients/service users, and reduce the overall cost of unused and/or inappropriate drugs through the better management of drugs and medication to reduce the number of admissions to acute care.

In 2012/13 286 patients were reviewed in their own home with 176.4 emergency admissions to hospital avoided (based on RIO assessment).

The special sheltered element of the project reviewed 34 patients in 2012/13 with 9 patients with clinical issues arising from their medication being identified and 4 emergency admissions to hospital avoided.

5. **Improve end of life care by increasing the social care capacity. There will be two components to the investment.**

Project A: to expand the support to care homes to enable them to make better provision under the Gold Standard Framework (GSF).

The CCG has been working across Croydon to develop end of life care in Nursing Care Homes with the Gold Standards Framework (GSF). This is the 5th year of the project. The scheme was extended to Residential Care homes in 2012; to date 4 residential homes have been piloted. 16 Nursing homes have received full accreditation, 4 are awaiting results, 4 are preparing for accreditation and 6 are still in the process of undertaking the GSF programme.

The aim of the project is to promote best practice to care homes and formally accredit them in the use of the GSF.

The high facilitation model is used by St Christopher's to roll out the model, and ensures that the GSF is fully embedded across all operational processes at the time of accreditation.

The service facilitates:

- Advance Care Planning for residents
- Appropriate and timely discussions with relatives
- Monthly review meetings with GPs
- General advice and support
- End of Life medications as stock in nursing homes

This project supports the wider end of life care agenda and support to care homes to improve quality and outcomes for patients. There has been an increase in the number of patients dying in a nursing home, rather than in an acute hospital, over the past 5 years.

CCG	Sept 2007 – Aug 2008	Sept 2008 – Aug 2009	Sept 2009 – Aug 2010	Sept 2010 – Aug 2011	Sept 2011 – Aug 2012	Sept 2012- Aug 2013
Croydon	55% [63/115] deaths across 8 NHs	66% [248/375] deaths across 23 NHs	71% [341/477] deaths across 23 NHs	76% [331/435] deaths across 25 NHs	79% [389/492] deaths across 25 NHs	80% [326/408] deaths across 25 NHs

Further investment is required to:

- Undertake the GSF in 5 new and 1 remaining nursing home
- Provide sustained support to nursing homes requiring re-accreditation
- Roll GSF programme out to 27 residential care homes

Project B: to work with St Christophers Hospice in the expansion of their social care service.

This is a project which aims to increase the number of people in the last year of their life who choose to end their lives in their own home (including care homes) and therefore reduce the use of acute care. The service provided by St Christopher's has 20 to 25 carers and provides approximately 200 hours care per week (around 30 clients at any one time). The service is available between 6am and 11pm for 7 days of the week.

In 2012/13 St Christopher's dealt with 143 referrals and care hours provided rose to 234 hours per week in February 2013. The project enabled 77% of those referred to St Christophers to die in their own homes.

6. Better audit of infection control/ tissue viability in care homes for the prevention of admissions/ readmissions to acute care and enable earlier hospital discharge by enabling better management in care homes with/ without nursing.

This initiative aims to ensure the better audit of infection control/tissue viability in care homes in order to reduce unplanned admissions or readmissions to acute care and enable earlier hospital discharge by enabling better management in care homes.

The 2 infection control nurses and the project officer work within the DASHH Care Support Team and undertake care home audits and direct guidance and clinical interventions at care homes with the aim of reducing unplanned hospital admissions. An important focus of is to work with care homes has been on

improving competence in practice areas where a skill deficit or lack of confidence are likely to result in avoidable A&E attendance.

In 2012/13:

- **39** homes have been directly supported
- **31** baseline audits have been completed

The nurses have trained care home managers in the following:

- Diabetes Awareness/Foot care – Total trained - **32**
- Skin/wound care and pressure ulcers and safeguarding responsibilities of manager and staff. – Total trained – **21**
- Infection Control/ Health care acquired infection/10 compliance criteria. – Total trained **21**
- Role of Health Protection Unit with regards to supporting and advising care home managers (outbreaks) – Total trained **21**
- Continence and catheter care – Total trained **21**

No figures for the number of hospital admissions avoided as a direct result of nurse intervention were formerly recorded in 2012 as the emphasis was on the provision of training to care homes. The formal monitoring of specific client interventions was started in August 2012 using the RIO methodology. Therefore, based on this methodology since August 2012 to March 2013 a total of 9.2 hospital admissions were avoided providing an estimated cost saving of £25,760.

Month	Total number of resident specific interventions	Number of RIO level 1 interventions	Number of RIO level 2 interventions	Number of RIO level 3 interventions	Number of avoided hospital admissions	Cost avoidance (number of prevented admissions x £2,800)
Aug-12 Total	0	0	0	0	0	0
Sept-12 Total	7	0	7	0	0.7	1960
Oct-12Total	15	0	15	0	1.5	4200
Nov-12 Total	0	0	0	0	0	0
Dec-12 Total	1	0	1	0	0.1	280
Jan-13Total	11	0	9	2	2.9	8120
Feb-13 Total	8	0	6	2	2.6	7280
Mar-13 Total	7	2	4	1	1.4	3920
Grand Total	**49**	**2**	**42**	**5**	**9.2**	**25760**

Between April and August 2013 there were a further 4 avoided admissions recorded by the nursing team, but this was not based on RIO scoring.

The impact of the advice and training intervention work being undertaken in care homes by the nursing team will need to be monitored over time to assess the impact through reduction in A&E attendance, and unplanned hospital admissions. This analysis is not available at time of this report.

7. **To provide reablement, recovery or treatment at venues round the borough, and to provide follow up support to ensure**
   a. the progress has been maintained
   b. to ensure any problems are resolved and
   c. make sure any equipment is being used properly and is appropriate for the assessed need.

   The aim of this initiative is to:

   - Ensure that the improvements achieved through treatment, reablement and recovery are maintained and built upon.
   - Offer reablement and recovery services for older people with mental ill health and dementia
   - Ensuring the health and well-being of people is maintained and reducing the need for acute or emergency care.

   People being discharged from Croydon University Hospital are screened by occupational therapy service to identify suitability for reablement, either at home or in one of 6 reablement beds at Addington Heights Residential Home.

   Activity from April 2012 is detailed below:

   <u>1st April 2012 – 31st March 2013</u>

   Reablement programmes (provided within own home) - 504

   Two handed packages of care (reducing need for two Carers to assist a patient). - 74

   Patients discharged from hospital into reablement beds at Addington Heights and provided with a reablement programme. - 39

   <u>1st April 2013 – 31st July 2013 (4 months)</u>

   Reablement programmes (provided within own home) - 386

   Two handed packages of care (reducing need for two Carers to assist a patient). - 9

   Patients discharged from hospital into reablement beds at Addington Heights and provided with a reablement programme. - 13

The Adult Community Occupational Team (ACOT) reablement activity has improved with an increase in staffing levels. Accompanying this, the team have reviewed all O.T reablement processes, reviewed and improved information for patients, and dedicated physiotherapist time has been secured for reablement clients in the community and at Addington Heights. The impact of this is that delays in patients accessing the O.T reablement service has been reduced with referrals being picked up within 5 days post discharge.

Personal Support Division /ACOT held a stock take workshop on 27th June 2013 to review progress to date, and look at new developments within the reablement service offer to be launched to enhance the existing OT led service, and to set a clear pathway for future development within the "whole system" of health and social care in Croydon. This workshop reviewed the demand and financial pressures facing DASHH as a consequence of hospital discharge and reablement in order to inform the next steps in developing the reablement service. Further work will follow on from the workshop with a further workshop with health partners planned for October to coincide with planned launch of Falls and Bone Health Service (See appendix 3), Rapid Response Service, and the continued development of resources supporting G.P cluster multi-disciplinary teams (see appendix 3).

8. **Further investment in Telehealth including the recruitment of a community matron and setting up costs for IT hardware and software to enable more GPs to get online.**

The aim of this project is to expand the use of telehealth and telecare technology to enable improved health care monitoring and enabling patients to improve their health and well-being by increasingly taking responsibility for monitoring their own health condition. The specific aim of this project was to develop the use of telehealth in community nursing services, and pilot the use of telehealth within a residential care home.

However, the reablement funded telehealth project and the NHS Croydon funded G.P telehealth project were brought together in November 2012 and are now being managed as one project.

Whilst progress had been slower than anticipated telehealth has started to gain momentum. The focus has continued to be the appropriate targeting of telehealth on patients where a benefit can be identified, rather than the large scale distribution of equipment to patients where there is not a clear purpose.

From March 2012 to May 2013 the following patient activity was recorded:

	Active	Discharged	Grand Total
Primary Care	21	16	37
Central Triage	36	13	49
Grand Total	**57**	**29**	**86**

In terms of recorded condition of patients referred to telehealth by project:

Condition	Primary Care (G.P)	Community Matron (Central Triage)
Chronic Heart Failure (CHF)	5%	43%
COPD	85%	33%
CHF/COPD	10%	19%
Hypertension		5%
	100%	100%

Analysis undertaken by the University of Kingston of a control group of 31 patients provided with telehealth through this initiative suggests that there was a reduction in both the number of A&E visits (by 22%) and a reduction in unplanned admissions (by 34%). Whilst it is acknowledged that the control group was small the findings indicate the potential for telehealth in Croydon. A telehealth event has been held for G.P.s in May 2013 and follow up work is being taken forward to build on the positive response received.

The telehealth (remote monitoring) project to date has illustrated that there are different types of telehealth solutions to suit different cohorts of patients. This need for a range of telehealth solutions was highlighted at the G.P Open Meeting in May where the opportunities for primary and community health were discussed. These included remote monitoring, remote consultation, and the use of health Apps for android devices (phones and tablets) to enable self-management.

The project is:

- Working with GPs in developing the use of a message and advice texting telehealth service to meet the requirement of the Department of Health GP Remote Monitoring Directed Enhanced Service (DES).
- Working with Croydon University Hospital who are now starting to look at using telehealth to support discharge for people with COPD

- To work with Heart Failure team to identify a cost effective telehealth solution that avoids committing to expensive equipment on a per patient basis
- An “Apps” Advisory Group has been established (August) with the purpose of highlighting Health Apps which GPs and the primary care team can recommend to patients who have been recently diagnosed with a Long Term Condition.

9. To provide a service through the night including turning people in bed to manage skin integrity and to assist in toileting to reduce the need for pads and/or reduce the risk of infection and prevent falls.

Reablement Board has made the decision to close this project as it felt that the demand for this type of intervention is adequately met through community nursing services and other services.

10. Provision of step up, step down and convalescence beds to enable respite, recovery, hospital avoidance, early hospital discharge.

The purpose of this investment is to maintain people in their own homes through the strategic use of beds in care homes for short term post hospital discharge stays that will include reablement alongside recovery and treatment**.**

These short term beds enabled quick discharge from hospital for people who had been deemed fit for discharge by CUH but were not well enough to go home. They were provided by a number of independent providers. The demand for beds had exceeded budget allocation for 2012/13 and created an additional cost pressure on the adult social services budget of £220,000.

11. Using Social Care Triage model based in A&E to ensure patients known to Adult services or new people can access appropriate help and support and if admitted to ensure early discharge plan is put in place.

The aim of this investment is to reduce unnecessary admissions for acute care from A&E by enabling people to return home with short term support following focused treatment.

This initiative has been operational since May 2012 with two care managers working closely with A&E colleagues (Doctors, Nurses, OTs and Physios), to determine the needs of clients presenting to the A&E department. Current service times mirror the hours worked by A&E liaison (9am – 5pm Monday to Friday and 10am to 6pm Saturday and Sunday).

Where there is no medical reason for admission to the hospital but there are possible social care needs, the care managers will complete an adult needs assessment (NHS & Community Care Act) and if required will initiate new services or increases in support. Where clients meet the Fair Access to Care Services (FACS) eligibility criteria for Council social care services and require short term support care packages will be arranged. Where clients do not meet

FACS criteria, advice, information and support is arranged from the Age UK/Red Cross service at Croydon University Hospital. Both options are fully or partly funded by the reablement programme.

In 2012/13 the following action was facilitated by the social care A&E Liaison workers to prevent admission to CUH or minimise near future readmission.

	2012/13
Referrals to A&E Care Management	**279**
People discharged with new or increased package of care	76
People discharged with restart of existing services	40
People discharged requiring Croydon Intermediate Care Services (CICS)	2
People requiring Interim/temporary placement	17
People requiring third party support (i.e. Red Cross)	26
People requiring information and advice	63
Admitted to hospital	55

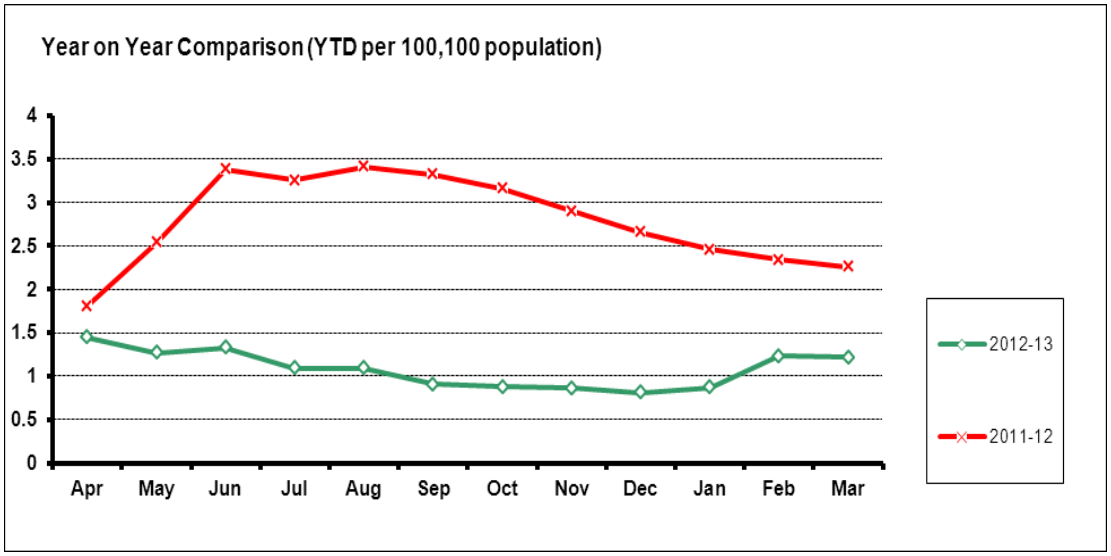
12. Increase the numbers of social care discharge coordinators to join the integrated discharge service to ensure multi-disciplinary teams (MDTs) are brought up to strength.

The aim is to provide better coordinated discharge including people not necessarily the responsibility of the council to ensure safe return home.

Two posts have been funded to supplement the care management discharge team at CUH. This has ensured that care managers are able to be clustered to wards, enabling a closer working relationship, attendance at MDTs and liaison with key staff to facilitate safe and timely discharges. Social care delayed discharges have been maintained at between 0 and 4 per month, at a time of high bed demand at CUH, improving on 2011/12 Department of Health reported performance.

ASCOF 2c Part 2 Delayed transfers of care from hospital, and those which are attributable to adult social care per 100,000 population (measures overall delays attributable to Social Services only)

		Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
2012-13	No. delays	4	3	4	1	3	0	2	2	1	4	2	3
	Monthly	1.45	1.09	1.45	0.36	1.09	0.00	0.73	0.73	0.36	1.45	0.73	1.09
	YTD	**1.45**	**1.27**	**1.33**	**1.09**	**1.09**	**0.91**	**0.88**	**0.86**	**0.81**	**0.87**	**0.86**	**0.88**



13. To provide support for people in the community to prevent a return to acute care or into a care home of any kind by using peripatetic staff (generic community workers) to provide follow up care and support.

To prevent inappropriate returns to acute care and prevent loss of income for treatment for acute hospitals for patients discharged from hospital that had not been assessed as eligible for reablement but required short term packages of care at home in order for them to be discharged from hospital.

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Support continued to be offered through approved agencies and arranged through Council Brokerage Teams.

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14. Development of support services for people with psychological issues including depression.

The aim of this initiative will be to decrease the number of people needing to access acute or institutional care for treatment and support because of a lack of a community based psychological alternative.

The IAPT (Improving Access to Psychological Therapies) therapist at the heart of this pilot took up their post in mid-August 2012

Key outputs to be delivered by the project, and progress to date, are set out below numbered 1 to 3:-

1. Complete psychological treatment of 60 individual patients from Croydon University Hospital (CUH):- older adults, with a chronic history of inpatient use for physical health care problems, with identifiable common mental health problems.

Clients Commencing Treatment

2012	
September	8
October	9
November	8
December	5
2013	
January	12
February	5
March	6
April	4
May	4

The service remains on course to complete the treatment of 60 persons within the life of the pilot.

2. Train acute care staff to identify their clients with common mental health problems; the treatment of which will mitigate their use of acute care services, particularly inpatient care at CUH.

- The pilot has been slow in enabling acute care staff to incorporate case finding of suitable mental health cases into usual assessment processes. Work will continue to improve this situation.

3. Train acute care staff to support their patients with self-help materials that will assist the patient to self-manage low levels of depression and anxiety.

- Self-help materials have been developed and are in use in the service, including audio Compact Discs (CDs). Take up by patients' remains low.

Planning for the future of the second year of the pilot has begun. New directions to develop the service include:

- Establishing a care pathway to the Intermediate Care Teams for cardiac and COPD patients;
- Removal of the lower age limits, to include adults of all ages;
- Establishing the service in a primary care setting.

Additional Reablement Projects - Funding from Previous Years Allocations

15. Alcohol Liaison Service:

Alcohol Liaison/Diversion service is an approach to remodeling service provision in both the community and the acute settings, to improve both quality of care and cross agency working to reduce alcohol related hospital admissions.

The Alcohol Enhanced Outreach Practitioner started on the 4th March 2013 and the Community Alcohol Nurse started on 8th July 2013

An initial list of clients was identified following project launch from people already known to the service, although it was acknowledged that many of these did not exactly fit the project criteria as several had already engaged with treatment services. As part of the early work of the project the outreach worker began to develop the client base for the project with clients that fit the criteria (alcohol dependent, high levels of unplanned contact with CUH) and is building up baseline data and client profiles as the project progresses.

The number of clients seen by the outreach worker to date is 12. The outreach worker is currently case managing 12 clients from Palmer House. There has already been a noted reduction in ambulance call outs and hospital admissions with this initial cohort of clients in the first 4 months of the project. This has been evaluated by looking at the pattern of call-outs and admissions for this group of clients for 5 months pre project start and 5 months after the start of the project start.

The project has faced some challenges and delay in the recruitment of the community nurse post. After a second interviewing process a community nurse has been recruited.

16. Reablement Service for Mental Health Services

A pilot to develop a reablement service designed to provide an improved service option for clients diagnosed with severe mental illness, who would ordinarily be accepted for care-coordination support delivered by the secondary mental health service.

This service became operational in February 2013.

To date three out of four posts in the service have been filled; staff were appointed to both Support Worker roles, and one senior post has been filled. There has been difficulty in recruiting to the fourth post and efforts to fill this vacancy continue.

As at 17th June 2013 the service caseload stood at twenty-two clients. Of this:

- 4 clients have been discharged.
- 8 are being prepared for discharge.

One issue that is being addressed is that the clients suitable for the Re-ablement and other SLaM services are not being identified in the numbers anticipated at planning. Therefore, there is a risk the service will not be able to reach the notional target of 400+ cases completed in the course of a year of operation.

17. Voluntary sector support to prevent return to acute care

Around 25% of elderly people need assistance to leave hospital and usually get timely and proportionate assistance. Most of this group will need help with part or all of their activities of daily living and would fit into the adult social services eligibility criteria and usually require community health support for the short to long term.

The purpose of the joint service between Age UK and Red Cross is to reduce pressure on hospital services by facilitating discharge or preventing the unnecessary admission of individuals perceived as vulnerable, who may or may not meet the eligibility criteria for the statutory services. To support these actual or possible patients/ service users the project has recruited 7 student social workers, has 6 part-time volunteers in place and held a recent Volunteer Open Day with another 10 new potential volunteers currently beginning with the project. To date the project has supported 250 clients leaving hospital from the start of project.

A joint service leaflet has been designed and distributed. A programme of talks and regular ward visits have been arranged to promote the service.

18. Data Sharing – Health and Social Care Dashboard

The Health & Social Care Portal (HSCP) represents a vital conduit for data sharing and analysis between the diverse range of healthcare organisations within Croydon and the Local Authority Social Care provision. The recent paper from NHS England: Improving A&E Performance - Gateway ref: 00062 - outlined the issues facing urgent care in the UK and listed several measures to be implemented which could potentially aid recovery. This included an emphasis on the need for cross-sector information sharing in accord with the Health & Social Care Act (2012) and dashboard-type data availability.

In conjunction with the South London Commissioning Support Unit (SL CSU) - currently our hosting partner of choice - we have moved discussions to the point whereby a Memorandum of Understanding between the two parties has been released. This will enable us to rapidly forge ahead with the further development of the Portal and allow for real use of this important facility by staff within both the NHS and Local Authority (where previously security concerns may have halted this). In parallel, we have also progressed discussions with alternative hosting providers who could be commissioned to step in, should the SL CSU agreement not provide adequate room for real progress to be made.

Reablement Board has continued to support this project through underspends in other projects in 2011/12 as the original anticipated delivery timescale for this complex project proved unrealistic. The increased priority on integrated working between health and social care (whole system planning and commissioning) has increased the need for Board to continue to support it in 2013/14.

19. Enhanced Staying Put Scheme

This service has been operational since January 2013.

The aim of this service is to provide a one stop after care service in conjunction with the reablement service to provide practical housing support to people who are in danger of admission to hospital or who are about to or have recently been discharged from hospital, to continue to remain living independently and safely in their own home. This support includes:

- Access - Furniture moving. Minor/major adaptations to provide safe access
- Hoarding issues – arrange blitz cleans, access funding. Work with clients to de-clutter property and maintain a safe environment.
- Repairs & refurbishment of clients' property – Advice and support to carry out minor and major work to enable independence in the home. Source funding options.
- Winter Pressures – Overview of living conditions; provide additional heaters, cooking facilities. Advise on energy efficiency measures, loft insulation etc.
- Moving on – Assist in finding alternative accommodation if no longer able to remain in their present home. De- cluttering, packing. Moving, purchase/re cycling of furniture.
- Joint working with Age UK & British Red Cross to provide minor handy-person repairs, gardening, home security measures,

  <u>Activity to date</u>

  100 referrals have been received to date for the Service.

  Examples of cases dealt with to date:

  Client A - Was in a care home after a hospital discharge. The service was asked to visit regarding a blitz clean. Case worker visited with Contractors as client had no water, no working toilet. The service undertook the blitz clean and replaced the client's toilet within 24 hours and reinstated water in the home. The client was able to return home.

  Client B – referred by Croydon University Hospital the service was asked if it could do a clear up of the rubbish at the property, and asked to disconnect and remove an unsafe gas cooker and check the boiler, as they wanted to discharge the client from hospital. This was done within 24 hours enabling the client to return home.

  Client C - We were able to fund some electrical work for one client to enable her to shower / bathe her elderly mother safely.

Appendix 2

REABLEMENT PROGRAMME FUNDING -2013/14

WS	Investment	Budget Allocated 2012/13	Recommended Budget Allocation 2013/14	Commentary
1	G.P access to home care hours using simple process of call off from providers	100,000	0	Project Closed. Due to the out of hours remit and the response times required by G.P's this proved a high cost service. Low take up by G.P's and out of hours G.P service means it is not cost effective to continue.
2	Easy access to equipment using prescriptions from GP's from local suppliers and the LATC.	50,000	30,000	Funding has been reduced to reflect anticipated demand for the service from G.P's.
3	Carers access to services	50,000	60,000	Funding increased to match anticipated demand.
4	Increased community pharmacy capacity	127,346	130,000	Reablement Board agreed that the project should focus on the following priorities: (1) Residential Care Homes (2) Special Sheltered (3) Domiciliary The Board also agreed that the allocation can be used flexibly as long as the progress on the first 2 priorities of Board was met. In addition, if there was slippage in the overall reablement programme funding in 2013/14 then Board would be prepared to reconsider request for additional funding at that time.
5a	Improve end of life care - support care homes under gold standard framework	16,000	0	Work will be completed in 2013/14 with costs being met from reserves held following slippage in other projects.
5b	Improve end of life care - expansion of work of St Christopher's	179,000	180,000	Funding for 2013/14 agreed in order to enable continued development of a successful project and enable CCG End of Life hub proposal to be developed and the completion of the End of Life Strategy.

WS	Investment	Budget Allocated 2012/13	Recommended Budget Allocation 2013/14	Commentary
6	Better audit of infection control/tissue viability	97,250	160,000	Reablement Board agreed increase in budget for this project to ensure staffing costs are met for full year and enable work with residential homes, in liaison with CCG, is completed.
7	Provide reablement, recovery or treatment at venues around borough	385,000	542,000	In 2012/13 the care package costs to cover 6 weeks non chargeable care post discharge alone came to the original cost estimate for whole project. Additional spend required to cover O.T reablement posts, and cover the additional costs for the resource base reablement service.
8	Further investment in Telehealth/Telecare	80,000	100,000	To cover staff release and project management costs.
9	Provide service through the night including turning people in their bed …	60,000	0	Project inactive and money used to support additional domiciliary care spend to support hospital discharge.
10	Provision of step down & convalescence beds	250,000	500,000	In 2012/13 demand for step-down beds following hospital discharge exceeded budget allocation by circa £220,000. Allocation increased to meet this additional cost pressure.
11	Social care Triage	93,000	125,000	Allocation increased to meet social worker staffing cost (including cover for annual leave and sickness absence), and out of hours management cover.
12	Social Care discharge coordinators	93,000	125,000	Allocation increased to meet social worker staffing cost (including cover for annual leave and sickness absence)
13	Support to prevent return to acute care or care home - use of peripatetic staff	375,000	375,000	This expenditure was for patients discharged from hospital that had not been assessed as eligible for reablement (OT) but required

WS	Investment	Budget Allocated 2012/13	Recommended Budget Allocation 2013/14	Commentary
				short term packages of care at home. 2012/13 expenditure matched allocation.
14	Support services - psychological	75,000	75,000	Extension funding agreed from 2013/14 to enable continuation of project. This will enable meaningful period of time to develop client base and enable meaningful evaluation of project outcomes.
15	Demographic pressures	995,000	1,500,000	Additional monies allocated is to ensure sufficient monies to cover demands on social care in supporting people in the community (across client/patient groups) and enable hospital avoidance. If this funding was not available then the range and extent of services in place to enable this would have to be reduced or stopped leading to increase pressure on CUH beds.
16	Preventative Services via the Voluntary Services	84,000	0	Funding allocated in 2012/13 is for 18 months and will enable services to run to end of 2013/14 financial year.
	Sub total	3,109,596	3,902,000	
	Programme support Costs	48,442	55,000	
	Adults DH allocation Total	3,158,038	3,957,000	

Appendix 3

2013-14 - Reablement Programme New Projects

	£	Commentary
DASHH Proposals		
Primary Mental Health	80,000	To fund 2 care management posts for the extension of the LIT team allowing extension to 2 teams. Would be part of the development of Multi-Disciplinary Team.
Social Work input into rapid response service	302,926	This to fund 7 senior practitioner posts plus management support to provide social work support to the G.P Multi-Disciplinary Teams and the Rapid Response Service for 2013/14 (part year). These posts will also have the remit to look at needs of non FACS eligible patients as appropriate. This funding would need to be extended to April 2015 by which time it is anticipated that MDTs and Rapid Response would be well established, and agreement about future resourcing reached.
Multi-Disciplinary Team - alignment to G.P networks		
Sub total	**382,926**	
CCG Proposals		
Psychological Support Service	100,000	The focus is to support people with long term conditions post discharge and will concentrate on providing short term input/package of care. Confirmed that as post discharge it is additional to the £75K continuation funding agreed for MH IAPT workstream.
Falls and Bones Health Service	206,000	This service is being introduced to pick up and work with patients before they meet the criteria of 3 falls for the existing small falls service. This service would also tie into the OT reablement service and the day resource centre reablement service. The funding will predominately cover staff costs with the CCG meeting clinical elements such as Dexascan and pharmacy costs.
Mental Health needs - adult and children	75,000	This service will develop a small team of specialist mental health workers to provide input across all family members who have experienced, or are experiencing, domestic violence in order to reduce their need for later more costly health and social care services by improving their social and emotional well-being.
Sub total	**381,000**	
Total	**763,926**	

Appendix 4

Summary: Department of Health Allocation to Social Care (DASHH) 2013/14

2013/14 Department of Health allocation to social care in Croydon	**5,015,000**
2013/14 Reablement monies for Continuation of projects and services (appendix 1)	3,957,000
Sub Total	**1,058,000**
2013/14 New Projects (Appendix 2)	763,926
Balance (to be allocated – see paragraph 4.6)	**294,074**