OFFICER REPORT TO LOCAL COMMITTEE (TANDRIDGE)

HEALTH & SOCIAL CARE JOINT SERVICE IN EAST SURREY

5 March 2010

KEY ISSUE

To update the Committee on the Integrated Health and Social Care Services for Tandridge.

SUMMARY

The community health and social care services in east Surrey are under integrated management to ensure effective design and delivery. They total 590 staff and annual budget of £53m. The services are carefully designed and managed to ensure that the community service is available on a 24-hour basis. Through community management of the Urgent Treatment Centre at East Surrey Hospital, a Rapid Response Service, and a range of services at Dormers care home and at Caterham Dene hospital the joint service has an extensive service for community support, rehabilitation and support for people to live independently. There are improvements planned for 2010/11 which will lead to people having more control of their own care arrangements, easier access to therapy services and collocation of community nursing and care management staff. The prospects for funding public services over the next few years necessitate greater efficiencies which will be easier to deliver effectively in the context of joint service design.

OFFICER RECOMMENDATIONS

The Local Committee in Tandridge is asked to:

(i) Consider the effectiveness of the current integrated health and social care service

(ii) Agree in principle the general approach to the developments of the service

1 INTRODUCTION AND BACKGROUND

1.1 The Joint Service for community health and social care in east Surrey was set up in 2002 to combine the management of NHS and Surrey County Council resources and ensure the maximum effectiveness for the public. This report aims to:

- Update the Committee on the design of local services
- Show the access routes and care pathways
- Report developments planned for 2010/2011

1.2 The service covers the Tandridge area plus Reigate, Redhill, Merstham and Horley. An approximate population of 161,000. The annual budget is £53m (£18m in health and £35m in social care) and the staff total is 590 (health 350: social care 240).

2 ANALYSIS

2.1 Local health and social care services and the system for their delivery need to be:

- easily understood and accessible to the public
- without gaps or delays
- cost effective and value for money
- supporting independence
- avoiding unnecessary bed based care

2.2 The challenge is that the traditional routes for accessing care services are driven by the higher public image of A&E departments, GP surgeries and care homes. Care at home has a much lower public profile. This means that the public choose health routes into the system and have an expectation that bed based care will be offered. If people spend time in bed-based care when they don't need to they risk losing self care skills and confidence. This is particularly the case for older people or people with disabilities.

2.3 Community services in east Surrey are specially designed

- to promote their accessibility as the first point of call for non acute care and
- to give full support and rehabilitation care for people to live at home with as much independence as possible

2.4 The configuration of community services in east Surrey is shown in Annex A. A fuller depiction of services is shown in Annex B.

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3 Access to Services

3.1 This design recognises that the three main referral points for the public are the Surrey Contact Centre, GP surgeries and the hospital.

3.2 Community services are closely linked to the Contact Centre so that information need be given only once and then passed electronically for the Rapid Response team to pick up.

3.3 The Rapid Assessment Clinic, which is sited at Caterham Dene Hospital, sees patients referred by GPs and provides diagnostics and treatment to help people stay at home.

3.4 The Urgent Treatment Centre is at East Surrey hospital and sees all people presenting at A&E. about 100 people per day. It quickly assesses their needs, arranges x-rays and other diagnostics, and provides treatment for people to return home with community support if needed. Patients must be treated and discharged within four hours of arrival. All patients are screened on arrival and those with emergency needs are passed immediately through to the emergency department.

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4 Rehabilitation

4.1 The Rapid Response Service is able to respond within two hours if necessary. Its Advisory Officers discuss needs with the public and link them with local services. People needing care services are visited by a member of the team, usually on the same day, and they are provided with a specially designed rehabilitation programme and with care support. This programme is adjusted over a maximum of six weeks and most people do not need ongoing care. However where it is needed this is set up and responsibility is then passed to the community teams.

4.2 The Promoting Independence Team provide a rehabilitation service for people for people who need a longer programme lasting up to 4/6 months. It has had considerable success in helping people to leave residential care and return home.

4.3 The Community Therapies service provides a range of therapies for people living at home with about 1,000 patients per year visiting the clinic at Oxted and about 3,500 per year going to the clinic at Caterham Dene.

5 Step up/down care

5.1 Most people receive their rehabilitation whilst living at home but some people need to have a short stay in a care home as part of their care programme. The service has developed arrange of short stay provision.

5.2 The Dementia Rehab unit at Dormers provides short term care for older people with dementia supported by the Consultant Nurse from the Rapid Response team. It has had great success in supporting carers and helping people to return home.

5.3 Caterham Dene hospital provides care for people needing high levels of health input. It has 28 beds and the ward area was refurbished in 2008.

5.4 The service also has a contract with Tandridge Heights nursing home in Oxted for ten places for people to stay for up to two weeks with supported by Rapid Response staff to provide rehab programmes.

5.5 Additionally the service has a contract with a nursing to provide short stay care for people being discharged from hospital who cannot immediately return home. This enables people to leave hospital as soon as they are safe whilst taking time to prepare for their future care again with rehab support.

6 Support at Home

6.1 Following the rehab programme the service has a full range of services to help people stay at home. A total of 196 people in Tandridge are receiving long term home car support funded by the County Council. Additionally 26 people are provided with funding to purchase there own care services.

6.2 A key service supporting people at home is the integrated nightcare service which does planned visits throughout the night to people at home as well as visiting people referred on the night as emergencies.

7 Support in Care Homes

7.1 The service is currently supporting approximately 250 people living in care homes in Tandridge on a long-term basis. At Dormers the service includes 20 people with long term dementia needs in addition to the rehab unit mentioned earlier. Dormers also provides 10 places for people with care needs and a day hospital for people with palliative care needs.

8 PLANNED SERVICE DEVELOPMENTS

8.1 **Caterham Dene developments**
The Dene is undergoing a full programme of development and refurbishment. The ward area was refurbished in 2008. The front entrance and reception area was renewed in 2009 to accommodate the Rapid Assessment Clinic which was opened by the Department of Health's national Director of Nursing. The first floor is currently being repaired and refurbished. The unit that was previously used by the Surrey and Borders Trust has now been vacated and is been considered for increased availability of therapy services.

8.2 **Collocation of Community health teams**
The community nursing teams and the care management teams are currently sited separately. This hampers the joint working with individual service users and it is hoped to site the teams together during 2010.

8.3 **Self-Directed Support**
From June 2010 all east Surrey users of the social care service will be considered for the self-directed support programme. This will mean discussing with users and their supporters/carers the use of a cash budget for them to run their own care at home services. This exciting opportunity will allow people to have real control of their care arrangements whist making sure that they fully meet the outcomes that the public funding is given for.

8.4 **Safeguarding Awareness**
There will be a special programme to raise awareness of the need to safeguard vulnerable people from abuse and harm in national awareness week. SunnyArts will be doing a play called " Someone to Watch Over Me at 12.00 – 13.00 on Friday 11 June 2010 at Bletchingley Village Hall. All Members are very welcome.

8.5 **Service Redesign**
The financial prospects for public services over the next few years require all service providers to re-examine self design and delivery to achieve greater efficiencies. In east Surrey it is recognised that this can be achieved only by all partners working closely together to make sure that costs are genuinely removed and not just passed across agencies and that services are as effective as possible in meeting public needs. The GPs, health commissioners, health providers and the acute hospital are meeting to discuss the service effectiveness across the East Surrey hospital catchment area.

9 OPTIONS

9.1 The options are covered in para 8 above

10 CONSULTATIONS

10.1 The service is delivered in partnership with the NHS who are, and will be, fully involved in the service.

11 FINANCIAL AND VALUE FOR MONEY IMPLICATIONS

11.1 The integrated approach helps to ensure whole system value for money and the most efficient use of resources.

12 EQUALITIES AND DIVERSITY IMPLICATIONS

12.1 Access to services is made easier by the extensive provision of care at home delivered through the service.

13 CRIME AND DISORDER IMPLICATIONS

13.1 The Urgent Treatment Centre regularly supports people who are affected by crime.

14 CONCLUSION AND RECOMMENDATIONS

14.1 The integration of services is effective in east Surrey and the proposed service developments will improve the public experience.

15 REASONS FOR RECOMMENDATIONS

15.1 Members are asked to consider the contents of this report and give views about the proposed service developments.

16 WHAT HAPPENS NEXT

16.1 The forward programme is set out in the report. Members are asked to come to the Safeguarding event and are very welcome to visit the service.

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BACKGROUND PAPERS: