MINUTES OF A MEETING OF THE ADULT SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE HELD IN THE COUNCIL CHAMBER ON WEDNESDAY, 11 FEBRUARY 2016 AT 10.00AM

Present

Councillor D Sage – Chairperson

MW Butcher	PA Davies	RC Jones	LC Morgan
NC Clarke	EM Hughes	J Lewis	M Thomas

Officers:

Sue Cooper	Corporate Director Social Services and Wellbeing
Kym Barker	Scrutiny Officer
Michelle Chilcott	Integrated Community Services Manager
Mark Galvin	Senior Democratic Services Officer - Committees
Councillor Huw David	Deputy Leader
Judith Brooks	Group Manager Business Support

30. APOLOGIES FOR ABSENCE

Apologies for absence were received from the following Members:-

Councillor P John
Councillor P White

31. DECLARATIONS OF INTEREST

The following Members declared an interest in the Agenda item so stated:-

Councillor D Sage declared a personal interest in Agenda item 4 in that he previously received some of the support services mentioned in the report.

Councillors LC Morgan and MW Butcher declared a personal interest in Agenda item 5 in that they had previously had received adaptations to their property undertaken by Care and Repair.

32. FORWARD WORK PROGRAMME UPDATE

The Scrutiny Officer presented a report in relation to the above.

The Committee noted the topics to be considered at the meeting on 6 April 2016, and to consider, revise and reprioritise the list of future potential items for the Forward Work Programme as the Committee feels appropriate.

RESOLVED:

(1) That Members requested that an Officer working directly in community co-ordination is invited to attend for the item on Prevention, Wellbeing and Local Community Co-ordination which is scheduled for the meeting dated 6 April 2016.

(2) That Members requested that an item on the two new Extra Care build projects be added to the 2016/17 Forward Work Programme.

33. COMMUNITY SERVICES

The Chairperson on behalf of Members, welcomed the Invitees to the meeting.

The Corporate Director Social Services and Wellbeing introduced the report, the purpose of which, was to update Committee on the progress in community services, to include an update on the future of Occupational Therapy in the community.

She explained that the services outlined in the report and the attached Appendix 1, were being delivered as part of the Western Bay Health and Social Care Programme. The aims and objectives of the report and supporting document "What Matters to Me" – Supporting the health and wellbeing of our older population, were to deliver improved Community Services by introducing one regional model across the Western Bay region.

She explained that the focus was to achieve consistency in terms of what was being delivered across this region, particularly in relation to service delivery and performance, and the report she felt, would guide Members through the different elements of the services that were intended to be provided.

The Corporate Director Social Services and Wellbeing explained that the first Phase of the Programme had been to invest in an optimal Intermediate Care Service Model which comprised of a number of elements, for example a Common Access Point (CAP) into health and social care services. The CAP could be accessed by the public and professionals and performed the following functions:-

- Information, advice and assistance including direction to Third sector and community services where this is the best place to have well-being needs met, and;
- Multi-disciplinary triage and urgent response in the community for people who do require assessment or immediate service

There was also an Acute Clinical Service, which was a model led by a community consultant and delivered by a highly experienced nurse practitioner workforce. This function would provide rapid assessment, diagnostics and treatment in the community in order to avoid a hospital admission. It would assist in:-

- Reablement – A professional therapy led reablement service which was critical to supporting timely discharge for patients from hospital, and
- Residential Reablement/Assessment Beds – In addition to community residential capacity, the service model also provides residentially based reablement for people who would otherwise require a longer hospital stay prior to commencement of a community based service and also assessment of people who are potentially on a pathway to a long term residential care placement

As part of the second phase of the Programme, the community network development had been the focus of attention, and more recently, funding.

This included the development in Bridgend, of 3 Community Network Teams, (North, East and South West) with district nursing, social work and community occupational therapy co-located and grouped under the leadership of single integrated Managers.

Following this introduction, the Chairperson invited questions from Members.

A Member referred to the Acute Clinical Model and reference being made to a common access point available for people who require support services either relating to Mental

Health care or for physical disabilities. She asked where the common access points would be for these two different services.

The Integrated Community Services Manager advised that there were common access points in place to support individuals with both physical and mental health needs. In terms of people needing support for physical problems then the common access point would be by telephone to a member of the team in the Western Bay Community Services Section, where the person would initially be supported through a GP in a primary care setting.

Any person requiring Mental Health support would need to contact the ABMU through the Princess of Wales hospital, as this service was classed as a secondary health care service that came under the ABMU rather than Western Bay Community Services. These services were provided through initiatives such as CAMHS or mental health support services for older people

A Member pointed out that the Acute Clinical Service was working extremely well in Neath Port Talbot County Borough Council. This service allowed patients to be treated at home primarily by nursing staff, as opposed to them having to be placed in hospital to be treated. This was a far better environment for the patient. She noted that this model of care was continuing to be developed in Bridgend, and she asked when this would be fully adopted and up and running.

The Integrated Community Services Manager advised that this service in Neath Port Talbot was going extremely well. The Acute Clinical Service there had been in operation for approximately 10 years, so therefore the team providing this service was well established and experienced. The similar service that would be provided in Bridgend, was still in its infancy stages, however, 2 Community Consultants had now been employed as part of the Western Bay project, and the intention was to establish an Acute Clinical Service that would be operational in the County Borough as soon as this was further developed.

A Member added that progress should be accelerated with a view to providing an Acute Clinical Service in Western Bay, to include Bridgend, as this would allow professionals to treat people without admitting them to hospital, which would go a considerable way to preventing problems in hospital such as patient overloading and/or bed blocking. There were 22 Independent Sector Homes within the County Borough he stated, and it would be beneficial if people in the receipt of care were able to be treated by professionals in these homes rather than being admitted to hospital.

The Corporate Director Social Services and Wellbeing advised that there had been a delay in the e 2 posts of Community Consultants becoming established within the community but this was now in place..

A Member referred to page 9 of the report, and noted that there was no common access point for patients/residents requiring Mental Health support under the Acute Clinical Service.

The Integrated Community Services Manager confirmed that this service provision sat under the Mental Health Directorate rather than the Community Services team per se. Work was underway however, to explore how the service could bridge the current common access point to the joint health and social services single access point operating within mental health services.

The Corporate Director Social Services and Wellbeing, added that support and stay for people with Dementia was of paramount importance, and funding was being committed

by Welsh Government to support services in this very important area of health. This formed part of the services under the Mental Health Directorate within the ABMU, and had specific criteria under which individuals were able to be referred. She advised Members that discussions had begun to clarify the model and develop a clear pathway for Dementia services within the Community Resource Teams.

A Member referred to paragraph 3.2 of the report where reference was made to silo-type forms of delivery of health and social care. She asked what was meant by this term.

The Corporate Director Social Services and Wellbeing confirmed that this was referring to how the services were previously being delivered, and the fact that Officers now recognised that these services needed to be delivered in a more efficient and innovative way, including through providing shared services through joint working, that would improve services to that which were previously provided.

A Member referred page 8 of the report, and the paragraph headed 'Reablement', where people are discharged from hospital and await either the initiation of a reablement service or the restart of a current package of care which can usually be reinstated within a 3 day period, particularly if their stay in hospital was for just a short time period. She asked if when the relevant package of care was reinstated, was this the same or similar to the package they received prior to their admission to hospital.

The Corporate Director Social Services and Wellbeing confirmed, that if after receiving hospital treatment for any amount of time, the person following treatment and recuperation would then return to the same care support package that they received prior to their admission to hospital. If however, the health of the person in question had deteriorated (or improved) following the above, then the package of care they would receive would be altered accordingly to either provide more or less support than they had previously received. A Member noted from the report and some of the services outlined therein, that Community Network teams assisted people at home or in a residential/community based reablement environment. She asked if the services of an Occupational Therapist were available in Community Network Teams.

The Integrated Community Services Manager confirmed that they were.

She added that a pool of Carers were available to support people after they were discharged from hospital, and a member of the Community Services team worked alongside hospital staff, in order to ensure that an interim package of care was put in place initially for the individual, prior to a more appropriate longer term package subsequently being devised.

A Member asked Invitees if the word "frail" was a clinical description of a certain individual, and the Corporate Director Social Services and Wellbeing confirmed that it was.

The Deputy Leader advised that words such as this and others were regularly and consistently used by medical professionals, in order to ensure a common language was adopted by all partners and stakeholders, where the meaning of these words were classed as the same for all partner health support services.

A Member referred to page 20 of the report, and bullet point 4 where it listed points that people should take into consideration, , ie regular exercise, not smoking, reduced alcohol consumption and healthy eating , so as to avoid the possibility of being the subject of social exclusion by other members of society. She felt that personal hygiene could be added to the points listed.

The Integrated Community Services Manager advised that the model document shown at the Appendix to the report had been largely developed through a consultation process with key stakeholders and service users, and personal hygiene had not been raised in this regard, but the words personal hygiene and personal care could be added to this part of the document to further support the maintenance of a healthy lifestyle.

A Member referred to page 22 of the report and the role of a Care Co-ordinator, and asked if there was also a contact point for a Deputy Care Co-ordinator in their absence.

The Integrated Community Services Manager replied that there was an alternative contact point for the Care Co-ordinator, and this could be located within the Community Network team as part of contingency support plans.

A Member referred to page 14 of the Appendix, and the assurance that “we will minimize delays for patients who have had unplanned admissions to hospital by improving the interface between community services and hospitals.” She asked if Invitees could further explain how this would be achieved.

The Integrated Community Services Manager advised that there was an In-Reach facility that linked the Community Services team with the Princess of Wales hospital, whereby unplanned admissions could be more easily identified in order to ensure that people subject to these admissions are appropriately supported from a medical perspective, and in order to establish if and when they could be discharged following their admission.

The Corporate Director Social Services and Wellbeing added that there was a member of the hospital social work team that could be located in the appropriate Ward of the hospital, the hospital social workers worked closely with the community services to establish when they were ready to be discharged following being treated, and what package of care they would require post discharge. . She emphasised that the Acute Clinical Service had been fully operational in the Neath Port Talbot area for some considerable time and that Members should note, as was previously touched upon, that Bridgend were not nearly so advanced having this fully up and running as of yet. She pointed out that a considerable number of checks were in place to facilitate a proper discharge from hospital for the above category of patients.

A Member asked if there were cases of any re-admissions in terms of the hospitalisation of any individuals that had been the subject of Community Services support.

She advised that she would have to check any data for this, and come back to the Member outside of the meeting.

The Deputy Leader added that whilst there was a focus on getting people out of hospital back into a community or residential based setting, this was only possible after they had received treatment in the hospital and were ready to be discharged. As Officers had explained, following this process taking place it was then about ensuring that they then had an appropriate package put in place, to adequately support and reable them, in order to ensure that they remain healthy and safe, so that they could consequently regain their independence.

With regard to previous debate in relation to treating patients at Care Homes etc where possible and appropriate rather than placing them in hospital, he added that he had previously been involved in meetings with representatives of the ABMU including the extent of the role of Community Consultants, and as Members had been informed, this was work in progress. He advised the Committee that he would be attending a Western Bay collaboration meeting this afternoon, where he would stress the importance of

developing an Acute Clinical Service across the Western Bay region and to ensure that this was fully up and running as soon as possible. He further added that a considerable amount of investment had been committed by Welsh Government to strengthen health services across the Western Bay region, and it would be committing a further £20m this year which was excellent news given that people were living longer. He was also aware that the ABMU had looked at investing into more pharmacies as well as medications being given to people, particularly the elderly, more quickly and readily than was previously the case.

A Member pointed out that certain external organisations, for example Care and Repair, had a full time employee based in the Princess of Wales hospital in order that they could give consideration, where necessary, to providing adaptations for people at home or in a Care Home to adequately cater for any disability or condition they may have been hospitalised for prior to their returning to their previous setting.

The Integrated Community Services Manager advised that as part of the drive to support the health and wellbeing of our older population, the service was looking to raise awareness in communities of older people who lived at home alone, for visitors to these individuals to look out for any signs that their health was deteriorating. Work was also ongoing with the likes of libraries and leisure centres and other places regularly visited by the public, in order to promote the use of these facilities by older people, in order to maintain and promote their health and independency.

Under the new Social Services and (Wales) Wellbeing Act 2014, the Deputy Leader added that certain steps would be followed and promoted -to inform constituents of the County Borough particularly the elderly, that there are support services available to them which would help improve their quality of life, either through the ABMU or the Western Bay Health and Social Care Programme, including the development of a section of the BCBC website that would detail what these are.

A Member referred to page 20 of the report, and to the sub-heading Self-Care/Prevention – primary prevention supporting people at risk of frailty, where an aim of this was to help people take action to manage their health and wellbeing; live as independently as possible and to keep out of hospital. She noted bullet point 1 of this section of the report, how to support to combat loneliness and social isolation. She asked how people would be identified if they were not already in the system, including those people who were blind or suffering from other physical disabilities.

The Corporate Director Social Services and Wellbeing advised that this would be targeted through ways such as those mentioned immediately above by the Deputy Leader, and through other methods such as GP referrals in accordance with the Torbay model that the Council had adopted entitled ‘Anticipatory Care’, which was being pioneered currently in the north of the County Borough. As soon as new people were captured on the system via avenues such as visiting the website, the Social Services signposting system, making enquires with or being referred from a medical professional, then a Care or Response Plan would be put in place for them in order to provide whatever method of support they required. Support of Community Co-ordinators would also be sought if considered necessary.

A Member referred to page 27 of the Appendix and the proposal to have a Regional Planning and Delivery Board for Community Services, and she noted who the Board would be made up of in terms of stakeholders. She felt that consideration should be given to also having a lay person on this Board. She also noted within the Appendix that there was reference made to similar Strategies introduced by other Authorities in the UK, where best practice existed. She asked if sum of these initiatives would be adopted into the Western Bay Care model.

The Corporate Director Social Services and Wellbeing confirmed that as part of underpinning the 'Caring Together Model' a Stakeholder Group would be established and this would include both Third sector groups, as well as representation from other key organisations that work together to support the health of people in the County Borough, particularly the elderly population. Ideas of best practice from similar Strategies adopted by other local authorities would be looked at to inform the Strategy subject of the report she confirmed, particularly those that be most suitable to be included as part of this document.

A Member asked how many acute and in-patient beds had been lost across the ABMU within the last 5 years.

The Invitees confirmed that they would look into this request and inform Members of the Committee of the number so lost, outside of the meeting.

Conclusions:

The Committee noted the report, which provided Members with an update on the progress in community services and on the future of occupational therapy in the community.

- Members raised concerns that the development and implementation of an Acute Clinical Service in Bridgend needs to progress more quickly and asked for clarification regarding the status of the development of the service and the team. The Officer responded that the Authority now has two Community Consultants and that they are now able to introduce the medical aspect and develop the service in a similar way to the one currently in operation in Neath Port Talbot.

- Members asked for clarification regarding the role of the Community Consultant and queried whether there are now sufficient resources and commitment to enable community services to support interventions carried out in the community. The Deputy leader responded that the subject of the role of the Community Consultant would be raised later that day at a meeting Western Bay Partnership Forum.

- Members asked how people are able to access the Acute Clinical Service. The Officer responded that the service can be accessed by referral from a GP or District Nurse and that friends and neighbours can also contact the service if they have concerns about anyone.

- Members were pleased to note that services are coming together and working successfully to address the care and support needs of people within the community.

- Members asked what support is available for people who do not have family or friends to help them to re-settle at home. The Officer responded that there is a pool of people who can help to provide interim arrangements for people re-settling at home while a long term package is being established for them.

- Members asked why there was no representation from a layperson perspective on the Regional Planning and Delivery Board for Community Services. The Officer responded that service users and carers had been involved via stakeholder group consultations and that there may be better ways to involve users rather than at meetings. The Officer also responded that they would feed the comments from Members on user and carer inclusion back to the Leadership Group.

Recommendations

- The Committee recommend that more progress is made in developing and implementing the Acute Clinical Service and establishing an Acute Clinical Team in Bridgend.

- The Committee recommend that awareness of services available is increased, including information on how to access services and the benefits in using them, using a variety of formats to ensure that the information is accessible to all.

Further information requested

- Members request further information on the number of people who had been discharged from hospital over the past three years, to include information on what happened to them following discharge and how many people were re-admitted.

- Members request further information on how many beds have been lost over the past five years, to include information on the type of bed/provision lost, such as residential, nursing, acute etc.

- Members request an example of the assessment documentation when the new version becomes available.

- Members request an update on future plans regarding number and location of residential reablement/assessment beds.

- Members request an anonymised case study to help to illustrate the experience of people receiving services to help them to re-settle at home.

33. ROTA VISITING

The Corporate Director Social Services and Wellbeing presented a report, the purpose of which, was to provide the Committee with an update on the programme of rota visiting to the Council's adult social care establishments and independent sector establishments, as well as to share information on the outcome of the pilot visits by Council Elected Members to home care recipients, including plans to take the scheme forward.

She confirmed that Members were no doubt aware of the importance of visiting social care establishments as a valuable contribution to the safeguarding of vulnerable adults, children and young people, and ensuring that the quality of care provided is appropriate, as information regarding this was included in Annual Reports as part of the process of ensuring Quality Assurance. Rota visiting was also the subject of CSSIW Inspection reports as well as Contract Monitoring Inspections.

The Corporate Director Social Services and Wellbeing added that Social Workers also asked both residents of these Homes and Carers for any feedback, and this included also instances of anonymous feedback.

She advised Committee that there were 14 of our own Care establishments and 18 that were operated independent of the local authority, and advised wherever possible, Members (or at least the same Members) should not visit the same establishment more than once a year

In terms of the programme of visits to Council-run and independent sector establishments, the Corporate Director Social Services and Wellbeing stated that the 2014/15 rota programme involved 12 teams of elected Members, required to visit 16 Council operated adult social care establishments, and 13 independent sector establishments.

She added that the 2015/16 rota programme involved 14 teams required to visit 14 Council operated adult social care establishments and 18 independent sector establishments.

The Group Manager, Business Support encouraged more Members to commit to the Rota Visiting Programme, though she was conscious that they did have a considerable number of other commitments throughout the course of the year.

A Member referred to page 53 of the report, and the summary of Members comments made in respect of a previous visit to the Ty Cwm Ogwr establishment. This was in respect of a request for a waste disposal system at the property requested at the last visit by the Members. She asked if this had now been installed there.

The Group Manager, Business Support advised that she would check if it had, and come back to the Member outside of the meeting.

Appendix 1a to the report detailed the premises visited during the period April 2014 to December 2015, including how many times these different establishments were visited. She noted from this Appendix, that Council run establishments seemed to be visited far more than privately operated establishments, and she felt therefore, that an increase in visits should be made to these establishments. She also noted that Bryn-y-Cae Home in Brackla had been visited a considerable number of times, where others had been visited less frequently, and some not at all.

The Corporate Director Social Services and Wellbeing confirmed that it was a requirement for Members to visit Council run Care Homes, though it was voluntary only in relation to the Independent Sector Homes. She confirmed that further dialogue could be made with Managers of these private homes, in order to look to increase the number of visits to these establishments.

The Group Manager, Business Support, confirmed that options were specified in letters to the Homes as to their preferred visiting cycle, which were either monthly, bi-monthly or quarterly.

A Member noted from paragraph 3.5 of the report, that it stressed the importance of visits being made to Care Homes periodically, as Members were an important form of contact for service users. She asked if it was preferable to contact the Home in advance of a Member visiting there, or rather to turn-up unannounced.

The Group Manager, Business Support advised Members had the choice of either option under the rota visiting guidance.

A Member noted that 4 Independent Care Homes had not been visited in the above mentioned period as referred to in the report.

The Group Manager, Business Support confirmed that Member visits to Independent Care Homes had been very limited in the past, however, these were now increasing year on year.

A Member felt that there were not enough Members involved in Rota Visits and if this number increased, more Homes would be visited and at more regular intervals also.

A Member also agreed with the comment made in paragraph 4.14 of the report, that service users and staff at certain Homes had commented that visitations by Members for a period of 15 minutes, was an insufficient amount of time within which to discuss issues with them, including to resolve any queries Members may have, and/or to solve any problems that may exist at the Home that may be being experienced by the service user. She noted however that the pilot undertaken to conduct a series of visits to Home Care recipients across the County Borough involving 5 Members had largely been successful.

The Corporate Director Social Services and Wellbeing confirmed that this pilot was successful, and that it would be followed-up, in order that Members could report upon these visits, and follow-up any actions they may have requested in a subsequent visit. An option had been looked at, namely to form 2 groups of Members who would make 3 visits to Homes within an agreed period. The groups would be mentored by Members who took part in the original pilot.

Conclusions:

The Committee noted the report, which provided Members with an update on the programme of rota visiting to the Council's Adult Social Care Establishments and independent sector establishments and on the outcome of the pilot of visits by Elected Members to home care recipients.

- Members commented that the Member Champion visits had been very successful and asked when they would be resumed. The Officer responded that the visits would resume and that the views of Members would be sought regarding the frequency of visits in future. Support and training for Members was also discussed and several options put forward, including peer support and mentoring between Members.

- Members queried whether carrying out unannounced visits resulted in lack of availability of residents and staff during visits, due to other events or activities occurring at the time of the visits. The Officer said that whether or not visits were announced was optional and may be dependent on the type or size of the facility being visited. Members commented that, in most cases, unannounced visits are still the best way to ensure a completely representative picture of the service.

- Members queried whether any establishments had not been visited during the programme. The Officer responded that the intention is that all establishments would be visited this year.

- Members supported the intention stated by Officers to pursue further discussion on increasing visits to private sector establishments.

- Members queried the accuracy of some of the information included in the schedule of visits at Appendix 1a, the Officer responded that the information would be updated where necessary.

Recommendations

- The Committee was pleased to note that the rota visiting programme will resume and recommend that the team of Members undertaking the visits is increased, that peer mentoring and support is provided by Members who were involved in

the previous programme and that the frequency of visits is reviewed to ensure that the schedule is manageable.

- The Committee recommend that particular care is taken to ensure that visits are accessible, to enable all Members to take part in the programme.

Further information requested

- The Committee requests information on the outcomes from comments and queries fed back to Officers by Members following the visits, to include information on actions taken as a result of the feedback.

34. URGENT ITEMS

NONE

The meeting closed at 1.00 pm