BRIDGEND COUNTY BOROUGH COUNCIL

REPORT TO ADULT SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

13 SEPTEMBER 2016

REPORT OF THE CORPORATE DIRECTOR, SOCIAL SERVICES AND WELLBEING

COMMUNITY SERVICES PHASE 2

1. Purpose of Report

1.1 This report will update the committee on the development and progress of new short-term and long-term approaches to Community Services that have been developed in response to the implementation of the Social Services and Wellbeing Act (Wales) 2014 and as part of the Western Bay Collaborative.

1.2 It will explain the developments of short-term preventative and pre-emptive approaches to information, advice and assistance, including developments in Bryn y Cae home for Older People, to support and enable our citizens to continue to live independently in our communities.

1.3 It will explain how these developments will affect the organisation of services for people who need managed care and support at home and long-term care in residential or nursing care settings.

2. Connection to Corporate Improvement Plan / Other Corporate Priority

2.1 This service development relates to:

- Helping People to Be More Self-Reliant;
- Smarter Use of Our Resources.

3. Background

Delivering Improved Community Services: Western Bay Optimum Model

3.1 *"Integrated care describes the coordinated delivery of support to individuals in a way that enables them to maximise their independence, health and wellbeing" (DH Care Networks, 2009)*

3.2 Over the last five years Bridgend County Borough Council and ABMU Health Board have demonstrated a commitment to delivering integrated services and have developed a wide range of services as part of the integrated health and social teams. This has ensured better outcomes for people whilst also meeting the policy aspirations of Welsh Government for better joined up care.

3.3 In September 2013, the Western Bay Health and Social Care Programme set out a joint commitment to work together to integrate and improve the planning and delivery of community services for older people, delivering improved community services. There has been a whole systems approach to addressing the challenges

presented by an ageing population. The first phase of integration focused on intermediate care services and this has been a catalyst for change across the rest of the system.

3.4 The key priority of 'Delivering Improved Community Services' and the subsequent business case was to achieve a sustainable approach to the delivery of health and social care for frail, disabled, or older people. We needed to provide better assessment, care and support at lower cost; something that was impossible were we to be tied to traditional, silo-type forms of both health and social care delivery.

3.5 As a consequence of the business case, investment was made in an optimal intermediate care service model as set out below.

3.6 In January 2016, the Overview and Scrutiny Committee was informed of the following progress against the Optimum Model from a Bridgend perspective.

KEY:

Y- Yes N- No D- Under development

Key features of optimal model	
Multi-disciplinary triage in common access point	Y
Mental Health provision within common access point	N
Third Sector Brokerage in common access point	Y
Acute clinical response, Nurse Practitioners and Community Consultant – virtual ward model	D
Therapy led reablement service	Y
Intake & review reablement	Y
Therapy led residential reablement	Y
Support & stay for people with dementia	N
Step up / down intermediate care (residential or community)	Y

3.7 By way of definition of each element:

Common Access Point - The Western Bay Community Services model has at its front end a Common Access Point (CAP) into health and social care services. The CAP can be accessed by the public and professionals and performs the following functions:

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

Acute Clinical Service - The Western Bay Community Services Board agreed an acute clinical model which is led by a community consultant and delivered by a highly experienced nurse practitioner workforce. The purpose of this function is to provide rapid (within 4 hours) assessment, diagnostics and treatment in the community, thus avoiding a hospital admission. This service would link the day hospital; community based clinics (known as hot clinics) and provides a virtual

hospital ward in the community. This model continues its development in Bridgend where the current consultant and the Lead Advanced Nurse Practitioner are redesigning the operational model to meet the agreed optimal service model.

Reablement – This is therapy led and is critical to supporting timely discharge from hospital (Also known as Step Down support). The Western Bay model is based on supporting effective safe discharge from hospital either into a residential or community based reablement service. Timely discharge is supported within Bridgend with the service known as Better@Home. This provides a short term bridging care service that supports people with levels of care whilst they wait for either the initiation of a reablement service or the restart of a current package of care; this can be usually up to 5 days, depending on the complexity of the discharge. Although, if someone has only been in hospital a short time their existing care package can usually be re-instated within 3 days. Step up Reablement provides a therapy led service that aims to address deterioration in the person's condition, putting an individual's independence and ability to remain at home at risk.

Residential Reablement – In addition to community based Reablement capacity, the service model also provides residential 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. In Bridgend there are 6 beds in Bryn y Cae Residential Home performing this function. Please see paragraph 4.4 below.

The Long-Term Managed Care and Support Services

3.8 The implementation of comprehensive short-term intervention and reablement services for all frail, older and disabled has resulted in many people being enabled to return to live independently within their own community. However there are people, who following six weeks of intensive support and intervention, still require assistance with personal care and daily living tasks, because they have eligible needs for care and support in accordance with the 2014 Act. The guidance from the Social Services and Wellbeing Act states that,

The adult has an eligible need for care and support if an assessment establishes that they can only overcome barriers to achieving their personal outcomes by the local authority working with them in jointly preparing a care and support plan, and ensuring that the plan is delivered.

The New National Eligibility Criteria for Wales

3.9 Eligible needs for adults are determined to be as follows by *The Care and Support (Eligibility)(Wales) Regulations 2015:p4, are where* :

(a) The need arises from the adult's physical or mental ill-health, age, disability, dependence on alcohol or drugs, or other similar circumstances;

(b) The need relates to one or more of the following —

i. ability to carry out self-care or domestic routines;
ii. ability to communicate;
iii. protection from abuse or neglect;
iv. involvement in work, education, learning or in leisure activities;

v. maintenance or development of family or other significant personal relationships;
vi. development and maintenance of social relationships and involvement in the community; or
vii. fulfilment of caring responsibilities for a child.

3.10 To be eligible for a plan of care and support from the Local Authority, the Social Services and Wellbeing Act, determines that an individual needs must be such that,

"…the adult is not able to meet that need, either,

(i) alone;

(ii) with the care and support of others who are willing to provide that care and support; or

(iii) with the assistance of services in the community to which the adult has access; and

…the adult is unlikely to achieve one or more of the adult's personal outcomes unless,

(i) the local authority provides or arranges care and support to meet the need; or

(ii) the local authority enables the need to be met by making direct payments

(The Care and Support (Eligibility)(Wales) Regulations 2015 p4-5)

3.11 The guidance from the Act requires, that for people with care and support plans (and for carers with plans of support), local authorities must keep under review, care and support plans for adults and support plans for carers, who have needs for care and support which meet the eligibility criteria. This duty also applies to people, where it appears to the local authority that it is necessary to meet the person's needs in order to protect the person from abuse or neglect, or the risk of abuse and neglect.

3.12 In the Act, Local Authorities and Health Boards are instructed to enter into partnership arrangements for the provision of care and support and specifically:

… are required to establish and maintain pooled funds in relation to –

(a) the exercise of their care home accommodation functions

2015 number 1989 (W.299) social care, Wales the partnership arrangements (Wales) regulations 2015 P13

3.13 Presently within the Directorate, there are a number of teams providing long term managed care and support who also support people in care home placements. Currently these include teams within the newly developed short-term services of the Community Resource Team, including the common access point, as well as in the long-term Integrated Community Network Teams. Many of the existing social work management structures are legacy arrangements from previous organisational structures and no longer meet the needs of the service, as it is redesigned to meet the requirements of the Social Services and Wellbeing (Wales) Act 2014.

3.14 It is in that context and in order to offer clarity of roles and responsibilities across the adult social care services, it is felt necessary to realign the existing social work resource into teams supporting short term, pre-emptive and preventative services based within the Community Resource Team, and into long-term managed care and support services, based within the Integrated Community Networks.

4. Current Situation / Proposal.

Delivering Improved Community Services: Western Bay Optimum Model

4.1 This table is a revised summary of progress against the optimum model in Bridgend:

KEY: Y - Yes N - No D - Under development

Key features of optimal model	
Multi-disciplinary triage in common access point at Trem y Mor	Y
Mental Health provision within common access point at Trem y Mor	Y
Third Sector Brokerage in common access point at Trem y Mor	Y
Acute clinical response, Nurse Practitioners and Community Consultant – virtual ward model	D
Therapy led reablement service	Y
Intake & review reablement	Y
Therapy led residential reablement	Y
Support & stay for people with dementia	N
Step up / down intermediate care (residential or community)	Y

4.2 In order to access these services, referrals are via, for example, social workers, hospital professionals, and GPs.

4.3 The table above summarises the progress since January in delivering the optimal model in Bridgend. The table indicates requirement to further develop certain aspects, those being:

- Acute Clinical Response remains Amber - this service requires additional funding to move to a 7 day provision and an announcement is due shortly from Welsh Government with regard to additional Intermediate Care Funding. Additional funding will enable the recruitment of nurses in sufficient numbers to deliver more acute care services such as Intra Venous antibiotics. At present the community services are unable to respond to these types of referrals and therefore individuals are highly likely to be referred to hospital.
- Support and Stay for people with Dementia: this service forms part of the services under the Mental Health Directorate within ABMUHB. This has specific criteria under which individuals are able to be referred and access this service. Further work is required between the mental health directorate and community services to clarify and develop the right model for people with dementia. This will be undertaken on regional basis when the re- structure in ABMUHB Mental Health Services is completed.

Further Development of the Integrated Reablement Unit at Bryn y Cae Residential Home, Brackla

4.4 The Residential Reablement Unit in Bryn y Cae Residential Home has provided a residential reablement unit to compliment the services delivered by the Integrated Community Resource Team. This made reablement accessible to individuals whose presenting needs could not be supported by a large package of care in the community and thus enabled them to improve their independent living skills.

4.5 The success of this unit in terms of outcomes for individuals and impact on the whole health and social care system enables the opportunity to explore extending this service jointly with Health. There are, however, resource funding requirements on an ongoing basis that need to be scoped out and discussed further with partners before any large scale commitments are made.

4.6 Extending the service in this way could potentially deliver opportunities to:

- extend access to Reablement to individuals living at home and not in secondary care;
- extend access to a period of assessment of functional skills to individuals living at home and not in secondary care;
- provide crisis respite bed(s) capacity for individuals living at home;
- provide planned respite that is delivered in an enabling way to ensure individuals' independent living skills are not compromised during their respite stay;
- develop Bryn y Cae as a centre of excellence for community bed based Intermediate Care within a residential setting;
- develop the skills and competencies of the workforce within Bryn y Cae by enabling them to focus on promoting independence.

4.7 The anticipated potential benefits for people living in Bridgend County Borough:

- For the older person who has had a hospital admission and is clinically ready to leave hospital, will have the opportunity of time to rebuild confidence, regain abilities and maximise independence in a reablement/ enabling setting.
- For the older person at home and due to deterioration in health and wellbeing is at risk of an avoidable admission to hospital, to provide the opportunity to receive appropriate level of intervention, care and support within a reablement/ enabling setting.
- For the older person at home, who, due to a change in their health and wellbeing or due to a change in their social circumstance (includes adult protection concerns) is at risk of premature admission to long term care establishments, to have the opportunity to receive an assessment of their functional abilities and time to rebuild confidence and regain abilities in a reablement/ enabling setting. This will facilitate decision making and planning in a less pressured context.
- For the older person at home, supported by a carer who becomes unexpectedly, temporarily unable to provide support, who is at risk of an avoidable admission to hospital or long-term care, to receive support in an enabling setting. Returning home with the same (or hopefully improved) functional abilities they arrived with.

- For the older person who continues to be supported at home due to access to planned regular periods of respite, preventing unscheduled/ crisis triggered transitions of care.

4.8 The development of such a facility in the community will take a considerable amount of collaborative work with partners and stakeholders to develop the model, and consider the impact and requirements on the building of such a facility; it is proposed that scoping and development work will commence within the next year.

Realignment of Social Work to Meet the Needs of Short-Term Intervention Services and Long-Term Manage Care and Support

4.9 In order to ensure the Directorate's existing social work resources within Adult Social Care, are realigned to meet the needs of the Social Services and Wellbeing (Wales) Act, work is currently being undertaken to scope the required workforce realignments to deliver on a model of short-term pre-emptive intervention and long-term manage care and support, and resource that can support an integrated approach and pooled fund for the provision of long-term care home placements. The proposals will be finalised and form part of a consultation with staff towards the end of this year.

5. Effect upon Policy Framework and Procedure Rules.

5.1 None

6. Equality Impact Assessments.

6.1 An equality impact screening assessment was completed in 2011 when the integration of community health and social care services commenced. If the proposed developments are progressed, a review of the equality impact assessment will be completed.

7. Financial Implications.

7.1 In relation to further exploring the potential to extend the current Reablement provision in Bryn y Cae Residential Home, there are both Capital and Revenue implications. The proposal is still in its early stages and the financial model is almost complete as the proposal continues to be scoped.

7.2 There has been a successful bid (agreed in principle) against the Welsh Government's Intermediate Care Funding Capital Grant, with grant potentially available to the cover the costs of any agreed building works. The financial model is almost complete to enable further discussions with partners. The capital bid will not be formally approved until recurring revenue funding is identified.

7.3 Early discussions have commenced with ABMUHB regarding the proposal and the implications for staffing and medical cover. In addition the Western Bay partnership are also awaiting confirmation relating to additional revenue monies attached to the Intermediate Care Funding stream, which potentially could support such development amongst other priorities. However, due to the uncertainty of the grant

availability from one financial year to the next, this would only be on a short term basis and would not meet recurrent revenue costs.

7.4 There are no financial implications in the realignment of the health and social care teams and provision into short term intervention and long managed care and support term approaches; all of the proposals are to be managed within the existing budget.

8. Recommendation.

8.1 It is recommended that the Committee note:

- The progress in the last year on delivering the Western Bay optimum model for intermediate care within Bridgend County Borough;

- The early proposals for the development Bryn y Cae residential home into a facility that delivers intermediate care alongside planned and crisis respite services;

- The proposals are considered for the realignment of the social work provision for adult social care within the integrated services required to deliver on the requirements of the Social Services and Wellbeing (Wales) Act 2014.

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10 Background documents:
None