ADULT SOCIAL CARE SCRUTINY COMMITTEE

Minutes of the Adult Social Care Scrutiny Committee held on Tuesday, 27th September 2011 at 6.00 p.m. in the Civic Offices, Telford, Shropshire

PRESENT:
Councillors C. Turley (Chairman), F. Bould, J. Greenaway, J. Loveridge, C. Mason, J. Seymour.

Also Present**:** Cllr. Liz Clare, Cabinet Member Adult & Social Care; Karen Kalinowski, Head of Care & Support; Christine Harrison, Service Delivery Manager - Commissioning; Stephanie Jones, Scrutiny Group Specialist.

ASCSC-1 MINUTES

The minutes of the meeting held jointly with the Health Scrutiny Committee on 25th August 2011 were agreed as an accurate reflection of the meeting.

ASCSC-2 APOLOGIES FOR ABSENCE

Maurice Viney, Co-optee

ACSSC-3 DECLARATIONS OF INTEREST

None

ASCSC-4 TRANSFORMING REHABILITATION AND RE-ABLEMENT SERVICES IN TELFORD & WREKIN

The Commissioning Service Delivery Manager presented the proposals for transforming rehabilitation and re-ablement services in Telford & Wrekin.

The following key points were highlighted:

- That the proposed model was set in the context of national DoH strategies and findings, and on the local evidence-base built up by the 2008 Care Service Improvement Partnership mapping and a series of service reviews and audits during 2009/10.

- Findings had shown that although there were pockets of good practice, services were patchy and not joined up, and there were some inequalities of provision within the borough. What people wanted was a single point of contact, a quick and responsive service and for health professionals to talk to each other so they only had to tell their story once. There was a sense of missed opportunity to develop co-ordinated and effective pathways for rehabilitation.

- The principles behind the proposed model were that services should be joined up and co-located, with constructive relationships, common aims and goals and, importantly, with aligned management and budgets with resources focused on rapid, intensive re-ablement for the people of Telford and Wrekin.

- The overall aims of the model were to help people maintain, or retain, their independence and quality of life, to prevent unnecessary hospital admissions, to reduce long-term admissions, to facilitate and co-ordinate speedy discharge from hospital and to reduce the number of hospital re-admissions or inappropriate referral to community services. This was best achieved by health and social care professionals working together.

- There were 2 strands to the strategy;

  - Rapid assessment and intervention (first stage)
    The service would include managing the process from referral, to assessment and diagnosis to agreeing and putting interventions in place. This would be community based support with diagnostics built around enhanced care teams to provide wrap-around support with the aim of preventing the need for hospital admission.

  - Intensive Rehabilitation/Re-ablement (second stage)
    This would be an intensive, time limited rehabilitation and re-ablement service to maximise independence and prevent admissions and dependency on long-term care. There was a wide range of providers offering specialist services such as community physiotherapy, speech and language therapy, interim and intermediate care beds, the falls programme, community equipment and stroke rehabilitation. These services would need to be connected across the service areas. Equality issues would need to be looked at to ensure equality of access across age ranges and location. The strategy needed to be flexible and responsive and to recognise that people are individuals with different needs.

- The next steps for the development of the transformation model would be detailed work on combining services, the development of rehabilitation and re-ablement care pathways (linked to stroke work), detailed cost modelling and work-force mapping. This was linked to the service review and restructure in Adult Care & Support.

- The model was being developed at a time of unprecedented change in the NHS. Resources would be a key challenge with the need to consider resources across acute, community and adult care services in order to realise savings across the health economy and to improve outcomes. The Council had made £500k available from money transferred from T&W PCT under a Section 256 agreement, and the PCT had agreed an additional £488k, to develop rehabilitation services. It was emphasised that the strategy had to be a **joint** strategy as it depended on the shared resources of health and adult social care budgets.

- A report had gone to Cabinet on 22nd September seeking endorsement of the model, support for its further development with partners, and support for the use of the Section 256 money for rehabilitation services. Cabinet had approved the recommendations. The proposed model had also been approved by the Health & Well-being Board, the Shrewsbury and Telford Hospital Trust Board and the PCT Board.

- Case studies were presented which illustrated the positive impact of the model. A hospital patient receiving support from the Intermediate Care team had been discharged home with a care plan and had undergone rehabilitation. The person had shown a marked improvement, increased independence and a low level care need. A similar patient who had not accessed the Intermediate Care team had been discharged from hospital without a care plan and with no support which had led to deterioration, re-admission to hospital and the need for a longer term care plan with physiotherapy. The message is that if the right support is available at the right time, there is a better outcome for less resource. Resources needed to be considered across health and social care budgets.

- Currently, only 20% of patients pass through the Intermediate Care team and have the opportunity for rehabilitation/re-ablement services. This needs to be increased to maximise opportunities.

Following the presentation, members asked a number of questions and made some observations:

Cllr. Seymour felt that the strategy was potentially very exciting, and that it was important for all people to receive immediate support and not have to wait for a financial assessment.
Members were informed that the first 30 days of re-ablement were free of charge and no financial assessment was done until then.

A member gave a case study of a 95 year old patient who had been discharged from hospital but had not been contacted by their GP or any other health or social workers, and there had been no support offered to the patient or their carers. The member asked how many other patients were in a similar situation.
Officers responded that this is why the strategy is so important to prevent this from happening. Currently, only approximately 20% of people access the Integrated Care Service and the restructure and targeting of resources was about changing this. The model would bring the health and social care systems together so that social care would be involved with health to support people . A home from hospital service had been set up which includes link workers who makes contact with people who require help and support. It was also important that people have access to good quality information.

A member raised the question of how the strategy would support carers.
Members were told that work was being done with partners and GPs to develop and promote a carersperspective. Carers were very important, and the needs of both the patient and carers needed to be considered. Partners and GPs would raise awareness and encourage people to have a care assessment and the emphasis was on “mainstreaming” support. Training for carers such as movinga nd handling was available. A Carers’ Contact Centre had been set up, and there was a Carers’ Forum, with an appointed Board, for carers to raise issues and input into the process. There had been a focus on respite care.

Members asked whether the evidence gathered locally, especially the 2008 Care Service Improvement Partnership mapping, was kept up to date to keep on top of numbers and demand.
Members were assured that data was constantly updated. The mapping exercise had been robust, and service audits and reviews identified changing numbers and demand which was monitored through a quality performance framework.

Members were very concerned about vulnerable people living alone who may not be able to cope, but who did not visit their GP or ask for help, and what could be done to stop people from falling through the net.
Members were reminded that safeguarding is everybody's responsibility and that communities and neighbours had to be educated to step in to help people or report people they are worried about. However, individuals have choices and can make their own decisions even though they may not always make the right decision. Some people are cautious about involving social services because they are worried about interference and losing their independence.

Members asked whether there is a clear route into the system.
The access team has one telephone number which has facilitated a clear route. GPs have welcomed the strategy, and a lot of work has been done with GPs to raise their awareness of local authority services and how to recognise early signs and indicators of when people may need help so that they can be referred for assessment. Awareness will increase as the GPs disseminate this information to other GPs. The NHS reforms would bring health and social care much closer together and it was important that the GPs and clinicians who would be commissioning services understand local authority services.

Members wanted to know how community services would be joined up with voluntary sector services and how they could be opened up to help more people.
The voluntary sector plays a key role and the message is about co-operation, collaboration and working across boundaries. Discussions are taking place to develop an "information hub" (such as Age Concern UK's Education Through Information Hub) approach to bring together the plethora of information so that each organisation knows what is available and can sign-post people to other organisations. Volunteers will be encouraged to look out for signs that people are not coping so they can refer them to the appropriate organisation. Prevention will be the key aspect.

Members were assured that the service was linked into Senior Citizen's Forum/LINk survey on the discharge of patients.

Members wanted to know how patients sent to hospitals outside the borough would be picked up and were informed that work would be done with social workers in other authorities to pick them up. Members stressed that it would be a priority to speak to patients in other hospitals especially ones admitted as emergencies.

Members were reminded that the strategy would require a lot of work with partners to implement and that this would take time.

RESOLVED
That an update on the Strategy would be brought to the Committee in March/April 2012 to monitor progress.

ASCSC-5 UPDATE ON THE SOUTHERN CROSS CARE HOMES IN TELFORD AND WREKIN

The Head of Care & Support gave an update on the position with the two Southern Cross care homes in Telford & Wrekin. Southern Cross' financial situation had been widely reported in the media. The company announced in July that it would cease trading and the care homes would be transferred to alternative providers. The situation was complex because Southern Cross was operating homes on a lease basis from as many as 80 different landlords. The Council had been working very closely with Southern Cross Management, the PCT and the Association of Directors of Adult Social Services (ADASS) to monitor the situation in the borough and in neighbouring authority areas where closure of a home could have an impact on spaces in Telford and Wrekin.

There were Southern Cross homes in Telford and Wrekin, both registered with the Care Quality Commission:

1. St. George's Park Care Centre has a 71 bed capacity including for dementia which was important locally. It was reasonably priced and popular. There had been concerns about the quality of care, but the Council had been working with the care home management, the Care Quality Commission (CQC) and health to develop an improvement plan which had led to significant improvement in recent months and the Council continued to monitor the situation closely. There had been low occupancy rates over the previous few months due to an embargo while quality issues were being resolved.

   The landlord was NHP, a large national landlord with 248 homes nationally, and the Council had been advised that the care provider Court Cavendish would take over the lease and the running of the home from 31st October. A new company HC1 was being created as a branded delivery model of Court Cavendish. The financial stability of NHP was being monitored.

2. The Christian Cottage Nursing Home has a 40 bed capacity. There was a private landlord, and the Council had been advised that Coverage Care would take over the running of the home from 30th September. Coverage Care is a local not-for-profit provider with a good reputation and good outcomes.

The transfers were progressing and there were on-going meetings with Southern Cross, the care home staff, patients and unions with a view to TUPE transfer of staff. Both new providers had Care Quality Commission registration. There had been meetings with patients and their families to provide information and reassurance.

Following the report, members asked a number of questions:

Were the quality issues at St. George's to do with the building or with standards of care?
Quality of care was the primary concern and there were a number of key issues relating to personal care and dignity. The building was not a concern other than decoration. The improvement plan would continue to be monitored, and each home will have a compliance statement from the CQC.

Have you had any contact yet with Court Cavendish?
We have not met them locally, but have met the regional Southern Cross Manager, their regional Quality Manager and have met the Court Cavendish Director at a regional ADASS meeting. The company is being re-engineered to take over from Southern Cross, but the registered managers and front line care staff will remain the same. We will be asking Southern Cross to link us into HC1 and request a meeting to ensure continuity and to continue to drive the improvement plan. Quality is monitored with unannounced spot checks, and we will continue to monitor quality with the new company locally, regionally through ADASS and nationally.

Are there any other care homes at similar risk in the borough?
No, there are only two Southern Cross homes in the borough, and we are not looking to expand residential care at present.

Is the Council responsible for the inspection of care homes?
Responsibility for the registration and inspection of care homes lies with the Care Quality Commission, and the funding that used to go to local authorities for inspections has been passed to the CQC. However, the council feels it has a duty of care for people it places in a care home, and we inspect homes where there is a contractual arrangement. We do not inspect homes where there is no contractual arrangement, unless there is a safeguarding alert. We work with the CQC on safeguarding issues, complaints and case management so there is a circle of intelligence, and we tend to work on a risk basis.

For residents in care homes who are not funded by the authority and who have to rely on CQC inspections, what voice do they have, and who would they complain to about standards of care?
Residents can complain to the Local Involvement Network (LINk), and the transition to Healthwatch will extend the existing reach and remit of the LINK to be the voice of residents.

Do you receive many complaints from residents in care homes with which the authority has no contractual relationship?
It varies. If there is a safeguarding alert, we would investigate even if we had no people placed at the home, but unless we have a contractual arrangement we have no right of entry.

The Cabinet Member assured the Committee that a Telford and Wrekin resident who had been living in a Castlebeck home in Solihull which had closed had been dealt with swiftly and satisfactorily, and that the resident concerned had been relocated back to the borough. The Cabinet member commended the hard work of the social workers on this successful outcome.

ASCC-6 FORWARD PLAN

There was a discussion about the Forward Plan and members agreed the timing for items to come to the Committee.

Cllr. Seymour updated the Committee on a useful seminar she had attended in Shrewsbury which was about how NICE could support the work of scrutiny committees. The Health and Social Care Bill would extend the remit of NICE guidance and quality standards to include social care. The Scrutiny Officer would circulate a copy of the presentation.

Cllr. Seymour also brought the members attention to a collection of essays by experts in public health about the shift of responsibility for health outcomes to local authorities which would provide some useful food for thought for the Committee. The Scrutiny Officer would circulate a copy.

RESOLVED

- **That Phase 2 of the Adult Care & Support service review and restructure would be looked at in October. It was noted that the Committee may wish to submit a response to the proposals as part of the consultation.**

- **To meet in November to consider a response to the government's "Caring for Our Future" consultation. The Scrutiny Officer would circulate further information.**

- **To review the Adult Safeguarding Annual Inspection Report in December 2011**

- **To review the impact of the withdrawal of CHC funding during January/February 2012**

- **To receive an update on the Rehabilitation and Re-ablement Strategy in March/April 2012**

The meeting ended at 7.40 p.m.

Chairman: .....

Date: .....