Date: **Wednesday 26 May 2004**

Venue: **Committee Room, National Assembly for Wales**

Title: **Report of Fact Finding Visits by Members on 18 March 2004**

1. As part of its policy review of the interface between health and social care services, Members of the Health and Social Services undertook a series of fact finding visits on 18 March.

2. Projects visited were:

- the Blaenau Gwent Assist Project
- the Forge Centre, Port Talbot and the Re-ablement Unit at Cimla Hospital
- Dinefwr Cict (Community Intermediate Care Team) Project

3. Reports of the visits are attached at Annexes 1, 2 and 3.

Visit to the Blaenau Gwent Assist Project

On Thursday 18 March, Jonathan Morgan AM, Claire Morris and Catherine Lewis, from Committee Services, and Stephen Boyce, from the Members' Research Service, visited the Blaenau Gwent Assist Project as part of an information gathering exercise for the Committee's review of the interface between health and social care services.

A Community Psychiatric Nurse and Social Worker with the Blaenau Gwent Mental Healthcare Team for the Elderly developed the project concept. The project was set up to find out if the use of new technology could help a small number of people with dementia to remain living independently longer.

Research was carried out over 18 months and the project was identified as an appropriate approach to promote independence to older people with dementia and was a practical response to issues facing both health and social care in reducing premature admissions to residential and nursing care beds.

The purpose of the project was to introduce a variety of professionals and non-professionals, carers and users to the potential use of assistive technology; and provide a framework for meeting the needs of people with dementia at home and their carers in order to improve quality of life, prevent and reduce behavioural problems, prevent and avoid premature admission to long-term care and reduce stress for all concerned.

The project has brought together the following organisations:

- **Gwent Local Health Board Professionals** - this includes medical and psychology staff, day hospital managers, occupational therapy ward staff and community psychiatric nurses.
- **Blaenau Gwent County Borough Council Social Services** - this includes team leaders, social workers and support staff.
- **Blaenau Gwent County Borough Call Centre**
- **Gwerin Housing Association**
- **Gwent Constabulary** - local crime prevention officers
- **Voluntary Organisations** - this includes Alzheimer's Society and Age Concern
- **Private Sector Organisations**
- **Blaenau Gwent Care & Repair** - Handyperson service
- **Technology Companies** - Technology in Healthcare, Wanderguard UK and Tunstall Telecom
- **Norvartis Pharmaceuticals**

A demonstration house has been set up to demonstrate a range of technologies that are available commercially or are being piloted. These include flood, gas, smoke and carbon monoxide detectors, fall monitors, bed occupancy sensors which link to lighting controls, incontinence sensors, wander alarms and personal safety measures such as a doorbell camera that links to the television and a bogus caller

panic button. All of the monitors are connected to a telephone control system that links to the Blaenau Gwent Control Centre.

The team was keen to point out, however, that the technology is actually secondary to putting in place effective partnership working across the different sectors. There are issues relating to funding, particularly agreeing which sector's budget will provide the funding, which would be simplified by the introduction of joint funding.

An evaluation of the project will be carried out to assess:

- Impact on carers stress levels;
- Which sensors/alarms are most used;
- Comparison between the cost of the equipment and the cost of providing hospital/residential care.

Annex 2

Report of visits by Members to the Forge Centre, Port Talbot and the Re-ablement Unit at Cimla Hospital Thursday 18 March 2004

The visits were made by John Griffiths AM and Val Lloyd AM, accompanied by Jane Westlake, Committee Clerk

The Forge Centre, Port Talbot

We met

Barbara Bowness, Director Mental Health Services;
Jackie Cooper, Team Leader, Nursing Forge Centre;
David Edwards, Team Leader, Social Services;
Diane Davies, Clinical Nurse Manager; and
Ian Maunder, Principal Officer, Mental Heath Social Services.

For over ten years the centre has provided a comprehensive multi-discipline service for people with varying degrees of mental health problems. It is staffed by a consultant psychiatrist, mental health nurses, social workers, a psychologist (post currently vacant) and administrative staff. Most are employed by Bro Morgannwg NHS Trust, but social workers from Neath Port Talbot Borough Council are also based there.

Similar centres now operate in Pontardawe and Tonna, Neath.

It is housed in a purpose built building and its facilities are also used by other organisations in the community, including; the Sunday school of the adjacent church; Cruse; Lay Advocacy; Gofal Housing;

and a drop-in social group.

Most patients are referred by their GPs, some by hospital consultants and some by other means. The Centre aims to respond to referrals within10 days, offering an appointment for assessment by an appropriate professional. At times cases have to be prioritised. There can be a three month wait to see the consultant psychiatrist. Subsequent services may be provided at the centre or in the patient's own home depending on the nature of the problem. Services may be provided for no more than six sessions or for several years.

The resource centre's counselling /therapy team run regular group therapy sessions on assertiveness, and management of anxiety, depression and anger. Art therapy is also provided for those who have difficulty in expressing their feelings.

The Centre is funded jointly, but the budgets are not integrated. Full integration could bring problems in accountability and professional governance.

The Centre now benefits from links with the new Neath Port Talbot Hospital and staff attend weekly clinical meetings there.

There is a joint planning structure working within the Mental Health NSF, and engaging with a multi agency forum with representation from the NHS Trust, LHB, local authority, voluntary sector, a GP, service users and carers. There are a number of sub groups.

Evaluation has been through Best Value / Wales Programme for Improvement; joint SSIW / Audit Commission inspections.

Service Users are involved in the setting of service standards, despite it being a difficult client group to engage. Initially the standards were drafted from a professional standpoint, but users did not feel they reflected their needs.

Cimla Re-ablement Unit

We met:

Paul Williams**,** Chief Executive, Bro Morgannwg NHS Trust;
Katie Norton, Chief Executive, Neath Port Talbot LHB;
Tony Clements, Deputy Director of Social Services, Neath Port Talbot CBC;
Rachel Marsh**,** Director of Community and Therapies Services; *plus*
Around 20 staff working in the re-ablement team.

The main aim of the Neath Port Talbot Re-ablement Service, based at Cimla Hospital, is to enable people who normally live independently at home, but may have lost the confidence or physical ability to

do so, to regain their independence. Re-ablement provides individually designed, intensive programmes. This may include support to regain skills in personal care, meal preparation, domestic and social activities, as well as exercises to improve mobility and physical function. Services may be provided in the service user's home or in a residential / respite care home setting.

Other aims of the service are to:

- facilitate earlier hospital discharge;
- offer an alternative to placement in residential and nursing homes;
- prevent inappropriate hospital admissions; and
- to reduce the number of complex domiciliary care packages required.

Referrals come from primary care, therapists, hospital consultants, discharge liaison nurses, ward staff and social workers.

Funding

The service is funded from a variety of sources, initially from the "invest to save" initiative. It now receives money through joint working special grant, the six weeks free home care funding and health improvement programme. In line with Wanless recommendations the service is being mainstreamed.

Capacity, Staffing and Support Levels.

The two community reablement teams together have the capacity to offer services to up to 32 clients at any one time. The residential reablement unit offers places in single bedrooms to five service users at a time. The residential re-ablement unit is staffed 24 hours a day, and is therefore appropriate for service users who have more intensive support needs than could be managed in the community.

The full establishment of staff is now 24.3 full time equivalents, with the following range of staff groups:

Team Manager
Team Co-ordinators
Occupational Therapists
Physiotherapists
Nurse
Technical Instructors
Community Reablement Support Workers
Residential Reablement Assistants
Admin support

The team are managed by a multi-agency steering group, who in turn report on progress and outcomes to

the Neath Port Talbot Joint Executive Group.

Outcomes

Patient / client outcomes

The Community Reablement Team has used the Functional Independence Measure (FIM) as a tool for assessing service users' functional abilities pre and post scheme. The outcomes of treatments achieved remain excellent for both the community and residential reablement services. The vast majority of patients are assessed as having goals wholly or partly achieved.

Savings from Community and Residential Reablement

The team estimate the savings for each client discharged from the service. In September 2003 it was estimated that there was a saving of £50,000 per year on the clients discharged that month i.e. the system would have had to fund £50,000 of domiciliary or care home costs if these patients had not received the reablement service. This demonstrates the scope of this service to move resources around different parts of the health and social care system.

Key Points

- fundamental change in ethos from services that looking after people by doing things for them to services that enable people to care for themselves again.
- Carers are important in helping to achieve this.
- After a period of intensive re-ablement, less home care, and in many cases no home care, is required. This frees scarce resources.
- Patients are assessed and decide their personal goals.
- The unit has some items of small equipment to meet discharge needs. There is currently a joint equipment store with Swansea, but Neath Port Talbot is now looking to develop links with Bro Morgannwg.
- Although a larger equipment store on a regional basis has advantages of scale, there are problems in accessing and delivering equipment.
- The importance and difficulties of mainstreaming effective innovative schemes are recognised. Budgets and priorities may need adjustinging. It was vital to take an holistic approach to service planning at joint executive levels.
- Recruitment of physiotherapists to the unit was difficult as the work was not as "hands on" as many would like, but more about assessing and planning. Consideration was being given to inviting physiotherapists to work in the unit on a rotational basis.
- Neath Port Talbot is developing an extra care scheme in Aberavon for 50 tenants.

Joint Planning

Paul Williams also briefed us on the progress being made in joint planning between Bro Morgannwg Trust and Neath Port Talbot. A summary is appended.

Appendix

Review of the Interface between Health and Social Care

Briefing on progress made by Bro Morgannwg NHS Trust with its partners in Neath Port Talbot

The Trust, working closely with the Neath Port Talbot Local Health Board, has robust joint working arrangements with our social services partners in Neath Port Talbot. Detailed below is an overview of areas of good practice under each of the headings of the review, together with some areas in which improvements are being planned.

To review the mechanisms for joint planning and provision of services in health and social care and the quality of the evidence base.

At a strategic level, the Trust is a key member of the Health Social Care and Wellbeing Partnership Board in Neath Port Talbot. This Partnership includes council members and non-executive members of the Trust, LHB and Voluntary organisations, supported by an executive / officer group. The Partnership Board takes action on areas of joint responsibility and interest, including development of the Health Social Care and Well Being strategies, development of client group strategies, implementation of Unified Assessment, Delayed Transfers of Care, service reconfigurations in mental health, and use of Joint Working special grant monies. The Trust is also represented on the Neath Port Talbot Children and Young Peoples Framework Partnership and close linkages between the strategic partnership groups are being established.

Achievements of the Partnership to date include:

- Strategic plans agreed for most main client group areas;
- Agreement on innovative new uses for delayed transfers of care and new flexibilities funds;
- Senior Joint Commissioning Managers established between the Local Health Board and Local Authority to support the strategic development of mental health, learning disabilities, older people, and children's services
- Joint action plan for reducing delayed transfers of care;
- Project board structure set up for unified assessment across NPT and Bridgend Local Authority areas;

At a client group level, there are joint planning groups in existence for adult mental health, learning disabilities, older people, the Children and Young People's framework partnerships and the ACPC.

The Learning Disabilities Directorate has worked with 10 Local Authorities in the planning and implementation of the Hensol resettlement programme, with a multi-agency and multi-professional team undertaking this work.

There are also some examples of joint provision of services, including:

- Community and residential reablement service;
- Health visitors for looked after children and special needs children working within social services teams;
- Social workers in all adult mental health CMHTs, with shared management arrangements in NPT, currently working towards a joint Mental Health Access team.

To examine the accountability arrangements for joint planning and service provision

Overall accountability for joint planning arrangements lies with the Health Social Care and Wellbeing Partnership Board, with Childrens Services being overseen by the Children and Young Peoples Framework Partnership. In terms of service provision, accountability lies either through the joint executive group and partnership board for some services (for example reablement), or through each individual organisation for other services (for example mental health teams).

To evaluate the effects (both positive and negative) that decisions in one service can have on another.

There are examples of decisions within the Trust boundaries that have had both positive and negative effects:

- Decisions by Local Authorities on the way in which funds are allocated makes a significant impact on numbers of delayed transfers of care. In both main authority areas the councils have taken significant steps to alleviate these pressures;

- Trusts undertaking waiting list initiatives often do not take account of the additional social care needs of patients for that period of time, which impacts particularly on the home care sector;

- Decisions taken on acceptance criteria for child protection cases within social services can affect workload within healthcare;

To examine key areas that impact on the quality and provision of a seamless service:

Hospital discharge

The Trust has agreed with all 3 Social Services departments and LHBs a joint hospital discharge policy and set of procedures. This will improve communication between professions and streamline the discharge process for patients, ensuring in particular that discharge planning begins on admission to

hospital.

Ward staff in acute areas have worked well with hospital based social workers for years as an integral part of the discharge planning team;

Intermediate care

In June 2003 the Local Health Board established an Intermediate Care/NHS Long Term Care Task and Finish Group to review the current planning and provision of intermediate and continuing care services across Neath Port Talbot to inform the future strategy for the locality. A number of new intermediate care services have already been implemented, including reablement team and residential reablement beds. New developments will include a new intermediate care facility to replace Groeswen Hospital, linked to the Primary Health and Social Care Centre for Port Talbot, and a redevelopment of Cimla into an intermediate care center. In addition, plans are being developed for a rapid response team to complement the work of the reablement service. There is also the potential for increasing the integration of the day hospital and other intermediate care services.

Residential and nursing home services

A number of liaison posts have been funded both in NPT between health and the residential / nursing home sector, for example an EMI liaison team including a CPN and OT. The aim of these posts is to provide support to the residential care home sector, allowing them to continue to provide care for a greater dependency of patients.

To review the role of health and social services in promoting the independence of patients and the prevention of unnecessary admission or re-admission to hospital.

Health and social services have a significant role in this regard. Areas where work has been undertaken through the partnership arrangements include:

- Reablement teams – these services have been demonstrated to improve independence and significantly reduce the need for large packages of support to the home;
- The developing intermediate care services which will contribute to a further prevention of admissions for elderly patients to acute hospitals, with a focus on joint health and social care assessment earlier in the care pathway;
- Agreement to establish a community based COPD team which will work to reduce the need for admission. This Team has been funded by the Local Health Board through inequalities in health funding within Neath Port Talbot.

Whilst, as described above, the Trust has worked well with social services colleagues there are nevertheless areas in which further improvements and advances can be made.

Firstly, there is a need to extend areas of joint service provision, perhaps into areas of core services such as district nursing and home care for palliative or continuing care patients. Issues to be addressed will include:

- common operational policies,
- joint management arrangements,
- pooled budgets,
- common patient records and information sharing
- skill mix issues, including potential generic health / social care workers.
- Accountability arrangements
- Performance management and outcome measurement

Secondly, there is likely to be an increase in joint commissioning of services, which is an area that is in need of development if joint provision is to become a reality.

Lastly, at a national level, the continuing drive to integrate strategy and planning between health and social care is welcomed.

These issues are forming the basis of the Local Wanless Action Plan for Neath Port Talbot.

Future Developments

The team is currently actively engaged in:

- Ensuring that the team becomes fully integrated with core services and links to the emerging intermediate care pathways.
- Continuing to actively promote the service, particularly in relation to engaging with primary care teams.
- Improving joint management and performance information and audits.
- Identifying ways of more accurately measuring service user outcomes and client satisfaction, and calculating savings on acute hospital beds and residential /domiciliary care packages.
- Continuing to review roles within the team to ensure that staff-mix most appropriately meets the needs of service users.

Annex 3

Report of visit to Dinefwr Cict project (Community Intermediate Care Team)

The Dinefwr Community Intermediate Care team (Cict) has been built up since January 2002 from the vision of a consultant geriatrician in the area. Initially it served the Amman Valley area, but has expanded to cover the Llandeilo/Llandovery area from February 2003. It was initially support by Flexibilities Grant money but funding is now more stable.

The team comprises:

- Team leader
- Occupational therapist
- Physiotherapist
- Speech and language therapist
- Dietician
- Community Psychiatric Nurse
- Social Worker
- District Nurse
- Generic Support workers

The service is aimed at enabling adults who would benefit from time limited rehabilitation to restore and/ or maximise their levels of function to aid independent living. It therefore aims to:

- Optimise the quality of life for the client and the carer.
- Prevent hospital admission where appropriate.
- Facilitate early discharge from hospital.
- Facilitate a reduction in placements into residential /nursing home care.
- Facilitate a reduction in home care provision.

It receives referrals from GP, social services and health representatives. Specific eligibility criteria have been agreed including, in particular, that the client will benefit from a short-term intensive period of domicilliary rehabilitation usually delivered for up to 6 weeks. Dinefwr CiCt is working with approximately 25-30 clients at any one time.

The Dinefwr CiCt has a main office at Amman Valley Hospital with a satellite office at Llandovery Community Hospital. Clients are organised in 2 ‘patches’; Amman Valley and Llandeilo/Llandovery. Each patch holds a weekly client meeting where each client is discussed in-depth giving the team members the opportunity to feedback and confirm treatment aims with colleagues. Each client is allocated a care co-ordinator who undertakes initial client-centred assessment, agreeing goals with the client. The care co-ordinator meets the client (and carers) after 3 weeks and will assess any additional need for support following the initial 6 week period. There is follow up of patients after 3 months and the team can provide short periods of additional intervention if needed (this would need to be agreed with GP or social worker). The whole team meets once a month to agree working arrangements/system and processes.

GPs in the area represent the biggest source of referrals (37% of referrals), a quarter of referrals are from social services and a further 19% from Occupational Therapists.

The team is managed by a Steering Group comprising representatives from the NHS Trust, Therapy

managers and Social Services. A report on the Dinefwr CiCt scheme will be available in April and can be supplied to the Committee.

The Carmarthenshire Health and Social Care Partnership Board have recognised the scheme is working and a new service was established in Llanelli last autumn. GPs in that area, who do not have access to GP beds in the local area, can now refer to the CiCt team rather than to acute care beds.

Key issues:

- Weekly meetings mean that interventions can be dovetailed better. Clients' views on how frequently they should be visited are taken into account and care is taken to co-ordinate visits of members of the team in a pattern acceptable to the client.
- Team is able to focus on promoting independence as far as possible rather than just ensuring that clients are safe to return home. Team's assessment relates to mood and more general well-being as well as functional issues.
- Clients could see improvement in co-ordination of interventions including need for equipment etc. and also recognised a greater emphasis on enabling the client to become more independent.
- Team works on basis of a single patient record – all members of the team have access to it. The client retains a copy at home.
- A district nurse only recently joined the team. There is an intention to develop this link. Medical responsibility remains with the GP.
- Whilst unified assessment is not yet implemented it is, in effect, what the team undertakes with clients.
- From community hospital's point of view, after initial hesitation over the new team's role, there has been some change in attitude towards rehabilitation and some benefits that have arisen from working with the team. There has been a reduction in admissions.
- Some work is ongoing in Llandovery hospital with new ward being built but also a multipurpose therapy room that can be used by the Cict team.
- Other benefits include greater understanding of other professionals' perspectives through team meetings, building of trust between disciplines, better decisions on care made as team contributes in discussion.
- Social Services are still working to raise profile of team and working with team on criteria for referrals. Since Cict team started there has been reduced demand for home care and meals on wheels though more evidence is needed as to whether this is due to the implementation of the Cict team.
- Difficulties have included:

    - short term nature of flexibilities funding – difficulties in attracting staff for piloting new ways of working;
    - establishment of pooled budgets – difficulties over who owns what;

    - priorities - Government targets relate more to acute throughput than

rehabilitation or keeping people out of hospital. Team can be torn between different organisation's priorities;

- differences in manual handling policies between trust and social services;

- IT systems aren't compatible;

- Personnel and supervisory issues - terms and conditions can be different between different members of the team;

- Looking for flexibility of budget to allow new ways of working such as a member of the team working with (double staffing) private social care workers or providing similar intensive period of rehabilitation to people in a nursing/residential home to enable them to go home with more independence. Aim to seek opportunities through Wanless money and action plans.
- It could be appropriate to introduce targets related to integrated rehabilitation services.
- The CiCt Team is in touch with a network of Community Rehabilitation teams across Wales which shares information and best practice.