MINUTES

Date: Thursday, 11 December 2003

Time: 2.15pm to 4.20pm

Venue: Cothi Suite, Halliwell Centre, Carmarthen

Attendance: **Members of Health & Social Services Committee**

David Melding (Chair)	South Wales Central
Jocelyn Davies	South Wales East
John Griffiths	Newport East
Christine Gwyther	Carmarthen West and South Pembrokeshire
Jane Hutt (Minister)	Vale of Glamorgan
Val Lloyd	Swansea East
Rhodri Glyn Thomas	Carmarthen East & Dinefwr
Kirsty Williams	Brecon and Radnorshire

In Attendance

Yvonne Apsitis	Day Break Wales
Jim Crowe	SCOVO
Beverlea Frowen	Welsh Local Government Association

Hugh Gardner	Association of Directors of Social Services
Cllr Meryl Gravell	Welsh Local Government Association
Bruce McLernon	Association of Directors of Social Services
Kemi Nevins	Wales Council for Voluntary Action

Officials In Attendance

Dr Ruth Hall	Chief Medical Officer
Ann Lloyd	Director, NHS in Wales
Helen Thomas	Director, Social Policy Department
Bob Woodward	Social Services Inspectorate Wales

Secretariat:

Jane Westlake	Committee Clerk
Claire Morris	Deputy Committee Clerk

Item 1: Apologies and Substitutions and Declarations of Interest

1.1 Apologies had been received from Ann Jones, Jonathan Morgan and Gwenda Thomas. Christine Gwyther substituted for Gwenda Thomas.

1.2 There were no declarations of interest.

Item 2: Review of the Interface between Health and Social Care Services (2.20 – 4.15pm) Papers: HSS(2)-08-03(p.1); HSS(2)-08-03(p.2); HSS(2)-08-03(p.3)

2.1 The Chair welcomed Cllr Meryl Gravell and Bevelea Frowen, representing the Welsh Local Government Association; Hugh Gardner and Bruce McLernon, representing the Association of Directors of Social Services; and Kemi Nevins, Yvonne Apsitis and Jim Crowe, representing the Wales Council for Voluntary Action.

2.2 Cllr Gravell made the following introductory comments:

- Local government was committed to improving the way it worked with the NHS, and were working more closely with the independent and voluntary sector.
- Health and social care was being considered in the wider agenda of health and wellbeing.
- The interface between health and social care was important but should be viewed within the wider agenda or there was a danger of not looking at the impact one part had on the whole, e.g. the effect of housing and environment on health.
- Modernisation had resulted in local authorities taking a corporate perspective on social services which no longer operated in isolation.
- Each local authority had a dedicated officer for co-ordinating the health and wellbeing strategy.
- Examples of good practice in collaboration were being collected for publication in the Near Year, which would inform Local Health Boards (LHBs).
- The 'Excellence Wales' programme was being developed to foster sharing of good practice.
- Local authorities' struggled to meet the costs of residential care and were unable to attract and retain high calibre staff within overall resources. Increased resources were needed
- A system for rewarding success and supporting those doing less well was needed.
- Local government had different accountability arrangements from the NHS, but this should not cause difficulties in joint working.
- Greater research, development and investment were needed to build capacity in social care.

2.3 Hugh Gardner made the following introductory comments:

- The advent of local health boards provided the foundation for improved collaboration. However, social services should strive to be a national service delivered locally to ensure consistency in standards.

- Pooled funding through LHBs should be clearly designated and its use agreed jointly.
- Social care was the foundation for and bridge to other aspects of local authority responsibility, such as education, housing and environment.
- Local authorities should help people live independently and avoid admission to social care as well as hospital. This would require greater investment in primary level services.
- Social Services did not provide an out of hours service and this meant that some people were admitted unnecessarily to hospital as emergencies.

2.4 In response to comments and questions from Members, the WLGA made the following points:

- LHBs had a better understanding than NHS trusts of the problems facing local government, and joint working was taking place.
- There was not enough flexibility within budgets to address the wider health agenda, for example the effects of housing on health and the need for improved health education.
- Current structures allowed for pooling of many budgets. What had been lacking was the corporate ability to come together with a common understanding of why a pooled budget was needed, what it would achieve and whether is was appropriate to do so.

- There were examples of people wanting to pool budgets at different levels and LHBs provided a comprehensive structure to enable this.
- Pooled budgets were not just about money but about time, resources and expertise.
- It was hoped that new commissioning arrangements would allow greater involvement of the voluntary and independent sectors in joint planning and pooling resources.
- It would be helpful in preparing community plans to bring budget timetables together.
- Local authorities needed to continue to work with the NHS and other partners on housing adaptations that would help people to live independently. Ad hoc additional funding could be spent effectively on housing adaptations, but there was a danger that such one-off funding would not be used strategically.

2.5 In response to comments and questions from Members, the ADSS made the following points:

- The community planning framework provided for the collection of information the opportunity to look collectively at the resources available, how they were being used and whether they were being targeted in the most appropriate area.
- Working together, pooling resources and pooling intelligence or knowledge was going on but this needed to be done in a more structured way.
- There were areas where dedicated funding was needed. The recommendations of the Wanless review presented real challenges in terms of reshaping services whilst continuing to deal with current demands and pressures. A twin tracked approach was needed, which would provide continuing investment to deal with current pressures and new investment, which could be through the LHB, that was pooled to reshape services for the future.
- Structural changes did not necessarily change the way in which people behaved.
- There were situations where pooled funds worked well, for example in tackling substance misuse and commissioning continuing care. There was value in partners putting money into the fund which they could then use flexibly without having to negotiate every issue.
- There were a number of areas where pooled resources worked well. Services for children with complex needs was an area where health, education and social care services should develop integrated strategies. Equipment services was another and it was important to look across boundaries to how budgets could be pooled. Another area was out of county or out of country placements. The ring fenced flexibilities funding would need to be mainstreamed. Joint funding itself was not crucial to the development of co-ordinated services. It was possible to create effective partnerships and deliver by agreement on funding without moving money into a single pot.
- The flexibilities fund had encouraged joint working but there were examples of joint funded arrangements that pre-dated it, albeit on a smaller scale.
- Care pathways tended to happen in a hospital setting around a particular specialty and where social care was a part of that specialty there had been some involvement.
- The Swedish model of dealing with delayed transfers of care referred to in the Wanless review would not encourage joint working. People should be encouraged to work together to reach solutions not punished because they don't.
- There was a degree of disparity between the way in which provision of intermediate care was

being tackled in Wales compared to England, with a need to reform services here. However, there was strength in the commitment of the public sector but there had to be shared vision across services that took account of differences.
- Social care had been marginalised within Wales because it had not received the same level of investment as England.
- There was an all Wales bed bureau initiative which helped identify bed vacancies, but the main problem was in funding placements.
- There was little evidence of the overall capacity for continuing care within NHS trusts.

2.6 Kemi Nevins made the following introductory comments:

- Support had been provided through "Building Strong Bridges" for the voluntary sector to create posts for a national Health & Social Care Facilitator and facilitators to work locally with the county voluntary councils (CVC) to look at national and local projects and help to drive the health and social care agenda forward.
- The positive way the voluntary sector had been working with organisations across Wales to tackle delayed transfers of care, the important work it did with carers, and the contribution made by carers had to be recognised in the new LHB driven partnerships.
- The work of Care and Repair could be high tech and very complex or as simple as changing a light bulb.
- The voluntary sector could play a key role in unified assessment because they were experienced in putting the patient's needs first.
- The voluntary sector had the diversity and ability to work at all different levels and communicate with different clients, without the constraints faced by statutory bodies.

2.7 In response to questions and comments from Members, the WCVA made the following points:

- Short term funding could be wasteful. Projects were made to fit within specific grant schemes and often there was no evaluation built in, so at the end of the scheme there was no evidence of how successful it had been and whether continued funding should be sought.
- The Strategy for Older People was providing funding through an alliance of older people's voluntary organisation on a three-year basis. This had been welcomed as there would be evaluation and staff could be recruited for a reasonable period of time.
- LHBs had two voluntary sector members, a lay member and a carer. Local facilitators supported the voluntary sector and carer members and in some LHB areas the lay members had also become involved in this because they felt that the weighting of LHB membership was medically top heavy. Another part of the facilitators' role was to share information and disseminate examples of good practice to LHBs.
- There were some good examples of participation in joint planning for social care. Practices were still too variable in terms of voluntary sector input across Wales.
- The voluntary sector needed to be involved at the start of the planning process and it was hoped that the new commissioning guidance would address this.
- It was important to differentiate between services that were commissioned by local authorities

from the voluntary sector and those that were given separately by the voluntary sector to people in the community.

- Guidance issued by SSIW on commissioning would be helpful in clarifying the legitimacy of voluntary sector input into commissioning without any conflict of interest.
- Unified assessments should not be seen as the answer to all problems. It was most appropriate for people with high dependency needs, where it was vital for health and social services and families to be involved.
- The unified assessment and the much larger preventative agenda were equally important.
- Many people had needs that required a quick and simple response and they wanted to be self-sufficient. They wanted information but did not want to have to go through a very complicated process to get it. It was vitally important that the whole raft of different types of support needed in the community was recognised.
- In Catalonia there were examples of multi-disciplinary teams in the community which were very effective at identifying immediate problems and putting in place either the nurse, social or family support that was necessary.
- The value of multi-disciplinary teams that could act quickly to solve problems and avoid hospital admittance had not yet been recognised in Wales.
- A lot of voluntary sector activity took place that was not funded by local authorities. It was hoped that through some of the new planning structures in place an holistic approach to local services could be achieved.
- Concern was expressed at the way in which some of the carers' funding was being managed by local authorities. Carers felt it was unfair that services were available in one county but not in another and were concerned about what would happen to carers' funding if it were absorbed into local authorities.

Action

- The Minister would provide details of the 160 projects funded through the flexibilities grant.

Item 3: Minutes (4.20 - 4.25pm)
Papers: HSS(2)-06-03(min) and HSS(2)-06-03(min)

3.1 The minutes of the meeting held on 13 November were agreed.

3.2 The minutes of the meeting held on 26 November were agreed subject to the amendment of Item 2: Ministerial Report - Consultant Contract to read "19m would be made available for the new consultant contract from 1 December 2003" not "90m".

Item 4: Any Other Business

Adoption and Children Act (Commencement No.5) (Wales) Order 2004

4.1 A copy of a letter dated 9 December 2003 from the Minister to the Chair regarding the Adoption and Children Act (Commencement No.5) (Wales) Order 2004 had been circulated. The Committee agreed that the Commencement Order could go to the Business Committee on 13 December.