Gareth Owens LL.B Barrister/Bargyfreithiwr
Chief Officer (Governance)
Prif Swyddog (Llywodraethu)

To: Cllr Carol Ellis (Chair)

Councillors: Amanda Bragg, Peter Curtis, Adele Davies-Cooke, Andy Dunbobbin, Veronica Gay, Cindy Hinds, Hilary Isherwood, Stella Jones, Brian Lloyd, Mike Lowe, Hilary McGuill, Dave Mackie, Ian Smith and David Wisinger

CS/NG

23 January 2015

Tracy Waters 01352 702331
tracy.waters@flintshire.gov.uk

Dear Sir / Madam

A meeting of the **SOCIAL & HEALTH CARE OVERVIEW & SCRUTINY COMMITTEE** will be held in the **DELYN COMMITTEE ROOM, COUNTY HALL, MOLD CH7 6NA** on **THURSDAY, 29TH JANUARY, 2015** at **2.00 PM** to consider the following items.

Yours faithfully

Democracy & Governance Manager

A G E N D A

1 **APOLOGIES**

2 **DECLARATIONS OF INTEREST (INCLUDING WHIPPING DECLARATIONS)**

3 **MINUTES** (Pages 1 - 8)

To confirm as a correct record the minutes of the last meeting.

4 **SOCIAL SERVICES INTERMEDIATE CARE FUND (ICF)** (Pages 9 - 22)
Report of Chief Officer (Social Services) enclosed.

5 **REABLEMENT/INDEPENDENT LIVING IN FLINTSHIRE** (Pages 23 - 34)

Report of Chief Officer (Social Services) enclosed.

6 **KEY PARTNERSHIP PROJECTS WITH HEALTH AND THE THIRD SECTOR** (Pages 35 - 42)

Report of Chief Officer (Social Services) enclosed.

7 **ROTA VISITS**

To receive a verbal report from Members of the Committee.

8 **FORWARD WORK PROGRAMME** (Pages 43 - 48)

Report of Environment and Social Care Overview and Scrutiny Facilitator enclosed.

SOCIAL & HEALTH CARE OVERVIEW & SCRUTINY COMMITTEE
18 DECEMBER 2014

Minutes of the meeting of the Social & Health Care Overview & Scrutiny Committee of Flintshire County Council held in the Delyn Committee Room, County Hall, Mold on Thursday, 18 December 2014

PRESENT: Councillor Carol Ellis (Chair)
Councillors: Amanda Bragg, Adele Davies-Cooke, Andy Dunbobbin, Veronica Gay, Hilary Isherwood, Brian Lloyd, Hilary McGuill, Dave Mackie and David Wisinger

SUBSTITUTE: Councillor Joe Johnson (for Cindy Hinds)

APOLOGY: Councillor Peter Curtis

CONTRIBUTORS: Cabinet Member for Social Services, Chief Officer (Social Services), Service Manager (Resources), Service Manager - Disability Services and Team Manager - Performance

Representatives from the Care & Social Services Inspectorate Wales (CSSIW) for minute number 41
Vicky Poole (Regional Director for North Wales) and Rob Gifford (Regional Manager)

IN ATTENDANCE: Environment & Social Care Overview & Scrutiny Facilitator and Committee Officer

39. DECLARATIONS OF INTEREST (INCLUDING WHIPPING DECLARATIONS)

Councillors David Mackie and Hilary McGuill both declared a personal interest as members of the Community Health Council.

40. MINUTES

The minutes of the meeting held on 13 November 2014 had been circulated with the agenda.

Matters Arising

Minute 34: Single Point of Access (SPOA) - In response to a query from Councillor Hilary McGuill, the Chief Officer (Social Services) advised that Cabinet had agreed to develop the SPOA which was due for implementation by Spring 2015. In terms of the Regional Collaboration Fund and the decision by Welsh Government to reduce the third (final) year grant for 2015/16, it was envisaged that sufficient funding would be available to support the SPOA elements.

RESOLVED:

That the minutes be approved as a correct record and signed by the Chair.

41. CSSIW ANNUAL REPORT

The Chief Officer (Social Services) introduced the Care & Social Services Inspectorate for Wales (CSSIW) annual report on the evaluation of performance of Flintshire Social Services for 2013/14.

In presenting the report, Mr. Rob Gifford of CSSIW advised that previous feedback on paragraph numbering had been taken on board for future reports. Councillor David Mackie conveyed Members' appreciation for this. Mr. Gifford provided background to the self-assessment of performance of Social Services carried out within each Council which, together with a range of supporting evidence, contributed to the publication of the CSSIW Annual Report. In summarising the key messages for Adult services, he stated that there was evidence of progress in a number of areas, leading to more individuals living independently and fewer requiring residential care. Less consistent performance was found on Children's services, with some areas requiring strengthening, although there had been evidence of recent signs of improvement. However, it was indicated that there had been an increase in the number of referrals to Children's Services and those on the Child Protection Register.

Mr. Gifford drew attention to the Council's response on progress to address areas for improvement identified for 2012/13, together with information on visits undertaken during the year and areas for follow-up next year.

The Chief Officer thanked Mr. Gifford for the report and said that the Council worked closely with CSSIW on performance issues and shared best practice throughout the year. Within the Service Plan Improvement Priorities appended to the report, he drew particular attention to progress made on:

- *Ability to influence locally focussed strategic planning with BCUHB* - where a high level of activity had been undertaken across the Council.
- *Initial child protection conference timescales / statutory visits for looked after children / timely personal education plans (PEPs) for looked after children* - some areas had been identified as requiring further investment and the approach taken forward to look at the stories behind indicators to improve the quality behind statistics, for example the joint working with Education colleagues to improve PEPs.
- *Addressing the fall in numbers of known young and adult* carers - good progress had been achieved through the resolution of data collection issues.
- *Reviewing the impact of recent senior management structural changes* - significant progress was reported in moving to a new operational structure, with agreement of the senior management model and a third member of the team due to start in February 2015.
- *Absence Management outcomes and impact upon capacity* - where significant improvements had been shown in the last year and would continue to be monitored for 2014/15. The importance of considering the detail behind statistics was highlighted to ensure that individuals complied with reasonable expectations in terms of attendance.

In highlighting two areas of significant challenge, the Chief Officer referred to Health assessments for looked after children and work by the Council in

encouraging Health partners to improve their performance. He said that adult high quality nursing care was a national issue and that despite progress made in Flintshire, as indicated in the report, this remained a 'Red' risk status.

Councillor Mackie referred to concerns previously raised with the Betsi Cadwaladr University Health Board (BCUHB) about the impact of its performance on the Council's performance indicators, and asked if a letter could be sent on behalf of the Committee to reinforce this message. On the educational attainment of looked after children, he said there was a recognition of the challenges due to the different circumstances of children coming into care, eg if the child had not received prior schooling, and therefore setting realistic targets for individuals was a better approach.

The Chief Officer suggested that further concerns on BCUHB could be raised directly with its Chief Executive who was due to attend a future meeting of the Committee. He spoke of the need for the Council to maintain influence and pressure on partnership working with BCUHB, whilst recognising it was currently undergoing a period of change. On educational attainment, he agreed with the need to look at the quality and nature of provision through joint working with Education. The Service Manager (Resources) gave assurance of close working arrangements between Social Services, Education and a range of school partners.

Councillor Hilary McGuill raised various concerns on changes within BCUHB, the impact of any Council merger on outcomes for Children's Services and the challenges on encouraging looked after children to take up health assessments. In terms of educational attainment of looked after children, she commented on the impact from stability of placements which could be shared with the Committee, and the potential for access to Child & Adolescent Mental Health Services (CAMHS). Mr. Gifford agreed that baseline data should be assessed to establish reasonable expectations in terms of educational attainment and that presenting the stories behind individuals to CSSIW could be reflected in future reports.

In respect of BCUHB, the Chief Officer said that good professional and corporate relations were being maintained with BCUHB as one of the Council's major partners, but appropriate challenge was an ongoing theme. He advised that every opportunity was being taken to improve take-up of health assessments, as that the issue was regularly highlighted at meetings. The Chair said that this also could be raised at the joint meeting with Lifelong Learning Overview & Scrutiny in Spring 2015. The Cabinet Member for Social Services added that the issues of health assessments and educational attainment of looked after children had been highlighted at meetings of the Children's Services Forum.

As a kinship carer, Councillor Andy Dunbobbin acknowledged the challenges around education attainment of looked after children but added that support was available through effective partnership working such as courses offered by Coleg Cambria.

Councillor McGuill asked how many beds were commissioned in nursing homes for patients leaving community-based hospitals. The Chief Officer

advised that a number of beds were available through the Intermediate Care Fund and a breakdown of the provision was shown on page 87 within the Improvement Plan progress report.

Councillor Amanda Bragg queried the reason for the increase in referrals to Children's Services and those on the Child Protection Register during 2013/14. The Chief Officer said that this rise had been experienced across many other Authorities and was thought to be due to increased awareness resulting from a number of high-profile child safeguarding cases reported nationally. However, the level of referrals to date for 2014/15 had stabilised and was more in line with the Wales average. Mr. Gifford was in agreement with these comments, as the data for previous years had been lower.

RESOLVED:

That the CSSIW evaluation of performance and the Authority's response to areas that have been identified for improvement, be noted.

42. NORTH WALES ADULTS SAFEGUARDING BOARD

The Chief Officer (Social Services) introduced a report to consider the proposal that the statutory requirement to establish a Safeguarding Adults Board be discharged on behalf of the Authority by the North Wales Safeguarding Adults Board (NWSAB). This would put the safeguarding of adults on to a statutory footing similar to that already in place for safeguarding children.

The report set out the development of arrangements for the NWSAB in comparison to that for children's boards, with the recommended approach for a regional board with sub-regional delivery groups to ensure that local practice met local need. The implementation plan with proposed timescales was appended to the report.

In response to a query from Councillor Hilary McGuill, the Chief Officer explained that the NWSAB membership would comprise senior officers with responsibility for safeguarding from each Authority, together with colleagues from Health and North Wales Police. It was indicated that Jenny Williams (Director of Social Services in Conwy CBC) would chair the Board initially until agreement could be reached on a permanent arrangement. The Chief Officer agreed to email the Committee with confirmation of the membership.

Following comments from Councillor McGuill about Member involvement and accountability, the Chief Officer said it was likely that senior officers on the Board would be responsible for cascading information to Members and that Flintshire's view would be represented in discussions on governance and responsibility within the Board. He added that regular reports on the activities and effectiveness of the Safeguarding Children's Board would give Members the opportunity to challenge, and felt that the same approach would apply for the NWSAB.

Councillor McGuill raised concerns about the use of electronic communications due to the potential increase in travel by some NWSAB members. The Chief Officer acknowledged this but gave assurance that

appropriate decisions on the use of such equipment as opposed to a one-to-one meeting would need to be assessed, depending on each situation.

RESOLVED:

(a) That the statutory requirement to establish a Safeguarding Adults Board be discharged on behalf of the Authority by the North Wales Safeguarding Adults Board; and

(b) That the structure for the regional Safeguarding Adults Board, to be known as the North Wales Safeguarding Adults Board (NWSAB) as shown in Section 4.2 of the report, be noted.

43. MID YEAR CHIEF OFFICER PERFORMANCE REPORT

The Chief Officer (Social Services) presented his 2014/15 mid-year service performance report for his portfolio, covering the period April to September 2014.

On Direct Payments, the Committee was informed of details of positive work undertaken such as identifying areas of good practice and information exchanges with external groups.

In response to queries from Councillor Hilary McGuill, the Service Manager - Disability Services provided explanation on the use of the multi-room sensor pilot in Telecare and a video-based alarm facility which was due to be piloted in January 2015 using funding from the Intermediate Care Fund. She offered to provide the Committee with further details on this at a future meeting.

Councillor Amanda Bragg sought assurance on the procedure for assessing suitability of properties, particularly for those who were unable to communicate effectively. The Service Manager - Disability Services explained that the process was based around the needs of individuals, involving consideration of a number of factors. She spoke of good links with housing associations on the identification and acquisition of suitable properties for rental to service users. On Telecare services, she provided information on the initial assessment, review and monitoring of equipment.

Councillor David Mackie commented on potential problems on shared properties. The Service Manager explained that each service user within each property was given an individual Tenancy Agreement. If one individual chose to end their agreement, options were available for the remaining tenants to maintain theirs or for an Accommodation Panel to consider a replacement. Although there had been no long-term tenancy problems to date, the Council had a responsibility to address voids.

In response to a question, the Service Manager said that out of approximately 120 placements, there were only around five or six voids. She went on to say that a single occupancy property would need to be sourced for individuals in some circumstances.

RESOLVED:

(a) That the report be noted; and

(b) That the comments/observations of the Committee are fed back to the Corporate Resources Overview & Scrutiny Committee who are responsible for the overview and monitoring of performance.

44. QUARTER 2 IMPROVEMENT PLAN MONITORING REPORT

The Chief Officer (Social Services) introduced the report for the Committee to note and consider elements of the 2014/15 Improvement Plan Monitoring Report relevant to the Committee for the period July to September 2014.

Independent Living

The Team Manager - Performance referred to measure PSR/009a which represented Disabled Facilities Grant (DFG) adaptations for one child and explained that the outturn had been adversely impacted by the sourcing of specialist equipment required for the work and delays to the grant process. She went on to say that the work had been completed one month after it had started.

The Chief Officer stated that performance had been improved through adjustments to the Occupational Therapist assessment process, with no negative impact on quality.

Councillor David Mackie raised concerns around the average days taken to deliver major adaptations in owner/occupier and private rented properties compared with those in Council owned properties. The Chief Officer commented on improvements made to the joined-up approach by Social Services and Housing to undertake this work and suggested this as a topic for the joint meeting to be arranged in the New Year. The Service Manager - Disability Services spoke about the different processes involved and the potential for delays if consent was not received promptly from landlords.

In response to similar comments from Councillor Joe Johnson, the Service Manager pointed out the complexities for some adaptations which could involve seeking planning permission or obtaining quotes from contractors. She said that improvements had been made to reduce stages of the process and welcomed any suggestions from Members.

Councillor Hilary McGuill suggested the grants could be accessed directly by the applicant to arrange their own adaptations. The Service Manager said that this was already an option, however most residents preferred the Council to undertake this. It was hoped that the introduction of a further option to enable Care & Repair to carry out work would help to speed up the process and improve future performance figures.

In response to a request from Councillor McGuill, officers agreed to provide details on the time taken from a request for DFG adaptations through to completion of the work.

Councillor David Wisinger asked about the various sections involved in processing a DFG application and whether this could be better prioritised, possibly with involvement by the Planning department. The Service Manager explained that the Housing section had undertaken work on the list of approved contractors to speed up the process on quotations.

The Chair reminded the Committee of the recommendation in the report which gave an opportunity to feedback comments to the Corporate Resources Overview & Scrutiny Committee.

Councillor Hilary Isherwood felt that the application process could be further simplified through the use of a single point of contact and that perhaps Age Concern could be involved to assist with applications from vulnerable people.

The Service Manager suggested that a group of Members may wish to view the flowchart process to see if any improvements could be made. The Chair said that this had already been done and that a better approach could be through a joint workshop between the Committee, the Housing Overview & Scrutiny Committee and officers from the Planning department.

Councillor Veronica Gay suggested that a request be made for the Planning Protocol Group to consider the DFG process.

Integrated Community Social and Health Services

The Chief Officer commented on the Council's effective use of the Intermediate Care Fund and future risk, explaining that more information would be received by the Committee in the New Year including discussion on how best to provide support using current resources.

RESOLVED:

(a) That the report be noted; and

(b) That feedback be provided to the Corporate Resources Overview & Scrutiny Committee who are responsible for the overview and monitoring of performance;

(c) That the Environment and Housing Overview & Scrutiny Committees be requested to examine the adaptation process with a view to suggesting any improvements; and

(d) That the item on adaptations be discussed further at the joint workshop with the Housing Overview & Scrutiny Committee.

45. ROTA VISITS

The Facilitator asked Members to stay behind after the meeting to view the list of rota visits to be covered over the next six months. In response to a query by Councillor McGuill, the Facilitator agreed to confirm the number of outstanding reports.

RESOLVED:

That the information be noted.

46. FORWARD WORK PROGRAMME

The Facilitator introduced a report to enable the Committee to consider the Forward Work Programme. She confirmed that as requested at the previous meeting, a representative from the Assessment Team would be present at the next meeting on 29 January 2015.

Following comments raised by Members on Ambulance response times, the Facilitator explained that a mutually convenient date was being sought from representatives of both the Ambulance Trust and Betsi Cadwaladr University Health Board, as discussion on this matter concerned both parties. The Chair suggested it would be useful for any queries and comments to be forwarded to the Facilitator to collate prior to the meeting.

The Committee agreed the following:

- A special meeting may be required for the relevant representative to attend for the Collaborative Projects item (currently scheduled for March 2015).
- On the educational attainment of looked after children item for the joint meeting with Lifelong Learning Overview & Scrutiny Committee in Spring 2015, a request would be made for example case studies from across the board, including any impact from disruptive placements.
- The joint meeting with Housing Overview & Scrutiny Committee (yet to be scheduled) to include an extra item on homelessness issues.
- In consultation with Chair, the items yet to be scheduled would be allocated dates. The Chairman of the Children's Services Forum would asked to provide an update, to be circulated to the Committee. Any questions raised could then be passed back to the Chairman for a response.

RESOLVED:

That the Forward Work Programme be updated accordingly.

47. MEMBERS OF THE PRESS AND PUBLIC IN ATTENDANCE

There were no members of the press or public in attendance.

(The meeting started at 10.00 am and ended at 11.50 am)

.....

Chairman

FLINTSHIRE COUNTY COUNCIL

REPORT TO:	**SOCIAL & HEALTH CARE OVERVIEW & SCRUTINY COMMITTEE**
DATE:	**THURSDAY, 29 JANUARY 2015**
REPORT BY:	**CHIEF OFFICER, SOCIAL SERVICES**
SUBJECT:	**SOCIAL SERVICES INTERMEDIATE CARE FUND (ICF)**

1.00 PURPOSE OF REPORT

1.01 Members will be aware that Welsh Government developed a one year 'Intermediate Care Fund' (ICF) to encourage integrated working between local authorities, (including Housing and Social Care), Health and other partners.

1.02 This report provides Committee with an overview of the projects delivered by the Intermediate Care Fund and the opportunity to scrutinise the outcomes that have been delivered.

2.00 BACKGROUND

2.01 What is Intermediate Care?

"Intermediate care services are provided to patients – generally older – to help them avoid going into hospital unnecessarily, to help them be as independent as possible after discharge from hospital and to prevent them having to move into residential or nursing homes until they really need to. These services are generally time-limited, until the person has regained independence or medical stability, and are provided in people's own homes, in community hospitals or sometimes within local nursing homes" Kings Fund, 2013.

2.02 The Intermediate Care Fund

The ICF Fund was set up by Welsh Government to support older people, particularly the frail elderly, to maintain their independence and remain in their own home. Funding was allocated on a regional footprint with £1,926m allocated to Flintshire. This consists of £642k capital and £1,284m revenue funding. Welsh Government were clear that the Fund could not be used to substitute existing funding streams and must be used to support new, or additional, provision of services and ways of working. The ICF was designed to be one year funding (2014/2015) and Welsh Government have confirmed that the Fund will cease on 31st March 2015.

2.03 Managing the Fund

The ICF was allocated on a regional footprint with Flintshire leading the management of the Fund on behalf of North Wales. Each authority within the region developed their own bid for funding and the individual bids were pulled together to form a coherent regional bid. Flintshire's bid was developed with contributions from Social Services, Housing, BCUHB & Third Sector organisations. The bid for Flintshire was based upon three key themes with a consistent focus on enhancing services for people with dementia:

Theme 1: Improving preventative care & avoiding unnecessary hospital admission and delayed discharge

Theme 2: Promoting and maximising independent living opportunities

Theme 3: Supporting recovery and recuperation by increasing the provision of reablement services

3.00 CONSIDERATIONS

3.01 The ICF has enabled the following projects to be delivered in Flintshire:

Provision of step up/step down beds in residential care homes	Funding has been used to purchase beds within 3 Care Homes in Flintshire (LLys Gwenffrwd, Marleyfield and Croes Atti) for people who are ready to come out of hospital but need some more support in the community before they can go home. Funding is also used to purchase additional beds across the County if there is a need. The project has facilitated timely hospital discharge and supported people to develop their independence in a safe environment with a view to enabling them to return to live in their own home.
Purchase of a dementia assessment bed	A bed is available at an EMI Residential Care Home where people with dementia can have their needs assessed over a period of time, enabling a fuller understanding of the person and their needs. This approach provides an effective alternative to people being assessed on a hospital ward when they can be confused and distressed.
Increasing staff resource	The Fund has enabled additional staffing across Health and social care to support intermediate care. There has been an increased in Occupational Therapy provision in Wrexham

	Maelor Hospital to support timely hospital discharge with plans to fund an additional 0.5 of post in Glan Clwyd over the winter months. Additional Social Worker and Occupational Therapy provision in the Reablement team and additional Nurse capacity into the Crisis Intervention Team. This additional capacity has helped ensure people are supported to live independently and to provide intensive in reach support to people in Step Up/Down provision to help them return to the community.
Extending Specialist Dementia Care in the Community	A range of initiatives have been funded including plans to roll out the “Living Well” service model. This service provides an outcome focussed approach to supporting people with dementia living to in their own homes. Work has been undertaken to promote the development of dementia friendly communities and, working with NEWCIS, to deliver dementia awareness to carers – including e-learning opportunities.
End of Life Care	BCUHB Macmillan End of Life Care Facilitation team are piloting the “Six Steps to Success Programme for Palliative Care" in Nursing Homes. The aim is to ensure people have improved end of life care with choice and control over their end of life care plans whilst increasing staff confidence and understanding of end of life care. The pilot also aims to reduce inappropriate hospital admissions and delayed transfers of care for those who are at end stage palliative care. A number of Residential Homes have also indicated that they would like to introduce this programme.
Equipment, aids and adaptations	A range of projects to extend the availability of assistive technology, aids and adaptations to people living at home to maintain their independence and wellbeing. Also included are additional adjustable beds, available to loan through the Red Cross.
Enhanced Pharmacy Support within the community	Funding has been used for a Pharmacist and Pharmacy Technician to provide more direct support to Residential Care Homes and to GP’s for example to make targeted visits to people in their own home to review medication use.
Falls Prevention	Two staff members from the Therapies Team in BCUHB have been funded to conduct in depth assessments with older people identified as being at risk of falls to find ways that their risk can be reduced.
Dementia	The Alzheimer’s Society has been funded to

Community Support Service – Alzheimer's Society	provide one to one personalised support for people living with dementia in their own homes. The focus of the work is to enable people with dementia to continue with personal hobbies and interests, try new experiences and continue with daily living and other activities that are important to them. The support is time limited and focuses on supporting people to access activities themselves.
Intermediate Care Support Service – British Red Cross	British Red Cross has been funded to provide a rapid response, low level support service through volunteers to people who are in receipt or leaving other Intermediate Care Services. For up to three hours a week, for up to 6 weeks, low level practical and emotional support is provided to help individuals feel confident and independent at home.
Healthy Homes for Discharge Project – Flintshire Care & Repair	Flintshire Care & Repair have been funded to work with individuals to address concerns that could be preventing a safe discharge from hospital. Team members carry out a full assessment of the person and their property and then make the appropriate links to a wide range of services and organisations that can provide any assistance that is needed.
Hoarding Tendencies Support Project – Flintshire Care & Repair	Flintshire Care and Repair will use specially trained staff to assist individuals with hoarding tendencies to provide practical help and support in order to address any immediate issues preventing an individual from returning home safely after a hospital stay and to address the causes and consequences of their hoarding behaviour to prevent further ill health, reduction in independence. There has been a high demand for this services and additional ICF money has been reallocated to help meet demand.
Neurotherapy Centre	To provide additional Counselling, Occupational Therapy and fatigue management support for older people with a neurological condition and their Carers, many of whom will be spouses of a similar age, in order to promote wellbeing, increase independence and reduce the need to access statutory services.
Support at Night	Working to transform the way we support some of our service users at night through improved technologies and having staff available to offer support to a cluster of people living in the community. The service will be trialled in the New Year and evaluated.
Conversion of a	A property is being converted to provide

property for short term intermediate care accommodation	accommodation for an individual to live on a short term basis whilst they regain their independence. The property will be equipped with telecare equipment and where appropriate a package of health and/or social care will be provided to meet their needs to facilitate their return home.
Development of Extra Care	A significant element of the capital element of the ICF (£550k) is being used to support the development of additional Extra Care Facilities. Capital funding has provided leverage for investment in the development two additional Extra Care provisions. Plans are underway to develop Extra Care at Flint and Holywell.

3.02 **Achievements to date:**

3.03 During the first 6 months of the project (April – September 2014)

- 25 people were supported through ICF step down beds for a total of 396 nights. The average length of stay was 16 nights for each patient.

The following case study provides a real life example of how the ICF step up/step down beds have made a real difference to the lives of vulnerable older people:

Case Study:

Mr G is 90 and lives alone in a flat on the eleventh floor of a large building. Mr G was admitted to hospital in February 2014 for neurology investigations, following a period of ill health, confusion and poor mobility.

In May 2014, Mr G was able to be discharged to an ICF step down bed. Mr G was concerned about returning home, stating he did not feel safe and expressed a desire to enter 24 hour care, which was supported by his family.

The Intermediate Care and Reablement teams engaged with Mr G and his family, carrying out multi-disciplinary assessments, including a Carers Assessment. Working with Mr G and his family, a range of personal outcomes were identified and a program of interventions put in place. Through this fully supported process, Mr G was able to regain his confidence and some independent skills resulting in his decision to return home.

Mr G returned home after a period of 12 days in the step down bed

and a week after doing so said “he was happy he had returned home”.
His return home was facilitated by the implementation of a Reablement package providing ongoing support, including Telecare equipment and equipment to aid his mobility, three home care calls a day from care services and family support at lunch time.

The Intermediate Care intervention enabled Mr G to be discharged from hospital to a safe environment for assessment, and prevented an unsafe discharge home/or admission to a care home. Through the collaborative efforts of Health, Flintshire Council, Mr G’s carers and third sector involvement, Mr G was able to return home with support to live independently.

3.04 Further case studies are included in Appendix 1 of this report. Other achievements during the first 6 months of the ICF include:

- 18 people supported through the Care and Repair ‘Healthy Homes for Discharge Project’ which works with vulnerable older people in hospital to help ensure they return to secure, safe and warm homes.

- 8 people with dementia supported by the Alzheimer’s Society, to access and engage in activities that interest them. The people supported, and their carters, have reported:

    - Reduced social isolation
    - Increased motivation and now engaging in daily tasks
    - Carer feeling more relaxed
    - Person with dementia reporting feeling happier

- 12 people referred to the Care and Repair Hoarding Tendencies Project which supports vulnerable people who hoard and are at risk of falling in their home. 5 of the people referred were in hospital at the time of referral.

The ICF will be evaluated in Spring 2015 both at a regional and local level.

3.05 <u>Challenges</u>

There have been some challenges with the programme particularly relating to the one year, short term nature of developing additional/new services which involve a range of organisations. The most significant challenge has been recruiting staff as there can be long lead in times and, at times, specific skills have been needed.
One particular example was a project which looked to bring additional CPN capacity to Flintshire. The capacity was intended to provide particular out of hours support for Care Homes to minimise hospital admission and enable support/treatment in the Care Home setting.

Unfortunately BCUHB were unable to attract appropriate staff and the project did not proceed. Arrangements are in place for agreeing processes and priorities for any slippage in the Fund.

3.06 Governance Arrangements

The regional ICF allocation has been overseen by North Wales Integrated Services Programme Board. The Board has representation from all 6 local authorities, Health and Housing with arrangements to co-op independent and 3rd sectors where appropriate. The Board forms part of the governance arrangements that feed into the North Wales Regional Leadership Board. The Board is chaired by Flintshire's Chief Officer, Social Services. This forms part of reciprocal arrangements across North Wales for leading on regional initiatives.

The Board has received regular reports on progress and outcomes delivered. Welsh Government have attend the meetings on two occasions and at their visit in December described North Wales' approach to managing the ICF as being an 'exemplar'.

3.07 Exit Strategies

Welsh Government have confirmed that the ICF fund will cease on the 31st March 2015. We have been advised that there is a degree of flexibility in funding projects until the end of April to ensure that projects are appropriately closed and to finalise support for people who have already started a short term service.

As a region we are working to identify critical ICF projects where it is considered that the end of the project will have a significant adverse impact on the delivery of effective intermediate care. In Flintshire the critical projects have been identified as:

- Step up/Step down provision and the associated investment in in- each support staff to enable people to return back to the community
- The falls prevention project
- The palliative support project and associated nursing support
- A regional project for minor adaptation and equipment

We have communicated these priorities to BCUHB so there is an opportunity for dialogue aligned to the development of their 3 year plan. In addition we will continue to explore any potential funding opportunities from the Welsh
Government.

4.00 RECOMMENDATIONS

4.01 Committee are asked to note the report including the progress made with the effective use of the Intermediate Care Fund.

4.02 Given the importance and early success of the priority services which have been recognised by BCUHB, other partners and Flintshire County Council, Committee should consider whether it would support the case being made to Welsh Government for continuing financial support when new funding possibilities arise.

5.00 FINANCIAL IMPLICATIONS

5.01 The end of the Fund will mean that successful projects will no longer have funding streams. Work is taking place to look at how critical projects could be supported (see 3.07 above).

6.00 ANTI POVERTY IMPACT

6.01 None

7.00 ENVIRONMENTAL IMPACT

7.01 None

8.00 EQUALITIES IMPACT

8.01 The end of projects will have an adverse impact for older people. However, this is a one year Fund.

9.00 PERSONNEL IMPLICATIONS

9.01 None

10.00 CONSULTATION REQUIRED

10.01 None

11.00 CONSULTATION UNDERTAKEN

11.01 None

12.00 APPENDICES

12.01 Appendix 1 – Case Studies

LOCAL GOVERNMENT (ACCESS TO INFORMATION ACT) 1985
BACKGROUND DOCUMENTS

None.

Contact Officer: Craig Macleod
Telephone: 01352 701313
Email: craig.macleod@flintshire.gov.uk

This page is intentionally left blank

Appendix 1 Case Studies

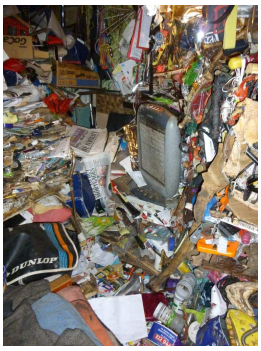
Case study 1:

A Hoarding tendencies case study
A 71 year old gentleman who lives alone was in Deeside Hospital unable to be discharged due to his home circumstances as he was unable to move around the property with a Zimmer frame or on sticks due to clutter.

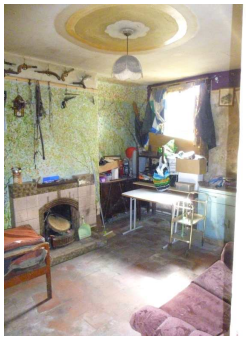
The client was offered temporary accommodation with Local Authority which he declined and chose temporary residential care option fully self funded. A quote was obtained to de-clutter the property and a contract was drawn up with the client and family member for the works to be completed. The property was cleared enough for a technical survey of the property.

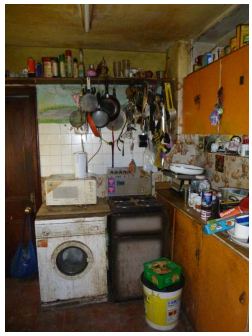
Some more clearing is required in the property for any works to be started. A survey of defects and deficiencies has been conducted and discussed with the client. He is now considering his options of re-housing or renovation of his home. We are supporting him to find the best choice for his health and circumstances, looking at the private rented and council sector.

The client has received 10 casework visits, 2 Technical Officer visits, and contractor visits. He has stated that without the support of the Hoarding Caseworker he would not have achieved the clearance or essential housing maintenance to ensure the property was warm, safe and secure. He is now feeling more confident and wants to engage into society.



Before and After





Case Study 2

A life changing experience:

After her husband died Mrs B moved from her family home to a high rise 12th floor council flat. Her health and mobility deteriorated leaving her feeling isolated with a fear of lifts and she became disorientated looking out of the window. Mrs B often called the care link service to be reassured someone was there.

Mrs B had had a number of hospital admissions, most recently after falling and lying on the floor for 3 days having forgotten how to use her care link. On this occasion she was adamant she was not returning to her flat and had decided to fund a placement in a residential care home.

It was arranged that Mrs B have a period of time in an intermediate care step up / step down bed placement which would enable her long term care needs to be assessed. During the first few days of the placement Mrs B and her family announced they had secured a private residential care home placement and they made it clear she would not return to her high rise flat.

The occupational therapist carried out assessments and interventions that determined Mrs B had Reablement potential. Together with holistic assessment and case management by the social worker, this brought about number of concerns including

- Mrs B did not meet the criteria for residential care, meaning an inappropriate Care Home placement with a potential loss of independence.
- Mrs B savings would only fund the private residential placement for 18 months to 2 years before the funding threshold was triggered.
- Mrs B had given in notice on her flat.

Mrs B received a period of Reablement with daily occupational support. A Financial Assessment took place and Extra Care housing schemes were discussed, viewed and applications made. Within 4 weeks of admission into the intermediate care placement Mrs B successfully moved into a housing support scheme, offering a spacious open space living area and a daily warden service. She continued to receive occupational therapy for a week after her move and was then discharged from the intermediate care service having settled into her new tenancy.

Mrs B maintained her independence with improved well-being and social interaction in a more appropriate living environment. She was also able to retain her financial independence as her savings were not unnecessarily depleted. Mrs B and her family said they would never have known such an option existed.

Case Study 3

Alzheimer's Society Case Study

Mrs X does not receive any services so mainly spends time with her husband or her sister. Following the assessment Mrs X had said that she would like to go along to the gardening group at P&A in Mold. When I picked her up for the first session she said that she felt quite anxious and worried about going to the group. I sat and talked to her about the group and what we would be doing there and reassured her I would be with her throughout the session. Once there Mrs X was very sociable and joined in with the group. On the way back home she said that she really enjoyed the session and liked to meet new people.

On our second session at the gardening group Mrs X seemed much more settled and relaxed. She was quite chatty with other members of the group and me. When we got back home Mrs X was giggling and telling her husband how much she enjoyed going to the group. Her husband commented on how she had returned to the house in a much happier mood.

This page is intentionally left blank

FLINTSHIRE COUNTY COUNCIL

REPORT TO: **SOCIAL & HEALTH CARE OVERVIEW & SCRUTINY COMMITTEE**

DATE: **THURSDAY, 29 JANUARY 2015**

REPORT BY: **CHIEF OFFICER (SOCIAL SERVICES)**

SUBJECT: **REABLEMENT / INDEPENDENT LIVING IN FLINTSHIRE**

1.00 PURPOSE OF REPORT

1.01 To update Members on the progress made by the Reablement and Telecare service.

2.00 BACKGROUND

2.01 Over the past decade there have been increasing numbers of reablement services being developed by local authorities, often in partnership with the NHS. Evidence has shown that reablement can lead to major improvements in the well-being and independence of older people and other groups.

2.02 This report provides Scrutiny Committee Members with an update on the Reablement and Telecare service in Flintshire.

3.00 CONSIDERATIONS

3.01 **What is reablement :** In Flintshire we use the Social Services Improvement Agency definition of reablement – The process of restoration of skills by a person who has had an illness or injury so as to regain maximum self-sufficiency and function in a normal or as near normal manner as possible .

3.02 **Who reablement is for:** Reablement has the potential to help many different people, including older people, people with physical disabilities or sensory impairments. Reablement can also support people with a learning disability and people with dementia.

3.03 In Flintshire like many other authorities, we have in the main concentrated on supporting older people, including people with a mild to moderate dementia, and people with physical disabilities. However, we are seeking to extend the service to support people with a learning disability and have had some recent successes in this area.

3.05 **How Reablement Works in Flintshire**

3.06 If you look across Wales and indeed England you will find a number of differing models and approaches to reablement. In Flintshire we operate an Intake Model which in essence means that **all** referrals are reviewed for reablement potential at the first point of contact. For example, Hospital Social Workers will always screen for reablement potential whilst undertaking an assessment of need on a hospital ward. First Contact staff will always consider reablement service in the first instance when speaking to people.

3.07 Reablement support is free for up to a maximum of six weeks. In Flintshire the average length of service is approximately 3 to 4 weeks and in the main reablement is provided in the individuals own homes.

3.08 Flintshire also provides 4 reablement / assessment places in a care home for individuals who need some overnight support following a hospital admission. These people will have a care programme based on reablement within a care home setting, with the main aim of undertaking an in depth assessment whilst in a safe 24 hour staffed environment, with individuals moving back home once we have a clearer understanding of the persons needs.

3.09 There are a number of teams involved in providing the reablement service, including:-

- First Contact, this includes occupational therapy alongside disability officers who assess for small equipment aids, staff who provide advice and support and sign posting as appropriate
- The Reablement Team are a multidisciplinary team consisting of Social Work, Occupational Therapy, Physiotherapy and Telecare staff.
- The Homecare team provide the hands on reablement.
- The Care home staff provide the assessment and overnight support service and reablement support in a care home.
- The Hospital Social work team cover Countess of Chester, Wrexham Maelor, Glan Clwyd Acute hospitals and the community hospitals.
- North East Wales Community Equipment Store (NEWCES) provide and fit equipment to peoples own homes.

Social Services has worked hard to ensure that all its staff have an enabling ethos.

3.10 **Outcomes and Performance**

3.11 Between April 2013 and March 2014 we received 933 referrals for reablement, of those 503 (53.9%) required no further support at the end of the

period of reablement.

In the 9 month period between April 2014 and December 2014 we received 905 referrals for reablement of those 469 (a higher referral rate with 51.8%) required no further support at the end of the period of reablement.

3.12 We measure outcomes in the attached chart.

Reablement Outcomes
No Further support required at end of Reablement
Assessed support at start **reduced** by end of Reablement
Assessed support at start **maintained** at end of Reablement
Assessed support at start **increased** at end of Reablement
User did not complete Reablement phase: e.g. referred to other services including LTC or health, declined service once started or died before end of Reablement

3.13 In the 9 month period between April 2014 – December 2014 51% of people who have received reablement have gone on to receive no further support following reablement, 9% had a reduction in their assessed support following reablement with 18% having their assessed support maintained following reablement. The percentage of people whose assessed support has increased following a period of reablement has remained consistently very low over the last 2 years averaging 2.5% in 2013/14 and to date this year 3%.

A full analysis of these outcomes is included in Appendix 1.

4.00 RECOMMENDATIONS

4.01 Note the good progress of the reablement team and the approach the service is taking.

7.00 ENVIRONMENTAL IMPACT

7.01 None.

8.00 EQUALITIES IMPACT

8.01 None.

9.00 PERSONNEL IMPLICATIONS

9.01 None.

10.00 CONSULTATION REQUIRED

10.01 None.

11.00 CONSULTATION UNDERTAKEN

11.01. None.

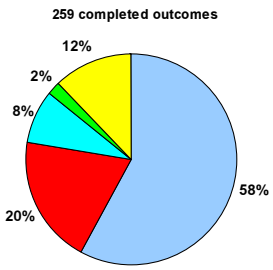
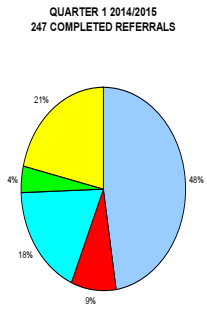
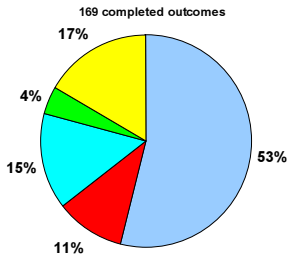
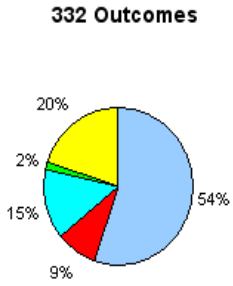
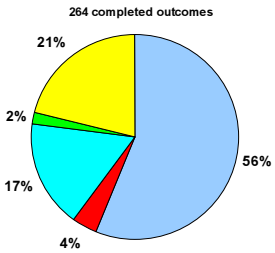
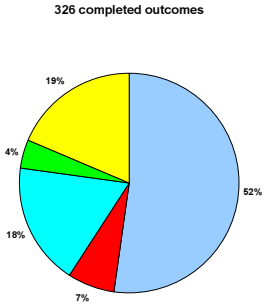
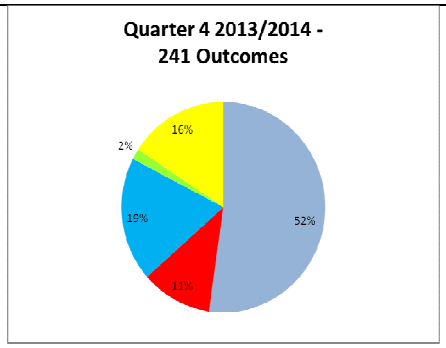
12.00 APPENDICES

12.01 Appendix 1 Reablement outcomes 2013/14 and 2014/15
12.02 Appendix 2 Telecare Case Studies
12.03 Appendix 3 Reablement Case Study

LOCAL GOVERNMENT (ACCESS TO INFORMATION ACT) 1985 BACKGROUND DOCUMENTS

None.

Contact Officer: **Susie Lunt**
Telephone: **01352 701360**
Email: susie.lunt@flinthsire.gov.uk

	2013/2014	2014/2015	KEY
Q1			No Further support required at end of Reablement
Q2			Assessed support at start **reduced** by end of Reablement
Q3			Assessed support at start **maintained** at end of Reablement
Q4			Assessed support at start **increased** at end of Reablement
			User did not complete Reablement phase: e.g. referred to other services including LTC or health, declined service once started or died before end of Reablement

This page is intentionally left blank

Older People - Mrs A	
Mrs A is a 92 year old lady who lives alone. She has short term memory difficulties, she also has diabetes type 2 which is tablet controlled. Mrs A has left her home during the night in her nightdress and has been taken home by neighbours on two occasions. She enjoys going out alone to her local shops during the day, she usually returns home safely but has become disorientated on two occasions and has got lost. She has fallen on 3 occasions at home and remained on the floor until carers arrive in the morning. Mrs A receives a domiciliary care package of two, half hour calls per day for assistance with morning personal care, prompting with medication and meal preparation. She also attends day care twice per week. Mrs A receives support from her daughter who lives locally and is willing to act as a responder for an Intellilink alarm and any Telecare sensors required.	
Risks identified	**Telecare sensor/equipment required to minimise these risks**
Risk of Mrs A becoming disorientated and becoming lost in her Local area during the daytime / risk of Mrs A losing her independence to venture out alone in her local area.	Buddi GPS location system required with a virtual boundary around her local area required. Family helped to establish area which Mrs A visits and agreed to respond to any calls from the monitoring centre if virtual boundary is broken. Carers to ensure Buddi is placed in Mrs A`s handbag each morning.
Risk of wandering during the night	Door exit sensors set to be active between the hours of 8pm and 7am required, also Carers to place Buddi system in handbag which she usually takes out with her.
Risk of disorientation of time	Memory clock required
Risk of falling when at home	Wrist worn impact falls detector which will alert the monitoring centre in the event of a fall required/
Risk of fire due to Mrs A`s memory difficulties impairing her judgement around general fire safety issues	Heat and Smoke sensors required, also Home Fire Safety Check to be carried out by Flintshire Fire Service.
Risk of carbon monoxide poisoning due to Mrs A often sleeping in her lounge chair in the same room as a gas fire	Carbon Monoxide detector required.
Risk of flooding due to history of Mrs A leaving taps running and using	Flood detector required in kitchen and bathroom.

copious amounts of toilet paper causing toilet to overflow	
Risk of being unable to raise an alert in the event of an emergency	Intellilink alarm and pendant required.
Outcome Mrs A continues to live at home, her domiciliary care package has increased to two half hour calls and one full hour call per day, she continues to attend day care twice per week.	

Children's Services - C	
C is a 6 years old boy, he has autism, ADHD. epilepsy, behavioural problems and a Learning Disability. He lives with his mother and father who provide all his care needs. C is hyperactive and has recently been attempting to open the front door in an attempt to leave the house, this is extremely dangerous as he lives on a busy main road and has no road safety awareness. Mother states "we try to keep the front door locked at all times but we need to open the door sometimes, if we forget to lock it again he gets out and has even run into the road. We need something to act as an alarm to alert us if the front door is opened". He can use the back door freely as the back garden is secure. C has also started to get up during the early hours of the morning to try to open the front door, and although the door is locked, going downstairs alone exposes C to other risks including him attempting to turn the cooker on. He has nocturnal Tonic Clonic seizures which require rescue medication. Telecare assessment completed	
Risks identified	**Telecare sensor/equipment required to minimise these risks**
Risk of C coming downstairs at night and attempting to leave the property or turn on electric cooker	PIR movement sensor to be installed on second stair down in order to alert parents via a Carer Alert if C attempts to go downstairs at night.
Risk of C opening the front door and leaving the property and parents being unaware	Property exit sensors required to front door, to be monitored via a Carer Alert by parents.
Risk of C having a nocturnal Tonic Clonic seizure and parents being unaware he needs medication-	Chubb epilepsy sensor required, to be monitored by parents via a Carer Alert.
Outcome C`s mother states that the equipment has " helped to keep C safe and provided her with reassurance, especially during the night. She states that " I feel I am getting a much better quality sleep as I know if he has a seizure or attempts to go down stairs during the night I will be woken"	

Learning Disabilities - Mr S

Mr S is a 27 year old man who lives with a learning disability, he lives with his mother who provides prompting and support with most daily living activities. Mr S is currently supported by Work Opportunities service 4 days per week, working 3 days at a catering project and one day at a supermarket. Mr S requested an assessment of needs as he would like to explore the possibility of having some support to allow him to develop his independence, with a view to him spending time alone in his home.

Following a Telecare assessment Mr S and his mother agreed to the installation of an Intellilink community alarm and various telecare sensors in order to ensure his safety within the home while carrying out daily living activities independently.

Risks identified	**Telecare sensor/equipment required to minimise these risks**
Risk of Mr S being unable to make contact with the outside world in the event of an emergency when left alone at home	Intellilink alarm with pendent required. (mother and next door neighbour agreed to be responders).
Risk of Social Isolation due to Mr S being unable to sequence telephone numbers, resulting in him being unable to make outgoing telephone calls	Picture telephone required, Mrs S will insert pictures of friends and family which will enable Mr S to make outgoing calls to people of his choice..
Risk of Fire in the kitchen when Mr S is preparing hot food independently	Heat sensor installed in kitchen which will activate on a rapid rise in temperature and provide a local alert by sounding and activate a call to the monitoring centre will provide a high level of protection and reassurance to both Mr S and his mother.
Risk of Fire and flooding	Telecare Heat and Smoke detectors to be installed by Flintshire Fire Service, also a Home Fire Safety Check to be carried out by Flintshire Fire Service.
Risk of flood.	Flood detector provided required in upstairs bathroom and downstairs toilet .

Outcome

The provision of this equipment has enabled Mr S to spend some time alone within his own home.

His mother states " I feel happy that if my son needs help the equipment will alert either myself or the monitoring centre. Not only has it helped my son it has also provided me with reassurance".

Mr S states " I am pleased that I can come home from work and let myself into my own home and spend some time alone".

Case Study Mrs H

Mrs H who is 100 years of age has a medical history of chronic kidney disease stage 3, rheumatoid arthritis, osteoporosis and hypertension.

Mrs H lives alone in her own bungalow and has had four falls recorded in the past six months, fourth fall resulted in fractured femur and admission into Countess of Chester Hospital , Mrs H attended theatre for right femoral nailing.

Following surgery mobility was reduced with partial weight bearing with a wheeled frame and she was transferred to Deeside Hospital for rehab. Hospital Social Work Team completed assessment and identified Reablement intervention. Due to Mrs H being in hospital for a long period of time (ten weeks), four calls a day requested to regain skills and confidence with personal care, meal preparation tasks and to re-establish her routines.

Reablement services started.
Mobility prior to admission: used no walking aid within her home and was discharge home with a frame and a kitchen trolley.

Services monitored and Mrs H progressed well with her lunch and evening routines and tailored support. Calls reduced from four to two. Mrs H was only using her kitchen trolley within her home as felt the frame was too big and benefited from being able to transfer items.
Telecare equipment identified and fitted: intelli link alarm, smoke detectors and key safe.
Identified Reablement OT as prior to admission Mrs H was stepping into her bath to have a wash but since her fall felt could no longer manage to bathe.
Tea call tailored and only morning call continued as OT completed assessment and provided bath lift and staff to continue practicing with bath lift.
Review completed as Mrs H independently using bath lift and feels confident and is completing all her daily living activities. Agreed to end services as care plan objectives achieved.

Mrs H now returned back to her routine, she has supportive granddaughter who visits twice a week, has a hair dresser once a week and a cleaner every other week.
Advised of private agencies if felt the need for a pop in call but Mrs H feels that she currently does not require it. Informed of Age Connects services and Library Home Services.

Provided First Contact number for when Mrs H feels ready to return to her routine on a Tuesday, when we can assess for going shopping into Buckley precinct to rebuild confidence with outdoor mobility.

Mrs H stated that “I have been very happy with the service and all are very nice, it has been excellent”.
Granddaughter stated “Flintshire Social Services have been very good I must say”.

Comments from other services users following reablement services

"Thank you so much for all your help and support you have been fantastic and have made a difference to my life"

"We would like to express our gratitude for the whole "package" which has been provided. Public services today come in for plenty of "blanket" criticism, but we would like you to know that we have been amazed at the support we have all received"

FLINTSHIRE COUNTY COUNCIL

REPORT TO:	**SOCIAL & HEALTH CARE OVERVIEW & SCRUTINY COMMITTEE**
DATE:	**THURSDAY, 29 JANUARY 2015**
REPORT BY:	**CHIEF OFFICER (SOCIAL SERVICES)**
SUBJECT:	**KEY PARTNERSHIP PROJECTS WITH HEALTH AND THE THIRD SECTOR**

1.00 PURPOSE OF REPORT

1.01 To update Members on the progress made with key partnerships and locality developments.

2.00 BACKGROUND

2.1 The legislative, financial and ethical imperative for organisations to increase and improve the way that they work together to improve health and social care outcomes for citizens is well understood. For individuals and their families the impact of effective partnership working is evident through the fact that the support and services they receive are “seamless” and meet their needs in an efficient and responsive way.

2.2 This report provides Members with a number of updates relating to the way that Flintshire County Council and its partners within Health and the Third Sector are working together and outlines a number of key developments for 2015.

2.3 This update is in addition to the report to Committee relating to the utilisation of the Intermediate Care Fund during 2014/15.

3.00 CONSIDERATIONS

3.1 **Merging of Locality Leadership Teams and GP Cluster Meetings**

In 2014, a new 3 year development programme was introduced to encourage GP’s working in a “Cluster” or Locality to collaborate with each other and wider partners to identify improved ways of working to meet the needs of the local population. Cluster Plans have subsequently been developed and meetings of GPs and other key partners to take forward those plans have been taking place in line with contractual obligations.

In addition, each of the three localities in Flintshire have a multi-agency Locality Leadership Team with a clear role to consider how

local partners working within that geographical area can work together to meet the health and social care needs of the population.

There is a currently a vacancy for a Locality Lead within North East Flintshire. This appointment is scheduled to be made following recruitment by the Health Board to the Area Director role for the East. There is also a growing consensus that the separation thus far across North Wales between the work of the GP Cluster and Locality Leadership Teams (LLT) is not realising maximum benefits for joint working as well as being unsustainable.

For these reasons, (the multi-agency) Strategic Locality Group for Flintshire has agreed to trial a new approach in the locality where the work of both the existing GP Cluster and previous LLT is brought together. The first meeting to agree a way forward into 2015/16 is scheduled for January 2015.

As is the case across much of North Wales, the Locality Leads within North West and South Flintshire are considering adopting a similar approach and will be informed by the learning from the North East locality.

3.2 **Enhanced Care**

The Health Board has confirmed its ongoing commitment to enhance the care provided at home to patients who would otherwise need to be in hospital. It is however acknowledged that the service provided needs to reflect local needs, and make the best use all of the resources available within a community.

The anticipated appointment of the new Area Directors responsible for primary and community services will support an acceleration in determining how to improve the “community resource” within each of the 3 localities in Flintshire. Senior Managers within the local authority have been invited to take part in the consideration of options and progress will be monitored through the Strategic Partnership Group.

North West Flintshire Enhanced Care continues to be well received by patients and progress is being made to increase the reach into the Holywell area.

The Health Board has confirmed its’ ongoing commitment to enhance the care provided at home to patients who would otherwise need to be in hospital. However the Board have taken time to consider revised business models for the remaining areas in Flintshire and North Wales and the impact to date. This is in order to ensure that future models of delivery best meets the need of all localities in North Wales and compliments existing community based resources.

The anticipated appointment of the new Area Directors responsible for

primary and community services will support an acceleration in determining how to improve the “community resource” within each of the 3 localities in Flintshire. Senior Managers within the local authority have been invited to take part in the consideration of options and progress will be monitored through the Strategic Partnership Group.

3.3 **Single Point of Access (SPoA)**

After appraisal of a number of options, the preferred location for the SPOA has been identified as Preswylfa, Mold. Work is currently progressing to finalise designs for internal works to be completed within the building and to secure the required resources to complete the work with the intent of going live in April 2015.

The SPOA Partnership Board has agreed that an incremental approach will be taken to the introduction of the SPOA to build on existing arrangements in order to ensure that there is a smooth transition and to manage expectations. The initial SPOA team will consist of the First Contact Team, an Improving Access Officer from the Third Sector and Flintshire’s Falls Coordinator (BUCHB) with support from the Crisis Intervention Team and administrative support.

A decision is still to be finalised regarding the impact of the reduction in funding by the Welsh Government to the Regional Collaboration Fund as the primary source of funding for the introduction of SPOA’s in North Wales. However, it is highly likely that sufficient funding will be maintained in 2015/16 to allow the project to continue successfully.

3.4 **Co-location of Health and Social Care Locality Teams.**

The co-location of Health and Social Care Locality Teams within North West Flintshire (based at Holywell Hospital) continues to support closer partnership working.

Local Authority concerns relating to the delay in finalising suitable accommodation for joint teams in the South and North East of the county have been escalated to the Health Board through the Strategic Locality Group.

Social Care teams have previously been re-configured to work within the localities to achieve benefits in anticipation of such moves.

3.5 **Care Homes**

The risks posed by the lack of capacity for nursing input into Care Homes in North Wales has been identified and raised with the Health Board.
Recruitment of nursing staff as well as other health professionals is an area of significant activity for the Health Board and it is recognised that securing appropriately trained, qualified and experienced staff to

provide nursing input into care homes poses a specific challenge within a market where there are many career options for those with the appropriate qualifications.

Senior managers within Health and Social Care have agreed to consider a range of approaches that are needed in partnership to both stimulate the market, thereby attracting more providers of high quality care into North Wales and appropriately trained and experienced nursing staff.

Issues relating to the availability of and retention of skilled and experienced nurses within the Care Home market are reflected across the region. A regional meeting will be called in early 2015 with CSSIW and BCUHB to explore how we can take a regional, co-ordinated response, to managing and strengthening this area of concern.

This objective will be included as a priority within the review of Priority 3 within the Single Integrated Plan for the Local Service Board.

3.6 **Social Prescribing**

Work is taking place to trial a new model in South Flintshire whereby patients aged 65+ are identified from a GP list where they are “at risk” of hospital admission or readmission based on factors such as having a number of co-morbidities or exhibiting increasing frailty for example.

Those patients will be contacted by their GP and asked if they would like to be referred through the SPOA voluntary sector worker for an assessment by a Third Sector organisation who can work with them to identify ways that they can improve their own wellbeing and/or access support that would be beneficial to them before a crisis arises.

This approach of proactively identifying patients who are at risk but not yet approaching services for support is new for Flintshire and responds to the evidence that the “prescribing” of community based support and/or “self-help” can be an important factor in improving wellbeing and reducing or delaying admission to hospital.

3.7 **Working with the Third Sector**

In order to strengthen partnership working with the Third Sector, discussions are due to take place between senior managers within Social Services and the Health Board to improve the way that commissioning intent and process for example are aligned and to improve transparency. Social Services maintain an excellent relationship with the Third Sector partners and this work will build on this to achieve greater consistency between Health and Social Services commissioning.

3.8 **Single Integrated Plan (SIP) Priority 3 Review**

The Health, Well Being and Independence Board which is accountable to the Local Service Board is conducting a review of Priority 3 objectives to ensure that current and future priorities for partners are appropriately reflected.

3.9 **Early Years and Family Support**

Following the retirement at the end of November 2014 of the Children and Young People's Partnership Coordinator (Early Years), Gail Bennett, the new Early Years and Family Support Manager is now in post.

The Families First programme, supporting families of children until the age of 19 continues to benefit from and demonstrate the importance of effective partnership working at both a strategic and operational level. The Child and Adolescent Mental Health Service work closely with the local authority team members to provide support for example by offering family members of children and young people with ADHD or Autism appropriate training as well as one to one case management.

Work continues to take place to achieve the aspiration that the benefits of the Flying Start Programme can be extended beyond the geographical boundaries covered by the Welsh Government funded programme. One example is the extended role of Health Assistants who have been trained in aspects of the “Incredible Years” parenting programme so that they can work in partnership with CAMHS and Schools to meet the needs of parents through joint delivery of programmes and sharing of information. Through the additional support that can be offered to parents by these staff, positive improvements have been seen and reported by parents.

Work with the Elfed Consortia has resulted in 16 staff members completing City and Guilds qualifications in 2014 enabling them to work more effectively with parents. Those staff members have now begun to work on individual plans for their schools, and some early impacts can be seen for example within the Elfed School that has created a dedicated parents centre within the school.

Ysgol Merllyn in Bagillt has worked with its local community and parents to develop a new approach to parent engagement. In addition to allocating space within the school for parents to come and talk in an informal way to the school staff, the school also offers opportunities for parents to come into the school to witness and learn from teaching techniques used in classrooms and for parents to take part in innovative ways as volunteers within the school.

In early January 2015, it has been confirmed that the Welsh

Government has awarded £143k to modernise the former Youth Club on the site of Sandycroft Primary School. This improved asset will be available for use by the school, Flying Start, the Youth Service and wider community.

It is anticipated that schools who employ a Family Liaison Officer/ Parent Support Advisor will be monitored on the Education database, to identify the impacts on attainment, behaviour and attendance as there have been positive benefits reported due to the links between family work and schooling.

4.00 RECOMMENDATIONS

4.1 That the Committee note and comment on the content of this update.

5.00 FINANCIAL IMPLICATIONS

5.01 None.

6.00 ANTI POVERTY IMPACT

6.01 None.

7.00 ENVIRONMENTAL IMPACT

7.01 None.

8.00 EQUALITIES IMPACT

8.01 None.

9.00 PERSONNEL IMPLICATIONS

9.01 None**.**

10.00 CONSULTATION REQUIRED

10.01 None.

11.00 CONSULTATION UNDERTAKEN

11.01 None.

12.00 APPENDICES

12.01 None.

LOCAL GOVERNMENT (ACCESS TO INFORMATION ACT) 1985
BACKGROUND DOCUMENTS

None.

Contact Officer: Susie Lunt
Telephone: 01352 701360
Email: Susie.lunt'flintshire.gov.uk

This page is intentionally left blank

FLINTSHIRE COUNTY COUNCIL

REPORT TO: **SOCIAL & HEALTH CARE OVERVIEW & SCRUTINY COMMITTEE**

DATE: **THURSDAY 29 JANUARY 2015**

REPORT BY: **SOCIAL CARE OVERVIEW & SCRUTINY FACILITATOR**

SUBJECT: **FORWARD WORK PROGRAMME**

1.00 PURPOSE OF REPORT

1.01 To consider the Forward Work Programme of the Social & Health Care Overview & Scrutiny Committee.

2.00 BACKGROUND

2.01 Items feed into a Committee's Forward Work Programme from a number of sources. Members can suggest topics for review by Overview & Scrutiny Committees, members of the public can suggest topics, items can be referred by the Cabinet for consultation purposes, or by County Council, or Chief Officers. Other possible items are identified from the Cabinet Work Programme and the Strategic Assessment of Risks & Challenges.

2.02 In identifying topics for future consideration, it is useful or a 'test of significance' to be applied. This can be achieved by asking a range of questions as follows:

1. Will the review contribute to the Council's priorities and/or objectives?
2. Are there issues of weak or poor performance?
3. How, where and why were the issues identified?
4. Do local communities think the issues are important and is there any evidence of this? Is there evidence of public dissatisfaction?
5. Is there new Government guidance or legislation?
6. Have inspections been carried out?
7. Is this area already the subject of an ongoing review?

3.00 CONSIDERATIONS

3.01 Overview & Scrutiny presents a unique opportunity for Members to determine the Forward Work Programme of the Committees of which they are members. By reviewing and prioritising the forward work programme Members are able to ensure it is member-led and includes the right issues. A copy of the Forward Work Programme is attached at Appendix 1 for Members' consideration which has been updated following the last meeting.

4.00 RECOMMENDATIONS

4.01 That the Committee considers the draft Forward Work Programme attached as Appendix 1 and approve/amend as necessary.

5.00 FINANCIAL IMPLICATIONS

5.01 None as a result of this report.

6.00 ANTI POVERTY IMPACT

6.01 None as a result of this report.

7.00 ENVIRONMENTAL IMPACT

7.01 None as a result of this report.

8.00 EQUALITIES IMPACT

None as a result of this report.

9.00 PERSONNEL IMPLICATIONS

9.01 None as a result of this report

10.00 CONSULTATION REQUIRED

N/A

11.00 CONSULTATION UNDERTAKEN

11.00 Publication of this report constitutes consultation.

12.00 APPENDICES

12.00 Appendix 1 – Forward Work Programme

LOCAL GOVERNMENT (ACCESS TO INFORMATION ACT) 1985 BACKGROUND DOCUMENTS

None.

Contact Officer: **Margaret Parry-Jones**
Telephone: **01352 702427**
Email: **margaret.parry-jones@Flintshire.gov.uk**

Social & Health Care Overview & Scrutiny Forward Work Programme APPENDIX 1

DRAFT

Date	Item	Purpose of Report/Session	Scrutiny Focus	Responsible/ Contact Officer	Submission Deadline
Thursday 5 March 2015 10.00 a.m.	Collaborative projects/Regional Initiatives update	To receive a progress report on projects and services running collaboratively across North Wales and Nationally.	Partnership Working/ Performance Monitoring	Chief Officer Social Services	
Thursday 16 April 2015 10.00 a.m.	Q3 Performance Reporting	To enable members to fulfil their scrutiny role in relation to performance monitoring.	Performance Monitoring	Chief Officer Social Services	
	Annual Council Reporting Framework	To consider the final draft of the Flintshire County Council Social Services Annual Performance Report 2014/15.	Service Delivery	Chief Officer Social Services	
Thursday 14 May 2015 2.00 pm	Complaints & Compliments - lessons learned	To receive a report on the compliments, representations and complaints received by Social Services for the year April 2014 – March 2015.	Performance Monitoring	Chief Officer Social Services	
	Single Point of Access update report	To receive an update on the implementation of SPOA in Flintshire	Information report	Chief Officer Social Services	
	CSSIW Safeguarding and Care Planning Looked After Children progress report	To receive a progress report	Progress Report	Chief Officer Social Services	

Date	Item	Purpose of Report/Session	Scrutiny Focus	Responsible/ Contact Officer	Submission Deadline
Thursday 18 June 2015 10.00 a.m.	Year End and Quarter 4 Performance Reporting	To enable members to fulfil their scrutiny role in relation to performance monitoring.	Performance Monitoring	Chief Officer Social Services	

Regular Items

Month	Item	Purpose of Report	Responsible / Contact Officer
January	**Safeguarding & Child Protection**	To provide Members with statistical information in relation to Child Protection and Safeguarding	Director of Community Services
March	**Educational Attainment of Looked After Children**	Education officers offered to share the annual educational attainment report which goes to Lifelong Learning OSC with this Committee	Director of Lifelong Learning
March	**Corporate Parenting**	Report to Social & Health and Lifelong Learning Overview & Scrutiny	Chief Officer Social Services
Half-yearly	**Betsi Cadwaladr University Health Board Update**	To maintain 6 monthly meetings – partnership working	Facilitator
May	**Comments, Compliments and Complaints**	To consider the Annual Report.	Chief Officer Social Services
Sept	**Protecting Vulnerable Adults & Inspection Action Plan Update**	To inform Members of the annual adult protection monitoring report submitted to the Welsh Government and to monitor progress of CSSIW Inspection Action Plan	Chief Officer Social Services

Joint Meeting with Lifelong Learning Spring 2015

Corporate Parenting
Safeguarding and Child Protection
Educational Attainment of Looked After Children
Hearing Impairment (Adults & Children)
Childcare Sufficiency Assessment
Youth Justice Services

Joint meeting with Housing

Extra Care/Telecare/Telehealth

Items to be scheduled

Demands on Children's Services
Fostering Services
ACRF Scrutiny Challenge
Day Services proposals
Older People's Strategy Group rep to be invited – Ageing Well in Wales
Full Review of Adoption Service 12 months after implementation.
BCUHB & Ambulance Trust

This page is intentionally left blank