REPORT FOR INFORMATION - 15/03/16

COUNCIL SEMINAR
15th March, 2016

Present:- Councillor Roche (in the Chair); Councillors Atkin, Beaumont, Buckley, Burton, Cowles, Elliot, Ellis, Godfrey, Hughes, Khan, Mallinder, McNeely, Reeder, Russell, Sansome, Sims, Julie Turner, Wyatt and Yasseen.

Apologies for absence were received from The Mayor (Councillor M. Clark), Councillors Ahmed, Currie, Hamilton, Hoddinott, Jepson, Pitchley, Watson and Whelbourn.

INTEGRATION OF HEALTH AND SOCIAL CARE IN ROTHERHAM

Councillor Roche, Cabinet Member for Adult Social Care and Health, welcomed those in attendance. He spoke about the poor health picture in Rotherham with many residents not in good health and the significant differences between the most deprived communities in the town. People in Rotherham lived longer with ill health.

Within that context there were Government funding cuts requiring the Local Authority to look carefully at the services it provided; the Clinical Commissioning Group (CCG) would also be facing similar cuts in 2016/17.

Strong relationships had been built with Health partners through Officers, the Health and Wellbeing Board and the Health Select Commission with both the CCG and Rotherham Foundation Trust (RFT) independently stating that relationships were the best they had been for 15 years.

There was now a strong desire to move forward with integration. It was the Government's aim to increase personalisation to give people more choice and have an integrated Health and Social Care Service.

The Chair introduced the officers in attendance: -

Jon Tomlinson, Assistant Director Commissioning (Adults)
Sarah Farragher, Interim Change Manager;
Prof Graeme Betts, Interim Director, Adult Care and Housing

Jon and Sarah gave the following presentation on the priority areas from the Adult Social Care perspectives for integration of health and social care in Rotherham:-

Desired Outcomes

- Shared vision for what the services look like
- Pooled resources
- Integrated/co-located services
- Utilising shared technology
- Reducing dependence, promoting self-serve and increasing resilience

Priority Work Areas

- Pilot integrated locality team
- Improved intermediate care
- Single point of access
- Ongoing review of the Better Care Fund

The Integrated Locality Team

- One lead co-ordinator jointly funded (overseen by a joint steering group)
- Team to include community nurses, therapists and mental health, assessment and care management and social prescribing
- Staff work exclusively with the locality population
- Serves practice populations and designated care homes
- Co-location one locality access point of access
- Integrated service specification
- Integrated care planning

Intermediate Care – the ambition(s)

- Development of an intermediate care centre of excellence
- Cater to a wider customer base to maximise independence
- Reduce residential care placements and hospital admissions
- Combine intermediate care with Extra Care, Assistive Technology, health services

Intermediate Care – the model

- Consolidate and share resources (building and staffing) to reduce duplication and provide excellent services
- Build on the strengths whilst improving the accessibility and reach of the serves to maximise impact
- Reduced complexity of systems and processes
- Improved availability of social work and therapy resources through more flexible seven day working

Single Point of Access Proposed Principles

- Single point of access for health and social care for Rotherham (customer or patient tells us once)
- Covers RMBC, TRFT, RDASH
- Triage/assess based on customer outcome not service provision
- Operates on a 24 hour a day 7 day a week basis
- Does not replace professional to professional contacts

What Adult Social Care can contribute

- Social Care inter-disciplinary and multi-disciplinary input with particular emphasis on
  Information and self-serve
  Safeguarding/Making Safeguarding Personal
  Mental Capacity
  Carers services
  Input into Continuing Health Care

Best Interest Assessments
DOLs
Assessment and support planning

Adult Social Care Outcomes (must be Care Act compliant)

- Reduction in citizens being bounced around the system
- Maximum choice and control or citizens to remain as independent as possible
- Keeping people safe when needed and doing this in a personalised framework
- Good support for carers
- Timely assessments, reviews
- Promoting wellbeing

Discussion ensued on the presentation with the following issues raised:-

The Chair was in favour of the locality model described within the Council but was aware that Area Assemblies had their own localities as did Children and Young Peoples Services.

Sarah Farragher stated that as part of the restructure consideration was being given to two locality models. The RFT had seven localities, RDaSH two and the Therapists had three. The Council would be looking at working around one of the seven that the Trust had identified but wanted to ensure alignment. This would be established during the pilot period.

Prof Betts reported that in reality there would always be different boundaries but it had been made clear that the Authority's resources would be used to support that approach and there would be more named workers.

Councillor McNeely agreed that the services should be available 24/7 as a common reason for an elderly person to go into care was due to their concern regarding the support available in the evening/during the night.

Prof Betts reported that very few elderly people were actually in residential care. It was important to think about the options available as to how people were supported to stay in their own home rather than the straight choice of going into residential care.

Sarah Farragher acknowledged that some parts of the service were currently not available 24/7. In order to achieve a fully integrated service, the availability would increase in stages in recognition of the need for support.

Councillor McNeely asked if the complex would definitely be situated on Doncaster Gate as this would be problem to the elderly due to its position on a hill. How would it impact on the facilities already on the site?

Sarah Farragher reported that three different integration projects had

been presented. The perfect locality was based around the locality of the District Nurses which was Doncaster Gate.

Councillor Burton asked if the multi-disciplinary team would be a single point of access for people and whether the team would include the voluntary and the informal sector?

Prof Betts agreed that it was absolutely right that the voluntary and informal sector, carers etc. were reflected in the locality approach otherwise it would have a narrow focus of people being discharged from hospital and would miss out on people before they reached that point. All were working together with the aim of locality way of working.

Councillor Burton stated that multi-disciplinary teams and co-location had been considered before but had encountered problems with pooled budgets/resources, differing priorities of agencies and management. Had account been taken of past experiences in the new proposal?

Prof Betts agreed that budgets, shared priorities/outcomes and targets were issues for large scale integration and would have to be addressed.

Councillor Mallinder asked if Assessment Direct and CARATS would be built into the future plans?

Councillor Mallinder queried who would be the lead agency for the localities?

Sarah Farragher reported that a three way split on funding had been agreed for a designated Manager. It was planned that the Manager would report to a steering group made up of all the partners.

Councillor Reeder queried whether facilities such as Addison Road would be affected by the proposal?

Prof Betts replied that there was no mention of the Addison Road facility in the proposal. Nobody was talking about shutting it at the current time but users and carers in the wider community would be consulted on the services they needed in the future. Work would take place on building on the good things that were in place and how they could be taken forward at the same time as being mindful of a range of issues including duty under the Care Act.

Councillor Ellis asked for assurance that the evaluation of the pilot had a proper timeline and was conducted by someone independent of the project

Councillor Ellis queried what happened if one of the key funders, in view of future funding cuts, decided that the project was not one of their priorities?

Councillor Elliot sought clarity whether the co-location for the pilot at Doncaster Gate would include workers from areas such as Learning Disability, Physical Disability, head injuries or would it just focus on elderly people and people with mental health problems?

Sarah Farragher reported that, in terms of the population served by the pilot locality, from the Local Authority's perspective it would expect that anyone who had social care or health needs in that area would be picked up by that "perfect" locality. If any additional support was required it would be provided. The majority of the resources going in were around the older people as it came from a model that RFT had put on the table.

Councillor Elliot referred to those who were social funded and health funded and queried if it would affect access to fairer charging? Would people be charged whether they had health funding or social funding?

Sarah Farragher stated that it was the desired outcome of CHC funding that recipients would not know they were moving between the two charging schemes.

Councillor Elliot queried if there had been a risk assessment and an equality impact assessment conducted of the call centre system?

Assessment Direct was a call centre model with very experienced staff. Work was already taking place to move towards social care with triage and assessment behind the call centre. It was hoped that there would be a multi-disciplinary team to look at the needs of the person and ability to support quite quickly.

Councillor Elliot asked, in the case of someone who had a Social Care Assessment, who was not receiving a service but had a known disability, would they still be reviewed or would only those who received a service be reviewed?

Sarah Farragher replied that the Social Care Assessment would state whether a person was eligible for a Social Care Service but might still have involvement of a District Nurse or therapist. Just because a person had social care needs did not preclude them from the social care model.

Councillor Reeder asked what benefits/difference there would be from the Service?

Sarah Farragher reported that currently the Department had to refer clients who were passed around the system until they received what they required. If all agencies worked together the client would be screened and assessed as to who the best person was to support them. It would hopefully improve the efficiency of services.

Councillor Burton asked who would supervise the multi-disciplinary teams?

Prof Betts stated that the importance of supervision had been re-emphasised and discussions had taken place with RDaSH on this issue. It was absolutely critical that it was built into the proposal.

If the co-ordinator was not from a social care background then professional supervision from one of the Social Care Teams would be offered. Every profession would have a clinical lead into their professions.

Councillor Mallinder queried if there would be any affect in the way a person received care because of their health needs?

Sarah Farragher replied that it would depend upon where the funding came from. If the person had a package of support which was assessed and provided on behalf of Adult Social Care, it was chargeable and was quite often a mixed package. There was a need to improve the relationship with the CHC teams to ensure the right package and charge was provided.

The Chair thanked Members for their attendance.