SOCIAL SERVICES, HEALTH AND HOUSING SCRUTINY COMMITTEE

10TH SEPTEMBER 2015

REPORT OF HEAD OF COMMUNITY CARE AND COMMISSIONING – C. MARCHANT

COMMUNITY RESOURCE TEAM AND COMMUNITY NETWORKS REPORT CARD 2015/16

SECTION C – MATTER FOR MONITORING

WARDS AFFECTED: ALL

Purpose of Report

To provide Members of the Scrutiny Committee with information to assist them to scrutinise the performance of the Community Resource Team and Community Networks, which sit within the portfolio of Head of Community Care & Commissioning.

Background

The Council introduced a revised Performance Management Framework in 2014/15. One of the requirements within that framework is the production of service report cards by service managers which will enable Members to scrutinise the performance of all services within its remit.

This report will also enable the Social Services, Health & Housing Cabinet Board and Scrutiny Members to discharge their functions in relation to performance management of the Community Resource Team and Community Networks.

Report Cards

Community Resource and Community Networks have developed service report cards to demonstrate which is being achieved for the resources invested in these

service areas from the perspective of customers, staff, internal processes and finance, and impact on service users.

It is a means for the services to translate their vision and strategies into action which is particularly important at a time when resources are diminishing. This will ensure a culture of continuous improvement aligned to individual standards and performance measures.

The following report cards provide Members with further details of the services provided by the teams, reviewing performance during 2014-15 and the focus of work going forward for 2015-16.

Appendices

None

List of Background Papers

None

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COMMUNITY RESOURCE TEAM AND COMMUNITY NETWORKS

REPORT CARD – August 2015

Brief Description of the Service

Community Resource Team (CRT)

The Neath Port Talbot Community Resource Team is a joint service provided by the Abertawe Bro Morgannwg University Health Board and the Neath Port Talbot Local Authority.

The team provides help to adults (over the age of 18 years) living in Neath Port Talbot who require support to stay independent within their own homes. They offer a service that ensures patients receive the right intervention, at the right time, from the right professional. It simplifies the process by coordinating both health and social care needs.

Five community based teams bring together professionals from health and social care and the third sector to provide care for patients with complex needs at home. They are:

- Acute Clinical Team
- Sensory Support Team
- Community Occupational Therapy Team
- Reablement Team
- Assistive Technology Team

Community Networks

The Community networks teams were recently formed after the re-configuration of the NPT social work model. They consist of multi-disciplinary teams, comprising of District nurses and social workers who share common caseload and deliver anticipatory long term care programmes of support to people receiving primary care services.

Key Priorities for 2014/15

- Further development of Intermediate tier in line with Western Bay Business case
- Integration of long term health and social care teams within Community networks – initially within the Neath network.
- Reduce long term residential placements
- Increase the number of Carer's assessments undertaken
- Reduce the number of unscheduled admittance to hospital.

Key Priorities for 2015/16

- Development of Gateway service as a vehicle to deliver Information Advice and Assistance in line with the Social Services and Wellbeing Act 2014.
- To integrate District Nurse triage into the Gateway
- To review external Domiciliary Care and double staffed calls
- To roll-out of Intake Reablement Model across Neath Port Talbot
- Pilot Local Area Coordination within Neath Network to assess feasibility for potential roll out across Neath Port Talbot.
- To integrate District Nurses and Social Work Teams within the Port Talbot Resource Centre
- Pilot alignment of social workers with GP practice – as per current District Nurse model as part of the Early Adopter Network
- To realign Gwalia residential Short Breaks, intermediate and long term care.
- To review Homecare provision
- Develop and implement new residential care pathway that includes a Fair Access to Care Panel and Step Up/Down assessment beds.

	• To ensure continued Organisational Development • Increase the use of Direct payments to further enhance choice and control for those who have eligible care and support needs.

How Are We Doing

Progress 2014

- The CRT has been significantly expanded during 2014/15 as per the Western Bay Community Services Programme. Financial resources for 2014/15 to support this were the Intermediate Care Fund (ICF) with circa £1.5 million revenue and £750K Capital to support costs across the NPT CBC and ABMU NPT Locality.

- In 2014, the Rapid Response team worked with 919 individuals, facilitating 53 early discharges from hospital and preventing 866 people from being admitted to hospital. 72% of all interventions resulted in the situation being completely resolved or improving significantly.

- Activity within the Community Resource Team has avoided 755 hospital admissions.

- In July 2014, we have opened a Residential Reablement Unit in partnership with Grwp Gwalia, at Llys Y Seren Residential home. There are currently 9 residential reablement beds available to individuals from both the community and hospital setting who require rehabilitation and reablement to enable them to return home. 78 people were supported between July 2014 -2015 to regain their independence; 60% of people who entered the unit on a pathway to long term residential care, returned home. With only 2 individuals being admitted into a Residential Care home.

- Between 2014/15 the number of people entering into long term residential care reduced by 21.78%

- In 2014/15 the number of new homecare starts reduced to 447, compared to the previous year (n=474)

- The number of carers assessments that have been completed have significantly risen to 40.5 %

- The number of carers receiving a service following an assessment has increased to 71.4%

- Delayed transfer of care for social care reasons have reduced to 3.21%

- Unscheduled admissions to hospital for >65 per 1000 population have decreased indicating the that the CRT and reconfiguration of the adult Social Care is having the desired impact in NPT.

Progress 2015

- **Development of Gateway service as a vehicle to deliver Information Advice and Assistance in line with the Social Services and Wellbeing Act 2014**
  - Section 2 (17) Social Care and Well Being (Wales) Act requires that each Local Authority will provide '*information, advice and assistance'* to its population about the range of services it provides, how to access them and how to raise concerns. It is proposed that the Gateway is ideally placed to allow this responsibility to be fulfilled.

  - Digital by Design is a NPT CBC corporate programme that is aiming to improve remote access to information and services provided and we will be working alongside staff from this programme to integrate this work into achieving the SC&WB Act requirements.

  - Section 2 (18) Social Care and Well Being (Wales) Act, requires the Local Authority to establish and maintain a register of sight impaired, hearing impaired and other disabled people. We propose that this can be safely and appropriately undertaken by the Gateway.

  - ABMU Health Board are piloting the NHS 111 service in Wales and access to a common point of access into Community Health and Social Care Services could be achieved via the Gateway. Work is currently underway to enable this to happen.

- **To integrate District Nurse triage into the Gateway**
  - A scoping exercise has been undertaken, in order to understand the total demand for referrals into the district Nursing Service and to identify and estimate the workforce required. At present, there has been no engagement with Primary Care partners as a change to a common point of access will alter current arrangements GP practices have with District Nurses across NPT.

- **To review external Domiciliary Care and double staffed calls**
  - Review currently being undertaken

- **To roll-out of Intake Reablement Model across Neath Port Talbot**
  - Staff capacity within the current service has been increased and a rolling recruitment programme implemented, in order to ensure demand for the service can be met once it becomes regional. An implementation plan has been developed and is on course for full roll-out in October 2015.

- **Pilot Local Area Coordination within Neath Network to assess feasibility for potential roll out across Neath Port Talbot**

- Local Area Coordination Business Case has been developed outlining two geographical areas for delivery (Skewen (Neath) and Sandfields (Port Talbot). Recruitment for two Local Area Coordinators is currently underway, along with community/professional engagement sessions and information workshops.

- **To integrate District Nurses and Social Work Teams within the Port Talbot Resource Centre**
  - A scoping exercise has been undertaken, in order identify physical location of rooms and IT equipment. A consultation document has been circulated to all District Nurses affected by the proposal. It is envisaged that the integration be completed by the end of October.

- **Pilot alignment of social workers with GP practice – as per current District Nurse model as part of the Early Adopter Network**
  - Pilot is currently underway. A multi disciplinary team comprising of GPs, Social Workers, District Nurses, Therapy Staff and CPNs has been established in line with the Early Adopter Network. An initial cohort of individuals identified, reviewed and a care coordinator assigned.
  - The Early Adopter Network is part of the Western Bay Community Services Programme that focuses on proactive care for the most vulnerable patients in the community – ensuring that there is a care plan in place and good care coordination arrangements with a named care coordinator for each person identified.
  - **Neath Port Talbot Afan Network** has identified a cohort of 23 patients registered with a Port Talbot GP practice. Weekly multi-disciplinary team meetings, consisting of GPs, District Nurses, Social Workers, Community Psychiatric Nurses and ACT nurses, have cross matched individual patients, prioritized their care needs and identified a single professional as care coordinator. Work is currently being undertaken to develop anticipatory action plans for each individual.
- **To realign Gwalia residential Short Breaks, intermediate and long term care**
  - A public consultation outlining the proposed realignment has been undertaken, with a follow up report due to be presented to the Social Care, health and Housing Cabinet Board for decision on the 10th September.
- **To review Homecare provision**
  - Review currently being undertaken

- **Develop and implement new residential care pathway that includes a Fair Access to Care Panel and Step Up/Down assessment beds.**
  - To be completed by December 2015

- **To ensure continued Organisational Development**
  - Development of Performance Management Framework for all elements of long term social care, focusing of outcomes, quality assurance, proportionality and efficiency. Effective management of resources across geographical networks, service user feedback and participation are essential.

  - Establishment of Consultant social work posts through the management of change process has enabled Carers champions to be further embed across teams, increasing the focus on carers and their participation in service development.

  - Up-skilling of existing staff under BIA, Non criminal Investigation and Designated Line Manager for POVA to increase flexibility across the workforce and provide resilience in these areas.

Story Behind the Performance:

The expansion of the Community Resource Team in Neath Port Talbot has enabled the team to provide care for patients with more complex medical and social needs. These are patients who require short term higher level interventions that cannot be supported by core community services within their own home but do not require a hospital setting. Through the delivery of reablement, multi disciplinary short term interventions and rapid response, individuals are being supported within their own homes and enabled to maintain their independence for longer. As such, unscheduled admissions to hospital and long term residential care placements have begun to reduce and will continue to do so, as the integration of care pathways continue to develop in order to provide a seamless pathway or care.

After a significant management of change process in April 2014, social work teams within the networks are entering in a significant and exciting programme of cultural development. Complementing the work undertaken by CRT, the Community Networks are progressing the use of geographical based working using an anticipatory care model. The co-alignment of District Nursing services and in the near future, Mental Health service will further enhance working practice, reducing duplication between professionals and the need for crisis interventions that lead to admission to acute hospital and long term care placements.

In addition, work to further enhance front line early intervention, wellbeing and prevention initiatives is also underway. Recruitment to the Local Area Coordination roles will support the role of the Community Networks, address social isolation and build community/social capital in line with the new Social Services and Well- being ACT. Community well being officers will also begin to work in communities, facilitating engagement with Primary Care and links into local and third sector groups, in order to negate the need for statutory services. Moreover, a comprehensive programme of cultural change is underway to further support changes in practice to support the new ways of working in line with the ‘ ACT’. This also includes the promote the use of direct payments to promote more choice and control for individuals who require support

Next Key Actions For 2015/16		
Alongside higher overarching Key Actions	**Who**	**By When**
• Reconfiguration of the short breaks model in Neath Port Talbot and introduction of step Up/Down beds	LB/AG	September 2015
• Increase use of Direct payments to increase more choice and control for service users who receive services	LB/AG	July 2015
• To roll out an Intake model in Neath Port Talbot so that all individuals have an opportunity to maximise independence either through reablement programmes or CRT services	AG	October 2015
• Review external Domiciliary Care and double staffed calls.	AG	November 2015