MINUTES OF THE MEETING OF THE DELIVERING INDPENDENCE FOR OLDER PEOPLE IN MILTON KEYNES REVIEW GROUP HELD ON THURSDAY 11 APRIL AT 7.00 PM

Members Present:	Councillors Brunning, M Burke and Zealley
Officers Present:	Anne Loftman (Head of Intermediate Care Services), Lyn Scott (Assistant Director [Adult Social Care]), Elizabeth Richardson (Overview & Scrutiny Officer)
Visitors:	Lyn Davis (Re-ablement Manager, AgeUK MK)
Apologies:	Jan Lloyd (Older Person's Champion)

Election of Chair

Councillor Zealley proposed that Councillor Brunning take the Chair. Councillor Burke seconded the proposal.

Councillor Brunning agreed to take the Chair.

Terms of Reference

The following Terms of Reference as set out in the Review Group's Scoping Document were agreed:

- To consider the ways in which the policies and actions of the Council and other agencies take account of and impact upon the particular needs of older people wishing to maintain their independence.
- To consider the effectiveness and robustness of the existing provision and if there are areas for improvement.
- To make recommendations on ways of assisting older people to maintain their independence and the actions required to accomplish this.

Presentation – Intermediate Care Services

The Review Group received a presentation from Anne Loftman, the joint Head of Intermediate Care Services for Milton Keynes Council and the Milton Keynes Community Health Service and noted that:

- Hospital was not a good place for older people to recover from illness / medical treatment nor was residential care;
- The provision of Intermediate Care Services (ICS) was supported by the Department of Health, although there was no prescriptive model of how ICS were delivered and methods varied between local authorities. However, there was a gradual move towards aligning these services across authorities;
- The Department of Health had produced a guidance document entitled *Intermediate Care – Halfway Home.* The main points of this guidance were:
    - ✷ There is greater emphasis on preventing admission to residential or nursing care;
    - ✷ Intermediate Care Services should now include adults of all ages, such as young disabled people managing their transition to adulthood;

- ✷ There should be better services for people with dementia or mental health needs and greater flexibility on length of stay for these service users;

(ER to download and circulate copy of guidance to Review Group Members)

- The DH guidance called for a greater integration between health and social care which was already being achieved in MK.
- The guidance also recommended a Single Point of Access (SPA) to filter out inappropriate referrals and signpost people to appropriate parts of the service;
- In MK there was a SPA (both telephone and e-mail) for referral of patients by professional health / social care staff such as GPs, hospital staff, district nurses, social workers etc. This enabled the appropriate co-ordination of services for each individual. Once in the system, clients could use the SPA on a personal basis;
- Individual personal referrals were made via the Adult Social Care Access Team (ASCAT) who had the right set of questions to make an assessment of the referral and arrange re-ablement assistance if appropriate;
- Re-ablement helped people to remain independent for longer, prevented admissions to hospital and long term care, and enabled them to continue to carry out activities and tasks themselves;
- National statistics showed that after a 6 week period of re-ablement 56% of people no longer needed a home care package and 48% of these still did not need home care after 2 years. Figures in MK matched the national average;
- Re-ablement / Intermediate Care in MK were provided by a number of teams staffed by various specialist workers. They included the Rapid Assessment and Intervention Team (RAIT), the Intermediate Care Team, Rapid Response Team, Early Stroke Rehabilitation Team, Re-ablement and Hospital Discharge Team and the Home to Stay Team.
- Care was also provided by the Windsor Intermediate Care Unit and Orchard House, where there were 18 units (bedsits), which although not suitable for long term occupancy, were ideal for re-ablement stays;
- All Intermediate Care staff were specialists in their field and were trained safeguarding investigators;
- Recent CQC inspections of Orchard House and the ICS team assessed all five standards reviewed as compliant and all Key Performance Indicators, Adult Social Care Outcomes Framework etc consistently received a green RAG rating.

The Next Step

- Review Group agreed that as the next stage of their investigation they would like to make site visits to Orchard House, the Windsor Intermediate Care Unit, the care teams and to speak to staff and service users.
- Jan Lloyd as Older Persons' Champion and Lyn Davis, Re-ablement Manager with AgeUK MK, to be invited to attend the site visits;

- Review Group would also be interested to receive a presentation from Lyn Davis about his work and to meet the Home from Hospital Team at AgeUK MK.

Dates for Future Meetings

- ER to canvass members about suitable dates for the site visits.

Future Work Programme

- First round of site visits arranged for 9 May as follows:

Intermediate Care Services, Bletchley Community Hospital, Whalley Drive, Bletchley MK3 6EN at 9am to meet the teams:

9am – Denise Miles Manager of:

RAIT – Rapid Access & Intervention Team
ESRT – Early Stroke Rehabilitation Team
She also manages the Home to Stay Team and will provide information on their work

She will then handover to **Michelle Smith, Re-ablement & Hospital Discharge Team Manager – her team consists of:**

Single Point of Access (all the referrals come into here)
Hospital Discharge Team (Social Workers)
Intermediate Care Team (Team Leaders / Carers providing care at home)

11am – Lorraine Chantler, Manager, Windsor Intermediate Care Unit (WICU)

THE CHAIR CLOSED THE MEETING AT 8.20 PM