Herefordshire Council

Minutes of the meeting of Adults and wellbeing scrutiny committee held at The Council Chamber - The Shire Hall, St. Peter's Square, Hereford, HR1 2HX on Tuesday 27 March 2018 at 2.00 pm

Present: **Councillor PA Andrews (Chairman)**
Councillor J Stone (Vice-Chairman)

Councillors: MJK Cooper, PE Crockett, D Summers and SD Williams

In attendance: **Herefordshire Council: J Coleman, A Russell, M Samuels, K Thompson-Dixon, L Tyler, S Vickers, K Wright**
NHS Herefordshire Clinical Commissioning Group: J Brooks
2gether NHS Foundation Trust: R Jefferies, E O'Neil, M Scheepers
Healthwatch Herefordshire: S Brazendale, C Price

Cllr Williams was welcomed as a new committee member following the resignation of Cllr RL Mayo.

It was noted that Martin Samuels, Director for adults and wellbeing would be leaving the council on 29 March 2018 and he was thanked for his contributions to the committee.

Stephen Vickers was welcomed as the incoming Interim director for adults and wellbeing.

Karen Wright was welcomed as Director of public health.

35. APOLOGIES FOR ABSENCE

Apologies were received from Cllr CA Gandy.

36. NAMED SUBSTITUTES (IF ANY)

There were no substitutes.

37. DECLARATIONS OF INTEREST

There were no declarations of interest.

38. MINUTES

RESOLVED

That the minutes of the meeting held on 25 January 2018 be confirmed as a correct record and signed by the chairman.

39. QUESTIONS FROM MEMBERS OF THE PUBLIC

There were no questions from members of the public.

40. QUESTIONS FROM COUNCILLORS

There were no questions from councillors.

41. PERFORMANCE UPDATE - SUBSTANCE MISUSE SERVICES PROVIDED BY ADDACTION

The Addaction service manager gave a presentation which provided a service update following the update provided to committee on 21 September 2017, the main points being that:

- There had been significant improvements and this was set to continue, both in terms of organisational performance and outcomes for service users
- Improvements in outcomes for services users was supported by focusing on recovery and making use of support networks including volunteers, peer mentors and local communities
- The council had reviewed the contract, effective from April 2018, which would mean some challenges to staff capacity, focused working such as time-limited and structured care, clearer pathways and use of group work. Although the outreach programme would be reduced, there would be increased information and signposting for referrals and more service advertising.
- Addaction had listened to recommendations from the last meeting regarding publicity and this was being developed.

The chairman welcomed the improvements and asked how people were accepting new approaches to treatment. The service manager explained that service users understood and preferred having more contact and more on offer, particularly group work, to support recovery. There were some long-standing users who had resisted engagement but this was being addressed with the support of a key worker.

A member asked for more clarity on the groupings of types of substance misuse, and it was clarified that Public Health England had introduced a fourth primary group where there was combined use of alcohol and non-opiates.
The member welcomed the group work approach, commenting that there should be more group work. He asked what was in place to enable support groups such as AA and Al-anon to continue, and whether the Stonebow Unit was being used for people with mental healthcare needs as well as substance misuse treatment needs. The service manager confirmed that dual diagnosis clinics were being explored with 2gether NHS Foundation Trust and there was support to help upskill staff to refer into the service. As part of this work, it was recognised that mental healthcare needs could be addressed alongside substance recovery support and so the use of pathways was being reviewed so that people did not need to complete one care pathway or achieve recovery before accessing other care. Addaction had clinical psychologist input but referred people to other support for one to one counselling.

The vice-chairman thanked Addaction for the opportunity for members to visit to the Leominster base, and asked what progress had been made in Leominster regarding group provision on offer and how the co-production panels were helping to increase engagement and community involvement with Addaction. It was recognised that there was more that could be achieved around increasing Addaction's presence in Leominster and the appointment of a new team leader would support development in this area. It had been found that the Leominster service was better suited to smaller groups of 4 or 5

people but the plan was to have a core user group each for cannabis, stimulants and low-level alcohol followed by an opiate user group.

A member asked how the Care Quality Commission inspection went.
The service manager explained that the CQC identified some areas to address but it was generally a positive inspection. The inspector was due to return this summer but had not identified any immediate concerns and it was hoped that further improvements would be noticed. The service had acted on the CQC's findings regarding quality of risk assessments and recovery plans and there had been comprehensive training for all staff in those aspects.
The member referred to one remaining outstanding issue regarding record keeping and it was explained that to overcome the care plans and risk assessments being in both paper and electronic format, staff were encouraged to upload paper copies to the case management system so they could be stored electronically. This had presented practical problems around needing to re-use the forms for treatment reviews and so there was a push throughout Addaction nationally to consider introducing tablets to record reviews online, although this was some way off.

A member asked what had brought about the improvements after three years, and whether this was due to the service settling-in or because operating in Herefordshire was different. The service manager recognised that it did take time to establish a service and that short contracts could prevent services becoming fully embedded in an area. This could have a detrimental effect if service users were unable to see benefits of a new service and as a result did not engage. However, it had helped to have consistent management of the service to have staff engaged and people were starting to believe in the model of support. He acknowledged that Herefordshire was different in terms of its cohort of long-standing service users and people on higher levels of medication. There was also a cohort of older service users whose needs were different.

In answer to a question from the chairman about whether there was contact with the police regarding drug suppliers, it was confirmed that there were meetings with the police around tackling re-offending.

A member noted that the NHS was promoting the use of e-cigarettes as an alternative to smoking tobacco. Referring to a point made at a previous meeting, he asked whether there was any new information regarding the use of e-cigarettes as a vehicle for taking opiates and whether there was any cause for concern. It was confirmed that there had been no reports of this, and because it was unusual practice, there was confidence that staff would flag this activity.

The chairman asked for clarification regarding the main drugs used in the county. It was confirmed that aside from alcohol, heroin and crack were the most prevalent. There was little known use of new psychoactive substances such as Spice or Xanax in the county.

The vice-chairman commented on the reduction in the outreach programme given county's rurality, limited transportation and scattered communities, and asked about information and awareness raising of the service in focal points within the more isolated areas. It was recognised that some areas had not yet been reached and more use would be made of leaflets and building digital capacity, and advice from members about how best to target communities was welcomed. The commissioning officer added that there were links with Smart UK which offered online meetings and which could help to widen the recovery network. Addaction also had a strong social media presence.

Healthwatch asked about the work with 2gether on developing the dual diagnosis pathways, noting feedback received that progress was not being made.
The service manager confirmed that changes were evident and services were working together to address individual cases and encouraging partnership working.

The representative from the Clinical Commissioning Group gave assurance that people with dual diagnosis would be accepted as inpatients by the Stonebow Unit, that the community outreach team would also work with dual diagnosis and that training for staff would be welcome.

The chairman welcomed this assurance.

The director of public health referred back to the point regarding use of e-cigarettes and commented that these were promoted by Public Health England as a way of helping people to stop smoking. She asked for it to be flagged up if there was evidence that e-cigarettes were found to be used for taking opiates.
The director also asked whether more could be done to encourage people in recovery to access social enterprise and volunteering. The service manager explained that there was limited influx of volunteers to the service and the service was considering how best to co-ordinate community engagement, perhaps through the peer mentor network. Responding to a further point made by the director of public health regarding making every contact count, he believed that other agencies were receptive to accessing training and Addaction's in-house training was offered to other agencies to support keeping training local and accessible.

RESOLVED
That:

a) **the performance improvements be commended;**
b) **continued performance improvements be encouraged; and**
c) **development of group work be supported.**

42. LEARNING DISABILITY JOINT SERVICE OVERVIEW

A presentation was given by the senior commissioning officer, Herefordshire Council and the community learning disability team service manager, 2gether NHS Foundation Trust. It was noted that the presentation was a brief tour of the service, which provided long-term work covering each person's life span, all health needs and all aspects of daily living.

The presentation highlighted the following key points:

- Although statistics could not be relied upon, it was estimated that 2.32% of the county's population had a learning disability diagnosis, and this covered a wide spectrum of needs. This figure broadly fitted national demographics; however it was noted that the county had a good reputation for the care of people with a learning disability which resulted in people moving here to access services
- In terms of funding, learning disability services represented 30% of the adult social care budget, supporting 550 people, which was broadly equivalent of 25% of council tax income, and which was typical of national picture.
- As shown in the adults and wellbeing blueprint, there was a move towards mainstreaming peoples' experience and accessing universal services rather than looking to adult social care, which represented significant culture change.
- Work on developing access to information and improving the "front door" would help people know where to access information and support. Success in achieving changes to the pathway was facilitated by community brokers, in getting more consistent and richer information, and all information was being linked into WISH online which was starting to show success.
- In terms of health provision, providers and commissioners were working together to ensure contracts were directed in the right way and meeting long term needs. The focus was on making sure reasonable adjustments were made so that people could routinely go straight to the service they needed. This was

supported, for example, in acute care by acute liaison nurses. Herefordshire had been successful in limiting the use of out of area placements for people with learning disabilities, and those people who were out of county were on planned return. This was an excellent position as continuing healthcare for this small cohort was known to present a challenge, and the intention was to bring everyone home to the county. Service provision cost around £250k per person annually, so a possible way to support this outcome was to develop specialised services shared with neighbouring authorities.

- Access to the community learning disability team was supported by a multi-disciplinary approach and an open referral system. The aim of the service was to provide person-centred support for people to access mainstream services whilst recognising the need for some specialist support.
- The service was supporting access to annual health checks and there was a lead nurse providing training for GPs to increase access which was currently around 60%. Take-up of health checks was lower than in the general population, so this was being promoted with input from the Clinical Commissioning Group and the council. This was a critical area of focus as someone with a learning disability could have a life expectancy of 20 years less compared with other people.
- Feedback on service provision was always sought. There was an effective user engagement process and it was recognised that there was still work to do around addressing lack choice of where to live, access to work and training. The council needed to lead by example and there were opportunities to offer employment and meaningful training. Health inequalities remained, and there were not enough opportunities to demonstrate social value. Too few people had choice or control over life decisions and access to advocacy.
- A new strategy was in development and this would put greater emphasis on delivering changes to have meaningful impact.

The chairman noted the lack of robust data and asked why this might be. The commissioning officer explained that it was a complex picture and that people were within a spectrum of learning disability, some of whom were not always identified because of lifestyle or level of need, so it could be possible for someone to present as an adult who had been previously unknown to services.

The chairman asked what employment opportunities had been explored.
It was explained that there were some good examples of support into employment but more could be done. Supermarkets, for example, had done well and understood what peoples' support needs were, and so there was learning to take from them and provide opportunities. The council, for example, had contractors which could be accessed for employment and training, and this level of support added value across the sector because people were seen in a valid role.

A member noted the variety of needs of people with a learning disability. In the context of a learning disability not being immediately apparent and the limited time GPs had for consultations which did not provide time to identify someone with particular needs, people could fall through the gap, and so alternative ways of addressing this needed to be identified.
The commissioning officer commented that it was important to give GPs the tools to support people and that practice nurses could be involved more in this respect. He added that the annual health check was so important, with appropriate help, in establishing a picture of a person to enable their ongoing good health. The service manager added that in providing training to the whole practice, practice nurses or healthcare assistants would be enabled to conduct pre-assessments before someone sees the GP.

The chairman asked about the prevalence of the learning disability nursing speciality. The service manager confirmed that this was still offered and the service took some

specialist nurses who were coming through that line of training, although this was a small cohort.

A member commented on the importance of employment opportunities in supporting peoples' integration. She referred to a recent visit by committee members to a local service provider's centre which was found to be inspirational and forward thinking. The member noted that there had been a shortage of speech and language therapists and asked if this had been addressed.
The service manager explained that there remained a national shortage, and it had been a challenge to recruit a speech and language therapist to the team. However, a newly qualified therapist had been appointed and they had been inducted alongside an experienced mentor, which meant that there was now a highly specialised speech and language therapist in the team, although there was just one.

A Healthwatch representative welcomed reasonable adjustments within universal services as this had been recognised by Healthwatch as an issue for people with additional needs. The Healthwatch representative also enquired about whether the learning disability strategy would be presented to the committee for scrutiny.

On the point of reasonable adjustments, the commissioning officer explained that there would be an incremental process to ensure that services understand what support someone needed and making sure the referral process was right. This would enable better use of specialist services if they could support mainstream services and have clear referral pathways. The new strategy would demonstrate how services would interact. The commissioning officer commended 2gether NHS Foundation Trust for the training they provided and for working across the sector.

As regards the strategy, this was being developed and was at the stage of incorporating comments from the engagement process to ensure it was meaningful. It was noted that timing of the decision to be taken by Cabinet was prior to the next scrutiny committee.

The assistant director, operations and support commented on the paternalistic nature of the current culture, and that if people could move away from this and manage risk, opportunities would be realised. The adult social care model challenged the level of risk for people in communities and people needed to embrace this by starting conversations earlier in life with parents. It was important to get this right to achieve what people with learning disabilities wanted the strategy to achieve.

The chairman commented on the low number of people noted on GP records as having a learning disability and asked if the Clinical Commissioning Group could promote recording. The CCG's assistant director commented on the learning disability spectrum and issues around choice as factors influencing the level of recording, but confirmed a commitment to work with primary care to support people. She added that recording was critical as it linked to outcomes and the CCG was working with primary care to establish attempts to improve peoples' outcomes.
In answer to a further question from the Chairman regarding people with multiple needs including dementia, the CCG assistant director confirmed that a joint pathway was being developed as this was identified as a key area of growth and that it was also essential to engage with families on such matters.

RESOLVED
That

- **a) The service overview be noted; and**
- b) **Further information on the implementation of the joint learning disability strategy be awaited**

The meeting ended at 3.52 pm **Chairman**