Delivering Integrated Health and Social Care for Older People with Complex Needs

Caring for the Future in Mid and West Wales

Cyngor Sir Gâr Carmarthenshire County Council

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Statement of Intent

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1. Introduction and Summary

This Statement of Intent has been produced by the partner organisations with statutory responsibility for health and social care services in Mid and West Wales, namely:

- Carmarthenshire County Council
- Ceredigion County Council
- Hywel Dda University Health Board
- Pembrokeshire County Council

The Statement reflects a longstanding strategic commitment between the organisations to develop and deliver health and social care services, including those for older people, in an integrated way. This includes services for older people with dementia and other mental health conditions. The assessment of our current position in relation to integrated services for older people with complex needs and our commitments for the future have been informed by ongoing dialogue between our organisations and with other partners, most recently through a review of locality arrangements commissioned by the Health Board and preparatory work underway to inform the development of its Integrated Medium Term Plan. This review will need to be ongoing in order to develop a comprehensive picture of our current arrangements and to identify improvements as they are introduced.

Our Statement reiterates existing commitments contained within *'The ABC of Integrated Community Services: A Strategic Framework'* (2010). More broadly, it reflects arrangements that are in place for the integration of service delivery in the region, for example:

- The establishment of multi-disciplinary Community Resource Teams (CRTs) across the Health Board area and continual review and refinement of arrangements, for example through the Transforming Adult Social Care (TASC) programme in Carmarthenshire, King's Fund-led 'Care Closer to Home' initiative in Pembrokeshire and Integration Project in Ceredigion
- Development of a model of integrated care that aligns with 'Setting the Direction', 'Together for Health' and 'Sustainable Social Services for Wales: A Framework for Action'
- Delivery of primary and community services within seven geographical localities designed to provide bespoke services to meet the needs of local populations
- Ongoing development of financial governance arrangements to support integrated working, for example the Carmarthenshire Community Services Section 33 Agreement

We recognise that, in an environment of rising demand and expectations coupled with unprecedented financial constraints, it is not sustainable for our organisations to operate in isolation from each other. We are clear of the need to build upon the above activities and accelerate change. We will continue to work in partnership to improve integration, developing a range of common objectives that deliver the requirements of this Framework, the forthcoming Social Services and Wellbeing (Wales) Bill and *'Delivering Local Health Care: Accelerating the Pace of Change'* at a local level. We

will also ensure that assessment, planning and review arrangements for older people remain citizen centred and outcomes focused and that these arrangements are made consistent across our region, as required by the Welsh Government. We will use the Welsh Government's *'More than Just Words'* Framework to provide a systematic approach to improve services for those who need or choose to receive their care in Welsh, sharing successful approaches within and beyond our region.

Strategic ownership of this agenda will be maintained through the Mid and West Wales Health and Social Care Collaborative and County-level Health and Social Care partnership forums. A regional Older People's Programme Board will be established, reporting to the Collaborative Board and coordinating the range of initiatives that are being delivered across our area to transform and integrate services. Cross-sector engagement will be ensured through county-level partnership forums and clinical input into service modelling secured through the Elderly and Neurological Population Health Group established by the Health Board in late 2013.

We will look to ensure that our strong record of achievement in relation to health and social care integration can be carried forward under new local government structures resulting from the recommendations of the recent report from the Commission on Public Service Governance and Delivery in Wales. We will continue to make strategic links with our colleagues in the Powys teaching Health Board area, who are also members of the Collaborative Board, and consider opportunities for collaboration and integration across our boundaries where this makes sense. We welcome the recommendations within the Commission's report for the strengthening of local authority representation on Local Health Boards as a further driver for integration of services within the area.

We are committed to monitoring achievement of our joint objectives and commitments using appropriate outcome measures and other performance information. We believe that such information and the supporting performance indicators should be made consistent across Wales, enabling comparison and facilitating the exchange of intelligence and effective practice. The ongoing development of a National Outcomes Framework provides an opportunity to achieve this.

Our baseline assessment contains information at locality level. Our proposed actions, which are informed by the baseline assessment and seek to address the issues identified within the Framework, are set for the entire Health Board area. This reflects our determination to ensure consistency in the extent and impact of integration across our region, albeit with the flexibility needed to ensure that services meet the specific needs of local communities.

2. Where we are now: Baseline Assessment

As organisations we regularly review our arrangements for delivering integrated services and the extent to which this is happening on the ground. In late 2013 Hywel Dda University Health Board led a focused review of locality arrangements and current capability to inform its Integrated Medium Term Plan. This work involved assessment of arrangements in each locality against the maturity matrix provided within the *Framework for Delivering Integrated Health and Social Care for Older People with Complex Needs*. Our analysis also takes into account the 16 core planning issues taken from *'Making Integration happen at scale and pace: Lessons from experience'* (King's Fund, 2013). Our key findings are reflected throughout this section.

Senior officers from the three local authorities and the Health Board have been engaged in dialogue as part of our assessment. We are committed to taking forward conversations to ensure our assessment is accurate and that it informs and reflects ongoing improvement.

Our initial assessment of arrangements at locality level is provided in Annexe 1.

A coherent vision and strategy for integration

Each of our organisations recognises the value of integrated services in ensuring that services meet the needs of individuals and are delivered safely, effectively and efficiently and also that policy and statutory requirements are met in our region. This is reflected in our longstanding commitment to model an integrated approach across our area. The advantages of an integrated approach in services for older people are particularly significant in view of demographic pressures, levels of demand and the evidenced benefits of a joined up, reablement-focused service developed across the system to promote independence and avert the need for higher level interventions.

An ageing population and the increased prevalence of chronic diseases among older people require a strong reorientation away from historic emphasis on acute care, towards prevention, self-care and coordinated community and primary provision. The evidence of benefits, particularly to service users and their families, makes a compelling case for care to be coordinated around the needs of people and their populations, ensuring the right care is provided at the right time in the right place. These principles underpin a shared vision for older people's services in Mid and West Wales.

The ABC of Integrated Community Services, developed by the four partner organisations in 2010, setting out a high level strategic framework for provision across the Hywel Dda area, was driven by the recognised need to develop 'a more integrated health and social care system that is more effective at managing both its internal relationships and the external interface with other public, private and voluntary sector partners'. Recognising the need for 'genuine engagement and participation with staff and the public at a local level', the Framework emphasised the need to concentrate 'not on revolutionary change of organisational structures but on breaking down barriers and embedding the key messages and principles to manage change going forward and develop and enhance services for people within the community'.

The ABC Framework identified the following specific goals:

- We will work to overcome the existing fragmentation of service by developing seamless systems of care provided by integrated teams working across traditional boundaries
- We will advocate that all services follow a common pathway based on personalised care planning to produce a single coordinated journey through care
- Every activity we undertake is to be based on a person centred assessment of need and the genuine right to informed choice rather than organisational constraints
- There will be an open and transparent approach to ongoing design and development of local services, driven by public and professional participation and engagement
- We must protect those who are deemed to be most vulnerable alongside supporting the general population to maintain and improve health and wellbeing in the long term

These goals have provided a common narrative which has driven integration in service delivery, notably the establishment and ongoing development of CRTs across the region, the development of Integrated Locality Networks to promote joint working, break down barriers between services and drive the greater integration of health and social care in the community and the development of a common infrastructure for the planning and delivery of services across the area. Integrated posts across health and social care that have been introduced in some areas have also contributed significantly to the effective sharing of resources and development of a joined up approach to service delivery.

This blueprint for integration has been carried forward under the auspices of the Mid and West Wales Health and Social Care Collaborative, led by a Strategic Board of Directors of Social Services and senior Health Executives which also extends into the Powys Health Board area. In its submission to Welsh Government for funding to support collaborative working under the Regional Collaboration Fund (RCF) in 2013, the Board articulated its core purpose as *'providing a strategic framework for coordinating and delivering a range of health and social care programmes across the region, maximising resources available, reducing duplication, achieving consistency and bringing about service improvement and transformational change in how we jointly commission and procure high quality services at a better price, improving outcomes for citizens in the region.'*

Board members recognise the need for further development of the Integration agenda including refreshing of the vision and have agreed to a facilitated programme of activity in early 2014 to help achieve this. This programme of activity is reflected within the Health Board's Integrated Medium Term Plan.

There is also a recognition amongst partner organisations that the third sector has an important part to play in delivering the above vision and in ensuring 'best value' care for our population. Significant progress has been made in implementing *'A Co-Designed Future'*, the first health and social care co-design framework in Wales which was published in December 2011. The aim has been to ensure best use of resources, as well as opening up opportunities for organisations to enter into robust contractual

arrangements and align their business planning processes to fit with the strategic direction for future health and social care provision across the Hywel Dda footprint.

Specific deliverables include:

- A tripartite Compact agreement across the health board region which includes county voluntary councils, local authorities and the Health Board
- The establishment of third sector broker roles in each locality, working closely with health and social care
- Development of a Commissioning Code of Practice specifying future working arrangements between the health board, county voluntary councils and third sector organisations
- Establishment of stronger links with County Voluntary Councils to take forward volunteering in a more integrated manner, based on the successful Volunteering in Health Scheme

The *Healthy Ageing Action Plan (HAAP) 2012-16* forms part of our local response to the Older Peoples Strategy in Wales and is another example of partnership working with a range of both statutory and third sector partners across the Hywel Dda footprint. While the emphasis is on promoting health and well-being, the focus is very much upon partnership working across sectors to identify emerging priorities and to meet the needs of a rapidly evolving health and social care environment. Many improvements have been brought in through the Plan, supporting better nutrition, physical activity, mental health and chronic conditions.

Partnership working and collaborative approaches have also been developed with other local authority services such as regeneration and leisure, as well as with community organisations. These help achieve a holistic approach to the wellbeing of older people.

In addition, the latest Reports of the Statutory Directors of Social Services for each local authority contain specific commitments in relation to taking forward the integration agenda generally, and specifically in services for older people. Hywel Dda Health Board's last annual report describes a series of touchstone tests that demonstrate commitment to citizen engagement and partnership working, promising 'more seamless care when more than one organisation is involved with individual's care' and 'more personalised care designed to fit in with individual circumstances and closer to home'.

Strong and shared leadership

True partnership brings challenges: reaching a common understanding of vision and aims; aligning objectives and targets of individual organisations and sometimes adjusting these for the common good; breaking down professional boundaries and practical obstacles to joint working; and sharing financial and other resources and constantly ensuring that services are designed and delivered around the needs of individuals rather than the exigencies of particular agencies. This requires a fundamental shift in culture, which in turn will happen only where there is strong professional, clinical and political leadership to help drive change.

The Mid and West Wales Health and Social Care Collaborative provides a focus for the development and delivery of integrated approaches to services in the region. In addition, an Older People's Programme Board is to be established to coordinate the range of initiatives that are being delivered across our area to transform and integrate those services. Additional arrangements at county level, for example health and social care sub groups of Local Service Boards delivering elements of Single Integrated Plans and the Carmarthenshire and Pembrokeshire Health and Social Care Boards, provide further strategic leadership and a mechanism for engaging with other statutory services and the third and independent sectors. The recently established Population Health Group for Elderly and Neurological conditions is bringing together strategic leaders with clinicians and practitioners to develop further a model for older people's services and work collectively to deliver it. Part of this group's work focuses on areas of service described within the Social Services and Wellbeing (Wales) Bill in relation to well-being, prevention and meeting the care and support needs of adults.

We are engaging increasingly with Council Leaders and Cabinet Members to secure political buy-in to the resulting changes. These activities demonstrate our continued commitment to change political, organisational and professional systems to support integrated service arrangements, as set out in the ABC of Integrated Community Services. Regular interaction with the Chief Executives of the four partner organisations ensures a corporate perspective and ownership of the wider wellbeing agenda.

The current reconfiguration within Hywel Dda University Health Board will result in the three County Directors having responsibility solely for primary and community services within their areas. Working closely with Directors of Social Services and Heads of Adults' Services within the local authorities, this will help provide further strategic focus to an integrated approach to services for older people with complex needs, including joint commissioning of services where this is appropriate.

Bringing about real change on the ground

Our assessment of arrangements across the region picked up clear examples of local innovation at the front-line – effectively building change from the top down and bottom up. Examples include the ongoing development and refinement of the CRT model across the three counties and increasing engagement with clinical and third sector colleagues in the development and delivery of services.

The development of locality networks and CRTs providing focused, multi-disciplinary services and a coordinated link between primary and secondary care services, were identified as priority areas within the ABC Framework and good progress has been made in establishing these arrangements with the aim of creating whole system impact. The Transforming Adult Social Care (TASC) programme in Carmarthenshire, King's Fund-led 'Care Closer to Home' initiative in Pembrokeshire and Integration Project in Ceredigion provide examples of continuous review and improvement.

The CRTs coordinate care that is designed around the needs of the individual. Support is provided by a local interdisciplinary network of people with a range of skills that work to shift patients/service users from a model of dependency to self-care and enablement. Some of the benefits have been:

- Improvements in the consistency of service delivery and individual outcomes
- More appropriate targeting of resource due to joint working with GP practices and secondary care specialists to help identify those people who are frail and most ‘at risk’
- Provision of surveillance and care co-ordination, including telephone case management, guided self management and secondary prevention
- Improved communication, including information sharing through agreed WASPI
- Reducing risk of falls with the implementation of evidence based Postural Stability Instruction (PSI) programmes through partnership working between health and leisure services
- Reducing Unscheduled care demand in A&E for fallers and some specific health conditions through improved pathway work with Welsh Ambulance Services NHS Trust (WAST) and community services

We recognise the need for a joint, strategic approach to commissioning to ensure whole system remodelling of older people’s services and development of a sustainable local market to deliver agreed services. Notwithstanding the commissioning of joint packages of care for individuals eligible for Continuing Health Care, we are some way from achieving a consistent, joined up and strategic approach across the commissioning cycle, including assessing current and future needs, testing markets, engaging with providers and monitoring delivery to ensure services are of the highest quality and are cost-effective. The Welsh Government’s new Continuing Health Care Framework and the establishment of an all Wales Health and Social Care Commissioning Board provide the opportunity for us to deliver improvements locally that draw on the experience and proven effective practice of colleagues across Wales. This will be a key priority for the Mid and West Wales Health and Social Care Collaborative over the coming period.

Already community budgets for nursing and general management are devolved to the three Counties. The Health Board is committed to the principle of further devolving budgets to the localities if clear benefits are identified in doing so. This will only be enacted once the maturity of the localities is considered sufficient in terms of structure and accountability. This will provide new opportunities for consideration of pooling health and social care resources at a local level.

The agreement of an overarching Section 33 agreement between Carmarthenshire County Council and Hywel Dda University Health Board represents a further major step that could facilitate the pooling of financial resources to support the delivery of integrated services. The forthcoming allocation of money to the region through the Welsh Government’s Intermediate Care Fund provides further potential opportunities to develop jointly commissioned and funded services for older people. We are already working collectively on the development of proposals for our area.

A further key enabler for reducing pressure across the system and ensuring people receive interventions at the appropriate level include the development of consistent arrangements for assessment, care planning and review, on which we are currently working. Joint plans on meeting seasonal winter pressures reflect new integrated ways of providing community-based services.

Hywel Dda University Health Board has been engaged for a number of years in trialling and testing the use of new technologies such as telehealth and telemedicine initiatives to aid prevention and help manage specific local challenges such as rural topography and high levels of chronic disease among our older population. Research and our own experience indicates that such approaches can significantly improve the quality of life of individuals with health and care needs, promoting self management and reducing the need for secondary healthcare services. A European-funded telehealth project – 'United4Health' - is currently being taken forward to build on these foundations and optimise benefits of technology-based service models. This work will dovetail with several initiatives being taken forward by the three local authorities to increase the range and level of telecare services available, complementing reablement-based approaches and helping maximise people's independence within their own homes. The Intermediate Care Fund will help resource a number of these improvements.

Citizen-focused approaches such as the development of new, integrated roles for health and social care staff within a community setting, will be progressed in the coming period, ensuring that care on the front line reflects our overall strategic direction.

We are committed to becoming more sophisticated in capturing and sharing information about what works across our area and beyond. The planned action learning pilot on co-production is just one example of how we will ensure that we obtain information about what works and what is less successful and apply lessons across our area as we progress the transformation of our services.

Delivering across the footprint

Whilst a broadly consistent approach to the integration of services for older people has been adopted across the Hywel Dda footprint, precise arrangements for delivering the model vary across individual County areas.

Carmarthenshire

In Carmarthenshire work to integrate community health and social care services has been ongoing for five years. Whilst it is recognised that there is still more work to be done, there is a level of maturity in the way in which partners plan and deliver care, and in engaging individuals in shaping that care.

The CRT structure is now embedded in daily work practice, with a CRT in each of the three localities of the County; Aman/Gwendraeth, Llanelli and the 3Ts. Each operates on the primary purpose of *'empowering people to make informed decisions and to support and enable them to do what matters to them'.* The model is based on a number of core principles, such as better holistic working, better outcomes for the public, shared resources equating to efficiencies, increased service capacity, reduced bureaucracy and intra-professional working. These are translated into operational principles which include:

- Only do what matters to the individual, rather than what's important to us, giving consideration to significant others

- Professional standards and autonomy
- Eliminate duplication: Do it once, do it right
- Understand legislation
- Multi-disciplinary working – accepting others professional judgement
- Continuity of professional practice
- Utilise the community innovatively
- Measure only what matters
- Timely easy access with an effective response

Primary care involvement with the CRTs has always been considered essential. GPs, practice nurses and community nurses (who have a base within the CRT offices) attend weekly multi-disciplinary team meetings which are aligned to GP practices within certain areas, and which regularly include social workers, occupational therapists, physiotherapists, a third sector broker, community psychiatric nurses, reablement officers and housing officers amongst others. The Transforming Adult Social Care (TASC) project aims to further refine the model by working across sectors to review and enhance existing arrangements.

Alongside the Section 33 agreement between the Health Board and Carmarthenshire County Council service specific schedules are being developed which will outline the services aims and objectives, financial arrangements including aligned or pooled budgets and commissioning arrangements.

Work is also ongoing to develop a set of community metrics that will allow us to measure what matters and we will be looking to align these with the Welsh Government's National Outcomes Framework.

Ceredigion

In Ceredigion a new model of care for older people is a key element of our integration of health and social care services and we continue to make good progress in this area. Two key partnership projects in Cardigan and Tregaron are progressing well, with funding released from Welsh Government to allow a Design Team and Health Planning Team to do more detailed work around the new Cardigan Integrated Resource Centre. The integration project is supported by the Social Services Improvement Agency (SSIA) and recommends a model which could be replicated in other parts of Wales, in line with the recommendations of Professor John Bolton in the SSIA report '*Better Support at Lower Cost: Improving efficiency and effectiveness in services for older people in Wales'* (2011), along with the drivers for change within *'Together for Health'* and *'Setting the Direction'*.

A detailed project plan has been prepared and four work-streams developed to take forward the work on integration. The proposed model is based on the development of a new way of helping people who have lost life skills to regain their independence through a joint health, social care and support service. The model has received Cabinet approval and further detail is being developed with Hywel Dda University Health Board for implementation.

We also aim to test a new way of working in the Aberaeron area, by creating integrated teams of health, social care and domiciliary care workers. This relies on us getting a better understanding of our service users and what matters to them, helping us help them to regain life skills before they become reliant on care and support.

Referrals are received direct from community and hospital-based healthcare professionals, or re-directed from our call centre. The service is free of charge, is available for up to six weeks and maximises a person's independence so that, ideally, no on-going support is needed. However, it is recognised that, at times, long term care and support may need to be delivered following an episode of reablement.

The service helps prevent hospital admissions and facilitates timely discharges so that a customer can return home straight from an acute hospital without the need for a transfer to a community hospital. We will closely evaluate the new approach, which will be introduced and rolled out further in 2014. Components of the service are:

A Single Point of Access (SPA) - an integrated single point of contact which has common pathways in terms of referral, screening with professional input and sign-posting to appropriate services. In terms of the NHS, customers will receive good quality advice and reassurance from an appropriate, registered professional. This will enable customers to experience a positive outcome from contacting the SPA as well as streamlining pathways in relation to community health services which, in turn, will release more time to undertake related tasks. The SPA will also coordinate telecare and streamline access to equipment.

Links will be made with out-of-hours services to ensure a smooth transition between health and social services. This will ensure clarity of roles and avoid confusion.

It is expected that the SPA will deliver improved outcomes for service users in relation to:

- Information giving and sharing at the front end of service
- Appropriate sign-posting away from statutory services and closure of intervention where appropriate within the SPA, at front end of service
- Promotion of independence with less reliance on traditional longer-term services
- Improved pathways for referrals
- Screening and coordination of referrals resulting in appropriate coordination of intervention
- Telecare advice support and access to equipment
- Call handlers from health and county councils will be skilled in order to take each other's calls
- Direct referral to the Targeted Intervention of Planned Care and Support Team's services when appropriate

Targeted Intervention Team (TINT) - requiring a review of roles to ensure the workforce is appropriately skilled, duplication minimised and a citizen focus maintained. The service will require the skills of social workers, nurses, occupational therapists, physiotherapists, technical assistants and support workers to ensure effective delivery of short term reablement, rehabilitation and other specific interventions aimed at those who are:

- At risk of unnecessary hospital admission
- Medically fit for discharge from hospital and in need of support with activities of daily living or further interventions to support recovery to enable them to return home
- Experiencing deterioration in their independence or health due to illness or accident in activities of daily living in their own home
- Needing assessment for social care

Planned Care and Support Team (PCST) - supporting citizens with long-term social care needs to access services such as day care, domiciliary care and residential or nursing home placements as appropriate. The majority of cases will be referred from TINT if it is identified that further support is required. Eligibility will be based on the current eligibility criteria of substantial and critical need for services.

If the service user follows this journey to long term social care support provided by the PCST, much of the 'assessment of need' work will have already been undertaken and helpful and supportive interventions will already have been explored. Individuals requiring longer term health interventions or review will continue to receive care from community based nurses or therapists.

Pembrokeshire

In Pembrokeshire current arrangements provide for health and social care teams to work as multi-disciplinary Teams supporting localities. We have a joint discharge team and four CRTs. The Head of Adult Care and Health and a number of other management posts have a dotted line reporting arrangement to managers in both the Council and the Health Board reflecting our integrated approach.

A current restructure within adult care in the local authority seeks to strengthen these arrangements. The restructure has been based on the following principles:

- People are safeguarded
- A single point of contact for all
- Early intervention and prevention, hearing the customer voice- listening and acting with good professional information and advice.
- A single customer record, with real time recording
- Working as one team, aiming to get things right first time.
- Delivering in partnership with the NHS and other key stakeholders
- People with specialist needs are supported by appropriately skilled staff

Staff will remain co-located and locality facing and we are increasing the numbers of managers that need to be professionally qualified, and also the number of social workers and further enhancing our safeguarding arrangements.

Joint commissioning arrangements are being further developed and the Local Authority has recently invested in a new post of Head of Service, Commissioning, who will be working to ensure a joint approach to commissioning both across the council

and with health partners. The strategic commissioning framework will reflect and support the Adult Social Care transformation principles, with an emphasis on building community capacity, prevention and self help, maximising people's independence by providing integrated rehabilitation and reablement services and, where people require longer term care, ensuring they have a greater voice in how they wish their needs to be met.

Excellent relationships have been established on the ground between health and social care. Effective partnership working has contributed to a consistently low level of Delayed Transfers of Care. Over the past three years Pembrokeshire has been a pilot site for 'Care Closer To Home' which is focussing on integrated working and has been overseen by the King's Fund. This has ensured that the change of culture is embedded and arrangements around MDTs and multi-agency working underpin the structural arrangements in place.

As well as ensuring a joined up approach the 'Care Closer To Home' arrangements have also led to services being more designed around the individual. The ongoing development of the existing commissioning hub will focus on service user engagement and shaping of services and will build on the current arrangements.

The council welcomes the opportunity that the Intermediate Care Fund will bring, building on the positive joint arrangements in place to date which will support joint commissioning and further develop integrated working. There is an opportunity to further develop our approach to preventative services by harnessing the potential of the voluntary sectors and working more collaboratively for example connecting the excellent work of the good neighbours scheme, home from hospital and other community based initiatives. We will look to use the funding to use further develop our rehabilitation and enablement services building on good practice, ensuring value for money and reflecting evidenced based initiatives to maximise people's independence.

Intermediate Care

We welcome the recent announcement by Welsh Government of the Intermediate Care Fund and have developed an ambitious programme of change for Mid and West Wales. We will use the Fund to develop new services, optimise existing capacity and work across sectors to build community-based wellbeing services that strengthen resilience and are more supportive of Intermediate Care. Specific initiatives within our regional programme include:

- Development of an integrated health and social care workforce supporting Rapid Response and other services
- Improving therapy input into reablement services
- Development of integrated 'twighlight' services providing responsive transport home from hospital and home-based mobility support to prevent admissions
- A project led by Care and Repair which will speed up minor adaptations and provide 'handy man' services to help keep people in their homes
- Further development of supported accommodation, including dementia 'move-on' flats in Pembrokeshire, and Extra Care housing
- Extension of telecare support, embedding the service into the core CRT working arrangements.

The Older People's Programme Board will coordinate activity across the region, monitor its impact and disseminate learning from the programme.

Engaging with users

Separate and complementary mechanisms exist within the Health Board and the three local authorities to ensure accountability to the public for the services we provide. Ultimately, local authorities are accountable to their citizens through Elected Members. Hywel Dda Community Health Council is an independent statutory organisation which represents the interests of patients and the public in the NHS providing an independent voice in relation to the shape and quality of services. A key role of both the local authorities and the Health Board is to scrutinise services provided locally and to work with commissioners and providers to improve quality and the experience of service users. We recognise the benefits of a collaborative approach to scrutiny and are developing this across the region, for example through joint scrutiny reviews of dementia and day services within Carmarthenshire. We welcome the recommendations within the report from the Commission on Public Service Governance and Delivery in relation to strengthening the public accountability of LHBs and engagement between Boards and local authorities to support the planning of local government scrutiny.

We are constantly looking at new ways of enhancing the voice of users and carers. Hywel Dda University Health Board has an established involvement and engagement scheme known as *Siarad Iechyd /Talking Health*. This scheme has around 1000 members and offers genuine opportunities for them to influence and shape services, through participation in focus groups, interest groups and citizens' panels across the three counties. Each panel is a local partnership and currently includes Dyfed Powys Police and the local authority as key partners.

We also have an established Stakeholder Reference Group through which stakeholders have the opportunity to discuss and influence issues relating to services and change. The Population Health Programme is able to engage with a wide network of third sector organisations through identified leads from the Association of Voluntary Organisations who are members of each Population Health Group, thus ensuring wide engagement in the development of services.

We recognise that Welsh is the first language for a significant number of service users and carers in our part of Wales. Local plans are already in place to ensure delivery of care services through the medium of Welsh for those that want and need them and we will be looking to share local examples of effective practice to accelerate progress across the region.

Carers are recognised in the Hywel Dda Region as equal partners in the provision of care. A recent study commissioned by the Care Council for Wales identified that 96% of all community care is provided by unpaid carers, predominantly family members. Fundamentally, carers are service providers as opposed to service users and deserve status and recognition from within all the allied health and social care professions. Hywel Dda University Health Board and the three local authorities have well-established carer networks which have evolved alongside the various national

initiatives and legislation supporting carers. More recently the Carers' Strategies Measure 2010 has focused these networks to work collaboratively with health colleagues to deliver consultation at both strategic and interpersonal levels. Carers' Forums are growing in each area and gaining in terms of respect and credibility with Carmarthenshire's Forum leading on two recent initiatives – the Carer Demonstrator Project and the Health and Social Care generic workforce.

Sharing information safely

There are examples of effective sharing of information between agencies. However, obstacles remain particularly in relation to sharing of information by GPs. System constraints also prevent the sharing of individual care plans across agencies. Solutions to these issues will be sought as part of our work on implementing new, consistent arrangements for assessment, care planning and review in the region.

Carmarthenshire County Council and Hywel Dda University Health Board are working together to develop an interface between the NHS' *Myrddin* system and the Council's *CareFirst* system. Underpinned by an Information Sharing Protocol, this will enable staff to access one system and transport data from the other through one access point. This work is almost at roll-out stage and is currently being piloted with multi-agency staff in Llanelli. It will transform the day to day working practices of staff working within integrated teams. Work is also ongoing to secure mobile working options for community teams and provide access to Wi-Fi at certain hotspots across the County including Council and Health buildings so staff do not have to return to their base of work to upload patient data.

Effective use of workforce

We recognise that building a workforce which can genuinely work across professional boundaries brings tangible benefits in terms of the service user's experience and in building the overall capacity of the service.

CRTs and other initiatives have provided an opportunity for co-locating professionals and developing more seamless delivery across professional boundaries. The need to further develop an integrated and complementary workforce across health and social care to make delivery more efficient and avoid unnecessary duplication is a priority for action over the next period. Activity will include testing approaches that provide integrated health and social care roles within the community. Joined up approaches to professional development will also be necessary and are being pursued.

There are opportunities to undertake joint education and training regionally for core common programmes but the organisations are currently tied into specific educational funding streams which is limiting and needs addressing for real progress to be made. e.g. joint middle and senior management and leadership training could develop the right thinking and culture amongst current/future staff to better understand and take forward the integration and modernisation agenda.

Varying terms and conditions between health and social care present another challenge, meaning that for individuals crossing from one sector to another there could be significant personal ramifications, for example in relation to salary and/or

continuous service. We are of the view that such issues need to be addressed on a national level and look to the Welsh Government to take forward work in this area.

Setting objectives and measuring progress

As set out elsewhere in this document, we will seek to refine and develop specific objectives around integration to ensure that we can accurately assess our progress towards seamless services and accelerate or refocus change as necessary. Measuring progress effectively will require identification of jointly agreed outcomes and using performance information to track progress. Our early work will focus on developing robust performance management and evaluation arrangements for our ambitious Welsh Government-funded Intermediate Care programme.

However, we would stress the need for nationally agreed metrics to assess performance against the indicators outlined within the Framework in order for analysis of the data to be meaningful and to facilitate exchange of learning and dissemination of effective practice across Wales. We welcome the Welsh Government's commitment to address this through the development of a national integrated outcomes framework and commit to contributing appropriately as this work progresses.

One of the main challenges facing the organisations is lack of an integrated information system capturing health and social care performance against agreed indicators. Work underway by the National Community Informatics Programme to procure such a joint system is supported by partner organisations.

Meeting the cost of change

We are clear that, whilst new service models may through emphasising independence and prevention, bring about savings over time, the costs of developing and implementing new service models are significant. Our ongoing refinement of a model for older people's services will need to include a realistic assessment of costs.

We will continue to ensure that funding provided to our region, for example through the Welsh Government's Delivering Transformation Grant and Intermediate Care Fund, is invested wisely to ensure maximum benefit to service users and a focus on priority elements of service. Longer term sustainability of new service models will need to be addressed in order to secure the beneficial impacts on the whole health and social care system from the wider service and system changes this enables. This will present particular challenges given current and future financial constraints and the rising demand of an ageing population.

3. Building on Success: Next Steps

Our baseline assessment provides many examples of how we are looking to consolidate existing arrangements and progress the integration of services for older people with complex needs across the region. In this section we identify specific actions that we will be taking over the coming period to achieve this. Once again these reflect the areas for action identified within the Framework.

Ensuring a relentless focus on delivering locality based, citizen centred, co-produced services, focusing on the pivotal role of primary care services in delivering person centred care

Our baseline assessment demonstrates the extent to which the locality-based, citizen centred model of care is already informing the development and delivery of services for older people. We will build on this in the future as we look to develop and refine our service model.

We will:

- **Use the new Older People's Programme Board, county-based partnership forums and the Elderly and Neurological Population Health Group as mechanisms to engage professionals, clinicians and partners in further developing our model for older people's services and clarifying how this will be delivered on a locality basis**
- **Refresh our initial baseline assessment contained within this Statement to review progress, facilitate learning and inform ongoing improvements**
- **Use existing and new approaches to engage actively with users, carers and providers to ensure their views are taken into account when developing the model and to explain the thinking behind and implications of changes to services**
- **Increase support for people to live independently through informed, relevant prescription of Assistive Technology, minor adaptation and access to disabled facilities grants,**
- **Continue to work with housing and third sector partners to provide supported alternative accommodation i.e. Extra Care and sheltered housing**
- **Continue to develop and improve services for those who need or choose to receive their care in Welsh using the Welsh Government's *'More than Just Words'* Framework**

Maintaining robust partnership arrangements that reflect a willingness to delegate responsibilities and providing leadership and commitment at all levels and across sectors, with strong governance and clear accountability across the system

Our baseline assessment contains details of governance arrangements which are already in place to provide leadership and coordination for integrated health and social care in our region. These will now be consolidated and refined as necessary to maintain momentum and ensure ongoing transformational change.

We will:

- **Through the Mid and West Wales Health and Social Care Collaborative, develop a clear and shared vision for integration of health and social care which focuses on improving outcomes for service users and carers, is sustainable into the future and ensures that each organisation's statutory requirements are delivered as part of an integrated service**
- **Continue to actively seek opportunities to strengthen integration within older people's services, by continuing to define common population and service objectives and ensure these are prioritised within the region**
- **Develop the Older People's Programme Board, the Elderly and Neurological Population Health Group to ensure they provide genuine mechanisms for engagement across sectors and professions in developing service models that are co-produced by health and social care**
- **Review other existing forums such as the Pembrokeshire and Carmarthenshire Health and Social Care Partnership Boards and streamline governance structures to eliminate duplication and support consistency across the region**
- **Report regularly at regional and national level on progress in relation to the integration of older people's and other services and the impact of service transformation**
- **Develop appropriate outcome measures to track progress and work with Welsh Government to ensure alignment with the forthcoming National Outcomes Framework**

Developing a single commissioning plan which will operate across partners, moving in time to a consistent approach across Wales

Our baseline assessment noted that we have more to do to develop a genuinely integrated approach to commissioning of older people's services. This will be a priority in the coming period.

We will:

- **Secure expert support for leaders across health and social care to develop a strategic approach to commissioning across the region, informed by an agreed regional collaboration strategy for older people's services**
- **Ensure this approach aligns with national arrangements being developed across Wales**
- **Move towards a single, outcomes-focused commissioning plan for older people's services in the Hywel Dda area**
- **Ensure the active engagement of providers from the statutory, independent and third sectors in developing the commissioning arrangements and developing and sustaining a local market that can deliver new services**
- **Develop joined up commissioning and contracting processes for the funding of services and packages of care for individuals eligible for Continuing Care, both through a better use of core Services across our Health and Social Care Organisations, and, where appropriate, jointly pursuing contracts with a range of providers for different client groups**
- **Continue to review and develop our joint monitoring of Providers of services**

to ensure that the services commissioned are both cost effective, and of the highest quality

- **Use the implementation of the Welsh Government's new Continuing Health Care (CHC) Framework to streamline and strengthen our local processes and ensure that CHC is recognised as part of our wider system of care**

Managing resources collaboratively through options such as a financial governance framework, joint commissioning plans and pooled or integrated budgets

Following on from a joint approach to commissioning, we will build on current arrangements and consider options such as the devolution of budgets for nursing and management to localities and develop new mechanisms for sharing and pooling resources.

We will:

- **Use the Carmarthenshire Community Services Section 33 Agreement to manage joint arrangements in particular areas of service**
- **Review the need for similar agreements in the other County areas**
- **Ensure that funding provided, for example, through the Welsh Government's Delivering Transformation Grant and Intermediate Care Fund, are invested wisely to ensure maximum benefit to service users and a focus on priority elements of service**
- **Actively seek other mechanisms for pooling and sharing of resources, as enabled by the Social Services and Wellbeing (Wales) Bill**

Building an appropriate workforce across all partners as an early opportunity to enhance the citizen's experience

As mentioned in our baseline assessment, we recognise the importance of an appropriately integrated workforce to deliver new models of service.

We will:

- **Ensure that workforce implications of new service models are identified and addressed at all stages of the transformation process**
- **Look for opportunities to test out cross-professional and joint health and social care worker models and use the outcomes of pilots in this area to inform ongoing workforce planning**
- **Ensure that the health and social care workforce is accessible on a 7 day a week basis and driven by a culture of prevention, empowerment, information provision and health improvement rather than a predisposition towards long term and/ or acute care**
- **Through the Mid and West Wales Health and Social Care Collaborative, develop joint workforce plans and professional development across the region and ensure that resources such as the Social Care Workforce Development Fund are used to support the delivery of transformational change**
- **Enhance opportunities for action learning in relation to co-production and develop a co-production demonstrator project for national dissemination**

Annexe 1: Assessment of Localities

Provisional Assessment of Locality Maturity and Capability			
COUNTY	**LOCALITY**	**MATURITY (SEE KEY BELOW)**	**INTEGRATION CAPABILITY (OPERATIONAL)**
Carmarthenshire	**Carmarthen**	Maturity assessed at level 3- 4 (the most mature of the partnerships between HB and the 3 LAs). Positive relationships between LSB membership & Health & Social Care Board membership. Single Integrated Plan (SIP) in place and priorities agreed with Stakeholders. Positive changes are evident by the changes to the pattern of local service provision.	**Level 3+** • Three distinct Localities each with a Locality Manager, Primary Care Locality Development Manager, & professional / clinical leads for GP, Nursing, Therapies & Social Care & third sector broker. • Culture generally one of accepting responsibility for population need and the wider system. Community services making a difference for individuals and the health and social care system. • Information sharing is enabling higher risk patients to be identified and proactively managed with some solutions found to overcome electronic system constraints. Some GPs have governance concerns and are less accepting of sharing information. • The need for individual care plans is accepted by the wider MDT but not yet universally accepted by GPs. • CRTs working towards local joint performance measures.
	Amman **Gwendraeth**		**Level 3+**
	Llanelli		**Level 3+** Also include: • Historical funding issues drive GPs to focus on individuals within own practice and currently less likely to work in clusters or for the needs of locality population.
Pembrokeshire	**North** **Locality**	Maturity assessed at level 2-3. LSB agreed SIP in place. Initial dashboard for SIP agreed but not yet reporting. Relationships with relevant organisations across the partnership being developed with some positive dialogue regarding planning & joint	**Level 2/3** • Primary Care Locality Development Managers and GP leads in place in both North & South localities. third sector broker & Social Worker in each locality. Operational Management of community services is County wide and for individual services, therefore not locality specific. • Clinicians engaged in integrated care vision but not yet sufficient critical mass to accept responsibility for patient population & the wider system to make sufficient difference. (although seeing outcomes improve for individuals). Still need to get wider GP engagement for MDT working. The need for sharing information is generally accepted

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Provisional Assessment of Locality Maturity and Capability			
COUNTY	**LOCALITY**	**MATURITY (SEE KEY BELOW)**	**INTEGRATION CAPABILITY (OPERATIONAL)**
		investment opportunities underway.	(less so by some GPs) but there are systems & governance constraints to sharing. • Individual care plans for people with complex needs and chronic diseases are available but due to system constraints not always available to the right people. • Care coordination & MDT working is variable and is not consistently systemised in order to target high risk individuals. • Local RBA measures of performance agreed and baseline collated. Not systematically reported yet.
	South **Locality**		**Level 2/3**
Ceredigion	**North** **Locality**	Maturity assessed at level 2. LSB agreed SIP in place. Health & Social care executive group in place. Relationships with relevant organisations being developed.	**Level 2+** • Primary Care Locality Development Managers and GP leads in place in both North & South localities. Locality Managers recently appointed. Clinicians social care & voluntary sector brokers working within localities but locality team sub structure still to be agreed with partners and formalised. • Clinicians engaged in integrated care vision but not yet sufficient critical mass to accept responsibility for patient population & the wider system to make sufficient difference. (although seeing outcomes improve for individuals who have complex needs and being managed by an MDT). MDTs working well with some GP practices but not scalable across the county due to PC & community capacity constraints. • The need for sharing information is generally accepted but there are severe systems constraints including lack of hardware & access to systems. Ceredigion has the least developed electronic capability for record keeping & performance management within their localities and is reliant on paper based systems. • QP work within GP practices underway to risk stratify and care plan for highest risk patients but care coordination & MDT working is variable and is not consistently systemised. Similarly the discharge process across boundary of acute and community is not always consistently applied. • Individual care plans for people with complex needs and chronic diseases are available but due to system constraints not always available to the right people / services. • Local RBA measures of performance agreed and baseline collated. Not systematically reported yet.

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Provisional Assessment of Locality Maturity and Capability			
COUNTY	**LOCALITY**	**MATURITY (SEE KEY BELOW)**	**INTEGRATION CAPABILITY (OPERATIONAL)**
			• North Locality working takes account of differences in service provision across the border with Gwynedd and Powys when planning discharges from Bronglais
	South **Locality**		**Level 2+** Also include: • South Locality working takes account of differences in LA provision in Carmarthenshire and Pembrokeshire as residents generally flow to GGH for hospital care and may be discharged to joint care beds in either county.

Key to Maturity Levels

1. Basic level: Principle accepted and commitment to Action

2. Early progress: Early progress in development

3. Results: Initial achievements evident

4. Maturity: Comprehensive assurance in place

5. Exemplar: Others learning from our consistent achievements

Ongoing work across the four partners will ensure this assessment is built upon and further evidence gathered to inform ongoing service improvement

March 2014