

AGENDA ITEM 5**RHONDDA CYNON TAF COUNTY BOROUGH COUNCIL****CABINET****25TH JUNE 2015****RHONDDA CYNON TAF COUNTY BOROUGH COUNCIL, MERTHYR TYDFIL COUNTY BOROUGH COUNCIL AND CWM TAF UNIVERSITY HEALTH BOARD - JOINT COMMISSIONING STATEMENT FOR OLDER PEOPLE'S SERVICES****REPORT OF GROUP DIRECTOR, COMMUNITY & CHILDREN'S SERVICES**

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1. PURPOSE OF REPORT

To present a draft of the Joint Commissioning Statement for Older People's Services 2015-2025 and seek approval from Members for officers to undertake a period of public and stakeholder engagement in partnership with Merthyr CBC and Cwm Taf UHB.

2. RECOMMENDATION

It is recommended that Members:

- 2.1 Note the content of the draft Joint Commissioning Statement for Older People's Services 2015- 2025.
- 2.2 Note the accompanying draft public facing engagement summary and questionnaire.
- 2.3 Authorise a period of public and stakeholder engagement.
- 2.4 Receive a further report in October detailing the outcome of the public and stakeholder engagement exercise and recommendations for changes required as a result to the draft Joint Commissioning Statement for Older People's Services 2015- 2025.

3. BACKGROUND AND INTRODUCTION

- 3.1 In January 2014 Welsh Government announced the Intermediate Care Fund for 2014/15 for all regional collaboration footprints. The aim of the fund was to maximise support for people requiring intermediate care by developing new models of sustainable integrated services that maintain and increase people's well being and independence.

- 3.2 The Cwm Taf health & social care economy was awarded £4.37m non-recurrently, which included both revenue and capital funding. The proposal developed by Cwm Taf partners (including RCT and Merthyr local authorities, Cwm Taf UHB and the County Voluntary Councils) was informed by the “Statement of Intent – Integrated Care” (March 2014) and grouped in to five themes as follows:
- Project management and evaluation;
 - Laying the foundations for transforming services;
 - Promoting well being;
 - The significance of the physical environment; and
 - Commissioning for the whole health and social care economy.
- 3.3 To deliver this latter component it was agreed that a Joint Commissioning Statement for Older People would be developed across the Cwm Taf Region to:
- Replace the separate strategies and approaches of each of the public sector agencies.
 - Improve care co-ordination between health, social care, third sector and Housing;
 - Promote/maximise independent living opportunities;
 - Support recovery by increasing reablement provision;
 - Establish more proactive approaches; and
- 3.4 Avoid unnecessary admission or delayed discharge.
4. **JOINT COMMISSIONING STATEMENT FOR OLDER PEOPLE'S SERVICES**
- 4.1 The draft Joint Commissioning Statement is attached as **Appendix 1**.
- 4.2 The Joint Commissioning Statement has an overarching goal of moving away from a response that offers institutional care as almost inevitable and necessary for older people as they acquire increasing frailty, to responses which focus on outcomes, promote independence and prevent crises.
- 4.3 This will involve the three public sector agencies making very different choices, particularly in what they offer through their own services, as well as what they commission others to provide (either via the Third Sector, Social Enterprise or Independent Sector).
- 4.4 The Joint Commissioning Statement for Older People's Services is significant for Rhondda Cynon Taf CBC as it represents a public expression of our commitment to work in partnership with others and move towards the development of integrated services. It also reinforces how we intend to transform our services to focus on prevention, self-management and

independence within the spirit of the Social Services and Wellbeing Act (Wales) 2014.

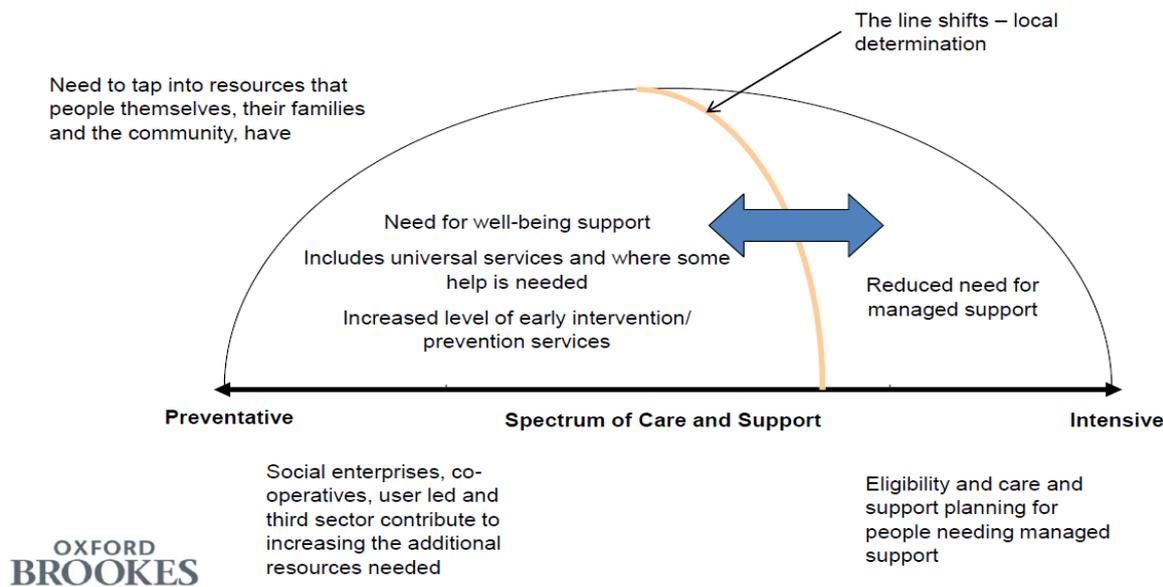
In summary we will need to:

- promote a model based on supporting people to stay “at home for life” with less emphasis on eligibility. This means that we will have to support our staff to work with people to assess and manage the risks associated with remaining independent at home;
- strengthen our preventative services for older people who do not currently need care or support from health or social care services;
- wherever possible support people to stay independent in their own homes through the provision of reablement, housing related support, aids and adaptations, telecare and an appropriate range of supportive accommodation;
- reduce substantially the need for people to be cared for in institutional environments such as residential and nursing homes;
- ensure the quality of services is assured and continues to improve.

4.5 Continuing with current models of service is not an option. There are considerable challenges that, if not managed innovatively, will see resources increasingly targeted only at those with greatest need.

4.6 Restricting the number of people receiving support to only those with the highest needs may result in a short term reduction in demand on services but without putting in place adequate preventative strategies, we will not secure longer term sustainability neither in terms of the effectiveness of outcomes for individuals nor from a financial and capacity perspective for formal health and social care services.

4.7 The service model agreed across the partner organisations is influenced by the requirements of the Social Services & Wellbeing (Wales) Act 2014 as illustrated in the diagram below.



4.8 The above is translated in this joint commissioning statement as a model of service with 3 inter-related levels:

- Community, Universal and Prevention Services.
- Early Intervention and Reablement Services.
- Specialist and Substitute Services.



4.9 The characteristics of these services are summarised below:

4.9.1 Community, Universal and Prevention Services

This fundamental “universal” level of service is available to anyone of any age within our communities (e.g. leisure services or primary care services). It seeks to support and build on the strength of communities and family support networks. In the context of the Social Services and Wellbeing (Wales) Act 2014, we see our role as public service organisations increasingly as nurturing and supporting these informal support networks.

Generally this means we will be:

- Working with people to promote independence, community engagement and social inclusion, strengthening social capital and re-circulating local resources.
- Meeting universal needs that all families and individuals have at one time or another, and ensuring that these services are easily accessible and available to all.
- Identifying those with emerging difficulties and making sure they get effective help quickly, by ensuring that early intervention, reablement and specialist services are closely linked.
- Providing people with good quality information and signposting them to the services they need.

4.9.2 Early Intervention and Reablement

For those who have needs which cannot be met purely by community, universal and preventative support, we will offer early intervention and reablement services to help them address their difficulties and recover their independence within the community to avoid the need for specialist or substitute care.

We will make sure that these services work closely with universal community and preventative services and where necessary they will identify and respond effectively to the needs of individuals and families with emerging problems by:

- Providing good advice and information so that people can get the right services.
- Focusing on those people that we can help best through early intervention and reablement.
- Responding quickly and flexibly enough to help them address their problems.
- Ensuring that our support is intensive enough to have a real impact.
- Working alongside people to help them build on their strengths.
- Working closely with colleagues in universal, community and preventative services to ensure support is well co-ordinated and comprehensive.

By improving our ability to respond quickly through early intervention and reablement, we will help more people to live fulfilled lives and reduce the need for specialist and substitute services.

4.9.3 Specialist and Substitute Services

The third level of services is for those people whose conditions or circumstances mean that they need longer-term specialist or substitute care or support. Examples In social care services include residential and nursing care, domiciliary care, and safeguarding services.

Health and social care services at this level will work in partnership to assess people's needs holistically, to be able to respond to their needs and wishes, supporting people to help build their independence, comfort and confidence.

The services will be centred on promoting choice and control, and will work with people to improve their quality of life in ways that work for them. We will ensure that people have access to good quality information and advice to help them make informed choices.

5. PUBLIC AND STAKEHOLDER ENGAGEMENT

- 5.1 A public facing document has been prepared outlining the key elements of the Joint Commissioning Statement (**Appendix 2**). This document simplifies the key messages contained within the statement
- 5.2 The public and stakeholder engagement will be active for 8 weeks throughout July and August 2015.
- 5.3 Initially the public engagement will be facilitated through questionnaires on the hub website and using a sample of service users and carers, in addition presentations to appropriate public meetings using existing networks (e.g. the older peoples forums, the health and wellbeing forum etc.).
- 5.4 The outcomes from the initial questionnaires will inform more focused group activity (picked for relevance) to explore any significant emerging themes.
- 5.5 A further report will be presented to Cabinet in October 2015. This will provide a record of the views and representations received during the engagement process and include recommended changes to the final Joint Commissioning Statement for Older People's Services

6. EQUALITY IMPACT ASSESSMENT

- 6.1 An Initial Equality Impact Assessment has been prepared for this statement which identified no negative impact. A full assessment will be reported to Cabinet following the engagement period in October



Appendix 1

Rhondda Cynon Taf County Borough Council, Merthyr Tydfil County Borough Council and Cwm Taf University Health Board

Joint Commissioning Statement For Older People's Services 2015- 2025

Version Control			
Version Ref	Status	Date	Author / Owner
1.1	Draft	3 rd July 2014	G. Davidson
1.2	First redraft following discussions with SMG including changes to scope.	20 th October 2014	G. Davidson
1.3	Including comments SS-E	30 th October 2014	G. Davidson
1.4	Including comments from Steering Group; 06.11.14 Including material contributed by steering group members.	2 nd December 2014	G. Davidson
2	Including comments from Steering Group	11 th December 2014	G. Davidson
3	Further comments	26 th January 2015	G. Davidson

4	Including comments from Strategic Managers Group and additional appendices	23 rd February 2015	G. Davidson
5	Including final comments from the Commissioning Sub-Group	18 th May 2015	Angela Edevane

1. Introduction

This commissioning statement describes a strong and shared commitment by Rhondda Cynon Taf (RCT) County Borough Council, Merthyr Tydfil County Borough Council, and Cwm Taf University Health Board (UHB) to ensure seamless and integrated health and social care services for our older population.

We recognise the invaluable role of Third Sector organisations and have developed our commissioning statement with this extended sense of partnership in mind.

We share a clear vision to transform the way we support individuals, families and communities, adopting a new model of integrated health and social care services. This document extends the commitment made in our “*Statement of Intent – Integrated Care*” (March 2014)¹ and describes the approach we will take to meet our new responsibilities under the Social Services and Wellbeing (Wales) Act 2014².

Our shared and agreed vision for Integrated Services is:

‘Supporting people to live independent, healthy and fulfilled lives’ to be achieved by providing health and social care services that are:

- Integrated, joined up and seamless.
- Focused on prevention, self-management and reablement.
- Responsive and locally delivered in the right place, at the right time and by the right person.
- Safe, sustainable and cost effective.

Statement of Intent – Integrated Care”(March 2014)¹

<http://www.cwmtafuhb.wales.nhs.uk/opendoc/246002>

² Social Services and Wellbeing (Wales) Act Welsh Government: 2014

http://www.legislation.gov.uk/anaw/2014/4/pdfs/anaw_20140004_en.pdf

That will:

- Promote healthy lifestyles and prevent ill health.
- Promote independence and protect the vulnerable.
- Improve services and joint working.

Throughout health and social care communities in Wales and other parts of the UK there is an increasing emphasis on finding ways to support people in ways that help them to retain their ability to live in the community, maximise their independence and give them choice and control over the services they receive. There is also an increased emphasis and requirement to engage people in preserving and improving their own health and wellbeing, supporting informal carers and encouraging people to play an active role in decisions about their health and wellbeing.

Substantial advances in preventative medical interventions and the promotion of public health have led to the population as a whole living longer. In spite of these successes, inequalities still remain in how these benefits are distributed within the population and there are financial implications due to expectations and demand from those who have been assisted to live longer. Local demographic changes, i.e. an increasingly ageing population, mean that significantly more people are likely to seek access to health and social care support over the next twenty years. This increase in demand will occur alongside challenges to the current pattern of services, as public sector spending also comes under increasing pressure. If care services were to simply increase in line with the population, this would lead to a near doubling of care costs between 2010 and 2026.

Continuing with current models of service is therefore not an option. There are considerable challenges that, if not managed creatively, will see resources increasingly targeted at those in greatest need. Restricting the number of people receiving support, to those with the highest needs, may result in a short term reduction in demand, but without adequate preventative strategies, we will not secure the sustainability that can deliver long term financial and workforce capacity, to guarantee better outcomes for people.

A whole system approach is required where public sector agencies work with third and private sector partners, to identify risk and take action before or at times of crisis, so that people can regain independence. There is a strong approach to partnership between our three organisations, along with our third sector partners, but this needs to be consolidated into a "whole system".

2. Our Shared Approach

2.1 Definitions

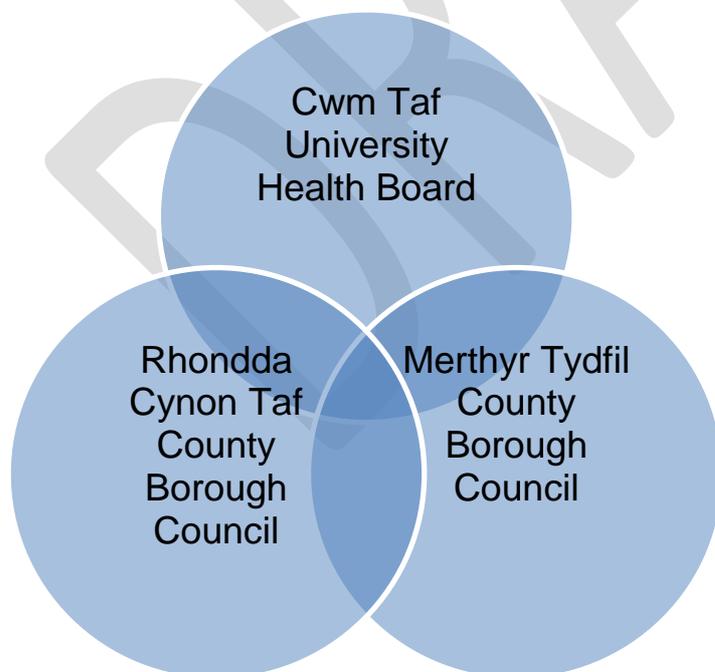
2.1.1 Commissioning

A commissioning statement is *“A formal statement of plans for securing, specifying and monitoring services to meet people’s needs at a strategic level. It applies to services provided by the Local Authority, NHS, other public agencies and the private and voluntary sectors”*.

2.1.2 Working together

As three public service organisations, we have developed, and will implement this strategy in partnership.

We recognise that, as public bodies with legislative duties, we have complex responsibilities. However these responsibilities overlap, and where they do, we are committed to working together and sharing responsibility. We recognise the importance of “common endeavour” and this joint commissioning statement identifies and addresses those areas of overlap/common endeavour.



Beyond the interrelationship between our statutory roles and functions, we know that we share considerable common endeavour with a variety of other organisations

ranging from small, informal community groups to larger regional and national organisations. We are committed to reinforcing and developing strong partnerships with these organisations.

2.2 Principles/Values

To underpin this commissioning statement we have agreed the following principles/values:

Promoting independence – Supporting individuals to retain independence in their own homes and local communities.

Prevention – Offering information and support which preserves health and wellbeing and prevents the need for more intensive services.

Early intervention – Identifying risks to people's independence early and providing effective interventions to address these.

Rapid response – A range of focused and responsive services which provide support at times of greatest need.

Integration of services – Health and social care services that work together to provide a seamless, whole system approach.

Community empowerment – Supporting individuals, families and communities to take control over the support that is offered.

Co-production - Delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours.

Partnership – Our organisations working together at every level to ensure that our collaborative efforts produce the best possible outcomes for our citizens and make best use of our resources.

3. National & Local Context

3.1 The national policy context

National policy over the last 5 years has focussed on service improvement, co-ordination between national and local government and greater integration of social care, health services and other agencies in Wales, notably the third sector. There is increasing emphasis on individuals and communities being at the centre of decision-making about their care and on providing care and support at home where possible. A full analysis of the national policy context is provided in Appendix 1.

The Social Services and Wellbeing (Wales) Act (2014) received royal assent on 1st May 2014. It reforms and integrates social services law and emphasises improving wellbeing outcomes for people who need care and support, including carers. It is intended that the Act will help Local Authorities and other partners address the challenges of changing societal expectations, demographic change and a difficult resource environment. The Act introduces a common set of processes for people, strengthens collaboration and the integration of services, and provides for an increased focus on prevention and early intervention.

The Act sets out a challenge for us to fundamentally reshape the way individuals, families and communities are supported by our statutory organisations. We need to ensure that people are at the centre of decisions about their health, care and wellbeing and to build on the strengths of individuals and their social and community networks.

This means that the relationship between professionals and people who require our services must change. Fundamentally we will be supporting people to take responsibility for their health and wellbeing. We will make sure that people can easily get good quality advice and information, to help them resolve their problems by making best use of resources that exist in their communities. We will encourage people to develop their own solutions that do not require complex assessment and formal provision of care. Where necessary, by using simple assessment processes that are proportionate to people's needs and risks, we will provide targeted and co-ordinated interventions, based on preventative approaches, which support people to continue to feel confident to live independently at home. Where people have complex needs which require specialist and/or longer term support, we will work with them and their social networks to ensure that high quality and cost effective services are available and to deliver positive outcomes.

This approach is illustrated in the diagram below which demonstrates that service provision can be dynamic in response to people's changing needs, providing targeted intervention and support where needed, enabling individuals to return to independence as quickly as possible, supported by continuing access to universal services and community support.

- Development of the @Home Service.
- Nursing Home Support.
- The establishment of 5 Community Co-ordinator posts.
- Implementation of the Extended Reablement Service.
- Continued dialogue with the Older People's Advisory Groups.
- The "Keep Well This Winter" scheme.
- Development of a Carers Strategy and the identification of Carers Champions across Cwm Taf.
- Remodelling of older people's mental health services.

The variety of service developments that we have implemented demonstrates our commitment to a "whole system" approach, including with the third sector.

Our initial approach to implementing the Social Services and Wellbeing (Wales) Act 2014 and the detailed guidance contained in "A Framework for Delivering Integrated Health and Social Care for Older People with Complex Needs" is described in our earlier document, "Statement of Intent: Integrated Care" (March 2014). This Joint Commissioning Statement clarifies our vision, defines our shared service model and describes our priorities for implementation.

3.2 Local Policy and Corporate Plans

3.2.1 Regional Collaboration and Single Integrated Plans

Our approach is based on partnership working across the regional Local Service Boards in Cwm Taf and the development of the Single Integrated Plans (SIP) for Merthyr and Rhondda Cynon Taf, produced to complement each other. The Plans do not belong to an individual organisation or department – these are the key overarching plans for both councils, developed in partnership with the third sector and University Health Board. Some of the key messages are:

- Early intervention- with the aim of either preventing things from worsening or, better still, occurring in the first instance.
- Inequalities- ensuring that we focus on our most deprived communities or most vulnerable groups.
- A culture change within each of the partner organisations ensuring a skilled, flexible and fit-for-purpose workforce.
- Better coordination- joining up services and activities across partner organisations.

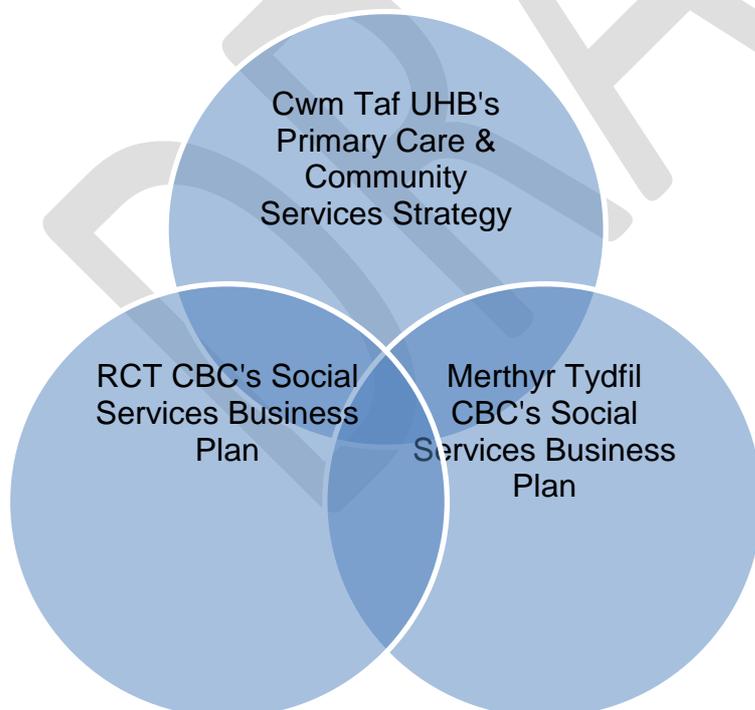
3.2.2 Cwm Taf University Health Board

In April 2014, Cwm Taf University Health Board published its first Three Year Integrated Plan: "Cwm Taf Cares", recently refreshed for 2015-18⁴. Within the Plan the UHB sets out its priorities and for older people these include:

- Further improving capacity and capability in primary care and community services.
- The development of intermediate care and integrated services.
- The remodelling of older people's mental health services.
- Continuing Healthcare.
- Promoting healthy lifestyles.

The UHB recognises that it cannot progress any of these priorities in isolation and is committed to working collaboratively with the local authorities and third sector to deliver this Joint Commissioning Statement. The UHB also aims to build capacity and capability in its primary care and community services which will be driven through the development of a new Primary Care & Community Services Strategy.

Its aim is to build capacity and capability in primary care and community services



⁴ Cwm Taf Cares: Cwm Taf University Health Board Three Year Integrated Plan 2015-18

4. Our Older Population

The table below shows that our adult resident population in 2013 was 231,670.

Table 4.1: Cwm Taf Population aged 18 and over, by age, projected to 2030

	2013	2015	2020	2025	2030
People aged 18-24	27,640	27,130	24,530	23,500	25,630
People aged 25-34	37,670	38,110	38,330	36,810	33,690
People aged 35-44	36,550	35,560	35,410	37,430	37,670
People aged 45-54	41,320	41,580	38,850	34,550	34,450
People aged 55-64	35,430	35,260	38,060	39,790	37,280
People aged 65-69	17,200	17,850	15,780	16,700	18,570
People aged 70-74	12,590	13,330	16,170	14,380	15,330
People aged 75-79	10,000	10,190	11,390	14,020	12,570
People aged 80-84	6,850	7,260	7,950	9,110	11,390
People aged 85 and over	6,420	6,580	7,700	9,260	11,350
Total population aged 18 and over	231,670	232,860	234,190	235,540	237,930

Source: Daffodil

Cwm Taf is geographically the second smallest Health Board area in Wales, but also the second most densely populated. Compared to the Wales average there are over three times as many people per square km living in the area. Within Cwm Taf, 20 per cent of the population live within the County Borough of Merthyr Tydfil with the remaining population in Rhondda Cynon Taf.

Merthyr Tydfil contains the smallest population whilst Rhondda Cynon Taf has the second largest population in Wales.

The age profile is similar to Wales, but with slightly higher proportions of children under 5 and people between 20-44 years old and a slightly higher proportion of people 60 and over.

In Cwm Taf there are over 53,000 people over 65 and over 23,000 people over 75. The local authorities successfully support more than 5,000 people over 65 to live in the community. This suggests that there are more than 48,000 people living in the community without formal support.

Table 4.2: Number of People Supported by Adult Social Care Services

Rhondda Cynon Taf	Merthyr Tydfil
4,444	1,121

Current projections see a rise in the total adult population of Cwm Taf to 237,930 by the year 2030. This represents an increase of **2.7%**.

However this figure masks a disproportionate increase in the older population. Overall, the population under 54 will decrease by c. 14,000 (10%). However, the table shows that we expect the number of older people to grow much more rapidly. By 2030, people **over 65 years** will increase from 53,060 to 69,210 (**30.4% increase**) and people **over 80 years** to increase from 13,270 to 22,740 (**71.3% increase**).

Meeting the needs of an increasingly ageing population will be a key challenge for the Partnership. In the current economic climate, the relative (and absolute) increase in people who are economically dependent and, in some cases, care-dependent, will pose particular challenges to communities.

4.1 People with Dementia

We expect dementia to be an issue of increasing significance for older people. Table 2 below shows the expected incidence of the condition in Cwm Taf.

Table 4.3: People aged 30-64 predicted to have early onset dementia, and people aged 65 and over predicted to have dementia, by age, projected to 2030

	2013	2015	2020	2025	2030
People aged 30-39 with early onset dementia	3	3	3	3	3
People aged 40-49 with early onset dementia	9	9	8	7	8
People aged 50-59 with early onset dementia	36	38	40	38	34
People aged 60-64 with early onset dementia	28	27	28	31	31
Total population aged 30-64 with early onset dementia	76	76	79	80	76
People aged 65-69 with dementia	214	222	196	207	231

	2013	2015	2020	2025	2030
People aged 70-74 with dementia	345	365	443	394	419
People aged 75-79 with dementia	586	597	665	819	735
People aged 80-84 with dementia	823	869	948	1,083	1,355
People aged 85 and over with dementia	1,494	1,527	1,771	2,118	2,586
Total population aged 65 and over with dementia	3,463	3,580	4,024	4,621	5,325

Therefore we expect to see the number of people over 65 with dementia growing from 3,463 to 5,325 (a **53.7% increase**) and for those over 75 from 2,903 to 4676 (a **61% increase**).

Generally we are seeking to improve our detection rates within the primary care service.

When combined with the projected increase in physical health needs, the overall impact upon health and social care services will be significant and therefore require a fundamental change in the way that these needs are addressed/ met.

4.2 Carers

The 2001 census shows that 12.6% of the population in Merthyr Tydfil and 12.5% in Rhondda Cynon Taf provide care to a family member, friend or neighbour. In 2001 in Rhondda Cynon Taf, there were 29,640 Carers and in Merthyr, 7,427 Carers a combined total of 37,067.

Of those carers that we know about, a total of 11,752 carers provide over 50 hours of care per week. This has increased by 9% in Merthyr Tydfil and 7% in Rhondda Cynon Taf since the 2001 Census.

It is possible that the number of carers is even higher, as the census indicates that 65,055 people reported a long term limiting illness, yet only 32,497 reported they were carers. Whilst not everyone with a limiting long term illness would have a carer, it is surprising the number of people reporting themselves as a carer is not higher.

Source: "Informed Carers Cwm Taf Carers Information and Consultation Strategy 2012-15"⁵

⁵ "Informed Carers Cwm Taf Carers Information and Consultation Strategy 2012-15"
<http://www.cwmtafuhb.wales.nhs.uk/opendoc/214939>

Table 4.4 below shows the rate change in the number of carers by age group. It can be seen that in both of local authority areas, we expect the number of carers over 65 to grow by more than 30%.

Table 4.4: Provision of Unpaid Care by Age: Percentage Change 2001 – 2011

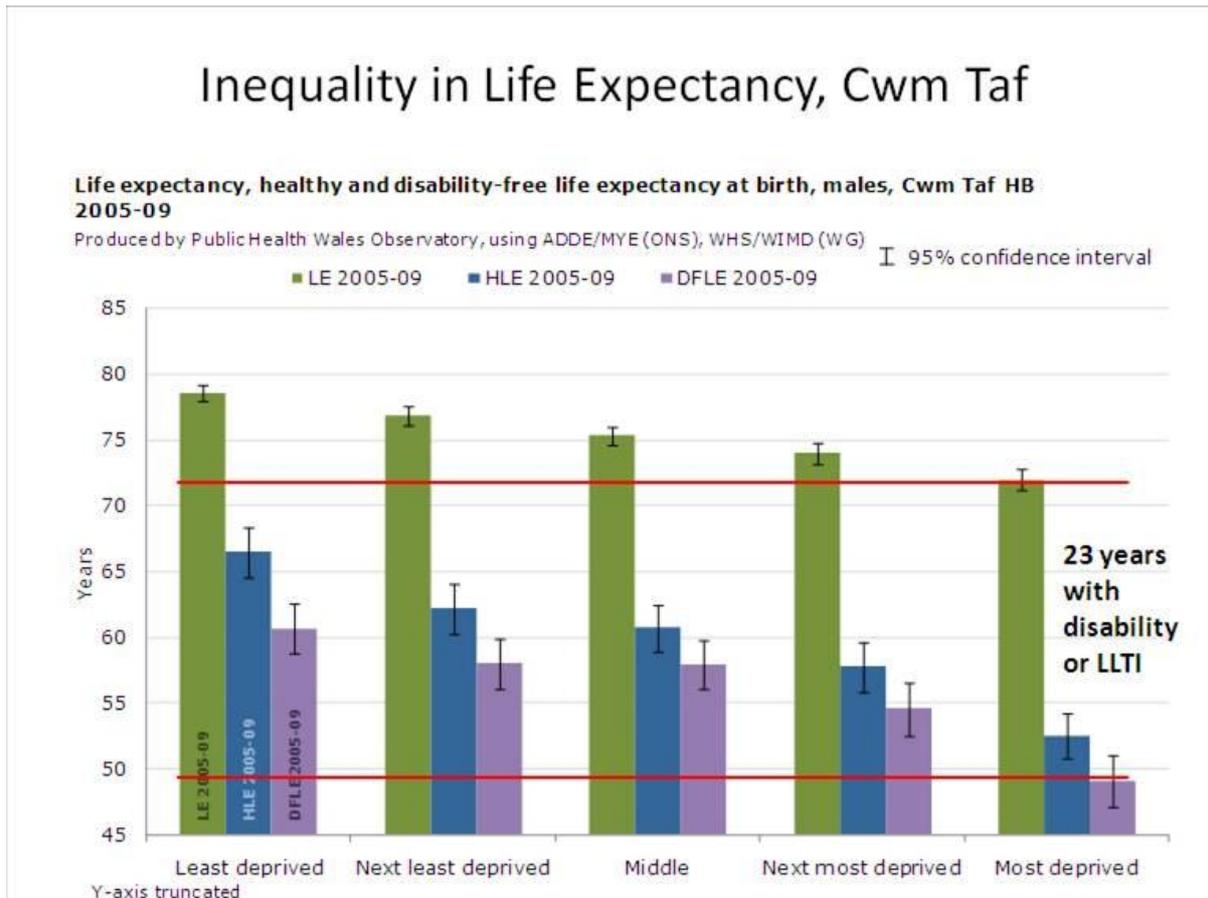
	% change 2001-2011				
	total	0-24	25-49	50-64	65+
RCT	2.3%	15.0%	-14.9%	5.5%	32.2%
Merthyr	5.4%	32.5%	-11.2%	8.5%	30.8%

Source: Office for National Statistics

4.3 Healthy Living Years

We are all familiar with levels of deprivation in our communities. Cwm Taf UHB is the most deprived in Wales with 34% of the population living in some of the most deprived areas of Wales.

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4.4 Key Messages

This analysis of our population gives us some important messages which we must make sure informs our future commissioning intentions:

Over the next 15 years, we expect:

- our adult population to increase by 2.7%
- our population of people over 65 years to grow by 30.4%
- our population of people over 80 years to grow by 71.3%
- our population of people over 65 years with dementia to grow by 53.7%
- our population of people over 80 years with dementia to grow by 61%
- The number of carers who are providing over 50 hours of care per week has increased by as much as 9% since 2001.
- The number of carers over the age of 65 has grown by over 30% since 2001.
- Cwm Taf UHB is the most deprived in Wales with 34% of people living in some of the most deprived areas of Wales.

- People in Cwm Taf area have one of the lowest life expectancies in Wales and a longer than average period of their lives limited by disability or long term illness.

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5. Our Service Model

An analysis of key government policy and an understanding of the future needs of our growing population of older people show that it is now time to reshape the way we offer support and care. To do this we need to:

- Adopt a “whole system” approach based on a strong partnership between health, social care and housing.
- Make sure we work in much closer partnership with the third and independent sector.
- Design and develop our services in partnership with citizens and other partners, informed by the principles of co-production.
- Ensure more people can access a broader “offer” of services from health and social care agencies and third sector and community groups.
- Ensure people experience less “interference” and more support from public agencies.
- Ensure our initial assessments seek to establish how much people and their support networks can do for themselves and how we can support that.
- Have mechanisms through which we can respond rapidly and effectively at times of increased vulnerability.

Promote a model based on supporting people to stay “at home for life” with less emphasis on eligibility. This means that we will have to support our staff to work with people to assess and manage the risks associated with remaining independent at home.

- Strengthen our preventative services for older people who do not currently need care or support from health or social care services.
- Wherever possible support people to stay independent in their own homes through the provision of reablement, housing related support, aids and adaptations, telecare and an appropriate range of supportive accommodation.
- Reduce substantially the need for people to be cared for in institutional environments such as residential and nursing homes.
- Ensure the quality of services is assured and continues to improve.

5.1 Our Vision

Together, we have adopted a common vision for integrated health and social care services for older people:

“Supporting people to live independent, healthy and fulfilled lives”. This will be achieved by providing health and social care services that are:

- Integrated, joined up and seamless.
- Focused on prevention, self-management and reablement.
- Responsive and locally delivered in the right place, at the right time and by the right person.
- Safe, sustainable and cost effective.

5.2 Outcomes

We need to be sure that we focus our attention on making a difference. We need to be able to see that the support that we offer has improved the health and wellbeing of our citizens. For that reason we need to be clear what “outcomes” we are seeking through this joint commissioning statement:

- Older people live longer, healthier and happier lives.
- Older people live life to the full and are enabled to maintain their independence for as long as possible.
- Older people who become ill, frail or vulnerable receive the care and support they need at the right time in the right place.
- All individuals and communities recognise the need to take more responsibility for their own health and wellbeing and are supported to do this.

We will maintain a clear focus on these and more specific outcomes, defined later in this document

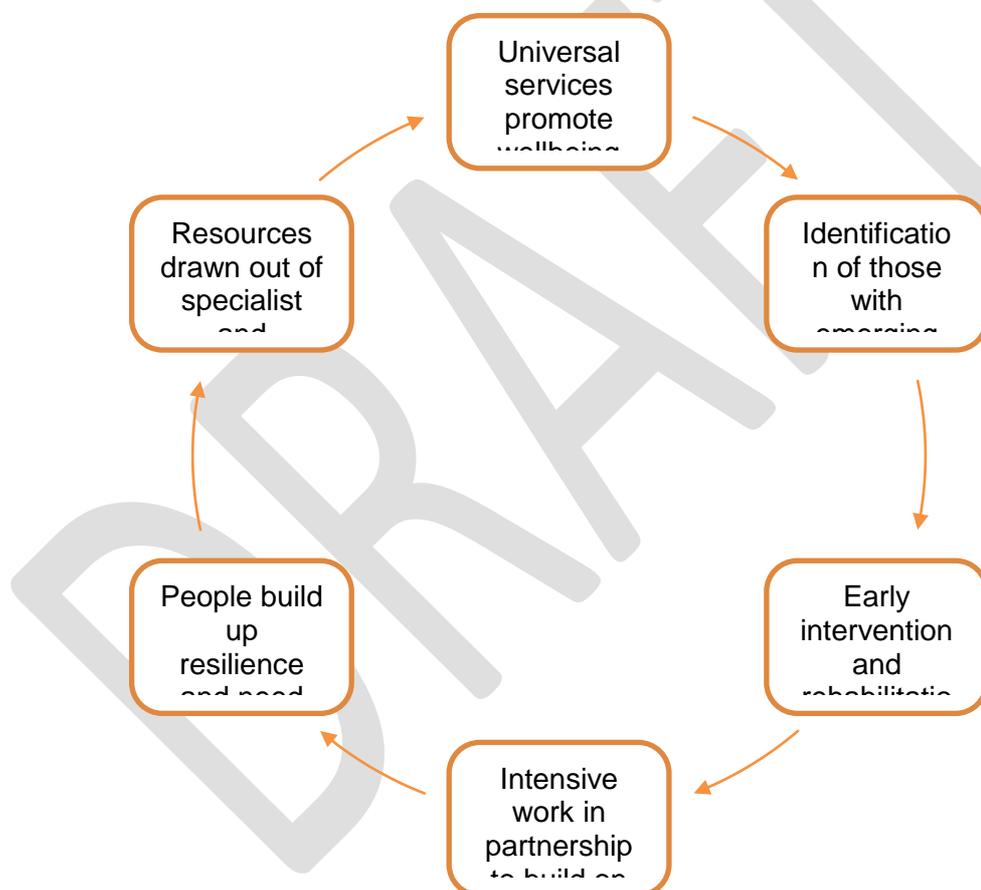
5.3 Our Assumptions

The starting point for our new model of service emphasises the key role of families and communities in offering support and care to their members. All our citizens are surrounded by a network of family, friends and neighbours that influence their quality of life. They in turn contribute to the community in which they live. This is perhaps especially true for our older community members.



Our role is to complement these networks by supporting people to continue to live fulfilled lives as they grow older, and when they need it, to help them tackle life problems (e.g. ill-health, bereavement, becoming socially isolated). This is important not only for the individuals concerned, but for the resilience, wellbeing and development of our communities as a whole. It is our intention to support older people who have become isolated to reconnect with their communities.

To do this we need to make the right services available at the right time, and ensure that they are efficient and well co-ordinated. By doing so we can support people as soon as they need it, help them to remain happily within their family and community, and for some, avoid expensive and disruptive specialist and substitute care. By doing this successfully over time we can also take some resources out of specialist and substitute care and into better community and universal services.

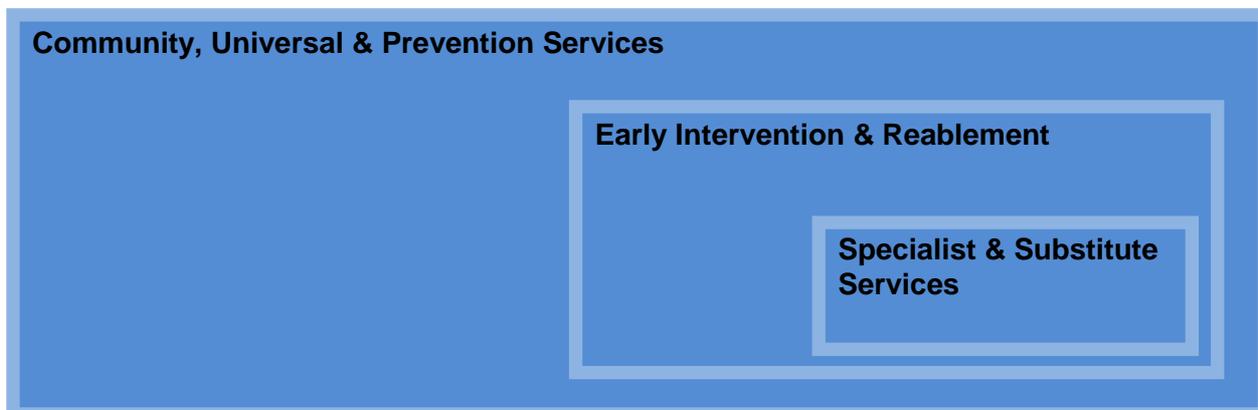


5.4 Our Service Model

Our service model is based on three tiers of support and we will enhance these tiers by building an integrated, co-ordinated approach to health and social care services (where they overlap)

- Community, Universal and Prevention Services.

- Early Intervention and Reablement Services.
- Specialist and Substitute Services.



The characteristics of these services are described below:

5.4.1 Community, Universal and Prevention Services

This fundamental “universal” level of service is available to anyone of any age within our communities (e.g. leisure services). It seeks to support and build on the strength of communities and family support networks. In the context of the Social Services and Wellbeing (Wales) Act 2014, we increasingly see our role as public sector organisations, as nurturing and supporting these informal support networks.

Through the provision and commissioning of a range of local services, we will ensure that our older people have the opportunity to stay healthy and safe for as long as possible.

Generally this means we will be:

- Working with people to promote independence, community engagement and social inclusion, strengthening social capital and re-circulating local resources.
- Meeting universal needs that all families and individuals have at one time or another, and ensuring that these services are easily accessible and available to all.
- Identifying those with emerging difficulties and making sure they get effective help quickly, by ensuring that early intervention, reablement and specialist services are closely linked.
- Providing people with good quality information and signposting them to the services they need.

5.4.2 Early Intervention and Reablement

For those who have needs which cannot be met purely by community, universal and preventative support, we will offer early intervention and reablement services to help

them address their difficulties and recover their independence within the community to avoid the need for specialist or substitute care.

We will make sure that these services work closely with universal community and preventative services and where necessary they will identify and respond effectively to the needs of individuals and families with emerging problems by:

- Providing good advice and information so that people can get the right services.
- Focusing on those people that we can help best through early intervention and reablement.
- Responding quickly and flexibly enough to help them address their problems.
- Ensuring that our support is intensive enough to have a real impact.
- Working alongside people to help them build on their strengths.
- Working closely with colleagues in universal, community and preventative services to ensure support is well co-ordinated and comprehensive.

By improving our ability to respond quickly through early intervention and reablement, we will help more people to live fulfilled lives and reduce the need for specialist and substitute services.

5.4.3 Specialist and Substitute Services

The third level of services is for those people whose conditions or circumstances mean that they need longer-term specialist or substitute care or support. Examples in social care services include residential and nursing care, domiciliary care, and safeguarding services. In NHS it will be community hospital services, continuing healthcare and respite care.

Health and social care services at this level will work in partnership to assess people's needs holistically, to be able to respond to their needs and wishes, supporting people to help build their independence, comfort and confidence. The services will be centred on promoting choice and control, and will work with people to improve their quality of life in ways that work for them. We will ensure that people have access to good quality information and advice to help them make informed choices.

5.5 Defining Our Role and Making it Happen

We have shown that we need to fundamentally reshape our services. We will now look in detail at each level of our service model, considering:

- **What specific outcomes we want to achieve.**
- **What key components of service we need to have in place?**

- **“What do we know”** - What do we already commission? Is it working? What are the issues? What needs to change?
- **What do we propose to do?** - What developments need to take place over the next 10 years? What will we stop doing or do less of?

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6. Community, Universal and Prevention Services

We see a key role for ourselves in nurturing supportive communities and family networks. The availability of easily accessible universal services together with general and targeted health and wellbeing initiatives is the foundation of our service model.

6.2 Outcomes

Outcomes define the difference we want to make. For our older citizens and their families and communities, we want to support the following outcomes:

- People are empowered to sustain their independence and live healthy lives in their communities.
- People are informed about, and can access, community and neighbourhood facilities that support wellbeing and recovery.
- People live in safe, sustainable and accessible homes.
- People have a greater sense of wellbeing.

6.3 Key Functions

The key components of our role in supporting strong communities through universal and preventative services are as follows.

- Supportive Communities – Building Community Capacity & Resilience.
- Information advice and support.
- Health and Wellbeing.
- Housing Related Support.
- Responsive Primary Care Services.

6.4 Supportive Communities – Building Community Capacity

The Department for Social Development in Northern Ireland describes capacity building as *‘the process of supporting individuals and community organisations to help them better identify and meet the needs of their areas. It involves building on the existing skills, providing opportunities for people to learn through experience and increasing people’s awareness and confidence to enable them to participate more fully in society.’* (DSD 2009) ⁶

⁶ “Report of the Project Team”: North Belfast Community Action Project; May 2002

Strong, supportive communities help people to maintain health and wellbeing and retain their independence and dignity. Risks to health and independence can be identified early and local support can be mobilised. Informal social networks can be supported by volunteers and carers support services.

6.3.1 What Do We Know?

Cwm Taf has a proud legacy of well-connected networks and strong communities. We have recently employed “Community Co-Ordinators” whose work demonstrates that there are significant numbers of informal and formal community organisations carrying out vital work in Towns and villages throughout Cwm Taf.

The Community Coordinators have found that, although there are various community groups for older people to join, there is a significant need for 1-1 support for those who are house-bound. There are long waiting times for befriending services and some organisations struggle in particular areas (such as the Rhondda and Cynon Valleys) to recruit volunteers to deliver these services effectively.

Many third sector organisations report that current commissioning practice can be overly bureaucratic, emphasise price over quality and prevent collaboration between agencies. On the other hand, commissioners report difficulty in evaluating the impact of third sector organisations, that there is duplication of services and a lack of information about how the services operate.

Generally commissioning with the third sector is in the form of high value contracts to organisations to deliver relatively “formal” services. Limited funding is available to generate informal, local initiatives to increase community capacity. We are undertaking a more detailed population needs assessment and this will identify more accurately what informal services are needed at a local level. Reliance on formal contracts for large services will be reduced and investment targeted at local, smaller and lower cost initiatives.

The two County Voluntary Councils (CVCs) are umbrella third sector organisations and will have a fundamental role in developing and supporting the community and voluntary sector across Cwm Taf. They can explore and build on evidence of what has been working elsewhere, both nationally and internationally, and also provide funding, development support, and training. In future, we see a greater role for the CVC’s in building community capacity and linking with commissioners to promote collaboration, quality and sustainability.

6.3.2 What do we propose to do?

Our response to the Social Services and Wellbeing (Wales) Act 2014 will require that we ensure we have a network of formal and informal community/third sector

http://www.taristeachnorthbelfast.org/nbcau_dunlop_report.pdf

arrangements. We will rely on this network to ensure we are able to signpost people effectively and confidently.

We will have a responsibility to identify the needs of the population and in shaping and nurturing the 'market' to make sure those needs are met. Some of the shaping will be in the form of direct commissioning arrangements for a particular service but in order to nurture the community capacity, we will need broader and less prescribed funding initiatives alongside mechanisms to co-ordinate effort.

We believe that the CVCs will have a key role in building the capacity of our communities. We will work with Interlink RCT and Voluntary Action Merthyr Tydfil to review, develop and formalise their future role to ensure that they can continue as strong partners in the delivery of our vision of supporting our older citizens. Specifically, we will reshape our agreements with these organisations, delegating more responsibility for them to:

- Shape the local third sector 'market' using more collaborative models of commissioning.
- Implement a collaborative campaign around volunteering and befriending by and for older people and develop more extensive networks of volunteers.
- Make sure information about the availability of third sector support is easily accessible for the public.
- Develop low cost models of delivering services to address isolation and improve wellbeing, building on our existing local assets (both human and physical), and supporting volunteer and community based approaches.
- Develop a comprehensive information system to support a Single Point of Access for the public access to services, ensuring third sector investment in gathering, updating, accessing and promoting information.

6.4 Information advice and assistance (IAA)

All citizens need to have access to good quality information. The organisation of our services is often complex and by working together we need to simplify this and, where necessary, help people to navigate their way around our systems.

We need to make sure we have clear and well-publicised websites, single points of telephone access and good quality written information. There are also opportunities to consider how to actively seek out people who could benefit from information and advice, and from supporting staff to deliver a system where “no door is the wrong door”, ensuring that every contact made with a person counts as an opportunity to signpost people to appropriate information and support.

6.4.1 What Do We Know?

Both local authorities operate central telephone contact centres. These are the “single point of contact” for all council enquiries and provide a “first response service”

for all adult social services enquiries. There are dedicated customer services staff that deal with social services enquiries providing early intervention and prevention through advice, information and advocacy in RCT, but this arrangement is not replicated in Merthyr.

They each produce leaflets and both have a website, but keeping these up-to-date is a challenge. In the absence of clear internal pathways for information updates, there remains a risk that out-of-date information will remain on the website and in the public domain.

Recent consultation with deaf and hearing-impaired user groups has identified improvements which could be made for them to better access information.

We recognise that we need to:

- Develop a directory of services and ensure systems are in place to ensure good quality and up to date information is available
- Identify a clear process for updating and sharing information, so both councils' websites and any other information are available and accurate.
- Place the research and information team at the "front" of the adult services model to ensure First Response and the preventative services are supported with up-to-date information on both social care options and other community options.
- Improve the sharing, production and provision of information with partner organisations to ensure where possible we reduce duplication. This will include the information compiled by the community coordinators.

6.4.2 What do we propose to do?

The Social Services and Wellbeing (Wales) Act 2014 places greater responsibility on us to collate and provide information and advice to people to enable them to manage their support needs. The implications of the Act will be identified during 2015 and the actions required to meet its requirements will be managed through the Cwm Taf regional implementation plan.

Based on the guidance accompanying the Act, there will be the development of an information and communications strategy which will embed the principle that the information, advice and assistance service will be the first line of contact to social care services. It will describe how we work together to ensure we have good systems to:

- Support people to access information on services available to meet their wellbeing needs.
- Record information and advice provided.
- provide people with information on:
 - o How the care and support system operates;

- o The types of care and support available;
- o How to access the care and support that is available; and
- o How to raise concerns about the wellbeing of a person who appears to have needs for care and support.

It is expected that in addition to the above actions we will:-

- Launch a safeguarding website.
- Improve the intranet and public facing website.
- Improve access to information for deaf and hearing-impaired people and other minority groups.
- Ensure access points and public information sites have good information on community services to enable signposting to other agencies as appropriate.
- Maintain pace with technological changes to the way people access information.
- Establish improved links with partner agencies to reduce duplication of information provision.

6.5 Health and Wellbeing

The Social Services and Wellbeing (Wales) Act 2014, places upon us a clear responsibility to promote the health and wellbeing of our citizens. We will ensure we provide a greater range of accessible services so that our older citizens have the opportunity to stay healthy and maintain independence for as long as possible. We know that initiatives such as exercise referral, healthy eating and falls prevention schemes can make a significant contribution to promoting continued good health and independence.

6.5.1 What Do We Know?

The three public sector bodies commission a variety of health and wellbeing services predominantly from the third sector. There is a clear opportunity to align these processes into more co-ordinated commissioning activity across Cwm Taf with robust contracts/service level agreements/grant agreements which ensure strategic alignment and best value for citizens.

Through the use of the Intermediate Care Fund we have been able to trial new and innovative approaches, examples of which include:

- 5 Ways to Wellbeing (Merthyr and Valleys MIND).
- Interlink RCT AND VAMT– Community Co-ordinators.
- The use of a Community Capacity fund managed by the CVCs to support enhancing community capacity

The National Exercise Referral Scheme is well established across Cwm Taf and opportunities exist to explore how we can expand/evolve this further

Cwm Taf has seen significant success in reducing smoking rates over recent years, achieved, in the main, through the provision of smoking cessation services and brief interventions

The UHB continues to expand the Education Programme for Patients, which is a self-care initiative supporting people to look after their own health and wellbeing.

The UHB is working on the implementation of the Carers Strategy including working with University of South Wales to deliver Carer Awareness workshops to undergraduate qualifying programmes for nurses and social workers. Additionally we have:

- Recruited 190 Carers Champions across Cwm Taf.
- Secured funding via the Intermediate Care Fund to develop Carer Protocols in 8 GP Practices across Cwm Taf.

An analysis of the way in which we commission health and wellbeing services leads us to the following conclusions:

- We currently commission services separately that can result in the duplication of services by other commissioned services. Given the level of investment we have to be clearer in how these services add value.
- We commission services based on service user categories rather than to support the wellbeing of people generally.
- We invest in isolation of each other and therefore are unaware of what each agency is funding, which may lead to duplication or the creation of gaps (LA, NHS, Social Services, Children and Adults, Communities First, Supporting People).
- We have no effective means of measuring the overall success of what each of us is doing with regards to the health and wellbeing of the population – not all of this is deliverable in the long term.

6.5.2 What do we propose to do?

Together, we have identified the following areas for further development:

- Joint commissioning of third sector services (where there is common endeavour), using the definition of wellbeing in the Social Services and Wellbeing Act (Wales) 2014 and the requirements in the National Outcome Frameworks (also the Future Generations Bill) to structure our approach.
- Further expansion and development of the Education Programme for Patients.
- The further expansion and development of volunteering opportunities.

We propose to take the following action:

- Implement a community weight management programme.
- Develop and implement the Housing & Health Action Area (Taylorstown).
- Develop a National Asthma and Housing best practice module for use by housing and health practitioners.
- Develop a Pilot Falls Prevention Programme in Sheltered Housing Schemes (RCT Homes).
- Organise Health & Wellbeing Events with each of the five 50+ Forums that will be open to the wider public too.
- Implement an accredited Carers Protocol award for GP Surgeries for Recognition of Carers.
- Continue to recruit Carers' Champions.

6.6 Housing Related Support

We recognise that there are risks associated with ageing and frailty that can challenge people's wish to remain independent in the community. There will an increasing number of older people living alone by 2030, so it is crucial that a range of services are available to support people to remain in their own home, alongside alternative housing and support options, if they want and need somewhere that is easier to maintain and more suitable.

- Relatively modest services, provided at the right time, can have a major impact on the quality of life for excluded older people... (Office of Deputy Prime Minister- Excluded Older People- 2005.⁷).
- Simple, low level services- such as home visits can reduce mortality and admission to long term care (Elkan et al 2001 – BMJ⁸).
- Reducing fuel poverty and supporting people to make improvements to their living conditions through warmer homes could reduce yearly excess winter deaths of 35,000 in 2008/09.

6.6.1 What Do We Know?

The majority of older people want to continue living in a home of their own for as long as possible. As services move away from buildings-based interventions, a person's home and their involvement in their community will become the focus for a wider range of services, supporting older people, in particular, to live safe, meaningful, healthy, inclusive and active lives.

⁷ Excluded older people: Social Exclusion Unit interim report: ODPM, 2005

⁸ Effectiveness of home based support for older people: systematic review and meta-analysis: Elkan et al, BMJ 2001

With an increasing focus on independence and the provision of preventative services, housing-related support services will need to be available to a much wider range of people regardless of their tenure. The services that we commission will be expected to play an important role in supporting older people at times of change or transition and before they develop more limiting, complex and disabling conditions.

6.6.2 What do we propose to do?

We have already begun to enhance and improve the range of wellbeing or housing related support that is available to older people, who may not have a health or social care need, but require some support and assistance following a change in their circumstances.

In response to such a need, a whole scale review of services for Older People funded by Supporting People is underway. This will ensure that the recommendations from the Aylward review can be met, whilst also ensuring that support services continue to be available and are targeted to those older people most in need.

6.7 Responsive Primary Care Services

Primary Care and Community Services provide the first point of contact between an individual and a healthcare professional in approximately 90% of contacts with health care services. The role of primary care services is to:

- Provide a first point of contact with healthcare services.
- Offer continuity of care (diagnosis, prescribing and care management).
- Provide a universal service co-ordination of care 24/7 across primary, secondary and social care systems.
- Improve the health of the population through health promotion and primary prevention.

6.7.1 What Do We Know?

One of the UHB's top priorities under its 3-Year Integrated Plan is to develop a new vision for primary care and community services. This has recently been completed. We have used several different sources of information to highlight some of the emerging priorities:

- Outputs from the 4 public fora that we have facilitated for several years.
- Themes from our Stakeholder Reference Group.
- Review of our complaints.
- Surveys at 'Big Bite' community events.
- Information from our Community Health Council colleagues.

Some of the key themes which have arisen are:

- Timely access to GP appointments.
- Access to GP of choice to aid continuity.
- Local access to services rather than provision at acute hospital sites.
- More services provided within patients' homes for older people .
- More joined up services between health and social care and across different elements of health.
- Support at home on discharge from hospital.
- Services at home to stop people having to go unnecessarily into hospital.

6.7.2 What do we propose to do?

The UHB is proposing to remodel primary care services to include the following key levels of service:

- **Self-Care & Staying Healthy** - Maintaining healthy lifestyles.
- **Advice and Support** - NHS Direct, 111, Third Sector and Social Media.
- **Core Primary Care Service** - GP, Dentist, Optometrist, Pharmacy, District Nursing, Health Visiting, School Nursing, Community Midwives, Range of Diagnostics etc within or as close to home as possible.
- **Cluster Hubs (Locality)** - More complex services across more than one GP Practice often in partnership with other professionals provided from specific GP premises or within a community facility such as a Cluster Hub or Health Park within each locality i.e. Dewi Sant, Ysbyty Cwm Rhondda, Ysbyty Cwm Cynon, Kier Hardie Health Park.
- **Intensive Community Services** - Specialist Nursing, Community Resource Services e.g. the newly integrated @home service, targeted at frail older people at home and within nursing & residential homes.
- **Rehabilitation Beds** - Beds for "step-up" from community and "step-down" from acute hospitals provided at Ysbyty Cwm Rhondda and Ysbyty Cwm Cynon.
- **Acute Services** - GP OOH's and "in-reach" services at PCH & RGH.

Key elements of this model relating to integrated health and social care services are:

- **GP Cluster Plans** – Where GP practices within our localities will work together to identify top priorities for the local population and work together to achieve them.
- **Cluster Hubs** – Modeled on Kier Hardie Health Park, these sites will be able to provide services that cannot be provided in local GP surgeries or health centres but do not need to be provided in our hospitals. We wish to develop a

Primary & Community Hub in each locality which is likely to be provided out of the following facilities in the main:

- Kier Hardie Health Park
 - Ysbyty Cwm Cynon (YCC)
 - Dewi Sant
 - Ysbyty Cwm Rhondda (YCR)
- Merthyr Tydfil
Cynon Valley
Taf Ely
Rhondda Valleys

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7. Early Intervention and Reablement

For those who have needs which cannot be met purely by community, universal and preventative support, we will offer time-limited and goal orientated services to help them address their difficulties, by supporting them to recover and regain their independence preventing the need for specialist or substitute care. We will ensure a “whole system” approach where older people and their support networks will experience a single integrated care pathway.

7.1 Outcomes

Outcomes define the difference we want to make. For our older citizens and their families we want our targeted early intervention and reablement services to be defined by the following outcomes:

- People have greater control and choice over their lives.
- People are able to access recovery, reablement and rehabilitation services wherever they live.

7.2 Key Functions

The key components of our role in supporting strong communities through universal and prevention services are as follows.

- Single Point of Access.
- Integrated Assessment Process.
- Reablement Service.
- Integrated community health and social care services (@home service).

7.3 Single Point of Access

A Single Point of Access (SPA) forms a key component of our model for integrated health and social care services for older people. It enables professionals to respond quickly and effectively to enquiries and referrals. Speedy co-ordinated interventions are playing a significant role in preventing avoidable hospital admissions and effectively managing long-term conditions in the community.

The Single Point of Access exists at the interface between primary care, community, universal and preventative Services and rapidly accessing integrated community teams and reablement services. It also can act as a central point for the provision of good quality information and signposting to appropriate community support services.

The exchange of patient information supports professionals to make co-ordinated assessments and interventions.

7.3.1 What Do We Know?

We currently have contact centres in Rhondda Cynon Taf and Merthyr which act as a first point of contact for the citizens of Cwm Taf and other professionals with whom they have contact. These provide a gateway for people to access a range of preventative services to maximise their independence as part of the assessment process.

The contact centres provide information and advice and where appropriate redirect or signpost people towards support from other organisations. However we know that the potential for signposting is not supported by well organised information.

7.3.2 What do we propose to do?

In the context of the development of our Integrated Health and Social Care Service (see section 7.6) we will develop a joint Single Point of Access (SPA) to be the entry point for the integrated @home service across Cwm Taf. We will ensure the service consists of health, social care and third sector staff.

The SPA will manage initial calls for support, gather information and support the caller to identify possible solutions to help them. This may include the provision of information and advice, referral or signposting to a community-based resource or referral into the wider @home service for a period of reablement or for further assessment of their needs

Part of the development of @home services will be strengthening third sector activity and the ability of SPA to directly commission these services – i.e. shopping calls, community activities, befriending schemes.

We expect to develop the SPA to have the ability to review and amend service provision, preventing duplicate services going into a person's home, e.g. hospital discharge – home care package restarted for existing service users alongside intermediate care.

7.4 Integrated Assessment Process

In December 2013, WG published the guidance document; “Integrated Assessment, Planning and Review Arrangements for Older People”⁹. This guidance sets out the responsibilities and duties on health and social care services to provide integrated arrangements for assessment and care management for older people.

⁹ Integrated Assessment, Planning and Review Arrangements for Older People: Welsh Government, 2013

<http://www.rcpsych.ac.uk/pdf/131217reporten.pdf>

7.4.1 What Do We Know?

An initial pilot scheme on direct discharge arrangements to social care across Cwm Taf provided the basis for the development of an integrated assessment process.

In line with WG guidance, a Project group was established. Guidance requires the UHB and LAs to have “integrated wellbeing, assessment, care support planning and review arrangements specifically to support older people, which will support the wider agenda and be the catalyst to support the broader integration of care.”

We have already achieved the following:

- A common local assessment template meeting the national minimum core data set has been agreed and is now used by the two Local Authorities and UHB.
- An Integrated Assessment referral form is now used for referring patients from hospital to both local authorities.
- The format for collecting the national minimum core data set is now consistent across all agencies.
- Where a more complex assessment is required, it has been agreed that this will include a compendium of one or more professional assessments.
- A WASPI Information Sharing Protocol has been developed.
- A patient information leaflet has been developed to be given to each patient where it has been identified that their information will be shared.

7.4.2 What do we propose to do?

The integrated assessment documentation is shared in paper format as there is no single IT system across health & social care, which inhibits the sharing of current information relating to people supported.

A detailed action plan for the Integrated Assessment Process is currently being prepared.

7.5 Short Term Intervention and Reablement Service

Reablement has been defined as ‘services for people with poor physical or mental health to help them accommodate their illness by learning or relearning the skills necessary for daily living’¹⁰

A reablement intervention usually lasts between six to twelve weeks and for the initial six-week period is not chargeable. The focus of Reablement is to promote

¹⁰ Homecare Reablement: Retrospective Longitudinal Study: White Rose University Consortium, 2007
<http://eprints.whiterose.ac.uk/73250/1/Document.pdf>

independence in activities of daily living, e.g. mobility, personal and domestic occupations, restoring confidence and regaining the ability to engage more fully with the community. This is an integrated health & social care team for people who are able to engage with rehabilitation and enabling approaches, directly following a hospital admission or when at home and experiencing difficulties. Rehabilitation would traditionally have been received in a community hospital setting but, through this service, can be delivered within the person's home.

There is a recently developed specialist element to the Reablement service, which focuses on people with mild to moderate cognitive impairment or dementia.

7.5.1 What Do We Know?

Short term intervention and Reablement services across Cwm Taf are provided jointly by the local authorities and the UHB. The service has been reconfigured to:

- Ensure that people's independence is maximised as part of the assessment process.
- Reduce bureaucracy in the system to maximise the resources available and improve response times.

The short term intervention services have been successful in achieving these outcomes and they are working effectively. However there is further scope to enhance these services through further integration of elements of health services into a single service.

The key issue for short term intervention services is that of increasing demand, exceeding the current capacity. In addition to increasing numbers of people requiring support, there has been an increase in the level and complexity of community support packages required.

Whilst there has been a significant level of integration within these services, there is scope to integrate health, social care and third sector services still further. Our ambition is to develop that more fully in the newly integrated @Home service.

7.5.2 What do we propose to do?

A key priority for 2015/16 will be the development of an operating model and implementation plan for the @home service, which will pay due consideration to:

- Single point of access
- Integrated management arrangements.
- Single assessment process.
- Further link with voluntary sector services.
- Development of the information and advice service.
- Pooled budget arrangements.

- Future configuration of service.

7.6 Integrated Community Health and Social Care Services

“A Framework for Delivering Integrated Health and Social Care for Older People with Complex Needs” identifies that the purpose of integrated health and social care systems is “...to improve care and support for people. This means ensuring people have more say and control over the care they receive. People should experience care and support that is seamless. Not a fragmented series of interventions than can lead to confusion, disruption and poor outcomes..... This requires integrated working between local authorities, health and housing, with the third sector and independent sector.”(WG, 2013)

A key principle of our service model is for health and social care professionals to work together, taking a holistic approach to the needs of older people, identifying vulnerability early, responding swiftly and effectively and supporting people to regain independence.

7.6.1 What Do We Know?

Primary and Community health services within Cwm Taf are now managed on a locality basis by two Locality Management Teams:

- Rhondda and Taff Ely.
- Merthyr Tydfil and Cynon.

These teams deliver services as close to peoples’ homes as possible with a holistic approach. It is already showing benefits for service users in terms of quality of care, access and timeliness.

The key component to our integrated health and social care service are our current @ Home Services, that are being developed unit the newly integrated @home service, referred to elsewhere in this statement. Currently @home is the overarching name for a range of services provided in the community which include the existing core health services of:

- Palliative Care.
- Community Mental Health.
- Parkinson’s and other chronic disease Nurse Specialists
- Community Integrated Assessment Service (CIAS).
- Community Ward.
- Community IV Service
- Nursing Home Support Team.

The @Home model was launched in October 2012 and in its first year:

- CIAS avoided 344 admissions to hospital;
- 2,037 acute bed days were avoided via the Community IV Antibiotic service; and
- 1,498 patients were discharged from hospital to a Reablement programme.

The current @Home service also works closely with a range of other services including:

- Joint Emergency Therapy Team (JETT).
- Early Supported Discharge Team for Stroke

There are a range of social care community-based services that work in partnership with those delivered via the current @home service, where people require a range of support services to enable them to remain in the community these include

- Intermediate Care Services
- Assessment and Care Management services
- Community Occupational Therapy services
- Day Services

Whilst these services collaborate on an individual basis the only integrated service that operates across health and social care in the community Reablement service

7.6.2 What do we propose to do?

Our intention is to integrate health & social care services to improve the outcomes for older people. We will achieve this through the development of a clear action plan outlining how this will be undertaken. It will include:

- Implementing the agreed operating model.
- A communication plan to ensure that workers in all agencies and the public understand the changes that are being put in place.
- Expanding and embedding the newly integrated @home service as the foundation for supporting older people who need care and support to regain and retain control over their own lives.
- Building strong alliances with GPs and other primary care workers so that there is one system that everyone uses, with the aim of offering consistent and improved outcomes for older people and their carers.

8. Specialist and Substitute Services

The third level of services is for those whose conditions or circumstances mean that they need longer-term specialist or substitute care or support, which can be delivered in their own home or an alternative setting. Examples of such social care services include residential and nursing care, domiciliary care, and safeguarding services.

Substitute services would only be provided when it has been determined that the person is not able to regain their independence and their needs can only be met through interventions by public sector services. The provision of services at this level would be in response to a holistic assessment that takes into account people's needs and wishes. They will be centred on promoting choice and control, and will work with people to improve their quality of life in ways that work for them. We will ensure that people have access to good quality information and advice to help them make informed choices.

8.1 Outcomes

Outcomes define the difference we want to make. For our older citizens and their families we want our specialist and substitute services to be defined by the following outcomes:

- People are able to receive the right care in the right place by the right person at the right time.
- People who can no longer stay at home will be able to access high quality specialist care which is as close to their local communities as possible.
- People who require long term, specialist care are supported, treated with dignity and encouraged to retain their independence.

8.2 Key Functions

The key components of our role in commissioning and/or providing high quality specialist and substitute services are.

- Equipment and adaptations service.
- Telecare.
- Long Term Domiciliary Care.
- A range of supportive accommodation including extra care housing and residential and nursing home provision.

8.3 Equipment and Adaptations

Community equipment services play a vital part in supporting people to live independently in their own homes and although considered a specialist service it also supports short term interventions enabling people to maintain their independence.

Suitable adaptations can be made to people's homes so they continue to be suitable environments for them to lead meaningful lives whilst receiving care and support. It is important that adaptations take place quickly and efficiently in order to avert the need for placement into institutional care and to ensure speedy hospital discharge.

8.3.1 What Do We Know?

The provision of suitable aids and adaptations assists people to remain independent and provides a suitable environment where their support needs can be met in their own home. There is an existing regional partnership in place for the provision of equipment supported by a Section 33 Agreement (NHS Act (Wales) 2006).

Both local authorities and UHB commission Care & Repair separately to support low level adaptations to people's homes.

8.3.2 What do we propose to do?

In response to these issues, we agree that we need to:

- Review the provision of equipment under the current agreements with partner organisations.
- Agree future equipment provision, to include what provision would be seen as preventative, what equipment we would signpost people to purchase for themselves and what equipment we would expect to be provided by partner organisations.
- Review our current contracts with Care and Repair and consider jointly commissioning their services.
- Support Care and Repair to develop the provision of services directly to the public at a reasonable cost.

8.4 Telecare

We expect telecare services to play an increasingly important role in supporting people to live independently at home. Telecare systems use telecommunication and computerised services such as sensors and alerts to provide continuous "live" monitoring of care needs and emergencies. For example sensors can detect falls, or when a person gets out of bed, or leaves their property. These sensors can be connected to alert a call centre, family, or live-in carer.

In most cases the provision of telecare equipment must be supported by the availability of a rapid response at any time of day or night. So when considering our telecare service, it is important that we consider our capacity to respond to alerts and emergencies.

8.4.1 What Do We Know?

The largest component of assistive technology utilised is Telecare which is available throughout Cwm Taf and operates alongside the directly delivered care call systems operating in Merthyr and Rhondda Cynon Taf.

The telecare services are established and can be subdivided into 3 Tiers:

- Tier 1 - Lifeline only.
- Tier 2 - Home safety environment package.
- Tier 3 - Assessed Need.

With the exception of the lifeline component, there is limited take-up of telecare services in Cwm Taf.

Initially the focus has been on those services categorised as Tier 2, however there has been an increased focus on Tier 3 services to support people to remain at home as they assist in the management of risks in the community especially in relation to people with a dementia.

The range of stand-alone assistive technologies available continues to grow providing technological solutions to support people to remain independent.

The response to activation of equipment is limited to family members and the emergency services and it is yet to be determined whether there is sufficient demand to warrant the development of a designated service that responds to activations.

Pilot schemes established to develop Telehealth have not been progressed to full service implementation

8.4.2 What do we propose to do?

We will review our current provision of telecare and telehealth services and develop a strategy which will include:

- Developing appropriate ways to measure and evaluate the effectiveness of telecare in service avoidance.
- Improving information and access to the Lifeline and Telecare service in line with the development of the Information and Advice service.
- Developing systems to record and monitor telecare activations in order to predict and prevent problems from escalating with early intervention.
- Continuing to promote the use of telecare as an alternative solution to traditional social care support services both internally and externally.

8.5 Domiciliary Care

The provision of personal care to individuals in their own home remains fundamental to our vision of supporting people to live at home. The role played by domiciliary care staff cannot be underestimated.

8.5.1 What Do We Know?

The domiciliary care service currently provides a long-term maintenance service, alongside and complementing the short term reablement service also provided by the local authorities. It is regarded as successful at keeping people at home and preventing people from going into a residential / nursing care

Services are currently commissioned on a traditional "time and task" delivery model. They are provided for all categories of need from low to critical in Rhondda Cynon Taf whereas in Merthyr, they are only available to those with critical or substantial need.

Currently in Rhondda Cynon Taf, 60% of domiciliary care service is commissioned from the independent sector with 40% provided from their-house service. In Merthyr, 100% of long term domiciliary care is commissioned from the independent sector and contract monitoring arrangements are in place to support the transition to independent sector provision of these services.

We recognise that domiciliary care services delivered by the local authorities cost considerably more than the independently commissioned services.

We are aware that independent sector providers require a significant lead-in time in order to respond to significant fluctuations in service demand which affects flexibility at times of increased demand.

8.5.2 What do we propose to do?

The implementation of the Social Services & Wellbeing (Wales) Act 2014 will have clear implications for the delivery of domiciliary care. There will be a fundamental cultural shift away from the direct provision and even commissioning of services towards a role for local authorities of supporting people to commission services directly through Direct Payment arrangements.

There will also be greater empowerment and choice given to the service user in agreeing their outcomes and how they will be met. Consequently, we will commission a less prescriptive service, empowering the provider, in discussion with the service user, to determine how best to meet the agreed outcomes. This will provide a more modernised service with the aim of being to move to a more community-based service, linking in with third sector and community groups where appropriate

There will be a greater requirement for providers to be competent to deliver services with an enabling approach and to deliver ongoing programmes/care plans.

We will reduce the level of services directly delivered by Rhondda Cynon Taf CBC and increase the percentage share in the independent sector.

8.6 Accommodation with Support

8.6.1 What Do We Know?

We currently commission placements for individuals in care homes to a “traditional” model of residential and nursing care. We recognised that this approach is not going to be adequate to meet expected demographic changes and in particular, the growing demand for residential and nursing placements for older people with dementia and other mental health issues.

Service providers report continued problems with maintaining a stable and high quality workforce and there are problems particularly with the recruitment and retention of qualified nurses. It is reported also to be hard to retain good quality management and turnover is known to be high. Generally recruitment processes are known to be inconsistent.

We have established arrangements between the public sector agencies to jointly commission services for individuals in nursing homes, however these need to be reviewed.

We have an effective partnership for the sharing of information via our 'escalating concerns' process

The Older People's Commissioner for Wales has recently published the findings of her review on the quality of care provided in care homes across Wales and produced a report entitled 'A Place to Call Home'. In response to the report, the three public sector agencies and local care home providers have worked together to consider its implications and have developed a Cwm Taf-wide action plan, in order to respond to the actions required and to avoid looking at the report in organisational silos.

We intend to continue this collaborative approach, working in partnership across Cwm Taf and will be meeting bimonthly to oversee its implementation and monitor progress. In recognition of the importance of this work and the commitment from our organisations to deliver on it, in addition to our individual organisational governance arrangements, we will be reporting quarterly to the Cwm Taf Social Services and Wellbeing Partnership Board to ensure that actions are being taken and followed through and any issues or concerns can be raised at the highest level.

8.6.2 What do we propose to do?

The implementation of the Social Services & Wellbeing (Wales) Act 2014 will have clear implications for our approach to the commissioning of services from care homes. We will not accept a care home placement as the default option for individuals with more complex or long term needs. Instead we will increasingly take the role of “facilitators”, supporting people to access information and support to avert the need for long term care. We will intervene effectively and responsively at times of acute need, to return people to independence and we will develop and support a vibrant market of service providers to support people to retain as much independence as possible in their own homes.

This will fundamentally affect the position of care homes (and residential care in particular) in the spectrum of support and services that can be accessed by older people and those that care for them.

Where people are no longer able to live in their own homes our priority will be to ensure there is a comprehensive range of housing, and in particular, housing with support options available for them, to retain independence and control over their living arrangements for as long as possible (e.g. adapted housing, sheltered housing and extra care housing).

We will significantly reduce our reliance on the residential category of care and seek better quality of life opportunities for people to live in accommodation with support, whilst retaining their "own front door".

We will increase the capacity in the market for EMI residential care and EMI nursing care placements but will commission only from providers who deliver good quality care and recognised best practice models of care for people with dementia (e.g. the Butterfly project). We will also explore how we can work together with providers to develop innovative new models of care for people with complex needs related to dementia.

We will reduce the number of people we place in the nursing category of care and offer an integrated social and nursing care model within our model of accommodation with support

These models may also support intermediate care and the interface between hospital and community where people require more time for rehabilitation to enable them to manage within extra care or residential settings rather than a nursing home.

Where it is necessary, we will only commission placements for the nursing category of care where the provider meets set quality standards of care and best practice. We believe this approach will help us prioritise the quality of life of people who need to be cared for in a nursing care home

The further development of extra-care schemes will be explored – one scheme has recently been built in Merthyr and another is in the early stages of construction in RCT. We will monitor the impact of this alternative accommodation model in terms of outcomes for residents and also in terms of their impact on demand for care home placements.

We will identify suitable sites for the development of future extra care housing and engage with Registered Social Landlords to develop a strategy to expand this service model across Cwm Taf.

We will produce a Market Position Statement for accommodation with support, based on needs analysis and in partnership with providers.

9. Our Key Priorities

This document describes our commitment to work together to transform the way in which we commission and/or provide social care, health and wellbeing services for older people in Cwm Taf.

In response to the Social Services and Wellbeing (Wales) Act, we have developed and agreed an integrated service model which emphasises community support, health and wellbeing, early intervention with proportionate assessments and the promotion of independence, supporting people to live in their own homes and communities wherever possible.

We expect that this model will make a fundamental difference to the outcomes that can be achieved by our older citizens. But achieving this fundamental transformation will require an ambitious programme of work. Sections 6, 7 and 8 provide detail of our intentions regarding each component of our shared service model. Drawing from this, our immediate priorities are as follows:

Building community capacity

- We will work together to review the way in which we commission services from the third sector and build structures for joint commissioning.
- We will develop our partnership with the CVCs and agree with them an extended role which builds community and volunteer capacity based on the principles of co-production.
- We will provide a community capacity fund for the region that will be used to initiate and promote the development of social enterprises/co-operatives/third sector organisations in order to expand the range and availability of local universal/preventative services
- We will delegate responsibility for the management of the fund to the CVCs and strengthen their role in building community and volunteer capacity - based on the principles of co-production
- We will encourage the development of consortia arrangements between third sector organisations and social enterprises

Information, Advice and Assistance

- We will develop a Joint Information and Advice Strategy which addresses our revised responsibilities under the Social Services & Wellbeing Act
- We will maintain the community information database and build on the information being compiled by the community coordinators.
- We will agree a process for updating and sharing of information so both the council's website and any printed information is available and accurate.
- We will place the research and information team at the "front" of the adult services model to ensure First Response and the preventative services are

supported with up to date information on both social care options and other community options.

- We will improve the sharing, production and provision of information with partner organisations to ensure where possible we reduce duplication.
- We will commission the County Voluntary Councils (CVCs) to develop and maintain a community information database across the region that includes detailed information of local, informal community support systems.
- We will develop a web based portal that enables service users to access universal community based services independently.

Health and Wellbeing

- We will develop a Joint Health and Wellbeing Action Plan which will address the issues and activities identified in Section 6.5.2 of this document.
- We will encourage social inclusion by promoting “age friendly” communities, providing opportunities for meaningful and accessible wellbeing activities which support older people to get out and about through:
 - the use of natural and built environments that encourage and support people to be more active
 - community and intergenerational educational and social activities
 - befriending and volunteering schemes
- We will develop opportunities to tackle obesity by improving nutrition through healthy eating and increasing physical activity levels which will help older people to maintain a healthy weight
- We will review the opportunities to prevent falls through both primary prevention that raises awareness and supports healthy ageing (such as physical activity and safe homes) as well as more targeted falls prevention activities for older people identified at risk
- We will promote healthy ageing activities which raise awareness and understanding of how lifestyle issues such as diet, exercise, smoking, alcohol and emotional wellbeing can impact on later life and encourage uptake of appropriate interventions.

Primary Care Services

- Cwm Taf UHB will agree our Primary Care and Community Services Strategy which has been developed in conjunction with this Joint Commissioning Statement.

Newly integrated @home service

- We will establish an integrated core @home service and formalise the governance and financial arrangements required to include single line management and a single point of access).

Domiciliary Care

- We will continue to develop solutions that reduce long term dependence on our services and ensure that long term arrangements (including Direct Payment) are commissioned only where less invasive alternatives such as Reablement, Reablement (Dementia), Telecare, aids and adaptation have been fully explored.
- Where domiciliary care is required we will commission outcome based domiciliary care that will empower the service user and carer to exert more choice and control over the way in which their care is delivered and focus attention on the wellbeing outcomes they want to achieve
- We will review the domiciliary care services directly delivered by local authorities.
- We will work together to develop a model of commissioning which supports service providers, in discussion with the service user, to determine how best to meet the agreed outcomes.

Accommodation with Support

- We will ensure there is a comprehensive range of accommodation, and in particular, accommodation with support options available for people to retain independence and control over their living arrangements
- We will produce a Joint Market Position Statement for Accommodation with Support which will articulate in detail our intention to shift our emphasis away from the provision of institutional care towards a model of independence through care and support in individual's own homes.
- We will review the way we use our allocation of Supporting People Grant for sheltered and community-based housing support services. This will release funding which we will direct towards the emerging needs of older people.
- We will also review our contractual arrangements with Care and Repair and develop a Joint Agreement to support the organisation to develop the provision of services directly to the public at a reasonable cost.
- We will review the position of our in-house residential care homes.
- We will work to reduce the number of nursing care placements that we need to commission and explore integrated social and nursing care options within our accommodation with support model

- In the longer term, we will not continue to commission the residential category of care home and replace it with better quality options to live in accommodation with support and retain their “own front door”.
- We will work with our partners in the housing sector to set out an Extra Care development strategy to provide (amongst other interventions) an effective alternative to residential care
- We will identify suitable sites for the development of extra care housing and engage with Registered Social Landlords to identify where they can be developed in future.
- We will work to develop new models of EMI nursing care (which may be provided by social enterprises and/or by the statutory sector itself).
- We will increase the capacity in the market for EMI residential care and EMI nursing care placements.
- We will undertake a range of activities to improve standards and practice within care homes for people with dementia (e.g. the butterfly project).
- In particular, there will be a review of the joint contract for the provision of residential/nursing care to ensure compliance with the recommendations of the Older People's Commissioner and support for the sector to improve service quality.

Governance and Infrastructure

- We will continue to develop our partnership arrangements to make sure that we work together to implement our shared vision and commissioning plans for the integrated services described in this document.
- We will develop appropriate legal structures under Section 33 of the National Health Service (Wales) Act 2006 to enable us to achieve joint governance and pooled budget for the commissioning of specific services where appropriate.
- We will strengthen our partnership arrangements through the establishment of an integrated commissioning team for the region.

10. Making it Happen: Commissioning in Partnership

Welsh Government has a clear expectation that we develop a model of integrated health and social care services. This is articulated in their recently published document “A Framework for Delivering Integrated Health and Social Care Services for Older People with Complex Needs” (WG 2013).

“The purpose of developing integrated services is to improve care and support for people. This means ensuring people have more say and control over the care they receive. People should experience care and support that is seamless; not a fragmented series of interventions than can lead to confusion, disruption and poor outcomes.” (WG 2013)

This joint commissioning statement demonstrates our commitment to delivering a proactive, responsive and seamless service to our older population and those that support and care for them.

We will build a strong partnership between our organisations to push forward the delivery of our joint service model.

10.1 Our approach to partnership

Section 165 of the Social Services and Wellbeing Act (Wales) 2014 states:

“A local authority must exercise its social services functions with a view to ensuring the integration of care and support provision with health provision and health-related provision where it considers that this would:

a) *promote the well-being of:*

- children within the authority’s area,
- (adults within the authority’s area with needs for care and support, or
- carers within the authority’s area with needs for support,

b) *contribute to the prevention or delay of the development by children or adults within its area of needs for care and support or the development by carers within its area of needs for support, or*

c) *improve the quality of care and support for children and adults, and of support for carers, provided in its area (including the outcomes that are achieved from such provision).”*

The Welsh Government Policy document “*Making the Connections - Delivering Beyond Boundaries*” (otherwise known as “The Beecham Report”) states:

“Partnership...has a key role to play in delivering significant improvement in services...the whole architecture of public services and the culture, skills and behaviours of those who work in them must be made more conducive to shared delivery.” (WG 2006)¹¹

The Audit Commission (1998)¹² defines partnership working as:

“A joint working arrangement where the partners:

- *are otherwise independent bodies*
- *agree to co-operate to achieve a common goal*
- *create a new organisational structure or process to achieve this goal*
- *plan and implement a joint programme*
- *share information, risks and rewards”*

We have a strong history of working together as public organisations. Our implementation of the WG guidance *“A Framework for Integrated health and Social Care for Older People with complex Needs”* has supported us to develop and consolidate these partnerships. We will build joint governance and commissioning arrangements to support our delivery of the commitments we give in this document.

10.2 Governance and Performance Management

We must be able to produce robust evidence to measure our progress against delivery of this Joint Commissioning Statement. This will allow us know whether we are making a positive difference to the lives of older people in Cwm Taf, to celebrate and build on our successes, and, where appropriate, target more energy and resources into areas which are not delivering as planned.

How will we know we’re making a difference?

We recognise that many of the actions proposed within this Joint Commissioning Statement will not be ‘quick fixes’. We want the changes we deliver to be sustainable and influence life in Cwm Taf over the next 10-15 years. However, we are able to track progress on delivery of specific actions, we can monitor changes, analyse

¹¹ Making the Connections - Delivering Beyond Boundaries: Transforming Public Services in Wales: Welsh Government, 2006

<http://webarchive.nationalarchives.gov.uk/20060715141954/http://new.wales.gov.uk/dpsp/publications/policies/delivering/Responsee?lang=en>

¹² *A Fruitful Partnership*: Audit Commission (1998).

<http://www.audit-commission.gov.uk/Products/NATIONAL-REPORT/A190CA25-7A7E-47D1-BCAB-373A86B709C0/A%20Fruitful%20Partnership.pdf>

trends and we are keen to ensure that you know how well we are doing in different projects even if they don't directly affect you.

The Cwm Taf Social Services and Wellbeing Board and Executive will lead this work and will be accountable for the delivery of the Joint Commissioning Statement. They will:

- Look at what's been done to date, whether all actions have been progressed as planned and what impact there has been on older people living in Cwm Taf;
- Listen to the people who work in these services tell us what they've done and how they think it went;
- Hear about what you thought of the service or problem and whether it's made a difference in your life;
- Look at the overall picture; and
- Make decisions on what to do next.

At the end of each financial year there will be a full and formal review of progress, where the partner agencies will be looking back over what's been done over the last year and thinking about what still needs to change for the future. This will be collated into an Annual Report, which will be published.

10.3 How will we pull this evidence together?

This Joint Commissioning Statement is centred on delivering improved outcomes for older people rather than organisations. Although we want our services to be used as widely as possible, we don't want to count how many people have used a service; we're more interested in how pleased they were with the service, or whether it has made a difference to their lives – no matter how big or small. This is called "Results-Based Accountability™", or RBA for short, because it looks at the *results* of doing something.

Some things are more difficult to measure than others but we'll be constantly looking at ways to improve what information we collect and how we interpret the results.

Our processes will include ensuring that we fulfil all of our statutory responsibilities in relation to the breadth of work covered by this Joint Commissioning Statement.

We also believe that it's important for people to know why they're doing something, so we'll be making sure that every service is aware that their work is valued at the very top level of our organisations.

Who will take an independent view on progress?

We'll be making the annual progress report we write available to other organisations such as the Welsh Government and Wales Audit Office.

Each of the partner agencies also gets independently inspected and inspectors will use this Joint Commissioning Statement and the reports we write every year to see whether we have delivered the things we promised.

10.2 Resources

The way in which the three partner organisations distribute our resources across the three tiers of our service model is shown in the table below. The service budgets included in each tier of the model is shown in Appendix 2.

Table 10.1 – Resource Distribution across Integrated Service Model

	Budget 2013-14					
	RCT		Merthyr		Cwm Taf UHB*	
	£	%	£	%	£	%
Tier 1 – Community, Universal and Prevention Services	1,961,580	3.3	283,000	2.0	54,341,849	64.0
Tier 2 – Early Intervention and Reablement	4,772,710	8.0	2,094,000	14.0	1,011,172	1.0
Tier 3 – Specialist and Substitute Services	52,917,583	88.7	12,508,000	84.0	29,800,150	35.0
Total	59,651,873		14,885,000		85,153,171	

(* Please note that some aspects of UHB funding, e.g. funding for General Medical Services in Primary Care and mental health funding, are subject to ring-fencing)

This shows very clearly that around 85% of our resources are focussed on Tier 3 services and over 95% in Tiers 2 and 3.

Our implementation of the Social Services and Wellbeing (Wales) Act requires a much stronger emphasis on Tier 1, community and universal prevention services. We are committed to shifting the emphasis in our budget allocation significantly away

from traditional long terms services towards services that promote wellbeing and independence.

This fundamental transformation in the way we commission services will be challenging. However, through strong partnership and methodical and robust implementation, we are committed to a bold and radical transformation of our fundamental role, and of the services we commission.

10.3 Commissioning

We regard the process of commissioning as the means by which we will translate the intentions and commitments made in this document into reality: into a better experience and better outcomes for our older population.

The Yorkshire and Humber Joint Improvement Partnership define commissioning as follows:

“Commissioning is a broad concept and there are many definitions. The Department of Health describes commissioning as the means to secure the best value for local citizens and taxpayers. It is the process of translating aspirations and need, by specifying and procuring services for the local population, into services for users which deliver the best possible health and wellbeing outcomes and provide the best possible health and social care provision within the best use of available resources. Commissioning is an on-going process which applies to all services, whether they are provided by the local authority, the NHS, other public agencies or the independent sector.”¹³

The table below shows that there are a number of ways that we can collaborate to undertake our commissioning function together:

Table 10.2 Levels of Partnership in Commissioning

¹³ *What is commissioning?*: Yorkshire and Humber Joint Improvement Partnership
<http://www.yhsccommissioning.org.uk/index.php?pageNo=539>

Separate - independently and without co-ordination	Parallel – with reference to other agencies	Joint – in partnership by separate agencies	Combined – through a single organisation or partnership
Agencies have separate approaches and do not liaise e.g. the financial impact of services and policies on other agencies is not considered	Agencies liaise over commissioning activities e.g. separate cost, benchmarking and market intelligence shared by agencies	Agencies work jointly on commissioning activities e.g. a jointly researched and produced market position statement	Single, combined functions or arrangements e.g. a single, integrated commissioning function

We believe that each of these approaches to commissioning in partnership is valid. We will use them in combination to deliver our commissioning intentions.

10.4 The Role of the County Voluntary Council (CVC) in Commissioning

VAMT and Interlink are the CVCs in the Cwm Taf region. They support, develop and represent third sector organisations and promote volunteering. CVCs do not provide services which are in competition with other providers.

Their role involves ensuring third sector representation and involvement in strategic developments, as well as being brokers and facilitators in the commissioning process.

10.5 Formal Partnerships and Pooled Budgets

Section 33 of the NHS Act (Wales) 2006, gives public bodies the flexibility to establish formal partnership arrangements to support the delivery of truly integrated services.

The National Leadership and Innovation Agency for Health (NLIAH) notes that *“...Good partnerships are less focussed upon the differences between partners and more focussed upon the shared approach to achieving outcomes, with the organisational supports to do so. There is no need for this to undermine individual agency autonomy and every possibility for partners to overcome challenging objectives for their organisation through a shared approach to managing change.”*¹⁴

¹⁴ *Partnership and Pooled Budgets*; National Leadership and Innovation Agency for Health (NLIAH) <http://www.wales.nhs.uk/sitesplus/829/page/48750>

In its advice notes: “Making the Connections – Partnerships for Delivery; Advice Note 2: Practicalities of Partnership Development”, WG identify the value of pooled budgets as a “...mechanism by which the partners to the agreement each contribute to the delivery of the outcomes required by creating a discrete fund. The intention must be to enable flexibility in fulfilling the functions that are part of the pooled fund arrangement and therefore the use of these funds.”

We will make use of formal partnership arrangements and pooled budgets wherever appropriate.

10.6 Our Shared Approach to Commissioning with the Third Sector

Our shared document “Commission Accomplished”¹⁵ is a code of practice for commissioning third sector services in Merthyr Tydfil and Rhondda Cynon Taf. It lays out a set of general commissioning principles which have been agreed by this partnership as underpinning this strategy.

We are committed to operating an effective and sustainable funding framework for the third sector based on sound decision making and effective relationships, and underpinned by the following principles:

- **Delivery of strategic policy objectives** - acknowledgement of the role the third sector can play in delivering these through innovative solutions and often being able to reach groups that public sector organisations cannot.
- **Respect for the third sector's independence** - recognition that third sector organisations have a right to exercise independence irrespective of funding. This should be in line with their governing document and based on the best interests of the organisation and the needs of its beneficiaries.
- **Early and constructive dialogue** - opportunities to discuss proposals well in advance of the formal application deadline and early in the budget planning cycle.
- **Timely decisions** - wherever possible, written notification of in principle grant approvals for each financial year by 31 December of the preceding year and written confirmation of grant approvals by February following budget setting. In exceptional circumstances where this is not possible, notice should be given of an alternative timescale by 31 December;
- **Security of funding** - longer term commitments, subject to performance, to support a sustainable approach to funding: up to 3-5 years for strategic core funding and commitment for the life of any specific projects which are funded, providing firm year one funding and clear baselines for subsequent years. A three year funding commitment will be seen as a basic minimum unless the source of funding does not allow it.

¹⁵ Commission Accomplished: Public Sector Code of Practice for Commissioning Third Sector Services in Merthyr Tydfil and Rhondda Cynon Taf: Commissioning Policy Development Project, 2011 http://www.commissionaccomplished.co.uk/uploads/Commission_Accomplished_English.pdf

- **Fair funding levels** - levels of funding for the sector should be determined no differently than for other sectors or agencies in relation to planning for inflation and growth. Where the funding stream permits it, increases for inflation and growth should be allowed.
- **Full Cost Recovery** - levels of grant funding will be based on, and reflect the principles of, Full Cost Recovery; and the significance of submitting bids on the basis of Full Cost Recovery principles should be made clear to third sector organisations.
- **Fair procurement** - the level of required disclosure on pricing and its relation to costs must be consistent across all potential providers and should be in keeping with the good practice guidance laid out in the Welsh Assembly Government's Procurement and the Third Sector: Guidance for the Public Sector in Wales (2008)
- **Payment in advance** - provision for advance payment of grant where a clear financial need is established.
- **Fair and reasonable treatment** - including prior discussion and reasonable notice before any policy changes or decisions that may lead to withdrawal or significant reduction of grants; reasonable timescales; and proportionate processes.
- **Joint approach to monitoring and evaluation** - the simplest outcomes-based procedures consistent with ensuring proper use of public funds.
- **Who does what best** - commitment to identifying where the third sector might take the lead in, or contribute to, the implementation of new policies, and ensuring that appropriate funding mechanisms are in place.
- **Mediation and Disputes Resolution Process** - a commitment to make appropriate use of the local Compact Mediation and Disputes Resolution process (in Merthyr Tydfil) to resolve any disputes arising from commissioning.
- **Infrastructure support** - recognition of the importance of, and need to resource, a local third sector infrastructure to underpin the third sector's coordinated involvement in commissioning.

10.7 Co-Production

A Framework for delivering Integrated Health and Social Care for Older People with Complex Needs notes that: "It is the people (and their carers) who use services and receive care and support who know best what their individual needs, preferences and circumstances are. Planners and service providers need to build on this potential to 'co-produce' to ensure the best services and best outcomes for individuals." (WG, 2013)

The same document notes that co-produced services will ensure:

- *"People who use services, including their carers, take an active role in developing their plan of care to achieve the outcomes that are important to them. This will include a named single point of contact, an assessment of their support needs and having access to relevant, up to date information."*

- *An increased focus on preventative community based interventions to reduce or delay dependency upon support services.*
- *Financial benefits by reducing demand and levels of support for statutory services and reducing costly failures in care.*
- *A smooth and seamless transition between different parts of the system, ensuring the right care, at the right time, in the right place, by the right person.*
- *Services are developed to meet local circumstances whether in urban or rural areas.*
- *Capturing information once and ensuring it is accessible to those who need it (including across sectors).*
- *Ensuring appropriate and proportionate needs assessment, with a plan of care and responds accordingly.*
- *Services that operate across sectors, ensuring access to 24/7 care.*
- *Early intervention and support for independent living including rehabilitation and reablement and intermediate care, with pathways into secondary care, residential care or specialist services when required.*
- *Consideration is given to language and communication needs.”*

We are committed to the principles of co-production and will use them to inform the way we implement the vision described in this Joint Commissioning Statement.

10.8 Adopting a “bold” approach

If we accept that “we can’t go on as we are” with public services then we need to “be bold”.

We need to accept:

- That changing structures alone does not change services and can divert attention away from service redesign to internal reorganisation
- Our traditional models of commissioning may be challenged given what we know about future demographic changes and the severity and duration of austerity measures.

As public sector bodies, we recognise we have a crucial role in investing in communities and supporting the social fabric so that demands on its services can be reduced. We need to develop a new approach which build services around the person and the community and unlocks potential resources of time, money and expertise, with the statutory services as supporter and enabler. This is in accordance with our understanding that our quality of life is determined by a mix of individual, family, community and statutory services. We recognise our role in expanding and nurturing this social capital.

We need to ensure that our approach to commissioning is consistent with a community-based citizen approach.

This approach is not without its challenges. It needs to recognise that there are inequalities in social capital within and between communities and additional support and investment will be required in some areas to increase capacity and confidence. Equally there is unlikely to be a large reservoir of citizens just waiting to volunteer. However our experience is that where people are engaged meaningfully and can contribute positively there are always willing participants.

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11. Summary and Conclusion

“We have to do different things, not the same things differently”

(Gwenda Thomas, Deputy Minister for Social Services: January 2014)

The number of people that live in our communities in Cwm Taf is growing. We have achieved real improvements in the effectiveness of our medical and public health services and, as a result, people are living longer healthier lives. In the next 15 years, we expect our population of people over the age of 65 years to grow by 30% and those over the age of 80 years to grow by 70%.

The services we commission to support our older citizens and their carers are often already stretched. It has been estimated that if these services simply increase to keep pace with demographic change, this will result in a near doubling of care costs by 2026. We know that we have to adopt a new approach to use our resources as wisely as possible.

We also know that we must improve the experience of our older citizens as they come to require the support and care that we provide. As large public bodies, we are complex organisations. We have each developed systems to assess people's need for support and to arrange and provide it. These systems are often complex and hard for people to navigate. Our services can operate alongside each other in a way that can make people feel as if they are “being given the run-around”. We are committed to improving the way we work together to place our older citizens at the very centre of the services they receive.

The Social Services and Wellbeing (Wales) Act (2014) received Royal Assent on 1st May 2014. It sets out a challenge for us to fundamentally reshape the way individuals, families and communities are supported by our statutory organisations. In responding to the Act, we must make a radical change in our “offer” to individuals, families and communities; supporting them to take responsibility for their own health and wellbeing. We must shift our emphasis from reactive long term (often institutional) services to an approach which promotes choice, dignity and independence, focusing on the strengths of individuals and their social and community networks.

Cwm Taf University Health Board, Rhondda Cynon Taf County Borough Council and Merthyr Tydfil County Borough Council all share a common responsibility and duty to support the health and wellbeing of the citizens in our area. The radical transformation of services will not succeed unless we adopt a “whole system” approach.

We have worked together to produce this Joint Commissioning Statement for Older People. We are committed now to a single model of integrated health and social care. It requires a radical transformation in the services we provide and the way we

work together. The changes required are ambitious and bold. They will only be achieved through a strong partnership to which we are each firmly committed.

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Appendix 1

1. National Policy Context

There has been a continuum of policy development over a number of years which has focused on service improvement, co-ordination between national and local government and greater integration of social care, health services and other agencies in Wales, notably the Third Sector. Policy development has increasingly focused on putting the individual at the centre of decision-making about their care and on providing care and support at home where possible.

The process of policy development has been set out in a series of documents and statements from the Welsh Government over a number of years. These have included the development of a series of targets and indicators for local authorities and health boards to measure their progress against.

2. Social Care Policy development

The **2009 Local Government Measure** provided the Welsh Government with enabling powers to remove obstacles to local councils collaborating to secure their duty towards continuous improvement and to meet improvement objectives.¹⁶

This was followed in 2011 by '**Sustainable Social Services for Wales: A Framework for Action**'¹⁷, which identified a clear need for greater collaboration between social services, health and other public sector service providers in response to forecast increased demand and changing expectations from service users. The framework stated the intention to ensure that assessment of needs would focus on outcomes. This policy statement envisaged a national framework to address the duty to maintain and enhance wellbeing, which would support the development of local arrangements by local authorities. It also gave Ministers powers to require partnerships between social services departments and Local Health Boards. 'Sustainable Social Service for Wales' identified older people's services as a particular priority for partnership working.

A statutory requirement on local authorities to produce single integrated plans to replace earlier models (community strategies, children and young people's plans, health, social care and wellbeing strategies, and Community Safety Partnership Plans) was introduced in guidance from the Welsh Government in 2012. '**Shared**

¹⁶ Local Government Measure, Welsh Government, 2009
<http://wales.gov.uk/legislation/programme/previouslegislation/assemblymeasures/localgovernment/?lang=en>

¹⁷ Sustainable Social Services for Wales: A Framework for Action, 2011
<http://wales.gov.uk/topics/health/publications/socialcare/guidance1/services/?lang=en>

Purpose, Shared Delivery (Single Integrated Partnership Plans) required local authorities to develop these local five year plans and to ensure they were supported by local partner organisations, with the responsibility for delivery resting with local authorities.¹⁸

Alongside policy development, the Welsh Government and Welsh local government agreed a voluntary '**Compact for Change**'¹⁹ in 2011 which sought to define a partnership between national and local government with the aim of improving performance and outcomes and achieving efficiencies. The 'Compact' again highlighted the importance of greater co-ordination of services locally, as well as the need for a proper monitoring and reporting framework to support implementation of reform.

The Well-being of Future Generations (Wales) Bill (2014)²⁰ will place a duty on public bodies, including Welsh Government; local authorities and health boards to "make decisions that leave a positive legacy for our children, and children's children." The Bill strengthens existing governance arrangements for improving the well-being of Wales in order to ensure that the needs of the present are met without compromising the ability of future generations to meet their own needs. It aims to improve well-being in accordance with the sustainable development principle, which means seeking to ensure that the needs of the present are met without compromising the ability of future generations to meet their own needs.

The fundamental driver for the way in which we want to reshape our services is the **Social Services and Wellbeing (Wales) Act 2014**, which received Royal Assent on 1st May 2014. This significant new piece of legislation places greater emphasis on the role of local health boards and local authorities in supporting the well-being of their populations. The Act provides a legal framework for the continued transformation of social care and requires local authorities to promote cooperation with other bodies to improve the wellbeing of those people who need care and support, as well as their carers.

The Act strengthens the duties on us to work together in the planning, design and delivery of services and developing integrated primary, community and well-being services which are focused on the holistic needs of people. It requires the integration of care and support with health and health-related provision and Ministers will have explicit powers to prescribe partnerships between social services departments and local health boards. The Act focuses on identifying those people who need support, promoting wellbeing and the provision of earlier targeted support with the aim of reducing overall demand.

¹⁸ Shared Purpose, Shared Delivery (Single Integrated Partnership Plans), Welsh Government, December 2012

<http://wales.gov.uk/topics/improvingservices/publicationevents/publications/sharedpurpdel/?lang=en>

¹⁹ A compact for change between the Welsh Government and Welsh local government, Welsh Government, <http://wales.gov.uk/docs/dpsp/publications/110812compacten.pdf>

²⁰ The Well-being of Future Generations (Wales) Bill Welsh Government, 2014, <http://www.assembly.wales/laid%20documents/pri-ld9831%20-%20well-being%20of%20future%20generations%20%28wales%29%20bill/pri-ld9831-e.pdf>

A framework for delivering integrated health and social care for older people with complex needs²¹ was published in July 2013. The consultation document required Health Boards and local authority partners to submit strategic 'Statements of Intent' to the Welsh Government by the end of January 2014 setting out how they will progress arrangements for integrated care within their areas, setting out their ambitions against a review of their current situation measured against 16 issues set out in the consultation. The document required local partners to develop integrated services for older people with complex needs by December 2014 and offered a series of indicators to enable partners to measure progress.

Integrated assessment, planning and review arrangements for older people²² was published in December 2013. This new guidance aims to simplify administrative burdens to ensure that people get better services and outcomes. It emphasises the importance of professionals being given the freedom to make decisions with service users. The guidance replaces the earlier 'unified assessment process' for people aged 65 and over, confirms the intention to place individuals at the centre of decisions about their care provision and re-states the ambition to keep people in their homes where possible. The guidance sets out the requirement for a consistent approach across Health and Social Care agencies and the use of a National Minimum Core Data Set and common assessment templates, both of which need to be in place by April 2014. The guidance is intended to be an essential element of the introduction of the 'Framework for delivering integrated health and social care for older people with complex needs'.

To support the work of local partners in developing integration and more person-centred care and support, the Welsh Government is offering new, one year funding through an **Intermediate Care Fund**. The funding, £50m in total available from April 2014, is designed to support Councils, Local Health Boards and other partners in developing integrated strategic services which will help older people, particularly the frail elderly, to maintain independence and remain in their own homes. A particular focus will be on avoiding unnecessary hospital admissions, averting inappropriate admission to residential care and preventing delayed discharge from hospitals.

There is an additional emerging challenge for local authorities in Wales following the publication of a report on 17 January 2014 by the **Williams Commission on Public Service Governance and Delivery in Wales**²³. This report recommended a reduction in the number of Councils in Wales from 22 to a maximum of 12, with Neath Port Talbot merging with Bridgend as a minimum change. The report suggests that Swansea might join these two authorities in a single entity. The Commission recommended greater co-ordination between public sector organisation

²¹ A framework for delivering integrated health and social care for older people with complex needs, 2013, Welsh Government <http://wales.gov.uk/consultations/healthsocialcare/integration/?lang=en>

²² Integrated assessment, planning and review arrangements for older people, Welsh Government, 2013 <http://wales.gov.uk/topics/health/publications/socialcare/guidance1/assessment1/?lang=en>

²³ Commission on public service governance and delivery, January 2014, <http://wales.gov.uk/docs/dpsp/publications/psgd/140120-psgd-summary-report-en.pdf>

and suitable alignment of boundaries which, the report acknowledged, are reasonably well-aligned in Wales.

3. NHS Continuing Health Care policy development

NHS guidance on **Continuing Health Care** (CHC), ongoing care provided and fully funded by the NHS through Local Health Boards (LHBs), was published in 2010. The framework sought to introduce a consistent approach to assessment, commissioning and provision across Wales. The framework referred to the need for coordination with social care services to ensure effective service delivery.²⁴

The latest guidance, published in June 2014 replaces the earlier document, updating and revising the guidance therein. **Continuing NHS Healthcare: the national framework for implementation in Wales** follows a review carried out in 2013 and interim guidance issued by the Welsh Government to clarify and strengthen eligibility guidelines.²⁵

This new guidance places CHC within a continuum of services provided by NHS organisations and local authorities and confirms the need for a consistent foundation for assessment, eligibility and provision of care and support for adults across Wales, including CHC. It supports the aim of social care legislation to support independence and to seek to prevent the need for more intensive services through interventions such as reablement and rehabilitation. As with social care guidance, NHS CHC guidance emphasises the need to work with individuals when considering their needs and confirms as one of the core principles the statement 'no decisions about me without me'.

'[Together for Health](#)' sets out the tough challenges facing our healthcare system in Wales which it identifies to be – a rising elderly population, enduring inequalities in health, increasing numbers of patients with chronic conditions, rising obesity rates and a challenging financial climate.

It grouped these challenges into five main themes:

- Health has improved but not for everyone and our population is ageing;
- Health care quality has improved but the NHS can do even better;
- Expectations are continually rising;
- Medical staffing is becoming a real limitation on our services;
- Funding is limited.

²⁴ Continuing Health Care, NHS Wales, 2010, <http://www.wales.nhs.uk/document/168534>

²⁵ Continuing NHS Healthcare: the national framework for implementation in Wales, NHS Wales, 2014 <http://wales.gov.uk/consultations/healthsocialcare/continuing/?lang=en>

“Trusted to Care”²⁶ (May 2014) (otherwise known as “The Andrews Report”) was initiated following concerns raised over standards of care for older patients in two Welsh hospitals. It focussed on the culture of care especially on medical wards, the administration and recording of medicines, the oversight of nursing standards and the way in which complaints were handled. It found poor practice in all areas underpinned by a professional culture which was of concern.

In May 2014, The Minister for Health informed the Chief Executives of all Welsh Health Boards requiring that they absorb the findings of the report and satisfy themselves that such departures from basic professional standards are not present in their organisations.

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²⁶ Trusted to Care, Welsh Government, 2014,
<http://wales.gov.uk/docs/dhss/publications/140512trustedtocareen.pdf>

Appendix 2

Services Included in Resource Distribution: Table 9.1

	Local Authority Services	Health Board Services
Tier 1	<ul style="list-style-type: none"> • Grants etc to Third Sector (excluding Children's and Mental Health) • Carers • Any Council housing related support (eg Sheltered housing) • Information and advice 	<ul style="list-style-type: none"> • GP Services • Other Primary Care • District Nursing • EPP • Carers • Third Sector Spend (excluding children & mental health) • Inverse Care Law • Primary Care Bids
Tier 2	<ul style="list-style-type: none"> • Reablement • @ Home Service • Single Point of Access • Assessment 	<ul style="list-style-type: none"> • @Home • Reablement • Other ICF • Community Hospitals
Tier 3	<ul style="list-style-type: none"> • Equipment and adaptations • Telecare • Domiciliary care • Care homes 	<ul style="list-style-type: none"> • Nursing Home Care • CHC

APPENDIX 2**Public Engagement on Commissioning Statement for Older People's Services**

Your local council and health board are working together to look at the way they provide health and social care services to older people across Merthyr Tydfil and Rhondda Cynon Taff (an area called Cwm Taf).

What does this mean for me?

As healthcare has improved, we are all living longer, and the number of older people in our area is increasing. If we continue with our current services, we won't be able to meet this increase in demand. In the near future, there will be a lot more older people who will need health and social care services, which means that the way we provide these services needs to change.

New law for health and social services means we need to do things differently if we want older people to have independent, healthy and fulfilled lives. We want to support older people to stay independent, have more control and choice over the care they get, and to be able to live at home and be part of their local community.

Why do we need your views?

We need your views so we can plan services that reflect what you want. You may already get care and support, or you might need it in the future. Either way, we'll use what you say to help us plan our approach to health and social care for older people.

Our new Service Model and Priorities for Health and Social Care Services

If we are going to meet the needs of the growing number of older people in the future, we need to change the way we offer health and social care to people across Cwm Taf.

The **service model** shows what we think health and social care services for older people should be like in the future, **our priorities** are the things we need to focus on so we can make changes work for older people.

The information about Our Service Model and Priorities is split into 3 parts that we'd like you to read:

1. **Our Vision**..... page 1
2. **Our Service Model**..... page 2
3. **Our Priorities**..... page 4

Part 1- Our Vision for Older People's Health and Social Care

This is what we want for older people in the future.

"We want to support older people in Cwm Taf to live independent, healthy and fulfilled lives."

- We want older people to live longer, healthier and happier lives.
- We want older people to live life to the full, and to stay as independent as they can be for as long as possible.
- We want to help older people who become ill, frail or vulnerable to get the care and support they need, when they need it, the way they want it.
- We will support people and communities in Cwm Taf to take more responsibility for their health and wellbeing.

Our New Approach to Health and Social Care Services for Older People

In our new service model and priorities families and communities play a much greater part in offering people care and support. Our role is to work alongside these networks, rather than instead of them, and support people to live independent, healthy, and fulfilled lives as they get older.

We need to make the right services available at the right time to support people as soon as they need it. This will mean that we can help older people stay with their family and local community, and will limit the number of older people who need expensive and disruptive care services later on in their lives.

Part 2- Our Service Model

This service model describes how we'll achieve what we want for older people in the future. It describes what each part of the service will do, and how it works together. It describes what we need to do to achieve 'Our Vision'.

Our new approach to health and social care services has three levels which overlap.

Level 1 Community, Universal and Prevention Services

These types of service are universal, anyone in the community can access them, an example of this type of service would be your local leisure centre.

In the future, our role will be to support and help start-up informal support networks, such as the care and support provided by family and friends or by voluntary/ charitable groups and organisations that work in your local community.

By creating these types of local services, we will give people across Cwm Taf the chance to stay healthy, and independent for as long as possible.

As part of these services we will be:

- Helping people stay independent, looking at what's available for people in their local community, and encouraging people to play a more active role in their local community.
- Making sure that people have easy access to these types of services.

- Giving people good information on what's available to them in their local area and helping them find opportunities.
- Making sure that those who need more intensive help, now or in the near future, get the right help at the right time.

Level 2 Early Intervention and Reablement Services

We must be able to respond to people's needs quickly, to help people live healthy and fulfilled lives, and there is less need for additional health and social care services.

When people's needs aren't met through Community, Universal and Preventative Services (Level 1), we will offer people early intervention and reablement services, which will help older people deal with the difficulties they may be having, and help them remain independent and living within their community.

As part of these services we will be:

- Giving people good information and advice so they can get the right services.
- Responding to people's needs quickly, to help people work through their problems.
- Making sure the support we give is intensive enough to have a good impact.
- Work 'with' the people who use our services to help them achieve their goals.
- Making sure that we work closely with other services, so people get the right support

Level 3 Specialist and Substitute Services.

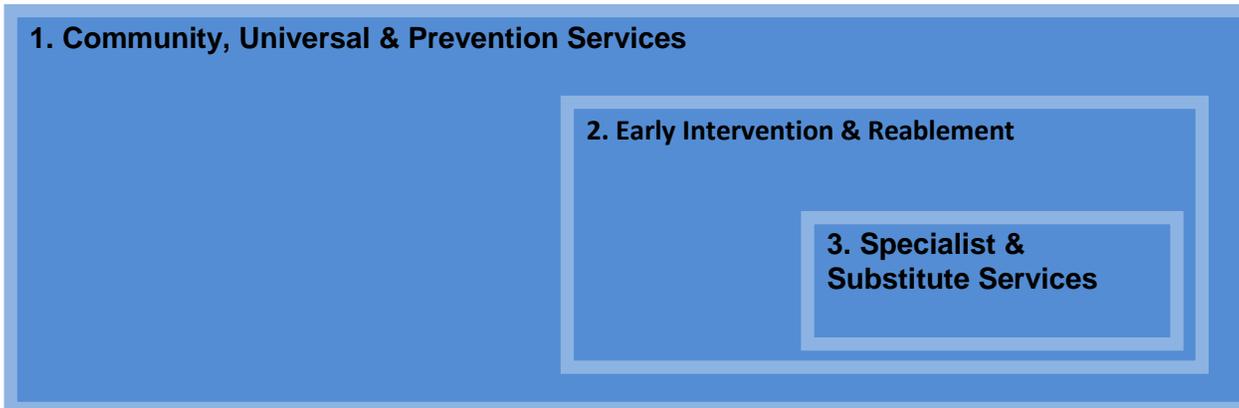
This level of service is the most intensive, and is for people who have health problems, or circumstances that mean they need long-term specialist or substitute care and support.

Examples of these types of services are: residential and nursing care, community hospital services.

As part of these services we will be:

- Working closely with a variety of services, to make sure we can respond well to the care and support people using our services want.
- Giving people good information and advice so they can make well thought out choices.
- Making sure the people getting our services are given choices and have control over the care and support they get, so they can improve their quality of life in ways that they want.

How it all works together



As you can see from the diagram above, all three levels overlap to make-up our approach for health and social care services for older people. The services work at different levels of need, as the services get more specialised, they are smaller and provide specific interventions.

In our new approach to health and social care services our focus is on local solutions, and planning services that prevent older people's health and wellbeing getting worse. We will make sure that services at different levels talk regularly and work closely with each other, so that people receive the help they need, when they need it, the way they want it.

We think that by providing more support at Level 1 (Community, Universal and Prevention Services), less older people will need to get Level 2 (Early Intervention and Reablement) and Level 3 (Specialist and Substitute Services). This will mean that more older people will stay independent and have healthy, fulfilled lives at home or within their local community.

Question 1

Do you agree with our service model?

Question 2

When thinking about health and social care for older people, what are the issues that are important to you?

Question 3

Is there anything else you would like to tell us?

Part 3- Our Priorities for Older People's Health and Social Care

Our priorities are what we think are the most important changes we need to make, to achieve our vision and get to where we want to be. There are 6 different areas that we need to make changes in.

Area 1 Building Community Capacity

When we say 'Building Community Capacity' we mean, helping communities work together so that they can find local solutions to some of the problems people have. For example this could be setting up lunch clubs, or befriending services for older people.

We need to make sure that there are lots of new community projects, and that they are supported by us so they can continue to work well for individuals in the community.

In order to make this key priority happen, we will need to:

- Look at the way we work with voluntary and charity organisations, and develop ways of starting new services together.
- Support the voluntary sector to create more community organisations, and recruit more volunteers.
- Set aside money to help local organisations, or people who want to start local organisations, so that there are more care and support services on offer in your local community.
- Help the voluntary sector and social enterprises create services together.

Area 2 Information, Advice and Assistance

When we say 'Information, Advice and Assistance' we mean creating information, advice and assistance services for Merthyr Tydfil and Rhondda Cynon Taf, to make it easier for local people to find out about care and support services available in their area.

In order to make this happen, we will need to:

- Make sure that the database we have on local care and support is kept up to date, and added to with new information.
- Make sure that our staff know how to update and share information.
- Make it easier for our different teams to share information about the community and social care support available, so they are kept up to date.
- Share information we have between the key partner organisations, i.e. the two councils and the NHS, so we don't repeat the same work.
- Work with the voluntary sector, to create a database about local support services, that are run by voluntary or charity organisations.
- Create a website where people can find information and advice about care and support easily.

Area 3 Health and Wellbeing

When we say 'Health and Wellbeing' we mean helping older people to stay healthier and happier for longer so they can lead fulfilled lives, be independent and can be part of their communities.

In order to make this happen, we will need to:

- Help older people stay connected to their local communities, by making sure there are lots of opportunities for them to get involved in activities and stay active.
- Create more activities that tackle obesity, and increase healthy eating and exercise, so older people can stay a healthy weight.
- Look at how we can prevent falls, by raising awareness, creating physical activities, encouraging safer homes, and targeting support for those at risk.
- Promote healthy ageing activities about how lifestyle issues such as diet, exercise, smoking, alcohol and emotional wellbeing can impact on later life, and encourage people to make changes.

Area 4 Domiciliary Care

When we say 'Domiciliary Care' we mean care and support that is provided to people in their own homes. In the future we want people to stay independent for longer, and a big part of this is having support to stay healthy, happy and safe at home.

In order to this we need to:

- Look at ways to maximise older people's independence so that people don't become dependent on our services, and only look at providing domiciliary care when we've tried lots of other solutions that aren't as intrusive .
- Make sure that if an older person does need domiciliary care, they have choice and control about how and what they get.
- Review the level of services directly delivered by the council
- Encourage services where the person providing the service and the person getting the service, work together to decide their goals and how to achieve them.

Area 5 Accommodation with Support

When we say 'Accommodation with Support' we mean, a number of different housing options that allow you to keep 'your own front door'. We want older people to have lots of accommodation options, in particular those that mean older people can live independently with support for as long as possible.

In order to do this we need to:

- Look at the way we use our 'supporting people grant', and allocate more of it to older people's emerging needs.

- Help the 'Care and Repair' service (who support older people to live well at home) to provide services directly to the public at a reasonable cost.
- Look at whether we need to have as many residential care homes.
- Reduce the number of nursing care places, and offer people social and nursing care at home.
- Longer term we will replace residential care homes with better quality housing options, so older people maintain their independence and have 'their own front door'.
- Work closely with housing services to make sure there are good quality alternative housing options for older people, rather than rely on residential homes.
- Work with Housing Associations who provide social housing to find sites to create housing options for older people.
- Create new ways of providing nursing care for older people with dementia, which may mean it is provided by social enterprises, or the independent sector.
- Engage in lots of activities that continue to raise the standards in care homes for older people with dementia.

Area 6 Governance and Infrastructure

When we say 'Governance and Infrastructure' we mean the way we (the council) and our key partners (the health board) will make sure that we work well together to be able to make the changes to achieve our vision for older people.

In order to do this we need to:

- Strengthen the way we work together and make sure that we have the same goals and vision for older people.
- Use the right legal structures so we have a shared budget with health, and can create services for older people together.
- Create a joint team that will work on providing health and social care services across Cwm Taf.

Question 4

Do you agree with our priorities?

Question 5

Do you think there's anything we've missed?

Question 6

Is there anything else you'd like to tell us?

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