RHONDDA CYNON TAF COUNTY BOROUGH COUNCIL

MUNICIPAL YEAR 2014-15

COMMUNITY AND CHILDREN'S SERVICES SCRUTINY COMMITTEE **10th SEPTEMBER 2014** **REPORT OF THE GROUP DIRECTOR, COMMUNITY & CHILDREN'S SERVICES**	**Agenda Item No. 3** **SOCIAL SERVICES AND HEALTH – PROMOTING INTEGRATED SERVICES**

Author: Bob Gatis, Service Director, Adult Services
Tel. No. 01443 425527

1.0 PURPOSE OF REPORT

To advise Scrutiny on the progress of the Welsh Government initiatives to promote the integration of Health and Social Services in Wales and seek approval for the direction we propose to take with the Cwm Taf University Health Board (UHB) and Merthyr Tydfil County Borough Council. This report was initially reported to Cabinet on 8th April 2014.

2.0 RECOMMENDATIONS

It is recommended that Members:

2.1 Scrutinise and comment on the information provided, namely:

- the final guidance on the framework for delivering Integrated Health and Social Care for older people with complex needs.
- the guidance on integrated assessment, planning and review arrangements for older people.
- the draft 'Statement of Intent' which was agreed in principal by the Cabinet on 8th April 2014.
- the provision of the Intermediate Care Fund to further support integration.

2.2 Consider whether they wish to make any recommendations or receive further detail on any matters contained in the report.

3.0 BACKGROUND

- Information on Welsh Government initiatives to promote the integration of Health and Social Care Services was reported to Cabinet on 28th October 2013.

- The report identified the determination of Welsh Government to significantly increase the pace of integration, through two new, key, policy documents:-

  a) **Delivering Local Health Care – Accelerating the pace of change**: which requires Health Boards to meet a range of largely Health led targets over the course of the next three years. Key themes within Delivering Local Health Care include:-

     - Improving health and wellbeing by an increased focus on prevention and rapid intervention.

     - Providing improved support for older people and people with long term conditions.

     - Strengthening locally led service planning and delivery.

     - Delivering co-ordinated care, focused and designed around people.

  b) **A Framework for Delivering Health and Social Care for Older People with Complex Needs**: At the time of the last report to Cabinet it was being consulted on. The final guidance has now been issued and has taken account of some of our concerns in relation to performance indicators and lessened the emphasis on pooled budgets as a measure of successful collaborative working.

3.3 Within the Framework for Delivery Health and Social Care for Older People with Complex Needs, the Welsh Government sees integration from the perspective of the individual and states that the term 'integration' has many definitions, but for people needing care and support it should mean:-

"*My care is planned by me with people working together to understand me, my family, and carer(s), giving me control, and bringing together services to achieve the outcomes important to me."*

3.4 The Framework sets out Welsh Government's expectations on all partners, placing a strong emphasis on:

- Early intervention and prevention.

- Co-production, building integrated services with and for people, including carers.

- Multi-agency assessment and ensuring that information is captured once and then shared appropriately to support the care and support of individuals.

- Care and support being available 24/7 and ensuring that consideration is given to the language and communication needs of individuals.

3.5 Welsh Government expects continued work to ensure people are not unnecessarily admitted to hospital and prevent delayed discharges.

3.6 The Framework has a number of key actions for partners and Welsh Government. Even though the final guidance was not published until mid March 2014, there was a requirement to submit an initial draft Statement of Intent, for the Cwm Taf Region, on integrated care by the end of January 2014 with a final version to be submitted by the end of March 2014.

3.7 By September 2014 local planning mechanisms should reflect the requirement that collaborative planning at a local level is based upon a citizen-centred model that allows older people in Wales to have a voice and to retain control of their life.

3.8 By December 2014, Health and Social Care Partners need to ensure that integrated services for older people with complex needs are embedded within mainstream delivery and are designed in line with the Framework.

3.9 Welsh Government was required by April 2014 to publish an initial outcomes Framework setting out the most important wellbeing outcomes for people. Health and Social Care Partners will need to ensure we can monitor progress against these outcomes. Welsh Government will use the Statement of Intent as a means of reviewing progress in delivering the outcomes required in this document.

4.0 STATEMENT OF INTENT

4.1 Attached at Appendix 1 is the draft Statement of Intent, required by Welsh Government.

4.2 The Statement of Intent outlines how across the Cwm Taf Region we will move to more integrated services over the next 3 year period and Cabinet approved this statement in principal on 8th April 2014. The document identifies areas for development both strategically and operationally. It seeks to pull together a number of areas of work and builds on current developments with the Cwm Taf UHB in relation to community based services, the hospital community interface, and services to older people with dementia.

4.3 We intend to develop a joint commissioning strategy for areas of common interest such as the third sector and the independent residential sector. We also intend to look at how we can further develop our short term intervention services by developing a single point of access for community health and social care referrals and consider the possibility for the development of greater managerial integration of our community services.

4.4 We know that housing and the provision of equipment can play a pivotal role to support people to remain independent and the Statement of Intent identifies the need to progress this, particularly in relation to the availability of tenancies suitable for people who are clinically obese.

4.5 An early draft has been commented on by Welsh Government, who commented positively on the document, though noting that they believe we should clarify the role of pooled budgets in supporting a faster pace of change.

4.6 Given the relatively early stage of our progress towards integration it is important that it is carefully planned and continues to build on work already being taken forward following work from the Institute of Public Care for the Cwm Taf Region last year. This recognised the need for a clear vision, understood at all levels of Partner Organisations and that change should look to deliver closer collaboration rather than necessarily full organisational integration.

4.7 Pooled budgets should not be regarded as the panacea for integration and are not a quick solution. Like other approaches it needs to be understood and carefully evaluated and we will maintain a position of considering pooled budgets alongside other financial arrangements where they show demonstrable benefit to both the Council and individuals.

5.0 INTERMEDIATE CARE FUND

5.1 Within the framework document Welsh Government identify a number of funding sources to support the integration agenda. The Cwm Taf UHB has already received £1.5 million through the Welsh Government 'Invest to Save Scheme' and the Cwm Taf Regional Collaboration Board have also attracted some European Social Fund to support closer collaboration.

5.2 For 2014/2015, Welsh Government has announced a non-recurring fund to support this agenda and across the Cwm Taf Region we have been allocated £4.377 million made up of £2.918 million revenue and £1.459 million capital. The money available for the Rhondda Cynon Taf area is £2.346 million revenue and £1.173 million capital.

5.3 Welsh Government has made clear this is to support older people and the integration agenda and bids for use of the fund will be measured against the Statement of Intent and have to be agreed by the respective University Health Boards and Local Authorities.

5.4 Initial bids have had to be submitted to Welsh Government for the Cwm Taf Region at a high level and we have stressed the need for flexibility in the use of the money given the short timescale to spend it and the size of the grant available. The intention is that the grant will be agreed by the end of March 2014 to enable full use of the funds in 2014/2015.

5.5 Whilst additional resources are always welcome, the fund is only for one year and it will be a challenge to deliver additional support that may be removed in future years. However, we have included elements within the bid that create additional one-off support and enhanced delivery frameworks and will build in evaluation methods so that each proposal can be monitored and reviewed for sustainability beyond 2014/15.

5.6 Key elements of the funding bid are to:-

- Support further development of our intermediate care and reablement services, including 7 day working and greater integration with the University Health Board.

- Support wellbeing and utilising community coordinators to link older people with community opportunities to remain independent.

- Develop third sector capacity to support delivery of this agenda.

- Use capital resources toward providing additional Disabled Facilities Grants.

- Explore with Housing Associations development of tenancies suitable for people who are clinically obese.

- Develop a commissioning strategy for the Cwm Taf Health and Social Care community.

- Look to change models of care within residential homes for people with dementia utilising the successful model within Clydach Court.

5.7 A summary of the Intermediate Care Fund bid for the Cwm Taf Region is included at Appendix 2.

6.0 INTEGRATED ASSESSMENT

6.1 In advance of the publication of the Framework for Delivering Health and Social Care for Older People with Complex Needs, Welsh Government in December 2013 issued new guidance on 'Integrated Assessment, Planning and Review Arrangements for Older People', to broadly replace the Unified Assessment guidance.

6.2 The purpose of the new guidance is to set out the responsibilities of Health and Social Care professionals in supporting older people and to allow older people to exercise a strong voice and control in decisions about their care. It also seeks to minimise administrative burden and drive integrated practice.

6.3 Requirements of the new guidance are that:-

- Local Authorities and University Health Boards will work together and introduce common arrangements to ensure older people are able to access advice and information to promote their wellbeing.

- Assessments will be proportional to needs.

- Systems, forms and practices are consistent between Local Authorities and University Health Boards.

6.4 The new guidance provides clarity on who can undertake an assessment and introduces the term 'delegated professional'. It sets out how assessments should be undertaken and some core information that needs to be included in the assessment. There is also guidance on how care and support plans should be developed where there is a need for ongoing support.

6.5 Whilst the guidance was issued in December 2013 for immediate implementation, there is recognition that it will take some time to fully implement.

6.6 The minimum expectation of the Welsh Government was that by April 2014, there would be in place a common format for undertaking an integrated assessment and we will be able to share that information across the Health and Social Care community.

6.7 The expectations of the new guidance will mean considerable work over the short and medium term and we will need to continue to place people who need our support at the centre of our work. We will meet the deadline set by Welsh Government utilising paper based documentation. Ultimately the key to success will be the ability to share assessments and care and support plans electronically which is being worked upon. This remains a significant challenge for both ourselves and Cwm Taf UHB.

7.0 CONCLUSION

7.1 Welsh Government is seeking to increase the pace of integration across the Health and Social Care system. They have issued revised guidance on a framework for integration and on the assessment, and care planning arrangements for older people.

7.2 The scale of expectation from Welsh Government cannot be underestimated and will need all Partners to play a significant part if we are to meet the aspirations not only of Welsh Government but also older people who may be in need of support from Health and Social care services.

7.3 To support the changes the Welsh Government has established a one-off Intermediate care fund for 2014/15. As the funding is for one year only, any proposals for work extending beyond 31 March 2015 will clearly state how we will ensure sustainability will be achieved and where any future funding will come from. We will also indicate if there are plans to contribute funding from other existing sources to the proposal and, if so, set out the detail of these plans.

LOCAL GOVERNMENT ACT 1972

AS AMENDED BY

THE LOCAL GOVERNMENT (ACCESS TO INFORMATION) ACT 1985

RHONDDA CYNON TAF COUNTY BOROUGH COUNCIL

COMMUNITY & CHILDREN'S SERVICES SCRUTINY COMMITTEE

10TH SEPTEMBER 2014

REPORT OF THE GROUP DIRECTOR, COMMUNITY & CHILDREN'S SERVICES

SOCIAL SERVICES AND HEALTH – PROMOTING INTEGRATED SERVICES

Background Papers:

- **A Framework for Delivering Health and Social Care for Older People with Complex Needs**
- **Statement of Intent**

Officer to contact: Ann Edwards. Tel. No. 424102

Appendix 1

Statement of Intent – Integrated Care

The following paper has been produced for Welsh Government and constitutes the Statement of Intent on Integrated Care for Older People with Complex Needs between Cwm Taf University Health Board (CTUHB), Rhondda Cynon Taf County Borough Council (RCTCBC) and Merthyr Tydfil County Borough Council (MTCBC).

The statement has been formally endorsed by all three organisations.

March 2014

Introduction

This Statement of Intent has been developed by members of Cwm Taf University Health Board (CTUHB), Rhondda Cynon Taf County Borough Council (RCTCBC) and Merthyr Tydfil County Borough Council (MTCBC) in response to a number of Welsh Government (WG) documents highlighted below. The organisations have also sought the contribution of third sector partners in its development and in particular in their application to the Intermediate Care Fund.

Delivering Local Health Care (2013) which is a plan to provide as much care at, or as close to home, as possible. The Plan builds on the progress made in response to *Setting the Direction (2010)* and has identified key themes which the WG believe will be achieved by ensuring greater integration between health and social care and other key partners.

A Framework for Delivering Integrated Health and Social Care (2013) which is based on the same principles as Delivering Local Health Care (DLHC) but is specifically for older people with complex needs. This has been produced because evidence demonstrates demand is increasing for both acute and community care services for older people and an ageing population suggests this will continue. In response, a new approach is required to integrate health and social services for older people with complex needs reducing fragmented care as a result.

In implementing this Statement of Intent we will ensure that the issues raised by the Older Person's Commissioner in response to the *Framework for Delivering Integrated Health and Social Care* are recognised and addressed.

Integrated Assessment, Planning and Review Arrangements for Older People (2013). 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 aged 65 years and over. With immediate effect all Local Authorities and Local Health Boards are expected to make arrangements to implement the requirements set out in the guidance; with the exception of the requirement to develop and implement a common assessment template, which must be implemented by 30 April 2014.

The drive for integration between Health and Social Care and the need to accelerate the pace of change is reflected in the above documents published over the last two years. Our organisations support the Welsh Government direction seeking to place the citizen at the centre of our work and ever increasing collaboration and integration between Health and Social Care partners. We believe the Social Services and Well-being (Wales) Bill will provide a strong, coherent legal framework to buttress joined up working. The strategic vision outlined in Delivering Local Health Care and the Framework for Delivering Integrated Health and Social Care provides a detailed framework for the partnership to build on progress to date, respond to current challenges and to provide high quality, equitable services to meet the needs of people across the Cwm Taf region.

The Wider Policy Context

The draft ***Social Services and Well-being (Wales) Bill*** was introduced in to the National Assembly for Wales on 28th January 2013 for consideration and scrutiny. It will provide the legal framework for improving the well-being of people who need care and support and will transform social services in Wales. Integration and simplification of the law will also provide greater consistency and clarity, promote equality, improve the quality of services and the provision of information people receive. It will also encourage a renewed focus on prevention and early intervention.

The Williams Review (2013) – In 2013, the First Minister established a commission to "examine how public services are governed". The programme includes a series of reforms and reviews to strengthen the delivery of efficient, effective and accessible public services. The aim of the Commission is to look hard, honestly and objectively at the way public services are governed and delivered in Wales, and how they may be improved.

Today, the challenge is to work together in health and social care, and with the third sector to look ahead, rather than backwards to build strong, dynamic, healthy and sustainable communities.

Cwm Taf Region

Our area is made up of four localities – the Cynon Valley, Merthyr Tydfil, the Rhondda Valleys and Taff Ely. It is the second most densely populated Health Board area in Wales, covering 3% of the landmass of Wales with approximately 289,400 residents. When compared to the Welsh average there are over 3 times as many people per square km living here. Almost 81% of the population live in the Rhondda Cynon Taff Local Authority area and the remainder within the boundaries of Merthyr Tydfil. Services are also provided to the people of the South Powys, North Rhymney, North Cardiff and other adjacent health community areas. In addition, some specialist services are provided to the wider catchment area in South Wales.

Cwm Taf University Health Board serves the most deprived population in Wales evidenced by levels of unemployment, inequalities in health and low educational achievement in the area. There is also significant variation in deprivation at a local level. This can be illustrated by the differences in health and affluence across Rhondda Cynon Taf. There are significant differences in healthy life expectancy across the County Borough and average house prices vary from around £52,000 to £200,000 depending on where you live.

We've undertaken a detailed needs assessment of the Cwm Taf area. Based on the most recent population estimates, Rhondda Cynon Taf is the third largest local authority in Wales with a population of 234,400. Our population growth is following national trends with more people aged over 65 years old, but no major increase in other age groups. Within this we have an ethnic minority population of less than 3%, which is below the Welsh average of over 4%.

Between 2001 and 2011, the population of Merthyr Tydfil grew by 4.6% (an increase of 2593 people) to 58,802. Although in recent years there has been an increase in the number of births, Merthyr Tydfil, like the rest of the country, has an ageing population. The population of those aged 65 years and older is projected to rise from 9,800 in 2011 to 13,800 by 2033 and the percentage of people aged 75 and over is projected to increase from just fewer than 8% at local authority level to around 12.5% by 2033. The percentage of people aged 85 and over is projected to double from around 2% to around 4% by 2033. Merthyr Tydfil has a minority ethnic population of 3,167 individuals (2011 Census).This represents 5.4% of the total population, up from less than 1% in the 2001 Census, which is higher than the Welsh average of 4%.

The increase in the number of older people is likely to be associated with a rise in chronic conditions whose prevalence is strongly age-related such as circulatory and respiratory diseases and cancers. Meeting the needs of these individuals will be a key challenge for the partnership. In the current economic climate, the relative (and absolute) increase in economically dependent and, in some cases, care-dependent populations will pose particular challenges to communities.

As the population ages, the mental health conditions most common in this age group become more prevalent. Dementia is much more common in people over the age of 85. It is anticipated by 2030 there will be a large increase (almost double) in the number of people with dementia in the 80-84 and 85+ age groups in Rhondda Cynon Taf, likely to be the result of greater life expectancy and the effect of the baby boom population reaching the 85+ age group during the period.

Progress to Date

Our approach is based on partnership working across the Cwm Taf region through priorities set by the Regional Collaboration Partnership the Local Service Boards and the development of the Single Integrated Plans (SIP) for Merthyr and Rhondda Cynon Taf which have been produced to compliment each other. The Plans are not an individual organisation's or an individual department’s plan – these are the key overarching plans for both County Boroughs developed in partnership with the third sector and University Health Board. Some of the key messages are:

- The Plans are based on need, not demand.
- They are very much based on a partnership approach.
- They focus on prevention and early intervention rather than cure, changing outcomes rather than fixing problems.
- They pay attention to the needs of the whole population but with a specific focus on groups who are disadvantaged, vulnerable and at risk of becoming vulnerable.

There are a range of strategies and plans that support the aspirations of the SIPs and the Statement of Intent will further inform and influence these strategies and plans. CTUHB is developing its 3 year plan which sets out the overarching service strategy for the University Health Board and a broad framework for delivery. The Statement of Intent agreed by all partners will

inform this plan and the strategic direction for primary and community services therein.

The Local Authorities are in the process of developing their annual strategic and operational plans for 2014-15 based on areas for development identified in the Single Integrated plans and self assessment of current services delivered by the Local Authorities.

There are five streams of work, which are currently contributing to the delivery of care and support to older people and which therefore influence this Statement of Intent, these are:

1. Frail Elderly and Rehabilitation model
2. Localities Partnership working
3. Unscheduled Care
4. Older Persons Mental Health Services
5. Primary Care Services

1. Frail Elderly and Rehabilitation Model

The three organisations are currently developing a frail elderly model for Cwm Taf which will set out how we build on achievements to date with @Home and further develop services (where possible on an integrated basis) to meet the needs of our population. This will include for example; our ability to support patients who attend A&E but do not necessarily require admission, how we streamline access to our services via a single point of access and a more proactive “in-reach” approach to ensure patients with complex needs do not remain in hospital longer than required. The model will outline the contribution of the University Health Board, Local Authority and third sector partners in improving the services provided to older people with complex needs.

Our aim is to:

- Reduce the number of admissions to Care Homes direct from hospital;
- Decrease length of stay in hospital where appropriate; and in line with
- Increasing the range and timeliness of support available in the community (for example access to 24/7 services).

2. Localities Partnership Working

The University Health Board’s locality model has been developed in conjunction with Local Authority partners. Primary and Community services within Cwm Taf are managed on a locality basis by two Locality Management Teams:

- Rhondda and Taff Ely
- Merthyr Tydfil and Cynon

Delivering services on a locality basis as close to people’s homes as possible with a holistic approach will lead to benefits for service users in terms of quality of care, access and timeliness. By providing a visible seamless and reliable community and primary care structure, co-ordinated across health and

social care, our citizens will have increased confidence in local public services.

Merthyr Tydfil and Rhondda Cynon Taf Local Authorities have over the last three years reshaped their first response assessment and care management services to have a greater focus on short term interventions that support people to maintain their independence. We continue to provide a range of services across Merthyr, Rhondda, Cynon and Taf Localities that support, on a longer term basis where needed, vulnerable older people.

Over the last three years we have increased the pace of integration within our short term intervention services so that within both MTCBC and RCTCBC we have well integrated Reablement and Initial Response services that have: improved the flow from hospital, increased referrals from the community and delivered very positive outcomes for older people. Both MTCBC and RCTCBC services are integrated with the UHB therapy services and we need to continue to develop these.

In April 2012 an 'Invest to Save' (I2S) application was submitted to the Welsh Government to support the further development of community services. The funding is based on the premise that investment in these services (known as @Home) will support the shift in resources required to reduce reliance on acute services. The @Home service is the overarching name for a range of services provided in the community which include the existing core services of:

- District Nursing Services
- Primary Care GP Services
- Reablement Services
- Joint Emergency Therapy Team (JETT)
- Palliative Care
- Community Mental Health
- Community Stroke Services
- Parkinsons and other chronic disease services

The invest to save funding enabled us to develop new services and enhance existing services to compliment core service provision. These are listed below:

- Community Integrated Assessment Service (CIAS)
- Community Ward
- Community IV Service
- Reablement

The new elements of @Home model were launched on 29 October 2012 and an evaluation of the impact of the services in the first year is being undertaken. To date:

- CIAS has avoided 344 admissions to hospital;
- 2,037 acute bed days have been avoided via the Community IV Antibiotic service; and

- 1,498 patients have been discharged from hospital to a Reablement programme

Initial findings highlighted a number of issues which the University Health Board is currently pursuing. These include:

- Developing a single point of access across health and social care to streamline the pathway for frail elderly patients and provide primary care colleagues with a more robust and timely response.
- The current CIAS model will be reviewed to identify opportunities to increase the number of admissions avoided. This could be achieved by implementing a risk stratification tool in primary care, thereby targeting the resource at those patients at greatest risk of admission.
- There is further potential to provide additional support to Care Homes using the CIAS outreach model maintaining complex patients within this environment where traditionally care may have been delivered in hospital.
- An assessment of the potential benefits of using the current resource to deliver an Initial Response service and associated implications of refocusing the resource in this way (this will allow the team to manage acute short term conditions e.g. COPD exacerbation).
- The function of the Community Resource Team needs clarification and the University Health Board is currently exploring how this resource could be used to more effectively to manage more complex cases in the community.
- There is potential to increase the capacity of the Community IV Antibiotic service and a need for a 7 day service.
- Reablement services have yet to realise full capacity and therefore greater impact could be achieved with a full compliment of staff.

The above will inform the next stage of development of our @Home services ensuring that we further strengthen our community infrastructure and develop the model to meet the growing demands on these services. Central to the further development of the @Home model will be consideration as to where services can be delivered on an integrated basis.

3. Unscheduled Care

All the partners have contributed to and are working to an unscheduled care plan, a key component of which is managing winter pressures. All agencies contribute to the Winter Planning Group with a focus on the following:

- A review of the choice procedure to ensure this is consistently applied to all patients and to reduce the number of delayed transfers of care;
- Opportunities to jointly fund interim placements have been explored with the aim of improving the discharge process and reducing the number of delayed transfers of care;
- Continued development of WAST pathways aligned to @Home Service which has reduced the number of patients transported to hospital where appropriate community services are available;
- Improved GP access during core hours;
- Closer working with regard to escalation procedures at times of increased demand; and

- Development of step up / down beds in Rhondda Cynon Taf.

Implementation of the Unscheduled Care Plan has delivered significant improvements in patient flow in the last 6 months. In particular the number of delayed transfers of care in our Community Hospitals has reduced from 46 patients in September 2013 to 20 in February 2014.

4. Older Persons Mental Health Services

Cwm Taf has been working to improve mental health services for all adults living in Merthyr Tydfil and Rhondda Cynon Taf. A first phase of work, which looked at services for people of working age, has been completed and the second phase of work concentrating on services for older people is now underway and is currently in engagement phase.

Older people's mental health services have traditionally been available for people over the age of 65. It is proposed that eligibility for the new services for Cwm Taf will be based on what best meets the needs of patients and not age. The proposed new service model for older adults will include:

- Develop and enhance the role of the crisis team to signpost to appropriate community services.
- Extend home treatment to include all ages – this will help reduce admission rates and length of stay.
- A needs led primary care mental health support service – this will include screening of those presenting with memory issues and access to the Memory Assessment Pathway via the clinical nurse specialist for dementia based in the service.
- Improve discharge efficiency by planning discharge from point of admission.
- Improve services to nursing home residents by developing a liaison and in-reach service to provide advice and guidance, develop skills and support early discharge.
- Develop additional day care services.
- Improve services to primary care e.g. joint visits with GPs.
- Address inequitable workloads at consultant and locality levels.

5. Primary Care Services

We have indentified the need to establish a primary care work stream to explore potential opportunities for integrating services in this area. Via the Local Service Development domain of the Quality and Outcomes Framework we will strengthen the delivery of local health care. As part of a three year local service development programme, GP practices will strengthen their ability to improve coordination of care, improve the integration of health and social care and improve collaborative working with local communities and networks including third sector organisations.

Next Steps

We recognise that we need to complete the model for Frail Elderly which will assist in a greater integration of the five work streams above and finalise a model of governance, this is part of our Statement of Intent.

In May 2013, the Institute of Public Care at Oxford Brookes University (IPC) were commissioned to undertake a review of arrangements supporting health and social care integration for the Cwm Taf locality partners of CTUHB, RCTCBC and MTCBC. In June 2013 they produced a report summarising their findings from the project and made recommendations to help further integration.

This work provided the baseline assessment of our current situation in relation to integration of our locality services and action required in relation to the key planning principles were addressed within this work.

The report identified the following recommendations:

- Progress has been made in integration of services at a locality level in recent years, and this can be taken further. It is recommended that partners respond to the national integration agenda and growing evidence of the impact of integration on outcomes, by working together to take forward their integration arrangements at both a locality and organisational level.
- Partners should build further integrated arrangements.

The feedback from (IPC) laid the foundations for joint discussions to consider our future intention for integrated working. Therefore, CTUHB, RCTCBC, MTCBC have endeavoured to develop an approach which meets the needs of our citizens and reflects best practice of all three partners.

Taking into account the IPC recommendations, a Localities Partnership Board was established and project management resource identified to take forward the collaboration and integration agenda across the four established localities. This work will build on existing strong working relationships. Our current emphasis is on implementing the 'Integrated Assessment, Planning and Review Arrangements for Older People' guidance whilst having a continued intent to develop and deliver services within the four localities. The Board has been established to bring together public service officers across the Cwm Taf region to focus on the integration of health and social services (specifically Adult services) both in terms of management arrangements and also operational delivery. The Cwm Taf Localities Partnership Board is comprised of:

- Service Director, RCTCBC
- Assistant Director, MTCBC
- Assistant Director of Operations, CTUHB
- Head of Primary Care, CTUHB
- Assistant Director of Partnerships - Planning and Performance, CTUHB

The Board is supported by a Project Manager for Integration of Health and Social Care (Adult Services). This post is shared between CTUHB, RCTCBC and MTCBC.

Statement of Intent

Within this section we begin to articulate our intent over the next 1- 3 years both strategic and operational. We recognise that once the Statement of Intent has been agreed we will need to develop an action plan linked to all partners business plans to deliver integrated health and social care for older people with complex needs. We will do this in collaboration with our Third Sector partners.

Our Vision of Integrated Services

Cwm Taf Localities Partnership Board Vision is: '*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

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

All of the partners recognise that the issues facing older people are complex and interrelated, requiring a joined up response across all sectors, combining and focusing efforts of different service providers to achieve maximum effect and avoid duplication. We also recognise that many people can only communicate their care needs effectively through the medium of Welsh, and this has to be seen as a core component of care, not an optional extra.

Therefore we commit to working together to achieve the benefits and have established very clear objectives, which are:

- To continue to give priority to implementation of the unscheduled care delivery plan which improves the experience of the community and hospital interface for individuals;
- To integrate service delivery and management arrangements in the four Localities across Cwm Taf;
- To determine a joint performance management framework;
- To review the opportunities for more collaborative use of resources both in terms of workforce and finances;
- To develop and implement joint commissioning arrangements;

- To review the need for information sharing protocols and use of IT systems;
- To review the opportunities for other partners to work effectively as part of the Locality model; and

- We will work with Welsh Language Officers to identify how we can improve access to information and services through the medium of Welsh.

Outcomes that set out the difference the partnership wants to make to people's lives represent the other key aspect of any vision. These are important in a number of respects. They are an important way of binding together the activities of partners, of motivating staff and of providing a test of whether any particular actions are appropriate. Local policy documents currently include a variety of broad outcome statements, but a number of people have commented that outcomes should be more tangible and turned into 'something real' – specific projects with clear outcome criteria. For example, ensuring that people have a genuine choice to stay in their own homes; living independently, and not living in institutions; and enjoying a decent quality of life - outcomes that can only be delivered through a suite of effective community based services.

Intent

- **We will continue to develop our vision for services through the completion of the frail elderly model which will provide the framework for the Partnership for integrating services for this cohort of the population.**
- **Whilst there are clear governance arrangements for all of the five work streams identified earlier these will be kept under review and consideration given to the need for a senior officer multi agency group that that can ensure a coherency to the plans going forward and provide the necessary leadership.**

Financial Resources

The current financial position of all of the agencies and limited funding going forward will pose significant challenges. In order to deliver the changes that are inherent in this Statement of Intent we will need to explore the use of pooled budgets, undertaking work as a partnership and not separate organisations. We will need to look to opportunities to use short term monies such as the Intermediate Care Fund as testing grounds for innovative solutions and as bridge funding to different models of care.

Intent

- **We will explore the use of pooled budgets and through exploring joint commissioning we will identify opportunities to use resources more effectively.**

Workforce

Although relationships across the organisations are well developed, it should not be ignored that there are many differences between the different

organisations in terms of culture, background, training, roles, outlook and traditions, coupled with differential levels of understanding about the work of partner agencies. In this respect there is a need to address the cultural issues that either support or prevent effective integration.

A common vision and operational principles will assist in this area, but we need to plan to encompass training and development, including induction; change management, including the use of 'champions'; and promoting cross organisation understanding through projects that allow people to work together in different ways and gain a new perspective.

New roles operating across professional boundaries can support integrated delivery such as workers who combine reablement based domiciliary care skills with auxiliary nursing and community networking skills and Health and Social Care Co-ordinators who facilitate the referral process.

Intent

- **We will work within the health and social care system to ensure that we have more flexible professional roles that allow care to adapt to the changing needs of individuals.**
- **We will work to ensure an appropriate mix of more generically trained staff and specialists within the system.**
- **We will explore ways of bringing relevant health and social care staff together to share learning and development opportunities**

Information Sharing

Our Information Sharing Protocols need revision to support the changing agendas and having separate information systems compounds the problem. Our information systems are incompatible with different formats for documents, and no facility for shared access to information about patients / service users, makes the co-ordination and delivery of care more difficult.

Ideally there is a need for one system to support the partnership. SWIFT which is a common database for both MTCBC and RCTCBC and parts of CTUHB, may provide an opportunity to do so; in the mean time we will aim to put in place a more co-ordinated approach to effecting practical solutions to information sharing problems that obstruct our ability to support individuals.

Intent

- **We will review and update our Information Sharing Policy and Information Sharing Protocols across the partnership and explore opportunities to find IT solutions, including the use of SWIFT in order to share information in real time.**

Commissioning

At the present time there are individual Commissioning Strategies for MTCBC and RCTCBC. There are opportunities to develop a single Commissioning Strategy where relevant across the Cwm Taf region for areas such as the third

sector and accommodation with support including residential, nursing and CHC placements.

Similarly we commission services individually through our own commissioning teams or individual staff. There are opportunities to consider how this could be improved through lead commissioning opportunities or a single commissioning and contracting team.

Early work has commenced in RCTCBC on a market position statement for accommodation with support, this will feed a revised Commissioning Strategy and improve connections with the providers of accommodation.

Intent

- **We will develop a joint Commissioning Strategy for appropriate areas across the Cwm Taf region.**
- **We will explore opportunities for closer collaboration in regard to commissioning of services.**
- **We will establish a Collaborative Commissioning Group with RCTCBC, MTCBC and CTUHB to explore opportunities to jointly commission services from the third sector. It will have a key emphasis on support to individuals and carers that help maintain peoples' independence and reduce their need for more acute services. We will arrange opportunities for the third sector to influence this work.**
- **We will explore the possibility of a more strategic approach to and jointly commission accommodation with support services across CTUHB, RCTCBC and MTCBC.**
- **We will explore opportunities to jointly commission interim Nursing Home placements where first choice is not available.**
- **We will continue to develop a multi agency group to develop opportunities for assistive technologies to support people's independence.**

Preventative Services and Information

Access to information and advice is critical to enabling people to be able to make choices. At the present time each organisation is working in isolation of the other in relation to for instance websites and public leaflets, we need to improve and continue to understand the different and emerging ways older people access information when they need it and do that in a more co-ordinated way.

We have commenced collaborative work on commissioning preventative services from the third sector as identified earlier and this will be supported by the local county voluntary councils (CVCs).

Intent

- **We will explore opportunities for closer collaboration on the production and dissemination of information.**
- **We will develop and test the use of community coordinators in each locality. The Community Coordinator role will develop a knowledge base of locality services and will act a resource to assist front line**

staff such as Duty Officers to enable them to redirect individuals to alternative community based services.
- **We will arrange training days for professionals where the third sector can inform staff about their services.**
- **We will engage more closely with the Voluntary Sector Councils, Voluntary Action Merthyr Tydfil and Interlink to explore the role the Third Sector should play in developing services that support people to remain independent at home.**

We have already identified the importance that we place on the development of our community based services that support people's independence and whilst these are some of our most integrated services there is more that we can do in relation to coordination of referrals, development of dementia services and exploring how dedicated step up/ down services can support this element of the model.

Intent
- **We will scope a single point of access for referrals into our @home services.**
- **We will look to develop our reablement services that support people with dementia.**
- **We will review the use of existing step up down facilities and evaluate their role within the reablement model for Cwm Taf.**

Integrated Assessment Care Planning, Review

We are implementing the revised guidance on integrated assessment and critical to the long term success of this work will be the use of shared IT systems. We have many therapy assessment and nursing teams that are at the least co-located which assists with communication.

Intent
- **We will develop and implement the revised arrangements for integrated assessment and care planning across CTUHB, RCTCBC and MTCBC. This will be monitored and reviewed utilising the Localities Partnership Board as the lead for the work.**

Service provision

We already provide a wide range of services that support a spectrum of need and the revised Commissioning Strategy will update this. There are services which we know we need to develop more immediately which will have a significant impact on older people. For instance there are substantial needs for people who are clinically obese. We have a Section 33 agreement for the Community Equipment Service and there is more the partnership can achieve, as we know the provision of equipment can play a very important part in maintaining peoples' independence. The work in RCT on residential care for people with dementia has been highlighted as an exemplar by CSSIW. We have a multi agency assistive technology group that will continue to explore the use of telecare and telehealth opportunities.

Intent

- **We will test with Registered Social Landlords the possibility of providing housing accommodation that can support bariatric patients.**
- **We will explore how we can extend the Butterfly Project, which is an accepted approach to support people with dementia in residential placements.**
- **We will explore how we can further improve our provision of equipment.**
- **We will continue to develop and promote the use of assistive technology to support older people with complex needs.**

Conclusion and next steps

This Statement of Intent has been formally endorsed by our individual organisations, we ask therefore that the Welsh Government note and support our intention for the future direction of services.

The statement of intent will be shared widely with our stakeholders and has formed the basis of the Cwm Taf region bid for Intermediate care fund monies for 2014-2015.

The statements will form part of collective and individual actions by the partner agencies going forward and as work progresses will be updated to reflect progress.

March 2014

Appendix 2

Intermediate Care Fund Application for Cwm Taf - 2014/2015

Name/ Description of Scheme	WG Allocation Revenue £'000	WG Allocation Capital £'000
Project Management	£95	-
Evaluation	£75	-
Programme Event	£5	-
Public Information	£30	-
Volunteering	£50	-
Planning for Integrated @home Service	£150	-
Enhancing Capacity towards development of Integrated @home Service	£1.290	-
Community/Locality Coordinators	£188	-
Creating and Sustaining Neighbourhood Capacity	£150	-
Step up/down Facilities	£350	£150
Enhancing Housing Options and Adaptations Services	£205	£1.250
Establish Cwm Taf H&SC Economy Commissioning Team	£3	-
Commissioning Strategy	£47	-
Secure Interim Placements where First Choice is not Available	£180	-
Improve Quality of Care and Support Provided to Older People with Dementia	£100	-
Assistive Technology	-	£59
TOTAL	**£2.918**	**£1.459**