AGENDA ITEM 4

RHONDDA CYNON TAF COUNTY BOROUGH COUNCIL

CABINET

18TH FEBRUARY 2016

SOCIAL SERVICES AND WELLBEING ACT: IMPLEMENTATION PROGRAMME JOINT COMMISSIONING STATEMENT FOR OLDER PEOPLE

REPORT OF GROUP DIRECTOR, COMMUNITY & CHILDREN'S SERVICES, IN DISCUSSION WITH THE RELEVANT PORTFOLIO HOLDER, COUNCILLOR FOREY

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1. PURPOSE OF REPORT

1.1 To present the Joint Commissioning Statement for Older People's Services to Cabinet in four parts:

- Part 1 – Outcome of public engagement on the draft Joint Commissioning Statement for information;
- Part 2 –The Equality Impact Assessment of the draft Joint Commissioning Statement, which has been developed jointly by the partner organisations for endorsement;
- Part 3 – The final Joint Commissioning Strategy for Older People's Services 2015-25 for endorsement;
- Part 4 – Identification of next steps for discussion and endorsement.

2. RECOMMENDATION

It is recommended that the Cabinet:

2.1 Note the views received during public engagement.

2.2 Receives the Equality Impact Assessment.

2.3 Endorses the Joint Commissioning Statement for Older People's Services 2015-2025; and the proposed next steps.

3 REASONS FOR RECOMMENDATIONS

3.1 To ensure Cabinet are appraised on the development of the Joint commissioning statement for Older People's Services and that there is formal

endorsement from RCT as a key partner to the statement and supporting documents

4. BACKGROUND

4.1 In January 2014 Welsh Government announced the Intermediate Care Fund for 2014/15 for all regional collaboration footprints. The aim of the fund is 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.

4.2 One of the priorities for the partnerships was to develop a vision of commissioning for the whole health and social care economy. To deliver this it was agreed that a Joint Commissioning Statement for Older People's Services would be developed across the Cwm Taf Region to replace the separate strategies and approaches of each of the public sector agencies.

4.3 The first draft of the Joint Commissioning Statement for Older People's Services was presented to Cabinet on the 25th of June 2015 and an engagement programme with stakeholders and the public was authorised

4.4 This report summarises the outcome of this consultation exercise and presents the second draft of the Joint Commissioning Statement for Older People's Services and its Equality Impact Statement for formal endorsement

Part 1 Outcome of the Public engagement process for the draft Joint Commissioning Statement

4.5 The outcome of the public engagement phase is attached as **Annex 1**.

4.6 Public engagement on the draft Joint Commissioning Statement ran for nine weeks from Monday 27th July until Friday 18th September 2015. An engagement document was developed, which was accompanied by a questionnaire. Both were made available bilingually.

4.7 In line with previous engagement processes the main focus of activities was:

- Direct engagement with and discussion at the Older People's Forums and Older People's Advisory Groups across Cwm Taf;
- Engagement with the general public via RCT's Big Bite event in August 2015, which was attended by approximately 12,000 people;
- Engagement with the Third Sector through the Health & Social Care Network (facilitated by VAMT and Interlink);
- Targeted engagement via the existing Citizens' Panel; and
- Presentations to the Cwm Taf Community Health Council and the UHB's Stakeholder Reference Group;
- An open invitation for Officers from the partner agencies to attend any community, service user, carer or Third Sector group who requested further information or discussion.

4.8 The engagement document and questionnaire were also made available on the partner organisations' websites as well as the Cwm Taf Consultation Hub.

4.9 The views gathered during engagement have been analysed and the Joint Commissioning Statement has been amended accordingly.

4.10 A total of 136 questionnaires were completed via the leaflet and an additional 37 were completed online. **Annex 1** provides full detail of the views and comments provided.

4.11 The views received were generally supportive of the Joint Commissioning Statement although there was a strong view that the devil would be in the detail of prioritisation and implementation.

4.12 Where the views received had the greatest influence was in amending and strengthening the principles and values that underpin the Joint Commissioning Statement (see pages 5 and 6 of **Annex 3** for the full list of principles and values). For example public engagement confirmed support for the following principles:

- The majority of views received during the engagement period provided strong support for the principle of **Promoting Independence**.

  "People should be able to remain as independent as possible within their own homes and communities for as long as they are able".

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

  "Prevention is better than cure".

  "Yes, the emphasis is on prevention and early intervention if good investment is made at these levels this will prevent escalation of need at a higher level. However without meaningful engagement and sound investment at a community/ lower level we could be heading for greater difficulties".

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

  "The better we are looked after, the less we will cost!".

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

  "Real joined up care working between health and social care to provide a seamless, unified service based on need that can respond quickly to changes in the needs of individuals".

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

  "The provision of any care and support that the older person may require that truly puts the older person at the centre of anything that we do and giving them the options for them to maintain living independently for as long as they possibly can".

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  "Listen to people, care and have time for staff and clients".

- **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.

  "Is this a lot of words? Sounds okay as long as it is implemented".

  "Stop talking and writing about it and do it!"

  However, public engagement also identified the following areas that we had not made explicit but which as a result have now strengthened the underpinning principles of the Joint Commissioning Statement

- **Dignity** - Our organisations and our staff will treat service users and their carers with dignity and respect.

  "As you would like them to be treated with respect as we were always told to respect our elders!".

  "Safe environment, treating people with respect, maintaining people's dignity at all times, being treated as a person not a number".

  "My 91 year old mum, who has dementia, and has a care package provided, is distressed by the number of different people who are sent by the care company (as many as 15 different people in a week). Because of her memory loss, and the fact that many of them come only occasionally, they seem like total strangers to her. She would be a lot happier with a few familiar people providing the intimate services".

  How we train and supervise staff who deliver directly provided or commissioned services will be key to maintain the expected levels of dignity and respect to our service users and their carers, as will robustness in measuring patient/ client experiences and monitoring complaints, and ensuring genuine co-production.

- **Tackling isolation** – Supporting people to feel connected to their local community.

"Greater focus on tackling loneliness and isolation is needed to prevent deterioration in mental well-being and dependence".

In terms of how we will address this, tackling isolation in communities is one of the main aims of our priority to build community capacity and resilience.

- **Accessibility** – Factors such as the timeliness of a response and access/ transport to services will be a key consideration in the way we commission and provide services. Accessibility is also a main feature of the aligned *Aging Well in Wales Plan* for Cwm Taf.

Part 2 – Equality Impact Assessment (EIA)

4.13 The EIA is attached as **Annex 2**. Whilst this is set out in the Cwm Taf UHB format all the partners contributed to its development

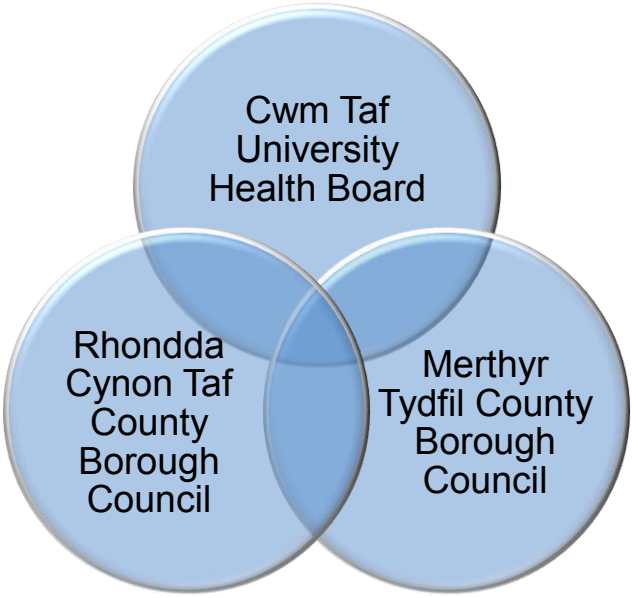
4.14 The full EIA, like the final Joint Commissioning Statement itself, has been informed by the wealth of intelligence, information and views gathered as part of the public engagement process.

4.15 The EIA identifies the potential positive and negative impacts arising from the Joint Commissioning Statement, and outlines actions to alleviate any potentially negative impacts. Overall the EIA concludes that the General Public Sector Equality Duty under the Equality Act 2010 has been met.

Part 3 – The Joint Commissioning Statement for Older People's Services 2015-2025

4.16 The Joint Commissioning Statement is attached as **Annex 3**.

4.17 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. 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).



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

4.19 The partners share a clear vision to transform the way we support people to live independent, healthy and fulfilled lives. This will be achieved by providing health and social care services that are:

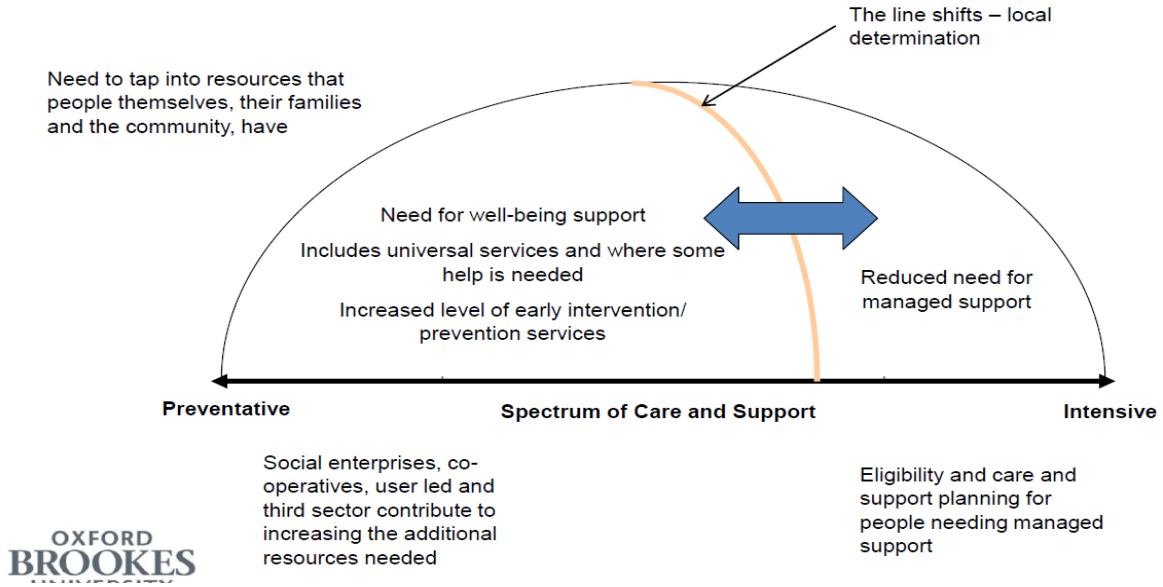
- Integrated, joined up and seamless.
- Focused on prevention, self-management and reablement.
- Responsive and locally delivered in the right place, at the right time and by the right person.
- Safe, sustainable and cost effective.

Which will:

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

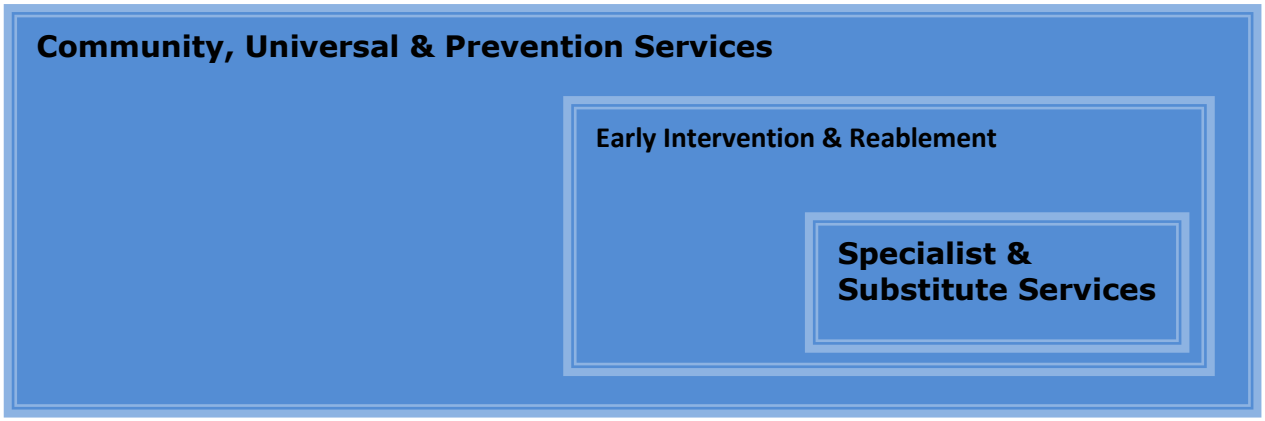
4.20 Continuing with current models of service is not an option. There are considerable challenges that, if not managed innovatively, will see resources increasingly targeted only at those with greatest need. Restricting the number of people receiving support to only those with the highest needs may 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.

4.21 This approach is in line with the requirements of the Social Services & Wellbeing (Wales) Act 2014 as illustrated in the diagram below. This demonstrates that the emphasis of service provision can be dynamic in response to the changing needs of individuals, providing targeted intervention and support where needed, enabling individuals to return to independence as quickly as possible, supported by ongoing access to universal services and community support.



4.22 We will achieve this by building an integrated, co-ordinated approach to health and social care services comprising 3 inter-related levels:

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



4.23 The characteristics of these services are summarised below:

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.

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

Early Intervention and Reablement

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

These services include enhanced reablement, intermediate care, and rapid response services. We will make sure that these services work closely with and within universal community and prevention services.

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, often but not always outside of their family or home setting. Examples of such social care services include residential and nursing care, domiciliary care, and safeguarding services. Equivalent examples in health include community hospital services, continuing healthcare and respite care.

Health and social care services at this level work in partnership to assess needs holistically, respond effectively to individuals' needs and wishes, and work with service users to help build their independence, comfort and confidence. 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.

Part 4 – Next Steps

4.24 Endorsement of this Joint Commissioning Statement will represent a major milestone and confirms a level of trust and maturity within the Cwm Taf health and social care community. However, this is only the beginning of the journey. The important next phase will be implementation of the Statement, which will deliver improved outcomes for older people in the Cwm Taf Region.

4.25 Aligned to this is the wider work that the Partnership is progressing to implement and ensure readiness for the all ages Social Services & Well-Being (Wales) Act 2014, which goes live in April 2016. To assist with this the Partnership will progress a conversation, to be facilitated by the Institute of

Public Care, in the New Year to determine how it can successfully deliver outcomes against a set of defined priority areas.

4.26 It is also understood that the Welsh Government is likely to increase the recurrent allocation of Intermediate Care Funding across Wales from £20m to £50m in 2016/17.

4.27 In light of the above two developments, Cabinet is asked to endorse the following Year 1 (2016/17) actions to support the successful delivery of the ten year Joint Commissioning Statement for Older People's Services 2015-25:

Community, Universal & Prevention Services:

- Working with the Third Sector and commissioning a range of services which build community capacity and resilience (e.g. in order to reduce social isolation amongst older people);
- Continuing to develop and strengthen the role of Community Co-ordinators;
- Networking Primary Care Services so they operate more effectively for the patient in partnership with Local Authorities and the Third Sector, particularly through the development of Cluster Hubs;
- Expanding health & well-being and self-care opportunities within communities (e.g. by tackling obesity or by introducing Housing and Health Action Areas);
- Developing the information, advice and assistance service to the public in Cwm Taf to ensure the effective introduction of the Dewis Cymru information Directory and compliance with the Social Service and Wellbeing (Wales) Act 2014.

Early Intervention & Reablement:
Closing the gaps between hospital and home and between health and social care through;

- The development of integrated @Home Services, supported by;
- The development of a Single Point of Access;
- The further roll-out of Integrated Assessment Processes;
- A review the provision of equipment.

Specialist & Substitute Services:

- Development of an accommodation with support strategy for older people exploring new models of care, to ensure a comprehensive continuum of options are available to avoid further reliance on residential care in the future;
- Retender the domiciliary care contract across RCT and Merthyr with emphasis on an outcome based approach to this service
- Undertake a joint market position statement for the care home market to inform the development of a pooled budget for care homes by April 2018;
- Continuing to improve the quality of Nursing Home Care through the Older People's Commissioner Action Plan including work to review the joint care home contract.

4.28 A detailed Year 1 implementation plan will be developed by the Partnership to reflect how these priority areas will be delivered by the Local Authorities and UHB in collaboration with the Third Sector and Independent Sector. The

implementation plan will also need to be underpinned by robust engagement with local communities and older people specifically.

5. EQUALITY AND DIVERSITY IMPLICATIONS

An Equality Impact Assessment (EqIA) is attached as Annex 2

6 CONSULTATION

The outcome of public consultation is attached as Annex 1

7. FINANCIAL IMPLICATION(S)

7.1 There are no financial implications aligned to this report for the council and the services will be funded within existing service budgets or through access to the ICF Grant

7.2 Currently 85% of the partnership resources are focussed on specialist and substitute services. Our implementation of the Social Services and Wellbeing (Wales) Act requires a much stronger emphasis on community and universal prevention services and we are committed through this commissioning statement to shifting the emphasis in our budget allocation significantly away from traditional long terms services towards services that promote wellbeing and independence.

8 LEGAL IMPLICATIONS *OR* LEGISLATION CONSIDERED

8.1 The Joint commissioning Statement for older people supports our implementation programme for the Social Services and Wellbeing (Wales) Act 2014

8.2 The Social Services and Wellbeing Act (Wales) received Royal Assent on the 1st May 2014 and takes effect from April 2016. The Act creates a new legal framework to bring together and modernise Social Services law.

8.3 The fundamental principles of the Act that are supported by this joint commissioning strategy for older people are:

People	Putting an individual and their needs, at the centre of their care, and giving them a voice in, and control over reaching the outcomes that help them achieve well-being
Well-being	Supporting people to achieve their own well-being and measuring the success of this care and support
Earlier intervention	Increasing preventative services within the community to minimise the escalation of critical need

Collaboration Strong partnership working between all agencies and organisations

9. LINKS TO THE COUNCILS CORPORATE PLAN/OTHER CORPORATE PRIORITIES/ SIP

9.1 The approach taken within the Joint Commissioning statement is based on the Single Integrated Plans (SIP) for Merthyr and Rhondda Cynon Taf. The key messages supported within this document 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.

Other information:

Relevant Scrutiny Committee

Health and wellbeing scrutiny committee

LOCAL GOVERNMENT ACT 1972

AS AMENDED BY

THE LOCAL GOVERNMENT (ACCESS TO INFORMATION) ACT 1985

RHONDDA CYNON TAF COUNTY BOROUGH COUNCIL

18TH FEBRUARY 2016

CABINET

REPORT OF GROUP DIRECTOR COMMUNITY AND CHILDREN'S SERVICES IN DISCUSSIONS WITH THE RELEVANT PORTFOLIO HOLDER (COUNCILLOR FOREY)

SOCIAL SERVICES AND WELLBEING ACT: IMPLEMENTATION PROGRAMME - JOINT COMMISSIONING STATEMENT FOR OLDER PEOPLE

Background Papers

- Annex 1 – Outcome of public engagement on the draft Joint Commissioning Statement for information
- Annex 2 – The Equality Impact Assessment of the draft Joint Commissioning Statement, which has been developed jointly by the partner organisations for endorsement
- Annex 3 – The final Joint Commissioning Strategy for Older People's Services 2015-25 for endorsement

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Annex 1

Social Services and Well-being (Wales) Act

The Cwm Taf Joint Commissioning Statement for older people's services.

Consultation Analysis Report
October 2015

1. Introduction

1.1 The Social Services and Well-being (Wales) Act 2014 (SSWA) will change the way local authority social services and other care services work together in partnership to help and support people. It will help make sure people enjoy well-being in every area of their lives.

1.2 In preparation for the new Act, Local Authorities and Local Health Boards have to know and understand the needs of the people who live in their area so that services can support and care for them.

To do this, a number of public consultations will be held to ensure that residents, particularly those who may be affected by this new way of working, are able to have their say. These views will contribute to the way we provide future services in Cwm Taf (Merthyr Tydfil and Rhondda Cynon Taf).

1.3 Currently, 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 Cwm Taf. As healthcare has improved we are all living longer and the number of older people in our area is increasing. 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.

1.4 The new Act also 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.

1.5 To help plan our way forward we have written a draft 'Cwm Taf Joint Commissioning Statement for Older People's Services' and recently carried out engagement activities with people living in Cwm Taf to ask for their views to ensure that the final document reflects their health and social care needs. This report summarises the findings from that consultation.

2. What did we do?

2.1 Over a 9 week period, between the 27th July and 28th September 2015, a number of face to face and online consultations were held which resulted in a total of 173 individual responses. Feedback was also received during discussions at group meetings (see page 10)

2.2 A short leaflet was developed which briefly described the 3 levels of services and asked for people's views on these new proposals. In addition to this, a longer online version of the leaflet was also produced, which explained the proposals in more detail.

2.3 The leaflet was circulated widely throughout the Cwm Taf area and was available within all public access areas in partner organisations.

- It was taken by all partners to organised events, for example, The Big Welsh Bite, an annual food and agricultural festival held in Ynysangharad park, Pontypridd.

- Presentations were made to a range of groups including:
  - RCT Older Persons Advisory Group (OPAG)
  - County Voluntary Council (CVC) Joint Engagement Event
  - Cwm Taf Community Health Council Service Planning Committee
  - UHB's Stakeholder Reference Group
  - Merthyr Tydfil 50+ forum

- The five Community Co-ordinators visited a range of groups for older people, Community Integrated Assessment Service (CIAS) clinics, INR clinics, GP practices and flu clinics. At these groups, they spoke to individuals about the consultation and supported them to complete the questionnaires which resulted in 44 hard copy responses.

2.4 An online version of the questionnaire was available to all residents via the Cwm Taf Community Engagement Hub (www.cwmtafhub.co.uk) and was promoted using Local Authority (LA) and Partner websites:

- Rhondda Cynon Taf Local Authority (www.rctcbc.gov.uk)
- Merthyr Tydfil Local Authority (www.merthyr.gov.uk)
- The Cwm Taf Health Board (www.cwmtafuhb.wales.nhs.uk)
- Interlink (www.interlinkrct.org.uk)
- VAMT (www.vamt.net)

The link was also circulated to all County Voluntary Council (CVC) members throughout Cwm Taf and to the Cwm Taf Citizens Panel (a group of 1000+ adults that are representative of the population across Cwm Taf), with paper copies being sent by post to those members without email access.

3. Consultation Findings

3.1 A total of 136 questionnaires were completed via the leaflet and 37 were completed online. The following is a summary of the responses received during the engagement period.

Question 1: Do you agree with the Service Plan?

The majority of those who responded to this question (93%) stated that they agreed with our service plan.

	Yes	No
Leaflet	120	7
Online	31	4
Total Responses	**151**	**11**

You said:
"Supporting people at an earlier stage makes sense. Having the 3 levels makes it easier for people and professionals to understand and identify what type of services a person would need."

"It tackles overall well being which is not the case at present e.g. older people can be isolated and depressed if not engaged in local events."

"Yes, services have to have more of a joined up approach, there are currently too many gaps and a lack of knowledge and understanding of older people needs."

Negative responses included:
"There is too much emphasis on families providing support - this assumes people have family members who don't work, or who live locally."

Question 2: Do you think we have the right priorities for older people's services?

Again, a high number of respondents (89%) stated that they thought we had the right priorities for older people's services.

	Yes	No
Leaflet	115	11
Online	28	6
Total Responses	**143**	**17**

You said:
"Yes, prevention is always better than cure"

"Yes, but it will take more than one generation for the ideology to be accepted. Financially they require significant investment which isn't achievable in this time of austerity."

Negative responses included:
"No, a greater focus on tackling loneliness and isolation is needed to prevent deterioration in mental well-being and dependence."

Table 1: Common Themes

Throughout the questionnaire, respondents were encouraged to include comments in their responses. The comments made often referred to the same subjects, which are summarised below.

Subject / theme	No. of occurrences
Living independently at home	**37**
You said: *"Help older people stay in their own homes for longer, giving them as much independence as possible."*	
Accessing accessible information and advice	**22**
You said: *"Easier access to information regarding support / services from voluntary organisations available for public access. So we all take responsibility for are own lives and those of our families."*	
Social isolation/loneliness	**21**
You said: *"Loneliness should be a priority. People need companionship"*	
Transport	**19**
You said: *"A big issue with community projects and support is transport. A viable system has to be put in place to get elderly people to community-based projects, as families are not always able to do this. Currently, and historically, this has seen the demise of good community-based initiatives."*	
Dignity, Respect and Compassion	**15**
You said: *"Treating people with respect, maintaining people's dignity at all times, being treated as a person not a number."*	
Easier/quicker access to GP	**14**
You said: *"Patients tell me it is very difficult to get appointment with GP - so usually GPs are left out from dealing with chronic mobility problems or declining in health. More GPs and easier access to them would be needed."*	
Family/Carer Support	**11**
You said: *"Need to consider the additional stress placed on family members when put into the 'voluntary carer' role. Whilst those that do it usually do it willingly that does not mean that it is OK as their quality of life is reduced, which can have an effect on their health."*	

Table 1: Common Themes (continued)

Subject / theme	No. of occurrences
Accommodation/Housing	**9**
You said: *"The extra support and housing talked about should be in place asap. More sheltered housing is certainly required, more communal houses where elderly are encouraged to go in the mornings, afternoons or all day even with transport provided."*	
Funding/Resources	**7**
You said: *"Providing alternatives (private services / 3 sector services / home support) requires a wealth of resource and with the private / 3rd sector agencies the funding is often time limited / non recurring and services fail."*	

Other comments received

Throughout the consultation, a small number of comments were made about the following topics.

- Collaboration

"The idea of a more collaborative working is very beneficial provided that it works to the best that it possibly can."

- Health

"Patients are more quickly accessed in hospital and moved into the correct environment suitable for their means, too many patients languish in hospital beds despite being medically fit and unfortunately seem to deteriorate especially mentally and sometimes physically (falls. hospital acquired infections, infections from outside the hospitals control) compounding their issues."

- Staffing

"What happens in practice is the most important thing - ensure there are sufficient people, with the right attitude and resources available to care for these vulnerable people."

- Support and Care

"The provision of any care and support that the older person may require that truly puts the older person at the centre of anything that we do and giving them the options for them to maintain living independently for as long as they possibly can."

And some final words:

"The better we are looked after, the less we will cost."

"Listen to people, care and have time for staff and clients."

"Older people are living longer and need all the help they can receive."

Suggestions and ideas

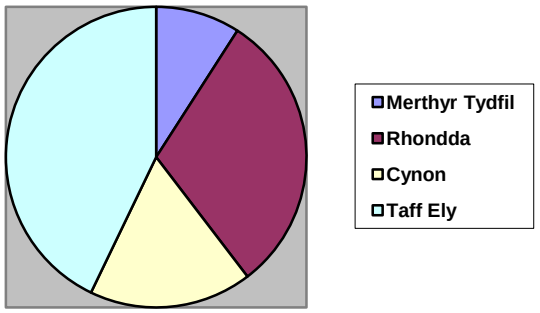
Many respondents took the opportunity to make their own suggestions about how they felt services could be improved.

They suggested:

- Bridging the generation gap by mentoring young unemployed people in care service settings and holding more intergenerational activities.
- Offering complimentary therapy services, named GP's and educating people about their illnesses.
- Better centrally located housing ring fenced and designed for older people.
- Setting up information points in community settings such as libraries and leisure centres.
- Tackling long term isolation by having welcoming social centres hosting a variety of different groups and promoted by local coordinators.

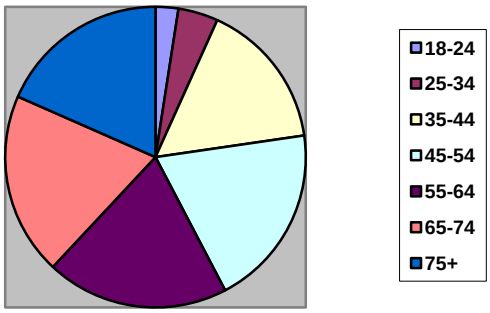
4. Respondent Demographics

The final section asked all about the individual completing the questionnaire.



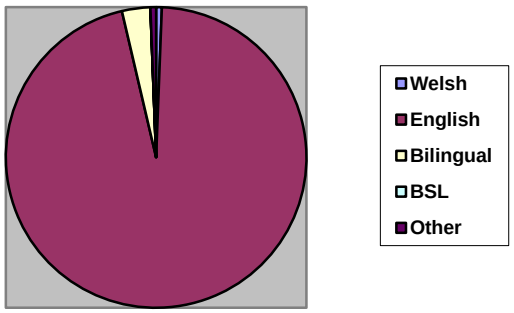
- 9% were from Merthyr Tydfil
- 30.5% were from the Rhondda Valley
- 17.5% were from the Cynon Valley
- 43% were from Taff Ely

Figure 1. Area of responder



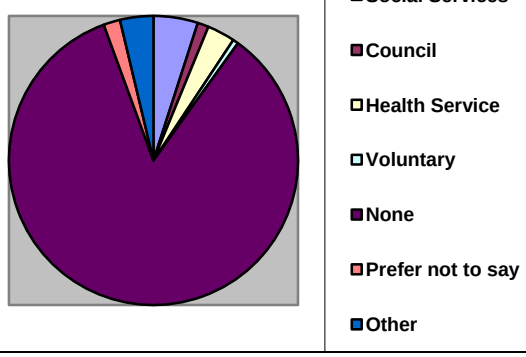
- 2% were aged between 18 and 24
- 4% were aged between 25 and 34
- 16% were aged between 35 and 44
- 20% were aged between 45 and 54
- 20% were aged between 55 and 64
- 20% were aged between 65 and 74
- 18% were aged 75+

Figure 2. Age Range of responder



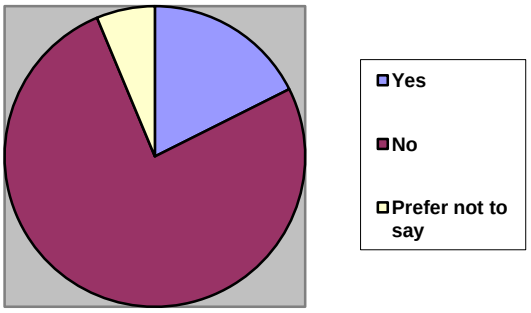
- 96% use English as their day to day language
- 3% were bi-lingual
- 0.5% use Welsh as their main language
- 0.5% can use basic sign language

Figure 3. Preferred language?



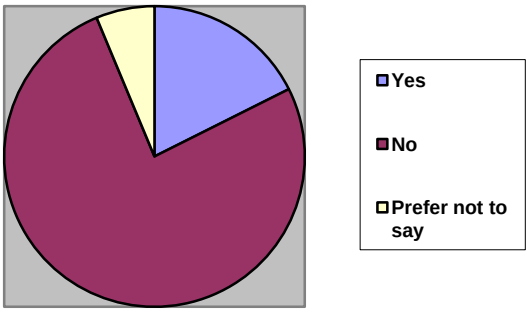
- 5% received a service from Social Services
- 3% received a service from Health
- 1% received a service from the Council
- 1% received a service from the Voluntary sector

Figure 4. Do you receive any support?



- 18% were carers

Figure 5. Are you a carer?



- 19% considered themselves as disabled

Figure 6. Consider to be disabled?

4.1 The final question that people were asked was: **'Do you feel that the proposed changes would have more of an impact on you (positive/negative) because of the things you've told us about yourself above?'** (i.e. in the demographic section of the questionnaire.)

Just over half (52%) of the people who responded to this question felt the proposed changes would have a positive impact on them.

"*I do believe that this would have a positive impact on myself because even though I am disabled person, I do try to live very independently for as long as I possibly can and these changes would make this possible for all older people. Getting older with these changes in mind would make my life less daunting."*

Whilst, 48% of respondents felt the proposed changes would not have an impact on them personally.

"Not now, I am quite independent and can manage ok on my own."

5. Feedback from meetings and group discussions

5.1 Throughout the engagement period, presentations were made to a number of groups to explain the consultation and give people the opportunity to ask questions, comment or complete the questionnaire. The following is summary of the feedback from these sessions.

5.2 **RCT Older Persons Advisory Group (OPAG) presentation**
The meeting was held on the 22nd July. Attendees were very supportive of the model and particularly liked the idea of reducing reliance on care homes and increasing alternative accommodation opportunities.

They were concerned that at a time when Council's are shutting community facilities we would be expecting people to find more support in informal settings - but they recognised that there was a wide range of facilities in the community (local cafe's etc.) that provide meeting places for people etc. which they use themselves.

As, this was one of the first consultation events, feedback was given on the questionnaire itself, its layout and the way it was worded, This feedback led to some changes being made before circulating the questionnaires more widely.

5.3 **County Voluntary Council (CVC) Joint Engagement Event**
Interlink (RCT) and Voluntary Action Merthyr Tydfil (VAMT) held a joint Health, Social Care & Wellbeing Forum event on 5th August. 28 people attended representing a wide variety of organisations. A detailed presentation was devised and delivered.

Feedback included:

- "How can the provision of social and nursing care at home be achieved? Family? Local Authority? Capacity within families needs to be considered".
- "Greater expectations on carers"
- "What are the Local Authorities intentions around charging carers for services?"
- "Money for small groups to enable the requirements of the SSWBA"
- "Stroke – more support for reablement. Dementia – more support for mainstream activities"

Whilst the offer for collating a Forum response was made to attendees, they were also invited to send individual responses and encourage their beneficiaries/service users to respond too.

5.4 **Cwm Taf Community Health Council Service Planning Committee**
The meeting was held on the 12th August 2015 and there were approximately 10 people in attendance - due to limited time, the engagement was brought to the attendees attention and members were requested to share the information and encourage responses. It did also generate a request for more information on the Social Services and Wellbeing Act.

5.5 **University Health Boards (UHB) Stakeholder Reference Group**
The meeting was held on the 18th August 2015 and there were approximately 20 people in attendance. The main themes discussed were around residential care and carers.

5.6 **Merthyr Tydfil 50+ forum**
The meeting was held on the 28th of September which provided an opportunity to discuss the statement. 89 individuals attended. There were no comments.

6. Conclusion

6.1 The responses received during this consultation confirmed that the majority of people agreed with our service plan and believe we are focussing on the right priorities for older people's services.

6.2 The most common issues raised by participants were regarding:

- Living independently at home
- Accessing accessible information and advice
- Social isolation and loneliness
- Transport
- Dignity, respect and compassion
- Easier and quicker access to their GP
- Family and carer support
- Accommodation and housing
- Funding and resources

6.3 We'd like to take this opportunity to thank all who took part in this consultation.

This important feedback has been used to update our 'Joint Commissioning Statement for Older People's Services 2015 - 2025' which will help to shape the way in which we provide our services for older people in the future throughout Cwm Taf whilst at the same time, meeting our duties under the new Social Services and Well being (Wales) Act.

ANNEX 2

SERVICE PLANS AND PRIORITIES FOR OLDER PEOPLE'S SERVICES ACROSS CWM TAF
EQUALITY IMPACT ASSESSMENT

1. INTRODUCTION

The development of a Cwm Taf Joint Commissioning Statement for Older People's Services 2015-2025 has been considered against the Equality Act 2010 and specifically the Public Sector Equality Duty, which came into force on 5th April 2011.

As part of this duty, public sector bodies in Wales are required to publish an assessment of impact in order to be transparent and accountable i.e. their consideration of the effects that their decisions, policies or services have on people on the basis of their gender, race, disability, sexual orientation, religion or belief, and age, to include gender re-assignment, pregnancy and maternity, marriage and civil partnership issues. These are classed as 'protected characteristics'. Whilst deprivation does not constitute a 'protected characteristic' it is relevant because people from protected groups are more likely to experience it and because there are such high levels of deprivation in our local community. 36% of the Cwm Taf population live in areas which are among the most deprived 20% in Wales.

The need for the collection of evidence to support decisions and for engagement mean that the most effective and efficient impact assessment is conducted as an integral part of policy development or service re-design, with the assessment being commenced at the outset. These will help to eliminate discrimination, tackle inequality, develop a better understanding of the community, and target resources effectively.

2. SERVICES FOR OLDER PEOPLE

Improvements in health care and more effective medical interventions, together with a greater emphasis on prevention and public health activities, have led to the population as a whole living longer. In spite of these successes, inequalities still remain in how these benefits are realised across our population and local communities. Demographic changes and the ageing population mean a significant increase in the number of older people who will need access to health and social services over the next twenty years. This increase in demand will challenge the current pattern of services at the same time as public sector spending is also under severe pressure. Continuing with current models of service will not

be an option. Restricting the number of people receiving support to only those with the highest needs may result in a short term reduction in demand for services. However, without putting in place adequate preventative strategies, we will not secure longer term sustainability, neither in terms of the outcomes for individuals nor from a financial and capacity perspective for health and social care services. We need to change the way we offer support and care to older people through statutory and voluntary services.

Partners wish to move away from a response that offers institutional care as almost inevitable and necessary for older people as they become frailer. Instead our responses should be focused on individual outcomes, preventing crises and promoting independence.

Rhondda Cynon Taf (RCT) County Borough Council, Merthyr Tydfil County Borough Council and Cwm Taf University Health Board have worked together to develop a Joint Commissioning Statement for Older People's Services which describes a strong and shared commitment to deliver a new model of integrated health and social services for our older population. The invaluable role of the Third Sector has also been recognised and the plans and priorities outlined in the Commissioning Statement have been developed with this extended sense of partnership in mind.

2.1. THE VISION AND SERVICE MODEL

We have adopted a common vision for older people in Cwm Taf:

VISION FOR OLDER PEOPLE IN CWM TAF

We want to support older people in Cwm Taf 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
- Focussed 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

Our new service plans include an emphasis on the important part families and communities play in offering people care and support.

Our role is to work alongside and complement these networks, rather than instead of them, and support people to live independent, healthy, and fulfilled lives as they get older.

When people do need help, we need to make the right services available at the right time. 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 more intensive, institutional and disruptive and expensive care services later on in their lives.

Our new approach to health and social care services has **3 levels** which overlap:

Level 1 Community, Universal and Prevention Services

These types of service are universal, anyone in the community can access them, and an example of this type of service would be local leisure centres or primary care services. It seeks to support and build on the strength of family and community support networks.
In the future, our role will be to nurture and support informal support networks, such as the care and support provided by family and friends or by voluntary/ charitable groups and organisations that work in local communities. 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.

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 which mean that there is less need for additional health and social care services. When people's needs cannot be met through Community, Universal and Preventative Services (Level 1), we will offer people early intervention and reablement services. These will help older people deal with the difficulties they may be having, and help them recover their independence and remain living within their community.

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 longer term specialist or substitute care and support.
Examples of these types of services are domiciliary care, residential and nursing care, and community hospital services.

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 required by a smaller number of people but provide specific, more tailored 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 are coordinated effectively and work closely with each other, so that people receive the help they need, when they need it, they way they want it.

We anticipate that by providing more support at Level 1(Community, Universal and Prevention Services), fewer older people will need 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.

2.2 OUR COMMISSIONING PRIORITIES

The Commissioning Statement identifies a number of Priorities:

- Building Community Capacity
  Helping communities work together to find local solutions to problems older people face.
- Information, advice and assistance
  Making it easier for people to find out about and access a range of preventative, care and support services
- Health and Wellbeing
  Helping older people to "age well", stay healthier, happier and able to participate in local activities
- Domiciliary care
  Care and support provided to people in their own home which empowers service users and carers to have more choice and control
- Accommodation with support
  Different housing options to enable people to live independently for as long as possible
- Responsive Primary care services and an integrated@Home service
  Development of the UHB's Primary care and Communities Services strategy
- Governance and infrastructure
  The way the Health Board, Local Authorities and other key partners will work together to deliver the changes needed.

2.3 THE OUTCOMES WE WANT TO ACHIEVE

We need to be sure that we focus effort on making a difference and improving the health and wellbeing of our older citizens. We have

identified the following outcomes and will measure the success of the Commissioning Statement against them.

- 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.

3. UNDERSTANDING THE DEMOGRAPHIC PROFILE

Information relating to the local community is based on Public Health Observatory and 2011 Census information. Staffing information is based on the Electronic Staff Record (ESR). It is limited to data that is collected and available at this point in time.

Cwm Taf includes 4 localities which are Rhondda, Cynon Valley, Taf Ely and Merthyr Tydfil. It has an ageing population, recognised health inequality (Inverse Care Law) and high levels of deprivation. There is an associated lower life expectancy (8 less years for males and 6 less years for females between the poorest and most affluent areas within our own community), shorter good health (the lowest in Wales) and high incidence of multiple morbidities including stroke.

The population is growing and there is low employment and low levels of academic achievement.

A detailed Needs Assessment has been undertaken to inform the development of the Commissioning Statement. In addition, the following information is relevant in relation to protected characteristics.

3.1 Gender

There are a very slightly higher proportion of female residents living in the Cwm Taf area and this is broadly consistent with the rest of Wales. Women are expected to live longer than men so may need more access to services if they become increasingly frail. Women are more dependent on public transport and the importance of providing locally based services within community settings as far as possible is an important element of our service plans.

Men and women experience loneliness differently, as evidenced in the report "Evaluation of the Isolation to Integration Project" completed in May 2015 which looked at the issues of isolation and loneliness in the over 65s population in RCT. Studies have linked male loneliness to the lack of a spouse or partner. Women tend to develop relationships with a wider network of people which means they have access to a larger resource that can cushion and support them during times of need.

3.2. Age

The 2011 Census indicates that Cwm Taf has a slightly higher proportion of younger people than Wales as a whole, particularly in the 0-4 and 5-15 bands. Other groups are broadly consistent with the rest of Wales, except for 25-44 group and 65-84 age band which is 1% higher.

In Cwm Taf there are over 53,000 people over the age of 65 and over 23,000 people over 75. The Local Authorities successfully support more than 5000 people over 65 to live in the community which suggests that there are more than 48,000 people living in the community without formal support.

Current projections see a rise in the total adult population of Cwm Taf to 237,930 by 2030, 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%) whilst 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** will increase from 13,270 to 22,740 (**71.3% increase**).

Meeting the needs of an increasingly ageing population will be a key challenge. 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 individuals, families, communities and public sector organisations.

Without a change in approach and service redesign, projecting the current proportion of over 65s in receipt of community services or in care homes to the increased population figures, indicates a significant level of demand with a need for increased places and associated financial pressures.

In addition to care needs (considered further below eg under Disability and Health) there are a range of other issues. For example, older people are less likely to have access to a car which

highlights the need for services to be as local as possible, within their own homes and communities.

Implications of lower income levels, reliance on benefits and issues such as fuel poverty and digital inclusion will also cause difficulties for many older people and may prevent them from participating in health and wellbeing activities, accessing information or services or contribute to them becoming socially isolated. Older people are more likely to live alone which can present problems if they become unwell or have been in hospital and unable to be discharged without support.

3.3 Disability

Cwm Taf has a significantly higher proportion (2.8%) of residents who declare that their day to day activities are 'limited a lot' and a slightly higher proportion whose activities are 'limited a little' as described in Census 2011 categories. This is consistent with the age profile as more than half of men and women over 65 years say that they have a limiting long term illness (How Fair is Wales 2011). Disabled people are ten times more likely to report ill health and also approximately half are likely to experience mental ill health (How Fair is Wales?).

People who have a disability are twice as likely than people without a disability to have no access to a car (Office for Disability Issues 2009). Disabled people are also less confident in using public transport because of physical access issues but also because of staff attitudes (Framework for Action on Independent Living 2012).

The numbers of people with sensory impairments will increase with age. Such people may have difficulty accessing services and participating in activities that promote their health and wellbeing or social inclusion as well as maintaining independent living in their own homes.

3.4.Ethnicity

Cwm Taf has lower representation from ethnic groups other than white than Wales as a whole. However there are Polish, Portugese and Czech people living in the local community and their access issues will need to be considered in terms of language issues and availability of transport.

Language can represent a barrier in accessing public transport (Public Transport Needs of Black and Minority Ethnic and Faith Communities, Department of Transport 2003) and services generally. It can also limit understanding during diagnosis,

treatment and during recovery. The use of translation services may be appropriate and there are policies in relation to these services.

Evidence shows that people from different ethnic groups respond differently to health promotion campaigns which may not be sensitive to language or cultural differences. In planning and delivering health and wellbeing activities, providers need to be mindful of these issues. However, the importance of family and community support networks is well recognised by many ethnic groups which will be helpful in building community capacity. The Isolation to Integration report found that ethnic minority elders may be among the most lonely in their communities.

The Health ASERT Programme Wales, investigated health issues among ethnic minority groups, refugees/asylum seekers and gypsy travellers and resulted in a series of reports on these issues (Papadopoulos and Lay, 2005; Aspinall, 2005, 2006a, 2006b). These reports have highlighted the paucity of Wales-specific information in terms of research undertaken and of specific statistical Wales-based data on the groups being examined. This is an issue for Cwm Taf UHB as there are established gypsy traveller sites within our geographical area.

3.5.Marriage and Civil Partnership

The number of people who are married or in a same-sex civil partnership living in Cwm Taf is the same as for Wales as a whole.

For the majority of people, including older people, losing a long term partner as a result of bereavement can be a life changing event that has a significant impact on their health and wellbeing.

3.6.Religion

There is a lower representation in every religious group in Cwm Taf than is seen in Wales as a whole. Higher than average proportions of the population stated that they had no religion.

However it is important that services take cultural needs into account. A guide to cultural issues has been developed by Mental Health Advocacy Services (partly commissioned by the Health Board).

3.7.Sexuality and transgender

This information is not currently available. However in general terms, research has suggested there may be an association between harassment and poor mental health. Some evidence suggests lesbian, gay and bisexual and transgender people, are perhaps more likely than other groups to face hostility and

misunderstanding, and are more likely to experience poor mental health.(How Fair is Britain?). Recent research looking at the mental health and emotional wellbeing of transgender people has found rates of current and previously diagnosed mental ill health are high.

The Isolation to Integration report found that gay men and lesbians are at greater risk of becoming lonely and isolated as they age because they are more likely to live alone and have less contact with family.

It is also recognised that these groups find it particularly difficult to access services and their dignity and respect must be protected in both hospital and community settings. It can also be an issue for older people who may feel less comfortable about disclosing their sexuality e.g. when living in care homes or when admitted to hospital and their relationships are less likely to be taken into account This is being addressed by the Older Person's Commissioner in the Welsh Declaration of the Rights of Older People.

3.8.Deprivation

Over 40% of residents in Merthyr Tydfil live in the most deprived fifth of Wales and within Rhondda Cynon Taf over 30% of residents live in the most deprived fifth of Wales. Higher levels of deprivation are evident in every category compared with the rest of Wales and this has implications for access to health generally, as well as other issues such as transport, unemployment and prosperity.

This has implications for our health and wellbeing given the association between deprivation and ill-health, which manifest in shorter life expectancy than the rest of Wales. There is also a gradient in life expectancy across Cwm Taf with higher levels of deprivation in valley communities, compared to the less deprived areas along the M4 corridor. A man born in the most deprived areas of Cwm Taf can expect to live 5 years less than if he were born in the less deprived areas.

We also observe this gradient in healthy life expectancy - defined as the number of years lived in good health and Disability-Free Life Expectancy. This means that a man born into one of our most deprived communities can expect to live 23 years of his already shortened life with a disability or limiting long term illness.

People in more deprived areas are more likely than people in other areas to report a range of key illnesses including high blood pressure, diabetes and mental health problems.

3.9.Physical and Mental Health

The projected increase in the number of older people (75 and over) is likely to cause a rise in chronic conditions such as circulatory and respiratory diseases and cancers. Acute exacerbations and social problems in such people will have implications for A&E services AND emergency hospital admissions. Stroke is more common over the age of 55, with the rate doubling with every decade of life thereafter.

The Cwm Taf population report the poorest mental health status of all Health Boards in Wales. This could have implications in terms of recovery as emotional well-being, positive attitude and happiness are likely to contribute to a good recovery (as found by the Care Quality Commission).

In relation to older people, we expect dementia to be an issue of increasing significance. By 2030, our population of people over the age of 65 with dementia will increase by 53.7% and an increase of 61% is expected for people over 80 years old. When combined with the projected increase in physical health needs (from a range of illnesses and conditions that become more prevalent with age), the overall impact on health and social care services will be significant. Our proposed new service model is intended to address this challenge by changing the way these needs are met in the future.

Estimates suggest that one in three people aged 65 years and over experience a fall at least once a year – rising to one in two among 80 year-olds and older. Although most falls result in no serious injury, approximately 5 per cent of older people in the community who fall in any year sustain a fracture or require hospitalisation. Approximately 70 people over the age of 65 attend A and E services in Cwm Taf every week. The consequences of a fall in later life can be significant, both physically and emotionally, causing loss of function, mobility, independence and confidence.

Poor health and disability, including reduced mobility, cognitive and sensory impairment, all increase older people's chances of being lonely. A number of studies, cited in the Isolation to Integration report, highlight the serious ill health consequences of being lonely or isolated and a close association with higher rates of mortality. According to the Depression Alliance (2015) depression causes loneliness and loneliness causes depression – both are closely linked.

3.10. 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. It is probable 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.

Of those carers that we know about, a total of 11,752 carers provide a significant level of support - 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.

As a very general guide, the Survey of Carers in Households - England, (Health and Social Care Information Centre 2009-10) found that carers were more likely to be women than men; 60 per cent of carers in England were women; carers were most likely to be aged 45-64 (42 per cent); a quarter (25 per cent) were aged 65 or over. Around half (46 per cent) of carers were in paid employment, 27 per cent were retired from paid work and 13 per cent were looking after their home or family; 92 per cent of carers were white, while 8 per cent were from black and minority ethnic (BME) backgrounds.

Figures from the Office for National Statistics show that the rate change in the number of carers by age group is most significant for people over the age of 65. From 2001- 2011, there was an increase of over 30% in both RCT and Merthyr Tydfil in the number of carers over 65.

This is relevant to issues raised in relation to gender, age and ethnicity and also to references to empowering users and their carers.

3.11.Welsh Language

In Cwm Taf, 12.3% of adults and 8.9% of children are able to speak Welsh. The proportion of those who are able to understand, speak and/or write Welsh varies within this. It is possible that the elderly or confused may prefer or need to communicate in Welsh and every effort will be made to accommodate this eg Ward B2 at Ysbyty Cwm Rhondda has recently been designated a Welsh language ward.

3.12. Human Rights

At its most basic, care and support offers protection of people's right to life under Article 2 of the European Convention by ensuring their most fundamental physiological needs, such as eating, taking medication, getting up in the morning and going to bed at night are met. But for those who require it, and those with whom they share their lives, the availability and organisation of care and support also determines whether they enjoy a number of other important human rights including freedom from inhuman and degrading treatment (under Article 3 of the Convention) and the right to respect for private and family life (under Article 8). These rights are underpinned by some important human rights principles: dignity, autonomy and respect.

One of the main changes will be the emphasis on early discharge and community care and the Equality and Human Rights Commission led an inquiry in England into 'the protection and promotion of human rights of older people requiring or receiving care and support'. Whilst it focused on home based domiciliary social care, the findings and recommendations are also relevant to other services. The inquiry stated that 'all public authorities have duties to promote human rights.

4. STAFF WHO MAY BE AFFECTED BY THESE PROPOSED CHANGES

Analysis undertaken to develop the Joint Commissioning Statement has shown that the majority of partner resources, including staffing, are focussed on services at Level 2 and 3 (see page 3 above for description of Levels) whereas we need a stronger emphasis in the future on Level 1, Community and universal preventative services.
We will need to consider the implications of the new service models for our staff. It is important that if staff are required to relocate or work differently, eg as part of integrating services, their personal characteristics and circumstances are taken into account, particularly if their journey is more difficult or their work pattern changes e.g. their age and family commitments. Appropriate organisational change policies should be taken into account.

5. THE ENGAGEMENT EXERCISE

Considerable engagement has been undertaken in the development of the Joint Commissioning Statement. A public facing summary of the draft Statement was prepared together with a leaflet and questionnaire. All documents were also available in Welsh.

In line with previous engagement processes the main focus of activities was:

- Direct engagement with and discussion at the Older People's Forums and Older People's Advisory Groups across Cwm Taf.
- Engagement with the general public via the next round of UHB Public Forums in July.
- Engagement with the Third Sector through the Health & Social Care Network (to be facilitated by VAMT and Interlink).
- Targeted engagement via the existing Citizens' Panel.
- Targeted engagement by the Intermediate Care Fund Community Coordinators who visited local Older peoples groups and also hospital clinics and services.
- An open invitation for Officers from the partner agencies to attend any community, service user, carer or Third Sector group who would like further information or discussion.
- Involvement through any appropriate public events or stakeholder meetings eg the Big Bite weekend in Ynysangharad park, Pontypridd , meetings of Cwm Taf Community Health Council, Stakeholder Reference Group

The engagement document and questionnaire were made available on the partner organisations' websites, as well as the Cwm Taf Consultation Hub. Individual partners used their own additional mechanisms as appropriate eg the UHB published the engagement document via Sharepoint and used the Chief Executive's weekly blog in order to ensure that staff were also actively engaged and had the opportunity to respond.

Public engagement ran for 9 weeks from 27th July to 18TH September 2015. A detailed Consultation Analysis report has been written which is attached as Appendix 1. This outlines the engagement activities undertaken and presents the results, including the findings from the 193 responses received. 58% of responders were aged over 55, 18% considered themselves carers and 19% considered themselves as disabled.

The key feedback received was overwhelmingly positive as summarised below:

a)Do you agree with the Service Plan

93% of respondents agreed with the Service Plan with comments highlighting that

- care at crisis points is not sustainable
- services need to be more coordinated and better understand older people's needs
- supporting people at an earlier stage makes sense

Concern was expressed by a few that there is too much emphasis on families providing support and that there is a lack of suitable specialist accommodation. Others wanted more information, recognising that this was a high level, brief document which will need to be supported with more detailed action and delivery plans.

b)Do you think we have the right priorities for older people's services

89% of respondents agreed that we had the right priorities. Comments included

- Prevention is always better than cure
- Emphasis on early intervention will prevent escalation of need

Those who disagreed felt there was insufficient focus on tackling loneliness and isolation, an over emphasis on Level 1 Services and not enough choice of good quality care homes.

c) COMMON THEMES

A number of common themes and suggestions emerged from the additional text/responses people made:

- **Living independently at home** - welcomed as a positive approach and the right way forward
- **Accessible information and advice** - essential but we must be mindful of formats, means of accessing eg digital, face to face, the needs of people with sensory impairments and the general level of literacy/understanding amongst the population
- **Social isolation/loneliness** – recognised as a key issue and the need for a wide range of free/low cost social activities/ befriending schemes to support people to become more involved
- **Transport** - always seen as a barrier to accessing services for older people who are reliant on public transport
- **Dignity, respect and compassion -** being treated as an individual and having choice and control. We need high quality standards of care
- **Easier/quicker access to GP –** need for more GPs and/or improved access. Better coordination and continuity of help/services
- **Family/Carer support** – we must support carers and make it easier for them to undertake their caring role
- **Accommodation/Housing** - we need a range of accommodation options

- **Funding/Resources** – investment will be needed, particularly in the community. Effective integration is difficult with separate budgets, information systems etc

The engagement on the draft Joint Commissioning Strategy has therefore confirmed that it is generally accepted and supported by stakeholders. The draft Statement has been amended to reflect the findings of the engagement eg by quoting some of the comments made and also acting on the responses by clarifying, adding to or strengthening the proposals as appropriate.

6. POTENTIAL POSITIVE AND NEGATIVE IMPACT IDENTIFIED

The engagement questionnaire asked specifically if people felt that the proposed changes would have more of an impact (positive or negative) on them because of their individual characteristics.
52% of people felt there would be a positive impact. 48% did not feel there would be any impact on them personally.

More specific impacts that have been identified are as follows:

6.1. Positive:

i) The primary beneficiaries are older people which provides a positive focus rather than any negative discrimination based on age. The proposals will affect all older people for example in relation to community, universal and preventative services but also have an overall benefit for the resilience of the wider population, recognising that many people are affected by the ageing of family members, friends and neighbours etc .

ii) There will be a positive impact in terms of a culture change which promotes independence and social inclusion, greater choice and control for older people and values the contribution they can make in their communities.

iii) The proposed service model (three interrelated Levels) will improve health and social care outcomes eg by increased availability to services that promote health and wellbeing but also the opportunities to target support and care to those who need more intensive help. This will have a positive impact on those with more complex needs including health conditions or disabilities.

iv) Women in Cwm Taf have a higher life expectancy than men so the Joint Commissioning Statement is likely to have a greater beneficial impact on them. However, a greater focus on the quality of life of older people in total is likely to result in greater attention

being paid to the needs of men who often tend to become more isolated as they get older.

v) The emphasis is for the majority of services to be available as locally as possible, at home or within local communities. This will have a positive impact by promoting accessibility and addressing barriers like transport. Home based and community care can minimise disruption to people's lives. It can also be easier to meet individual spiritual and cultural needs if older people remain part of their own community and any groups to which they belong. Privacy eg LGBT status and family life, including marital and civil partnership status can be preserved.

vi) The improved coordination of services to be achieved by the collaborative approach taken by partners and the development of a Joint Commissioning Statement will ensure older people can access the services they need in the right place at the right time, delivered by the right person.

6.2. Negative

i) There may be a negative impact on family members/carers who feel that they have to take on additional responsibilities and a significant unpaid caring role. This could particularly impact on certain cultures and/or where women are traditionally expected to take on that role.

ii) There is an expectation that suitable alternative preventative and support services will be available at Levels 1 and 2 to address the increased demand that is anticipated as a result of demographic pressures etc. If these services are not available quickly enough with sufficient capacity, there will still be additional demand at Level 3 which may be difficult to meet.

iii) Some groups, eg people with sensory impairment, may be unable to access appropriate information, advice and assistance which will disadvantage them further.

It is accepted that there are some groups within the older population eg LGBT or ethnic groups whose needs are not currently as well understood due to lack of data (both quantative and qualitative) However it is not anticipated that there will be a negative impact on them.

Overall it is considered that the benefits to be gained from the implementation of the Joint Commissioning Statement for Older People will outweigh any negative impacts. The potential negative

impacts will be addressed as identified below and as the Strategy is implemented.

7. PLANS TO ALLEVIATE ANY NEGATIVE IMPACT

7.1. Support for carers

Carers need to be identified, recognised as carers and valued as partners in care. They need to have the right information, advice and assistance to enable them to balance their caring role and their life outside caring.

The work currently being undertaken to support Carers as part of the implementation of the Carers Measure (Wales), for example through the identification of Carers Champions, will continue. There are now over 300 Carers Champions working in the UHB, LAs, Third sector and Job Centre Plus. Feedback from WG in August 2015 to the partners' Annual Report on Carers was that it provided a *"detailed and robust analysis of the achievements to date and an insight into the favourable improvements hoped to be made in the future. A number of case studies have provided the qualitative information to help measure the outcome for Carers. There is clear evidence that the implementation of the Carers Measure has made a real difference to the lives of carers in Cwm Taf."*

We will be building on this further during 2016 as the UHB, Merthyr Tydfil County Borough Council and Rhondda Cynon Taf County Borough Council continue to work together to improve the ways we provide support to Carers of all ages. We are developing a new Cwm Taf Carers Strategy and the views of key partners, but most importantly Carers themselves, will inform what we do and shape our plans. The feedback from the engagement on the Joint Commissioning Statement will also be fed into the work on the new Carers Strategy.

7.2. Whole system approach

To mitigate against a lack of coordination which considers the planning and delivery of the different Levels of the new service model in isolation, a whole system approach will be adopted where public sector agencies work together with Third Sector and private sector partners to identify risk and take actions in a planned and proactive way. The Joint Commissioning Statement for Older People advocates this approach and commits our organisations to shifting the emphasis in budget allocations away from traditional long term services towards services that promote wellbeing and independence. It is intended to act as a catalyst to transform the way we commission services in partnership.

We are already looking at opportunities to develop more preventative activities and building community capacity with our

Third sector and community partners eg our priority to support health and wellbeing initiatives includes activities such as the 5 Ways to Wellbeing programmes; the Neighbourhood Capacity grant scheme and Community coordinators funded through the Intermediate Care Fund; befriending schemes and initiatives to reduce social isolation and loneliness.

7.3. Implementation of the NHS All Wales Standards for Accessible Communication and information for people with sensory loss

This will present a real opportunity to implement the NHS All Wales Standards for Accessible Communication and Information for People with Sensory Loss with particular reference to identifying, recording and meeting people's individual needs, providing information in accessible formats, improving access to services and effective communication.

7.4. Staff training

Training will be needed to support staff in adapting to new service models and ethos of care as well as legislative changes which will have implications for older people such as the Social Services and Wellbeing Act

For example, in the UHB we will be addressing Carer awareness training and e learning; Sensory loss awareness training; Goal Planning training which focuses on providing individualised, person-centred care both in an inpatient setting and within the person's own home; e-learning module on equality and human rights 'Treat me Fairly' ; use of the cultural awareness toolkit and sensory loss resource pack.

8. MITIGATION

An effective EIA takes into account the views and opinions of those who may be affected by the policy and what is already known about how the policy might affect different groups. This includes national evidence, Public Health Wales information, census data, public and service user views wherever possible in order to identify and address issues.

The consideration of mitigating measures and alternative ways of doing things is at the heart of the Equality Impact Assessment process. Different options have been considered in the development of the Joint Commissioning Statement for Older People. The consideration of mitigation of adverse impacts is intertwined with

the consideration of all actions. Mitigation can take the form of lessening the severity of the adverse impact.

Ways of delivering services which have a less adverse effect on the relevant equality category or issue, or which better promote equality of opportunity for the relevant equality category, have been considered. The preliminary issues and potential mitigations have been listed earlier in this document and will be revisited as the service changes are agreed and developed. However it is important to stress that the whole ethos of the Joint Commissioning Statement is to support older people to lead independent, healthy and fulfilled lives, recognising the need to protect the vulnerable and deliver effective and efficient services.

This initial document represents stage one of the equality impact assessment.

9. SUMMATION – GENERAL DUTY

Due Regard to 3 elements of general equality duty

This Equality Impact Assessment is representative of a real attempt to address the following questions:

- Does this service change help to eliminate discrimination?

Yes, although there is no perceived discrimination in the way services are currently provided, the focus on the needs of older people and the intentions within the Joint Commissioning Statement which will support them to lead healthy, independent and fulfilled lives will have a positive impact. The provision of more care within people's own homes and communities will enable greater privacy and personalised care that meets their individual needs and lifestyles.

- Does this service change help promote equality of opportunity?

Yes - older people will receive more appropriate support and services. For many, this will enable them to remain at home with the consequent benefits in terms of their individual needs, lifestyle choices and community links.

- Does this service change help foster good relations between people possessing the protected characteristic and those that do not?

Yes - The Joint Commissioning Statement is built on a co productive approach. The focus on building community capacity and working alongside individuals, families and communities will encourage good relations, intergenerational working and a sense of ownership and belonging.
Where staff are better trained to meet individual needs and where services are also designed to meet them, this can also minimise problems for and between people.

Where any concerns relating to equality have been raised, these have been identified and explored in order to establish possible mitigation and to avoid discrimination against any particular groups and to promote equality of access to services. This has involved engagement with different groups in relation to the protected characteristics in accordance with the Equality Act 2010 through the use of appropriate media, fora and by building on existing relationships.

The composition of the local population (2011 Census and Public Health information) has been analysed and issues considered.

10. MONITORING ARRANGEMENTS

The impact of the proposals will be closely monitored and careful consideration will continue to be given to the points highlighted in this equality impact assessment. EQIA issues will be included in progress reporting.

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

4	Including comments from Strategic Managers Group and additional appendices	23rd February 2015	G. Davidson
5	Including final comments from the Commissioning Sub-Group	18th May 2015	Angela Edevane
6	Including comments from Public Engagement	5th November 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 2014[2].

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.

That will:

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

- 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”.

Members of the public and our stakeholders were invited to comment upon the draft Joint Commissioning Statement during a 9 week engagement process which ran from July to September 2015. There was a good response to the Statement (both through individual written responses and views collated at meetings, forums and events. The views received have been used to shape and influence this final Joint Commissioning Statement. Full details of the outcome of engagement are contacted in **Annex 1**)

2. Our Shared Approach

2.1 Definitions

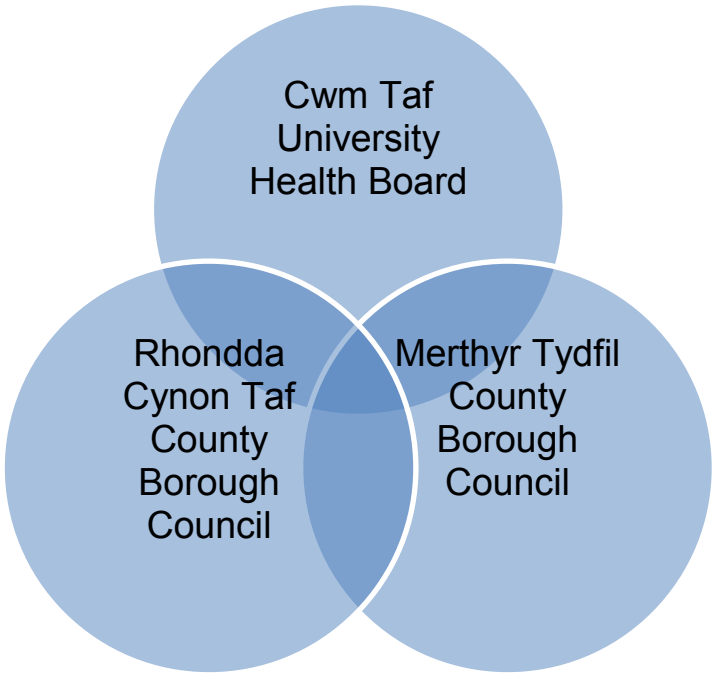
2.1.1 Commissioning

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 statement 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 which include comments obtained during the public consultation phase:

Promoting independence – Supporting individuals to retain independence in their own homes and local communities. (The majority of views received during the engagement period provided strong support for this principle).

"People should be able to remain as independent as possible within their own homes and communities for as long as they are able".

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

"Prevention is better than cure".

"Yes, the emphasis is on prevention and early intervention if good investment is made at these levels this will prevent escalation of need at a higher level. However without meaningful engagement and sound investment at a community/ lower level we could be heading for greater difficulties".

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

"The better we are looked after, the less we will cost!".

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.

"Real joined up care working between health and social care to provide a seamless, unified service based on need that can respond quickly to changes in the needs of individuals".

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.

"The provision of any care and support that the older person may require that truly puts the older person at the centre of anything that we do and giving them the options for them to maintain living independently for as long as they possibly can"

."Listen to people, care and have time for staff and clients".

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.

"Is this a lot of words? Sounds okay as long as it is implemented".

"Stop talking and writing about it and do it!"

The public consultation also identified the following areas which have been included as additional principles as a result:

Dignity - Our organisations and our staff will treat service users and their carers with dignity and respect.

" As you would like them to be treated with respect as we were always told to respect our elders!".

"Safe environment, treating people with respect, maintaining people's dignity at all times, being treated as a person not a number".

"My 91 year old mum, who has dementia, and has a care package provided, is distressed by the number of different people who are sent by the care company (as many as 15 different people in a week). Because of her memory loss, and the fact that many of them come only occasionally, they seem like total strangers to her. She would be a lot happier with a few familiar people providing the intimate services".

Tackling isolation – Supporting people to feel connected to their local community.

"Greater focus on tackling loneliness and isolation is needed to prevent deterioration in mental well-being and dependence".

Accessibility – Factors such as the timeliness of a response and access/ transport to services will be a key consideration in the way we commission and provide services.

Other themes also emerged which we agree are important, and are implicit in this Statement, but will be delivered explicitly through other complementary strategies, including:

A safe & warm home – This will be addressed by the Cwm Taf Ageing Well in Wales Plan Both Authorities have a Housing Strategy document. (RCT CBC has a Housing Energy Efficiency Officer who engages with vulnerable groups. In Merthyr Tydfil NEST(the Welsh Governments fuel poverty scheme) which is available to everyone in Wales is the means by which this element is supported.) Both schemes aims to help reduce the number of households in fuel poverty and make homes warmer and more fuel efficient places to live.

Support to families and carers – This principle is reflected throughout this Joint Commissioning Statement, but will be addressed directly in the new Cwm Taf Carers Strategy.

3. National & Local Context

3.1The national policy context

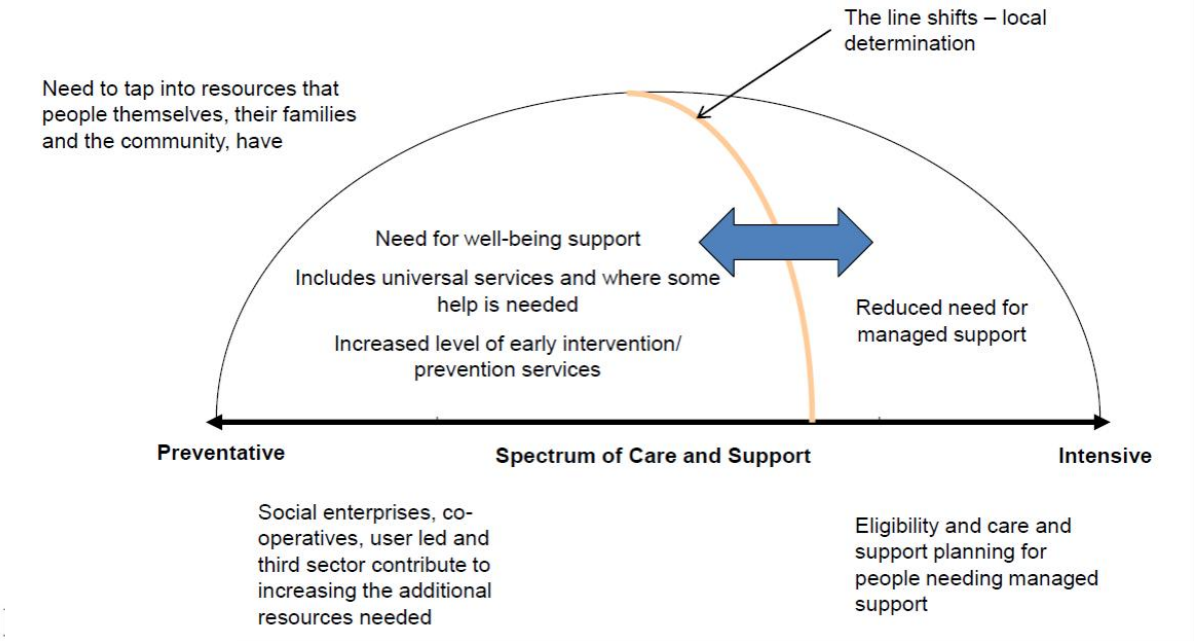
National policy over the last 5 years has focussed on service improvement, co-ordination between national and local government and greater integration of social care, health services and other agencies in Wales, notably the third sector. There is increasing emphasis on individuals and communities being 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.



Section 9 of the Act emphasises the importance of public sector agencies working in partnership. As the three key local public bodies concerned with health and wellbeing, we will take this statutory lead seriously and adopt a whole system approach to delivering the spirit of the Act.

The Welsh Government Guidance, "**A Framework for Delivering Integrated Health and Social Care for Older People with Complex Needs**" (2014)[3] defines in more detail the expectations of WG for older citizens. It calls for, and we commit to, delivering "a truly integrated system" which displays three key characteristics:

- *"Services should be co-designed with the people who use them.*
- *Services are consciously planned, refocusing activities on those people receiving care and removing barriers to integrated working.*
- *Services should be developed in partnership with all of our key partners including different sections of our own Local Authorities, health, housing and the third and independent sectors."*

We are already making some progress implementing a number of service developments in partnership, notably:

- An integrated assessment for hospital discharges.
- Our programme of work funded by the Welsh Government Intermediate Care Fund.
- Development of the @Home Service.
- Nursing Home Support.
- The establishment of 5 Community Co-ordinator posts.

[3] A Framework for Delivering Integrated Health and Social Care for Older People with Complex Needs: Welsh Government, 2014
http://wales.gov.uk/docs/dhss/publications/140319integrationen.pdf

- 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.

In preparation for the forthcoming implementation of the Well-Being of Future Generations (Wales) Act 2015, the partners will soon commence work to prepare for the requirements of new Public Service Boards and Well-Being Plans.

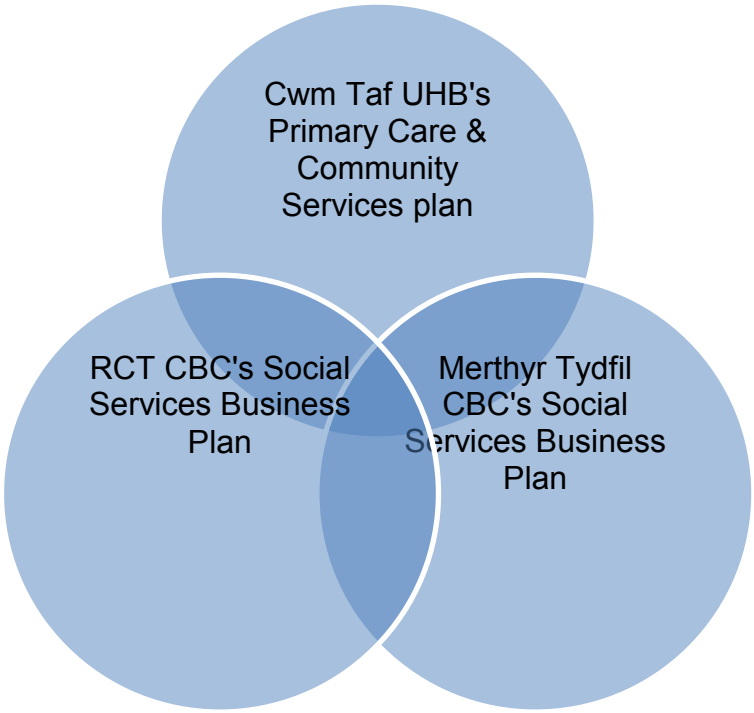
In developing this Joint Statement we have been mindful of how it will need to contribute to achieving the 7 Wellbeing Goals for Wales. It has also been developed in accordance with the sustainable development principle and ways of working. (Long term, integration, collaboration, involvement and prevention)

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 2015-18[4]. 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 Plan.



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

The UHB's priorities will be refined further through the refresh of its Three Year Integrated Plan for the period 2016-19.

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 lives 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

	2013	2015	2020	2025	2030
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
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 2001in 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.

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

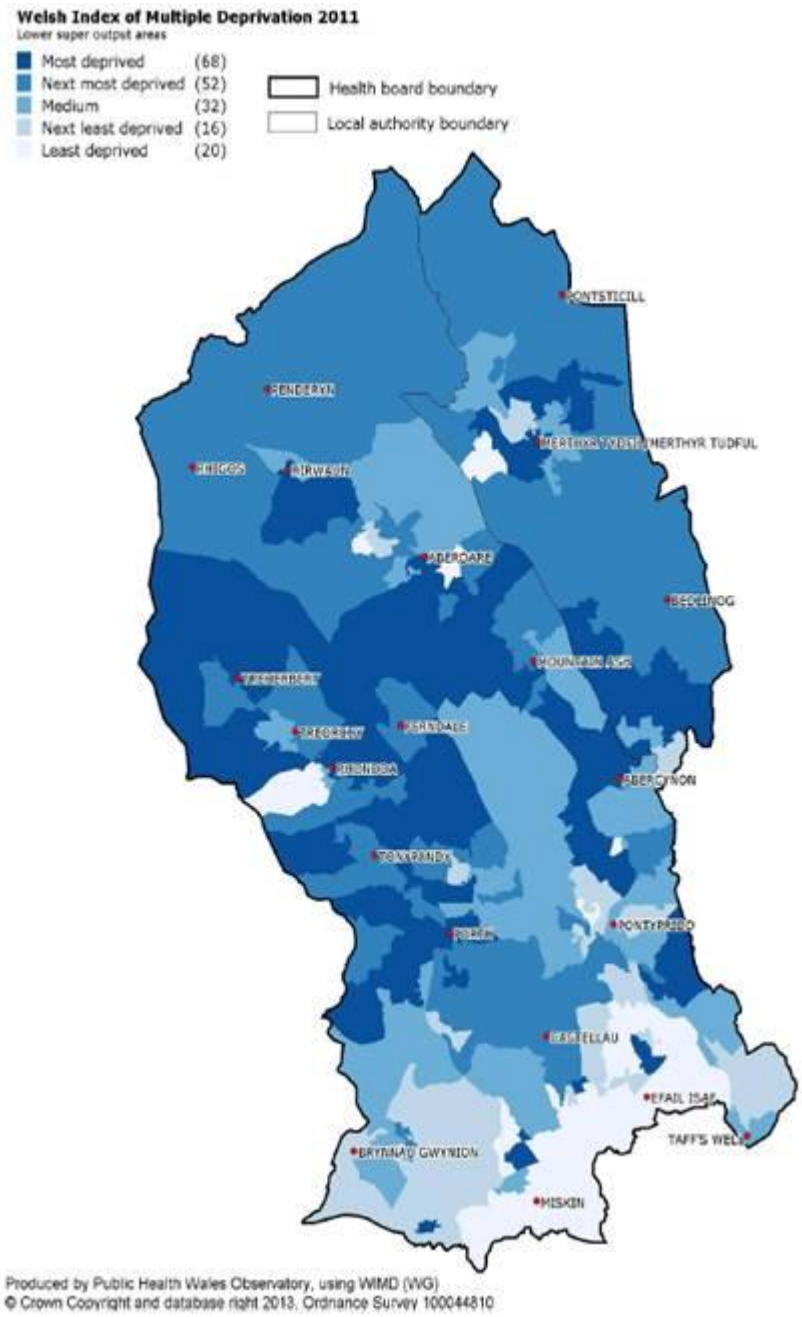
Table 4.4: Provision of Unpaid Care by Age: Percentage Change 2001 – 2011

	% 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

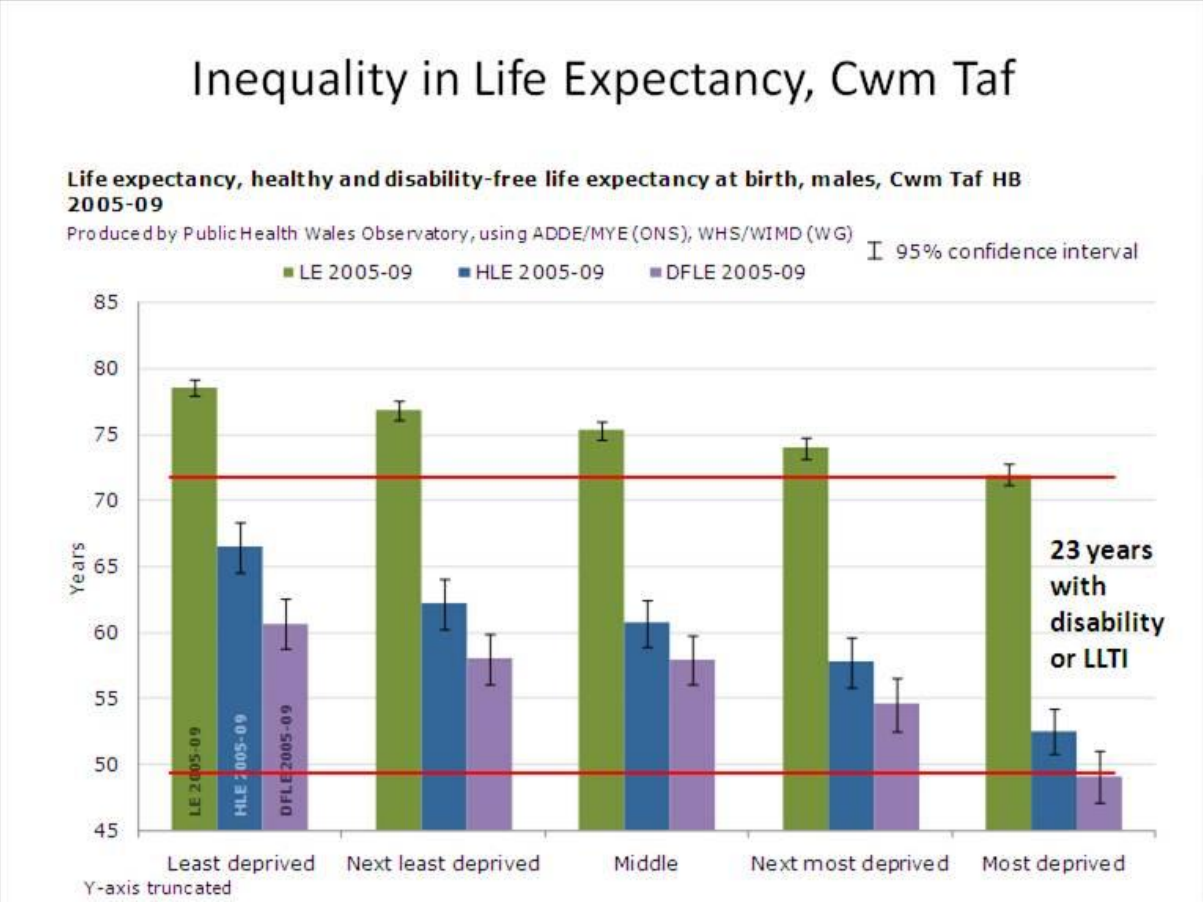
4.3 Healthy Living Years

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.



This has implications for our health and wellbeing given the association between deprivation and ill-health, which manifest in shorter life expectancy than the rest of Wales. There is also a gradient in life expectancy across Cwm Taf with higher levels of deprivation in valley communities, compared to the less deprived areas along the M4 corridor. A man born in the most deprived areas of Cwm Taf can expect to live 5 years less than if he were born in the less deprived areas.

We also observe this gradient in healthy life expectancy - defined as the number of years lived in good health and Disability-Free Life Expectancy. This means that a man born into one of our most deprived communities can expect to live 23 years of his already shortened life with a disability or limiting long term illness.



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.

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 residential and nursing homes by providing alternatives which reduce dependency and promote independence.
- 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.
- That people are treated with dignity and respect and treat others the same
- That People are heard and listened to.
- That People know and understand what care, support and opportunities are available and use these to help them achieve their well-being
- That people get the right care and support, as early as possible.

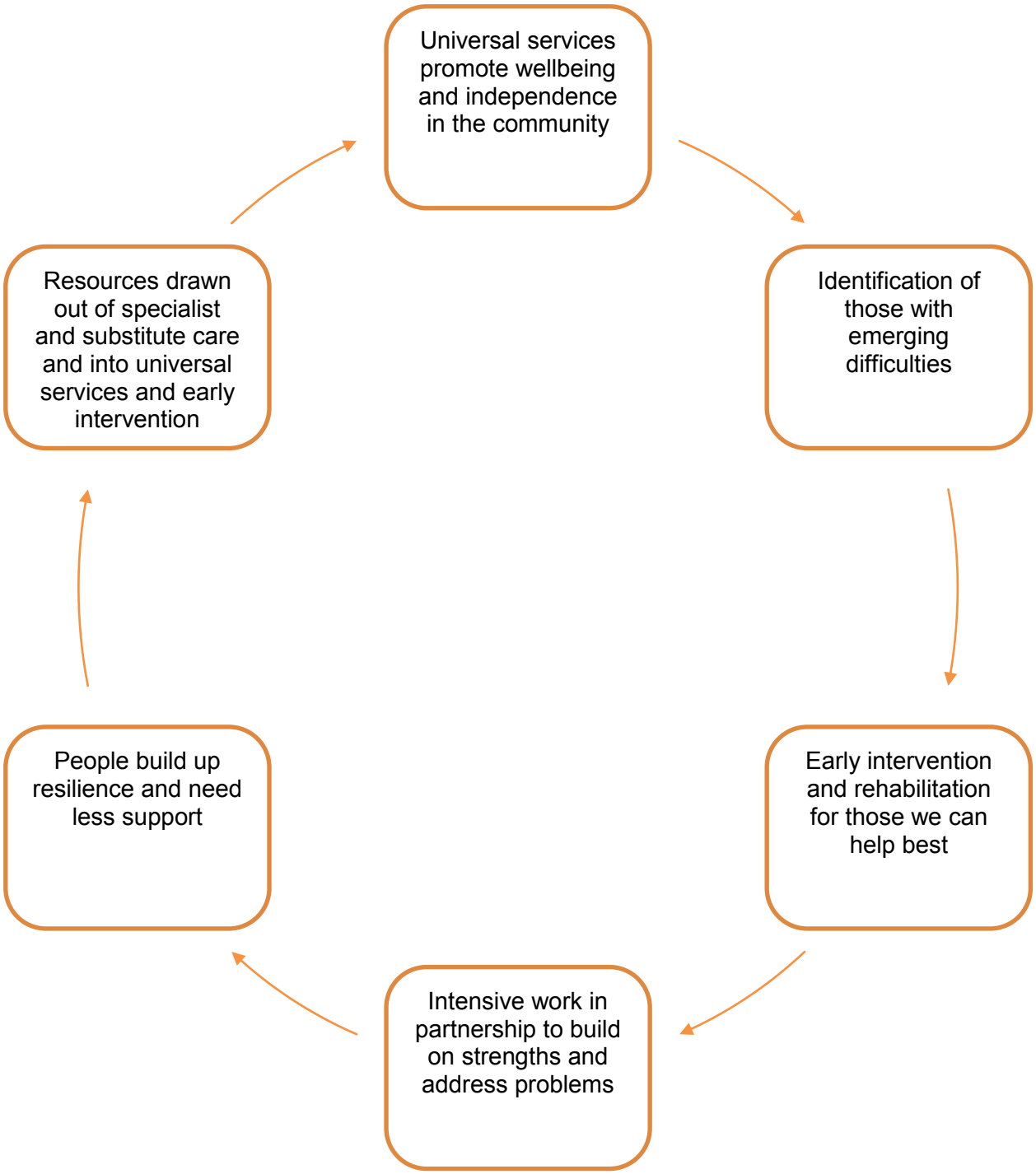
We will maintain a clear focus on these and more specific outcomes, defined later in this document

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.

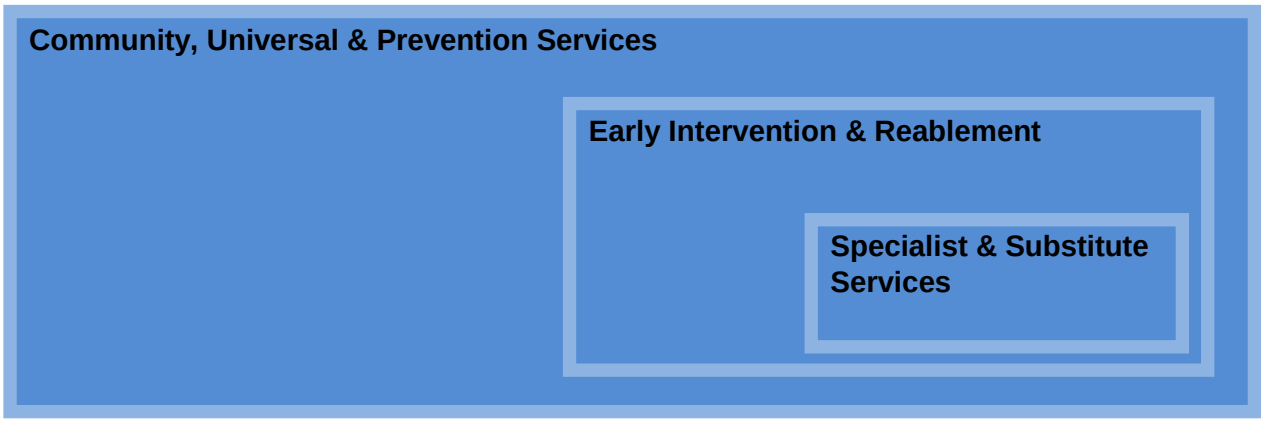


5.4 Our Service Model

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?

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.

6.1 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 active 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.
-

6.2 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.

6.3 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) [5]

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 advice on 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.

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[5] "Report of the Project Team": North Belfast Community Action Project; May 2002
http://www.taristeachnorthbelfast.org/nbcau_dunlop_report.pdf

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 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:

    - How the care and support system operates;
    - The types of care and support available;
    - How to access the care and support that is available; and
    - 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.

In addition we will be working across Cwm Taf to support the Ageing Well in Wales Programme which was launched by Welsh Government in October 2014 and addresses the following themes

- Age Friendly Communities
- Falls Prevention
- Dementia Supportive Communities
- Opportunities for Learning and Employment
- Loneliness and Isolation

A Cwm Taf Ageing Well in Wales Plan is being developed which will be seen as a “sister” document to the Joint Commissioning Statement.

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 Wellbeing of Future Generations Act) 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 (Tylertown).
- Develop a National Asthma and Housing best practice module for use by housing and health practitioners.
- Evaluate a Pilot Falls Prevention Programme in Sheltered Housing Schemes (RCT Homes) and consider options for roll out of the project across a range of community groups
- Organise Health & Wellbeing Events with each of the five 50+ Forums that will also be open to the wider public
- Implement an accredited Carers Protocol award for GP Surgeries for Recognition of Carers.
- Continue to recruit Carers' Champions across all sectors

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.[6]).
- Simple, low level services- such as home visits can reduce mortality and admission to long term care (Elkan et al 2001 – BMJ[7]).
- 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.

With an increasing focus on independence and the provision of preventative services, housing-related support services will need to be reconfigured based on need rather than 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 began to reconfigure 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, regardless of tenure.

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.

[6] Excluded older people: Social Exclusion Unit interim report: ODPM, 2005
[7] Effectiveness of home based support for older people: systematic review and meta-analysis: Elkan et al, BMJ 2001

- 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 (Localities)** - 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 Out of Hours and “in-reach” services at Prince Charles and the Royal Glamorgan Hospitals.

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

- **GP Cluster Plans** – Where GP practices within our localities are working together to identify top priorities for the local population and work together to achieve them.
- **Cluster Hubs –** Modeled on the new 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	Merthyr Tydfil
• Ysbyty Cwm Cynon (YCC)	Cynon Valley
• Dewi Sant	Taf Ely
• Ysbyty Cwm Rhondda (YCR)	Rhondda Valleys

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 early intervention and reablement 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"[8]. 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.

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.

[8] Integrated Assessment, Planning and Review Arrangements for Older People: Welsh Government, 2013
http://www.rcpsych.ac.uk/pdf/131217reporten.pdf

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. This will incorporate the development of a complex care discharge team and the requirements of the Social Services &Wellbeing (Wales) Act. This work will also link in to the all Wales development of a single health & social Care information system (CCIS)

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[9]

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 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

[9] Homecare Reablement: Retrospective Longitudinal Study: White Rose University Consortium, 2007 http://eprints.whiterose.ac.uk/73250/1/Document.pdf

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 andsupporting 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 is the community Reablement service

7.6.2 What do we propose to do?

Our intention is to integrate heath and 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 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 the 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 the in-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 & Well-Being (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 though 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, enabling them to identify what they want to be able to do for themselves and what lifestyle they want to live. Provider's will be required to take a wide view of the person's health and wellbeing and take action to minimise the risk of social isolation, unplanned hospital admissions etc, They will be required to provide an enabling approach to service delivery, helping the service user to either maintain their current levels of ability, re-learn skills they previously had or learn new skills. 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 an ongoing review in respect of the level of service directly delivered by Rhondda Cynon Taf CBC and the independent sector in order to ensure we continue to provide a responsive, modernised service, which is cost effective and allows developing the local market.

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.

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 has agreed its Primary Care and Community Services Plan which will be delivered alongside 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, to develop an enabling approach to meet the agreed service user 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 type 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.
- 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 Well-Being 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)[10]

The Audit Commission (1998)[11] 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 to 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 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:

[10] 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

[11] *A Fruitful Partnership*: Audit Commission (1998).
http://www.audit-commission.gov.uk/Products/NATIONAL-REPORT/A190CA25-7A7E-47D1-BCAB-373A86B709C0/A%20Fruitful%20Partnership.pdf

- 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.

10.4 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.

10.5 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."[12]

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

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.

10.6 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.

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

10.7 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."*[13]

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.

The Social Services & Wellbeing (Wales) Act 2014 will place a greater responsibility on Health Boards and Local Authorities to formalize partnerships and extend the use of pooled budgets for areas such as nursing home placements.

10.8 Our Shared Approach to Commissioning with the Third Sector

Our shared document "Commission Accomplished" [14] 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.

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

- **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.
- **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.

10.9 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.

10.10 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.

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 out 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.

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. Health & 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.[15]

This was followed in 2011 by **'Sustainable Social Services for Wales: A Framework for Action'**[16], 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**

[15] Local Government Measure, Welsh Government, 2009
http://wales.gov.uk/legislation/programme/previouslegislation/assemblymeasures/localgovernment/?lang=en

[16] 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.[17]

Alongside policy development, the Welsh Government and Welsh local government agreed a voluntary **'Compact for Change'**[18] 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)[19] 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.

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[17] Shared Purpose, Shared Delivery (Single Integrated Partnership Plans), Welsh Government, December 2012
http://wales.gov.uk/topics/improvingservices/publicationsevents/publications/sharedpurpdel/?lang=en

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

[19] 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 needs[20] 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 people[21] 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**[22]. 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

[20] 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
[21] Integrated assessment, planning and review arrangements for older people, Welsh Government, 2013 http://wales.gov.uk/topics/health/publications/socialcare/guidance1/assessment1/?lang=en
[22] 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.[23]
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.[24]

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.

[23] Continuing Health Care, NHS Wales, 2010, http://www.wales.nhs.uk/document/168534
[24] 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"[25] (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.

[25] 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	• Grants etc to Third Sector (excluding Children's and Mental Health) • Carers • Any Council housing related support (eg Sheltered housing) • Information and advice	• GP Services • Other Primary Care • District Nursing • EPP • Carers • Third Sector Spend (excluding children & mental health) • Inverse Care Law • Primary Care Bids
Tier 2	• Reablement • @ Home Service • Single Point of Access • Assessment	• @Home • Reablement • Other ICF • Community Hospitals
Tier 3	• Equipment and adaptations • Telecare • Domiciliary care • Care homes	• Nursing Home Care • CHC