ISLE OF ANGLESEY COUNTY COUNCIL
Scrutiny Report Template

Committee:	Partnership & Regeneration Scrutiny Committee
Date:	12 March 2019
Subject:	Health & Social Care Developments in the Community for Adults
Purpose of Report:	To provide an update to members regarding areas of joint working and scrutinise partnership arrangements
Scrutiny Chair:	Cllr Gwilym O Jones
Portfolio Holder(s):	Cllr Llinos Medi Huws
Head of Service:	Alwyn Rhys Jones
Report Author: **Tel:** **Email:**	Alwyn Rhys Jones 01248 725707 Alwynjones3@ynysmon.gov.uk
Local Members:	N/A

1 - Recommendation/s

The Partnership and Regeneration Scrutiny Committee is requested to:
Scrutinise information in this report regarding areas where the Health Board and Isle of Anglesey County Council are working in partnership to change how support is provided within communities.

2 – Link to Council Plan / Other Corporate Priorities

1. These areas of joint work aim to better support individuals to maintain their health and wellbeing within communities.

2. This goal is entirely consistent with the Council's goal to support vulnerable adults and those in need of support to remain safe, healthy and independent.

3 – Guiding Principles for Scrutiny Members

To assist Members when scrutinising the topic:-

3.1 Impact the matter has on individuals and communities **[focus on customer/citizen]**

3.2 A look at the efficiency & effectiveness of any proposed change – both financially and in terms of quality **[focus on value]**

3.3 A look at any risks **[focus on risk]**

3.4 Scrutiny taking a performance monitoring or quality assurance role **[focus on performance & quality]**

3.5 Looking at plans and proposals from a perspective of:

- Long term
- Prevention
- Integration
- Collaboration
- Involvement

[focus on wellbeing]

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4 - Key Scrutiny Questions

1. What are the impacts of the current joint working arrangements and how are these influencing outcomes for service users?
2. Are there any specific risks associated with these arrangements that may have an impact on service resilience or early intervention strategies to manage demand?
3. What plans are in place to further develop current partnership arrangements between the Health Board and the Council?
4. Are there any specific areas of partnership working that the Committee would wish to explore in further detail?

5 – Background / Context

This paper provides an overview of 4 areas where Anglesey County Council is working closely with our partners in BCUHB to alter the pattern of care and support provided to adults in Anglesey.

These areas of work will be fundamental in changing our approach over the coming years. The areas covered are **Clusters, Community Resource Teams, Mental Health Developments and the work of Linc Cymunedol Mon.**

1. Clusters

In order improve Primary Care Practitioners ability to support their communities the GP Cluster Model is being strengthened across North Wales. A cluster is a group of primary care practitioners who work together in defined geographic areas to ensure appropriate services, and support are available locally delivered within that area.

In Anglesey there is one cluster.

Recent improvements locally include

- Capacity has been increased through additional **Physiotherapists** and **Pharmacists.** Advanced Practice Physiotherapists allow people presenting with musculoskeletal problems to be seen locally by an Advanced Physiotherapy Musculoskeletal (MSK) Practitioner as an alternative to seeing their GP. The Physiotherapy led service provides a fast local access and early management for

patients, preventing clinical deterioration and the risk of developing chronic conditions.

- **Care of the Elderly GP (COTE)** supports patients in care homes and supports the delivery of TEPs (Treatment Escalation Plans) to reduce inappropriate admissions to Secondary Care.

- **Social Prescribing** – funding 3 Local Asset Co-ordinator working as part of Community Link Mon, Medrwn Mon. All 7 Local Asset Co-ordinators are in post and have been linked to individual practices in order to support Primary Care. The social prescribing service has been introduced to the Cluster area to achieve more appropriate use of health and social services, improve health and well-being outcomes and enable patients to be pro-active in managing their own conditions and well-being. The service proposes to maximise the use of community assets, build on the use of volunteers and existing voluntary services so that people can access the right support and be accessible to as many people as possible within the community.

  GPs can now refer patients for LAC support electronically in a click of a button from their clinical system and frequent attenders have been identified in each practice to receive support from the LACs .

- ***FALLS Prevention*** *:* Falls and fractures in the elderly are extremely damaging to patient quality of life and place a large demand on primary, community and secondary care services.High risk patients over the age of 65 were invited for an assessment carried out by advanced clinical pharmacists to aid reductions in the risk of falls for those individuals

- Anglesey cluster have been working closely with the Mental Health and Wellbeing centre Abbey Road to set up support provision for Tier 0 Mental Health patients within the practice setting initially before patients attend the Abbey Road centre directly for support

- Cluster meetings have been themed meetings over the year focusing on specific priority areas including Mental Health, Children's Services and Public Health.

Anglesey cluster will be focusing on and further developing the following areas from April 2019 onwards.

- Social Prescribing Model working with Medrwn Mon developing the service further around the community hubs in order to pull patients away from the GP practice.
- Further work with the Police and Crime Commisioner in developing the SPOA and early intervention support for vulnerable people and their families. This includes supporting the roll out of the 2 Children and young People LACs that will be funded by Children's Services following the success of the LAC model.
- Full launch of the Anglesey Social Prescribing model in April

2. Community Resource Teams

Within the Anglesey Cluster there will be 3 Community Resource Teams (CRT). The CRTs will cover three areas of the island consistent with the domiciliary care patches recently tendered for.

Within each area, there will be office space that will allow staff from across Health and the Local Authority to work alongside each other and access their own IT networks / systems. Within each area, there will also be at least one easily-accessible space (either a permanent space or somewhere that can be rented / utilised as needed) that will allow MDT patient centred discussion. In practice the development of CRTs in Anglesey will mean that our Adult Social Workers and Occupational Therapists will primarily work from these locality bases,

In the short term our goal is that the CRTs will include the following core roles .

- GP
- COTE (Care of the Elderly Staff)
- Community Nursing
- Social Worker (adults)
- Social Work Practitioner (adults)
- Domiciliary Home Care Provider (adults).
- Physiotherapists
- OTs (Health and Local Authority)
- Local asset coordinators
- CPN/Older Persons Mental Health
- Advanced Nurse Practitioner; Advanced Paramedic Practitioner; Urgent Care Practitioner.

The goal of the CRT is that by the end of 2019/20 all adults living in Mon will have simple and direct access to a Community Resource Team. Teams will provide a seamless service by providing a co-ordinated approach to health & social care. They will build on individual strengths and community networks and draw in specialist support where necessary to promote wellbeing and enable individuals to live their lives as they want to live them.

Some support will exist at locality/cluster level, and will be shared across all areas. Examples include Income and Charging Support,Specialist Medical Services – Diabetes, Heart Failure. Etc, Podiatry, Dieticians, Speech and Language Therapy and Arts Therapy,Mental Health Support Workers, Specialist Nursing and Housing

Other specialist roles will be available to pull in, from a Gwynedd & Mon, West or North Wales team. These roles will still form part of the CRT, but will not be present or available on such a regular basis. They include Welsh Ambulance Service including other emergency response teams and Adults and Children Safeguarding Teams

The CRTs will be

- configured to meet demand both in and out of hours.
- will be central to developing resilient communities
- support monitoring of high risk patients to support admission avoidance and support early discharge from hospital and support people back into their communities

- Providers of Information Advice and Assistance/ Single Point of Access across Health & Social Care

Each person who needs support will be assigned a support coordinator to work alongside them, pulling in support from elsewhere as needed.

3. Mental Health Developments within our communities

For each local area of North Wales Local Implementation Teams have been developed to ensure implementation of the changes to mental health services set out in the strategy "Together for Mental Health in North Wales." Anglesey and Gwynedd Local Authorities work in partnership with the Health Board as part of the LIT.

The LIT aims to

- Use the 5 Ways to Wellbeing as the foundation of emotional and psychological wellbeing
- Working with voluntary and third sector agencies to review their role with people at risk of severe mental health crises
- Developing local alternatives to admission: crisis cafes, sanctuaries, strengthened home treatment services, step-down services
- Ensuring Welsh language needs are considered and provided for throughout mental health service provision
- Working with statutory, voluntary and third sector agencies to review the unmet needs of people with mental ill health and working to ensure gaps in service provision are addressed
- Creating platforms to engage with citizens around the mental health agenda
- To undertake engagement events with the public and professionals to raise awareness of the LIT and its work including promotion of the ICAN campaign

Indicators of progress in addressing this priority will include:

- The number of admissions to local mental health inpatient care
- The number of placements of local people in services outside North Wales
- The number of detentions of people under S. 136 of the Mental Health Act
- The improved experience of local people who have a mental health crisis

Since its inception in 2017 the Local LIT has shaped and progressed the following developments

Emergency/Crisis care:

- I-Can centre in Ysbyty Gwynedd providing 'safe space' for people with mental health issues who attend Emergency dept. The centres are open during the evening/night and staffed by volunteers.
- A local work group looking at the development of the crisis café model
- In Ynys Mon we have worked with Digartref Ynys Mon and focussed on support for homeless people.

- A significant amount of work has been undertaken to analyse the data regarding use of S136 MHA in order to understand the local patterns and work with partners to look at alternatives.

Well-being: (We have adopted Public Health Wales' 5 ways to wellbeing as our approach to meeting this objective)

- There has been a significant emphasis on working with partners across the sector to co-ordinate our approach.
- We held a workshop with key agencies to learn about who's doing what.
- There is an emphasis on developing group work in the Community Mental Health Team (CMHT) eg, mindfulness, anxiety management, eco-therapy
- The support services team facilitate a range of group opportunities e.g, badminton, walking, healthy eating, running, as well as running weekly well-being groups.
- The support services team is currently exploring ways of using the Council web-site as a platform to provide up to date information on what's available.
- The focus on all the group work is to promote Recovery and working with partner agencies, using local resources and promoting user participation.

Housing:

- We have developed a Mental Health Housing pathway in order to ensure that people with mental health issues are provided with equal opportunities in securing appropriate accommodation. A multi-agency group meets regularly to identify and prioritise housing needs.
- The Supporting People team has commissioned an additional 5 units of mental health supported housing through its contract with Wallich.
- A 'step-down' pilot project has been developed by the Council's Housing dept.

Awareness raising:

- A Conference was held in July 2018 with an emphasis on learning from people's experiences
- A programme was developed with local barbers on international men's day to raise awareness of mental health.
- An awareness raising training package has been developed and will be rolled out to staff in other settings eg, bar staff, taxi drivers, nail bars etc. – any venue where people are likely to discuss their mental health.

This partnership approach aims to better support individuals and prevent unnecessary escalation of their needs

4. Link Cymunedol Mon work with Medrwn Mon

Medrwn Mon as the Local CVC have been a vital partner in assisting both Health & Social Care Services to support communities differently through the development of Link Cymunedol Mon.

This devolved information advice and assistance service assists Anglesey County Council to meet our Statutory Duty under Social Services and Well-being (Wales) Act

2014 and supports the health board in maintaining individuals independence in the community.

The service is funded by a pooled budget between Medrwn Môn, BCUHB, Anglesey GP Clusters and Anglesey County Council and operates a Email and phone line service, 9am and 5pm, Monday-Friday and is based in the Medrwn Môn in Llangefni.

Dedicated Link Officer handle all enquiries and referrals- deals with requests for information or advice, or will pass referrals on to one of a team of 7 LAC's (Local Asset Co-ordinators) referred to earlier in this report.

The support is available to those members within our community who may be feeling isolated or lonely, or would simply like to take part in more activities in their local area. Referrals in to the service can be made by a number of partners including Social Workers, GP's, Community Mental Health Teams, Physiotherapists, Third Sector Organisations or by the person themselves.

LAC's work on a one-to-one basis with individuals, helping to identify activities and solutions to reconnect them with their communities. This could include initially supporting them to attend activities but also to identify similar people within their communities to create long-term networks of support. Each LAC is based in or around GP's surgeries and community hubs.

6 – Equality Impact Assessment [including impacts on the Welsh Language]

Equality Impact Assessment of Individual Projects and Schemes is available by request.

7 – Financial Implications

From a financial perspective all work carried out in partnership occurs either from within current allocated staff and resources, or is sourced from Integrated Care Fund or other grants which partners have access to.

8 – Appendices:

None

9 - Background papers (please contact the author of the Report for any further information):

None