ISLE OF ANGLESEY COUNTY COUNCIL	
COMMITTEE :	**Partnership and Regeneration Scrutiny Committee**
DATE:	**22 11 2016**
SUBJECT:	**Integrated Health and Social Care Services for Anglesey**
PORTFOLIO HOLDER(S):	**Councillor Aled Morris Jones**
HEAD OF SERVICE :	**Alwyn Jones & Llŷr Bryn Roberts**
REPORT AUTHOR: **Tel:** **E-mail:**	**Margaret Peters & Alwyn Jones** **1812 2707** **MargaretPeters@ynysmon.gov.uk** **AlwynJones3@ynysmon.gov.uk**

1.0 RECOMMENDATION

1) Receive this report as a formal update regarding integrated services or those provided in partnership across health & social care
2) Support future partnership and joint working under the ICF Grant

2.0 BACKGROUND

2.1 Information about Integrated Health and Social Care Services for Anglesey to inform the Partnership Scrutiny Committee in November 2016

There is a long history in Ynys Mon of successful joint working. Good examples include Model Môn (the locality leadership team) and integrated health and social care services including multi-disciplinary teams in some service areas. This way of working is nothing new for Anglesey.

There has been an Integrated Health and Social Care Delivery Board (IDB) in place since January 2014. We consider that the Authority and Betsi Cadwaladr University Health Board work effectively together using this forum to plan and ensure the delivery of integrated care and support services, to best meet the needs of people Anglesey. This includes the development of new models of delivery, shifting the focus towards preventative services, and early intervention with individuals.

The IDB provides the governance arrangements in relation to specific projects/work streams for integrated working such as: Integrated family support service (IFSS), The Community Mental

Health Team (CMHT), Community Learning Disability Team (CLDT) and Specialist Children's Service (SCS).

There is a good working relationship between the Authority and the Health Board from a strategic point of view through the IDB, and also from an operational prospective through Model Môn - the delivery group for the IDB. The IDB meets on a regular basis to discuss operational and strategic issues and opportunities for further integration and partnership working between social care and health. Model Môn meets on a monthly basis and escalates issues when necessary to the IDB.

These examples of integrated working fits well under the ethos of Part 9 of the Social Services and Well-being (Wales) Act 2014 ("the Act") which requires local authorities to make arrangements to promote co-operation with their relevant partners and others, in relation to adults with needs for care and support, carers and children. It places a duty on relevant partners to co-operate with, and provide information to, the local authorities for the purpose of their social services functions. Part 9 of the Act also provides for partnership arrangements between local authorities and Local Health Boards for the discharge of their functions. The purpose of Part 9 is to improve outcomes and well-being of people, as well as improving the efficiency and effectiveness of service delivery. The key aims of cooperation, partnership and integration can therefore be described as follows:

- To improve care and support, ensuring people have more say and control.
- To improve outcomes and health and wellbeing.
- Provide co-ordinated, person centred care and support.
- Make more effective use of resources, skills and expertise.

Brief description of current integrated health and social care services
Môn Enhanced Care (MEC) The Môn Enhanced Care service is a community based service which is co-located within Ynys Môn's Adult Social Services' Department. The service provides short term intervention to individual cases to avoid the need for unnecessary admissions to hospital, and to provide an enhanced level of medical and nursing support to patients within their own homes and community. The service is mainly aimed at the frail elderly population and to adults suffering with chronic conditions, and cares for patients who would otherwise be admitted to hospital and can also facilitate discharge more rapidly for some individuals. **Intermediate Care Fund (ICF)** The Intermediate Care Funding (ICF) provided by Welsh Government and administered by BCUHB is in its third year. The funding is to be used to encourage collaborative working between social services, health and housing, to support people to maintain their

independence and remain in their own homes. The allocation of this grant, to both strengthen and enhance current services and develop new ones, has been successfully managed across health care, social care and partners in the independent and voluntary sector over the last 3 years. ***See Annex 1*** for a list of Anglesey ICF funded projects.

The Integrated Family Support Service (IFSS) works with families who wish to make changes within their family to keep their children safe. The IFSS works with families where alcohol or substance misuse is the main risk factor. The service is voluntary and available for a period of 12 months. The service seeks to work with every member of the family.

Môn Community Link is an information service based within Medrwn Môn, the local Community Voluntary Council. It provides information regarding support and community activities in Ynys Môn. This includes any 3rd sector services for individuals with low to medium needs. This includes activities such as social groups, lunch groups, befriending and community transport and numerous other services.

The Single Point of Access (SPOA) has been in existence on Ynys Môn since May 2011. The SPOA provides direct access to advice, assessment, and co-ordinated community health and social care services for adults, by contacting one central point. This consists of access to social workers, occupational therapists, physiotherapists and district nurses. The SPOA also aims to direct those who need support from within their communities to the Môn Community Link.

The Community Mental Health Team (CMHT) is a co-located team of health and social care staff who deliver mental health services in the community for Ynys Môn residents. The service supports adults with acute, short-term and long-term mental health issues, including those with enduring mental illness.

The Community Learning Disability Team (CLDT) is a co-located team of social care and health staff that support individuals with a learning disability in Ynys Môn. The team is one of six similar teams across North Wales. Adult Social Care are the lead agency in the delivery of a social care model of learning disability, with health colleagues providing specialised health interventions for people on the Learning Disability Register.

Specialist Children's Service (SCS) is a joint agency team, made up of staff from Health (BCUHB) and Children's Social Services (Ynys Môn County Council). The service was set up under the auspices of a Section 33 Agreement between both agencies in 2013. The Service was an integrated team prior to this date. The service works with disabled children and young people with complex needs who are between the ages of 0 -18 years, and who live on the island.

What is the staffing complement of the integrated services?

Name of the service	Health Staff	Council staff	Medrwn Môn
MEC	7	0.5 WTE	
ICF projects	Staffing varies from project to project		
IFSS	2	4	
Môn Community Link *(Third Sector SPOA)*			2
SPOA	Possibly 1 in the future	6	
CMHT	25	29	
CLDT	10	5	
SCS	5	7 Core staff not including support workers	

**Please note that these are a mix of full time and part time staff*

What works well in terms of the service/what are the benefits?

MEC

- Patients receive access to an enhanced level of medical/nursing assessment within their own homes, avoiding the need to attend a hospital environment(where appropriate, or where hospital admission has been declined by patient)
- Co-location within Anglesey County Council Social Services department affords the benefit of closer working relationships, ease of access to Social Services support at the point of need, and strengthens communication for joint care planning.
- Rapid access to diagnostics (i.e. full blood screen, including some using Point of Care testing in patients home with results within minutes, ECG, 24 hour ECG) enabling quicker decisions regarding management plans for professionals and patients.
- Avoids the known adverse effects of hospital admission including Hospital Acquired Infections and increases the likelihood of patients remaining within their own homes longer.
- Reduces bed utilisation within the hospital, thus supporting an improved patient flow.
- Reduces the likelihood of need on longer term Social Care support through earlier intervention, quicker recovery and referral into other community support services.
- Cost effective- a recent service evaluation by the University of Bangor (2014) estimated a cost saving of £2000 per 14 night MEC episode.

ICF Projects

I. The Third Sector **SPOA – Linc Cymunedol Môn** has clear outcomes with a focus on advice, assistance and information. Benefits include:-

- A service which is more responsive to the needs of the individual.
- Supporting people to maintain or regain their independence.
- Reducing barriers for people to access care and support.
- Contributing to a seamless service between partner organisations.
- Encouraging and empowering people to manage their own health and well-being.

II. **Step Up/ Step down**

- Support clients to remain living safely and independently within their own homes.
- Avoidance of inappropriate hospital and care home admissions.

III. **Dementia projects**

- People report an increase in their health and wellbeing and feel supported and less isolated.
- To reduce hospital admission and readmission and also to prevent or delay admittance to a care home.
- Enhanced quality of life for people with care & support needs.

IV. 7 day Integrated Community Resource Teams – Night Time Response 'Night Owls'

- Reducing the length of stay older people are having in hospital
- Reducing delayed transfers of care
- Reducing the number of overall hospital admissions for older people
- Reducing the number of emergency hospital admissions for older people
- Reducing readmissions to hospital within 30 days for older people
- Reducing permanent admissions to residential care
- Increasing the number of older people supported in the community.

V. **7 Day Integrated Community Resource Teams – Weekend Capacity**

- Effective co-ordination of assessment and care planning arrangements including therapeutic and nursing interventions across 7 day working.
- Strengthened operational processes within community health and social care to dovetail the additional weekend capacity in a streamlined manner.

VI. **Enhanced Care and Accommodation project – Dementia**

- Adopting a social model of dementia care by regarding dementia as an impairment, where a marked difference can be made to quality of life by the way people with dementia are supported and through their built and social environment.
- The provision of innovative approaches and service models to enable people living with dementia to be supported in appropriate care settings on Anglesey.
- Contribute to a reduction in unplanned admissions and re-admissions of people living with dementia to general and community hospitals from care homes.
- Reduction in Delayed Transfer of Care.

IFSS

- Working to a model which promotes a change in people's behaviour.
- Collaboration within a team where workers have high level and varying skills

Môn Community Link

- Môn Community link have their own contact number and e-mail – so if a member of the public requires community information, they do not need to contact Social Services in the first instance.
- Good links with Social Services – if a call is directed incorrectly the person is redirected.

SPOA

- The service works well as Social Services, Health and the Third Sector work closer together in a more co-ordinated and streamlined way. This benefits both the public who require a service as the process is much more efficient and also front line staff who work with the same adults out in the community. Working together avoids duplication in efforts. Also, the individual does not have to repeat the process of sharing their own information, history and needs to several workers involved in their care. This also applies to workers.
- The SPOA provides a citizen-centered, flexible and integrated model that captures efficiencies within the system and provides a response is appropriate to the level of need.
- Staff within Adult Social Services are allocated work in a more effective way and they have better access to information regarding service users, thereby enabling them to work in a more timely way, without having to chase for information.
- Staff within BCUHB receive referrals in a more effective way and receive better quality information to inform them of services required. It makes it easier for staff out in the community to be able to find information required.
- Third Sector organisations receive more enquiries regarding the services that they provide due to increased signposting through the SPOA.

- SPOA strengthens the screening process and co-ordinates appropriate signposting on to relevant services.
- It streamlines the referral pathway for hospital and community referrals requiring multidisciplinary (MDT) input including Intermediate Care and promotes and facilitates hospital discharge.
- It also strengthens patch based MDT working arrangements to improve consistency within the Integrated Assessment Framework process

CMHT

- The service is well established and the co-located model is long standing and understood by stakeholders.
- Practitioners work together to deliver positive outcomes.
- Many of the practitioners are bi-lingual.
- The service has close links with many statutory services (e.g., In-patient, Police, Housing, Substance misuse, Probation, Fire, Children services) and third sector organisations (CAIS, Hafal, Mind,)
- Support for carers is delivered through a contract with Hafal. The Hafal officer has a regular presence in the CMHT office.
- Advocacy services (IMHA, IMCA, etc) are well represented across service provision.
- The community support service (CSS) supports individuals in their own homes and in supported housing projects.CSS delivers support to people with primary and secondary care needs and has recently been awarded a contract to deliver housing related support under the Supporting people grant scheme.

CLDT

- Clarity of response to assessed need
- Close effective MDT working
- Access to professionals from various disciplines on day to day basis.
- Shared processes – NOT information systems
- Shared philosophy
- Joint Assessment and Care planning
- Shared service development opportunities

SCS

- The service is able to offer a 'one stop' type service to new referrals and families who are already receiving services. All workers have their individual caseloads and depending on the complexities of each individual case there may be a need for more than one professional/team member to be involved.
- Workers will also liaise with other agencies and professionals who are not part of SCS service in the interests of the disabled children and young people they work with e.g. Community Paediatrician, Health Visitor, School Nurse, School staff, Speech and

Language Therapists, Complex Needs service etc.

- All service staff work in partnership with the family and other professionals and are able to co- ordinate complex care packages by holding regular Multi-Disciplinary Team Meetings, and review if services are working effectively.
- As the service is based in one place, professionals are able to react promptly to any problems that may arise for families and resolve them as soon as possible.
- The staff team is stable and between all members there is a wealth of knowledge and experience that is shared willingly on a multi-disciplinary level.
- Families are aware that even if their own worker is not available another team member would be able to offer support and guidance in the interim.
- The team has a positive attitude towards their work and this is reflected in the staff retention record of the service.

How many people have benefited from this service in the community during the last 12 months?

Name of the service	Adults	Children
MEC	**122** (April- Sept 2016)	
ICF – Spot purchase intermediate care beds in private care homes	**61**	
ICF Intermediate care beds in Plas Mona	**32**	
ICF Dementia Cafes	**50**	
ICF Homeshare	**18**	
ICF Nightowls	**23**	
IFSS	**50**	**63**
Môn Community Link *(Third Sector SPOA)*	**3461** (558 Direct Contact with Môn Community Link & 2903 Calls transfered from Medrwn Môn Contact)	
SPOA	**6,648** referrals were received via the SPOA April15-March16. This includes referrals for community Health and Social Care referrals, but does not include the Linc Cymunedol Môn element. This does not reflect the amount of people who have benefited from this service, but gives an indication of how many referrals are received.	

	1,728 referrals were received between April16-June16	
CMHT	**800 to1000** Ynys Mon residents at any one time	
CLDT	**312** People known to SSD team for past 12 months **250** people (190 referrals in last 12 months) worked with by health team*	
SCS		**125** disabled children and young people and their families.

* *Some of these people will be double counted due to our joint working philosophy*

What difference has this service made to people receiving the service?

MEC

Patient/Carer satisfaction questionnaires generated very positive feedback in relation to:

- Avoiding the need to spend lengthy time in a hospital environment.
- Care being provided at home where recovery time was felt to be much quicker and better.
- Less stress on carers in having their loved ones in a hospital environment and where travel to visit may be difficult.

ICF projects

- Support from the project allowing (number of) third sector groups to promote services they offer to local people and communities.
- (Number of) Gaps in services being identified and addressed.
- Success will be when: Linc Cymunedol Môn provides up-to-date information and will be the recognised and go-to service for individuals seeking information on 3rd Sector providers of low-level Health, Social Care and Well-being services and will play an important part in Public and Health Sector colleagues' toolbox of support services.
- Reducing the length of stay older people are having in hospital
- Reducing delayed transfers of care
- Reducing the number of overall hospital admissions for older people
- Reducing the number of emergency hospital admissions for older people
- Reducing readmissions to hospital within 30 days for older people
- Reducing permanent admissions to residential care
- Increasing the capacity of EMI Nursing beds on Anglesey by developing innovative service models.
- Clients receiving a social care service 7 days a week.
- Reduction in the number of people having to go Out of County for Dementia Care.

IFSS

- Families appreciate the new way of working.
- Leads to change within families.
- Keeps children safe.
- An opportunity to train staff within the service. Case study available – ***see Annex 2***

Môn Community Link

Case study available – ***see Annex 3***

SPOA

- This provides a single point of contact for adults and their families and carers and means that they do not have to contact several different points regarding different aspects of their care and support. This makes it much simpler and efficient when needing to make contact with community services. They also do not have to repeat their needs and confirm their details several times to different workers.
- The people of Anglesey receive information, advice and support that allow them access to services from one central point. The referral process is easier and more straightforward.
- The SPOA supports the Social Services and Well-being (Wales) Act 2014 ethos of reducing dependency on statutory services and encouraging citizens to become more independent. The SPOA, along with the Linc Cymunedol Môn element, encourages people to use what they have in terms of support and resources within their own families and communities.
- Individuals access early intervention and preventative services which may delay their need for statutory and compulsory services, by moving away from a 'service-led' model of care. This encourages people to positively support themselves within their own communities.

CMHT

- Service responses are co-ordinated and proportionate to need thus avoiding duplication.

CLDT

- Support around their social care and health needs – support with where they live type of support they require ensuring effective and appropriate care services are identified commissioned and reviewed. Support around complex challenging behaviours in 4 key areas of Mental health/Forensic/PMLD & challenging behaviours.

SCS

- The service acts as a first point of contact for the families of disabled children and young people and is able to offer practical help and support to meet their needs and offer a preventative approach to overcome difficulties and issues that arise.
- The main difference is that all staff are available and based in the same office. It is easy for families and professionals to access advice and guidance from Team members.

How much is the budget for this service and where does it come from?

Name of the service	Annual budget for the service	Funding source
MEC	**£204,776**	BCUHB
ICF projects including Capital	**£986,355 (£742,172 & £243,643)**	Welsh Government Intermediate Care Fund.
IFSS	**£288,000**	From Welsh Government to the RSG
Môn Community Link *(Third Sector SPOA)*	**£36, 000**	Welsh Government Intermediate Care Fund.
SPOA* *The Senior Duty Officer post*	**£26,400**	Welsh Government Intermediate Care Fund. The ICF has funded this post since 2014/2015. This is on annual basis and is currently funded up to the end of March 2017.
2 of the Duty Officer posts	**£48,000**	CHC (Continuing Health Care) funding
3 Duty Officer posts	**£75,309**	Adult Services core budget
CMHT	**£1.8 million**	The service is funded jointly by the Council and BCUHB.
CLDT	**£4.9 million**	Adult Services
SCS	**£225,440**	7 Council funded posts (£225,440) 5 Health Board funded posts (£136, 179)

SPOA has become an integral part of the core service and the operational element is mainly funded via the core budget of Adult Services. Presently considering a different model going forward. This would involve a structure of short term and long term teams within Adult Services which may have an impact dependent on the agreed model for the future.

Annex 1

Anglesey funded ICF projects:

For the financial year 2016/17 Anglesey has received an allocation of £742,712 and a further £243,643 capital expenditure.

SPOA Coordination – Linc Cymunedol Môn

The aim of the project is to make information available to people and public sector colleagues about 3rd sector organisations that can provide support and information to address low level health, social care, wellbeing and social needs through community based activities to maintain and improve people's wellbeing in their communities.

Step Up Step Down Service / Spot purchase care beds

The aim is to deliver an integrated, responsive and inclusive service which will be mainstreamed within health and social care.

Dementia Programmes

Aims to be a preventative service and help to avoid carer breakdown.

Project is in 2 Parts:

1. Café Cofio
2. Homeshare

7 day Integrated Community Resource Teams – Night Time Response 'Night Owls'

The Night Owls services will help avoid unnecessary hospital admissions, inappropriate admission to residential care or nursing care, as well as supporting early discharge from hospital.

7 Day Integrated Community Resource Teams – Weekend Capacity

Improved care co-ordination between social services, health, housing third and Independent sector, to focus on preventative care and to avoid unnecessary hospital admission or delayed discharge for older people, particularly the frail elderly.

Garreglwyd Enhanced Care and Accommodation project- Dementia

To work in partnership with BCUHB to develop appropriate care models for people living with dementia and other complex presentations.

Annex 1 continued

Capital projects

Capital expenditure to ensure the physical environment at Garreglwyd meets with the standard required by the Dementia Kite Mark.

Develop **Smart Home and Enhanced Assessment Unit** within the premises of LA care home as a community resource.

Develop **community hubs** by utilising existing community facilities and adopting a co-productive approach with citizens to co-design a programme of activities

To purchase specialist equipment such as **trikes and bikes** for children with disabilities. To also purchase **sensory equipment** for children with complex needs.

To re-furbish and enhance the internal fixtures and fittings at the **Old Rectory** (LD Respite care facility) in order to accommodate people with complex physical needs and to promote independence with self-care tasks.

In partnership with Cyngor Sir Ynys Mon's Housing department to develop a range of **independent living units** to enable people with complex support needs to live safely in ordinary housing that's equipped for their needs.

Annex 2 Observations on integrated working within the IFSS:

Author: Llyr ap Rhisiart (Consultant Social worker IFSS Ynys Mon a Gwynedd) October 2016

The IFSS team consists of three Social workers from child care backgrounds and three nursing staff from substance misuse, school nursing and mental health. All team members' work to the same model of intervention with the families allocated to the service. The model has its roots in social care and medical models of intervention. There are several advantages in working within a multi-disciplinary and integrated team;

- Each worker brings his or her own experience of working with families' adults or children. Workers within the team are experienced individuals who have a wealth of knowledge and experience in their respected field of expertise.
- Case discussions within the service can be extremely beneficial and using the knowledge and skills of each worker can provide us with better possible solutions for parents and children. This is now core to out practice.
- As a consequence services can be provided in a time appropriate manner reducing the pattern of providing services to families at times when it may not be the best time for them.
- The team are trained in several interventions decreasing the need for multiple workers within a family. Feedback from families suggests that this is very beneficial for them and creates a close working relationship with the family.
- The service has a role in improving the co working and understanding between children and adult services. This task can be challenging at times, however it is helpful that the IFSS consists of workers from different backgrounds who can provide different perspectives into what can be challenging for different agencies.
- The IFSS working group is a forum for all agencies to discuss effective co working and collaboration emphasising on good practice.
- All the workers are located in one centrally located office and cover both counties. Having health and Social Services staff working closely together is a benefit for both workers and families.
- It also promotes the notion and ethos that the IFSS belongs to all agencies health and social care alike (even though it's funded and lead by the Local Authority).
- The IFSS team have access to a multitude of training opportunities from Health and Social Services. In return the IFSS can offer training for both social care and health staff (free of charge).
- The IFSS can bring agencies together and promote collaborative working in safeguarding children.

Annex 3 Linc Cymunedol Môn

Mr. P (aged 72) had lost his wife suddenly 4 months ago, and was feeling very lonely. His son lived in England and was very supportive, but was too far. Mr P had received 2 private bereavement counselling sessions to help with the loss of his wife, but cannot afford any more. He was very sad on the phone, and was crying. He also revealed that the week earlier, his sister in law (his late wife's only sister) had passed away – and that she had been the only connection to his late wife's family. He was clearly bereaving, not only for his wife, but also his sister in law, and was in need of bereavement support as well as social groups and activities.

How was the Person supported by the Linc Cymunedol Môn officer?

Mr. P was introduced to the Royal Voluntary Service, who offered a befriending schemes as well as transport and social activities in the area. It was explained that they would not only be able to come to the house to meet up with him, but could help him out into the community to meet other local people.

It was also suggested that he contact the communal hub that had recently been set up in the area in which he lived, they offer a range of activities, from keep fit to lunch clubs, as well as having a staff member in the hub to encourage the individual to get involved as well as introducing them to others in the area. Cruise Bereavement care was also suggested, but due to their high demand and waiting lists – they were unable to support him at this time.

10 minutes after this conversation, the Linc Cymunedol Môn officer received a call from the Royal Voluntary Service, noting that they had received a phone call from Mr. P and that they were arranging that a volunteer would go and visit him the following day.

Feedback from Mr.P on the impact of the service

After 6 weeks, the Linc Cymunedol Môn officer gave Mr P a phone call to ask how things were. His attitude over the phone had completely changed, he was chatty and sounded happier than the first conversation they had. He noted that a volunteer from the Royal Voluntary Service did indeed visit him very soon after the original contact to Linc Cymunedol Môn (he could not recall if it was the following day), and that they have encouraged him to get out of the house and he has attended some of their activities.

He noted that he had not contacted the community hub as of yet, because he was enjoying the company and activities offered by the Royal Voluntary Service, but was happy that he had that information, if he ever wanted to contact the hub in the future. He noted that the contact had been "Very helpful, and was feeling a lot better. The RVS have been brilliant".

When I asked if there was anything else that we could help him with, he replied no, and thanked Linc for getting him in touch with the Royal Voluntary Service, and that he was feeling so much better.