AGENDA ITEM NO.

ISLE OF ANGLESEY COUNTY COUNCIL	
Report to	**Executive Committee**
Date	**13 January, 2014**
Subject	**North Wales Statement of Intent**
Portfolio Holder(s)	**Councillor Kenneth Hughes**
Lead Officer(s)	**Gwen Carrington, Director of Community**
Contact Officer	**Gareth Llwyd, Business Support Unit Manager**

Nature and reason for reporting

To seek approval of the Joint North Wales statement of Intent for submission to welsh Government by 31/01/14 in response to the requirement set out in the 'Framework for Integrated Services for Older People with Complex Needs' published in July 2013.

A – Introduction / Background / Issues

In July 2013, The welsh Government published a Consultation Document that sets out requirements and expectations on health boards and local authorities to accelerate the pace of integrating health and social care services and to embed these into mainstream service delivery by the end of December 2014 in order to facilitate access to services and to improve outcomes for citizens.

B - Considerations

The 'Integrated Services Framework' document places an expectation on Health Boards and local authorities at the regional level to produce a '**Statement of Intent'** that outlines the current situation and future intent for outlining a Work Programme that will promote more formal collaboration to deliver and embed integrated services within mainstream provision by the end of 2014.

C – Implications and Impacts		
1	**Finance / Section 151**	
2	**Legal / Monitoring Officer**	
3	**Human Resources**	
4	**Property Services** (see notes – seperate document)	
5	**Information and Communications Technology (ICT)**	
6	**Equality** (see notes – seperate document)	
7	**Anti-poverty and Social** (see notes – seperate document)	
8	**Communication** (see notes – seperate document)	
9	**Consultation** (see notes – seperate document)	
10	**Economic**	
11	**Environmental** (see notes – seperate document)	
12	**Crime and Disorder** (see notes – seperate document)	
13	**Outcome Agreements**	

CH - Summary

The Statement is a First Iteration of the Intent of the 6 North Wales Local Authorities and Betsi Cadwaladr University Health Board to deliver integrated services for Older People with complex needs. Consideration of this first Iteration with Council Members and Health Board Directors, feedback from Older People and from Welsh Government will all contribute to a final Statement to be accompanied by an Action Plan by 31/3/14

Whilst the Framework document requires the Statement of Intent to be focused on Older People with Complex Needs we consider this to be an approach we would wish to utilise for all other service user groups in the future.

We fully recognise that in order for our Vision to succeed, there will need to be a shift of resources from acute / critical services to primary / community services and that this poses considerable challenge in the current financial climate. For BCUHB, this challenge is identified within the 3 Year Plan 2014-17.4

D - Recommendation

R1. That the Executive Committee approves the first iteration of the North Wales Statement of Intent – that includes contributions from the Isle of Anglesey County council – for submission to welsh Government by BCUHB and the 6 counties by 31/01/14 in order to conform with the statutory requirements set out in the document 'Framework for Integrated services for Older People with Complex Needs'.

R2. That the Executive Committee authorises the Community director to collaborate with BCUHB and the 6 other local authoriites across the North wales Region and locally here on Anglesey through the proposed Integrated Delivery Board for Health and Social Care that we intend to establish to strenghten and provide robust governance arrangements to identify priorities to drawn up a Work Programme for the delivery of integrated services for older people with complex needs.

Name of author of report: **Gareth Llwyd**
Job Title: **Business Support Unit Manager**
Date: **6 January, 2014**

Appendices:

North Wales Statement of Intent

Background papers

Welsh Government (July 2013) Consultation Document - Framework for Integrated Health and Social care services for Older People with Complex Needs.

CYNGOR SIR YNYS MÔN	
COMMITTEE:	Executive Committee
DATE:	13 January, 2014
TITLE OF REPORT:	North Wales Statement of Intent
PURPOSE OF REPORT:	To seek approval of the Joint North Wales statement of Intent for submission to welsh Government by 31/01/14 in response to the requirement set out in the 'Framework for Integrated Services for Older People with Complex Needs' published in July 2013.
REPORT BY:	**DIRECTOR OF HOUSING & SOCIAL SERVICES**

1.0 Background

1.1 Consultation document

In July 2013, The welsh Government published a Consultation Document that sets out requirements and expectations on health boards and local authorities to accelerate the pace of integrating health and social care services and to embed these into mainstream service delivery by the end of December 2014 in order to facilitate access to services and to improve outcomes for citizens.

1.2 Policy context

An expectation is placed on Health Boards and local authorities to integrate services in the national policy context outlined in:

- **'Together for Health'** that sets out the ambition for person-centred health services to be provided as close to home as possible.

- '**Sustainable Social Services in Wales'** that envisages a social care service based on outcomes focused portable assessments and enabling people to make informed decisions, with more consistent care eligibility and planning.

- **The Social Services and Well-being (Wales) Bill** will significantly strengthen the legislative requirements for Health Boards and Local Government to integrate services.

1.3 Expectation to Submit a Statement of Intent

The 'Integrated Services Framework' document places an expectation on Health Boards and local authorities at the regional level to produce a '**Statement of Intent'** that outlines the current situation and future intent for outlining a Work Programme that will promote more formal collaboration to deliver and embed integrated services within mainstream provision by the end of 2014.

2.0 North Wales Response

2.1 The Statement is a First Iteration of the Intent of the 6 North Wales Local Authorities and Betsi Cadwaladr University Health Board to deliver integrated services for Older People with complex needs. Consideration of this first Iteration with Council Members and Health Board Directors, feedback from Older People and from Welsh Government will all contribute to a final Statement to be accompanied by an Action Plan by 31/3/14

2.2 Whilst the Framework document requires the **Statement of Intent** to be focused on Older People with Complex Needs we consider this to be an approach we would wish to utilise for all other service user groups in the future.

2.3 We fully recognise that in order for our Vision to succeed, there will need to be a shift of resources from acute / critical services to primary / community services and that this poses considerable challenge in the current financial climate. For BCUHB, this challenge is identified within the 3 Year Plan 2014-17.4

2.4 Health Board Financial Projections

However, this must all be set in the context of the financial environment affecting all public services including the NHS. Our medium term financial planning assumptions are indicative at present, but continue to show consistent inflationary and cost pressures against a very small level of increased investment planned from Welsh Government. Early projections for the medium term financial plan indicate a potential financial gap of 12.1% over the three years to 2016/17, before mitigation and savings plans are applied. Of this gap, 4.2% will need to be addressed in 2014/15, the first year of the three year plan. It is clear therefore that there will be a need to make difficult decisions and prioritise between approaches to improvement of health and delivery of health and social care services.

3.0 Recommendations

3.1 That the Executive Committee approves the first iteration of the North Wales Statement of Intent – that includes contributions from the Isle of Anglesey County council – for submission to welsh Government by BCUHB and the 6 counties by 31/01/14 in order to conform with the statutory requirements set out in the document 'Framework for Integrated services for Older People with Complex Needs'.

3.2 That the Executive Committee authorises the Community director to collaborate with BCUHB and the 6 other local authoriites across the North wales Region and locally here on Anglesey through the proposed Integrated Delivery Board for Health and Social Care that we intend to establish to strenghten and provide robust governance arrangements to identify priorities to drawn up a Work Programme for the delivery of integrated services for older people with complex needs.

North Wales Statement of Intent—

1 Introduction

The following paper constitutes the Statement of Intent on Integrated Care for Older People with Complex Needs between the North Wales Local Authorities and Betsi Cadwaladr University Health Board.

It has been developed jointly by colleagues from the North Wales Authorities and Betsi Cadwaladr University Health Board, to provide a single regional statement.

Across North Wales, there is a strong recognition of the need to work within a regional footprint—both to accommodate the LHB structure and to maximise efficiencies; whilst also being responsive to local need and historical service developments. This results in service planning and delivery needing to operate on a regional, sub-regional and county level.

Currently the LHB's clinical management structure is under review whilst Local Authorities are awaiting the outcome of the Williams Review—this inevitably leads to a level of organisational uncertainty. However, the paper has been written to reflect the strategic intent of Partners, with the Vision, Aims and Objectives for Integration across North Wales being ones which will be actioned regardless of future organisational structures.

The need to take a more robust and immediate approach to the Integration of Services for Older People, has been clearly disseminated by the Minister and Deputy Minister for Health and Social Services. This message is one that partner agencies across North Wales welcomes and indeed there are many examples of strong partnership working which demonstrate the commitment to this approach. We intend to build on this in order to develop an ambitious agenda which pushes existing boundaries and develops new, innovative services and systems.

'Integrated working' can have a variety of interpretations and for the purposes of this report, we are using the following (organisational) definition:

A single system of needs assessment, commissioning, and/or service provision that aims to promote alignment and collaboration between the care and the cure sectors (Ham, 2008).

This definition, should also be considered against the Narrative to explain integrated care and support to the citizen, developed by Welsh Government:

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

We understand that Integrated Care is not about structures, organisations or pathways per se, nor about the way services are commissioned and funded. Its primary purpose is to ensure that citizens have a better experience of care and support, experience less inequality and achieve better outcomes.

However within the current financial climate, it is also essential to recognise, the imperative for any change to be at least cost neutral in the long term.

When considering any move to Integration, we need to ask the following:

- Will it improve quality of life?
- Will it improve the quality of care?
- Will it improve the citizen's experience?
- Will it maximise cost efficiencies?

The paper is also predicated on the understanding that for Older People, health, social care, third sector and independent services should be designed and delivered to promote and maximise well-being; enabling the person to live independently in their community for as long as possible with services being provided in the person's own home or within community settings to avoid the need for ongoing, acute or institutional care.

These core features are the underpinning foundation for recent joint policy—Setting the Direction, Sustainable Social Services, Delivering Local Health Care and A Framework for Delivering Integrated Health and Social Care . They are also fundamental to the new Older People's Assessment Framework and the Social Services and Wellbeing (Wales) Bill.

Through integrated working Partners would expect to utilise their combined skills, knowledge, experience and resources to deliver better outcomes for Older People.

Specifically they would expect to:-

- Promote citizen ownership and control over their personal well-being and care needs, creating an independent rather than a dependent care culture.
- Support older people to live independently and be connected to their home and community, with the aim of reducing the possibility of loneliness and isolation.
- Provide proactive as well as reactive care, considering ways in which the individuals needs can be met through a variety of supports within the community and irrespective of their eligibility criteria.
- Streamline services and care to meet the individual needs of the older person better.
- Reduce duplication and increase awareness of services delivered across all sectors to older people.
- Reduce the inappropriate use of longer term and more intensive or acute care.
- Drive down the cost of caring for older people.

2 Conceptual Framework

In order to plan for and describe the development of Integrated Services, this Statement of Intent has utilised a Partnership Continuum [(i)](see Appendix 1) which can be applied at Strategic, Managerial and Service Delivery levels; with implementation possible on a regional, sub-regional, county wide and locality basis.

Integrated working will develop at a different pace and for different services across North Wales. We will ensure that learning is shared through partnership structures. This may be through a shared website with a resource library and common templates for key documents and / or regular learning events.

Learning from "Collaboration in Social Services Wales" [(ii),] from key documents such as "Making integrated care happen at scale and pace"[(iv)] and experiences nationally have highlighted the issues which help and hinder Integration and will bring pragmatism to our debate.

3 Model for the Integration of Health and Social Care Services for Older People / Target Operating Model

Currently within North Wales, there is no one coherent model for Integration which encapsulates all public health, primary, community, acute, social care and third sector services, and which is endorsed by all stakeholders—not least its citizens.

However the following components of a service model are ones we recognise which can meet the 4 key themes identified by older people when asked about the service difficulties they experienced i.e. co-ordination of care, continuity of care, straightforward and consistent referral and communication systems and access to services[(v):-]

- Integrated Structures within a Governance Framework
- Operational/Service Integration
- Prevention and early intervention
- Intermediate Care/Short Term Intervention
- Longer Term Community Support
- Sub Acute/In-patient Care
- Planned workforce
- Streamlined back office functions

The development of a North Wales Integrated service model for Older People is a clear priority for Partners and one which we will work to achieve over the next 12 months. In this undertaking, we recognise that there may be variations between the 6 Local Authority Areas as to which of the components listed above will be adopted, at what stage in the Partnership Continuum and whether at strategic/managerial or service delivery level.

4 Current Arrangements and Future Intent

The following sections provide a baseline of current "integration" together with the intent and aspiration for the future in North Wales.

4.1 Leadership to drive the Vision

Current arrangements

i)The **North Wales Regional Leadership Board** is comprised of:-

- The Leaders and Chief Executives of the six North Wales Local Authorities
- The Chair and Chief Executive of the Betsi Cadwaladr University Health Board
- The Chair and Chief Officer of the North Wales Fire and Rescue Service
- The Police and Crime Commissioner for North Wales
- The Chief Constable of North Wales Police

A key objective for the North Wales Regional Leadership Board is the promotion of joint working between local authorities and between local authorities and other public services like police, health and fire and rescue services. To this end it manages a portfolio of collaborative projects.

ii) Partnership working within North Wales is further supported by the **Social Services and Health Programme Board.** This Board is chaired by a sponsoring Chief Executive and its membership consists of Directors of Social Services; Lead or Executive member for Social Care; Betsi Cadwaladr University Health Board officers and WLGA, WG, SSIA representatives.

iii) Social Services Directors also meet formally with BCUHB Executive Directors on a quarterly basis at the **NWSSIBCUHB Quarterly Strategic Forum.**

iv) Each **LSB**, within its Single Integrated Plan has a commitment to improve collaborative working.

v) Local Authorities have key links with four of the BCUHB **Clinical Programme Groups (CPGs)** - Primary, Community and Specialist Medicine, Children and Young People, Therapies and Clinical Support, and Mental Health and Learning Disabilities. A senior Social Services Manager is included as a member on each of the four CPGs and invited to attend monthly meetings.

vi) Locality working is the foundation for Integrated services in North Wales. Within the joint working arrangements in North Wales key partners come together at the (regional) **Community Services Partnership Forum**. This Forum includes representatives from BCUHB (in relation to public health, primary care, community health services and mental health), independent contractor professions, social services (from each of the six Local Authorities) and the Third Sector. The Forum

was originally established to drive forward the development and implementation of locality working and other key elements with *Setting the Direction*.

Discussion is now underway to ascertain whether the Forum can take a broader strategic role to become a regional Delivery Group which has the responsibility of driving forward all the required actions outlined in both "A Framework for Delivering Integrated Health and Social Care" and "Delivering Local Health Care". Through this Forum, the needs of the older population of North Wales for co-ordinated and consistent service delivery will be planned, using locality/ county/ regional and national data.

Future intent

i)The need for strong county governance structures which promote and support joint leadership at strategic, managerial and service delivery levels has been recognised , with a local Framework structure (attached as Appendix 2) showing the links between localities, county and the whole region of North Wales. This has been adapted to meet the needs of each County. The Forum at County level is intended to support integrated working by unlocking barriers and unnecessary bureaucracy.

ii)The Chair of Betsi Cadwaladr University Health Board has recently instigated a Partnership Review, the findings of which will help to inform strategic plans for Integration.

4.2 Commissioning

Current arrangements

i) The BCUHB Director of Public Health Annual report 2012, provides information on and further links to population needs assessment and priorities relating to the health and well-being of older people across North Wales. Additionally there are Older Peoples Indicators (2012) which have been developed by Public Health Wales.

ii) As an initial move towards a single commissioning plan, a regional working group comprising social care and health managers, has been established to scope existing provision and identify the continuum of community based services which come under the broad umbrella of "Intermediate Care Services".

iii) The North Wales Commissioning Hub for high cost, low volume placements is a positive example of regional joint commissioning activity and one which can be built on to develop joint procurement of residential placements, oversee a regional contract and ensure a consistent approach to fee setting.

Future Intent

Commissioning is a broad concept and there are many definitions. It can be described 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.

i) For Older People's services such benefits can be realised by planning and commissioning services jointly across social care and health in partnership with the third and independent sector. These will be developed at a locality, county and regional level.

ii) An initial element of this activity will be the development of market position statements.

iii) Risk stratification will also be incorporated as this enables appropriate services to be targeted in order that pro-active, personalised care planning can be achieved. Users who require case management due to the complexity and unpredictability of their condition could then expect to receive care via co-ordinated care pathways that will ensure a smooth transition between services.

iv) A key issue will be to take a joint approach to ensure that providers of health and social care services operate in an enabling culture, support independence and avoid unnecessary escalation e.g. hospital admission.

v)The need to develop a strong model for joint commissioning has been agreed by Partners as a priority for action and a bid for additional support in this endeavour is currently being developed.

4.3 Resource Management/Pooled Budgets

Current arrangements

i) In respect of Formal S33 Agreements, all Counties have a Pooled Budget for the Community Equipment Service.

ii) **Conwy** has

- two jointly funded Extra Care Housing Short Term Flats to facilitate early discharge and reablement where people cannot return home.

iii) **Denbighshire** has

- a pooled budget agreed for health and social care workers.

iv) **Wrexham** has

- health and social care currently joint funding a number of initiatives including telecare, intermediate care, falls prevention programme and third sector contracts delivering low level preventative services for example.

v) **Ynys Môn** has

- a Complementary Purchasing Scheme which has existed over the last 15 years to jointly fund health and social packages of care to maintain and support people at home with intensive and complex care needs in order to avoid inappropriate or premature admissions to long term care.
- long standing arrangements with Health to fund Rapid Response services in order to facilitate hospital discharge and to provide emergency intervention to avoid inappropriate admissions to hospital..

Future intent

i) All organisations are required to make significant efficiencies over the next few years and this could be a barrier to the further development of formal pooled budgets. However, it could also be argued that pooling budgets could lead to efficiencies. As with any aspect of integration, the rationale for taking such action requires the citizen and organisational benefits to be explored. This is an identified objective in respect of the Intermediate Care services working group referenced above.

However, it is clear that we need to have an improved understanding of the resources available within the County, preferably by locality, so as an initial step Partners will work together to map out the current budget, estate and staffing currently allocated to services for Older People.

4.4 Managerial/Service Integration

4.4.1Workforce

There is an ambition across North Wales to move to a more integrated workforce structure for Older People. The predictions for future demand will be based on demographic change and the shift of services from ongoing, acute or institutional care to the community, whilst also taking into account additional demand arising from the need to address well-being, social inclusion, public health and the expected rise in the management of chronic conditions.

Current arrangements

i)All organisations provide development opportunities that support staff from both health and local authorities as well as utilising Social Care Workforce Development grants to support developments in the third and independent sector.

ii)**Conwy** has

- single management of Adult Mental Health Services.
- co-location of health and social care staff for older people in Canolfan Crwst, Plas Menai and Abergele Surgery with Llys Dyfrig in Llandudno opening in March 2014..
- integrated care & treatment planning in respect of Mental Health Measures.

ii) **Denbighshire** has

- a single line management arrangement for Adult Mental Health Services and a small team for Older People's Services.

iii) **Flintshire** has

- a single line management arrangement for Adult Mental Health Services.

- 3 Locality teams for Older People's Services that are coterminous with health locality boundaries. One is co-located with health colleagues in a local community hospital. These have been established including Social Workers and Occupational Therapies with the aspiration of co-locating the remaining 2 teams in 2014.

iv) **Gwynedd** has

- social care staff working in Meirionnydd co located with health colleagues . Currently staff work from 6 "touchdowns", 5 of which are based in Health Centres or Community Hospitals.

v) **Wrexham has**

- strong partnership working in relation to intermediate care services with health employed generic workers based with the older people's social work team and managed by the social work team manager.
- an integrated multi-disciplinary team approach being piloted at the Maelor Hospital as part of the frailty project to reduce avoidable admissions and facilitate timely discharge.

vi) **Ynys Môn** has

- co-location of District Nursing Team within Adults Social care services in Llangefni.
- an integrated Gwynedd and Ynys Môn Social Work Team based at Ysbyty Gwynedd.
- co-location of integrated Community Mental Health services on two sites in Llangefni and Holyhead.

<u>Future intent</u>

i) We will determine the workforce required to meet the agreed Integrated Service Model for Older People to ensure that we have sufficient staff with the right skills in the right place. It is axiomatic that this is a particular challenge for the rural areas of the County.

ii) We will explore opportunities for the joint location of teams—noting the need for pragmatism in the shared cost implications of such provision.

iii) Shared arrangements have been identified as key in leading change and cutting across the fragmented services and silo working that characterise dysfunctional systems. We need to develop well co-ordinated, integrated pathways to ensure that citizens do not experience disconnect. We intend to commence discussion to explore the options of establishing joint Locality Managers who would have operational and developmental responsibility for the management of a complex range of specialist, multi-agency services in a cost effective and responsive way, integrating established practices and multi-disciplinary staff across care pathways.

iv) A recent Partnership Assessment exercise undertaken by the Locality Teams in each County, has provided an analysis of current working arrangements and

identified areas for improvement. This assessment will provide a baseline for the future.

4.4.2 Back Office functions

The need to ensure that Integration is based on a whole systems/organisational approach is highlighted in "Collaboration in Social Services in Wales"[ii]. This document evidences the risks to developing integrated services when all key departments eg finance, human resources, information, are not engaged in the journey from the outset. They need to be involved in agreeing the level to be achieved on the Partnership Continuum.

For the Health Board, support functions such as 'payroll, procurement and transactional aspects of HR'are provided by the all Wales Shared Services Partnership.

Effective integrated working should be supported by policies and procedures that are at best joint and at least aligned and we will explore this in the context of the all Wales Partnership. There is also a need for shared training programmes, "joint" data management and information systems that "talk" to each other.

<u>Current arrangements</u>
i) BCUHB and the 6 Local Authorities are developing a shared Choice Policy to support timely and appropriate hospital discharge.

ii) **Conwy** has
- developed an information sharing protocol in respect of care home monitoring and a joint monitoring arrangement.
- an agreement to make funded nursing care payments on behalf of the Health Board.

iii) **Denbighshire** and iv) **Flintshire** have
- WASPI agreements in a number of services to support joint working.

v) **Gwynedd**
- is a member of The Welsh Systems Consortium [WSG] which consists of 8 Local Authority's in Wales who purchased a social care system in 2003 . The WSC are currently undertaking a joint procurement with Health for a Community Care information system in order to realise the vision of Social Care and Community Health using the same system.

vi) **Wrexham** has
- an Adult Social Care's Workforce Strategy and Development team providing training to operational staff working across the Health and Social Care spectrum.
- Intermediate Care, Enhanced Care and South Locality Project – which are supported by joint data management systems.

vii) **Ynys Môn** has

- an agreement to make funded nursing care payments on behalf of the Health Board.

Future intent

i) Within North Wales we will consider how development of joint information systems can be taken forward within the current model of the Shared Services Partnership. This will consider the national procurement programme for a Community Care Information System ie an electronic solution that will facilitate data sharing across Community Health and Social Care.

ii)The Welsh System's Consortium (WSC) which includes three North Wales Local Authorities - Wrexham Borough Council, Gwynedd Council and Ynys Mon County Council along with five other Local Authorities, have signed up to a joint procurement exercise with NHS Informatics Service (NWIS). This has been named the Community Care Information System (CCIS). All 22 Local Authorities and all 7 Regional Health Boards have been named in the tender process, which is well underway

iii)A regional North Wales CCIS group has been established including Business Support leads and Heads of ICT. The group also includes partners from current PARIS Suppliers (Conwy, Flintshire & Denbighshire) with a view of gaining a regional approach across North Wales.

iv) The intention is to support the integrated working objectives which in themselves deliver improvements for patients and more efficient working practices. In general a single system for community health and social care would enable:

- Improved decision making leading to better outcomes for people– through access to more complete data. This should improve patient outcome and help avoid admissions and improve service planning.
- Improved coordination – between authorities and thereby resulting in efficiencies and better service to patients.
- Improved individual patient safety – through less transcription errors, improved timeliness, reduction in 'lost' referrals, traceability to one point.
- Reduced visits to base – through access to information on the move.
- Reduced duplication in data capture and checking information.
- Reduction in unnecessary interventions.
- Increased confidence in the identity of the person.
- A joint core data set across health and social care.

4.4.3 Wider Partnerships

A range of services apart from health and social care are required by citizens and carers to live independent lives. For example, housing and transport equally affect the way people live, yet these services can sometimes operate in parallel, rather than in partnership with each other.

Current arrangements

To-date there have been some discussions and collaboration undertaken through existing partnerships, particularly through the Health, Social care and Well Being strategies, and occasional involvement in specific projects.

A North Wales Transport to Health Group has been established which is chaired by BCU HB and involves Welsh Government, representatives of the six Local Authorities, Taith – the regional transport consortium - WAST and Community Transport.

The aim of this group is to understand and improve access to health services and facilities in North Wales. The group is also seeking to ensure a better strategic fit between planning and delivery for all partners involved.

Future Intent

In response to some of these difficulties, we should have care pathways that assist patients in their journey through multi-agency services and that work across boundaries to support people in accessing and negotiating services and in making the transition from one care setting to another. This is particularly relevant for those citizens and carers who experience difficulties in accessing care from teams that fall outside the remit of integrated provision.

4.5 Citizen Centred / Co-produced services

Current arrangements

In North Wales, we recognise the value not only of adopting healthy lifestyle behaviours, but ensuring strong social networks are in place to support individuals. Being an active member of a community can increase the level of control people have over their lives and contribute to improved health and well-being. Co-production – using the experience, knowledge and abilities of professionals, partner agencies, people using services and their communities – can contribute to improved outcomes. It can also help ensure that better value for money is achieved and can help in empowering communities.

The Director of Public Health's Annual Report 2013 recognises and supports the importance of such approaches. "Co-production means that people share decisions about their health and wellbeing with health and social care professionals. It means that health and social care workers move towards a facilitation role and away from the traditional fixing role. It means a shift of power, and it means that everyone needs the skills to take part in shared decision making."

Co-production approaches are being used in the planning and development of some community based initiatives and the six Local Authorities are developing a shared understanding of this methodology.

We are also exploring the potential development of social enterprise schemes – businesses that trade to tackle social problems, improve communities, people's life chances, or the environment.

The Local Authorities and the Health Board have identified the need to develop a shared approach to social enterprise as part of the transformational change required for the implementation of the Social Services and Wellbeing Bill. Our proposals for use of the funding for implementation include the commissioning of expertise to support us in this approach.

The Strategy for Older People was launched in 2003 to address the issues and aspirations of people aged 50 and over living in Wales. The strategy is grounded in ageing as a positive concept. Mechanisms and structures have been established at local levels across North Wales that allow public services to hear the voice of older people and to allow older people to be involved in decisions that affect their lives.

It is recognised that Carers are a key partner in the delivery of care and supporting their involvement is central to the sustainability of care provision. The Health Board, Local Authorities and Third Sector organisations in North Wales are expected to work in partnership to achieve the cultural change and deliver the main duties arising from the Carers Strategies (Wales) Measure 2010. Strong and effective partnerships will be crucial to enable the successful delivery of the key actions that include improved joint working, joint reporting systems and strengthened carer information services.

i) In **Conwy**. .

- The Consultation on the modernisation of Older Peoples Services ensured that citizens were at the heart of the developments and each new scheme has been oversubscribed.
- Similarly Carers have a high profile and are actively involved in the development of services. The Health Board and Conwy Local Authority have been working together to prepare, publish and implement a Strategy for Carers.
- A cultural change in empowering carers to be part of the decision making processes around care management.
- Moving On Solutions, re-provision of health and well being activities (social and Leisure) is a good example of co-production, managed by third sector with a volunteer base and support from the LA via grant.

ii) In **Denbighshire**

- the North Denbighshire Community Healthcare Services project has been working with service user and community representatives, who are taking part in the development of proposals for the planned new community hospital in the locality. We are exploring the potential for social enterprise or

entrepreneurship to support local people becoming involved in the hospital facilities and services, working with other local agencies.

iii) In **Flintshire**

- there are a number of excellent examples of citizen centred/ co produced services. These include:-
- current and former service users in Mental Health as partners in all aspects of service provision. They support delivery of training, attend training courses and are part of the overall positive approach to co-producing service provision and delivering outcomes.
- as part of ongoing service development, Flintshire County Council providing opportunities for communities to co-produce options for future service delivery in 2014
- individual Business Plans by service considering options to develop further co-produced services.

iv) In **Gwynedd**

- there are a number of existing groups for example the Older People's Forum and Ageing Well Centres which provide regular opportunities for conversations which help inform the citizen cantered direction of our service. The intention is to increase the use of existing groups ensuring that any gaps are filled re citizen engagement.

v) In **Ynys Môn**

- there are a number of existing groups which include for example the Older People's Council and Forum and 3 Age Well Centres which provide regular opportunities for conversations which help inform the citizen centered direction of our service developments and delivery. The intention is to increase the use of existing groups in the development of community-based preventative support services across the Island.
- under the Strategy for Older People, a tried and trusted model of engagement has been developed with a number of local communities to reshape and develop a range of community-based preventative services which promote health and well-being and social inclusion for older people.
- as part of ongoing service development under the Transformation Programme for Older Adults Services, opportunities will continue to be provided for communities to co-produce options for future service delivery in 2014 and beyond. A Community Partnership approach with key stakeholders and local community groups is being developed in the Beaumaris area to make more effective use of community assets and resources.

<u>Future Intent</u>

i) We will explore together how we can build on early work on co-production, working to embed the principles into our planning and development of future services.

ii) Local Authorities and the Health Board will work with LA Regeneration Departments and established social enterprises across North Wales to research, explore and learn more about the development of social enterprises and co-operatives. Although there are examples of well-established social enterprises operating across North Wales there is room to learn from these, develop these further and to establish Social Enterprises and / or Co-operatives in other service areas. North Wales will undertake a series of events to learn more about the development of such initiatives and will strive to establish further initiatives across social care and health services.

iii)The Locality Leadership Team recognises the need for an Outcomes Focused approach in working directly with older people and also when developing services. The new Assessment Framework will ensure outcomes are captured by whichever professional undertakes the assessment, whilst the recent regional document "Developing Joint Outcomes for Localities" will enable partners to agree the priority outcomes to be achieved through respective organisational actions.

iv)The provision of pathways that encompass self-management through to end of life care will be developed.

v) **Conwy** has

- a Corporate group established to consider the opportunities of working with social enterprise to deliver a range of services including social care.

vi) In **Flintshire**

- Mental Health Support Services expect to progress a Social Enterprise in early 2014 with service users, the community and the council to allow wider community and individual engagement in service provision.

4.6 Service Delivery Integration

4.6.1 Service provision

<u>Current arrangements</u>

i) In **Conwy**

- the provision of Community Mental Health Services for adults is provided through a single line management arrangement.
- The Local Authority provides professional input into Intermediate Care services and has Service Level Agreements in place to provide support for Intermediate Care Services and End of Life services.

ii) In **Denbighshire**

- Community Mental Health Teams for adults are provided through a single line management structure. The Health & Social Care Support Workers are managed locally by the Local Authority through a pooled budget. The Local

Authority provides professional input to the Enhanced Care Service and supported the Seasonal Plan.

iii) In **Flintshire**

- the Crisis Intervention Team consists of health and social care staff and works in partnership across health & social care boundaries to maintain people at home during a medical crisis and support speedy discharge from hospital.
- 3 Dementia Support Workers are funded by Continuing Health Care Funding delivered by Social Care specifically to link people with dementia into community support services and enable them to maintain their place in the community for as long as possible.
- an Early Onset Dementia Social worker works across the boundaries of health & Social care specialising in uniquely complex cases and supporting creative solutions that maintain people at home.
- the North East Wales Carers Information Service deliver carers assessment on behalf of statutory partners
- Service Agreements exist for the provision of equipment services with "Care and Repair" and for visual and hearing impairment support with Vision Support and North Wales Deaf Association and Wales Council for the Blind
- 3 health staff within the Re-ablement team based within the local authority are managed on a daily basis by the Re-ablement Manager.

iv) In **Wrexham**

- the Intermediate Care Service represents a joint partnership between Wrexham Adult Social Care Department and Betsi Cadwaladr University Health Board. This initiative successfully supports the achievement of joint health and social care outcomes whilst delivering care and support which best meets the needs of older people in Wrexham.
- Enhanced Care has been successfully implemented within South Wrexham and demonstrates effective joint working between health and social care at both a strategic and operational level.
- The South Locality Pilot represents a successful joint Health and Social Care Initiative which manages the discharge home of patients with chronic conditions and who might otherwise face unnecessarily lengthy hospital admissions.
- A number of pilot projects are underway to assess (a) the value of an expanded Intermediate Care Service (Social Workers, Therapists, District Nurses and generic workers) – available over the weekend in order to increase the number of safe discharges during the Winter pressures period; (b) the value in having social work presence within the Medical Assessment Unit at the Maelor hospital to help prevent avoidable hospital admissions and facilitate earlier discharge.

v) **In Ynys Môn**

- Effective multi-disciplinary assessment and care management arrangements have been in existence over the last 20 years through the Model Môn Scheme which has operated across all 6 geographical patches which are co-terminus with GP catchment areas. Currently, the Locality Team lead on the ongoing support and development of these arrangements at the local level.

- Enhanced Care has been successfully implemented within Ynys Môn and demonstrates effective joint working between health and social care at both a strategic and operational level.
- There is ongoing collaboration through Locality Team arrangements to develop a more integrated approach to the delivery of Intermediate care services which include a Rapid Response Service and an in-take model of a Re-ablement Service.
- District Nursing staff have been co-located within Adults Social Care Services in Llangefni in order to support the Single Point of Access, Assessment and care Management arrangements.
- Dementia Support Workers are funded by Continuing Health Care Funding delivered by Social Care specifically to link people with dementia into community support services.

Future Intent

i) In **Conwy**

- Enhanced Care, Intermediate Care and End of Life Care will be jointly delivered through a Memorandum of Understanding.

i) In **Denbighshire**

- the Local Authority is working with BCU in the development of the North Denbighshire Community Healthcare Services Project and the Llangollen Primary Care Centre and the roll out of Enhanced Care Services in the Central and South Locality area.

ii) In **Flintshire**

- the Local Authority is working with BCUHB in the development of Primary Care Centres in Buckley & Flint and the roll out of Enhanced Care Services in all areas of Flintshire. Health and Social Care operate co-terminus locality structures and have developed locality leadership teams driving local agendas.

iii) In **Wrexham**

- the Intermediate Care Service will be enhanced both in size and scope in order to meet the growth in demand. It is the aspiration that the service operating hours will be extended in order to accept referrals at evenings and weekends.
- Intermediate Care, Enhanced Care and Re-ablement services will be developed to deliver a seamless, proportionate, needs led service.
- the value of further integration and co-location of health and social care staff will be evaluated and pursued as appropriate.
- the value of the future development of a step-up / down facility to support the achievement of Intermediate Care outcomes will be investigated.

iv) In **Ynys Môn**

- the Intermediate Care Service will be enhanced both in size and scope in order to meet the growth in demand. It is the aspiration that the service

operating hours will be extended in order to accept referrals at evenings and weekends.

- Intermediate Care, Enhanced Care and Re-ablement services will be developed to deliver a seamless, proportionate, needs led service.
- the value of further integration and co-location of health and social care staff will be evaluated and pursued as appropriate.

4.7 Engagement

Current arrangements

i)Within the regional Locality model, Locality Stakeholder Groups were identified as the mechanism for engaging directly with the population, to discuss current provision and identify future need/ options for change. This approach was initially used to debate changes to health provided community services.

ii)Local Service Boards are developing engagement strategies to enable local communities to be better able to understand the work of the LSBs. Similarly, shared engagement strategies around the Single Integrated Plans are being used or developed.

iii)Initial exploration of shared approaches to engagement and consultation has commenced through the North Wales Consultation Officers group, which comprises representatives of the six Local Authorities and more recently the Health Board.

iv)The advantages of a shared approach are recognised in the Guidance for Engagement and Consultation on Changes to Health Services[(v)] which anticipates that in engagement and consultation, Local Service Board partners should be fully involved to ensure that proposals are seen and addressed within the context of the "whole system" of public service provision.

v) In **Conwy**

- the Joint Localities Board (delivering the current Health, Social Care and Wellbeing Strategy) is currently developing a participation strategy to ensure a citizen focussed approach.

vi) In **Denbighshire**

- there is an Older People's Strategy Group, a My Life, My Way Group and contracts with third sector organisations for advocacy and consultation in order to inform service quality and developments. We are currently engaging with groups to explore 'Supporting Independence in Denbighshire', characterised by 'SID', an older man representing individuals with a range of different social, health and care needs and how services can support his independence and wellbeing.

vii) In **Flintshire**

- services for adults in social care were transformed following extensive engagement with community partners.

- there are strong multi agency arrangements to engage with older people in Flintshire and a locality service questionnaire is used to gain vital information from the community. In Mental Health there is a strong structure to support service user engagement in current and future service delivery.
- It is commonplace for service users to sit on panels to support appointments within key areas.

viii) In **Gwynedd**

- A process of community engagement has recently commenced with groups of citizens. This is in order to both inform them about, and create opportunities to help shape the development of the Integrated Single Point of Access (SPOA) between community health and Gwynedd Adult Social Care services.

ix) In **Ynys Môn**

- under the Transformation Programme for Older Adults, engagement arrangements with key stakeholders and local communities are being developed in order to consult on proposals to reshape and develop a range of community-based services which will include care and accommodation services for Older People.

- effective links exist with the Older People's Council in order to promote discussions on future service developments and the remodelling of services under the Transformation Programme.

- there are a number of service level agreements with 3rd sector organisations to provide advice and advocacy support and forums for service users.

<u>Future Intent</u>

i) The need to review the work and focus of Locality Stakeholder Groups has been identified and will be discussed within the Community Services Partnership Forum. These groups present an opportunity for a shared approach between the six Local Authorities and the Health Board.

ii) We will explore opportunities for development of shared engagement and communications.

As part of the transformational change under the Social Services and Wellbeing Bill, it is proposed that a regional strategy is developed to be delivered over 3 years which would secure effective communication, including consideration of suitable materials such as banners, leaflets, materials for media and engagement with communities. This is to underpin a shared approach to community engagement and information.

iii) We will continue to explore and identify opportunities for bringing together of activities on the spectrum of participation - communication, information, engagement

and consultation, shared decision making – within the governance arrangements of each organisation.

iv) All the partners are committed to the provision of all services in the language of choice and to the implementation of More Than Just Words – the Welsh Government's strategic framework for Welsh language services. This is important for services which we commission from other providers, as well as services provided by the Health Board and the Local Authorities. We will seek to ensure Welsh language services are available wherever possible; greater collaborative working may help facilitate this. We are also committed to promoting the use of the language and maintaining Welsh culture and will strive to ensure that our strategies for integrated working support and complement these commitments.

v) We are also committed to advancing equality of opportunity and protecting and promoting the rights of everybody to achieve better outcomes for all. Our collective focus is on well-being in its widest sense to improve and enhance the lives of individuals, communities and the population of North Wales. We are required by the specific equality duties for authorities in Wales to undertake Equality Impact Assessment (EqIA) on any policies or proposals which might affect protected characteristic groups and to engage with those groups who may be affected by proposals. As we develop our thinking on the integrated model of care for older people with complex needs, we will undertake impact assessment and seek to engage with representatives of groups who may be affected.

4.8 Transforming Access

Current arrangements

i) **Conwy**

- is part of the regional project around transforming access. It is clearly understood that the development of a SPOA is fundamental to the success of community based services. Conwy has undertaken a piece of research to consider access into services and identified a range of desired outcomes which will be achieved over net 12 – 18 month via a project management approach.

ii) In **Denbighshire**

- there has been a project team developing a Single Point of Access (SPoA) for health and social care services for adults. Agreement has been reached on what will be included in Phase 1 of the development, in order to use the learning from this to inform both local and regional approaches.

iii) **Flintshire**

- is the host organisation for the Regional Programme Manager and is currently developing a local Single Point of Access (SPOA) project team to take the development forward locally.
- Current Hospital Social Work arrangements and first contact structures support excellent access to social care support for service users and for

referrals from partners. Additionally adult social care have developed Self Assessment for equipment provision which reducing waiting times and becoming highly regarded.

- are also working with BCUHB to develop a falls pathway and are seeking to make the documentation more user friendly for Care Home Managers.

iv) **Gwynedd**

- have an established SPOA (Integrated Single Point of Access) Strategic Group. This multidisciplinary partnership Group is transforming access to integrated community based services through leading the SPOA development for Gwynedd. The decision to extend the remit of the Group to include the broader integration agenda was made recently. This Strategic Group also established (November 2013) a SPOA operational group for the Meirionnydd Locality to begin to deliver the SPOA on the ground.

ix) In **Ynys Môn**

- A Single Point of access has been established within the Social Services Duty System to process referrals following hospital discharge and referrals to all community disciplines which include Social Work ,District Nursing and Community Therapies.
- A multi-agency Project Board has been established to take forward an agreed Work Programme to develop business processes and IT linkages which will enable Health staff to access the RAISE community Care Information System.

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Future Intent

i) North Wales Local Authorities in partnership with BCUHB, the voluntary and independent sector are currently taking forward plans to develop Community Single Points of Access in each local authority area. This programme of work is supported via funding received through the National Regional Collaboration Fund with the aim of establishing all access points by April 2016. This development will be crucial in supporting our commitment to provide rapid and coordinated access to advice and support that is coordinated across agencies and will play an ongoing part in supporting unscheduled care pressures.

ii) In **Denbighshire**

- during Phase 1 the SPoA will:

  -- process referrals for health and social care community services to support Denbighshire residents' hospital discharge.(this to include referrals for Enhanced Care, Rhyl District Nursing Team, Community Therapy services, community Hospitals.

  -- co-ordinate a service response according to an individual's presenting needs.

--inform the referrer and all services which other services are to be involved, with details of each care coordinator where appropriate when multiple referrals are made for a patient / service user.
-- offer telephone advice, information and signposting (or referral as appropriate) to non-statutory sector community services in Denbighshire.
-- maintain and develop the Directory of Services for Denbighshire, publish the information on the Family Information Service website and become involved in future public-information developments in the county.
-- record and analyse SPOA activity.

- The SPOA workers will be co-located and managed by a single Team leader but their work will not be fully integrated. A 'health' staff member will always be on duty to lead on Health referrals and a Social Services staff member will be on duty to lead on Social Services referrals. All workers will be familiarised with each other's procedures so that work can be shared but workload will be managed according to the resources available. Exceptions will be noted and capacity will be monitored daily by the Team Leader so that issues can be escalated immediately.

iii) In **Flintshire**

- the SPOA will build on the already well-established First Contact team.

iv) In **Ynys Môn**

- in respect of the single Point of Access established within the Social Services Duty Team discussions are taking place to improve business processes by allowing frontline Health staff from key disciplines to have access to the RAISE Community care Information system. The current arrangements process referrals for health and social care community services to support service users discharged from hospital or referred through community services.
- A Project Manager – funded through the regional collaboration Fund – will commence duties in January 2014 to take forward developments identified in the Project Initiation Document which has been drawn up and approved by the Project board

4.9 Assessment of Older People

Future intent

We will implement the Guidance in respect of Integrated Assessment, Planning and Review Arrangements for Older People, as required by Welsh Government on December 2nd 2013, recognising this action as being the catalyst to support the broader integration of care

We are mindful that in order to deliver the new Framework there are requirements for both operational and cultural change in practice and it is the latter which may prove most challenging

5.References

I. adapted from Community Based Collaborations,
Oregon Centre for Community Leadership 1994
II. Collaboration in Social Services Wales,
SSIA 2013
III. Lessons from experience—Making integrated care happen at scale and pace
King's Fund, March 2013
IV. Mc Cormack et al 2008
V. Guidance for Engagement and Consultation on Changes to Health Services,
Welsh Assembly Government

Partnership Continuum

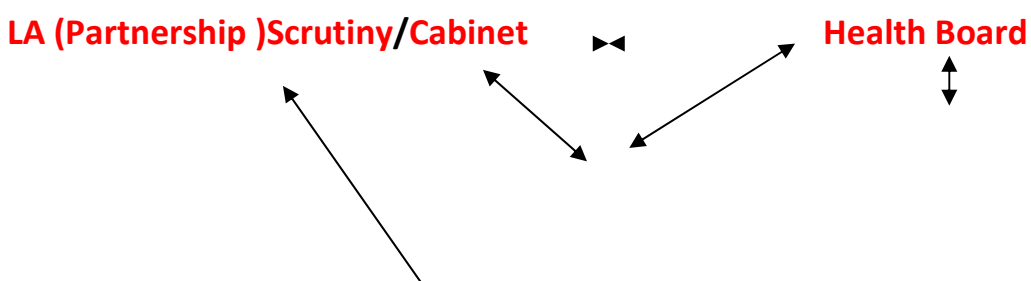
Appendix 1

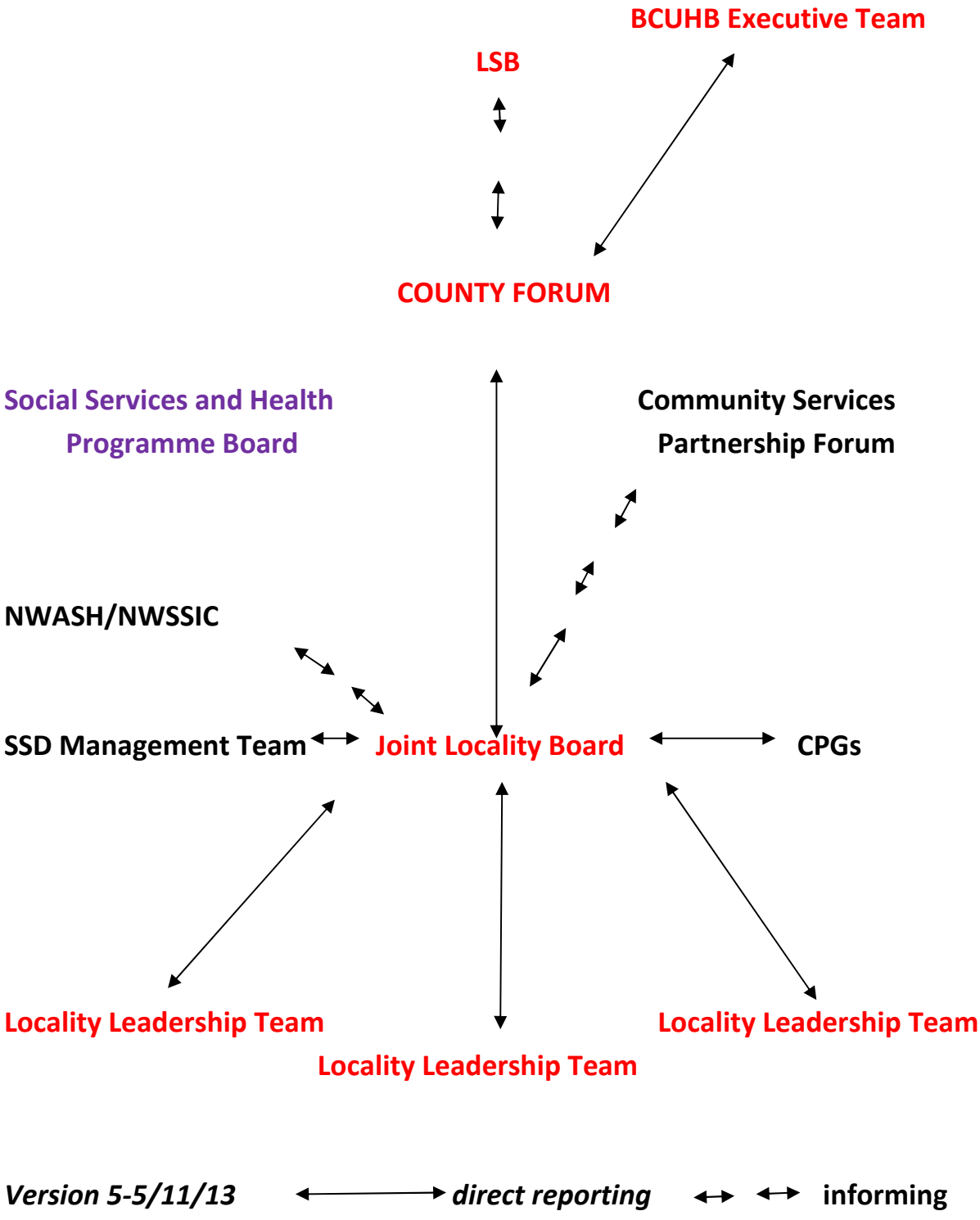
Levels	Purpose
Networking	* Dialogue and common understanding

	* Clearing house for information * Create base of support
Cooperation or Alliance	* Match needs and provide coordination * Limit duplication of services * Ensure tasks are done
Coordination	* Share resources to address common issues * Merge resource base to create something new
Coalition	* Share ideas and be willing to pull resources from existing systems * Develop commitment for a minimum of three years
Integration	* Accomplish shared vision and impact benchmarks * Build interdependent system to address issues and opportunities

Appendix 2

GOVERNANCE STRUCTURE FOR INTEGRATED COMMUNITY BASED SERVICES




BCUHB Executive Team
LSB
COUNTY FORUM
Social Services and Health
Programme Board
Community Services
Partnership Forum
NWASH/NWSSIC
SSD Management Team
Joint Locality Board
CPGs
Locality Leadership Team
Locality Leadership Team
Locality Leadership Team
Version 5-5/11/13
direct reporting
informing

Number: **WG19385**

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Consultation Document

A Framework for Delivering Integrated Health and Social Care

For Older People with Complex Needs

Date of issue: **22 July 2013**
Action required: Responses by **31 October 2013**

Overview

Demographic and other trends in Wales mean that there is increased demand for both acute and community care services for older people, particularly those aged 85 and more. Frailty, dementia and the effects of multiple chronic conditions are more prevalent in this population group. Building on investment in collaborative working over the last ten years and more, Ministers believe that these changes require a new prioritised and robust response to integrate health and social services for older people with complex needs

A task group of NHS, Third Sector and local authority social care leaders has been working with and advising Welsh Government during the development of the Framework, and also considering options to support roll out and implementation. At this stage, we would welcome your views on the proposed Framework for Integration.

We are committed to further dialogue at a national and regional level to shape how integration in Wales is progressed which will be taken forward initially through the meetings of the Health Minister with LHB Chairs and the Deputy Minister's National Partnership Forum for Social Services which includes cross party local government representation. The Welsh Government led Multi-stakeholder Task Group will also need to have an on-going co-ordinating role and in supporting development and implementation of the Framework.

Ministers want to give priority and momentum to the Framework and to allow partners the opportunity to plan for implementation of integrated services during 2013/14 before implementation commences fully from April 2014. Ministers have asked that each local health board and local government partnership should on a public services foot print basis, develop an agreed Statement of Intent for integration of health and social services and submit these by the end of January 2014 for consideration.

It would therefore be helpful to receive your initial views and comments on the Framework and the way forward outlined by end October 2013. We would welcome shared responses across partnership groupings in line with locally agreed preferences.

How to respond

Please respond by email or in hard copy

Social Services Directorate
Department of Health and Social Services
Welsh Government
Crown Buildings
Cathays Park
Cardiff
CF10 3NQ

Email:FrameworkIntegratedServicesOlderPeople ComplexNeeds @wales.gsi.gov.uk

Further information and related documents

Large print, Braille and alternate language versions of this document are available on request.

Contact details

For further information:

Social Services Directorate
Department of Health and Social Services
Welsh Government
Crown Buildings
Cathays Park
Cardiff
CF10 3NQ

Email:FrameworkIntegratedServicesOlderPeople ComplexNeeds @wales.gsi.gov.uk

Data protection

How the views and information you give us will be used

Any response you send us will be seen in full by Welsh Government staff dealing with the issues which this consultation is about. It may also be seen by other Welsh Government staff to help them plan future consultations.

The Welsh Government intends to publish a summary of the responses to this document. We may also publish responses in full. Normally, the name and address (or part of the address) of the person or organisation who sent the response are published with the response. This helps to show that the consultation was

carried out properly. If you do not want your name or address published, please tell us this in writing when you send your response. We will then blank them out.

Names or addresses we blank out might still get published later, though we do not think this would happen very often. The Freedom of Information Act 2000 and the Environmental Information Regulations 2004 allow the public to ask to see information held by many public bodies, including the Welsh Government. This includes information which has not been published. However, the law also allows us to withhold information in some circumstances. If anyone asks to see information we have withheld, we will have to decide whether to release it or not. If someone has asked for their name and address not to be published, that is an important fact we would take into account. However, there might sometimes be important reasons why we would have to reveal someone's name and address, even though they have asked for them not to be published. We would get in touch with the person and ask their views before we finally decided to reveal the information.

Contents

Joint Foreword

Mark Drakeford AM, Minister for Health and Social Services
Gwenda Thomas AM, Deputy Minister for Social Services

It is excellent news that people in Wales are living longer and healthier lives than ever before. We now need to ensure that our services adjust to help people of all ages enjoy their lives to the full in line with the commitment in our *Programme for Government* to '*develop high quality, integrated, sustainable, safe and effective people-centred services that build on people's strengths and promote their well-being*'.

We know that there is going to be a greater demand in future for care services for older people, particularly those aged 85 and more. *Together for Health* sets out our ambition for person-centred health services provided as close to home as possible. *Sustainable Social Services* envisages a social care service based on outcomes focused portable assessments and enabling people to make informed decisions, with more consistent care eligibility and planning. The *Social Services and Wellbeing (Wales) Bill* will significantly strengthen the legislative requirements for Health Boards and Local Government to integrate services.

Our policy aim is to improve existing services and develop a wide range of preventative services that can help people of all ages manage their own lives at home and avoid as far as possible having to go into hospital or residential care.

The core concern of this framework is to bring an end to fragmented care that confuses and frustrates providers and recipients alike. Fragmentation wastes resources, effort and opportunities. The document sets out essential requirements that we believe must be put in place as the standard model across Wales. We are not at this point looking to structural changes to achieve this, but change there must be.

It complements the framework for developing community services issued by Welsh Government in June 2013, *Delivering Local Health Care: accelerating the pace of change.* The two should be implemented through a single process of rapid, integrated action, involving local health boards, local government and their partners in the independent and third sector partners.

This Framework has been developed with the NHS, Local Government, Directors of Social Services and the Third Sector, and others such as Care Forum Wales have indicated their support for this approach. We encourage all interests to do the same to improve the services we provide to older people in Wales. It is this practice of 'co-production' that we wish to see both in the planning and the delivery of services and extending to include those who receive the services.

We commend it to you and would ask that you let us have your views and comments on it.

1. Overview and Context

Wales already has a higher proportion of people over 85 than the other countries of the United Kingdom and it is likely to rise in the next decade. If services are to help older people have a happy, independent life, action is needed now to ensure the right services are in place, especially in light of the current financial challenges. Services that are fragmented or unreliable or undermine people's ability to live where and how they would like will neither use increasingly scarce resources well nor meet the needs of people who need support.

A new pattern of services is needed, building on, adapting and developing the good foundations already in place. Recognising the growing evidence that demonstrates the benefits of integration, this document sets out how the Welsh Government ambition for truly integrated health and social care services for older people is to be implemented. Partners across Wales are expected now to move rapidly on making this model the norm. A marked change is needed over the next three years.

The term 'integration' has many definitions which reflect the spectrum of levels at which integration can take place. Integration is the opposite of fragmentation. For people needing care and support it should mean:

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

To achieve this, care delivery must be aimed at achieving improved user and patient care through better co-ordination of services. Integration requires a combined set of methods, models and processes that seek to bring about this improved co-ordination.

The essential elements are that:

- service providers take down the barriers that have prevented effective collaboration and shape the service around a common understanding of the outcomes important to the individual
- the recipient will have a greater say and more control over the care received.

This framework:

- summarises the relevant policy and key principles;
- provides clear definitions;
- sets out the Welsh Government's expectations for how all the different partners need quickly to develop and deliver integrated health and social care services, not as something extra but as the normal way of working;
- identifies what the evidence indicates as the core requirements on which to base local planning and delivery; and
- states the outcome-based indicators that will help establish the present baseline position and measure progress.

It is anticipated that this approach will make health and social care outcomes better and more consistent, and strengthen community-based care. Good multi-disciplinary assessment will become standard practice, the role of the GP more central, and

early intervention, reablement and intermediate care part of a single co-ordinated system. Dignity and privacy will be protected.

While it takes time to achieve this, there is already good practice in place on which we must build. Examples include the areas that have pioneered frailty services, joint locality teams and community resource teams, and in mental health and learning disability services. There has also been solid progress in creating integrated support for families with complex needs. The principles applied there and lessons learned will be essential in supporting rapid progress.

2. The Case for Change

People in Wales are living longer and healthier lives than ever before, and services to meet their needs must keep up. Wales has the highest rate of growth for those aged 85 years and over of the UK countries - by 2030 people aged over 85 will jump by 90%, to 85,000

Older people have higher levels of frailty, dementia and chronic conditions, often in combination with each other - already there are more than 42,000 people with dementia in Wales, which affects two thirds of older people in residential care, and by 2021 the number is projected to rise by 30% and as much as 44% in some rural areas.

This will drive a growing demand for services. Community services and home based care will have to expand at a time when real term resource increases to meet this growing demand is no longer assured.

There is research and anecdotal evidence that services are fragmented, both within and across organisational and sectoral boundaries. Like others, older people want to be in control of their own lives and continue to be part of and contribute to their community. This implies that services should offer graduated, co-ordinated support to help them live independently in their own home for as long as possible. Evidence shows how disrupting older people's usual living arrangements can very quickly undermine their confidence and capability, even to the extent of making it impossible for them to live independently as before.

Providing community-based, fully co-ordinated services that are designed to support them and give them a say and the chance retain control of their lives is clearly the model that older people want and need to experience. Services that are co-ordinated and work as one can best achieve that.

This also chimes with the wish of people working within health and social care services. They recognise the need to empower older people, and welcome models of care and support that respects people's broader sense of personal wellbeing and a strong community.

Refocusing services, then, is a high priority area. Integrated models can better meet older people needs. They can also help address the increasing demand for care and support both now and in the future. Not changing is simply not an option. Urgent action is needed.

Change is achievable. There are already many examples across Wales of good integrated working including through: single agency responsibility for certain mental health services, integrated children's services - Integrated Family Support Service and Families First, integrated hospital discharge services, joint reablement and rehabilitation services and joint equipment stores. The Welsh Government 'Invest to Save' funding already supports frailty service models across much of Wales. On an on-going basis, the Invest to Save process, the Regional Collaboration Fund and the Wales Council for Voluntary Action's Wales Wellbeing Bond provide partners with access to resources to support further development.

Further progress is essential, and quickly. LHB and related Councils must plan a year on year increase in shared budgets and resources and set a specific locally agreed target for the proportion of resources relating to older people that are committed to a pooled budget. Action is essential now on what the King's Fund describe as a 'burning platform' with no alternative but to accelerate the pace and scale of developing integrated health and social care as core services.

3. What do we want to achieve?

The recognition that change is essential opens an opportunity to create a new truly integrated system. It should have two main characteristics.

1. It should be a consciously planned and managed system, built on ambition. Working closely together to reduce barriers between them, local partners will need to refocus their activities around those receiving care. This will require attention to:

    - preventative interventions that stop an avoidable slide into increasing dependency upon services;

    - locating and linking services in community settings with smooth transitions between different elements and into more specialised services;

    - creating fully integrated referral pathways that enable service users too easily cross organisational and sectoral boundaries without any harm or loss;

    - capturing once, and addressing all the needs of the service user

    - a balanced set of services operating where necessary 24 hours a day, integrating early intervention services, support for independent living, rehabilitation and reablement, intermediate care, end of life care and pathways into specialist services and less often used services;

    - full engagement all parts of secondary care focusing especially on those points of the pathway where the risk of undermining independence is greatest;

    - enabling service users to take part in developing their plan of care, with a named single point of contact, and to express their views regarding how the care is delivered;

- enabling carers to take part in developing the plan of care, receive an assessment of their support needs, have access to relevant, up-to-date and targeted information at every stage and express their views regarding how the care is delivered;

- initiate joint action when young carers are identified who may appear to be at risk or a 'child in need' because of their caring role are identified

2. It should be built with and for service users and the local community. Services should not be designed and run with out reference to the people they serve. The definition of integration in Section 2 focuses on the experience of the recipient of services.

   There must then be a strong commitment in developing services to increase the voice of the users and the community. This should aim both to support and facilitate community wellbeing in the broader sense and also to encourage and help individuals and communities to take more responsibility and control for themselves.

   Services should recognise that communities and individuals are themselves assets. Together service providers and recipients can help create a more effective service. Professionals have specific training, experience and skills while the recipient of care knows best his or her needs, preferences and situation. Planners and others need to build on this potential to 'co-produce' the best service and best outcomes.

   The same idea of co-production can apply in developing healthier communities and reducing dependency. A fully integrated approach can also build on community-oriented actions such as:

   - specific initiatives to develop social networks;
   - encouragement for volunteering, including time banking;
   - working on 'community currencies' which not only strengthen the social resilience of communities, but also local economies;
   - developing models of social enterprise.

3. There must be a real commitment to constant monitoring and improvement. Explicitly moving to a more integrated approach means that responsibilities are sometimes not so clear. The partners will need to work closely together to ensure there are safe and clear governance arrangements for delegating responsibilities, sharing resources, and ensuing accountability. There must be careful attention to reviewing quality and outcomes, even more important when services are in flux.

4. Making it Happen

In making the necessary changes, a decision has been made that at this point reforms to structures are ruled out, but change there must be. The requirement therefore is that local bodies now progress along a clearly defined path, linking at each stage their actions to those being delivered in parallel in response to *Delivering Local Health Care.*

In doing so they should draw on the mass of evidence that suggests that, while there are many ways of integrating care, the key principles remain consistent. These have been helpfully summarised by the King's Fund[1] and based on their work sixteen issues are set out in the box below that must be taken into account in developing and mainstreaming integrated services for older people over the next three years.

The core planning issues

To be clear about:

1: our common cause – why we are doing this
2: our shared narrative - why integrated care matters
3: our persuasive vision – what it will achieve
4: shared leadership – how we are going to do this
5: how to build true partnership
6: what services and user groups offer the biggest benefits
7: how to build from the bottom up and the top down
8: how to pool resources
9: how to use commissioning, contracting, money and the independent sector to create integration
10: how to avoid the wrong sort of integration
11: how to support and empower users to take more control
12: how to share information safely
13: how to use the workforce effectively
14: how to set objectives and measure progress
15: how to avoid being unrealistic about the costs
16: how to build this into a strategy

Actions required:

1. Local partners must **by end of December 2013** assess their current situation and action required, both at footprint and locality/cluster level, against the 16 issues in the box above, and define local action required.

2. All local partners must **by end of January 2014** sign off and publish a Statement of Intent on Integrated Care.

[1] *Making integrated care happen at scale and pace: Lessons from experience.* London: King's Fund, March 2013

The Statement must include the baseline assessment required under 1 above and set out clearly how:

- they will build an appropriate workforce across all partners as an early opportunity to enhance the citizen's experience;

- they will ensure a relentless focus on delivering locality based citizen centred, co-produced services, focusing upon the pivotal role of primary care services in delivering person centred care.

- they will maintain robust local partnership arrangements that reflect a willingness to delegate responsibilities;

- they will provide leadership and commitment at all levels and across all sectors, with explicit governance and accountability arrangements;

- a single commissioning plan will operate across partners, moving over time to a consistent approach across Wales;

- collaborative resource management will be managed through options such as a financial governance framework; joint commissioning plans and intentions; pooled and/or integrated budgets.

- how pooled budget arrangements will be extended, stating first what these currently are .

3. The Welsh Government will use the baseline assessments in the Statement of Intent as a means of reviewing progress in delivering the requirements in this document.

4. Also **by end of January 2014**, in developing the service, partners should, using the evidence base and their own experience and assets, develop shared local health and social care outcome measures that will demonstrate the impact of integration and drive further progress.

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

6. Partners need to **by December 2014** to have developed within mainstream services for older people integrated services for older people with complex needs, designed in line with this Framework will be embedded**.**

The maturity matrix included at Annex A in this Framework provides an additional tool for partners to use to establish the current position of collaborative service planning and delivery locally, and to organise the journey forward and capture progress.

5. Measuring Success

Recognising and reporting success in integrating health and social care services is essential. All partners will already have performance targets and outcome measures in place that gauge progress in developing integrated services.

As stated above local partners will be expected to establish their baseline position, both at a public service footprint and locality/cluster level against the 16 issues and to set these out in the Statement of Intent and also to agree their own priorities and measures for use in assessing the pace of change. These should be reported to the LHB Board and the Local Authority and to other interested bodies on a regular basis.

In addition, the Welsh Government will use the key indicators below adapted from the Audit Commission's '*Joining up health and social care: Improving value for money across the interface*' (December 2011), along with data available on carers to monitor progress.

The Performance Indicators: Indicator		**Anticipated direction of travel**
1	Emergency admissions to hospital for people aged 65 and over	Decrease
2	Emergency bed usage for people aged 65 and over	Improved performance benchmarked against CHKS © Peer Group
3	Shift in balance from care home to home care provision	More people supported to live in their own homes
4	Admissions and re-admissions avoided by appropriate community based intervention models	Increase
5	Falls data captured and submitted to the Reducing Harm from Falls Collaborative	Continuous improvement Benchmarked with collaborative
6	Admissions to care home direct from acute hospital	Decrease
7	Discharge to usual place of residence	Increase
8	Number of people choosing where to die (end of life services)	Increase
9	Unplanned hospital attendances	Decrease
10	Readmission within 14 days of discharge	Decrease
11	Delays in transfer of care due to waits for packages of care or modifications to the home environment	Decrease
12	The proportion of carers assessments undertaken	Increase

6. The next steps

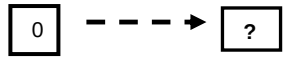
A 12 week consultation process will now commence. This will seek not only responses to specific issues, for example how best to capture and measure success, but will also give people using services and carers, the public, interested organisations, local statutory bodies and providers, and others an opportunity to share their views on the overall intentions and the proposed approach.

Responses should be sent by 31 October to:

Social Services Directorate
Department of Health and Social Services
Welsh Government
Crown Buildings
Cathays Park
Cardiff
CF10 3 NQ

A Maturity Matrix to Support Health and Social Care Integrated Care Partnerships

Using the matrix: Identify the level you believe your partnership has reached for each key element and then draw an arrow to the level you the level you intend to reach within the next 12 months. Review the partnership's maturity matrix position on a frequent basis.



Progress Levels / Key Elements	0	1	2	3	4	5
	No	Basic level Principle accepted and commitment to action	Early progress Early progress in development	Results Initial achievements evident	Maturity Comprehensive Assurance in place	Exemplar Others learning from our consistent achievements
Purpose and vision		Purpose debated and agreed. Values and priorities agreed, and documented. Political agreement to integration confirmed and documented cross Health, Social Care, Third Sector and Partners. 'Health and Social Care Integration Partnership' (H&SCIP*) understands its role.	Priorities and stretch goals have been agreed with stakeholders =. Robust mechanism for adding and removing services and/or care settings agreed. Plans rooted in local population needs.	Evidence priorities are being met, with progress towards stretch goals in some areas. Evidence of citizen engagement and public accountability testing purpose and vision. Existing partnership work considered.	Systematically match how purpose dovetails with population needs. Evidence that integrated care is enhancing the quality of services and experience for the citizen	Confidence in achieving purpose and vision as population health benefitting in accordance with plans. Local health planning, local authority commissioners, third sector and other partners have been influenced. Evidence of reduction of waste and duplication through tackling duplication and fragmentation
Strategy		All stakeholder strategies relevant to work gathered and timetable set for developing integrated strategy. Base for all 'H&SCIP' strategic decisions. Political sign-off of strategy by all partners	Strategy development underway. Arrangements in place for areas of joint planning/commissioning and investment opportunities.	'H&SCIP' has a current published strategy, which includes improvement milestones and how they will be measured and monitored.	Strategy refined in light of successful achievement of milestones, and new intelligence and aspirations	Strategy has benefitted other health and social care economies, as well as influencing the strategic direction of all local partner organisation.
Leadership of the local health and social care integration economy		'H&SCIP' leadership agreed and appointed. Key stakeholders aware of leaders and how to contact. Relevant stakeholders identified and invited to participate. Local health, social care, third sector and partner resources understood.	Leadership development for 'H&SCIP' discussed and agreed. Development plans initiated. Stakeholders understand leadership issues. Relevant stakeholders regularly attend and provide input into work programme	Results of partnership working systematically reviewed. Relationships with partners are positive and ongoing dialogue about planning, commissioning, contracting decisions and joint investment opportunities. Public health voice is evident in decisions.	Review of success of leadership approach. Ongoing succession plans in place. Benefits of partnership working have enabled the majority of stakeholders to meet their improvement objectives and resource allocation.	Benefits of partnership working have enabled majority of stakeholders to exceed their improvement objectives. Outcomes improved and this is traceable back to initiatives from the 'H&SCIP'
Governance		Membership and terms of reference for the 'H&SCIP' Board drafted and shared.	'H&SCP' board set up and first annual cycle of business agreed. Relationships with relevant local organisations being developed.	Local stakeholders have clearly incorporated 'H&SCIP' Board accountabilities into their own governance arrangements.	'H&SCIP' Board has reviewed its first year of working through a structured annual review process and made improvements to structure and organisation	Good governance benefits identified and the 'H&SCIP' Board know better governance practice has influenced local partner organisations.
Information and intelligence		Information requirements identified and format of initial dashboard agreed	Developed a dashboard of key information and information improvement continues. KPIs reflect shared performance objectives across health, social care and partners	'H&SCIP report confidence with levels of intelligence they receive, and that information systems are reliable and working. H&SCIP receiving evidence of performance improvement against KPIs.	'H&SCIP' informed by real-time intelligence, demonstrating improved outcomes, quality and efficiency across health and social care.	A single information system established and utilised across the partners. Outcomes and performance benchmark against best performers.
Expertise and skills		Skills and expertise for 'H&SCIP' have been identified and agreed	Induction and development plans for 'H&SCIP' partners and staff are up and running	The 'H&SCIP' influencing skills are evident by success in positive change to local planning and the pattern of local service provision.	The 'H&SCIP' supports LHBs, Local Authorities, Third Sector and partners by valuing key planning/skills. The H&SCIP Board acts as a forum to bring in specialist skills and expertise to support planning/commissioning.	The 'H&SCIP' influences the organisational development of partner organisations. The local health and social care economy is recognised as being a good career choice for planning/commissioning professionals.

*The H&SCIP is generic term for the purpose of this matrix. Please replace with your local equivalent.

Source: Adapted from the London Health and Wellbeing Board Maturity Matrix

Consultation Response Form

Your name:

Organisation (if applicable):

email / telephone number:

Your address:

Question XX: We have asked a number of specific questions. If you have any related issues which we have not specifically addressed, please use this space to report them:

Please enter here:

Responses to consultations are likely to be made public, on the internet or in a report. If you would prefer your response to remain anonymous, please tick here: ☐