



## A FRAMEWORK FOR DELIVERING INTEGRATED HEALTH AND SOCIAL CARE

for

**OLDER PEOPLE with COMPLEX NEEDS**

## **NORTH WALES STATEMENT OF INTENT**

**Date:- March 31<sup>st</sup> 2014**

## **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.

Whilst the original Framework for Delivering Integrated Health and Social Care for Older People with Complex Needs, did not require third sector endorsement both BCUHB and the Local Authorities recognise these to be crucial partners in both the shaping and delivery of person centred, co-produced and integrated services. The third sector are represented in the Partnership fora which considered the initial iteration of the Statement and feedback will be requested in respect of this final Statement and Action Plan. It is intended that the third sector ( and independent sector) will be involved in the working groups established to drive forward the Statement of Intent

Across North Wales, there is a strong recognition of the need to work within a regional footprint—both to accommodate the Local Health Board (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 considering 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.
- Maximise the benefits from the resources invested in 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 <sup>(i)</sup>(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” <sup>(ii)</sup>, from key documents such as “Making integrated care happen at scale and pace”<sup>(iv)</sup> 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<sup>(v)</sup>:-

- 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 Welsh Local Government Association (WLGA), Welsh Government (WG), Social Services Improvement Agency (SSIA) representatives.

iii) Social Services Directors also meet formally with Betsi Cadwaladr University Health Board (BCUHB) Executive Directors on a quarterly basis at the **North Wales Social Services Improvement Collaborative (NWSSIC)/BCUHB Quarterly Strategic Forum**.

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

v) An **Integrated Services Board** has recently been established to accelerate and provide a relentless focus on achieving the expectations within the Statement of Intent.

vi) 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.

vii) 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". The outcomes of this group will be informed by the recommendations of the recent SSIA Reablement Position Statement. Initiatives utilising the Intermediate Care Fund will be informed by the Service Model developed.

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.

Such an integrated approach will encompass the full range of solutions to meet assessed need ie community and nursing/residential care including CHC care

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 has been approved for support within the Strengthening the Connections initiative

### **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) **Gwynedd** has

- one jointly funded Extra Care Housing Short –Term flat for respite and intermediate care



v) **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.

vi) **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**

### **4.4.1 Workforce**

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.
- iii) **Denbighshire** has
  - a single line management arrangement for Adult Mental Health Services
  - 2 Locality Teams that are coterminous with health locality boundaries. There is a shared office facility in one part of the County.
- iv) **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.
- v) **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.
  - A single line management arrangement for the Adult Mental Health Service.
- vi) **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.
  - Social workers co-located in Chirk Hospital as part of the South Locality Project.
  - Integrated care and treatment planning in respect of Mental Health Measures.
- vii) **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.

#### Future intent

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”<sup>(ii)</sup>. 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 Human Resources (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.

### Current arrangements

i)BCUHB and the 6 Local Authorities are developing a shared Choice Policy to support timely and appropriate hospital discharge.

ii) All Local Authorities have an agreement to make funded nursing care payments on behalf of the Health Board

iii) **Conwy** has

- developed an information sharing protocol in respect of care home monitoring and a joint monitoring arrangement.

iv) **Denbighshire** and v) **Flintshire** have

- Wales Accord on the Sharing of Personal Information (WASPI) agreements in a number of services to support joint working.

vi) **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.

vii) **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.

### 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 – Welsh Ambulance Services NHS Trust (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.
- North East Wales Carers Information Service (NEWCIS) are contracted to undertake Carers' Assessments

### 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 centered 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 **Wrexham**

- The co-production of services and the development of strong and resilient communities is a priority for the Authority. The Adult Social Care department have lead on a range of co-produced initiatives, including the Community Inclusion Grant scheme, which provides seed funding to new and existing community groups in order to develop low-level community-based support for older people. Wrexham also use peer interviewers, recruited from the Wrexham Over 50s Forum, to undertake in-dept qualitative interviews with users of older people's services.

### vi) 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 centred 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.

#### Future Intent

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.

vii) **Wrexham**

- plan to extend and build upon the positive work undertaken in relation to co-production in partnership with BCUHB

## 4.6 Service Delivery Integration

### 4.6.1 Service provision

#### Current arrangements

##### 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 Reablement team based within the local authority are managed on a daily basis by the Reablement Manager.

##### iv) In **Gwynedd**

- The provision of Adult Mental Health services is through a single line management arrangement
- The Local Authority provides professional input into Intermediate Care and Enhanced Care services

- Specialist Day Care provision for individuals with dementia is jointly funded within two locality areas - Dwyfor and Arfon

v) 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.
- Health employed TIs are a core part of the Reablement Service
- 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.

vi) 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 Reablement 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.

### ii) 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.

### iii) 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.

### iv) In **Gwynedd**

- Specialist day care for individuals with dementia will be jointly funded in the third locality area--Meirionnydd

### v) 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 Reablement 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.
- In line with the SSIA Reablement Position Statement (2013) – the development of a joint Reablement Strategy, and opportunities for enhanced joint funding explored

#### vi) 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 Reablement 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.

#### 4.6.2 Telecare, Telehealth and Assistive Technology

##### Current arrangements

The need to promote and provide services through the use of new technology, consistently and cost effectively across the region has been recognised and Telecare, Telehealth & Assistive Technology Board established for this purpose. As a partnership, the group has recently submitted a bid to the National Health Technology Fund. This bid aims to enhance infrastructure at the regional monitoring centre to support and monitor individuals utilising new technology in Telecare and Telehealth. The group, and the core goal of the bid is to integrate health and social care at the point of service delivery. This will ensure a proactive approach to prevention, enablement and supporting independence, wellbeing, self care and self management to be realised through the expansion of technology-enabled service redesign.

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#### 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<sup>(v)</sup> 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 **Wrexham**

- A robust process for community and service user engagement is embedded within the commissioning function in order to ensure the voices of key stakeholders are heard and taken into account when planning and developing services

#### x) 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 3<sup>rd</sup> sector organisations to provide advice and advocacy support and forums for service users.

#### Future Intent

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.

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 2<sup>nd</sup> 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**

| <b>Levels</b>                  | <b>Purpose</b>   |
|--------------------------------|--|
| <b>Networking</b>              | <ul style="list-style-type: none"><li>* Dialogue and common understanding</li><li>* Clearing house for information</li><li>* Create base of support</li></ul>                  |
| <b>Cooperation or Alliance</b> | <ul style="list-style-type: none"><li>* Match needs and provide coordination</li><li>* Limit duplication of services</li><li>* Ensure tasks are done</li></ul>                 |
| <b>Coordination</b>            | <ul style="list-style-type: none"><li>* Share resources to address common issues</li><li>* Merge resource base to create something new</li></ul>                               |
| <b>Coalition</b>               | <ul style="list-style-type: none"><li>* Share ideas and be willing to pull resources from existing systems</li><li>* Develop commitment for a minimum of three years</li></ul> |
| <b>Integration</b>             | <ul style="list-style-type: none"><li>* Accomplish shared vision and impact benchmarks</li><li>* Build interdependent system to address issues and opportunities</li></ul>     |

GOVERNANCE STRUCTURE FOR INTEGRATED COMMUNITY BASED SERVICES

