



**Caring Together  
Western Bay**

*Health and Social Care Programme*

**Gofalu Gyda'n Gilydd  
Bae'r Gorllewin**

*Rhaglen Gofal Iechyd a Chymdeithasol*

# **Delivering Integrated Health and Social Care for Older People with Complex Needs across Western Bay**

***Statement of Intent***

**March 2014**

## 1. Introduction

This document sets out our commitment to deliver integrated health and social care for older people with complex needs across Swansea, Neath Port Talbot and Bridgend. The document has been developed through a process of discussion and collaboration with partners in health and local government, through the *Western Bay Health and Social Care Programme* which was initiated in 2012.

The Western Bay Programme was established to deliver integrated care models across older people, mental health and learning disability services. Significant progress towards this goal has already been made, and our organisations have agreed to work together progress the development of joined up care for older people signalling our intent in a document agreed by ABMU Board and Cabinets within each of the three Local Authorities during the Autumn of 2013.

Multi agency and multidisciplinary community teams will continue to be the mainstay of mental health services with work carried out to develop integrated teams within older people's mental health services across the three local authority areas. A third element of the overall Western Bay Programme is focussing on learning disability services. Increasingly it is recognised that having age appropriate models of care will be an important issue for learning disability services.

This document reaffirms our commitment across the Western Bay to transforming care provision, particularly in terms of moving the delivery of care from institutionalised models to independent living and community based care. ***Delivering Improved Community Services*** which was endorsed by our organisations in the Autumn of 2013, brings together two strategic programmes, ABMU's *Changing for the Better* and Western Bay in order to build a collaborative approach to service transformation from the beginning. It is based on extensive public engagement and dialogue with the third sector and primary care in addressing local health and social care issues.

The overarching aim of the Western Bay programme is to deliver integrated health and social care services that will ensure:

- Support for people to remain independent and keep well
- More people cared for at home, with shorter stays in hospital if they are unwell
- A change in the pathway away from institutional care to community care
- Less people being asked to consider long term residential or nursing home care, particularly in a crisis
- More people living with the support of technology and appropriate support services
- Services that are more joined up around the needs of the individual with less duplication and hand-offs between health and social care agencies
- More treatment being provided at home, as an alternative to hospital admission
- Services available on a 7 day basis
- Earlier diagnosis of dementia and quicker access to specialist support
- Ensure that the needs of carer's are included in the development of new service models.

***Delivering Improved Community Services*** sets out three key priorities over the next three which are:

1. **Wellbeing and keeping healthy** – making sure older people who are frail and those with long term conditions are given the opportunities and support to take care of themselves and be independent, for example through innovative community resilience initiatives
2. **Strengthen community teams** – making sure people default to the community for assessment and if necessary care rather than hospitals and institutional care, for example by investing more in CRTs, community networks, older people’s mental health services, etc.
3. **Sustainable services** – ensuring the enablers are in place to allow community services to be the best they can be for the long term future, for example through better technology, better workforce planning, etc

The aims of the programme are in line with the key principles underpinning the proposed Social Services and Well Being (Wales) Bill particularly in terms of:

- Moving to a ‘strengths based’ approach – focussing on helping people to live independent lives
- Shifting the emphasis towards prevention and working with third sector and other partners on innovative approaches such as Local Area Coordination to help people to be supported in different ways, within their own communities
- Developing consistent services available across the 7 day period across our Health Board area
- Using technology to support people more effectively.

## **2. Policy context**

The Welsh Government policy framework is set out within ***Together for Health (2011)***, and confirms its commitment to improve the health of people in Wales, and to take tough action on health inequalities over the next 5 years by creating a 21st century healthcare system.

The key challenges are:

- Demographic changes leading to more older people and increasing frailty
- Rising number of people with chronic ill health and long term conditions
- Lifestyle choices that are worsening population health
- Widening health inequality between rich and poor
- Difficulties in recruitment in a number of key areas including, but not restricted to medical manpower several groups of clinical staff, particularly some doctors
- Falling real terms revenue available each year to the NHS and Local Authorities in Wales.

**Shared Purpose – Shared Delivery (Single Integrated Partnership Plans (SIPP))** is the guidance issued by Welsh Government in June 2012 that states each local authority area, through its Local Service Board, will produce a single integrated plan that replace the following:

- Community Strategy
- Children & Young People's Plan
- Health, Social Care & Wellbeing Strategy
- Community Safety Partnership Plan.

SIPPs are 5 year plans and are a statutory requirement. Local Service Boards are not statutory bodies so the duty lies with the Local Authorities to implement these important plans with support and sign up from partner organisations.

**Setting the Direction**, the vision for primary and community services, issued in 2010, paved the way for the development of locality working and was seen as the cornerstone of the new model for primary and community care. A particular focus is on those individuals who are frail, vulnerable and who have complex care needs, with key themes as follows:

- Confidence to self manage
- Sharing information
- Health and social care alignment
- Local clinical leadership and engagement
- Flexible working
- Principles of public health
- Joined-up and easily navigated services
- Seamless between in and out of hours services
- Service excellence & accessibility

**Sustainable Social Services: A Framework for Action** sets out the action needed to ensure care and support services respond to rising levels of demand and changing expectations, bringing consistency, for example in standard contracts for care homes. Frail older people are one of three priority areas for greater integration of delivery:

- Placing reablement at the heart of the approach
- Maximising recovery for people with long term care needs
- Addressing the needs of people with dementia
- Using technology effectively
- Ensuring a confident and competent workforce.

**Designed to Add Value (2008)** outlines the key role the Third Sector plays in supporting health and social care to make a real difference to the health of individuals and the community ensuring:

- That the right services are delivered at the right time and in the right place, to the right person across the care pathway.
- The integration of the contribution of volunteers, Carers and the third sector in better health.
- Engagement of the public, including vulnerable groups, in identifying needs and determining how best they can be met.
- Volunteers also bring considerable value to the daily lives of people and to health and social care services in a variety of ways. They support and enhance services to patients provided by statutory services with little or no cost but significant gains for people, patients and professionals.

***The Social Services and Wellbeing (Wales) Bill***, currently awaiting Royal Assent, will provide the legal framework to support the transformation of care and support in Wales.

The *Bill* focuses on three key themes:

- Identifying those in need of support;
- Promoting wellbeing;
- Earlier targeted support (aimed at reducing demand for long term care).

The new legal powers will include:

- Strengthened powers for safe-guarding;
- Increasing services covered by direct payments;
- National eligibility criteria and portable assessments;
- Equivalent rights for carers.
- Strengthening duties on Health Boards and Local Authorities to work together to develop integrated services.

The Bill provides the legislative framework for implementing the vision set out in *Sustainable Social Services*. It focuses on empowering people and recognises that Social Services need to move from crisis management and deliver earlier intervention to be sustainable. The Bill, therefore, requires local government and partners in the NHS to understand the dimensions and shape of the population in need in their areas, to make this public and to use its powers to make arrangements to provide a range of services to meet these needs.

Some people will require an intensive and comprehensive range of services. The Bill makes it clear that local authorities have a duty to provide, or commission, social care services and will bring forward a definition of these types of services that will draw on the existing definitions and take account of proposals put forward by the Law Commission. This will include the development of social enterprise and co-operatives as delivery agents. The legislation will also provide individuals with a stronger voice and real control. The starting point is enabling individuals to understand fully how care and support may help them. The proposals give individuals a right of access to an assessment of their needs and will require those assessments to be carried out in a way that focuses on the outcomes that people.

In the summer of 2013, two further policy documents reinforced the need for urgent and transformational change. The first of these – *Delivering Local Health Care* – required Health Boards, working with partners, to focus on the development of community (locality) networks as a means of securing a different approach that brings together primary, community and social care services, in geographical networks serving 30-50,000 population. This policy ‘refreshed’ the vision set out within *Setting the Direction*. The Bevan Commission also provided advice to the Minister on the development of health and social care services during the autumn of 2013. A policy document published in mid 2013 set out *A Framework for Delivering Integrated Health and Social Care for Older People with Complex Needs* which required partners to accelerate the development of integrated services. Partners were also required to publish this ‘statement of intent’ setting out how they would respond to the key requirements by the end of January 2014.

The development of the new ***Integrated Assessment, Planning and Review*** framework provides a timely opportunity to review existing systems and processes to streamline access into services and ensure that assessments are proportionate to need.

### 3. **Where are we now?**

In response to both national policy frameworks and strategic and operational pressures at a local level, ABMU and the three Local Authorities have worked hard over recent years to build local community services. These include:

#### **Community Resource Teams (CRTs)**

The aim of CRTs was to provide integrated and co-ordinated care management including specific admission avoidance and supportive discharge schemes, chronic condition case management, enhanced preparation for scheduled care, enhanced medicines management and advanced access to diagnostics.

In the Western Bay area, CRTs have been established in Swansea, Neath Port Talbot and Bridgend to provide specialist care to people in the community. As well as other services in the community, the teams include nurses, therapists and social workers with advanced skills in assessment and management of complex needs. These teams provide a strong, multidisciplinary approach focused on the maintenance of more complex cases in the community.

A recent baseline assessment of the three CRTs highlighted the lack of pace in implementing these specialist community services. The following were key findings from the analysis:

- Each CRT has been established differently in response to local pressures and historical ways of working within each Locality.
- Service provision differs in each area due to differences in population size, resource allocation and strategic priorities, making it difficult to provide a comparative analysis of the three teams.
- Integration between health and social care is at varying stages of development in each area.

- **Bridgend**
  - 3 community network health and social care teams bringing together social workers, district nurses and occupational therapists are co-located in community hubs working within an integrated management structure
  - A single point of access to intermediate care and adult social work through the development of an Integrated Referral Management Centre (IRMC) providing a gateway to services
  - An integrated Community Resource Team with a full range of intermediate and reablement services together with rapid response nursing service, and an innovative mobile response team which enhances the telecare service
  - A joint residential reablement service is in place to provide step down beds for patients who require additional support before being able to return home from hospital.
  
- **Swansea**
  - A joint Community Resource Team is in place with a single manager
  - Integration of Occupational Therapy services has begun to be integrated with the CRT therapy services.
  - The next phase of work will move to using a single IT system for referral, work allocation and as a single record.
  - The role of Gorseinon Hospital as a 'step down' facility operating as part of the CRT is in place. There are step down beds available in Local Authority homes across Swansea. Innovative approaches being tested to bring together reablement, domiciliary care and health care support workers into an integrated team in Gower to overcome issues of hard to reach areas that were impacting on the recruitment of domiciliary care staff.
  
- **Neath Port Talbot**
  - The CRT is a joint team with a single management structure for all health and council employees in place.
  - The NPT Community Gateway provides a common access point for the CRT and Adult Social Care. A multidisciplinary team of staff work within the Gateway to ensure that referrals are managed in the most appropriate way. Allocation of work from the Gateway to the CRT is all managed electronically.
  - Residential Reablement and Step up/down beds are currently being developed.
  - The Reablement and Acute Clinical Team in NPT CRT were already using a single paper based client record and work is well advanced to move all of this onto a IT system.
  - The CRT are co-located on the same site (Cimla Hospital) and this is proving to be highly supportive in terms of integrating work practices and pathways for service users.

There are however recognised issues and limitations cross the Western Bay area that have been identified through the local review work undertaken. These include:

- The majority of services operate on a 5 day basis (with notable exceptions in the Neath Port Talbot area)
- ABMU is unique in Wales in that there are 4 information systems in use across the ABMU footprint: Draig in Bridgend, a bespoke system in NPT, PARIS in Swansea and the Health Board has adopted Myrddin as its patient administration system. The evidence base is clear in that a key success factor in developing integrating services is the ability to access a single record so the current infrastructure presents significant barriers, and pragmatic solutions are needed to overcome the lack of a single integrated system being in place
- The medical model differs across ABMU with differing levels of input being provided across the Health Board area
- Telecare has developed differently - Bridgend has the strongest model with an innovative and flexible mobile response service, with a high uptake of telecare because of its history of being developed as a core function within the CRT.
- Core community service models have emerged differently in each of the three areas, with Swansea having a strong chronic conditions management model in place that complements the delivering of primary, community and intermediate care services.

### **Community Mental Health Teams**

The Older People's Mental Health Teams within ABMU include staff from both health and social care. There are good examples of joint working between the health and social care teams, including joint visits, assessments, care and treatment plans and joint team meetings to discuss cases and allocation. However, this is not standardised and improvements need to be made. There is a commitment from all services to achieve full integration of these teams to deliver responsive and equitable service for older people with mental health needs and to develop systems for monitoring performance.

The success of integration will be measured against its achievement of improved outcomes for people and carers who need care and support including:

- Improved support in the community, reducing unplanned admissions to hospital and enhancing discharge planning following admission
- Reduced duplication between health and social care services by removing the need for multiple assessments which recommend the same outcome;
- Delivery of ongoing services in a more timely manner by reducing the number of assessments that need to be undertaken to access health or social care services;
- Improved outcomes of Carers Assessments that are undertaken and individual support plans specifically for Carers;
- Engagement at an earlier stage with Service Users and Carers to offer more timely advice and support to reduce admissions to residential or nursing care homes;
- Agreed contingency plans to reduce crises in the community and avoidable hospital and care home admissions.



## **Community Networks**

Based on GP Practice populations of between 30,000 and 60,000, eleven community networks have been established across ABMU to plan, co-ordinate and ensure delivery of services that meet the needs of people living in the local community. Three networks have been established each in NPT (discussions underway about reshaping the networks into two) and Bridgend and five in Swansea (due to the population size).

The networks have a diverse membership ranging from GPs, community nurses and health visitors to social workers and third sector representatives. The teams have clinical leadership in the main and are supported by dedicated resources provided by ABMU Health Board staff, including management support, administration and business planning functions. Since their inception, networks have identified service development priorities that are important to the practices in meeting local health needs and challenges. Each network meets regularly, with educational sessions provided and the opportunity to share information. Regular newsletters are produced and this is supported by dedicated websites for the local community to access information on the work of each of the networks.

Since their inception, community networks have done a considerable amount of work to address local needs. During the autumn of 2013, the Health Board has engaged widely with partners and community networks to discuss proposals to strengthen their role.

The Health Board has committed to strengthening the role of community networks and has identified a number of functions that networks could undertake in future, including:

- Improving population health and tackling health inequalities
- Developing and expanding primary care services
- Managing community health services
- Shaping service integration with social care
- Developing pathways between primary and secondary care

In principle, the Board have agreed to explore more innovative organisational arrangements that maximise the autonomy and flexibility of networks to carry out these functions. At this stage, it is recognised that further discussion with partners will be required to look at the balance of service delivery across networks and more specialist services, including the CRT. A detailed plan is being developed for 2014/15.

***All partners have committed to a service model that integrates health and social care services using community networks as a footprint to integrate primary, community health and social care services.***

## **Local Authorities**

In the three Local Authority areas there has been considerable innovation in tackling the pressures on long term care services and meeting need in ways which maximise independence and reduce dependency. All three areas have reviewed or are reviewing care home provision with a view to delivering a clear and sustainable future for current or former Local Authority care home provision, to improve the quality and provision of independent sector care home provision, particularly for people with dementia, and to continue a move

to care for people in their own homes, where appropriate in extra care settings in the community.

All three Authorities are also reviewing strategically their long term domiciliary provision and particularly the balance between directly provided services and services commissioned from the independent sector. Key questions in this approach include the balance between specialist, for example for people with dementia, and more general domiciliary support, how to commission for outcomes, rather than inputs, and the balance between quality, sustainability and cost of service.

### **Third Sector**

There are over 2000 third sector organisations operating across the Western Bay area. The services offered range from, for example, befriending and mental health services through to prevention, carers and bereavement services. They offer flexible and professional services that also aim to complement those provided by the statutory agencies, which together ensure that there is choice and diversity for a host of service users.

The third sector operate a health and social care network in the Western Bay area where organisations come together to share information and discuss local health and social care developments. The network continuously identify areas where they can add value and provide services that prevent ill health, ways they can bolster health, social care and well being services and support for carers' and local communities.

Third sector brokerage models are in place within each Local Authority area which are a significant step towards helping to support people within their own communities, by identifying and matching the needs of individuals with potential support systems or organisations locally. During the early part of 2014, more formal arrangements around Local Area Coordination are being explored. A feasibility study into tier zero services has been commissioned, and investment will be made into this area during 2014. Both Local Area Coordination and Tier zero (as well as a complementary Health Board programme focussing on 'Staying Healthy') will help to drive new service models and approaches that are intended to strengthen the preventative agenda and deliver services in line with the Social Services and Well Being Bill.

There is a strong relationship with Care & Repair across Western Bay who provide flexible, timely support to enable people to remain independent within their own homes, and also in supporting hospital discharge schemes.

## Current Pooled Budget Arrangements

The following table highlights the current pooled budget arrangements active for the financial year 2012/13.

**Table**

**1**

<b>Type</b>	<b>Service Area</b>	<b>Parties</b>	<b>Parties</b>
Pooled Budget	Community Equipment	ABMU Health Board (Swansea & Neath Port Talbot localities)	City and County of Swansea/Neath Port Talbot County Borough Council
Pooled Budget	Assisted Recovery in the Community (ARC)	ABMU Health Board (Mental Health Directorate)	Bridgend County Borough Council
Pooled budget	Community Equipment	ABMU Health Board (Bridgend locality)	Cwm Taf Health Board, Merthyr & RCT Local Authorities, Bridgend County Borough Council

Although the number of pooled budget arrangements is limited, there are broader arrangements for joint working that include:

- Joint management arrangements – in Bridgend and Neath Port Talbot, with plans in place to integrate management arrangements in Swansea well advanced
- A number of pre-existing financial arrangements and grant funding between health and social care.

Through the Western Bay Programme, all partners have committed to a full and detailed review of existing financial arrangements and a pooled budget for the intermediate tier of service will be in place by April 2015.

#### 4. Transforming our services: what we intend to do next

At the beginning of this document we set out the three key priorities for the Delivering Improved Community Services programme, they were:

- Wellbeing and keeping healthy
- Strengthening Community teams
- Making services sustainable.

Since September 2013, the main focus has been on strengthening community teams through development of the Intermediate care function. This was as a result of the Western Bay Programme Board approving a Strategic Outline Business Case in June 2013 for a Transformation Programme to develop services to support frail older population across Western Bay. Following the submission of a strategic outline case, it was agreed to proceed to the development of a detailed business case which was agreed by the Programme Board in February 2014. The business case focusses on developing the intermediate tier of services because this is seen as a vital building block for wider whole system change.

The intermediate tier consists of short term interventions that address needs at a time of crisis or when people's needs change, with the aim of maximizing recovery and on-going independence. It is linked, but is not the same as on-going support in either health or social care. Developing the Intermediate Tier is a 'first step'. The further development of wellbeing services to reduce future needs from escalating, together with services to support those with complex and high levels of need for ongoing care remain as critical next steps for the Delivering Improved Community Services Programme.

An integrated intermediate tier of services provides a number of functions. These are illustrated in Figure 2. The intermediate tier of services needs to make a significant contribution to what the wider health and social care community wish to see at a whole system level and as a result of the joint commitment *Delivering Improved Community Services*, i.e.

Support for people to remain independent and keep well;

More people cared for at home, with shorter stays in hospital if they are unwell;

A change in the pathway away from institutional care to community care;

Less people being asked to consider long term residential or nursing home care, particularly in a crisis;

More people living with the support of technology and appropriate support services;

Services that are more joined up around the needs of the individual with less duplication and hand-offs between health and social care agencies;

More treatment being provided at home, as an alternative to hospital admission;

Services available on a 7 day basis;

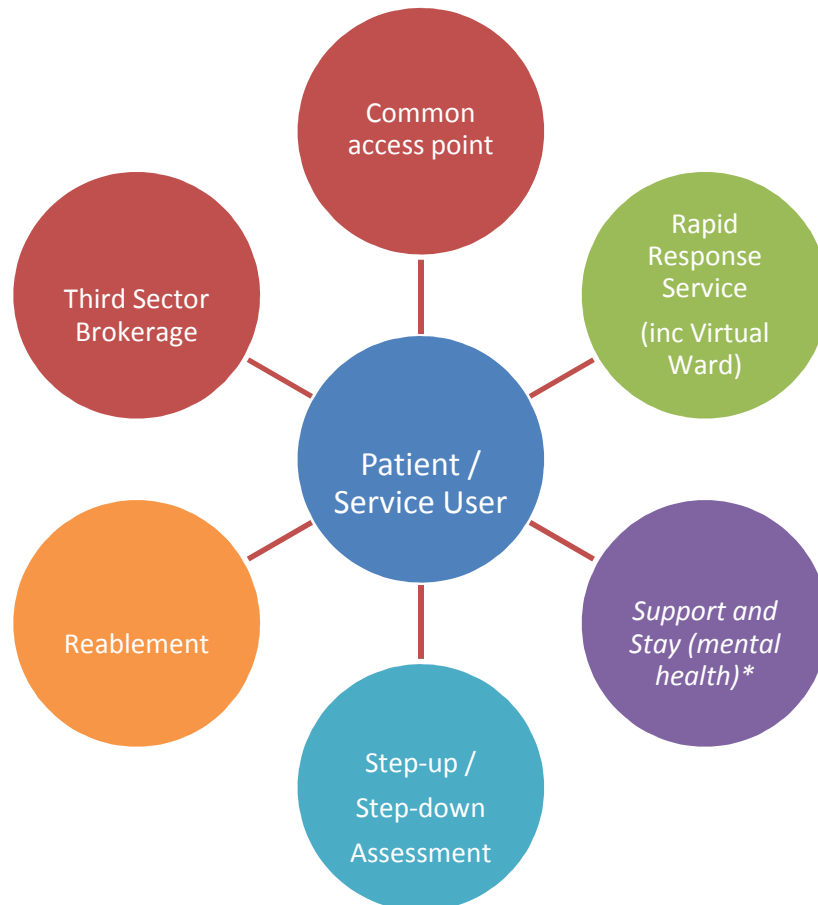
Earlier diagnosis of dementia and quicker access to specialist support for those who need it.

This means that we need:

Services that support people to remain confident independent and safe in their own homes for as long as possible and in accordance with their dignity and choice.

Services that are coordinated to reduce the number of unplanned admissions into hospital and long term care and support timely discharge when a hospital admission is appropriate.

A realignment of capacity, and a shift of resources, into community services to enable more people to receive the right assessment and service in the setting most able to meet their needs.



**Figure 1 Functions undertaken by the Intermediate Tier**

Together, this service model will help us to achieve significant improvements for services users, including:

The person, their choice and preferences will be at the centre of every intervention, where appropriate.

More people remaining independent confident and safe in their own homes for longer.

Appropriate assessment and intervention carried out in a person's home and realignment of capacity to enable this to happen.

A suite of support care services are available so less people are asked to consider long term residential or nursing home care, particularly in a crisis.

Whilst the main focus has been on developing the business case for intermediate care there has been work ongoing to ensure the other priorities are developing. In particular:

## Wellbeing and keeping healthy

The programme team has been working with Welsh Government and Third sector partners with regards an innovative model for community resilience linked to issues of social isolation and loneliness amongst older people. A proposal is currently being developed using the principles of co-production and linked to the concept of social finance. A series of scoping sessions have taken place to plan this innovative approach to service provision.

### Sustainable services

A comprehensive bid to the Health Technologies Fund has been developed over several months and is detailed more in the 'Enabling' section below.

### **Assessing Need**

One of the main, and quantifiable, pressures on current services arises from the growth in the number of people who are frail. People who are frail are also typically, though not exclusively, old and many will therefore have dementia. Identifying the potential impact on services, and resource use, from this group of people, and then focussing our efforts on meeting these needs differently through an enhanced intermediate tier is therefore vital.

The modelling work undertaken has included the development of projections for the change in the older population over a 5 year period. These have been used to gain an understanding of the increases in demand that might be expected, were there to be no change in services or in people's access to and expectations from these services.

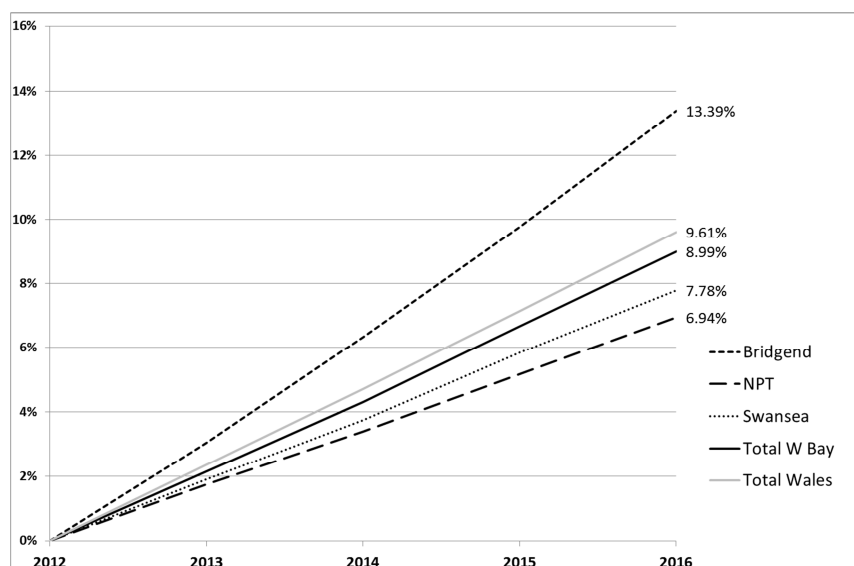
The projections developed are based on existing research on the prevalence of physical frailty, plus assessments of the varying impact of local health status and local population changes. The headline projected changes in the numbers of older people as a whole, and in older frail people are identified in Table 2 and Figure 2. Differences in the expected level of change between the >65s and the frail older population are due to different age distribution in each locality, for example Neath Port Talbot has a 'younger old' population whilst Bridgend will have a higher proportion of its older population in the 'old old' age bands.

	Total >65s			Est. of frail population			Frail per 1,000 >65
	2012	2018	Change	2012	2018	Change	
<b>Bridgend</b>	25,880	29,980	+15.8%	2,582	3,001	+16.2%	100
<b>NPT</b>	27,450	31,214	+13.7%	2,837	3,198	+12.7%	103
<b>Swansea</b>	44,290	49,396	+11.5%	4,687	5,226	+11.5%	106

**Table 2 Future needs based on demographic projections<sup>1</sup>, healthy life expectancy and expected prevalence of frailty**

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<sup>1</sup> Based on 2008 ONS demographic projections in IPC/ WG Daffodil database: projections derived from the 2011 census will be used to update modelling data once available through this source.



**Figure 2 Projected change in frail population, 2013-2016, compared to 2012 baseline**

### ***Changes in the population with dementia***

The modelling work has also looked at the number of people with dementia, because evidence indicates that people with a range of conditions are twice as likely to be admitted to hospital if they also have dementia. Using the same demographic profiles as above, and applying appropriate incidence and prevalence rates, it has been estimated that by 2016 there will be a total of 2,098 new cases of dementia a year across the Western Bay area – many of whom may go undiagnosed until later in the disease progression. The total number of people expected to have dementia by 2016 across Western Bay will be c 7,590, with just under 3,000 of these having a severe dementia. Table 2 shows the change from a baseline of 2012.

Locality	Expected prevalence in 2018	Change from 2012
Bridgend	2,074	+18.2%
Neath Port Talbot	2,239	+13.6%
Swansea	3,696	+13.0%

**Table 3 Expected change in the prevalence of dementia**

### ***Combining physical frailty and dementia***

People with both dementia and frailty have particular needs that can be complex and that therefore require particular attention in our planning and delivery of services. An indication of the levels of co-morbidity also informs where, and to what extent, services would benefit from closer alignment or integration. In summary, it suggests that across Western Bay:

- 8,050 people who will be frail without having any form of dementia;
- 4,580 people who will have dementia but will not be frail;
- 2,410 people who will have both dementia and who will be frail.

This means that about 16% (1 in 6) of people with either dementia or frailty will experience both. However, when a similar estimate of cost is made across Western Bay we have

estimated that £54M out of £110M (i.e. c 49%) is spent on the group who have both dementia and frailty.

### **Development of a Frailty Model**

The Community Services Project has made a commitment to develop a Frailty Model as part of the implementation of *Delivering Local Care*. This will be a key piece of planning work during 2014/15 in order to be in a position to implement by March 2015 in line with the timescales set out by Welsh Government.

Western Bay has already made significant progress in articulating the frailty model, with the detailed service model and business case produced for intermediate care. The work in 2014/15 will focus on aligning this work with the development of community networks and core community services. It will also include core primary care and hospital services, ensuring frailty is addressed as a system of care and all are working to a common set of principles with regards the management of this complex group.

Work on the model will begin with a Frailty Symposium in the Spring 2014, which will invite a wealth of experienced specialists and academics in the care and research of frail older people. The conference will set the scene for the development of the model and to ground the work in a foundation of best practice and innovation.



## Summary of Next Steps

During 2014/15 we intend to:

- Use the Intermediate Care Fund to strengthen intermediate care services in line with the business case outlined to provide a core and consistent set of services across ABMU, moving towards those services being available on a 7 day in line with the year 1 investment plan
- Develop a detailed implementation plan to support community networks having more responsibility for shaping and delivering care within their areas, and using networks as the key organising platform for a range of health, social and third sector services
- Develop a 'frailty model' ensuring this is system-wide design of services in line with Welsh Government directives
- Align / pool resources across health and social care to deliver integrated care
- Develop a common performance management framework with a suite of whole system measures that operate across health and social care
- Agree how we will formally evaluate the transformation programme of change
- By implementing the business case, begin to shift the delivery of care from institutional models (eg hospital beds and care home placements) to community models by extending rapid response and re-ablement services that will support people to live within their own homes and allow the health and social care system to deal with the impact of an ageing population
- Develop a broader approach to consider how we can influence and support people to live independently including tackling broader issues of social isolation, loneliness and developing community resilience by taking forward the principles of co-production and prudent health care.
- Develop joint market position statements and progress the development of joint commissioning functions within each of the three areas, aligned to the overall Western Bay commissioning and contracting project.
- Begin implementation of the 'Integrated Information in Integrated Care' agenda as part of the Health Technologies (once approved by WG)
- Agree a consistent model of 'support and stay' as part of a comprehensive review/strategy for Older People's Mental Health Services
- Consider how to better integrate housing and other support plans into the development of integrated health and social care models for the future and progress other initiatives that maximise the ability of people to live within their own communities (for example, progressing 'Dementia Friendly' communities).

## 5. Our approach to Integration

An option appraisal for determining the nature of the transformation programme for frail older people was included in the Outline Business Case. It considered a short list of options from 'do nothing more' through to a substantial transformation programme that sought to deliver a fully optimised system of care.

However, to support this Investment Plan a further formal options appraisal has been undertaken by members of the Western Bay Community Services Project Board. This has been focussed on determining the future arrangements for the implementation of proposed service changes with a particular emphasis on the nature and extent of integration, including the presence of pooled budget arrangements.

The options considered were built up using four components as indicated below:

- The service functions to which integration might apply – Demand management, intermediate tier, ongoing community support;
- What part of the system will be integrated, i.e. community health services, social care professionals and mental health staff;
- The footprint for a Section 33 pooled budget Agreement i.e. None, by locality or across Western Bay;
- The extent of any pooled budget agreement i.e. transformation programme only or also including 'business as usual'.

These components can be combined in a variety of ways to create a wide range of options. However, eight options were identified and assessed in the option appraisal as being representative of this wider range of possibilities.

A key focus of the option appraisal was to determine whether the service functions detailed should be integrated, and if so to what extent. Integration can be across health and social care older peoples services or across health and social care including mental health. For the purposes of the option appraisal an integrated service was taken to mean:

- A multi professional team with specialist and generic staff appropriate to meet the needs of the client;
- Co-location with single management, joint training and a single budget;
- Joint care planning and coordinated assessments of care needs;
- Named care co-ordinators acting as navigators;
- Recording on single clinical record.

In total, 8 options were appraised with criteria identified in a workshop session at one of the Changing for the Better events that included service users, carers, representatives from third sector as well as statutory partners.

The preferred option that emerged from this process was:

*Delivering transformation through integration of health, social care and mental health services for all three components of community services using local pooled budget arrangements for transformation funding and ongoing business. (The 3 components being common access point, intermediate tier and ongoing community support.)*

Partners also agreed that the extent of mental health integration under this option is that there will be co-location and alignment of mental health teams within the intermediate tier, in the first instance, building from a point of having link posts within each of the 3 CRTs. The term 'local' indicates a preference towards subsidiarity, ie. doing things at the most local level consistent with delivering value for money and improved outcomes.

In line with this agreement, detailed discussions on financial and governance models required. Partners have agreed to begin discussions on pooling/aligning budgets in each of the three local areas across the Western Bay area. The pool could apply to the transformation funding only or also include 'business as usual' funding. Further discussion on the range of budgets that could be considered as part of this pooling arrangement will be considered as part of the finalisation of the business case.

## **Commissioning**

There has been recent agreement to establish a formal contracting and procurement workstream under the auspices of the Western Bay Programme. Some initial preparatory work has already been taken forward, and a number of commissioning leads have been appointed to take forward the next phase of work.

Each of the Western Bay projects has commissioning as a priority and are developing common service models that will be delivered in each Authority area. For older people, work is progressing to develop a common vision and service model for frailty and also one for dementia, recognising there is a significant number of older people who will experience frailty and dementia.

An integrated contracting and procurement project has been established and work has progressed to develop a common quality framework for care homes and a market position statement and costing model for domiciliary care. Dedicated capacity is now in place for this project and the principle of a regional contracting and procurement hub agreed.

## **6. Supporting people to live in their home of choice**

People want a home that they can afford, that is safe, warm and secure, that meets their needs whether that be owned or rented and is in an area where they want to live and are supported to do so. Housing has a huge impact on a person's quality of life, wellbeing, health and life chances. People's homes are the focus for the delivery of many services including health and social care.

The aspirations and expressed preference of people with care and support needs is that placement in a care home is the least preferred care option.

It is critically important that where a care home is the preferred option of an individual that this is a positive choice, planned for and not made at a time of crisis, and that the care home is of a high quality in terms of the care provision, the homeliness of the environment and integration with the community. People in residential and nursing care can feel part of the community and retain as much independence as possible in well designed and sensitively managed care homes.

Supported housing is able to meet particular needs including 'own front door' options like sheltered and extra care (for older people) and independent or supported housing to meet other needs. Increasingly, there are people who in the past would almost certainly have been in residential care but who can now retain a large degree of independence if they are in well designed and supported accommodation housing is outcome focused, based on the needs and abilities of the individual, and people are not 'over supported' in an alternative setting.

People may need at certain times of their life accommodation based support in their own homes, wherever they live, which may be funded through the Supporting People Grant programme. They also may require aids or adaptations to enable them to remain in their home of choice. People who are becoming progressively frailer as they get older can stay at home much longer if that home has no stairs (or can take a stair-lift), has a bathroom big enough for a wheelchair to turn in, wide doors and appropriate equipment to live at home safely. Assistive technology provides huge potential for supporting people with complex needs within the community, including younger people with learning disabilities, and older people with mental health difficulties or dementia. Developing 'dementia friendly' communities is a priority across the Western Bay area. The Western Bay Supporting People Regional Collaborative Committee will take forward a review of older person's services in 2014/15.

Each Local Authority, working with the Health Board, will ensure that housing remains integral to the development of services that maximise people's independence and ability to live within their own community, preferably in their own home, for as long as possible.

## **7. Governance**

A governance structure to ensure delivery of the Intermediate Tier developments and identified benefits detailed in this business case will be put in place, building on existing Western Bay arrangements.

A Community Services Board currently oversees and is responsible for the delivery of the *Delivering Improved Community Services* Programme of which the Intermediate Tier developments are one key element. It is accountable to the Western Bay Programme Board.

The current Board has membership from ABMU (Localities and Mental Health Directorate), the three Local Authorities and the third sector. To ensure it is fit for purpose in its enhanced role, membership will be reviewed both in terms of seniority and size for effective decision making. Local governance arrangements (at an individual local authority level) will be shaped as required. Formal partnership boards are being established in each area to oversee developments at a local level and ensure that there are appropriate governance and scrutiny arrangements in place.

## **8. Learning and Development**

There is a growing evidence base within the UK which identifies the critical success factors required to deliver integrated care, and these present opportunities to identify learning from elsewhere.

As part of the development of the business case, we will be commissioning a formal evaluation of the development of intermediate care locally to supplement the local performance management. We will also be building in patient experience measures locally to ensure that we are making progress towards delivering high quality, patient centred care.

Partners locally have benefited from the shared learning opportunities provided through the re-ablement learning network, and would be keen to see the establishment of a similar network having a broader remit around integrated care. This is an area that has been flagged as an issue to the Integrated Care workstream reporting to the Unscheduled Care Board as an opportunity.

## **9. Performance Management**

Partners within the Western Bay Programme have committed to the development of an integrated performance management approach, using a set of joint measures and metrics that look at performance across the health and social care system. It is recognised that the business case for intermediate care will require very tight performance management to ensure that the benefits realisation framework is delivered. This will need to operate at both a Western Bay and local level and will be developed further as part of the work with Swansea University to develop an evaluation framework for the programme as a whole.

## **10. Other Enablers**

### **Health Technologies Fund**

The vision set out in *Delivering Improved Community Services* is ambitious but recognises that community teams cannot achieve these aims without transforming the way they work. Community services will need to adapt quickly and effectively ensuring they are fit for purpose, safe and sustainable, with the following technology priorities:

- Information and new technology is used to its maximum effect and acts as the enabler for coordinated care, shared records and innovative solutions to care and support in the community

- Widespread use of telecare, assistive technology and telehealth, where appropriate, to support frail and older people to be independent in their own homes and to provide additional confidence and support for carers
- Community teams will have access to the electronic equipment needed to make their work more efficient and effective, such as hand held devices and remote capability for working away from their team base.

The bid to the Health Technologies fund seeks to address the availability and use of new technologies within community care settings in order to improve efficiency and safety and increase productivity. It also seeks to increase the quality of services in the community and provides a bridging effect to enable these services to embrace future technological changes as part of national ICT programmes.

The technology will include:

- Digital pen and tablet technology for staff in the community to enable point of care recording of information, digital care documentation and the piloting of information sharing between community and secondary care.
- Telecare and telehealth technologies for patients and service users to feel safe and for their care to remain in their own homes. This will include the development of an out of hours service across Western Bay following the successful evaluation in the Bridgend locality.
- Remote clinical management capability for staff in the community using the same digital pen and tablet technology, along with state of the art telehealth to monitor patients with long-term conditions, including care home 'Skyping' to replace traditional clinical consultations.
- Simplified access to citizens' health and social care information by utilising existing integration software within the Health Board to bring together data from disparate systems in partner organisations

### **Information Sharing**

The provision of integrated health and social care services will rely on an ability to share information. In fact, without the ability to do this the programme of integration will only be realised in a limited and clumsy manner. IT systems can make this process of sharing information more efficient and opportunities to develop this should be taken. Information sharing will allow for:

- Improved health and social care outcomes
- Improved wellbeing
- More effective and efficient service provision
- More effective and efficient service planning

The legislative framework with Wales supports information sharing across statutory and non statutory providers. Work to develop Information Sharing Protocols across the Western Bay community will need to be undertaken to advance this across the Western Bay area.

## **Information System Development**

A joint forum bringing together the ICT Heads from each of the local authorities and the Health Board meets regularly. There is a reporting mechanism to the Western Bay Programme Team. The initial focus of the work has been on discussing practical arrangements to facilitate joint working at a locality level (for example, access to respective IT systems for health and social care staff who are co-located). Work has also shaped a proposal submitted under the Health Technologies Fund. The potential options to develop a more strategic approach to ICT are being explored, and the potential benefits of procuring the Community Care Information Solution (CCIS) across Western Bay needs to be considered in this context.

## **Workforce Planning & Development**

Similarly the respective Heads of Workforce across Western Bay also now meet to consider both practical and strategic workforce issues. There are opportunities to explore innovative workforce models, as well as opportunities to look at more sustainable workforce solutions in key areas – for example, development and skilling up of the non qualified support worker role – an area where both health and social care struggle to recruit.

## **Regulatory Issues**

Current organisational models govern the regulation of health and social care separately and this can be a barrier to progress. Whilst pragmatic and flexible solutions have been put in place to try and address individual service issues, it would be helpful for Welsh Government to assist in ensuring that regulatory arrangements reflect the need to support new care models.

## **11. Measuring Success**

As part of the development of the business case for intermediate care, a range of performance indicators will be used to judge the success of the integration programme. These are currently being refined. In addition a clear programme of research and evaluation will be agreed to support the wider transformation programme

## **12. Conclusion**

ABMU Health Board and the City and County of Swansea, Neath Port Talbot County Borough Council and Bridgend County Borough Council are committed to the development of integrated health and social care services. A major transformation programme is underway across Western Bay to realise our ambitions and deliver joined up care for older people with complex needs.

## **Appendix A**

### **Examples of Integrated Services developed within the ABMU Area**



## ***Swansea: Integrated Gower Team***

In August 2013, there was little way of provision in community domiciliary care for the rural Gower area of Swansea. This problem was leading to delays in hospital discharge for patients requiring packages of care within the home setting. There were also difficulties in establishing packages of domiciliary care for those people at home requiring extra support in care, this included, palliative care, continuing care, rehabilitation and long term care.

The rural nature of the Gower area necessitates long driving distances between patient calls and therefore, there has been a long standing problem of maintaining domiciliary care services in this area. There were 4 different health and social domiciliary care teams working within the area. These teams were criss-crossing one another when visiting patients and there was an obvious waste of resources and an inefficient way of working. Something different had to be done with the winter season looming.

Working in a collaborative and efficient way with the local authority, a small Integrated Gower Team was formed with a selection of health and social care staff from all four existing teams.

The team which is comprised of health care support workers (HCSW), nursing and team leaders, is based with the Gower community nursing team and they deliver highly skilled care to all people living in the Gower area. Duplication and driving times have been significantly reduced and capacity has been created to allow domiciliary care provision to all residents requiring support in this rural area.

In the three months since the creation of the Integrated Gower Team has:

- There is currently no waiting list for any care within the Gower Area
- No patients are waiting unnecessarily in an acute hospital bed for care provision
- Patients within the hospital and home setting now have access to a responsive domiciliary care service
- Response times are range from 2 hrs to 2 working days.
- There is continuity, quality and safety in care provision.
- Patients requiring palliative care and wishing to die at home can do so without delay.

The importance of following a change process has been key to the success of the new integrated team. Involving all stakeholders early on in any key change was also important in gathering support.

The key lesson learnt was that not all problems can be solved at the outset; many issues follow a PLAN, DO, STUDY, ACT (PDSA) cycle of change. All members of the team are still learning and implementing changes as the service evolves over time.

## ***Bridgend: Integrated Community Resource Team***

The following client case study illustrates a complex programme of intervention from CRT services.

We received a referral for a young man living with his partner and young family who was independent with all aspects of his personal care and family life. He was admitted to hospital following a CVA with a dense left sided weakness and spent 14 weeks at hospital. He experienced low moods as he coped with major life changes and adjustments; he was discharged home with Reablement. His support on discharge consisted of 4 double handling calls 7 days per week.

All personal reablement goals were achieved and his ongoing support needs drastically reduced.

Incontinence was an issue initially, but with the provision and optimal siting of the appropriate equipment this ceased to such a problem.

Once home, his mood improved, he received intense Social Work support and his partner was offered and accepted a carers assessment. There were access issue to the first floor in the privately rented house rendering access the toilet and bathroom as challenging. The Social Worker was able to refer the family to housing services to facilitate the identification of more suitable housing through the Accessible Housing scheme.

He had also developed problems with his eyesight following the CVA for which he received support from the Sensory Impairment Team within the CRT. The Team made applications for support to the RNIB and Servicemen Associations.

Skin problems that were affecting both his and his partners' sleep were reviewed by a CRT Nurse and the advice and intervention resolved the acute symptoms.

Telecare service and Mobile Response Team support was arranged to enable his partner to feel more confident about returning to work, knowing that help would available should it be needed in her absence.

As the Reablement intervention progressed the service linked in with the Hospital Physiotherapist to consider the most appropriate on-going Therapy following Reablement and a referral for Outpatient Neuro physiotherapy was arranged.

The Stroke Association offered excellent support and the family were planning to join the local groups. He was definitely feeling more positive about the future.

At the end of CRT intervention, the feedback from the young man was *"The service was fantastic and an enormous support for my partner. I was originally sceptical but the service was inspiring, motivating and gave my confidence back that there is light at the end of the tunnel."*

## ***Neath Port Talbot : Integrated Community Resource Service***

A 76 year old lady who suffered a stroke about 25 years ago, which had left her with weakness down her right side though she lived independently in England until a few years ago when her general health started failing and she came to live closer to her family.

During this period she had a prolonged admission to a community hospital . She returned home but due to her increasing frailty she had to have a large package of care to maintain her at home. She was coping reasonably well which in part was due to the excellent family support that she received. She became unwell October 2012 and was taken to the Emergency Department at Morriston Hospital. It was felt that she had a urine infection and she was discharged with antibiotics. These proved unsuccessful and she was admitted to a Community Hospital where she spent about 6 months. Due to her general condition and dependency it was felt that she needed to be looked after in a nursing home (NH). In addition to her above problems she also suffered from poor swallow, a mood disorder, diabetes, and had some cognitive problems.

She became unwell in the NH and was seen by her GP who thought it was a urine infection and treated her with antibiotics. She was subsequently seen by 2 on call GPs and given more antibiotics with no improvement, eventually the out of hours GP asked the staff to admit the patient her to hospital. Nursing home staff asked the GP to refer to the on call nurse practitioner (NP) from the Acute Care Team (ACT) who provide in-reach services into care homes.

He did this and the patient was examined by the NP who undertook an assessment. It was 4.30pm by the time the NP had a good picture of the patient and following liaison with the consultant, family and nursing home it was agreed that we could look after the lady in the community.

Regular and frequent care and treatment from Nurse Practitioner, District Nurses and Consultant Physician was provided into the care home. This included intravenous fluids and antibiotics. End of life care was discussed with the family and the Consultant and a do not resuscitate agreement was made. Through discussion with the family it was felt that the most appropriate way forward was to keep her in the NH and not to proceed with artificial feeding. There was a feeling that she may require end of life care including a syringe driver (to give drugs for symptom control) district nurses were happy to support as nursing home staff felt that they would not be able to manage it.

This was a frail lady who was comfortable and well looked after in a NH and who with the support of the CRT was able to remain at her home with appropriate levels of skilled and caring staff. Without the intervention of the CRT she would have most likely been put through the whole process of an unscheduled admission to a hospital.