Integrated Health and Social Care Services for Older People with Complex Needs

North Wales Statement of Intent

1 Introduction

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

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

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

Currently the LHB's clinical management structure is under review, whilst Local Authorities are awaiting the outcome of the Williams Review - this inevitably leads to a level of organisational uncertainty. However, the paper has been written to reflect the strategic intent of Partners, with the vision, aims and objectives for integration across North Wales able to 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 welcome and indeed there are many examples of strong partnership working which demonstrate the commitment to this approach. Partners 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 citizens, developed by National Voices:

"I can plan my care with people who work together to understand me and my carer(s), allow me control and bring together services to achieve the outcomes important to me"[(i)]

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 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:

- 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 better meet the individual needs of the older person
- Reduce duplication and increase awareness of services delivered across all sectors to older people
- Reduce the inappropriate use of longer term and more intensive or acute care
- Drive down the cost of caring for older people

2 Conceptual Framework

In order to plan for and describe the development of Integrated Services, this Statement of Intent has utilised a Partnership Continuum[ii] (see Appendix 1) which can be applied

at Strategic, Managerial and Service Delivery levels, with implementation possible on a regional, subregional, county and locality basis.

Integrated working will naturally develop at a different pace for different services in different Localities across North Wales. However, we will ensure that learning is shared through partnership structures in a timely fashion to inform new developments. This may be, for example, through a shared website with a resource library and common templates for key documents and/or regular learning events.

Learning from key documents such as "Collaboration in Social Services Wales"[iii], "Making integrated care happen at scale and pace"[iv] and other 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

Within North Wales, there is no one agreed model for integration which encapsulates all public health, primary, community, acute, social care, independent and third sector services. However the following components of a service model:

- 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

are ones that partners recognise which can meet the 4 key themes identified by older people when asked about the service difficulties they experienced ie:

- co-ordination of care,
- continuity of care,
- straightforward and consistent referral and communication systems,
- access to services[v]:-

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 Councils
- 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. 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 members for Social Care, Betsi Cadwaladr University Health Board officers and WLGA, WG and SSIA representatives.

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

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

v) 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 3rd Sector.

The Forum was originally established to drive forward the development and implementation of locality working and other key elements for delivering community services laid out in *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, counties and the whole region of North Wales. This has been adapted to meet the needs of each County. The County Forum level of the framework has been established with a key intent to support integrated working by unlocking barriers and unnecessary bureaucracy.

ii) The new 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.

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

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

Future Intent

i) 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 which deliver the best possible health and wellbeing outcomes for individuals and provide the best possible health and social care provision within the best use of available resources.

ii) 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 3rd and independent sector at a locality, county and regional level. An initial element of this activity will be the development of a Market Position Statement.

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 ensure that providers of health and social care services operate in an enabling culture, supporting independence and avoiding unnecessary escalation, e.g. hospital admission.

4.3 Resource Management/Pooled Budgets

Current arrangements

i) All counties have a Pooled Budget for Community Equipment Services.

ii) In **Denbighshire**, there is also a pooled budget agreed for the provision of health and social care support workers.

Other LA information to be added

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.

ii) 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

Current arrangements

i) All organisations provide staff 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 3rd and independent sector.

ii) In **Denbighshire**, there is a single line management arrangement for Adult Mental Health Services and co-location of health and social care staff for Learning Disability Services and a small team for Older People's Services.

Other LA information to be added eg re ECS

Future intent

i) 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.

ii) 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 region.

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

iv) 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.

v) A recent Partnership Assessment exercise undertaken by the Locality Teams in each County has provided an analysis of current working arrangements and identified areas for improvement. This assessment will provide a baseline for the future.

4.4.2 Back Office functions

The need to ensure that Integration is based on a whole systems/organisational approach is highlighted in *"Collaboration in Social Services in Wales"*[ii]. This document evidences the risks to developing integrated services when all key departments, e.g. 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. Effective integrated working needs to be supported by policies and procedures that are at best joint and at least aligned. There is also a need for shared training programmes, "joint" data management and information systems that "talk" to each other.

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

However, effective integrated working would best 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.

Current arrangements

i) In **Denbighshire**, the co-located Learning Disability Team use a single client database, PARIS, which is managed by the Local Authority. There are WASPI agreements in a number of services to support joint working.

Other LAs to include any examples of co-ordinated systems and processes

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.

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

- Improved decision making – 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 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 patient

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.

(all to insert examples)

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.

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.

   The 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.

(Any county-specific initiatives??)

ii) 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

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

Should also include Older People's Strategy Work in this section?

4.6 Service Delivery Integration

Current arrangements

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.

Each LA needs to state here what they are currently doing jointly with Health/ other partners

Future Intent

As above

In **Denbighshire**, the Local Authority is working with BCU in the development of the North Denbighshire Healthcare Complex and the Llangollen Primary Care Centre and the roll out of Enhanced Care Services in the Central and South Locality area.

4.7 Engagement

Current arrangements

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.

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.

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.

The advantages of a shared approach are recognised in the Guidance for Engagement and Consultation on Changes to Health Services, 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.

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n **Denbighshire**, there is an Older People’s Strategy Group, a My Life, My Way Group and contracts with 3rd 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.

Each LA needs to state here what else they are currently doing jointly with Health/ other partners eg shared participation strategy

Future Intent

The need to review the working 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.

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.

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.

Need to add Welsh Language issues here?

4.8 Transforming Access

Current arrangements

Each LA needs to state here what else they are currently doing jointly with Health/ other partners

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.

Future Intent

SMW to ask Alwyn Jones to provide a statement re regional working

In **Denbighshire**, during Phase 1 the SPoA will:

- Process all referrals for health and social care community services to support Denbighshire residents' hospital discharge.
- Process all Enhanced Care Referrals for North and Central & South Denbighshire
- Process all other referrals for District Nursing team in Rhyl. (For referrals for all other District Nursing teams, the SPOA will forward referrals to the appropriate office for onward processing)
- Process all referrals for Community Therapy services in Denbighshire (but not 'self-referrals')
- Process all referrals for Community Hospitals and prepare and submit 'bed-states' (twice daily).
- Fulfil First Contact Team responsibilities to Adult Social Care services
- Coordinate a service response according to an individual's presenting needs.
- Where multiple referrals are made for a patient/service user the SPoA will inform the referrer and all services which other services are to be involved, with details of each care coordinator where appropriate.
- 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.

D) Assessment of Older people

Future intent

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

5 References

(i) Integrated Care and Support—our shared commitment
National Collaboration for Integrated Care and Support, May '13

(ii) adapted from Community Based Collaborations
Oregon Centre for Community Leadership 1994

(iii) Collaboration in Social Services Wales,
SSIA 2013

(iv) Lessons from experience—Making integrated care happen at scale and pace
King's Fund, March 2013

(v) Mc Cormack et al 2008

Appendix 1

Partnership Continuum

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

Appendix 2

COUNTY STRUCTURE FOR INTEGRATED COMMUNITY BASED SERVICES