

**Statement of Intent for Delivering Integrated Health and Social Care for Older People with Complex Needs**

**1 - Background**

**The Strategic footprint**

The Aneurin Bevan University Health Board (ABUHB) and the five Local Authorities of Blaenau Gwent, Caerphilly, Monmouthshire, Newport and Torfaen have well established arrangements for aligning the planning and delivery of some services but more needs to be done to integrate services to deliver health and social care support for Older People with Complex Needs on a whole system basis. We have achieved much, at both a strategic and operational level, primarily through our Frailty programme, as one of the community responses to the wider Clinical Futures programme, where the aim is to build capacity within community settings, to reduce demand on health and social care resources, particularly acute and institutional care.

The priority for integrating community based services is already well advanced through the delivery frameworks of the Single Integrated Plan (SIP) arrangements in each Local Service Board at a borough level and the structures around the established Neighbourhood Care Networks (NCNs), which have a community population focus of between 30,000 to 50,000 people.

We are starting to describe our integrated working within a greater Gwent health, social care & well-being economy, as we recognise that there are many agencies involved in the planning and delivery of treatment, care and support to citizens. This description is reflected in our emerging joint governance framework and should enable us to focus on strategic improvements, which are not dependent on current or future Local Authority boundaries.

**The operational footprint**

Welsh Government guidance suggests that NCNs need to become the delivery mechanism for operational service delivery, so that health and social care resources can be better aligned to meet different local needs. However, our experience, to date, does not yet provide the evidence we need to assure ourselves that this is the right delivery footprint and we will monitor and revise this as we go forward. We know that many localities have significant social and economic challenges. This means that a "one size fits all" approach is not sustainable if we are serious

about tackling inequalities, acknowledging different community contexts and meeting specific language, cultural and well-being needs, thereby redressing the Inverse Care Law. We will maximise the potential of the new GP Contract to develop robust needs assessments that will inform service planning.

For many community based services, NCNs appear to be the right level of population size to plan and deliver integrated support for citizens. However, if we are thinking beyond health and social care and also including well-being, it may be prudent to think in terms of Neighbourhood Networks that can deliver a wide range of support and services, delivered by public, private and third sector agencies at an even lower level, aligned to natural communities. To maximise the potential for better meeting citizen needs at a local level, we need to align resources, recognising that some services need to be delivered at a borough, regional or national level to ensure sustainability and value for money.

A useful model for considering the “whole” needs of Older People is presented by the King’s Fund, 2014 (See Appendix) For Older People with Complex Needs, a comprehensive range of component services, delivered to consistent standards, needs to be available to each area. Work will be needed to define, design, specify and commission or provide these component services regardless of which organisation will eventually deliver them in each local area. We are keen to utilise the skills and capacity of 3<sup>rd</sup> sector, social enterprise, RSLs and independent sector organisations, moving towards a joint commissioning framework for Re-ablement and Intermediate Care type services.

The Welsh National Service Framework (NSF) for Older People requires intermediate care to be established as a mainstream, integrated system of health and social care and definitions of Intermediate Care vary but have some common elements. These include services that are designed to enable people to maintain their independence through early intervention and prevention of higher care needs. Avoidance of hospital admission and support for rehabilitation on discharge are key drivers for success. Rapid response services, crisis intervention and prompt specialist interventions are also important “step/Up” features. A useful description of Re-ablement services was set out by SSIA in 2013, as “Services for people with poor physical or mental health or disability to help them live as independently as possible by learning or re-learning the skills necessary for daily living”. Our Frailty programme contains many of these elements and our proposals submitted to the Intermediate Care Fund will build our capacity and capability in the region.

Looking specifically at supporting older people with complex needs, we will use the new Integrated Assessment Framework, to provide a holistic

response for vulnerable people. We are currently piloting the new Assessment documentation within Community Resource Teams, to ensure alignment with our strategic Frailty Programme and information systems. We want to avoid duplicate systems for assessment and requested the Minister to consider the use of the new Integrated Assessment Framework for all adults with complex needs, regardless of their age and the Minister has responded positively.

Each NCN will have strong professional and operational leadership, supported by an effective business team, who is able to assess population need, develop priorities, effectively challenge the status quo; work with all front-line professionals, citizens and their families to develop creative solutions, by utilising all the resources available within that community to deliver the agreed outcomes. This will require new skills and knowledge for professionals who may have limited experience of working beyond the statutory sectors. Co-production with citizens, RSLs, 3<sup>rd</sup> sector and independent sector providers will be essential to shape new service responses to meet agreed priorities.

## **2 - The vision - What needs to change**

The demographic and financial pressures are well known and are not repeated in detail here but form the context of the whole system transformation that is required. We know from ONS data, that the number of people aged over 85 in UK has doubled in the past three decades and by 2030, one in five people will be over 65. Wales already has a higher proportion of people over 85 than other parts of the UK, so the need for change is more significant, as percentage of 85 year old's increase by 90% by 2030 and a growth of 30-44% of people with dementia. At the same time, public sector resources are reducing in real terms and new ways of working must be delivered. Many people will stay healthy, happy and independent well into old age. However, as people age, they are progressively more likely to live with complex co-morbidities, disability and age-related conditions and we will need to re-design services to better meet a wide range of complex needs, including dementia and frailty.

Our vision is to improve the health and well-being of older people, no matter how complex their needs, so that they are supported to maintain their independence and live a good life. In order to achieve this, we need to take a "whole system" approach and consider the following elements of treatment, care and support, as described by the King's Fund.

- Supporting and promoting healthy, active ageing and independence, through suitable housing, healthy lifestyles and meaningful relationships.

- Helping people live well with simple or stable long term conditions
- Helping people live with complex co-morbidities, including dementia and frailty
- Providing rapid support, close to home, in times of crisis
- Providing good hospital care, when needed
- Ensuring good discharge planning and post-discharge support
- Ensuring good rehabilitation and re-ablement (outside hospital) after acute illness or injury.
- Providing high-quality residential or nursing care for those who need it.
- Ensuring choice, control, care and support towards the end of life.
- Integrating care to support older people and their families.

The intention is always to develop the whole pathway of advice, support, care and treatment for older people and their families; to ensure the right response is given at the right time and place.

The purpose of our integration activity for citizens will mean:

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

The health and social care economy in the greater Gwent area recognise that the Frailty programme does not cover all aspects of need and more work is required to better align arrangements to manage core services, as well as tackling the determinants of health and wider health improvement activities, so that health and social inequalities are reduced. Our health improvement activities are not described here but are contained within our public health strategies, which addresses priorities across the life-course, at both a local and regional level. It is essential that we continue to focus attention on lifestyle issues, so that all citizens are supported to make healthier choices.

The partners embrace the challenge to shift resources upstream, so that preventive and early intervention measures can be developed to delay frailty and reduce crises, which usually require more expensive and complex support. Intermediate and Re-ablement services are a key feature for development and capacity building within and beyond the Frailty programme.

We are committed to utilising the expertise and knowledge of front-line practitioners, who need to be able to support people to make healthy choices, find creative solutions to meet their health and care needs and signpost them to alternative sources of advice and support, which promotes their independence and well-being. At the same time, this new

approach will re-focus demand on statutory health and social care resources, to meet demographic pressures and in line with expectations set out in Delivering Local Health Care and Sustainable Social Services as well as the forthcoming SS & WB Bill.

For older people with complex needs, we recognise that the referral pathway into our health and social care system can determine how well we are able to respond. For this reason, we believe that the front line should be delivered by experienced professionals, who are able to triage and problem solve. The experience of the Monmouthshire FISH service desk and the Torfaen Adult Social Care hub, supports this approach, with demand being pro-actively managed, through effective risk management and sign-posting to alternative services. Most of the localities have or plan to have a number of joint senior management posts and we will use staff turnover opportunities to enhance this approach, where that would add value to the integration journey.

We also recognise the future for joined up more integrated working lies in how we share the responsibility and jointly plan, design, commission and provide services across all partners in the statutory, third and independent sectors, as well as encouraging new forms of social enterprise. The role of housing and housing related support is particularly important in meeting the needs of older people with complex needs and we have established a regional planning group within our joint governance structure that specifically considers housing, health and social care needs. We will use the expertise of that group to develop our Intermediate Care proposals.

We recognise that this is challenging and requires a mature strategic partnership approach that is able to set the vision, strategic direction and expected outcomes and standards, whilst freeing up and empowering operational professionals to design sustainable solutions that meet local needs and provide value for money, within a reducing resource context.

The role of RSLs, 3<sup>rd</sup> sector and independent sector providers is critical to delivering a better alignment of support, if we are to maximise resources and find creative solutions to meet well-being needs. This will require a mature joint approach to strategic planning and commissioning and our "In One Place" model to initially meet the complex housing and support needs of people with a learning disability will provide a useful test-bed for this new approach to delivery.

People will need to play a more pro-active role in developing and utilising community capacity to help them stay independent and as active and engaged in community life as possible. Professionals will need to recognise that people are the experts of their own lives and care needs and are often ingenious in managing their own limitations, by calling on

their own strengths and resources. The challenge for professionals will be to enable and support people to continue to operate within their own family and neighbourhood support structures and to provide help when there are gaps. Professionals will need to work with people to understand risks and creatively design solutions and offer support which prevents dependency. There will also be times when interventions and care has to be provided when risk becomes unacceptable.

People may need help to plan for their own potential future and to consider issues such as frailty when planning for their older age and to do this early enough so that plans can be put into effect, e.g. this may include support to plan for more suitable housing which allows people to stay in their own home environment for longer, should they become less mobile, cognitively or sensory impaired.

### Outcomes for Older People

We want Older People and their Carers to:

- Be well informed and engaged.
- Maximise their well-being
- Have easy access to community based services, that are well co-ordinated
- Get help when and where it is needed
- Receive high quality advice, support and services
- Avoid unnecessary hospital admissions or institutional care
- Have more options to access advice, support and services, including on-line, telephone and face to face interactions.

### **The critical role of unpaid Carers**

Research shows that for 4 out of 5 Carers, their first point of contact with any statutory agency is with a community-based health service. Also that this first point of contact is generally within a primary care setting, either at a health centre, GP practice or at home. In the Aneurin Bevan Health Board area there are known to be approximately 65,960 Carers, 12% of the total population. (See Carer's Strategy Principles in appendix)

The burden of caring on individuals and families is well recognised and there is a need to support carers well (Carers, UK), through effective advice and support. Through the auspices of the Gwent Carer's Measure Partnership Board, we are currently utilising SSWB Transformation funds to find out what carers really need to help them in their caring role, as we recognise that each carer has unique needs. This is underpinned by training and support to healthcare professionals, so that carers can be

identified and early support and advice provided by those same professionals, to avoid unnecessary referral to other agencies and eventual carer breakdown. Statutory agencies need to recognise that caring is a choice and relatives should not be pressurised to provide unreasonable amounts of care. We cannot assume that people will provide care without due regard to this right of choice and must consider the impact on the carer's own health and well-being. As the numbers of older people increase in proportion to the numbers of younger people in the population it must be recognised that there will be fewer people who are in a position to take on additional responsibilities, as they may already be providing care within their family as well as maintaining their own occupation and leisure activities.

### **Putting People First - A Strong Voice and Real Control**

The strategic partners in the greater Gwent health and social care economy believe that people know best what well-being outcomes they want to achieve and our approach should be to support achievement of those outcomes, rather than assume a service response is required.

Our approach needs to shift to become enablers, whilst safeguarding the most vulnerable; recognising that people manage risks in all parts of their lives. We recognise that this will be a new approach for local leaders, professionals, politicians and the public. These are the aspirations set out in the forthcoming SSWB (Wales) Bill and we support those aspirations but recognise the challenge ahead.

One of our significant challenges is to ensure meaningful co-production and to evidence how well we have listened to individuals seeking our help and advice. We also need to improve how we use that "customer intelligence" to deliver service improvement at both a team and strategic level.

We will use a new governance framework to provide assurance and collective scrutiny, with a focus on transparency for people to assess how well we have done and where we still need to improve.

### **Creating a new shared purpose**

King's fund evidence is clear that marginal change is not sufficient; change is needed at scale and pace. These changes are significant and require a commitment at all levels and across many organisations, including the public themselves. This needs strong political and professional leadership, within a robust governance framework and programme management approach, that is flexible enough to respond to potentially conflicting priorities.

Our vision and strategic approach needs to be robust and flexible enough to withstand organisational changes arising from the Williams Commission and potential future changes to public sector footprints. We believe our joint governance framework can support this approach.

### The current picture

We have well established Community Resource Teams in each of the five boroughs and are planning to increase capacity and capability, utilising the Intermediate Care Fund for 2014/5. We have commissioned independent expertise to help us review current arrangements, to ensure we are developing the best model that delivers the outcomes we have prioritised. The Frailty programme recognises that some form of risk stratification may be helpful, to ensure resources are targeted to prevent deterioration and we are working with GP teams to develop suitable tools and systems. We support the concept of Anticipatory Care Planning, so that people's needs and wishes can be supported, even in times of crisis. We anticipate this would reduce unplanned hospital admissions for those who would prefer to remain at home or within a care home setting to receive treatment. We also support Advanced Care Planning when people need end of life care, as this can be seen to support more people to die with dignity in their usual place of residence. The role of case co-ordinators is being explored, so that older people with complex needs have a single point of contact, who is able to cross professional and organisational barriers to find solutions to meet a wide range of individual needs. However, we are aware that the evidence of effectiveness for this way of working is weak in terms of managing demand on unplanned hospital admissions, so we will test out this approach and adapt as necessary.

The design and delivery of services through condition specific care pathways, which are promoted within the NHS, may not be effective in meeting the needs of older people with complex needs (King's Fund, 2014). Many experience co-morbidities and challenges to activities of daily living at home, that require the support and advice of many agencies and professionals. This may be better achieved through the use of key-workers, who are empowered and enabled to access specialist skills when required. These roles can be delivered by professionals from a range of disciplines and help to break down professional and organisational barriers. We will consider the national evidence to develop appropriate solutions at NCN levels.

Resource alignment and service integration does not always need to result in a single budget, single manager and single employer unless we can demonstrate that people will benefit from this, as any change process distracts staff at all levels from service delivery. A flexible approach will

enable each type of service and each NCN to progress at a pace that is achievable and sustainable in the longer term, as budgets are increasingly squeezed. However, once the essential elements of local service needs are established and service gaps agreed, the expectations are that these will be available at each NCN, to ensure primary, community, intermediate and acute resources are better utilised.

This will require consideration of extended and 24/7 working, with some key services re-designed to meet this requirement. We already provide most Frailty services 7/7, 365 days per year and we can build on this to create an integrated health and social care service that better meets the expectations of older people with complex needs. However, a cost benefit analysis will be conducted before extending services beyond core hours in each NCN area. We will consider the national changes proposed for Phone First/111 as well as our experience of GP Out of Hours and Social Care Emergency Duty Teams to inform future decisions.

Some areas are actively considering how they can create age and/or dementia friendly communities and we will share the learning from these approaches across the area. Torfaen Local Service Board has recently concluded a study on potential approaches to prevent frailty and this work will be shared to avoid duplication of effort. Newport Local Authority is working with the Health Board to develop a robust profile of data regarding the use of services by older people and the outcome of this work will be shared and implications considered regionally. The North Resource Centre in Caerphilly borough, which became operational this month, will provide an opportunity to integrate service delivery at a very local level and learning will be shared across the area, so that opportunities to align services, where this would add value, can be taken forward with pace. Monmouthshire has developed a Frailty service that does not include consultant posts but uses the expertise of local GPs to provide medical support. Blaenau Gwent are currently integrating some operational core teams, beyond the Frailty Community Resource Teams and other areas are planning a similar journey, with consideration to the recent report from the Williams Commission. We will be formally evaluating the Frailty programme during 2014, so that adjustments can be made, where necessary, to ensure value for money and sustainability across the region. We will ensure the same outcomes and standards are agreed but local flexibility to meet local needs and contexts will be supported, where appropriate.

### **3 – A new shared Governance and Accountability framework**

The attached schematic (Appendix 1) describes our emerging joint strategic governance structure and you will note that we are embarking upon an ambitious transformation programme, that will support delivery of integrated services in several areas, notably Frailty (OP with complex

needs); Mental health; Learning Disability; Dementia; Community Equipment; Support to Carers and Unscheduled Care. These programmes are at various stages of development and a Joint Committee will be developed (building on the Frailty Joint Committee) to provide the overarching political and organisational leadership and governance framework. This framework has already been shared with the Deputy Minister, by the chair of the Frailty Joint Committee, who is content that we are on the right integrated governance pathway.

Our new arrangements will be underpinned by a new set of principles that will guide our future work, using evidence of successful partnerships that are delivering integrated health and social care elsewhere.

We are keen to explore operational governance models that satisfy professional, clinical and organisational requirements and these will be designed and tested during 2014 to find the best fit for each service type. Key to this work will be to ensure that decision making on the ground, at the patient/service user interface is supported by clarity of accountability for each member of staff and each organisation, as teams will consist of people employed by a range of organisations, including independent primary care contractors. This means further work is needed to ensure that clinical and social care decisions are made in line with professional codes of practice, protocols and procedures that are agreed by the relevant statutory bodies and can be measured and seen to deliver the right outcomes. During 2014, we will also review the current NCN functions and footprints, to ensure they are fit for purpose and are future proofed.

Much of the operational functioning will rely on clear business processes to enable joint working. This will include clear accountability structures which enable delegation of responsibilities and financial control across boundaries and teams. The partners agree that the degree of risk involved, albeit in these times of financial constraint, has to be managed and this cannot be allowed to get in the way of innovation. We have demonstrated we can deal with these challenges through the use of Section 33 Agreements for Community Equipment Services and the Frailty Programme.

Joint commissioning processes need to be established, where appropriate, to ensure that commissioning skills are utilised effectively across the partnership. The skills of needs assessment, engagement, negotiation, political awareness and creativity, alongside business acumen and financial and analytical skills are in short supply and staff with these skills need to be nurtured and developed.

Recent policy updates from the Deputy Minister, regarding expectations set out for the SSWB (Wales) Bill, give clear indications of the leadership

role of the Director of Social Services to ensure joint needs assessments are conducted to meet the care, support and well-being needs of their population. This needs assessment will utilise evidence gathered via the new GP contract, aggregated at an NCN level, as well as building on the work of Public Health Wales and include the different language needs of local people, specifically the Welsh language but a wide range of languages in some parts of greater Gwent.

#### **4 - Empowering the front-line**

We recognise that each registered health and social care professional has a personal responsibility to deliver best practice and to work within their own capabilities. This is particularly relevant when practitioners may be working alone within someone's home or a community setting. Therefore, our operational governance structure will embrace this, so that unregistered professionals are working within a well governed service and the public can be re-assured that risks are being well-managed. The varying responsibilities and requirements of regulatory and inspection bodies will need to be considered, as we re-design services that will transcend organisations that have distinct statutory functions.

The challenge of recruiting and retaining adequate numbers of registered health and social care professionals will mean that we will need to rely on more generalists and unregistered staff to support professionally led services. This is seen as a positive step to ensure that specialist skills are retained where they are needed most, with the expectation that more work will be delivered by multi-professional teams at a local level, with specialist support outreaching to local teams, to reduce the need for referrals onto another part of the health and social care system. This approach should also help to break down potential barriers between primary, community and acute based services, ensure unplanned admissions to hospital are minimised and primary and community resources utilised to best effect.

There is a need to develop joint training and organisational development programmes to support teams to understand and work within the different cultures that may exist within professional groupings and organisational structures and to address and celebrate the various perspectives these differing backgrounds and skills bring. For some key functions, future training programmes will be co-designed and made available to 3<sup>rd</sup> sector and independent sector providers.

There are many examples of good practice across the UK (King's Fund 2014), which can be adopted to better meet the needs of older people. For example, the role of community pharmacists could be strengthened to support front-line practitioners care for older people with complex needs living at home; as non-compliance with medication, is a contributory

factor in many unplanned hospital admissions. There are pockets of good practice and these should be rolled out across the region, utilising the Intermediate Care Fund to pump-prime new service models.

The strategic partners are keen to ensure we focus where integration will add most value to people and that we prioritise work on developing the outcomes, standards and principles, whilst operational governance and organisational structures and systems are developed through a journey of shared learning, testing and implementation, during 2014 onwards. We would aim to have developed the best operational governance model within the next 2 years, alongside changes to Local Government re-organisation and would require each NCN (or service delivery team) to adopt the preferred governance model.

We will work in partnership with national and local professional bodies, including NHS Confederation, ADSSC, LMC, LOC, LPC, LDC, RCN and others, to develop a skilled workforce that is able to deliver new services, which are likely to challenge traditional professional and organisational models.

## **5. Promoting Quality, Safeguarding and protecting people**

It will be critical that, as we integrate service delivery, there is a clear path that ensures lessons are learned from safeguarding failures, clinical incidents, near misses, complaints and poor professional practice. Our strategic and operational governance framework will ensure this, so that accountability for professional practice is demonstrated.

We will embrace the Quality Delivery Plan for NHS Wales, "Achieving Excellence", utilising the skills and resources of the Community Health Council to focus on service improvement.

We will use peer review, PDSA, audits, LEAN and other evidence based improvement methodologies to reduce harm, variation and waste and find innovative solutions to meet service demands.

We already have well established regional Safeguarding boards for Children and Adults and will consider the national report on Safeguarding which is expected soon, to review current arrangements.

We are designing a new collaborative citizen focussed scrutiny body, which will help to ensure our integration journey leads to service improvement and makes life easier for people who rely on our services – a key demonstration of this will be fewer people "getting the run around and being passed from one sector to another".

We will work pro-actively with regulators and inspectors (primarily CSSIW and HIW) to develop new joint service models that can evidence delivery to acceptable standards. Where appropriate, we will work with regulators to develop rationalised regional regulatory frameworks, to avoid

duplication and, at the same time, ensure service delivery is safe and effective

We want our front-line professionals to be supported to deliver the highest quality services, which are evidence based and meet priority needs. We will regularly review national and international evidence to inform our work.

## **6. Fostering and sustaining innovation and learning**

We will encourage innovation, recognising that this requires a mature approach to managing risks. We will use the evidence from the national Health and Well-being Best Practice & Innovation Board, to create the right culture and environment for sharing and disseminating good ideas that flow from the front line to executive levels and vice versa, acknowledging that good ideas transcend hierarchies.

We want our NCNs to be learning organisations and will work with universities and other educational bodies to provide opportunities for under-graduate and post-graduate training and experience. We will encourage and support our staff to demonstrate continuous professional development, so that skills are enhanced to meet new and diverse demands. We will work with local and national improvement teams and agencies to achieve this goal.

## **7. Enabling tools and potential challenges**

### Financial mechanisms

The use of pooled budgets is already well-established for Community Equipment Services, with Torfaen LA acting as the lead commissioner; for Frailty services, with Caerphilly LA acting as the lead commissioner, Newport managing IFST programme and Blaenau Gwent will manage the SEWAS budget from April 2014. The forthcoming Intermediate Care Fund will also be pooled, with Caerphilly using the Frailty commissioning team to manage this fund on behalf of the partners. We will use the evidence from NHS Benchmarking England, as well as the King's fund evidence, to inform our development of a range of Intermediate Care solutions. We note the Deputy Minister may determine which particular services will require a pooled fund, through the SSWB (Wales) Bill and we are confident we can implement such a requirement fairly quickly. There will need to be a balance between pooling resources through an agreed Gwent wide service model and meeting specific local needs in a way that utilises the resources available locally. For example, some areas have well developed 3<sup>rd</sup> sector organisations that are able to deliver effective services that support older people and it will take time for current resources to be re-directed into new models. There are also potential skill or capacity gaps that will not be easily filled in each NCN area. We need

to explore whether a franchise model is acceptable, that is capable of embracing local contexts.

### Charging for care

We also recognise the complexity created through social care services that are chargeable (Most LAs derive more than 20% of their income through client charges), when most health services are free at the point of delivery. It is pleasing to note that the Minister has asked his officials to consider if and how a similar approach can be developed for some community health services (using similar mechanisms for dentistry and optical service charges), or how the local health and social care economy could be compensated for the potential loss of income if more services are integrated. We will endeavour to make rapid progress on integration, where that will improve service delivery, despite this challenge.

It is worth noting the local experience of social care charging regimes; some people are not prepared to pay for social care services, even when they have the means to do so and will manage without statutory support. Social Workers experience this on a regular basis, as people decline a service once a financial assessment has been completed. This supports the shift towards raising eligibility criteria for social care support that most councils' have implemented. Conversely, some Local Authorities experienced a significant increase in demand when a £50 weekly cap on charges was introduced, as people who had previously helped themselves, using their own resources, grasped the opportunity for the state to provide at a subsidised cost. This was experienced acutely in Vale of Glamorgan but also locally. In recognition of this, Welsh Government provided all Local Authorities with additional funds to offset some of the income foregone.

The Deputy Minister has recently published a policy update on charging, which confirms the current situation will be improved through a national framework for financial assessments and potential reforms from 2016.

### New delivery models

The opportunities to develop social enterprises and other new forms of service delivery will be explored during this testing phase. We recognise that some communities are more empowered and ready to take up the challenge of direct service delivery but we will need to support those areas where the conditions are not yet ready. We will encourage 3<sup>rd</sup> sector organisations and County Voluntary Councils to access the WCVA Well-being Bonds and other funding sources to pump prime new user-led services.

We will work with GP practices and their teams to maximise the potential of the new GP Contract in Wales. There is potential to work with other

primary care contractors to develop new responses that meet our priority needs.

Direct payments are widely used across Wales to deliver social care and this promotes independence. However, their use is patchy and for older people, is not as wide as we would like to see. Their use will be encouraged, building on the achievements to date, so that people are more empowered to design their own solutions when they have eligible care needs.

#### Workforce challenges

We have set out, above, the recruitment challenges, which will mean developing and employing new generic roles, who are able to support registered professionals. Further work needs to be undertaken, nationally and locally, to enable staff to more easily transfer their employment status between NHS, Local Authority, voluntary, independent or social enterprise sector organisations to maximise the potential and pace of integration. It may be helpful to develop national employment principles that secure pension and other rights for individuals who transfer to new organisations. We recognise that terms and conditions vary, and this poses particular challenges for multi-agency teams.

#### Embracing Technology and Information governance

New ways of engaging with people and providing information are being designed, including new Citizen Portals, social media and other forms of communication to promote easy access to support. We agree this requires full engagement of all stakeholders but also needs to take account of the wider family networks and community support, through linkages to other support systems, to ensure older people are well supported in their own homes. We will adapt new methods of using technology to communicate and provide professional assessment and support, recognising that some people do not have access to technologies or the infrastructure to support new ways of working.

We recognise the challenge for Welsh Government and statutory bodies to invest in new integrated IT systems, that would enable more effective integration at the person and service level. There is a role for NWIS and the Local Government Data Unit in supporting and facilitating this across Wales, whilst new systems are being procured. We already embrace WASPI, to ensure effective information sharing at the person level, which aids integrated working. The challenge of ensuring that professionals working with an individual within a family context and sharing information safely (with those who need to know) is significant and needs professional involvement at all levels to work through the ethical and confidentiality issues; such discussions would need to include clinical information systems to facilitate working out of hours and across the region. There

are plans to develop a more robust integrated information system and we will take advantage of that across the region.

Recent proposals being submitted under the Health Technology Fund will support the transformation to deliver integrated services by supporting web-based and mobile devices that enable clinical advice and professional assessments to be delivered within community settings. One of the key changes will be in supporting care homes to better manage older people with complex needs; to reduce unplanned admissions to hospitals and improve the quality of life for those who are not able to remain in their own homes, as it becomes more risky and challenging to meet their needs in a domestic setting. There is significant work to be done to support residential and nursing care home providers to improve the quality of care they provide, through offering specialist training and access to clinical expertise. We will use the findings of the review of residential care, conducted by the Older Person's Commissioner to develop a regional improvement action plan, in collaboration with residents and provider staff.

#### Co-production and commissioning services

Our partners in the third sector and independent care home sector need to be more fully involved in planning and improving service delivery, maximising the mutuality of commissioner/provider relationships through a co-operative approach. A key challenge for commissioning these services will be to take a longer term view and ensure sufficient capacity and flexibility in the market is developed where needed. Each Local Authority is currently developing its market position statements to inform commissioning intentions and these will be ready by end of March 2014. The aim will be to develop joint commissioning plans to meet the health, housing and social care needs of older people and there are areas of good practice that can be adopted locally.

#### The Estate

We recognise that our primary, community and social care estate will require a significant investment and development over time but it will not be sustainable or affordable to develop every site. Opportunities to co-locate multi-agency teams will be considered, to maximise the available public sector asset in each NCN area. GP Practices will increasingly collaborate to deliver some services across a federated network and some community services may be of a more specialist nature and will only be available at a borough or regional level, to ensure skills are maintained and economies of scale delivered. The potential to utilise housing stock, vested in Local Authorities or RSLs, to better meet complex health and social care needs is being actively explored through our "In One Place" programme and for our Intermediate Care proposal.

### **8 - Progress against the core planning issues**

We will have finalised the design of our new governance framework by April 2014 and this will be the overarching mechanism to drive through integration. We will develop terms of reference and agree membership of the key decision making groups, so there is a clear mechanism for developing and agreeing new service models and determining how resources are to be utilised. Each of the Local Authority Cabinets and the Aneurin Bevan Health Board will be asked to formally endorse the new arrangements, once they have been finalised. This Statement of Intent will form part of the governance framework and it will be published on all agencies' websites, once it has been accepted by the relevant statutory bodies.

We have considered the King's Fund evidence and will take this work further, through facilitated regional sessions, led by WHISC via the Strengthening the Connections collaborative programme. This independent assessment will be completed in April 2014. The outcome of the assessment will be to engender ownership of the baseline position and formulate the critical issues that we will prioritise to deliver pace on integration.

The Maturity Matrix & assessing the current position:

We held a specific workshop in November to assess our position and developed a SWOT analysis (Appendix 2)

In December, we held an independently facilitated event, to take stock on our Frailty Programme, to ensure our re-modelled services are still on track to deliver our vision. The outcome of that event is attached (Appendix 3). These two key events have been used to inform our response to the Framework for Integration and to develop the Action Plan (Appendix 4) and to inform the forthcoming proposal to enhance technology and develop Intermediate Care services.

We are currently assessing ourselves within the Range of 2/3 of the Maturity Matrix, with some variation in progress across the region and our aim will be to progress along the matrix over the next 3 years, aiming to reach Level 4 by March 2015.

## **9 – Creating the Pace for delivery**

Change of this nature will be both challenging and rewarding for all those involved in the transformation. Champions for change will need to be found and nurtured at all levels and in all organisations. The investment

in developing a shared vision and agreed outcomes for each service type will help foster shared ownership and effective working relationships and practices, which are fundamental to success. We can build on our Frailty Programme to promote and enhance the “Happily Independent” vision and strategy to meet the needs of older people with complex needs.

The intention is to use the independent facilitation and knowledge of best practice that WIHSC will bring to the region during our baseline assessment and prioritisation process. We will also use this work to develop new or refresh existing joint outcome statements and performance indicators, reflecting those set out in the consultation document and any that may emerge when the substantive guidance is produced.

ABHB have recently appointed a dedicated Director post to lead on the integration work for the NHS and the 5 LAs will complement this by using the SSWB Transformation Fund and the Intermediate Care Fund to develop a new senior role to work alongside the Integration Director, so that integration can be jointly delivered at pace.

Our Action Plan (Appendix 4) sets out our journey and emerging priorities, which will be amended when feedback from WG is received and when we have completed our work with WIHSC.

## **10 - Measuring Success**

Success will be demonstrated when citizens tell us that:

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

Success for organisations should include staff who are motivated and capable of delivering quality, evidence based services and financial, human and physical resources are aligned, effective and efficient

We are mindful of and support the government’s aspiration to develop national outcome indicators that are more meaningful to citizens and front-line staff. However, we recognise that we also need to ensure we are able to account for how public resources are used, so that standards, targets and PIs can be benchmarked to ensure quality and VFM; recognising that health improvement and service transformation takes time to deliver the expected improvements.

Any change in the way we measure performance needs to empower professionals to seek continuous improvement. One of the challenges is to move away from counting processes, tasks and timescales, which have

largely dominated the public sector. There is much work to be done at a national and local level to achieve this and many organisations are adopting RBA approaches at Local Service Board and service levels, which help to shift the emphasis to outcomes, which transcend organisational and professional boundaries. We will consider adopting this approach for some services.

We will use the learning from the independent review of our Frailty programme to inform future performance measures for older people with complex needs.

On a more global level and in terms of integration, we will use the maturity matrix to annually review progress at NCN, borough and regional level. We will also use the evaluation framework for service integration, currently being developed by Swansea University, through the auspices of the national ESG Board.

One of our key principles is to use evidence to inform decision making at both a strategic and operational level. We will contribute to research and share best practice across Wales, so that we can deliver integration at scale and pace.

**Report Prepared by :**

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**Date : 28 March 2014**

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