Community Planning & Development Scrutiny Committee

Part 1
10 September 2014
Item No. 6

Subject Integrated Pathway for Older People

Purpose To present a report on the new pilot for an integrated pathway for older people for consideration.

Author Overview & Scrutiny Officer; Head of Integrated Services Social Care & Health.

Ward General

Summary In the meeting held on 23 April 2014 the Committee considered the Draft Carers Strategy and an update from ABHB on activity to support Carers across Gwent. Members were advised of a new initiative looking at an integrated pathway for older people, to be piloted in West Newport linked to a GP practice, hopefully from July. This would provide an early intervention team delivering a more flexible community service, aiming to highlight different ways of working with adults who are very frail and aren’t getting the resolutions they need through current services. It was agreed that a report on the new pilot for an integrated pathway for older people would be presented to the September Committee meeting for consideration.

Proposal To consider the progress to date in establishing the integrated pathway for older people being piloted in West Newport and provide any comments for consideration.

Action by Head of Integrated Services Social Care & Health.

Timetable As reported
This report was prepared after consultation with:

- Head of Law & Standards;
- Head of Finance;
- Head of People and Transformation.

Background

Demographic changes and other trends in Wales mean that there is increased demand for both acute and community care services for older people, particularly those aged 85 and more. Frailty, dementia and the effects of multiple chronic conditions are more prevalent in this population group than in any other. Wales overall has the highest rate of growth for those aged 85 years and over of the UK countries. In Newport it is projected that the number of people aged over 85 will increase by 74%, to 6,000 in 2030.

With the projected increase in the older population and the additional pressures this will bring on statutory services, new ways of working are needed to best ensure these services can cope with the demand while still providing excellent levels of care. Managing future demand will now focus on prevention and treating citizens before they reach a crisis point. The undertaking of this however is often hindered by silo working practices with traditional thinking tending to separate citizens into pathways of ‘acute’, ‘primary’ or ‘social’, when in fact these are all interdependent and require effective collaboration and integration between social care and health.

With this in mind, a task group of NHS, Third Sector and local authority social care leaders has been working with and advising the Welsh Government who published a Framework for delivering integrated care for older people to help meet the anticipated demand of caring for the elderly. It is now up to local government and regional health boards to implement this. The intended outcomes are:

- A “consciously planned and managed system” that reduces barriers between local partners and is centred around patient care
- Co-production between communities and services for the needs of service users, and developing new services where those needs are not met.

To aid in this, the Welsh Government have set up an Intermediate Care Fund (ICF) and £50 million in funding is available for 2014/15, of which £700k has been awarded to Newport City Council to support this programme along with the introduction of ‘Step Down’ facilities for people leaving hospital. This will be used to achieve greater integration of social services, health and housing in order to deliver lasting and sustainable change.

The purpose is to support people and allow them to remain ‘happily independent’ in their home for as long as possible. It is therefore intended that the fund will help prevent unnecessary hospital admissions or inappropriate admission to residential care and to
prevent delayed discharges from hospital. The fund will target strategic projects, in particular those that:

- Improve care co-ordination between social services, health and housing to prevent hospital admission and delayed discharge for older people
- Promote and maximise independent living opportunities in response to referrals from health and care services
- Promote recovery and recuperation at home or through the provision of convalescence beds in the community setting.

To this purpose, Newport City Council have partnered with Aneurin Bevan Health Board (ABHB) to deliver an integrated pathway for the older people that reside within Newport, the primary objectives of which include:

- To keep people living safely and independently in their own homes
- Avoid unnecessary admission into institutionalised care
- Develop effective anticipatory care planning with care wrapped around the individual
- Development of a continuum of multi-agency provision, deploying the right resources at the right time in a holistic manner
- Develop capacity for effective early prevention
- Develop outcome focused service provision within a community setting as an alternative to primary care

It is imperative that this programme is aligned to existing strategies and considers current initiatives across both organisations, to avoid duplication or conflicting priorities. For example, ABHB responding to the vision of integrated health and social care outlined by the Welsh Government in 2011 are already integrating services as seen by the development of their Neighbourhood Care Networks. The Neighbourhood Care Networks have been established to incorporate representation from public health, local authorities, hospital consultants, housing and third sector organisations. As a result they are in ideal position to act as vehicles for change and the creation of a NCN Delivery Network to ensure delivery of the pathway, with patient focused and fit for purpose services to meet the future needs of the local population they serve, is critical to the effectiveness of this model.

The ICF funding has allowed not just the local authority and the health board to work in real partnership together, but numerous 3rd sector organisations such as Age Cymru and Care and Repair have also been engaged to aid in the delivery of the pathway. This cross-sector partnership is fully committed to the above goals, with staff at all levels across the organisations excited for what they deem to be a real change in the way the system works, with the hope that a real difference is felt by the most important person – the citizen.

To facilitate the integration, IC funding has been used to develop integrated assessment forms and anticipatory care plans that can be used by both the local authority, health board and agreed partners. In addition funding has also been used to expand the capabilities of an existing portal system to allow all clinical and social care staff access to these.
A new ‘bespoke’ role has been created that is critical to the success of the programme – the Care Facilitator. The facilitator will not only identify citizens that would benefit from preventative services through risk stratification, but they will help coordinate with health, social and third sector teams to ensure the citizen receives the right care, at the right time, in way that best meets their personalised outcomes.

The pathway requires sharing of sensitive patient data between health and social care services, as such existing information sharing protocols were updated to ensure the pilot was in compliance with these and all aspects of the Data Protection Act 1998. Letters were sent out to a cohort of citizens to seek their permission to participate in the pilot, and their agreement that relevant clinical and social care data pertaining to them would be shared with our partners involved in the pilot.

The pilot for the pathway will run for a period of 8 months following which a robust evaluation of the programme will take place. Key milestone dates are laid out below:

- 31st March 2014 – sign off for the proposed operating model/ pathway to deliver the primary objective – admission avoidance to institutionalised care – Signed off and Frailty agreed as the delivery mechanism for the pilot
- 1st July 2014 – pilot for initial target group goes live – agreed that the pilot will commence in the West of Newport – Pilot has launched
- February 2015 – pilot is fully evaluated and if effective in meeting primary objective the model is rolled out across Newport
- March 2015 – consider extension of the model/ pathway to focus on those individuals identified through appropriate risk stratification as at risk of admission to institutionalised care in the immediate future, shifting to early identification and prevention.

For the duration of the pilot the OP Pathway Programme Board will remain in place to act as a point of escalation and ensure the objectives of the programme are achieved. The Board meets monthly and includes senior representation from both Adult Social Care and Aneurin Bevan Health Board including Community Services and GPs.

The pilot has received funding to operate to the end of this financial year 2014/15. The costs associated with the pilot are all one off costs except the role of the Care Facilitator which if the pilot were to be expanded and continued, would need to be funded. There are no additional staffing issues or workforce related issues, as given the numbers to be included in the pilot and the phased process of assessing then assigning to case-loads, we anticipate the additional demand can be absorbed within existing resource requirements - this will be reviewed part way through the pilot. Work to be carried out by the community connectors and through engagement of the voluntary sector will create sustainable capacity within the community that should outlast the lifespan of the pilot.

**Financial Summary:**
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<td>£117,600</td>
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<td>£26,000 secondment cost for Care Facilitator</td>
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<td>Capacity amongst Health and Social Care colleagues to support the programme</td>
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<td>L</td>
<td></td>
<td>Ensure senior management buy in to the programme and prioritise resources appropriately. May also be opportunity to secure additional funding</td>
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**Engagement from clinicians and GPs**

Engage all stakeholders from the outset, identify key benefits to each stakeholder group and involve them in the development of the pathway and subsequent evaluation against these.

**Data sharing protocols between multiple systems**

Confirm existing protocols and establish any changes required so staff can access multiple systems.

**The pathway encourages unnecessary wrap around care increasing dependency on partners services**

Staff receive training in outcome focused care planning in order to reduce dependency and a QA process is installed.

**Given the age of the cohort, there is a risk of some natural degradation due to age of the pilot group, this may affect the findings of the evaluation as long term outcomes cannot be measured.**

Having the Care Facilitator based in the practice hopefully will encourage GPs to widen this cohort if they see it is effective. Also this risk needs to be evaluated during the course of the pilot and a recommendation made to widen the cohort if felt appropriate.

**Links to Council Policies and Priorities**

To make our city a better place to live for all our citizens

The pathway will ensure that for our older citizens, they receive the best care from all appropriate services rather than being pushed down a single pathway of care. This holistic approach will see citizens being proactively managed to ensure they avoid a crises and are able to stay ‘happily independent’ within their own home for as long as possible.

With a strong push on creating capacity in the community and by engaging the voluntary sector, it is hoped that there will be greater community cohesion and more informal avenues of care for our older citizens so that they do not suffer in silence or risk being socially isolated. It is hoped this will be one of the sustainable outcomes of the programme which will continue after the pilot has ended.
To be good at what we do

The pathway will ensure that citizens receive the best care available to them, by expanding on current best practice and reducing areas of duplication and waste. This will ensure that pathway operates in an efficient cost effective manner to both the Local Authority and the Health Board while not compromising on the quality of care a citizen will receive.

By being co-produced by health and social care, staff in Newport are well placed going forward to meet the aims of likely future Government policy on integration of health and social care services, with disputes less likely to happen and established relationships being able to push and promote change more readily in the future.

The pilot has aligned itself with other initiatives that are operating in tandem to ensure that all similar programmes are working together with a common goal and vision and reduce any risk of duplicating work.

To work hard to provide what our citizens tell us they need

The Local Authority and the Health Board have held a number of listening events in which older people and their carers were invited to voice their opinions on the care they currently receive. The feedback from these events has informed part of the direction of this pilot. This has included:

- a named care professional to act as a single point of contact who manages and knows the care needs of the citizen and provides continuity of care
- better data sharing between services, so that citizens are not repeating themselves to different care professionals
- having their personal outcomes inform the care they receive rather than being dictated to by a clinician

These opinions are by no way unique to Newport and indeed this is seen replicated across the UK. The Older person’s pilot has been developed in such a way that the views stated have been addressed.

Options Considered/Available

<table>
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<tr>
<td>Option 1 - Do nothing</td>
<td>Carry on with current procedures and practices with no change</td>
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<tr>
<td>Option 2 – Work in isolation of Health</td>
<td>Attempt to reform and change care provision in isolation from health</td>
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<tr>
<td>Option 3 - Integrate with Health</td>
<td>Reform and co-produce change in tandem with health</td>
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Preferred choice and reasons

Option 3 - Integrating with Health was the chosen way forward, as the other options would put the Council in conflict with the Welsh Government directive for integrating care. Given the complex health needs of the older population, to make any reform without consulting or including the health board would be detrimental to the Authority and its citizens, as social care and health needs can no longer be seen to be independent of each other given the huge impact each has on the other.

By integrating with health, we can ensure citizens receive ‘better outcomes’ to their general well-being which includes their physical, mental and social needs. This can be achieved through integrated assessment and care planning undertaken by a multi-disciplinary team of health and care professionals.

In addition to better outcomes for individuals, working in an integrated approach will reduce duplication and unnecessary hand offs, driving efficiency, service improvement and ensuring maximum utilisation of resources.

The pressure in respect of future demand for services is once that is faced by both organisations, by working together and developing joint strategies, ideas are shared, best practice encouraged and the risk of conflicting priorities and duplication eradicated.

Comments of Chief Financial Officer

The ICF grant funding awarded to Newport in 14/15 equates to £778 in revenue and £560k capital. The potential on-going resource needed for the role of the Care Facilitator, which if the pilot were to be continued, would need to be funded could cause pressures if the existing resource was not sufficient to cope with on-going demand. Apart from this issue, there is no financial impact in 14/15 as all expenditure relating to the pilot will be met from the ICF Grant.

Comments of Monitoring Officer

There are no specific legal issues arising from the Report. The pilot project for the Integrated Pathway for Older People has been developed and implemented in accordance with statutory guidance and is consistent with the requirement for integration of social care and health services, which is reinforced by the statutory duties imposed under the Social Services and Well-Being Wales Act 2014.

Staffing Implications-: Comments of Head of People and Transformation

There are no direct HR implications within this report
Local issues
None

Consultation

The pathway has been developed in consultation with the Aneurin Bevan Health Board and representation from the third sector including the British Red Cross, Age Cymru and Care and Repair. A series of workshops were held with attendance from all partners who subsequently provided input into the agreed model for the pilot.

In April 2014, an Older Person’s listening event was held in Newport to gain the views of patients and carers on the current care they receive, and what they would like to see differently. The feedback from this event has also been used to inform parts of the pathway.

There has been further consultation with GPs and patients from St David’s GP Practice who were identified to participate in the pilot.

Background Papers

- Elderly Integrated Pathway - Outline Business Case
- Welsh Government Consultation Document – A framework for delivering integrated health and social care
- Intermediate Care Fund Case Study
Project Start up Document

Elderly Integrated Pathway

Project Manager: Maggie Kenney
Project Sponsor: Mike Nicholson, Danny Antebi, Gary Hicks
Date Published: 5th March 2014
Version: 1.0
**PROGRAMME START UP DOCUMENT**

**Version Control:**

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<td>Katrina Rowlands</td>
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<td>Gary Hicks</td>
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**PROGRAMME BOARD:**

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<tr>
<th>Name</th>
<th>Project role</th>
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<tr>
<td>Mike Nicholson</td>
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1. INTRODUCTION AND BACKGROUND

Demographic changes and other trends in Wales mean that there is increased demand for both acute and community care services for older people, particularly those aged 85 and more. Frailty, dementia and the effects of multiple chronic conditions are more prevalent in this population group than in any other. Wales overall has the highest rate of growth for those aged 85 years and over of the UK countries. In Newport it is projected that the number of people aged over 85 will increase by 74%, to 6,000 in 2030.

A task group of NHS, Third Sector and local authority social care leaders has been working with and advising the Welsh Government who published a Framework for delivering integrated care for older people. It is now up to local government and regional health boards to implement this. The intended outcomes are:

- A “consciously planned and managed system” that reduces barriers between local partners and is centred around patient care
- Co-production between communities and services for the needs of service users, and developing new services where those needs are not met.

To aid in this, the Welsh Government have set up an Intermediate Care Fund (ICF) and £50 million in funding is available for 2014/15. This will be used to achieve greater integration of social services, health and housing in order to deliver lasting and sustainable change.

The purpose is to support people and allow them to remain ‘happily independent’ in their home for as long as possible. It is therefore intended that the fund will help prevent unnecessary hospital admissions or inappropriate admission to residential care and to prevent delayed discharges from hospital. The fund will target strategic projects, in particular those that:

- Improve care co-ordination between social services, health and housing to prevent hospital admission and delayed discharge for older people
- Promote and maximise independent living opportunities in response to referrals from health and care services
- Promote recovery and recuperation at home or through the provision of convalescence beds in the community setting.

Aligned to the requirements of the ICF, the Aneurin Bevan Health Board (ABHB) and Newport City Council are working in partnership to deliver an integrated pathway for elderly people living in Newport. This will be focused around patient centred co-ordinated care, with individuals benefiting from a single holistic care plan accessible to all practitioners and delivered in an appropriate environment. This will not only improve the outcomes
for patients/ service users, but will in turn drive efficiency and economies of scale ensuring a Return on Investment that justifies community focused funding. It is also imperative that this programme is aligned to existing strategies and considers current initiatives across both organisations, to avoid duplication or conflicting priorities. For example the ABHB responding to the vision of integrated health and social care outlined by the Welsh Government in 2011, are already integrating services as seen by the development of their Neighbourhood Care Networks.

The Neighbourhood Care Networks have been established to incorporate representation from public health, local authorities, GPs, housing and third sector organisations. As a result they are in ideal position to act as vehicles for change to ensure delivery of service, which are patient focused and fit for purpose to meet the future needs of the local population they serve and therefore need to be a key consideration for this programme moving forward.

2. PROJECT OBJECTIVES

The primary objectives of an effective integrated care pathway for older people living in Newport will be:

- To keep people living safely and independently in their own homes
- Avoid unnecessary admission into institutionalised care
- Develop effective anticipatory care planning with care wrapped around the individual
- Development of a continuum of multi-agency provision, deploying the right resources at the right time in a holistic manner
- Develop capacity for effective early prevention
- Develop outcome focused service provision within a community setting as an alternative to primary care

3. PROJECT CONSTRAINTS & DEPENDANCIES –

Constraints –
An integrated pathway for delivery of coordinated care cannot be implemented in isolation. It will require engagement and investment from social services, health as well as the third sector, in order to develop effective pathways in support of the primary objectives.

- With a pilot tentatively set to start in July, not all the features of a long term solution will be in place or ready by July, meaning the pilot and its outcomes should focus on what is achievable by then.
Resources from existing teams may need ring-fencing to deliver the new pathway requiring back fill of their posts.

Dependencies –

- Pursuing a community based prevention strategy is dependent upon the development of outcome focused support services within the community.
- Several data systems are in place, with social services, ABHB and GPs using a plethora of systems, data sharing and governance issues must be addressed early on, as access to systems is a critical factor for the project to succeed.
- As above, the data held on various systems when pertaining to a desired service user in the pathway, must be accessible and visible by all social workers and clinicians.
- Care coordinator in the MDT team will need sufficient training and knowledge of all services available to a patients / service users and act as a font of all knowledge.
- Significant cultural changes in organisational thinking must be achieved in order for the new pathway to develop and succeed. It is imperative that this pathway does not increase dependency and therefore cost.
- An agreement with patients to allow access to their records is required so that base line performance data can be obtained.
- Templates for an integrated assessment and co-ordinated outcome focused care plan require development and agreement.
- It is essential that outcomes in order to evaluate the success of the pathway are agreed and tracked through the use of key performance indicators and baselines.

4. PROJECT STRUCTURE –

Maggie Kenney – CE Peopletoo is the designated Project Manager for the Programme.

The Project Manager reports directly into the Elderly Integrated Pathway Board. The Board has senior representation from across Health and Social Care and attendees are detailed below:

<table>
<thead>
<tr>
<th>Name</th>
<th>Organisation</th>
<th>Role</th>
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<tbody>
<tr>
<td>Mike Nicholson</td>
<td>NCC</td>
<td>Project Sponsor</td>
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<tr>
<td>Jonathan Griffiths</td>
<td>NCC</td>
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4.1 Roles & Responsibilities

**Project Sponsor** – Will approve the project mandate and approve the project team and project board composition.

**Project Board** – The role of the Board is to:

- To set a strategic direction and the primary objectives of the programme.
- To lead the Older Persons Integrated Care Pathway programme and oversees progress.
- Each member is responsible for communicating and obtaining sign off from their respective organisation and ensuring key stakeholders remain engaged and informed.
- To act as the point of escalation for the programme.
- To manage project risks and issues, and support mitigation or resolution of risk and issues that cannot be controlled by work stream leads.
- To commit (or source from elsewhere) resources across the project to ensure activities will be successfully achieved

**Project Manager** – Will be responsible for the day to day management of the project. Will be responsible for ensuring work is completed on time and in accordance with the project plan. While the Project Manager is responsible for day to day management, team members will be responsible for completing assigned activity.

**Workstreams** – It is proposed that workstreams will be developed to in accordance with the agreed implementation plan in order to undertake assigned activity. These workstreams will be coordinated by the Project Manager.
6. SCOPE –

The initial target group for the new pathway will be those individuals 75+ who are already accessing multiple services; delivering tangible benefits to Health and Social Care through reduction in spend on institutionalised care, as well as improved outcomes for patients and service users.

Once the pathway has been proven for this target group the scope will be extended to those who are identified through appropriate risk stratification as at risk of admission to institutionalised care in the immediate future. The focus will therefore shift to early identification and prevention. The objective of this second phase will be to manage increasing demand through cost avoidance.

It is imperative that this programme considers and is aligned to the wider strategy across the Health and Social Care arena in Wales when developing the pathway, with particular reference to the ABHB Neighbourhood Care Network Strategic Plan 2013 – 2018 as referred to earlier in this report.

7. DELIVERABLES –

➢ Development and sign off of a model to successfully deliver an elderly integrated pathway to meet the primary objectives – admission avoidance to institutionalised care.

➢ Detailed business case in line with the agreed model to incorporate:
  - Comprehensive Demand / Data Analysis
  - Detailed Financial Plan/ Return on Investment model
  - Detailed Operating Model
    - Processes mapped
    - Uniform working practices developed
    - Structure outlined
    - Skills gap analysis undertaken
    - Location and non-salary costs identified
  - Outcome framework and evaluation methodology
  - IT Strategy
  - Commissioning Strategy
  - Communications Plan
  - Data Sharing Protocol
Detailed Implementation Plan/ Key Dependencies/ Resource Plan

Overarching Comprehensive Report Incorporating:
  o Governance model
  o Partnership working principles
  o Risk and issues analysis

- Commencement of the pilot of the new model in the West of Newport
- Evaluation of the pilot
- Roll out of pilot across Newport
- Extend focus to incorporate Early Identification and Prevention

8. BENEFITS –

Non-financial -

- Person centred holistic care plan developed for those individuals identified initially for the pilot and then on roll out through the risk stratification model – key performance indicator to be defined
- Improved patient and service user experience - measured through patient and service user feedback

Financial –

Prior to commencement of the pilot both Health and Social Care financial data will analysed and a baseline of current spend established against which to measure the financial benefits detailed below:

- Reduction in spend on institutionalised care – for target group
- Analysis of spend on community / primary care pre and post pilot – for target group
- Reduction in spend on social care package – for target group

9. BUDGET –

The pilot will be funded through the redistribution of resources and funding secured through the Integrated Care Fund.
Whilst it is recognised in the ABHB Neighbourhood Care Network Strategic Plan 2013 - 2018 that there will be a transfer of activity from acute to primary and community services relevant to agreed pathways longer term, post evaluation of the pilot and prior to formal roll out of the model if deemed successful, a robust Return on Investment for each organisation must be evidenced.

11. MILESTONES AND TIMESCALES TO ACHIEVE OUTCOMES –

Refer to the project plan in Appendix A, please note this is a working document.

In summary:

**31st March 2014** – sign off for the proposed operating model/ pathway to deliver the primary objective – admission avoidance to institutionalised care

**1st July 2014** – pilot for initial target group goes live – agreed that the pilot will commence in the West of Newport

**February 2015** – pilot is fully evaluated and if effective in meeting primary objective the model is rolled out across Newport

**March 2015** – consider extension of the model/ pathway to focus on those individuals identified through appropriate risk stratification as at risk of admission to institutionalised care in the immediate future, shifting to early identification and prevention.
### 10. KEY RISKS IDENTIFIED –

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<th>Mitigating Actions</th>
<th>Comment/ Update</th>
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<td>R3</td>
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<td>R4</td>
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11. KEY STAKEHOLDERS MAPPING –

Please note that wider stakeholder engagement to commence April ’14.

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<th>Stakeholder</th>
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<th>Current Influence (high to low)</th>
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<td>Social Workers</td>
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12. EVALUATION CRITERIA –

Evaluation for the pilot to be defined and agreed as part of the Detailed Business Case, however key critical success factors include:

- Reduction in institutionalised beds days for pilot group
- Reduction in unscheduled reviews undertaken by social care for pilot group
- Reduction in GP visits for pilot group
- Improved Health and Wellbeing – measured before and post pilot
## NEWPORT OP INTERGRATION PATHWAY: PROJECT PLAN

### Date: 17/02/2004

<table>
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A Framework for Delivering Integrated Health and Social Care
For Older People with Complex Needs

Date of issue: 22 July 2013
Action required: Responses by 31 October 2013
Overview
Demographic and other trends in Wales mean that there is increased demand for both acute and community care services for older people, particularly those aged 85 and more. Frailty, dementia and the effects of multiple chronic conditions are more prevalent in this population group. Building on investment in collaborative working over the last ten years and more, Ministers believe that these changes require a new prioritised and robust response to integrate health and social services for older people with complex needs.

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

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

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

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

How to respond
Please respond by email or in hard copy

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

Email: FrameworkIntegratedServicesOlderPeopleComplexNeeds@wales.gsi.gov.uk

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

Contact details
For further information:

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

Email: FrameworkIntegratedServicesOlderPeopleComplexNeeds@wales.gsi.gov.uk

Data protection
How the views and information you give us will be used

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

The Welsh Government intends to publish a summary of the responses to this document. We may also publish responses in full. Normally, the name and address (or part of the address) of the person or organisation who sent the response are published with the response. This helps to show that the consultation was
carried out properly. If you do not want your name or address published, please tell us this in writing when you send your response. We will then blank them out.

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

Joint Foreword

1. Overview and Strategic Context
2. The Case for Change
3. What do we want to achieve?
4. Making it Happen
5. Measuring Success
6. The next steps

Annexe A - Maturity Matrix
Joint Foreword

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

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

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

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

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

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

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

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

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

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

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

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

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

The essential elements are that:

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

This framework:

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

It is anticipated that this approach will make health and social care outcomes better and more consistent. and strengthen community-based care. Good multi-disciplinary assessment will become standard practice, the role of the GP more central, and
early intervention, reablement and intermediate care part of a single co-ordinated system. Dignity and privacy will be protected.

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

2. The Case for Change

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

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

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

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

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

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

Refocusing services, then, is a high priority area. Integrated models can better meet older people needs. They can also help address the increasing demand for care and support both now and in the future. Not changing is simply not an option. Urgent action is needed.
Change is achievable. There are already many examples across Wales of good integrated working including through: single agency responsibility for certain mental health services, integrated children’s services - Integrated Family Support Service and Families First, integrated hospital discharge services, joint reablement and rehabilitation services and joint equipment stores. The Welsh Government ‘Invest to Save’ funding already supports frailty service models across much of Wales. On an on-going basis, the Invest to Save process, the Regional Collaboration Fund and the Wales Council for Voluntary Action’s Wales Wellbeing Bond provide partners with access to resources to support further development.

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

3. What do we want to achieve?

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

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

   - preventative interventions that stop an avoidable slide into increasing dependency upon services;
   - locating and linking services in community settings with smooth transitions between different elements and into more specialised services;
   - creating fully integrated referral pathways that enable service users too easily cross organisational and sectoral boundaries without any harm or loss;
   - capturing once, and addressing all the needs of the service user
   - a balanced set of services operating where necessary 24 hours a day, integrating early intervention services, support for independent living, rehabilitation and reablement, intermediate care, end of life care and pathways into specialist services and less often used services;
   - full engagement all parts of secondary care focusing especially on those points of the pathway where the risk of undermining independence is greatest;
   - enabling service users to take part in developing their plan of care, with a named single point of contact, and to express their views regarding how the care is delivered;
• enabling carers to take part in developing the plan of care, receive an assessment of their support needs, have access to relevant, up-to-date and targeted information at every stage and express their views regarding how the care is delivered;

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

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

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

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

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

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

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

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

In doing so they should draw on the mass of evidence that suggests that, while there are many ways of integrating care, the key principles remain consistent. These have been helpfully summarised by the King’s Fund¹ and based on their work sixteen issues are set out in the box below that must be taken into account in developing and mainstreaming integrated services for older people over the next three years.

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

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

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

¹ Making integrated care happen at scale and pace: Lessons from experience. London: King’s Fund, March 2013
The Statement must include the baseline assessment required under 1 above and set out clearly how:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Responses should be sent by 31 October to:

Social Services Directorate
Department of Health and Social Services
Welsh Government
Crown Buildings
Cathays Park
Cardiff
CF10 3 NQ
# A Maturity Matrix to Support Health and Social Care Integrated Care Partnerships

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

<table>
<thead>
<tr>
<th>Progress Levels</th>
<th>Key Elements</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purpose and vision</td>
<td></td>
<td>Purpose deleted and agreed. Value and priorities agreed, and documented. Political agreement to integration confirmed and documented across Health, Social Care, Third Sector and Partners. ‘Health and Social Care Integration Partnership’ (HASCIP) understands its role.</td>
<td>Early progress</td>
<td>Early progress in development</td>
<td>Results</td>
<td>Initial achievements evident</td>
<td>Maturity</td>
</tr>
<tr>
<td>Strategy</td>
<td>All stakeholder strategies relevant to work gathered and timetabled set for developing integrated strategy. Basis for all HASCIP strategic decisions. Political sign-off of strategy by all partners.</td>
<td>Strategy development underway. Arrangements in place for areas of joint planning/commissioning and investment opportunities.</td>
<td></td>
<td></td>
<td>Systematically matching how purpose dovetails with population needs. Evidence that integrated care is enhancing the quality of services and experience for the citizen.</td>
<td></td>
<td>Confidence in achieving purpose and vision as population health benefitting in accordance with plans. Local health planning, local authority commissioners, third sector and other partners have been influenced. Evidence of reduction in waste and duplication through tackling duplication and fragmentation.</td>
</tr>
<tr>
<td>Leadership of the local health and social care integration economy</td>
<td>‘HASCIP’ leadership agreed and appointed. Key stakeholders aware of leaders and how to contact. Relevant stakeholders identified and invited to participate. Local health, social care, third sector and partner resource understood.</td>
<td>Leadership development underway. Arrangements in place for areas of joint planning/commissioning and investment opportunities.</td>
<td></td>
<td></td>
<td>Results of partnership working systematically reviewed. Relationships with partners are positive and ongoing dialogue about planning, commissioning, contracting decisions and joint investment opportunities. Public health voice is evident in decisions.</td>
<td></td>
<td>Strategy refined in light of successful achievement of milestones, and new intelligence and aspirations.</td>
</tr>
<tr>
<td>Governance</td>
<td></td>
<td>Membership and terms of reference for the HASCIP Board drafted and shared.</td>
<td></td>
<td></td>
<td>Results of leadership approach. Ongoing succession plans in place. Benefits of partnership working have enabled the majority of stakeholders to meet their improvement objectives and resource allocation.</td>
<td></td>
<td>Benefits of partnership working have enabled majority of stakeholders to avoid their improvement objectives. Outcomes improved and this is a return back to initiatives from the HASCIP.</td>
</tr>
<tr>
<td>Information and intelligence</td>
<td>Information requirements identified and format of initial dashboard agreed</td>
<td>Developed a dashboard of key information and information improvement contours. Key indicators reflect shared performance objectives across health, social care and partners</td>
<td></td>
<td></td>
<td>HASCIP report confidence with levels of intelligence they receive, and that information systems are reliable and working. HASCIP evolving evidence of performance improvement against KPIs.</td>
<td></td>
<td>HASCIP informed by real-time intelligence, demonstrating improved outcomes, quality and efficiency across health and social care.</td>
</tr>
<tr>
<td>Expertise and skills</td>
<td>Skills and expertise for HASCIP have been identified and agreed</td>
<td>Induction and development plans for HASCIP partners and staff are up and running</td>
<td></td>
<td></td>
<td>The HASCIP influencing skills are evident by success in positive change to local planning and the pattern of local service provision.</td>
<td></td>
<td>The HASCIP influences LHs, Local Authorities, Third Sector and partners by valuing key planning skills. The HASCIP Board acts as a forum to bring in specialist skills and expertise to support planning/commissioning.</td>
</tr>
</tbody>
</table>

*The HASCIP is a generic term for the purpose of this matrix. Please replace with your local equivalent.*

Source: Adapted from the London Health and Wellbeing Board Maturity Matrix
Intermediate Care Fund Case Study

Older Persons Integrated Care Pathway - Newport City Council and Aneurin Bevan Health Board

With the need to reduce pressure on the acute and focus care in the community as well as manage future demand through prevention, integrated care is now a key focus for Health and Social Care across the UK. The undertaking of this however is often hindered by silo working practices with traditional thinking tending to separate citizens into pathways of ‘acute’, ‘primary’ or ‘social’, when in fact these are all interdependent and require effective collaboration and integration between social care and health.

To this purpose, Newport City Council have partnered with Aneurin Bevan Health Board (ABHB) to deliver an integrated pathway for the older people that reside within Newport, the primary objectives of which include:

- To keep people living safely and independently in their own homes
- Avoid unnecessary admission into institutionalised care
- Develop effective anticipatory care planning with care wrapped around the individual
- Development of a continuum of multi-agency provision, deploying the right resources at the right time in a holistic manner
- Develop capacity for effective early prevention
- Develop outcome focused service provision within a community setting as an alternative to primary care

It is imperative that this programme is aligned to existing strategies and considers current initiatives across both organisations, to avoid duplication or conflicting priorities. For example the ABHB responding to the vision of integrated health and social care outlined by the Welsh Government in 2011, are already integrating services as seen by the development of their Neighbourhood Care Networks. The Neighbourhood Care Networks have been established to incorporate representation from public health, local authorities, hospital consultants, housing and third sector organisations. As a result they are in ideal position to act as vehicles for change and the creation of a NCN Delivery Network to ensure delivery of the pathway, with patient focused and fit for purpose services to meet the future needs of the local population they serve, is critical to the effectiveness of this model.

The ICF funding has allowed not just the local authority and the health board to work in real partnership together, but numerous 3rd sector organisations such as Age Cymru and Care and Repair have also been engaged to aid in the delivery of the pathway. This cross-sector partnership is fully committed to the above goals, with staff at all levels across the organisations excited for what they deem to be a real change in the way the system works, with the hope that a real difference is felt by the most important person – the citizen.

To facilitate the integration, IC funding has been used to develop integrated assessment forms and anticipatory care plans that can be used by both the local authority, health board and agreed partners. In addition funding has also been used to expand the capabilities of an existing portal system to allow all clinical and social care staff access to these.

The Community Connector role has been developed in partnership with Caerphilly to promote and expand current provision in the community, and encourage citizens to be more proactive about their care. The goal is to develop sustainable social networks that service users can access rather than rely solely on statutory services. IC funding has also enabled the Council and Health Board to work in partnership with Care and Repair and the British Red Cross to help develop voluntary capacity out in the community, again supporting sustainability of the pathway post IC Funding.
The programme is being undertaken in two parts:

**Part 1 – Pilot**

St David’s practice in Newport has been identified for the initial pilot, due to high numbers of older people and high numbers of admission to acute. For the purposes of the pilot we have identified a cohort of 251 patients who are over the age of 85 and are not currently residing in residential or nursing care or part of the palliative care programme. High level analysis has identified that:

- 91 service users were known to frailty
- 122 service users were known to social care – 47 active cases
- 32 service users known to mental health
- 108 service users known to district nursing – 25 active cases
- 197 service users known to occupational therapy (this includes those that received blue badges)
- 60 service users known to both social care and frailty
- 113 service users known to more than one team
- 72 service users not known to any service, (39 if the occupational therapy data is included)

It is envisaged that not all 251 will agree to participate in the pilot, which in turn will create the control group.

Anticipatory care plans covering both Health and Social Care needs will be developed by the Care Lead who will be assigned based on the primary need identified from existing GP records. The Care Lead will then undertake an integrated assessment and develop the anticipatory care plan with the individual their family / carer. What is critical here is that the Care Plan considers general health and wellbeing and uses ‘low cost and no cost services’ to maintain this.
During the pilot agreed performance indicators will be monitored and will include:

- Reduction in institutionalised beds days for pilot group
- Reduction in unscheduled reviews undertaken by social care for pilot group
- Reduction in GP visits for pilot group
- Improved Health and Wellbeing – measured through a questionnaire before and post pilot
- Reduction in costly interventions
- Reduction in unscheduled admissions to care
Part 2 – Roll out of the model

Following an agreed period of evaluation (proposed 8 to 12 months), if the pathway has been proven to be effective for this target group, the scope will be extended to those who are identified through appropriate risk stratification as at risk of admission to institutionalised care in the immediate future and will shift to GP practices across Newport. The focus will very much be early identification and prevention, the objective to manage increasing demand through cost avoidance.

Based on some initial modelling 72% of people aged 85+ in Newport could be supported by the pathway, with large proportions of the over 65+ also benefiting from some degree of early intervention/prevention, thereby delaying or avoiding access to costly services.

Whilst we are only just commencing the pilot, what has been achieved to date cannot be underestimated, in terms of bringing together teams from Social Care, Frailty, Acute and Community Services, Mental Health, GPs and the Third Sector, to develop a joint model for delivery of the Pathway and working together to develop an integrated assessment and anticipatory care plan.

What has been critical to the success of the programme to date is:

- Effective communication and engagement with all stakeholders from across the health and social care spectrum - these included: Geriatricians, District Nurses, Mental Health Nurses, Occupational Therapists, Social Workers and GPs, Service Users and Patients.
- Working directly with operational staff to understand current and future pressures in order to develop a pathway that mitigates these pressures and is fit for purpose moving forward – formulating a model of best practice which can be replicated elsewhere.
- Putting the citizen at the heart of all change, to ensure that they receive the best outcomes possible.
- Robust governance with senior representation from Health and Social Care – to drive the programme forward, acting as a point of escalation where appropriate.