To: Chairman, Ladies and Gentlemen

Social Services and Health – Promoting Integrated Services

PURPOSE OF THE REPORT:
To provide an update on Welsh Government’s initiatives to promote the integration of Social Services and Health Services in Wales, a summary of our current position and proposed response to these initiatives.

1.0 INTRODUCTION AND BACKGROUND

1.1 The directorate has been working with colleagues in RCT and Cwm Taf to respond positively to two important Welsh Government policy initiatives:

(a) **Sustainable Social Services – Framework for Action** which sets out a vision for social services focussed on the needs of the service user with emphasis on prevention and collaboration. This document is the foundation on which the Welsh Government has built its Social Services and Wellbeing Bill now before the Welsh Assembly.

(b) **Setting the Direction: Primary & Community Services Strategic Delivery Programme** which described a commitment to delivery of primary and community care services integrated with Social Services at a local level.

1.2 In response to these Policy initiatives, the directorate reconfigured services for adults and children to deliver greater focus on improved information at the first point of contact, strengthened short term support where needed and long term care and support where necessary. In terms of Health integration there has also been a joining up of a range of provision for adults at the Health Park.

1.3 These changes were implemented during 2012 and as the recent CSSIW Annual report stated; this places the Council in a good position to take the next steps in providing more integrated, localised services for adults, particularly for older people with complex needs.
1.4 However Welsh Government has determined that the pace of integration needs to be increased, particularly in Older People’s Services where they have recently published two policy documents on the subject and which the Council needs to consider its response.

1.5 There is little doubt this additional urgency results from the experience of the demand pressures on the NHS and Social Services systems last winter.

1.6 The new Policy documents are:

(a) “Delivering Local Health Care” - Accelerating the Pace of Change - which requires Local Health Boards to meet a range of largely health led targets over the course of the next 3 years.

(b) “A Framework for Delivering Health and Social Care for Older People with Complex Needs”. This is a Consultation document on proposals to establish a “Health & Social Care Integration Partnership”, the establishment of shared health & social services outcome measures and the development of integrated pathways for older people which would include targets for pooled budgets and joint appointments

1.7 Accelerating the Pace of Change is not a Consultative document so the Council will not be making a formal response to it but will be assisting Cwm Taf Health Board, where we are able to do so, in meeting a set of actions required of them which are detailed below.

The intention of the document is to:

- Improve health and wellbeing by an increased focus on prevention and rapid intervention.
- Provide improved support for older people and people with long term conditions.
- Strengthen locally led service planning and delivery.
- Deliver co-ordinated care, focused and designed around people.

The directorate is entirely supportive of these aims.

1.8 “A Framework for Delivering Health and Social Care for Older People with Complex Needs”. By way of introduction, this document identifies integration for people needing care and support as:

“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.”

It suggests the 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.”
1.9 It also suggests that the essential elements to improve integration are:

- Service providers take down the barriers that have prevented effective collaboration through better co-ordination.
- 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.

1.10 The Consultation document makes the case for change and sets out principles to which an integrated service should aspire. 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 care plan, 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; and
- 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 is identified.

1.11 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.
1.12 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; and
- Developing models of social enterprise.

2.0 INTEGRATED ASSESSMENT, PLANNING AND REVIEW ARRANGEMENTS FOR OLDER PEOPLE

2.1 The Welsh Government having set out its requirements for the integration of health and social care as above, has also issued draft guidance setting out a process for delivering the integrated assessment processes. This is seen as a key part of implementing the overall framework.

2.2 On 15th August 2013, the Welsh Government Director for Social Services and Integration (a role which now incorporates “Integration” in its title) issued a letter requiring Local Authorities and Health Services to work with Welsh Government, under statutory direction, to implement a new Assessment process for Older People. Two representatives from each Health Board footprint attended a series of weekly meetings in Cardiff throughout September and October. The Draft Guidance for Professionals in Supporting the Health, Care and Well Being of Older People has been issued as a consultation document with implementation in December 2013. This is an interesting challenge which is set out below.

2.3 The Government’s vision is for primary, community and well-being services that are reliable, accessible and help people to improve their lives, to maintain independence, to support them when they are vulnerable and to remain safely in their home wherever possible. The vision requires bold changes in services to better promote people’s well-being and reduce inappropriate admissions to hospital, nursing and care homes through an integrated system of community support, early intervention, re-ablement and intermediate care.

2.4 The Guidance will be issued under section 12 (3) of NHS Wales Act 2006 and sections 7 and 7(A) of the Local Authority Social Services Act 1970 and Local Authorities and Health Boards must comply with the Guidance. This Guidance covers the duties and functions on Local Authorities and Health Boards to promote the well-being, assessment, care and support planning and review arrangements for services for people aged 65 and over, irrespective of presenting need, disability or condition and supports access to care and support in the community. This Guidance is to apply in any situation where an older person needs help from the NHS or a Local Authority to:

- Maintain or promote their well-being;
- Regain or maintain their independence;
- Be discharged from hospital;
• Return or continue to live in their own home;
• Secure appropriate residential or nursing care;
• Help protect them from abuse and neglect; and
• Help them manage continuing health conditions.

2.5 The Guidance applies specifically to promoting well-being, assessment, care and support planning and review for older people who need support from any health or care professional, and for the following range of services provided by Local Authorities, the NHS and the independent sector:

• Services to help people to avoid the need for hospital care or to help recover in the community, commonly called re-ablement services;
• Other health services such as hospital care, continuing health care support, equipment, secondary mental health support, nursing care;
• Social care services such as domiciliary care, equipment, day care, residential care;
• Community health services such as General Practice, district nursing, continence, and physiotherapy; and
• Services in the community to support older people’s well-being such as transport, leisure and housing support.

2.6 The Guidance requires Health and Local Government in Wales to ensure that they have integrated well-being, assessment, care and support planning and review arrangements specifically to support older people, which will support the wider agenda and be the catalyst to support the broader integration of care. Local partners can also wish to apply the principles of the guidance to their local arrangements to meet the needs of people less than 65 years of age but this is not a requirement. In doing so, Local Authorities and Health Boards must have regard to existing duties that continue to apply to people less than 65 years depending on their circumstances.

2.7 With some exceptions, from 31st January 2014 the Guidance replaces (in its application to people who are aged 65 and over) the guidance on the ‘Unified Assessment Process (UAP)’. The exception is the eligibility criteria decision guide provided for in Chapter 5:

Fair Access to Care Services: Setting eligibility criteria for all adult groups (FACS). These elements of the UAP Framework remain applicable and must be used by Local Authorities and LHBs where appropriate. Similarly, the Continuing NHS Health Care Decision Tool remains applicable. The requirement to provide usual ‘Monitoring/Performance Information’ remains for both Local Authorities and Health Boards.

2.8 The Guidance must be considered along with key statutory provisions including:

• Chapter 5 of Fair Access to Care Services: Setting the Eligibility Criteria (FACS) Creating a Unified and Fair System for Assessing and Managing Care.
• Guidance and Decision Tool on Eligibility for Continuing NHS Health Care.
• Framework for Individual Care Plans.
• Code of Practice to Parts 2 and 3 of the *Mental Health (Wales) Measure 2010.*
• Protection of Vulnerable Adults (POVA) guidance.
• Direct Payments Guidance: Community Care, Services for Carers and Children’s Services (Direct Payments) (Wales) Guidance 2011.
• Guidance for Nurses on recording.

2.9 Professionals must apply the Guidance in supporting an individual’s journey through the well-being, care and support pathway, ensuring that older people, their families and carers are enabled to:

• Communicate with an appropriate person to get help and advice and support to maintain or promote their well-being;
• Get a care and support assessment from the right NHS or LA professional;
• Take part in an assessment which will consider the individual's needs, capacity and resources, desired outcomes and eligibility for services, and help them to complete a care and support plan to address those needs (where appropriate);
• Access help to arrange or secure services that are agreed in the care and support plan (where appropriate); and
• Take part in a timely review of their care and support plan (where appropriate).

3.0 IMPLEMENTATION CHECKLIST

3.1 Local Authorities and Health Boards will need to embed the implementation of this Guidance into the overall implementation of *A Framework for Delivering Integrated Health and Social Care for Older People with Complex Needs.*

3.2 Specifically in relation to the arrangements required in this Guidance Health Boards and their partner Local Authorities will need to consider the following:

• Ensure that the implications of the Guidance are fully understood at a strategic and operational level across partners.
• Ensure people aged 65 and over and their carers fully understand these new arrangements. In particular their right to; Information and advice about their well-being and care and support; an integrated assessment; ownership of their core data set, right to have a copy of the core information and where relevant assessment and a care plan.
• Local systems for monitoring compliance with the Guidance.
• Local measurement of improved outcomes for people aged 65 and over through the new integrated arrangements to underpin the indicators that the Welsh Government will be monitoring.
• Engage with professions about the best approach to undertaking more creative well-being assessments with individuals.
• Review existing information systems and information sharing protocols and identify improvements needed.
• Develop and implement a common communications strategy to ensure that professionals and citizens understand the arrangements and their roles and rights.

• Undertake a cost-benefit analysis of the plan and review budgets accordingly.

• Ensure new arrangements are accommodated with any national performance or statistical return required by Welsh Government.

4.0 **MAKING IT HAPPEN**

4.1 The consultation document is also very clear that structural change is not on the Welsh Government Agenda. It states:

“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.”

4.2 It makes reference to work carried out by the Kings Fund (March 2013) “making integrated care happen at scale and pace: Lessons from Experience” and suggests a set of 16 principles that need to be taken account of in considering integrating services. They very much mirror the work of IPC indicated in Section 4.3

4.3 The core planning issues are:

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

4.4 Finally the Consultation document sets out a set of actions that are required of “Local Partners”, which presumably includes the Council, HB and third sector organisations.

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. The Statement must include the baseline assessment required under 1 above and set out clearly how:

- We will build an appropriate workforce across all partners as an early opportunity to enhance the citizen’s experience.
- We 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.
- We will maintain robust local partnership arrangements that reflect a willingness to delegate responsibilities.
- We 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.

4.5 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.

4.6 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.

4.7 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.

4.8 Partners need to **by December 2014** have developed within mainstream services for older people integrated services for older people with complex needs.

4.9 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>
<thead>
<tr>
<th>The Performance Indicators: Indicator</th>
<th>Anticipated direction of travel</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Emergency admissions to hospital for people age 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 Benchmarked 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>

4.10 In addition to these new requirements the Health Minister has required each Local Health Board, in partnership with their respective Local Authorities, to submit a set of Local Authority/Local Health Board joint arrangements that are currently in place. This was completed using a template created by ABMU Health Board and a copy is attached as Appendix A.

4.11 All of these new initiatives come at a time when Welsh Government are in the process of considering the Social Services and Wellbeing Bill which, in itself heralds, changes in the delivery of Social Services in the future. The full consequences of implementation of the Social Services and Wellbeing Bill are yet to be fully understood as much of the detail will be in the form of regulations, which have yet to be placed before the Welsh Assembly.

5.0 KEY ISSUES

5.1 Prior to the Welsh Government’s latest initiatives, staff from Cwm Taf Health Board, Merthyr Tydfil County Borough Council and Rhondda Cynon Taf County Borough Council had been working with the Oxford Brookes Institute of Public Care (IPC) to provide a framework for us to take forward the integration agenda across the Cwm Taf footprint. In Cwm Taf there are 4 identified Localities within the Cwm Taf footprint - Merthyr Tydfil, Rhondda, Cynon & Taf. Locality networks are expected to reach a level of maturity described in “Setting the Direction” whereby they have:
• Assessed local needs;
• Facilitated all parts of the NHS to work better together with social services, Third sector and local communities; and
• Made commissioning decisions about local resources to meet local needs.

5.2 Very helpfully their report, entitled “Integrated Service Management Arrangements Review”, is now available to us in responding to the demands of Welsh Government on this agenda.

5.3 The conclusions and advice of IPC (who also supported the reconfiguration of our services) were as follows:

• Progress has been made in integration of services at a locality level in recent years, and this can be taken further. It is recommended that partners respond to the national integration agenda and growing evidence of the impact of integration on outcomes, by working together to take forward their integration arrangements at both a locality and organisational level.

• Partners should build further integrated arrangements which focus on 3 priority targets:
  
  o Better outcomes for people, eg. living independently at home with maximum choice and control.
  o More efficient use of existing resources by avoiding duplication and ensuring people receive the right care, in the right place, at the right time.
  o Improved access to, experience of, and satisfaction with, health and social care services.

• This further work on integration between partners should be based on and informed by the 16 principles drawn up by IPC and agreed in consultation.

<table>
<thead>
<tr>
<th>Focus</th>
<th>Trajectory</th>
<th>Style</th>
<th>Leadership</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Centred on outcomes</td>
<td>7. Avoid a focus on structure</td>
<td>11. Take time to develop</td>
<td>14. Provider relationships &amp; roles</td>
</tr>
<tr>
<td>5. Locally rooted</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
• **Partners should commit to the extension of the existing approach to integration** – which is one of ever closer collaboration between independent agencies, without moving for the present, to full structural integration.

• **An ‘integrated locality collaboration and investment plan’ should be created, overseen by the ‘Setting the Direction’ collaborative, which in turn would report to the Collaboration Board. The plan should be informed by its initial work on a joint vision from 2011 and the principles referred to above.**

5.4 In essence, the IPC work has validated the appropriateness of our work so far, warns us against simply seeking structural solutions to the development of integrated services and advises us to press on with integration but on a carefully considered “bottom up” approach.

5.5 It is our intention to use the findings of this research in constructing our response to the Welsh Government and in approaching the on-going review of Learning Disability services across the region and locality.

### 6.0 IMPLICATIONS FOR THE COUNCIL

6.1 The Council has been committed to the Integration agenda for some time. Our work with partners on reconfiguring Adult Services into Localities, the establishment of multi agency reablement services, improved hospital discharge arrangements and targeted short term interventions have all been part of this process.

6.2 The work which has been carried out by IPC across the Cwm Taf region also demonstrates the careful thought which is needed to be given to delivering successful outcomes, validates progress made so far and is consistent with the direction of travel set by Welsh Government.

6.3 The Welsh Government document encourages us to establish these arrangements on a more formalised footing and provide evidence of collaborative commitment to services for Older People with complex needs.

6.4 We have been successful in winning European Funding to appoint a time-limited Regional Programme Officer to assist us in meeting the targets set out in the Consultation document.

6.5 The areas of potential contention are:

- The extent to which Welsh Government is pressing for the use of targets for Pooled budgets as a measure of successful Collaborative working. In our response we will be seeking to clarify what Welsh Government actually mean by the use of the term. Issues of accountability and governance remain significant hurdles to overcome, particularly when applied at times of austerity and budget cuts.
- The creation of yet more performance Indicators for us to be reported and monitored on. We would seek to minimise any extension of performance management arrangements.
7.0 **FINANCIAL IMPLICATIONS**

7.1 As yet the potential financial implications cannot be identified until we have clarity on the use of pooled budgets, the future direction on working arrangements regarding delivering 24/7 services and the associated costs with new staff training and the use of integrated IT systems with Health.

8.0 **SINGLE INTEGRATED PLAN AND SUSTAINABILITY IMPACT SUMMARY**

8.1 The sustainability impact assessment identified that the delivery of integrated Social Services & Health Services will have a positive impact on a number of areas which include People in Merthyr Tydfil have the opportunity and aspiration to learn and develop their skills to maximise their potential; People, who live and work in Merthyr Tydfil are supported to enjoy a healthier and better quality of life; Prevention and Early Intervention - in order to break cycles of dependency and prevent the persistence of poor outcomes from one generation to the next; Financial Sustainability of Public Services; and Equal Opportunities – ending discrimination, ensuring equality of opportunity and that all parts of our population can live together, where every person has an equal chance to participate and has equal access to services. No negative impacts have been identified.

9.0 **EQUALITY IMPACT ASSESSMENT**

9.1 An Equality Impact Assessment (EqIA) screening form has been prepared for the purpose of this report. It has been found that a full EqIA Report is required. Both forms can be accessed on the Council’s website/intranet via the ‘Equality Impact Assessment’ link.

9.1.1 The positive impact is improved service delivery for older people and people with a disability.

9.1.2 There are no negative impacts.

9.1.3 Current proposals to address the issues are that the impact be monitored through the Locality management Board.

GIOVANNI ISINGRINI
DIRECTOR OF COMMUNITY SERVICES

<table>
<thead>
<tr>
<th>BACKGROUND PAPERS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Title of Document(s)</strong></td>
</tr>
<tr>
<td>Sustainable Social Services – Framework for Action</td>
</tr>
<tr>
<td>Integrated Service Management Arrangements Review (IPC)</td>
</tr>
<tr>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td>A Framework for Delivering Integrated Health and Social Care for Older People with Complex Needs Integrated Assessment, Planning and Review Arrangements for Older People</td>
</tr>
<tr>
<td>CSSIW Annual Performance Report</td>
</tr>
<tr>
<td>Fair Access to Care Services: Setting eligibility criteria for all adult groups (FACS)</td>
</tr>
</tbody>
</table>

**Consultation has been undertaken with Executive Board in respect of each proposal(s) and recommendation(s) set out in this report.**
### JOINT LOCALITY/LOCAL AUTHORITY SCHEMES

<table>
<thead>
<tr>
<th>No.</th>
<th>Scheme</th>
<th>Merthyr Tydfil -</th>
<th>Cwm Taf Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Step Down Beds</td>
<td>Thomastown House has integrated its service with Cwm Taf HB in order to facilitate hospital discharge and prepare vulnerable individuals to return to the community. Development of a step down re-ablement service within Bargoed House which consists of four rehabilitation beds which facilitates hospital discharge and move on is also being considered. Rhondda Cynon Taf - RCT currently fund two step down beds for reablement would need further discussion with LHB about funding if further beds needed.</td>
<td>Cwm Taf - Cwm Taf HB commissioned five step down beds and two crisis beds within Thomastown House Mental Health Hostel. Access is across the region.</td>
</tr>
</tbody>
</table>

| 2.  | Discharge to Assess           | Merthyr Tydfil - Patients following MDT as it determines and identifies the need and care category of the service user. Assessments are conducted prior to move on. The position of the Local Authority is to prioritise returning people to their own home/community and to avoid placements directly into residential settings from hospital wherever possible. Rhondda Cynon Taf - The pathways to the integrated Intermediate care and Reablement (IC&R) service provide for this type of service, further discussion with the LHB suggested to look at if there is a need to extend beyond IC&R. |  |

<p>| 3.  | Community Resource Team (CRT) | Merthyr Tydfil - The Council’s Initial Response Team is co-located with Health colleagues and provides a free 6 week response for assessment and rehabilitation of patients discharged from hospital. This integrated service response includes Occupational Therapist and community support. CRT has direct access to the provision of assistive technology, the use of which is incorporated into assessment plans, with a focus on the maximisation of independence. | Cwm Taf - Cwm Taf Health board fund the support@home service that is in place across Cwm Taf region. Cwm Taf Health Board explores assistive technology opportunities as part of the assessment process prior to hospital discharge. |</p>
<table>
<thead>
<tr>
<th>No.</th>
<th>Scheme</th>
<th>LA Position</th>
<th>Cwm Taf Position</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rhondda Cynon Taf</td>
<td><strong>Rhondda Cynon Taf</strong> - The IC&amp;R service is an integrated one and there is no charge for the service, it has good links to the Support@home scheme. Telecare is offered free of charge to people using the IC&amp;R service and an officer is in post to promote the wider use of assistive technologies.</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Inter Team Working</td>
<td><strong>Merthyr Tydfil</strong> - The development of the local One Stop Shop centre is on-going and work is set to commence on the 19th of August 2013. This initiative will bring multi-disciplinary teams together to provide a single point of access. Keir Hardie Health Park provides for integration of the Dementia Team, Initial Response, Community Mental Health team and the Psychiatry of Old Age team. It also houses Third sector representation in Gofal and Age concern. Learning Disability and EMI day services for adults alongside the equipment demonstration smart house are also provided in this location. This enables effective partnership working across sectors and teams, to deliver a streamlined and high quality service. <strong>Merthyr Tydfil &amp; Rhondda Cynon Taf</strong> - The work being taken forward to support the Multi Agency Safeguarding Hub will further strengthen our integrated approach and will include Police, Probation, Education and other partners as necessary. Our CMHT’s and Learning Disability teams are co-located. The Cwm Taf out of hours service is located in a RCT communications hub for out of hours, lifeline, home care and will be joined by the Social services Emergency duty team in September which supports RCT, Merthyr and Bridgend.</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Reducing Longer Lengths of Stay</td>
<td><strong>Merthyr Tydfil &amp; Rhondda Cynon Taf</strong> - The Re-ablement service is integrated with Initial Response team (short term intervention service in RCT) and allows direct discharges to be made from hospital back to the community without the need for social work assessment. This significantly reduces the delay in hospital discharge. The team is integrated with Cwm Taf Health Board colleagues.</td>
<td><strong>Cwm Taf</strong> - Cwm Taf are exploring options regarding hospital discharge into primary care for older People across the region.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>No.</th>
<th>Scheme</th>
<th>LA Position</th>
<th>Cwm Taf Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.</td>
<td>Improving flow across patient pathway interface with Community /Primary care within the medical wards at PCH / RGH.</td>
<td><strong>Merthyr Tydfil</strong> - The Discharge liaison Nurse is an integral member of the Residential Placement Panel. This supports communication and early discharge from hospital and helps to address DTOC issues. <strong>Rhondda Cynon Taf</strong> - A discharge Liaison Nurse work within the IC&amp;R service and provides good in reach into the hospital and supports prevention of hospital admission. However discussions needed to ensure that this is permanently based within the team.</td>
<td><strong>Cwm Taf</strong> - The Institute of Public Care at Oxford Brookes University (IPC) have completed a review of arrangements supporting health and social care integration for the Cwm Taf locality partners of Merthyr Tydfil County Borough Council, Rhondda Cynon Taf County Borough Council and Cwm Taf Health Board.</td>
</tr>
<tr>
<td>7.</td>
<td>Choice of Accommodation policy</td>
<td><strong>Merthyr Tydfil</strong> - Choice protocol has been developed in conjunction with Health. Social Services training has been undertaken within the wider care management teams. <strong>Rhondda Cynon Taf</strong> - Date for implementation of the policy now been agreed with the LHB all RCT staff trained and aware of process and responsibilities.</td>
<td><strong>Cwm Taf</strong> - Processes are currently being developed for implementation.</td>
</tr>
<tr>
<td>8.</td>
<td>Capacity Planning in local authority</td>
<td><strong>Merthyr Tydfil</strong> – Two new residential homes are set to open in September 2013. All domiciliary Care Contracts have recently been retenders. All Supported Accommodation Services were retendered in 2012 alongside a rightsizing exercise to determine levels of need. The Ty Cwm Extra Care development opened in July 2012 and is currently fully occupied. The scheme has been future proofed as part of the design. The scheme has facilitated discharge from hospital and step down from residential settings. It has also prevented escalation of need to residential/hospital/institutionalized care. An Adult Placement scheme across the South East Wales region is now in place and offers an additional choice of respite provision alongside long term placement and short term seasonal support which helps to reduce the instances of high cost out of county placements.</td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>Scheme</td>
<td>LA Position</td>
<td>Cwm Taf Position</td>
</tr>
<tr>
<td>-----</td>
<td>--------</td>
<td>-------------</td>
<td>------------------</td>
</tr>
</tbody>
</table>
|     |        | **Rhondda Cynon Taf** –  
RCT has recently implemented a revised operating model which focuses on early intervention and reablement. Looking to expand IC&R resources to respond to both Community and hospital demand.  
Wish to consider with LHB need for and joint commissioning of interim beds within care homes.  
Recently commissioned two tenancy and wellbeing schemes using a supported living model with a total of 33 units.  
Looking to continue to increase EMI capacity within the market. |