“Setting the direction for Older People’s Services”

(Report of the End to End Review)

DRAFT

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1. Introduction and Background

1.1 This is the report of the End to End Review of services to older people. The Review ran from April 2014 until May 2015 and during this period there were many streams of development on Older Persons Services. One of our main tasks was to assist in co-ordinating these and help to pace their progress with the intention of arriving (by early summer 2015) at a cohesive & coherent strategy statement that sets the direction for these services in the period 2015-2018.

1.2 So this Report:

- Looks at how other local authorities are modernising their services, seeking to learn valuable lessons about innovation from elsewhere
- Considers the available performance information, using national benchmarks, the "family" comparator group of LA's and any relevant local performance indicators
- Reflects on Gwynedd's progress & achievements to date, especially our developments (practical and transformational) in response to emerging national policies/strategies and to changing perceptions of need.
- Summarises the changes which the Council aims to sponsor over the next 3 years, both in terms of its strategic organisational development and its commissioning intentions

1.3 Social Care Services for Older People in Gwynedd cost the Council £25m net (£36m gross pa) in 2013/14 and is expected to reduce in real terms to £21m by 2017/18. The number of Older People in the County Is expected to rise modestly from 27,310 in 2015 to 28,420 in 2020. However, this overall figure masks a 3%, decrease in the 65-74 band, an 11% increase in the 75-84 band and a 14% increase in the over 85's during this period. The current spend represents annual net expenditure approximately £3.7m above the average of the relevant "family" group of LA's.

1.4 In line with other authorities in Wales, Gwynedd recognises that its traditional adult social care models are not affordable or desirable in the longer term and that new, more flexible and responsive approaches must be developed so that older people's needs can be met without compromising their independence.

1.5 We also recognise that to make significant improvements in the way we help older people to get the best outcomes, we must embrace new concepts that may not have a fully proven record of success. Reductions in LA resources and changes in lifestyles mean that we (along with other LA's) find ourselves operating at the cutting edge of social policy development & implementation – it is a challenge that requires a bold, imaginative and potential radical response from us. We require a health and care system that enables people to have the right care, at the right time, in the appropriate location, for the best price.

1.6 The End to End Review took place at a key point in the implementation of Social Services and Well-being (Wales) Act 2014. This important legislation seeks to give people a voice, choice and control in the way they are supported in overcoming barriers to their well-being. At its heart lies the principle of co-production in social support planning, empowering people and giving them the flexibility to decide how their outcomes are achieved. The concepts of early intervention & prevention are inherent within the Act. The Act also gives the context for the Local Authority roles in relating to citizens & service users:

- Better access to information and general resources for all
- A proportionate, community based response to those who require some assistance
- Well-designed assistance to meet the needs of more vulnerable citizens.

1.7 These 3 streams have underpinned the Councils recent restructuring of Social Services, based on:

- Wellbeing
- Enablement
- Complex Needs

1.8 We want Gwynedd to be a good place in which to grow old; the Council will promote and support independence by enabling people to live at home for as long as possible. We aim to commissioning services that:

- Meet the needs of the individual
- Contribute toward maintaining independence
- Are appealing, appropriate and sustainable for the future
- Offer choices and options to the individual
- Offer value for money / are cost effective
- Meet the expected standards
- Are flexible enough to be able to change to address any changes to circumstances and the individual's needs.

As we do this we will apply the following principles:

- Promote independence by ensuring the necessary support to enable people to continue to live at home as long as possible
- Reduce loneliness and social isolation
- Concentrate on dignity in care and the quality of services
- Work in partnership
- Recognise the role of carers and ensure there's support for them to be able to continue to care

1.8 Three pieces of local research were undertaken in 2014 and are referred to at points in this Report. These are:

- A Case-file Review seeking to establish how well social work practice was helping to achieve the optimum demand management platform
- A Pathways Review of cases seeking to establish the factors that had led to an increased use of Nursing Home Placements
- A Pathways Review of cases seeking to establish (inter alia) the factors that led to admissions to Residential Care

1.9 Also referred to at many points within the Report is the Intermediate Care Fund (ICF). This national programme has been utilised to assist in the transformation of older people services in Gwynedd, with the objective of supporting older people to maintain their independence for as long as possible, thus reducing the need for unnecessary health and social care intervention and managing the demand in a more effective manner.

2. Wellbeing and Primary Demand Management

Best Practice

2.1 "There is broad consensus on what the future needs to be. It is a future that empowers patients to take much more control over their own care and treatment. It is a future that dissolves the classic divide, set almost in stone since 1948, between family doctors and hospitals, between physical and mental health, between health and social care, between prevention and treatment" (NHS 5 Year Forward View- England 2014).

2.2 Councils are developing successful approaches to managing demand for services despite increased demographic pressures. Three key approaches have emerged:

- diverting people away from formal care where appropriate
- promoting independence and resilience
- offering preventative interventions prior to assessment for longer-term care.

2.3 Most Councils in England have adopted a front-of-house arrangement that assists in diverting people who do not require formal care, away from the Council assessment services towards solutions from within their families, their neighbourhoods, their communities, the voluntary sector or even sometimes from within their own capabilities. Councils might expect to divert 75% of people towards a solution of this nature before an assessment or offer of formal help is made (LGA Adult Social Care Efficiency Programme). Most authorities favour a specialist service which has a better opportunity to ensure people get the right help at the first contact.

2.4 As an example, Barking & Dagenham's organisational front-end is operated by fully qualified and experienced social workers. Arguably, this type of resource provides the best and safest judgement on when to offer a fuller assessment and when to divert to a community-based solution. However, a smaller number of Councils (e.g. Shropshire, Gateshead) have been using volunteers and business support staff at the initial contact point, a configuration that reduces cost and enables the front-end to have a distinctive character that is not necessarily "social services".

2.5 Stockport commissions a service from the voluntary sector called FLAG which helps people who are diverted away from the Council's social care contact team. It offers advice and information including signposting people to voluntary and community organisations. It has been rolled out through the CAB, the Council's One Stop Shop and Care Line. It is able to identify and target those people who are on the margins of the eligibility criteria and direct them towards appropriate, time-limited, preventative services. Interestingly, the SPOA within the

Community Mental Health Service in Gwynedd adopts a similar practice to this; diverting individuals who present with low level need/risk at the point of referral, to a single organisation providing talking therapies without the need for a full assessment.

2.6 Work undertaken by Kent and Kingston revealed that despite the locally published eligibility criteria, different workers (whether qualified or not) apply different thresholds and solutions for people with similar problems. Some workers were found to be better than others at diverting people away from formal care solutions or at finding more creative solutions to meet people's needs.

2.7 The availability of a wide range of community-based provisions is key to maintaining independence & community resilience. These low level & universal services could be described as being part of a continuum of support, but access is not always easy for older adults:

- Libraries
- Leisure Centres
- Local sports clubs
- Local special interest societies etc.
- Local cafes and pubs, churches and chapels

2.8 Leading on from these are more age-specific facilities e.g. Ageing Well Centres where attention is paid to the health and wellbeing of adults as they grow older with the aim of preventing ill-health and loss of independence.

2.9 The factors which initially impact in a negative manner on people's ability and confidence in maintaining their independence are often the very small things involved in daily living (and are also often are the signs of coping / not coping to the outside world) e.g.

- Tidy garden
- General property maintenance
- Clean windows
- Clean curtains
- General tidiness and cleanliness of the home
- Shopping
- Cooking

2.10 There is a traditional belief in some quarters that these (particularly cleaning and shopping) are the "duty" of social services when, in reality, they have not been part of the home care offer for some time. These are all services which are better when not provided in a "social services" context; best practice would indicate that they could/should all be provided on a local community / third sector basis.

Summary of best practice examples

- A screening tool for the contact which assists staff to make judgments and give advice in a consistent and constructive way

- An independent social enterprise that delivers the front-end adult social care service (e.g. Shropshire County Council).

- Community care assessments arranged at the office - home visits only offered to those people who really need them.

- 'Different conversations' to capture "what matters".

- Traditional service solutions only considered once community-based solutions have been exhausted.

- Development of an "innovation fund" to encourage community activities to support this approach.

- Up to 75% of the people who come into contact get assistance without the need for a full social care assessment (some Councils report a figure as high as 97% but differing definitions make comparison difficult).

- Trained staff from health and social care operating the front-end on behalf of both agencies.

- Focus on preventative outcomes that help people to stay out of the formal care system.

- Build and maintain a strong set of connections with community organisations and the local voluntary sector.

- Help people to find local solutions that specifically avoid admissions to residential care.

- Stall trained to be more confident and able to divert people away from social care.

Performance analysis & commentary on Gwynedd's development

2.11 On support to community care organisations, Gwynedd's spending is approximately £450,000 p.a. a figure very close to the (population adjusted) average for Wales and for our "family" group. In view of the very open nature of access to these services, it is very difficulty to assess how many citizens per annum benefit from them.

2.12 A snapshot analysis of adult referral data indicates the largest source of referrals (42%) is self/family member/neighbour. This is followed by the

NHS (34%) made up of hospitals (19%) and community & primary (15%). The remaining 24% largely represents three categories; police (7%), social service (5%) and Other (10%), the latter including independent sector organisations. An analysis of adult referral data for all of 2014/15 indicates that approximately 15% of "contacts' are signposted to other agencies/community services, thereby not becoming referrals.

2.13 The Gwynedd Case-file Review seeking to establish how well practice was helping to optimise demand management, found that:

- Outcomes were not used in a structured way, and were rarely related consistently to the desired outcomes for the individual
- Wellbeing, the concept of co-production and self-directed care were not central to social work functioning in older persons services
- Some preventative work was present but not necessarily well-evidenced (see reference to outcomes)
- On services there was a lack of diversity (and perhaps capacity) to meet needs, particularly in "crisis" situations

2.14 The Ffordd Gwynedd initiative was launched in early 2015 to deliver a new approach to client centred services. It is operating in a prescribed locality in an integrated way, with a Social Care & NHS team:

- Defining a purpose - helping people to live their lives as they want to.
- Using a set of nine (Vanguard) principles.;
- Putting together a set of measures that demonstrate whether or not we are achieving our purpose.
- Concentrating on what is important to the client with the same worker holding the citizen's story end-to-end and able to pull the right expertise at the right time.
- Leading change on the basis of front line learning from real cases - experimenting with different ways of working and learning through the normative experience.
- Using an integrated IT system and focusing on less paperwork, more time spent with the citizen.
- Helping the citizen help themselves, thus reducing the dependency on public services.

2.15 What the Ffordd Gwynedd team has learnt:

- The NHS & Social Care currently have different priorities, separate budgets and management structures. Their different purposes are often not based on what matters to customers and can work contrary to each other.
- The same clients keep coming back because services did not take the time at the beginning to understand what matters. The current

way of working does not always grasp what really matters to the client

- Paperwork is excessive e.g. a 100+ page form to be filled to get funding for 4 hours a week home based nursing care to satisfy NHS panels. A Social Services basic assessment form is 26 pages.
- Of the fairly low volume of cases dealt with by the team to date, traditional home care has only been commissioned in two instances. It is early days but it does suggest that investing in understand "what matters" to the client could reduce reliance on formal (and expensive) care services whilst having a more positive impact on the client

2.16 There are a range of organisations contributing to meeting some basic care and domestic needs but the current situation is "ad hoc" across Gwynedd with some communities more able to support themselves and some areas better served by the 3rd sector. Our aim should be the development of strong, supportive communities backed up by suitable & widespread 3rd sector services, all working to support people to live in the home of their choice and to maintain independence

2.17 The Dementia GO project (ICF) expands on the current NERS scheme, raising awareness in the over 40's of what can help to prevent or halt dementia later in life, especially physical exercise, healthy eating and social activities. It also seeks to improve the lives of those suffering from dementia, including families &carers.

2.18 'Age Cymru' have developed 'Living Well Centres" (ICF) to offer companionship and somewhere to learn new skills and build confidence in a supported environment with trained professionals on hand. It has also further developed partnership work with the Cynefin Social Housing group for their residents. A total of 185 individuals attended the centres and have 120 active members still attending weekly (64.9% retention). Funding of wellbeing rooms (ICF) in 3 Leisure Centres provide a space for 'drop-in' physiotherapy triage service and use by Dementia GO.

2.19 The Stroke Association expanded their stroke rehabilitation service (ICF) to allow further opportunities to socialise for stroke survivors and their carers', with the support of volunteers in local cafes in Dwyfor and Meirionnydd. This has increased their confidence and communication in public areas and reduced loneliness. The development of a Parkinson cafe (ICF) in the Bangor area, improves health and wellbeing of the participating individuals and reduce social isolation.

2.20 Working together with GPs, community nursing, social services and carer agencies the Pharmacy Teams (ICF) across North Wales have been able to target housebound or care home older citizens on multiple medicines, in order to take regular medication reviews in the home. Working to improve medications compliance, the programme aims to improve discharge arrangements/avoid unnecessary hospital admissions, streamline medication administration processes, reduce

medication errors and unnecessary prescribing. The total number of service users seen in the 12 month period was 702 across North Wales with savings across the NHS & LA's estimated to be £279,800

2.21 The Red Cross Enablement Support Service (ICF) pilot is an enhancement of the Home from Hospital scheme to support the older person to rebuild their confidence, to improve and gain further links with society and improve independence. The scheme consists of low level practical & emotional support, one step down from input currently offered by the statutory sector.

2.22 The Physiotherapy Department at Betsi Cadwaladr University Health Board jointly with Gwynedd's National Exercise Referral Scheme (NERS), have developed a scheme aimed at tackling falls in those aged over 65. This involves a 32 week Falls Prevention and Balance Exercise class. The Falls Prevention programme was designed by Later Life Training and follows evidence based research. It can offer exercise opportunities, physiotherapy and home safety assessments.

2.23 As part of the Councils' Strategic Plan we have the Care Challenge Project; designed to ensure that the people of Gwynedd truly understand the challenge that faces us and to motivate & support communities to contribute by taking action. The success of this project will be crucial for the preventative agenda, and will ensure that we as a Council (and our partners) will respond proactively to change.

<u>Gwynedd Strategic and Commissioning Intentions</u>

2.22 In the future we intend to:

- Reposition the Council's relationship with users - focusing on facilitating, enabling and recovery rather than 'doing for' (as part of the Care Challenge Project).

- Create a Housing and Wellbeing Service within the Adults, Health and Wellbeing Department. This Service will lead Wellbeing activities and develop a more resilient, supportive and preventative community fabric to reduce the need for recourse to formal care.

- Create an Enablement Service within the Adults, Health and Wellbeing Department. Located in this Service will be integrated Enablement Teams (Social Services/NHS) with a key first contact/demand management role to reduce repeat demand.

- Implement the Vanguard/Ffordd Gwynedd initiative. This will (later in 2015) be rolled out to a larger geographical area and a larger volume of cases– we will use light-touch processes, integrated working and a focus on “what matters” to users, thereby enabling needs to be met “upstream”.

- Reposition the Council’s relationship with communities and community organisations to ensure that we maximise the potential of all community resources and assets (as part of the Care Challenge Project).

- Develop a Wellbeing strategy/commissioning plan by April 2016 (in consultation with partners) to define the key steps to achieve an enhanced, community-grounded range of wellbeing responses (as part of the Care Challenge Project).

3 Practice Development (Including Safeguarding)

Best Practice

3.1 It is a significant challenge for practice stakeholders to embrace the type of change now required of them. It's not easy for staff to change their practice from a traditional assessment of needs to a more asset based approach, one that promotes independence. Research has identified considerable differences between individual Assessment and Care Management staff in terms of achieving a successful and cost effective response to client need – these variations are now viewed as a legitimate area for performance consideration within many English Councils. It can also be difficult for users and carers to adjust their expectations of the type of care available. The cultural/behavioural changes need to impact on a range of key partners who are involved in providing and delivering care. Councils that are successful in comprehensive practice transformation recognise it is only possible within an appropriate timeframe (it takes a period of 2/3 years before a new culture is embedded).

3.2 Evidence suggests that those Councils that have succeeded in reducing reliance on residential care have done so through concentrating on cultural change in the practice environment. Many have successfully changed their model of care from one of paternalism (with protective interventions) to one which better promotes independence and manages risk. The potential for preventative services & strategies to reduce the need for mainstream services is high on the political & policy agenda, with the prospect of early help (from low-level services) reducing more significant need as people age.

3.3 Tameside's "Opening Doors for Older People " was designed to reduce or delay older people's need for hospital, residential or intensive home care. The project has two strands - first it identifies/contacts older people and their carers who are most at risk of losing their independence but who do not yet require intensive, formal care. They are offered a free "community options for remaining active" (CORA) check and support visit where the client will be given information and advice including directing or signposting to services or other sources of help. The second strand involves re-shaping community-based services by using Cora visits to get the views of older people and their carers on the type of community services that need commissioning/developing, to support their independence and well-being.

3.4 The health or independence of older people with complex needs can deteriorate rapidly at any time and require effective & speedy support from practitioners who understand their individual circumstances/conditions and can offer effective alternatives to institutionalised care. Older people who are frail, cognitively impaired or disabled can become rapidly immobile or confused, suffer falls, or go

very quickly from coping to not coping in the face of even minor acute illness or a worsening or an existing condition (Clegg et al, 2013). At times of ill health, older people may not be well enough to manage their own care but with the right intervention and support can make partial or full recovery.

3.5 Narrative data from older people and their carers suggests that a lack of offer of alternative services is behind many admissions to hospital and residential care, where within a matter of days they can became dependent on others, making it all the more difficult to re-gain their independence. So admissions as a response to a crisis could well be reduced if other services are available to better manage their health and wellbeing. Whilst addressing the crisis, services need to focus on recovery, rehabilitation and recuperation. These measures must be delivered in a timely way and are usually best organised in an integrated model with the NHS or in close alignment with health services. In Milton Keynes and Sandwell there are jointly funded/managed services. In South Wales there is experience of using pooled budgets and deploying multi-disciplinary teams. Best practice evidence highlights the key role that GP practices have, in relation to identifying & supporting people with emergent needs and in maintaining older people with complex needs within community settings. The role of care co-ordinators is also seen as increasingly important for this latter cohort of people.

3.6 The evidence suggests that appropriate social care services should be available out of hours, and should enable swift assessment of an individual's care and support needs with the aim of stabilising the situation and assembling a care plan that avoids clinically unnecessary admissions to hospital or to long-term care. The recommended "Silver Book" standard is that a 24/7 single point of access (SPOA), including a multidisciplinary response within 2 hours should be commissioned (Kings Fund, 2014). The new Better Care Fund in England requires local authorities and clinical commissioning groups to provide seven-day services to support hospital discharge and prevent any unnecessary admissions.

3.7 A consistent theme across high-performing Councils involves taking steps to reduce admission to residential care- ensuring effective early interventions to prevent admission and appropriate secondary interventions, for example in handling any follow-on crisis. Availability of a range of services is key to success, especially community based resources to help people live with dementia. Indeed the common precipitants of moves into institutionalised care include recurrent falls, incontinence and behavioural symptoms of dementia (Centre for Policy on Ageing and Bupa 2012). Appropriate assessment, treatment & support for these conditions therefore has the potential to prevent expensive & unnecessary admissions.

3.8 One matter that has received little research attention is the phenomenon of a “supply-led” whole system – where rather than demand/need “pushing” the shape & scale of the service supply side, the supply side “pulls” demand/need to fit its shape & scale (with practice playing a subtle but complicit role). In 2014 the Kings Fund noted that areas with higher numbers of care home places may experience a lower threshold for admissions, an example of this dynamic.

3.9 Direct payments (monetary amounts made available by LA’s) to individuals, or their representative, to enable them to meet their care and support needs are an important mechanism by which people can exercise choice and control. They are an integral part of meeting people’s needs through care and support planning, and must not be seen as a separate or secondary consideration. Offering Direct Payment’s is no longer discretionary; where a service user/ carer expresses a wish for Direct Payments they must be made available as long as they will enable well being outcomes to be achieved.

3.10 In 2007 Welsh Assembly Government commissioned research into the reasons for variable take up of Direct Payments across Wales. The main reason appeared to be social workers’ reluctance to accept that service users could manage Direct Payments effectively and, as a consequence, their reluctance to even discuss Direct Payments as an option. The research stimulated a number of recommendations based on the findings- most appear to have been incorporated into the recent Act and its Code of Practice.

3.11 Recently a new citizen led direct payment co-operatives project was established led by Disability Wales and the Wales Co-operative Centre. This will provide the more than 4,000 Direct Payment recipients in Wales with a new way to manage their payments. Service users will own and run the cooperative, will inform its development and provide an opportunity for individuals to come together to can pool resources and design their own services. The co-operative will manage the financial aspects thus reducing any anxiety felt by individual users. There is little doubt that if successful this development will also prove to be a driver for increased take up of Direct Payments.

3.12 Summary of best practice examples:

- A determination to raise practice standards and make practice development a key organisational imperative.

- Significant cultural change within assessment & care management staff and within the wider “whole system”.

- Well-designed care pathways that assist people at the right time and offer help in a way that does not lead to dependency.

- Tighter eligibility panels and strong performance management.

- Well developed integration or co-ordination with NHS; pooled budgets and multi-disciplinary working.

- A consistent push to reduce admission to residential care.

- The use of "asset based assessment" and "promoting independence reviews".

- Direct Payments being embedded as a fundamental aspect of social work practice.

Performance analysis & commentary on Gwynedd's development

3.13 Gwynedd's net spend on Assessment & Care Management per older people's population, is now well above the 'family" average, although close to the national average. This is a recent trend with the differential emerging in 2012/13 and getting slightly wider in 2013/14. As a consequence we spend at least £0.4m above the "family" median (the differential could be up to £1.0m, depending on how costs are apportioned between the Older People and 18-64 Physical Disabilities client groups).

3.14 If the number of social care clients aged 65+ is used as a proxy for the need to spend on Assessment and Care Management, Gwynedd's spend per user is the 2nd highest in the "family". Conversely, the reported number of service users (per population) has fallen significantly since 2010/11– the national & "family" trend has also been downward but the Gwynedd fall has outstripped these and we have moved from a "higher than average position" to our current "lower than average position".

3.15 On the key performance indicators, which relate to timescales for assessment/serviced commencement, Gwynedd performs well. The latest data on local targets (2012/13) shows good performance will 99.4% of POVA plans appropriately in place and 76.8% of case reviews appropriately undertaken (compared to target of 67%).

3.16 Much of the Safeguarding training is undertaken locally (on a multi-agency basis, including personnel from the independent sector) with some specialist training provided elsewhere. These include:

- "'All Wales Basic Safeguarding Awareness Training'', which replaced the Level 2 POVA Awareness
- 'Investigation skills in Adults Safeguarding' (jointly organised with Anglesey) -run on a regular basis, attended by a mixed audience from Social Services, Health and Police.

- ‘’Note taking in Adult safeguarding meetings’’ to ensure administrative staff have correct skill levels.
- “Mental Capacity Act & Deprivation of Liberty”- leading to the accreditation of 17 Best Interest Assessors within the Council.

3.17 The Gwynedd Case-file Review seeking to establish how well practice was helping to optimise demand management, found that:

- The application of the eligibility criteria was functional & appropriate and the referrals process was tidy & responsive
- A suitable and timely flow through the stages of assessment, care planning and (where necessary) service delivery existed for most cases
- Most assessments lacked substance and inter-agency multi disciplinary work was underdeveloped
- Outcomes were not used in a structured way, and were rarely related consistently to the desired outcomes for the individual
- Wellbeing, the concept of co-production and self-directed care were not central to social work functioning in older persons services
- Some preventative work was present but not necessarily well-evidenced (see reference to outcomes)
- Cases usually showed a proportionate & appropriate resource response to the needs of individuals, without being over-protective behaviour. However, responses were constrained by a traditional outlook and reliance on traditional services
- There was a lack of practice clarity regarding the outcomes (and therefore the purpose) of Enablement programmes, with them often identified in very general terms
- On services there was a lack of diversity (and perhaps capacity) to meet needs, particularly in “crisis” situations
- Any shifts in services following review of cases, tend to be incremental and service-bound

3.18 The Pathways Review seeking to establish the factors leading to an increased use of Nursing Home Placements found that:

- Individual workers’ definitions of similar case situations, can vary significantly
- 47% of admissions to nursing care were straight from acute hospital - worrying as good practice suggests this should not happen
- 23% of admissions to nursing home care were straight from community hospital
- 23% of admissions to nursing home care straight from residential care
- When analysing admissions from permanent address (ie viewing hospitalisation as only an interim episode) 43% of admissions were from “home, in receipt of formal care” and 47% were from residential care

- Out of county placements can distort the picture as in many such cases, the placement was actually nearer the service user's home
- A small reduction in the numbers leaving nursing care was seen during the period 2013 – 2014 – though no trend was identified this contributed to the overall increase in nursing home care placements
- 10 fewer cases transferred to Continuing Health Care (CHC) in 2013-2014 than in 2012-2013 – though no clear pattern can identified over a 5 years period

3.19 Take up of Direct Payments by older people in Gwynedd has been low in comparison with other local authorities. However the Council has recently approved a new Direct Payments Policy that seeks to improve the service and increase the number of participants. The new process will be straightforward, simple and inclusive. Suitable information, advice and support will be available and the focus will be on working with people to achieve their well-being outcomes. We will actively promote this option when assessing/reviewing- a major step in empowering people.

3.20 ICF initiatives that relate to practice include:

- Improving Communication between Professionals – this involves building an extension to co-locate staff from social care and NHS in Ysbyty Gwynedd to be be completed in June 2016.

- 7 day multi-disciplinary working - he aim is 7 day working of the intermediate care teams in the community and advanced discharge teams from the hospital (NHS and Social Services staff). To date (due to recruitment problems in both NHS & Social Services), only the hospital initiative has proceeded but this has proved the need for weekend services. Planning has started for future employment contracts changes for physiotherapists/OT's and for additional nursing staff to bolster their weekend team.

<u>Gwynedd Strategic and Commissioning Intentions</u>

3.21 In the future we intend to:

- Make assessments more proportionate to need, reducing duplication and re-assessment, thereby creating the opportunity to reduce staff numbers and bring our costs closer to the family median.

- Stop admissions to long-term residential care direct from acute hospitals, except in exceptional circumstances (2015/16).

- Commence discussions with BCUHB on reducing admissions to nursing homes direct from hospitals and to clarify the role of Community Hospitals (2015/16).

- Reduce the number of residential placements we make by 5% in 2015/16, 10% in 2016/17 and 20% in 2017/18 (all calculated from the 2014/15 base).

- Move to a full “outcomes” model of assessment, care management & review by the end of 2016/17, dovetailing it with the Ffordd Gwynedd initiative.

- Establish multi-disciplinary Enablement Teams in 2015/16 and commence discussions with BCUHB with a view to establish multi-disciplinary Complex Needs Teams by 2017/18.

- Launch the Departments Social Work Practice Development programme (in 2015/16) to achieve “best practice” standards on wellbeing, co-production, prevention, and demand management by the end of 2017/18.

- Implement the new Direct Payments Policy including changes in social work culture & working with service users as partners. Establish a target of 100 users by 2016/17.

- Work with Regional partners to improve & update our Safeguarding activities by 2016/7.

4 Support to Live at Home

Best practice

4.1 "Frailty" is a common aspect in older people who requiring care and support at home, those who are housebound and those admitted to hospital (British Geriatrics Society 2011). It can often remain unrecognised until something triggers people to present to services. Clinically, older people who are frail have poor functional reserve, so that a relatively minor illness can initiate a catastrophic functional decline. The evidence suggests that, as people enter very old age (aged 85 years and over), it is highly likely that they will have higher levels of frailty, dementia and chronic conditions, often in combination with each other.

4.2 Dementia is progressively common in older age and often complicates the diagnosis of multiple co-morbidities associated with frailty. Research in relation to dementia care shows the importance of tackling the myths, increasing public awareness of the condition and training staff who work with people living with dementia. Independent advocacy should be a standard requirement in cases where the individual cannot speak up for themselves, or have no one else able to do so. A "person centred approach" is considered as good practice in relation to all social work with adults this is particularly true in relation to those living with dementia. Professor Bob Woods notes 4 elements essential to person centred practice:

- Valuing people with dementia and those who care for them
- Treating people as individuals
- Looking at the world from the perspective of the person with dementia
- A positive social environment in which the person living with dementia can experience relative wellbeing

4.3 Eileen Spencer and Dr. Joy Probyn (in research undertaken for the North Wales Commissioning Hub on behalf of NWSSIC (Supporting People with Dementia and their Carers- Models of Positive Practice) provide details of a range of projects considered to have contributed to the development of good practice in relation to dementia care.. Currently 1 in 5 people (over the age of 80) have dementia and it is anticipated that over the next 6 years the number living with the condition in Wales will increase by almost a third (Welsh Government). The "myths" about this condition (e.g. that it only affects older people and that nothing can be done to help those affected to live well) lead some individuals/families to "hide" what is happening for as long as possible, with a consequential risk of isolation. It has also led to unequal treatment of people with dementia, including lack of diagnosis and appropriate services. Discrimination is exacerbated by the fact that people living with dementia may not be able to speak up for

themselves, may well suffer abuse and are in danger of having no " voice, choice or control" (Older People's Commissioner).

4.4 Older people with complex needs require higher levels of support and care from a range of service providers (Welsh Government, 2014). There is published research and anecdotal evidence that services for those older people who are frail and/or with complex needs are fragmented, both within and across organisational and sector boundaries. Refocusing community-based services to respond to these complex needs is a high priority for Councils in Wales and the NHS:

- In Gwent, the concept of frailty has been developed with services to target "frail" population.
- In Pembrokeshire, those with "complex chronic conditions" have been identified and targeted, with service provision designed around this cluster of the population.
- In Powys, and elsewhere in Wales, we see the "virtual ward" using a predictive risk model to identify patients at risk of admission to hospital, and proactively managing them through community based multi-disciplinary teams. .
- In Ceredigion, we see an example of a service being developed around short-term and longer-term conditions. This is also the case in Bridgend with two service streams being available to older people.

4.5 Best practice would indicate that services, including day care, should be tailored to suit the strengths, interests & ambitions in addition to the needs of the individual. This is a significant change to current practice. A model based on the use of a Day Care Broker or Village Agent (or similar) can be developed. This model was successfully deployed in Torfaen some years ago – officers and members from Gwynedd visited the project and reported positively on their findings. Here, Day Care is arranged following discussions with the service user and includes utilising the assets and resources available in an individual's community. In practical terms this can include making use of local clubs and societies, leisure centres and swimming pools, churches and chapels etc. In addition, local cafes, restaurants, and pubs agreed to provide meals (at a discount), for older people at lunch time. This meant that the Day Care Centre, which was purpose built some years previously, ceased to exist as a traditional day care provision but continued to act as a local "resource centre".

4.6 Continence is a major factor affecting a person's ability and confidence to cope at home but incontinence is not an inevitable part of growing older - clear diagnosis and appropriate medical intervention can make a huge difference, as can:

- Practical assistance -toilet rails, toilet seats, walking aids or stairlift to get to the toilet in time.

- Easy–use devices - commodes or hand held urinals (men and women) which can be used in bed or sitting.
- Advice on suitable clothing (fewer layers of clothing, stockings instead of tights, elasticated waists and the use of Velcro rather than zips or buttons).
- Bladder and Bowel Foundation's "Just Can't Wait" toilet card - to avoid a queue for those that need to use a toilet quickly.

4.7 NHS projects in **Lincolnshire & Newcastle** have shown how early clear assessment address's avoidable incontinence and how hospital admissions for urinary tract infections (some catheter associated) can be reduced.

4.8 In 2005 the Welsh Government produced guidelines to assist localities in developing Telecare strategies followed in 2006-2009 by capital and revenue for implementation. The North Wales Social Services Improvement Collaborative (NWSSIC) has taken the lead in attempting to ensure a regional approach to the field of Assistive Technology and in doing so has developed a regional Call Monitoring Service (Galw Gofal) under a regional partnership board.

4.9 Telecare can be a basic alarm service, with a 24/7 response or it can include sensors and triggers such as motion or fall detectors and fire and gas alarms, that trigger a warning to a response centre staffed 24 hours a day, 365 days a year. It can also include location devices that can be used to enable an individual to have security outside of their home. In addition, telecare can act as a preventative tool by helping to detect deterioration in an individual's health or wellbeing.

4.10 Following a high profile, well funded launch within Wales, Telehealth has developed at a pace and has increased its range of opportunities for the use of technologies - the development of Telecare has (in comparison) been slower. Telehealth has also had many research & evaluation papers published while recent research in relation to the effectiveness of Telecare is much more limited. Scotland is a leading country in telehealth and telecare with an emphasis on co-ordinating NHS, social care, housing, the independent sector and the Ambulance Service. Reductions in the number of emergency hospital admissions have been achieved through this approach.

4.11 The limited research into the cost-effectiveness of telecare shows mixed results. The Whole Systems Demonstrator cluster randomised trial (British Geriatrics Society 2014) examined the cost-effectiveness of 'second-generation' telecare, in addition to standard support and care that could include 'first-generation' forms of telecare, It concluded (by measuring using a quantity and quality of life tool) that second-generation telecare did not appear to be a cost-effective in addition to usual care

4.12 Further research "Does telecare prolong community living in dementia" commenced in 2014 to seek robust evidence for its cost effectiveness

or benefit; results should be available 2016. Two different approaches to the use of telecare are emerging, one seeing it as part of a universal offer that is preventative (i.e. deflecting people from formal care services). Alternatively, focusing it as part of a care package for those with significant needs. The cost reduction impacts of the former can be hard to ascertain, but the latter has been claimed to be successful (in some LA's) in realising considerable savings especially when used as a substitute for traditional services.

4.13 Best practice indicates that telecare can assist people to maintain their independence and there is an argument for making it available and on both a universal (basic package) and targeted (individual needs addressed) basis.

4.14 Methods of achieving optimum telecare performance (across the UK) have included:

- Partnership with a commercial organisation
- Training and cultural change amongst front line workers
- Improved process for deploying/ maintaining equipment
- Replacing waiting night staff in LD establishments
- Stimulating greater numbers of self-funders

4.15 Research commissioned by the Betsi Cadwaladr University Health Board found that some 2,916 falls could be prevented each year in North Wales at an estimated saving at more than £4 million. There is a clear link between falls and admissions to hospital, care or nursing home. It is not clear, however, whether care or nursing home admissions are as a result of the older person's informed choice having lost confidence in their ability to manage at home, lack of appropriate and timely community based interventions or pressure on the older person from medical and social work staff and family members in order to ensure their future "safety". Local research(into admissions to nursing homes) has shown that the majority entered care directly from hospital.

4.16 In research across councils in England (John Bolton) it was found that LA's had overused (relatively expensive) enablement interventions – giving it to some service users who did not require it or by providing it for to long. Much of this was though the adoption of an intake model (which was initially promoted as good practice) and through providing the service for free. This meant that there was little, if any targeting and the service can be viewed by users and other professions (medical staff in particular) as a free home care service available for a period of 6 weeks at least).

4.17 Unit cost awareness for each episode of enablement has become an important factor, enabling judgements to be made about cost effectiveness. Recently, such services have been able to be even more robustly focused through improved modelling, excluding those who recover or fall out of the care/health system without needing a such a service, being more selective about people who enter and more precise about outcomes. A ratio of 60% of people using enablement services not requiring any on-going formal care is the benchmark.

4.18 In Torbay they found that (in common with enablement programmes elsewhere), referrals were often for clients requesting a new or increased package of care on discharge from hospital. Frequently these were people who had undergone surgery for a fractured neck or femur or a hip replacement. A subsequent audit of these service users compared with a benchmark cohort showed that an outcome of 'reduced' or 'no further care' occurred regardless of an enablement intervention - that is the people would have improved anyway. As a result, Torbay took a decision to stop automatic referral and to ensure that enablement is used on a more targeted basis. The input of a physiotherapist to the assessment process has given them the best possible insight into the potential for recovery for each person. (LGA Adult Social Care Efficiency Programme). Other key features of enablement good practise are:

- It should be outcome based – workers and users need to clear about the anticipated outcomes and those outcomes should be measurable.
- An integrated approach between health and social care can avoid duplication and bring a higher-impact range of services together.
- Predictions of future demand for longer-term care and support can be made, based on the trajectory of enablement-based services.

4.19 Some Councils, such as Coventry, have reduced their costs by putting the enablement service out for contract. Others have externalised the service, either fully or in part. For example in Wirral a small in-house team provides guidance to external providers to ensure quality and positive outcomes. In Wiltshire there is no specific enablement service as all domiciliary care is commissioned in such a way as to deliver outcomes that promote independence, replacing the former in-house function. As a result Wiltshire enables 60 per cent of older people who are referred to their services to regain independence (not needing a further service) within six weeks of their receiving domiciliary care.

<u>Performance analysis & commentary on Gwynedd's development</u>

4.20 Since 2011/12, the number of our home care users (per population) has fallen slightly. As a result Gwynedd's number of home care users per population is slightly higher but close to the family median and the national median. The Gwynedd net spend on home care per older

persons population mirrors this – it is slightly higher than the 'family' median (Gwynedd is the 3rd highest in this category), constituting a spend of £0.5m above the 'family' median.

4.21 Conversely, Gwynedd's spend per home care user is notably less than the 'family" average and the national average. This trend has emerged as significant since 2011/12 as the 'family" and national average spend per home care users has increased, compared to our stable spend per user. This suggests that we may be providing relatively smaller packages, to a greater number of service users, compared to the general pattern within the "family" and Wales generally.

4.22 At the end of 2014/15 approximately 860 older people were receiving a home care service, the majority of them aged 85 or over. Approximately 10,000 hours of home care service per week is delivered in Gwynedd, with around 42% being proved by the in-house service and 58% provide by the independent sector (though this ratio varies considerably between geographical areas).

4.23 In the course of a year, approximately 500 people will be engaged in an enablement programme; a short, intensively response promoting skills for independence and avoiding creating dependence. It has been successfully operational in Gwynedd since 2010 with around 58% of users staying away from other service for at least a year. In line with growing national evidence on cost effectiveness, a more targeted approach to those being offered the service is emerging.

4.24 Gwynedd's spend per service user on Equipment & Alterations is substantially more than the 'family" average and the national average. In turn this converts into a higher net spend on Equipment & Alterations (per older peoples population) than the 'family" average and the national average. The number of service users (per population) in Gwynedd is close to the family average. Local targets for increasing use of telecare have not been fully met.

4.25 Day Care Services are commissioned around four tiers of care, with 3 of these designed to meet the care needs and outcomes of the older population, including respite for their carers.

Level 4	High level needs or challenging behaviour
Level 3	Socialising and Personal Care Needs – developed skills and to sustain independence
Level 2	Not applicable to OP
Level 1	Support to take part in socialising opportunities

4.26 The Third Sector currently provides socialising opportunities for people 50+ years old through Ageing Well Centres and Luncheon Clubs.

Traditional Day Care provision which incorporates socialising opportunities and personal care or supervision is provided by in-house Provider Service. Specialist Day Care provision has been developed in Partnership with the Betsi Cadwaladr Univeristy Health Board and provides specialist day care for people living with Dementia or Alzheimers.

4.27 The Ageing Well Centres Age (Cymru)are open to all over 50 years and do not require an assessment of the needs of the individual attendee; their remit is to assist older people retain good health and wellbeing and improve both respond to rather than to provide “care” for a specified period. These centres do not provide “personal care” (e.g. bathing) but it is being considered as a future development.

4.28 The other types of Day Care in Gwynedd are very traditional and are provided following an assessment of need. The first is based within residential establishments (both private and internal care homes). The care generally (but not always) includes attention to personal care including bathing and includes joining residents at meal times

4.29 The Day Care based in “centres” is group based with events organised to entertain the majority with most activities being “craft based”. Meals are provided. Again, admission is based on an assessment of need. One new specialist day care facility for service users living with dementia has opened in Bangor.

4.30 Whilst the traditional Day Care model serves a need in that meals are provided and service users are able to socialise a further aim is to provide carers with periods of respite. In order to develop this model social workers / brokers would need to be aware of local resources and discussions would need to take place in order to gain local co operation. This could be achieved at low cost.

4.31 A “Continence Advisory Service” is provided by the Betsi Cadwaladr University Health Board. This Service is available to all adults over 16 years and includes a team of registered nurses who have undergone specialist training in continence management. The service is available across North Wales and patients can be referred by GPs, other health professionals or can self refer. The service includes advice, assessment, treatment and management of bladder and bowel problems with “the aim of curing or improving symptoms”.

4.32 The North Wales Social Services Improvement Collaborative (using Welsh Government Regional Collaboration funding) launched the North Wales Dementia project ‘Inspiring Action’ aiming to improve services to people living with dementia and their carers. As part of this, a Regional Dementia Market Position Statement will outline currently available services and what gaps exist in social care, primary care and community support services (including carer services).

4.33 The Dementia RED service (commissioned from the North Wales Alzheimer's Society) was launched earlier this year. The Support Manager and 2 Dementia RED Information Officers have been recruited & trained along with over 20 Dementia RED Volunteers. The Regional Dementia Education and Support Programme (in partnership with BCUHB Clinical Psychology team) aims to improve skill levels and will pilot the delivery of the programme over this summer:

4.34 In 2014/15 the Supporting People expenditure on older people in Gwynedd amounted to £416,609 -.per capita this is lower than in neighboring authorities. This include 319 units of warden/alarm and 279 units of alarm services provided by Cartrefi Cymunedol Gwynedd. Changes are planned to ensure compliance with the recommendations made in the Aylward Review which requires that "…*the eligibility criteria for older people …. should be based on need rather than age or tenure"*

4.35 ICF initiatives that relate to Support at Home, include:

- Housing stock adaptations **-** 5 additional adapted units of temporary accommodation are now available (within the social housing stock) for service users who have a disability. The properties provide an element of geographical distribution, based on previous demand, population distribution and the distribution of other facilities. Consideration is given to linked support services with resources allocated to support the placements and assist rehabilitation - whilst the availability of accessible accommodation can make a valuable contribution, it will not itself resolve social care or health challenges.

- 'Care and Repair' Gwynedd - middle level (between £1,000 and £5,000) adaptations for owner occupiers and those in private rented/social housing.. Targeted at older people on 'waiting lists', awaiting hospital discharge or those but individual circumstances dictate intervention to facilitate safe discharge or those that desire to remain at home, living as independently and as safely as possible. To date 31 cases have been complete at a total value of works £113,482 (average cost of works is £3,660).

- Carer support - reviewing the current structures & services available and identifying good practice from other areas that could be adopted within Gwynedd. We are now in the process of creating an implementation plan for Gwynedd Carers Partnerships to implement in 2015/16. An information leaflet has been created detailing independent sector respite services and an outreach project for male carers has been successful in Dwyfor and Meirionnydd in:

    - Encouraging co-production
    - Working across boundaries in partnership with the third sector
    - Empowering carers to optimise their own health

- Helping to prevent avoidable breakdown and hospital admission

4.36 Step up / Step down facilities -this project increases respite, enablement and intermediate care capacity in 25 beds in existing residential homes, facilitating discharge from hospitals & reducing the length of stay in secondary care. Staff are trained on the principles of intermediate care/enablement and tele care equipment is available, allowing residents to become accustomed with the technology that may be required & utilised when discharged home. From September 2014 to end of March 2015 the units have supported a total of 116 people. Of these 27 were discharged from hospital to the unit and 89 were admitted to the unit from home. This has saved an estimated total of 2009 hospital bed days which equates a cost of £719,997.

4.37 The Council has the "Living Independently" Programme as part of its governance & change initiative to help people live independently.

<u>Gwynedd Strategic and Commissioning Intentions</u>

4.38 In the future we intend to:

- Adopt a well structured approach to Day Care which differentiates service on the basis of client need- a new strategy will be developed

- Target our "hands on" enablement activities on those who most benefit from them, using the findings of the Vanguard/Fford Gwynedd initiative to determine the future scale of activity

- Make a market shift in Home Care, with the Council become a less prominent provider of service, in some geographical areas, enabling others to expand or start-up.

- Use our "Living Independently" Programme to fine-tune our approach to:

  - Incontinence services
  - Telecare
  - Rapid & crisis response services
  - Care/domestic home services support services
  - The timely availability of aids & adaptations
  - Post-hospital discharge support
  - Specialist support at home for people with dementia and their families.

5 Accommodation

Best practice

5.1 There is a general consensus that older people should not move into long-term care directly from an acute hospital setting, when they are at their most vulnerable. Many Councils now operate a policy where no one can be admitted to permanent residential care from a hospital bed. Indeed any admission to residential care should only be considered when other avenues have been explored and proved inappropriate. The Councils making the biggest reductions in admissions to residential care cite the importance of cultural change in the workplace (LGA Adult Social Care Efficiency Programme).

5.2 IPC (Institute of Public Care 2003) researched a cohort admitted to residential care homes, seeking to estimate how many might have been able to take advantage of Extra Care accommodation as an alternative. In over three quarters of cases researched, the decision to enter a care home followed a critical event such as a fall and/or hospital admission. In the absence of community-based 24 hour care, residential care was seen by relatives and professional teams as the option of least risk, and clients acquiesced in the decision in order not to become a burden.

5.3 It was estimated that two thirds of the cohort could actively have benefited from Extra Care provision, either currently or at the time of an earlier move.

5.4 South Tyneside sought to reduce admissions to residential care for older people through the combination of culture change and tight managerial controls, reporting a 30% reduction from 2011/12 to 2013/14 by:

- Training aimed at social work assessment practice and developing a shared understanding amongst practitioners about what “good” looks like when helping a person to achieve their personal outcomes.

- Commissioners included in all training to ensure an understanding of (in) adequacy of the type/range/capacity of community based services /accommodation available.

- A cultural shift, moving from a paternalistic model of care to one that focused on the wishes of older people, promoting recovery and independence.

- Joint commissioning with NHS to develop step- up and step-down beds.

- Increasing help to carers.

- Investment in specialist housing for older people.

- Greater use of telecare and telehealth.

5.5 Policy documents and published research notes the inter-relationship between housing and the individual's environment as being a critical factor to the quality of life of an individual. Research also concludes that housing needs to be suitable for adapting as people age and their needs change.

5.6 "Better Housing for people in Wales" notes that older people need housing that is adaptable and has good access to resources. "Improving Lives and Communities – Homes in Wales" outlines the different ways of meeting this challenge:

- Provide more housing of the correct type
- Improve housing and communities (including energy efficiency) in new and existing homes
- Improve support services that are connected to housing

5.7 Our own consultation (and consultation by Public Health) in Gwynedd on accommodation indicates that older people want:

- Homes that are easy to look after
- Are safe
- Access to transport and facilities
- Good neighbourhoods
- Homes that are attractive and fit for purpose
- To stay in their own homes instead of having to move to residential care

5.8 This requires age-friendly housing (including sheltered accommodation and extra-care housing) in the right capacities

<u>Performance analysis & commentary on Gwynedd's development</u>

5.9 The Gwynedd net spend on residential care per older persons population is higher than the national average, constituting a spend of £0.9m above the 'family' average.

5.10 It is difficult to analyse the precise extent to which this high level of spend on residential care is due to high spend on residential care per user, or to a high rate of residential users per older people population. This is due to apparent inconsistencies in the recording of "self-funding" clients across authorities (this has a particular impact for

Gwynedd's comparative position since we have a high proportion of clients in LA-run homes, therefore more self-funding clients are "known" to the authority).

5.11 The officially reported figures suggest that spend per client in Gwynedd is lower than average, and that the rate of residential care users per population is significantly above average.

5.12 However, when the figures are adjusted for the estimated level of "self-funders" in each authority's data, the position changes significantly. Gwynedd's spend per client is then estimated to be the highest in the "family", and the rate of service users per population becomes close to the "family" median.

5.13 Although it is difficult to be precise because we are relying on estimates obtained by contacting other authorities, rather than officially published figures, it is clear that the main reason for Gwynedd's high level of spend on residential care is that the cost per client is comparatively high.

5.14 Gwynedd's net spend per older persons population on nursing home care is also £0.9m above the 'family' average (Gwynedd is the highest spender in this category). As the Gwynedd spend per nursing home care user is very close to the 'family average and the national average, its clear that this spend differential arises from our significantly higher number of nursing home care users (per older persons population) compared to the 'family average and the national average. This difference has occurred since 2010/11 as Gwynedd's indicator has risen, contrary to the decreasing trend in both the family and the national average.

5.15 The Pathways Review seeking to establish the factors leading to an increased use of Nursing Home Placements found that:

- A small reduction in the numbers leaving nursing home care occurred in 2013 – 2014; though no trend was identified this contributed to the overall increase in nursing home care placements
- 10 fewer cases transferred to CHC in 2013-2014 than in 2012-2013 ; though no clear pattern can identified over a 5 years period
- 47% of admissions to nursing care were straight from acute hospital -worrying as good practice suggests this should not happen
- 23% of admissions to nursing home care were straight from community hospital
- 23% of admissions to nursing home care were straight from residential care
- However, when analysing admissions from permanent address's (ie viewing hospitalisation as only an interim episode) it was revealed that 43% of admissions were from "home, in receipt of formal care" and 47% were from residential care

5.16 The Pathways Review seeking to establish the factors leading to admission to Residential Care found that:

- In the 6 months period there were a total of 50 applications for long-term residential care, evenly spread across the County.

- Approximately 80% were Female. The average age of the cohort was 85 years (average for females 87, for males 79). 38% were diagnosed as having Dementia / Alzheimers / Memory.

- 44% had spent a period in Hospital before moving to residential care. 32% of these had been admitted more than once to hospital following falls at home. There were a few examples of individuals being assessed in Hospital and deemed to need a long-term residential placement.

- 10% of the cohort were unable to move to their preferred choice of Residential Home, 6% of these cases were in the Meirionnydd area. This led to the 6% receiving their care out-of-county.

5.17 Within Gwynedd, at the end of 2014/15 there were:

- 72 purpose-built extra care dwellings (with an additional 40 commissioned for 2017)
- 539 Residential beds, 248 of which are provided by the Council
- 95 Residential EMI beds, 37 of which are provided by the Council
- 356 Nursing beds
- 118 Nursing EMI beds

5.18 Funded by ICF, the Accessible Housing Register identifies available properties that have been adapted, together with a list of people requiring adaptations and seeks to match appropriate properties to individual requirements. Also the Moving On scheme with Canllaw, facilitates the process of older people moving into more appropriate homes. The pilot has concentrated on relocating people to an extra care facility in Bangor, but has also negotiated discounts with Estate Agents and conveyance solicitors and vetted removal/house clearance firms.

5.19 Our work on an accommodation strategy has identified key geographical areas to prioritise to develop and expand accommodation options. These are are:

- Dyffryn Ardudwy a Llanbedr

- Tywyn and Aberdyfi, Bryncrug & Llanfihangel

- Aberdaron, Botwnnog, Tudweiliog and Llanbedr & Abersoch

- Porthmadog West

5.20 The North Wales Social Services Improvement Collaborative (NWSSIC) has produced an outcome based service specification to support service users living with dementia in residential / nursing care settings. This is focussed on achieving positive outcomes for service users living with dementia their Carers / Provider which will enrich quality of life and promote the wellbeing of residents.

5.21 Plans for new Extra Care Housing in Porthmadog are well advanced and the project will be operational in the summer of 2017

Gwynedd Strategic and Commissioning Intentions

5.22 In the future we intend to:

- Secure a shift in the Residential Care market, with an increased proportion of provision from the independent sector and a reduced contribution from the Council's In-house Services.

- Reduce the overall number of Residential beds by 10% by the end of 2016/17 and by 20% by the end of 2017/18 (calculated using 2014/15 base).

- Clarify (with our BCUHB partners) the future role of Community Hospitals and increase the provision of general nursing care & EMI nursing care accordingly.

- Increase the number of Extra Care dwellings to 160 by 2020.

- With partners, pursue improvements in suitability of accommodation provision across the private & social housing market, ensuring that full & appropriate use is made of sheltered housing.

- Develop specific plans for key geographical areas (as identified in the report), to prioritise the expansion of accommodation options.

- Ensure that citizens are more aware of available accommodation options by improving the quality of information to them.

6 Integration with NHS Services

Best practice

6.1 "Integrated care is capable of achieving positive outcomes, although it is not always clear which combination of strategies, and under what circumstances, produce the best results" (Kings Fund, 2012).

6.2 Where Council's are successfully taking opportunities to integrate with the NHS it is based on shared key objectives for the future, such as the need to retain independence for older people and reduce longer-term admissions to institutional care. There is evidence that such integration gives a benefit to service users with the joined-up service providing a more positive experience. Integration has also emerged as a principal vehicle for better use of resources in the future, enabling agencies to meet their longer-term funding challenges. Firm evidence of this is elusive though and some experience suggests that the NHS is better placed to reap the financial rewards than Councils are. It may also be that up-front funding to secure effective integration is required, before services can realise actual savings.

6.3 In England, evidence has highlighted some successful models of integration such as the intermediate care/re-ablement schemes seen in Swindon, Torbay or Richmond and the "Gateway to Care" in Calderdale. Multi-disciplinary team working is one of the most popular integration steps.

6.4 As another example, Northumberland has had a joint arrangement for health and social care since the 1990's. More recently £5m pa of savings were delivered in adult social care recently, as a direct result of the integrated model. This was partially achieved by multi-disciplinary teams that were successful in holding demand for domiciliary care at a steady rate, while reducing the numbers in residential care by 12%.

6.5 From an NHS perspective, the work by the NHS Confederation shows that when done well, integration reduces fragmented service delivery and avoids duplicative processes. If the financial framework is constructed well, integration can address the current systemic disincentives and contribute towards ameliorating budgetary pressures. Integration delivers a more seamless experience, better health outcomes and the opportunity for more care closer to home.

6.6 From a Social Care/LA viewpoint (ADASS), a critical success factor is leadership, with political leaders encouraging discussions at all levels about the future of health and care services and a focus on getting the best outcomes with limited money. Alongside this, system leaders must move away from purely organisational perspectives and take decisions on the basis of pursuing improvements in the health and wellbeing of the local population. It is important that the political and policy debate isn't driven by crisis or seen disproportionately through an NHS lens.

6.7 Shared accountability will be enhanced through simpler, more unified health and social care outcomes framework. On the financial front, aligned payment mechanisms that support more integration and incentivise outcomes-focussed care will assist the development of integration. Transitional funds to move to new models of care and sustainable longer-term financial plans, are essential.

6.8 "Intermediate Care" is a term that is used to describe a range of services that appear to fall between traditional NHS & Social care, as well as being the title (ICF) of a major Welsh Government programme aimed at transforming service. However, in a Kings Fund review of Intermediate Care (Intermediate Care -Models in Practice, B. Vaughan and J. Lathlean) the authors note the lack of clarity and consensus regarding the nature of these services. They originally defined Intermediate Care as:

"That range of services designed to facilitate the transition from hospital to home, and from medical dependence to functional independence, where the objectives of care are not primarily medical, the patient's discharge destination is anticipated, and a clinical outcome of recovery (or restoration of health) is desired."

6.9 As the review proceeded, however, they broadened the definition to include:

"Those services which will help to divert admission to an acute care setting through timely therapeutic interventions which aim to divert a physiological crisis or offer recuperative services at or near a person's own home".

6.10 Intermediate care often has two key components; a rapid response intervention (to stabilise, meet immediate need & prevent deterioration) and an enablement intervention (to assist functional recovery).

6.11 However the Integration debate should start with users not structures or service titles, as people themselves have the biggest interest in getting things right. Evidence shows that with the right support, people themselves are the best integrators of care. (Forder et al 2012). The evaluation of Personal Health Budget Pilot Programme, (University of Kent) showed significantly improved quality of life for individuals and carers, with more flexible services being developed & reduced hospital admissions

6.12 Examples of best practice:

- A rapid/crisis response service following hospital discharge or critical event - including nursing, therapies, and personal care, operated and run within a multi-disciplinary team on enablement principles.

- A risk stratification approach – operated with GPs to identify vulnerable patients who are referred to the multi-disciplinary team for action to prevent needs escalation and to support them to remain in their communities.

- Long-term conditions integrated specialism -focusing on people who have complex needs.

- Joint Commissioning - shifting resources towards community-based services.

- Multi-disciplinary Teams & pooled budgets.

Performance analysis & commentary on Gwynedd's development

6.13 Gwynedd received £1.9m from the Welsh Government via the Intermediate Care Fund (!CF) in 2014/15.

6.14 The objectives of the programme are to:

- Move the change programme onwards in an integrated way.
- Support and promote transformation through developing and testing new models of services that ensure sustainability for the future & improve results for older people.
- Evaluate and review the "current system of work".
- Research good practice and learn from it.
- Take a full strategic overview of the paths for older people and evaluate them.
- Change culture.
- Achieve the best results for older people, ensuring that a correct system is in place to support and serve, to ensure that people stay safe in their homes or communities for as long as possible.

Examples of ICF initiatives have been illustrated in the chapters of this Report.

6.15 The programme had four themes:

- Enhance integration and remove barriers to integrated working, across LA's, Health, Third and Independent sectors.
- Strengthen the Enablement ethos and improve the range of services in the community.
- Provide more responsive services.
- Avoid unnecessary admissions to the hospital/care services.

6.16 As part of the Councils' Strategic Plan, we seek redesign our current working methods to achieve integration with NHS services. The County Forum has been established as a key platform in the integration

apparatus in Gwynedd, including the third sector in addition to statutory agencies. This is a high level group which has the capability to abolish barriers to integrated working for older people, avoid unnecessary admission to hospital and also to promote a culture & fabric of community support for them.

Gwynedd Strategic and Commissioning Intentions

6.17 In the future we intend to:

- Commission services jointly so that the best health and well-being results are achieved.

- Establish multi-disciplinary Enablement Teams (comprised of NHS and Social Services staff).

- Promote close joint working between other teams and establish further integrated services, with an emphasis on developing streamlined care pathways for older people.

- Ensure a better understanding of financial matters amongst partners in the older people field and that the workforce and the management system are fit for purpose for the future.

- Ensure that 'back office' systems connect together easily (including a shared information system for Social Services and Communiy Health).

- Implement the Framework for Delivering Integrated Health & Social Care (for older people with complex needs)

- Ensure continuation of key ICF initiatives, with the allocation of £744,000 to support them in 2015/16.

7. Conclusion

7.1 Undertaking this whole systems review has been an enormous task. The nature of the "whole system" is dynamic and that means that any review will only capture the position at a point in time – the work in managing this whole system needs to become part of the core business of the Department and the Council. What is clear is that through our work on:

- Wellbeing and primary demand management
- Practice development
- Support to live at home
- Accommodation
- Integration

we can re-shape the whole system and provide greater independence, reduce social isolation, raise dignity & quality of services and provide better support for carers.

Appendix 1 - Performance and Comparative Data Pack