**Date:** **Wednesday 14 July 2004**
**Venue** **Committee Room , National Assembly for Wales**
**Title:** **Review of the Interface between Health and Social Care**

## Purpose

This paper sets out the main themes that have emerged from the evidence the Committee has received since the start of the review. The paper is arranged in sections following the terms of reference. The Committee is invited to reach conclusions on the evidence and make recommendations.

## Background

The Committee's review commenced on 9 October last year when public consultation started. 69 responses were received from individuals and organisations. In November the Committee received oral evidence from Derek Wanless and has taken further oral evidence since January. Committee Members made visits to four projects in South Wales and Professor Vivienne Walters, the Committee's expert adviser on the review, held three focus groups with service users and providers. Further information is provided in the Annexes as follows:

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| Annex 1 | Summary of written responses to public consultation |
| Annex 2 | Summary of main themes emerging from oral evidence |
| Annex 3 | Note of Committee Members' visits |
| Annex 4 | Note of Focus Groups |
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## 1. To review the mechanisms for joint planning and provision of services in health and social care and the quality of the evidence base.

- The creation of LHBs and their co-terminosity with local authorities has had a positive impact on better joint working.
  *Association of Welsh Community Health Councils (AWCHC) Association of Directors of Social Services, Wales (ADSS) Wales Council for Voluntary Action (WCVA)*;
- There are problems with short term funding and use of grant schemes. These include the projects not being absorbed into mainstream provision; insufficient evaluation of projects; staffing difficulties, short term contracts making it difficult to recruit and / or it may be that the best staff are seconded to a project, depriving core services.
  *AWCHC; Welsh Therapies Advisory Committee (WTAC); Royal College of Nursing, Wales (RCN); Expert Reference Group on Domiciliary Care (ERGDC); WCVA; Dinefwr Cict.*
- Incompatibility of ICT systems has proved to be a big hindrance to sharing information effectively. The implementation of Informing Healthcare and Informing

Social Care is key to this. Derek Wanless said that there needs to be a balance between providing individuals with better service and protecting confidentiality, and there should be more scope for anonymised use of data for planning. Other respondents advocated the use of a single patient record.
*WTAC; Age Concern Focus Group; Dinefwr Cict.*

In a paper to the Committee on these initiatives the Minister said: "In summary, *Informing Healthcare* and Informing Social Care have been produced as separate strategies because of the environmental constraints at the time of their development. Both have an evidence-based and incremental approach to implementation, and both are committed to the long-term integration of health and social care information (subject to legal constraints). In the short-term, work is being undertaken to ensure that all health and social care staff have a common and commonly understood set of rules for using and sharing information. This work will then be taken forward by ensuring that the Unified Assessment Process in particular is well supported by information systems across health and social care. Further opportunities for joint working will be sought on an ongoing and pragmatic basis."

- There is no evidence of support for a single health and social care organisation.
  *AWCHC; NHS Confederation Wales; Welsh Institute of Health and Social Care (WIHSC)*
- It is important to involve he voluntary ad independent sectors in the planning process.
  *Welsh Local Government Association (WLGA) and WCVA*
- Children's centres were effective partnerships between local authorities and the health service, with co-ordinated joint planning.
  *SCOVO*

**2. To examine the accountability arrangements for joint planning and service provision.**

- There is a lack of mechanisms for evaluating joint performance. Common performance measures across the health social care and voluntary sectors could address this, with the Assembly Government Regional Offices supporting the process
  *AWCHC; RCN;Caerphilly LHB; NHS Confederation; Dinefwr Cict.*
- Access to budgets and joint funding was found by some to be difficult, due to differences in organisational culture and "ownership" of budgets.
  *Caerphilly LHB; Blaenau Gwent Assist Project; WLGA*
- There is potential for problems with accountability and professional governance for fully integrated budgets.
  *The Forge Centre.*
- The NHGS and local authorities have different decision making processes, accountability and planning timetables
  *Pembrokeshire*
- Joint funding is not crucial to the development of co-ordinated services. It is possible to create effective partnerships and deliver through agreement on funding without having to pool the money.
  *ADSS*
  **Note:** Is there scope for SAFFs and the local authority performance management system to include joint working?

**3. To evaluate the effects (both positive and negative) that decisions in one service can have on another**

- There is a need to engage more effectively with other local authority service areas such as housing, transport, education, street lighting. LHBs are limited in the influence they have over wider LA services.
  *WTAC; WLGA; ADSS; NHS Confederation; Care and Repair Cymru; and SW Wales Regional Committee*
  **Note** – consideration of role of health impact assessments.

**4. To examine key areas that impact on the quality and provision of a seamless service**

- There are already a number of ways in which good practice is shared. Examples cited include Innovations in Care conferences; meetings between members of LHBs across Wales; All Wales Unit website; "Excellence Wales" programme; voluntary sector health and social care facilitators disseminating good practice to LHBs.
  *AWCHC; RCN; WTAC; Caerphilly LHB;WLGA; WCVA.*
  **Note:** there was little evidence of sharing or seeking good practice outside Wales.
  **Note;** should consideration be given to some form of award scheme or chartermark for good practice?

- Unified assessment was constrained by incompatible IT, lack of trust in other professionals and lack of access to medical records *(AWCHC)*. Rhondda Cynon Taf felt that the voluntary sector had a key role to play in view of their experience in starting with patients' needs, but it would be most appropriate in high dependency cases.
  **Note** – could unified assessment be an indicator of effective joint working?

- Better shared learning opportunities and joint training to help professionals understand one another's role. There should be an holistic approach to training. Medical students at the Welsh College of Medicine shadow physiotherapists to gain a better understanding of rehabilitation.
  *WTAC: RCN: SW Wales Regional Committee*

  **Note:** Use of the patient held record was an important issue (but may be too detailed a recommendation for the report).
  **Note:** Access to services in one place could be used as an indicator of effective joint working.

***i. Hospital discharge***

- There are hospital discharge schemes in many areas. Some have discharge liaison nurses who are specially trained in social services criteria and able to access funding and services. Some discharge schemes have encountered difficulties because of short term funding. Premature or poorly planned discharge can result in unnecessary re-admission. Premature discharge may result from the need to meet inappropriate performance targets. Planning for discharge should start at the time of admission.
  *RCN; Age Concern, Swansea; Age Concern Swansea Focus Group; Caerphilly LHB; ERGDC; Derek Wanless.*

**Note:** Another key measure of effective joint working.

***ii. Intermediate care***

- This should be part of a unified service *(RCN).* Wales could learn from England about developing intermediate care *(ADSS).*

***iii. Residential and nursing home services***

- There is a lack of capacity, adequate levels of funding needed to ensure quality of care and workforce. LAs struggling to meet costs. There is a need for research, development, investment and long term planning.
  *RCN; LGA, AWCHC and Derek Wanless*

***iv. Domiciliary care services***

- Planning for domiciliary care is often non-existent, often is just what LA is able to provide. Currently not working together to have that intelligence gathering network. Domiciliary care increasingly important as more people wished to remain in their home with support. Quality of service from private carers is not as good as from local authority provided services. The new regulation arrangements for domiciliary care would have an impact on provision
  *Service Users' Focus Group and ERGDC*

***v. Involvement of the independent and private sectors***

- The fragmentation of the independent care home sector makes it difficult to engage them in joint planning *(RCN*).

  **Note:** the long term planning and commissioning of residential and nursing home provision as well as domicilairy care needs addressing. There has been little evidence about this in respect of the former.

***vi. Support for carers***

- There is a lack of appropriate and timely respite care.
  *AWCHC; Service Users' Focus Group*
- There should be greater recognition of the burden on carers, their need for support and the impact on their own health. Their needs should be monitored throughout the care pathway
  *AWCHC; Service Users' Focus Group; SW wales Regional Committee; Age Concern Focus Group.*
  **Note**: A key measure of effective joint working.

**5. To review the role of health and social services in promoting the independence of patients and the prevention of unnecessary admission or re-admission to hospital**

- Housing adaptations are important in promoting independence and the role of Care and Repair was acknowledged *(AWCHC and WLGA.)* However there were some delays and inadequate provision of stair lifts and hoists. *(Service User*

*Focus Group)* The ability to maintain a home and garden contributed to health and wellbeing *(Care and Repair Cymru; SW Wales Regional Committee).*

- The introduction of specialist falls clinics and simple adaptations to homes could help to prevent accidents and hospital admission *(Derek Wanless)*.
- A number of initiatives were cited as preventing admission or re-admission: crisis management at home, patient held records, preventative check-ups for over-75 year olds *(AWCHC);*
  rapid access schemes (NHS Confederation;
  holistic services for over-75 year olds*(Caerphilly LHB)*; and
  better out of hours services for social care (ADSS).
- There is a need for easier access to information, services and sources of help. *AWCHC; SW Wales Regional Committee; Age Concern Focus Group; Service User Focus Group.*

**Annex 1**

**HEALTH AND SOCIAL SERVICES COMMITTEE**
**REV IEW OF THE INTERFACE BETWEEN HEALTH AND SOCIAL CARE**

*Summary of Responses to Public Consultation*

| **1** | **Bro Taf Medical Committee** |
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| **Willing to give oral evidence to the Committee?** | Yes |
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| **Summary of response** | |
| ◊ Commend attachment of social workers to GP practices as happens in Cardiff;<br>◊ Otherwise GPs do not experience much effective interface between health and social care | |

| **2** | **The Stroke Association – Regional Manager Community Servcies** |
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| **Willing to give oral evidence to the Committee?** | Not stated |
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| **Summary of response** | |
| ◊ The Association contracts with 16 LHBs / LAs in Wales to provide community services for people after they have had a stroke and / or are suffering from dysphasia. A more cohesive and proactive approach to joint commissioning in this area would be more effective. | |

| **3** | **Morgannwg Local Medical Committee** |
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| **Willing to give oral evidence to the Committee?** | Yes |
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| **Summary of response** | |
| ◊ Difficulties over whether GPs or Trusts prescribe for patients in intermediate care;<br>◊ Nursing home care is not included in the GMS contract and GPs are not required to work in them. The needs of nursing home patients may exceed the capacity of the home and staff to provide for them.<br>◊ Demarcation lines in domicilary care need to be addressed.<br>◊ Poor interface between the private / independent sectors needs addressing.<br>◊ Carers need more support;<br>◊ Simple aids, such as walking frames, can be key to a person remaining at home rather than being admitted to hospital. These are often low priority in the NHS. | |

| 4 | Age Concern Cymru |
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| **Willing to give oral evidence to the Committee?** | Not stated |
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| **Summary of response** | |
| ◊ Number of partnership, strategy etc groups is a problem for Age Concern;<br>◊ Cites a number of instances where joint working is ineffective as well as examples of good practice;<br>◊ Concludes that the voluntary sector should be involved in joint working as a major supplier of services, but more funding for the sector is needed for it to to be a reality. | |

| 5 | Welsh Food Alliance |
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| **Willing to give oral evidence to the Committee?** | Not stated |
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| **Summary of response** | |
| ◊ The importance of nutrition as a preventative pubic health measure should be recognised through *community nutrition services*<br>◊ The nutritional status of hospital patients should be monitored at all stages and data collected by the Audit Commission;<br>◊ Meals on wheels services should be audited for quality and the availability of special diets, including those required for black and ethnic minority groups. | |

| 6 | North Glamorgan NHS Trust |
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| **Willing to give oral evidence to the Committee?** | No |
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| **Summary of response** | |
| ◊ The Trust has joint planning and service arrangements for older people and some children's services. It is involved on project working in Youth Offenders Teams, Surestart and community First Projects. Evaluation has shown that there is less duplication, more effective use of resources and an holistic approach to meeting needs.<br>◊ Reablement teams are working jointly in the community to provide care packages and OT equipment, reducing the number of unnecessary hospital admissions.<br>◊ Problems with organisational boundaries and information sharing. | |

| 7 | DayBreak Wales |
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| **Willing to give oral evidence to the Committee?** | yes |
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| **Summary of response** | |
| ◊ Daybreak has submitted its report, published in 2002, on their experiences in developing a social rehabilitation model of intermediate care for people in their home. The model is service user centred and based on outcomes.<br>◊ There is a need for an urgent and fundamental review of domiciliary care to enable it to be more effective and efficient at the interface between health and social care. | |

| 8 | North West Wales NHS Trust |
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| **Willing to give oral evidence to the Committee?** | Yes |
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| **Summary of response** | |
| ◊ Examples of good joint working in NW Wales health and social care communities include:<br>- intermediate care services through the multi-agency / discipline emergency Pressures Planning Team; and<br>- multi-professional / agency specialist Community Paediatric teams and Learning Disabilities Resettlement Programme.<br>◊ Potential Barriers to joint working include:<br>- *disruption to working relationships at operational level in health and social care resulting from restructuring of NHS;*<br>- lack of resources for new initiatives, eg no Welsh Assembly Government funding for Unified Assessment process;<br>- bidding process for additional funds from Assembly Government is not conducive to good planning and time is often insufficient to prepare bids and demonstrate achievement of goals;<br>- some Assembly government initiatives create difficulties by not understanding how health and social care services can work together locally. | |

| 9 | School of nursing and Midwifery, University of Sheffield |
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| **Willing to give oral evidence to the Committee?** | Not stated |
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| **Summary of response** | |
| ◊ Have provided a case study of the events preceding the death of a lady with learning difficulties, but do not want it quoted or cited without permission. | |

| 10 | Parkinson's Disease Society in Wales |
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| **Willing to give oral evidence to the Committee?** | Not stated |
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| **Summary of response** | |
| ◊ It has been estimated that the employment of a Parkinson's Disease Nurse Specialist can save the NHS £25,000 in consultant time. The specialist nurse provides access to quick advice, and health and social care signposting and support.<br>◊ The Parkinson's Disease Society (PDS)works with local health and social care professionals to provide integrated information, awareness, advice and training for sufferers and carers.<br>◊ PDS are working with Rhondda Cynon Taf CBC to provide a part time Community Information Officer and would like to develop the model elsewhere.<br>◊ The long term nature of the disease means that people have many continuing needs which should be co-ordinated across the various disciplines and agencies. | |

| 11 | Expert Reference Group Domiciliary Care Wales |
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| **Willing to give oral evidence to the Committee?** | Not stated |
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| **Summary of response** | |
| ◊ Domiciliary Care wil have an important role in implementing the recommendations of the Wanless report.<br>◊ Workforce issues must be addressed to improve recruitment and retention.<br>◊ Adequate support and training must be provided for the implementation of the new statutory regulations. | |

| **12** | **Gwynedd County Council Care Directorate** |
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| **Willing to give oral evidence to the Committee?** | Yes |
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| **Summary of response** | |
| ◊ Developing with partners a co-operation and flexibilities agenda to strengthen joint working and joint planning groups for different categories of clients have been established.<br>◊ Three multi-agency / disciplinary schemes are reducing the incidence of unnecessary hospital admission and ensuring that community services are available to facilitate to discharge of hospital patients:<br>- a rapid response service in Arfon;<br>- Social Care assessors based in primary care surgeries;<br>- Re-ablement scheme provided by specially trained occupational therapists and home carers to reduce hospital stay and long term dependence.<br>◊ An action group representing health and social care is preparing for the introduction of *Creating a Unified and Fair System for Assessing and Managing Care.* | |

| **13** | **University of Wales college of Medicine – Department of Child Health** |
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| **Willing to give oral evidence to the Committee?** | Not stated |
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| **Summary of response** | |
| ◊ In the past joint working has been unsuccessful because health and social services have had conflicting priorities. A joint budget and joint management structure outside the local council and NHS Trust, where the child comes first is needed.<br>◊ Joint offices and joint databases are also needed especially for child protection.<br>◊ The Joint Office for Child Protection in Cornwall could be a good model to follow in Wales | |

| **14** | **Cardiff and the Vale NHS Trust** |
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| **Willing to give oral evidence to the Committee?** | Not stated |
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**Summary of response**

◊ Joint working takes place at all levels, often without formal co-ordination.

◊ The Trust has provided responses to each of the points in the terms of reference and theses are summarised using corresponding numbering:

i. The Trust has established a post of *Head of Partnership Development* to develop a strategic and corporate approach, especially with LHB / LAs. Good practice in working in partnership depends on the willingness of individuals and time is needed to develop relationships. Regular reorganisations mitigate against this. Wales wide systems are needed to reduce reliance on individuals.

ii. In Cardiff the Health Alliance is chaired by the LA cabinet member and the LHB Chair is vice chair. In the Vale, the Strategic Executive Group is chaired by the Director of Community Services. The Trust is actively involved in both of these.

iii. Changes to services in one area impact on another, eg the move to community based social work teams means that without ward based social workers hospital discharge is more difficult to effect.

iv. - Joint equipment stores would help to alleviate some of the problems in iii above.

- *Development of joint care packages can delay discharge – the establishment of single records would help. Shortages of therapy and social work staff prevent seamless services.*
- The Welsh Assembly Government needs to give guidance on the *Choice Directive for Nursing and Residential Home placements*. NHS and LAs need to work together locally and nationally, together with housing services and the voluntary sector, to address innovatively the shortage of nursing and residential home places.
- There are difficulties in both Cardiff and the Vale in setting up domiciliary care. The NHS and LAs need to address this together.
- There are examples of good practice at operational level in working with the voluntary sector, but a more strategic approach is needed.
- Better support is needed for carers, through the voluntary and independent sectors.

v. Initiatives such as the Elderly Care Assessment Scheme and the Rapid Response Re-ablement Service are effective in keeping people out of hospital, but they are not cheap money saving options.

◊ The NHS should be a formal partner to the new LA Social Workforce Confederations.

| **15** | **Swansea Council for Voluntary Service** |
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| **Willing to give oral evidence to the Committee?** | Yes |
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| **Summary of response** |
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| ◊ The Council has responded following the points numbered in the terms of reference:<br>iii.- joint funding / equipment stores fail when one partners budget runs out.<br>- *Change in NHS policy resulted in long term clients no longer having access to old people's day centre. Not all users were suitable for alternative provision and in consequence health may deteriorate and need higher costing services.*<br>- Scope for better joint working in respect of continuing health care at home.<br>iv. - Better communication and better informed hospital staff would facilitate hospital discharge.<br>- *Intermediate care requires joint planning, budget and training.*<br>- Shortage of EMI beds; fees levels are inadequate to to provide care to required standards.<br>- There are problems in recruiting and retaining domiciliary care staff and meeting the costs of statutory requirements.<br>- The independent / private sector needs to be more involved in joint planning.<br>- More respite care is needed especially where nursing care is involved.<br>v. The role of health and social services in promoting independence and preventing hospital admission should be reviewed. Good communication and the role of the voluntary sector are important. Often low level intervention is all that is needed and the voluntary sector can provide this effectively. |

| **16** | **NCH Cymru** |
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| **Willing to give oral evidence to the Committee?** | Yes |
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| **Summary of response** | |
| ◊ Planning for children's services is still complex and confusing because of the relationship between the Children's Framework and Health and Wellbeing Strategies. Legal and political differences between LAs and Health hinder joint planning.<br>◊ There are problems with joint funding for service providers who often have to contract separately with both "partners", although some examples of good practice are given .<br>◊ NCH Cymru will be publishing a report on research into the health needs of young carers. (Executive summary appended to the submission.) | |

| **17** | **Welsh local Government Association** |
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| **Willing to give oral evidence to the Committee?** | Oral evidence presented to the Committee on 11 Dec 2003. |
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| **Summary of response** |
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| ◊ There is a strong commitment to joint working from staff at all levels.<br>◊ LHBs need time and freedom to demonstrate that they work in meeting local needs. Developing them is resource intensive.<br>◊ Joint priorities should result from health and well being strategies, but they should operate in a context that rewards success, supports failing areas and creates opportunities for improvement.<br>◊ The WLGA is promoting the sharing of good practice and working with LHB and LAs to identify good practice and situations where good practice is being sought.<br>◊ There are difficulties in reconciling LAs' accountability for funding health and social care within their accountability overall for non- hypothecated budgets. This could be resolved by the agreement of joint targets reflecting priorities from the Health, Social Care and Wellbeing Strategies.<br>◊ Joint targets need to be developed locally reflecting national and local priorities. Significant investment in information m management and technology is needed to enable both the NHS and LAs to manage performance effectively.<br>◊ The decline in investment in research and development must be redressed to enable managers and practitioners to have a better understanding of what works in a non-clinical setting. |

| **18** | **Association of Directors of Social Services, Wales** |
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| **Willing to give oral evidence to the Committee?** | Oral evidence presented to the Committee on 11 Dec 2003. |
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| **Summary of response** |
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| ◊ The interface between Health and Social Care is a major defining issue in the shape of future services in Social Care.<br>◊ The Health and Social Care Review sets a comprehensive framework to address the issues and is strongly supported.<br>◊ A whole systems approach, which sees services as a local economy is the right context, but there are concerns about how this will operate because there is significant disparity between Health and Social Care, which needs to be addressed if this approach is to work properly.<br>◊ There is a need to re-balance services towards a primary level in which Social Care has a lot to contribute in terms of cost effectiveness and fulfilling people's wish to receive treatment and care close to home.<br>◊ The differential treatment in pay is undermining the effectiveness of services and will hold back progress in joint working until it is addressed.<br>◊ The fragility of the independent sector is a major risk issue, but there are a wider range of issues than fees alone.<br>◊ Progress is being made to improve joint working and more integrated operation, but is variable across Wales. Least progress is being made in Older People's Services in links with primary care.<br>◊ Local Health Boards working with Local Authorities to plan local economies of service through Health, Social Care and Well Being Strategies offers a lot of promise in addressing the issues, but needs to be fully supported politically, financially and through performance management.<br>◊ Social Services needs to become much more collaborative in sharing, learning and development, and in working collectively to provide a consistent platform of services providing the necessary foundation for an efficient Health Service.<br>◊ Clearly designated funds forecast more than a year ahead are necessary to plan local service economies. There are a number of avenues for achieving more integrated funding which require more detailed work.<br>◊ Pooling budgets through LHBs is a useful mechanism provided spending is joint agreed through joint plans.<br>◊ Social Care is unable to fulfil its potential contribution to the overall cost effectiveness and efficiency of services. This will depend on achieving a major re-balancing of investment towards primary level services as proposed in the Wanless Review. |

| **19** | **Wales Council for Voluntary Action** | |
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| **Willing to give oral evidence to the Committee?** | | Oral evidence presented to the Committee on 11 Dec 2003. |
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| **Summary of response** |
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| ◊ Initiatives such as *Building Strong Bridges* are allowing the voluntary sector to increase its contribution within the new NHYS structures.<br>◊ Voluntary sector organisations are able to work across boundaries and take an holistic approach to meeting need.. Many are involved in preventative work and are able to respond flexibly to needs.<br>◊ Flintshire County Voluntary Council undertook research in 2002 to examine the contribution of the sector and the paper includes some examples. The WCVA will be publishing shortly the report on the research, entitled *Reaching the Other Parts: Voluntary Sector Health and Social Care Services in Wales*. |

| **20** | **The Chartered Society of Physiotherapy Cymru** |
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| **Willing to give oral evidence to the Committee?** | Yes |
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| **Summary of response** | |
| ◊ Information systems in both health and social care need to be compatible, with single records. This should extend to education in the case of children.<br>◊ A culture change including common definitions, protocols, policies and processes is needed to achieve seamless services. Different management structures hinder seamlessness.<br>◊ Following the numbering in the terms of reference:<br>*i.* *- The Welsh Assembly Government should build in more sustainability to funding and ensure that partner organisations have the protocols and processes to assist joint working.*<br>- Physiotherapy and other professions should be involved in the development of local health alliance plans.<br>*ii.* *Accountability needs to be clearly defined and performance monitored jointly.*<br>iii. - Joint working has positive outcomes, eg joint equipment, aids and adaptations for children in N Wales.<br>- However there can be tensions over issues such as different policies and criteria for services; different terms and conditions of appointment; and different bureaucratic processes.<br>iv. - Discharge planning must be whole systems and needs led process which starts on admission. The procedure should be standardised across Wales to have a full impact.<br>- Intermediate care services should be reviewed to ensure they meet local need and are sustainable.<br>- There is potential for LHBs to develop services through block booking beds for intermediate care.<br>- Better communication and access to information is needed to enable the independent and private sector to play a greater role.<br>- Carers can be key to discharge, but need more information and empowerment. There are examples of good practice in the voluntary sector which should be disseminated.<br>*v.* *The sectors need to work together to create a healthy population, with people encouraged to take responsibility for their health and helped to manage any condition.*<br>◊ Physiotherapy is often an untapped resource, but the profession is keen to adopt new ways of working and to contribute to the modernisation agenda. | |

| **21** | **Wales Centre for Health** |
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| **Willing to give oral evidence to the Committee?** | Not stated |

**Summary of response**

- ◊ Preventive services should be identified in the terms of reference.
- ◊ Wales Centre for Health and its partners could develop a stronger evidence base on the effectiveness of joint working initiatives

| **22** | **RNIB Cymru** |
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| **Willing to give oral evidence to the Committee?** | Yes |

**Summary of response**

- ◊ A joined up approach between health and social services is vital to people who have a sight problem so that they can be referred from health to appropriate social services departments. Information should be provided in an appropriate accessible manner.
- ◊ Wales has an increasingly elderly population which is proportionately high compared to other parts of the UK and Europe. This will have implications for future services to help those with eyesight problems to live safely and independently.
- ◊ Voluntary Sector organisations such as RNIB have considerable expertise and can train people in health and social services as well as providing and facilitating support services.
- ◊ The Welsh Assembly Government's recent appointment of a Children's Low Vision Advocate who can work across health, social services and education is welcomed. The concept should be applied for people of all ages who have sight loss.

| **23** | **College of Occupational Therapists** |
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| **Willing to give oral evidence to the Committee?** | Yes |

**Summary of response**

- ◊ Conflicting statutory responsibilities, policy drivers, competing priorities, resources and budgets are among the things that prevent effective joint working. As a result therapy services are not used effectively.
- ◊ There are not enough occupational therapists in community based rehabilitation and primary care, nor enough opportunities for them to continue to work with a client throughout their care journey.
- ◊ The separation of responsibility for different parts of the care process to health or social care results in duplicated referrals, wasted resources and additional waiting lists.
- ◊ Access to equipment is bureaucratic and needs to be better integrated and more flexible in meeting people's needs. An All-Wales equipment strategy would help.
- ◊ There are a number of staffing issues affecting occupational therapists that need to be addressed in order to reduce stress and improve morale.
- ◊ Funding short term projects can be beneficial in encouraging innovation, but the results need to be evaluated and disseminated. They can have an adverse effect in that they are not always well integrated with other services and can drain staff away from other services which are under pressure.
- ◊ A number of examples of service configuration which facilitate joint working are given including:
  - Giving GPs direct access to inter-professional teams, as in the Elderly Care Assessment Service at Rookwood Hospital.
  - Multidisciplinary team at the A&E unit at UHW prevents unnecessary hospital admission.
  - Employment of a re-ablement occupational therapist within the Home Care Service in Ceredigion to help individuals retain independence.
  - Occupational and physiotherapists supporting rehabilitation in intermediate care, as in the Mardy scheme in Abergavenny.
  - In Wrexham, health occupational therapists have direct access to Housing Department budgets for minor adaptations.
  - A senior occupational therapist is employed by Gwent NHS Trust and financed by Caerphilly social services to provide a continuum of care to patients who require maximum support to return home.
- ◊ The College has submitted an extract from its strategy, published in 2002, for modernising occupational therapy services in local health and social care communities, as it applies in Wales.

| **24** | **Wrexham Social Services and Wrexham Local Health Board** |
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| **Willing to give oral evidence to the Committee?** | Not stated |

**Summary of response**

- ◊ Health and social services in Wrexham have used opportunities provided by Health Act flexibilities and special grant to develop a number of strategic and operational initiatives such as Integrated Mental Health Provision; joint equipment stores, intermediate care beds; pooled budgets for EMH nursing beds; rehabilitation flat within a sheltered housing scheme. Training has also been given to appropriate staff to understand the frameworks necessary to achieve change.
- ◊ A joint Workforce Initiative Group has been formed to support training. Health and Social Care Services in Wrexham are working to identify common service outcomes.

| **25** | **McCarrison Society** |
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| **Willing to give oral evidence to the Committee?** | Not stated |

**Summary of response**

- ◊ Limited intelligent data is available to inform the Committee. The need for information about the performance in the NHS and healthcare needs to be addressed.
- ◊ The Committee should consider focussing on the quality of care, patient experience and organisation.
- ◊ The committee might also look at the way the professions are regulated: Sir Ian Kennedy concluded that while self regulation should continue, there should be lay involvement. The Committee should consider the role of lay people in health and social care.
- ◊ The Committee should have regard to the work Derek Wanless is doing on the public health review in England.

| **26** | **Quality Resource Management Ltd** |
|---|---|
| **Willing to give oral evidence to the Committee?** | Not stated |

**Summary of response**

- ◊ Much data is collected in Wales, but is not used to inform performance management.
- ◊ A strategic review of the collection and use of data should be undertaken urgently.
- ◊ The review outcomes should include joint performance indicators for health and social services, portray present services and set targets to bring the quality of the Welsh public sector up to that of England in the next five years.

| **27** | **Cardiff Local Health Board / Cardiff Council** |
|---|---|
| **Willing to give oral evidence to the Committee?** | Yes |

**Summary of response**

- ◊ the submission details the work of the Cardiff Health Alliance in respect of points i and ii in the terms of reference:
  - *The Joint Commissioning Group and the Advisory Planning Group were established in 2002, to examine structures and explore scope for improvement, eg a more robust commissioning framework across health and social care.*
  - The Cardiff Community profile, published in 2002, brought together key plans for health and social care and laid the foundation for the joint Health, Social Care and Wellbeing Strategy.
  - The Alliance Board is the project board for the development of the joint Health, Social Care and Wellbeing Strategy
  - In 2001 the Alliance established a process for prioritising bids for the Flexibilities Joint Working Special Grant.

| **28** | **Mr Orwig Owen** |
|---|---|

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| **Willing to give oral evidence to the Committee?** | Yes |
| | |

**Summary of response**

◊ Mr Orwig sought domiciliary care from social services, shortly beforec his mother died in May 2003. An assessor was sent but advised Mr Orwig hat no help could be given as there was waiting list for home care. The County Council subsequently advised that help would have been given if it had been appreciated that Mr Orwig's mother had been terminally ill.

◊ Mr Orwig contends that
- *if no help was available it was waste of resources sending an assessor; and*
- the assessor could have contacted the GP from Mr Orwig's home for confirmation of his mother's condition.

| **29** | **The Stroke Association –Chief Executive, Wales Regional Office** |
|---|---|
| | |
| **Willing to give oral evidence to the Committee?** | Yes |
| | |

**Summary of response**

◊ Interface between social care and primary health care is underdeveloped. Where joint working is effective it is the result of co-operation, trust and mutual respect.

◊ "Delayed transfer of care of a stroke patient due to poor integration of care will impact on trolley waits. We must ensure joint working across professional and organisational boundaries and need true integrated care overcoming the barriers between health and social care" *(A practical guide to deveoping stroke services. March 2003)*

◊ Where patients are treated in dedicated stroke units seamless services are good.

◊ Needs assessment should be combined with a service that facilitates the implementation of care plans.

◊ There is evidence that a relatively short term intervention on discharge from hospital by a Home Therapy Service was a good investment and prevented the need for ongoing social services.

◊ Local commissioning of short term contracts for services in Wales compounds the issue of disjointed services. Full integration of services and pooling of funding streams would be more effective and would reduce the number of negotiations needed.

| **30** | **Royal Pharmaceutical Society of Great Britain, Welsh Executive** |
|---|---|
| | |
| **Willing to give oral evidence to the Committee?** | Yes |
| | |

| **Summary of response** |
|---|
| ◊ The RCP recommends that medication problems should be addressed when planning services at the health / social care interface. Service commissioners should consider how pharmacists can be used to tackle them.<br>◊ The flow of information about medication between care settings should be a priority when patients cross organisational boundaries.<br>◊ The submission sets out a number of obstacles relating to commissioning, and communication.<br>◊ Pharmacists working across primary and secondary healthcare can provide a seamless interface on medication and can help improve the quality and safety of medicines use. Community pharmacists are able to provide training, information, support and advice to patients and their carers.<br>◊ The submission includes examples of good practice. |

| **31** | **Age Concern, Swansea** |
|---|---|
| | |
| **Willing to give oral evidence to the Committee?** | Yes |
| | |
| **Summary of response** | |
| ◊ Experience of five years membership of Health and Social Care Joint Planning Committee indicates that staff from NHS Trust and Social Services have different levels of responsibility and some may not be authorised to take decisions. Lack of continuity in people attending is a barrier to progress. Restructuring of the Health Service has hindered the work and led to frustration.<br>◊ Hospital staff often disagree about a patient's readiness for discharge and premature discharge can lead to patients not being able to care for themselves. Discharge policies need to be reviewed and brought up to date.<br>◊ Nursing staff have insufficient knowledge of community support available.<br>◊ Age Concern run a Hospital Discharge Service involving managers and staff from primary health and social care and volunteers.<br>◊ Demand for domiciliary care means that the service is task led not client centred.<br>◊ Both the voluntary and independent sector need to be involved in planning.<br>◊ There is a lack of appropriate respite care. Jointly funded day centres are needed. These could offer preventative/ screening/ assessment services.<br>◊ More needs to be done to improve servcies for promoting independence | |

| **32** | **North Wales Commission Partnership** |
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| **Willing to give oral evidence to the Committee?** | Yes |
| | |

| Summary of response |
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| ◊ A lead commissioning manager has been appointed with New Flexibilities grant to commission services for adults up to the age of 65 with long term health and social care needs.<br>◊ Work to date includes:<br>- *plans to set up a pool of health and social care workers trained to support the people with complex needs resulting from physical disability;*<br>- working with housing organisations on plans to provide suitable accommodation;<br>- considering options for intermediate care; and<br>- developing advocacy services.<br>◊ Challenges to date include:<br>- incompatibility of IT systems;<br>- developing links with the NHS Trust on commissioning;<br>- staff feeling threatened by change; and<br>- overcoming differences in working practices between health and social services. |

| 33 | Disability Rights Commission |
|---|---|
| | |
| **Willing to give oral evidence to the Committee?** | Not stated |
| | |
| **Summary of response** | |
| ◊ Co-ordination of services and communication can be an issue *within* health and social care as well as *between.*<br>◊ The Pan Wales Social Care Commissioning and Contracts Officers Group is trying to develop all-Wales models of good practice in commissioning and contracting with the Independent Sector, including common contracts for domiciliary care and for residential and nursing care.<br>◊ Independent service providers in Wales are experiencing difficulties due to lack of clarity over responsibility for funding.<br>◊ Local authorities have been slow to set up and publicise independent living schemes.<br>◊ Disabled people have been badly served by provider led health and social care services. Their needs must be integral to policy, planning, commissioning, service delivery and performance management.<br>◊ Seamless care pathways must be based on agreed protocols and shared organisational cultural values. | |

| 34 | Leonard Cheshire |
|---|---|
| | |
| **Willing to give oral evidence to the Committee?** | Not stated |
| | |

| **Summary of response** |
|---|
| ◊ The role of the voluntary sector and user representatives on local health boards is welcomed, but there are concerns about some aspects of the new arrangements:<br>- *commissioning high cost specialist care requires expertise as well as resources;*<br>- complex joint / regional commissioning and funding can diminish informed participation and be time consuming; economies of scale in specialist provision may be lost;<br>- the costs to the voluntary and independent sectors of linking with 45 health and local authorities is high.<br>◊ Local plans and strategies are not well developed in many areas, with a lack of an needs analysis and targets for service development .<br>◊ The framework of principles for voluntary agencies working in Wales needs to be fully implemented. |

| **35** | **Mind Cymru** |
|---|---|
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| **Willing to give oral evidence to the Committee?** | Yes |
| | |
| **Summary of response** | |
| ◊ **Does not wish to make written evidence public.** | |

| **36** | **Pembrokeshire County Council / Pembrokeshire LHB / Pembrokeshire and Derwen NHS Trust** |
|---|---|
| | |
| **Willing to give oral evidence to the Committee?** | Not stated |
| | |
| **Summary of response** | |
| ◊ The statutory bodies are involved in several joint initiatives.<br>◊ Details are given of the Pembroke / Pembroke Dock scheme to provide a totally integrated service for home based care. This is testing the reality of multi-agency working.<br>◊ With regard to accountability health is the lead agent, with social service staff seconded to in the NHS.<br>◊ Robust communication is key to minimising negative and maximising the positive effects of decisions made in one service.<br>◊ Scheme focuses on the use of a unified assessment tool and unified process of care management. This is supported by training, unified policies and procedures and eventually integrated management and pooled budgets.<br>◊ Fundamental differences which are proving challenging include:<br>- *different accountability of health and social services – national versus local agenda;*<br>- professional tensions and differences, eg in perception of risk;<br>- Incompatibility in planning and budgeting processes and timescales.<br>◊ National guidance on governance and the development of joined up performance indicators would be helpful. | |

| 37 | Carmarthenshire NHS Trust |
|---|---|
| | |
| **Willing to give oral evidence to the Committee?** | Not stated |
| | |
| **Summary of response** | |

◊ Resources for children's services have not grown in tandem, with children first money not reaching health.

◊ There are concerns about funding for children from elsewhere being fostered in Wales.

| 38 | Mencap Cymru |
|---|---|
| | |
| **Willing to give oral evidence to the Committee?** | Yes |
| | |
| **Summary of response** | |

◊ Many people with a learning disability are now receiving good support as a result of effective joint planning and working, with joint service aims, values and principles.

◊ The submission discusses some of the key issues and cites examples of good practice.

◊ The following recommendations are made:

- Disability Awareness Training for all health professionals including the needs of people with a learning disability and those whose behaviour may challenge the service;
- joint training for community based health teams alongside their social services colleagues and the independent and private sector providers on appropriate responses to individuals whose behaviour may challenge the service;
- a clear process for agreeing any additional support over and above the hospital provision that is needed on admission and people identified as being responsible for reviewing the support provided at regular intervals;
- research the benefits and risks associated with training non-health staff in some basic health care for specific individuals support packages;
- requirement for primary and secondary health services to meet the needs of individuals who would be more effectively treated at home or greater time allowed; and
- continue the good work started in multi-disciplinary planning and ensure the full inclusion of people with a learning disability and their carers in planning forums.

| 39 | University of Wales College of Medicine |
|---|---|
| | |
| **Willing to give oral evidence to the Committee?** | Not stated |
| | |

| Summary of response |
|---|
| ◊ Pressures on the acute sector mean that an effective system of collaboration and communication between stakeholders is needed to ensure a safe, appropriate discharge. A lead professional should oversee the process.<br>◊ Reconfiguration of occupational therapy services from its focus in secondary care to a community based service would enable practitioners to support users in the primary care and community liaising with hospital based colleagues during acute care.<br>◊ Multi professional teams working in the community with people with mental health problems or learning difficulties have worked successfully through effective leadership and joint working policies. The key is the sharing of information between team members from different agencies.<br>◊ There are problems in providing student placements for occupational therapy students.<br>◊ There is a need to develop leadership in cross–agency teams and UWCM is considering whether it should provide post registration training. |

| 40 | ***Cancelled*** |
|---|---|
| | |

| 41 | **Multiple Sclerosis Society - MS Cymru** |
|---|---|
| | |
| **Willing to give oral evidence to the Committee?** | Not stated |
| | |
| **Summary of response** | |
| ◊ National Institute for Clinical Excellence guidelines Management of Multiple Sclerosis in Primary and Secondary Care, 2003 sets out a number of recommendations on joint working.<br>◊ The MS society advocates the appointment of key workers to help people with MS access services as their needs change. | |

| 42 | **Caerphilly Local Health Board** |
|---|---|
| | |
| **Willing to give oral evidence to the Committee?** | Not stated |
| | |
| **Summary of response** | |
| ◊ A joint planning structure is in place with accountability vested in the Health, Social Care and Wellbeing Partnership - the chief officers' group.<br>◊ Th LHB and County Council work with the Gwent Association of Voluntary Organisations.<br>◊ Several schemes have been established using joint flexibilities<br>◊ The LHB's whole systems action plan includes:<br>-rapid response and re-ablement schemes;<br>- respite care; and<br>- 0ver-75s holistic assessment.<br>◊ As part of planning a new hospital in Caerphilly, a group has been established to develop service models that will prevent unnecessary admission or re-admission to hospital and facilitate early discharge. | |

| 43 | **Blaenau Gwent LHB** |
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| **Willing to give oral evidence to the Committee?** | Not stated |

**Summary of response**

- ◊ The LHB works closely with its statutory and non- statutory partners and there is a strong and high level commitment to the development of the Health, Social Care and Wellbeing Strategy.
- ◊ However there are practical problems and planning timescales need to be harmonised, eg Health, Social Care and Wellbeing Strategies need to be harmonised with the Community Plan.
- ◊ Performance Management of the various statutory bodies by different parts of the Welsh Assembly Government needs to be rationalised to provide coherent accountability and feedback.
- ◊ The availability of joint working special grant has been welcome. The extension of direct funding for partnerships is advocated, rather thatn the poling of budgets.
- ◊ Joint working needs to be facilitated at national as well as local level.

| **44** | **Carers Wales** |
|---|---|
| **Willing to give oral evidence to the Committee?** | Yes |

**Summary of response**

- ◊ Despite good discharge policies and joint working arrangements across Wales there are still major problems at operational level.
- ◊ Problems over who pays for what will continue as long as there is disparity in the funding and charging arrangements between health and long term social care.
- ◊ Carers Wales and the Wales Carers' Alliance are conducting surveys of carers and of services that have been provided by Carers' Special Grant and a risk assessment of what will happen to those services when the grant ends in 2005.

| **45** | **Care Council for Wales** |
|---|---|
| **Willing to give oral evidence to the Committee?** | yes |

**Summary of response**

- ◊ The Council is responsible for developing and promoting the National Occupational Standards for Social Care and is working with the health sector to address the needs of both workforces and the skills blends required to provide those services.

| **46** | **Swansea Local Health Board** |
|---|---|
| **Willing to give oral evidence to the Committee?** | Not stated |

**Summary of response**

- ◊ **Does not want response published**

| **47** | **N. Wales Association of Approved Domiciliary Care Providers.** |
|---|---|

| | |
|---|---|
| **Willing to give oral evidence to the Committee?** | Yes |
| | |
| **Summary of response** | |
| ◊ Evidence of participation and partnership with the independent sector is patchy in N Wales, although there is a willingness to involve the sector in discussions on planning and commissioning.<br>◊ In Flintshire the sector participates actively at every level in the planning and commissioning of services for adult social care. | |

| **48** | **Brecknock and Radnor CHC** |
|---|---|
| | |
| **Willing to give oral evidence to the Committee?** | Not stated |
| | |
| **Summary of response** | |
| ◊ The process of joint working is just beginning.<br>◊ Organisational difficulties and differences might best be addressed by integrating fully health and social services to a single health and social wellbeing organisation, along the model of Holland and other European countries.<br>◊ Local authority Community Strategy Forums are complicating joint working and public participation.<br>◊ Hospital discharge in Powys fails to address patient choice and sometimes patients are trying to discharge people to an area at a distance from their home.<br>◊ There is an imbalance between the powers of the acute hospital sector and the community which weakens the interface. | |

| **49** | **Community Pharmacy Wales** |
|---|---|
| | |
| **Willing to give oral evidence to the Committee?** | Not stated |
| | |
| **Summary of response** | |
| ◊ It is critical that under the new Pharmacy Contract new models and standards of service delivery are developed on all-Wales basis for implementation within each locality according to local need. | |

| **50** | **Association of Welsh Community Health Councils** |
|---|---|
| | |
| **Willing to give oral evidence to the Committee?** | Not stated |
| | |
| **Summary of response** | |
| ◊ Consideration should be given to integration of services working via one health and social wellbeing organisation with shared budgets and no overlapping of duties.<br>◊ Consideration should be given to a national tariff for nursing home beds.<br>◊ Funding for social services should be linked to the numbers of people over 65 and numbers of supported children.<br>◊ Primary care services should be developed to monitor people over the age of 65 not in regular receipt of health servcies | |

| 51 | National Public Health Servcice |
|---|---|
| | |
| **Willing to give oral evidence to the Committee?** | Not stated |
| | |
| **Summary of response** | |
| ◊ Integration of services for elderly people would best be effected by joint older persons' team accessed through the GP practice. A model has been evaluated in Cardiff and the Vale.<br>◊ Delegation of appropriate budgets should be the next step.<br>◊ Possible constraints around accommodation, resources for clerical support | |

| 52 | Care and Repair Cymru |
|---|---|
| | |
| **Willing to give oral evidence to the Committee?** | Not stated |
| | |
| **Summary of response** | |
| ◊ Needs Assessment mapping process within each LA is key to joint planning.<br>◊ Development of compatible IT between Health and Social Care would give evidence of effectiveness of local jointpPlanning and delivery.<br>◊ An example of how decisions in one service impact adversely on another is given. Suggests that stakeholders need to be involved in decision process with clear communication.<br>◊ The Rapid Response Adaptations Programme, funded by the Welsh Assembly Government, and administered by Care and Repair Agencies across Wales, focuses on hospital discharge and reducing the number of admissions. It is delivered in partnership with health and social care bodies.<br>◊ Care and Repair's work leads to health gains, enhancing independence and lessening the need for social care intervention.<br>◊ Appropriate housing is key to independence and preventing hospital admission. Care and Repair Cymru and Shelter Cymru have produced a Housing Checklist and Information pack for health professionals. | |

| 53 | Welsh Therapies Advisory Committee |
|---|---|
| | |
| **Willing to give oral evidence to the Committee?** | Not stated |
| | |

**Summary of response**

Following the numbering in the terms of reference

- ◊ i. While welcomed, Joint Flexibilities funding is short term and this can lead to difficulties in recruiting and retaining high calibre staff. There can be tensions over charging and different working practices.
- ◊ i. There needs to be greater inclusion and integration in health promotion embracing housing, education, leisure and amenities.
- ◊ ii. There are tensions between LHBs and LAs over spending priorities for areas of LA responsibility and accountability problems in a number of operational areas affecting therapists.
- ◊ iii. Partnership agreements between health, education and social services are effective in securing joint working, but a number of negative effects listed of tensions resulting from the different cultures are listed.
    - ◊ iv. - Multi-disciplinary team working essential to safe hospital discharge. Pressures of bed management and issues around the patient record also impact.
    - *development of intermediate care has sometimes been haphazard, but there is evidence that it can be effective and sustainable.*
    - There is potential for residential and nursing homes nursing homes to provide intermediate care, but staff need training to work with community therapy teams.
    - Conflicting policies between health and social care sectors can impact on provision of domiciliary care services.
    - Communication and access to information is vital to the successful involvement of the private / voluntary sectors. The lack of a single patient records is a barrier.
    - There can be problems when the carer is not involved in the discharge process.
    - ◊ v. - A number of ways for improving collaboration to create a healthier population are cited.
      - a joint approach to information management and the introduction of the single patient record is fundamental tot he successful integration of services.

| **54** | **Newport Local Health Board** |
|---|---|
| | |
| **Willing to give oral evidence to the Committee?** | Not stated |

**Summary of response**

- ◊ Differences in structure, culture and accountability, focus etc need to be addressed by the partners and the Assembly Government to realise the full benefits of joint working.
- ◊ Challenges include:
    - differences in the overall sizes of the LHB and local authority;
    - short lines of reporting and accountability in LHB compared with the local authority, and resultant difficulties in reaching joint decisions.
    - Different policy drivers between the two organisations.
    - Ambiguity around statutory planning requirements.
    - LHBs are commissioners of service, but LAs both commission and provide services and are also major employers. This can lead to conflicting aims. This could be resolved if LAs separated their commissioning and provision roles

| 55 | Welsh Ambulance Services NHS Trust |
|---|---|
| | |
| **Willing to give oral evidence to the Committee?** | yes |
| | |
| **Summary of response** | |
| ◊ The Trust is affected by decisions made in other services, eg closure of A and E Departments and would welcome a formal mechanism for assessing the impact of such changes. | |

| 56 | United Kingdom Home Care Association Ltd. |
|---|---|
| | |
| **Willing to give oral evidence to the Committee?** | Yes |
| | |
| **Summary of response** | |
| ◊ The submission details the current position on independent domiciliary care and discusses future challenges such as the regulation of the sector that will come into force later this year.<br>◊ The paper makes 20 recommendations including:<br>- *the need for domiciliary care to be represented on strategic and local policy and implementation groups that advise on the implementation of change at the interface between health and social care;*<br>- funding for domiciliary care must take account of the needs of vulnerable people and the workforce.<br>- Commissioners need to understand the implications of the new legal requirements of the Care Standards Act 2000.<br>- Commissioners will need to be more specific about outcomes required to ensure the provider can deliver and providers will need to be supported to enable them to identify and access training for staff.<br>- Joint Review teams should engage with the domiciliary care sector.<br>- New models of targeted domiciliary care can be cost effective and should be adopted. A review of current patterns would ensure best value for service users and money.<br>- The Assembly Government should review domiciliary care to confirm and identify problems and ensure that there are services to meet future needs. | |

| 57 | Royal College of Nursing |
|---|---|
| | |
| **Willing to give oral evidence to the Committee?** | Yes |
| | |

| **Summary of response** |
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| The response follows the numbering in the terms of reference.<br>◊ i. The use of pooled budgets has tended to be for specific projects and not general service planning and provision.<br>◊ i. The introduction of Health, Social Care and Wellbeing Needs Assessments should be the foundation for joint working.<br>◊ i. The implementation of the ICT strategies for health and social care services will be key to improving the interface.<br>◊ ii. Performance management frameworks need to be used to secure the achievement of "whole system" goals.<br>◊ ii. Similar accountability arrangements need to be introduced for local authority social services as now apply to the health service in Wales.<br>◊ ii. It is too early to evaluate the effectiveness of care trusts in England and the Royal College does not advocate merging health and social care into one commissioning body at this stage.<br>◊ iii. The unavailability of social care is identified as the major cause of delayed discharge.<br>◊ iii. Discrepancies in hours of operation between health and social services can result in delayed transfers.<br>◊ iii. Differences in charging regimes often gives the impression that there are no costs associated with NHS care.<br>◊ iii.Different attitudes of health and social care workers can affect the care pathway.<br>◊ iv. Protocols and training should be provided so give nurses the authority to discharge patients, to avoid waiting for the consultant's next round.<br>◊ iv. Patients and carers need to be involved at an early stage of discharge planning, and referral systems reviewed.<br>◊ iv. Clinicians should be given clear guidance on the rights of patients to remain in hospital to reduce the number of patients and families who do not co-operate on discharge plans.<br>◊ iv. A number of ways of enhancing community nursing services are suggested with the aim of facilitating discharge and improving patient care, including for patients with serious or terminal conditions.<br>◊ iv. A range of high-tech services can be provided in a patient's home as part of intermediate care.<br>◊ iv. Research has shown that up to 25 per cent of hospital patients could be more appropriately cared for in intermediate care. Intermediate care needs to be properly supported though, or patients may deteriorate.<br>◊ iv. Many of the community hospitals in Wales are not suitable for intermediate care and this should be a priority for the capital programme.<br>◊ iv. The Assembly Government should give guidance to local authorities on the funding of care homes, including fee levels.<br>◊ iv. The capacity of care home provision should be properly planned and the process should involve the independent sector.<br>◊ v. Hospital outreach services, working with community services, can minimise hospital admissions and facilitate discharge. |

| **58** | **Swansea NHS Trust** |
|---|---|
| | |
| **Willing to give oral evidence to the Committee?** | Not stated |
| | |

| Summary of response |
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| ◊ Joint working and co-operation is well established in Swansea, with evidence from the external evaluation of the implementation of the joint agencies' Intermediate Care Strategy demonstrating both positive and negative aspects of joint working.<br>◊ Several areas of good practice are cited.<br>◊ In the light of Swansea's experience improvements can be made by:<br>- *streamlining strategic and planning guidance and focusing on outcomes;*<br>- joint accountability for joint objectives, with the same outcomes and targets;<br>- increased availability of joint pump-priming funding to test out service changes;<br>- all-Wales policies on issues such as patient choice and reducing delayed transfers of care; and<br>- developing joint budgets, underpinned by performance and outcome measures. |

| 59 | Rhondda Cynon Taf county Borough Council and Rhondda Cynon Taf LHB |
|---|---|
| | |
| **Willing to give oral evidence to the Committee?** | Not stated |
| | |
| **Summary of response** | |
| Some 21 case studies are provided. These appear to relate to schemes for flexibilities funding. | |

| 60 | Cancelled |
|---|---|
| | |

| 61 | Monmouthshire Local Health Board and Monmouthshire County Council |
|---|---|
| | |
| **Willing to give oral evidence to the Committee?** | Not stated |
| | |
| **Summary of response** | |
| ◊ There is a formal structure for joint posts and joint planning.<br>◊ Examples of joint working are given.<br>◊ The following promote joint working:<br>- whole systems thinking;<br>- unified assessment<br>- Wanless;<br>- joint flexibilities and s31 agreements;<br>- involvement of elected members in LHB;<br>- Shared vision and helping people.<br>◊ The following inhibit joint working:<br>- dominance of acute sector and financial balance in NHS<br>- Royal College protection of single disciplines.<br>- Cultural, structural and management differences; and<br>- High profile of health while social care is still a "Cinderella" service. | |

| 62 | All Wales Gerontology Practitioner Network |
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|---|---|
| **Willing to give oral evidence to the Committee?** | Not stated |

**Summary of response**

- ◊ Collaboration works well at local level, but fails at the higher level when budgets are involved.
- ◊ Nurses with gerontology experience should be more widely used to manage more complex care.
- ◊ There are dangers that health needs may be overlooked as more care is transferred from health to social care.
- ◊ Social workers, and allied health professions should be trained to work with older people alongside nursing and medical staff, to promote person-centred, holistic practice.
- ◊ Independent Service Brokerage, eg the Canadian model, would enable a current stereotypical attitudes. more objective view for the service user and would challenge

| **63** | **Wales Council for the Blind** |
|---|---|
| **Willing to give oral evidence to the Committee?** | Yes |

**Summary of response**

- ◊ Would like to present oral evidence to the Committee on
  - developments in the visual impairment pathway and
  - how joint planning would impact on the pathway

| **64** | ***Permission to publish witheld*** |
|---|---|

| **65** | **Audit Commission for Wales** |
|---|---|
| **Willing to give oral evidence to the Committee?** | Not stated |

**Summary of response**

- ◊ The Audit Commission have provided a comprehensive response covering:
  - shared vision and joint planning;
  - integrating services;
  - information systems;
  - managing and measuring performance;
  - policy alignment
  - promoting independence; and
  - role of regulation.
- ◊ It concludes that key challenges still need to be met with over-arching policies and strategies that identify the levers and incentives to ensure that services are appropriately refocused and are informed by the views of patients and their carers.

| **66** | **Welsh Nursing and Midwifery Committee** |
|---|---|

| **Willing to give oral evidence to the Committee?** | Not stated |
|---|---|

**Summary of response**

- ◊ Both professions and agencies are involved in the interface, and structural changes to health and social services do not necessarily result in more joined up services and better user experience.
- ◊ The Centre for Mental Health Services Development has evaluated the joint commissioning and provision of mental health services in Somerset since the beginning of the decade.
- ◊ Sainsbury Centre for Mental Health study in 2001 produced six key indicators for the development of effective joined up services. Delivering Health and Social Care study found evidence of goodwill and creativity on the part of care providers working across boundaries, which contradicts the view that there are conflicts in inter-professional care. A professional lead co-ordinator is key where there are complex care needs.
- ◊ External performance reviews and audits need to be integrated.
- ◊ IT systems need development to improve communication.
- ◊ Inter- professional education and training is important, but little takes place..

| **67** | **Community Practitioners and Health Visitors' Association** |
|---|---|
| **Willing to give oral evidence to the Committee?** | Yes |

**Summary of response**

- ◊ Recommends that the Assembly should, among other things,
  - support better commissioning of Child Protection Services;
  - improve the processes of joint planning and remove legal barriers to information sharing in primary and community care; develop a comprehensive school health service.
- ◊ Recommends for successful joint working:
  - specific posts to facilitate and manage service developments;
  - joint training opportunities, to engender trust and professional understanding; and
  - appropriate strategic lead for projects, so that decisions can be followed through and implemented.

| **68** | **Welsh Institute of Health and Social Care, University of Glamorgan** |
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| **Willing to give oral evidence to the Committee?** | Yes |

**Summary of response**

- ◊ Suggests three areas of evidence based research and development work on which the Committee might wish to take oral evidence:
  - *Substitution of In-patient Focused Technologies -which showed that 90% of elderly people on a waiting list for institutional care in Powys could have remained at home with technological support.*
  - Balance of Care model – developed for Dyfed Powys but not implemented.
  - Community Health Alliances through Integrated Networks (CHAIN). Action research project in Rhondda Cynon Taf focusing on improving quality of life for older people. The project has looked at service integration form the strategic, operational planning, management and practice perspectives.

| 69 | Dr Colin Young, Professional Tutor, Cardiff University |
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| **Willing to give oral evidence to the Committee?** | Not stated |
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| **Summary of response** | |

- ◊ Whole systems approach to health and social care depends on strong *informal* links between professionals.
- ◊ Older people need time to adjust and make decisions when their health deteriorates. They should have the opportunity to try an intensive home care package, rather than be admitted immediately to residential care.
- ◊ Respite care beds in hospital should be available for the terminally ill who do not need acute palliative care.

**Annex 2**

**Issues arising from oral evidence presented to HSS committee's review of the Interface between Health and Social Care.**


## Abstract

This paper draws together the main issues arising from the evidence presented to the Health and Social Services Committee in the conduct of its review of the interface between health and social care to the end of June 2004. It encompasses oral evidence presented to date, evidence from committee visits and from the focus groups and information presented to the South East Wales Regional Committee in its 7 May meeting.

The main themes that have been brought out in the evidence made available to the Committee are shown in relation to the terms of reference of the review in section 1. Some further themes not directly related to the terms of reference but still needing consideration in relation to joint planning are given in section 2. The source of the evidence has been included. There is a summary of other issues raised by individual organisations that are not part of the key themes but may still warrant attention in section 3.

Sections 4 and 5 summarise the key issues raised in the committee visits and the focus groups, respectively.

Annex A gives a list of the oral evidence sessions held to the end of June 2004, the visits undertaken by the committee and the focus groups undertaken. This also gives a key to the abbreviations used below.


## 1. Main themes emerging

**i. To review the mechanisms for joint planning and provision of services in health and social care and the quality of the evidence base.**

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| General support of better working together through LHB structures, in particular coterminosity with local authorities | AWCHC;<br>ADSS;<br>WCVA – 2 voluntary sector members (lay member and carer) on LHBs<br>Age Concern Cymru – positive developments in Health, Social Care and Well being strategies<br>Pembrokeshire CC/LHB/NHS Trust |
| Problems in maintaining good joint working due to short term funding | Age Concern Cymru – sometimes by time scheme was up and running the funding had ceased. Greater continuity needed. Better evaluation of schemes needed.<br>AWCHC – schemes in Cardiff and Vale – not transferred to core budgets (COPD – self management, Vale short term intervention, Cardiff Acute Response team), better evaluation needed;<br>WTAC – affects staff morale, better evaluation needed;<br>RCN Wales – funding not absorbed into core services despite proven worth;<br>ERGDC – problems on hospital discharge schemes over short term funding; |

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| | WCVA – short term funding can be wasteful – not enough evaluation so little evidence of success of projects;<br>Dinefwr Cict – short term funding affects ability to attract staff.<br>Staff and Managers Focus Group – limited flexibility, protected funding would help promote collaboration. |
| Incompatibility of ICT systems | Caerphilly LHB; Care and Repair Cymru; Wanless; Dinefwr Cict;<br>RCN Wales – much worse than in other areas of UK. |
| Sharing information and records | WTAC – practical difficulties – hope for improvement with Informing Healthcare and Informing Social Care;<br>Wanless – balance needed between providing individuals with better service and protecting confidentiality, more scope for use of anonymised data for planning;<br>Age Concern focus group – wanted greater sharing of single case file;<br>Dinefwr Cict – single patient record shared by practitioners |
| Possibility of single health and social care organisation | not supported by AWCHC; NHS Confederation; WHISC- not wanting more reorganisation, |
| Involvement of voluntary/independent sector in joint planning | WLGA;<br>WCVA;<br>RCN Wales;<br>SCOVO – despite clear guidance appeared the voluntary had become more removed from planning process. |

**ii. To examine the accountability arrangements for joint planning and service provision.**

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| Differing practices in funding and accountability arrangements (Health vs social care, also from one LA to another) | AWCHC;<br>WLGA – can cause difficulties in joint working;<br>CaerphilllyLHB/CBC – Seeking common purpose and understanding but differences in organisations' culture and accountability causes difficulties;<br>Pembrokeshire CC/LHB/NHS Trust – including difficulties of timescales in decision making processes<br>Staff and Managers Focus Group |
| Joint performance management related to joint working | AWCHC – support for consideration of this;<br>Pembrokeshire CC/LHB/NHS Trust – work being undertaken by WLGA on developing joint performance indicators.<br>RCN Wales - common performance measures needed across H, SC and voluntary sector; Assembly regional offices could be expanded to cover both health and |

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| | social care and deal with joint performance management;<br>Caerphilly LHB – support;<br>NHS Confederation – supportive of balanced scorecard approach;<br>Dinefwr Cict – targets relating to integrated rehabilitation would help focus priorities |
| Access to budgets/joint funding within joint working arrangements | Caerphilly LHB/CBC – mentioned difficulties over access to budgets;<br>ADSS – Joint funding itself is not crucial to the development of co-ordinated services, developments possible without pooling budgets;<br>Dinefwr Cict – difficulties of 'ownership' of joint budgets;<br>The Forge Centre – jointly funded services but not integrated budgets – potential problems with accountability and professional governance;<br>Blaenau Gwent Assist Project – difficulties over who pays for what |

**iii. To evaluate the effects (both positive and negative) that decisions in one services can have on another.**

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| Role of wider LA issues (e.g. street lighting, environment, transport, housing, education) | WTAC – LHBs not able to influence LAs priorities on these as they relate to health and well being;<br>Minister said (12 Feb) bringing housing into planning process may be important for this review,<br>WLGA – danger of not looking at H& SC within the wider agenda;<br>ADSS;<br>NHS Confederation;<br>Care and Repair Cymru – link between housing and health/injury and wellbeing, need for housing to be more involved in LHB structures/considerations;<br>South West Wales regional Committee – link between poor housing and ill health and injury |
| Benefits to one service from investment in the other | WTAC - tensions when therapy funded by one agency but benefiting another, health money supporting social services doesn't necessarily lead to improvement in service as LA may shift money to other priorities;<br>Wanless – Sweden's system addressed this |

**iv. To examine key areas that impact on the quality and provision of a seamless service**

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| Sharing good/best practice could be improved | AWCHC;<br>RCN Wales;<br>Already done in number of ways:<br>WTAC – Innovations in Care conferences; |

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| | NHS Confederation – mentioned DToC local and national forums;<br>Caerphilly LHB – mentioned LHB members meeting across Wales,<br>Caerphilly CBC Director of SS – mentioned feeding schemes onto All Wales Unit website;<br>WLGA – mentioned 'Excellence Wales' programme being developed to foster sharing of good practice;<br>WCVA – Voluntary sector H&SC facilitators disseminate examples of good practice to LHBs<br>Dinefwr Cict, [Forge Centre] – mentioned rehabilitation network |
| Unified assessment (UA) | Age Concern Cymru – cited slow implementation of Unified Assessment in Swansea. Different groups developing unified assessment with little co-ordination. Not seen as relevant to the voluntary sector. Overly bureaucratic and needing simplification;<br>Pembrokeshire CC/LHB/NHS Trust – voluntary sector involved in developments in Pembrokeshire ; UA could be undertaken by anyonew ho understood the process.<br>AWCHC – UA constrained by incompatible ICT and sometimes insufficient trust in other practitioners, access to medical records;<br>RCN Wales – guidance on unified assessment is clear;<br>Care and Repair Cymru – UA 'will be the key';<br>RCT – Voluntary sector can play role in unified assessment as experienced in putting patient's needs first, but not seen as answer to all problems, most appropriate for people with high dependency needs; progress slow;<br>RCN Wales – new concept about risk to patient's independence – being adopted by professionals.<br>Caerphilly LHB – UA should help to alleviate problems with quality of care. |
| Better shared learning opportunities/joint training | WTAC – UCWM medical students shadowing physiotherapy students to get better understanding of rehabilitation;<br>RCN Wales – need for whole systems approach in training;<br>SWW regional committee – joint training for Health, Social care and housing staff to understand each other's roles |
| Need for low level support/lowering of threshold | Care and Repair Cymru<br>Caerphilly LHB<br>Age Concern Focus Group<br>South West Wales Regional Committee |
| Access to services in one place | The Forge Centre – operates one stop shop facility; |

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| | Age Concern Focus Group – wish for joint health and social care day centres allowing 'one stop' care. |

**iv (a). hospital discharge**

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| Hospital discharge schemes | RCN – hospital discharge liaison nurses already a reality in many areas;<br>Age Concern Swansea run Hosp Discharge Service (2 nurses, 1 social worker and 1 welfare benefits officer), Inequalities in Health funding had enabled expansion;<br>Caerphilly LHB – hospital discharge liaison nurses trained in social services criteria and able to directly access funding and social services;<br>ERGDC – oldest hosp discharge scheme in Wales in Cardiff. Some good schemes but difficulties over short term funding. |
| Discharge planning | Age Concern Focus group – discharge planning should start on admission, not always adequate, lack of information to patient's/carers of likely plan<br>Staff and Manager Focus group – sometimes unable to complete assessments due to lack of adequate provision in the community;<br>Caerphilly LHB - research into predictive indicators of risk of becoming delayed transfer, enabling action to be taken earlier. |
| Premature discharge/readmission | Wanless – can also be a problem and appropriateness of some of the targets placed on the NHS should be considered;<br>Age Concern Focus Group – combined with ineffective discharge planning can lead to readmission |
| Monitoring of continuing care needs | Age Concern Focus Group – lack of clarity of responsibility for this, seems to fall to carers or care assistants |

**iv (b). intermediate care**

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| Intermediate care | RCN – should be part of the unified service not an additional service;<br>ADSS – Disparity in way in which intermediate care is being tackled in England and Wales;<br>Age Concern Cymru – some excellent examples of intermediate care schemes exist in Wales but greater evaluation needed and further development |

**iv (c). residential and nursing home services**

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| Care homes | AWCHC – levels of funding to ensure adequate quality of care and suitable workforce;<br>RCN Wales – lack of capacity generally, LAs struggling to meet costs of residential care and attract and retain staff. |
| Building capacity in social care | WLGA – more research, development and investment needed;<br>Wanless – need to plan long term;<br>RCN – Assembly regional offices could be expanded to look at regional fees structures for care homes |

**iv (d). domiciliary care services**

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| Domiciliary care services | ERGDC – New regulation in domiciliary care from 2004<br>Service User Focus Group – strong desire to remain in own homes with adequate support<br>Staff and Managers Focus Group – only those in greatest need receiving home care but organisational difficulties in providing intensive home care can be very challenging and often make it unrealistic, recruitment can also be a problem. |
| Quality of carers | Service User Focus Group – quality of service from private carers not as good as care assistants funded by social services |

**iv (e). involvement of the independent and private sectors**

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| Joint planning | RCN – Difficulty of involving independent care home sector in joint planning due to fragmentation of services (RCN registered nurses also working in independent sector)<br>Staff and Managers Focus Group – involvement of independent sector has increased flexibility in planning services. |
| Gaps in advocacy service | AWCHC, |

**iv (f). support for carers**

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| Lack of appropriate respite care | AWCHC;<br>Service User Focus Group – waiting times for respite care; |
| Recognition of burden on carers | SWW Regional Committee – Need for increased support and recognition of burden placed on formal and informal carers;<br>Service User Focus Group and Age Concern Focus Group – need for recognition of effect on health of carer, need for adequate carer's assessments;<br>Crossroads – providers range of services for carers. |
| Continued monitoring | AWCHC – Carers should be monitored throughout care pathway i.e. after discharge |

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| | to ensure still able to cope |

**i. to review the role of health and social services in promoting the independence of patients and the prevention of unnecessary admission or re-admission to hospital**

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| Housing Adaptations/ equipment | AWCHC and WLGA – Support for Care and Repair<br>Service user Focus Group – praise but noted some increase in waiting times for Care and Repair response, inadequate provision of stair lifts/hoists<br>Staff and Managers Focus Group – need to give consideration to discussing housing needs with older people. Also for people to take more responsibility for acquiring appropriate housing. |
| Avoiding admissions | AWCHC – Crisis Management at Home services; patient-held records; preventive annual maintenance checks for >75s;<br>NHS Confederation – Rapid Access schemes; Caerphilly LHB – Holistic service for >75s; ADSS – better out of hours service for social care |
| Prevention of accidents | Wanless – introduction of falls clinics and simple adaptations to homes |
| Ability to maintain home and garden contributed to health and wellbeing, particularly for older people. | Care and Repair Cymru;<br>SW Wales Regional Committee;<br>Age Concern Focus Group |
| Need for easy access to information, services and sources of help | AWCHC – common points of access in common locations;<br>South West Wales Regional Committee;<br>Age Concern Focus Group;<br>Service User Focus Group;<br>Staff and Managers Focus Group – however, difficulties over retention of information by clients/users. |
| Assisted technology | ERGDC;<br>Care and Repair Cymru – considering doing research on assisted technology – not currently general practice to advocate it;<br>Wanless – more work needed in developing technology and researching people's aspirations for the kind of home they want (link to Review of Housing for Older People) |

## 2. Other themes

There are a number of themes that are coming through the evidence that are not strictly related to the terms of reference of the review but are nevertheless issues that may need to be taken into account in joint planning and therefore mentioned in any report.

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| Significant differences in H&SC terms and conditions and policies (e.g. manual handling) | WTAC;<br>Dinefwr Cict – problems when working on joint projects |

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| Professional boundaries | AWCHC – Can be difficulty in agreeing assessments;<br>Dinefwr Cict – had to overcome some initial concerns<br>Staff and Managers Focus Group – tensions can arise around assessments |
| Workforce development | WTAC – continued investment in undergraduate training of therapists required, training health and social care workers to deliver certain therapies (within a robust governance framework) could increase capacity;<br>RCN Wales – workforce development in H& SC needs to considered as a whole;<br>ERGDC – potential for home care sector to undertake wider role (intermediate care at home) and to help develop more solutions in future |

### 3. Other issues brought out by individual organisations

*Age Concern Cymru (26 May 2004)*

- Referred to lack of cascading of information from top of organisations to all staff, particularly in hospitals.
- Variations in working practices and inconsistencies in funding, joint commissioning and transparency existed even within local health board areas.
- Joint working taking place at an operational level but not always higher up in the organisation.
- Voluntary sector felt marginalised in unified assessment development.
- Funding from different agencies made it difficult for the voluntary sector to plan strategically.
- Commissioning and planning processes did not build on new developments but sometimes just expected service to continue once short term funding had ended.
- The social model of care was better than the medical model because it helped people maintain their independence.
- Joint commissioning would enable monitoring of contracts and clearer strategic focus and cohesiveness for role of voluntary sector.
- Ideally users should be involved in planning processes.
- Older People's strategy provides much-needed focus on needs of older people. Assembly should put pressure on local authorities to ensure recommendations of strategy are achieved.

*Pembrokeshire County Council (CC), Pembrokeshire Local Health Board (LHB) and Pembrokeshire and Derwen NHS Trust (26 May 2004)*

- Description of development of fully integrated Pembroke/Pembroke Dock project. Difficulties had included different IT systems, differing charging regimes, issues regarding regulation.
- Charging for services was a major issue between the two sectors and clear guidance was needed.
- Differing regulatory regimes e.g. space regulations applying to social care accommodation did not apply to health care. Can cause problems in integrated health and social care facilities.
- The local authority scrutiny committee had recommended to its cabinet a greater emphasis on Wanless and other change agendas and work programme more focussed on joint working.
- Director of local voluntary association was member of strategic management board . No compact was in place so strategy was needed to determine what services to commission from the voluntary sector.
- Allied Health Professionals also involved in management process with a place on the executive board. Recognition of their potential to work across boundaries and bring two sectors together.
- A more flexible approach to training for speech and language therapists was needed.
- Joint performance indicators being developed by the WLGA should include hospital admissions, re-admissions and keeping people at home.
- Current performance indicators can cause conflict between organisations and in some cases result in inappropriate outcome for the patient.

*SCOVO (26 May 2004)*

- Interface between health and social care critically important in the field of learning disabilities. Particularly because general health of people with learning disabilities was worse than average for the population, people receive frequent, even daily, services from both health and social care for life, and people didn't recover from learning disabilities.
- Hope that local authorities would maintain lead for learning disability services.

- Welcomed strategic policy initiatives taken by the Assembly.
- Role of Health Commission Wales in commissioning some specialist services was not yet clear.
- Sometimes the voluntary sector, even when a significant service provider, can be marginalised in planning the future care of patients.
- Learning disabilities would be good area in which to pilot schemes to overcome cultural differences as the services provided were so intense.
- Lack of therapists in Wales but also concern over how their time is spent (much of which is on statementing processes). Difficulties over which service pays for therapy services.
- Administration of medication is important issues. Work being undertaken on this in Wrexham.
- Children's centres example of good joint working bringing health, social care and education together to obtain joint funding and co-ordinate planning process.
- The key worker should ensure delivery of care programme identified in unified assessment and can contribute to assessment process.
- Competing priorities in local authorities meant that earning disabilities received a fairly low focus.
- Good relations between local authorities and supported housing sector but still confusion at point of delivery.
- Issue of consent for adult with learning disabilities needed to be addressed.

*Gwent NHS Trust (7 May 2004)*

- Delayed transfers of care in Gwent higher than average for Wales per 10,000 populations. Length of delay increasing and higher than Welsh average. Significant variations between LA areas. Funding problems for social care differ between LA areas. Greatest difficulties in Blaenau Gwent and Torfaen.
- Developments include admission avoidance and community re-ablement, developing out of hours schemes, improving hospital assessment and discharge processes, and undertaking collaborative research in Caerphilly looking a key determinants of likelihood of delay.
- Not in favour of financial penalties for local authorities. Councils should be part of the answer.
- Some of the difficulties e.g. in delayed transfers of care could be dealt with without the need for lots of money. Some local authorities and local health boards in the area have tackled the problems better than others. Joint working with LHBs and LAs in those areas is better.
- Where there are difficulties there is little community infrastructure and difficulties over the balance between elective and emergency treatment.
- There is potential to reduce lengths of stay in hospital.
- Need for greater clarity over patient choice issues.
- Raised issue of risk aversion within primary care sector.

*Crossroads (7 May 2004)*

- Provides care in the home for carers.
- Emphasis is on needs of carers. Provide practical support including sitting service, one to one support for the cared for, day clubs for both carers and those cared for, night sitting service.
- Regulation has led to Crossroads carers improving qualifications and improving their opportunities.

### *Welsh Institute of Health and Social Care (WIHSC) (24 March 2004)*

- Use of facilitated networks with neutral 'Virtual Organisation co-ordinators' being used in RCT through the CHAIN project to get organisations working together with a structured approach to a range of issues. Agreed as approach for Older people's strategy. Outcomes include unified assessment programme in Royal Glamorgan, mobility scheme giving elderly people access to taxi services, development of a reablement team in Methyr Cynon involving physios, OTs – training home carers.

- Telecare - Study of 127 older people in Powys around 92% admitted to institutional care could have stayed at home if technologies available. (WIHSC evidence)
- Nuffield Institute in Leeds has developed tools to measure and evaluate partnership development [ how partnerships have developed not what the outcomes are ]

*Association of Welsh Community Health Councils (AWCHC) (24 March 2004)*

- Difficulties of different professions/therapists not trusting each other in assessments (AWCHC evidence)
- Gaps in advocacy services – effective use, particularly for those without other support can lead to savings in costs elsewhere
- LAs have different thresholds for funding provision of social services – national standard needed
- Preventive annual maintenance health checks for >75s
- Care home charges – sufficient for quality of care needed. Need to attract and maintain suitable staff (salary levels)
- Access to Crisis Management at Home schemes to prevent unnecessary admissions.
- Patient held records for those with chronic illness could prevent admissions (drs visits at night)
- Common complaints procedures needed (health and social care)
- Not advocating one H&SC org (as in English Care Trusts). Need joint funding and authority to work together for seamless service. Whilst powers are already there some LAs not wanting to take up opportunities due to differing priorities.
- Greater co-ordination between NHS, LA and voluntary sector before discharge to ensure sufficient support at home
- Care and Repair providing good minor adaptations service
- Greater feedback required from home care services re any change in need. What is their responsibility? Adequate training for home carers to recognise changing needs.

*Welsh Therapies Advisory Committee (WTAC) (24 March 2004)*

- Therapist have developed higher profile in strategic planning and policy as well as service development
- Innovative projects can cream off best staff and resources from core services.
- Innovative projects sometimes haphazard and not always properly evaluated.
- Therapists getting used to working across boundaries and addressing tensions with other professionals, as well as working with change agents.
- Therapists working as enablers to get people to take responsibility for own health.
- Therapy strategy being developed.
- Support key principles in Wanless review and believe they have pivotal role to play.
- Therapists treating some patients at home – but not possible for all specialties. Need greater clarity about access to services.
- Strengthening of Joint Professional Forum for Health and Wellbeing (including medics and nurses) – helps to resolve some of the tensions between professions.

*Royal College of Nursing (RCN) (24 March 2004)*

- Nursing profession well represented in strategic and operational planning in LHBs and in regional offices
- Good guidance on NHS continuing care available
- Need better guidance on differing needs in urban and rural areas
- more evidence required on benefits of Swedish model. It was felt that approach could cause antagonism and blame not conducive to co-operation required.

- Need some guidance on patient choice in relation to choosing care settings on discharge.
- New minimum standards in care homes – why aren't these applied in hospitals as well?

### *South West Wales Regional Committee (3 March 2004)*

- Link between poor housing and ill health and injury
- Need for continuation of partnership working to ensure most effective use of available resources and avoid duplication
- Need for services that prevent the early onset of dependency (moving up the care ladder) and admission

*Caerphilly LHB/CBC (12 February 2004 and 7 May 2004)*

- Partnership working for 3 years in the area; joint teams for mental health, substance misuse and learning difficulties.
- Works best when joint policies are agreed and joint training undertaken, but with retention and recognition of individual skills
- Structures linked into community planning structures (which incorporates wider LA issues); HSC and WB Partnership links into these. Some limitations on decisions over funding without reference back to council. Communities First partnerships have been encouraged to develop health subgroups.
- Business case being been developed for joint community and hospital service to replace Caerphilly Miners Hospital – aim to keep people out of hosp if poss.
- DToC reduced due to better whole systems working adopted by LHB, the LA, Gwent NHS Trust and voluntary sector given impetus by creation of LHB
- Particular difficulties in EMI – lack of provision in residential care. LHB trying to increase provision through conversion of other residential care home beds. Difficult negotiations with private sector.
- Step change in relationships on creation of LHB (including with Gwent NHS trust)
- Example of Holistic service for over 75yr olds, developed from targeted Townsend money. Don't need to be ill to be assessed. Example of pre-crisis intervention.
- Need for 24 hour access to emergency services.
- NHS funded nursing care from April 2004 may be a lever to improve quality of care from independent sector.
- Need effective use of transitional and intermediate care services.
- Discharge management – use nurse case managers who work with social workers who can concentrate on putting care package in place. Nurse case managers can refer directly to voluntary services and access social services.
- Research working looking at predictive set of indicators that patient may have high risk of becoming a delayed transfer of care – enables action to be taken earlier.

### *Expert Reference Group on Domiciliary Care (ERGDC) (12 February 2004)*

- Major issue is new regulation in domiciliary care in 2004 and new domicilary cere manager role – Welcome new regs and believe new manager role vital for developing and monitoring social care delivery but issues over funding and recognition by those commissioning of the need for meeting the new standards and costs involved
- Costs of new regs could be as much as £3 per hour. Disproportionate costs on small providers. Risk that volume of service will reduce in no new money available.
- Little known about the sector; generally there is lack of understanding of sector which is barrier to most effective use
- Call for greater representation of the sector in decision making processes

- Examples cited from Bridgend; 6 weeks support at home, Rapid response teams, Reablement teams
- Capacity diminished by people leaving sector because they no longer have time to do what they want to/ to do a good job for client. Pay also an issue.
- Since Community care reforms in 1990s home care providers doing wider variety of tasks including quasi- medical/nursing tasks e.g. PEG feeding
- All Wales strong lead for direction on domiciliary care would be helpful
- Need for care pathways that encourage getting back out of residential care
- Care providers could be much more involved in reviewing care packages – currently reviewed by social workers with clients and carers.
- Rapid response teams – immediate support followed up by proper assessment e.g. within 2-3 days
- Age profile of workforce – many older workers in the sector

*Care and Repair Cymru (12 February and 7 May 2004)*

- Ability of Care and Repair Cymru to be effective is enhanced by core funding from the Assembly
- Rapid Response Adaptation service rolled out across Wales – referrals from OTs and Social services, quoted an average of £134 per job for clients, turnaround time averages a few days.
- Appropriate housing important for maintaining independence; accident and injury prevention. Person centred approach to provision of service.
- Difficulties in accessing health care professionals – though good links with health visitors and OTs
- Each Care and Repair has Strategic Business and Planning Committee with input from health and social care agencies
- Housing checklist prepared for healthcare professionals to raise awareness.
- Services used mainly on preventative work but also on discharge.
- Also run handyperson scheme. Demand for service for people who feel concerned about using other builders to make improvements.

*NHS Confederation (4 February 2004)*

- View that fining LAs for delayed discharges would not contribute to building trust in partnership working; better to use stronger performance management in this area.
- Disagreements do exist between professional boundaries – though believed not to be any wilful obstruction.
- Good example of information sharing protocol in Gwent (to be sent).
- Not supporting one organisation for health and social care.
- Greater understanding of patient journey required to establish types of support needed at each stage.
- Many examples of LHBs and LAs working together to manage chronic conditions in primary care, reducing need for hospital admission.
- Development of 5 year SaFF welcomed to enable NHS to plan better.
- Culture changes needed to facilitate interface between H&SC.

*Welsh Local Government Association (WLGA) (11 Dec 2003)*

- LAs improving way they work with NHS and independent and voluntary sector
- LAs taking a corporate perspective on social services which no longer operated in isolations
- Each LA had dedicated officer for co-ordinating health and well-being strategy
- System of rewarding success and supporting those doing less well was needed

- Not enough flexibility within budgets to address wider health agenda e.g. effects of housing on health and need for improved health education
- Whilst structures allowed pooling of budgets, there was lack of corporate ability to come to common understanding of why a pooled budget was needed, what it would achieve and whether is was appropriate.
- LHBs provided comprehensive structure to enable use of pooled budgets
- Time, resources and expertise needed to manage pooled budgets and resolve issues
- Hope that new commissioning arrangements would allow greater involvement of independent and voluntary sectors in joint planning and pooling resources
- It would be helpful to bring budget timetables for HSC&WB strategies and Community Plans together
- LAs need to work with NHS and other partners on housing adaptations to help people live independently. Ad hoc additional funding can be spent on adaptations but danger that one-off funding would not be used strategically

*Association of Directors of Social Services (ADSS) (11 December 2003)*

- Pooled finding through LHBs should be clearly designated and its use agreed jointly
- LAs should help people live independently and avoid admission to social care as well as hospital. Greater investment in primary services needed.
- Community planning framework and its link to H SC & WB strategies important
- Working together, pooling of resources and intelligence or knowledge was going on but could be done in more structured way
- Some areas where dedicated funding was needed e.g. in Wanless recommendations for reshaping services so that continuing investment was available to deal with current pressures whilst new investment was available that was pooled to reshape services for the future
- Pooled funding has worked well in tackling substance misuse and commissioning continuing care, children with complex needs and equipment services. Value in partners contributing to a fund that could be used flexibly to avoid having to negotiate every issue
- Ring fenced flexibilties funding will need to mainstreamed. Joint funding itself is not crucial to the development of co-ordinated services. Possible to create effective partnerships and deliver by agreement on funding without moving money into a single pot. Whilst flexibilities fund had encouraged joint working there were examples of joint funded arrangements that pre-date the availability of special grant money
- Swedish model of health and social care would not encourage joint working. Need for encouragement to work together not punishment if they don't.
- Disparity in way in which intermediate care is being tackled in England and Wales. Need to reform services here. Needs to be shared vision across services that took account of differences.
- Social care has been marginalised in Wales; not receiving same level of investment as in England
- There is an all Wales Bed bureau initiative to help identify bed vacancies but problem in funding placements
- Little evidence of the overall capacity for continuing care within NHS trusts

*Wales Council for Voluntary Action (WCVA) (11 December 2003)*

- Support had been provided for the voluntary sector to create national and local health and social care facilitators
- Positive working between voluntary sector and other organisations to tackle delayed transfers of care, important work done with carers.
- LHBs need to recognise contribution made by carers.
- Voluntary sector has diversity and ability to work outside the constraints faced by statutory bodies.

- Voluntary sector needs to be involved in start of planning process and hopes that new commissioning guidance will address this.
- Need to distinguish between those voluntary sector services commissioned by LAs and those given separately by voluntary sector for people in the community
- Need to clarify legitimacy of voluntary sector input into commissioning without conflict of interest. Guidance from SSIW on commissioning expected to help.
- Preventative agenda very important.
- Need to recognise the whole raft of different types of support needed in community. Many people require quick and simple response to remain self-sufficient, as they want to be.
- Example from Catalonia of multi-disciplinary teams in community effective at identifying immediate problems and putting in place nursing, social or family support as necessary.
- Much voluntary sector activity takes place without LA funding. Hope that more holistic approach to local services can be achieved through new planning structures.
- Concern about management of carer's funding by LAs. Carers felt it unfair that services were available in one county but not in another.

*Derek Wanless (13 November 2003)*

- Reshaping services – Consideration of Swedish model of health and social care where LAs responsible for providing care once a doctor has certified that a patient was medically fit to leave an acute bed. More effective use of community hospitals is needed. Could be used for intermediate care but not all such facilities are appropriate for intermediate care. The health or social care sector could lead in regenerating community hospitals, depending on whether they were to be used primarily for health or social care.
- In the long term acute hospital beds should rarely be the place where care services ought to be delivered
- Care needs assessment is particularly important. A model developed in USA looked closely at needs of people who use a lot of resources and gave close attention to the care needs assessments. Possibility of predicting which patients will be expensive users (some work in PCTs in England) and providing more intensive care services to these.
- Some employers are producing individual health improvement plans for their employees. This could be extended usefully to primary care.
- Variation in quality of management could be reduced for more effective use of resources.
- Mixed economy of provision required to create longer term, sustainable solutions provided by the private or public sector.
- The Assembly should set standards and processes to enable people at local level to tackle local issues, but should not micro-manage them.
- Little evidence of use of pooled budgets in Wales. Assembly should identify and tackle underlying cause.
- In England some examples of organisations making joint staff appointments, particularly in the field of public health. If H, SC and WB strategies succeeded in Wales they would provide better structure for budget sharing.
- Quality of information – better in health service than in social care. More data collected than needed. Use of data (including PSS data) in assessing long-term future demand.
- Need systems that reward success and encourage innovation rather than penalise failure.
- Local commissioners and providers need freedom to choose what is right for their local area but should be assessed on those decisions. Should look at CHI's use of high quality, rigorous and constructive audits.

## 4. Committee Visits (18 March 2004)

### *4.1 Dinefwr Cict*

Community intermediate care scheme aimed at rehabilitation to restore and maximise independent living.

- Planning; Government targets skew provision towards acute care rather than rehabilitation and prevention; weekly meetings of team to discuss client's care and co-ordinate visits in accordance with clients wishes.
- Accountability; short term funding arrangements, such as flexibilitites money make it difficult to attract staff and pilot new ways of working. Looking for further opportunities to develop new ways of working through further flexibilities in budget.
- Seamless service; patients perceiving improvement of co-ordination in areas such as equipment and emphasis on achieving independence, suggest use of patient-held records for some patients.
- Independence and prevention; reduction in admissions to Community hospital.

### *4.2 The Forge Centre, Port Talbot*

Integrated community based mental health and social care services.

- Planning and provision; 10 years experience providing joint health and social care community based mental health provision; joint planning structure with NHS Trust, LHB, LA, voluntary sector, GP and service users and carers; Links with local hospital- staff attend weekly clinical meetings there.
- Seamless service; One stop shop facility, from attendance by consultant psychiatrist to drop-in social activities. Includes counselling and therapy.
- Preventing unnecessary admissions; referral by GPs and hospital consultants enables people to be assessed and treated in the community.

### *4.3 Cymla Re-ablement Unit., Neath Port Talbot*

Client centred integrated service to help people regain independent living.

- Planning and provision; unit is managed by a multi-agency steering group reporting to the Neath Port Talbot Joint Executive Group. Funding from several short term initiatives but now mainstreamed in line with Wanless recommendations.
- Seamless service; Multi-disciplinary team providing fully co-ordinated rehab in patient's home or in small residential unit
- Independent living; main aim to rehabilitate people through an intensive programme so that they can live independently again.

### *4.4 Blaenau Gwent Assist Project (Smart House), Tredegar*

Pilot project highlighting technology that can monitor people's safety and well being in their own home.

- Planning and provision; effective partnerships more important to success of scheme than the technology.
- Accountability; difficulties over who pays for what – need joint funding.
- Seamless service; monitors are connected to a central control point.
- Promoting independence; aim of project in to inform professionals of the technology that is available and to keep people with dementia living at home as long as possible.

## 5. Evidence from Focus Groups

### *5.1 Focus Group with staff of Age Concern*

6 staff and one volunteer with Age Concern

Hospital Discharge

- if a person has a carer, nothing has improved in the past 10 years
- evidence of discharge planning not starting at point of admission (cases cited of discharge without discharge plan)
- problems that lead to re-admissions
- differences in professional outlook; nurses 'don't see beyond the bed' to consider the emotional and social sides of patient's needs
- Ward staff don't know where to refer patients. Lack of co-ordination.
- Lack of clear information to patients and carers about what is likely to happen on discharge and when it will take place
- Assumptions about ability of carers to provide care required. Need for recognition of effect of caring responsibilities on physical and mental health of carers.
- Age Concern's hospital discharge scheme – includes nurses and social workers working outside their normal structural limitations.

Re-admission

- Patients discharged too early with no effective discharge plan often end up being re-admitted. Typically these cases are processed through A&E again rather than being re-admitted to ward from which they have been discharged.
- Patients have been readmitted to hospital following closure of day hospital facility in Morriston (this provided weekly checks and reassurance for carers).
- Lack of clarity of responsibility for patients continuing care needs; discharge care plans often time limited. Carers or care assistants may be relied on to highlight changes in need.

Some types of people neglected

- those falling below eligibility levels – needing low levels of assistance e.g. shopping, home and garden maintenance, cooking advice, help with filling out forms.
- Attention focused on over 75yr olds. 50 year olds and over receive less attention, yet it is this age group where preventative work/health promotion is most valuable.
- people who refuse care initially. Voluntary organisations can work to gain trust and then provide help or signpost to other services available.

Role of voluntary organisation such as Age Concern compared to statutory organisations

- Age Concern staff felt they could were more able than statutory agency staff to build trust, adopt a holistic approach, be person-centred and bridge gaps.
- They felt that people working in statutory organisation were more taks oriented, following narrow job descriptions, ruled by structures of responsibility and seeing people as 'care packages' and 'hours' rather than as people.

Role of primary care

- GPs were criticised for not being very helpful, particularly in first week following hospital discharge. They may typecast patients which may affect their willingness to attend.

Joint working

- Difficulties due to different cultures, levels of responsibility and decision making in different sectors. Need to look outside narrow remits and at underlying problems.

Changes they would like to see:

- readmission of older people should not take place through A&E
- discharge planning should start on admission

- discharge co-ordinator on each hospital ward to ensure smooth discharge and that plans are put in place prior to discharge
- one point of information for carers and patients
- greater sharing of information between services and a single case file open to all practitioners
- greater appreciation of roles of other practitioners. This would help patient assessments and development of appropriate care plans
- joint health and social care day centres would allow 'one stop' care for patients who need several tests/procedures
- more funding for Care and Repair who are responding less quickly than in the past
- improvement in working conditions for care assistants bearing in mind their perceived responsibility in monitoring a client's progress/deterioration

### *5.2 Focus Group with service users*

3 carers and 6 people who receive or recently received care.

Sense of control
- Need for sense of choice and control over situations
- Need for access to information (on services, entitlements and who to contact when help is needed). Social workers can help with this.

Staying in own home
- Strong desire expressed about wishing to stay in their own homes
- Particular concerns from those who may face having to sell their homes
- Some recognition that changes in health and social care in past 5 years may have increased chances of being able to remain in their own homes

Social Services
- praise for social services provided, social workers, carers, respite care, rehabilitation and day centres; also for Care and Repair.
- No mention of poor co-ordination of services
- Public resources not enough. Waiting lists for respite care and day centres, carers not available in a crisis, inadequate provision of stair lifts/hoists, waiting times for adaptations (even through Care and Repair). Some people had paid for equipment and modifications themselves either due to lack of information or not wanting to wait.
- Quality of private carers not considered as good as care assistants funded by social services.

Information
- People talked of confusing range of agencies and providers involved in their care and lack of understanding about who was providing the services they received.
- Lack of knowledge of where to go for information or for help if there was a problem
- Lack of knowledge of extent of services available and entitlements
- Some suggestions about information being available with pension books or council tax forms, via doctors' surgeries, NHS Direct type card that could be kept 'on the fridge'.
- Need for link to a real person (no recorded messages) on the telephone who could provide information and point them in the right direction

Family
- Reliance on family carers. Need for recognition of effect on carers health of their caring responsibilities.
- Need for adequate carers assessments.

Need for change – policy initiatives
- better pensions
- better access to information

- more investment in local authority services so that respite care, carers, day centres, home adaptations and equipment are more accessible
- better training and supervision of private carers
- better transport and more buses with low platforms and sympathetic drivers
- incontinence pads should be delivered to people's homes rather than them having to collect them

*5. 3 Focus Group with Staff and Managers*

7 participants, including Directors and managers as well as front line staff.

Parallel Systems

- 2 systems will continue to work in parallel, no drive to merge.
- Differences in funding, priorities and terms and conditions stand in way of joint working.
- Separate IT systems and strategies in health and social care
- Consistency of message from Welsh Assembly Government would be helpful e.g. on unified assessment.
- In services for children and young people, little clarity as to how one sphere can influence changes in another when there is no responsibility or accountability.

Financial Barriers

- Limited flexibility on finance makes it difficult to work collaboratively and innovate. . Example - money saved by Trust by increasing day surgery must go to reducing waiting lists rather than to social care whom the change affects.
- Cost benefit evaluations do not take into account the broader balance of costs and savings.
- A protected funding process would be a key way 'to move Wanless forward', promote collaboration and 'unlock convergence problems'.

Different cultures

- typically, practitioners know little about what each other do.
- this is accentuated by the medical vs. social models of care and varying professional approaches. Tensions can arise particularly around assessments.
- joint training, rotation and shadowing could help as can practitioners working in the same location.
- Few formal mechanisms for discussing clients. Possible difficulties of staff taking on responsibilities that are not allocated to them.
- Example of a combined nursing post, encompassing health and social care, limited success.

Problems with discharge and continuing care: resources and management

- Shortage of nursing home places, community therapists and waiting list for home care. Recruitment to provide intensive home care is a problem.
- Those receiving home care are those in greatest need.
- Some patients are not assessed in hospital as there is no provision available for them in the community.
- May help to provide additional training to carers to take on extra tasks.
- Due to shortages staff are working to capacity.
- Bureaucracy is very frustrating.
- Organisational difficulties in providing intensive care at home can be very challenging and sometime mean it is unrealistic.
- Difficulties in co-ordinating the various agencies involved in providing social care e.g. sheltered housing, home care, district nursing, occupational and physiotherapy, Care and Repair etc.
- Involvement of independent, not for profit sector in providing services has increased flexibility in planning services. Can provide services at lower cost.
- Issues need to be considered in the round . Managers and directors are brought together informally and through more formal structures but recognise that decisions made in one sector can profoundly influence other sectors.

Patients and their families

- Difficulties if there is no family support for those needing care.
- Difficulties relating to relocation to an area, no knowledge of social or medical background.
- Clients have greater expectations than in the past.
- Lack of retention of information provided to clients/users. People now recevie written care plans which can help.
- Need for people to take responsibility for themselves including acquiring appropriate housing.

Looking forward

- Difficulty of gauging future demands.
- No coherent preventive policy in place currently.
- Role of meals on wheels to combat social isolation.
- Some consideration given to discussing housing needs of older people and to introducing a befriending service.
- Role of Age Concern in gathering views of older people to input into service planning.

Sue Leake
Jane Westlake
Vivienne Walters

Members Research and Committee Services

**Annex A**

**Evidence Sessions:**

| | |
|---|---|
| 13 November 2003 | Derek Wanless |
| 11 December 2003 | Welsh Local Government Association (WLGA)<br>Association of Directors of Social Services (ADSS)<br>Wales Council for Voluntary Action (WCVA) |
| 4 February 2004 | NHS Confederation |
| 12 February 2004 | Caerphilly LHB<br>Expert Reference Group on Domiciliary Care Wales (ERGDC)<br>Care and Repair Cymru |
| 3 March 2004 | South West Wales Regional Committee:<br>Carmarthenshire County Council<br>Care and Repair Carmarthen<br>Carmarthenshire Pensioners Forum<br>Age Concern Swansea<br>Mid and West Wales Fire Service |
| 18 March 2004 | Informal visits:<br>Dinefwr Community Intermediate Care Team (CiCt)<br>Blaenau Gwent Assist Project (Smart House), Tredegar<br>The Forge Centre, Port Talbot<br>Cymla Re-ablement Unit, Neath Port Talbot |
| 24 March 2004 | Welsh Institute of Health and Social Care (WIHSC)<br>Association of Welsh Community Health Councils (AWCHC)<br>Welsh Therapies Advisory Committee (WTAC)<br>Royal College of Nursing Wales (RCN Wales) |
| 26 May 2004 | Age Concern Cymru<br>*Pembrokeshire County Council, Pembrokeshire Local Health Board (LHB) and Pembrokeshire and Derwen NHS Trust*<br>SCOVO |

**Additional evidence obtained from:**

Focus group meetings with:

- Users
- Staff from Age Concern
- Staff and managers

South East Wales Regional Committee, 7 May 2004 - “Patterns of care on release from hospital”. Evidence presented by:

- Gwent Healthcare Trust
- Caerphilly Local Health Board

Care and Repair Cymru
Crossroads

**Annex 3**

## Note of Committee Members' visits

### Visit to the Blaenau Gwent Assist Project

On Thursday 18 March, Jonathan Morgan AM, Claire Morris and Catherine Lewis, from Committee Services, and Stephen Boyce, from the Members' Research Service, visited the Blaenau Gwent Assist Project as part of an information gathering exercise for the Committee's review of the interface between health and social care services.

A Community Psychiatric Nurse and Social Worker with the Blaenau Gwent Mental Healthcare Team for the Elderly developed the project concept. The project was set up to find out if the use of new technology could help a small number of people with dementia to remain living independently longer.

Research was carried out over 18 months and the project was identified as an appropriate approach to promote independence to older people with dementia and was a practical response to issues facing both health and social care in reducing premature admissions to residential and nursing care beds.

The purpose of the project was to introduce a variety of professionals and non-professionals, carers and users to the potential use of assistive technology; and provide a framework for meeting the needs of people with dementia at home and their carers in order to improve quality of life, prevent and reduce behavioural problems, prevent and avoid premature admission to long-term care and reduce stress for all concerned.

The project has brought together the following organisations:

- **Gwent Local Health Board Professionals** - this includes medical and psychology staff, day hospital managers, occupational therapy ward staff and community psychiatric nurses.
- **Blaenau Gwent County Borough Council Social Services** - this includes team leaders, social workers and support staff.
- **Blaenau Gwent County Borough Call Centre**
- **Gwerin Housing Association**
- **Gwent Constabulary** - local crime prevention officers
- **Voluntary Organisations** - this includes Alzheimer's Society and Age Concern
- **Private Sector Organisations**
- **Blaenau Gwent Care & Repair** - Handyperson service
- **Technology Companies** - Technology in Healthcare, Wanderguard UK and Tunstall Telecom
- **Norvartis Pharmaceuticals**

A demonstration house has been set up to demonstrate a range of technologies that are available commercially or are being piloted. These include flood, gas, smoke and carbon monoxide detectors, fall monitors, bed occupancy sensors which link to lighting controls, incontinence sensors, wander alarms and personal safety measures such as a doorbell camera that links to the television and a bogus caller panic button. All of the monitors are connected to a telephone control system that links to the Blaenau Gwent Control Centre.

The team was keen to point out, however, that the technology is actually secondary to putting in place effective partnership working across the different sectors. There are issues relating to funding, particularly agreeing which sector's budget will provide the funding, which would be simplified by the introduction of joint funding.
An evaluation of the project will be carried out to assess:

- Impact on carers stress levels;
- Which sensors/alarms are most used;
- Comparison between the cost of the equipment and the cost of providing hospital/residential care.

**Report of visits by Members to the Forge Centre, Port Talbot and the Re-ablement Unit at Cimla Hospital**

The visits were made by John Griffiths AM and Val Lloyd AM, accompanied by Jane Westlake, Committee Clerk

**The Forge Centre, Port Talbot**

We met
Barbara Bowness, Director Mental Health Services;
Jackie Cooper, Team Leader, Nursing Forge Centre;
David Edwards, Team Leader, Social Services;
Diane Davies, Clinical Nurse Manager; and
Ian Maunder, Principal Officer, Mental Heath Social Services.

For over ten years the centre has provided a comprehensive multi-discipline service for people with varying degrees of mental health problems. It is staffed by a consultant psychiatrist, mental health nurses, social workers, a psychologist (post currently vacant) and administrative staff. Most are employed by Bro Morgannwg NHS Trust, but social workers from Neath Port Talbot Borough Council are also based there.

Similar centres now operate in Pontardawe and Tonna, Neath.

It is housed in a purpose built building and its facilities are also used by other organisations in the community, including; the Sunday school of the adjacent church; Cruse; Lay Advocacy; Gofal Housing; and a drop-in social group.

Most patients are referred by their GPs, some by hospital consultants and some by other means. The Centre aims to respond to referrals within10 days, offering an appointment for assessment by an appropriate professional. At times cases have to be prioritised. There can be a three month wait to see the consultant psychiatrist. Subsequent services may be provided at the centre or in the patient's own home depending on the nature of the problem. Services may be provided for no more than six sessions or for several years.

The resource centre's counselling /therapy team run regular group therapy sessions on assertiveness, and management of anxiety, depression and anger. Art therapy is also provided for those who have difficulty in expressing their feelings.

The Centre is funded jointly, but the budgets are not integrated. Full integration could bring problems in accountability and professional governance.

The Centre now benefits from links with the new Neath Port Talbot Hospital and staff attend weekly clinical meetings there.

There is a joint planning structure working within the Mental Health NSF, and engaging with a multi agency forum with representation from the NHS Trust, LHB, local authority, voluntary sector, a GP, service users and carers. There are a number of sub groups.
Evaluation has been through Best Value / Wales Programme for Improvement; joint SSIW / Audit Commission inspections.

Service Users are involved in the setting of service standards, despite it being a difficult client group to engage. Initially the standards were drafted from a professional standpoint, but users did not feel they reflected their needs.

**Cimla Re-ablement Unit**

We met:
Paul Williams**,** Chief Executive, Bro Morgannwg NHS Trust;
Katie Norton, Chief Executive, Neath Port Talbot LHB;
*Tony Clements, Deputy Director of Social Services, Neath Port Talbot CBC;*
Rachel Marsh**,** Director of Community and Therapies Services; *plus*
**Around 20 staff working in the re-ablement team.**

The main aim of the Neath Port Talbot Re-ablement Service, based at Cimla Hospital, is to enable people who normally live independently at home, but may have lost the confidence or physical ability to do so, to regain their independence. Re-ablement provides individually designed, intensive programmes. This may include support to regain skills in personal care, meal preparation, domestic and social activities, as well as exercises to improve mobility and physical function. Services may be provided in the service user's home or in a residential / respite care home setting.

Other aims of the service are to:

- facilitate earlier hospital discharge;
- offer an alternative to placement in residential and nursing homes;
- prevent inappropriate hospital admissions; and
- to reduce the number of complex domiciliary care packages required.

Referrals come from primary care, therapists, hospital consultants, discharge liaison nurses, ward staff and social workers.

**Funding**

The service is funded from a variety of sources, initially from the "invest to save" initiative. It now receives money through joint working special grant, the six weeks free home care funding and health improvement programme. In line with Wanless recommendations the service is being mainstreamed.

**Capacity, Staffing and Support Levels**.

The two community reablement teams together have the capacity to offer services to up to 32 clients at any one time. The residential reablement unit offers places in single bedrooms to five service users at a time. The residential re-ablement unit is staffed 24 hours a day, and

is therefore appropriate for service users who have more intensive support needs than could be managed in the community.

The full establishment of staff is now 24.3full time equivalents, with the following range of staff groups:

Team Manager
Team Co-ordinators
Occupational Therapists
Physiotherapists
Nurse
Technical Instructors
Community Reablement Support Workers
Residential Reablement Assistants
Admin support

The team are managed by a multi-agency steering group, who in turn report on progress and outcomes to the Neath Port Talbot Joint Executive Group.

**Outcomes**

**Patient / client outcomes**

The Community Reablement Team has used the Functional Independence Measure (FIM) as a tool for assessing service users' functional abilities pre and post scheme. The outcomes of treatments achieved remain excellent for both the community and residential reablement services. The vast majority of patients are assessed as having goals wholly or partly achieved.

*Savings from Community and Residential Reablement*

The team estimate the savings for each client discharged from the service. In September 2003 it was estimated that there was a saving of £50,000 per year on the clients discharged that month i.e. the system would have had to fund £50,000 of domiciliary or care home costs if these patients had not received the reablement service. This demonstrates the scope of this service to move resources around different parts of the health and social care system.

**Key Points**

- fundamental change in ethos from services that looking after people by doing things for them to services that enable people to care for themselves again.
- Carers are important in helping to achieve this.
- After a period of intensive re-ablement, less home care, and in many cases no home care, is required. This frees scarce resources.
- Patients are assessed and decide their personal goals.
- The unit has some items of small equipment to meet discharge needs. There is currently a joint equipment store with Swansea, but Neath Port Talbot is now looking to develop links with Bro Morgannwg.
- Although a larger equipment store on a regional basis has advantages of scale, there are problems in accessing and delivering equipment.

- The importance and difficulties of mainstreaming effective innovative schemes are recognised. Budgets and priorities may need adjustinging. It was vital to take an holistic approach to service planning at joint executive levels.
- Recruitment of physiotherapists to the unit was difficult as the work was not as “hands on” as many would like, but more about assessing and planning. Consideration was being given to inviting physiotherapists to work in the unit on a rotational basis.
- Neath Port Talbot is developing an extra care scheme in Aberavon for 50 tenants.

**Joint Planning**

Paul Williams also briefed us on the progress being made in joint planning between Bro Morgannwg Trust and Neath Port Talbot. A summary is appended.

**Appendix**

***Review of the Interface between Health and Social Care***
**Briefing on progress made by Bro Morgannwg NHS Trust with its partners in Neath Port Talbot**

**The Trust, working closely with the Neath Port Talbot Local Health Board, has robust joint working arrangements with our social services partners in Neath Port Talbot. Detailed below is an overview of areas of good practice under each of the headings of the review, together with some areas in which improvements are being planned.**

**To review the mechanisms for joint planning and provision of services in health and social care and the quality of the evidence base.**
*At a strategic level, the Trust is a key member of the Health Social Care and Wellbeing Partnership Board in Neath Port Talbot. This Partnership includes council members and non-executive members of the Trust, LHB and Voluntary organisations, supported by an executive / officer group. The Partnership Board takes action on areas of joint responsibility and interest, including development of the Health Social Care and Well Being strategies, development of client group strategies, implementation of Unified Assessment, Delayed Transfers of Care, service reconfigurations in mental health, and use of Joint Working special grant monies. The Trust is also represented on the Neath Port Talbot Children and Young Peoples Framework Partnership and close linkages between the strategic partnership groups are being established.*

*Achievements of the Partnership to date include:*
- *Strategic plans agreed for most main client group areas;*
- *Agreement on innovative new uses for delayed transfers of care and new flexibilities funds;*
- *Senior Joint Commissioning Managers established between the Local Health Board and Local Authority to support the strategic development of mental health, learning disabilities, older people, and children's services*
- *Joint action plan for reducing delayed transfers of care;*
- *Project board structure set up for unified assessment across NPT and Bridgend Local Authority areas;*

At a client group level, there are joint planning groups in existence for adult mental health, learning disabilities, older people, the Children and Young People's framework partnerships and the ACPC.

**The Learning Disabilities Directorate has worked with 10 Local Authorities in the planning and implementation of the Hensol resettlement programme, with a multi-agency and multi-professional team undertaking this work.**

There are also some examples of joint provision of services, including:

- Community and residential reablement service;
- Health visitors for looked after children and special needs children working within social services teams;
- Social workers in all adult mental health CMHTs, with shared management arrangements in NPT, currently working towards a joint Mental Health Access team.

To examine the accountability arrangements for joint planning and service provision

*Overall accountability for joint planning arrangements lies with the Health Social Care and Wellbeing Partnership Board, with Childrens Services being overseen by the Children and Young Peoples Framework Partnership. In terms of service provision, accountability lies either through the joint executive group and partnership board for some services (for example reablement), or through each individual organisation for other services (for example mental health teams).*

To evaluate the effects (both positive and negative) that decisions in one service can have on another.

*There are examples of decisions within the Trust boundaries that have had both positive and negative effects:*

- Decisions by Local Authorities on the way in which funds are allocated makes a significant impact on numbers of delayed transfers of care. In both main authority areas the councils have taken significant steps to alleviate these pressures;

- Trusts undertaking waiting list initiatives often do not take account of the additional social care needs of patients for that period of time, which impacts particularly on the home care sector;

- Decisions taken on acceptance criteria for child protection cases within social services can affect workload within healthcare;

To examine key areas that impact on the quality and provision of a seamless service:

Hospital discharge
*The Trust has agreed with all 3 Social Services departments and LHBs a joint hospital discharge policy and set of procedures. This will improve communication between professions and streamline the discharge process for patients, ensuring in particular that discharge planning begins on admission to hospital.*

*Ward staff in acute areas have worked well with hospital based social workers for years as an integral part of the discharge planning team;*

*Intermediate care*
In June 2003 the Local Health Board established an Intermediate Care/NHS Long Term Care Task and Finish Group to review the current planning and provision of intermediate and continuing care services across Neath Port Talbot to inform the future strategy for the locality. A number of new intermediate care services have already been implemented, including reablement team and residential reablement beds. New developments will include a new intermediate care facility to replace Groeswen Hospital, linked to the Primary Health and Social Care Centre for Port Talbot, and a redevelopment of Cimla into an intermediate care center. In addition, plans are being developed for a rapid response team to complement the work of the reablement service. There is also the potential for increasing the integration of the day hospital and other intermediate care services.

*Residential and nursing home services*

A number of liaison posts have been funded both in NPT between health and the residential / nursing home sector, for example an EMI liaison team including a CPN and OT. The aim of these posts is to provide support to the residential care home sector, allowing them to continue to provide care for a greater dependency of patients.

To review the role of health and social services in promoting the independence of patients and the prevention of unnecessary admission or re-admission to hospital.

Health and social services have a significant role in this regard. Areas where work has been undertaken through the partnership arrangements include:

- Reablement teams – these services have been demonstrated to improve independence and significantly reduce the need for large packages of support to the home;
- The developing intermediate care services which will contribute to a further prevention of admissions for elderly patients to acute hospitals, with a focus on joint health and social care assessment earlier in the care pathway;
- Agreement to establish a community based COPD team which will work to reduce the need for admission. This Team has been funded by the Local Health Board through inequalities in health funding within Neath Port Talbot.

Whilst, as described above, the Trust has worked well with social services colleagues there are nevertheless areas in which further improvements and advances can be made.

Firstly, there is a need to extend areas of joint service provision, perhaps into areas of core services such as district nursing and home care for palliative or continuing care patients. Issues to be addressed will include:

- common operational policies,
- joint management arrangements,
- pooled budgets,
- common patient records and information sharing
- skill mix issues, including potential generic health / social care workers.
- Accountability arrangements
- Performance management and outcome measurement

**Secondly, there is likely to be an increase in joint commissioning of services, which is an area that is in need of development if joint provision is to become a reality.**

Lastly, at a national level, the continuing drive to integrate strategy and planning between health and social care is welcomed.

These issues are forming the basis of the Local Wanless Action Plan for Neath Port Talbot.

**Future Developments**

The team is currently actively engaged in:

- Ensuring that the team becomes fully integrated with core services and links to the emerging intermediate care pathways.
- Continuing to actively promote the service, particularly in relation to engaging with primary care teams.

- Improving joint management and performance information and audits.
- Identifying ways of more accurately measuring service user outcomes and client satisfaction, and calculating savings on acute hospital beds and residential /domiciliary care packages.
- Continuing to review roles within the team to ensure that staff-mix most appropriately meets the needs of service users.

Report of visit to Dinefwr Cict project (Community Intermediate Care Team)

The Dinefwr Community Intermediate Care team (Cict) has been built up since January 2002 from the vision of a consultant geriatrician in the area. Initially it served the Amman Valley area, but has expanded to cover the Llandeilo/Llandovery area from February 2003. It was initially support by Flexibilities Grant money but funding is now more stable.

The team comprises:

- Team leader
- Occupational therapist
- Physiotherapist
- Speech and language therapist
- Dietician
- Community Psychiatric Nurse
- Social Worker
- District Nurse
- Generic Support workers

The service is aimed at enabling adults who would benefit from time limited rehabilitation to restore and/or maximise their levels of function to aid independent living. It therefore aims to:

- Optimise the quality of life for the client and the carer.
- Prevent hospital admission where appropriate.
- Facilitate early discharge from hospital.
- Facilitate a reduction in placements into residential /nursing home care.
- Facilitate a reduction in home care provision.

It receives referrals from GP, social services and health representatives. Specific eligibility criteria have been agreed including, in particular, that the client will benefit from a short-term intensive period of domicilliary rehabilitation usually delivered for up to 6 weeks. Dinefwr CiCt is working with approximately 25-30 clients at any one time.

The Dinefwr CiCt has a main office at Amman Valley Hospital with a satellite office at Llandovery Community Hospital. Clients are organised in 2 ‘patches’; Amman Valley and Llandeilo/Llandovery. Each patch holds a weekly client meeting where each client is discussed in-depth giving the team members the opportunity to feedback and confirm treatment aims with colleagues. Each client is allocated a care co-ordinator who undertakes initial client-centred assessment, agreeing goals with the client. The care co-ordinator meets the client (and carers) after 3 weeks and will assess any additional need for support following the initial 6 week period. There is follow up of patients after 3 months and the team can provide short periods of additional intervention if needed (this would need to be agreed with GP or social worker). The whole team meets once a month to agree working arrangements/system and processes.

GPs in the area represent the biggest source of referrals (37% of referrals), a quarter of referrals are from social services and a further 19% from Occupational Therapists.

The team is managed by a Steering Group comprising representatives from the NHS Trust, Therapy managers and Social Services. A report on the Dinefwr CiCt scheme will be available in April and can be supplied to the Committee.

The Carmarthenshire Health and Social Care Partnership Board have recognised the scheme is working and a new service was established in Llanelli last autumn. GPs in that area, who do not have access to GP beds in the local area, can now refer to the CiCt team rather than to acute care beds.

**Key issues:**

- Weekly meetings mean that interventions can be dovetailed better. Clients' views on how frequently they should be visited are taken into account and care is taken to co-ordinate visits of members of the team in a pattern acceptable to the client.
- Team is able to focus on promoting independence as far as possible rather than just ensuring that clients are safe to return home. Team's assessment relates to mood and more general well-being as well as functional issues.
- Clients could see improvement in co-ordination of interventions including need for equipment etc. and also recognised a greater emphasis on enabling the client to become more independent.
- Team works on basis of a single patient record – all members of the team have access to it. The client retains a copy at home.
- A district nurse only recently joined the team. There is an intention to develop this link. Medical responsibility remains with the GP.
- Whilst unified assessment is not yet implemented it is, in effect, what the team undertakes with clients.
- From community hospital's point of view, after initial hesitation over the new team's role, there has been some change in attitude towards rehabilitation and some benefits that have arisen from working with the team. There has been a reduction in admissions.
- Some work is ongoing in Llandovery hospital with new ward being built but also a multipurpose therapy room that can be used by the Cict team.
- Other benefits include greater understanding of other professionals' perspectives through team meetings, building of trust between disciplines, better decisions on care made as team contributes in discussion.
- Social Services are still working to raise profile of team and working with team on criteria for referrals. Since Cict team started there has been reduced demand for home care and meals on wheels though more evidence is needed as to whether this is due to the implementation of the Cict team.
- Difficulties have included:
    - short term nature of flexibilities funding – difficulties in attracting staff for piloting new ways of working;
    - establishment of pooled budgets – difficulties over who owns what;
    - priorities - Government targets relate more to acute throughput than rehabilitation or keeping people out of hospital. Team can be torn between different organisation's priorities;
    - differences in manual handling policies between trust and social services;

- IT systems aren't compatible;
- Personnel and supervisory issues - terms and conditions can be different between different members of the team;

- Looking for flexibility of budget to allow new ways of working such as a member of the team working with (double staffing) private social care workers or providing similar intensive period of rehabilitation to people in a nursing/residential home to enable them to go home with more independence. Aim to seek opportunities through Wanless money and action plans.
- It could be appropriate to introduce targets related to integrated rehabilitation services.
- The CiCt Team is in touch with a network of Community Rehabilitation teams across Wales which shares information and best practice.

**Annex 4**

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HEALTH AND SOCIAL CARE

REPORT OF A FOCUS GROUP WITH STAFF FROM AGE CONCERN

March 2004

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The focus group involved six staff members and one volunteer with Age Concern. The following points emerged in the discussion.

**Hospital discharge:**

- if a person has a carer, nothing has improved in the past 10 years. An example from the previous weekend was cited:

  *a man was discharged too early, help was not in place, there was no referral to social services, no care assistant was provided, the carer was not told she would have to change a catheter and she had none of the equipment she needed (such as a commode and a backrest). Because it was a weekend nothing could be done.*

- discharge planning does not start as soon as a patient is admitted to hospital. One participant in the focus group (who 'knows the system') told of the problems she had encountered. She felt powerless in acting as her father's advocate.

  *when her disabled father in his early 80s (deaf, asthmatic and with only one leg) was admitted to hospital, they waited from 5.00 'til 11.30pm and when they got a bed, there was no porter. She described the confusion over his treatment as being 'Third World medicine'. He was discharged without his care being completed and with no care plan or contact with social services, even though she had requested this; no one asked her whether she could manage. He was readmitted 3 days later when he collapsed, but there is still no mention of discharge plans.*

- nurses see things differently, 'they don't see beyond the bed' and neglect the emotional and social side of patient needs. Ward staff do not know where to refer patients. No one knows what other people are doing and how they can work together

- patients and carers face major problems in obtaining information in hospital and in finding out what is likely to be happening, when they might be discharged and what care will be put in place.

- it is often assumed that carers are relatively healthy and that they can cope, yet often this is not so. Carers may have health problems of their own and it may be a considerable struggle to fulfill their caring roles. Even those who do enjoy good

health can develop physical and mental health problems as a result of their caring responsibilities.

**The revolving door:**

- patients too often are discharged early with no effective care plan in place and they find themselves back in hospital within a few days. In these cases they are typically processed in A&E yet again, repeating the same procedures, rather than being readmitted to a ward.

- some patients are kept in the holding bay overnight and then discharged without a discharge plan/care assessment. This increases the likelihood of them returning to hospital.

- the day hospital in Morriston has been closed and the vast majority of patients (often from the Valleys) have been readmitted to hospital. It had been a valuable resource which patients attended 1 day a week for checks, and which helped to reassure carers.

- many of the problems faced by older people are not self limiting and yet service provision appears to assume that this is so. Care plans are set up for a period of six weeks. After that, it is not clear who bears responsibility for continuing assessments of need and changes in plans to reflect a gradual (or more immediate) deterioration in health or level of ability. Care assistants are generally low paid and relatively unskilled, yet appear to be responsible for monitoring patients.

**The needs of some types of people are neglected** and this can lead to a deterioration in their health and greater demand on services than might otherwise have been the case:

- people who fall below eligibility criteria yet who do need low level assistance with tasks of daily living such as shopping, house cleaning, gardening, washing nets and so on. People's embarrassment about the cleanliness of their house can prompt social isolation and this in turn can prompt other problems. Help with filling out forms and claiming benefits is also crucial. In one instance a man simply needed cookery lessons. If there is a carer and s/he is also frail, there is a risk that both will 'slip through the net'.

- attention is often focussed on those who are 75 years and older. This means that people who are 50+ receive less attention, yet this is the age group where preventive work/health promotion is most valuable.

- people who refuse services may have considerable need for help. This is where voluntary organisations such as Age Concern appear to play an important role in building trust and helping people. Two of the examples cited in the group are:

  (i) *a woman who refused care - Age Concern persisted and regularly visited, talking with her through the letter box. When she did let them into the house, they found she had a wet bed, no heating, no way of heating food and walls that were running with damp. They helped with food and warmth and made her aware of other services, including housing. She is one of their clients.*

(ii) *a fellow with a false arm who was knocked down by a car had little knowledge of services available - Age Concern were able to gain his trust and found that he was heating his room with a toaster weighted down with a brick and leaving huge burn marks on the carpet. Because of a stroke he could not put money in his gas meter and he was not able to do his garden. They helped him apply for benefits which rose from £57 to £172 with a back payment of £1,000. They got him a microwave, arranged for him to see a dentist and got him fitted for a new arm as the other had been damaged in the accident. 'He got control of his life again'.*

**Differences between Age Concern and Statutory organisations**

- staff at Age Concern felt that they could work in a different way than those employed by statutory organisations. They are able to build up trust and be persuasive, they can adopt an holistic approach, they are able to give their time more freely, they can be person centred and they can bridge gaps.

- in contrast, they portrayed people working in statutory organisations as being task centred, following narrow job definitions, ruled by structures of responsibility and not seeing people as human beings but as 'care packages' or 'hours'.

**General Practitioners:**

- GPs were criticised for not being very helpful, especially in the 5 - 6 days after discharge when they will not visit a patient.

- it was felt that they would often typecaste patients and may refuse to attend. Because the patient had 'cried wolf' so many times, one GP refused to attend a women who fell in the night and thought that she had broken her hip. The woman called Age Concern who, in turn, called an ambulance. She had broken a bone.

**Joint working:**

- joint working will take place but will be 'painful' - boundaries of responsibility will have to be blurred and people will have to see beyond their narrow remit.

- it will be necessary to look at underlying problems (adopting a broad rather than a narrow approach)

- it will be difficult because of the different cultures, levels of responsibility and decision making in different sectors. One person felt that senior managers were like children in tackling these issues and she said 'I'd like to knock their heads together....'

**Best practice:**

- Age Concern is responsible for a hospital discharge scheme. It includes nurses and social workers who work together outside their normal structural limitations. Working jointly requires a blurring of boundaries and feeling responsible for things beyond their usual remit. [I have included documentation on this.]

**Changes they would like to see implemented:**

- readmissions of older people should not take place through A&E
- discharge planning should start when the patient is admitted
- there should be one discharge co-ordinator on each ward to ensure that the work proceeds smoothly and that plans are in place before a patient is discharged.
- there should be one point of information for carers and patients who currently face major problems in accessing information about care and future possibilities, including problems such as how to get a bed downstairs.
- greater sharing of information between services should take place and there should be a single case file open to all practitioners
- practitioners often do not appreciate what each other do in the course of their work. There needs to be some way of finding out what everyone does. This would help with patient assessments and the development of appropriate care plans.
- joint health and social care day centres would promote joint working and would allow 'one stop' care for patients who need several tests/procedures. It would save them travelling 'all over the place' for different tests on different days.
- more funding for Care and Repair who are overstretched and unable to respond as quickly as they have previously.
- care assistants should be better paid and better trained. They carry a considerable responsibility in monitoring a client's progress/deterioration.

**Annex 2**

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HEALTH AND SOCIAL CARE

REPORT OF A FOCUS GROUP WITH USERS OF SERVICES

March 2004

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The group was made up of 3 women who are carers and 6 people who receive or have recently received care. They ranged in age from 56 to 93 and, as their participation in the group indicates, they are not completely housebound. The following are the main themes which emerged during the discussion.

**Feeling a sense of control**

- several people spoke of the importance of having choices and feeling that they retained some control over their lives. This was particularly pronounced for one woman, a carer, who had been told that she and her husband would have to sell their house because (seemingly simple) modifications - the construction of a ramp - could not be financed by the local authority. After a series of other housing problems she said that 'I feel everything has been taken out of my hands'.

- social workers can be very important in providing clients with information, which can increase their sense of control. The importance of having information was a *very* strong theme: information on services, entitlements and who to contact when in need of help.

**Staying in your own home**

With only one exception, people wanted to stay in their own homes and felt that they should not be compelled to sell homes that they had struggled to pay for.

- it was a source of great stress for one woman when she and her husband had to sell the home they had lived in for about 40 years. She said 'I miss my garden terrible'. She felt she had a relationship with her garden which had a tree for each of her grandchildren.

- one woman said that she had struggled to pay for her home after her husband's death and she refused to sell when told to do so by social services.

- no one wanted to go into a 'home'; the feeling was unanimous, even though they recognised that there were good as well as bad residential homes. People wanted to die in their own homes and they felt that the changes in health and social care over the past 5 years or so made this more likely.

- one person had sold her house and moved to sheltered accommodation. For her, it was the best solution but others were more emotionally attached to their homes and perceived sheltered accommodation as too cramped and likely to change their way of life. They said that they did not want to live surrounded by nothing but old people.

**Social Services**

- the care provided by social services was praised in many ways. People spoke highly of their social workers, their carers, respite care, rehab and day centres; Earlsmoor was praised by several people, as was Care and Repair. There was no mention of poor co-ordination of services; 'it all fell into place'. One woman said she was so poorly, she didn't know what was happening, and she was well cared for. Another said 'I didn't know who or where I was' and was full of praise for the help she received - 'it was wonderful'.

- yet public resources are too few. The participants in the group spoke of waiting lists for respite care and wondered how many people were waiting for this. Carers were not available in a crisis and when one woman broke her arm she had to turn to private care for the extra help her husband needed. Several people were limited in the number of days they could go to day centres and they said that there were waiting lists for these, too. Provision of stair lifts and hoists was inadequate and one woman had to pay for her own, even after being told that a grant would cover a replacement stair lift (she was now in debt to her daughter). Modifications to their homes were also a problem (e.g. waiting times for Care and Repair) and these were not necessarily funded by the local authority, though they were crucial in maintaining people's independence.

- in several instances people had to pay for equipment or modifications themselves. They bought hoists, installed stair lifts, hired their own carers. In some cases, they did not know what help was available for them. In other cases, the waiting lists were in excess of a year or two and they felt they could not wait so long.

- private carers are not as good as care assistants funded by social services; this point was made forcefully. One woman spoke of their obvious lack of training and felt it was inappropriate that she had to train them.

**Information**

- this was a key issue than ran through the discussion. People spoke of the confusing range of agencies and providers involved in their care and often had no idea who was providing the services they received.

- typically, people did not know where to go for information or who to contact if there was a problem.

- they did not know the extent of the services that were available to them and the focus group was probably helpful as a means of sharing information.

- one woman said 'you only find things out when something happens' and while this might be appropriate, it was clear that people often did not know of their entitlements or the choices they might have.

- a discussion of how information could be made available touched on enclosures with pension books or council tax forms, leaflets in doctors' surgeries, and a card such as the NHS Direct cards that could be kept on the 'fridge. The consensus was that one telephone number should link them with a real person (no recorded messages) who could provide information and point them in the right direction.

**Family**

- several women relied on their families for help. For example, one could not go out alone and she relied on her daughter or her grandson. Another relied on her daughter who lived next door, but the daughter was almost 70 and not in good health.

- the dedication of family carers was obvious and one woman described it as a 'labour of love'. They made many sacrifices and in some cases their own health suffered. One woman described how her back problems disappeared when she and her husband bought a hoist to lift him. Another woman had several health problems and was experiencing considerable stress as a result of housing difficulties.

- the importance of having a carer's assessment was emphasised by one woman who had gone through this process and found it very helpful. Never before had she been asked what would make her life easier. As a result of this she was taking driving lessons and she also had a mobile phone, both of which promised to be a tremendous help.

**Policy initiatives**

These are the strongest themes that emerged when people spoke of the need for change:

- better pensions - the recent increase in pensions was completely inadequate in the light of other cost increases (such as the council tax).

- better access to information

- more invested in local authority services so that respite care, carers, day centres, modifications to their homes, and equipment such as hoists are more accessible.

- better training and supervision of private carers.

- better transport and more buses with low platforms and sympathetic drivers.

- incontinence pads should be delivered to people's homes.

People wanted to be able to stay in their own homes but with appropriate help for their varied needs. They spoke highly of Age Concern, services in Bonymaen, Care and Repair, the Carers' Association, Earlsmoor and Gwenda Thomas.

NOTE: The discussion could not capture the experiences of patients who are in hospital or on the brink of being discharged, clients who are housebound bound (except through the views of their carers) and people who have refused services.

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HEALTH AND SOCIAL CARE

REPORT OF A FOCUS GROUP WITH STAFF AND MANAGERS

IN HEALTH AND SOCIAL SERVICES

April 2004

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The group was made up of seven participants and it included Directors and Managers of services as well as front line workers. The area for which they are responsible is large, yet it is small in population and this means that informal ties across organisations may be stronger than in areas with larger and more heterogeneous populations. Partnerships may assume a less formal quality. The following are the main themes that emerged.

**Parallel systems**

- the Welsh Assembly Government (WAG) has given no explicit direction concerning the merging of health and social care; essentially, the two systems will continue to work in parallel in the area.

- the two systems have distinct methods of funding; different priorities; and differences in terms and conditions of work. All of these stand in the way of joint working.

- the continuing separation of the two systems is highlighted by the parallel development of two different IT systems in the NHS and in Social Services.

- the WAG has given contradictory messages which also reduce the likelihood of collaborative working: for example, Unified Assessments are a priority in Social Services but not in the NHS. ‘Consistency would help’.

- similarly, policy is not explicit with respect to children and young people, though a view is emerging. There is no clarity of roles or direction as to how one sphere can influence changes in another when there is no responsibility or accountability.

**Financial barriers**

- both sectors are heavily stressed financially and have little flexibility, which makes it difficult to work collaboratively and innovate. For example, if acute hospitals increase day surgery, the consequent increase in discharged patients in the community is a cost that Social Services must bear with no budget transfer from the Trust - the money 'saved' by the Trust has to go to clearing waiting lists. This is but one example of how decisions in one area affect another. Cost benefit evaluations do not take into account the broader balance of costs and savings.

- a protected joint funding process would be a key way 'to move Wanless forward', promote collaboration and 'unlock convergence problems'.

### Different cultures

- typically, practitioners do not know very much about what each other do and this can inhibit joint working.

- differences between practitioners are also accentuated by medical vs social models of health and varying professional approaches. This can result in professional tensions and uneasiness about assessments done by a colleague with a very different background and training.

- joint training, periodic rotation to other jobs and shadowing colleagues might be some of the ways of overcoming these multiple solitudes.

- experience has taught practitioners that working in the same location can facilitate collaboration and a better understanding of what other people do. It has enabled them to talk to each other and share information on clients, though there is no formal mechanism for discussing clients. This can sometimes increase workloads as front line staff take on problems not allocated to them.

- a different means of 'overcoming separations' has been tried in one town with limited success - a 'hybrid person' combines health and social care tasks at a nursing level

### Problems with discharge and continuing care: resources and management

- the area has a shortage of nursing home places and there is a waiting list for home care. Recruitment of staff to provide intensive home care is a problem, often because of the number of staff required to meet the needs of one person (typically six staff). There is also a shortage of community therapists. Some patients are not assessed in hospital as there are no places to which they can be discharged and no staff to follow up on discharge or to provide community rehabilitation. The people who do receive home care are those in greatest need.

- it might be helpful to train carers in various generic tasks such as chest percussion or administering eye drops - this would compensate for the lack of specialised care.

- there are shortages of staff and everyone is working to capacity. The amount of paperwork required of front line staff is especially frustrating; 'the paperwork is phenomenal' and 'it intrudes into care'. One person, in an unusual situation because she works for both the Trust and the Local Authority, has to do duplicate paper work when she refers patients to herself.

- managerial problems also stand in the way of service provision. When a 'hybrid' care worker was piloted, it was difficult to organise services which included 75% home care and 25% health care (where a charging element applied to the 75%) and also manage the wider responsibilities of social services - 'it is difficult to rota people in'. It is financially and organisationally impossible to provide eye drops three times a day for patients who might live in a rural area. [Could consultants be encouraged to prescribe drops to be applied just once a day?] People want to die in their own homes but the cost and organisational challenge of providing intensive care to several people make it an unrealistic option.

- the various services involved in providing social care are more cohesive, but still not managed as one unit. As a result, it is difficult to coordinate sheltered housing, home care services, the district nursing service, occupational and physiotherapy, Care and Repair, other voluntary organisations, the private sector and so on.

- the involvement of the independent, not for profit sector in providing services has increased flexibility in planning services. It can also provide services at lower cost, partly because of lower wages.

- issues have to be considered 'in the round' and management has to look at the 'totality' which means taking into account Social Services, Health, the private sector and, most recently, the LHB. Managers and directors are brought together informally and in meetings, yet these are separate sectors and decisions in one can profoundly influence other sectors. (For example, if there are pay increases in Health, recruitment and retention of home care workers will be more difficult.) Trade offs and efforts to balance the effects of change may actually inhibit change. Inadequate funding compounds the problems, 'the pot isn't big enough'.

## Patients and their families

- many people retire to this area of Wales and there are often problems when they have no family supports and especially when one partner dies. Typically, it is the wife who is left and sometimes she cannot drive which makes her more dependent.

- people who move into the area 'have no history' and practitioners find that these clients have more complicated backgrounds (social and medical) than is first realised: 'we never know what we're walking into'. Medical records do not appear to move with people when they relocate.

- clients have much greater expectations than in the past, though providing services can create dependency.
- people are given information, but they do not remember; they are given booklets, but do not read them; even though front line staff explain who they are, clients do not remember.
- people now receive care plans with names and numbers on them so that may improve their access to information.
- people must learn to take responsibility for themselves and this must include buying appropriate housing.

## Looking forward

- at present, the needs assessment prepared by the LHB has identified current services.

- it is difficult to gauge what future demands will be made on health and social services - ‘you can’t guess the future’, ‘will there be more or less demand with life style changes?’

- there is no coherent preventive policy in place at the moment. Some moves have been made to discuss with planners the types of housing needed by older people, and to discuss with estate agents the need for older people to buy appropriate houses (e.g. clients might be warned that if they buy certain types of houses, the local authority will not cover the costs of modification).

- organisations such as Age Concern (which is ‘robust’ in the area) help to provide services such as a chiropody service (‘things the family used to do’). As part of the Older Person’s Strategy, Age Concern also gathers the views of older people so that they have input into service planning.

- meals on wheels help to combat social isolation. Also, it might be possible to introduce a befriending service, for people isolated in their homes

**Good Practice in Joint Working at operational level highlighted in responses to HSS Committee Policy Review: Interface between Health and Social Care**

| Organisation | Joint working examples | Also cited by: |
|---|---|---|
| **Age Concern(4)** | ♦ **Joint Assessment/ rehabilitation** teams in **Conwy and Denbighshire**<br><br>♦ **Integrated Health and Social Care centre in Aberaeron (nearing completion).** Partners include NHS Trusts, LHB, Ceredigion County Council and the CHC.<br><br>♦ Joint health and social services funding for **Rapid Response Adaptations Programme** administered through Care & Repair mentioned by Age Concern organisations in **Ceredigion** and **Cardiff and the Vale.**<br><br>♦ From across Wales some positive examples were given of voluntary sector hospital discharge services involving such organisations as local Age Concerns, Red Cross, and Care and Repair and Adref yn Saff. | Care & Repair Cymru |
| **North West Wales NHS Trust** | ♦ Intermediate care services have been developed primarily through the multi-agency, multidisciplinary Emergency Pressures Planning Team, which meets on a regular basis and is serviced by the Trust. The most significant developments resulting from joint work in this forum are:<br><br>• **Rapid Response Teams for both Mon and Arfon** which deliver care in community settings, home or private sector in order to avoid admission to hospital for patients whose needs can be met effectively elsewhere. The Rapid Response Teams are also developing their role in supporting discharge of patients from hospital, where the rehabilitation model of care they have developed can be successfully employed to facilitate earlier discharge.<br><br>• **Tuag Adref** – a multi-agency service concentrating on **resettlement and** | Gwynedd County Council<br><br>Gwynedd County |

| | | |
|---|---|---|
| | **rehabilitation in the patient's own home**, preventing long-term dependency and the subsequent need for services. This service is based on a model in which **specific patient centred goals are agreed with Occupational Therapists**.<br><br>• **Home Loans Service** – this is jointly provided by Trust and Local Authority, supported by service level agreements.<br><br>♦ **Specialist Community Paediatric Teams** and **the Learning Disabilities Resettlement programme** are supported by multi-professional and multi-agency working at both strategic and operational levels. | Council |

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|---|---|---|
| **Gwynedd County Council (12)** | ♦ **Rapid Response Service** Joint service between the North West Wales Health Trust and the Council (Social Services). This service enables patients to leave hospital safely and without unnecessary delay, and it helps to reduce the length of stay in hospital. It also prevents unnecessary admission to acute hospitals and enables patients to remain at home by receiving multi-disciplinary health and social care. During 2002-03 the service enabled 233 patients either to be released from hospital (96) or not to have to go to hospital at all, by arranging intervention and appropriate support at home (137). At present, the service is restricted to one area of Gwynedd, namely Arfon (North Gwynedd). It is estimated that the service has saved over 3000 bed days in the acute and community hospitals during 2003-03. The Rapid Response Service includes a physiotherapist, occupational therapist, nurse, social worker, support care worker, therapy assistant and administrative assistant.<br><br>♦ **Social Care Assessors Based in Surgeries** This is a pilot scheme which addresses people's needs by addressing lower levels of need (preventative work) and carries out assessments and care management in less complex cases within Primary Care. The intention is to prolong the period of independence of individuals and to make them less dependent in the long term on social and health care. Some doctors state that the service reduces their burdens by avoiding having to contact the social services office and avoids having to follow up on cases as they receive direct feedback from the social care assessor in the surgery.<br><br>♦ **Tuag Adref.** A successful multi-disciplinary project which seeks to promote early release for patients from hospitals and to reduce long term dependence. It is provided by joint resources, the Occupational Therapy Service of the Health Trust and the Home Care Service of Social Services. Joint reablement packages are provided by the occupational therapists and home carers who are supported and trained to undertake therapeutic and reablement work with patients in order to reduce the length of stay in hospital and long term dependence. | North West Wales NHS Trust<br><br>North West Wales NHS Trust |

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|---|---|---|
| | ♦ **Unified Assessment Action Group –** close co-operation to prepare for the introduction of "Creating a Unified and Fair System for assessing and Managing Care " across health and social care.<br><br>♦ In addition to these schemes, there are a number of other joint working arrangements which address needs e.g. mental health, physical disability and learning disability services users. In the field of Disabled Children and Children who are ill, there is close co-operation and planning, as previously noted, to set up a multi-agency and multi-disciplinary service that will lead to a formal agreement under section 31 of the Health Act 1999. | |
| **Parkinson's Disease Society** | ♦ **The PDS and Rhondda Cynon Taff County Borough** run a successful service level agreement to establish a part time **Parkinson's Disease Society Community Information Officer**. The post successfully promotes awareness of the condition locally with health and social care professionals and provides support, signposting, information and advice for people living with the condition, their families and carers in the borough. | |
| ***NCH Cymru (16)*** | ♦ The **M.I.S.T. project**, a new **Tier 3 CAMHS service** to be managed by NCH Cymru in **Torfaen,** has multiagency funding, but a single contract. This service aims to provide intensive local CAMHS for young people who might otherwise require specialist residential services out of county.<br><br>♦ The **NCH Pembrokeshire Children's Centre for children with disabilities** is jointly funded through a tripartite agreement between Health, Social Services and Education, which has been running successfully since 2000.This high level of commitment to working together, both financially and in terms of interest, has enabled the development of innovative schemes such as keyworking, as well as management of a multiagency child development team and an active and effective Register for children with specific needs. The NCH staff team is small but draws on willingly contributed resources from all the partner agencies to achieve all these activities. The impact of the service on children and families is highly effective, and helps to maintain children within their own homes.<br><br>♦ **Flintshire Family Project** this year secured health inequalities funding to match Children's Services funding, enabling the development of outreach to children and young people experiencing emotional and | Pembrokeshire County Council/Local Health Board and Pembrokeshire and Derwen NHS Trust |

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| | behavioural difficulties and creche facilities for parents to attend therapeutic sessions. | |
| **WLGA (17)** | ♦ **Joint Working with Children and their Families** There is a **multi disciplinary family support** team comprising of practitioners from social services, health and education. It has based in **Carmarthen and Llanelli**. The team provides help and support to disabled children and their families. The team also works closely with other agencies to ensure that disabled children and their families receive appropriate respite services, financial support etc. They are presently in contact with approximately **800** children.<br><br>♦ A **joint project between Gwent Healthcare NHS Trust and Social Services** is reducing hospital admissions among **older people with mental health problems** in most parts of **Caerphilly** county borough. **The Home Treatment Team** give support to people in their own homes and respond to psychiatric emergencies. Their work allows people to come out of hospital earlier and prevents some patients from having to enter hospital.<br><br>♦ Also in Caerphilly, the **Occupational Therapy service** in **Caerphilly CBC** and a parallel Occupational Therapy service within the **Gwent NHS Trust** has completely reviewed how they work together. Waiting times for people who need an assessment for home adaptations has reduced significantly. The results have improved customer satisfaction and the numbers of people going into hospital. It has also turned around declining morale and improved the retention of skilled practitioners. | Caerphilly LHB<br><br>Caerphilly LHB |

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| **WCVA (19)** | ♦ '**A Caring Break' Swansea** A partnership project with Age Concern, Alzheimer's Society, Swansea Council & Princess Royal Trust. Provides Day Care and Home Sitting Services for elderly frail people. Accommodation provided rent free by Swansea County Council.<br><br>♦ **Anglesey Crossroads Care** attendant service to people who live at home, providing **respite for carers**. All client groups are eligible. The largest client group are carers of older people with mental illness<br><br>♦ **British Deaf Association Visible Voices Wales Project.** The project has developed a platform where local deaf communities cam meet representatives from health and Social Services<br><br>♦ **Arthritis Care UK Challenging Arthritis "Expert Patient"**. Participants learn how to manage their condition and acquire new skills in controlling pain, depression and anxiety and in goal planning. Research has shown that participants experience substantial benefits in terms of their health and well being. Partly funded by Health and Social Services<br><br>♦ **Age Concern Morgannwg Hospital Discharge Services & Primary Care Service** Complements the role of social services and supports those who may not be eligible for statutory support. Support for people in their own homes for up to eight weeks after discharge from hospital. Helping to prevent re-admission | |
| **Chartered Society of Physiotherapy in Wales (20)** | ♦ North Wales appears to have fewer problems in the area of equipment, adaptations and aids provision for children. The three sectors, education, health and social services have reached agreements and operating arrangements, which are understood and acceptable to all concerned.<br><br>♦ **Intermediate care facilities** such as 'step-up' and 'step-down' facilities with access to therapists so that rehabilitation can be continued. E.g. | College of |

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| | **Mardy Rehabilitation Scheme, Abergavenny** A multidisciplinary team at this intermediate care facility seeks to provide a 'half-way house' between in-patient treatment and independent living. Patients stay 4 – 6 weeks and the physiotherapists provide vital rehabilitation. It enables discharge from Nevill Hall Hospital and provides a constructive alternative to people in the community who require rehabilitation but do not need a medical admission to hospital.<br><br>♦ **Community reablement teams** who can assess and provide intervention hopefully to prevent admission or who can continue rehabilitation programmes on discharge from hospital. E.g.<br>**Neath Port Talbot, Re-ablement Team** The physiotherapist and other members of the team provide multidisciplinary assessment based on the patients' needs and a 4 – 6 week re-ablement programme for clients in their own home. The team aims to enable people who have lost their skills for living independently to relearn them, or acquire new ones so they may regain the confidence to live independently and remain in their own home which is where most people prefer to be.<br><br>♦ **A&E multi-professional assessment units** to provide intervention and links with community services to prevent unnecessary admission. E.g.<br>**A & E assessment unit – University Hospital of Wales, Cardiff**<br>*A multidisciplinary assessment team in UHW's A & E Unit is preventing unnecessary hospital admissions. After the initial 10 weeks the scheme was reaping rewards with 6 out of 10 patients going home after receiving emergency unit assessment and treatment rather than being admitted. The team includes a physiotherapist and occupational therapist who check on all aspects of the patients' physical ability, provide equipment and link with services in the community.*<br><br>♦ **Elderly Care Assessment Teams and Rapid Response Teams.** E.g.<br>**ECAT – Elderly Care Assessment Team – Conwy and Denbighshire**<br>*This multi-agency team which includes a physiotherapist provides a seamless package of care for patients in **Abergele**. It aims to enable as many elderly people as possible to continue to live in their own homes by assessing them quickly and providing rehabilitation and support. This prevents admission to hospital and delayed discharge from hospital.*<br><br>♦ **Bridging teams** who deal with **specific condition** based areas such as orthopaedics. Patients can be discharged home far sooner and continue their rehabilitation in the | Occupational Therapists(COT)/ Monmouthshire LHB/LA<br><br>COT<br><br>COT/University of Wales College of Medicine (UWCM)<br><br>Age Concern |

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| | comfort of their own home. E.g.<br>**Orthopaedic Bridging Team – Morriston Hospital, Swansea**<br>*A 'hospital at home' service is provided. A package of home based rehabilitation services, aimed at facilitating early discharge from hospital for patients following joint replacement, revision or resurfacing. Patients are discharged quickly and are then followed up by a team containing a nurse, physiotherapist and an occupational therapist. The patients are visited within 24 hours of discharge and monitored for post- operative complications for up to 15 days. The service has led to quicker recovery of patients and rehabilitation more appropriate to the patient's own home.*<br><br>♦ **Condition based teams in the community** such as Chronic Obstructive Pulmonary Disease (COPD) teams or neurological teams, again providing rehabilitation and treatment in people's own homes.<br><br>**Community Respiratory Resource Unit – Llandough, Cardiff**<br>*This multi-disciplinary community service was set up in 2001 to provide a service to Chronic Obstructive Pulmonary Disease (COPD) patients following hospital discharge. The team is conducting a randomised controlled trial piece of research to measure the effect on bed use. Patients are followed up at home for an 8-week period by the team, which includes physiotherapy.* | |
| **College of Occupational Therapists (23)** | ♦ In North East Wales the Trust and Local Authorities have funded a project officer to consider the potential of fully integrating equipment loan stores.<br><br>♦ In **primary care, giving general practitioners direct access to inter-professional teams.**<br><br>***Elderly Care Assessment Service (ECAS), Rookwood Hospital***<br>*ECAS provides an alternative and more direct route to multidisciplinary assessment for primary care teams and social services teams who are managing frail older people in the community. The team consists of doctors, nurses, physiotherapists, occupational therapists, dietician, speech and language therapist, clinical psychologist and social worker. The 18-month experience has shown: The elderly client group have complex needs. A significant number of new medical diagnoses were made (50%). The client group had high rehabilitation requirements (70%). General practitioners, clients and their families positively evaluate the service. In financial terms alone, over the 18 months ECAS:*<br>▪ *prevented 10 admissions to residential or nursing homes* | UWCM |

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| | ▪ *saved £175,000 (nominal costs) for the first year of home care costs*<br>▪ *prevented 98 acute hospital admissions*<br>▪ *avoided 2,548 UHW bed days – the continuous occupation of 7 UHW beds*<br>▪ *potentially saved £568,000 (nominal costs) in acute hospital costs*<br>*( Morse & Birkett 2002)*<br><br>♦ In **Accident and Emergency** helping to reduce admissions<br><br>***University Hospital of Wales, Cardiff***<br>*A multidisciplinary assessment team in UHW's A & E Unit is preventing unnecessary hospital admissions. After the initial 10 weeks the scheme was reaping rewards with 6 out of 10 clients going home after receiving emergency unit assessment and treatment rather than being admitted. The team includes an occupational therapist and physiotherapist who assess all aspects of the client's ability, provide equipment and link with services in the community*<br><br>♦ In **medical emergency admission units (MEAU**) increasing rapid, safe, sustainable discharge<br><br>***Llandough Hospital, Penarth***<br>The occupational therapy service to the MEAU was funded with Welsh Assembly Government Emergency Winter Pressures funding. By linking with the new community services safe discharge could be achieved direct from the Unit, avoiding the need for admission. Patients needing admission for medical needs would also have had their occupational therapy intervention started earlier thus facilitating faster discharge.<br><br>♦ In **Elderly Care Assessment Teams, Rapid Response Teams and Re-ablement Teams** preventing admission<br><br>***Neath Port Talbot, Re-ablement Team***<br>*The occupational therapist, physiotherapist and other members of the team provide multidisciplinary assessment based on the client's needs and a 4 – 6 week re-ablement programme for clients in their* | Chartered Society of Physiotherapy in Wales (CSPW)/ UWCM |

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| | *own home. The team aims to enable people who have lost their skills for living independently to relearn them, or acquire new ones so they may regain the confidence to live independently and remain in their own home, which is where most people prefer to be.*<br><br>***Re-ablement occupational Therapist within the Home Care Service in rural Ceredigion***<br>The project is funded by Flexibilities money for a fixed term of a year to identify clients (within public and private sector) with the potential to regain skills and maximize independence and prevent them moving into a downward spiral of dependency and residential or hospital admission. The therapist trains the Home Carers to enable individuals to 'do' themselves, rather than doing tasks for them. There is access to a joint equipment store for equipment and links are developing with the occupational therapy and Social Work services in West Wales General Hospital. Aims to prevent unnecessary hospital admissions, reduce need for residential care thus freeing up places for delayed discharges, assisting with the prevention of falls by the management of risk, regain skills in ADL and avoid 'revolving door' syndrome, learn new skills/techniques. Outcomes should include: reduction of Home Care hours due to a decrease in dependency reduction in the number of client falls, reduction of unnecessary hospital admissions, reduction in delayed discharges, a multi skilled Home Care workforce, the development of an inter-agency enabling approach to the care of clients in their own homes.<br><br>♦ In **intermediate care** providing vital rehabilitation supports quicker, safer & more effective discharge from hospital plus preventing admission:<br><br>***Mardy Rehabilitation Scheme, Abergavenny***<br>*An occupational therapist leads the multidisciplinary team based in a residential home. The scheme seeks to provide a 'half-way house' between in-patient treatment and independent living. Patients stay 4 – 6 weeks and the physiotherapists and occupational therapists provide vital rehabilitation. Nine beds are available for patients from two G.P practices in the Abergavenny area. It enables people who are discharged from Nevill Hall Hospital to receive rehabilitation prior to their return home; or provides a constructive alternative to people in the community, who require rehabilitation, but do not need a medical admission to hospital.*<br><br>***Short term Intervention Service, Vale of Glamorgan*** | CSPW and UWCM<br><br>CSPW and Monmouthshir |

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| | Vale Social Services Department has a short-term intervention service where home carers are trained by occupational therapists to enable patients to increase their independence in occupations rather than doing the occupations for them. Thus retaining important skills and benefits.<br><br>♦ In housing departments better use of adapted property and quicker access to adaptation and preventing admission<br><br>***Joint access to Housing in Wrexham***<br>The occupational therapists in health have direct access to the Housing Department budget in **Wrexham** Social Services for minor adaptation work up to £2,500. In practice this is usually for rails, ramps, fixed toilet equipment etc. Although the funding would allow the therapists to be involved in larger projects such as level access showers, in practice this is rarely possible as this would require site visits and follow-up visits for which the therapists cannot release the time and commitment. There is also access to the Rapid Adaptation Programme through Care & Repair in Wrexham and Flintshire, where the health occupational therapists can directly refer for minor work to be done to facilitate discharge e.g. rails, plugs changed, minor home repairs. This can make a real difference to efficient and safe discharge.<br><br>♦ As **extended scope practitioners**, working on waiting lists triage models lead to resolution of problems without the need for medical intervention – freeing up valuable consultant and therapist time<br><br>***Collaborative Working to facilitate Play and Leisure Opportunities for Children with Developmental Co-ordination Disorder***<br>The occupational therapy service for children in Wrexham has worked with Wrexham Sports and Leisure Services to enable children to access supported sport activity. | e LHB/LA |

***Pre operative assessment team- Llandough Hospital, Cardiff***

Pre operative assessment teams screen patients prior to elective surgery to ensure they are well informed and prepared for surgery and any complex issues which may delay discharge are planned for in plenty of time, thus preventing discharge delays. This is reducing consultants' waiting lists.

***Teaching Teachers - Developmental Co-ordination Disorder (DCD) in the Classroom, Wrexham***

The occupational therapy service for children had a waiting list for children with DCD. Many of the issues affecting these children present as complex and difficult issues for teachers to recognise and manage within the classroom. The paediatric occupational therapist in Wrexham has designed the 'Teaching Teachers' programme using a variety of resources currently available to teachers. Up to date research and development with regard to management of occupational issues for children with DCD is used within the programme.

*Outcome:* ***Participants are now more confident about trying strategies for themselves and less likely to request an occupational therapy referral. All participants claim that they have changed one aspect of their teaching of a child that has made a positive impact on that child's performance.***

Schools with special educational needs co-ordinators (SENCO's) who have attended the training are more likely to use recommended strategies first before making a request for occupational therapy assessment. Therapist time is reduced since education staff understand the role of occupational therapy and do not always request school visits as they have the confidence to support therapy intervention with their own knowledge gained from the training programme. Children who attend occupational therapy intervention groups are more able to share and develop their individual strategies if the SENCO has attended further training It is hoped that in 2004 the package will be available on a regular basis to SENCO staff in Wrexham and Flintshire. Both LEAs are keen to use the programme and it is hoped that the small revenue raised will help fund stationary costs and administration and clerical support time that is currently unavailable to the occupational therapy for children service. Requests have also been received from SENCO staff in England raising the possibility of future development and income generation. An email support line has been established for quick problems solving and ultimately it is hoped that an information website could be developed for teachers, children and families.

- In **integrated or joint-funded posts** allowing the therapist to provide person centred

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| | services regardless of the employing organisation and prevent duplication of assessments and actions.<br><br>***Springfield Project, North East Wales***<br>Social services adapted a residential flat into a fully adapted rehabilitation flat for clients who require short-term rehabilitation or who are awaiting major home adaptations and who require further rehabilitation to manage independently. Occupational therapists in health & social services are responsible for agreeing the rehabilitation programme with the client and support staff in the flat. They visit regularly to monitor progress and adapt programmes. Social services pays a small amount to the health occupational therapy service to supply training in rehabilitation principles for the generic support workers who support the residents for 6 – 8 weeks. The occupational therapists can also give advice on approaches with individual clients. The Head Occupational Therapist in health collaborates with the residential officer at the flat to co-ordinate the use of the flat and to monitor outcomes.<br><br>***Joint Occupational Therapy post between Caerphilly Borough Council and Gwent Healthcare NHS Trust***<br>A senior occupational therapist post was made available in 2001 from the Flexibilities Initiative, employed by health and financed from Social Services. The inclusion criteria for patients to access the project is multiple pathologies, requiring maximum support to return home. The aim is to achieve a continuum of occupational therapy provision from hospital to home, with one therapist following them up at home for a period of six weeks post discharge. The therapist has access to Social Services Database from a health site, and can access all necessary equipment for safety at home, and can recommend major adaptations. The post has integrated both services by joint training, with equal access to equipment and developed shared protocols of care. At present a document, which has been jointly designed from both agencies, is being piloted for the Unified Assessment Process. Existing evaluation has indicated high levels of service satisfaction from patients, carers and professionals within the multi- | |

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| | disciplinary teams. A second therapist has been seconded from Social Services to the project, which has enabled the service to be offered for student placements.<br><br>***Joint Support Worker in Blaenau Gwent***<br>A support worker is employed across both health and social services who is also able to follow the patient into the community or hospital and ensure support. This has been very successful in allowing support and follow up for the client and ensuring safe delivery and use of equipment The funding for this will end December 31 2003 and won't be replaced.<br><br>***Joint Paediatric Occupational Therapist, Torfaen***<br>Flexibilities funding enabled the creation of a new post in Torfaen, Gwent, whereby the occupational therapist is employed by the Trust and managed by the Head Occupational Therapist but works exclusively in the children with disabilities team in the Social Services Department. This has enabled a co-ordinated approach to therapy provision for children in this area, drawing on the expertise and resources of occupational therapists from both agencies and reducing duplication. Extensive audit work has facilitated the allocation of previously shared cases to either the health or social services occupational therapist according to client need. There is agreed, managed input from both agencies only where there is recognisable benefit for some children and their families with complex needs. This has ensured the most effective use of scarce resources. A professional Head of Children's Occupational Therapy Services manages the 'social services' occupational therapist. This has enabled the occupational therapist role within a social services department to be protected and the skills and knowledge base of the occupational therapist in post can be developed to the benefit of children and their families. In other areas of Gwent where occupational therapist's working in social services departments with children remain managed within the social services department, a collaborative practice protocol guides the interface between occupational therapists in health and social services. A full evaluation of the benefits of both models would be useful in informing the current drives to reconfigure OT service provision. | |

***Joint Adult Services Occupational Therapist, Wrexham***
Wrexham Social Services fund an occupational therapist who is managed by Health to provide a service across both agencies for clients with degenerative neurological conditions. The occupational therapist is then able to take referrals direct from primary or secondary/tertiary care and provide the input across the traditional contribution of both service areas. A pilot post was very successful and has led to permanent funding. Client feedback has been excellent, with appreciation of the consistent approach and ability to follow through on complex issues. The therapist benefits from the enhanced terms and conditions of NHS employment.

***Flint Social Services Department***
In Flintshire Social Services Department a social services funded elderly care management: occupational therapy rehabilitation scheme has demonstrated clear outcomes for clients on a quality basis as well as cost benefits for services.

- Overcoming system barriers

***Protocols with other agencies***
The **Vale Social Services** Department has established protocols with a local hospice (voluntary agency) for rapid access to equipment resources.

***Collaborative Working***
**Wrexham Social Services and NEW Trust** are working together to develop training, cross agency basic grade staff rotations and joint training. Therapists in North East Wales are also working innovatively with the charity Whizzkids to help overcome inflexibilities in accessing individualised equipment. Therapists in **South Wales Artificial Limb and Appliance Service** have collaborated with **the Department of Medical Genetics and the Muscular Dystrophy Campaign** to produce equipment guidelines for those with Duchenne Muscular Dystrophy. These guidelines are now

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| | available on the Welsh Neuromuscular website for information purposes.<br><br>♦ The education of a future workforce<br><br>The nature of practice based learning needs to be considered. Placements should be established in modern integrated services, which allow students to see the future potential of integrated services. If students continue to only learn to practice within traditional boundaries this culture will continue. The UWCM is working closely with services to develop new models of services and help students to envisage a better way of working. For example<br><br>***Gwent Interagency Placement***<br>Gwent Healthcare and Newport Social Services Department accept students on an interagency placement, which allows the student to access the resources of both agencies and deliver an integrated service. The student was the only team member able to support clients in hospital and follow them up in the community.<br><br>***Homeless Hostel Placements***<br>For the last 6 years the Department of Occupational Therapy Education has been placing students in two Hostels for Homeless men. There is no therapist in post here and supervision is provided from the University. The students have demonstrated the clear benefit of occupational therapy for this population. They learn to work across boundaries and set up an occupationally focussed service. This is a new and developing role for occupational therapy. The students who have experienced this are able to bring a broader, more integrative perspective to their work: essential for the reconfigured services the Welsh Assembly Government will need. | |
| **Wrexham** | ♦ Key strategic and operational initiatives i.e.<br>• Integrated Mental Health provision; | |

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| **County Borough Council (24)** | • Joint Equipment Stores (across NEW Trust) :<br>• Section 31 Agreement for intermediate care beds;<br>• pooled budget for EMH nursing beds;<br>• rehabilitation flat within a sheltered housing with support scheme.<br><br>♦ Our most recent initiative has been a 2 day training event – "Change Leaders Tool-kit" - in which the managers, in Health, Social Services and the Voluntary Sector, who are charged to deliver on the change agenda, worked together to understand the frameworks necessary to achieve change. By undertaking this training together, we now have a common frame of reference and models to action.<br><br>♦ Wrexham Social Services and Local Health Board also work successfully together with NEW Trust in the Emergency Pressures arena. Significant improvement in Delayed Transfer of Care and utilisation of resources from a Question of Balance – JDI initiative has enhanced capacity within the community and acute sectors.<br><br>♦ We are building on the outcomes of a process mapping exercise to develop a whole systems approach to the provision of services for Older People / people with chronic diseases. We acknowledge the need to ensure all resources available – buildings/budgets/staff/expertise are identified in the quest to ensure best use of our current capacity.<br><br>♦ Recognising the need to address workforce pressures as a whole sector issue, a Joint Workforce Initiative Group has been formed comprising representation from Health, Social Services, FE college, careers organisations, independent and voluntary sectors. We have initiated joint management training for health and social services personnel; supported NVQ training for care staff in the independent sector and are developing a "passport " approach to lifting and handling training which will ease the transfer of staff across sectors | Audit Commission/ COT<br><br>COT<br><br>COT |
| ***Royal Pharmaceutical Society of*** | ♦ **Medication Administration by Domiciliary Care Staff – Cardiff**<br>A partnership approach between Cardiff LHB and Cardiff Social Services department has developed and piloted a successful scheme to train, support and monitor Domiciliary | |

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| ***Great Britain: Welsh Executive (30)*** | Social Services Care Staff in the administration of medication to patients who fulfil a set of assessment criteria identifying them as needing help with medication administration. The scheme allows the home care service to operate flexibly by offering support to more complex cases, thus enabling service users to remain at home rather than be admitted to another care setting. Help with medication administration has also facilitated earlier discharge from secondary care. The health and wellbeing of patients within the scheme have benefited from improved compliance and the ongoing medication reviews.<br><br>♦ **Communication of medication information at discharge- Kettering**<br>The Kettering K-Med system, uses a team approach to produce a Total Medication Summaries (TMS) which is sent to GPs and nominated community pharmacists (with patient consent). It is targeted to specific groups of patients to maximise impact (chronic diseases, elderly, complex or changing medication needs). The TMS identifies discharge medication, drugs stopped, new drugs and dose changes and includes an indication of monitoring or review date(s).<br>♦ **Medication Assessment Tool – Devon**<br>A 'concordance assessment tool' has been developed for use by community pharmacists when dispensing to vulnerable patients, linking into the Single Assessment Process. The tool consists of a two-side checklist covering a range of medicines issues – both practical and also relating to whether the patient understands the purpose of the medicine and agrees that they should be taking it. Having identified patients who might benefit, the pharmacist takes about 15 minutes to go through the tool with the patient. He/she can then offer advice, information and support, and refer back to the primary care team for patients where the medication regimen needs to be changed, a medication review is required or some other practical support (such as home support) is needed. | |

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| **Pembrokeshire County Council/ Local Health Board and Pembrokeshire and Derwen NHS Trust (36)** | Joint initiatives have developed including:<br><br>• Common contracts for the developing purchase of nursing home placements.<br>• Joint Review processes for Local Authority and NHS funded nursing care.<br>• A project for children with complex needs involving health, social care and education.<br>• An agreed approach to decision making to meet the needs of people who have a learning disability utilising an assessment matrix.<br>The use of flexibilities money for joint posts such as Adult Protection Officer and Intermediate Care Co-ordinator.<br><br>♦ A significant project within Pembrokeshire, which is testing and expanding the interface between health and social care, is the Pembroke/ Pembroke Dock scheme to provide a completely integrated service.<br><br>This project is enabling us to test the reality of multi agency working, identify the problem areas and develop solutions.<br><br>For this project the accountability arrangements are based on health being the lead agent, and in the first instance with social service staff being seconded to work in the NHS. This allows the provision of Welsh Risk Pool cover in the integrated staff teams, with the Trust Chief Executive retaining accountability for risk management. The integrated health and social care team will work as one in the new resource centre. The project is focusing upon the use of a unified assessment tool together with a unified process of care management. This is being supported by joint training, unified policies and procedures and eventually integrated management and pooled budgets to purchase customer focused support services. This will impact directly on the quality of hospital discharges.<br><br>The project focuses on home based care and the plans accordingly include: | NCH Cymru |

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| | • Maximising independence<br>• Making homes safer including falls prevention<br>• Joint staff training of generic rehabilitation assistants<br>• Full assessments, as relevant, for nursing, physiotherapy, social care, occupational therapy and podiatry<br>• Rapid response team<br>• 24 hour district nursing service<br>Hospital at home scheme. | |
| **Mencap Cymru** | ♦ Pilot study with GPs to ensure that appropriate regular checks meeting good practice guidance is undertaken<br>♦ Multi-disciplinary discharge meetings that plan for discharge in anticipation of the fact enabling preparations to be made for the person's return home<br>♦ Some GPs flexibility in visiting people at home when appropriate and in particular where this reduces the unacceptably high levels of anxiety experienced by the patient.<br>♦ Joint review meetings on a monthly or quarterly basis for jointly commissioned services. These often include regular joint working between health services and support providers and result in consistent approaches from staff and clear improvements in quality of life for individuals.<br>♦ Community based learning disability teams often provide useful and expert support to individuals and their support providers yet waiting lists are long and teams are frequently reactive to situations rather than preventative in their responses as a result. | |
| **University of Wales College of Medicine (39)** | ♦ Elderly Care Assessment Centre (ECAS) Rookwood Hospital, Cardiff<br><br>♦ Occupational Therapists and Physiotherapists based in Accident and Emergency Units at University Hospital of Wales Cardiff and Princess of Wales Hospital, Bridgend. | COT<br><br>COT |

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| | ♦ The establishment of multi-professional re-ablement teams provide support to individuals in their own homes for a fixed time period following hospital discharge. (e.g. Neath-Port Talbot, Vale of Glamorgan, Wrexham). These teams can include home care workers as well as occupational therapy and physiotherapy staff<br><br>♦ joint funding of therapy staff has enabled them to work across organisational boundaries in particular care pathways. (e.g. Wrexham for neurology, Torfaen for paediatrics).<br><br>♦ Joint access to aids and equipment stores has been established but their effective operation is dependent on protocols negotiated between occupational therapists in the NHS and Social Services. | COT mentions re-ablement in Neath/Port Talbot and Ceredigion<br><br>COT<br><br>Wrexham |
| ***MS Society Cymru (41)*** | ♦ **The MS Society MS Nurse Programme**. The Society has provided partnership funding for over 70 MS nurse, therapist and social work posts, to stimulate the development of more MS multi-disciplinary health and social care teams. Through this programme, we have also funded the set up costs of information services which fit within the care pathway, and are collaborations between professionals and volunteers. One example of this is in Conwy and Denbighshire Rehabilitation unit.<br><br>♦ The **Measuring Success Award Scheme** encourages and supports professionals in meeting standards of care; a unique feature of the scheme is the enabling of lay assessors affected by MS to audit services. The Conwy team have won this award.<br><br>♦ Living a healthy life – self-management courses. The voluntary sector has led the way in delivering the expert patient programme in Wales. | |
| ***Caerphilly LHB (42)*** | ♦ Joint service level agreements with voluntary sector organisations, e.g. Drugaid and Islwyn Drug and Alcohol Project where Caerphilly County Borough Council has assumed the role of lead Commissioner.<br><br>♦ Joint reablement scheme across health and social care. | |

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| | ♦ Appointment of a Joint Officer for the management of Emergency Pressures.<br><br>♦ Examples of the schemes established/planned<br>• Rapid Response scheme<br>• Reablement Scheme<br>• Respite care<br>• Over 75 years old holistic assessment<br><br>♦ The over 75 years old holistic assessment scheme is a particularly good example of whole systems working in practice. Funded from Townsend monies, the aim of the scheme is to identify those who may be at risk of increasing dependency on services by providing an annual assessment of over 75's. The assessment:<br><br>• Promotes health and well-being;<br>• Facilitates early detection and prevention of disease;<br>• Facilitates the implementation of the Unified Assessment Process;<br>• Gathers, systematically the views of older service users and their carers to inform future service development;<br>• Enhances practice knowledge of individual and community health profile of older residents;<br>• Enhances integration of primary and community services; and<br>• Maintains the independence of the over 75 age group to enable them to remain living in their homes.<br><br>♦ The **Caerphilly Borough Hospital and Community Services Project** has been established to develop plans for a new hospital in Caerphilly Borough which will replace some of the existing hospital facilities.<br>Examples of the proposed developments include:<br><br>• An **Integrated Care Centre**, including a **Chronic Disease Resource Centre**, due to the | |

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| | growing need for chronic disease management services in Caerphilly Borough. The resource centre will enable promotion/prevention. Primary, Community, Social and Secondary Care facilities to be integrated in one building, with access to diagnostic services and teaching facilities.<br><br>• A **Rapid Access Stroke Clinic**, which would be a nurse-led service with access to GP/Consultant input. The aim of the clinic would be to prevent admission to hospital.<br><br>• A service for older people whose focus is on prevention, self-care, elderly screening initiative, joint agency initiatives – reablement, joint admission and discharge teams, rapid response, hospital at home and a joint 24hour service to include out-of-hours health and social care model. | |
| ***National Public Health Service (51)*** | ♦ In Cardiff and the Vale, social services older person's social workers (or care co-ordinators) are co-located in GP surgeries, with the social workers working closely with not only GPs but also practice nurses and particularly district nurses who are practice based. Effectively this arrangement has produced a health and social services *joint older persons team* accessed via the GP's surgery. | Bro Taf LMC |
| ***Care and Repair Cymru (52)*** | Cites clear joint planning structures in Pembrokeshire, Newport and Wrexham.<br><br>♦ The Rapid Response Adaptations Programme (RRAP) is funded by the Welsh Assembly Government, administered by Care & Repair Cymru and provided through Care & Repair Agencies across Wales. The service focuses on hospital discharge and reducing hospital admissions. It has a 'Safety at Home' component which the majority of Care and Repair Agencies in Wales operate but with a wider remit in the nature of the repairs covered. It was introduced in June 2002.<br><br>The Rapid Response Adaptations Programme (RRAP) aims to ensure that older and disabled people who are to be discharged from hospital have a safe home to which to return. It also has a significant role in preventing hospital admissions by addressing | Age Concern |

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| | problems of homes that are no longer safe or appropriate for older and disabled people.<br><br>RRAP services can be accessed through referrals to a local Care & Repair Agency by either health or social care professionals. RRAP has been rolled out across Wales and is delivered through partnerships with health and social care bodies. | |
| ***Swansea NHS Trust (58)*** | ➢ Unified assessment process and documentation;<br>➢ C.R.E.S.T. – a community based rehabilitation team;<br>➢ R.E.A.C.H. – an enhanced home care service;<br>➢ Single patient records used by all agencies for Mental Health patients. | |
| ***Monmouthshire LA/LHB (61)*** | ♦ **Joint Hospital Discharge Teams (flexibilities funded)**<br><br>The first team commenced operation in the South of the County in January 2001, dealing with acute sector discharges (**Royal Gwent** Hospital) as a priority. A team consists of a G grade nurse and a social worker managed and sited within a social services locality team. They complete the same assessment and the nurse can purchase/arrange care at home and directly utilise social services budgets. The throughput is approximately 40 patients per month and includes follow up to review stage, which is approximately two weeks after discharge. To date there remain no delayed transfers of care for the Royal Gwent Hospital from Monmouthshire. From May 2002 another team has covered the North of the County.<br><br>♦ **Rehabilitation approaches**<br><br>**Mardy Park** is an example of utilisation of one wing of a Local Authority residential home as an 8 bedded occupational therapy led rehab facility. This is financed by the Local Health Group and now the Local Health Board and Social Services and is due to be the first formal Section 31 agreement in the County. | CSPW/COT |

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| | ♦ **Monmouth Health and Social Care Facility**<br><br>The replacement of outdated<br><br>• Hospital including inpatient and outpatient services<br>• Day services including for e.m.i.<br>• Social work and district nurse office bases<br>• Therapies<br><br>*These were in scattered locations in the town and are to be replaced with one new build facility operating an integrated multi-disciplinary approach. The project is in its final stage of choosing a partner to build the facility under the P.F.I. initiative.* | |
| ***Audit Commission Wales (65)*** | ♦ In some areas such as Wrexham, the CMHT is a fully integrated unit consisting of Community Psychiatric Nurses, therapists and social workers. Case notes are fully integrated into a single file, there are single policies and a single point of referral. In Ceredigion, CMHTs are co-located and have the benefit of being managed by an officer jointly funded from health and social care budgets. However, case notes remain on a single agency basis.<br><br>♦ Auditors found encouraging examples of jointly funded units which provide both inpatient and day services. The Havenhurst Unit in Pembrokeshire is an example of such a scheme. | |

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| **Welsh Nursing and Midwifery Committee** | ♦ There are developments in England that have relevance for this review; there are a number of combined health and social care trusts delivering mental health services. A particularly interesting example is in Somerset. Here, the Centre for Mental Health Services Development (CMHSD) has been evaluating the joint commissioning and provision of the 'health' and 'social' aspects of mental health since the beginning of the decade. | |
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**Annex 6**

## Review of the Interface between Health and Social Care Services

### Schedule of evidence received

**Written evidence**

Age Concern Cymru
Age Concern Swansea
Association of Directors of Social Services
Association of Welsh CHCs
Audit Commission in Wales
Balenau Gwent LHB
Brecknock & Radnor CHC
Bro Tâf Local Medical Committee
Caerphilly LHB
Cancelled
Cancelled
Cardiff & Vale NHS Trust
Cardiff County Council / Cardiff LHB
Cardiff University School of Social Work
Care & Repair Cymru
Care Council for Wales
Carers Wales
Carmarthenshire NHS Trust
Cartrefi Cymru
Chartered Society of Physiotherapy
College of Occupational Therapists
Community Pharmacy Wales
Community Practitioners' and Health Visitors' Association
Daybreak
Denbighshire Strategic Partnership Board for Health Social Care & Well Being
Disability Rights Commission
Expert Reference Group Domiciliary Care Wales
Gwynedd Council – Care Directorate
Gwynedd LHB
Leonard Cheshire
McCarrison Society
Mencap Cymru –(Part of the evidence given in confidence)
Mind Cymru –(Evidence given in confidence)
Monmouthshire CC / LHB
Morgannwg Local Medical Committee
Mr Orwig Owen
MS Cymru
National Public Health Service
NCH
Newport LHB
North Glamorgan NHS Trust
North Wales Association of Approved Domiciliary Care Providers
North West Wales NHS Trust
Parkinson's Disease Society Wales
Pembrokeshire CC / LHB / Pembrokeshire & Derwen NHS Trust
Quality Resource Management Ltd
RCN Wales

Rhondda Cynon Taf CBC / LHB
RNIB Cymru
Royal Pharmaceutical Society
Stroke Association – Chief Executive
Swansea Council for Voluntary Service
Swansea LHB –(Evidence given in confidence)
Swansea NHS Trust
The Stroke Association – Regional Manager – Community Services, South & Mid Wales
UK Home Care Association
University of Wales College of Medicine – Department of Child Health
University of Wales College of Medicine
Wales Centre for Health
Wales Council for the Blind
Wales Gerontology Practitioners Network
Welsh Ambulance Service NHS Trust
Wales Council for Voluntary Action
Welsh Food Alliance
Welsh Institute for Health and Social Care
Welsh Local Government Association
Welsh Nursing and Midwifery Committee
Welsh Therapies Advisory Committee
Wrexham LHB / Social Services

## Supplementary evidence

**NHS Confederation in Wales**
**Unified Assessment Process (HSS(2)-09-04(p.5))**
**Adults with Learning Disabilities: Assessment, Care Planning and Medication HSS(2)-09-04(p.6)**

### Oral evidence

Age Concern Cymru
Association of Directors of Social Services
Association of Welsh Community Health Councils
Audit Commission in Wales
British Medical Association General Practitioners Committee (Wales)
Caerphilly Local Health Board
Care and Repair Cymru
Care Forum Wales
Derek Wanless
Expert Reference Group Domiciliary Care Wales
NHS Confederation in Wales
Pembrokeshire County Council / Pembrokeshire Local Health Board / Pembrokeshire and Derwen NHS Trust
Royal College of Nursing
SCOVO
Wales Council for Voluntary Action
Welsh Institute of Health and Social Care
Welsh Local Government Association
Welsh Therapies Advisory Committee
Wrexham Social Services / Wrexham Local Health Board

## Committee fact finding visits

The Blaenau Gwent Assist Project
The Dinefwr Cict (Community Intermediate Care Team) Project

The Forge Centre, Port Talbot
The Re-ablement Unit at Cimla Hospital

**Focus Groups**
Staff and Volunteers from Age Concern, Swansea
Service users in Swansea
Service Providers in Ceredigion