APPENDIX 2

Priority:	**Living Well**
Sub-Priority:	**Integrated Community Social and Health Services**
Impact:	**Helping more people to live independently and well at home**

What we said we would do in 2013/14: -

1. Integrate community based health and social care teams within localities

Progress Status	**Progress RAG**	**G**	**Outcome RAG**	**A**

What we did in 2013/14 –

Work has continued to implement action plans based on regional and local priorities. Locality Leadership Teams have completed self assessments as part of a North Wales review of the 14 localities across the region. Each of the locality leads are currently developing action plans to respond to the findings of these assessments. The Flintshire Strategic Locality Group oversees and supports the work of the localities in Flintshire and has been strengthening its role in this regard, bringing key issues that are impacting on localities to senior decision makers across partnership organisations.

Managers are progressing agile working across services ensuring staff maximize their working time whilst reflecting the needs of the individual service.

A regional Statement of Intent and local action plan have been agreed to take forward collaborative work for the National Framework for Older People with Complex Needs.

The local project manager for the Single Point of Access (SPOA) has been appointed and is in post. We are working regionally to take forward the model and are aiming to have SPOA in place in Flintshire in 2016.

What went well –

In December 2013, the first co-located team of Social Workers, Occupational Therapists and Districts Nurses became based within Holywell Community Hospital. The second team will be co-located in 2014/2015 and the final locality team in 2015/2016.

What did not go so well – Finding suitable bases for co-location has been a challenge. We have succeeded in Holywell and now have a way forward to pick up the pace for co-location in the other two localities once bases of a suitable size have been identified.
Achievement will be measured through: • development of one co-located team this financial year - Achieved **Achievement Milestones for strategy and action plans:** (Lead Officer – Head of Adult Social Services) Development of one co-located team this financial year – March 2014 - Achieved Joint processes and procedures in place for co-locating teams – March 2014 – The co-located teams in Holywell are benefitting from a greater shared understanding of each others work and closer working arrangements. Joint processes and procedures will be developed once all locality teams are in place and the SPOA is implemented.

Risk to be managed – Ensuring effective joint working with BCUHB to achieve common goals, in order to ensure that people can safely remain at home and be medically and socially supported.

Gross Score (as if there are no measures in place to control the risk)			Current Actions / Arrangements in place to control the risk	Net Score (as it is now)			Future Actions and / or Arrangement to control the risk	Manager Responsible	Risk Trend	Target Score (when all actions are completed / satisfactory arrangements in place)		
Likelihood	Impact	Gross Score		Likelihood	Impact	Gross Score				Likelihood	Impact	Gross Score
(L)	(I)	(LxI)		(L)	(I)	(LxI)				(L)	(I)	(LxI)
H	H	R	Working together strategically to ensure effective communication and forward planning. Working together operationally to prevent unnecessary hospital admissions. Action plans in place for LLT's	M	M	A	Continue to identify suitable bases for co-location and implement Action Plan for co-located services.	Head of Adult Social Services	⟷	M	M	A

2. Support the introduction of Enhanced care Service (ECS) in the North West Locality by summer 2013 and in North East and South Localities by autumn 2013				
Progress Status	**Progress RAG**	**A**	**Outcome RAG**	**G**

What we did in 2013/14 –
Enhanced Care Service was implemented in the North West Locality in September and will be implemented in the two remaining localities by the first quarter of 2014 / 15

As part of the move to locality bases the Enhanced Care at Home model brings together our Reablement Team and the Crises Intervention Team from Health. Enhanced Care at Home provides short term "step up" intensive community based care as a credible alternative to hospital admission or "step down" support to enable early discharge from hospital. It builds on the existing range of mainstream social care, health and third sector services to support people safely in their own homes. Enhanced Care is a core element of the locality working model which we implemented in our North West locality area in September 2013 with the two other locality areas following by the summer of 2014. We have positive working relationships with colleagues from BCUHB and continue to work to influence locality planning at ground level.

What went well - Enhanced Care Service was implemented in the North West Locality in September and will be implemented in the two remaining localities by the first quarter of 2014 / 15. Very positive feedback has been received from service users and carers and their families.

What did not go so well – This is a new service model, and a high degree of support and focus has been required to ensure that all partners have bought into the Enhanced Care Service model. In some instances it has taken longer than anticipated to get all stakeholders on board. Having cases that clearly demonstrate positive outcomes is now enabling us to evidence the value of the scheme to reluctant partners.

Achievement will be measured through:

- agree and implement the business case for ECS in the North West locality - Completed
- the experiences of patients – evidenced and ongoing.

Achievement Milestones for strategy and action plans: (Lead Officer – Head of Adult Social Services)
Option for co-location explored by June 2013 - Achieved
Preferred recommendation delivered by September 2013 - Achieved

Achievement Milestones for strategy and action plans: (Lead Officer – Director of Community Services)
Agree the business case for ECS in the North West locality – June 2013 - Achieved

Achievement Milestones for strategy and action plans: (Lead Officer – Head of Adult Social Services)
Implement the business case for ECS in the North West locality – September 2013 - Achieved

Achievement Milestones for strategy and action plans: (Lead Officer – Head of Adult Social Services)
Three patient stories to be gathered in first quarter – October 2013 – the feedback from patients was very positive and was reported in the Annual Council Reporting Framework (ACRF) Overview Report 2013/14.

Achievement Milestones for strategy and action plans: (Lead Officer – Head of Adult Social Services)
Agree and implement proposals for new models of sustainable integrated care under the Intermediate Care Fund by July 2014.

Risk to be managed – Ensuring that the new model does not result in unexpected increased costs to the Council.

Gross Score (as if there are no measures in place to control the risk)			Current Actions / Arrangements in place to control the risk	Net Score (as it is now)			Future Actions and / or Arrangement to control the risk	Manager Responsible	Risk Trend	Target Score (when all actions are completed / satisfactory arrangements in place)		
Likelihood	Impact	Gross Score		Likelihood	Impact	Gross Score				Likelihood	Impact	Gross Score
(L)	(I)	(LxI)		(L)	(I)	(LxI)				(L)	(I)	(LxI)
M	M	A	Planning for implementation of Enhanced Care Service (ECS).	M	M	A	Continue to monitor cost of packages of care funded by the Local Authority for those people receiving Home Enhanced Care who would previously have gone into hospital.	Head of Adult Social Services	↓	L	L	G

Risk to be managed – Public support for the changes to the services.

Gross Score (as if there are no measures in place to control the risk)			Current Actions / Arrangements in place to control the risk	Net Score (as it is now)			Future Actions and / or Arrangement to control the risk	Manager Responsible	Risk Trend	Target Score (when all actions are completed / satisfactory arrangements in place)		
Likelihood	Impact	Gross Score		Likelihood	Impact	Gross Score				Likelihood	Impact	Gross Score
(L)	(I)	(LxI)		(L)	(I)	(LxI)				(L)	(I)	(LxI)
M	M	A	Planning for implementation of Home Enhanced Care Service (HECS).	M	M	A	Continue to gather patient stories in partnership with BCUHB to evidence the effectiveness of HECS, and make outcomes public.	Head of Adult Social Services	↓	L	L	G

3. Ensure that effective services to support carers are in place as part of the integrated social and health services				
Progress Status	**Progress RAG**	**G**	**Outcome RAG**	**G**
What we did in 2013/14 – Our Modernisation of Social Services programme reaffirms our commitment to working in partnership with carers and we have continued to protect funding for carers through our multi-agency Carers Commissioning Strategy 2012 - 2015. In response to the Carers Strategies (Wales) Measure 2010 a priority for 2013/2014 was to implement the regional Carers Information Action Plan to keep carers better informed. The Measures intention is to ensure carers are identified, informed of their rights to an assessment and receive the right information and advice when making decisions about the provision of services to the person they care for. Our Council has been part of a North Wales group which has developed the new North Wales Carers Information and Consultation Strategy 2012 – 2015. We are working with our local partners to ensure carers get the information and advice they need. We have commissioned a new local information booklet for carers which will be published in 2014.				
What went well - We have delivered on our priority to implement a model of support that will provide carers with flexible breaks and alternative care. With an investment of £50k, the Bridging the Gap pilot scheme was launched in April 2013 to address the identified need that carers breaks and replacement care should be more flexible and sometimes available at short notice. Coordinated by North East Wales Carers information Service (NEWCIS) this has developed to include 8 providers across all client groups with further providers due to come on board. Between April 2013 and January 2014, 173 requests for breaks were received with 16 of these being for emergency breaks.				
What did not go so well – Over the last 18 months, the capacity of staff to deliver training on Carers Needs Assessments had diminished. We have now successfully delivered a pilot course, led by NEWCIS, which is open to providers, staff from all agencies and the voluntary sector, and the intention is to roll this training out in 2014/15. Parents of children with a disability identified a difficulty accessing carers services; this has been addressed with Bridging the Gap funding, and has resulted in a steady increase in referrals and carers needs assessments for parent carer services.				
Achievement will be measured through: • plans to support carers are agreed and implemented				

Achievement Measure	Lead Officer	2012/13 Baseline Data	2013/14 Target	2016/17 Aspirational Target	Year-End Outturn	Performance RAG	Trend
Percentage of plans to support carers agreed and implemented	Head of Adult Social Services	72%	74%	90%	**85%**	**G**	**Improved**

4. Ensure Health and Social Care and Well Being Strategy priorities are progressed through localities

Progress Status	Progress RAG	A	Outcome RAG	A

What we did in 2013/14 - Each of the Locality Leadership Teams' 2013/14 action plans contained priorities that were consistent with the priorities within the HSCWBS.

Each locality developed action plans and/or task and finish groups to work on the priorities that had been identified with a varied level of progress and success as identified in the following sections.

Each of the 3 Locality Leadership Teams undertook a Partnership Assessment to assess the strength of the partnership groups and to identify ways to improve.

One locality now has a co-located health and social care team in place within Holywell Community Hospital. Plans for co-location within the other 2 localities are ongoing.

What went well (examples)–

- Each of the LLT's did identify priorities within their action plans that would contribute to HSCWBS priorities
- Introduction of co-located teams and the Enhanced Care at Home within the North West Locality
- First drop in session took place for members of the public to come and talk to LLT members about what is important to them as part of the engagement activity for localities.
- Strengthening role of the Strategic Locality Group including in the development of Flintshire's Statement of Intent Action Plan (for older people with complex needs)
- Improved access to Emergency Contraception and Long Lasting and Reversible Contraception
- Introduction of Level 3 Pharmacy Support in a number of locations in the county to improve access to evidence based Smoking Cessation Support
- Improved networking of multiagency LLT team members through involvement in the LLT

What did not go so well –

- Lack of clarity about the role of the LLT in contributing to some of the priorities was evident on occasion (a message to emerge from the Partnership Assessment).
- Delay in the introduction of co-located teams and Enhanced Care at Home within South and North East Flintshire

Achievement will be measured through:

- Locality action plan outcomes

Achievement Milestones for strategy and action plans: (Lead Officer – Director of Community Services)
Inclusion of relevant HSCWB Strategy priorities in the Locality Leadership Teams plans – June 2013
Achievement of relevant outcomes in Locality Leadership Teams plans – March 2014