



ADSS Cymru

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Cymdeithasol yng Nghymru
Leading Social Services in Wales



Seamless services to improve outcomes for people

This briefing provides an insight into the aims of providing seamless services and showcases the different ways health and care are now delivered.

Key Points

- Services should be organised around the individual to provide person-centred care.
- A seamless health and care system results in efficient and effective care that delivers the right outcomes for individuals.
- Organising the collective skills and resources in a community around an individual can provide better outcomes for them.
- Regional Partnership Boards are central to the delivery of seamless services and new models of care.
- Across Wales, new ways of working are already providing a seamless response.



What do we mean by seamless services?

Good population health and wellbeing is a complex issue with many contributors to poor outcomes and many motivators for positive self-care. All public services have a role to play in prevention, health and care – from the NHS and local government to the housing and education sectors, and the third and independent sectors.

Providing seamless services means all the components of health and social care working together to make the best use of the collective skills and resources in the community. It sees locally-based services organised around the needs of the individual, their family and informal support networks.

The Parliamentary Review of Health and Social Care in Wales, published in January 2018, highlighted that care should be *“organised around the individual and their family as close to home as possible, be preventative with easy access and of high quality, in part enabled via digital technology, delivering what users and the wider public say really matters to them, Care and support should be seamless, without artificial barriers between physical and mental health, primary and secondary care, or health and social care”*. In addition, it recommended that the *“public, voluntary and independent sectors all have a role to meet the needs of the population now and in the future.”*

The Welsh Government’s vision is for services moving from hospitals to communities, and from communities to homes, with people being supported to remain active and independent, in their own homes, for as long as possible.

This approach to health and care as outlined in the Welsh Government’s plan *A Healthier Wales*, published in June 2018, focuses on prevention, health improvement and equality based on person-centred planning and delivery of care for the whole person – in other words, seamless services.

It is intended these new community-based models of health and social care will combine seamlessly, including the use of assistive technologies, to provide the same high quality of support in their own home as they would in a residential care setting, or in a hospital.

The Kings Fund has highlighted, hospital is the default option for many patients because in the past we have failed to rethink how primary, community and social care could operate. Wrapping community services, mental health services and social care around groups of practices, creating more systematic approaches to working collaboratively provides continuity or rapid access to care depending on an individual’s needs.

Similarly, a major cultural shift is required to move away from the view of public services as delivery agents to passive populations, to a greater focus on localities in which everyone contributes to maintain and improve services. Digital technology provides a great opportunity for public services to engage more closely with the public and patients, using social media and interactive technology to support self-care and management.

To embed this overall approach, all public sector organisations must now consider ‘healthier Wales’ as required in the Wellbeing of Future Generation Act (Wales) 2015.



Why is it important to health and social care?

If we can provide a seamless response to everyone who uses health and social care services, the result will be efficient and effective care at the right time and in the right place that delivers the right outcome for an individual.

Being connected reduces duplication of effort across a range of functions and professional boundaries that can result in delays and frustrations for people who use health and social care services. The delivery of seamless services can reduce inefficiencies and ensure that we are spending our funding in the most productive way, combining and directing resources appropriately.

The Welsh Government's investment over recent years in the Integrated Care Fund has led to the introduction of a number of preventative and new ways of providing services across Wales. Its success comes from having dedicated resources, supported by focused leadership, joint decision-making and governance, to enable the NHS and social care to concentrate on working to deliver transformational change. The fund has supported collaboration and partnership working across social services, health, housing, the third sector and the independent sector and has been used to build on existing good practice and to roll this out more widely

Regional Partnership Boards

The NHS and local government are equal partners in changing the way services are provided. The Social Services and Well-being (Wales) Act 2014 established seven Regional Partnership Boards (RPBs), bringing together health boards, local authorities, the third sector and other partners to improve the efficiency and effectiveness of service delivery.

In the *A Healthier Wales* plan, RPBs are considered central to driving the transformation of health and social care. They are key to implementing new service models which have the capacity to scale from a local level, to regional and national levels. The positive relationships already being built across regional partnerships are reflected in the progress being made on the development of these models which are building on local innovation including through clusters of primary and community care providers.

As discussed within the *Healthier Wales* Plan, these ways of working will be supported through the Welsh Government's national Transformation Programme and the RPBs. The initial focus of the Transformation Fund will be on models which make early progress on: seamless alignment of health and social care services; local primary and community-based health and social care delivery; and new integrated prevention services and activities.



Workforce

The workforce is key to developing a truly seamless health and social care system. Long term workforce planning needs to reflect the system that we are aiming to create and include the whole health and social care workforce across the public, independent and third sector. It is important to ensure that unpaid carers are also included as part of workforce planning.

There is an increasing need to develop a workforce in both primary and social care with the skill mix required to work effectively within multi-disciplinary teams. This needs to be built into the education and training of health and social care professionals, including the provision of more integrated training opportunities.

Retaining the valuable staff members currently employed, who have been significantly invested in, is a key element of meeting this challenge. It is through the development of a range of approaches to address and improve staff experience that we will ensure that our workforce is supported throughout their careers to deliver high quality services.

In September 2014 the NHS in Wales became a living wage employer, with all staff being paid at least the living wage of £7.65 an hour – more than the minimum wage rate of £6.31 an hour, which increased to £8.45 an hour, in line with the Living Wage Foundation's Living Wage, in 2017. In April 2016 the Westminster Government introduced a new National Living Wage, initially paying £7.20 an hour. To support social care partners the Welsh Government, in January 2017, invested an additional £10m to assist with funding the implementation of the National Living Wage for social care workers.



Good practice

Evidence based good practice focuses on understanding what matters most to an individual. Working in a coordinated way, to build support around achieving the outcomes that are important to them, improves the quality and consistency of services for individuals, carers and their families, as well as for those who work within health and social care.

Across Wales, we recognise the requirement to provide high quality services in community settings and closer to people's homes. Initiatives such as social prescribing are providing timely access to services outside traditional settings. By understanding different professional perspectives, sharing existing expertise and coordinating resources it is possible to improve the delivery of health and social care.

The examples on following pages illustrate how we are changing the ways health and care services are provided and showcase the breadth of initiatives.

Seamless services in action across Wales

Multi-agency community and primary multi-disciplinary team - Hywel Dda UHB

Across Wales, it is accepted that services for older people need to change to match the predicted future demand. The expected population increase in people over 70 will result in significant and increasing pressure on acute services as the risk of being admitted to hospital increases with age. This problem is exacerbated by the rural nature of Pembrokeshire with frail older people often living in isolated communities with minimal support.

A pilot project initiated by Hywel Dda UHB tested and evidenced the potential benefits of delivering frequent community Multi-Disciplinary Team (MDT) meetings in three GP practices across the county to improve coordination of the care older people receive in their communities. Since June 2017, the pilot has held 27 MDT meetings across the three practices, seeing 117 patients with complex needs who on average were discussed at between two and three meetings.

To evidence this approach to integrated care, attendance data was collected to identify the representation of different services. This data showed significant buy-in across the sectors involved and clearly demonstrated the true MDT nature of the meetings.

All professionals involved in the MDT pilot were invited to submit responses through an online questionnaire. The responses highlighted that increased communication between professionals shortened lines of referrals, improved awareness of individual roles and contributing to saving staff time as better co-ordination of services resulted in less professionals overall having to visit patients. This way of working is now being explored by other GP practices in the county.

Example

Mrs A, a frail 93 year old housebound woman with co-morbidities and poor mobility lived alone with no family living near, was thought to be a risk of falls by a Community Nurse. A risk assessment was carried out as she was sleeping on a single bed, in a cramped small bedroom upstairs and when mobile she would walk on her toes. Other assessments from the social worker, OT, physiotherapist, third sector agency, Paul Sartori Services and a polypharmacy review were undertaken. Working as a team collectively to support Mrs A, a care package is now in place that meets her needs, her medication is managed, a profile bed situated in a more suitable location has been provided and has completed her rehabilitation. In addition, there have been fewer calls to the GP surgery for home visits.

'Stay Well @Home' - Cwm Taf Social Services and Well-Being Board

Cwm Taf is home to approximately 53,000 people over the age of 65 and 23,000 people over the age of 75. Challenges managing patient flow at A&E departments and people waiting significant times to access available beds can sometimes unfortunately occur due to limited alternative options for community support at home. This places increased pressure on the availability of beds at the two acute hospitals in Cwm Taf, which can lead to increased transfer rates to community hospitals and delays in patients being discharged from hospital.

Due to an extended period of winter pressures in 2015-16, the Cwm Taf Social Services and Well-Being Board committed to working collaboratively across partners to do something different.

Stay Well @Home, a multi-agency project group, was established and a model was developed to provide an integrated assessment and response service. A priority of the project was to support care professionals to think about the outcomes that mattered most to patients and changing the culture to a default position of supporting discharge home or into the community. Social Workers, Occupational Therapists, Physiotherapists and Therapy Technicians were recruited and trained as 'trusted assessors', with a single line management structure.

The Stay Well @Home team, as it is now known, are based in both acute hospital sites and promote a 'fit to assess model'. The aim is for patients to be referred to the service where appropriate, on arrival at A&E, from the medical assessment units or indeed the wards, once they are deemed medically fit for discharge. An assessment is undertaken and the trusted assessor speaks with the patient to agree the outcomes that matter most to them. As a result, patients feel that they are active and involved partners in the services they receive. Having agreed a set of outcomes, the trusted assessor is able to commission a range of tailored responses within four hours, to be delivered in the community. These services range from nursing care, medicines management and social care service support, all provided at the person's home. Early evaluation is demonstrating a number of measurable improvements for elderly patients including avoided admissions and reduced lengths of stay in hospital once they are medically fit for discharge.

The following extract is a response from a citizen involved with the Stay Well @Home service:

"Thank you for taking the time to listen. I now feel that my mother will get the support she needs and my father will start accepting more support at home. The experience has turned from a negative, from coming into hospital after my mother fell, to having a positive impact on my mother and father's care and support".

Integrated Health and Social Care teams - Powys Teaching Health Board and Powys County Council

Powys Teaching Health Board and Powys County Council began the journey in partnership to create an integrated health & social care team in the Ystradgynlais in South Powys 2016. With external support to assist in developing the team, they quickly adopted the 'What Matters to Me' approach throughout the person's pathway, from initial referral, discussing the best person to undertake the first visit, agreeing the preferred 'intervention', discussing further as a multidisciplinary team, and in reviewing the desired person-centred outcomes.

The team of district nurses, a social worker, an occupational therapist, a physiotherapist, a reablement team and Community Connector are all based within the community hospital. GPs support the hospital daily and are fully connected with the Integrated Team. An integrated team leader is in place, and a daily duty officer supports the referral process and co-ordinates responses. The Integrated Clinical Team Manager (ICTIM) oversees all processes and delivery agrees to packages of care on behalf of Powys County Council.

Daily case discussions with all members of the multi-disciplinary team present for those who are being supported in the Community, plus daily attendance at the 'Board Round' meeting to review and plan discharge from the community hospital ensures more timely flow. Delayed transfers of care have been brought down and kept down.

Whilst there is a vibrant third sector in Powys, residents are not always aware of the range of support in their community. This means there are missed opportunities to maintain local independence and a risk of avoidable admissions or referrals to higher intensity health and care services which may be located outside the county.

Community Connectors, as part of the Integrated Team, play an active role in providing patients and staff the right information at the right time about community and third sector services available.

While there is still work to do to further integrate roles, budgets and processes, the health and social care team has provided improved access to, and improved quality of, care in the community.

Example

Mrs X is an elderly lady who lives alone and felt isolated in her cluttered flat. She was referred to the team by the Support Officer (SO), who then liaised with a district nurse, social worker and GP simultaneously. Previously, this would have required several phone calls and emails.

Having the Health and Social Care team in place meant that the SO was able to raise the issue with the integrated team immediately. Through an initial 'What Matters to Me' chat via telephone, an occupational therapist was able to understand Mrs X's living situation, and following a visit to her home, arranged for a GP and a community connector to visit her at her home over the next couple of days. With support and approval from Mrs X, the flat was gradually decluttered during several more visits. Mrs X was also encouraged to learn self-care skills and join community activities. Mrs X is now leading a more fulfilled life within the community and does not require ongoing support from statutory services.

The Nuka System of Care - Alaska, USA

For the Native population in and around Anchorage, Alaska, health care delivery was organised with the hospital at the centre until the mid-90s. At that time, patients received their health care as beneficiaries of the Indian Health Service's Native hospital, controlled from Washington, DC. This was not culturally oriented for them, facilities were rundown, and patients entered the health care system through the ED. Patients didn't have access to, or were even aware of, primary care services and waited weeks to get an appointment. The quality of health care services and associated outcomes were among the worst in the US.

In the mid-1990s, legislation allowed tribes to take ownership over local care delivery services. With this, the Alaska-Native led Southcentral Foundation, a non-profit health care organisation serving Alaska Natives and American Indians living in Anchorage, took over.

Patients were asked what they liked, disliked, and what they needed from their health care system. From these discussions the Southcentral team built their healthcare economy on the foundation of an effective partnership between providers and patients, grounded in three beliefs:

- The whole system needs to transform in order to improve citizens' wellbeing;
- The relationship between primary care and patients is key; and
- Health care is just another consumer industry. Alaska Natives are referred to as "customer owners" rather than patients, acknowledging the fact that they own their health.

Southcentral Foundation transformed the ineffective care model by defining a clear partnership ambition and transforming the primary care model. They focused on accessible and multi-disciplinary primary care delivery, as well as integrated budgets and IT systems. Each patient is supported by a core Integrated Care Team that consists of a GP, a Registered Nurse case manager, a case management administrative support staff, and a medical assistant. In addition to the core care team is an extended team, which consists of a behavioural health consultant, registered dietitian, pharmacist, nurse, midwife, non-clinical practice manager, co-located psychiatrists, and coders/data entry staff. There is one 'extended' team per six GPs.

Unique to the Nuka system is that every patient has a case manager, regardless whether they are high, rising, or low-risk, and each case manager has a different strategy for different types of patient to make the process scalable. This strong relationship between the primary care team and the service user has ensured individuals are using the system more intentionally. Case management is most important for high and rising-risk patients, so GPs and their team review consumer utilisation patterns regularly and then connect with patients who utilise too many services. They ask these customer owners how the system is failing them and how the system can support them more effectively.

Today, the Nuka system is now recognised as one of the world's leading models of health system transformation. It has achieved a 36% reduction in hospital admissions, 28% reduction in GP visits, and scored in the top quartile for performance outcome measures across the whole of the US. The Southcentral Foundation leadership team attributes this success in great part to their patient-centric approach.

Medicines management domiciliary visits and support - Abertawe Bro Morgannwg UHB

This initiative supports patients with known problems managing their medicines who don't have a package of domiciliary care. The aim is to enable patients to manage their medicines at home wherever possible, linking with health and social care professionals where appropriate. Typical patients might include the frail elderly with early dementia. The scheme builds on the existing experience of the domiciliary medicines management team who provide support for patients with a package of care. Referrals are accepted from a variety of sources including the acute care team, community and hospital pharmacies, GPs, practice/district nurses, social work and gateway teams.

Patients are offered support such as counselling on medicines knowledge and use; changes to timings and types of medicines including discontinuation; ways to link medicines to daily living cues; and getting friends and family involved in their medicine management. There has been 100% positive feedback from patients so far, saying that they found the service useful. Seventy three percent of vulnerable people who took part in the scheme said that they felt able to manage their medicines by themselves following the initial visit and intervention. The Health Board believes there has been a 70% reduction in the likelihood of an unplanned care admission for those who took part in the scheme.

Example

Mr B was referred by the acute clinical team, as he was not taking his medicines and his long-term conditions and function were worsening. Mr B was not eating well and would often stay in bed for most of the day. He struggled with washing and dressing but was not keen on having any help.

The Health Board team simplified his medicines and linked the times he took them with daily cues and routines. But Mr B's main challenge was low motivation and mood following the loss of his wife two years ago. What mattered to him was addressing this issue, not managing his medicines. The idea of attending a day centre did not appeal to him and he declined invitations to join befriending groups. Mr B had been a keen artist in the past, so the team liaised with a third sector co-ordinator and identified a local arts group. Mr B enjoyed the class, immediately found greater meaning to his life, felt less lonely and managed his medicines much more effectively.

Community Resource Teams - Betsi Cadwaladr UHB

In line with BCU Health Board's strategy, *Living Healthier Staying Well*, the Central Area (Conwy and Denbighshire) is developing the Community Resource Team (CRT) project.

Nine CRTs have been agreed across the area - each team is made up of a range of professionals including GPs, Social Workers, District Nurses, Therapists, Health Visitors, School Nurses and other children's service professionals who work together to support the health and wellbeing needs of their populations. To support the development of CRTs, Local Development Groups have been established with a range of service representatives to improve cross-organisation and cross-service working. The Local Development Groups are used as the vehicle to identify better ways of working, as well as to address challenges, issues or concerns that prevent successful collaboration.

The vision for the CRT project is to enable and support more collaborative, flexible and responsive working across multi-agency services. The services provided will be more easily accessible, support independence, create a strong, multidisciplinary approach with a focus on the care of patients with complex needs and enable better outcomes for people within a community.

Example

Health and Social Care Occupational Therapists (OTs) have been working more closely together thanks to roll-out of the Rhyl CRT. They identified that the therapists could support one another to reduce waiting lists and with triage and allocation of cases, depending on their capacity.

The improved lines of communication between OTs across the area has already resulted in five cases where OTs delivered treatment at a patient's home. This has meant that they no longer need to be on a waiting list for treatment at a local hospital or community, which frees up capacity for hospital staff and reduces waiting time for other patients.

Befriending - Aneurin Bevan UHB

A befriending initiative has been bringing generations together. A recently developed partnership involving Year 6 pupils from Griffithstown Primary School visiting units for older people has proved very successful with many positive outcomes. The Health Board provided Dementia Friend Awareness sessions to all the teachers of the school and Year 6 pupils. Activities during visits have ranged from learning how to play dominoes, arts, crafts, 'getting to know you' talking, singing, dancing, and decorating zimmer frames with the patients.

Research shows that intergenerational activities can reduce negative stereotypes, reduce loneliness and isolation, and improve people's wellbeing and sense of self-worth. A multidisciplinary team is being planned to sustain and improve this initiative. Staff have spoken to the children about their jobs, to enhance the children's understanding of roles within health and care, with some stating that they now want to become a nurse or doctor.

This initiative is in line with Welsh Health Policy and has been promoted by the Older People's Commissioner for Wales and The Children's Commissioner for Wales.

Symphony Programme - Somerset, England

A few years ago, a CCG in Somerset commissioned an extensive analysis to determine what groups of patients were costing the health and social care system the most money and would most benefit from better co-ordinated and integrated care. What they found surprised them. While they expected to see costs primarily associated with age—with older people experiencing higher costs—what they found was that higher costs were explained more by the number of chronic co-morbidities than by age. The leadership team at Yeovil Hospital realised the most impactful way to improve the primary-acute integration would be to focus on multi-morbid patients. With Vanguard funding, they launched their initial integrated care pilot to provide multi-disciplinary primary care for 1,500 high risk, multi-morbid residents.

The Symphony Project has expanded over the last few years to include a variety of initiatives and populations. A key part of their work is integrated care hubs that provide advanced multi-disciplinary primary care services and care transition support to complex multimorbid patients. The hubs, led by an extensivist (a clinician that splits their time between the hospital and the community caring for high-risk patients), were initially based at the local hospital, and they provide care co-ordination, senior medical input, and a single personalised care plan co-developed with patients. The multi-disciplinary nature of the team enables each clinician to work at top-of-license. It also includes a care co-ordinator, mental health and social care workers, and ancillary specialists. In between visits, patient conditions are remotely monitored through a web platform where the hub team and patients can connect and view their care plan.

At the start of the project, Symphony did not truly engage or hear from GPs. GPs would refer their patients to the hub, which would then completely take over care of the patient instead of working in partnership with the GP. Since GPs wanted to continue to manage their patients, they simply stopped referring patients to the hub.

Recently, Symphony has adjusted the model so that hub teams integrate into primary care. Each hub sits out with three or four practices. GPs remain in charge of their patients, and the hubs act as support and wraparound services. This model focuses on prevention and education, as well as providing the specialist care that patients with complex long-term health conditions need. The advanced primary care provided in the complex care hubs has produced great results - from 2014 to 2015, ED admissions reduced by 33%, hospital attendances by 29%, and acute length of stay by 46%.

Nutrition Skills for Life (all-Wales initiative / Cardiff and Vale 'Flying Start' programme)

Nutrition Skills for Life is an all-Wales programme developed and co-ordinated by NHS Wales dietitians. It provides training to enable frontline workers, volunteers and peer leaders from health, social care and third sector organisations to promote healthy eating and prevent malnutrition by incorporating evidence-based food and nutrition messages into their work.

There are two key aspects to the programme:

- **Accredited nutrition skills training for community workers** such as nursery nurses, teaching assistants, youth and leisure centre workers, foster carers, substance misuse practitioners, housing association staff, those working with the homeless and carers of vulnerable older people. The training helps them to competently cascade nutrition messages and support the development of community food initiatives. It supports those working in the community to provide healthy and nourishing food and drink options in nurseries, play groups, after school clubs, residential homes and care settings for older adults.
- **Co-production of healthy eating initiatives with community groups.** The programme aims to reach community groups who may not have the knowledge, skills and confidence to prepare and eat a healthy balanced diet. It supports community workers, who complete accredited nutrition skills training, to plan, implement and evaluate healthy eating initiatives at a community level. This can include offering accredited practical cooking skills, nutrition skills or weight management courses depending upon identified need. Courses are accredited by the Welsh awarding organisation Agored Cymru, enabling people to gain credit for learning, a route into further learning and employment opportunities.

Example

The Dietetics Service within Cardiff Flying Start (FS) makes an important contribution to the health and wellbeing of families living in the most deprived areas of the city. The programme uses the all-Wales Nutrition Skills for Life training model. Trained workers deliver nutrition programmes with professional support and governance from the dietetic team. These programmes include accredited practical cookery course for parents and carers; weaning parties for new parents to support with complementary feeding and delivering practical food sessions with pre-school children and their families.

Inside Out Cymru - Aneurin Bevan UHB

Inside Out Cymru is part of the Gwent Mental Health Consortium and funded directly by Aneurin Bevan University Health Board (ABUHB). Working in collaboration with partners Mind, Hafal, Growing Space and CMIG, Inside Out Cymru recruits and supports artists to deliver projects and arts activities promoting good mental health and wellbeing in the community across Gwent.

Inside Out Cymru provides a programme of integrated community arts workshops for adult mental health service users and for the general promotion of mental health and wellbeing across the Greater Gwent area. Workshops are open to the general public, but participants with mental health issues are particularly welcomed.

Inner City Health - Ottawa, Canada

Health providers in Ottawa were failing to address the underlying substance abuse and behavioural health issues that commonly confound the clinical care of homeless patients. Ambulances and police dispatchers routinely brought homeless patients to EDs, and once admitted, they used a disproportionate share of resources. In response, Ottawa Inner City Health was established with the main goal of creating a system that would comprehensively serve the clinical and social needs of Ottawa's homeless population. Since its initial pilot in 2001, Ottawa Inner City Health has evolved to oversee several different programmes for the homeless population, including special care for women, hospice, and primary care. The programmes also address patients' social needs, with services provided for alcohol addiction and short-stay housing.

One of the programmes is dedicated to diverting homeless patients from the emergency department by providing scaled-up support at homeless shelters for patients that would otherwise have been brought to the ED. Between January 2013 and January 2014, the targeted diversion programme for homeless patients avoided 618 ED presentations, a net cost savings of \$170,000 CAD. Moving services further upstream for homeless patients has led to significant cost savings for the system, demonstrating high potential for systems that proactively connect health and social services, especially for their traditionally underserved populations.

Connected Generation - Age Cymru Powys

This project is made up of an alliance of Credu, Age Cymru Powys, Disability Powys, Powys Citizens Advice, and Royal Voluntary Service (RVS). It is designed to enable the most vulnerable older people to achieve self-determined, sustainable livelihoods using an innovative hybrid of methods that have a strong co-productive ethos. The project supports older people through building on individual strengths, social networks and enriching the relationship between citizen and service providers. It models a positive approach to enabling a growing aging population to thrive and sustain optimum wellbeing.

Individualised support helps to ensure that basic needs are met and builds on personal strengths using Sustainable Livelihoods Approaches as well as rights-based approaches.

From a community perspective, the project helps build individuals' social networks, community links and peer support using Asset Based Community Development. Local Government and the Local Health Board work with individuals and public sector leaders using methodologies that enable citizens to influence and successfully pilot community action planning methods.

Pharmacist involvement in primary care - Northumberland Accountable Care Organisation, England

The Northumberland Accountable Care Organisation (ACO) in England has spent the past two years evaluating strategies to reduce unnecessary hospitalisation. One of their most successful initiatives has been placing hospital-employed senior clinical pharmacists directly in primary care. Northumberland's goal was twofold: increase primary care practice capacity by adding an FTE to local teams; and decrease medication-related hospital admissions. The pharmacist ensures GP clinics avoid costly indemnity insurance and small practices are still able to have support. Meanwhile, the pharmacist can offer same-day medication management in the clinic or in the form of at-home visits. This helps guard against care delays and unnecessary escalation. Pharmacist input has helped improve patient understanding of medication, involve care home residents in decisions about medication and, ultimately, reconcile unnecessary medication use and cost.

The results have been strong. The pharmacist serves as a complimentary peer to the nurses and GP, provides additional expertise to the team and coaches patients in the community in medications management. They also free up GP and nurse time to work more top-of-license.

North Wales Learning Disability Strategy - Betsi Cadwaladr UHB and six local authorities

The North Wales Learning Disability Strategy is a joint project between the six local authorities in North Wales and Betsi Cadwaladr University Health Board. The aim is to deliver seamless services across North Wales to people with learning disabilities. Their vision is to achieve a better quality of life for people living with learning disabilities and create an environment where they feel valued, safe, independent and included in their communities.

To develop the strategy, the group built on the work of the population assessment tools and gathered additional baseline data about the needs of local populations. The group have worked closely with regional participation groups and self-advocacy groups to find out what matters to people with learning disabilities and have used these themes as the basis of the resulting strategy. Their research revealed that what mattered most to people with learning disabilities was a safe place to live; having something to do; having friends, family and relationships; staying healthy and active; and having access to the right support.

Running throughout the strategy are the needs of people with profound and multiple learning disabilities. Support is focused through changes in life from early years to ageing well and includes the needs of older carers and the transition from children's to adult services.

The strategy group have conducted a series of events, interviews and surveys with service users, parents, carers, local authority staff, Health Board staff and independent providers of services to find out what needs to happen next to achieve the outcomes that matter most to people living with learning disabilities in North Wales. The group are well placed to achieve these outcomes with established regional structures and examples of excellent practice throughout the region. The group will continue to share these examples across North Wales and are currently developing workshop sessions that will focus on workforce development, commissioning and procurement, community and culture change and assistive technology, among others.

Pembrokeshire Prevention Programme Board (PPPB) - Hywel Dda UHB

In early 2015, the PPPB was established to provide high quality, accessible information and assistance to vulnerable people across Pembrokeshire. The primary objective of the Board is to support projects that promote independence, individual choice and patient control. The Board is led by the Heads of Adult Services and Strategic Joint Commissioning within Pembrokeshire County Council, and includes representatives from Hywel Dda UHB, Public Health Wales, the Pembrokeshire Association of Voluntary Services (PAVS), Swansea University and the Pembrokeshire Local Action Network for Enterprise and Development (PLANED). Central to this approach has been the development of the Active and Connected Communities programme, which is made up of three integrated elements of work:

- **Community Connectors** – working in four geographic locations across Pembrokeshire to improve individual and community wellbeing, connecting people to local activities, groups, events and volunteering opportunities, and building social capital by bringing people together to create informal networks.
- **Active citizenship** – encouraging more people to volunteer in roles that support prevention and early intervention and to take an active role in their local communities.
- **Community resilience** – providing outreach services to support grassroots community and voluntary action, with a focus on developing community halls as service hubs.

The Wales School of Social Care Research at Swansea University is currently supporting the Board to drive system change by gathering and analysing stories of people's lived experiences.

Example

The following is an extract from a 'Most Significant Change' story, gathered from one of the people supported by Community Connectors as part of the evaluation of a two-year pilot. The question was 'What was the most significant change for you? This was the answer:

"Working with Matt and his people [Community Connector Project] was key. It helped me to link with so many other people. Living so rurally, it's difficult to know what is out there but having this bridge to help me connect with people has been invaluable".

Pharmacist Facilitators - Hawke's Bay District Health Board, New Zealand

Many progressive institutions and population health managers recognise primary care should not always be synonymous with GPs. In New Zealand, Hawke's Bay District Health Board (DHB) estimated a \$1.15 million NZD overspend on their community pharmaceuticals budget for 2010-11. They found their projected costs for medications were due to a high incidence of polypharmacy, particularly among the elderly population.

In response, the DHB agreed to fund a trial programme to combat polypharmacy at three proof-of-concept general practice sites. To help reconcile multiple medications, the DHB appointed two clinical pharmacist facilitators (CPs) to give primary care doctors holistic, best-practice advice on medication management. Integral members of the primary care team, CPs were based in these three general practices to facilitate face-to-face coordination with primary care. In one year, the pilot sites saved half a million dollars due to reduced polypharmacy and care avoidance by almost 20%.

Conclusion

From the moment an individual has need of care, we want their experience to be seamless. To achieve this aim we need to have a different health and care system and work collaboratively across all parts of the public, independent and third sectors with a commitment to person-centred care.

As outlined in the examples in this briefing, changes can be achieved with local services focusing on better outcomes for individuals and their local communities. Pro-actively seek out opportunities to share our aspirations for seamless services, build our knowledge and networks in other sectors and harness our collective expertise has the potential to deliver the best possible services to those who need them.



ADSS Cymru

Yn arwain Gwasanaethau
Cymdeithasol yng Nghymru
Leading Social Services in Wales

ADSS Cymru is the Association of Directors of Social Services in Wales. Its role is to represent Directors of Social Services, Heads of Adult Services, Childrens' Services and Business Services, together with professionals, their families and communities.

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The Welsh NHS Confederation is a membership body representing all the organisations making up the NHS in Wales: the seven Local Health Boards and three NHS Trusts.



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