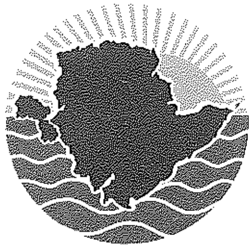

CYNGOR SIR YNYS MÔN ISLE OF ANGLESEY COUNTY COUNCIL

Anwen G Davies MA, FCMI
Pennaeth Gwasanaethau Oedolion -
Head of Adult Services

CYNGOR SIR YNYS MÔN
ISLE OF ANGLESEY COUNTY COUNCIL
Swyddfa'r Sir – Council Offices
LLANGEFNI
Ynys Môn - Anglesey
LL77 7TW

ffôn / tel: (01248)752700
ffacs / fax: (01248) 750107
ffôn testun yn unig / text phone only:
(01248) 750602

Gofynnwch am - Please ask for:

ffôn / tel (01248)

E-Bost - E-mail:
Ein Cyf - Our Ref.
Eich Cyf - Your Ref.

Ms Ruth Marks
Older Peoples Commissioner for Wales
Cambrian Buildings
Mount Stuart Square
Cardiff
CF10 5FL

13/06/2011

Dear Ms Marks,

Re: Dignified Care,? - The experiences of Older People in Hospital in Wales

I have pleasure in enclosing the Isle of Anglesey's response to Recommendations 5 of the 'Older Peoples Commissioner Report – Dignified Care ? - the experiences of Older People in Hospitals in Wales, compiled in consultation with Health colleagues.

Your recommendations will form a basis for improved partnership arrangements for planning and commissioning Dementia Care and improve the experience of older people during a period of hospitalization, in order to facilitate more streamlined discharge planning.

Yours sincerely

Anwen Davies

Anwen G Davies pp.
Head of Adult Services

Recommendations 5.

Health Boards, the Trust and Local Authorities should jointly develop more focused and effective commissioning of services and care for older people, including those with dementia, in order to reduce further the level of delayed discharges ; and support this work through more robust embedding of Social Services staff in this process through ward level multi-disciplinary teams.

Recommendations 5.

Recent Health and Social Care strategies are moving towards models of support and services that enable citizens to live in their own home and communities for as long as possible. To enable this to happen there needs to be further investment in some services provided and disinvestment in others scoped in a Modernisation and remodelling agenda. The vast majority of people who develop Dementia and their carers have a desire to remain in the local community of choice; and Health and Social care services should respect such decisions. The primary aim of services is to support the quality of life of the individual with dementia and their carers, with their needs central to all planning of dementia service related activity in Anglesey. Ynys Môn Locality Development Group have prioritised key initiatives in support of these agendas, capitalising on Welsh Assembly Continuing Health Care funding to drive service improvements across the island.

Dementia Care

The Ynys Môn Dementia Planning Group draws its membership across Health, Social Care, Third sector, and service user representation, and jointly commission's services to meet the needs of service users and informal carers.

- A jointly agreed Dementia Action Plan 2011-2014 is currently out for consultation to all stakeholders, and has prioritised key themes for service improvements:-
- Access to service
- Improve housing supply and design including housing related support
- Use of telecare / Telehealth and Assistive Technology
- Improved access to information
- Reference to diagnosis protocols
- Medicines management
- End of life care pathways
- Improved training and workforce development across care sectors
- Advocacy services

- Anglesey has secured recent expanding capacity of residential dementia care beds in the independent sector, with work ongoing to further stimulate the market with a view to providing more localised nursing care beds. Local authority provision has designated one care home (Plas Crigyll) as a Centre of Excellence for Dementia Care, and has specialist beds in all 5 residential care homes for Older People. The Dementia action plan has identified that there continues to be insufficient capacity to meet the needs of younger adults presenting with Dementia and has prioritized this agenda for 2011-2014.

- Delayed Transfer of Care data currently reflects increased capacity in the residential care sector with an aligned decrease in waiting times for placements.

- An innovative initiative in Plas Crigyll (Centre of Excellence) has developed a 24hour outreach support for Carers, enhancing out of hours support and positively reflecting on minimizing the need for crisis intervention and hospitalisation or long term care. Evaluation will dictate the need to extend the service island wide.

- Continuing Health Care joint funding will be utilized to develop specialist dementia support workers, aimed at promoting/maintaining independence and supporting Carers to extend their caring role. Initial progress will focus on linkages and support offered from a designated Dementia care home (Plas Crigyll)

- An integrated Single Point of Access for Health and Social care referrals is currently in its pilot phase aiming to facilitate access to services across Health and Social Care and strengthening our Intermediate Care pathway. Additionally a Re-ablement service includes a designated 3 bed unit in a residential care home aimed at facilitating swifter discharge and avoidance of admissions for all service users supporting a crisis intervention agenda. It is anticipated that all admissions to long-term care will be assessed utilising these step up/ step down provision.

- A locally based assessment hospital (Cefni Hospital) provides the focal point for ongoing assessments of dementia patients presenting with complex care needs operating a pro-active approach to multi-disciplinary care planning within the 'Model Môn' assessment and Care management framework.

- Supporting People funding has secured the commissioning of an early intervention housing related service to individuals with memory related problems, offering a 2hr weekly service in order to prompt and maintain financial independence, promoting domestic routines and encouraging social inclusion. Initial evaluation of this project is suggestive of the need to expand this service to support additional service users. We will explore joint Health and Social care funding to re-commission this preventative provision.

Effective and Timely Discharges

- A Model Mon multi disciplinary patch based model of assessment and care management is well embedded in practice providing a sound framework for coordination of care and support .

- Hospital social workers are actively involved in discharge planning at both the Acute (Ysbyty Gwynedd) and community Hospital (Ysbyty Penrhos Stanley – Holyhead) participating within a multi-disciplinary multi/ agency framework seeking to provide seamless discharges into the community. Staff are aware and utilise Voluntary organizations in care planning for onward discharge.

- A collaborative initiative has seen the development of a Single point of Access for Adult social work referrals in Ysbyty Gwynedd, working across Ynys Môn, Gwynedd and Conwy, Local Authorities, facilitating simplified referral and assessment processes and targeting staff resources in accordance with complexity of need. A Health and Social Care operational managers' working group , regularly monitors progress and agrees further developmental plans. Positive initial feedback provides the momentum for enhanced partnerships in order to address the barriers aligned to more complex discharges, with particular reference to decision making around CHC eligibility and complex care provision. Social work team re-modelling has secured continuity of intervention and social work follow- through from community to hospital.

- Ynys Mon, Conway ,Gwynedd and Betsi Cadwaladr Universioty Health Board have collaboratively (Section 33 Agreement) developed an Integrated Community Equipment Store in order to benefit from economies of scale, and allow for joint access and delivery to support the promotion of independence in community based environment and accommodate timely hospital discharges. Increased demand for more complex high cost equipment poses a particular challenge in an environment of financial austerity.

- Intermediate care services provides access to step down services, either in a residential care setting (3 bed unit) or the deployment of Reablement support workers to expedite more appropriate and effective hospital discharges. Intermediate care resources are currently being integrated in partnerships with Health and the Third sector, recognising the need to develop and deploy Health and Social Care support workers. Additionally joint funding for Telecare and Telehealth projects complements our Intermediate Care strategies.

- It is positive to note good working relationships between the hospital based social work team and Discharge Coordinators, however there is a need to consider the benefits of co-location to further strengthen interventions and avoidance of duplication of roles / responsibilities. This agenda will be given priority by the Operational working group during 2011.

- A joint 'Predicted date of Discharge ' meeting is held weekly in the Acute Hospital coordinating interventions and enhancing onward care planning which is attended by representatives across Health and Social Care. I.T connectivity and improved data sharing would have a positive impact on the discharge planning process, - a challenge that requires shared drive and funding to realize positive outcomes.

We fully recognise the challenges effective and streamlined hospital discharges presents and embrace opportunities to work more collaboratively to achieve jointly agreed objectives, in acknowledgement of the contribution of the Third sector, and in full engagement with service users and informal Carers.

Iola .L. Richards - Operations Manager, - Ynys Môn County Council.

June 2011