CITY & COUNTY OF SWANSEA

CABINET – 8 APRIL 2014

APPENDICES INDEX

AGENDA

Agenda Item 9.a

Dated 2014

CARMARTHENSHIRE COUNTY COUNCIL
CEREDIGION COUNTY COUNCIL
CITY & COUNTY OF SWANSEA COUNCIL
NEATH PORT TALBOT COUNTY BOROUGH COUNCIL
PEMBROKESHIRE COUNTY COUNCIL
POWYS COUNTY COUNCIL

AGREEMENT

-to-

constitute a Joint Committee to deliver educational improvements in schools in central and south-west Wales

Miss Claire N. Jones
Assistant Chief Executive – Legal
Ceredigion County Council
Penmorfa
Aberaeron
Ceredigion SA46 0PA

THIS DEED is made the day of 2014

BETWEEN:

(1) **CARMARTHENSHIRE COUNTY COUNCIL** of County Hall, Castle Hill, Carmarthen SA31 1JP (''Carmarthenshire'')

(2) **CEREDIGION COUNTY COUNCIL** of Neuadd Cyngor Ceredigion, Penmorfa, Aberaeron, Ceredigion, SA46 0PA (''Ceredigion'')

(3) **CITY AND COUNTY OF SWANSEA COUNCIL** of Civic Centre, Oystermouth Road, Swansea SA1 3SN (''Swansea'')

(4) **NEATH PORT TALBOT COUNTY BOROUGH COUNCIL** of Civic Centre, Port Talbot SA13 1PJ (''Neath Port Talbot'')

(5) **PEMBROKESHIRE COUNTY COUNCIL** of County Hall, Haverfordwest, Pembrokeshire SA61 1TP (''Pembrokeshire'')

(6) **POWYS COUNTY COUNCIL** of County Hall, Llandrindod Wells, Powys LD1 5LG ("Powys")

(together called "the Authorities" or, if any one of them, ''the Authority'')

BACKGROUND

(1) The Authorities are the statutory education authorities for their respective administrative areas located in south-west and central Wales, or such other combined area from time to time for which the Authorities, or their successors, have responsibility

(2) The Authorities have lately operated as a consortium in the Region under an Agreement dated the 6th March 2013 with a view to improving the standard of education of children and young persons

(3) In pursuance of sections 101, 102 and 113 of the Local Government Act 1972, section 25 of the Local Government (Wales) Act 1994, sections 13 and 13A of the Education Act 1996, sections 2, 19 and 20 of the Local Government Act 2000, section 9 of the Local Government Wales Measure 2009 and/or all other powers enabling them, the Authorities have agreed to establish under this Agreement a joint committee with a view to constituting a regional consortium with the following core aims and objectives:

a) improving learning outcomes for all children and young people

b) ensuring delivery of high quality teaching and learning

c) supporting and empowering school leaders, staff and governors through training, mentoring and opportunities for secondment to better undertake their responsibilities

d) testing and reviewing the impact of support on teaching and learning, pupil progress and attainment and the development of school staff and governors

e) doing anything else within the law that promotes or contributes to the aims and objectives

IT IS AGREED as follows:

1 INTERPRETATION

1.1 In this Agreement, unless the context otherwise requires:

"Agreement" means this Deed comprising the terms and conditions and the Schedules to it

"Annual Cost'' means the cost to the Lead Authority of discharging its obligations on behalf of the Authorities under this Agreement repayable by way of each Authority's Contribution

"Authorities'' is defined above

"Budget'' means an itemised summary of intended income, revenue and capital expenditure for the Financial Year as described in Schedule 5, Part 1

"Business Plan'' means the annual plan prepared by the Executive Board on behalf of the Consortium and the Authorities for the Joint Committee as more particularly described in Schedule 5, Part 2

"The Central Team'' means the unit set up to support the Executive Board and to perform the roles described in Schedule 6

"Chair'' means the presiding chairman of meetings of a committee or board under this Agreement

"Commencement Date" means the day of 2014

"Confidential Information'' is defined in Clause 16

"Consortium" means the Authorities acting in collaboration in the Region with a view to achieving the Objects effectively, efficiently and economically, and in accordance with Schedules 1 and 2

"Contribution'' means each Authority's contribution towards the Annual Cost calculated according to the proportion of pupil numbers in each Authority's administrative area as agreed by the Executive Board and supported by an invoice submitted by the Lead Financial Officer

"Executive Board'' means the body appointed by the Joint Committee on behalf of the Consortium the responsibilities of which are set out in Schedule 4

"Financial Year'' means a year beginning on the 1st April

"FOIA'' means the Freedom of Information Act 2000 referred to in Clause 19 and for the purpose of this Agreement will include the Environmental Information Regulations 2004

"Functions'' includes those roles, responsibilities and duties of the Authorities described in Clause 5

"Funding'' means funding, including grant aid, provided or advanced to the Consortium, otherwise than by the Authorities, and as described in Clause 10 and referred to in Schedule 5, Part 1

"Hub'' means a sub-regional pair of Authorities within the Region the arrangements in respect of which are described in Schedule 2 Part 1

"Joint Committee'' means the committee established in accordance with, and as described in, Clauses 7 and 8 and Schedule 3

"Lead Authority" means the Authority which, under Clause 5 of this Agreement, is appointed by the Joint Committee to carry out a particular role on behalf of the Consortium for the Executive Board

''Lead Chief Executive'', ''Lead Director of Education'' and ''Lead Financial Officer'' means the chief officer appointed by the Joint Committee under Clause 6 to undertake on behalf of the Consortium the roles mentioned in Clause 5, or as provided for in this Agreement

"Lead Officer'' means the appropriate officer appointed by the Joint Committee under Clause 6 to undertake on behalf of the Consortium each of the roles mentioned in Clause 5

"Loss" means any loss or liability arising out of this Agreement in contract, tort or otherwise directly suffered by an Authority together with any damage, expense, liability or costs reasonably incurred in contesting or quantifying such loss or liability

"Managing Director'' means an individual with qualities agreed as appropriate and appointed by the Joint Committee (in consultation with Welsh Government) with executive responsibility on behalf of the Consortium for achieving the Objects

"Members'' means the appointed (or nominated) members of the Joint Committee, and ''Member'' means any one of those individuals

"Objects'' means the core aims and objectives of the Consortium as shortly described in recital (3) above and including those set out in Schedule 2

"The Region'' means the combined administrative areas of the Authorities from time to time for which the Authorities, or their successors, have responsibility

"Responsibilities'' means the core duties and responsibilities of the Authorities and the Consortium in the pursuance of the Objects as set out in Schedule 1 and Schedule 2 part 3 respectively

"RISIS'' means Regional Integrated School Improvement Services the consortium established under an Agreement between the Authorities made the 6th March 2013

"Services'' means the services to be provided by the Consortium to the Authorities under the direction of the Joint Committee and the Executive Board in pursuance of the Objects, and as referred to in Schedule 2 Part 2 of this Agreement, (but which may, during the Term, be extended or reduced if unanimously agreed by the Authorities)

''System Leader'' means an individual employed by the Consortium to challenge head teachers and school governors to set aspirational targets to ensure high levels of motivation and to improve significantly pupil attainment; and as more particularly described in Schedule 2, Part 3, paragraph 3

"Term'' has the meaning in Clause 2 of this Agreement

"Working Day" means any day on which an Authority's offices are normally open for business

1.2 Reference to any statute or statutory provision includes a reference to that statute or statutory provision as from time to time amended extended or re-enacted

1.3 Words importing the singular include the plural, words importing any gender include every gender, the words importing persons include bodies corporate and unincorporated, and (in each case) vice versa

1.4 Reference to Clauses and Schedules are references to clauses and schedules of this Agreement and any reference to a sub-provision is, unless otherwise stated, a reference to a sub-provision of the provision in which the reference appears

1.5 The Clause and paragraph headings and titles appearing in this Agreement are for reference only and shall not affect its construction or interpretation

2 TERM

2.1 This Agreement shall come into effect on the Commencement Date and shall continue in force until terminated by the Authorities in accordance with this Agreement

2.2 The Authorities agree that this Agreement shall supersede RISIS which shall cease to have effect from the Commencement Date

3 GENERAL PRINCIPLES

3.1 The Authorities agree to work together as a Consortium, through the Joint Committee and the Executive Board, in good faith and in an open, collaborative and constructive manner in pursuance of the Objects.

Members and officers will work together in a spirit of mutual trust and will respond in a timely manner to all relevant requests from the Authorities

3.2 Each of the Authorities represents to the others that it has obtained all necessary consents and authority sufficient to ensure the effective delegation of the Functions to enable the provision of the Services in the attainment of the Objects

3.3 The Authorities shall use all reasonable endeavours to ensure that the Members and their officers act in the best interests of the delivery of the Services and attainment of the Objects

3.4 The Authorities agree to share relevant data and knowledge, including access to IT networks, where appropriate

4 STATUS OF THE AGREEMENT

The Authorities acknowledge that the Agreement shall be evidence of a legally binding relationship and mutual commitments between them for the delivery of the Services and attainment of the Objects and this Agreement shall be construed accordingly

5 ROLES OF THE LEAD AUTHORITIES

5.1 The Functions listed in column 1 below shall, from the Commencement Date, be discharged on behalf of the Consortium by the Lead Authority listed in column 2

Column 1	Column 2
Management of Central Team	Pembrokeshire
Administration of Joint Committee and Executive Board	Carmarthenshire
Legal and Monitoring Officer services	Ceredigion
Contracts and Procurement	Powys
Human Resources	Neath Port Talbot

5.2 The Joint Committee shall be responsible for appointing the Lead Authority for each of the Functions, and each Lead Authority shall act under the direction of the Executive Board which may, from time to time, vary the roles

5.3 The Lead Authority shall, when required, act on behalf of each or all of the Authorities in respect of the provision of the Functions

5.4 The Lead Authority responsible for management of the Central Team shall, subject to the provisions of Schedules 1 and 2, employ and manage sufficient staff as it considers reasonable for delivery of the Functions in a cost-effective and efficient manner

5.5 The Lead Authority responsible for administration shall act as clerk to and host the Joint Committee and the Executive Board and provide other requisite support services including translation

5.6 The Lead Authority responsible for Finance shall manage the costs of provision of the Functions, and the Budget, and will ensure that accounting practices adopted comply with relevant legislation and good practice

5.7 The Lead Authority responsible for Legal and Monitoring Officer services shall supervise the governance arrangements and operation of the Joint Committee, the Executive Board and the Consortium in accordance with the terms of this Agreement, conduct legal proceedings under Clause 11 of it, and ensure compliance with relevant legislation and good practice

5.8 The Lead Authority responsible for Contracts and Procurement will act as the contracting authority for and on behalf of the Consortium, and in accordance with that Authority's Contract Procedure Rules and, on behalf of the Consortium, will make all payments under a contract when they fall due; and shall, when required, carry out the instructions of the Executive Board and ensure that its activities are competent, legally compliant and in

accordance with relevant regulations, good practice and the terms of this Agreement

5.9 The Lead Authority responsible for Human Resources shall supervise and advise on common employment issues arising out of the provision of the Functions and the operation of this Agreement

5.10 The Joint Committee shall determine which Authorities shall act as a Lead Authority to hold, manage and distribute Funding and financial contributions from and on behalf of the Authorities

5.11 Where a Lead Authority for a Function incurs costs or liability in providing the Function, the appropriate officer of the Lead Authority discharging the Function shall, on a monthly basis, provide details of that cost or liability to the Lead Financial Officer

6 LEAD OFFICERS

The Lead Chief Executive, the Lead Director of Education and the Lead Financial Officer to the Consortium shall be appointed by the Joint Committee and their duties shall include ensuring, as far as possible, that:

6.1 actions and decisions required from each Authority in relation to the Functions are taken promptly

6.2 each Authority provides sufficient and appropriate support to secure effective delivery of the Functions

7 JOINT COMMITTEE

7.1 The Authorities agree to constitute themselves as a Joint Committee on the terms set out in Schedule 3 to this Agreement subject to the Budget arrangements described in Schedule 5, Part 1

7.2 The Authorities shall ensure that Members have:

7.2.1 appropriate skills, experience and seniority to make effective decisions

7.2.2 a clear understanding of their collaborative regional responsibility

7.2.3 a clear appreciation of their roles and responsibilities and how these dovetail with democratic accountabilities

7.3 Each Member of the Joint Committee shall have responsibility for supporting the Objects and for securing, as far as possible, that any matter recommended by the Executive Board for decision is considered, determined and implemented expeditiously

8 MEMBERSHIP OF THE JOINT COMMITTEE

The Joint Committee shall be constituted as set out in Schedule 3 and each Authority shall make such officers available to the Joint Committee as are reasonably necessary for the attainment of the Objects

9 ROLE OF THE EXECUTIVE BOARD

9.1 The Joint Committee will constitute the Executive Board to which it will delegate the operational decision making of the Consortium in accordance with Schedule 4

9.2 The Executive Board may recommend action on matters outside the ambit of Schedule 4 for consideration by the Joint Committee

10 FUNDING

10.1 The Consortium will receive funding from the following sources (amongst others):

10.1.1 the Authorities' share of the school improvement element of the Revenue Support Grant received from Welsh Government which the Consortium will transfer to each Authority

10.1.2 other Welsh Government grants and associated local authority match-funding (except those payable directly to schools) which will be transferred by the Consortium to each Authority

10.1.3 funding generated by the Consortium arising out of charges for services to others (including schools)

10.2 If the Lead Authority for Finance is in receipt of Funding on behalf of all the Authorities, and subsequently disburses some or all of it to the other Authorities, the other Authorities shall each, in the event that the Funding subsequently becomes repayable because of breach of the conditions of the Funding, or because the Agreement is terminated, or for any other reason, forthwith repay to the Lead Authority for Finance the Funding advanced to them and now repayable; and each agrees to indemnify and keep indemnified the Lead Authority for Finance against all Loss in respect of the same

11 LEGAL PROCEEDINGS

11.1 Any legal action or proceedings in respect of any contract or other matter in dispute with a third party under this Agreement may be taken or defended only by the Lead Authority for Legal and Monitoring Officer services for and on behalf of the other Authorities, and in accordance with the instructions of the Joint Committee or the Executive Board

11.2 If, notwithstanding Clause 11.1, legal proceedings are issued by any one of the other Authorities such proceedings will be amalgamated into one claim to be taken by the Lead Authority for Legal and Monitoring Officer services alone for and on behalf of the one or all of the other Authorities

11.3 If any legal action, proceedings or claims are instituted against any of the Authorities arising out of any contract or otherwise, then the costs of

defending the proceedings or claims, and the payment of any damages or settlement arising out of the proceedings or claims, shall be shared between the Authorities according to the Contribution, provided that the claim is not solely attributable to the actions or omissions of the Authority against whom the claim has been made, and that the Authority notifies and consults the other Authorities prior to defending the proceedings or claims

11.4 In the event that a claim is made which is solely attributable to the actions or omissions of an Authority, or an Authority has failed to notify and/or to consult with the other Authorities prior to defending the proceedings or claims as required by Clause 11.3 above, the Authority against whom such proceedings or claim has been made will be solely be liable for the payment of any damages or settlement arising out of the proceedings or claim

11.5 If the Lead Authority for Contracts and Procurement incurs a Loss as a result of:

11.5.1 following an instruction from the Executive Board pursuant to Clause 5.8 above, such Loss shall be shared between the Authorities according to the Contribution; or

11.5.2 an act or omission of an Authority or Authorities under the Agreement, such Loss shall be met wholly by the Authority or Authorities whose acts or omissions caused the Loss

11.6 The Lead Authority for Contracts and Procurement shall indemnify the other Authorities against any Loss occasioned as a result of its own negligent actions or omissions as Lead Authority

11.7 Any Authority seeking indemnity from another Authority under this Agreement shall:

11.7.1 promptly notify the indemnifying Authority of known circumstances giving rise to such claim

11.7.2 not admit, compromise or settle any claim without the consent of the indemnifying Authority except where such consent would be unreasonable in the circumstances of the case

11.7.3 take reasonable steps to mitigate any claim for which an indemnity may be sought

11.8 The other Authorities agree to cooperate with a Lead Authority as required to enable it to fulfil its role as Lead Authority

11.9 Nothing in this Clause shall require any Authority to indemnify any other Authority for Loss occasioned by the claiming Authority as a result of that claiming Authority's negligent acts or omissions

12 LIABILITIES, IMMUNITY AND INDEMNITIES

12.1 Member and officer liability

12.1.1 When working as an elected member of an Authority, such member shall be deemed to be working on behalf of her own Authority even where the particular matter under consideration relates to or also relates to the other Authorities

12.1.2 In consequence of the above, both members and officers of an Authority shall be treated as falling within the statutory immunity provided by Section 265 of the Public Health Act 1875, as amended, in respect of their actions or omissions in pursuance of the Objects

13 INTELLECTUAL PROPERTY

13.1 All intellectual property in any material created under the Agreement shall be owned by the Consortium and shall be available equally to each Authority

13.2 Each Authority warrants that any intellectual property created by its officers for the purposes of the Agreement will not infringe any third party's intellectual property rights

13.3 Each Authority shall indemnify the other Authorities against any loss arising out of any dispute or proceedings brought by a third party alleging infringement of its intellectual property rights by use of the first Authority for the purpose of the Agreement

14 DISPUTE RESOLUTION

Prior to any dispute or difference being formally referred to mediation in accordance with Clause 14.4 below, the Authorities in dispute shall seek to resolve the matter as follows:

14.1 In the first instance the matter shall be considered by the relevant Directors of Education of the Authorities

14.2 If the Directors of Education are unable to resolve the matter within thirty working days or such additional time as may be agreed between the Authorities, then it shall be referred to the Chief Executive Officer of each relevant Authority

14.3 If the Chief Executive Officers are unable to resolve the matter within a further thirty working days then the provisions of sub-Clause 14.4 shall apply

14.4 If a matter is not capable of being resolved informally, then it shall be deemed to be a 'dispute' and the following provisions shall apply:

14.4.1 the Chief Executive of one of the Authorities shall serve on the other Chief Executive(s) notice(s) in writing stating the nature of the dispute and requesting mediation

14.4.2 every dispute notified under this Clause 14.4 shall be referred to Mediation in accordance with the mediation procedures of the Alternative Dispute Resolution Group, London

14.4.3 unless otherwise agreed, the Authorities shall share equally the costs of mediation

15 WITHDRAWAL AND INDEMNITY FOR CONSEQUENCES OF WITHDRAWAL

15.1 Any Authority may withdraw from this Agreement by giving notice in writing to each of the other Authorities to expire 12 months from the end of the Financial Year in which the notice is given

15.2 Each Authority agrees that, in the event that it gives notice of withdrawal to the other Authorities, and that proposed withdrawal is voluntary and not arising out of an action of or decision by Welsh Government, it will indemnify the other Authorities against any Loss to the other Authorities arising directly out of the consequences of its withdrawal from this Agreement

15.3 Where any Authority withdraws from this Agreement the Executive Board shall continue to subsist provided at least two Authorities remain as members and, if only one Authority remains, the Agreement shall continue in force in respect of:

15.3.1 any financial liability which has arisen or which may arise out of the performance of the Agreement

15.3.2 the cost of any redundancies consequent upon withdrawal

15.3.3 any liability of each Authority to indemnify the other Authorities under this Clause; and

15.3.4 any matter referable to the Dispute Resolution procedure under Clause 14 above arising out of the performance of or withdrawal by any Authority under this Agreement

15.4 If this Agreement continues, notwithstanding the withdrawal of one or more Authorities from the Consortium, the Authorities so withdrawing

shall remain liable for their Contribution calculated to the date upon which its notice expires provided that the withdrawing Authority or Authorities shall also remain liable for the costs of any redundancy directly attributable to the withdrawal of that Authority as follows:

A redundancy in respect of which notice has been given within:	**% of cost**
1st year after withdrawal	100
2nd year after withdrawal	100
3rd year after withdrawal	80
4th year after withdrawal	60
5th year after withdrawal	40
Thereafter	nil

15.5 Subject to the liability of a withdrawing Authority under Clause 15.4, the remaining Authorities shall be liable for the costs of any redundancy according to the Contribution of each after deducting the Contribution of the withdrawing Authority

16 CONFIDENTIAL INFORMATION

16.1 Subject to Clause 19, the Authorities shall at all times use their best endeavours to keep confidential (and to ensure that their respective employees agents consultants and sub-contractors keep confidential) all Confidential Information arising under the Agreement, or the business and affairs of the other Authorities, which may now or at any time be in their possession and shall not disclose the same except with the consent of the other Authority, such consent not to be unreasonably withheld

16.2 For the purpose of this Agreement "Confidential Information" means any information:

16.2.1 imparted to any Authority or its employees, agents, consultants or sub-contractors ("the Receiving Party") on the basis that it was to be kept confidential or would, by its

nature, normally be regarded as being confidential; or

16.2.2 to the knowledge of the Receiving Party, was obtained by the other Authority on the basis that it was to be kept confidential or is of commercial value

but shall not include any information which is for the time being in the public domain otherwise than by reason of its wrongful disclosure by the Receiving Party

16.3 This Clause 16 shall continue without limit of time and shall survive the termination of this Agreement

17 COMPLIANCE WITH LAWS

17.1 The Authorities shall at all times comply with all laws including but not limited to the Data Protection Act 1998 and will, where appropriate, maintain a valid and up to date registration or notification under such laws

17.2 Each Authority shall indemnify and keep indemnified the other Authorities against all Loss incurred by the other Authorities in respect of any breach of this Clause by the Authority

17.3 Each Authority shall grant to the other Authorities the right of reasonable access to all records of personal data relevant to the Agreement, as defined in the Data Protection Act 1998, and shall provide reasonable assistance at all times during the currency of this Agreement to ensure the quality and security of data collected

18 NO PARTNERSHIP

Nothing in this Agreement shall be construed as establishing or implying any partnership between the Authorities and, except as stated in this Agreement, nothing in it shall be deemed to constitute any of the Authorities as the agent of the other Authorities or authorise any Authority:

18.1 to incur any expenses on behalf of any other Authority

18.2 to enter into any engagement to make any representation or warranty on behalf of any other Authority

18.3 to pledge the credit of or otherwise bind or oblige any other Authority; or

18.4 to commit any other Authority in any way whatsoever without in each case obtaining that other Authority's prior written consent

19 FREEDOM OF INFORMATION

19.1 Each Authority acknowledges that the other Authorities are subject to the requirements of the FOIA and the EIR and each Authority shall, where reasonable, assist and co-operate with the other Authorities (at their own expense) to enable the other Authorities to comply with these information disclosure obligations

19.2 Where an Authority receives a request for information under either the FOIA or the the Environmental Information Regulations 2004 ('EIR') in relation to information which it is holding on behalf of any of the other Authorities under this Agreement, it shall:

19.2.1 notify the request for information to the other Authorities as soon as practicable after receipt and, in any event, within two Working Days of receiving a request for information

19.2.2 provide the other Authorities with a copy of all information in its possession or power, in the form that the Authorities reasonably require, within ten Working Days (or such longer period as the Authorities may agree) of the Authorities requesting that information; and

19.2.3 provide all necessary assistance as reasonably requested by the other Authorities to enable the Authority to respond to a request for information within the time for compliance set out in the FOIA or the EIR

19.3 Where an Authority receives a request for information under the FOIA or the EIR which relates to the Agreement, it shall inform the other Authorities of the request for information as soon as practicable after receipt and in any event at least two Working Days before disclosure and shall use all reasonable endeavours to consult with the other Authorities prior to disclosure and shall consider all representations made by the other Authorities in relation to the decision whether or not to disclose the information requested

19.4 An individual Authority shall be responsible for determining at its absolute discretion whether any information requested under the FOIA or the EIR:

19.4.1 is exempt from disclosure under the FOIA or the EIR

19.4.2 is to be disclosed in response to a request for information

19.5 Each Authority acknowledges that the other Authorities may be obliged under the FOIA or the EIR to disclose information:

19.5.1 without consulting the other Authorities where it has not been practicable to achieve such consultation; or

19.5.2 following consultation with the other Authorities and having taken their views into account

20 SEVERANCE

20.1 If any provision or part-provision of this agreement is or becomes invalid, illegal or unenforceable, it shall be deemed modified to the minimum extent necessary to make it valid, legal and enforceable. If such

modification is not possible, the relevant provision or part-provision shall be deemed deleted. Any modification to or deletion of a provision or part-provision under this clause shall not affect the validity and enforceability of the rest of this Agreement.

20.2 If one Authority gives the others notice of the possibility that any provision or part-provision of this Agreement is invalid, illegal or unenforceable, the Authorities shall negotiate in good faith to amend such provision so that, as amended, it is legal, valid and enforceable, and, to the greatest extent possible, achieves the intended commercial result of the original provision

21 ENTIRE AGREEMENT

This Agreement constitutes the entire agreement and understanding of the Authorities and supersedes any previous agreement between the Authorities relating to the subject matter of this Agreement

22 WAIVER

22.1 The failure to exercise or delay in exercising a right or remedy provided by this Agreement or by law does not constitute a waiver of the right or remedy or a waiver of other rights or remedies

22.2 A waiver of a breach of any of the terms of this Agreement or of a default under this Agreement does not constitute a waiver of any other breach or default and shall not affect the other terms of this Agreement

22.3 A waiver of a breach of any of the terms of this Agreement or of a default under this Agreement will not prevent an Authority from subsequently requiring compliance with the waived obligation

23 GENERAL

23.1 Nothing contained or implied in this Agreement shall prejudice or affect the

Authorities' rights and powers duties and obligations in the exercise of their functions as local authorities and/or in any other capacity, and all rights powers discretions duties and obligations of the Authorities under all laws may at all times be fully and effectually exercised as if the Authorities were not party to this Agreement and as if this Agreement had not been made

23.2 The Authorities shall only represent themselves as being an agent partner or employee of any other Authority to the extent specified by this Agreement and shall not hold themselves out as such nor as having any power or authority to incur any obligation of any nature express or implied on behalf of any other Authority except to the extent specified in this Agreement

23.3 This Agreement shall be governed by and construed in accordance with the laws of England and Wales and shall be subject to the jurisdiction of the courts of England and Wales

23.4 This Agreement is personal to the Authorities and no Authority shall assign transfer or purport to assign or transfer to any other persons any of its rights or sub-contract any of its obligations

23.5 No person other than the Authorities shall be entitled to enforce any of the terms of this Agreement under the Contracts (Rights of Third Parties) Act 1999

23.6 Any notice required or permitted to be given by an Authority to another Authority under this Agreement shall be in writing and addressed to the Director of Education of the other Authority at its principal office

24 INSURANCE

24.1 Each Authority shall obtain and maintain throughout the Term insurance sufficient to cover all of its obligations under this Agreement and shall indemnify the others against Loss sustained as a result of a breach of this Clause

24.2 The Lead Authority shall indemnify the other Authorities against any Loss they sustain as a result of the Lead Authority failing to comply with the insurance requirements in any contract

25 VARIATION

The Executive Board in consultation with the Joint Committee may, at any time, recommend changes to this Agreement by giving notice in writing to each Authority. Each Authority shall, on receipt of a notice, use all reasonable endeavours to consider, within six weeks of such receipt, whether to accept the recommendation. If all the Authorities agree to the recommended changes a memorandum of variation shall be prepared by the Executive Board for execution on behalf of each Authority and appended to this Agreement

IN WITNESS of which the Authorities have executed this Agreement as a deed the day and year first written

SCHEDULE 1

Each Authority's Responsibilities

1. Each Authority will retain statutory accountability for school performance and the exercise of statutory powers of intervention and organisation of schools. They will not duplicate the work or activities of the Consortium

2. The Consortium will nominate a senior officer to liaise with each Authority's relevant Lead Officer who shall jointly agree on the scope and frequency of their meetings having regard to issues requiring attention

   The Authorities' responsibilities will include:

   a) recommending a Lead Director of Education, for appointment by the Joint Committee, to act as the main point of contact with the Consortium

   b) discussing with the Consortium their respective roles, functions and actions with a view to avoiding duplication of effort and, in particular, each Authority shall share with the Consortium information relating to:

      i. the overall vision and social and economic development priorities for their areas, having particular regard to issues that are likely to affect schools

      ii. school organisation, including plans for federations, amalgamations, closures and delivery of their 21st century school strategies

      iii. support for those having special educational and additional learning needs

      iv. the organisation of behaviour support and education welfare services

      v. their youth engagement strategy

      vi. safeguarding arrangements for children and young people

vii. arrangements to promote effective procurement and the development of business support services within schools

3. Authorities will monitor progress of schools in their area through their member-level scrutiny arrangements

4. Each Authority's scrutiny committee for children's and education services will meet at least once a year to consider performance and progress in their schools such meetings to be attended by Consortium staff equipped to answer questions

5. Authorities shall provide the Consortium with access to relevant data systems including anonymised data sets on pupil performance where these are held at local authority level

6. Authorities and the Consortium shall jointly consider recommendations on statutory school interventions and, in the absence of exceptional circumstances, will implement them in accordance with agreed protocol

7. Each Authority undertakes to act reasonably in their expectations of Consortium staff and resources and agrees that staff shall not be required to spend a disproportionate amount of their time on reporting and scrutiny work

SCHEDULE 2

The Consortium: Organisation, Services and Responsibilities

Part 1: Organisation

The Hub Arrangements

1. The Consortium, through the Executive Board, may decide, because of the geographical size of the Region, or the need adequately to reflect cultural and language differences, to organise delivery of the Services through Hubs centred on Swansea / Neath Port Talbot; Ceredigion / Powys, and Carmarthenshire / Pembrokeshire

Hubs: core principles

2. Hubs will deliver to the Consortium an agreed programme for each of their sub-regions whilst respecting the following core principles:

   a) all actions directed by the Executive Board will be delivered within the area of the Hub in an efficient and effective manner and so as to ensure consistency and equality of provision throughout the Region

   b) the Services will be delivered in such manner so as to avoid duplication by the Authorities whilst taking into account local differences including the incidence of the Welsh language

   c) the Authorities will at all times work together through their respective Hubs so as to ensure value for money

Hubs: operation

3. Each Hub shall:

   a) be composed of the Directors of Education (‘’the Directors”) and the relevant portfolio holders of education within each Authority in the Hub and any other officers at the discretion of the Directors

b) meet at least once in each school term

c) comply with the directions of the Joint Committee and the Executive Board in the provision of the Services in pursuance of the Objects and in accordance with the provisions of this Agreement

d) ensure clarity of roles for the System Leaders

d) ensure that each Hub works in cooperation with the other Hubs and that duplication is avoided

e) prepare and present to the Executive Board regular reports on each Hub's work and contribute to the annual report to the Executive Board detailing the Hub's progress

Retention of central powers

4. The Consortium will ensure that there is sufficient expertise in the Central Team to manage the following matters effectively:

a) data collation, analysis and application from the Authorities on school and pupil performance and progress across the Region (based on the core data sets established by Welsh Government and the Fischer Family Trust projections)

b) planning and coordination of the improvement service, quality assurance of the challenge function and performance management of its effectiveness in delivering the Objects

c) strategic leadership of key strands of work such as leadership development, literacy and numeracy and the Welsh medium

d) business planning including management of financial resources, risk assessment, human resource management of Consortium staff and commissioning of services

Part 2: Services

a) Services by the Consortium will include: intervention, challenge and support strategies to improve teaching and learning in classrooms leading to improved pupil attainment and progress at all levels, and in all contexts, including closing gaps in attainment and addressing specific needs such as Special Educational Needs (SEN) or More Able & Talented (MAT) Learners

b) collating from the Authorities and schools in the Region data on school and pupil performance and progress (based on the core data sets established by Welsh Government and the Fischer Family Trust projections), and using that data to benchmark and challenge school performance and, for schools, setting challenging targets for improvement

c) supporting the development of school leadership at all levels including affording opportunities for emerging and senior leaders to develop their experience and expertise through assignment and secondment to other schools, and commissioning and co-ordinating the provision of training and development programmes

d) supporting and promoting the development of school improvement linked to learner well-being, including issues concerning behaviour and attendance

e) ensuring the effective delivery in all schools of the National Literacy and Numeracy frameworks and co-ordinating and quality assuring the provision of training and development to achieve this

f) providing challenge to the performance and delivery of foundation phase settings and, if necessary, commissioning, co-ordinating and quality assuring training and development support

g) aligning National and local age 14-19 strategies across the Region to help in raising standards in the core subjects of English, Welsh and mathematics and ensuring the provision of high quality courses offering relevant training for pupils

h) working with the Authorities to ensure that their plans for developing and implementing strategies for 21st Century schools align with plans for school improvement

i) enabling the aims of Welsh Government's Welsh-medium Education Strategy (WMES) to be delivered by ensuring the alignment of the Welsh in Education Strategic Plans (WESP) and the Welsh in Education Grant (WEG) across each Authority to achieve consistency in the development of excellence in education in both the Welsh-medium and bilingual sectors and also in the delivery of Welsh as a second language

j) commissioning, coordinating and quality assuring delivery of high quality governor training and advice services, including the requirements for mandatory training for governors

k) providing specialist human resources advice to support head teachers and governing bodies in dealing with performance management and capability issues

l) assisting schools in the delivery of high quality education to children with additional learning and special educational needs, drawing on the expertise of the best special schools, and good practice and systems adopted by the best mainstream

Part 3: Responsibilities

1. **Core**

The Consortium's Responsibilities will include:

a) monitoring the work and performance of schools, using all-Wales standardised data sets, Fischer Family Trust projections and in-school and in-year data on pupil progress and the quality of classroom teaching and learning, to categorise a school's performance and development needs in accordance with the nationally agreed categorisation model

b) examining, with school leaders and chairs of governors, performance and provision at whole-school level and for different subjects, year groups and sub-

categories of pupils, for the purpose of comparing the progress of individual and/or groups of pupils with progress made in other schools, and to identify areas of underperformance and attainment gaps

c) confirming with head teachers and chairs of governors the priority areas for improvement and the strategies to be deployed to secure improvement

d) agreeing targets to raise expectations and to set the standard for improving the quality of teaching and learning, and to provide the success criteria against which pupil attainment and progress may be measured. Where agreement cannot be reached the Consortium will advise the Authority to enable it, in accordance with current legislation, to determine the appropriate targets

e) assessing schools that are in special measures, require significant improvement, are subject to Estyn or local authority monitoring or otherwise identified through the categorisation process as causing serious concern; and making appropriate recommendations

f) advising in situations where statutory intervention is required and the form such intervention may take (for example, federation with another school, deployment of an executive head teacher, establishment of an interim executive board)

g) Identifying and recruiting suitably qualified and experienced System Leaders and facilitating training by Welsh Government

Support by the Consortium will be applied proportionately: those schools most in need will be monitored most closely whilst strongly performing schools will be subject to 'light touch' treatment

2. **Relationship with schools**

The Consortium will:

a) establish a head teachers' panel and a governors' panel (''user panels''). Each user panel will include representatives of primary, secondary and special schools and will consult respectively with school leaders and school governors on plans and proposals for developing school improvement and will receive feedback on the

quality of service received in respect of the Consortium's challenge and support functions, and on any other relevant matter

b) ensure that the user panels meet at least once a term and that the meeting in the Autumn term considers the draft Business Plan. Significant concerns from school leaders and governors regarding the content of the draft Business Plan will be reported to the Joint Committee by the Executive Board as part of the latter's consideration of the Business Plan

The Consortium through the Central Team shall also make arrangements for collecting systematic feedback from participants on their programmes and this information should be collated and presented to the user panels

3. **System Leaders**

System Leaders may be employed full-time or part-time by the Consortium to advise and assist in relation to the Services or Responsibilities. They will, ideally, possess all of the following attributes:

a) experience of leading in a successful school, including being a member of a senior leadership team in such a school

b) expertise in analysing and using school improvement data

c) an understanding and experience of how to implement school improvement

d) strong interpersonal skills and the ability to command and maintain respect from schools

The Consortium will share monitoring information with the Authorities on a termly basis, and more frequently in relation to schools in special measures, require significant improvement, are subject to Estyn or local authority monitoring or are otherwise identified through the categorisation process as causing serious concern

4. **Co-ordination, brokering and improvement support**

The Consortium will co-ordinate, broker and provide improvement support for schools

in the Region including:

a) facilitating the use and interpretation of data to support school self-evaluation and identification of gaps in attainment

b) publishing anonymised benchmarking data on the performance and progress of comparable groups of pupils in different subjects and phases to encourage and enable schools to learn from each other

c) supporting school leaders to broker appropriate support from other schools, Consortium-commissioned programmes and other sources, where a school has the capacity to lead its own improvement;

d) overseeing the implementation of a support programme, including the deployment of head teachers of lead practitioner schools, and other head teachers capable of acting as executive heads, in those schools that are in special measures, require significant improvement, are subject to Estyn or local authority monitoring or otherwise identified through the categorisation process as causing serious concern

e) commissioning and quality assuring a range of predominantly classroom-based training and development programmes to support improvements in teaching and learning and subject knowledge

f) working with head teachers and other leaders through joint lesson observations to develop a consistent understanding of what constitutes excellent teaching and learning

g) identifying excellent departments and lead practitioners using nationally agreed criteria who can be deployed to support schools in the Region for part of their working week

h) providing mentoring support for head teachers and school leadership teams that need support in leading improvement

i) encouraging, incentivising and steering schools to work on school improvement together through local clusters of schools

j) supporting the formation and development of federations and interim executive boards where this is agreed as a way to effect school improvement

k) facilitating the development and work of professional learning communities, lesson study and other means for teachers to work together within and across schools to review and improve their pedagogical practice

l) working with university education departments to provide access to knowledge about teaching and learning and to support research projects based in schools, and

m) co-ordinating support and training for teaching assistants and newly qualified teachers

5. **Development of school leadership**

The Consortium will, in partnership with leading educational practitioners:

a) commission from schools, universities and other specialist providers development and training programmes for middle leaders the better to equip them to analyse and use data, assess the quality of classroom learning and coach other colleagues (reflecting the work of the National Leadership Development Board as it develops)

b) support succession planning by working with the Authorities to aggregate data on projected turnover and retirements of senior school leaders

c) commission from schools, universities and other specialist providers development and training programmes for emerging senior leaders (reflecting the requirements and work of the National Leadership Development Board as it develops)

d) commission programmes that will empower and enable effective head teachers to support other schools through leading a lead practitioner school, acting as an executive head teacher, leading a federation or working for part of the week as a system leader

e) encourage and co-ordinate opportunities for emerging leaders to have access to leadership secondments in other schools

f) ensure that every new head teacher in their first year of headship has access to an effective head teacher mentor

6. **Literacy and numeracy training and development**

Through the System Leaders process, the Consortium will assess the general and specific needs of schools in the Region in relation to literacy and numeracy training, and the development required. In consultation with head teachers and the Welsh Government's contractor for literacy and numeracy training, the Consortium will commission and facilitate the delivery of a strategy that will provide the required support at classroom level including:

a) challenging leaders of the Early Years Foundation Phase settings and liaising with head teachers and other providers to audit training needs and commission and quality assure an appropriate range of programmes

b) ensuring the alignment of the Welsh language in Welsh-medium Education Strategy Plans (WESP) and the Welsh in Education Grant (WEG) across each Authority, so as to achieve consistency in the development of excellence in pedagogy, and the meeting of agreed targets in the Welsh-medium and bilingual sectors, and also in the delivery of Welsh as a second language

7. **Co-ordination of ICT strategy throughout the Region**

The Consortium will co-ordinate school ICT self-evaluation, leadership and planning of ICT for learning; safeguarding emerging technologies, virtual learning environments, learning technology and the national literacy and numeracy framework; running networks for heads of departments and ICT coordinators; support for pedagogy and curriculum development (with reference to the Learning and Digital World Strategy)

8. **Strategic overview of the regional 14-19 Grant**

Including:

a) allocation of resources to programmes in line with Welsh Government priorities

b) support for planning the use of grants

c) working with the Authorities to provide a strategic overview to challenge and support all providers, including FE Colleges and private training providers, to ensure equality of access to the development opportunities

d) administering the relevant grants and co-ordinating and supporting bids for emerging grant opportunities

9. **Governor support services**

Including:

a) commissioning and quality assuring delivery of governor support services and training for governors, including the mandatory training programmes required for new governors and training for chairs of governors including the understanding and applying of data effectively

b) facilitating and encouraging the development of governor networks to enable governors to observe each other's meetings; deploying able chairs of governors to mentor other governing bodies finding difficulty in undertaking their role effectively

c) developing, in consultation with the Authorities, governors and head teachers, a performance data template for head teachers to use to report to governors on a termly or half termly basis a school's in-year performance on:

i. pupil performance and standards

ii. pupil attendance

iii. pupil exclusions

iv. staff sickness absence

v. quality of teaching (as assessed through classroom observation)

vi. progress and attainment data relative to targets

vii. identifying a pool of able candidates willing to serve on governing bodies where governance is weak

10. **Specialist human resource advice**

Including:

a) facilitating and encouraging training for head teachers and chairs of governors on performance management

b) advice on managing situations where a teacher's performance is less than capable and capability procedures have to be invoked, or where a teacher's absence or sickness record is such that it requires serious action to be considered

11. **Stocktakes**

Including:

a) arranging at least two sessions each year involving the Managing Director and the managing directors of the three other regions in Wales to discuss, and challenge and review, all Welsh Government and Estyn performance data and intelligence on each region in Wales with a view to building on each region's self-knowledge and the expertise available regionally

b) an annual challenge and review session chaired by the Minister for Education and Skills to review progress by each Welsh consortium on school improvement in each region. The Consortium will be represented by the chair of the

Executive Board, the Managing Director and the Joint Committee, and the Managing Director will prepare a report on proceedings

c) implementing the actions and priorities agreed by the Consortium and the Authorities arising out of the challenge and review sessions and including them in the Business Plan

The Minister for Education and Skills will have the power, in consultation with the Joint Committee, to make alternative arrangements for school improvement and Consortium functions where she reasonably believes that the Consortium lacks the capacity or will to deliver its functions adequately

SCHEDULE 3

The Joint Committee

Membership

1. Membership of the Joint Committee shall may consist of the leader for the time being of each Authority or its education portfolio holder

2. Each Member of the Joint Committee shall hold office until that Member:

   a) dies; or

   b) resigns; or

   c) is disqualified in accordance with section 80 of the Local Government Act 1971; or

   d) ceases to be a member of the Authority she represents; or

   e) is suspended; or

   f) the Authority which the Member represents decides that another Member should act in her place

Responsibilities

1. Overall responsibility for successful attainment of the Objects for delivery by the Consortium under the direction of the Executive Board

2. Consulting with, advising and directing the Executive Board and the Consortium on strategic and financial issues concerning the identification and attainment of the Objects

3. Appointing members (including a representative of the Joint Committee) and the Chair of the Executive Board

4. Appointing (in consultation with the Executive Board and Welsh Government) the

Managing Director

5. Appointing senior staff and dealing with Human Resources and disciplinary issues

6. Meeting (normally) not more than once in each school term to oversee the work of the Consortium to include considering reports from the Managing Director on outcomes and monitoring progress towards the attainment of the Objects. One meeting shall focus on considering and agreeing the draft Business Plan and the Budget

7. Approving the Budget (including recommendations on the level of remuneration for senior management) and the Business Plan for signing off by Welsh Government

8. Authorising the Executive Board to bid for Funding necessary for attainment of the Objects

9. Providing members of the Executive Board and the Lead Authority with opportunities to raise any issues of common concern relating to the operation, Funding and performance of the Consortium in pursuance of the Objects

10. Reviewing annually the operation of the Executive Board and the Central Team, and considering an annual self-evaluation report prepared by the Managing Director with a view to maintaining or improving their or her performance

Operation

1. The first Chair and Vice-Chair of the Joint Committee, following the signing of this Agreement, shall be such Members of the Joint Committee as the Authorities shall agree

2, Subsequently, at the first meeting held after [2016], and then biennially, a new Chair and Vice-Chair shall be appointed from amongst the Members of the Joint

Committee to hold office for the following two years

3. Following the appointment of the first Chair and Vice-Chair, the right to appoint them shall rotate biennially in favour of each Authority in turn as agreed between the Authorities

4. The Chair and Vice-Chair of the Joint Committee shall represent different Authorities

5. In the absence of the Chair at a meeting the Vice-Chair shall take the chair and, in the absence of the Chair and the Vice-Chair, a chair for that meeting shall be appointed by the Joint Committee from amongst the members in attendance

6. The Joint Committee shall meet quarterly during the school term, or at such frequency as the Joint Committee shall determine

7. If a Member is, for whatever reason, unable to attend a meeting, she may be represented by a deputy appointed by the Authority the Member represents

8. Meetings of the Joint Committee shall be convened by notice in writing issued at the direction of the Chair, in consultation with the Lead Chief Executive and the Managing Director, and delivered with the agenda and all reports to each Member or sent by post or electronically to the Member's address, to reach the Member at least three clear working days before the date of the meeting

9. The Lead Chief Executive shall attend meetings of the Joint Committee to support the Chair and advise Members

10. The Managing Director shall attend meetings of the Joint Committee and provide a a report to each dealing with progress in attaining the Objects and the preparation of the Budget and Business Plan, and any other matters including Funding

11. The Chair of the Executive Board shall attend meetings of the Joint Committee to present and advise on reports from the Executive Board

12. To constitute a valid meeting of the Joint Committee at least three Members shall be present in person

13. Meetings of the Joint Committee will normally be open to the public save where matters are deemed to be confidential by virtue of Schedule 12A of the Local Government Act 1972

14. Every issue shall be decided by a simple majority of the votes cast by the Members present and voting by a show of hands with the Chair having a second or casting vote in case of equality of votes

15. Copies of the draft minutes of the proceedings of meetings of the Joint Committee shall, after each meeting, be sent to all Members and to members of the Executive Board, and to such other persons as the Chair, in consultation with the Lead Chief Executive, Lead Director of Education and the Managing Director, may reasonably determine

SCHEDULE 4

The Executive Board

Membership

1. The Joint Committee will delegate the operational decision making of the Consortium to the Executive Board whose role will be to oversee, support and challenge the work of the Consortium and report regularly on the same to the Joint Committee. The membership of the Executive Board may comprise:

   a) One representative of the Joint Committee, appointed by the Joint Committee, who will act also as the champion of the Consortium

   b) A nominee of Welsh Government (who will have observer status only)

   c) The Directors of Education of each Authority, or persons nominated by the Directors

   d) The Managing Director

   e) Not more than five individuals, approved by the Joint Committee, recognised for their experience of leading in education and expertise in corporate governance drawn from an approved pool of individuals assembled by the Welsh Local Government Association and Welsh Government. Those appointed shall include at least one serving head teacher selected from a school within the Region

2. Each member of the Executive Board shall hold office until that member:

   a) dies; or

   b) resigns; or

   c) is disqualified in accordance with section 80 of the Local Government Act 1971; or

   d) ceases to be a member of the Authority or body she represents; or

e) is suspended; or

f) the Authority or body which the member represents has decided that another member should act in her place

Delegated responsibilities

The Executive Board's responsibilities will include:

1. Contributing to the development and formulation of strategy for the attainment of the Objects and, when necessary, challenging the Joint Committee in this regard

2. Preparing the Budget and the Business Plan for approval by the Joint Committee

3. Scrutiny and monitoring of the operation and performance of the Consortium, the Central Team and each of the Authorities in pursuance of the Objects

4. Advising, setting targets and monitoring the work of the Consortium, ensuring that all targets towards the attainment of the Objects are met and, to this end, requesting and considering regular reports from the Lead Authority

5. Scrutiny and monitoring of financial controls and systems of risk management and ensuring production and dissemination of accurate financial information

6. Consulting with the Joint Committee over the appointment (and removal) of the Managing Director and senior management and recommending appropriate levels of remuneration

7. Monitoring and receiving reports from the three Hubs regarding the Hub arrangements

8. Approving the staffing structure of the Central Team

9. Advising, setting targets and monitoring the work of the Central Team and, to this

end, requesting and considering regular reports from the Lead Authority having responsibility for management of the Central Team

10. Overseeing the work streams of the Central Team with a view to ensuring that all targets towards the attainment of the Objects are met

11. Approving all contractual arrangements necessary for the attainment of the Objects to be entered into by the Lead Authority for Contracts and Procurement on behalf of the Consortium

12. Doing such other things in accordance with the terms of this Agreement as may be agreed from time to time

Operation

1. The first Chair and Vice-Chair of the Executive Board shall be appointed by the Joint Committee

2. Subsequently, at the first meeting held after 2016, and then biennially, a new Chair and Vice-Chair shall be appointed [elected?] from amongst the members of the Executive Board to hold office for the following two years

3. In the absence of the Chair at a meeting the Vice-Chair shall take the chair and, in the absence of the Chair and the Vice-Chair, a chair for that meeting shall be appointed by the Executive Board from amongst the members in attendance

4. The responsibilities of the Chair will include:

a) deciding, in consultation with the Managing Director, the agenda for each meeting of the Executive Board

b) ensuring the provision of accurate, timely and clear information for members

c) ensuring the Executive Board operates effectively in all aspects of its role

d) facilitating and encouraging effective contributions from members and appropriate and effective relationships between members and officers

e) supporting effective communication with the Authorities and Welsh Government

f) attending (with the Managing Director) meetings of the Joint Committee

5. The Executive Board shall meet quarterly during the school term, or at such frequency as the Executive Board shall determine

6. If a member of the Executive Board is, for whatever reason, unable to attend a meeting, she may be represented by a deputy nominated in writing by the Authority or body she represents to attend the meeting and vote in her place

7. Meetings of the Executive Board shall be convened by notice in writing issued at the direction of the Chair, in consultation with the Managing Director, and delivered with the agenda and all reports to each member or sent by post or electronically to the Member's address, to reach the member at least three clear working days before the date of the meeting

8. The Managing Director and the Lead Chief Executive shall attend meetings of the Executive Board to advise members and present reports

9. To constitute a valid meeting of the Executive Board at least two-thirds of the members of it shall be present in person

10. The Managing Director shall provide a report to each meeting of the Executive Board dealing with progress in attaining the Objects and preparation of the Budget and Business Plan, and any other matters including Funding

11. Every issue shall be decided by a simple majority of the votes cast by the Members present and voting by a show of hands with the Chair having a second or casting vote

in case of equality of votes

12. Copies of the draft minutes of the proceedings of every meeting of the Executive Board shall, after each meeting, be sent to the members and to the Members of the Joint Committee and to such other persons as the Chair, in consultation with the Managing Director, may reasonably determine

SCHEDULE 5

Part 1

The Budget

1. The Consortium shall operate within the Budget as agreed by the Joint Committee and the Executive Board subject to maximum thresholds also agreed by the Joint Committee and the Executive Board as part of the Budget process

2. The Consortium shall provide a Budget forecast to each Authority and to the Executive Board for consultation (prior to referral to the Joint Committee for final approval) at least three months before the start of the following Financial Year as part of the Business Plan

3. The Lead Authority shall be entitled to recover from the other Authorities each Authority's Contribution in total equivalent to the Annual Cost properly and reasonably incurred in undertaking its responsibilities under this Agreement

4. Each Authority shall pay the Contribution half yearly in arrears

5. The Lead Financial Officer shall supply to each Authority and to the Executive Board a half yearly a statement of income and outgoings and an estimate for the following half year such forecasts to identify any possible need to spend over the Budget

6. If a half yearly forecast indicates a possible need to spend over the Budget, each Authority shall, in consultation with the Consortium, consider whether such overspend is necessary or permissible and, if so, identify the Funding available. Any such intended overspend must be agreed by the Executive Board before implementation

7. The Lead Financial Officer shall, on at least a half yearly basis, report to the Executive Board on all Funding which has become available for the Objects

8. Any underspend of the Budget will be rolled forward to the next Financial Year and used for such purposes as agreed between the Authorities, the Executive Board

and the Joint Committee

9. Overspends will be promptly notified by the Lead Financial Officer to the Joint Committee, the Executive Board and the Authorities with a clear explanation of the reasons for the deficit. Any underspends referred to in paragraph 8 will be utilised in the first instance towards the overspend and any remaining deficit will be met by the Authorities according to their Contribution out of the Funding

10. The Lead Financial Officer shall ensure that any purchase or supply of services made on account of the Consortium which are subject to VAT, whether or not the purchase price includes an element of VAT, shall be paid for only on the receipt by the Lead Financial Officer or other responsible financial officer of the Lead Authority an invoice complying with VAT regulations or a written guarantee that an authenticated VAT receipt will be issued on payment

11. VAT will be chargeable on payments between the Authorities only where a taxable supply of goods or services is deemed to have been made as defined by statute in the VAT Act 1994 as amended

Part 2
The Business Plan

The overall Consortium Business Plan

1. The Consortium will produce an annual Business Plan setting out:

   a) a summary of the Consortium's strategic objectives, priority outcomes and targets

   b) a report summarising the performance of the schools in the Region over the previous twelve months and an analysis of the main areas of strength and weakness within the Region

   c) the priorities for improvement both with regard to particular schools and 'cross-cutting' issues

d) the work programmes to be undertaken over the following twelve months,

e) measurable improvement in school performance to be achieved over the following twelve months.

2. The Managing Director will discuss the draft Business Plan with each Authority, and with representatives of the schools of the Region, and report the outcome of such discussions to the Joint Committee when submitting the draft Business Plan to the Joint Committee for approval.

3. The Business Plan, as approved by the Joint Committee, shall be submitted to Welsh Government by the end of February in each year with the final sign-off by Welsh Government by the end of March in each year

Authority annex to the Business Plan

1. Each Authority may prepare for approval an annex to the Business Plan concerning its schools, school improvement priorities, improvement services and improvement targets specifying how these matters interact with the Business Plan

2. Each Authority shall provide to the Consortium a statement of any changes it proposes to make in the following twelve months in school organisation and for delivery of services for special educational and additional learning needs, behaviour support, education welfare and wider children's services

3. The draft annex and statement will be discussed by the Managing Director and the Authority's Education Director and the portfolio holder for children's and education services

4. If, following discussions, an Authority raises concerns in relation to the content of its draft annex that cannot be resolved between the Managing Director and that Authority, such concerns shall be reported in writing to the Joint Committee and the Executive Board as part of their consideration of the Business Plan

5. An annex prepared by an Authority will be complementary to and not duplicate other

corporate plans concerning the education function of that Authority

6. An annex and statement prepared by an Authority may, once approved, constitute a service level agreement between the Consortium and the Authority

Approval of the Business Plan by Welsh Government

1. The Welsh Government, through the Minister for Education and Skills, will be responsible for approving the Business Plan

2. The Managing Director, with the managing directors of the other Welsh consortia, will meet the lead officials of Welsh Government on a half-termly basis in a spirit of co-operation to:

   a) review progress of the Authorities' draft annexes

   b) exchange information on the working of the consortia

   c) identify factors that are enabling or holding back progress on school improvement

   d) liaise on the implementation of government programmes and initiatives such as the literacy and numeracy programme or the work of the School Lead

SCHEDULE 6

The Central Team

The Central Team will be managed by the Managing Director and be accountable to the Joint Committee through the Managing Director

1. Functions to support the Joint Committee

a) preparation of annual self-evaluation reports on the performance of the Region in relation to the regional strategy

b) production of the operational business plans to support the agreed priority areas for the Region during any one academic year

c) production of quarterly financial reports including income and expenditure linked to the ring-fenced allocations under this Agreement, grant funding streams and central costs

d) preparation and presentation of various discussion papers under this Agreement and in response to the challenges from Welsh Government associated with the expectations of the National Model for Regional Working on which this Agreement is based

e) engaging with key stakeholders including other consortia, WLGA, Welsh Government and research establishments.

2. Functions to support the Executive Board

a) co-ordination of data analysis for the relevant and appropriate key indicators to assess the performance of the Region effectively

b) monitoring the delivery of the operational business plans and ensuring consistency of implementation

c) ensuring the effective utilisation of the ‘Support Challenge and Intervention Framework’ (the internal operational framework for the Region that determines level of support etc) and appropriate resources deployed according to the information received from the Lead Officers of the three Hubs through the ‘Categorisation Model’ (the national tool for assessing school performance) . The resources will be deployed in line with the common agreed approach to address need rather than demographic entitlement

d) co-ordinating and managing events and meetings including organising venues, costs, drafting schedules, agenda and taking of minutes

e) preparing interim and final progress reports for various funding organisations that are providing grants to the region

f) engaging with key stakeholders including teachers, head teachers, governors and System Leaders

THE COMMON SEAL CARMARTHENSHIRE
COUNTY COUNCIL was affixed in the presence of:

THE COMMON SEAL of **CEREDIGION**
COUNTY COUNCIL was affixed in the presence of:

THE COMMON SEAL of **THE CITY & COUNTY**
OF SWANSEA COUNCIL was affixed in the presence of:

THE COMMON SEAL of **NEATH PORT TALBOT COUNTY**
BOROUGH COUNCIL was affixed in the presence of:

THE COMMON SEAL of **PEMBROKESHIRE COUNTY**
COUNCIL was affixed in the presence of:

THE COMMON SEAL of **POWYS**
COUNCIL was affixed in the presence of:

Appendix 1

INTERMEDIATE CARE FUND 2014-15

APPLICATION

Before completing this form please read the Intermediate Care Fund Guidance, available at:

http://wales.gov.uk/topics/health/publications/socialcare/guidance1/?lang=en

It is strongly recommended that you discuss your proposal with Welsh Government officials before applying for funding.

Any enquiries relating to, and submissions of, applications should be sent to: **IntermediateCareFund@wales.gsi.gov.uk**

Alternatively, any enquires arising regarding applications is available on **02920 82 5860**

The deadline for applications to be submitted is **Midday 7 March 2014**.

All applications will be acknowledged via e-mail within 1 week of receipt.

PART 1 PROPOSAL DETAILS

A: Outline

Proposal Title	Delivering improved community services
Lead Local Authority	Neath Port Talbot CBC
Senior Responsible Officer	*Name* Stephen Phillips *Address* *Telephone* *Email*
Other organisations/partners involved in delivery	ABMU Health Board City & County of Swansea Bridgend CBC
Estimated total cost of proposal	ICF Revenue £5,263k
	ICF Capital £2,526k

Estimated Start and Finish date of proposal
The proposals in this application represent the first phase of a strategic transformation programme for community services. This comprehensive programme is supported by a 3 year business case to deliver the transformational change envisaged.

B: Description and Fit against Criteria

Note: Please be as concise as possible, ***within a maximum of 150 words for each section below****. The table in the guidance sets out the eligibility criteria against which proposals will be considered.*

NOTE WHERE YOUR PROPOSAL CONTAINS SEVERAL SCHEMES PLEASE USE THE SUMMARY TABLE ATTACHED AT ANNEX 1.

BRIEF OVERVIEW / SUMMARY OF PROPOSAL: (*summarising aims, objectives and milestones)*
The Western Bay proposal represents the first year of funding to support a 3 year Business Case for the Intermediate Tier. The primary objectives for this proposal are: 1. To strengthen the 'demand management' function undertaken by common access points into the intermediate tier of services. 2. To support 3rd sector involvement in brokerage and short term support as an integral part of the intermediate tier. 3. To optimise services, and provide the necessary housing adaptations, equipment and support, in order to provide genuine alternatives to a hospital or long term care admission. 4. To provide the context, physical estate and care pathways for integrated services between health and social care and, where appropriate, with mental health services. 5. To act as a catalyst for the transformation of services for frail older people and achieve, over time, a shift in how and where this care is delivered.

STRATEGIC ALIGNMENT: Briefly outline how this programme of work will align with Welsh Governments strategic aims for Social Services
This bid will: 1. Improve care coordination across statutory and 3rd sector organisations through its emphasis on the key functions that need to be delivered by an intermediate tier of services and by carrying through the local ambition for integration described in the output from a multi-agency workshop held in September 2013. 2. Promote and maximise independent living opportunities by providing additional capacity (including adaptations and equipment) at times of crisis, where, and to the extent to which, this has been identified by analysing existing activity and impact for intermediate care services. 3. Support recovery and recuperation through the development of additional capacity in 'step-down' services where this has been assessed as currently not meeting the optimal level of demand.

INTEGRATION: How will the programme of work demonstrate better integration across delivery partners within the region?

Your proposals should clearly demonstrate the role and contribution of all relevant partners within the region

The Business Case on which the bid is based has been the product of extensive local engagement over the last year which has resulted in a clear and consistent service model for the intermediate tier, the analysis of current costs and activity and the development of what we believe to be an optimised set of services undertaking key functions within an intermediate tier of services. The engagement process has been undertaken in the context of the Western Bay Programme Board and its Community Services Project Team, both of which have inclusive membership and extensive means of providing ongoing engagement.

The programme of work reflected in this bid therefore combines:

- The 3rd sector, in its contribution to the brokerage function within the initial common access point and any subsequent short term periods of support;
- Housing, in the provision of adaptations and equipment in a timely way where this supports any of the key stages within an intermediate care episode;
- Social care, by integrating the demand management function within a common access point, the provision of reablement support, and the impact on the commissioning for ongoing support;
- Health care, both acute and community, as key reablement, rehabilitation or recuperation services are provided in an integrated way alongside other agencies.

TRANSFORMATIONAL MODELS OF CARE: How will new service models be mainstreamed into future delivery models?

The proposals should demonstrate a recognisable shift in the way services are delivered or in the ways the collaborating organisations operate. They must create a long-term impact and achieve sustainable integrated services.

The establishment of an integrated approach to the intermediate tier will act as a catalyst for further integration across community services. The key transformational elements of the bid are:

1. The emphasis on bringing together an effective demand management function that will direct people to appropriate services or interventions according to need.
2. The new ways of working that will be required 'at scale' in a community setting, though still for discrete episodes of care aimed at improving independent.
3. The development of a new culture and set of behaviours that assume the potential for reablement and rehabilitation which will be carried forward into future years and will therefore sustain the transformation programme.

NEW/ ADDITIONAL SERVICES: How will you demonstrate this programme of work is in addition to existing provision?

The Fund must be used to support new/additional provision of services and ways of working. Proposals must clearly demonstrate how they will be delivered and measured.

The specific proposals contained within this bid have all been developed as part of the 3-year Business Plan (which has been provided a supplementary information). Each service development has been the output of work to baseline existing capacity and then to estimate, using local intelligence and comparative benchmarks, the scope for optimisation. This additional investment has then been translated into workforce wte of an appropriate mix to ensure that on implementation additional capacity, throughput and impact will also be delivered.

The fund will also support new ways of working, as well as additional capacity. This will focus on new opportunities for integration in each of the key components of the local model for the intermediate tier, including:

- Closer working between statutory and 3rd sector organisations in the common access points where diversion from hospital or reablement services are offered;
- Closer working with housing as 'step-down' care and support is supplemented with additional resources for home adaptations and equipment;
- Closer working with mental health services as a mental health link worker takes up their role in the common access point;
- Closer working between health and social care in each part of the system as it is scaled up and allows for economies of scale, joint management and training opportunities.

C: Delivery of Benefits:

The Fund can be used to build on existing good practice and to increase the scale of provision of integrated services across Wales. It can also be used as pump-prime funding to assist transformation and change and to test out new models of delivery.

The next three boxes indicate the key objectives of the Fund. For these, and the additional evidence box, please set out, **within a maximum of 150 words for each section,** the benefits your proposal will deliver, how this will be done and when they will be realised.

IMPROVING PREVENTATIVE CARE AND AVOIDING UNNECESSARY HOSPITAL ADMISSION AND DELAYED DISCHARGE OF OLDER PEOPLE, PARTICULARLY THE FRAIL ELDERLY:

Please detail your plans to address this through improved care co-ordination between social services, health, housing, third and independent sector.

The Common Access Point proposals in the bid build on existing common points of access but refocus these to provide the key intermediate tier function of demand management and rapid response. The strengthening of the brokerage role using third sector involvement also ensures integration with this sector.

The business case sets out how it will seek to optimise the impact of these services across Western Bay such that:

- The rapid response service will save an additional 29 hospital admissions per week.
- The intake reablement function will address the needs of an additional 16 people a week.

PROMOTE AND MAXIMISE INDEPENDENT LIVING OPPORTUNITIES:

Your proposals may include ensuring increased provision of timely home adaptations in response to referrals from health and care services.

A significant proportion of the people identified in the box above will also expect to benefit from the provision of timely home adaptations. Capital sums have been included to provide for specialist equipment as well as 'lower level' care and repair support to ensure people's homes remain safe as people's need increase. The 'Trusted Assessor' scheme including the fitting of equipment to avoid falls will also support this key objective.

Development of the intermediate tier will speed up response times for those who need support, with packages of care implemented in a timely manner leading to better outcomes. The 'right sizing' of care packages from the outset will lead to better outcomes and improved independence.

SUPPORT RECOVERY AND RECUPERATION BY INCREASING THE PROVISION OF REABLEMENT SERVICES:

Your proposals must demonstrate the provision of those services at home or through the provision of step-down/convalescence beds in the community setting):

The focus on planned reablement and intermediate care as a step-down from hospital features as a key function within the business case. As a result of this investment:

- By the end of 2014/15 750 more people across Western Bay will have had step-down rehabilitation and reablement at home or in a 'step-down' bed rather than in an acute hospital.

This will be secured primarily through enhanced home based intermediate care services with some residential beds.

EVIDENCE OF YOUR PROPOSAL DELIVERING BENEFITS

This may include reference research, pilot study work etc.

Please refer to the full business case in support of this set of proposals and appendices on evidence from elsewhere.

In particular evidence emerging from areas who have pioneered the development of intermediate tier services have been reviewed, including Torbay, Pembrokeshire and North East Lincolnshire. This has enabled a picture of an optimised intermediate tier to be developed for the intermediate tier functions included in the 3 year business case. An optimised system is described as one that will deliver the following:

Single Point of Access: increase percentage of new contacts relating to community health and social care directed through the single point of access.

Rapid Response: 15% of baseline unscheduled admissions for >65 year olds are diverted to Rapid Response.

Intake: 100% of all potential new homecare clients receive intake intermediate care.

Review: 100% of homecare clients for whom a potential significant change is identified receive review intermediate care.

Step down care: 100% of post-acute care that is suitable for domiciliary intermediate care is delivered at home rather than in a hospital bed.

Step up care: Step up care provision is expanded proportional to future change in the frail older population.

Residential intermediate care: provision of intermediate care in residential beds continues to be provided at the current rate in each locality with full utilisation of planned developments.

D: Delivery Arrangements

i) Governance Arrangements

What is the governance framework for delivering this proposal? How will all partners be involved in oversight and delivery?
Proposals should set out how delivery will be managed within a rigorous and transparent governance framework, with clear leadership accountabilities, milestones and progress measures. (Max 250 wds) Governance arrangements for the implementation of the Intermediate Tier transformation programme will be firmly embedded within the existing Western Bay Programme Board, and in particular in its Community Services Programme Board. The proposed arrangements include: • Strengthening community teams to ensure delivery as well as to be a key part of the monitoring and learning process as implementation proceeds; • Establishing dedicated programme management and support capacity; • Developing a strong internal monitoring and validation process for impact and identifying cash-releasing savings for reinvestment, mirrored by an externally commissioned piece of evaluation work. This will be supported by formal monitoring and governance arrangements that will consist of: • Local weekly reporting of key activity & impact by practitioners gathered by team managers in 'real time'; • Monthly reports to the Community Services Programme Board prepared by locality managers, supported by the central Intermediate Care Programme Office. These will be linked to budget reporting and will include an alignment with budgets and the planned investment profile; • Quarterly reporting to the Western Bay Programme Board with external validation and comment, prepared by the Intermediate Care Programme Office. The process will ensure the involvement of all staff in understanding and evaluating the impact of the new services to ensure early feedback of lessons learnt and any adjustments necessary in the implementation process.

List the key milestones i.e. the main things that will be done to deliver the programme of work. *Note payments will be made against evidence of delivery against these milestones. Without detailed milestones we will be unable to schedule payments.*	
Key Milestone	**Indicative delivery date**
Governance arrangements in place HR recruitment team operational Performance Framework in place and operational Appointment of early posts (tranche 1) Evaluation commissioned Third sector contracts in place	End June 14
Appointment of tranche 2 posts (the majority) Common Access Point (Swansea) taking all health and social care enquiries Rapid Response & enhanced reablement in place	End Sept 14

(Bridgend) Rapid Response & planned health response in place (Swansea) Rapid Response in place NPT Operational hubs in place (Bridgend)	
Remainder of posts recruited (tranche 3) Enhanced reablement function in place (NPT) Operational hubs in place (NPT & Swansea)	End Dec 14
Section 33 arrangements developed for pooled fund for implementation 1/4/15	End March 15

Please state any key risks identified and mitigation measures proposed	
Risk	**Mitigating Action**
A full risk assessment and management plan forms part of the Intermediate Tier Business Case and will be part of the ongoing project delivery approach. Key identified risks are:	
Recruitment and training of the appropriate skilled workforce	Recruitment team / programme established. Previous experience in recruiting to step changes will be drawn on and discussions entered into with local education provider to secure fast track training or development of cohorts of staff to fill key roles.
Confidence in the enhanced intermediate care services is lacking within the consultant and primary care workforce	Involvement of key clinicians in the development of the service model and aligning the intermediate care developments with proposed developments in medical staffing
Ability to release cashable savings to support recurrent funding requirements	Finance and operational managers have been fully engaged in development of the proposals and will be involved in the implementation process retaining a focus on the need to release savings.
The impact on on-going primary and community services is no properly understood and addressed	Alignment of project teams across community services with a remit to continue the development of on-going services in the community in such a way as to dovetail with the intermediate care implementation.

Please confirm that you have the following (If not yet in place please indicate when you expect them to be in hand):	
Proposal management arrangements in place	Yes
Evaluation Framework developed	In development – specification currently being designed in

	collaboration with Swansea University
Necessary Impact Assessments carried out	Impact of proposals assessed re activity / finance Impact assessments to be completed by end June

ii) Monitoring and Evaluation

(Please include in your answer, key performance indicators (KPI's) and whether a measurement baseline has been established.

Briefly outline your plans for how you will monitor the progress and evaluate the achievements of the programme
A full evaluation of the Intermediate Tier developments to be implemented in Western Bay is to be commissioned from an academic institute. Discussions are currently taking place with Swansea University regarding the design of a specification. £100k has been allocated for the evaluation. Internal formal monitoring of progress will consist of: • Local weekly reporting of key activity & impact by practitioners gathered by team managers in 'real time'; • Qualitative reporting via case studies, service user satisfaction surveys and service user stories linked to the I ROC & Hope framework. These will focus on the concept of highlighting 'social return on investment'. • Monthly reports to the Community Services Programme Board prepared by locality managers, supported by the central Intermediate Care Programme Office. These will be linked to budget reporting and will include an alignment with budgets and the planned investment profile; • Quarterly reporting to the Western Bay Programme Board with external validation and comment, prepared by the Intermediate Care Programme Office. The process will ensure the involvement of all staff in understanding and evaluating the impact of the new services to ensure early feedback of lessons learnt and any adjustments necessary in the implementation process. This strategic programme will deliver transformational change over a three year period with benefits developing over the three years and fully realised by the end of 2016/17. The identified position for key indicators at this point is detailed below:

Description of indicator	Baseline (13/14)	Expected future state (March 2017)	Frequency of data collection
Home Care starts	1,578	1484	Monthly
Care home admissions	1,107	943	Monthly
>65 unscheduled admissions to hospital	14,505	14163	Monthly
Post acute episodes in hospital	1,344	944	Monthly
Rapid response	1,653	5124	Monthly

clients			
Intake of review reablement clients	2,682	3954	Monthly
Domiciliary or bed based intermediate care	4,533	5823	Monthly

What arrangements are you proposing to capture and cascade the lessons from this programme?

Implementation of the Intermediate Tier Business Case constitutes a major programme of transformational change. The process identified to monitor and evaluate both implementation and impact has the full involvement of staff at its core. This will ensure capture and early feedback of lessons learnt and any adjustments necessary in the implementation programme.

Through the governance arrangements there will be regular reporting to the Community Services Programme Board that will include both progress on implementation, impact and lessons learnt. These will be fed back to services and teams (both within the intermediate tier and more broadly) through both on going mechanisms and specific learning and development events. Detailed plans for this will be developed as part of the implementation programme.

Regular multi agency learning events are already held as part of the Western Bay Changing for the Better Programme and these will provide a forum for the cascading of information on the changes and the lessons learnt from the Intermediate Tier proposals.

E: Funding Details

The £50 million Fund (£35 million revenue, £15 million in capital) is available for the 2014-15 financial year only and cannot be extended after the 1st of April 2015

Please provide details of funding required:

A brief explanation of activity should be provided as appropriate. Please provide in the table below an overview of revenue and/or capital costs for your proposal.

Revenue Funding	Q1	Q2	Q3	Q4	Total
Bridgend	£115k	£345k	£405k	£405k	£1,271k
Neath Port Talbot	£121k	£440k	£510k	£541k	£1,612k

Swansea	£45k	£360k	£880k	£1,095k	£2,380k
Capital Funding	Q1	Q2	Q3	Q4	Total
Bridgend	£390k	£101k	£72k	£72k	£635k
Neath Port Talbot	£120k	£248k	£198k	£134k	£700k
Swansea	£222k	£366k	£459k	£144k	£1,191k
TOTAL FUNDING					
Bridgend	£505k	£446k	£477k	£477k	£1,906k
Neath Port Talbot	£241k	£688k	£707k	£675k	£2,312k
Swansea	£267k	£726k	£1,339k	£1,239k	£3,571k
Western Bay	£1,013k	£1,860k	£2,523k	£2,391k	£7,789k

Additional Information

Please use the separate box below for any additional narrative on what any successful application will be spent on (e.g. staffing, expert services, implementation etc.) (max 200 wds)

The summary figures on expenditure of the revenue and capital elements of the ICF in Western Bay are supported by detailed proposals for the development and enhancement of teams and functions that support the Intermediate Tier in line with the three year strategic Business Case. A full schedule is provided as an appendix to this submission. In summary they include:

1) Health and social care practitioner staffing (including mental health) in the functions of:
   - Rapid response
   - Common Access Points
   - Reablement / Intermediate Care
   - Medicines Management and medical staffing to support the intermediate tier

2) Investment in the third sector (e.g. Care & Repair, third sector brokerage)

3) Community Equipment and aids and adaptations required to support the increased number of people supported at home

4) Infrastructure developments reflecting the significant increase in the number of community staff and integration of teams across health and social care.

5) Vehicles required for enhanced services

6) Local staffing to support the implementation of these major service developments

7) Academic evaluation of the Intermediate Tier implementation

What funding and other resources, if any, will contributing partners commit to the delivery of the proposal?
The business case for the Intermediate tier constitutes a three year programme of strategic change. Western Bay partners are committed to full implementation of the programme with the ICF monies forming a vital role in developing new services in 2014/15 that will generate benefits (both in service delivery and savings) over the next two years. Local partners are committed to further investment in the Intermediate Tier in 2015/16 to achieve the service configuration required to deliver the improvements identified. Bridging monies will be made available to cover the short term gap between investment required and savings delivered in years two and three of the programme. The Western Bay Partnership has also committed to capital and revenue costs associated with a bid to the Health Technologies Fund (HTF) which is linked to this bid. The HTF bid includes technology that will allow smarter and more efficient working for community staff through the use of remote devices, telehealth and digital pen technology.

Are you applying for other Welsh Government funding to deliver this proposal?
Please provide details of which funding streams and the amount secured

PART 2: FURTHER INFORMATION

For this part of the application you are given the opportunity to expand upon the summary information provided above. This may include further details on the background, governance, rationale and forecast benefits of the proposal.

(max 300 words)

The Business Case for the Intermediate Tier submitted as part of this application provides full details on the work undertaken in Western Bay and development f proposals for the Intermediate Tier upon which this bid is based.

See Appendix 2

PART 3: CONFIRMATION

Please sign, date and return this completed form to the address shown below:

I confirm that the proposal outlined here has been agreed and authorised and if funding is awarded, it is ready to proceed in the 2014 / 2015 financial year.

Signature:

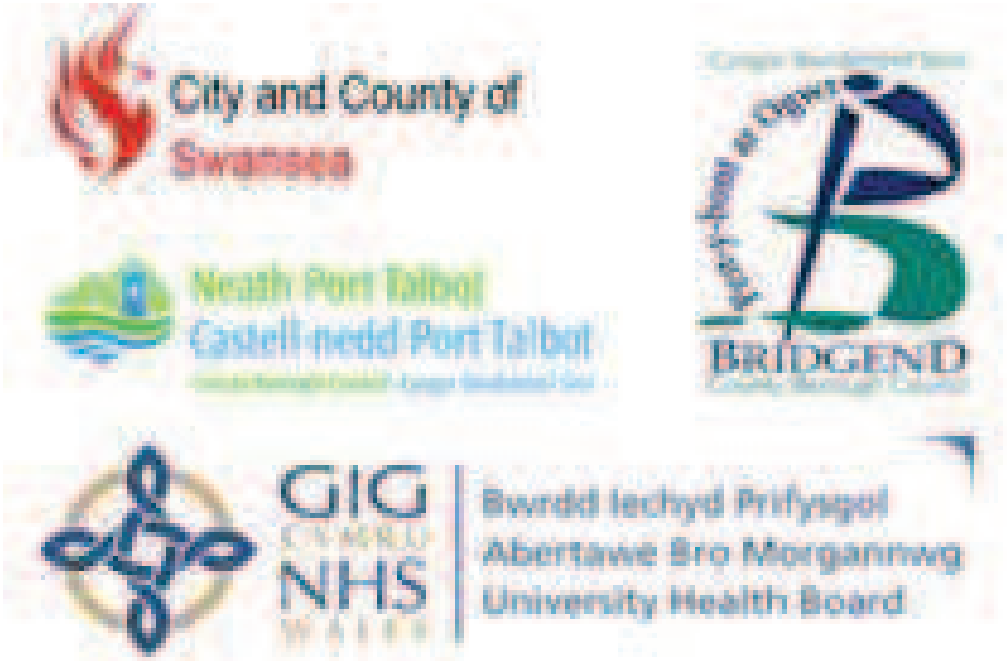
Name:

Chief Executive and / or Chief Financial Officer:

Date:

Appendix 2

Western Bay Community Services



Transforming care through investment in the intermediate tier

3 year business case

27th January 2014

This business case provides details of the investment necessary to develop intermediate care services, as outlined in the Strategic Outline Business Case for Community Services signed off by the Western Bay Programme Board in June 2013. It focusses on Intermediate Care Services because they can act as a catalyst for wider system change at a time of significant pressure across the health and social care system. The focus on intermediate care also recognises the opportunity to bid against the Welsh Government's recently announced Intermediate Care Investment Fund, although further local investment, and a commitment to work together to deliver complex changes, is also necessary to deliver and then sustain this three year programme of transformation.

Contents:

Appendices:

Executive Summary

This is an ambitious but necessary plan aimed at developing intermediate care services across Western Bay. It is necessary because without a proactive approach to the growing needs within our communities crisis will follow crisis and risks, instead of being managed, will be realised in real people's lives. We have estimated that growing demand for services by 2016/17 would mean that without commensurate increases in resources, 450 people across Western Bay would be denied the Social Care they need; or, alternatively, every discharge from a post-acute episode of care would be made 5 days later, irrespective of need. ***Were we to spend what was necessary to avert these risks it would cost Western Bay partners an additional £1.5M every year cumulatively***.

However, knowing the current pressure on resources, even providing the same levels of support for people's health and care needs will not be possible. It is therefore essential that an 'invest to save' strategy is put in place so that we reduce radically the rate at which people access health and social care services. The Williams report includes recommendations to develop integrated services, such as intermediate care, and the recent announcement of the Welsh Government's Intermediate Care Investment Fund provides a one-off opportunity to get this transformation programme underway in 2014/15, albeit with the need for other resources to bridge the programme in 2015/16 to a more sustainable footing beyond that.

Intermediate Care across Western Bay is already working, and many people benefit from the services they provide. However, there is ***clear evidence that there are gaps in the focus and size of many of these services***. These services also often operate in isolation, reducing their potential impact as well as the economies and improved effectiveness that can come from integration.

This business case therefore sets out the vision and ambition for a comprehensive and integrated service model for intermediate care that will match the growing needs of the local population. It describes two broad functions; one that provides immediate support at a time of crisis, wherever you are in the system; and another that provides a planned response, but that is time limited and aimed at optimal reablement.

Current investment in the Intermediate Tier is fairly evenly matched between health and social care in each Western Bay locality, even though the make-up of the different contributions varies. ***A total of £8.2M is currently spent on these services***. Through an engagement process we have mapped out and explored the potential for these services and believe that ***approximately £14.5M will be needed by 2016/17*** to transform the services and deliver ongoing savings by reducing other long term support needs and/or dependency on hospital care for people whose needs can be met better elsewhere.

By modelling the current intermediate care activity and understanding the potential for further impact by examining best practice elsewhere, we have scaled these services in terms of workforce, finance and levels of activity, to arrive at a clear plan for expansion to achieve the impact necessary.

For workforce we have identified a ***current workforce of 252wte*** across Western Bay. Plans have been drawn up, sensitive to local needs and within the financial resources identified by the modelling work, to ***increase this staffing by a further 138wte***. The staff required include Nurses, Social Workers, Care Staff, Occupational Therapists, Physiotherapists, Speech and Language Therapists, Dieticians and Pharmacists.

The financial plan translates the activity and workforce profiles into a three year approach to investment and the recycling of benefit. ***In the first year c.£6.5M will be invested*** recurrently and non-recurrently from the Welsh Government Intermediate

Care Investment Fund. ***This will release £2.3M of in-year savings*** to be reinvested in the service and to sustain the recurrent commitments. However, there is a need for ***further bridging in 2015/16 of £3.9M***. Chief Executives will need to consider how to fund this gap as we move into 2016/17 where we anticipate a more balanced position. Different scenarios have been run to test the sensitivity of the financial model and a full risk management approach has been outlined. The programme is not without risk, but we have set out the implications of the alternative 'do nothing' option, which are clearly unacceptable. We are also conscious of the risk of a half-hearted sign-up that would reduce confidence in the service to address the challenges ahead, for example in being able to recruit high quality staff to a service in which they can see a longer term career development path.

To give clarity and confidence to proceed, the plan also sets out the type of reductions in key health and social care activity which would be expected to release resources, particularly in the short term. A quarterly profile of reducing numbers of new home care clients, care home admission and post-acute episodes of care will be directly attributable to these service changes. Across Western Bay we will look to ***reduce post-acute episodes of care in a hospital setting from 3,700 to just under 3,000; new home care starts from c.1,600 to c.1,350 and new admissions to care homes from c.1,100 to just under 1,000***. These are achievable targets, but can only be delivered safely and effectively with the best intermediate care services being in place.

To ensure the programme is managed well an Implementation Group will be established, answerable to the existing Western Bay Project Board. A team of senior and operational champions and change agents will be identified and provided with dedicated time to deliver this programme. Evaluation and ongoing learning will be built into the programme, as well as commissioning external experts to undertake formal evaluation.

Finally, it is recognised that there are a wide range of services that will also need to be developed that can contribute to addressing the needs of a growing older population. Many of these will interface in some way or other with the intermediate tier of services. We have described, in an appendix, the work that is either underway elsewhere or that will need to take place to ensure that community services for people who are frail continue to deliver effective, and value-for-money solutions that keep people healthy and independent for as long as possible.

1 Introduction

1.1 Our vision

The number of people who are frail or who are vulnerable across Western Bay is increasing, largely because we have become better at treating conditions that might have killed people in previous decades and generations. But those who become vulnerable in this way deserve the very best quality of care that provides genuine choice for frail older people, maximises independence and optimises outcomes.

For many people the conditions that contribute to increasing risk are well understood. Much can be done in the management of long term conditions to slow the rate of progress or to manage these conditions in ways that reduce hospital admissions and other incidents that lead to increased dependency levels. These are important preventative and maintenance strategies that need to dovetail with the development of intermediate care described in this document.

Many frail older people are vulnerable and without the sort of short term support that the intermediate tier can give they are likely to end up being increasingly dependent on ongoing health and social care. These are the words of one such older person who, as well as caring for others in his family, had his own care needs:

> *"I have had various assessments from social care giving me a range of support to help me continue caring. I have been ill myself recently due to being tired and exhausted, and received short term help, which was provided promptly giving me support and peace of mind.* ***I know that without me caring for them, both my mother and brother would almost certainly be in full time residential care. However with the support I have received, we as a family are able to stay together at home."***

However, what is also increasing at a greater rate than simply the number of older people, is the rise in multi-morbidity. These increases require any intermediate care services to become increasingly integrated with 'expert generalists' becoming core to meeting the complex needs of an increasing number of people. Here is a 'before and after' example of what an effective intermediate tier of services meant for one person:

<table>
<tr><td colspan="2">A lady in her 80's with diabetes and a heart problem, lived with her husband but was known to be not eating and drinking properly or taking her medication. She was offered a number of services, many of which were refused. The lady stated that she wanted to die.</td></tr>
<tr><td>Before: The lady developed an infection that led to her husband calling for an ambulance late one night. She was assessed at A&E and because of the complexity of her case she was admitted. Her mental health meant that it was difficult to co-ordinate all the assessments and treatment necessary. Because there was no significant improvement in her underlying condition she was assessed as needing to be admitted to a care home, but delays in finding one with suitable mental health expertise meant that she was in hospital was an extended period of time before finally being transferred.</td><td>After: The lady developed an infection that led to her husband calling the local access point for health and social care. After gathering the relevant information over the phone a member of the Rapid Response Team visited and arranged for a mental health assessment. This led to her being prescribed anti-depressants, with weekly follow up visits. She is now eating, drinking and taking all necessary medication. Her mood has improved, she states that she no longer wants to die, and has agreed to further services to assist her.</td></tr>
</table>

In the work leading up to the development of this business case people expressed the desire to see services for people who were frail that:

- Helped frail older people to stay healthy, for example through support to self-care, improved medicines management, housing adaptations, health screening and community activities that reduced the risk of isolation;
- Was proactive – a pull rather than push approach – that identified those most at need and supported them by identifying key workers and made best use of technology;
- Ensured that people were admitted to hospital only when absolutely necessary, that when they were admitted, their stay in hospital was of the highest quality and when they were ready to be discharged that they were helped to optimise recovery and reablement.

This business case is focussed on a key part of the system that is necessary to deliver this future vision – intermediate care services. These services are largely community based services provided by either health or social care where there is a strong rehabilitation or reablement focus. They are the catalyst for wider system change and help to shift the balance away from institutional care to support at home, sometimes with minimal input from professionals.

1.2 Outline and purpose for the Business Case

This Business Case focusses on developing the intermediate tier of services because this is seen as a vital building block for wider whole system change. The intermediate tier consists of short term interventions that address needs at a time of crisis or when people's needs change, with the aim of maximizing recovery and on-going independence. It is linked, but is not the same as on-going support in either health or social care. Developing the Intermediate Tier is a 'first step'. The further development of wellbeing services to reduce future needs from escalating, together with services to support those with complex and high levels of need for ongoing care remain as critical next steps.

The Intermediate Care Business Case is organised in such a way as to clearly identify:

1. The case for change and the service model for the Intermediate Tier that is designed to address the challenge.
2. How we have modelled the local system of health and social care to arrive at the investment and impact described in this Business Case.
3. The business case for additional investment in the intermediate tier for each Western Bay locality to deliver key strategic changes.
4. The governance and monitoring that will be put in place to ensure delivery of the programme.
5. The strategic consequences of this investment on related services in the wider system of care (see Appendix 1).

1.3 Strategic context

In June 2013 the Western Bay Programme Board approved a Strategic Outline Business Case for a Transformation Programme relating to the needs of the frail older population across Western Bay. The underlying analysis and modelling work that supported the outline business case has since informed the '*Delivering Improved Community Services – a joint commitment*' paper.

'*Delivering Improved Community Services*' also reflects initial work on dementia, which is still underway. This work identifies the level of need, and the options for strategic redesign for people with dementia. In order to facilitate a local conversation about the

overlap and opportunities for integration between services for people with dementia and those who are frail, two further pieces of work have been undertaken:

- A workshop with the C4B programme and the Community Services Project Board was also held in September 2013 to explore the challenges and opportunities for integration. This has subsequently underpinned the options appraisal undertaken, which is reflected in this Business Plan and described in more detail in Appendix 2.
- A high level Investment Plan for the Intermediate Tier was approved by the Community Services Programme Board in December 2013. This Business Case provides the detail to support the Investment Plan.

2 The case for change

2.1 Changes in the older frail population

One of the main, and quantifiable, pressures on current services arises from the growth in the number of people who are frail. People who are frail are also typically, though not exclusively, old and many will therefore have dementia. Identifying the potential impact on services, and resource use, from this group of people, and then focussing our efforts on meeting these needs differently through an enhanced intermediate tier is therefore vital.

The modelling work undertaken has included the development of projections for the change in the older population. These have been used to gain an understanding of the increases in demand that might be expected, were there to be no change in services or in people's access to and expectations from these services.

The projections developed are based on existing research on the prevalence of physical frailty, plus assessments of the varying impact of local health status and local population changes. The headline projected changes in the numbers of older people as a whole, and in older frail people are identified in Table 1. Differences in the expected level of change between the >65s and the frail older population are due to different age distributions in each locality.

	Total >65s			Est. of frail population			Frail per 1,000 >65
	2012	2018	Change	2012	2018	Change	
Bridgend	25,880	29,980	+15.8%	2,582	3,001	+16.2%	100
NPT	27,450	31,214	+13.7%	2,837	3,198	+12.7%	103
Swansea	44,290	49,396	+11.5%	4,687	5,226	+11.5%	106

Table 1 Future needs based on demographic projections[1], healthy life expectancy and expected prevalence of frailty

2.2 Changes in the population with dementia

The modelling work has also looked at the number of people with dementia, because evidence indicates that people with a range of conditions are twice as likely to be admitted to hospital if they also have dementia. Using the same demographic profiles as above, and applying appropriate incidence and prevalence rates, it has been estimated that by 2018 there will be a total of 2,205 new cases of dementia a year across the Western Bay area – many of whom may go undiagnosed until later in the

[1] Based on 2008 ONS demographic projections in IPC/ WG Daffodil database: projections derived from the 2011 census will be used to update modelling data once available through this source.

disease progression. The total number of people expected to have dementia by 2018 across Western Bay will be c 8,009. Table 2 shows the change from a baseline of 2012. It shows that in all three areas the percentage increase in dementia is greater than that for the older population as a whole reflecting an increasingly ageing older population.

Locality	Expected prevalence in 2018	Change from 2012
Bridgend	2,074	+18.2%
Neath Port Talbot	2,239	+13.6%
Swansea	3,696	+13.0%

Table 2 Expected change in the prevalence of dementia

2.3 Combining physical frailty and dementia

People with both dementia and frailty have particular needs that can be complex and that therefore require particular attention in our planning and delivery of services. An indication of the levels of co-morbidity also informs where, and to what extent, services would benefit from closer alignment or integration. The approach to determining the extent of co-morbidity is detailed in Appendix 3. In summary, it suggests that across Western Bay:

- 8,050 people who will be frail without having any form of dementia;
- 4,580 people who will have dementia but will not be frail;
- 2,410 people who will have both dementia and who will be frail.

This means that about 16% (1 in 6) of people with either dementia or frailty will experience both. However, when a similar estimate of cost is made across Western Bay we have estimated that £54M out of £110M (i.e. c 49%) is spent on the group who have both dementia and frailty (see Appendix 3).

2.4 The financial consequences of 'no change'

From the above demographics it is clear that the demand for care and support will increase by a significant amount in coming years. A system of support that simply delivers the current model of care, to the same kinds of people, is unsustainable particularly in an economic environment that requires savings year on year. The cost of meeting the needs of an increased number of people using the current reactive service models cannot be met. Indeed, it has not been met in recent years leading to the pressures we currently experience, particularly in the acute hospital sector.

The modelling work underpinning this plan has been used to assess the potential demand on care and support if the number of frail older people increases as identified above, and if rates of access to services remains the same (i.e. general hospital unscheduled admissions per 1,000 frail older people, home care new starters per 1,000 etc.).

Based on current unit costs the modelling suggests increases in expenditure from the 2012/13 baseline as identified in Table 3. If, as we expect, these costs are not met and traditional services are not increased to meet these needs (more hospital beds, a greater number of care home places etc.) then the cost pressures provide an indication of unmet need. For example, the cost pressure of c£3.3M in social care across Western Bay by 2016/17 (compared to 2012/13) would mean that about 450 fewer people could be provided with support at home, without any compensation in prevention, rehabilitation or reablement services. The £2M cost pressures in health would mean the equivalent of discharging everybody in a post-acute bed 5 days earlier irrespective of need, again without any compensating services or support.

The differential change in whole system costs between the three localities, and where these additional costs will fall (health or social care), reflects the differing demographic profiles and differing current rates of usage of health and social care., The figures suggest that in 2016/17 whole system cost pressures across Western Bay will be c£5.8m more than in 2012/13.

Change in annual spend	2013/14 £000's	2014/15 £000's	2015/16 £000's	2016/17 £000's
Bridgend				
Intermediate Care	£31k	£65k	£101k	£137k
Social Care	£146k	£349k	£592k	£864k
Hospital Care	£165k	£337k	£515k	£687k
Whole System	£343k	£752k	£1,208k	£1,687k
Neath Port Talbot				
Intermediate Care	£32k	£59k	£85k	£110k
Social Care	£321k	£632k	£871k	£1,086k
Hospital Care	£127k	£244k	£358k	£469k
Whole System	£480k	£935k	£1,313k	£1,665k
Swansea				
Intermediate Care	£89k	£169k	£251k	£328k
Social Care	£391k	£692k	£1,003k	£1,335k
Hospital Care	£206k	£407k	£610k	£810k
Whole System	£686k	£1,268k	£1,864k	£2,473k
Western Bay				
Intermediate Care	£152k	£293k	£437k	£575k
Social Care	£858k	£1,673k	£2,466	£3,285k
Hospital Care	£498k	£988k	£1,483k	£1,963k
Whole System	£1,509k	£2,955k	£4,385k	£5,825k

Table 3 Cost pressures using a 2012/13 baseline with 'no change' in service design

3 Service model for an integrated Intermediate Tier

3.1 What do we want the intermediate tier to achieve?

An integrated intermediate tier of services provides a number of functions. These are illustrated in Figure 1. The Intermediate Tier of services needs to make a significant contribution to what the wider health and social care community wish to see at a whole system level and as a result of the joint commitment Delivering Improved Community Services, i.e.

- Support for people to remain independent and keep well;
- More people cared for at home, with shorter stays in hospital if they are unwell;
- A change in the pathway away from institutional care to community care;
- Less people being asked to consider long term residential or nursing home care, particularly in a crisis;

- More people living with the support of technology and appropriate support services;
- Services that are more joined up around the needs of the individual with less duplication and hand-offs between health and social care agencies;
- More treatment being provided at home, as an alternative to hospital admission;
- Services available on a 7 day basis;
- Earlier diagnosis of dementia and quicker access to specialist support for those who need it.

This means that we need:

1. Services that support people to remain confident independent and safe in their own homes for as long as possible and in accordance with their dignity and choice.
2. Services that are coordinated to reduce the number of unplanned admissions into hospital and long term care and support timely discharge when a hospital admission is appropriate.
3. A realignment of capacity, and a shift of resources, into community services to enable more people to receive the right assessment and service in the setting most able to meet their needs.

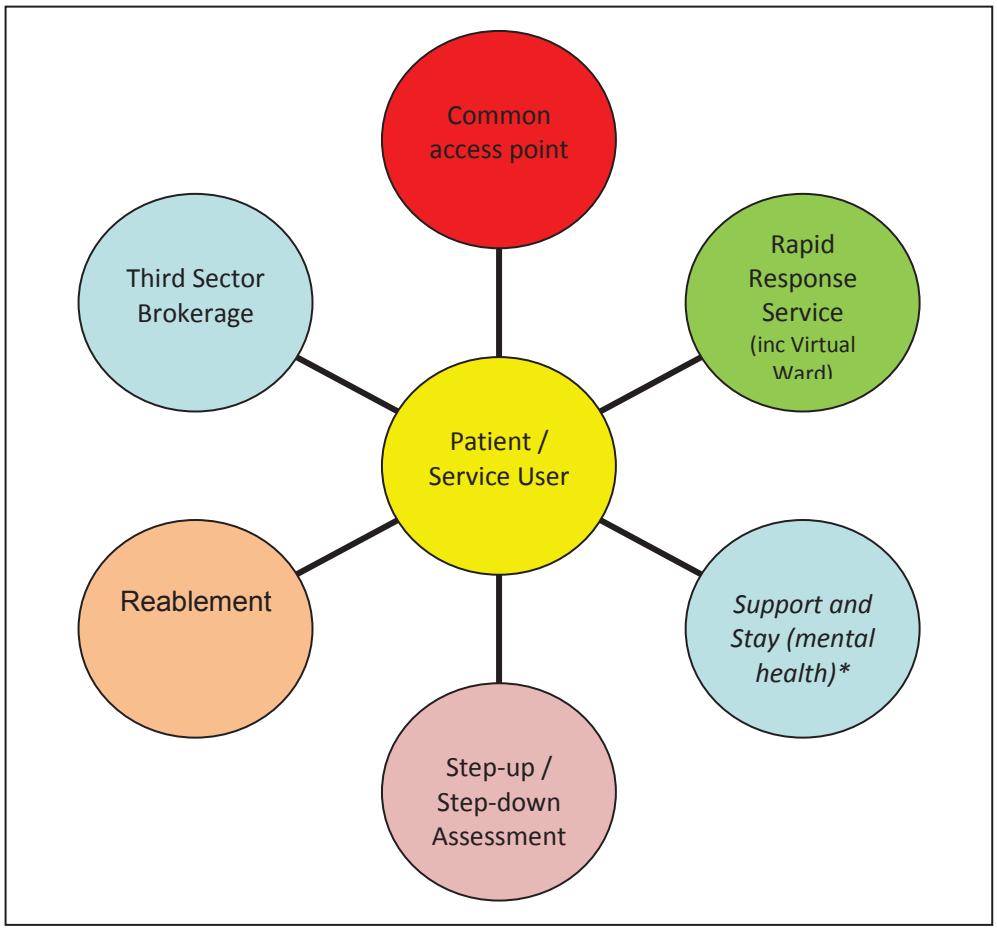


Figure 1 Functions undertaken by the Intermediate Tier

[*Support and Stay provides a dedicated service for older people with mental health needs and is being pursued in the context of the local dementia service development process.]

Together, this service model will help us to achieve significant improvements for services users, including:

- The person, their choice and preferences will be at the centre of every intervention, where appropriate.
- More people remaining independent confident and safe in their own homes for longer.
- Appropriate assessment and intervention carried out in a person's home and realignment of capacity to enable this to happen.
- A suite of support care services are available so less people are asked to consider long term residential or nursing home care, particularly in a crisis.

3.2 What will the intermediate tier look like?

The different functions outlined above are described in detail in this section. However, the integration expected within this service means that two broad 'umbrella' functions can be described:

- Those that rely on an immediate response (measured in hours) and where support is typically relatively short lived (measured in days);
- Those where response can be planned (measured in days) and support provided over a longer period (measured in weeks).

These two components of an intermediate tier still need to work closely together with the sharing of assessments and internal referrals between them. An outline of this is provided in Table 4.

	Immediate response (measured in hours and days)	**Planned response (measured in days and weeks)**
Functions	Demand management Rapid response	Reablement functions either at: • 'Intake' to home care • Review whilst being supported at home • Step-up or step-down from hospital
Access	Via Integrated common access point	
Operating Hours	7 days a week – 365 days a year 8am to 8pm	
Response time	Within 2-4 hours (Telecare Mobile response within 30 minutes)	Within 10-12 hours following initial telephone contact
Assessment	Integrated assessment, planning and review documentation	
intervention duration	- Urgent Assessment within 2-4 hours - Short term support (up to 7 days)	Up to 6 weeks of input
Access to	- Frail Assessment Unit / Hot Clinics - Virtual Ward at home - Frailty Case Management - Step-up/step-down beds in residential , domiciliary or hospital setting Hospital diagnostics - Mental Health Liaison workers - End of Life Nurses / workers - Pharmacy	Up to 6 weeks reablement including: - Intake reablement - Review reablement - Residential reablement - Care coordination Telecare - Community Equipment Service - Therapies – SALT/Dietetics/Physio and OT - Pharmacy - Psychology

	Immediate response (measured in hours and days)	Planned response (measured in days and weeks)
The team	- Geriatrician – specialist GPs?? - Nurse Practitioners - End of Life Nurses / Support Workers - Therapists – OT/Physio – other therapists? - Pharmacy technician - Mental Health Liaison worker - Social Workers - HCSWs – see new role below - Telecare Mobile response (OOH) **Coordinated with WAST and APPs	- Nurses - Therapists – OT/Physio/SALT/Dietetics - Therapy technicians - Social Workers - Pharmacy technicians - HCSWs ** New role identified here for generic role 'Care Coordinator' - Carer's support worker - [*Support and stay for people with dementia*][2]

Table 4 The core elements of the Intermediate Tier

The team providing the service consists of therapists (e.g. Physio, OT, SALT, Dietetics) and highly trained healthcare support workers (HCSW) and social workers who will in most cases be the care co-ordinators, supported by HCSWs. The HCSWs have a generic set of skills that allow them to care for frail older people, who usually have a wide range of care needs based on them having a number of illnesses or chronic conditions. The care coordinator for those frail older people and can access a range of services in the community based on the needs of the service user.

The intermediate care teams work closely with long term care managers and case workers in order to determine long term care packages when a person is not responding to time-limited intermediate care packages. The team works closely with community network teams, including District Nursing, Occupational Therapy, Social Work, Chronic Conditions teams and third sector partners. The teams have a mental health liaison worker embedded within them and work closely with specialist mental health teams to ensure people with mental health problems who can benefit from intermediate care receive the service and that there is specialist input and smooth onward referral were necessary.

3.3 What different elements make up the intermediate tier?

3.3.1 Common access point

What is it?

Citizens, their Carers and Professionals can access the service via one contact number, (telling the story once). On the basis of that conversation either they are offered a rapid response, advice and information or signposting to another service, where appropriate. Where applicable, a proportionate assessment will be carried out by an appropriate person who will then either refer to or plan for the most suitable response and intervention. The service can be accessed by anyone older than 18 years of age and including those with cognitive and sensory impairment.

How will it work?

- An integrated common access point that consists of a multi-disciplinary team who are able to effectively triage callers and direct them to the most appropriate outcome: urgent clinical response, reablement, long term community network service, specialist mental health service or a third sector or community solution (e.g. housing). The team can also carry out urgent

[2] Support and Stay services are not included in this business case but are being taken forward in the context of service development plans for services for older people with mental health needs.

assessments. The centre operates 8am until 8pm, 7 days a week and has access to both health and social care information systems.

- The multi-disciplinary approach to assessing calls in the SPA will screen referrals and calls based on a risk stratification tool and refer to the most appropriate service and assign a priority.
- A large proportion of frail older people will have a dementia so mental health liaison workers are based in the team to ensure an assessment by a mental health professional is accessible quickly.
- Access to Geriatricians, Nurse Practitioners and Therapists ensure timely clinical response is available.
- Social Workers also work in the team to ensure a person's social needs are assessed quickly and efficiently.
- Third Sector workers are based within the SPA to ensure a quick response to specific needs such as housing adaptations, carer services, etc.

3.3.2 Rapid Response

What is it?

The rapid response service is available either through a rapid clinical response (doctor, nurse and/or therapist) or through a mobile response service linked with assistive technology. Early clinical response will be within 4 hours between 8am and 8pm and mobile response services will respond within 30 minutes (out of hours). This response is coordinated with WAST where appropriate.

How does it work?

The team manages a crisis through the following:

- A 'virtual ward' can be established in a community setting, whether this is in a person's own home, or residential care setting, etc. This 'virtual ward' is exactly the same as a hospital ward, where specialist consultant and nursing staff provide rapid medical assessment and intervention and have access to appropriate diagnostic tests. 24 hour care is provided in the virtual ward and could include assessment by various specialists including mental health professionals, therapists and social workers, as well as personal support to assist recovery at home.
- The Welsh Ambulance Service (WAST) is a satellite link to the team and works in partnership with team members to ensure care is provided as close to or in people's homes as possible and as part of the virtual ward model
- A lead clinician will be responsible for the rapid care needed for the patient and this will either be a geriatrician or a GP
- Specialist nurses are available within the service in order to provide specific procedures and care normally undertaken in a hospital setting, such as IV Antibiotics. Nurses are based within the intermediate tier but do have a particular responsibility for a community network area in the locality, therefore allowing ease of referral from the SPA.
- Access to a Frail Assessment Unit is available if a specialist diagnosis is needed. The aim is to admit the person for that specific assessment and then return home within the same day for their virtual ward based care if needed.
- The service works closely with Welsh Ambulance services, ensuring this includes being a first responder for example for those that have fallen, and is trained to risk assess whether a person's safe to remain at home or needs to be transported to hospital.

3.3.3 Intake intermediate care

What is it?

Intake intermediate care focuses on helping people to regain skills that they may have lost, due to hospital admission or illness, with the objective of minimising the numbers starting to receive a new package of care or entering a care home for the first time.

How does it work?

A package of care lasting up to 6 weeks is planned by the intermediate care team, which may include both health and social care interventions as required to address the client's individual needs.

Services are delivered in most cases in people's own homes, or (where this is not possible) in a short term care home bed.

3.3.4 Review intermediate care

What is it?

Clients currently receiving homecare are assessed at a review as potentially requiring a significant increase in homecare package or transfer to a care home/ extra care housing. They receive a time limited package of intermediate care, delivered in their home, before any changes to the care plan are agreed.

How does it work?

A package of care lasting up to 6 weeks is planned by the intermediate care team, which may include both health and social care interventions as required to address the client's individual needs.

Services are delivered in most cases in people's own homes, or (where this is not possible) in a short term care home bed.

3.3.5 Step down intermediate care

What is it?

Following an admission to hospital for acute treatment, a time limited package of care and support is delivered to people (either at home or in a short term care home bed), to facilitate earlier discharge from hospital and to maximise recovery and reablement

How does it work?

A package of care lasting up to 6 weeks is planned by the intermediate care team, which may include both health and social care interventions as required to address the client's individual needs.

Services are delivered in most cases in people's own homes, or (where this is not possible) in a short term care home bed.

3.3.6 Step up intermediate care

What is it?

People experiencing a temporary increase in their needs as a result of a crisis event receive a time-limited package of care and support with the objective of minimising their need for ongoing care and/or admission to hospital.

How does it work?

A package of care lasting up to 6 weeks is planned by the intermediate care team, which may include both health and social care interventions as required to address the client's individual needs.

Services are delivered in most cases in people's own homes, or (where this is not possible) in a short term care home bed.

3.3.7 Support and stay for people with dementia

This service aims to put in place a rapid response to a person with dementia that needs support from a mental health professional during a crisis.

The service offers an intermediate time limited service to manage crisis and is linked in via the Mental Health Liaison worker based in the common access point who will triage the referral quickly. The support and stay element is provided by a CPN and will usually be within a domiciliary setting to avoid the patient having to go into hospital. The CPN will act as the care coordinator and will provide case management / assessment of ongoing needs. This then improves alignment with Frailty/general service provision.

3.4 Other supporting elements for the intermediate tier

Case management

A 'Frailty Caseload' is monitored proactively and closely by the community intermediate tier through a robust risk stratification system (?Prismatic). The caseload is a group of patients that have either been identified as being at risk of hospital admission (due to issues such as irregular prescribing patterns, hospital admission recently, etc.) or have deteriorated whilst on a reablement programme and need some short term care package.

Those being monitored by the community teams as part of the frailty caseload have the benefit of a suite of options within the community in order to respond to any deterioration of their condition – referral to Virtual Ward for assessment and care, referral to Frail Assessment Unit or referral to Reablement teams, etc.

Integrated assessment and review

All Health and social care professionals will use one set of standards and documentation for the assessment and review and planning of patients/service users care and needs. This includes things like Discharge to Assess, where a model of ownership and responsibility will be in place for the referring clinician/therapist/social worker. If the patient is better assessed in the community then they should be discharged from hospital for the assessment to take place – if it is better for the patient for the assessment to be carried out in hospital then it will be carried out in hospital.

Telecare

Telecare equipment is available for service users in their own homes. This equipment raises an alarm if for example the person has fallen, or if there is extreme heat or flood in a person's property, it can also provide reminders to take medication, etc. A mobile response team, of registered care of response workers is in place to respond quickly to the alarms raised by assistive technology equipment and are available throughout the day and night.

The community resource service has seamless links with community equipment services (including third sector), ensuring equipment and adaptations can be put into people's homes quickly and efficiently.

Information systems

It is recognised that each locality has a different information system in place for care management of service users. However, technology will be in place to allow all information systems to talk to each other and share information in a safe and effective way. 'PIMS Community' will be used for more specialist community care (i.e. early

response/virtual ward) and local systems (Draig/NPT Bespoke/PARIS) for lower level referrals through the SPA. PIMS Community has electronic transfer of care (ETOC) ability so all info can be transferred to GP following episodes of care and intervention.

Premises – a community hub

A building with a central location in each locality will be the base of the intermediate tier hub, which houses the team base and the Integrated Referral Management Centre.

3.5 How will we know that the service is working as we want it to?

A comprehensive and integrated set of measures will be needed to indicate the Intermediate Tier is actually achieving what we want it to. An initial set of impact measures might include:

- Reduced numbers of people being admitted inappropriately to an acute hospital;
- People having shorter lengths of stay in hospital;
- Reduced numbers of people delayed in hospital or other care settings waiting for the next stage of care;
- Reduced demand for large, complex care packages;
- Increases in the number of people who are enabled to live independently rather than becoming dependant on social care;
- Reductions in the number of people being admitted to a care home;
- Improved patient flow through services, in particular secondary care;
- Improved access to community based services, 24 hours, seven days a week;
- More people being supported through voluntary or third sector organisations;
- More people being helped to live at home confidently & safely or in their own community.

Measuring the demand on the Intermediate Tier itself will also be key to managing the transformation and impact programme. This means that we will need to monitor key activity and indicators of complexity, for example:

- The number of new patients assessed by the Rapid Response team (and number of interventions completed);
- The number of people sign-posted to independent or voluntary sector services;
- The number of people leaving intermediate care with no ongoing social care needs;
- The number of new intermediate tier assessments including all disciplines;
- The number of domiciliary visits by Consultant Physician;
- The number of rapid access appointments made by the Early Response team;
- The number of referrals to hospital for patients in Nursing Homes;
- The number of people deemed to have continuing health care needs.

Timeliness is a key indicator of quality and it will therefore be helpful to ensure that we measure:

- Response times from referral to assessment (in days);
- Number and % of responses within 2 hours and 4 hours;
- Number of mobile response team interventions within 30 minutes;
- Average Length of Stay (ALOS) in the Virtual Ward;

- Number of delayed transfers on to the next stage of care due to waits for package of care;
- Number of delayed transfers on to the next stage of care due to waits for home adaptations.

And finally, there will be the need to ensure effectiveness of the service. The following represents examples of the key indicators in this respect:

- Number of people signposted by the common access point to third sector or other low level support;
- Number of avoided unscheduled care admissions;
- Number of avoided re-admissions to hospital within 14 days of discharge;
- Number of avoided re-admissions to hospital within 6 weeks;
- Number leaving reablement with reduced care needs;
- Number leaving reablement with zero care needs;
- Number and % who were assessed as requiring the same level of care or the need for care was not assessed prior to receiving reablement;
- Number and % of admissions to care homes direct from acute hospital;
- Number of patients returning to usual place of residence direct from acute hospital;
- Number of referrals for carers assessments.

It will be essential that this basket of measures is refined in the context of local service development by those who will be implementing the changes. It is also crucial that the final measures match what is necessary to achieve cash releasing savings on which this plan is dependant. Further work will therefore be carried out through the proposed governance and project management arrangements described later in this document.

4 Modelling the investment in the Intermediate Tier

4.1 Introduction

The importance of the intermediate tier within the new service model cannot be underestimated as it is this range of services that will ensure that people's needs are met speedily with the best possible health outcomes and ongoing independence for people who are frail or who have dementia. This investment plan therefore outlines the development in each Western Bay locality of an optimised and integrated intermediate tier to deliver the functions outlined in section 2.

In building this capacity it has been assumed that implementation will be undertaken during 2014/15 with some part-year effects, whilst full year effect will commence from April 2015. It should be noted, however, that even with the full extent of these services being in place from April 2015 some of the benefits in other parts of the system will not be fully realised until subsequent years.

4.2 The intermediate tier now

4.2.1 Activity and costs

Information on current activity and unit costs in the intermediate tier is not consistently collected or reported across Western Bay. Available information has been collected from each locality and best estimates used to generate the baseline analysis shown below. The development of an improved information system and investment in IT Infrastructure for the intermediate tier and core community and social care services is therefore a crucial requirement for the future to support effective delivery and

performance management, especially as localities work to develop increased integration.

Improvements in the gathering of intelligence to inform this work going forward should be developed using the Commissioning Activity Tool and the Health Technology Fund bid were that to be successful. In addition there is a national procurement exercise for an Integrated Health & Social Care community information system. Activity information collected to support this baseline analysis includes:

- Unscheduled over 65 medical hospital admissions and subsequent hospital stays, including both the acute and post-acute phase (i.e. time spent in a hospital bed after the end of the acute phase of treatment that may perform an intermediate tier function of active rehabilitation or be for another reason, for example recuperation without active rehabilitation, waiting for assessment, waiting for transfer, etc).
- Home care delivered by the LA's internal provider or by independent sector providers.
- LA funded admissions to permanent care homes (i.e. excluding self-funders).
- Intermediate tier functions delivered by the Community Resource Team in each locality or by other teams or services (e.g. DCAS and ReCAS in Swansea).

The baseline information and assumptions underlying the system model, and used in the development of the projections shown in this business case, are set out in previous versions of the Investment case for the Intermediate Tier with the headlines described in this section.

All information and assumptions will be reviewed as implementation plans are developed to improve baseline understanding of the intermediate tier. The unit costs in the baseline analysis include:

- Bed day costs for hospital based post-acute care;
- Weekly costs of home care and permanent care home admission;
- Cost per case of assessment by a common access point of potential home care clients;
- Cost per case of current intermediate tier functions delivered in the community (excluding medical input).

They exclude costs of medical supervision, diagnostics etc.

Each locality has developed its community intermediate tier functions in a different way. Table 5 shows an analysis of 2012/13 actual spend by each organisation on community intermediate care functions (i.e. excluding post-acute care in hospitals).

	Total spend £000 pa	Health spend £000 pa	Social care spend £000 pa	Percentage spend health:social care
Bridgend	£1,455k	£751k	£704k	52:48
NPT	£1,854k	£882k	£972k	48:52
Swansea	£4,930k	£2,228k	£2,702k	47:53
Total	£8,239k	£3,861k	£4,378k	47:53

Table 5 Actual spend on intermediate tier services (2012/13) as identified in local documentation

The baseline of current costs in community intermediate tier services reflects different availability of services against the standard service model of 7 days a week 8am – 8pm. There are therefore two elements to the 'scaling up' in terms of capacity and availability. Modeling of this change, reflected in this section of the plan, only covers capacity changes. Local implementation plans will need to consider and balance the additional resources invested on this basis and the potential economics of scale that should enable greater availability.

The financial plan underpinning this Business Case will need to be rebased when actual spend on 2013/14 is known. The modelling tool assumes an uplift for demographic change during 2013/14, which is a reasonable modelling position given that even when efficiencies are taken into account evidence suggests that spending on this range of services is growing as its value is recognised.

In order to project future potential costs within the whole systems modelling tools, and to properly take account of proposed changes in different parts of the system and their impact elsewhere, activity and unit costs data has been used to replicate, as far as is possible, the known spend in Table 5. The modelled baseline spend (column 1 in Table 6) differs slightly from actual baseline spend due to the rounding of unit costs, the removal of part year effects, and to allow for an element of baseline spend that would be deployed on other CRT functions, and therefore not forming part of the intermediate tier.

	Community intermediate tier £000 pa	All post-acute care £000 pa[3]	Assumed Post-acute intermediate tier (20% of all) £000 pa	Total intermediate tier £000 pa
Bridgend	£1,289	£1,773	£355	£1,644
NPT	£1,872	£5,656	£1,131	£3,003
Swansea	£4,766	£3,713	£743	£5,508
Total	£7,927	£11,141	£2,228	£10,155

Table 6 Level of baseline spend (by locality of patient/ user in 2012/13) on intermediate tier and related services included in the modelling tool

The spend on post-acute care shown in Table 6 is a reflection of the different levels of reliance on the acute sector in the absence of a comprehensive and optimised range of community intermediate care services. It includes all patients who were admitted for unscheduled medical treatment, assumes that current length of stay for these patients is the same as for all post-acute patients and includes post-acute care for patients admitted for unscheduled, scheduled or surgical care. However, only a proportion of this post-acute activity could be described as intermediate care that could be delivered in the community (i.e. time limited rehabilitation to maximise independence). This business case estimates that 20% of admissions to post-acute care fall into this category.

4.3 Towards an optimised intermediate tier

4.3.1 Introduction

There are a range of examples that demonstrate the potential for intermediate care services, although it is fair to say that no single 'best practice' model for the intermediate tier has emerged. However, practice emerging from areas who have pioneered the development of intermediate tier services have been reviewed (including

[3] Based on transferable bed day costs provided by ABMU and the patient's locality of residence.

Pembrokeshire, Torbay and North East Lincolnshire). This has enabled a picture of an optimised intermediate tier to be developed for the intermediate tier functions covered in this business case, although local requirements will continue to inform detailed staffing structures and skill mix.

The optimised intermediate tier is expressed in terms of expected levels of activity, and while it is assumed that it will be delivered on the basis of maximal locality integration it does not assume a particular staffing structure or skill mix: this will be for localities to determine in implementation planning stages.

The sections that follow describe the characteristics of an optimised system, and compare baseline performance in each of the Western bay localities to this 'gold standard'. They set out the projected impact of developing the intermediate tier in each locality to deliver the following:

- Common access point: 100% of all new contacts relating to community health and social care are directed through the common access point.
- Rapid Response: 15% of baseline unscheduled medical admissions for >65 year olds are diverted to Rapid Response.
- Home care intake: 100% of all potential new homecare clients receive intake intermediate care.
- Care home intake: 50% of all potential new care home admissions direct from hospital receive intake intermediate care
- Review: 100% of homecare clients for whom a potential significant change is identified receive review intermediate care.
- Step down care: post-acute care that is suitable for domiciliary intermediate care (20% of sub-acute activity) is delivered at home rather than in a hospital bed.
- Step up care: Step up care provision is expanded proportional to future change in the frail older population.
- Residential intermediate care: provision of intermediate care in residential beds continues to be provided at the current rate in each locality with full utilisation of planned developments.

4.3.2 Demand management (common access point)

Function: enquiries about, and potential referrals to, community health and social care services home care are directed to a single point for initial information gathering and top level assessment, which will signpost some people to alternative forms of support and direct others on to intake reablement/intermediate tier services.

Optimised level: 100% of all new contacts relating to community health and social care are directed through the common access point

The Outline Business Case identified a potential level of optimised spend on this function equivalent to the well developed service in North East Lincolnshire. Assuming comparable cost levels, this would equate to a budget of c.£600k in Bridgend, £640k in Neath Port Talbot and £1,030k in Swansea. It has been assumed in this investment case that 50% of the resources required for this level of SPA are already in social care budgets, and that these would be transferred to the budget for the intermediate tier together with new investment to fund the expansion of the SPA to deliver the full service.

4.3.3 Rapid Response

Function: people are diverted from hospital to the community Rapid Response (RR) service for an intensive period of care.

Optimised level: 15% of baseline unscheduled admissions for >65 year olds are diverted to Rapid Response.

Table 7 shows activity from each of the three Western Bay localities that is consistent with this Rapid Response function. It assumes that half of the current activity is effective in avoiding unnecessary hospital admissions and compares this with actual unscheduled hospital admissions for >65 year olds. This enables us to identify the current level of optimisation in each locality, for example NPT already achieves 11% compared to the target of 15%. (It should be noted here that Swansea provides rapid *access* to intermediate tier but that the service is delivered over an average of 6 weeks and thus does not fit the usual description of a 'rapid response' service.)

	Baseline RR cases pw from diversion	Baseline saved adm'ns pw (@ 50%)	Baseline unsched >65 adm'ns pw	Baseline % of potential admissions saved	Target % of admissions saved	Distance from target
Bridgend	7	3.5	69.3	5	15	-10%
NPT	18	9	73.2	11	15	-4%
Swansea	0	0	128.0	0	15	-15%

Table 7 Estimates of current rapid response function and distance from target

4.3.4 Intake intermediate care (potential new homecare clients)

Function: potential new homecare clients receive a time limited package of intermediate care before a care plan is agreed.

Optimised level: 100% of all potential new homecare clients receive intake intermediate care.

Table 8 shows activity within existing services that perform the intake intermediate care function and distance from target in each locality.

	Baseline intake cases per week	Baseline homecare referrals per week	Baseline % of homecare referrals to intake	Target % of homecare referrals to intake	Distance from target
Bridgend	10	14.9	67	100	-33%
NPT	8	17.4	46	100	-54%
Swansea	30	32.1	93	100	-7%

Table 8 Estimate of current intake intermediate care activity and distance from target

4.3.5 Intake intermediate care (potential new care home admissions)

Function: potential new admissions to a care home receive a time limited package of intermediate care before a care plan is agreed, with a particular focus on people being discharged from hospital.

Optimised level: It is unlikely that all potential new admissions to care homes will be suitable for intake intermediate care: some people will have already spent a long time in the care system and their needs will be well known. It is suggested that the initial focus of intake intermediate care for potential new care home placements should be on people referred for care home placement direct from hospital. This will include a mix of people previously not known to services and those who are known, but whose needs have changed significantly over the course of their hospital admission.

Information on current levels of admission to care home direct from hospital has not yet been analysed in the project to date. As a starting point for further work, it is suggested that a potential aspiration could be that:

- 50% of direct care home admissions from hospital are diverted to intake intermediate care
- 25% of those diverted are diverted to a residential intermediate care bed, and 75% to a domiciliary service
- 50% of care home intake interventions are successful (ie the service user is prevented from admission to a care home on exiting the intake service)
- Any diversions who were not previously receiving home care will need an ongoing package of home care on exiting the intake service if they are not admitted to a care home

It has been assumed that this function is not currently delivered in any of the Western Bay localities at present.

4.3.6 Review intermediate care

Function: homecare clients assessed at a review as requiring a significant increase in homecare package or transfer to a care home or extra care housing receive a time limited package of intermediate care before any changes to the care plan are agreed.

Optimised level: 100% of clients for whom a potential significant change is identified receive review intermediate care.

Table 9 suggests that only Bridgend currently undertakes this type of intermediate care activity and indicates the likely level of activity required to achieve these targets. The targets are based on a conservative estimate that each home care client will have a full review every two years and that in 50% of cases a period of intermediate care is thought to be beneficial (this would be the same as 25% of cases were there an annual review).

	Baseline review cases pw	Baseline homecare reviews pw	Baseline reviews pw IDd as potentially significant	Baseline % of IDd cases to review IC	Target % of IDd cases to review IC	Distance from target
Bridgend	2	6.7	3.4	59%	100%	-41%
NPT	0	7.8	3.9	0%	100%	-100%
Swansea	0	12.3	6.2	0%	100%	-100%

Table 9 Estimates of current review intermediate care activity and distance from target

4.3.7 Intermediate care delivered in hospital

The use of hospital beds for post-acute care has been analysed in detail as part of this work. Providing alternatives to this part of the system is a key area for investment and therefore re-balancing of care over coming years. Great care will be needed to ensure that new services are in place in the community, whether at home or in alternative bed based services, before hospital beds are reduced, but this shift in care and therefore resource is a key ingredient of the future model of service. Appendix 1 outlines some of the consequences of this new service model for the acute sector.

Optimised level: 100% of post-acute care (across all hospital sites) and step up hospital activity that is suitable for domiciliary intermediate care is delivered at home rather than in a hospital bed. Current levels of post-acute episodes of care in hospital are shown in Table 10.

	Baseline new post-acute stays (unsched adm'n) pw	Baseline unsched admissions pw	Baseline IC post ac stays: % of unsched adm'ns	Target IC post ac stays: % of unsched adm'ns	Distance from target	Baseline new scheduled PA stays pw*	Baseline step up admissions pw
Bridgend	11.8	69.3	3.4%	0	+3.4%	2.0	0.3
NPT	21.2	73.2	5.8%	0	+5.8%	9.7	6.3
Swansea	15.6	128.0	2.4%	0	+2.4%	2.3	0.3

Table 10 Assumptions for post-acute activity suitable for intermediate care

Table 10 assumes that:

- 20% of baseline post-acute care and step up community hospital admissions would be suitable for intermediate care, which is an estimate based on local intelligence from CRT operational managers.
- * The split of new scheduled PA activity by locality is an estimate, matching the split of new unscheduled PA activity

4.3.8 Domiciliary step up and step down intermediate care

Function: this covers step down care (packages of intermediate care delivered at home following a hospital admission) and step up care (packages of intermediate care delivered at home, sometimes following on from an initial 'rapid response' intervention, to prevent an admission and/or referral for ongoing packages of care).

Optimised level: The optimised level of step-down intermediate care from hospital is a function of the use of post-acute stays as discussed above. However, the greater the optimisation of hospital diversion the less demand there will be for step-down support. This means that estimating an optimised level for both step-up and step-down intermediate care activity is dependent on the impact of other redesign features of the new service model.

In arriving at these estimates it should be noted that:

- Step down packages may be provided to people following an admission for any reason (i.e. for planned/ surgical care as well as for unscheduled medical care).
- Step up packages are shown in Table 11 as a rate per 1,000 modelled frail older people.
- The Swansea step up figure includes those identified locally as referred into the service via rapid access (but who do not receive an intervention of the type normally identified as Rapid Response).

The proportion of step down care currently being delivered in hospital and community is discussed later in this section.

	Baseline new step down cases pw	Baseline unscheduled admissions pw	Baseline new step down % of unsch admns	Baseline new step up cases pw	Baseline new step up cases pa per 1000 frail
Bridgend	6	69.3	8.7%	2	37
NPT	4	73.2	5.5%	4	115
Swansea	18	128.0	14.1%	47	514

Table 11 Estimates of current domiciliary intermediate care

4.3.9 Residential step up and step down intermediate care beds

Function: beds in residential care homes used for intermediate care.

Optimised level: provision of intermediate care in residential beds continues to be provided at the current rate in each locality with full utilisation of planned developments. Table 12 provides an estimate of current activity in this area. [4]

	Baseline admissions to residential IC beds pw	Percentage of admissions step up: step down	Average length of stay in days	Baseline bed days pa	Baseline bed days pa per 1000 frail
Bridgend	1.25	20:80	35.4	2301	826
NPT	0	-	-	0	0
Swansea	2.5	60:40	17.9	2327	489

Table 12 Estimate of current activity in bed based intermediate care

4.4 The impact of developing the intermediate tier

4.4.1 Introduction

This section sets out the projected impact of implementing a transformation programme, in the context of rising demographic pressures, assuming the following system changes:

The implementation of an optimised intermediate tier including the following the functions:

- Common access point
- Rapid Response
- Intake intermediate care (potential new homecare)
- Review intermediate care
- Domiciliary step up and step down intermediate care
- Residential step up and step down intermediate care

The provision of alternatives to hospital based 'step-down' or post-acute care by re-providing all step down intermediate care currently delivered as post-acute care in a hospital bed as a community-based function.

The projected impacts of the transformation programme are presented in the sections below, with the 'do nothing' scenario as a comparator. This section therefore sets out the projected impact of implementing a transformation programme, assuming demographic change, including all the proposed changes in the intermediate tier described in section 4 above. The projected impacts of the transformation programme are presented in the sections below, with the 'do nothing' scenario as a comparator.

The 'do nothing' comparator assumes:

- Projected increases in the numbers of older people, and within that in the numbers of frail older people;
- No change in current rates of access to unscheduled hospital care, home care, permanent care homes, and intermediate tier services by older people;
- No change in current models of service for older people (i.e. assessment criteria, lengths of stay, levels of input per unit time, and relative flows between services remain unchanged from baseline values);

[4] NPT will have 7 residential intermediate care beds from April 2014.

- No change in unit costs over time (there is no allowance for inflation);
- Staffing for intermediate tier functions is able to be increased proportionately to the rise in demand.
- Spend on intermediate tier functions therefore rises proportionately to increases in demand;
- Spend on hospital and social care core services therefore rises proportionately to increases in demand due to demographic changes and the cost increase is proportional to the demand rise;

4.4.2 Impact within the intermediate tier

The development of an optimised intermediate tier will have a significant impact on activity and associated resource requirements in each locality:

- Referrals and new admissions to services delivering intermediate tier functions will increase;
- Staffing requirements for services delivering intermediate tier functions will increase.

Because each locality currently has a different model of service delivery, working at varying levels of integration and different access times/days the development of an optimised intermediate tier on the basis of maximal locality integration will have a differential impact on staffing models and associated staffing costs. The financial modelling and the indicative workforce numbers include the projected costs of scaling up activity within the intermediate tier on an as-is basis in each locality. They therefore take no account of the potential increases in productivity, and consequent efficiency savings, achievable through increases in integration at local level. These will be modelled in detail at the next stage of locality implementation planning between January and March 2014.

4.4.3 Impact elsewhere in the system

Developing the intermediate tier will also have impacts on demand for ongoing community support, including, in ongoing community services:

- Reducing new homecare packages via signposting by a common access point and increased levels of intake intermediate care;
- Reducing escalation in existing homecare packages via increased levels of review intermediate care;
- Reducing new permanent care home placements via increased levels of review intermediate care.
- And, in the hospital sector:
- Reducing unscheduled admissions to hospital (and therefore bed days) via increased diversion to Rapid Response;
- Reducing post-acute hospital stays for unscheduled, scheduled and surgical patients via increased step-down domiciliary intermediate care.

The nature and potential scale of these impacts are described in the Strategic Consequences appendix. The financial impact of the whole system change resulting from investment in the intermediate tier is included below.

4.4.4 Projected changes in intermediate tier activity

Table 13 shows the impact of the proposed development of the intermediate tier on average caseloads, compared to the do nothing comparator. These are presented as year-end ‘snapshots’ of domiciliary intermediate tier patients/ service users, across all

functions (ie Rapid Response + intake + review + step up + step down). They exclude occupancy of residential intermediate care beds.

	March 13	March 14	March 15	March 16	March 17
Bridgend	128	131	212	218	224
Do nothing comparator	*128*	*131*	*135*	*139*	*143*
Neath Port Talbot	142	144	269	274	278
Do nothing comparator	*142*	*144*	*147*	*149*	*151*
Swansea	581	592	692	704	715
Do nothing comparator	*581*	*592*	*602*	*612*	*622*

Table 13 Projected caseloads for intermediate tier by locality: year-end snapshots

5 The workforce plan

5.1 Baseline intermediate tier staffing and projected impact of changes

Current community-based staffing figures for the intermediate tier have been estimated for each locality (note that this represents the majority of the work delivered by the CRT in each area, plus in Swansea the staffing establishments for DCAS and ReCAS). These have been used to develop initial projected staffing requirements for delivering future intermediate tier activity for the recommended option.

	Community intermediate tier staffing
Bridgend	39.8 WTE
NPT	65.1 WTE
Swansea	147.1 WTE

Table 14 Baseline intermediate tier staffing by locality

The scale of change in activity will have major implications for future staffing requirements, especially (but not exclusively) in those community services delivering intermediate tier functions. The tables below show an indication of the potential impact of implementation of the proposed developments on WTE staffing for these services at year end. It should be noted that:

- These projections are based on current identified staffing within Community Resource Teams, plus (in Swansea) DCAS and ReCAS.
- These projected staffing numbers should be treated as indicative only because they assume no change in working hours skill mix or productivity. In practice, increasing levels of integration would be expected to deliver staffing efficiencies, for example as duplication is reduced and/or back office functions rationalised. The extent of potential productivity gains will also depend on the current scale of integration and planned extension of working hours to deliver 7-day working, additional evening access etc.
- Projected staffing requirements are therefore proportional to the increase in activity for the relevant function compared to the baseline (and note that this baseline is derived from best local estimates of activity where robust data is not available).
- Swansea Rapid Response staffing projections are based on baseline staffing ratios in Bridgend.
- These figures exclude staffing requirements for the common access point/intake functions for potential new care home admissions.

Bridgend	March 13	March 14	March 15	March 16	March 17
Rapid Response WTE staffing	8.4	8.6	21.4	28.2	29.0
Other intermediate tier staffing (intake + review + domiciliary intermediate care)	31.4	32.2	43.7	48.5	49.7
Neath Port Talbot					
Rapid Response WTE staffing	13.2	13.4	16.1	17.5	17.8
Other intermediate tier staffing (intake + review + domiciliary intermediate care)	51.9	53.0	95.3	113.8	115.3
Swansea					
Rapid Response WTE staffing	0.0	0.0	20.5	30.9	31.5
Other intermediate tier staffing (intake + review + domiciliary intermediate care)	147.1	150.0	162.4	169.1	171.9

Table 15 Impact on WTE staffing levels of proposed investments in the intermediate tier

5.2 Developing a workforce plan

Further work has been undertaken starting with a more bottom up approach to determine the precise number, grading and mix of staff required to deliver the intermediate tier functions described in the service model underpinning this business case. This has involved local nursing, therapy, integrated community service managers, mental health managers, medical and medicines management staff from health and social care and ABMU corporate workforce managers. The work was undertaken through an initial workshop and then subsequent confirm and challenge to align broadly with the expected changes from the systems modelling work.

Attendees were provided with details of the projected changes in activity at March 2017 (end of the modelling period) for each function and asked to confirm these and to provide an initial assessment of the additional staffing requirement for these functions. Additional input was provided of plans being developed for the medical workforce in Swansea that will support the intermediate tier and plans developed for medicines management, although funding for medical staff are not included in this business case.

Attendees were encouraged to consider innovative ways of delivering services, to take account of skill mix, and the potential efficiency and productivity gains that could be achieved through integration. There was a general consensus that the extent of service enhancement envisaged by the plan was consistent with the potential unmet need for intermediate care and that real impact could be achieved through this additional investment. However, this was not without its challenges and workshop participants identified some of the key issues in delivering these additional staffing requirements, including:

- A shortage of Advanced Nurse Practitioners and general nurses;
- Timescale for skills development;
- Difficulty in recruiting AHPs at higher skill levels;
- Potential for destabilising private provider workforce – domiciliary care, care homes, nursing;

- Crucial requirement for medicines management skills across all elements of the workforce.

Participants also identified opportunities in working with education and training providers to accelerate workforce development and also noted that levels of unemployment might suggest that there are some skills available in the workforce from which to recruit. There are also opportunities over time for encouraging the workforce to reskill and transfer to new areas of work, for example from some acute settings to the community.

Considerable further work needs to be undertaken on these in the next few weeks to develop them further, to test robustness and sense check. They do, however, provide an overall framework and shape of the workforce required by 2016/17 to deliver the new service model and changes in activity. A number of areas were identified where further scoping of the detailed service model is required to inform workforce requirements. These include:

- Determining precise hours of operation;
- Clarification of operational practice;
- For some functions the quantity of care to be provided in a domiciliary setting and in a residential setting;
- Determining the interfaces with other public facing services and the Common Access Point;
- Confirming how mental health expertise will be provided in/to the intermediate tier;
- Scaling up of identified staff numbers to 24/7 working

5.3 Workforce requirements

Since the workshop detailed work has been undertaken in each locality to specify the workforce that needs to be recruited in the first year of the programme. In determining these account has been taken of the local priorities for service development, reflecting on current gaps and areas of potential biggest impact, and the potential for speedy recruitment. It is recognised that in some professions such as Advanced Nurse Practitioners there is a significant training / lead in time and plans are being put in place now to grow capacity to come on stream in future years.

The additional workforce proposed for 2014/15 for each locality are detailed in the following tables. As implementation progresses these may be refined further in light of learning and experience.

5.3.1 Bridgend

Intermediate Care function	Staff Group	WTE	Grade	Cost £000's FYE	Cost £000's 2014/15
Rapid Response					
(a) Rapid Response	Advanced Nurse Practitioner	1	A4C 7		
	Qualified Nursing	2	A4C 6		
	Occupational Therapist	0.5	A4C 6	£559k	£391k
	Physiotherapist	0.5	A4C 6		
	Social Worker	0.5	LA 9		
	Care Services (bridging)	5.7	LA 6		
(b) Mobile Rapid response	LA Care Staff	4.8	LA 3		
	Team Leader	0.5	LA 8		
Planned Care					
(a)Bridging service extension	Team Leader	2	LA 8		
	Occupational Therapist	0.5	LA 11		
	Therapy Technician	1.0	A4C 3		
	Coordinator	1	LA 6		
	Social Care Worker	5.7	LA 5		
	Community care worker	1	LA 8	£546k	£382k
	CRT Support assistants	1.8	LA 5		
	Physiotherapist	0.8	A4C 6		
	Admin / ICT	1	LA 3		
	Speech & language Therapist	1	A4C 6		
	Dietician	0.8	A4C 7		
(b) Bridgeway Service	MH Occupational Therapist	0.5	A4C 6	£122k	£86k
	Social Care worker	3.6	LA 5		
Contingency (10%)				£133k	£94k
Bridgend Total				£1,462k	£1,023k

NB: Staffing based on band / grade midpoint including on costs and non-pay (mainly travel)
7 day working and nights enhancements included where appropriate

5.3.2 Swansea

Intermediate Care function	Staff Group	WTE	Grade	Cost £000's FYE	Cost £000's 2014/15
Common Access Point					
	Advice officers	10.0	LA 5	£468k	£234k
	Supervisor	01.0	LA6		
Rapid Response					
	Occupational Therapist	4.0	A4C 6	£648k	£364k
	Speech & Language Therapist	1.0	A4C 6		
	Physiotherapist	4.0	A4C 6		
	Dietician	0.5	A4C 6		
	Admin	1.0	LA 2		
	Advanced Nurse Practitioner	1.0	A4C 7		
	Qualified nurse	2.	A4C 6		
Planned Response					
	CCA/HCSW	15.0	LA 2	£828k	£646k
	Senior CCA	3.0	LA 6		
	Speech & Language Therapist	0.5	A4C 6		
	Dietician	0.5	A4C 6		
	ReCAS Carers (CCA/HCSW)	12.0	LA 2		
	Social Worker	1.0	SW grade		
Pan Intermediate Care					
(a) Medication Management	Medication Management Nurse	2.0	A4C 6	£197k	£148k
	Pharmacy Technician	20.	A4C 6		
(b) Peripatetic response Team	CCA/HCSW	4.0	LA 2	£172k	£86k
	Supervisor	1.0	LA 6		
Contingency (10%)				£232k	£162k
Swansea Total				£2,544k	£1,638k

NB: Staffing based on band / grade midpoint including on costs and non-pay (mainly travel)
7 day working and nights enhancements included where appropriate

5.3.3 Neath Port Talbot

Intermediate Care function	Staff Group	WTE	Grade	Cost £000's FYE	Cost £000's 2014/15
Planned Care					
(a) Review Reablement	Therapist	3	A4C6	£1,094k	£766k
	Reablement Support Worker	16	LA 4		
(b)Bridging service extension	Qualified nurse	2	A4C5		
	HCSW	10	A4C 3		
Rapid Response					
(b) Care Home preventative model	H&SC Professionals	4	A&C 6	£174k	£122k
Common Access Point					
	Third sector Broker	1		£120k	£84k
	Mental Health Worker	1	A4C 6		
Pan Intermediate Care					
	Pharmacist	0.6	A4C 8b	£136k	£100k
	Pharmacy technician/MMN	1	A4C 6		
	Mental Health Worker	1	A4C 7		
Contingency (10%)				£152k	107k
NPT Total				£1,830k	£1,408k

NB: Staffing based on band / grade midpoint including on costs and non-pay (mainly travel)
7 day working and nights enhancements included where appropriate

5.4 Costing the workforce growth & reconciling the workforce plans

The whole system capacity modelling undertaken to determine the scale of the challenge for this Business Case remains the indicative, high level estimate of funding required, and of savings from the impact of this investment. The financial assumptions underpinning this modelling work has been based on unit costs for service interventions rather than staffing levels. It is therefore necessary to reconcile these two approaches, using the strategic modelling outputs as the 'touch-stone'.

The workforce profiles represent the conclusions arrived at by service leads through a process of:

1. Considering the full complement of workforce required for an optimised service (by 2016/17).
2. Targeting year 1 investment at recognised service gaps where the greatest impact can be achieved.
3. Scaling the investment, at a locality level, to broadly match the modelling outputs for 2014/15 only, whilst leaving flexibility for local implementation plans.

This has enabled us to arrive at a strategic workforce plan that is consistent with the high level modelling outputs, allows for flexibility in local implementation, and is targeted at achieving the greatest impact.

6 The financial plan

6.1 Financial context

This Business Case is not being implemented in isolation from a range of pressures, inclusion ambitious and challenging cost improvement programmes. Both Health Board and Council financial plans currently require savings to go to the bottom line, e.g. care homes (LA) and Continuing Health Care (Health). No assumptions are therefore made about re-directing these savings where they are not the result of the changes being implemented in the Intermediate Tier.

However, due to the strategic importance of this transformation programme, and the inherent risks of 'business as usual' (£6.2M recurrent cost pressure by 2016/17 compared to 2013/14) financial modelling has been undertaken, and will be illustrated here, to warrant such reinvestment.

The financial plan outlined in this section therefore assumes the achievement of anticipated impact from the intermediate tier, particularly on post-acute activity, home care starts and care home admissions. It recycles this and identifies the extent of further bridging required after any initial investment from the Welsh Government Intermediate Care Fund. A local policy about using reserves, invest to save and/or to make different decisions about wider contributions to the bottom line will be required to address the bridging required after the first year of WG monies.

6.2 Modelling the financial impact

In order to model the financial impact arising from the proposed service redesign we have estimated the combined spend on health and social care for the Western Bay frail older population (i.e. existing intermediate care, emergency hospital admissions for the >65 and social care spend) at £91M (2012/13). Cost pressures within the system from demographic change amount to c.£6.2M by 2016/17 – but budgets are being reduced meaning that efficiencies, changes in eligibility and/or developing more effective services are essential.

The modelling undertaken to support this Business Case suggests that the pressures will be addressed with full implementation such that by 2016/17 the cost pressures noted above will have been fully absorbed, with a small saving of £125k. The level of additional investment over the 2012/13 baseline indicated by the modelling work amounts to £6.5M by 2016/17. The tables in this section show projected investment requirements and projected shifts in spend on the basis of the service modelling tool developed with the engagement of local stakeholders.

Bridgend	2013/14	2014/15	2015/16	2016/17
Intermediate care costs over 2012/13 baseline	32	1,140	1,687	1,761
Change in annual spend on social care over 2012/13 baseline	**153**	**-16**	**-400**	**-863**
Do nothing comparator	153	364	620	909
Change in spend on hospital services - acute	133	16	12	140
Change in spend on hospital services - post acute phase	48	-146	-394	-479
Change in annual spend on hospital care over 2012/13 baseline	**181**	**-130**	**-382**	**-339**
Do nothing comparator	181	369	563	752
Change in annual spend over 2012/13 baseline - whole system	**366**	**-146**	**905**	**559**
Do nothing comparator	**366**	**799**	**1,287**	**1,801**
Neath Port Talbot	**2013/14**	**2014/15**	**2015/16**	**2016/17**
Activity costs over 2012/13 baseline	32	1,440	2,110	2,162
Change in annual spend on social care over 2012/13 baseline	**276**	**-17**	**-619**	**-1,210**
Do nothing comparator	276	566	841	1,078
Change in spend on hospital services - acute	77	57	77	142
Change in spend on hospital services - post acute phase	109	-424	-1,171	-1,464
Change in annual spend on hospital care over 2012/13 baseline	**186**	**-367**	**-1,094**	**-1,322**
Do nothing comparator	186	353	514	670
Change in annual spend over 2012/13 baseline - whole system	**494**	**-384**	**397**	**-369**
Do nothing comparator	**494**	**978**	**1,440**	**1,858**
Swansea	**2013/14**	**2014/15**	**2015/16**	**2016/17**
Activity costs over 2012/13 baseline	89	1,727	2,571	2,687
Change in annual spend on social care over 2012/13 baseline	**356**	**52**	**-946**	**-1,409**
Do nothing comparator	356	641	957	1,311
Change in spend on hospital services - acute	159	-156	-419	-457
Change in spend on hospital services - post acute phase	66	-334	-932	-1,176
Change in annual spend on hospital care over 2012/13 baseline	**225**	**-490**	**-1,350**	**-1,633**
Do nothing comparator	225	445	667	886
Change in annual spend over 2012/13 baseline - whole system	**670**	**-438**	**274**	**-355**
Do nothing comparator	**670**	**1,255**	**1,875**	**2,525**

Table 16 Outline investment plans for each locality – compared to 'do nothing'

6.3 The revenue financial plan underpinning the business case

6.3.1 Outline of the approach

The approach to the financial plan underpinning this business case, applied in a consistent way in each Local Authority but scaled and targeted appropriate to local need, is:

1. A 'one-off' resource for 2014/15 is secured from the Welsh Government Intermediate Care Investment Fund to enable the expansion of key services, as well as to make the necessary non-recurrent investment in infrastructure and training.
2. Service and financial monitoring is undertaken alongside implementation in order to refine current assumptions about financial benefits secured in other areas of the system as a direct result of the Intermediate Care investment, and that these resources are transferred to a pooled budget in 2015/16.
3. That partners identify the extent and sources for any necessary bridging required in 2015/16 (and potentially in 2016/17 in some scenarios).
4. That the pooled budget arrangements are extended during 2015/16 to include on-going support in the community for health and social care so as to manage risk and secure future flexibility to secure the appropriate level and mix of on-going community support.

6.3.2 The 3-year plan

Table 17 shows the 3-year plan that arises having applied the above approach. In summary it indicates that:

- The sum total of spend on intermediate care for 2014/15 would amount to £14.5M, of which £6.5M (£4.2M of which is revenue) would come from the Welsh Government Intermediate Care Investment Fund;
- In 2015/16 a transfer of £0.8M from social care and £1.6M from health would be made to the pooled funds that is directly attributable to savings and efficiencies in services where the intermediate Care developments have had an impact during 2014/15;
- To meet the ongoing requirements of the developing intermediate tier further bridging in 2015/16 would be required totalling £3.9M;
- The total recurrent budget for the Intermediate Tier in 2015/16 would then be £14.3M (£2.3M capital funding from Welsh Government Intermediate Care Investment Fund is not re-provided in the pool);
- In 2016/17 a transfer of £2.0M from social care and £1.8M from health would be made to the pooled funds that is directly attributable to savings s in services where the intermediate Care developments have had an impact during 2015/16;
- The total recurrent requirement for the Intermediate Tier in 2016/17 would be £14.5M;
- A further requirement for bridging in 2016/17 is then identified for Bridgend of c.£0.6M whilst Neath Port Talbot and Swansea return a small surplus;
- In 2017/18 a transfer of £1.5M from social care and £0.5M from health would be made to the pooled funds that is directly attributable to savings and efficiencies in services where the Intermediate Care developments have had

an impact during 2016/17. This would mean that the Pooled Fund totals £16.2M;

- In 2017/18 Bridgend remains slightly in deficit (£0.2M), although the overall surplus for Western Bay amounts to £1.7M.

2014/15 budget	Bridgend	NPT	Swansea	**TOTAL**
Welsh Government Int Care Investment Fund for recurrent spend	£1,108	£1,408	£1,638	£4,154
Baseline spend - health	£751	£909	£2,301	£3,961
Baseline spend - social care	£704	£1,002	£2,414	£4,120
Total recurrent budget placed in pooled arrangement	**£2,563**	**£3,319**	**£6,353**	**£12,235**
Welsh Government Int Care Investment Fund for non-recurrent spend	£621	£722	£959	£2,302
Pooled budget (including non-recurrent spend)	**£3,184**	**£4,041**	**£7,312**	**£14,537**
IMPACT:				
In-year direct social care savings from impact of IC	£169	£293	£304	£766
Absorption of social care cost pressures	£211	£290	£285	£786
In-year direct health savings from impact of IC	£311	£553	£715	£1,579
Absorption of health cost pressures	£188	£167	£220	£575
Savings from mainstream budgets	**£879**	**£1,303**	**£1,524**	**£3,706**
Cash releasing	£480	£846	£1,019	£2,345
Cost avoidance	£399	£457	£505	£1,361

2015/16 budget	Bridgend	NPT	Swansea	**TOTAL**
Baseline health and social care spend for IC	£1,455	£1,911	£4,715	£8,081
Transfer of savings from mainstream budgets	£480	£846	£1,019	£2,345
Total recurrent pooled budget	**£1,935**	**£2,757**	**£5,734**	**£10,426**
Actual recurrent commitment	£2,563	£3,319	£6,353	£12,235
Gap (+ive figure requires bridging, -ive is a saving)	£628	£562	£619	£1,809
Additional investment to optimise IC service	£547	£670	£844	£2,061
Level of budget spend required to optimise IC service	£3,110	£3,989	£7,197	£14,296
Further bridging required for 2015/16	**£1,175**	**£1,232**	**£1,463**	**£3,870**
IMPACT:				
In-year social care savings from impact of IC	£384	£602	£998	£1,984
Absorption of social care cost pressures	£256	£275	£316	£847
In-year health savings from impact of IC	£252	£727	£860	£1,839
Absorption of health cost pressures	£194	£161	£222	£577
Savings from mainstream budgets	**£1,086**	**£1,765**	**£2,396**	**£5,247**
Cash releasing savings	£636	£1,329	£1,858	£3,823
Cost avoidance	£450	£436	£538	£1,424

2016/17 budget	Bridgend	NPT	Swansea	TOTAL
Baseline health and social care spend for IC + 2014/15 recurrent savings	£1,935	£2,757	£5,734	£10,426
Further transfer of savings from mainstream budgets (2015/16)	£636	£1,329	£1,858	£3,823
Total recurrent budget available	**£2,571**	**£4,086**	**£7,592**	**£14,249**
Final investment needed to optimise IC service	£74	£52	£116	£242
Level of recurrent budget spend required to optimise IC service	£3,184	£4,041	£7,313	£14,538
Gap (+ive figure requires bridging, -ive is saving)	**£613**	**-£45**	**-£279**	**£289**
IMPACT:				
In-year social care savings from impact of IC	£463	£591	£463	£1,517
Absorption of social care cost pressures	£289	£237	£354	£880
In-year health savings from impact of IC	-£43	£228	£283	£468
Absorption of health cost pressures	£189	£156	£219	£564
Savings from mainstream budgets	**£898**	**£1,212**	**£1,319**	**£3,429**
Cash releasing savings	£420	£819	£746	£1,985
Cost avoidance	£478	£393	£573	£1,444

2017/18 budget	Bridgend	NPT	Swansea	TOTAL
Baseline health and social care spend for IC plus recurrent savings	£2,571	£4,086	£7,592	£14,249
Further Transfer of savings from mainstream budgets (2016/17)	£420	£819	£746	£1,985
Total recurrent pooled budget	**£2,991**	**£4,905**	**£8,338**	**£16,234**
Actual recurrent commitment	£3,184	£4,041	£7,313	£14,538
Gap (+ive figure requires bridging, -ive is a saving)	**£193**	**-£864**	**-£1,025**	**-£1,696**

Table 17 Three year financial plan

6.4 The implications arising from the plan

6.4.1 Variations on the plan

Alternative scenarios and assumptions can be made to inform local risk management. For example, if the resource equivalent to the absorption of cost pressures in the services directly impacted by the Intermediate Tier were included in the annual transfers alongside cash releasing savings then the level of bridging required in 2015/16 would reduce from £3.9M to £2.5M. However, if this were not adopted and only 60% of the cash releasing savings were achieved then this bridging requirement would increase to £4.8M.

6.4.2 Implications for each partner

It has been acknowledged from the start of this work that intermediate care services are at different levels of development and integration in each of the three Western Bay areas. The development path, and financial consequences are also therefore different and need to be spelt out. Table 18 provides the headline messages for each organisation party to this transformation process.

	Bridgend LA	NPT LA	Swansea LA	ABMU
Baseline spend on intermediate care (2012/13)	£704k	£1,002k	£2,414k	£3,961k
'Do nothing' increase in spend by 2016/17 arising from demographic pressures on social care or unscheduled and post-acute medical hospital admission	£909k	£1,078k	£1,311k	£2,308k
Proposed investment in the intermediate tier by 2016/17 (split 50:50 LA/HB for illustrative purposes)	£880k	£1,081k	£1,343k	£3,305k
Savings in other services by 2016/17 with investment in the intermediate tier	£863k	£1,210k	£1,409k	£3,294k
Expected bridging requirement for 2015/16 (split 50:50 LA/HB for illustrative purposes)	£588k	£616k	£731k	£1,935k

Table 18 Partner financial benefits arising from investment

6.4.3 Bridging requirements

Because the resource available from the Welsh Government is for one year only, and the scale of the implementation challenge and timing of future financial benefit will accrue over a three year period, it is necessary to find other resources to bridge the gap. The final row of Table 18 adds up to £3,870k of bridging required for 2015/16. The precise split between organisations may differ but on the basis of current 50:50 funding of the service we have used this as an indicative basis for estimating the bridging requirement. Potential ways of filling this gap include:

- Assuming that each organisation's Long Term Financial Plan includes funding earmarked to cover cost increases for demand growth (including that due to demographic changes), each organisation could agree to earmark a sum of that funding for Intermediate care that equates to the costs avoided in those mainstream services directly affected by the Intermediate Tier (under the do nothing comparator this is the impact of demand growth due to demographics). These costs avoided are identified in the Financial Plan summary as circa £1.4M (£0.8M Social Care & £0.6M Health) across Western Bay in 2014/15;
- Additional savings being achieved through the intermediate care not currently factored into the modelling, for example savings in acute medical admissions in addition to post-acute episodes of care. During 2014/15 the impact of the intermediate tier on acute bed occupancy is estimated as resulting in a real reduction (including the impact of demographics) of 24 beds. At a bed day cost of £120 this would equate to £1,051k, although two factors would reduce the availability of this sum, namely that there would only be a part-year effect and that some of these costs would be fixed;
- Achieving further efficiencies in the Intermediate Tier of services, without affecting their capacity to deliver the necessary impact. A 5% efficiency in a service valued at £14.3M would equate to £715k;
- Local Authorities accessing organisational reserves;
- Making further 'spend to save' bids against Welsh Government funds.

Taking these opportunities together there is the potential to bridge the gap and realise a more sustainable financial position from 2016/17.

6.5 Non-recurrent spend and capital

The Welsh Government has made indicative capital resources available as part of the investment fund recently announced of £2.3M across Western Bay. A separate process is underway to ensure that these resources are targeted at the necessary infrastructure and associated non-recurrent spend. The Governance and project management section of this plan identifies a sum of £427k for project management and evaluation that will be part of this non-recurrent bid. Measures will be taken to ensure that the final bid to the Welsh Government will not duplicate the bid against the Technologies Investment Fund process.

7 Impact and service reconfiguration

7.1 Overview and approach

Whilst there are a wide range of strategic consequences arising from this Business Case (see Appendix 1) across the health and care system, the plan depends on the identifiable impact, and therefore release of appropriate resources in three key areas:

1. A reduction in the use of post-acute beds and their substitution with community based, time limited, episodes of intermediate care.
2. A reduction in the commissioned packages of care for people with ongoing needs for social care as a result of the extensive reablement and rehabilitation activities carried out within the new and expanded services.
3. A reduction in the number of new placements in care homes for the same reasons as above, including a key focus on discharges from hospital that currently result in care home admissions but where targeted intermediate care activity can enable people to return home (the support they need is netted off the second element above).

The intermediate tier will also be impacting on medical unscheduled admissions to hospital. However, the evidence of impact from integrated community services such as intermediate care remains unclear in this respect. Our modest assumptions within the modelling result in the system managing to address underlying demographic pressures but not making a significant impact on reducing these admissions. No assumptions of cost savings and future transfer of resources from acute admissions to intermediate care is therefore currently being made. However, monitoring of 'step-up' services, i.e. saving hospital admissions, will be included in the reporting mechanisms. It is therefore proposed that where direct impact is evidenced a potential transfer of resource is considered in future years.

To arrive at the financial impact indicated in section 6 the modelling tool has made assumptions about local unit costs and activity in the key services where impact is expected. Building on 2012/13 data (which should be updated when a full set of 2013/14 data is available) we have made an initial estimate of the baseline activity for 2013/14 using underlying demographic changes as the key driver. The tables in the following sections identify, at an average Western Bay unit cost, the reductions in activity in the three areas noted above that would be required to meet the savings and reinvestment targets.

7.2 Impact on sub-acute activity and beds

The intermediate tier will have a significant impact on post-acute episodes of care. The financial plan estimates £1.6M across Western Bay of cash releasing savings in

2014/15 from this reduction in activity. At an average length of stay of 28 days, and an average bed day cost of £110, with two thirds of this cost being variable and therefore being released, the number of episodes for 2014/15 would need to reduce from 3,724 to 2,972. A possible profile of this per quarter is shown in Table 19.

Post-acute episodes of care	2013 /14	Ave per qtr	Qtr1	Qtr2	Qtr3	Qtr4	Total
Admissions	3724	931	892	750	680	650	2972
Reduction in admissions from 13/14			39	181	251	281	752

Table 19 Reductions in post-acute episodes of care to achieve financial savings

Appendix 1, section 2 identifies the impact expected from this reduction in activity on bed numbers in the 'sub-acute' sector. It indicates an underlying demographic pressure across Western Bay for sub-acute capacity that would otherwise see it grow between April 2014 and March 2017 from 290 occupied beds to 305 (+15 beds). The one-off impact of the intermediate tier during 2014/15 is expected, subject to the reductions in admissions outlined above, to release 93 beds (12 in Bridgend, 38 in Neath Port Talbot and 43 in Swansea). The modelling assumes that the investment in the Intermediate tier also enables the increased demand on the hospital sector due to demographic changes to be dealt with. This underlying demographic impact is estimated to equate to an additional 40 beds (15 post-acute & 25 acute).

7.3 Packages of home care

Through the work of the intermediate tier, particularly through the home care reablement functions, the number of new packages of care being commissioned will reduce. This reduction will occur over the year so early diversions will have a greater financial impact on the Business Case projection for 2014/15 than those occurring later in the year.

The average weekly cost of a home care package is £138 and an estimate of the new starts in 2013/14 is 1,578. Table 18 shows the profile of reduced home care starts per quarter to achieve a reduction to 1,356 new starts, which is the output from the modelling tool having applied the assumptions outlined regarding impact earlier in this business case.

Home Care	2013 /14	Ave per qtr	Qtr1	Qtr2	Qtr3	Qtr4	Total
New home care starts	1578	395	386	350	320	300	1356
Reduction in new starts			9	36	30	20	
Weeks in year with reduced cost			45	32	19	6	
Weekly saving per client week	£138						
Savings			£52,785	£158,976	£78,660	£16,560	**£306,981**

Table 20 Reductions in new home care starts to achieve financial savings

7.4 Supporting people in care homes

The work of the intermediate tier, particularly through the step-down functions, will impact on care home admissions. As with home care, the number of new care home admissions will occur over the year so early diversions will have a greater financial

impact on the Business Case projection for 2014/15 than those occurring later in the year.

The average weekly net cost of a care home place is £346 and an estimate of the new admissions across Western Bay in 2013/14 is 1,108. Table 19 shows the profile of reduced care home admissions per quarter to achieve a reduction to 991 new admissions, which is the output from the modelling tool having applied the assumptions outlined regarding impact earlier in this business case.

The combined savings from social care identified in Tables 18 and 19 is c.£734k compared with £766k in the financial plan. These profiles of quarterly activity are therefore sufficiently close to the financial savings targets to inform the next stage of locality specific targets that can be owned and monitored at this level.

Care homes	2013 /14	Ave per qtr	Qtr1	Qtr2	Qtr3	Qtr4	Total
New care home admissions	1108	277	265	250	240	236	991
Reduction in admissions			12	15	10	4	
Weeks in year with reduced cost			45	32	19	6	
Weekly net saving per client week	£346						
Accrued savings			£186,840	£166,080	£65,740	£8,304	**£426,964**

Table 21 Reductions in new care home admissions to achieve financial savings

8 Governance and Implementation arrangements

8.1 Governance structure

A governance structure to ensure delivery of the Intermediate Tier developments and identified benefits detailed in this business case will be put in place, building on existing Western Bay arrangements. This is illustrated below:

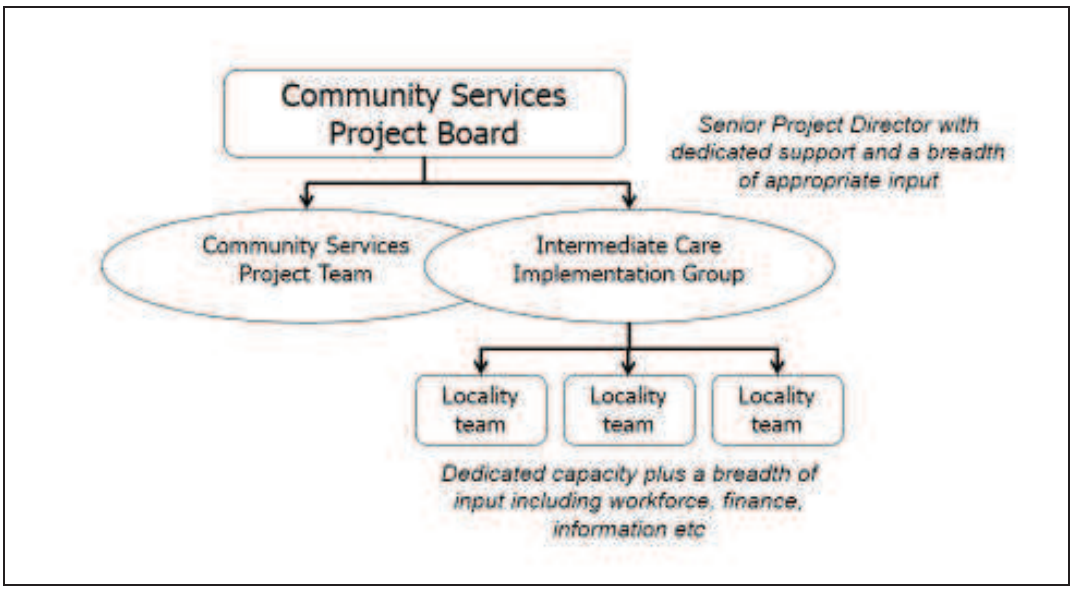


Figure 2 Overview of governance structure

The key elements of this arrangement are:

Senior Responsible Owner

Dr H Laing, ABMU Medical Director is the current SRO for the Western Bay Community Services Project and will continue in this role.

Western Bay Community Services Project Board

Function: The existing Board currently oversees and is responsible for the delivery of the Improving Community Services Programme of which the Intermediate Tier developments are one key element. It is accountable to the Western Bay Programme Board. The Community Services Project Board will have delegated responsibility from the Western Bay Programme Board to implement this Business Case. Quarterly reporting of progress, or more frequently if the implementation plan varies significantly from this Business Case, will be provided from the Community Services Project Board to the Western Bay Programme Board.

Membership: The current Board has membership from service functions at ABMU (Localities and Mental Health Directorate), the three Local Authorities and the third sector. To ensure it is fit for purpose in its enhanced role, this service membership will be reviewed both in terms of seniority and size for effective decision making. In addition it is proposed to further strengthen the Board with senior finance, corporate and legal representation.

Chair: The Head of Service Neath Port Talbot will continue to chair the Board and retain their ongoing role as project lead for community services.

Programme Director: The recent appointment of a Western Bay Programme Director will ensure significant dedicated time at a senior level is available to the Intermediate Tier Business Case implementation.

Western Bay Community Project Team

Currently there is a Community Services Project team who have co-ordinated the development of the Intermediate Tier service model and this Business Case. This group will continue to have a role alongside the implementation of this Business Case and will continue to develop other community services project areas. They will also ensure that the wider community services work is coordinated with the intermediate tier developments.

Western Bay Intermediate Tier Implementation Group

Due to the size and significance of the investment and the risks associated with it, a dedicated Project Implementation Group will be established to drive forward the Intermediate Tier programme. We recommend that membership should include:

The Western Bay Programme Director	Locality Intermediate Care Change Agents
A senior finance manager	A senor workforce manager
A representative from each of information and performance, communications / engagement, legal and corporate services. These members will have a role in linking with and as appropriate co-ordinating work across colleagues in their respective functions across Western Bay	
ABMU Mental Health Directorate representative	
Two existing Community Services Project team support staff to undertake discrete tasks within the plan and to ensure continued linkage across the range of community service development	

The Implementation Group will be chaired by the Western Bay Programme Director working closely with the Community Services Project lead.

Locality Implementation Teams

A local implementation team will be put in place in each locality supported by the Locality change agent and chaired at a senior level. The precise make-up of these teams will be determined locally but will cover all relevant organisations and functions. Their overarching remit will be to develop and implement a Local Implementation Plan.

8.2 Project Management & evaluation

The scale and pace of change requires that there is a dedicated support in place to deliver the service changes, system and behavioural change and secure the financial benefits identified. The project will be coordinated and driven forward through a Western Bay Programme Office comprised of the staffing identified in the table below:

Staff	WTE	Grade	Cost
Project Manager	1	A4C 8b	£60k
Project Support	1	A4C 5	£30k
Locality Change Agents*	3	A4C 8a	£155k
Senior Finance	0.5	A4C 8a	£26k
Senior Workforce	0.5	A4C 8a	£26k

Table 22 Proposed project management resource

* Drawn from social care, community health and mental health

The proposed cost of this support is therefore proposed as being £297k. This represents just under 7% of the investment being sought from the Welsh Government in year 1 of the programme. In addition there will need to be provision for accessing legal services.

Establishing the baseline and monitoring impact from day 1 of the project will be a key requirement of the project team. This essential part of any evaluation process will then be supplemented by an externally commissioned evaluation of the programme. A further indicative sum of c.£130k (3% of year 1 investment) is suggested. The costs associated with this work will, in year 1, be a call on the non-recurrent element of the Welsh Government Intermediate Care Fund. Means of providing continuing support to this infrastructure will need to be factored into the second and third year of the programme, albeit at a reducing level toward the end of the programme as the new services become part of normal business.

8.3 Financial Governance

If the bid to the Welsh Government Intermediate Care Investment Fund is successful it is a requirement that these resources are delegated to the relevant Local Authority. Deployment and monthly monitoring of this fund will be overseen jointly by identified Local Authority and ABMU senior finance staff with regular reporting to the Western Bay Community Services Project Board. Existing financial agreements for the virement of funds held by Local Authorities for spend on health components of the Intermediate Tier will be used to enable draw down. This will facilitate risk sharing and will dovetail with other required processes. The Western Bay Programme Board will need to satisfy themselves that appropriate existing mechanisms are appropriate for this purpose in the context of the Intermediate Tier investment outlined in this business case.

During 2014/15 detailed work will be undertaken by finance leads on the mechanisms necessary for the use and management of the fund in future years. Sustainability of the programme is reliant on the identification of direct savings emerging from the

programme, which will enable other resources, including in particular cost savings in health and social care as a result of the investment in the intermediate tier, to be incorporated into a future pooled fund arrangement from April 2015. A formal agreement will be put in place signed off by the Western Bay Programme Board.

8.4 Impact monitoring

As noted above, the identification of direct impact and savings from investment in the intermediate tier has been identified and a value determined for this benefit. This is described in section 7 of this Business Case. What will be required from day 1 of implementation is a clear framework that reflects these assumptions and a weekly monitoring process for activity levels in each component of the intermediate tier at a locality level. Critical to the sustainability of the work, therefore, is the impact that this activity achieves. At six months the programme will be reviewed so as to indicate the extent of the impact and savings with a view to informing 2015/16 savings transfers to ensure ongoing support for service development.

8.5 Risk management

The implementation programme is not without its risks. The table below provides an initial risk assessment and the management approach to each.

Risk	a) Likelihood (scale of 1-6)	b) Impact (scale of 1-6)	Score (a x's b)	Risk management (where the risk score is 8 or higher)
Political				
That LA members and ABMU Board members will not give full support	2	6	**12**	Briefings have been prepared and clarity of message is being worked on.
That the Williams report causes a reluctance to proceed	1	4	**4**	
Financial				
That the new services, whilst achieving the necessary increased activity will, nonetheless, not achieve the impact, i.e. the improved outcomes for people	2	4	**8**	Care has been taken to evidence impact from similar schemes elsewhere and to be conservative in the impact anticipated.
That the anticipated savings cannot be identified	2	5	**10**	Existing modelling work has provided clear targets for quarterly impact. The business case therefore clearly identifies the unit cost/benefit of each unit of impact. These have also been varied to provide an indication of the implications of not achieving the full impact anticipated. The approach to performance management will ensure a tight grip is maintained on this.
That savings cannot be released	3	5	**15**	Engagement of finance leads and operational managers in the implementation process will retain a focus on the need to release savings.

Risk	a) Likelihood (scale of 1-6)	b) Impact (scale of 1-6)	Score (a x's b)	Risk management (where the risk score is 8 or higher)
That LA CIPs and HB savings plans make the provision of additional bridging money unachievable.	2	4	**8**	The business case clearly identifies the level of further bridging and a variety of sources are being explored for this to cover the possibility of a longer time to achieve savings and impact than envisaged.
That agreement cannot be reached between all parties on the 'rules' for recycling of savings from health and social care to sustain the intermediate care developments	2	4	**8**	During the first year of the programme existing arrangements for the virement of funds will be relied upon. Work will be undertaken to determine common ground as to when a piece of activity results in a cash releasing saving.
Service				
That it will take longer than envisaged to establish links with the wider system to enable new referrals to be made	2	2	**4**	
That confidence in the enhanced intermediate care services is lacking within the consultant and primary care workforce	2	5	**10**	Involvement of key clinicians in the development of the service model and aligning the intermediate care developments with proposed developments in medical staffing.
Inconsistency in medical leadership across ABMU could stall implementation	4	2	**8**	A medical workforce plan is being developed as a priority.
That the level of behavioural and cultural change required across the whole system is such that it cannot be fully achieved on the required timescale to deliver the service changes and financial savings	2	4	**8**	The implementation programme will be accompanied by a workforce development and training programme to be agreed by all parties.
That there will be an adverse impact on core community services	3	3	**9**	Alignment of project teams across Community Services with a remit to continue the development of on-going services in the community in such a way as to dovetail with the intermediate care implementation

Risk	a) Likelihood (scale of 1-6)	b) Impact (scale of 1-6)	Score (a x's b)	Risk management (where the risk score is 8 or higher)
That patient pathways, having been redesigned for increased intermediate care activity, will find other bottle-necks in the system	3	3	**9**	The ongoing use of a systems modelling approach to understanding and mapping patient pathways and the needs of patient cohorts will support the learning and understanding necessary to recognise and address this risk.
That new services will attract unmet demand rather than those most in need of intermediate care	4	2	**8**	Criteria for access to intermediate care services will be clearly defined and the expectation of significantly improved outcomes through the impact monitoring will reinforce this requirement.
Implementation				
That project management capacity is not adequate or senior enough to enable the changes	2	4	**8**	An additional 5% is being invested in project management capacity at a levels with the most senior position being answerable directly to the W Programme Board
Workforce				
That recruitment to key roles is not possible	4	3	**12**	Previous experience in recruiting to stepped changes in services will be drawn on and discussions entered into with the local education provider to secure fast track training or development for cohorts of staff to fill key roles
That recruitment will have a detrimental impact on other providers (private dom care, nursing, residential homes)	2	3	**6**	
That the plans do not dovetail with Health Board medical workforce plans	2	2	**4**	

Appendix 1: Strategic Consequences

1 Introduction and scope

1.1 The wider impact of proposed intermediate tier investment

Doing things in one part of the system will have inevitable consequences elsewhere. Figure 3 provides an illustration of the wider context in which the investment in intermediate services is expected to have an impact. This appendix details the impact (activity and cost) and strategic consequences of the proposed investments with regards to the following sectors:

- General hospital
- Care Homes
- Homecare
- Ongoing community support
- Specialist mental health services

It draws on the modelling work undertaken across Western Bay in relation to frail older people and people with dementia. Whilst highlighting the specific impact of the proposed investment it also identifies where further impact could be achieved through the implementation of further developments as part of a broader programme of transformation for community services.

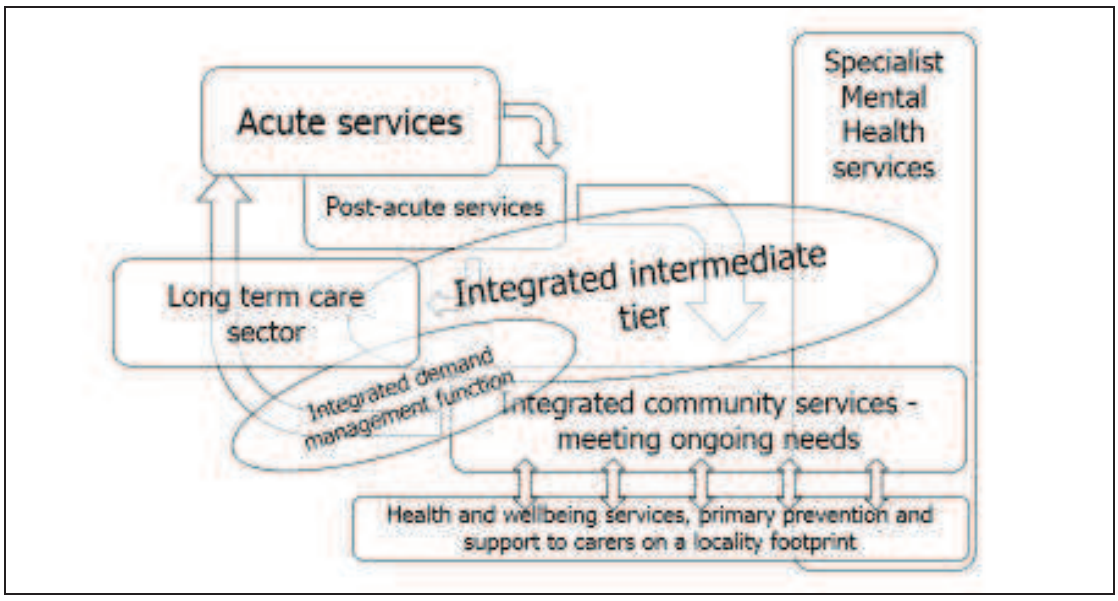


Figure 3 The wider system on which changes in the intermediate tier will impact

The development of the intermediate tier cannot be seen in isolation and sits within a broader context. Nationally and locally other policies, plans and service redesign will also impact on the health and social care system. These are identified in this paper to reflect the many other factors that will impact on local activity, cost and system design. Developing the intermediate tier will have impacts on the demand for care and support, including:

In ongoing community services:

- Reducing new homecare packages via signposting by a common access point and increased levels of intake intermediate care;

- Reducing escalation in existing homecare packages via increased levels of review intermediate care;
- Reducing new permanent care home placements via increased levels of review intermediate care.

In the hospital sector:

- Reducing unscheduled admissions to hospital (and therefore bed days) via increased diversion to Rapid Response;
- Reducing post-acute hospital stays for unscheduled, scheduled and surgical patients via increased step-down domiciliary intermediate care.

As each locality currently delivers intermediate care to varying levels then the investment proposed will have a differential impact on the whole system in each locality.

1.2 The impact of community and mental health programmes other than intermediate tier services

Planned investment in the intermediate tier will deliver significant reductions in demand for other parts of the whole system in each locality compared to the 'do nothing' scenario. These changes in demand will be experienced by both health and social care services, but to varying degrees. Integration will be required to maximise the extent to which resources can be released by the investment made. However, optimising the intermediate tier cannot, on its own, deliver the level of savings currently required for the system as a whole (especially if investment funding is only available on a non-recurring basis, meaning that recurring funding for the intermediate tier must be found from elsewhere in the system).

The planned service changes detailed in the investment plan form part of a broader transformation programme for community services that will be detailed in a full business case in January 2014. Implementation of these will be crucial to contributing to the savings required. The modelling work to date has included developing estimates of the impact across the system of a number of specific service developments which form part of this transformation programme. These are:

- Reducing lengths of stay in general hospital for acute unscheduled care;
- Reducing lengths of stay in general hospital for post-acute care;
- Delivering enhanced home care for 6 months to delay admissions to permanent funded care home placements;
- Increasing the provision of extra care housing for new clients and for clients transferring from permanent funded care home placements.

Detailed modelling work has also been undertaken across Western Bay with regard to people with dementia and the services to support them. Areas identified for possible development would impact on:

- Reductions in general hospital unscheduled admissions for people with dementia;
- Reductions in general hospital lengths of stay for people with dementia;
- Reductions and delay in care home admissions for people with dementia;
- Reduction in care home admissions direct from general hospital for people with dementia.

1.3 Impact of Wider System Changes

Other factors outside the development of the Intermediate Tier will impact on the health and social are system, the key areas are outlined below. The modelling work

has not taken these into account explicitly although it is clear that they will be significant in taking this programme forward.

1.4 Welsh Government

Three key current Welsh Government policies will shape the future of health and social care provision locally:

The Social Services and Wellbeing Bill currently going through the Welsh Assembly. This will introduce national eligibility criteria, a national outcomes framework and equal rights for carers to those they care for.

A framework for delivering integrated health and social care for older people with complex needs – which sets out the essential requirements re the standard model for Wales.

Integrated assessment, planning and review arrangements for older people (December 2013). To be implemented immediately, this sets out the duties and responsibilities on health and social care services to provide integrated arrangements for assessment and care management for older people. It replaces 'Creating a unified and fair system for assessing and managing care in respect of people aged 65 years and over'.

In addition **the *Commission on public service governance and delivery*** due to report early in the new year will potentially impact on the local government organisational arrangements in Western Bay. This could facilitate the development of an integrated intermediate tier but at the same time might lead to short term planning blight.

These set the current context for the development of an integrated intermediate tier of services. Local implementation will have implications and impacts across the sectors covered in this paper beyond those identified in relation to the development of the Intermediate Tier. The consequences of developing the intermediate tier should not therefore be considered in isolation but forming a part of a bigger jigsaw.

1.5 Western Bay

Locally a number of factors will also impact on the delivery of services and have consequences for the local system beyond those identified in this paper. Key areas include:

Changing for the Better programme that incorporates 9 work projects. Key projects pertinent to the development and impact of an integrated intermediate tier relate to Rapid Access, Hospitals usage and outpatient modernisation. These will impact on hospital and community activity levels and costs and have broader consequences for the health and social care system.

South Wales Programme is looking at the future of hospital sites across South Wales. This will potentially have implications for the nature of the services delivered by Bridgend in the future.

Financial Constraints Across the health and social care system in Western Bay there is a requirement for financial constraint and budget reductions. This means organisations will be making individual decisions as to how to manage this situation. This will mean some reductions in current services presenting a significant risk to the local health and social care economy. There is a danger that any service / staff reductions in current services will impact on the ability of the intermediate tier to deliver the activity and cost changes identified in this paper.

2 Strategic consequences for the Acute General Hospital

2.1 Changes in activity

In analysing current patterns of hospital usage across Western Bay, it has proved helpful to consider each patient's journey in two stages:

- The acute phase - the period from admission to a DGH until the end of active treatment
- The post-acute phase: time spent by the patient in a hospital bed after the end of the acute phase. This is likely to be in a different location from the acute phase, and may involve more than one transfer between hospital sites or wards. It may take place in a DGH, a community hospital, or a combination of both.

Post-acute care may be delivered after a planned or surgical admission. It is important to note that, at this stage, these have been excluded from the analysis below.

2.2 Unscheduled admissions to general hospital

The table below (based on over 65's unscheduled care activity for the 7 month period September 2012 – March 2013) illustrates the variation in the number and rate of unscheduled general hospital admissions for the residents of each of the three localities.

Locality	Admissions pa	Rate pa per 1,000 over 65s	Rate pa per 1,000 frail older people
Bridgend	3,603	139	1,294
NPT	3,807	139	1,203
Swansea	6,661	150	1,400

Table 23 Current unscheduled over 65's general hospital admissions

The proposed intermediate tier developments will have an impact on unscheduled over 65 admissions as detailed in the table below. This compares the number of admissions under the 'do nothing' scenario with the number the modelling work estimates if the proposed changes in the intermediate tier are implemented.

	2012/ 13	2013/14	2014/ 15	2015/ 16	2016/17
Bridgend					
With IT developments	3603	3700	3605	3612	3704
Do Nothing	*3603*	*3700*	*3800*	*3904*	*4004*
NPT					
With IT developments	3807	3877	3855	3876	3936
Do Nothing	*3807*	*3877*	*3941*	*4003*	*4065*
Swansea					
With IT developments	6661	6778	6399	6273	6374
Do Nothing	*6661*	*6778*	*6893*	*7009*	*7122*

Table 24 Unscheduled over 65 admissions (annual at year end) with and without planned intermediate tier developments

Whilst unscheduled admissions are a little higher in 2016/17 than currently in both Bridgend and Neath Port Talbot, as a result of the investment in the intermediate tier,

they are well below those pertaining under the do nothing scenario. For Swansea the modelling suggests an absolute reduction in the number of unscheduled admissions in 2016/17 over the 2012/13 baseline but by then they are again on a slightly upward trend.

2.3 Impact of Intermediate tier development on hospital bed occupancy

The modelling suggests that the implementation of the planned changes to the intermediate tier will have the impact on 'average' occupied beds relative to the do nothing scenario as detailed in the table below. The figures represent snapshot occupancy at the end of March each year.

The figures suggest that, with enhanced intermediate care in place, the number of acute phase occupied beds will remain broadly the same over the period to 2016/17, mitigating the impact of demographic growth. As a result of the implementation of increased step down intermediate care the modelling suggests total Western Bay average post-acute bed occupancy will fall in absolute terms.

Bridgend	**March 13**	**March 14**	**March 15**	**March 16**	**March 17**
Acute phase beds occupied (over 65 unscheduled medical)	115	118	112	115	118
Do nothing comparator	*115*	*118*	*121*	*124*	*127*
Post-acute and step up beds occupied (all sources of acute admission)	44	45	31	32	33
Do nothing comparator	*44*	*45*	*46*	*48*	*49*
Neath Port Talbot	**March 13**	**March 14**	**March 15**	**March 16**	**March 17**
Acute phase beds occupied (over 65 unscheduled medical)	97	98	97	98	100
Do nothing comparator	*97*	*98*	*100*	*102*	*103*
Post-acute and step up beds occupied (all sources of acute admission)	150	152	109	110	112
Do nothing comparator	*150*	*152*	*155*	*157*	*159*
Swansea	**March 13**	**March 14**	**March 15**	**March 16**	**March 17**
Acute phase beds occupied (over 65 unscheduled medical)	209	212	193	196	199
Do nothing comparator	*209*	*212*	*216*	*219*	*223*
Post-acute and step up beds occupied (all sources of acute admission)	91	93	61	62	63
Do nothing comparator	*91*	*93*	*94*	*96*	*97*

Table 25 Occupied hospital beds (over 65 unscheduled medical acute, all-cause over 65 post-acute, and step up) with and without intermediate tier developments by locality of residence of patient

2.4 Acute sector cost changes

The projected reductions in admissions, and the shift of post-acute care from hospital to the community, resulting from investment in the intermediate tier provides the potential for reductions in hospital costs, or alternatively for the redeployment of resources to other parts of the hospital system. The extent to which potential cost savings can be realised depends on the ability of resources to be released or shifted.

The investment case assumes an average delay of 6 months between any reductions in activity resulting from improvements in the intermediate tier to the release of costs for savings or redeployment.

The table below summarises the projected change in spend in the hospital sector, by locality, on this basis, compared to the 'do nothing' position. Note that this table includes only those costs assumed to be transferrable (hotel costs and ward staffing costs).

Change in spend	2013/ 14 £000's	2014/ 15 £000's	2015/ 16 £000's	2016/ 17 £000's
Bridgend				
With Intermediate Tier development – acute phase	£125k	£15k	£11k	£132k
With Intermediate Tier development – post acute phase	£40	-£123k	-£331k	-£402k
With Intermediate Tier development – total hospital sector	**£165k**	**-£108k**	**-£320k**	**-£271k**
Do Nothing	*£165k*	*£209k*	*£447k*	*£622k*
NPT				
With Intermediate Tier development – acute phase	£71k	£52k	£70k	£130k
With Intermediate Tier development – post acute phase	£56k	-£234k	-£641k	-£798k
With Intermediate Tier development – total hospital sector	**£127k**	**-£182k**	**-£571k**	**-£668k**
Do Nothing	*£127k*	*£122k*	*£301k*	*£413k*
Swansea				
With Intermediate Tier development – acute phase	£151k	-£148k	-£396k	-£432k
With Intermediate Tier development – post acute phase	£55k	-£285k	-£790k	-£994k
With Intermediate Tier development – total hospital sector	**£206k**	**-£432k**	**-£1,186k**	**-£1,426k**
Do Nothing	*£206k*	*£203k*	*£508k*	*£710k*

Table 26 Projected change in spend in the hospital sector by locality compared with the do nothing scenario

For Western Bay as a whole, investment in the development of the intermediate tier is projected to generate a cumulative reduction in hospital costs of £5.2 million over the 3 years from April 2014 to March 2017. This compares to additional cumulative costs of £3.5 million in the equivalent period in the 'do nothing more' scenario, i.e. assuming that hospital activity would otherwise have risen in line with demographic change in each locality.

2.5 Further potential changes to the hospital sector

It is only through implementation as a whole of all aspects of the identified programme of transformation for community services that full benefit identified through the modelling work is to be achieved across the system. Within the Business case currently under development further specific changes that have an impact on length of stay in general hospital have been identified and modelled. These are:

- A reduction of 2 days in the average stay in the acute phase (note that if all hospitals matched the current 'best' this would equate to a reduction of 1.4 days);

- A reduction of 5 days in the average stay in the post-acute phase (note that if all sites matched the current 'best' this would equate to a reduction of 4.5 days in DGHs and 6.9 days in community hospitals).

Changes in activity, and potential savings realisable through these system changes, are not included in this paper. The modelling work to date however indicates that these savings could amount to £1.1M across Western Bay in 2014/15 rising to £1.8M by 2016/17. Some of these savings may, however, be double-counted in existing hospital redesign programmes and/or work on managing long term conditions differently.

Two potential developments for services and support to people with dementia are being considered. These are:

- Enhancing memory assessment and associated ongoing support to increase the proportion of people with dementia with a diagnosis and in touch with services
- Enhancing general hospital and care home mental health liaison.

If implemented they will impact on general hospital admissions, length of stay and care home admissions. The modelling undertaken suggests the impact could be significant.

It needs to be noted that at this point no explicit modelling work has been undertaken to scale the potential double counting in savings identified between interventions to support fail older people and those to support people with dementia. As identified earlier there is a significant overlap between these cohorts of people.

Other programmes of work underway within the acute sector locally will impact on hospital admissions and bed occupancy over and above those described in this Intermediate Tier Investment Plan. Key areas are:

- Hospital services redesign to reduce bed occupancy to 85% which will necessitate changes in clinical approaches away from admission and increases in those supported in the community;
- Programmes of work around unscheduled care and patient flows.

Changes in activity, and potential savings realisable through these system changes, are outside the scope of the modelling work undertaken.

2.6 Strategic consequences of developing the intermediate tier for the acute sector

- Investment in the intermediate tier will produce a requirement for additional community-based staff. Locality implementation planning will include skill mix analysis and the identification of the mix of staffing required for an integrated intermediate tier service. This will lead to a significant need for the redeployment, and potential training and re-skilling, of some hospital ward staff.
- Shifting a proportion of post-acute care from hospital to community will require a change in clinical approach which will facilitate earlier discharge and a 'discharge to assess' mentality.
- Local culture and patient/ carer expectations may currently regard hospital care as 'the safe option' given the long stays that are the norm for many older people. Increased diversion to community services and reduced lengths of stay may challenge this view. Communications will need to be developed to reassure patients, carers and potential referrers that the new ways of working represent safe, effective practice and to provide a clear picture of what people can expect from the transformed system.
- It will require patients receiving post acute care in the community to have access to the same range of diagnostics, medical and/or therapy inputs etc as

is currently the case for post-acute patients in hospital. This will require changes in working patterns, referral systems and so forth.

- As an increasing proportion of people are supported in the community the overall acuity of patients who are admitted to general hospital will increase with implications for staffing and skills requirements.
- Longer term projections of demographic change will continue to exert upward pressure on demand for hospital beds for years to come. The proposed transformation programme represents a one-off shift in the service model and should not be seen as a panacea for managing long term demand. Commissioning strategy for hospital services will need to incorporate additional measures to set against this demographic pressure. Current examples include:
  - The development of 'hospital at home' services to support people with enhanced input from community health services
  - Work on future hospital capacity requirements which models the potential impact of other changes in hospital egg improved medicines management, improved bed management etc.

3 Strategic consequences for Care Homes

The information and projections in this section refer to total levels of LA funded long term care placements. Figures for each locality are for all funded placements, including both those delivered by internal provider arms of the Council and those delivered through contracts with external providers for the private and/or voluntary sector. Neither continuing health care patients nor people self-funding their long term placement are included.

3.1 Baseline activity

The three local authorities each fund people in long term care home placements according to their local policies on eligibility. The number of placements in long term care homes at March 2013 and the rate of admissions per 1,000 frail older people are given in the table below.

	People supported in a care home	People supported in a care home per 1,000 frail older people	Admissions to long term care per 1,000 frail older people
Bridgend	494	177	1.36
NPT	624	197	1.90
Swansea	996	209	2.12
Western Bay	**2,114**		

Table 27 **C**are home admissions and placements by locality

3.2 Impact of intermediate tier development on long term care home activity

There are two potential levels of impact on care home admissions, dependent on the functioning of the intermediate tier.

- The impact of review reablement on the rate of admissions to care homes, leading to a marginally lower rate of care home admissions and a small downward pressure on funded care home places

- More significantly, the introduction of care home intake for a proportion of people currently admitted to a care home following a hospital admission.

The modelled intermediate tier development programme results in a reduction in new admissions to care homes, which will feed through over time into a reduction in average occupancy.

The table below shows projected year end occupancy levels by locality, compared to the 'do nothing' scenario:

Bridgend	**March 13**	**March 14**	**March 15**	**March 16**	**March 17**
Funded care home placements	495	499	486	471	463
Do nothing comparator	*495*	*499*	*505*	*513*	*523*
Neath Port Talbot	**March 13**	**March 14**	**March 15**	**March 16**	**March 17**
Funded care home placements	626	632	600	568	553
Do nothing comparator	*626*	*632*	*639*	*646*	*654*
Swansea	**March 13**	**March 14**	**March 15**	**March 16**	**March 17**
Funded care home placements	998	1005	960	916	894
Do nothing comparator	*995*	*1005*	*1014*	*1025*	*1037*

For Western Bay as a whole, the projected impact by March 17 of intermediate tier development on the care home population is a reduction of 205, compared to an increase of 96 for the 'do nothing' scenario.

Changes in costs associated with the impact of intermediate tier development on care homes are included in the overall modelled financial impact for social care set out below.

3.3 Further potential changes to the care home sector

The overall transformation programme includes a proposal to introduce enhanced homecare in order to delay care home admission which, when implemented, will impact further on the number of placements. The modelling work has been used to assess the impact of an increased level of home care (150% of existing weekly contact hours) to people at the point where they would otherwise transfer to a long term care home, thereby delaying the transfer to a care home, and reducing the time supported in a care home, by 6 months.

Further, the transformation programme includes the potential development of additional extra care housing placements in order to reduce new care home placements, and to allow for the transfer of some people currently in a care home. The modelling work has been used to determine the potential impact of the provision of extra care housing placements for 25% of people who would otherwise enter long term care homes for the first time, and the transfer of 5% of existing residential care home clients to an extra care housing placement.

The impact of these changes is not included in this paper but will form part of the overall business case.

The dementia modelling work has assessed the impact of a number of service interventions. Of the development proposals increasing diagnosis through memory assessment and provision of ongoing support, and the introduction of general hospital

mental health liaison will impact on the number of people with dementia admitted to a care home. These impacts are not included in this paper.

Whilst the developments in the Intermediate Tier will have some impact on the overall number of people supported in care homes there are other factors that will have an influence. There is already evidence locally that the national policy to place a £50 cap on homecare charges has resulted in fewer people going into long term care as families recognise the financial benefits of people being supported to remain at home . The potential impact of this policy is outside the scope of the modelling work undertaken.

3.4 Strategic consequences

There are a number of consequences for the care home sector resulting from the proposed development of the intermediate tier:

- Changes to the care home market as demand and usage change with placement numbers decreasing but increases in complexity, and a shift to short term models of care through residential reablement;
- The potential for providers to seek increases to fees as the mix of clients and service delivery changes;
- An increase in the quantity and nature of equipment required by care homes to support clients with more complex needs ;
- The potential for changes in the behaviour of self-funders in terms of long term placements as they have access to intermediate care will require a further analysis of likely changes in levels of self-funding;
- A need for effective liaison between the intermediate tier (who will act as gatekeepers to new long term care placements through the review function) and care home providers, to enable the right 'fit' between client and placement and the minimisation of moves between placements over time;
- There is the potential that families and carers will still perceive an admission to a care home as the 'safe option'. The 'story' around intermediate tier will need to be communicated effectively to service users, families and carers and the public at large.

These changes bring significant consequences for the commissioning and contracting of long term care with the need for:

- Development of a proactive approach to market management to encourage providers who are able to support complex clients for longer and deliver new models of care;
- A strategic approach to commissioning and the development of flexible contracts that can adapt to changing requirements over time;
- Rigorous approaches to quality assurance, monitoring and the escalation of concerns to ensure that all care delivered is of an appropriate standard and quality as specified in contracts. There has been an increase over time in challenges and litigation, serious case reviews and safeguarding issues with regards to care home placements; the potential for further escalation of these as the demands and expectations of care home providers increase needs to be mitigated;
- A strategic approach to workforce development across all providers, both independent and in house, so that staff have the skills and competencies required to deliver the new models of care, meet the more complex needs of clients and attain the quality standards that will be required. The scale of the challenge this creates should not be under estimated.

4 Strategic consequences for homecare

The information and projections in this section refer to total levels of homecare provision. Figures for each locality are for ongoing packages of homecare, including both those delivered by internal provider arms of the Council and those delivered through contracts with external providers from the private and/or voluntary sector.

4.1 Baseline homecare activity

The three local authorities each fund support to people at home provided in house or from independent providers in line with their local policies on eligibility. The number of people supported at home at March 2013 and the baseline rate of new starts per 1,000 frail older people is given in the table below.

	People supported at home	People supported at home per 1,000 frail older people	Annual new home care starters per 1,000 frail older people
Bridgend	721	259	166
NPT	772	244	132
Swansea	1,282	270	133

Table 28 People supported at home and new homecare starts

4.2 Impact of intermediate tier development on homecare activity

The modelling suggests that the implementation of the planned changes to the intermediate tier will tend to reduce the number of people supported at home, through a combination of increased signposting by a common access point, increased intake intermediate care with a resulting decrease in new homecare packages, and an optimised review function which will end homecare packages that are no longer required to support the client's ongoing needs. The table below shows projected end of year snapshots of homecare clients, and compares them to the do nothing scenario.

For Western Bay as a whole, the proposed investment in the intermediate tier would result in a reduction of 161 homecare clients between March 2013 and March 2017, compared to an increase of 187 under the 'do nothing more' scenario.

In addition to the change in overall numbers, investment in the intermediate tier would be expected to deliver a change in the average level of homecare package delivered to clients. If the outcome of optimised review function is (as expected) to reduce levels of ongoing care where appropriate, this would be expected to result in a lower average package of care across all clients than would be the case in the 'do nothing more' scenario.

Bridgend	**March 13**	**March 14**	**March 15**	**March 16**	**March 17**
Total home care clients	726	738	696	679	679
Do nothing comparator	*726*	*738*	*756*	*776*	*798*
NPT	**March 13**	**March 14**	**March 15**	**March 16**	**March 17**
Total home care clients	776	784	755	748	747

Do nothing comparator	*776*	*784*	*794*	*806*	*817*
Swansea	**March 13**	**March 14**	**March 15**	**March 16**	**March 17**
Total home care clients	1287	1299	1304	1325	1345
Do nothing comparator	*1287*	*1299*	*1314*	*1333*	*1352*

Table 29 Home care clients all providers with and without intermediate tier developments

Changes in costs associated with the impact of intermediate tier development on homecare are included in the overall modelled financial impact for social care set out below.

4.3 Strategic consequences of developing the intermediate tier for home care

There are a number of consequences in relation to homecare that result from the proposed development of the intermediate tier.

- Changes to the provision of home care as a result of investment in the intermediate tier will require a robust homecare commissioning strategy to be developed in each locality. This would need to specify the scale and nature of home care provision required from both in house and independent providers. There will a need for proactive market management to develop the home care market to meet the more sophisticated requirements demanded by the new service model. Ways of incentivising the market need to be developed;
- Changes in homecare requirements will necessitate a review of both the fees paid to providers and of charging to clients ;
- Rigorous approaches to quality assurance, monitoring and the escalation of concerns to ensure that all care delivered is of an appropriate standard and quality;
- There will be an increased demand and associated cost for assistive technology and the need for specialist equipment advice and support to be available to providers. The additional costs of using assistive technology to support people with dementia needs to be recognised;
- There will need to be a major up skilling of staff across all providers to meet the changing requirements of homecare delivery;
- Care managers will need to move to developing care plans that are outcome focused rather than based on hours of service provision;
- The will be a need for improved processes for matching clients with providers, aimed at minimising delays (and consequent bottlenecks in discharging clients from the intermediate tier);
- Effective communication with home care providers will be essential if the benefits of the development of the intermediate tier are to be achieved. Providers will need to change their approach to the ongoing provision of support, identifying potential changes in needs and timely referral for review Intermediate Care.

5 Strategic consequences for wider social care costs

5.1 Note on this section

This section brings together the projected change in costs for social care associated with the proposed investment in the intermediate tier. This projected change is made up of three elements:

- Changes associated with long term LA funded care home activity.
- Changes associated with homecare activity.
- Changes associate with the transfer of costs for existing activity to form part of a new common access point function within the intermediate tier: the assumption in the investment plan is that 50% of the costs of a full service SPA are already within social care budgets and will be transferred to the intermediate tier alongside the extra investment required to fund the SPA.

5.2 Social care cost changes

The table below summarises the projected change in spend in the social care sector, by locality, compared to the 'do nothing' position.

	2013/ 14 £000's	2014/ 15 £000's	2015/ 16 £000's	2016/ 17 £000's
Bridgend				
Change in annual spend on social care	153	-16	-400	-863
Do nothing comparator	*153*	*364*	*620*	*909*
NPT				
Change in annual spend on social care	-17	-619	-1210	-17
Do nothing comparator	*566*	*841*	*1,078*	*566*
Swansea				
Change in annual spend on social care	356	52	-946	-1409
Do nothing comparator	*356*	*641*	*957*	*1,311*

Table 30 Projected change in spend for social care compared with the do nothing scenario

For Western Bay as a whole, investment in the development of the intermediate tier is projected to generate a total decrease in social care costs of £5.4 million over the 3 years from April 2014 to March 2017. This compares to additional costs of £6.8 million in the equivalent period in the 'do nothing' scenario, i.e. assuming that care home and homecare activity continues to rise in line with demographic change in each locality.

6 Strategic consequences for Ongoing Community Support

6.1 Service changes

Within this context ongoing support covers as wide range of services and support functions available in the community through universal services, community networks, the third sector etc. Some aspects of these services will require reshaping as explicit intermediate tier functions are developed. The modelling work undertaken has not explicitly estimated the impact in activity terms of changes in the intermediate tier to these services / functions.

The planned transformation programme will see this support complimenting primary care at a locality level in case finding and care management for those needing support due to increasing frailty or dementia (i.e. district nursing, chronic disease management). They will take full advantage of the opportunities created by assistive technology and advise and support people to access additional support from the independent and voluntary sector.

6.2 Strategic consequences of developing the intermediate tier for ongoing community support

There are a number of consequences in relation to ongoing community support that result from the proposed development of the intermediate tier:

- There will be a significant increase in the number of people with complex needs supported to remain in their own home. Maintaining them at home will require a greater use of assistive technology. Community staff will need to understand the role these technologies can play and have easy access to them. The development of a local approach to the development and implementation of these technologies and appropriate funding will be required;
- The requirement for community equipment, beds, hoists and more advanced equipment will increase. This will require funding but also effective processes to be in place to ensure equipment is provided and, where necessary, installed promptly if hospital admission is to be avoided and early discharge facilitated. Effective links will need to be in place with the third sector for any housing adaptations necessary;
- The effectiveness of an integrated Common access point in managing demand will be influenced by the extent to which non-public sector support and services are available within the local community to which people can be signposted. Currently third sector support is relatively underdeveloped. An approach to stimulating and, as necessary, investing in the third sector to provide low level support will be required;
- The development of the intermediate tier will necessitate changes in the working practices of the District Nursing Service, for example in new areas such as medicines management. There is already a shortage locally of District Nurses and the need to recruit and train will create issues for implementation timing;
- Increasing numbers of frail older people will require some short term assessment / reablement to be undertaken in a domiciliary setting in the future rather than in a hospital or care home bed. Review reablement will be crucial to prevent gridlock in the system and will require a change of approach by professionals with 'review' becoming part of their day to day activities;
- There will be a need to enhance the workforce and recruitment of additional staff as the intermediate tier is developed. An approach to the recruitment and transfer of staff will be required that can overcome the current delays experienced in recruitment. This is critical due to short term additional investment being available for one year only;
- The development of explicit intermediate tier functions will necessitate changes in current services, teams and staffing. The potential for 'disruption' as changes are introduced are high and for performance to temporarily dip. A robust approach to organisational development as part of the programme of implementation will be required;

- The service developments create the opportunity for enhancing community based therapy services. The longer term goal would be to see therapy services as part of the locality networks.

7 Specialist Mental Health Services

7.1 Specialist support to the intermediate tier

As identified in the Investment Plan there is a significant cohort of older people who are both frail and have dementia. There are also significant levels of other mental health problems (depression, anxiety, alcohol issues etc) in the older population. The proposed service model for the intermediate tier will see mental health link workers based in the Common access point. This will facilitate signposting to the broad range of support available in the community, the spread of knowledge and expertise within the staff team and reduce inappropriate referrals and admissions. It will allow for timely assessment of older people with mental health needs and onward referral as necessary to specialist services.

A support and stay team will also be in place for people with mental health problems as part of the Rapid Response function. These changes will have an impact on the work of the Older Peoples CMHTs strengthening their focus on those with the most complex needs.

The developments will be implemented in a phased approach starting initially with mental health professional expertise being available to the Common access point and moving over time to mental health workers embedded within the intermediate tier. Development of the current support and stay service will initially focus on a levelling up of current provision to those with complex needs across the Western Bay area before further extension to cover those with mild to moderate mental health problems.

The impact of these developments on activity and costs in mental health services has not been modelled explicitly to date.

7.2 Proposals for developing further specialist support to people with dementia

Detailed modelling work on dementia has adopted a similar approach to the work on frail older people looking at the impact of demographic change and thus the prevalence of dementia on service activity and costs if no new action is taken and assessing the impact of specific service interventions. The outputs from this work are detailed in full in the report that has been prepared for Western Bay Partners on the dementia project.

The dementia modelling work has identified in particular the impact of:

- Increasing the number of people with dementia with a diagnosis and the provision of ongoing community based support to them and their carers;
- The implementation of general hospital and care home mental health liaison across Western Bay.

These suggest there are potential savings to be made compared with the do nothing scenario in terms of hospital and care home admissions and reductions in hospital length of stay if these services are developed further.

Beyond these financial savings, specialist support to care homes should assist in improving the quality of care provide as staff become more able to meet the requirements of people with dementia, particularly those with behavioural difficulties. Locally the lack of the development of the care home market and its poor response in meeting the needs of people with dementia is reflected in the number of extended assessment beds for people with dementia who meet Continuing Health Care criteria

that are provided by ABMU. Over time improvements in care home quality through liaison may allow the market to develop to the extent that it is possible to commissioning more specialist dementia beds from within the community and so reduce the number of people who are staying long term in an extended assessment beds within a hospital setting.

7.3 Strategic consequences

There are a number of consequences in relation to specialist mental health services that result from the proposed development of the intermediate tier:

- In the shorter term (up to 2 years) there is the potential for increasing demand on mental health support services as mental health professionals supporting the intermediate tier identify unmet demand (depression, anxiety, alcohol issues etc) and additional support to carers (e.g. respite). However, in the longer term this may be balanced by the effect of increases in preventative and early intervention work;
- There is the potential for increasing the proportion of people with dementia who are diagnosed and in touch with services as a result of mental health expertise being available to services focused on the physical health of older people;
- Investment in mental health professionals in the intermediate tier will facilitate the process of CMHTs delivering Part 1 of the Mental Health Measure. It should improve links between mental health services and primary care and facilitate access to primary care mental health services. This will then potentially prevent escalation to secondary care services.

8 Primary Care

8.1 Overview

There are a number of consequences in relation to primary care that result from the proposed development of the intermediate tier:

- Development of the intermediate tier and maintenance of an increased number of people with complex needs in the community will require changes and enhancements to the medical workforce. A medical workforce plan will be required to be developed along with associated additional investment;
- There is a need to review and develop a commissioning approach for primary care services that will support the development of the intermediate tier and the care of frail older people living in the community and in care homes;
- The critical interplay between the development of the medial workforce to support the intermediate tier developments and work currently underway in locality networks with primary care needs to be recognised.

There will be a specific impact in terms of increasing the volume of work being undertaken through intermediate care, as well as growing pressures on "core" primary care services as a result of changing demographics and an increase in the number of patients with complex and co-morbidities.

Proposed changes to the GMS contract that will take effect from 1st April 2014 will support the development of new care models and to encourage practices to work together. There will be a specific focus on the development of care pathways that address emergency admissions and unscheduled care admissions. A local service development programme will require GP practices to participate in three national care pathways covering the early detection of cancer, end of life care and the frail elderly, which is pertinent to the development of this business case.

8.2 Capacity

A joint report produced by the Wales Deanery and the National Leadership and Innovation Agency for Healthcare in July 2012 summarised work undertaken to model the anticipated future supply of new GPs in Wales and to compare it against the most likely levels of future demand. The conclusions of the review indicated that there is likely to be a shortfall in the supply of GPs in the near future.

As a result of the Deanery report, a local workforce analysis has been undertaken within the Health Board. Since the Deanery report was published, there are other factors that are also likely to impact on the supply of GPs including pension and tax changes that are beyond the control of NHS Wales. Other factors that are relevant include an increase in part time working.

Our initial assessment has highlighted the potential shortfall in the number of GPs given predicted retirement patterns and on the basis of the 'known' shortfall in the number of GPs being trained. Earlier retirement patterns, and changes to the GP training programme could result in a markedly worse situation. New workforce models may therefore need to be considered, both to address the 'core GMS work' as well as to address some of the demand factors, such as complexity, increasing number of frail older people, and the need to address the widening gap in health inequalities.

In terms of the development of the intermediate tier there will be a need to consider whether there is sufficient medical manpower available in the community to provide the level required. There is potential to develop new ways of working, and new roles, to support the expanded intermediate tier including the following:

- ‘Expert’ GPs working across practices in network arrangements or within the CRT framework to provide medical support for rapid response services, in particular;
- Practices collaborating to strengthen input into fixed settings of care, e.g. step up/step down provision, particularly support into care homes (partly addressed by proposed to change the current arrangements for providing enhanced care to care homes);
- GP champions at a locality network level – to provide a source of expertise and advice – particularly about the potential alternatives to admission and a source of knowledge about intermediate care services;
- Effective case management and care coordination and the appropriate use of risk stratification tools that will help to identify frailty and put a proactive support plan in place – the potential to look at risk identification in the context of a network model needs to be explored further, and the resourcing of GPs becoming engaged in proactive and anticipatory care planning needs to be considered further.

8.3 Links with GP Out of Hours

As services develop on a 7 day basis, it is important that there is a clear pathway and good communication between a range of unscheduled care services. Maximising the opportunities to keep people within their own homes, avoiding the need for a conveyance to hospital and potential admission will require there to be absolute clarity on the alternative services available (particularly over the weekend) and clear and simple processes to divert or signpost patients to the most appropriate service, as well as the ability to share relevant information in a timely way.

8.4 Governance

It will be essential that arrangements for care co-ordination and medical responsibility are addressed in line with the new model of care. GPs will retain responsibility for the provision of general medical services. New models of community based geriatrician support will provide valuable expertise and advice to GPs. Ensuring an effective interface so that there is clarity about the responsibility for prescribing, care planning, , support for step up/step down provision, information sharing, discharge communication and effective handover of care following intervention is critical.

As new models emerge, for example, GPs supporting the Community Resource Team in an ‘expert GP role, more nurse practitioners working in community settings, the overall governance and responsibility framework will need consideration to ensure that it remains fit for purpose. A lead clinician who is most appropriate to provide the level of support should be identified, this could be a geriatrician, a specialist GP or the patient’s own GP if specialist medical input is not required.

8.5 Integrated Assessment and Review

The role of the GP in supporting the integrated assessment and review process (whether at a locality or CRT level) will need to be explored. The potential for moving towards shared health and social care records will require further consideration, as well as the potential for existing systems to be used to better effective to improve coordination between primary, community and acute settings.

8.6 Access to specialist support

The enhancement of rapid response models, and the move to develop services on a 7 day basis will also have a requirement to ensure that there can be rapid access to assessment and investigative support to enable patients to receive appropriate

diagnosis and treatment, avoiding the need for an admission. This work is being taken forward through the rapid access project (within the C4B Programme).

The potential for patients to be seen in ambulatory care setting should also be explored. This is a key strand in the modernisation plans being taken forward within the Health Board to ensure that there are pathways in place for access to specialist advice, when required. The role of the traditional day hospital and links with intermediate care services need to be further explored.

An effective medicines management plan is also required to ensure that older people can be supported safely at home. This is important as:

- 4 in 5 people over 75 take at least one medication with 36% taking 4 or more;
- Up to 50% of patients do not take medicines as intended;
- Adverse drug events are attributed to 5-17% of hospital admissions;
- Capacity to manage medication becomes complicated by disease states and increasingly complicated regimes;
- Older people have increased adverse drug events;
- Poor medicines management contributes to an increase in unscheduled care and admissions, as well as delayed transfers of care;
- Cost avoidance through improved medicine management and reduced wastage, could potentially free up resources to invest in improved services.

A separate analysis of the potential to enhance existing pharmacy models has been scoped and a discussion on resourcing these plans will need to be taken forward.

9 Overarching strategic consequences

The sections above have detailed the strategic consequences for individual sectors. There are however a small number of common themes that emerge for the Western Bay system as a whole and for commissioning and contracting.

Workforce

Without the right staff, in the right place, with the right skills and competencies the new service model and its expected impact across the system will not be secured. Co-ordinated workforce planning and workforce development needs to be an essential element of the change programme.

Cultural change

For the new system to work it requires behavioural change across sectors in the approaches adopted to supporting individuals (enabling, rehabilitation, discharge to assess and so forth), integrated working (more than simply co-location), recognising the role and capability of the community as opposed to hospital care. Changing behaviour is not easy and will require significant investment in time and energy and needs to be supported by appropriate underpinning frameworks including risk management.

Behavioural change also relates to families and carers. Hospital care and care home placements can be seen as the ‘safe’ option. An explicit and comprehensive approach to communication will be required to inform people of what they can expect from the changed system and that it represents safe, effective practice.

Rebalancing of financial resources

As more people receive their care outside a hospital setting there is a requirement for a rebalancing of financial resources between hospital and community services.

Unlocking hospital resources for reinvestment in the community will be key to delivery of the change programme.

Developing the market

The revised system of care places new requirements and expectations on service providers (both independent and in house). A proactive approach to market management is required to encourage providers who are able to support complex clients for longer and deliver new models of care. A fragile local and regional market with its own drivers for change means that without market stimulation and direction it may not be capable of delivering the changes required. This could include stimulating the growth of smaller social enterprises to deliver care, who pay above the minimum wage helping to foster a more stable staff group, crucial for the delivery of out of hospital care.

Commissioning, contracting, quality assurance

A strategic approach to commissioning is required with a move away from spot contracts and the development of flexible contracts that can adapt to changing requirements over time. The move to more people with complex needs being cared for in the community emphasises the need for rigorous approaches to quality assurance, monitoring and the escalation of concerns to ensure that all care delivered is of an appropriate standard and quality as specified in contracts. Changed requirements of providers may require a review of fees and of charges.

Appendix 2: Options appraisal for integration

1 What options have we explored?

1.1 Introduction

An option appraisal for determining the nature of the transformation programme for frail older people was included in the Outline Business Case. It considered a short list of options from 'do nothing more' through to a substantial transformation programme that sought to deliver a fully optimised system of care.

However, to support this Investment Plan a further formal options appraisal has been undertaken by members of the Western Bay Community Services Project Board. This has been focussed on determining the future arrangements for the implementation of proposed service changes with a particular emphasis on the nature and extent of integration, including the presence of pooled budget arrangements.

In this section we therefore describe the options and the weighted criteria against which they were scored. The relative scores for each option are detailed and a preferred option identified. Through the process of the options appraisal a number of issues and comments were raised which will need further consideration in taking forward the proposals for community services and these are noted. The option appraisal was undertaken as part of the Community Services Project Board meeting on 7th November. The details of the scoring is included as Appendix 1 whilst the options and the outcome from this work is detailed here.

1.2 The options

The options considered were built up using four components as indicated below:

- The service functions to which integration might apply – Demand management, intermediate tier, ongoing community support;
- What part of the system will be integrated, i.e. community health services, social care professionals and mental health staff;
- The footprint for a Section 33 pooled budget Agreement i.e. None, by locality or across Western Bay;
- The extent of any pooled budget agreement i.e. transformation programme only or also including business as usual.

These components can be combined in a variety of ways to create a wide range of options. However, eight options were identified and assessed in the option appraisal as being representative of this wider range of possibilities. Whilst not covering all possible options they constitutes a short list of the most likely combinations that matched the expectations from the integration workshop and discussions at a Changing 4 The Better community services workshop held on 1st November and attended by some Board members.

The options appraisal considered the three key community service components within the service model, namely:

i. Demand management function

ii. Intermediate tier

iii. Ongoing support function

1.2.1 Integration

A key focus of the option appraisal was to determine whether the service functions detailed should be integrated, and if so to what extent. Integration can be across health and social care older peoples services or across health and social care including mental health. For the purposes of the option appraisal an integrated service was taken to mean:

- A Multi professional team with specialist and generic staff appropriate to meet the needs of the client;
- Co-location with single management, joint training and a single budget;
- Joint care planning and coordinated assessments of care needs;
- Named care co-ordinators acting a navigators;
- Recording on single clinical record.

1.2.2 Pooled Budgets

This component within the options included using the opportunity to establish pooled budgets under the national Health Service Wales Act 2006. Pooled budgets could be established for each of the three local areas or a single pool across the Western Bay area. In addition a pool (whether 3 or 1) could apply to the transformation funding only or also include 'business as usual' funding.

1.3 Appraisal process

1.3.1 The options

The eight options considered in the appraisal are detailed in Appendix 1. They are:

1. Delivering transformation through the existing mechanisms with no additional integration or pooled budget arrangements.
2. Delivering transformation through existing mechanisms except for the intermediate tier where reablement support and short term interventions would be delivered in an integrated health and social care service using pooled budgets for the transformation funding.
3. Delivering transformation through integrated health and social care services in all three elements of community services using pooled budgets for the transformation funding.
4. Delivering transformation through integrated health and social care services in all three elements of community services using local pooled budgets for transformation and business as usual.
5. Delivering transformation through integration of health, social care and mental health services for the intermediate tier and ongoing support, but without any pooled budget arrangements.
6. Delivering transformation through integration of health, social care and mental health services for all three components of community services using local pooled budget arrangements for transformation funding.
7. Delivering transformation through integration of health, social care and mental health services for all three components of community services using local pooled budget arrangements for transformation funding and ongoing business.
8. Delivering transformation through integration of health, social care and mental health services for all three components of community services using a single

Western Bay pooled budget arrangement for transformation funding and business as usual.

1.3.2 Domains, questions and weightings

At the 'Changing 4 the Better' workshop participants had discussed, agreed and ranked the criteria against which the options presented at that point should be assessed. These were subsequently developed into five domains with three or four specific questions within each. The domains were then weighted (points out of 100) based on the ranking. Then the questions were weighted within each domain to sum to the domain total. The domains and weighting used in the appraisal are as follows:

Criteria	C4B Ranking	Weighting
Patient Experience	1	30
Independence	2	25
Patient Journey	3	20
Finance	4	15
Implementation	5	10

Table 31 Ranking and weightings for the options appraisal around integration

The full set of domains, questions and weightings are included at Appendix 1.

1.3.3 Appraisal process

Participants were asked to score each of the options against each question on a scale of 1 to 5 where 5 represented 'meets entirely' and 0 represents 'does not meet at all'. The exercise was undertaken as a group with individuals developing their personal scores followed by a group discussion to secure a 'group' score.

1.4 Option Score analysis

1.4.1 The option scores and preferred option

The final weighted scores for each of the eight options are given in the table below. The scores for each question are given in Appendix 3.

	Option							
	1	2	3	4	5	6	7	8
Weighted score	150	234	242	297	282	359	437	325

The highest scoring option overall was Option 7:

> ***Delivering transformation through integration of health, social care and mental health services for all three components of community services using local pooled budget arrangements for transformation funding and ongoing business.***

The current understanding of the extent of Mental Health Integration under this option is that there will be co-location and alignment of Mental Health teams within the intermediate Tier, with link posts. Further, the term 'local' indicates a preference toward subsidiarity, i.e. doing things at the most local level consistent with delivering value for money and improved outcomes.

The weighting used in the scoring (based on the C4B discussion) gives greater weight to the patient experience, promoting independence and the patient journey, than to financial matters and the feasibility of implementation. After the option appraisal a set of revised weightings have been applied to the scores recorded at the event for the purposes of sensitivity testing. These place much greater emphasis on the finance and implementation domains. Whilst changing the total weighted scores Option 7 still retains first position scoring 389 with option 6 in second position scoring 340.

1.4.2 Score analysis

There are common features in the top three highest scoring options (numbers 6, 7 and 8), indicating the importance of these to local partners, namely:

- Integration of mental health along with community health and social care;
- The inclusion of all three service functions – demand management, intermediate tier and ongoing community support;
- The use of a pooled budget.

There is a 78 point difference in the scores between options 6 and 7(the highest scoring) but the only variance between them is the inclusion of 'business as usual' funding in the locality pooled budgets in option 7. A review of the scoring indicates that there is a strong perceived benefit in the impact on the patient experience, independence and the patient journey domains when 'business as usual' funding is pooled.

Option 8 proposed a pooled budget across Western Bay for both transformation funding and 'business as usual'. Compared with option 7 it received lower scores for the patient experience, promoting independence and improving the patient journey. This reflects comments made by some members during the process of the importance of localism, having services that are a tuned to local needs and a view that this could not necessarily be secured under a pan Western Bay arrangement. However, with the development of commissioning by localities it was suggested this may not be such an issue.

Option 8 also scored lowest of all options on the implementation domain, which may be a reflection of current uncertainty regarding local government boundaries. When greater clarity emerges on the future direction this option may be more deliverable and scores can be revisited. Whilst scoring maximum points for delivering consistency across the localities it scored zero in terms of deliverability, high level leadership commitment and being able to be delivered without undue disruption and risk to patient safety. It did however score highly for cost containment, with the debate suggesting that a Western Bay approach could drive out inefficiencies, duplications and deliver reductions in back office functions.

1.5 Issues to be considered

Through the option appraisal process a number of issues emerged that will require careful consideration by Western Bay partners.

1.5.1 Specialist Mental health

Whilst it was considered by many that it was essential for mental health professionals to be an integral part of the three service functions – demand management, intermediate tier and ongoing community support, significant concern was raised by ABMU mental health members. Whilst acknowledging the benefit of mental health involvement in these functions for people with physical and mental health problems their concerns were that if resources were to be deployed in this way, they would not be able to adequately support those people with complex needs as the specialist

service would be diluted. Potentially there would also be some misalignment with their developing all age tiers of service under the Mental Health Measure. Currently there is a national requirement for a specific proportion of health funding to be spent on mental health. Any pooled budget arrangement would need to be cognisant of this

Finding a means of addressing the mental health needs of older people in general as well as those with complex needs as the transformation programme is developed further now appears to be a priority issue to be resolved. A phased approach that initially focusses on liaison posts, co-location and alignment of boundaries will be pursued alongside the delineation of team criteria in line with part 1 and part 2 of the Mental Health Measure.

1.5.2 Business as Usual funding

Within the options appraisal the term 'business as usual' funding was used. It became clear as the process and discussion progressed that there were different perspectives on what constituted 'business as usual'. This ranged from a fairly narrow definition incorporating current funding in Community Resource Teams and others involved in intermediate care through to all community and social care funding for both direct service provision (e.g. district nursing) and commissioned services (e.g. residential care). Given that the preferred option would see such funding in a locality pool it is important that local partners reach a common agreement on the precise definition of 'business as usual. The timescale for developing pooled budgets based on business as usual also needs to be considered. It may be appropriate for transformation funding to be pooled from April 2014 with work undertaken during 2014/15 to establish further pooled budget arrangements from April 2015.

1.5.3 Demand management

Of the three service functions being considered for an integrated arrangement the importance of the demand management function and in particular a Common access point were emphasised. From an implementation perspective it was thought that these needed to be put in place first as well as being the priority for initial levels of integration and alignment with mental health services.

1.5.4 Localism v's Western Bay

A number of issues were raise during the appraisal process regarding having a pooled budget across Western Bay and the potential difficulties associated with this. Apart from the localism mentioned earlier there were concerns over governance and potential additional layers of bureaucracy. From the third sector perspective considerable advantage was seen in a Western Bay approach streamlining commissioning / contracting arrangements and giving the opportunity to re-commission third sector services in a coordinated way. There is current political uncertainly in terms of the future footprint for local authorities and it is important to recognise therefore that the questions, particularly those relating to implementation, are set within this context. Option 8 could potentially score higher were the footprint to be known.

2 The options

The options:		Integration	Functions	Section 33 Pooled Budget
1	Delivering transformation through the existing mechanisms with no additional integration or pooled budget arrangements	No	Demand Management Ongoing support Intermediate tier	No
2	Delivering transformation through existing mechanisms except for the intermediate tier where reablement support, and short term interventions to prevent admissions to hospital and long term care, as well as to speed discharge from hospital, would be delivered in an integrated health and social care service using pooled budgets for the transformation funding.	H&SC	Intermediate Tier	3 separate pooled budgets for transformation
3.	Delivering transformation through integrated health and social care services in all three elements of community services using pooled budgets for the transformation funding.	H&SC	Demand Management Intermediate tier Ongoing support	3 separate pooled budgets for transformation
4	Delivering transformation through integrated health and social care services in all three elements of community services using local pooled budgets for transformation and business as usual.	H&SC	Demand Management Ongoing support Intermediate tier	3 separate pooled budgets across Western Bay for transformation & business as usual
5	Delivering transformation through integration of health, social care and mental health services for the intermediate tier and ongoing support, but without any pooled budget arrangements.	H&SC including mental health	Ongoing support Intermediate tier	No
6	Delivering transformation through integration of health, social care and mental health services for all three components of community services using local pooled budget arrangements for transformation funding.	H&SC including mental health	Demand Management Ongoing support Intermediate tier	3 separate pooled budgets for transformation
7	Delivering transformation through integration of health, social care and mental health services for all three components of community services using local pooled budget arrangements for transformation funding and ongoing business.	H&SC including mental health	Demand Management Ongoing support Intermediate tier	3 separate pooled budgets for transformation & business as usual
8	Delivering transformation through integration of health, social care and mental health services for all three components of community services using a single Western Bay pooled budget arrangement for transformation funding and business as usual.	H&SC including mental health	Demand Management Ongoing support Intermediate tier	Single pooled budget across Western Bay for transformation & 'business as usual' funding

3 Domains and weightings

1- Patient Experience	Relative weighting within domain
1.1 To what extent will the option deliver care that is ***personalised***?	7
1.2 To what extent will the option deliver better ***outcomes for patients*** allowing them to live the life they want to the best of their abilities?	10
1.3 To what extent will the option deliver better ***co-ordinated seamless care*** with fewer barriers between services, multiple assessments, multiple information giving etc	6
1.4 To what extent will the option deliver improved ***outcomes for families and carers*** through recognition of their needs and provision of support?	7
Weighting of domain	30

2- Independence	Relative weighting within domain
2.1 To what extent will the option contribute to the ***early identification*** of people's needs?	13
2.2 To what extent will the option help to ***minimise the risk*** to people's independence?	6
2.3 To what extent will the option increase the proportion of people who are ***supported at home***?	6
Weighting of domain	25

3- Patient Journey	Relative weighting within domain
3.1 To what extent will the option deliver ***improved access*** to services and support (e.g. Common access point, 24/7 services)	5
3.2 To what extent will the option ***reduce handoffs*** between professionals and teams and the current gaps between services?	5
3.3 To what extent will the option improve the ***timeliness*** of service delivery (e.g. provision of equipment)?	5
3.4 To what extent will the option maximise the ***staff time available*** for direct patient care?	5
Weighting of domain	20

4- Finance*	Relative weighting within domain
4.1 To what extent will the option contribute to the ***containment of cost increases*** over the next 10 years?	10
4.2 To what extent will the option facilitate flexibility ***in the deployment*** of financial resources to meet needs?	5
Weighting of domain	15

* Two additional questions were included in this domain, namely:
    1. To what extent can the option be implemented without the need for significant ***investment in new / redesigned se***rvices?

2. To what extent can the option be implemented without the need for significant ***investment in local infrastructure*** (e.g. premises, Information Technology etc?

However, participants found it impossible to score these and it was therefore agreed during the workshop to give them '0' weighting and therefore leave them outside the process.

5- Implementation	Relative weighting within domain
5.1 To what extent could the option ***actually be delivered*** across Western Bay over the next 3 years	3
5.2 To what extent could the option be ***delivered in a consistent manner*** across the three localities?	2
5.3 To what extent could the option be delivered with the current level of high level ***leadership commitment*** within the Western Bay partnership?	2
5.4 To what extent could the option be delivered without causing undue ***disruption and therefore risk to patient safety*** in the system?	3
Weighting of domain	10

4 Scoring

1 Patient Experience	Option							
To what extent will the option deliver	1	2	3	4	5	6	7	8
1.1 Care that is personalised	1	1	1	2	2	3	4	3
1.2 Better outcomes for patients	1	1	1	2	2	3	4	3
1.3 Better coordinated seamless care	1	1	1	2	2	3	4	3
1.4 Improved outcomes for families and carers	1	1	1	2	2	3	4	3
Weighting of domain = 30								

2. Independence	Option							
To what extent will the option	1	2	3	4	5	6	7	8
2.1 Contribute to the ***early identification*** of people's needs	1	3	3	3	4	4	5	3
2.2 Help to ***minimise the risk*** to peoples independence	1	3	3	3	4	4	5	3
2.3 Increase the proportion of people who are ***supported at home***	1	3	3	3	4	4	5	3
Weighting of domain = 25								

3 Patient Journey	Option							
To what extent will the option deliver	1	2	3	4	5	6	7	8
3.1 ***Improved access*** to services & support	3	3	3	4	3	4	5	5
3.2 ***Reduce handoffs*** between professionals & teams & gaps in services	3	3	3	4	3	4	5	4
3.3 Improve ***timeliness*** of service delivery	3	3	3	4	3	4	5	4
3.4 Maximise the staff time available for direct patient care	3	3	3	4	3	4	5	4
Weighting of domain = 20								

4. Finance*	Option							
To what extent will the option be implemented	1	2	3	4	5	6	7	8
4.3 Contribute to containment of cost increases	1	2	3	3	2	4	4	4
4.4 ***Facilitate flexibility*** in deployment of financial resources	1	2	3	4	2	3	4	5
Weighting of domain = 15								

5 Implementation	Option							
To what extent could the option be implemented	1	2	3	4	5	6	7	8
5.1 Actually be delivered	5	4	3	3	3	3	2	0
5.2 Be delivered in a ***consistent manner***	0	4	3	3	4	4	4	5
5.3 Be delivered with current high level of leadership commitment	1	5	4	4	3	4	3	0
5.4 Without undue disruption & risk to patient safety	1	3	3	3	3	3	3	3
Weighting of domain = 10								

Appendix 3: Identifying frailty and dementia co-morbidity and associated costs

1. Introduction

Much work nationally and locally has been done to understand the progression of dementia and, separately, the onset of frailty in a population, and to identify the services that are needed to meet these needs in as effective and efficient way as possible. However, less is known about the extent of co-morbidity between dementia and frailty, although it is clearly a relatively common occurrence.

More work is needed to understand how we meet the needs of such people in a way that avoids duplication but retains access to appropriate specialist care but this appendix builds on the ambition reflected at the Western Bay engagement event for integration and provides a provisional estimate of:

1. The number of people experiencing dementia and frailty separately and together, and therefore the different population cohorts of need.
2. The total spend on services to meet these needs across health and social care, avoiding double counting wherever possible.

Considerable further work will be necessary to refine our understanding of these areas of need. One way of doing this is through the use of the SAIL database at Swansea University[5], which provides an opportunity to match data from across several different sources. The first questions that are being asked of this database are:

1. Is the rate of unscheduled hospital admissions for people with a diagnosis of dementia higher than for people without a diagnosis?
2. What is the proportion of people receiving home care support/care home residents with a positive diagnosis of dementia?

It is recognised that as well as co-morbidity between dementia and frailty other factors or conditions can contribute to increasing needs within the population. Many of these will have contributed to a person's frailty but at this stage no attempt is made to identify the single conditions, apart from dementia, that contribute to the wide range of long term healthcare needs prior to people becoming frail. However, there is clearly a strong link between advancing dementia and frailty. One of the key areas of overlap for these client groups is the nature of support required toward the end of life, for which we will also provide an initial estimate in this appendix.

2. Estimating cohorts of need for frailty and/or dementia

Using local demographic profiles from GP networks and expected prevalence rates for frailty and dementia we can estimate that there were approximately 10,460 people who were frail and 6,990 who had dementia in April 2012[6]. However, we know that some people will fall into both cohorts – and that supporting these people in a holistic and integrated way is of critical importance. In order to estimate the number of people who might experience both frailty and dementia a brief literature search has been undertaken. This has identified an initial sample of research that suggests that if you

[5] See http://www.biomedcentral.com/1472-6963/9/157

[6] Based on GP registered population for ABMU constituent GP practices, drawn from the Exeter system, as at the 1st of April 2012.

are frail then you are twice as likely to also have dementia[7]. Using this intelligence we have:

1. Identified the expected prevalence of frailty by 5 year age bands in each local network.
2. Applied the expected population prevalence for dementia to each of these age bands and doubled this to reflect the research noted above.
3. Netted this cohort of people expected to have both frailty and dementia from the expected prevalence of frailty and of dementia respectively.

At a Western Bay level this methodology provides an estimate of 2,409 people who will have both frailty and dementia. This is illustrated below in Figure 3. At a local network level the breakdown of needs is illustrated in Figure 4. The 15,040 people suggested in Figure 1 represent 14.6% of the over 65 population, with a range from 13.6% in Bridgend North to 15.6% in Swansea Bay.

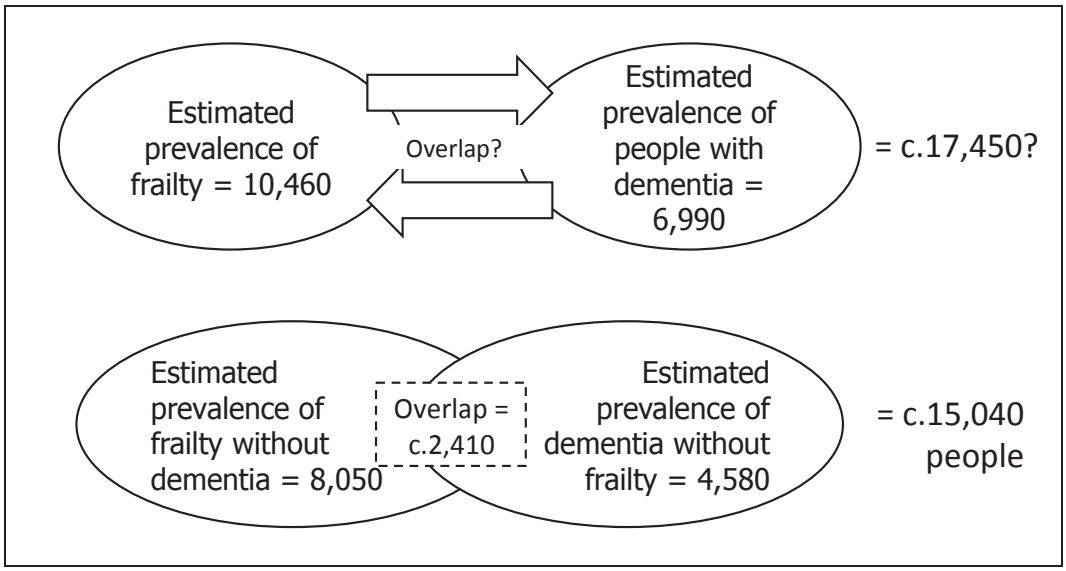


Figure 4 Estimate of population cohorts of need for dementia and frailty

[7] The J Am Med Dir Assoc (2013) Jul;14(7):518-24 article entitled "*Combined prevalence of frailty and mild cognitive impairment in a population of elderly Japanese people*" found a significant relationship between frailty and MCI with an odds ratio adjusted for age, sex and education of 2.0.
Alzheimer's Dement. 2013 Mar;9(2):113-22. doi: 10.1016/j.jalz.2011.09.223. Epub 2012 Dec 12. article entitled "*Frailty syndrome and the risk of vascular dementia: the Italian Longitudinal Study on Aging*" identified an overall hazard ratio of 1.85 for the risk of dementia when someone is frail.
J Gerontol A Biol Sci Med Sci. 2013 Sep;68(9):1083-90. doi: 10.1093/gerona/glt013. Epub 2013 Feb 18 article entitled "*Frailty and incident dementia*" identified a similar hazard ratio of 1.78.

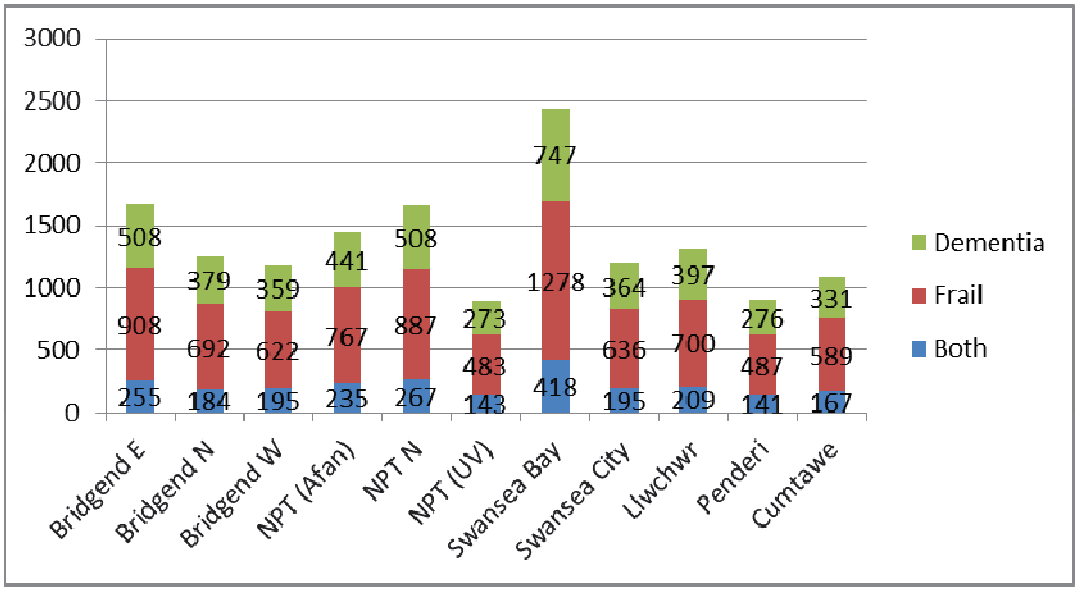


Figure 5 Cohorts of need at a Network level estimated for April 2012

3. Estimating the costs of services

The modelling tools developed to support the current strategic redesign programmes for frailty and dementia identifies baseline activity (either at April 2012 or for the full year 2012/13) and unit costs. The purpose of this data was to estimate the capacity and resource impact of different redesign options, i.e. a change from baseline spend. The results of this are covered extensively in the reports for the frailty and dementia projects respectively.

The primary reason for collecting this information was not therefore to construct a budget or to reconcile back to overall spend, in part because a lot of the services included were non-specialist meaning that spend on people with dementia or frailty could not be identified precisely. However, using this data it is possible to provide an indication of the costs associated with these clients, and once again to identify any overlap so as to avoid double counting.

The estimate of gross spend on these two client groups by both health and social care is:

- £72.6M for dementia, which includes spend on admissions to hospital for people with dementia (for all causes); specialist mental health services for this client group; home care services for people expected to have dementia; and care home spend, again for that proportion of residents expected to have dementia.
- £91.6M for frailty, which includes spend on the proportion of acute and post-acute hospital admissions expected for frail older people; Intermediate Care services; all home care services; and all Local Authority supported care home residents.

There is clearly an overlap between these two sets of costs and we have therefore identified duplication and estimated total spend on these two clients as set out in Table 1. A further illustration of this overlap is provided in Figure 5.

Element of spend	Estimate	Balance or split of spend
General acute	£15.7M	Of which just over half will be for people with dementia
Intermediate care	£5.6M	Of which the majority will be spent on people who are frail
Home care	£13.6M	Of which c 60% will be spent on people with dementia
Care homes	£22.1M	Of which about two thirds will be spent on people with dementia
Specialist MH services for people with dementia	£18.0M	All of which will be spent on people with dementia
TOTAL	£109.7M	

Table 32 Estimate of total costs for people with dementia and/or that are frail

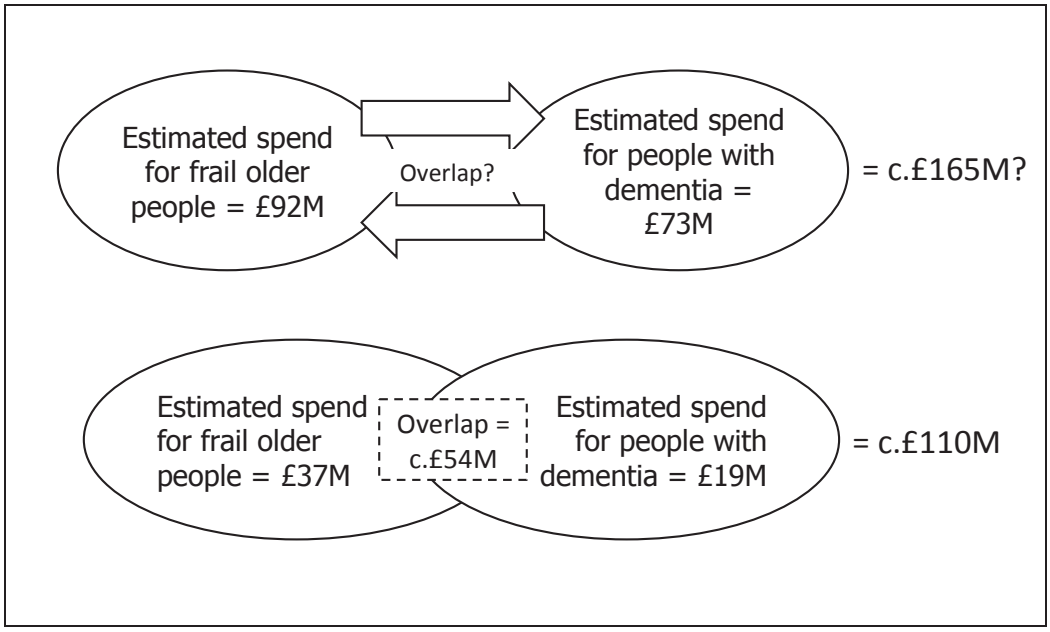


Figure 6 Estimate of health and social care spend on people with dementia and/or frailty

4. End of Life Care

End of Life Care has not been a specific focus of the work commissioned by the Western Bay Partners to date. However, the tools used to develop the dementia and frailty simulations rely on an underpinning demographic that also, as a consequence, identify the number of people who will die each year. The modelling work on frailty estimates 5,600 deaths each year, which is 1.03% of the GP lists across Western Bay[8]. The number of people who die with dementia can also be estimated from the

[8] This is consistent with the Gold Standard Framework which suggests that 1% of people will die in any one year of all causes.

modelling tool associated with this work. It suggests that 1,770 people will die each year with dementia, which means that just under one third of people who die will have some level of dementia.

To arrive at an estimate of deaths for people with dementia and/or frailty we have applied the same methodology as set out in section 2. Figure 6 provides a breakdown of these estimates by locality. It suggests that frailty and/or dementia will be a part of people's needs during the last year of life in 63% of all deaths (3,600). When compared to the total combined prevalence of frailty and/or dementia this also means that 24% (1 in 4) of people with frailty and/or dementia can be expected to be in their last year of life.

The Welsh End of Life Care Strategy stresses the importance of providing an integrated care plan for people at the end of life, as well as other aims for improving choice at the end of life. The estimates in this paper therefore provide a useful starter to explore service redesign and its impact on this area of strategy.

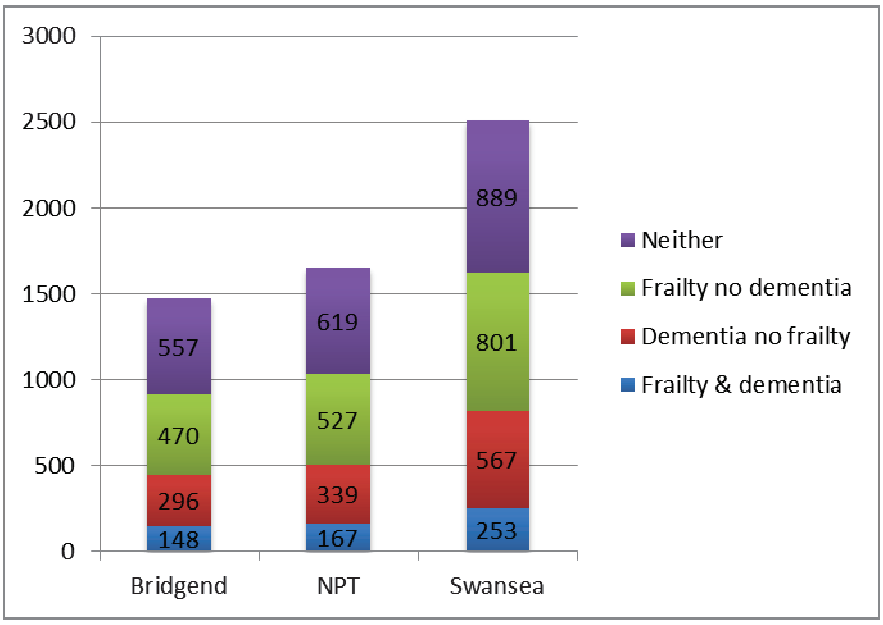


Figure 7 Estimate of deaths where frailty or dementia are present

Definitions for Figure 4:

A. People whose last year of life will be characterised by frailty with dementia and potentially other conditions.

B. People who will have dementia and potentially other conditions but will not be frail.

C. People who will be frail, potentially with other conditions, but will not have dementia.

D. People who will not have dementia and will also not be frail.