Cyngor Abertawe
Swansea Council

Report of the Cabinet Member for Care, Health & Ageing Well

Adult Services Scrutiny Performance Panel – 25th September 2018

WESTERN BAY HEALTH AND SOCIAL CARE PROGRAMME

Purpose	To provide a briefing as required by the board in relation to: • An overview of the Western Bay Health and Social Care programme to include governance arrangements and current workstreams. • The goals to be achieved by 2019/2020, for each workstream.
Content	This report includes an overview of the Western Bay Health and Social Care Programme, including the Vision and Aims of the Programme, Governance, Key Workstreams of the Programme and the Western Bay Programme Review This report will be of interest to the Members of the Adult Services Scrutiny Performance Panel The report concludes with the next steps of the Western Bay Review
Councillors are asked for their views on	• The overview of the Western Bay Programme including the current governance arrangements and workstreams • The workstreams for 2018/19 and beyond • The Western Bay Programme Review including the updated Population Assessment, Area Plan and Action Plan
Lead Councillor(s)	Cllr Mark Child, Cabinet Member for Care, Health and Ageing Well
Lead Officer(s)	Dave Howes, Director of Social Services
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1. Vision of Western Bay

1.1 The vision of the Western Bay Health and Social Care Programme (WBHSCP) is to work collaboratively to provide high quality services that protect children and adults from harm, promote independence and deliver positive outcomes for people across Bridgend County Borough Council, Neath Port Talbot County Borough Council and Swansea Council.

1.2 To achieve this, the Abertawe Bro Morgannwg University Health Board (ABMUHB) and the Local Authorities of Bridgend County Borough Council, Neath Port Talbot County Borough Council and Swansea Council will work together through the Western Bay Health and Social Care Collaborative, with third and independent sector partners. The primary purpose of the Collaborative is to provide a strategic mechanism for coordinating a programme of change through a suite of projects that partners have identified as common priorities. These priorities are designed to support and improve local delivery arrangements so that they benefit citizens and the care that they receive. This means that local authorities and Health Boards remain responsible for the delivery of Health Care and Social Services in their associated localities, but Western Bay as a region can work collectively to identify priorities that are addressed in an agreed manner. The Social Services and Wellbeing (Wales) Act 2014, requires regions to focus on opportunities for prevention and early intervention, an example is the Integrated Family Support Service developed on a Regional basis.

2. Aims of Western Bay

2.1 The long term and primary aim of the WBHSCP is to ensure services are resilient and sustainable and that there are demonstrable improvements in service delivery for all service users across the ABMU footprint encompassing Bridgend CBC, Neath Port Talbot CBC and the Swansea Council. Health and Social Care Services are currently over-stretched, with a growing demand and therefore the main aim of the programme is to make service improvements, to avoid service costs increasing and to ensure services are sustainable for the future. In order to do this the programme aims to achieve effective collaboration so that capacity is used in a more efficient and effective way, which will save time, resources, expertise and contribute to citizens' improved wellbeing.

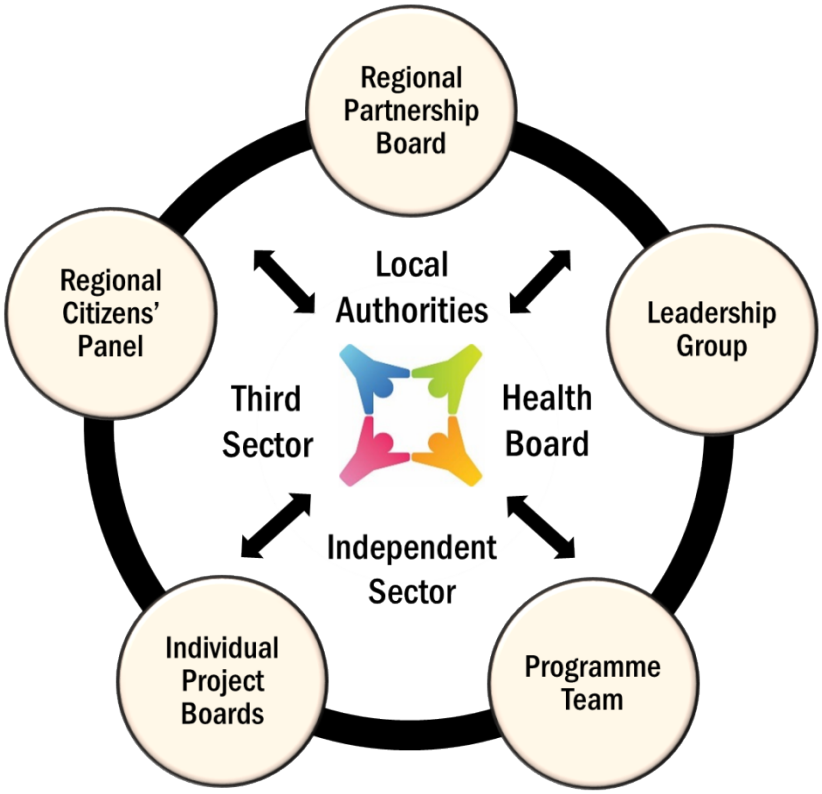
2.2 The key aims of the Western Bay Health and Social Care Programme are:

- To promote **prevention and wellbeing** from a citizen centred perspective, that will support and strengthen both the care delivered and the health and wellbeing benefits to the people of Western Bay
- To **integrate** services more effectively for the benefit of service users and carers
- To focus on the person through an approach committed to personalisation, **independence**, social inclusion and choice
- To fulfil a shared responsibility so that adults and children at risk of harm in Western Bay are **safeguarded** against all forms of abuse by working together to keep adults and children safe and to promote their welfare
- To make **service improvements**, to **avoid service costs increasing** and to **ensure services are sustainable** for the future, in the face of growing demand and the current financial climate.

- To recognise that incremental changes to existing models of care will not be sufficient and that a bolder approach is needed to bring about innovative models that are appropriate to the needs of the population.

3. Governance

3.1 The Western Bay Regional Partnership Board (RPB) is responsible for managing and developing services to secure strategic planning and partnership working between Local Authorities, the Health Board, Third Sector partners and citizens.

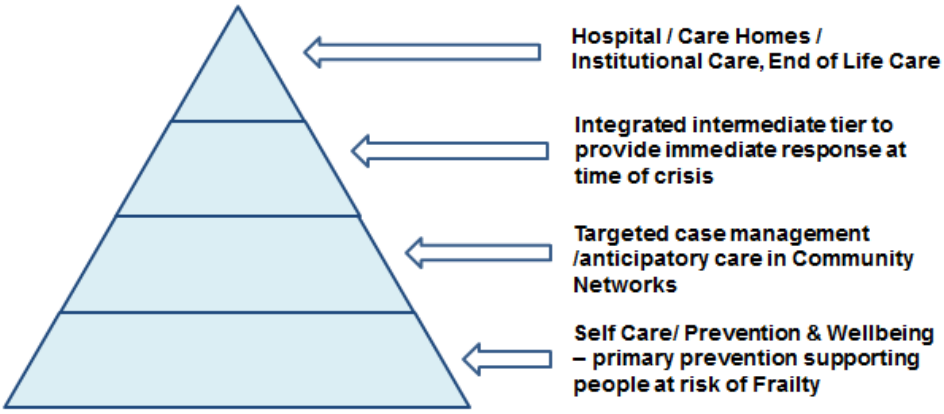


3.2 The full Western Bay Governance diagram can be viewed in Appendix 1

4. Key Workstreams and Activities

4.1 Community Services (Services for Older People)

The top 3 elements of the diagram below demonstrate the areas of focus for the Western Bay Community Services Programme



4.1.1 Intermediate Care Services – Optimal Model

The vision is to support the health and wellbeing of older people at home whenever possible; however people will require support at certain times throughout their later life and we aim to offer the right support, at the right time and in the right place for the individual.

Taking a person centred approach, working in collaboration with the individual, their family/carers across health and social care we can offer a co-ordinated service.

This approach builds on exiting core services, recognising gaps and developing workforce capacity and capability; it is a culture change and staff are supported to look at new ways of working.

By asking *'What matters to you….?* ' Rather than '*What is the matter with you?* we ensure that we keep the individual at the centre of service provision, working with rather than limiting services to what has been traditionally available.

Intermediate care services aim to 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.

Services are coordinated to contribute to:

- reducing the number of unplanned admissions by providing a response at time of crisis
- maximising independence
- reducing reliance on institutional care.

Rapid, close to home support is provided when necessary with short term interventions of reablement/rehabilitation after injury or illness.

The aim is to prevent admission to hospital by delivering care in people's homes (when appropriate), reduce the relience on long term care, supporting timely discharge when a hospital admission is appropriate.

4.1.2 Key Features of the Optimal Model which are now in place across Western Bay are:

- Multi-disciplinary triage in common access point
- Mental Health provision within common access point
- Third Sector Brokerage in common access point
- Acute Clinical Response (Rapid Response) 7 day service
- Therapy led reablement service
- Intake & review reablement
- Therapy led residential reablement
- Access for people with dementia
- Step up/step down intermediate care (residential or community)

4.1.3 The integration of Health and Social Care across Intermediate Care Services is making a significant contribution to the wider Health and Social Care Community.

There is a joint commitment to delivering Community Services which:

- Supports people to remain independent and keep well
- Enables more people to be cared for at home with shorter stays in hospital
- Changes the pathway from institutional care to community care
- Supports fewer people being asked to consider long term residential or nursing home care
- Will make more use of technology to support people
- Ensure services are joined up around the needs of the individual with less duplication across health and social care agencies
- Provides more treatment and care provided at home, as an alternative to hospital admission
- Makes services available on a 7 days a week basis
- Supports earlier diagnosis of dementia, and quicker access to specialist support for those who need it

This means that we are now delivering:

- Services that support people remain confident independent and safe in their own homes for as long as possible, and in accordance with their dignity and choice
- 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 deemed appropriate.

4.1.4 The diagrams below have been taken from of an independent evaluation of the Intermediate Care Services.

4.1.5 The graph below shows the projected admissions for those over 65 across the Western Bay Region

The Blue line shows that the predicted admissions, without any intervention, would continue to rise, putting pressure on both secondary and community resource.

The Orange line on the graph shows the initial Business case prediction of impact

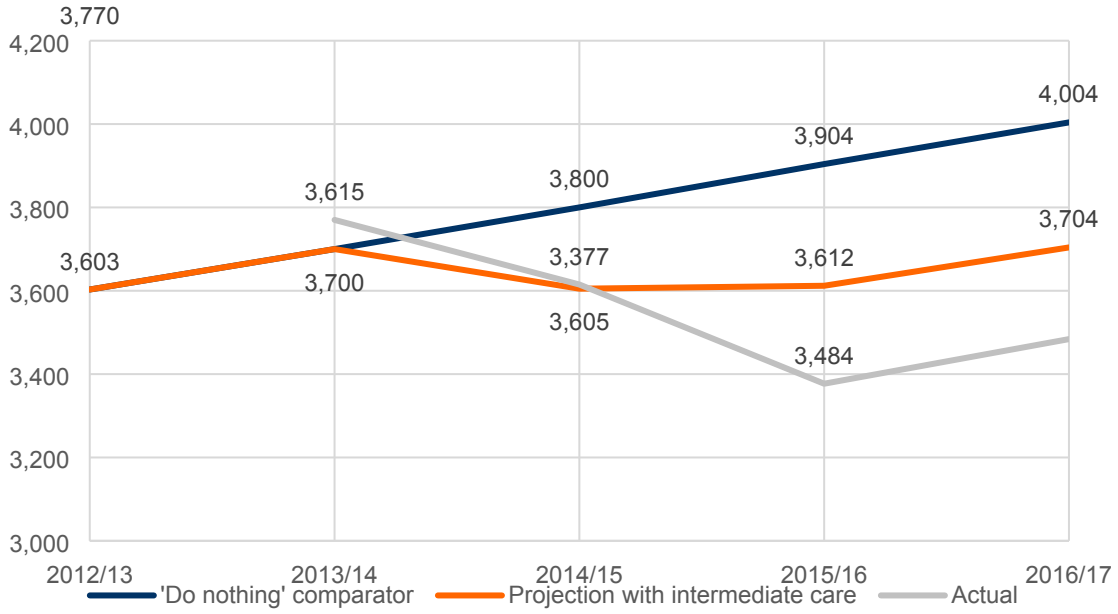
The Grey line shows the actual impact

This shows that the services implemented has reduced the impact more significantly than expected.

The Bridgend data has been shown below as this very clearly shows the impact

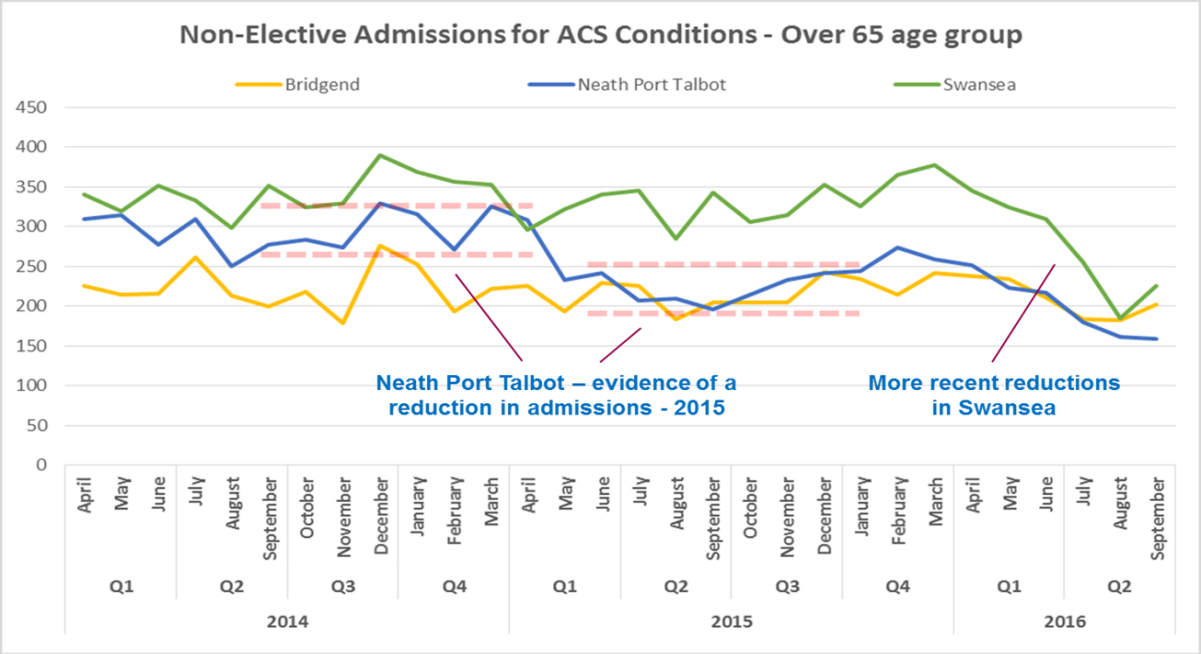
It should be noted that the impact in Swansea is similar however due to the way data was initially collected we cannot clearly show what is known to be happening.

The issues around data collection have largely been resolved now and teams are routinely collecting equivalent data across the region.



4.1.6 The graph below shows the reduction in admissions of Non–elective admissions Ambulatory Care Sensitive Conditions for the over 65 age group.

This graph demonstrates the reduction in admissions across the 3 areas – Swansea is the green line



4.1.7 Both graphs suggest that the Western Bay programme is performing effectively in a number of areas; the independent external evaluation (Cordis Bright 2017) further suggests investment in intermediate care services should be continued.

4.1.8 The independent evaluation report highlights cost savings of an estimated £4.9m through reductions in use of hospital beds, home care packages and care home placements; also in excess of £769k cost savings due to reductions in unscheduled admissions for people aged 65+. (These are all conservative estimates as data from Swansea has not been available, however as noted this is being addressed and will be forthcoming going forward).

4.1.9 Key recommendations from the evaluations are informing the Western Bay Community Services work plan going forward to ensure continued development and effectiveness.

4.2 Commissioning for Complex Needs

The Commissioning for Complex Needs Programme is a key work stream across Western Bay. The ethos of the programme is one of true collaboration and as required of the Social Services and Wellbeing (Wales) Act (2014) puts the person at the centre of service planning and delivery. Care providers work closely with representatives from health and social services to create bespoke, outcome-focussed packages of care for each individual.

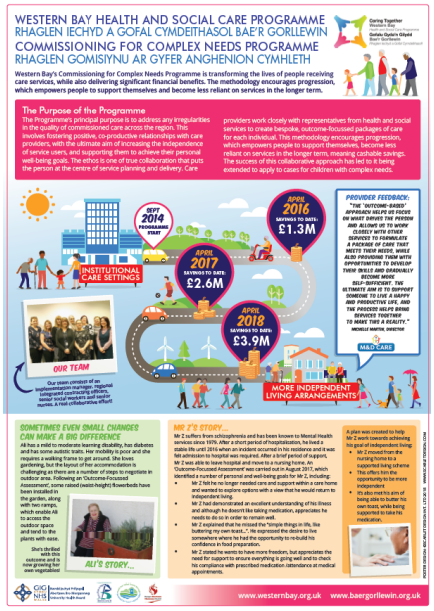
4.2.1 Outcome Focused Commissioning – Adults with Complex Needs

This methodology encourages people to live as independently as possible, by empowering people to support themselves, it enables them to become less reliant on services in the longer term, meaning cashable savings are also realised.

This work stream reviews existing packages of care and devises new packages of care for individuals both in residential or supported living placements whose needs are complex.

The aim of each review is to ensure that the individual receives services that enable them to live as independently as possible. Each review involves both health and social care staff, as the majority of cases reviewed are jointly funded. The team of 'outcome-focused assessors' comprises senior social workers, nurse specialists and contract officers funded by the Welsh Government's Integrated Care Fund. This team also calls upon staff from across the region, such as health care support workers, occupational therapists, clinical psychologists and psychiatrists.

- A quarter of the overall care packages have been reviewed by the Commissioning for Complex Needs team. This joint working approach has enabled individuals to have progressive care plans that support them to live as independently as possible. The holistic "home" review of all the individuals in a property has allowed economies of scale to be driven thus allowing the Programme's partners to make cash savings as a result of recommissioning care whilst also looking at providing alternative solutions.



- The team have created their own methodology and forms which they follow and complete for each assessment, that take account of the Health Needs along with identifying Outcomes for each individual reflecting the National Outcome Indicators, linked to the Social Services and Well-being (Wales) Act 2014.
- There is still a constant flow of individuals requiring a residential placement. To this end, the collaborative came together to coproduce a more efficient and effective way of commissioning known as the 'Brokerage Service', the aim of which is to commission appropriate placements for individuals to progress, whilst ensuring value for money. A panel of health and social care practitioners review and endorse these placements.
- Recognition of Western Bay achievements at the All Wales Continuous Improvement 2018 Annual Awards, when the region received two prestigious awards under the categories of Best Local Government initiative and Achieving a Common Purpose.

Financial Achievements

- Since the Programme's inception in 2014, there has been a saving of £4,527,053
- Between September 2014 and March 2016, a total of £1.3 million was saved, exceeding the £1m target even after taking into consideration that the full complement of staff was not achieved until May 2015
- Between April 2016 and March 2017, the target of £1m was again exceeded and the Programme saved £1,310,256
- Between April 2017 and March 2018, the Programme exceeded the target of £1m and saved a total of £1,479,583
- To date the Programme is on target for the annual saving of £1m with savings from April to July 2018 standing at £426,628

Individual Personal Achievements

<u>Sometimes Even Small Changes Can Make A Big Difference</u>

Ali has a mild to moderate learning disability, has diabetes and has some autistic traits. Her mobility is poor and she requires a walking frame to get around. She loves gardening, but the layout of her accommodation is challenging as there are a number of steps to negotiate in outdoor area. Following an 'Outcome-Focussed Assessment', some raised (waist-height) flowerbeds have been installed in the garden, along with two ramps, which enable Ali to access the outdoor space and tend to the plants with ease.

She's thrilled with this outcome and is now growing her own vegetables!

MR Z'S STORY...

Mr Z suffers from schizophrenia and has been known to Mental Health services since 1979. After a short period of hospitalisation, he lived a stable life until 2016 when an incident occurred in his residence and it was felt admission to hospital was required. After a brief period of support, Mr Z was able to leave hospital and move to a nursing home. An 'Outcome-Focussed Assessment' was carried out in August 2017, which identified a number of personal and well-being goals for Mr Z, including:

- Mr Z felt he no longer needed care and support within a care home and wanted to explore options with a view that he would return to independent living.
- Mr Z had demonstrated an excellent understanding of his illness and although he doesn't like taking medication, appreciates he needs to do so in order to remain well.
- Mr Z explained that he missed the "simple things in life, like buttering my own toast…". He expressed the desire to live somewhere where he had the opportunity to re-build his confidence in food preparation.
- Mr Z stated he wants to have more freedom, but appreciates the need for support to ensure everything is going well and to check his compliance with prescribed medication /attendance at medical appointments.

A plan was created to help Mr Z work towards achieving his goal of independent living:

- Mr Z moved from the nursing home to a supported living scheme
- This offers him the opportunity to be more independent
- It has also met his aim of being able to butter his own toast, while being supported to take his medication.

4.2.2 Mental Health and Learning Disabilities Brokerage Regional Service for New Residential Placements

This work stream falls under the umbrella of Commissioning for Complex Needs which provides a Brokerage Service for individuals who have either mental health issues and / or learning disabilities who require a new placement in a residential or nursing home.

This service has improved the sustainability of new placements and in addition has improved the progression of individuals, which can be demonstrated by a number of available case studies.

A methodology for the 'Brokerage Service' has been developed along with an assessment form designed to support staff in demonstrating the outcomes expected for each individual.

Providers have welcomed this process and form, as quoted:

"Effective joint-working is an absolute must in this business, and the process is a good means of facilitating this. It's a structured and supportive way of managing a person's progression and helping them take steps to build their confidence and live more independently.

The 'outcome-based' approach helps us focus on what drives the person and allows us to work closely with other services to formulate a package of care

that meets their needs, while also providing them with opportunities to develop their skills and gradually become more self-sufficient.

The process enables us to track a person's progress and highlight key achievements. It also makes us as care providers think about what we're doing and why we're doing it.

The ultimate aim is to support someone to live a happy and productive life, and the process helps bring services together to make this a reality".

***Michelle Martin of* M&D Care**

Since the inception of the Brokerage Service, the partner organisations have achieved cost avoidance savings of £1,252,274. 131 cases have been referred to the service, with 73 new outcome-focused placements being made.

4.2.3 Optimal model – Embedding the Process

This work stream is designed to plan and implement the methodology and lessons learned through the experiences of the 'Outcome Focused Commissioning – Adults with Complex Needs' initiative. The Optimum Model will be developed to ensure that the delivery of services for individuals with Mental Health or Learning Disabilities are designed to provide the ideal best possible care and support.

This work stream is also linked to the implementation of the Mental Health Strategic Framework, which is a regional priority identified in the Area Plan and Action Plan for Western Bay.

The development of the optimal model is in its infancy and a high level overview of potential work streams listed below will be presented to the appropriate Boards throughout the year:

- Development of an Operational Model
- Development of Regional Commissioning
- Development of a Single Entry Point to the Service

4.2.4 Joint Funding Matrix

- The joint funding matrix is being developed to support decision making in relation to placement and care funding for those with mental health and learning disability within the Commissioning for Complex Needs area.
- A collaborative group across Western Bay with Health and Social Care staff have devised the draft joint funding matrix tool.
- The tool is currently being evaluated by Swansea University to ensure academic validity and reliability.
- The expected benefit of the tool is that each partner across the region will have a method for making clear funding decisions which do not impede on any progress of care for individuals.

4.2.5 Regional Supported Living Process

A process for setting up new supported living schemes to enable individuals to live close to home. Each local authority either have their own framework or are in the process of setting up a framework for supported living providers. However a

regionally coordinated process is required to ensure all partners are involved at the correct stages and that suitability of supported living and compatibility of the residents is discussed as early as possible.

4.2.6 National Integrated Health & Social Care Collaborative Commissioning Programme

All four partners have now signed up to use the NHS Wales National Framework for Adults in MH and LD Care Homes with/without Nursing. The main aims of the framework are to:

- Improve health and wellbeing outcomes
- Improve quality and safety
- Reduce overall publicly funded costs

As part of the tender evaluation and selection process, providers' capability and capacity to deliver services required is evaluated. Providers are assessed against a set of Framework Care Standards and for any standards that have not been achieved, providers are issued with a Remedial Action Plan which details the work that must be undertaken to meet the Framework requirements.

Western Bay undertook a cost benefit analysis before moving any current packages of care onto the framework. Packages are reviewed as part of the Outcome Focused Assessments workplan prior to moving over to the framework to ensure the correct number of support hours is commissioned. To date 12 packages of care have moved across. New packages that are agreed at complex case panels are now being made via the framework. To date, 2 new packages have been placed via the framework.

4.3 Welsh Community Care Information System

4.3.1 Western Bay have previously identified a vision for Welsh Community Care Information System (WCCIS) in the region recognising that the system has the ability to enable the transformation of services and to make appropriate information readily available to practitioners. The regional commitment to WCCIS has continued during 2018/19. The three regional posts are continuing to support the implementation of Wales Community Care Information System across the region. These posts have been funded by the Integrated Care Fund and have introduced a necessary resource to help services focus on the benefits of WCCIS. The regional posts are working closely with the organisations within the region to support their readiness activities and to assist the organisations progress their intentions to sign the necessary Deployment Orders.

Welsh Community Care Information System

4.3.2 During the year, Swansea Council have approved their business case for WCCIS, and are finalising their requirements to update their Deployment Order. This will then be agreed with the supplier and will result in the agreed implementation plan. Neath Port Talbot Council have also progressed their interest in WCCIS and are considering their options with regards to implementation. An options paper is being developed and will be presented to senior management in due course to agree on the best way forward for Neath Port Talbot. Meanwhile ABMU recently

reaffirmed their commitment to WCCIS at executive board level, where it was agreed that the Health Board would recruit resources to complete their business case and undertake necessary "readiness" work in preparation for their implementation plan. ABMU are also in the process of deploying 2,500 iPads for community-based staff in readiness for WCCIS.

4.3.3 The Regional WCCIS team have undertaken targeted pieces of work to ensure services are preparing for WCCIS, and any learning is being gathered in readiness for organisational implementations. For example, a workshop has been held with the Regional Adoption Service to ensure that the WCCIS functionality meets the requirements of the regional service. Most notably is the implementation of WCCIS within the Bridgend Community Resource Team based in Trem Y Mor, to evidence how the system can benefit an integrated team of health and social care workers. This work has been phased across a range of community health workers including therapy staff and is proving to be of significant value not just to Trem Y Mor, but to the wider region. This has also gained national interest, resulting in presentations being provided to Welsh Government and other audiences. The regional team have also been approached to contribute to a workshop alongside CareWorks, the system suppliers, to present the findings from this piece of work at the National Social Care Conference in Wales.

4.3.4 The learning that has emerged from this piece of work has resulted in the product being further developed to meet the needs of community-based staff. This work has proven that existing WCCIS functionality has the ability to deliver a range of benefits to an integrated team. The provision of essential devices, such as laptops, is enabling a more agile way of working, leading to staff working more efficiently and effectively. A detailed and structured ongoing evaluation of the implementation presents a valuable learning resource that will continue to be updated as the system is rolled out to additional workers based in Trem Y Mor.

4.3.5 In addition, it has been confirmed that selected health and social care staff based in Trem Y Mor will participate in the national testing of the WCCIS mobile application. This will be tested on tablet devices that have been procured via the regional budget and will present another opportunity to evaluate the effectiveness of the mobile application in a live operational environment. As Bridgend are the only authority currently live with WCCIS within the region, the mobile application will also be tested by Bridgend social care staff. This maintains Bridgend's position in leading the development of WCCIS, continuing to drive and promote positive change.

4.4 Children and Young People's Programme

The aims of the Children and Young People's Programme are:

- To plan and commission children and young people's services that require a common approach across the region
- To agree a common model for service delivery for children and young people across the region (in health and social care terms)
- To oversee the strategic planning and commissioning of service models for children and young people's services, researching best practice and evidence of effectiveness from elsewhere

4.4.1 Outcome Focused Commissioning – Children with Complex Needs

This work stream's principal aim is to address any irregularities in the quality of commissioned care across the region. This involves fostering positive, co-

productive relationships with care providers, with the ultimate aim of increasing the independence of service users, and supporting them to achieve their personal well-being goals.

The ethos is one of true collaboration that puts the child/person at the centre of service planning and delivery. Care providers work closely with representatives from health and social services to create bespoke, outcome-focussed packages of care for each individual.

This methodology encourages progression, which empowers children to develop skills that enable them support themselves as they become adults and ensure that they are able to be less reliant on services in the future. Reviewing existing and devising new packages of care for children in residential living placements whose needs are complex.

The aim of each review is to ensure that the child receives services that will enable them to live as independently as possible in the future. The team of 'outcome-focused assessors' comprises senior social workers, nurse specialists and contract officers funded by the Welsh Government's Integrated Care Fund. This team also calls upon staff from across the region such as health care support workers, occupational therapists, clinical psychologists and psychiatrists.

The methodology was developed in line with the processes and paperwork that has been used in the Outcome Focused Commissioning for Adults with Complex Needs since 2014.

Outcomes are as follows:

- The programme has identified a number of areas that require further investigation and the knowledge gained to date will be shared with the teams supporting the children and the Children's Commissioning Consortium Cymru (4'C's). Examples of the findings are:
    - Discrepancies between 1 to 1 commissioned hours and the services being delivered/identified
    - Information flow between partners and providers
    - Having the ability to review packages across the partnership has provided us with a collective view of all issues such as the reporting of incidents.
    - Charges for some aspects of care are higher than we pay in Adult Services
    - In some cases, recreational provision and costs are not utilised by the children.
    - With regard to Education, in some cases discrepancies were found between commissioned provision and actual provision.
- Delivery of regional workshops to share the findings of the project, with all staff involved in placements have taken place in Neath Port Talbot County Borough Council and Bridgend County Borough Council. The workshop for Swansea Council staff will take place at the end of September 2018

4.4.2 Multi-Agency Placement Support Service (MAPSS)

Development of Multi Agency Placement Support Service (MAPSS), a multi-disciplinary team that aims to help children with, or at risk of mental illness and emotional and behavioral difficulties by providing specialist placement support and therapies

The work stream is looking to have a team of staff consisting of a Lead Clinical Psychologist, a Clinical Psychologist, a Team Manager, Consultant Social Workers, Therapists and Family Support Workers.

Staff continue to be recruited to post, however to date a number of outcomes have been achieved. For example, 91 children have been referred into the Multi Agency Placement Support Service with each of them identified to receive therapeutic interventions.

The following additional benefits are expected as the service develops:

- Improved placement stability for looked after children;
- Improved educational stability;
- A reduction in the number of looked after children subject to school exclusion and number of looked after children changing school for reasons other than normal transition;
- An improvement in the capacity and ability of in-house fostering services to meet the needs of Looked after Children.

To date the Lead Clinical Psychologist, Team Manager, 2 consultant social workers, 1.5 therapists and 2 family worker have recently been recruited to the team. The team are currently located in the Guild Hall in Swansea.

4.4.3 Continuing Care for Children with Complex Needs

The arrangements for funding children and young people with complex needs has become increasingly problematic, particularly in the current economic climate where Health, Education and Social Care are finding their budgets challenging and children are presenting with increasingly challenging needs.

The aim of this project is therefore to review the current arrangements and make recommendations for change in the light of good practice, and the implications of the Welsh Government legislation.

Stage 1 which reviewed the existing processes is now complete. Stage 2 is underway where interviews with individuals or small groups of key system stakeholders including families, clinicians and social care practitioners to design preferred options into a draft operating framework.

The final step to be undertaken is testing and adjusting this framework through case study exercises with the key system stakeholders and the steering group members.

4.5 Carers Partnership Board

4.5.1 Partner organisations including Abertawe Bro Morgannwg University Health Board, Local Authorities, Swansea and Bridgend Carers Centres and Neath Port Talbot Carers Service and other Third sector organisations demonstrate their commitment to working together on the Carers agenda by participating in the Western Bay Carers Partnership Board and its subgroups; in working across organisational and area boundaries to share best practice and deliver services to Carers and Young Carers. The Board has been active since 2012 to increase Carer awareness, engagement and assisting Carers by providing information, advice and support.

4.5.2 Update 2018/19

The Carers Partnership Board commissioned a third sector organisation (Bridgend Association of Voluntary Organisations) to research and produce Carers services

mapping report. The findings of the report have been used to inform the development of the Board's action plan for Carers 2018/19. This also reflects the three Welsh Government national priorities for carers and themes identified in the Carers Chapter of the Western Bay Area Plan.

4.5.3 There are four primary outcomes for carers and young carers within the draft Action Plan

a. Ensure work continues to promote early recognition of Carers and Young Carers so that they are signposted to information and support in a timely manner.

b. Develop and continue to provide information, advice, assistance and support to Carers and Young Carers enabling them to make informed choices and maintain their own health and well-being

c. Work co-productively with the Carers on an individual and strategic basis so that their contribution is acknowledged and voice is heard.

d. There is improved partnership working between funders and service providers (for Carers). This will result in Carers moving easily between partner organisations, Carers being able to access sustainable 3rd sector services which are funded on evidence of need and outcomes

4.5.4 Welsh Government Funding

£179,000.00 was made available to ABMU by Welsh Government to support work with carers and young carers during 2018-19.

The funding has been allocated to the following projects; the majority of which will be delivered by local 3rd sector organisations

- Providing a Link Worker to 3 GP Clusters to improve Carer recognition.
- Regular weekly Carer Helpdesks, supporting 6 GP surgeries providing a direct, accessible service for carers via their local surgery.
- Young Carers Information Assistance and Advice to run alongside the existing Young Carers Service adding value and additional support to young carers.
- Providing timely support service for carers across Swansea, to facilitate discharge and upon discharge from hospital.
- Providing timely support service for carers across Neath Port Talbot, to facilitate discharge and upon discharge from hospital.
- Carers Communication & Information Officer to provide appropriate service information to carers.
- Carer Co-ordinator to work with Partner organisations across Western Bay

In addition funding will be allocated to local and regional Carers events for Adult and Young Carers, to produce Carers information and for Development of Carers Awareness Recognition Scheme.

4.5.5 Integrated Care Fund 2018-19

£125,000 via the large grant scheme has been allocated this year for projects which support Carers and Young Carers in the Western Bay area.

Projects funded include

- Young Carers in Education Projects in Swansea and Bridgend

- Welfare Benefits Advisor
- Integrated Carers Assessment Worker
- Integrated Carers Support Worker (Hospital Based)
- Single Point of Contact / Triage Project for Carers
- Carers Support - Transfer of Care & Liaison Service (TOCAL)

£56k has also been allocated via the ICF 3rd sector small grants scheme for Carers. Projects funded include:

- Help desk at a number of GP surgeries in Swansea
- Activities for children with autism and their families over the school holidays
- Multi-lingual support to for carers
- Emotional and mental health well being sessions for 18-25 year olds in NPT
- Support and information for children and adults living with Spina Bifida and/or Hydrocephalus, their parents/carers and siblings

4.6 Mental Health and Learning Disability

4.6.1 The ABMU Health Board established the Mental Health and Learning Disabilities Commissioning Board across Health and Social Care and includes:

- Bridgend County Borough Council,
- Neath Port Talbot County Borough Council,
- Swansea Council,
- Primary Care and the Third Sector.

4.6.2 The Mental Health and Learning Disabilities Commissioning Board have agreed to the joint development of three strategic frameworks, which focus on adult mental health services, adult learning disability services and services for people with dementia. In addition the Board has agreed the following four priority areas, access to services, substance misuse, high cost residential and nursing placements and acute assessment services.

4.6.3 During 2017/18, the Regional Framework for Mental Health was developed and endorsed by the Regional Partnership Board and Local Authority Cabinets. During 2018/19 an Implementation Manager will be recruited and a plan for implementing the strategic framework will be developed.

4.6.4 As a result of the work to date, we are ambitious to develop services to meet people's outcomes in a different way. Work is ongoing to identify more opportunities for supporting independence and to develop new and more imaginative ways to support individuals.

4.6.5 A significant challenge is evidencing how lives have been changed for the better. Measuring positive outcomes for people who are non-verbal or lacking in capacity can be difficult to demonstrate, but we are working to overcome this by establishing relationships and maintaining a dialogue with family members, carers and professionals involved in arranging or delivering a person's care making for a truly integrated and co-productive approach.

4.7 Integrated Autism Service

4.7.1 An Integrated Autism Service (IAS) is currently being rolled out across Wales on a regional basis, utilising a national service model which was developed following extensive consultation with individuals with autism, parents and carers.

4.7.2 In Western Bay, this Integrated Autism Service will be hosted by Abertawe Bro Morgannwg University Health Board, working directly in partnership with the three Local Authority partners within the region and Third Sector organisations.

4.7.3 The Integrated Autism Service is a pioneering new service for children and adults with autism across Bridgend, Swansea and Neath Port Talbot. The service will be integrated and outcome-focussed with the aim of addressing the gaps highlighted in the recent national consultation, for example, diagnosis and assessment services for adults, support for emotional and behavioural issues, support for Autistic Spectrum Disorder (ASD) specific issues and life skills and access to social and leisure opportunities within communities.

4.7.4 Western Bay was one of the last regions in Wales to receive funding from Welsh Government and submitted their funding proposal to Welsh Government towards the end of 2017, which was subsequently approved. The Integrated Autism Service has been agreed as a priority project in the Western Bay Programme and is overseen by Western Bay Regional Partnership Board. The Head of Child and Family Services in Swansea Council is allocated as Project Sponsor and the Head of Psychology and Therapies in ABMU Health Board is allocated as Project Lead.

4.7.5 A Regional Autism Strategy Group was established in 2017 to oversee the Integrated Autism Service project and includes representatives from three Western Bay Local Authorities, the ABMU Health Board, Third Sector, Education, the National Integrated Autism Service team and the Neuro-Developmental Service. An Integrated Autism Service Operational Group has also been established.

4.7.6 A team of ten staff will be recruited during 2018 and will include the following posts, based on the national model: Service Manager, Clinical Psychologist, Occupational Therapist, Speech and Language Therapist, Specialist Practitioner, Coordinator/Admin post and four Well-being Support Workers.

4.7.7 The Service Manager has been recruited ahead of the rest of the team in order to drive forward the establishment of the Integrated Autism Service and commenced her role on 6th August 2018.

4.7.8 Activity has been underway preparing for this new service, and has included:

- A development day in January 2018 for staff in all partner organisations and the Third Sector in order to inform them of the new service
- Funding in 2017/18 was utilised to purchase Information Technology equipment for the team and a wide range of resources for the service
- Training was purchased for both professionals and parent/carers
- Service user and carers engagement event took place on 2nd May to inform them about the new service and help inform and shape the development of the new service
- Recruitment processes underway for the remaining 9 IAS staff
- Options for office accommodation for the Integrated Autism Service team are currently being explored. ICF Strategic Capital bid has been agreed for the refurbishment of accommodation for the IAS team and has been to submitted to WG on 31st August

4.8 Transformation Fund

4.8.1 A letter was received from Dr Andrew Goodall on 13th July to inform Partnership Boards of the Transformation Fund Guidance.

4.8.2 A series of meetings between representatives of the ABMU Health Board, Neath Port Talbot CBC and Swansea Council were held to outline a combined regional offer to the Cabinet Secretary and Minister for Children and Social Care on Western Bay's intent to radically transform our care system into one that is integrated to respond to issues that matter to the people we serve and care for, and our priorities to achieve this.

4.8.3 In a **Healthier Wales: our Plan for Health and Social Care** Welsh Government wants everyone to have long, healthy, happy lives. For this to happen we need to help people look after themselves well, and we need to make sure we have the right health and social care services to help people stay well, to get better when they are ill, or to live the best life possible when they have problems that won't get better.

The five main ways in which health and social care need to change are:

In each part of Wales **the health and social care system will work together** so that people using them won't notice when they are provided by different organisations. New ways of joined-up working will start locally and scale up to the whole of Wales. We will make sure local services learn from each other and share what they do, because we want everyone in Wales to have the same high quality services. We also want services to use a single digital record so that they can give the most appropriate support and treatment based on a complete picture of a person's needs.

We want to **shift services out of hospital to communities**, and we want more services which stop people getting ill by detecting things earlier, or preventing them altogether. This will include helping people manage their own health, and manage long term illnesses. We also want to make it easier for people to remain active and independent in their homes and communities.

We will **get better at measuring what really matters** to people, so we can use that to work out which services and treatments work well, and which ones need to be improved. We will identify and support the best new models of health and social care so they scale up more quickly to the whole of Wales.

We will **make Wales a great place to work in health and social care**, and we will do more to support carers and volunteers. We will invest in new **technology** which will make a real difference to keeping people well, and help our staff to work better. By making health and social care a good career choice, investing in training and skills, and supporting health and wellbeing at work, we will be able to get and keep the talented people we need to work in Wales. We will look to introduce digital advances that help staff work more effectively.

To make our services work **as a single system, we need everyone to work together** and pull in the same direction. We think we can do this in a small country like Wales, especially if we as a government provide stronger national leadership, and make sure we keep talking – and listening – to the people who deliver and use our health and social care services.

4.8.4 The combined regional offer paper has been sent to the Cabinet Secretary and Minister for Children and Social Care for consideration, we are awaiting the outcome.

4.9 Workforce Development

4.9.1 In 2017/18, Social Care Wales's Regional Facilitation Grant part funded a coordinator post to maintain partnerships and develop new links in the wider social care community across Western Bay. The coordinator has the capacity and network to ensure the sector is kept updated on relevant and pertinent information and gathering information of emerging issues that informs the core regional partnership work in developing workforce priorities to meet new ways of working.

4.9.2 The Regulation and Inspection of Social Care (Wales) Act 2016 (RISCA) has been the focus of regional work in 2017/18, which impacts on the role and responsibilities of 'Responsible Individuals' in provider organisations. Training and awareness has focused on the expectations of the Responsible Individual to take a more active role in the management of their organisations and workshops have been delivered across Western Bay to support these changes.

4.9.3 Another requirement of the Regulation and Inspection of Social Care (Wales) Act 2016 is that care workers will be required to register with Social Care Wales from 2018 (voluntarily) with a relevant qualification. As of 2020, registration will be mandatory. In order to register, care workers will be required to provide evidence of competency or have completed the Health and Social Care Induction Framework and be working towards the new Level 2 qualification.

4.9.4 The main thrust of the work has therefore been to support home care workers to achieve the required qualifications to ensure sustainability of home care services.

4.9.5 <u>'Join Our Caring Community' - Care Worker Recruitment Campaign</u>

A Welsh Government Integrated Care Fund grant of £35k was awarded to Western Bay partners to improve the reputation and raise the profile of care work, with the aim of attracting more people with the right values into the sector.

A key component of this initiative was the delivery of a campaign focusing specifically on recruiting Care Workers employed by Private Domiciliary Care Providers and Social Care Personal Assistants. This was launched in early January 2018 and was overseen by the Western Bay Workforce Development Steering Group.

Activities comprised:

- A bus rear poster campaign
- Coverage in the South Wales Evening Post and Glamorgan Gazette - 4 page supplement and advertisements featuring images and quotes from real-life care workers from across the region
- Articles and digital advertising on Wales Online
- Facebook+ advertisements and sponsored tweets (delivered via @WalesOnline, @SwanseaOnline and @GlamGazette) linking to the campaign's main landing page (www.westernbay.org.uk/care) and encouraging use of hashtags #JoinOurCaringCommunity and #YmunwchanCymunedOfalu
- Facebook and Twitter promotion via Western Bay partners' platforms
- Bilingual radio advertorials featuring real-life care worker testimonials on The Wave, Swansea Sound and Bridge FM

- Distribution of bilingual campaign posters and flyers to various locations across the region.

The campaign's landing page received 3110 views between 8th – 31st January 2018.

Neath Port Talbot Council's dedicated 'Social Care Personal Assistants' recruitment webpage (www.npt.gov.uk/pa) also saw a sharp rise in page views following the launch of the campaign.

4.9.6 Provision of Information, Advice and Assistance (IAA)

Care Choices Directory

Care Choices' regional care directories are currently being produced for over 35 Local Authority areas across the UK. They aim to promote care services directly to the people who are looking for them, both in printed format and via an online e-book. The guides provide a comprehensive outline of care services available for citizens (both self-funders and Council clients) and professionals alike, as well as including advice on undergoing assessments and accessing support services within the community.

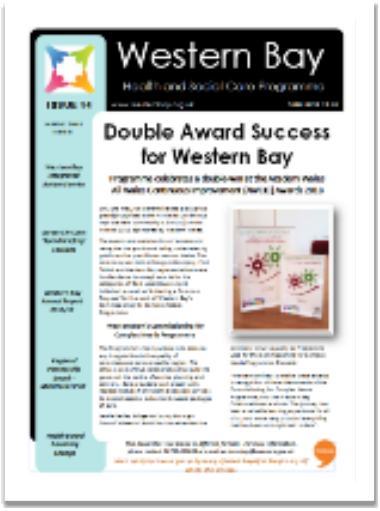
Western Bay is the only region in Wales to offer this publication, which comes at no cost to the Programme's partners as charges associated with production and distribution are covered by revenue generated by private advertising.

In 2017/18, thousands of printed copies have been distributed to larger Council buildings and a number of satellite sites, including hospitals, Common Access Points and offices of Third Sector organisations. An electronic version is also available via the Care Choices website.

The content of the 2017/18 edition of the directory was compiled by the Western Bay Communications and Engagement Officer, with input from officers in each of the three Local Authority areas.

4.10 Communications

Western Bay's dedicated Communications and Engagement Officer has delivered the following during 2017/18:



- A quarterly bilingual newsletter highlighting the progress of Western Bay projects and work streams, and promoting positive outcomes for service users and their families. The 14th issue, published in August 2018, celebrates Western Bay's success at the All-Wales Continuous Improvement Community (AWCIC) Awards 2018. It also features a short report on Welsh Government Minister Huw Irranca Davies's visit to the Western Bay Regional Partnership Board meeting in April 2018, and an introduction to the new Integrated Autism Service (IAS) due to be launched later this year.
- Content management for the Western Bay Programme's website (www.westernbay.org.uk), producing clear and concise copy describing the Programme's key areas of work, sourcing links to training resources/learning materials and drafting 'Latest News' items from across the region.
- Liaison with Communications leads, and other relevant colleagues from across the Western Bay constituent organisations to promote the health and social care integration agenda and raise awareness of the work of the Programme. The Communications and Engagement Officer is a member of the WCCIS Communications Sub Group and the Western Bay Safeguarding Communications Group, and also took the lead on the design and delivery of all promotional materials pertaining to the 'Join Our Caring Community!' campaign (see page 18).
- Digital promotion of the Programme's activities/service users' experiences via the 'Western Bay TV' YouTube channel. Following the Local Government elections in May 2017, a short video was produced to provide newly elected Councillors with an overview of Western Bay and its key areas of work. This can be found here.
- The Communications and Engagement Officer has created visual display boards and marketing materials promoting the work of the Programme. These were displayed during information-sharing sessions aimed at newly elected Councillors following the local government elections in May 2017.

5. Bridgend and ABMU Transition to Cwm Taff

5.1 In December 2017, Welsh Government launched a 3 month public consultation which proposed changing the Health Board boundary for the Bridgend population.

5.2 Taking into consideration all the views expressed through the consultation process, the Cabinet Secretary for Health and Social Services, Vaughan Gething AM, announced that from 1st April 2019, the responsibility for providing healthcare services for people in the Bridgend County Borough Council area will move from ABM University Health Board to Cwm Taf University Health Board.

5.3 In addition services and programmes provided by and implemented via the Western Bay Health and Social Care Programme will be affected as Bridgend will be included into the Cwm Taf Regional Partnership Board.

5.4 All Services and programmes are currently being reviewed by senior officers to ensure that all services provided continue and do not adversely impact the individuals receiving services.

6. Western Bay Review

6.1 Scope

6.1.1 Partners in the Western Bay programme requested that the Institute of Public Care at Oxford Brookes University (IPC) to undertake a review of the programme to ensure it is fit for future purpose, given impending policy and organisation changes in the region and across Wales. To develop the scope of the review, an initial telephone conference was held on 28 February with project sponsors Chris Sivers, Siân Harrop-Griffiths and Sara Harvey, proposing the project scope and activities will be completed.

6.1.2 There has been a great deal of progress made in building the partnership and delivering better outcomes in Western Bay since it's last review of arrangements in October 2013. There are a number of changes facing the Partnership in Western Bay in the next period:

- A new national action plan for health and social care is due in the Spring following the Parliamentary Review report in January 2018, and there are continued changes required by the Social Services and Wellbeing (Wales) Act 2014.
- A consultation period on the future of Bridgend as a part of the Western Bay Regional Partnership Board (RPB) is about to finish, and there is the likelihood that it will leave.
- There are leadership changes imminent in the Programme Office.

6.1.3 As a result, partners have agreed that it is now an appropriate time to undertake a review with the following purpose:

- Recognise the progress made by the RPB and the Programme in the last 5 years.
- Consider the implications of the changing legislative and policy framework within which the RPB will need to work in the next period.
- Propose a new vision and focus for the work of the Partnership going forward.
- Propose a future shared approach to integration or joint working

- Propose a new set of governance and working arrangements for the Partnership and the Programme Office
- Provide Bridgend CBC with a summary document which will provide sufficient information including achievements, outcomes and challenges to support the potential transition to Cwm Taff, subject to the consultation outcome.

7. Western Bay Review Findings to Date

7.1 Current Approach adopted by Western Bay

7.1.1 'Develop regionally, deliver locally' – in other words, in most projects the design, testing and development of service models has been undertaken by regional project teams comprising both operational and commissioning staff from across the agencies involved.

7.1.2 This is complemented by the expectation that once testing and development stages are complete it is up to local organisations to deliver changes in their services on a bi-lateral or individual basis. There are exceptions to this, notably in areas where there is a national requirement to be delivering on a regional basis, including for example Adoption and ASD.

7.1.3 The programme office was set up as a function to support the regional projects primarily through project management, co-ordination and support. They are expected to work with and to operational leads on the projects to ensure the agreed objectives are achieved.

7.1.4 The Programme Office have a wider role in: data collection, analysis and review to ensure that reporting on projects and budgets is of good quality, in publicising the programme and the wider aspirations of the Partnership, in undertaking projects directly for the RPB to analysis population needs and complete an agree Area Plan.

7.2 Current Challenges

7.2.1 The programme has struggled to be clear regarding its direction of travel. The overall vision its aspirations are clear, but more clarity is needed on the model the partnership it aspires to, and how partners will work together in the future to deliver better care.

7.2.2 The programme covers a very wide range of activities involving many project groups and teams and the steer from the RPB has not always been evident.

7.2.3 The programme office have been very effective in the role they have undertaken for the RPB, ensuring that projects are well organised and supported and that the strategic monitoring and decision-making needed from the RPB is undertaken on the basis of good quality information and analysis. However, the model chosen has meant they are not project leaders, and the leaders from the operational services have not always been able to commit their time and energy to the projects in a way that the projects needed.

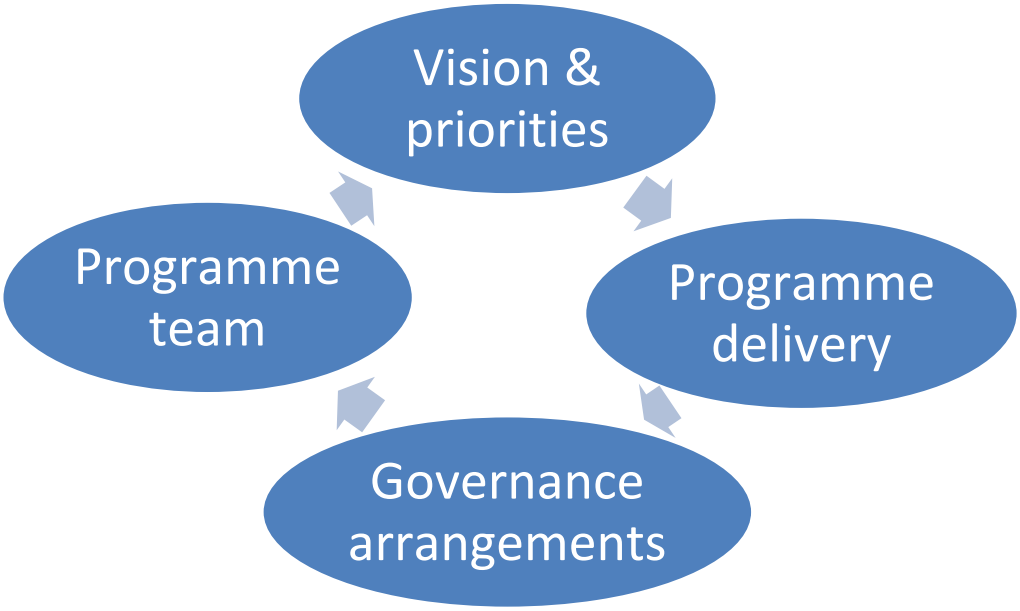
7.3 Welsh Government Plan for Health and Social Care

7.3.1 Will place a greater emphasis on preventing illness, on supporting people to manage their own health and wellbeing, and on enabling people to live

independently for as long as they can, supported by new technologies and by integrated health and social care services which are delivered closer to home.'

7.3.2 Have noted that '..regional partnership working will be at the heart of how we will develop high value models of integrated health and social care and Regional Partnership Boards, which bring together local authorities, health boards and Third Sector providers, will occupy a strong oversight and coordinating role, including on a national Transformation Programme will ensure that change happens quickly, and with purpose, across Wales'.

7.3.3 Specifically, each RPB will be required to review their Area Plans to set out new models of seamless care, pooled budgets and joint commissioning arrangements, and to identify and promote at least two models of seamless locality-based health and social care



services, and Clusters will need to work closely with RPBs to promote transformational ways of working, so that they are adopted across Wales.

7.4 Areas of improvement identified to develop of the Western Bay Health and Social Care Programme

7.5 Vision and Priorities

7.5.1 The Regional Partnership Board will need to:

- Describe what services will look like in 5 years including acute and specialist health.
- Focus on priorities described in the national plan for health and social care including care closer to home, early intervention and prevention.
- Focus particularly on the importance of effective seamless locality community and primary care services
- Raise partner's ambitions for delivering significant changes in health and social care services across the region, including private, voluntary and public services, and across community, primary and tertiary care.
- Recognise the financial and resource challenges partners are facing.
- Confirm the default approach to partnership across the region.
- Confirm a willingness to work beyond regional boundaries where appropriate
- Emphasise the commitment to citizen engagement and partnership.
- Deliver through a combination of a central programme team and operational leaders.
- Focus on outcomes.
- Cover a scope across all wellbeing services including for example education and housing.
- Be very clear about how partners see the future governance and accountability arrangements underpinning the regional programme, and clear about what form of alignment partners are aiming for in the longer term

7.6 Programme Delivery

7.6.1 Current Challenges

- The regional projects and workstreams have struggled at times to secure sufficient commitment from partners, and there have instances where similar issues were being dealt with by parallel regional and local projects, causing confusion and wasting resources.
- Perhaps in part because of the ICF funding requirements, but also because of the complexity in establishing regional groups for the first time, some of the workstreams and projects have been somewhat slow to get established, and unresponsive to changes of circumstances. They are often seen as additional to the local priorities rather than as one of them.
- The workstreams and projects have at times not had the senior organisational backing to ensure that all partners play their full part, or that the changes proposed are agreed regionally and delivered locally.
- The Regional Partnership Board has had limited success in actively overseeing and influencing the projects and workstreams. This is not surprising given the low frequency of meetings and the extended membership, but it has meant that the governance on projects and workstreams has tended to be actively undertaken in the Leadership Group which involve fewer of the representative bodies.

- The projects have tended to be fairly technical in focus and most have had very limited public, user or carer involvement. Because of the need to involve people from across the region to represent their local organisation meetings and decision-making can be unwieldy.

7.6.2 The Regional Partnership Board will need to Review:

- Refocus projects and resources on key joint strategic priorities for the new Western Bay collaboration.
- Ensure that each project is working to a specific model agreed by partners within an agreed timescale which delivers on the new vision of the collaborative.
- Ensure that projects are designed effectively to deliver on the 'regional design, local delivery' principal.
- Ensure that each major project has the right architecture to ensure delivery including senior staff, project management and skills.
- That each project has built in engagement with appropriate stakeholders including the third and private sector, service users and carers.
- Ensure that where existing projects are not considered to be a regional priority, they are handed over carefully to relevant organisations to progress.
- The programme review should be overseen by the RPB and delivery ensured by the Leadership Group

7.6.3 The programme will also need to Deliver a New Area and Action Plan for the "New Western Bay"

- An emphasis on the joint development of locality-based seamless health and care services building on work on the 11 GP clusters across the new region, and a clear description of the implications of this for partners including local authority, independent, primary and tertiary health services.
- For each major priority project a description of what model of integration partners are working towards, what services will look like, how they will be different, and how resources will shift over time. This will need to include shared responses to, for example, questions of social value and alternative delivery models, pooled funds, integrated locality teams, joint management arrangements and co-terminosity for example.
- For each major project priority a plan for how partners will work together to develop an agreed design for services across the region, and a detailed plan for delivery in each local area which can be held up to regional scrutiny. To be clear, we do not propose that the delivery of every project is left to local priorities. A number of services (eg adoption, youth offending) seem to be appropriately run on a regional basis and there may be more services to join them – but where there is agreement that local delivery makes sense, there should be clear plans for how this will be overseen regionally, and how all partners will remain accountable.
- For each major project priority a detailed description of how development and delivery will be informed by all stakeholders including service users and carers.
- A much stronger regional approach to wider public information and engagement with partners working together to publish, broadcast and

engage with the public and with staff about the need for changes in services and practices and how these will be delivered.

7.7 Governance Arrangements

The “New Western Bay Region” will still be required to:

- A Regional Partnership Board meeting Partners statutory responsibilities and linking closely with the PSB and local governance arrangements.
- A Leadership group ensuring close co-ordination of executive actions to support delivery of the shared vision and RPB agenda.
- A citizens advisory function to the RPB.
- A programme team managing both the administrative and project management demands of the Programme.
- A range of project teams with a tasks and finish remit to deliver projects agreed within the programme.

7.8 Programme Management

The Western Bay Regional Partnership Board will need to consider

- The primary care clusters agenda currently runs separately from the Western Bay programme – this needs to be extended to a combined primary and community care agenda and brought under the umbrella of the programme.
- Projects will need to work on projects in two distinct phases – development and implementation, and will each need to hold local partners to account on the local delivery of agreed regional priorities and approaches – including how they have engaged with and worked with local communities.
- Ensure the scope, membership and deliverables of existing projects encompass acute and specialist health agendas wherever appropriate and that NHS input to them is commensurate.
- It is highly unlikely that any of the projects or services should be dropped or removed from the regional governance umbrella. A clearer and stronger set of timescales and deliverables from each project, should enable partners to be able to agree relative priorities.
- Issues concerned with the boundaries of responsibility between local authorities and the NHS – eg EMI beds, support for people with complex physical disabilities and acquired brain injury, CHC and transition to children and young people, and support for looked after children - should be addressed through revisions to the scope of existing projects.
- Do not simply reduce the central team capacity in line with the overall reduction in resources as a result of changes in government grants./ Bridgend move
- Ensure that the projects which partners are committed to are sufficiently well resourced to deliver what has been agreed. Review the teams for each project on the basis of what is required project by project – these will be different according to the aims and resources available. Consider both operational leadership and project management and co-ordination requirements.

- Tidy up the project co-ordination and reporting arrangements by bringing all of the projects under the Western Bay programme to report directly to the Programme Director – including, if they continue as currently configured, community services, carers and commissioning for mental health and learning disabilities, and the new locality programme incorporating the primary care clusters.
- Maintain a central programme team able to manage the reporting requirements on grants including ICF, regional governance arrangements and good communications between partners and with the pubic and staff. The number and type of posts will need to be worked out in relation to the overall programme but we would estimate that the overall task is unlikely to be much reduced despite Bridgend leaving, as the reporting requirements will remain broadly the same as currently.
- Ensure that the real and perceived balance of skills and experience reflects the multi-agency agenda for the programme – including by ensuring that there is sufficient health service experience in the team.
- Establish permanent posts for the team leadership and the central co-ordination roles, to reduce the risk of the experience and relationships established by people in these posts being lost.
- The Programme Director post is currently filled on an interim basis. We propose that as part of the review of the programme vision, priorities and projects, that this post is strengthened, enabling it to have:
- Greater influence with each of the senior management boards of the statutory agencies through direct reporting arrangements to the Leadership Group, and line management from the Chair of the Leadership Group.
- Particular skills and experience in working with health and social care services in community and primary care settings and of working with public health services.
- Sufficient seniority to challenge operational leads on regional projects if they are not delivering against the agreed goals of each project.
- Sufficient seniority to challenge individual agencies if they are not meeting their commitments to the implementation of regionally agreed priorities.
- A clear representative role on behalf of the partnership with Welsh Government, other national and regional bodies.

7.9 Next Steps of the Western Bay Review

7.9.1 Kelly Gillings of the Western Bay Programme Office and Keith Moultrie of the Institute of Public Care (IPC) at Oxford Brookes University at the request of the Western Bay Regional Partnership Board July 2018 have developed a document proposing a series of activities to complete the project, to ensure that all key partners have the opportunity to consider the findings, and to enable the Programme to agree a concrete and practical plan for the work of the Partnership going forward.

7.9.2 The activities are:

Dates	Activities	Rationale	People
August 2018	IPC review comments from RPB, workstream reporting arrangements	The report will provide the starting	Keith Moultrie (KM) Kelly Gillings (KG)

Dates	Activities	Rationale	People
	with the programme office, risk profiles and produce draft report	point for discussion by the RPB, PSBs and partners	Nicola Trotman (NT)
	Confirm membership and meeting arrangements for the Implementation Group in Western Bay	This was agreed by the RPB on 20 July	RPB Chair and lead Directors
October 2018	Half-day workshop for RPB and Workstream Board members to: ■ Develop and agree vision and principles statement drawing on the IPC draft report. ■ Review the Transformation Bid for Western Bay and its implications. ■ Learn together on approaches and principles of co-production. ■ Agree the workstreams to be included in scope of the review (inc any Tier 2) ■ Review governance arrangements for RPB, including scrutiny across the programme ■ Review role's within RPB – Chair, Vice Chair, Citizen Reps	Recommended by the IPC draft report and discussed at RPB	RPB Workstream Board Leaders Programme Office KM
	Prepare materials for the '3-day review exercise' including key workstream and project reports against the agreed vision and principles, and overall of governance and programme office arrangements drawing on IPC draft report.	To ensure review below is effective	Implementation Group and Programme Office
October/November	Undertake '3 days review exercise' for the RPB to review ■ Each workstream and new potential workstreams ■ Population Assessment and the implications for the area plan and action plan ■ Risk Profiles of each partner organisation ■ Overall governance ■ Programme office ■ Branding and communications plan ■ Update the Population Assessment in preparation for the relocation of BCBC to the Cwm Taff Region ■ Develop the 5-year Area and Action Plans	Recommended by IPC report	RPB Workstream Leads Programme Office Relevant members of the citizen panel to attend sessions
November /	Prepare materials on:	To support effective	Programme office

Dates	Activities	Rationale	People
December	Programme plan and plans for each workstream Area Plan implications Public and staff information	engagement	and Implementation Group
January / February	A series of short engagement events for staff, public and users and carers	To inform and consult on the new vision, principles and programme targets for Western Bay	RPB members, workstream leads and the Programme Office
February	Complete sign-off of the newly branded Western Bay Area Plan, Programme and targets by RPB and individual authorities	To complete the exercise and formally commit agencies to the revised plans	RPB Local executives and members

8. Financial Implications

There were no financial implications in completing this report.

9. Workforce Impact

Not applicable.

10. Equality and Engagement Implications

Not Applicable.

11. Legal Implications

Not Applicable.

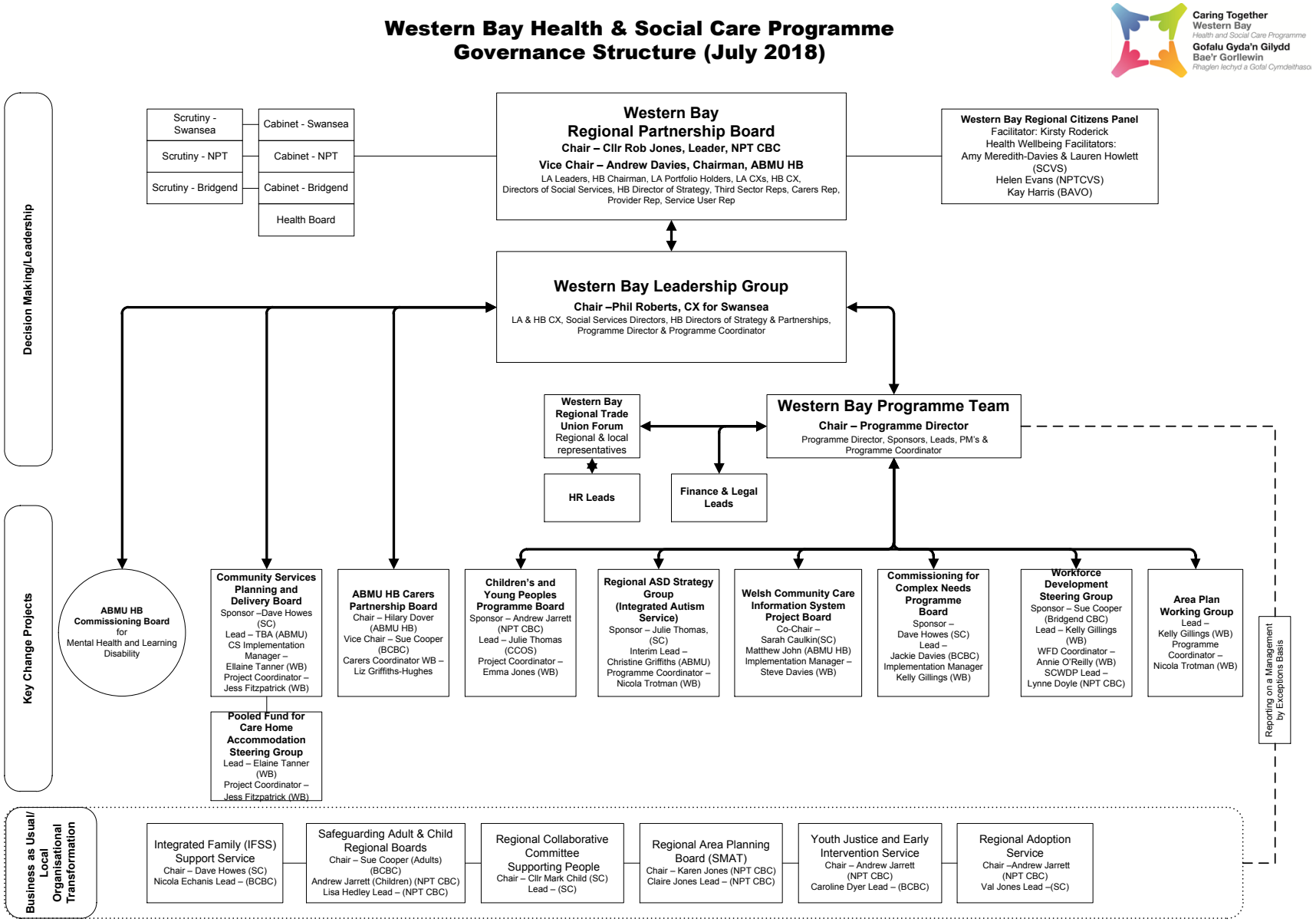
12. Risk Management

Not Applicable.

13. Background Papers:

Not Applicable

Appendix 1 – Western Bay Health and Social Care Programme Governance Structure



Appendix 2 – Commissioning for Complex Needs

WESTERN BAY HEALTH AND SOCIAL CARE PROGRAMME
RHAGLEN IECHYD A GOFAL CYMDEITHASOL BAE'R GORLLEWIN
COMMISSIONING FOR COMPLEX NEEDS PROGRAMME
RHAGLEN GOMISIYNU AR GYFER ANGHENION CYMHLETH

Caring Together Western Bay
Gofalu Gyda'n Gilydd Bae'r Gorllewin

Western Bay's Commissioning for Complex Needs Programme is transforming the lives of people receiving care services, while also delivering significant financial benefits. The methodology encourages progression, which empowers people to support themselves and become less reliant on services in the longer term.

The Purpose of the Programme

The Programme's principal purpose is to address any irregularities in the quality of commissioned care across the region. This involves fostering positive, co-productive relationships with care providers, with the ultimate aim of increasing the independence of service users, and supporting them to achieve their personal well-being goals. The ethos is one of true collaboration that puts the person at the centre of service planning and delivery. Care providers work closely with representatives from health and social services to create bespoke, outcome-focussed packages of care for each individual. This methodology encourages progression, which empowers people to support themselves, become less reliant on services in the longer term, meaning cashable savings. The success of this collaborative approach has led to it being extended to apply to cases for children with complex needs.

SOMETIMES EVEN SMALL CHANGES CAN MAKE A BIG DIFFERENCE

Ali has a mild to moderate learning disability, has diabetes and has some autistic traits. Her mobility is poor and she requires a walking frame to get around. She loves gardening, but the layout of her accommodation is challenging as there are a number of steps to negotiate in outdoor area. Following an 'Outcome-Focussed Assessment', some raised (waist-height) flowerbeds have been installed in the garden, along with two ramps, which enable Ali to access the outdoor space and tend to the plants with ease.

She's thrilled with this outcome and is now growing her own vegetables!

ALI'S STORY...

MR Z'S STORY...

Mr Z suffers from schizophrenia and has been known to Mental Health services since 1979. After a short period of hospitalisation, he lived a stable life until 2016 when an incident occurred in his residence and it was felt admission to hospital was required. After a brief period of support, Mr Z was able to leave hospital and move to a nursing home. An 'Outcome-Focussed Assessment' was carried out in August 2017, which identified a number of personal and well-being goals for Mr Z, including:

- Mr Z felt he no longer needed care and support within a care home and wanted to explore options with a view that he would return to independent living.
- Mr Z had demonstrated an excellent understanding of his illness and although he doesn't like taking medication, appreciates he needs to do so in order to remain well.
- Mr Z explained that he missed the "simple things in life, like buttering my own toast...". He expressed the desire to live somewhere where he had the opportunity to re-build his confidence in food preparation.
- Mr Z stated he wants to have more freedom, but appreciates the need for support to ensure everything is going well and to check his compliance with prescribed medication /attendance at medical appointments.

A plan was created to help Mr Z work towards achieving his goal of independent living:

- Mr Z moved from the nursing home to a supported living scheme
- This offers him the opportunity to be more independent
- It's also met his aim of being able to butter his own toast, while being supported to take his medication.

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