Neath Port Talbot
Castell-nedd Port Talbot
County Borough Council Cyngor Bwrdeistref Sirol

AGENDA

SOCIAL CARE, HEALTH AND HOUSING CABINET BOARD

Immediately Following Scrutiny Committee on
THURSDAY, 8 OCTOBER 2015

COMMITTEE ROOMS A/B - NEATH CIVIC CENTRE

PART 1

1. To agree the Chairperson for this Meeting.

2. To receive any declarations of interest from Members.

3. To receive the Minutes of the previous Social Care, Health and Housing Cabinet Board held on 10 September, 2015 *(Pages 5 - 10)*

To receive the Report of the Head of Business Strategy and Public Protection

4. NPT Homes Progress Report to September 2015 *(Pages 11 - 36)*

5. Environmental Health & Trading Standards - Changes to Officer Delegation *(Pages 37 - 40)*

To receive the Report of the Head of Community Care and Commissioning Services

6. Section 33 Agreement with ABMU *(Pages 41 - 136)*

7. Safeguarding and Quality Annual Report 2014-15 *(Pages 137 - 198)*

8. **To receive the Forward Work Programme 2015/16**
(Pages 199 - 200)

9. Any urgent items (whether public or exempt) at the discretion of the Chairman pursuant to Statutory Instrument 2001 No 2290 (as amended).

10. Access to Meetings - to resolve to exclude the public for the following items pursuant to Regulation 4(3) and (5) of Statutory Instrument 2001 No. 2290 and the relevant exempt paragraphs of Part 4 of Schedule 12A to the Local Government Act 1972.

PART 2

To receive the Private Report of the Head of Business Strategy and Public Protection

11. Supporting People Local Commissioning Plan 2014-17 (Exempt Under Paragraphs 12 and 14) *(Pages 201 - 232)*

12. Afghan Resettlement Scheme (Exempt Under Paragraph 14) *(Pages 233 - 278)*

To receive the Private Report of the Head of Community Care and Commissioning Services

13. Dynamic Purchasing System (Exempt Under Paragraph 14) *(Pages 279 - 310)*

S.Phillips
Chief Executive

Civic Centre
Port Talbot **Friday, 2 October 2015**

Cabinet Board Members:

Councillors: J.Rogers and P.D.Richards

Notes:

(1) If any Cabinet Board Member is unable to attend, any other Cabinet Member may substitute as a voting Member on the Committee. Members are asked to make these arrangements direct and then to advise the committee Section.

(2) The views of the earlier Scrutiny Committee are to be taken into account in arriving at decisions (pre decision scrutiny process).

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EXECUTIVE DECISION RECORD

CABINET BOARD - 10 SEPTEMBER 2015

SOCIAL CARE, HEALTH AND HOUSING CABINET BOARD

Cabinet Board Members:

Councillors: J.Rogers (Chairperson) and P.D.Richards

Officers in Attendance:

Mrs.C.Marchant, Mrs.A.Thomas and Mrs.T.Davies

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1. **APPOINTMENT OF CHAIRPERSON**

   Agreed that Councillor J.Rogers be appointed Chairperson for the meeting.

2. **MINUTES OF THE SOCIAL CARE, HEALTH AND HOUSING CABINET BOARDS HELD ON 30 JULY AND 3 AUGUST 2015**

   Noted by the Committee.

3. **QUARTER 1 PERFORMANCE REPORT**

   Decision:

   That the report be noted.

4. **SOCIAL SERVICES AND WELLBEING (WALES) ACT 2014**

   Decision:

   That the report be noted.

5. **FOOD STANDARDS AGENCY AUDIT ACTION PLAN**

Decision:

That the report be noted.

6. **COMMISSIONING AND CONTRACTING UPDATE**

Decision:

That the report be noted.

7. **GRWP GWALIA RE-ALIGNMENT OF RESIDENTIAL CARE**

Decisions:

1. That regular short break service reviews be implemented, to ensure services are responsive to population needs, and in order to minimise any potential adverse impact caused to individuals by the changes;

2. That the new model of Grwp Gwalia residential services, as detailed within the circulated report, be approved.

Reason for Decisions:

To reshape the current residential services for older people to assure that they remain and continue to be responsive and pertinent to meet the changing needs of the population.

Implementation of Decisions:

The decisions will be implemented after the three day call in period.

Consultation:

This item has been subject to a 60 day public external consultation.

8. **REVIEW OF DIRECT PAYMENTS**

Decisions:

1. That consultation be undertaken with Service Users, families and providers to establish their views on the effective use of Direct Payments;

2. That a review of all Direct Payments be undertaken as the next phase of Pathways to Independence, to ensure that all outcomes have been delivered and that this was a cost effective use of resources.

Reason for Decisions:

To ensure that the Authority's resources are being utilised effectively and that individual outcomes are being delivered for service users.

Implementation of Decisions:

The decisions will be implemented after the three day call in period.

Consultation:

Consultation will take place with the service users, families and the provider.

9. **FORWARD WORK PROGRAMME 2015/16**

Decision:

That the Forward Work Programme be noted.

10. **ACCESS TO MEETINGS**

Decision:

That pursuant to Regulation 4(3) and (5) of Statutory Instrument 2001 No. 2290, the public be excluded for the following items of business

which involved the likely disclosure of exempt information as defined in Paragraphs 12 and 14 of Part 4 of Schedule 12A to the Local Government Act 1972.

11. **HOUSING RENEWAL AND ADAPTATION SERVICE - FINANCIAL ALLOCATIONS 2015-16**

Decisions:

1. That the General Capital Fund allocation be apportioned as detailed within the circulated report;

2. That the Specific Capital Grant allocation be split and apportioned to the individual operational categories for each Renewal Area, as detailed within the circulated report;

3. That the Vibrant and Viable Places, ARBED2 and ECO funding be fully allocated to the Vibrant and Viable Places Regeneration works;

4. That the recyclable loans be distributed, as detailed within the circulated report.

Reason for Decisions:

To enable the Authority to utilise its Capital Allocations for 2015/16.

Implementation of Decisions:

The decisions will be implemented after the three day call in period.

12. **SUPPORTING PEOPLE PROGRAMME GRANT**

Decisions:

1. That the Head of Community Care and Commissioning Services be authorised to finalise the appointment of separate Block Gross contract agreement(s) with Clos Care Cymru, S.T.A.R Services and Walsingham Learning Disability Services, and to instruct the Head of Legal Services to enter into these agreements with the aforementioned providers;

2. That in the event of a change in the amount of the Supporting People Programme Grant that will be paid to Clos Care Cymru, S.T.A.R Services and Walsingham Learning Disability Services, the Head of Community Care and Commissioning Services be authorised to vary these figures accordingly to a level to be determined by the Head of Community Care and Commissioning Services.

Reason for Decisions:

To ensure the Authority is making the best possible use of any Supporting People Programme Grant funding that it receives during the period 2014-17 and by acknowledging the performance of currently commissioned services in line with efficiencies savings as requested by the Local Authority.

Implementation of Decisions:

The decisions will be implemented after the three day call in period.

CHAIRPERSON

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NEATH PORT TALBOT COUNTY BOROUGH COUNCIL

SOCIAL SERVICES, HEALTH AND HOUSING CABINET BOARD

8th October 2015

REPORT OF THE HEAD OF BUSINESS STRATEGY AND PUBLIC PROTECTION – A. THOMAS

SECTION C – MATTER FOR MONITORING

WARD(S) AFFECTED: ALL

NPT HOMES PROGRESS REPORT – TO SEPTEMBER 2015

Purpose of Report

The purpose of the report is to provide members with an overview of progress made by NPT Homes in respect of the promises made to tenants in the Council's Offer Document.

Background

The Council transferred its housing stock to NPT Homes on 4th March 2011.

As part of the Transfer Agreement, NPT Homes committed to providing half yearly update reports to the Council's Social Care, Health and Housing Cabinet Committee on progress made in respect of the delivery of the Offer Document promises to tenants.

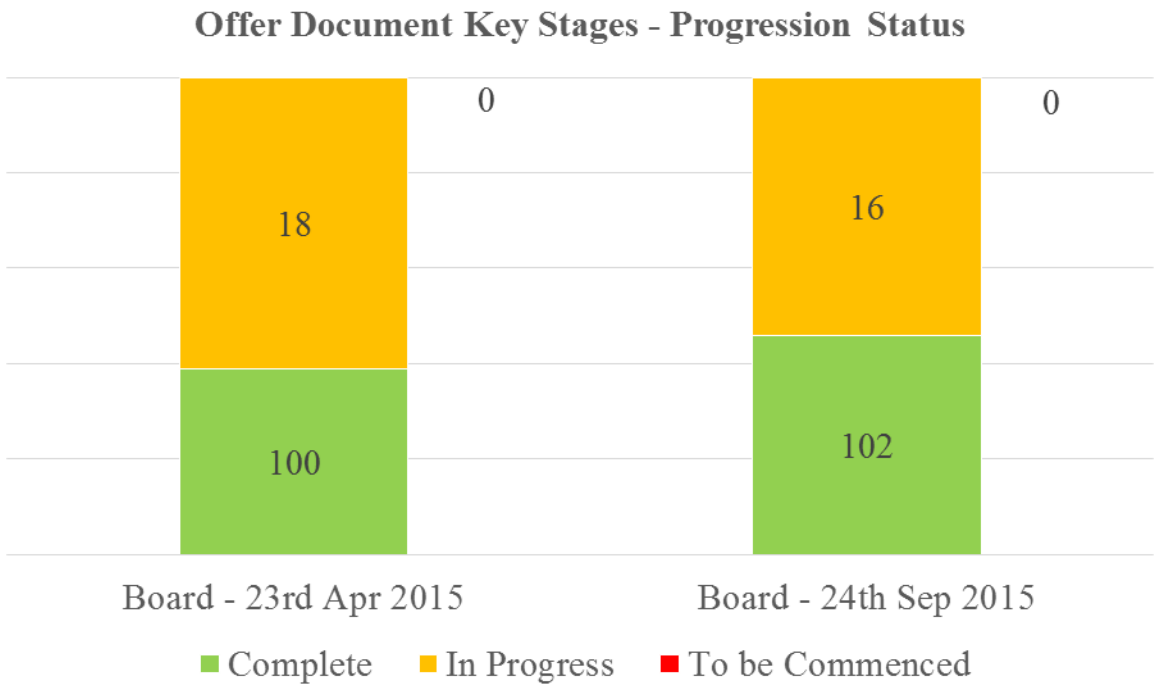
It is worth noting that the scrutiny of these update reports is complemented by regular meetings between the Chief Executive of NPT Homes and previously the Head of Community Care and Housing Services, and now the Head of Business Strategy and Public Protection.

Delivering the promises made in the Offer Document – Progress update

Attached is an action plan which is in a format agreed by Social Care, Health and Housing Cabinet Board on 28th July 2011.
In the report to Members on 13th March 2014 it was noted that future reports will be shorter by only including promises that are yet to be delivered.

Promises which have been completed since the report was last presented to members are also included. This approach has been taken by the Board of NPT Homes which now monitors the progress in this way circa. April and September of each year. The full list of promises and their status will still be accessible on the NPT Homes website.

The attached report uses red, amber, green (RAG) reporting to show the status of the promises – those yet to commence are red, those in progress are amber, those completed (since the last report) are green.



One of the key elements of the Offer Document is the completion of the Welsh Housing Quality Standard (WHQS) works programme by 31st March 2017.

Good progress continues to be made with the WHQS programme having completed the following works since transfer:

- 5,577 kitchens
- 5,088 bathrooms
- 4,392 heating system installations
- 1,230 roof replacements
- 2,032 window and door installations.

Appendix 1 summarises the outstanding Offer Document promises and progress made.

NPT Homes' first new housing development in Melin, Neath is now complete. The £1.7m development, which received £1m funding as part of a Social Housing Grant through Welsh Government's Smaller Properties Programme, took just over 12 months to complete. It includes eleven, two bedroom houses and four, one bedroom flats providing much needed affordable housing for people in the area. The Welsh Government's Smaller Properties Programme is aimed specifically at helping to alleviate the impact of the UK Government's "Bedroom Tax" and is managed and prioritised locally by Neath Port Talbot Council in its role as local strategic housing authority.

As well as providing much needed affordable housing in the area, the development provided three people with employment and four apprentices from Cyfle Shared Apprenticeship scheme with the opportunity to gain valuable hands on learning. NPT Homes' own carpentry apprentices, who needed to undertake some aspects of new build work rather than repair, worked on the site and the high quality windows were also built in NPT Homes' own manufacturing unit in Seven Sisters

The new site has been named Furnace Place by local pupils at Melin Infants School. After the contractor Morganstone conducted a health and safety assembly with the entire school, pupils took part in a safety poster competition with the winning design being displayed on site throughout the duration of the build.

The official opening of the scheme was attended by the Leader Cllr. Ali Thomas, NPT Homes' Chair and Chief Executive, Morganstone and pupils from Melin Infants School.

Conclusion

Members are asked to note the content of the report and to note that further updates will be provided to Members following NPT Homes' April and September Board meetings.

Appendices

Appendix 1 – Offer Document Promises - Tracking Document.

List of Background Papers

None

Officer Contact

Angela Thomas, Head of Business Strategy and Public Protection.
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E-mail: a.j.thomas@npt.gov.uk

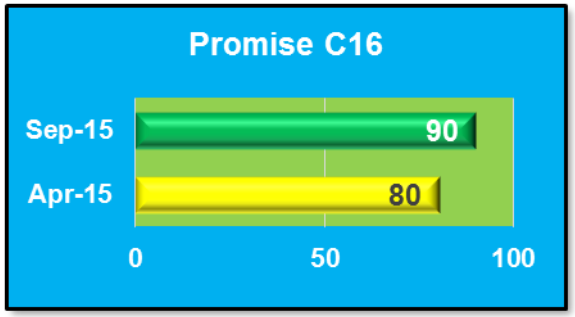
Appendix 1 - Offer Document Promises Tracking Document

Key:

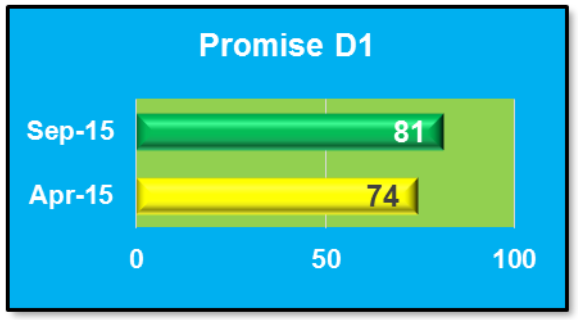
Complete

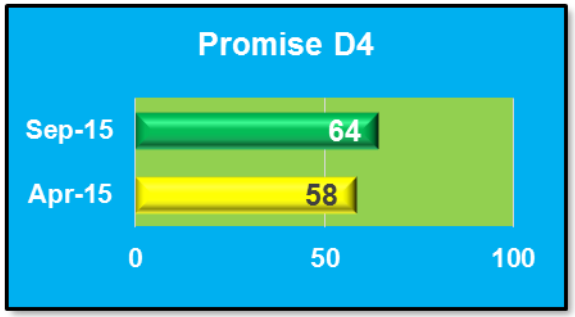
In progress

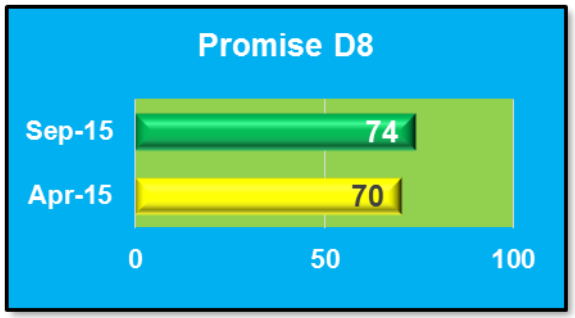
To be commenced

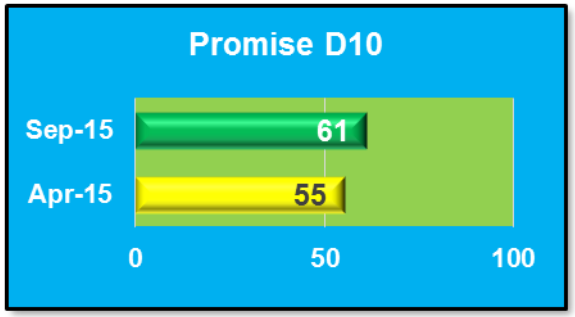
Promise No.	Nature of Work	To be commenced	In Progress	Complete	Comments
Part C	**Delivering local services and tackling anti-social behaviour – NPT Homes would plan to:**				
	Service Improvements:				
	Anti-social behaviour and breach of tenancy				
C16	Develop expertise and best practice in dealing with anti-social behaviour problems and gather evidence to help ensure successful court action.		✓		 The Director of Housing has been invited to sit on the Safer Neath Port Talbot Partnership Board. An NPT Homes case review group has been established with clear terms of reference. Relevant cases which are identified through this process are reviewed by officers with our specialist lawyers.

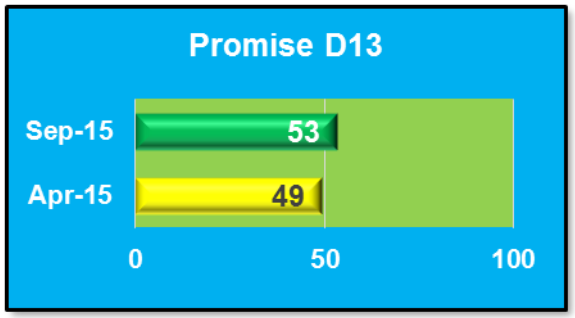
Promise No.	Nature of Work	To be commenced	In Progress	Complete	Comments
C16 Cont.					Staff involved in ASB cases attended both the review group and the joint meetings with our specialist lawyers allowing them to benefit from the best practice being implemented elsewhere and contribute to their training & development in this area. NPT Homes is a member of the Social Landlords ASB forum. The purpose of this group is to: Share good practice; Consider prevention tools; Share resources, e.g. in house mediation skills. Welsh Government use this group as part of their consultation processes for new legislation or guidance. A suite of KPIs have been established in relation to ASB; these are reported quarterly. An ASB internal audit (June 2015) reported a 'substantial' level of assurance regarding the way in which NPT Homes seeks to address/prevent ASB.

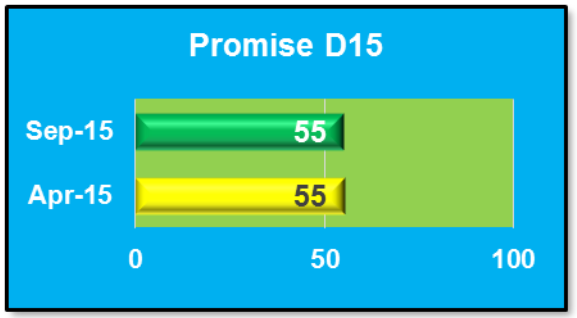
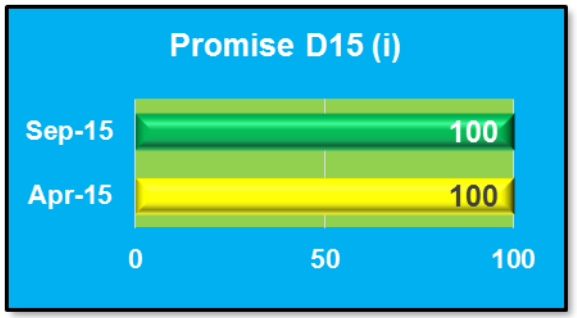
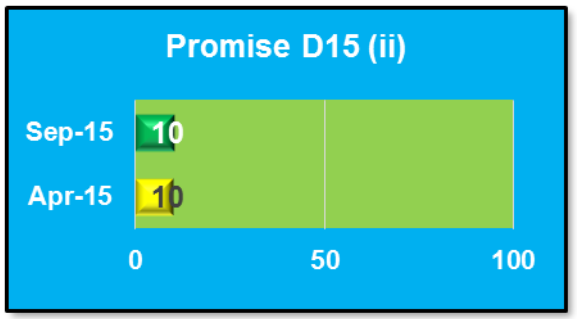
Promise No.	Nature of Work	To be commenced	In Progress	Complete	Comments
C16 Cont.					The feasibility of applying for Housemark ASB accreditation will be considered; if appropriate this will be submitted and will result in the 100% completion of this promise.
Part D	**Improving and repairing your home**				
	Planned Maintenance and Improvements				
	Windows and external doors -				
D1	There would be double glazed window installations to approximately 2,500 homes which would where possible have: - High quality double glazed uPVC windows - Secure locking handles to ground floor windows and doors. It is planned that, wherever possible, all homes would have double glazed windows within six years of transfer. New double glazed uPVC front and rear external doors would be provided where not already in place within six years of transfer. They would be of high quality and where possible contain: - Multi point locking system complying with, Secure by Design Standard; - Security chain.		✓		 PVC door and window renewal programme is ahead of target to meet WHQS by 2016/17. As at 30/06/2015 2,032 properties have been completed with double glazing.

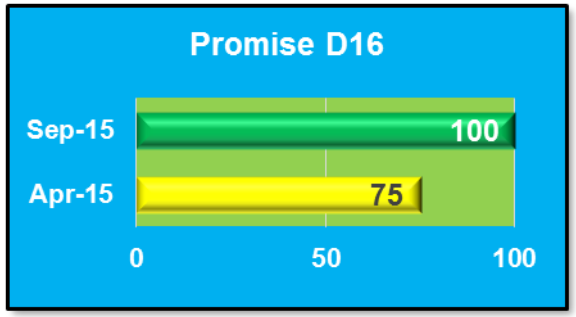
Promise No.	Nature of Work	To be commenced	In Progress	Complete	Comments
	Kitchens –				
D4	Kitchens would be modernised and tenants would where possible be given a choice of worktops, doors and tiles. It is planned that all kitchens would meet WHQS within six years of transfer. Around 3,700 new high quality kitchens would be fitted in the first 6 years following transfer. Around 4,800 kitchens would be upgraded. *Further survey work since transfer has led to a revised target of 8,740 new or upgraded kitchens and the percentage completion is reviewed against this figure which may be further revised as the programme is completed.*		✓		 The kitchen replacement programme has made excellent progress since it commenced 3 ½ years ago. A delivery strategy has been developed which will achieve our deadline of 2016/17. As of 30/06/15, 5,577 properties had received new kitchens.

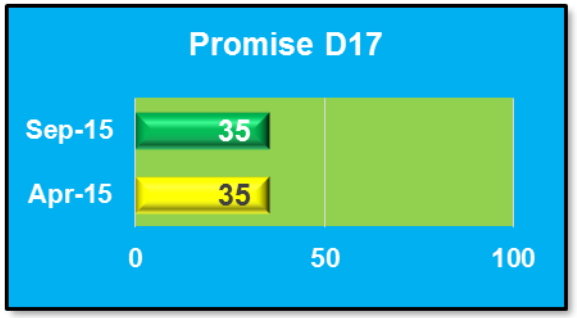
Promise No.	Nature of Work	To be commenced	In Progress	Complete	Comments
	Heating -				
D8	It is planned that all homes where heating systems fail the WHQS would be offered a new full central heating system with boilers and radiators, with approximately 6,000 central heating boilers being replaced in the first 6 years following transfer. All new systems would where possible include: - separate radiator thermostats; - energy efficient boilers; - programmable heating timers. *Further survey work since transfer has led to a revised target of 5,900 new or upgraded heating systems and the percentage completion is reviewed against this figure which may be further revised as the programme is completed.*		✓		 The main programme commenced in October 2011. As at 30/06/15, 4,392 new heating systems have been installed and the programme is on target to complete during 2016/17.

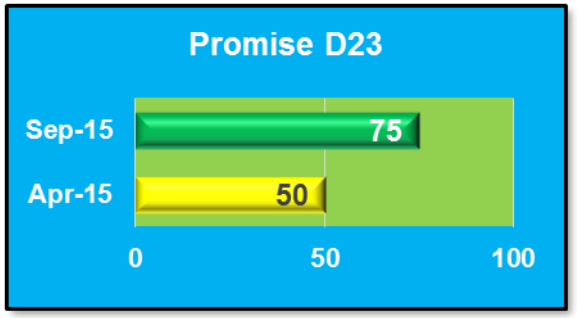
Promise No.	Nature of Work	To be commenced	In Progress	Complete	Comments
	Bathrooms -				
D10	Around 2,400 homes would be fitted with new bathrooms within six years of transfer allowing for where possible: - over bath electric showers (or separate shower cubicles where space and budget permit); - extractor fans; - non-slip flooring; - a choice of tiles. Around 6,000 bathrooms would be upgraded. It is planned that all bathrooms would meet the WHQS within six years of transfer. *Further survey work since transfer has led to a revised target of 8,339 new or upgraded bathrooms and the percentage completion is reviewed against this figure which may be further revised as the programme is completed.*		✓		 The bathroom replacement programme has made excellent progress since it commenced 3 ½ years ago. As of 30/06/15, 5,088 properties had received new bathrooms and the programme is on target to complete during 2016/17.

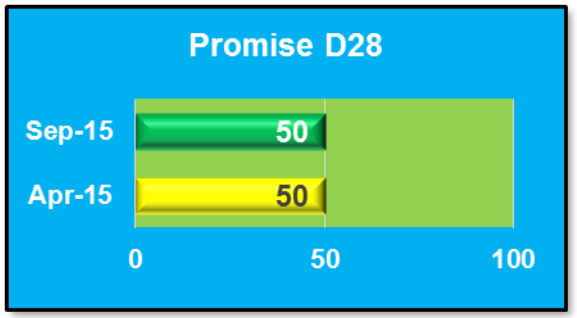
Promise No.	Nature of Work	To be commenced	In Progress	Complete	Comments
	Roofs -				
D13	NPT Homes would have a budget of around £2.8 million for a programme of roof repairs and renewal in the first six years after transfer including on-going replacement of roof coverings as necessary throughout the 30 years of the business plan. *Further survey work since transfer has led to a revised target of 2,319 new or upgraded roofs and the percentage completion is reviewed against this figure which may be further revised as the programme is completed.*		✓		 The roof repair programme has continued since transfer and is programmed to be completed within 6 years. As at 30/06/15, 1,230 roofs have been replaced since transfer and the programme is on target to complete during 2016/17.

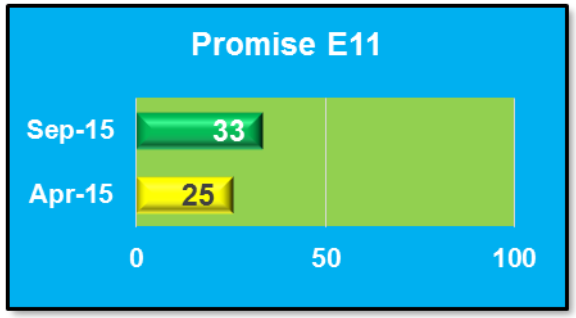
Promise No.	Nature of Work	To be commenced	In Progress	Complete	Comments
	Security -				
D15	Tenants would be offered (where appropriate): - (i) front and rear external entrance lights; - (ii) NPT Homes would have a budget for improvements to fences and gates.		✓		  

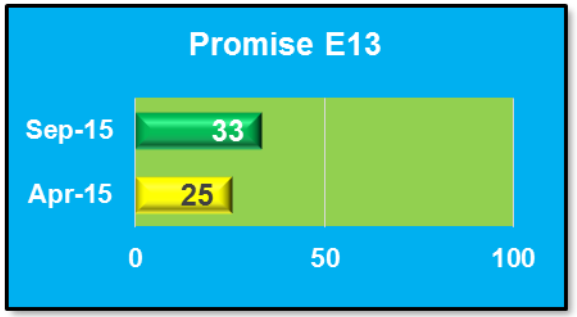
Promise No.	Nature of Work	To be commenced	In Progress	Complete	Comments
D15 Cont.					Security lights form part of D14 rewiring works which has previously been signed off as complete. The provision of gates and fences is being assessed (globally) as part of the land appraisal process with works anticipated to start early 2016. The data regarding fences and gates is currently being collected.
	Disabled Adaptations -				
D16	A budget of £26.75 million within the investment programme over 30 years on disabled adaptations, including approximately £6 million in the first 6 years after transfer.			✓	 NPT Homes has spent in excess of the promised £6M on disabled adaptations since transfer and has set up a dedicated team to manage adaptation works going forward to meet the promise within the offer document.

Promise No.	Nature of Work	To be commenced	In Progress	Complete	Comments
	Environmental and Security Improvements				
D17	NPT Homes would have a budget of £13.5 million within its investment programme for environmental and security improvements in the first six years alone - over £10m on estate and environmental improvements and over £3.5m on security. Examples of improvements that could be provided for each estate include: - improved estate car parking; - fencing, walls and railings around communal blocks; - improved external lighting and security lighting; - repairs to walkways, pathways and other hard landscaping; - enhancing the landscaping features around the homes; - reviewing the use of and improving communal drying areas; - reviewing the use of underused garage sites and rationalising their provision; and - play areas.		✓		 The Regeneration Team has an on-going programme of community consultation following Welson Government best practice (50% completed as at 31st March 2015) which will establish a resident led approach to define estate based priorities and neighbourhood enhancements. Interpreting the environmental standard will be different for each area as it will have to meet the needs of each local neighbourhood. The Regeneration Team will ensure that community based priorities are captured accurately and effectively leading to a delivery plan of environmental improvements commencing early 2016.

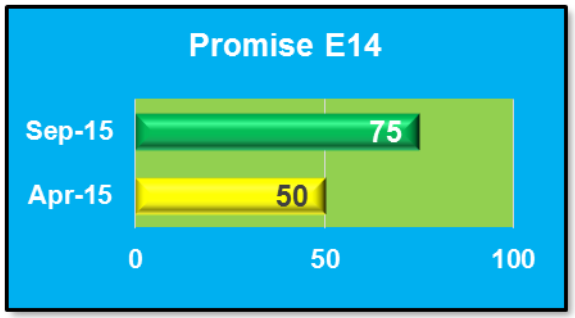
Promise No.	Nature of Work	To be commenced	In Progress	Complete	Comments
	Repairs Service -				
	NPT Homes would plan to:				
D23	Extend the times during which day-to-day repairs are carried out, such as early evenings on weekdays and on Saturday mornings so as to be able to offer more convenient appointments for working tenants.		✓		 Pilot to commence from Monday 5th October 2015, where working tenants will be able to request an early evening (up to 6.00 pm) or Saturday morning between 8.00 am and 12.00 midday appointment for non-urgent internal works.

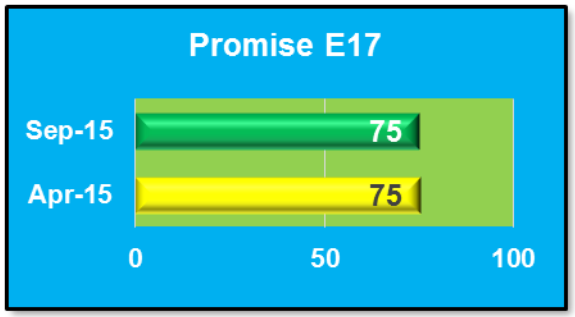
Promise No.	Nature of Work	To be commenced	In Progress	Complete	Comments
	Planned Maintenance Programmes -				
D28	Decorate internal communal areas in sheltered schemes and blocks of flats.		✓		 A review is currently underway of all communal areas to identify the full extent of the works required to upgrade the communal areas. A pilot refurbishment scheme has been completed in Gwent House, Sandfields. The tenants in the 5 sheltered housing schemes that will be included in the WHQS programme 2015 have been consulted on what they would like to see with regard to the communal areas and communal facilities.

Promise No.	Nature of Work	To be commenced	In Progress	Complete	Comments
Part E	**Service for older people and sheltered housing services**				
	Improvements to Sheltered Schemes:				
	NPT Homes would plan the following improvements to sheltered schemes:				
E11	Where appropriate, and subject to resources being available, give a choice of a replacement of bath with shower or a walk-in shower to tenants with mobility problems when bathroom replacement programmes are carried out.		✓		 Work to bring sheltered schemes up to WHQS has commenced with 3 schemes completed by 31st March 2015. Work has commenced at a further 3 schemes. Where appropriate tenants receive an assessment from a qualified Occupational Therapist so that their needs can be accommodated, wherever possible, in the upgrade works. Showers are fitted as standard and, where feasible, an assisted bathing/communal bathing facility is made available.

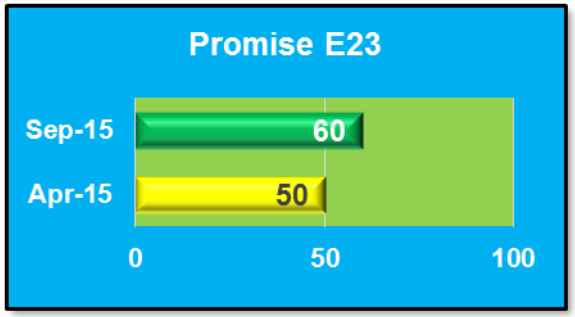
Promise No.	Nature of Work	To be commenced	In Progress	Complete	Comments
E13	Ensure accommodation is more accessible where possible by automotive doors to communal areas.		✓		 This is being considered/delivered as part of the sheltered housing WHQS programme; this commenced in Summer 2014 and will be completed during 2017. New doors to individual dwellings have been provided in Riverside Court; they have been fitted with assisted door openers which means they can be opened with the minimum of effort. Where replacement doors are required to communal areas the feasibility of these being fully automated will be considered.

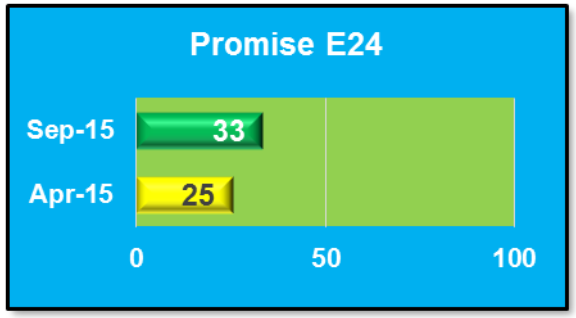
Promise No.	Nature of Work	To be commenced	In Progress	Complete	Comments
E13 Cont.					Notwithstanding the work that will take place as part of WHQS, progress has been made towards the achievement of this promise through the following actions: 1) An automated door and access ramp have been installed at Ty Llansawel sheltered housing complex. 2) An automated door is already in place at Michaelstone Court and Gwyn Court. 3) The ramp and entrance door to the rear of Cysgodfa have been reconfigured to allow ease of access. 4) A vertical lift has been installed at Cysgodfa and Mozart Court sheltered housing scheme. 5) A lift has been installed at the newly developed Ty Maes Marchog Sheltered Housing scheme.

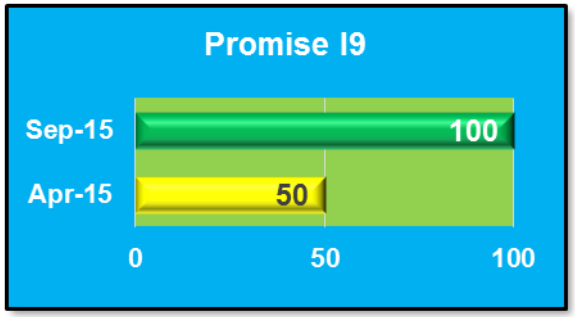
Promise No.	Nature of Work	To be commenced	In Progress	Complete	Comments
	Scheme Managers				
	NPT Homes would also aim to improve services provided by the scheme managers in order to meet the needs of older people. It would consult with tenants on a range of possible improvements which, for example, could include:				
E14	Introducing a tenants' handbook specifically for tenants of sheltered housing.		✓		 A draft handbook has been produced. The handbook's content was produced by a working group made up of tenant volunteers, scheme managers and the tenant empowerment officer with responsibility for 'older persons'. The working group was split into small task and finish groups, looking at individual subjects/sections of the handbook in more detail.

Promise No.	Nature of Work	To be commenced	In Progress	Complete	Comments
E14 Cont.					As well as hard copies it is envisaged that the content of the handbook will also be presented in the form of a DVD which will be shown in the communal lounge of each sheltered housing scheme. We are in the process of rebranding our sheltered housing / support service as well as redesigning the service that tenants will receive. It is prudent to delay the publishing of the handbook until this piece of work has been completed. This promise will be considered to have been achieved once any amendments have been made and the handbook published.
E17	Developing communities around sheltered schemes.		✓		 The Sheltered Tenant Empowerment Officer has initiated a sheltered social group in conjunction with NPTCVS.

Promise No.	Nature of Work	To be commenced	In Progress	Complete	Comments
E17 Cont.					This group aims to empower those tenants who are looking for a challenge, to help set up social activities for other sheltered tenants. A co-design approach has been taken to the re-design of the sheltered housing scheme manager/support service. This has seen tenant volunteers/ambassadors work together to design the future service – utilising the assets available within sheltered schemes and the community that surrounds it will be fundamental to meeting the needs of tenants at a time when the Supporting People budget is reducing. This promise will be considered to be 100% complete once the new support service to older people has been launched; the anticipated implementation date is April 2016

Promise No.	Nature of Work	To be commenced	In Progress	Complete	Comments
	Other improvements:				
	Additional improvements could include:				
E23	Developing a good neighbour scheme for sheltered accommodation so that additional on-site support would be available for emergencies outside office hours.		✓		 A number of information arrangements are in place at each scheme; these have been set up/developed by the tenants themselves. As part of the co-design approach taken to the review of the scheme manager/support service tenant volunteers have been identified to work with NPT Homes in order to establish the feasibility of progressing this action/formalise the arrangements that are in place. The implementation of this promise will be fundamental to meeting the needs of tenants at a time when the Supporting People budget is reducing.

Promise No.	Nature of Work	To be commenced	In Progress	Complete	Comments
E23 Cont.					This promise will be considered to be 100% complete once the feasibility of a good neighbour scheme has been explored by the working group of tenants and staff that has been set up.
E24	Within its investment programme, NPT Homes would have a budget of up to £5.5 million in the first six years after transfer for improvements and re-modelling work in sheltered schemes. This work would be undertaken in consultation with tenants to provide self-contained flats with their own bathrooms and to upgrade bedsit flats to provide separate bedrooms and living rooms.		✓		 The Sheltered Housing WHQS programme commenced in the summer 2014 and due to finish 2017. As at 31st March 2015 3 schemes have been completed and a further 3 schemes are in the process of having works completed. Based on the work carried out to date and the costs of other planned work it is estimated that circa £11m will be spent on bringing all schemes up to the WHQS.

Promise No.	Nature of Work	To be commenced	In Progress	Complete	Comments
Part I	**Community and economic regeneration**				
I9	Supporting the development of community owned social enterprises to supply goods and services.			✓	 Following the creation of two local social enterprises to a sustainable level, NPT Homes continues to explore opportunities to support and develop more local social enterprises. NPT Homes has supported local businesses such as the Dove Workshop, Neath YMCA and Glynneath Training Centre to provide training and support to its tenants. It also has close links with NPTCVS. Support of social enterprises is embedded in the organisation. As part of its Business Development, NPT Homes is currently exploring the utilisation of its environmental programme to support the creation of more sustainable social enterprises.

NEATH PORT TALBOT COUNTY BOROUGH COUNCIL

SOCIAL CARE, HEALTH AND HOUSING CABINET BOARD

8th October 2015

REPORT OF THE HEAD OF BUSINESS STRATEGY AND PUBLIC PROTECTION – A. THOMAS

SECTION A - MATTER FOR DECISION

WARD(S) AFFECTED: All

ENVIRONMENTAL HEALTH AND TRADING STANDARDS CHANGES TO OFFICER DELEGATION ARRANGEMENTS

PURPOSE OF REPORT

To seek approval from Members to amend the authority's current delegation arrangements to officers in relation to the legislation enforced by the Environmental Health and Trading Standards Service {which are currently set out in the Authority's Constitution [version 14.08.15]}; in order to add further legislation.

EXECUTIVE SUMMARY

This report seeks to add the Consumer Rights Act 2015 to the list of legislation that is enforced by the Environmental Health and Trading Standards Service. As the Act centralises and standardises a range of current Trading Standards powers the request to delegate it is essential.

BACKGROUND

The Neath Port Talbot Constitution lists in Schedule 1 (pages 3.130 – 3.135) the legislation that is currently delegated to, and enforced by, the Environmental Health and Trading Standards Service of the Authority.

Over time this legislation can be subject to revocation, repeal or amendment and occasionally further additional legislation is identified and is required to be added.

Accordingly the following addition to the delegations to officers currently listed in Schedule 1 are required to be made by Cabinet Board.

[1] The following legislation needs to be added to Schedule 1 and delegated to specific Officers:-

- Consumer Rights Act 2015

The Act is part of a wider reform of Trading Standards legislation within the United Kingdom. There are 4 main elements that effect change:-

1 It reforms consumer rights within the United Kingdom (formerly the Sale of Goods Act, Supply of Goods & Service Act, Unfair Contract Terms and associated legislation). The Act clarifies elements of consumer rights and takes into account the sale and supply of digital content.

2 It amends primary legislation by centralising and standardising Trading Standards investigatory powers to sit under the one Act (with the notable exception of Food Standards). The service cannot enforce the legislation without its investigatory powers. It also introduces requirements on trading standards services to give written notice to businesses of their intention to inspect (with exemptions under specific circumstances).

3 It Introduces a duty on letting agents to publicise their fees, and a duty on local Weights and Measures Authorities to enforce this provision.

4 It Introduces specific information requirements on secondary ticketing agencies (i.e. the re sale of tickets for sporting and cultural events) and a duty on local Weights & Measures Authorities to enforce this provision.

We also request that Members delegate authority under this legislation to the Director of Social Services, Health and Housing; The Head of Business Strategy and Public Protection and the Principal Officer Environmental Health and Trading Standards so that they in turn may authorise competent staff to act under this legislation.

CONSULTATION

There is no requirement under the Constitution for external consultation on this item.

PROPOSED DECISION

1. That the delegation arrangements currently in force and set out in Schedule 1of the Authority's Constitution [version 14.08.15] be amended to:

[a] add the Consumer Rights Act 2015 to the list of legislation currently delegated to officers and delegated authority is hereby given to the Director of Social Services, Health and Housing, the Head of Business Strategy and Public Protection and the Principal Officer Environmental Health and Trading Standards to authorise competent staff to act under that legislation .

2. That the Head of Legal Services be authorised to seek amendment of the Constitution by the Council in due course in order to reflect the above changes to the delegation arrangements which are currently set out in Schedule 1 on pages 3.130 – 3.135] of the Constitution [version 14.08.15]

REASON FOR PROPOSED DECISION

To ensure that the Constitution reflects changes that have been made to certain legislation and that identified further legislation has been added.

IMPLEMENTATION OF THE PROPOSED DECISION

The decision is proposed for implementation after the three day call in period.

LIST OF BACKGROUND PAPERS

None

OFFICER CONTACT

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Steve Adie, Principal Officer Environmental Health and Trading Standards. Tel: 01639 685644, email s.adie@npt.gov.uk

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`SOCIAL CARE, HEALTH & HOUSING CABINET BOARD

REPORT OF THE HEAD OF COMMUNITY CARE AND COMMISSIONING – C. MARCHANT

8TH OCTOBER 2015

SECTION A – MATTER FOR DECISION

WARDS AFFECTED – ALL

Delivering Improved Community Services For Older People- 'What Matters To Me' Service Model And Agreement Between Neath Port Talbot County Borough Council And Abertawe Bro Morgannwg Health Board In Accordance With Section 33 National Health Service (Wales) Act 2006

1. PURPOSE

The purpose of this report is to set out for Cabinet Board consideration and approval:

- an analysis of progress in the implementation of the business case approved in May 2014 to deliver integrated intermediate care services at an optimal scale
- an integrated service model, 'What Matters to Me' to meet the well-being, care and support needs of older people
- a formal agreement for the provision of adult and older people (intermediate care) services between Neath Port Talbot County Borough Council (NPT CBC) and Abertawe Bro Morgannwg University Local Health Board (ABMU HB) in accordance with Section 33 of the National Health Service (Wales) Act 2006.

2. BACKGROUND

In September 2013 the Western Bay Health and Social Care Programme set out a joint commitment to work together to integrate and improve the planning and delivery of community services for older people, *Delivering Improved Community Services.* The commitment was a whole systems approach to addressing the challenges of the issues presented by an ageing population. It stated clearly the first phase of integration would

focus on intermediate care services which in turn would act as a catalyst for change across the rest of the system. A detailed business case, *'Delivering Improved Community Services – Business Case for Intermediate Tier Services'* was developed. This was approved by the Social Services Health and Housing Cabinet Board in May 2014.

The crux of the *Delivering Improved Community Services* and the subsequent business case was; to achieve sustainable health and social services for frail or older people, we need to provide better assessment, care and support at lower cost; something that is impossible were we to be tied to traditional, silo-type forms of both health and social care delivery. The tendency toward individual agencies cost-shunting in an uncoordinated system that lacks significant integration is also highly undesirable as it leads to poorer outcomes for older people.

Cost pressures due to demographic change are considerable, and they impact across social care and health services. The business case stresses that the issues of trying to manage the current and future challenges that an increasingly older and frailer population presents. It states the risks inherent in continuing to operate the health and social care system as we do now, (the 'do nothing' scenario), and estimates cost pressures of £3.3million in social care and a further £2million in the NHS or 450 fewer people receiving additional support by 2016/17[1]. The business case described how developing an effective intermediate tier of services is central to this wider transformation programme. Intermediate tier services provide the critical boundary between wellbeing and the need for managed care, with the potential to enable more people to maintain their independence.

As a consequence of the business case, investment was made in an optimal intermediate care service model. The optimal model comprised 3 elements:

- Common Access Point - 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)

- Rapid Response - The rapid response service provide a rapid clinical response (doctor, nurse and/or therapist) for people who require immediate assessment, diagnosis and sometimes treatment who would otherwise be admitted to hospital. Clinical response is within 4 hours of referral.
- Reablement – therapy led reablement helps people to retain or regain skills that they may have lost, due to hospital admission or illness, with the objective of minimising the need for ongoing domiciliary care and support.

The business case attracted an investment of £1.612million revenue and £0.7 million capital totalling £2.312 million in intermediate care in Neath Port Talbot in 2014/15 as a consequence of grant funding made available for one year only through the Intermediate Care Fund. In approving the business case, Cabinet Board noted that the business case represented a 5 year programme of transformational change and in addition recognised the challenges presented by the bridging finance requirements in 2015/16 and 2016/17 to make the model financially sustainable. In its commitment to the Business Case, Cabinet endorsed a recommendation to 'approve in principle the establishment of an arrangement to pool resources with partners in the Western Bay Programme, subject to formal agreement in accordance with Section 33 of the National Health Service (Wales) Act 2006 by April 2015'.

3. PROGRESS IN DELIVERING THE INTERMEDIATE TIER BUSINESS CASE

Year one of the business case was pump primed by Intermediate Care Fund (ICF) funding, and concentrated on achieving the recruitment of new staff to enable a fully optimised service model to be developed. The case stated benefits would start to come on line circa six months after full operational capacity had been achieved. This assumed that all elements of the model were functioning at optimal levels.

In developing the business case, a detailed baseline summary was undertaken of current intermediate tier capacity across Western Bay. There was a longstanding, successful acute clinical service in

Neath Port Talbot, well developed reablement in Bridgend and reductions in long term care placements in Swansea as a result of the step up step down capacity in Bonymaen House and Ty Waunarlwydd. It was clear considerable investment and service development work was needed in all 3 areas to reach optimal capacity and performance levels.

The ICF investment in 2014/15 pump primed the scaling up of intermediate tier services. 2014/15 was identified as a transformational year. Recruitment timescales means the fully optimised model is not in place fully across the region, although considerable progress has been made in all areas. Table 2 summarises the recruitment profile and position.

Bridgend	NPT	Swansea
ICF investment	ICF investment	ICF investment
Rapid Response Consultant, Nurse Practitioner, Nursing, Therapy, Social Work and Social Care staff Planned Response Therapy, Medicines Management, Social Care staff, and Admin Speech and Language Therapy, Dietetics	Common Access Point Management, Therapy, Social Work. Assistive Technology and Third Sector Broker Rapid Response Nurse Practitioner, Community Nurses & HealthCare Support Worker Planned Response Therapists & District Nurses Support across the piece Medicines Management, Therapy Technicians, Social Care, Management and Community Consultant	Common Access Point Access & Information Assistants Rapid Response Therapy, Advanced Nurse Prac, Nursing, Social Work and Social Care Workers Planned Response Therapists, Medicines Management and Community Care Assistants Support across the Intermediate Tier Project Management, Staff Development & Performance & Information Assistant
	22 fixed 33	

		term posts	permanent posts		
ICF WTE	28	ICF WTE	55 wte	ICF WTE	62
Less attrition	6	Less attrition	8	Less attrition	42
Net gain	22	Net gain	47 wte	Net gain	20

Table 2

Table 3 summarises the proximity in delivering the optimal model in each of the 3 areas.

Key features of optimal model -	B	N	S
Multi-disciplinary triage in common access point	Y	Y	N
Mental Health provision within common access point	N	D	N
Third Sector Brokerage in common access point	Y	Y	Y
Acute clinical response, Nurse Practitioners and Community Consultant – virtual ward model	D	Y	N
Therapy led reablement service	Y	Y	N
Intake & review reablement	Y	Y	N
Therapy led residential reablement	Y	Y	Y
Support & stay for people with dementia	N	N	N
Step up / down intermediate care (residential or community)	Y	D	Y
Key; *Y(yes) N(no) D(in development)*			

Table 3

There have been some variations in achievement of the optimal model and this reflects the decision that there should be a 'franchise' approach to the delivery of the model. This ultimately meant that whilst the service model and outcomes were described how it should be implemented; it was not prescribed in detail and was thus left to local determination. Emerging from this approach is some evidence that the areas in which there is closer proximity

to the model (as summarised in table 3) are achieving the better level of performance across the whole system.

The business case contained a set of performance measures as a means of determining effectiveness of the business case. Table 4 outlines where performance is against the anticipated benefits once the services were in place.

Business case anticipated benefits	Benefit realised by 2014/15
93 hospital beds closed	40 hospital beds closed (Gellinudd & Gorseinon). These were closed prior to the new investment but the bed activity did form part of the baseline within the business case
117 reduction in care home placements	37 reduction in care home placements (25) Swa; (21)NPT, (+9) Bridgend
222 reduction in homecare packages	12 reductions in homecare packages. (+62)Swa; (27)NPT;(47) Bridgend

Table 4

This analysis is also reflected in an initial evaluation report into the implementation of the intermediate tier business case which is appended to this paper. It has resulted in Western Bay Leadership Group directing that the optimal model should be strictly adhered to in all areas and revised performance framework and governance arrangements have been established.

4. ‘WHAT MATTERS TO ME’ SERVICE MODEL

The ‘What Matters to me’ service model is presented in **Appendix 1** of this paper and details the whole systems integrated approach to delivering improved outcomes for older people with well-being, care and support needs. It is a person centred approach which focuses on a proactive and preventative approach to meeting the needs of people at risk of losing independence and tackling social and health needs holistically. The model details eleven initial steps

which need to be taken together to deliver better outcomes for people, and deliver services which are financially sustainable. These range from initiatives to tackle loneliness and social isolation, through to strengthening existing intermediate care services and developing proactive anticipatory care planning for people at risk of losing their independence. The model also includes a clear commitment to integrate older person's mental health services into community teams so services are delivered through 'one team' around the older person.

'What Matters to Me' is the product of significant engagement undertaken as part of the Changing for the Better programme, then strengthened with engagement on *Delivering Improved Community Services* and further strengthened as a result of the 'Focus on Frailty' event in March 2015. The latter event was attended by 220 stakeholders across health, social care, third sector and service user representatives. Apart from the rich feedback on the various service elements of the model, one of the outcomes of that event was a challenge to the descriptor of frailty by older people as they do not consider themselves as being 'frail' nor do they appreciate the label. The branding of the model 'What Matters to Me', which reflects the ethos of what this service model represents, is as a result of feedback from that and also engagement with older people and key partners.

5. SECTION 33 AGREEMENT

In approving the Business Case for Intermediate Tier Services there was approval to establish a formal pooled fund in accordance with Section 33 of the National Health Service (Wales) Act 2006. The original intention was for the pooled fund to be in place by April 2015. The agreement which has been developed represents an extensive endeavour by all four organisations involved in the Western Bay collaborative and by service, finance and legal colleagues in NPT CBC and ABMU HB.

The agreement sets out in detail within the body of the document and associated schedules, the:-

- services covered by the agreement
- the performance measures for those services
- the health care related functions of the Health Board and the Council in entering into the agreement

- finance and buffer setting arrangements and governance.

The agreement is important both practically and symbolically as demonstrating the commitment of NPT CBC and ABMU to deliver integrated services.

6. FINANCIAL ANALYSIS

In approving the business case for intermediate care, NPT CBC and ABMU HB committed to making intermediate care services sustainable with recurrent funding. The recommendations approved were to:

- ' Note the challenge presented by the bridging requirements in 2015/16 and 2016/17 and that further work is required to detail the benefits realisation framework and risk sharing arrangements required'
- 'Agree the requirement to re-invest the cash releasing savings achieved from remodelling services into intermediate tier pooled funds to achieve the sustainability of the intermediate tier of service'

In March 2015 Welsh Government announced it would be providing a reduced allocation of ICF available recurrently as a result of successful outcomes from the use of the fund across Wales. Welsh Government asked in doing so that all partnerships across Wales confirm the services that would be funded sustainably. In Neath Port Talbot, £908,400 of the pooled fund budget of £4.9million is funded via ICF. This has reduced the requirement for bridging finance to be made available to sustain the services in 2015/16.

The s33 outlines in detail the formula governing budget setting, outturn and balancing payments for pooled fund resources. In summary, in setting the budget for the pooled fund NPT CBC and ABMU HB need to confirm to the other partners their anticipated commitment by 31st January each year and agreed budget by 31st March. This governance ensures that the budget for the pooled fund is not set outside the usual budget setting process of either partner.

7. Equality Impact Assessment

Each of the statutory partners has undertaken an individual equality impact assessment of the implications of the business case and intermediate care fund proposals. Board/Cabinet members are asked to have due regard to the equalities impact assessment in considering the recommendations of this report.

8. Recommendations

Cabinet Board is asked to:

- Note the progress made in the implementation of the business case to deliver integrated intermediate care services at an optimal scale approved in May 2014
- Approve the 'What Matters to Me' model as the overarching service model for integration of community health and social care services to meet the well-being, care and support needs of older people
- Approve entering into the overarching partnership agreement in accordance with Section 33 of the National Health Service (Wales) Act 2006 to for the provision of intermediate care services between Neath Port Talbot County Borough Council (NPT CBC) and Abertawe Bro Morgannwg University Local Health Board (ABMU HB) for Adult and Older People's Services.
- Note the financial position and approve. The finance contributions included in the Section 33 for NPTCBC and ABMU Health Board is Appendix 2 to this document.

9. List of Background Papers

None

10. Officer Contact

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Tel. No.: 01639 684791

11. Appendices

Appendix 1 – 'What Matters to Me' Model
Appendix 2 – EIA
Appendix 3 – Section 33 Agreement

Appendix 1 – 'What Matters To Me' Model

Caring Together
Western Bay
Health and Social Care Programme
Gofalu Gyda'n Gilydd
Bae'r Gorllewin
Rhaglen Iechyd a Gofal Cymdeithasol

"What matters to Me" – Supporting the health and wellbeing of our older population

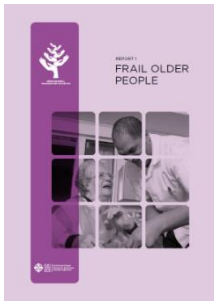
The new way of working for health and social care across the Western bay region

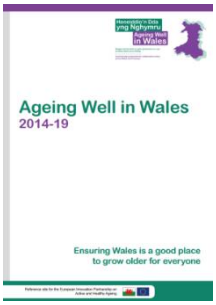
What we will do

1. We will focus on the needs of older people at risk of losing their independence
2. We will all plan and implement community services around the 11 Community Networks
3. We will focus on early intervention and prevention to tackle loneliness and social isolation
4. We are committed to implementing 'What Matters To Me' consistently across Western Bay, ensuring all older people have the same services available to them and are called the same thing irrespective of where they live
5. We will roll out the same 'acute clinical team' model across all localities, ensuring the right service for those in crisis and linked to ambulatory care
6. Our core community services will deliver pro-active anticipatory care planning to keep care as close to home when needed
7. We will integrate services on the basis of 'only doing things once' where possible, such as assessment, single case manager and single care plans, including integrated Older People's Mental Health in a 'team around the person' approach
8. We will use innovative ICT solutions to give the workforce the tools they need to do the job
9. We will develop our workforce through team development and leadership for staff – moving to a 'core competency framework'
10. We will work with third sector to build the infrastructure needed in communities to support people
11. We will minimise delays for patients who have had unplanned admissions to hospital by improving the interface between community services and hospitals

1. Introduction

The need to change ways of delivering care and supporting the health and wellbeing of older people is well evidenced in health and social care research and policy, with the drivers for change more pressing than ever.





People are living longer and as a result are vulnerable to mental and physical ill health conditions and have complex needs that require care. Across the Western bay area it is predicted there will be a 34% increase in the number of people aged 65+ by 2033.

Whilst significant progress has been made, health and social care provision in the Western Bay area needs to adapt further to ensure services are fit for purpose and sustainable; giving individuals every opportunity to take ownership of their own health.

In 2013, *Delivering Improved Community Services* set out an ambitious plan for addressing the pressures resulting from an ageing population. We have come a long way in the last 18 months – through delivering phase 1 of that plan, for example through delivering the intermediate care programme – but over that time period we have learnt a lot. This document sets out how phase 2 of the project will be implemented, taking the learning so far and applying it to new models of care arising in different parts of the UK.

As such, this document sets out our commitment to deliver high quality integrated health and social care that meets the current and future needs of older people across Swansea, Neath Port Talbot and Bridgend. The document has been developed through a process of research and discussion with partners in health and social care, including the 'Focus on Frailty' event on 27th March 2015 and building on the engagement with partners as part of *Delivering Improved Community Services.*

2. Our Vision

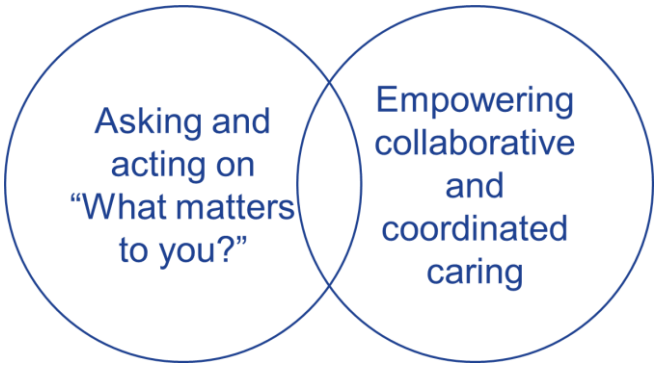
"Healthy independent ageing with proactive high quality care close to home when needed"

We aim to support older people in our community to:

- Live healthy, independent lives in their own homes
- Be listened to by people who are responsible for services, working with them to understand how they can live the lives they want
- Stay as independent as possible through accessing the right information, advice and assistance
- Receive services in their home when needed
- Have their health and social care problems solved quickly and considered as a whole rather than individually

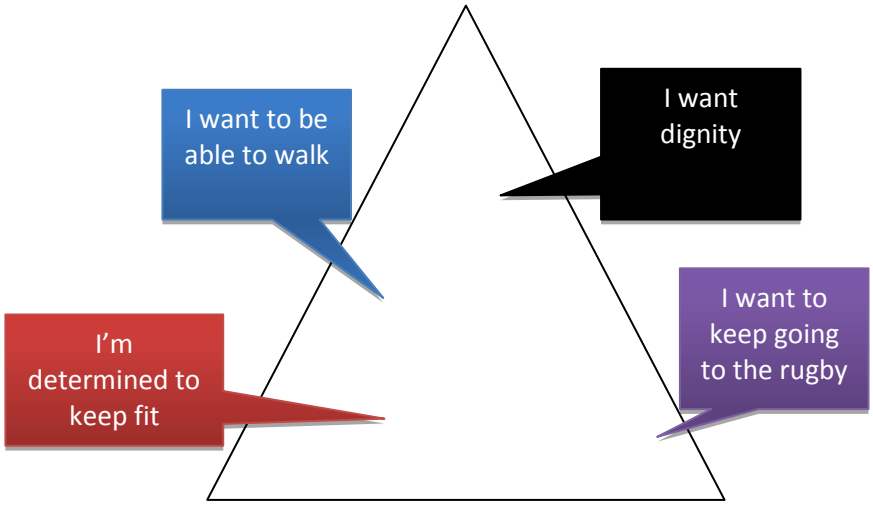
3. Principles

Two overlapping principles are central to helping us deliver our vision:



Asking and acting on "What matters to you?"

All individuals are different. They have different life priorities combined with different health and social care needs.



Central to effectively and efficiently supporting the health and wellbeing of our older population is understanding these perspectives by asking **"What matters to you?"**

This must be at the forefront of all care and organisational thinking.

By doing this we will:

- Ensure the relevant health and social care needs of people are met
- Help individuals engage in their personal care and have a positive experience when interacting with health and social care systems.

Box 1. **Using personal stories to inform better health and social care**

We intend to engage members of the public and staff to understand stories of experiencing health and social care. This will provides a consistent foundation for transforming care. *(Example below)*

DORIS' STORY – MAY 2015

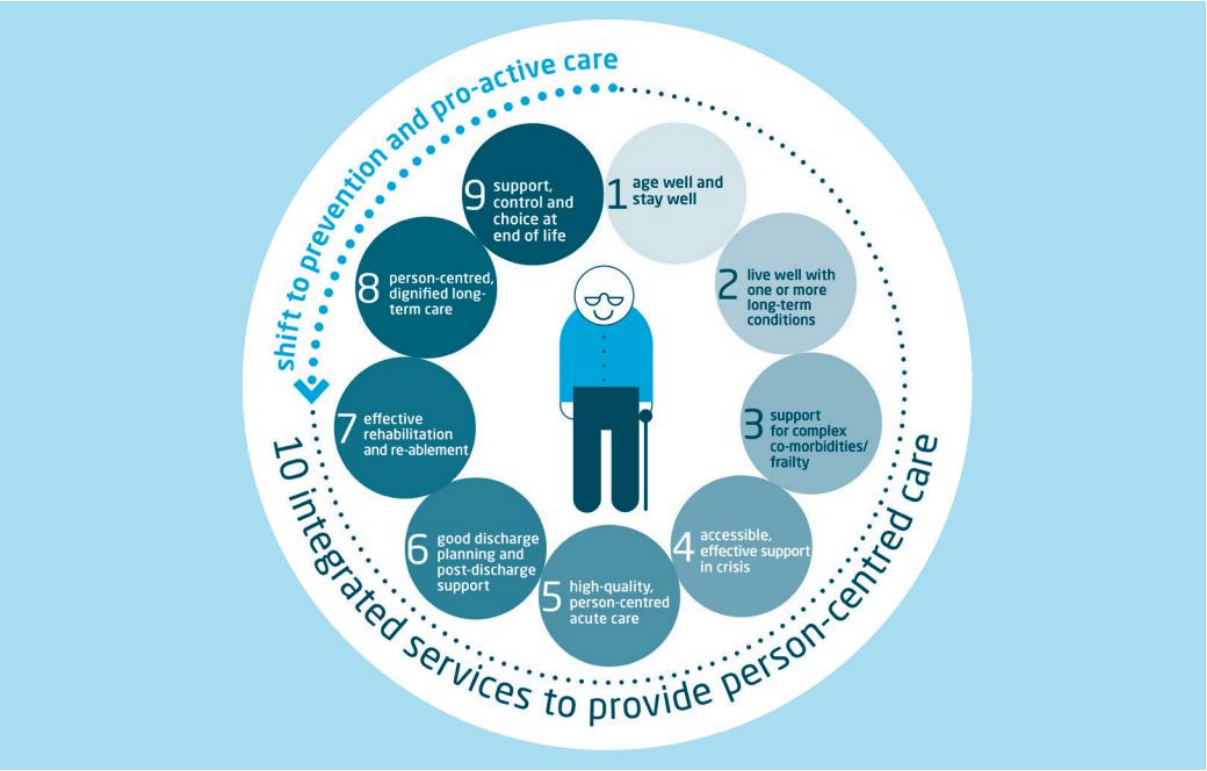
I was talking to my daughter recently about the huge change there has been over the last couple of years in the care and support I receive. I am 85 years old, and have lived in the area for most of my life. The past ten years since my husband died have been a struggle. I have lived with diabetes for twenty years, and now have heart and breathing problems as well. If that were not enough, I've been getting a bit confused at times.

Since last year though, things have got a lot better. The main difference has been Penny. I think she is a nurse, and her main job is to co-ordinate the care I need. I still see some different people, but they all now seem to have an up to date picture of how I'm doing. I still regularly see a physiotherapist and a mental health man has started to visit. They've recently added an extra carer visit, so I now see somebody who helps me with my medication and to get up and dressed and things three times a day. Penny says that most of them are now based in an office nearby, so there is only one number we need to phone if there's a problem. The person who answers the phone is really helpful, and will always put me in touch with somebody if Penny is not there.

The great thing is that I've not had to go to hospital, except for appointments for the past twelve months. The year before, I was taken in three times, twice in the middle of the night. When I got out of the ambulance and into hospital, nobody seemed to know much about me, and it looked to be a real struggle to make arrangements to get me home. They were also talking about me maybe needing to go into a care home, but that seems to have stopped now.

I see my GP every two months, and she says that this new system is fantastic. She works closely with Penny and her team, and says she knows I will get the help I need if there's a problem. She also says it makes her life a lot easier, and that the area does this better than most places. I always used to think the people I saw talked to one another. It's so much better now that they do.

Empowering collaborative and coordinated caring



Supporting the health and wellbeing of older people often involves addressing a range of physical, mental, environmental and social needs and the collaboration of multiple individuals and groups, with the older person themselves at the centre.

To support the health and wellbeing of the older population we must empower this collaboration and ensure it is coordinated in a seamless manner. This includes:

- enhancing integrated teams already developed
- making new connections between individuals and groups
- harnessing the power of third sector and communities
- giving confidence to the public and staff to proactively assess needs, deliver care for themselves or others and acts as brokers of knowledge

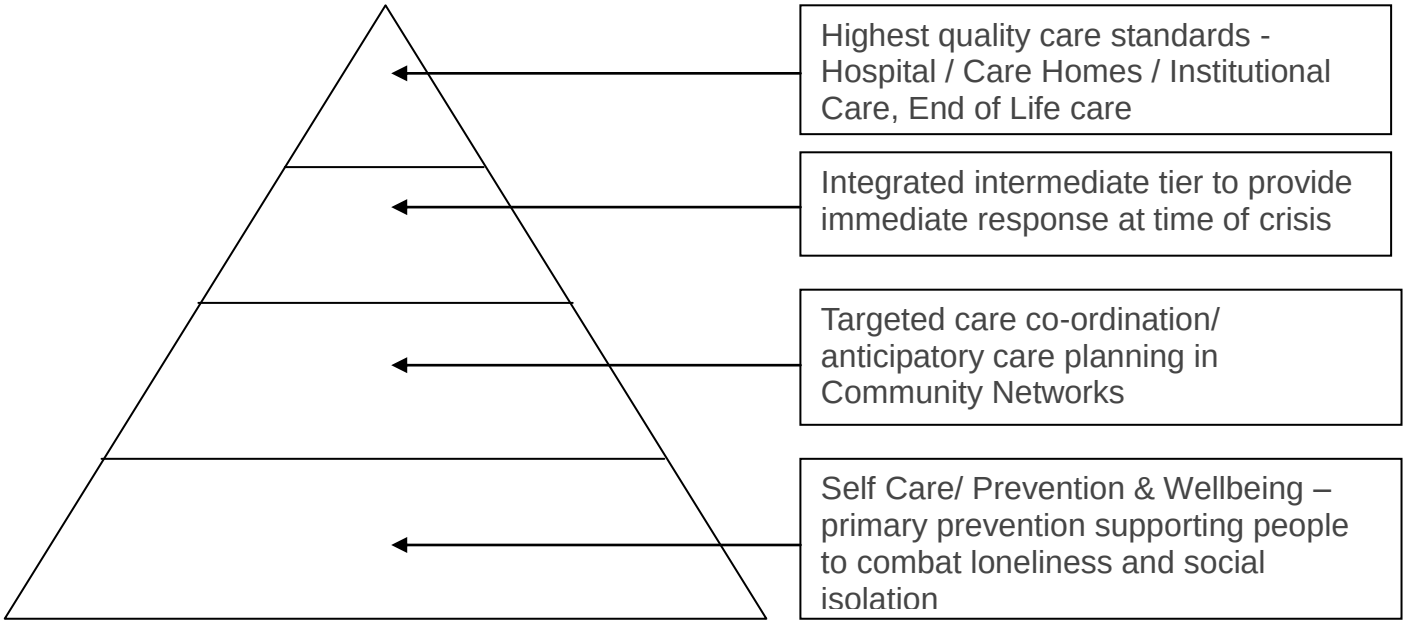
By doing this we will:

- ensure all the people necessary are involved and engaged with care
- develop structures and pathways to facilitate transitions of care
- install the required capacity and capability for those involved – including the ability of the public and staff workforce development

4. Delivering at a service level

With these principles in mind, to turn our vision into reality requires the specification of difference levels of care to frame decisions, conversations and delivery of care. These delivery aims were designed as a result of direct feedback from over 220 stakeholders at the Focus on Frailty Event on 27th March 2015.

(A collation of best practice from other areas of the country is provided in an appendix to this document)



The sizes of the segments emphasises our vision of **supporting the health and wellbeing of older people at home when possible** and in healthcare institutions when necessary.

The levels of care do not suggest additions to the current health and social care services but rather **a new way of person centred, collaborative and coordinated** working that builds upon existing core services and organisations and addresses recognised gaps in services and workforce capacity and capability.

a. Self-Care/ Prevention & Wellbeing – primary prevention supporting people at risk of frailty

Aim: to help people take action to manage their health and wellbeing, live as independently as possible and to keep out of hospital.

How:

- Support to combat loneliness and social isolation
- Tools, motivation and confidence to take responsibility for their health and wellbeing
- Taking the learning from local initiatives such as Local Area Coordination to begin to use innovative ways of tackling loneliness and social isolation
- Supporting the maintenance of a healthy lifestyle – regular exercise, not smoking, reduced alcohol consumption, health eating
- Installing a culture of independence and empowerment through self-care and wellbeing, supported by families, carers and community
- Enabling people to live healthy and independent lives engaged in their community and remaining active
- Ensuring there are regular mechanisms in place to check-in with people and their health and wellbeing

This support for patients could be provided by a range of sources - from health and social care organisations to families and communities to other public groups or mechanisms that can facilitate any of the above points.

b. Targeted care co-ordination/ anticipatory care planning in Community Networks

Aim: To deliver anticipatory care for those most vulnerable in communities

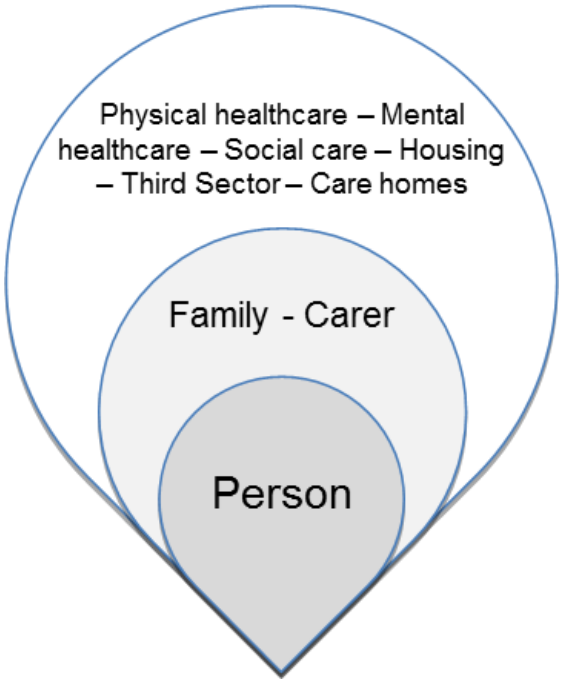
How:

- Case finding and regular review of individuals who would benefit from coordinated care and continuity with a named case manager
  - Includes patients with simple or complex long term medical conditions as well as with a range of other health conditions and changing social support needs
- Encourage individuals and carers to play an active part in determining their own care and support needs as part of a collaborative care planning process
- Develop personalised care plans through shared decision making between the person and staff centred on “what matters to me?”
  - An iterative process based on co-creating goals for maintaining and improving health, support options, personal preferences and the needs of family and carers
- Capture care plans on a standardised, person held document ("This is me" passport).
  - Supports and reduces duplication of conversations between individuals, families, carers and health & social care
  - The care plan is shared with all those who may touch the lives of those people, such as the Ambulance service, GPs, day service provider, etc.

- Ensure the proactive ***case management*** of those at risk of deterioration and the best possible ***care coordination*** arrangements are in place with a named case manager and coordinator

To achieve this requires close working with General Practice, community teams and families to identify and coordinate care to help people live independently in the community.

The above aims and service level



Box 2. Definitions for Targeted care co-ordination/ anticipatory care planning

Case management

Case management is a personalised and time-limited intervention aimed at preventing a specific occurrence or event, often a deterioration of health and hospital admission.

It may involve a range of groups or people delivering a range of interventions or support services.

Care coordination

The role of a care coordinator is to act as the first point of contact for questions, concerns or problems for an identified person in regards to their health.

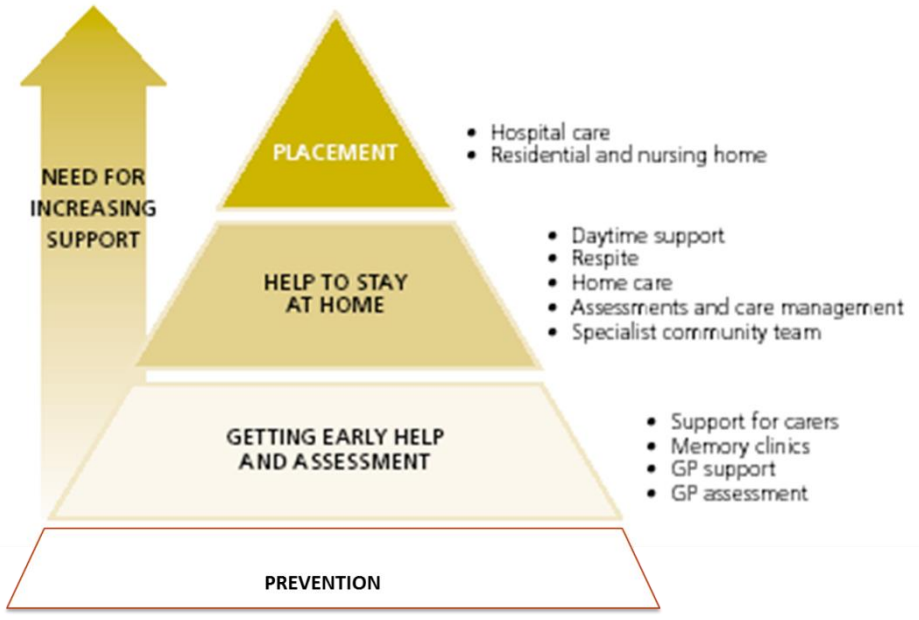
They would take responsibility for checking in with the person and having oversight of their care plan, but not necessarily responsible for delivering the care plan.

Tasks would also include medicines management, self-care support, advocacy and negotiation, psychosocial support etc.

The process of care coordination is seen as a way of working which can be adopted by a range of staff, rather than an additional caseload or task ascribed to an individual practitioner on top of existing duties.

Box 3. Older people's mental health

Care for older people with mental health needs can also be viewed in a similar format and will be considered within every level. An example below outlines this for care of people with Dementia



c. Integrated intermediate tier to provide immediate response at time of crisis

Aim: Maximise recovery and on-going independence and reduce the need for institutionalised care whilst also limiting duplication and hand-offs between health and social care agencies

How

- Short term interventions that address needs at a time of crisis, when people's needs change, of after illness or injury
  - Rapid support close to home when required
  - Good rehabilitation/ re-ablement after acute illness or injury

Much progress has already been made at this level of care through the development of community resource teams (CRTs). These teams support integrated and co-ordinated care management including specific admission avoidance and supportive discharge schemes, chronic condition case management, enhanced preparation for scheduled care, enhanced medicines management and advanced access to diagnostics. Going forward, it will be necessary to harness the learning in developing these teams and integrate with the other levels of care

d. Hospital / Care Homes / Institutional Care, End of Life care when required

Aim: Deliver high quality care in healthcare institutions for those that need it

How

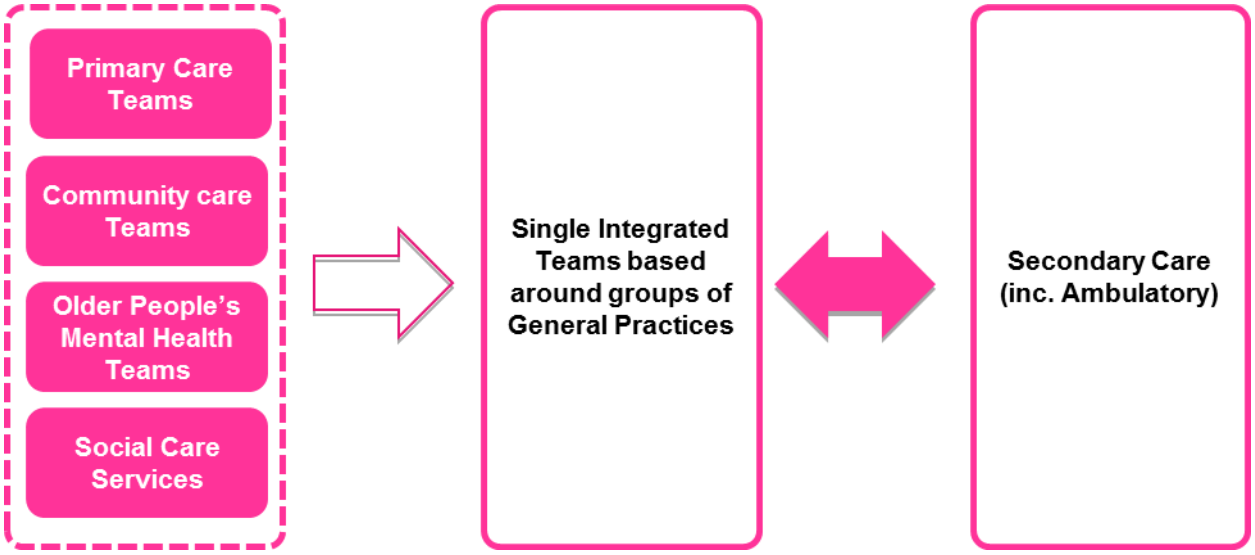
- Good acute hospital care when (and only when) needed
- High-quality nursing and residential care for those who truly need it
- Choice, control and support towards the end of life
- Good discharge planning and links to post-discharge support aiming to return to their community without delay.

Collaborative and coordinated working with other individuals and groups is necessary to ensure this is a smooth, safe, proactive transition of care.

Box 4. Interface between community, hospitals and ambulatory emergency care

For the levels of service delivery to function effectively there needs to be seamless interface between secondary care and community services (including primary care)

To do this effectively we will look to leverage the integrated community workforce which assesses & proactively plans to meet the needs of older people.



The aim will be to provide community services that are coordinated for people. Our local older people in Western Bay, if unwell or need support, will be cared for or supported by the most appropriate professional – this might be the Community Mental Health Nurse, the GP or a Social Worker – whoever it is the care and support will be coordinated around the needs of the individual.

Community teams are also pivotal to ambulatory care working well, that is treating people on the basis of need when in crisis without the need for admission to hospital – ambulatory care as the default. A key issue facing the NHS is that of managing the increased demand for emergency care within a reducing resource of inpatient beds and staff. Ambulatory care aims to ensure a significant proportion of emergency patients are managed safely and efficiently on the same day, avoiding admission to a hospital bed. Pivotal this is the joint working of community and secondary care.

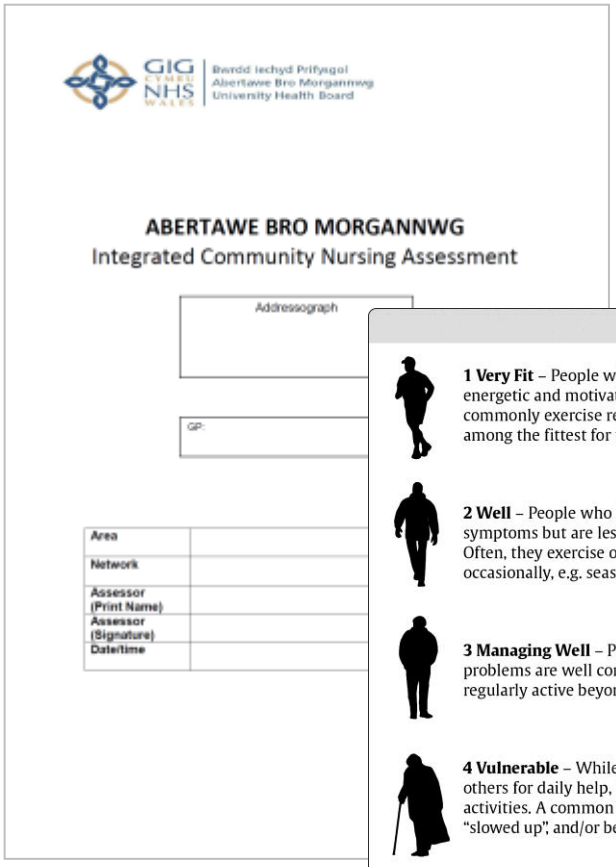
The Western Bay region has recently joined the Ambulatory Care Network which will be used to extend the good foundations already achieved.

5. Enablers

Integrated Assessment

Key to enabling the health and wellbeing of the older population is the ability and consistency to identify support needs. A focused Task and Finish Group was established in November 2014 to research the most suitable assessment criteria for older people requiring health and social care. The rationale for this was that many different assessment criteria were being used across health and social care.

The group consisting of Geriatricians, nurses and social work professionals agreed the common assessment should be the Integrated Assessment documentation. This will be supplemented by the Rockwood Frailty Scale for further assessment of frailty.



GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Abertawe Bro Morgannwg University Health Board

ABERTAWE BRO MORGANNWG
Integrated Community Nursing Assessment

Addressograph

GP:

Area	
Network	
Assessor (Print Name)	
Assessor (Signature)	
Date/time	

Integrated Assessment documentation

Clinical Frailty Scale

1 Very Fit – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 Well – People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g. seasonally.

3 Managing Well – People whose medical problems are well controlled, but are not regularly active beyond routine walking.

4 Vulnerable – While not dependent on others for daily help, often symptoms limit activities. A common complaint is being "slowed up", and/or being tired during the day.

5 Mildly Frail – These people often have more evident slowing, and need help in high order IADLs (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 Moderately Frail – People need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing.

7 Severely Frail – Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 Very Severely Frail – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9 Terminally Ill – Approaching the end of life. This category applies to people with a life expectancy <6 months, who are not otherwise evidently frail.

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia,** recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia,** they cannot do personal care without help.

Rockwood Frailty Scale

Workforce Development

Another key enabler is the development of skilled and motivated workforce with the right number and allocation of roles.

The future health service will see more person-centred systems of care and less division between primary, secondary, community, voluntary and social care organisations. Individual roles, teams and governance arrangements will need to be developed to support the increasing numbers of staff that will be in training, on placement and working independently outside hospital, and in community settings. The workforce will frame, prepare and deliver an organisational development programme.

We aim to develop a working environment and culture where everyone comes to work each day thinking they can improve outcomes and customer service within the resources we have – providing better care for our older population. To achieve this, our strategic and operational visions will be linked to a complementary Organisational Development strategy.

Planning for these workforce developments is already underway. Some potential actions to continue these efforts include:

Skills and motivation

- Develop culture change examples and morale boosters – aiming to get everyone on the same page in terms of integration and focus on proactive and not reactive care models
- Develop a core competency framework
- Modify core training programmes to align with new service needs
- Develop new learning environments that build on multidisciplinary approaches

Number and type of roles

- Take a stocktake of the current workforce and its needs
- Manage immediate and forecasted workforce supply shortages
- Reshape existing roles through ongoing training, education and development
- Develop and pilot new roles
- Evaluate and research the effectiveness of new roles and workforce configurations

6. How we'll deliver on 'What Matters To Me'

At a meeting of the Western Bay Leadership Group on 1st July 2015, it was agreed there needs to be a robust governance structure for the Community Services programme to implement the work going forward. The specific request was to amend the current governance arrangements and set up a new Community Services board/group which includes all the relevant stakeholders and reports up to Leadership Group.

It is therefore proposed to have a *Regional Planning and Delivery Board for Community Services*, which will have responsibility for planning and commissioning of community service for older people as well as providing a strategic cross challenge function on service implementation. This would address the issue of inconsistent local implementation and provide the mechanism for standardisation across the region. By establishing a Board that addresses both planning and delivery it will allow one meeting per month for key stakeholders rather than two separate meetings. The stakeholders will include:

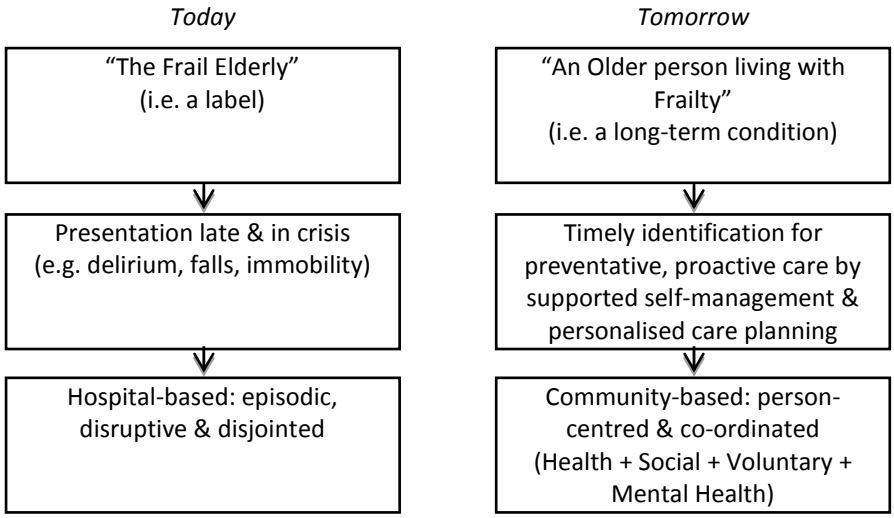
- x3 Directors of Social Services/Heads of Adult Services
- Service Director for Primary and Community Care – ABMU
- Nurse Director/Medical Director – Primary and Community Care
- Service Director/ Medical Director for Mental Health
- General Practitioner
- Third Sector Chief Officer
- CS Programme support

A Terms of Reference will be drawn up in consultation with the key stakeholders before the Board commences in October 2015.

Examples of best practice to guide our work

Examples of best practice that link with the articulated priorities within the system are outlined below from an overarching view of care and within the individual levels. These have been drawn from and summarised for the Kings Fund archive of best practice and NHS England publications.

1 Overarching views of caring for older people



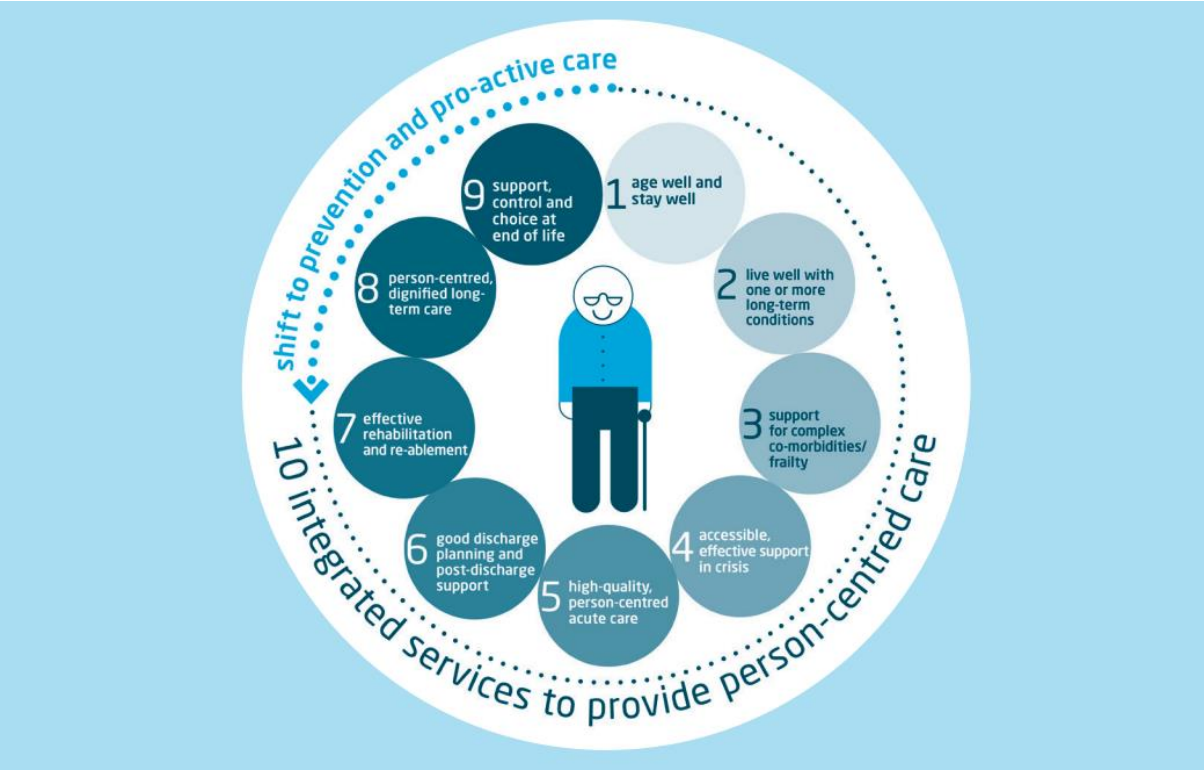
The full presentation can be found here - http://www.kingsfund.org.uk/audio-video/professor-john-young-primary-care-based-model-frailty

Making our health and care systems fit for an ageing population – The Kings Fund & Safe, compassionate care for frail older people using integrated care pathway - NHS England

The Kings Fund and NHS England both outline a wide overview of evidence based elements of care for older people. They identify 9 key areas which are outlined in the list and diagram below and overlap the 4 levels of car outlined.

- Good acute hospital care when needed
- Good discharge planning and post-discharge support
- High-quality, long-term nursing residential care for those who need it
- Choice, control, care and support towards the end of life
- Healthy active ageing and supporting independence

- Helping people to live well with simple or stable long-term conditions
- Helping people live with complex co-morbidities, including dementia and frailty
- Rapid support close to home in times of crisis
- Good rehabilitation and re-ablement (outside acute hospitals) after acute illness or injury



2 Highest quality care standards - Hospital / Care Homes / Institutional Care, End of Life care

Emergency care pathway for older patients - Sheffield Teaching Hospitals NHS Foundation Trust

Sheffield Teaching Hospital one of the hospital's three MAUs has become a unit focusing on the medical admissions of frail older people with the co-location of all the specialist, medical, nursing and therapist staff who deal with frail older people.

To overcome the often delayed process of discharge from hospital for these patients, where the patient is medically fit to leave hospital but waiting for home support to be in place, inter-agency working with both the local authority and primary care has supported the introduction of a 'discharge to assess' system. This is where patients are discharged once they are medically fit and have their support needs assessed on arrival at home by members of the community intermediate care and social care teams. This enables them to access the right level of home care and support much more quickly

Following this introduction he Frailty Unit saw a 34% increase in patients being discharged on the day of their admission or the following day, with no increase in the proportion of patients readmitted to hospital. The change has truncated a discharge process of up to two weeks to care packages being put in place directly with the patient at home, enabling the Frailty Unit to reduce length of stay and therefore shortening the overall patient pathway.

Further information can be found here - http://www.health.org.uk/media_manager/public/75/publications_pdfs/Improving%20the%20flow%20of%20older%20people.pdf

3 Integrated intermediate tier to provide immediate response at time of crisis

Examples of addressing these elements are provided in the overarching best practice examples.

Joint emergency team (JET) - Greenwich

A collaboration between Greenwich Community Health Services, Oxleas NHS Foundation Trust and Royal Borough of Greenwich Social Care has seen the development of a team of nurses, social workers, occupational therapists and physiotherapists working together to provide a multi-disciplinary response to emergencies arising within the community which require a response within 24 hours.

The team responds to emergencies to which they are alerted within the community at care homes, A&E and through GP surgeries, and handle those which could be dealt with through treatment at home or through short-term residential care.

Over a two-and-a-half-year period, over 2,000 patient admissions were avoided due to immediate intervention from the Joint Emergency Team (JET). There were no delayed discharges for patients over 65 and over £1m has been saved from the social care budget.

Further information can be found here - http://www.local.gov.uk/documents/10180/12193/Greenwich+-+Getting+back+on+your+feet+-+value+case/9cd224ae-b63d-42f9-872e-18943767a695

Frailty Pathway - Lincolnshire West CCG

Lincolnshire West CCG led the creation of an integrated frailty pathway, supported by a wider range of services including a community response team, to enable the frail elderly to remain healthy and safe at home.

It included a number of service changes, including:

- Developing a range of third sector services (e.g. transport and befriending services)

- Creation of a community geriatrician post
- Establishment of integrated community response teams
- Additional training and enhanced GP involvement for local care homes.
- Use of the Canadian Frailty Scoring Tool to identify patients at risk of unnecessary hospital admissions

They have reflected upon the importance of securing buy-in from all partner organisations from the start, acknowledging the time and effort that is required to develop such a pathway and the benefits of involving patients and carers to help articulate how the new service will be different in practice and how this will improve the care that is delivered

Further information can be found here - http://www.nhsiq.nhs.uk/media/2570535/ltc_case_study_lincolnshire_frailty_pathway.pdf

4 Targeted care co-ordination/ anticipatory care planning in Community Networks

Transforming Primary Care in London - London Primary Care Transformation Board and Primary Care Transformation Clinical Board.

A new framework for commissioning primary care in London has outlined elements of Accessible, Proactive and Coordinated care specification. The coordinated care specification refers to patient centred, coordinated care and GP/patient continuity. A number of elements apply to the provision of care for the frail elderly:

Case finding and review

- Practices will identify patients who would benefit from coordinated care and continuity with a named clinician, and will proactively review those that are identified on a regular basis.
- Patients with complex conditions who need care from more than one professional or team are to be added to a coordinated care register and will be provided with an enhanced level of service. These patients may have long term conditions but may also be patients with a range of other health conditions and social support needs such people with mental health conditions; people in nursing homes; people at the end of life; or vulnerable people who find it hard to access services.
- Patients are to be identified using a combination of clinical alerts, risk profiling and clinical judgment. Every practice or network of practices where appropriate, will run a regular risk profiling/risk stratification process in order to identify patients who should be on their care coordination register.

Named professional

- Patients identified as needing coordinated care will have a named professional who oversees their care and ensures continuity.

- Patients may also be allocated an additional member of the practice team or an additional health or social care professional as a care coordinator to act as their first point of contact if they have questions, concerns or problems. This person who coordinates their care should work with the patient to achieve their goals.
- Patients with more complex needs would ideally be able to contact their care coordinator 24/7 for certain periods of very acute clinical risk or towards the end of their life.

Care planning

- Each individual identified for coordinated care will be invited to participate in a holistic care planning process in order to develop a single care plan that can be shared with teams and professionals involved in their care.
- Development of the care plan should follow the approach described in Delivering Better Services for People with Long Term Conditions – Building the House of Care. This represents a departure from the current focus on individual diseases towards a generic approach in which patients' goals drive care delivery and greater attention is paid to the contribution that people make towards managing their own health. Care planning should be based on a philosophy of co-created goals for maintaining and improving health. It should be an iterative process that continues for as long as an individual has complex needs. Patients identified for coordinated care, and their carers, should be encouraged to play an active part in determining their own care and support needs as part of a collaborative care planning process. This should involve discussing care and support options, agreeing goals the patient can achieve themselves, and co-producing a single holistic care plan that includes the needs of family and carers.

Patients supported to manage their health and wellbeing

- Primary care teams will create an environment in which patients have the tools, motivation and confidence to take responsibility for their health and wellbeing. A culture of self-management support will underpin care coordination, recognising that the personal information that patients, their carers and families bring to the development of care plans can be as important as the clinical information in medical records.
- Support for patients could be provided by individual practices or across a number of practices and could for example include internet resources; advice from staff skilled in lifestyle training and/or motivational support; information packs; services provided by volunteers or voluntary organisations and access to patient groups in which patients support each other.

Care Coordinator - Wiltshire CCG, The Great Western Hospital Foundation Trust (GWHFT) and Primary Care in Wiltshire

At a local level, Wiltshire NHS organisations have collaborated to develop a new model of care targeted at frail older people and people with complex long term conditions.

It has seen the deployment of 23 WTE Care Coordinators (one per 20,000 population) to work in GP surgeries and focus on ensuring that the people referred to them by GP's and sometimes identified using a Risk Stratification Tool:

- re receiving the right care, at the right time, in the right place,
- Know what services they can access and how
- Have support for their discharge from hospital
- Access appropriate community resources (not just those traditionally available from statutory authorities).

The Care Coordinators links with practices themselves but also with their local Community Teams, acute hospitals, social care, and voluntary sector and community groups.

Further information - http://www.kingsfund.org.uk/sites/files/kf/media/Great%20Western%20Hospital%20NHS%20Foundation%20Trust%2C%20Care%20Cordination%20Project.pdf

Clinical Management Plan (CMP) - NHS South Worcestershire Clinical Commissioning Group

Targeted art care home residents, but applicable to a wider range of individuals, NHS South Worcestershire have developed a Clinical Management Plan (CMP) to help improve the coordination and management of care.

The CMP is one single individualised patient plan, available for any health care clinician treating the patient and includes details of a residents care needs and preferences in regards to end of life care or avoidance of hospital admission. The CMP facilitates residents living well by ensuring their CMP is agreed between the resident, Community Nurse Practitioner (CNP), care home staff and the GP. It remains with the patient at their care home, allowing direct access to ambulance crews and GP Out of hour's services for rapid support close to home.

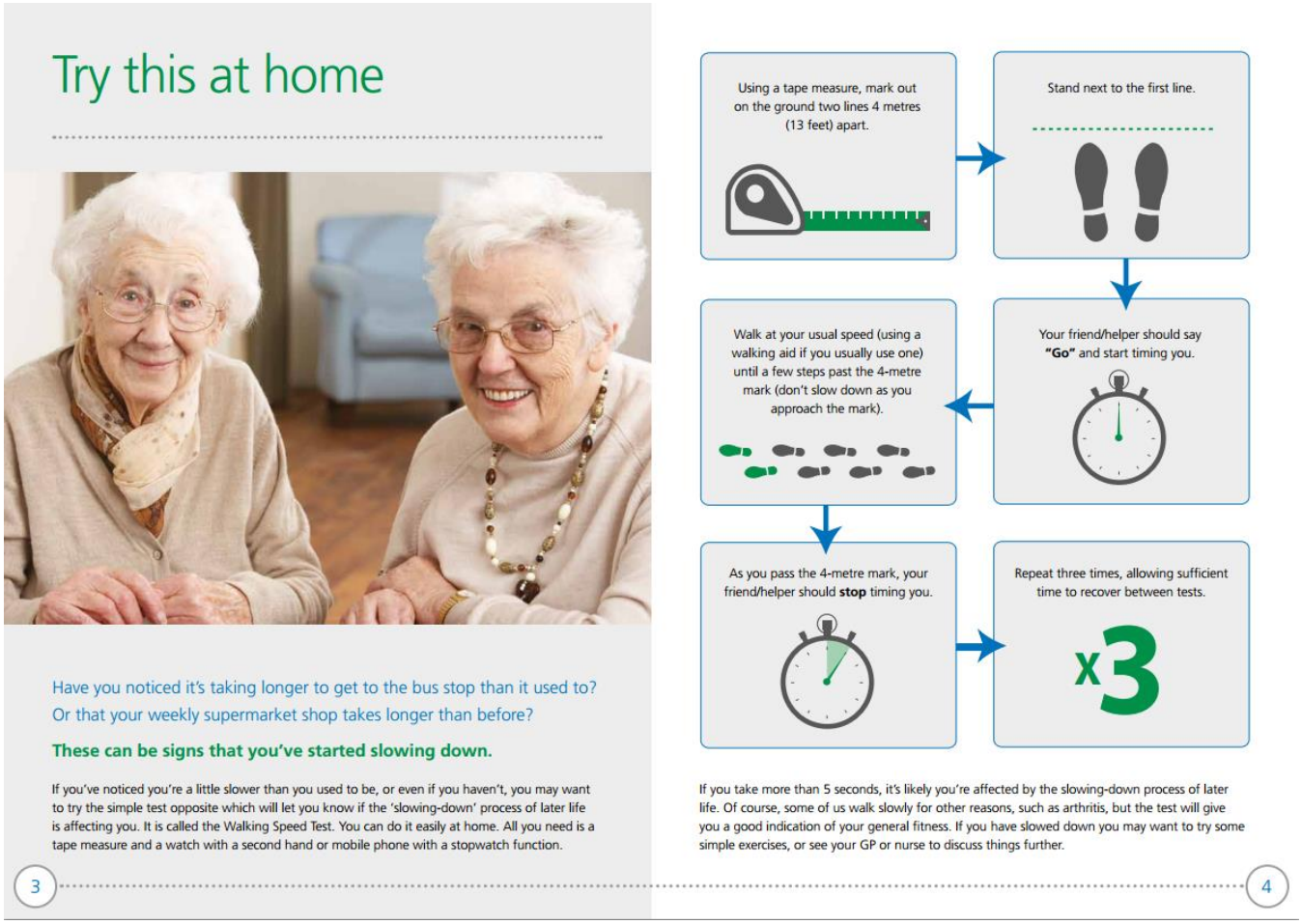
The individualised CMP facilitates patient engagement and offers care home residents the opportunity to express and record their care wishes, particularly in regards to end of life care. One CMP accessible for all helps to avoid error and improves communication speed

After 11 months the evaluation of the project has seen a 15% reduction in admissions from Care homes in South Worcestershire, fewer ambulance call outs and fewer episodes where residents were conveyed to hospital, with savings in the region of £500.000. More recent information suggests a 25.3% reduction in all admissions when compared to this time last year.

Further information - http://www.kingsfund.org.uk/sites/files/kf/media/NHS%20South%20Worcestershire%20Clinical%20Commissioning%20Group%2C%20Clinical%20Management%20Plan.pdf

5 Self-Care/ Prevention & Wellbeing – primary prevention supporting people at risk of frailty

Practical guide to health ageing – NHS England & Age UK



Try this at home

Have you noticed it's taking longer to get to the bus stop than it used to? Or that your weekly supermarket shop takes longer than before?

These can be signs that you've started slowing down.

If you've noticed you're a little slower than you used to be, or even if you haven't, you may want to try the simple test opposite which will let you know if the 'slowing-down' process of later life is affecting you. It is called the Walking Speed Test. You can do it easily at home. All you need is a tape measure and a watch with a second hand or mobile phone with a stopwatch function.

3

Using a tape measure, mark out on the ground two lines 4 metres (13 feet) apart.

Stand next to the first line.

Your friend/helper should say **"Go"** and start timing you.

Walk at your usual speed (using a walking aid if you usually use one) until a few steps past the 4-metre mark (don't slow down as you approach the mark).

As you pass the 4-metre mark, your friend/helper should **stop** timing you.

Repeat three times, allowing sufficient time to recover between tests.

x3

If you take more than 5 seconds, it's likely you're affected by the slowing-down process of later life. Of course, some of us walk slowly for other reasons, such as arthritis, but the test will give you a good indication of your general fitness. If you have slowed down you may want to try some simple exercises, or see your GP or nurse to discuss things further.

4

NHS England, in partnership with Age UK, have produced a leaflet with advice to help improve the health and general fitness of people of any age, but written to be particularly relevant for people who are 70 years or older. It includes a guide to a self-assessment of the "slowing down" process related to the effects of ageing on the body and specific advice regarding a number of areas: looking after feet and eyes, making the home safe, keeping active, talking about medicines, getting hearing testing, preventing falls. Looking after mental well-being, and getting ready for winter.

To access the leaflet: http://www.england.nhs.uk/wp-content/uploads/2015/01/pract-guid-hlthy-age.pdf

An Ageing Well strategy - Newcastle West CCG & Newcastle Council

Newcastle CCG & Council also provides a specific example of a local region developing a strategy which considers a range of different stages of ageing, including: preparing for active old age; active old age; vulnerable old age; and dependent old age.

The strategy includes:

- Health checks aimed at identifying risk factors such as obesity, physical inactivity and poor diet in those aged 40-74
- Engaging older people as volunteers and health champions
- A focus on case-finding to identify older people who are vulnerable to deterioration or dependency so that they can received proactive support
- Focus on supported self-management

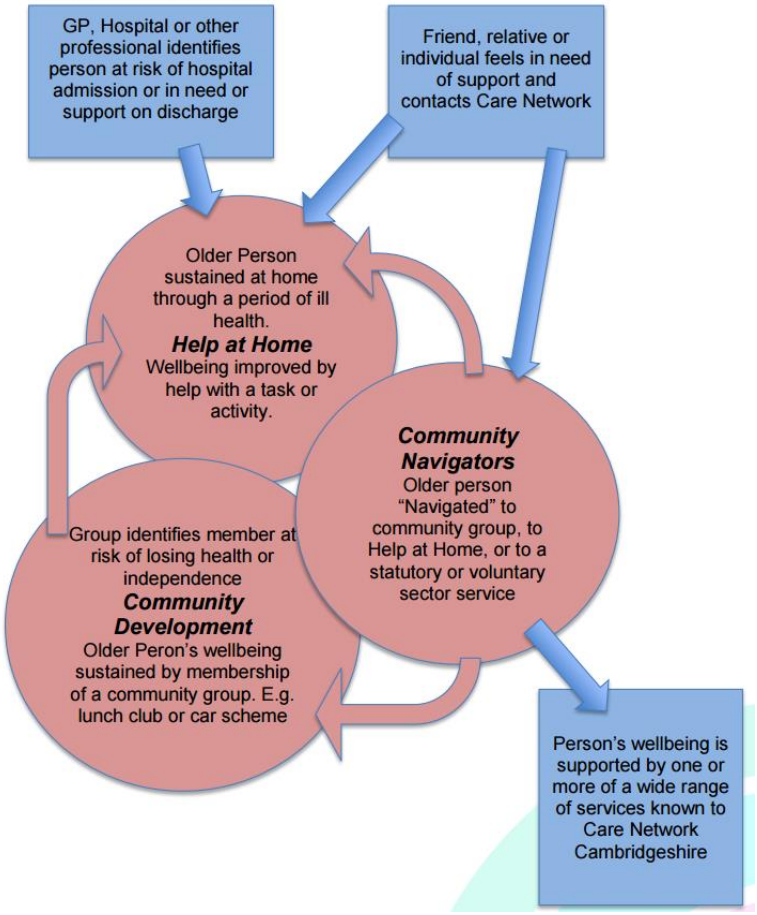
Care Networks – Cambridgeshire Care Network

The Cambridgeshire Care Network, through a combination of qualified paid staff and trained volunteers, has developed an infrastructure of support for over 100 local community groups. Approximately 1,200 volunteers have been engaged in the work. The network includes:

1. **Community Development** – supporting communities and groups to support local older and vulnerable people.

2. **Community Navigators** – providing information about activities and services which older people might enjoy or find helpful

3. **Help at Home** – providing short-term practical and emotional support to older and vulnerable people at a time of need.



Finance Contributions by NPTCBC and ABMU Health Board extracted from the Intermediate Care Agreement in accordance with Section 33 of the National Health Service (Wales) Act 2006

NPT Locality

	LA	Health	Total
Common Access Point			
Gateway Team	308,710	33,804	342,514
Rapid Response			
Acute Clinical Team		662,742	662,742
Planned Response			
Reablement Service	1,496,650	1,281,045	2,777,695
CRT Social Work Team	435,640		435,640
Residential Intermediate Care Beds		193,000	193,000
Medicines Management Team		135,408	135,408
Assistive Technology Team	392,170		392,170
Total	**2,633,170**	**2,305,999**	**4,939,169**
	53.3%	46.7%	

Appendix 2

Equality Impact Assessment (EIA) Report

This form should be completed for each Equality Impact Assessment on a new or existing function, a reduction or closure of service, any policy, procedure, strategy, plan or project which has been screened and found relevant to equality.

Please refer to the 'EIA Report Form Guidance' while completing this form. If you need further support please contact accesstoservices@swansea.gov.uk.

Where do you work?
Service Area: Western Bay - Community Services – Intermediate Care Services
Directorate: People/Social Services

(a) This EIA is being completed for a…

Service/ Function	Policy/ Procedure	Project	Strategy	Plan	Proposal
☒	☐	☐	☐	☐	☐

(b) Please name and describe below…

Western Bay - Community Services – Intermediate Care Services

The Intermediate Tier Business Case focusing on community services for older people aged 65 years and over was developed and approved by the 4 statutory Western Bay partners in April/May 2014. The business case outlines that given the demographic challenges of an older and frailer population, the risks inherent in continuing to operate the health and social care system as we do now, (the 'do nothing' scenario), were estimated cost pressures of £3.3million in social care and a further £2million in the NHS or 450 fewer people receiving additional support by 2016/17.

An **optimal service model** for the intermediate tier (described below in Aims) was advocated, which once fully operational, had the potential to reduce unscheduled hospital admissions and post-acute episodes of care. Similarly, increased reablement and step up / down residential activity would reduce long term care home placements and new domiciliary care packages ultimately allowing older people to remain in their own homes and communities for longer.

(c) It was initially screened for relevance to Equality and Diversity on…

22/08/2013 as part of the Community Services Project.

(d) It was found to be relevant to…

Children/young people (0-18)	☐	Religion or (non-)belief	☐
Any other age group (18+)	☒	Sex	☐
Disability	☒	Sexual orientation	☐
Gender reassignment	☐	Welsh language	☐
Marriage & civil partnership	☐	Poverty/social exclusion	☐
Pregnancy and maternity	☐	Carers (inc. young carers)	☒
Race	☐	Community cohesion	☒

(e) Lead Officer

Name: Rhodri Davies

(f) Approved by Head of Service

Name: Claire Marchant

Job title: Improvement Manager – Community Services **Date (dd/mm/yyyy):** 10/09/2015
Date (dd/mm/yyyy): 10/09/2015

Section 1 – Aims (See guidance):

Briefly describe the aims of the initiative:

What are the aims?

In September 2013 the Western Bay Health and Social Care Programme set out a joint commitment to work together to integrate and improve the planning and delivery of community services for older people, *Delivering Improved Community Services.* The commitment was a whole systems approach to addressing the challenges of the issues presented by an ageing population. It stated clearly the first phase of integration would focus on intermediate care services which in turn would act as a catalyst for change across the rest of the system. A detailed business case, *'Delivering Improved Community Services – Business Case for Intermediate Tier Services'* was developed. This was approved by the Social Services Health and Housing Cabinet Board in May 2014.

The crux of the *Delivering Improved Community Services* and the subsequent business case was; to achieve sustainable health and social services for frail or older people, we need to provide better assessment, care and support at lower cost; something that is impossible were we to be tied to traditional, silo-type forms of both health and social care delivery. The tendency toward individual agencies cost-shunting in an uncoordinated system that lacks significant integration is also highly undesirable as it leads to poorer outcomes for older people.

Cost pressures due to demographic change are considerable, and they impact across social care and health services. The business case stresses that the issues of trying to manage the current and future challenges that an increasingly older and frailer population presents. The business case described how developing an effective intermediate tier of services is central to this wider transformation programme. Intermediate tier services provide the critical boundary between wellbeing and the need for managed care, with the potential to enable more people to maintain their independence.

As a consequence of the business case, investment was made in an optimal **intermediate care service** model. The optimal model comprised 3 elements:

- Common Access Point - 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
- Rapid Response - The rapid response service provide a rapid clinical response (doctor, nurse and/or therapist) for people who require immediate assessment, diagnosis and sometimes treatment who would otherwise be admitted to hospital. Clinical response is within 4 hours of referral.
- Reablement – therapy led reablement helps people to retain or regain skills that they may have lost, due to hospital admission or illness, with the objective of minimising the need for ongoing domiciliary care and support.

The business case attracted an investment of £7,804,642 of revenue and capital funding in intermediate care across the region in 2014/15 as a consequence of grant funding made available for one year only through the Intermediate Care Fund. In approving the business

case, Cabinet Boards in Swansea, Neath Port Talbot and Bridgend and the Health Board noted that the business case represented a 5 year programme of transformational change and in addition recognised the challenges presented by the bridging finance requirements in 2015/16 and 2016/17 to make the model financially sustainable.

In activities approving the Business Case for Intermediate Tier Services there was approval to establish a formal pooled fund in accordance with Section 33 of the National Health Service (Wales) Act 2006. This was agreed to ensure coordinated arrangements for integrated provision of high quality, cost effective Intermediate Care services which meet local health and social care needs The pooled fund will be in place by October 2015. The agreement which has been developed represents an extensive endeavour by all four organisations involved in the Western Bay collaborative and by service, finance and legal colleagues within BCBC, NPTCBC, CCoS and ABMU HB. The agreement sets out in detail within the body of the document and associated schedules, the:-

- services covered by the agreement
- the performance measures for those services
- the health care related functions of the Health Board and the Council in entering into the agreement
- finance and buffer setting arrangements and governance.

The Joint Partnership Board ("JPB") is collectively responsible for the tracking of progress of the Partnership Scheme, within their aims and objectives within any defined resources and the Western Bay Programme Strategy and Plan. A JPB will be set up in each local authority area, in Swansea, Neath Port Talbot and Bridgend.

Joint Management Boards will also be set up in each locality and will assist the JPB in its through oversight of day to day management of the agreed Scheme.

Further details of these Boards can be found in the section 33 agreements.

The expected outcomes are:

- 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

Who has responsibility?

Western Bay Community Services Planning and Delivery Board, Western Bay Programme Team and Western Bay Leadership Group

Project Manager – Rhodri Davies, ABMU

Project Lead - Claire Marchant, Head of Community Care and Commissioning, NPTCBC

Project Sponsor – Alex Howells – Chief Operating Officer, ABMU

Intermediate Care Leads:

Alex Williams - Head of Adult Services, City & County of Swansea

Jackie Davies - Head of Adult Services, BCBC

Claire Marchant - Head of Community Care and Commissioning in NPTCBC

Hilary Dover - Service Director for Primary and Community Care, ABMU HB

Pooled Fund Managers:

Michelle Chilcott - Integrated Community Resource Team Services Manager, Bridgend

Andy Griffiths - Integrated Community Services Manager, Neath Port Talbot

Karen Gronert - Head of Integrated Community Services, Swansea

Who are the stakeholders?

The public/residents across Western Bay (e.g. service users, patients, carers, people wanting information and advice on older peoples services)

Social Care and Health staff working in CCoS, NPTCBC, BCBC and ABMU

General Practitioners

Mental Health Services

Third Sector providers of services including advocacy

Councillors in each of the 3 LA's

Care providers including community and residential

Section 2 - Information about Service Users (See guidance):

Please tick what information you know about your service users and provide details/ evidence of how this information is collected.

Children/young people (0-18)	☐	Carers (inc. young carers).....	☒
Any other age group (18+).....	☒	Race.....	☐
Disability	☒	Religion or (non-)belief.....	☐

What information do you know about your service users and how is this information collected?

Extensive information has been gathered from each of the LA's and ABMU in relation to older people over the age of 65 who live in the Western Bay area. This is contained in a number of key reports including:

- Strategic Case for Change produced for the Western Bay Programme Board in June 2013
- Western Bay Business Case for People with Dementia
- Western Bay Business Case for Frail Older People

These can be provided in full if required.

Demographic data has been collected from Daffodil Statistics and displays the following:

Over the next 10 years (2015 – 2025) it is expected that the composition of the population across Wales will change:

- The total population of people over the age of 65 across Wales is expected to grow from 626,300 to 734,450; an **increase of 17%**
- More significantly, it is expected that the population of people over the age of 80 years to grow from 166,230 to 223,270; an **increase of 34%**
- Across Western Bay the total population of people over the age of 65 is expected to grow from 103,140 to 120,260; an **increase of 17%**
- Whilst the population of people over the age of 80 years will grow from 27,430 to 35,870; an **increase of 30%**
- At the same time, adults of working age (18 – 64) will increase only slightly from 319,720 to 320,070 which is an increase of less than 1%

This clearly reflects the ageing population in Wales and the need to tailor and revolutionise existing services in order to meet the needs of these individuals now and in the future across Western Bay.

Further statistical data reflecting service users usage of the Intermediate Tier service is collected using an integrated approach by each organisation (assigned officer in each Local Authority and in the Health Board) on both a weekly and monthly basis and can be provided as required broken down by each aspect of the service i.e. Common Access Point, Rapid Response (Acute Clinical Team) and Reablement. The data includes number of phone calls received by the common access team, new referrals to the Acute Clinical Team and the Reablement caseload figure. This information is used to monitor and evaluate all aspects of the service and can be given in more detail if required.

Information is also in the process of being collected and collated by external independent evaluators Cordis Bright across the four organisations included in the Western Bay collaborative and specifically focusing on the Intermediate Tier. A final version of the Evaluation Performance Framework can be made available if required.

Gender reassignment	☐	Sex	☒
Marriage & civil partnership	☐	Sexual orientation	☐
Pregnancy and maternity	☐	Welsh language	☐

Any Actions Required?

- Further information gathering in relation to liaising directly with stakeholders and specific liaison with service users will be collected, analysed and reported on by external evaluator Cordis Bright who have been commissioned to complete a longitudinal 2 year evaluation on the Intermediate Tier across Western Bay. This engagement is estimated to take place from October 2015 to conclusion in April 2016 where findings will be presented to the Community Services Programme.
- Cordis Bright will gather information on the other protected characteristics listed above including service users' sexual orientation, ethnic origin, religion, and language choice.
-

Section 3 - Impact on Protected Characteristics (See guidance):

Please consider the possible impact on the different protected characteristics. This could be based on service user information, data, consultation and research or professional experience (e.g. comments and complaints).

	Positive	Negative	Neutral	Needs further investigation
Children/young people (0-18)	☐	☐	☒	☐
Any other age group (18+)	☒	☐	☐	☐
Disability	☒	☐	☐	☐
Gender reassignment	☐	☐	☒	☐
Marriage & civil partnership	☐	☐	☒	☐
Pregnancy and maternity	☐	☐	☒	☐
Race	☐	☐	☒	☐
Religion or (non-)belief	☐	☐	☒	☐
Sex	☐	☐	☒	☐
Sexual orientation	☐	☐	☒	☐
Welsh language	☐	☐	☒	☐
Carers (inc. young carers)	☒	☐	☐	☐

Thinking about your answers above, please explain in detail why this is the case.

As mentioned in the previous sections, the Intermediate Tier services as part of the Community Services Programme are aimed specifically at adults aged over 65 in order to promote independence and maintain wellbeing in the community for as long as possible. With the support of the Intermediate Tier, individuals are able to regain the independence reducing the need for longer stays in hospital (if admitted at all) and reducing residential care admissions. This will have a positive impact on individuals aged over 65 with disabilities and will improve the wellbeing of carers by maintaining the independence of service users for as long as possible. The Section 33 Agreement will ensure that delivery of Intermediate Care Services continues to reflect the needs of the population within Western Bay and that the right level of care is provided to older people at the right time and in the right place.

Social isolation is also addressed by the Intermediate Tier with a Third Sector Broker based in the integrated Common Access Points across Western Bay who can be referred to in order for individuals to access social groups and wellbeing support in the community. This Third Sector Broker is also able to signpost and can provide information to carers of older people who are able to access support services through the Third Sector.

Based on the information gathered to date, no adverse impact on any of the above protected characteristics as referred to as neutral in the above section is anticipated. The above protected characteristics marked as neutral will be unaffected by this service.

What consultation and engagement has been undertaken (e.g. with the public and/or members of protected groups) to support your view? Please provide details below.

- Recruitment of Communications and Engagement Officer Oct 2014
- Established dialogue with service users and staff responsible for delivering Intermediate Care Services. This included the 'Focus on Frailty' conference in March 2015, which saw service providers, third sector organisations and service users participate in a series of workshops to inform the direction of the programme and shape the model going forward (see https://www.youtube.com/watch?v=Devj0pKsnu0 and page 2 of the latest newsletter http://issuu.com/westernbayprogramme/docs/western_bay_newsletter_-_issue_3_-_).
- Service user stories have been captured and conveyed in a variety of formats including both written case studies and digital stories. E.g. Caring Closer to Home and Rena's Story https://www.youtube.com/watch?v=hQNzNkKmvM8
- Regional Citizens Panel
    - SH and KR attended the HSCWB network on 17.6.15 to discuss the creation of a Regional Citizen's Panel for WB with 3rd Sector colleagues
    - It is expected that the WB panel will mirror the arrangements of the National SS Citizens Panel, the Communications and Engagement Officer will attend the next meeting of the National Panel to observe and discuss the approach on a regional basis
    - Colleagues from the 3 CVCs will play a key role in establishing and co-ordinating the regional panel in partnership with Western Bay.

Any actions required (to mitigate adverse impact or to address identified gaps in knowledge).

- Development of a robust 'customer feedback' mechanism that records and acts on service user and carer comments and a 'stakeholder feedback' mechanism to capture ideas from referrers, Health and social care staff and the Third sector.
- Data on the other protected characteristics needs to be collected and the effects of the changes on these groups needs to be assessed.

Section 4 - Other Impacts:

Please consider how the initiative might address the following issues.

You could base this on service user information, data, consultation and research or professional experience (e.g. comments and complaints).

Foster good relations between different groups	**Advance equality of opportunity between different groups**
Elimination of discrimination, harassment and victimisation	**Reduction of social exclusion and poverty**

(Please see the specific Section 4 Guidance for definitions on the above)

Please explain any possible impact on each of the above.

Foster good relations between different groups – In terms of staff engagement, this service has improved relations between Health, Social Care and Third Sector Support as the Intermediate Tier has provided an integrated service encompassing staff from all three areas since its development. Feedback received has highlighted the importance of this integrated approach going forward improving outcomes for service users by providing a single collaborative service.

Reduction of social exclusion – The Intermediate Tier promotes independence for older people thus enriching lives and promoting closer communities as people live in their own homes for longer. The inclusion, as previously mentioned, of the Third Sector Broker in the Common Access Points provides an interface with wellbeing services at the first point of contact which gives those contacting due to social isolation and /or loneliness the opportunity to engage with third sector wellbeing services. **What work have you already done to improve any of the above?**

The Western Bay Community Services project has brought together practitioners, managers and Third Sector providers and advocates at a number of engagement events in order to develop a shared understanding and collaborative approach to developing good practice.

Ongoing involvement and contribution from all stakeholders has been taken into account whilst developing the Intermediate Care services with Local Authority, Health, Third Sector and Welsh Government representatives all part of the membership of the Community Services Planning and Delivery Board that oversees the implementation of the optimal Intermediate Care model.

The external evaluation and internal evaluation of each service with comments requested from all stakeholders on how to improve the service is also ongoing e.g. the Common Access Point service is currently being reviewed to ensure optimal performance of all aspects of Intermediate

Care.

Is the initiative likely to impact on Community Cohesion? Please provide details.

This Agreement is likely to have a positive effect on community cohesion as the project/service is centred around strengthening community services to enable older people (including those with dementia) to remain at home and participate within their own communities and remain independent for as long as is possible.

How will the initiative meet the needs of Welsh speakers and learners?

The service changes will be delivered on a local basis by each of the 3 Local Authorities and ABMU Localities and will be developed with due regard to their local implementation of the Welsh Language Standards, including the 'Active Offer'.

Actions (to mitigate adverse impact or to address identified gaps in knowledge).

- N/A

Section 5 - United Nations Convention on the Rights of the Child (UNCRC):

In this section, we need to consider whether the initiative has any direct or indirect impact on children. Many initiatives have an indirect impact on children and you will need to consider whether the impact is positive or negative in relation to both children's rights and their best interests

Please visit http://staffnet/eia to read the UNCRC guidance before completing this section.

Will the initiative have any impact (direct or indirect) on children and young people? If not, please briefly explain your answer and proceed to Section 6.

We would suggest Intermediate Care will not have any impact on children and young people as the service is specifically designed and delivered to provide services to older people aged 65 and over. In the situation where a child or young person was caring for an older person aged 65 or over, this Agreement would have a positive effect on their caring responsibilities in providing support to the adult to assure they are able to live a more independent life with improved wellbeing therefore requiring less support from their carer once the Intermediate Care and the rehabilitation service over 6 weeks has ceased.

Is the initiative designed / planned in the best interests of children and young people? Please explain your answer.

Best interests of the child (Article 3): The best interests of children must be the primary concern in making decisions that may affect them. All adults should do what is best for children. When adults make decisions, they should think about how their decisions will affect children. This particularly applies to budget, policy and law makers.

This initiative is specifically designed to improve the health and wellbeing of older people over the age of 65, although this could have a positive impact on children and young people if they are responsible for caring for an older person that has received this service that is designed to improve their quality of life.

Actions (to mitigate adverse impact or to address identified gaps in knowledge).

- N/A

Section 6 - Monitoring arrangements:

Please explain the arrangements in place (or those which will be put in place) to monitor this initiative:

Monitoring arrangements:

Initially via the Western Bay Community Services Planning and Delivery Board, Western Bay Programme Team and Western Bay Leadership Group. The full Community Services Governance Structure can be provided if required.

Intermediate Care Services will be managed on an integrated basis between the 3 Local Authorities within Western Bay collaborating with the Health Board via local arrangements through Joint Partnership Boards and Joint Management Boards in each locality.

The Joint Partnership Board (JPB) is collectively responsible for the tracking of progress of the Partnership Scheme, within their aims and objectives within any defined resources and the Western Bay Programme Strategy and Plan. A JPB will be set up in each local authority area.

Joint Management Boards (JMB) will also be set up in each local authority area and will assist the JPB in its oversight of day to day management of the Agreement.

The Pooled Fund Managers (as referred to in the Responsibility section earlier in this document) shall ensure that the Pooled Fund is maintained to national and professional standards and that the payment of suppliers' invoices complies with their payment terms. They will also be responsible for ensuring that appropriate financial systems are operational and in place for the Pooled Fund to provide the necessary control and production of financial information.

The Pooled Fund Manager shall supply to the JPB and to the JMB on a monthly basis the financial and activity information. They will also submit a summary report of performance and matters for its attention.

Governance arrangements will be reviewed on an annual basis.

Further details of these arrangements can be found in the Section 33 agreements.

Actions:

- Joint Partnership Boards and Joint Management Boards to be set up in each locality and to ensure they monitor ongoing effectiveness of the delivery of the Intermediate Care Service.

Section 7 – Outcomes:

Having completed sections 1-5, please indicate which of the outcomes listed below applies to your initiative (refer to the guidance for further information on this section).

Outcome 1: Continue the initiative – no concern ☒

Outcome 2: Adjust the initiative – low level of concern ☐

Outcome 3:Justify the initiative – moderate level of concern ☐

Outcome 4: Stop and refer the initiative – high level of concern. ☐

For outcome 3, please provide the justification below:

For outcome 4, detail the next steps / areas of concern below and refer to your Head of Service /

N/A

Director for further advice:

Section 8 - Publication arrangements:

On completion, please follow this 3-step procedure:

1. **Send this EIA report and action plan to the Access to Services Team for feedback and approval – accesstoservices@swansea.gov.uk**
2. **Make any necessary amendments/additions.**
3. **Provide the final version of this report to the team for publication, including email approval of the EIA from your Head of Service. The EIA will be published on the Council's website - this is a legal requirement.**

Action Plan:

Objective - What are we going to do and why?	Who will be responsible for seeing it is done?	When will it be done by?	Outcome - How will we know we have achieved our objective?	Progress
Further information liaising directly with stakeholders and specific liaison with service users will be collected	Analysed and reported on by external evaluator Cordis Bright	April 2016	Presented to Community Services Programme following April 2016	
Further information on protected characteristics will be gathered e.g. sexuality and religion				
The number of Welsh speakers to be gathered and taken into account when planning services				
Languages spoken to be gathered. E.g. People can revert back to their language of origin after a diagnosis of dementia				
Develop robust customer feedback mechanism that records and acts on service user and carer comments				
Develop 'stakeholder feedback' mechanism to capture ideas from referrers, staff and the Third sector.				

Data on the other protected characteristics needs to be collected and the effects of the changes on these groups needs to be assessed.				
Joint Partnership Boards and Joint Management Boards to be set up in each locality and monitor ongoing effectiveness of delivery.				

*** Please remember to be 'SMART' when completing your action plan (Specific, Measurable, Attainable, Relevant, Timely).**

DATED 2015

NEATH PORT TALBOT COUNTY BOROUGH COUNCIL

and

ABERTAWE BRO MORGANNWG UNIVERSITY HEALTH BOARD

AGREEMENT

SECTION 33 OF THE NATIONAL HEALTH SERVICE (WALES) ACT 2006

OVERARCHING PARTNERSHIP AGREEMENT

for

ADULT AND OLDER PEOPLE SERVICES

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Prepared in association with lorimer@btconnect.com

SCHEDULE 1: THE SERVICES:
Host Partner, Aims and Outcomes & Access to Service

SCHEDULE 2: THE HEALTH BOARD'S NHS FUNCTIONS AND THE COUNCIL'S HEALTH RELATED FUNCTIONS

SCHEDULE 3: RESOURCES:
Finance and Budget Setting

SCHEDULE 4: GOVERNANCE:
Approvals, Oversight & Performance

THIS AGREEMENT is made the first day of October 2015 **BETWEEN NEATH PORT TALBOT COUNTY BOROUGH COUNCIL** ("the Council") of Civic Centre, Port Talbot, Neath Port Talbot SA13 1PJ of the one part and **ABERTAWE BRO MORGANNWG UNIVERSITY HEALTH BOARD** ("the Health Board") of One Talbot Gateway, Baglan Energy Park, Baglan, Port Talbot, SA12 7BR of the other part.

WHEREAS:

A This Agreement covers arrangements to plan, and arrange provision for adult and older people's services pursuant to Section 33 of the Act.

B This Agreement provides for the establishment and management of individual Pooled Funds between the Health Board and the Council where either Partner will from time to time be the Host Partner for a Scheme for the purposes of the Regulations.

C For the purpose of the implementation of the Partnership Arrangements under this Agreement:

1 The Health Board has agreed that the Council may, in conjunction with exercising its Health Related Functions, exercise the Health Board's NHS Functions in relation to the Services and;

2 The Council has agreed that the Health Board may, in conjunction with exercising its NHS Functions, exercise the Council's Health Related Functions in relation to the Services.

D Where the Health Board and the Council arrange Services pursuant to Section 33 of the Act the Services which the Partners arrange shall be set out according to the Schedules and the terms herein.

E The Partners shall carry out consultation on the proposals for any Scheme with those persons, user groups, staff and statutory and non-statutory providers, who appear to them to be affected by the arrangement, as required by Regulation 4(2) of the Regulations.

F The Partners have agreed to enter into this Agreement to fulfil the requirements in Regulation 8(2) of the Regulations and to record their respective rights and obligations under the Partnership Arrangements and the terms on which the Partnership Arrangements will be exercised and the Service will be delivered.

G The Partners wish to improve the effectiveness of the Services delivered by them.

IT IS AGREED AS FOLLOWS:

1. DEFINITIONS AND INTERPRETATION

1.1 In this Agreement, except where the context otherwise requires, the following expressions shall have the meanings respectively ascribed to them:-

"Act"	means the National Health Service (Wales) Act 2006;
"Agreement"	means this Agreement and any variation of it from time to time agreed between the Partners;
"Authorised Officers"	means the persons notified in writing from time to time by each of the Partners to the other from time to time as authorised to act on behalf of that Partner in that capacity (which person shall until further notice be for the Council its Head of Paid Service and for the Health Board its Chief Executive);
"Budget"	means the budget for a Scheme as set out in or ascertained in accordance with Schedule 3
"Commencement Date"	means 1st October 2015;
"Council"	means Neath Port Talbot County Borough Council (and any successor to their statutory function);
"Directions"	means such statutory directions in respect of services as the Partners must follow;
"Eligibility Criteria Threshold"	means the four criteria as derived from the Welsh Government's Guidance on "Fair Access to Care" as set out in "Creating a Unified and Fair System for Assessing and Managing Care", April 2002 and these being critical, substantial, moderate and low.

"Financial Year"	means the financial year from 1st April in any year to 31st March in the following calendar year;
"Functions"	means the NHS Functions and the Council's Health Related Functions which may be carried out (in whole or part) by either Partner for any Scheme approved by the Partners and which are reproduced in Schedule 2 for ease of reference
"Health Board"	means Abertawe Bro Morgannwg University Health Board (and any successor to its statutory function);
"Health Related Functions"	means the Council functions set out in regulation 6 of the Regulations, which are reproduced in Schedule 2 for ease of reference;
"Host Partner"	means the Partner responsible for any Pooled Funds within a Scheme and to operate in accordance with Regulation 7 (4) of the Regulations;
"Joint Management Board"	means a group of officers for each Scheme who will assist the JPB in its activities through oversight of day to day management of the particular agreed Scheme and in accordance with Schedule 4;
"Joint Partnership Board referred to by abbreviation as JPB"	means the membership set out at Schedule 4 and which is responsible for the management of any scheme established under this Agreement and its delivery in accordance with the provisions of Schedule 4;
"Locality"	means the administrative area of the Council;
"Month"	means a calendar month;
"NHS Functions"	means those functions set out in regulation 5 of the Regulations as reproduced in Schedule 2;

“Partners”	means the Council and the Health Board, and the term “Partner” shall mean either;
'“Partnership Arrangements”	means the arrangements as set out in this Agreement concerning the planning, or arranging of services to Adults and Older People and in accordance with the Regulations and any Scheme;
“Partnership Lead”	means the officer responsible within the office of the Host Partner approved by the JPB who shall be the chair of the Joint Management Board;
“Pooled Fund Manager”	means the person determined from time to time under Clause 7.5 and who has been identified in the particular Schedules for a Scheme agreed by the JPB;
“Pooled Fund/Pooled Funds”	means the joint fund or joint funds of monies administered by the Partners from time to time being shared contributions from the Partners for the purpose of securing the Services in the Locality pursuant to this Agreement;
“Regulations”	means the NHS Bodies and Local Authority Partnership Arrangements Regulations 2000, S.I. No. 2993 (W.193) as amended or replaced from time to time;
“Revised Annual Plan”	means an annual statement of agreed intentions referred to in Schedule 4;
“Scheme”	means:- firstly at the Commencement Date the arrangements for the provision of Services set out in the Schedules and secondly any additional Services which may be added by the method referred to in Clause 32;

"Scheme Schedules"	means Schedules 1, 3 and 4;
"Services"	means the services which are to be made available to Service Users as described in Schedule 1 and such other services as the Partners may agree to be arranged for any particular Scheme and whose costs are to be met from the Pooled Fund or in respect of which the Partners have agreed to make expenditure;
"Service Users"	mean the people who receive the Services to be arranged by the Partners;
"Term"	means the period from the Commencement Date and ending on 31st March 2018 subject to earlier termination in accordance with the terms of this Agreement;

1.2 Save to the extent that the context or the express provisions of this Agreement otherwise require:-

1.2.1 obligations undertaken or to be undertaken by more than a single person shall be made and undertaken jointly and severally;

1.2.2 words importing any gender include any other gender and words in the singular include the plural and words in the plural include the singular;

1.2.3 References to statutory provisions shall be construed as references to those provisions as respectively amended or re-enacted (whether before or after the Commencement Date) from time to time;

1.2.4 Headings and the Index are inserted for convenience only and shall be ignored in interpreting or in the construction of this Agreement;

1.2.5 references in this Agreement to any Clause or Sub-Clause Paragraph or Schedule without further designation shall be construed as a reference to the Clause or Sub-Clause of or Schedule to this Agreement so numbered;

1.2.6 any obligation on any of the Partners shall be a direct obligation or an obligation to procure as the context requires;

1.2.7 any reference to “indemnity” or “indemnify” or other similar expressions shall mean that either Partner indemnifies, shall indemnify and keep indemnified and hold harmless the other Partner; and

1.2.8 any reference to a person shall be deemed to include any permitted transferee or assignee of such person and any successor to that person or any person which has taken over the functions or responsibilities of that person but without derogation from any liability of any original Partner to this Agreement;

1.2.9 this Agreement and its Schedules should be read as a whole but in the event of any inconsistency the Schedules shall have precedence

2. TERM

2.1 This Agreement shall commence on the Commencement Date and shall continue for the Term, subject to earlier termination as provided below.

2.2 The Agreement may be terminated in accordance with the provisions of Clause 11.

3. AIMS AND OBJECTIVES

3.1 The aims, benefits and intended outcomes of the Partners in entering in to this Agreement are to:

3.1.1 provide high quality, efficient and cost effective Services to meet the needs of the Partners, Service Users and other authorised users according to any specific Scheme set out in the Schedules;

3.1.2 provide the best value Service to the Partners, Service Users and other authorised users;

3.1.3 develop a quality-management system for continuous service improvement in line with measures and targets for the Schemes contained in the Schedules including risk management and workforce training.

3.2 The targets for any Scheme are set out in Schedule 1 for that Scheme and which are to be updated annually for approval in accordance with Schedule 4 along with a Revised Schedule 1 and Schedule 3 (as a revised Annual Finance Agreement) and Appendix to Schedule 4 which collectively here shall form a Revised Annual Plan for a Scheme.

4 FINANCIAL CONTRIBUTIONS

4.1 The Budget for the first Financial Year together with the mechanism for calculating subsequent Budgets and contributions is set out in Schedule 3.

4.2 The arrangements for outturn and balancing payments between the Partners are described in Schedule 3 to this Agreement.

4.3 Any increases to the amounts described at Clause 4.1 shall be dealt with by the procedure set out in Schedule 3.

4.4 No provision of this Agreement shall preclude the Partners by mutual agreement making additional contributions of non-recurring monies to the Pooled Fund for a Scheme from time to time but no such additional contributions shall be taken into account in the calculation of the Partners' respective contributions for the purpose of apportionment at Clause 8. Any such additional contributions of non-recurring monies shall be explicitly recorded in JPB minutes and recorded in the budget statement for a Scheme as a separate item.

5. NHS FUNCTIONS AND COUNCIL HEALTH RELATED FUNCTIONS

5.1 The NHS Functions and the Council's Health Related Functions which may be carried out (in whole or part) by either Partner from time to time according to any Scheme are set out in Schedule 2.

6. THE SERVICES

6.1 The Host Partner for the Scheme is identified in Schedule 1.

6.2 The Services shall be arranged by the JPB in accordance with the provisions of the relevant Schedules.

6.3 The Partners will ensure that the Welsh Government's Guidance on "Fair Access to Care" is fully implemented and that the Eligibility Criteria Thresholds as agreed by the Council are consistently applied.

6.4 The Eligibility Criteria Threshold for the provision of Services will operate according to Schedule 1 for any Scheme.

7. ARRANGEMENT OF SERVICES

7.1 Pooled Funds shall be established for arranging the Services.

7.2 For any Scheme the Council or the Health Board shall be the Host Partner for the purposes of Regulation 7(4) of the Regulations.

7.3. The JPB will be established in accordance with Schedule 4 to carry out the functions as set out in Schedule 4 and shall be supported by a Joint Management Board according to that Schedule's requirements.

7.4 The Pooled Fund Manager shall be responsible for the management of the Pooled Fund for a Scheme.

7.5 The Pooled Fund Manager shall be approved by the Partner who is not the Host partner for a Scheme (such approval not to be unreasonably withheld) and affirmed in the role by the Joint Partnership Board at the outset of a Scheme.

7.6 The Pooled Fund Manager where the Council is the Host Partner shall be accountable directly to the Partnership Lead for an approved Scheme.

7.7 The Pooled Fund Manager where the Health Board is the Host Partner shall be accountable directly to the Partnership Lead for an approved Scheme.

7.8 The internal regulations of the Host Partner shall apply to the management of the Pooled Funds under this Agreement, insofar as the funding is held and defrayed by the Host Partner.

7.9 The Pooled Fund Manager shall be responsible for authorising payments and the Host Partner shall make payments from the Pooled Fund and shall be responsible for authorising payments, insofar as the funding is held and defrayed by the Host Partner, in accordance with the Service description and the Aims and Objectives, as set out in Schedule 1 provided that the Partners shall be responsible for payments under regular day to day provision of the Service supplied directly through their own employees and/or contractors.

7.10 The Pooled Fund Manager shall be responsible for managing the Pooled Fund and forecasting and reporting to the JPB upon the targets and information in accordance with and any further targets or performance measures that may be set by the JPB from time to time.

7.11 The Pooled Fund Manager shall report to the Authorised Officers in accordance with the requirements of the Regulations. The Council's Authorised Officer shall in turn ensure reporting on the same to the officer of the Council responsible for the administration of their financial affairs under Section 151 of the Local Government Act 1972.

7.12 Each Partner shall comply with all Statutes, Regulations, Guidance, Directions and Directives relating to the provision of the Services or any part thereof.

8. FINANCIAL PERFORMANCE AND RISK SHARING ARRANGEMENTS

8.1 The Pooled Funds are to be used solely to achieve the aims and objectives of a Scheme set out in Schedule 1 and according to the arrangements for spend and performance set out at schedule 3 and 4.

8.2 The Pooled Fund Manager of a Scheme shall submit information monthly and report every three months in summary form to the JPB at its meetings, on spend and the performance information specified in the Appendix to Schedule 4 for a Scheme. The Partners agree to provide all necessary information to the Pooled Fund Manager in time for the reporting requirements to be met.

8.3 The Partners shall ensure:-

a) The Pooled Funds are used efficiently to deliver agreed outcomes.

b) The expenditure and income within the Pooled Funds remain within budget, and that any exceptions to this are reported to the JPB in a timely manner.

c) A high level of probity in financial management arrangements.

d) Resources allocated to Pooled Funds are adequately protected.

8.4 The benefit of any surplus in the Pooled Fund at the end of any Financial Year may:

8.4.1 Be used for such other expenditure of the same general nature as that contained within the Scheme as the Partners may determine and

8.4.2 Where the Partners agree, remain within the Pooled Fund for a Scheme to be used to meet such other expenditure as the Partners may determine.

8.5 Where there is not agreement under Clause 8.4. in full or in part and no other purpose is agreed, the benefit of any surplus in the Pooled Fund at the end of any Financial Year shall be distributed to the Partners pro rata to their contributions for the Financial Year.

8.6 The Partners shall take mitigating action as appropriate to ensure expenditure remains within the limit of a Pooled Fund and neither party shall act unreasonably to expose the other to undue financial risk.

8.7 Save:

8.7.1 to the extent that a party's liability arises pursuant to clause 12 and/or

8.7.2 to the extent agreed between the parties in writing;

The Partners shall be jointly responsible (in the proportions determined according to the formula for balancing payments as at Schedule 3 to the Agreement in respect of a Pooled Fund for the Financial Year) for any such

costs, claims, expenses or liabilities incurred in accordance with the terms of this Agreement.

8.8 The monthly reports of the Pooled Funds Manager to be submitted to the JPB shall include monthly financial performance reports detailing performance against agreed funding. The report will include a variance analysis for the period and expected forecast outturn and where required, an explanatory note setting out actions being taken to tackle areas where there is a projected underspend or overspend against agreed budgets. Annual statements of spend and performance against the Pooled Funds will also be provided in line with any statutory timescales required by either The Health Board or the Council.

8.9 The Pooled Funds Manager shall maintain and provide in addition to information provided under Clause 8.8 above when requested by either of the members of the JPB at the expense of that Partner such information as shall be appropriate to describe the cost of arranged Services for so long as any part thereof is being provided to Service Users notwithstanding any notice of termination in accordance with Clause 11.

8.10 The governance arrangements shall be as set out in Schedule 4 for a Scheme.

8.11Approval for all other reasonable administrative expenses incurred by the Pooled Funds outside of the budget in-year must be approved in writing in advance of spend and will require the agreement of the Partners before being accepted as an allowable charge to the particular Pooled Fund for a Scheme.

9. REVIEW

9.1 The Partners, through the JPB, shall review the operation of the Scheme annually by 1st July of every year.

9.2 Reviews of this Agreement shall be conducted in good faith and in accordance with the governance arrangements set out in Schedule 4; shall be based upon information to be provided as set out in Schedule 4.

9.3 The Partners shall review the operation of this Agreement on the coming into force (or anticipation of the coming into force) of any legislation or guidance affecting the terms of this Agreement so as to ensure that the terms of this Agreement comply with such legislation or guidance.

10. FINANCIAL PLANNING AND BUDGET SETTING PROCESS

10.1 The Partners will prepare planning assumptions of inflation allowances for pay and non-pay expenditure and income together with proposed variations to the expenditure budget in respect of for example:

- Growth and demographic changes
- Service enhancements and reductions
- Required efficiency/quality improvements
- Cost pressures/increases in demand; and expected changes in Service delivery costs
- National initiatives

10.2 These will be considered in the context of the overall budget of the Council and the Health Board as applicable.

10.3 The Budget for a Scheme and which is to be agreed by the Partners will take into account effects on other budgets and the financial resources of the Partners.

10.4 Where the Partners do not agree an annual Budget by the time of the commencement of a new Financial Year they shall remain liable to contribute the same sum as was identified as their contribution in the previous Financial Year (together with any inflation on salaries including increments and pay settlements) until such time as an annual review at Clause 9 or termination takes effect.

10.5 As part of the annual Budget setting process, the Partners shall seek appropriate advice in respect of the factors outlined in clauses 10.1 and 10.3 above.

11. TERMINATION

11.1 If the Health Board or the Council fails to meet any of its respective obligations under this Agreement, either Partner may by written notice request the Partner in default to take such reasonable action to rectify such failure within 60 days of the date of the notice.

11.2 Should the Partner in default fail to rectify such failure within such time-scale, the other Partner may give a minimum of three months written notice to terminate the Agreement.

11.3 Either Partner shall be entitled to terminate this Agreement immediately by notice to the other Partner, if the other Partner, its employees or agents either offer, give or agree to give to anyone any inducement or reward or confers any other benefit in respect of this or any other Agreement (even if the Partner is unaware of any such action) or otherwise commits an offence under the Bribery Act 2010 or Section 117(2) of the Local Government Act 1972.

11.4 Either Partner is entitled to terminate this Agreement forthwith by written notice to the other Partner if an event of force majeure pursuant to clause 28 persists for more than 3 months.

11.5 Either Partner is entitled to terminate this Agreement by giving not less than twelve months written notice to the other such notice to end at the end of a Financial Year.

11.6 The Partners may mutually agree that this Agreement is terminated on an agreed date.

11.7 Any termination of this Agreement under this Clause shall be without prejudice to any continuing obligations of the Partners under Clause 12.

11.8 Any addition or removal of a Scheme or the Services provided pursuant to this Agreement shall be dealt with in accordance with Clause 32.

12. EFFECTS OF TERMINATION

12.1 Notwithstanding any notice of termination in accordance with Clause11

12.1.1 the Partners shall continue to be liable to arrange the Service within a Scheme in accordance with this Agreement until the actual date of termination;

12.1.2 the Partners shall remain liable to operate the Pooled Fund for a Scheme in accordance with this Agreement so far as is necessary to ensure fulfilment of the obligations in Sub-Clause 12.1.1; and

12.1.3 for the avoidance of doubt the Partners shall remain liable to contribute that proportion of the cost of a Scheme which comprises its contribution until the termination takes effect;

12.1.4 in the event that the Partners have jointly agreed to procure a contract with a provider for the provision of any part of the Services and one Partner has agreed to make a contribution to the other in respect of the costs of that contract the contributing Partner shall continue to pay such contribution while that contract subsists.

12.1.5 the Partners shall cooperate together to ensure that any Service User who has started to receive a service under this Agreement continues to receive an appropriate service whilst the Partners make arrangements to revert to separate service provision.

12.2 Subject to the foregoing commitments of the Partners, following termination of this Agreement, in the event that the Host Partner holds any funds for the purpose of the Service those funds shall be divided between the Partners in the percentage shares identified in paragraphs 3 and 4 of Appendix 2 to Schedule 3

12.3 Assets purchased from the Pooled Fund will be disposed of by the Partners for the purposes of meeting any of the costs of winding up the Service or where this is not practicable such goods will be shared proportionately between the Partners in the percentage shares identified in Clause 12.2 above.

12.4 In the event that this Agreement is terminated the Partners agree to co-operate to ensure an orderly wind up of their joint activities as set out in this Agreement so as to minimise disruption to all Service Users carers and Staff, and comply with individual rights as set out in their contract of employment.

12.5 The operation of this Clause 12 together with Clauses 14, 15, 17, 18 and 19 shall survive the termination or expiry of this Agreement.

13. SCRUTINY

13.1 The Partners will make senior officers available to attend each other's committees and boards with responsibility for the development of policy and the scrutiny of decisions taken in relation to the Services.

14. EXTERNAL INSPECTION AND MONITORING

14.1 The Partners:

14.1.1 Shall comply with any statutory inspection requirements in relation to Services and will liaise as required with the Care and Social Services Inspectorate Wales (CSSIW) and /or Healthcare Inspectorate Wales (HIW) and/or other relevant regulatory bodies.

14.1.2 Shall provide appropriate access and information to any external body empowered by statute to inspect or monitor the Partners' discharge of the Services.

14.1.3 Shall work together to ensure that recommendations made to the Council pursuant to its outcome agreement with the Welsh Government or any other administrative procedure which replaces it are implemented.

15. INDEMNITY AND INSURANCE

15.1 The Partners shall maintain public liability insurance or its equivalent in respect of the Services provided under this Agreement to a minimum level of ten million pounds (£10,000,000) per claim or aggregate cover of ten million pounds (£10,000,000) of claims in any Financial Year and shall review the adequacy of such cover not less frequently than once in each Financial Year.

15.2 Either Partner shall upon request from the other Partner from time to time:

15.2.1 provide evidence that the insurance arrangements required by clause 15.1 and 15.10 are fully paid up and in force;

15.2.2 allow the requesting Partner to inspect its insurance policies; and

15.2.3 provide the requesting Partner with copies of the full policy document.

15.3 Subject to Clause 15.4 each Partner (the "Indemnifying Partner") shall indemnify the other Partner, their officers, employees and agents against any damage, cost, liability, loss, claim or proceedings whatsoever arising in respect of:

15.3.1 any damage to property real or personal including (but not limited to) any infringement of third party patents copyrights and registered designs;

15.3.2 any personal injury including injury resulting in death;

15.3.3 any fraudulent or dishonest act of any of its officers, employees or contractors;

15.3.4 any breach of the obligations under Clause 17 or any related statutory provision

or arising out of or in connection with the Service.

15.4 Where the Indemnifying Partner has only contributed partially to the cause of any damage, cost, liability, loss, claim or proceedings, it shall only be liable to indemnify the other Partner for such proportion of the total costs of such damage, cost, liability, loss, claim or proceedings as its contribution to the cause bears to the total damage, cost, liability, claim or proceedings. Where the Partners are unable to agree any such apportionment, the disputes procedure in Clause 19 shall apply.

15.5 Neither the indemnity from the Council nor that from the Health Board at Clause 15.3 shall apply to any such claim or proceeding:-

15.5.1 unless, as soon as reasonably practicable following receipt of notice of such claim or proceeding, the Partner in receipt of a claim shall have notified the other Partner in writing of it, and shall, upon any of the latter's request and at the latter's cost, have permitted the former to have full care and control of the claim or proceeding, using legal representation approved by the latter Partner, such approval not to be unreasonably withheld; or

15.5.2 if the Partner in receipt of the claim or proceeding, its employees or agents shall have made any admission in respect of such claim or proceeding or taken any action related to such claim or proceeding prejudicial to the defence of it without the written consent of the other Partner (such consent not to be unreasonably withheld or delayed), provided that this condition shall not be treated as breached by any statement properly made by the Partner in receipt of the claim, its employees or agents in connection with the operation of its internal complaints procedures, accident reporting procedures or disciplinary procedures or where such statement is required by law.

15.6 Each Partner shall keep the other Partner and their legal advisers fully informed of the progress of any such claim or proceeding, will consult fully with the other Partner on the nature of any defence to be advanced and will not settle any such claim or proceeding without the written approval of the other Partner affected (such approval not to be unreasonably withheld).

15.7 Without prejudice to the provisions of Clause 15.5, the Partners will use their reasonable endeavours to inform each other promptly of any circumstances reasonably thought likely to give rise to any such claim or proceedings of which they are directly aware and shall keep each other reasonably informed of developments in relation to any such claim or proceeding even where they decide not to make a claim under this indemnity.

15.8 The Partners shall each give to the other such help as may reasonably be required for the efficient conduct and prompt handling of any claim or proceeding.

15.9 The Partners shall ensure that they maintain policies of insurance (or in the case of the Health Board, equivalent arrangements through the schemes operated by the Welsh Risk Pool) to cover the matters referred to in Clauses 15.3 including but not limited to employers liability, public liability and other liabilities to third parties.

15.10 The Partners will maintain the insurances set out in Clause 15.1 and 15.9 for a period of 12 years following any termination or expiry of the Agreement

16. VARIATION

16.1 No variation to this Agreement shall be effective unless it is in writing and executed by the Partners using the same formalities as this Agreement.

17. CONFIDENTIALITY AND DATA PROTECTION

17.1 The Partners comply and have adequate measures in place to ensure its compliance at all times with the provisions and obligations of the Data Protection Act 1998 (the “DPA”). This shall include but is not limited to:

17.1.1 Partners shall not use Personal Data and Sensitive Personal Data (as both defined in the DPA) or any part thereof for any purposes whatsoever other than for the purpose of performing the Services

17.1.2 Partners shall keep and dispose of all Personal Data and Sensitive Personal Data in a safe and secure manner

17.1.3 Partners shall retain all Personal Data and Sensitive Personal Data for only as long as is necessary for performing the Services

17.2 Partners shall immediately inform each other in the event of any breaches or suspected breaches of the provisions of the DPA in relation to information obtained in the course of performing the Services

17.3 Each Partner shall:

17.3.1 treat as confidential and provide appropriate safeguards for all or any information which belongs to and has been supplied by and designated as confidential by the other Partner howsoever or in whatsoever manner such information is conveyed or stored, including information which relates to the business, affairs, assets, goods or services or operations of the other Partner ("Confidential Information"); and

17.3.2 not disclose any Confidential Information to any other person without the prior written consent of the Partner, except to such person and to such extent as may be necessary for the performance of the Services or as required by law.

17.4 The Partners shall take all necessary precautions to ensure that all Confidential Information obtained from either Partner under or in connection with the Services:-

17.4.1 is given only to such of the staff engaged in connection with the performance of the Services as is strictly necessary for the performance of the Services and only to the extent necessary for performance of the Services;

17.4.2 is treated as confidential and not disclosed (without prior approval) or used by any staff otherwise than for the purposes of the Services.

17.5 The Partners agree that information relating to the provision of Services as defined in this Agreement may also be shared with the Welsh Government, Welsh NHS bodies, the Audit Commission and the Wales Audit Office where this is necessary for them to meet their obligations as defined by statute, regulation or contractual commitment.

17.6 The obligations of confidentiality in this clause 17 shall not extend to any matter which either Partner can show:

17.6.1 is in, or has become part of, the public domain other than as a result of a breach of the obligations of confidentiality under this Agreement; or

17.6.2 is required to be disclosed under any applicable law, or by order of a court or governmental body or authority of competent jurisdiction.

18. FREEDOM OF INFORMATION

18.1 The Partners agree that they will each co-operate with one another to enable any Partner receiving a request for information under the Freedom of Information Act 2000 or Environmental Information Regulations 2004 to respond to that request promptly and within the statutory timescales. This co-operation shall include but not be limited to finding, retrieving and supplying information held, directing requests to other Partners or parties as appropriate and responding to any requests by the Partner receiving a request for comments or other assistance.

19. DISPUTE RESOLUTION

19.1 Prior to any dispute difference or disagreement being referred to mediation pursuant to the remaining provisions of this paragraph 19 the Partners shall seek to resolve the matter as follows:

19.1.1 in the first instance the issue shall be considered by chief officers with delegated responsibility for the Service

19.1.2 if the aforementioned chief officers are unable to resolve the matter within 30 working days then the issue shall be referred to the Head of Paid Service of the Council and the Chief Executive officer of the Health Board ('the Heads of Paid Service')

19.1.3 if the Heads of Paid Service are not able to resolve the matter within a further thirty (30) working days the provisions of paragraph(s) 19.2 and 19.3 shall take effect

19.2 In the event of the Heads of Paid Service not being able to resolve the matter shall be dealt with by the following mediation procedure:

19.2.1 for the purpose of this paragraph 19.2 a dispute shall be deemed to arise when one Partner serves on the other a notice in writing stating the nature of the dispute

19.2.2 every dispute notified under this paragraph 19.2 shall first be referred to mediation in accordance with the mediation procedures of the Alternative Dispute Resolution Group London

19.2.3 the mediator shall be agreed upon by the Partners and failing such agreement within fifteen (15) working days of one Partner requesting the appointment of a mediator and proposing a name then the mediator shall be appointed by the head of the division of the Welsh Government for the time being with responsibilities for the oversight of the Services

19.2.4 unless agreed otherwise the Partners shall bear their own costs of the mediation and share equally the costs of the mediator

19.2.5 the use of mediation will not be construed under the doctrines of laches waiver or estoppel to affect adversely the rights of any Partner and in particular any Partner may seek a preliminary injunction or other judicial relief at any time if in its judgment such action is necessary to avoid irreparable damage

19.3 In the event of the Partners failing to reach agreement following mediation the following procedure shall be followed:

19.3.1 in the event of the Partners failing to reach agreement on their dispute or difference following mediation pursuant to paragraph 19.2 one Partner may serve on any other a notice in writing stating the nature of the matters still in dispute

19.3.2 the dispute or difference shall then be referred to the arbitration of a sole arbitrator to be appointed in accordance with Section 16(3) of the Arbitration Act 1996 ("the Arbitration Act")

19.3.3 in the event of failure of the Partners to make the appointment pursuant to Section 16(3) of the Arbitration Act the appointment shall be by the President (or if the President be unwilling, unable or unavailable) the Vice President for the time being of the Law Society

19.3.4 the arbitration will be regarded as commenced for the purposes set out in Section 14(1) of the Arbitration Act when one Partner sends to the other written notice in accordance with the Arbitration Act

19.3.5 the arbitration shall be conducted in accordance with the Rules of the Chartered Institute of Arbitrator(s) or any amendment or modification thereof being in force at the date of commencement of the arbitration

19.4 This dispute resolution procedure cannot be used in relation to any dispute relating to the setting of the Budget or any revision of this Agreement

20. EXCLUSION OF PARTNERSHIP AND AGENCY

20.1 The Partners expressly agree that nothing in this Agreement in any way creates a legal partnership between them.

20.2 No Partner nor any of its employees or agents will in any circumstances hold itself out to be the servant or agent of the other Partner, except where expressly permitted by this Agreement.

21. ASSIGNMENT AND SUB AGREEMENTS

21.1 Neither Partner shall assign nor transfer the whole or any part of this Agreement, without the prior written consent of the other Partner, except where expressly permitted by the Agreement.

21.2 Either Partner shall be entitled to assign novate or otherwise transfer its rights and obligations pursuant to this Agreement to a statutory successor. This Agreement shall be binding on and shall endure to the benefit of the Health Board and the Council and their respective successors and permitted transferees and assignees.

22. THE CONTRACTS (RIGHTS OF THIRD PARTIES) ACT 1999

22.1 The Contracts (Rights of Third Parties) Act 1999 is hereby excluded.

22.2 No variation to this Agreement and no supplemental or ancillary agreement to this Agreement shall create any such rights unless expressly so stated in any such agreement by the parties to this Agreement. This does not affect any right or remedy of a third party, which exists or is available apart from the Contracts (Rights of Third Parties) Act 1999.

23. PREVENTION OF CORRUPTION / QUALITY CONTROL

23.1 The Partners shall have mutual policies and procedures to ensure that relevant controls, assurance, probity and professional standards are met.

24. COMPLAINTS

24.1 The Partners shall ensure that any complaints received about the Service shall be dealt with promptly and in accordance with their adopted complaints procedures.

24.2 Where applicable any complaints which have not been resolved under the above sub clause shall be dealt with under any appropriate statutory complaints procedure which applies to that class of complaint

25. NOTICES

25.1 All notices under this Agreement shall only be validly given if given in writing, addressed as follows:-

25.1.1 if to the Health Board, addressed to its Chief Executive as above; or

25.1.2 if to the Council, addressed to its Chief Executive as above.

25.2 Any notices required to be given under this Agreement must be in writing and may be served by personal delivery, post (special or recorded delivery or first class post) or facsimile at the address set out at the beginning of this Agreement or at such other address as each party may give to the other for the purpose of service of notices under this Agreement. Notices shall be deemed to be served at the time when the notice is handed to or left at the

address of the party to be served (in the case of personal delivery) or the day (not being a Saturday, Sunday or public holiday) next following the day of posting (in the case of notices served by post) or at 10 a.m. on the next day (not being a Saturday, Sunday or public holiday) following dispatch if sent by facsimile transmission.

25.3 To prove service of any notice, it shall be sufficient to show in the case of a notice delivered by hand that the same was duly addressed and delivered by hand and in the case of a notice served by post that the same was duly addressed prepaid and posted special or recorded delivery or by first class post. In the case of a notice given by facsimile transmission, it shall be sufficient to show that it was dispatched in a legible and complete form to the correct telephone number without any error message on the confirmation copy of the transmission.

26. NOTIFICATION TO THE WELSH GOVERNMENT

26.1 In accordance with the relevant guidance the Partners agree that they shall lodge with the Welsh Government a copy of this Agreement and any Services added under Clause 32.

27. GENERAL PRINCIPLES

27.1 In relation to the Services, the Partners shall:

27.1.1 treat each other with respect and an equality of esteem;
27.1.2 be open with information about the performance and financial status of each;
27.1.3 provide early information and notice about relevant problems; and
27.1.4 co-operate with each other to agree joint protocols and any variance in such protocols as may be required from time to time.

28. FORCE MAJEURE

28.1 In this Agreement "force majeure" shall mean any cause preventing either party from performing any or all of its obligations which arises from or is attributable to acts, events, omissions or accidents beyond the reasonable control of the party so prevented including without limitation act of God, war, riot, civil commotion, malicious damage, compliance with any law or governmental order rule regulation or direction, accident, fire, flood or storm.

28.2 If any party is prevented or delayed in the performance of any or all of its obligations under this Agreement by force majeure, that party shall forthwith serve notice in writing on the other party or parties specifying the nature and extent of the circumstances giving rise to force majeure and shall, subject to service of such notice (and to Clause 28.4), have no liability in respect of the performance of such of its obligations as are prevented by the force majeure events during the continuation of such events.

28.3 The party affected by force majeure shall use all reasonable endeavors to bring the force majeure event to a close or to find a solution by which the Agreement may be performed, despite the continuance of the force majeure event.

28.4 If any party is prevented from performance of any or all of its obligations for a continuous period in excess of three months the other party may terminate this Agreement forthwith by written notice, in which case neither party shall have any liability to the other except that rights and liabilities which accrued prior to such termination shall continue to subsist.

29. SEVERABILITY

29.1 If at any time any part of this Agreement (including any one or more of the clauses of this Agreement or any sub-clause or paragraph or any part of one or more of these clauses) is held to be or becomes void or otherwise unenforceable for any reason under any applicable law, the same shall be deemed omitted from this Agreement and the validity and/or enforceability of the remaining provisions of this Agreement shall not in any way be affected or impaired as a result of that omission.

30. WAIVER

30.1 The rights and remedies of any party in respect of this Agreement shall not be diminished, waived or extinguished by the granting of any indulgence, forbearance or extension of time granted by such party to the other nor by failure of, or delay by the said party in ascertaining or exercising of any such rights or remedies. The waiver by any party of any breach of this Agreement shall not prevent the subsequent enforcement of any subsequent breach of that provision and shall not be deemed to be a waiver of any subsequent breach of that or any other provision.

31. GOVERNING LAW

31.1 This Agreement shall be considered as a contract made in England and Wales and shall be subject to the laws of England and Wales as they apply in Wales.

31.2 Subject to the provisions of any jointly agreed dispute resolution procedure, all the parties agree that the courts of England and Wales shall have exclusive jurisdiction to hear and settle any action, suit, proceeding or dispute in connection with this Agreement and irrevocably submit to the jurisdiction of those courts.

32. ADDITION OR REMOVAL OF SERVICES

32.1 The Partners may by mutual consent add further Schemes or Services to this Agreement or remove Schemes or Services from it.

32.2 The Schemes or Services shall be added or removed by such amendment to the Schedules and the body of this Agreement as the Partners may agree which may include separate description of the Schemes or Services, Pooled Funds and management arrangements such as JPBs and Joint Management Boards.

32.3 These amendments shall be contained in an agreement executed using the same formalities as this Agreement

IN WITNESS whereof the Partners have executed this Agreement as a Deed the day and year first before written.

Executed as a deed by affixing the

COMMON SEAL of

THE ABERTAWE BRO MORGANNWG UNVERSITY HEALTH BOARD
In the presence of:

Signed (Authorised Officer):

Name/Position:

Executed as a deed by affixing the

COMMON SEAL of

NEATH PORT TALBOT COUNTY BOROUGH COUNCIL

In the presence of:

Proper Officer

SCHEDULE 1: THE SERVICES:

Host Partner, Aims and Outcomes & Access to Service

INTRODUCTION

Services Aims and Outcomes for the service at commencement of this Agreement are as set out here with details of the Host Partner.

1. NEATH PORT TALBOT INTERMEDIATE CARE SERVICES

2. HOST PARTNER: Neath Port Talbot County Borough Council

3. NEATH PORT TALBOT INTERMEDIATE CARE JOINT MANAGEMENT BOARD:

3.1 The Partnership Lead Officer:…….

3.2 The Pooled Fund Manager …….

3.3 Other members comprising

- One non-host partner officer……..
- One Finance officer (Council)……..
- One Finance officer (Health Board)…….

4. AIMS & OBJECTIVES FOR 2015/16

4.1 The overarching strategic aim of this Agreement is:-

4.2 To ensure coordinated arrangements for ensuring for integrated provision of high quality, cost effective Intermediate Care services which meet local health and social care needs, through the establishment a pooled fund arrangements under Section 33 of the Act from 1st April 2015

4.3 The Western Bay Health and Social Care partnership was established to co-design and deliver services that meet the current and future needs of people in Bridgend, Neath Port Talbot and Swansea.

4.4 This Agreement seeks to maximise the efficiency of Intermediate Care by delivering integrated provision from a pooled fund from 2015/16. It builds on the Western Bay documents: August 2013 "*Joint Commitment - Delivering Improved Community Services*", January 2014's "*Transforming care through investment in the intermediate tier - 3 year business case*" and the *"Statement of Intent on Integration"* from July 2014.

4.5 The document takes account of other local plans being developed, such as the Health Board's Three Year Plan, the Primary Care Plan, the Local Authority's Commissioning intensions and the major business change programmes (such as Changing For The Better and the Western Bay Programme).

5. PURPOSE AND KEY PRINCIPLES

5.1 Across the Western Bay footprint there are excellent examples of innovative community services, with health and social care increasingly being delivered through integrated care models. A similar model of care is being implemented in the three Localities and each has a similar Pooled Fund Agreement. The Agreement for this Locality builds on the achievements to date and enables its further development. It is based on an established set of principles and provides a mechanism for closer and faster integration.

5.2 The approach of the Partners will be consistent with the principles in "Sustainable Social Services: A Framework for Action" which sets out the action needed to ensure care and support services respond to rising levels of demand and changing expectations, particularly for frail older people.

5.3 This will help the Partners deliver their stated commitment to benefit adults in the region:

- Support for people to remain independent and keep well
- More people cared for at home to maximise their recovery, with shorter stays in hospital if they are unwell
- A change in the pathway away from institutional care to community care, available on a 7-day basis
- Fewer people being asked to consider long term residential or nursing home care, particularly in a crisis
- Earlier diagnosis of dementia and quicker access to specialist support for those who need it
- More people living with the support of technology and appropriate support services
- Provision of services that are more joined up around the needs of the individual with less duplication or hand-offs between health and social care agencies

5.4 Through this Agreement the Partners will pool their funds and resources so as to deliver the maximum impact for residents.

5.5 The Agreement's primary purpose is to:-

- To achieve the highest quality of seamless care with service users being at the heart of service planning, commissioning and delivery via a single Pooled Fund
- To increase the operational efficiency and economies of scale of the services and ensure sustainability of the rebalanced health and social care services
- To optimise the mix of service provision skills across health and social care and develop more rewarding jobs and careers for staff
- To support greater and more coordinated engagement with the third sector and carers
- To enhance creativity and problem solving within the various multidisciplinary services with quicker decision making
- To support the delivery of the Primary Care and Community Strategy for Wales, Welsh Older person's NSF, Fulfilled Lives Supportive Communities and the Welsh Government's Chronic Condition Model.

6. SERVICE DELIVERY OBJECTIVES

6.1 The Pooled Fund will fund a seamless range of services that reflect the needs of the local population, in line with the agreed policies and the services commissioned by the Partners. Within the defined scope it will fund the care for the residents of the Locality who present with health and social care issues by ensuring that the right care is provided at the right time, in the right place and at the optimum cost.

6.2 Early assessment will be delivered through an appropriate single process to assess the needs of service users. Where possible, interventions will be provided to people in their home for people who meet the prevailing eligibility criteria. The preference will be for time limited interventions, with publicly-funded longer-term support (outside the scope of these Intermediate Care services) only where absolutely necessary.

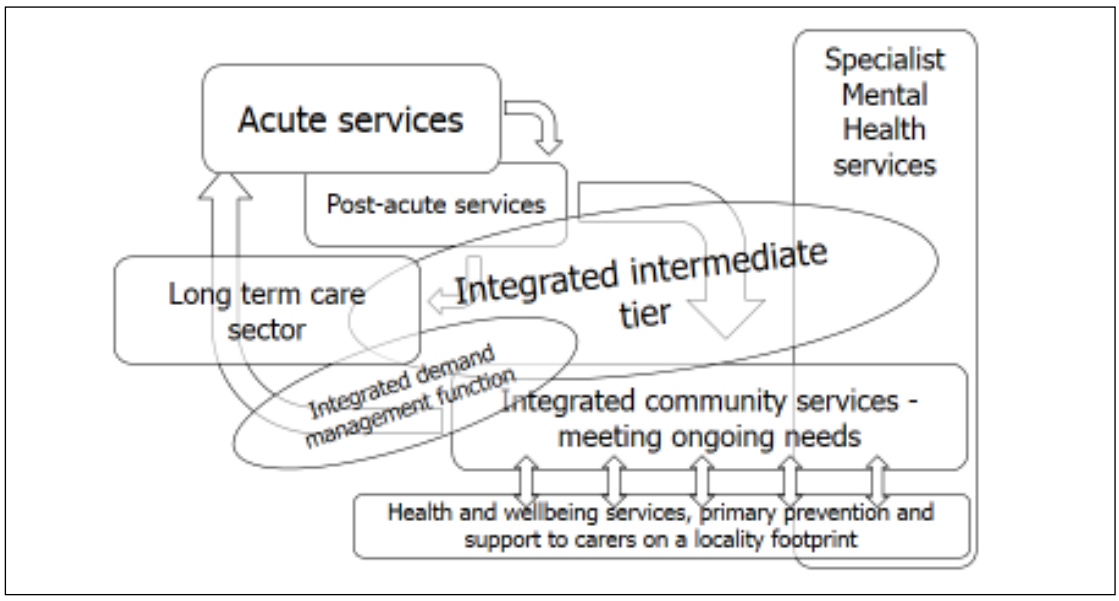
6.3 Intermediate care services will be planned and delivered according to a single model across providers so that the clinical and social care needs of the service user are met in the most effective way.

6.4 The Partners will ensure that the access pathway into specialist services is made easier for Service Users with intermediate care needs including referral pathways to allied services and also those provided by the third sector. Services may include a rapid mobile response to respond to Telecare activations and assist timely discharge from hospital pending a social work assessment.

6.5 The new arrangements will allow more effective service planning as the traditional barriers between health and social care definition and funding can be overcome by the Pooled Fund and a single management structure. This

will make the most efficient and effective use of public service and third sector resources together with carers in the community.

6.6 The integrated care operational manager shall maintain an awareness and knowledge of the Council and Health Board's policies and procedures so far as they relate to the service and ensure that the service complies.



7. Key service delivery objectives shall include:-

- To reduce unscheduled hospital admissions through enhanced rapid response and more focus on reablement
- To reduce occupancy of hospital beds by residents of the Locality utilised for post-acute recuperation or step up.
- To reduce the number of placements in residential and nursing homes
- To reduce the need for ongoing domiciliary care packages through increased reablement and right-sizing care (regular objective reviews of needs and eligibility)
- To have reduced the hours of support that were provided at commencement of enabling intervention when leaving short term enabling services intervention.

8. SERVICE IMPROVEMENT OBJECTIVES

8.1 The Pooled Fund arrangement is being implemented as part of the Western Bay Community Services Project. It will support a range of service improvements as required and funded by the Partners.

8.2 The objectives for improvement will include:

- Enhancement of access and the speed of referral by developing the common access point and improving the subsequent end-to-end pathways
- Embedding the new model of integrated care and ensuring the benefits are delivered as planned to patients, service users and each organisation
- Development of the support processes and improvement of efficiency by reducing duplication, improving business processes and reducing administration effort
- Optimisation of the skills mix across health, social care, third sector and carer provision and development of a cost effective working pattern make best use of the expanded intermediate tier
- Delivery of the intermediate care-related elements of wider business change programmes such as Changing For The Better and the Western Bay Programme
- Workforce development and enhancing job satisfaction and career options by addressing the traditional barriers to inter-disciplinary working and staff progression
- Capture and reporting of better information about service user outcomes, the use of resources and the cost of services for use in continuous improvement
- The development of a 'customer feedback' mechanism that records and acts on service user and carer comments and a 'stakeholder feedback' mechanism to capture ideas from referrers, Health and social care staff and the Third sector
- Development of an audit plan to evidence quality in relation to interventions and record keeping.
- Maximising the impact of the Budget by improving the resourcing processes, developing multi-disciplinary teams, enhancing cross-organisation team working, reducing operational duplication/administration and sharing equipment and facilities.

9. SERVICE PERFORMANCE MEASUREMENT

9.1 A set of measures will be adopted to monitor, report and improve the service. They will be produced monthly to demonstrate the extent to which the Partnership's objectives are being delivered.

9.2 They will include:

- Unscheduled care admissions

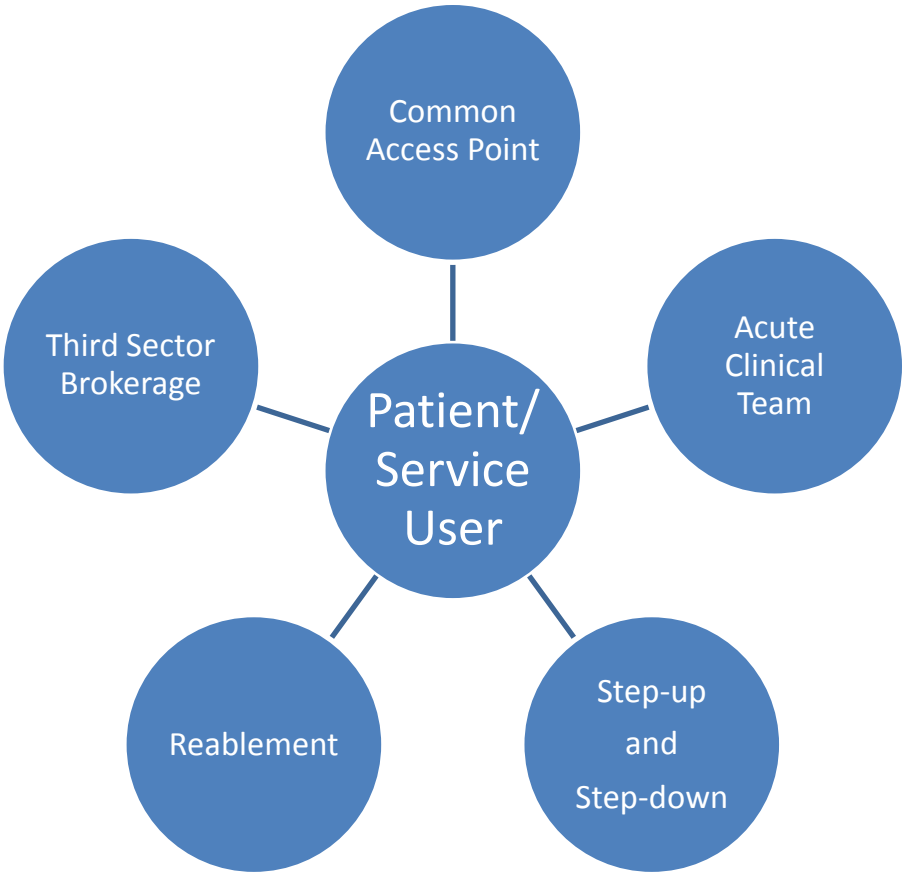
- Post-Acute bed occupancy Care Home admissions
- Support hour's reduction from Reabling service commencement to end of same intervention.

10. SCOPE OF SERVICES

10.1 Functional Description

The scope encompasses a range of intermediate care services, specifically those which deliver improved local performance by allowing more flexible use of intermediate tier resources between Partners including:

- Interventions that provide an alternative to a hospital bed
- Interventions that support timely safe discharge from hospital
- Interventions that reduce or avoid the need for an ongoing domiciliary care package
- Interventions that reduce the need for long term residential care
- Interventions that reduce the need for long term nursing care or continuing health care
- Interventions that optimise independent living or improve carer's ability to manage
- Services and facilities that manage access to the above such as the Common Access Point.



The Pooled Fund will cover the full costs of this provision, as detailed in Schedule 3.

10.2 Service Description

The functions and services included within the scope of the Scheme are to be:

Function	**Services included (as at the Commencement Date)**
Common Access Point	The Gateway
Rapid Response	Acute Clinical Team
Planned Response	Reablement Service CRT Social Work Team Residential Intermediate Care Beds Medicines Management Team Assistive Technology

11. ELIGIBILITY

11.1 The recipients of the Service are to be:

- adults of 18 years of age or over
- who are normally resident within the Locality whether at home or in a residential setting
- with a clinical or social care issue that threatens their physical health or independence
- who require an Intermediate Care service that is funded by the Health Board or the Council (regardless of who provides it).

11.2 This does not include:

- Acute hospital care
- Funding for long term residential care home placements
- Continuing Health Care, apart from some assessments in the community,
- Mental Health or Learning Disability services, although these patients may also have needs that are within the defined scope of Intermediate Care,
- Palliative care, although some physical care to support District Nursing services may be included, Care provided by the Community Networks, the scope of which varies across Western Bay.

11.3 The Eligibility Criteria Threshold for services will be as per the funding organisations' prevailing policies. Any changes to the Eligibility Criteria threshold may result in changes to the funding requirements and this should be taken into account during the planning.

11.4 Access to services is available from a number of locations and across a number of channels and will develop over time. .

SCHEDULE 2:

THE HEALTH BOARD'S NHS HEALTH CARE FUNCTIONS AND THE COUNCIL'S HEALTH RELATED CARE FUNCTIONS

THE HEALTH BOARD'S NHS HEALTH CARE FUNCTIONS

The LHB's NHS Health Care Functions of providing, or making arrangements for the provision of, Services:-

(a) (i) under sections 2 and 3(1) of the National Health Service Act 1977, including rehabilitation services and services intended to avoid admission to hospital but excluding surgery, radiotherapy, termination of pregnancies, endoscopy, the use of Class 4 laser treatments and other invasive treatments and emergency ambulance services; and

(ii) under section 5(1), (1A), and (1B) of, and Schedule 1 to, the National Health Service Act 1977; and

(b) the Functions under sections 25A to 25H and 117 of the Mental Health Act 1983.

THE COUNCIL'S HEALTH RELATED CARE FUNCTIONS

The Council's Health Related Functions are:-

(a) the Functions specified in Schedule 1 to the Local Authorities Social Services Act 1970 except for the Functions under:-

(i) sections 22, 23(3), 26(2) to (4), 43, 45 and 49 of the National Assistance Act 1948;

(ii) sections 6 and 7B of the Local Authorities Social Services Act 1970;

(iii) sections 1 and 2 of the Adoption Act 1976;

(iv) sections 114 and 115 of the Mental Health Act 1983;

(v) The Registered Homes Act 1984; and

(vi) Parts VII to X and section 86 of the Children Act 1989; and

(b) the Functions under sections 5, 7, or 8 of the Disabled Persons (Services and Consultation and Representation) Act 1986 except in so far as they assign Functions to a Local Authority in its capacity of a Local Education Authority.

SCHEDULE 3: RESOURCES:
Finance & Budget Setting

1. Introduction

1.1 This Schedule outlines the formula governing budget setting, outturn and balancing payments for Pooled Fund resources.

1.2 This Schedule provides details of the budgets, goods and services to be made available by the Partners for a Scheme.

2. Budget

2.1 For the Financial Year 2015/2016 the Budget for the Service shall be as set out in Appendix 1 to this Schedule notwithstanding that the Commencement Date is after the start of that Financial Year.

2.2 The initial budget planning assumptions of each Partner shall be shared by the Partner's financial leads and the Pooled Funds Manager shall ensure that any matters relating to the Pooled Fund of a particular Scheme that might have a material effect on planned expenditure or income are identified and reported to the JPB which shall be no later than 31 December prior to the commencement of any Financial Year provide the Partners a proposed budget for that Financial Year.

2.3 By 31st January before the commencement of the second or any subsequent Financial Year of the Term the Council and the Local Health Board shall advise each other of their anticipated budgeted expenditure in respect of that Financial Year. In the event that the amount of the anticipated budget alters during any formal budget approval process, then the one party shall advise the other party of that change without delay.

2.4 By 31st March before the commencement of any Financial Year the Council and the Local Health Board shall advise each other of their agreed budgeted expenditure on the Service for the following Financial Year.

2.5 The Budget as approved by the Partners will be presented by the Pooled Fund Manager to the JPB in each Financial Year for the Budget to be received by the JPB.

3. Calculation of Outturn and Balancing Payments

3.1 For the purpose of calculating the percentage contribution of the Partners, the outturn of expenditure and any balancing payments which may be required between Partners the provisions of Appendix 2 to this Schedule apply.

3.2 If there is any underspend of pooled budgets at the end of the financial year, the split should be based on the original percentage contribution agreed in Appendix 2 to this Schedule.

4. Financial Performance and Risk Sharing Arrangements

4.1 The Host Partner for the operation of the Scheme shall appoint a Pooled Funds Manager (and there may be a separate Pooled Funds Manager for each Scheme) with responsibility for the integrated management of the Pooled Fund, subject to the governance arrangements set out in Schedule 4 to this Agreement.

4.2 The Budget is to be used solely to achieve the aims and outcomes set out in Schedule 1 to this Agreement and which, with revision to the Schedule 3 for a Scheme and the performance framework as appended at Schedule 4 for a Scheme will comprise the Revised Annual Plan for a Scheme.

4.3 Each Partner will provide data to the Pooled Funds Manager by the following 20th of each month to enable the Pooled Fund Manager to submit reports to the JPB and Joint Management Board on a monthly basis on the financial information and spend as referred to as Schedule 3 and the information specified at the Appendix to Schedule 4.

4.4 Quarterly reports in summary will be provided to the JPB at its meetings or more frequently if required.

4.5 Information is to be reported separately in respect of Pooled Funds for each Scheme. The Partners agree to provide all necessary information to the Pooled Funds Manager in time for the reporting requirements to be met.

4.6 The Pooled Funds Manager shall ensure that action is taken to manage any projected under or overspends from the budgets relating to the Fund, reporting on the variances and the actions taken or proposed to the JPB.

4.7 If at any time during the Financial Year there is a projected under or overspend on the Fund the Pooled Funds Manager will prepare an action plan for presentation to and agreement of the JPB in order to manage the variance, for the particular scheme as quickly as possible.

4.8 The JPB will consider any action plan where required and amend if appropriate or agree additional actions to be taken to manage the variance.

4.9 The Pooled Funds Manager will provide monthly progress reports to the JPB on implementation of any action plan, until such time that the under or overspend has been dealt with to the satisfaction of the JPB keeping it informed at all times.

5. Construction of Budget and Basis of Contributions

For the avoidance of doubt, any personal contributions payable by Service Users towards any Council services will continue to be collected by the Council, and not form part of the Pooled Fund.

6. Resources Available and in Support of the Partnership Outside of Pooled Funds

6.1 Each Partner shall provide resources outside of the Pooled Fund, unless otherwise agreed by the JPB, for those activities deemed necessary to enable this Agreement to be discharged. These include, but are not limited to the following services:-

- Personnel
- Contracts and management functions
- Operations functions
- IT functions
- Finance functions
- Property functions

6.2 Where additional work in support of the Service outside of Pooled Funds is at the request of either Partner to the other Partner, a charge can be raised by mutual agreement of the Partners where this constitutes an additional expense for the requesting Partner.

7. Accommodation Arrangements for Services

The Partners shall continue to provide or make available the premises (or suitable alternatives) that they provided or made available for the purposes of the Service before the Commencement Date, with the same level of support services and facilities management.

8. Commissioning and Procurement Arrangements

8.1 The Partners agree that:-

8.1.1 The Financial, Procurement and Contract Procedure Rules of the Council will apply to all procurement activity undertaken by the Council

8.1.2 The Standing Orders and Standing Financial Instructions of the Health Board will apply to all procurement activity undertaken by the LHB.

8.1.3 Procurement activity will only be undertaken from the Pooled Fund in accordance with commissioning plans approved by the JPB.

9. Hosting and Administration of the Pooled Fund

9.1 The Pooled Fund Manager shall ensure that the Pooled Fund is maintained to national and professional standards and that the payment of suppliers' invoices complies with their payment terms, ensuring that no late payment charges are incurred by the Partners.

9.2 The Pooled Fund Manager shall be responsible for ensuring that appropriate financial systems are operational and in place for the Pooled Fund in order to provide the necessary control and production of financial information.

10. Information Requirements

10.1 The Pooled Fund Manager shall ensure that all financial and other information required by the Partners in relation to compiling performance statistics, statutory and other returns is made available by any agreed deadlines.

10.2 The Pooled Fund Manager shall ensure that all financial and other information required to measure performance against the Services, as set out at Schedule 4, is made available by any agreed deadlines.

10.3 The Pooled Fund Manager shall establish arrangements for making available all financial and other information necessary to assist the Partnership.

11. Audit arrangements

11.1 The Host Partner's auditors will be the external auditor of the Pooled Fund.

11.2 It shall be the responsibility of the Host Partner (if required) to include the Pooled Fund in its end of year accounting processes, produce the required memorandum of account in respect of the Pooled Fund and arrange for its audit in time for its inclusion in all Partners' year end accounts.

11.3 Should the annual audit letter contain any direct reference to the Pooled Fund, the Host Partner will send copies of the excerpts of the letter to the other Partners.

11.4 The cost of specific external audits required shall be borne by the Pooled Fund.

11.5 The appointed Auditor's reports on the Services commissioned and provided from the Pooled Fund shall be presented to the JPB and shall be made available to the Partners' internal auditors.

11.6 The Pooled Fund and the implications for the Services arranged from it will be incorporated into the risk assessed Internal Audit Programme of the Partners.

11.7 The costs of any required audits of the Service shall be borne by the Pooled Fund.

12. VAT

The VAT regime will operate in accordance with partnership structure (a) as referred to in the joint guidance issued by the Department of Health and HM Customs and Excise.

13. Capital

The Pooled Fund shall not normally be applied towards capital expenditure.
If a need arises for the transfer of any agreed capital funds between the Partners then, unless the Partners agree otherwise, the Partners shall use the grant making powers under Section 194 or Section 34 of the Act.

APPENDIX 1

NPT Locality	LA	Health	Total
Common Access Point			
Gateway Team	308,710	33,804	342,514
Rapid Response			
Acute Clinical Team		662,742	662,742
Planned Response			
Reablement Service	1,496,650	1,281,045	2,777,695
CRT Social Work Team	435,640		435,640
Residential Intermediate Care Beds		193,000	193,000
Medicines Management Team		135,408	135,408
Assistive Technology Team	392,170		392,170
Total	**2,633,170**	**2,305,999**	**4,939,169**
	53.3%	46.7%	

APPENDIX 2

FINANCIAL CONTRIBUTIONS FORMULAE

1. For the purposes of the calculation set out in paragraph 3.3 the Local Authority initial budget expenditure shall be A the Local Health Board initial budget expenditure shall be B

2. The total budget expenditure shall be represented by C and shall be calculated as follows:-

A + B = C (total agreed budget expenditure)

3. The Council percentage of budgeted expenditure shall be represented by D% and shall be calculated as follows:-

$\frac{A}{C}$ x 100 = D%

4. The Local Health Board percentage of budgeted expenditure shall be represented as F% and shall be calculated as follows:-

$\frac{B}{C}$ x 100 = F%

Outturn Expenditure

5. On or before 30th April each Partner shall provide a return to the other indicating its outturn expenditure on the service which shall be represented as follows:-

For the purposes of the calculation in paragraph 3.7:

Council outturn expenditure shall be G
Local Health Board outturn expenditure shall be H

6. The total outturn expenditure shall be calculated as follows:-

G + H = I (total outturn expenditure)

7. The Council percentage of outturn expenditure shall be calculated as:-

$\frac{G}{I}$ x 100 = J%

8. **The Local Health Board outturn expenditure shall be calculated as**

$\frac{H}{I}$ x 100 = K%

9. Balancing Payments

10. In relation to the Council if J% differs from D% the balancing figure is calculated as follows:-

I x D ÷100 – G = balancing payment.

11. In respect of the Local Health Board if K% differs from F% the balancing figure is calculated as follows:-

I x F ÷ 100 – H = balancing payment.

12. Expenditure shall only be counted towards outturn and any balancing payment if that expenditure has been jointly approved specifically for that purpose by the JPB

SCHEDULE 4: GOVERNANCE:
Approvals, Oversight & Performance

1. Introduction

1.1 The Partners have agreed the governance arrangements set out in this schedule in furtherance of the aims and objectives as described in Clause 3 and Schedule 1 of the Agreement.

1.2 It is the intention of the Partners to review the governance arrangements at least annually as a part of the Annual Review process set out below and as at Clause 9 of the Agreement.

1.3 Any variation to the Agreement shall be effected through the mechanism of Clause 16 of the Agreement.

1.4 The arrangements set out in this schedule shall apply until such time as the Partners agree otherwise.

1.5 Any changes to the approved Scheme must be confirmed by the JPB.

2. Joint Partnership Board

2.1 The Joint Partnership Board ("JPB") is collectively responsible for the tracking of progress of the Partnership Scheme, within their aims and objectives within any defined resources and the Western Bay Programme Strategy and Plan.

2.2 Schemes or Services may only be added to this Agreement under Clause 32 through the agreement of the Council and the Health Board.

2.3 Schemes or Services may be removed from this Agreement under Clause 32 through the agreement of the Council and the Health Board and as to be confirmed at the JPB.

2.3.1 The JPB shall:

- receive all reports required under this Agreement and agree actions or refer proposals for action back to the Partners for approval as the case may be.
- review annually the operation of the Scheme which is the responsibility of the JPB for consistency with the Western Bay Programme strategy and plans;
- consider progress on the Aims and Outcomes at Schedule 1 for the Scheme;

- review and confirm the Scheme and undertake any risk assessment and agree actions and recommendations arising following the review;
- provide an Annual report to the Western Bay Leadership Group and at such additional frequency as the JPB deems necessary
- consult further and agree actions where appropriate on any plan and progress on priorities as necessary to ensuring suitable consultation and Equality Impact Assessments are undertaken for any major changes to services arising from the Annual Plans for commissioning;

3. JPB Membership

3.1 The membership of the JPB will be as follows:-

i. <u>The Health Board</u>

…….

or a named deputy as required who will have the same rights on-behalf of the respective member for whom they are deputising. All deputies will be notified in writing to the other Partner.

ii. <u>The Council</u>

…….

or a named deputy as required who will have the same rights on-behalf of the respective member for whom they are deputising. All deputies will be notified in writing to the other Partner.

iii. The Pooled Fund Manager for a scheme and for who for the avoidance of doubt will be a non-voting member

3.2 Any change in membership of a Health Board member of the JPB will be notified in writing by the Authorised Officer of the Health Board to the Authorised Officer of the Council

3.3 Any change in membership of a Council member of the JPB will be notified in writing by the Authorised Officer of the Council to the Authorised Officer of the Health Board

3.4 If agreed by the JPB, additional invitees may be requested to attend their meetings; such invitees will attend in a non-voting capacity and will usually include the Partnership Lead Officers for any Scheme.

4. JPB Meetings

4.1 The JPB will meet three monthly and at a time and day to be agreed but in the absence of agreement set by the Authorised Officer of the host Partner.

4.2 A special JPB can be called at any time by a JPB member or an Authorised Officer where they deem it necessary.

4.3 The quorum for meetings of the JPB shall be a minimum of both members not counting the Pooled Funds Manager or other non-voting members listed at 3 above.

4.4 Decisions of the JPB shall be made unanimously

4.5 Minutes of all decisions shall be kept and copied to the Partners within fourteen (14) days of every meeting.

4.6 The JPB will be supported by a Joint Management Board for any agreed Scheme appointed pursuant to paragraph 6 of this Schedule.

4.7 The JPB members are authorised within the limits of delegated authority (which is received through their respective organisation's own schemes of delegation):-

- To confirm the allocation of funding within the overall budget approved by the Health Board and the Council for any particular Scheme including any additional non-recurring contributions
- To confirm additional non-recurring contributions approved by the Health Board and the Council for any particular Scheme to which they are a party, where anticipated future commitments are likely to exceed the aggregate contributions of the Health Board and the Council to the Pooled Funds confirmed or agreed pursuant to Clause 4 of this Agreement; and;
- To authorise or enter into any Contract, for any particular Scheme to which they are a party, subject to the Contract Standing Orders of the Council or the Health Board where these are necessary for the achievement of Scheme aims and where such a contract will create a liability for both Partners beyond the end of the Financial Year of the Agreement;
- To agree changes to the working arrangements of any Scheme provided that any amendments comply with the Agreement;
- To review and agree annually for any particular, the schedule, plan, objectives, resources and the performance measures;

- To consider progress on the Aims and Outcomes at Schedule 1 for each Scheme;
- To consult further and agree actions where appropriate on any plan and progress on priorities as necessary to ensuring suitable consultation and Equality Impact Assessments are undertaken for any major changes to services arising from the Partnership Arrangements;
- To agree the appointment of the Partnership Lead and the Pooled Fund Manager within 30 days of commencement of each Financial Year for each Scheme.

5. JPB Agendas

5.1 The JPB will follow a two part agenda. The first part will consider any reports from the Pooled Funds Manager.

5.2 The second part will consider any other matters of progress from the Joint Management Board

6. Joint Management Board

6.1 A Joint Management Board for the Scheme will assist the JPB in its activities through oversight of day to day management of the agreed Scheme.

6.2 The Joint Management Board will meet at a least 10 times per annum.

6.3 The membership of the Joint Management Board shall be agreed by the JPB upon admittance to the Partnership Arrangements and the JPB shall confirm the name of the officers comprising:

- The Partnership Lead Officer from the Host Partner for any established Scheme
- The Pooled Fund Manager from the Host partner for the Scheme
- Other members comprising
    - One non-host partner officer
    - One Finance officer (Council)
    - One Finance officer (Health Board)

6.4 The role of the Joint Management Board will be to receive such information as is necessary and as outlined in the Scheme reporting framework and to assist the Partnership Lead and the Pooled Fund Manager in the review, and development of the draft Annual Plan (the objectives at Schedule 1) and any other actions deemed necessary or helpful to effective arrangements for of the Services from time to time.

7. The Pooled Fund Manager

The Pooled Fund Manager may delegate the day-to-day management of funds and objectives in accordance with the Host Partner Procedure Rules, Financial Regulations and such other applicable Scheme of Delegation.

8. Information Planning and Reports

8.1 The Pooled Fund Manager shall supply to the JPB and to the Joint Management Board on a monthly basis the financial and activity information as referred to as Schedule 3 on Resources and as set out at the Appendix to this Schedule 4 as the Financial and Activity Reporting Framework as amended from time to time for a particular Scheme.

8.2 The Pooled Fund Manager shall supply three monthly to the JPB meetings a summary report of performance and matters for its attention.

8.3 The Partnership Lead and the Pooled Fund Manager will refine the Aims and Outcomes set out in Schedule 1 into targets and performance measures to be agreed by the JPB from time to time and in any event by 30th July each year following a strategic and financial review to be led by the Joint Management Board

8.4 Preparation of the Revised Annual Plan for Financial Years after the initial Financial year of the Term will be according to the following process in each Financial Year:

- **October- December:** The Pooled Fund Manager will prepare a draft Revised Annual Plan. This will incorporate any proposed changes and will be in the form of a revised Schedule 1 of Service Aims and Outcomes, a draft Budget and any necessary revision of the Financial and Activity Reporting Framework content for JPB.

  The JPB will consider the draft Revised Annual Plan

- **By 31st January:** The Pooled Fund Manager will submit to the JPB the draft Budget and a Final Draft Annual Plan for confirmation of their recommendation to the Partners for the next Financial Year

- **By 1st May:** The Pooled Fund Manager shall report to the JPB on the performance of the Service against any aims objectives or performance

measures which relate to the Service together with the general effect of the Scheme and in particular its effect on Service Users and the financial position of the Partners

10. Post-termination

The JPB shall continue to operate in accordance with this Schedule following any termination of this Agreement under Clause 11 of this Agreement insofar as in necessary to manage the effects of termination as at Clause 12 including any winding up arrangements.

APPENDIX: PERFORMANCE MANAGEMENT

Financial and Performance Reports

Neath Port Talbot Intermediate Care Scheme

	PERFORMANCE AREA	KEY DELIVERABLES	HOW MEASURED	FREQUENCY
1	Finance	Expenditure in line with profiled budget	Budget reports – reviewed at monthly review meetings	Monthly

A quarterly summary will also be submitted to the JPB along with necessary reports including progress on Objectives as set out at Schedule 1 and the following service performance data.

SERVICE ACTIVITY

- Domiciliary Package of Care starts
- Total Care home admissions
- Total >65 unscheduled admissions to hospital
- Post-acute bed occupancy by residents from NPT locality
- Total Rapid response clients
- Total Intake or review reablement clients
- Total Domiciliary or bed based intermediate care

CRT

Common Point of Access (known as Gateway in NPT)

Referrals managed:

- <24 hours
- <48 hours
- <1 week
- >1 week
- Total referrals received

Intake Reablement

- Hospital admissions prevented
- Hospital discharges supported
- Domiciliary POC hours prevented
- Care home admissions avoided

Rapid Response

- Hospital admissions prevented
- Hospital discharges supported
- Domiciliary POC hours prevented
- Care home admissions avoided

SOCIAL SERVICES, HEALTH & HOUSING CABINET BOARD

REPORT OF HEAD OF COMMUNITY CARE – C. MARCHANT

8TH OCTOBER 2015

SECTION C – FOR MONITORING

WARDS AFFECTED: ALL

Safeguarding and Quality - Key Issues and activity for 2014/15

1. Purpose of Report

The purpose of this annual report is to provide an overview of the key activity in the Safeguarding and Quality area of Adult Services and to highlight the key issues leading into 2015/16.

2. Introduction and Background

This report covers three key areas of responsibility which is provided under the auspices of Adult Services and relates specifically to the activity delivered by the Safeguarding and Quality team. The three areas are;

- Safeguarding and protecting vulnerable adults from harm
- Deprivation of Liberty and Mental Capacity
- Quality and Review of Care Homes.

There are specific reason for including the three areas in one report which will be alluded to in the attached report

3. List of Background Papers

None

4. Wards Affected

All

5. Officer Contact

Steve Garland, Principal Officer for Managed Care, Safeguarding & Quality
Email: s.garland@npt.gov.uk
Tel: 01639 687447

6. Appendices

Appendix 1 – Annual Report of Safeguarding and Quality
Appendix 2 – Protection of Vulnerable Adults Performance data
Appendix 3 – Briefing of Deprivation of Liberty
Appendix 4 – Performance Data for Deprivation of Liberty
Appendix 5 – Operational Policy for Quality Team
Appendix 6 – Quality of Life guidance
Appendix 7 – Operational Model

Appendix 1

Safeguarding and Quality-Key Issues and activity for 2014/15

1. Purpose

The purpose of this annual report is to provide an overview of the key activity in the Safeguarding and Quality area of Adult Services and to highlight the key issues leading into 2015/16.

2. Background

This report covers three key areas of responsibility which is provided under the auspices of Adult Services and relates specifically to the activity delivered by the Safeguarding and Quality team. The three areas are;

- Safeguarding and protecting vulnerable adults from harm
- Deprivation of Liberty and Mental Capacity
- Quality and Review of Care Homes.

There are specific reason for including the three areas in one report which will be alluded to in due course.

Safeguarding and protecting vulnerable adults from harm

Mirroring Child Protection Procedures, there are policies and process in place to ensure that in the event of an adult who is deemed vulnerable and at risk of abuse and/or harm , Adult Services are able to respond quickly, effectively and appropriately to remove reduce and alleviate the alleged or actual harm. The All Wales Interim Policy and Procedures for the Protection of Vulnerable Adults from Abuse(January 2013) is the key driver for Local Authorities and Health Boards to develop their response and in NPTCBC we have robust team that provides a formal response to any enquiry from the public where they have concerns about a vulnerable adult. The new Social Services and Well Being Act 2014 will also provide legislative duties on Adult Services which are still in the regulatory stage but we will need to respond to the Act with appropriate structures in place. This is due to be implemented in April 2016 and we are planning for this.

The team is made up of;

- Team Manager ,who also has responsibilities for deprivation of Liberty and Quality Team
- Deputy Manager as above
- POVA Coordinator
- Designated Lead Manager role which is provided by all social worker staff
- Business Support

Activity is provided below in part .

Deprivation of Liberty

On 19 March 2014, the Supreme Court handed down its judgment in the case of “P v Cheshire West and Chester Council and another” and “P and Q v Surrey County Council”. The judgment is significant in the determination of whether the care and treatment of an individual lacking capacity to consent to those arrangements amount to a deprivation of liberty. As predicted, the outcome of this judgment resulted in a sharp increase in the number of Deprivation of Liberty referrals to Local Authorities and Health Boards across Wales and the UK and has a subsequent impact on resources and costs.

In essence, any person who is supported and funded by the State or self funded and who are in a care home, Hospital or domestic situation in a permanent arrangement and do not have capacity to make decisions for their care could potentially be illegally deprived of their liberty by the provider of the service. In order to allow for a legal deprivation of liberty a complex process of assessment has to be implemented in order to make this decision legal and for the Provider to be given the authority to prevent the individual from leaving and to apply reasonable restraint. The Cheshire West ruling extended that principle to a significantly greater number of people prior to March 2014.

The impact on Neath Port Talbot County Borough Council has been significant in terms of financial resources and on staffing arrangements .The tables below highlight the detail in terms of activity and cost but to summarize the response to the ruling, NPT committed the following additional resources;

- Two Specialist Internal Assessors
- Use of external assessors due to lack of capacity
- Budget for external medical assessors

- 1.8 wte Administrative support

Quality and Review Team

A new operational model for the reviewing of people placed in Residential Care and Shared Lives has been developed to ensure that there is a more integrated and quality based approach to supporting people who are living in care homes. This was developed in 2014/15 and is now embedded in 2015.There is a quality of life standard that is used to measure if a person is receiving the right support at the right time and each care home has a dedicated worker who is responsible for reviewing all the packages in the home and is an important link for people who live there, families, CSSIW the provider and other key people and organizations. As well as the Team Manager and Deputy referenced above there are two Social Workers and eight Quality Officers.

Case Study

An 89 year old woman has been living in a care home for five years, is suffering from Dementia and lacks the capacity to make decisions about her care and her future needs. There is evidence that she is being neglected and not cared for effectively.

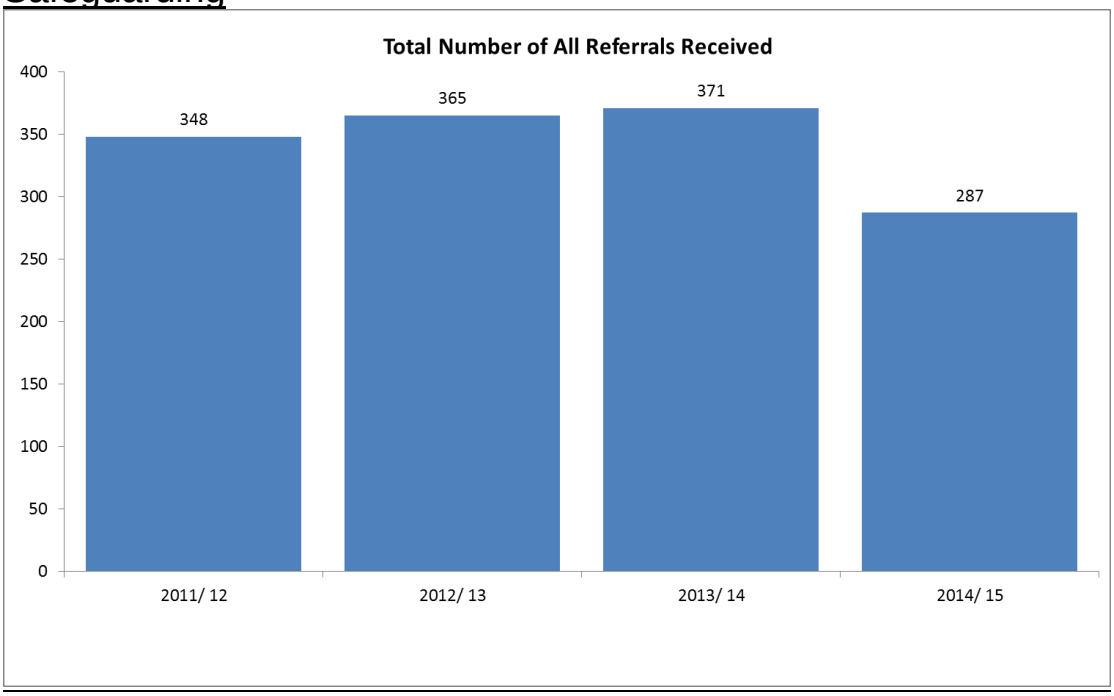
In this example, all three areas identified above will come into play;

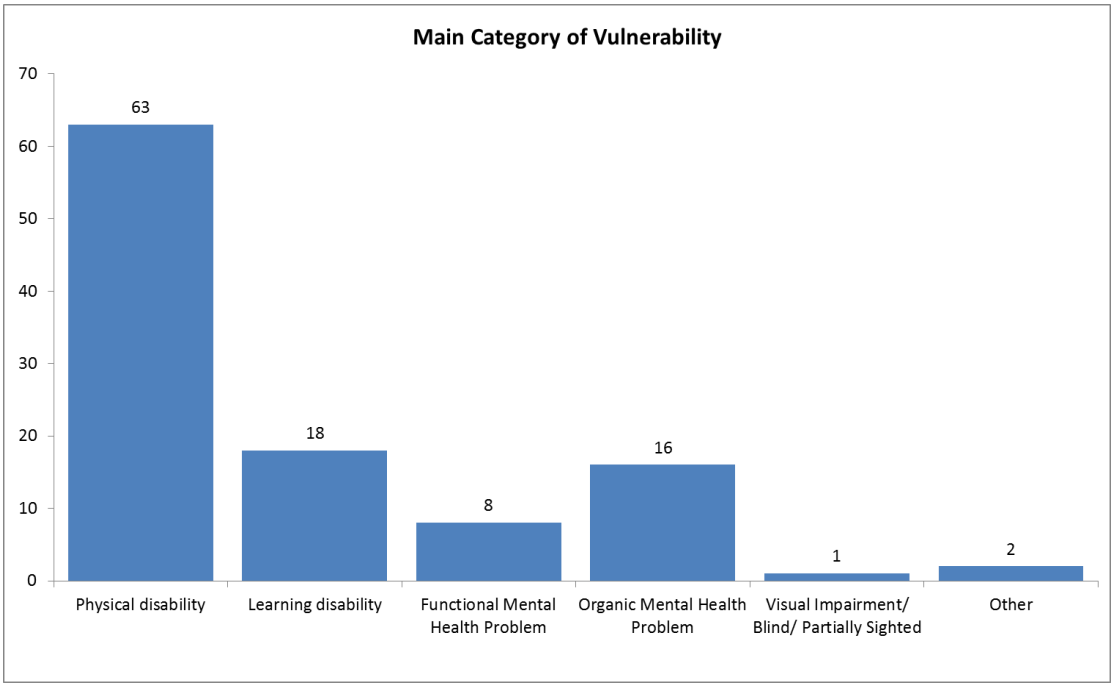
1. In relation to Safeguarding, the Protecting Vulnerable Adult Policy will be implemented and the family, friend or professional visiting will make a referral into the team to look at a protection response
2. As the woman lacks capacity, the Deprivation of Liberty legislation may be relevant and the provider must make a referral to the Local Authority to ensure that she is not illegally deprived of her liberty
3. The Quality and Review Team will be monitoring and reviewing the person plan to ensure that it is providing the right level of care and support.

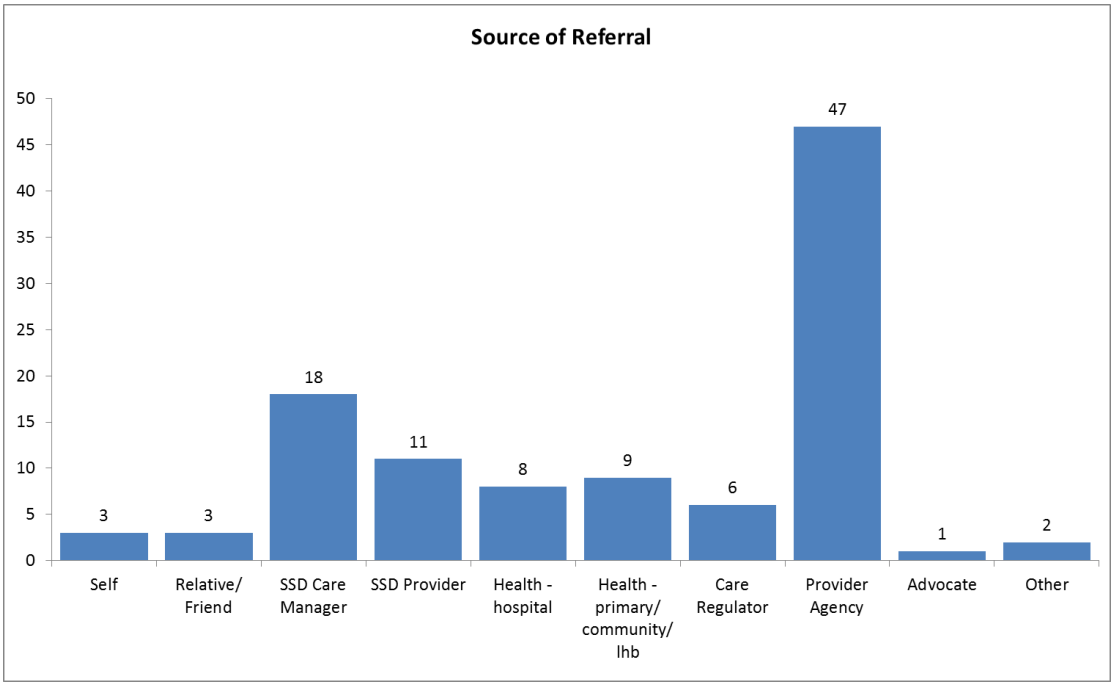
The above identifies why it is essential that there is an integrated approach to supporting vulnerable adults and therefore the future commitment is to continue to manage the process across the three areas under one umbrella.

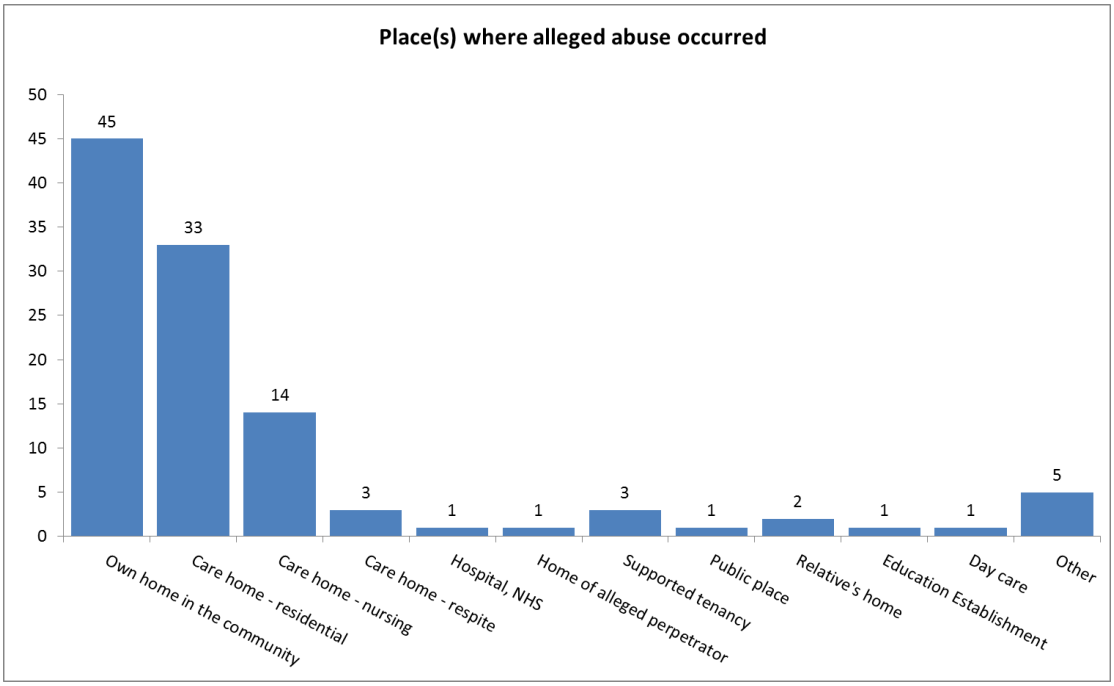
3. Performance Activity for 2014/15

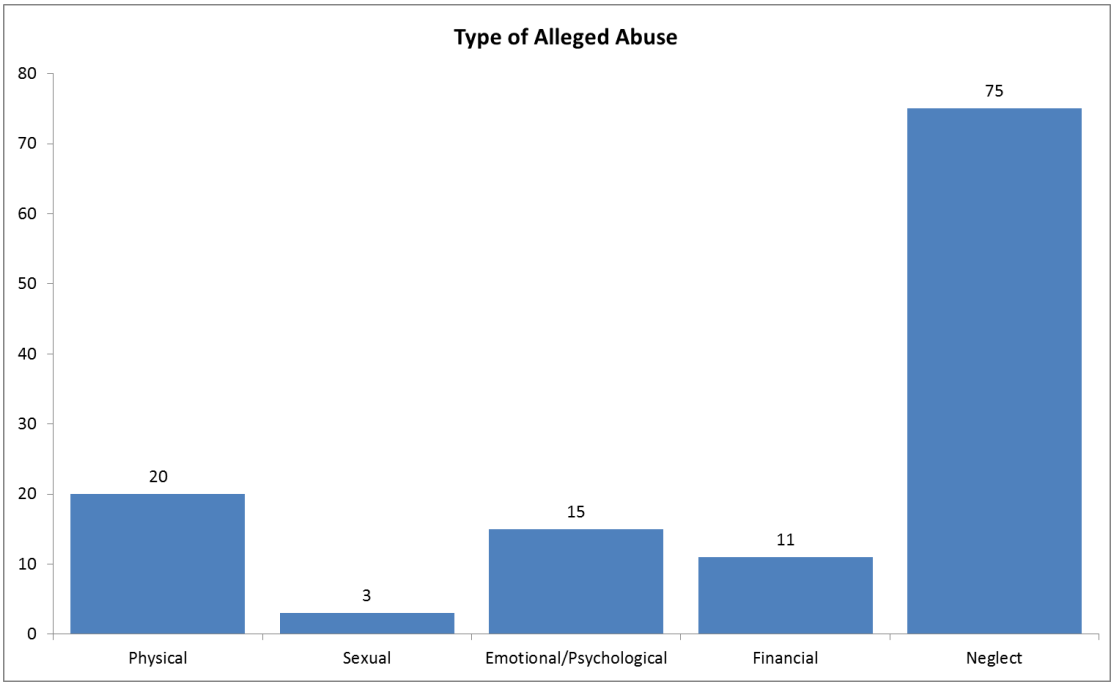
Safeguarding






Source of Referral
50
45
40
35
30
25
20
15
10
5
0
3
3
18
11
8
9
6
47
1
2
Self
Relative/ Friend
SSD Care Manager
SSD Provider
Health - hospital
Health - primary/ community/ lhb
Care Regulator
Provider Agency
Advocate
Other


Place(s) where alleged abuse occurred
50
45
40
35
30
25
20
15
10
5
0
45
33
14
3
1
1
3
1
2
1
1
5
Own home in the community
Care home - residential
Care home - nursing
Care home - respite
Hospital, NHS
Home of alleged perpetrator
Supported tenancy
Public place
Relative's home
Education Establishment
Day care
Other



Narrative

- Decrease in the number of referrals over the four year period
- Significant proportion of referrals from providers, with our own staff next
- Highest numbers of referrals from people at home, followed by care homes.
- Neglect is the highest form of abuse
- Further information Appendix 2
- We have trained up a significant number of Social Workers to carry out the role of Designated Lead Manager who are critical to the coordination of the protection plan and has supported us in delivering effective safeguarding responsibilities

Deprivation of Liberty

	Year 2013/14	Year 2014/15	1st Qtr. 2015/16	Projected 2015/16
Number of referrals	8	447	195	780
Number of SA 1s*	2	407	106	424
Number of SA 5s*	0	0	61	244
UA 1s	6	38	28	112
UA 2s	3	15	7	28

Narrative

- SA represents Standard Authorisation which allows for 21 days to assess
- UA represents Urgent Authorisation which the provider can authorise but only for 7 days
- SA5 represents renewal which must happen every twelve months. The Cheshire West judgement occurred in March 2014 which explains increase and renewals.
- Dramatic increase in referrals due to Cheshire West. Further breakdown is provided in Appendix 3 which describes resource implications for NPTCBC.
- Performance Data Appendix 4

Quality and Review.

See Appendix 5,6and 7.

Conclusion

The integration of the Safeguarding, Deprivation of Liberty and Quality and review processes has enabled Adult Services to maximise the resources, improve the communication across the areas and ensure that the people who are at the most risk in the community and supported by providers who we commissioning from are given the best support possible. With the model in place, it is clear that this is a more effective system to support and protect vulnerable adults.

Appendix 2

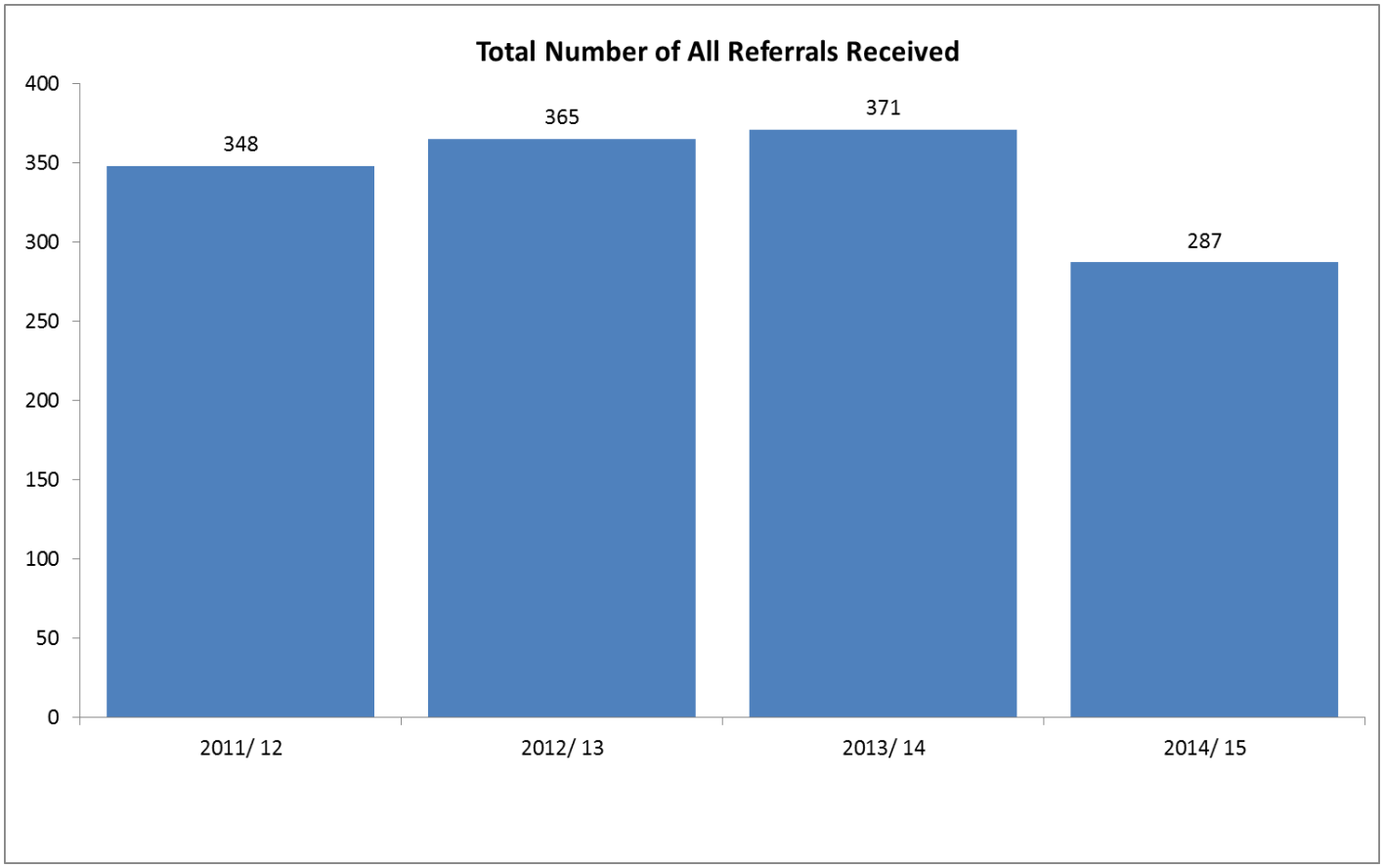
POVA SUMMARY CHARTS 2014/15

Please note that some of the data highlighted in these graphs is related to multiple choice questions so will not correspond with the number of referrals completed.

Referrals

Total Number of Referrals by year for Neath Port Talbot

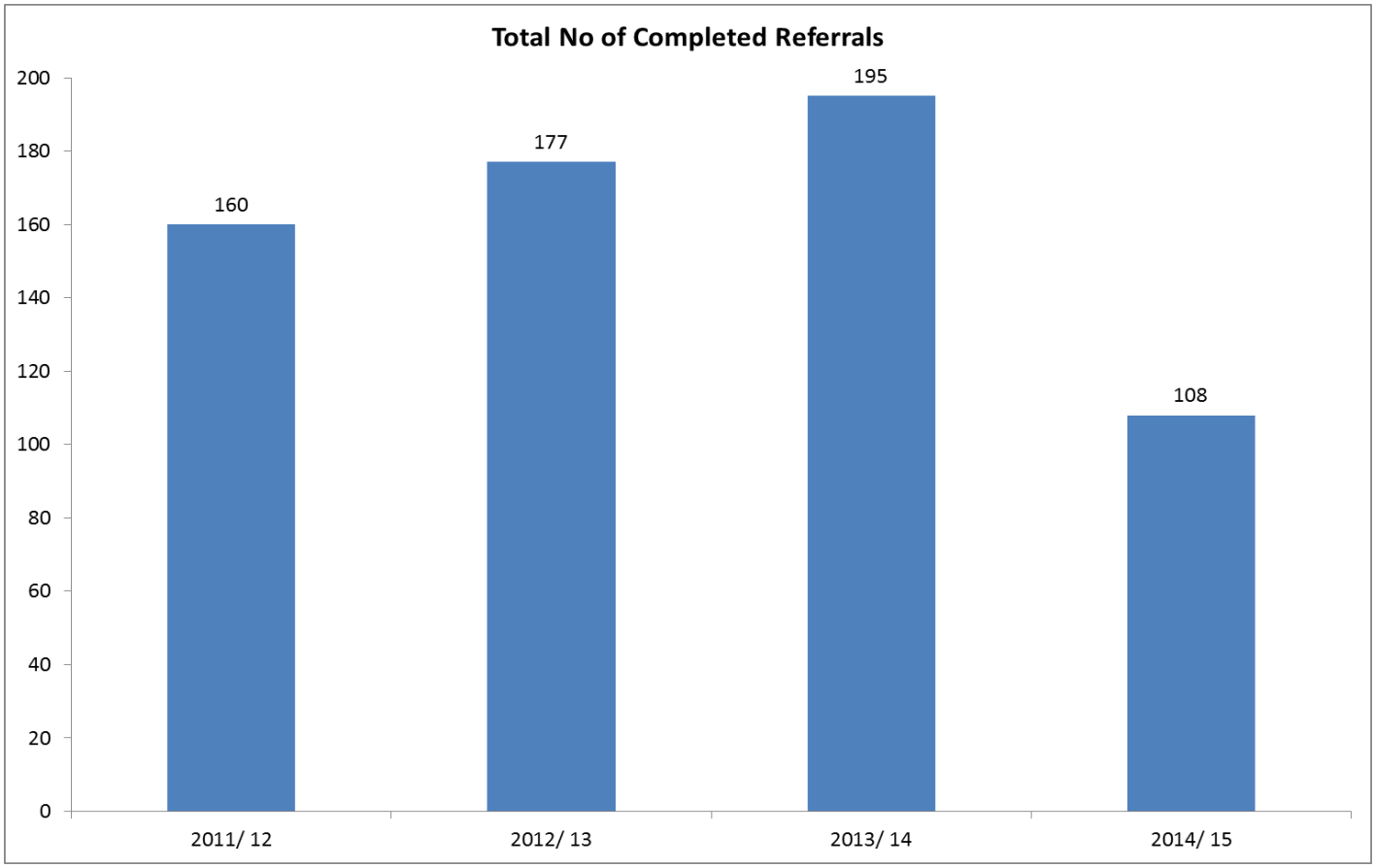
2011/ 2012	348
2012/ 2013	365
2013/ 2014	371
2014/ 2015	287



The figure above reflects the number of referrals received, and not those that have been closed.

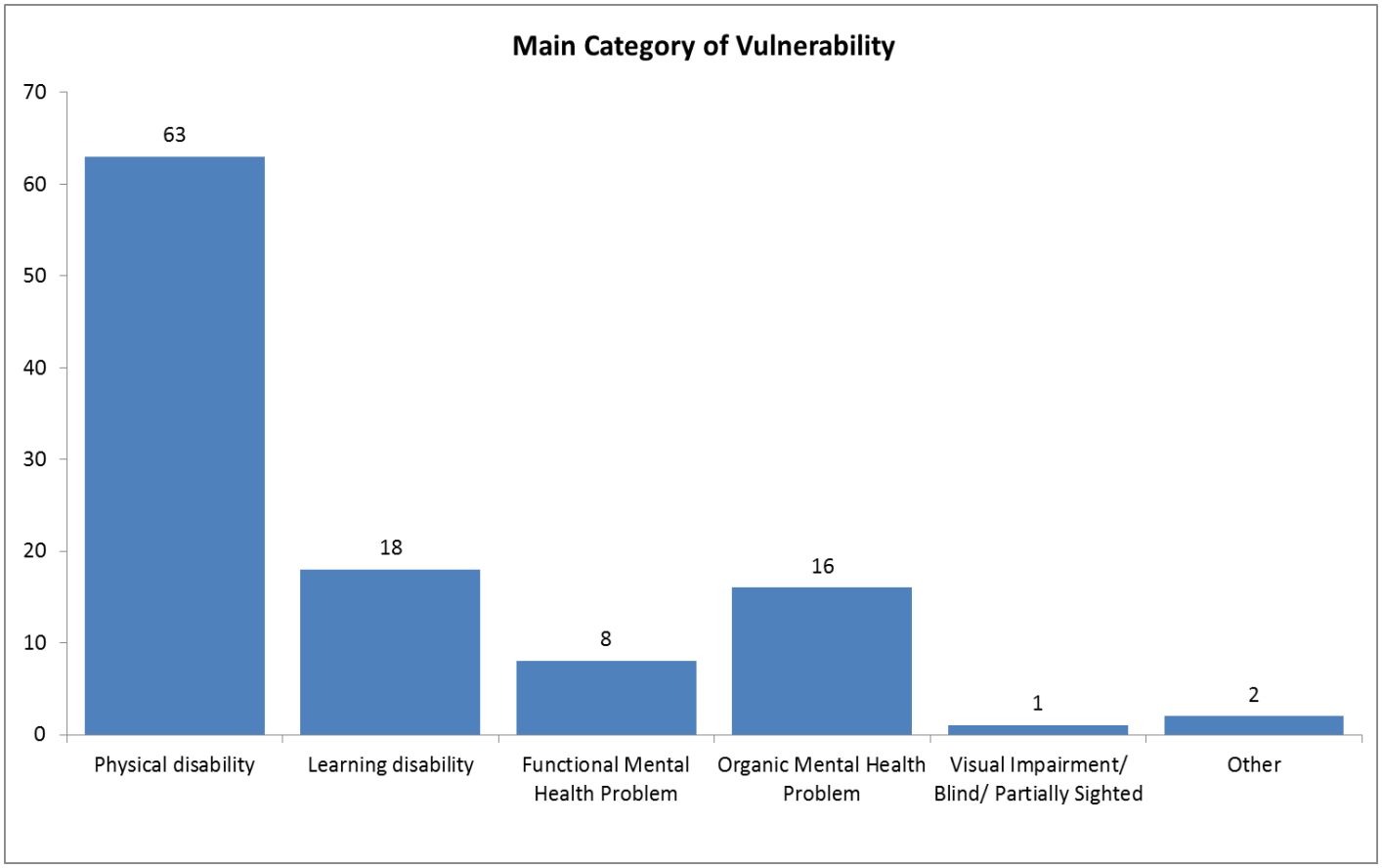
Total No. of Completed Referrals

Total Number of Completed Referrals	
2011/ 12	160
2012/ 13	177
2013/ 14	195
2014/ 15	108



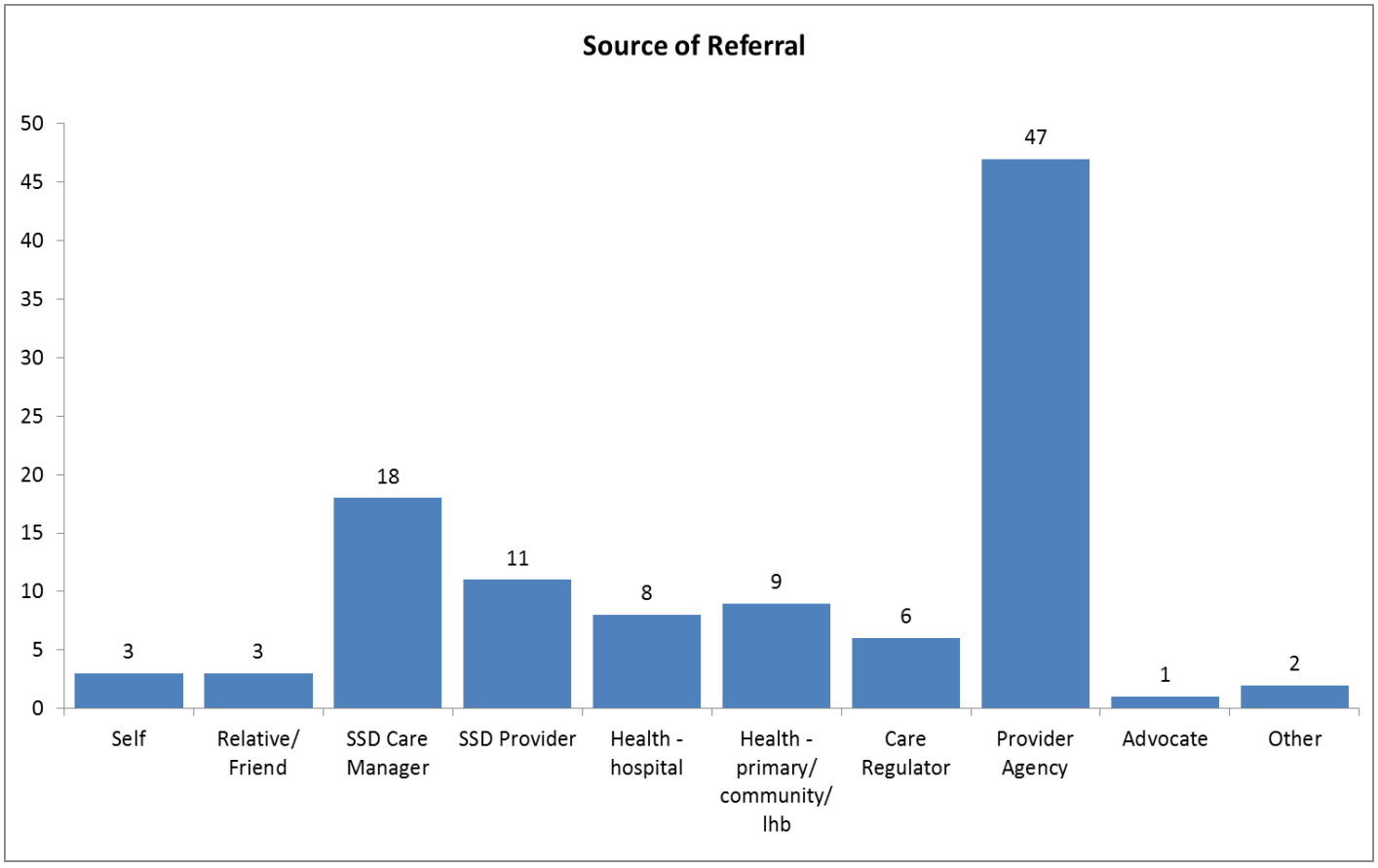
MAIN CATEGORY OF VULNERABILITY

Main Category of Vulnerability		
Physical disability	63	58%
Learning disability	18	17%
Functional Mental Health Problem	8	7%
Organic Mental Health Problem	16	15%
Visual Impairment/ Blind/ Partially Sighted	1	1%
Other	2	2%
	108	



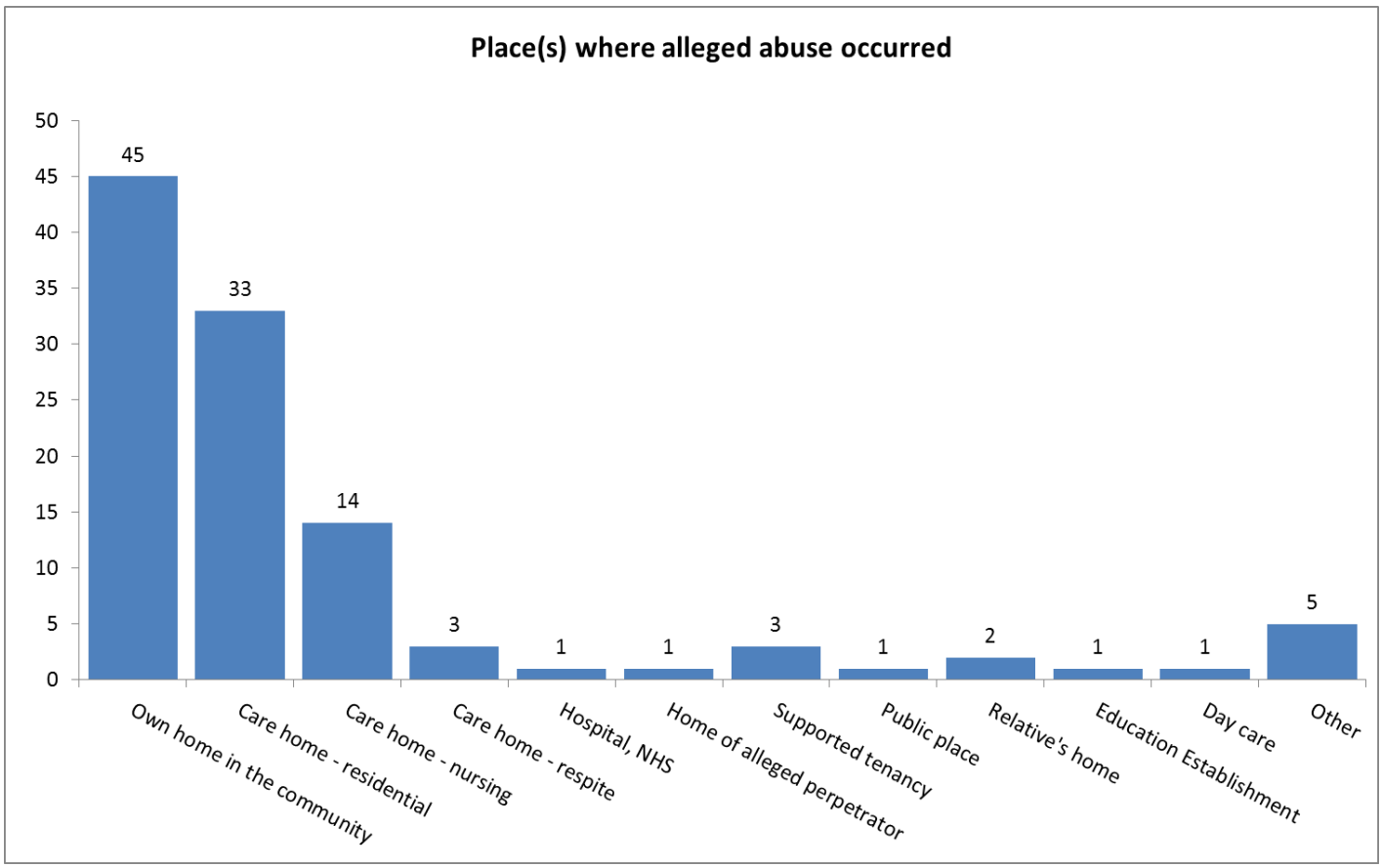
SOURCE OF REFERRAL

Source of Referral		
Self	3	3%
Relative/ Friend	3	3%
SSD Care Manager	18	17%
SSD Provider	11	10%
Health - hospital	8	7%
Health - primary/ community/ LHB	9	8%
Care Regulator	6	6%
Provider Agency	47	44%
Advocate	1	1%
Other	2	2%
Total	**108**	



PLACE(S) WHERE ABUSE OCCURRED

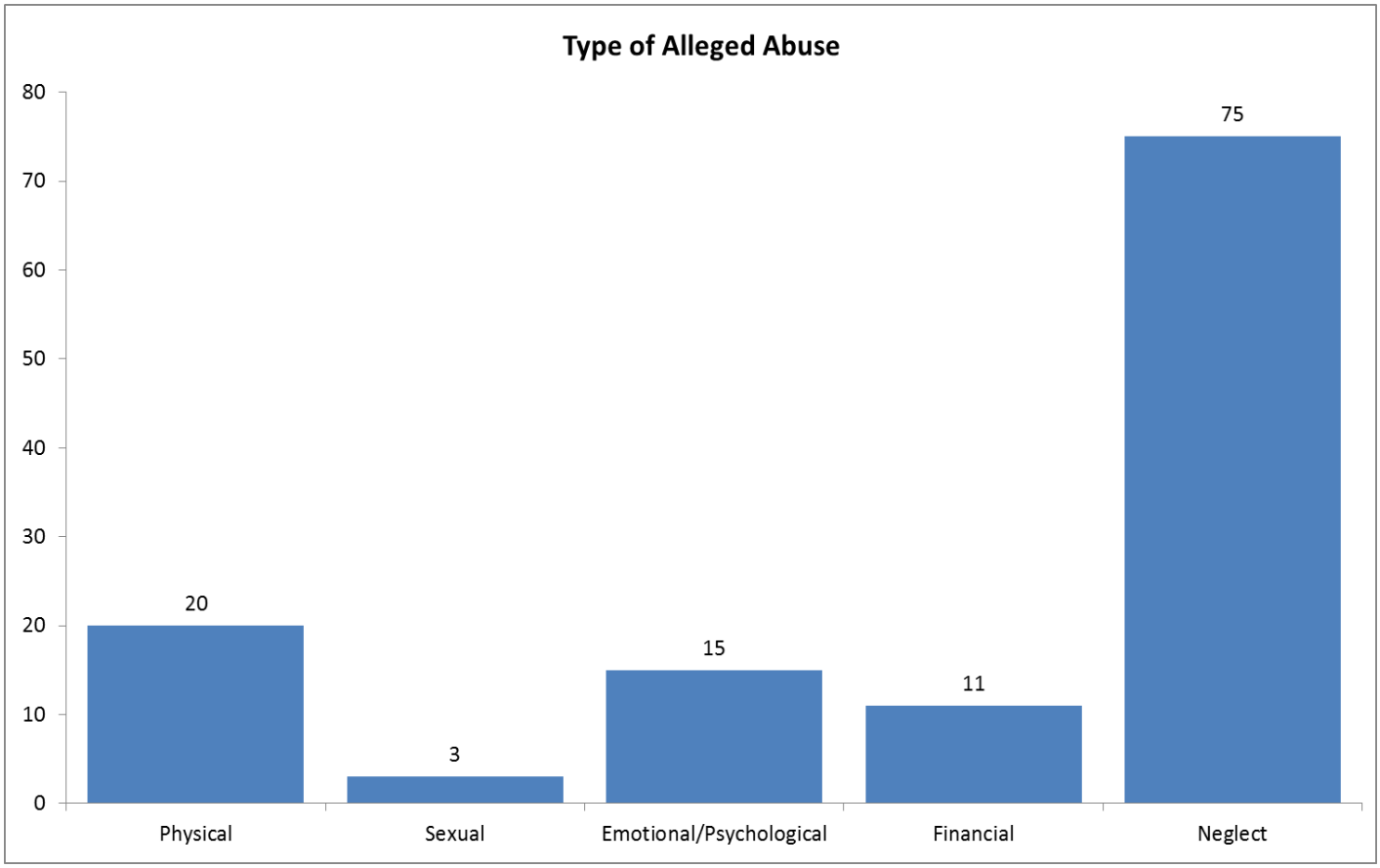
Place(s) where abuse occurred		
Own home in the community	45	41%
Care home - residential	33	30%
Care home - nursing	14	13%
Care home - respite	3	3%
Hospital, NHS	1	1%
Home of alleged perpetrator	1	1%
Supported tenancy	3	3%
Public place	1	1%
Relative's home	2	2%
Education Establishment	1	1%
Day care	1	1%
Other	5	5%
	110	



This figure is higher that the number of completed referrals as this question can have multiple responses.

TYPE OF ALLEGED ABUSE

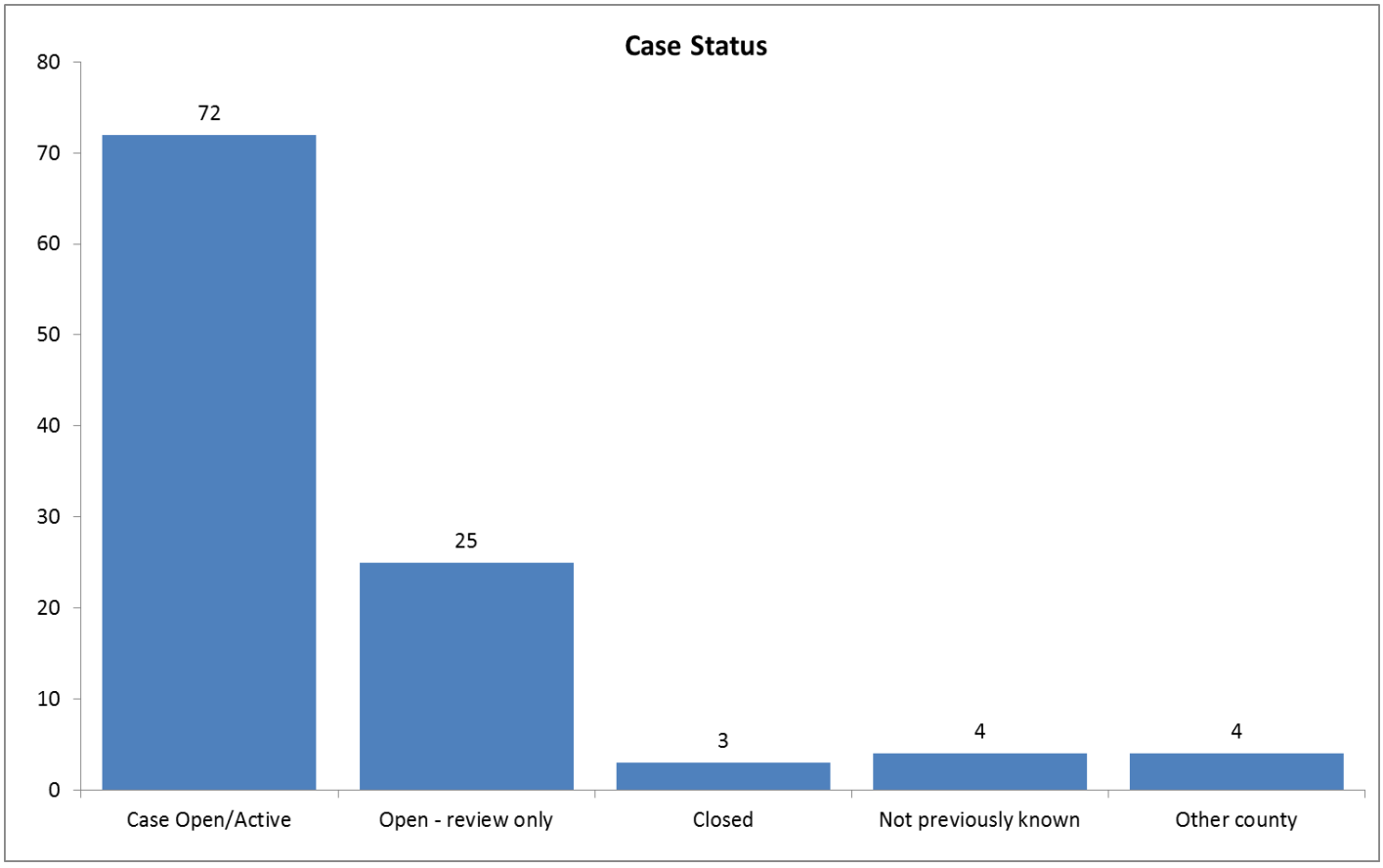
Type of abuse		
Physical	20	16%
Sexual	3	2%
Emotional/Psychological	15	12%
Financial	11	9%
Neglect	75	60%
	124	



This figure is higher that the number of completed referrals as this question can have multiple responses.

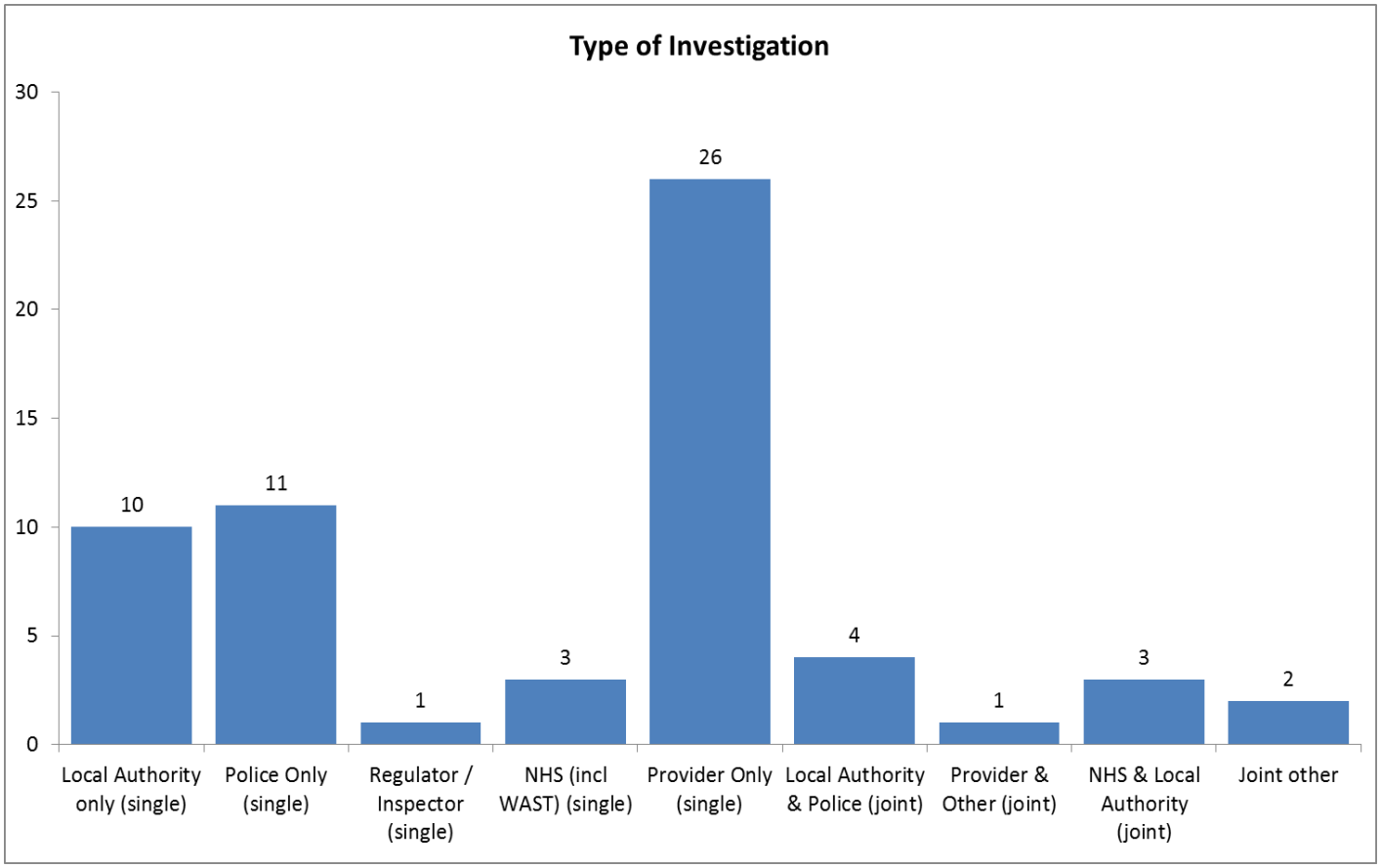
CASE STATUS

Case Status		
Case Open/Active	72	67%
Open - review only	25	23%
Closed	3	3%
Not previously known	4	4%
Other county	4	4%
	108	



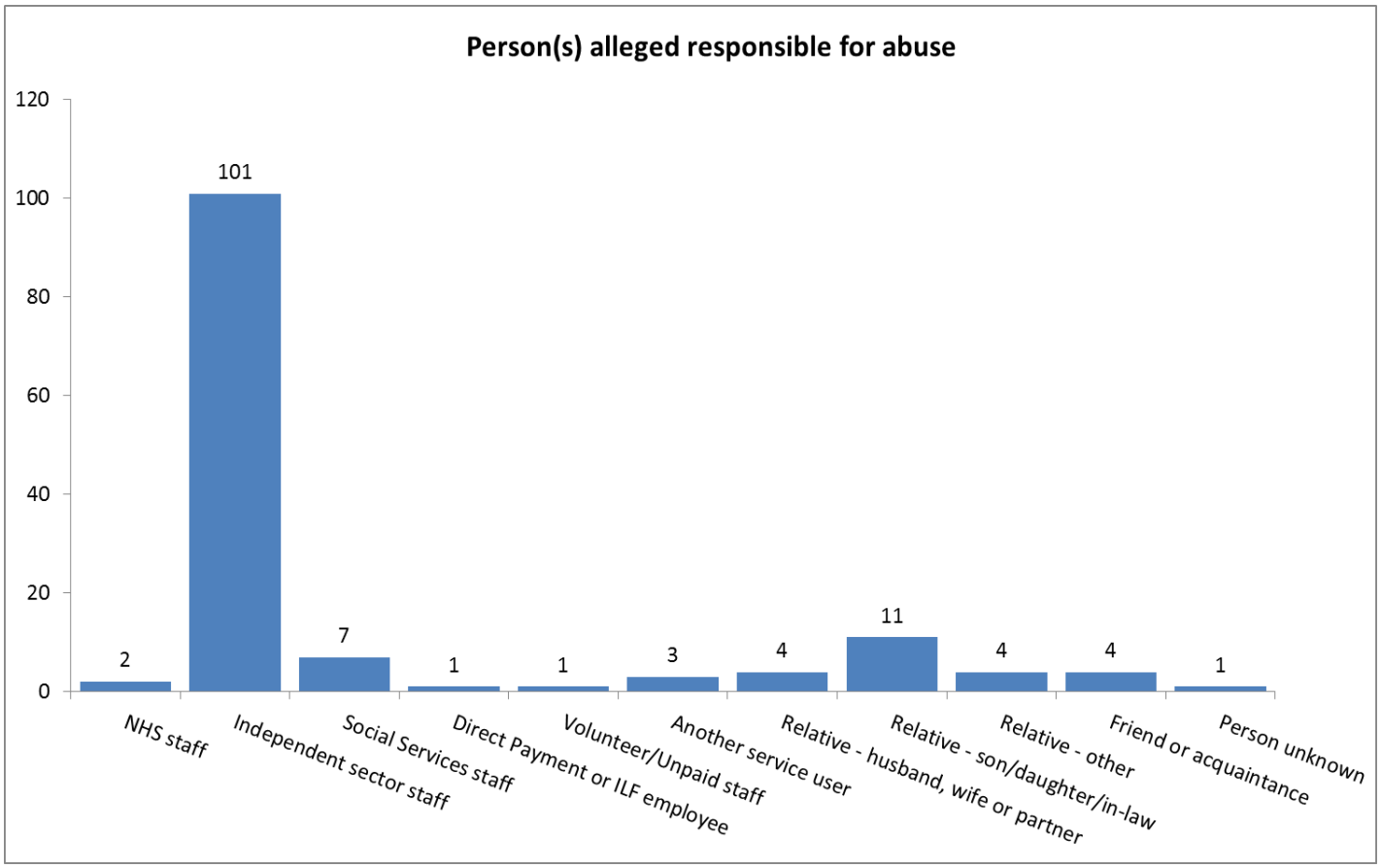
TYPE OF INVESTIGATION

Type of investigation		
Local Authority only (single)	10	16%
Police Only (single)	11	18%
Regulator / Inspector (single)	1	2%
NHS (incl WAST) (single)	3	5%
Provider Only (single)	26	43%
Local Authority & Police (joint)	4	7%
Provider & Other (joint)	1	2%
NHS & Local Authority (joint)	3	5%
Joint other	2	3%
	61	



PERSON ALLEGED RESPONSIBLE FOR ABUSE

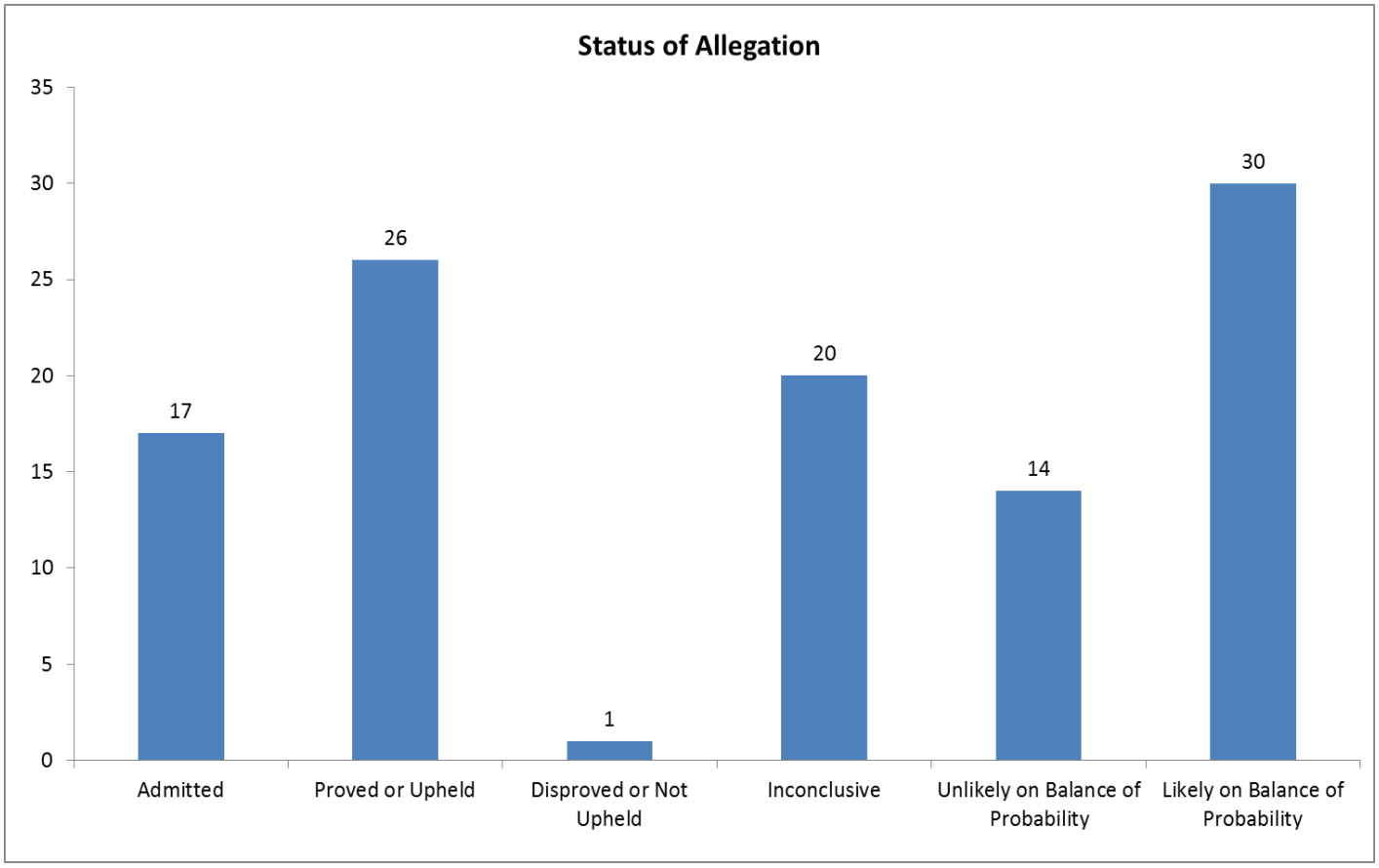
Person(s) alleged responsible for abuse		
NHS staff	2	1%
Independent sector staff	101	73%
Social Services staff	7	5%
Direct Payment or ILF employee	1	1%
Volunteer/Unpaid staff	1	1%
Another service user	3	2%
Relative - husband, wife or partner	4	3%
Relative - son/daughter/in-law	11	8%
Relative - other	4	3%
Friend or acquaintance	4	3%
Person unknown	1	1%
	139	



This figure is higher that the number of completed referrals as this question can have multiple responses.

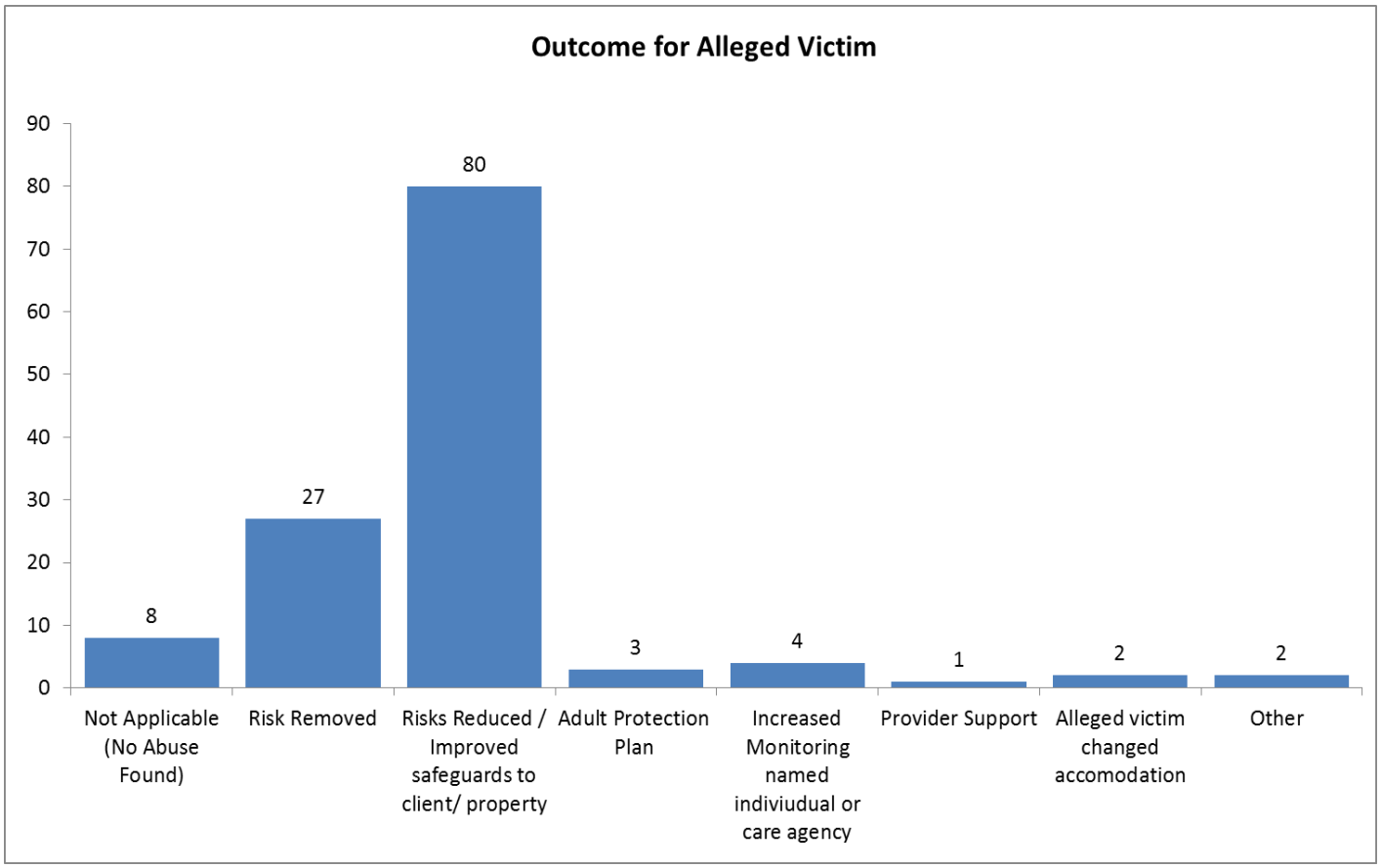
STATUS OF ALLEGATION

Status of Allegation		
Admitted	17	16%
Proved or Upheld	26	24%
Disproved or Not Upheld	1	1%
Inconclusive	20	19%
Unlikely on Balance of Probability	14	13%
Likely on Balance of Probability	30	28%
	108	



OUTCOME FOR ALLEGED VICTIM

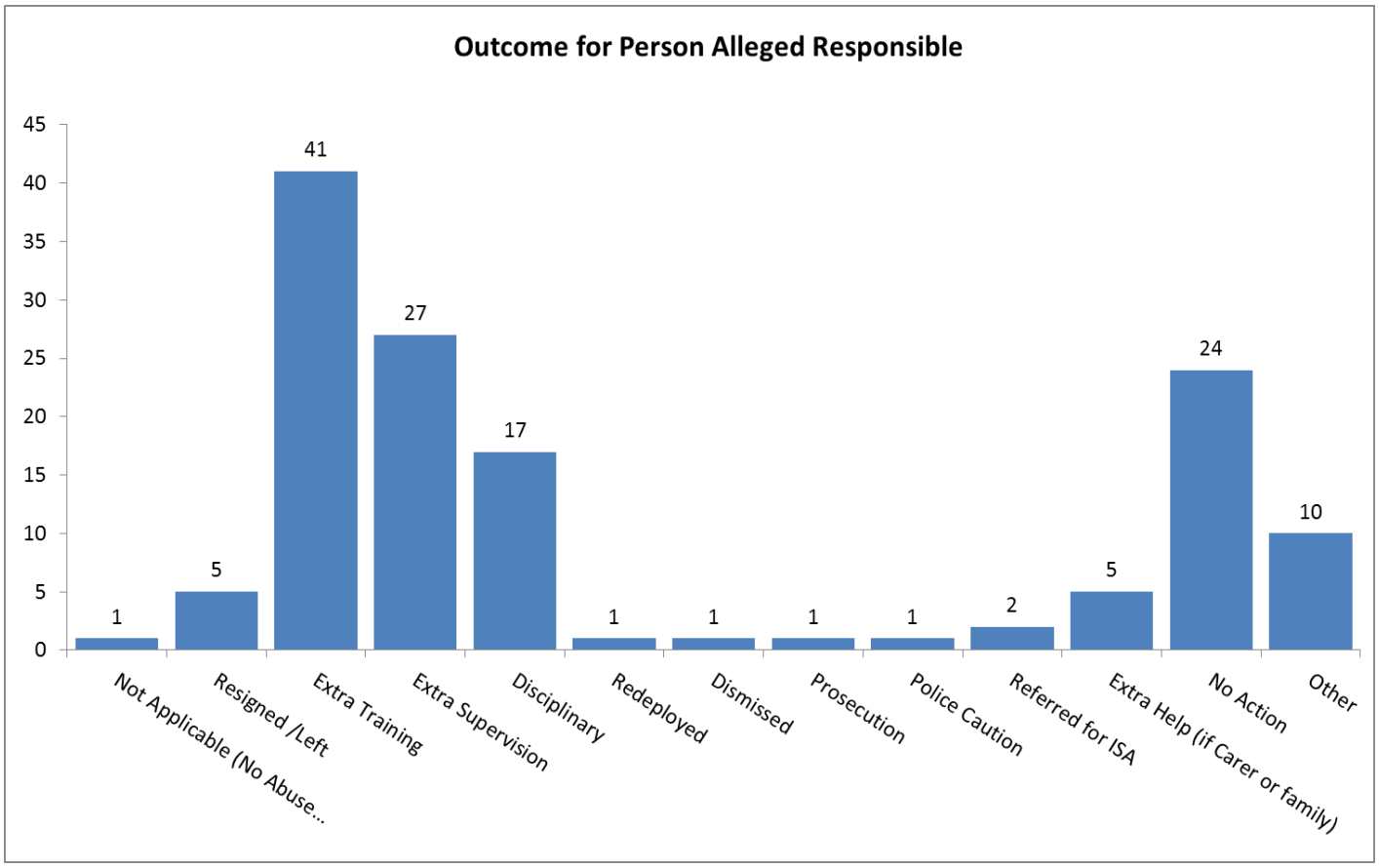
Outcome for Alleged Victim		
Not Applicable (No Abuse Found)	8	6%
Risk Removed	27	21%
Risks Reduced / Improved safeguards to client/ property	80	63%
Adult Protection Plan	3	2%
Increased Monitoring named individual or care agency	4	3%
Provider Support	1	1%
Alleged victim changed accommodation	2	2%
Other	2	2%
	127	



This figure is higher that the number of completed referrals as this question can have multiple responses.

OUTCOMES FOR PERSON ALLEGED RESPONSIBLE

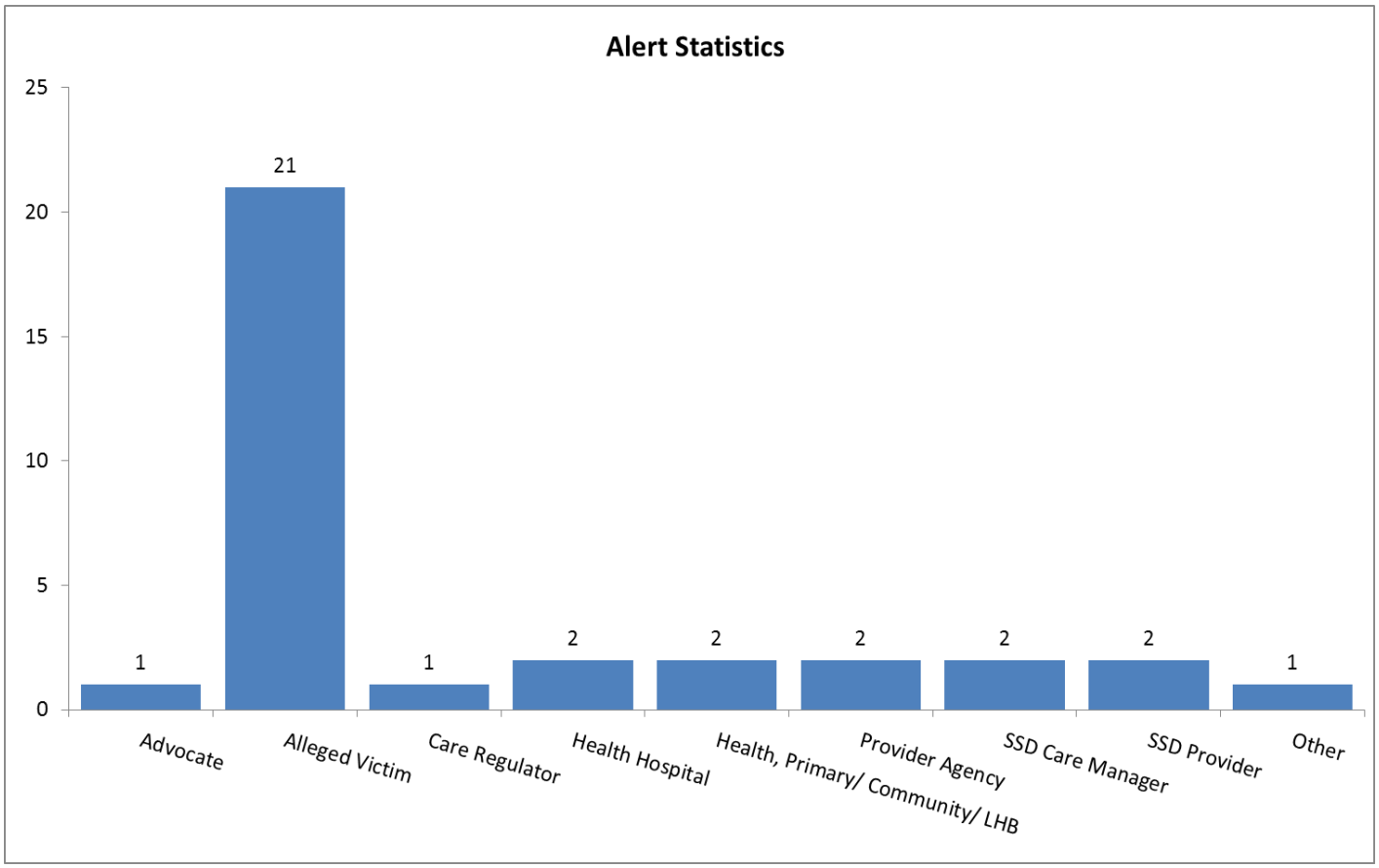
Outcome for Person Alleged Responsible		
Not Applicable (No Abuse Found)	1	1%
Resigned /Left	5	4%
Extra Training	41	30%
Extra Supervision	27	20%
Disciplinary	17	13%
Redeployed	1	1%
Dismissed	1	1%
Prosecution	1	1%
Police Caution	1	1%
Referred for ISA	2	1%
Extra Help (if Carer or family)	5	4%
No Action	24	18%
Other	10	7%
	136	



This figure is higher that the number of completed referrals as this question can have multiple responses.

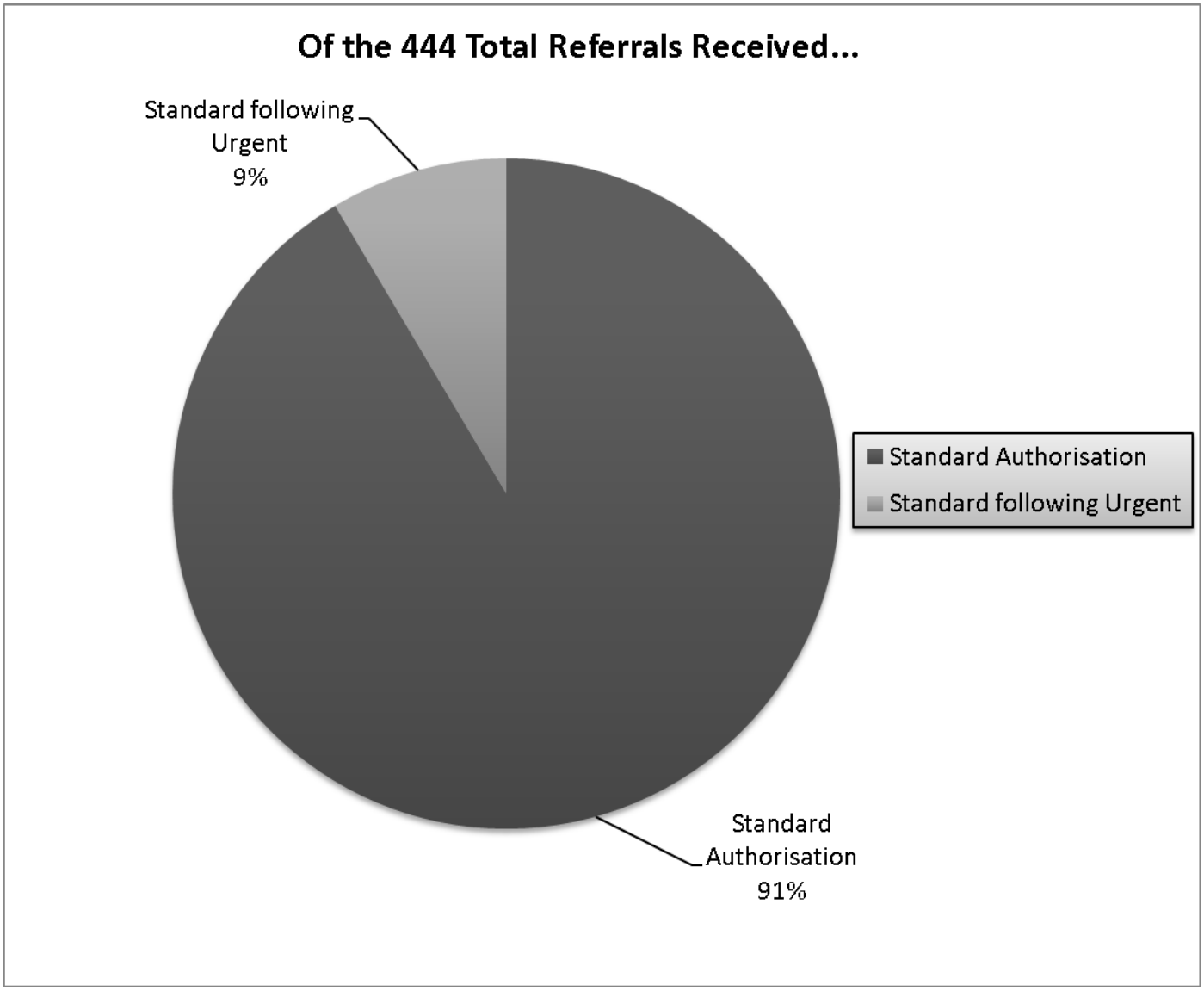
ALERT STATISTICS

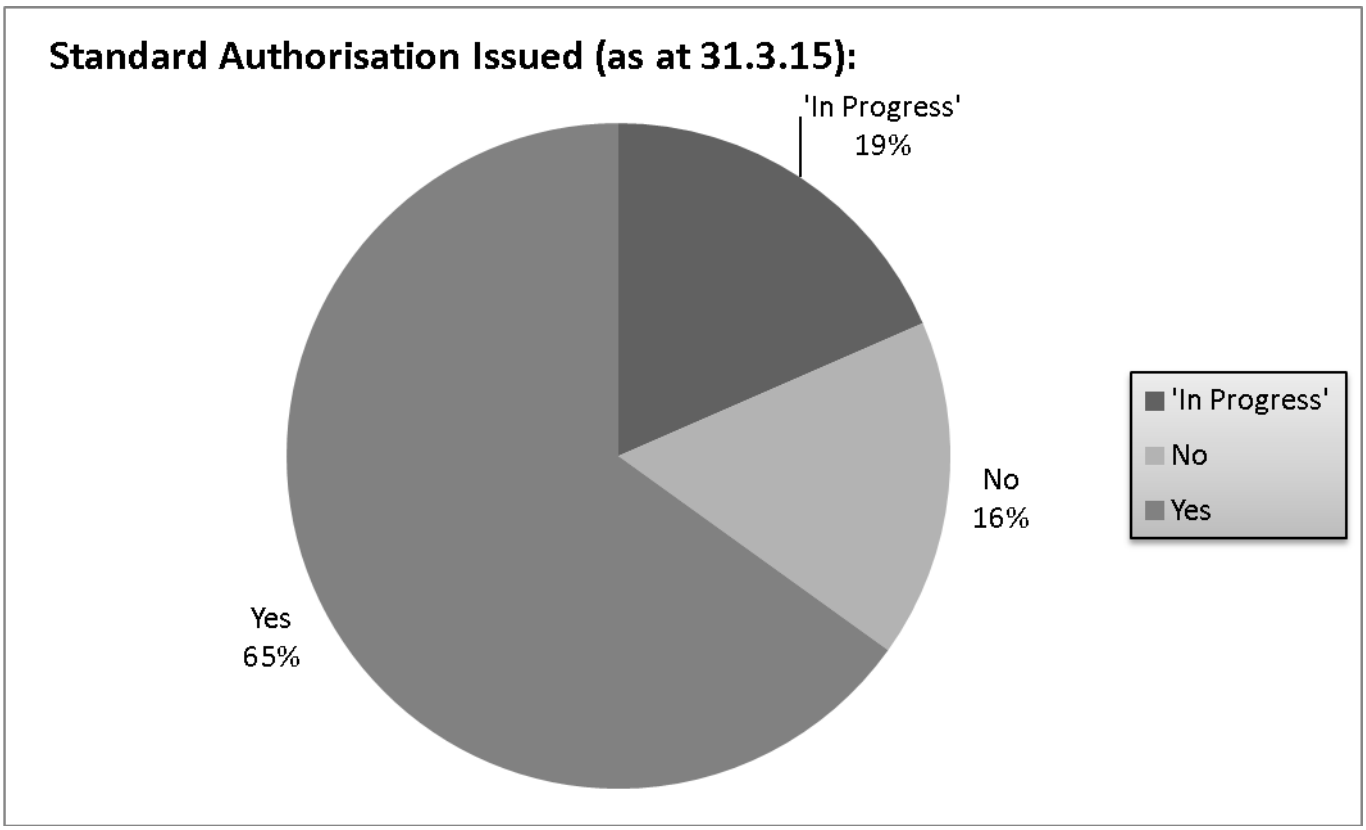
Alerts		
Advocate	1	3%
Alleged Victim	21	62%
Care Regulator	1	3%
Health Hospital	2	6%
Health, Primary/ Community/ LHB	2	6%
Provider Agency	2	6%
SSD Care Manager	2	6%
SSD Provider	2	6%
Other	1	3%
	34	

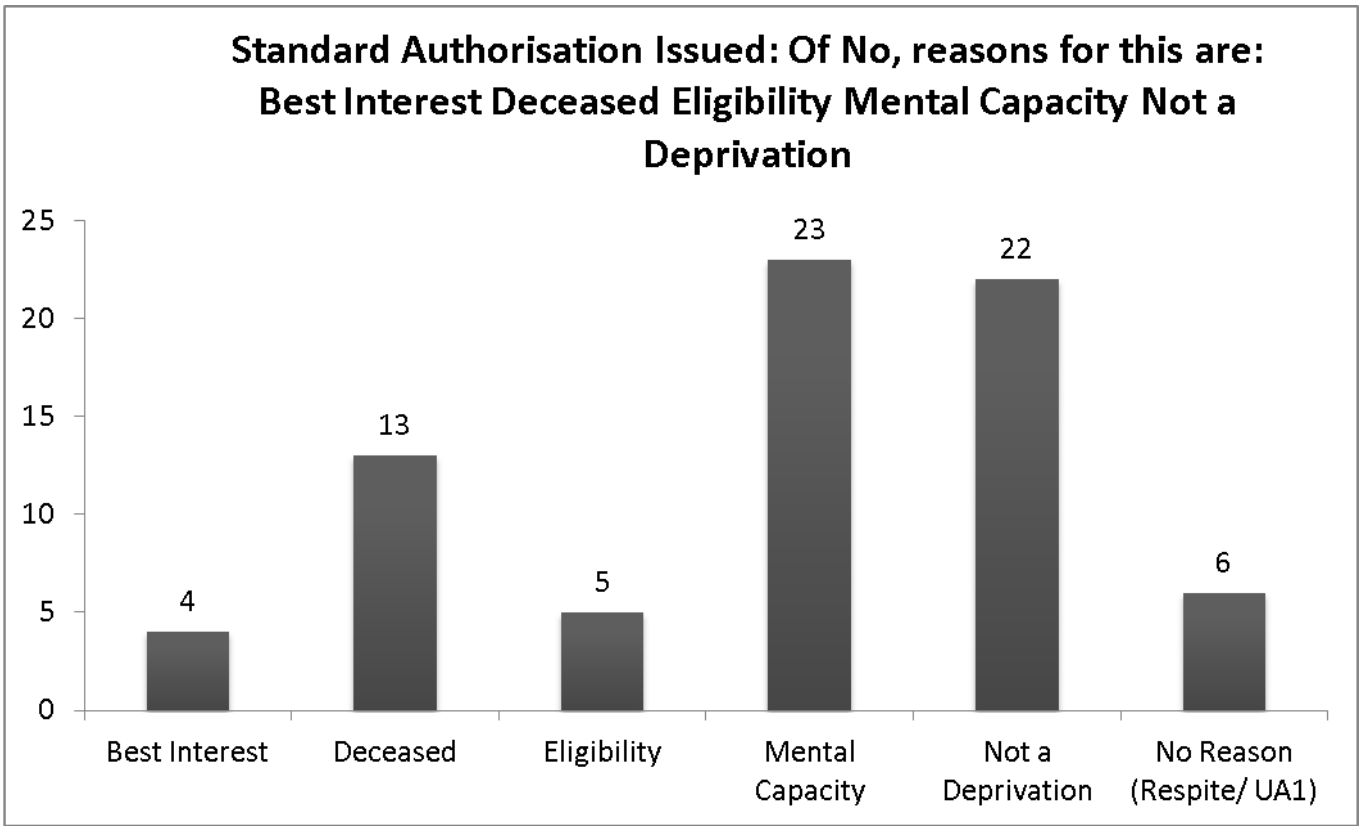


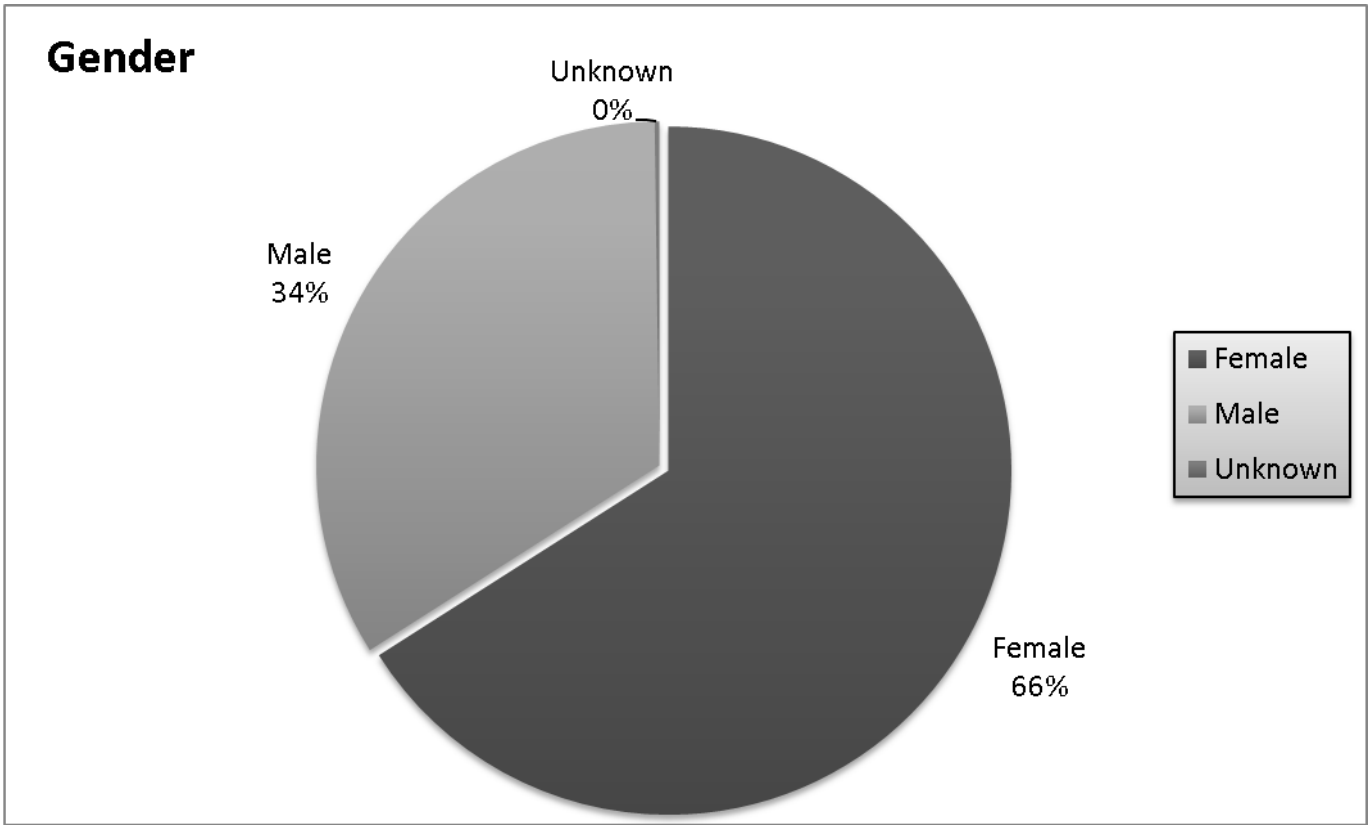
Appendix 4
DoLS
END OF YEAR SUMMARY CHARTS

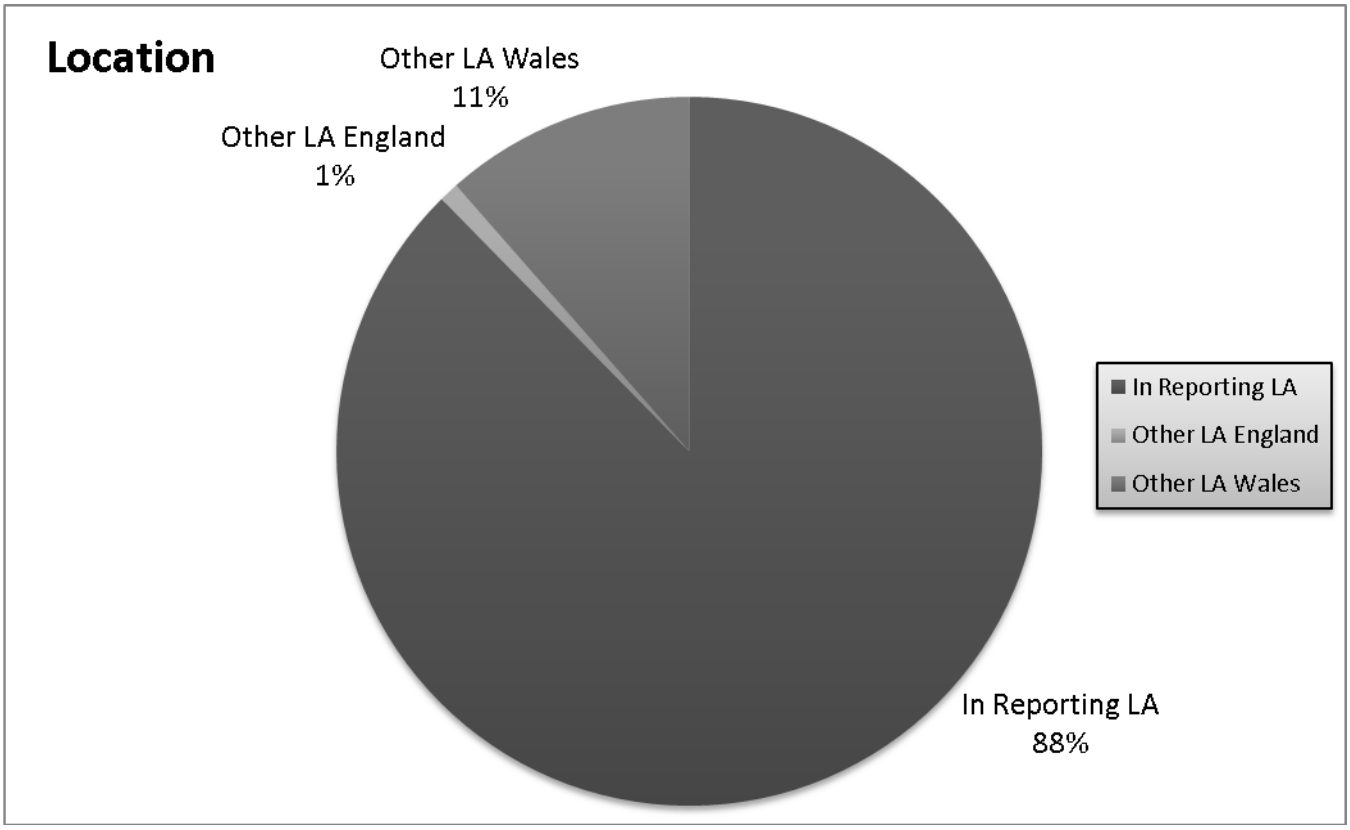
These charts are taken from the End of Year Return to the CSSIW for 1St April 2014 to 31st March 2015




Standard Authorisation Issued (as at 31.3.15):
'In Progress'
19%
No
16%
Yes
65%
'In Progress'
No
Yes


Standard Authorisation Issued: Of No, reasons for this are:
Best Interest Deceased Eligibility Mental Capacity Not a Deprivation
25
20
15
10
5
0
4
13
5
23
22
6
Best Interest
Deceased
Eligibility
Mental Capacity
Not a Deprivation
No Reason (Respite/ UA1)


Gender
Unknown
0%
Male
34%
Female
66%
Female
Male
Unknown


Location
Other LA Wales
11%
Other LA England
1%
In Reporting LA
88%
In Reporting LA
Other LA England
Other LA Wales

Appendix 5

Operational Policy for The Quality Reviewing Team [2015]

Primary Author:	Adam Greenow
Approved:	
Effective from:	
Date for review:	

Contents

1. Purpose

The purpose of this document is to outline the roles and responsibilities of the Safeguarding and Reviewing Team in carrying out placement reviews. It also covers agreement with partner agencies in relation to integrated working specifically in relation to:

Agreed working arrangements and sharing of intelligence between internal and external partners.

Therefore this document will be relevant to the following:

- NPT Quality Safeguarding Team
- NPT Contracting and Commissioning Team
- CSSIW
- ABMU

2. Persons Affected and Scope

Within the Safeguarding Team this document is particularly applicable to the following:

- Quality Reviewing Officers
- Social Workers
- Deputy Manager
- POVA Coordinator
- Team Manager

It will also be of a wider interest to:

- Nurses
- Nurse Assessors
- Contracting Officers
- Care Home inspectors
- Protection of Vulnerable Adult Coordinators

Primarily, this document outlines the operational model of practice for the Safeguarding Team including information on joint working arrangements with partner agencies.

3. **Team Remit**

The team will accept referrals for reviews for people in permanent placements in the following settings:

- Nursing Placements
- Residential Placements
- Adult Placements

The team will review those people that are the responsibility of Neath Port Talbot based on current legislative guidance relating to ordinary residence. This can include self funders, people funded in other ways (e.g. Continuing Health Care) who are also subject to Deprivation of Liberty Safeguards. The team will also, where requested, carry out reviews on behalf of other authorities where requested in return for remuneration based on the cost of providing that service.

It is not currently within the team's remit to review people residing in their own homes in the community.

4. Roles and responsibilities

Quality reviewing officers will be given the responsibility for named care homes rather than just individual reviews. This will be done on the basis of geographical clusters taking account of fair workload distribution. This is currently done on the basis of four clusters.

Social Worker x 1	Quality Reviewing Officers x 2	Cluster 1	Name Inspector, Named Contracting and Monitoring Officer, Named Nurse Assessor
	Quality Reviewing Officers x 2	Cluster 2	Name Inspector, Named Contracting and Monitoring Officer, Named Nurse Assessor
Social Worker x 1	Quality Reviewing Officers x 2	Cluster 3	Name Inspector, Named Contracting and Monitoring Officer, Named Nurse Assessor
	Quality Reviewing Officers x 2	Clsuter 4	Name Inspector, Named Contracting and Monitoring Officer, Named Nurse Assessor

Quality reviewing officers will be allocated work for the financial year, April to April. They will be supported by the team managers to schedule visits for the next twelve months on a home by home basis.

Planning will take into account the number of residents in each home the estimated time required to complete the reviews. By reviewing on a home by home basis reviewing offers will have the opportunity to complete work in a discrete period of time allowing for an economy of scale not previously possible. It will also allow more opportunity to build a relationship with the home and staff as well as residents.

They will be support by a social worker who will have responsibility for two clusters. The deputy and team manager will also support as required.

By agreement each cluster will also have named equivalents in terms of responsibility in health, safeguarding, CSSIW and contracting and commissioning.

5. Reviewing process

Reviews will be carried out in line with Quality of Life Guidance and other good practice principles. The format for this is set out in a separate document: “Guidance for completing reviews for older people in care homes [2015]” (NPT 2015).

6. Quality Assurance Intelligence gathering

To improve the quality and standard of care in our homes NPT are committed to a clear quality assurance process. In conjunction with our partners in Bridgend and Swansea we have developed questionnaires for key stakeholders, family and health staff.

For each home Quality Reviewing Officers will complete a questionnaire at the end of their scheduled work in that home. For each individual review family will be offered the option of completing a feedback form. Any other key stakeholder can also be offered a form to provide feedback. The service user's views will be recorded in their individual review forms.

Quality Assurance Feedback	
Service User	Recorded in QoL Review
Family and Friends	Family Questionnaire
QRO and Social Workers	Stakeholder Questionnaire
Health	Health Professional Assessment Questionnaire
Anyone else	Stakeholder Questionnaire

All these questionnaires will be collated and stored in the QA email box: qa@npt.gov.uk .

7. Quality Assurance Intelligence sharing

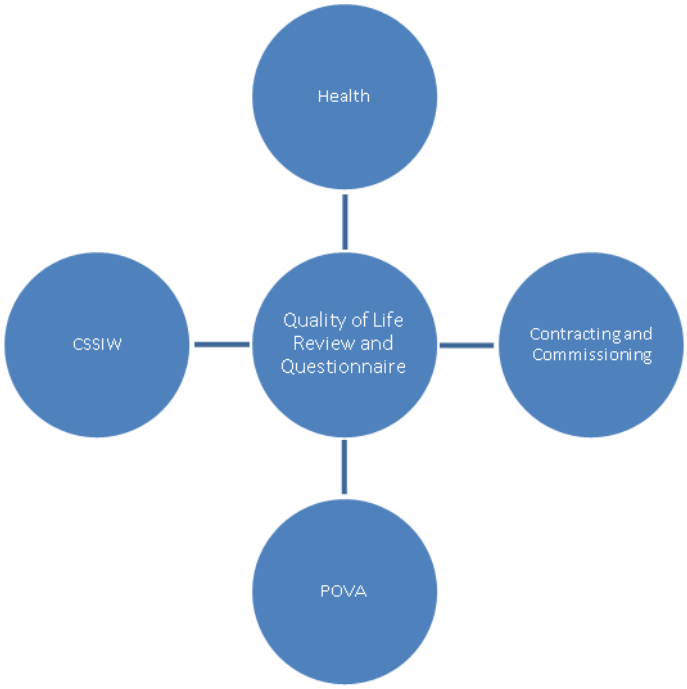
It is the team manager's responsibility to ensure that intelligence gathered by the team is analysed, shared and utilised to improve the standard of service in NPT. The will include:

- Providing a regular report on feedback to the NPT QA Panel which meets on a monthly basis
- Sharing the information and report for each home or company with contracting and commissioning and holding a regular information sharing meeting to share information prior to or post visits
- Sharing the information and report for each home with CSSIW
- Sharing the information and report with Health

Roles and responsibilities	
Safeguarding and Quality Manager	Provide a written summary report each month on intelligence gathered highlighting both negative and positive feedback
Contracting Officers	Meeting with SF team on a monthly basis to share information
QRO	Provide questionnaires for the QA process
CSSIW	Accept reports and feedback to team any actions or intelligence that they feel appropriate
Health	Accept reports and feedback to team any actions or intelligence that they feel appropriate

Sharing information schedule	
Contracting and Commissioning	Monthly meeting with SF team
POVA	Monthly meeting with SF team
CSSIW	Report format – meeting as required
Health	Report format – meeting as required

It is envisaged that the information gathered and shared will help with identifying homes who need to be part of a wider process e.g. HOSG, JIMP or escalating concerns. The information may will also be benefit from homes subject to one of these processes and could be part of an improvement plan.



8. Monitoring, tracking and review

This policy will be monitored on a annual basis along with the Quality of Life Reviewing Guidance.

Monitoring and tracking of reviews will take place via the QA panel.

9. Revision History

Author	Summary	Date
Adam Greenow	First draft	24-08-2015

Appendix 6

Guidance for completing reviews for older people in care homes [2015]

Primary Author:	Adam Greenow
Approved:	
Effective from:	
Date for review:	

1. Purpose

The purpose of this document is to offer clear and concise guidance on the type of information that needs to be captured in a review for older people living in a residential or nursing home to ensure that quality of life issues are a central part of the review process.

The information is based on: 'A Place to Call Home? *A review of the quality of life and care of Older people living in Care Homes in Wales.'*

2. Persons Affected and Scope

This document is for all staff carrying out reviews with older people in care homes. It is not designed to be used for reviews carried out in community settings.

3. Checklist

Please utilise the following checklist and where appropriate use the suggested headings in your review to ensure these areas have been discussed and referenced. Not every section may be relevant and these are prompts only not an exhaustive list of everything that should be discussed or covered.

It is also important to note that the purpose of asking these questions is to support care homes to improve and to share useful information with our partner agencies under the new operational model. It is not simply to catch people out. We want to work in partnership with other agencies including the care homes themselves to improve the quality of life for older people in residential and nursing care in NPT.

Section 1.01	***Day- to-Day Life***
Heading	Things to look for
Potential barriers	Risk aversion, poor staffing and organisation, treating people as individuals
Section 1.02 Social participation	Evidence of social stimulation?
	Physical and mental stimulation?
	Choice and control over activities?
	Supported to do what they want to do?
	Communication needs are considered by staff?
	Welsh Language needs are considered?

Section 1.03	***Day-to-Day Life***
Heading	Things to look for
Potential barriers	Risk aversion, misunderstanding health and safety
Section 1.04 Meaningful occupation	Making tea?
	Baking?
	Gardening?
	Setting the table?
	Keeping pets?
	Religious services?
	Helping others?

Section 1.05 Day-to-Day Life	
Heading	Things to look for
Potential barriers	Task based approaches, staff ratios, leadership
Section 1.06 Personal Hygiene, Cleanliness and Comfort	Is this delivered in a person centred way?
	Choice and control, e.g. over times using the toilet?
	Appropriate use of incontinence pads? i.e. not used for convenience or out of necessity?
	Pads changed regularly?

Section 1.07 Day-to-Day Life	
Heading	Things to look for
Potential barriers	Home culture, leadership
Section 1.08 Personal Appearance	Choice and control over what to wear
	Supported to maintain personal appearance and identity
	Comfortable and relaxed

Section 1.09 Day-to-Day Life	
Heading	Things to look for
Potential barriers	Task based approaches, staff ratios, leadership
Section 1.10 The Dining Experience	Are mealtimes seen as a 'feeding activity' i.e. a task to be completed?
	Opportunity for positive interaction?
	Choice about what to eat, when and where?
	Communication between staff and residents informing what is on the menu?
	Does the experience enhance life?

Section 1.11 Day-to-Day Life	
Heading	Things to look for
Potential barriers	Task based approaches, staff ratios, leadership
Section 1.12 Care Home Environment	Does the home have a functional and clinical feel?
	Is the design and layout suitable?
	Is it homely and comfortable?
	Dementia friendly? i.e. pictorial signs and destination points?
	Consideration for those with sensory loss? Assistive equipment? Hearing loops? Lighting? Ramps?

Section 1.13 Factors which could influence day-to-day life
Institutional regimes, task based approach concentrating on schedules, processes and checklists rather than the needs of individuals?
Clear variations in the quality of care provided.
Older people in the home have low expectations about quality of life in the home?
Older people only expecting an adequate quality of life.
Role of independent advocacy and its importance understood and recognised. Advocacy actively promoted?

Section 1.14 Health and Wellbeing	
Heading	Things to look for
Potential barriers	Training, staff resources
Section 1.15 Prevention and Reablement	Does the home have a functional and clinical feel?
	Is the design and layout suitable?
	Is it homely and comfortable?
	Dementia friendly? i.e. pictorial signs and destination points?
	Consideration for those with sensory loss? Assistive equipment? Hearing loops? Lighting? Ramps?
	Access to preventative and reablement services?
	Working to a dependency model?

Section 1.16 Health and Wellbeing	
Heading	Things to look for
Potential barriers	Culture, acceptance, lack of challenge
Section 1.17 GPs	Able to access GP service, get appointment when needed and access out of hours service?
	Over reliance on telephone diagnosis?
	Are all medical records in place?

Section 1.18 Health and Wellbeing	
Heading	Things to look for
Potential barriers	Culture, training, lack of awareness
Section 1.19 Sensory Loss	Assessment on admission?
	Ongoing assessment?
	Maintenance of sensory aids?
	Support in using aids?

Section 1.20 Health and Wellbeing	
Heading	Things to look for
Potential barriers	Culture, leadership, focus on profit over wellbeing
Section 1.21 Diet	Fresh produce
	Fruit and vegetables readily available?
	Meals having a ‘ready meal’ appearance?

Section 1.22 Health and Wellbeing	
Heading	Things to look for
Potential barriers	Training, on oral hygiene
Section 1.23 Oral Hygiene	Access to a dentist?
	Is there an appointment scheduled?

Section 1.24 People and Leadership	
Heading	Things to look for
Potential barriers	Culture, training, leadership, lack of challenge, motivation, morale
Section 1.25 Care staff	Staff ratios adequate?
	Morale and culture positive?
	Task orientated procedures?
	Staff turnover?
	Adequately trained staff?
	Good values evident, e.g. dignity, empathy and respect?
	Nursing staff supported by the NHS?

Section 1.26 People and Leadership	
Heading	Things to look for
Potential barriers	Leadership, culture, staff training, modelling behaviour
Section 1.27 Care Home Managers	Promotes good practice
	Good culture
	High morale
	Leadership
	Support of owners

4. Example recording

Summarise how far the outcomes in the support plan have been achieved (including citizens view of how their needs are being met) What is happening to help this citizen to meet the stated outcomes?

Day-to-life:

Mrs Jones likes to go out on trips. These are normally provided by the home on a monthly basis. It would be better if she could go more often and at times to suit her. She sees her family regularly and no restrictions are put on visiting times. She speaks Welsh and there are Welsh speaking staff who work with her on a regular basis and this makes her feel more comfortable in communicating her needs.

She sometimes helps out with tasks when she feels up to it. For example she helps to prepare the table for meals and makes her own tea. The home encourages this.

Mrs Jones has a wash at the same time each day based on the staff schedule. I have spoken to the home about ways this could be done in a more person centred way.

Mrs Jones always appears smartly dressed and she chooses her own clothes each day.

Mealtimes are at set times. Mrs Jones and other residents could be offered more say in choosing the menu. Mrs Jones could also be given the option of having meals with people she can communicate with better, i.e. Welsh speakers.

The home itself is comfortable looking and has lots of nice homely touches. There could be more signs and destination points to support those who are confused.

Health and Wellbeing:

Mrs Jones has not seen the dentists since being admitted. She has also not had an eye tested in over three years. These needs to be arranged as a matter of priority.

She does see the GP when he visits the home but it is often difficult to get him to call when needed. I will query with the GP the amount of medication being taken as this seems to have increased due to a number of telephone consultations.

Mrs Jones says the meals are ok but they do not always match what is put on the board. Fresh fruit and vegetables seem to be lacking. I will raise this with the home and in our information sharing days.

People and leadership:

Staff morale is generally good. Mrs Jones gets on with most of the staff but 'one or two' have a

groan. Staffing ratios are mostly adequate but not enough to offer a complete person centred approach as some tasks seemed routine and task based.

The manager is keen to work to improve things and is aware of the new drive to improve quality of life for residents.

Identified outcomes:

Outcome	Action
Healthy, pain free teeth	Appointment schedule to be set up with dentist
To be able to see well enough to read and enjoy TV	Staff to support to make sure glasses are on hand and clean. Appointment with opticians to be arranged
Enjoy company of friends and have a chat	Meals to be arranged with friends (Welsh Speaking). Staff to support Mrs J to go out and meet people on days that suit.
Be healthy and not overly reliant on medication	Social worker to speak to GP about the amount of medication prescribed over the telephone and ask for review.
Go to Bingo once a week.	Home to arrange for Mrs Jones to go to Bingo on a Thursday with her friends.
Feel individual and needs met as required	Will discuss with contracting officer training and resource issues at the home and work in conjunction with partner agencies to see if an improvement plan can be encouraged

8. Revision History

Author	Summary	Date

Operational Model of Practice

Neath Port Talbot Safeguarding Team

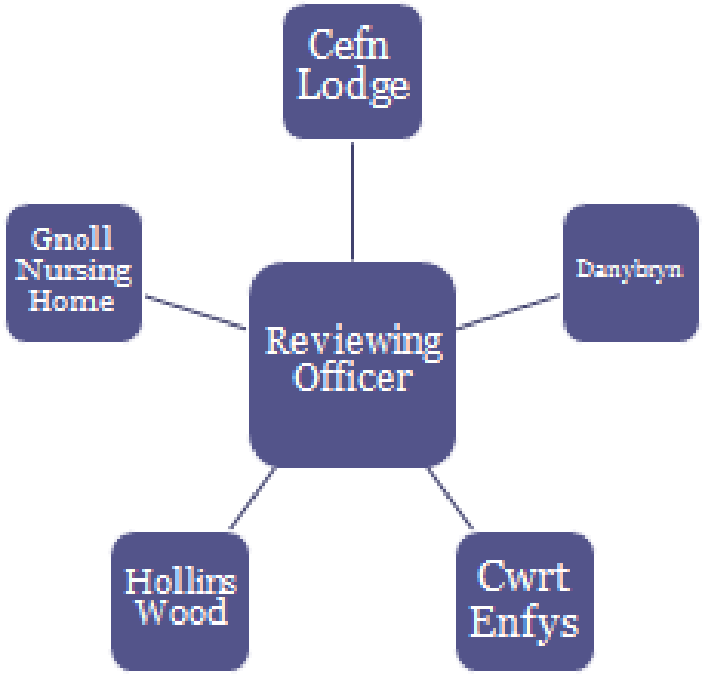
Why do we need a new operational model?

- New Act
- Older Person's Commissioner Review of Care Homes
- New Team/Structure
- Increasing call for integrated working
- Case Review (MJ)

Old operational practice

Commissioners and key agencies largely working in silos.

Work was allocated across the authority to individual reviewing officers:



Current model inefficient

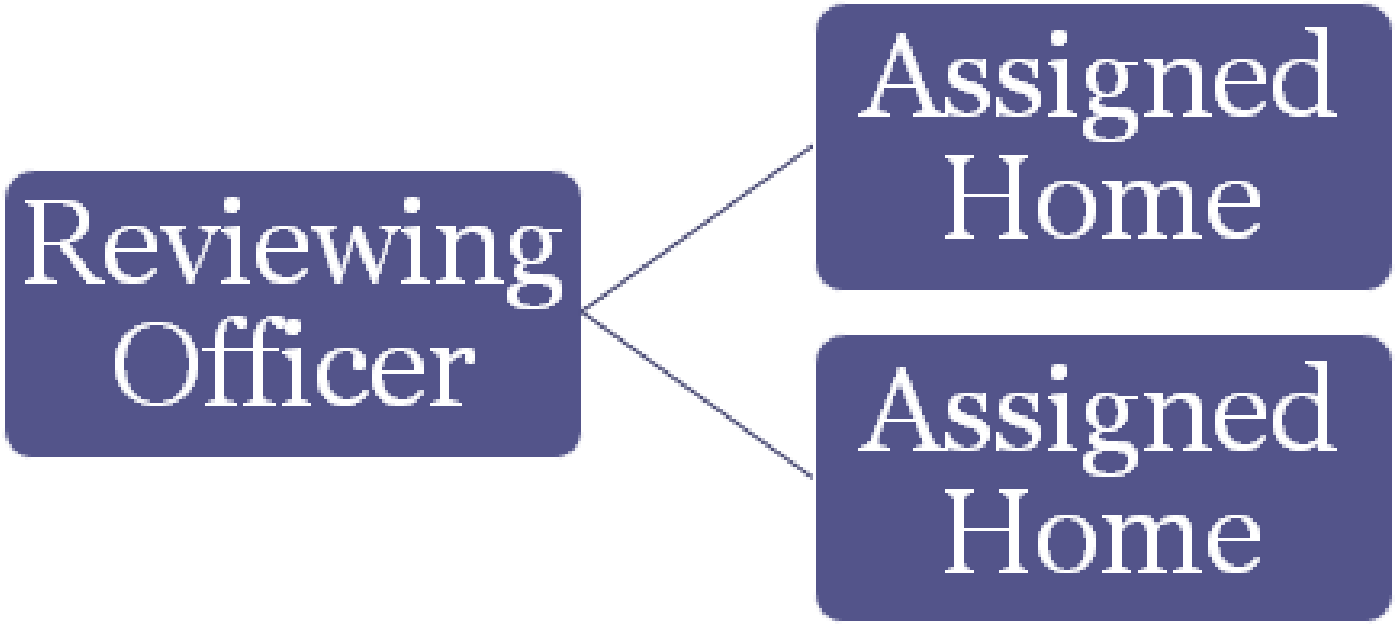
- Not enough joined up working
- A single worker had to cover a potentially large geographical area
- Little opportunity to build relationships
- Workload difficult to quantify and unevenly distributedleading to:
- Backlogs
- Loss of morale

The new model is integrated

By Integrated we mean:

- We have agreed how we work together
- How we communicate information and concerns
- We give individuals more ownership and responsibility of particular homes so they can speak about those homes
- We ask key stakeholders to complete questionnaires to build intelligence on specific homes

Quality Reviewing Officers work with one cluster of named homes:



This will mean:

- Opportunity to get to know the home better and the people
- People will know who to talk to if they want information
- Economy of scale when carrying out reviews (all in one place)
- A less blinkered approach than focussing on individuals

New guidance in relation to reviews :

- Quality of life criteria
- Well-being criteria
- Ensure equality of service
- Ensure opportunities for social interaction
- Better outcomes

How we will share information

- Every month we have information sharing days with POVA and Contracting and Commissioning
- Look at questionnaires, look for patterns and themes
- Pass on concerns to partners, e.g. health and CSSIW
- Use information to inform other processes e.g. escalating concerns

What do you think?

- Any questions?
- Thank you.

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2015/2016 FORWARD WORK PLAN (DRAFT)

SOCIAL CARE, HEALTH AND HOUSING CABINET BOARD

Meeting Date and Time	Agenda Items	Type (Decision, Monitoring or Information)	Forwarded to: CDG, CMB, Cabinet, Council	Rotation (Topical, ,Annual, Biannual, Quarterly, Monthly)	Head of Service Contact
5th Nov 2015	(Special Budget Scrutiny Meeting) Social Care, Health and Housing				

Meeting Date and Time	Agenda Items	Type (Decision, Monitoring or Information)	Forwarded to: CDG, CMB, Cabinet, Council	Rotation (Topical, ,Annual, Biannual, Quarterly, Monthly)	Head of Service Contact
26th Nov 2015	Direct Services Operational Policies	Decision		Topical	CM
	Grwp Gwalia	Monitor			CM
	Maximum Expenditure Policy for Community Care	Decision			CM

Social Care, Health and Housing Cabinet Board – Forward Work Programme

Meeting Date and Time	Agenda Items	Type (Decision, Monitoring or Information)	Forwarded to: CDG, CMB, Cabinet, Council	Rotation (Topical, ,Annual, Biannual, Quarterly, Monthly)	Head of Service Contact
17th Dec 2015	Multimedia Care Plan Review Evaluation Report	Info			CM

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