Western Bay Health and Social Care Programme

Joint Paper Outlining Priorities and Successes for the Region

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

1. Purpose of Paper

This document is the Western Bay Regional response to the letter received from the Minister for Health and Social Services dated 11th April 2018. The purpose of the document therefore is to provide Welsh Government with:

- An overview of the programme in the region
- Identification of the Joint Regional priorities for the programme as set out in its Area Plan 2018 – 2023 (http://www.westernbay.org.uk/wp-content/uploads/Western-Bay-Area-Plan-Full-Version.docx.pdf).
- Identification of a number of examples of successes that the programme can evidence as models of good practice that have delivered a range of benefits across Health and Social Care services

This paper presents progress and priorities derived from existing Western Bay Governance arrangements and do not therefore reflect the ambitious discussions that were recently held between local leads from within Western Bay which will result in the development of new arrangements that will be agreed with and supported by Welsh government. The paper also reflects the contribution of Bridgend CBC as an equal and critical partner to the Western Bay Programme. Nevertheless it is important to acknowledge that the proposed boundary changes that will impact on both Bridgend CBC and part of ABMU means that Bridgend priorities are already being communicated with the Cwm Taf region to ensure that Bridgend are able to be included in future Cwm Taf Transformation Grant bids, should the need arise.

2. Overview of Western Bay Programme

The Western Bay Health and Social Care Programme was initially established by the four Chief Executives of the three Local Authorities and the Health Board in January 2012, prior to any legislation mandating partnership working.. The programme got political commitment across the region and a Partnership Forum comprising of elected members, and the Chairman of ABMU Health Board and wider partners was established in 2014 to further embed joint working and act as a precursor to the Regional Partnership Board as required by the Social Services and Wellbeing Act.

The governance arrangements have been reviewed and amended as the programme has evolved and new legislation introduced to ensure robust decision-making processes. The groups and boards for the various strands of the programme include officers from all partner organisations, including the third sector and these groups are used to share health and social care intelligence in order to inform changes, which will improve delivery of services, care and support. Robust governance arrangements has been a key factor to the success of the Western Bay Programme and is included in **Appendix 1**, this demonstrates the commitment to the Key Programmes having a Regional Implementation Manager for each along with a Director as a Sponsor, which helps drive the change at both a strategic and political level.

A joint programme office has been established to support and coordinate partnership arrangements with the necessary allocated resources through a Section 33 Agreement for the Western Bay Programme Office infrastructure, which has been approved by all partners to 2020 demonstrating the commitment to partnership working.

There are a number of other partnership agreements and pooled fund arrangements that have been developed for Western Bay services over the last few years. A major achievement of the partnership was to construct and obtain approval for the Section 33 agreement, established for Intermediate Care Services across Western Bay that is managed through Joint Partnership Boards in Bridgend, Neath Port Talbot and Swansea.

Western Bay partners are continually working towards ensuring services and resources are used in the most effective and efficient way to improve outcomes for people in their region.

2.1 Communications and Engagement

Western Bay has also developed mature communication and engagement mechanisms that include:

- The Western Bay Regional Citizens' Panel was established in 2016. Panel meetings are rotated and held in different venues across the three Local Authority areas and offer citizens the opportunity to discuss a wide range of health and social care matters, demonstrating the Programme's commitment to fostering positive relationships with stakeholders. Panel membership is drawn from the mailing lists of the three Councils for Voluntary Services in Bridgend, Neath Port Talbot and Swansea.
- Western Bay have developed its own website http://www.westernbay.org.uk/
- Digital promotion of the Programme's activities/service users' experiences via the 'Western Bay TV' YouTube channel (www.youtube.com/channel/UCsOWHVVBy63xWHXHfNLXDxg) .
- The production of a quarterly bilingual newsletter highlighting the progress of Western Bay projects and work streams, and promoting positive outcomes for service users and their families. The fourteenth edition has recently been produced and is scheduled for circulation at the end of April 2018
- Western Bay is the only region in Wales to offer Care Choices' Regional Care Directories, which comes at no cost to the Programme's partners as charges associated with production and distribution are covered by revenue generated by private advertising. A key advantage in producing the directory is the fulfilment of the Information, Advice and Assistance (IAA) requirement under the Social Services and Well-being (Wales) Act 2014. Whilst the document is available on line (www.carechoices.co.uk), and particularly given the target demographic and the known issues around digital exclusion, thousands of printed copies have been distributed to larger Council buildings and a number of satellite sites, including hospitals, Common Access Points and offices of Third Sector organisations.

2.2 Information Advice and Assistance (IAA)

IAA requirements is organised and delivered locally, with a regional overview of the IAA position reported through the Western Bay governance arrangements. Work is ongoing around linking the various IAA systems currently being utilised by all partners, which includes the Third Sector Info-engine system, the National Local Authority DEWIS platform and the Health Board's 111 system.

2.3 Local Area Co-ordination / Local Community Co-ordination

A key initiative introduced through the Western Bay Programme and funded initially by ICF was Local Area Co-ordination (LAC)/Local Community Co-ordination (LCC). This is a long-term and preventative approach, to supporting people (both adults and children) who may be isolated or socially excluded and face challenges due to their age, or physical and/or mental health.

The evidence base is well-documented, and shows that LAC and LCC empower people to achieve their 8 personal well-being goals by recognising that individuals with care and/or support needs can often be supported in place by accessing the strengths within themselves, their families and communities. In Western Bay, Neath Port Talbot County Borough Council and Swansea Council subscribe to the 'Inclusive Neighbourhoods' model of Local Area Co-ordination. Bridgend County Borough Council's approach is being progressed as Local Community Co-ordination. It is recognised that there are also a significant number of Third Sector community resilience initiatives that support the prevention and well-being agenda.

2.4 Management of ICF Funding

The Integrated Care Fund has been a key enabler in the development of a variety of innovative schemes, at the same time strengthening the partnership arrangements. Priority has been given to regional schemes, with local delivery, for revenue funding, which enables a consistent approach across the region. Robust process has evolved for prioritising and approving revenue and capital applications, utilising multi-agency panels which includes finance and service representatives across the 3 local authorities, the health board and third sector. Approval via the Western Bay governance has ensured visibility and transparency of the decisions made, with final endorsement at the Western Bay Regional Partnership Board (RPB).

A set allocation of revenue funding has been allocated to the Third Sector for the last few years through a small and large grant scheme. The Western Bay Programme Office administers the large grant scheme and the small grant scheme is administered by SCVS. The small grant scheme has been amalgamated with ABMU changing for the better large and small grant scheme, which has meant that organisations only have one process and application form to utilise for both schemes. Multi-agency panels are utilised for the large and small grant applications. During 2017/18 two ICF workshops have been organised in order to give the opportunity for all the project leads to have open dialogue to talk about the application process and more importantly the outcome measures they were collecting and reporting on, with a view to moving towards a more consistent approach. It was also an opportunity to share best practise not only within the region but also by inviting other regions, to share their best practise schemes.

3. Enablers

3.1 Welsh Community Care Information System

Bridgend County Borough Council were the first organisation to implement WCCIS not just in the Western Bay Region but also across Wales. Consequently, the Region in 2016 signed up to a Business Case that committed the organisations in the region to implementing WCCIS to deliver the agreed vision which is:

"To enable the delivery of integrated health and social care services through transformational change to better deliver high quality, person centred care through the implementation of Welsh Community Care Information System (WCCIS) ensuring the system is safe and effective; with people receiving the right care, at the right time, in the right place, from the right person."

This vision statement confirms the benefits of WCCIS working across Health and Social Care and was deemed to be a critical enabler to support the delivery of integrated services. As a consequence of the Regional ambition and the availability of dedicated ICF Funding, the Region developed a Regional WCCIS Implementation Team that consists of three posts and were employed during 2017/18. The Regional WCCIS team have worked with each of the four organisations in Western Bay and most notable, they have undertaken a Proof of Concept pilot project in the Bridgend Community Reablement Team based in Trem Y Mor to evidence how WCCIS can benefit an integrated team of health and social care workers. This work is being phased across a range of Reablement community health workers and is proving to be of significant value not just to Trem Y Mor, but to the wider region and due to the learning presented by the structured evaluation, is also proving of national interest and benefit.

3.2 Workforce Programme

Following the Regulation and Inspection Social Care Act 2016, the Facilitation Grant is employed by Western Bay to augment current engagement activity across Western Bay and to ensure all stakeholders have an opportunity to engage: inform and critique on the wide number of changes relating to that are currently under consultation. This work is coordinated though the Workforce Steering Group which is chaired by the Lead Director for Western Bay. It will enable communication processes to be more robust and facilitate cooperation and joint working; building on current activity and relationships. It is essential to keep provider organisations well informed and connected, fully aware of the considerable changes taking place and the effect of these changes will have on the expectations of service delivery going forward.

3.3 Other Partnership Bodies

In addition to current work programmes, other regional Partnership Bodies and services have been developed, that have their own discernible Action Plans and Governance arrangements and should be referenced separately. This includes:

- Western Bay Safeguarding Board
    - Adult Business Plan
    - Children's Business Plan
- Western Bay Area Planning Board (Substance Misuse)
- Western Bay Youth Justice and Early Intervention Service (IFSS) Management Board – to oversee the Annual Youth Justice Plan
- Western Bay Supporting People Regional Collaborative Committee
- Western Bay Adoption Service
- ABMU Mental Health and Learning Disability Commissioning Board – which has membership from across Western Bay partners

4. Identification of Regional Priorities

This Area Plan sets out how the Western Bay Regional Partnership Board (RPB) will respond to the findings of the Western Bay Population Assessment published on the 1st April 2017, which captured the health and social care needs of people across the region. It explains how the Western Bay Local Authorities and the Health Board, with partners, will address the requirements of the Social Services and Well-being (Wales) Act 2014. It is the first time an Area Plan has been prepared.

The main focus of this Plan is on the RPB priorities for regional and integrated working between health and social care, and includes the following themes:

- Older People
- Children and Young People
- Mental Health
- Learning Disability and Autism
- Carers (cross-cutting theme)

These priorities are being addressed as Regional priorities and therefore form part of the Western Bay Health and Social Care Programme. Other areas of the Population Assessment (including Health and Physical disability, Sensory Impairment, Violence against Domestic abuse and Sexual Violence, Safeguarding and DOLs and secure Estate) are being addressed by Local Authorities and the Health Board, or associated partners as part of their core business on a local basis or via existing partnerships between organisations across the region.

The Area Plan has been made available on the Western Bay website and can be located at this web page: http://www.westernbay.org.uk/areaplan

5. Examples of Successful Western Bay Programme Initiatives

The Western Bay Programme is structured around a series of projects (see **Appendix 1** – Governance Chart). The following examples are based on the programme structure and include activities under the headings of:

5.1 Community Services
5.2 Commissioning for Complex Needs
5.3 Children and Young People
5.4 Carers Services

5.1 Community Services Programme

One of the greatest pressures on Health and Social Care services arises from the growth in the number of people who are frail and elderly. The Programme is designed to identify the potential impact of demographic shift across the region in regard to delivery and affordability of services, service users personal outcomes and "what matters to them".

Western Bay has developed an ambitious programme that focuses on developing community services such as Intermediate tier of services because this is seen as a vital building block to a wider "whole systems change". The Programme is delivering substantive change to ensure consistency and availability of service across the region whilst integrating teams that work together to deliver improved outcomes for citizens.

There is clear and robust Governance to support the delivery of the Community Services element of the Western Bay programme (**Appendix 2**)

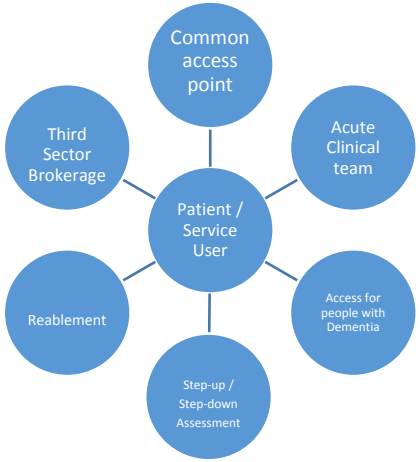
The Community Services Programme actively supports:

- The frail and elderly who are in crisis or need reablement following an episode in hospital
- Individuals and families to ensure services are enabling and 'working with' rather than people 'doing to'
- Embedding the principles of 'What Matters to me' using an integrated approach ensuring staff with the appropriate skillset are working with individuals
- Supporting and delivering only what is needed, no more, no less, doing no harm and strengthening care closer to home

Aim & Objectives of Community Services

- Plan and commission community services for older people that require a common approach and integration of Health and Social Care across the region
- The implementation of the "What Matters to Me" Model and development of core services within the wider Community Services system
- The strategic planning and commissioning of service models for community services and development of operational models with a robust performance framework for the agreed service models
- Implement the necessary operational processes and pathways across the three LA areas and Health to ensure consistency across the region
- To ensure the right support services are in place to support community service integration

Activity	Description of Workstream	Outcomes and Expected Benefits

Activity	Description of Workstream	Outcomes and Expected Benefits
Embed and evaluate the Intermediate Care optimal model	The Optimal Model of Intermediate Care comprises several key features that have been implemented across the region to ensure equity and consistency of access to services.  <u>Common Access Point</u> Access via one contact number, on the basis of that conversation, either they are offered a rapid response, advice and information or signposting, including third sector, where appropriate. Where applicable, a proportionate assessment will be undertaken to access the most suitable response or intervention. <u>Acute Clinical Team</u> A rapid response service is available through a rapid clinical response (doctor, nurse and/or therapist). The response will be within 4 hours between 8am and 8pm. The main intention of rapid response is avoiding admission where appropriate or expediting discharge.	As a result of joint commitment from all partners the integration of health and social care, which includes shared/cross management roles from both sectors, significant contribution is being made to the wider health and social care community. This has enabled service delivery which supports people to remain independent, keep well and safe in their own homes for as long as possible, and in accordance with their choice, maintaining dignity and control. The integration of health and social care is making a significant contribution to the wider health and social care community as a result of the joint commitment delivering improved community services enabling: • Support for people to remain independent and keep well; • More people to be 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;

Activity	Description of Workstream	Outcomes and Expected Benefits
	Access for people with Dementia A rapid response access pathway for a person with dementia that needs support from a mental health professional during a crisis. Step-up/Step-down Assessment A package of care lasting up to 6 weeks, commonly in an individual's usual residential setting, which provides care and support to maximise independence. This would normally be offered where support is needed to avoid hospital admission, or when someone needs intensive support upon discharge from hospital. Reablement Reablement focuses on helping people to regain skills that they may have lost, due to hospital admission or illness. A package of care lasting up to 6 weeks which may include both health and social care interventions to address the client's individual needs. Third Sector Brokerage A third sector representative who operates as part of a Common Access Point to provide alternative solutions where statutory support is not needed. Integrated services are underpinned by a Section 33 pooled fund agreement between constituent partners, reflecting robust governance arrangements. Investment in the services is significant on an annual basis from all partners from core funds and is enhanced by the Integrated Care Funding which has created an opportunity	• 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. • An independent external evaluation in 2017 demonstrated that integrating health and social care as Western Bay have, along with the introduction of intermediate care services has improved outcomes for older people (Embedded document: Cordis Bright Evaluation)  Cordis Bright Western Bay Interme • This review conservatively estimated , in June 2017, cost avoidance of £4.9m through reductions in use of hospital beds, home care packages and care home placements; also in excess of £769k due to reductions in unscheduled admissions for people aged 65+ • Case studies available via the Western Bay Area Plan (Hyperlink: http://www.westernbay.org.uk/wp-content/uploads/Western-Bay-Area-Plan-Full-Version.docx.pdf; p13-14) • Agreed key performance indicators are in place across the partnership and are reported on a monthly basis, cumulating with a formal presentation to the Community Services Planning and Delivery Board each quarter. Analysis of these indicators

Activity	Description of Workstream	Outcomes and Expected Benefits
	to accelerate service redesign and develop new ways of working.	supports the Western Bay ambition of continuous improvement to service delivery and more importantly ensuring that we are achieving better outcomes for the citizens of Western Bay.
Introduce and embed Anticipatory Care Planning (ACP) Approach	Anticipatory care is a way to enable multi-disciplinary teams to focus on the most vulnerable in the community and manage care holistically; it asks the teams to consider who they are most worried about. The model was initially adopted from a 'Proof of Concept' pilot in Torbay which demonstrated a reduction in hospital and residential care home admissions. The principles of this approach have been adopted consistently across the region and developed to address need relevant to the local population.	Taking a multi-disciplinary approach to decision making has resulted in improved and proactive communication across services, which include: The Welsh Ambulance Service Trust; Out of Hours GPs and Mental Health colleagues. The approach has been a vehicle for improving integration of community teams including integration across multi-disciplinary teams. Following a pilot, the principles of Anticipatory care have been embedded in community service teams and is now part of core service delivery. Contingency plans are being developed for the most vulnerable older people across Western Bay, enabling them to stay safe and independent in their own communities for as long as possible. Plans are in place to link contingency plans to carers assessments and to explore the contingency planning section within WCCIS, to enable plans to be easily shared across all Health and Social Care disciplines who may come in contact with individuals.
Commissioning Strategy for Care Homes for Older People 2016-2025	Over the past 5 years, the care homes market has become increasingly complex, with a number of different challenges, such as demographic changes, closure of homes, homes not	To commission care homes that support independence, choice and wellbeing in a person-centred and responsive manner providing high quality services across Western Bay

Activity	Description of Workstream	Outcomes and Expected Benefits
	meeting quality thresholds and increasing numbers of older people with complex needs. All four organisations across Western Bay have approved and signed up to the Implementation of the Western Bay Commissioning Strategy for Care Homes for Older People 2016 - 2025. The strategy envisages an environment that actively promotes choice and control, underpinned by robust quality assurance tools ensuring the delivery of effective, positive outcomes. It seeks to ensure that residents can access to information and advice, including advocacy, to make informed choices. A Pooled budget for care homes for older people is required as stated in the Social Services & Wellbeing (Wales) Act. A sub group is working across all 4 partners to develop an agreed approach to a pooled fund for care homes as directed.	Western Bay Commissioning Strategy for Care Homes for Older People 2016 – 2025 has been developed which will enable: • Better access to care home services most suitable to people's needs. • Increased choice for service users • Consistent high levels of quality standards for service users • Increased independence for service users • Services that offer value for money • An effective and sustainable care home market • Attract high quality care home providers to the Western Bay area Pooled funds will achieve the highest quality of care with service users being at the heart of service planning, commissioning and delivery. Pooled funds and resources will enable Western Bay to deliver maximum impact to improve outcomes for residents.
Develop a Western Bay Domiciliary Care strategy	An independent Domiciliary care position statement was commissioned in 2017 to identify prospective common values and principles for adoption by all partners to support a sustainable domiciliary care market across the Western Bay region; from this key actions were identified and form the work plan of a task and finish group: • Workforce development • Commissioning and Contracting	Improved understanding of the domiciliary care market Agree key indicators and a framework to asses domiciliary care delivery Improved understanding of the recruitment and retention of domiciliary care staff Improved sustainability of domiciliary care market as part of a whole system approach

Activity	Description of Workstream	Outcomes and Expected Benefits
	• Promotion of partnerships	

5.2 Commissioning for Complex Needs Programme

Aims and Objectives

- To effect a sustainable and efficient 'practice to commissioning' methodology across Western Bay which commissions high quality health and social care services which are proportionate to need and are cost effective.
- To enable sharing and coordination of information, intelligence and planning together in service areas of common interest.
- To help partners shift front line practice towards the requirement of the Social Services and Well Being Act 2014

The expected benefits of the programme overall are:

- Ensure Better quality services (local authority and health) for vulnerable adults addressing the implications for commissioners of the Winterbourne Review.
- Clear and better outcomes for service users.
- Better value for money for both local authorities and health services.
- The development of a robust market that is able to meet current and future needs of people using the services.

The Workstream for the whole Programme can be found in **Appendix 3**

Activity	Description of Workstream	Outcomes and Expected Benefits
Outcome Focused Commissioning – Adults with Complex Needs	The Workstreams principal aim is to address any irregularities in the quality of commissioned care across the region. This involves fostering positive, co-productive relationships with care providers, with the ultimate aim of	The Programme's process for reviewing packages of care is wholly outcome-focused, which has made a significant difference to the lives of many, and has helped build stronger and more productive working relationships with care providers.

Activity	Description of Workstream	Outcomes and Expected Benefits
	increasing the independence of service users, and supporting them to achieve their personal well-being goals. The ethos is one of true collaboration that puts the person at the centre of service planning and delivery. Care providers work closely with representatives from health and social services to create bespoke, outcome-focussed packages of care for each individual. This methodology encourages progression, which empowers people to support themselves, become less reliant on services in the longer term, meaning cashable savings are also realised. Reviewing existing and devising new packages of care for individuals both in residential or supported living placements whose needs are complex. The aim of each review is to ensure that the individual receives services that enable them to live as independently as possible. Each review involves both health and social care staff as the majority of cases reviewed are jointly funded. The team of 'outcome-focused assessors' comprises senior social workers, nurse specialists and contract officers funded by the Welsh Government's Integrated Care Fund. This team also calls upon staff from across the region such as health care support workers, occupational therapists, clinical psychologists and psychiatrists. This Workstream is also a regional priority identified in the Area Plan and Action Plan for Western Bay	Here are some examples of how the Programme has benefitted individuals and providers alike: • Case Study Ali's Story – **Appendix 4** • Case Study Z's Story – **Appendix 5** • Case Study David's Story - www.youtube.com/watch?v=YsfrJh2nnyE • Total savings across Health and Social Care since programme inception in September 2014 is **£3.9m – Appendix 6** • A quarter of the overall care packages have been reviewed by the Commissioning for Complex Needs team. This joint working approach has enabled individuals to have progressive care plans that support them to live as independently as possible. The holistic "home" review of all the individuals in a property has allowed economies of scale to be driven thus allowing the Programme's partners to make cash savings as a result of recommissioning care whilst also looking at providing alternative solutions. • The Team have created their own process methodology (**Appendix 7**) and forms which they follow and complete for each assessment, that take account of the Health Needs along with identifying Outcomes for each individual reflecting the National Outcome Indicators, linked to the Social Services and Well Being Act 2014 • There is still a constant flow of individuals requiring a residential placement. To this end, the collaborative came together to coproduce a more efficient and effective way of commissioning known as the "**Brokerage Service"**, the aim of which is to

Activity	Description of Workstream	Outcomes and Expected Benefits
		commission appropriate placements for individuals to progress, whilst ensuring value for money. A panel of health and social care practitioners review and endorse these placements. **Looking to the future…** • As a result of the work to date, we are ambitious to develop the market to meet people's outcomes in a different way. Work is ongoing to identify more opportunities for progression and to develop new and more imaginative ways to support individuals. • A significant challenge is evidencing how lives have been changed for the better. Measuring positive outcomes for people who are non-verbal or lacking in capacity can be difficult to demonstrate, but we are working to overcome this by establishing relationships and maintaining a dialogue with family members, carers and professionals involved in arranging or delivering a person's care making for a truly integrated and co-productive approach.
Outcome Focused Commissioning – Children with Complex Needs	Linked to the Children and Young Peoples Programme	
Brokerage for Mental Health and Learning Disability Residential and Nursing Placements	Provide a Brokerage Service Individuals who have either mental health issues and / or learning disabilities who require a new placement in a residential or nursing home. This Workstream is also a regional priority identified in the Area Plan and Action Plan for Western Bay	• This service has improved the sustainability of new placements and improved the progression of individuals. An example of this can be seen through the case example of Mr Z in **Appendix 5** – who has entered the brokerage service after a period of time in hospital, the "brokerage service" sought a residential placement that was to offer him a quick progression route to independent living. Mr Z is now living in independent living

Activity	Description of Workstream	Outcomes and Expected Benefits
		• A process methodology for the "Brokerage Service" (**Appendix 8**) was designed by the team along with an Assessment Form designed to support staff in demonstrating the outcomes expected for each individual. Each provider responds informing the Multi-Disciplinary Group how they will meet the outcomes and needs of the individual • Providers have welcomed this process and form as quoted: *"Effective joint-working is an absolute must in this business, and the process is a good means of facilitating this. It's a structured and supportive way of managing a person's progression and helping them take steps to build their confidence and live more independently.* *The 'outcome-based' approach helps us focus on what drives the person and allows us to work closely with other services to formulate a package of care that meets their needs, while also providing them with opportunities to develop their skills and gradually become more self-sufficient.* *The process enables us to track a person's progress and highlight key achievements. It also makes us as care providers think about what we're doing and why we're doing it.* *The ultimate aim is to support someone to live a happy and productive life, and the process helps bring services together to make this a reality".* • Total cost avoidance via Brokerage since September 2014 is **£1,119,041.** This has been achieved through ○ 113 Cases have entered Brokerage Process since Sept 2014 ○ 57 individuals have been placed via the brokerage system

Activity	Description of Workstream	Outcomes and Expected Benefits
		○ 27 cases are in progress where placements are being sourced ○ 29 cases were removed from the list, as they no longer required a residential or nursing placement. This has been due to the individuals becoming unwell or being placed in in house services.
Optimum Model for Commissioning Mental Health and Learning Disability Care	This Workstream is designed to plan and implement the methodology and lessons learned through the experiences of the Outcome Focused Commissioning – Adults with Complex Needs Workstream. This Workstream is also linked to the Implementation of the Mental Health Strategic Framework which is a regional priority identified in the Area Plan and Action Plan for Western Bay.	This Workstream is in its infancy and a high level overview of potential Workstreams such as the ○ Development of an Operation Model ○ Development of Regional Commissioning ○ Development of a Single Entry Point to the Service has been presented, which is with senior officers across the region for comment.
Joint Funding Matrix	A draft matrix has been developed to provide guidance for clear decision making around funding splits between partners for individuals within the Mental Health & Learning Disability service areas. This Workstream is also a regional priority identified in the Area Plan and Action Plan for Western Bay	A collaborative group across Western Bay with Health and Social Care staff have devised the draft joint funding matrix tool. The tool is currently being evaluated by Swansea University to ensure academic validity. The expected benefit of the tool is that each partner across the region will have a method for making clear funding decisions which do not impede any progress of care for individuals.
Regional Quality Framework (RQF)	In care homes for older people, the quality of life and care of its residents must have priority. All users of care services deserve the best services in supporting them to enjoy the best quality of life they can.	• To monitor and support providers so that they may achieve the best quality of life in care homes in a way that improves outcomes for individuals and follows the ethos of My Home Life and the principles of person/ relationship centred care.

Activity	Description of Workstream	Outcomes and Expected Benefits
	The Western Bay Collaborative covers the local authority areas of Swansea, Neath Port Talbot and Bridgend. The development of the RQF included officers and staff from care home providers, local authority contract and commissioning officers, Care and Social Services Inspectorate Wales (CSSIW), My Home Life and Abertawe Bro Morgannwg University Health Board. This Framework and supporting Toolkit provides incentive for continuous improvement and striving for excellence in care homes for older people. This document is an integral part of how the Western Bay local authorities assess the quality of care within care homes and a part of the contract between those organisations. This Workstream is also a regional priority identified in the Area Plan and Action Plan for Western Bay	• Using a Gold Silver Bronze (GSB) grading system, providers are and will be able to utilise their own quality assurance tools e.g. annual reports, satisfaction surveys etc. • Incentivise continuous improvement and the adoption of recognised best practice by care homes. • Monitor quality of service in care homes in a robust and consistent manner. • Provide a basis for partnership between care home providers and local authority/ health board commissioners to work together to improve quality. • Help individuals make informed choices between providers and provide information to professionals and agencies about the quality of care and support being provided.
Regional Review of Unmet Need within Mental Health Managed Care	Both the Commissioning for Complex Needs Programme Board and the Mental Health and Learning Disabilities Commissioning Board, commissioned Alder Advice to review Unmet Need in Mental Health services across the Region. The aim of the report was to identify gaps in the system of care and support against this vision. The scope only covered 430 people from Western Bay who have complex mental health needs and are either jointly supported by ASC and ABMU Multi-Disciplinary Community Mental Health Teams (CMHT) or are supported in NHS low or medium secure settings.	Senior staff from across health and social care in Western Bay articulated a future vision for mental health care and support as "having *an integrated "Whole System" of care and support that consistently focuses on enabling recovery and maximising independence, while keeping people safe during acute mental health episodes*". This report provided a position statement on mental health services available across Western Bay as at 31st January 2017. It quantified unmet need and recommend the steps needed to achieve a more cost effective "*Whole System*"

Activity	Description of Workstream	Outcomes and Expected Benefits
	This Workstream is also linked to the Implementation of the Mental Health Strategic Framework which is a regional priority identified in the Area Plan and Action Plan for Western Bay.	of care and support for adults living with or recovering from mental illness in Western Bay. Western Bay will be using the data and recommendations from the report to inform the Western Bay Strategic Mental Health Framework Implementation.

5.3 Children and Young People's Programme Board

Aims and Objectives

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

It should be noted that the programme has been evolving over the last year and was established as a full programme of work in April 2018 in order to provide governance and to manage the inter-dependencies across the whole Western Bay Programme – Appendix 9

Activity	Description of Workstream	Outcomes and Expected Benefits
Outcome Focused Commissioning – Children with Complex Needs	The Workstreams principal aim is to address any irregularities in the quality of commissioned care across the region. This involves fostering positive, co-productive relationships with care providers, with the ultimate aim of increasing the independence of service users, and supporting them to achieve their personal well-being goals. The ethos is one of true collaboration that puts the person at the centre of service planning and delivery. Care providers work closely with representatives from health and social services to create bespoke, outcome-focussed packages of care for each individual. This methodology encourages progression, which empowers children to develop skills that enable them support themselves as they become adults and ensure that they are able to be less reliant on services in the future.	The methodology was developed in line with the processes and paperwork that has been used in the Outcome Focused Commissioning for Adults with Complex Needs since 2014. **Appendix 7** • To date 19 assessment are complete and a further 7 assessments are timetabled for April and May. • The programme has identified a number of areas that require further investigation and the knowledge gained to date will be shared with the teams supporting the children and the Children's Commissioning Consortium Cymru (4'C's). Examples of the finding are: ○ Discrepancies between 1 to 1 commissioned hours and the services being delivered/identified

Activity	Description of Workstream	Outcomes and Expected Benefits
	Reviewing existing and devising new packages of care for children in residential living placements whose needs are complex. The aim of each review is to ensure that the child receives services that enable will enable them to live as independently as possible in the future. The team of 'outcome-focused assessors' comprises senior social workers, nurse specialists and contract officers funded by the Welsh Government's Integrated Care Fund. This team also calls upon staff from across the region such as health care support workers, occupational therapists, clinical psychologists and psychiatrists. This Workstream is also a regional priority identified in the Area Plan and Action Plan for Western Bay	○ Information flow between partners and providers ○ Having the ability to review packages across the partnership has provided us with a collective view of all issues such as the reporting of incidents. ○ Charges for some aspects of care are higher than we pay in Adult Services ○ In some cases recreational provision and costs are not utilised by the children **Looking to the future…** • Development of regional workshops / session to share the finding of the project, with all staff that have input into a child's placement.
Multi Agency Placement Support Service (MAPPS)	Development of MAPSS (Multi Agency Placement Support Service), a multi-disciplinary team that aims to help children with, or at risk of mental illness and emotional and behavioural difficulties by providing specialist placement support and therapies The Workstream is looking to have a team of staff consisting of: Lead Clinical Psychologist; Clinical Psychologist; Team Manager; 3 x Consultant Social Workers; 2 x Therapist's; 2 x Family Support Workers This Workstream is also a regional priority identified in the Area Plan and Action Plan for Western Bay	Staff continue to be recruited to post, however to date a number of outcomes have been achieved including 32 children have been referred into the MAPPS service with each of them identified to receive therapeutic interventions. The following benefits are expected as the service develops: • Improved placement stability for looked after children: • Improved educational stability: Reduction in the number of looked after children subject to school exclusion and number of looked after children

Activity	Description of Workstream	Outcomes and Expected Benefits
		changing school for reasons other than normal transition • Improve the capacity and ability of in-house fostering services to meet the needs of our looked after children
Continuing Care for Children with Complex Needs	The arrangements for funding children and young people with complex needs has become increasingly problematic, particularly in the current economic climate where Health, Education and Social Care are finding their budgets challenging and children are presenting with increasingly challenging needs.	The aim of this project is therefore to review the current arrangements, and in the light of good practice, and the implications of the Welsh Government legislation in relation to the funding of children and young people with complex needs, to determine whether any changes would enhance/simplify the current systems and processes.

5.4 Carers

Vision – Valuing Carers 2016 – 2018 Western Bay Carers Partnership Board

Our vision is that all Carers, irrespective of age and situation, should be supported throughout their time as a Carer, given information when they need it and in a way which meets their needs and be full partners in the planning and provision of care and support for those they care for...

Western Bay (previously ABMU) Carers Partnership Board has been meeting since 2012. The Board comprises representatives from Bridgend, Swansea and Neath Port Talbot local authorities, ABMU Health Board ABMU Carers Champion, Managers of Swansea, Bridgend and Neath Port Talbot Carers Services, County Voluntary Services Health and Well-being Facilitator and the Regional Programme Director, Western Bay. This board reports directly to Leadership Group and Regional Partnership Board.

Aims and Objectives

- Building on the progress achieved as a result of the Valuing Carers Strategy
- Maintaining the momentum of Carers awareness
- Providing a framework for partner organisations to respond to Carers within the remit of the Social Services and Well-Being Act 2014 (Wales)

Transition Plan 2016 to 2018– Expected Outcomes for Carers in the ABMU area

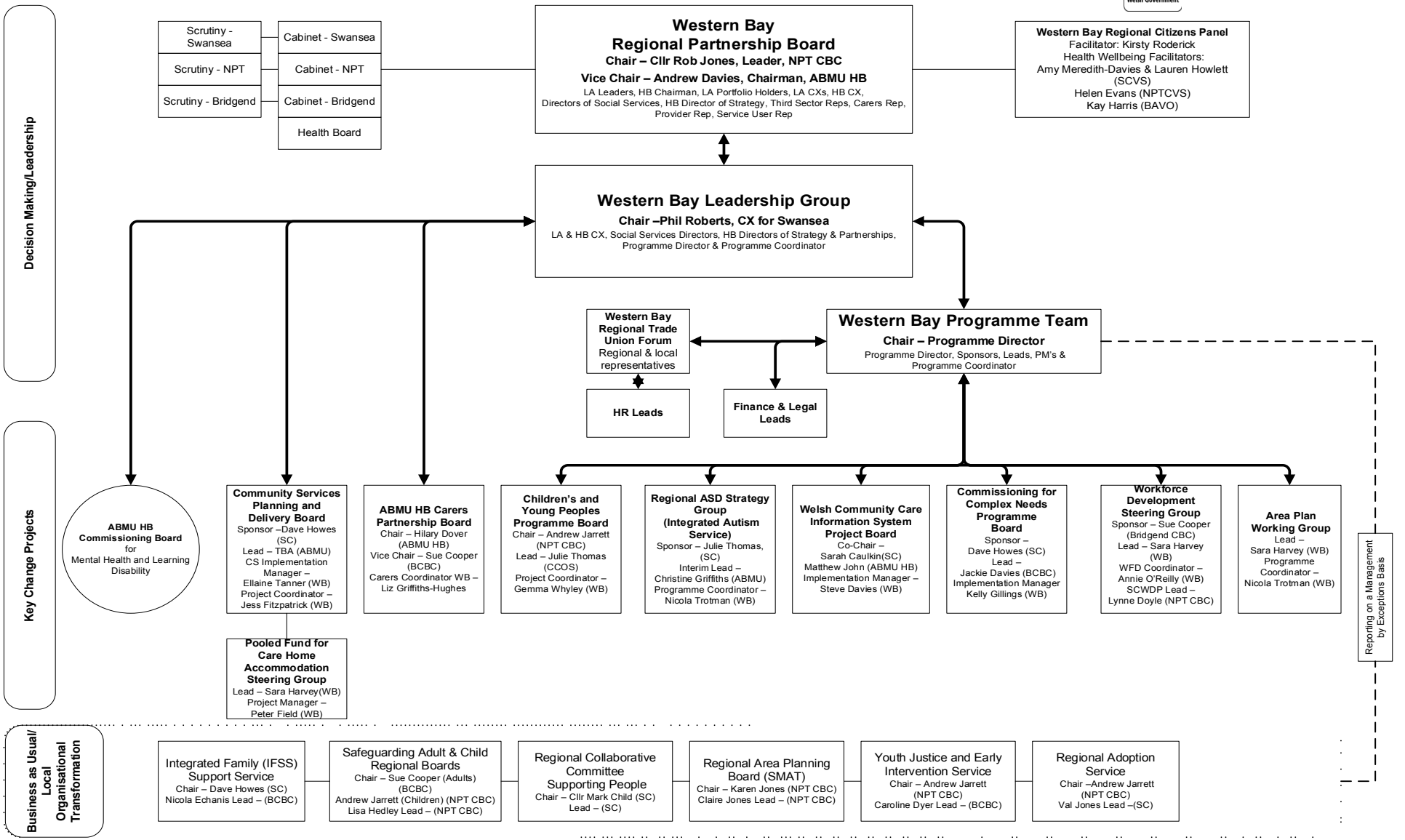
- Carers can access up to date information at the right time and from the right place.
- Carers are identified by staff who recognise their needs, provide them with appropriate information and signpost them to relevant services.
- Carers are engaged and consulted regarding any decisions made during their journey through health and social care services that affect them or the person they care for.
- All Carers are offered a Carers Assessment ensuring their needs are identified and addressed.
- Young Carers are identified and provided with appropriate information, assessment and support.

Activity	Description of Workstream	Outcomes and Expected Benefits
Work strategically on Carers 'agenda' across sectors.	The Carer's Board oversee the development and Implementation of a regional strategical plan for Carers. Four subgroups are tasked with provide direction and oversight for the Training, Young Carers, Performance and Finance and Transition/ Strategic work streams.	Expected benefits - *Strengthening the partnership approach at a regional level* Third Sector organisations are actively involved strategically in working with health and Local Authority colleagues on the Carers Partnership Board and subgroups. Close partnership working enables the sharing of best practice when delivering services to Carers and Young Carers. A part-time Western Bay Carers Co-ordinator has been employed to work with partner organisations in delivering the Carers Partnership Board strategic Plan. The post holder is an employee of Bridgend Association of Voluntary Organisations (BAVO) and is based in the Western Bay Programme Office.
Carers Service/ Carers Centre staff attend ABMU Hospitals	Neath Port Talbot Carers Service, Bridgend Carers Centre and Swansea Carers Centre attend hospitals within ABMU. Carers hospital workers staff information stands in public areas of the Hospitals and /or visit wards.	Expected benefits – *Carers can access the right information at the right time.* Carers are provided with or signposted to information, advice and assistance. During the first three quarters of 17/18 over 1500 Carers had contact with either a Hospital or CRT worker. "I attended an appointment and was able to speak to the *(Carers)* Hospital Worker; she gave me advice on benefits and put me in touch with someone from the Carers service/centre. I am now having a Carers assessment" <u>Future developments</u> Western Bay Carers Partnership Board plan to focus on supporting more Carers through the discharge process as highlighted in the 'Carer Friendly Wales' priorities.

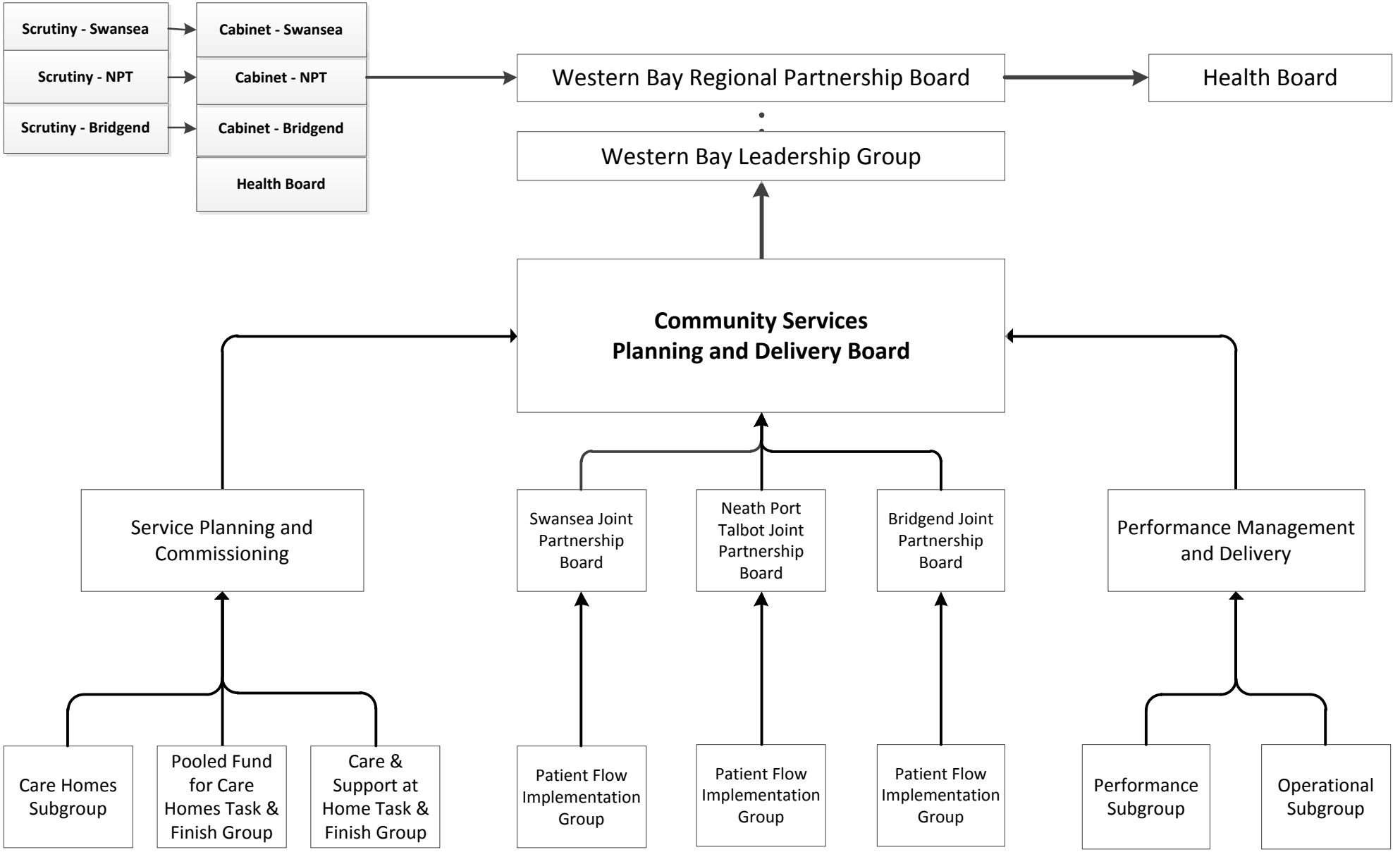
Activity	Description of Workstream	Outcomes and Expected Benefits
Carers Service/ Carers Centre GP liaison	Neath Port Talbot Carers Service, Bridgend Carers Centre and Swansea Carers Centre have contact with Primary Care practices in ABMU. Contact is maintained through regular e-mail newsletters, visit to practices, staffed information stands. Carers Service/ Centre staff have been invited by some practices to Practice Time for Learning sessions and to be available to provide information at Flu inoculation sessions. In addition Carer Service/ Centre information is provided on screen.	Expected benefits – *Carers are identified by staff who recognise their needs, provide them with appropriate information and signpost them to relevant services*. Carers Awareness is maintain with primary care staff. 'There has been a lot of interaction with primary care, making the services available *(to Carers)* widely known and accessible' <u>Future developments</u> Western Bay Carers Partnership Board plan to develop work with Primary Care in line 'Carer Friendly Wales' and priorities. In addition the new Social Care Wales e-learning programme will be promoted.
Regional Events for Carers and Young Carers	ABMU Carers Partnership Board and partners organise regional events for Carers and Young Carers, which provide a platform for carers to 'have a say' and receive information and updates on progress. Regional Carers Event - The focus of the event held on 16th June 2017 was the Social Services and Well Being (Wales) Act 1 year on and the progress being made with the ABMU Carers Partnership Transition Plan. Regional Young Carers Event – 'You said… we did'. The event included a presentation about the things Young Carers and Young Adult Carers have said during consultations and what has been done in response. In addition a speed briefing session where Young Carers and Young Adult Carers could share their views with a range of people including elected members, Senior Social Services Officers and Carers Champions.	Expected benefits - *Carers are engaged and consulted regarding any decisions made during their journey through health and social care services that affect them or the person they care for*. More than 70 Carers and staff from across the Western Bay area came together on Friday 16th June 2017.A number of common themes emerged as to why delegates found the event useful include being able to access information …a chance to network …having an overview of developments and the work being done locally; an opportunity to share views during the afternoon roundtable discussion. Young Carers Event was attended by 50 young carers and young adult Carers from Bridgend, Swansea and Neath Port Talbot.

Activity	Description of Workstream	Outcomes and Expected Benefits
		Today benefitted me as we spoke about the pros and cons of being a young carer
Young Carers Schools Projects	Action for Children Young Carers Project Bridgend and YMCA Swansea Young Carers Project have been working in Bridgend, Swansea and Neath Port Talbot with the aim of increasing awareness of young carers and the needs of young carers in primary, secondary and sixth form school as well as colleges. The projects have been delivering PSE lessons, assemblies, train the trainer sessions, supporting young carers champions and assisting in the development of young carers groups in schools.	Expected benefits - *Young Carers are identified and provided with appropriate information, assessment and support.* 22 staff members have been involved in training the trainer. 127 Young Carers have received one to one support. <u>Future developments</u> Western Bay Carers Partnership Board plan to consolidate the work of the Young Carers Schools project by agreeing a set of core information materials for Young Carers.

Western Bay Health & Social Care Programme Governance Structure v14 (February 2018)



Appendix 2 – Community Services Governance Structure



Commissioning for Complex Needs Programme Board

KEY
Key Projects
Supporting Work

Commissioning for Complex Needs

For Younger Adults and Children across Western Bay

Programme Lead – Jackie Davies

Programme Sponsor – Dave Howes

Programme Implementation Manager – Kelly Gillings

Outcome Focused Commissioning Adults with Complex Needs:	Outcome Focused Commissioning Children with Complex Needs:	Brokerage for MH & LD Residential and Nursing Placememts:	Optimum Model for MH & LD Care (Embedding the Process):	Regional Supported Living Framework Review and Coordination	National Integrated Health and Social Care for MH & LD Residential Placements (CCAPS):	Funding Splits Matrix and Plan for MH &LD:	Regional Quality Framework:	Unmet Need in Mental Health:
Lead – Jackie Davies PM – Kelly Gillings Support – Mel Blake	Lead – Andrew Jarrett PM – Kelly Gillings Support – Emma Jones	Lead – Jackie Davies PM– Kelly Gillings Support – Mel Blake	Lead – Jackie Davies PM – Kelly Gillings Support – Mel Blake and Emma Jones	Lead – Kelly Gillings P Cord – To be filled (G9) Procurement – TBC Support - TBC	Lead – Jackie Davies PM – Kelly Gillings	Lead – Mike Sullivan PM – Kelly Gillings Support: Mel Blake	PM – Kelly Gillings In Transit to Care Homes Sub Group	Lead – Mike Sullivan PM – Kelly Gillings
Key Activities Complete Outcome Focused Assessments Identify individuals for move on Gather Case Studies Just Checking	**Key Activities** Recruit Staff Complete Outcome Focused Assessments	**Key Activities** Ensure the brokerage process is followed Locate placements for individuals Obtain costs for placements Complete Placement	**Key Activities** Organise an Expert Group to develop an Optimum Model Develop an Implementation Plan for the Optimum Model Implement the Optimum Mode Service User Engagementl	**Key Activities** Develop a JD for the Coordinator Recruit Staff Review Lessons from previous close to home framework Develop a new Close to Home Framework Coordinate placements to be made on the framework Analyse future requirements	**Key Activities** Obtain approval for the first phase Business Case Complete a Brief for the Senior Officers to take through WB Governance and to Cabinet If approved develop an implementation plan Maintain engagement with the National Project	**Key Activities** Develop the Matrix Develop guidance on the use of the matrix Obtain approval for the matrix and guidance Develop an implementation Plan Transition to Live (Business as usual)	**Key Activities** Finalise the Updated RQF with Provider Groups and WB Governance Finalise the regional questionnaires Transition to Live (Home Care Community Services Group)	**Key Activities** Obtain the data required for the report Receive the Unmet Need in MH Report (alder) Present the report to Senior Officers Develop an Implementation plan based on Recommendations
Key Outcomes / Measures Number of outcome focused care plans in place Number of placements with clear costing structures	**Key Outcomes / Measures** Number of outcome focused care plans in place Number of placements with clear costing structures	**Key Outcomes / Measures** Number of placements made by the brokerage service	**Key Outcomes / Measures** Optimum Model Agreed and Embedded across the region Number of social care and health staff shadowing outcome focused assessors Number of outcome focused assessments completed since shadowing/training	**Key Outcomes / Measures** Existing Framework Agreed New Framework in place including Performance Management Number of placements co-ordinated via Western Bay	**Key Outcomes / Measures** Report Approved Number of placements made on the Framework Number of providers engaged with the framework	**Key Outcomes / Measures** Matrix and Governance Approved Matrix and Governance Implemented Number of cases assessed for funding via the matrix	**Key Outcomes / Measures** RQF update approved RQF handed to Community Services Programme Board for Governance	**Key Outcomes / Measures** Implementation plan created Commissioned Services within MH have been enhanced to offer more choice

Key Outcomes / Measures across Programme

Savings target of £1,000,000 achieved in 2017/18

Better Outcomes for Individuals, evidenced by Case Studies

CONTRACTING & PROCUREMENT: OUTCOME-FOCUSSED ASSESSMENTS

Case Example: Ali's Story

Ali has been known to services since 1990 and has been in her present residential placement since July 2015 after residing alone in a house owned by a trust. The house fell into a state of disrepair and Ali moved into a respite facility while work was carried out on the property. Due to a number of care and support needs being identified during her time in respite, she did not return to the house.

Ali has a mild to moderate learning disability, suffers from diabetes and also has some autistic traits. She has been known to be verbally aggressive, and has lashed out at another tenant on one occasion. Her type 2 diabetes is managed with medication, but she tends to make poor choices in terms of her diet.

Her mobility is also poor and she requires a walking aid to get around safely. The accommodation layout can be challenging as there are a number of steps to negotiate in the kitchen and in the outdoor area.

Miss E requires 1-1 support in the community (primarily due to her mobility), and 1-1 assistance for her personal care.

An 'Outcome-Focused Assessment' was undertaken in May 2016, which identified a number of personal and well-being goals for Ali...

- Ali expressed an interest in gardening, but access to the garden area was limited due to her mobility issues.
- Ali wanted to get out and about more, and maybe consider participating in an activity where she could meet others in the local community
- A plan was devised to encourage Ali to make more sensible food choices, in order that her weight and diabetes could be managed more effectively
- Ali indicated that she would like to spend more time alone in the house, and would appreciate some support to achieve this.

What happened next?

A plan was put in place to help Ali work towards achieving her set goals over the next year. Her progress was reviewed in September 2017 and the following outcomes had been achieved:

- A number of raised (waist-height) planters on wheels have been brought into the garden, which can be moved around the outdoor space enabling Ali to tend to the plants with ease. She is thrilled with this outcome and has even grown lettuces, carrots and green beans.
- Ali attends a 'Time to Meet' group in the local community. The group meets on a weekly basis and members take part in activities such as board games and arts and crafts. She also enjoys a pub lunch once a week, and likes to go shopping occasionally, but states that she still tires easily so isn't able to go too often.
- Ali has lost around 14lbs in weight since moving into the residential placement in 2015. She enjoys the occasional treat, but follows a low-fat, low sugar-diet and is weighed once a week to ensure she stays on track.
- The time Ali spends alone at the property has been increased from two hours to three hours per day. She enjoys people watching from her bedroom window, which overlooks the main road.
  When alone in the house, Ali wears a lifeline pendant so she can call for assistance, if required.

These changes have resulted in a financial saving of £291.60 per week, and the plan will continue to be reviewed as Ali's progression journey continues.

CONTRACTING & PROCUREMENT: OUTCOME-FOCUSSED ASSESSMENTS

Case Example: Mr Z

Mr Z has had one hospital admission to Cefn Coed Hospital in 1979 following an episode of elation. He received ECT treatment and was not hospitalised again until May 2016 when he was diagnosed with Schizophrenia.

Leading up to his last admission, there was a marked deterioration in his mental state. Several telephone calls from a Warden at his previous residential accommodation were received explaining there had been an incident that morning where Mr Z had put an electric kettle on the cooker, which had blown the electrics in his flat. The Warden was very concerned about his safety and the safety of the other residents in the property. CRHTT became involved at this time and attempted to support him within his home, and to manage the deterioration in his mental state. The potential risks were considered too high for him to manage within his own home and he was subsequently admitted to Cefn Coed Hospital under Section 2 of the Mental Health Act 1983 (later amended to Section 3).

During this admission, Mr Z was assaulted by a fellow inpatient and required treatment at a general hospital. He was later discharged and transferred to Derwen Ward. The team carried out various assessments and queried early onset of Dementia type symptoms. Tests have shown evidence of shrinkage of the brain, and he presented with delusional beliefs and reported experiencing hallucinations.

A Section 117 and Best Interest meeting took place, where it was agreed that Mr Z would not be able to manage living independently and required a nursing home to be able to provide 1:1 support to meet his mental health and social care needs. He was also prescribed a different medication and it was agreed that he required ongoing support to monitor compliance.

A review was carried out by the ABMU Health Board case manager, who identified that Mr Z was complying with medication and symptoms were improving. Following a team review, it was concluded that a DOLs was no longer required. The home liaised with the Care Coordinator and a very gradual plan was devised to increase his independence within the community. Episodes of verbal aggression and complaints had significantly reduced. It was determined that this placement would need to be reviewed.

An 'Outcome-Focused Assessment' was undertaken in August 2016, which identified a number of personal and well-being goals for Mr Z...

- From the assessment, it was significantly clear that Mr Z's compliance with his medication has improved, along with his symptoms. His level of irritability has diminished after a few weeks.
- Mr Z identified that he felt he no longer needed care and support within a nursing home and wanted to return to independent living. Mr Z has demonstrated an excellent understanding of his illness and although he doesn't like taking medication, appreciates he needs to do so in order to remain well. He explained his only concern was his anxiety that he would be assaulted by someone with very poor mental health again.

- Mr Z explained that he missed the “simple things in life, like buttering my own toast…”. He expressed the desire to live somewhere where he had the opportunity to re build his confidence with his food preparation and cooking skills.
- Mr Z requires prompts to attend to his activities of daily living, however he explained he has no means of doing his own laundry due to lack of access to the appropriate facilities.
- Mr Z stated he wants to have more freedom, but appreciates he may need support at times to ensure everything is going well and to check his compliance with his prescribed medication/attendance at medical appointments.
- The assessment also found that Mr Z was becoming more isolated and appearing low in mood.

What happened next?

A discussion was held between the home manager and Care Coordinator. The home manager identified that unfortunately they did not have the facilities for Mr Z to prepare a basic meal, nor to attend to his laundry. They identified that he had settled exceptionally well within the 3 months and is a pleasure to have around.

The Care Coordinator feels that he has received the appropriate level of support to ensure compliance with his medication and has agreed that Mr Z is no longer appropriately placed and would benefit from a less restricted environment.

In order to achieve this:

- the Care Coordinator will look into appropriate supported accommodation and determine if any preparation is required for move on.
- Mr Z will attend Cwmbwrla Day Centre in the meantime to socialise with others and participate in activities.

Outcomes Achieved…

A discussion with the Care Coordinator in November 2017 confirmed that Mr Z has successfully moved on to a supported living property. Support is on hand to ensure he takes his medication and covered by supported funding people and his benefits.

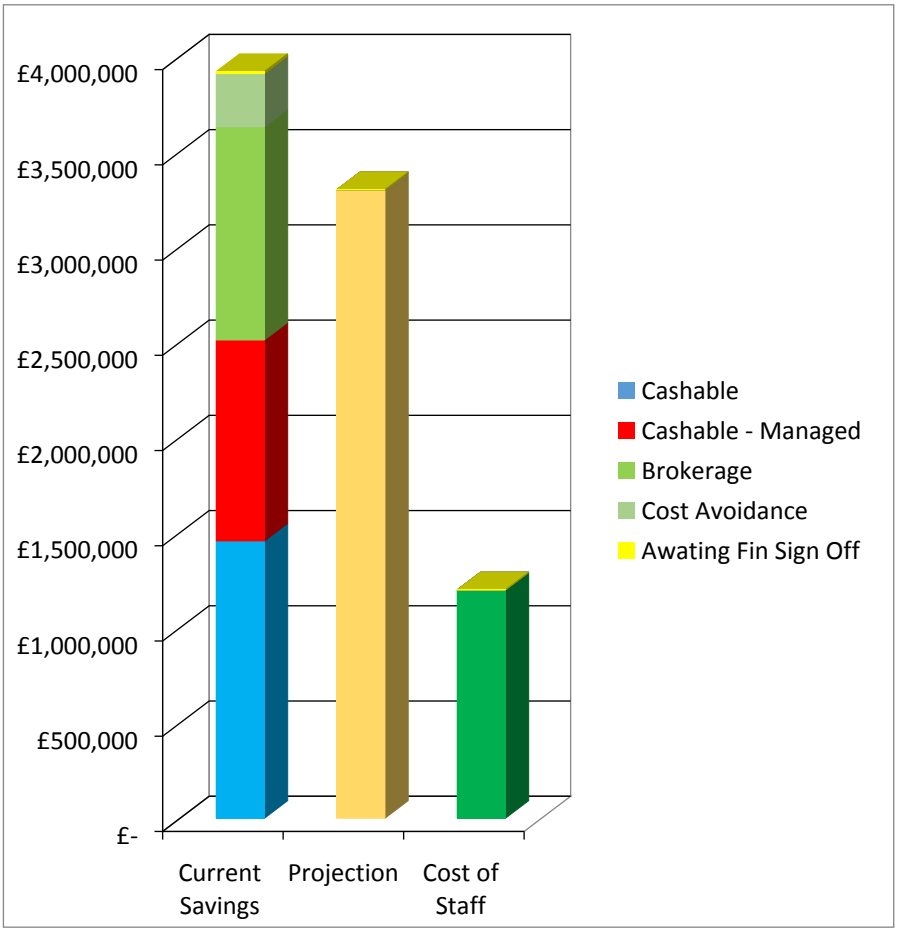
These changes have resulted in the following cashable savings:

Swansea - £139.37 per week

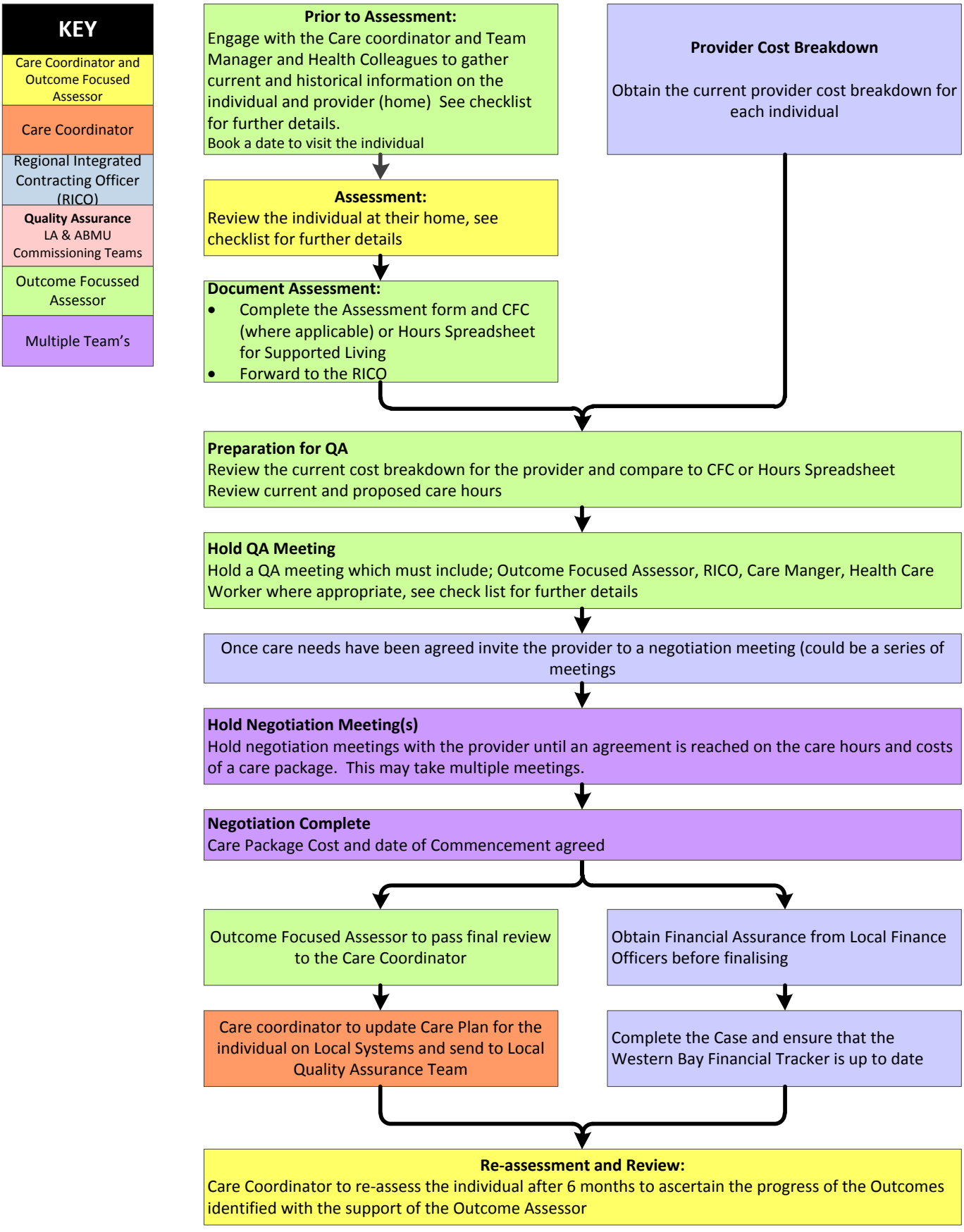
ABMU - £194.44 per week (£104.45 direct saving; £89.99 cost avoidance due to uplift request).

- Total Savings are **£3,920,588**

- £2,511,100 annual cashable savings
- £1,398,682 annual avoidance savings through the brokerage service and through avoidance of uplift to current costs.
- Between Sept 2014 and March 2016 we achieved the target of £1.3 million, even after taking into consideration that the full complement of staff was not achieved until May 2015.
- Between April 2016 and March 2017 we exceeded the target of £1m and saved £1,310,256
- Between April 2017 and March 2018 we exceeded the target of £1m and saved £1,288,941



Western Bay Outcome Focused Assessment Process



Version 1.0

Western Bay Adult Mental Health & Learning Disability Service Funding and Placement Process for Residential Care

KEY

- ABMU Commissioning Team
- Care Coordinator
- Regional Integrated Contracting Officer (RICO)
- **Quality Assurance** LA & ABMU Commissioning Teams
- Complex Case Panel
- MDT

MDT Develop Care & Treatment Plan
Identify need for care and type of care required

Care Coordinator Completes either:
Western Bay Joint Funded Brokerage From (incl S117) or the CHC/FNC Decision Support Tool
Both forms need the following supporting information

- Completed Care and Treatment Plan
- Risks Assessments
- Any Psychology or OT Reports
- MHRT report or recommendation if applicable
- i.e. if Tribunal are recommending step down to community
- Minutes of Best Interests Meetings if patient does not have Capacity or is being placed on DoLS

Is this case CHC or Joint Funded (incl s117)

CHC

Joint Funded (incl s117)

CHC Decision Support Tool and other supporting documents to be sent to the ABMU Commissioning Team rosemarie.williams@wales.nhs.uk

Consider evidence of need and ratifies CHC eligibility via scrutiny panel

- If placement is being sought brokerage form to be completed by Care Coordinator and submitted to ABMU Commissioning Team for scrutiny.
- Once review is complete and funding in principle has been agreed, the brokerage form to be sent to westernbaybrokerage@swansea.gov.uk

S117 Brokerage Form including all supporting information to be sent to ABMU Commissioning Team at rosemarie.williams@wales.nhs.uk and the Local Authority Principal Officer

- LA and ABMU Commissioning Team's quality assure the completed brokerage forms and review with the Care Coordinator
- Once review is complete and funding in principle has been agreed, the brokerage form to be sent to westernbaybrokerage@swansea.gov.uk

Anonymised brokerage form and costs spreadsheet send to appropriate providers for consideration and completion. Providers have 1 week to undertake the assessment and submit completed forms

Returned brokerage and finance paperwork to be sent to ABMU Commissioning Team; Care Coordinator; LA Principle Officer; LA Contracts Officer

MDT consider returned brokerage forms decide on which provider will be more suitable to meet the needs of the individual consults with RICO and indicated preferred provider. RICO Liaises with ABMU Commissioning Team and PO

- Preferred provider and cost presented by Care Coordinator and RC if required with justification for ratification
- The CHC will confirm date of meeting and request attendance

Placement and cost agreed and Placement commissioned.

Care Coordinator/Ward to arrange placement and inform ABMU Commissioning Team of admission date.

Care Coordinator to complete placement memo and circulate to LA Contracts Officer; LA Principal Officer and ABMU Commissioning Team

Unsuccessful Providers contacted by RICO with feedback

Appendix 9 – Children's and Young People's Board Governance Structure