Meeting of:	**SOCIAL SERVICES, HEALTH AND WELLBEING OVSC**
Date of Meeting:	**09 JULY 2025**
Report Title:	**REGIONAL PARTNERSHIP AGREEMENT**
Report Owner / Corporate Director:	**CORPORATE DIRECTOR SOCIAL SERVICES AND WELLBEING**
Responsible Officers:	**MICHELLE KING, INTEGRATED COMMUNITY SERVICES MANAGER AND MATT JENKINS, REGIONAL SERVICES DIRECTOR (CTM REGIONAL PARTNERSHIP BOARD)**
Policy Framework and Procedure Rules:	**THERE IS NO EFFECT UPON THE POLICY FRAMEWORK OR PROCEDURE RULES**
Executive Summary:	**This report provides an update on Bridgend County Borough Council's ongoing work to integrate health and social care services to create better outcomes for our population. It recommends approval of a new Regional Partnership Agreement (RPA), which will formalise collaboration with Cwm Taf Morgannwg University Health Board (CTM UHB) and other local authorities – Rhondda Cynon Taf County Borough Council and Merthyr Tydfil County Borough Council (other local authority partners) - in the Cwm Taf Morgannwg (CTM) region.** **The RPA is a key enabler for the Council's statutory duties under the Social Services and Wellbeing (Wales) Act 2014 and supports wellbeing objectives, including improving service accessibility and promoting healthy lifestyles. The report outlines our long-standing commitment to integrated care, dating back to the former Western Bay Partnership, and highlights how this experience is shaping the development of a region-wide Integrated Community Care System (ICCS). The RPA will provide a strengthened legal and operational framework for shared governance, pooled resources, and aligned service delivery, ensuring that integrated care is strengthened in our area and becomes the default model across the region.**

1. Purpose of Report

1.1 The Council has been working with Cwm Taf Morgannwg University Health Board (CTMUHB) and Rhondda Cynon Taf County Borough Council (RCT) and Merthyr Tydfil County Borough Council (other local authority partners) to strengthen joint working arrangements so that our residents that are living with disability and frailty can be supported by better, more integrated health and social care services.

1.2 This report provides an update on that programme of work and recommends approval of a Regional Partnership Agreement (RPA) which will support this ongoing agenda of service improvement for people across the Cwm Taf Morgannwg region. The RPA sets out a shared vision for improving outcomes for older people living with frailty. It addresses our statutory duties under Part 9 of the Social Services and Wellbeing (Wales) Act 2014 and supports the phased implementation of the Integrated Community Care Service (ICCS) model. By formalising governance, delivery, and accountability arrangements, the RPA will ensure that local services are better coordinated, more responsive, and sustainably resourced to meet the needs of our communities.

2. Background

2.1. Bridgend's journey toward integrated health and social care began over a decade ago under the Western Bay Health and Social Care Partnership. The 2014 Western Bay Community Services Business Case laid the foundation for a new model of intermediate care, designed to support people with frailty and dementia through timely, coordinated interventions. This model emphasised pooled funding, multidisciplinary working, and a shift away from hospital-based care toward community-based solutions.

2.2. One of the key outcomes of this early work was the establishment of the Bridgend Community Resource Team (CRT), which became a cornerstone of integrated care in our area. The CRT aims to support people to live independently at home, reduce hospital admissions and long-term care placements by providing rapid, multidisciplinary support in people's homes. Over time, this evolved into a broader system of care that included shared access points, reablement services, and integrated discharge planning.

2.3. Following Bridgend's transition from the Western Bay region to Cwm Taf Morgannwg (CTM) region, the focus shifted to aligning local successes with regional transformation goals. Bridgend's integrated model has been recognised as a pathfinder for the wider Integrated Community Care System (ICCS) now being implemented across the region. While other areas are aligning existing services, Bridgend is developing new tools such as a demand and capacity framework that will inform the next phase of regional rollout.

2.4. This evolution reflects a commitment to building on local strengths while contributing to a consistent, sustainable model of integrated care across the whole of CTM.

3. Current situation/ proposal

3.1 In March 2025 Cabinet approved a regional Memorandum of Understanding that has guided the detailed work on the RPA. Working regionally with the CTMUHB and other local authority partners to develop an ICCS means that continuity and coordination of care for residents will be enhanced, and we contribute to the scaling of best practice as required in Welsh Government guidelines. The components of the ICCS 'target model' are described in figure 1.

Figure 1: Cwm Taf Morgannwg ICCS

3.2 The development of a RPA means we can update the existing formal working arrangements with the health board for the CRT. Whilst in this model there is no change to Councils' and CTMUHB's statutory duties, a legal agreement enables us to retain joint posts, strengthen existing pooled budgeting arrangements and improve scrutiny across health and social care. It will increase transparency about the delivery of health and social care services in the community.

3.3 The RPA attached as **Appendix 1** has been co-produced by the Council and its partners, with detailed input by senior managers and legal leads from each organisation. The intention is for the agreement to be approved by each partner in July 2025 prior to going live in its first iteration in the Autumn.

3.4 In including a service schedule for the Bridgend Community Resources Team, the RPA is careful to delineate the responsibilities of the four organisations collectively (i.e. the main body of the agreement describing shared aims and quantifiable improvement objectives) and where service delivery is arranged bilaterally (i.e. at this point only for the Bridgend Community Resource Team as set out in Schedule 1). Box 1 provides representative examples of the positive impact of the CRT.

Box 1: Case Study Summary from the Community Resource Team (CRT)

Case Study 1: Acute Clinical Team (ACT)

A 78-year-old man with multiple chronic conditions—including kidney disease, heart failure, diabetes, and COPD—was referred by his GP due to worsening breathlessness after a recent hospital stay. Despite antibiotics, there was no improvement. ACT assessed him and found no signs of acute infection or heart failure decompensation, but blood tests showed worsening kidney function and hypotension.

Following a brief A&E visit due to collapse, he was diagnosed with a lower respiratory tract infection and returned to ACT care. A consultant-led home review led to IV diuretic therapy, which was later transitioned to oral medication. The patient was at high risk of falling due to fatigue from frequent urination, so ACT's physio and OT arranged an urgent bariatric commode to reduce this risk.

Further assessment during a routine visit revealed unmanaged chronic respiratory issues. Based on his history, the consultant suspected undiagnosed COPD. Given the patient's frailty, spirometry was not pursued, and advanced care planning was discussed with the family. Salbutamol nebulisers were trialled with good effect, and COPD management was initiated in line with national guidance.

All care was delivered in the community by ACT's advanced practitioners with consultant support. The patient and family gave positive feedback, noting improved health and avoidance of another hospital admission.

Case Study 2: Mobile Response and Comprehensive Geriatric Assessment

Mrs A, an older adult with a complex medical history including mild cognitive impairment, stroke, osteoarthritis, and chronic kidney disease, was referred to the ACT via the Falls Pathway following a pattern of frequent falls—approximately three per week. Although there had been no emergency callouts in the six months prior, her risk had escalated.

She lived with her husband and received support from her daughter. While independent with personal care, she needed help with cooking and cleaning. A Comprehensive Geriatric Assessment was completed, including a medical review by an ACT nurse and a pharmacist-led medication review.

Mrs A expressed low mood and frustration due to being housebound and experiencing dizziness during falls, often in the lounge. These insights helped shape a personalised care plan focused on improving safety and wellbeing.

3.5 For the next iteration of the RPA in Spring 2027, the intention is to create complementary schedules for RCT and Merthyr Tydfil once the initial alignment of community teams has been achieved. At that stage the schedules will be scoped

more widely to include integrated community 'Network Teams' who support people with longer-term needs to live as independently as possible at home. Examples of the positive impact of the Bridgend Network Teams are included in Box 2.

Box 2: Case Studies from Bridgend Integrated Community Network Teams

Case Study 1: East Integrated Network – Safeguarding and Hospital Admission Avoidance
Laura, a 73-year-old woman living with her husband, was the subject of a domestic violence incident. She was confined to bed with a suspected broken arm and a non-functional hoist. Emergency services were delayed, but a social worker intervened promptly, contacting the integrated team. Within two hours, Laura was relocated to a place of safety. Occupational Therapists supported her safe transfer, and Day Services arranged transport and staff. This coordinated response avoided a hospital admission and enabled safeguarding teams to begin longer-term planning.

Case Study 2: North Integrated Network – Safeguarding and Frequent Hospital Admissions when
Nancy, aged 92, had a history of frequent hospital admissions, cognitive challenges, and frailty. Concerns were raised about neglect, weight loss, and medication compliance. A safeguarding referral led to a multidisciplinary team response, including OT, physiotherapy, dietetics, and pharmacy. A bed-to-chair programme was introduced, and Nancy began gaining weight. She has not been admitted to hospital in six months, and district nurse input is no longer required. Nancy and her husband now feel supported and stable at home.

3.6 The RPA will evolve on a staged basis through periodic iterations. This will provide scope to develop further integrated delivery mechanisms to drive performance improvement, enhance outcomes and guide investment including through the Regional Integration Fund and other relevant sources.

3.7 Robust governance will be established to see overall delivery of the RPA. The three Councils and the health board remain fully accountable for their respective statutory responsibilities. We will be supported by the Regional Partnership Board at regional level and Joint Partnership Boards (JPBs) in each locality to oversee performance and drive the development of the integrated model. The development and agreement through the RPA to a shared outcomes and performance framework for community care will enhance visibility and scrutiny.

3.8 In summary the RPA offers a structured and accountable framework for delivering integrated health and social care services across the region. It enables partners to align commissioning priorities and reduce duplication - ultimately improving outcomes for individuals and communities. By formalising shared governance and delivery arrangements, the RPA strengthens our collective ability to respond to complex needs, support early intervention, and deliver person-centred care in line with the Social Services and Wellbeing (Wales) Act 2014.

4. Equality implications (including Socio-economic Duty and Welsh Language)

4.1. An initial Equality Impact Assessment (EIA) screening has identified that there would be no negative impact on those with one or more of the protected characteristics, on socio-economic disadvantage or the use of the Welsh Language. It is therefore not necessary to carry out a full EIA on this proposal. Impact assessment will be undertaken on future service changes that may be initiated by this high-level agreement.

5. Well-being of Future Generations implications and connection to Corporate Well-being Objectives

5.1 The development of an ICCS through a partnership approach fits with our Corporate Wellbeing objectives. Specifically, the RPA supports the Council's commitment to support people to live healthy and happy lives, and a County Borough where we protect our most vulnerable. The development of the ICCS is a way of delivering on our commitment to work even more closely with the NHS so all people receive the right health or care service at the right time.

5.2 It also puts the Ways of Working into practice as follows:

- Long-term – the focus on older people and frailty reflects the projected growth in the increase in the number of people aged over 65 for the next two decades;
- Prevention – this is the focus of the prevention pathway in figure 1, strengthening the long-term support services that the Council provides;
- Integration – the main purpose of the RPA is to enhance integration;
- Collaboration – this is the basis of multi-disciplinary ways of working which these developments are intended to enhance; and
- Involvement – fundamentally 'what matters' to people, as identified for example through recent RPB 'hackathons' will steer pathway and services development in this new framework.

6. Climate Change and Nature Implications

6.1 This proposal does not have significant climate change and nature implications; however, a benefit of the RPA is the emphasis on delivering care closer to home, which may reduce the need for travel by both service users and the workforce.

7. Safeguarding and Corporate Parent Implications

7.1 This proposal will have positive implications for Safeguarding and Corporate Parenting. The access to a multi-disciplinary team around the person approach will reduce risk and enhance safeguarding support.

8. Financial Implications

8.1 No additional financial commitments arise from the recommendations in this paper.

8.2 The intention in aligning and integrating community teams is to provide proactive care to people, avoiding unnecessary hospital admissions and overly long hospital stays which increase dependence on social care services. As better information on demand and capacity becomes available through the ICCS program, that will be available to inform future financial decision making in Councils and the health board.

9. Recommendation(s)

9.1 It is recommended that Members scrutinise this report prior to Cabinet consideration of the following recommendations:

- Note the progress made towards creating an Integrated Community Care System for older people and people living with frailty;
- Agree the ICCS model (figure 1) as the basis for integrated service development;
- Approve the Regional Partnership Agreement at Appendix 1;
- Note the intention to seek similar approval from CTMUHB and the two other local authorities in the region within the same timescale, and in advance of commencement of the Agreement in the Autumn of 2025;
- delegate authority to the Corporate Director, Social Services and Well-being, after consultation with the monitoring officer and Section 151 officer, to approve the final terms of the Regional Partnership Agreement, including any amendments to the terms approved here as may be necessary, and to enter into the Regional Partnership Agreement and any further deeds and documents which are ancillary to Regional Partnership Agreement.

Background documents

None