Adults Locality Services

Team Plan 2015/16

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Service Plan: Social Services
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Contents

Team Overview – Adults Locality Service

The Adults Locality Service has been reconfigured during the last financial year and is now operating in its distinct areas of business, under three separate integrated managers, operating in close partnership with good working relationships. Therefore this overarching team plan is a hybrid due to the transitional arrangements and the integration that is currently progressing with health and social care. This is reflective of the current stage of the integration journey where elements of Cardiff Council, Cardiff and Vale University Health Board (UHB) are jointly working with the Vale of Glamorgan Council.

Adults Locality Services are now focused in the following key areas:

1 Intake and Assessment
2 Reablement Services
3 Integrated Discharge Service
4 Longer Term Care Service
5 Day Services (Older People and people with a Physical Disability)

1. Intake and Assessment

This integrated health and social care team operates from ContactOneVale (C1V) and is referred to as the Customer Contact Centre (CCC). It encompasses the Adults Outbound component of the contact centre function which responds to the needs of the general public and professionals. The team of Customer Service Representatives (CSRs) are skilled at signposting individuals to the correct services. These may not be Council services, or statutory bodies, but may signpost to our third sector partners or community groups who can support individuals and their carers who may not require or be eligible for our statutory services. The CCC also supports the district nursing service, GP out-of hours, Telecare, nurse assessor team at present, and is looking to further expand through the mobilisation of government grant funding (Intermediate Care Fund (ICF))

Following initial conversations with people we are able to determine initial eligibility and offer an assessment of an individual's needs. We then process an 'enquiry' which may lead to a referral into our services. At this point a 'referral' is considered by a multi-disciplinary, multi-agency team and the referral directed to the most appropriate service(s) for assessment and service provision where appropriate.

The remit of the Intake and Assessment team is to provide the initial assessment and set up any services to ensure the person is safe and their initial assessed needs are met. At this point both a service user and their carers' needs may be assessed. The team comprises of several professionals including Social workers and Social Care officers. The team links into Carers Support Officers, Therapists, Nurses, Housing specialists, Telecare services, Extra Care provision and links strongly with our reablement service (Vale Community Resource (VCRS)) Services, Day Services, Discharge service and third sector brokerage.

This team facilitates less complex hospital discharges for both Cardiff and Vale UHB and Princess of Wales Hospital. We have a dedicated function to restart packages of care following a hospital admission, and making small amendments to packages of care following the admission. This is in order to facilitate discharge in a timely manner and support shorter stays in hospital.

Usually the maximum period a service user will be supported by this team is six weeks. If they need longer intervention or are more complex in nature they will be referred through to our Longer Term Care Service.

2. Reablement Services

The Vale Community Resource Service, based at Barry Hospital is a successful integrated team which supports people when they initially are discharged from hospital, or to prevent them from being admitted to hospital. The aim of the multi-disciplinary team is to support individuals for up to six weeks to endeavour to motivate them to regain and achieve their maximum level of independence.

The team supports people who require a period of either therapy or home care, or a combination of both. The therapy team includes Occupational Therapists, Physiotherapists, Speech and Language Therapists, Dietician and Integrated Nurses, all of whom are co-located at Barry Hospital. The therapy team is complimented by our own home care service (domiciliary), comprising of approx. 45 home carers who support individuals in an enabling manner to assist and support them in gaining their maximum level of independence following an episode of ill-health/fall etc. There are dedicated social workers who also support this team, who link into the remainder of assessment and care management teams within Social Services and assist in setting up packages of care following the reablement package if people require ongoing support.

This team is managed by an integrated reablement manager who is jointly appointed across health and social care.

3. Integrated Discharge Service

The Integrated Discharge Service is a team that supports residents of both Vale of Glamorgan and Cardiff whilst they are in hospital. The patients this service supports are assessed as having more complex needs and work with a dedicated team of Social Workers and Discharge Liaison nurses. This team works with ward staff to ensure that patients are discharged safely from hospital in a timely fashion. This team has improved the communication between the organisations and the likelihood of a successful discharge (preventing readmission) is increased. The team is managed jointly by a Social work team manager and Lead Nurse who effectively navigate the required systems to support an individual and their carers to move out of the hospital system.

Ordinarily, the IDS team cease working with an individual once they leave the hospital and if ongoing support is required then the individual is referred onto the Longer Term Care Service for this support.

4. Longer Term Care Service

The Longer Term Care service is an umbrella term for a collection of teams that support people with longer term conditions. This team supports individuals whose needs could not be met on a long term basis through the Intake and Assessment Team, Reablement service or the Integrated Discharge Service (all short term support services). This is usually due to the speciality or complexity of their needs and circumstances and require ongoing social work support to maintain their wellbeing. All Longer Term Care Services teams are based at Canolfan Ty Jenner

The teams included in the longer term care service are:

- ***Community Mental Health for Older People***
  This is an integrated team of social care staff and community psychiatric nurses with access to a specialist MDT team including medics, therapists and REACT. They support older people with a severe and enduring mental illness and their eligibility is determined through the Mental Health measure applicability.

- ***Occupational Therapy Service***
  This is a team of community Occupational therapy staff, who assist in the provision of advice for safe manual handling, support people to maintain independence in their own home through the provision of grants, equipment and adaptations. This team supports the grants team for the Disabled Facilities Grants (DFGs)

- ***Sensory Impairment Service***
  The Sensory service is supported through specialist staff for assisting people with either visual or auditory impairment, or dual sensory loss. The team has a social worker, social care officer and a rehabilitation for visual impairment (ROVI) officer.

- ***Integrated Health Team (Nurse Assessor team)***
- This integrated team of nurse assessors and social workers support people who are in Nursing homes. This team assess and support people who are eligible for the Continuing Healthcare (CHC) funding through the NHS, both in Nursing home placements and the community. In addition, they support the Nursing homes with standards of practice and training. This team predominantly supports the district nursing team in completing DST assessments for eligibility for CHC funding. The team also approves the applications for funded nursing care elements of nursing home placements.

- ***Day Services*** (discussed separately)

  The Day Service for Older People based at Rondel house and the Day Service for people with a Physical Disability based at Hen Goleg Resource Centre are also teams that are part of the Longer Term Care Service.

5. Day Services

Rondel House

Rondel House supports older people day services. The service supports people who are socially isolated or their carers need a break from their caring role. The Day Service support staff provide a range of stimulating activities to motivate people to engage in things they found interesting prior to older age, or enable them to learn new skills. The Meals on Wheels service operates from Rondel House, providing meals to the community seven days per week. Due to current demographics the service is developing more specialist services for those with dementia. To recognise this demographic the Council has invested in a Resource Centre manager position to be a champion for Dementia services and seek partnerships with other providers and statutory partners to support those with dementia and those that provide a primary caring role for them.

New Horizons

New Horizons is our day service for people with a physical disability. This service is attended by a younger group of service users, some of which were employed in important roles prior to the incident leading to their disability. The service offers a place for people to gain physical and emotional strength to nurture their skills and their wellbeing to gain their maximum potential. Service users are actively engaged in shaping the service and take advantage of some of the activities on offer at the centre – these include Boccia, woodwork, gymnasium with specialist equipment, cooking, arts and crafts to name a few of the regular activities on offer. Since the services supporting people with a learning disability have co-located with New Horizons both services have been able to share activities and take advantage of the skills and perspectives of service users across both service user groups.

The Team's broad functions are:

1. **Intake and Assessment**

- Support people initially referred to Social Services to ensure they are safeguarded
- Complete an initial assessment of eligibility and need
- Signpost people to the most appropriate service at the earliest opportunity
- Assess and support people who are known to Social Services but whose needs have changed and require a new assessment
- Facilitate non-complex hospital discharges to ensure people are safely discharged in a timely manner.
- Commission packages of care/placements to support people in the short term
- Refer onto other services within an integrated system to find the most appropriate service/professional to support the individual's needs.
- Refer onto the Longer Term Care service any complex or longer term conditions requiring ongoing support and intervention.

2. **Reablement service**

- To maximise the levels of independence for an individual through the provision of therapy support and reablement home care.
- To support hospital discharge
- To prevent hospital admission
- To work with an individual to encourage them to reach their potential in contributing towards their own care
- To prevent service users requiring ongoing support from the longer term care teams
- Provide a high quality registered domiciliary care service
- Mobile the support around the individual through accessing a multi-disciplinary team

3. Integrated Discharge Service

- The team across Cardiff Council, Vale of Glamorgan Council and Cardiff and Vale UHB to work collectively to ensure all patients with complex needs are discharged safely following their hospital admission
- Support the ward staff with complex discharge planning
- Work with families to facilitate discharge, taking account of the individuals and the families' wishes whilst balancing the risks and opinion of the MDT.
- Reporting on an Delayed transfers of Care and taking an active role in eliminating any social care reasons for delay through communication of the issues to those concerned
- Maintaining the throughput of patients through the acute system

4. Longer Term Care Service

- To support service users with long term needs to maximise their potential
- Ensuring that packages of care are appropriate to the individuals needs through robust monitoring and review (complimenting those initiated through the shorter term teams)
- Reviewing residential and nursing placements
- Continuity of relationship through allocated workers using the best skills to match needs
- Provision of equipment and adaptations and for Occupational Therapists to support the review function for packages of care to ensure they are tailored to the assessed needs.

5. Day Services

- To provide a high quality day service to service users
- Provision of respite for carers
- Delivery of a stimulating program of activities and events for service users
- Minimise social isolation and exclusion
- Provide opportunities for interaction with other peers
- Encourage service users to become interested in past activities and learn new skills
- Support service users to learn to live with the conditions/frailty they face
- Ensure that service users have a voice and control over their care, and are actively engaged in shaping future service delivery.

Our Contribution to Service Plan priorities 2014/15

Our contribution to the Service Plan priorities last year:

- The reablement service has been enhanced through additional funding, this has increased the capacity (both internally and through work with external providers) to help support older people to prevent them from experiencing a crisis. The number of individuals achieving full independence following enabling interventions from the VCRS is close to 70%.

- The creation of a Resource Centre Manager, Dementia service post, introduction of a third sector broker within the Customer Contact Centre and the continued involvement of the third sector at Barry Hospital within VCRS has meant that we have delivered a preventative, community approach to supporting older people to live as independently as possible. This includes those with dementia related illness, and we have supported the implementation of the Dementia three year plan.

- The successful completion of the locality restructure, establishing integrated social care and health assessment and care management teams for all adults services in partnership with the Cardiff and Vale UHB. These integrated models are now in place for the following teams within Adults locality services:

    - *Customer Contact Centre (Intake and Assessment team)*
    - *Community Mental Health for Older People (CMHTOP)*
    - *Integrated Health Team (Nurse Assessor)*
    - *Longer Term Care Service*
    - *Vale Community Resource Service (VCRS – Reablement)*
    - *Integrated Discharge Service (IDS)*

- Improved service integration in adult services is providing better experiences for service users who have both health and social care needs. This has been achieved through the reduction of duplication and streamlining assessments, sharing information and communicating better to ensure the right professional is providing the right support at the earliest opportunity.

- Supported the pilot initiative to provide carers with support in hospital settings. Implemented the respective parts of the Carers Information and Consultation Strategy and been involved in the development of the future interim plan. The pilot project has resulted in carers assessments and associated needs being identified earlier and support offered at the appropriate time.

- Supported the work with Cardiff and Vale UHB to provide an increased range of community based health and social care services. The successful co-location of health and social care staff at Barry hospital, which was developed as a centre of excellence for reablement services (VCRS)

- Successful completion of the Vale of Glamorgan's first Extra Care facility, supporting older people to live independently for longer through the provision of this facility. The Scheme is fully occupied with a manageable waiting list when vacancies arise.

- Contributed to the improvement in the timescales for the completion of Disabled Facilities Grants (DFGs) and the corresponding performance indicator through the introduction of revised working practices to refine the process. This has resulted in improved response times and that the waiting time is now shorter than ever and continuing to reduce.

- Ongoing engagement in the management and reporting of the patient flow around the Delayed Transfers of Care (DToC) to support the discharge of patients from the acute system and understand the blockages and find sustainable solutions. The performance for delays by social care reasons improved significantly compared with the previous year with just over half the number of people delayed compared with 2013/14.

- The development and appointment of a Day Opportunities Manager within the Physical Disabilities Day Service following the success of the Learning disability post and Commissioning strategy. This has led to better coordination with other day services on the same site resulting in service users being able to access a wider range of opportunities.

Our Team Plan 2015/16

Service Outcome 1:	**People in the Vale of Glamorgan are able to request support and receive help in a timely manner**							
Objective 1:	*To ensure that people have access to comprehensive information about Social Services and other forms of help and support, and are appropriately signposted to help and supported by proportionate assessments, care and support plans, and service which meet their individual assessed needs.*							
Ref.	**During 2015-16 we plan to:**	**Success Criteria/ Outcomes we'll achieve from this action are:**	**High, Medium or Low priority**	**Officer responsible for achieving this action**	**Start date**	**Finish date**	**How will the work be resourced?**	**Progress**
SS/A011 (CP/HSCW 5) (IO2)	Increase the take up of assistive technologies such as Telecare that enable older people and their carers to manage the impact and risks associated with chronic ill health (CSSIW/AREF/IP5/2011)	More people enabled to remain within their own homes safely and with a better quality of life, alongside more effective use of resources. This is a long term action and is due for completion in 2015/16	Medium	Chris Darling – Assistant Locality Manager	01/04/2015	30/03/2016	Telecare Project lead and support from Corporate Communications	
	Implement the recommendations of the Telecare task and finish group	Achievement of the tasks outlined in the recommendations	Medium	Chris Darling - Assistant Locality Manager	01/04/2015	30/03/2016	Telecare team, with links to the relevant staff as referred in the action plan.	
SS/A060	In co-operation with partners establish an effective information, advice and assistance services in accordance	We effectively support and promote the wellbeing of clients	High	All Operational Managers, Team Managers	01/04/2015	01/04/2016	Existing resources initially to be reviewed as statutory	

	with the requirements of the Social Services and Wellbeing (Wales) Act.			and Practitioners Managers within the Adults Locality Service			regulations from the Welsh Government are circulated.	
	Review all information provided and how this can be accessed - e.g. Directory and Web-based. Including being able to offer services and information in Welsh	Increase in the number of enquiries supported by a welsh speaker. Increase in the available literature presented in Welsh Development of an interactive website to facilitate self-assessment and access to alternative services	Medium	Suzanne Clifton – OM, Adults Locality Services Chris Darling, Assistant Locality Manager Paula Cornelius – VCRS Integrated Manager	01/07/2015	April 2016 and ongoing into next financial year following implementation of the Act.	IT staff Service staff Third sector partners	
SS/A061	Embed the locality restructure integrated health and social care model of service through clear processes of a service user's journey through the health and social care system-	Minimal number of transition points. Increased service user satisfaction levels, reduced duplication of information	High	Suzanne Clifton – OM Locality Longer Term Care Service	01/04/2015	31/01/2016	Existing resources – HoS, OMs together with managers from Cardiff and Vale UHB (PCIC Division)	

	streamlining processes and making best use of resources/professionals and skills.	gathering, shared assessments and recording systems in place.						
	Ensure that there is clarity of role between the teams through a series of Organisational Development/process workshops	Staff are clear on remit of team and role within the team. Processes are clear for those referring to our services and people are in receipt of the appropriate service first time Further reduction of duplication	High	Suzanne Clifton – OM, Locality, Longer Term Care Service. Chris Darling – Assistant Locality Manager Paula Cornelius, VCRS Integrated Manager All TMs/PMs to engage with staff	01/06/2015	30/01/ 2016	Existing resources from VoG council and UHB, include the support of Organisational development colleagues and Business Improvement Teams where required	
	Ensure that the Integrated Assessment process is embedded within ALL locality teams equally	The number of integrated assessments are increased Service user satisfaction is improved as they	High	Suzanne Clifton – OM, Locality, Longer Term Care Service.	01/04/2015	30/10/2015	Performance management staff from BMI team	

		are not repeatedly asked for the same information		Chris Darling – Assistant Locality Manager All TMs/PMs to engage with staff				
	Improve the quality of care and support plans across locality services to ensure consistency and improve relationships with providers	Improved communication and documentation with providers and families Clear, detailed care and support plans provided for all service users/carers	Medium	Suzanne Clifton – OM, Locality, Longer Term Care Service. Chris Darling – Assistant Locality Manager All TMs/PMs to engage with staff	01/05/2015	30/01/2016	Audit/quality Assurance officer	
	Maintain/ improve current position in relation to the processing of Occupational Therapy referrals in order to improve the timescale	Further improvement of the PIs relating to DFG	High	Suzanne Clifton – OM Locality, Longer Term Care Service	01/04/2015	31/03/2016	Grants team OT team	

	for access to services/adaptations and grants			Joanne Thomas, Team manager, OT				
	Engage in the Community Review for Mental health Services for Older People to improve access to services for people with a severe and enduring mental illness (as defined within the Mental Health Measure)	Permanent integrated management arrangements Clear pathway to access support for service users	High	Suzanne Clifton OM Locality Longer Term Care Service	01/04/2015	31/12/2015	Mental Health Directorate – Cardiff and Vale UHB	

Service Outcome 2:		**The Vale of Glamorgan Council protects vulnerable people and promotes their independence and social inclusion**						
Objective 2:		*Through the council working in co-ordination with other organisations to ensure that people are helped to achieve their best possible outcome and that people at particular risk have their wellbeing promoted and are safeguarded from abuse and exploitation.*						
Ref.	**During 2015-16 we plan to:**	**Success Criteria/ Outcomes we'll achieve from this action are:**	**High, Medium or Low priority**	**Officer responsible for achieving this action**	**Start date**	**Finish date**	**How will the work be resourced?**	**Progress**
SS/A073 (CSSIW/AREF/IP5/2014)	Work with Cardiff and Vale Health Board to fully implement the Integrated Discharge Operational Policy	Improved independence of older people. Reduced delayed transfer of care rates. Lower rates of readmission	Medium	Suzanne Clifton – OM, Locality Longer Term Care Service	01/04/2015	31/03/2016	OM to work with Team Manager for IDS and with Cardiff and Vale UHB officers	
	Work in partnership with other organisations to implement actions identified in the Delayed Transfers of Care (DToC) Action Plan	Improved PI regarding DToC	High	Suzanne Clifton- OM, Locality, Longer Term Care Service	01/05/2015	31/03/2016	OM to work with Team Manager for IDS and with Cardiff and Vale UHB officers	
	Identify any issues with discharge planning for patients who utilise Abertawe Bro Morgannwg UHB (ABMU)	Improved PI regarding DToC Improved relationships and communication with ABMU	High	Suzanne Clifton – OM, Locality, Longer Term Care Service	01/05/2015	31/03/2016	OM to work with Team Manager for IDS and with ABMU Officers	

		colleagues						
SS/A062 HSCW5 (IO2)	Implement recommendations of the Task and Finish group for Telecare Services	Increased take up of service and more effective use of resources	Medium	Chris Darling – Assistant Locality Manager with Telecare Project lead	1/04/2015	31/03/2016	HoS, Assistant Locality manager and Telecare Project lead	

Service Outcome 3:	**Social Services in the Vale of Glamorgan review, plan, design and develop quality services that deliver best value for money to improve outcomes for individuals.**
Objective 3:	*To have in place clear planning and programme management processes, which are identified in commissioning strategies and annual commissioning plans, and help to ensure an appropriate range of services that deliver equity of access, joined up services and best value from a variety of providers with defined, proportionate budgets directed to meeting service priorities.*

Ref.	**During 2015-16 we plan to:**	**Success Criteria/ Outcomes we'll achieve from this action are:**	**High, Medium or Low priority**	**Officer responsible for achieving this action**	**Start date**	**Finish date**	**How will the work be resourced?**	**Progress**
SS/A065	Consider the Day Opportunities Strategy and its applications for service users with physical disabilities	Increase in the types of opportunities offered to service users and their carers at times of the day and week where respite is most needed	Medium	Suzanne Clifton, OM, Locality Longer Term Care Services	01/04/2015	31/03/2016	OM with Day Opportunities manager and Business Support Manager, will include work with officer for consultations.	
	Review the activities offered within our locality day services and consider any	Joint activities provided to assist with transition to services Joint activities in the	Medium	Suzanne Clifton OM – Locality, Longer Term	01/07/17	31/03/2016 and into future financial years	OM with Day Opportunities Manager, resource Centre Manager – with support from	

	opportunities for sharing resources/activities.	community with other providers (outside of the council) Examples of co-production explored and developed into a plan. (e.g social enterprise)		Care Service		under the Reshaping Services agenda	Business Improvement Team (corporate)	
SS/A066 HSCW7 (IO2)	Develop a Dementia resource Service for service users and their carers to better support and care for those whose lives are directly affected by dementia.	Service users/carers have improved satisfaction levels. Reduced number of referrals for commissioned packages of care on a crisis basis. Reduced reliance on respite facilities.	Medium	Suzanne Clifton, OM, Locality Longer Term Care Service	01/04/2015	31/03/2016	OM with Resource Centre Manager	
	Complete project recommendations with PDR (Product Design and re-engineering) including a program of work to enable Rondel house to be a more dementia friendly environment	A renewed environment to support service users and motivate them to engage in activities/reminiscence work A positive atmosphere for service users and their carers which they find welcoming.	High	Anne Lintern, Resource Centre Manager, Dementia Services	01/05/2015	31/03/2016	Public buildings Contractors for tradesmen Cardiff Metropolitan University (PDR)	
SS/A068	Prioritise completion of actions set out in the Social Services	The Social Services budget is managed effectively and services are delivered	High	OM, All Locality management including joint	01/04/2015	31/03/2016	All staff within the locality teams, supported by finance and HR	

	Budget Programme	within available resources		appointments and Practitioner Managers,			representatives	
	Continue to work with colleagues in BMI to understand more about the commitments and ensure robust plans to reduce the ongoing commitments. Reinforce the message to social care staff regarding the need to provide care for assessed eligible needs and taking into account other sources of support.	Improved understanding and therefore control over the community care commitments. Reduction in the commitments during the financial year.	High	Suzanne Clifton OM – Locality, Longer Term Care Service All TMs, PMs and Staff within the Longer Term Care Service Chris Darling, Assistant Locality Manager All PMs and staff within Intake and Assessment	01/04/2015	31/03/2016	All staff within the locality teams, supported by finance and HR representatives	
	Achieve the allocated £50k saving for Adults services as a result of the reconfiguration.	Full year effect of saving shows in the budget line.	High	Suzanne Clifton OM – Locality – Longer Term Care Service	01/04/2015	31/03/2016	Finance HR	
	Develop an electronic authorisation tool	Effective system, with robust monitoring and audit trail in operation	High	Suzanne Clifton, OM – Locality,	01/07/2015	31/01/2016	IT Finance	

	for service requests for packages and placements	across locality teams Improved efficiency of authorising offers, without compromising the robust decision making by reducing the time taken to authorise funding through introduction of streamlined processes.		Longer Term Care Service Caroline Ryan-Phillips, Business Support Manager, Longer Term Care				
	Implement the actions required to address the Reshaping Services agenda for Meals on Wheels	An options appraisal for future plan/proposal as to how the service will be provided.	High	Suzanne Clifton OM-Locality – Longer Term Care Service Anne Lintern, Resource Centre Manager,	01/04/2015	31/03/2016	Business Performance Team	
	Undertake a review of Meals on Wheels	As above – shorter term goals for service provision whilst planning the longer term under reshaping services	High	Suzanne Clifton OM-Locality – Longer Term Care Service Anne Lintern, Resource Centre Manager,	01/04/2015	31/03/2016	Business Performance Team	
	Establish a review	Reduction in average	High	Suzanne	01/09/2015	31/03/2016		

	function within the Locality Assessment and Care management teams to review effectively and equitably the provision of packages of care. To include the introduction of an Occupational Therapist and Social Care staff to jointly review	hours per care package Consistency in review Improved numbers of reviews conducted within timeframe (as per PI)		Clifton – OM, Locality, Longer Term Care Service Caroline Ryan-Phillips, Business Support manager, Longer Term Care Service Joanne Thomas, Team Manager OT				
	Increase capacity/resilience within the VCRS team – therapy and home care	Improved screening times for referral to provision of care Improved access to service – higher number of patients receiving care within a reablement model. Increase in the number of people who regain their independence Reduced referrals	High	Paula Cornelius, VCRS Integrated Manager	01/07/2015	31/03/2016		

		onto Longer Term Care for pacakges Reduced packages of care for those who do require longer term support Improvement in the financial position for Adults Services (ACO65)						
	Implementation of the 'Just Checking' equipment to support assessment	Commissioning packages based on actual data regarding the individuals movements, rather than what we are told. Reduction in the number of hours within a package of care following a short period of assessment with Just Checking units.	High	Caroline Ryan-Phillips, Business Support Manager, Longer Term Care Service	01/05/2015	30/09/2016		
	Review the function of the Integrated Health Team (Nurse Assessor team) to eliminate duplication. Focus on the boundaries	Eliminate duplication in the assessment and care management functions. Policy implemented and reviewed/monitored in	High	Suzanne Clifton OM, Locality, Longer Term Care Service Caroline Ryan-Phillips,	01/04/2015	31/10/2016	Policy officer Cardiff and Vale UHB medicine management Legal Organisational	

	between health and social care responsibilities – e.g. medication policy review and implementation, joint funding arrangements and Continuing Health Care (CHC) processes	relation to medication, joint funding and CHC Exploration of pooled budgets.		Business Support Manager, Longer Term Care Service			development/ Business Process team	
	Develop the Sensory Impairment Service	Equitable service across service users with Visual and Hearing Impairment Policy ratified re charging for equipment	Medium	Joanne Thomas, Team Manager OT	01/09/2015	31/12/2015	Policy officer Sensory social worker/care officers Rehabilitation officer for the Visually Impaired	
	Review Day Services across the locality in line with the reshaping services agenda	New model of service provision proposed with feasibility established.	Medium	Suzanne Clifton OM-Locality, Longer term Care Service Anne Lintern, Resource Centre Manager Louise Payne, Day Opportunities Manager, Physical	01/09/2015	31/03/2016	Business Improvement/Process team	

				Disabilities				
SS/A069	Deliver actions identified in the implementation plan to meet the requirements of the Social Services Wellbeing (Wales) Act	We meet the duties/requirements of the Act	High	OM, All Locality management including joint appointments and Practitioner Managers,	01/04/2015	31/03/2016		
	Increase capacity within the Intake and Assessment Team to support people short term and signpost them effectively early on in their involvement with Social Care and Health.	Improved response times to referrals Increase in referrals to other organisations Increase in the provision of alternative information – i.e. access through website Reduction in referrals to the Longer Term Care Teams	High	Chris Darling, Assistant Locality Manager	1/7/2015	30/11/2015	Corporate Contact Centre Cardiff and Vale UHB	
SS/A070	Implement key improvement areas as identified by relevant regulatory reports	We can demonstrate progress and improved performance and outcomes in future regulatory reviews	High	Integrated VCRS Manager, Paula Cornelius	01/04/2015	31/03/2016	Relevant staff as required to be mobilised to meet the recommendations of the reports	
	Implement actions following the receipt of the VCRS CSSIW report (due	Achieve all tasks outlined as recommendations from the Inspection report	High	Paula Cornelius – VCRS Integrated Manager	Dependent on receipt of report			

	following an inspection in March2015)							