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Gwasanaethau Cyfreithiol a Rheoleiddiol / Legal and Regulatory Services
Deialu uniongyrchol / Direct line /: 01656 643385
Gofynnwch am / Ask for: Sarah Daniel

Ein cyf / Our ref:
Eich cyf / Your ref:

Dyddiad/Date: 31 March 2016

Dear Councillor,

ADULT SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

A meeting of the Adult Social Care Overview and Scrutiny Committee will be held in the Council Chamber, Civic Offices Angel Street Bridgend CF31 4WB on **Wednesday, 6 April 2016** at **10.00 am**.

AGENDA

1. Apologies for Absence
   To receive apologies for absence from Members.

2. Declarations of Interest
   To receive declarations of personal and prejudicial interest (if any) from Members/Officers in accordance with the provisions of the Members Code of Conduct adopted by Council from 1 September 2008 (including Whipping Declarations)

3. Approval of Minutes 3 - 14
   To receive for approval, the minutes of the meeting of the Adult Social Care Overview and Scrutiny Committee of 11 February 2016

4. Forward Work Programme Update 15 - 18

5. Prevention, Wellbeing and Local Community Co-ordination 19 - 34
   Invitees

   Cllr P White - Cabinet Member Adult Social Care Health and Wellbeing
   Susan Cooper Corporate Director – Social Services and Wellbeing
   Jacqueline Davies - Head of Adult Social Care,
   Mark Wilkinson - Group Manager - Learning Disability
   Judith Brooks - Group Manager - Business Support

6. Direct Payments 35 - 44

Invitees

Cllr P White - Cabinet Member Adult Social Care Health and Wellbeing
Susan Cooper Corporate Director – Social Services and Wellbeing
Jacqueline Davies - Head of Adult Social Care,
Mark Wilkinson - Group Manager - Learning Disability
Judith Brooks - Group Manager - Business Support

7. Nomination to Standing Budget Research and Evaluation Panel 45 - 48

8. Urgent Items
To consider any items of business in respect of which notice has been given in accordance with Part 4 (paragraph 4) of the Council Procedure Rules and which the person presiding at the meeting is of the opinion should by reason of special circumstances be transacted at the meeting as a matter of urgency.

Yours faithfully
P A Jolley
Assistant Chief Executive Legal and Regulatory Services

Distribution:

Councillors:	Councillors	Councillors
M Butcher	EM Hughes	JE Lewis
N Clarke	PN John	LC Morgan
PA Davies	B Jones	D Sage
N Farr	RC Jones	M Thomas

MINUTES OF A MEETING OF THE ADULT SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE HELD IN THE COUNCIL CHAMBER ON WEDNESDAY, 11 FEBRUARY 2016 AT 10.00AM

Present

Councillor D Sage – Chairperson

MW Butcher	PA Davies	RC Jones	LC Morgan
NC Clarke	EM Hughes	J Lewis	M Thomas

Officers:

Sue Cooper	Corporate Director Social Services and Wellbeing
Kym Barker	Scrutiny Officer
Michelle Chilcott	Integrated Community Services Manager
Mark Galvin	Senior Democratic Services Officer - Committees
Councillor Huw David	Deputy Leader
Judith Brooks	Group Manager Business Support

30. APOLOGIES FOR ABSENCE

Apologies for absence were received from the following Members:-

Councillor P John
Councillor P White

31. DECLARATIONS OF INTEREST

The following Members declared an interest in the Agenda item so stated:-

Councillor D Sage declared a personal interest in Agenda item 4 in that he previously received some of the support services mentioned in the report.

Councillors LC Morgan and MW Butcher declared a personal interest in Agenda item 5 in that they had previously had received adaptations to their property undertaken by Care and Repair.

32. FORWARD WORK PROGRAMME UPDATE

The Scrutiny Officer presented a report in relation to the above.

The Committee noted the topics to be considered at the meeting on 6 April 2016, and to consider, revise and reprioritise the list of future potential items for the Forward Work Programme as the Committee feels appropriate.

RESOLVED:

(1) That Members requested that an Officer working directly in community co-ordination is invited to attend for the item on Prevention, Wellbeing and Local Community Co-ordination which is scheduled for the meeting dated 6 April 2016.

(2) That Members requested that an item on the two new Extra Care build projects be added to the 2016/17 Forward Work Programme.

33. COMMUNITY SERVICES

The Chairperson on behalf of Members, welcomed the Invitees to the meeting.

The Corporate Director Social Services and Wellbeing introduced the report, the purpose of which, was to update Committee on the progress in community services, to include an update on the future of Occupational Therapy in the community.

She explained that the services outlined in the report and the attached Appendix 1, were being delivered as part of the Western Bay Health and Social Care Programme. The aims and objectives of the report and supporting document "What Matters to Me" – Supporting the health and wellbeing of our older population, were to deliver improved Community Services by introducing one regional model across the Western Bay region.

She explained that the focus was to achieve consistency in terms of what was being delivered across this region, particularly in relation to service delivery and performance, and the report she felt, would guide Members through the different elements of the services that were intended to be provided.

The Corporate Director Social Services and Wellbeing explained that the first Phase of the Programme had been to invest in an optimal Intermediate Care Service Model which comprised of a number of elements, for example a Common Access Point (CAP) into health and social care services. The CAP could be accessed by the public and professionals and performed the following functions:-

- Information, advice and assistance including direction to Third sector and community services where this is the best place to have well-being needs met, and;
- Multi-disciplinary triage and urgent response in the community for people who do require assessment or immediate service

There was also an Acute Clinical Service, which was a model led by a community consultant and delivered by a highly experienced nurse practitioner workforce. This function would provide rapid assessment, diagnostics and treatment in the community in order to avoid a hospital admission. It would assist in:-

- Reablement – A professional therapy led reablement service which was critical to supporting timely discharge for patients from hospital, and
- Residential Reablement/Assessment Beds – In addition to community residential capacity, the service model also provides residentially based reablement for people who would otherwise require a longer hospital stay prior to commencement of a community based service and also assessment of people who are potentially on a pathway to a long term residential care placement

As part of the second phase of the Programme, the community network development had been the focus of attention, and more recently, funding.

This included the development in Bridgend, of 3 Community Network Teams, (North, East and South West) with district nursing, social work and community occupational therapy co-located and grouped under the leadership of single integrated Managers.

Following this introduction, the Chairperson invited questions from Members.

A Member referred to the Acute Clinical Model and reference being made to a common access point available for people who require support services either relating to Mental

Health care or for physical disabilities. She asked where the common access points would be for these two different services.

The Integrated Community Services Manager advised that there were common access points in place to support individuals with both physical and mental health needs. In terms of people needing support for physical problems then the common access point would be by telephone to a member of the team in the Western Bay Community Services Section, where the person would initially be supported through a GP in a primary care setting.

Any person requiring Mental Health support would need to contact the ABMU through the Princess of Wales hospital, as this service was classed as a secondary health care service that came under the ABMU rather than Western Bay Community Services. These services were provided through initiatives such as CAMHS or mental health support services for older people

A Member pointed out that the Acute Clinical Service was working extremely well in Neath Port Talbot County Borough Council. This service allowed patients to be treated at home primarily by nursing staff, as opposed to them having to be placed in hospital to be treated. This was a far better environment for the patient. She noted that this model of care was continuing to be developed in Bridgend, and she asked when this would be fully adopted and up and running.

The Integrated Community Services Manager advised that this service in Neath Port Talbot was going extremely well. The Acute Clinical Service there had been in operation for approximately 10 years, so therefore the team providing this service was well established and experienced. The similar service that would be provided in Bridgend, was still in its infancy stages, however, 2 Community Consultants had now been employed as part of the Western Bay project, and the intention was to establish an Acute Clinical Service that would be operational in the County Borough as soon as this was further developed.

A Member added that progress should be accelerated with a view to providing an Acute Clinical Service in Western Bay, to include Bridgend, as this would allow professionals to treat people without admitting them to hospital, which would go a considerable way to preventing problems in hospital such as patient overloading and/or bed blocking. There were 22 Independent Sector Homes within the County Borough he stated, and it would be beneficial if people in the receipt of care were able to be treated by professionals in these homes rather than being admitted to hospital.

The Corporate Director Social Services and Wellbeing advised that there had been a delay in the e 2 posts of Community Consultants becoming established within the community but this was now in place..

A Member referred to page 9 of the report, and noted that there was no common access point for patients/residents requiring Mental Health support under the Acute Clinical Service.

The Integrated Community Services Manager confirmed that this service provision sat under the Mental Health Directorate rather than the Community Services team per se. Work was underway however, to explore how the service could bridge the current common access point to the joint health and social services single access point operating within mental health services.

The Corporate Director Social Services and Wellbeing, added that support and stay for people with Dementia was of paramount importance, and funding was being committed

by Welsh Government to support services in this very important area of health. This formed part of the services under the Mental Health Directorate within the ABMU, and had specific criteria under which individuals were able to be referred. She advised Members that discussions had begun to clarify the model and develop a clear pathway for Dementia services within the Community Resource Teams.

A Member referred to paragraph 3.2 of the report where reference was made to silo-type forms of delivery of health and social care. She asked what was meant by this term.

The Corporate Director Social Services and Wellbeing confirmed that this was referring to how the services were previously being delivered, and the fact that Officers now recognised that these services needed to be delivered in a more efficient and innovative way, including through providing shared services through joint working, that would improve services to that which were previously provided.

A Member referred page 8 of the report, and the paragraph headed 'Reablement', where people are discharged from hospital and await either the initiation of a reablement service or the restart of a current package of care which can usually be reinstated within a 3 day period, particularly if their stay in hospital was for just a short time period. She asked if when the relevant package of care was reinstated, was this the same or similar to the package they received prior to their admission to hospital.

The Corporate Director Social Services and Wellbeing confirmed, that if after receiving hospital treatment for any amount of time, the person following treatment and recuperation would then return to the same care support package that they received prior to their admission to hospital. If however, the health of the person in question had deteriorated (or improved) following the above, then the package of care they would receive would be altered accordingly to either provide more or less support than they had previously received. A Member noted from the report and some of the services outlined therein, that Community Network teams assisted people at home or in a residential/community based reablement environment. She asked if the services of an Occupational Therapist were available in Community Network Teams.

The Integrated Community Services Manager confirmed that they were.

She added that a pool of Carers were available to support people after they were discharged from hospital, and a member of the Community Services team worked alongside hospital staff, in order to ensure that an interim package of care was put in place initially for the individual, prior to a more appropriate longer term package subsequently being devised.

A Member asked Invitees if the word "frail" was a clinical description of a certain individual, and the Corporate Director Social Services and Wellbeing confirmed that it was.

The Deputy Leader advised that words such as this and others were regularly and consistently used by medical professionals, in order to ensure a common language was adopted by all partners and stakeholders, where the meaning of these words were classed as the same for all partner health support services.

A Member referred to page 20 of the report, and bullet point 4 where it listed points that people should take into consideration, , ie regular exercise, not smoking, reduced alcohol consumption and healthy eating , so as to avoid the possibility of being the subject of social exclusion by other members of society. She felt that personal hygiene could be added to the points listed.

The Integrated Community Services Manager advised that the model document shown at the Appendix to the report had been largely developed through a consultation process with key stakeholders and service users, and personal hygiene had not been raised in this regard, but the words personal hygiene and personal care could be added to this part of the document to further support the maintenance of a healthy lifestyle.

A Member referred to page 22 of the report and the role of a Care Co-ordinator, and asked if there was also a contact point for a Deputy Care Co-ordinator in their absence.

The Integrated Community Services Manager replied that there was an alternative contact point for the Care Co-ordinator, and this could be located within the Community Network team as part of contingency support plans.

A Member referred to page 14 of the Appendix, and the assurance that “we will minimize delays for patients who have had unplanned admissions to hospital by improving the interface between community services and hospitals.” She asked if Invitees could further explain how this would be achieved.

The Integrated Community Services Manager advised that there was an In-Reach facility that linked the Community Services team with the Princess of Wales hospital, whereby unplanned admissions could be more easily identified in order to ensure that people subject to these admissions are appropriately supported from a medical perspective, and in order to establish if and when they could be discharged following their admission.

The Corporate Director Social Services and Wellbeing added that there was a member of the hospital social work team that could be located in the appropriate Ward of the hospital, the hospital social workers worked closely with the community services to establish when they were ready to be discharged following being treated, and what package of care they would require post discharge. . She emphasised that the Acute Clinical Service had been fully operational in the Neath Port Talbot area for some considerable time and that Members should note, as was previously touched upon, that Bridgend were not nearly so advanced having this fully up and running as of yet. She pointed out that a considerable number of checks were in place to facilitate a proper discharge from hospital for the above category of patients.

A Member asked if there were cases of any re-admissions in terms of the hospitalisation of any individuals that had been the subject of Community Services support.

She advised that she would have to check any data for this, and come back to the Member outside of the meeting.

The Deputy Leader added that whilst there was a focus on getting people out of hospital back into a community or residential based setting, this was only possible after they had received treatment in the hospital and were ready to be discharged. As Officers had explained, following this process taking place it was then about ensuring that they then had an appropriate package put in place, to adequately support and reable them, in order to ensure that they remain healthy and safe, so that they could consequently regain their independence.

With regard to previous debate in relation to treating patients at Care Homes etc where possible and appropriate rather than placing them in hospital, he added that he had previously been involved in meetings with representatives of the ABMU including the extent of the role of Community Consultants, and as Members had been informed, this was work in progress. He advised the Committee that he would be attending a Western Bay collaboration meeting this afternoon, where he would stress the importance of

developing an Acute Clinical Service across the Western Bay region and to ensure that this was fully up and running as soon as possible. He further added that a considerable amount of investment had been committed by Welsh Government to strengthen health services across the Western Bay region, and it would be committing a further £20m this year which was excellent news given that people were living longer. He was also aware that the ABMU had looked at investing into more pharmacies as well as medications being given to people, particularly the elderly, more quickly and readily than was previously the case.

A Member pointed out that certain external organisations, for example Care and Repair, had a full time employee based in the Princess of Wales hospital in order that they could give consideration, where necessary, to providing adaptations for people at home or in a Care Home to adequately cater for any disability or condition they may have been hospitalised for prior to their returning to their previous setting.

The Integrated Community Services Manager advised that as part of the drive to support the health and wellbeing of our older population, the service was looking to raise awareness in communities of older people who lived at home alone, for visitors to these individuals to look out for any signs that their health was deteriorating. Work was also ongoing with the likes of libraries and leisure centres and other places regularly visited by the public, in order to promote the use of these facilities by older people, in order to maintain and promote their health and independency.

Under the new Social Services and (Wales) Wellbeing Act 2014, the Deputy Leader added that certain steps would be followed and promoted -to inform constituents of the County Borough particularly the elderly, that there are support services available to them which would help improve their quality of life, either through the ABMU or the Western Bay Health and Social Care Programme, including the development of a section of the BCBC website that would detail what these are.

A Member referred to page 20 of the report, and to the sub-heading Self-Care/Prevention – primary prevention supporting people at risk of frailty, where an aim of this was to help people take action to manage their health and wellbeing; live as independently as possible and to keep out of hospital. She noted bullet point 1 of this section of the report, how to support to combat loneliness and social isolation. She asked how people would be identified if they were not already in the system, including those people who were blind or suffering from other physical disabilities.

The Corporate Director Social Services and Wellbeing advised that this would be targeted through ways such as those mentioned immediately above by the Deputy Leader, and through other methods such as GP referrals in accordance with the Torbay model that the Council had adopted entitled ‘Anticipatory Care’, which was being pioneered currently in the north of the County Borough. As soon as new people were captured on the system via avenues such as visiting the website, the Social Services signposting system, making enquires with or being referred from a medical professional, then a Care or Response Plan would be put in place for them in order to provide whatever method of support they required. Support of Community Co-ordinators would also be sought if considered necessary.

A Member referred to page 27 of the Appendix and the proposal to have a Regional Planning and Delivery Board for Community Services, and she noted who the Board would be made up of in terms of stakeholders. She felt that consideration should be given to also having a lay person on this Board. She also noted within the Appendix that there was reference made to similar Strategies introduced by other Authorities in the UK, where best practice existed. She asked if sum of these initiatives would be adopted into the Western Bay Care model.

The Corporate Director Social Services and Wellbeing confirmed that as part of underpinning the 'Caring Together Model' a Stakeholder Group would be established and this would include both Third sector groups, as well as representation from other key organisations that work together to support the health of people in the County Borough, particularly the elderly population. Ideas of best practice from similar Strategies adopted by other local authorities would be looked at to inform the Strategy subject of the report she confirmed, particularly those that be most suitable to be included as part of this document.

A Member asked how many acute and in-patient beds had been lost across the ABMU within the last 5 years.

The Invitees confirmed that they would look into this request and inform Members of the Committee of the number so lost, outside of the meeting.

Conclusions:

The Committee noted the report, which provided Members with an update on the progress in community services and on the future of occupational therapy in the community.

- Members raised concerns that the development and implementation of an Acute Clinical Service in Bridgend needs to progress more quickly and asked for clarification regarding the status of the development of the service and the team. The Officer responded that the Authority now has two Community Consultants and that they are now able to introduce the medical aspect and develop the service in a similar way to the one currently in operation in Neath Port Talbot.

- Members asked for clarification regarding the role of the Community Consultant and queried whether there are now sufficient resources and commitment to enable community services to support interventions carried out in the community. The Deputy leader responded that the subject of the role of the Community Consultant would be raised later that day at a meeting Western Bay Partnership Forum.

- Members asked how people are able to access the Acute Clinical Service. The Officer responded that the service can be accessed by referral from a GP or District Nurse and that friends and neighbours can also contact the service if they have concerns about anyone.

- Members were pleased to note that services are coming together and working successfully to address the care and support needs of people within the community.

- Members asked what support is available for people who do not have family or friends to help them to re-settle at home. The Officer responded that there is a pool of people who can help to provide interim arrangements for people re-settling at home while a long term package is being established for them.

- Members asked why there was no representation from a layperson perspective on the Regional Planning and Delivery Board for Community Services. The Officer responded that service users and carers had been involved via stakeholder group consultations and that there may be better ways to involve users rather than at meetings. The Officer also responded that they would feed the comments from Members on user and carer inclusion back to the Leadership Group.

Recommendations

- The Committee recommend that more progress is made in developing and implementing the Acute Clinical Service and establishing an Acute Clinical Team in Bridgend.

- The Committee recommend that awareness of services available is increased, including information on how to access services and the benefits in using them, using a variety of formats to ensure that the information is accessible to all.

Further information requested

- Members request further information on the number of people who had been discharged from hospital over the past three years, to include information on what happened to them following discharge and how many people were re-admitted.

- Members request further information on how many beds have been lost over the past five years, to include information on the type of bed/provision lost, such as residential, nursing, acute etc.

- Members request an example of the assessment documentation when the new version becomes available.

- Members request an update on future plans regarding number and location of residential reablement/assessment beds.

- Members request an anonymised case study to help to illustrate the experience of people receiving services to help them to re-settle at home.

33. ROTA VISITING

The Corporate Director Social Services and Wellbeing presented a report, the purpose of which, was to provide the Committee with an update on the programme of rota visiting to the Council's adult social care establishments and independent sector establishments, as well as to share information on the outcome of the pilot visits by Council Elected Members to home care recipients, including plans to take the scheme forward.

She confirmed that Members were no doubt aware of the importance of visiting social care establishments as a valuable contribution to the safeguarding of vulnerable adults, children and young people, and ensuring that the quality of care provided is appropriate, as information regarding this was included in Annual Reports as part of the process of ensuring Quality Assurance. Rota visiting was also the subject of CSSIW Inspection reports as well as Contract Monitoring Inspections.

The Corporate Director Social Services and Wellbeing added that Social Workers also asked both residents of these Homes and Carers for any feedback, and this included also instances of anonymous feedback.

She advised Committee that there were 14 of our own Care establishments and 18 that were operated independent of the local authority, and advised wherever possible, Members (or at least the same Members) should not visit the same establishment more than once a year

In terms of the programme of visits to Council-run and independent sector establishments, the Corporate Director Social Services and Wellbeing stated that the 2014/15 rota programme involved 12 teams of elected Members, required to visit 16 Council operated adult social care establishments, and 13 independent sector establishments.

She added that the 2015/16 rota programme involved 14 teams required to visit 14 Council operated adult social care establishments and 18 independent sector establishments.

The Group Manager, Business Support encouraged more Members to commit to the Rota Visiting Programme, though she was conscious that they did have a considerable number of other commitments throughout the course of the year.

A Member referred to page 53 of the report, and the summary of Members comments made in respect of a previous visit to the Ty Cwm Ogwr establishment. This was in respect of a request for a waste disposal system at the property requested at the last visit by the Members. She asked if this had now been installed there.

The Group Manager, Business Support advised that she would check if it had, and come back to the Member outside of the meeting.

Appendix 1a to the report detailed the premises visited during the period April 2014 to December 2015, including how many times these different establishments were visited. She noted from this Appendix, that Council run establishments seemed to be visited far more than privately operated establishments, and she felt therefore, that an increase in visits should be made to these establishments. She also noted that Bryn-y-Cae Home in Brackla had been visited a considerable number of times, where others had been visited less frequently, and some not at all.

The Corporate Director Social Services and Wellbeing confirmed that it was a requirement for Members to visit Council run Care Homes, though it was voluntary only in relation to the Independent Sector Homes. She confirmed that further dialogue could be made with Managers of these private homes, in order to look to increase the number of visits to these establishments.

The Group Manager, Business Support, confirmed that options were specified in letters to the Homes as to their preferred visiting cycle, which were either monthly, bi-monthly or quarterly.

A Member noted from paragraph 3.5 of the report, that it stressed the importance of visits being made to Care Homes periodically, as Members were an important form of contact for service users. She asked if it was preferable to contact the Home in advance of a Member visiting there, or rather to turn-up unannounced.

The Group Manager, Business Support advised Members had the choice of either option under the rota visiting guidance.

A Member noted that 4 Independent Care Homes had not been visited in the above mentioned period as referred to in the report.

The Group Manager, Business Support confirmed that Member visits to Independent Care Homes had been very limited in the past, however, these were now increasing year on year.

A Member felt that there were not enough Members involved in Rota Visits and if this number increased, more Homes would be visited and at more regular intervals also.

A Member also agreed with the comment made in paragraph 4.14 of the report, that service users and staff at certain Homes had commented that visitations by Members for a period of 15 minutes, was an insufficient amount of time within which to discuss issues with them, including to resolve any queries Members may have, and/or to solve any problems that may exist at the Home that may be being experienced by the service user. She noted however that the pilot undertaken to conduct a series of visits to Home Care recipients across the County Borough involving 5 Members had largely been successful.

The Corporate Director Social Services and Wellbeing confirmed that this pilot was successful, and that it would be followed-up, in order that Members could report upon these visits, and follow-up any actions they may have requested in a subsequent visit. An option had been looked at, namely to form 2 groups of Members who would make 3 visits to Homes within an agreed period. The groups would be mentored by Members who took part in the original pilot.

Conclusions:

The Committee noted the report, which provided Members with an update on the programme of rota visiting to the Council's Adult Social Care Establishments and independent sector establishments and on the outcome of the pilot of visits by Elected Members to home care recipients.

- Members commented that the Member Champion visits had been very successful and asked when they would be resumed. The Officer responded that the visits would resume and that the views of Members would be sought regarding the frequency of visits in future. Support and training for Members was also discussed and several options put forward, including peer support and mentoring between Members.

- Members queried whether carrying out unannounced visits resulted in lack of availability of residents and staff during visits, due to other events or activities occurring at the time of the visits. The Officer said that whether or not visits were announced was optional and may be dependent on the type or size of the facility being visited. Members commented that, in most cases, unannounced visits are still the best way to ensure a completely representative picture of the service.

- Members queried whether any establishments had not been visited during the programme. The Officer responded that the intention is that all establishments would be visited this year.

- Members supported the intention stated by Officers to pursue further discussion on increasing visits to private sector establishments.

- Members queried the accuracy of some of the information included in the schedule of visits at Appendix 1a, the Officer responded that the information would be updated where necessary.

Recommendations

- The Committee was pleased to note that the rota visiting programme will resume and recommend that the team of Members undertaking the visits is increased, that peer mentoring and support is provided by Members who were involved in

the previous programme and that the frequency of visits is reviewed to ensure that the schedule is manageable.

- The Committee recommend that particular care is taken to ensure that visits are accessible, to enable all Members to take part in the programme.

Further information requested

- The Committee requests information on the outcomes from comments and queries fed back to Officers by Members following the visits, to include information on actions taken as a result of the feedback.

34. URGENT ITEMS

NONE

The meeting closed at 1.00 pm

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REPORT TO ADULT SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

6 APRIL 2016

REPORT OF THE ASSISTANT CHIEF EXECUTIVE – LEGAL AND REGULATORY SERVICES

FORWARD WORK PROGRAMME UPDATE

1. Purpose of Report

1.1 The purpose of this report is to present the items due to be considered at the Committee's next meeting to be held following the Annual General Meeting of Council.

2. Connection to Corporate Improvement Objectives / Other Corporate Priorities

2.1 The key improvement objectives identified in the Corporate Plan 2013-2017 have been embodied in the Overview & Scrutiny Forward Work Programmes. The amended Corporate Improvement Objectives adopted by Council on 25 February 2015 formally set out the improvement objectives that the Council will seek to implement between 2013 and 2017. The Overview and Scrutiny Committees engage in review and development of plans, policy or strategies that support the Corporate Themes.

3. Background

3.1 At its meeting on 24 June 2015 the Corporate Resources and Improvement Overview and Scrutiny Committee determined its Annual Forward Work Programme for 2015/16.

4. Current Situation / Proposal

4.1 In relation to the Committee's next meeting the table below lists the potential items to be considered and the invitees due to attend.

Topic	Invitees	Specific Information Requested	Research to be Undertaken by the Overview & Scrutiny Unit
Day Services for people with learning disabilities.	tbc	Report to include information on what facilities are provided for clients to enable them to get out and about, how often clients are taken out in the week, where are they taken etc.	
Bryn Y Cae	tbc	From ASC OVSC meeting on 13 January 2016 - Members requested that an item on Bryn Y Cae be added to the Forward Work Programme.	

Extra Items for Consideration

4.2 The list below contains potential items as yet to be decided for the 2016-17 forward work programme. The prioritisation and timings of these will be agreed at the Committee meeting following the Annual General Meeting.

Topic	Purpose of Report	Invitees
New Extra Care Housing schemes	From the ASC OVSC meeting on 13 January 2016 - Members requested that an item on the two new Extra Care schemes is added to the 2016/17 Forward Work Programme.	
The Social Services and Wellbeing (Wales) Act 2014		

Corporate Parenting

4.3 Corporate Parenting is the term used to describe the responsibility of a local authority towards looked after children and young people. This is a legal responsibility given to local authorities by the Children Act 1989 and the Children Act 2004. The role of the Corporate Parent is to seek for children in public care the outcomes every good parent would want for their own children. The Council as a whole is the 'corporate parent' therefore all Members have a level of responsibility for the children and young people looked after by Bridgend. [1]

4.4 In this role, it is suggested that Members consider how the services within the remit of their Committee affects children in care and care leavers, and in what way can the Committee can therefore assist in these areas.

4.5 Scrutiny Champions can greatly support the Committee in this by advising them of the ongoing work of the Cabinet-Committee and particularly any decisions or changes which they should be aware of as Corporate Parents.

5. Effect upon Policy Framework and Procedure Rules

5.1 The work of the Adult Social Care Overview and Scrutiny Committee relates to the review and development of plans, policy or strategy that form part of the Policy Framework and consideration of plans, policy or strategy relating to the power to promote or improve economic, social or environmental well being in the County Borough of Bridgend.

6. Equality Impact Assessment

6.1 None

7. Financial Implications

7.1 None.

[1] Welsh Assembly Government and Welsh Local Government Association *'If this were my child… A councillor's guide to being a good corporate parent to children in care and care leavers'*, June 2009

8. Recommendations

The Committee is recommended to:

(i) Note the topics due be considered at the next meeting of the Committee to be scheduled at the Annual General Meeting of Council;

(ii) Determine the invitees to be invited to attend, any specific information it would like the invitees to provide and any research that it would like the Overview & Scrutiny Unit to undertake in relation to this meeting.

Andrew Jolley,
Assistant Chief Executive – Legal & Regulatory Services

Contact Officer: Kym Barker, Democratic Services Officer - Scrutiny

Telephone: 01656 643161

Email: scrutiny@bridgend.gov.uk

Postal Address: Democratic Services - Scrutiny
Bridgend County Borough Council,
Civic Offices,
Angel Street,
Bridgend,
CF31 4WB

Background Documents: None

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BRIDGEND COUNTY BOROUGH COUNCIL

REPORT TO THE ADULT SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

6 APRIL 2016

REPORT OF THE CORPORATE DIRECTOR, SOCIAL SERVICES AND WELLBEING

PREVENTION, WELLBEING AND LOCAL COMMUNITY COORDINATION

1. Purpose of Report

1.1 To provide the Committee with an update on the development of preventative services and local community coordination in line with the implementation of the Social Services and Wellbeing (Wales) Act 2014.

2. Connection to Corporate Improvement Plan / Other Corporate Priority

2.1 The report links to the following improvement priorities in the Corporate Plan:-

- Working together to help vulnerable people to stay independent;
- Working together to make best use of our resources.

It is in accordance with the following:-

- Adult Social Care Commissioning Plan 2010-20: Living Independently in Bridgend in the 21st Century;
- Draft Adult Social Care Learning Disability Commissioning Plan 2014-17;
- The Remodelling Adult Social Care Programme;
- The Council's Medium Term Financial Strategy (MTFS).

3. Background

Social Services and Wellbeing (Wales) Act 2014

3.1 The Social Services and Wellbeing (Wales) Act 2014 (The Act) comes into force on 6th April 2016. The Act places a strong emphasis on the development of services that prevent or delay the need for formal care and support services.

3.2 A report was presented to Health and Wellbeing Overview and Scrutiny Committee about 'Prevention and Wellbeing and Local Community Coordination' on 22nd April 2015 and developments in local community coordination were reported to the Committee in the 'Remodelling Learning Disability services' report on 11th November 2015.

3.3 The implementation of the Social Services and Wellbeing (Wales) Act 2014 has been coordinated by a project team in the Social Services and Wellbeing Directorate and has included work on:

- Awareness raising sessions.
- Provision of information about the Act and the Codes of Practice.

- Provision of information on the BCBC website and Intranet.
- Training events.
- Development of Policies and Procedures.

3.4 The Act is made up of eleven parts and part 2 sets out the council's responsibilities in relation to prevention and wellbeing:

Part 2 General Functions – this part of the Act details overarching duties, duties in respect of well-being outcomes and strategic and operational duties in respect of preventative services.

Overarching duties – The Act requires that persons 'exercising functions' under the Act give due regard to the UN Principles for Older People (1991) and the UN Convention on the Rights of the Child. The duties are:

- Well-being Outcomes - this duty requires Local Authorities to be proactive in seeking to improve well-being for people who need care and support and carers who need support, when exercising social services functions for a person.
- Population Needs Assessments - Local authorities and Local Health Boards are required to work together on a regional basis to produce an evidence base in relation to care and support needs and carers' needs. The first population assessment must be produced by April 2017.
- Preventative services - local authorities **must** provide or arrange for the provision of a range and level of preventative services which they consider will prevent people's needs for care and support and stop needs from escalating. Authorities should promote well-being in delivering universal services.
- Social enterprises - local authorities must promote the development of social enterprises and co-operatives and/ or involve people and carers in the design and operation of care and support and preventative services.
- Provision of information, advice and assistance - Each local authority, with the assistance of Local Health Board partners, must secure the provision of a service for providing people with information and advice relating to well-being, care and support in their area, and (where appropriate) assistance in accessing these.
- Local authorities must develop registers of sight-impaired, hearing impaired and other disabled people.

3.5 Some elements of this work have been done through the partnership arrangements in the Western Bay and are coordinated through the Western Bay Prevention and Wellbeing Project Board. One of the main elements of this has been the development of Local Area Coordination (LAC) in Swansea and Neath Port Talbot and Local Community Coordination in Bridgend. This is explained in detail in the next section.

Prevention and Wellbeing

3.6 As part of the implementation of the Act, work has focussed on the development of preventative services and the Western Bay region has overseen a joint approach through a Prevention and Wellbeing Board. A key workstream overseen by the Board has been to pilot Local Area Coordination (LAC). The aim of LAC is to work co-productively with citizens to develop strong, inclusive and vibrant communities. These innovative approaches seek to transform the relationship with the

community; sharing power and working together with individuals, families and local groups to effect real and lasting change by helping individuals to recognise their inherent strengths, skills and abilities. In accordance with the principles of the Act, LAC places a strong emphasis on prevention and empowering people to achieve their own personal well-being goals. In this way people are supported to have greater choice and control over their lives and how they can become more self-reliant.

3.6.1 The Prevention and Wellbeing Board has also overseen mapping of prevention and wellbeing third sector and community services coordinated by the three County Voluntary Councils in the region, including Bridgend Association of Voluntary Organisations. This has been migrated to the "InfoEngine platform." This resource will be available across Western Bay with information on wellbeing and prevention services and activities provided by the Third Sector. The web based tool will be uploaded by community and voluntary groups with information about what is available locally. 'InfoEngine'. community road shows are being planned to support additional organisations to upload their services directly to InfoEngine once it is available.

3.6.2 Western Bay has led the way in Wales by launching the first DisabledGo accessibility guide in Wales. Disabled residents and visitors across Swansea, Bridgend and Neath Port Talbot have an access guide, which provides detailed accessibility information to 350 venues. The guide covers many different places including leisure centres, libraries, restaurants, community centres, council buildings and shops which have been visited and assessed by a DisabledGo surveyor. The surveyors have looked at a whole range of accessibility features from hearing loops and parking to accessible toilets. The Western Bay venues will join 125,000 other locations across the UK that already feature on DisabledGo. The access guide has been produced in partnership with leading disability organisation DisabledGo and was commissioned by Bridgend Association of Voluntary Organisations on behalf of Western Bay. The guide was launched in February 2016 and can be found on www.disabledgo.com.

3.6.3 A 'library' of mental health self-help information leaflets has been developed through the Western Bay Prevention and Wellbeing Board led by the 3 Council for Voluntary Services with ABMU Health Board. The leaflets have been translated and can be seen at http://www.selfhelpguides.ntw.nhs.uk/abmu/ These were formally launched in August 2015 as part of a service user conference.

3.6.4 Part time Social Enterprise posts in each of the three County Voluntary Councils are supporting a range of community social groups to formalise their status as social enterprises and provide guidance and advice.

3.6.5 The Prevention and Wellbeing Board has also progressed a regional framework for prevention and wellbeing services underpinned by local Prevention and Wellbeing implementation plans in each area. This framework and its outcomes will be reported to the Western Bay Leadership Group and the Partnership Forum with a recommendation that it be adopted by each core partner.

3.6.6 LAC has evolved in different ways in each local authority area and in Bridgend the Local Community Coordination (LCC) project has been in place since February 2015. The LCC project in Bridgend is based on the local area coordination model

but has been adapted to take advantage of similar work that was already in place in Learning Disability services and to be responsive to the communities in which local community coordinators are based.

3.7 The LCC operational model is based on a nationally recognised design by which LCCs are allocated on a geographical population basis. The model states that an LCC should work with a manageable population (maximum of 10,000) who live in a defined geographical area. This allows the LCC to work with people in a locality which enables networks of support to be developed.

3.8 The LCC project is based on the idea that providing people with services does not necessarily increase resilience or resolve issues of loneliness and isolation. The LCC approach is about connecting people to their local community and each other to support the development of networks and relationships which can help people remain independent. This can prevent or delay the need for formal services such as Social Services or secondary Health Care. There are three case studies at **Appendix A**.

4. Current situation / proposal.

4.1 The development of prevention and wellbeing services is a critical aspect of the implementation of the Act. The Bridgend Prevention and Wellbeing Board is coordinating this work and has set up a number of workstreams including:

- The communication of information about the Act and local community activities.
- The coordination of community projects being carried out by the partner organisations.
- Taking forward the 'Ageing Well in Bridgend' initiative.
- The Local Community Coordination project.

4.2 The LCC project in Bridgend started in February 2015 with the appointment of the first coordinator. The LCC team now consists of three coordinators, and a support officer. All of these are temporary appointments.

4.3 The team is managed by the Project Development Officer who was initially managing the learning disability service developments where the LCC model was being developed.

4.4 The Coordinator who has been in post for a year is based in the Llynfi Valley and the other two, who began work in December 2015 and January 2016, are based in the Ogmore and Garw Valleys. The support officer works across the county and has coordinated the production of publicity materials, a website and helps the development of community groups.

4.5 The Coordinators engage in community development work and also carry a caseload of people who they provide advice and support to or engage in longer term intensive work.

4.6 Some examples of the projects of the LCC team have been involved in are set out below:

- Strictly Cinema.

As part of the Learning Disability Project, work was being done on the development of a cinema club, as many service users love going to the cinema. It was quickly realised that this was a project which could appeal to other client groups, and it was decided to base it in the Llynfi Valley as part of the LCC Project. The name 'Strictly Cinema' was devised by a steering group, made up of interested local people, who plan the organisation of showings and select the films. The scope of the project has been widened to provide a full cinema experience with a Tea Dance and buffet included. Funding and support for this project has been provided by Bridgend County Borough Council, Zoom Cymru, Film Hub Wales, Moviola, Welsh Government, National Lottery, Film Audiences Network, Neighbourhood Cinema, and the British Film Institute. The project was funded for an initial six months and the group has now been fully constituted and raises its own funds. The response has been overwhelming, with very high attendance figures. It has been recognised by the British Film Institute as one of the best cinema clubs in Wales, so much so that they have visited to film an event.

- IPads project.

One of the Coordinator's has made a link with staff at Maesteg Day Hospital and a series of IPAD Technology sessions have been run there with a small group of older patients. These sessions have focussed on understanding and using the internet and social media. The project is building on these sessions by encouraging people to continue meeting when they are discharged from hospital and by attracting new members. The group will meet in Maesteg library and group members will have the opportunity to develop skills to use the internet, shop online, use FaceTime, Facebook and Twitter, or keep in touch with friends and relatives via Skype. Some of the people from the hospital have been referred to the day service at Cwm Calon but this provides a community alternative.

- Memory walks.

This is a project about collating people's memories of living in the Llynfi Valley. Funding will come from Bridgend County Borough Council's Social Services and Wellbeing Directorate and further partners are currently being identified. People's stories and memories of the area (stretching over last 100 years) will be collated from Primary Schools, Care Homes and community groups such as Strictly Cinema. People will be encouraged to share objects, photos and letters which will be will be digitally recorded (audio, video and stills photography) and then turned into Digi Stories (image and audio) to be included on the 'Digi Bridgend App' as a 'trail' and audio will be formatted as a radio show on Celtica Radio. The 'trail' that will be created for Digi Bridgend App will be used in the Love2Walk festival in June 2016 and will be used to create an actual walking route for people to follow using mobile devices such as Tablets/Ipads and Mobile phones. The aim is to involve as many people in the walk as possible, particularly those who have contributed memories. The walk will be done in stages, mobility issues will be considered and there will be transport between pick up and drop off points, as appropriate. The digital trail will be there in the future for people to use, and can be added to over time. The trail will be added to the national archive.

- Mindfulness group.

This is a group that meets weekly to learn about relaxation techniques and is led by a qualified therapist. A session has been set up on 'You Tube' by the therapist; so that the group can continue to meet independently and use some of the relaxation techniques they have learned in the live sessions. Feedback from participants has been very positive.

- Try it, Do it sessions.

These sessions have been established weekly in four venues across Llynfi Valley, bringing together small networks of older people to socialise, using various themes, such as 'games we used to play'. One session has been exclusively for older men. Early feedback has been very positive. They have been developed in partnership with the Bridgend County Borough Council, 'Being Active Bridgend Initiative'.

4.7 The project has also been involved in supporting the development of a number of community groups which are well attended and offer a greater choice of activities in the community. Examples of these groups are set out at **Appendix B.**

4.8 The team has also made links with the Communities First project which is managed in the Communities Directorate. The Communities First project has reached the end of its current funding cycle and has made a bid to the Welsh Government for funding in the next Communities First programme. This round of funding, which begins in April 2016, is based on the key themes of prosperity, learning and health through employment. Once funding for the project is confirmed the LCC team will try and identify ways in which relevant activities in the community can be jointly supported.

4.9 A plan is in place to transform the local day service bases in Maesteg, Pyle, Sarn and Bridgend into community hubs. This means that as well as providing a day service the hubs will offer an advice, support and signposting service to the public in the local area. The hubs will become a centre for generating community activities which will be supported by the local coordinator and provide a link with other community projects and events.

4.10 The LCC project has produced publicity material which is distributed locally and has a website which explains the project and how to get in touch with team members. The website address is www.lcc.comunity The website also contains a presentation about the LCC project.

4.11 The LCC project is being evaluated by a researcher from Swansea University. This work is being coordinated through the Western Bay and each local authority area has a report. The Bridgend report presents a favorable analysis of the progress with LCC and makes suggestions for future developments. The report is currently in draft and will be available when the final version is agreed.

Some of the key points are:

- LCC is supported and driven by a small but passionate and committed team with 'buy in' reported at all levels within the organisation.

- Emerging cases via self-referrals suggest LCC is already being effectively communicated to the Llynfi population.

- LCC has the potential to make a valuable contribution to communities in Bridgend, with benefits already emerging from these very early stages of delivery, albeit as part of a contribution to a wider ecosystem of efforts across statutory services and third sector.

- LCC has made good progress as evidenced by a growing database and case studies. A continued approach to LCC by BCBC and partners would establish LCC and place it in a position for further meaningful engagement.

4.12 At an operational level, the LCC may wish to refer individuals into BAVO when and where appropriate and to take initial discussions around the setting up of groups to BAVO for advice and due process.

4.13 The LCC project managers have been making links with the Bridgend Association of Voluntary Organisations (BAVO). This has involved establishing the Bridgend Prevention and Wellbeing Board. The Board is made up of stakeholders from Bridgend County Borough Council, BAVO, Public Health Wales and ABMU Health Board.

4.14 The Board has met on two occasions and arranged a Workshop for 22nd March 2016. The Workshop was called 'Prevention and Wellbeing Everyone's Business' and was designed to identify and make links so that all the work being done is joined up with a common purpose.

4.15 This work also has a strong link to the preventative work being done with older people.

4.16 In response to the next stage of the Older Persons Strategy for Wales, Bridgend County Borough Council has worked with partners to develop the Ageing Well in Bridgend action plan. The plan responds to key national themes that include the development of Age Friendly Communities, Dementia Supportive Communities, Falls Prevention, Opportunities for Learning and employment and also the reduction of loneliness and isolation. The plan builds on the commitment made by the 22 local authorities in Wales via the Dublin Declaration to make Wales an age friendly country.

4.17 The programmes aim to recognize the voices of older people and the Ageing Well consultation received almost 300 responses on their quality of life and the barriers that they face. There is ongoing work in partnership with Age Cymru to build the capability of the older person's forums and to represent their views on issues that are important.

4.18 A programme of Later Life training has been developed with over thirty participants receiving accredited training to support people in care settings to build strength and resilience and reduce falls due to frailty.

4.19 An Ageing Well web resource is being developed as a source of information that can connect older people to their communities and also provide information for families and carers in relation to the key themes.

4.20 Community walking opportunities are promoted via the “Love to Walk” programme reducing social isolation and volunteering opportunities are being developed through the regional Park Lives programme encouraging active use of the outdoors. The national free swimming programme for the over 60,s is achieving the highest participation rates in Wales and a recent initiative has provided free access to veterans linked to the Armed Forces Community Covenant.

4.21 The National Exercise Referral Scheme is working in partnership with the health board to develop enhanced support for chronic conditions and age acquired disabilities.

4.22 Programmes are being developed to make areas of Bridgend Dementia Friendly Communities (e.g. Llynfi valley) and to explore multi-generational approaches to understanding dementia.

4.23 Working from the umbrella of the Llynfi 2020 project, the Dementia Friendly Community initiative of Maesteg was established to make Maesteg the first area in Bridgend to become a Dementia Friendly Community.

4.24 With the support of BAVO, the Council has held 2 engagement sessions to seek the views of the people of Maesteg. The first was part of the Maesteg festival, and a stall was set up to explain the Llynfi 20 project and gain the views of what was important to the people of the area. The second engagement session was held in a local church, just before Christmas and was supported by 2 of the local choirs.

4.25 Following the engagement sessions, the Council was invited to give a presentation to the Town Council, who were excited to become a Dementia Friendly Town Council and have voted a Town Councillor to champion the project.

4.26 The Directorate has set up a strategic group to develop the Dementia Friendly Community, and have started a series of Information Sessions, to encourage people from the area to become “Dementia Friends”. There has been a a great deal of support from Police Officers, Fire service, Halo Leisure Company, two of the main banks in the town centre and the local Councillors.

4.27 The Directorate is in the process of completing registration with the Alzheimer’s society, Dementia Friendly Communities Project, to become a recognised Dementia Friendly Community, and hope to achieve this status by May 2016.

4.28 The LCC project has developed and grown quickly in its first year. A small team has been put in place and links have been made with a wide variety of organisations working in the community. The project has also been able to support 100 people (mostly in the Llynfi valley) to take greater control of their personal circumstances and engage more in their local communities.

4.29 The ambition of the project is to have local Community Coordinators covering the whole of the county. This requires expanding the team from four to twelve people and encouraging partners to contribute to the funding that is required.

4.30 The impact LCC is having on people lives can be illustrated by the comments made about the coordinator in the Llynfi Valley:

"Laura has helped me a lot. I get a bit depressed and I think if it wasn't for her I'd be dead now. She's getting me to meet people again".

"I put my trust in her. I've seen lots of professionals, but this time it's different, she has really helped me".

"She's been my lifeline, she's so compassionate. I feel like I was a dead flame, and Laura has been like a spark to light it again. I'll never go back on the drugs now – she's made me determined to be a survivor, not a victim".

"She's outstanding, awesome! She's one in a million. I lost my wife, lost my car, can't drive now, felt I'd lost everything. When I was referred to Laura, I thought 'here we go again', but now I'd do anything I could to support her in return for how she's helped me back on the road to recovery".

"I know when there's a problem I can ring her, and she will do everything she possibly can to help. She doesn't frighten me like some others".

"When I met Laura I felt lost. Life was difficult and had been for some time. Since then Laura has changed my life, and helped me gain the support I needed from other services. I feel more myself now and I'm more positive about the future, which has really improved family life at home".

Next Steps

4.31 In order to take this work forward and develop the projects already in place the following steps will be taken:

- Continue to be part of the Western Bay Prevention and Wellbeing Board and contribute to the regional developments.
- Take forward the recommendations from the evaluation report.
- Progress work from the workshop on the 22nd March 2016 and develop a local plan which will be part of the Western Bay Framework.
- Continue to develop the LCC website and publicise information about LCC events and groups through the BCBC websites and social media.
- To work with partners to identify permanent funding arrangements so that the number of coordinators can increase.
- Develop a system of performance measures and outcome targets for the LCC project.
- To produce a 'code of practice' for the LCC project.
- To continue to work with communities and individuals to take forward the aims of the LCC project and the Prevention and Wellbeing aspect of the Act to support people to have greater choice and flexibility over the support they receive and to promote self-reliance in line with the Council Corporate Plan.

5. Effect upon Policy Framework and Procedure Rules.

5.1 There is no effect upon the policy framework and procedure rules.

6. Equality Impact Assessments.

6.1 There are no equality implications.

7. Financial Implications.

7.1 The LCC has been funded since February 2015 by BCBC and its Western Bay funding partners. During 2015/16 the funding was for 3 Local Community Coordinators, an Arts Connector and a team manager post. This source of funding is due to end on 31st March 2016.

7.2 As indicated in paragraph 4.31 there is a need to identify future funding arrangements in the longer term. In 2016/17 the directorate will maximise the use of the Welsh Government's Delivering Transformation Grant and will also utilise the Remodelling Adult Social Care earmarked reserve to fund this service.

7.3 There is an expectation that the LCC will contribute towards generating savings identified in the MTFS – ACS25: Impact of the Prevention and Wellbeing agenda of £978,000 savings in 2017/18 and £740,000 savings in 2018/19.

8. Recommendation.

8.1 It is recommended that the Committee note the contents of this report.

Susan Cooper
Corporate Director, Social Services and Wellbeing
August 2015

9. Contact Officer: **Mark Wilkinson Group Manager**
Telephone: **01656 642281**
Email: **mark.wilkinson@bridgend.gov.uk**

10. Background documents
None

Well-being in Action: Neath Port Talbot

Festive Fun in Ystalyfera

Spirits were high on 21st December 2015 as Kirstie Richards, Neath Port Talbot's Local Area Coordinator for Ystalyfera hosted the very first festive community lunch at popular local café Y Gegin Fach.

Local Area Coordination is new to Neath Port Talbot, but is already making its mark. Its ethos is based around building stronger communities and supporting people who are vulnerable or socially isolated.

"The key purpose of Local Area Coordination is to bring people together and help them achieve their own personal well-being goals", said Kirstie.

"The Christmas lunch is an ideal opportunity for residents to come together to share a bite to eat and connect with each other. We've also had a lot of support from locals who've come along as volunteers to entertain the diners with Christmas songs and carols on the piano."

Since starting in her role in November 2015, Kirstie has engaged with a variety of local services and community groups, including 'Dragon Arts and Learning' in Pontardawe - an organisation that provides a range of arts based opportunities to local people of all ages and abilities.

Community resilience and asset based models that focus on prevention are developing across Western Bay: in Neath Port Talbot and Swansea Local Area Coordination is up and running, and in Bridgend they have developed an approach called Local Community Coordination.

The Coordinators have a broad knowledge of local groups and services and support people to find locally based solutions.

Kirstie Richards

Local Area Coordinator for Ystalyfera

Well-being in Action: Swansea

Local Area Coordination supports people and communities to develop skills and ideas that help them to avoid crises, find practical solutions to everyday issues and problems, stay strong and build a 'good life'. The whole approach is about developing sustainable solutions with people and communities that will help to prevent problems from reaching crisis point.

In **Swansea**, the first three Local Area Coordinators started on June 1st 2015. Local Area Coordinators are recruited by local people, for local people—inclusion, contribution and co-production in action. They act as a single point of contact in the community for people of all ages with mental health conditions, learning disabilities or physical disability, and for older people, families and carers, supporting them to stay strong, safe and connected.

Sheila's story

The power of relationships-overcoming isolation and nurturing contribution

The Local Area Coordinator is introduced by a District Nurse to Sheila, a 70 year old woman who lives alone since her husband died. Sheila is a poet who still writes but is having problems with her computer which she must use due to her health condition. In addition, Sheila's garden, once her husband's pride and joy, is rapidly becoming overgrown and she fears 'letting the neighbourhood down'.

The Local Area Coordinator takes time to get to know Sheila and is able to connect her with a local church group who tend older peoples' gardens. One of the group of gardeners is Barbara, a young woman who is interested in creative writing but who has suffered with anxiety and depression. She also happens to have expert knowledge about computers. The Local Area Coordinator is taking time to get to know Barbara via the gardening group and both she and Sheila have indicated that they would like to be introduced to each other. The plan is for Barbara to help Sheila with her computer problem, and for Sheila to share her considerable skills in poetry and writing with Barbara. Both women have something to offer each other in a reciprocal, positive and natural way.

This has helped two people avoid the need for more expensive services and is building their long term resilience in their local community.

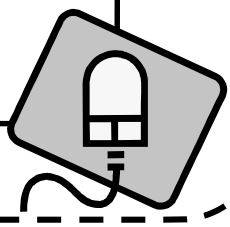
Building more welcoming, inclusive, supportive communities, spotting and creating new opportunities

A piece of derelict land has become an eyesore in a local community. The land is adjacent to 2 restaurants, 2 supermarkets and near to the local Comprehensive school. The Local Area Coordinator knows through his work that there are several isolated people who would love to be connected with others to do some gardening and perhaps grow some vegetables. He has contacted the supermarkets and restaurants who are all interested in the idea of selling and using local produce, and the Comprehensive school who would like to incorporate the healthy eating message in to the curriculum. He is working with the local Councillor to bring these interests together so that the piece of land can be transformed by local people to become a 'kitchen garden' resource which enhances the wellbeing of everyone in the community.

Transforming local systems

In one community in Swansea there is no local surgery offering blood tests to its older or disabled patients, who then have to travel to a distant surgery or the local hospital for this service. This is resulting in increased home visits and higher service costs. Through connections with local organisations, the Local Area Coordinator has linked the District Nurses with an under-used community centre to develop a local, accessible and cost-effective alternative. **Helping people make good use of necessary services and uncovering solutions that are straightforward, local and sustainable.**

For more information on the Local Area Coordination model, please visit www.lacnetwork.org



Local Community Coordination

Laura Semmens
LCC for Bridgend

Laura Semmens is the Local Community Coordinator for the Bridgend locality. Her role involves supporting people who may need some extra help to achieve their own personal wellbeing outcomes. Those who are referred to the service may need help for any number of reasons, including social isolation or issues with physical or mental health.

Here she tells us about her journey with one service user who's starting to make some positive changes thanks to this new, person-centred way of working.

Mary's Story…

Mary is in her 50s and has suffered with agoraphobia, severe anxiety and depression for many years. She has a lot of practical support from her daughter, who does the shopping, sometimes cooks her meals and deals with all of her correspondence as Mary is unable to read or write.

The feelings of intense panic Mary experiences when leaving the house mean she only does so when it's absolutely necessary (usually for medical appointments). She has previously been referred to the local Mental Health Team, but has been discharged. Mary was referred to me by the local Job Centre.

Personal Well-being Goals

I've met with Mary on a number of occasions now and we've drawn up a plan of action to achieve her own personal well-being goals. She would like to be able to visit her daughter's house one day – something she's been unable to do due to her anxiety around leaving the house.
Mary also used to go walking with her late husband and has expressed an interest in taking up country walking again.

In addition to these goals, Mary has needed support to apply for the correct benefits and practical help to deal with her social housing landlord with a few queries she has about her tenancy.

I successfully supported Mary and her daughter to claim their full PIP and Carer's Allowance entitlements. Mary has also been referred to a telephone befriending scheme run by 'Mental Health Matters Wales'. She now receives a phone call from a volunteer every Wednesday and has told me how chatting to someone outside of the family has helped reduce her feelings of loneliness and isolation.

It's clear from speaking to Mary that her problems with literacy weigh on her mind, so I've made a referral to the Community Companions scheme and hope to find a volunteer who can support her in her learning.

In the meantime, I've supported Mary to register with 'Booklinks'; a local audiobook loaning scheme and have sourced a relaxation CD which is helping her to manage her anxiety.

Looking to the future, I'm pleased that Mary has agreed to come along to a relaxation class that I'll be arranging in the new year. I also hope to be able to introduce her to another resident who enjoys walking and also suffers with severe anxiety – with the goal of the two of them starting a walking club for women who've experienced similar issues…watch this space!

Mary did achieve one key goal she set herself recently, which was to attend a health event arranged by the Job Centre. I mentioned that I would also be attending and was delighted to see her walk through the door having faced her fear.

Onwards and upwards over the next few months!

My Local Community Coordinator is an outstanding worker. She's one of the best!

Mary, Bridgend

LCC / LAC are being delivered as part of the Western Bay Programme's Prevention and Wellbeing project, and are clear examples of how services are doing things differently to help maximise the independence and well-being of individuals.

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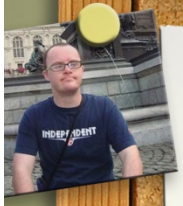
What's going ON in Bridgend?



- Monday -

Nolton Church - Community Crafters
10am to 3pm
Helen and Sarah 01656 815353

- Tuesday -

Skill Centre Brackla Industrial Estate Crafty Apprentices
10am to 3pm
Sue (Cartrefi Cymru) 01656 655606
and Karen (Mirrus) 01656 769073

- Tuesday -

Bethlehem Life Centre Crafts/Social Group
(Downstairs group) 10am to 3pm
Anne (Cartrefi Cymru) and Lorraine (Mirrus) 01656 769073

- Wednesday -

Y Centre Porthcawl Crafts/WII Games/Computer/Social
10am to 3pm
Anne (Cartrefi Cymru) 01656 655606

- Wednesday -

Coytrahen Phillip Squire Community Centre Music and Craft
10am to 3pm
Catherine (Drive) 01443 845260

- Thursday -

Coytrahen Phillip Squire Community Centre- Sports and seated Zumba
10am to 3pm
Trudy (Drive) 01443 845260

- Friday -

Tondu Methodist Church – Sports/Craft /Gardening
10am to 3pm
Richard (Trinity Club) 01656 782104

***Skill Centre** open 5 days a week
Tempest House Brackla
Industrial Estate Garth Drive.
- Work opportunities
Sue and Wendy (Cartrefi Cymru) and Rob and
Gareth (Homestyle) 01656 651441

cartrefi cymru
Cefnogi Pobl a Chymunedau
Supporting People and Communities

Drive

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possibilities into realities

TRINITY
CARE AND SUPPORT

BRIDGEND
County Borough Council

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BRIDGEND COUNTY BOROUGH COUNCIL

REPORT TO THE ADULT SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

6 APRIL 2016

REPORT OF THE CORPORATE DIRECTOR, SOCIAL SERVICES AND WELLBEING

DIRECT PAYMENTS

1. Purpose of Report

1.1 To inform the Committee of the current situation with the provision of Direct Payments and the plans for the development of the use of Direct Payments in line with the implementation of the Social Services and Wellbeing (Wales) Act 2014.

2. Connection to Corporate Improvement Plan / Other Corporate Priority.

2.1 This report links to the following improvement priorities in the Corporate Plan:

- Working together to help vulnerable people to stay independent;
- Working together to make best use of our resources.

Plus the following initiatives or plans:-

- Adult Social Care Commissioning Plan 2010-20: Living Independently in Bridgend in the 21st Century;
- The Remodeling Adult Social Care Programme;
- Reconfiguring Learning Disability Services Project;
- The Councils Medium Term Financial Strategy (MTFS).

3. Background.

3.1 Purpose of Direct Payments

3.1.1 Direct Payments are cash payments made to a person who is eligible for care and support from social services, to enable them to arrange and pay for their own care and support. Direct Payments are a different way of delivering social services responsibilities where there is an assessed eligible need. The purpose of Direct Payments is to give people:

- Flexibility over when their care is provided and the exact nature of the care.
- Choice and control over who they have caring for them and the standards and quality of that care.

3.1.2 Direct Payments can be used to purchase care and support services in order to meet the persons care and support needs or the person's carer needs. Typically direct payments are used for:

- Personal care services

- Personal assistants
- Community activities
- Equipment and minor home adaptations
- Respite

3.1.3 The provision of Direct Payments is a key element in the Council's strategy of helping individuals to live independently in the community and be able to exercise choice over how their support is provided. A fundamental principle of providing Direct Payments is that support is purchased and managed by individuals so as to enable them to live more independently and actively in their communities and to engage with their friends, families and wider social groups without the need for statutory support services.

3.1.4 Direct Payments are also a key part of the Council's Corporate Agenda because they give vulnerable people greater choice and control over how they can enhance and maintain their independence in the community. The development and increase in the use and number of Direct Payments is part of the Remodelling Adult Social Care agenda which represents a transformation in the way in which people receive support services. People will organise and manage their own care and support arrangements rather than the Council doing this through the provision of services. The impact of increasing the number of Direct payments is reflected in the Medium Term Financial Strategy where cost savings are identified from a reduction in the cost of statutory provision.

3.2 Legislation

3.2.1 The Social Services and Wellbeing (Wales) Act 2014 (The Act) repeals previous legislation concerning entitlements to direct payments. The Care and Support (Direct Payment) (Wales) Regulations 2015 (Regulations) provides the latest guidance on when local authorities are either required or allowed to make Direct Payments under the Social Services and Well-being (Wales) Act 2014.

4. Current situation / proposal.

4.1 Prior to the implementation of the Act, a local authority was required to provide a Direct Payment if:

- It was requested by the person;
- The Authority is satisfied that the individuals care and support needs, or a carers support needs can be met through the provision of a direct payment;
- The person is capable of managing the payment (either with or without support). If a person does not have the mental capacity to consent, the payment could be made to the 'suitable individual' to manage on the persons behalf.

4.2 The Act and associated Regulations do not change the previous legislation and Guidance but add to it by extending the range and scope of the use of Direct Payments. This includes:

- Steps authorities must take and information they must provide to an individual or their carer so they can make an informed decision to request a direct payment;

- Enabling individuals with a drug or alcohol dependency to request a direct payment (with suitable safeguards);
- Prohibiting local authorities from stipulating that the direct payment must be used in a particular way;
- Allowing an individual to purchase care and support from the 'the authority which made the payment';
- Authorising the use of direct payments to purchase care and support or help managing the payments from a relative living in the same household if appropriate for promoting the persons wellbeing;
- Requiring the first review of the direct payment arrangement at 6 months (previously 12 months).

4.3 The Act also makes provisions for the use of direct payments for meeting a child's care and support needs and for meeting a carers support needs.

4.4 The first Direct Payments were made in 2000/01 as part of a pilot scheme. Over subsequent years the use of direct payments to meet a person's care and support needs has grown. The table below sets out the number of Direct Payments provided by service user group and the associated costs over the last 5 financial years.

The second table shows the average cost of a Direct Payment **per annum** by service user group.

	£	No Service Users	£	No Service Users	£	No Service Users	£	No Service Users	£	No Service Users	£	No Service Users
Service Area	**2010/11**	**2010/11**	**2011/12**	**2011/12**	**2012/13**	**2012/13**	**2013/14**	**2013/14**	**2014/15**	**2014/15**	**Current**	**Current**
Learning Disabilities	742,161	48	879,735	52	1,154,957	63	1,424,253	69	1,390,043	74	1,476,536	89
Physical Disabilities	275,185	36	331,554	45	385,405	52	442,440	54	456,399	63	499,629	86
Children's Services	288,654	37	313,576	46	264,280	45	247,812	60	270,370	73	235,324	99
Older People	96,960	9	142,041	13	176,652	13	122,108	7	136,181	8	112,386	31
Mental Health	8,637	3	23,957	4	48,008	6	61,096	6	70,058	8	76,988	11
Miscellaneous												
Total	**1,411,597**	**133**	**1,690,863**	**160**	**2,029,302**	**179**	**2,297,709**	**196**	**2,323,051**	**226**	**2,400,863**	**316**

Service Area	Total Projection 2015/16	Total Number of Cases	Average
	£'s	No.	£'s
Older People	112,386	31	3,625
Physical Disabilities	499,629	86	5,810
Learning Disabilities	1,476,536	89	16,590
Mental Health	76,988	11	6,999
Children's Services	235,324	99	2,377

4.5 The Direct Payments have been made on the basis of an assessment of need and provide a cash alternative to the provision of a service. In most cases the payment

is being made in place of domiciliary, day and respite services. A small number of larger Direct Payments are in place of accommodation services.

4.6 The demand for Direct Payments will increase with the implementation of the Act particularly from young people who wish to take advantage of the opportunity to control their services. A scoping exercise is currently underway to analyse the future demand for Direct Payments and the financial implications for the Council. The growth in the number of Direct Payments should enable the council to reduce its provision of commissioned statutory services as people exercise choice and control over their care arrangements.

4.7 Direct Payments are an essential tool for the Council in meeting the Welsh Governments strategic aim of supporting people who require support and care to achieve their wellbeing outcomes and also to support carers who require support in achieving their wellbeing outcomes. Ensuring Direct Payments are an integral part of the assessment and care planning process will support the Council in supporting individuals to have more independence, choice and control over the services they require, in line with the requirements of the Act.

4.8 Some people who have a Direct Payment require support to administer the payments and employ personal assistants; to enable this the Council commissions a support provider and, after the previous contract came to an end in 2014, the Council entered into a formal collaborative agreement with Neath Port Talbot (NPT) and City and County of Swansea (CCS) for the delivery of a regional direct payment support service. CCS is the lead authority and holds the current contract with the provider on behalf of NPT and BCBC. Due to changes within the contractual arrangements, this arrangement has been reviewed and is coming to an end in June 2016. The Council are currently in the process of commissioning a direct payment support service for Bridgend which will be in place when the current contract expires. Officers have developed a robust service model that will meet the Council's requirements for a high quality and financially sustainable Direct Payment support service and has developed a service specification and contract based on this model. This service will provide support to individuals requesting a Direct Payment and will build on current numbers of people supported by the service.

4.9 In anticipation of the new Act, the Social Care Workforce Development team have been providing training on the changes that the Act will bring; this includes the emphasis on individuals having choice and control over the services they require and the role that Direct Payments can play in this. With a Direct Payment an individual can choose how their support is delivered and make the arrangements for this to happen. This gives individuals direct control over their support arrangements instead of the Council providing support through the provision of statutory services. Many people choose to employ a personal assistant to provide support; this is a person directly selected and recruited by the individual rather than a council employee. There are two case studies attached at **Appendices 1a and 1b** which give examples of how this works in practice.

4.10 The Council Lead Officer for Direct Payments is a member of the All Wales Direct Payments Forum. The purpose of this forum is to:

- establish and maintain an All Wales approach to the

recognition and promotion of Direct Payments as a core or mainstream option of delivering Social Care Services.

- provide a Forum for discussion and joint development of Direct Payments across Wales
- gather and disseminate good practice and highlight issues and inform all stakeholders within Local Authorities, Association of Directors of Social Services Cymru, the Voluntary Sector, the Support Services Network, the Welsh Assembly Government, and service users and carers.

5. Effect upon Policy Framework and Procedure Rules.

5.1 There is no effect on the policy framework and procedure rules.

6. Equality Impact Assessments.

6.1 There are no equality implications arising from this report.

7. Financial Implications.

7.1 The directorate is currently undertaking a tendering exercise to commission a support provider as referred to in paragraph 4.8. The contract amount will be circa £100,000, which will be met from the current directorate budget.

7.2 The actual financial impact on direct payments in 2016/17 as a result of the Social Services and Wellbeing (Wales) Act is unknown at present. Direct payments are expected to increase; however, the directorate budget of £2,350,000 is currently projecting an underspend of £235,000 as at the end of February 2016, mainly due to account reimbursements where service users haven't utilised their full direct payment allocation.

8. Recommendation.

8.1 It is recommended that the Committee note the report.

Susan Cooper
Corporate Director, Social Services and Wellbeing
March 2016

9. Contact Officer: Mark Wilkinson Group Manager
Telephone: 01656 642281
Email: mark.wilkinson@bridgend.gov.uk

10 Background documents
None

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Case Study R

R is a young man, who lives in the family home with his mother (carer) and his father who works full-time. They live in accommodation which meets R's needs. Family are an important part of R's life and they support him with most of his care needs.

R was born prematurely, which resulted in him developing Chronic Lung Disease (CLD) and delayed development. The CLD causes R to have shortness of breath and he becomes easily fatigued. He finds the CLD impacts significantly on his daily life routines. R is dependent on oxygen on a daily basis. R is able to walk short distance independently and uses an attendant-propelled wheelchair (WC) for longer distances. R was also diagnosed with Crohns Disease at the age of 16. He finds this condition can be very embarrassing at times and it has a negative effect on his overall self-esteem and emotional wellbeing.

R did study at College; he enjoyed studying although he constantly found juggling the academic side of things and coping with his illnesses very demanding. R received support from Classroom Assistants both in school and college.

R was known to Children Services before transferring to Adult Services. He used to receive support from a Disability Support Worker through Day Services. R's experience of the support was that it was inflexible and there was lack of choice of who supported him.

During an annual review the Direct Payment Scheme (DPs) was discussed with R and his mother; and the family haven't looked back since. Over the last several years R's DP has increased from the initial 4 hours to 10 hours. It supports R to achieve his ongoing outcomes. It also provides R's mother with some valuable respite time. Additionally it provides the family with peace of mind that R is safe with people they trust.

R's DP is very important to him since it provides him with independence outside of his family networks. R feels DPs facilitate in him being able to take control of his own life providing him with flexibility and choice and giving him autonomy.

R uses his DPs to prevent social isolation which was a big problem he experienced after leaving full-time education. R is now able to access activities of his choice which contributes to R developing life skills, such as developing independence skills, organising his own time management, developing confidence skills and being able to advocate for himself.

R has been pro-active in finding and employing his own PAs. He now feels confident enough to engage in this without support. R enjoys having choice and control of who can support him and most importantly when.

The Direct Payment Scheme had made a marked improvement of on the quality of life that R now has. This in turn has a beneficially effect on his family who continue to support him with the day-to-day tasks he cannot do himself.

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Case Study P

P was living at home with his family; he has ASD and a learning disability. P's family were finding it increasingly difficult to care for P who has very ritualised and routine behaviour. P had a direct payment to enable him to access the community and give his family respite. P also has a friend, T with a direct payment and they would engage in community activities together.

The care manager coordinated discussions between a local landlord who had a house for rent close to P's home and it was agreed that P and T would have a shared tenancy in the house. It was also agreed that support would be provided to P and T by the existing P.A's by combining and increasing the two direct payments.

A support plan was agreed and P and T have been living independently in the community close to their families for 5 years. They both access a range of community groups and activities and have their own home. They are also able to maintain close contact with their families who are very happy with the arrangements.

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BRIDGEND COUNTY BOROUGH COUNCIL

REPORT TO ADULT SOCILA CARE OVERVIEW AND SCRUTINY COMMITTEE

6 APRIL 2016

REPORT OF THE ASSISTANT CHIEF EXECUTIVE – LEGAL & REGULATORY SERVICES

NOMINATION TO STANDING BUDGET RESEARCH AND EVALUATION PANEL

1. Purpose of the Report

1.1 The purpose of the report is to seek nominations for the Budget Research and Evaluation Panel.

2. Connection to the Corporate Improvement Objectives / Other Corporate Priorities

2.1 The priorities identified in the Corporate Plan 2013-2017 have been embodied in the Overview & Scrutiny Forward Work Programmes. The Corporate Improvement Objectives were adopted by Council on 19 February 2014 and formally set out the improvement objectives that the Council will seek to implement between 2013 and 2017. The Overview and Scrutiny Committees engage in review and development of plans, policy or strategies that support the Corporate Themes.

3. Background

3.1 The BREP was originally set up on an annual basis and focussed on examining the annual draft budget proposals to aid the scrutiny process. In contrast, the standing BREP whilst examining annual draft budget proposals, also undertakes informal consideration of proposals related to medium and longer term reviews linked with the Council's Strategic Change Management Programme. It seeks to assist management in the delivery of the plans to support change and the Medium Term Financial Strategy by fully utilising its community representational role to inform policy changes and provide challenge and the BREP will develop its terms of reference and methodology within that function.

4. Current Situation

4.1 The BREP 2015/16 agreed that the Panel should continue to consider which services will be delivered differently, which will no longer be provided directly by the local authority and which services will no longer be provided at all. This consideration should be extended to all service areas, regardless of the extent of the budget savings required of them.

4.2 The BREP noted the recent review of the Corporate Priorities and considered that there should be an ongoing role for the Panel to take part in a wider discussion with Cabinet and CMB about the future delivery of services.

4.3 The BREP requested that as part of their future work they be involved at the planning stage of any public consultation or engagement surrounding the draft

budget and at key stages throughout the process such as where questions and methodology are formulated.

4.4 The BREP considered that the work of the Panel is a vital and important mechanism for budget setting and monitoring to ensure an objective, democratic approach from the start of the budget setting process.

4.6 In addition to this the Panel requested that the 2015/16 BREP undertake a review of the process following the setting of this year's budget. The purpose of this would be to evaluate the effectiveness of BREP, to identify any potential improvement, establish how recommendations are taken forward and to provide evidence of the impact and outcomes from the work of the Panel. This is due to take place in April/June 2016.

Membership and Relationship to Overview and Scrutiny Committees

4.7 To ensure the focus and analytical depth necessary for the Panel, total membership should be no more than ten Members, therefore the Standing BREP will consist of the Chair and one other Member nominated from each of the five Overview and Scrutiny Committees. The Chair of the BREP will be nominated by the members of the BREP itself at its first meeting. A further nomination is also being proposed as a reserve, to try to alleviate any potential impact resulting from any changes to the Committee membership at the Annual General Meeting of Council.

4.8 The standing Panel's Forward Work Programme (FWP) should be informed by the Council's Medium Term Financial Strategy and Strategic Change Management Programme.

5. Effect upon Policy Framework and Procedure Rules

5.1 The report has no direct effect but seeks to broadly support the Authority in the development of future services.

6. Equalities Impact

6.1 There are no implications in this report.

7. Financial Implications

7.1 None

8. Recommendations

The Committee is asked to:

- Nominate the Chair and one other Member of the Committee onto the standing Budget Research & Evaluation Panel.

- Nominate a further Member as a reserve, to try to alleviate any potential impact resulting from any changes to the Committee membership at the Annual General Meeting of Council.

Andrew Jolley,
Assistant Chief Executive – Legal and Democratic Services

Contact Officer: Kym Barker
Scrutiny Officer

Tel: (01656) 643161
Email: Scrutiny@bridgend.gov.uk

Background Documents:

Bridgend County Borough Council Constitution
Part II of the Local Government Act 2000: Executive Arrangements

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