BRIDGEND COUNTY BOROUGH COUNCIL

REPORT TO THE OVERVIEW AND SCRUTINY COMMITTEE NUMBER 2

7 MARCH 2018

REPORT OF THE CORPORATE DIRECTOR, SOCIAL SERVICES AND WELLBEING

PREVENTION AND WELLBEING AND LOCAL COMMUNITY CO-ORDINATION

1. Purpose of Report

1.1 To present to the Committee the range of prevention and wellbeing services and community based opportunities for support that is being developed and their strategic importance.

1.2 The report includes:

- Information about the number of different initiatives that are available within the community as an alternative to statutory services.
- Information on the work being undertaken with the 3rd Sector.
- Initiatives that are available within the community
- The input provided by Abertawe Bro Morgannwg University Health Board (ABMU), BCBC and other partners.

1.3 The report will be supported by a presentation which will include details of local initiatives and perspectives of people who have accessed prevention-based opportunities.

2. Connection to Corporate Improvement Plan / Other Corporate Priority

2.1 The report links to the vision of the Council to act as ‘One Council working together to improve lives’ in an environment where people and communities are being encouraged to have more responsibility for their own wellbeing.

2.2 The report aligns to the principle that the Council will support communities and people to create their own solutions and reduce dependency on the Council.

2.3 In particular, the report links to two of the three identified corporate priorities:

- Helping people to be more self-reliant
- Smarter use of resources

2.4 The report identifies the importance of progressively developing a ‘one Council’ approach to prevention and wellbeing that collaborates to build resilient and supportive communities.

2.5 There are also identifiable links to other established plans and strategies including:

- Adult Social Care Commissioning Plan;

- The Remodelling Adult Social Care Programme;
- The Third Sector Action Plan;
- Ageing Well Plan for Bridgend;
- The Council's Medium Term Financial Strategy.

3. Background

3.1 The context of the Prevention and Wellbeing agenda was initially reported to the Health and Wellbeing Overview and Scrutiny Committee in April 2015 with a review of progress presented to the Adult Social Care Overview and Scrutiny Committee in April 2016.

3.2 This report reviews the progress being made within the Social Services and Wellbeing Directorate but also recognises collaborative working across the organisation, within key partnerships and also with local communities.

3.3 The legislative frameworks that Wales has established to improve wellbeing highlight the benefits and importance of preventative support and serve to drive policy and strategy within and between services.

3.4 The Social Services and Wellbeing (Wales) Act 2014 requires due regard to UN Principles for Older People (1991) and UN Convention on the Rights of the Child (1989). The duties include conducting joint population needs assessments with Health Boards, proactively improving the wellbeing of service users and carers, developing preventative services that universally promote wellbeing but also reducing escalating needs, providing wellbeing related information, advice and assistance and also the development of social enterprise and cooperative responses to needs.

3.5 The Wellbeing of Future Generations Act (Wales) 2015 has established 7 wellbeing goals that focus on increasing prosperity, resilience, health, equality, cohesion, global responsibility, culture and Welsh language. The principles that underpin the Act of long term sustainability and developing the connectivity between organisations, services and resources, support the case for prevention and wellbeing approaches.

3.6 The Bridgend Public Service Board has developed a draft Wellbeing plan as a consultation document. The plan recognises the importance of working in partnership as a long term commitment to preventing the underlying causes of problems or reducing their escalation in an integrated and collaborative manner. The plan identifies the importance of social wellbeing and the value placed by local people on being connected within communities. The need to develop age friendly communities based on demographic changes is identified, the negative impact that some experiences can have from early life throughout the life course, but also the use of social prescribing opportunities to signpost people to support networks.

3.7 At a national level, Welsh Government has produced 'Prosperity for All – the National Strategy' (2017), recognising the need for an agile public sector to do things differently and also do different things to contribute to the wellbeing goals for Wales. The prevention and wellbeing approach being developed in Bridgend connects particularly to the 'healthy and active' and 'united and connected' themes of the national strategy, setting long term foundations for the future.

3.8 The Prevention and Wellbeing agenda also has strong links to the joint work that is taking place with BAVO and the Third Sector Stakeholder group to develop an action plan that recognises the future importance of the third sector and the role played in developing resilient and supportive communities.

4. Current Situation/Proposal

Prevention and Wellbeing Leadership

4.1 To date, the development of preventative and wellbeing approaches has been taken forward in the Social Services and Wellbeing directorate and a Prevention and Wellbeing Project Group has been established to oversee this work.

4.2 There is an identified opportunity to develop a robust performance framework for preventative work with the development of evidence and impact measurement by type of intervention. The prevention model is still relatively new and therefore it is essential to share and adopt learning and good practice and a need to expand the range of services and partners engaging in prevention and wellbeing.

4.3 In September 2017, the Social Services and Wellbeing directorate carried out a realignment of structures across the whole directorate which enabled the Group Manager of Sport, Play and Active Wellbeing to change the focus of his role and become the Group Manager of Prevention and Wellbeing. This has supported a focus on prevention and wellbeing and the broader service area to contribute to community wellbeing development opportunities. This approach adds to the experience of the directorate management team focusing on prevention and ensures a focus on community and third sector is integrated in planning and evaluation.

4.4 At an operational level, training events have been held to better understand the Prevention and Wellbeing agenda and opportunities for partners to contribute. These sessions have seen mixed representation including social care, third sector, volunteers and national bodies. The focus has been on Asset Based Community Development (ABCD) that aims to co-produce work with communities and build on skills and capabilities. 50 people have attended and been engaged to date.

4.5 A new project plan is being developed to support a Prevention and Wellbeing workstream that will initially report to the Remodelling Adult Social Care Programme board but will need to reach further across the organisation within time and also connect with external partners.

Local Community Coordination (LCC)

4.6 Local community coordination aims to support people to create their own practical solutions to identified needs and within inclusive and supportive community opportunities. The programme offers support to vulnerable adults, carers, people with disabilities and young people who present wide ranging difficulties and issues.

4.7 The support is provided at differing levels commencing with information, advice and assistance that connects people to local organisations or support networks on issues such as health, housing or finance. There is also a casework aspect for

people whose needs are more complex and need more engagement to develop skills and confidence to connect with local or community support opportunities.

4.8 An additional dimension to the work of the Local Community Coordinators has seen support for people who have been receiving managed care but who could integrate into alternative community based opportunities and transition into more local and more cost effective support. An evaluation conducted in 2017 indicated that the LCC programme had supported day services provision with 80 people provided with alternatives to managed care potentially releasing £216k of social work time to support other demands.

4.9 The sources of referral for the LCC support are many and varied and include carers, Care and Repair, Police and Fire Rescue Services, Health, Job Centre, ARC, Social Services, mental health partners, Doctors, community workers and substance misuse organisations. This highlights the variety of presenting needs and illustrates how some people's needs might be lower level but multi-factorial. It is also relevant that people can self-refer into the LCC programme.

"Through your connections and knowledge, our patients have benefitted from being able to access different facilities….Having you available on your visits and being on the end of a phone have meant we have been able to point patients in the right direction for their individual needs." Surgery Practice Manager – LCC Programme.

4.10 In terms of the outcomes delivered, there is also variance by individual needs although reductions in isolation, increased sense of financial security, reductions in anxiety and depression, feeling more in control of life and with improved physical wellbeing are all relevant outcomes identified by local people.

"X had severe agoraphobia and had not left the house for 10 years. She would self-harm and had frustration and depression which made her further withdraw…..she how has a plan for the future and wants to return to work….she is a natural leader in our community group, has gained in confidence and has enrolled on to online learning". LCC Coordinator.

4.11 The pilot phase of local community coordination commenced in the Llynfi Valley in 2015 and this has subsequently been followed by programmes in the Ogmore and Garw Valleys. As such, the LCC programme is now active in three areas.

4.12 The LCC programme is based on the models of local area coordination as an evidence-based preventative intervention. This approach has been evaluated at a national level and identified as producing a social return on investment (SROI) of 4:1 for every £1 invested. SROI is a methodology used by Government, National Audit Office and the third sector to identify the value of interventions related to investment.

4.13 The initial evaluation report conducted by Swansea University discovered benefits such as avoided calls for Social Worker support, avoided GP visits, avoided calls for mental health services and identified links to volunteering. There was a suggestion of anticipated further benefit relating to employment, avoided community nurse visits, delay or avoidance of residential or nursing care and avoided home care visits.

4.14 The needs of people are diverse but are illustrated in terms of how this prevention based approach can contribute to improved wellbeing in **Appendix 1** by connecting people together.

4.15 An important aspect of the LCC model is that longer term support can be found in the community but this relates to the needs of individuals (including appropriate levels of complexity) and the locally available opportunities. The detail as to opportunities that are currently linked to is shown at **Appendix 2** on an area by area basis.

"The participants were individuals with various needs including mental health issues, depression, anxiety, chronic health conditions and loneliness and isolation. The group is now run by group members with craft skills; they have become friends and contact and support each other. They have reported their own wellbeing improvements, fundraise and are more in control." Wellbeing Through Creativity Group – LCC Programme.

4.16 There are three performance indicators within the Directorate Business Plan that the LCC programme directly contributes to:

- The number of people who have been diverted from mainstream services to help them remain independent for as long as possible (local indicator), the LCC programme has supported 350 people since its commencement to connect with lower level support (186 Llynfi Valley, 101 Ogmore Valley, 73 Garw Valley);
- The number of people reporting that they have received the right information and advice when they needed it (national indicator);
- The number of adults who receive a service provided through a social enterprise, cooperative, user-led service or third sector organisation during the year (national indicator).

4.17 The model of local community coordination is founded on a population base of 15,000 people and a caseload of up to 60 people at a given time. The Garw and Ogmore programmes have a scale comparable to the model whilst the Maesteg area has a higher population base and has been longer established. The numbers of active cases on the respective databases are 53 for Maesteg, 28 for Ogmore and 42 for Garw Valley. Beyond the volume of participants it is important that the complexity of referrals is not so great that people cannot connect with lower level support offered by communities.

4.18 The local community coordination staff and programme have, since June 2017, been transferred to the Prevention and Wellbeing service area. This has provided a cost-effective management arrangement for the service and linked the work to other community development initiatives including external partners.

"People were chatting and forming friendships. A lady with a recent bereavement said she had got a lot out of attending and was comforted by meeting others with similar experiences. Another person who had been drinking excessively had ceased since joining the group." Café project to support bereavement – LCC/ARC.

4.19 A new performance and outcomes framework is being developed including a mental wellbeing assessment tool and a progress tracker against 13 potential outcomes.

The themes include personal safety, managing accommodation, managing relationships, community connections, financial stability, education and learning, employment and volunteering, lifestyle and physical/mental health. The service has been reviewing and comparing other programme frameworks that can be considered and also the contribution to national performance indicators.

4.20 A number of core services that contribute to the Prevention and Wellbeing agenda are continuing to develop and support the local community coordination approach.

4.21 A consistent barrier to connecting vulnerable people to community based opportunities is transportation. BCBC has been supported via Integrated Care Funding to work with Bridgend Community Transport to develop improved support for local people in the Ogmore, Llynfi and Garw valleys. These investments will have links to local community coordination but also broader community development approaches. The scheme will support access to health and wellbeing and domestic needs also. A steering group is developing a series of performance objectives for the scheme linked to group activities, volunteering, adult learning and more.

"Transport difficulties have resulted in older ladies being unable to attend social wellbeing groups. One of the ladies had cancelled her day service and meal prep/personal care support as she prefers this local community group activity to the day centre. The fear is that the lack of accessible transport may lead to their return to isolation and be detrimental to their friendships, wellbeing and physical health". Local Community Coordinator.

4.22 There are four community hubs in operation at Cwm Calon (Maesteg), Sarn Adult Support Centre, Ty Penybont (Bridgend) and Pyle Life Centre. The community hub model is based on meeting needs locally, connecting individuals within their own communities to support an independent lifestyle and decrease dependency. There is evidence to suggest community hub models deliver £5.05 of social and economic value for every pound invested and including £1.65 of care related savings. The alternative to community hub support might be a higher cost placement based on a higher level of managed care. BCBC is seeking support from the Integrated Care Fund to appoint a Community Access Development Officer. The community hubs will add more opportunities beyond managed care and current activities include physical activity, mindfulness, yoga, crafts, drama and counselling.

"The community hubs are linking with Bridgend College to encourage Social Care students to volunteer up to 120 hours of their time. X is now volunteering and has experience in health care having trained as a Medical Secretary. She is friendly and outgoing and spends 6 hours a week providing information, advice and assistance to the community. Our aim is to encourage more students to support IAA and community hubs." Community Development Coordinator.

4.23 The important role of carers in supporting people to maintain their independence is recognised within legislation and reflected in the development of local support services. Welsh Government suggests that between 70% and 95% of the care provided to people in communities across Wales is given freely by family and friends. The support provided for carers is preventative in that it helps maintain the caring relationship and supports people to stay independent at home and prevent escalation of needs.

4.24 **Appendix 3** illustrates the levels of need of carers and the various support that can be identified at each level.

4.25 The Assisted Recovery in the Community programme (ARC) provides support for a range of mental wellbeing issues including depression, anxiety and panic. ARC can provide individually tailored support based on presenting needs and is connected to health partners and third sector providers including counselling support. The programmes of support can include developing community links, accessing educational and employment services and engaging in beneficial community activity. Regular programmes include substance and alcohol, citizens advice, post-natal depression, carers support, veterans support, mental health and more.

"X is a lady with a learning disability who lives alone. I met X during a joint visit with ARC who were following up on a GP referral. She was tearful, anxious, depressed and struggling to manage everyday life. Today X has made many friends and is active in her community. She is volunteering, undergoing training for anxiety and anger management and has led the establishment of a community group. She is now supporting other people and is attending family events." Local Community Coordinator.

"With your help in recognising the issues and sign-posting me to the appropriate services in a timely fashion, I have been able to develop my coping strategies…I feel blessed to have been given the opportunity to join the Mindfulness Group….I returned to work after 2 months and whilst I am still finding my feet and treading carefully, I am far better equipped to deal with things". ARC service user.

Developing Age Friendly Communities

4.26 The Ageing Well Plan for Bridgend identifies that prevention and wellbeing approaches can help to improve the quality of life for older people and ensure frailty is not inevitable.

4.27 The Public Service Board has recognised the growth in the older population and the need to support their wellbeing under the theme of healthy choices in a healthy environment.

4.28 Investing in falls prevention is taking place with the NHS identifying a social return on investment of 7.5:1 for each £1 invested. A falls prevention network group is active and coordinated by Care and Repair. Falls are a cause of distress, pain, injury, loss of independence and mortality.

4.29 There is a potential 31% increase in people living with dementia in Bridgend by 2021 and investment is progressing into community based opportunities and lifestyle management. Increased physical activity, improved diet, managing body weight and blood pressure are prevention based interventions.

4.30 Loneliness and isolation has a negative impact on mental health, cardiovascular disease, hypertension and dementia risk and 75% of women and a third of men over 65 years live alone, highlighting the need to connect to communities.

4.31 The prevention and wellbeing work can support people at earlier stages of the life course to help take responsibility for their wellbeing and quality of life. This is compatible with the Older Person's Strategy for Wales and Bridgend's commitment to the themes via the Dublin Declaration provided in 2013.

4.32 The work of the Public Service Board will develop indicators that illustrate how the Ageing Well Plan for Bridgend is contributed to by partners and how the quality of life of older people is impacted on.

Working with Social Enterprise, Cooperatives and Mutuals

4.33 The management of the Healthy Living Partnership with GLL/Halo Leisure and also the cultural partnership with Awen Trust sits within the Social Services and Wellbeing Directorate and service development planning is focused on the Prevention and Wellbeing agenda.

4.34 The Healthy Living Partnership provides support in the following ways:

- The National Exercise Referral Scheme funded by Public Health Wales engages every GP surgery and supports lower level interventions alongside chronic condition pathways. Over 1,500 people per annum are supported including cardiac, back care, pulmonary, falls, stroke, mental health and cancer programmes, and over 27,000 visits targeted;
- The accessibility of membership is evidenced with over 166,000 visits under the means tested access to leisure programme and with 1,239 older people and 576 disabled people having membership;
- The over 60 Free Swimming programme supports social wellbeing opportunities with over 80,000 visits, the highest in Wales, and additional opportunities for forces veterans supported by WLGA. The use of Hydrogym activities is included supporting rehabilitation;
- BCBC is discussing with Halo any additional support that could be formalised for carers whilst recognising existing support that is in place;
- Partnership working with the Alzheimer's Society has developed dementia friendly swimming opportunities and created organisational learning via Dementia Friends training;
- The Health Board is funding additional pulmonary rehabilitation programmes in community settings (100 people per annum supported), and the north cluster is investing in lifestyle management support and screening for residents who do not access their GP. 622 people have accessed lifestyle checks with 24% identified as medium to high risk and connected to support programmes;
- The development of a Wellbeing hub at Bridgend Life Centre is also being progressed with capital investment via Integrated Care funding.

4.35 The Cultural Trust Partnership also is growing in its support for the Prevention and Wellbeing agenda via Awen:

- The Hynt Scheme is being used to support cost-effective access to theatres and arts centres for visitors with an impairment or specific access requirement and their carers or personal assistants;
- The mobile library and Booklink service supports the vulnerable, isolated and less mobile to access resources and helps combat loneliness and isolation;

- Awen have conducted outreach work to support the development of Men's Sheds projects at Maesteg and Ogmore, promoting health, wellbeing and social inclusion;
- Trainees with learning disabilities accessing BLeaf and Wood B are now supported by Awen;
- A community programme 'My Sporting Days' has been developed to promote social interaction and combat mental health issues, piloted in the Ogmore Valley.

"An elderly lady (in her 80's) opened up and expressed regretting never learning to swim because of a scar on her body. She was asked if she still wanted to learn now and said 'yes'. She went for her first swimming lesson with 3 friends a week later." My Sporting Days – Awen.

4.36 Both of the above are examples of the preventative work in a community setting that is developing with key partners.

Building Resilient Communities

4.37 The Social Services and Wellbeing Directorate has been leading on the corporate project to develop a third sector scheme as required by Welsh Government. This work has been progressed with the third sector and includes:

- Development of a draft action plan;
- Consultation and focus group work;
- Internal focus group work.

4.38 The next steps will include the finalisation of the plan based on evidence gathered, development of a training resource on co-productive working, developing a formal mechanism for ongoing partnership working and celebrating and building on good practice. 106 organisations have contributed to the related survey and 24 organisations to focus group discussions.

Information, Advice and Assistance

4.39 This is an integral part of the Prevention and Wellbeing Agenda and work has been progressed in a number of areas:

- The directorate has been updating its information as part of the development of the new Council website;
- The Dewis web development project has progressed including information on community opportunities and support at a local and national level;
- BAVO has been supported to develop Info Engine information on the third sector and to enable it to connect to the Dewis resources;
- An Ageing Well web resource has been created to signpost local people to appropriate community support, linked to the national themes;
- Care and Repair have been supported to create online resources for local people and professionals on falls prevention;
- BCBC is now working with the Older Persons' Forum to establish network groups that can act as 'connectors' and share information with people who are digitally excluded.

Active Bridgend Programmes

4.40 The focus on prevention and wellbeing has resulted in a series of new developments that benefit a broader range of people and improve both physical and mental wellbeing.

4.41 Bridgend supports the National Disability Sport Community Programme and has achieved silver accreditation for inclusive provision by working with the community. There are now 13 accredited clubs and organisations offering opportunities to disabled people and families organised and run by the community.

4.42 After school activity programmes and school holiday short breaks and respite are offered for households with disabled children and young people as community support. 36 households are currently supported and include looked after children. Conditions such as autism, cardiac, cerebral palsy, sensory impairments and physical disability are supported. The programmes support social wellbeing of disabled children and also support family resilience and opportunities for siblings.

"D has autism and this support was recommended to us by Occupational Therapy. It has helped him manage his stress and anxiety and he is less violent. D has gained a sense of achievement, become more confident and becoming more interactive. D is overweight and this helps him to increase his physical activity." Parent - Community Rebound sessions.

4.43 The 'Move More Often' programme has been developed to support older people in day care, residential care and community settings to be less sedentary, maintain strength, balance and flexibility and to reduce falls. There have been 99 participants in training programmes to expand these interventions. The Olympage games have become an annual event and regular community opportunities are being developed with partners. Evidence suggests that 30% of over 60s fall each year resulting in high health and social care costs. Falls rates are higher in residential settings.

"The qualifications and knowledge I have gained through the Olympage programme has meant I can engage and inspire more people within our libraries and increase the role of our libraries". Library Development Officer – Olympage.

4.44 Bridgend has been the first area in Wales to run the 'Get on Track' programme for vulnerable young adults including some with adverse childhood experiences. There have been 3 programmes to date with high levels of retention and young people connected to employability opportunities. The Mental Health Foundation suggests 75% of mental health problems are established by age 24. External evaluation suggests Get on Track has a social return ration of 4.3:1.

"X was a looked after young person who had faced many challenges in life and saw Get on Track as a last chance. She thrived and successfully completed the first programme, secured employment, learnt to drive and now mentors other challenged young people across Wales. She was a BBC finalist for Most Inspiring Young Person in 2017." Get on Track – AYP Team/Early Help. Following the local programmes, 74% are now in education, training or employment; 33% are volunteering and 55% are physically active.

4.45 Bridgend has developed its FAZ (Family Active Zone) training and resources to support whole household approaches to improving lifestyles. The approach has been recognised as sector leading by Estyn. There are now 25 partners involved in the delivery of FAZ and there have been 15 programmes and 156 families supported. There is current dialogue with East Cluster GP Federation to develop this approach further linked to an emerging national obesity strategy.

Next Steps

4.46 The following aspects are relevant to the next stages of the development of prevention and wellbeing:

- Ensure that the current positive work that is progressing is integrated in transition planning relating to the proposed Health Board boundary changes;
- Work closer with health and public health partners to clarify the "burden of disease" and poor wellbeing that should be prioritised at a local level to deliver savings;
- Develop services and opportunities that promote community resilience and contribute to performance of the local Wellbeing Plan and Public Service Board;
- Develop the Prevention and Wellbeing Board structure in Bridgend to engage more internal services and more external partners also;
- Make use of the evidence base where it exists in selecting preventative interventions and progressively build the evidence base where it is less established;
- Recognise the importance of the third sector in delivering community based prevention and wellbeing opportunities that can become sustainable;
- Review how prevention and wellbeing is considered and co-designed within commissioning processes;
- Develop clarity of the complementary roles of partners and the opportunities to contribute to prevention and wellbeing, linked to collective delivery of shared outcomes;
- Ensure that where digital approaches are developed to support vulnerable people that they are supported to access information, advice and assistance where they are digitally excluded.

5 Effect Upon Policy Framework and Procedure Rules

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

6. Equalities Impact Assessment

6.1 There are no implications for equalities.

7. Financial Implications

7.1 The overall costs of the LCC programme have reduced via changes in management structure but there will be a need to identify sustainable core or external funding in future years. The current cost of LCC team is currently approx. £132k per annum and is funded from the Adult Social Care earmarked reserve and grant funding. The directorate needs to consider the longer term funding.

7.2 Where financial savings are being delivered, they are in a range of cost centres and often based on identifiable cost avoidance. In this sense, prevention and wellbeing is contributing to cost reduction or demand management for a number of service areas including children, young people and adults.

7.3 The report identifies the responsibility for 'One Council' to support the prevention and wellbeing efficiencies including contracted or commissioned works and to make best use of the existing resources available.

8. Recommendation

8.1 It is recommended that the Committee notes the contents of the report and provides comments on the work in this area.

Susan Cooper
Corporate Director, Social Services and Wellbeing
February 2018

9. Contact Officer: Andrew Thomas, Group Manager, Prevention and Wellbeing

Telephone: 01656 642692
Email: andrew.r.thomas@bridgend.gov.uk

10 Background documents

None

Appendix 1

Community Connections

In Partnership with BAVO, Public Health Wales , the Health Board and Valley and the Vale Arts, the Local Community Coordination programme was part of setting up a 12 week 'Wellbeing Through Creativity' craft group. The participants were individuals who had been referred to LCC for various reasons that included mental health issues as well as chronic health conditions, loneliness and isolation. The individuals vary in age range from 30s to late 80s and on average between 12 -14 people attended each week.. The individual ladies scored their wellbeing at the start of each session, which often would be low, and at the end, which would be significantly higher.

The individual ladies are all from the Llynfi Valley and most did not know each other. Many of them did not feel able to attend other local craft groups, such as WI, due to their mental or phyiscal health.. After 24 weeks of being together they bonded and could identify with each others issues. They became friends who cared about each other.. Following the end of the project with Valley and the Vale, the LCC worked in partnership with Halo to source a free room at the local leisure centre. Individuals who were eligible, were signed up for the Town Rider Community Transport scheme and others planned to make their own way.

The Group now continues and Two of the members with craft skills 'run' (co-produce) the 2 hour weekly sessions, when they can, as there are occassions they are unable due to mental or physical health.

B who has become one of the leads suffers with a chronic health issue, despression and anxiety. Her mobility fluctuates due to her health issues and she occassionally has to use a wheelchair. Even though Bs physical health continues to fluctuate, her mental health has significantly improved. She had a lot of skills that she was not sharing with others and now she is teaching the group and sharing her knowledge, which has boosted her mental wellbeing. B enjoyed leading the Llynfi group so much, that she now volunteers in the Ogmore Valley Arts on prescription group. .

C has a diagnosis of Personality Disorder and has struggled with her mental health all her adult life. C had been discharged from an acute mental health ward when she was referred to LCC by Mental Health Matters.. C, once again has a lot to offer her local community and many skills and is the second person leading the group. She planned and purchased (with money the group raised) many of the items needed to 'set up' the group. She has been pivotal to it continuing.

A is in her late 80s and was referred to LCC by her daughter/carer. A lives in a sheltered complex and due to her poor mobility was alone most of the time in her small flat.. A uses the community transport to get to the group ,enjoys the group and has made some good friends. One of the group has arranged to see her outside of the group to go for meals.

M is 89 with Macular Degeneration, hearing difficulties and other health issues. M was suffering with depression and had been referred to the CMHT. M was referred to LCC from Social Services. M has become an important member of the group and describes it as 'a family'. M has started to make and sew items for the group to sell so it can continue to buy craft materials. M says she hadnt made things in years due to her poor eyesight and arthritis, but she has been spurred on as she wants the group to continue . She is a creative lady and she has offered to take A out for meals etc, and they phone each other.M says the group is a lifeline. She used to attend day services.

A suffers with chronic anxiety, agorphobia, depression and was attending 6 monthly out-patient appointments with CMHT Psychiatry. A had barely left her home for over 17 years. LCC had supported her to attend a mindfulness group, which helped build up enough trust and confidence to agree to attend the Art group. A has gone on to help the older ladies who struggle with mobility and eyesight. She suffered a stroke at Christmas that set her back, but she has returned to the group determined as she says its become so important to her. A's husband had previously had to leave work to care for her. He was able to return to work as A was making such progress managing her anxiety and mental health. Following the stroke, he has had to care for her once again, but now she has returned to the group, he is hoping to return to work shortly as she is making great progress.

G is in her 80s and recently lost her husband of over 60 years. She has been left bereaft and she has had difficulties with her memory (Dementia is being queried). The OT at a local day hospital referred her to LCC as G felt lonely and isolated. G was welcomed into the group and quickly became friends with A (who rings and reminds G about being picked up). They have also attended Strictly Cinema together.

Al is in her late 70s and was referred by her GP to LCC as she was a regular attender and they felt she was lonely. Al suffers with COPD, Macular degeneration, arthritis and other chronic health conditions including depression. Al comes to the group instead of attending the day centre where she had been referred. Al talks about her love for the group and the friends she has made. They all phone each other and Al and G have attended Strictly cinema together. There are plans for other days to meet up for meals etc. Al says its her family and lifeline.

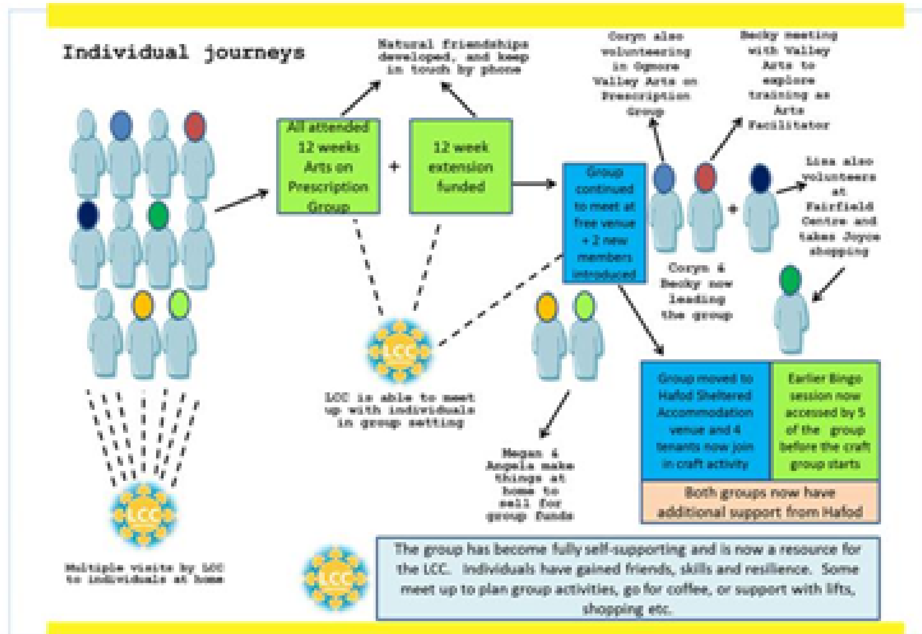
J was referred to LCC by Occupational Therapy. J is in her late 80's, lives alone and had recently been in hospital following a fall. She has no family contact and described how life was quite lonely. She had concerns that no-one cared about her. J was dubious about attending the group at first and soon realised that it was not about the craft element that was important, it was the contact with people. Recently, J was talking to a new younger member of the group (early 40s) and said how expensive taxis were to take her shopping as she cannot use the bus due to her mobility issues. The new member said " well J, I have to go shopping on my own, I like your company, why don't I take you shopping with me!"… (Perfect solution!)

S cares for her husband who has Alzeimers. S is in her 80s and self referred to the LCC. She felt more and more isolated due to caring for her husband and the group provides her with a break, new friendships and an opportunity to laugh. She says she 'needs' the group.

Outcomes achieved:

- The group have become friends, swapped numbers and are in regular contact with each other rather than the LCC.
- The group have reported an increase in their wellbeing as a result of attending the group.
- This group is co-produced by the community members.

Individual Journeys



Appendix 2

Local Community Coordination Support Networks (local level)

Llynfi Valley

Wellbeing Craft Group
Dementia Friendly Memory Café
Ex Miners Group
ASD Group
Men's Shed (Caerau)
Men's Shed (Maesteg)
Fairfield Centre Befriending (New)
Telephone Befriending Scheme (New)
Sunday Lunch Isolation Group (New)
Mini Olympage Programmes (New)
Craft Groups (Garth/Fairfield)
Maesteg Arts Society
University of Third Age
Llangynwyd Table Tennis
Caerau Community Centre
Garth Senior Citizens
Maesteg Canoe Club
Noddfa Sewing Group
Cwm Calon Stitch and Sew
Maesteg Knitting Shop
Fairfields Crafternoon
Maesteg Park Community Garden
Mental Health Matters
Parkinson's Support Group
Gateway Club
Y Llynfi Library
Oracle Job Club
Maesteg Library Reading Group
Caerau Senior Citizens
Caerau Social Centre
Caerau Boxing Club
Maesteg Bowling Club
Special Families
Armed Forces/Healing the Wounds

Ogmore Valley

Crossroads Community Café
Men's Shed Group
Wellbeing Craft Group
Housebound Group
Nantymoel Knitters
Over 50's Exercise Group
Sensory Group
Love to Walk
Blackmill Nordic Walking
Ogmore Primary Drop-In
Ladies' Choir
Foodbank
Ogmore Valley Pride
Cwrt Gwalia Armchair Aerobics
Ogmore Valley Archers
Ladies' Working Group
Comfort Cafe
Credit Union/Lewistown
Ogmore Vale Craft Group
Tondu Farm Wellbeing Centre
Valley Olympage (New)
Nantymoel Primary Time Banking (New)
Light Bite Café/Afternoon Tea (New)
Valleys Ravens
Halo Life Centre
Tai Chi for Wellbeing
Ogmore Valley Community Tennis
Cwrt Gwalia Community Garden

Garw Valley

Cwm Garw GP Practice
Tynycoed Surgery
Valley and Vale Arts
Royal British Legion
Bridges Into Work
Bridgend Community Transport
Bettws Arts Group
Olympage Programmes (New)
Foodbanks (Pontycymmer, Aberkenfig, Bettws)
Awen Trust
Cruse Bereavement
Ty Ellis
Garw Valley Railway
Halo Leisure/Life Centre
Butterfly Garden Project
Walking Groups (New)

County and Regional Support

Beyond the localised support there are connections with a range of partners and organisations including:

Social Services
Surgeries
ARC
Gwalia
Gofal
Wallich
Care and Repair
Hafal
Age Connects
RNIB
Samaritans
Victim Support
Carers' Centre
Age Concern
Emmaus

Ty Ellis Counselling
Communities First
Calan DVS
People First
Coal Industry Welfare Organisation
Step Change
ABFAB
Just Ask
Hafod Housing
Learn Direct
Job Centre
V2C Housing
WCDA Drug and Alcohol Support
Citizens' Advice Bureau
Macular Society

Appendix 3

Carers Services for Adults & Young Carers: Health; Local Authority; Third Sector (Western Bay Carers Partnership)

To support a person who provides or intends to provide care for an adult or disabled child

Universal (Preventative) Services for Independent Living	Community Support (including elements of commissioned services via Social Services)	Managed Care Services to Maintain Independence

Community assets universally available to all - for independence and healthy living.

>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>Increasing levels of need >>

Services require support from health, local authority and third sector.

Match-funding is required in supporting partnership working and the sustainability of services.

- active life, healthy eating - Public Health
- holistic therapies, Ageing Well initiatives - Public Health
- Support a Home, Shopping gardening, DIY
- Dewis Cymru / Third Sector / Other partners
- CAB, GPs, Community Practitioner
- Connectors **Carers Assessment**
- school support, **Training for Carers**
- Meals at home, Community Transport
- Telecare / Apps / Hoists etc
- Carers Card
- PA, personal choices
- Break (**Short Breaks, respite at home**)
- residential homes