Building on Strengths, Improving Lives

A Three-Year Plan for Sustainable Care and Support for Adults in Bridgend

Executive Summary

This plan has been developed to set out our strategic objectives, priorities and plans to deliver sustainable and effective social care and wellbeing support for adults in the County Borough.

The next three years are going to be very challenging for all local authorities and their partners across Wales. Resources are likely to be scarcer than ever before. Our population is growing and ageing. People and families are still recovering from the impact of the covid-19 pandemic and the cost-of-living crisis. To deal with these challenges we will commit to deliver fundamental changes to the design and delivery of our services and to the way we work with people.

We will need to target our limited resources on those who most need them, encourage active citizenship and make sure that the way we practice helps people to live as independently as possible, resilient and connected to friends, family and their community as much as possible. We will not do this alone; we will need to work closely with our colleagues across the Council, in the third sector, communities and in the health services and other public sector bodies to be successful.

We are clear about our direction of travel. We have already made significant progress but there is much more to do. We now need to:

- Deliver the improvements resulting from our new adult social care operating model.
- Deliver on our commitment to outcomes-focused strengths-based practice which will help us promote resilience and independence for the people we support.
- Drive through further improvements in our front door response, hospital discharge, reablement and long-term support in the community to ensure that our services are most effective in promoting resilience and reducing unnecessary demand.
- Secure greater cost-effectiveness through our transformation plans for learning disability, mental health, and long-term conditions services.
- Ensure that our support for staff, community engagement, technology and partnerships are all geared towards cost-effective and sustainable social care in the longer term.

This plan outlines how we will take these priorities forward with focus and commitment. between 2024 and 2027.

Introduction

This plan has been developed by the Bridgend County Borough Council Social Services and Wellbeing Directorate on behalf of the Council. It sets out our strategic objectives, priorities and plans to deliver sustainable and effective social care and wellbeing support for adults in the County Borough in the period 2024 - 2027.

The plan covers how we will transform our services and practices to meet changing population needs and demand identified in the Cwm Taf Morgannwg Population Needs Assessment, details of which are in our commissioning strategies. It sets the direction for the work we will do to ensure our services are sustainable, remain in line with national policy and best practice, and further embed a culture of continuous improvement in the way we work.

The plan shows how working in partnership with individuals, families and communities to promote people's independence, resilience, wellbeing, and safety will be at the heart of everything we do. This is what people want from us. It is both the most effective way of working and it is the most cost-effective way of delivering our services.

In Part 1 we describe the context for the plan. The next three years are going to be very challenging for all local authorities and their partners across Wales. Resources are likely to be scarcer than ever before. To deal with these challenges we need to take forward further fundamental changes to the design and delivery of our services and to the way we work with people. We will not do this alone; we will need to align our work closely with our colleagues across the Council, in the third sector, communities and in the health services and other public sector bodies to be successful.

In Part 2 we set out the progress that has been made to date. We are already implementing huge changes to our operating and practice models, but we recognise that in the next three years we will need to transform our services even further and faster if we are to respond successfully and sustainably to peoples care and wellbeing needs in the future.

In Parts 3, 4, 5, 6 and 7 we detail our priorities for this transformation, including our approach, priorities for specific population groups and what we will do to support these changes. Implementing these priorities will help us to be as cost-effective as possible, support more people to live independently and focus our work more on effective targeted prevention rather than intensive remedial support. This will include helping people access support, where needed, from friends, family and local community, encouraging local communities to engage more in local volunteering and community improvement. In doing so we will facilitate local capacity building, support people to live the lives they want to live and ensure we can meet the care and support needs of adults when, and only when, their own resources are not sufficient.

We are changing the way we work with people, targeting our limited resources on those who most need them, encouraging active citizenship and making sure that the way we practice helps people to be independent, resilient and connected to friends, family and their community where possible.

This plan is presented in draft form for consultation with the public, with people with care and support needs, families and carers and with professionals and partners prior to formal decision by the Council.

1 Context

Significant challenges are being faced by Bridgend County Borough Council (CBC) and its partners in supporting the health, wellbeing and care of our population and will continue in the next few years. Analysis shows future demand across the region is likely to continue to grow. The Cwm Taf Morgannwg population needs assessment[1] sets out that:

'Over the next 10 years our population is predicted to rise to 463,809 (3%) and to 475,229 over the next 20 years (5%) …. we are expecting an increase in the number of people aged 65 years and over, with the most significant increase in those aged 85 years and over. This is going to have a considerable effect on individuals, their communities and the services that support them.'

For people with conditions such as dementia, for example, this is likely to generate significant increases in demand for care, and Bridgend County Borough Council is projected to have the highest increase in the number of people living with dementia in the Cwm Taf Morgannwg region through to 2030:

Local Authority	2020	2025	2030	% increase 2020 - 2030
RCT	3,319	3,724	4,207	27%
Merthyr	813	931	1,063	31%
Bridgend	2,139	2,457	2,841	33%

Similar levels of projected increases are noted in the population assessment for people with learning difficulties and disabilities, neurodiversity, mental health challenges and sensory disabilities.

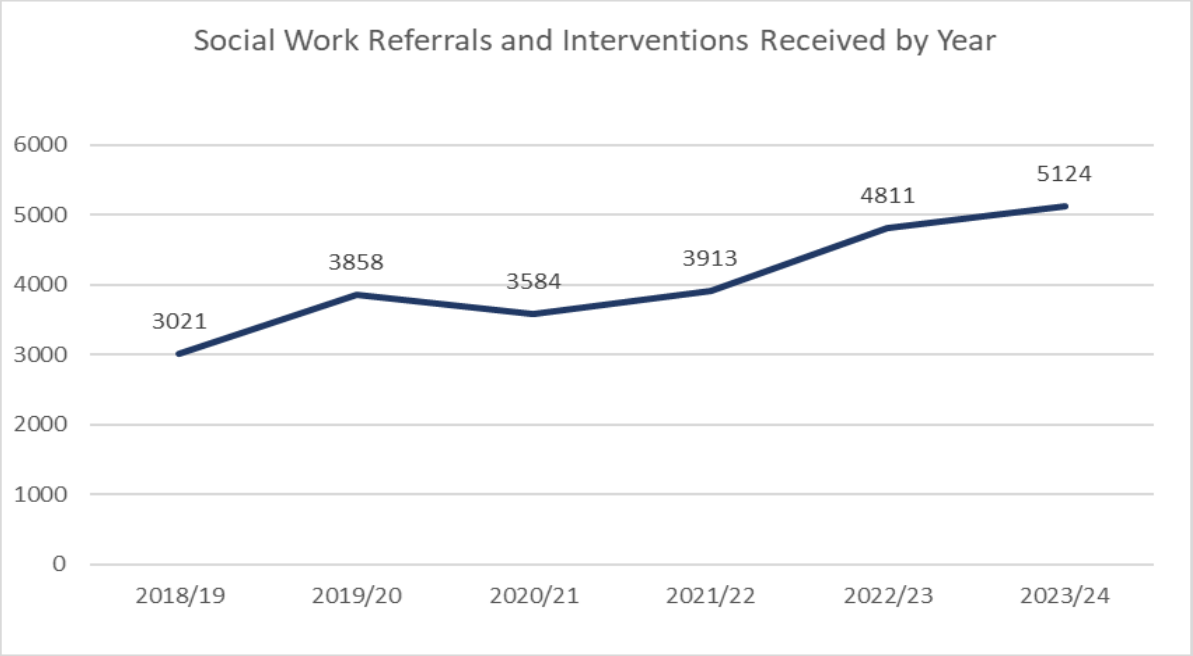
On the supply side, resources and staffing will also continue to be challenging. The Cwm Taf Morgannwg regional market stability report produced in 2023 summarised the situation as:

'With the data suggesting there are going to be more people living with dementia, chronic conditions and co-morbidities, the services that support them will have to adapt to the changes in demand. The national shortage of staff to deliver key social care and health services is having a significant impact on the capacity to meet growing

[1] CTM Regional Partnership Board: Population Needs Assessment in Cwm Taf Morgannwg 2022-2027

domiciliary and residential care, which has seen an increase in demand during the pandemic.'[2]

These factors have been influencing the number of people needing social care for some time, but this has been exacerbated in the last few years. As can be seen in the graph based on Council activity and performance data below, social work referrals and interventions have been increasing on average at a rate of around 13% per annum over the last 5 years.



Similarly, post-pandemic increases in demand for information, advice, assistance and support are evident across all population groups. For example, using internal Bridgend performance and activity tracking data we can see that adult social care contacts have increased since 2022/2021 and assessments have been increasing rapidly in the last two years:

	2020/21	2022/23	2023/24	Increase/Decrease
Number of contacts received by adult social services	4,361	6,044	5,782	-4.3%
Number of new assessments completed	1,389	1,815	1,850	1.9%

Adult safeguarding referrals have also increased recently, suggesting both greater awareness and greater need coming to the attention of the Council:

[2] CTM Regional Partnership Board: Market Stability Report June 2022.

- There were 634 adult safeguarding referrals received during 2023/24. This is a 130.5% increase when compared to 2018/19 where there were 275 safeguarding referrals.
- In response to these referrals there were 584 formal 'adult at risk' enquiries completed by the Council during 2023/24. This is a 123.8% increase when compared to 2018/19 where there were 261 such enquiries completed.

Demand is not just at the front door. In terms of supporting people with longer-term multiple care needs such as residential care funded by the Council, overall demand from all adults has increased by almost 20% from March 2021 to March 2024, with the number of older people (including mental health) needing this care increasing by more than 19.4% (86 people) in that time.

Year	March 2021	March 2022	March 2023	March 2024
Drugs and alcohol	1	1	1	1
Physical disability	10	8	12	14
Older people mental health	136	151	170	193
Older people	232	253	246	262
Mental health	46	45	44	38
Learning disability	19	19	20	22
Total	444	477	493	530

This trend is not exclusive to Bridgend. Across Wales the number of people receiving support from their local authority with long-term home accommodation has increased by about 7.5% (from 12,264 to 13,183) between November 2022 and March 2024[3].

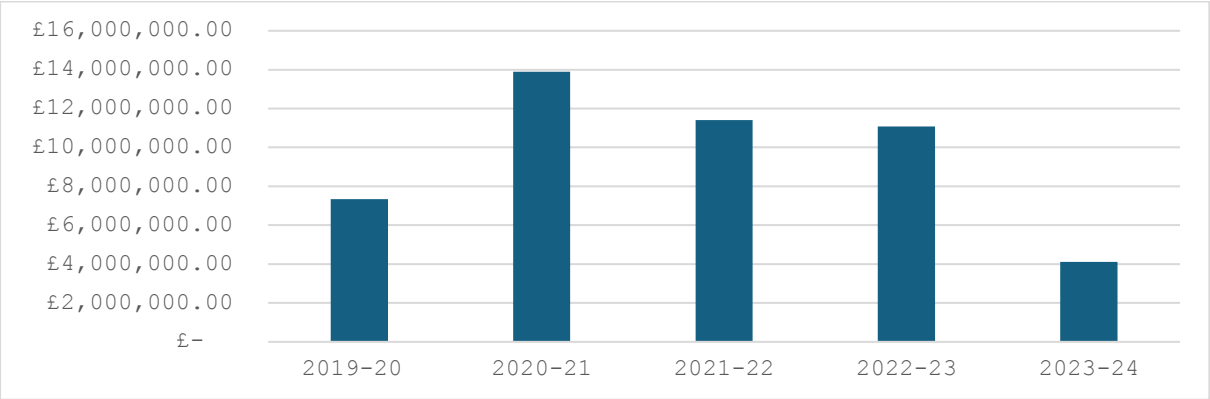
Another example of increasing demand has been in learning disability services, where in addition to residential care being used more often, intensive two-to-one and one-to-one support for individuals in the community has increased; for example, between April 2021 and February 2023 almost 60% of supported living packages have had to increase hours provided to meet increased assessed need, resulting in an overspend of on the original budget for 2023-24.

Similar experiences have been seen in other areas of adult social care including those for people with mental health problems and adults with physical and sensory disabilities. There does not appear to be one single cause of this additional demand, but rather a combination of changing expectations and demand on families and carers,

[3] Welsh Government Social Care Statistics Report March 2024

as well as the ongoing impact of austerity, the Covid-19 pandemic, and the capacity of other services in the community to contribute to people's health, wellbeing and support.

Overall, these demand increases have placed huge pressures on core adult social care budgets in the last few years, and they have been exacerbated by reductions in Welsh Government grants such as Housing Support Grant made available to meet housing support needs in adult services as homelessness has been prioritised, Social Care Pressures and Recovery Grants as the additional funding to support recovery from the Covid-19 pandemic has tailed off. Indeed, the total grants received by the Social Services and Wellbeing Directorate from Welsh Government has reduced since 2020-21 as follows:



There have also been direct additional budget pressures because of:

- Increases in cost of contracts simply to maintain existing provision.
- The Real Living Wages pledge made by Welsh Government.
- Recommissioning to secure better quality domiciliary and supported living provision.
- A review of cost of care provision from local residential care providers.

The table below shows the impact of increased demand on adult social care from core spend between 2020/21 and 2023/24.

	2020/21 Actual Spend	2022/23 Actual Spend	2023/24 Revised budget Feb 2024	Increase in spend over 3 years
Adult Social Care Total	£44.985m	£58.148m	£65.949m	£20.964m (46%)

When compared to other local authorities, the spend on adult social care is around the Welsh average based on published data (StatsWales data below):

	Net spend on Social Services 2022/23 (£000s)	Population	Spend per head (£000s)	Compared to BCBC
Wales	2,610,791	3,169,586	0.824	+0.2%
RCT	228,623	241,873	0.945	+14%
Merthyr Tydfil	48,551	60,424	0.803	-2.3%
NPT	124,983	144,386	0.866	+5.3%
Bridgend	**121,317**	**147,539**	**0.822**	**0%**

Population need is continuing to drive additional demand and the Council as a whole recognises the challenges that adult social care is facing. In its Medium-Term Financial Strategy[4] approved by Council in February 2024, it committed to an adult social care budget of just over £71m for 2024-25. This is an increase of 7.7% on the 2023-24 revised budget of just under £66m.

However, there are other big pressures on overall Council finances, and it is unlikely that there will be further significant increases in social care budgets over the lifetime of this plan. Indeed, the Council signalled further overall reductions in its Medium Term Financial Strategy:

'Due to the impact of current year and anticipated future pressures, the amount of budget reductions required for 2024-25 is substantial. Over the period of the MTFS the financial forecast for 2024-2028 is currently predicated on £44.9 million of budget reductions being met from Directorate and Corporate budgets…however the assumptions beneath them can change quickly and with an uncertain, but probably more challenging financial settlement likely going forward, this level of reductions could change.'

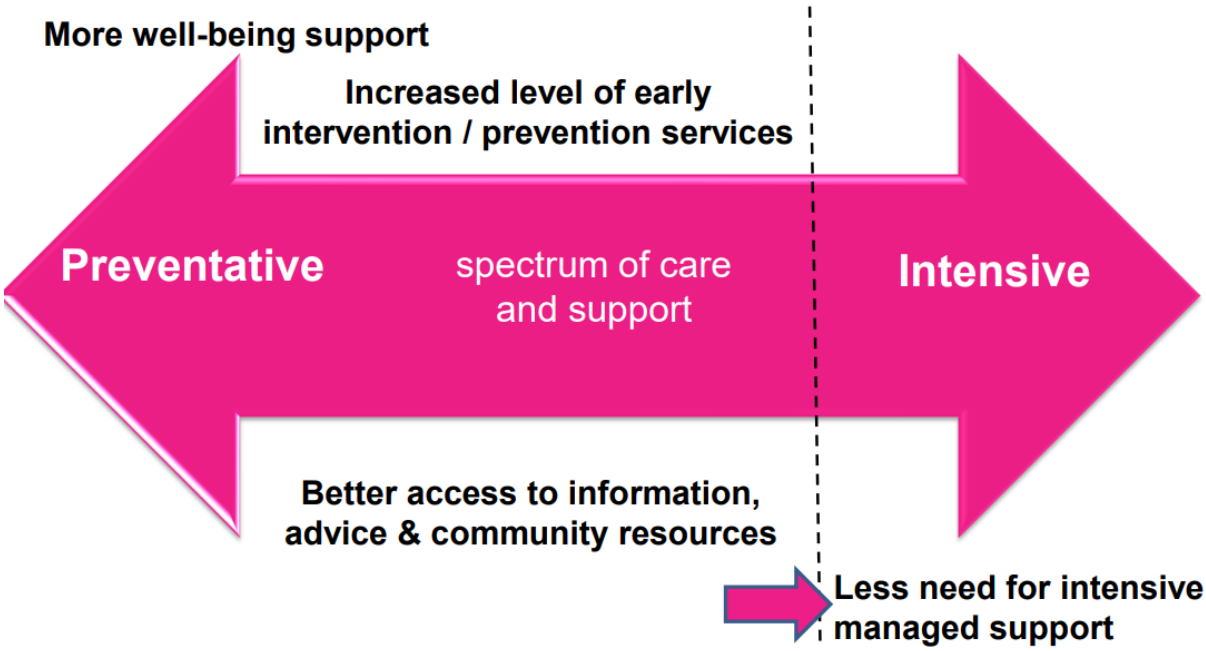
This plan therefore is based on our analysis that, while recognising the huge progress that has been made in adult social care already to reshape services and people's expectations, further transformation is needed to ensure that our services are financially sustainable and that with our partners and our local communities we are effective in meeting need and promoting wellbeing and independence in the future.

We need to work with people, with our local communities, our third and independent sector services and our health partners and other public sector bodies to enable people to help themselves with appropriate information, advice and assistance and preventative support. If we can minimise the number of people who need to be referred to us in the first place, work intensively with people who need care and support to help them live independently, and reduce the need for intensive and long-term

[4] Bridgend CBC Medium Term Financial Strategy Appendix F February 2024

support, then we have the chance to limit demand, respond more effectively when people do need our services, and encourage a more resilient local population.

To achieve this, we need to make sure that the resources which are available to us are used in the most cost-effective and sustainable ways, and this will require further fundamental changes in how people with care and support needs are helped to live good lives, supported by their own resources and connected to their families, friends and communities, rather than by drawing people into an ongoing reliance on our services. This is turn will need us to engage with local communities in asset-based community development to build local supports which help to prevent people needing more formal care. This focus on prevention is summarised in the following diagram quoted from the Social Care Wales introduction to the Social Services and Wellbeing (Wales) Act 2014:



If we do not manage to make this change, then it is clear from the trends to date, that demand will increasingly outstrip available resource and supply. This will put further pressure on our services and resources and may result in people waiting longer for vital care and support. Without progressive statutory services and local community and partner efforts geared to prevention, independence and enabling / reablement in the community, we will be caught in a cycle of increasing demand and inadequate provision.

We set out in the sections that follow the progress that we have already made, what will be different as a result of this plan, and how our sustainable social care wellbeing services will improve outcomes for people and make the best use of our resources.

2 Our progress so far

We are already in the middle of a period of transformation for adult social care in Bridgend. We have set out our way forward this year in two key developments:

- Our adult social care operating model introduces major changes to the way in which our services are organised and interact with each other and the public. We have set a clear direction of travel and are implementing that model.
- Our outcome-focused strengths-based practice model underpins the way in which all our staff are expected to work and respond to people's needs. We have set out our approach, and we are already using it to change practice across the service.

Both are informed by national policy and guidance including:

- The Wellbeing of Future Generations (Wales) Act (Welsh Government, 2015).
- Social Services and Wellbeing (Wales) Act 2014.
- A Healthier Wales Plan (Welsh Government, 2018) and the national Transformation Programme (2018-21).
- Regional Integration Fund (Welsh Government 2022-27) commitment to national models of integrated practice for 2027.

The two models are already having an impact and they underpin all the improvement work we have been doing in Adult Services to date. There is much more to do, however, and we plan to use them to help drive forward our transformation further and faster to promote self-reliance and independence, reduce need for care and support, and encourage people across Bridgend to take a lead responsibility for their own wellbeing and health and for their local community.

2.1 Adult Social Care Operating Model

The operating model sets a blueprint for our services and how they interact with each other and our partners to ensure that we are effective in promoting independence, resilience and community-based care and support. These aspirations are consistent with national policy and legislation and help deliver our priorities to:

- Provide services which increase the number and proportion of people who can live well at home or in the community.
- Work with our partners to build seamless care and support services.
- Help build well-resourced and responsive communities which ensure that people with care and support needs can live well at home.
- Reduce the proportion of people in Bridgend who need long-term intensive care and support from the Council.

The operating model is creating the best possible conditions to allow our staff to work in an outcomes-focused, strengths-based way. It includes strategic actions to deliver the following:

- A three-tier operating model with clear delineation between early intervention and prevention, long-term generic and specialist social work teams.
- At the early intervention and prevention tier a multi-disciplinary team with Social Work Practitioners, Nurse, Occupational Therapists and good links with Local Community Connectors, the Carer's Wellbeing Service and the third sector.
- A focus on maximising community assets and using preventative approaches to avoid early entry to the higher, specialist tiers, and people being assessed and supported for no longer than 12 weeks.
- At the long-term integrated locality teams tier, work within primary care networks and cluster teams with a wider brief and stronger support ensuring they can access community and partner agency resources to support individuals.
- At the specialist tier new arrangements for social care mental health, older persons mental health, safeguarding, learning disability, commissioning for complex needs and substance misuse support.

The operating model will help us to take our programme of transformation forward further and faster and make even better use of our resources by:

- Helping people to make best use of their local support and resources.
- Reducing people's reliance on social care services.
- Promoting independence and family and community-based support.

2.2 Outcomes-Focused Strengths-Based Practice

To be successful in delivering a service which promotes independence and resilience, maximises the number of people who live well without care and support, and reduces the number of people relying on intensive and long-term social care, needs a shared approach and consistent practice across our workforce. We need all our staff to work in a strengths-based way, even where this might cause some short-term discomfort or challenges. To secure this, our new practice model was launched in April 2023. It is based on ten principles of practice:

- We will engage with individuals, build relationships in a spirit of collaboration and person-centred care.
- People are their own experts on their own lives. We will encourage the person to describe what matters to them in their own words or own way, thereby promoting choice and control.
- People may need help to do this. We will listen actively and check that we have understood.
- We will listen out for, affirm, and encourage people to use their own strengths and capabilities.
- Safeguarding – we will be alert to risks and support people to take steps to reduce or eliminate them.
- We will assist the person to clarify their own outcomes that emerge from collaborative, sensitive conversations.
- We will be open and honest about our own views about what we can do and are unable to do.

- We acknowledge that people's carers, their families, their local community, and our professional colleagues can be valuable contributors in supporting a person to achieve their outcomes.
- We will support informal carers in the same way with their own outcomes, and as care partners where appropriate.
- We will respect cultural considerations, including language, and the Welsh language 'Active Offer.' We are committed to upholding and implementing the principles of equality, diversity, and inclusion.

We have already laid the foundations in this area –we have worked hard to implement service-wide guidelines for staff and managers in areas such as supervision, quality assurance and direct work with adults. We plan to move forward with implementation at greater pace. Our key priorities are:

- To ensure that all staff are working within a common 'Strengths and Outcomes' framework and the partners understand and support it.
- To successfully develop and disseminate further clear guidance for managers and workers on key areas of practice including strength-based reflective practice and supervision.
- To strengthen management oversight of practice through outcomes 'surgeries' providing real time quality assurance, ensuring a culture and practice of promoting independence and connection, reducing dependency on commissioned services.
- To successfully revise and implement the framework for quality assurance which evidences how effective our practice is.
- To ensure better outcomes for people without the need for Council commissioned or provided care and support.

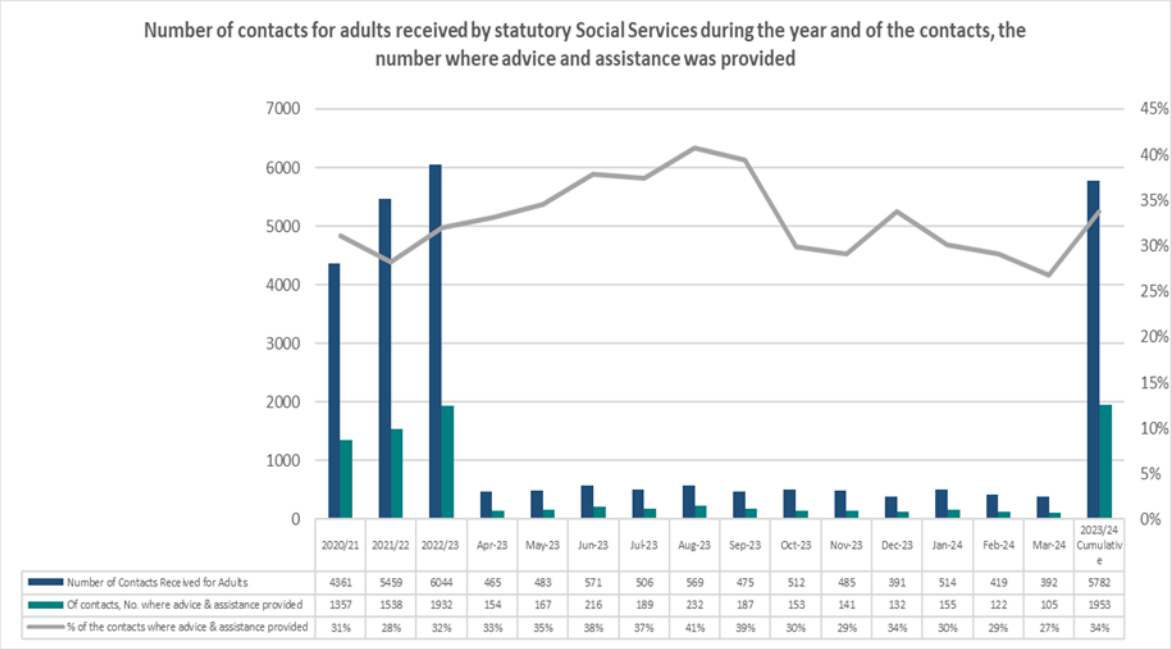
To achieve these, we will:

- Deliver an ongoing comprehensive ongoing training and development programme to support consistent implementation of the model of practice to ensure it is embedded across the service and supported in supervision and peer support.
- Ensure that learning from inspection and reviews is systematically embedded through learning, training and development and follow up quality assurance and review.
- Ensure the successful implementation of a quality assurance framework across the service.
- Ensure effective governance through our 'outcomes surgeries'.
- Deliver an ongoing management and leadership development programme to support all managers in adult social care to develop their skills in leading teams and services.

2.3 Impact to date

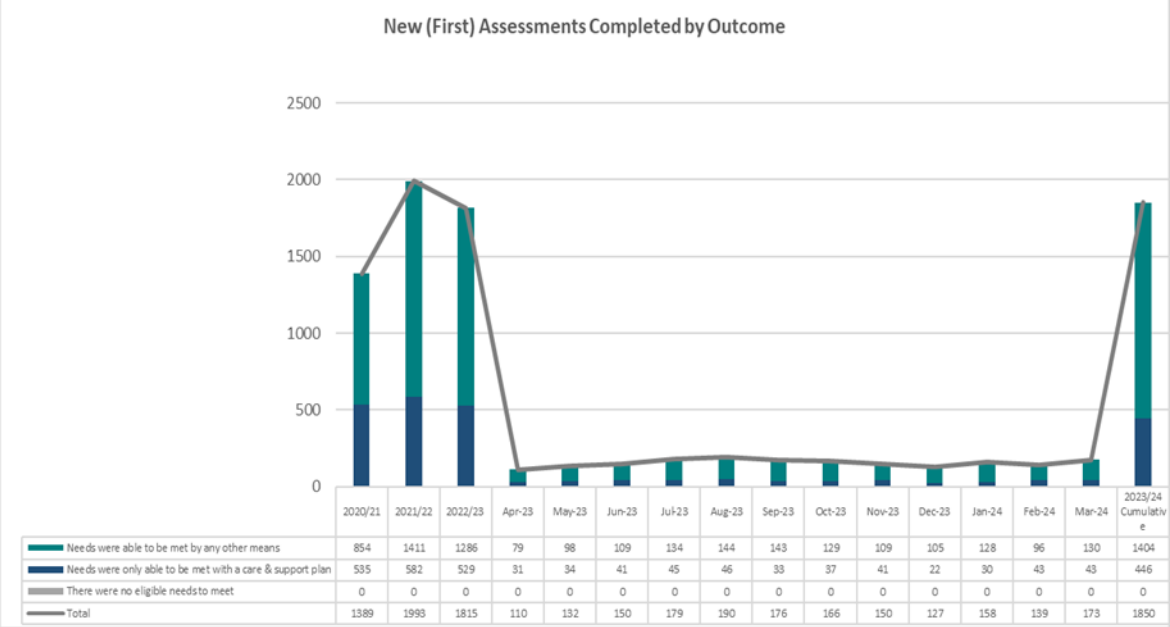
The work we have done on both practice and operating models has already had an impact. In the graph below covering 2023/24, based on internal performance data,

there has been a slight increase in the proportion of contacts proceeding to advice/assistance during 2023/24 when compared to 2022/23.



	2020/21	2021/22	2022/23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	2023/24 Cumulative
Number of Contacts Received for Adults	4361	5459	6044	465	483	571	506	569	475	512	485	391	514	419	392	5782
Of contacts, No. where advice & assistance provided	1357	1538	1932	154	167	216	189	232	187	153	141	132	155	122	105	1953
% of the contacts where advice & assistance provided	31%	28%	32%	33%	35%	38%	37%	41%	39%	30%	29%	34%	30%	29%	27%	34%

In terms of recent performance on the proportion of assessments which result in a care and support plan, the proportion has decreased from 29% in 2022/23 down to 24% during 2023/24, indicating that more assessments are leading to alternatives to formal plans.



	2020/21	2021/22	2022/23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	2023/24 Cumulative
Needs were able to be met by any other means	854	1411	1286	79	98	109	134	144	143	129	109	105	128	96	130	1404
Needs were only able to be met with a care & support plan	535	582	529	31	34	41	45	46	33	37	41	22	30	43	43	446
There were no eligible needs to meet	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	1389	1993	1815	110	132	150	179	190	176	166	150	127	158	139	173	1850

These are good indications that practice is changing, and that Bridgend is working with people to find solutions to wellbeing challenges which do not always need formal social care assessments or care and support plans. There have been no indications (such as increase in complaints) that these solutions are any less satisfactory or that they

achieve less successful outcomes – but the Council will continue to pay close attention to feedback from people and professionals.

However, given the scale of the challenges facing the Council which we outlined in section 2 of this plan, it is clear that we need to move forward with further and faster transformation of services and of professional practice. We also need to strengthen engagement and involvement of individuals and get ever-improved feedback on how well we are supporting people to ensure their needs are met. The following sections describe what else, in addition to the implementation of practice and operating models, that we plan to deliver in 2024-27 to make this happen.

3 Our service transformation priorities

Our basic purpose as a Council responsible for adult social care is to exercise our legal and professional duty to help those who need care and support in Bridgend to have the best possible outcomes and experiences in their life. We remain committed to this, to the Directorate principles and standards (summarised in the appendix), and to the principles underlying the Social Services and Wellbeing (Wales) Act 2014:

- Voice and control – putting the individual and their needs, at the centre of their care, and giving them a voice in (and control over) reaching the outcomes that help them achieve well-being.
- Prevention and early intervention – increasing effective preventative services within the community to reduce the number of adults who need intensive or substitute care.
- Well-being – supporting people to achieve their own well-being and measuring the success of care and support.
- Co-production – encouraging people to become more involved in the design and delivery of services.

The evidence base behind these principles, and the impact they can have when applied effectively, is clear. However, we can do much more as a Council to transform how we help people to minimise their dependence on formal care and support and encourage them to live as independently as possible, connected to their family, friends, and local communities. In particular, we think that evidence from Professor John Bolton at the Institute of Public Care following work with Local Government Association in England and Welsh Local Government Association and Welsh Government in Wales gives us a good starting point for key areas that we need to get right in the next stage of our transformation to enable us to manage demand effectively:

- Managing demand through the front door of the Council - handling and resolving initial enquiries more effectively.
- Managing demand from acute hospitals – supporting people to recover and regain skills and minimising poor discharges which result in unnecessary care and returns to hospital.
- Effective short-term interventions for people in the community – short term help that may reduce or eliminate the need for longer-term solutions.
- Redesigning care and support for people with long-term needs - helping people with long-term conditions gain opportunities for greater independence in the longer term.
- Investing in place-based local approaches, understanding the partners and assets within each local community and connecting people to that, to help people live well and build their local social capital.
- Developing the workforce to better support people – building skills in working with people to promote independence.
- Governance and management arrangements to sustain improvement – holding people to account for the delivery of their desired outcomes.

We have made progress in all these areas, but we recognise that we need to drive forward further and faster to build an approach that encourages more people to live as independently as possible within their local community, and only to rely on our services when they need help to regain independence or help to live as independently as possible in the longer term.

This is not simply about resources and local authority capacity; it is also about promoting people's voice and control, encouraging them to maintain their own wellbeing and promoting a healthy, fulfilling lifestyle for people even where they need care and support. Our approach continues to accord with national policy and guidance. For example, the recent Welsh Government Statement of Intent 'Building Capacity through Community Care' (2023)[5] summarised the issues to be tackled as:

'There is currently a clear imbalance in our health and social care system. Specifically, there are missed opportunities for prevention and early intervention in the community, and people stranded in acute hospital and care home settings. This is leading to people being disadvantaged and 'what matters to them' not being achieved, including at the end of life.'

We have identified the following five key priorities based on evidence of what works in John Bolton's work which we will use to drive forward our transformation of adult services and enable us to address the challenges described above. If we are successful in delivering these priorities and in implementing our operating and practice models then we will have a very different service, more manageable demand and better outcomes for our population.

We will closely monitor our progress and adjust our priorities annually as needed. Our priorities are shared across Adult Social Care, and they apply to all our population groups and cohorts.

Bridgend 5 Adult Social Care Service Transformation Objectives

- Manage demand through the front door of the Council – to handle and resolve initial enquiries more effectively.
- Work with partners to manage demand from acute hospitals – supporting people to recover and regain skills and minimising poor discharges which result in unnecessary care and returns to hospital.
- Increase the number and range of effective short-term interventions for people in the community – short term help to reduce or eliminate the need for longer-term solutions.
- Promote asset-based community and targeted preventative support to help people live well in thriving and supportive communities.
- Work with partners to redesign care and support for people with long term needs - help people with long-term conditions to gain opportunities for greater independence in the longer term.

[5] Welsh Govt: Building Capacity through Community Care – Further Faster Welsh Government Statement of Intent 2023

Each of the adult social care priorities is described below.

3.1 Manage demand on the front door of the Council.

There is more that we can do to ensure that there is an effective Council front door which finds solutions for people and their problems and that can demonstrate its impact in terms of diversions from formal care and support and delivering good outcomes. We need to challenge ourselves to make sure we are delivering these services in the most efficient and effective ways possible, and that wherever appropriate, the social care front door responsibly sign-posts elsewhere for help, particularly where needs are better met outside of social care. We have introduced our new operating model across adult social care to ensure that our front door response is as effective as possible in helping people to explore solutions other than social care wherever appropriate.

We will continue to increase the proportion of people being helped in a way that resolves the problems they have at the point of initial contact rather than needing a more in-depth assessment for adult social care.

We will further reduce the proportion of people who receive a social work assessment but who do not receive any services as a result. This cohort can be better helped prior to receiving a full assessment by getting the right information, advice and assistance to help them with solutions which rest within their own resources, their community, their family and friends, and who do not require a package of formal care. We will make sure that our resources are not “wasted” on undertaking disproportionate assessments when there are relatively straight forward solutions available on which front line staff should be able to advise.

3.2 Work with partners to manage demand from hospitals.

There is evidence from across England and Wales that adults leaving hospital can be ‘over-prescribed’ the level of care they require. A significant number of direct permanent admissions to residential care from acute hospital beds are avoidable if alternatives are available. There is also evidence that due to pressures on beds some people who have ongoing healthcare needs leave hospital without the right multi-disciplinary assessment of those needs.

The services offered to a person needing care and support at the point of discharge make a significant difference to their longer-term outcomes. For example, research has shown that too often older people placed in a standard residential care bed on a short-term basis will in fact remain in that bed for the long-term. Conversely for those with similar assessed needs placed in an intermediate care bed with a focus on helping people’s recovery, the majority will return home. We are developing our services to be more focused on recovery; for example, we already have a small number of community beds, known as ‘discharge to recover and assess’ beds (D2RA), in Bridgend but the numbers are not sufficient. There are not currently any community hospitals in Bridgend which means there is more pressure on other community services.

We are clear that people in Bridgend should not go directly into long-term residential care or be subject to long-term intensive care at home without first having had re-ablement support and the opportunity to regain maximum independence.

To help achieve this we will ensure that we are assessing more people leaving hospital at the right points and ensuring that their needs are not overstated or that they are assessed either too early or inappropriately. We will work with our health colleagues more effectively to deliver the best outcomes for people. Our prime aim will always be to help the person to return home and to live as independently as possible, and we will make sure that our arrangements with hospitals do not inadvertently undermine this aim. The recent development of D2RA within the regional is designed to enable this to become operational across all three acute sites.

We will review our discharge arrangements and services to ensure they offer the most effective environment for speedy discharge to aid recovery for all adults. We are in the process of implementing and embedding national D2RA across the region, which is developing new pathways for people and using a trusted assessor model to support discharges.

We will also ensure there is timely, targeted, and effective use of reablement and rehabilitation that has a focus on enabling independence and self-management and avoiding the over-prescription of care. The remodelling of our in-house support at home service is seeking to ensure that at least 80% of people will have a short-term enabling/reablement intervention before any long-term care packages will be commissioned. We will ensure that health professionals managing medical conditions and delivering therapeutic help work closely with those offering reablement/rehabilitation to deliver the persons outcomes, and finally ensure that there are sufficient intermediate care type services available in the community to support discharge.

3.3 Increase short-term interventions in the community.

Most people come to social care when they are in some kind of crisis. We want to make sure that when this happens, we do not inadvertently create unnecessary long-term reliance. In some instances, the response must not be to assess the person when they are in their crisis but to find a way of helping them to address any immediate risks whilst options for the future are tried and explored.

The needs from the acute sector can dominate the overall demands on our social care services if this is not well managed. It is important that people who are referred through the community are given the same range of short-term support as those who may have been referred from hospital. We want effective enabling/reabling to be available as an approach to assisting anyone with social care needs, along with a wide range of aids and adaptations essential to helping people regain or maintain independence.

Before anyone is assessed for long-term support, there needs to be a period in which they can be assisted to help manage their long-term condition and retain or regain the independence they may have temporarily lost. We will ensure that for every person who identifies with a current (eligible) set of needs there is consideration of the short-term assistance that could be offered to assist them in regaining independence or to

better manage their condition. Our aim is that as described previously at least 80% of people will not have a long-term package of care unless they have had a short-term therapy led reablement support first.

3.4 Promote community-based prevention.

As a Directorate and as a wider Council we are working together with partners, including the third and independent sector, to support people to stay well at home and in their local community, and so avoid the need to visit our front door in the first place. Our community hubs, life centres and other community services make a huge contribution to the wellbeing of adults and older people across the County Borough.

We also know that many parts of the Council, as well as universal community services such as cultural and leisure, are very important in helping create positive, supportive, and sustainable communities in Bridgend. We invest significant amounts of taxpayers' money in these services through direct delivery and commissioning. We will continue to build on the good practice in place to support people via our cultural and leisure partners who have already in place support to targeted population groups such as support to carers and people with cognitive issues. We will make sure that these services are effective at helping adults with their health and wellbeing, and that their needs do not escalate to require social care. There are many people playing different important roles in their local communities, and we will work closely with our partners in each community. Our Local Community Coordinators will support the development of services and approaches that reflect what people need to stay well and connected.

Support for citizens goes much further than this though. We want to work with local communities to build more asset-based voluntary capacity to support people who need help, and we want to encourage more people to volunteer and contribute to the overall wellbeing of their local communities. As a Council we will work to ensure that in every community in Bridgend there is sufficient wellbeing and preventative groups and activities to support people with care and support needs to live well, and we will continue to work with our partners and the rest of the Council to review where these arrangements are working and where they need to be developed further.

3.5 Redesign care and support for people with long-term needs.

We want to ensure that every person within the formal social care system has a plan of care and support which helps to maximise their opportunities for living independently. We will build on the work we have progressed since the introduction of the Social Services and Wellbeing (Wales) Act 2014 to focus further on what people can do for themselves, how their families, neighbours, friends and the wider community can assist them, and how any formal care will support and build on their strengths and capabilities rather than take agency or control away from the person. We will work with people to help them to use their own resources to meet their needs in areas such as transport, leisure and occupation.

This approach can have a big impact on the size and the type of care and support a person might require and can lend itself much more to personalised support through community connections and direct payments. Progression planning is an important

concept underpinning our work, emphasising as it does the potential for every person to live well and as independently as possible.

In all forms of care and support, whatever the plan, it is possible either to create an institutionalising experience that encourages dependency on care, or to create an environment that helps to promote people's independence. We are committed to the principles of "promoting independence," enabling connection and progression and to helping people to access a wide range of aids and adaptations essential to helping them regain or maintain independence. We will ensure that people are not unnecessarily reliant on care to live well. The way that the care is delivered has a huge influence on dependency, not just the health conditions or the needs of the person alone.

4 Priorities for particular population groups

In addition to the five key priorities and the operating and practice models which apply to all adult social care described above, there are three areas where we will focus on particular population cohorts to ensure that the particular issues facing them are addressed as part of our overall plan for 2024-27. They are:

- Learning disability transformation.
- Adult community mental health.
- Substance Misuse
- Adults with lifelong conditions or complex care needs.

For each area the Directorate has prepared a detailed plan with delivery priorities and outcome measures. Each plan has a governance framework and implementation programme and there is a body with responsibility for delivering the plan and reporting to the Cabinet and Corporate Management Board on progress.

4.1 Learning Disability

The evidence base which underpins care and support provision is improving all the time. Our services need to constantly improve, and they need to draw on this evolving evidence base to ensure they help secure the best possible outcomes. We are clear that our learning disability services need to progress significantly over the next 3 years, to promote more strengths-based support, encourage greater independence and help people build resilience. We have a clear plan for moving forward. Our key objectives in this area are:

- To systematically implement progression as a core model of practice, recognising and reflecting people's strengths, capabilities, and aspirations for a good life in line with our recently launched new practice model.
- To review needs and services in key internal and commissioned services for learning disability to ensure they are delivered cost effectively and drawing on latest evidence of impact.
- To ensure that where there needs to be changes in delivery to focus more on employment and skills (and less day-time activity), and they are addressed by clear strategies and implementation plans.
- To ensure that we work closely and effectively with key partners to deliver these service improvements.
- To ensure that all reviews are conducted co-productively so that people with care and support needs are central to service development.

The key vehicle for achieving these changes is our learning disability transformation programme which will:

- Reduce the level of overservicing and budget overspends that has emerged in recent years.
- Enable staff to use the Progression Approach and the Outcome Focused Strengths Based Practice Model in learning disability services more consistently.

- Develop local day employment opportunities to better meet the varying degrees of complexities of the local population. This relates to the modernisation of current day services and significantly strengthening community integration and supported employment pathways for people with learning disabilities.
- Review how we commission and provide services for people with a learning disability including the use of technology.
- Improve operational, monitoring, and planning systems and processes to support the delivery of care and support in line with the Progression Approach. This includes a brokerage for specialist, complex placements.

4.2 Adult Community Mental Health

The services which we run with our partners to meet the needs of adults with mental health challenges are developing all the time. We think there is more that we can do together to ensure that our practices and our services offer the most effective strengths-based support, promoting independence and resilience. We will be informed by national policy in this area including:

- The Wellbeing of Future Generations (Wales) Act (Welsh Government, 2015).
- Social Services and Wellbeing (Wales) Act 2014.
- A Healthier Wales Plan (Welsh Government, 2018) and the national Transformation Programme (2018-21).
- Regional Integration Fund (Welsh Government 2022-27) commitment to promote national models of integrated practice for 2027.
- The Welsh Government 'Together for Mental Health' new strategy currently out for national consultation.

Overall, our objectives are to:

- Review needs and services in key internal and commissioned services for mental health, to ensure they are delivered cost effectively and draw on latest evidence of impact.
- Ensure that where there are gaps in provision or emerging needs they are addressed by clear strategies and implementation plans.
- Ensure that we work closely and effectively with key partners to deliver these service improvements.
- Ensure that all reviews are conducted co-productively so that people with care and support needs are central to service development.

To deliver this we will implement the Adult Community Mental Health Services Strategy which is focused on the following joint health and social care priorities, all of which will contribute to our capacity to intervene effectively early, help people build resilience and promote longer-term independence:

- Support people in crisis through a wellbeing retreat commissioned by the NHS and run by the third sector.
- Improve rehabilitation accommodation support pathways.

- Work with our Housing colleagues in the local authority to commission specialist mental health residential and supported living accommodation including local accommodation provision for those that need it.

Substance Misuse

Substance misuse services are delivered within four levels or tiers in Bridgend and form part of a regional driven service, these tiers being:

Tier 1 Prevention and early identification / intervention

Tier 2 Advice and Support Services

Tier 3 Specialist Treatment Services

Tier 4 Inpatient Detoxification and Residential Rehabilitation

Across the region Tier 1 and 2 services are provided by the independent sector who are commissioned via the regional team and tier 3 and tier 4 detoxification services are led by CTM Health Board in partnership with the local authorities. The governance of these services is overseen by a statutory partnership board known as the Area Planning Board supported by the regional substance misuse team. The priorities for 2024/2025 are to support a partnership response to the reduction of fatal and non-fatal drug poisonings, to continue to support the Service User Involvement agenda across CTM, work to improve the services in line with national direction for Tier 1 and 2 services.

4.3 Adults with Lifelong Conditions or Complex Care Needs

We are proud of our long record of working closely with our colleagues in health and voluntary services to build seamless responses to people with health, care and wellbeing needs. However, we are clear that our services for adults with lifelong conditions and complex care needs need to move forward significantly over the next few years, and that together we need to ensure that they are doing the most possible to promote strengths-based practice, greater independence and resilience. Our plans in this area will be held within an Adults with Lifelong Conditions or Complex Care Needs Commissioning Strategy and are informed by the national policy context in this area including:

- The Wellbeing of Future Generations (Wales) Act (Welsh Government, 2015).
- Social Services and Wellbeing (Wales) Act 2014.
- A Healthier Wales Plan (Welsh Government, 2018) and the national Transformation Programme (2018-21).
- Regional Integration Fund (Welsh Government 2022-27) commitment to promote national models of integrated practice for 2027.

Our key objectives are:

- To develop local capacity in community, residential and nursing provision with partners to minimise the reliance on hospital provision.
- Work with the Health Board to create more community discharge to recover and assess beds in Bridgend CBC
- To extend the level of joint working across the health, voluntary and care sectors so that people with more complex and longer-term care needs experience seamless care and support.

The key strategic actions we will focus on will involve the delivery of our commissioning strategy and include the following:

- Work with our colleagues in Housing to develop Housing with Care provision sufficient to meet future need and demand, and reprofile BCBC's accommodation-based services (both internally and externally) to ensure the most appropriate and best levels of care can be achieved.
- Implement the 'reablement reset' programme in our internal services to reshape existing provision.
- Remodel our internal domiciliary services to take a more outcome-focused and strengths-based approach and in line with the new operating model.
- Explore the most appropriate delivery models and recommission locality-based domiciliary care services to meet quality and capacity demands.
- Expand and diversify our Shared Lives (Adult Placement) Scheme.
- Develop a business case for Core & Cluster Accommodation / Community Living Networks, Supported Living, and Specialist Supported Living (Closer to Home) provision to achieve a better balance with residential provision.
- Better match our emergency, short stay and respite provision to the needs of our local population and redesign our services so they meet these needs.
- Expand the capacity and responsiveness of specialist care and support for people at home or in the community.
- Optimise existing BCBC community resources and assets with local partners to offer a wider range of appropriate and accessible daytime or evening support, including weekends.
- Help people to access a wide range of technology, aids and adaptations essential to helping people regain or maintain independence.

5 Supporting Priorities

To help us deliver on the priorities above we will undertake support actions on public engagement, our people, work with partners and technology. They are:

5.1 Public engagement, participation and co-production

- All services and interventions to have customer feedback mechanisms to support continuous improvement.
- We will develop and implement an engagement and involvement framework so that people we work with have an opportunity to become meaningfully involved in all aspects of the work of adult social care in Bridgend.
- We will ensure that quality assurance (QA) of practice enables the quality and effectiveness of practice to be evaluated through the lens of the experience of the people who we work with.
- We will develop a participation charter so the experience of the people who use adult social care is understood and used to enhance our practice.

5.2 Our people

The effectiveness of our services relies fundamentally on our teams of skilled, well supported and appropriately motivated staff who are able to support people, often at the most challenging points in their lives. Recruitment and retention of staff in adult social care has never been easy, and since the pandemic it has become significantly more difficult. We are starting to see an improving picture of being apply to recruit and retain to core staffing groups as we have had a comprehensive programme to address this. Our plan is to strengthen our core staff groups and for less reliance on agency staff in some areas. Our key objectives in this area are:

- To improve the experience of our workforce so they feel consistently well supported and valued.
- To get the right balance of skills and experience in our teams to achieve best outcomes for people.
- To retain and recruit a high standard of practitioner to our service.

We need our staff to continue to move forward with us as we build a new and more effective relationship with people who need care and support. There are a range of very particular skills and ways of working which we need to apply, for example:

- All staff understand the options in the community and to where people could be sign-posted and be able to see the outcomes of their work.
- Practitioners in the hospital and those working in the community are able to assess for the most appropriate intervention that will assist a person maximise their opportunities for independence post-discharge.
- Staff working in the post-hospital discharge services have the skills to assist people in reaching their maximum potential.
- Staff working in domiciliary care enabling/reabling services understand the ways in which they can help a person regain confidence and skills for daily living.

- Staff working in the community understand the various conditions that people might have and the best way to assist those people, both to live with their long-term conditions and reduce their need for longer term services, where appropriate.
- Staff in residential and nursing care understand the nature of the person's care and support needs and how these can be assisted.
- All staff understand how to manage risk in order to get the right balance between assisting people to gain independence and protecting people from harm.

Many of our colleagues lead the way in these areas and demonstrate through the quality of their work that they have people's long-term wellbeing at the forefront of their practice, but there is always more to do. Our operating model and practice model delivery plans set the direction for this ongoing shift in the way we work. More broadly we will work with colleagues in the Council and our partner agencies as follows:

- We will improve support and well-being for the workforce through systematically implementing the standards in a social care charter including best practice standards for caseloads, management support through supervision, flexible working practices and support dedicated time for research and reflection.
- We will ensure that the benefits of living and working in Bridgend are effectively promoted and success is celebrated so that the reputation of the Council as a good adult social care employer is enhanced.
- We will ensure timely and effective well-being support to our workforce including through line management, peer support and timely access to specialist support.
- We will continuously improve our recruitment processes, drawing on marketing expertise to enhance campaigns and ensure the most efficient selection processes.
- We will work with other local authorities in Wales to strategically manage the relationship with agency workforce.

5.3 Seamless Working with Partners

The huge progress towards seamless health, care and wellbeing services in the community have been noted in other priorities in this plan. We want to move further and faster on this in the next three years to build a care and support environment in which all our citizens will have confidence. This will require close co-operation between partners and the breaking down of traditional professional barriers, but we are clear it is worth doing, to enable us to offer comprehensive and cohesive community-based support to promote wellbeing and meet health and care needs throughout the County Borough. Without stronger community-based support from the voluntary and health services the ability of our more formal social and health care services to cope with future demand will be severely compromised. Support for this priority is evident in national policy such as:

- The Wellbeing of Future Generations (Wales) Act (Welsh Government, 2015).
- Social Services and Wellbeing (Wales) Act 2014.
- A Healthier Wales Plan (Welsh Government, 2018)

Our key objectives in this area are:

- To work more effectively with partners at operational service and strategic levels to agree shared priorities for service improvement and implement them.
- To ensure there is a clear offer that partners make jointly for people in need of care or support in every local community in Bridgend, and that this is based on a 'Strengths and Outcomes' approach.
- To secure a joint plan that partners have agreed for a shared model of integrated or aligned care based on local network clusters / localities across Bridgend.
- Work with public health and partners to ensure our priorities are linked to the evidence-based population health data set.
- To have a strong and effective shared approach to adult safeguarding understood and implemented by agencies and practitioners across Bridgend.

The key strategic actions we will take include:

- We will work with partners to review the effectiveness of our current inter-agency arrangements and agree where and how they can be improved.
- We will agree a shared approach with partners to a future integrated service model for all practice clusters / localities across the County Borough, and we will agree an implementation and delivery plan for the model and work together to implement it.
- We will work with partners across the region to deepen integrated and aligned working through enhanced join governance arrangements and, if appropriate, integrated leadership arrangements.

5.4 Technology-enabled care, intelligence and information systems

Bridgend is currently using the Welsh Community Care Information System (WCCIS) which is a key information system supporting effective practice. Work is underway both nationally and locally to replace this system and Bridgend needs to be able to utilise the system effectively and to appropriately share information with our partners, and we also need to continue to improve our capacity to analyse individual and population data to inform our plans and practices. Our key objectives in this area are:

- To ensure that the information that operational staff and managers are using is of the highest possible quality.
- That our information can be shared appropriately more often and more usefully with partners.

The key strategic actions we will undertake include:

- Work with partners regionally and nationally ensure that social care teams have an effective case management IT system which enables integrated working and supports strengths and outcomes-based practice and the safeguarding and protection of adults.
- Continue to enhance the use of business intelligence in social care teams, through live performance dashboards which support safe and effective practice and management oversight and decision making.

Bridgend is also a leading authority in Wales in the development and roll-out of telecare support and the development of digital systems to support people in their own homes. In addition to the wide range of aids and adaptations which are delivered via the Council and NHS and are essential to helping people regain or maintain independence, the Council will invest in the further development of digitally based services such as:

- Self-assessment
- Self-support
- Prompt systems
- Personal alarms
- Companion and contact services
- Care and repair support
- Fall detectors, intruder detectors.
- Health and wellbeing observation systems
- The digital infrastructure to makes sure that these services are equally accessible across all parts of the County Borough.

31st October 2024

Appendix 1– Summary of key objectives

Priority area	Key objectives
Adult Social Care Operating Model	• Provide services which increase the number and proportion of people who can cope well at home or in the community. • Work with our partners to build seamless care and support services. • Help build well-resourced and responsive communities which ensure that people with care and support needs can live well at home. • Reduce the proportion of people in Bridgend who need long-term intensive care and support from the Council.
Adult Social Care Outcomes-Focused Strengths-Based Practice Model	• To ensure that all staff are working within a common 'Strengths and Outcomes' framework and the partners understand and support it. • To successfully develop and disseminate further clear guidance for managers and workers on key areas of practice including strength-based reflective practice and supervision. • To strengthen management oversight of practice through outcomes 'surgeries' providing real time quality assurance, ensuring a culture and practice of promoting independence and connection. • To successfully revise and implement the framework for quality assurance which evidences how effective our practice is. • To ensure better outcomes for people without the need for Council commissioned or provided care and support.
Adult Social Care Transforming Services	• Manage demand through the front door of the Council by handling and resolving initial enquiries more effectively. • Work with partners to manage demand from acute hospitals by minimising poor discharges which result in unnecessary care provision and returns to hospital. • Increase the number and range of effective short-term interventions for people in the community through short term help to reduce or eliminate the need for longer-term solutions. • Promote asset-based community and voluntary preventative support to help people live well in thriving and supportive communities. • Redesign care and support for people with long term needs by helping people with long-term conditions gain opportunities for greater independence in the longer term.

Priority area	Key objectives
Learning Disability	• To systematically implement progression as a core model of practice – recognising and reflecting people's strengths, capabilities, and aspirations for a good life in line with our recently launched new practice model. • To review needs and services in key internal and commissioned services for learning disability to ensure they are delivered cost effectively and drawing on latest evidence of impact. • To ensure that where there needs to be changes in delivery to focus more on employment and skills, (and less day-time activity) they are addressed by clear strategies and implementation plans. • To ensure that we work closely and effectively with key partners to deliver these service improvements. • To ensure that all reviews are conducted co-productively so that people with care and support needs are central to service development.
Adult Community Mental Health	• Review needs and services in key internal and commissioned services for mental health, to ensure they are delivered cost effectively and draw on latest evidence of impact. • Ensure that where there are gaps in provision or emerging needs they are addressed by clear strategies and implementation plans. • Ensure that we work closely and effectively with key partners to deliver these service improvements. • Ensure that all reviews are conducted co-productively so that people with care and support needs are central to service development.

Priority area	Key objectives
Adults with Lifelong Conditions or Complex Care Needs	• Work with our colleagues in Housing to develop Housing with Care provision sufficient to meet future need and demand, and reprofile BCBC's accommodation-based services. • Implement the 'reablement reset' programme in our internal services to reshape existing provision. • Remodel our internal domiciliary services to take a more outcome-focused and strengths-based approach and in line with the new operating model. • Explore the most appropriate delivery models and recommission locality-based domiciliary care services to meet quality and capacity demands. • Expand and diversify our Shared Lives (Adult Placement) Scheme. • Develop a business case for Core & Cluster Accommodation / Community Living Networks, Supported Living, and Specialist Supported Living (Closer to Home) provision to achieve a better balance with residential provision. • Work with partners to develop a new multi-disciplinary service to help people with disabilities or sensory loss to access support and adaptations to help them live at home. • Better match our emergency, short stay and respite provision to the needs of our local population and redesign our services so they meet these needs. • Expand the capacity and responsiveness of specialist care and support for people at home or in the community. • Help people to access a wide range of technology, aids and adaptations essential to helping people regain or maintain independence.

Priority area	Key objectives
Adult Social Care Supporting Priorities	• Build a stable, supported, well-motivated workforce, good retention and recruitment, leading to an optimal mix of skills and capabilities, with a reputation of being a safe, supportive, reflective organisation that professionals want to work for. • Work nationally, regionally and at a local level on the procurement of a replacement system for its current case management IT System (CareDirector (WCCIS). • Deliver an ongoing comprehensive ongoing training and development programme to support consistent implementation of the model of practice to ensure it is embedded across the service and supported in supervision and peer support. • Ensure that learning from inspection and reviews is systematically embedded through learning, training and development and follow up quality assurance and review. • Deliver an ongoing management and leadership development programme to support all managers in adult social care to develop their skills in leading teams and services

Appendix 2: Related Plans

The plan is located within a wider programme of development being undertaken by the Council in partnership with the people and communities of Bridgend, statutory and non-statutory partners which include:

- Progressing the priorities in the Council's Corporate Plans for 2024 onwards.
- The Cwm Taf Morgannwg Regional Partnership Board (RPB) Population Needs Assessment and Area Plan which set out an assessment of the needs of the populations of Bridgend, Rhondda Cynon Taff and Merthyr Tydfil and is also an assessment of the range of health, social care and wellbeing services needed to meet those needs.
- The priorities of the Cwm Taf Morgannwg Regional Safeguarding Board (RSB) which provides strategic leadership for safeguarding children and adults at risk across the region.
- Contributing to the Council's medium-term financial strategy (MTFS).
- Legislation set out in the Social Services and Wellbeing (Wales) Act (2014), the Regulation and Inspection of Care Act (2016), the Wellbeing of Future Generations Act (2015) and other statute and guidance.

Appendix 3: Principles and Standards

Like colleagues across the Council, we are all committed to the following working principles:

- Promoting choice and control for the people we work with by actively listening, and acting on what people tell us matters to them.
- Treating people with respect for them, their culture, their characteristics and beliefs, and their language.
- Taking relationship-based approaches with people, helping them to have autonomy and reach their full potential.
- Being outcomes focused and strengths-based in understanding and acting upon what matters to the people we support.
- Working in a constructive and creative professional partnership with our colleagues.
- Respecting people's privacy and dignity.
- Safeguarding and protecting people whenever needed.
- Seeking greater equality and inclusion for people who need care and support.

We have high standards in adult social care and expect of ourselves and our colleagues that we:

- Be respectful of each other's work.
- Work as a team with colleagues in the Council and partner agencies, to secure the best possible outcomes for people in need of care and support.

- Listen and have open and honest styles of communication.
- Commit to reflection, understanding and acting on our learning.
- Work with others to improve systems, practice and process where this will improve outcomes for people.
- Be passionate and motivated about the work we do and the difference we make.
- Be mindful of our own and our colleague's wellbeing.
- Work equitably and fairly, creatively, and innovatively.
- Observe cultural considerations, including language.