ADSS Cymru
Yn arwain Gwasanaethau Cymdeithasol yng Nghymru
Leading Social Services in Wales

ASSOCIATION OF DIRECTORS OF SOCIAL SERVICES CYMRU

Delivering Transformation Grant Programme 2018-19

Report on Innovative Care Delivery Models in the Community

April 2019

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1. Introduction and Overview

1.1. In February 2018, the Welsh Government announced a £100 million Transformation Fund to transform the way health and social services are delivered. The Fund is one of its responses to the recommendations of a Parliamentary Review of Health and Social Care. In July 2018, it published “A Healthier Wales: Our Plan for Health and Social Care”, which set out a broad framework of commitments and action to ensure everyone in Wales have longer, healthier and happier lives and remain active and independent in their own homes for as long as possible. A Healthier Wales sets out ten principles to support the translation of ideas into reality and guide innovation and change.

1.2. ADSS Cymru is leading several pieces of work in the Transformation Programme for 2018-2019. This paper reports back on the findings of Workstream 2 which has focused on Innovative Care Delivery Models in the Community and in particular those models that specialise in joint working between the NHS and social care and housing. The aim was to “identify new service developments that have been implemented on a local or regional basis to improve peoples’ lives and make recommendations on whether and how these projects/approaches and models can be scaled up and rolled out more widely across the region or, implemented by other regions”.

1.3. We have examined a range of projects, models and approaches being delivered across Wales that have involved the design of new models for care. ADSS Cymru specified a focus on those that incorporated two of the national design principles:

- Scalable – ensuring that good practice scales up from local to regional and national level, and out to other teams and organisations.
- Transformative – ensuring that new ways of working are affordable and sustainable, that they change and replace existing approaches, rather than add an extra permanent service layer to what we do now.

1.4. As part of this approach ADSS Cymru has engaged with a wide range of national organisations to promote effective models of service delivery and understand how any new national service developments will improve outcomes for people.

1.5. In particular, we have recognised the importance of housing on people's health and well-being and explored joint working between the NHS, social care and housing organisations and the impact these are having on improving people's well-being outcomes.

1.6. In addition, we have examined new models of care that involve micro-cooperatives and other self – directed support looking at the principles of co-production and how the evaluation and measuring of projects, models and approaches can be more effective

1.7. We would like to acknowledge and thank all the people we met or worked with across Wales and who so readily provided details of their local or regional initiatives and worked with us to get the narrative right. We would also like to pay tribute to our friend and colleague Stewart Greenwell, former Director of Social Services, who passed away just before the conclusion of this Workstream. Stewart was a real inspiration for this work and showed boundless energy to seek out and understand a wide range of examples of innovation and transformation.

2. Methodology

2.1. The main elements of the methodology for this work programme led by Giovanni Isingrini for ADSSC and supported by the ADSSC Business Unit were:

- Identification of projects/models and or approaches that have proved successful in delivering improved outcomes for people or delivered prevention or early intervention services to reduce the impact on the public sector.
- Seeking guidance from Regional Implementation leads on good examples of successful integrated projects/models and/or approaches from within their regions.
- We met with all regional leads to take their steer and to obtain contact details for the 'best 'examples. The requirement was for the examples selected to exhibit one or more of the Healthier Wales: Our Plan for Health and Social Care Design Principles. However, following discussion with Welsh Government and ADSSC, it was agreed that this work stream should particularly focus on projects that exhibit the 2 principles of scalability and transformative. This is so that the best practice learning can be 'rolled out' more widely across Wales and that this is a sustainable approach.
- Examination in more detail of those projects/models/approaches that met the criteria determined in the brief set by ADSSC/ Welsh Government. We worked with the project leads to identify the key principles that make these successful to understand what would be needed if they are rolled out more widely across the region or in other regions.
- Contact with all Directors to ensure they were kept up to date with the approach being taken and to give them advanced notice of the projects being considered.
- Development of a separate paper that considered examples of joint working between Housing, Health and Social Care.
- Review of a co- productive approach in innovative care delivery models including discussions with Co – Productive Network Wales and the review of a new evaluation and measurement toolkit
- Review of the principles for working effectively in a co-operative way and examples of Co-operatives across Wales.
- Monitored progress on this wide-ranging remit and adjusted as necessary through the DTG Programme mechanism. The field work was undertaken over a period from August 2018 to March 2019.

3. Design Principles

3.1. A Healthier Wales (2018) explains how in Wales we will use 'design principles' to help the public and staff to understand in practical terms how the Quadruple Aim and the wider philosophy of Prudent Healthcare can be applied to drive change. These design principles will help to align the many change projects and programmes and help people to check whether they are heading in the right direction, at the right pace.

3.2. The Strategy sets out the need to balance a nationally consistent framework and set of expectations with local delivery and opportunities to innovate. The design principles it is said will help to guide the innovation and appetite for change, so that it builds more quickly and with more purpose into new models of seamless local health and social care, which can be scaled regionally and nationally, in line with the future vision of a whole system approach.

3.3. A Healthier Wales (2018) – The ten national design principles to drive change and transformation – and examples of how they could be applied are:

Prevention and early intervention – acting to enable and encourage good health and wellbeing throughout life; anticipating and predicting poor health and wellbeing.

Safety – not only healthcare that does no harm but enabling people to live safely within families and communities, safeguarding people from becoming at risk of abuse, neglect or other kinds of harm.

Independence – supporting people to manage their own health and wellbeing, be resilient and independent for longer, in their own homes and localities, including speeding up recovery after treatment and care, and supporting self-management of long-term conditions.

Voice – empowering people with the information and support they need to understand and to manage their health and wellbeing, to make decisions about care and treatment based on 'what matters' to them, and to contribute to improving our whole system approach to health and care; simple clear timely communication and co-ordinated engagement appropriate to age and level of understanding.

Personalised – health and care services which are tailored to individual needs and preferences including in the language of their choice; precision medicine; involving people in decisions about their care and treatment; supporting people to manage their own care and outcomes.

Seamless – services and information which are less complex and better co-ordinated for the individual; close professional integration, joint working, and information sharing between services and providers to avoid transitions between services which create uncertainty for the individual.

Higher value – achieving better outcomes and a better experience for people at reduced cost; care and treatment which is designed to achieve 'what matters' and which is delivered by the right person at the right time; less variation and no harm.

Evidence driven – using research, knowledge and information to understand what works; learning from and working with others; using innovation and improvement to develop and evaluate better tools and ways of working.

Scalable – ensuring that good practice scales up from local to regional and national level, and out to other teams and organisations.

Transformative – ensuring that new ways of working are affordable and sustainable, that they change and replace existing approaches, rather than add an extra permanent service layer to what we do now.

3.4. In the context of this Report the two final design principles of "scalable" and "transformative" are particularly important if we are to achieve effective wider dissemination of innovation and good practice. These respectively offer transferability and sustainability: two objectives that must be achieved if the benefits of local and regional innovation are to be shared and replicated by organisations across Wales – to support and improve the care and support for people wherever they live. The concept of "Once for Wales" has much to commend it to make more effective use of scarce resources too but also needs a common systematic approach that is owned and practiced at all levels and locations in Wales.

3.5. The inclusion in "A Healthier Wales" of a set of clear design principles is very helpful. As the document states, there is no requirement for any development to meet all the principles. It is acknowledged some may just meet one or a few of the principles. When assessing and applying the principles, one can question the extent to which a design principle is present. For example, a development may move towards a "seamless" service but is it as seamless as it possibly can be i.e. there is no scope at all for further improvement? Similarly, the concept of "scalability" can be explored further.

3.6. The "scalable" principle is defined as ensuring good practice scales up from local to regional and national level, and out to other teams and organisations. One could apply the term "spreadable" to this i.e. spreading the same (or similar) practice more widely across geographic, professional and sectoral boundaries. However, there is another dimension. For example, in addition to scaling something up from local to regional levels, consideration should also be given to increasing the scale of specific projects or programmes locally to increase their capacity to help more people. A good example of this is in the housing, health and social care report in Appendix 5, namely the "Hapus Pawb" project run by Rhondda Housing Association. Given the benefits of the programme, there is a desire to help more people locally, but current funding and resources means it must be limited to the Association's tenants. Ignoring the scalable potential of this programme within the local area as well is depriving other local people of realising its benefits and other local services, notably health and social care, of valuable prevention and early intervention activity which helps reduce demand.

3.7. Another example of 'spreadability' is the Dementia Friendly Communities approach which has the potential to be spread across local areas so that their capacity is increased to help more people. The approach adopted in Gwent (Appendix 1a) is a good example of this.

4. Findings – Part 1: Innovation in Practice

4.1. This section of the Report covers examples that our research has identified are successful in delivering improved outcomes for people and have done so in practice and meet our criteria to be scalable and transformative. They are selected from different regions of Wales and cover separate sector issues that are being addressed. A summary of each project/model/approach is provided which refers to a separate appendix for each that lists the factors/principles that need to be in place to ensure success. Together these appendices form a set of Guidance to support implementation.

4.2. The Guidance sets out the key characteristics of the projects and approaches, whilst highlighting some of the local factors, e.g. having a lead who is innovative and creative with a 'can do' attitude and prepared to engage widely, and/or the length of time that has been given to changing culture to enable change to happen. This guidance also lists the other factors necessary to deliver the project successfully elsewhere, as well as the potential barriers to easy transferability.

The examples covered are:

i Dementia Friendly Communities – Gwent Region

ii Delta Well-being Project – Carmarthenshire, West Wales

iii Stay Well@home – Cwm Taf Region

iv Early Help Hub – Flintshire, North Wales

4.3. The principles that are common to all these projects can be summarised in the table below:

Principle	Explanation
Vision	A shared vision between Health and Social Care with all parties understanding the benefits for people using services
Leadership	Identification of one person with the vision, passion and commitment to keep the momentum going and act as the strategic lead
Commitment and "Can do" Approach	All partners demonstrating a robust commitment to improving outcomes. A strongly committed group of people across the multiagency partnership. Developing a flexible approach and continuous improvement
Working Together	Good working relationships with a great deal of trust on all sides and an understanding that all are working to achieve the best outcomes. Involvement of service users and their representatives
Change Management	Supporting change, mapping of processes, common systems/locations where feasible. Good communications
Resources	Sharing of budgets/resources/information between Health and Social Care so that a joint service is established
Project Management	Effective accountability, monitoring, assessment of risks and

Principle	Explanation
	keeping to timetable, but not too bureaucratic
Recruitment and Training	A multi-disciplinary team with a good skill sets who have the right attitude and are prepared to learn and accept new ways of working

I) DEMENTIA FRIENDLY COMMUNITIES – GWENT REGION

Background

In February 2018 Welsh Government published a Dementia Action Plan 2018-2022 with the vision of Wales as a dementia friendly nation that recognises the rights of people with dementia to feel valued and to live as independently as possible in their communities.

A main theme within the Action Plan is to enable people living with dementia to maintain their independence and remain at home where possible, avoiding unnecessary admissions to hospital or residential care and delays when someone is due to be discharged from care. The Public Sector has been using a range of innovative and integrated approaches to delivering care services and meet the challenges set out in the Dementia Action Plan, encouraging services to become community focused rather than centring on hospital-based care. A Dementia Oversight, Implementation and Impact Group (DOIIG) has been established to inform, oversee and monitor progress with the Plan.

The Dementia Friendly Communities Approach launched by the Alzheimer's Society in 2013, is one way that people can act and change to better support people with dementia and enable them to live well in the community. The Gwent Region has fully embraced this approach and over several years all areas have been developing dementia friendly communities. They have been very successful in involving a wide range of organisations working towards this vision and have demonstrated they are able to respond to local need and ensure that people across the region are aware of and understand dementia and that people with dementia feel included and involved. The Alzheimer's Society independently evaluates the approach Gwent has taken and has endorsed the good progress that is being made by the wide range of communities within this Region.

What does a Dementia Friendly Community mean?

The changes in demographics and the recognition that dementia is becoming an increasing issue for people and communities, has meant that there is more focus on being dementia friendly. Many organisations and communities are recognising the need to act and change to better support people with dementia and enable them to live well in their communities. It is important that the views and opinions of people with dementia and their carers are at the heart of any considerations or decisions.

The Alzheimer's Society describes a dementia friendly community as:

> '*A city, town or village where people with dementia are understood, respected and supported, and confident they can contribute to community life. In a dementia friendly community people will be aware of and understand dementia, and people with dementia will feel included and involved, and have choice and control over their day-to-day lives'*

It is recognised that becoming dementia friendly takes time and that working towards this approach will benefit people with dementia, their carers and the communities they are part of.

Communities that have registered for the recognition process will be working towards becoming dementia friendly. Once registered the community is making a commitment to work within seven foundation criteria, interpreting them from a local perspective, describing what they are working towards and the actions they intend to take.

Once registered a Community can display the 'Working to become Dementia Friendly' logo.

The seven criteria are:

- Ensure the right local **STRUCTURE** is in place to maintain a sustainable dementia friendly community.
- Identify leads- **CHAMPIONS** - to take responsibility for driving forward the work to support the organisation to become dementia friendly
- Have a plan to raise **AWARENESS** about dementia to ensure a better understanding of dementia and an appreciation of the condition.
- Develop a **STRONG VOICE** for people with dementia and their carers.
- **RAISE THE PROFILE** of your work to increase reach and awareness to different groups in the community
- **FOCUS** your plans on a number of key areas that have been identified locally
- Have in place a plan or system to **UPDATE THE PROGRESS** of your organisation as part of the community once year.

A model developed by one of the Dementia Friendly Coordinators encapsulates what working to dementia friendly means. It recognises that there are three pillars of people, place and process that need to be place and that a dementia friendly community supports people with dementia and their carers by increasing awareness, empowering people and providing a supportive environment.

Dementia Friendly Communities in Gwent

In October 2014, the Gwent Region started to work towards Dementia Friendly Communities (DFC). A decision was taken to adopt a whole region, strategic approach. This initiative is now led and monitored through the Gwent Regional Partnership Board, which is a strategic multi-agency group with membership at Chief Officer level from a range of partners such as local authorities, Aneurin Bevan University Health Board (ABUHB), Housing Associations and the Voluntary Sector. The RPB developed a Population Needs Assessment which set out the predicted levels of need for the next 20 years. Under the Social Services and Wellbeing (Wales) Act 2014, the RPB have also developed an Area Plan and one of the objectives is to *'improve outcomes for people living with dementia and their carers'.* Working towards DFCs contributes to this objective and improves well-being outcomes for people in need of care and support and carers in need of support. The RPB have adopted DFC as a priority work programme and this has ensured strategic 'buy in' from partners with accountability at the highest level.

Each of the five boroughs in Gwent (Blaenau Gwent, Caerphilly, Monmouth, Newport and Torfaen) has established a Dementia Friendly Community (DFC) Implementation Group which meets on a quarterly basis to coordinate awareness and support. These groups provide regular feedback to the RPB and Public Services Board and produce comprehensive annual progress report with impressive examples of the work that has been on going. Example case studies from the 2017/18 Annual Progress Reports are contained in Appendix 1 (a) and give examples of the good practice that is happening throughout the Region.

A regional Dementia Board has been established by the ABUHB and chaired by the Director of Nursing. The regional board leads on the implementation of the Welsh Government's new *'Dementia Action Plan for Wales 2018/22'* and a corresponding regional action plan. Each DFC Group also reports to the Dementia Board to ensure regional alignment with other areas progressing DFC. Each implementation group also works in partnership with ABUHB's Neighbourhood Care Networks (NCNs) to ensure partnership working with local GPs and other health practitioners.

The strategic oversight and 'buy in' from the Regional Partnership Board, the Public Service Boards and Dementia Board has created an effective and sustainable structure, to ensure that DFC is progressed and overseen at the highest level. This governance structure demonstrates a real commitment to ensuring Gwent is truly Dementia Friendly.

The number of organisations that have been accredited and take part in Dementia Friends sessions continues to grow. Information on the organisations involved is held on a joint data base between the Local Authority and the Alzheimer's Society. Organisations from the public, private and third sectors have signed up including the Arts, Theatres, Leisure, Libraries, Schools, Pubs, Shops, Primary Care, Fire and Ambulance service and other public sector organisations. Case study examples are included in Appendix 1(a). To date over 20,000 people have received '*Dementia Friends'* awareness sessions across the Region. These awareness sessions help get the message across of what dementia is, dispel any myths and give practical examples of how people can help. The initiative has grown quickly and is supported by a great number of bodies.

A Dementia Roadmap Website has been developed, funded by local GP's through the Neighbourhood Care Networks. This is coordinated by the Gwent Association of Voluntary Organisations. The website provides a one stop shop for information and advice to support people living with dementia and their carers. An example can be found at:
https://wales.dementiaroadmap.info/torfaen/#.W2QOO8uWzIU

In partnership with Gwent Police a regional missing persons protocol has been developed 'Herbert Protocol' which sets out safeguards to reduce the risk of people living with dementia going missing; and simple steps that can be taken if a person goes missing
w.gwent.police.uk/news/article/article/gwent-partners-will-use-herbert-protocol-to-help-locate-people-with-dementia-who-go-missing-1/

One of the Gwent Dementia Friends Champions, Ray Morrison has recently received a recognition award by the Alzheimer's Society for the work he has done to raise awareness in a wide variety of public and private organisations in Newport. Mr. Morrison is the Director of Bluebird Care, and as well as ensuring his own organisation is dementia friendly, he supported St. Joseph's RC High School in Newport to become the first dementia friendly secondary school in Wales. The staff and pupils took part in interactive information sessions run by Mr. Morrison.

The Welsh Ambulance Services NHS Trust was recently named Dementia Friendly Organisation of the Year at the prestigious Alzheimer's Society Dementia Friendly Awards in London. They were deemed to have an outstanding level of investment into improving the lives of people living with dementia, and they engaged with a number of people living with dementia in Gwent to develop dementia informed practices and that contributed to this accolade.

The Alzheimer's Society confirmed they are impressed with the way that DFC has been developed in Gwent and the scale of the take up of the initiative. They have reported on the genuine collaboration between all sectors to ensure needs are met and that all are pulling in the same direction as a result of the high-level accountability through the multi-agency Boards. They

reported that they feel they are listened to and treated as an equal partner on the Dementia Board and that there is a high level of openness and transparency in decision making.

Future Opportunities for scaling services

Two of the design principles identified in 'A Healthier Wales: Our Plan for Health and Social Care' are for services to be scalable and transformative. There is potential for the governance structure, principles and ways of working adopted by Gwent in delivering Dementia Friendly Communities to be scaled up and rolled out more widely to effectively deliver a similar model in other areas. This initiative can make a real difference and improve well-being outcomes for people with dementia and their carers and if supported well provides a sustainable approach which can become a social movement.

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II) Delta Well-Being Model – Carmarthenshire, West Wales

Background

Delta Wellbeing is a Local Authority Trading Company wholly owned by Carmarthenshire Council. They were established in June 2018 involving the transfer of the Council's Careline service which had been in operation for over 30 years. This new Company is a centre of excellence for Technology Enabled Care. Their focus is on ensuring that their customers receive the very best advice on how the latest technology either at home or out and about in the community can improve independence. As an arms-length company they have greater flexibility and adaptability to offer service users the most up to date technology by working directly with industry partners and groups. They ensure that they are able to easily access a wide range of equipment to develop bespoke solutions for customers so that individuals can maintain their independence for a wide range of needs. Being wholly owned by a Local Authority provides access to the structure and infrastructure of the public sector which brings lots of advantages when delivering services in the community.

Delta Wellbeing was originally established to deliver the IAA Service and Technology Monitoring Centre for Carmarthenshire and its partners. However, as the service has grown and demonstrated that it can be delivered efficiently, and effectively other organisations have entered into contracts with Delta Wellbeing for them to provide an out of hours service on their behalf.

Services being delivered by Delta Wellbeing

The services provided by Delta wellbeing can be broadly split into 2 main elements of service delivery:

a) The provision of an IAA Service through a First Point of Access
b) The provision of a Monitoring Centre for Technology Enabled Care.

Delta Wellbeing provides the First Point of Contact for all Adults in Carmarthenshire. This includes all Adult Social Care and Adult safeguarding issues. Teams from across the Social Care, Health & Housing settings are co- located and include Social Workers, Safeguarding Officers, District Nurses, Occupational Therapists, Physiotherapists, a Psychologist, the Community Resource team, the Disabled Facilities Grants Improvement team and the Adult Services Care and Support teams dealing with Short- and Long-term interventions. It is the principle provider of the preventative and early intervention service for Carmarthenshire. The focus of the Well-being Adviser is to work with the individual to find a solution to their problem which may or may not require access to public services.

Services are provided bi-lingually on a 24/7 basis as the First Point of Contact for citizens in Carmarthenshire. This is the main part of the Authority's Information, Advice and Assistance (IAA) Service as defined in the Social Services and Well-being (Wales) Act 2014. When demand decreases in the evening/night the levels of staffing are reduced to provide an appropriate response to meet this reduced demand. The team are trained to respond to emergency scenarios and provide the out of hour's service for emergency calls relating to any social care emergency request including safeguarding. A multi-disciplinary team is on hand and located at this centre to provide whatever solutions are required on a 24/7 basis. Out of hours social worker capacity is a challenge across Wales but as the team is co-located at this venue it is able to meet demand and respond to requests from across a range of customers across Wales. There are plans to develop an option for customers to Skype or Face Time into the Centre. The combined effect of their input ensures that a complete wrap around service is provided for the individual's needs.

The team also provide a Monitoring Centre for Technology Enabled Care (TEC) which operates an Alarm Call Monitoring service. Smaller areas may have specific challenges in finding the resources required to provide the 24/7 service needed to safeguard individuals. This is proving to be especially effective for the out of hour's service as there is limited capacity across Wales for social care officers working throughout the night. The Alarm Call Monitoring service provides 24/7 monitoring for vulnerable individuals in Carmarthenshire, Pembrokeshire, Ceredigion, Powys, Wrexham, Neath Port Talbot and Swansea. Cover is also provided for Merthyr and the Vale of Glamorgan in times of reduced resources (e.g. staff sickness) or increased demand. Some Local Authorities have also arranged for Delta Wellbeing to provide the out of hour's service for all Local Authority services, not just those requiring social care input. In addition, Delta Wellbeing have just been awarded the contract to provide out of hours call handling services for Trivallis Homes, this adds to a number of other Housing association customers they have.

Service Level Agreements are in place with each organisation that has requested Delta Wellbeing to provide a service.

The scale of the service being provided means that Delta Wellbeing are able to maintain staffing levels at the rate required to deliver the service. As an arm's length company, they have flexible working arrangements so that if demand increases or if there is an increased pressure on one of the Local Authorities they serve, they can react quickly by bringing in more resources. They have also been able to put in place effective contingency planning arrangements to ensure operational resilience.

The team prioritise workload throughout the night and if there needs to be an update to IT systems this can be done at a time when there are no other priorities and the traffic over the internet is less. If the IAA Service requires additional information on an individual, they are able to contact the hospital over the night or at the weekends as staff are often be able to provide information at these times rather than in the middle of a busy working day.

During the day the team are able to make proactive outbound calls to "frequent flyers" to check that they are well and assess emotional/mental wellbeing. They also proactively make 'birthday calls' to wish service users a happy birthday. This may be the only call someone may get on that day and has proved a positive part of the service for both staff and service users and an important factor in improving emotional wellbeing and reducing social isolation.

Delta Wellbeing has delivered a surplus in the first 6 months of trading. Any surpluses delivered are re-invested into social care with options for providing improvements and an expansion to the services being currently provided. One of the areas being looked at in more detail is improving well-being for people in the community and providing more Technology Enabled Care in people's homes.

Since this new way of working was introduced Adult Services has consistently delivered services within budget; waiting lists and annual review lists have reduced. The staff sickness absence levels have dropped, and staff retention has increased. The staff feel more engaged with the service users and enjoy being closer to the decision making.

Future Opportunities for scaling services

One of the design principles identified in Healthier Wales is for services to be scalable. The 2 parts of service being provided by Delta Wellbeing have potential to be scalable and there are elements that may benefit from being delivered on a larger scale.

The provision of an IAA Service through a First Point of Access

> The First Point of Access works well for Carmarthenshire as the co-located multi-disciplinary team has maximised the benefits available to the service user. This team has a complex range of skill sets, supported by comprehensive training and development. These skills have been put to good use on a 24/7 basis providing an emergency out of hours response service for the Area. Whilst most Local Authorities have already provided a good day time First Point of Access in their area in response to the requirements of the Act, not all have been able to effectively deliver the out of hours service required. Delta Wellbeing is already effectively providing this out of hour's service for many local authorities and other organisations across Wales in response to demand. There may be potential to increase the provision of this service for other organisations in Wales and wider.

What is not clear is whether it would be politically acceptable for many local authorities to ask for their first point of contact to be provided by an organisation that is out of county. Although, as the well-being advisers respond to emails or telephone calls and not to face to face callers there is an argument that it doesn't matter where this service is located as long as it is delivered well, and service users' outcomes are being met.

The provision of a Monitoring Centre for Technology Enabled Care.

Research has shown that the optimum level of connections for a Monitoring Centre is 15,000 to enable a comprehensive fully operational service to be provided efficiently on a 24/7 basis (10,000 connections is recommended as the minimum number for a fully functional service). Economies of scale can be delivered on a pro-rata basis.

For many Local Authorities in Wales the numbers of connections are not sufficient to provide an effective alarm call monitoring service. Delta Wellbeing is already providing an alarm call monitoring service for service users in Carmarthenshire and eight other local authorities. This is working well and there may be more opportunities for other Local Authorities to enter into a Service Level Agreement to 'buy' into this tried and tested model.

One of the advantages of this approach is that if additional staff are required to meet increased demand, the service can get on with recruitment without the constraints that are often in place in the public sector and may lead to a delayed provision.

Another advantage for Delta Wellbeing providing a comprehensive Technology Enabled solution to care in the home is that they are able to provide bespoke packages of care that require specific pieces of equipment or aids that are often not available to the public sector. An example would be for an individual with a specific condition who may require equipment that is only available out of area or from another country. The nature of the procurement arrangements for Delta Wellbeing, as a commercial entity, is that they can obtain products on loan for a 3 months trial before making an informed decision on whether it meets the service user's needs. This is not a way of working that sits well within the constraints of a local authority procurement process. The buying power of a larger entity brings even more economies of scale. If more organisations commission Alarm Call Monitoring Services from Delta Wellbeing this could further increase the benefits.

The delivery of both types of services from one location means that a multi – disciplinary team is available 24/7, 365 days a year and is able to provide advice and guidance as required on a full range of professional requirements. This maximises the available resources. As well as providing a reactive service, from calls received and responses to alarm calls, in quieter times they are also able to schedule proactive calls which may prevent an individual going into a crisis situation which would in turn place a greater demand on services.

Appendix 1 b) sets out the key principles adopted to ensure this project was a success.

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III) STAY WELL@HOME – CWM TAF REGION

Background

Cwm Taf Stay Well@Home (SW@H) is a collaborative project between Rhondda Cynon Taf CBC, Merthyr CBC and Cwm Taf University Health Board. This regional service aims to prevent unnecessary hospital admissions and ensure timely discharge for those people that have been admitted to hospital.

In 2016 the Cwm Taf Regional Partnership confirmed its vision for an integrated model of service focusing primarily on a Community @Home provision. Initially officers from the Health and Social Care sectors got together informally to consider options for developing a solution to provide an assessment at the front door of the hospital (A & E departments) and the provision of home support quickly for those people who didn't need to be in hospital. The SW@H Service was developed to respond to the needs of the community and improve service performance. The aim of this new service was to improve communication and performance of health and social care services at the critical interface that occurs during presentation at A&E and hospital admission through to discharge. A business case was prepared and in July 2016, Cwm Taf Regional Partnership approved funding of the SW@H Service through an Integrated Care Fund (ICF) allocation of £1.8m. The new service started in Rhondda Cynon Taf in April 2017 (Merthyr Tydfil followed shortly after), with the mandate to provide a hospital-based team at Royal Glamorgan Hospital and Prince Charles Hospital with 2 functions:

- Hospital Avoidance at A & E and the Clinical Decisions Unit (CDU). Safely turn around those people who attend A & E to their homes with appropriate community support. GP Out of Hours also has access to this service via A & E.
- Facilitate complex and simple discharges from the wards - Assessments undertaken by social care staff based at the hospital as soon as a person is fit to be assessed rather than wait until a person is ready for discharge and then send a community social worker to the hospital. Rather a trusted assessor role was developed across disciplines

This approach to working in partnership has transformed the experience of people in hospital, particularly at A&E, and through a revised approach to early intervention, joint working and flexible deployment of resources people are able to return to their home earlier with support rather than face prolonged unnecessary admission to hospital.

At the time of writing the SW@H service has been operational for nearly two years and continues to provide excellent outcomes for individuals, avoid any unnecessary hospital admissions and facilitate timely discharges.

The service has undergone independent evaluation and has been successful at achieving highly commended at the social care accolades 2018 and winner in the category of partnership working and overall winner of prudent healthcare at the National Healthcare Awards 2018.

Services being delivered by Stay Well@ Home

The Stay Well@home Service consists of a multidisciplinary hospital-based team made up of Social Workers, Occupational Therapists, Physiotherapists and Therapy Technicians, sited within the acute hospitals of Royal Glamorgan (RGH) and Prince Charles (PCH) hospitals. All professional disciplines within the team have the "Trusted Assessor" role and are able to undertake a proportionate assessment. This includes the asking and recording of the response to the 'What

Matters" conversation and agreeing, recording and providing a copy of agreed outcomes. All staff are supported to make decisions to ensure the timely release of patients or providing support for an individual in their home so that they do not need to be admitted to hospital. The service is provided for residents of Rhondda Cynon Taff and Merthyr Tydfil with existing pathways protocols continuing to be used for 'out of area' patients, this is mainly those attending PCH from the Aneurin Bevan University Health Board.

The service operates 7 days a week, 365 days a year between the hours of 8 am and 8 pm and is supported by a range of community-based responses across health & social care provision.

Staff in the SW@H Service work in the same way as the Single Point of Access (SPA) for community referrals and have been trained to deliver:

- Initial assessments and commission/provide health, social care and third sector community support to facilitate safe and timely return home from A&E and the Clinical Decision Unit (CDU), thereby preventing unnecessary admission to hospital. This includes the commissioning of a community response from the appropriate community teams (4 hours response time from community services); and
- Integrated complex discharge assessments for those patients who are admitted, applying the default position that individuals are supported to return to a community setting.

Alongside the Trusted Assessor role another key to the success of the hospital-based team is the ability to commission community services quickly and have the services in place for the person to be turned around in a timely manner.

Performance information for the first year of operation demonstrate all requests for social care packages of support are agreed within 1 hour of assessment and are where required able to commence within 4 hours. The following areas of the service have been fully operational since April 2017 and are available 365 days a year between the hours of 8.00a.m.and 8.00p.m.

- SW@H hospital-based team (RGH & PCH);
- Nursing @Home;
- RCT Support @Home;
- Initial Response MTCBC.
- Your medicines @home is operational Monday to Friday in core hours

The SW@H initiative has proved to be successful in supporting people to be as independent as possible, ensuring they receive the right service at the right time. It is a combination of timely assessments at A & E and access to responsive community services.

The third sector also forms an important part of the Team and Age Connects provides a transport home and settling into home service for those service users who don't have family or friends who are able to assist with this.

The SW@H service has continued to expand and puts the service user/patient at the centre of the solutions being developed to ensure personal well-being outcomes are achieved.

One issue that was proving difficult to resolve was the administering of medication and who can/should do this if the service user is not able to manage on his/her own. After much discussion/negotiation between all parties and trialling of new models a Single Medication Policy was introduced supported by a new team to undertake medication administration assessments called Your Medicines @home, and is used by all service providers, both in house and the external sector. All parties understand the importance of making sure service users receive their medication

on time. The new Policy is clear that if the safe use of medication is the only issue stopping a person being discharged from hospital i.e. there are no social care and support needs, then Cwm Taf will commission a medication administration service. This is one issue that could have proved problematic if all parties, including the Community Pharmacists hadn't approached finding a solution in a 'can do' way. Over 1,000 support workers have now been trained in this new Policy.

One of the strengths of the SW@H project is that there is an overriding will and desire of all partners to make things work and find ways around potential barriers to keeping people out of hospital and maintaining their independence at home.

Appendix 1c) sets out the principles adopted to deliver a successful Stay Well@Home initiative.

Future Opportunities for scaling services

One of the design principles identified in Healthier Wales is for services to be scalable and there is evidence that the principles and processes adopted by SW@H can be scaled and rolled out more widely to effectively deliver a similar model in other areas. The development of a Single Medication Policy has meant that not being able to administer medication is no longer a barrier to hospital discharge. Development of this Policy has proved challenging, but it is now working well and proving very successful in getting people home more quickly.

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IV) Early Help Hub – Flintshire, North Wales

Background

The cycle where childhood adversity can lock successive generations of families into poor health, poor life chance outcomes and anti-social behaviour is reflected through the growing recognition of Adverse Childhood Experiences (ACEs). ACE's are traumatic experiences that occur before the age of 18 and are remembered throughout adulthood. These experiences range from suffering verbal, mental, sexual and physical abuse, to being raised in a household where domestic violence, alcohol abuse, parental separation or drug abuse is present.

In Flintshire, in line with many other Local Authorities, there is a cohort of families who:

- Are often known to multiple agencies;
- Don't meet thresholds for 'social services';
- Are receiving time intensive short-term interventions;
- Display reoccurring patterns of behaviour/challenges/crisis;
- Have a clear risk that their needs may escalate.

Many of these families have complex needs and an initial analysis revealed a minimum average cost of £107,500 per family related to these needs. Costs particularly related to domestic abuse, substance misuse, children becoming looked after, children missing school and crime and anti-social behaviour. The research also identified that multiple needs were largely met through multiple interactions with different services all of whom have their own eligibility thresholds and systems of assessment and planning. This can make each individual problem more difficult to tackle and doesn't make transparent how different problems cumulatively present significant overall risks. Prior to the EH Hub, these people would have had their circumstances assessed as 'no further action'.

The Early Help Hub

In response to the challenges identified, Flintshire's Public Service Board's established an Early Help Hub (EH Hub) in July 2017. When first established, this was a multiagency initiative that made additional information, advice and assistance available to families experiencing two or more adverse childhood experiences (ACEs). This was an important building block in bringing focus and agreement between partners in how to support families. However, through the implementation of this model Flintshire moved to a position which recognises that all children and families have a right to early help and support. The EH Hub was therefore designed around ensuring that they are able to target early help and support to families, recognising the challenges associated with ACE's. They no longer use the criterion of 2 or more ACE's, although in reality the families referred have at least 2 ACE's present.

Working together North Wales Police, Flintshire County Council, North Wales Health Board and Flintshire Local Voluntary Council have pooled resources into a single Hub to offer co-ordinated support targeted at supporting families with greater needs. The model for the multi-agency EH Hub was developed collaboratively involving a range of stakeholders. The model brings significant service transformation across partner agencies to work collaboratively in identifying, understanding and supporting the health and well-being of families. A key objective of the EH Hub is to provide the greatest level of knowledge and analysis of relevant intelligence and information across the multi-agency partnership to ensure families have access to advice and information about relevant early support to build coping skills and address problems before these become entrenched. For

families that are at greater risk of escalating problems, the EH Hub facilitates access to appropriate multidisciplinary interventions as a matter of priority.

Existing resources were complimented by additional capacity secured through the alignment of services commissioned through Flintshire's 'Families First' programme. A core team of people, who continue to be employed by their individual agencies, are co-located, with meetings twice a week involving wider agencies to share information and agree multidisciplinary support. Agencies include North Wales Police, Social Services, Health, Education, Youth Justice, Housing, Flying Start, Action for Children, Homestart and Leisure and Play Services, an employee of Flintshire Local Voluntary Council (FLVC) brings significant added value in making connections with wider 3rd sector provision. The EH Hub is not solely about the agencies that are co-located or attend professionals' meetings; it's about their connections to other services. For example, joint working with Health has unlocked support from mental health services and substance and alcohol misuse services.

Since the EH Hub has been in place all families with 2+ ACEs and where their needs would not be otherwise be met through statutory Children's Services have been offered bespoke information, guidance and support. This is a good example of how early interventions can improve outcomes and reduce the pressure on public services.

In April 2018 an independent review was published summarising the project and what has been learned from it. More detail can be found in the Flintshire Public Service Board Early Help Hub: The Story So Far - George Partnership Ltd. The WCVA has also published a case study looking in more detail at the learning from this project – Working together to support vulnerable families: https://www.wcva.org.uk/media/6174393/eng_earlyhelphub_casestudy1.pdf

Appendix 1 d) sets out the key principles adopted to ensure this project was a success.

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Examples of Emerging Initiatives

4.4. During the course of our research and field work, we identified a number of projects that were demonstrating that they had the potential to meet the criteria of “scalable and transformative”. However, in each case progress although promising, was still at a relatively early stage of development and more time would be needed to verify ultimate success and proven benefits for service users. Whilst all will be subject to further development, monitoring and evaluation, we have included a summary of each project here to give a flavour of what is being done and what is hoped to be achieved. These examples cover:

i. Neighbourhood District Nursing Model – Cwm Taf
ii. Porth y Gymuned and Porth Gofal – Ceredigion, West Wales
iii. Developing an ACE aware approach to resilient Children and Young People – Cardiff and the Vale
iv. “Creating a Place called Home - Delivering What Matters” – Flintshire, North Wales
v. Your choice – Vale of Glamorgan, Cardiff and the Vale of Glamorgan
vi. Regional Career Consortium – Billy the Superhero - Gwent
vii. Bevan Commission Exemplars – Across Wales

I) Neighbourhood District Nursing Model – Cwm Taf

In December 2017, the Welsh Government announced funding for the piloting of a Welsh Buurtzorg Model of Neighborhood District Nursing to test the approach in Valley, Urban and Rural locations. As part of this initiative it was agreed that three areas of Wales should pilot the Buurtzorg approach, testing a model of Neighbourhood District Nursing in valley, urban and rural locations in Cwm Taf UHB, Aneurin Bevan UHB and Powys THB

Each Health Board has received ring fenced funding for 2018/19 and 2019/20.

The Royal College of Nursing[1] describes the Buurtzorg model as a unique district nursing system which has garnered international acclaim for being entirely nurse – led and cost effective. In Wales we understand the challenge in meeting the needs of an ageing population increasingly susceptible to co-morbidity and complex long-term conditions[2] and this model has potential for addressing these issues. The Model was originally developed in the Netherlands to respond to the need for a reformed district nursing system to improve patient health and satisfaction and give district nurses a greater control over patient care.

The Buurtzorg model comprises six key services. These are:

1. Holistic assessment of the client's needs which includes medical, long-term conditions and personal/social care needs. Care plans are drafted from this assessment
2. Map networks of informal care and assess ways to involve these carers in the client's treatment plan
3. Identify any other formal carers and help to co-ordinate care between providers
4. Care delivery
5. Support the client in his/her social environment
6. Promote self-care and independence.

We have examined the application of this model in more detail in the Cwm Taf Region at the recommendation of the Regional Implementation Lead. Cwm Taf were keen to pilot this model as it encourages joint working between health and social care partners to improve the patient outcomes for those cared for in the Community and it also complements the community-based services already being delivered in the Region.

The Cwm Taf Neighbourhood District Nursing Model was launched on 3rd December 2018 and aims to provide a person-centred, co-ordinated and prevention focused nursing service to a local community that is built around the General Practitioner, "virtual ward" and enhanced multi-disciplinary teams in primary care. This Team takes a public health approach, caring for a designated population, aligned to GP Practices, promoting independence, safety, quality and experience within the ethos of home being the best and first place of care. The team works in partnership with patients, carers and their families, General Practitioners, other health and social care professionals, community and voluntary organisations to promote independence and community cohesion.

The five principles of the Neighbourhood District Nursing in Cwm Taf can be summarised as:

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[1] RCN Policy and International Department Policy Briefing 02/15 August 2015: The Buurtzorg Nederland (home care provider) model - Observations for the United Kingdom (UK)

[2] The King's Fund Report *Understanding Quality In District Nursing Services* (2016) and QNI's Report *Understanding Safe Caseloads In The District Nursing Service* (2016).

- Person centred care - putting the person at the centre of holistic care, maximising opportunities for co-production and co-design of service delivery;
- Building relationships with people to make informed decisions about their own care, which promotes well-being and independence with active involvement of family, neighbours and the wider community, where appropriate;
- Everyone, including support functions, will facilitate person-centred care at the point of delivery;
- Small self-organising teams that are embedded in the enhanced multi-disciplinary team in primary care and GP aligned within a geographical location;
- Supportive management structures that enable professional autonomy.

The pilot is being delivered in the Cynon Locality of Cwm Taf and is underpinned by a sophisticated IT infrastructure. As part of the pilot an automated clinical scheduling of patient visits is being tested. This model potentially offers a saving of nursing time and resource that is currently heavily dependent upon senior graded staff. Further investment in either smart phones or tablets for the team to run the necessary software has come from the pilot funding. This is helping to test the broad benefits of modern IT equipment including clinical “apps” to support the efficient delivery of nursing care.

Malinko has been engaged as the provider of the appropriate clinical software to test the perceived benefits of automated electronic patient scheduling. Tablets (iPads) have been purchased for team members to facilitate modernised access to all IT systems. Staff involved in the pilot have received bespoke training, coaching and education as this is a very different way of working. A full evaluation of this approach will be carried out in consultation with colleagues in Powys and the Aneurin Bevan University Health Board. This will include engagement with users and staff.

It is early days in the delivery of this innovative way of working but initial feedback from staff and patients is positive.

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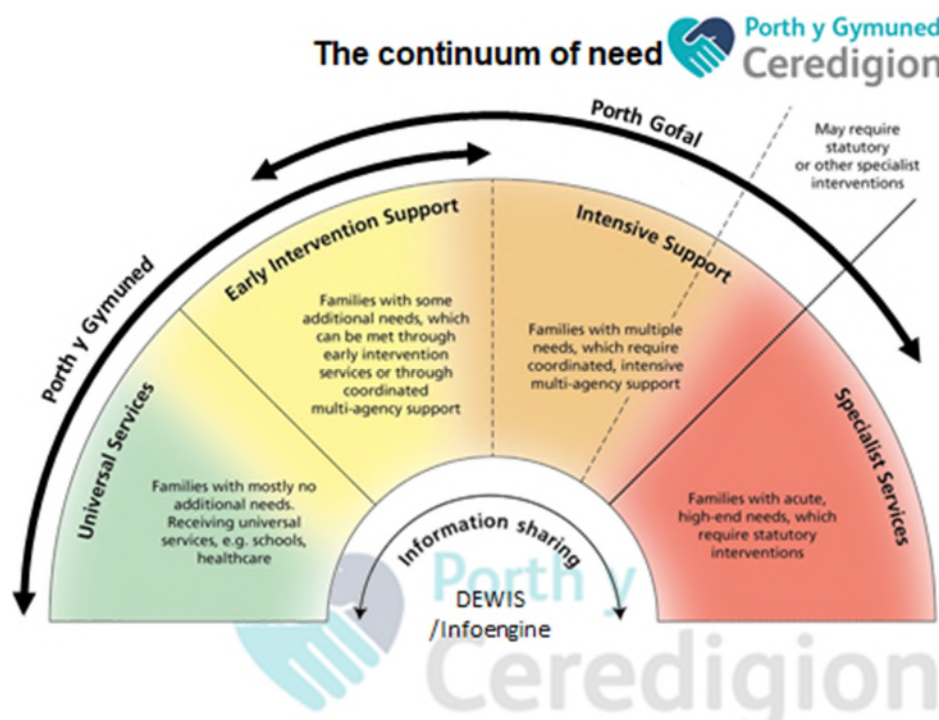
II. Porth y Gymuned and Porth Gofal – West Wales

Ceredigion Council implemented a new well-being and care pathway in June 2018, comprising of two key parts Porth y Gymuned and Porth Gofal. The aim of this new way of working is to provide residents with the right help they need at the right time, working with a person's strengths and finding solutions that are co-produced with the individual and their community. Dewis Cymru and Infoengine, the on-line resource directories that host a range of opportunities, events and services in the community are accessed to help identify information to support residents and prevent them escalating into statutory services.

The Diagram below shows the link between Porth y Gymuned and Porth Gofal in supporting service users.



Porth y Gymuned

Porth y Gymuned is a through age Customer Care Service providing a prevention and early intervention community portal supported by trained staff, known as Community Connectors (CC's). The four CC's have a wealth of community resource knowledge and assist residents of all ages in Ceredigion, helping them to make connections to access support opportunities in their area and maintain and improve their wellbeing. This service also includes Family Information Service (FIS) and works alongside Team around the Family (TAF)

The Community Connectors carry out the 'What Matters' conversation with people, using a Signs of Safety and Wellbeing approach and work with them to identify targeted solutions that meet their needs. The CCs support individuals and their families to access advice and assistance provided by the third sector, as well as identifying appropriate services and groups, within their own communities, such as social groups that could help contribute to their wellbeing. The team are mindful of all third sector /community services already in place and working together to make the support as full as possible – using connections and building on what's working – also identifying gaps in service provision

Furthermore, the CC's have an important role in encouraging and supporting community groups to place their information on Dewis. This is an important element of their role, in ensuring there is as complete a picture as possible of the support available in communities. This means that residents are placed in a stronger position to self-serve and access a well-resourced information portal, as well as ensuring those working with individuals and families both in the statutory and third sector have access to up to date information.

Porth y Gymuned will help fill the gap when someone's needs do not meet the threshold for statutory intervention dealt with through Porth Gofal. If an individual's needs are assessed as needing a higher level of social care input, they are automatically referred to Porth Gofal for a full assessment.

Importantly, Porth y Gymuned sits within the Customer Contact Service of Ceredigion County Council and not Social Care. This has been a conscious decision, as they recognise that not all enquiries, particularly those coming from residents of Ceredigion at a preventative / early intervention stage would need a response from social care.

Porth Gofal

Porth Gofal focuses on responding to the requirements of the most vulnerable people and families in the community by improving the flow of information between agencies to ensure faster decisions and a more consistent, coordinated care and support. Referrals are made to Porth Gofal from the Corporate Customer Contact Centre, or directly from other Health and Social Care professionals, such as G.P's, Social Workers and Nurses.

This service is a partnership between Ceredigion County Council, Hywel Dda University Health Board, and third sector organisations. It provides a multi- disciplinary team of Prevention Support Officers working alongside a Senior Social Worker, Occupational Therapist, Physiotherapist, Districts Nurses, links with the third sector and a dedicated input from Families and Children Services. This team triages people being referred to find the best way of meeting well-being outcomes including working with hospital teams to get faster discharges from hospital and to prevent admissions.

This integrated team of professionals closely consider every new referral that comes through to ensure the most appropriate response. Dedicated support is discussed with the individual and put in place to support their wellbeing. Under this new model, the focus of assessments is shifting from identifying problems and generating demand towards promoting the independence of people and working with them to find the right support or solution to deliver personal outcomes.

The two services are still in early stages but feedback to date is positive.

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III. Developing an ACE AWARE approach to resilient children and young people – Cardiff and the Vale

The ACE AWARE approach has been developed to address the step change needed in emotional and mental health support for children and young people in Wales. It is estimated that one in four children will show some form of mental ill health and half of all mental health problems begin by the age of 14.

Cardiff and the Vale are implementing this new way of working across health, social care, education and the third sector to increase resilience and awareness in children and young people (CYP) across the region through peer support, timely intervention and signposting.

New Resilience Worker posts are being recruited to deliver this approach. They are employed by the UHB and supervised by existing clinical staff from Primary Mental Health Services, Clinical Psychology and CAMHS. A transformative approach to changing professional culture and working practices means that the resource will be based in the two existing Education teams (Cardiff Specialist Teacher Team and Vale Outreach Team). These teams work in school clusters to support children's emotional wellbeing and the new approach is bringing the attachment, Adverse Childhood Experiences (ACEs) and mental health perspective to the teams in a holistic service spanning education, health and social care.

The Resilience Team is allocating a lead worker for each Cluster and there is an opportunity to flex this resource to meet demand. The intention is that each of the Workers, where possible, have a key expertise in a lead area e.g. Peer Support, Volunteering, Welsh language etc. providing an early intervention and prevention approach to reduce the need to access statutory services.

The Resilience Team will enable capacity building and up skilling of the Children and Young People workforce (including the third sector) and school community to be able support emotional wellbeing and specifically understanding ACE's and attachment. This is also enabling the integration of emotional and mental health in existing CYP services such as Families First.

The Resilience Team will work with the community to co-produce early intervention and training for the region, developing peer support and volunteering. This is being done in partnership with the Mental Health Foundation who are providing project management and evaluation support.

This approach is delivering the following outcomes:

- Improved mental health and wellbeing for children and young people
- Decrease in referrals to mental health services
- Increased knowledge and skills of non-mental health professionals in the community
- ACES/developmental trauma informed approach in the community
- An effective working model that can continue long term

Scalability and Transformative – This project is still in early stages but if the planned outcomes are delivered there is potential for the approach to be implemented regionally and nationally once evaluated.

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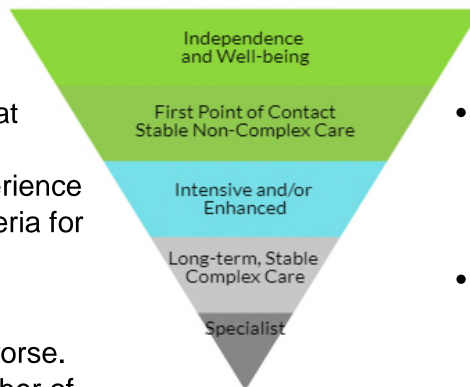
Practical Case Study example of what will be delivered with the ACE AWARE approach:

Sam's current experience…

- Sam is finding it difficult at school as a result of an Adverse Childhood Experience but doesn't meet the criteria for CAMHs
- Sam's behaviour and attendance are getting worse. There seem to be a number of services but all have different referral mechanisms resulting in both Sam's school and his mum (Cerys) not knowing where to turn to for advice.
- Sam is suffering from anxiety and low mood which Cerys suspects is as a result of bullying for being dyslexic. Sam is withdrawing and won't talk to her about it.



Sam's Future experience…

- School identify Sam is struggling with issues in school and are concerned about his well being
- School liaise with the Education Wellbeing team and request support
- Resilience workers visit to school; and talk to Sam's teachers, talk to Sam and observe his behaviour and meet Cerys.
- The resilience workers and Psychologists formulate a plan with school and mum which enables Sam to feel supported and ensures positive interactions with adults and peers
- The worker will visit Sam regularly and if Sam still has problems with anxiety and low mood will enable access to the appropriate Mental Health service and support any recommended intervention.

IV. “Creating a Place called Home – Delivering What Matters”

Flintshire County Council’s development of “Creating a Place called Home - Delivering What Matters” embeds an outcome-focused and personalised approach in the residential care services it commissions. It focuses on cultural change using person-centred tools and practices to improve well-being outcomes for individuals. Improving their quality of life, the quality of care delivered and helping to improve staff development and staff retention are its goals. The development has been shaped and influenced by the Social Services and Well-being (Wales) Act 2014 and the 2014 report of the Older People’s Commissioner for Wales (“A Place to Call Home”).

- The development is not about doing more but about doing things differently, with an emphasis on staff providing the best support they can in ways which reflect what matters to the person in their care. The latter is facilitated by the preparation of one-page profiles of individuals. A self-assessment tool was developed in partnership with care home managers to support progress monitoring and to encourage continuous improvement. The project is still in its early days. Monitoring and initial evaluation has identified good practice, which has convinced other providers to join the programme e.g. two residential homes providing nursing care. Some staff in the Betsi Cadwaladr University Health Board and staff from other organisations e.g. Age Connects Wales and Care Inspectorate Wales have also taken up the approach.
- Over and above addressing key requirements of the Social Services and Well- Being (Wales) Act 2014, the development sits well with the “personalised” and “voice” design principles of “A Healthier Wales”. The Council is expanding the programme to cover its other care provision such as domiciliary care and supported living. Where there is a need for an individual to move between care e.g. from short-term to permanent residential care, the development reflects moves towards the "seamless" design principle.

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V. Your choice – Vale of Glamorgan

This is a piece of work that addresses a fundamental concern for almost all Local Authorities and Health Boards: how do you shift the balance in providing domiciliary care to enable the person receiving the care to be in control?

Whilst it is planned across the Vale of Glamorgan, it is being piloted mainly through a single care agency who is currently working with over 30 people.

In summary, it enables a care agency to develop a collaborate relationship with the person receiving care, so that once the person has been assessed as needing care and support, a tri-partite meeting takes place, between the social worker, the person who has been assessed and the care agency that will be providing the service. The care agency will have been notified of the number of hours per week that are available to support the person. The meeting is a negotiation, enabling the person to work out how they will manage their ever-changing needs and circumstances with the care agency, without relying on constant contact with the social worker, to ask for authority to make changes.

The desire was to encourage workers to have creative conversations with people to develop truly person-centred care plans, but the regular experience was that the relationship fell into a 'care-planned' transaction offering little flexibility. It was piloted with one care agency, giving the workers in that agency the authority to have continuous conversations about what matters to the person receiving care to inform the day to day support. If the plan on any day has to be shifted around to meet the person's wishes, that is managed between them and the care agency. None of the time allocated is lost and the care agency listens to what the person wants.

The key characteristics are:

- Trusting care agencies to have meaningful conversations with people
- Providing specialist training for care agency staff on 'outcomes-based' working
- Flexibility and sharing decision-making with the person
- Ensuring that nothing is insurmountable, not limiting but expanding people's horizons
- Conversations that lead to better mutual understanding
- Once agreed finance is not a central issue

Inevitably there are teething problems and these centre around developing an agreed 'blended rate' that allows agencies to feel that they are being paid to be flexible. Administratively there are tricky processing issues because of inconsistencies between different teams, but there is a determination to prevent these being issues that could collapse a system that is highly regarded by the people who received services through 'Your Choice' and also by the care workers. One care worker has described the system as "it brings caring alive for the first time for me…. we are giving people what they want, not what they have been told they are going to get". A person receiving care put it very simply, "it gives more flexibility to do what I want and need".

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VI. Regional Career College Consortium – Gwent

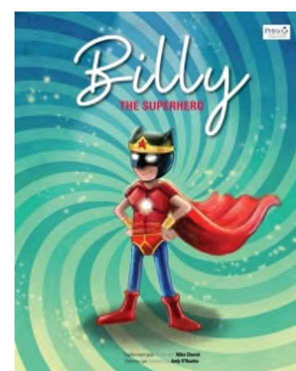
One of the priorities for the Gwent Region is ensuring that there is a suitably qualified work force, especially front-line social care staff working in the domiciliary or residential care settings, so that they fully engage in the community agenda, understanding the important role they have in building community resilience and contributing to a preventative approach. Gwent Regional Partnership Board (RPB) has established a Regional Career College Consortium for Health and Social Care Programme with 6 strands: Governance, Developing Provider Relationships and Qualifications, Marketing, Engagement and Communication, Finance, Employability Officer and Related Work Programmes. In addition to the usual partners on the RPB, Coleg Gwent, Career Wales and private social care providers are working in partnership to help deliver this programme.

Coleg Gwent are taking an active role in this partnership and are keen to work with the Gwent RPB to develop training and development programmes to meet any skill deficits in social and health care as well as the community development deficits and develop guidance on the learning and best practice in setting up a social care and health course to specifically target the skillset deficit.

A programme approach is being implemented and some key actions already being addressed include:

- Working with the private domiciliary and nursing care sector to develop an offer for students which supports a time specific, paid work placement once qualified.
- Develop relationships with local primary schools to raise the profile and understanding of Health and Social Care to educate and inspire younger children to think about health and social care.
- Develop relationships with local secondary schools to promote health and social care as a valuable career choice. This links to the wider intergenerational strategy being developed by ABUHB and Ffrind I Mi initiative.
- Develop a database of Health and Social care Students at enrolment and subsequent destination data to better understand why students decide not to enter the Health and Social Care sector once qualified.
- Improve the image of working in health and social care in the region, support regional recruitment initiatives, stream line application processes so they are more user friendly.

In December 2018 the Regional Consortium launched a Health and Social Care book for younger children 'Billy the Superhero'. This book is an innovative way of introducing the topic of health and social care to young children, to encourage them to reach their potential and spark interest into health and social care as rewarding careers. Copies of the book are available from Petra Publishing: caerphillypn@btconnect.com



Contact Details for the Regional Career Consortium Mark Saunders, Service Manager – Regional Commissioning and Partnerships, Social Care and Housing, Torfaen County Borough Council
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VII. Bevan Exemplars

In seeking to achieve its aims, the Bevan Commission (www.bevancommission.org) identified the need for an Academy to strengthen leadership and innovation in health locally, regionally, nationally and internationally. It established the Bevan Commission Academy for Leadership and Innovation in health to help develop prudent healthcare and other innovative actions needed to help sustain health and healthcare.

The Academy has three primary roles; informing the Commission's thinking, bridging theory and practice, and translating thinking into action at pace. It is supported by Bevan Commission Innovators. The Innovators include:

- Bevan Exemplars and Health Technology Exemplars - staff in NHS Wales with ideas for change to improve resource efficiency, health outcomes or patient experience.
- Bevan Fellows - healthcare professionals, clinicians and doctors in training who bridge clinical services, academia and practice. They are given space and time within their roles to lead and research more prudent solutions.
- Bevan Advocates - members of the public (patients, carers, volunteers) offering a personal perspective on services, health, wellbeing and illness.
- Innovation Hubs - The Central Hub is hosted within Swansea University and encourages and supports action to address challenging issues and questions. It supports and coordinates Local Bevan Innovation Hubs, each providing the opportunity for individuals or groups of people to come together to solve problems by testing new ideas.

The Academy established the Exemplar programme to stimulate, support and embed innovation within and across healthcare organisations. It was created in response to the need to strengthen innovation and leadership within NHS Wales to respond to the growing demands and challenges faced. It seeks to identify, drive and spread innovation and act as agents for change.

The inaugural pan-Wales exemplar programme was launched in December 2015. A showcase of projects for the first cohort (2016) was published in 2017. This was followed by a compendium of 2017-18 projects, which was published in January 2019.

Given the Commission's aims, developments within and across the NHS dominate the programmes. The emphasis is on better outcomes to individuals (as well as on health services themselves), some of the impacts and/or benefits of the developments will extend to organisations outside the NHS such as social services e.g. in terms of reduced support needs as a result of better health outcomes. We have selected five of the exemplars that are worthy of further review as they have the potential to be scalable and transformative:

(i) "Linking Mental, Physical and Social health to care for "Nobody's Patient": Quay to Well-Being (Q2W) Co-operative - A Proposed GP Practice (GMS) "Plus" Service"
(ii) "Providing holistic care to enable people with dementia to lead fulfilled lives"
(iii) "Intergenerational falls awareness sessions for community-dwelling residents"
(iv) "Person Centred Care in Diagnosed and Emerging Dementia: Impact on Personal Profiles on an Inpatient Mental Health Ward"
(v) "Implementation of a post-falls decision support tool ("I Fell Down") for use by care home staff"

Further details about these projects are contained in Appendix 2

5. Findings – Part 2: Overarching Themes

5.1. Beyond the particular regional and local examples, we have identified in Chapter 4, our research and field work revealed a number of “overarching” themes “to which the ‘Healthier Wales’ principles are relevant but where there was more of “national” approach to development and innovation. The issues covered below are:

i. Community Connection and Coordination

ii. Co-operatives and User- led Ways of Working

iii. Co- Production

i. Community Connection and Coordination

Over many years and driven by a variety of factors, including growing financial pressures, an ageing population and increasing demands on health and care services, there has been increasing recognition of:

(i) The need for considerably more action on prevention and early intervention;
(ii) People’s overall well-being in addition to health;
(iii) Mental health as well as physical health;
(iv) Social, economic and environmental factors which can affect people’s health, and thus the need for a more holistic approach;
(v) The need for more integrated people-centred public services which deliver what matters to them when they need it;
(vi) The role that health services play in helping people to improve their health and well-being but also recognition that others e.g. third sector organisations are sometimes better placed to help individuals instead of, or as well as, medical treatment;
(vii) The need for alternative ways of helping people, particularly to reach out to people who, for a variety of reasons, do not engage with services be they health, support or housing,
(viii) The need to keep people out of hospital as far as possible and to provide services and support to people in their communities.

There have been developments in relation to the above, but far more is needed to be able to cope with the challenges ahead. The ten design principles set out as “A Healthier Wales” provide a helpful framework and support to drive further improvements in services and, where necessary, significant changes i.e. “transformational change”, in the way services are delivered.

A variety of approaches have emerged. These recognise the services and support provided within communities by Third Sector organisations to help people manage their conditions, to address their personal circumstances and to overcome problems or difficulties. One such approach is social prescribing, which is sometimes referred to as “community referral”.

Recognising that people’s health is determined primarily by a range of social, economic and environmental factors, social prescribing seeks to address people’s needs in a holistic way. It aims to help people to take greater control of their own health. It enables GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical servicesi. There are many different models for social prescribing, but most involve a “co-ordinator” or “link worker” or “navigator” to help people to find and access suitable and appropriate support.

Similar approaches have emerged from the field of community development and community engagement. These have been driven by Third Sector organisations working with people in local communities and/ or with groups of people in the population who have common needs. In reaching out to people, they help people to engage with existing sources of support of which they may not be aware or develop new sources of support. In some cases, a person may simply need to know where and how to access support. However, some people such as those who are isolated and/or may be suffering from low level mental health problems require more personal support, assistance and encouragement to get to a stage where they feel able to engage with services and support.

There is a clear overlap between social prescribing, as defined above, and more general community connection and engagement activity. Both refer people to activities which are provided by voluntary and community organisations e.g. arts and interests activities, befriending, and healthy eating advice. Alternatively, they may use the services of organisations which specialise in certain matters (e.g. managing finances and debt; housing rights; homelessness) or conditions (e.g. mental health) or circumstances (e.g. bereavement). Some community connectors work with, or from, GP surgeries in addition to community settings and venues.

The roles which have developed in England and Wales around social prescribing and community connection are known by a variety of titles. For example:

- Link Worker[ii]
- Community Link Worker[iii]
- Community Navigator
- Care Navigator[iv]
- Community Care Navigator[v]
- Community Connector
- Carer Community Connector[vi]
- Local Area Co-ordinator
- Local Community Coordinator
- Community Co-ordinator[vii]
- Wellbeing Coordinator[viii,ix]

The following pages provide some examples of the above which are currently operating in Wales. It is not a comprehensive picture of all such action but in the time available to complete this report we have identified some examples which illustrate these forms of development and intervention. The examples cover each of the seven Regional Partnership Board areas.

Powys

Powys has a team of 10 Community Connectors plus a manager within its Community Health and Well-Being Coordination Service. Depending on the outcome of funding decisions, the team may expand to 13 Community Connectors for 2019-20. They help people 18 and over and their families or carers to access community services and activities. The aim is to support them to live independently and to prevent deterioration in circumstances to the point where they may need higher level health or social care services. It also helps people who have been in hospital when they return home to connect back to their community.

Powys is made up of thirteen localities. Currently some Community Connectors cover more than one locality area. The service also operates a Mon-Fri 9.00am - 5.00pm duty system out of Powys People Direct (now" Assist"). This ensures that people are able to access the service from any part of Powys and Powys People Direct contact officers are able to transfer clients to the

service directly without delay. The services deal with referrals or requests from organisations or individuals seeking to obtain support from local community and voluntary organisations for people who may need services such as befriending, shopping, advocacy, home adaptation, community transport, or support with specific health related concerns such as dementia.

Referrals are made by health and social care professionals, the individuals themselves, carers, family members and a small number by the police. When someone is referred, a Community Connector works with the individual to identify their requirements. They are then helped to access the community services or activities they feel are right for them. The aim is to provide this information on the first contact with the individual using a "right first time" approach.

Some Community Connectors work in local GP surgeries, brokering access to Third Sector support for frail/elderly patients across the whole of Powys. This is part of the Powys Teaching Health Board's 'Virtual Wards' service model. They also work within the multi-disciplinary teams in community hospital settings, providing support and guidance for local teams on what services are available locally which may assist people in getting out of hospital more quickly. In doing so, they help to identify areas of unmet need or gaps in service provision; evidence which is then used to help inform the planning of public sector and Third Sector services

Western Bay

The Western Bay area has developed its approach using the Local Area Coordination Model[x]. Developed in Western Australia in 1988, it follows a series of core characteristics and design principles. Local Area Coordinators are based in community venues, so they are easily accessible to people in the areas they work. They work in a defined geographical area[xi], which is no more than 12,000 people, as a single, accessible point of contact for local people.

They spend time supporting community building and building local connections as well as working with individuals. They take a strengths-based approach to helping people to plan or solve problems as a family or with friends. Coordinators try to support local or non-service solutions wherever possible, focusing on what the person can do for themselves using their skills and experience as well as the help that friends, family and the local community can provide.

Western Bay has coordinated the implementation of two initiatives[xii]. “Local Area Coordination” has been implemented in Swansea and Neath Port Talbot. In Bridgend, “Local Community Coordination” has been developed. Both are person-centred, aligned with the area’s prevention agenda and the ethos of co-production. The co-ordinators are a single point of contact. It caters for people who need a “light touch” approach through to more complex, longer-term needs. Interventions are not timebound. There is an emphasis on trusting and supportive relationships with individuals and their families to reduce the risk of future crisis and service dependency.

In Bridgend, Local Community Coordination is a small team within the Directorate of Social Services & Wellbeing (Adult Social Care). The approach shares its principles with Local Area Co-ordination but does not fully implement all core design features e.g. there are differences in the way it recruits, implements and supports the role of a Coordinator. It is a framework being built from the ground up and driven by the context within which it is operating. It relies on the Coordinator to shape and develop the working model and feed into the supporting team. It has a ‘slow-build’ approach, forging strong relationships with individuals, families, community and stakeholders.

In Neath Port Talbot, the Local Area Co-ordinators are managed within the same service as the Community Connecting Team and the Community Independence Service. This helps avoid

duplication and competition between services. We understand Neath Port Talbot has moved away from the specific Local Area Co-ordination model on the basis this allows them greater freedom. Whereas Local Area Co-ordinators in Neath Port Talbot are the single point of access out in neighbourhoods, the Community Connectors were introduced following modernisation of Day Services and the removal of a centre as the focus of day activities. They do not necessarily work 9.00am – 5.00pm, which was the pattern available under traditional day services. They connect with people where they live and when they want contact/activity.

All three services in Neath Port Talbot replace 'formalised' responses and services and work on what people want to do e.g. what matters to them, rather than simply implementing a care plan, which can have limitations, including timing. Local Area Co-ordinators bring people together and use all kinds of sources to gather intelligence. In fulfilling their role, it appears they are undertaking activities which can be considered community work or community development in nature. The Authority's Community Independence Service is aligned to the housing support service, which is worthy of note given the role housing plays in peoples' lives and the impact that housing-related problems can have on people's health and well-being, and vice-versa.

Gwent

A Community Connector pilot project was funded by the Intermediate Care Fund (now the "Integrated Care Fund")[xiii]. Twelve Community Connectors were aligned to the 12 Neighbourhood Care Networks across the Aneurin Bevan University Health Board's area - Caerphilly, Blaenau Gwent, Monmouthshire, Newport, and Torfaen. For example, in Caerphilly, their development and use featured in the Council's delivery plan for older people (define as 50+) in Wales[xiv].

The roles are described in more detail on the web sites of the relevant local authorities. The aim is to help residents to identify their own issues and solutions to enable them to help themselves, their relatives, friends and neighbours to age well. They aim to re-connect people with their communities by helping them find suitable activities and groups, linking people together who have similar interests and encouraging participation within their community. They provide information and advice on suitable community groups and activities. In doing so, they seek to promote well-being, reduce social isolation and promote independence.

The role is similar in Newport, tackling loneliness and social isolation by providing information, advice and assistance to people who live in the Newport area. Advice is provided face-to-face as well as by telephone, email or post. They seek to improve a person's confidence, well-being and social circle so that they can become more involved in community activities. A "what matters" conversation is the first step. Newport also has a role entitled "Carer Community Connector" to provide information on local support services and activities, and voluntary organisations[xv].

Cardiff and the Vale

A service funded by the Cardiff and Vale University Health Board combines elements of the social prescribing approach with that of community connectors. The Wellbeing4U programme was launched in May 2016. The service is delivered by United Welsh, a housing association, across three GP clusters in the Cardiff and Barry areas.

A team of Wellbeing Coordinators help patients to overcome situations affecting their health and wellbeing, whether health or lifestyle issues or broader matters e.g. debt; rent arrears. The approach builds on people's strengths to help them take control of their lives and to achieve goals.

People are referred by their GP or other primary care staff but can self-refer. It gives patients of primary care more support and support options, which also helps reduce demand on GPs.

More details on the project can be found in the appendix of this report on joint working between housing, health and social care.

West Wales

In Pembrokeshire, a Community Connectors service is a key element of a 2-year pilot programme. Led by the Third Sector, it is a people-centred approach to improve health and well-being by improving access to information, advice and assistance, dealing with referrals in a timely manner at the first point of contact, and achieving a shift towards earlier intervention. The programme is delivered by Pembrokeshire Association of Voluntary Services working in close partnership with Pembrokeshire County Council and Hywel Dda University Health Board. It is anticipated that the service will reduce the total number of calls to the contract centre Council's contact (approx. 30,000 per year) and enable more effective referrals to community-based services.

Community Connectors work across the county. Each has a designated area and will work remotely in community venues. This approach has similarities to the Local Area Co-ordinator model. In addition to networking and developing effective links within communities and working with partner organisations, they will work closely with GP surgeries, primary care clusters and social care hubs to support anticipatory care planning and social prescribing.

In Ceredigion, a new well-being and care pathway was implemented in June 2018. It has two main parts; Porth y Gymuned and Porth Gofal. The aim is to provide the county's residents with the right help at the right time, building on an individual's strengths and finding solutions which are co-produced. Both are in their early stages, but initial feedback has been positive, and we have included more on these projects in section 4 of this report.

Carmarthenshire is delivering a **P**revention, **E**arly **I**ntervention and **P**romoting **I**ndependent **L**iving, (PEIPIL) Approach focusing on increasing strengths in individuals and communities to maximise their potential. This approach is aimed at increasing independence, improving outcomes and the quality of life. It is also a more effective way to deliver services as a proactive preventative approach ensures that people receive the right support at the right time.

One of the projects being delivered within this model is Social Prescription: Living well no matter what. Officers are working with GP Clusters on an innovative Time Credits social prescribing programme. Social Prescribers are active across the seven GP practices in the Llanelli area and this will be extended more widely, working with patients to improve patient health and well-being through spending and earning Time Credits. The programme has been designed to work with a specific patient demographic that includes older people, regular attendees, patients living with chronic pain conditions and people with low level anxiety and depression. Direct referrals are made from the GPs which is more efficient and a peer to peer support group has been established for people with low level anxiety and depression. Early feedback on this model is encouraging.

North Wales

A Local Asset Co-ordination (LAC) approach has been established on Ynys Mon. The LAC's work on a one-to-one basis, using an asset-based, person-centred approach to identify activities & solutions and re-connect individuals into their communities without initially reverting to the

approach of signposting and receiving services. Individuals are supported to utilise the assets within their own communities to connect with others & to create long-term networks of support. Further information on this approach is described in the section on Co-operative working and the examples contained in Appendix 4

Denbighshire has appointed three Community Navigators employed by the British Red Cross to support the wellbeing of people by signposting them to information and advice in the third sector.

Cwm Taf

There are five Community Co-ordinators covering the Cwm Taf University Health Board area. The posts are funded by the Integrated Care Fund. Four of the co-ordinators each cover designated areas – Cynon, Taff Ely, Rhondda, Merthyr. The role of the fifth is to work specifically with primary care across the area. The co-ordinators provide information, advice and signpost to local community groups, activities and services, building strong partnerships with communities, agencies and services to support people aged 50 and over.

Available information also points to a **GP Wellbeing Community Coordinator covering the Rhondda GP cluster.** The post is hosted by the county voluntary council for RCT (Interlink). This allows the co-ordinator access to over 500 community and voluntary members which is a valuable resource in terms of services, activities, advice and groups.

An evaluation report (April – December 2017)[xvi] explains the background to the development, which was an investment by the GP cluster in a social prescribing' project, which included the employment of a Wellbeing Coordinator. The report documents the use of the service by GP practices, the reasons behind referrals and action. Six issues accounted for just over two thirds of the referrals – mental health, lonely and isolated, social care support, benefits advice, debt advice, and housing. These were the primary reason for patient referral at that time. However, it is worth noting the primary reason for referral often masked other, more complex issues, which could be uncovered and addressed by taking time to listen and encourage conversation and then working with individuals, some of whom are vulnerable, to help them to take action.

The report also analysed feedback from GPs and practice staff, and patients who received help. As such, it offers numerous learning points for the design and operation of such initiatives.

Purpose and function

Drawing on information gathered during this study, the aims and purpose of developments which involve social prescribing and/or community connection activities can include the following:

- Preventing ill-health
- Improving health and well-being
- Helping people to manage an existing condition to prevent it from deteriorating
- Helping people recognise their strengths and what they can build on
- Helping people to address issues, problems or difficulties which affect their health and well-being (e.g. lifestyle, debt, housing, skills, confidence, self-esteem)
- Helping people to be independent and to retain their independence for as long as possible
- Reducing loneliness and social isolation
- Helping people to feel part of their community through engagement in activities, by volunteering and by helping others.

There are some differences in the way the posts which sit under the different job titles listed in the paragraph above are configured. Some use a place or area-based approach with an individual operating within a designated area (of varying size in terms of population) while others work in community settings, sometimes with a community development element to their role.

While links to primary care services are embedded in social prescribing services, community connectors too have linked up with, or are developing their links with, GP practices in their area. Despite some differences, there is a high degree of commonality in the broad functions or types of activities of the roles. These can be summarised as:

- A proactive as well as responsive approach, taking referrals but reaching out to people who for several reasons, many not engage with services and support.
- Spending time with people; talking to them to find out about their circumstance and what matters to them
- Identifying sources of support and options which can meet their needs
- Plugging gaps in people's knowledge and awareness of help and support
- Providing information and advice on suitable community groups or activities
- In some cases, encouraging, facilitating or developing new groups, activities or means of support within the community
- Encouraging and supporting people to act including, where necessary, accompanying them to meetings and activities i.e. a form of "hand holding" to build their confidence
- Providing a pathway for referrals from public sector agencies, including the NHS, social care, and in some case the police, for help.
- Helping some people find their way through the "system" be it the NHS, social care or other, such as home adaptations, housing advice.
- Gathering intelligence on local needs and activities/interventions to meet needs, and gaps in provision (all of which can contribute to needs assessments and strategic and operational planning)

Over and above initiatives described as social prescribing, community connectors or similar, there are other forms of support in communities which help people to address problems they are facing. These include the support provided to tenants by social landlords and the services of providers of housing-related support. Over and above the example of Wellbeing4U mentioned earlier, further examples of support provided by social landlords can be found in the section of this report on joint working between housing, health and social care.

Conclusion

There is some evidence social prescribing can lead to positive health and well-being outcomes e.g. quality of life, emotional wellbeing, mental health and levels of depression and anxiety, and possibly a reduction in the use of NHS services. However, research has pointed to limited evidence of effectiveness, with small studies, research methods which lack control groups, and a reliance of self-reported outcomes. Researchers have also highlighted challenges in measuring the outcomes of complex interventions or making meaningful comparisons between very different schemes. Other research has pointed to social prescribing being successful for patients who engaged with the service but concluded that research on a larger scale is required to assess when and for whom social prescribing is clinically effective and cost-effective[xvii]

Local Area Coordination is positioned as an evidence-based approach which works for people of all ages including those with complex needs. Evaluations of the approach point to health outcomes, reductions in referrals or visits to health and safeguarding services, and reduced

dependence on day services. They also point to the contribution the approach makes to systems reform and cross-sector partnership working. Similarly, monitoring of the role of Community Connectors is generating encouraging feedback on utilisation e.g. volume of referrals, and self-reported outcomes.

Social prescribing and community connector initiatives are funded in several ways. A detailed review of the level of funding and budget sources was outside the scope of this element of the project. However, sources of funding are known to include the Integrated Care Fund, which features prominently, the Supporting People Programme, and other local authority and Third sector funding sources. There is, inevitably, variation in how specific posts are funded and, more than likely, the duration of funding and thus the sustainability of the services. The latter can be a particular challenge when funding decisions for future years are made at a late stage. The resulting uncertainty causes some experienced staff to leave in order to secure other employment, creating gaps in service coverage and continuity and the additional workload of recruiting and training replacements.

There are variations in the way resources are structured and deployed and how performance is monitored. The latter includes difference in key performance indicators set by different commissioners. Geographical coverage also varies with indications of gaps in some areas and potential overlaps or duplication in others. A recent national networking conference event on Community Connectors (March 2019) hosted in Powys was very well attended and shows the considerable interest in how social prescribing and community connection is working in different areas.

As stated at the outset, this element of the report is not a comprehensive review of social prescribing and community connection and co-ordination in Wales. However, there is clearly much being done using these approaches, which is clearly helping many people who might not otherwise be able to find help and support or who for a variety of reasons would not engage with services and support. Some developments are at a relatively early stage while others are more established. The nature of these interventions is a good fit with some of the requirements of the Social Services and Well-being (Wales) Act 2014. They also reflect some of the design principles in “A Healthier Wales”, which support changes in the way services are delivered, a more holistic approach to meeting people’s needs, increased linkage between health and social care services and alternative sources of support, and people being helped to help themselves.

Consideration of how such approaches are currently being used and can be used in future to improve health and well-being outcomes for individuals, to reduce demand on NHS and social care services through prevention and earlier intervention gives rise to a series of questions which Regional Partnership Boards and / or Public Services Boards may wish to consider. These are set out in Appendix 3.

Over and above reviewing the use of Community Connectors and social prescribing within Regional Partnership Board areas, there is some merit in further work to explore their use across Wales. This could serve as a platform for sharing learning and good practice, identifying how to further develop and support the roles (support for skills development and well-being support for the connectors themselves who may encounter distressing cases), and to maximise their effectiveness and impact.

ii. Co-operatives and User-led Ways of Working

Introduction

The Social Services and Well-being (Wales) Act 2014 and its Code of Practice outlines the Welsh Government's expectations in relation to the promotion of social enterprises, co-operatives, user-led services and the third sector.

The Code of Practice sets out the details of a duty on local authorities to promote the development in their area of not-for-profit organisations to provide care and support, and support for carers and preventative services. Local authorities must also promote the involvement of people for whom these care and support and preventative services are to be provided, in the design and operation of that provision.

The duty to promote, requires that local authorities 'must take a proactive approach to planning and delivering models that will meet the well-being needs of all people – children, young people and adults – in promoting models which are based on social values.

The aim of the duty is to expand the range of not-for-profit service models in the social care sector so as to increase the diversity of provision available, and improve support innovation and creativity, and increase community resilience.

We have looked in more detail at a number of projects, models and approaches that are co-operatives or other user led models of working. The projects outlined at Appendix 4 are of varying size and scale and some are yet to be scaled up and tested in a way that would lead to genuine whole-system focused transformation.

While the focus of this paper is on 'innovation', it is often said that there is no such thing as an original idea! Many of the approaches that are used in delivering Co-operatives are commonly used all over the world. We have determined that new ways of working in terms of Co- operatives are more likely to be innovative if:

- All sectors take responsibilities for communities and there is a shift from thinking that 'services' are the answer so that we co-produce and co-design together. The outcomes to be delivered will be dependent on those involved and their shared vision. There are certain key factors that support the delivery of co- operative working and these are outlined below. There is a good chance that approaches will improve outcomes for communities if these factors are applied.
- The inherent values or principles are as important, if not more so, than the models or tools being used.
- The new approaches become mainstream – using them across sectors and communities.

Probably one of the biggest challenges (and opportunities) to transformation, is the relationship between those who commission services and the people who are meant to benefit. Commissioning practice still tends to be an interface between the commissioner and the bigger providers. If we are to stimulate and support more cooperative and co-produced approaches, in line with what the Act requires, then commissioners need to reach out to citizens, communities and small third sector groups (constituted and un-constituted). Commissioners need to apply the co-production principles and work with and alongside people to co-commission or co-design better approaches to care and support. A number of the projects featured as best practice, have struggled to be part of that relationship, but have carried on regardless because of their social values.

Factors for Success

In broad terms the establishment of Co-operatives will benefit from involving people who the service is meant to benefit in the planning and delivery. There are a number of factors that need to be considered when establishing user led models of working and these are set out below:

Power sharing is fundamental – a genuine belief in and investment in co-producing with the people who the service/support is meant to benefit. This needs to happen at the very beginning of instilling innovation/doing things differently. Focus groups, engagement processes & consultation events can be limited in this respect. Co-production needs to be embedded in any innovation, with a focus on its five principles.

Language, behaviour and environment does matter – the notion and language of 'service users' is one that all of these projects are challenging. This challenges all sectors to think differently about working together on a more equal basis with the removal of symbols of status and hierarchy – dress, names, uniforms and organisational corporate branding. All of these elements often cause preconceived perceptions and, as a result, can create barriers to effective engagement. Attached to this, the creation of ordinary, non-clinical spaces and environments can help people to feel safe and welcomed with an open door.

Seeing and supporting people's strengths and not being risk adverse – This isn't about assessment it is about believing that everyone has something to offer, whatever their current circumstances. Not just 'what matters to you', but what are you passionate about, what is your story, who are/were the important people in your life and what difference do you want to make, for yourself and to your community? This requires a belief that people will try and do the right thing, if they are valued. A risk-averse culture that invests lots of energy in processes that focus on finding the potential problems and risks can disable a lot of the friendly, neighbourly support and relationships that these approaches require. One of the projects refers to their approach as 'ripping up the rule book'.

Relationships between people make the difference here – those who are the instigators of such work are often people who don't see hierarchy. They create ordinary, everyday relationships with the citizens involved, which helps create a different environment that says 'we are all in this together, we are all citizens. Creating strong relationships, both within the project and around the people supported is at the heart of this work. A deep understanding that having strong relationships creates confidence and can save lives.

Creating and maintaining a co-operative culture will ensure that this work lasts – an investment in shared power, interests, vision and ownership will protect this work from becoming systems-dominated. The citizens who become fully involved will be valued, sometimes through time-banking, sometimes by taking on responsible voluntary or helping roles and sometimes by becoming paid employees. A continuous reflection on these key characteristics and values should ensure that the work does not lose focus or become taken over by the system.

Measuring the impact of the Project/Model/Approach - One area that is proving particularly challenging is how to measure the impact the project/approach has on the local community or the wider population. This is particularly important if projects are to be sustainable and have access to future funding to continue the good work started. Further information on measuring and evaluating projects is contained in the next section of this report.

Appendix 4 provides examples that show co-operative ways of working that have embraced co-production and other common factors in their design and implementation. It covers:

(a) The Community Care Collaborative (CCC) – The Community Care Hub model

(b) Local Asset Co-ordination on Ynys Mon

(c) Flintshire DO-IT - Developing Opportunities & Interests Together

(d) Llanelli Social Prescribing through Time Credits project

(e) The Artisans Collective

iii. Co-Production

Co-production is an asset-based approach to public services that enables people providing and people receiving services to share power and responsibility, and to work together in equal, reciprocal and caring relationships. It creates opportunities for people to access support when they need it, and to contribute to social change.

Statutory Basis for Co-Production

Part 2 of the Social Services and Well-being (Wales) Act 2014 introduces the concept of co-production into Welsh law and its implementation is supported by a statutory Code of Practice that includes in Chapter 4 directions on co-production.

The Code of Practice (para 197) says:

The principles and practices of **co-production** are intended to build the local core economy of people exchanging their skills, interests and time. They will help to shift the emphasis towards support which is created through the shared interests and common commitment of people with an investment in it. Social enterprises, co-operatives and third sector organisations are types of organisation that lend themselves well to applying co-production principles because of the fact they are often democratic, membership organisations.

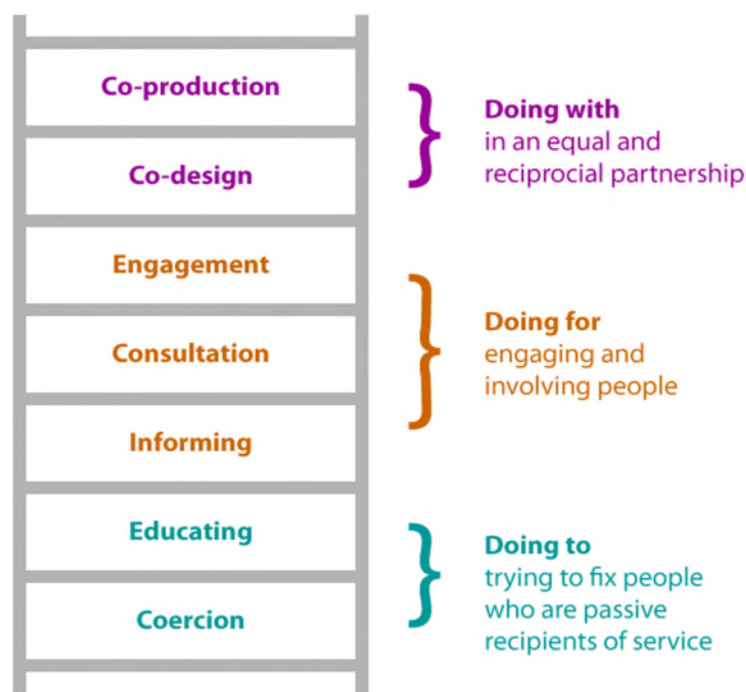
The term Co-production is widely used in many sectors and it is accepted that there are five key principles to follow for a co-productive approach:

- Value all participants, and build on their strengths;
- Develop networks of mutual support;
- Do what matters for all the people involved;
- Build relationships of trust; share power and responsibility; and
- People can be change makers, and organisations enable this.

Our research has shown that there is still some ambiguity about what real Co-production is and sometimes organisations are keen to demonstrate they are working together to solve problems and use this term when it is not appropriate, as they are not sharing a power base for decision making. There are several ways that organisations, communities and individuals can work together to make a difference.

Co-production builds upon a range of similar approaches such as consultation, engagement and co-design. Any one of these approaches will have a place in solving different problems to ensure sustainable solutions with improved outcomes for people. What is important is that if an organisation is looking for a solution to any problem, including how to establish a new model of working, the best way of working is applied to make a difference. There is no one size fits all and over working a problem may be counterproductive and not produce the best results. Clearly showing the difference between co-production and these related, but different, approaches is important if real co-production is to be put into practice.

The ladder of co-production is a useful way of making these important distinctions:



Co-production may not be the answer to simple or uncomplicated problems and if this approach is applied when it is not appropriate people may view it negatively. This is not to say that organisations shouldn't work with others on these problems, but the input should be scaled as appropriate to meet the need. Complex problems are the ones that will benefit most from Co-production. These problems often benefit from as many 'brains' as possible working together to solve them. This is when Co-production comes into its own and produces the best results. Spending time at the front end of complex problems to find the right solution will save time in the longer term and produce sustainable solutions.

Examples of Projects/Communities making effective use of the Co-productive approach.

An **Interactive Catalogue** produced by Public Health Wales and Co-production Wales, is an excellent resource and clearly sets out key principles behind co-production, along with some critical questions to help people think about how this approach might be used. It. has three sections: Introduction, Case Studies, and Resources. The Catalogue offers a range of inspirational co-production initiatives, both established and emerging. All are based on an explicit commitment to the principles of co-production – equality, reciprocity and trust. These '**Seeing is Believing'** documents are interactive PDFs and can be accessed through:
https://www.goodpractice.wales/co-production-catalogue-from-wales

The Case Studies give good examples of where using a Co-productive approach has contributed to the success of projects. It includes 21 projects each of which sets out:

- A summary of the project
- Where they started
- What they did
- Key Learning

- Why the approach used in this project Co-production

Another example of Co productive working raised by the Co – production Network is the Community Care Collaborative CIC (CCC): https://ccc-wales.org/. More detail on this approach is described in the section on Co-operative working and Appendix 4

The Community Lives Consortium, is a Domiciliary Care Agency providing support to people with learning disabilities and physical disabilities in the Swansea and Neath Port Talbot areas. This support is provided in supported living houses where people have their own tenancies, and in people's own homes. Further information can be found at: https://www.communitylives.co.uk/about-us/ Contact is Rick Wilson

Another example of a smaller project in Wales that has successfully worked co- productively is the Me Myself & I project in Briton Ferry: Contact Anita Tomaszewski anita.tomaszewski@gmail.com

Measuring and Evaluation

The Co- Production Network Wales has been developing a Measuring toolkit to provide clear and simple support to non-experts in navigating the wealth of information and guidance which is available to them regarding data collection and evaluation. It aims to contribute to rising standards of evidence and evaluation within statutory bodies and third sector organisations, and encourage a more co-productive approach to planning and carrying out data collection. It helps with understanding: what are the right questions to ask; who needs to be involved and what is the best technique to use. This toolkit is available on the Co-production Network for Wales Knowledge Base https://info.copronet.wales/category/what-is/ and provides information, links and resources relating to every data collection method referenced in the guidance.

6. Joint working between housing, health and social care

6.1 There is growing recognition of the interconnections between housing, health and social care and the benefits that better joint working between these areas bring to people who use their services. The recent change proposed by Welsh Government to the membership of Regional Partnership Boards recognises the role of housing in improving well-being outcomes for people. The commitment to representation of housing specialists on the Regional Partnership Boards is significant to achieving this goal and reinforces the view that housing, health and social care are intrinsically linked.

6.2 As part of this review we have researched and identified projects, models or approaches in Wales, which have introduced integrated health, housing and social care to improve outcomes for people. The full report at Appendix 5 reviews the findings of this study and outlines factors which contribute to their development.

6.3 In summary, the following examples of joint working are identified in Table 1:

Table 1: Examples of joint working between housing, health and social care organisations

Title / Theme	Housing Organisation	Key feature(s) of action
Closer to Home	First Choice Housing	Reducing the need for out-of-area placements
Lighthouse project	Taff Housing Association	Reducing delayed transfers of care by addressing housing and support needs
Remodelling sheltered housing	Cynon Taf Housing Association	Alternative use of existing accommodation to meet needs
Remodelling sheltered housing	Trivallis	Alternative use of existing accommodation to meet needs
Training Flats	Trivallis	Help for independent living for young people leaving care
Well Being 4U	United Welsh	Social prescribing intervention based on three GP clusters
2025 Movement	Various organisations	Strategic level forum to stimulate joint working
Mental health pathway	Isle of Anglesey/ Ynys Mon CC / BCUHB	Improving services and support to prevent cyclical problems
Hospital discharge	Conwy County Borough Council (lead)	Reducing delayed transfers of care by addressing housing and support needs
Health inequalities and rough sleepers	North Wales Housing Association (lead)	Improving access and support to people who are homeless and sleeping rough
CARIAD	Linc	Step down arrangements and alternative pathway

6.4 The examples in Table 1 vary and have been identified for the different settings in which they operate, and the different models deployed. The factors behind their development also differ as does the precise nature of the help being given to people to improve health and well-being outcomes.

6.5 Looking at the models of working behind the examples, they can be grouped under six main headings. Better outcomes for individuals directly or indirectly are common to all. The broad ways in which the NHS and social care can work with, and benefit from, registered social landlords and local authority housing departments are:

- Using local housing providers to reduce the need for, and cost, of, out-of-area placements;
- Preventing delayed transfers of care (and as far as possible, the possibility of readmission) by addressing housing or housing-related issues;
- Using housing providers to identify opportunities to provide earlier intervention and more support, and options for primary care to address health and non-health issues which affect people's health and well-being;
- Alternative use of existing local housing assets to better meet the needs (sometimes complex needs) of people who are receiving services and support from the NHS and/or social care;
- Improving the lifelong prospects of care leavers by using local housing provision to help equip them with the skills necessary for successful independent living;
- Improving the way in which services and support are delivered by involving housing providers (social landlords and/or housing-related support providers) in service delivery (i.e. towards more of a "whole system" approach).

6.6 The full report, in Appendix 5 has been drafted as a 'stand-alone' paper. It is anticipated that this will inform future discussions on the potential benefits of projects delivering joint housing, health and social care outcomes.

7. Recommendations

7.1 This Workstream has researched and analysed an extensive range of effective and emerging good practice from projects across Wales. The aim of this programme is to support delivery of the Prosperity for All commitment to "invest in a new model in the community" and the Parliamentary Review focuses on new models of care. This work has been shaped by the national principles in A Healthier Wales and in particular the principles of "scalable" and transformative". In the light of our findings we would make the following recommendations:

(i) Without adding to the 'Healthier Wales' principles, Welsh Government should consider how the concept of "spreadability" as defined at paragraph 3.6 can best be promoted as a means of implementing verified examples of excellence across Wales and removing barriers to creating more integrated care.

(ii) Chapter 4 has identified emerging initiatives from across Wales that have the potential to meet the criteria of "scalable" with strong indications that transformative benefits are likely to be delivered in due course. For each project, it is recommended that a monitoring and evaluation process is established to verify whether the initial promise identified has been achieved. Where the project can demonstrate success, it is recommended that practice guidance should also be produced so that others can benefit from the lessons learned.

(iii) Chapter 5 has examined broader issues that have been addressed through innovatory projects – community connection and co-ordination, co-operatives and co-production. Given their significance and potential to help deliver the principles and practice of a modernised social care sector in Wales, we recommend that each theme should feature in the implementation of the National Transformation Programme.

(iv) The Parliamentary Review of Health and Social Care in Wales and Healthier Wales provide some high-level criteria for examining models of care. Having considered the position in Wales and through Workstream 1, elsewhere in the UK, it would be valuable if Welsh Government further developed our Guidance at Appendix 1 to produce composite common criteria for Wales. This would assess and measure what an innovative, good or promising example of practice looked like and how organisations can scale up examples of practice that are clearly leading the way.

(v) We could not find a single comprehensive access point to obtain examples of innovatory practice in Social Care delivery in Wales. This made the job of finding, analysing and comparing the range of practice examples that had been verified, something of a challenge. Using the SCIE database as an example, ADSS Cymru should liaise with Social Care Wales to see if this is a facility they could develop for the sector in Wales.

(vi) In the light of the comparative analysis at Appendix 3: *Strategic consideration of community connectors and co-ordination,* Regional Partnership Boards should challenge whether they are utilising their Community Connectors in the most effective way.

(vii) In the light of intended membership changes, Regional Partnership Boards should give careful consideration to the role that Housing should take in their work to maximise the benefits that housing sector representation brings.

(viii) To take recommendation (vii) forward Regional Partnership Boards should review the six ways in which the NHS and social care can work with, and benefit from, registered social landlords and local authority housing departments (Chapter 6 and Appendix 5) and implement a programme of action accordingly.

(ix) Regional Partnership Boards should review the Bevan Academy examples at Appendix 2 to consider the scope for implementation in their region.

(x) The Welsh Government and ADSS Cymru should approach the Bevan Commission to propose that the remit of the Bevan Exemplar programme is extended to include models of integrated care that reflect the 'Healthier Wales' principles and promote partnership working between health and social care.

ADSS Cymru

Leading Social Services in Wales

Yn arwain Gwasanaethau Cymdeithasol yng Nghymru

Delivering Transformation Grant (DTG) Innovative Care Delivery Models in the Community

APPENDICES

April 2019

Appendices

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Appendix 1: Guidance for Successful Projects/Models/Approaches

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b) Delta Wellbeing Model – Carmarthenshire, West Wales
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Appendix 2: Bevan Commission Exemplars

Appendix 3: Community Connection and Co-ordination

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Appendix 5: Housing, Health and Social Care: Examples of Joint Working and Support for Tenants

Appendix 1 (a)

DEMENTIA FRIENDLY COMMUNITIES – GWENT REGION

Future Opportunities for scaling services and key principles to ensure success

A Dementia Friendly Community is described by the Alzheimer's Society as:

> '*A city, town or village where people with dementia are understood, respected and supported, and confident they can contribute to community life. In a dementia friendly community people will be aware of and understand dementia, and people with dementia will feel included and involved, and have choice and control over their day-to-day lives'*

The Dementia Friendly Communities Approach launched by the Alzheimer's Society in 2013, is one way that people can act and change to better support people with dementia and enable them to live well in the community. The Gwent Region has fully embraced this approach and over a number of years all areas have been developing dementia friendly communities. They have been very successful in involving a wide range of organisations working towards this vision and have demonstrated they are able to respond to local need and ensure that people across the region are aware of and understand dementia and that people with dementia feel included and involved.

Future Opportunities for scaling services

Two of the design principles identified in 'A Healthier Wales: Our Plan for Health and Social Care' are for services to be scalable and transformative. There is potential for the governance structure, principles and ways of working adopted by Gwent in delivering Dementia Friendly Communities to be scaled up and rolled out more widely to effectively deliver a similar model in other areas. This initiative can make a real difference and improve well-being outcomes for people with dementia and their carers and if supported well provides a sustainable approach which can become a social movement.

Key principles required to ensure success

Other Regions may benefit from understanding the principles adopted in making this approach a success in Gwent. The key principles adopted in Gwent are endorsed by the Alzheimer's Society and include:

- Inclusion of 'Working towards Dementia Friendly Communities' as a clear priority in Corporate Improvement Plans, PSB Wellbeing Plans and the Regional Area Plan.
- Accountability for monitoring and delivery needs to be at the highest level with regular reporting and updates to the Public Service Boards, the Regional Partnership Board and a Dementia Board.
- Identification of one person with the vision, passion and commitment to keep the momentum going and act as the strategic lead for this initiative.
- Finding the right people to become dementia friendly champions who are passionate about making a difference and improving outcomes for people with dementia and their carers.

- Keeping things simple so that all sectors understand the role they have to play in developing dementia friendly communities and have a sense of belonging to a community that wants to make a difference for people with dementia.
- All parties, including people with dementia and their carers contributing to the Communities annual progress report which is used to monitor progress in each area.
- Development of action plans with people who are affected by dementia to ensure they are relevant and appropriate for needs.
- Continuously reviewing the Community Action Plans so that they continue to add value for the local community.
- Embracing the bureaucracy of monitoring and progress reporting without it becoming too bureaucratic. Make this side of the reporting as creative as possible!
- Learning from each other, if there are a number of communities reporting to an overarching Board it is easier to learn what has worked well in nearby Boroughs.
- Using the existing reporting structures for progress updates i.e. Public Service Boards and Regional Partnership Boards.
- Maximising the use of captive audiences such as school children and recognising the important part they have to play e.g. intergenerational projects are a win/ win for all parties!
- Working towards making DFC becoming mainstream – aim for it to become a social movement. This is possible when the tipping point is reached and enough organisations/ people have been trained.
- Encouraging developments that meet local needs, maximising available local resources but within a consistent framework, so that all know if they see the 'Working to become Dementia Friendly Community' Logo they can expect a good quality service that meets the needs of people with dementia.
- Supporting good relationships between all who are involved from all sectors.
- Putting in place excellent integrated support networks and follow up services for anyone at the point of diagnosis so that they are not alone.
- Working with the regional Dementia Friendly Co-ordinators as they have a lot of experience and good ideas on how to make a difference.
- Recognising that the Alzheimer's Society's externally accredited model with independent validation, gives added assurance that organisations displaying the logo are working to a consistent high standard.
- Not imposing dementia friendly standards on any organisation, start small and simply and if working well other organisations will want to get involved.
- Adopting a secret shopper approach to keep checking on quality and standards.
- Understanding and supporting those DFC's that are community led as they will need more support from the coordinators and champions.
- Commissioning good delivery partners at an early stage will help to progress DFC's in an efficient and effective way.

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Gwent Dementia Friendly Communities - Case Study Examples

Case Study: New Dementia Friendly Town BLAENAVON. Blaenavon has had its commitment to becoming a Dementia Friendly Town recognised with an award from the Alzheimer's society. The award recognises the achievements and progress the town is making to becoming dementia friendly, which includes the creation of a new dementia friendly intergenerational group at Big Pit, public awareness sessions, and a range of activities linking school children with local care homes. Blaenavon is already home to the first Dementia Friendly post office in Gwent, a dementia friendly library, and many businesses in the town have undertaken dementia training. The award was given as part of Dementia Action Week to Blaenavon Town Council and Big Pit, who have jointly led on the initiative. Big Pit National Museum are working with Blaenavon Town Council towards #DementiaFriendlyBlaenavon and have delivered dementia friendly art activities with local business. They have promoted the Museum's dementia work at four national conferences and input a case study into national publication about dementia friendly heritage. Have also delivered 'Kids in Museums' Takeover Day with Blaenavon Heritage School & Arthur Jenkins Care Home – creating dementia friendly intergenerational Christmas activities.

Case Study: Blaenycwm Primary School has become the first school in Blaenau Gwent to be awarded the dementia friendly logo. Staff and pupils in key stage two received Dementia Friends awareness to learn about the five key messages in relation to dementia and what life is like for people living with dementia. Younger pupils also learnt about dementia through a story book, 'The Elephant That Forgot'. Pupils have been using their new knowledge when visiting local care homes. The aim is to help increase young people's understanding of the illness and how important it is to support and care for loved ones and neighbours who may be living with dementia. http://www.southwalesargus.co.uk/news/15901194.Brynmawr__39_s_Blaen-y-Cwm_becomes_the_first_dementia_friendly_Blaenau_Gwent_school/

Case Study: Nationwide Building Society in Pontypool is one of the latest organisations in Torfaen to gain their 'Working Towards being Dementia Friendly' status. The branch is committed to helping support customers living with dementia and on Friday 11 January, Lynne Neagle AM presented the building society with a Dementia Friends award on behalf of the Alzheimer's Society. Greater Gwent Health, Social Care and Wellbeing Partnership Officer, Natasha Harris, provided Dementia Awareness training to all staff at the Nationwide branch in Pontypool and is supporting with future training needs and events. The training gives an insight into what it is like to live with dementia and how people can be supported to live well and independently. Torfaen AM Lynne Neagle said: "I am really pleased that the Nationwide Building Society in Pontypool has taken the

time and effort to put its staff through the Alzheimer's Society's Dementia Friends training programme. Access to banking is vital for everyone and the training will enable Nationwide's staff to deal with people with dementia in a more sympathetic and understanding way. I am delighted that more and more schools and businesses in Torfaen are completing the training – we really are well on the way to a dementia friendly Torfaen and I believe that will be a kinder Torfaen for everyone."

Pontypool branch Manager Darren Lewis has since trained as a Dementia Friends Champion and is able to support further awareness sessions throughout the organisation in Gwent. As a result, Nationwide is looking to team up with partner agencies including Gwent Police to provide sessions supporting financial independence and fraud awareness. Darren said, "Becoming a dementia friendly branch is important to us at Nationwide, we want to ensure that we can provide support to those affected by dementia. Members of the team have faced the difficulties of dealing with dementia first hand with family members and friends.

We know the challenges ahead for both families and the individuals can be difficult, but we would like to ease this a much as possible for our customers, by understanding the affects Dementia can have on the individual and their finances."

Other Nationwide branches in Cwmbran and Monmouthshire are also set to gain their accreditations with support being provided through the Greater Gwent Health team. Both branches will be making improvements to how they support people living with dementia. Many other organisations are coming forward in Torfaen to develop Dementia Friendly Communities and provide more understanding and support for people living with dementia, their families and their carers.

Case Study: First Primary school to be awarded Dementia Friendly Community logo. On Thursday 15th February, pupils and staff from Rhiw Syr Dafydd Primary School were the first primary school in Caerphilly to be presented with a Dementia Friendly Award from the Alzheimer's Society as a result of training sessions delivered to both pupils and teachers at the school. All pupils at Rhiw Syr Dafydd Primary School were made aware of Dementia in an age appropriate way. This included the junior pupils attending workshops with Phil Diamond, Dementia Theme Lead for Gwent transformation Team and an assembly for Foundation pupils which featured around the reading of 'The Elephant Who Forgot' – a story aimed at raising awareness of Dementia in young children. Staff also attended sessions which focused around certain issues

associated with Dementia and how they could support people. Rhiw Syr Dafydd Primary School also have close links with Oakdale Manor Residential Home, where residents come to the school for Christmas dinner and attend the school's Christmas concert. Pupils from the school also visit Oakdale Manor to sing to the residents.

Newport Case Study: Derwen and Newport Care and Repair have provided Dementia Friends awareness training to over 75% of their staff. They have also included a link on their website to sign post to the Alzheimer's Society. Their 'Reality Theatre' project with residents worked with reminiscence to develop a play based on the resident's lives. This was shown at the Riverfront Theatre in April 2018 – supporting a bid for more funding developing further work with residents.

Appendix 1 (b)

DELTA WELLBEING MODEL – WEST WALES REGION

Future Opportunities for scaling services

Delta Wellbeing provides two key services, both of which have potential to be scalable. There are elements that may benefit from being delivered on a larger scale.

The provision of an IAA Service through a First Point of Access

The First Point of Access works well for Carmarthenshire as the co-located multi-disciplinary team has maximised the benefits available to the service user. This team has a complex range of skill sets, supported by comprehensive training and development. These skills have been put to good use on a 24/7 basis providing an emergency out of hours response service for the Area. Whilst most Local Authorities have already provided a good day time First Point of Access in their area in response to the requirements of the Act, not all have been able to effectively deliver the out of hours service required. Delta Wellbeing is already effectively providing this out of hour's service for many local authorities and other organisations across Wales in response to demand. There may be potential to increase the provision of this service for other organisations in Wales and wider.

The provision of a Monitoring Centre for Technology Enabled Care.

Research has shown that the optimum level of connections for a Monitoring Centre is 15,000 to enable a comprehensive fully operational service to be provided efficiently on a 24/7 basis (10,000 connections is recommended as the minimum number for a fully functional service). Economies of scale can be delivered on a pro-rata basis.

For many Local Authorities in Wales the numbers of connections are not sufficient to provide an effective alarm call monitoring service. Delta Wellbeing is already providing an alarm call monitoring service for service users in Carmarthenshire and eight other local authorities. This is working well and there may be more opportunities for other Local Authorities to enter into a Service Level Agreement to 'buy' into this tried and tested model.

One of the advantages of this approach is that if additional staff are required to meet increased demand, the service can get on with recruitment without the constraints that are often in place in the public sector and may lead to a delayed provision.

Another advantage for Delta Wellbeing providing a comprehensive Technology Enabled solution to care in the home is that they are able to provide bespoke packages of care that require specific pieces of equipment or aids that are often not available to the public sector. An example would be for an individual with a specific condition who may require equipment that is only available out of area or from another country. The nature of the procurement arrangements for Delta Wellbeing, as a commercial entity, is that they can obtain products on loan for a 3 months trial before making an informed decision on whether it meets the service user's needs. The buying power of a larger entity brings even more economies of scale. If more organisations commission Alarm Call Monitoring Services from Delta Wellbeing this could further increase the benefits.

The delivery of both types of services from one location means that a multi – disciplinary team is available 24/7 and is able to provide advice and guidance as required on a full range of professional requirements. This maximises the available resources. As well as providing a reactive service, from calls received and responses to alarm calls, in quieter times they are also able to schedule proactive calls which may prevent an individual going into a crisis situation which would in turn place a greater demand on services.

Key principles required to ensure success

Delta Wellbeing have applied several key principles to deliver a successful service.

These include:

- Fully integrated services with no boundaries between the different service providers in Health, Social Care and the Third Sector.
- Strong leadership with a clear vision provided by the senior managers and elected members.
- Clear support for this vision from senior managers and elected members.
- Sharing of budgets/resources between Health and Social Care so that a joint service is established that provides benefits to both partner organisations.
- Equality of outcome for all service users with this principle being consistently applied through all the service delivery processes.
- Flexibility/adaptability in service provision. The Arm's length company structure enables the team to respond quickly to changing needs. Bureaucracy has been stripped out of the system to ensure a speedy response.
- An agile recruitment process has been adopted so turnover of staff can be dealt with quickly to ensure limited down time and gaps in service
- A co-location multi - disciplinary team of specialist Social Workers, Occupational Therapists, safeguarding officers, District Nurses, Physiotherapists, a Psychologist and Third sector brokerage means that professional standards are shared and a learning environment is created so that each specialism better understands the role of the others. Being able to talk quickly and easily to another discipline means that issues can be more quickly resolved.
- Providing this multi- disciplinary team at the 'front door' provides a much stronger preventative service.
- Well-being Advisers sitting alongside social workers as part of the same team means that they get a better understanding of the work they do and the options that are available to meet an individual's wellbeing outcomes.
- Alignment of the eligibility assessment process with key players on hand to ensure the service user is asked the 'what matters' question and the process is not duplicated making it more stream lined for service provision.
- Recruitment of staff with the right skillset so that they are able to respond to all circumstances. Key skills required are the ability:
  - to respond well in a crisis;
  - to be able to challenge professionals if there are asking for something not appropriate or practical, skilled; and
  - to confidently ask the right questions to understand what matters to the client and the need to be compassionate and caring.

- Taking the learning from the blue light services recruitment process and tailoring it so that the staff recruited have the right skills to meet the needs of those services users and their families who may be in crisis and need an emergency response.
- A mixed skillset of the team to ensure that there are sufficient numbers who can converse in the welsh language
- A comprehensive training programme to meet any gaps in the skill set of the team.
- An on-going comprehensive training programme in core competencies to include the 'what matters' question so that this is intuitively applied when responding to service users. Operators/advisors receive the following training/develop before they take on any live calls with the public.
    - IAA qualification NVQ Level 4 (1-year course)
    - Evidence of competencies provided through case studies
    - Classroom based training sessions
    - Senior operator listens into call and coaches/mentors and the use of taped calls to assist with training
    - Training with a different Third Sector provider every Tuesday morning so that the team understands the preventative and early intervention role that this sector provides for service users.
    - Understanding how the Dewis Cymru and Info Engine data bases work so that they can be accessed to provide up to date information and advice to anyone contacting the service.

- Providing the training to the whole team including Well-being Advisers, O. T's, District Nurses, Social Workers, etc so that all are clear on the overall vision of the service.
- Delta Wellbeing operatives do not use algorithms when speaking with service users.
- Empowering the Well-being Advisers to be creative in finding the right solutions to meet an individual's well-being outcomes and encouraging service users to do this independently. Advisors are trained not to over promise anything to the service user and understand when it is the right time to involve a team manager for advice.
- Ensuring staff are trained to understand the bigger picture and the detrimental effect of people going into hospital (both on limited hospital places and the impact on the individual) if this is not required and they can be better supported at home.
- Establishing a Governance Board to provide the company governance. The Company has an overarching Social Care DNA.
- Getting the right membership of the Board, including:
    - Director of Communities (the Social Services statutory post)
    - Director of Resources
    - Head of Integrated Services
    - Cabinet Member for Social Care (Chair)
    - Opposition elected Members

- Ensuring all staff are clear about the Delta Wellbeing principles. These are exhibited on the wall adjacent to the wellbeing advisors who are taking calls and/or emails from professionals, service users and their families.
- Ensuring the team pride themselves in putting their customers at the heart of everything they do, focusing on improving an individual's independence by providing help or support whenever it is needed
- Having clear team objectives, understood by all:
    - Do what matters to the individual, giving consideration to significant others
    - Understand our customers' needs and add value

- Ensure equality of outcome and opportunity for all
- Get it right first time
- Treat everyone with dignity and respect
- Communicate effectively
- Work effectively, within clear protocols
- Challenge and improve our service, based on evidence
- Understand legislation and meet contractual obligations
- Trust and support each other
- Share knowledge and experience and learn from others

Next Steps

A Transformation Funding Bid has been submitted to expand the IAA service and to put in place a Rapid Response Team Model, based on the work carried out in Barcelona/ Bilbao. They have already started talking with Tunstall on how this model will be taken forward.

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Appendix 1 (c)

STAY WELL@HOME (SW@H) – CWM TAF REGION

The Stay Well@home Service

The Stay Well@home Service consists of a multidisciplinary hospital-based team made up of Social Workers, Occupational Therapists, Physiotherapists and Therapy Technicians, sited within the acute hospitals of Royal Glamorgan (RGH) and Prince Charles (PCH) hospitals. All professional disciplines within the team have the "Trusted Assessor" role and are able to undertake a proportionate assessment. This includes the asking and recording of the response to the 'What Matters" conversation and agreeing, recording and providing a copy of agreed outcomes. All staff are supported to make decisions to ensure the timely release of patients or providing support for an individual in their home so that they do not need to be admitted to hospital. The service is provided for residents of Rhondda Cynon Taff and Merthyr Tydfil with existing pathways protocols continuing to be used for 'out of area' patients, this is mainly those attending PCH from the Aneurin Bevan University Health Board.

The service operates 7 days a week, 365 days a year between the hours of 8 am and 8 pm and is supported by a range of community-based responses across health & social care provision.

Staff in the SW@H Service work in the same way as the Single Point of Access (SPA) for community referrals and have been trained to deliver:

- *Initial assessments and commission/provide health, social care and third sector community support to facilitate safe and timely return home from A&E and the Clinical Decision Unit (CDU), thereby preventing unnecessary admission to hospital. This includes the commissioning of a community response from the appropriate community teams (4 hours response time from community services); and*
- *Integrated complex discharge assessments for those patients who are admitted, applying the default position that individuals are supported to return to a community setting.*

Future Opportunities for scaling services

One of the design principles identified in Healthier Wales is for services to be scalable and there is evidence that the principles and processes adopted by SW@H can be scaled and rolled out more widely to effectively deliver a similar model in other areas. The development of a Single Medication Policy has meant that not being able to administer medication is no longer a barrier to hospital discharge. Development of this Policy has proved challenging, but it is now working well and proving very successful in getting people home more quickly. Other Regions may benefit from understanding the principles adopted in making this service a success.

Key principles required to ensure success

Key factors that have been applied to make this service successful include:

- A shared vision between Health and Social Care with all parties understanding that there are benefits to the service users/patients and to the public sector in finding the right solution:

  - Reduced length of stay for patients
  - Faster discharge times.
  - Reductions in the number of people going to Community hospitals
  - Reduction in the number of people going into hospital
- Being able to identify as early as possible the people ('Implementers') who need to be on side to deliver a vision of timely discharge for service users. In the case of Cwm Taf this was the Health Board's Deputy Chief Operating Officer and the Director of Therapies, R.C.T. Social Services Heads of Short-Term Intervention and Merthyr Tydfil's Principle Manager ensuring representation from across the region.
- These key people need to have responsibility for decision making, or be able to influence decision makers in their respective organisations.
- Getting the 'Implementers' from each sector together and taking them 'off line' giving them the time and space to gain agreement, identify shared principles and develop trust in each other so that they will deliver a Stay Well@Home model and do whatever it takes to make it work.
- The relationship between the key implementation team members needs to be based on trust so that each are sure they were all speaking with 'one voice'. No one partner should deviate from this message, even though behind closed doors there may be robust discussions about how things should progress, once this is disseminated to others it will be with one voice.
- The Implementers need to prepare the Business Case for the project involving a wider group of officers as required. Once it has been determined that a Business Case is needed this should be prepared quickly so that it doesn't delay progress. It will confirm the shared vision, the reasons why this new way of working is needed, the outcomes to be delivered and an understanding of organisational constraints. Each organisation needs to commit the personnel resources required to do this. This includes support functions such as IT, Human Resources and Finance colleagues.
- Consultation was undertaken with the Joint Trade Unions who provided support to employees during the development and implementation of the new model.
- The footprint for the model should be the Health Board area and each Local Authority within this area needs to be signed up to this new way of working.
- Once there is clear direction and the key principles are established, these should be presented to the Regional Partnership Board for sign off. Each partner representative on this Board should report back to their organisation from an operational and strategic perspective so that all parties are fully on board and the changes needed are implemented.
- Each partner organisation has to sign off approval for the changes and give the mandate to proceed. In the early stages of the project all partners need to share a clear vision.
- Effective leadership needs to be in place at all levels in each partner organisation and these people need a 'can do' attitude and an understanding of the 'bigger picture' and the benefits being delivered to the service user. It is vital that any 'local politics doesn't get in the way of progress.
- A project management approach needs to be put in place for the implementation phase with a dedicated full-time project manager identified to take responsibility for turning the business case into implementation. The project manager will report to the project lead who will also chair the multi- agency SW@H Implementation Board which is made up of key representatives from the disciplines involved in the new model i.e. Social Care, Occupational Therapy, Nursing, Pharmacy etc.
- The project lead supported by the project manager needs to oversee the development and implementation of the new way of working. This includes finding the right resources to

support implementation, and in particular a project support officer and a business analyst resource to develop local processes that work for each sector so that it is clear what is required from each partner to ensure effective implementation
- Specific work streams need to be established with a lead officer responsible for developing and delivering each work area. Examples of work streams are:
    - Information Technology and shared data management
    - Infrastructure
    - Legal Agreement
    - Governance
    - Process mapping and design
    - Medication
    - Roster planning system
    - Transportation
    - Third Sector support
    - Performance
    - HR
- It is easier to implement if there is a shared IT System in place. A decision needs to be made on which system is being used to ensure there is a single version of the service user's records. The use of technology to ensure, all service user records are recorded centrally and monitored quickly and easily.
- Any disagreements about the process or use of resources need to be ironed out quickly and worked through in a positive 'can do' way so that energy is applied to finding a solution rather than finding a way not to deliver. If there is no resolution between the teams the issue needs to be escalated to the SW@H Implementation Board for a decision which is binding on all parties.
- A safe environment needs to be created for staff who are not comfortable with the changes proposed so that they can constructively challenge the process and ask questions supported by their trade unions.
- There are some things that can't be easily resolved between sectors but if you focus on these it is not acceptable to say this won't work. The overriding principle for success is that 'no issue is insurmountable, there is always a solution' and if you get the right people with the right attitude in a room, they will find a solution and make it work.
- A Trusted Assessor role needs to be in place so that any one professional can commission services on behalf of SW@H. This includes Social Workers, Occupational Therapists, Nurses and Physiotherapists.
- The working relationship between staff from all sectors needs to be very good with a great deal of trust on all sides and an understanding that all are working to achieve the best outcomes for the service user to resolve any issues together and arrange hospital discharge as quickly as possible.
- The '@home' nurses play an important role in helping to 'educate' hospital teams and provide support to avoid a 'too risky to discharge' approach. There needs to be an understanding from the hospital team that it is possible for the right medical and social support at home for people being discharged with complex needs.
- Certain services with health only aspect e.g. leg dressings, catheter checking needs to be commissioned by the Health Board.
- Branding for team members is helpful, in the case of Cwm Taf a new logo was developed, all SW@H staff wear the same green uniform with the logo so are easily identified as part of the team and take pride in this. This way the service is seamless as there is no distinction between health or social services staff.

- A pooled budget needs to be established, in the case of Cwm Taf, this was through the Intermediate Care Fund (ICF). Without this dedicated resource the project would have taken a lot longer to get off the ground. This needs to be managed by one of the partner organisations.
- A legal agreement was developed and signed by all partners accepting levels of risk as the project was grant funded.
- Clear commitment from the Health Board and the local Authorities to underwrite the costs of SW@H if the pooled (ICF) budget did not continue.
- Training and development for staff working on SW@H is important. The use of patient stories and case studies are a far more effective way of getting the message across and are a helpful supplement to more traditional training methods. Example case studies should cover all eventualities e.g. service user in receipt of direct payments, person discharged form hospital needing an increased package of care. They help to endorse the overarching vision of working together, with a 'can do' ethos to improve outcomes. Operational guidance was developed by the team.
- Process maps also have a place in developing the new way of working and these need to be prepared by staff who have a specific skill set of business analysis so that the way of doing things is captured easily in a diagram and supports the training for staff working in this new way.
- Regular briefing papers need to be prepared for staff so regardless of which shift they are working they can access information on how successful the new way of working is and be clear about why they are working in this way and understand any changes needed. Team briefings for staff are also an important part of the communication strategy.
- A more relaxed reduced eligibility criterion is applied to ensure discharge is not delayed for people with complex needs. All staff work together to find the most appropriate support whether it's social care or health care to make sure there is a timely discharge. No questions are asked in the first 2 weeks about costs of care, these needs are funded from the pooled fund. A review is then undertaken within the 2-week period post discharge.
- In the 2 weeks immediately after discharge, all social care support is provided by the in-house team to ensure there is no delay. If a person was previously receiving care from an external provider, this is suspended until the full assessment is carried out in the home. This is done within 2 weeks and if an increased Package of Care is still required after 2 weeks it is recommissioned with the original providers.
- Social care services being accessible 365 days per year between the hours of 8.00a.m. and 8.00p.m. with a 4-hour response has been instrumental in facilitating discharges and building positive relationships between acute hospital sites and social care community services.
- The Third Sector needs to be involved from the outset and in the case of Cwm Taf the Age Connects Better at Home Service has proved invaluable in supporting getting people home from A&E as quickly as possible.
- Specific issues that are preventing discharge or require a person to be taken into hospital may need specific policy development e.g. support with medication. In Cwm Taf, a Single Medication Policy has transformed the way the team work and all sectors including external Domiciliary Care providers work to this policy so that a medication issue does not delay a discharge from hospital.
- Continuous review of the service, including lessons learned to improve the service being delivered is required, especially in the first year of implementation.
- Simplified performance measures need to be agreed at the outset with data gathered to show that the improved way of working is making a difference. It is important not to over

record data, a streamlined approach is best so that staff can focus more time on delivery than collecting stats. However, performance across all areas of the SW@H service needs to be monitored and tweaked to ensure efficiency during the first year of operation.

- Regular monitoring on a monthly and quarterly basis is needed with a more detailed review after the first 12 months of the service being in place.
- Examples of helpful measures to determine improvements are
    - % reduction in people admitted to a hospital bed from A&E (data available for age 61 - 74 and 75+)
    - % increase in numbers admitted but returning home earlier (data available for 0,1-2, 3-4 and 5 days plus, split by age group)
    - % reduction for those transferred to a community hospital
    - Reponses times for community services
    - Outcomes of community services
    - Service user satisfaction with each element of the service (survey monkey is used)

Next Steps

A Transformation Funding Bid has been submitted to expand the SW@H to develop a Stay Well in the Community Approach to prevent conveyance to hospital and a response to community professionals such as nurses, GP's in and out of hours and WAST with a greater emphasis on the use of Technology to support the service user.

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Appendix 1 (d)

EARLY HELP HUB – FLINTSHIRE, NORTH WALES

The Early Help Hub

Flintshire's Public Service Board established an Early Help Hub (EH Hub) in July 2017. When first established, this was a multiagency initiative that made additional information, advice and assistance available to families experiencing two or more adverse childhood experiences (ACEs). This was an important building block in bringing focus and agreement between partners in how to support families. Following the implementation of this model Flintshire moved to a position which recognises that all children and families have a right to early help and support. The EH Hub was therefore designed around ensuring that they are able to target early help and support to families, recognising the challenges associated with ACE's. They no longer use the criterion of 2 or more ACE's, although in reality the families referred to the EH Hub have at least 2 ACE's present.

The model brings significant service transformation across partner agencies to work collaboratively in identifying, understanding and supporting the health and well-being of families.

Future Opportunities for scaling services

Two of the design principles identified in 'A Healthier Wales: Our Plan for Health and Social Care' are for services to be scalable and transformative. There is potential for the governance structure, principles and ways of working adopted by Flintshire in delivering the Early Help Hub to be scaled up and rolled out more widely to effectively deliver a similar model in other areas. This initiative can make a real difference and improve well-being outcomes for children and families.

Key principles required to ensure success

Other Regions may benefit from understanding the principles adopted in making the Early Help Hub a success in Flintshire. These principles include:

- Senior leaders from all partners demonstrating a robust commitment to improving outcomes.
- A strongly committed group of people across the multiagency partnership - where the voluntary and community sector sits as an equal partner with statutory colleagues on the Board and take an active part in decision making.
- Excellent multiagency governance arrangements chaired by a senior officer from one of the PSB partners (in the case of Flintshire this is the Police)
- Strategic advisory and project support capacity made available through the Flintshire PSB, this helps to nurture excellent partnership working and ensure a focus on delivery
- Agreement across all partners to 'soft launch' the Hub so that processes can be tested to ensure they are sustainable. This approach helps build confidence, commitment and understanding.
- Co-location of staff and the identification of the right office space with a welcoming lobby where people seeking help can be effectively supported.
- High-quality information sharing processes need to be in place, with effective enabling infrastructure such as a common information management system (adapting and adopting

an existing system) for recording key elements of the family journey and a bespoke WASPI. All staff need to be able to access up to date information from any of the partner's records, including the police.

- Development of information protocols for sharing of information where families are not content for this to happen. This includes how to proactively build relationships with families with high levels of need to help them understand the benefits of giving consent so that they can achieve their personal well-being outcomes.
- Involvement across agencies in the design of the scope and processes of the EH Hub, including how the EH Hub interacts with statutory Children's Services to limit the risk of any families not having access to the right support quickly.
- Willingness and support from senior managers for the EH Hub to 'do the right thing' rather than simply 'doing things right'. Being responsive to changing needs and reviewing the profile of families to refocus on what is the right thing at any given time.
- Alignment with the Families First programme to help encourage EH Hub development.
- Progressively embed the Families First programme within the EH Hub to enable direct help and support deployed through the Hub
- Wider workforce communications and awareness raising activities to ensure understanding of the purpose and focus of the EH Hub.
- The processes need to make sure that people are seen quickly in a safe environment and are responded to within a maximum of 5 days after the first meeting.
- Development of good links to CAMHS and Primary Care so that GP's are able to access the Hub when they need to.
- Well –informed multi-disciplinary teams meeting regularly and readily sharing of information and ideas to resolve issues for service users. There needs to be a high degree of trust as part of the culture of the EH Hub to deal with vulnerable people quickly and safely in a well-thought-out and coordinated way.
- Delivery of information seminars across statutory agencies, third sector organisations and for schools to ensure that consistent information is disseminated as widely as possible.
- Developing capacity for the third sector to respond and ensuring that third sector colleagues take a critical role in considering how best to offer help to people with circumstances that do not warrant allocation to any statutory service team.
- Developing a flexible approach and continuous improvement to find new ways of providing a better response to vulnerable families

Next Steps

A full evaluation of the Early Help Hub is planned in 2019.

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Appendix 2

BEVAN EXEMPLAR PROJECTS

The Bevan Commission was established in 2008 to provide independent, authoritative advice and guidance to the then Minister for Health and Social Services. Its creation coincided with the 60th Anniversary of the founding of the National Health Service. The Commission draws its board of expert members from Wales, the UK and internationally.

The Commission set itself eight principles:

1. A shared responsibility for health between the people of Wales and the NHS;
2. A service that values people;
3. Getting the best from the resources available;
4. A need to ensure health is reflected in all policies;
5. Minimising the effects of disadvantage on access and outcome;
6. A high quality service that maximises patient safety;
7. Patient and public accountability;
8. Achieving continuous performance improvement across all dimensions of healthcare.

Amongst key features such as the quality of services, it saw integration across all levels with functional and effective links between health and social services as a key need. Success would be people having confidence that:

- Services will be seamless and integrated, as if all were provided by a single organisation that knows the problems and co-ordinates each element of the response;
- Services will be available when needed, delivered in a timely fashion and locally (where appropriate) in a high-quality environment;
- All care will be safe, of high quality, effective (and cost-effective), and supported by publicly available information;
- Services will be delivered so that the person's experience as a service-user means they feel respected, treated appropriately, listened to (and responded to) and their dignity has been preserved;
- Individuals will be empowered to take care of themselves and feel compelled to act responsibly towards their own healthcare.

Challenges to integration were recognised. These include achieving a shift of care from hospitals to the community, establishing new forms of organisation and governance, and the difficulties caused by differences in policy, aims and culture across different organisations. Other challenges included a lack of support systems e.g. electronic patient records accessible across joined-up services and gaining public involvement and input into service developments.

Bevan Exemplars

As part of this ADSSC work stream we have examined the most recent compendiums of Bevan Exemplar projects

http://www.bevancommission.org/en/publications?id=52 and have selected five that are worthy of further review as they have the potential to be scalable and spreadable:

(vi) "Linking Mental, Physical and Social health to care for "Nobody's Patient": Quay to Well-Being (Q2W) Co-operative - A Proposed GP Practice (GMS) "Plus" Service"

Q2W is a model of care designed for "Nobody's Patient", the people whose problems fall between mental and physical health services, between primary and secondary care, and between health, social care and third sector agencies. It is a psychological and social-trauma informed approach, which links mental, physical, social and spiritual health to the quality of relationships. It is relevant to addressing matters which stem from adverse childhood experiences.

The concept has been developed and refined over some 20 years but over the last year has been implemented as with positive outcomes reported for patients and services as part of the Bevan Exemplars programme. Key features of the work of Q2W include putting the lived experience at the heart of health and social care by encouraging community engagement, assisting people with chronic disease management, the effects of psychological/social trauma and conditions with persistent debilitating physical symptoms, and creating a well-being hub which encourages collaborative working and co-production for prudent healthcare. It is developing and intermediary care space between GP surgeries and hospitals and social care.

Q2W is a not-for-profit company which operates on co-operative principles. A proposal to move a GP practice under the Q2W Co-operative is reported to be underway, and funding is being sought to scale-up the approach.

(vii) "Providing holistic care to enable people with dementia to lead fulfilled lives"

The aim of this Fulfilled Lives model of care for people living with dementia is to provide holistic support which enables them to live their lives as the condition progresses, ensuring support which helps to maximise their independence. This overcomes the tendency for domiciliary care to focus on providing physic care rather than supporting a person's emotional, social or economic well-being. The model seeks to co-ordinate support around the individual, his/her network and the community. Broader developments are envisaged e.g. the development of dementia-friendly communities and shopping centres, awareness programmes and the use of assistive technology.

Positive outcomes for a pilot group of people with dementia compared to a cohort receiving traditional domiciliary care are reported. They include a consistent level or gradual reduction in the level of support required by individuals compared to increased care hours for those in the other cohort, and unscheduled hospital stays reduced by an average of 11.5 days. Also worthy of note are benefits to domiciliary care staff, with greater satisfaction from the role of a "key worker" as opposed to the role of a "home carer". Reasons given included more rewarding, more person-centred and feeling part of a team, having contact with other professionals.

The plan is to roll out this model of care in Ammanford and Llandeilo in early 2019, followed by Carmarthen later in the year. The intention is to commission a more formal evaluation of the project.

(viii) "Intergenerational falls awareness sessions for community-dwelling residents"

Cardiff and Vale University Health Board and Cardiff University have worked with local primary schools to on an intergenerational project to provide falls awareness sessions for older people who live in the community. The pupils perform the sessions, which utilise the Wales falls campaign 'Steady on stay safe', in schools or in the local community. They invite people such as their grandparents, elderly neighbours and friends, or local residents. Each presentation is led by a Physiotherapy or Occupational Therapy student in their 2nd or 3rd year of training.

After each session the children mingle with the attendees to complete a basic falls questionnaire and a feedback questionnaire about the session. If any questions receive an undesirable response, they link the older person to advice on that topic which is on the reverse of the questionnaire. Where possible, there is a follow-up meeting of the children and older people 4-6 weeks later, at which the children will ask the older people whether they have followed their actions from the session.

(ix) "Person Centred Care in Diagnosed and Emerging Dementia: Impact on Personal Profiles on an Inpatient Mental Health Ward"

Three documents are used to support person-centred and holistic care for people living with a diagnosed or emerging dementia on a mental health ward. The documents include a collaborative version of "This is me" and life story work called a personal profile, and a positive behaviour support traffic light management plan in case the person starts to experience behaviours that challenge. The documents will be reviewed between every 3-6 months and further developed collaboratively with the person living with dementia and with their family/carers. The profile is designed to follow the patient after discharge into their own homes or a care home placement. It can continue to support someone in a holistic way as well as adding consistency and growth to their care plan.

The project will be evaluated, based on confidence and knowledge of dementia for staff, quality of interaction between patient and staff and quality of life for the person living with dementia. It will consider whether the personal profile has had any impact on admission length (excluding patients that are delayed transfer of care) and anti-psychotic prescription.

(x) "Implementation of a post-falls decision support tool ("I Fell Down") for use by care home staff"

Falls are a common and often unavoidable consequence of reduced mobility for elderly residents in a care home environment. Many homes may still have policies that advise calling 999 to respond to such a situation whether or not someone is injured. Triage of all 999 calls will often grade these patients as very low acuity calls. An ambulance may therefore take an extended time to get on scene. Leaving an elderly person on the floor for more than an hour can have implications physically, socially, and psychologically. Some complications associated with lying on a hard service for long periods of time are hypothermia, pressure areas and renal failure. It can also hurt a person's dignity and can be distressing for both the person and others around them.

The Trust's Clinical Support Team has been assisting care homes to make safe and sensible decisions on assisting their residents to get up after a non-injury fall, A decision-support tool has been designed. This will, where appropriate, allow a care staff member to make the decision to get a resident off the floor whether injured or not and where required to refer on to an appropriate agency, be that the Ambulance Trust, GP or a Community Nursing Team.

References:

- Bevan Commission (2017) Bevan Academy for Leadership & Innovation - 2016/17 showcase. Bevan Commission, Swansea, UK
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- Rich, N (2018) A Powerful Force for Change in Wales Evaluation of the Bevan Commission Exemplar Programme Cohort Two. Bevan Commission, Swansea, UK
- Bevan Commission (2019) Transformation from within: a compendium showcasing Bevan Exemplar projects from 2017-18. Bevan Commission, Swansea, UK http://www.bevancommission.org/en/publications?id=52

(Note: above are documents read during preparation of the text)

Appendix 3

STRATEGIC CONSIDERATION OF COMMUNITY CONNECTORS AND CO-ORDINATION

In looking ahead to reviewing the delivery of services and configuring future models of care and developing more integrated services, Regional Partnership Boards and/or Public Services Boards may wish to consider the following questions:

(i) What is the complete picture of social prescribing/community connector action in the Board's area? How are such services and support configured?

(ii) Are all parts of the Board's area covered by such provision? Are there any gaps in coverage and unmet need(s)?

(iii) Could additional investment in such services and support generate more positive outcomes and further reduce demand on health and social care services?

(iv) If considering further investment, can the Board draw on good practice for the design and configuration of services, including the skillset required for the recruitment of connectors / co-ordinators.

(v) What is being achieved by using funding in this way? What arrangements are in place to monitor and evaluate such interventions? How does the Board use such information to inform decision making for planning and investment?

(vi) What is the level of funding / investment in such services and what are the sources of funding? Is best possible use being made of current available funding? What is the duration of funding for individual services and initiatives?

(vii) Is the deployment of resources effective? Is there any duplication and overlap in provision, or possible competition between services?

(viii) If outcomes are satisfactory, is the funding sustainable over the longer-term? What are the risks to services (and thus the outcomes) from funding being withdrawn?

(ix) To what extent have connections been made between such services and support in the Third Sector and public sector, particularly primary care and other community health and care services? Are they working in terms of more people being reached with more help to address their needs, be they health, health-related or other?

(x) What other forms of similar support are being provided in the area, but which may not be labelled or tagged as social prescribing or community connector e.g. by social landlords or by specialist providers in the Third Sector?

Appendix 4

EXAMPLES OF CO-OPERATIVE WORKING

The examples below show co-operative ways of working that have embraced co-production and other common factors in their design and implementation.

(a) The Community Care Collaborative (CCC) – The Community Care Hub model

CCC is a GP-lead *Community Interest Company*, whose vision is to develop and deliver innovative models of community-based care, taking a 'whole-person' approach to addressing people's physical health, mental health and social needs together. 18 months ago, the '*Community care hub'* was created, and they piloted an *'Everyone in the room'* model, bringing services and support networks together, in an informal, accessible non-threatening way, initially focused on homeless people and rough sleepers in the Town of Wrexham. The Town has the highest number of rough sleepers in north Wales and the second highest nationally. The Hub is a multi-agency weekly drop-in held every Friday morning at the Salvation Army. As an example of how this has changed things, the DWP say this has reduced time administering claims from weeks to minutes. In the last 12 months there has been a reported 42% reduction in police activity for the cohort of people using the Hub. Having stabilised people in terms of enabling access to the basic support they need, they are now moving onto using an *'Asset-Based Community Development'* (ABCD) approach, empowering people to develop activities & projects based on their strengths & interests. By working with the *'DO-IT'* approach (see below) and valuing individual input through *time credits* (Tempo), the aim is to empower people to co-create their own solutions. They are also employing people to become *'care navigators'* to institute a version of *'social prescribing'*, one of the first people employed is a former homeless person and ex-addict. CCC have now secured a Contract to manage 3 new GP practices and within this will roll out the 'Everyone in the room' model to the general community population.

(b) Local Asset Co-ordination on Ynys Mon

The 'Building communities' approach/model has built upon the Seiriol Alliance project which started in 2013, through a joint project between Community Voice, (a strategic grants project funded by the Big Lottery), Adult Social Services, Anglesey Council and the Local Service Board. Inspired by the approach used in establishing the Seiriol Model, (combining *'Local Area Co-ordination'* and *'Asset Based Community Development)*' the Local Authority converted a traditional Social Worker post into a *'Local Asset Co-ordinator* (LAC)' role, initially focused on older people. Through a co-produced approach Anglesey County Council, Medrwn Mon (the Voluntary Council), and Primary Health care services (GPs) have combined to develop a truly integrated model. Through the *pooling of budgets,* they now fund 7 LAC's across the island - in effect this is *'Social prescribing'*. There is also a *'Community Link'* service (Single Point of Access - Information, Advice & Assistance service) which connects isolated & lonely individuals to LAC support. The LAC's work on a one-to-one basis, using an asset-based, person-centered approach to identify activities & solutions and re-connect individuals into their communities without initially reverting to the approach of signposting and receiving services. Individuals are supported to utilise the assets within their own communities to connect with others & to create long-term networks of support. Where new groups start-up they can get support from the Third Sector & Well Being Officer to become self-standing. This approach has led to the creation of a user-led, community commissioned service. Working with Wales Co-op *Care to Co-operate* team, the Seiriol

Alliance has worked in Partnership with a local Social Enterprise (Canolfan Beaumaris) and the County Council to establish *Care Co-operatives* who can deliver support & activities best suited to local circumstances. The Alliance has also recently established another community commissioned dementia service where those living with dementia can meet socially over a few hours in a community hub and pay jointly for that care, helping to reduce their need to use the standard day care services. Finally, another cog in the model is the development of a *local community-commissioning model*, whereby local Alliances distribute funding into activities which build social capital, supporting communities to help themselves. Money raised by fundraising or profits is paid into the Alliance and this is then used to achieve their priorities for developing the area identified in the asset mapping process.

(c) Flintshire DO-IT - Developing Opportunities & Interests Together

Flintshire DO-IT began as a *Co-production* project in 2014, with a number of their founding members being connected to the Co-production movement and being passionate about *Asset Based Community Development*. Using the principles of these movements partners from the Voluntary & Statutory sector began hosting *'community conversations'*, initially focused on the Town of Mold. They created the banner - 'DO-IT', to represent a culture of doing, not just talking - bringing people together based on their assets - *Developing Opportunities & Interests Together*. The ambition was to make communities more connected, friendly, positive places. Based on people's interests they initially co-created 3 projects - community music & drama courses, community cinema and bringing people together to go to events (Gig Buddies). With very little additional resources, in-kind support and by finding hidden resources (such as mobile cinema gear within an Arts Organisation) good outcomes were achieved. Two community bands were created ('Rock-it'), a sustainable community cinema was set up ('Watch-it') and evidence was created to show that the Gig Buddies approach could work ('Gig-it'). Through the support of the *'Care to Co-operate'* project, Flintshire DO-IT is now a *Community Interest Company (CIC) and a Co-operative*. They are currently being engaged in various projects working with the Community Care Collaborative (described above) and Quay 2 Wellbeing (Bevan Exemplar project) and have a hugely diverse group of Co-Directors and Members with lived experience. Their ambition is to raise resources and mobilise 'DO-ER's' (Developers of Opportunities & Enablers of Relationships) in each community across Flintshire. They are developing a mixed-models approach, using *'Person Centred Planning'*, *'Circles of Support'*, *'Asset Based Community Development'* and *'Local Area Co-ordination'*. They support and stimulate community activity through *'Tempo time credits'* and have developed the 'DO-IT sessions' - an adaptable course to help communities to help themselves. They also have an ambition to bring Direct payment users together, to look at opportunities to cooperate, to co-produce projects together, based on personal strengths & outcomes.

(d) Llanelli Social Prescribing through Time credits project

Tempo (formerly SPICE) has been working in partnership with Carmarthenshire Council and Hywel Dda University Health Board over the last four years to develop a county-wide *Time Credit network*. This also includes piloting the first GP Cluster funded Time Credits Social Prescribing programme in the UK. The Time Credits model works simply: people earn Time Credits for time contributed to their community or service. These Time Credits can then be spent on accessing activity across Tempo's national network, such as local attractions, training courses or leisure, or gifted to others. The GP Cluster funds two *Social Prescribers* who engage with patients and prescribe them a small number of time credits. The Patient then makes a pledge to earn time credits in the future. This enables them to immediately

access a wide range of wellbeing activities through spending Time Credits, and to identify a way they can play a positive role in the community through earning. Earning itself has a positive impact, particularly for mental health and social isolation. In contrast with many traditional social prescribing or community navigation approaches, embedding Time Credits transforms engagement from passive to active, overcoming participation barriers and enabling the prescription to become sustainable as through earning individuals can continue to access spending opportunities. In terms of the difference that time credits can make, the evidence that Tempo has gathered is impressive. 83% report an improved quality of life, 59% of people had never volunteered before and 52% feel less lonely and isolated. They apply a *co-operative approach* by holding Patient co-design Days to give people a chance to shape how the service develops. In addition, they enable peer-to-peer support opportunities and support individuals with shared interests to create new community groups. Due to the success of the Pilot project another GP cluster has funded 2 more Social Prescribing posts to use the same approaches.

(e) The Artisans Collective

In 2013 two Prestatyn-based ‘Social entrepreneurs’ approached Denbighshire Council to see if they might turn the un-used former Library into a Community Hub. The Artisans Collective was formed (*a Community Interest Company*) and have been growing an impressive range of community groups and activities, both within and outside of the Hub. They support *a Men’s Shed* which has now spread into its own workshop premises, a Coffee-pod Bereavement Support group, a Dementia-friendly community drop-in, an Art group, a *Nature for Health* group and the Morfa Gateway group - restoring a piece of green common land that had become a dumping ground. They have a strong relationship with the neighbouring Health Centre, from which many people are sign-posted in (*Social prescribing*). All of this is done on very low running costs.

Appendix 5

HOUSING, HEALTH AND SOCIAL CARE - EXAMPLES OF JOINT WORKING AND SUPPORT FOR TENANTS

1. Introduction

1.1 In February 2018, the Welsh Government announced a £100 million Transformation Fund to transform the way health and social services are delivered. The Fund is one of the Government's responses to the recommendations of a Parliamentary Review of Health and Social Care. In July 2018, it published "A Healthier Wales", which sets out a broad framework of commitments and action to ensure everyone in Wales have longer, healthier and happier lives and remain active and independent in their own homes for as long as possible.

1.2 ADSS Cymru is leading several pieces of work in the Transformation Programme for 2018-2019. Workstream 2 focuses on Innovative Care Delivery Models in the Community with the aim of designing new models for care. As part of this "Big picture" work, ADSS is committed to engaging with others to identify and promote effective models of service delivery and to support new national service developments to improve peoples' lives.

1.3 Over and above examining joint working between the NHS and social care organisations and recognising the importance of housing to people's health and well-being, ADSS commissioned a small study to explore joint working between the NHS, social care and housing organisations.

Project

1.4 The purpose of the study was to research and identify projects, models or approaches in Wales, which have integrated health, housing and social care to improve outcomes for people. Factors which contributed to their development were of interest as was the extent to which they reflect the national design principles set out in "A Healthier Wales".

1.5 In addition to identifying examples of joint action by housing, health and social care, there was also interest in the support provided to tenants by registered social landlords and the use of neighbourhood or community workers.

This report

1.6 This report summarises the findings. It is based on the results of a trawl for information on the internet, requests to organisations and requests to representative bodies.

1.7 Chapter 2 summaries the key findings, providing examples of joint working and considering these against the design principles of "A Healthier Wales". Chapter 3 provides examples of tenant support activities by registered social landlords. It also includes a commentary on what is helping or hindering the prospect of increasing joint working in the future. This information was captured during telephone and face-to-face interviews. The Appendix contains more detailed descriptions of the examples of joint working which are listed in Chapter 1.

1.8 The small-scale nature of this study means the outcome is by no means the complete picture of all joint working and co-operation between housing, health and social care organisations in Wales. That said, it has generated a robust set of examples which show the different ways in

which housing can assist health and social care organisations to deliver good outcomes for individuals. This provides a solid foundation to increase joint working in all parts of Wales.

Acknowledgements

1.9 The help of all who responded to requests for information and those who gave their time for discussion is gratefully acknowledged and appreciated, as is the help of Community Housing Cymru and the Welsh Local Government Association in facilitating requests for information.

2. Joint working between housing, health and social care

2.1 This chapter summarises data gathered on joint working across Wales. As stated at the outset, it is not the complete picture as a more extensive review would no doubt uncover further examples. However, it is a robust set of examples of different types of action, which demonstrates what has already been achieved or is being done, and which provide the basis for increasing joint working across Wales.

2.2 The examples are set out in the table below:

Table 1: Examples of joint working between housing, health and social care organisations

Title / Theme	Housing organisation	Key feature(s) of action
Closer to Home	First Choice Housing	Reducing the need for out-of-area placements
Lighthouse project	Taff Housing Association	Reducing delayed transfers of care by addressing housing and support needs
Remodelling sheltered housing	Cynon Taf Housing Association	Alternative use of existing accommodation to meet needs
Remodelling sheltered housing	Trivallis	Alternative use of existing accommodation to meet needs
Training Flats	Trivallis	Help for independent living for young people leaving care
Well Being 4U	United Welsh	Social prescribing intervention based on three GP clusters
2025 Movement	Various organisations	Strategic level forum to stimulate joint working
Mental health pathway	Isle of Anglesey/ Ynys Mon CC / BCUHB	Improving services and support to prevent cyclical problems
Hospital discharge	Conwy County Borough Council (lead)	Reducing delayed transfers of care by addressing housing and support needs
Health inequalities and rough sleepers	North Wales Housing Association (lead)	Improving access and support to people who are homeless and sleeping rough
CARIAD	Linc	Step down arrangements and alternative pathway

2.3 Each of the above is described in more detail in Appendix 1.

2.4 Some other examples of joint working were noted during of this study. These range from working protocols between organisations or departments within organisations to co-locating members of staff on a part or full-time basis. Co-locating staff was frequently highlighted as important to stimulating and sustaining joint action between organisations.

2.5 Over and above the examples in Table 1, examples of joint working which are at a relatively early stage were also identified:

- **Coastal Housing** is working with the Accident and Emergency Department in Moriston Hospital. Where frequent attenders are identified as tenants of the Association, consideration is given to additional support which could be offered, particularly if it can prevent the need for further attendance.
- **Monmouthshire County Council** is leading a regional dementia project with the NHS and other local authorities. The potential of assistive technology will feature as part of the project
- In Gwynedd, **Grwp Cynefin** is working with Betsi Cadwaladr University Health Board, the local authority, two single-handed GP practices, a pharmacy practice, and the local community. The aim is to develop accommodation under one roof in a "hub" type approach. Time is being devoted to engaging with, and involving, the community to design an appropriate model thus ensuring a "doing it with the community" approach as opposed to "doing it to the community".
- The Welsh Government's **Integrated Care Fund** continues to support a variety of work, some of which is engaging registered social landlords and local authority housing departments.

2.6 Better outcomes for people, notably health and well-being, is common to all examples of joint working. In achieving this, other social issues e.g. housing, debt, etc as well as physical and mental health issues often need to be addressed. Problems are often interrelated, which emphasises the importance of the "whole system" approach and joint working by organisations to identify and help people to address the root cause(s) of problems as opposed to simply treating only issues e.g. health issues, which may surface as the symptoms. For example, a mental health issue may present as the problem whereas housing and/or related problems, particularly those which could result in losing a home, may also be underlying factors which cause or exacerbate the condition. Identifying issues as early as possible and acting by way of interventions and preventative action to negate, or at the very least to limit and manage, the problem(s) before they get worse is vital. Given the interface they have with tenants and communities, social landlords are very well placed to do this and as Chapter 3 shows, this is happening in communities across Wales.

2.7 Achieving better outcomes for individuals often generates benefits for others. In some cases, this will be the families of individuals who need and receive help. However, it also extends to the organisations involved. This includes preventing or reducing the need to use, or reuse, NHS services, or social care services and reducing overall demand. For social landlords, it can help to ensure stable tenancies.

2.8 The examples in Table 1 vary. They have been identified for the different settings in which they operate, and the different models deployed. The factors behind their development also differ as does the precise nature of the help being given to people to improve health and well-being outcomes.

2.9 Looking at the models of working behind the examples, they can be grouped under six main headings. Better outcomes for individuals directly or indirectly are common to all. The broad ways in which the NHS and social care can work with, and benefit from, registered social landlords and local authority housing departments are:

- Using local housing providers to reduce the need for, and cost, of, out-of-area placements;
- Preventing delayed transfers of care (and as far as possible, the possibility of readmission) by addressing housing or housing-related issues;
- Using housing providers to identify opportunities to provide earlier intervention and more support, and options for primary care to address health and non-health issues which affect people's health and well-being;
- Alternative use of existing local housing assets to better meet the needs (sometimes complex needs) of people who are receiving services and support from the NHS and/or social care;
- Improving the lifelong prospects of care leavers by using local housing provision to help equip them with the skills necessary for successful independent living;
- Improving the way in which services and support are delivered by involving housing providers (social landlords and/or housing-related support providers) in service delivery (i.e. towards more of a "whole system" approach).

2.10 The follow pages look at each of the above in turn and consider the examples of joint working against the design principles of "A Healthier Wales".

Using local housing providers to reduce the need for, and cost, of, out of area placements

2.11 "Closer to Home" by First Choice housing is a good, and long standing, example of joint working between a registered social landlord, the NHS, local authority and other support providers to accommodate people with complex needs. The original development was not driven by a top-down directive but by like-minded individuals seeking to help people with complex needs. At the same time, the prospect of financial and other benefits of a local solution were recognised.

2.12 First Choice undertakes the landlord function, providing ongoing housing management. In conjunction with the NHS and local authority, its sources and develops the type of accommodation needed with appropriate care and support, which is contracted out to specialist providers.

2.13 The savings from a local registered social landlord accommodation solution over of out-of-area placements can be considerable. For example, an out of area placement cost of £311,000 per annum compared to an annual cost of £90,000 under a "Closer to Home" arrangement would generate a saving of £221,000 per annum. There is a lead time for development before savings can be realised e.g. not necessarily in the first year or so given the set-up costs. The timescale for savings will vary according to a range of factors, including whether the solution is new build or the conversion of an existing property. However, when in place, the savings are realised on an ongoing basis.

2.14 Anecdotal information points to similar developments in other parts of Wales, some of which have been possible as a result of funding from the housing capital budget element of the Integrated Care Fund. However, there is far from a complete picture of all developments which have happened, or which are in train, and the precise nature of developments and individuals who have been helped. A more extensive trawl of developments which captures more evidence of the outcomes (financial and non-financial benefits) and the experience of

those involved would be valuable as a rich source of learning to inform future developments and greater use of the approaches.

Preventing delayed transfers of care by addressing housing or housing-related issues

2.15 Examples of this approach fall into two categories – hospital based and community-based interventions.

2.16 The Lighthouse Project and the project led by Conwy County Borough Council involve housing professionals at the front end i.e. hospital based. The Lighthouse Project was developed by Taff Housing and Newport City Council's Supporting People team. The development in which Conwy is the project lead was the result of discussion and joint working commitments at a strategic level via the 2025 Movement in North Wales.

2.17 Having a housing professional based in hospital realises the benefits of co-location and of being part of the whole team, which goes some way towards the whole system approach. The latter is important when matters such as suitable housing play such an important part in people's health and well-being and in helping them to live safely and as independently as possible in their own homes for as long as possible. It also helps to overcome factors which work against joint working i.e. lack of understanding of others' roles, who to contact, and how systems work. There are clearly gaps in the knowledge and understanding of health and social care by people who work in housing and vice versa, a lack of knowledge among health and social care professional of housing, housing rights and entitlements (in some cases), and perhaps most importantly, all that can be done for people in respect of housing and housing-related support.

2.18 The CARIAD scheme, developed by Linc, aims to ensure patients who no longer require a medical bed have an alternative pathway which supports and facilitates their long-term care needs. It enables them to 'step-down' from hospital when their treatment has finished and when they may require a further period of assessment. It also aims to prevent unnecessary admission to hospital due to short-term illness or injury.

Using housing providers to provide earlier intervention and more support and options to address health and non-health issues which affect health and well-being.

2.19 The Wellbeing4U programme was launched in May 2016 after being commissioned by the Cardiff & Vale University Health Board. The specification for what is a social prescribing approach was broad, with the emphasis on developing a service to test what works and what doesn't. United Welsh secured the contract and developed the service.

2.20 The model, which has evolved over time and with experience, is flexible enough to work in different ways and to different needs and priorities. It operates across three GP clusters. The 2-year contract was retendered in 2018 with the specification being more detailed as a result of experience and practice in the first two years. United Welsh secured a further 2 years funding from the Health Board plus a possible one-year extension.

2.21 The service harnesses the resources and expertise of a registered social landlord with a track record of providing specialist housing and support to improve people's health and capacity for selfcare. This fits well with the aims of the NHS but goes further. It provides a means of giving patients of primary care more support and support options to address health and health-related matters including, but not limited to, housing. This also helps reduce

demand on GPs. The benefits of co-location – housing staff working in GP surgeries - also shines through with increased understanding of what housing and support providers can do to help people.

2.22 The challenge in the early days was getting GPs on board as the service depended on referrals. Now, in its third year, it has clearly proved its worth in the eyes of GPs. Word has spread with more GP practices requesting the support. This is a challenge as the funding and thus the capacity of the service is limited. Two GP clusters have funded support from their own budget albeit on short-term funding when budgets permit. This is encouraging although of some concern as people can be wary of short-term funded projects which may at some point disappear leaving gaps in the support available.

2.23 Given the direction towards community-based care and their interface with the public, General Practice is a vital part of a “whole system” approach, particularly for early intervention on matters which may present as health problems e.g. mental health problems, anxiety etc. but where the root causes are, for example, debt and financial problems which risk eviction and homelessness. The effects of the latter extend to whole families with major negative health impacts on all concerned but particularly children. For this reason, preventing homelessness is a national priority and its positive impact can be further increased if part of a “whole system” approach involving GPs and social care professionals.

2.24 Opportunities for an early intervention/prevention approach are enhanced if GP practices work with other organisations which can provide support for people, be it health, health-related or other matters which affect people’s health and well-being. Co-location and its benefits are also important. The Wellbeing4u project is a very good example of what is possible, and action is in hand to enhance the “hard numbers” evidence base for it. Issues such as data sharing need to be addressed to achieve this.

2.25 Anecdotally, there are other examples of third sector organisations working with, and in, GP surgeries. The picture of local arrangements, and the benefits it brings, is not clear. It is reasonable, however, to conclude the picture is inconsistent across Wales. While the priorities in different parts of Wales e.g. priority needs identified by GP practices and clusters, may vary, it is reasonable to assume there is a Wales-wide need for the type of support delivered by the Wellbeing4u model, which is flexible enough to be adapted to suit local circumstances. Furthermore, if such a model can work for GP practices, to what extent could it be used by social care providers to help their clients?

Alternative use of existing local housing assets to better meet the needs of people receiving services and support from the NHS and/or social care

2.26 Cynon Taf Housing Association and Trivallis, which operates in Rhondda Cynon Taf, have worked with the local authority and/or Cwm Taf University Health Board to utilise existing accommodation for which there is much lower demand or no demand at all. This is a win-win situation, making the best possible use of local assets and at the same time meeting the accommodation needs of people who require on-going support.

2.27 Cynon Taf is converting accommodation into 19 one-bedroom flats to house adults with learning difficulties. They will not mean living in just one bedroom; residents will have their own front door, kitchen, and adapted shower, with support available on site 24/7. This helps them live in a community not an institution. A community hub facility has been designed into

the development. Similarly, Trivallis have remodelled two buildings for a supported housing project for people with low-level ongoing support needs and for crisis accommodation.

2.28 Both developments stem for good working relationships between individuals in the respective organisations. Understanding needs and constraints but also opportunities provides a solid foundation for dialogue to find long-term solutions which work for both parties and for prudent financial decisions to achieve this.

2.29 There is anecdotal evidence of changes to sheltered housing and the use of community hubs in other areas. In Monmouthshire, for example, a “tired” sheltered housing scheme was converted to provide a 5-unit scheme for people with learning disabilities and two bespoke units for NHS patients.

Improving the lifelong prospects of care leavers by using housing provision to equip them with skills for successful independent living

2.30 Working with RCT Council, Trivallis provides one-bedroom accommodation to young people leaving care on a trial basis for independent living. A training flat was set up as a pilot in Aberdare in 2009, and another in Rhydyfelin, Pontypridd in May 2010. It came about after a review of tenancy failures among care leavers revealed young people were unable to deal with the realities of everyday life such as paying bills, prioritising expenditure and ultimately facing the reality of living alone.

2.31 The flats are aimed at young people (17+) in residential or foster placements. Young people are referred if their social worker believes that the experience would be valuable as a step towards independent living. The referral is for up to one week initially with an option of a 4-week placement. The trial links with arrangements for care leavers to move to full tenancy via the process for allocating general needs housing.

2.32 The Trivallis example is a long-standing one. Discussions during the study point to similar arrangements being considered elsewhere e.g. Monmouthshire. The extent to which every local authority has such a facility, or has access to such a facility, is not known. While the number of care leavers in different parts of Wales will undoubtedly vary, the importance of looking after care leavers and helping them in their transition from care to independent living will be common to all. The help provided by Trivallis with the local authority is very much early intervention and preventative. The effect, and the benefits, can last a lifetime.

Improving the way in which services and support are delivered by involving housing providers (social landlords and housing-related support providers) in service delivery (i.e. towards a “whole system” approach)

2.33 A Mental Health Pathway has been developed by the Isle of Anglesey/Ynys Mon County Council and the Betsi Cadwaladr University Health Board. The project, which followed discussions which were triggered by the 2025 Movement in North Wales, is one of two focusing on better links between housing and health services.

2.34 The Pathway has been developed to improve the way in which support and accommodation is provided to people with mental health needs who are accessing services via the Health Board’s Mental Health Services, primary care or Housing’s Supporting People programme. The aim is to help people to find and maintain a tenancy. and to ensure accommodation is

available for individuals with low level mental health and enduring mental health needs. It offers offer choices to the individual to help them to move on towards full independence.

2.35 It is in the relatively early stages of implementation. It facilitates early intervention/ prevention by ensuring housing needs assessments are completed to prevent someone becoming homelessness, including a Mental Health Needs Assessment within the procedures. It is also helping to build closer working relationships between housing and health staff including the Community Mental Health Team and for the development of robust information sharing protocols.

2.36 Also, in North Wales, a cross-agency network was established to discuss and provide support for those in housing difficulty. The goal is preventative with action that ultimately reduces evictions thereby reducing homelessness (and thus avoids the significant negative impacts on people's health and wellbeing) and impact on housing services.

2.37 Challenges have included ensuring early identification of individuals and families experiencing difficulties. This does not always happen. Not all people identified as needing help have a need for secondary mental health services and therefore, there appears to be a gap around who can support people with mild/moderate mental health difficulties. The root causes of the latter vary considerably and manifest themselves in different ways. On this note, it is interesting to note projects such as Wellbeing4U and Hapus Pawb featured elsewhere in this report, which provide means of addressing such needs. Another common issue which was mentioned by several social landlords is "hoarding" behind which usual sits some form of mental health issue.

2.38 Another project in North Wales under the auspices of the 2025 Movement is helping rough sleepers. This aims to address health inequalities which covers not only the inequality in physical and mental health suffered by that group compared to the population but, importantly, inequalities in access to health services. Drawing on local experience, it is led by North Wales Housing and is focusing initially on the Gwynedd area. It started by interviewing rough sleepers to record their experiences of living with poor health and the barriers they encounter to accessing health services. One-to-one working with rough sleepers was required thus action was labour intensive

2.39 As a result of the project. rough sleepers in Gwynedd can now access GP services. They are now offered flu vaccinations (at a GP surgery) as they are considered health vulnerable as a group within the general population. They can also access emergency dentistry (information provided to all rough sleepers) and they have improved access to mental health services both in the community and in hospital.

Examples of joint working: The fit with "A Healthier Wales"

2.40 "A Healthier Wales" is the Welsh Government's response to the Parliamentary Review of Health and Social Care it commissioned. It sets out a long-term vision of a "whole system approach to health and social care", which is focused on health and wellbeing, and on preventing illness.

2.41 To help translate ideas into reality, the approach incorporates ten "design principles". They are listed in the following table:

Table 2: Design principles of "A Healthier Wales"

- Prevention and early intervention – acting to enable and encourage good health and wellbeing throughout life; anticipating and predicting poor health and wellbeing.
- Safety – not only healthcare that does no harm but enabling people to live safely within families and communities, safeguarding people from becoming at risk of abuse, neglect or other kinds of harm.
- Independence – supporting people to manage their own health and wellbeing, be resilient and independent for longer in their own homes and localities, including speeding up recovery after treatment/care, and supporting self-management of long-term conditions.
- Voice – empowering people with the information and support they need to understand and to manage their health and wellbeing, to make decisions about care and treatment based on 'what matters' to them, and to contribute to improving our whole system approach to health and care; simple clear timely communication and co-ordinated engagement appropriate to age and level of understanding.
- Personalised – health and care services which are tailored to individual needs and preferences including in the language of their choice; precision medicine; involving people in decisions about their care and treatment; supporting people to manage their own care and outcomes.
- Seamless – services and information which are less complex and better co-ordinated for the individual; close professional integration, joint working, and information sharing between services and providers to avoid transitions between services which create uncertainty for the individual.
- Higher value – achieving better outcomes and a better experience for people at reduced cost; care and treatment which is designed to achieve 'what matters' and which is delivered by the right person at the right time; less variation and no harm.
- Evidence driven – using research, knowledge and information to understand what works; learning from and working with others; using innovation and improvement to develop and evaluate better tools and ways of working.
- Scalable – ensuring that good practice scales up from local to regional and national level, and out to other teams and organisations.
- Transformative – ensuring that new ways of working are affordable and sustainable, that they change and replace existing approaches, rather than add an extra permanent service layer to what we do now

2.42 The table below is the result of assessing each of the examples against the ten design principles of "A Healthier Wales".

2.43 Inevitably, the assessment is subjective and based on the information obtained, some of which is limited by the fact that several developments are relatively new. Nevertheless, and as set out in “A Healthier Wales” as one of the reasons for the principles, it provides a basic check of the extent to which the developments are heading in the right direction and in line with the vision.

Table 3: Examples of joint working set against the design principles of “A Healthier Wales”

Title / Theme	Organisation	Relevant design principle(s)
Closer to Home	First Choice Housing	Safety; Independence; Personalised; Seamless; Higher Value; Evidence driven; Scalable
Lighthouse project	Taff Housing Association	Safety; Independence; Personalised; Seamless; Scalable
Remodelling sheltered housing	Cynon Taf Housing Association	Safety; Independence; Personalised; Seamless; Scalable
Remodelling sheltered housing	Trivallis	Safety; Independence; Personalised; Seamless; Scalable
Training flats	Trivallis	Independence; Seamless; Scalable
Well Being 4U	United Welsh	Prevention and Early Intervention; Independence; Personalised; Seamless; Evidence driven; Scalable;
2025 Movement	Various organisations	n/a (Strategic measure)
Mental health pathway	Isle of Anglesey/ Ynys Mon CC	Safety; Independence; Personalised; Seamless; Scalable
Hospital discharge	Conwy County Borough Council (lead)	Safety; Independence; Personalised; Seamless; Scalable
Health inequalities and rough sleepers	North Wales Housing Association (lead)	Prevention and Early Intervention; Voice; Safety; Independence; Personalised; Seamless; Scalable
CARIAD	Linc	Safety, Independence; Personalised; Seamless; Scalable

2.44 There is no requirement for any development or idea for change to meet all the design principles It is acknowledged that some may just meet one or a few of the principles.

2.45 The table reflects is based on available information and is thus a basic, initial, assessment of which principle(s) appear to fit each of the examples. Additional information would be required for a more robust assessment to be made. This is particularly true for the “transformative” principle given its “affordable” and “sustainable” characteristics, hence its absence from the table. With one exception, the position is similar for an assessment of the extent to which a development embodies the “voice” principle. The exception is the health

inequalities and rough sleepers project, where information about the project shows an explicit, early, stage in its development to talk to rough sleepers about their experience, their needs and what they wanted.

2.46 The basic nature of the above assessment also holds true for the “evidence-driven” principle. Two of the examples have been tagged against this principle. This has been done on the basis that the “Closer to Home” project has been implemented over several years, more developments are being commissioned and some cost savings information has been identified. There are similar developments elsewhere, some of which e.g. the “In One Place” development in Gwent and developments funded by the Integrated Care Fund, may also have produced hard evidence of cost savings.

2.47 The “Wellbeing4u” project has been tagged with the “evidence-driven” principle on the basis that the experience of the first two years of the project led to it being contracted for a further two, possibly three, years. The model of delivery has changed as a result of learning from the first two years and decisions by some GP clusters to fund it from their own budget, albeit for relatively short periods, also suggests evidence is playing some part in the direction of travel. As stated earlier, the team is working to generate more hard, quantitative evidence of the project’s impact and benefits, which will also assist an assessment of the “transformative” nature of the project.

Refining the use of the design principles

2.48 In assessing and applying the principles to development and actions for change, one can question the extent to which a design principle is present. While in some clear-cut cases the answer could be a straight “yes/no” answer, there is logic in considering not just whether something demonstrates a straightforward indication of a principle but the extent to which a principle is shown. This will help determine the relative strength of different developments and actions. For example, is something is as seamless as it possibly can be i.e. there is no scope at all for further improvement? Is preventative or early intervention action as effective, and perhaps cost-effective, as it could be?

2.49 The assessment and application of the design principles warrants further consideration. However, to have such a set of clear principles to guide and frame developments and change is very helpful. The priority is to use the characteristics of the design principles described in Table 2 to stimulate and drive change and developments including, but not limited to, joint working between all organisations who can play a part in improving the outcomes for individuals and their families. This approach can also be applied to existing services and working arrangements with the aim of building on what is already in place – systems, services, ways of working - and enhancing them wherever possible. As time passes and with the benefit of experience, there will be ample scope to capture learning to refine the approach to assessment and application, and to document the increase and spread of joint working.

Recommendations – Rolling out developments across Wales

2.50 Spreading good practice and developments across Wales remains a challenge but must be addressed if people are to receive consistent, and consistently good, services irrespective of where they live.

2.51 There is nothing to suggest that the examples of the projects mentioned earlier cannot be replicated across Wales. Their costs, and thus the costs of extending the model elsewhere, will vary. Some developments seek to improve working practices by better use of existing resources e.g. better co-ordination and liaison between services; co-location etc. and are therefore at the low end of the extra cost scale. Some depend on additional funding initially to do more for people, with benefits realised over time. For others, there are up-front costs, but the cost savings are clearer and can be realised within a shorter timescale. Notwithstanding matters such as additional funding where needed, the local capacity and support for change also needs to be considered.

2.52 The examples of joint action appear to address issues which are common to all areas and therefore, they should be considered for adoption elsewhere. This does not necessarily mean a straight copy lifted from one area and placed into another. There are good reasons not to simply lift something from one area and place it "as seen" in another. It is better to take the core features and ethos of a development, including its design principles, and consider how it can be made to work in another area, with any refinements necessary to reflect and suit local circumstances. Where possible, involving service users and the broader community in the process of design and implementation of an idea, whether new or from another area, also has many benefits.

2.53 Seldom is it possible to do everything at once. Given the benefits of a phased approach in rolling out practice and developments, some may warrant earlier consideration that others. The following, which are not in any order of priority, vary in nature, target population group(s) and benefits:

(i) **The "Closer to Home" approach** by First Choice Housing (Rationale: benefits for individual and families from local solutions which avoid out-of-area placements for people with learning difficulties and for people with complex health needs; costs savings to NHS/social care);

(ii) **Hospital discharge projects** such as Taff Housing's Lighthouse project and a similar development led by Conwy County Council (Rationale: to prevent non-health matters such as housing from stopping or delaying discharge; to ensure discharge into a safe home environment for independent living; to help prevent the need for readmission; demand management for the NHS by freeing up beds);

(iii) **Alternative use of existing community assets** e.g. changes of use of sheltered housing by Cynon Taf Housing and Trivallis, and respite care development by Cynon Taf (Rationale: helping people with complex needs to live more independently in a community not institutionalised setting; potential costs efficiencies for local authorities);

(iv) **Training flats** e.g. Trivallis (Rationale: Care leavers are a priority and the benefits of equipping individuals with the skills necessary to live independently last a lifetime);

(v) **Early intervention and prevention in the community and in GP clusters** e.g. Wellbeing4u developed by United Welsh; Hapus Pawb run by Rhondda Housing (see next chapter); tenant support via front-line staff (Coastal Housing) (see next chapter) (Rationale: identifying people's health and other social needs such as housing-related

needs, and intervening as early as possible to help them overcome problems and/or manage conditions; to prevent or reduce the need for health and care; assisting and providing more options to primary care to help patients).

2.54 The above provides a portfolio of joint working developments in areas which should be considered for adoption by other areas. A planned approach is needed to ensure the examples are considered by organisations, and groups of organisations working in the variety of partnership fora which exist, and decisions made for development and implementation action.

2.55 The examples and experience of the joint working identified in this report and those behind the developments offer a rich source of learning. More detailed information on each of the models, their development and implementation might be needed to inform their use elsewhere and can be obtained if needed. If tapped, this information can drive the spread of joint working. It can also help to strengthen the evidence base for, and inform the design of, seamless services between housing, health social care and other public services and third sector providers. All this will contribute to achieving the whole system approach required in “A Healthier Wales”.

3. Supporting tenants and communities and increasing joint working

This Chapter provides examples of action being undertaken by social landlords to support tenants and communities which is linked in some way, directly or indirectly, to better outcomes for health and wellbeing.

3.2 The work in identifying and collating information this information and examples of joint working between housing, health and social care involved a series of telephone and face-to-face discussions. These provided valuable context for the work but also a rich source of information on broader issues which are being encountered by social landlords in supporting tenants and in pursuing joint working with health and social care.

3.3 The preparedness of social landlords to do more than provide a basic landlord function shone through in discussions. So too did the desire to do even more. Improving people's health and well-being and better working links with the NHS (primary and secondary care) and social services to develop more integrated services featured prominently. It is driven by a commitment to deliver good services and social responsibility, which improves outcomes for people, be they finding and keeping a home, better health, tackling loneliness and isolation, or economic e.g. employment. Much of this activity, which happens day to day in communities across Wales and which undoubtedly helps reduce demand on other public services, is largely unseen and thus is probably undervalued.

3.4 At the same time, better health and well-being outcomes for tenants and others in the community can benefit social landlords through better engagement which can result in more stable tenancies. The aim is to avoid housing issues and other matters which may cause or have a negative effect on someone's ability to find and keep a home e.g. matters which could ultimately lead to rent arrears, eviction or other difficulties. The importance of a proactive approach to reaching out to people and early identification to offer help to prevent problems in the first place or action to prevent situations from becoming more difficult, time-consuming and costly to resolve is recognised. It can be seen in the following examples.

Examples of supporting tenants

3.5 The examples of support for tenants are:

- Rhondda Housing
- Cynon Taf Housing
- Linc Housing
- Coastal Housing

3.6 Given the limits of this study, the sample nature of the following information must be emphasised. A wide range of support is provided by registered social landlords and by local authorities. This extends well beyond priorities such as homelessness to address issues of debt and personal budget management, skills, volunteering and employment, substance misuse and anti-social behaviour. The following illustrate what is being done and why, and some of the benefits in doing so.

3.7 **Rhondda Housing Association** runs the "Hapus Pawb" project in partnership with Cambrian Village Trust. Established in May 2017 with grant funding, it was originally known as "Strive and Thrive". The Association was one of the partners and became the main source of referrals to the project. It recognised there were clear benefits for its tenants who participated, including better mental health, improved mood, self-esteem and confidence,

social and community interaction (e.g. tackling loneliness and isolation), and trying out activities they wouldn't have otherwise tried. When grant funding came to an end, Rhondda Housing took it over the project and now funds it from its own resources.

3.8 The core of the project is a six-week interactive course to improve people's social, health and well-being. Ten people are on each course and there are currently four courses per year. The target audience is tenants of the Association (age range is broad 16-80) with low level mental health issues and people with learning difficulties. They are reached by home visits or by calling direct, and referrals from housing officers, maintenance staff and other front-line staff.

3.9 After the course, there are opportunities to join established groups, to organise their own social activities with others who have been on the course e.g. friendship groups (thus continuing to address social isolation and community building), volunteering (e.g. on an allotment project in Treherbert). Some of those who have participated in the project have gone on to act as mentors to new people joining the project.

3.10 The project helps to maintain and improve the Association's overall relationship with its tenants. If someone has rent or tenancy issues, they may feel more confident to approach the Association for help. It helps to reduce any "us and them" situation. Ideally, the scheme could be expanded to take referrals from local GPs, community nurses etc. At present, however, due to funding and capacity constraints, the scheme is limited to its own tenants.

3.11 **Cynon Taf Housing Association** has 13 staff in support roles. The basic concept of the model – early intervention and prevention – is straightforward. Basic needs such as food in cupboard and money in the meter are fundamental. Without those and setting aside the potential health problems that could result, it can be difficult to maintain a tenancy.

3.12 The Association is helping people in several ways, including the basics of budgeting, action to ensure appropriate benefits are claimed, and action which helps people into employment or helps move them towards employment e.g. by volunteering. Tackling issues such as a lack of friends, family or support in the community support and helping them to engage in social activities is also important and helps tackle loneliness and isolation

3.13 Low level mental health issues including stress and anxiety are common. A survey of tenants by the Association revealed nearly three out of four (72 per cent) reporting they had some mental health issues. The Association works with Merthyr and Valleys MIND with one of its staff co-located with housing staff. Action from this arrangement includes the delivery of therapies and mindfulness. It also provides access to counselling which can be accessed sooner than via health services e.g. within 2 weeks.

3.14 The pressures on tenants continue to increase. The benefits freeze for several years, bedroom tax and now Universal Credit, combined with rising costs of living have taken their toll. There is a sense that levels of vulnerability have increased. The Association is proactive in reaching out to its tenants to identify needs and to provide support.

3.15 The front-line staff of social landlords are utilised to spot tenants who may need help or issues which need to be addressed and referred e.g. to social services if circumstances warrant. The proactive approach taken by **Rhondda Housing** is typical of many. Additional support is given to a tenant if a notice or eviction situation is becoming a reality. The underlying issues tend to be medical/health, substance misuse, chaotic lifestyles, etc. With zero evictions last year, its preventative approach is working, and the Association is keen to

increase joint working with health and social care to maintain this and as part of its support for tenants.

3.16 **Linc** set up a small community empowerment team in 2017. The aim was to support tenants who would struggle to maintain their tenancies without support. These were often tenants who either do not meet the thresholds of existing support provision or have failed to engage with existing support. It currently has two officers, who support up to 40 tenants between them. They work with tenants on a short or long-term basis, dependent on the needs of the individuals. Issues addressed include domestic abuse; hoarding; low level mental health and confidence building. The team has trialled using a star outcome framework to measure individual's progress and whether they have met their personal goals. The team have also explored the 'HACT – Social Value Measurement Tool' to track positive outcomes.

3.17 Recognising the potential of front-line staff to identify issues and the benefits of early identification and engagement, **Coastal Housing** has refocused the role of its front-line staff. It has moved away from what was originally a reactive approach i.e. if nothing heard from a tenant, the assumption was that everything was alright. However, this did not uncover loneliness and isolation, mental health problems, alcohol misuse and other problems such as hoarding. etc. Now, it does not assume no contact means nothing is wrong or no help is needed and has a far more proactive approach.

3.18 It has found time for its 20 housing officers to understand their locality, local activities and community events. Thirty caretakers work day-to-day on estates and know the communities and people. The Association's repairs team undertake around 20,000 repairs each year. They are not driven by targets and it is perfectly acceptable for them to spend time to have a cup of tea with someone, to get to know them and identify any issues or help they may need.

3.19 All of this provides better intelligence and increases the Association's capacity to understand tenants and their circumstances and its ability to help them. If front-line staff locally can help someone – and they are often able to – there is signposting to in-house service or to external services and providers, and grassroots community support connecting with others who can share skills (community assets). The approach aims to be restorative, working with tenants so they can achieve what matters to them rather than doing things to, or for, people.

Broader issues relevant to more/better joint working between housing, health and social care

3.20 The benefits of joint working are recognised and there is commitment and enthusiasm among social landlords to do more.

3.21 Positive and negative issues came to the fore during discussions with social landlords and local authorities on examples of joint working and support for tenants. These are important to identifying matters which, if they can be addressed, will at least support but more likely stimulate more and/or better joint working between housing, health and social care organisations.

3.22 Co-location and the benefits were frequently mentioned for the benefits it brings. This can be housing staff working all or part of the time from health or social care premises or vice versa, with health or social care and other staff from specialist third sector organisations working from housing association premises. Over and above the practical working connections, it increases mutual respect and understanding of roles and opportunities to do more for people

by staff from the respective organisations working more closely together. This fits well with the aim of, and indeed need for, achieving a "whole system" approach.

3.23 Given the interface social landlords have with the public through their services, their front-line staff are a particularly valuable resource in generating a true early intervention/prevention approach within communities. The value of training staff in a trauma-informed approach and/or restorative practice was mentioned on several occasions.

3.24 Joint working around hospital discharge where a housing professional is co-located is welcomed. It can ensure a housing issue does not delay or stop someone from being discharged after medical treatment. Over and above helping to speed up discharge, it can also help ensure that when someone can return home, they can live safely and as independently as possible. Additional aids can be arranged and adaptations e.g. to prevent circumstances where someone is discharged back home yet has been unable to use aids e.g. a wheelchair, due to the physical aspects of the property.

3.25 Discussions have reinforced the idea that people make the difference as far as joint working is concerned. Many examples of joint working have come about as a result of like-minded, forward thinking, individuals coming together, keen to make a difference to people's lives, being prepared to push for change and overcome hurdles along the way. One challenge is to convert joint working developments into standard, and sustainable, practice, so it becomes "the way things are done". This overcomes situations where someone changes job, a previous joint working arrangement withers and things revert to how they were before. This is particularly relevant when organisations are in a state of flux due to organisational change although currently, this appears to be less of an issue.

3.26 Experiences with health services across local areas and regions is mixed. Positive interactions with district nurses, GPs and Occupational Therapist services are often reported. Helping tenants to access primary care when it is needed can sometimes be a challenge. As a need, mental health is an issue that is presenting to landlords more and more frequently. Initially, support in terms of going through primary care system is quite straightforward. However, after initial assessments, support from health services can sometimes dissipate. For some clients, loneliness and isolation exacerbates their health conditions. Delays in being able to help people to engage with statutory or third sector services and support risks further deterioration of health to the extent that someone's willingness to engage, be it a tenant of a social landlord or someone else with a housing need, can disappear.

3.27 There is anecdotal evidence of social landlords and housing staff from local authorities struggling to get referrals on behalf of individuals who present to them. For example, a referral may be turned down if there is just a possibility that someone could lose their home but accepted if a social landlord serves a notice of eviction. This appears to work against the broad principle and goal of prevention and early intervention. It certainly sits awkwardly with national policy (and law) on preventing homelessness, in which earlier intervention to avoid someone becoming homeless is a fundamental principle. Capacity problems and demands pressures may well be behind this. However, the result of circumstances where someone "doesn't meet the need for referral" or "doesn't meet the criteria for support" means that some people fall into gaps in provision. Single people of working age are particularly affected, and it seems more difficult to get them into services. And there can be a gap between what might be considered "low level" mental health and the threshold for NHS services, with waiting times for assistance e.g. counselling and other specialist services, also being mentioned.

3.28 When referrals are made e.g. to social services, feedback afterwards can be missing. Without feedback, a social landlord does not know whether to continue supporting a tenant. The social landlord must rely on the tenant themselves to give feedback on the situation and any assistance being given, which may not be complete or accurate. Where someone has been sectioned and there are no family members, the social landlord often needs to chase for feedback and it is not always forthcoming, possibly on ground of data protection of professional confidentiality. If they can't be overcome, data protection and patient confidentiality issues can be a barrier to effective joint working and ongoing support for tenants.

3.29 Developments such as the proposal to amend the Partnership Regulations under Part 9 of the Social Services and Well-being (Wales) Act 2014 for housing representatives to sit on Regional Partnership Boards are welcomed for the potential to stimulate more joint working. It is recognised that given the number of social landlords, such a development would require sound practical working arrangements, and over time, there would be benefits to be gained by Boards learning and sharing information on how any new arrangements work in practice.

3.30 At all levels, better knowledge and understanding on all sides – housing, health and social care – is critical to joint working. This ranges for the basic knowledge e.g. who to contact (easily) in “xx” to help an individual, to a better understanding e.g. of respective roles, how organisations work, and what can be done for people. It tends to happen more where co-location is involved but there is scope and need for more joint training and continuing professional development activities to play a part.

Appendix 6

Projects/Developments

"Closer to Home"
First Choice Housing Association
First Choice provides housing throughout Wales and Shropshire to enable adults with a learning disability to live independently in the community with support. "Closer to Home" was established in 2011 to reduce the number of people with a learning disability and/or challenging behaviour being placed in institutions The aim was threefold: to enable people with a learning disability and challenging behaviour living out-of-area to move back to their local area in Bridgend, Neath and Swansea, to prevent further out of area placements; to reduce the need for admissions to acute services.
The development was not "top down" but was spearheaded by like-minded individuals committed to joint working for the benefit of people who need accommodation and support.
A Framework was established comprising the 3 local authorities, Abertawe Bro Morgannwg University Health Board ("UHB"), 2 registered social landlords and, via an open tender / framework opportunity, 5 support providers. The framework ran to 2015 but relationships between individuals in the Association, the NHS and relevant local authorities continue for commissioning purposes. Discussions have now commenced with Hywel Dda and Carmarthen to try and replicate the joint commissioning arrangements.
First Choice undertakes the landlord function, providing ongoing housing management. In conjunction with partners, it sources and develops the type of accommodation needed with Local Authorities commissioning appropriate care and support. The latter is contracted out to specialist providers. It has delivered 11 schemes under the Closer to Home Framework, providing suitable homes for 39 tenants. Discussions on 2 more homes in Carmarthen are in hand with Abertawe Bro Morgannwg UHB. These are supported by the Integrated Care Fund and bids for similar provision are with Betsi Cadwaladr UHB. Developments are based on a front-end agreement - 50/50 funding split with the local authority and NHS.
First Choice Housing has 850 tenants. It works across 19 local authority areas and this year will developing 19 new homes in 10 areas. The complexity of individuals' needs varies, with the most complex requiring, for example, tracking hoists, specialist baths, and a wide range of features which assist with managing challenging behaviours.
The savings on the cost of out-of-area placements can be considerable. For example, an out of area placement cost of £311,000 per annum compared to an annual cost of £90,000 under a "Closer to Home" arrangement would generate a saving of £221,000 per annum. The savings in some cases could be even more. here is a lead in time before these come through e.g. not necessarily in the first year or so given the set-up costs. However, when in place, the savings can be realised on an ongoing basis and, importantly, it is also possible to respond to changes in the support needs of individuals and their families.
Over and above cost savings, having suitable specialist housing options locally is preferable to someone being accommodated far away from their community and family. It produces better health and well-being outcomes for all. The benefit of supported living accommodation is that is also promotes an individual's right and independence to live in an ordinary home in the community, with a property adapted to meet their personal needs and appropriate care and support.

The Lighthouse Project - Reducing delayed transfers of care
Taff Housing Association

The Lighthouse Project was developed with Newport City Council's Supporting People team. Floating housing-related support is provided to vulnerable adults to enable them to live independently in their own home (funded via Supporting People programme)

A tenant support worker based in hospital was the result of a request from Newport Social Services via its hospital social work team. Discharging patients is a challenge, particularly where housing issues create difficulties or delays in achieving discharge. Third sector providers already worked to assist people with poor mental health and social services are involved automatically for patients of a certain age. The Lighthouse Project allowed assistance to be given to younger people and people with specific problems such as substance and alcohol misuse. The needs of all patients are considered and actioned as necessary, not just social housing tenants. And all housing matters can be addressed, not only adaptations to homes.

The prime aim was to reduce delays in people leaving the Royal Gwent as a result of referrals, paperwork and liaison, and a more comprehensive support package. However, over and above faster discharge, desired outcomes for the project included the arrangement of ongoing floating support, preventing the need for re-admissions to hospital, and cost savings for health and social services.

There is one support worker – a housing/homelessness professional - based in the Royal Gwent hospital but also covering St Woolos. He/she works on wards as part of hospital teams and proves the benefits of co-location. Their knowledge and experience facilitated pre-discharge action such as arranging for adaptions to someone's home. However, it extended to challenging housing and housing decisions e.g. someone being discharged back to same block of flats to mix with same people which can result in a cyclical problems and readmission, or a homeless situation. Similarly, it helps avoid problems associated with rent arrears and possible eviction, the risks of which can now be higher where Universal Credit is concerned.

The Integrated Care Fund did allow another support worker to be based on the hospital to cope with demand and to maximise the benefits of joint working and the prevention of delayed transfers of care and future problems. However, the funding from the ICF was not renewed so assistance is currently provided by one support worker.

Remodelling Sheltered Housing – Pen Llew Court, Aberdare
Cynon Taf Housing Association with RCT County Council

Sheltered housing has been a good home to many people. However, over time, the needs which underpinned the concept have changed. People are living longer and prefer to stay in their own homes. Adaptations and, where necessary, social care support packages help them to do this and to live safely and as independently as possible for as long as possible. Consequently, there is now lower demand for sheltered accommodation in RCT.

Cynon Taf Housing Association experienced low demand for its Pen Llew Court property in Aberdare. Thirty per cent of the property was always void and could not be filled. Financially, and socially this was unsustainable as the need to let the scheme had historically meant that some client groups not ideally suited to communal living had been offered properties at the scheme. After considering alternative uses and as a result of close working with Rhondda Cynon Taf County Council, the property is being remodelled.

The 34 homes (14 flats and 20 maisonettes) are being converted into 19 one-bedroom flats to house adults with learning difficulties. This means people will not being living in just one bedroom but will have their own front door, a living room and bedroom, kitchen, and adapted shower. Support will be available on site 24/7. The goal is for individuals to be able to live in a community not an institution. Reinforcing this concept, a community hub is part of the design. This will reduce the need to move people out to day centres. The hub will also be open for schools, communities, IT facilities, cooking available for everyone locally not just people with learning disabilities.

The property is owned by Cynon Taf Housing Association The costs of remodelling is £2.3 million of which £1 million is funded by the Integrated Care Fund and a £1.3 million loan to the association from RCT. The timescale for the loan and for the guaranteed rent over 15 years for the provision of accommodation provides the basis for prudent financial decisions. An efficiency in social care is envisaged which can be reinvested in frontline service provision as a result of the development. Accepted tender – delivery by end of 2019.

The Association is considering a similar scheme for Oxford Street in Mountain Ash town centre. It has also developed respite accommodation for use by RCT in Treforest. The development, which was handed over on 21 December, takes advantage of reducing student demand for houses in multiple occupation. A large property has been renovated without the need for grant and a long-term arrangement agreed with the local authority for 4 spaces plus sleeping accommodation for support workers.

Remodelling sheltered housing
Trivallis
Two of the Association's sheltered housing schemes (out of 27) were assessed as having no future due to lack of demand. Alternative use was explored with Cwm Taf UHB and RCT Council. The Health Board and Council had undertaken an analysis of the accommodation needs of 2 vulnerable client groups - those with a learning disability and with mental ill health. This identified need for a supported housing project for people with low level ongoing support needs and for crisis accommodation.
A scheme was developed to accommodate vulnerable people with a social care need aged 18 and over. Two buildings were remodelled to provide high quality self-contained apartments (Penygraig – 15 properties; Ynysybwl – 18 properties) with communal space being open and welcoming. Trivallis met the cost of the refurbishment and agreement reached for a minimum period for the use of the scheme. 24-hour support was commissioned by RCT. Each scheme has a part-time Manager, and suitable cover, including sleep-in cover where needed. Ynysybwl uses one property as emergency accommodation and one property for staff sleepover.
The buildings were handed over in 2013 and a support provider contracted. Homes were allocated by a panel. Tenants who were allocated a property experienced a range of needs including mental health, learning disability, and brain injury.

Training flats
Trivallis
Social landlords in RCT Taf provide one-bedroom accommodation to young people leaving care via an application to the Common Housing Register. It was apparent that many tenancies were ending, with reasons including abandonment and eviction for rent arrears. Investigation revealed the failure of tenancies was simply due to young people being unable to deal with the realities of everyday life such as paying bills, prioritising expenditure and ultimately facing the reality of living alone.
Joint working between Trivallis (or RCT Homes as it then was) and the Council sought to address the problem. A training flat was set up as a pilot in Aberdare in 2009, and another in Rhydyfelin in May 2010. The flats are aimed at young people (17+) in residential or foster placements. Young people are referred if their social worker believes that the experience would be valuable as a step towards independent living.
The referral is for up to one week initially with an option of a 4-week placement. The young person is expected to produce a portfolio of their experience to record life skills developed during their stay, to develop their learning and support needs and to evidence their ability to live independently on referral to the Move on Panel. The Panel will give additional priority to those having had successful stays in the training flat when allocating suitable general needs housing. If the first stay is not a success, the young person can return to their former residence and can then be offered a second period later. This helps promote sustainable long-term tenancies following Move-On.
When the young person has completed their stay(s) at the training flat, they return to their former residence before making a more informed decision on whether to pursue supported accommodation or independent living

Wellbeing 4U
United Welsh
As a specialist housing and support service provider, United Welsh has long provided opportunities to improve people's health and capacity for selfcare, which align with aims of other agencies. Improving people's well-being is inherent in its strategy. It works with people experiencing social challenges and lifestyles that affect their health.

Wellbeing 4U was launched in May 2016. It was developed as a result of a tender issued by Cardiff and the Vale University Health Board. The tender was broad in terms of the need – social prescribing – with the emphasis on developing a service to test what works and what doesn't. The 2-year contract was retendered in 2018 with the specification being more detailed as a result of experience and practice in the first two years. United Welsh securing a further 2 years plus a one-year possible extension.
The service (team of 11) works across 3 GP clusters covering 25 surgeries in the Cardiff and Barry areas. The Association's team delivers support to help patients to overcome situations affecting their health and wellbeing. This may be managing health or lifestyle issues but could be broader matters e.g. debt; rent arrears, which can be the root cause of low -level mental health problems. The approach builds on people's strengths rather than deficits to help them take control of their lives and to achieve goals. People are referred by their GP or other primary care staff but can self-refer. The approach is flexible enough to be adapted to work to different locations and needs. For example, the service delivered in the Vale is different that of the City. It is aligned with the needs identified by each GP cluster thus helping them to deliver to their plans.
The service has evolved. The model now is quite different to the original. While originally interventions discussed and agreed with patients could last as long as needed, there is now a greater focus on achieving behavioural change and avoiding support becoming an ongoing counselling service. Interventions range from signposting people to wellbeing and community activities, arranging home adaptations and other support through to therapeutic approaches on issues such as substance misuse or depression. The medium-term approach is now 1-4 sessions with a longer-term intervention option to the Association's "Healthful Network", which delivers courses and other assistance on matters such as stress and anxiety control, and nutrition/healthy eating (Foodwise, which is linked to the local Dietetic Team). The Association also has a means of allowing people to engage again with the support and to keep in touch with others they met while on courses. The manager of the service has also introduced measures to ensure the resilience of the team members. This is particularly important given the nature of some cases encountered.
1,749 referrals were made to the service in the first 2 years (includes an additional 252 referrals made by the South-East Cluster from Oct 2017 – March 2018, the support for which was funded by the cluster itself). The results are positive and wide-ranging and the decision by a cluster to invest some of its own budget to extend the service is proof of this. Detailed information is available. It has allowed more support and options to be provided to people presenting to their GP. It has also reduced pressure on GPs' time.
Early challenges were getting GPs on board as the service depended on referrals. Now, in its third year, it has proved its worth in the eyes of GPs; word has spread. More practices are requesting support which is a challenge as funding and thus capacity of the service is limited. Encouragingly, two GP clusters have funded support from their own budget albeit on short-term funding when budgets permit. This is of some concern as people can be wary of short-term funded projects which may at some point disappear leaving gaps in provision and the support people can access.

2025 Movement
Various organisations across North Wales
The 2025 movement is a strategic development which has stimulated joint working on several themes. The following text summarises the Movement itself. Some workstreams involved housing associations and local authority housing departments working with the NHS and/or social care. These are featured in more detail in separate descriptions in following pages.
The Movement comprises senior leaders and practitioners from North Wales local authorities, four housing providers; (Cartrefi Conwy / North Wales Housing Association, Cartrefi Cymunedol

Gwynedd Cyf, Canllaw (Eryri) Cyf), Betsi Cadwallader University Health Board (BCUHB), Public Health Wales, Wrexham Glyndwr University, North Wales Police, and North Wales Fire & Rescue Service.

The group first came together in 2015 with the aim of enabling organisations to take a new approach to working together to address shared challenges to end avoidable health and housing inequalities across North Wales. A Programme Management Group meets bi-monthly and oversees seven work areas or 'Just Do' teams;

- Flint Regeneration (currently focusing on youth physical inactivity and food poverty)
- Healthy Homes – Healthy People
- Mental Health & Hoarding
- 'Made in North Wales' Social Prescribing Network
- Public Services Leadership Programme supporting the aims of 2025 in conjunction with Wrexham Glyndwr University
- Tackling Health Inequalities for Homeless Rough Sleepers
- Facilitating Improvements in Hospital Discharge

Mental Health Pathway
Isle of Anglesey/Ynys Mon County Council / BCBU

A Pathway has been developed to improve the way in which support and accommodation can be provided to people with mental health needs who are either accessing services via Betsi Cadwaladr UHB Mental Health Services, primary care or Housing's Supporting People secondary services. Embryonic – 3 months old. It developed from discussions triggered by the 2025 Movement. The overall aim is to help people to find and maintain a tenancy. and to ensure accommodation is available for individuals with low level mental health and enduring mental health needs. It offers offer choices to the individual to help them to move on towards full independence.

People with mental health needs will have access to short-term preventative and recovery services. The services provide a mixture of accommodation based short and long-term services as well as floating support services. In addition to the short-term prevention and recovery services, there is a need for long-term support and accommodation-based services.

The 'pathway' will provide support as service users' needs change. It facilitates early intervention / prevention by ensuring housing needs assessments are completed to prevent someone becoming homelessness, including a Mental Health Needs Assessment within the procedures. It also helps build closer working relationships between Housing and Health Workers including the Community Mental Health Team and to develop robust Information Sharing Protocols

When someone is admitted (to any hospital in the area), the unit will be informed which allows planning for discharge to begin, this is reassuring for the individuals concerned particularly those with no accommodation. Came about as a result of a member of the local authority's Housing Department was once a service manager in Social Services. The development was informed by personal experience of cases where individuals were discharged only for temporary accommodation arrangements to fail. The person then re-presented to housing without any notice. The arrangement allows three key public services – health, housing and social services - to focus on providing co-ordinated support for an individual to prevent cyclical problems as far as possible. Working relationships and mutual understanding of roles has improved as a result of the development. behaviour.

A Stakeholder Panel has been established to ensure the Pathway is successful. It also facilitates communication and information sharing between all agencies and key stakeholders, helps ensure people have access to primary care services and secondary support services via Supporting People to help them maintain their tenancy. It will also inform future planning and commissioning arrangements and where required and appropriate to inform and make recommendations. The group includes representatives of the local authority's Supporting People, Community Support, Community Safety, Children's Services and Housing Options teams, the NHS Community Mental Health and Substance Misuse teams

Hospital Discharge Project
Conwy County Borough Council (project lead)

The Hospital Discharge Project was established in December 2016 after discussions triggered by the 2025 Movement. It works across Conwy and Denbighshire in partnership with Betsi Cadwaladr UHB, Conwy Housing Solutions, Denbighshire Housing Solutions and Conwy & Denbighshire Care & Repair Agency. A Housing Officer is based full-time in Ysbyty Glan Clwyd. The postholder works with patients and partners to address any housing issues which enable timely discharge from hospital to home or, where necessary, to temporary accommodation. The role has been piloted within the Step-Down team since the end of December 2016. Initially funded to run for 3 months, positive outcomes saw an additional 6-month extension. In November 2017, the Health Board confirmed permanent funding for a full-time Officer.

The role evolved and developed during the first six months to establish. The Officer endeavours to attend all board rounds, which was particularly important in the first months as it was an opportunity to meet with ward and therapy staff and discuss the benefits of the role to support discharge planning. The service was promoted on all wards in acute and community hospitals and in the emergency quadrant with posters, and education pack and contact details. The education pack also contains helpful housing-related prompts for staff when completing the 'what matters' conversation with patients.

The housing officer initially visited each hospital site weekly but as more case are identified within the acute site, the necessity of visits to community hospitals has reduced. The officer endeavours to attend community sites within 24hrs of a patient being transferred from acute where the patient is already known to them. This provided valuable reassurance to staff within the community setting that plans are in place and that the patient's referrals need not be re-started. This has aided and developed trust.

The officer contributes to the weekly delayed transfer of care meetings. This has provided valuable information to the housing officer and a weekly link to discharge liaison nurses working in community hospitals, it has improved their knowledge of housing options. A file system has been developed for the Emergency Quadrant. A staff member who believes that there may be a housing-related concern that could delay discharge simply places the patient's G number sticker in a designated file in their area. Files are checked daily by the housing officer who approaches the patient and establishes what options/services may be available to them. This has been of real benefit where a patient's medical needs have seen them admitted onto a ward as the housing officer can effectively 'track' their case and ensure that where appropriate, support is offered. The results are positive with 47% of cases identified within the Emergency Quadrant.

The support provide to the Acute Mental Health (Ablett) Unit and attendance at weekly meetings allows early intervention in cases. This is particularly important when dealing with patients who are being treated for mental health conditions as their cases tend to be complex with several underlying factors which can mean housing options are more limited.

In the first 6 months, 80 patients benefited from the service. Further analysis was undertaken in October 2017 to capture the total notional savings to BCUHB using a formula developed by Nottingham University. Applying Nottingham University's formula, the early intervention of the housing officer role saved BCUHB 1,293 bed days. This does not include potential front-door savings from avoiding readmissions and staff time savings knowing where to refer/signpost and support for the "What matters" conversations. Other benefits include increased knowledge and understanding of housing matters and options

Tackling Health Inequalities for Rough Sleepers
North Wales Housing Association (Project lead)

Triggered by discussions from the 2025 Movement, a project group was set up to focus on the Gwynedd area. This was agreed based to North Wales Housing's expertise in working with rough sleepers in Gwynedd through their outreach and resettlement services. Key goals were to meet rough sleepers in Gwynedd, to record their experiences of living with poor health and the barriers they encounter to accessing health services (22 interviewed January to March 2017). Also, as a means of ensuring the project made a difference, to identify one thing that's not working in terms of rough sleepers accessing healthcare.

Ensuring positive engagement with a group which is traditionally difficult to engage with is a challenge. One-to-one working with rough sleepers was required thus the action was labour intensive

As a result of the project. rough sleepers in Gwynedd can now access GP services as a result of the team's liaison with GPs in the area. They are now offered flu vaccinations (at the GP surgery) as they are considered health vulnerable as a group within the general population. They can also access emergency dentistry (information provided to all rough sleepers) and they have improved access to mental health services both in the community and in hospital.

The Project has had a positive impact so far in Gwynedd with health outcomes integrated into the Services delivered by North wales Housing's Outreach and Resettlement Team across Gwynedd. They are currently engaging with all 45 or so rough sleepers in the Bangor area and regularly engage with rough sleepers in Porthmadog and other towns in South Gwynedd. Most of the rough sleepers need support with mental health, drug or alcohol misuse issues. The stronger partnership developed with BCUHB has had some positive impact in encouraging rough sleepers with mental and physical health issues to engage with services. The team ensures that the hot meals prepared daily are balanced and nutritious, as well as providing ready prepared sandwiches and cakes as available. To a certain extent the service depends on the generous donations of businesses such as Greggs and Marks and Spencer.

A further 2025 project has now been agreed to explore and support the development of homeless day centres and night shelters in two geographical locations in North Wales, to look at offering a one stop service for rough sleepers, under one roof.

CARIAD Scheme
LINC

The CARIAD scheme aims to ensure patients who no longer require a medical bed are provided with an alternative pathway that supports and facilitates their long-term care needs.

It is a means of enabling people to 'step-down' from hospital when their treatment has finished, and they no longer need to be there, but may require a further period of assessment in an alternative setting. The acronym stands for "Collaborative Assessment Reducing Interventions, Admissions and Delayed transfers of care".

The scheme aims to prevent unnecessary admission to hospital due to short-term illness or injury, to reduce the risk of admission/ re-admission to hospital, and to shorten the length of time someone who is medically stable and needs help with rehabilitation is in hospital. The aim is to rehabilitate people to be able to return home or to another appropriate care setting.

Circumstances in which it can help include issues affecting mobility e.g. plaster cast; to allow time to establish the level of care needed and to consider housing options, to manage delays in returning home because of delays in setting up home care, the lack of a carer for a time, and obtaining equipment or carrying out repairs or adaptations.

The project has 4 locations, which include Extra Care, Residential Care and Sheltered Housing.

Support is provided by the Blaenau Gwent Community Resource Team, which comprises Social Workers, Intermediate Care Consultant, Occupational Therapists, Physiotherapists, Rapid Response Nurses, Health and Wellbeing Support Workers. While part of the CARIAD scheme, the support provided is tailored to an individual's needs and any goals or outcomes that he/she may have are discussed and support provided to enable them to be achieved.

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