SOCIAL SERVICES AND WELLBEING DIRECTORATE

SERVICE DELIVERY PLAN

OUR STRATEGIC 5 YEAR VISION

2020 – 2025

CONTINUING TO LIVE INDEPENDENTLY IN BRIDGEND IN THE 21ST CENTURY

PLANNING SERVICES FOR FUTURE NEED

Cabinet Approved Version September 2020

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Executive Summary

This Service Delivery Plan sets out a five year strategy for the Council's Social Services and Wellbeing Directorate. Whilst identifying future intentions to improve a wide range of services, the plan also identifies what has been achieved to date recognising that despite increasing service pressures and reducing budgets, the Council has been able to transform services that have delivered more effective services that are in line with changes to legislative requirements.

Since the Service Delivery Plan has been drafted and consulted upon, the COVID-19 Pandemic has impacted on the way that the Council would normally deliver a wide range of services. The pandemic has challenged the Council and has required significant flexibility in response from our in-house and commissioned services for Social Services and Wellbeing Directorate. It was evident during this period that the Council has robust partnership arrangements with other statutory organisations, with our provider services and with the Third sector, and provides real evidence that our services are durable and able to respond effectively to very challenging situations.

At the time of finalising this document and in response to the COVID-19 pandemic, the Council are in the process of establishing a Recovery Plan for Social Services and Wellbeing Directorate to reflect the "new normal" that will have to accommodate the ongoing challenges of COVID-19. It is not anticipated that this will impact on the desired service changes set out in this document, but the ongoing disruption caused by COVID-19 could well interfere with anticipated timelines, as new services may need to be prioritised to deal with the ongoing challenges.

In September 2009, Bridgend County Borough Council Cabinet endorsed a ten year Commissioning Strategy for Adult Social Care that presented its intentions to redesign and commission services that supported Adults in need of social care services. These intentions preceded the Social Services and Wellbeing (Wales) Act (2014) which brought in itself a range of significant changes to expectations that require local authorities across Wales to change its traditional ways of working.

The "Act" emphasised collaboration and co-production and the importance of working with individuals to achieve personal outcomes and having a range of preventative services including the promotion of Well-being activities and

services that delays and prevents the need for care and support. The Social Services and Wellbeing (Wales) Act is all embracing and inclusive of adults and children and therefore , it is an opportune time to refresh and set out the commissioning intentions for both Adult Social Care and Children's Social Care and ensure that the contribution of Well-being services remains relevant in future.

This document identifies that the transformation of services has been extensive and has been achieved through the implementation of effective programme management arrangements. Transformation can be delivered even in the most challenging of circumstances that include increasing demands and reducing budgets. The following are a summary of some of the key changes that have been achieved:

- In Children's social care, there has been a real increase in the range of "Universal, Additional and Vulnerable" services that assist with supporting children and their families to prevent their circumstances deteriorating and becoming more complex. In addition for those children that require "complex" care and in need of support for acute services, much has been done particularly in Residential Care where in-house residential services have been reconfigured so that they now operate as "hubs" targeting a range of services that better support complex needs.
- To assist the families, children and young people who are transitioning from children's social care services into Adulthood, Transition services are being developed improving services so that children in "transition" will receive effective joint care and support planning that ensures as minimal disruption as possible.
- The 2010 Commissioning document for Adult Social Care, set out a vast range of service change much of which has been progressed. This has reduced the dependency on traditional services such as domiciliary care, day services and Residential Care by the development of a range of essential preventative services that are provided by the Council's Community Resource Team. In addition the development of community based services and the introduction of new services like Extra Care housing are providing real and preferred alternatives to Residential Care which is providing more "choice" and control.
- The increasing importance of Wellbeing services has resulted in the contribution of targeted preventative service and the development of

community resilience which are considered a major contributor to the Social Care and Wellbeing ambitions of the Council.

Despite these and many more successes flagged up by this document, this Service Delivery Plan also identifies that the ambition to deliver improved and more relevant services is ongoing. Therefore by identifying "what else we need to do" this document sets out a range of ambitions over the next five years. But the backdrop of ongoing budget pressures and projected population changes means that service development will in future have to continue to be carefully managed and prioritised to ensure that the citizens of Bridgend are provided services that are appropriate and offer choice.

This will present challenges to the Council and its services, many of which will be overcome by working collaboratively with our partners that include the Cwm Taf Morgannwg Health Board, partner local authorities, third sector and independent providers.

Introduction

In September 2009, Bridgend CBC endorsed a ten year strategy for its Adult Social Care services that set out its commissioning intentions from 2010 until 2020. The Commissioning strategy was forward thinking and presented a direction for services that was intended to be sustainable and to accommodate the projected increases in population, for older people in particular, and set out a vision for essential changes to service delivery that has assisted the council to withstand the challenge of considerable increasing pressures.

It is now timely that those commissioning intentions are reviewed and extended to include in addition to Adult Social Care, the Council's Children's Social Care and Wellbeing Services. It is important to emphasise that the Social Services and Wellbeing (Wales Act) national emphasis on collaboration and co-production means that any service changes delivered in future will, where appropriate, be achieved with Regional partners including the Health Board, Third Sector and Independent providers of service.

It is vitally important that the role of Social Services is designed to support not only the vulnerable with Long Term services but to also assist with assisting people maximise their independence and maintain their "wellness". Therefore the Council will also take seriously the expectations that it will work closely with the Health Board to develop joint services that supports the prevention of unnecessary hospital admissions and can assist earlier hospital discharge

The Act requires local authorities to make significant changes to the way that social services are planned, designed, commissioned and delivered. The National Commissioning Board for Health and Social Care in Wales has emphasised that *"commissioning social care is much more than councils organising and buying services. It is about how councils, the NHS and other providers anticipate change, plan services to meet future demands and make effective use of the money available"*. This statement evidences that whilst the commissioning of services has a role in the provision of essential services, it can no longer be the only method of ensuring the range of required services are available. The Act requires local authorities to work collaboratively and coherently with partners such as Health Boards and the Third Sector to ensure services are designed and developed effectively and ensure good value for money.

The creation of designated Regions in Wales to improve the wellbeing of Children, and Adults with care and support needs is a prominent theme

presented by the Act which also specifies the need to undertake Regional Population Needs assessments that identifies regional priorities that inform a Regional "Area Plan". The move of Bridgend from the former Western Bay to Cwm Taf Morgannwg Region in 2019, was inevitably going to disrupt the authority's regional working arrangements in the short term, but nevertheless the value and importance of regional working and its ability to commission services collaboratively must continue to be embraced and extended as appropriate, and therefore must feature in future Service Delivery Plans.

The Act emphasises that local authorities must extend its service delivery to include preventative services, and the promotion of Well-being activities and services, in order that this delays and prevents the need for care and support. In addition the Act stresses the need for local authorities to treat carers as equals to those being cared for in addition to introducing new and additional service responsibilities such as Advocacy and Secure Estate. The Act makes clear the responsibility for the social care of adults in the secure estate in Wales rests with the local authority within which that secure estate facility is located. This means that with these expectations, Bridgend CBC acquired additional responsibility for HMP Parc Prison which also needs to be considered in future planning and commissioning of services.

Working with individuals to ensure services support the achievement of personal outcomes is one of the key changes required by the Act. The Act also highlights the importance and contribution of "untapped resources" that are available from individuals and communities and leads to identification of the importance of services being planned and commissioned in a co-productive way.

Such statutory changes have imposed on local authorities the need to plan future commissioning of Social Care carefully and to recognise and respond to the challenges set out by the Act and to ensure that services are designed to maintain and support Well-being, Independence, Person Centred Planning and Voice and Control. It is also expected that such service delivery cannot be achieved in isolation and requires the Directorate and its services to work collectively, closer with other Council services to ensure that service strategies are informed and aligned, and in collaboration with other partners such as the Health Board and regional partners.

This document therefore sets out for Bridgend Social Care its service delivery intentions for both Adults and Children's Social Care and how these services will be underpinned by the provision of targeted Well-being services, designed to support independence and choice. Inevitably this document will present

information that has previously been reported in the Director of Social Services Annual Council Reporting Framework reports, which report progress on a yearly basis, and it is intended that progress will continue to be reported via this mechanism in future.

For Adult Social Care, this document will take into account the intended actions in the 2010 Commissioning document, identify progress made and what else needs to be achieved. The document will also provide a service vision for Children Social Care that will identify its current position and future direction and to identify opportunities of how the Directorate as a whole can work cohesively both within the Directorate and across the Council in addition to partner organisations.

In summary this document will provide the Service Delivery Plan for how Social Care in Bridgend continues to transform its service design so that it maintains its ambition to deliver quality services against a backdrop of increasing financial pressures and cumulative challenges posed by increases to population and complexity of need.

Corporate Context

Bridgend County Borough Council has a number of key principles that underpin the way that it delivers its range of services. The Council has developed a vision which is to act as "One Council working together to improve lives" is fundamental to how the council wants to deliver services that benefit the citizens of the County Borough. In recognition that services are better delivered in collaboration, the Council also highlights the importance of working in partnership with our citizens, our communities and with other organisations to develop and deliver sustainable services.

Within these principles, we have embedded the principle of Sustainable Development, aligned to the five ways of working, as expressed in the Well-being of Future Generations (Wales) Act 2015. The five Ways of Working are:

- Long Term
- Prevention
- Integration
- Collaboration
- Involvement

The Council also has developed values that represent what we stand for and shape how it works these are:

Fair - taking into account everyone's needs and situation

Ambitious - always trying to improve what we do and aiming for excellence

Citizen-focused - remembering that we are here to serve our local communities

Efficient - delivering services that are value for money

Amongst the pressures arising from increased demand and reduced resources, the Council's ambition is to have a clear focus on what are national priorities set for Wales and for our communities in Bridgend, both for now and in the future. To support this ambition, the Council has adopted three Well-being objectives under the Well-being of Future Generations (Wales) Act which are:

1. Supporting a successful sustainable economy –. taking steps to make the county borough a great place to do business, for people to live, work, study and visit, and to ensure that our schools are focussed on raising the skills, qualifications and ambitions for all people in the county borough.

2. Helping people and communities to be more healthy and resilient - taking steps to reduce or prevent people from becoming vulnerable or dependent on the Council and its services. Supporting individuals and communities to build resilience, and enable them to develop solutions to have active, healthy and independent lives.

3. Smarter use of resources – ensure that all resources (financial, physical, ecological, human and technological) are used as effectively and efficiently as possible and support the creation of resources throughout the community that can help to deliver the Council's well-being objectives.

The production of this Social Services and Wellbeing Service Delivery Plan is deemed to be good practice by the council as it ensures that the delivery of service change is in line with corporate objectives. Therefore the corporate objectives are central to the themes of this Service Delivery Plan. This plan will confirm that with the increasing service demand and increasing budget pressures, has required the Council to deliver more service for less resource, which has to continue into the future, in order that resources are utilised to

continue to support the increasing demand. This Service Delivery Plan also confirms the need for the Council to work together both internally across services and departments, and in addition to working collaboratively with other partner agencies that include the Cwm Taf Morgannwg Health Board, other local authorities, and the Third Sector and Independent Provider of Services.

Background

The ten year plan for Adult Social Care created in 2010 provided the blueprint for how Adult Social Care Services would need to be delivered to meet expected changing demands. In 2015, the Council formed the Social Services and Well-being Directorate which reunited Adults and Children Social Care Services in the same Directorate. Since this time, the Directorate in 2016 launched the "Vision into Action" strategy that set out the Vision for Children's Social Care to enable "better outcomes for children, young people and their families".

The Adult Social Care document led to the creation of the Remodelling of Adult Social Care programme(s) which has resulted in the transformation of Adult Social Care services which since 2011 has delivered significant reshaping of Adult Social Care. This has included the development of evolving models of integrated working including the creation of the acclaimed Community Resource Team and Community Integrated Hubs with the former ABMU Health Board. Such models have been designed to provide prescribed intervention that enables intensive support for a managed period that support achievement of personal outcomes and independence that have successfully reduced the dependence on long term services that require recurring costs.

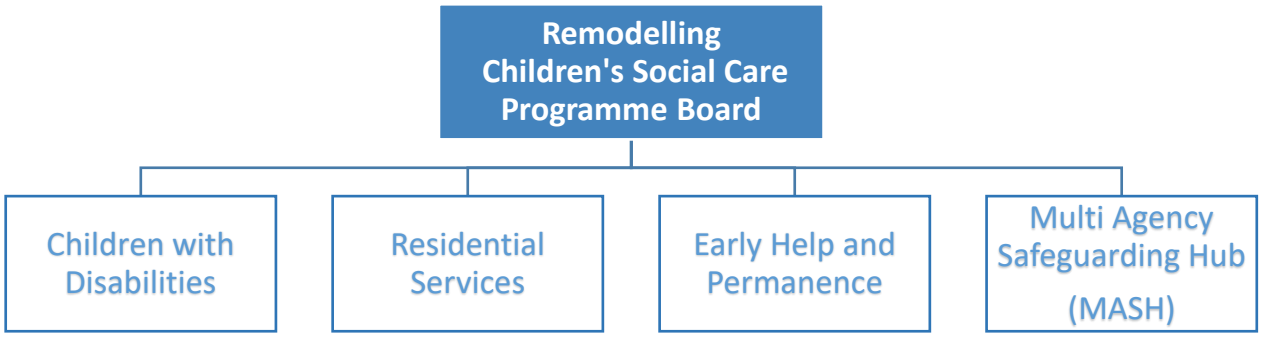
This programme has also accommodated the requirements and expectations of the Act and there is significant evidence to show how Bridgend Council has embraced the prevention agenda. Even prior to the introduction of the Act, Bridgend had developed an agreement to work in partnership with an external provider (Halo Leisure) to modernise its Leisure services in 2012, and similarly its cultural services including Libraries were developed by creating a partnership with Awen Cultural Trust in 2015.

It was these changes that made way for the Social Services and Well-being Directorate and the inclusion of Healthy Living Services that also has contractual monitoring of both Awen and Halo. This strategic decision has resulted in the Council, creating excellent working arrangements with both Halo and Awen that has enabled these providers to offer flexibility in the way that they have shaped and delivered service arrangements. The prevention and wellbeing focus within

the Council has allowed the assets such as community centres and the services that they can deliver to be aligned to desired wellbeing outcomes. This would include the Ageing Well plan for Bridgend, Active Bridgend and Building Resilient Communities programmes which have helped refocus service delivery and re-design of service model that are delivered jointly and delivered in partnership with Halo and Awen Cultural Trust. This has seen the transformation of the former Leisure Centres and other related services, so that they are better able to meet the needs of the unfit as well as the fit. Such developments can be directly aligned to the principles of the Act, in particular the need for preventative services that create community resilience.

The Children Social Care "Vision For Action" paper set out the vision for Children Services which was: 'Together enabling better outcomes for children, young people and their families via responsive and timely services which support them to live together, work on difficulties and be safe'. This vision was developed by service managers and shaped by operational and front line staff and was designed to underpin a whole service ambition and approach and resulted in a Transformation programme that continues to Re-model Children Services. The Transformation programme was based on the delivery of four key priorities that are set out in Figure 1 below.

Figure 1: Children Services Remodelling Programme



Social Services is largely a demand led service and whilst the long term strategy is to enable people to be more self-reliant, the demographics show that people are living longer, often with more complex conditions than ever before. This means that there are increasing numbers of older people living in the community who would previously have remained in hospital or entered a care home. Similarly Children's social care is also challenged by the need for some

children and young people to become “Looked After” which requires careful management and decision making of individual cases that can result in adding to financial pressures that can fluctuate very rapidly.

Within the Directorate, there is a strong culture of professional social care and there is an emphasis on ensuring positive outcomes for those people we work to support. The Council continually strives to develop new approaches to service delivery that promotes better support and outcomes for prevention, early intervention and wellbeing. This approach supports the Council’s corporate priority of ‘helping people be more self-reliant’ and is also part of the Directorate’s transformation plan in Adults with a clear link to the Council’s medium term financial strategy.

How this Commissioning Plan is Set Out

The ambitions of this document are informed by key national and local strategic policy drivers that underpin our objectives, outcomes and priorities. The Remodelling Plan is divided into four distinct Parts. This will assist those using the document to ensure that they are provided the relevant information most appropriate to them. To this end, the plan can be considered as a whole or each part can stand alone. It comprises of:

1. Setting the Scene
2. Children’s services
3. Transition Services – Children to Adulthood
4. Adult Social Care Services
5. Well-being Services
6. Delivery Action Plan

This document is aimed at our stakeholders which includes Elected Members, staff, providers and people who use services, carers, professionals and partners, but can also be made available electronically to any interested person.

SECTION 1: Setting the Scene

1.1 Challenges

1.1.1 Population Changes

The Welsh Local Government Association have previously identified that:

- Our rapidly ageing population means that the number of older people was estimated to outstrip the number of working age family members as early as 2017
- More people born with disabilities are surviving into adulthood and later life
- Many more people are surviving serious illness such as cancer or stroke and those living with long term conditions increases demands for health and care services
- Across the UK, there are 1.87 million people employed in the care sector and 70% of people have personal or immediate family experience of using care services
- The number of people with dementia is projected to increase rapidly. The Alzheimer's Research UK is predicting that the numbers of people with dementia will rise by up to 35% by 2025 and 146% by 2050.

People with dementia tend to want to stay in their own homes and retain as much independence as possible. This increases the demands on carers, the numbers of which are expected to be aligned to the increases in cases of dementia. Largely due to people living longer, the population in Wales is expected to continue to increase. In 2016, 1 in 5 people were aged 65 and over and by 2039, the figure is expected to increase to 1 in 4. This predicted change represents a 40% increase for the over 65 population, however for 85 and over the population increase by 2039 is expected to be 137%.

At a Bridgend level, the current predictions are that from 2017 to 2025, the overall Adult population is expected to increase by 7.6% (see Figure 2 below). However the population changes for older people presents more challenges. By 2025 the over 65 population is expected to increase by 16% and the numbers of over 85 population is expected to increase by 39%.

In 2017 Bridgend provided services to more than three quarters of the over 85 population. Taking into account the short term prediction for Bridgend, if the proportion of over 85 population requiring services continues, then we should

expect the demand for services to increase from 2,850 people (in 2017) to nearly 4,000 by 2025.

Whilst the predicted rise in population in Bridgend is significant, the continuation of the increasing trend as predicted for Wales is of more significance. Assuming that the All Wales increase in the over 85 population of 137% by 2039 is applicable to Bridgend, then it should be expected that the numbers of people receiving services will increase by a similar level which would result in an increase to current packages of care to be in excess of 6500 for the 85+ population.

These population projections should expect to continue to increase pressures on Adult Social Care and underlines the need for the Council to continually review its commissioning and design of service provision in order that it can maximise the available capacity to overcome such significant challenges.

Figure 2: Population changes in Bridgend during 2013 – 2030

The projected increase for the over 85 population poses significant challenges ahead

	2013	2015	2017	2020	2025	2030
People aged 0- 18	28,979	29,117	29,280	29,760	30,130	28,120
People aged 18-24	11,310	11,010	10,520	9,950	9,380	9,950
People aged 25-34	17,460	17,710	18,120	18,170	17,410	16,030
People aged 35-44	18,350	17,920	17,300	17,350	18,470	18,940
People aged 45-54	20,720	20,980	21,160	20,210	18,290	17,750
People aged 55-64	17,350	17,610	18,230	19,510	20,800	20,100
People aged 65-69	8,420	8,720	8,520	8,170	8,800	10,050
People aged 70-74	6,530	6,880	7,540	8,140	7,680	8,300
People aged 75-79	5,070	5,330	5,550	6,070	7,260	6,900
People aged 80-84	3,520	3,690	3,880	4,290	4,980	6,040
People aged 85 and over	3,170	3,340	3,620	4,030	5,040	6,310
Total population aged 18 and over	**140,879**	**142,307**	**143,720**	**145,650**	**148,240**	**148,490**

Sourced by BCBC Residential and Nursing Care Homes Market Position Statement (June 2017)

Due to the longevity of these anticipated population changes, the challenges will severely test Bridgend and all Local Authorities across Wales to respond to the changing population landscape. The increase to the over 65 population and in

particular the 85+ presents an expected and unprecedented increase in demand on Social Care services. This underlines the need to create support and services that promotes and maximises independence in order that the provision of longer term support is targeted to those in most need and when needed. Whilst this ambition is in line with the existing strategic design of services, the pressures of demand and other challenges creates an increasingly difficult situation that will continuously challenge the council to manage.

Another aspect of the figures presented in Figure 2 is that the trend indicates that between 2017 and 2025 it is anticipated that the numbers of 18 – 64 year olds will reduce by 3%. This reduction could impact on the numbers of available people to be employed in the care industry which would also impact on all providers (Local Authority, Third Sector and Independent Sector) of care. This will require the Council to consider how it can work with the independent and Third Sector providers of services to ensure that their workforce is appropriate to meet the expected increases in demands.

1.1.2 Financial Pressures

In 2019/20, the total net budget for Social Services and Well-being Directorate is £71 million. This is broken down to:

Adult Social Care	£47m
Children's Social Care	£19m
Well-being & Prevention	£5m

Since 2014/15, the Social Services and Well-being Directorate have experienced total budget savings of nearly £14 million as set out below:

Budget Reductions 2014/15 - 2019/20	**£'000**
Older Persons Services	2,818
Learning Disabilities Services	2,265
Physical Disabilities Services	64
Mental Health Services	247
Day Services - OP / LD / MH / PD	341
Assessment Framework - OP / LD / MH / PD	2,363
Fairer Charging & other income increases	845
Management & Admin Staff Related	1,777
AWEN & HALO related savings	1,840
Children's Services	1,287
	13,847

These savings represent in the region of a 20% budget reduction of the current £71 million budget, and whilst the budget settlement for Bridgend Council in 2020/21 is better than originally expected, the settlement for future years is uncertain and therefore the pressures on Social Services and the Well-being Directorate could well continue. It is important to emphasise that these financial pressures have been achieved whilst responding to the increasing demands due to population changes that are already being experienced in Bridgend. This in part has been achieved by both Adults and Childrens Social Care having received considerable funding through Welsh Government Grants such as the Integrated Care Fund. In summary Bridgend has since 2015/16, received an increase in grant funding from £2.04 million to £5.14 million in 2018/19 which represents an increase of more than 250% which whilst presents a notable and needed increase, it does not replace the overall reduction of nearly £14 million that has reduced since 2014/15. Such a deficit in funding creates inevitable difficulties to sustain service transformation and therefore the Directorate has become over reliant on non-recurring and short term grants to deliver care services. This trend and provision of funding has been achieved through the collaborative working that Bridgend has achieved in working successfully with the former Western Bay Region and sets a determination to continue this success in the new Cwm Taf Morgannwg Region.

These budget reductions whilst challenging are particularly significant when aligned to the population changes that are already increasing service pressures. Closer analysis of Figure 2 will show that the over 85 population in Bridgend will have increased from 3,170 in 2013 to 4,030 in 2020. This increase presents a 27% increase in a population group that is particularly dependent on social care services and will inevitably result in the creation of additional demand. This has required the Council to meet the increasing demand whilst managing reducing budgets and this would not have been achieved without the development of new ways of working. These combined pressures have driven the Directorate to increase the value of outcomes for every pound spent, but even so, there is more that is expected to be achieved.

The Council's Medium Term Financial Settlement anticipates that there are further budget reductions expected to be made by the Council over the next four Financial Years (2021 - 22 to 2023 – 24) that could require the Social Services and Well-being Directorate to make further budget reductions as set out below in Figure 3:

Figure 3: Medium Term Financial Savings

Over the forthcoming financial years, the Social Services and Well-being Directorate could be expected to save in the region of a further nine million pounds

	2019-20	**2020-21**	**2021-22**	**2022-23**	**TOTAL**
Anticipated Corporate **Savings**	£'000	£'000	£'000	£'000	**£'000**
Best Scenario	**7,621**	**9,773**	**7,584**	**7,398**	**32,376**
Most Likely **Scenario**	**7,621**	**10,732**	**8,519**	**8,309**	**35,181**
Worst Scenario	**7,621**	**13,609**	**11,267**	**10,932**	**43,429**
In 2019/20, the Social Services and Wellbeing *Directorate were allocated 28% of the corporate savings. The following calculation uses the 28% as a proxy figure of the "most likely scenario"*					
Social Services and Wellbeing Directorate Potential savings	**2134**	**3005**	**2385**	**2327**	**9851**

In addition, the Welsh Local Government Association have identified additional financial concerns that will impact on Social Care across Wales. These include:

- It is estimated that local government in Wales is already facing a cumulative shortfall of £750 million in social services funding in 2019-20.
- Budget pressures in social care are rising as social care services are heavily concentrated on Older People and the population with learning disabilities.
- Growing pressures on social services includes increasing demand for complex services linked to demographic change and the National Living Wages.
- Latest figures reveal that dementia, including Alzheimer's disease has overtaken heart disease as the leading cause of death in England and Wales.

- In the WLGA submission to the Finance Committee's inquiry on the Welsh Government's draft budget proposals, it was estimated that inflation for the whole of Local Authority services is running at close to 6% over the period to 2019-20.
- CSSIW's Domiciliary Care Review in Wales, published October 2016, highlighted the fragility of the social care market and concluded that current approaches are unsustainable.
- Public and private expenditure on care services is worth more than £30 billion per annum across the UK
- There are rising costs for employers at a time when budgets are shrinking, requiring more efficiencies and greater productivity
- New technologies are changing the way in which some care is delivered – e.g. telecare. However new service delivery models requires a greater degree of multi-disciplinary working with an emphasis on independent living skills

1.1.3 LEGISLATIVE CONTEXT

1.1.3.1 The Impact of the Social Services and Well-being Act (Wales) 2014

The Social Services and Well-being (Wales) Act came into force on 6 April 2016. The Act provides the legal framework for improving the well-being of people who need care and support, and carers who need support, and ultimately for transforming the delivery of Social Care in Wales.

The White Paper, Sustainable Social Services for Wales: A Framework For Action, published in 2011, highlighted a number of challenges faced by public services in Wales. These included demographic changes, increased expectations from those who access care and support as well as continuing hard economic realities.

The Act aims to address these issues and in doing so will give people greater freedom to decide which services they need while promoting consistent, high-quality services across the country. The intent of the Act is that it will transform the way social services are delivered, promoting people's independence to give them stronger voice and control.

The fundamental principles of the Act are:

Voice and control – putting the individual and their needs, at the centre of their care, and giving them a voice in, and control over reaching the outcomes that help them achieve well-being.

Prevention and early intervention – increasing preventative services within the community to minimise the escalation of critical need.

Well-being – supporting people to achieve their own well-being and measuring the success of care and support.

Co-production – encouraging individuals to become more involved in the design and delivery of services.

The Act is constructed around a number of Codes of Practices that are designed to help people and organisations understand how the requirements of the Act should be implemented. For Local Authorities the Codes of Practice provide guidance as to how they must act when exercising their social services functions.

Such requirements have caused Bridgend and all other Local Authorities across Wales to redesign their traditional behaviours regarding social services and to transform the delivery of care to be more outcome focussed and person centred and also promote Well-Being and preventative services. The Act therefore required the introduction of new ways of working that have raised expectations as to how Social Care practice is delivered which have required significant changes to care management processes.

1.1.3.2 Regulation and Inspection of Social Care (Wales) Act 2016 (RISCA)

At the heart of the Social Services and Well-being (Wales) Act is the need to improve service quality and to strengthen protections for those who need it, and therefore ensure services deliver high quality care and support. The Act therefore made way for changes to the Registration and Inspection of Social Care (RISCA) which were introduced in 2018 for care homes, children's homes, domiciliary care, residential family centres and secure accommodation. For other services that include fostering, adoption, adult placement and advocacy services, new regulations came into effect in April 2019.

RISCA has introduced a new level of registration and inspection to providers of services which whilst is designed to improve the quality of services provided, has also introduced increased expectations on providers of social care services by introducing new workforce regulations, training and qualification requirements in addition to market stability and financial assessment provisions which have inevitably introduced financial implications. Under RISCA a provider must register to provide any service which is regulated by the Act and a single registration will contain all the details of the types of service and the details of

the locations where the service(s) is provided. By April 2022, the majority of the social care workforce (including residential care home workers and domiciliary care workers (required by April 2020)) will be governed by the new RISCA framework.

Such registration also requires that social care workers "are appropriately qualified" and Social Care Wales has set out training and qualification requirements for each category of social care worker. Therefore social care workers will be required to hold a listed qualification in order to register with Social Care Wales, which will also require a fee for registration.

The impact of associated fees and associated qualifications relating to the independent providers of domiciliary care and care home provision will need to be negotiated for future contracts, but will add additional costs to both the independent providers and in-house services and therefore add costs to the overall commissioning of services.

1.1.3.3 Well-being of Future Generations (Wales) Act 2015

The Well-being of Future Generations (Wales) Act is about improving the social, economic, environmental and cultural well-being of Wales and has to be considered as part of any future planning for Social Care. The overarching aim of the Act is to address the future challenges that are recognised as being relevant to Wales such as climate change, poverty, health inequalities and jobs and growth. The ambition of this Act is for the collective Public Sector to work together to tackle the challenges by considering the Long Term impact of its decisions and has required the creation of Public Service Boards across Wales.

The Well-being of Future Generations Act (Wales) 2015 has established seven wellbeing goals that focus on increasing prosperity, resilience, health, equality, cohesion, global responsibility, culture and Welsh language. The principles that underpin this Act include long term sustainability and developing the connectivity between organisations, services and resources, and support the case for prevention and wellbeing approaches. This Act identifies the five ways of working being long term, prevention, integration, collaboration and involvement, which are familiar themes within the Social Services and Well-being Act.

The Well-being and Future Generations (Wales) Act has a much broader view on the Public Sector than the Social Services and Well-being Directorate, nevertheless, there are overlaps such as the prevention agenda between the two acts. This raises the expectations that Public Service Boards and Regional

Partnership Boards should work closer together, which could influence the priorities and delivery of social services in future.

The Bridgend Public Service Board is founded on partnership working that has led to the development of the Bridgend Well-being plan. The plan recognises the importance of working collaboratively as a long term commitment to preventing the underlying causes of problems or reducing their escalation in an integrated and collaborative manner. The plan identifies the importance of social wellbeing and the value placed by local people on being connected within communities. It confirms the need to develop age friendly communities based on demographic changes and also identifies, the negative impact that some experiences can have from early life throughout the life course, and points to the use of social prescribing opportunities to signpost people to support networks. There are 4 key objectives being: best start in life; to support communities in Bridgend to be safe and cohesive; to reduce social and economic inequalities; and to support healthy choices in a healthy environment. The Bridgend Public Service Board has established a range of work streams to support the delivery of these outcomes.

1.1.4 Regional Working

Part 9 of the Act set out the requirements of regional working across Wales by prescribing seven regions for Wales and the creation of Regional Partnership Boards to oversee the development of improved Health and Social Care services in the region.

The introduction of Regional Partnership arrangements was not a new initiative for Bridgend, as Bridgend had already been part of the development of Western Bay Region (consisting of Bridgend, Swansea and Neath Port Talbot Local Authorities and ABMU Health Board) since 2012. However the targeting of Integrated Care Funding at a Regional Level has caused regions to work in a more structured way and to undertake required joint activities such as the development of regional priorities that were derived from the Regional Population Assessment and Area Plan. The subsequent boundary changes that were introduced in April 2019 have required Bridgend to move from the former Western Bay Region to the new Cwm Taf Morgannwg Region, and has required Bridgend to align its local priorities identified by the Western Bay Population Assessment with those that were previously identified by the former Cwm Taf Regional priorities. These Regional priorities therefore remain very relevant to the future design of services for Bridgend moving forward.

The expectations of the Act therefore is that Regional working will not only identify Regional priorities that are published through the Regional Area Plan, but will also result in collaborative approaches to Regional commissioning that deliver agreed approaches that are enabled through Grant Funding by Welsh Government in addition to the creation of required pooled budget arrangements between Regional partners.

1.1.5 Training and Development of Social Care staff in Bridgend

Welsh Government provide funding referred to as the Social Care Workforce Development Grant, which is expected to be used not just for Local Authority staff, but to be targeted and shared with external providers of Social Care services in both the Independent and Third Sector.

There are other stipulations with the Grant that are designed to ensure that it is used to achieve national strategic objectives including specific directives that are intended to develop social services practice nationally. Since the implementation of the Social Services and Well-being (Wales) Act in 2015, the Social Care Workforce Development Grant (SCWDWP) has been allocated to regions which has required local authorities within the regions to work collaboratively and with service providers to identify both national, local and common regional requirements.

By Bridgend being moved from the former Western Bay Region to Cwm Taf Morgannwg in 2019, has required the previous Cwm Taf Regional Governance arrangements to be reviewed and a new structure has been agreed, which will be operational from April 2020

Bridgend, Cwm Taf and Merthyr submitted a regional application for the 2019/20 SCWWDP grant in compliance with grant conditions. The application supports the objectives of the SCWWDP and in line with the Grant Circular identified how the region aimed to meet national priorities alongside regional and local priorities over the current financial year and in some cases into 2022.

Bridgend have previously and will continue to work with the regional arrangements to ensure that they contribute to and benefit from collaborative working but they will also be able to identify local service priorities that need to be supported by bespoke innovative training programmes

Therefore to ensure staff are equipped and developed to meet changes to national, regional and local requirements, the training and development of social care staff remains a priority to Bridgend. Consequently training needs will

be reviewed on an annual basis to ensure learning and development plans support service priorities and staff development.

1.1.6 Impact of COVID-19 Pandemic

Since the Service Delivery Plan has been drafted and consulted upon, the COVID-19 Pandemic has impacted on the way that Social Services and Wellbeing services deliver a wide range of services. The pandemic presents what is, thankfully a rare, but nevertheless serves as, a real example as to how service delivery can be challenged. The Council's in-house and commissioned services for Social Services and Wellbeing were required to react collectively and in a coordinated manner. The coordinated and close working between the Social Services and Wellbeing Directorate and BAVO has demonstrated the importance and effectiveness of the third sector in providing essential community services and support. This experience of how services have worked together during COVID-19 evidences the importance of strong foundations of partnership working with our statutory partners, our providers and third sector, and provides real evidence that our services are durable and able to respond effectively to very challenging situations.

At the time of finalising this document and in response to the COVID-19 pandemic, the Council are in the process of establishing a "Recovery Plan" for Social Services and Wellbeing to reflect the "new normal" that has to accommodate the anticipated ongoing challenges of COVID-19. It is not anticipated that this will impact on the desired changes required that are set out in this document. However the experience of COVID-19 has enabled the Council to grasp opportunities to change the way that services can be delivered and there is a determination that where this is of proven value, such changes will continue into the future and will be considered as part of the Directorate COVID-19 recovery plan. But it is also recognised that ongoing disruption caused by COVID-19 could well impact on anticipated timelines as new services may need to be prioritised to deal with the ongoing challenges.

SECTION 2: CHILDREN SERVICES

2.1 Context

2.1.1 Children's Social Care – Financial Context

Prior to 2015/16, Children's Social Care Services did not experience the budget reductions that were required from other Council services. This was largely due to historical budget overspends caused by the pressures of high levels of demand and increasing numbers of "Looked After Children". However since 2016/17, the increasing pressures on the council's budget has resulted in the need for Children Services to also consider how it can also deliver budget savings.

Children Services net budget in 2019/20 is £19 million, and the majority of its costs are allocated as follows:

- Staffing. Approx. 28% of net budgets
- Fostering allowances (Independent Fostering Agencies and Internal). Approx. 35% of net budgets
- Residential costs (Internal and Independent). Approximately 18% of net budgets
- Adoption service. Approx. 8% of net budgets

The fluctuating numbers and needs of "Looked After Children" has for many years placed significant pressures on Children's social care budgets and as a result the service has carried a significant overspend. However 2018/19 saw an improved budget outcome that can be attributed to the "Vision into Action" strategy (2016) that introduced a series of new approaches that were designed to deliver better cost effective services that improved outcomes for children. This strategy for the Remodelling of Children Services set out a vision and ambition for Children Services that would instil a change in Social Care practice so that it was better aligned to the Social Services and Well-being (Wales) Act.

2.2 Our Vision For Children's Social Care

Together enabling better outcomes for children, young people and their families via responsive and timely services which support them to live together, work on difficulties and be safe'

What we have done

Since 2016, Children Social Care has been remodelling its services so that services are based on delivering "Early Help" and effective permanence arrangements that are designed to improve and promote outcomes for children and young people in Bridgend. An Early Help strategy was developed in 2016 that was aligned to the priorities of the Authority's Corporate Plan. The strategy identified that its successful delivery was dependent on the strength of partnership working, Leadership and Management commitment and having a clear, robust and agreed framework from which to work.

The strategy set out an ambition for the Children Services as follows:

- Know which children need safeguarding
- Know which children need early help
- Help individuals, families and communities to help themselves
- Work in strong partnerships
- Swift, sensitive and effective intervention
- Understand how successful we are

The objectives of the strategy identified that "*The aim of early intervention is to prevent the needs of the children and families from escalating rather than to respond only when the difficulty has become so acute as to demand attention*".

Such objectives were in line with the Social Services and Wellbeing (Wales) Act for services to focus on preventative services that reduce demand. Nevertheless the Early Help strategy also identified that it would be based on a Thresholds of Need Model that is designed to inform professional decision making to maximise opportunities for the right level of support to be offered at the right time. This "Continuum of Need" means that a child or young person's needs are met in a proportionate, robust and timely way, improving life chances and keep children and young people safe. The thresholds should always be viewed as a clear and fluid continuum, responsive to changing circumstances and environments through which children may travel both down and up and will on occasion be accessing services across the continuum, as need determines.

The Continuum of Need is separated into levels of need as follows:

1. **UNIVERSAL:** At this Level, support is Universal which means that it is generally available to all children and young people such as schools, leisure centres, GP surgeries. Children and young people are making good overall progress across all areas of development. It is likely they live in a protective environment where their needs are well understood and met. These children need no additional support other than those universally available within public services

2a **ADDITIONAL:** Children and young people who need additional support this may relate to their health, educational or social development. Support is required to improve the chances of reaching their full potential if not identified and addressed at an early stage, these issues may escalate and become increased concerns under level 2b or 3 below.

2b **VULNERABLE**: Children, young people and their families have a range of needs. Multi-agency support is required to reduce levels of vulnerability and/or to reduce risk taking behaviours. If needs are not met then children's health, social development, or educational attainment may be significantly impaired. A Joint Assessment (JAFF) is required along with the appointment of a lead professional who will coordinate the support through the establishment of a Team around the family (TAF)

3. **COMPLEX:** Children with complex needs which appear chronic and enduring, these children are considered highly vulnerable or living in the greatest risk of adversity. The needs of many of these children and young people can be met through a Joint assessment and plan (JAFF) with a lead professional coordinating support. There will be occasions when a child or young person requires a STEP UP specialist assessment and support from a range of specialist agencies.

4. **ACUTE:** Children in need of immediate care and protection, this is the most urgent category and always requires an immediate referral to Children's Social Care. These are children and young people whose care is so compromised as to place them at risk of significant harm and potentially in need of a Child Protection Plan and all children and Young People already subject of a Child Protection Plan. This level includes children and Young People who are identified as a risk of becoming "Looked After" by the local authority. These children/young people will be subject to the STEP DOWN process once safety is secured.

These Continuum of Need categories will be used to structure the future Children Services Commissioning requirements as set out in sections 2.3 to 2.7 in this document.

Recruitment and Retention of Staff

In 2014, the service restructured and established teams within safeguarding hubs that are strategically aligned to the new team locality areas that they are designed to serve. These hubs work with Children and Young People in need of care and support, those on the Child Protection Register and those Looked After.

In addition, the Council has more recently renewed its Senior Management structure for Children Social Care to reduce duplication, clarify roles and responsibilities and ensure that the new structure is child focussed by design and the elements therefore work closer together to ensure that day to day decisions are better joined up to deliver the right outcomes for children.

In addition, the Council has invested in the development and training of staff which has seen improvements in recruitment and retention allowing the service to stabilise and develop. This has been underpinned by a Recruitment and Retention strategy that has been designed around four priorities that include:

- Priority 1: Ensure that newly employed Social Workers are well supported through their induction and probation period to enable them to complete their first year in practice.
- Priority 2: Strengthen retention capability by promoting a range of appropriate career development opportunities to both qualified and unqualified staff.
- Priority 3: Actively encourage staff engagement by promoting communication and acting upon feedback
- Priority 4: Promote a positive working environment and culture to support Social Work practice

Within each of these priorities, there are a range of related tasks, many of which are implemented and are being monitored to ensure that they are achieving the intended benefits.

However the recruitment and retention of the range of all Social Care staff that includes qualified, non-qualified and direct support staff is an ongoing challenge and the Council continues to seek new ways of investing into existing employees to assist their personal development, in an effort to ensure that staff are skilled and retained in their employment with Bridgend County Borough Council.

2.3 Universal Services: *are those services that are generally available to all children and young people such as schools, leisure centres, GP surgeries. Children and young people are making good overall progress across all areas of development. It is likely they live in a protective environment where their needs are well understood and met. These children need no additional support other than those universally available within public services*

What we have done

- Placed a focus on health at the heart of everything that we do
- Helped children and young people to develop healthy behaviours through their formative years
- Developed a programme of events under the "Getting Bridgend Moving" that include activities targeting children and young people
- Invested in early years and whole household approaches recognising the importance of the "First 1000 days" in a child's life
- Developed positive parenting programmes and partnerships with "Flying Start"
- There is growing engagement with primary and secondary schools, recognising their potential to contribute to Ageing Well in Bridgend, intergenerational working and the development of age friendly communities.

What else we need to do

- Continue to increase children and young people physical, mental and educational development
- Continue to work with schools so that they increase their contribution to Ageing Well in Bridgend intergenerational working and the development of age friendly communities.

2.4 Additional Services: *Children and young people who need additional support, this may relate to their health, educational or social development. Support is required to improve the chances of reaching their full potential if not identified and addressed at an early stage, these issues may escalate and become increased concerns and escalate to categories of more need.*

What we have done

The Council has established a range of Family Support Services in Bridgend which are referred to as Early Help Service which is situated in the Education and Family Service Directorate due to its close working with schools. The teams work with families identified as having additional needs that would benefit from a package of support using a preventative approach. The aim of the service is to prevent family situations from deteriorating or becoming more complex.

Referrals for these services are accepted through a 'one front door' route from numerous agencies including schools and by self-referral.

The service provision involves assessing family need and providing the necessary support to meet these needs from within the team or through other available services. Bridgend Family Support Services now revolve around Early Help hubs set in three locations across the authority using a 'team around the family' approach. In addition, there is a central hub which offers a range of specific family support services across the whole of the county borough.

Each Early Help locality hub consists of a family support team made up of:

- Family Support Workers
- Family Engagement Officers
- Education Welfare Officers
- School Counsellors
- Lead Workers
- Parenting Workers

The central hub contains specific services such as the Connecting Families team who offer intensive family support to families open to Children's Safeguarding Teams. Other services include Flying Start and the regional Western Bay Integrated Family Support Service.

An outline of the roles and services provided is detailed below:

Education Welfare Officers: Education Welfare Officers have a statutory responsibility in addressing issues of poor school attendance in both primary and secondary schools. Their base within locality hubs means that Education Welfare Officers can act as a gateway to accessing additional early help services, with the aim of overcoming barriers to school attendance.

School Counsellors: Provide therapeutic one to one counselling within school settings to comprehensive school children. Counselling is also available to children in Year 6 in primary school; this is delivered from a central, community based location.

Lead Workers (Inspire 2 Achieve): Lead workers work with comprehensive school pupils at Key Stages 3, 4 and post-16, who have been identified as being 'at risk' of becoming not in education, employment or training (NEET), when compulsory education ends. Lead workers deliver a range of formal and evidence based interventions on an individual and/or group basis to reduce barriers to engagement in education. They also work in partnership with Careers Wales to support young people to identify, and secure, their preferred post-16 destination.

Family Engagement Officers: Family Engagement Officers work with children of primary school age to provide early intervention and prevention support to families of children with low attendance/attainment and with behavioural support needs. Support can be delivered in a school or community setting, and can involve group-based learning programmes, as well as individual support.

Parenting Worker (Flying Start): Parenting workers work within Flying Start areas to provide direct support and advice to children, and their families, assisting in the delivery and support of devised programmes of support including the delivery of evidence based identified parenting programmes.

Family Support Workers: Family support workers act as key workers to assess unmet needs, devise and coordinate support plans and ensure that families are in receipt of the most appropriate support services to meet those needs. The aim is to prevent or minimise the risk of needs escalating. Family support workers also provide direct support and advice to children, and their families, assisting in the support of community-based interventions.

Inspire 2 Work: Employability service for young people (16 to 24 years old) who are NEET and looking at developing self-esteem, confidence for education, training and/or employment opportunities. Participants are also able to access a range of formal and work related qualifications to enhance their CV and employment prospects.

Youth Mental Health Team Mental and/or emotional health and wellbeing support for young people aged 11 to 24 years old living in the county of Bridgend. Provision of tailored support for identified needs around:

- Eating disorders

- Acute mental/emotional health and wellbeing concerns
- Youth offending
- Co-occurring mental health and substance misuse issues

Youth Housing Support Team: Early identification and intervention service that aims to prevent homelessness, increase the resilience of those we work with and energise opportunities for employment, education, training & volunteering.

Children's Rights and Participation Team: Working with young people to participate in the Youth Council. Also delivering tailored workshops on United Nations Convention of the Rights of the Child (UNCRC), children's rights and the new Participation Standards.

Play Therapy: Counselling service for children aged 4-10 years

Community Counselling: Youth counselling service for 11-25 year olds.

The purpose of the early help service is to prevent the needs of the children and families from escalating rather than to respond only when the difficulty has become so acute as to require input from Children's Social Care. The service therefore is intended to:

- Improve outcomes and life chances for children, young people and families placing the well-being of the child / young person at the centre of all that we do.
- Increase access to timely, targeted and appropriate services.
- Manage highly predictable risk better (e.g. parents who have been in care themselves and parents who have previously had children removed.)
- Refocus resources and expenditure from crisis intervention to early help, investing in proportion to need.
- Provide a focus on the whole family and the role of the family in the planning and delivery of early help.
- Ensure interventions have a strong evidence base and any services commissioned are able to evaluate and demonstrate impact and outcomes.
- Further develop multi-agency and integrated working, including using and sharing data and information more effectively.
- Strengthen the role of universal services provision in early help.
- Communicate the early help offer and how it can be accessed
- Develop skills and management support/supervision for early help workers

What else we need to do

- To continually develop the service so that it plays a pivotal role in the provision of Information, Advice and Assistance. This will ensure that contacts and referrals to Children's Social Care are dealt with appropriately by the right level of service at the right time. In addition the service will continue to deliver its strategic plan that includes:
    - High quality universal and additional services are the building blocks of effective early help.
    - Childrens workforce is able to identify additional needs at an early stage.
    - To review the service directory to ensure that it assists the children's workforce to have a clear understanding of how services are designed to support levels of need, and how all services, including those provided by partners, can be accessed.
    - There is a clear process in place to support effective multi- agency co-ordination of targeted support.
    - There is a clear Step Up and Step Down process in place.
    - A co-ordinated delivery programme of early help services and support across all ages and stages of a child's development.

2.5 Vulnerable Services: *Children, young people and their families have a range of needs. Multi-agency support is required to reduce levels of vulnerability and/or to reduce risk taking behaviours. If needs are not met then children's health, social development, or educational attainment may be significantly impaired. A Joint Assessment (JAFF) is required along with the appointment of a Lead Professional who will coordinate the support through the establishment of a "Team Around the Family" (TAF)*

What we have done

- Bridgend has established a Multi-Agency Safeguarding Hub (MASH) that became fully operational in July 2018. In addition to Social Workers, Public Protection Safeguarding Nurses and Police Officers, the MASH also includes a Child and Adolescent Mental Health Service professional as part of the Information, Advice and Assistance Service. This individual assists with the assessment of children who are displaying mental/emotional vulnerabilities at the point of initial contact. The Public Protection Safeguarding Nurses (PPSN) work collaboratively with partner agencies across health, social care and others to safeguard children and adults and promote their welfare at a local level, providing consistent health input to the MASH. They also assist, support and advise health staff to recognise

their responsibilities in relation to safeguarding children, adults-at-risk, Deprivation of Liberty Standard (DoLS) and domestic abuse and to support them to plan, deliver and evaluate appropriate interventions. The PPSN will plan and deliver the training programme around safeguarding children, adult at risk and domestic abuse to Health Board staff and assist in the delivery of multi-agency safeguarding training with partner agencies. A Social Navigator also sits within the MASH concentrating on navigating our teams and clients to support activities, information and advice in the voluntary and community sector. The post is pivotal in promoting and supporting the use of the voluntary sector in meeting the health and well-being needs of people in the county borough. Work will be undertaken with young people and their families to:-

  - increase understanding of choices people have;
  - support and empower people;
  - improve social and emotional wellbeing of people;
  - promote independence; and reduce social isolation, loneliness and exclusion.

- The Advocacy for Children and Young People service has previously been commissioned through a regional (former) Western Bay contract led by Swansea Council. However the move from Bridgend to Cwm Taf Morgannwg Region has led to the development of a new commissioning arrangement with Rhondda Cynon Taf County Borough Council as the lead contracting authority. The new arrangement means that Children and Young Person's Independent Professional Advocacy Service remains in place with a local provider.

Integrated Family Support Service (IFSS): The aim of the IFSS is to keep families affected by parental substance misuse together by empowering them to take positive steps to change and improve their lives whilst addressing any safeguarding concerns. Using evidence based interventions we aim to bridge the gap between children and adult services across Local Government, non-statutory sectors and health partners. The IFSS Service is designed to support a range of needs as follows:

- When there is a parental drug and/or alcohol problem in the family
- Families (with children at home) are in a crisis and there is a risk of the children being placed on the Child Protection Register.
- Where there is a reunification plan that IFSS may contribute to

- Expectant parent(s) where there is identified substance misuse
- Offering support in the community for young people at risk of sexual exploitation, requiring sexual health advice and substance misuse support.
- Rapid Response Service designed to work with children and families in a crisis situation to prevent the child from becoming Looked After. This service includes 2 Rapid Response Workers who work with children aged 0-18 years.
- Intensive Whole Family Support is offered to children and families either early in mornings, during day time, evenings and on weekends where required. The aim of the service is to prevent children becoming known to social services, prevent children's names from being added to the child protection register, prevent children from becoming Looked After and for those that are, increase the number reunified with their family in a timely way.

Connecting Families: Family Support Workers offering intensive interventions to children and families known to Children Services Teams. The focus of the work is around prevention of children becoming Looked After, reunifying families where this has been a necessity and delivery of parenting groups including:

Non Violent Resistance – Parenting programme for children who are displaying challenging and aggressive behaviours.

Incredible Years – Parenting programme for younger children exploring attachment, routines, boundaries and play.

Grobrain – Early years programme for parents with babies looking at secure attachment, interactions and play.

Connecting Dads – a programme for fathers looking at their role as a Dad and the importance of this.

Chill Out Group – Group for teenagers looking at anxiety and stress management and strategies to deal with this.

Baby in Mind Service, a service for families where unborn babies are at risk of becoming looked after at birth. This service was developed in response to the high number of babies aged 0-2 years in the care system and the associated high costs of Mother and Baby placements. The service includes a Consultant Social

Worker, a part time health visitor, 2 family support workers to work with families where mothers are under 26 weeks pregnant where Social Care have deemed the child to be at risk of entering the care system. The support for families will focus on addressing these concerns and working intensively with the aim of keeping the child within the family.

Bridgend has already developed a Regional Reflect service with Rhondda Cynon Taf and Merthyr CBCs which is delivered by Barnardos. This project works with mothers who have had children removed from their care to prevent any further pregnancies which may lead to further statutory intervention. The development of this project is in its infancy and will be reviewed and developed as necessary.

The Youth Justice Service sits within the Education and Family Support Directorate in Bridgend. There is a joint statement in place with Children's Social Care around the principles of working between the two services. The aim of this agreement is to ensure there is clarity on roles and responsibilities of both services and how the two services will interact to ensure children and young people's needs are met safely and consistently. Both services are committed to working in partnership towards the prevention of offending by children and young people as detailed by the Crime & Disorder Act 1998 and to safeguard and promote the welfare of children as detailed in the Social Services and Wellbeing Act 2015.

What else we need to do

There are ongoing challenges for early help services in responding to this demand and with the newly developed processes within children services. Bridgend will continue to explore and develop additional innovative ideas and maximise the potential that exists within existing services. In addition other service developments are ongoing and include:

- **Reunification and Practice Support Workers:** A service has recently been introduced that is targeting a reduction in the number of breakdowns of Foster Care Placements. This followed a review of support services for children and young people in March 2018 which identified gaps in service delivery. This included a need for support for children in the care system whose foster placements are at risk of placement breakdown or require support to Step Down in terms of placement provision or to be reunified into the care of their birth family. Historically our edge of care Rapid Response Team (RRT) has been called upon to work on these type of cases, this had meant that the RRT had less opportunity to prevent

children from coming into the care system. Therefore to increase capacity the Reunification Support Workers are being introduced.

- **Family Support Workers**: The introduction of the Early Help service and associated "Hubs" has seen a significant increase in service demand. Therefore in order that more cases are prevented from escalating, additional Family Support Workers are being introduced to work with families.
- **Advocacy:** To continue to maximise the use of the Advocacy service through the implementation of the "Active Offer" to ensure that all children receiving statutory care and support intervention are provided equal access to an Advocacy service.
- **IFSS Service:** The IFSS is required to be developed further. In particular the increasing number of referrals into the service is stretching the existing resources available, and Welsh Government has issued further guidance in respect of the criteria for IFSS in which the service could work with families affected by domestic abuse and mental health issues as well as parental substance misuse. Bridgend is evaluating this guidance to ensure that the service is upskilled to respond to these issues.

2.6 Complex and Acute Services:

Children with complex needs which appear chronic and enduring, these children are considered highly vulnerable or living in the greatest of adversity. The needs of many of these children and young people can be met through a Joint Assessment and plan (JAFF) with a lead professional coordinating support. There will be occasions when a child or young person requires a STEP UP specialist assessment and support from a range of specialist agencies.

Acute Services: Children in need of immediate care and protection, this is the most urgent category and always requires an immediate response from Children's Social Care. These are children and young people whose care is so compromised as to place them at risk of significant harm and in need of a Child Protection Plan and all children and Young People already subject of a Child Protection Plan. This level includes Children and Young People who are identified as a risk of becoming "Looked After" by the local authority. These children/young people will be subject to the STEP DOWN process once safety is secured.

What we have Done

The Multi Agency Placement Support Service (MAPSS) has been established across the former Western Bay. This is a multi-disciplinary team that aims to help children with, or at risk of mental illness and emotional and behavioural difficulties by providing specialist placement support. The creation of the service was driven to improve the mental health and emotional wellbeing of "Looked After Children" with particularly complex needs needing carers who are resilient enough to provide them with a stable base from which to start to understand their story and start to develop positive relationships.

Residential Accommodation

A significant development for Children Services has been the introduction of a new Model to the traditional Local Authority provision. Previously our residential accommodation consisted of three units being:

- Bakers Way: disabled children's respite service,
- Newbridge House: transition unit for 16/17 year olds
- Sunnybank: Complex needs unit for 11-15 year olds

The remodelling has resulted in the creation of a "Hub" (Maple Tree House), which is designed to provide support in a time-effective way in order to facilitate move-on to one of the other placement options within the model. Maple Tree

House consists of a four-bedroom assessment facility with a separate two bedroom emergency provision The Hub aims and objectives are as follows:

AIMS

- Maple Tree House provides care and support for up to six children / young people within the age range 8 – 17 years (mixed gender) at any one time. This consists of four placements within the assessment facility and two within the emergency provision.
- Admissions to Maple Tree House are made via referrals from the Councils social care teams. The Placements team co-ordinate planned admissions during office hours, out of hours placements are managed by senior staff and the Emergency Duty Team.

OBJECTIVES

- To undertake assessment and provide therapeutic intervention by appropriately qualified staff. Models of intervention will assist to stabilise the child's / young person's behaviour to facilitate a return home or where this is not possible to a suitable alternative long-term placement.
- To have in place for each child / young person a care and support plan and a behaviour management plan so that any challenging behaviour is consistently managed. Wherever possible, unless there is risk of harm, staff will use de-escalation techniques providing trauma informed care and support.
- To support young people's education, training or employment, to maximise opportunities.
- Vocational outreach workers will support young people who are not in full time education or employment, working in line with the young person's education plan.
- Staff will work in partnership with young people, carers and parents/persons with parental responsibility.
- To provide outreach support to children / young people, families and foster carers.

In addition, Sunnybank has been developed into a Medium-term Unit by utilising a detached two storey house with space for four young people to be accommodated. The aim of this service is to "to offering a stimulating, safe

caring environment that promotes a holistic approach to all aspects of the child/young person's life". The objectives of the service are as follows:

- •Providing children/young people with an individualised package of support that focuses on their assessed needs.
- Offering children/young people therapeutically informed interventions to assist them in achieving personal well being
- Assisting children/young people to explore their own issues and experiences and work through any emotions and feelings which may become a barrier to a stable placement and future accommodation.
- Providing appropriate levels of support that recognise, value and encourage children/young people to maintain personal skills and competencies and promote their confidence and self esteem
- Providing a comprehensive package of educational support to promote the best possible outcomes for children/young people within their educational setting
- Working closely with families or substitute families to ensure that when children/young people return home or go to other suitable placements, adequate support via a transition plan is given to both the young person and their family to ensure success.
- Provide age appropriate independent living programmes to assist young people to be able to develop the necessary skills to enable them to, if appropriate, live independently. Young people based at this home would also have access to the Hub, including the therapeutic interventions and Vocational Outreach Workers.

The services described above were created following an extensive review of children's residential provisions within Bridgend. Maple Tree House was developed with the aim of working with young people to assess their needs to support consideration of where their best long-term placement needs could be met. The home provides in-house therapeutic services and emergency beds which are a less costly alternative to other specialist residential provisions. In addition there are cost saving benefits by maintaining young people within Bridgend provisions, lessening the need to accommodate with high-cost Out Of County placements. The development of the service aims to reduce costs associated with other similar placements in future years.

The Council has also prioritised the development of local solutions to support children by bringing children and young people back from high-cost out of county placements, currently placed at an average cost of £160,000 per annum. This has resulted in significant numbers of children being relocated within the County Borough normally at a reduced cost, which has contributed significantly to the achievement of financial targets. When compared to costs within the new 'Hub model', each placement made in the 'Hub' when compared to an out-of-county placement generates a saving/cost avoidance of circa £60k per child each year. The creation of Hub Models has not only increased the range of internal services available to meet the needs of children, but the service has also proven to be cost effective and ensured that children are cared for closer to their communities and have easier access to their social worker as appropriate.

The Council has also developed models of Supported Living Accommodation that enables children's services in providing Step Down accommodation for "Looked After Children" residing in placements before they turn eighteen. Previously care leavers were only able to access supported accommodation through the Homelessness pathway. This process made it difficult for Social Workers and young people to plan ahead and added additional pressure on the Homelessness service.

To overcome this problem, a pilot project was developed and operated for almost twelve months during 2018/19 and has accommodated and supported a range of individuals and circumstances that include:

- placement breakdowns;
- homeless 16/17 year olds requiring a joint assessment;
- transitioning Out of County Placements back into Bridgend; and
- supporting move on to more independent settings

The pilot project provided 4 supported accommodation beds and has been evaluated and proven that the model assists care leavers considerably to adapt to independence and to provide time to find suitable longer term accommodation.

Consequently the Council agreed to extend the service by commissioning two providers to deliver a total of 7 "Transitional" Supported Accommodation beds, in addition to 4 "Step Down" beds. This provision is designed to support young people with flexible staffing support to "Step Down" from care environments where they were previously provided 24 hour care support. It is intended that such accommodation ensures we support care leavers to move onto more

permanent and independent housing accommodation and prevent them from becoming homeless.

Bridgend Foster Care assess, recruit and support a wide range of carers including general foster carers, relatives, Parent and child, transitional Family Link, Supported Lodgings and When I'm Ready households. They also have a small team who coordinate placements and commissioning. This area of service continues to experience challenges in relation to the lack of placement choice locally in house and with Independent providers. Despite this the teams are committed to matching children with the most appropriate carers with the overarching aim of achieving stability and minimising disruptions. Bridgend foster care has also further developed their recruitment campaign in conjunction with the marketing team. The service follows robust assessment processes and is required by fostering regulations to undertake a range of references/checks in addition to comprehensive interviews with the applicants themselves which normally take at least 20 hours. Applicants must also attend a bespoke three day training 'skills to foster' course.

The ability of the Bridgend Foster Carer Service to better support an increasing range of needs has seen it develop new services. The "mother and baby service" is an innovative approach to the demand for high supervision of parent and baby, forming part of the parenting assessment completed by the safeguarding team within proceedings. It can be a direct alternative to residential or can be a preferred resource in in its own right. We currently have 2 carers who have been recruited and train within this specialism. This has proved to be a cost effective service, which is now sited within the fostering team. We expect to recruit further carers within the next phase of recruitment. During this financial year we have provided a placement to another authority which has generated income.

A further important development has been the introduction of "Transitional Carers". The transitional carers are experienced short term carers who have a therapeutic approach to parenting. They have close working relationship with both fostering and residential, providing a step-down transitional placement for children currently in residential care. The role of the carers is to use their parenting skills as part of a multi-disciplinary team to prepare children for transition to a permanent placement, this might be within fostering or reunification to family.

We have also created Harwood House which is a high quality residential Looked After Children service for up to three children/young people with complex needs

including a learning disability aged from eight to eighteen years; and are enrolled in Heronsbridge School. The service is located within the grounds of Heronsbridge School enabling ease of access for the children to the school, and promoting contact with parents/carers and multi-agency professionals involved with the children. The aims and objectives of this service are:

AIMS

- At Harwood House we are committed to providing a high quality 52 week residential service for up to three children/young people with complex needs, including a learning disability, aged from eight to nineteen years (nineteen age limit applies to any young person with Additional Learning Needs.) Children/young people are usually enrolled in Heronsbridge School.
- The service is located within the grounds of this school enabling ease of access to the school for the children/young people. In addition, fostering a close liaison between staff and a shared understanding of the complex needs of the children/young people and consistency of approach in working with the children/young people which support better outcomes.
- The service enables children/young people with complex needs who are unable to reside with their families to continue to attend their specialist school and remain living locally to their family, friends and school.

OBJECTIVES

- To assess each child/young person's needs before the service commences, to develop an individualised package of care and support that focuses on their needs and to review it regularly.
- To introduce children/young people to Harwood House at their pace, through a series of familiarisation and tea-time visits, prior to moving in.
- To offer children and young people interventions to assist them in achieving their personal outcomes. To meet each child/young person's emotional, social, behavioural, health and developmental needs during their placement, in a way that ensures their dignity and promotes self-reliance.
- To provide a homely relaxed environment within which children/young people are encouraged to achieve their personal goals and individual potential.

- To support all children/young people to make good use of all community based resources, thereby promoting social and economic inclusion.
- To provide a comprehensive package of educational support to promote the best possible outcome for the children/young people.
- To assess the child/young person's level of life skills and to develop these skills through an individual living skills assessment programme. Providing support through transition planning through to adult social care.
- To consult with children/young people, parents, carers, social workers and other professionals so that the service continually adapts and develops.
- To resolve issues for children/young people and parents promptly, and to address concerns wherever possible, with the residential manager and social worker.

As a result of these accumulative developments:

- Numbers of children being placed into out of county accommodation have been greatly reduced.
- Numbers of "Looked After Children" has reduced over the last five years from 412 in 2014 to 381 in 2019. In addition the numbers becoming "Looked After" by monthly average has also reduced from 12.2 per month in 2013/14 to 7.7 in 2018/19

The requirement to establish Regional Adoption arrangements across Wales has resulted in Bridgend receiving its Adoption Service from the former Western Bay Region (now West Glamorgan Region). The sustainability of this arrangement has been reviewed in light of the recent transfer of Bridgend from the former Western Bay region to the new Cwm Taf Morgannwg region. The findings of the review concluded that the current regional Adoption arrangements should continue, which means that Bridgend will remain with the former Western Bay Region. However it was also recommended that these arrangements only remain in place for a minimum period of three years during which time, there is consultation with stakeholders and early planning for the longer term.

What else we need to do

- Finalise our placement commissioning strategy
- Progress a more suitable and sustainable site to build and embed the hub provision
- Work with partners in the new Cwm Taf Morgannwg Region to develop and introduce a MAPPS service to the benefit of the Region, whilst

ensuring all services commissioned under the current arrangement with our former MAPPS partner, (which ends March 2020) continue.

- Develop closer working with other Council services and in particular Housing services in order that Housing needs are identified and housing strategies are developed.
- Fully implement the Supported Accommodation solutions and ensure the service delivers the intended outcomes.
- Further develop accommodation and placement opportunities for children and young people by greater collaboration with partners such as health and housing
- Consider how children's therapeutic needs can be met through further developing in-house provision. Continue to have discussions with current therapeutic providers with a view to 'securing a menu' of bespoke options, which meet the individual needs of children within a common model or framework.
- Consult with stakeholders on the most appropriate Adoption arrangements provided to Bridgend and to plan for their longer term provision

SECTION 3: TRANSITION SERVICES

The Transition stage of when a child moves from childhood into adulthood is a very important stage in a young person's life because they need to make plans for their future care arrangements which will help them live as independently as possible. Therefore, transition of children with support needs requires their care packages to be carefully planned to ensure that they receive appropriate services required to maximise independence and to support them in achieving their desired outcomes.

Without the joined up management of transition of care, there is a real risk that young people will leave Children's Social Care without effective planning to support their transition into adulthood. As a result the continuity of care will be disrupted and even paused, or alternatively the provision of an inappropriate care package which can cause inconvenience and disruption to both the cared for and their families and carers.

Whilst Bridgend CBC has operated a transition panel that met regularly to agree transition pathways for individual children and young people, the introduction of a transition team was identified as the preferred long term approach. In 2014, Bridgend was a member of the Western Bay Region and the regional Learning Disability Programme Team had identified the difficulties with existing Transition arrangements in the region, and commissioned a piece of work to develop a service model for young people in transition from children's to adult's services in the Western Bay region. The report was produced in July 2014 and the programme team agreed with the recommendation to develop an integrated multiagency transition team in each local authority area.

Consequently the Directorate created a Business Plan aim which identified the need to "*Develop an appropriate service model for children in transition from childhood to adulthood, including children with disabilities and children leaving care*". Consequently a working group was created which developed a proposed operating model and a set of values that include:

- Each young person experiences smooth and timely support to prepare for adulthood so that they are supported to meet their outcomes appropriately;
- Each young person is involved in the process, contributes their views and wishes, and has as much choice as possible about the future outcomes they hope to achieve and how they will be supported in this;

- The parents or carers of each young person are involved in the process as partners, and have clear and early information about how the transition process works and what the options may be for the young person;
- Adult Social Care receive sufficient advance notice of young people whose needs they will be responsible for meeting, so that financial and other planning can be undertaken in time. Having a sense of the "time line" relevant to each young person preparing for adulthood and to the agencies that will need to plan to meet their needs. Without this, work may not be well planned or start early enough.
- Working in as "joined up" a way as is possible with all other agencies, departments and with the young person and their parents. This means working together so that, wherever possible, separate assessments and planning processes can be combined, run together, or at the least, cross-referenced;

A project was developed to create a “pilot” transition team, which was dependent on additional Funding that was acquired from the regional Integrated Care Fund. This team was introduced in 2018 as a pilot and a Performance Management Framework was developed to evaluate its impact and effectiveness.

Traditionally, whilst there were processes in place between Children Services and Adult services to identify children that would transition into Adult Social Care, the arrangements were not always joined up and the transition for children was found at times to be problematic. Therefore the progress made with developing a new service that bridges Children’s and Adult’s services, provides a real example of how the Directorate is bringing together services to jointly solve service improvements by working closer together to the benefit to the residents of the County Borough.

What we have done

- Established a Transition Panel that consists of managers from Adults and children services that has provided a mechanism that monitors and plans for children in Transition
- Held workshops to consult with key stakeholder to identify a range of issues and problems that needed to be addressed to improve support for young people through the Transition process and into Adulthood, and inform the development of the new and improved service.

- Created a pilot Transition Team that allowed social workers from Adults and Children Services to work together. The pilot team was created by utilising existing resources.
- Operated the pilot from October 2018 to March 2019 and undertook an evaluation of the learning which evidenced that there is a need to establish the team by removing the virtual nature of the team and placing the Transition Team within the Children's structure.
- Identified how referrals should be managed between teams by confirming the role of the Transition panel that is designed to ensure that referrals into the Transition Team and from the Transition Team to Adult Services are appropriate.
- Developed a series of Short, Medium and Long Term Recommendations that include:
    - Short Term (3-6 months). Create a Transition team in its own right within BCBC.
    - Medium Term (4-8 months). Develop a strategic plan for a multi-disciplinary team in partnership with Cwm Taf Morgannwg Health Board.
- Developed an Accommodation Action Plan that identifies the need to have effective transition planning for "Looked After Children" accommodation needs as they approach Adulthood. This includes the development of a range of Supported Accommodation options for care leavers that support "Step Down" accommodation for Care Leavers

What else we need to do

- The Directorate Transition Project Board will continue to oversee the implementation of the "Child Disability and Transition Team" and ensure that its creation delivers the anticipated benefits.
- Establish ways to engage with Education and Early Help services with the long-term goal of them being virtual members of the transition team. This engagement will attempt to ensure that transition is not seen as a social services only issue, but to ensure that services are better joined up and delivered holistically.
- Discuss and agree with Cwm Taf Morgannwg Health Board how they can be engaged as appropriate to jointly work cases in transition and ensure

that children and adults are provided effective and equitable specialist health services. This also includes children's access to appropriate mental health services as required.

- To develop a Commissioning Model that is supported by the development of a "pooled budget" made up of budget from Adults and Children services in order that services are better designed to meet the needs of young people in transition.
- To continue the previous regional vision that was developing in Western Bay with Cwm Taf Morgannwg region to ensure that potential benefits to support transition services that could be achieved by a collaborative approach are identified and implemented as appropriate.

SECTION 4: ADULT SOCIAL CARE

The Commissioning Plan for Adult Social Care produced in 2010 set out Bridgend County Borough Council's intentions for modernising adult social care over ten years. The plan described how the Council would contribute to the wider health and wellbeing agenda by promoting independence and choice for vulnerable adults living in the County Borough. At the time the intentions were ambitious and the following presents a summary of what was said should happen, progress to date and what needs to happen next. This report will be structured around the following headings:

1. Our Vision For Adult Social Care
2. Adult Social Care Financial Pressures
3. Enabling Approaches
4. Preventative Approaches
5. Specialist Preventative Approaches
6. Integrated Living
7. Interventionist Approaches (including Specialist Interventions)

4.1 Our Vision for Adult Social Care

To actively promote independence, wellbeing and choice that will support individuals in achieving their full potential"

(Social Services and Well-being Directorate Business Plan 2019-20)

To achieve this vision will require the Council's Social Care Services to promote the principles of choice, independence, empowerment, opportunity, dignity and respect. It will involve safeguarding vulnerable people and developing preventative approaches to ensure that people receive the most appropriate level of assistance at any time to avoid the need for long term support from statutory agencies.

We aim to achieve this vision by focussing on the following key principles**:-**

Empowering service users and carers - We aim to develop a person- centred approach responding appropriately to a person's needs and preferences. We aim to support a person's right to maintain, support or restore as appropriate their independence whilst recognising their rights to exercise choice and control over any decisions which affects their lives. Fundamental to this is protecting such people from physical, sexual, psychological or financial abuse and neglect. We also aim to acknowledge and support the role of carers so that they can continue performing their caring roles.

Promoting independence - We aim to establish integrated, inclusive and seamless advice and assistance that promotes positive outcomes for vulnerable people. This approach will involve flexible and accessible preventative responses within local communities which are tailored to individual circumstances and choice. This approach will focus on assisting people to identify the risks to their independence, and jointly determining strategies to minimise that risk as appropriate.

Improving commissioning approaches - We aim to make the most of the opportunities afforded by Regional working and integrated working with the Cwm Taf Morgannwg Health Board and other local authority partners to ensure services are cost effective and are continually developed and designed around effective Integrated services. We aim to identify, plan and develop joint approaches for maximising our effort to improve the health, social care and wellbeing of the local population within the resources available to us. We will also continue to work closely with the Third Sector to identify opportunities for the sector to provide services as appropriate. Adopting this approach may mean changing some things that we currently do in favour of new and better advice, support and assistance.

Co-production and commissioning: We will develop our commissioning processes so that they are better aligned to the co-productive approaches. For example:

- **By commissioning for co-production** – We will deliver Commissioning principles of co-production to be reflected within the services we purchase. In this context we will ensure providers from whom we commission services encourage and enable the involvement of all people in designing services and how they will operate to deliver personal outcomes. Providers will also be expected to involve people in evaluation and review processes.

- **By co-producing commissioning** – we will develop processes where people are involved in commissioning from the very beginning. This includes involvement in the assessment process (whether at an individual level or as part of the wider population assessment), agreeing what needs to be transformed so that services can improve people's lives, co-designing services and taking part in reviews and evaluations. In these examples, the commissioners themselves are involved in the co-production process and they involve people using services and carers in commissioning from the outset.

Shaping the market - We aim to build on our current partnerships with providers and consolidate effective working relationships by establishing more robust contracting processes. The aim is to involve providers in a positive way to participate in planning and commissioning to help drive up quality and improve value for money. We will work co-operatively and be both transparent and flexible so that we can establish a more financially affordable mixed economy of care; improved quality responses and outcomes for service users, and greater employment opportunities for local people.

Promoting workforce development - We aim to work in partnership with the private sector, voluntary sector and key stakeholders to promote a whole sector workforce approach within the local market. We will assist adult social care staff to become appropriately skilled, trained and qualified to perform the range of responses and functions required in the future. We will also target funding that sustains the adult social care employment market and improve staff recruitment and retention arrangements.

Better responses - We aim to develop frameworks which focus on quality, best practice and meeting expectations of people who use our services, carers and key stakeholders. Our contracting and quality frameworks will strive to promote choice, independence and empowerment, as well as looking at who is most suitable to supply advice and assistance to best meet individual needs. We will ensure that the services we buy demonstrate value for money, economic viability and their ability to demonstrate continuous improvement. We will also have effective arrangements for monitoring and review with a particular focus on addressing inequality of access and positive outcomes for people.

In October 2019, the Care Inspectorate Wales undertook an inspection of the council, with its partners to explore how well it promotes independence and prevents escalating needs for older adults for older adults". Overall the report confirmed many positive aspects of available services. The Inspectorate published a report in January 2020 which commented on how the "council's

vision for Adult Social Care is very well embedded". The Inspectorate also found good health and social care services…..that benefits people through quick decision making and a joined up approach". In general the review was positive but inevitably the inspectorate found areas of service in need of improvement and recommendations were made that have been included as appropriate in this document.

4.2 Adult Social Care – Financial Pressures

The prolonged financial cuts and challenges that local authorities have faced over recent years has resulted in Bridgend reducing Adult Social Care budget by 27% since 2013/14. This has resulted in actual savings being identified as being in the region of £10.7 million. This further reduction doesn't take into account other financial pressures such as funding staff national living wage and other service pressures such as the funding of increasing complexity of need for LD and other clients and therefore the real financial pressures are even greater. Such Financial reductions has been a challenge but have also provided the opportunity to accelerate the development of new ways of working that has contributed to the transformation required.

However the contribution of Grant funding such as the Integrated Care Fund (ICF) and more recently the Healthier Wales Transformation Fund cannot be underestimated as ICF in particular has provided essential funding that supports the delivery of some of the most essential services in Adult Social Care. The use of ICF and the development of the Transformation Funding proposals has proven to be a critical financial enabler to the development of essential Integrated services which has required close working with the former ABMU Health Board that has continued with Cwm Taf Morgannwg Health Board in order that Bridgend can work collaboratively to deliver effective and affordable services that are sustainable in future.

4.3 Enabling approaches

We believe enabling approaches will provide people who are not familiar with the adult social care system, to navigate the system and make better-informed decisions about the type of assistance they need. The provision of a range of enabling approaches that assist people to self-manage their own support needs will lead to greater independence and fulfilled lives. This requires us to design services that are influenced by positive risk taking in order that whilst we recognise the potential of risk, we provide services that are designed to be safe

and encourage enabling approaches in the achievement of individual outcomes. In our model of assistance and support we have identified a range of enabling approaches.

Services that were identified as being enabling services include:

- Information and advice
- Advocacy
- Citizen directed support (Direct Payments)
- Carer and family support

The following presents: What we said we would do (as stated in the 2010 Adult Social Care commissioning plan): What we have done and What else we need to do next.

4.3.1 Information and Advice

What we said we would do:

Information and Advice - to improve signposting and information about support options to enable people to continue self-managing their own needs.

Desired outcome:

Increase level of advice and information available about promoting good health and social wellbeing to equip people to make informed lifestyle choices and to get help, assistance and protection should it be required.

We propose to:

- operate help-lines and a single point of contact arrangement for people to access information and advice based on an integrated multi agency approach linked to the Unified Assessment Process.
- provide a greater resource of accessible information for general public consumption and rationalise signposting activities so that people can be empowered to successfully navigate around social care health and Third Sector systems to obtain the information they require.
- raise public awareness and understanding of disability and mental health issues and other social care issues and to assist in the promotion and implementation of the Council's Public Information Strategy.
- provide a web site that is suitably linked to other appropriate web sites so that innovative ways of making information available within local communities can be developed and explored.
- work with partners to develop an accessible interpreters service.
- signpost people to the most appropriate providers of information, advice and support to assist them to make informed decisions about the difficulties they are encountering.
- maximise people's income so that they are able to participate as much as possible in their communities.
- work with internal and external partners to develop stronger links with voluntary and community based services in order to create opportunities for people to access locally based services which foster a community spirit.

What we have done

Bridgend Adult Social Care has established a Common Access Point as a single point of access for Adult Services with the exception of Learning Disability and Mental Health services.

The introduction of the Act replaces the previous requirements of Unified Assessment Process and required local authorities to secure the provision of service for providing people with information and advice relating to care and support, and assistance in assessing care and support. This requirement resulted in Bridgend developing their Information and Advice service by utilising available systems such as DEWIS which has enabled the authority to make use of technology. However the provision of Information and Advice should not be restricted to contact with social services, and more needs to be done to ensure that information and advice is consistently provided over a range of information centres within and across communities including those provided by the Third Sector. The provision of Information and Advice continues to challenge all local authorities across Wales and the ambition is that Information and Advice service continues to be developed to ensure that available information is consistently provided to citizens

The Council has also supported the introduction of three Local Community Coordinator roles in the Ogmore, Garw and Llynfi Valleys. The model is founded on the Local Community Coordinator roles supporting a population of 8,000 - 12,000 people, supporting people to find solutions through community or family resources and to reduce isolation. The focus is on developing resilience within vulnerable individuals and connecting them into supportive, community based opportunities. The Council is working closely with the Bridgend Association for Voluntary Organisations to assist in the development and delivering of resilient communities.

To support Mental Health services, an information and signposting service for the public who can either be directed by GPs or can attend one of a number of drop in information clinics throughout the Borough. This service assists in identifying where specialist assessments are required and through the Assisted Recovery in the Community (ARC) team of support workers and Occupational Therapists who work closely with psychological therapy staff, and can provide a range of needed interventions.

What else we need to do

- Give people more choice and control over what support they receive by providing early access to advice and information;
- Continue to improve the ways in which the Council provides good information, advice and assistance to the public, including increasing the support available through local community co-ordinators;
- To develop long term sustainability by working with the Third Sector to:
    - Connect local people with their communities, develop the use social prescribing opportunities to signpost people to support networks
    - Increase the use of Local Community Coordinators beyond the "valleys" to all other areas in the County Borough
    - Introduce "Community Navigator" roles that support people to meet their needs in community settings and reduce the need for managed care
    - To ensure that the roles and responsibilities of all services are understood so that cases are appropriately managed by the correct service. This will require the development of criteria and pathways that enable people to be escalated and de-escalated between services as necessary.
- To make better use of available resources such as DEWIS and Info engine so that citizens will increase their use of such services before contacting Common Access Point
- To continue to develop the role of the Common Access Point (CAP) to ensure that contacts are dealt with by the appropriate level of expertise, to ensure that right level of response is provided by the right service.
- Improve on consistent signposting, quality assurance and ensuring sufficiency of ongoing staffing in the Common Access Point
- Develop a culture within Adult Social Care so that all staff make better use of available information resources.
- To continually develop information and how it is used for community resources in order that practitioners are able to consider the potential of community groups as a mainstream service to provide additional care and choice.

4.3.2 Advocacy

What we said we would do:

Advocacy – to expand the range of independent advocacy support available to assist people to make informed choices and decisions about support arrangements that impact on their lives.

Desired outcome:

Adults receive appropriate support to make informed decisions and choices, within a framework of rights, equality and diversity.

We propose to:

- develop a range of high quality advocacy support options for adults across the county borough which are available to people from the first point of contact.
- consolidate and develop existing commissioning arrangements for advocacy support for adults and to explore with others options for developing specialist advocacy options for differing complex needs.
- enhance the role of internal support mechanisms for promoting the concept of advocacy in order to reflect service user comments and experiences within our commissioning arrangements.

Part 10 of the Act sets out the requirements for local authorities in relation to advocacy, which are to:

a) ensure that access to advocacy services and support is available to enable individuals to engage and participate when local authorities are exercising statutory duties in relation to them and

b) to arrange an independent professional advocate to facilitate the involvement of individuals in certain circumstances.

An advocate is defined as an 'appropriate individual' who can speak on behalf of someone who is facing barriers to communicating or understanding, weighing-up, or deciding on information related to services that they receive. Advocacy services come in a variety of forms, and range from informal, peer and voluntary advocacy through to paid, independent professional advocates (IPAs). The over-arching duties under the Act require that any person exercising functions under

the Act must in so far as reasonably practicable, ascertain and have regard to people's views, wishes and feelings. In addition, any person exercising functions under the Act must have regard to the importance of providing support to enable the individual to participate in decisions that affect him or her, to the extent that it is appropriate in the circumstances, particularly where the individual's ability to communicate is limited for any reason.

These over-arching duties, together with the United Nation Principles and Convention under section 7 of the Act are integral in understanding and assessing people's well-being outcomes; what matters to people; and people's needs for care and support to enable them to achieve their personal well-being outcomes.

The Act also sets out:

- people's choice to have someone to act as an advocate for them
- a clear framework to support and empower individuals to make positive informed choices
- a clear recognition of the benefits of advocacy
- the range of advocacy available to people
- the key points when people's need for advocacy must be assessed when independent advocacy must be provided
- the circumstances that impact on peoples need for advocacy
- the circumstances when it is inappropriate for certain people to advocate
- the arrangements for publicising advocacy services and charging.

What we have done

The Council promotes the statutory Independent Professional Advocates service with posters, leaflets and website via partners and local organisations, and service centres. However this is not as a replacement to other forms of advocacy, it is regarded as a last resort where other individuals such as family, friends are not available to provide a voice for the individual.

Bridgend has secured the support of the Golden Thread Advocacy Programme (GTAP) funded by Welsh government to support local authorities with the commissioning of a statutory IPA service. Bridgend used GTAP to help local stakeholders to co-design a 'Hub & Spoke' service model, tested and evaluated this in a pilot scheme, and based on this the Council subsequently fully commissioned via an open tender process.

The local service is called 'Bridgend Voice & Choice' (BVC) and acts as a public-facing contact point (the Advocacy Hub) to signpost and refer Individuals to the most appropriate advocacy service based on their main needs and presenting issues. The Council promotes the BVC service with posters, leaflets and website via partners and local organisations, and service centres. Statutory Independent Professional Advocacy is offered via BVC in addition to other forms of advocacy where other individuals such as family, friends, peer groups, or care professionals are not available or appropriate to provide a voice for the individual.

The Council is proactively engaged with local, regional and national stakeholders to ensure best practice is being developed within our local service.

What else we need to do

- Develop our Advocacy service further so that it supports local knowledge exchange via a Bridgend advocacy network
- Link the Advocacy Network to wider Information, Advice & Assistance services offered by the Council and others, and will help those involved in the referral process to provide a more collaborative approach to supporting individuals.
- Enable access via the Advocacy Hub to experienced specialist advocacy providers able to support specific needs, and to also link to other services including informal community support services, peer advocacy and referrals into Independent Mental Health Advocate/Independent Mental Health Advocacy as required.
- Continue to work strategically with Golden Thread Advocacy Programme to help refine and to continually improve the Bridgend Voice & Choice service.

4.3.3 Direct Payments

What we said we would do:

Direct Payments – to promote and improve the take up of direct payments and to encourage people to get involved in the planning of future support and having more control of their own future.

Desired outcome:

Flexible responses, reduced dependence on direct support arrangements, extended individual choice and people empowered to take greater responsibility and control of their own support and assistance arrangements

We propose to:

- develop a coordinated strategy for raising awareness among service users, developing performance indicators and local targets that lead to an increase in the take up of direct payments and citizen centred directed support arrangements.
- explore in greater detail the linkages between a person's direct payment and other benefit entitlements in order to maximise financial inclusion and personal lifestyle outcomes.
- review and rationalise the level of bureaucracy and reduce delays associated with processing an application and setting up direct payments and individualised budgets.
- arrange appropriate support and advice that assists a person to set up and manage a direct payment.
- identify more flexible ways of releasing monies from existing service budgets.
- map the care provider market and make this information accessible and available to interested parties and to promote alternatives to direct support arrangements provided by statutory agencies.

What we have done

In order to increase and widen the scope for direct payments and to help meet the requirements of the Act, in 2017/18 BCBC commissioned an external review of the direct payments scheme in BCBC, to develop a strategy and action plan in moving forward.

Engagement and consultation was also carried out with wider commissioned services that are linked to the direct payments scheme, and also recipients of direct payments.

The strategy was developed to progress the Council's use of Direct Payments over the following three years. The strategy identified the essential contribution of Direct Payments to the ambitions of the Act to "increase independence choice and control".

In 2018-19 we held a number of engagement events in order to involve our service users, carers and communities in the further development of carers' support, direct payments, support providers and our shared lives services. As a result we have been able to commission new services in each of these areas and new contracts have been introduced for a Carers Well-being Service, a Short Breaks (Respite) Provider Framework, a Direct Payments Support Service, and a new regional collaboration to start with the Vale of Glamorgan Council for our Shared Lives (Adult Placement) Scheme.

A series of workshops have been held to launch the revised policy and practice guidance for Direct Payments. The briefings introduced staff to Bridgend's new Direct Payments strategy and described the aims, principles, and duties in relation to Direct Payments linked to the Act. The purpose of these briefings was also to encourage innovative thinking and take up of Direct Payments. Over 100 practitioners have attended these workshops and to ensure that Direct Payments are being used effectively, we are monitoring their use during 2019-20 and beyond if necessary.

The use of Direct Payments has expanded considerably over recent years. From 2012 until 2019, the number of recipients of Direct Payments has doubled from 160 to 322. Since 2014, the Council has also increased its spend on Direct payments by 51% to £3.2m in 2018/19. However the Council is keen to ensure that the use of Direct Payments continue to increase and being used effectively.

What else we need to do

- To continue to increase the use of Direct Payments by identifying new opportunities that can benefit from their use
- To broaden the use of Direct Payments beyond the traditional additional groups of Learning Disabilities and Physical Disabilities
- Develop the use of "pooling" Direct Payments to ensure that they are used in a cost effective way and available "personal assistant" resources are used effectively.
- To explore the use of developing cooperatives in relation to the provision of direct payments

4.3.4 Carer support

What we said we would do:

Carer and family support – to increase the offering and take up of carer assessments; to continuously improve the involvement and engagement of carers, including young carers, in care networks, to improve consultation processes and the flow of information to carers.

Desired outcome:

All carers have an enhanced quality of life through reliable, responsive support so that they are able to continue performing their caring role thereby assisting family(s) stay together and to prevent an adult or child/ young person having to be directly cared for by the Council. This will ensure that carers continue to be able to participate fully in their community.

We propose to:

- develop a Carers Strategy which sets out our arrangements and priorities for supporting carers in the county borough.
- increase the ongoing opportunities for the training and support of carers who provide assistance to adults with complex needs to ensure they do not put themselves or the person they support at risk.
- improve internal systems for offering and undertaking carer assessments to ensure that individual carers can routinely access a timely assessment of their needs and/ or to access relevant assistance and support if required.
- commission a greater range of short break for carers using a range of facilities and events in different community settings so that their opportunities are not limited.
- further raise awareness of the role of carers in the community and consolidate strategic partnerships with carer support networks, carer forums and within planning mechanisms in order to inform the objectives and priorities of the 'Carer Strategy'.
- support and promote the 'carers' network, support services for working with carers and carers' advocates scheme.
- remodel traditional forms of carer support and to promote integrated support arrangements for carers that connect with mainstream community based approaches.

What we have done

Bridgend secured the support of the Wales School for Social Care Research to independently facilitate stakeholder engagement with unpaid carers, social work practitioners and service providers. The engagement was used to co-produce a 'vision' for carers services which was tested and refined through local focus groups. With an estimated 18,000 unpaid carers in the borough, but with only around 1,600 currently identified through existing partnerships, the result of the engagement work was to commission a new Bridgend Carers Well-being Service with a priority to offer outreach to as many previously unidentified carers as possible.

The new service is establishing an 'Expert Panel' made up of local carers, it is undertaking initial carers assessments for newly identified carers, and has held a high-profile public launch event and is establishing a presence at community venues around the borough. It is anticipated this approach will support the process of promoting 'carer-friendly communities' agenda as a way to engage with wider stakeholders and partners that can help to further identify and advise carers as an early stage preventative measure.

In addition to these activities, we have:

- Developed effective working with the Third Sector who provide a variety of services and activities in the community and the creation of peer group
- Commissioned services from the Third Sector to provide welfare benefit advice and other advice and support
- Increased the use of Direct Payments to support carers
- Developed Anticipatory Care Plans to support Carers and Cared for
- Engaged with carers to identify what works well and areas for improvement
- Developed Regional approaches in the former Western Bay to work collaboratively to address the priorities for Carer services as identified in the former Western Bay Area Plan.

What else we need to do

- Support carers in maintaining their roles;
- Bridgend will continue to work collaboratively within the new region arrangements to improve support and services for carers
- Improved identification of carers of all ages
- The mainstreaming of carers services to make it 'common practice' as opposed to a separate provision/consideration

- Increasing access to support from an early stage in the caring role, making carers aware that there is help and where to access it
- Ensuring a single point of contact for carers where they can access information, advice (including financial advice) and signposting
- Increasing the awareness and uptake of carers assessments
- Increasing the use of direct payments for carer's by being more creative with their use
- Engaging the Third Sector in the provision of services for carers
- Increasing planned break services including respite provision, group support and other support services to provide relief to carers from their caring responsibilities

4.4 Preventative approaches

What we said we would do:

Preventative approaches will focus systems on the early identification of changes in a person's needs that constitute a risk to their continued independence and ability to self-manage their own needs.

We propose to:

- **Supporting independence in the home** – to increase the range of options for self-support and targeted assistance in a person's own home that helps them build on their strengths and needs and maintain and or improve their quality of life
- **Community opportunities** - to expand the use of individually planned support arrangements in a range of integrated community settings that reduces the reliance on traditional support options
- **Community equipment, aids adaptations and Telecare** - to integrate and consolidate health and social care approaches to the provision of community equipment to maximise the number of people who can access and use independent living equipment in their own home.
- **Short breaks** – to increase the range of appropriate, accessible short break options in the community for service users and carers, which offer flexible and outcome-focussed breaks from usual care routines
- **Supported employment** – to create more flexible opportunities to support people to access voluntary work, paid work either through specialist initiatives or open employment which reduces the need for formal support

4.4.1 Supporting independence in the home/ Domiciliary Care Services

What we said we would do:

Supporting independence in the home – to increase the range of options for self-support and targeted assistance in a person's own home that helps them build on their strengths and needs and maintain and or improve their quality of life.

Desired outcome:

People receive appropriate support for their assessed personal and social care needs to minimise their risks to their independence, based on enabling approaches to maintain their self-determination and dignity in the community.

What we said that we would do:

- further modernise our in-house provision of assistance and support for people in their own home to promote independence and to maximise their potential.
- ❖ develop diversified service responses and approaches that link to Bridgestart and intermediate care support services on a borough wide basis.
- ❖ develop a greater range of specialist services in the home for people with dementia, physical and sensory impairments, learning disabilities and mental health needs.
- ❖ review traditional aspects of the Council's internal Domiciliary Care provision and develop proposals for reconfiguring and modernising the approaches.
- ❖ outsource elements of non specialist in house provision to support the development of a mixed economy of care and an integrated model of provision.

What we have done

Domiciliary Care Services

The transformation of Older People Services presented significant challenges. The increasing population and related demand, required significant changes to Older People Services in particular that would require the careful redesign of services that not only enabled the control of spend, but also met the increasing demand.

This has been achieved through the transformation of how services are commissioned particularly regarding the provision of Domiciliary Care Services. Traditionally, the provision of Domiciliary Care services has been the fundamental cornerstone of keeping people at home, and thereby preventing the need for Residential Care admissions. The development of Domiciliary Care Services to include Re-ablement type services that are designed to increase the independence of individuals has made a significant contribution to reducing the demand associated with increasing population.

Previously Bridgend delivered the greater proportion of Domiciliary Care hours compared to what was procured from the Independent Domiciliary Care sector. Table 1 below provides a summary of hours provided during the financial years 2013/14 and 2018/19, where it can be seen that there has been an increase (of 14%) in the total number of Domiciliary Care hours provided in 2018/19 compared to those provided in 2013/14.

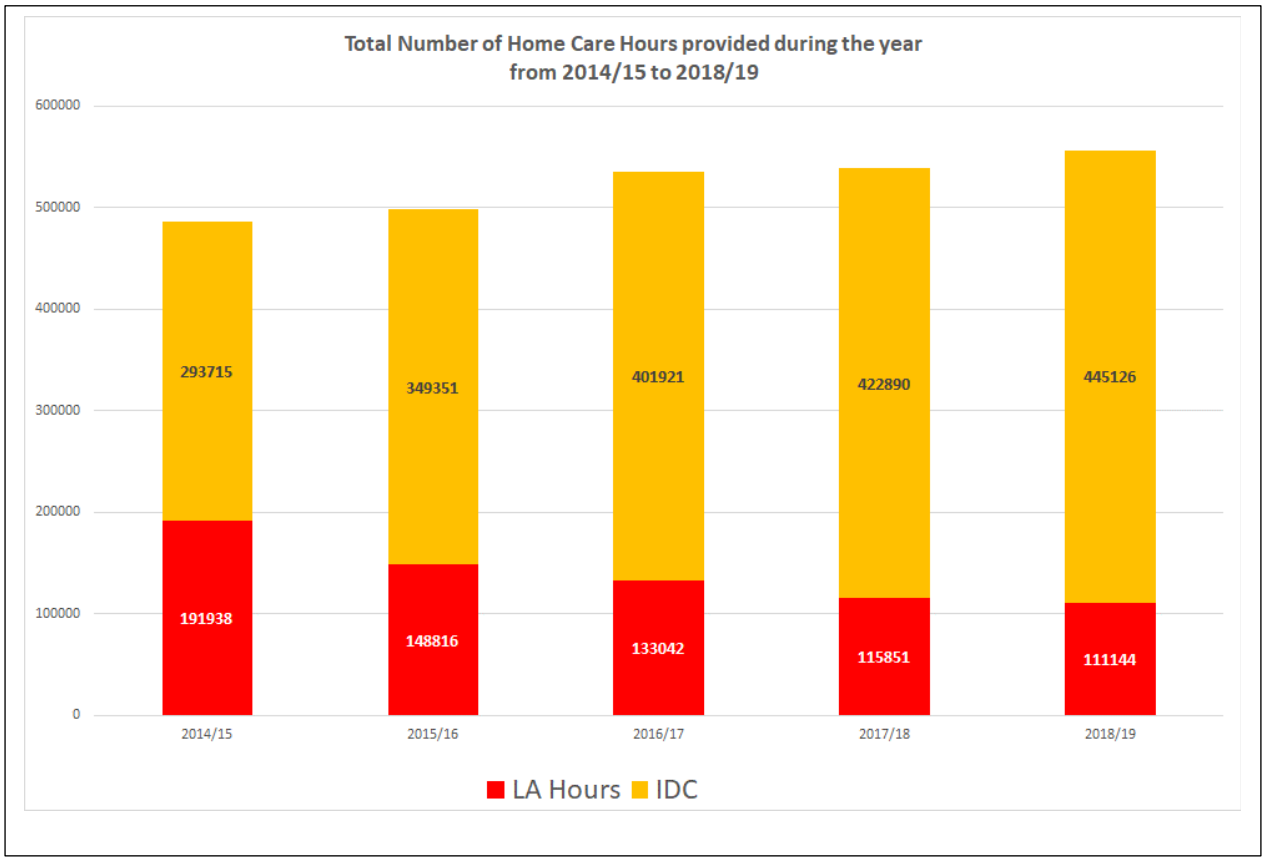
Table 1: Total Numbers of Domiciliary Care Hours provided during the year

Financial Year	Bridgend CBC Domiciliary Care Hours provided	Independent Domiciliary Care Hours provided	Total Domiciliary Care Hours provided
2013/14	224,568 (46%)	264,061 (54%)	488,629 (100%)
2018/19	111,114 (20%)	445,126 (80%)	556,240 (100%)

The impact of this reducing trend in Local Authority Hours can be seen in Figure 4 below, which confirms that whilst Local Authority Hours provided have been halved since 2014/15, the total number of hours provided have increased by 14% which indicates that the hours commissioned with the Independent Domiciliary Care market has increased by nearly 70% during the same period.

FIGURE 4 COMPARISON OF TOTAL NUMBER OF HOURS OF DOMICILIARY CARE PROVIDED DURING A YEAR

Since 2014/15 reducing the In-House Domiciliary Care Hours and increasing the numbers of IDC Hours provided has enabled an overall increase in hours of 15%



It is of note that Bridgend has not followed the trend of other local authorities who have commissioned out their entire Domiciliary Care Service and have since found it difficult to commission the required levels of service due to rising charges and the creation of a fragile Independent Domiciliary Care market. This balance of Domiciliary Care provision in Bridgend County Borough Council is strongly considered as something that should be retained as it is required to enable and support market stability.

4.4.2 Community Opportunities

What we said we would do:

Community opportunities - to expand the use of individually planned support arrangements in a range of integrated community settings that reduces the reliance on traditional support options.

Desired outcome:

A person is able to access a range of mainstream community based social, leisure and educational activities that can build confidence, social competence and/or maximise their potential improving their quality of life in accordance with their personal needs.

We propose to:

- develop more opportunities for people to access mainstream support arrangements within their local community, underpinned by appropriate transport arrangements.
- develop community based outreach support from a variety of settings to better support people in their own localities.
- develop new and creative commissioning processes to purchase meaningful daytime opportunities to be delivered by internal and external providers.
- reconfigure centralised and traditional transport arrangements in order to promote localised community based support arrangements accessed by personal or public transport whenever possible.
- promote a mixed economy of provision and to engage the independent and voluntary sector in order to diversify the range of localised services provided.
- build on successful longstanding partnerships with Community Education and Bridgend College in order to sustain the development of new models of integrated community support approaches.

What we have done

The key theme of prevention of the Social Services and Well-being (Wales) Act has been embraced by Bridgend as a means of improving the wellbeing of targeted population groups through specific areas of focus within our healthy living and cultural services. Since 2012 the healthy living partnership with GLL/Halo Leisure has been established to develop healthier communities, that are strong and cohesive, and to support children and young people to live healthier and more active lives. Similarly, the creation of a partnership with the Awen cultural trust in 2015 has developed a focus on how the use of arts, culture and creative activities can improve community wellbeing with growing focus on targeted population groups and use of social prescribing. Historically, Leisure and Cultural facilities across the UK might have provided benefit to narrower populations but the new focus in Bridgend has been to respond to the challenges of the key pieces of wellbeing legislation and to those people who would benefit from improved wellbeing. These key partnerships and the related community facing facilities including leisure centres, libraries, community centres and theatres are well located and well placed to contribute to our service delivery plan. In recent years, Bridgend in partnership with HALO and AWEN has successfully developed services to encourage and support the inactive to become more active and to become engaged in their communities in activities designed to aid their Well-being.

The development of preventative and wellbeing approaches is being taken forward in the Social Services and Well-being Directorate and a prevention and wellbeing project work stream has been established to further develop this work as part of transformation planning. Well-being Services have successfully been added to the fabric of Social Care and assisted in targeting issues and population groups. This has been achieved by the conversion of the former “Sport and Play” type services into Well-being services that are also targeting specific population groups. Consequently there are new services that have been developed that include Falls Prevention, the regional Super-Agers programme and initiatives such as Olympage Games and Dementia friendly swimming that are demonstrating positive outcomes including reductions in loneliness and isolation for many population groups. This has supported a greater focus on prevention and wellbeing and now the broader service area is contributing to community wellbeing development opportunities. This approach contributes to the collective directorate management team focus on prevention and ensures a recognition of community and Third Sector roles is integrated in planning and

evaluation. There has progressively been a growth in prevention and wellbeing work across the Social Services and Well-being Directorate and this focus is becoming embedded in teams.

In addition the Well-being Service also manages the work of the Local Area Coordinators which play a critical role in supporting individuals by providing lower levels of service and support. The Local Community Coordinator roles and services is currently funded by Welsh Government legacy funding and would support a caseload of up to seventy vulnerable people per role at any given time. The focus is on developing resilience within vulnerable individuals, building on strengths and aspirations and connecting them into supportive, community based opportunities.

The prevention and wellbeing agenda also has strong links to the joint work that is taking place with BAVO (the local CVC), and the Third Sector Stakeholder group that recognises the future importance of the Third Sector and the role played in developing resilient and supportive communities. In recent years there has been collaborative and cross sector working between the Council and BAVO that is now developing into delivery of strategic programmes and interventions. Both the Council and the Third Sector have worked together to co-produce the "Building Resilient Communities" plan. The Well-being Services contribution provides essential low level services that has allowed the services to be bolstered by the contribution of the Third Sector which has attracted a range of Grant funding including:

- ICF Capital Grant applications to develop Well-being Hubs in Bridgend and Maesteg. The Well-being Hub at Bridgend Life Centre has been supported by the Welsh Governments Integrated Care Funding and Halo Leisure and was completed in October 2019. The facilities will support employability, community and workforce development, Third Sector engagement space and group activity rooms. The outcomes will focus on dementia support, falls prevention, combatting loneliness and isolation and physical and mental wellbeing. This focus on co-location and accessibility of facilities and services will be expanded to other locations where supported by the business case. Considerations would include Maesteg Town Hall, Maesteg Sports Centre, Grand Pavilion (Porthcawl) and community centres.
- Building on the work developed by the "Olympage" scheme, the Council has been successful in securing investment for a regional programme from the Healthy and Active fund to develop a "Super Agers" project. The key objective of the Super-Agers project is to enhance the physical

wellbeing of older adults in the Cwm Taf Morgannwg area by increased physical activity developed as a regional partnership. The "Super Agers" project is designed around collaboration and includes Third Sector, health board, public health and the local authorities in the region.

- The successful Bridgend bid for Transformation Funding includes a proposal to develop and deliver "Resilient Coordinated Communities". This bid is led by BAVO and will work closely with Well-being Services to deliver a network of services that will work collaboratively to apply preventative approaches that enhance the wellbeing of the population of Bridgend. This project will build in the work of the Local Area Coordinators resource to support people with higher levels of need and complexity whilst Third Sector and Community Navigator roles serve to address lower levels of need, connecting people to communities and helping to develop an enhanced range of community support opportunities
- There is a growth in programmes that support people living with dementia and carers for example "The Memory Lane Café", Dementia Swimming programme, Bridgend Carers choir, "Sing and Smile".
- Mental Health services has developed the "Developing Emotional Well-being and Resilience" (DEWR) service that provides high-quality, person-centred support to citizens designed to enable them to achieve and sustain optimum levels of independence and mental wellbeing. The service works directly with young people, adults and their families and carers to ensure that their views, wishes and feelings are central in the planning of their future life.
- Traditional Day service provision has been reviewed (2014) and the number of buildings has been rationalised and new service model has been developed.
- Community Services exist that provide specialist services that support people to regain and sustain their emotional Well-being.
- Traditional Model of Learning Disability Day Services has been replaced by Community Hub Model, which is based on the principle of localised services support a positive community presence with relationships being developed with local people. Historically, investment has been made by the service in developing plans to establish Bridgend Resource Centre, Work Related Services (WOOD B/BLEAF) and four strategically positioned

Localised Services based on a model of “Active Citizenship” which are based at:

  - Cwm Calon – Maesteg Localised Service;
  - Sarn Adult Support Centre – Valleys Gateway & Pencoed Localised Service;
  - Ty Penybont – Bridgend Localised Service;
  - Pyle Life Centre – Pyle & Porthcawl Localised Service.
  - Specialist Dementia Unit in Bridgend Resource Centre

- Older Persons Day Services and Learning Disability Day services were brought under one line management in 2014 which has enabled the services to be co-located and rationalised. A further review of Older Persons Day Services was undertaken between January and May 2019 to identify how Older People Services need to be developed to accommodate the expected increases in older people population
- Transport links have been improved and the take up by Older People and/or disabled people has increased

What else we need to do

- Ensure that stakeholders and our teams have knowledge and understanding of the support that the local community co-ordination resource and the navigators can provide which will relate to the geographical populations and locations supported and the roles and capabilities of the staff to support various levels of need and complexity.
- Support the development of a new generation of community health and wellbeing centres for our residents with health partners;
- Reshape the current model of Older People Day Services so that people are supported to access a wider range of day time opportunities.
- Work in partnership with the Third Sector, town and community councils and community groups to meet local needs;
- Work with partners and the Third Sector to strengthen communities and identify the best way of providing services locally;
- Enable community groups and the Third Sector to have more choice and control over community assets;
- To develop a means of measuring and monitoring impact of preventative interventions
- To continue to increase the contribution of schools to the “Age Friendly” communities

- Invest into community based services that provide a wider range of mental health services including the expansion of more community based help and support.
- The Council needs to develop and align transport links that better support people to access and benefit from the range of wellbeing services that have and continue to be developed. This will require a corporate approach to resolving this critical issue.
- Develop the multi-agency model to create a brokerage type service in the community areas that recognise the broader range of opportunities to connect people to.
- Ensure that there are clear pathways in place for individuals to self-refer or for professionals to connect people into community support opportunities. This will include establishing clarity on the need for people to be able to be connected into community based opportunities sustainably including those run by volunteers and the Third Sector.
- Development of a communication plan that ensures the range of stakeholders are aware of the objectives of the transformation investment and its objective of accelerating the pace of change for a defined period of time.
- In partnership with BAVO and the Third Sector, to work with navigators to identify gaps that exist within communities and to utilize the transformation related grant schemes to build Third Sector capacity.
- To ensure that there is a focus on medium term sustainability and to ensure that investment into the Third Sector and volunteer effort builds a resilient model for when funding might no longer be available for roles identified.
- In discussion with health colleagues to identify the development of a specialist dementia model. This will be progressed as part of the development of localised services and in particular the unlocking of specialist capacity at Bridgend Resource Centre

4.4.3 Community Equipment, Aids Adaptations and Telecare

What we said we would do:

Community equipment, aids adaptations and Telecare - to integrate and consolidate health and social care approaches to the provision of community equipment to maximise the number of people who can access and use independent living equipment in their own home.

Desired outcome:

A person is able to access and use assistive technology, community equipment, aids and adaptations which enables them to continue to live within their home and perform daily tasks irrespective of the limitations of their impairments resulting from their frailty or disability.

- maximise the efficiency, effectiveness and best value of commissioning arrangements administered by the Council and Health partners for integrating community equipment services.
- operate an integrated health social care and education, demonstration and teaching facility for Community Equipment and Telecare.
- operate integrated therapeutic health and social care teams with responsibility for prescribing and requisitioning Community Equipment, aids, adaptations and Telecare.
- maximise the potential of Telecare and develop in partnership with Health agencies opportunities for extending the use of TELE-HEALTH technology through integrated working with people with long-term conditions.

What we have done

- Telecare and the Mobile Response Team have developed substantially over time. This service, sits within the Community Resource Team and provides a comprehensive 24-hour service as part of a telecare package, responding to calls for assistance either via a lifeline activated by the service user or by the proactive use of telecare sensors. The service provides direct assistance including personal care where appropriate and also co-ordinates and supports an emergency response when required. The service also supports the assessment, installation and maintenance of the

telecare equipment and can carry out proactive calling to support service users when required.

- At 31st March 2019 there were 2640 users of Telecare in Bridgend.
- The service has created a post dedicated to developing specialist knowledge of assistive technology as well as identifying opportunities to further the use of assistive technology in Bridgend.
- As part of the service's collaboration with Care & Repair it is trialling an "Assess & Install" function, where Trusted Assessors based in Care & Repair can improve the timeliness of assessment and installation of assistive technology. This is especially useful in instances such as facilitating earlier hospital discharge.
- The successful Transformation bid for Bridgend includes building further on the already established Bridgelink service by developing another 24/7 team. This aims to increase even further the availability of MRT to respond to Telecare alerts, avoiding inappropriate ambulance call out and transfer to hospital. This new model of service will have sufficient capacity to link with WAST and respond to fallers outside of the Telecare service within the context of a criteria. This has the potential to reduce the number of ambulance callouts to fallers over the age of 65 years and transfers to hospital.
- We have worked with housing providers to adopt the principles in the Royal College of Occupational Therapists publication 'Minor Adaptations without Delay'. This enables housing associations tenants to go directly to their housing provider for a defined range of minor adaptations rather than waiting for an assessment by a Community Occupational Therapist. Tenants can be signposted to this service at the point of contact with us and allows the Community Occupational Therapists to focus on the most complex cases.
- We have extended the above arrangement to owner-occupiers and those in the privately rented sector by setting up an agreement with our local Care & Repair agency to assess and provide a defined range of minor adaptations on our behalf. Callers to our single point of access can be signposted directly to Care & Repair at that

point or at the point of triage by the Occupational Therapy Manager.

- We have established an Occupational Therapy post in our Housing Department to expedite requests for rehousing to more accessible properties under the Housing Options scheme. This reduces the demand on Disabled Facilities Grants by accurately identifying applicants needs and matching them to vacant adapted properties. The post also provides Occupational Therapy advice and expertise to Housing staff and releases capacity within the Community Occupational Therapy team. The creation of this post also allows a number of other developments which will improve flow and reduce waiting times for assessment.
- We have a dedicated Occupational Therapy post within HMP Parc Prison. The role is to replicate community services as far as is practicable with older, frail and disabled prisoners. The role involves supporting prisoners to maintain their independence, enable the delivery of care and identifying housing needs prior to release. We are in discussions regarding an expansion of the 'Occupational' element of the role to include preparing prisoners for release by focussing on activities of daily living, meal preparation, money management, etc.
- We have strengthened the Occupational Therapy contribution to our 'BridgeWay' service enabling Domiciliary Care service for people with dementia and cognitive impairment by doubling the establishment of Occupational Therapists, upgrading one of the posts to a Senior Practitioner/Clinical Lead post and developing strong links with the Memory Team of Cwm Taf Morgannwg Health Board. This ensures that our assessment are more robust and focussed on maintaining people in their own homes and that we are able to meet the increasing demand within dementia services.
- We have integrated our Community Occupational Therapy service into the Community Resource Team. This has provided a critical mass of Occupational Therapists with the associated access to management and peer support, improved the equity of service across the authority and improved communication between all the short-term community-based enabling and Re-abling services, which includes Community Occupational Therapy.

What else we need to do

- Explore expanding the access to assistive technology and Bridgelink Mobile Response Team to individuals who do not have a Care & Support i.e. a Private Pay option.
- Explore the use of assistive technology and how it can support Adult Social Care's ambition of supporting people to stay at home for longer.

4.4.4 Short Breaks

What we said we would do

Short breaks – to increase the range of appropriate, accessible short break options in the community for service users and carers, which offer flexible and outcome-focussed breaks from usual care routines.

Desired outcome:

A person can continue to have choice and control about the setting in which they receive support, by enabling them and people who care for them, to continue to receive the support they require to live in the community.

We propose to:

- shift away from traditional short break models based on temporary breaks at long-stay residential units, towards the development of specialist short stay resources and community based services which offer support for people in their own home.
- develop innovative arrangements for people and/or their carers to engage in themed activities using mainstream facilities, groups and artists.
- consider how facilities in the ownership of the Local Authority might be used to provide respite to carers.
- increase the range and variety of appropriately equipped specialist break services available to people with complex needs and promoting equity and consistency across the sector.
- work in partnership with NHS partners, local voluntary groups and independent providers to improve and extend the model of provision.
- administer seamless care pathways for people between day hospital, rehabilitative and social community support services.
- develop appropriately equipped person-centred bespoke short breaks that can address and take account of the individual needs of both the carer and the person they care for.

What we have Done

- During 2017-18 a series of engagement activities were held around unpaid carers that focussed on a specific commissioning activity that provides respite to unpaid carers. As a consequence of these events, the Council moved from holding two block contracts with specific providers supporting specific cohorts of Individuals, to a Short Breaks Framework which includes 11 local Providers able to support all client groups and which was fully commissioned in May 2019.
- Following stakeholder input, the new Short Breaks Framework offers a 4-weekly window in which carers can 'bank' their weekly assessed hours and use them more flexibly at times and in lengths that better suit their individual needs. The Framework has allowed an expansion and diversification of the market and should improve the Council's ability to measure and monitor services that directly benefit carers.
- In addition to the Short Breaks Framework, the Council has entered into a new regional arrangement with the Vale of Glamorgan Council to operate an Adult Placement Scheme which also offers Short Breaks opportunities, and the aim is to develop this as an alternative service to people using traditional residential care homes for respite.

What else we need to do

- Increasing respite provision, group support and other support services for carers
- Increase the availability and uptake of short break/respite services considering alternative models that ensure flexibility of provision

4.5 Specialist Preventative Approaches

Specialist preventative approaches. *We will provide alternative options of support for those adults and young people who are at high risk of requiring long term care and support and/or face unnecessarily prolonged hospital stays, inappropriate admission to acute in-patient care, long term residential care or continuing NHS in-patient care.*

The approach will embrace an intermediate care model of assistance and support that focuses on multi-disciplinary assessments and a process of reablement and rehabilitation at the interface or crossover between the hospital, long term care and the community.

What we said we would do

Providing a rapid response and supporting people at a time of personal crisis - to increase the range of specialist support arrangements for people in crisis that prevent unnecessary admission to a residential care or nursing care home or hospital and the need for 'total care', i.e. a joined up approach, as part of the range of responses to unscheduled care and the delivery of support.

Desired outcome:

A person with a substantial long-term and adverse condition who has experienced a sudden, serious, or acute health event which could lead to a health crisis can access an alternative to being admitted to and/or retained in an acute ward or a residential or nursing care placement.

We propose to:

- extend crisis resolution approaches developed in partnership with NHS partners to provide an increased range of alternatives to admission to hospital or residential setting in a crisis
- strengthen the profile and access arrangements of crisis resolution approaches to support and rehabilitate people with complex and challenging needs and to take account of the changing needs of the service user population.
- develop timely social care mobile responses 24 /7 in order to respond to a crisis at home and thus prevent unnecessary admission to hospital or care home.
- develop a wider range of integrated health and social care mobile responses which can provide appropriate support for people experiencing a crisis until a planned response to their ongoing needs can be arranged
- explore, with partners, the flexible use of emergency units and step-up step-down facilities, such as residential reablement in social care settings.

What we said we would do

Intermediate care and reablement approaches - to develop a range of early and mobile response services, reablement and rehabilitation approaches that offer short term intensive support to enable people to either regain or maintain their level of functioning for living independently.

Desired outcome:

A person can live independently have a better quality of life in terms of functional improvements as that maximises the independence through intensive support over a specific period of time, which is determined by need and minimising risks to independence.

We propose to:

- continue with the development an Early and Mobile Response Service (ERS) which is designed to prevent avoidable admissions to hospital by providing rapid health and social care assessments, diagnosis and if appropriate is immediate access to short-term nursing therapy and social care support.
- integrate the management and support functions of the ERS community reablement and community disability rehabilitation approaches; to deliver a single secondary point of referral for health and social care agencies and explore options for formalising these arrangements with Health Partners under section 33 agreements.
- ensure planning mechanisms for developing reablement and rehabilitation approaches encompass all user groups with particular emphasis on people with dementia, older people with mental health problems and younger adults with complex physical needs such as acquired impairments and degenerative neurological conditions and learning disabilities.
- develop multi-disciplinary, multi-skilled community-based teams of health and adult social care staff who can co-ordinate health and social care responses effectively across a range of different settings community-based settings.
- target people who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute in patient care, long term residential care or continuing NHS in-patient care to access specialist residential placements in health and social care resource.
- provide opportunities for the emotional and psychological aspects of disability to be addressed with people and/or their families through interventions with Social Work and Psychology.

What we said we would do

Specialist community support – to remodel community support facilities into integrated specialist community support resources that can deliver specialist and intensive support packages for people on a time limited basis.

Desired outcome:

Adults with complex and challenging needs are able to improve their level of social interaction, communication skills and coping mechanisms for managing change in order to live a better quality of life in the community.

We propose to:

- develop an integrated model of health and social care which involves the establishment of multi disciplinary move-on projects for adults with complex and challenging needs who: -
    - are at risk of becoming dependent on institutional forms of care.
    - return from institutional care to appropriate community settings unless there is a justifiable reason for their not doing so.
- increase the scope and accessibility of community based responses for adults with complex and challenging needs.
- make appropriate arrangements for the early identification of people with complex and challenging needs to ensure that specialist approaches are targeted for those in greatest need.
- develop a variety of specialist integrated models of support which are inclusive and accessible to people with a range of conditions.
- develop, with partners as appropriate, seamless integrated specialist outreach end of life and palliative care teams that can provide the appropriate support for people who would prefer to die in their own home
- support NHS partners in developing integrated teams to care for people at home to provide appropriate support for people who are living with chronic deteriorating conditions and who potentially may be receiving or go on to receive specialist palliative care services.

What We Have Done

4.5.1 Community Resource Team

The Community Resource Team has been developed as an Integrated Health and Social Care service that is able to respond with essential services that support the prevention of emergency admissions into Hospital in addition to supporting early hospital discharge. This confirms the importance of effective services that are not only responsive but wide ranging so it can respond to a range of service needs. Consequently we have developed an integrated service that is regarded as a good example of integrated Health and Social Care working not just in Bridgend but across Wales.

The Community Resource Team has been developed to consist of a range of services that include:

Common Access Point (CAP): Supported by a Multi-Disciplinary Team that consists of Nurses, Occupational Therapist and Social Workers. The CAP provides the sole point of access to all of the CRT services. CAP also has a clear link to each of the different community teams and professionals, and manages all referrals and patient enquiries coming into the CRT. CAP will therefore ensure all citizen/patient needs are met by directing patients to the most appropriate resource or team, and also provide Information and Advice as required.

Better at Home: Is led by CRT Social Workers and supported by CRT coordinators and carers. The Better at Home service is a bridging team that is designed to get patients home from hospital while awaiting other services for which there may be waiting periods. The service can also support patients with mild to moderate frailty such as arm fractures who are usually independent but may benefit from Better at Home to enable them to achieve full functionality.

Bridgelink (Telecare) and Mobile Response Team: Bridgelink is a home and personal alarm service which in the event of an emergency can automatically contact a 24/7 control centre who will summon appropriate assistance. A Mobile Response Team has also been developed as part of their service that can attend a property to render assistance with emergencies including falls.

Reablement Team: The Reablement Team provides a service for up to six week that is goal focussed to assist patients be re-enabled by working to clear and realistic goals that assist the patient to regain or improve their independence following acute illness and de-conditioning. The goals are agreed with the

patient and their achievement are used as a means of defining any level of support that is required following the initial six week intervention.

Bryn Y Care Reablement Unit: Bryn Y Cae is a six bedded residential reablement unit for patients with clear re-enabling goals who are not quite ready for discharge home but would benefit from discharge from the hospital environment. The service is led by Reablement Therapists and supported by Acute Clinical Team (ACT) Nurses, Therapy Technicians and staff at Bryn Y Cae.

Bridgestart Team: The Bridgestart Team is an Occupational Therapy led service that is supported by Therapy Technicians and CRT Coordinators and Carers. The service is suitable for patients who require care to remain at home or to be discharged from hospital and there are agreed goals to improve the person's independence. The service will undertake a short term assessment and following intervention, evaluate of the patient has ongoing care needs.

Bridgeway: Bridgeway is a similar service to Bridgestart and includes Occupational Therapists to provide assessment services for Dementia/cognitively impaired patients with similar functional needs.

Acute Clinical Team (ACT): The ACT manage community patients in acute crisis at risk of unnecessary admission and also undertake domiciliary falls assessment. They also manage an array of IV therapy, clinical reviews and undertake clinical workup on patients where normal hospital/clinic services are not suitable for that patient's circumstances. ACT is a team of multi-professionals which whilst is led by Clinical Practitioners, are supported by Consultant Physicians, Nurses, Physiotherapists, Occupational Therapists and CRT Social Workers. The service is able to access to a range of other professionals that include the Community Dementia Team, Speech and Language Therapists and Dieticians, Pharmacy Technicians and the CRT Equipment store.

Sensory Team: The sensory team provides both specialist rehabilitative and social work support to patients with visual, hearing and or dual sensory loss according to their individual need and circumstances. The service is open to all ages and disabilities.

Community Dementia Team (CDT): Led by CRT Mental Health Link Practitioner (MHLP) and supported by Dementia Practitioners (Social Working Nursing and OT Backgrounds) and Dementia Support Workers. The CDT provides support for patients living with dementia or their carers and also assist other community healthcare colleagues supporting and caring for them. The CDT practitioners

also provide expert advice, signposting and education of practical skills to support those with dementia and their families and carers.

What else we need to do

- We need to further develop our working relationships with Cwm Taf Morgannwg Health Board to ensure integrated services are continually improved and better support Hospital Discharge and unplanned admissions and other critical services.
- Further modernise our in-house provision of assistance and support for people in their own home to promote independence and to maximise their potential.
- Provide a common access point open seven days a week for extended hours for access to coordinated community health and social care and Third Sector support
- Provide a non-selective reablement/enabling services accessible over seven days,
- An expansion of the better at home bridging service, learning from the Cwm Taf regions Stay Well At Home project accessible over seven days
- Increased the capacity of the Mobile Response Team and introduce capacity to deliver care at night
- Expanded Acute Clinical Team supporting admission avoidance from the community
- Step Up Step Down facility focusing on reablement, recovery and enabling respite, with the potential of delivering further alternatives to post-acute stays in secondary care, for example out of hospital assessment for long term care assist people to have their own

4.6 Integrated living

Integrated living options will enable people with complex needs (for example people with a Learning Disability) who have become socially isolated to access some form of flexible social care housing- related support, and in some circumstances, to access integrated community based housing schemes where there is access to higher levels of social care support e.g. intensive 'extra care'.

Targeted and coordinated social care housing support arrangements will enable people to maintain their independence, functioning and quality of life in the community. As part of the approach we will replicate a 'family model' of assistance and support for those people who may need additional support to develop social and networking skills in a protected environment.

We have identified a range of Integrated living approaches being:-

4.6.1 Supported Independent Housing (including *Core and Cluster*)

4.6.2 Extra Care Housing

4.6.3 Adult Placement (*Shared Lives*)

What we have done

- We have created a variety of accommodation that is designed to assist people to have their own meet a range of needs
- A needs analysis has been undertaken that has identified accommodation needs of the following groups of people in Bridgend:
    - People known to the Community Mental Health Teams
    - People with a Learning Disability known to the Community Learning Disability Team
    - People known to the Community Drug and Alcohol Team
    - Young people in Transition from children's to adult services

4.6.1 Supported independent housing (including *Core and Cluster*)-

What we said we would do

Supported independent housing (including *Core and Cluster*)- to consolidate and increase the number of supported independent housing schemes based on a hub and spoke model of assistance and support for people with more complex and challenging needs.

Desired outcome:

People with complex social care needs are assisted to access suitable accommodation and support services within a recovery and rehabilitation model of services which will help to improve their quality of life and their ability to maximize their independence in their community.

We propose to:

- implement the strategic objectives of the Local Housing Strategies, Local Homelessness Strategies and Supporting People Operational Plans and to forge more effective partnership working arrangements between, health, housing and social care agencies.
- prioritise developments that meet the needs of people with mental health problems and streamline referral and contact arrangements for accessing accommodation within both the statutory and independent sector.
- develop peripatetic rehabilitation services focussing at maintaining people in their own homes in the community.
- engage with the independent and voluntary sector to further develop the range of supported accommodation locally for people in their own homes or in other local settings.

Whilst this detail needs to be updated, it provides important context for the availability of Residential/Nursing Care Homes in the Bridgend Locality.

What we have done

The majority of individual tenancies are provided in properties, which are owned by Registered Social Landlords. A tenancy agreement is put in place, which enables the individual to have his or her own home. Previously, the Council has adopted Tenancy Agreements to provide optional residential

services to People with a Learning Disability and Mental Health, but with the introduction of Extra Care accommodation, this practice has now been extended to other service areas.

If the individual requires support to live in their own home, this can be provided either by a Specialist Care provider, a domiciliary provider, or through a Core and Cluster network or a Direct Payment as described above.

Most support service providers are registered with the Care Inspectorate for Wales and have to comply with the relevant regulations.

Closer to home refers to a specialist supported living service for individuals with a Learning Disability and or Mental Health Difficulty and Complex Challenging Behaviour including Autistic Spectrum Conditions.

The aim of the Closer to Home project is to avoid the need for Out of County placements by providing local, specialised supported living services for people who have both health and social care needs and whose condition may be considered complex and challenging.

The Closer to Home project was a Western Bay collaboration and we are now working with Cwm Taf Morgannwg University Health Board to take it forward

There are currently two Closer to Home schemes in Bridgend and one in development.

What else we need to do

- We need to continue to develop a range of housing accommodation that supports independence for those with complex and challenging needs.

4.6.2 Extra Care housing

What we said we would do

Extra Care housing – to build on the experiences of developing an extra care scheme and to enhance the range of support options for people living in different housing models.

Desired outcome:

People with complex needs are supported to remain in their own communities, living as independently as is possible, with support packages tailored to their needs.

We propose to:

- ❖ continue developing the extra care housing model within the County Borough subject to the continued availability of funding from the Welsh Assembly Government .
- ❖ explore opportunities for developing business cases for converting Council buildings that become surplus to requirement to extra care housing to prolong their relevance to changing pattern of needs amongst vulnerable adults.
- ❖ identify sustainable internal and external funding streams for financing extra care housing schemes. Options for progressing proposals are based either on releasing monies from decommissioning services, securing external funding or encouraging these developments within the third and private sectors.

What we have done

Extra Care housing enables older people to live in their own homes and maintain their independence in a safe and secure environment with an onsite care service that is specifically tailored to meet individual needs. Extra Care services can act as a community hub and can meet the needs of the wider community. It is possible to offer day services with activities and respite. It can also offer employment opportunities to the local community.

The ongoing challenge to Older People Services has been how the service can continue to get more for less. The introduction of the council's first Extra Care service in 2012 evidenced how a dated Council Owned Residential Home could be converted into a modern fit for purpose Extra Care scheme that delivers cost effective benefits that deliver better outcomes for individuals. The success of the early model and the financial challenges has led to the Council to work in

partnership with a care provider (Linc-Cymru) to develop 2 new Extra Care Schemes (Ty Ynysawdre and Ty Llynderw) that replaced two of its previous owned Residential Homes (Glanyrafon and Hyfrydol). This development and closure programme was based in recognition that the previous Residential Homes were not sustainable and there was a need for the council to modernise its residential care services with the creation of two new Extra Care Schemes that provide a total of 25 Residential beds and 45 Extra Care beds.

This extension of service provides a very cost effective alternative to the traditional Residential Service and is another example of how Bridgend has made difficult decisions to transform its delivery of Adult Social Care Services. Furthermore, Bridgend has also converted parts of another of its Residential Home (Bryn Y Cae) to deliver a Residential Reablement service that provides a "Step Up" and "Step Down" model that enables people to be discharged from hospital, and be provided intense reablement services that assists them to return home, rather than be admitted into Residential Care

What else we need to do:

- To evaluate and learn from what has been achieved to date and to identify opportunities to develop the future Model
- Ensure arrangements in extra care are responsive to the wishes of tenants and allow them to meet their personal outcomes.

4.6.3 Adult Placement

What we said we would do

Adult Placement - to broaden the model of shared lives, where an adult carers share their home with an adult needing support, to include a greater number of people who are at risk of being isolated and/or losing their independence.

Desired outcome:

People are given a choice of opportunities for community living, community integration and independence in a family setting. People receive the support they need to become valued members of their local community and achieve their potential in all aspects of their lives.

We propose to:

- Increase the coverage and remit of Shared Lives to ensure the scheme is recognised as a flexible, naturalistic and responsive, value for money solution to addressing individual need.
- Prioritise and respond to issues of difficulty such as support when leaving care for young people and the delayed discharge from hospital of older people.
- Explore options for forming local and regional partnerships with health and other local authorities to widen the remit of the service to support people with more complex needs.
- Continue to offer this service to other authorities as appropriate and to utilise the skills of the scheme in offering specialist placements to people with complex needs.
- Continue to diversify the scheme in response to the needs for skill development, combating social isolation, supporting families to care as well as offering periods of support to enable development of the skills for independent living.

What we have done

- The Council has undertaken an independent review of its Shared Lives/Adult Placement service for people with a Learning Disability to inform the development of an internal options paper that set out options that allowed the service to continue and be developed further in a cost effective way.
- The council made a decision that allowed Bridgend to make an agreement with the Vale of Glamorgan Council to provide a collaborative Adult Placement Scheme that includes Bridgend and Vale of Glamorgan Councils.
- The collaborative scheme commenced in May 2019

What else we need to do

- The quality and outcomes of the new collaborative service that are being monitored to ensure that the service “beds in”.
- The service will be developed and expanded to ensure that the benefits of the new Adult Placement Scheme are continually extended to meet other service needs including Dementia.

4.7 Interventionist approaches

Interventionist approaches will be necessary to protect and support people in circumstances where support networks in the community are unable to maintain their independence without the need in some cases for the provision of care packages of intensive support. The model of residential reablement will provide a critical stage of interventionist approaches involving both specialist inputs from the NHS and social care to help adults regain their ability to look after themselves and continue to live in the community. For those for whom independence is no longer an option e.g. people with progressive life-limiting conditions in the latter stages of their life, more specialist inputs will be required which can offer a choice of quality support in a residential care home and or nursing care home.

4.7.1 Integrated specialist health and social care resources

What we said we would do

Integrated specialist health and social care resources – to develop integrated NHS and social care resources based on the reablement model of assistance and support tailored to 'individual needs' rather than 'specific conditions'.

Desired outcome:

A person with complex and challenging needs which cannot be met in their own home, is able to live in the least restrictive environment possible and is able to access, as appropriate, flexible care and support in residential care and nursing care home settings.

We propose to:

- explore options for de-commissioning models of non specialist residential care provision in order to develop alternative, specialist health and social care resource(s), supported living schemes and extra care housing.
- develop with partners specialist integrated health and social care resources to meet higher level of needs such as traumatic injury, dementia, mental health conditions or profound and multiple disabilities.
- develop short-term residential rehabilitation and reablement placements with a coherent set of step up and step down facilities following hospital discharge or deterioration at home.
- commission supported living or a 'Shared Lives' placement for people with complex and challenging needs who want to move on from the more traditional model of residential care.
- develop more diversified models of care in the last year(s) of life in residential and nursing care homes in partnership with the third and private sectors.
- continue administering a mechanism for determining a fair price for care home fees, that will promote quality and consistency of care within a sustainable financial framework.

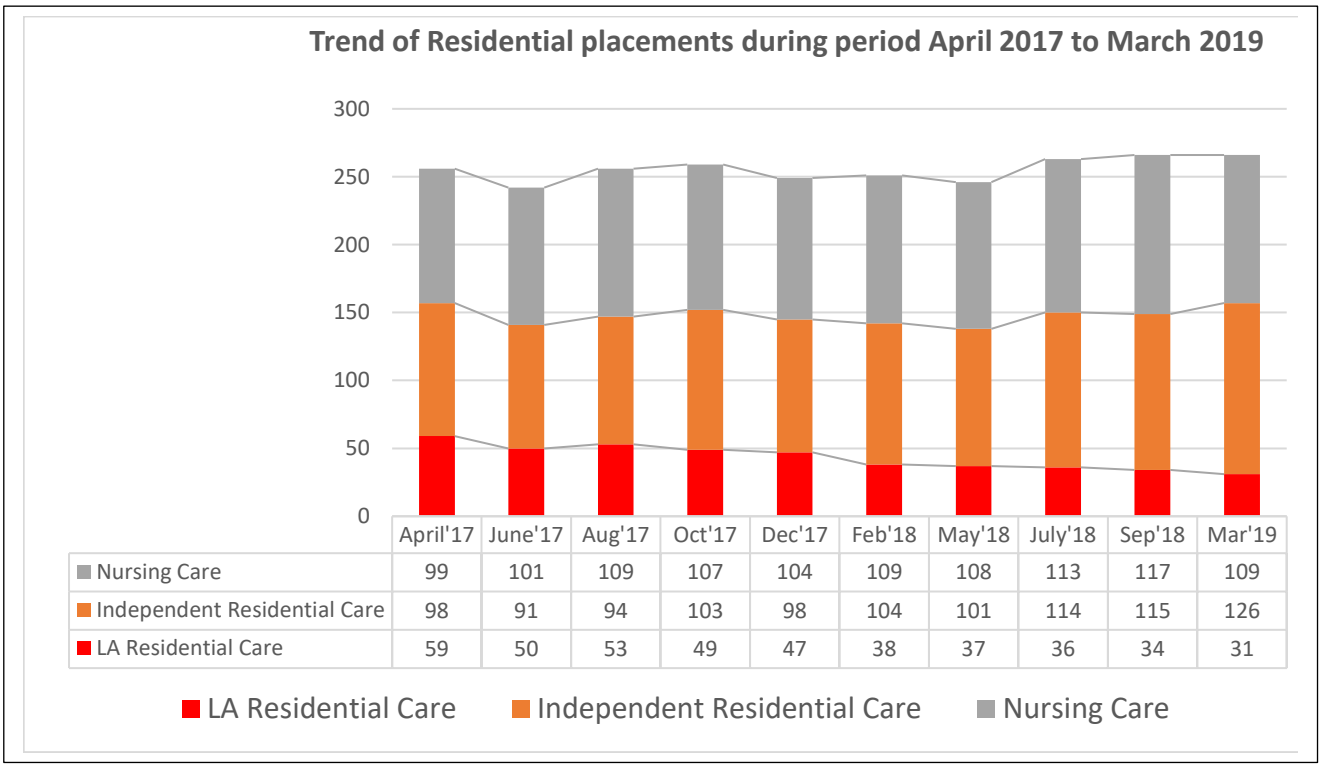
Residential Placements

The Remodelling of Adult Social Care programme has seen significant changes to the commissioning of Residential and Nursing placements which continues to contribute a major cost to Older People Services.

Figure 6 below shows that during the two year period April 2017 to March 2019, the total number of residential placements increased from 256 to 266 and in particular there has been the decrease in LA provision due to the closures of Glanyrafon and Hyfrydol Residential Homes. These planned closures were to accommodate the development of Extra Care Housing in the County Borough, which is regarded as being a much more sustainable model that better fits with the ethos of services that support Independence.

Figure 6: Number of Placements to Residential Care during Period April 2017 and March 2019

Despite reshaping of services, the increases in the ageing population ensures that the demand for Residential placements continues



	April'17	June'17	Aug'17	Oct'17	Dec'17	Feb'18	May'18	July'18	Sep'18	Mar'19
Nursing Care	99	101	109	107	104	109	108	113	117	109
Independent Residential Care	98	91	94	103	98	104	101	114	115	126
LA Residential Care	59	50	53	49	47	38	37	36	34	31

In June 2017, Bridgend produced a Market Position Statement (MPS) for Residential and Nursing Care Homes that was designed to assist current and potential service providers to make informal decisions about if and how to invest and develop services. This document fed into the former Western Bay Regional MPS. The key messages from the Bridgend MPS identified that:

- The number of placements into residential care is falling. This situation conflicts with the projections of an ever increasing Older Persons population profile.
- The availability of alternative forms of care which enable people to remain independent for longer are resulting in admissions to residential care increasingly being those individuals with complex or multiple care needs.
- The level of vacancies in those homes providing specialist and/or Dementia nursing care is minimal (with these homes stating that a waiting list is in place) and hence the current level of supply may not be sufficient to the current level of demand. This tends to support the preceding comment i.e. that increasingly, admissions are for people with more complex care needs.
- The development of the new model of intermediate care will further impact on the preceding point, in that the enhanced multi-disciplinary support to be provided in the community will result in a reduced level of placements to care homes, with those people with complex needs that cannot be met in a community based setting.

It was concluded that:

- The need for more specialist care will continue increasing, as service users needs become more complex and demanding, and this will require the market to respond by providing differing types of care that meet service users changing needs.
- With the incidence of dementia increasing rapidly in the 85+ population, and with others in the same population group having multiple and complex needs, the focus will need to be on providing services that meet such needs.
- Given the alternative support mechanisms in place and being developed, the need for residential care facilities for frail Older People will continue to reduce which could have a significant impact on demand for the residential care beds currently available in the Borough.

Whilst this detail needs to be updated, it provides important context for the availability of Residential/Nursing Care Homes in the Bridgend Locality.

What else we need to do

- We need to continue to work with Cwm Taf Morgannwg Health Board and providers to develop more provision for Dementia care
- To work with providers to develop more Extra Care Accommodation options
- Working closely with the Cwm Taf Morgannwg Health Board, we need to increase the numbers of community based Reablement “Step Up, Step Down” beds in the County Borough so that we have the flexibility to meet current needs.
- Ensure services can meet the growing number of older people with LD who may have additional age related needs such as dementia or physical frailty
- In summary we need to identify and commission different accommodation options.

SECTION 5.0 Wellbeing Services

The introduction of the Social Services and Wellbeing (Wales) Act in 2015 challenged the Council to understand how its Wellbeing services could respond to the increasing challenges being presented by key legislation (including the Wellbeing of Future Generations (Wales) Act). Consequently in 2017 the previous roles of Sport, Play and Active Wellbeing services was reviewed and the opportunity was recognised for the service to focus more fully on prevention and wellbeing. This approach has enabled prevention and wellbeing to be strategically aligned more closely to Social Services which has seen a progressive growth in prevention and wellbeing work across the Social Services and Wellbeing Directorate and this focus is becoming embedded in teams.

This was confirmed by the Care Inspectorate Wales Report published in January 2020 which was positive about Bridgend's "*relatively advanced focus on early intervention and community services to relevant escalation of need*" which was confirmed as benefitting Older People in the County Borough. The Inspectorate recognised how the Council is able to evidence at an operational and strategic level, examples of good practice that confirmed the positive contribution that well-being services are making to communities and individuals on the edge of social care.

Much of this success has been achieved by working in partnership with BAVO and broader third sector, communities, including delivery partners Awen Cultural Trust and GLL/Halo Leisure to identify areas of need. This has resulted in an extensive range of targeted activity programmes for Adults and Children being delivered.

The strength of partnership with BAVO, has enabled the development of a successful bid for Welsh Government Transformation Funding, an "Ambition" of which was to develop and deliver "Resilient and Coordinated Communities". Some of the operational elements of this "Ambition" include:

- With the CVC develop a third sector brokerage service that will operate alongside core services providing support for service deliverers as well as information to individuals
- The brokerage would support a single information access point approach, on what is available in local communities in relation to community activities, groups, services and facilities. This includes public, third sector and private provision.

- Create a long-term and sustainable approach to Resilient Coordinated Communities by developing effective information that enables a service that ensures “every contact counts” which is recognised as being essential to promoting wellbeing and resilience and is founded on good connections between local services and accessibility of support.

Many of the achievements of Wellbeing services are set out below.

What has been achieved

- Bridgend has invested in a targeted phase of local community coordination that has evidenced some achievement but also served to identify some areas for review and opportunity. This programme connects to the objectives of the Social Services and Wellbeing Act (2014).
  - Supporting and enabling people to make their own choices and to be more independent.
  - Making sure that people are given voice and control to achieve what they want in life and that they are able to express the outcomes that they want for themselves.
  - Recognising that carers also have support needs and that these should be given equal importance.
  - Finding different ways to support people that will involve local communities.
- The ‘Olympage’ programmes have been developed to support older adults to live more active and healthier lives. Such programmes have grown from day care and residential care settings to programmes linked to the community hubs, programmes for people with learning disabilities, activities in community centres and leisure / cultural venues and independent care settings also.
- By working in partnership with Awen Cultural Trust, the Olympage theme has been extended in the creation of ‘Cultural Olympage’, which has focussed on enabling cultural and creative activities to be integrated and potentially linked to social prescribing. This has highlighted the value of creative and cultural activity to improving mental wellbeing in addition to physical activity opportunities.
- Engagement with primary and secondary schools is increasing and the ability of schools to contribute to Ageing Well in Bridgend intergenerational working and the development of age friendly communities, is being progressed. Consequently projects have been developed that include:

    - Dementia friends and champions training in secondary schools (Archbishop McGrath School, Pencoed Comprehensive School). This has involved strong partnership working with BAVO;
    - Inter-generational activities between primary schools and older adults (Local Community Coordinator programme – Ogmore Valley, nursery school visits to Bryn Y Cae etc.);
    - Facility projects that help to bring people together (Bryn Y Cae dementia garden).
- Other activities to support Older Adults have been developed and include:
    - Park Lives Programme regional programme has been working with older adults to access doorstep opportunities in the natural environment
    - The Community Chest Scheme is managed by the Council on behalf of Sport Wales and has supported local projects with funding.
    - The Love to Walk programme supports volunteer led community walking opportunities that are inclusive and contribute to mental wellbeing.
- A website (Ageing Well in Bridgend) has been developed to provide information about available activities and related information
- Three Local Community Coordinator (LCC) roles have been developed, one for each of the Ogmore, Garw and Llynfi valleys. The objective is to help local communities to be inclusive, self-supporting places that help people to stay strong, preventing or reducing the need for services in their lives
- In partnership with BAVO, the council is introducing five "community Navigator roles that have been designed to complement the role of the LCC to develop "Resilient and Coordinated Communities" and with a pathway that avoids duplication.
- The partnership between the council and GLL/Halo Leisure (Healthy Living partnership) is responding to the prevention and wellbeing challenge and supporting local people and carers to be healthy and resilient. For example:
    - Participation by the over 60's in the National Free Swimming programme is consistently amongst the highest in Wales
    - The Healthy Living Partnership successfully delivers the National Exercise Referral Scheme providing access to tailored and supervised activity for those who are inactive or at risk of or currently experiencing a long term or chronic health condition

    - Halo have developed a mobile falls prevention programme in the Ogmore Valley linked to sheltered accommodation and community venues
    - There is a growing focus on the importance of carer wellbeing and Halo are consulting with carers to identify activities and opportunities that could improve lives and wellbeing.
- In 2015 the Council established a twenty year partnership with the Awen Cultural Trust to assist in the provision of facilities for culture and to jointly increase participation in cultural activities. The following provide some examples of how this partnership has enabled a range of targeted activities to be developed:
    - Awen support the Hynt scheme which is a national access scheme that works with theatres and arts centres to support visitors with an impairment or specific access requirement (and carers or personal assistants)
    - Awen support the Social Services and Wellbeing Directorate by operating the B-Leaf and Wood B supported training and employability programmes
    - The Council has been supported by Awen to develop a carers' choir project as a pilot social prescribing opportunity with support by Bridgend Carers' Centre
    - Bridgend libraries have integrated a range of social prescribing opportunities including dementia supportive activities and community cafes in partnership with community groups
    - Awen have also introduced the 'Live and Loud' programme providing affordable access to the arts in library settings
- The Wellbeing Hub at Bridgend Life Centre has been supported by Welsh Governments Integrated Care Funding and Halo Leisure and was completed in October 2019. The facilities will support employability, community and workforce development, Third Sector engagement space and group activity rooms. The outcomes will focus on dementia support, falls prevention, combatting loneliness and isolation and physical and mental wellbeing.
- Social business is active in Bridgend and can include co-operatives and mutual (including social enterprise) or employee owned organisations. In 2019 there were 2022 social businesses identified across Wales employing an estimated 55,000 people and with a sector value of £3.18 billion.

- In 2018, Bridgend had seen a growth in social business with 83 identified and placed 9th in terms of the contribution of social business to overall business stock. For BCBC ,the approach that is being taken forward progressively with BAVO, through the Welsh Government Transformation funding as part of the "Building Resilient and Co-Ordinated Communities" ambition is well aligned to mutually understand the current and potential for such partnerships as a collaborative cross sector approach.

- The transformation investment introduced in 2019/20 has helped identify the health and social care pressures that could be supported by third sector including social business with small, medium and larger collaborative investment schemes commencing and continuing in 2020-21 also.

What else we need to do

- We need to develop our resilient communities so that they are able to contribute to the objectives of the Council and partner organisation such as:
    - Develop links with the voluntary sector to promote and support self-care and independence (includes communication and integration).
    - Increase wellbeing, resilience and early intervention to support the health and wellbeing of the population.
    - Increase integration with other sectors to provide a key focus on wellbeing and prevention through engagement and active promotion of social prescribing.
    - Use a 'make every contact count' approach to advise and educate citizens how to manage self-care.
    - Reduce obesity in clusters through education and the promotion of wellbeing and prevention messages.
    - Proactive identification and signposting of people living with dementia to community based wellbeing and support opportunities.
    - Increase integration with the third sector and focus on prevention and wellbeing via promotion and engagement.
    - To expand the number of opportunities that are available for Older People to remain active and to encourage their contribution to communities and feel a sense of purpose and value in their lives
    - Promote Choose Well and health and wellbeing approaches across clusters/primary prevention programmes.
    - Develop local cluster counselling services to maintain access to mental health and wellbeing support.

    - Improve access to weight management interventions for overweight and obese patients within the cluster.
    - Early identification and proactive management of respiratory patients (e.g. pulmonary rehabilitation in the community).
- We want to increase some of the programmes such as falls prevention to maximise their benefits to the wider population
- To continue to seek opportunities to work in partnership to continue to expand Prevention and Wellbeing services for the benefit of the population of Bridgend.
- Further work is required to continually develop alternative community models including social enterprises and cooperatives that contribute to the ambition of developing resilient communities. This will be achieved by the ongoing seeking of opportunities to identify suitable facilities or potential services that can be developed to meet the needs of local communities. This will require close working with partners including the Third Sector and ensure that where available, community resources are maximised by co-productive design and delivery of services where appropriate.
- There are identifiable opportunities to support local people and communities to maintain or enhance their wellbeing by further developing our partnership and new approaches with the third sector. This approach would include a recognition of the current and potential contribution to the prevention and wellbeing agenda of social business.
- A focus on encouraging collaborative working and use of co-production is being taken forward.
- By working with Wales Co-Operative Centre we will start exploring how a "Connecting Carers" programme can promote collaboration and co-operation within 3-4 themed networks or groups including parent carers with children with additional needs, older adults who connect to social prescribing opportunities and also people with physical wellbeing challenges .There will be engagement with Digital Communities Wales recognising digital exclusion challenges.
- BCBC will build on its successful Healthy Living Partnership with social enterprise Halo Leisure and also the Awen cultural trust to improve community wellbeing and develop innovative responses to the prevention and wellbeing agenda.

SECTION 6: SUMMARY

Bridgend has been able to progress some significant service delivery transformation despite the challenges of increasing demand and budget pressures. There is still more to do to make sure that new service delivery models are fully bedded in and it is important that the momentum of change does not suffer as result of budget pressures. Since 2014/15 the Social Services and Well-being Directorate budget has been reduced by nearly 14 million pounds (20%). It is of note that such significant reductions in budget have resulted in the Directorate becoming more dependent on grant funding such as the Integrated Care Fund. Since 2015/16, grant funding has increased from 2.04 million to 5.14 million in 2018/19 which is an increase of more than 250% and whilst this presents a notable and needed increase, it does not replace the overall 14 million reduction that has been consumed since 2014/15. Even so, grant funding has become a critical source of funding to not only assist the transformation of service delivery, but also sustain services such as the Community Resource Team which remains largely dependent on ongoing Integrated Care Fund. The benefits of Integrated Care Fund would not have been achieved without successful collaborative working in the Western Bay Region that Bridgend is committed to achieving in the new region of Cwm Taf Morgannwg.

The changes in budget to the Social Services and Well-being Directorate has required the Directorate to make informed decisions including the careful targeting of resources. This has enabled Adults and Children services to pursue their commitment to service transformation. The transformation has been overseen by the Remodelling Programme Boards which have prioritised and managed the service change projects that have ensured that services and support are more preventative, person centred and cost effective. Examples of service changes achieved to date include:

- ✓ The Council has developed a range of “Early Years” services that are designed to deliver preventative services to families and children with the intention of preventing escalation of problems that previously would have resulted in reaching crisis before they were dealt with.
- ✓ To retain staff in Children Services, a Recruitment and Retention strategy has been developed.

- ✓ The Council has developed a Multi-Agency Safeguarding Hub (MASH) that brings together a range of partners to collectively respond to "vulnerable" children and ensure that each referral is dealt with appropriately.
- ✓ Advocacy Services for Adults and children services have been developed and improved.
- ✓ A range of preventative services that include IFSS (Integrated Family Support Services), and Connecting Families have been developed to work with families to take positive steps to change and improves their lives.
- ✓ The transformation of previous Children's accommodation into new models such as Sunnybank and Maple Tree House has enabled the implementation of new services that are designed to provide support to the most vulnerable of children looked after in a time effective way.
- ✓ Bridgend has also expanded its in-house Foster Care service by recruiting and supporting a wide range of carers and reduce the previous need to commission similar services from more costly Independent Foster Carers. In addition other services such as Reunification Support workers have been introduced to support Foster Carers and children to reduce the number of Foster Care Placements.
- ✓ A Transition Team has been created that will better support Children with Disabilities into Adult Services. This Transition Team will better plan the transition of children by sharing and combining assessments to ensure that information is shared between Adults and Children Services.
- ✓ An Accommodation Plan has been developed that identifies the need to have effective transition planning for "Looked After Children" accommodation needs as they approach Adulthood. This includes the development of a range of Supported Accommodation options for care leavers that support "Step Down" accommodation for Care Leavers
- ✓ The Council has introduced Local Community Coordinator roles to the three valleys of Ogmore, Garw and Llynfi. The focus of developing community resilience with vulnerable individuals and connecting them into supportive community based opportunities continues to be progressed by working closely with Bridgend Association of Voluntary Organisations, to continue the growth of the Third Sector in supporting communities.

- ✓ The Council will continue to increase the use of Direct Payments as a means of delivering increased choice and control, and also as a means to better support carers.
- ✓ To better support carers, Bridgend has commissioned services from the Third Sector to provide welfare benefit advice and other advice and support.
- ✓ By "mainstreaming" carers so they are considered a service user in their own right means that carer's assessments are offered and provided more consistently.
- ✓ Whilst commissioning of domiciliary care from the independent sector has increased, Bridgend has ensured that it has retained a necessary balance of in-house domiciliary care services.
- ✓ The Council has developed preventative and wellbeing approaches by establishing a "Well-being" project workstream that is aligned to the contribution of wellbeing services to the delivery of social care.
- ✓ Programmes have been developed that increase services that support dementia
- ✓ Traditional models of Learning Disability Day Services have been replaced by Community Hubs that is based on the principle of localised support services.
- ✓ The use of Telecare and assistive technology services have increased and wrap around services such as "Bridgelink" Mobile Response Team have developed to provide services that keep people safe in their own homes.
- ✓ Occupational Therapy Services have been developed and are targeted so that the service is responsive to needs in different settings.
- ✓ Following a consultation approach with carers, the short break service has been improved and now includes an Adult Placement Scheme which also offers Short Break services.
- ✓ The development and expansion of a range of integrated services provided by the Community Resource Team has resulted in the Council increasing its success in keeping people at home for longer and supporting earlier hospital discharge.

- ✓ The Council has also developed and expanded a range of accommodation services that include Extra Care services, “Closer to Home” and “Core and Cluster”. Such services whilst adding more choice, have also reduced the dependency on traditional models such as Residential Care, but also enabled people to be provided suitable care settings closer to home, thereby reducing the need for out of county specialist placements.

The above evidence the transformation of services that have resulted in a shift in culture and a re-balance towards increasing preventative services that where possible target those situation that would have previously been subject to more expensive Long Term Care. However as services become leaner this shift of resource from Long Term services is becoming increasingly more difficult as whilst Preventative Services can slow down the need for Long Term Care, the need for Long Term services will continue, particularly with changes in the ageing population and socio economic circumstances that impact upon children.

The Directorate budget is also at constant risk of volatile cases especially in Learning Disability and Children’s Services that can result in unavoidable costs that can exceed 400k per annum. This plus the ongoing expectation that the council will be required to reduce their budget by a further £30 million over the next three financial years. This will inevitably impact on the Social Services and Well-being Directorate budget which could be expected to be reduced by a further £10 million over the same period. This additional challenge will require even more careful consideration as to how it can be achieved. Services are now “less fat” and therefore there is a real risk that to make service changes incoherently, will result in the balance of services becoming destabilised and the delivery of care becoming more costly.

6.1 Delivery Action Plan

The table below presents a summary of the identified actions for each service area that are described as “What else we need to do”, and also includes a description as to how this will be achieved

Children Services

What else we need to do	How will this be achieved	Desired Outcome
Universal Services • Continue to increase children and young people physical, emotional and educational development • Continue to work with schools so that they increase their contribution to Ageing Well in Bridgend intergenerational working and the development of age friendly communities.	The design of universal services is that we provide services to a wide range of children to provide support and where necessary early intervention services, that prevent unnecessary deterioration that can result in the need for higher level services. Closer working with schools is critical to develop knowledge of teachers and how to refer and access appropriate services as required.	• The provision of Universal Services which support children and families • Schools understand the range of services on offer and how they can be accessed appropriately.
Additional Services • To continually develop the service so that it better supports Information, Advice and Assistance. This will ensure that contacts and referrals to Children Services will be dealt with appropriately by the right level of service at the right time. In addition the service will continue to deliver its strategic plan that includes: ○ High quality universal and additional services are the building blocks of effective early help.	To continue to work closely with other professionals to advise on how services can be accessed appropriately. In addition to develop available information by continually improving content to provide information that is clear, concise and provides confidence.	• Maximisation of the benefits that can be achieved from the provision of good quality information that is timely and accessible and

○ Develop Childrens workforce so that it is able to identify additional needs at an early stage. ○ To review the service directory to ensure that it assists the children's workforce to have a clear understanding of how services are designed to support levels of need, and how all services, including those provided by partners, can be accessed. ○ There is a clear process in place to support effective multi- agency co-ordination of targeted support. ○ There is a clear Step Up and Step Down process in place. ○ A co-ordinated delivery programme of early help services and support across all ages and stages of a child's development.	The streamlining of pathways between services is also important in order that different levels of services are widely understood and reduces inappropriate referrals and contacts.	• Reduction in inappropriate contacts and referrals.
Vulnerable Services • **Reunification Support Workers**: A service has recently been introduced that is targeting a reduction in the number of breakdowns of Foster Care Placements. Following review of support services for children and young people in March 2018 which identified gaps in service		

delivery. This included a need for support for children in the care system whose foster placements are at risk of placement breakdown or require support to Step Down in terms of placement provision or to be reunified into the care of their birth family. Historically our edge of care Rapid Response Team (RRT) has been called upon to work on these type of cases, this had meant that the RRT had less opportunity to prevent children from coming into the care system. Therefore to increase capacity the Reunification Support Workers are being introduced and needs to be developed further. • **Family Support Workers**: The introduction of the Early Help service and associated "Hubs" has seen a significant increase in service demand. Therefore in order that more cases are prevented from escalating, additional Family Support Workers are being introduced to work with families. • Bridgend is also currently working with Rhondda Cynon Taf and Merthyr CBCs to develop a service linked to setting up a regional Reflect project. This project will aim to work with mothers who have had children removed	The creation and development of a range of "vulnerable services" has resulted in the availability of new services that have successfully delivered intended benefits. However the range of available services that have been developed means that some are better resourced and in some cases more mature than others. The intention therefore is to continue to seek opportunities to increase capacity of those services that have the potential to deliver additional benefits. This will require the performance management of these services so that their capacity is fully utilised and service shortfalls identified.	Increased capacity in a wide range of support services for those deemed 'vulnerable' that will meet a variety of needs and keep people out of statutory services.

from their care to prevent any further pregnancies which may lead to further statutory intervention. The development of this project is in its infancy and will be led by Barnardos • **IFSS Service**: The IFSS is required to be developed further. In particular increasing the number of referrals into the service is stretching the existing resources available, and Welsh Government has issued further guidance in respect of the criteria for IFSS in which the service could work with families affected by domestic abuse and mental health issues as well as parental substance misuse. Bridgend is evaluating this guidance to ensure that the service is upskilled to respond to these issues. • To continue to develop the use of the Advocacy service through the use of the "Active Offer" to ensure that all children receiving statutory care and support intervention are provided equal access to an Advocacy service.		

Complex and Acute Services • Establish a new model of residential provision for "Looked After Children" and young people and seek the best ways of meeting their individual needs including support beyond the age of 18 by offering specialist accommodation • We are working with partners in the new Cwm Taf Morgannwg Region to develop and introduce a MAPPS service to the benefit of the Region, whilst ensuring all services commissioned under the current arrangement with our former MAPPS partner, (which ends march 2020) continue. • To develop closer working with other Council services and in particular Housing services in order that Housing needs are identified and housing strategies are developed. • Fully Implement the Supported Accommodation solutions and ensure the service delivers the intended outcomes. • Further develop accommodation and placement opportunities for children and young people by greater collaboration with partners such as health and housing • Consider how children's therapeutic needs can be met through further commissioning of	The very nature of Complex and Acute services is that they are available to support and assist children that are either Looked After or Children in Need. Therefore to better support the most vulnerable of children we will continue to work with others to develop new and expand existing services to ensure that the needs of the most vulnerable are supported. This will require us to work closely with other Council services such as Housing in order that Housing strategies are better informed and a better range of accommodation is commissioned. In addition we will work in collaboration with the Cwm Taf Morgannwg Health Board and Local Authorities in the region to develop new regional services and to continually improve existing service provision.	• A range of cost effective services that better support our most vulnerable children will be available

services within placement services and within reunification team. Continue to have discussions with current therapeutic providers with a view to 'securing a menu' of bespoke options, which meet the individual needs of children within a common model or framework, to be phased in by the end of the current financial year. • Review of Brain based attachment trauma and reliance training programme (BBAART) which will continue to be rolled out during 2019/2020 to social worker and foster carers and residential workers. The training department will lead this review to ensure that the programme is revised, maximising learning and development for all social care staff. • We will meet and reflect on a quarterly basis, to ensure that all models of therapeutic intervention and learning will work in a complimentary way, and that each will have mechanism for reviewing and measuring outcomes		

Transition Services

What else we need to do	How will this be achieved	Desired Outcome
• The Directorate Transition Project Board will continue to oversee the implementation of the Transition Team and ensure that its creation delivers the anticipated benefits. • Establish ways to engage with Education and Early Help services with the long-term goal of them being virtual members of the transition team. This engagement will attempt to ensure that transition is not seen as a social services only issue, but to ensure that services are better joined up and delivered holistically. • Discuss and agree with Cwm Taf Morgannwg Health Board to identify how they can be engaged as appropriate to jointly work cases in transition and ensure that children and adults are provided effective and equitable specialist health services. This also includes children access to appropriate mental health services as required.	The service strategy to improve Transition arrangements is based on the creation of a Transition Team that is already under development. This team will create the essential bridge between Children's and Adult's services and ensure that the care arrangements for young people in transition will be planned for from 14 years of age. The Transition Team will also be provided with a "pooled budget" that will consist of funding provided by Children and Adult services	• The planning arrangements for young people in transition into adulthood will be effectively managed from 14 years of age.

What else we need to do	How will this be achieved	Desired Outcome
• To develop a Commissioning Model that is supported by the development of a "pooled budget" made up of budget from Adults and Children services in order that services are better designed to meet the needs of young people in transition. • To continue the previous regional vision that was developing in Western Bay with Cwm Taf Morgannwg region to ensure that potential benefits to support transition services that could be achieved by a collaborative approach are identified and implemented as appropriate.		

Adult Social Care

What else we need to do	How will this be achieved	Desired Outcome

INFORMATION AND ADVICE
• Give people more choice and control over what support they receive by providing early access to advice and information;
• Continue to improve the ways in which the Council provides good information, advice and assistance to the public, including increasing the support available through local community co-ordinators;
• To develop long term sustainability by working with the Third Sector to:
  ○ Connect local people with their communities, develop the use social prescribing opportunities to signpost people to support networks
  ○ Increase the use of Local Community Coordinators beyond the "valleys" to other areas in the County Borough
  ○ Introduce "Community Navigator" roles that support people to meet
	Adult Social Care is already working in collaboration with Bridgend Association of Voluntary Organisations to expand the use of community resources that can build "Resilient Communities". The expansion of community resources such as "Navigators" and Coordinators will provide an accessible service that understands available local services and provide information and advice as appropriate.
	
	Such developments will be underpinned by the development of the Common Access Point and closer working with the Corporate Contact Centre in order that the services are coordinated and better support the public to receive the right level of service when needed. This will require the ongoing development of quality service information that can be easily accessed in a timely manner.
		• Effective maximisation of the benefits that can be achieved from the provision of good quality information that is timely and accessible and reduces inappropriate contacts and referrals.

What else we need to do	How will this be achieved	Desired Outcome
their needs in community settings and reduce the need for managed care ○ To ensure that the roles and responsibilities of all services are understood so that cases are appropriately managed by the correct service. This will require the development of criteria and pathways that enable people to be escalated and de-escalated between services as necessary. • To make better use of available resources such as DEWIS and Info engine so that citizens will increase their use of such services before contacting Common Access Point • Develop a culture within Adult Social Care so that all staff make better use of available information resources. • To continually develop information and how it is used for community resources in order that practitioners are able to consider the potential of community		

What else we need to do	How will this be achieved	Desired Outcome
groups as a mainstream service to provide additional care and choice.		
ADVOCACY • Develop our Advocacy service further so that it supports local knowledge exchange via a Bridgend advocacy network • Link the Advocacy Network to wider Information, Advice & Assistance services offered by the Council and others, and will help those involved in the referral process to provide a more collaborative approach to supporting individuals. • Enable access via the Advocacy Hub to experienced specialist advocacy providers able to support specific needs, and to also link to other services including informal community support services, peer advocacy and referrals into IMCA/IMHA (mental capacity and mental health advocates) as required. • Continue to work strategically with Golden Thread Advocacy Programme to	Whilst Bridgend has made considerable progress with improving available and accessible Advocacy services, there is more to be done. Therefore Bridgend will continue to work closely with others such as the Golden Thread Advocacy Programme and expand the Advocacy services available	• Individuals will be better supported as they seek assistance from Adult Social Care in Bridgend and will also ensure that service users have access to Advocacy services when needed.

What else we need to do	How will this be achieved	Desired Outcome
help refine and to continually improve the Bridgend Voice & Choice service.		
DIRECT PAYMENTS • To continue to increase the use of Direct Payments • To broaden the use of Direct Payments beyond the traditional additional groups of Learning Disabilities and Physical Disabilities • Develop the use of "pooling" Direct Payments to ensure that they are used in a cost effective way and available "personal assistant" resources are used effectively. • To explore the use of developing cooperatives in relation to the provision of direct payments	The use of Direct Payments has been increased considerably over recent years. This has resulted in providing better choice to individuals and reduced individuals dependency on traditional services such as Domiciliary Care and Day services. Direct Payments therefore enable service users to live more independently and therefore we will continue to offer Direct Payments appropriately Build on existing relationships with Wales Co-operative Centre and third partner organisations such as BAVO	• Individuals who access a Direct Payments will benefit from greater flexibility, independence and choice
CARER SUPPORT • Support carers in maintaining their roles; • Bridgend will continue to work collaboratively within the new region arrangements to improve support and services for carers	Bridgend remain committed to ensuring that services for Carers are well informed and are developed to ensure that there are a range of services available.	• Carers will be better supported to provide

What else we need to do	How will this be achieved	Desired Outcome
• Improved identification of carers of all ages • The mainstreaming of carers services to make it 'common practice' as opposed to a separate provision/consideration • Increasing access to support from an early stage in the caring role, making carers aware that there is help and where to access it • Ensuring a single point of contact for carers where they can access information, advice (including financial advice) and signposting • Increasing the awareness and uptake of carers assessments • Increasing the use of direct payments and being more creative with the use of direct payments • Engaging the Third Sector in the provision of services for carers • Increasing respite provision, group support and other support services for carers	Therefore we will continue to ensure that carers are identified and we will work closely with regional partners to develop collaborative services that are aligned to services that are commissioned locally.	essential care and support to those that they care for.

What else we need to do	How will this be achieved	Desired Outcome
COMMUNITY OPPORTUNITIES • Ensure that stakeholders and our teams have knowledge and understanding of the support that the local community co-ordination resource and the navigators can provide which will relate to the geographical populations and locations supported and the roles and capabilities of the staff to support various levels of need and complexity. • Support the development of a new generation of community health and wellbeing centres for our residents with health partners; • Reshape the current model of Older People Day Services so that people are supported to access a wider range of day time opportunities. • Work in partnership with the Third Sector, town and community councils	We will develop community opportunities that are local by design and supported of targeted groups such as Mental Health and Dementia. This will be achieved by the ongoing seeking of opportunities to identify suitable facilities or potential services that can be developed to meet the needs of local communities. This will require close working with partners including the Third Sector and ensure that where available, community resources are maximised by co-productive design and delivery of services where appropriate. To work closely with Town and Community Councils to ensure that joint approaches are developed to address similar ambitions.	• A greater range of community services that will deliver targeted services and support the development of Resilient Communities.

What else we need to do	How will this be achieved	Desired Outcome
and community groups to meet local needs; • Work with partners and the Third Sector to strengthen communities and identify the best way of providing services locally; • Enable community groups and the Third Sector to have more choice and control over community assets; • To develop a means of measuring and monitoring impact of preventative interventions • To continue to increase the contribution of schools to the "Age Friendly" communities • Invest into community based services that provide a wider range of mental health services including the expansion of more community based help and support. • The Council needs to develop and align transport links that better support people to access and benefit from the	To work more closely with more schools and extend the current programmes.	

What else we need to do	How will this be achieved	Desired Outcome
range of wellbeing services that have and continue to be developed. This will require a corporate approach to resolving this critical issue. • Develop the multi-agency model to create a brokerage type service in the community areas that recognise the broader range of opportunities to connect people to. • Ensure that there are clear pathways in place for individuals to self-refer or for professionals to connect people into community support opportunities. This will include establishing clarity on the need for people to be able to be connected into community based opportunities sustainably including those run by volunteers and the Third Sector. • Development of a communication plan that ensures the range of stakeholders are aware of the objectives of the transformation investment and its objective of accelerating the pace of change for a defined period of time.	The council will take opportunities to improve Transport links that improve access to available Wellbeing services	

What else we need to do	How will this be achieved	Desired Outcome
• In partnership with BAVO and the Third Sector, to work with navigators to identify gaps that exist within communities and to utilize the transformation related grant schemes to build Third Sector capacity. • To ensure that there is a focus on medium term sustainability and to ensure that investment into the Third Sector and volunteer effort builds a resilient model for when funding might no longer be available for roles identified. • In discussion with health colleagues to identify the development of a specialist dementia model. This will be progressed as part of the development of localised services and in particular the unlocking of specialist capacity at Bridgend Resource Centre		
COMMUNITY EQUIPMENT, AIDS, ADPATATIONS AND TELECARE • Explore expanding the access to assistive technology and Bridgelink Mobile	The use of assistive technology is still developing. Advancements in this	

What else we need to do	How will this be achieved	Desired Outcome
Response Team to individuals who do not have a Care & Support i.e. a Private Pay option. • Explore the use of assistive technology and how it can support Adult Social Care's ambition of supporting people to stay at home for longer.	technology is increasing at speed and we will therefore ensure that such advancements inform our future use of such technology that is becoming increasingly important to support people to live safely and independently in their own homes.	• More people will be supported to live at home for longer.
SHORT BREAKS • Increasing respite provision, group support and other support services for carers • Increase the availability and uptake of short break/respite services considering alternative models that ensure flexibility of provision	As the numbers of carers increase, the availability of short breaks needs to increase. This will be achieved by commissioning more respite beds and services that are flexible to provide respite at home	• Carers will have access to essential breaks which will enable them to continue in their caring role.
COMMUNITY RESOURCE TEAM • We need to further develop our working relationships with Cwm Taf Morgannwg Health Board to ensure integrated services are continually improved and better support Hospital Discharge and	The Community Resource Team plays a critical role in supporting Early Hospital Discharge and preventing unnecessary Hospital Admission, but its restriction to five day working is recognised as being a	

What else we need to do	How will this be achieved	Desired Outcome
unplanned admissions and other critical processes. • Further modernise our in-house provision of assistance and support for people in their own home to promote independence and to maximise their potential. • Provide a common access point open seven days a week 8 AM to 8 PM for access to coordinated community health and social care and Third Sector support • Provide a non-selective reablement/enabling services accessible over seven days, • An expansion of the better at home bridging service, learning from the Cwm Taf regions Stay Well At Home project accessible over seven days • Increased the capacity of the Mobile Response Team and introduce capacity to deliver care at night • Expanded Acute Clinical Team supporting admission avoidance from the community	constraint on the service potential. The ambition therefore to extend the service over 7 days and from 8:00am until 8:00pm will be piloted through the "Healthier Wales" Transformation Funding that is available until March 2021. The evaluation of the effectiveness of the outcomes from the Transformation Funding will identify if the extended hours are delivering the intended benefits, which if are proven, it is expected that Cwm Taf Morgannwg Health Board will continue the investment as a means of saving hospital bed days and freeing up essential inpatient capacity.	• There will be greater ability to prevent unplanned Hospital Admissions and support earlier discharge from Hospital to home.

What else we need to do	How will this be achieved	Desired Outcome
• Step Up Step Down facility focusing on reablement, recovery and enabling respite, with the potential of delivering further alternatives to post-acute stays in secondary care, for example out of hospital assessment for long term care		
INTEGRATED LIVING • We need to continue to develop a range of housing accommodation that supports independence for those with complex and challenging needs.	We will continue to invest into a range of housing options such as "Core and cluster" to provide accommodation that promotes independence and choice. In the absence of Local Authority Capital Funding, we will continue to seek funding opportunities such as Integrated Care Fund to work in partnership with housing partners	• Increased number of people will have their needs met and will have greater opportunity to have choice and independence.
EXTRA CARE HOUSING • To evaluate and learn from what has been achieved to date and to identify opportunities to develop the future Model • Ensure arrangements in extra care are responsive to the wishes of tenants and allow them to meet their personal outcomes.	The development of additional Extra Care facilities will be explored with Housing providers.	• There will be a greater choice of alternative care settings to Residential Care.

What else we need to do	How will this be achieved	Desired Outcome
ADULT PLACEMENT • The quality and outcomes of the new collaborative service that are being monitored to ensure that the service "beds in". • The service will be developed and expanded to ensure that the benefits of the new Adult Placement Scheme are continually extended to include other services including Dementia.	The Adult Placement Scheme will be developed in partnership with the Vale of Glamorgan Council (the contracted service provider) to provide cost effective alternative services to other service groups such as dementia, as a means of providing carer relief.	• Greater choice of alternative family based care and support.
RESIDENTIAL PLACEMENTS • We need to continue to work with Cwm Taf Morgannwg Health Board and providers to develop more provision for Dementia • To work with providers to develop more Extra Care Accommodation • Working closely with the Cwm Taf Morgannwg Health Board, we need to increase the numbers of community based Reablement "Step Up, Step Down"	Working collaboratively with Cwm Taf Morgannwg Health Board and Housing partners will help us develop a range of improved cost effective alternatives to Residential Care that would deliver benefits to service users and partners	• Greater availability of suitable accommodation that meets increasing demands and range of needs.

What else we need to do	How will this be achieved	Desired Outcome
beds in the County Borough so that we have the flexibility to meet current needs. • Ensure services can meet the growing number of older people with LD who may have additional age related needs such as dementia or physical frailty • In summary we need to identify and commission different accommodation options.		

Wellbeing Services

What else we need to do	How will this be achieved	Desired Outcome
• We need to develop our resilient communities so that they are able to contribute to the objectives of the Council and partner organisation such as: ○ Develop links with the voluntary sector to promote and support self-care and independence (includes communication and integration). ○ Increase wellbeing, resilience and early intervention to support the health and wellbeing of the population. ○ Increase integration with other sectors to provide a key focus on wellbeing and prevention through engagement and active promotion of social prescribing.	This will be achieved by the ongoing seeking of opportunities to identify suitable facilities or potential services that can be developed to meet the needs of local communities. This will require close working with partners including the Third Sector and ensure that where available, community resources are maximised by co-productive design and delivery of services where appropriate. There are identifiable opportunities to support local people and communities to maintain or enhance their wellbeing by further developing our partnership and new approaches with the third sector. This approach would include a recognition of the	To build resilient communities that are able to work in partnership with the Council and contribute to joint objectives

What else we need to do	How will this be achieved	Desired Outcome
○ Use a 'make every contact count' approach to advise and educate citizens how to manage self-care. ○ Reduce obesity in clusters through education and the promotion of wellbeing and prevention messages. ○ Proactive identification and signposting of people living with dementia to community based wellbeing and support opportunities. ○ Increase integration with the third sector and focus on prevention and wellbeing via promotion and engagement. ○ To expand the number of opportunities that are available for Older People to remain active and to encourage their contribution to communities and feel a sense of purpose and value in their lives ○ Promote Choose Well and health and wellbeing approaches across	current and potential contribution to the prevention and wellbeing agenda of social business. A focus on encouraging collaborative working and use of co-production is being taken forward. By working with Wales Co-Operative Centre we will start exploring how a "Connecting Carers" programme can promote collaboration and co-operation within 3-4 themed networks or groups including parent carers with children with additional needs, older adults who connect to social prescribing opportunities and also people with physical wellbeing challenges .There will be engagement with Digital Communities Wales recognising digital exclusion challenges. BCBC will build on its successful Healthy Living Partnership with social enterprise Halo Leisure and also the Awen cultural trust to improve community wellbeing and develop	

What else we need to do	How will this be achieved	Desired Outcome
clusters/primary prevention programmes. ○ Develop local cluster counselling services to maintain access to mental health and wellbeing support. ○ Improve access to weight management interventions for overweight and obese patients within the cluster. ○ Early identification and proactive management of respiratory patients (e.g. pulmonary rehabilitation in the community). • We want to increase some of the programmes such as falls prevention to maximise their benefits to the wider population • To continue to seek opportunities to work in partnership to continue to expand Prevention and Wellbeing services for the benefit of the population of Bridgend.	innovative responses to the prevention and wellbeing agenda.	

What else we need to do	How will this be achieved	Desired Outcome
• Further work is required to continually develop alternative community models including social enterprises and cooperatives that contribute to the ambition of developing resilient communities.		

6.2 Consulting on the Service Delivery Plan

This Service Delivery Plan has attempted to capture the range of service transformations that have occurred over the last decade for Adult Social Care and more recently for other service areas. Many of these changes have been guided either by legislative changes such as the Social Services and Well-being (Wales) Act and or, in the case of Adult Social Care, intended as a result of the 10 year Commissioning Plan that was developed in 2010.

However the real purpose of this document is to provide strategic direction that identifies future service change for Social Care and Well-being services that will continue to provide transformational change. These ambitions cannot be developed in isolation, and any future changes will be underpinned by our commitment to engage and consulting with service users, citizens and partners to ensure that services are developed in a co-productive manner.