# Briefing report on the current position in relation to Preventative Services across Cardiff and the Vale of Glamorgan

CARDIFF & VALES OF GLAMORGAN SOCIAL SERVICES

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March 2016

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## Background

The Social Services and Well Being (Wales) Act 2014 signalled Welsh Government's intention to shift the emphasis of Social Care from acute and intensive services towards prevention, health promotion and community services. It encourages investment in Prevention to improve people's wellbeing and wherever possible to prevent hospital admissions and the use of institutional care. In order to achieve this aim it will be important to embed a preventative ethos in partnership with the Third Sector, local business sector and public services across Cardiff and the Vale of Glamorgan, so that people are actively supported to:

- Look after themselves, stay healthy and retain their independence
- Participate fully as active members of their communities
- Choose and have easy access to the type of help they need, when they need it
- Remain safe and secure and continue to enjoy a good quality of life

The purpose of this paper is to describe the current position with regard to preventative services across Cardiff and the Vale of Glamorgan, as well as setting out the linkages to other relevant areas of Act implementation and key actions to take forward the agenda.

## The Social Services & Well Being (Wales) Act and Preventative Services

The Social Services & Well Being (Wales) Act will be implemented from 6 April 2016. It brings in new duties for local authorities, local health boards and other public bodies, and covers adults, children and carers.

The Act aims to reform and simplify the law: it repeals many previous laws and guidance relating to care and support and replaces them with this Act. It builds on the White Paper 'Sustainable Social Services for Wales: A Framework for Action' to modernise the law for care and support in Wales.

The Act aims to change the way **people's** care and support needs are met – putting an individual at the centre of their care and support and giving them a voice in, and choice and control over, reaching the personal outcome goals that matter to them. Central to this is the concept of **well-being** – helping people to maximise their own well-being.

The Act attempts to rebalance the focus of care and support to **prevention and earlier intervention** – increasing preventative services within the community to minimise the escalation of needs to a critical level.

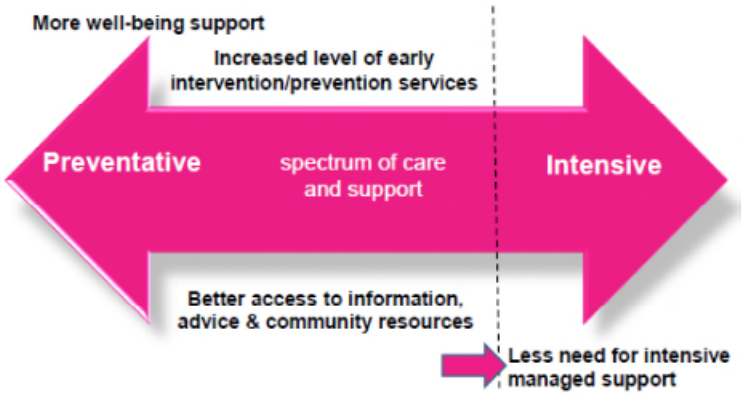
The Act creates both a strategic and practical duty in relation to preventative services. At a strategic level, local authorities and local health boards will be under a duty to assess the extent of need for a range and level of preventative services (see Population Assessment pages 16 - 19). At a practical level, local authorities are required to provide/ arrange for the provision of services that will contribute towards preventing/ delaying/ reducing the development of needs for care and support; minimising the effect on disabled people of their disabilities; helping to prevent people suffering abuse and neglect and enabling people to live their lives as independently as possible.

Strong partnership working between organisations and co-production with people needing care and support is a key focus of the Act. The Act requires a culture change from the way in which services have often been provided, to an approach based on **collaboration**, and an equal relationship between practitioners and people who need care and support and carers who need support.

These principles will enable people to be at the centre of their care and support and ensure their well-being will be central to any decisions made about their lives.

Part 2 outlines the overarching duties that relate to anything people do under the Act, including the well-being duty. Part 2 also sets out the requirements to undertake a population assessment, and provide preventative services and an information, advice and assistance service, as well as the duty to promote social enterprises / diverse forms of delivery.

## What the Act is trying to achieve in relation to Prevention




*Shown above is a diagrammatic representation of the principles and assumptions underpinning the Act.*

The key assumption is that through an increased level of effective earlier intervention / preventative services, including better access to information and advice for everyone, and well-being support for those who need some help (the left hand side of the care and support spectrum), more people will be able to be supported without need for managed intensive support. Hence the dotted line moves to the right: fewer citizens will need care and support planning for managed, complex care.

The Act attempts to rebalance the focus of care and support to prevention and earlier intervention – increasing preventative services within the community to minimise the escalation of needs to a critical level. The Act also recognises carers' vital input and aims to help them maintain their caring role, which of course will often help the people they care for to postpone the need for more managed, complex care.

Promoting prevention needs to happen at a strategic, operational and individual level by local authorities and their partners. The Part 2 Code of Practice identifies ways that local authorities can 'do' prevention on a strategic level by setting out tools, methodologies, services and behaviours. This will require a robust population assessment and good partnership working to collect, analyse and act on information about the needs and outcomes that are important to the population.

At an individual level, the local authority has a duty to assess whether, and if so, to what extent, the provision of preventative services could contribute to the achievement of personal outcomes or otherwise meet the needs of an individual. The assessment of individuals and getting this right is crucial to not only the success of promoting prevention but also providing evidence about what type of preventative services are needed and where.

## Code of Practice

The Code of Practice for Part 2 states that *"There is no one definition for what constitutes preventative activity. It can be anything that helps meet an identified need and could range from wide-scale measures aimed at the whole population to more targeted individual interventions, including mechanisms to enable people to actively engage in making decisions about their lives… local authorities should consider the range of options available*."

The Act does require that local authorities must provide or arrange for the provision of a range and level of preventative services which they consider will achieve the following purposes:

a. Contributing towards preventing or delaying the development of people's needs for care and support

b. Reducing the needs for care and support of people who have such needs

c. Promoting the upbringing of children by their families, where that is consistent with the well-being of children

d. Minimising the effect on disabled people of their disabilities

e. Contributing towards preventing people from suffering abuse or neglect

f. Reducing the need for:

   i. Proceedings for care or supervision orders under the Children Act 1989

   ii. Criminal proceedings against children

   iii. Any family or other proceedings in relation to children which might lead to them being placed in local authority care, or

   iv. Proceedings under the inherent jurisdiction of the High Court in relation to children

g. Encouraging children not to commit criminal offences

h. Avoiding the need for children to be placed in secure accommodation; and

i. Enabling people to live their lives as independently as possible.

Local Health Boards must also take a preventative approach that helps achieve these aims, collaborating where appropriate.

## Charging for Preventative Services

Regulations and the Code of Practice in relation to Part 5 of the Act set out the arrangements for charging. The Act (section 69) makes clear that local authorities may impose flat rate charges for preventative services or assistance it provides or arranges in order to help the service be viable. However, flat rate charges made **must not** exceed the cost incurred in arranging or providing for the care and support, preventative service or assistance to which they relate. Local authorities should also avoid a situation where the charge discourages take up of preventative services.

In addition, the local authority **must not** charge for Reablement services provided to people returning from hospital for the first six weeks following discharge.

The local authority **must not** charge for preventative services for children.

## A Prevention Approach

Prevention is a term that is used increasingly frequently when describing health and social care services and policy. There is no definition or consensus as to what constitutes 'preventive services'. Compounding this lack of clarity is a further haziness around the boundary between health and social care and between social care and wider community services such as housing and transport. At its simplest, taking a prevention approach means building a stronger community infrastructure in neighbourhoods/localities and providing accessible public services for vulnerable adults to reduce, delay or prevent them from becoming socially excluded and needing more intensive, costly support. Its primary focus is not personal care for those with substantial and complex needs and it is not a simple re-labelling of existing traditional low level services, e.g. laundry services, meals-on-wheels.

From a narrow perspective, a preventive service may be one that aims to prevent or delay a specific condition or outcome. An example could be a service that aims to prevent admission to hospital because of a fall, where there is a well-defined outcome. A holistic or whole-systems approach to prevention carries within it both the idea of inclusion and engagement. It adds value to the social cohesion agenda, by delivering services and support that help to create and strengthen the 'glue' that binds communities together. People are enabled and supported to maintain and improve their own wellbeing, that of their families, neighbours and local communities. Using a wider definition, prevention includes activity that enhances and extends quality of life.

The Act reinforces a partnership approach to prevention and a recognition that developing and delivering preventative services can only occur through the local authority working closely with key relevant partners. Indeed, the whole local authority, not just social services needs to have a stake, and in terms of assistance to improve well-being, people may well require input from a variety of different key sectors, community and local businesses. The Act brings in new duties to promote not for profit organisations to provide preventative services which include social enterprises, co-operatives, user-led services and the third sector. The NHS also has a key role to play in terms or preventing and managing health issues for adults and children in line with "prudent health care." The contribution to prevention made by other statutory services such as the police, the fire service and schools is also very important.

The principle of supporting families in caring for children is also emphasised by the Act with a focus on helping parents develop their own ability to identify and manage problems, keeping families together in a safe, supportive and stable environment. The Act identifies specific areas for focus when considering preventative services for children and families. These are:

- The importance of cross agency work to prevent children from suffering from abuse of neglect
- The importance of preventing or delaying circumstances that might lead to a child or young person being looked after by a local authority
- The importance in youth justice to prevent offending or re-offending by children and young people

It is clear that children and families present a wide range of areas for preventative activity and there is already considerable experience to be drawn from national programmes such as Flying Start and Families First which have developed significant local approaches and initiatives.

## A Prevention Framework

In the absence of any specific definition for prevention, it may be useful to think about a prevention framework which is broken down into three general approaches – primary, secondary and tertiary prevention. These are described in more detail below.

### 1. Prevent: Primary prevention/promoting wellbeing

These are activities and services aimed at individuals who either have no current particular health or care and support needs, or where there is some identified risk that their wellbeing or quality life isn't as good as it could be. Promoting wellbeing services are often provided outside of the scope of traditional health and social care settings and provided in the community through voluntary groups or not for profit organisations. These services are focused towards people who are basically healthy but require some form of low level support or intervention to maintain their health, to be safe or get the most out of their lives.

Delivering and driving improvements in any approach to supporting independence within social care services must be seen in the context of this wider preventative agenda. Actions to address healthy lifestyle and the determinants of health through changes in behaviour can result in better health in the longer term, reduction in disease and limiting conditions and an associated reduction in demand for health and social care services. External factors such as inadequate housing and welfare reform also need to be considered.

Adopting a universal approach to this type of prevention across all sectors can help to reduce levels of need and the associated pressure that this places upon the health and social care sector as well as improving life experience and chances for people living in Cardiff & the Vale of Glamorgan. However, it is clear that much of the activity to deal with the wider prevention operates over a significant length of time and the outcomes of such interventions are not always clear. For this reason it will be important to also think about an approach in the short term which supports independence within the services that people access.

Primary prevention includes services, activities, facilities or resources provided or arranged that may help an individual avoid developing needs for care and support, or help a carer avoid developing support needs by maintaining independence and good health and promoting wellbeing. They are generally universal (i.e. available to all) services, which may include, but are not limited to interventions and advice that:

- promote access to good quality information
- support safer neighbourhoods and safer homes
- promote healthy and active lifestyles (e.g. physical activity, health walks)
- encourage lifestyle changes (e.g. stop smoking, weight loss, health trainers)
- reduce social isolation (e.g. befriending schemes)
- provide services for parents, children and young people (e.g. health visiting, basic parenting courses, teaching lifestyle skills to young people)
- encourage early discussions in families or groups about potential changes in the future, e.g. conversations about potential care arrangements or suitable accommodation should a family member become ill or disabled.

### 2. Reduce: Secondary prevention/early intervention

These are more targeted interventions aimed at individuals who have an increased risk of developing needs, where the provision of services, resources or facilities may help slow down any further deterioration or prevent other needs from developing. Research highlights effective interventions to tackle social isolation in vulnerable people to prevent loneliness are: community navigators, befriending, social interaction through community involvement and hobbies. Social group activities included group exercise, art, therapeutic writing and aspirating activities, with different studies showing a reduction in falls and improved physical health.

Early intervention includes falls prevention, floating support to help people to live in their own homes, minor adaptations to housing which improve accessibility or provide greater assistance for those at risk of a fall, and assistive technology including Telecare services. Targeted interventions also include approaches to identifying carers, including those who are taking on new caring responsibilities. Carers can benefit from support to help them develop the knowledge and skills to care effectively and look after their own health and wellbeing. Flying Start and Families First are networks of support for children and young people which also fall within the framework of preventative services.

Maximising independence services such as reablement type activities are designed to help those who already have an illness or disability to live as active and full a life as possible and to be safe in the services that they access. These services could be traditional social care and health based interventions but they need to be tailored to give people the right sort of support and help so that they can do more for themselves and remain independent for longer. Interventions will be for a short-term defined period, rather than on-going which can inadvertently lead to a reliance on services and reduce independence. Short-term targeted care and support is support required in the short term to assist people to recover their health and wellbeing.

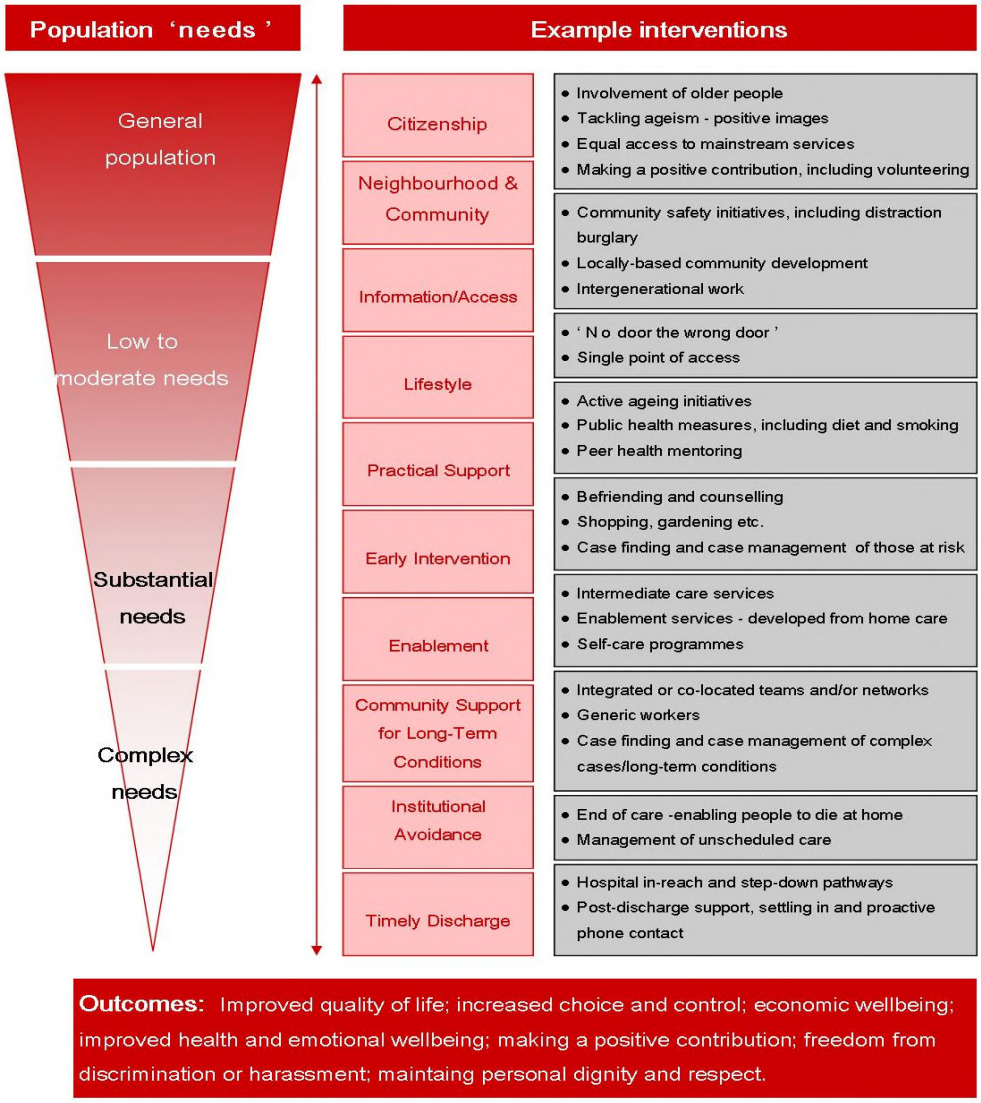
### 3. Delay: Tertiary prevention

This is aimed at minimising disability or deterioration in people who already have an established health condition/s or complex social care need/s and are at risk of needing further or more intensive services at a further point. This could be because of normal deterioration of a progressive condition or an adverse or trigger event which if not responded to effectively could be triggered into a high cost service, emergency care or residential and/or nursing care. These interventions include supporting people to regain skills and reduce need for intensive services wherever possible and also help to manage the volatility of unscheduled or unplanned care. Examples of tertiary prevention include:

- Post discharge support to reduce the risk of someone being readmitted to hospital
- Hospital at home services to prevent unnecessary hospital admissions
- Reablement and rehabilitation services which support both prevention to hospital and post discharge arrangements
- Support to improve the quality of life of carers
- Purposeful programmes in residential, day and extra care that prevent and delay deterioration or minimise disability rather than just “contain” need
- Family support services that prevent the need for substitute care for children

## The Spectrum of Prevention

Interventions are required across all three categories of prevention set out above in order to deliver the wellbeing outcomes to which people aspire. The spectrum of prevention in relation to older people is well illustrated diagrammatically in the figure below.




***(Reference: 'Improving care and saving money: learning the lessons on prevention and early intervention for older people' DH, January 2010)***

# Cardiff & Vale of Glamorgan Prevention Services Overview

### Links with Dewis project

It was agreed at the Regional Health and Social Care strategic implementation group on 23 October 2015 that Dewis Cymru would be the regional directory of choice used across health and social care service in Cardiff and the Vale. Dewis Cymru has been developed against Section 17 of the Social Services and Well Being (Wales) Act 2014 (The Act), in terms of supporting the provision of Information, Advice and Assistance (IAA) to Citizens through the development of IAA services.

*NB: Dewis Cymru will be referred to as Dewis from now on within this report. Where Dewis appears it is referring to Dewis Cymru and not the Third Sector organisation called Dewis.*

The Dewis project ( see Project Brief at Appendix 1) has been established to support the development of a comprehensive, up to date directory of services and resources available across Cardiff and the Vale of Glamorgan. It is intended that the directory will be used by local authority staff, Cardiff and Vale of Glamorgan citizens, the Third Sector and Health professionals.

The Dewis Cymru website includes a resource directory (a database) to which local, regional or national resources that promote and support wellbeing can be added. The inclusion of these resources within the website will enable citizens to see what is available in a particular area that might be of benefit to themselves, their family member/friends or the people they care for. It will also be of equal use to professional when developing a support plan and when information/advice advisors need to discuss or suggest options of support or engagement.

The resource directory is supported by a sophisticated search function that can return results based on keywords and/or geographical areas. This approach is aimed at replacing the more traditional approach of simply collecting and listing services that may be available in a particular area.

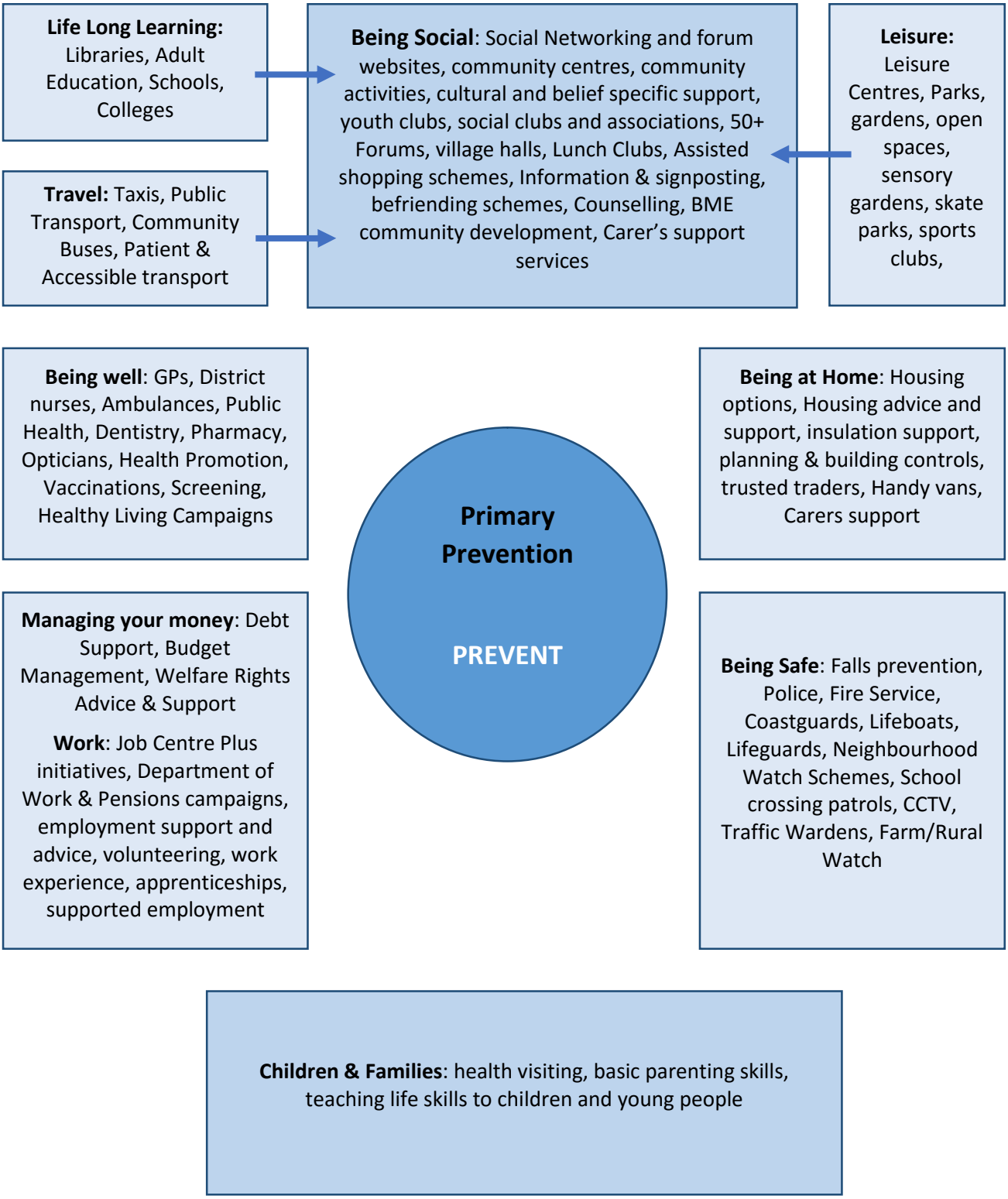
Dewis is expected to have a number of benefits for professionals and citizens alike including:

- Improved access to information and advice
- Improved access to prevention and well being services and an increase in self support
- Putting the citizen at the centre of the decision making process.
- In the longer term, Dewis is expected to support the further development and commissioning of preventative services across Cardiff and the Vale of Glamorgan as local authorities working in partnership with the University Health Board and the Third Sector make increasing use of the database to identify how services are being utilised as well as any gaps in services.

Set out below is an overview providing an example of services, broken down into primary, secondary and tertiary prevention service categories. It should be noted that some services fall into more than one category, in that they can support people with different levels of need. Not all services will be available across Cardiff and the Vale of Glamorgan and the intention of the Dewis project will be to map the current range of services to provide this picture.

Included under each of the categories below is a diagram representing the current 'What matters to you' fields found on Dewis Cymru which may be helpful in visualising the potential scope and extent of preventative services across the region. NB: A separate section for Carers is currently under development by Dewis Cymru.

**PRIMARY PREVENTION**

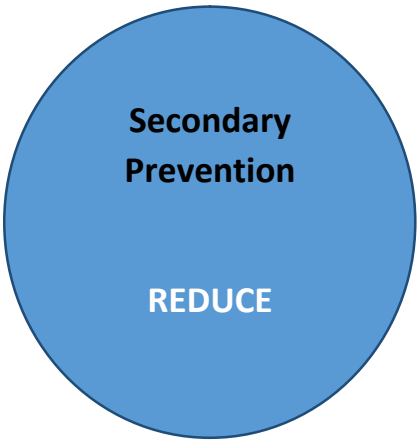


**SECONDARY PREVENTION SERVICES**

**Being Social:** Day opportunities, Social Activities, Group and community activities, Resource Centres, Drop-in centres, Peer Group support, Advocacy, One Stop Shops, Befriending, Dementia Memory Cafes, Support Workers, Self Help Groups, Advocacy, Volunteering, Carer's Support Services, Direct Payments

**Managing your money**: Debt support, fuel poverty and energy efficiency advice, Welfare rights advice & support

**Being at Home**: Supported Housing services, Sheltered Housing, Extra Care, Resettlement support, Floating support, Aids for daily living, Assistive technology, Community alarms, Telecare, Adaptations, Care & Repair, Handy Person Schemes, Carers Support



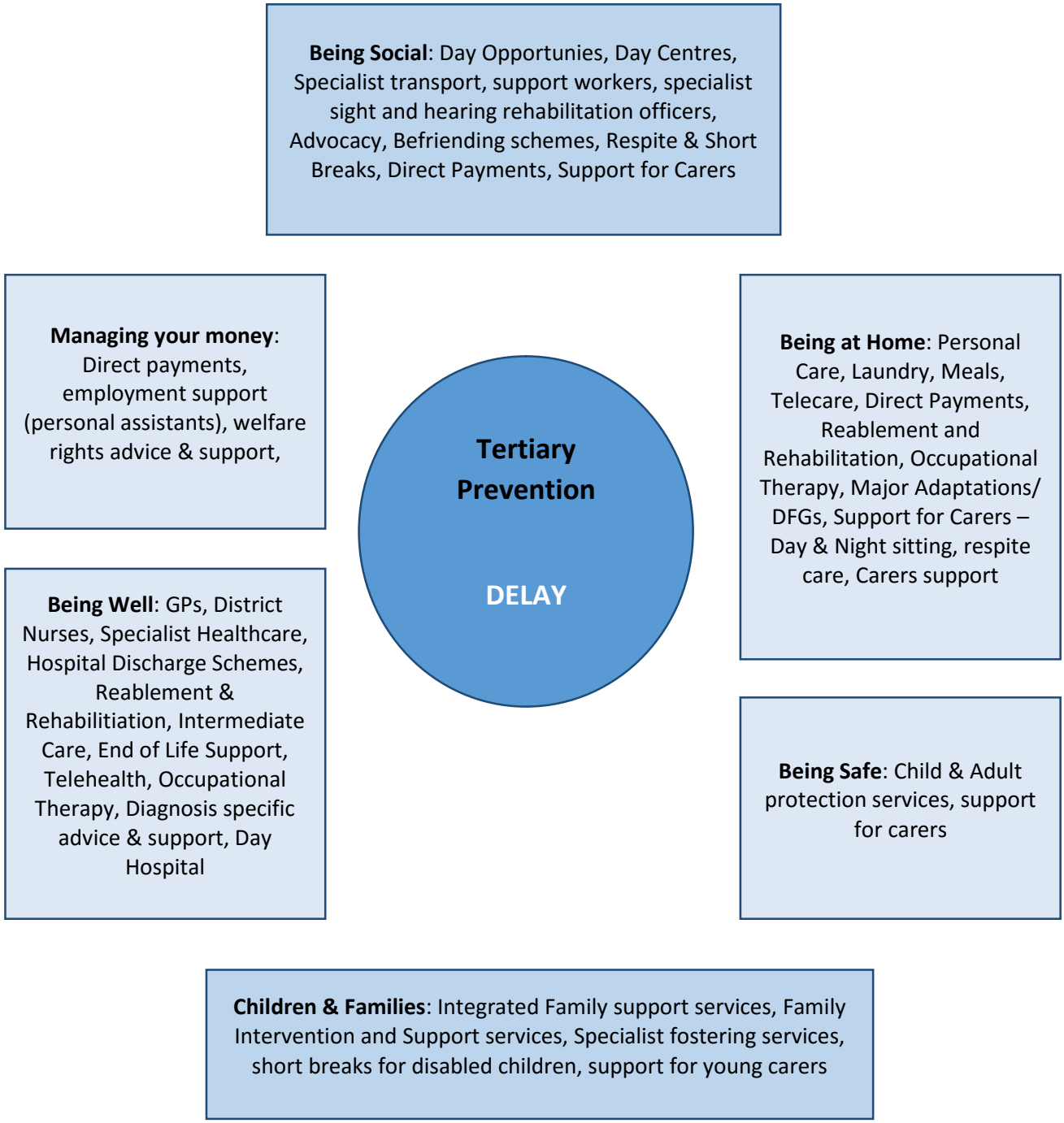

**Practical Assistance**: Shopping, Laundry, Housework, Bathing, Meals, Daily Living skills, Reablement, Carers Support, Direct payments

**Being Well**: GPs District Nurses, OTs, Physiotherapists, Allied Health Professionals, Bereavement support, Counselling, Continence Support, Home from Hospital Support, Footcare, Harm Reduction Service, Substance misuse advice, Mental health support services, Health Visiting, Therapeutic intereventions for children & families, intermediate care & reablement

**Being Safe**: Falls prevention, Family Intervention & Support Services, telephone help lines (domestic violence, crisis, rape etc) Advocacy

**Children & Families:** Flying Start, Families First, Communities First and Supporting People services, support for young carers

**TERTIARY PREVENTION SERVICES**



## Current Position re: Preventative Services across Cardiff & Vale of Glamorgan

As part of the Dewis project it was agreed to undertake a scoping exercise to identify across Cardiff and the Vale of Glamorgan:

- Directories / Databases already in existence
- What detail of information do they hold
- How and when data is being updated on them
- What programme have they been written in
- Number of organisations/ services that are held on the directory/database
- Are there paid staff to support them or are they maintained by volunteers

The results of the scoping exercise are summarised in Appendix 3 indicate that there are currently 28 known Directories/ Databases of services across Cardiff and the Vale of Glamorgan. These include the Third Sector membership directories held by the CVCs (including National organisations), Family Information Service Directories for children and families, Carers support directories, Supported Housing Directories, NHS Directories and bespoke Directories relating to Mental Health Services, Armed Forces etc.

It should be noted that there are some distinct differences between the directories and databases and the rationale for developing these. Some directories such as Cardiff & Vale Mental Health Services and "Where U stand" contain information about how to navigate the range of mental health and learning disability services, how to get and assessment, definitions of conditions etc. and provide a good resource for carers to use as a reference. Some databases such as those used by the CVCs are the mechanism used to invite members to whom they are accountable, to AGMs so that they are properly involved in the process of electing trustees, receiving information etc. Further consideration about how the information contained in these databases/ directories is captured in the future will need to be considered as part of the Dewis Cymru project and the future development of this going forward.

The scoping exercise revealed that information relating to more than 9,400 organisations/services across Cardiff and the Vale of Glamorgan are included in the directories. There is a great deal of duplication and overlap in the information contained within the directories/databases and the detail of the information held also varies significantly. The scoping exercise also highlighted a diverse range of programmes used to hold the information – excel, access, paper based systems, word list & bespoke systems, and showed that there is currently no consistent approach to how and when the data contained within the directories/databases is updated.

The aim of the Dewis project will be to provide a single point of information for citizens and professionals across Cardiff and the Vale of Glamorgan which avoids duplication and means that anyone with information about resources in their area can contribute to the database. The action plans and timescales for completing the upload of information on to the Dewis database from each organisation involved in the Dewis project are still being finalised, although the aim is to get all the known resources from both Councils on by 31 March 2016 ahead of the Act implementation date of 6 April 2016.

A key factor in the success of the Dewis project will be ensuring the sustainability, quality and consistency of the information held on the database. It is intended that this will be achieved through effective governance and management arrangements ensured by cooperative working between organisations and networks and adherence to clear website administrative roles and resource directory content standards.

## The role of the Information, Advice and Assistance Service (IAA) in supporting a preventative approach

Information, advice and assistance has a vital role to ensure preventative services are accessible, that they are known about and that people are supported to gain access to them. People need to be able to make informed choices about what outcomes they wish to achieve and how best to live their lives and manage their well-being. To support this, the Act requires that local authorities put in place an information, advice and assistance (IAA) service to ensure that all people within the local authority area have suitable information, advice and assistance to access the most appropriate services. The IAA service will be a preventative service in its own right and will offer a first point of contact with the care and support system. For many people this will be their first encounter with social services. The Code of Practice for Part 2 says that "The information, advice and assistance service will be easy to use, welcoming and informative" and people must have an opportunity to explain what matters to them, to explore what options are available, and to find the help that they feel is right for them to achieve their personal outcomes.

Professionals involved in the IAA service will have a key role in signposting and referring people to support services available in their locality, particularly preventative services. For the most part these preventative and early intervention services are not part of the social care or statutory sector market so the role of the IAA service will be to inform people about the options available to them through the local community and where appropriate to support them to access these services by assisting them to make contact rather than solely offering them basic contact details.

The commitment given to the development of Dewis as an online resource directory to identify the services that are available and how they can be accessed, is fundamental to ensuring that the IAA service operates effectively in both local authorities. It will be important to also link both Dewis and IAA to commissioning and procurement so that there is a robust commissioning cycle, which utilises all data, and involves all partners in the planning and development of preventative services. By delivering this approach it is anticipated that as a region, Cardiff and the Vale of Glamorgan will build a stronger community infrastructure which is underpinned by an improvement and expansion of information, advice and assistance which is focused towards reducing health inequalities, delaying or preventing social exclusion and the need for more intensive, costly support from statutory agencies.

Further information about how the IAA service operates across Cardiff and the Vale is included at Appendix 3 together with some examples of case studies demonstrating the benefit of a preventative approach.

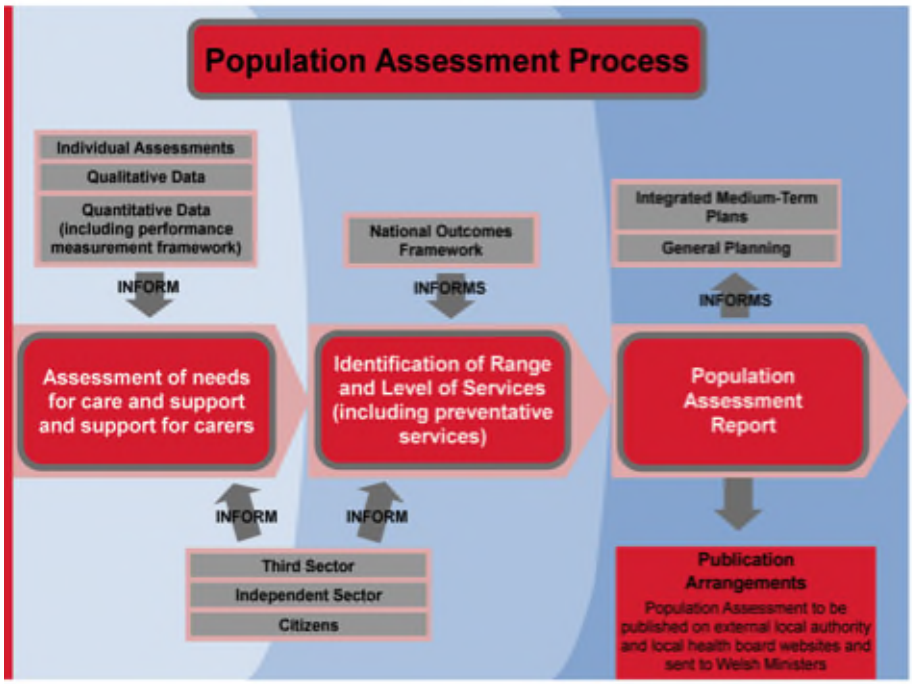
## Population Assessment

The Act requires local authorities and local health boards to jointly assess the extent to which there are people who need care and support, or carers who need support, in the local area. This population assessment links to and supports other requirements on local authority social services under the Act. For example, this assessment will inform local authorities in meeting the requirement contained within section 16 of the Act to promote social enterprises, co- operatives, user led services and the third sector. It will support the requirement to identify the care and support, and preventative services, these alternative service models should provide. It will similarly inform the nature of the information, advice and assistance service required.

In summary, the outline requirements set out in the Code of Practice are:

- That the responsible bodies (local authorities and Local Health Boards) must jointly produce a report of the outcome of the population assessment.
- That local authorities and Local Health Boards must have regard to the statement of well-being outcomes (issued under section 8 of the Act) when carrying out population assessments.
- That local authorities and Local Health Boards must engage with people (including adults and children with care and support needs, carers, and the parents of children with care and support needs) in the production of a population assessment report and establish a procedure for this engagement.
- That local authorities and Local Health Boards must engage with private sector and third sector organisations concerned with the provision of care and support or preventative services to the local population in the production of a population assessment report.
- That the first population assessment reports must be produced by 1 April 2017. Each local authority and Local Health Board must publish the relevant population assessment on its website and submit a copy to Welsh Ministers.
- That population assessment reports must be kept under review.

The following diagram is included in the Code of Practice as an illustration of what the process is all about:



It is intended that the population assessment will drive change, by enabling both local authorities and Local Health Boards to focus on preventing approaches to care and support needs. It will provide the information required to support resource and budgetary decisions; ensuring services and outcomes are targeted, sustainable, effective and efficient.

The draft Code refers to the population assessment ensuring good outcomes for people. It also refers to the Outcomes Framework and performance measurement framework in respect of how need should be assessed. In summary, the purpose of the assessment is to:

- Ensure services and strategies are based on evidence;
- Ensure a focus on prevention;
- Inform other activity such as developing social enterprises and information and advice services;
- Ensure a link with other strategic planning requirements including the Integrated Medium Term Plan (IMPT) and housing and homelessness services.

At a strategic level the population needs assessment will provide the opportunity to review not just population needs but the effectiveness of those currently being provided. The population assessment is intended to be a key tool to assist with monitoring and evaluating services to establish whether they are meeting individual and population well-being outcomes. The first population assessment reports must be produced by April 2017 and currently SSIA and PHW are working together to create a toolkit to support the development of these reports. The final content of the toolkit is in the process of being developed with an anticipated publication date of April 2016.

It is clear that the population assessment will be a vital component in assessing the current range and level of preventative services and whether these are sufficient. However, the requirement on local authorities to provide or arrange preventative services will come into force from 6 April 2016 a full year before the population assessment reports have to be completed. In the meantime it is expected that local authorities and health boards will provide or arrange services based on their current knowledge and understanding of the care and support needs and the support needs for carers and the Dewis project will have a key role to play in supporting this. Ensuring that as much information as possible about preventative services can be uploaded on to the Dewis ahead of the Act implementation date of 6 April 2016 will be vital to ensuring that the region is able to meet the requirements of the Act in this respect.

## Conclusions and Next Steps

Work already undertaken with regard to the Dewis project and the development of IAA services across Cardiff and the Vale of Glamorgan indicate that there is already a range of provision within the community and many of the primary, secondary and tertiary preventative services identified on pages 12 – 14 already exist. However, until the population assessment has been completed, the region will not be able to identify specific services, who these services are for – whole population, specific user groups, eligible individuals etc; the geographical coverage; or whether there are any gaps in the current provision.

**In the short term** there is a need for:

- The Dewis Cymru project to deliver on its Project Brief and Plan:
    - To complete regional and local action plans
    - Upload information about resources into the Dewis database ensuring that sufficient information is available for the system to go "live" by 6 April 2016
    - Promote the use of Dewis with staff across both local authorities, the health board, the Third Sector and other providers
    - Publicise Dewis and the IAA service externally to the public across Cardiff and the Vale of Glamorgan
- The project plans for Dewis and the IAA service to be effectively linked ensuring that IAA staff receive appropriate training to deliver the service and the requirements of the Act
- Ensure that there are effective arrangements in place to undertake the population assessment and that information uploaded into Dewis can be used to contribute to identifying the range of preventative services currently available
- Consider how the local authority and its partners will identify wider community and neighbourhood activities and groups not captured in the current range of Directories and resources to be uploaded on to Dewis.

**In the longer term** following the completion of the population assessment report, consideration will need to be given to:

- Developing a joint prevention strategy with key partners which seeks to create a culture of prevention and early intervention and supports the ethos of the Act. This would need to be developed across statutory agencies, third sector organisations and private providers in consultation with citizens and could potentially focus on the following key commitments:
    - Making enablement and prevention 'everyone's business'
    - Offering early support to all people
    - Ensuring that prevention and enablement activities reach all people
    - Enabling people to live in accommodation and access aids to daily living that support their independence, health and wellbeing
    - Delivering Public Health activities that have been proven to help people stay healthy and well, and that are targeted to people who most need that help
    - Giving people information, advice and support so they can help themselves to stay as healthy and well as possible
    - Enabling family carers to continue caring and stay well
    - Ensuring that networks of community support are built around people who are isolated
    - Developing partnerships with community organisations and groups to deliver early intervention and prevention activities across the region
    - Making sure people get more 'joined up' health and care support, and staff work in a more unified way around individuals with significant health and care needs

- Developing joint commissioning strategies to support the required strategic re-orientation of health and social care towards prevention and early intervention and enable a sustainable approach to offering opportunities for people across the region to stay active, healthy and independent for as long as possible in their home and community of choice.
- Agreeing with partners, priorities for investment to support the shift towards prevention and early intervention ensuring that there is a balanced investment in respect of services available for:
    - The general population (universal services) – primary preventative services and support
    - Low level preventative services for more vulnerable groups of people – secondary preventative services and support
    - People with high level, more complex needs – tertiary preventative services and support.

## Recommendations

1) Ensure that the Dewis Cymru project delivers on its Project Brief and Plan within the required timescales and that this is monitored and evaluated.

2) Ensure that there are effective links between the Dewis project plans and those required to deliver the IAA service and Population Assessment.

3) Ensure that staff who deliver IAA services receive appropriate training so that they are competent and skilled in accordance with the requirements of the Act.

4) Consider developing a joint prevention strategy with all key partners and stakeholders.

5) Consider the arrangements required to develop a joint commissioning approach which supports the shift in health and social care towards prevention and early intervention.

6) Agree with partners, priorities for investment which support a preventative approach.

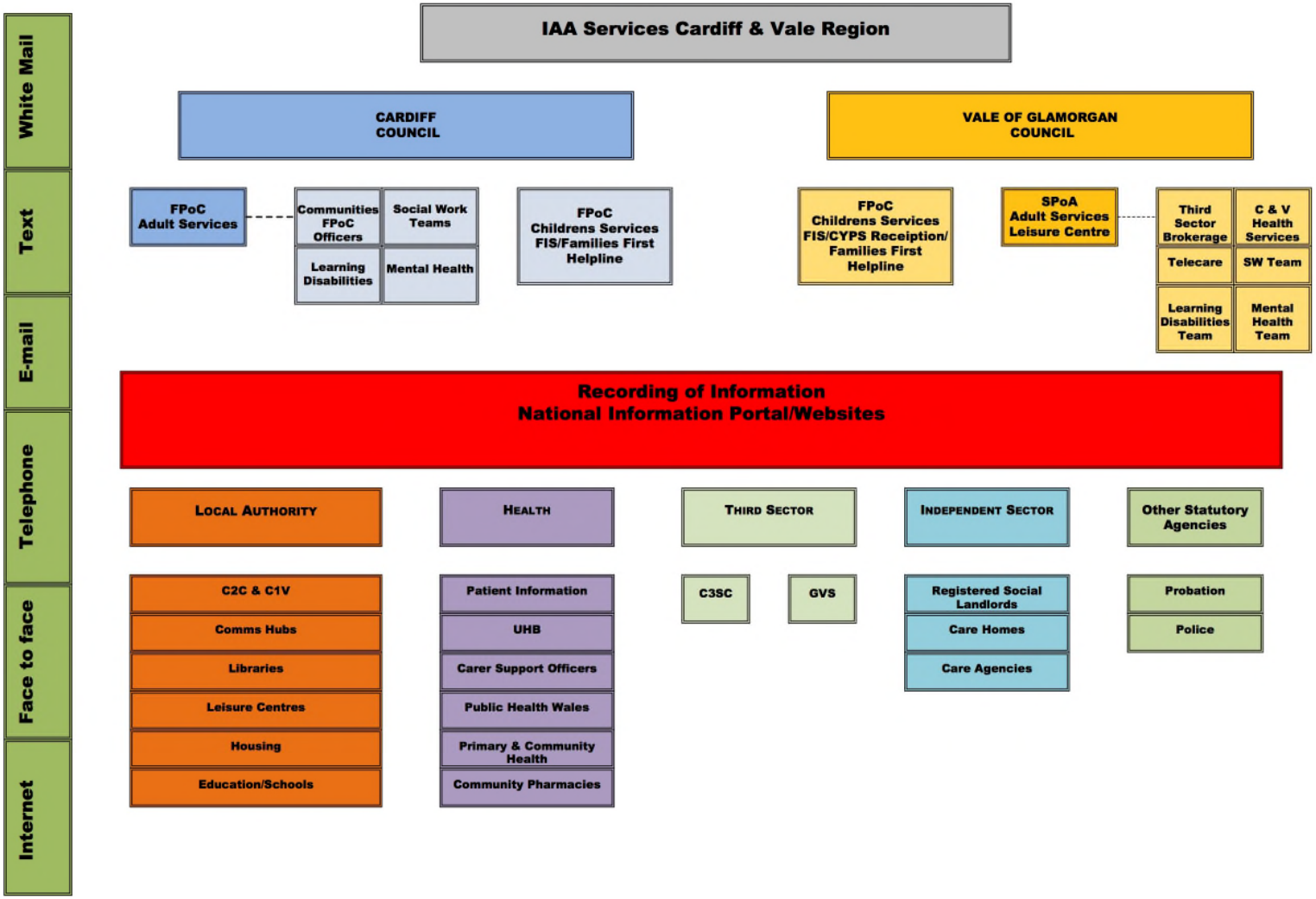
# Appendix 1

To view the Dewis Project Brief, please click on this link:

Dewis Project Brief v0.4

## Appendix 2

The diagram below sets out the approach to IAA services across Cardiff & the Vale of Glamorgan and highlights the range of different services and partners who provide these services.



# Case study examples

## Case Study 1: Care and Repair Cardiff and the Vale Casework Service

**Background**

Mr M contacted Care & Repair Cardiff as he had been sent a letter from the GP surgery offering him a 'Healthy@Home Check' from Care & Repair. Mr and Mrs M have never asked for help in the past but contacted us as were curious as to what we could offer.

**What did we do?**

- A Caseworker visited Mr and Mrs M and identified that both would be eligible for Attendance Allowance due to health conditions. A claim was put in and both received High Rate. Due to this, the Caseworker put in for Carers Allowance for both and as a result, they were then entitled to claim Guaranteed Pension Credit and full Council Tax Benefit, Severe Disablement Allowance and Carers Premium.
- The Caseworker also identified the need for rails and a stair lift in the home. In turn, a referral was made to Care & Repair's Occupational Therapist who assessed and referred them for a heavy duty stair lift, two internal grab rails, an external rail and a 5" bath step.
- Due to the nature of Mrs M's health and her need for a downstairs toilet, the Caseworker sought funding via the ILG grant (Independent Living Grant) to fund a downstairs toilet extension. Care & Repair's Contractors Panel was used to source quotations and to undertake the works. Care & Repair's Occupational Therapist provided the Caseworker with a report to enable the fees for the Building Planning and Building Control to be waivered.
- As a result of the Pension Credit Award, the couple were now eligible for an ECO grant for a new boiler.
- The Caseworker also referred to Care & Repair's Home Safety and Security Project for 2 smoke detectors.

**How are they better off?**

- Both Mr and Mrs M can live in dignity in respect to personal care, due to the stair lift and the down stairs toilet being provided. The stair lift cost £3,000.00 and the ILG was £6,748.00.
- Both Mr and Mrs M were at risk of falls and the stair lift has lowered that risk. The other adaptations provided may also prevent falls in the home, at a cost of approximately £120.00.
- Mr and Mrs M feel safer by having the smoke detectors in place at a cost of £50.00.
- Mr and Mrs M feel more independent and financially stable due to the extra money they have received. The couple are now better off by £272.00 extra per week.
- Due to the new boiler, Mr and Mrs M are now warmer and saving on fuel bills and due to the efficiency of the new boiler approximate value of £3,000.00. Their worries about the old boiler – numerous repairs, have now been removed.

**What would have happened if Care & Repair did not exist?**

- Mr and Mrs M may have fallen without the use of the adaptations in the home.
- Their well-being (due to personal issues) may have also suffered without the use of the stair lift and the downstairs toilet.
- Again, poor well-being could have been caused by worry over the high heating costs and the repair costs of the old boiler.

- Mr and Mrs M would have missed out on benefits and thus extra money per week helping them to stay independent.
- Should there have been a fire in the home, Mr and Mrs M may not have been able to get out of their home in adequate time, without the early detection from the smoke detectors that had been provided.

## Case Study 2: Cardiff Independent Living Service

**Background**

Mr L is 51 years of age and has Necrotic Toes causing severely reduced mobility. District Nurses attend every day for wound care. Mr L requested assistance with a benefit entitlement checks and advice on somebody to help with household tasks.

**What we did and How the person is better off:**

An independent living visiting officer visited Mr L and undertook a full holistic review of the service users needs in order to remain independently living in their own home.

Mr L mobilises on crutches and it became apparent that he struggled to get to back into the chair's low position. After discussing how he bathes and mobilises around the house it was agreed that I refer to the Occupational Therapy Service.

Full income maximisation review was undertaken by the visiting officer, and a referral for a new claim for Daily Living component of PIP of an additional £82.30 per week was made. Once in payment Mr L will then be eligible to the Severe Disability Premium payment within his Employment Support Allowance, which is £61.85 per week. Both benefits provided him with an additional £7,495.80 per year!

Mr L's home had no smoke alarms therefore referral made to the Fire Safety team to visit.

The visiting officer completed a Swalec Warm Home Discount Scheme application form completed to get £140 off his energy bills.

A referral to Speakeasy was made as due to his mobility he struggles to prepare food in the kitchen, which has been compounded by the fact that his microwave blew up which he said was 'his life line'. Speakeasy were able to provide Mr L with a microwave from a contact they had in a nearby church to where Mr L lives as they had a spare – the church arranged to drop the microwave to Mr L. Mr L also had arrears with his energy bills which Speakeasy also helped with.

Mr L had a leak in his bathroom which is causing a damp smell therefore referral was made Care and Repair to get assistance with this.

The visiting officer assisted Mr L to search for cleaning services and he us

**Service user/citizen feed back**

Mr L was amazed at the number of things the Independent Living Visiting Officer was able to help him with. He said having his microwave back was such a relief. All this would not have been provided without this intervention. He is better equipped in his home to get around after the Occupational Therapy visit. Mr L could not believe he would be better off by £7,495.80 per year. He sent a thank you to the officer involved.

## Case Study 3: Independent Living Service Cardiff

**Background**

Mr S is in his mid 70's and lives with his 16 year old granddaughter who is disabled and requires 24 hour care. Mr S lost his wife to cancer just after Christmas who had been the main carer to his granddaughter.

The telephony Contact Officer from our first Point of Contact team identified that the support from an Independent Living Visiting Officer was required.

**What We Did**

The visiting officer checked Mr S income with the DWP to ensure that his pension was up to date since his wife had passed away as Mr S didn't know what money he had to manage with. The visiting officer made a phone call to his bank for him to check his balance and find out his payment dates. A request was also put in to set up internet banking.

The visiting officer contacted SSE due to an overdue bill and his wife was still the main account holder. The name was changed a cheaper tariff identified. She also checked they had his granddaughters oxygen tank on their system as that would reduce the bill.

The visiting officer showed Mr S how easy it was to order shopping off his smart phone which he was using and we got some quotes for an internet package. The visiting officer also connected him to set him up with an Asda shopping app via his phone.

The Visiting officer also provided Mr S with a list of clubs to meet people and be less isolated. He discussed being able will be able the clubs once assistance organised through a carers assessment was in place for his granddaughter.

**How the person is better off:**

Mr S is very happy knowing that he will be able to take care of the essential things around the home and be self-sufficient.

**Service user/citizen feed back**

Mr S said "I would not have managed without you, a great help, something easy to you but seemed impossible to me and now I know what I am doing. You have been a saviour today."

## Case Study 4: Putting Families First

**Background**

The parent was identified by the school as being disengaged and uninvolved with her children's education. She was approached by the Learning Support Assistant who encouraged her to join the group. After much persuading, the parent attended sessions in Reading Readiness and the Parent Nurture Programme. Initially she was a quiet group member, reserved and uncommunicative; she struggled with group situations and was withdrawn, choosing not to participate due to a lack of confidence in her own abilities.

**What we did**

Over a period of weeks and then months, the parents confidence began to grow as she attended a number of other Putting Families First courses. On attending a Welsh course the parent began to help other learners struggling with their pronunciation. The Parent moved on to becoming more involved with school life and supported the planting of trees within a school group activity. The parent has progressed from being completely disengaged with the school and every aspect of her children's education, to being affirm advocate for education, and leading on several projects which benefits both herself and her family.

**How the person is better off**

The parent has grown in both experience and confidence and is now re-engaging with her children's education and has reported as now having the confidence to support them with their school work. Her children regularly see their mum coming to school and taking part in school life.

The parent is now a trustee for the committee set up to improve the school café, she supports the drop in at the café every week and makes herself available to chat with other parents. She has trained to deliver Geo-cache sessions for forest schools, she assists with the vegetable co – op and supports and promotes all learning / school and community activities that are offered. She seeks opportunities to share what she has gained with others.

She found that she enjoyed working with children so much that she sought advice from the Putting Families First Learning Support Assistant, who guided her on the next steps to becoming a Learning Support Assistant. The parent has now enrolled on a Level 3 Childcare course and is currently undertaking a placement at Ysgol Gwaun Y Nant.

## Case Study 5: Western Vale Family Support project

**Background**

The family - a single mum and her two children aged 4 and 3 months, live in the Western Vale. A referral was made for parenting support from the health visitor. There was a history of domestic violence as well as mum suffering from depression and having financial and housing issues. Both the children's names were on the child Protection register. The youngest child also had health problems and was due to have tests.

**What we did**

Support initially concentrated on routines for both children as well as boundaries and consequences for the older child. This incorporated sleep and bedtime routines as well. Due to mum's financial situation a referral was also made to the local food bank, with mum engaging well with the support from Western Vale Family Support and with Social Services and Atal Y Fro. Mum was happy to take on board the advice and support given and put this into practice, she was able to acknowledge and comment on the positive changes she was noticing with the children's behaviour, especially the good behaviour demonstrated by the older child, and put this down to the more structured routine she had established.

As the support continued Mum reported that she felt more confident in her parenting, and although the children's names remained on the Child Protection register at the time of the review case conference it was acknowledged how much progress mum had made.

An incident with mum's ex-partner, and with the youngest child reaching new stages of development, resulted in a new referral being put in from the Social worker for further ongoing support, as mums confidence about going out had dipped due to the incident with her ex. Despite this, Mum continued to evidence that she was sticking with her daily and bedtime routine and was using the strategies and advice given to deal with unwanted behaviour from her oldest daughter.

The health issues with the youngest child continued, with mum having to attend a number of hospital appointments, along with two weeks stays in hospital. Despite this, mum continued to progress and gain confidence in her parenting ability. In addition to receiving the 1-1 support within her home, she now started to attend the Pop in and Play sessions at the gathering Place.

**How the person is better off**

In May 2014 the children's names were removed from the child protection register with acknowledgment of the progress mum had made in respect of her parenting skills and confidence being recognised. This resulted in the 1-1 support ending. Prior to the end of the programmes support a home safety review was carried out, with equipment and advice given. Mum continues to access the pop in and play session at the gathering Place where she can access support and advice if needed on an informal basis and the children having the opportunity to enhance their social development, as well as having fun and enjoying the variety of toys and art and craft activities on offer.

Mums comment on her evaluation form stated "I *have learnt a lot from all the sessions and I have learnt to priorities my children's needs over my own. I am extremely grateful for all the help and support I've received"*

## Appendix 3: Results of the Scoping exercise for the Dewis Project

| List directories / databases already in existence | What detail of information does it hold? | How is the data updated? E.g. Role of staff member / volunteer? | When is data updated? | What programme have they been written in e.g. Excel, Access etc | Number of organisations that are held on the directory/database | Duplication? |
|---|---|---|---|---|---|---|
| **C3SC** | | | | | | |
| C3SC Membership directory of Third Sector Organisations | Name, contact details and brief description of the organisation (generally not individual services) | Electronically via admin staff at C3SC | Adhoc when people contact us. | E-vol | approx 640 | |
| **VALE FIS** | | | | | | |
| Family Information Service (FIS) Childcare Directory https://earlyyears.valeofglamorgan.gov.uk/fiso_live/publicenquiry/Default.aspx | Comprehensive details of childcare settings including childminders, day nurseries, playgroups etc. Info includes: opening times, contact details, cost, age range, facilities, whether can cater for special needs, school pick up, description etc | Annual review whereby staff in the FIS Team contact the service by email and phone. Also the facility for services to update their own details on line. Childminders are updated 6 | Nov - Jan annually (in preparation for the Childcare Sufficiency Assessment CSA) | External system - Tribal, hosted on Vale Council website | 320 | no |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | monthly. | | | | |
| FIS Family Support Directory https://earlyyears.valeofglamorgan.gov.uk/fiso_live/fsd/ | Comprehensive details of services that support children and young people and their parents eg. parenting, child development, health, disability, substance misuse, carers etc. opening times, contact details, cost, age range, language used, whether can cater for special needs, description, referral process, eligibility criteria, area served etc | Annual review whereby staff in the FIS Team contact the service by email and phone. Also the facility for services to update their own details on line | Annually throughout the year. | External system - Tribal, hosted on Vale Council website | 327 | Yes as contains information on Children & Young People Services teams and many third sector organisations |
| FIS Activities for Children & Young People age 0-20yrs https://earlyyears.valeofglamorgan.gov.uk/fiso_live/publicenquiry/Default.aspx | Details of leisure activities, parent & toddler groups, art and music groups, soft play etc. Info includes address, description, contact, age range, cost, opening times, whether cater for special needs, language used etc | Annual review whereby staff in the FIS Team contact the service by email and phone. Also the facility for services to update their own details on line | Annually throughout the year. | External system - Tribal, hosted on Vale Council website | 251 | Yes with leisure, sports, community centres and third sector |

| | | | | | | |
|---|---|---|---|---|---|---|
| Sports clubs for children, young people and adults (Sports & Play Development Team) | Online - name of club, type of sport, contact name, email and tel number. Back office - age, disability friendly, area, description, child protection trained and policy, DBS check, insurance | Used to be the role of an administrator but no funding so not being updated at the moment | When they are notified of changes. Less than annually depending on resources | Access | 140 | some with FIS activities directory and third sector sports clubs |
| Community Centres in the Vale | Address, contact details, cost, facilities, all activities taking place in the community centres, including name of activity, day and time | Staff member updates when he receives an update | When notified | word list | | Activities for children and young people will also be held on FIS Activities directory and duplication with third sector |
| Care Directory | Contact details of approved residential, nursing, domiciliary and day care services | Role of the Contract Monitoring Officer. Constantly updated | As and when changes occur | word list | 44 | no |
| Supporting People Directory (Accommodation, supported housing, floating support, services for older people | Housing related support services funded by Supporting People that currently exist in the Vale of Glamorgan, the services that they provide, who they are for, their location and how they can be accessed. | Contracts Officer updates info as they commission the services | At least annually, usually in June (in line with tendering process) | word as lots of narrative | approx. 70 | yes - housing associations, third sector support, FIS Family Support Directory |

| | | | | | | |
|---|---|---|---|---|---|---|
| Armed Forces Directory | Contact details, who the service supports etc (lots of national organisations) | | | | | yes but most are national organisations |
| Adult Courses (paid courses) | details of course, venue, dates costs for all Vale | Area Development Officer updates daily | Daily | In-house IT system that links to website | | no |
| Get Back On Track courses (free or subsidised courses) | details of course, venue, dates costs for all Vale | Adult Education Development Officer updates as and when | monthly when new courses arise | word flyer | | no |
| Youth Engagement Directory | | | | | | |
| **Other directories we are aware of** | | | | | | |
| NHS Direct Wales - Health & Wellbeing services http://www.nhsdirect.wales.nhs.uk/localservices/ | | | | | | |
| Cardiff & Vale Mental Health Services Directory http://www.cavamh.org.uk/directories/mental-health-directory/introduction | Comprehensive information about third sector, and other sector, mental health services. | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Cardiff & Vale Parents Federation 'Where U Stand' Directory http://www.whereyoustand.org/ | Extensive database of groups and organisations with information on services and how to access them. Written for carers by carers, especially those caring for a person with a learning disability. Hard copy is over 200 pages of A4. The online version is updated weekly and is far larger in content. The guide has a regional bias with much Wales-wide and UK content. It includes searchable database features by topic, region and keywords plus feedback by members. Enjoys around 2000 visits per quarter and used by social work professionals and families alike. | All staff maintain it but we dedicate some time per week for this | weekly or when information is presented | JOOMLA online content | 350 | Many databases have used Where You Stand as the basis for their content over the years. We have been involved in the development of several LG resources over the past two decades. In addition to around 350 groups and organisations held online a further 100 plus entries are included relating to a variety of services and opportunities including legislation and where to go to seek assistance. |
| **Cardiff FIS** | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Directory of Childcare Provision (registered and unregistered) | A range of information about childcare provision in Cardiff required by customers to enable them to make informed choices about childcare provision along with contact details for settings. Information used to inform Childcare Sufficiency Assessments (statutory duty of Local Authority) | By FIS, By identifiable staff member | Providers regularly reminded of the need to update details especially when required due to changes to service. | In house Cardiff Council database that can be extracted to Excel/PDF. | 467 | |
| Directory of Family Support Services | A range of information about Support Services for children, young people and families in Cardiff to enable customers to make informed choices about services available to meet their needs along with contact details for services. | By FIS, By identifiable staff member | Providers regularly reminded of the need to update details especially when required due to changes to service. | In house Cardiff Council database that can be extracted to Excel/PDF. | 294 | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Directory of Activities | A range of information about activities and play provision in Cardiff to enable customers to make informed choices about activities and play provision with contact details for settings. Information used to inform Play Sufficiency Assessments (statutory duty of Local Authority) | By FIS, By identifiable staff member | Providers regularly reminded of the need to update details especially when required due to changes to service. | In house Cardiff Council database that can be extracted to Excel/PDF. | 70 | |
| **Glamorgan Voluntary Services Directories** | | | | | | |
| GVS Members Directory | Contact details, area of interest, brief description, memberships related information, confidentiality option | Shared responsibility between staff | As and when an organisation joins / contacts GVS. Also verified annually | Access and Evol | 487 | Is specifically a members databases for purpose of charity operations. |
| Cardiff and Vale Carers Directory | A - Z of third sector, and other services for carers. Brief description of service and contact details | GVS. Ceri Venners and Linda Pritchard | Periodically - dependent on funding | Paper document and PDF on line | 150 | Some duplication, but this is specifically about carers services. |
| Older Peoples Directory | Brief description of service and contact details. Listed by type of service, eg. advocacy, befriending. | GVS. Ceri Venners and Linda Pritchard | Periodically - dependent on funding | Paper document and PDF on line | Approx 180 | Some duplication. |

| **Wales Council for Voluntary Action** | | | | | | |
|---|---|---|---|---|---|---|
| WCVA Directory | Broken into categories based on type and size, basic information, company house / charity number, active location, summary | WCVA contacts directly on a monthly basis (Nigel Evans) | Monthly mail outs - aim to target entire directory once per year | SQL | 4196 (includes duplicates, and potentially out of date) | |
| WCVA National Voluntary Organisation Directory | Broken into categories based on type and size, basic information, company house / charity number, active location, summary | WCVA contacts directly on a monthly basis (Nigel Evans) | Monthly mail outs - aim to target entire directory once per year | SQL | 700 (National) | |
| Community Database (Library Service) | Name, description, times, contact details, last updated, associated costs, other notes | Role of staff within the Library service | As and when the library service is approached | Library management system - 'V Smart' | | |