



ADSS Cymru

Leading Social Services in Wales

Yn arwain Gwasanaethau

Cymdeithasol yng Nghymru

THE **WELSH NHS CONFEDERATION**
CONFFEDERASIWN **GIG CYMRU**

Health and Social Care Celebrating Well-being

A selection of case study examples



“My care is planned by me with people working together to understand me, my family, and carer(s) giving me control, and bringing together services to achieve the outcomes important to me.”

Code of Practice definition of people needing care and support

Introduction

This publication has been developed by ADSS Cymru and the Welsh NHS Confederation to evidence integrating working and its benefits for the well-being of individuals. It provides examples of positive joint working between health and social care and the third sector. It focuses on well-being and presents a range of benefits that have occurred since the introduction of the Social Services and Well-Being (Wales) Act 2014 (2014 Act).

The Welsh NHS Confederation is the national membership organisation representing all the NHS organisations in Wales: the seven Local Health Boards and the three Trusts. It works to support members by acting as a driving force for positive change through strong representation and policy, influencing, communications and engagement work.

The Association of Directors of Social Services Cymru (ADSS Cymru) is the professional and strategic leadership organisation for social services in Wales and is composed of statutory Directors of Social Services, and the Heads of Service who support them in delivering social services responsibilities and accountabilities; a group of 80 or so social services leaders across the 22 local authorities in Wales.

A variety of anonymised case studies are presented that cover different service areas and client groups, provide regional variation across Wales. Whilst primarily looking at the person's perspective they also show how the family carer, nurse or health professional, social care worker or professional or Third Sector professional contributed to the desired outcome. In each case the main relevant themes of the 2014 Act are highlighted.

The new legislative framework including the Code of Practice, introduce new requirements and opportunities for health and social services to work even more closely together.

The principles underpinning this transformation are:

- > the promotion of well-being;
- > citizens and professionals sharing power and working together as equal partners;
- > ensure voice and control for people who need care and support, and carers who need support;
- > multi-agency working and co-operation;
- > prevention and early intervention.

The new Statutory Regional Health and Social Care Partnerships provide the strategic direction to drive forward change and deliver more integrated and targeted support for citizens. However, it is at the front-line that partnership working can have the most tangible benefits, purpose and outcomes for the individual.

These case studies show that giving a clear focus to well-being and personal outcomes and working in an integrated approach can have significant benefits for individuals and their families, as well as for people working in health and social care and for the effective use of resources. The case studies emphasise the value of a trained and committed workforce, without which we would not be able to deliver the care and support people need. Positive collaborative working and good assessment and care management for people are evident in these case studies as well as a demonstration that more can be achieved together than working from an inward looking or transactional perspective.

We hope that these case studies will be utilised across Wales to improve understanding of the challenges of providing good services and to inform practice development and improvement and to stimulate debate about how better partnerships and integrated services can be achieved at a local and regional level.

The Challenge (Themes of 2014 Act)

- ✓ **well-being and personal outcomes**
 - > co-production
 - > new models of care
 - > voice and control for people
 - > prevention and early intervention
- > information, advice and assistance
- > proportionate assessment, eligibility and care planning
- ✓ **integration, partnership and co-operation**
- ✓ **safeguarding and protection**
- ✓ **advocacy**

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Client Group

Older person awaiting discharge from hospital.

Personal circumstances

A 93 year old lady had been admitted to hospital with pressure sores. She had been temporarily living in a care home, who had stated that there would be no place available for her on discharge. She had a son who was very involved in her daily care. The son was keen for her to be discharged to a care home and the lady, who had been assessed as having capacity, fluctuated between saying she wanted to go to a care home and that she wanted to return to her flat.

What was done (arrangements)

The lady was referred by the hospital discharge team, who requested an advocate to attend the discharge planning meeting as there appeared to be differences in her wishes and those of her son. It was hoped that by having an advocate present the lady would feel confident to state her preferred option, which did appear to be different when she was asked on her own and when her son was present.

The son was very opposed to the input of an advocate and queried what help an advocate could be. It was agreed that the advocate would be accompanied by the supervisor for the initial visit at the hospital, as the son had shown opposition to advocacy involvement, but the lady herself had expressed a wish to see an advocate.

The son got in touch with the advocate requesting that she be present at a meeting he was arranging for his mother to sign a form relinquishing the tenancy of her flat. The advocate stated that she was unable to do this and that this was not the role of advocates. It was also still not clear whether the lady wished to return home with a package of care or to have a place in a nursing home. It was felt that this could have been an attempt at coercion and deprivation of assets by the son, as he had stated that he wished his mum to be discharged to a care home, not to her flat, where he would still have caring responsibilities. The lady was in very poor health and very frail so it is probable that a best interest decision would have had to be made, despite an assessment having already been made stating that she had capacity. The son was insisting that she didn't have capacity.

Outcome

The advocate contacted the Health Board's Protection of Vulnerable Adults (POVA) Co-ordinator. Following input from the advocate including advice on options for the lady, it was agreed that a further capacity assessment be undertaken and that at the discharge planning meeting a decision that was in her best interests could be made.

Contact Point

Age Connects Wales

Jeff.Hawkins@ageconnectscardiff.org.uk

The Challenge (Themes of 2014 Act)

- ✓ **well-being and personal outcomes** > information, advice and assistance
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- > voice and control for people ✓ **safeguarding and protection**
- ✓ **prevention and early intervention** > advocacy

Client Group

Child at risk.

Personal circumstances

Lucy was not returning home to her parents at the agreed time and was deemed at risk of Child Sexual Exploitation due to inappropriate friendships, her age and vulnerabilities. Her parents were unable to manage Lucy's aggressive behaviour at home which also put her at risk of hurting herself. Lucy was permanently excluded from school and feeling isolated.

What was done (arrangements)

A safety plan was reinforced by a family support worker at every appointment. The support worker has addressed emotions, thoughts and feelings of anger and aggression with Lucy. Triggers and strategies, ABS work, motivation and desires for the future were all explored. CAMHS completed a full Mental Health Assessment in relation to her substance misuse. Lucy agreed to engage in a harm reduction programme, advice and drug education. Lucy was advised to keep a thought diary regarding her mood and anger which was reviewed using CBT techniques. A Cycle of Mood questionnaire was completed to identify patterns of behaviour and develop an understanding of that behaviour and reflection to make changes. The support worker offered a session of sleep hygiene and advised Lucy on building structure into her daily routine. Routine mental health assessments were requested from a medical colleague. Lucy received once weekly sessions via Youth Mentor service to explore activities and maintain safety in the community.

Outcome

Following discussion with the Education Welfare Officer, tutoring was commenced three days a week at a local Hub. Lucy will commence at a Pupil Referral Unit in a few months. Lucy has changed her friendship group after realising those she previously associated with were of a negative influence. Lucy stated that she has rekindled past friendships with those her mother approves and now feels supported as they keep her out of trouble. Lucy is aware of her curfew and what is expected of her. This has been developed between Lucy and her parents. Army cadets were identified to promote positive use of Lucy's leisure time and the support worker helped Lucy to complete an online enrolment form.

The parents have agreed to Family Support. The initial aim was to support both parents in managing Lucy's behaviour appropriately and also provide parenting strategies to ease the tension within the family home. Family Intervention & Support Service (FISS) is supporting the family at the weekends and offered Lucy's mother additional support during the week. Work was undertaken on rewards, praise, consequences and boundary setting. Direct work with Lucy's father was also put in place as their relationship is strained. Families Together Adolescent Carer Violence (APV) referral has been made in relation to aggression towards parents. Goal setting intervention is being completed to try and improve the current situation.

Contact Point

City of Cardiff Council

Carys.Davies@cardiff.gov.uk

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Client Group

Pre-school child in need of support and development.

Personal circumstances

Child A began in childcare at age 2 years with very poor language and communication skills and delayed physical development. The child had received very little stimulation at home and spent long periods of time fastened into a pushchair or highchair. He was very unsure on his feet and struggled to stand. Most of his communication was through grunts and mumbles and his vocabulary was limited to the word 'no'.

What was done (arrangements)

The liaison between agencies prior to child A starting playgroup allowed for the essential transition work from home to pre-school and ensured the child was assigned a keyworker and 1:1 support worker from the beginning. The 1:1 support worker supported the child's mobility needs and encouraged his language and communication. The member of staff developed a wonderful relationship with the child and ensured he was able to take part in all activities with the necessary support. Activities were developed appropriate to the child's stage of development, supported by the Flying Start advisory teacher and with specialist resources from the lending library which the playgroup would otherwise have been unable to afford.

Outcome

After several months in childcare this child accessed six weeks of Forest School sessions. It was at one of these sessions that the child began to walk more confidently, on uneven grassy surfaces. He enjoyed bending down and stretching to collect sticks and within a couple of weeks of Forest School was attempting to climb a wooden stile with assistance. He also uttered his first short phrases at Forest School. The playgroup staff were astounded at the progress he made in such a short time. He was given opportunities which allowed him to progress developmentally which he would otherwise have missed out on.

Collaborative working between the pre-school staff, Flying Start advisory teacher, Conwy Pre-School Support Scheme and the Conwy Child Development Centre ensured that the very best services were provided for child A. Without the Flying Start childcare entitlement this child would very likely not have accessed any childcare provision. The advisory teacher liaised with the health visitor to provide up to date information, as they supported mum's mental health and well-being, as well as providing for the child's health needs.

Contact Point

Conwy County Borough Council

Flying.Start@conwy.gov.uk

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Client Group

Disabled people using direct payments.

Personal circumstances

Mr D was struggling with the way the care agency wanted to limit his choices through restrictive care practices, such as not building the support package around him. A meeting was requested to discuss ways forward. Mr B, who is Mr D's partner, was caring for someone else using direct payments and Mr B was asked to increase his hours because the client was reacting well due to Mr B's understanding of Autism. So, Mr B contacted Mr D's social worker to advise that he was needing his support package increased but it was uncertain whether this could be achieved due to the agency's capacity issues. After much negotiation, the agency agreed to increase the hours in line with the local authority's wishes. Mr D was pleased that this was able to happen because it would allow his partner to go and help somebody else who was entitled to direct payments.

What was done (arrangements)

On the night before Mr B was due to start the increased hours for his client, the agency notified him that they were unable to support the increased package and the family of his client said they could not wait for Mr D's support to be sorted out. An emergency case conference was held to try and develop a workable plan; Mr D knew that finding an agency in the rural area where he lives could be a challenge but was aware that new legislation for social services placed the emphasis on the local authority to look at new and innovative service models. The conclusion was reached that direct payments might be the solution but there was uncertainty that this would work because Mr D's support costs were covered by a joint arrangement between health and social services.

After further discussion that included the Council, the Local Health Board and direct payments agency, Mr D confirmed that his husband Mr B, an experienced carer, would be happy to work for him as his Personal Assistant. It was unusual for the local authority to allow partners to take on support duties under direct payment legislation but in exceptional circumstance Mr D knew it could and should be explored.

Outcome

Mr D and Mr B were able to illustrate direct payments would deliver the outcomes in accordance with the care and support plan so a multi-disciplinary team was set in motion. This went on for weeks because of health and social services did not know their legal position and the intention of future guidance in these circumstances. Throughout this process, Mr D and Mr B were left in limbo without any support with daily living tasks causing undue pressure on them. This frustrated Mr D who contacted his local Councillor to ask senior directors within the local authority to find a solution. The senior director asked for immediate action to be taken so that Mr D and Mr B could carry on with their lives with the support required. The agreement given to direct payments is a good example of the social services and well-being legislation being a catalyst for new ways of working and resulted in further dialogue with the local health board to work through a model of implementation for this service area.

Contact Point

Disability Wales

damian.bridgeman@bridgemanhealthcare.co.uk

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Client Group

Young adult with care and support needs following discharge from hospital.

Personal circumstances

BR was a 24 year old gentleman discharged from the acute surgical ward following bowel resection and formation of colostomy. He lived with his partner and son of nine months in a rented housing association flat. A routine discharge referral was instigated for the local district nursing team to visit for post-operative wound care and general support and advice with stoma management.

What was done (arrangements)

A hierarchy of solutions model was used within the team so BR was able to focus on his strengths and abilities, collaborating with family and friends and communities to achieve 'What Matters'. The surgery and colostomy formation BR underwent in his opinion would be the best decision/choice made, as this would improve his quality of life and ensure all aspects of well-being. What mattered to BR were his family's well-being and the ability to provide financially for them. He was currently on sick leave and was in receipt of benefits and this caused him significant anxiety overriding any physical outcomes. He was concerned of how he was going to feed his family and pay any outstanding bills. Putting his family first at the detriment of his recovery, "I would rather do without than my son have to go without food and nappies". The hidden cost associated with this case is unknown i.e. as to how this would have affected his post-operative recovery, wound healing and general well-being.

Outcome

In this particular case, in addition to the clinical aspect of the care, emphasis was given to the 'What Matters' conversation. Instead of a referral elsewhere in the care system, the nurse retained the lead so that services that were previously only available to social services colleagues, were now available to all partners. A simple telephone call resulted in a visit by a welfare rights colleague and the district nurse. This combined with BR's own strengths and personal networks and minimal support from the third sector resulted in BR achieving his personal outcomes. Consequently, despite being of less importance to him, post-operative wound healing/recovery and stoma management were also achieved without problem as a by-product of focusing on what was of real importance to BR.

Contact Point

Gwynedd Council

Telerisamueltoohill@gwynedd.llyw.cymru

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Client Group

Particularly rural dwellers returning home after inpatient care.

Personal circumstances

Eirian was in hospital following a broken hip and needed to return home with reablement and support. Returning home after a period of inpatient care and treatment can be challenging, particularly for people living in a rural area such as Powys. It doesn't take long to lose those simple day-to-day living tasks when you have been immobile for a period of time. Getting them back over night is no easy task when recovering from an unexpected injury or long term illness that resulted in being away from home.

What was done (arrangements)

Powys County Council and Powys Teaching Health Board have developed an Integrated Reablement Service. It offers intensive support to help people who are recovering from an illness or injury to regain their independence.

The reablement team includes an occupational therapist, physiotherapist, and trained support workers. Working closely together, the team develops a plan that supports an individual from as early as possible, all the way through discharge and on to home, the place they love most and want to be.

Outcome

Supporting someone to remain independent in their own home, close to family and friends is our shared goal, but it also has significant financial benefits for the council. In the past, someone who may have been in hospital for a period of time would lose some skills that we take for granted.

On returning home people would often be unable to support themselves, either putting pressure on the family or council support, such as domiciliary care, which may carry a high cost depending on the level of need.

Early intervention followed by intensive support was key in enabling Eirian to go home following a broken hip. The multi-disciplinary team worked closely together to draft a service plan that would support Eirian with adaptations to her family home so she could move around more freely.

For Eirian, the team visits and adaptations made a big difference after losing her confidence, she also said: "It did help to have the team come in, they encouraged me and gave me the confidence to try harder. Being home, with your warm surroundings you get better quicker."

Contact Point

Powys Teaching Health Board

adrian.osborne@wales.nhs.uk

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Client Group

Older people needing care and support to maintain independence in the community.

Personal circumstances

Mr and Mrs S are both over 90 years old. Mrs S is virtually blind and her husband has progressive dementia and other chronic conditions. Despite her visual impairment, they have always been very independent and able to care for one another until recently when they reached a crisis point. Mrs S realised that they needed help if they were to carry on living independently. She was interested in information and support on how to better manage her husband's Alzheimer's, they needed assistance with personal care, domestic chores and any social events that would help alleviate her role as his main carer whilst maintaining social activities.

What was done (arrangements)

An assessment visit determined care needs, risks, levels of mobility and activities of daily living. Support with household chores and laundry and shopping were provided. Day centre attendance for both was explored. Intervention from visual impairment social worker provided help and advice. Crossroads Care assisted with Mr S and counselling for Mrs S as carer. Signposting to Age Connects provided a befriending service. Financial assessment was provided by the community care finance team. A multi-disciplinary team (MDT) was brought together in a timely matter. Age Connects Good Neighbour Scheme carried out holistic assessment; information on social activities provided, befriender matching and help with health appointments transport were offered. The Alzheimer's Society provided information on condition management, a tracking device, a local Dementia Café and organised related transport.

Outcome

The patient and his wife were able to access all health and social care services available by making one telephone call. By pooling resources and discussing the situation, appropriate referrals were made without delay or duplication. A unified approach managed to prevent admission and supported the couple in the community.

Regular visits of the befriending volunteer helped alleviate Mrs S's loneliness and stimulated Mr S by engaging him in conversations. The volunteer was able to raise any issues with the service coordinator and early stage actions taken reduced risks of a crisis. The Alzheimer's Society support officer has enabled Mrs S to take more control of the situation and to better manage the care of her husband.

Mr S was assessed for a care package which relieved some of the pressure on Mrs S. Carers could also undertake some domestic duties enabling Mrs S to spend more quality time with him. Both were assessed to attend a day centre as a couple and enjoyed this, providing an element of respite for Mrs S. Financial assessment has also highlighted the cost of their care and identified areas of welfare and benefit they may qualify for such as Attendance Allowance and Pension Credit.

Contact Point

Vale of Glamorgan Council

SDSmith@valeofglamorgan.gov.uk

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✓ information, advice and assistance

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- ✓ **advocacy**

Client Group

Care and support for older person living in the community.

Personal circumstances

Mrs X is a 75 year old who states that she has suffered from anxiety for many years and that she has poor health and that her conditions deteriorate over the weekend. Following the death of her son, there now remains limited family interaction. Mrs X made multiple calls and visits to NHS Services. She was abusive towards healthcare staff and portrayed inappropriate behaviours towards other service users and is not responding to interventions to reduce use of services. She declines to accept any diagnosis and will attend other healthcare providers until she gets the response she wants. Mrs X has had numerous investigations all with a satisfactory outcome.

What was done (arrangements)

Age Connects Community Liaison Officer (CLO) represented Mrs X at a multi-disciplinary team meeting where she was able to discuss her actions. The team agreed to monitor the situation and initially there was a good response. However, the Community Mental Health Team deemed that Mrs X had insight and capacity to make decisions. In discussions with South Wales Police the team felt that Mrs X's behaviour did constitute an anti-social element, and it would be reasonable, should things not improve, this route would be looked into.

Age Connects (CLO) explained the ramifications of her behaviour to Mrs X and, due to her continued misuse of Emergency Services, an Integrated Management Plan was actioned for her care provision. This plan required the Emergency Unit, the GP (telephone calls and weekly appointment), Welsh Ambulance Services Trust and Out of Hours services, to follow the plan with Age Connects to providing daily monitoring, weekly visits and research alternative service interventions.

Age Connects CLO intervention include:

- > Accompanying Mrs X's visits to appointments, social activities, support groups and therapy sessions
- > Advocacy to rectify housing issues
- > Explaining alternative housing choices and properties viewed
- > Benefit check completed, applications submitted and successful
- > Private service intervention arranged.
- > Referrals to Third Sector Agencies and to NHS teams
- > Support to access and maintain shopping delivery services
- > Developing preventative coping strategies to reduce anxiety
- > Providing information on alternative transport options and holiday/respite breaks.

Outcome

Mrs X has displayed an improvement in behaviour and has refrained from using Emergency Services inappropriately. Mrs X's future goals are to be registered with the same GP practice and meet new friends. These goals appear to be motivating the change in behaviour. Pulling together resources from a variety of agencies has contributed to Mrs X making some positive changes in her interactions and has resulted in reduced A&E attendances and inappropriate demands on NHS services. Mrs X continues to have 'Daily Comfort Calls' and a weekly visit from Age Connects.

Contact Point

Age Connects Cardiff and the Vale

sharon.adams@ageconnectscardiff.org.uk

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- > advocacy

Client Group

Older people needing care and support to remain independently in the community.

Personal circumstances

A call was received to Preventative Services through First Point of Contact (FPOC) as Mrs I felt she needed a social worker. Mrs I was struggling with mobility and was fully dependent on her husband and daughter when leaving the house and worried about falling. She had issues with her hearing which was causing her to lose sleep, as she was concerned that in the event of a fire she wouldn't hear the house fire alarm and evacuate safely in the event of a fire. Mrs I was troubled about her health and was going to contact her GP for help.

What was done (arrangements)

Using experience and understanding of the needs of older people, the FPOC arranged for a joint visit with an Independent Living Visiting Officer and Occupational Therapist to go through a full holistic and well-being assessment. Inter-team working within Preventative Services and strong relationships with partners in the public and third sectors, enabled Preventative Services to provide multiple solutions to help Mrs I with:

- > Installation of hand rails by the disabled facilities team allowing her to leave her home and access her garden without the need for support;
- > Signing up to the Blue Badge Scheme, conveniently removing barriers that can impact upon daily life;
- > Hearing assessment resulting in the provision of a Loud and Light Up Doorbell;

- > Arranging for South Wales Fire Service to provide a vibrating Fire Alarm for under her pillow;
- > Given Mrs I's reduced mobility, Telecare was also provided;
- > Supporting Mr and Mrs I with claiming DWP Attendance allowance, it was identified that they would be £4,280 per year better off, helping to cover the costs of travelling to GP appointments, getting out more and feeling more financially secure.

Outcome

Mrs I and her husband were able to remain in their home, improve their well-being, reduce their potential for social care, all of which met Mrs I's personal outcomes without the need for health interventions. In addition, with Mrs I using Telecare, her family were provided with the reassurance and confidence that should anything happen, Mrs I could be monitored and attended to if they were not at home.

Contact Point

City of Cardiff Council
CGilhooly@cardiff.gov.uk

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Client Group

Child with specialist needs.

Personal circumstances

Jane was struggling with her 10 year old son, Josh, who has high levels of anxiety and was diagnosed with ASD and ADHD at age 5. Josh was a school refuser and had not been in any form of an education for two years. Different options had been tried, including smaller classes, ASD units and behavioural units, however Josh still refused to go after an occasion when he was restrained by a teacher.

Jane was becoming more isolated, as Josh would not leave the house, which was impacting on her mental health. Jane turned to alcohol to help cope with the demands on her. She self-referred to Team Around the Family (TAF) asking for help with her son.

What was done (arrangements)

A multi-agency meeting was set up by the TAF Co-ordinator with Education social worker, the Social Inclusion Team and Jane to discuss Josh's options. From the meeting, a placement was offered in a school Josh hadn't attended and a transition plan developed.

TAF supported Jane and Josh to visit the school repeatedly before summer holidays. The TAF Co-ordinator made a book with photographs of Josh's new teacher and classroom for him to read in the holidays. Jane agreed to drive past his new school weekly to get Josh used to the idea of going there in September. A phased return was agreed with Josh attending mornings from 9.30-11.30am. In September, Josh went to school for the morning sessions which were increased by an hour after half term.

Outcome

Josh's anxiety remains and he will refuse on occasion to attend school. However, Jane is more confident to deal with this after having support with parenting strategies by a TAF information support worker e.g. a consequence for Josh choosing not to attend school is no internet in the house until he returns the following day. Jane has followed through with this faithfully.

This was a positive outcome and it was great for TAF to share the experience with Jane, seeing Josh go to school after two years of being at home. It's unlikely Josh would be in school now if co-ordinated services with the right professionals involved hadn't happened. Jane's well-being has improved and she no longer uses alcohol as a coping mechanism. Instead, Jane calls TAF for any problems she is unsure how to handle. TAF are supporting Jane and Josh with the transition to high school next September and Jane is looking at returning to work when Josh is settled in school. They are working to ensure that this is a transition, not a dependence which is being created.

Contact Point

Conwy County Borough Council

plant@conwy.gov.uk

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Client Group

Care and support to help maintain independence of an older person in the community.

Personal circumstances

Episodes of confusion for Mrs A had led to intervention. Mrs A suffered with short term memory issues but had insight into her illness and actively needed support with various issues. Mrs A has severe allergies to various items and suffered with epilepsy and restricted mobility.

What was done (arrangements)

After having a 'What Matters' conversation with Mrs A, it was agreed that it was paramount to her to maintain her independence for as long as possible. Mrs A wanted help to find a flat within a sheltered accommodation environment to feel safe, secure and less lonely. She also wanted to establish a routine in her daily life and to be more financially secure.

Support from Community Psychiatric Nurse (CPN) was provided and this led to the diagnosis of Vascular Dementia. Joint visits of the social worker and CPN were made to ensure consistency of care from both professions. A support worker visit of half-hour a day maintained routines e.g. to check all food labels, sort out mail, note appointments and prompts to clean her home. Mrs A now receives attendance allowance after submitting a claim for a full benefit check. Mrs A was successful in being offered a ground floor flat in sheltered accommodation. Following exploration of grant options, due to her having no savings to help with removal costs such as new carpets, blinds, bed and bedding etc., she was successful in obtaining over £2,200 in grant and local shops were used to furnish and help with the move.

An application for a blue badge was made and she was encouraged to attend local physical activity groups for people with dementia and their carers. The Care Plan was adapted once Mrs A moved to include new tasks of accompaniment to local shops and to support her in getting to know her local surroundings, and to support her in understanding how to use electrical appliances. Mrs A is now a member of a dementia group to provide a service user perspective.

Outcome

By focusing on Mrs A's well-being, the CPN and social worker explored different ways of working to achieve what mattered to her. The close relationship established by the CPN and social worker helped in ensure no duplication or miscommunication in the service that was provided. Mrs A felt that the joint working helped especially with her condition as she can call and know she doesn't have to repeat herself.

Contact Point

Gwynedd Council

Telerisamueltoohill@gwynedd.llyw.cymru

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Client Group

Older people needing care and support to maintain independence in the community.

Personal circumstances

Mrs L is 80 years old and lives alone. She has long-term depression which has caused a lack of motivation and isolation. More recently she had a fall, causing further deterioration of her general well-being as now she only goes out if assisted by her family. Support was requested with social stimulation.

What was done (arrangements)

Mrs L's daughter is her main carer and provides daily support. She informed us that her mum does not engage well on the phone and would possibly decline any support offered, suggesting that a home visit would be a more effective way to discuss options of support available. The broker visited Mrs L in the company of her daughter and discussed and provided detailed information on local social groups, a free counselling service and Green-links transport. Mrs L engaged well and showed interest in some of the options provided.

Outcome

The Third Sector broker service focus on the person needing support and the personal approach that was provided to Mrs L has demonstrated that this has made all the difference. The face-to-face contact by the broker fuelled her interest and confidence to start going out again, socialising and meeting people. Mrs L is slowly resuming her lost confidence and motivation to do things she once enjoyed doing, as well as gaining a sense of self-worth and self-esteem. Mrs L is now attending a local lunch club twice a week and another group weekly. She is also hoping to join a local choir as music has been one of her life passions.

Mrs L's daughter provided feedback quoting: "How amazing that mum has gone from being home every day, unless my brothers and I could take time off work, to now having such a busy schedule. It's made an absolute huge difference to mum's life and has helped her depression enormously. It has given her conversation and stories outside of the family. The knock-on effect is that mum is now thinking what to wear...new clothes, news shoes, hair and makeup again. She is looking forward to day trips and paying for things in advance to ensure she books herself a place on things happening in the future! I'm not doing all the thinking and planning anymore!"

Contact Point

Vale of Glamorgan Council

SDSmith@valeofglamorgan.gov.uk

The Challenge (Themes of 2014 Act)

- ✓ **well-being and personal outcomes**
 - > information, advice and assistance
 - > co-production
 - > new models of care
- ✓ **voice and control for people**
 - > proportionate assessment, eligibility and care planning
- ✓ **prevention and early intervention**
 - > **integration, partnership and co-operation**
 - > safeguarding and protection
 - > advocacy

Client Group

Older person with complex needs requiring care and support to remain independent.

Personal circumstances

Originally from Somalia, Mr AB in his seventies, lives with his wife in an upstairs flat with a supportive family. Visiting his homeland in 2015, he suffered a severe stroke and was admitted for hospital treatment. After discharge he remained in Somalia for eight months as he had high blood pressure and was unable to fly.

When he returned home, his family were unable to cope and he was admitted to hospital for rehabilitation. After six weeks he was discharged home under the care of the Community Resource Team. The physiotherapists advised that, due to the circumstances, he missed out on treatment that he should have received, and they had to work hard to enable further progress with his rehabilitation and recovery. Mr AB was well motivated, but hampered by having to stay in bed permanently. His limbs were becoming contracted and being in bed was also isolating for him as it was unsafe for him to sit in an armchair.

What was done (arrangements)

A specialist hydro-lift chair was ordered by physiotherapists which was very successful. He was able to sit safely in the chair and there was hope that in time, it would assist in enabling him to stand for transfers. However, the cost of the chair, £2,660, was beyond the reach of the family and it had to be sent back.

The physiotherapists' assessment was that Mr AB's recovery would be greatly enhanced by using the chair, even if he only had it for a few weeks. It was established that the hydro-lift chair could be hired for a six-week period for £666. After discussion with the Community Liaison Officer, Age Connects Cardiff & the Vale, and the Stroke Association provides grants

of £300 each to cover this cost to give Mr AB the chance of maximum recovery. The family contributed the remainder.

Outcome

Once the chair had been delivered, an intensive rehabilitation programme was provided by physiotherapists and occupational therapists. In consequence, over the next six weeks, Mr AB's tolerance and strength improved greatly, enabling safe and independent sitting balance and posture in his own armchair, which was raised to enable access using a steady.

Despite setbacks along the way, Mr AB has worked hard and made significant progress. The partnership between the Community Resources Team and the third sector, through the temporary provision of the hydro-lift chair, has given him the opportunity to be able to sit with his family in his own armchair, rather than being confined to the bedroom. In time, when he takes delivery of his powered wheelchair, it is hoped that Mr AB's quality of life will be further improved by accessing outdoors.

Contact Point

Age Connects Cardiff & the Vale

Sharon.adams@ageconnectscardiff.org.uk

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Client Group

Care and support for older person living in the community.

Personal circumstances

Mr VD, a 82 year old gentleman, moved into a caravan 24 years ago following a change in personal circumstances. He had never married or had children and his next of kin was a friend living some distance away. Mr VD had been diagnosed with vascular dementia and district nurses also visited weekly to support Mr VD with his catheter. Until a fall a year ago, resulting in a knee fracture, Mr VD had been a keen runner and cyclist. As winter developed the district nurses were concerned for him due to the condition of the caravan and lack of adequate heating. Mr VD was presenting as cold on their visits and he was losing weight.

What was done (arrangements)

Mr VD declined support from social services on two occasions following a referral from the district nursing team. However he was persuaded with the support of his friend to spend two weeks in the short term flat in the local Extra Care Housing Scheme funded jointly by health and social care.

Assessing Mr VD using a reablement approach, the team found that although Mr VD enjoyed company and the opportunity of conversations with the Extra Care scheme staff and manager, he struggled with socialising with large groups of people, preferring to dine alone. His friend was able to confirm that Mr VD had been like this all his life. Mr VD's catheter care and meal preparation continued but the team found that due to his dementia this support needed to be on going to prompt him with these tasks.

Outcome

Mr VD was reluctant to return to his caravan as the accommodation provided by the scheme had allowed him to manage his personal care independently, have a nutritious meal each lunch time and to enjoy a daily shower. On returning to his caravan he was accepting of reablement support workers and because of his health and the condition of the caravan he agreed to submit an application for a permanent flat in Extra Care Housing.

The application panel of health (Locality DN), Social Care (locality Social Work Team Manager and Reablement Manager) and the housing association were aware of the case because of the close working relationship of the co-located teams and housing association involvement as Mr VD had been in the scheme.

They acknowledged the urgent need for re-housing but could see Mr VD would not avail himself of the benefits Extra Care Housing offered in reducing social isolation and improved well-being as Mr VD had a phobia of engaging with groups of people. Building on strong working relationships, the panel members worked collectively to identify a solution. Mr VD was given the option of placement in the scheme or a placement in a sheltered housing scheme managed by the housing association.

Working together resulted in Mr VD accepting the placement in the sheltered scheme and the reablement support workers were able to continue with their intervention in his new home.

Contact Point

Conwy County Borough Council
debbie.liddell@conwy.gov.uk

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Client Group

Elderly parents caring for an adult with a learning disability and care and support needs at home.

Personal circumstances

Mr C is a 58 year old man with Down's Syndrome living at home with very elderly parents who have been his carers throughout his life. Mr C has early-onset dementia and his skills and mobility have declined rapidly. The social worker involved with the family received an urgent call that Mr C was unwell and they were unable to transfer him from the toilet. The social worker and nurses, who form a co-located team, visited immediately. While assisting, the nurses noted a grade 2 pressure sore and expressed concerns on how this private family had been managing.

What was done (arrangements)

An assessment identified that a profiling bed and hoist was needed to support the family and further adaptations in the home were required. To ensure the correct equipment was put in place, and to support the elderly parents as their son was unable to weight bear, a short period of respite was offered. The parents were strongly opposed to this as they had always remained together and the three became distressed at the thought of spending time apart. The nurses had recommended that respite in a nursing home was required to meet the needs of Mr C at this time. The learning disability nurses, social worker and community nursing team then approached the local Extra Care Housing Scheme requesting emergency support.

Outcome

The team at the scheme (housing and social care) were able to offer respite in the joint health and social care funded short term flat. They 'borrowed' an additional bed and were able to accommodate the whole family in the flat. The flat had a profiling bed and ceiling track hoist which enabled safe transfers of Mr C and the team ensured the parents were involved in the care and support of Mr C.

As the family began to trust the team, they were able to access other facilities in the scheme while support workers sat with Mr C and the locality district nursing team visited daily to manage the pressure sore. While the family were in the short term flat, adaptations were made at their home and the equipment to support them was delivered. The family also became used to the support staff visiting daily and were accepting of a care package when they returned to their own home.

Contact Point

Conwy County Borough Council

debbie.liddell@conwy.gov.uk

The Challenge (Themes of 2014 Act)

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 - > safeguarding and protection
 - > prevention and early intervention
 - > advocacy
- ✓ **integration, partnership and co-operation**

Client Group

Care and support for an older person living in the community.

Personal circumstances

An emergency 999 call was received from an individual, Mr GT, who had fallen in the hallway of the house. The Welsh Ambulance Services Trust (WAST) Warden responded on the scene in 12 minutes, assessed there were no injuries and assisted Mr GT to stand using the Mangar Elk lifting cushion.

What was done (arrangements)

During this attendance, the Warden informed Mr GT about the Telecare services in Cardiff and Occupational Therapy and left an information pack. Mr GT gave consent for a referral to Occupational Therapy. A full assessment was carried out five days after his fall and Community Resource Team Occupational Therapists involved took forward Mr GT's case. Telecare Cardiff received an application form for the Mobile Response Service and Mr GT was called by the administration team on the same day with an assessment carried out over the telephone. Within 10 days a Connections Officer visited to install the Telecare equipment and discuss full details of the service with Mr GT.

Outcome

Mr GT now has an emergency pendant to use when he falls rather than dialling 999. He has not yet required assistance, but if so, Telecare will respond within 45 minutes.

Contact Point

City of Cardiff Council
ZYarr@cardiff.gov.uk

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Client Group

Older person with physical disability needing care and support to remain independent.

Personal circumstances

Mrs X is 92, virtually blind and has some other chronic health conditions. Her husband is also in his nineties and is in an advanced stage of dementia. They have been fiercely independent until more recently when they reluctantly accepted a small Package of Care to help Mr X in the mornings. However, the situation had got to a crisis point and Mrs X felt very stressed, isolated and recognised that more help was needed.

What was done (arrangements)

The Third Sector broker was able to engage Age Connects Western Vale Good Neighbour Scheme (GNS) and the Alzheimer's Society to provide the support required. The Co-ordinator of Age Connects GNS visited and explained about how she could help with transport and organised for a befriender volunteer to visit Mrs & Mr X on a regular basis. A dementia support worker from the Alzheimer's Society also visited, advising Mrs X on condition management skills and how to communicate with her husband in a more effective way, and providing information on devices that can identify where the individual is located.

Outcome

The ongoing regular visits of a befriender is alleviating Mrs X loneliness and keeping Mr X motivated. Should there be any issues of concern, the volunteer will be able to discuss it with the service coordinator at any early stage preventing another crises point. The Alzheimer's support officer has empowered Mrs X by providing her with more effective coping strategies in dealing with her husband's dementia. The joint efforts of Age Connects and the Alzheimer's Society will also allow Mr & Mrs X to attend a local monthly Alzheimer's Café.

Mrs X said that she is delighted with their befriender as he is such a nice person and is able to relate really well with her and her husband, providing Mr X with stimulation by engaging him in conversation of his interest and activities. They look forward to his regular visits which are in the evenings. She said that this will be especially good when winter approaches and they do not watch telly. Mrs X added that everyone that has been in contact with them has been so nice and supportive.

Contact Point

Vale of Glamorgan Council

SDSmith@valeofglamorgan.gov.uk

“Everyone, adult or child, can be given a voice – an opportunity – a right – to be heard as an individual, as a citizen, to shape the decisions that affect them, and to have control over their day to day lives.”

Code of Practice – measuring social services performance – Issued under Sect. 145 of the Social Services and Well-being (Wales) Act 2014

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Social Care Codes of Practice and Statutory Guidance

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Regional Partnership Boards in Wales

<http://www.ccwales.org.uk/regional-partnership-boards/>

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Transition between inpatient hospital settings and community or care home settings and community or care home settings for adults with social care needs settings for adults with social care needs – NICE guideline

<https://www.nice.org.uk/guidance/ng27>



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