Report of the Cabinet Member for Health & Wellbeing

Cabinet – 15 June 2017

ADULT SERVICES COMMISSIONING REVIEWS CONSULTATION OUTCOME

Purpose:	To seek agreement to adopt the final overarching Adult Services Service Model and implement the final recommendations that have emerged from the Domiciliary Care Commissioning Review.
Policy Framework:	Sustainable Swansea - Fit for the Future
Consultation:	Access to Services, Finance, Legal.
Recommendation(s):	1. That Cabinet adopt the overarching Adult Services Service Model as the preferred direction of travel for Adult Services in Swansea, subject to further discussion surrounding the future direction for residential care and day services for older people. 2. Note the recommendations that have emerged from the Domiciliary Care Commissioning Review which are in the process of being implemented as 'business as usual'. 3. Delegate decisions surrounding the procurement process options in relation to the agreed options for domiciliary care to the Chief Social Services Officer, in consultation with the Cabinet Member with support from Commercial Services.
Report Author:	Alex Williams
Finance Officer:	Chris Davies
Legal Officer:	Debbie Smith
Access to Services Officer:	Rhian Millar

1. Introduction

1.1 In line with the *Sustainable Swansea – Fit for the Future* approach, Adult Services has undertaken a Commissioning Review into domiciliary care services.

1.2 As part of this review an overarching Adult Services Service Model has been developed in line with the Social Services and Wellbeing Act to describe what

the optimum model for delivering integrated health and adult social care community services would look like.

1.3 An options appraisal took place on a range of potential future options for the delivery of domiciliary care services and Cabinet agreed to publicly consult on these preferred options as well as the overarching Service Model at their meeting of 20th October 2016.

1.4 The consultation commenced on Thursday 17th November 2016 and closed on Sunday 19th February.

1.5 This report summarises the original proposals, the results from the consultation and puts forward recommendations for approval informed by the consultation. This report also serves to update Cabinet on the preferred options that are already being implemented to support the 'business as usual' safe running of the domiciliary care service.

2. Overarching Service Model

2.1 The final draft of the Overarching Service Model for Adult Services is attached as Appendix 1 to this report.

2.2 The purpose of the Model is to describe the optimum model of what good would look like in a fully integrated health and social care community services model.

2.3 The model itself does not propose any changes, but sets a direction of travel for Adult Services and the Council to aspire towards.

2.4 Any proposals for change will be developed in line with this overarching Service Model.

2.5 Any proposals for change would be coproduced, publicly consulted upon in line with any consultation requirements, with a final decision informed by an Equality Impact Assessment prior to any such changes being implemented.

2.6 The outcome of the Domiciliary Care Commissioning Review therefore outlines how this aspect of the Adult Services Service Model will be implemented.

3. Domiciliary Care Commissioning Review

3.1 A Commissioning Review of Domiciliary Care Services was undertaken during 2015 and 2016.

3.2 During this review, 31 options for the way forward for the service were developed.

3.3 A stakeholder workshop took place to ascertain feedback surrounding the advantages/disadvantages of the full range of options in relation to Domiciliary Care on Tuesday 7th June 2016.

3.4 Stakeholders included a range of internal and external providers, care managers, support and inter-related services, service users, carers, representative groups and elected Members.

3.5 Attendees felt that 'Continuing As Is' was preferable in terms of minimising disruption to existing domiciliary care clients and promoting continuity of care. However, they acknowledged that this was not sustainable in terms of affordability due to the significant budgetary challenges that the Local Authority faced and the ability of the Local Authority to meet increased demand in the future and provide sufficient care hours to meet that rising demand.

3.6 Stakeholders identified more advantages than disadvantages to retaining a mixed model of service provision (i.e. internal integrated health and social care provision in addition to externally commissioned provision delivered by the independent sector) and could see the benefits of a geographical 'patch' based approach to commissioning as a means of maximising capacity in the sector through reduced travel times for care workers as well as targeting those traditionally difficult areas to cover such as the Gower and Mawr.

3.7 Following the stakeholder workshop, a dedicated session was also held with the Trade Unions on Tuesday 21st June 2016 to talk through their views on the options.

3.8 Following the stakeholder workshop and the feedback received, the 31 options were refined into 12 viable options and a detailed options appraisal was then held on Friday 24th June 2016.

3.9 The Panel comprised the Commissioning Review Lead and respective Principal Officer, the Head of Adult Services, Chief Social Services Officer, the Director of Place, the Cabinet Member as well as representatives from Legal, Finance, Procurement, HR and Corporate Property.

3.10 The criteria used to appraise each option were as follows:

Category	Criteria Questions	Weighting
1. Outcomes		
1.1	Promotes health and wellbeing	M
1.2	Maximise opportunities for greater independence	M
1.3	Promotes choice and control	L

1.4	Reduces demand for services	H
1.5	Improves performance	H
1.6	Improves user experience	M
2. Fit with Priorities		
2.1	Fit with SSWB Wales Act and Guidance	H
2.2	Fit with CCS Adult Services Model	H
2.3	Fit with corporate priorities	M
2.4	Fit with Western Bay priorities	L
2.5	Promotes partnership	L
3. Financial Impact		
3.1	Supports cost reductions (20% over 3 years)	H
3.2	Requires investment but supports savings elsewhere in the system	L
3.3	Makes better use of staff resources	M
3.4	Limited/no set-up costs	L
3.5	Achieves capital receipt	L
3.6	Reduce premises cost/maintenance backlog	M
4. Sustainability/Viability		
4..1	Promotes positive workforce	H
4.2	Shown to work elsewhere	L
4.3	Supports positive market development	M
5. Deliverability		
5.1	Legally compliant	H
5.2	Safe	H
5.3	Acceptable to stakeholders/public	H
5.4	Manageable project	H

3.11 Each criteria was weighted as per the Low, Medium and High category above to arrive at a final weighted score. It should be noted that a difference in just 1

point in the weighted score would have come about as a result of significant difference in several of the criteria highlighted above.

3.12 The options were considered against 4 distinct categories as follows:

1. Short Term Reablement Service Model
2. Long Term Service Model
3. Geographical Delivery Model
4. Management Model

3.13 The overall score for each option was as follows

Short Term Reablement Service Model:

	Option 1 Continue As Is	Option 2 Redesign Service
Weighted overall score	8.3	18.9

Long Term Service Model:

	Option 3 Continue As Is	Option 4 Expand the service to include additional specialisms (e.g dementia)	Option 5 Expand the service to include Rapid Response
Weighted overall score	8.3	21.0	21.0

Geographical Delivery Model:

	Option 6 Continue As Is - LA wide delivery	Option 7 Geographical patch base for all services	Option 8 Mix - Geographical patch base (e.g. maintenance & respite services) and whole area complex care service and reablement service
Weighted overall score	12.4	18.7	19.7

Management Models:

	Option 9 Fully external model of delivery	Option 10 Mixed model of delivery	Option 11 Defined internal and external services	Option 12 No defined internal and external

				services; both internal and external providers will do everything
Weighted overall score	16.3	19.8	18.8	17.0

NB Internal delivery only of the service was discounted as an option, as there is insufficient capacity within the internal service to be able to do this. The internal service currently only delivers a relatively small proportion of the total domiciliary care hours delivered across the County. 15.1% of care hours are currently delivered in-house and 84.9% are delivered by the external sector.

3.14 On the basis of scoring, the preferred options for the domiciliary care review were as follows:

1. Short Term Reablement Service Model:
   Option 2: Redesign Service

2. Long Term Service Model:
   Option 5: Expand the service to include additional specialisms (e.g dementia)
   Option 6: Expand the service to include rapid response
   (NB both options were preferred as they scored sufficiently high and were not mutually exclusive)

3. Geographical Delivery Model:
   Option 8: Mix - Geographical patch base (e.g. maintenance & respite services) and whole area complex care service and reablement in service

4. Management Model:
   Option 10: Mixed model of delivery
   Option 11: Defined internal and external services

3.15 A more detailed rationale is provided within the Options Appraisal Matrix within the Gateway Report which is available as a background paper. However, in summary the preferred options scored highest on the basis of the following:

1. *Fit with outcomes:*
   The preferred options will allow Adult Services to promote the health and wellbeing of service users, and fundamentally allow Adult Services to deliver a robust domiciliary care service which helps people remain independent in their own homes for longer and minimises the demand for higher end, more expensive long term care including residential care.

2. *Fit with priorities:*

The preferred options are fully in line with the priorities within the Social Services and Wellbeing Act and will allow Adult Services to manage a more effective system in keeping with the Adult Services Model. They also help Adult Services to address corporate priorities and are critical to the successful delivery of the Western Bay Intermediate Care Model.

3. *Financial impact:*
   Whilst the options themselves will not reduce investment in relation to domiciliary care, they will use the financial and staff resource available to best effect and it is anticipated that the preferred options can be delivered within the existing financial footprint even taking account of pressures including the New Living Wage, annual uplifts etc. This added to better demand management should allow for a reduction in need for domiciliary care and consequently spend over time as well as a reduction to recourse for more expensive types of care such as residential care. Getting domiciliary care right is a key preventative tool to reduce spend and need elsewhere in the system.

   It should be noted that key to the reduction in spend in relation to domiciliary care is the right sizing/review of all packages of care. This has already commenced in relation to the in-house long term service when it was agreed that this service would only focus on complex care and resulted in a number of packages of care being reduced and transferred to the private sector. A comprehensive programme to review all packages of care is currently being implemented. It is anticipated that this exercise will drive down spend by approximately £1million (approximately 10% of the external domiciliary care budget). The political implications of embarking on such a route should be noted, as in real terms it will lead to a reduction in care packages for some people. However, this will only be the case for individuals where it is safe to do this and all service users, carers and advocates (where appropriate) are involved in each and every review.

4. *Sustainability/viability:*
   The preferred options will allow for more effective delivery of care, particularly in those geographical areas where currently there is no service available. The recommendation however not to externalise all services, but retain some in-house service provides for resilience in the event of market failure. The preferred options will lead to a more specialised and skilled workforce and potential for external market development.

5. *Deliverability*
   The options are legally compliant and allow for safe care to be delivered. They are considered to be of greatest potential acceptability to stakeholders and the transformation whilst challenging is achievable.

4. Consultation process

4.1 A 13 week consultation was undertaken.

4.2 Hard copy consultation documents on the Overarching Service Model were sent to a sample of over 2,000 known Swansea Adult Social Care clients.

4.3 Hard copy consultation documents on the Domiciliary Care preferred options were sent to all existing clients of the in-house and externally commissioned service.

4.4 The consultation documents were also available on the Council's website for the duration of the consultation and people who accessed the consultation via this means were able to submit an electronic response.

4.5 There was a dedicated help number publicised alongside the consultations to allow members of the public to access support if needed. The phone line logged and handled 33 telephone enquiries during the consultation period. Alternative formats could also be obtained via this contact number.

4.6 Awareness raising sessions started in September 2016 with each of the internal domiciliary care staff teams to advise on the options available and to explain the rationale for the preferred options and what these would look like. Staff were invited to respond to the consultation and asked to encourage and assist their clients to participate in the process.

4.7 This exercise was repeated with the external domiciliary care providers at the Forum on 14th December 2016 and an offer extended to attend their own staff meetings.

4.8 A briefing was given to the Care and Social Services Inspectorate senior inspector on 17th October and again on 18th January 2017.

4.9 A briefing was sent to the Older Persons Commissioner on 18th November 2017.

4.10 A presentation was given to the Trade Union group on 4th January 2017 following regular updates at both the Social Services Trade Union Meetings and Council wide Trade Union Liaison Meetings.

4.11 A final presentation and update was given to the Prevention and Social Care Reform Cabinet Advisory Committee on 16th January 2017, following regular updates prior to this.

4.12 A dedicated session was also held with the Adult Services Performance Scrutiny Panel during the consultation period.

4.13 Two meetings were also held with the Disability Liaison Group on 8th February and 22nd February.

4.14 The consultation was actively promoted during the consultation period in the local media, via the Council's intranet, social media, and directly from the Head of Service to staff.

4.15 Whilst respondents were encouraged wherever possible to complete the consultation response in the questionnaire format, free text responses were also accepted.

5. Consultation responses

Adult Services Service Model

5.1 A total of 207 responses were received to the survey on the Adult Services Service Model.

5.2 Of those, 60% were from people receiving a service currently, 28% from a relative, carer or a friend of someone in receipt of a service currently and 14% from individuals whose job involves working with older people or vulnerable adults in Swansea.

5.3 64% agreed with the proposed model, 75% agreed with the overall vision for the service and 89% with the 6 key principles.

5.4 Respondents suggested that the following components were missing from the model:

5. A better quality of life
6. Compassion and respect
7. Fairness, and equality
8. Keeping families together
9. Improved communication
10. Trust
11. Better prevention
12. Putting the client first
13. Keeping people healthy including physical exercise
14. Reablement
15. Social integration
16. Tackling loneliness
17. Transport
18. Co-production
19. Better liaison with health staff including GPs and hospitals
20. Concern at the ability of charitable organisations to deliver services especially in tier 1, due to cut backs in their funding and, ensuring quality of service provision.
21. Whilst not missing from the key principles, one respondent stated “people’s right to be kept safe should be more important than anything else”.

5.5 Respondents reported the following impacts of the model on them:

- The model would ensure individuals retained their independence in their own homes
- It would promote better access to services and a more coordinated approach to service delivery.

5.6 Concerns expressed included:

- A lack of detail in the services to be provided under the model and the cost of its implementation.
- The ability of resources to support tiers 1 and 2 (including charitable organisations and volunteers)
- And the evidence of step services that enabled people to step down between tiers 3 and 2.

5.7 Respondents reported a need for:

- Equitable charging
- Better working across Adult Services and Child & Family Services
- Better and clearer communication
- Better terms and conditions and training for care staff and continuity of care
- Valued and motivated workforce
- Improved awareness of dementia
- A timeline for implementation
- Recognition that “a one size fits all approach will not work; People are individuals”.

5.8 One respondent reported a need to emphasise that “Social Services is not a stand alone service provider as its primary role will become assessment and referral to others for delivery” and another suggested that there was insufficient emphasis on younger adults and those living with a learning disability.

5.9 Finally, one respondent indicated that in their view, there are only 2 tiers “those that are eligible to receive a statutory service and those that are not.”

5.10 6 free text responses were also received in addition to completed questionnaires. The points raised in these responses can be summarised as follows:

- The need for better integration between health and social care, as well as better cross Local Authority working.
- The need for better assessment and earlier intervention.
- The importance of reablement as a key preventative service and the role that rehabilitation has in improving outcomes for people, and how this should be highlighted further under Tier 3 of the model.
- Rehabilitation services for people with sight loss need to be included under Tier 3 of the model.
- The importance of co-production in designing services and interventions.
- Direct payments should be more strongly referenced in the model.
- The importance of meaningful carer’s assessments.
- The need to ensure that support is available for people who do not have family or carer support.
- The importance of communicating with people in a format that is accessible to them.
- The need to recognise that communities are not necessarily geographical, but can also be communities of interest.
- The importance of ensuring that services and interventions are fully accessible to people with a range of disabilities.

5.11 The model has been amended to take account of the various comments raised. It is important to reiterate however that the model itself will not lead to any immediate change, but set a direction of travel and vision to aspire to. Detailed proposals surrounding implementation and timelines will emerge as proposals for change are developed in a co-productive way and consulted upon, as is the case for the Domiciliary care recommendations considered in this report.

Domiciliary care

5.12 A total of 269 responses were received.

5.13 Of those, 56% were from someone receiving a social care service, 34% were from a relative, carer and/or friend of someone who receives a social care service and 13% from someone who works with older people or vulnerable adults in Swansea. 9% stated that they were interested (for other reasons) the most common being that they were someone/ a carer of someone who had previously received domiciliary care or someone who envisaged that they may require a domiciliary care service in the future. Please note that the total exceeds 100% as respondents were able to, and did, tick more than one box.

5.14 Respondents were asked their views on our preferred options for

- Short Term Reablement Services
- Long Term Domiciliary Care Services
- Who should deliver domiciliary care services
- How the domiciliary care services should be organised

Short Term Service Model

5.15 In terms of the Short Term Reablement Service, 54% of respondents agreed, 31% didn't know and less than 16% of respondents disagreed with our preferred option to redesign the short term reablement service.

5.16 A wide range of text responses were received to support whether people agreed, disagreed or did not know whether they agreed with the preferred options and also demonstrate the impact they felt that preferred option would have on them as individuals/organisations.

5.17 In summary, these included the following:

- Positive comments about how a good reablement service would allow people to maintain independence, stay at home for longer and reduce the need for long term care.
- Positive comments about how more people would be able to access the service and how it would enable quicker discharges from hospital.
- The need for quick assessment into the service.
- The need for clear criteria as to who will be able to access the service.
- Clear care plans would need to be place which the individual themselves had access to.
- The need for a joined up approach between health and social care to deliver the service.

- The need for good links with Housing Adaptations and the Joint Equipment Store.
- Concerns surrounding the short-term nature of the service.
- Concerns from professionals/staff in terms of how the proposals might affect their jobs and that may need some upskilling to perform the role effectively.
- Support required for carers to ensure that carer's assessment takes place alongside reablement service.

5.18 The comments received are enormously helpful to guide how we should redesign the service going forward, but the positive response rate alongside these comments suggest that it is the right course of action to move forward with preferred option of redesigning the short-term reablement service.

Long Term Service Model

5.19 In terms of Long Term Domiciliary Care Services, 59% of respondents agreed with our preferred option to redesign the long term domiciliary care service, whilst 19% disagreed and the remainder didn't know.

5.20 Again, there were a wide range of text comments received in relation to the proposals. These included:

- Concerns that people may get a reduction in care.
- Fear of how the proposal could lead to a change in care received.
- Perception that better care would be received.
- Feeling that people would be able to stay at home and independent for longer.
- Positivity surrounding the potential introduction of a rapid response service and specialist dementia support service.
- Belief that would improve joint working between health and social care and the importance of working in a joined up way.
- The importance of valuing carers and families and ensuring good communication with them.
- Belief that may lead to Council staffing reductions.
- Some upskilling of staff might be required to introduce new specialisms.
- Concerns over how the service might be funded.
- Concerns that need to create an enabling service, not a dependency service.
- Concerns surrounding current arrangements being time and task driven, rather than outcome focussed.
- The importance of ongoing assessment and review and putting "the client at the heart of all decision making and take his/her wishes into consideration"
- The importance of good contract monitoring of external providers to ensure good quality and equity of service across the City and County.
- The importance of continuity of care staff and call times; this comment was reiterated on several occasions and comments included "It can be a surprise if a stranger turns up at your house at a strange time" and "it would be preferable to attach the same group or carers to a client so relationships, trust and knowledge can be formed".

- The importance of developing the external sector to maximise capacity available.
- The importance of recruitment and retention of staff.
- The potential to introduce an overnight sitting service.

5.21 The comments received were yet again enormously helpful to guide how we should redesign the long term service going forward and seemed to indicate positive support to enhance the service to potentially include rapid response and specialist dementia care in the longer term.

5.22 There were inevitably fears raised in relation to the potential change, but all packages of care should be reviewed at least annually in line with Welsh Government requirements and any changes to a package of care should be undertaken on a risk assessed basis in full liaison with an individual and their family/carers where appropriate.

5.23 The suggestion surrounding the introduction of an overnight sitting service was a good one, but not one that the City and County of Swansea is proposing to offer as offer this type of service in addition to a large package of care brings into question the appropriateness and affordability of keeping that individual at home. However, some individuals choose to purchase night respite sitting services via a direct payment and this practice will continue to be supported.

5.24 On balance, the positive support for the proposals and the comments highlighted indicated that the preferred option was the right direction of travel.

Geographical Delivery Model:

5.25 72% of respondents agreed that the Local Authority should continue to have a mixed provider base, 12% disagreed and the remainder didn't know.

5.26 Again, there were a large number of text responses which can be summarised as follows:

- A recognition that it was no longer feasible for Local Authorities to provide all care that they historically delivered.
- The importance of growing the private/independent sector to deliver care on behalf of the Local Authority.
- The Local Authority would be the provider of choice, but recognition that this was not feasible.
- Effective contract monitoring was essential to ensure good quality of care, including the comment, "It does not matter who delivers the service but what does matter is active council involvement in decisions who provides the service since this affects quality control."
- Fear of any changes that adoption of the model might mean in terms of potential for a change in care provider.
- The importance of continuity of care in terms of staffing.
- Comments surrounding the importance of good communication and partnership working.

- Concern surrounding the financial sustainability of the external domiciliary care market.
- Concern that recommissioning would have higher emphasis on cost rather than quality.
- Suggestion that direct payments should be supported in lieu of domiciliary care.
- The need to ensure that there is a properly trained workforce across the sector.
- The importance of supporting the independent sector to make caring a recognised career path, with comments including, “I would like to see Care Workers have a pay and career path recognising experience, training and knowledge whilst in role. This is to reward good practice and keep good staff doing this crucial work. It is also to avoid the position where staff are too easily financially better off moving to other employment such as in retail.”

5.27 The responses show a high level of support for the proposed approach in terms of a mixed delivery model. Again, the comments raised are very helpful in terms of how we should design this approach and how particularly we support the independent sector as a commissioner. The comments would suggest no change required to the preferred option of a mixed delivery model.

Management model

5.28 58% agreed that the Local Authority should adopt a patch based approach to respite at home and long term maintenance domiciliary care alongside county-wide short term reablement and long term complex care services, whilst less than 15% disagreed and the remainder didn’t know.

5.29 There were once again a wide range of text responses which can be summarised as follows:

- A patch based approach would be more efficient in terms of minimising travelling time and maximising time with the client
- Moving to such approach would allow for demand to be met more effectively.
- A patch based approach would allow for better continuity in terms of staffing for people receiving care.
- Carers would welcome the changes as it would allow them more time to work with people.
- A patch based approach would allow carers to develop better knowledge of communities.
- A patch based approach would help eliminate a postcode lottery for access to services.
- Concern raised that patch based approach may lead to change in providers for some individuals.

5.30 The responses received as well as the subsequent comments were broadly in agreement with the proposal for the management model going forward. Clearly, there were some concerns about how the approach could lead to a change in provider due to the proposed change from a whole County approach to commissioning to a patch-based approach for some services. The

commissioning process would have to be very carefully managed to manage any change in provider to minimise any disruption to service users. The response would not suggest a change in relation to the preferred direction of travel, but clearly the management of any process would need to take account of all the comments raised.

6. Final recommendations following the consultation

6.1 The consultation responses have led to an amended version of the Service Model being developed to take account of the text responses received (see Appendix 1).

6.2 The consultation responses led to no change to the original preferred options for the way forward for the Domiciliary Care Service.

6.3 The final recommendations informed by the consultation are as follows:

1. Adopt the overarching Adult Services Service Model as the preferred direction of travel for Adult Services in Swansea, subject to further discussion surrounding the future direction for residential care and day services for older people.
2. Redesign the Reablement Domiciliary Care Service.
3. Expand the Long-Term Care Service to include additional specialisms such as dementia support and rapid response.
4. Move to patch based commissioning for the long-term maintenance service and respite sitting in service.
5. Maintain a whole area complex care service and reablement service.
6. Continue to operate a mixed model of delivery with clearly defined internally delivered and externally commissioned services.

6.4 A more detailed risk analysis is contained within Section 8 of this report, but the significant issues relating to the sustainability of the domiciliary care market meant that moving forward with the preferred options as a matter of urgency were imperative to ensure both compliance with EU procurement roles and grow capacity in the market to minimise delayed transfers of care and help people stay safely at home for longer. The procurement process in relation to the preferred options is likely to take approximately 9 months so a further delay of 3 months due to the pre-election period was likely to compound the current issues. At the time of writing the report, the numbers of people waiting for external packages of care was on average 160 people per day. A sustainable working position is approximately 100 people per day.

6.5 Cabinet is therefore being asked to consider Recommendation 1 in today's meeting only.

6.6 In relation to recommendations 2 to 6, Officers resolved to use delegated authority to implement these as 'business as usual' at a meeting of the Corporate Management Team on 15th March 2017 due to the risks outlined in Section 6.4, due to the fact that the recommendations could not be reported back to Cabinet during the pre-election period.

6.7 In order to minimise delay in getting to a position of a recommissioned domiciliary care service, Cabinet is also being asked to delegate decisions surrounding the procurement process options in relation to the agreed options for domiciliary care to the Chief Social Services Officer, in consultation with the Cabinet Member with support from Commercial Services.

7. Equality and Engagement Implications

7.1 There are Equality implications for implementation of both the Adult Services Service Model and the preferred options for the Domiciliary Care Commissioning Review, due to the proposed changes to the way that we deliver services currently.

7.2 Separate EIAs have therefore been opened in relation to the Adult Services Service Model and the Domiciliary Care Commissioning Review. These EIAs have been informed by the consultation and have informed the final recommendations.

7.3 The full EIA on the Service Model was updated on 26th April 2017 to take account of the outcome of the consultation.

7.4 The information on protected characteristics gathered via the consultation demonstrated that responses had been received from a representative sample of the population that Adult Services tends to support in line with the current breakdown of people registered on the PARIS client management system. As such a higher proportion of respondents were female, older people, and considered themselves White British. It is also interesting to note that a large proportion (67.8%) of respondents considered themselves to have a disability, which is not unsurprising in that Adult Services's main focus is supporting either frailer older people or people with a range of disabilities.

7.5 Respondents were specifically asked what impact the model might have on them, and were allowed to provide free text response. A summary of the responses is outlined in section 5 and the final version of the model being recommended to Cabinet has been amended to take account of these responses.

7.6 The recommendation from the EIA was Outcome 2 (Adjust the initiative – low level of concern). The final version of the Service Model is attached to this report having adjusted it as a consequence of the responses received.

7.7 The Domiciliary Care Commissioning Review EIA was updated on 3rd March 2017.

7.8 The information on protected characteristics gathered via the consultation demonstrated that responses had been received from a representative sample of the older person domiciliary care service user base and their carers/relatives/friends as well as individuals whose job involves working with older persons.

7.9 Respondents were specifically asked what impact the preferred delivery options model might have on them, and were allowed to provide free text response. A summary of the responses is outlined in section 5 above.

7.10 As one of the preferred options is to maintain a mixed model of service delivery i.e. retaining an in house provision for the delivery of a short term reablement service and long term complex care service, and procuring long term maintenance care services and respite at home/sitting service from the external sector, work has commenced on developing a service specification to be used in a future Service Level Agreement with the Integrated Service and a procurement exercise to secure sustainable external service provision.

7.11 The service specification is being co-produced by key stakeholders, including service users, their carers/relatives/friends and paid domiciliary care workers, to ensure that it is fit for purpose and mitigates any adverse impacts on individuals either receiving or delivering the service.

7.12 The recommendation from the EIA was Outcome 1 (Continue the initiative – no concern).

8. RISK ANALYSIS

8.1 There are significant risks with not moving forward with the recommendations and preferred options outlined in this report.

8.2 In order to secure an affordable range of provision appropriate to current and predicted need, the City & County of Swansea needs to recommission domiciliary care. Failure to do so may result in the following issues not being addressed and risks and impacts being realised:

Issue	**Risk**	**Impact**
The externally commissioned market is operating at or near capacity	Increased numbers of people waiting longer for domiciliary care	Failure to meet assessed need in a timely manner
	Blocking of hospital beds and Increase in Delayed Transfers of Care for Social Care Reasons (DToC)	Knock on impact on the Health Board
	Increase in numbers of individuals being placed in more expensive residential forms of care unnecessarily	Detrimental impact on individuals placed – loss of independence
		Financial impact of making expensive placements on Local Authority budgets
Existing contracts are no longer fit for purpose	Difficult to take providers through performance / contract compliance measures resulting in	Quality of care provided on behalf of the Local Authority to its most vulnerable clients suffers /

Issue	Risk	Impact
	underperforming suppliers	not fit for purpose
	Failure to realise efficiencies identified in Corporate Commissioning Review into Business Support due to changes required in provider invoice methodology and supporting ICT	Financial impact on other corporate financial budgets
Absence of formal process for reviewing domiciliary care rates with providers	Increased risk of provider failure	Change of care provided for affected clients
		Change of employer for care workers
		Inability to meet identified need
Spot purchasing individual packages of care with no guarantee of business	This approach is not conducive to recruitment activity / capacity building	Reduced market capacity to meet identified care needs in timely manner
Existing provider contract terms are more than 5 years old	Potential breach of Contract Procedure Rules/EU legislation	Potential for challenge and associated cost implications
New providers are informed that the Local Authority is not looking to commission further providers pending the outcome of the domiciliary care commissioning review	Inability of new providers to access the domiciliary care market in Swansea. Continued overspend on domiciliary care budget	As above.
		Increased financial burden on budget. With no corresponding increase in budget, or change to the way in which care is commissioned, an increase in rates would mean that the Local Authority could support fewer individuals
Current approach to commissioning means that there is limited coverage in areas of the City and County of Swansea such as Gower and Mawr	Difficulty in securing care in those areas means that people in those areas potentially wait longer	People are potentially left without care, stay in hospital for longer and are at risk of entering into long-term residential care unnecessarily due to absence of provision in hard to reach areas.

9. Financial Implications

9.1 There are no immediate financial implications of implementing the Adult Services Service Model.

9.2 There are clearly financial implications attached to the implementation of the preferred options relating to the future direction of the Domiciliary Care service. However, these recommendations will allow Adult Services to better deliver the domiciliary care service within the budget already allocated. There is therefore no intention for these recommendations to lead to further spend in this area of Adult Services.

10. Legal Implications

10.1 Implementation of the preferred options for Domiciliary Care will lead to a re-tendering exercise for the externally commissioned long term maintenance and respite at home/sitting services. Acting in accordance with his delegated authority the Chief Social Services Officer has authorised this procurement exercise which will be fully compliant with EU procurement rules.

Background Papers:

- Domiciliary Care Gateway 2 Report
- Adult Services Service Model EIA
- Domiciliary Care Commissioning Review EIA

Appendices:

- Appendix 1: Overarching Adult Services Service Model

Appendix 1

City and County of Swansea
A Service Model for Adult Social Care

1 Introduction

This document has been prepared by the City and County of Swansea's Adult Services' department, in conjunction with other departments. It proposes an overarching service model for adult social care to deliver requirements of the Social Services and Wellbeing (Wales) Act 2014, the Sustainable Swansea programme and the Local Authority's corporate priorities.

2 Context

The Social Services and Wellbeing (Wales) Act 2014 came into effect on 6 April 2016 and provides the legal framework for improving the wellbeing of people who need care and support, carers who need support and for transforming social services in Wales. It reforms social services law, changes the way people's needs are assessed and the way in which services are commissioned and delivered. People with care and support needs will have more of a say in the care and support they receive and there is an emphasis on supporting individuals, families and communities to promote their own health and wellbeing.

The Act introduces common assessment and eligibility arrangements, strengthens collaboration and the integration of services particularly between health and social care, and provides for an increased focus on prevention and early help. Local Authorities and health boards come together in new statutory partnerships to drive integration, innovation and service change.

The Act also promotes the development of a range of help available within the community to reduce the need for formal, planned support. Local Authorities need to work with people to develop solutions to immediate problems and reduce the need for complex assessment and formal provision of care. Where people have complex needs, which require specialist and/or longer term support, local authorities will work with people and their families to ensure that high quality and cost effective services are available at the right time and in the right place.

Local Authorities and their partners need to make sure that people can easily get good quality information, advice and assistance, which supports them to help themselves and make the best use of resources that exist in their communities without the need for statutory support.

Local Authorities also need to ensure a shift from a deficit and dependency model to a model, which promotes wellbeing and independence focused on individual outcomes rather than service targets and objectives.

There will be stronger powers to keep people safe from abuse and neglect.

At the same time, across Wales, public sector funding is under increasing pressure and therefore in Swansea, our target for reducing expenditure on adult social care services is 20% by the end of 2017/18. Added to this pressure is a growing population, which is placing additional demand on our service. This means we need to save money and meet the additional demands placed on our service whilst delivering the requirements of the Act.

In the document "Better Support at Lower Cost" (2011)[1] the Social Services Improvement Agency notes:

"It is increasingly recognised that the twin goals of improving efficiency and delivering better outcomes for service users are not necessarily in conflict with each other. Some councils recognise that the kinds of service transformation they are now contemplating would make sense in terms of service improvement even if current financial constraints…. were not present"

3. Our Vision

Our vision for health, care and wellbeing in the future is that:

"People in Swansea will have access to modern health and social care services which enable them to lead fulfilled lives with a sense of wellbeing within supportive families and resilient communities. We will help people to keep safe and protected from harm and give opportunities for them to feel empowered to exercise voice, choice and control in all aspects of their lives. Our services will focus on prevention, early intervention and enablement and we will deliver better support for people making best use of the resources available supported by our highly skilled and valued workforce".

4. Our service model

Our service model needs to deliver:

- Our vision
- The requirements of the Social Service and Wellbeing (Wales) Act
- Our Corporate Priorities, and
- The savings required through the Sustainable Swansea Programme

The model is based upon the following six key elements:

Better prevention – by supporting care and wellbeing locally and offering good quality information and advice, we can help build more resilient individuals and supportive local communities within which people are safer, less isolated and more able to respond without requiring access to formal services

Better early help– by helping people quickly and effectively to maintain or regain their independence when they do have care and support needs. Through services such as local area co-ordination, re-ablement and intermediate care, we can help

[1] "Better Support at Lower Cost" SSIA 2011

keep vulnerable people safe, reduce the number of people who are dependent on care services and manage the demand for longer-term care.

A new approach to assessment - working in partnership with people to understand what matters to them by putting them at the centre and building on people's strengths and abilities to enable them to maintain an appropriate level of independence and better quality of life with the appropriate level of care and support. In doing this, we recognise that everyone is different, and a different response will therefore be needed. Wherever possible, we will ensure that this means that families can stay together and carers have appropriate levels of support.

Improved cost effectiveness – by engaging with people and our partners early on we can design services and approaches that are more efficient and cost effective. In addition, by commissioning and procuring services more effectively, and finding more cost–effective ways of delivering care we can ensure that every penny spent by the Council and its partners maximises the health and wellbeing of our population.

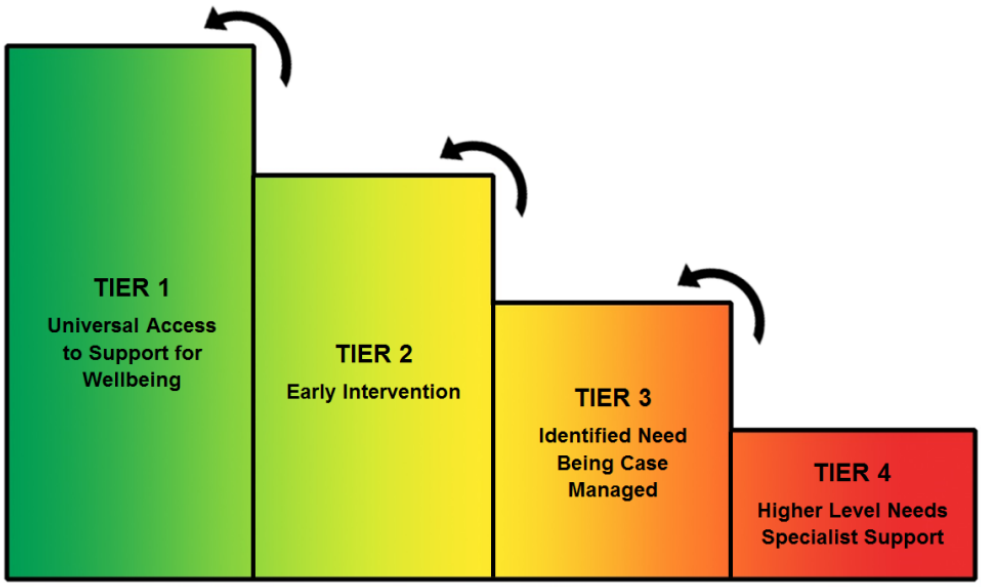
Working together better – by collaborating with our partners, particularly our health colleagues and internally across the Council, we can better integrate our services, assessments and resources to ensure that they are efficient and can deliver a more joined up approach, which makes sense to people whilst avoiding duplication and waste.

Keeping people safe – by undertaking a positive risk taking approach, responding proportionally to people's needs and ensuring people are treated with respect, dignity and fairness, compassion and respect.

Underpinning these principles is the need to build trusting relationships with those that we work with, improve communication and work **co-productively** to design and deliver services and interventions. This will include communicating with people in a way that is accessible to them and also designing services so they are accessible to all regardless of disability or any other protected characteristic.

The service model comprises four levels of health, wellbeing and social care support for our population. We think it will help us to deliver "better support at lower cost".

The service model is illustrated diagrammatically below:



Glossary
Tier 1 – Universal services aimed at all Swansea Citizens to enhance wellbeing
Tier 2 – Early intervention targeted support for people in need – single agency
Tier 3 – Managed care aimed at people in need of managed care to support achievement of person's own outcomes – Multi disciplinary approach
Tier 4 – Managed Care Complex/Higher needs aimed at people with long term complex needs

In practice we will support universal services to be more accessible and responsive to people who may have care and support needs to ensure that no matter how complex a person's needs are, they are able to access services which will enhance their wellbeing e.g. leisure services, libraries and community groups.

In this model a person's needs will always be met at the lowest appropriate level. Services at each level will work effectively with people to address their holistic needs and achieve their wellbeing outcomes without resorting to the next tier unless all avenues have been exhausted.

We believe that by ensuring that services at Tiers 1 and 2 are more effective in the way that they work with people we can reduce dependency and demand for statutory/complex care over time, and thus shift our joint resources from complex and statutory services to universal and early intervention. This is not about stopping people having services, but ensuring that people have access to the right level of care at the right time.

In addition, people receiving Tier 2 support may only need it for a short time and we will work with individuals and our partners to achieve this. Similarly, people in tiers 3 and 4, who currently require managed care, will have a package of support that encompasses elements from each tier and they will be supported to have more of their wellbeing outcomes delivered through the lower tiers, sometimes resulting in a move down into the next tier.

The model applies to all health, wellbeing and care and support for adults including older people and people with a learning disability, mental health issue and physically

disabled people. We plan to work with partners in a collaborative way to maximise the contributions of all agencies to this approach including:

- Abertawe Bro Morgannwg University Health Board.
- Public Health Wales.
- Other public agencies where appropriate.
- Independent sector organisations including the third sector, not-for-profit organisations and private businesses.
- Other sections of the Council such as child and family services, housing, leisure, education and wellbeing.

4.1Tier 1: Universal Access to Support for Wellbeing

Universal services must seek to ensure that adults are supported to keep active, stay healthy, avoid loneliness and isolation, and keep informed about and engaged in their local community. Tier 1 interventions include:

- **Primary Care Services** – Access to GP, dentist, pharmacy, optometry and expert patient programmes and other self-management programmes.
- **Common interest communities e.g. faith communities, disabled communities** - Bringing people together and supporting people to live more fulfilled, supported and less isolated lives.
- **Local Area Co-ordinators** - Strengths-based preventative approach, supporting people and communities to build resilience and 'stay strong'. By enabling people to develop natural relationships and community connections, formal services are more likely to become a back-up, rather than the first port of call, with people maintaining their independence for longer.
- **Assistive technology** – Making use of everyday technology e.g. phone Apps, door entry systems etc. to support independence and wellbeing.
- **Housing** – Good quality and appropriate housing is fundamental to an individual's wellbeing.
- **Housing Related Support**. - Including benefits advice, to ensure that citizens' homes continue to be appropriate environments in which they can maintain their independence.
- **Public Health Awareness** – Specific initiatives, which focus on avoidable risks to independence. For example, falls prevention, smoking cessation, "stay warm", anxiety management and positive mental health programmes.
- **Information, advice and assistance** – Supporting people to stay healthy and active and to seek support and develop their own solutions whenever necessary.
- **Self arranged help** – Information advice and assistance can be provided to help people arrange practical support for themselves such as laundry, ironing and help with the garden and/or home maintenance.
- **Sports and recreation facilities** – Encouraging people to participate and stay active and healthy.
- **Libraries** – Enabling people to access information and materials to support an active mind and continued learning.
- **Adult learning** – Enabling people to enrich their wellbeing through learning.

- **Social Opportunities** – Activities such as luncheon clubs and befriending groups offer individuals the opportunity to maintain a connection with their local community and avoid loneliness and social isolation, contribute to their local community and increase their wellbeing.
- **Volunteering** – Enabling people to stay active and contribute to their communities engaging in voluntary activity.
- **Transport** – Ensuring people can access the services they want through the provision of adequate public and other transport services.

The Council's Adult Social Care Services would be responsible for providing or commissioning Information, Advice and Assistance as required by the Social Services and Wellbeing Act. However, the other components of this Tier would be provided by a range of other partners within the Council, the third, public sector and communities. Crucially we will be looking for these services to actively identify and support those people who might be at risk of future health or wellbeing problems.

Case Study Examples
The model helps us to shape the way we assess, commission and deliver a balanced range of support to people in Swansea. It gives us a framework to help us make sure people get the right support at the right time and how different services fit together. The following case studies provide examples of how the service model might work in practice:

Gwen is 78 and lives with her husband Terry in a comfortable bungalow. Her son, Michael, is a successful and busy solicitor and lives with his wife and two teenage children.

Over the last few years, Terry and Michael have noticed that Gwen has become forgetful. However, between them they are able to manage this and live a comfortable and quiet life together. Terry has been over-weight for a number of years and the family are devastated when he has a heart attack while in bed at night and passes away.

The family rally round and, after the funeral, it is agreed that Gwen should stay with Michael for a couple of weeks until she can work out how to re-start her life without her partner of 56 years.

After Terry's funeral, Michael thinks about telephoning the Local Area Coordinator in his area to enquire what support might be available to his mum when she returns home. He is concerned about her loneliness and isolation and does not mention her forgetfulness.

Thomas, the Local Area Coordinator agrees to meet Gwen when she returns home and takes time to get to know her. He discovers that Gwen is a retired nurse who enjoyed an active social life and that she is a keen gardener. He gives her the contact for her local horticultural society and she starts attending their meetings.

Alice is 26. She is a lone parent, living with her 6-year-old son Riley in a privately rented flat. She moved from Coventry to Swansea at the age of 18 to go to University but was forced to leave her course after her depression deteriorated.

In the past, Alice has used drugs, but over the last year has made a determined

effort to separate herself from her peer group and concentrate on finding work and providing a stable environment for Riley.

Alice's parents have found her lifestyle difficult to accept and have become distant. They never visit and there is now little contact between them.

Alice is an avid reader and frequent visitor to her local library. The staff there have come to know her well and they chat when she visits. Jackie, one of the library staff, has received some "watchful worker" training and now makes a point of talking to Alice and, to an extent, Alice has confided in her.

Alice has confided in Jackie, letting her know that she would like a job. Jackie provides Alice with information about the local volunteer bureau and college courses available in the area to support her goal of getting into the job market. Jackie's support encourages Alice to take control and feel more confident in taking those first steps to improve her situation.

Alice finds work at the local charity shop and becomes friendly with Fran, one of the other volunteers. Although there is a significant age difference, (Fran is 68), the two share a love of literature and Fran invites Alice to join her book club. Riley even goes too and everyone makes a fuss of him and gives him biscuits.

Alice joins a jewellery making class in the evening while Riley goes to the early evening play group at the college.

2.1 Tier 2: Early Intervention

Prevention and early help services must seek to help people avoid risks to their health, wellbeing and independence, and ensure that when they do have difficulties, they are supported to recover their independence as quickly and effectively as possible. Tier 2 interventions include:

- **Appropriate and Sheltered Housing** – Access to good quality accommodation is a fundamental building block for a service model, which promotes good health, wellbeing and independence. More specialist accommodation which offers services such as community alarms and the availability of on-site wardens can greatly prolong an individual's ability to live safely and confidently at home.
- **Community Support and Engagement** – Community organisations supporting the early detection of risk factors.
- **Advocacy** – Services that provide advice and representation to individuals with regard to exercising choice and control over the services they receive.
- **Volunteer support** – Suitably trained and supported volunteers can provide practical support to citizens to prolong independence.
- **Carers Support** – Including information, advice, peer support and flexible and accessible sitting services (NB these services should be available to support carers of individuals receiving services at any of the following tiers below).
- **Integrated Community Equipment Service** – Prompt assessments for, and supply of, a range of equipment to support people to continue to live at home with speedy access to support to adapt the home environment.
- **Telecare and Telehealth** – Technological equipment which supports proactive responses from an appropriate range of services (linking to "Rapid Response

Services" in Tier 3, below). These services should also be available to individuals receiving services at Tiers 3 and 4, below.

- **Falls Prevention Support** – Help to ensure people are able to manage the risks of falling whilst staying at home.
- **Local Area Coordination** – Strengths based preventative approach to supporting people and communities build resilience and 'stay strong'. At Tier 2, the support offered by the LAC would be more likely to involve an ongoing relationship and tailored support.
- **Information, Advice and Assistance** - From the Council, third sector organisations and charities on specific issues e.g. Welfare Rights, Age Concern, Alzheimer's Society, MIND, Shelter Cymru.
- **Support for people with sensory loss** – This might include rehabilitation services for people coping with a sudden sensory loss or deterioration in sensory function and would include appropriate telecare and aids.

The Council's Adult Social Care Services and the local health board would be responsible for commissioning some, but not all, of the components of this tier in the service model. Others, including the wider Council, and our voluntary sector partners are crucial. We all need to make sure that our services at this level are focused on helping those most likely to need complex support if they are not supported early.

Gwen surprises everyone with how quickly she is able to get back on her feet. She leads a simple life that suits her. Her weekly visits to the horticultural group have given her a new lease of life and some new friends.

After 6 months, Michael notices that Gwen is becoming a little more forgetful and is concerned that she is not eating well and that her house is often cold. Michael goes back to Thomas and asks if he can discuss this with Gwen when he next calls in.

The 3 of them meet at Gwen's house. She feels well supported by Michael and Thomas, although the conversation is difficult and sad for her. She acknowledges that she is worried about her memory and is privately afraid that she is going to be "carted off to a home". She also admits that she worries about the little jobs around the house that Terry used to take care of.

Everyone is very reassuring and Gwen agrees that it is probably best that she visits her GP to talk about her memory problems.

Thomas also offers to put Gwen in touch with a handy-person scheme so that someone can come and help her with some of the home maintenance. He also recommends that she get a 'Lifeline' alarm in case she needs to call for assistance, and this reassures Michael that it is still safe for her to live alone.

After visiting her GP, Gwen is referred to her local Memory Clinic where she is assessed and, receives a diagnosis of Alzheimer's Disease.

Although Gwen and her family are shocked by the news they soon agree that they will work together to make the best of the situation. Gwen is clear that she wants to keep in control of the support she receives and to stay living in her own home.

Gwen and Michael agree to a visit from a Dementia Coordinator arranged through the GP.

Three days later, the Dementia Coordinator visits Gwen at her home and has a discussion with her and Michael about what aspects of her life matter most to her and

how she can be supported to stay independent for as long as possible. As a result of this:

- Gwen and Michael are given the number for the local Alzheimer's Society Support Group.
- Thomas accompanies Gwen to the horticultural group and they chat about her situation – one of the friends she has made offers to visit Gwen at home to see how the group can support Gwen to keep attending
- The Dementia Coordinator advises on technology that may be available to keep her safe at home. With Gwen's permission, Thomas supports Gwen to re-establish contact with her neighbours
- Michael and his wife agree to visit Gwen regularly to make sure she has everything she needs and to take her shopping when needed.
- Michael is put in touch with the local carers support group.

After a few months, Fran notices that Alice has stopped coming to the book group. She calls by her flat and finds Alice to be troubled and withdrawn. She notices that Alice's flat is cold and damp. She shares her concern with Alice and they agree that she should visit her GP to see what help is on offer.

Alice visits the GP, who discusses medication and refers her to the Local Primary Mental Health Service.

With Alice's permission, Fran is invited to sit in on the meeting. The discussion covers what aspects of Alice's life matter most to her and how she and Riley can be supported. As a result of this:

- Alice decides to keep contact with Kate from the Primary Mental Health Service.
- Alice asks about support to improve the relationship with her parents, as she knows this would help her. Alice decides to ask the Local Authority's Contact Centre whether there is any support available for someone in her situation. She is given the contact number for Robert, who manages the Family Group Conference Scheme.

2.2 Tier 3: Identified Need Being Case Managed

People who require 'managed care' need additional, often temporary, support to achieve their wellbeing outcomes. This builds on the support that is available in Tiers 1 and 2.

Services in Tier 3 should support people to:

- identify risks to their independence as early as possible
- receive responsive and targeted support in response to these risks
- return to and retain as much independence, relying on family, friends and communities without the need for ongoing formal support.

Tier 3 interventions include:

- **Community Multi-Disciplinary Team** - The team should include nursing and social work staff who will offer a range of interventions, including assessment and care and support planning.
- **Rapid Response** – A timely and effective response to unplanned events, which can co-ordinate a range of acute support without the need to resort to hospital or care-home admission.
- **An Integrated Community Therapies and Re-ablement Service** - Citizens experiencing planned or acute episodes can achieve as much independence as possible through a tailored package of therapies and social care support.
- **High quality systems to promote adult safeguarding** – Ensuring that the new legal requirements are met, that all staff understand their responsibilities, and helping create an understanding across the county that abuse of any adult is unacceptable.
- **Residential Re-ablement** – Rapid access to short-term care home accommodation supported by clinicians and appropriately qualified staff (including nurses) in which assessments and "step-up/step-down" interventions can be made whilst a person at acutely high risk is supported to develop strategies that enable them to return home.
- **Hospital Transfer Co-ordination** – Operating an "in-reach" system to follow people through planned and unplanned admission to undertake discharge assessment and organize subsequent interventions, across health and social care.
- **Employment Support** – Supporting physically disabled adults and adults with learning disability and mental health issues of working age to gain the skills and confidence necessary to find work.
- **Independent Living Skills** – Where necessary offering adults support to maintain the necessary living skills to maintain their independence.
- **Day Opportunities** – Provide social opportunities for otherwise isolated individuals, together with the opportunity to take up a range of services including, meals. Day opportunities for adults with a learning disability, mental health problem or physically disability offer support to develop and maintain independent living skills, promoting emotional wellbeing. Day opportunities also provide carers with a break from caring.
- **Direct Payments** – The provision by the Council of a payment in lieu of a service, which individuals can use to purchase their own support. This promotes choice, control, flexibility and independence.
- **Carers' Support** – Services such as respite care and information can support carers to continue in their caring role for as long as they want to do this.
- **Domiciliary Care –** Suitably trained experienced and competent carers provide personal care and support to people in their own home.
- **Supported Living** – Supporting individuals to maintain tenancies and live as independently as possible. Some people will require a few hours support and other will require higher levels of support including personal care.
- **Respite Care** –Support to give the carer and cared for person a break from the ordinary routine.

In partnership with Abertawe Bro Morgannwg University Health Board, the Council's Adult Social Care Services are responsible for commissioning or providing all elements of this Tier in the Service Model. Services at this level are geared towards helping people retain or re-secure their capacity and independence wherever possible enabling them to achieve their personal wellbeing outcomes.

One evening, while getting out of the bath, Gwen falls and breaks her wrist. She is able to call for help with her alarm pendant, which alerts Michael to her need for help. She is taken to Morriston Hospital where she has her wrist re-set and makes a good recovery.

After 24 hours on the ward, Gwen is seen by the Discharge Liaison Nurse and Social Worker who arranges for her to be discharged to a reablement bed at one of the local authority managed residential care homes.

Whilst staying here, Gwen is assessed by a member of the reablement team who designs a package of therapy and reablement support, which enables her to return home 5 days later.

Thomas visits her at the home to ensure that Gwen does not lose contact with her friends and networks in her local community so she can easily link back in when she returns home.

After 3 months, Alice is more positive about the future although she has struggled periodically with depression and on occasions has felt unable to cope with meeting Riley's needs. She has been able to maintain her volunteer role at the charity shop and has continued to enjoy her jewellery-making course.

She has been able to discuss her situation with Kate from the Primary Mental Health Service and they have agreed a strategy where Alice is able to recognise the onset of a period of depression and call for help.

Robert talks with Alice about her relationship with her parents and after listening to her, he suggests holding a Family Group Conference. Through this process, Alice's parents find it easier to understand and accept her challenges, respect her aspirations and recognise the good job she does caring for their grandson. They all enjoy seeing each other more often and Alice also gets a much-needed break when Riley spends time with his grandparents.

Robert also supports Alice to apply for a housing association property as she identifies that a fresh start is important to breaking old habits including her drug use. This is positive for Alice as the Housing Association will be able to provide support for Alice to manage her tenancy.

In this way, Alice is able to manage her depression and still provide a safe and reliable environment for Riley. She has continued in her volunteer work and hopes to gain a paid post with a mental health charity, supporting the volunteers that work in their three shops in Swansea.

When her depression becomes acute, she is able to trigger a rapid response to her needs. His grandparents can care for Riley and Alice can receive support and a sheltered environment if she needs to.

Alice now feels in control of her situation and Robert no longer needs to support her. She has been able to identify the things that matter most to her: a stable environment for Riley, improved relationships with her parents, a job and her

friendships. At this point, she is actually unlikely to require Tier 3 services.

2.3 Tier 4: Higher Level Needs – Specialist Support

These services seek to meet the needs of those whose conditions or circumstances mean that they need longer-term specialist or substitute care or support. These interventions must seek to ensure that adults:

- Are able to receive the right care in the right place by the right person at the right time.
- Can access high quality specialist care which is as close to their local communities as possible.
- Are supported to retain their dignity and as much independence as they can and wish to exercise.

Tier 4 interventions include:

- **Community Multi-Disciplinary Team** - The team should include nursing and social work staff who will also offer a range of more specialist interventions, including assessment and care and support planning for people with complex, long term needs.
- **Equipment and Adaptations** - Supporting community services, hospital discharges, re-ablement services and end-of-life services to ensure people can be supported at home for as long as possible.
- **Telecare** – The use of telecommunication and computerised services such as sensors and alerts to provide continuous “live” monitoring of care needs and emergencies.
- **Domiciliary Care** – Suitably trained experienced and competent carers provide personal care and support to individuals with more complex needs in their own home.
- **Carers’ Support** – Services such as respite care, support and information can help carers to continue to provide care and support for those who have ongoing care and support needs.
- **Accommodation with Support and Care** - The provision of care at home for older people, but also younger adults, supported by the increased availability of technology will mean that people will be able to stay at home much longer if they choose. The development of supported living and extra care accommodation will support people to maintain their “own front door” whilst still having increasingly complex health and social care needs met by community based services. Nevertheless, some people will still reach stages in their life where they will seek support in a care home environment and benefit from the security of 24-hour support in a safe and supportive environment.
- **Day support for people with complex social care and health needs including people whose behaviour challenges** - Day opportunities to develop or maintain physical and emotional health and to enable people to participate in their local community. Day opportunities also offer opportunity for carers to take a break.

In partnership with Abertawe Bro Morgannwg University Health Board, the Council's Adult Social Care Services is responsible for commissioning or providing many elements of this Tier in the Service Model, although many people fund their own care and support. It is as crucial at this level that services are designed and delivered to promote independence in the same way as at other levels in the model. There is a huge positive difference in outcomes and experience for people who are able to exercise choice and control even when they are dealing with the most intensive types of care and support.

After her discharge from hospital, Gwen is assessed as requiring additional support to help her manage with living at home. She is still fiercely independent and still takes an active interest in her garden.

She and Michael decide to accept a direct payment from Swansea Council which they use together to purchase support for Gwen in her home. Gwen employs a Personal Assistant to assist with personal care and Michael and his wife now visit her every day and support her with practical tasks like shopping. Friends from the horticultural society visit her regularly and enjoy spending time with Gwen in the garden.

Gwen continues to live a fulfilled life in her local community with support from family, friends and the services she purchases with her direct payment, although her Alzheimer's is progressing steadily. 18 months later, Gwen contracts a urinary tract infection and needs to be hospitalised.

Whilst staying in hospital, the same Discharge Liaison Nurse and Social Worker meet with Gwen to discuss her situation with Michael and professional colleagues. Gwen states that she no longer wants to live alone. After 6 days, she is discharged from hospital to a short-term care home bed, where she stays whilst waiting for a room to become available for her at a local care home, which is managed by an independent sector provider.

Gwen lives at the care home for a further three years receiving regular visits from her family and friends in her local community. She dies there, in her local community, peacefully and with her family around her.

Alice would not require Tier 4 services

5 What would be the consequences of not adopting the new model?

If we do not make the shift in services and approach in Adult Social Care Services in the next few years, and we continue with or even extend an approach characterised by:

- Level 1 and level 2 services not sufficiently effective in helping people avoid the need for complex care.
- Too many people not being helped to maintain their independence for as long as they can.
- Too many people being referred to hospitals and long-term care homes.

..then we think that the result will be that:

- We will not meet the legislative or performance requirements of the Welsh Government and its Inspectorates.
- Demand for our resources will continue to increase, putting severe pressure on reducing budgets.
- There will be increasing problems at boundary points between health and care including hospital discharge.

Social care will become an increasingly difficult and stressful field to work in, leading to greater recruitment and retention problems.

6 Our immediate priorities

This service model places a challenge before Swansea's Adult Social Care Services to embrace a culture, which places individuals, families and communities at the centre of the services we support, commission and provide. To make this a reality, we must undertake a fundamental transformation in our approach. In particular, we plan to focus on three key areas:

- Prevention and Early Intervention
- A different approach to Assessment
- Developing Strong Practice.

6.1 Prevention and Early Intervention

We plan to focus on:

- **Targeted Preventative Interventions** – A number of individuals make first contact with formal services in response to a single episode in their life. The provision of the right short-term help at the right time can reduce or eliminate the need for longer term care. This can include the provision of information, practical support, referral to community organisations and bereavement counselling. These interventions can also be pre-emptive, and focus on avoidable risks to independence. For example, falls prevention, vaccination and "stay warm" programmes.
- **Integrated Care Pathways** – A number of the approaches described above depend upon structured and effective joint working especially between health and social care professionals. The design and development of integrated care pathways support early identification of risk, targeted interventions, rehabilitation and re-ablement.
- **Stronger Rapid Response** – A swift and well-co-ordinated response to an individual's needs at the time of crisis has been shown to be effective at significantly reducing their need for longer term more complex services. These services can include the availability of a responsive out-of-hours community nursing service, rapid allocation of community equipment and "crisis intervention" domiciliary care service together with practical problem solving and rapid access carers' respite services.
- **Improved Intermediate Care –** To support effective planning and discharge from hospital, a variety of services "between hospital and home" will support an

individual to return to as much independence as possible. These services include good nursing; therapy (from a range of different therapists); re-ablement-based domiciliary or residential intermediate care; continence services; and dementia care support services.

- **Better Hospital Transfer Co-Ordination** - A proactive and multi-disciplinary approach to hospital discharge arrangements and out-of-hospital care can make a significant difference to the ongoing need for formal care and support services that an individual requires.

6.2 A different approach to assessment

Current systems tend to intervene when individuals are at a point of crisis and tend to focus on people's deficits and consequently assessments tend to be undertaken when people's needs are at their greatest. Levels of longer term service are established without recognition of an individual's capacity to recover. The longer-term provision of higher-than-necessary levels of care and support has been shown to "disable" individuals and promote reliance on those levels of care.

We plan to:

- use the opportunities afforded by the implementation of a new approach to assessment, required by the Social Services and Wellbeing (Wales) Act 2014, to instil a "strengths and assets-based" approach to assessment focussed on individuals' capacity to achieve greater independence and also emphasise the potential contribution from informal assets such as family, friends and others in the community. This will be developed with a clear eye on the importance of taking a measured approach to risk, the management of risk, and the importance of safeguarding vulnerable adults.
- Place an increased emphasis on reviews to ensure we capture and address any change in need that may require a change to how individuals and their carers are supported and understand how their wellbeing outcomes are being achieved.

6.3 Developing Strong Practice

In particular, we plan to:

- Develop a clear practice framework which will guide and inform the day to day work of our staff and their key partner professionals.
- Enable our managers to support and challenge their teams to embrace the required culture shift and embed new ways of working.
- Make every contact count; ensuring that staff and colleagues from other bodies work well together and ensure that individuals and families are supported seamlessly to build on their strengths and assets in developing innovative responses to their individual needs.

By focussing our attention on these three areas for change, we believe we can make the biggest difference. We recognise that the scale of transformation is ambitious and our task in achieving it is complex therefore we won't be able to implement this

model immediately, but rather build towards it carefully, with the full involvement of our partners and stakeholders including, communities and individuals.

7. Measurable Improvements

We believe that by taking a rigorous approach to working co-productively and managing demand for services within this model, and assuming the active engagement by our partners, we should be able to:

- Provide high quality services for those who need them within the current budget plans despite the additional demands likely as a result of adult population increases in Swansea in the next 3 years.
- Achieve a re-distribution of 5% of resources from Tier 3-4 to Tiers 1-2 across health, wellbeing and care agencies in Swansea in 5 years. We do not want to have to put our money into expensive substitute care for a few, when we can invest it better in early help for many.
- Continue to improve on the relevant performance targets required by the Welsh Government including:

    - Proportion of people reporting they have received the right information or advice when they needed it
    - The percentage of adults who have received support from the information, advice and assistance service and have not contacted the service again during the year
    - The percentage of adults who completed a period of re-ablement and have a reduced or no package of care and support 6 months later
    - Proportion of people reporting that they live in the right home for them
    - Proportion of people reporting they can do what matters to them
    - Proportion of people reporting they feel satisfied with their social networks
    - Proportion of people reporting that they feel safe
    - Proportion of people reporting that they feel a part of their community
    - The percentage of adult protection enquiries completed within statutory timescales
    - The rate of delayed transfers of care for social care reasons
    - Proportion of people reporting they felt involved in any decisions made about their care and support
    - Proportion of people reporting they were treated with dignity and respect
    - Proportion of people who are satisfied with care and support that they received
    - Proportion of carers reporting they feel supported to continue in their caring role
    - Proportion of people reporting they chose to live in a residential care home
    - The average length of time older people (aged 65 or over) are supported in residential care homes
    - Average age of adults entering residential care homes

8 Conclusion

Our proposed service model responds to the requirements of the Social Services and Wellbeing (Wales) Act 2014. It builds on, and adds detail to the implementation of the Sustainable Swansea programme, and draws on evidence of good practice from elsewhere – including children's services in Swansea.

Implementing the model will require a fundamental and ambitious transformation and evolution in public services. A number of key services and whole system approaches are identified as possible priorities. It is recognised that commissioning the services identified in this model will require a collaborative approach from a number of agencies and the four Adult Social Care Commissioning Reviews will make recommendations across adult services on service models and delivery arrangements. We will also need to work closely with our independent sector partners to ensure that we collectively grow a strong, skilled, motivated and valued workforce that is able to deliver the model.

This service model provides the framework to deliver the statutory requirements of the Social Services and Wellbeing Act and each of the Council's forthcoming adult social care Commissioning Reviews must be undertaken within this context. Each service must be "placed" in this strategic framework and its interdependencies with other services recognised.

We will be developing a programme of change in order to deliver this model and will collaborate with key partners to achieve this.

Any proposal for change will be co-produced, publicly consulted upon in line with any consultation requirements, with final decisions informed by an Equality Impact Assessment, prior to any changes being implemented. Any changes made will be fully accessible to all regardless of any protected characteristic in line with the Equality Act 2010 and the Welsh Language Wales Measure 2011.