Report of the Head of Adult Services

Safeguarding Policy Development & Delivery Committee

20 September 2017

Adult Services
Overarching Service Model

Purpose:	To brief the PDDC on the Adult Services Service Model, as agreed by Cabinet on 15th June 2017.
Corporate Priorities:	Safeguarding Vulnerable People
Reason for Briefing:	To ensure that the PDDC have a good understanding of the Service Model and the agreed direction of travel, to inform their ongoing policy development.
Consultation:	Public consultation undertaken.
Recommendation(s):	It is recommended that:
1) The PDDC note the report.	
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1. Background

1.1 As part of the Corporate Commissioning Review process, it was agreed that four reviews would be undertaken in Adult Services as follows:

- Domiciliary Care
- Residential Care for Older People
- Day Services for Older People
- Accommodation and day related support for people with Learning Disabilities, Physical Disabilities and Mental Health concerns.

1.2 As part of the Commissioning Review process, it became apparent that there was not a clear vision for Adult Services and an understanding of what ‘good’ looked like, and it was felt that it was particularly important to understand this due to the interdependent nature of the reviews.

1.3 In addition, we needed a clear Model which outlined how we would meet the requirements of the Social Services and Wellbeing (Wales) Act, our Corporate priorities and savings as required through the Sustainable Swansea programme.

1.4 It was therefore agreed that a Service Model would be developed that set out to achieve this.

2. Agreed Vision

2.1 A vision was developed in consultation with staff, Cabinet and CMT as follows:

"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".

3 Core principles of the model

3.1 The model is based on 6 key principles as follows:

- Better prevention
- Better early help
- A new approach to assessment
- Improved cost effectiveness
- Working together better
- Keeping people safe

3.2 These principles should be embedded in all the work that Adult Services undertakes.

4 Tiers of support

4.1 In line with the Social Services and Wellbeing (Wales) Act, the Model is based on four tiers of support as follows:

- 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

4.2 Under the Model, Adult Services and its partners aspire to support people at the lowest tier possible to maintain independence and reduce dependency on statutory support.

4.3 People may receive support in multiple tiers at the same time, and support from some tiers may be time limited whilst others will be longer term.

4.4 Adult Services cannot deliver this Model alone. Successful delivery of the Model is reliant on joint working both across the Council and with partners outside.

5 Implementation of the Model

5.1 The Model was agreed by Cabinet at their meeting on 15th June 2017, which is attached as Appendix 1 to this report.

5.2 The Model itself does not lead to any specific changes. It purely sets out an agreed vision, direction of travel and framework for Adult Services to work within.

5.3 The first step in implementing the Model is the delivery of the outcome of the Domiciliary Care Commissioning Review.

5.4 All proposed changes that emerge from the Model will need to be developed and consulted upon, in line with statutory requirements.

6 Financial Implications

6.1 There are no specific financial implications in relation to delivery of the Model, as financial implications will be considered each time a specific proposal is considered.

6.2 However, it is implied in the Model that longer term greater investment needs to be put into preventative and early intervention activities at Tiers 2 and 3 specifically, to prevent demand in long-term services in Tiers 3 and 4.

6.3 Delivering the Model will also help us to achieve long-term sustainability for Adult Services and deliver services within the challenging financial footprint.

6 Legal implications

6.1 Delivery of the Model will allow us to deliver our statutory obligations in relation to the Social Services and Wellbeing (Wales) Act.

7 Equality and Engagement Implications

7.1 A 13-week public consultation was undertaken in relation to the Model, and the Model was amended to take account of the consultation responses. This consultation consequently informed Cabinet’s final decision on approving the Model.

7.2 As part of the decision-making process, an Equality Impact Assessment was undertaken. Again, this was informed by the consultation process as well as demographic data in relation to current service users in Adult Services. This was also used to inform the final Cabinet decision on the Model.

Background Papers:
Report of the Head of Adult Services, Cabinet, 15 June, Adult Services Commissioning Reviews Consultation Outcome

Adult Services Model EIA.

Appendices: Appendix 1: Final 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 keep vulnerable people safe, reduce the number of people who are dependent on care services and manage the demand for longer-term care.

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

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.

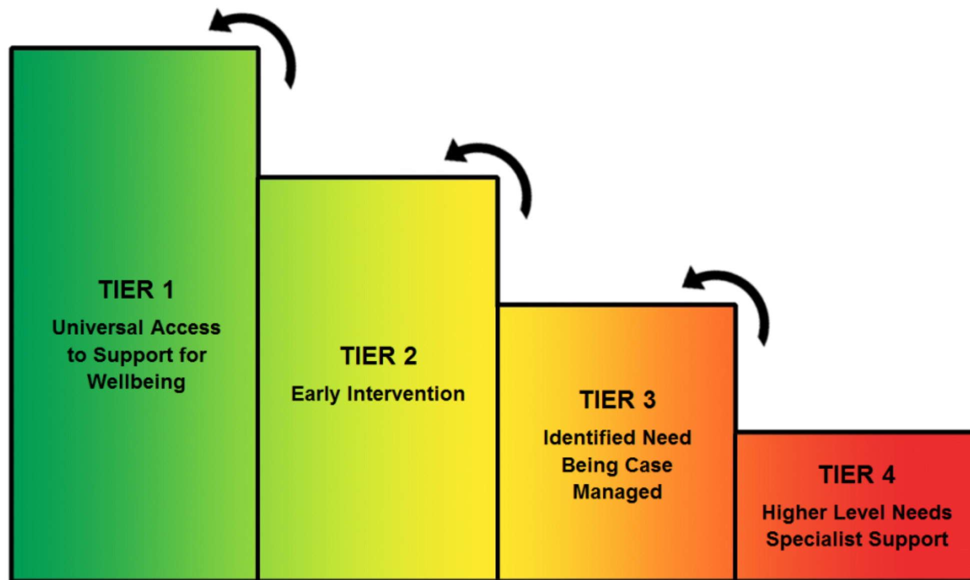
Working together better – by collaborating with our partners, particularly our health colleagues and internally across the Council, we can better integrate our services, assessments and resources to ensure that they are efficient and can deliver a more joined up approach, which makes sense to people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