CWM TAF MORGANNWG REGIONAL PARTNERSHIP BOARD – ANNUAL REPORT 2019/20

Contents

1.0 INTRODUCTION & FOREWORD BY CHAIR OF THE REGIONAL PARTNERSHIP BOARD, RACHEL ROWLANDS

As the Chair of the Cwm Taf Social Services and Well-being Partnership Board, I am pleased to introduce our 2019/20 annual report.

2019/20 was the first full year of the new regional partnership board Cwm Taf Morganwwg. New members of the board were welcomed and provide new insights and strength to the board.

The COVID-19 pandemic, has re written the landscape of current service provision with the health and social care workforce in large part redeployed and many services reconfigured to manage and meet the new demands.

The partnership response to this challenge has been quick, creative and solution focused. The Regions COVID-19 Hospital Discharge Pathway saw the development of a number of step down facilities that brought partners together from health board, local authority, third sector and care home sector.

Clearly the impact of Covid-19 has been disruptive and there are lessons to be learned from it that will take time to emerge and be properly understood. There have been some fantastic examples of partnership working and innovation. This innovation must be nurtured and built on. We cannot revert back to business as usual as we prepare for recovery/ second wave and winter.

Rachel Rowlands

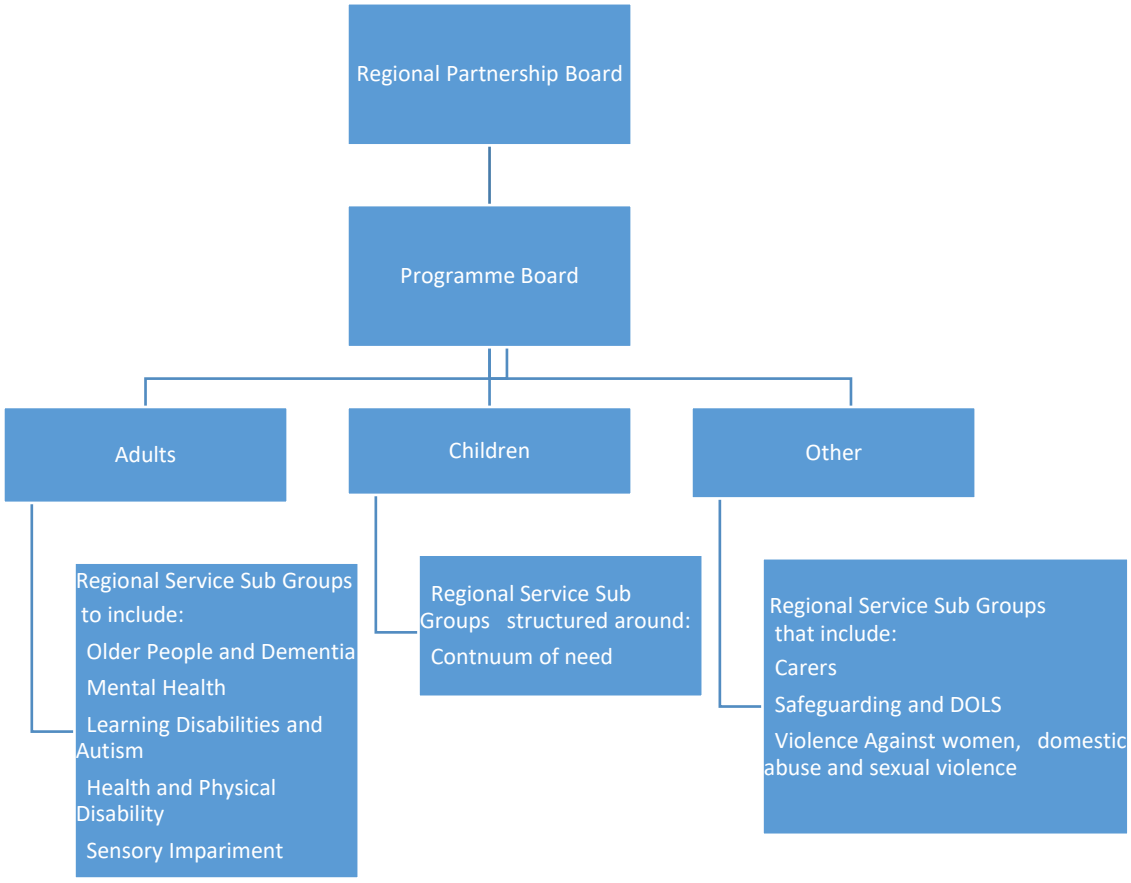
Chair of the Regional Partnership Board

2.0 PARTNERSHIP GOVERNANCE AND DEVELOPMENT OVERVIEW

The change in boundaries in April 2019, that saw the former Cwm Taf Region to extend to include Bridgend to create the Cwm Taf Morgannwg Region, has resulted in some significant change both for the region, Cwm Taf Morgannwg Health Boards and for Bridgend CBC.

During 2019 the board also welcomed new member's registered social landlords, housing colleagues and education.

A Review of regional governance commenced in December 2019. Whilst progress has been hampered by the impact of COVID-19 new governance arrangements are now being implemented.



In developing the revised governance structure we were able to revisit the priorities, structures and responsibilities of members but also the vision, values and behaviours.

The following vision have been agreed;

'Making a difference to people's lives by involving them, listening and taking action together to transform the way services are delivered'

Values

Inclusivity: Our work is led by our communities and we commit to ensuring everyone has the opportunity to be involved.
Equality: We believe in creating a fair and equal society. Every person should have access to services that support them to live happy and healthy lives.
Integrity: We promise to be honest, open and transparent in everything we do.
Collaboration: Our communities are at the heart of what we do. We will continually work in partnership with local people to design and deliver services to ensure they are receiving the right support and services.
Innovation: We will do things differently to better work with and support local communities.

Core behaviours

- We are respectful and polite
- We empower people to be leaders
- We are professional, efficient and effective
- We are driven and determined to ensure our communities receive the best services
- We recognise and celebrate achievements
- We are effective communicators
- We put people at the heart of design and delivery of services
- We adopt a 'can do' attitude
- We are focused at getting actions done in a timely manner
- We intend to link in with different groups to ensure we have all the context when making decisions
- We think 'outside the box' and are committed to doing things differently
- We treat others how we would want to be treated
- We are supportive
- We are willing to share resources and work in partnership to get things done effectively and efficiently
- We are flexible, adaptive and responsive

3.0 MEMBERSHIP OF THE BOARD

The Membership of the Cwm Taf Morgannwg Regional Partnership Board is based on Social Services and Wellbeing (Wales) Act 2014, Codes and Guidance Part 9 Statutory Guidance (version 2 – January 2020) and includes representation from Directors of Social Services, Health Board Executives, third sector representatives and service user and carer representatives. (See Appendix 1 for full membership Details).

4.0 TRANSFORMATION

In 2018, Welsh Government announced a £100m Transformation Fund to support RPBs across Wales to deliver the vision set out in 'A Healthier Wales: our vision for health & social care.'

The Fund is intended to meet the time-limited additional costs of introducing new models of health and social care. It is aimed at accelerating the wider adoption and scaling up of new ways of working which are intended to replace or reconfigure existing services.

In July 2019, £22.7m of funding was awarded to the Cwm Taf Morgannwg RPB to expand successful projects across RCT and Bridgend. Within the region there are a total of 8 projects funded that aim to provide greater choice and independence for individuals, whilst reducing pressure on social care GP surgeries and hospitals.

The focus of the Transformation Fund is on models;

- Seamless alignment of health & social care services.
- Primary and community based health and social care delivery.
- New integrated prevention services and activities.

All services were due to go live between January & April 2020 however there were some delays due to COVID and support being diverted.

Ambition 1: every day is a Tuesday

The Bridgend approach to the integration of services through the Community Resource Team model has been noted as an exemplar in the Parliamentary Review of Health & Social Care in Wales (2017).

Highlights;

- The acute clinical team have completed **107** facilitated discharges and avoided **5254** hospital bed days.
- The Intake Reablement team facilitated a cumulative total of **557** hospital discharges and avoided **1671** hospital bed days.
- **3,522** call outs for the Mobile response team are judged to have avoided an Ambulance call out.

Ambition 2: One team approach around people

Single Point of Access(SPoA) provides effective 'front door' to district nursing service, meaning nurses can focus on patients they are supporting and ensure a flexible and speedy response.

Implementation has been delayed due to COVID however developments are now moving ahead.

Next stage is to develop anticipatory (ACP) / contingency plans of care and support around people who cause greatest concern. Plans will be co-produced with families to ensure choice, voice & control.

This will be delivered through the development of multi-disciplinary teams within existing Integrated Community Cluster Networks:

- GPs will be able to draw MDT specialists to support people in need and offer tailored responses to individual circumstances
- Beneficial in terms of knowledge transfer and professional confidence
- Will provide an additional resource to respond to both a renewed surge of COVID-19 cases or increases in non Covid work

Ambition 3: resilient coordinated communities

The Coordinated Communities Programme has supported more than 60 to Engage and provide support in communities. All participants said that they have been supported to do things that matter to them.

During Covid-19, the Local Community Coordinator system responded to a spike in demand for practical and emotional support for isolated and shielding individuals providing practical support, access to food supplies, supported volunteers and befriending support. People have reported the support has "made a positive difference to their lives", and most now feel their circumstances have improved.

Other studies of similar approaches have demonstrated a benefit/cost ratio ranging from 2:1 to 4:1.

Risk stratification & population segmentation

Short/medium term impact:

- Enable improved identification of patients with greatest need
- Provide an evidence base for predictive ability of segmentation

Long term impact:

- Enable policies or integrated interventions targeting segments
- Outcomes of Welsh pilot published in BMC Public Health shows

wider implications for success of this work in terms of data sharing across NHS organisations, particularly in primary care.

Local example (risk stratification approach to identify patients at high risk of heart failure and focus preventative treatment on those individuals)

- 95 hospital admissions prevented
- Allocation of 62 devices potentially saved
- 50 lives saved
- A potential NHS saving of £0.75m-1.5m

Ambition 4: Assistive technology

Mobile Responder Service (MRS) has been really successful in reducing demand for services, and providing am efficient level of care& reassurance for residents.

- Since launch:
  - Nearly 200 people have been seen
  - Of the 602 visits between January & June, an ambulance was only called to support on 90 occasions, meaning 75% of cases were managed by the MRS
  - It takes responders on average:
  - 27 mins to arrive at the property
  - 26 mins to complete the call
  - 53 mins from request being made to call being completed
  - Up to 512 ambulance visits avoided

- Mobile Responders have provided support to NHS staff by contacting individuals who received a shielding letter & undertaking welfare checks & sharing information

- Staff recruited to First Response (FR) service have supported Local Authorities by calling vulnerable people.

- Managers from FR have supported development of pathways for the Community Resilience Centres and proactive calling linked to NHS shielding letters

- Introduction of MRS can have significant savings for ambulance service - up to £98,000

Ambition 5: Community health & wellbeing

- Multi disciplinary team (MDT) approach can provide support to the top 3% of service users in a GP practice, reducing demand on general practice both in and out of hours and on A&E.

- Benefits can be seen across financial, safety and quality, patient satisfaction, and the working lives of those working within primary care.

- Evidence so far suggests that if a virtual ward is run efficiently with the right processes and professionals in place, significant reductions can be made to GP in hours appointments, referrals to GP out of hours and to unscheduled hospital care e.g.

Ambition 6: Stay Well @ Home 2

Stay well @ Home 2 builds on the Stay Well at Home 1 that continues to be a flag ship project for the RPB and provided greater support in the community to vulnerable residents.

Highlights;

- 204 referrals to the programme from community health professionals since January 2020
- 91% of 204 referrals achieved response target of four hours
- 66 just needed advice, but out of the other referrals:
- 24 were explicitly requested by the referrer to avoid them having to convey/admit the person to hospital.
- 114 requested services to support them to help the person remain safe in their own home
- Programme has ensured SPoA is one entry point for community health professionals to access rapid responses to a range of services
- SPoA in RCT are now able to process hospital discharges over seven days instead of five
- Earlier access to enabling and preventative services including Reablement and OT assessment and programmes of support

Ambition 7: Urgent primary care services

Service operational during the COVID-19 pandemic providing triage services but doing so with fewer face-to-face contacts taking place, demonstrating the value it can provide both during and post the pandemic

Significant investment in training has been beneficial, with a range of opportunities for ongoing professional development that is appropriately linked to the types of clinical skills needed for OOH

Focusing services on respiratory care has allowed GPs and other community services to access specialist advice on managing the demand of COVID-19.

Reporting to date shows the service can support teams with decision making, create increased capacity in the system due to effectiveness of nurse triage, and the MDT set up can improve patient experience:

- Response times during the peak of the pandemic showed approximately 54% of all patients were seen and treated within 2hours of referrals.
- Peer Review shows encouraging findings for the OOH service, through recruitment of 21 new GPs, translating into more OOH GP sessions being filled.

Future potential

- Service has potential to provide streamlined pathways, with a stronger collaboration with social care, mental health and voluntary sectors
- It is believed that in time (within 18 months) this service will be able to reduce 25 – 30% of the patients from the GPs workload
- Ambition to deploy an Artificial Intelligence app and machine learning within two years, which will reduce patient demand (estimated by 35%) by encouraging self-care and providing appropriate advice on sources of support.

What's next?

- Funding for 2021/2022 for the 'Transformation Programme' has been confirmed, with RPB allocation to be confirmed.

- Welsh Government has acknowledged the benefits of the programme in supporting new ways of delivering health and social services for the people of Wales, particularly during COVID-19

- This new funding will give us the opportunity to further consolidate, embed and mainstream some of the most successful models during 2021/22.

5.0 INTEGRATED CARE FUND (ICF)

5.1 Capital

Cwm Taf Morgannwg's RPB allocation for 2019/20 was £5,049,000 and was directed toward 13 MCP large scale schemes.

The schemes formed a mixed model of social care housing; extra care schemes, supported living for people with learning disabilities, community hubs, integrated community bases, children's accommodation, all of which

are being developed across the new Cwm Taf Morgannwg footprint of Rhondda Cynon Taf, Merthyr Tydfil and Bridgend.

As a Regional Partnership Board we would highlight the following valuable aspects of the programme;

- The ability to invest capital funding strategically across both social care and housing, for both adult services and children services.

- The allocation of ICF capital funding, in turn allows for further funding to be drawn down/sought, with opportunities to match fund and increase overall funding streams, from other avenues.

- The opportunity to develop large scale schemes working with the independent sector and RSL's to create eg Housing and Accommodation Extra Care Schemes, building fit for purpose facilities for independent and supported living. (eg Extra Care Pontypridd).

- Ability to test out new and innovation digital technology supporting independent living within larger scale capital schemes; eg Penllew Court Supported Living, with the installation of a Tunstall digital system for monitoring client safety, for fall prevention.

- Address gaps in service provision, eg Children Respite Accommodation (Carn Ingli Residential Home) to offer short term temporary accommodation to children with complex emotional and behavioural needs and avoid out of county placements.

- Create new models of care, e.g a whole system approach to Dementia care provision, eg Kier Hardie Health Park Dementia Unit reconfiguration, creating a new Butterfly Model, approach to supporting people living with Dementia, along their cognitive ability journey. Evidence based on current sector wide innovation and best practice, and using co-productive models of client involvement in addressing their needs, and the ability to create modern environments which are conductive to enhancing their wellbeing.

- The ability to invest large scale capital funding into the 3rd sector, eg Cynon Linc scheme will see a Community Hub approach, with facilities for older people, GP surgery, childcare facility, community areas for use by members of the public and health services, eg, nail cutting etc, changing places for adults with physical disabilities, and income generation community café.

- Create Integrated Community Services locations for multi-disciplinary teams working across health and social care and working across

organisational boundaries, meeting ICF objectives of integration at the operational front line.

- In addition to large scale MCP funding, the ability to offer DCP smaller scale scheme funding, which is often hard to obtain for the third sector has been very beneficial. We have been able to support 29 smaller scale capital schemes, ranging from improving entrances and pathways, cycle paths for side by side bikes, and for improved access, sensory gardens for wellbeing for older people in the community, refurbishing sensory rooms for children with sensory impairment, hand held and mobile equipment with the ability to be taken into communities, supporting people's care and remain independent at home, and avoid hospital admission.

A selection of case studies are shown in appendix 3.

5.1 REVENUE

Cwm Taf Morgannwg received £12,967,664 ICF funding, with budgets and priorities split across services for Older People, People with Learning Disabilities, Children, services for Autism, Dementia services and the new social care database (WCCIS). See table of investment and budgets below:

Budget 2019 / 2020	£12,967,664
Budget Area	Budget Allocation
Older People with complex needs and long term conditions, including dementia	£5,521,000
People with Learning Disabilities/ Children with Complex Needs & Carers	£3,214,000
Children - Early Intervention, and support to Children & Families	£2,411,000
People with Dementia	£1,242,000
Integrated Autism services	£367,000
Wales Community Care Information System (WCCIS)	£212,664
Regional Infrastructure	£0
TOTAL	£12,967,664

By year end, the funding has been invested across the region, into the following health and social care services and themed areas:

- For older people - services that provide support for;

- ***Hospital Discharge and Patient Flow*** – including the flagship strategic project 'Stay Well at Home', supporting patients being discharged from hospital to home with packages of care support, promoting their long term wellbeing and health in their own home environment, and preventing escalation of need by preventing further hospital admission.
- ***Mobile response and Integrated Community services teams*** in the community.
- ***Care and Repair schemes***, supporting hospital discharge with provision of adaptations and equipment to keep services users safe, well and independent at home for longer, adapting homes, as required for falls prevention.
- ***Domiciliary Care Workforce*** - Domiciliary Care within client's homes, ensuring they remain cared for and supported within the safety of their own homes.
- ***Information and Community Capacity*** - Community Hubs, providing information and guidance to service users and Carers

- For people with learning difficulties;

    - ***Support with increased social worker and complex care packages*** of support, commissioning for complex needs, closer to home projects, preventing out of county placements, respite care and support services in communities

- For early intervention, prevention and help for Children and Families, projects were funded that supported;

    - ***Edge of Care and reunification*** for children looked after and preventing escalation of need for care leavers
    - ***Residential care services*** on short term basis as crisis intervention when children require urgent re-homing for their welfare and safety
    - ***Emotional Wellbeing, information and advice*** - emotional support for children with complex needs and safeguarding concerns.
    - ***Early Help Hubs and Emotional wellbeing*** support in schools.
    - ***Disabled children's team services*** and transition support into adult services.

An annual ICF report is developed annually. Appendix 4 provides a selection of case studies from ICF Revenue Projects.

6.0 COMMUNICATION, ENGAGEMENT AND SOCIAL VALUE

6.1 Communication and Engagement

As a new Cwm Taf Morgannwg Region the need to create a new identify and brand for the RPB was identified in 2019. At present there is a limited web presence and whilst information can be conveyed via Partners existing communication teams the requirement for Communication and Engagement capacity was prioritised.

A Communication and Engagement Officer has been appointed, funded across ICF, Transformation and Research and Innovation Hub the Officer now plays a key role in driving communication, branding, raising the profile of the RPB and identifying methods and opportunities for greater citizen engagement and co-production.

Examples of work undertaken;

- Consultation exercise undertaken with local authority, health, third sector, independent & education partners to inform them of communications & engagement aims, understand perceptions of RPB, engagement opportunities.
- Communications & Engagement strategy and plan running up until March 21 developed using insights from the wide scale stakeholder analysis and consultations.
- Website & branding commissioned to provide a 'one stop shop' for communications and engagement activity and to build the narrative around the RPB to drive better communication and engagement.
- Multiagency website core project group created with planned workshops with citizens and service users to co-produce contents.
- Supporting Community Resilience Volunteers working group to raise profile of volunteering and promote volunteering opportunities

- Communications Lead for the 'Protect' work stream in the TTP work, working closely with health partners, third sector and local authorities to ensure the right messages are disseminated to community groups.

6.2 Co-production

Co-production is an essential ingredient within the Social Services and Wellbeing Act, ICF Guidance and outlined in Cwm Taf Morgannwg Area Plan.

A co-productive approach to service development, design and delivery in Cwm Taf Morgannwg has been promoted through the Cwm Taf Social Value Forum, in line with the Act.

Under the direction of a multi-agency steering group, a co-ordinator was appointed by RCT Peoples first (ICF funded). The purpose was to;

- Develop a clear route and structure to ensure adults in need of care and support and carers have their voices heard.
- To enable and connect people who need care and support and carers with their communities and with each other to build a stronger, more connected network that increases the opportunities for co-production and engagement in the design and delivery of services.
- To transform the collective voice of people with disabilities, carers and people with lived experience in decision making across the region and achieve change in how people with lived experiences are viewed, valued and involved.
- Encourage and support Co-production, design, decision and evaluation of the planning and allocation of future services, creating new relationships between staff and those who use services recognising them as experts in their own right.

This Project provided much of the local intelligence on impact of COVID on our communities through the Citizen Engagement through Lockdown report that has fed into the rapid review of population needs and will inform

partnership priorities. Note #CTMLockdownVoices campaign that has been running throughout the lockdown period through RCT Peoples First.

7.0 REGIONAL COMMISSIONING UNIT

A Joint Regional Unit was formally created in March 2019. The Unit has several varied functions, including supporting Cwm Taf Morgannwg's Regional Partnership Board (RPB), coordinating a number of Welsh Government regional funding streams into priority areas of work, supporting the wider social care, health and housing priorities, reporting on service investment performance, to ensure client outcomes and value for money for service users and stakeholders, and to ensure those most in need, receive services, at the right time and in the right place.

8.0 POOLED BUDGETS

In the former Cwm Taf region, pooled budgets are in place for youth offending services, integrated equipment services and learning disability packages of care. These funds provide an enabler for increasing value and improving outcomes through integrated and seamless services for a range of patient and client groups.

An overarching Pooled Fund for residential and nursing care has been established and is operating as set out in a Legal Agreement between partners, hosted by Rhondda Cynon Taf County Borough Council. It essentially encompasses all older persons' independent residential and nursing placements in establishments located within the former Cwm Taf footprint. Bridgend's Care Home Pooled Funds were still within the Western Bay for 19/20 as a transition year. Further work is being undertaken to refresh Market Position statements across the Cwm Taf Morgannwg Region and review the recommendations from the KPMG review of pooled funds.

9.0 FORWARD LOOK

In light of the unprecedented scale and impact on population and services brought by the pandemic, RPBs and their partners were required to undertake a rapid review of their population needs assessments to understand the effect of the pandemic. This review focused on some of the most affected groups and how services may need to change in order to meet needs in the new landscape for the priority groups under the RPB;

- Children and young people with complex needs (ref new part 9 definition)
- Unpaid carers
- Older people, with specific reference to supporting people living with dementia
- People with physical disabilities
- People with learning disability/autism
- People with poor mental health
- Sensory impairment

The rapid review provided a summary of Population Needs assessment as compiled for original assessment (including additional information relating to Bridgend that was outside of the original scope), national survey information regarding the impact on specific priority groups and local intelligence including feedback from Strategic Sub Groups of the RPB where this was available.

Local intelligence priorities were captured through the Citizen Engagement through Lockdown report and has been used to inform Regional Partnership Boards planning and priorities and further support engagement and co-production with local communities.

In conjunction with the Public Service Board (PSB) we undertook a COVID-19 Community Impact Assessment and will continue dialogue with the PSB to work collaboratively where joint priorities are identified.

As a region we have reviewed the scenarios for winter and bed modelling forecasts to inform winter planning discussions and COVID surge readiness.

The new operating model for Cwm Taf Morgannwg University Health Board provided us further opportunity for engagement and Partnership working across the Integrated Locality Groups but also at a Systems level with engagement through adults and children Programmes Groups.

The priorities listed below are derived from a combination of local population assessment refresh, citizen engagement and priorities identified by the strategic adults and children's groups. Note that discussions are ongoing with health board System clinical and planning leads to align programmes of work where possible to avoid duplication and add value to existing planning networks which may result in further priorities being identified.

9.1 Overarching

Within sections 6.3 and 6.4 specific priorities are identified against adults and children and young people. In addition to specific priorities there are a number of overarching priorities as outlined below;

- Continue to support the health and care workforce and look at solutions for cross organisation support.
- Continue to Support the 'Protect' work stream linked to Test Trace and Protect.
- Work with the Together for Mental Health Partnership board to address mental health support needs.
- Drive co-production and citizen engagement through the work of the RPB.
- Continue support for implementation of Partnership programmes, Transformation and Integrated care fund.
- Recognising the value of the support provided through volunteers and community groups over the last 5 months look to strengthen this over the coming year.
- Develop RPB Stabilisation and Reconstruction plan (March 2021).

9.2 Children and Young People Regional Priorities

The Cwm Taf Morgannwg regional Children and Young People's group have identified a number of key areas for focused work through 2020/21, a number of which have been generated due to COVID, others remain as previously identified priorities;

- Integrated approach to accommodation, care and support for those with complex needs (includes CHC and residential).

- Integrated approach to promoting good emotional resilience, well-being and preventing poor mental health for young people across the spectrum of needs (includes the commissioning of MAPSS (Multi Agency Placement.
  Children looked after, those in foster care with historical placement breakdown, early help);

    - In particular, with feedback from Head Teachers and Youth teams - adolescent with increased requirement for Counselling, with increase in schools for counselling services and missing level between prevention and CAMHS.

    - Options for interventions include; youth services to support development of resilience programmes at universal level in schools, reducing the need for targeted interventions joining up with the whole school approach.

    - Schools for Early Years need additional staff to support the skills deficit of nursery and reception age pupils and to dedicate time with parents to ensure catch up over the coming years.

- Integrated approaches to provision of services at edge of care (supporting the aims of Part 9 of the Social Services Wellbeing Act and duty around IFSS services)

- Involving young people and their views in our priority setting (early development off a mobile phone app with Muse Care Ltd, co-production of a communication tool between children looked after (CLA) (aged 16+ years) and social care teams.

9.3 Forward Look – Older People, Dementia and services for those with Learning Disabilities.

Cwm Taf Morgannwg RPB Adults group held an initial meeting on 20th October to discuss and agree adults service priorities;

- **Delivering the Care Home Action Plan**

As part of the Welsh Government Rapid Review of Care Homes Cwm Taf Morgannwg RPB were asked to produce a regional action plan for care homes by early September 2020.

Key actions of the Regional Care Home Action Plan are;

- Review the CTM Complex Care Group objectives and representation
- Develop a Regional Support Structure / Escalation Process to assess Risk and provide appropriate support care homes who are experiencing difficulties. (Completed strategic and operation groups established and work plans being developed).
- Operational Group to present options to the Complex Care Group how the region can support Care Homes to provide appropriate level of care, emotional and well-being support to all residents
- Develop robust Contingency Plans and Infection Prevention Plans.

- **Winter Protection Plan**

The Cwm Taf Morgannwg Regional Winter Protection Plan sets out the regions response to the Welsh Government Winter Protection Plan. The plan has been developed with input from all of the regional statutory and voluntary sector partners and builds to demonstrate an integrated regional plan and an approach that is deliverable and addresses the challenges associated with both the COVID pandemic and usual winter pressures across the region.

The plan provides also looks to support and retain new ways of working adopted in the first COVID wave which supported integrated working between health, social care and third sector.

This means:

- A whole system approach where seamless support, care or treatment is provided as close to home as possible
- Services designed around the individual and around groups of people, based on their unique needs and what matters to them, as well as quality and safety outcomes
- People only going to a general hospital when it is essential, with hospital services designed to reduce the time spent in hospital
- A shift in resources to the community that enable hospital-based care, when needed to be accessed more quickly; using technology to support high quality services.

Implementation and monitoring of the Winter Plan, is a key focus for the adult services Programme group.

- **Carers**

Figures in a report from Carers Week (2020), including data from the Office for National Statistics and a YouGov survey, the COVID-19 pandemic has seen an increase of up to 196,000 additional unpaid carers in Wales. 98,000 of these new unpaid carers are also working alongside their caring responsibilities.

Carers Wales (2020) stated they have seen a rise in people accessing support from the charity with concerns around; their mental health, PPE, testing, food, medicine, feeling invisible or abandoned, and ongoing loss of independence.

- **Co-production of services**

Building on current service user engagement there are further plans to co-produce service developments focussed on learning disability and mental health.

10.0 CONCLUSION

Within Cwm Taf Morgannwg we are committed to continue Partnership working and providing the best possible services across health and social care whilst to protecting the health and wellbeing of staff.

We continue to plan and mange regional and local responses to COVID-19 and how to meet surges in demand across health and social care.

Building community resilience, social prescribing and embedding principles of co-production are priorities within the RPB. Over the coming year we will continue to deliver and support key partnership programmes, transformation and Integrated care fund and look at new opportunities for integration.

As required we will look to develop an RPB Stabilisation and Reconstruction plan (March 2021).

Appendix1: Membership of Cwm Taf Morgannwg Regional Partnership Board 2020

Name of RPB Member	Title	Email Address
Rachel Rowlands (Chair)	Chief Executive Officer, Age Connects Morgannwg	rachel.rowlands@acmorgannwg.org.uk
Maria Thomas (Vice Chair)	Vice Chair, Cwm Taf Morgannwg University Health Board	Maria.Thomas3@wales.nhs.uk
Cllr Christina Leyshon	Cabinet Member for Children Services, Rhondda Cynon Taf CBC	Christina.Leyshon@rctcbc.gov.uk
Cllr Rhys Lewis	Cabinet Member for Stronger Communities, Wellbeing & Cultural Services, Rhondda Cynon Taf CBC	Rhys.Lewis@rctcbc.gov.uk
Cllr Chris Davies	Cabinet Member for Social Services, Merthyr Tydfil CBC	chris.davies@merthyr.gov.uk
Lisa Curtis-Jones	Director of Social Services, Merthyr Tydfil CBC	lisa.curtisjones@merthyr.gov.uk
Gio Isingrini	Director of Social Services Rhondda Cynon Taf CBC	Giovanni.Isingrini@rctcbc.gov.uk

Pauline Richards	Acting Chair, Interlink RCT	Pauline@Valleyskids.biz
Mike Slator	Care Forum Wales Representative, Owner Osborne Care Homes	mikebslator@gmail.com
Anne Roberts	Chair of VAMT (County Voluntary Council for Merthyr Tydfil)	Anneroberts964@yahoo.co.uk
Clare Williams	Interim Director of Planning and Performance, Cwm Taf Morgannwg UHB	Clare.Williams11@wales.nhs.uk
Sarah Mills	Head of Regional Commissioning Unit	Sarah.Mills@wales.nhs.uk
Greg Dix	Director of Nursing, Midwifery and Patient Services Cwm Taf Morgannwg UHB	Greg.Dix@wales.nhs.uk
Alan Lawrie	Executive Director of Operations, Cwm Taf Morgannwg UHB	Alan.Lawrie@wales.nhs.uk
Karen Kitch	Service User representative	klewis11.kl3@googlemail.com
Kay Tyler	Carer representative	kay.tyler59@gmail.com

Jon Day	Assistant Director of Workforce, Social Care Wales	Jon.Day@SocialCare.Wales
Cllr Andrew Morgan	Leader, Rhondda Cynon Taf CBC	Andrew.Morgan2@rctcbc.gov.uk
Cllr Kevin O'Neill	Leader, Merthyr Tydfil CBC	Kevin.o'neill@merthyr.gov.uk
Cllr Huw David	Leader, Bridgend CBC	Cllr.Huw.David@bridgend.gov.uk
Cllr Phil White	Cabinet Member for Social Services and Early Help	Cllr.Phil.White@bridgend.gov.uk
Cllr Dhanisha Patel	Cabinet Member for Wellbeing and Future Generations, Bridgend CBC	Cllr.Dhanisha.Patel@bridgend.gov.uk
Claire Marchant	Corporate Director of Wellbeing, Bridgend CBC	claire.marchant@bridgend.gov.uk
Heidi Bennett	Chief Executive, BAVO	Heidibennett@bavo.org.uk
Rachel Honey-Jones	Rep Registered Social Landlord, Community Regeneration Manager, Newydd Housing Association	Rachel.Honey-Jones@newydd.co.uk
Luke Takeuchi	Chief Executive Officer,	luke@Rhondda.org

	Rhondda Housing	
Paul Mears	Chief Executive, Cwm Taf Morgannwg UHB	Paul.mears@wales.nhs.uk
Lindsay Harvey	Education Rep, Bridgend CBC (1 rep to attend only for 3 Local Authorities)	Lindsay.Harvey@bridgend.gov.uk
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Appendix 2

Capital Case Study

Full Project Title	Carn Ingli
Project Description and Brief Background to Project	Carn Ingli: The project provides a model of transitional accommodation for young people whose needs are best met through a specified model of care. The home has adopted a trauma informed approach to offer a positive intervention and stability to the lives of children and young people. The home offers 24-hour residential care and same day placements for children who need a structured assessment of their needs to be able to move on to suitable alternative provision. This can be at the point of crisis intervention with children removed from the family home, due to safeguarding concerns or complex challenges, or re-located from existing residential placement where crisis or breakdowns occur.
Project Overview	Following registration with CIW, Carn Ingli became operational in November 2019. The home has provided trauma informed care and support for 5 children between the ages of 8-17 since this time, since this time. At the time of placement, each child was in crisis, due to family and placement breakdowns, and early adverse experiences. Out of the 5 children placed throughout this time, the only alternative options were either Out of County Residential Placements,(outside Wales), or no other placement was identified or available to meet their needs. Practicing in a trauma informed way the project has been able to stabilise behaviours and assess needs. This has resulted in two children successfully moving on to local foster placements and two moving to long term residential provision. The fifth child remains in placement. Carn Ingli has worked closely with the Therapeutic Families Team, to provide holistic assessment and support. This has resulted in positive progress being made by children at the home and has supported care planning and transition into suitable longer- term provision. By maintaining children in or close to their home area, Carn Ingli has been able to offer support in relation to education, training and establishing work placements. The project has also enabled children to integrate into the local community, through joining local sports teams and activity clubs.

Funding Overview	*How much ICF capital (and when), other funding sources (inc any WG other), local/regional match funding. Also was project service delivery supported by other WG programmes e.g. Transformation Fund, ICF Revenue etc* *£320k ICF Capital funding in 2018/19* *£392k ICF Revenue funding 2019/20* *£400k ICF Revenue funding 2020/21* *£200k RCTCBC core funding (match) 2020/21* *£70k ICF Capital Bid (Pending) 2020/21*
Innovation & Service Delivery	*How has this project been innovative? How is it enabling services to be delivered differently or new services?* Carn Ingli has offered an innovative solution through the provision of a new model of care for children looked after. The project has provided intensive assessment accommodation over 3 month periods, and same day placements to children in crisis. This has enabled informed choices to be made in relation to ongoing care and support planning. The staff group have been trained to work to a single model of care using the Trauma Recovery Model. This has been effective in providing stability and a sense of safety for children in crisis. This new model, has equipped staff to work through immediate crisis, applying interventions, that support recovery. This is a new approach to the provision of care within Rhondda Cynon Taff. The project is also the first short term assessment and transitional accommodation within the authority. The home has offered for short-term placements, and provided the care and support necessary for children to move to alternative step-down accommodation options, including options to reunify to family.
What Aiming to Achieve/ Outputs and Outcomes Expected longer term	The longer term aims of the project will be meet the outcome of reducing the amount of time children are looked after, the number of placement moves, by supporting intensive assessment into the needs of children placed, and reduce the need for out of country (outside of Wales) placements. This also addresses the Welsh Government target to address the numbers of children looked after. Given the nature of same day placements, the home has cared for children who are traumatised by adverse childhood experiences, and in a state of crisis. Staff at the home are trained in trauma recovery and have completed a variety of direct work activities, providing a sense of safety and security for those in their care.

	The home has been successful in working through trauma, providing interventions that stabilise behaviours, allowing appropriate assessments to be made, which ensure that children are provided with care and support that meets their identified needs. Working to this model of care, we have witnessed the progress children are able to make in the right environment. This is a model of care that we will continue to use and promote within our service. To further progress trauma informed interventions, building on the work already undertaken, it would be beneficial to have a space separate from the home itself to provide direct work. Providing a therapeutic area outside of the home itself, would allow a physically and psychologically separate area to provide trauma informed interventions. This would support the emotional well-being of children, as it would prevent issues of re - traumatisation within the home itself. The refurbishment of the outbuilding at Carn Ingli house, would provide sufficient safety, space, and privacy to enhance the trauma informed interventions already provided, without impacting on the experience of 'home' within Carn Ingli itself. Situated within the garden, the refurbishment of the currently empty outbuilding would be a positive addition to the service, and is an area for future development that would further support those who live with us to continue making progress into more positive lives.
What has been Achieved/ Outputs and Outcomes realised through the project (to date)	Carn Ingli has successfully transitioned 4 children into appropriate longer-term provision. Two children have transitioned into residential placements and two into Foster Care. Working in a trauma informed way the project has enabled children to feel safe enough to begin to address early adverse experiences, and begin the process of recovery. This has enabled them to successfully move on from the project, and has reduced the levels of placement breakdowns. Children who have used the project have commented: *"I don't know what would happen if I had gone to England, I would have just felt lost"* *"I feel like this is the first time I can breathe properly in ages, I feel safe here"* *" before I came here, I didn't do any school or work, I didn't have any friends…now I'm in training for mechanics, got a work placement and really good friends since I joined rugby, it's like my life is completely different"* *"I feel like I have had a rest, I don't need to do stupid things because you lot listen, …. I know you care about what's going on with me"* *" Everything was a mess before I came here, I couldn't sort my head out, you have helped me do it"* *" I want to stay here forever, you are like a family to me"*

Conclusions and any lessons learnt	There is capacity to place two children at the home. The small number has been beneficial when working with children who have experienced trauma and are in crisis. Matching and compatibility are better managed where there are fewer placements. The staff numbers at the home provide a higher ratio of children to staff, which supports the intensive interventions provided. This structure also enables the project to be 'homely' and not institutionalised, giving children a sense of belonging and supporting positive relationships to develop. Children placed within Carn Ingli have benefitted from trauma informed care, which supports them to move through the immediate crisis and into a sense of stability and safety. Nurturing children with complex needs and experiences through this period of crisis produces challenges; however, the consistency of a single targeted approach and intervention enables children to begin their recovery. While the home provides a trauma informed living environment, the level of crisis experienced by the children placed, has required extensive work to be carried out in relation to early traumatic experiences. Reflecting upon the work carried out it is evident that we can further progress trauma informed interventions if we were able to use the outbuilding and refurbish this into a therapeutic area for direct work. This would enable a safe physical and psychological separation between home life and intervention sessions. The period of assessment supports a greater understanding of the child, and their desired outcomes, which can ensure that appropriate ongoing care is identified. This supports the continuing recovery of the child and increases their stability, and resilience, which reduces the number of placement breakdowns they experience. Working with parents and foster carers, to enhance their knowledge in this model of care helps to secure understanding and repair relationships where these have been fragile. This supportive approach to the care of the child and those around then, has enabled children to achieve their personal outcomes while living at Carn Ingli, and given them the security and feeling of belonging they have needed to consider their ongoing outcomes.

Case Study 2

<table>
<tr><td>Full Project Title</td><td>Hospital to Home – Rapid Response Adaptations Service Plus (i.e. RRAP Plus)</td></tr>
<tr><td>Project Description and Brief Background to Project</td><td>
A. Hospital to Home Rapid Response Adaptations Service (Capital ICF)

RRAP Plus provided a home safety, minor repairs and mid-level adaptation service that helped to facilitate hospital discharge to support older people with complex health needs who:

• required home safety measures prior to discharge
• had recently been discharged or had suffered accidental injury and had been admitted to A&E

The type of work carried included:

<table>
<tr><td>• Repairs/alterations to access & Steps</td><td>• Intercoms/key safes</td></tr>
<tr><td>• Stair rails/grab rails/hand rails</td><td>• Electrical Repairs</td></tr>
<tr><td>• Levelling/up-grading paths/steps</td><td>• Gas Safety/repairs</td></tr>
<tr><td>• Additional heating/repairs to heating</td><td>• Additional Lighting</td></tr>
<tr><td>• Fire safety/smoke alarms</td><td>• Floor safety/repairs to carpets/non-slip flooring</td></tr>
<tr><td>• Hot water safety/plumbing repairs</td><td>• Moving Furniture</td></tr>
<tr><td>• Toilet frames/raisers/sofa chair raisers</td><td>• Bed levers/drop down rails</td></tr>
</table>
</td></tr>
<tr><td>Project Overview</td><td>Theme of project, Client Group (ICF priority area), Overarching objective, project timeline, project partners etc.

The Project served as an additional resource for the Agency's Hospital to Home Service. The Project provided access to a range of interventions in a timely manner to support independence at home and helped to reduce the risk of falls</td></tr>
</table>

	and accidents in the home that could have resulted in readmission to hospital. Referrals were made via Health professionals based within the Princess of Wales Hospital and the Project supported the complex discharge team in order to prevent older and vulnerable people from becoming "stuck" within secondary care by arranging timely adaptations and interventions to improve their home environment. The Project also: • Provided direct access to Casework support that can help to increase income by welfare benefits maximisation • Signposted patients to a range of services that addressed other issues e.g. loneliness and social isolation • Helped too address wider issues of housing disrepair, low income, fuel poverty, falls prevention etc. • Provided accessible information and advice • Represented value for money in relation to bed days saved and possible avoidance of accidents/falls leading to admission hospital, the need for managed or residential care • Helped to facilitate the safe and timely discharge of older people with complex needs from hospital into the community • Focused on prevention and early intervention • Provided early environmental intervention that supported rehabilitation, care in the home and better patient experience • Helped older people with complex health problems and their carers
Funding Overview	***How much ICF capital (and when), other funding sources (inc. any WG other), local/regional match funding. Also was project service delivery supported by other WG programmes e.g. Transformation Fund, ICF Revenue etc.?***

	• The original amount of capital funding provided was £55,000. However additional slippage funding awarded at the end of the year increased this to a total of £70,000. • The Agency also received £70,440 to operate the Welsh Government's Rapid Response Adaptation Programme (i.e. RRAP) for 2019-20. The objectives of schemes are similar but the latter scheme is restricted to owner occupiers and private tenants. • Other complementary capital schemes include the Local Authority's Healthy Homes Assistance and Enable. • Cwm Taf Morgannwg University Health Board also provide capital funding to operate the Emergency Pressures Initiative that again helps to facilitate timely discharge of older people from hospital. **Revenue costs** to operate the Hospital to Home Service were met by Welsh Government and slippage funding provided by ABMU Health Board and Social Services carried forward from the previous year. Funding for 2020-21 is being provided by Cwm Taf Morgannwg University Health Board, Welsh Government and Transformation Funding.
Innovation & Service Delivery	***How has this project been innovative? How is it enabling services to be delivered differently or new services?*** • The ICF funded project for example worked on a "needs-led" basis and works across all tenures. • The service was based on timely intervention and prevention and access to the service was not restricted by a complicated referral process. • It provided an additional multi-disciplinary resource to discharge planning and helped patient flow and reduce Delayed Transfers of Care • Demonstrated effective integrated working and collaboration between health, housing and social care services • Provided early environmental intervention that can support rehabilitation, care in the home and better patient experience • Demonstrated prudent health care practices.

What Aiming to Achieve/ Outputs and Outcomes Expected longer term	• Improved independence and wellbeing • Reduced risk of falls and accidents in the home • Enables a smooth transition from hospital to home reducing the length of stay in hospital • Provides a risk based approach to home safety, thus lowering the risk of **readmission due** to an accident or fall in the home • Coordinates services around people in order to meet their individual needs
What has been Achieved/ Outputs and Outcomes realised through the project (to date)	• *We received 373 referrals* • *358* patients were assisted and had work carried out to facilitate safe discharge from hospital and/or to prevent readmission to hospital. • The work carried out involved a range of small level adaptations as well as home safety interventions to prevent falls and increase independence and wellbeing in the home. • 69% of patients responded to our client survey and 99% of people were satisfied with the quality of service and standard of the building work completed. • 92% of patients who responded to the survey stated that the work carried out had made them feel more independent at home. • The average cost of work was £220 **Client Comments ICF RRAP** • **The service that I had was very satisfactory and I would recommend it to friends and family** • **I think you are a great support. Thank you.** • **Service was very good and the operatives installing were polite and efficient** • **Excellent service - Thank you so much!** • **Very Satisfied with work carried out. Thanks to the workmen for doing such a good job. It's**

	made life so much easier. I feel more independent now. • **Everyone I dealt with were very helpful, nothing was too much trouble for them. They looked for other things to help me around the house.** • **I'm very pleased with the service and I feel much safer now and less frightened of falling** • **I have no suggestions to improve your service- you cannot improve on perfection!** • **Excellent workman, professional caring and helpful.** • **Keep up the excellent work - it is fabulous**
Conclusions and any lessons learnt *Please also supply any photos – start and end of project if available*	• The demand is higher than the resources available • It would if works cost of work could be in the region of £2,000 to allow for ramps and access issues for hospital discharge particularly complex issues • That the fund be available all year round in order to achieve consistency in service to both patients and health professionals • The RRAP Plus Project is a vital component in facilitating timely hospital discharge and without this additional resource, there will be additional pressures placed on the hospital in terms of patient flow.

Case Study 3

Full Project Title	Pen Llew Court Supported Living Accommodation
Project Description and Brief Background to Project	The Pen Llew Court Supported Living capital project is a scheme that will offer people with learning disabilities the opportunity to live independently in a fully adapted apartment with on-site care and support 24 hours a day. Residents of Pen Llew are free to access the community as and when they chose while knowing they have the care and support to live as independently as possible. The scheme has been developed between Rhonda Cynon Taff County Borough Council and Cynon Taff Housing Association, after gaps in service provision identified by Rhondda Cynon Taff Council, where there has been insufficient accommodation for people with learning disabilities, within the county. Through partnership working with the Council, Cynon Taff Housing were able to offer an underused vacant building to be developed into a new model of Supported Accommodation for people with learning disabilities. This scheme was fully completed in November, with a number of weeks taken for snagging and arranging tenancy/viewing and became operational with new tenants taking up occupancy from February 20. As at 31st March 2020 there are 15 occupants living in the new accommodation, leaving 4 empty units, which are hoped to be fully occupied by the Summer 2020. Pen Llew Court is a new model of accommodation support which allows individuals with learning difficulties to have their own space and develop independence by providing an environment which limits risk while promoting activity through the their own living area, with kitchen and bathrooms, within their own flats, and/or to make use of the communal skill teaching kitchen. It also allows the individual to develop new social skills and a new community within their lives. There are a range of levels of support the individuals can access from supported living to independent living, Pen Llew could be seen as an opportunity for individual to move on (step down) from more traditional supported living to develop their skills further, in the hope to move onto independent living. This step down approach would allow them to have targeted support, going into their own flats in the community, with a significant decrease in support required, due to the skills which they have developed, which would be is able to be assessed at Pen Llew, due to the individuals already living in their own flats. Pen Llew is a great opportunity for individuals who have the dream to live independently but is not essential for the individuals who live at Pen

	Llew Court, as some individuals are receiving the correct support which is as least restrictive as possibly can be.
Project Overview	The building works included. • Reconfiguration of 60 individual bedsits into 16 single occupancy flats, 1 double occupancy flat, 2 respite units, over two floors, a total of 19 flats/units. • Each flat is designed with a modern bright, living room area, open plan with accessible modern kitchen and in a number of flats the kitchen is wheelchair adaptable with rising and falling countertops and cupboards that are wheelchair accessible with pulldown baskets. All have private adjacent bathrooms either from the bedroom or in the hallway area, which are fitted as wet rooms, fully tiled with modern design. Sufficient storage area, wifi enabled and each flat includes assistive technology, that allows tenants to contact the Staff management team who area based in house. • Installation of a smart Tunstall system – the Tunstall system is a smart device which is hardwired within the building and allowed the supported people to communicate with each other and staff through video calling, this system is also connected to two pagers which remain switched on at all times, so the supported people are able to contact staff whenever they need additional support. This system is also linked in with the buildings fire system to allow staff to be aware of any risks throughout the building. The Tunstall system has an automated check in system which allows the supported people to let staff know if they do not require support that morning giving the supported person more autonomy over their independent living arrangements. • Adapting and widening of existing corridors to create passing points to allow for disabled and wheelchair access, in narrow corridors, which would not pass today's DDA compliance requirements. • Creation of a Community Activity room, for day services and external clients and groups to undertake daily and weekly activities and groups, which is hoped to include employment clubs and volunteer groups. • Creation of a skills teaching kitchen, whereby people can be supported to learn and become proficient in making their own meals and informed of nutrition, in order to promote more independent living. • Creation of a Sun room, for socialising, an area to gather eg and watch television together, host social gatherings and promote friending and wellbeing and encourages the development of social networks. • A fully secure front entrance with finger print access with secure mail delivery areas, with individual post boxes.

	The respite unit is equipment with rise and fall hobs and sinks and a fully adapted wheelchair accessible bathroom along with a profiling bed.
Funding Overview	£1,650,037 of funding was invested into this building by Cynon Taf Housing, supported with £1,037,943 of Integrated Care Fund (ICF) MCP main capital funding provided in both FY 18/19 and FY 19/20, to wholly transform and fully refurbish this existing building throughout, with a total scheme build cost of £2,687,980, taking 18 months to two years to complete.
Innovation & Service Delivery	Pen Llew Court is a new innovative model of support which allowed individuals with learning difficulties, to have their own space and develop independence through the use of their own kitchen within their own flats or the communal skill teaching kitchen. It also allows the individual to develop new social skills and a new community within their lives. Pen Llew Court is staffed 24 hours a day and is fully fitted with a Tunstall system. The innovative use of this assistive technology, allows staff to be contacted 24 hours a day for any support needs but allows people to live independently as far as possible. When support is required, the support ranges from Personal care needs, tenancy, meal preparation, community support and routine medication. Pen Llew court has also got a community hub and community hub kitchen, which community groups will be running from, such as gardening groups, work skills, educational course, and cooking groups etc. During its first operational year of offering accommodation, the community groups will be set up and established, adding a further wider extracurricular timetable of activities available for both in-house residents and the wider community groups.
What Aiming to Achieve/ Outputs and Outcomes Expected longer term	Pen Llew Court opened on the 3rd of February 2020 and 4 supported people moved in on the day of opening and a further two on the weeks commencing 10th , 17th , 24th February 2020. Pen Llew is currently at the capacity of housing 12 supported people with a further 4 flats and 1 respite flat available to fill. Pen Llew Courts aim is for individuals to develop further independence, the aim to achieve this is to develop skills in a controlled environment and also to reduce isolation and promote individual's health and wellbeing. Each of the supported people have their own tenancies which consist of 1 bedroom, 1 kitchen, 1 bathroom and a lounge, and they will share the communal sun room and the communal skills teaching kitchen. There is also a community hub facility which has its own kitchen, where it is planned community groups will access through a wide range of

	planned activities and group sessions, to be set up through the first year. Pen Llew Court also aims to support individual to develop skills to access voluntary placements / work placements.
What has been Achieved/ Outputs and Outcomes realised through the project (to date)	*"I love having my friends around if I want to see them, but I also like having my own space that to go back to when I have had enough"* *"Moving to Pen Llew Court has allowed me to build a better relationship with my Family"* *"I like having my own flat where I have my own space, but I can fetch staff when I need some help to do my cooking"* *"I like having my own space and I don't have to share with anyone else"* *"I like having the opportunity to socialise and do things which I haven't done for a long time, like building things from wood and having movie nights with my new friends"*
Conclusions and any lessons learnt *Please also supply any photos – start and end of project if available*	The clear benefit of partnership working between a local provider, Cynon Taf Housing Association and Rhondda Cynon Taff Council can be directly seen within this innovative model of supported living accommodation. What has also been essential is the Integrated Care Fund capital funding, that added additional funding, to create a fully integrated model of accommodation for people with learning disabilities.

Case Study 4: ICF REVENUE

Full Project Title	Dementia First Casework Service
Primary Beneficiary	Older People with Dementia
ICF Budget Allocation *How much was allocated towards the project?*	£34,500
Description *Clear description of what the project is and does. Please do not provide more than 80-100 words*	The Dementia First Casework service will provide a dedicated Casework service to support people with dementia and their carers to live independently and safely at home from early diagnosis to the later stages of the condition by addressing their specific housing needs. The project aims to fill a gap in existing service provision and complements services provided by the statutory sector and seeks to address: • Delays for minor adaptations and safety modifications that can result in falls and accidents in the home • The need to provide specialist housing support for carers in order to allow them to continue in their caring role that includes arranging essential and timely adaptations, repairs and financial support including access to grants and welfare benefits • The need for the timely and safe hospital discharge of people with dementia through the delivery of timely adaptations • Additional support and community engagement for people with dementia through effective signposting to a range of local services • The Agency has also developed new services to adapt to the challenges posed by COVID 19. These include our Helping Hands Service (picking up shopping and prescriptions etc.) as well as the Keeping in Touch Service that provides a telephone support service to people with dementia and their carers through this difficult time

Performance Outcomes (Revenue) or Outputs (Capital) *Ensure these are clear outcomes/outputs to really show how much the project has helped individuals. These will be turned into infographics like last year's Annual Report and will provide a snapshot of the benefits of the project.*	• Maximised weekly income by £143 a week and annual income by £7,436 plus backdated payment of £1,700. • Reduced risk of fuel poverty by additional income and access to warm home discount scheme • Provided advocacy services in terms of challenging DWP • Reduced the Risk of accidents by arranging a heat sensor to be fitted by the fire service • Installed extra light sensors to prevent disorientations and reduce the risk of falls and or accidents in the home • Grab rail in bathroom reduced risk of falls and increased independence • Referral to community services to prevent social isolation
Quote *A quote from an individual to show how they have personally benefitted from the project. Please no more than 30-40 words*	***"The Caseworker has been so kind and helpful and I can't believe what help I have had. I don't worry about the bills now and I am safer and can manage better in my flat. I am so grateful. She has been wonderful and she never gave up trying to get me what I was entitled to".***

CASE STUDY 5

Full Project Title	Dementia First Casework Service
About the Project:	The Health and Social Care Discharge Coordinators are a partnership arrangement between CTUHB, RCTCBC & MTCBC to support hospital discharge arrangements for all four Cwm Taf hospital sites. RGH,YCC and YCR managed by RCTCBC. PCH managed by MTCBC
Project's Aims:	To improve communication and information sharing between health and social care, and facilitate timely discharge, particularly for complex cases.
Project Outcomes:	Quarter 2 2019/2020 163 referrals processed via the Hospital based Coordinators. 27 referrals required further information. 163 discharges facilitated by the Hospital based coordinators (YCR,YCC and PCH)
About the person: *What is their age? Do they live alone? Are they a carer? Do they have family/friends nearby? How is their general well-being?*	An RCT resident, Female mid 60's was admitted to an Acute Hospital site. Living with her son in a Trivallis flat prior to this. Her son was providing support with collecting medication, otherwise she was managing daily routines independently. No support from Social Care or other agencies.
What was the situation: *Describe how the person became involved with the service you are writing about. – what challenge or issue were they facing and how was*	The individual was admitted with shortness of breath. Described by the Hospital staff as desperate to return home, to the extent that she was talking about discharging herself against advice from the Occupational Therapist. She had capacity to make this choice.

this affecting their life	Hospital staff felt that support would be required on discharge to ensure safety and a return to independence The ward approached the Hospital based Coordinator, fearful of this individual discharging herself without sufficient support in place. The ward felt that she was becoming quite distressed and needed someone to talk with her and explore options available.
<u>Impact statement</u> **How did the service make a difference?** *Describe what action the case worker/volunteer took to give support*	The Hospital based Coordinator met with the individual almost immediately following request. They were able to check Social Care systems to gain a previous history. The Coordinator spent time with the individual, gathering a picture of pre admission lifestyle and routines, talked about current circumstances and how they could be supported to return home quickly. The Coordinator was able to give advice on a number of options including RCT's Intermediate Care service. This direct conversation included advice on the risks of self-discharge.
What outcomes were achieved? *What was the outcome for the service user? What difference did the interventions make?*	This conversation was positive for the individual, their fears were allayed and they were happy to wait for services to be set up for discharge. The Hospital based Coordinator completed an Adult Assessment and was able to source and provide the service that afternoon. This swift response enable the individual to leave Hospital in a timely manner, avoiding unnecessary delay and preventing emotional stress.
Quotes/Feedback *Please provide a direct quote from the service user. What did they say about the service received and the*	The individual spent time with the Hospital based Coordinator and was able to express their feelings and wishes. She was able to discuss "what mattered" to her and how she could be supported to achieve this.

difference this has made to them?	The individual was thankful for the swift response and ability to set up support quickly to enable her to return home. The individual did not require any further allocated worker and was referred directly to RCT's preventative services. It is predicted that the individual will regain full independence.

CASE STUDY 6

Project Title	**Increased Capacity within Intermediate Care, Reablement and Initial Response Services**
About the Project:	This Project is an integrated (Health & Social Care) Short Term service which includes a specialist Reablement Service for people with cognitive impairment or memory problems. This case study is for the Memory Reablement work and this element of the service is supported by, 1 x band 7 Occupational Therapist (static 37.5 hrs) 1 x band 6 occupational (rotational 37.5 hrs) and a band 3 Occupational Technician (34 hrs) and our support @ home team of staff.
Project's Aims:	To support people to regain or maintain skills and remain living well, as independently as possible at home.
Project Outcomes:	Overall the service achieved 63 % independent levels for service users requiring no formal ongoing service provision
About the person: *What is their age? Do they live alone? Are they a carer? Do they have family/friends nearby? How is their general well-being?*	**Reason for Referral** Referral received from PCH to support hospital discharge. Mrs C was admitted following episode where she had taken to her bed for 3 weeks. **Past Medical History** COPD, hypertension, hyper-cholesterol, arthritis, acid reflux **Medication** Self-medicating

What was the situation: *Describe how the person became involved with the service you are writing about. – what challenge or issue were they facing and how was this affecting their life*	**Background** Mrs C lives alones in warden controlled accomadationand prior to admission was completely independent. Mrs C has not had services to support previously. She has a niece and nephew who live nearby and is very close to them. **Referral** Mrs. C is usually able to walk using a single walking stick and occasional furniture fixing point. She is able to manage her transfers without support, tend to her own care needs and accesses the community with her family (nieces and nephews). Prior to admission Mrs C retreated to her bed for 3 weeks and had a decrease in appetite. Mrs C was referred to Mental health occupational therapist assessment due to poor memory and confusion and scored LACLS assessment completed with recommendation for 3 x calls daily with Memory reablement
Impact statement How did the service make a difference? *Describe what action the case worker/volunteer took to give support*	Mrs C was discharged home from hospital, family present OT completed a therapy assessment. Mrs C also completed a hot drink assessment, and transfer assessment. During the assessment the Reablement purpose was discussed and purpose of each call as identified/ requested by the hospital. During the assessment family were also able to raise their own concerns and Mr.C's goals could also be discussed. When discussing goals and meal preparation Mrs C requested meals on Wheels which were then arranged which resulted in reduction of calls immediately. The purpose of the Reablement team was explained and levels of engagement required, Mrs C consented to the following programme:- • To support and encourage Mrs C to re-engage in her morning routine to include: washing/showering, dressing and breakfast preparation. • To support and encourage Mrs C to re-engage in her meal time routine breakfast, lunch and dinner. • To support and encourage Mrs C to re-engage in her evening routine, to include; personal hygiene, undressing and dressing for bed • To support and encourage Mrs C to utilise memory strategies (during all calls)

What outcomes were achieved? *What was the outcome for the service user? What difference did the interventions make?*	Mrs.C received a Reablement programme including x2 calls single staffed Monday to Friday and 3 x calls Saturday and Sunday. Mrs C engaged well in Reablement programme. During week 1 calls remained at 2 x day due to Mrs C appearing to need reassurance complete tasks. During week 3 OT reviewed and it was discussed between OT and Mrs C regarding reducing calls. Mrs C agreed that was progressing and agreed to stagger of morning calls, in week 4 we then staggered further to alternating calls between morning and tea, and then reduced further to just alternating days tea calls, ending service independent at week 5. Mrs C achieved independence with her personal care and meal preparation, has adopted a good routine and is able to follow this independently. Mrs C has regained her independence and has started to go back out into the community and attend events within her complex.
Quotes/Feedback *Please provide a direct quote from the service user. What did they say about the service received and the difference this has made to them?*	**Feedback** Throughout the programme Mrs C has expressed her thanks and appreciation to the frontline staff and therapists.