Contents

OVERVIEW

1. Adult services provide care and support to a wide range of people across the Vale of Glamorgan. This includes people with mental ill health, learning disabilities, physical disability, sensory impairment and frailty and/or mental health issues associated with ageing. £37.5 Million was spent on these services in 2015/16 indicating an increase compared with previous years. There was protection for the adult services budget, despite the Council's difficult financial position overall. This meant however that the division had to absorb significant cost increases and deliver savings. It succeeded in supplying greater levels of care and support.

2. Adult social care services across Wales are currently provided subject to a formal financial assessment. If people have sufficient disposable resources and can pay for services, they are required to do so. Since April 2015, the Welsh Government has set a maximum charge of £60 per week for non-residential care. This change in policy has had a significant effect in the Vale. It has increased the workload of the service and considerably reduced the income it can generate. Together with increasing costs for care in institutional settings and rising demand because of changes in the population, the effect has been to create significant pressure on both Adult Services budgets and operational delivery. The service continues with its rigorous budget plan in order to achieve essential savings in a very challenging context and it will have to continue remodelling service delivery to cope with the additional demand.

3. The scale of the support made available to vulnerable people in need of social care is shown by the following data for the twelve months from April 2015to March 2016.

Key adult social services activity data 2015/2016

The figures for the previous year are in brackets.

- 1692 people were supported to live at home (1665)
- 332 people received individualised Telecare support (309)
- 1062 older people were helped to live at home (1027)
- 374 older people were supported in residential/nursing home care (392)
- The rate of delayed transfers of care for social care reasons per 1000 of the population aged 75 or over was 4.70 (4.55)

4. Our efforts to integrate social care and community health services have been consolidated this year following the implementation of an ambitious locality plan for joining up the help offered to older adults and people with a physical disability. The development of GP led clusters has provided a new impetus to this model.

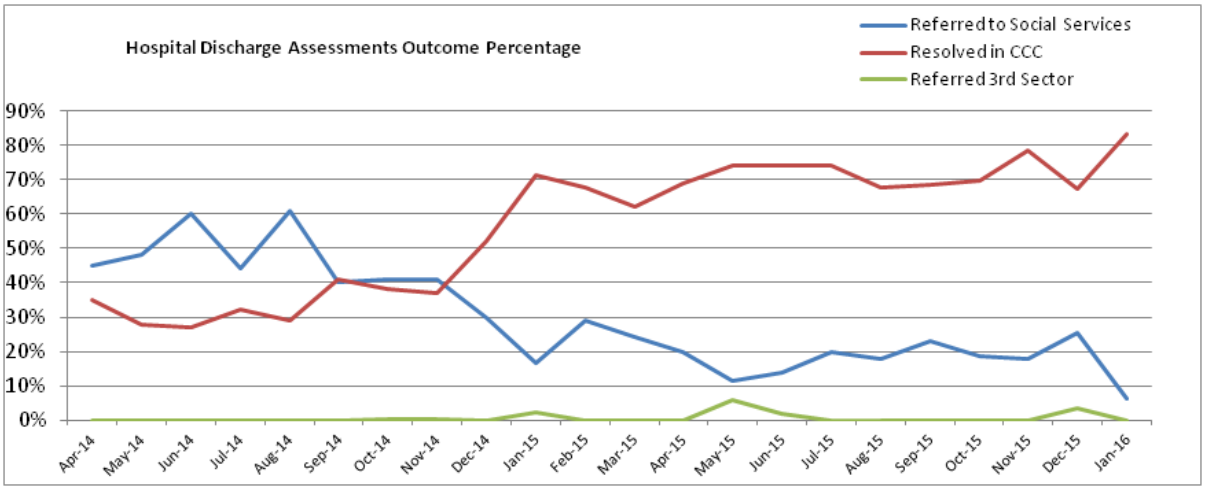
5. Within the Cardiff and Vale University Health Board (UHB), the Vale of Glamorgan is one of three localities. This means that adult social care and community health services in this locality can be managed by one person, appointed jointly by the Council and the UHB. The service, staffing and management structure for the locality has been extensively restructured creating further management roles which operate across the traditional health and social care divide. This has enabled us to create a completely unified approach to delivering adult social care and community health services for older people – with prevention, early intervention, reablement, intermediate and long-term care as part of a single, co-ordinated and community-based system. This is the model that older people have told us that they want and need to experience. It is designed to enable people to retain control of their lives while providing support and

care that guarantees their rights and dignity. The locality model removes many of the traditional boundaries between health and social care. Community services now operate with an integrated intake service and a longer-term care service

6. The Council's Customer Contact Centre at C1V increasingly operates as the main access point for health and social care community services. Staff from social services and the NHS are based here to help us direct people to the right sort of help and to assist people in making contact with those services. When the request or concern means that support from social services is needed, our staff and our partners in other agencies carry out integrated assessments with potential service users and (where appropriate) their carers. Support from family carers is often the most critical factor in helping people to remain as independent as possible; social services try to add to this help, not replace it. Based on the assessments, packages of reablement or care are developed in response to the needs which have been identified. Adult Services have a statutory responsibility to help meet this level of need through the provision of social care and support. An important role is to ensure that people can get access to other preventative service provision (e.g. housing, education, employment support) where this has been identified as an area for action within the assessment process. This single access point has been developed with 3rd sector partners to support the provision of information and advice that will be required through the Social Services and Wellbeing Act from April 2016.

7. We have been fortunate to receive continued funding from the Welsh Government Intermediate Care Fund to support the development of this locality restructure. The funding has been used to improve the Customer Contact Centre at C1V, to ensure that people have better access to health and social care community services. In the Centre, staff from social services, the NHS and the third sector work together to deal with requests for help. This has allowed us to direct people to the right services first

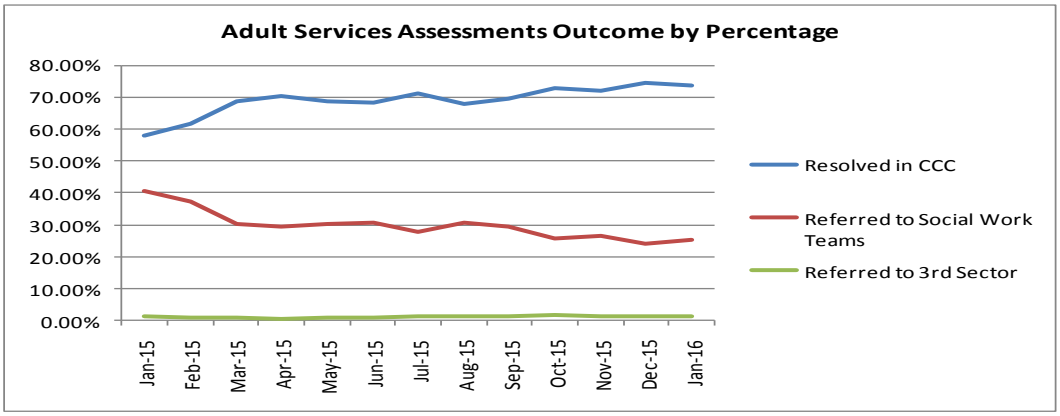
time. The changes to the Customer Contact Centre have been built upon throughout the year. The graph below indicates the change in where hospital discharge assessments are organised. The additional service first became functional in September 2014.



8. The number of social care referrals that have been resolved at the CCC has significantly increased and those requiring longer term intervention for care management teams has reduced. The number of daily service requests have continued to increase. This increase in demand has continued with being above 30 for all but 2 months and peaked at 36 for January 2016. It is anticipated that this upward trend will continue, although the impact of the Social Care and Wellbeing (Wales) Act is yet to be understood.

9. During 2015, the number of enquires resolved in the CCC increased to over 70% of the total workload. This reflects the added value created through the co-location of additional social worker resource at the point of contact.

10. There has been a reduction in both the volume and percentage of cases being referred onto the longer term social work team. During 2015 only around 5% of total work volume or an average of 38 enquiries per month have been assigned to the longer term care service.



11. The Integrated nature of the developing Customer Contact Centre has made a real and noticeable difference to the way we are involved in people's lives. Here is a recent case example to illustrate how the changes made have improved the outcomes for Service Users and their families:

C is an 83 year old lady living with her husband. She has multiple medical problems including diabetes managed by district nurse (DN) team and GP. Unfortunately, her husband was admitted to hospital following a stroke leaving her unable to look after herself at home. Social services provided a care package and DN called daily.

A referral was received from the GP asking the VCRS nurse to visit as issues were raised regarding the safety of the patient living alone. Examples of this included leaving the house inappropriately dressed, carrying a carving knife in her bag, eating a bag of sugar and setting fire to a tea towel in the kitchen.

The referral was triaged by the nurses based at the hub and it was established that the VCRS nurse would not be required. This was because the nurses at the hub work alongside the other agencies involved and could co-ordinate the response from the hub.

The GP was contacted and a referral to REACT was made to address mental health and capacity issues. An internal referral to Telecare was made to access the most appropriate community alarm equipment. Unfortunately, family relationships were strained adding to the complexity of the situation. A meeting was arranged by the triage nurse with the social worker, DN, REACT, daughter and patient to discuss the situation and provide a multidisciplinary approach to providing safe and appropriate care.

12. The additional grant funding made available through the Regional Collaboration Fund has continued in 2015/16 and we have used it to enhance reablement services and deliver improved response times. This additional funding provided the evidence for further funding for reablement from the Primary Care Fund organised through Cardiff and Vale UHB. Reablement services play an important role in helping people to re-learn the skills necessary for daily living, lost through deteriorating health. They help to ensure that people can return safely to their communities (after a hospital stay, for example), rebuild their lives and avoid institutional care. Improvements have been made to the systems for collecting information that allows us to measure properly the extent to which we have been able to increase individual levels of independence. Overall outcomes are very positive, with over 80% of people who received the service having improved levels of independence.

13. One of the ingredients which make reablement services so effective is the way people work together: the service user is a full partner with staff from statutory services, voluntary and independent sectors, all aiming to help them reach maximum independence and retain control over their lives. We are especially proud of the contribution made by our workforce. Staff have been provided with joint training, single management and one base. As a result, they have very quickly broken down unhelpful boundaries and started to deliver co-ordinated care.

14. The growth in the VCRS supported by the Primary Care Fund and RCF is significant. The service has extended its working hours and is now fully open at weekends. This has had an extremely positive effect by facilitating discharge from hospital and averting hospital admission at these key periods. The average response time for patients referred from hospital that require Home Care support in September 2015 was 16 days. Additional staff and significant improvement in communication and working processes means that in April 2016 the average response time dropped to 3.4 days. The average length of stay within the service following hospital discharge remains the lowest across the 3 localities at 53 days with Home Care support and 47 days without Home Care support.

15. Much work is also being done in the community to prevent hospital admission and maximise safety and independence. Investment in VCRS Physiotherapy has enabled further work to be completed in falls prevention. The VCRS Physiotherapy Team are now working with the residential and nursing homes in the area, teaching staff about the importance of falls prevention. Further investment in VCRS Dietetic Service has resulted in the 'Good Food First' training programme for staff working in residential and nursing homes within the Vale. On average the VCRS Nursing team are able to respond within 48 hours of referral to people in crisis with complex medical and social needs. The Occupational Therapy (OT) service within VCRS is now fully integrated and we now have 14 qualified OT's which has significantly improved capacity and the quality of the service offered.

16. These are crucial steps in shaping a sustainable social care system for the Vale that is capable of meeting the considerable demands that will be placed on it in the future. Focusing on the delivery of preventative care helps people to maintain their independence at home, while also helping to reduce demand on acute hospital services and the need for long-term residential care.

17. We can now demonstrate that some of our ambitious programmes of change are having an impact at the front-line - the place where they make a real difference to people's lives. There are similar changes occurring across the whole range of adult services including those for people with a learning disability or mental health problems. Further progress requires even more integrated working across social care and health services and strategic 'pooling' or alignment of financial budgets. We are determined to take forward this work in line with the requirement of the SSWWA, as part of our efforts to drive delivery of new service models that better reflect what people want and need if they are to remain independent.

18. The number of people supported to live at home has increased since last year. In addition the size of individual care packages has increased, indicating that we are meeting the needs of people with more complex difficulties and higher levels of acuity when they fall ill.

19. It has been pleasing to see the performance figure for delayed transfers of care (DTOC) from hospital be maintained following a significant decrease in the annual figure the year before. Significant winter pressures in the hospital system emerged again this year, albeit later than expected. The impact on social care discharges was well managed with the Integrated Discharge Service taking a pivotal role. The Council predicted this additional pressure and despite the financial context provided additional social work resource to support discharge from hospital. It is clear that new initiatives, such as the Customer Contact Centre, the enhanced Vale Community Resource Service and our more integrated approach to hospital discharge are supporting sustained improvement. There is more to be done, in collaboration with the UHB, and we are working to deliver a DToC action plan to help deliver even better outcomes for people who need to move out of hospital as soon as they are able to do so.

20. In 2015/16, the numbers of people being supported by Telecare has grown. The service still struggles to be resilient, although some staffing

areas have been enhanced. In 2014/15 the Council made Telecare a priority for a Task and Finish group led by members of the Social Care and Health Scrutiny Committee. This provided a thorough examination of the model operating in the Vale and reviewed it against best practice across the UK. A number of recommendations for the service have been put forward and an action plan was developed for delivery in 2015/16. This plan has predominantly been completed but there remain areas which require ongoing development.

21. The work of adult social services in meeting service users' needs cannot be done in isolation. It is especially important that we continue to develop our strong and purposeful partnership working with the NHS, housing, the police, the third or voluntary sector and independent providers of services. This helps to ensure that:

- staff from all agencies are all moving in the same direction and assisting each other to meet key goals (e.g. safe discharge after a stay in hospital);
- effective communication takes place; and
- funding is used properly.

22. The Integrating Health and Social Care Services Programme is in place to increase the scale and pace of work to join up health and social care services across the Cardiff and Vale region where there are clear benefits to service users and patients. The Programme includes the following partners:

- the Vale of Glamorgan Council;
- Cardiff Council;
- Cardiff and Vale University Health Board;
- Vale Centre for Voluntary Services; and
- Cardiff 3rd Sector Council.

23. An independent review of the existing integration arrangements across the region has been undertaken. It is anticipated that soon there will be further significant developments in the pattern of integrated UHB and

Council services and the extent to which all services operate together so that the system becomes much more streamlined and effective.

24. A Statement of Intent has been prepared by all the partners in response to the Welsh Government's Framework for Older People's Services. It commits the organisations to increasing the scale and pace of our work together so that we can deal with issues such as planning how to deal with winter pressures. The partnership has also developed its own Framework for Older People; it outlines the agreed vision for older people's services over the next five years.

25. Plans have been developed to ensure that each service area responds to the needs of Welsh speakers in line with the strategic guidance from Welsh Government "More than Just Words" by ensuring that each team or service area has Welsh speakers available to undertake the requests function. Information leaflets have been updated to ensure compliance.

26. Adult Services has achieved its challenging savings target of £956k for 2015/16. Further challenging savings have been set for 16/17 totalling £700k. These continue to be overseen by the Social Services Budget Programme Board which has representation from the highest levels in the Council. In addition savings are planned for subsequent years as part of the Council's "Reshaping Services" agenda. This is part of an ambitious programme of change which recognises the demographic and financial challenges we are experiencing and will support new models of service delivery.

SERVICES FOR PEOPLE WITH A LEARNING DISABILITY

27. Assessment and care management is carried out by a multi-agency team which works together to address the health as well as social care needs of people with a learning disability. This is proving to be a key building block for taking forward plans for increased integration of services with Cardiff Council and with Abertawe Bro Morgannwg Health Board as well as Cardiff and Vale University Health Board.

28. Day Services continue to undergo considerable change, based upon a new strategic vision for day opportunities. It is focusing on modernising day opportunities, including a move away from a building-based model of provision. We are actively seeking ways to work in partnership with a wide variety of organisations, including social enterprises and stakeholder cooperatives, to deliver models of provision that are more centred on meeting the specific assessed needs of individual service users. A pilot run by Scope and supported by the authority, has enhanced this person centred model of support. Utilising part of a community centre as a touch down base from which activities are accessed, has received extremely positive feedback from citizens attending, so much so that the pilot project will be expanded. Within Internal Day Services, successful provision of care and support to two young people with high levels of health and social care need, has enabled them to be supported within a safe, environment close to their home. The level of expertise staff have developed, has allowed parents and carers respite from their caring role, in the knowledge that competent high quality care is being provided to their son/daughter. Further development of Internal Day Services to support those with complex health and social care needs will continue into 16/17.

29. Supported accommodation continues to be provided through the successful delivery of the current contract. To enhance accommodation choices for citizens, expansion of the Adult Placement Service has taken place. This service offers both long-term and short-term placements to people, within a supportive family environment. There are currently 33

people in long-term placements and 51 people receiving short-term respite within Adult Placement. We have reviewed our respite care provision and we are currently scoping a model of service delivery as part of the Vale of Glamorgan Council's Reshaping Services programme, to ensure we have settings that are accessible to people with the most complex and challenging needs. Through the Learning Disability Partnership Group, work with Third Sector organisations is underway to explore with stakeholders how respite services may be delivered more flexibly in the future.

30. We have ensured that service users living in supported and other accommodation can make full use of Telecare equipment, to live more independently. Therapists within the Learning Disability Team and in collaboration with service users, have developed a tool that enables effective assessment of needs in relation to use of technology. Two supported living venues have been identified as a focus for exploring how technology can improve the quality of life for individuals in a cost effect way.

31. These were our improvement priorities for 2015/16 and the progress made:

- **We will consolidate the formation of an integrated social care and health assessment and care management team for Learning Disabilities in partnership with the Health Board to improve communication and information sharing, thus minimising duplication for service users.**

Joint referral and screening processes have been established with our ABMU health partners, enabling a more streamlined and person centred approach for citizens.

Within the existing staff establishment, we have established a review team comprising of health and social care staff. This has resulted in holistic reviews being completed in a timely manner.

Joint training in respect of Continuing Healthcare has taken place with agreement to develop further opportunities throughout 16/17.

- **We will continue to develop processes that ensure there is a full and timely exchange of information between the Child Health and Disability Team and partner agencies, to ensure that young people make a smooth and effective transition into adult services.**

A review of the Transition Protocol has taken place, in collaboration with Cardiff Council, health and education partners in order to promote a consistent , regional approach to supporting young people in transition.

The appointment of an Operational Change Manager; a regional post across the Vale and Cardiff, has enabled the sharing of good practice across the two authorities and the preparation of a regional delivery plan for children with complex needs moving into adult services.

Our improvement priorities for 2016/17

- **We will reshape the provision of respite to enable citizens with a learning disability and their carers, provision that can effectively meet their needs and outcomes.**

- **We will continue to increase the provision of direct payments to citizens with a learning disability, to enable greater choice and control.**

SERVICES FOR PEOPLE WITH MENTAL HEALTH PROBLEMS

32. Community Mental Health Services in the Vale of Glamorgan are organised around three integrated Community Mental Health Teams (CMHTs) with responsibility for providing accessible mental health services for adults with severe mental health problems based on their Well-being Assessment and their Care and Treatment Plan.

33. Each CMHT is led by an Integrated Manager who is responsible for the operation of a joint health and social care pathway, which includes access to social workers, social care officers and carers officers as well as relevant health colleagues (including psychiatrists, community psychiatric nurses and occupational therapists).

34. The teams have seen a significant increase in referrals from Vale of Glamorgan GPs, with an increasing expectation of high quality, rapid assessments and risk management. This has placed unprecedented demand pressures on the teams and they have had to focus an increasing proportion of their resources (including social work capacity) on the screening, assessment and management of referrals. Increasing demand on the frontline has placed a strain on the team's ability to offer evidenced-based social work interventions for people with mental health problems and their families.

35. The Vale of Glamorgan has worked alongside the Mental Health Clinical Board in undertaking a comprehensive review of Community Mental Health Services in order to address the increasing imbalance of workload across adult mental health. The next 12 months will see the details of the new model finalised, with the Vale of Glamorgan playing a key role in determining the future structure of adult mental health care, one that is able to meet the increasing demand for services while ensuring the provision of social work interventions.

36. The Carers Support Officer is an integral part of the team; their input ensures effective and timely assessment of carers' needs and development of a carer support plan where appropriate. It is an approach that aligns well with the work that Hafal provides on behalf of the Council in supporting individual carers and operating carers' support groups.

37. The Mental Health Community Support Work Team provide time-limited, recovery-focused community interventions to support vulnerable people through to greater levels of independence. The team work with service users to enable them to achieve their identified outcomes outlined in their Care and Treatment Plan. The team use the 'Recovery Star' approach as an integrated outcome measurement tool.

38. The Vale of Glamorgan has a team of experienced Approved Mental Health Practitioners (AMHPs) who undertake Mental Health Act Assessments as well as supporting the Mental Health Review Tribunal process and assisting in the creation of Community Treatment Orders. We have seen an increase in demand for assessments and are supporting a member of staff through the AMHP training this year so that we can continue to meet the local authority's statutory responsibilities for these services.

39. Within the overall Integrating Health and Social Care Services Programme for the Vale of Glamorgan and Cardiff, there is a specific project for mental health services. The Mental Health Partnership Board is taking responsibility for local implementation of the Welsh Government's 'Together for Mental Health' Strategy, which takes a cross-organisational view of mental health promotion for all citizens in Wales. This local delivery plan challenges the local authority to promote mental wellbeing of its employees and all of its customers through every contact.

40. These were our improvement priorities in 2015/16 and the progress made:

- **Following on from the establishment of Integrated Care Pathways in the Community Mental Health Team, we will evaluate the effectiveness of the social care component of secondary mental health care.**

We found that our contribution ensured the CMHTs were able to meet the increasing demand for assessments. By working alongside in-patient services and the Crisis Team people were discharged quickly and safely from hospital. Our input enabled people to positively manage risk and be as independent as possible.

- **We will progress work on the review of Community Mental Health Services with our partners in the health board, 3rd sector, Cardiff Council and Service Users and their families to inform the future development of community services.**

We were actively engaged in the consultation process which was completed in April 2016 and will continue to support the Mental Health Clinical Board in developing the agreed model throughout the next 12 months.

Our improvement priorities for 2016/17

- **We will consolidate the progress of health and social care integration within the Community Forensic Team, replicating the achievements of established partnership working in the CMHTs.**

- **We will develop more robust processes and arrangements to ensure a comprehensive exchange of information, enabling a smoother transition for young people into adult mental health services.**

SERVICES FOR PEOPLE WHO ARE FRAIL BECAUSE OF AGEING

41. Taking a lead from the Older People's Commissioner for Wales adult social care services for older people in the Vale hold the principle of safeguarding older people as our primary function. We do this by ensuring our services are set up to work in partnership with older people and their families to ensure that they don't feel isolated or discriminated against and have a growing sense of choice and control over the support and services that they need.

42. We believe that the restructuring of adult services in the Vale has enabled an improved efficiency to our services while improving transparency and accessibility to adult social care. Our Intake and Assessment Team, based within the Council's Contact Centre has opened up improved opportunities for Information Assistance and Advice to its citizens. This means that when a person phoning up the council about the assisted bin collection, is offered information about other services or community facilities that may help to maintain the person's safety and independence at home.

43. This improved accessibility is evidenced by a significant increase in the number of enquiries into adult services through the Customer Contact Centre from an average of 20 enquiries per day at the beginning of 2014/15 to an average of 36 at the end 2015/16. To cope with this demand the Intake and Assessment Team has grown through investment of the Intermediate Care Fund and is able to resolve over 70% of the enquiries within the contact centre, with the remainder being referred to Longer Term Care Services within Adult Services.

44. We continue to build on the reablement model to promote independence, reducing the need for long-term, intensive domiciliary packages of care and the pressure to accommodate an older person inappropriately in residential care settings. The enhanced community resource service based in Barry Hospital has seen significant investments through the

Primary Care Fund, Intermediate Care Fund and Regional Collaborative Fund to bring social workers and occupational therapists together to complete joint reviews of packages of care. Through this joint approach many service users were able to maximise their independence and reduce the need to have carers in their homes as frequently. Their assessed needs were met by alternative means, and the feedback from service users was that the review was meaningful, engaging with positive outcomes. This approach is being embedded across Adult Services.

45. Following on from the successful implementation of the Older People's Integrated Assessment Framework with its enhanced outcome focused care planning approach, we are embedding the Social Services and Wellbeing Act Assessment and Eligibility framework into our systems. We are clear that this represents a cultural shift away from a task and time care planning approach, but we believe that our integrated adult services are now leading on Outcome Focussed Assessment and care planning. This is a positive start but will require further development over time.

46. The Integrated Discharge Service continues to deliver safe discharges for patients from University Hospital Wales and Llandough Hospital and is establishing improved working systems with hospital wards, discharge liaison professionals and community services. Our delayed transfer of care figures (DTOC) clearly demonstrate the improvements made. This has been achieved within a particularly challenging context as the Local Health Boards have seen very high levels of bed occupancy/demand for services on a regular basis during this year. The team has also revised the discharge processes for the Princess of Wales Hospital to enable the same approaches for people across the Vale of Glamorgan.

47. Our Occupational Therapy (OT) teams have maintained improvements in waiting times for services during 2015/16. We have seen the benefits of an Occupational Therapist and Social Worker undertaking joint visits to service users to ensure that their packages of care support them in the most effective manner, maximising their independence, motivating them,

and making the most of assistive equipment to increase their privacy and dignity. We have embedded these practices into our assessment and review process as a required to improve outcomes for service users and avoid duplication of work.

48. The Vale Long Term Care Team continues to offer a care management service to people with more complex and unstable needs, through the provision of specialist social work support and by working in partnership with service users, families and commissioned care providers to ensure people are safeguarded and have improved choice and control over their services. The team works with over 700 of the most vulnerable people in our community and ensures that they have the right support to maintain their dignity and their independence and that this support upholds their human rights.

49. The Community Mental Health for Older Persons (CMHOP) team provides secondary mental health care as defined by the Mental Health (Wales) Measure 2010 to people living with dementia and older people with mental health problems. The team works closely with specialist mental health services based at Llandough Hospital to ensure people have the right care and treatment as they require it. The service is currently being reviewed by the Cardiff and Vale Mental Health Partnership, with the intention of re-locating to Llandough Hospital during 2016/17 to enable improved partnership working with Cardiff Council and specialist mental health services.

50. These were our improvement priorities for 2015/16 and the progress made.

- **We will develop a Dementia Resource Service to provide better support and care for those whose lives are directly affected by dementia.**

  Rondel House Day services, is developing into a specialist day time resource to provide meaningful occupation and social contact for people

with dementia and offering respite to families and carers. Rondel House has had significant investment for redecoration including reminiscence materials and locally significant archive murals to provide a pleasant place for people to visit. Alongside this development, the staff are receiving specialist training to be able to safely support people with more advanced needs. The next phase of the Rondel House development into a specialist dementia resource, is to work more closely with the UHB to reduce duplication and improve outcomes for service users.

- **We will embed the locality restructure, offering integrated health and social care services within a system that helps service users to navigate their way through complex systems.**

The locality structure is now embedded as business as normal, with robust systems for the safe hand over of care from the Contact Centre through to the Intake and Assessment Team or the Integrated Discharge Service and to the Long Term Care Service when people require more sustained interventions.

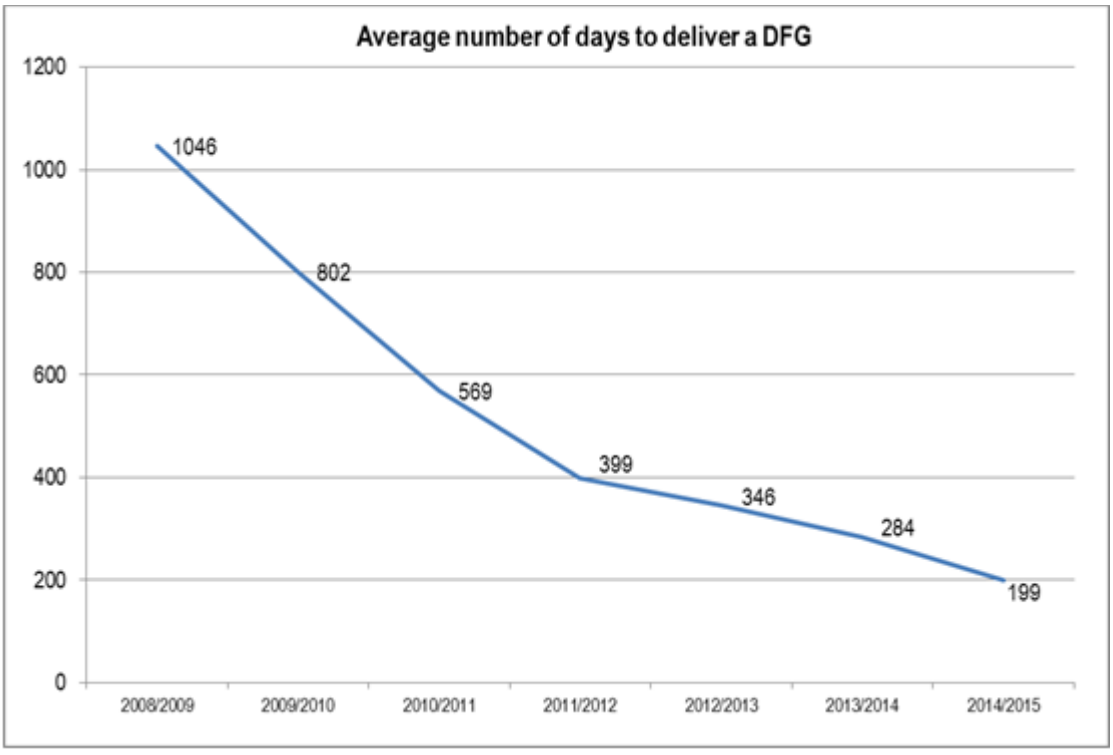
Our improvement priorities for 2016/17

- **We will develop a Long Team Care Review Team to ensure that every person receiving adult social service has an annual review of their services and a named contact for the rapid resolution of any problems.**
- **Further the developments of Rondel House Dementia Resource Centre to enhance the service provided through greater integration with specialist mental health services.**

SERVICES FOR PEOPLE WITH A PHYSICAL DISABILITY OR SENSORY IMPAIRMENT

51. The accessibility of the sensory impairment service has been improved through a streamlined process via the Customer Contact Centre and Intake and Assessment to our specialist social work staff working alongside the Occupational Therapy service. Response times are much improved, although further work is still needed to ensure that we meet the growing demands of those individuals with a visual impairment. The service is working to raise public awareness of the support available and to ensure that individuals are helped to remain in their own environment for as long as possible and in control of their own lives.

52. Through a partnership approach with colleagues in housing we have continued to reduce the time it takes for individuals to access a Disabled Facilities Grant. This has resulted in year on year improvements to the response time. (Awaiting figures for 15/16)



53. New Horizons Day Service based at Hen Goleg continues to offer highly valued occupation and social contact for people with physical disabilities in the Vale. The service has been able to support the co-located learning disabilities day service through arranging joint activities which has the effect of widening choice for service users. The enhancement of the New Horizons gym has been very popular with service users and care managers by offering specially adapted equipment in a non-threatening environment for people to improve their levels of activity with some significant health benefits.

54. The popularity of the gym has prompted a change to the way in which the service can be used. Many people are choosing to use New Horizons on a sessional basis rather than on a daily attendance routine. This means that people can choose what activities to attend for and is developing a much more customer focussed service rather than a traditional day service that service users have to fit into. This model of operation requires further development into 2016/17 and is being informed by individual care planning reviews with New Horizons staff and the Long Term Care Service.

55. New Horizons service users have been instrumental in the production of a professional training video for call centre staff on how to engage with people with disabilities in a manner that enables better communication. The video was made by Legal and General and New Horizons and has achieved many national accolades and awards and is becoming nationally recognised as best practice for call centres.

56. These were our improvement priorities for 2015/16 and the progress made:

- **We will consider the impact of the Learning Disability Day Opportunities Strategy and its potential application for service users with Physical Disabilities.**

Learning from the Learning Disabilities Day opportunities Strategy, New Horizons is developing a wider range of activities as requested by service users that can be accessed on a sessional basis. This new approach will be further developed during 2016/17 with the implementation of an outcome measurement tool so that the service can measure the impact of the service on people's quality of life.

- **We will ensure that the transition of the Independent Living Fund to Welsh Government and to service users in the Vale is facilitated at the end of June 2015 and monitored throughout the year.**

The transition has been managed smoothly with all users continuing to receive their funds without delay. Monitoring information has been returned to Welsh Government.

Our improvement priorities for 2016/17

- **Through listening what service users have said about New Horizons, we aim to improve the range of activities offered by the service with the possibility of extending the number of service users accessing New Horizons.**
- **We will implement a quality of life measurement tool that will compliment care management processes and will further inform service developments.**

SERVICES FOR PEOPLE WITH AUTISM

57. This is another area where we are able to demonstrate significant innovation and improvement.

58. Our on-line learning tool won a national award and continues to be adopted by seven other local authorities to help develop awareness of autistic spectrum disorders.

59. In partnership with carers, service users and third sector organisations, we have developed a three-year action plan across Cardiff and the Vale of Glamorgan to take forward service improvements in line with the Autism Strategy.

60. We have further developed user-led socialisation groups, including a monthly forum for adults to exchange views and to inform future service direction within services, an evening social group for higher functioning adults and a peer support group for couples where one or both of the partners is on the autistic spectrum.

61. We have delivered autism training to and awareness raising with a wide range of staff teams and external organisations such as education staff, Job Centre Plus, care providers, homeless services and eating disorder clinicians.

62. These were our improvement priorities for 2015/16and the progress made.

- **We will continue to improve multi-disciplinary transition support for young people with ASD moving into adulthood helping young people who move into adulthood have better life chances and more effective support**

A multidisciplinary pathway has been created jointly with Cardiff Learning Disability services, Careers Wales and Cardiff and Vale College to improve the transition of young people to local college placements.

- **We will continue to develop the information and advice service to support individuals and work with staff to develop materials to work directly with individuals.**

The Information and Advice service has delivered social skills training for adults with autism. It has continued to work with a group of adults initially brought together for an employment skills course and developed the group into a regular daytime forum in Barry YMCA Hub.

- **We will further develop an online presence for the employment and skills information resource for individuals, carers and professionals.**

The employment resource, Working with Autism has become a national resource supported by funding from Welsh Government and WLGA staff. 600 plus careers wales staff have taken the autism awareness course. Several 100 Job Centre Plus staff have completed the course and it has been demonstrated to a UK DWP director.

- **We will continue to deliver training for staff and other organisations working with adults on the autistic spectrum**.

Training has been delivered to various groups ranging from local authority staff, through residential and supported living providers to school governors.

Our Improvement priorities for 2016/2017

- **We will work towards better integration of the Information and advice service with the main stream social services framework. This will include storing information on the main social services system so that Information, Advice and Assistance provided in compliance with the Social Services and Wellbeing Act Wales can be consistently reported on. The team will also, when approached directly and where appropriate, record proportionate assessments.**
- **The Welsh Government have announced funding for a new Wales wide integrated autism service to be set up in 2016. We will work with WLGA staff to implement this service.**

SERVICES FOR PEOPLE WHO HAVE SUBSTANCE MISUSE PROBLEMS

63. We work closely with the Vale Community Safety Partnership and Cardiff Council, in particular as members of the multi-disciplinary Area Planning Board which operates across the two local authority areas. By collaborating with the voluntary sector and by using the single point of entry into Drug and Alcohol Services (EDAS), we continue to offer rapid access to assessments and appropriate interventions.

64. We were aware that people prefer to receive rehabilitation services closer to home and in response developed local social care support options for people accessing local NHS drug and alcohol treatment options, to help maintain motivation during the process. We have supported two people through residential rehabilitation in the last year, but through the use of EDAS and locally based NHS drug and alcohol treatment options, the demand for residential rehabilitation has declined as people receive support and treatment closer to home.

65. Significant changes in the structure and operation of Community Drug and Alcohol Services came into effect during 2015/16. The re-focusing of drug and alcohol services from statutory sector provision toward third sector provision has led to a more recovery-focused approach to supporting people with substance misuse problems.

66. The Vale's social care responsibilities have been delivered through a dedicated social work post, which has delivered evidence-based interventions as well as advice and consultancy to statutory and third sector teams.

67. We engaged in the consultation process for the Substance Misuse Delivery Plan for 2016-2018 and raised awareness of a need for specific rehabilitative services in Wales for people with Alcohol Related Brain Injury. Brynawel House has recently opened and is running an

assessment and treatment programme pilot. The Vale of Glamorgan sits on the Project Steering Group and is playing a key role in the shaping of the service.

68. The improvement priorities for 2016/17 continue to be shaped by the Area Planning Board and so individual priorities for Adult Services have not been created.