VALE of GLAMORGAN
BRO MORGANNWG

HEAD OF ADULT SERVICES

ANNUAL REPORT
2014 - 2015

The Adult Services Division provides services for people with a learning disability, autism, mental health problems, frailty because of ageing, a physical disability or sensory impairment and adults who need protecting from abuse

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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 or/and mental health issues associated with ageing. £35 Million was spent on these services in 2014/15, the same amount as the year before. There was some protection for the adult services budget, despite the Council's difficult financial position overall. This meant that the division had to absorb significant cost increases but it still 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 2014, the Welsh Government has set a maximum charge of £55 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 2014 to March 2015.

Key adult social services activity data 2014/2015

The figures for the previous year are in brackets.

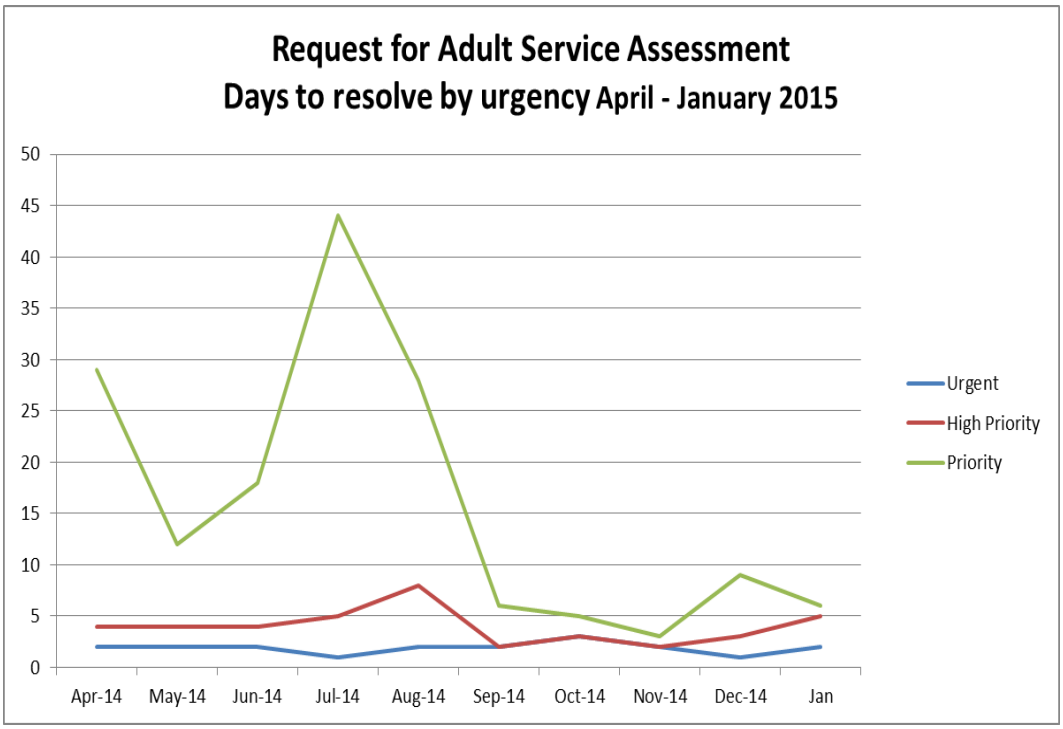
- 1665 people were supported to live at home (1822)
- 309 people received individualised Telecare support (250)
- 1027 older people were helped to live at home (1141)
- 392 older people were supported in residential/nursing home care (384)
- The rate of delayed transfers of care for social care reasons per 1000 of the population aged 75 or over was 4.55 (7.35)

4. 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 is being developed with 3rd sector partners to support the provision of information and advice that will be required through the Social Services and Well being Act.

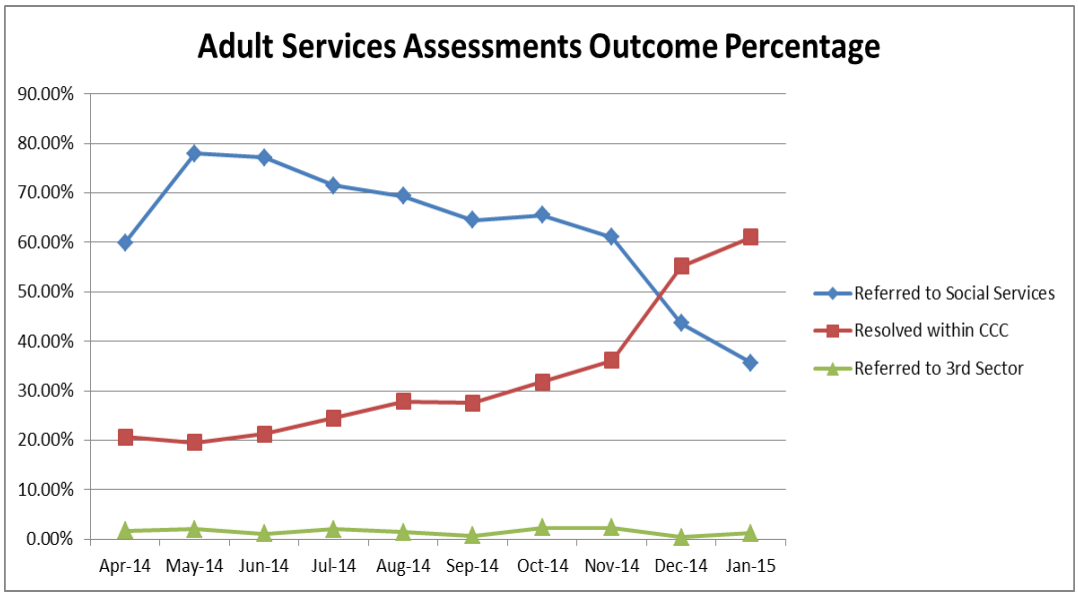
5. Our efforts to integrate social care and community health services have really accelerated this year, in part through implementing an ambitious locality plan for joining up the help offered to older adults and people with a physical disability. Within the Cardiff and Vale University Health Board (UHB), 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.

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 new locality model removes many of the traditional boundaries between health and social care. It has enabled us to redesign community services with an integrated intake service and a longer-term care service. Cardiff and Vale UHB describe in their recent Integrated Medium Term Plan the approach the Vale Locality is taking as "at the forefront of integration in Wales".

6. We have been fortunate to receive 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 up throughout the year but the early indications are that is achieving significant success. From September 2014, the response times for standard referrals were reduced by 75% and priority referrals by 50%. In addition, the number of referrals that are being resolved at the Customer Contact Centre also increased, meaning that people are receiving service more quickly. We intend to build on these improvements in 2015/16.


Request for Adult Service Assessment
Days to resolve by urgency April - January 2015
50
45
40
35
30
25
20
15
10
5
0
Apr-14
May-14
Jun-14
Jul-14
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14
Jan
Urgent
High Priority
Priority

7. The Customer Contact Centre has not just delivered improved response times. It is also helping the service manage growing levels of demand. It has also enabled an integrated community response right from first contact. This has changed the way our service interacts with our service users. The number of people being supported to live at home has reduced for the first time in several years. There has however been a rise in the complexity and need of those who are being supported.



8. 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 are some case examples to illustrate how the changes made have improved the outcomes for Service Users and their families:

9.

A) *Mr X is 78 years old and lives alone in sheltered accommodation flat. He has no family contact. He has emphysema, arthritis, osteoporosis and atrial fibrillation. In February 2015 concerns were raised to the call centre by a sheltered housing warden reporting that Mr X had become housebound and had been wearing the same clothes for past few weeks. The flat was in poor condition with rotten food, rubbish, and dirty dishes on every surface. The warden was also concerned that Mr X was not taking medication. Mr X was contacted by social services staff and he declined a social work assessment. In discussion with health colleagues it was felt that Mr X may accept a nurse visit and this should be offered. He agreed to this and a nurse visited him. They observed that he was at risk of further decline in health and mobility and admission to hospital without support. He was not taking medication as prescribed The nurse was able to reach agreement with Mr X for a Rehab Occupational therapist and social worker to visit. They established he was unable to manage washing, dressing and was barely eating food bought for him by a friend. Mr X accepted a GP visit but Mr X refused hospital*

admission. Mr X accepted the offer of six weeks free reablement from the Vale community Resource Service consisting of two support calls per day. He also agreed to on-going OT support and assessment. He has allowed carers from the reablement service to clean his flat, and do laundry. He is permitting them to open the curtains daily and has had a haircut and a beard trim. He is now eating regularly with encouragement. He has been supported to purchase a new fridge freezer and microwave. Carers have been able to check he had taken medication and supplements on visits. Mr X has, after weeks of support started to consent to changing his clothes. He has described the carers as 'as good as gold'. A social worker is currently working alongside OT and carers and in the process of developing a relationship with Mr X. This is with an aim of gaining consent for a social work assessment and provision of longer term care to enable Mr X to continue improve his health, mobility and remain at home for as long as possible as per his wishes.

B) *A call was received by the nurse at the Customer Contract Centre from Accident and Emergency at UHW regarding the admission of a man (Mr Y) who was the sole carer for his wife (Mrs Y). She was 96yrs old and experienced significant memory problems. Initially, both of them were in UHW waiting for acute beds to become available. Working with the Integrated Discharge Service a placement was arranged in a local care home as Mrs Y was considered to be unsafe to remain at home with a package of care. Mrs Y and her husband were consenting to the placement. Mrs Y was taken to the home that evening. Mr Y was discharged a few days later and his wife returned home to live with him.*

10. The additional grant funding made available through the Regional Collaboration Fund has continued in 2014/15 and we have used it to enhance reablement services and deliver improved response times. 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.

11. 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.

12. 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.

13. 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 at scale and at pace, 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.

14. The number of people supported to live at home has reduced in 2014/15 to a similar level last seen in 2012/13. 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.

15. It has been pleasing to see a significant decrease in the annual figure for delayed transfers of care (DTOC) from hospital. The beginning of 2015 brought significant winter pressures in the hospital system and this did have some impact on discharges. However, 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 prepare a new 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.

16. Progress on the use of Telecare services stalled in 2013/14. The Telecare team was then relocated, to ensure that it has good links with the Contact Centre, and some temporary staffing issues were resolved. In 2014/15, the numbers of people being supported by Telecare has grown. The service still needs to develop a longer-term strategy but it was hampered by the contradictory research evidence and the problematic quality of its own performance information. In response, the Council made Telecare a priority for a Task and Finish group led by members of the Social Care and Health Scrutiny Committee. This has 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 has been developed for delivery in 2015/16.

17. 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.

18. 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.

19. 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.

20. 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.

21. 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.

22. Adult Services has a challenging savings target of £956k for 2015/16. These continue to be overseen by the Social Services Budget Programme Board which has representation from the highest levels in the Council. These savings will be achieved through a number of changes including; supporting people to live in more independent care settings, reductions in management

posts through integrated working, and the end of a residential care contract arrangement.

SERVICES FOR PEOPLE WITH A LEARNING DISABILITY

23. 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 the Cardiff and Vale University Health Board.

24. 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.

25. The improvements already achieved in supported accommodation services have been enhanced through the process of retendering contracts with independent sector providers. Given the increasing need for this type of provision, the Community Support Team continues to explore options for expanding the number of properties that can be used as supported accommodation. 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.

26. We have ensured that service users living in supported and other accommodation can make full use of Telecare equipment, to live more independently.

27. These were our improvement priorities for 2014/15 and the progress made:

    We have implemented the Day Opportunities Strategy and action plans, to ensure that people are enabled to participate in meaningful and more typical day time activities and to maximise their independence. We have increased day time opportunities for 27 people who were within a traditional day centre based service. They are now part of two social enterprises, Snax café and Positive Images, undertaking voluntary and work opportunities. We have received really positive feedback, with service users expressing their excitement about being part of something new. For example, one man explained how he was 'proud to wear a work uniform for the first time'.

We have worked closely with the Vale of Glamorgan Housing Service and Registered Social Landlords to review the range of housing and accommodation options available, to ensure that agreed outcomes help people to develop their capacity for independence. We continue to use Telecare to ensure we are maximising independence for people**.**

We have relocated the Community Support Team to Hen Goleg and, in collaboration with our partners, looked at further ways to achieve integrated working. We continue to be committed to reducing duplication for service users and have mapped out opportunities in the screening and review process for individual cases. We have developed a pathway for service users and all services are now using the same monitoring and review tools. Where we can, we have worked in a more collaborative way with our health colleagues to ensure that people receive a seamless service

Our improvement priorities for 2015/16

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

- **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.**

SERVICES FOR PEOPLE WITH MENTAL HEALTH PROBLEMS

28. 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 Community Care Assessment and their Care and Treatment Plan.

29. 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 officer as well as relevant health colleagues (including psychiatrists and community psychiatric nurses).

30. 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.

31. The Vale of Glamorgan has worked alongside the Mental Health Clinical Board in undertaking a comprehensive review of Community Mental Health Services to address this increasing imbalance of workload across adult mental health. This work is ongoing into 2015/16 and it will help to determine 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.

32. The Carers Support Officer is now an integral part of the team; this has meant more effective and timely assessment of carers' needs. 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 and activity groups.

33. The Mental Health Community Support Workers are continuing to develop their recovery-focused community interventions to support some very vulnerable people through to greater levels of independence. The team has worked with Vale MIND to develop an integrated outcome measurement approach using the 'Recovery Star' approach. It is intended that all community support work services across Cardiff and Vale will use this single approach to measure the progress made by service users and service effectiveness.

34. In October 2014, the Vale Community Mental Health Services welcomed an external evaluation by the Care and Social Services Inspectorate for Wales (CSSIW) looking at social care practices within the CMHTS, with a focus on the service user's experience. The CSSIW site visit found services that were reassuringly person-centred and recovery-focussed, while acknowledging the increasing demand and expectation on mental health services.

35. Approved Mental Health Practitioner (AMHP) work in undertaking Mental Health Act Assessments continues to increase, as well as supporting the Mental Health Review Tribunal process and assisting in the creation of Community Treatment Orders. We are keen to support staff through the AMHP training this year so that we can continue to meet the local authority's statutory responsibilities for these services.

36. 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.

37. These were our improvement priorities in 2014/15 and the progress made:

- **We have explored with our partners the cost and benefits of re-organising the provision of CMHTs, to ensure our services are able to meet the challenge of increasing demand and expectations from primary care referrers while continuing to offer quality secondary care interventions.** This work is ongoing via the Mental Health Clinical Board at the UHB, which is developing a consultation document that will inform the future structure and operation of Community Mental Health services into the next decade.

- **We continue to work with Vale of Glamorgan Housing Service to develop innovative and cost effective housing and support options.** In partnership with the Vale Housing Supporting People Team, we have developed a new Floating Support Service to work with people known to secondary mental health services and to help them to live independently in their own homes. This will promote recovery and reduce dependency on secondary mental health care.

- **We have been unable as yet to consult with Cardiff Council and the Cardiff and Vale UHB upon a joint Commissioning Strategy for Mental Health Services.** However, we have contributed to the Cardiff and Vale Together for Mental Health Strategy which sets out strategic priorities for the promotion of mental wellbeing and the development of high quality mental health services.

Our improvement priorities for 2015/16

- **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 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.**

SERVICES FOR PEOPLE WHO ARE FRAIL BECAUSE OF AGEING

38. Adult social care for older people includes:

- assessment and care management
- nursing and residential care homes
- respite care
- community services (home care, day care, meals)
- re-ablement to prevent hospital admission or enable continued independence
- intermediate care (after a spell in hospital)
- supported and other accommodation (including adult placement and extra care)
- direct payments to service users
- safeguarding
- the provision of equipment and related areas (including Telecare).

39. This year, we have been determined to build further 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.

40. The Intermediate Care Fund has allowed a contract to be piloted with commercial sector service providers of domiciliary care to try and expand our reablement approach into that sector. The grant has also allowed us to enhance the community resource service through improved integration, continuously building upon co-location of staff in Barry Hospital achieved at the end of the previous financial year.

41. In addition further initiatives supported through government funding, Intermediate Care Fund and Regional Collaborative Fund have proved beneficial to service users. We introduced a project that brought 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. The service is now endeavouring to embed this approach across the wider staff group.

42. Furthermore, a review checklist was developed to support staff to conduct effective reviews. The approach is to motivate service users to achieve their

maximum level of independence and/or slow the pace of any deterioration. We realised that we needed to review the way in which we communicate with service users when they are initially in receipt of our services. An outcome has been an information sheet that outlines what they can expect from the initial stages of support and what can happen at the review stage.

43. As anticipated, 2014/15 continued to see increasing demand for older people's services. The introduction of the new integrated locality structure has meant that changes are in place to improve access to health and social care services. This has meant that there is less duplication of effort and people get the support they need at the right time. We are working hard to ensure that these improvements are sustained through an integrated contact centre for health and social care. This has allowed us also to put in place some of the foundations needed to support implementation of the Social Services and Wellbeing Act.

44. Adult services has successfully implemented the new Older People's Integrated Assessment Framework. This has required a redesign of our systems with the intention of delivering care through a more streamlined approach. This is supporting the service to work towards utilising Outcome focused care planning, where we work with the service user and their carer to focus on their desired outcomes. This represents a cultural shift away from focusing care planning on task and time in to supporting the outcomes identified. This is a positive start but requires further development over time.

45. Occupational Therapy (OT) teams have maintained improvements in waiting times for services during 2014/15. The wider OT service has benefitted from the Regional Collaborative Fund and Intermediate Care Fund which have allowed us to pump prime new ways of working. 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. These trials have been successful and, as a consequence, we are working to embed these new ways of working in to practice.

46. The Mental Health Measure and the locality reconfiguration have fundamentally changed the work of the Community Mental Health Older Persons (CMHOP) team. This has meant more individuals are being supported through mainstream health and social care services. It is anticipated that further partnership planning with Cardiff and Vale UHB and potentially Cardiff Council will be required to maintain a viable, coherent and well supported specialist team. The number of referrals in this area has steadied but the nature of the work remains complex. Significant work has been done to ensure that the waiting list/response time is minimal.

47. The Integrated Discharge Service has been through a consolidation period during 2014/15. It is now working well, with significant improvements made in the communication between health and social care to ensure the safe

discharge of patients. 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. We have been encouraged by improved partnerships with the Abertawe Bro Morgannwg University Health Board and the Velindre Trust.

48. These were our improvement priorities for 2014/15 and the progress made.

- **We have successfully reconfigured Locality Services to deliver a more integrated model of health and social care services that can meet the demands of the population in the future.**

- **The Social Care and Health Scrutiny Committee has reviewed how Telecare services can be utilised better to support people with dementia. The work has supported the development of an action plan designed to increase the number of people taking up the service. Moreover, through the locality restructure, we have been able to invest in a specific post to support the development of services for those with dementia and their carers. This Resource Centre Manager post will ensure that the three year plan for dementia services is implemented in an important area of provision for service users and carers.**

- **A joint contact centre/communications hub has been implemented which now completes screening, signposting, case prioritisation and onward referral.**

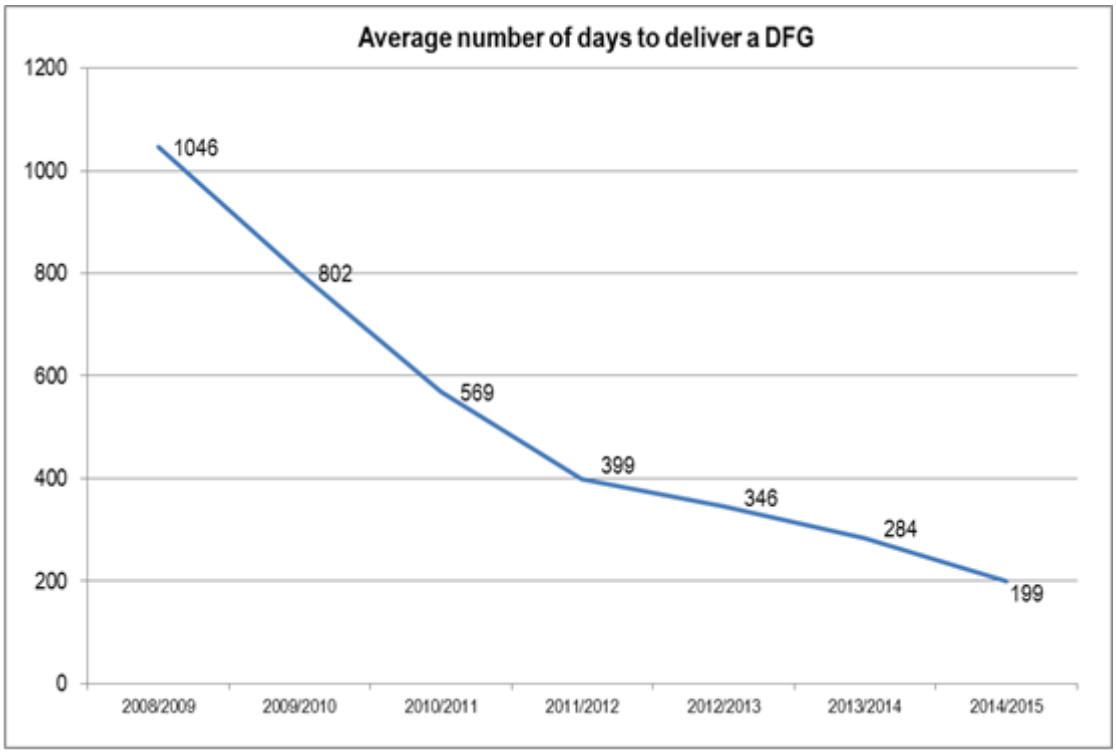
Our improvement priorities for 2015/16

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

SERVICES FOR PEOPLE WITH A PHYSICAL DISABILITY OR SENSORY IMPAIRMENT

49. The locality restructure has helped to refocus the sensory impairment service. This has involved specialist social work staff working alongside the Occupational Therapy service. The work undertaken by the Rehabilitation Officer for the Visually Impaired has been examined, with a view to supporting this specialist area. 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. We are trialling clinics at our day services, and other luncheon clubs etc where our specialist staff go to those who may need our services and provide them with information and support to ensure they remain independent for as long as possible.

50. 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



51. Our Council-run Day Services for Physical Disabilities (New Horizons) have responding to the fact that Learning Disabilities day services are now co-located in Hen Goleg. This has led to some initial steps towards integration on an individual basis, which has proven to be mutually beneficial for some

service users. For example, through joint events and activities, service users have been able to access a wider range of opportunities.

52. These were our improvement priorities for 2014/15 and the progress made:

- **We used the Intermediate Care Fund to further extend the reablement service made available within the private sector, complementing our integrated Community Resource Service and making sure that more people had the opportunity to maximise their potential for achieving and maintaining their independence.**

- **The Extra Care facility at Golau Caredig opened in October 2014 and the 42 apartments are full, with a waiting list for places. Feedback from the new residents has been very positive. It has enabled people to live more independently now that they have accommodation suited to their needs with access to a stimulating community environment and the on-site domiciliary care agency.**

Our improvement priorities for 2015/16

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

- **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.**

SERVICES FOR PEOPLE WITH AUTISM

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

54. 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.

55. 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.

56. 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.

57. 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.

These were our improvement priorities for 20114/15and the progress made.

- **We have completed the 'employment prospects' project for adults on the autistic spectrum.**
- **We have rolled out job skills workshops to all Job Centre Plus offices within the region. There is now a sustainable model within these centres to train staff about how to support an individual with ASD who seeks employment opportunities.**
- **We have delivered a series of training sessions for Day Service Staff and there is an ongoing programme of work for this.**

Our Improvement priorities for 2015/ 2016

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.

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.

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

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

SERVICES FOR PEOPLE WHO HAVE SUBSTANCE MISUSE PROBLEMS

58. We are working 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 with the development of the single point of entry into Drug and Alcohol Services (EDAS), we continue to offer rapid access to assessments and appropriate interventions.

59. We have supported four people through residential rehabilitation in the last year. However, we are aware that people wish to receive rehabilitation services closer to home. We have explored the development of more local social care support options for people accessing local NHS drug and alcohol treatment options, to help maintain motivation during this process. The introduction of EDAS and locally based NHS drug and alcohol treatment options has meant that demand for residential rehabilitation has declined as people receive support and treatment closer to home.

60. There have been significant changes in the structure and operation of Community Drug and Alcohol Services during 2014/15 which will come into effect during 2015/16. Re-focusing of drug and alcohol services from statutory sector provision toward third sector provision will lead to a less stigmatising and more recovery-focus approach to supporting people with substance misuse problems.

61. Given the level of change in this area, it is no longer considered appropriate to set specific improvement priorities for 2015/16 which relate only to social care services. Instead, improvement work work will be overseen by a regional area planning board. The Vale's social care responsibilities will continue to be delivered through a dedicated social work post.

These were our improvement priorities for 2014/15:

- **We have will explored how to develop support options for people accessing local NHS drug and alcohol treatment options, to help maintain motivation during this process.** The introduction of EDAS and the locally based NHS drug and alcohol treatment options mean that people receive support and treatment closer to home. This has led to a change in the work of the Vale Substance Misuse Social Worker because demand for residential rehabilitation has declined as people receive support and treatment closer to home.

- **We have worked with local providers of social care support to improve their skills and experience of providing support services to people using substances and those undergoing rehabilitation/treatment.** As more people are receiving treatment closer to home, the Substance Misuse Social Worker has been able to develop closer working relationships with local third sector organisations, other local authority social care teams and mental health services to ensure that appropriate wrap around support is available so enable people complete treatment programmes.