Cwm Taf Social Services and Wellbeing Partnership Board

Cwm Taf Social Services and Well-being Partnership
Report of the Community Panels held December 2017

Practice Solutions Ltd

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1. Introduction and Background

1.1 This report has been produced to summarise the key points identified in the engagement carried out as part of the ongoing development of the Cwm Taf Regional Plan. It is based on the input of people who engaged with the three workshops held in December 2017 and written input from people who also wanted to contribute.

1.2 The Cwm Taf Social Services and Well-being Partnership Board comprises representatives from the Cwm Taf University Health Board, Rhondda Cynon Taf and Merthyr Tydfil Councils, the Third Sector, Care Forum Wales, Social Care Wales, and service user and carers. Wider engagement informs the development of the Cwm Taf Regional Plan.

1.3 The first plan must be produced by April 2018, and will set out how the Partnership will respond to the findings of the Cwm Taf Population Needs Assessment published in April 2017 http://www.ourcwmtaf.wales/cwm-taf-well-being . The plan covers a five-year period and will outline the range and level of services to be provided in response to the needs for care and support identified in the Population Needs Assessment. The needs and priorities within the plan will be reviewed annually to monitor progress, and amended as required to ensure that people who live in Cwm Taf who need care and/ or support can achieve positive outcomes.

1.4 Priority areas set by Welsh Government under the Social Services and Well-being (Wales) Act 2014 are:

- Older people with complex needs and long-term conditions, including dementia
- People with learning disabilities
- Carers, including young carers
- Integrated family support services
- Children with complex needs due to disability and illness

1.5 The Population Needs Assessment emphasised the need to look at the whole person and not just one problem they might experience. In addition to the groups listed above, Cwm Taf has identified the need for more work to improve services in other areas, for example for people with physical disabilities and sensory impairments, those with mental health issues, substance misuse problems or victims of domestic abuse and sexual violence.

2. Methodology

2.1 Three Community Panels were held; in Abercynon, Porth and Merthyr Tydfil. The approach was adopted to ensure that those present were given time by facilitators who were able to listen to their specific views about the care and support they received from health and social care services. Due to the small numbers of participants, everyone was given opportunity to share their perspective in a relaxed and safe environment which is not always possible in larger scale public events. Attendance varied as the first Panel coincided with adverse weather conditions; however, the information gathered at each of the events provided a rich source of information to inform the development of the Regional Plan.

2.2 At each event, a presentation which gave an overview of the plan was provided, together with opportunities for questions. This was then followed by facilitated discussions which focussed on six key areas which reflected the overarching themes of the 2017 Population Assessment:

- Getting information, advice and assistance
- Stopping problems before they start
- Stopping problems before they get worse

- Connecting you to your community
- Seamless services
- Making it personal and working together with you

2.3 Those who attended were encouraged to share their own experiences and explore good practice though positive experiences, or use negative experiences to frame improvement opportunities.

2.4 Members of the Community Panels had an opportunity to respond to the Regional Plan by focussing on the following themes:

- Identifying positive opportunities for co-production and building on community assets.
- Identifying good practice in relation to the provision of information advice and assistance that supports resilience and well-being.
- Exploring what outcomes people would expect from efficient and reliable community services.
- How they want to be kept informed on progress and the changes to the area plan.

3. Common Themes

3.1 Running through each of the engagement events was the importance of communication – getting it right, and good quality information. This is covered in more detail under the headings which follow.

3.2 It was felt that the priorities and issues identified were broadly the right ones. The challenge of engaging people in developing the plan was identified and several suggestions and offers about how this could be done were provided. Using easy read, better use of IT where people access services, local hubs, running a dedicated group for people with dementia, using the auspices perhaps of the Alzheimers Society and/ or MIND.

3.3 Community assets were identified. These include initiatives and activities set up within communities by communities such as walking groups and community choirs, which also provide opportunities to improve well-being, remove social isolation and share information. The people who attended had very local information on issues in their geographical area and area of interest/ expertise which provided a rich source of information to help steer and shape plans. The willingness to engage, encourage others to engage and stay involved came through at each of the events.

4. Discussion Areas

GETTING INFORMATION, ADVICE AND ASSISTANCE

4.1 The importance of good quality, easily accessible and understandable information and advice was emphasised by all. The diversity of approach to seeking and obtaining information was also highlighted. There is no clear centrally used source that people can access. Examples of sources used were:

- Word of mouth
- Interlink
- Front line staff
- Carers Wales
- People First
- Posters at GP or library
- Internet
- Phoning the council
- Information board

- RCT Carers project

4.2 Having one "front door" was seen as essential, although attendees stressed the point that people want to get information by different methods, so as well as having one high profile front door, it was important that good quality up to date information was available at many access points. For example, it was very useful to have someone whose job it was to signpost people within the GP surgery. The importance of getting information from "trusted voices" was raised. It was noted that within Cwm Taf, there is the possibility of the development of community hubs/ neighbourhood networks.

4.3 It was recognised that the provision of an information, advice and assistance service is a statutory requirement, but there were concerns about variation across Wales and within regions, as well as a question mark over how performance was measured. How would people know the service was making a difference? Including equality monitoring as a statutory requirement would provide some information.

4.4 There was some awareness of Dewis Cymru as the national approach to information, advice and assistance, but it was not widely used and it was felt that information there was patchy and not easy to find. Additionally, while it's very useful to have online information, this does not work for everyone.

4.5 People must be put at the centre of the service, and that means that the first point of contact must be well informed and equipped to supply advice to ensure that those who seek help do not have to repeat their story several times. The contact needed to have knowledge about translation services, for example.

4.6 With respect to the way information was provided, several issues were raised. The need for easyread information to be routinely available, visual information like short video clips, and the need for other languages in addition to Welsh and English. The importance of keeping things simple, forms short, but also ensuring that if wanted, people had access to the full detail was important.

4.7 Specifically, it is challenging to access information for people who have severe learning disabilities, which are compounded by health problems - even GPs can be at a loss to know which service to refer these individuals to because of their learning disabilities.

4.8 Another specific area where it was felt it was difficult to access information was finance, debts and benefits – there is some available at CAB and Age Connect but identified as fundamental to well-being and not consistently provided or enough available.

What hinders

- Staff don't have the information people are seeking – provide consistent good quality training and awareness and make it the expectation that they do know.
- Lack of IT – access to internet in community centres and day centres. Specific example of learning disability given – if videos could be streamed or help given with internet based forms at day or community centres, this would support people and support Cwm Taf in its aspirations to involve people co-productively.

Good examples/ ideas of information provision

- Where queries have been emailed to the statutory authority a quick and helpful response received.

- Community well-being co-ordinator – provides signposting to a broad range of sources of information e.g. on housing, benefits etc (based in GP surgery and referral by GP).
- Six week sessions providing information to families of people with mental health issues.
- Carers three monthly event with speakers and information - keeps us in the loop in Pontypridd as part of the RCT Carers Project. There is a good mental health carers support group which provides a chance to air your circumstances and get information.
- Being part of local and national networks.
- Hands on and word of mouth is really good. Better than technology - because it's a distraction there's always something else to do.
- Hold a 'Freshers Weeks' for the Cwm Taf community in town centres to let people know about things that exist.
- Careful consideration needs to be given with regards to the marketing of these events. We need to use other forms of communication, for example video, and engage people who use services to encourage participation.

STOPPING PROBLEMS BEFORE THEY START

4.9 It was felt that good quality information, advice and assistance was strongly linked to preventing problems before they start. Without that, problems could escalate to a point where they needed a much more significant intervention. For many people, being independent and staying in their own home was essential for their well-being. Sometimes, extra help was needed to enable that to happen. Using social media effectively, e.g. in campaigns around public health, is useful.

4.10 For many, finding the information was challenging so again, the importance of a high profile and effective single point of access was emphasised. The local approach was valued, having a relationship of trust enabled people to seek out information before a crisis happened. Communication is key to good prevention – people need to know where, when and what preventative services exist.

4.11 To ensure people retain well-being they need to be able to get out of their house and to get to work, school, leisure, social and cultural activities and things like health and social care. Public transport needs to support this and it doesn't. Examples given of no Sunday bus service, and services ending early and starting late, leaving communities cut off.

4.12 Some very important elements which would empower people to seek help early were:

- Being able to speak to the right person at the right time
- Feeling confident and comfortable to speak up about their issues
- Trusting the person or organisation contacted

4.13 There were several discussions about people in work with the comment that sometimes it felt like there was no safety net. Having systems in the work place so that you felt that you could say to people that you're not very well is important, particularly with mental ill health.

4.14 We talked about some of the reasons people didn't seek out help at an early stage. Lack of knowledge, fear of what might happen to them or their loved ones (including pets), lack of community infrastructure and being isolated were contributory factors.

What hinders

- Lack of access points or understanding of where to get help
- Lack of confidence in services
- Lack of transport at necessary times

Good examples/ ideas of stopping problems before they start

- Good Networks are essential. 'Getting Porth Connected' was identified as a good example.
- Mind runs a Blue Light Champion scheme which is very good to learn about opening up when the culture or environment doesn't let you do that.
- Social prescribing – linking people in to services in their community e.g. a gym.
- Running tai chi classes for people in sheltered housing- helps prevent falls, improves well-being.
- Proactive approaches in GP surgeries, e.g. alerting people when blood tests needed.
- The Fire Service has a very good internal mechanism as well as an organisational culture that tries to stop problems before the happen.
- Community infrastructure such as a local community choir, which has the additional benefits or encouraging connectivity, reducing social isolation and is an example of co-production.
- Obesity prevention - some schools have children running a mile a day.
- Local Area Co-ordinators should be used as an additional mechanism for pushing information into communities. However, they need to reach out to more people under 50.
- Pet sitting fostering service for people who have to leave their animals behind because of circumstances. There are examples of it working well and relives the stress that could and would be caused to the person.

STOPPING PROBLEMS BEFORE THEY GET WORSE

4.15 To stop problems before they escalate, the starting point must be to put people at the centre, and design and deliver services around people. An assessment which is focused on what's important to people and follow up is vital. If after illness, physical or mental, contact and support was maintained over time with the person using the service, this could prevent problems getting worse.

4.16 Investment in community capacity and services is essential. Some places in Cwm Taf are lacking basic community amenities and there is insufficient transport and sometimes an inability to travel to where the amenities are. Financial issues are exacerbated if you are ill, a carer, disabled etc. Help for people who may be struggling on a limited income is needed.

4.17 Staff must have knowledge of different conditions and how their caring role might impact the person using the service and their carers. While there may be support in place, the reality is that there is frequently a waiting list which impacts on outcomes.

4.18 There needs to be a good understanding of the needs of carers and the stresses of caring. There are secondary conditions or ill health as a consequence of caring and services need to be prepared to provide an effective response when Carers are unable to carry out their role.

4.19 The need for respite and breaks must be recognised, as to provide some way of "recharging batteries" before carers become exhausted or ill through their responsibilities is important. This enable carers to continue and may prevent problems getting worse. Doing simple things like taking carers out for a coffee and listening to what they're up to and offering ways to help makes a positive difference. Getting respite for people when they need it will reduce problems.

4.20 The lack of bereavement support services was highlighted by a carer with reference to people with a learning disability. Supporting people, life after caring or for the cared for person when a carer is no longer there is a crucial area for consideration.

What hinders

- Services not talking to each other.
- Non delivery of a person centred approach to assessment.
- "When things have gone wrong, everyone pushes you around and no one wants to know".

Good examples/ ideas of stopping problems getting worse

- Value community voluntary transport, but different rules apply depending on where you live. Make them equitable and consistent and easy to understand.
- Put in place activities which reflect people's different needs and interests. There needs to be choice and variety of activity.
- Professionals should work with carers and service users to co-produce opportunities for well-being.
- Carers' advocates to support carers helps deal with individual situations. It can to help with reducing family and marriage tensions.
- Help carers build confidence and self advocate.
- Isolation is a real challenge for carers. They have set up a walking group that has been going for the last ten years. A yoga group for carers is also helpful.
- An idea is an all Wales respite place for carers - that recognises that carers can get away from their cared for to do something different / reenergise.
- Increase psychological support for carers to help people help themselves - increase personal resilience. There is some available through MIND, for example, and via the RCT Carers Project.
- Hospital Discharge Services have the potential to inform people about preventative services.

CONNECTING YOU TO YOUR COMMUNITY

4.21 Having a real connection within your own community supports well-being. Being part of social groups was seen as helping in preventing issues like loneliness and isolation, providing a rich source of information and to supporting positive activities. People can do much themselves, they can and do self-organise, but a level of support and co-ordination and funding is needed to make it happen and keep it going. The costs of supporting people to get and stay connected could be negligible when contrasted with the cost of putting in crisis support if problems escalated.

4.22 Some communities are isolated due to geography and transport and even travelling to the nearest town is a challenge with poor or no public transport. Some communities have no central "hub" such as a community centre, pub or post office.

4.23 Intergenerational projects should be run to connect people to the community, for example younger people teaching older people how to use technology.

4.24 Support in the community for people with a learning disability was highlighted as important. If there are no services, the result can be higher level interventions than are needed – e.g. residential care.

What hinders

- Not knowing what's available in the community – no one organisation/ person holds the knowledge.
- Not recognising the assets that people have – for example, people who use services can and want to contribute to society eg through work or volunteering.

Good examples of connecting

- Community choir.
- Facebook pages.
- Interlink resources help people connect – community co-ordinators.
- An example of a project in northern Europe was discussed where older people run a group for children in the community. Parents leave and the group cook with one another - parents return and then they eat together. This project helps to develop skills that highlight the importance of creating and sharing healthy meals and having time out to relax for all members of the family.

SEAMLESS SERVICES

4.25 Services designed around people, not restricted by organisational boundaries, are the ideal. This refers to all services – health, social services, housing, education, transport, leisure and should cut across the statutory and the third sector.

4.26 There were discussions about how we bring everyone to work together around the person. The bureaucracy in many organisations can be a barrier to effective seamless services. Professionals across organisations need to work together and share information. There should be a personal multi-agency plan designed around the individual who needs care and support, and that should be shared.

4.27 The changed role of the Fire Service was commended as a way that should be considered by health and social care services in exploring how the change from a reactive to a preventative service could be managed.

What hinders

- Bureaucracy and different rules in different organisations.
- Lack of understanding/ awareness of staff about the "systems".

Good examples of seamless services

- The fire service accesses the community about safety ...could we use iPads or other forms of smart phone technology to get the fire service to share useful information about care and support in the community.

MAKING IT PERSONAL AND WORKING TOGETHER WITH YOU

4.28 The importance of professionals working in partnership with people who use services and carers was emphasised and it was generally felt that there was a way to go to make this a reality, not just in Cwm Taf. The role of front line staff is important in setting the tone of co-production, of identifying opportunities for people to get engaged more generally e.g. as in these Citizen Panels. In one case, a social worker had informed a person about the events and actively encouraged an attendee to get engaged to ensure they were involved in wider practice and policy. This should be further encouraged, but requires front line staff to be very well informed about what's going on, and to be in tune with the co-productive approach.

4.29 It was felt that to maximise resources they must be shared and used effectively. There are opportunities. There are untapped resources in the form of public buildings which are used part time e.g.schools and could be used by people who use services, carers and organisations as places to engage, get information. Some commented that everyone needs to take ownership for their personal contribution to their local community.

4.30 Learning from mistakes is important. One example demonstrated an initial lack of understanding of the needs and abilities of an individual; but the willingness of the organisation to listen to the person who uses the service, the carer and be flexible was commended. The carer concerned had provided a source of expertise to the organisation to enable them to improve the quality of their service.

What hinders

- Lack of a can do attitude.
- A lack of understanding of the principles of the Social Services and Well-Being (Wales) Act around "what matters to me".

Good examples / ideas about making it personal and working together

- Young carers who work with the organisation (Action for Children, Barnardos) to design activities and events.
- Work with the people who work with the community e.g. pharmacies, doctors, postmen ... so that they are able to signpost people. Give them an iPad or other form of Smart Phone technology with information and ways to push information through to the relevant organisation or service.

5. Staying Engaged

5.1 People who came to the events felt they were valuable and wanted to stay engaged. When asked how they wanted to be kept informed about developments, they put forward a broad range of ideas. These were:

- Email
- Group meetings – another community panel
- Face to face carries a bit more weight and helps shares people's experiences.
- Videos
- You tube
- A freshers week for communities or wards or towns
- Information markets - something that used to happen
- Information boards in supermarkets, GPs, doctors surgeries, hospitals, libraries, charities based within the area
- Radio
- Newsletter
- Social media
- A share point as in software to share resources and gather comments.
- Posters displayed in dentists, DWP buildings, libraries, homeless shelters, churches and other religious settings

5.2 There were offers of future support from people who attended. "If we know about future design / consultation groups we could hopefully join ones that we are interested in and encourage wider engagement from our community; "I would like and I would offer to run something for people with dementia given enough notice".

Appendix 1

Dear Colleague,

CWM TAF REGIONAL PLAN - 2018-23

As an integral part of the Cwm Taf Social Services and Wellbeing Partnership Board's work to respond to the findings of the Cwm Taf Population Assessment published in April 2017, we are committed to involving citizens throughout the process. A Regional Plan has been developed and we are now at the stage where we wish to test the priorities and actions identified within the plan, with people who live in Cwm Taf.

We have asked an independent team to facilitate three Community Panels across the Cwm Taf region during December 2017. These groups are to be made up of individuals who have experience of using health and social care services, or who are carers of people who use health and social care services and I would be grateful if you could raise awareness of these events within your networks.

Each Community Panel event will host between 30 – 50 people and will take place on the following dates:

Date	Place	Time
11th December	Abercynon sports centre, Parc, Abercynon, Mountain Ash CF45 4UY	10 am -12:30pm
12th December	Rhondda Heritage park hotel, Coedcae Rd, Pontypridd, CF37 2NP	12:30 pm - 3:00pm
15th December	Canolfan Soar, Pontmorlais W, Merthyr Tydfil, CF47 8UB	10 am -12:30pm

The priorities and actions within the Regional Plan will have relevance to all people who access care and support services in Cwm Taf and we are seeking a cross section of views. It is likely that each session will last about two and a half hours.

It will not be necessary for participants to have knowledge of the work of the Cwm Taf Social Services and Wellbeing Partnership Board, but to have knowledge and experience of engaging with health and social care services, and a willingness to participate.

An organisation called Practice Solutions are arranging the Community Panels. People can register their attendance to attend one of the events by contacting Katie Lineham at Practice Solutions, by **Wednesday 6th December**. Her email address is:katie@practicesolutions-ltd.co.uk
and her phone number is 01443 742384.

You are welcome to use Welsh at the meeting, let Katie know when registering and please confirm any additional communication or access requirements.

Yours sincerely,

Sian Nowell
Head of transformation - Cwm Taf Region

CWM TAF REGIONAL PARTNERSHIP

COMMUNITY PANELS FACILITATION DECEMBER 2017

Background paper and basis of group work

The Social Services and Wellbeing Partnership Board consists of the Cwm Taf University Health Board and both Rhondda Cynon Taf and Merthyr Tydfil Councils.

The Regional Plan sets out how they will respond to the findings of the Cwm Taf Population Assessment published in April 2017. It is a five-year plan, which outlines the range and level of services to be provided in response to the needs for care and support identified in the population assessment. The Partnership Board must prioritise the integration of services in relation to:

- Older people with complex needs and long-term conditions, including dementia
- People with learning disabilities
- Carers including young carers
- Integrated Family Support Services
- Children with complex needs due to disability and illness

The Population Needs Assessment emphasised the need to look at the whole person and not just one problem they might experience and we know that more work needs to be done locally to improve services for people with physical disabilities and sensory impairments.

Our plans for older people and mental health services have been developed together to support people with dementia effectively. In relation to children's needs, issues relating to mental health, domestic violence and substance misuse are also relevant. The involvement of housing and education alongside health and social care services has also been considered.

The priorities and actions within the area plan will be reviewed annually to monitor progress. They will be amended as appropriate, to ensure that we empower and enable people in Cwm Taf who need care and support to live the best lives they can and achieve the outcomes that matter to them.

The Driving Force for Change

The Social Services and Well-being (Wales) Act (2014) sets out a challenge to reshape the way communities are supported by statutory organisations. We must make a radical change in our "offer" to individuals, families and communities; supporting them to take responsibility for their own health and well-being. We must shift our emphasis from reactive long term (often institutional) services to an approach which promotes choice, dignity and independence. it is important to recognise the assets and strengths that people bring to their own health and social care, and to their communities and networks

Working to co-produce positive outcomes for adults

The starting point is to emphasise the key role of families and communities in offering support and care to their members. All our citizens are surrounded by a network of family, friends and neighbours that influence their quality of life. They in turn contribute to the community in which they live.

Our role is to complement these networks by supporting people to continue to live fulfilled lives, and when they need it, to help them tackle life problems (e.g. ill-health, bereavement, becoming socially isolated). This is important not only for the individuals concerned, but for the resilience, wellbeing and development of our communities.

Accessing advice, information and assistance

We need to make the right services available to people at the right time. Where individuals, their families and carers may require care and/or support from more than one organisation this should be effectively coordinated and delivered. By doing so we can support people as soon as they need it, help them to remain happily within their family and community, and for some, avoid expensive and disruptive specialist and substitute care. If this done successfully, over time we can also take some resources out of specialist and substitute care and into better community and universal services.

Working with children and young people

We plan to improve the way we work partnership with local children, young people, their families and communities. We will work to involve them in decisions about their life which helps them to achieve personal outcomes, build on their strengths and become resilient.

We want to work collaboratively in, and with communities to develop the best possible environment for children and young people to thrive in Cwm Taf

We want to focus our intensive support on those children and young people who need help to deal with significant adverse experiences.

Acknowledging the role of Carers

Carers of all ages will be identified, and the contribution of their caring role recognised by professionals and the public. They need to be involved in decisions that affect them and the person they care for.

We want Carers, of all ages to have a voice with more choice & control over their lives. They should be involved in, and consulted on issues and decisions that affect their daily lives and the lives of the person they care for. Carers should also have a say about the design of future services that affect them.

We want to work positively with Carers of all ages by ensuring they have access to advice and assistance that provides up to date, relevant and timely information and access to the right services at the right time in the right place.

There should be support, services & training to meet the needs of Carers of all ages available. Carers should be able to maintain their own physical and emotional health and well-being and take up education, training and employment opportunities. They should also be able to participate in activities outside their caring role.

Appendix 3

Time	Task	Tools	Who
10.00	Welcome Write down what you expect from today?	Post it notes Flip chart paper Pens	Sarah Dafydd to lead Team support
10.05	Presentation – the context	PowerPoint presentation Laptop/Projector	Nicola/Gio
10.25	Write down/tell us what you think about the presentation	Post it notes to be collected and displayed on flip chart paper	Dafydd to lead
10.30	Group discussion 1 • **Getting information, advice and assistance** • **Stopping problems before they start** • **Stopping problems before they get worse** **Stage1:** Give an example of where has worked well? Using those examples of what's worked well. **Stage 2:** What would good look like? i.e. Where would it be? /Who would be using it? What would happen?	Flip Chart paper Pens for groups	Facilitation teams
11.05	Refreshment break		
11.15	Feedback – conversation highlights in relation to: • **Getting information, advice and assistance** • **Stopping problems before they start** • **Stopping problems before they get worse** **Stage 3: Brief** Discussion about what's feasible versus desirable.	Flip chart paper displayed around the room	Dafydd to facilitate discussion
11.25	Group discussion 2 **Connecting you to your community** **Seamless services**	Flip chart paper, pens and post it notes	Facilitation teams

	Making it personal and working together with you **Stage1:** Give an example of where has worked well? Using those examples of what's worked well. **Stage 2:** What would good look like? i.e. Where would it be? /Who would be using it? What would happen?		
12.00	Feedback Feedback – conversation highlights in relation to: **Connecting you to your community** **Seamless services** **Making it personal and working together with you** **Stage 3: Brief** Discussion about what's feasible versus desirable.		Dafydd to facilitate the whole group discussion
12.10	Tell us how you want to be kept informed with the plan. What works? Group discussion		Facilitation teams
12.20	What next? – short presentation	PowerPoint and laptop	Nicola
12.25	Have expectations been met?		Dafydd
12.30	Close		