Cardiff & Vale of Glamorgan Regional Partnership Board Development Session

15th September 2017
Welcome

Cllr Susan Elsmore

Chair of the Cardiff & Vale of Glamorgan Regional Partnership Board
Ffrind I mi/Friend of mine

Cardiff and Vale Regional Partnership Board

15th September 2017

Tanya Strange MBE, Divisional Nurse, Primary Care
Aneurin Bevan University Health Board
“We have to stop dishing out the pills…”

✧ **GP’s and SSAFA**

✧ **2015 - 79.5 million** prescriptions in **Wales**

✧ **5 million** were **anti-depressants** – more than **double** previous decade.

✧ **2016 - 30% increase** in anti-depressants prescribed to **children** in Wales

✧ Public Health Issue- **Loneliness Kills**

✧ ‘**Compassionate Communities’** Public Engagement Event (May 2016)

✧ **Loneliness Inquiry 2017**
What people told us (film)

Sarah Rochira - "The reality for our older people across Wales is that time is their enemy too, but for different reasons, not because there isn't enough but because there almost seems to be too much of it.

- Older People's Commissioner

Joan Watkins - "Loneliness is insidious. It's a very secret thing. It's an epidemic and as a society we should be working together to support those who are vulnerable.

- War Widow

Sarah Adams - "I can feel so lonely even in the most crowded of places.

- Mum of James, a fallen soldier

Febin Varghese - "I was very lonely when I moved here from India. I had no friends and no family. I could Skype my parents but it just wasn't enough.

- Registered Nurse (Migrant Worker)

Hugh Irvin - "Pills are not the answer. We need to ask people if they are lonely and what would help. People need people, they need purpose in their lives.

- Manager - Thrive United Welsh

Caroline Bovey - "There is a lot of discontent a lot of prejudice a lot of bias and a lot of bigotry still very much present in British Society. This can lead people to become socially isolated.

- Chair, ABUHB LGBT Committee

Rob Wiltshire - "No-one understands a soldier, like a soldier understands a soldier. We like to speak to people and say what we have seen.

- Former Royal Marine

Alan Morgan - "I'm lucky. I'm one of the lucky ones, I've found my solace, it's cost me dearly, but I've found it.

- Retired Postman

Andrew Finney - "I have a toy snow leopard at the end of my bed. I talk to him all day. I don't have anyone.

- Former Royal Marine

Dr David Minton - "I've seen it.

- Former Royal Marine

Danny Daniels - "I served 39 years in the army.

- Former Royal Marine

Martin Turner - "I spent 37 years in service.

- Former Royal Marine

https://www.youtube.com/watch?v=yJyd2m01sjY
Ffrind i mi: a social movement

Some examples of low cost/no cost meaningful activity............
#CountMeIn Challenge

“Blind date” approach to befriending

Persons Interests

Volunteer Interests

Match

A Volunteering Opportunity

Would you like to volunteer to support someone who is lonely or socially isolated?

Ffrind i mi/Friend of Mine is a partnership approach to combating loneliness and social isolation across our communities. Loneliness can affect anyone, at any time and at any age.

Ffrind i mi/Friend of Mine provide a robust volunteer recruitment process, all our volunteers will have:
- DBS check at no cost to the volunteer
- Occupational Health Check
- Reference check
- Free training
- Volunteer Peer Support

If your organisation is willing to support staff volunteering we will happily visit you in the work place to:
- Talk about Ffrind i mi/Friend of Mine
- Provide training
- Support with the application and DBS process

For more information please contact the Ffrind i mi/Friend of Mine team:

- 01495 341257
- Ffrindimi.obb@wales.nhs.uk
- www.ffrindi.mi.co.uk
- @Ffrindimi
"We need one point of contact"

www.ffrindimi.co.uk
“Keep talking and raising awareness of loneliness”

@FfrindIMi

- **GP CPD**
- **Forums** - veterans, carers
- National NHS **Confed**
- **International** RCN Conference
- **International** IHI Quality and Safety Forum
- **C&V** Health and Social Care Partnership
- **Inclusion** on PSB well being priorities
- **National Commissioning Conference (Derby Oct 17)**
Meaningful Activities for Wellbeing

"Bingo and Beyond!"

Compassionate Communities Inspiring Meaningful Days
Pontypool Active Living Centre, Trosnant St, Pontypool NP4 8AT
Friday 20th October 2017, 09:45am ~ 16:00pm

Meaningful days matter to everyone. Being involved in meaningful activity allows us to meet some of our most basic needs, such as socialisation, giving us a sense of purpose and stimulation. Opportunities for arts and creativity, digital communication, learning new skills, physical activity, volunteering and befriending can all provide meaningful activity. Activities also give us a sense of belonging when we participate with others.

However, for some people, especially older people, there are few meaningful days which means there is often little to look forward to. As a compassionate community, we need to add quality and value to people’s lives.

Our "Bingo and Beyond!" engagement event will bring people together to talk about meaningful days. If you work with people who are benefitting, or would benefit from more meaningful activities, or know others who would like to participate, please come and join us.

On the day you will be able to:

- Hear what people have said and recognise why things need to improve
- Gain a better understanding of what ‘meaningful activities’ really means
- Take part in discussions about positive activities including intergenerational befriending
- Help us to identify any barriers and what we can do together to ‘break’ them
- Join our ‘Bingo and Beyond’ challenge!

A light lunch and refreshments will be provided.

To confirm your place, please contact Karen Munro. Please RSVP by 30th September.

Email: Karen.munro@wales.nhs.uk
Telephone: 01495 241280
“More than just words”

Capel United Reformed Church
Y Fenni/Âbergavenny

Clwb Scrabble Dwyeithog/
Bilingual Scrabble Club

Pob Dydd Iau/Every Thursday
yn dechrau(starting)

Rhagfyr 1 December 2016
2.30 pm

Croeso cynnes i bawb/All welcome

Welsh Language Showcase National Conference
Sensory/Intergenerational Befriending

Hush Club

ACTION ON HEARING LOSS
CYMRU
A national charity since 1911

www.actiononhearingloss.org.uk/wales
ActionOnHearingLossCymru
@hearinglosscym

BRITISH SIGN LANGUAGE - FINGERSPELLING
british-sign.co.uk

RIGHT HANDED

Coleg Gwent

‘Mums without mums’

Sight Cymru
Dementia Specific

- No Grey Dementia Day: ‘Pimp My Zimmer’ Campaign
- International/Global Research
- Peer Support- “We get it!”
- Volunteer “Explorers”??
Going forward - still so much to do!

- Outcomes / **Research** / antidepressant **prescribing**

- **Trademark**

- Clinical **Assessments/Discharge** planning

- **Armed Forces:** homelessness/employment/wellbeing

- **Others:** Carers/LGBT/Migrant Workers/Childless etc

- Public Sector Volunteering? *(PSB’s) ‘Business in the Community’*
Thank you - Questions?

01495 241257

tanya.strange@wales.nhs.uk
Ffrindimi.abb@wales.nhs.uk

www.ffrindimi.co.uk

@FfrindIMi @strangetanya
Preventative Services and First Point of Contact

Carolyne Palmer
Operational Manager, Preventative Services, Cardiff Council
What was the issue?

- Based on data from the 2011 Census and WG forecasts, by 2035 the over 65 population of Wales is projected to increase 25% and the over 80 population by 40%.

- Limited consideration of alternative solutions to social care.

- Social Care far too often seen as the go to solution and cultural shift in thinking was required.

- No joined up approach to delivering alternative outcomes to retain independence.
Previously, access to the same services would have resulted in several contacts by the client to the Local Authority. It is now done in one!
What have we done?

• Expanded services to work in partnership with GP surgeries and frontline clinicians to encourage social prescribing.

• Overcoming barriers & working co-productively with colleagues in Health with shared outcomes.

• Using client feedback to tell us what they want in their communities.

• Started a cultural shift from dependency to independence.
What are the successes?

2016/17

- **70%** of new cases dealt with at first point of contact through alternative solutions to social care, compared to **30%**, 3 years ago.

- Sustained domiciliary care demand over the last 4 years.
Successes
2016/17

1,232 bed days avoided through use of Step Down.

OT’s identified actual savings of £262,000

70% of new cases dealt with at first point of contact, compared to 30%, 3 years ago.

4,464 Alternative Solutions found:
- Identification of £4.3 million in unclaimed benefits
- Low level aids
- Reducing social isolation

72% of people feel reconnected with their communities.

99% of customers felt able to remain living at home independently

95% of clients felt the Service had improved their quality of life

99% of clients were satisfied with the service provided.

Partnership working—moving from silo’s to joint focussed outcomes

Housing staff in the Hospital to address housing issues on the ward, reduce/avoid DTOC

Reduced delivery times of DFG’s, through partnership working with Occupational therapy from 247 days to 180 days.
What are the successes?

2016/17

What Clients have said:

What a very good idea this is, we love being in our home and most of all being independent.

Help to me has been invaluable, she has opened up my world, I cannot thank her enough.

Friendly, helpful and so informative.

The people who have visited us have been so good; you would love to have them as part of your family.

Extremely helpful, down to earth and knowledgeable – a credit to you.
What have been the challenges?

• Different ICT and differing information sharing policies have and do cause delays in service delivery.

• Developing trust with partners was difficult in the early stages, but demonstrating positive outcomes and effectiveness of services, the trust has been built and sustained.

• The non-recurrent nature of initial funding via the Intermediate Care Fund caused challenges in securing appropriately skilled staff and in managing turnover.

• A risk-averse culture that can limit opportunity for innovation.

• Encouraging a social prescribing approach.

• Bestowing the benefits of preventing entry to hospital against discharge.
What next?

• Enhance triage for the provision of adaptations using the principles of ENABLE therefore reducing the demand on OT’s and the provision of adaptations in a more timely manner.

• A review of the OT service covering community and hospital roles and how they can compliment each other, improving focus on getting the client home at the earliest opportunity.

• Development of a Hospital to Home service that ensures patients return to a safe environment with their housing and wellbeing needs met in tandem.

• Investigate and develop in partnership with Health a contact system similar to First Point of Contact.

• Establishment of a new Joint Equipment Service specification with partners, development of a same/next day delivery mechanism and extended opening hours.

• Developing a new suite of services provided by health, 3rd Sector and community groups using existing council buildings such as sheltered accommodation communal areas.
An Ounce of Prevention is Worth a Pound of Cure
- Benjamin Franklin -
Single Point of Access

Tony Curliss
Operational Manager for Customer Relations, Vale of Glamorgan Council
What was the issue?

Need for: Right Service, Right Place, Right Time

• **Complicated referral processes:**
  – “Scattergun Approach”.
  – Duplication of effort.
  – Increased costs.
  – Potential for delay.

• **Increasing demand for services:**
  – Issues with delayed access to services.
  – Increasing costs of managing demand.

• **Changes in citizen expectations and behaviour.**
Objectives

• **Simplify Referral process for practitioners & citizens:**
  – Reduce duplication.
  – Reduce risk of delayed support.

• **Improve access to services – regardless of citizens needs:**
  – Reducing “customer effort”.

• **Improve speed of response.**

• **Maximise First Contact Resolution:**
  – Reducing need to refer citizens on to other services.

• **Increase efficiency and reduce operational costs.**
What have we done?

What is SPOA?

• **Single Point of Access is a multidisciplinary / cross organisation service** co-located in a single, open plan environment sharing contact centre technology.

• **Technology allows for better demand management, citizen self service and improved citizen experience.**

Partners

• **Cardiff and Vale University Health Board – Communications Hub.**

• **Vale of Glamorgan Council Adult Social Services.**

• **Vale of Glamorgan Council Customer Services.**

• **Third Sector Broker (Age Connects).**
Services available at SPOA

Health

• District Nursing (C&V)
• Podiatry Booking Service (C&V)
• Vale Community Resource Team (Vale)
• Continence Service (C&V)
• Wound Management (C&V)
• Treatment Room Booking (C&V)
• Elderly Care Assessment Service (Vale)
• Emergency Dental Line (C&V)

Social Care / Council

• Adult Service Intake & Assessment Team
• Revenues & Benefits
• Shared Regulatory Services Partnership (C&V)
• Environmental Services
• Housing & Homelessness
• Housing Adaptations
• Blue Car Badge
• Concessionary Travel Passes
• Telecare
• Electoral registration
• All other council services
• 72% First Contact Resolution

IT DOESN’T MATTER WHETHER THE CITIZEN WANTS ONE, TWO OR ALL OF THESE SERVICES – THEY CAN BE ACCESSED IN A SINGLE ENQUIRY
What have been our successes?

• **Holistic approach** – address broader wellbeing needs, sharing information and guidance with health colleagues.

• **Sharing technology** – maximising use of existing resources and can facilitate more integrated working.

• **Information provision and signposting**.

• **Faster response to emergencies** through the Intake & Assessment Team.

• **Management of increasing demand** for services – using contact centre economies of scale and flexible resources.

• **Managing costs** at point of contact.

• **Integrated Health & Social Care response**.
District Nursing

Call Volume

<table>
<thead>
<tr>
<th>Year</th>
<th>Call Volume</th>
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<tbody>
<tr>
<td>2013/2014</td>
<td>105,000</td>
</tr>
<tr>
<td>2014/2015</td>
<td>110,000</td>
</tr>
<tr>
<td>2015/2016</td>
<td>90,000</td>
</tr>
<tr>
<td>2016/2017</td>
<td>100,000</td>
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Actual requests:

<table>
<thead>
<tr>
<th>Year</th>
<th>Actual requests</th>
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<tbody>
<tr>
<td>2013/2014</td>
<td>80,000</td>
</tr>
<tr>
<td>2014/2015</td>
<td>85,000</td>
</tr>
<tr>
<td>2015/2016</td>
<td>90,000</td>
</tr>
<tr>
<td>2016/2017</td>
<td>95,000</td>
</tr>
</tbody>
</table>
Average Daily Social Care Service Requests per Quarter

Q1 14/15: 20
Q2 14/15: 23
Q3 14/15: 29
Q4 14/15: 34
Q1 15/16: 31
Q2 15/16: 30
Q3 15/16: 30
Q4 15/16: 33
Q1 16/17: 34
Q2 16/17: 32
Q3 16/17: 33
Q4 16/17: 35
Q1 17/18: 32
Q2 17/18: 31
Adult Services - % Enquiries v Referrals
Scenario

- Mr and Mrs S are both over 90 years old. Mrs S is virtually blind and her husband has progressive dementia and other chronic conditions. Despite her visual impairment they have always been very independent and able to care for each other until recently when they reached a crisis point. Mrs S realised then that they need help if they were to carry on living independently.

- The referral / request for help came via the district nurse line, this was highlighted to the nurse based on the hub and discussed.

- She was interested on information and support on how to better manage her husband’s Alzheimer’s Disease, they needed assistance with personal care, domestic chores and any social events that would alleviate her role as his main carer whilst maintaining social activities.
Call Handler

MDT

Social Services
Assessment visit arranged to both Mr and Mrs S to determine any care needs, level of mobility, level of Ability with DLO's etc. Risk assess. Support with household chores and laundry. Shopping to be undertaken. Explore the possibility of day centre attendance for both possibly Rondel House. Intervention with visual impairment social worker for help and advice. When care authorised arrange agency with capacity to start care. Refer to Crossroads Care who can assist with Mr S and counseling for Mrs S as his carer. Signpost to Age Connects for befriending service. Request financial assessment from VOGC community care finance team. Care to be put in place and reviewed accordingly.

Health
Spoke to Mrs S to gather more information and gain consent to share. Identified problems that Mr & Mrs S are currently struggling with and assess what support is required.

Brought together a MDT within the department in a timely matter.

It was identified they were struggling with continence issues – continence assessment requested Commode ordered to be delivered

DN contact number provided should further intervention be required

Third Sector Broker
Contacted Mrs S to further ascertain needs and gain consent to make referrals to:

**Age Connects** → Coordinator of the Good Neighbour Scheme visited and carried out holistic assessment → Information on social activities provided, befriender volunteer matched and help with transport to/from health appointments offered, if needed.

**Alzheimer’s society** → Support worker visited providing information on condition management, tracking device and on local Dementia Café. These professionals liaised to organise transport for them to attend dementia Café, if they wished.
What have been the challenges?

• **ICT** – Health and Council staff using different networks and applications. Has been resolved to some extent but still some issues

• *Increase in demand* for services

• *Pressure on budgets*

• *Competing priorities* for same resource

• *Information sharing.*
What next?

- **Improve IAA process** to increase signposting at first point of contact
- **Reviewing resource structure** to enhance integrated working
- **Rationalise points of access** – reduce telephone numbers
- **Investment in customer contact technology** to support online self-service, web chat, social media, and operational efficiency
- **Grow the Service** to maximise value to our citizens and partners.
Wellbeing 4U

Karen Tipple
Specialist Housing and Wellbeing Lead, United Welsh
What was the issue?

• Cardiff and Vale University Health Board commissioned service

• Improving the links between GPs and the community to deliver public health priorities and enhance a social model of care

• Key Outcomes:
  – Increase in immunisation levels amongst hard to reach communities
  – Increase in screening levels amongst hard to reach communities
  – Increase in use of local community activities for patients
  – Reductions in inappropriate use of GP services
  – Reductions in referrals to social care
What have we done?

Patient Journey

- Patient Referral – GP / Self Referral
- Wellbeing 4uTeam in GP Surgeries
  - Signposting / Advice
  - Wellbeing Support
  - Wellbeing Coach
    - Community Health Walks / Food wise / Confidence Building
- Social Prescribing Partner Identified

3rd Sector
- Local Authority
- Educational Programmes
- Local Community
What are the successes?

838 referrals from GP

612 signposting's
490 follow through
What are the successes?

Other engagements:

- Community workshops 317
- Immunisations and screening 395
- Other opportunistic interventions 156

<table>
<thead>
<tr>
<th>Services</th>
<th>Number</th>
</tr>
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<tbody>
<tr>
<td>Community workshops</td>
<td>317</td>
</tr>
<tr>
<td>Immunisations and screening</td>
<td>395</td>
</tr>
<tr>
<td>Other opportunistic interventions</td>
<td>156</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1706</td>
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</tbody>
</table>

Numbers of patients referred / engaged

![Bar chart showing numbers of patients referred/engaged]
What are the successes?

Patient Feedback

“I am so happy I came to a wellbeing meeting to meet you, it’s been the best decision I have made. You are a wonderful organisation and it is doing wonders for me.

I feel like I'm being listened to for the first time ever and you have been great sorting out my needs and help for me. To be honest it's been the first time ever that I feel I'm getting real help with wellbeing.

The people are truly amazing - you are doing a fantastic job and have actually listened and have provided me with the best service anyone could ask for, so I would like to say thank you from the bottom of my heart for everything you have done and are still doing.”
What are the successes?

Patient Feedback

“I’m so happy that my GP referred me to the Wellbeing service. After telling them about my life in recovery and what’s important to me they put me in touch with a local church coffee morning.

I’m a committed Christian and thanks to making that connection I’ve made friends in the group and I also regularly attend church meetings on a Thursday and Sunday as well. I feel this has been a lifeline.

My confidence is growing and I don’t feel so lonely, in fact I feel I’ve met people who genuinely care about me and want to help me.

I’ve also been doing the EPP confidence-building course run by the Wellbeing service and met a lovely group of people. It’s good to meet people who also experience anxiety and depression and learn new ways to cope.

We’ve all grown and developed as a result and we think the team is wonderful. We really enjoy ourselves and have a good laugh too!”
What are the successes?

Third Sector Feedback

CDF Charity – Church charity running Coffee & Co and Make & Meet

“Rhian has been my main contact with the Wellbeing team and she has been an exceptional person to deal with. Her passion for the wellbeing of her contacts and help, advice and assistance she is prepared to give has given our community work a great boost.

Also, she has helped me to focus on what matters to the community in the area of wellbeing. This has particularly helped with some individuals who are currently being helped to cope with loneliness and reintegration into society from a life of addiction.”
What are the successes?

GP Feedback

The service started in July 2016 and gathered strength as time progressed. I place Wellbeing 4U support as a very important addition to our core services to the most vulnerable patients in the community.

The Wellbeing 4U team proved to be very efficient in helping people with various social difficulties. Their help and support made a big difference to the life of those patients in need of help.

Wellbeing support is fundamentally important; it fills a gap in supporting mental health problems created by social-economic difficulties which cannot be dealt with either by a Counsellor or Psychiatrist. Accordingly Wellbeing 4U is fundamental to primary care and I commend them to continue indefinitely as part of primary care support team."
What are the successes?

Case Studies:

Patient A
- Reduction in GP visits (estimated reduction from 20 to four in a 12 month period): £736 per year
- Treatment for depression and anxiety for A: £977 per year
- Cost of mental health support (including conduct and emotional disorders) for a young person: £271 per year
- Average cost of residential nursing care for A’s father: £25,056 per year
- Cost saving as a result of A providing home care for her father: £6,942

Total estimated savings: £33,982

Patient B
- More complex mental health treatment - £2,148 per annum
- Alcohol treatment - £1,962 per annum
- Reduced GP appointments by 4 in a 12 month period - £180 per annum

Total estimated savings: £4,290
What have been the challenges?
What next?

- Re commissioning process
- Impact report
- Increase remit – ACTion for Living and Stress Control Course
- Develop Health Coach role further
- Further targeted work with ‘at risk’ groups
- Expand into additional surgeries
- Address issues regarding sharing of information
- Software to track signposting outcomes
- Further data analysis
Delivering Information, Advice and Assistance (IAA) to Children, Young People and their Families in Cardiff and the Vale of Glamorgan

Rachel Evans
Head of Service, Vale of Glamorgan Council

Daniel Jones
Operational Manager, Multi-Agency Safeguarding Hub (MASH), Cardiff Council
What was the issue?

• Provision of an IAA Service is a duty introduced by the SS&WB Act.
• Intended to promote prevention and early intervention.
• Offers a first point of contact with the care and support system.
• Should be accessible and available at the right time for people who need it, in a range of formats and through a range of channels.
• Must be transparent, comprehensive and impartial, to promote understanding of the options available and to enable informed choices.
• Requires the completion of proportionate assessments, with the exception of information provision where no assessment is required.
INFORMATION AND ADVICE IN CARDIFF
What have we done?
Cardiff Early Help Strategy: putting together the pieces

The strategy identifies how we can all work together, share information and put the child and family at the centre to ensure they receive the right support, in the right way at the right time.

It provides guidance for anyone who works with children and young people and their families in Cardiff.
Working across the spectrum...

**Prevention**
- **Families With No Additional Needs**
  - Receiving Universal Services
  - e.g. schools, health care

**Protection**
- **Families With Additional Needs**
  - Receiving targeted resources for either singular or multiple needs
  - e.g. involved in anti-social behaviour or school truancy, or at risk of abuse or neglect

**Remedy**
- **Families with Complex Needs**
  - Receiving Statutory or Specialist Services
  - e.g. Looked after children
Cardiff Early Help Strategy

Strategic Outcomes

1. To reduce the number of children, young people and their families requiring support at the “remedial” end of the Cardiff continuum of support to families

2. To narrow the gaps for Cardiff children and young people at risk of poor outcomes and their peers
The impact will be wider than Children’s Services:

- Reducing the number of young people who disengage from education – improving attendance and learning
- Improving health and wellbeing
- Reducing the number of adults who are unemployed
- Reducing the number of young people entering Youth Justice
- Reducing the incidence and impact of domestic abuse and substance misuse
- Tackling poverty
Implementing the Strategy

• Improving the range and effectiveness of Early Help, Information and advice; getting the right services at the right time
• Improving the effectiveness of step up and step down pathways.
• Re-designing the delivery model for social work support and interventions using Signs of Safety beginning at the Front Door.
• Promoting kinship care.
• Breaking the cycle of LAC.
• A commitment to assess and support Young Carers.
Current Developments

• Refocusing the Early Help Information and Advice service to reduce referrals to MASH

• JAFF [Joint Assessment Family Framework] Pilot completed and being reviewed within Signs of Safety model implementation.

• Strengthening information about support for families – clearer processes and pathways for families and professionals to get support

• Central point of access – Early Help Front Door telephone service to launch this October.
Draft model for Support4Families@Cardiff

Co-location of front door staff from contributing teams on a rota basis
Single Freephone number/text service
Staff available to answer calls:
- Monday to Friday, 9.00am until 7pm
- Saturday, 10.00am until 1.00pm

Cardiff Team Around the Family / Early Help Front Door Service
- TAF workers complete JAFF with families and provide signposting and key working as needed
- TAF process and risk reduction for families with more complex needs (review criteria – more flexible than pre needs)
- Vulnerability Assessment Profile used to screen in schools (extended to primaries – also to youth mentoring)
- Support practice of others completing JAFF (e.g. other FF workers and school engagement officers)
- Outreach sessions in Foodbank and Hubs

Disability Team Around the Family
- DTAF workers complete JAFF with families where issues mainly relate to disability and provide key working
- ‘Better Than a Booklet’ stand at St David’s Hospital
- Support for practice in Special Schools

Childcare Strategy and training
Young People’s front door (One Stop Shop for 16+)
Parenting Services and Triage

Family Information Service:
- Maintenance and updating of FS website
- Support for Dewis
- Childcare duty
- Disability Index
- Outreach/info stands

Health front door?

Children’s Services:
- 2 x social worker advice and guidance
- direct links to MASH

MASH
I&I and targeted teams

2 x DTAF workers to deliver Better Than a Booklet
2 x DTAF workers to link with special schools
2 x DTAF workers to link Cardiff South East and schools
Family workers to link Cardiff West and schools
Family workers to link Cardiff South West and schools
Family workers to link Cardiff South and Central and schools
Family workers to link Cardiff North and schools
Family workers to link Cardiff East and schools
Family workers to link Cardiff South East and schools

2 x DTAF workers to deliver Better Than a Booklet
Between 01/03/2017 - 31/08/2017 MASH received **12,521** Contacts of which **1,365** were signposted to early intervention.

This equates to **10.9%** of all contacts received during the 6 month period have been signposted to Early intervention.

% of Contacts Signposted to Early intervention by Source between 01/03/2017 - 31/08/2017

- Police, 37.58%
- Primary health / Community health, 19.63%
- School, 13.48%
- Probation, 1.83%
- Other Agency, 8.79%
- Other Departments of own or other LA, 3.81%
- LA Housing Dept. or Housing Association, 2.05%
- Local Authority's own Social Services Dept., 3.74%
- Other Agency, 8.79%
- Friend/Neighbour, 0.73%
- Secondary health, 0.51%
- Family, 7.40%
# What have we done: IAA in the Vale of Glamorgan

<table>
<thead>
<tr>
<th>Information</th>
<th>Advice</th>
<th>Assistance</th>
</tr>
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<tbody>
<tr>
<td><strong>What we do</strong></td>
<td>Exploring options with the person</td>
<td>Taking action with the person</td>
</tr>
<tr>
<td>Providing data to the person</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information is quality data that provides support to an individual or family to help them make an informed choice about their well-being.</td>
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<td><strong>How we do it</strong></td>
<td>Telephone help or enquiry lines, one stop shops, walk in centres, assessment team, front line workers etc</td>
<td>Making contact, completing forms, transport, accompanying the person</td>
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<td>Leaflets, websites, libraries, Citizen Advice Bureau, directories, telephone lines, support group, one stop shops, front line workers, etc.</td>
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<td><strong>Who does it</strong></td>
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<td><a href="http://devicymru.org.uk">Devis Cymru</a></td>
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<td>Devis Cymru is the place for information about well-being in Wales. They have information that can help you think about what matters to you, along with information about local organisations and services that can help.</td>
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<tr>
<td>[Vale Family Information Service](tel:01646 704794)</td>
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<td>The Vale Family Information Service (VFS) provides information and guidance on childcare, activities and services for children and young people and family support services in the Vale. This includes: registered and unregistered childcare, parent &amp; toddler groups, holiday schemes and leisure activities, benefits for parents and help with childcare costs and services for children with disabilities or additional needs.</td>
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<tr>
<td>[Intake &amp; Family Support Team](tel:01446 722002)</td>
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<td>The Intake and Family Support Team are the first point of contact for anyone raising new concerns about the welfare of a child or new information about a child already known to the team. The team provides an assessment service as well as signposting to other appropriate services.</td>
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<tr>
<td>[Young Carer and Parent Carers](tel:01446 722002)</td>
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<tr>
<td>Care assessments for young carers (aged 7 – 18 years) and parent carers, can provide guidance and support to a carer in their own right. An assessment may include signposting, information, advice and consider any current or future transitions into further or higher education, employment or training.</td>
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**NB:** If needs cannot be met following IAA then they can go on to a specialist, social work care and support assessment.
IAA in the Vale of Glamorgan

Information, Advice and Assistance

Advice and support on family issues (FFAL)

Information about childcare, activities, groups and services and the Disability Index (FIS)

Welfare and safeguarding concerns (Duty function, Intake and Family Support Team)
• Developed by the Families First Management Board in response to increases in demand and as a mechanism to promote the provision of timely and effective support to families.

• Being considered going forward as the potential to become the single point of access to Families First services.
What are the successes?

- Received 966 calls since its inception in August 2015; 623 from parents, 343 from professionals.
- 9% of these calls have been received from Social Services.
- Only 4% of calls have been referred to the Families Achieving Change Together (FACT) – the Vale’s Team Around the Family.
- 89% of referrals made to FACT now meet the criteria and have been accepted at TAF panel, indicating that appropriate referrals are being made and capacity to accept referrals has increased.
- Referrals between the FFAL and FIS demonstrate an increasing appreciation of where information and advice differ.
Case example – FIS and FFAL:

Initial information

• Parent (E) had contacted the FIS and shared that her daughter L (16) had taken an overdose and was enquiring about emotional support services and advice on how to manage the situation. E’s call was transferred to FFAL as a result.

• The proportionate assessment identified the following concerns:
  • L had taken an overdose whilst on holidays a few weeks ago and had received acute medical care. L had been taken to her GP upon return to the UK.
  • E shared that L had a difficult year and had stresses in her life, which had resulted in her overdose. E was looking for services that could support her daughter’s mental health.
**The outcome from the call**

- E was given information about the Emotional Wellbeing Service. E was happy to self-refer. She was also provided with the Primary Mental Health consultation number.
- Further advice was provided regarding a Teenage Mindfulness book that was specifically linked with anxiety.

**Feedback**

- E self-referred to the Emotional Wellbeing Service and contacted the Primary Mental Health consultation line, which she found very helpful.
- E purchased the book for her daughter.
Case example – FIS and FFAL:

Initial information

• FIS received an enquiry from a grandparent who had recently been granted parental responsibility.

• The grandparent requested information regarding family support following the exclusion of one of their grandchildren from their school.

The outcome from the call

• It was identified that the child had been excluded from school due to behavioural/emotional difficulties, and that the other grandchild had speech and language difficulties.

• Both children were signed up to The Disability Index as a result of their needs, and information was sent to the enquirer with details of a number of support services.
The outcome from the call cont..

- Any services registered on the Dewis Cymru website were linked to their Dewis Cymru resource in the email enquiry.
- The grandparent was also referred to the Families First Advice Line for advice and support regarding some of the other issues her family was faced with.

Feedback

- The grandparent provided the following review via social media.....
  “I recently found this service in my hour of need and I cannot thank you enough for the practical and useful advice and the signposting service to help”. 
Case example – Duty and FACT

Initial information

- Concerns were raised relating to a family’s home conditions, Mother’s health, and domestic violence between the parents who had an 18 month old child.
- The family had recently moved into their home and conditions were deemed to be on the brink of being below a good enough standard.
- Mother reported to have some debilitating health issues which impacted on her physical ability to maintain routines. Father worked long hours and the couple would argue about him being too tired and not wanting to assist with chores when at home. There was no extended family support and they felt isolated.
Case example – Duty and FACT

Outcome of the referral

• A proportionate assessment was undertaken with the cooperation of the family.

• The assessment concluded outcomes could be met through the provision of preventative service and referrals were made to Atal y Fro (support for both parents), FACT (support for parenting, routines, organising the home, and support to nurture parents relationship) and to Assisted Places for childcare.

• The child and his parents were supported to achieve their well-being through accessing early intervention and preventative services which prevented the risk of escalation to critical needs and more formal statutory interventions being required.
In Cardiff.....

- **Strengthen partnership working through regular forums and close liaison.**
- **Develop the Early Help Front Door** *(reduce inappropriate referrals to MASH).*
- **Embed the Signs of Safety model from the Front Door to permanence.*
Challenges / What next?

In the Vale of Glamorgan.....

• Implementing revised reporting lines which will place FACT (inc FFAL), Flying Start and Intake and Family Support under the same Operational Manager.

• Further developing the effectiveness of our step up/step down arrangements.

• Continuing to raise awareness amongst partners about the arrangements for IAA to promote further improvements in the use of this service.

• Furthering discussions at the Families First Management Board with regard to the potential for the FFAL to become the single point of access to Families First services.
Table Discussions

What next?

Opportunities for the Regional Partnership Board
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<th>TABLE NUMBER</th>
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<tr>
<td>Preventative Services / First Point of Contact</td>
<td>1</td>
</tr>
<tr>
<td>Single Point of Access</td>
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</table>
Workshop Questions

Q1. What is our vision for delivering preventative services in Cardiff and Vale of Glamorgan over the next 1-3 years?
   - Regionally?
   - Local authority level?
   - Locality?
   - Neighbourhood/GP Cluster?
   - Community?
   - How does this service play a part in delivering the vision?

Q2. As a Partnership, how do we increase the overall emphasis upon prevention?
   - Are we really serious about investing in these services?

Q3. What leadership role can the RPB play in helping embed this approach in our core organisations?
Feedback and Next Steps