# Adult Services Overview

## Introduction

This is Monmouthshire's first Adult Services overview report. Its purpose is to give an accurate and honest appraisal of current services in Monmouthshire and outline the priorities for improvement over the next year or so.

The comments and judgements in the report are based on a number of sources of information including hard statistical information, feedback from service user questionnaires and other anecdotal information and stories. Our aim is to present a picture that "rings true" to service users, staff and other partners. In this context, minimising difficulties and under-playing our achievements are both equally unhelpful.

We have structured the report in two ways. There are chapters covering general issues common to all groups (ie safeguarding, access, assessment and care management and carers) and then chapters for each service-user group (eg older people, mental health). By doing this we have sought to minimise duplication; even so, there are inevitably overlaps within the report.

One of the most important aspects of the report is our "judgement". Each section starts with a grid summarising how we think we are doing and this is expanded in the text.

In summary then, how are we doing in adult services in Monmouthshire? My view, as Head of Integrated Services, is that our services are mainly good, with some areas of excellence and also some gaps where services are not consistent across the board.

I see our real strengths as:

- progressing the integration agenda with Health to deliver streamlined services;
- promoting reablement approaches and other innovative models to maximise independence;
- safeguarding vulnerable people.

Our areas for improvement are:

- ensuring services are consistent across the county;
- having systems that allow us to evidence the impact of new initiatives;
- maintaining quality and innovation with limited resources.

These are my views and we would like to hear what you think. In particular, are we describing the Monmouthshire social services that you know from your experience?

**Simon Burch**
**Head of Integrated Services**

## Access, Assessment and Care Management and Review

This first section of the report picks up the process issues around access, assessment, care planning and review that are common across the service user groups.

A key issue for us is making it easy for people to access our services. We produce a wide range of public information which is available via our One Stop Shops and on our website. We are satisfied that regular service users receive appropriate information[1] but we have more to do to ensure that new users can access the information they want.

A central role for social services is assessing people's needs, working with them to put in place appropriate support and reviewing this on a regular basis. We do this through our Unified Assessment approach (Care Programme Approach within Mental Health) and are receiving positive feedback on this. For example, our community care questionnaire regularly has 90+% positive response rates to questions such as "did we take your views into account?" and "were you happy with the speed of our response?".

> *"I am overwhelmed. Really excellent service. Quick, thorough, efficient and caring."*

Our approach is based on streamlining and integrating our processes whenever possible to make it simpler and more effective for the service user. In the last year, we have made significant progress, for example we have:

- simplified our documentation so staff spend less time at their desks and more time face to face with service users;
- joined up our allocation processes so that health and social service referrals are brought together and allocated to the most appropriate member of staff;
- integrated health and social services' Occupational Therapists. This has improved the service and led to a much shorter OT waiting list;
- introduced a more targeted and proportional review system. This is helping us to improve our performance in an area that has been a concern to us. We are now completing 88% of reviews within 3 months of the due date and are committed to improving on this figure;
- introduced integrated Short Term Assessment and Reablement Teams (START);
- changed the focus of our Home Care team to reablement. They work closely with the START teams and concentrate on helping people regain confidence and skills in order to live as independently as possible.

A measure of our success is the steadily decreasing level of delayed transfers of care.

| | 2006/07 | 2007/08 | 2008/09 | 2009/10 |
|---|---|---|---|---|
| Delayed Transfers of care for social care reasons - number | 58 | 25 | 24 | 6 |

(Source: SCA/001)

During 2010 we continue to operate within tight financial constraints and also must plan for these pressures to increase over future years. We continue to offer services to people whose needs are defined as critical, substantial and moderate and remain committed to

[1] 82% say they have enough information about our services, up from 78% in 2008/09.

supporting people in the moderate category. Ways in which we ensure tight financial management include:

- all requests for residential placements and complex care packages go through our Quality Assurance panel;
- we are preparing to tender for domiciliary care to ensure we have consistent costs, quality and availability across Monmouthshire;
- we have developed a Learning Disability budget plan to manage this volatile area of expenditure;
- developments such as home care reablement, increasing the use of Telecare and the continued expansion of Direct Payments and Citizen Centred Support (see below).

Two other important areas that we have developed over the past year are:

- A transition team that works intensively with young people approaching adulthood and involves lifelong learning and leisure, careers service etc to ensure a smooth transition into adulthood.

- A Citizen Centred Support (CCS) project has been established and will move forward in 2010/11. This will enable us to look at new ways of working alongside individuals to support them in designing the types of support they require.

**Judgement**

We are proud of the progress we have made in integrating services and introducing reablement processes. This is delivering tangible results in terms of more effective responses to individual and shorter waiting lists. However, we need to be better at evidencing the benefits of these approaches. We recognise the tension as a small authority between the need to evaluate services robustly and wanting to focus scarce resources on delivering rather than measurement.

Whilst we have good access points (via One Stop Shops in each locality and a dedicated hospital line) we must ensure that public information is readily available for new and potential service users and that there are clear arrangements for contacting teams, particularly as we work in increasingly flexible and integrated ways.

We are satisfied that we are meeting our statutory requirements and providing quality assessment and care management services on the whole. Whilst our review performance has improved, this remains an area that we must monitor carefully.

| Requires significant improvement | Inconsistent | Mainly good with some gaps | Well established and effective across the board |
|---|---|---|---|
| | | ✓ | |

**Priorities for action** (also see other sections)

- Implementing the Gwent Frailty project, which will build on our current integrated arrangements.

- Continue to develop integrated allocation, assessment and care management processes
- Ensure that there are clear access arrangements in place for contacting integrated teams
- Progressing the Citizen Centred Support project.
- Increase the use of Telecare as a feature of care packages.
- Monitor reviews performance and take action as necessary.

## Services for Older People (including those with mental health needs)

Older people make up the largest group of people who receive our services. Consequently, many of the issues raised in the preceding sections relate to Older People. The number of older people in Monmouthshire is increasing and this is to be celebrated as more people remain healthy and continue to play an active part in their communities into their 80's and beyond. At the same time, people over 85 tend to be heavy users of health and social care services and our challenge is to use our resources more effectively to meet people's needs. A particular challenge is dementia in older people. This increases sharply with age and we need to provide a range of services to meet these needs. Finally, aspirations are changing and our services must focus on supporting people to maintain healthy and active lifestyles into old age. After all, Mick Jagger is now a pensioner!

*"I want to thank you all for the way you cared for my grandmother, the kindness and dignity you afforded her was wonderful."*

As described in the 'Assessment and Care Management' section, our approach concentrates on integrating our services with health and actively reabling people rather than just providing long term support. A key initiative is the Gwent Frailty Project and Monmouthshire has been at the vanguard of taking this forward.

Alongside this there has been a great deal of activity to reconfigure services for older people, including:

- a pilot scheme within Chepstow/Caldicot to bring together the community care team and older people's mental health team. This will help us understand how much potential need there is and the best ways to configure services;
- we are involved in discussions with Health on their plans to develop an integrated mental health service. This includes older people's mental health and we must ensure that these arrangements are robust;
- undertake a review of Mardy Park with a view to this developing as an integrated health and social care hub;
- developing integrated and community focussed day services such as:
  - joint day service at Monnow Vale incorporating day hospital and older people's mental health services
  - reablement day service at Mardy Park
  - new community-based service at Trevor Bowen sheltered accommodation scheme;

- working with the voluntary sector to introduce a flexible transport scheme at Bridges in Monmouth and a toenail cutting service;
- developing new services for older people with mental health needs in the community including:
  - Rapid Response service/Saturday Drop-in Centre
  - Alzheimer's advocacy worker and additional befriending support.

In addition, we deliver substantial domiciliary, residential and meals services, whether directly or with other partners. The recent heavy snow in February 2010 demonstrated the resilience of these services and the huge goodwill amongst all providers to ensure that vulnerable individuals received critical support.

**Judgement**

Feedback from service users (eg community care questionnaire) and other data (eg proportion of people supported at home) suggest that the range and quality of our services is generally good. We are well positioned to move ahead with the Frailty Project and this will greatly enhance services for older people, particularly by offering community alternatives to hospital admission.

In order to address the increasing older population we need to push ahead on two levels:

- working in partnership with health to maximise independence and wellbeing;
- engaging communities, the rest of the council and other partners to build strong, supportive
communities (also see promoting independence and social inclusion).

Whilst there are many good examples of good day service developments these need to accelerate to ensure there is a consistent model across the county.

Finally, we need to ensure we have strong systems to monitor performance and respond to service user/carer views.

| Requires significant improvement | Inconsistent | Mainly good with some gaps | Well established and effective across the board |
|---|---|---|---|
| | | ✓ | |

**Priorities for action**

- Evaluate the community care/mental health pilot in Chepstow/Caldicot.
- Implement Mardy Park Review.
- Undertake domiciliary care tender.

## Services for People with Physical Disabilities and Sensory Impairment

These two areas have been put together for clarity within this report, though the analysis was carried out separately.

Physical disability services for people of working age are provided via specialist workers within the locality teams. They have access to the full range of reablement services as well as specialist services such as social enterprises, supported living and equipment via the Gwent Integrated Community Equipment Store (GWICES). Equally important is the availability to accessible transport eg via the Grass Routes scheme and those local taxi firms with wheelchair access. Direct Payments and access to the Independent Living Fund can enable individuals to take control of their own support needs and build in the flexibility they require. Currently, there is no planning forum for physical disabilities and developments in this area have been piecemeal (eg the excellent service at Drybridge Gardens).

Sensory Impairment services are provided via a specialist practitioner located within the Monmouth team and via a contract with Gwent Association of the Blind. A comprehensive range of services are available, including:

- sensory equipment
- adaptations
- mobility equipment
- specialist rehabilitation
- communication guides

Currently, referrals for deaf people and those with dual sensory loss are dealt with immediately but there is a five month waiting list for people with visual impairment. A fast track assessment system has just been introduced to respond to this.

In the last year, there has been a survey of people with dual sensory loss and a review of our progress in achieving our statutory duties re sensory impairment. Service users are members of the Dual Sensory Loss Project Group and regular user feed back is received via Gwent Association of the Blind.

**Judgement**

There are a range of services available for people with physical disabilities but more needs to be done to ensure a more responsive and cohesive service pattern. Alongside this, broader issues such as access and transport need to remain high on the council's agenda. Consequently, there needs to be a strategic planning forum that can engage with individuals with a physical disability and other partners and currently this is a gap.

Sensory impairment services are developing well and are well regarded. Resources available are limited and we need to continue to monitor the coverage and resilience of these services.

| Requires significant improvement | Inconsistent | Mainly good with some gaps | Well established and effective across the board |
|---|---|---|---|
| | ✓ (physical disability) | ✓ (sensory impairment) | |

## Priorities for improvement

- Establish a planning forum for physical disability issues.
- Link up with Falls service to look at ways to minimise falls for people with visual impairments.
- Deliver training programme re dual sensory impairment for Social Workers/OT's/District Nurses.
- Review the roles of specialist social workers within the community care teams

## Services for People with Learning Disabilities

The Community Learning Disability Team provides a wide range of support and services to people with learning disabilities and their families. This includes residential care, supported living, domiciliary support and a range of services to promote community engagement and independence (eg social enterprises, day services). Traditionally, the team has also responded to people with autistic spectrum disorders although there is now a move to broaden our response to autism.

A key piece of work is the Learning Disability Review. This piece of work, focussed on the themes of My Home, My Day, My Work and My Parent/Carer, has had high levels of service user and parent/carer involvement. The aim throughout this work is to extend choice and control for individuals and support them to live fulfilled lives in their communities. Person Centred Planning and Citizen Directed Support are two exciting initiatives in this area.

In common with the rest of the UK, there are pressures on the learning disability budget. In responding to this we need to maximise individual independence whenever possible and also develop more effective mechanisms to manage the market. Increasingly, we are working collaboratively with neighbouring authorities, for example on adult placement and advocacy services and the development of a 'pricing tool'.

Within the Welsh Autism Strategy, we have developed a Local Action Plan based on local needs analysis. Key issues are raising awareness and developing a clear 'pathway' through services for people with autism. This year we have trained 123 staff on basic autism awareness and a further 50 on autism assessment and diagnosis.

We are currently consulting on our respite care review. This proposes the closure of a valued facility and reprovision of a new service model and has understandably caused concern amongst a number of existing service users and their parents/carers.

## Judgement

We have a good range of services and invest a lot of resources into learning disability services. We need to move ahead on the person centred planning agenda to ensure that

we are really promoting independence, choice and inclusion. Alongside this we need to manage within an ever tightening budget. The Learning Disability review is an important tool in achieving these objectives.

Generally, we have worked hard to involve service users and parent/carers and this needs to continue. There is scope for further integration within the Community Learning Disability Team to provide a more streamlined service.

| Requires significant improvement | Inconsistent | Mainly good with some gaps | Well established and effective across the board |
|---|---|---|---|
| | | ✓ | |

**Priorities for improvement**

- Concluding the Learning Disability review.
- Agreeing and implementing the respite care model.
- Developing an Asperger's pathway.
- Introducing a Gwent-wide 'pricing tool'.

## Services for People with Mental Health Problems

Our services for people of working age with mental health needs are provided by two co-located Community Mental Health Teams (CMHT) one based in Abergavenny and one in Chepstow. These multi-agency teams include the functions of:

- early intervention (responding quickly to mental health crises)
- home treatment (working intensively with people to support them through periods of acute distress and avoid hospital admission)
- assertive out-reach (working proactively with people who are at risk and may not tend to access services)
- ongoing CMHT support.

The approach is based on helping people recover and maintain good mental health and consequently take control of their lives. The teams also provide a service to people who misuse alcohol or drugs.

The service uses the Care Programme Approval (CPA) to coordinate its work and ensure outcomes for individuals are achieved.

There is evidence that there is generally a good range of support available and that the comprehensive approach described above has led to less hospital admissions and is supporting more people in the community. It has also highlighted the need to develop

more community services (such as flexible support workers) and the importance therefore of collating unmet need and commissioning new patterns of services.

There is a well established service user forum run through the Gwent Association of Voluntary Organisations and a range of services are commissioned from MIND and other voluntary sector organisations. There is also an active programme of staff training around risk assessment.

We have been keen to integrate more fully with health colleagues for some years and the recent establishment of Aneurin Bevan Health Board (ABHB) is presenting an opportunity to do so on a Gwent-wide basis. We will embrace this opportunity whilst ensuring that the particular needs and opportunities within Monmouthshire are taken fully into account.

Finally, alongside these specialist services the wider community resources (eg housing, transport, social facilities and primary care health services) are crucial in supporting people with mental health needs.

**Judgement**

The development of the comprehensive services described above, supported by the CPA approach, has had a positive effect on people with mental health needs in Monmouthshire. At the same time this has highlighted some of the gaps particularly around support workers and cost effective supported living options. This needs to be addressed via a process of engagement, evaluation, service development and commissioning.

The proposal for an integrated Gwent-wide mental health service offers real potential; part of our role is to ensure that Monmouthshire's requirements are met fully within this.

| Requires significant improvement | Inconsistent | Mainly good with some gaps | Well established and effective across the board |
|---|---|---|---|
| | | ✓ | |

**Priorities for improvement**

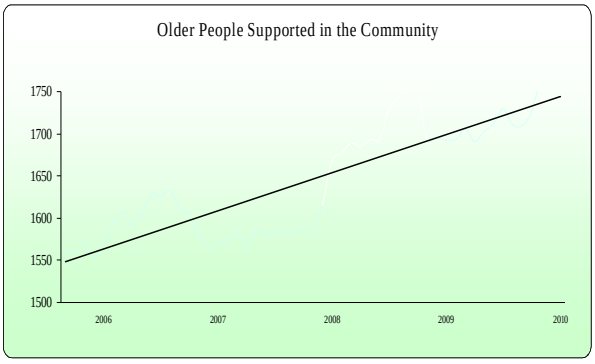
- Engage with Aneurin Bevan Health Board in the development of an integrated mental health service.
- Review current services to identify gaps and develop new service models.
- Involve the wider council and other parties in promoting good mental health in Monmouthshire.

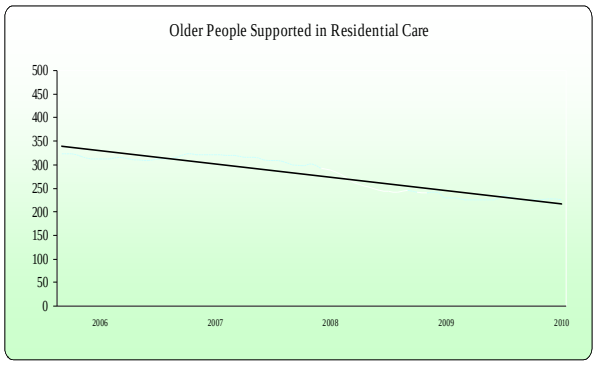
## Promoting Independence and Social Inclusion

This issue includes much of the work referred to elsewhere in this report (eg developing integrated reablement approaches) but also covers much broader issues. As a department we thus have to develop our relationships with communities and various

partnerships to increase social inclusion as well as delivering services that promote independence.

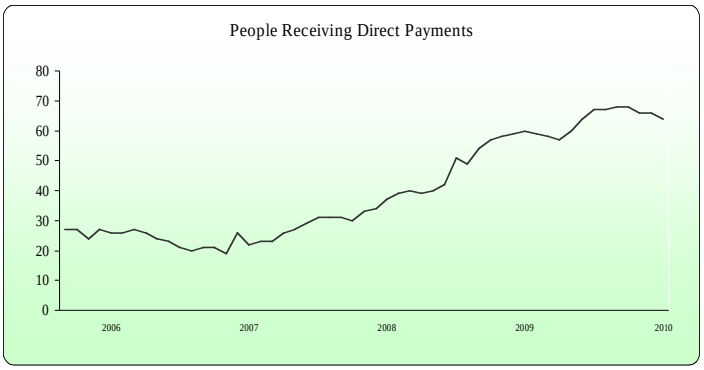
With regard to promoting independence, the following graphs demonstrates that our efforts to maintain people in their own homes and avoid institutional solutions are having the desired effect.




(Source: MCC Monthly Service Activity Reports)

Within our services the development of social enterprises such as 'Green Fingers' and the 'Office Project' has been a positive step. Similarly, the Community Meals service has established links with community policing. An area for improvement is the take up of Telecare, which, despite our efforts, is still not satisfactory. Our Healthy at Home scheme provides safety checks for people over 75 years of age and links in to other services, such as falls, as required. A very exciting development is the Citizen Centred Support project which will test out ways to empower people in the design and running of their services. Alongside this we must maintain the success of our direct payments scheme.




(Source: MCC Monthly Service Activity Reports)

Within the broader Health Alliance, initiatives such as the Expert Patient Scheme and GP Exercise Referral Scheme support people to live healthier lives. Health Challenge Monmouthshire, with its well established "Monty" brand, promotes healthy eating, exercise etc. Through the Strategy for Older People and the Community Focussed Schools initiative a number of projects are supported, especially around intergenerational activity. We are currently transferring the management of Boverton House in Chepstow over to Lifelong Learning to enable its development as an adult learning centre.

Adult Select Committee is undertaking a major piece of work on "The ageing population" and will report back later this year. The committee has heard evidence from officers, older people's groups and other partner organisations as well as visiting a range of services and groups in Monmouthshire.

## Judgement

Our services are increasingly promoting independence and we are on a journey from just looking after people to enabling them to maintain control and independence. We need to continue in this direction and ensure that such services are available consistently across the county. The Frailty project is an important element, as are the other aspects referred to above. We believe that Telecare has an important role to play in this and we need to increase significantly the use of Telecare, both for our service users and as an option for the wider public. Social enterprises are also in a transitional stage and ultimately we would want to see them moving away from social services into an enterprise-based model.

*"We would like to thank you for the arrangements you made for our dearly loved wife and mum. This enabled her to achieve her dream of spending her last weeks in the pleasant and peaceful surroundings of her own home."*

During the recent heavy snow social services coordinated a ring round of several hundred potentially vulnerable older and disabled people living at home. It was reassuring to discover that the combination of independent individuals, resilient services and supportive communities meant that all those contacted were found to be safe and well supported.

A recent Wales Audit Office report into independence of older people in Monmouthshire found that the above 'social services' issues were progressing well but noted a lack of strategic clarity across the council as a whole. Alongside the many good initiatives described we need to develop a more coherent council-wide approach.

| Requires significant improvement | Inconsistent | Mainly good with some gaps | Well established and effective across the board |
|---|---|---|---|
| | | ✓ | |

## Priorities for improvement

- Implement the Gwent Frailty Project
- Enhancing the Health Challenge Wales website.
- Continue to develop transition pathways
- Work via the new partnership and policy team to ensure strategic clarity and avoid duplication.

## Services for Carers

Carers are a crucial part of the health and social care system and we are committed to providing support and information to assist them in their role. Our approach is based around:

- carers' assessment workers based within community care teams. They carry out assessments of carer's needs (as opposed to the needs of the person they care for). Last year they undertook 153 assessments which resulted in services being provided in 103 cases;
- social workers also undertake some carers' assessments as part of their role;
- our carers' support and information worker bases herself at GP surgeries and local hospital and provides training to carers themselves and staff;
- we commission flexible respite care and support from a range of voluntary and independent providers.

We carry out a lot of work with carers that is not recorded by the current national performance indicators.

Our strategic direction is influenced by our Carers' Strategy Group. This includes carers and, in addition to the work above, has been instrumental in initiatives such as:

- producing a carers' handbook, based on the expressed needs of carers;
- organising carers' week and carers' rights day each year.

There are over 600 carers registered who receive regular information on events, changes in legislation etc. At present there is a new carers' measure under consideration at the Welsh Assembly Government. We will need to ensure that we work closely with our Health colleagues to implement this when it is passed by the Assembly.

**Judgement**

There is considerable good work undertaken in Monmouthshire to support carers as described above. Current processes do not capture all of this and we need better systems to record what is being achieved. There are also significant efforts in providing public information for carers (eg carers' database, carers' handbook) yet we still encounter carers who are not aware of the support available and need to continue to find ways to publicise these services.

*"When we first had my husband's diagnosis we felt as though we had been dropped in the North Sea and left to swim home. The Monmouthshire Carers Handbook is a Bible for carers. I would say it is vital – it saved my life."*

We have made good use of the carers grant alongside mainstream funding to develop innovative services. As finances become tighter we now need to review our funding sources and ensure we are delivering high quality cost effective services.

| Requires significant improvement | Inconsistent | Mainly good with some gaps | Well established and effective across the board |
|---|---|---|---|
| | | ✓ | |

**Priorities for improvement**

- Continue to review and develop public information.
- Review all carers' services, in partnership with the carers' strategy group.
- Develop a more appropriate performance monitoring system that captures all our work with carers.

## Protection of Vulnerable Adults

Monmouthshire's approach to safeguarding is based on involving all our team managers in managing protection of vulnerable adults (POVA) cases and in building strong relationships with other partner organisations. This is underpinned by a dedicated POVA Coordinator and a strong commitment to multi-agency training. Our recent inspection by CSSIW concluded that:

*"Overall, Monmouthshire and its partners have safeguarded people through the deployment of staff and resources and the implementation of adult protection procedures. The local authority is largely effective in identifying adult protection concerns, taking prompt and appropriate action and then working to improve individual circumstances."*

The report goes on to note:
*"evidence of good outcomes for service users … and commitment to providing an effective level of service."*
whilst noting the strain that these POVA demands place on our limited resources.

At a strategic level we have established a joint Area Adult Protection Committee (AAPC) with Torfaen and Blaenau Gwent. This is proving valuable in establishing strong leadership of safeguarding issues, engaging with partners and beginning to share some of the coordinators' workloads.

There are areas for further work indentified in our joint action plan. These include concentration on some under-represented client groups and improving risk assessments and recording. We are also committed to working closely with providers and strengthening the links between commissioning, CSSIW and POVA.

**Judgement**

We welcome the CSSIW report's findings that we deliver good outcomes for vulnerable adults and that there is a strong commitment to safeguarding at frontline practice, operational and strategic levels. We share their concern about limited resources and need to monitor this carefully to ensure that we continue to provide a safe and quality service. As an AAPC we need to provide strong support and leadership and look for opportunities to work more effectively with our partners. Finally, we wish to find ways to obtain the views of vulnerable people and their families to improve our systems and processes.

| Requires significant improvement | Inconsistent | Mainly good with some gaps | Well established and effective across the board |
|---|---|---|---|
| | | ✓ | |

## Priorities for improvement

- Deliver the actions in our annual action plan.
- Finalise our Escalating Concerns policy (this relates to care homes in which there are concerns re quality and safeguarding).
- Build on the role of the joint AAPC.