Social Services Annual Council Reporting Framework

Annual Report of the Head of Adult Services 2014

monmouthshire
sir fynwy

Introduction

Monmouthshire Adult Social Care and Health Services are striving to make sure that "people are able to live their own lives", and that people are protected from harm. People approach Adult Social Care Services for support at different times in their lives. We want to support and enable people to remain in control of their lives, working with people to find options/solutions that best meet their vision of a good life. We focus on people's strengths, abilities and contribution. We enable family/friendship networks and communities alongside services to support people to live their own lives.

In approaching the Annual Council Reporting Framework I thought it would be useful to include some information on the current vision/operating model which is driving the on-going transformation of Adult Social Care in Monmouthshire. The report will also capture the progress made against actions set out in last year's report including both, performance indicators alongside local evidence and stories of impact and how what we do makes a difference to people who approach us for support.
We have then identified what we need to focus on in the year ahead. The report has been informed by a range of information including feedback from people who use services, performance indicators, audit and inspection reports and case studies.

Vision/operating model

Over the last 3 years we have been changing the approach to the way we deliver Adult Social Care. Like many other local authorities Monmouthshire is faced with the twin challenges of declining budgets and an ageing population. If we want to keep delivering adult social care and health in the same old way we need to find another £25 million a year by 2030. Salami slicing isn't an option. We are re modelling/transforming what we do ensuring that the approach we take focuses on and is driven by what people see as their good life and with a real emphasis on delivering outcomes set by individuals.

What does this mean for people who approach us?

- People are supported at the first point of contact by the most appropriate person, whether that's an occupational therapist, a social worker or a district nurse.
- We've changed the way people are supported, discarding the deficit focussed approach in favour of having conversations with people about what matters to them.
- We are re focussing the way we deliver domiciliary support away from episodic to relationship based care.
- We are re focussing what practitioners spend their time doing, more time in communities and less time at desks and we are measuring our performance in terms of the impact we have had on people's lives.
- We are defining our longer term commissioning intentions in line with the transformation.
- In building Community Coordination we will see more people supported in their own communities with a support from family, friends and natural associations.

We're calling our whole service programme of transformation Changing Practice, Changing Lives. You can watch a short animation about this here.

These operating principles guide how we deliver support to people who are in contact with us;

OPERATING PRINCIPLES:

- We will work in **partnership** to facilitate solutions, building meaningful rappor/relationships with family's individuals and partners.
- We will know/be clear about the people who we will support in a **timely** manner.
- We will have a plan of how we will support people to develop a 'whole life' plan, and have a method to track progress and **communicate** effectively. (including commissioning)
- We will take an **outcome focused** approach to future planning (long term and short term) with families and individuals to meet their own aspirations and goals.
- We will involve the **right people** at the right time to help people in crisis and will take responsibility for the appropriate pace and continuity of our on-going intervention.
- We will have **honest and transparent** conversations with all people.
- We will work with and **respect** other colleagues and challenge systems to ensure best practice and service delivery.
- We will use knowledge to reflect **learn** and develop on our practice and decisions.
- Everything we record will be **purposeful** and proportionate.
- We will **value and respect our staff** and trust their judgement; and promote wellbeing in the workforce.
- Our IT system will work for us.
- We will work **creatively** and equitably within all resources available.

In summary over the last 12 months, how are we doing?

Our real strengths are that we have:

- A dedicated, passionate and committed workforce delivering high quality support and services to enable people to lead full lives.
- A clarity of vision and purpose which is based on continuous improvement and learning through doing
- Collaborative and partnership approaches to all that we do recognising the person at the centre and organising all that we do from that perspective.
- Influencing the wider direction of travel through work with key partners and Welsh Government on the Social Care and Health Bill.

We have continued to make progress in all areas but there have been some real strides forward in the following areas:

- Built on the success of the Raglan project and will be rolling out this approach.
- The Community Coordination approach which will be in place from April 2014.
- Progress in the 'My Day My Life' work is beginning to deliver real outcomes for individuals.
- A systems review of the Disability Service will see the development of a Children/Adults Disability Service.
- We continue to have high satisfaction levels with services.
- We are seeing a reduction in spend levels through understanding demand which is having a positive impact on the budget.

Further progress needed in:

- Ensuring we have sufficient capacity to maintain progression at pace.
- Succession planning and growing the skills we need in the workforce to meet the demands of the new approaches.
- Keeping the carers' agenda central to all we are doing to ensure support for the vital role carers play in helping deliver social care.

Overall the judgement would be that our services are "mainly good with some gaps"

These are my own views:

They have been informed by consultation and evidence gathered from a broad range of multi-agency staff and partners. It would be good to hear what you think, does this sound like the Monmouthshire Social Services you know from your experience?
We continue to deliver services within a challenging financial climate and are only too aware of the need to balance service transformation whilst maintaining quality and managing the resources we have available.

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Getting Help

(Access, Assessment and Care Management and review)

FISH “Find individual solutions here”, listening to understand, facilitating solutions, moving forward and community coordination

People contacting Adult Services for support need to have access to information and a response that is timely and proportionate.

Last year we said we would:

Continue to implement the Frailty core deliverables into a fully integrated health and social care model.

What did we do?

- We have continued to deliver the core deliverables from the Frailty agenda but this is incorporated into the integrated service model we operate in Monmouthshire. We have continued to improve our performance keeping people at home and living their own lives.
- A reduction in bed use in Chepstow Community Hospital as people have been using reablement approaches increasingly in their own homes.
- An average of 1.2 delayed transfers of care at Jan 14 which is considerably below the Wales average.
- The number of older people in residential care has fallen from 254 to 239 over the past year. This is the lowest level in Wales.
- Reablement success in reducing care needs is demonstrated by a reduction in the average size of care package from 10.1 to 9.7 hours in the past year. This was 12 hours before we began integrated working.
- We are continuing to see a reduction in the number of people who require long term packages of care.
- An effective fall service across Monmouthshire is supporting people to remain independent.
- Maintained acceptable lengths of hospital stay at Monnow Vale integrated facility.
- A new service model for nursing intervention available across the community e.g. Intra Venous service in persons home; Chronic Obstructive Pulmonary Disease home care service delivered by new integrated nursing teams.
  Frailty data summary – over past 12 months referral totals were: 3070 of which Falls 364
  Nurses 19
  Reablement 2349
  Rapid other 438

Last year we said we would:

Consolidate this platform of integrated delivery to deliver the drivers from the new Bill.

What did we do?

- In line with The new Bill we have been transforming our services and in particular looking at the response people have at the 'front end' of our service which is now known as FISH 'finding individual solutions here' on going feedback tells us people have been very satisfied with how they are dealt with (FISH-Feedback Link) On-gong transformation has included the development of a new integrated assessment (Integrated Assessment Link) care and support plan (Care and Support Plan Link) and an outcome measurement framework (Outcome Measurement Framework Link) which is all in line with the aspiration of the new Bill.
- Over the past year we have seen the number of calls that need to progress to assessment reduce by 30% as people get earlier access to professionals

Last year we said we would:

Work with the new Project Manager to make full use of the digital pens to record assessments.

What did we do?

All staff are now in use of the digital pen technology and are using this to record on via Frailty portal.

Last year we said we would:

Improve access to information for the citizens of Monmouthshire by re- designing the website.

What did we do?

- We have been developing the new website pages for Social Care and Health which now provides wider range information with easy access to a range of links for further information and advice. Furthermore we have created a more interactive facility and the potential for people to add content. We see this as a positive step.
- In line with requirements in the Bill and with a need to ensure people have access to the right information we have been using the website as a vehicle to both give information and inform people about how we are changing.
- In a recent SOCITM survey Monmouthshire's website was listed as the 8th best in the UK with a special mention in respect of the Residential and Nursing home pages as providing easy read and informative information**.** (Website Social Care & Health link)
- We have embraced the use of social media and also the use of tablets and i pads for the frontline staff who have been taking part in the Raglan project and the My Day My Life work. Using Evernote to record digital stories and impact this new service has had in the lives of the people using the service it has provided a powerful evidence base.

Last year we said we would:

Continue and review the 'doing it better doing it differently 'workshops to manage the cultural shift in practice development.

What did we do?

- The ' Doing it differently doing it better ' sessions that run monthly and have enabled a large integrated staff group to keep up the pace with and shape the transformation of our services. These sessions have enabled staff to develop the integrated assessment, evaluate the progress made with FISH and share and develop practice as we transform the approach to Adult Social Services**.** (Diddib-questionnaire-feedback Link)

- It has been crucial to support all practice initiatives with a new Information Technology System that enhances practice whilst not over burdening practitioners with excessive and unnecessary data entry. We have taken a proportionate and simplified approach to what we collect based on; does it add value to what we are trying to achieve. I.e. help people to live their own life.

Judgement

We have made some really big steps forward this year and consolidated a number of areas that have been a focus over the last 3 years. People are able to access support and have a listen to understand conversation with a professional and receive appropriate advice or action as necessary. The practice change required to underpin the outcomes strengths based approach is well underway but has some way to go.

In this area of our work I would judge we are still mainly good with gaps. This is based on the recognition that we have nearly all the building blocks in place but we require the practice changes to really embed further with consistent evidence that we are' helping people live their own lives'.

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

Click here to see our report card for Getting Help

COMMISSIONING

We are committed to a direction of travel that moves towards commissioning around outcomes for people 'helping people to live their own lives' and remain healthy, independent and engaged in a full life.

Last year we said we would:

Implementation of Strategic Commissioning approach to cover areas as physical disability, older people including dementia services including use of strategy market positions statements.

What did we do?

We have produced a Commissioning Plan which is currently out for consultation (March 2014) (Commissioning Plan Link) this will be the beginning of a conversation with the providers. This key plan details our direction of travel and describes our intention to commission in a way which must change shape to enable sustainable care and support systems in Monmouthshire.

The development of the Commissioning Plan has been extremely effective in enabling us to review our current provision of services against our direction of travel. From this we have been able to get a clear picture of present and future need and current service provision, thereby identifying the key commissioning gaps which will need to be addressed over the coming 3 years which in summary are :

1. A need for greater individually tailored support
2. Capacity to meet the growing number of older people who are frail (over 85)
3. Capacity to meet the growing number of people who have dementia
4. A need to respond to those with complex needs
5. Ensuring that the needs of individuals supported at home by an elderly carer are planned and the carer supported

Market position statements will follow when the commissioning plan is concluded.

Last year we said we would:

Implement the My Day initiative.

What did we do?

- A new approach for moving forward with My Day My Life 'work launched at an event in July 13 and an experiment based on Support Brokers performing new roles was then commenced.
  This new approach has been supported by fortnightly Action Learning Set meetings which support frontline staff to resolve issues and remove barriers.

- Service users from Office Services were the first to be part of this exciting initiative and it has quickly spread to other services including Ty'r fenni, Green Fingers with other areas such as Monmouth Day Services and Swan Craft Studio starting to come on board.

- There are now growing examples of different opportunities emerging for people who are being supported to undertake opportunities that they enjoy and that they are self-determining through different conversations and outcome planning with support brokers.
- A variety of different community opportunities have been found for service users across the Abergavenny area. (My Day, My Life Link)

Last year we said we would:

Continue the implementation of the Carers Strategy.

- The implementation of strategy has continued and also the Carers Strategy has been mapped against Welsh Government Strategy and Social Services Bill alongside a new work stream focussing on young carers / Young adult carers.
- Carer's week went well in November 2013 and the Carers Rights Day events had good attendance.
- The remodelling of Carers services using a systems approach has commenced with full support of 3rd sector agencies.
- Continued with the implementation of the Carers Strategy in line with the agreed action plan (April 2014)

Determine future strategic direction of SPPG services by March 2015 and Develop a strategic approach to quality assurance and implement a robust framework.

What did we do?

- Managed reductions in SPPG funding, produced the Local Commissioning Plan and begun implementing a project to deliver the Comprehensive Spending Review by 2015

- Supporting People Commissioning is now within the overall Adult Social Services Commissioning team'.

- Implemented new and improved quality assurance processes across commissioned and directly provided services.

- A new regulation 27 process has been developed and tested and is now being used on a quarterly basis to internally quality assure Budden Crescent, Mardy Park and Severn View and ensure compliance with the Care Homes (Wales) Regulations 2002.

- The process covers all four CSSIW themes (quality of life, staff, management and environment) and uses a range of different sources of information including discussion with service users, discussion with staff, document audit and premises inspection in order to identify areas of concern and highlight and share good practice across the three homes. The Policy and visit report template can be found here: (policy-and-procedure Link)

- Annual reports will be produced and submitted to Directorate Management Team in respect of both the Quality Assurance and monitoring work and the Regulation 27 work.

Last year we said we would:

1. Complete Review of Partnership and Planning Arrangements and implement improvements

What did we do?

- The partnership review has been completed. Consideration is being given to what resources within the commissioning team are required to ensure engagement/representation at key partnership interfaces. The aim is to prioritise participation in key areas and utilise wider team members as representatives and leads in certain areas.

Judgement

Overall our commissioning arrangements are good and well established; this view is shared by CSSIW following their consideration of Monmouthshire's self-assessment submission which formed part of their National review of Commissioning for social care in wales in 2013. The implementation of the new structure has brought improvements and enabled key priorities to be achieved. This has been achieved despite the team managing significant capacity gaps for the most part of the year. Progress is seen in areas including monitoring and quality assurance arrangements, service contract reviews, progress of My Day and the production of the Commissioning Plan. The coming year will be both a demanding and challenging one; with the need to deliver against new key priorities including managing a Childrens Services commissioning function, whilst still implementing improvement agendas within reduced capacity will need to be monitored and evaluated.

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

Services for Older people

(Including those with Mental Health needs)

We are committed to a direction of travel that 'helps people to live their own lives' and remain healthy, independent and engaged in a full life.

In order to manage demand we have been remodelling the way we deliver services to ensure we can work with people who need our support by delivering support primarily to people in their own homes wherever possible.
We are looking to ensure people have strong connections and are able to remain living their own lives.

Last year we said we would:

Complete the development and implementation of Quality assurance and bring all Domiciliary Care provision within overarching quality assurance framework.

What did we do?

Reported in Commissioning section.

Last year we said we would:

Collaborative work between Commissioning, Elected Members and CMC2 to develop the commercial tier of the community meals service.

What did we do?

- We commissioned Cardiff University to undertake a feasibility report to assess the viability and potential for a commercial market within Monmouthshire for the community meals service.
- The report concluded that the actual commercial market was extremely limited and did not view this as an option at this stage.
- However, the report included a number of very helpful recommendations for improving the uptake from existing market, better branding and marketing and enhancements to menu options. These recommendations are being considered and worked on for implementation.

  (Cardiff University Report)

Last year we said we would:

Commence development of Older Persons Commissioning strategy and approach/Strategy for older people with dementia.

- Reported in commissioning section

Last year we said we would:

Review Lavender Gardens including opportunities for Local area coordination and to link into SPPG review.

What did we do?

- The Lavender Gardens review commenced in January 2014.
  - The review group is established with representatives from the housing provider, direct care, Commissioning, care management and local area co-ordination.
- Work streams include:
  - Consultation group exploring the development of the scheme with those people living at Lavender Gardens (LG's).
  - Staff team development group exploring the development of their role and the overall development of the scheme.
  - Review of referral and admission criteria / processes to develop seamless support when people move into the scheme.
  - Exploration of community links and connections to develop LG's place in the local community and to create opportunities for inclusion and social interaction.
  - Review of all people living at the scheme to enhance support plans as per the above work streams.
  - Review and development of current activities on site and future opportunities.
  - Review has only recently commenced, however, initial work to develop on site activities has been positively received.
    (Lavender Gardens Project Link)

Last year we said we would:

Conduct a comprehensive spending review of supporting people for older people

What did we do?

Last year we said we would:

Implement Rural Schemes to support people with dementia

What did we do?

- A new domiciliary scheme for people with dementia commenced in May 2013. This project moves away from the current model of service delivery to one that doesn't focus on tasks. Staff have autonomy to support people with dementia in a way that makes sense to the person in their situation which may and does fluctuate from day to day.
- Each member of staff is full-time salaried and employed as part of a team to work flexibly across a service area. Only five staff work in that area and cover for each other.
- The time spent and activities undertaken are discussed daily with the service user and their family and respond to how they feel. Minimum service levels

remain but to deliver flexibility the care plan is a framework for delivery rather than a prescriptive list of tasks.

- A comprehensive evaluation was completed in February 2013 and a summary is linked (Raglan Project Link) In brief the evaluation detailed that the response from those receiving support and the teams involved stated that the following outcomes were met:
- The project delivered a relationship based experience of receiving care that supported choice, independence and a more natural experience of receiving support.
- Improved listening and assessment to understand what matters most to the individual.
- Direct support to the 'carer' that promotes their involvement and control.

- Reconnecting people with their local communities.
- The role of staff develops – they feel empowered and their health and well-being improves.
- That new models of delivery can be supported at the same cost.

Last year we said we would:

Review and remodel respite services at Severn View

What did we do?

- The aims of this project were limited following the request to support a married couple to live at Severn View. Consultation with care management teams supported the reduction of respite services for older people from three to two rooms
- And the increase long term rooms from 3 to 4.
- Successful support of the couple to live together at Severn View and increased occupancy of respite beds since reduction

Last year we said we would:

Review meal changes at Severn view and Mardy Park day resource centres this piece of work was not progressed in 13/14 due to competing demands and prioritisation of more urgent work. It is planned for 14/15

Last year we said we would:

Evaluate the new early onset dementia service.

What did we do?

- This small partnership with Abbeyfileds in Usk has enabled a small group of people with early onset dementia to continue living independently with on- site support. A quarterly quality assurance group has been established to monitor the quality of the service and help it to continue to develop and improve. The group includes tenants, support workers, family members, social workers, commissioners and Abbey field's general manager.

- A formal review currently underway. This includes interviews with tenants, staff and other interested parties as well as analysis of case files and review of financial and performance data.
- Quality assurance group has met twice and has been well attended, with tenants actively involved.
- The review is still in the process of being completed however initial evidence suggests that the service is resulting in positive outcomes for service users, for example individuals have spoken about their increased self-confidence, greater involvement in the local community and greater feeling of stability.

Judgement

We have made some real progress in the last 12 months and have placed more foundations blocks in place to delivering a better model of support for older people, with a clear direction of travel around relationship based care which we will continue to build over next 3/5 years.
We continue to deliver residential, domiciliary and community meals services to a high standard with a committed and well trained workforce. We need to ensure that we continue to embrace the potential for people to remain connected to their families, networks and communities and in particular that we can continue to deliver services that enable independence and focus on peoples strengths continuing to build on the integrated approach.
We receive consistently positive feedback both from the community care questionnaire and a large number of unsolicited compliments on a range of services delivered to older people.

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

Services for people with physical, learning disabilities and sensory impairment

We carried out a systems review in November 2013 and will be developing a Children and Adults Disability Service. We will be

rolling out the integrated person centred approaches seen in the rest of our integrated services, so people are supported to remain in control of their own good lives and as independent as possible.

For people with physical and sensory disabilities, Last year we said we would:

Support all providers, starting with domiciliary providers, to understand the value of the citizen directed support approach and to deliver flexible personalized approaches.

What did we do?

This area has not been progressed but with the recent evaluation and learning from the Raglan project evaluation and the recently developed commissioning plan with stated commissioning intentions this work will be progressed under the heading on 'new models for community living' in the next year.

Last year we said we would:

Raise awareness among all MCC employees about the communication needs of people with a sensory loss.

What did we do?

- Provided 12 training sessions to Monmouthshire County Council staff and Sensory loss information is now included in the Induction Pack.
- Sensory training has also been provided to 13 residential/nursing homes to support and develop staff understanding of sensory loss, alongside Sensory Training for In House Homecare.

Last year we said we would:

Continue to develop self-directed approaches, including creative uses for direct payments, to enable service users to achieve their own outcomes and to manage their Direct Payments with maximum efficiency.

What did we do?

- The Direct Payments Scheme has supported the development and assisted with roll out of 'outcome focused Integrated Assessment and Care/Support Plan by offering on-going support sessions (group supervisions, team meetings etc.)
- Direct Payments have been aligned to embrace the Personal Budget approach.
- Procedural Guidance being developed to support practice with Outcome Focused assessments.
- Independent Living Advisors continue to offer advice and support to practitioners and service users.
- To expand the personalisation approach to people who would like to manage their own budgets i.e. virtual budgets
- There are currently 31 Managed accounts. This level has increased by 10 since previous year.

Last year we said we would:

To enable people who use our services to live their lives on the same terms as people who do not need social care. To ask 10 people who have used a personalised approach what impact it has had on their lives.

What did we do?

- Not completed and has been replaced by the development of the outcomes framework as discussed in Accessing Support section.

Last year we said we would…

Improve Community Inclusion so people with a Learning Disability will be enabled to access a full range of community options/provision with access to:

- Day time opportunities
- Appropriate employment and training opportunities
- Appropriate educational opportunities

What did we do?

- The My Day, My Life transformation process has supported individuals to articulate their aspirations and then staff with a new focus on connecting people to communities have established networks enabling people to make contribution alongside undertaking a range of activities .

- My Day, My Life is being rolled out through an 'Experiment' involving eleven individuals currently using Office Services and Tyr Fenni, learning is shared through an Action Learning Set.

- This has meant that many more people than those in the 'Experiment' are on My Day journeys as the wider staff group and service users want to plan for their good lives using this approach.

- In particular six parents of children in transition who belong to the MAGIC a parent led group who are actively involved in taking this approach forward.

Last year we said we would:

Provide each individual with a learning disability with every opportunity to participate in community life, and to be valued for his or her uniqueness and abilities, like everyone else.

What did we do?

- As part of the My Day, My Life transformation, part of the Support staff's remit is to seek out opportunities in communities. We are working in Abergavenny and the surrounding communities at present. A wealth of community opportunities beyond

expectations has been offered and people are experiencing a wide range of different opportunities in the community alongside support in the current 'HUB'.

- Within My Day, My Life, Support staff are facilitating conversations with the individual and those closest to them to understand their family and other networks, to grow these and to utilise these to maximise opportunities.

- Staff have been part of training to look at setting out possibilities with people and actively working to set outcomes and work towards them with individuals.

- Working with housing colleagues we have identified further 7 people who would benefit from living in a core and cluster model and housing have allocated an area for development.

Last year we said we would:

A robust and person centred process will be developed to capture the aspirations and goals of the people we work with replacing the existing UAP process

What did we do?

- A Systems review started in November 2013 within Children and Adults with a learning physical and sensory disability with a view to enabling closer working.
- What emerged was the need to develop a better way to manage transition and a more integrated approach to families with Children/Adults with a disability.
- This is at an early stage of development but we are looking to create one service and a joined up approach.

Judgement

This is an area where progress over the last few years has not been at the pace we have wanted. We created a physical disability team two years ago, it had previously been part of an older people's service this has worked well and in the last couple of years have seen a significant improvement with real momentum and active collaborations on a number of fronts.

In the last 12 months we have carried out a wider systems review which is going to lead to further transformation. In line with our approach to working with peoples strengths as opposed to deficits we are embarking on a new journey to create a Children and Adult disability service. The task is big, but having carried out a Systems review in November has helped us understand how people who use services feel, describing being very much on the outside and to a large degree with no idea what was going to happen when their child moved into adult services and also that planning was often late and involved lots of disputes. We have to make this better.

That said, there are many excellent examples of individual person centred work delivering real outcomes and positive practice we are in the process of large scale change I would judge our position as inconsistent at present.

	Inconsistent	Mainly good with some gaps	Well established and effective across the board
	✓		

Services for carers

Carers play a vital role in Monmouthshire, we see Carers as key partners in delivering social care. Our aim is to support carers, enabling them, where they choose, to keep supporting the people they care for.

This is a key area for us and we want to be in a position where we build further our approaches for identifying carers who require support, listening to what matters most, provide timely and useful advice and helping carers to find solutions that most appropriately meet their needs.

Last year we said we would:

Continue to influence ABHB – led Carers Measure Group to ensure benefits for Carers are realised.

What did we do?

Carers Project Staff have been actively involved in all the groups implementing the Carers Measure. We have had positive feedback from ABHB who lead the implementation. Monmouthshire recorded the highest number of responses to the consultation around the Measure in the ABHB area

Last year we said we would:

Ensure the Carers Project continue to be involved in the implementation of the Strategy.

What did we do?

- Monitoring the Strategy is a standard item on the agenda of the Carers Strategy Group.
- The Strategy has been mapped against the Welsh Governments 'Refreshed Carers Strategy' and the Social Services Bill.

Last year we said we would:

Services will be monitored against the outcomes in the new specifications contracts to be issued in spring 2013.

What did we do?

All commissioned services are now monitored against the new specifications. The monitoring has proved to be more focussed and productive using the new specifications.

Last year we said we would:

Increase the hours of the Carers Information Worker for a fixed period to further develop the contacts with health settings and remodel the Befriending Project, using the established volunteers to support the Carers Information Officer in providing information services in health settings.

What did we do?

- A bid to increase the carers information workers post was unsuccessful. Befrienders have been involved in updating information in GP surgeries and supporting Carer Events.
- Volunteers have been involved in Carer events and 2 are working with the Carers Information Officer on stands in health settings.

Last year we said we would:

Organise a programme for Carers Week June 2013 and organise a programme for Carers Rights Day, November 2012 along with a programme of training for carers.

What did we do?

- There were 3 days events for Carers Week and a workshop/information day for Carers Rights Day. There was a high attendance at both events and positive feed-back from Carers.
- Various training events have been held throughout the year.
- There was high demand for the training and positive feedback on all the sessions.

Last year we said we would:

Initiate a systems approach to remodel all carer's services involving carers. 3rd sector organisations and ABHB.

What did we do?

- The process has begun with full support of all partner voluntary organisations.
- Carers Assessment Worker and Information officer posts have been restructured.
- Established 3 Carer Officers posts linked to the integrated teams and each taking responsibility for a specialism and linking to Primary Care.
- Work has commenced to develop a Carers Integrated Assessment Process and Form.

Judgment

Work with carers has been well established in Monmouthshire for a number of years. There is a small but committed team who coordinate this work. We continue to have high levels of engagement ensuring that partnerships and networks with carers are central to any developments. Carers are key in helping us develop the direction of travel needed to support them in their role.
An area we need to work on is how we deliver carers assessments and ensure we are supporting carers with significant needs, providing a timely assessment service. A key factor for us will be the implementation of the strategy and being able to evaluate the improvement in supporting carers moving forwards. This will need leadership at all levels; we will ensure that the amount of resource although small remains directed toward this area.

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

Mental Health

Support for working age adults with Mental Health needs are delivered from co-located teams in north and south Monmouthshire. The approach is one of recovery. There are a range of services configured to manage different aspects of Mental illness. These include: Early Intervention Services - now jointly managed with the Assertive Outreach Service; Home Treatment Services - now managed in a collaborative approach across three Gwent localities and Community Mental Health Teams.

Last year we said we would?

Assess the need for a social care worker within the primary care mental health team.

On a trial basis we placed 1.5 social workers to work alongside the memory assessment services (primary care). Evidence then showed that there is more work in primary care than this number of social workers can undertake. We have therefore reverted to all the mental health social workers covering both primary and secondary care work in order to share out the work more equitably.

What did we do?

Care and treatment plan process in place but needs to be monitored to ensure future compliance care and treatment plans.

Working alongside our health colleagues and in close partnership with the CTP administrators in ABHB we monitor compliance on a monthly basis and statistics are sent to Welsh Government monthly.

What did we do?

AMHPS to be re-warranted every 5 years

A pan-Gwent re-warranting policy is now operational. The AMHP's working within Monmouthshire's mental health teams have all been re-warranted within the last 5 years and a database is kept of future dates for re-warranting.

What did we do?

Continue with plans in order to get an integrated manager by summer 2013.

Local authorities and ABHB continue to work on the integration agenda, however the focus is currently on integrated working practices as opposed to appointing an integrated manager.

What did we do?

AMHP fit for future and practice / independence and risks around being an AMHP.

The Gwent consortium continues to provide regular training events for AMHPs and have put on additional training as identified as a need by Gwent AMHPs.

Monmouthshire has recognised the health and safety issues for AMHPs and AMHP's now attend every community based Mental Health Act assessment.

The management team within mental health have been working closely with the training officers to clearly identify learning and development needs of individuals prior to them partaking in the AMHP training course.

What did we do?

Monitor changes in practices – policy development SS Health Ambulance Police Magistrates 135 (1)

A Multi-agency, pan-Gwent group has been set up to clearly identify practice issues, develop working relationships and develop policy and procedure

Judgement

There have been some key developments this year with a real change in approach emerging with more personalised service options being explored and encouraged across a range of services. The focus on recovery, balanced with a person centred approach needs to be developed further. All Local Authorities in the ABHUB area along with the health board have undertaken a systems review of Mental Health services. This is being considered alongside the move towards integration of Mental Health Services, what was

learnt is that there is a need to ensure that what matters to people who have mental health problems needs to be centre stage.

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

Protection of Vulnerable Adults/Safeguarding

Adult protection/safeguarding remains a key priority for Monmouthshire. We work very closely with all partners in delivering our Adult Protection Service and these close working relationships enable an increasing amount of joint approaches in Adult Protection.

Last year we said we would

Continue to develop Designated Lead Manager (DLM) workshops to include wider people e.g. personnel.

What did we do?

- Three workshops were held in 2013 for Designated Lead managers in both Health and Social services.
- These sessions proved effective in sharing good practice and developing the trusted relationships needed in delivering adult protection.
- Two further Individual sessions held with newly appointed DLMs hosted by the POVA Co-ordinator and Group Manager. Case Studies were used to stimulate discussion regarding decision making.
- Training and on-going development for DLM's, Health and front line duty staff are being arranged with external trainers.
- The POVA Training Subgroup which reports to the Gwent Wide Safeguarding Adults Board is exploring opportunities for collaboration with regard to Investigation training.

Last year we said we would

Contribute to Hate Crime Group.

What did we do?

- A Group Manager with responsibility for wider safeguarding issues has attended Hate Crime Group. We recognise that there are wider safeguarding issue that need to have representation alongside the operational function of Adult Protection. Sharing the safeguarding role adds more resource to Safeguarding people.

Last year we said we would

Work with police regarding inappropriate adult in need forms, and to ensure people are safeguarded.

- There has been an increase in what we would see as inappropriate and generic adults in need information which largely is not the responsibility of Social services. This year we have managed to meet with Gwent Police and Monmouthshire County Council Data Protection officers to agree how data received from Police regarding vulnerable adults who are not known to Social Services should be stored.
- Referrals from Police are screened by Adult Protection Co-ordinators and then directed to the most appropriate team. There are also some impacts being felt as a result of partner reorganisations in particular accessing Police in a timely manner, this is being progressed through the Gwent Adult Safeguarding Board.

Last year we said we would

Identify with commissioners services areas where the referral rates are low and work to raise awareness and monitor referral levels.

What did we do?

Not progressed in this year will be carried forward as part of the Adult Protection Action plan (GWASB Annual Report Link)

Judgement

We continue to deliver good outcomes and have a strong commitment to moving forward and improving. This will remain a challenge in a small authority and has driven us to undertake a service review and look at the model for on-going delivery so we have some resilience around delivering the All Wales Adult Protection procedures. This review has looked at opportunities for more coordinated approach in collaboration with other local authorities; scoping what opportunities there may be to manage services together. The outcomes of the review are not known yet but will inform the future plans for delivering this service.

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

Key Priorities for Adult Social Care 2014/15

The way we are working has evolved. Over the last 3 years we have moved our emphasis towards our purpose; “helping people live their own lives” the operating principles are key to us delivering our purpose. Our approach places emphasis on individualised support, this sits in a wider integrated context and we are developing emergent models of delivery. So in order to capture the priorities moving forward for 2014/5 It becomes more complicated to separate out the priorities to individual service user groups so the following overarching priorities capture the direction of travel across a whole range of services user areas and will be reported on across all areas for next year. So in effect this report will next year be reporting on wider priorities with the detail and evidence from the service plans linking more formally.

Priorities.

1. **Developing new models for community living**

- Domiciliary Support: Roll out new delivery model from Raglan learning the rest of In House service.
- Commissioning: Explore models of domiciliary support delivery to inform future framework development.
- Residential: Progress core and cluster living options developments in Monmouth and Abergavenny.
- Progress community model approaches to Mardy Park including using step up step down approaches both in residential setting and community.
- Specialist Placement development including increased use of shared lives.

2. **Broaden reablement approaches.**

- Day care approaches to be focussed on reablement and community connections.
- My Day My Life – broadening opportunities and access to community activities.
- Well - being - focus on Mental Health and Loneliness
- Reablement support and re connection following intervention
- Carers support services to focus on strengths and connection

3. **Community Coordination**

- Community Coordination sites in Abergavenny and Caldicot supporting people with connections.
- Community enterprise and development of small enterprise.

4. Consolidate new ways of working/practice change

- Comprehensive roll out of integrated assessment care and support plan and outcomes framework.
- "Find Individual solutions here" FISH continues to manage demand.

5. Development of Children's/Adults Disability Service

- Integration of Adults and Childrens disability services
- Transition using "what matters" and integrated assessment approach.

6. Integration with Health.

- Develop pilot that will manage decision making locally to increase effectiveness of integrated approaches.
- Nursing service to pilot use of integrated assessment.
- Deliver workshops on integrated assessment development for Gwent Community.
- Participate in the 'experiment' and be part of the core group delivering a systems approach to Mental Health.

7. Safeguarding

- Conclude Adult safeguarding review
- Deliver against Gwent Adult Safeguarding board action plan.