Adult Services Overview

Introduction

This is the second Adult Services overview report. As the new Head of Adult Services preparing it has given me an opportunity to get a thorough picture of how we are performing and set clear priorities for action over the coming years. We face some key challenges including an increasing older population with changing needs and the modernisation of services to meet these needs. This has to be delivered against the backdrop of a tighter financial climate. We are in times of great change; this gives us both, opportunities and challenges in continuing to develop Adult Services for the future.

Adult social care is concerned with ensuring people live healthy and fulfilled lives live safely and are protected from harm. We do this by delivering a range of services to a variety of people. These services are delivered via a well trained motivated and experienced workforce, comprising a range of disciplines including care assistants, day care workers, social workers, home carers, residential services officers and occupational therapists.

We are increasingly looking at ways in which people can have simpler access to what is available and can have greater choice and control over how that is delivered.

This report is structured into chapters around service users groups with some core functions covered separately. The theme of promoting independence is central to everything we do and runs throughout the report. The chapter's are

- Getting Help (covers Access, Assessment, Care Management and Review)
- Older people including older people with mental Health problems
- Learning Disability
- Mental Health
- Protection of Vulnerable Adults
- Carers
- Physical and Sensory Disability

In approaching the Annual Council Reporting Framework this year we have looked back to last year to assess progress against the priorities we had set and assessed the impact for service users. 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 service user feedback, performance indicators, audit and inspection reports and case studies.

In summary how are we doing?

We have continued to make progress in most areas. We have improved the timeliness of our reviews for service users, further integrated health and social care services through the Gwent Frailty Programme and managed to maintain high satisfaction levels with services. There are areas for improvement including making more use of Telecare, meet the needs of new population's such as younger people with dementia and people with Autistic spectrum disorders and getting better at evidencing our successes. Overall the judgement would be that our services are "mainly good with some gaps"

Our real strengths are that we have:

- Continued improving and delivering integrated health and social care services to people, helping them to live at home and stay as independent as possible.
- Worked well with all partners to continue to deliver services that keep people safe and independent.
- A dedicated, well trained and committed workforce delivering high quality services to enable people to lead full lives.

Our areas for improvement are:

- Maintaining quality, at the same time as modernising service delivery in line with changing expectations.
- Collect better evidence to demonstrate continued improvement including improving involvement with service users so people have more control in the design and delivery of services.

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?

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Getting help (Access, Assessment and Care Management and Review)

We can only help and support vulnerable people if they know what services we have available and how they can access those services. Three quarters of new service users who responded to our survey found it easy or very easy to get in touch with us while 7% of people found it difficult or very difficult. Adult services deals with over 800 contacts a month.

People should have enough information to understand what options are available to them. Our information is available from a variety of sources including; One Stop Shops, directly from social service staff and our website which sees an average of 28,000 visitors a month. However, nearly 7 out 10 people contacting us for the first time did not have any information about our services before doing so.

Three quarters of service users told us they found it easy to get in touch with us.

We continue to produce a wide range of public information both in print and electronic versions. As services develop the information produced is updated. Examples this year include the Short Term Assessment and Reablement booklet and a new series of jointly developed Safeguarding Adults leaflets. New booklets have been produced about Individual Support, Adult Placement and the Office Services social enterprise. Of the people who had information about our services before contacting us 82% said the information was easy to find while 85% said it was useful.

We are rapidly beginning to appreciate the power of new digital technologies for communicating including social media such as Twitter, Yammer and You Tube. Some of these are being used very effectively corporately. Adult Services will be using this media to improve the range of options open to the changing needs of people who want to access information and services. This year has seen the development of two DVDs giving information on, Transition planning and 'Social Enterprise projects'. Planning is also underway to develop a mobile phone App for people with Aspergers to access information.

Access to our services is via a single point of access via the One Stop Shop's in Abergavenny, Monmouth and Chepstow where people have access to information, screening and signposting.

With the implementation of the Frailty Project from April 2011 there will be a new integrated Single Point of Access (SPA) which will begin to coordinate a health and social care response, and collect information about service users. Initially this will work alongside existing arrangements and will be reviewed as implementation of Frailty progresses. From which ever route a referral is received, if an assessment is required, this will be dealt with via a single point of allocation, to ensure that the right person with the right skill will make the most appropriate assessment in a timely way. This approach has helped us reduce overlap amongst professionals.

Assessment, Care Management and Review remains a central function for Adult services. The purpose of assessment is to evaluate persons needs, independence, daily functioning and quality of life so that appropriate help or services can be put in place. We deliver some of these services ourselves and organise others through the voluntary sector or private providers. Presently our staff carry out over 300 assessments of vulnerable people every month and completed 82% of assessments within our timescales – although

the figure is lower for some specialist assessments where people like occupational therapists are required. Nine out of every ten people surveyed said their needs had been taken into account during their assessment with only 3% giving a negative response.

Increasingly, we are looking at ways to reduce bureaucracy and increase simplicity. We want to enable service users and carers to have more choice and control, moving to a position where a higher proportion of assessments are self directed. Currently the unified assessment (UA) and Care programme approach (CPA) are the tools used to deliver assessments. We see self directed assessment approaches becoming more prominent in the coming year.

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. We remain committed to providing services to people who have critical, substantial and moderate needs.

Last year we said we would:

- Implement the Gwent Frailty project, building on our integrated approach
- Continue to develop integrated allocation/single point of access
- Ensure clear access arrangements in place for contacting integrated teams
- Progress the Citizen Centred Support project
- Increase the use of Telecare
- Monitor the timeliness of reviews work to improve performance

What did we do?

Many staff were engaged in the implementation of the Gwent Frailty programme work streams. Locally a multi professional operational group have driven how Frailty will be delivered in Monmouthshire, and importantly how this will fit with our integrated teams. Two Integrated Service Managers are now in place covering the north and south of the county. They are responsible for the delivery of an integrated response to ensure more people receive services at home.

Integrated allocation and single points of access are now fully operational in each area hub. This has reduced duplication for service users, and created capacity in teams to ensure the right person responds at right time.

'A view from practice'

Mrs J has been struggling with a range of problems and requires an assessment, previously a referral would have gone to a social worker and an occupational therapist, each would have visited Mrs J separately. Now Mrs J's case is considered at integrated allocation the most appropriate person will carry out the assessment. For Mrs J this meant one person visited, all her needs were identified and services were put in place the next day.

There has been further development of the way in which health and social care staff in the community work at the entry points to hospital to minimise unnecessary and avoidable hospital admissions across the county.

Meanwhile the number of delayed transfers of care from hospital, occurring because timely social care arrangements were not in place, have increased this year although still remain inside the target we set ourselves of no more than 51 delays.

	2007/08	2008/09	2009/10	2010/11
Delayed Transfers of care for social care reasons - number	25	24	6	40

(Source: SCA/001)

Telecare services provide security and confidence for some individuals to remain Independent at home. Active awareness raising included supplying a leaflet to all homes in the county has taken place. We continue to see Telecare as a priority but have seen a decline in referral rates over the past year. Since 2007 we have seen numbers of people using Telecare decline from a high of 275 in 2007 to 121 in March 2011, we will be reviewing our approach in this area in the coming year.

"I have to say that the Telecare system is brilliant - it means so much to know that someone is keeping an eye on things. I had my doubts at one time - not just about mum but anyone who suddenly hears a voice in their home. I thought it might cause distress, especially to people with mental health problems but it's funny how people adapt isn't it?" (Carer)

Phase 1 of a Citizen Centred Support pilot is underway. This is working closely with service users to identify the most effective self assessment tool. Use of direct payments continues to rise and currently stand at 82, up from 74 in the previous year.

We have been concerned at the comparatively low percentage of service user reviews being carried out on time. In the past year we have introduced telephone reviews and improved the way we monitor and validate performance. It is encouraging to see that the percentage of service users who have been reviewed in the 12 months to 31st March improved from 56% to 70%.

Judgement

Our progress remains strong and we have a high level of commitment and engagement to integrated working. We have a 'can do' approach and are committed to service delivery that is service user focussed, streamlined and effective.

The impact of the Frailty project will be significant and will add further to integrated working. There is concern that the added requirement to measure and evidence this new' approach whilst important, will be challenging within our resources.
Our population has changing needs and expectations and we need to improve the ways in which people access information and communicate with us using the full range of technology available.

We are able to meet our statutory requirements, providing good quality care management services. The challenge ahead is to further modernise and deliver a far more person centred service where more people are in control of how services are assessed and delivered.

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

Priorities for action

- Deliver five core elements of the Frailty Programme: Rapid response, urgent assessment, reablement, falls management and emergency social care
- Further develop integrated approaches and pathways to assessment, care planning and review through the implementation of Frailty including integrating community nursing service.
- Develop robust methods of recording success through the performance framework in Frailty.
- Pilot and evaluate Self Directed Support project; develop and introduce self assessments.
- Roll out of Social Work professional development modules.
- Review where Telecare should fit in our organisational structure to ensure maximum benefit to users.
- Monitor impact of changes in service delivery, e.g. agile working and Frailty Single Point of Access (SPA) on service users ability to get a timely response.
- Enhance further reporting systems for capturing review activity of integrated services.

Services for Older people (Including those with Mental Health needs)

The direction of travel for older people services remains one that is linked with our integrated approach. We are committed to enabling people to remain healthy, independent and engaged in a full life.

Older people remain the largest users of services in Monmouthshire with over 2,000 receiving services from us in 2010/11. Over the past decade we have been supporting increasing numbers of people in community based placements. The demographic trends tell us that this will continue to rise and a key challenge for us is to ensure our services continue to focus on keeping people independent, enabling people to make best use of all the communities resources not just those provided by Social Services.

The success of the 'Start' (Short Term Assessment and Reablement Team) teams is as a result of staff embracing this approach and we have seen a reduction in the amount of service people require following their intervention. Of the 500+ people who have been through the reablement service in the past year just under half were independent at following their reablement. 93% of people who responded to the reablement service questionnaire confirmed that staff encouraged them to do things for themselves and supported their independence and choice. Consistent with this we have amongst the lowest numbers of older people in residential and nursing care in Wales, 13.6 per thousand head of population in 2010-11.

Amongst older people with mental health problems we have seen an increase in the proportion of service users supported in the community from 62.4% to 64.8%[1] in the past year. Overall satisfaction level with our services remains very high with 92% of people responding positively when asked about the services they receive.

A commitment to review, re-model and keep pace with change is a feature of service delivery in Monmouthshire. This has seen the developments in the integration of older people day services/hospital with Health partners. We have helped fund an escorted minibus service with Bridges Community Centre in Monmouth, which enables frail people to access social activities and attend appointments. We also worked with Bridges and Age concern to develop a nail cutting service. There is work ongoing to maximise the opportunities to integrate services with health and other partners. Lavender Gardens (extra care) in partnership with Melin has continued to be part of delivering an alternative to residential care in the north of the county supported by a 200 hrs a week from a dedicated home care team.

We have also been ensuring practice is safe and reliable and at the right quality through contract monitoring. This did lead to an extensive piece of work with a nursing home in Abergavenny where the quality of care standards required were not able to be met. Through joint working with ABHB and CSSIW, the owner made the decision to close the home. We worked with them Aneurin Bevan Health Board and CSSIW to ensure safe and appropriate transfer of all of the resident to other homes was achieved. CSSIW's Inspection reports on all homes can be accessed through their website. www.csiw.wales.gov.uk/

Last year we said we would?

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

What did we do?

We established a pathway between the Mental Health Teams and Community Care Team in South Monmouthshire, including joint management meetings. This has resulted in a joined up process, speedier decision making, avoided service users getting caught between two services; enabled improved continuity of care, less repetition and one point of access.

[1] Derived from PM2, Table 2b, row 38

'A view from practice'

Following a long stay in hospital, becoming homeless and loosing confidence and skills, mental health and the START team worked jointly with D to secure accommodation, assist in regaining skills of day living activities and developed social activities to reduce social isolation. The START team worked with D to develop skills in managing life, self care, and bill paying, domestic tasks. The teams have also addressed bereavement and loss issues.

D initially found it hard to adjust to living alone and had difficulty coping. However, D is now excited about the prospect of being independent and, despite difficulties, wants to succeed. There have been subsequent readmissions to hospital but D has consistently received intensive support from both teams. This has enabled D to retain independence in to take part in activities in his local community.

We opened access for older adults with mental health needs to Reablement services. This has meant service users are supported to stay at home longer and maintain independence; carers are more involved in a whole system approach.

'A view from practice'

An example of working jointly with reablement has been assisting a service user to eventually have the confidence to go back downstairs, having previously been staying in the bedroom and feeling low and unmotivated. The service user's family were very anxious and preferred to stay in the house overnight. By the end of the reablement involvement we were able provide on-going support and the service user is now regularly coming downstairs and the family are making steps towards moving back to their own homes" .

A Dementia Homecare Service and referral pathway was established. The dementia service has invested in training staff to high level to enable a better service delivery strong emphasis on carers and outcomes.

We began to implement the strategic direction for Mardy Park. We reviewed all respite service users who access Mardy Park, remodelled the service to reduce costs and free-up resources and capacity to develop Mardy Park as an integrated hub for older people in the north of the county. The service has a clearer focus and is more sustainable. Although we had a gap when progress halted due to changes in personnel this is now moving forward.

The independent provision for domiciliary care has been remodelled. A new contract has been developed reducing the number of providers, developed a new contract, included service users and carers in the interview process. The expected impact is improved

quality and continuity, supporting wide needs of people to remain in their own homes within a more affordable framework. The transition will see large numbers of service users changing providers which we will be looking to manage as sensitively as possible to avoid undue anxiety.

Judgement

We receive consistently positive feedback both from the community care questionnaire and a large number of unsolicited compliments on range of services delivered to older people.

We continue to commission and deliver residential, domiciliary and community meals services to a high standard with a committed and well trained workforce. We work in partnership with the whole sector to deliver high standards of quality throughout all service provision. We need to ensure that this workforce in particular can continue to deliver services that enable independence and focus on peoples strengths continuing to build on the integrated approach.

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

Priorities for action.

- Roll out Mental Health Pilot to North Monmouthshire.
- Develop plans with Aneurin Bevan Health Board to promote integrated services for older people with Mental Health needs.
- Review Day Care and Rehabilitation unit at Mardy Park
- Develop Mardy Park Health and Social care hub, locating Integrated Services in line with the Frailty Model.
- Implement transition plans following awarding of Domiciliary Care contract; Develop robust contact monitoring process and evaluate against expected outcomes; develop providers understanding of outcomes for service users.
- Develop county wide commissioning plan for Day Activities
- Review the Community Meals service
- Review and reconfigure services at Severn View resource centre

Services for people with physical disabilities and sensory impairment

The services for people with a physical disability and sensory impairment continue to be delivered via the integrated services teams in each locality within what is known as the long term support team. These teams aim to support people to remain as independent as possible. This is an area we are keen to coordinate in a different way focussing on service user control and enabling independence.

Services for people with a visual impairment and people with dual sensory loss have been well developed in partnership with Sense and Sight Support (formerly known as Gwent Association for the Blind). This enables access to a range of services including specialist equipment and specialist Communicator/rehabilitation guides. In the last quarter, Sight support worked with 39 people, received 28 new referrals and had a waiting list of 39 people. Sense are working with 25 people with dual sensory loss in Monmouthshire.

'A view from practice'

A Sense worker has taught a service user and his wife the deaf/blind manual so if there is a complete loss of hearing his family will be able to communicate and he will be able to access a deaf/blind manual users group. Sense workers have enabled service users to overcome isolation as a result of deaf/blindness. This early intervention has promoted independence and confidence to service users.

Work is progressing in managing a virtual team for people with Aspergers. Social workers from across all the teams have been identified 45 people with Aspergers and, in addition to their roles have taken a lead on work with these people. This has enabled early identification of need and allocation of appropriate and timely response. It has helped manage the changing needs in the population within our resources. We will look to extend this approach to other groups of service users. 18 staff across adult's services including three parent carers of people with Aspergers undertook an Open University course in understanding Autistic Spectrum Disorders.

Day services for people with Physical disabilities are becoming more outcome focussed Progression from services is now beginning to happen with this year, 6 people moving onto work placements, two people moving into paid employment.

Work on Transition between children and adult services have progressed well. The project which has been running for the last two years will be ending in Monmouthshire in April 2011 as funding has come to an end. However the evaluation and recommendations will continue to be implemented via the multi agency Transition planning group.

Last year we said we would:

- Establish a planning forum for physical disability issues
- Link up with the Falls Service to look at ways to minimise falls for people with visual impairments
- Deliver a training programme on dual sensory impairment for Social Workers, Occupational Therapists and District Nurses
- Review the roles of specialist social workers in the community care teams
- Continue to develop Transition pilot/pathways

What did we do?

We established a Multi agency planning forum including service users for people with a sensory impairment. One positive outcome from this can be shown in the case study of a service user who attends the sensory group. Through this involvement he has developed his knowledge and now informs and helps other people with sensory loss. He also helps the group identify unmet need. The group includes two service users plus representatives from four voluntary organisations that supporting people with dual sensory loss.

Monmouthshire has participated in some Gwent wide collaborative planning groups regarding the development of more local acquired brain injury services. Further work is needed to progress this.

A specific project has been able to identify and support residents with sight and/or hearing impairment and to train care home staff to be more responsive to dual sensory loss. This was piloted in one residential home, and many others have expressed an interest. It is now being started in a second care home.

From close multi agency working and in partnership with Sense we have identified over 150 adults with dual sensory loss, assessed their needs, and looked for new ways to meet them: e.g. new optician referral system which can enable low level intervention to help maximise independence. This is a high number when compared with other Welsh Authorities.

As part of the work looking at the role of the specialist social work role for people with physical disabilities in the long term teams we have developed a virtual asperger's team. An increased number of people with autistic spectrum disorder now receive an assessment of their needs and support following assessments has included:

- Provision of accommodation via supported tenancies
- one to one personal assistant support within own home or within the home of a family member
- Access to residential colleges of further and higher education
- Access to direct payments to purchase specific personal assistant support
- Provision of transport support or access to transport training
- Support with seeking employment opportunities
- Access to professional social work support
- Provision of day time opportunities

There are a number of people with aspergers syndrome who now are able to manage their own tenancies as a result of support from the aspergers team.
In addition to the above the aspergers service forms part of a wider team that has been established to develop new and innovative opportunities for people with autistic spectrum disorder across our county .The team has also been instrumental in collaborating in the first stages of putting together a phone application for people with autism across Wales.

Younger adults are regaining independence and gaining skills training via day services and social enterprises by developing outcome focussed objectives. A new development committee has been established with people with a disability looking to take forward ideas for Social Enterprise development.

The Monmouthshire wide falls service is managed through our Integrated Service Teams. Falls prevention training has been delivered to all front line staff and to community groups.

Falls clinics are based at Mardy Park and Chepstow Community Hospital. The Team have carried out 250 assessments in service users home or in the clinics in the past year. This service is for a wide range of people including a high proportion of older people.

We began a pilot for self directed assessment for people with physical disabilities. This I sin the first phase of development and is focussing on developing self assessment tool.

A Multi Agency Transition Group has been developed to identify and support disabled young people reaching adulthood. The Transition project which has run for two years is now ending as a pilot and an evaluation report will be available shortly and the Transition group will be taking forward and implementing the recommendations that follow.

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

Judgement.

As a small authority it can be difficult to make progress on all fronts; however there has been good progress in this area. We have some well established relationships with organisations for people with sensory impairments that make a real difference to service users in Monmouthshire.

Progress for people with a Physical disability is moving in the right direction but will benefit from us progressing work on Self Directed Support approaches. Work on Transition with young adults using a person centred approach has proved successful. Alongside these service user populations we are seeing new populations emerge such as people with Asperger's for which we need to plan to ensure appropriate responses.

Priorities for Action.

- Self directed support pilot, phase1; developing self assessment.
- Review current structures for delivering services to people with a disability alongside developing a commissioning strategy for people with a physical disability.
- Explore opportunities for expansion of Direct Payments and Self Directed Support
- Continue collaborative working to develop specialist services including MS and Brain Injury
- Identify accommodation needs for younger people with ASD/physical disabilities
- Further develop virtual ASD Team exploring collaboration options
- Continue to roll out deaf/blind project to care homes in Monmouthshire
- Implement the recommendations following the Transition pilot evaluation.

Services for People with Learning Disabilities

We continue to deliver services to people with a learning disability from a co-located, joint team with Health partners. The services currently support over 300 people this includes access to a range of services:

- Supported living services
- Residential placements
- Day provision/social enterprise.
- Respite Services

90% of people supported by the Community Learning Disability Team have reported that they are happy with the services they receive. Meanwhile 86% of regular users reported that the services they get continue to meet their needs, which is a significant increase on the 74% who gave a positive response in 2009/10.

These services continue to be delivered by a mix of in-house and independent providers. This year has seen the culmination of a learning disability review which has been focussing on four key themes: My Home; My Day; My Work; My Parent/Carer. As with other sections in this report the focus is firmly around choice and control to support people with a learning disability to have fulfilled lives as part of a community.

A review of respite is now nearing implementation and has been a good example of how to re-model a service to deliver new outcomes for a wider range of people whilst managing in a tighter financial climate. A wide range of flexible respite options which be available to service users; including short breaks, holidays, adult placement and direct payments.

Transition planning is well established and this service has benefited from the Transition Pilot work with the multi agency Transition group will oversee the continuation of the projects work which finished in April 2011.

A new Joint strategic direction for Learning disability services to progress integration is now established through Partnership board, Gwent wide for local authorities in partnership with Aneurin Bevan Health Board.

Last year we said we would?

- Conclude the Learning Disability review
- Agree and implement the respite care model
- Develop an Asperger's pathway
- Introduce a Gwent wide pricing tool

What did we do?

The Learning Disability Review was completed and a programme of work has now been developed to move to implementation of the key themes: My Day; My Work; My Home; My Parent Carer.

As part of My Home, a two pronged approach has focused on identifying the accommodation needs of service users over a two, five and ten year period also challenging the costs and impact of accommodation provision.

The direct impact of My Home on service users will be felt in the longer term when we anticipate we will have in place more relevant accommodation services at a more reasonable cost.

An options appraisal was undertaken on the potential for taking a collaborative approach for the Shared Lives/Adult Placement service across Gwent, this is now progressing towards implementation; this will increase the amount, choice and flexibility of accommodation options available.

As part of the My Day work all current service providers have worked with Peter Bates, of the National Development Team for Inclusion, to understand how to develop services which better outcomes for people and to consider their application across Monmouthshire. This work has given providers the tools to enable them to better support service users to access the resources of the community. This will be built upon in the coming year.

Whilst there has been little appetite for a parent carer network, communication channels have been kept open through newsletters and events. Service users are informed and efforts made to engage throughout all aspects of the Review. However, in the coming year we would wish to look at how we further involve/empower service users in shaping services.

A new model of respite was implemented on the 1 April 2011 including 2 beds at Budden Crescent in Caldicot. The range of services will also include commissioned holiday provision, adult placement and Direct Payments. This will meet respite requirements for a wider range of service users. It is expected to deliver creative and flexible respite provision with more short term break options and increased choice and control.

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A Virtual Asperger's Team has been established as mentioned. Having a pathway in place means that people with ASD who do not have Learning Disability can access assessment and potential service provision.

For the 2010/11 financial year, there is agreement across the Gwent authorities not to increase fees across Learning Disability placements. This is part of a wider programme in which we individually and collectively have sought to challenge high cost placements, bringing greater equity into the market.

We have been working with an organisation called, OLM to renegotiate high cost care packages. This has resulted in 10 packages being identified and OLM working with the providers to reduce costs. We anticipate a £70,000 saving from this work.

Judgement

Learning disability services are well resourced and we are progressing with re-focussing services so that service users have choice and control and are accessing communities.

The learning disability review has provided the direction of travel and now the implementation will see key aspirations being reached. Integration is firmly on the agenda

in Learning Disability services, with the potential for further streamlining and maximising the efficiency of the Community Learning Disability Team.

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

Priorities for Action .

- Develop the My Day process by developing and introducing an inclusive model which supports individuals to access opportunities within Monmouthshire's communities.

- As part of My Home complete the process of understanding individual accommodation and develop a more strategic response through the developments of new needs based models.

- Continue to challenge the cost of placements by building on the work with OLM through a process of review and renegotiation and maximise this effect in collaboration across the South East Wales Improvement Consortium (SEWIC).

- Implement Shared lives/Adult Placement scheme.

- Develop and implement a two year ASD Action plan which focuses upon the achievement of: a multi-agency Asperger's Pathway supported by tailored support and service delivery; greater awareness of ASD across the community; better access to diagnosis and post-diagnostic support

- Work across Health and Social Care and engage in the delivery group linked to Partnership Board to achieve greater integration within learning disability services.

Services for Carers

Carers play a vital role in the delivery of services. We see ourselves as working in partnership with carers to support the people they care for and, delivering service to carers in their own right.

We deliver a drop-in support and information service via GP surgeries throughout Monmouthshire. Where more formal carer's assessments are needed they are delivered by our two carer's assessment workers or a social worker. The proportion of carers offered a review or reassessment increased by 6 percentage points in the past year. Alongside this the percentage who had an assessment has almost to 97%.

Monmouthshire's Carers Project has carers and young carer's development workers. These workers are actively involved in coordinating increased participation and partnership with Carers.

We have established strong relationships with carers who have been instrumental in shaping the new Carers Strategy and have made significant contributions to the

development of the Carers Handbook and the delivery of various training courses. A key development throughout 2010-11 has been the integration of the Young Carers into the strategy development process which has been welcomed by all.

We currently provide a wide range of flexible services to support carers including assessments, respite, training, information and general advice and support. Of the 144 carers who responded to our survey in the past year 86% were happy with the services they receive as a carer. The development of the new Carers Strategy will put us in a strong position to build on the progress so far.

Last year we said we would:

- Continue to review and develop public information
- Review all services to identify gaps and develop new service models
- Develop a more appropriate performance monitoring system that captures all our work with carers

What did we do?

We updated our information for carers including a leaflet called "Life after Caring" which was produced in consultation with carers whose caring role had come to an end. When an article promoting carers services was featured in our Community Spirit magazine we received 45 requests for the newly updated carer's handbook.

Consultation events have been held during the year with over 50 carers attending each event. These focused on carers and young carers having direct input into the development of the carer's strategy. This included psychology input to examine the emotional impact of the caring role.

"I feel re-energized. The [carers] events give me the energy to carry on for the next few months."

During Carers week a multi agency event was held with teams across the five local authority areas. This featured a presentation by a carer with an update on the carer's measure from Carers Wales. Dr Andrew Goodall Chief Executive of ABHB concluded the event.

Over 220 carers benefited from informal drop-in sessions at GP surgeries and hospitals and elicited a number of compliments ranging from "Glad you were here today" to "Sometimes you need to talk to someone and get it in perspective."

A range of training courses and event have been delivered aimed at addressing issues raised by carers themselves and fitting within the two key themes of the Carers Strategy to support people to be able to care and to have a life of your own. These have included two pilot training sessions "Working with Carers" with the Abergavenny District Nurse team and a presentation on carer awareness for the Gwent Frailty Project. This will be used as part of the induction programme for the Community Resource Teams/Integrated Services Teams.

We have reviewed existing service provision in partnership with carers and carer's groups including young carers. This has confirmed the range of issues needing to be addressed, profiled some examples of best practice and helped to identify what range of services

could be used to address carer's needs. More appropriate performance monitoring linked to new outcome focus in carers strategy is now being developed.

Judgment

Work with carers has been well established in Monmouthshire for a number of years. There is a strong committement to developing approaches for working with carers the team has some vacancies at present and we are looking to review current arrangements. We have high levels of engagement with carers and we will ensure that partnerships and networks with carers are central to any developments.

Carers are key in helping us develop information and services. As people live longer we will have an increasing number of people finding themselves in a caring role. We are looking to assist carers as much as possible with training and support to continue this vital role and satisfaction levels amongst those we support are positive. 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
		✓	

Priorities for action.

- Implement the ten specific workstreams within the carers strategy aligning current services against these priorities, identify significant gaps and develop new services or business plans where these gaps exist.
- Work with partners to fully implement the requirements of the Carers Measure.
- Address the data capture problem and establish an accurate picture of how many carers have received a carer's assessment in line with the Performance Indicator definitions.

Services for People with Mental Health Problems

We continue to provide services to working age adults with Mental Health needs from co-located teams in north and south Monmouthshire. The approach is one of recovery and 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.

A clear strategic commitment to progress integration has been established for 2011/2012 with a joint Partnership board between all Gwent local authorities and ABHB.

We have a good range of services, with new approaches on individual support being effective in supporting people with mental illness, including a re-focus of services to an outcome based approach.

'A view from practice'

In very complex cases it can be difficult to find the right level of support; using a person centred approach focussing on abilities and limitations and ambitions and desires for we were able commission an individual 20 hr a week care package. This package has combined the essential supervision with socialisation and support with rituals and has prevented an inappropriate residential placement.

The closure of a long term home for people with mental health needs saw some people regain independence in the community and with many positive outcomes for a range of people.

Service user engagement remains influential and is coordinated through Gwent Association for Voluntary Organisations (GAVO). In line with the development of the Partnership Board, GAVO have facilitated regular meetings of service users drawn from user support organisations throughout the Gwent area. The most recent one had 60+ service users attending

Last year we said we would?

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

How did we do?

Monmouthshire are active members of Joint Partnership Board, established to develop integrated approaches. Delivery Groups are in place for adults and older people with mental health needs. Joint work with ABHB on integration is a significant area for us and one we are keen to progress with pace. The development of services with Primary Care and the Mental Health measure will require monitoring to ensure these remain targeted.

Assertive outreach and early intervention services are now jointly managed by Assertive Outreach manager, both services are working well. The teams carry small caseloads, currently 22 and 24 service users respectively. In the Early intervention service a variety of interventions are used including the 'recovery model', family intervention and psycho-education. Service users are helped to identify the early warning signs of relapse which can help individuals avoid a serious relapse in mental health.

The Assertive Outreach service work with people who have a serious and longstanding mental illness. These people often have also have problems such as drug and alcohol addiction, homelessness and / or contact with the criminal justice system.

A review of Individual Support Services has commenced. It has been agreed that the service needs to change its focus to concentrate on shorter term recovery and independence. Currently this service works with 43 service users focussing on regaining life skills and confidence.

A review of day service has resulted in changes to the service delivered by MIND progressing from a drop-in provision to a service that is concerned with recovery with more of an outcome focus for the individual. There is improved occupation, physical and mental health as a result of changes in services. Mind Monmouthshire launched their new outreach support service 'Hiway' in April 2011 and has begun receiving referrals from the Community Mental Health Teams. They will be recruiting the final tranche of staff in June and the Service will be fully operational by the autumn.

The Commissioning Team continue to work closely with the Libraries Service to deliver the Book prescription Scheme in Monmouthshire.

An exercise referral scheme has been established. Evidence from the GP exercise referral scheme shows that the percentage of participants remaining physically active after 12 months has increased from 5% to 12% across all service user groups.

In October 2010 Triley Court Nursing closed as it was no longer fit for purpose. This meant that all residents were re housed some into independent accommodation. The outcome for a number of people was a move to independent living.

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 and independence needs to be developed further.

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

Priorities for Action.

- Ensure active participation in joint delivery groups to promote the Integrated Services approach.

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- Development of a Gwent wide Forensic Service.

- In partnership with ABHB: commission new Primary Care Mental health Service; ensure arrangements for service users discharged from secondary mental health services can

self refer back into services if the mental health deteriorates; review current provision of mental health advocacy services to ensure statutory requirements are met.

- Re-warrant Approved Mental Health Practitioners in line with new Gwent-wide policies and procedures.

- Develop pathways between Community Mental Health teams and Primary Care/Community Care Teams.

- Implement the provisions of the Mental Health Measure (Wales) 2010.

- Ensure all users of secondary care mental health service have a Care Programme Approach plan.

- Deliver training on substance misuse to equip our workforce for increasing needs in this area.

Protection of Vulnerable Adults

Adult protection remains a key priority for Monmouthshire and building on the positive outcome following the CSSIW inspection in 2009 we continue to develop our services. This inspection found "*evidence of good outcomes for service users and a commitment to providing an effective level of service".*

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.

We have looked to develop and strengthen our service delivery by enhancing our Designated Senior Officer numbers to include managers in direct service provision. The implementation of the New All Wales Procedures will place a number of new requirements and we are evaluating how these will be delivered in Monmouthshire.

Strategically, we continue to work in a tri partite arrangement with Torfaen and Blaenau Gwent. We are currently exploring moving to a Pan Gwent Adult Protection Committee and are engaged in work with SSIA on developing the strategic capacity of boards to deliver, which will assist our progress.

Last year we said we would?

- Deliver the actions in our annual action plan
- Finalise our escalating Concerns policy
- Build on the role of the joint Area Adult Protection Committee

What did we do?

We updated and developed user friendly information leaflets aimed at improving public awareness and developed and delivered training including: Investigation Skills, Domestic Abuse, and Training for Informal Carers to over 170 people

Training is increasing the skill and knowledge of frontline practitioners. As a result of more knowledgeable staff we are seeing an increase in provider services referrals which follows training at POVA level 2 in particular. Service providers are the highest referrers to Adult Protection:

	2008/09	2009/10	2010/11
Percentage of referrals to adult protection by service providers	17.9	26.0	26.6

Complex investigations were undertaken in a number of settings; this required managed home closures that have resulted in better outcomes for individuals. Three homes were subject to Escalating Concern procedures and two closed. Feedback from reviews was positive, some with much improved outcomes. The proportion of referrals where the risk was removed or reduced increased from 53% to 64% over the past year. Service users reported feeling safer as a result of work undertaken.

We established a Multi Agency Quality Assurance Group. This is used to share information on care sector provision, with a view to enable early intervention when concern is raised. A programme has been set for the Joint Area Adult Protection Committee while some early scoping of opportunities for collaborating on sharing POVA arrangements across all Gwent Local Authority areas has commenced.

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 forward to a more coordinated approach in collaboration with other Local Authorities; scoping what opportunities there may be to manage services together. This is not without difficulty or complexity but feels like the right move to sustain and build services in Adult Protection.

We remain focussed on involving the person in all aspects of Adult protection and want to see real progress in this area this year.

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

Priorites for Action.

- Improve the involvement of service users in the POVA process enabling us to learn from service user's experience.
- Continue to develop training to keep frontline practice up to date, this year to include training on new All Wales Policy and Procedures.
- Implement new All Wales Policies and Procedures from April 2011.
- Develop further Quality Assurance process for provider performance across POVA, Assessment and Care Management and Commissioning.

- Strengthen the Strategic direction for the Area Adult Protection Committee (AAPC); move from tripartite to Gwent-wide AAPC in conjunction with work via SSIA to include learning from practice being shared at AAPC.

- Review scoping exercise and agree if there are opportunities to join up POVA services across the Gwent-wide area.

- Continue to deliver against actions in the Annual Plan