Introduction

The focus for Monmouthshire Adult Services is to make sure that "people are able to live their own lives", and that people are protected from harm. People approach Adult Services for support at different times in their lives and we want to deliver an intervention and support that enables people remain in control of their lives, and in control of the solutions that best meets their vision of a good life.

We want to focus on people's strengths and abilities using family/friendship networks and communities alongside services to support and enhance people to live their own lives.

This is the third Adult Services annual overview report. As Head of Adult Services I am proud to be leading committed and motivated workforce who are driven to deliver a difference every day to people's lives in Monmouthshire.

In preparing this year's report I have been able to reflect and assess how we are delivering on the priorities set last year. I remember thinking we may have set too many priorities, had we set our sights too high? Although we continue to face some key challenges; the increasing older population with changing needs, the need to modernise services, the need to develop a sustainable future position, we have managed to deliver real progress against the priorities set.

As with last year this needs to be balanced 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.

This year and looking forward we have been doing some Systems Thinking work, this is at an early stage of development. Using this approach will change and improve the way we manage our services and deliver a streamlined and more focused approach

This year has also seen the commissioning function return to Adult Services management from a previous joint arrangement with Aneurin Bevan Health Board. The commissioning service is under review and a restructure is planned that will help us deliver more effectively across all service areas.

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

The chapters 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 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 all areas. We have re configured our approach for people with a physical disability, incorporated commissioning within Adult Services, continued the journey to further integrate health and social care services through the Gwent Frailty Programme and will be continuing this with Mental Health and Learning Disability services.

We have managed to keep high satisfaction levels with services[1], despite a number of key changes e.g. The domiciliary care re-tender process. There are areas for improvement including; how we take our work with Carers forward to ensure support for the vital role carers play in helping deliver social care. We need to ensure high quality services are able to support and protect people in Monmouthshire. 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?

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)

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

Our services can be accessed via two main routes; the One Stop Shop's in Abergavenny, Monmouth and Chepstow where people have access to information, screening and signposting, or via the single point of access (SPA) which gives access to a rapid response, avoiding Hospital admission and providing appropriate support to people in their own homes.

This is part of the Gwent Frailty Project . If people require support from whichever access point they will be referred to one of the following teams:

- Integrated Services team North (covering Abergavenny and Monmouth and surrounding areas)
- Integrated services South (Covering Chepstow/Caldicot and surrounding areas)
- Independent living team (All Monmouthshire)
- Learning Disability team (All Monmouthshire)
- Mental Health Team (All Monmouthshire)

If an assessment is required, a referral to the most appropriate team will be followed by a determination as to 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, therefore reducing the need to see more than one person. Nine out of every ten people surveyed said their needs had been taken into account during their assessment.

Vital Statistics

	2010/11	2011/12
Contacts (per month)	804	831
Delayed Transfers	40	21
People Assessed	2664	2699
Direct Payments	82	179
% Reviews on time	72.5%	65.3%

Use of direct payments doubled in the past year. 49 were as a result of flexibility offered during the transfer process during the domiciliary care re tender process.

We have been concerned at the comparatively low percentage of service user reviews being carried out on time. This has dropped back over the last twelve months with only 65% of reviews being completed on time compared to 72.5% last year[2].

We continue to believe that the recording is not in sync with the reality of the work carried out; people are reviewed by a variety of members of the integrated service. As we continue to work towards an integrated health and social care record using digital technology we will see an improvement in the reviews recorded as this will be recoded at the time the review took place.

Assessment, Care Management and Review remains a central function for Adult services. We are moving towards a more personalised, citizen centred approach in this area. A key focus for us is to establish as a priority:

- what matters to the person
- ensure we have listened and understood what really matters
- look at how can we facilitate solutions that enable people to live their own lives.

We want to see a greater emphasis on working with peoples strengths as opposed to what people are not able to do. We are seeing closer partnerships with families, networks and communities alongside our services as a key driver in delivering sustainability longer term.

"So good to find someone who listened and worked with me at my pace and only put things in place when I needed support." (Service User Feedback, Doing it Differently, Doing it Better Event, Feb 2012)

We are doing this by using a range of approaches including self -directed assessments and working with people to find some different solutions.

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.

Staff are working with people using some different approaches to establish 'what a good life look like' building on peoples strengths, enabling people to find solutions that are focused on what matters.

We are now dealing with significantly more complex people in hospital settings as the frailty approach has kept many more people at home. A recent audit showed the average age of people in the community hospital settings was 88 years. Discharge planning is often complex and requires a multi-disciplinary approach.

The numbers of people who are delayed transfer from hospital due to social care arrangements not being in place as shown below has improved in the last 12 months and are well within the target set. This is in some part due to the integrated approach we have to Frailty and hospital avoidance and early 'pull' from hospital settings.

	2008/09	2009/10	2010/11	2011/12
Delayed Transfers of care for social care reasons - number	24	6	40	21

(Source: SCA/001)

As part of quality monitoring we send out a community care questionnaire throughout the year. The percentage of new service users who said they found it difficult to contact us increased from 7% to 15%. This has also arisen consistently in feedback from both complaints and more generally. People have told us that we are not always easy to contact or can be some time in responding to individuals.

In response to this and our adoption of agile working we have opened access further this year. All people who are engaged with a social worker have access to the mobile telephone numbers of staff they are working with. In addition this year with the implementation of Frailty and delivering a timely response within 2-4 hours we are receiving feedback from General practitioners in particular that this is of positive benefit.

We continue to embrace the power of digital technologies for communicating including social media such as Twitter, Yammer and You Tube joining Monmouthshire's website. We continue to use a range of media to demonstrate what we are doing this year, I saw a DVD made by the service users and staff at Budden Crescent sharing their experiences of the new flexible respite options.

This year has seen the development of a pilot using touch screen tablet devices in day centres and some other settings. Our work is still in the early stages although research[3] suggests that this can make a substantial difference to people living well with certain conditions.

Our review process has been formally reviewed this year by an inspection carried out by CSSIW. CSSIW noted that:

> *"All service users whose files were examined or who were directly contacted had a review of their circumstances. Most of the reviews occurred through face to face contact. Service users were not always clear when a visit or a telephone call was a formal review, or just part of social work support and fine tuning to ensure that their care was effective."*[4]

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

Last year we said we would:

- 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 the impact of changes in service delivery, e.g. agile working and Frailty Single Point of Access (SPA) on service user's ability to get a timely response.

What did we do?

- Monmouthshire Integrated Service teams have delivered consistently three out of the five core deliverables required as part of the Frailty Programme; Reablement, falls management and emergency social care across Monmouthshire. The service continues to deliver 9 – 5 Monday to Friday with a standby response at the weekend. The full operational working hours of 8am to 8pm, seven days week is work in progress.
- Community nursing and long term conditions nursing services are now part of integrated services teams and an integrated structure providing line management through the integrated service managers is operational. This includes clear lines of accountability, robust supervision policy and a new operational policy which will support delivery of the new District Nursing Specification.
- We have delivered a management restructure to provide robust management and governance arrangements for the Integrated Community service providing clear lines of clinical accountability for all professional staff and delegation schedules for non-registered Staff.
- We are actively working with the entire integrated workforce to deliver person centred support in line with our strategic purpose.

> "Our analysis showed that most (94%) of the assessments sampled had a clear focus on helping people to keep their independence, remain in their own homes and supported social inclusion."
> (CSSIW Inspection Report, May 2012)

- The performance management framework developed as part of the Frailty programme to measure success is not functioning as expected, the IT system to support Frailty has not been fully implemented and as a result the information is presenting a patchy picture. From a Local Authority perspective we are developing data that will evidence the impact of Frailty from a social care perspective; this will be incorporated into Aneurin Bevan Health Boards data.
- The self-directed support project has developed a set of self-assessment tools which are being piloted across adult service staff.
- Work on Systems Thinking has developed this project further and we have been running an 'experiment' to understand how we can improve our system to deliver our purpose.
- As part of the self-directed support project we have linked with some All Wales work through the Self Directed support Learning and improvement network and submitted Monmouthshire's position statement to Welsh Government.

- To roll this work forward we have been running a series of workshops called “Doing It Differently Doing It Better” which has started to progress both the self-directed support work and System Thinking.
- We have not rolled out the original social work professional development modules as these have been overtaken by the work above around Self-directed support and “doing it differently doing it better”
- A six month telecare pilot has been undertaken; the scheme coordinator was placed with an integrated services team to look at increasing the uptake of the service and assist evaluating strategic direction for this service once completed. Early conclusions are that Telecare has limited efficacy in this area and despite our proactive approach to really establish a platform for this service user feedback tells us people are not receptive to the technology. A positive has been the uptake in care line alarms which is a first step to Telecare which can then be explored at a later date.
- The council’s agile working roll out is now nearing completion this has seen multiple moves for a range of Adult Service staff. All staff are now equipped with laptops including communicator software. The impact of the Frailty Single Point of access (SPA) and the IT difficulties have at times added an extra layer of complexity; through the systems experiment work we have carried, we have been able to recommend some solutions to the SPA review that could further improve responsiveness.

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 has been significant but further integration has been implemented. Measuring the impact of this new way of working has proved problematic, but anecdotally and from feedback we receive the impact to people is positive.

We are confident given some more time the performance measurement data will be realised.

Our population has changing needs and expectations, also we will need to continue 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 integrated care management services. The challenge ahead is to continue building on the person centred approaches to enable people to live their own lives.

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

Priorities for action

- The Frailty core deliverables will continue to develop as resources allow dependant on the shift of resources from acute to community.
- The generic workforce will further develop to deliver a mix of broad based competence and specialist competence skills, and the community nurses and long term condition nurses will further integrate into the integrated teams and deliver a wider range of nursing alternatives to admission to hospital.
- Implement the learning from the Systems Thinking experiment, and further develop an improved integrated assessment and care management pathway.
- Fully implement the IT capability of the Adastra system with Blackberries and digital pens and forms to record assessment and care planning, working towards delivering the single health and social care record.
- To continue to work with all staff to support the fundamental shift in thinking to deliver the new model of engagement required to progress Self-directed support /assessment and the outcomes from the systems thinking work.
- To develop a framework in Monmouthshire for delivering personalised budgets.

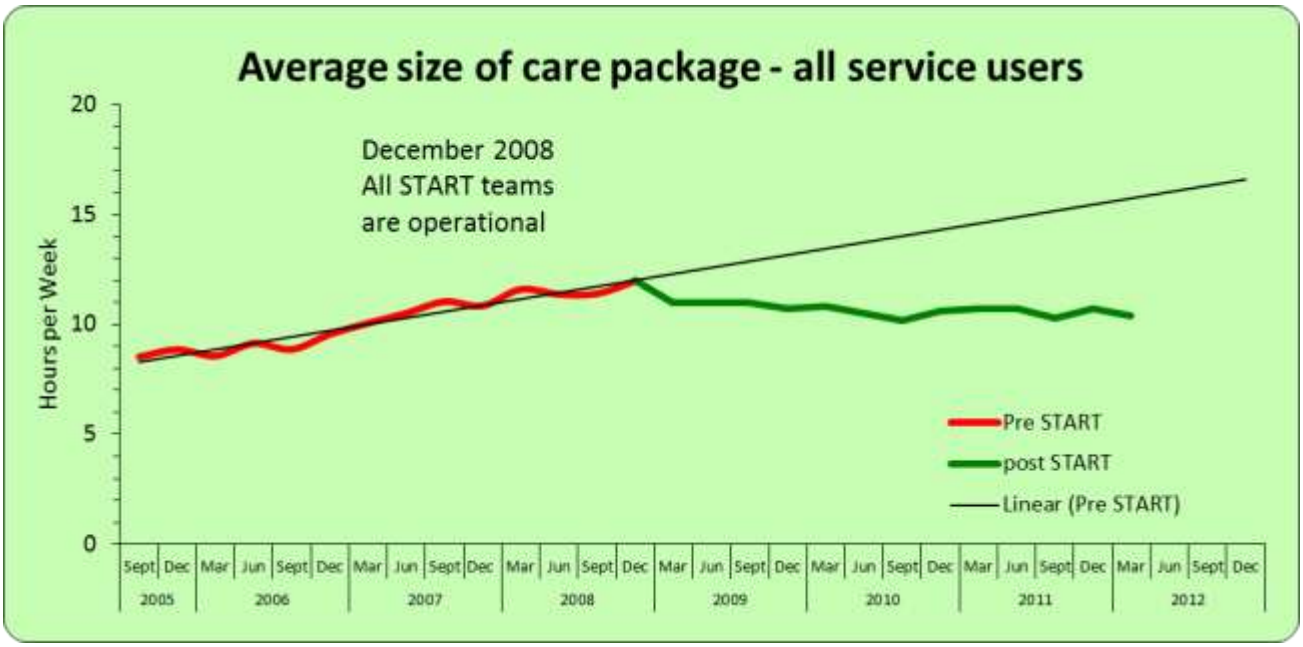
Services for Older people

(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 live their own lives and remain healthy, independent and engaged in a full life. Services to older people in Monmouthshire are delivered across a range of agencies Adult Services both provides and purchases services to meet the needs of older people.

Older people remain the largest users of services in Monmouthshire with over 2,500 receiving services from us last year. Over the past decade we have been supporting increasing numbers of people in the community. The demographic trends[5] 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.

Within the context of our wider integrated approach the success of the 'Start' (Short Term Assessment and Reablement Team) teams continues to be significant. However the implementation of Frailty has seen the demand for this service grow, which has resulted in some further investment to this manage demand. The 'Start' staff continue to embrace this approach and we continue to see a reduction in the amount of service people require following their intervention with 54% of people fully independent and not needing long term support. The average size of package, which had been rising year on year as we dealt with more complex packages has been declining since the inception of start and is now considerably below our pre-Start projections.



We are seeing continued benefits to this approach alongside the wider integrated working and Frailty approaches. Despite demographic pressures we are beginning to see a reduction in the need for residential care as we deliver more support to people in their own homes.

	2008/09	2009/10	2010/11	2011/12
Number of older people in local authority funded residential or nursing care	231	223	236	230

(Source SCA/002b)

Consistent with this we have amongst the lowest numbers of older people in residential and nursing care in Wales, 12.9 per thousand head of population in 2011-12**.**

Amongst older people with mental health problems we have seen a small increase in the proportion of service users supported in the community from 69% to 70%[6] in the past year. Overall satisfaction level with our services remains very high with 93% of people responding positively when asked about the services they receive.

This year has seen the development of a home treatment service for older people with mental health needs, this service operates 8 am to 8 pm, seven days a week, supporting people to remain at home.

Last year we said we would

- Develop plans with Aneurin Bevan Health Board to promote integrated services for older people with Mental Health needs.
- Develop Mardy Park Health and Social care hub, locating Integrated Services in line with the Frailty Model.
- Review Day Care and Rehabilitation unit at Mardy Park
- 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

What did we do?

- Gwent wide work on integration around the Mental Health strategy (including older people with mental health needs) has superseded local plans to promote integrated services for people with mental health needs.

- The vision for Mardy Park has been set it will be an integrated service hub for older people in North Monmouthshire. It is now providing a range of services to older people delivered by a multi professional work force including residential and day centre staff, occupational therapists, nurses and social workers. The full complement of integrated workers is now on-site.
- We have continued to implement the strategic direction for Mardy Park. Last year we reviewed all respite service users who access Mardy Park, remodelled the service to reduce costs and free-up resources and capacity to develop the wider vision Mardy Park. This service has now been in operation for 12 months. Some early concerns over numbers of beds and demands have been resolved.
- The Review of Day Care and Rehabilitation unit commenced at the end of 2011 and are awaiting report and recommendations.
- The independent provision for domiciliary care has been remodelled. A Framework agreement contract was awarded in April 2011. The transition process took place between June and August 2011. This saw (Number) people transfer to new providers for their support. The expected impact of this new arrangement is improved quality and continuity, supporting people to remain in their own homes within a more affordable framework. The Framework is currently being reviewed, including evaluations against expected outcomes.
- Quarterly provider forums have been developed as a platform to share knowledge best practice and increase shared understanding of service user needs and desired outcomes.
- CSSIW undertook an inspection of the domiciliary remodelling process in December 2011. Although there were a small number of cases where transition to new providers had not been as smooth as hoped the majority of people were satisfied with the way the re-tender had been handled.

> "Everyone we spoke to acknowledged that the options available to support them at home had been explained and efforts made to meet their wishes. Where a change of care provider occurred, most service users and their families indicated that despite considerable concern beforehand and some concerns during the period of change while they got to know new staff; they were largely now satisfied with the support provided."
> (CSSIW Inspection Report, May 2012)

- A Commissioning plan was initiated early in 2011 but due to unforeseen shortages in staff was put on hold while awaiting appointment of a lead person
- Plans to coordinate a county wide commissioning plan for day activities have not progressed this year due to unforeseen staff shortages and are being scheduled for 2012/13 as part of the commissioning plan for Older People

- A review of the Community meals service was completed in 2011. It identified the service was meeting the needs of those in greatest need in a cost effective manner. A recommendation of increasing the meal charge to incrementally reduce the level of subsidy has not been adopted as yet.
- The service has also successfully relocated to more suitable premises with better access in bad weather.
- A commitment to review, re-model and keep pace with change is a feature of service delivery in Monmouthshire. Reviewing and reconfiguring residential services has seen Severnview Resource Centre develop a further EMI wing which became operational in 2011, creating increased capacity for EMI provision in South Monmouthshire alongside a staff restructure to manage costs more effectively enabling increased proportion of spend on direct care support.

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 deliver residential, domiciliary and community meals services to a high standard with a committed and well trained workforce. Service reviews in each area have resulted in restructure to ensure efficiency and sustainability. We need to ensure that moving forward we 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 recognise the need for and plan to develop a more robust strategic commissioning position for older people's services.

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

Priorities for action

- Implement CSSIW report recommendations.
- Develop and implement a quality assurance and contract management framework. Ensuring compliance with contracts to improve quality and consistency and achieve financial efficiency.
- Develop county wide strategic Commissioning Plan for Day activities.
- Articulate strategic intent with regard to older people via the development of an older person's strategy including people with dementia.

- Improve information provided to and engagement with older people.
- Develop supported living scheme for younger adults with dementia in the south of the county.
- Evaluate and review Lavender Gardens extra care housing project.

Services for people with physical disabilities and sensory impairment

The services for people with a physical disability and sensory impairment are now being delivered through a single team .This team is concerned with ensuring people are supported people can remain in control of their own lives and independent as possible. This team is heavily involved in delivering self-directed support.

Working as one team for people with physical disabilities will give us:

- a better understanding of current and future needs
- The ability to identify and respond to potential opportunities for collaboration with other local authorities and third sector colleagues.

Services for people with a visual impairment and people with dual sensory loss have been well developed in partnership with Sense and Sight support. This enables access to a range of services including specialist equipment and specialist communicator/rehabilitation guides.

A virtual team for people with Aspergers is now operating. The Aspergers Virtual team consists of two nominated workers from each of the adult social work teams. The team meets bi-monthly and provides group support via practice exchange. The team has developed a referral pathway for adults including those coming through the 14 to 25 transition process. Referrals are based on need, not diagnosis. Adults with Aspergers Syndrome will have access to an assessment of their needs and, where eligible, people are allocated to the most appropriate team.

59 Individuals who have Aspergers Syndrome are currently accessing support. This approach has helped manage the changing needs in the population within our resources.

Work on Transition between Children and Adult Services has progressed well. The project which ended in Monmouthshire in 2011 is now being further implemented via the multi-agency Transition Group. Co-location of the Children with Disability and Independent Living team will provide a significant opportunity for closer joint working and improved transition outcomes.

Last year we said we would:

- Develop self-directed support, starting with the person and their desired outcome and develop a service user group to develop learning from the pilot.

- 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 Multiple Sclerosis and Brain Injury
- Identify accommodation needs for younger people with ASD/physical disabilities
- Further develop the virtual ASD Team exploring collaboration options
- Continue to roll the out deaf/blind project to care homes in Monmouthshire
- Implement the recommendations following the Transition pilot evaluation.

What did we do?

- A five day training programme with twelve staff from across Adult Services helped to develop a systems thinking approach to assessment and care management in Monmouthshire.
- A six week 'experiment' has followed with four front line staff working full time to use the systems approach from a person's point of contact with us right through to delivering a service if required. Completion and evaluation of this work will follow. Practitioner workshops known as 'Doing it Differently Doing it Better' have been held for all front line social work alongside the development of the systems work.
- Service users will be engaged in this work will be part of this work. Social workers will be supporting service users to articulate their own support plans and to carry-out self-assessment.
- A restructure has created the Independent Living Team, a team for people aged 18 to 64 with a physical disability or autistic spectrum conditions. The team also provides a rehabilitation service for all adults with sensory loss. In addition, the team includes the support service for people who receive a Direct Payment.
- The new team has given us the opportunity to look strategically at physically disabled people in a more connected way, hence the development of the physical disabilities strategy.
- Work has commenced on the development of a Physical Disabilities Strategy, and a Practitioner and Commissioning Workshop took place in Feb 2012.
- Direct payments remain a key driver for us this year, we have seen a large increase in uptake self-directed support approaches are evidence in part of the increase this year. We expect these to rise by a further 25 in 2012.
- 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. This is also a forum for all sensory loss workers to meet and share good practice. Work on a collaborative approach for people with an acquired sensory loss has not progressed but ABHB have appointed a specialist nurse in this area.
- Accommodation needs of individual younger people have been identified and efforts have been made to meet them, as part of support planning. Some good examples of using supported living and flexible use of the Adult placement/ Shared Lives service to facilitate individual solutions are evidence to progress this year. Further strategic work is planned as part of the Physical Disability Strategy development.
- The Virtual Asperger's Team continues to operate and people are receiving appropriate assessment and support. We now have a better understanding of the population. There is a clear allocation process and database. There are firm links with our transition process. The ASD coordinator influences practice and policy.
- A three-tier training package has been delivered to staff and provides different levels of training given depending on requirements: 18 people have successfully completed an Open University Understanding Autism Course; 150 people within Monmouthshire have completed the Autism Awareness scheme and in May 2011 we held an ASD information day for individuals and Families
- Following the three care homes, who benefitted from the deaf/blind project this has been extended to a further care home this year. On-going training is being offered to staff in these four care homes so they can identify deaf blindness and provide appropriate support. Nine residents of care homes were identified and supported.
- The Deaf blind Development Group continues to meet quarterly. People newly diagnosed with sight loss were able to meet together, share experiences, find out about services, and form on-going support networks.
- The total number of adults identified with dual sensory loss in Monmouthshire, at 158, is now in line with SENSE's prevalence figures. Forty one people were identified this year.
- The Low Vision Scheme continues to identify and refer to us, people with dual sensory loss.
- The Monmouthshire Multi Agency Transition Group (MMATG) meets bi monthly to carry out the recommendations of the Transition pilot evaluation and jointly plan support into adulthood for young people in transition.

Judgement

This is an area where progress over the last few years has not been at the pace we have wanted. This has become an area of growth with emerging

populations of need. This last year has seen some real progress and momentum which will set us in good stead for the coming years.

Progress in self-directed support, Transition, work with people with sensory impairments as well as people with Asperger's is now well established with a clearer direction.

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

Priorities for Action

- Evaluate the systems thinking 'experiment' and develop new process/flow for access/referral assessment and review system based on findings.
- Continue to develop self-directed approaches including more creative uses for direct payments to enable service users to achieve their own outcomes and to manage their Direct Payments with maximum efficiency.
- Write a commissioning strategy for Physical Disabilities incorporating; collaboration regarding MS and Brain Injury services, housing needs for younger disabled people.
- Establish close links with housing colleagues, Aneurin Bevan Health Board's newly appointed specialist acquired brain injury nurse and new Community Monitoring and Support Officer for ASD in ABHB to progress the work of the independent living team.
- Use the new Independent Living Team's county wide structure to continue developing a timely and creative response to young physically disabled people in transition, including developing an invest to save bid a social worker or senior practitioner to specialise in transition work in the Independent Living Team.
- Continue to introduce alternatives to Talking Books.
- Maintain the close partnership working in Dual Sensory Loss Project Group that enables us to identify so many people with dual sensory loss.
- Undertake a small pilot using self-assessment with people with dual sensory loss.
- Sign up to the 2011 pan-Gwent transition protocol.

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 including: Supported living services; Residential placements; Day provision/social enterprise and Respite Services

94% of people supported by the Community Learning Disability Team have reported that they are happy with the services they receive. Meanwhile 78% of regular users reported that the services they get continue to meet their needs[7].

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.

The respite review is now completed it 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 wider range of flexible respite options are now available to service users; including short breaks, holidays, adult placement and direct payments.

Transition planning is well established with a multi-agency transition group overseeing the continuation of the transition projects work which finished in April 2011.

A new joint strategic direction for Learning disability services to progress integration is now established through Gwent wide partnership board, including local authorities in partnership with Aneurin Bevan Health Board. A strategy has been produced based on the views and opinions of a number of key stakeholders across Monmouthshire including people with a learning disability, their parents/carers and people who work alongside people individuals with a learning disability. A comprehensive consultation exercise which saw 79 individual and service responses. The strategy will shape the direction for integration over the next few years.

Last year we said we would

- 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 Financial Management through a process of review and renegotiation and maximise this effect in collaboration across the South East Wales Improvement Consortium (SEWIC).
- Implement the 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.

What did we do?

Following the Learning Disability Review and the programme of work has now been developed to move to implementation of the key themes: My Day; My Work; My Home; My Parent Carer, there have been a number of developments in 2011/12;

A service model for My Day/My Work has been established which has as its main focus social inclusion and the need to tailor support to meet individual needs. So far there has been some good progress including:

- A number of bespoke day time opportunities have been established to ensure people's needs are met and that people contribute actively to their community.
- Progress made by a number of social enterprises within North Monmouthshire's (both in house and the private sector) with the main focus being to move from a traditional day service to one of offering genuine workplace skills and the opportunity for transition to employment.
- People have had access to new services over the last year – The Pathway Employment scheme has set up a café project in the Abergavenny area and has also improved links between services such as disability employment advisors.

- A private social enterprise has been registered to provide ASDAN and work right qualifications having a direct impact on people's opportunity to secure employment in the future
- A bespoke day service, using personal assistant support has been set up for a young man moving through the transition process.
- People with a learning disability who live within Monmouthshire have secured a number of employment opportunities supported by Mencap Pathway scheme
- As part of My Home a pro-active approach has been established in identifying and understanding the accommodation needs of people with a learning disability who live within Monmouthshire or who are provided with services commissioned by Monmouthshire, based on a 2, 5 and 10 year programme.

"94% of people supported by the Community Learning Disability Team have reported that they are happy with the services they receive" (Community Care Questionnaire, 2011/12)

- People who now live within supported tenancies coordinated by Reach have a very clear care plan in place along with specific assessment which clearly identifies specific need be it supporting people identified need or needs in relation to social care. An example is where a man has moved into his own accommodation following a period of time living within a supported tenancy – this has significantly increased his independence and enabled him to form an active part of his specific community
- A review of Reach, the supported tenancy provider has seen people who receive support being reviewed and new care plans put into place that clearly reflect the support and care hours received. There has been a reduction of support hours for a number of people who are increasingly reaching higher levels of independence.
- The OLM consultancy work has targeted high cost Learning Disability placements and identified where savings can be achieved by renegotiating high cost packages. This work has delivered some initial savings; building on this approach we will be using the links with South East Wales Improvement Collaborative (SEWIC) to further develop this approach using regionally agreed methodology.
- Monmouthshire has led on a South East Wales Adult placement/Shared Lives collaboration across six authorities to increase the number and range of available accommodation support options this service will go live in April 2012. People across Monmouthshire will have greater access to different options within the Adult Placement scheme and will be able to utilise this service for greater respite opportunities in addition to day time opportunities.
- Work on ASD actions is well developed. A database for people with Aspergers Syndrome has been established giving a greater understanding of the projected accommodation needs. There is a clear path with Adult services for support signposting and assessment if required

- An Autism Information Day proved useful in promoting transparency, giving people an opportunity to better understand the authority's aims, and to meet many of the key staff.
- A strategy has been established based on the views and opinions of a number of key stakeholders across greater Gwent including Monmouthshire. The development of the strategy included people with a learning disability, their parents/carers and people who work alongside people individuals with a learning disability.

Judgement

Learning disability services are well positioned to respond to the challenges of the new strategy, we are continuing to progress with re-focussing services so that service users have choice and control and are accessing communities.

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.

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

Priorities for Action

- A review of day service opportunities within Monmouthshire will look to develop appropriate day time opportunities including; employment/supported employment, education, leisure and day services.
- Continue to develop accommodation options for people with a learning disability including - core and cluster accommodation for three people In Monmouth.
- Review of all residential care services will be completed by the social work team with specific focus on service quality.
- Engage with people with Asperger's Syndrome to ascertain their views and opinions re future service provision.
- Work with the Gwent wide partnership board to develop implementation of integration within the principles set out in the Strategy.

Services for carers

Carers play a vital role in Monmouthshire, we see carers as key partners in delivering social care, and they are supporting a wide range of people who need the care of someone close to them. Our aim is to support carers, enabling them, where they chose, 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.

The recently completed Carers Strategy has seen carers identify two main themes as priorities

- A Life of My Own
- The Ability and Capacity to Care

These themes are supported by ten priorities which will be implemented over the next three years.

We deliver support and services to carers via two routes; Monmouthshire' s Carers Project provides a range of support advice and training coordinated through the Carers strategy group, and through social work teams using carers assessment workers to support carers through assessment to meet their needs as individuals.

We continue to deliver a drop-in support and information service via GP surgeries and community Hospitals throughout Monmouthshire. This is still proving to be an excellent way of identifying and supporting local carers.

We receive regular comments on how useful carers find the information and support on offer, with carers returning to the surgeries to say thank you. Recent examples include two carers returning to say the information supplied led to them to be able to access direct payments and housing benefit support respectively. This service has seen some 130 carers receiving support and advice in the last year.

	2009/10	2010/11	2011/12
The percentage of carers who had an assessment or review of their own needs	50.2%	72.5%	80.9%

(Source: SCA/018b)

Last year we said we would

- Implement the ten specific work streams within the carer's 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 national performance indicator definitions.

What did we do?

- The Carers Strategy completion was delayed but now complete so work to implement the work streams will from part of the coming years priorities.
- Work on implementing the Carers Measure is underway and is being led by our partners in Aneurin Bevan Health Board there has been close involvement and liaison with ourselves and we remain committed to supporting its implementation.
- Work to improve data capture has been ongoing. However we are not yet seeing a more accurate reflection of the work carried out although the proportion of carers offered an assessment, who subsequently receive one has improved for each of the past two years[8].
- This year has also seen the development of a Facebook page for the Monmouthshire carers project. We are keen to embrace technological advances and see this as a useful place where carers can have access to information and communicate together
- The Monmouthshire carers project have been working on a pilot project with former carers who are receiving training to become carer befrienders helping existing carers who may be socially isolated and in need of support. An evaluation will be carried out which will consider further recruitment of volunteer carers

Judgement

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 and 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
		✓	

Priorities for action

- Continue to work with ABHB on developing a communication strategy to be published by October 2012
- Work with Community Teams and Carers Assessment workers to ensure all carer's assessments are recorded.
- Work with ABHB Locality Office to ensure NHS elements of the Carers Strategy are implemented
- Review the role of Carers Assessment Workers.
- Develop Service Specifications for all services funded under the Carers Grant and Carers Mental Health Grant
- Review the role of Carers Information Worker.
- Review Carers Befriending Scheme after one year's operation
- Explore opportunities for joint working with other local authorities over carers' issues.
- The carer of every person assessed in the memory clinic will be offered a Carers Assessment

Services for people with Mental Health Problems

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.

A clear strategic commitment to progress integration of local authority and NHS mental health services was established in 2011/2012. A joint Partnership board for all Gwent local authorities and Aneurin Bevan Health Board saw the development of a Mental Health Strategy. The consultation has been completed, comments have now been collated and implementation is being planned.

We continue to have a good range of services. New approaches using individual support have been being effective in supporting people with mental illness, including a re-focus and use of personalised outcomes to support planning.

Service user engagement remains influential and was well coordinated through the strategy development.

Last year we said we would?

- Ensure active participation in joint delivery groups to promote the Integrated Services approach.
- Develop a Gwent wide Forensic Service.
- In partnership with ABHB: commission a new primary care Mental Health Service; ensure arrangements for service users discharged from secondary mental health services can self refer back into services if their 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.
- 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.

What did we do?

- We have been a key player in all of the delivery groups and we are currently looking at the revised system of delivery groups to ensure continuity of membership.
- The Forensic Service has been created, Newport will be taking the lead on this and social workers are being appointed at present. Service Users with a need for forensic support will receive more co-ordinated and coherent service.

"86% of people aged 18-64 with a mental health problem were supported to live in the community." (PM2, Table 2a)

- There has been some real progress in this area including:
  - A lead has been appointed for implementation of part one of the Measure.
  - A contract for advocacy services has been rolled over and extended to cope with the extra demands for this service. More people are now eligible under the measure to advocacy and are able to access it when required.
  - Service users are now being signposted on discharge from secondary services to self-refer.
- We now have a jointly approved policy amongst ABHB and the six Local Authorities to enable implementation of a re-warranting scheme for Approved Mental Health Practitioners every 5 years.
- A number of activities this year have improved the pathway between integrated teams and Mental Health teams; a Community Care Social worker undertook a secondment with the adult Mental Health team to develop understanding and relationships between the teams. Pathways into secondary Mental Health services and Memory Clinics have been established links between the integrated teams and mental health teams; Service User receives a more timely intervention from the most appropriate team.
- All Service Users have received a Care Programme Approach care plan and have a clearer understanding of what they can expect to receive.
- Training on substance misuse is being rolled out to staff. We have started to use the expertise of Kaleidoscope and Drug Aide to facilitate the assessment process. Staff is now more conversant with types of substances and their impact on mental health.

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. The

implementation of the Mental Health Strategy and the Mental Health Measure are significant areas of development for us and ones we are keen to progress with pace.

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

Priorities for Action

- Work with the strategic implementation group to progress the integration agenda following the strategy principles.
- Develop pathways for working with new joint Forensic Services.
- Establish joint scheme for implementing Primary Care services. Set up Primary Care Mental Health Teams.
- Review Monmouthshire's community advocacy scheme in light of the Mental Health Measure.
- All Service Users to have a care and treatment plan.
- Ensure warrant cards and re-warranting process in line with the new Mental Health Act.
- Review our response to provide statutory services under the Mental Health Act 2007 in light of changes.
- Establish the assessment process within the new Primary mental health care team
- Continue work on high cost placements within Mental Health services.
- Contribute to a review of MIND HiWay Services who provide Community Outreach Services

Protection of Vulnerable Adults

Adult protection 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.

We have continued 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 is now in place a number of new requirements are being implemented and we are evaluating how these are working in Monmouthshire.

Complex investigations are a feature of Adult Protection work but we are seeing a rise in the number of concerns regarding quality issues in some care homes which has resulted in activating the escalating concerns policy and monitoring concern for vulnerable adults.

Strategically, we are now part of a pan-Gwent Adult Protection Committee which will be known as the Gwent Adult Safeguarding Board and we have worked with the Social Services Improvement Agency (SSIA) to develop the strategic capacity of the board to deliver robust outcomes.

Last year we said we would

- 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.

What did we do?

- Monmouthshire Social Care and Health have been involved in a pilot with SSIA to look at outcomes for service users. This project involves workers from four areas of Monmouthshire working with service users with capacity using a 'guided interview' approach to gain feedback regarding POVA process. Evaluation is expected at the end of March 2012.
- POVA training, from awareness raising, refresher to non-criminal investigation was delivered to over 250 people in 2011. Training is increasing the skill and knowledge of frontline practitioners across all sectors. We are seeing evidence of increase in referrals following attendance on some courses.
- An electronic copy of the all Wales policy and procedures was circulated to all stakeholders across Monmouthshire including providers and Health colleagues.
- Designated Lead Manager meetings were held bi-monthly to discuss POVA operational issues and implementation of Policies and Procedures.
- An event on Friday 14th October launched the all-Wales policies formally and considered implementation across Monmouthshire. 67 Providers attended this event, which was facilitated by MCC staff and colleagues from Gwent Police.
- Links between the POVA coordinator the Commissioning manager for Older Adults and Designated Lead manager are now established and are progressing Provider / Quality Assurance issues.
- Workshops organised with the SSIA to develop the strategic direction of the Gwent-wide Adult Safeguarding Board have taken place and Newport and Caerphilly have now joined to establish a fully constituted Gwent Board comprising all five local authorities.
- Some early scoping work has been carried out to look at the opportunity to collaborate on a Gwent Wide POVA Service, this is still work in progress.

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
		✓	

Priorities for Action

- Evaluate the work on outcomes from service users following being involved in the POVA process and develop some more robust practice for involvement of service users as a result.
- Link with Health POVA coordinator to ensure health staff from all Monmouthshire services are trained using new Health e- learning modules.
- Continue to engage fully as a member of the Gwent Wide Safeguarding board to support strategic developments across the patch.
- To build on the partnerships with provider services forged through implementation of the new guidance to deliver further opportunities to develop preventative practice and fully implement the all Wales guidance.
- Develop a system for getting more accurate information about the outcomes of individual POVA referrals to evidence our activity.

References

[1] Results from our Community Care questionnaire show that 93% of adults who are regular recipients of social care were satisfied or very satisfied with the services they receive
[2] National Performance Framework Item SCA/007
[3] University of Worcester Report - www.aliveactivities.org/images/library/files/PDFs/iPad_Draft_Report_2011_FINAL.pdf
[4] http://wales.gov.uk/cssiwsubsite/newcssiw/publications/ourfindings/monmouthshire/ssreview/?lang=en
[5] The number of people aged 85 and over in Monmouthshire is projected to increase by 39% by 2020 and 121% by 2030, (Source: DaffodilCymru)
[6] Derived from PM2, Table 2b, row 38
[7] MCC Community Care Questionnaire 2011-12, based on 48 responses from people with learning disabilities.
[8] National PI SCA/018b improved from 72.5% to 80.9%