Introduction

Monmouthshire Adult Services is striving 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 approach that supports and 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 fourth 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. We have managed despite some key gaps deliver on many fronts. 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 continued to implement the learning from doing our Systems Thinking work, this is progressing well. It has set a good foundation for improving the way we manage our services and deliver a streamlined and more focused approach.

We have continued to re model the commissioning function since its return to Adult Services management from a previous joint arrangement with Aneurin Bevan Health Board. The commissioning service has been restructured and 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)
- Commissioning
- 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 and provide evidence of how this makes a difference to people who approach us for support. We have then identified what we need to focus on in the year ahead. The report has been informed by a range of information including feedback from people who use services, performance indicators, audit and inspection reports and case studies.

In summary how are we doing?

Our real strengths are that we have:

- A dedicated, well trained and committed workforce delivering high quality services to enable people to lead full lives.
- Continued improvement and delivery in 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.

We have continued to make progress in all areas:

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- We have re configured our approach for people with a physical disability to ensure we are able to support people to maximise their independence and potential to contribute.
- Incorporated the commissioning function within Adult Services enabling more effective quality assurance and strategic planning for service delivery.
- 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,

- Continued to transform our business to concentrate on 'what matters 'to people in all aspects of our service delivery.

Further progress needed in:

- How we articulate a vision for how older people including people with dementia are supported to live a good life in Monmouthshire.
- Collecting better evidence to demonstrate continued improvement including improving involvement with service users so people have more control in the design and delivery of services.

- Progressing the agenda for carers to ensure support for the vital role carers play in helping deliver social care.

- Ensuring 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"

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.

People have been telling us they want easy access and a prompt response when they contact us. In 2012 we started redesigning our 'front end' so people have access to the right person without being passed between 'call handlers' and that we are able to respond with the right information and support as required.

The new 'front end' now known as 'Finding Individual Solutions Here', or FISH for short, is currently working from two of our three main hub areas (Chepstow, Abergavenny and Monmouth –coming on line later this year).
As part of the Gwent Frailty Project people may also be signposted to us 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.

When people contact us now they will be speaking directly to staff that will be 'listening to understand' and looking to 'facilitate solutions' this may take place over the phone or face to face.
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 decreased from 15% to 4% which is a positive indication that the changes we have made in our 'front end' processes has made it far easier for people to contact us.

As part of implementing the new FISH approach we have been in contact with people to seek feedback to this new approach early findings are that people find it easier to get hold of us and experienced high levels of satisfaction with the contact they had with us.
We have also given mobile phone access to social workers for people we are working with. We continue via Frailty to deliver a response within 2-4 hours, we are receiving feedback from General practitioners in particular that this is of positive benefit.

If people require support following contact with either access point they will be put in touch with one of the following teams:

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

Vital Statistics

	2010/11	2011/12	2012/13
Contacts (per month)	804	831	741
Delayed Transfers	40	21	16
People Assessed	2664	2699	2302
Direct Payments	82	179	201
% Reviews on time	72.5%	65.3%	54.4%

If following a 'listen to understand' conversation further support or an assessment is required one of the above teams will be in touch to look at what is required. The team will ensure the best person is deployed to 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.

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. We want to enable people who use services and carers to have more choice and control, moving to a position where higher proportion of assessments are self-directed.

"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 2013)

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

Nine out of every ten people surveyed said their needs had been taken into account during their assessment.

With the introduction of the Social Services and Wellbeing Bill (Date) we will be increasingly expected to work with a range of agencies to enable people to have access to information and advice and address wellbeing to a wider population. This year will see us launch a new approach by way of a pilot, known as Local Area Coordination. We will be placing two coordinators in two areas of Monmouthshire to test out this evidence based

approach. The aim is to strengthen people's connections with community, family and key links enabling people to retain resilience and independence and delay the need for a more formal service intervention.

We have been concerned at the comparatively low percentage of service user reviews being carried out on time. This has dropped further back over the last twelve months with only 54% of reviews being completed on time compared to 65% last year[1].

We continue to believe that the recording is not in sync with the reality of the work carried out; we are continuing to redesign what reviews will look like when our systems work has been fully implemented .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 recorded at the time the review took place.

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. We aim to support people at home in all situations unless Hospital is necessary.

	2008/09	2009/10	2010/11	2011/12	2012/13
Delayed Transfers of care for social care reasons - number	24	6	40	21	16

(Source: SCA/001)

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. This year we have embarked on a re-design of the website and the Adult Services section is currently under construction. The new website will provide a wider range of support and resource information with easy access to a range of links for further information and advice. Furthermore we will be creating a more interactive facility and the potential for people to add content. We see this as a positive step.

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[2] suggests that this can make a substantial difference to people living well with certain conditions.

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

Last year we said we would:

- Work to embed the Frailty core deliverables and continue to develop resources that enable the shift of resources from acute to community.

- Develop the generic workforce to deliver a mix of broad based competence and specialist competence skills, including the further integration of community nurses and long term condition nurses into the integrated teams to 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.
- Evaluate the systems thinking 'experiment' and develop new process/flow for access/referral assessment and review system based on findings.

What did we do?

- Monmouthshire Integrated Service teams have continued to deliver consistently three out of the five core deliverables required as part of the Frailty Programme; reablement, falls management, rapid nursing alongside emergency social care across Monmouthshire. The service can accept referrals 9 – 5 Monday to Friday. The nursing and social care response is delivered 7 days a week 7am -11pm. The full operational working hours of 8am to 8pm, seven days week is still work in 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 integration has enabled delivery of a wider range of nursing alternatives further preventing admission to hospital, this service can now support the administration of Intravenous antibiotic treatment alongside intervention and management of long term conditions in the community which would previously have required hospital admission.
- The falls service has been disaggregated and is now working from each of our three hubs.
- Falls staff are working proactively with staff in hubs, community hospitals and care homes to help educate and support people who fall., again creating more opportunities for people to receive treatment at home as opposed to admission to hospital

- IT solutions to support the new 'frailty' model have been in roll out phase for the last couple of years, Adastra, the software required to run the capture of electronic data is not fully functioning .Progress is now being made and we expect the use of electronic data capture via the use of Digi pens to be operational shortly.
- 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.

- We are actively working with the entire integrated workforce to deliver person centred support in line with our purpose.
- Work on the self-directed support project has seen the development a set of assessment tools which are being used across adult service staff.
- Work on Systems Thinking has developed this project further and we have now re designed the assessment tools used in practice, this enables practitioners to work with people focussing on what matters, looking at peoples strengths and what we can do to support 'people to live their own lives' .

> "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)

- Following the systems review and the initial six week 'experiment' we were able to clarify where changes were needed, we have made some radical changes to the way we carry out our functions. To deliver the changes required we have worked with the workforce to re- design our process/flow this has happened largely as a result of Practitioner workshops known as 'Doing it Differently Doing it Better' these sessions have been in place for some 15 months now and have been key to getting buy-in to the changes. Key achievements include;
    - Change in practice to a focus on a strengths based approach.
    - New person centred tools for assessment and self- directed support.
    - Pilot of a new IT solution designed around the new flow, reducing time spent on inputting data.
    - Individual budget and managed accounts being tested in practice with increased take up.
- Recent feedback as to the use of these sessions has seen some positive from a range of practioners

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 focuses on what matters.
The work we have developed following the systems review is fundamental in ensuring we can respond to the ever increasing needs and expectations and build a response that provides the right support and der and more complex range of people. We are able to meet our statutory requirements, providing good quality integrated care management services. Our progress to deliver person centred support to people is moving at pace. The challenge ahead is to continue building on the person centred approaches having a workforce that can respond and support people to live their own lives.

The impact of the Frailty project continues to be significant, our Integrated model enables us to see the person and deliver a seamless approach which in turn has seen our performance improve. Measuring the impact of all our progress remains a challenge, however we are seeing demonstrable improvement in performance.
We are confident given some more time the performance measurement data will be realised.

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

Priorities for action

We want to ensure that:

- Vulnerable people are supported to remain at home by strong multi-agency teams
- We have clear evidence that demonstrates the impact of the service
- People will have the opportunity to have different conversations to help identify their support solutions and a range of opportunities to meet their support needs.
- We are in a position over the next two years to implement the new Social Services Bill

We will:

- Continue to implement the Frailty core deliverables into a fully integrated health and social care model.
- Consolidate this platform to deliver the drivers from the new Bill.
- Work with the new project manager to make full use of the digital pens to record assessments
- Improve access to information for the citizens of Monmouthshire by re designing the website
- Continue and review the ‘doing it better doing it differently
- Workshops to manage the cultural shift in practice development.

COMMISSIONING

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

Following the changes in 2011 which saw the commissioning team being relocated in Adult services following reorganisation of health boards in Wales, we have now restructured the team and are beginning to implement the new arrangements alongside closer working with operational services.

This implementation does present some challenges in ensuring that both health and social care services are developed in an aligned and cohesive way. However Monmouthshire County Council has strong partnership working with its local health colleagues and this is evidenced in the significant progress achieved in establishing the Integrated Services Teams, part of the Gwent wide Frailty initiative. We are confident that these strong working relationships which have been developed over many years will continue.

The establishment of a social services commissioning team for adults presented a timely opportunity to review our performance and structure and identify ways in which we could improve. This review has now concluded and a restructure has happened we believe we are better placed to improve our quality assurance, service development and partnership work, and refocusing out activities to ensure we are better outcomes for service users.

The last year has seen the achievement of a number of key priorities which we identified in last year's report; the supporting People team is now firmly embedded within the whole commissioning team and contract monitoring arrangements more cohesive, our care fees modelling work has been concluded. The South East Wales Adult Placement Scheme (Shared Lives) is nearly 12 months into delivering the new service and is growing from strength to strength.

Supporting People arrangements have undergone major changes with all funding now coming directly from the local authority and the formation of regional collaborative committees to oversee the development of services and allocation of funding. More work is planned to embed these changes throughout the year.

The past year has been challenging in terms of re aligning the structure and function of the commissioning team and managing increased workload with a reduced capacity. We have recently completed the recruitment to gaps in the service. With reduced capacity we have seen progression on a few fronts being delayed but expect this year to be back to full strength.

Last year we said we would

- Develop an overall commissioning strategy.

- Implement remodelling of day services for people with disabilities

- Develop and implement new quality assurance frameworks for all care homes, supported living and domiciliary care, linking into assessment care management - Vanguard Review work and new CSSIW Inspection regime.

- Lead on the development of:-

    1. Older persons Strategy

    2. Physical disabilities Strategy

    3. Carers (implementation only)

    4. Supporting Peoples Strategy

- Review of existing partnership/collaborative arrangements and clarify ongoing influence/priority.

What did we do?

- Approach developed which will enable a Commissioning Strategy to be developed in line with ADSS response to Sustainable Social Services (Commissioning) and allied to the work programme being developed as a result of the Commissioning Restructure. Working with SSIA to pilot the production of market Position Statements to set our strategic priorities for service development.

- My Day Programme Board have been meeting regularly. A Project Plan has been developed and progress being made against it. Some issues of capacity have now been resolved and work is progressing. A phased approach to delivering My Day objectives is being pursued with Tyr Fenni acting as the first 'building block'. Links to on-going work with Local Area Coordination are being developed. Staff development programmes under way for Tyr Fenni Staff to skill them to support users to access individual community responses.
- Local Commissioning Plan for supporting people are approved – an outline of how savings from reviews could be invested Regional Collaborative Committee are set up and operational. Outcome monitoring has been implemented and work undertaken with providers to develop consistent reporting.

- Carers Strategy approved by Cabinet and currently being published. Work plan for monitoring has been developed for development on older people and physical disability strategies detail in sections later on in this report.
- Fair rate for care agreed in July 2012 resulting in an increase in fees of between 5%-13% Improved relationships with providers which enabled wholesale acceptance of methodology and fee levels.

Judgement

Overall our commissioning arrangements are good and well established. The recent review has highlighted areas which we can build on and include: developing a comprehensive strategic commissioning plan, strengthening our contract monitoring and quality assurance arrangements, releasing capacity to develop new services and most importantly support the growing personalisation agenda, reviewing key service contracts and strengthening relationships with providers.

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

Priorities for Improvement

- Implementation of Strategic Commissioning approach to cover areas as physical disability, older people including dementia peoples services including use of strategy market positions statements.
- Implementation of My Day initiative.
- Implementation of the Carers Strategy.
- Determine future strategic direction of SPPG services by march 2015
- Develop a strategic approach to quality assurance and implement a robust framework.
- Complete Review of Partnership and Planning Arrangements and implement improvements.

Services for Older people

(Including those with Mental Health needs)

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

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[3] 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.

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

- The 'Start' (Short Term Assessment and Reablement Team) teams are a good example of how successful this approach is. We continue to see a reduction in the amount people requiring services following their intervention with an increase from 54% in 2011/2012 to 57% in 2012/13 of people fully independent and not needing long term support.
- We are now dealing with significantly more complex people in hospital settings our integrated approach and frailty 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.

- We are seeing continued benefits to this approach alongside the wider integrated working and Frailty approaches. Despite demographic pressures we are seeing older people living in their homes with more complex needs. As at the 31st March 2013 we had helped 1,183 adults aged over 65 to live at home.

	2008/09	2009/10	2010/11	2011/12	2012/13
Number of older people in local authority funded residential or nursing care	231	223	236	230	254

(Source SCA/002b)

- Consistent with this we have amongst the lowest numbers of older people in residential and nursing care in Wales, 13.2 per thousand head of population in 2012-13**.**

- 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%[4] in the past year. Overall satisfaction level with our services remains very high with 96% of people responding positively when asked about the services they receive.

- The implementation of the Mental Health Measure 2010 has seen a remodelling of services for older people with Mental Health problems and people are able to access Primary Mental Health care services where multi agency professionals can offer a range of interventions, signposting and assessment as this progresses further we are expecting this to enable better connectivity to community resources supporting people as close to their communities as possible.

- This year has also seen the development of an innovative approach to supporting people with dementia, a pilot is underway that will develop a person centred service to older people with dementia that will provide a more natural living experience – a move away from task and time orientated care to a service based on a detailed knowledge of the individual, and a service that responds to how a person is feeling and what they need at any given time. Once evaluated, we will be looking at the potential to scale up this approach.

- Work has commenced to look at the feasibility of options for the community meals service to expand into the commercial sector with a view to enabling the reduction on the subsidy Monmouthshire pays and to increase future sustainability.

Last year we said we would

- 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.

What did we do?

- An improved monitoring and quality assurance process was a recommendation following the CSSIW report carried out in December 2011.

  In addressing this we have created a lead commissioning post for quality assurance and a quality assurance framework has been developed and implemented.

  This framework has a more robust process in place for monitoring the performance of the framework providers , this includes electronic call monitoring where 75% of providers have implemented the system spot checking of service delivery against invoicing is carried out.

Significant increase in acceptance rates for new packages from 46% in January 2012 to 71% in Jan 2013.

Relationships with providers have been strengthened by the development of forum meetings also individual meetings with providers are held to address contractual compliance issues. An Annual self- assessment process has been developed and piloted across some framework providers. The Self-assessment process has been developed against Welsh Government Commissioning Guidance, the outcome of the pilot will result in development of an improvement plan for 13/14.

The Framework is currently being reviewed, including evaluations against expected outcomes.

- Phase 1 of the Commissioning Team restructure completed in Nov 2012 with phase 2 on track for completion in April 2013.

- Evaluation and review of Lavender Gardens extra care housing project has been postponed due to capacity issues and is being rescheduled for 2013/14.

- Development of a strategy and a commissioning plan for day activities was not commenced due to lack of capacity , however, the Strategic approach and the development of the Older Persons Strategy has now been determined and work is due to begin Feb 2013.
  Despite not having a strategy there has been a range of important activity developed. There is an active south Monmouthshire Day services network where all key providers across local authority and third sector meet to plan and develop more inclusive approaches to the provision of day activities for older people. This locality approach is focussing on people developing their own local support networks and seeing access to services to supplement this approach.

  There is active involvement from the changing lives /changing practice project manager to ensure the Local Area Coordination approach is built in.
  A new day service has been established in Caldicot by Age Concern and partners for older people.

- Supporting people programme grant has funded a service user involvement officer; initially focused on Older People Services, to find out what older people want in terms of support services. A mapping exercise is being undertaken to identify demographic details across the wards in Monmouthshire which will inform future information and engagement methodology and service development and assist in the older person's strategy development.
  Local Commissioning Plan consultation with older people and localised consultation with service users with dementia and their carers to develop pilot domiciliary services.
- The development of a supported living scheme for people with early on- set dementia opened in March 2013 in partnership with Abbeyfield. Review and evaluation is planned at regular intervals.

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. 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

- Complete the development and implementation of Quality assurance and bring all Domiciliary Care provision within overarching quality assurance framework.
- Collaborative work between Commissioning, Elected Members and CMC2 to develop the commercial tier of the community meals service.
- Commence development of Older Persons Commissioning strategy and approach/ Strategy for older people with dementia
- Review of Lavender Gardens including opportunities for LAC and to link into SPPG review
- Comprehensive spending review of Supporting people for older people
- Implement Rural Schemes to support people with dementia
- Review and remodel respite services at SV
- Review meal changes at Severn view and Mardy Park day resource centres
- Evaluate the new early onset dementia service.

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. Adopting self -directed approaches has contributed to ensuring people are supported to remain in control of their own lives and independent as possible.

Having one team for people with physical disabilities has given us:

- a better understanding of current and future needs
- The ability to identify and respond to potential opportunities for
- Collaboration and links 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 has enabled access to a range of services including specialist equipment and specialist communicator/rehabilitation guides.

A virtual team for people with Asperger's is now operating. The Asperger's 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 Asperger's 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 Asperger's 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 is l providing a significant opportunity for closer joint working and improved transition outcomes.

In addition this year we have been able to create a Transition Cooperative project, the vision is that we will have a Partnership led Social Cooperative/Enterprise comprising; Young people with disabilities, Parents, Community, Health and Social Care support (at least initially) that will:
Help people plan and develop meaningful life plans through their transition to adulthood.

- See a service user/parent led cooperative enabling people with disabilities to network and develop their own capacity for co-producing improvements and solutions.

- Grow local opportunities that connect people to community, family and services where needed.
- Explore opportunities for alternative or aligned funding streams that can develop and widen opportunities for young people in Transition and sustain the cooperative.
- Find creative solutions and broker the support needed using individual budget approaches.

Last year we said we would:

- 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.

- 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.

- Carry out care home project in a further 3 care homes in the county.

What did we do?

- Direct payments remain a key driver for us this year, we have continued to see increased uptake, this has been countered somewhat this year by a number of exits from the scheme but activity and referral rates remain very strong. Direct Payments across the county now stand at 172 with 30 new referrals.

  21 DP users have had managed accounts set up. These can make DPs accessible to people who otherwise might not choose them.

  We have managed to release some resource to progress our work to create individual budgets. A steering group and project plan has been developed to increase the use of individual budgets.

The profile of Individual Budgets has risen among all social work teams, so more service users are benefitting from creative approaches to providing support at home and remaining in control of their own lives.

- Work on developing a strategy for people with a Physical disability is well underway the needs of all younger people across the team have been scoped.

  In December 2012 a workshop with all housing providers resulted in a growing awareness of the needs of people with a physical disability amongst housing providers. An action plan was developed which will improve the situation for those currently waiting for housing and enable better planning for future needs.

  We were able to identify some of the system issues that preclude people with a physical disability being seen as a priority for social housing and are working to remedy this. Stronger links have been developed with all housing associations operating in Monmouthshire. The housing associations are working on trying to make their adapted tenancies more available to younger disabled people.

- Liaison and on-going work with ABHB brain injury nurse is working well. Establishing closer links with ABHB ASD worker has been problematic due to only working in Monmouthshire one day a week, but there has benefit from close work with the National Autistic Society. NAS also offers a range of local support groups and services which have been beneficial.
- Transition work is progressing well with individual service users, and links with Children with Disabilities team are good: being based in the same building has assisted. We have better systems so that we know about children who are likely to need adult services. It is therefore much less likely that a child is likely to enter adulthood without a plan being in place.
- We have better plans and processes in place so that we can deliver more people centred responses to young physically disabled people. We now use our new holistic assessment/self -assessment tools with all service users.
- A greater focus on the specific needs of young disabled people in transition and an agreement to work together to meet these needs.

- There are now 62 Talking Books issued, and each is reviewed yearly.

  People are being empowered to consider their own reading solutions and take advantage of the developments in new technology.

- The strong focus on dual sensory loss in Monmouthshire means that we have a good understanding of the profile of this service user group. We wish to respond to their needs in innovative and person centred ways and have solid partnerships across a range of stakeholders
- There has been an All-Wales data gathering approach looking at services for people with sensory loss, this is to try to increase collaboration across counties, share good practice, and offer some consistency across counties e.g. in provision of equipment. Regional collaborative workshops are being run by SSIA/Welsh Government.

Sensory loss awareness pilot ½ day training course is being arranged with SENSE for the multi-disciplinary team at Monnow Vale.
There is no outcome yet from the Supporting People bid for touch communicator guides.

- Rolling out further out further our work on identifying people with sensory loss has seen 199 assessments undertaken since this project started; the current register sits at 133. The Deaf Blind Officer has visited 8 care homes and identified 9 dual sensory impaired people. The feedback has been positive from the care homes visited and following the provision of awareness training we have had some very good comments.

Judgement

This is an area where progress over the last few years has not been at the pace we have wanted. The last couple of years have seen a significant improvement with real momentum and active collaborations on a number of fronts.

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

- To support all providers, starting with domiciliary providers, to understand the value of the citizen directed support approach and to deliver flexible personalized approaches.
- To raise awareness among all MCC employees about the communication needs of people with a sensory loss.
- To ensure that all MCC employees receive training in sensory loss awareness.
- To continue to develop self-directed approaches, including creative uses for direct payments, to enable service users to achieve their own outcomes and to manage their Direct Payments with maximum efficiency.
- To expand the personalisation approach to people who would like to manage their own budgets i.e. virtual budgets
- To enable people who use our services to live their lives on the same terms as people who do not need social care. To ask 10 people who have used a personalised approach what impact it has had on their lives.

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 service 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

Over the past year there has been a focus on the strategic direction of Learning Disability Services as a result of the development of the Pan Gwent Learning Disability

The strategy has developed a number of key work streams which focus on

- Enabling individuals with a learning disability to have access to a meaningful life
- Enabling people with a Learning Disability to have access to generic health care
- Access to a range of accommodation options
- Access to specialist learning disability provision

In response to the strategy Monmouthshire have responded by moving forward on a programme of transition to enable a move from traditional to transformational forms of delivery in the following key areas

- What people do in the day
- What work opportunities people have
- Where people live
- What support parents/carers need.

Over the 2011/12 period there have been significant developments in a number of further areas as follows;

- The development of the South East Wales Improvement Collaborative (SEWIC)
- There has been extensive work carried out to establish a South East Wales Adult Placement Scheme
- Review of key supported tenancy provider in Monmouthshire
- Commencement of high cost placement identification, data base completion and review
- Ongoing crisis intervention within social work team

There have also been a number of developments in the way that the local team operates with a change in assessment and care planning process and paperwork and some very positive evidence of how the team's interventions have positively impacted on people's lives.
A large scale investigation into a day services provision is due to conclude shortly and the finding and recommendations for actions will be acted upon once released.

An overview of performance is summarised in an OBA scorecard presented to adult select committee in March 2012.
http://www.monmouthshire.gov.uk/download/meetings/id/4958/8_performance_indicators_and_outcome_based_accountability_report

Last year we said we would

- 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.

What did we do?

- 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. Using this model and approach the review of Tyr Fenni Day Service in North Abergavenny will continue to be refined during the 2013/2014 period when real results are being expected in the way in which day time opportunities are facilitated for people with learning disability who live initially in the Abergavenny area. This work will run in parallel with the local area coordination agenda and we expect to see people with a learning disability afforded choices and various options to enable them to live a meaningful life within their community. In addition to this a small number of specific bespoke day service opportunities have already been developed:

A number of people have secured work opportunities or are carrying out training courses to enable them to access work opportunities within the future, including a woman who previously accessed our office services, has now secured admin work locally

A man who accessed our green fingers gardening project now has a job as a grounds man for a local football club

- 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 Accommodation options are continuing to be developed: The Monmouth core and cluster project is due to come on line in late 2013 early 2014, enabling 3 people to live within the new flats.

- 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 the service went live in April 2012. People across Monmouthshire are having greater access to different options within the Shared Lives scheme we are currently supporting more people to access this service.

A young man with Asperger's syndrome and alcohol dependency has recently moved into his own flat following number of years of living in unsuitable accommodation, limited support via a PA is provided and this young man is now alcohol free accessing areas of his where previously this would have proved difficult

An increased use of supported tenancy accommodation has seen some very positive outcomes for people with a learning disability being delivered.

- The review of the residential service quality did not progress due to staff shortage, however all supported tenancies provided by Reach were reassessed. This work will be built into the 2013/2014 period
- People with Aspergers Syndrome are now provided with a care management and assessment service via the virtual social work aspergers team. People are also signposted when required.

  Both the learning disability team and the independent living team have worked hard to ensure that the views and opinions of people with aspergers syndrome are actively secured. We are seeing good examples where people with aspergers syndrome have been provided with specific support and intervention in a number of key areas of their lives .
- Active participation in the integration and Strategy development for people with a learning disability during the last year. Monmouthshire have been integral to the decisions made in relation to the implementation of the LD strategy. A number of key areas have emerged within the last year that will now be further progressed across the Gwent area. These plans will be consistent with local development and include the following:
- People with Learning Disability to lead meaningful lives
- People with Learning Disability to have good access to generic health care support
- People with Learning Disability to have access to various accommodation options

- professionals who support people with Learning Disability to work in an integrated manner

"94% of people supported by the Community Learning Disability Team have reported that they are happy with the services they receive" (Community Care Questionnaire, 2012/13

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

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

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

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

Key staff are being provided with specific training to equip them to carry out person centred reviews in order that meaningful day time opportunities are identified and sourced for clients who live within the Abergavenny area

Person centred reviews will have been carried out for people who attend the current services at Tyr Fenni Newydd and Office services providing a realistic and meaningful overview of peoples aspirations

People who currently receive day time options at Tyr Fenni Newydd and Offices Services will be provided with access to new opportunities within their communities

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

Services for carers

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

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

The 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

- 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
- Implement the ten specific work streams 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 carers assessment in line with the national performance indicator definitions.

What did we do?

- The Carers Measure Consultation and Engagement Strategy was published in October 2012 and endorsed by Cabinet. It is awaiting final approval from Welsh Government. The Carers Project continues to make a significant contribution to the development of the ABHB led Strategy as part of the Carers Measure.
  Carers in Monmouthshire were consulted for their views on the proposed Strategy during Carers Week and at a special event to gather their comments. The final Strategy reflected the needs of Carers in Monmouthshire.
- ABHB has not spent its full allocation of funding for 2012-13
- Progress to improve recording of the work carried out in support of carers has been delayed due to capacity and vacancy issues. We expect this work to progress in 2013.
- Service Specifications have been developed for all current providers.
  Specifications are now based on outcomes for carers rather than service outputs.
- The Carers project information post has been reviewed as part of the Review of the Befriending Project. It was concluded that the role was extremely valuable,

particularly in light of the Carers Measure. However it is limited in scope as the resources only permit funding a part-time post.
The Carers Project has a robust database of carers and many of the referrals to it come from the contacts made in GP surgeries and the hospitals.

A review of the Befriending project concluded that the project in its present form was not working due to the lack of referrals and carers not engaging with the befrienders.

- There has been significant partnership working with other Local Authorities and ABHB in the development of the Carers Measure Strategy. Carers Measure Strategy reflects Local authority's approaches to Carers.
- Carer's needs are now being assessed as part of the process of the memory assessment service. If a more in depth assessment is required the MAS are referring to the social care worker in primary care and this piece of work is then undertaken by them.
- The events were well attended and there was a lot of positive feedback from Carers.

  53 carers attended Carers Week 2012
  72 carers attended Carers Rights Day 2012.

- Respite/transport is provided so all carers can access the events. Opportunities for carers to enjoy a 'Life of Their Own' and feel less isolated in their caring role.

  This may well have contributed to the huge increase (20% - the highest in Wales and one of the highest in the UK) in the number of people self-reporting as cares in the 2011 Census.
- The Carers Strategy completion was delayed but now complete so work to implement the work streams will from part of the coming years priorities.

Judgment

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

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

Priorities for action

- Continue to influence ABHB – led Carers Measure Group to ensure benefits for Carers are realised.
- To be included as part of the overall review of carers services to commence in April 2013
- The Carers Project needs to continue to be involved in the implementation of the Strategy
- Services will be monitored against the outcomes in the new specifications contracts to be issued in spring 2013.
- Increase the hours of the Carers Information Worker for a fixed period to further develop the contacts with health settings and remodel the Befriending Project, using the established volunteers to support the Carers Information Officer in providing information services in health settings.
- Monmouthshire Carers lead to coordinate approaches to implementing the Carers Measure Strategy.
- Organise a programme for Carers Week June 2013 and organise a programme for Carers Rights Day, November 2012
- Organise a programme of training for carers.
- Initiate a 'Vanguard' approach to remodel all carer's services involving carers. 3rd sector organisations and ABHB.

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?

- 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.
- 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

What did we do?

- We have remained a key player in the Strategic Implementation group working on developing an Integrated model for Mental Health Services. There is now agreement to a model which will see an Integrated Manager for each borough within Gwent.
  It is expected that this will be in place towards the autumn of 2013.

- Work started in Monmouthshire to develop a Dementia Care pathway ensuring the person's needs are the driver for intervention this will be rolled out across Gwent.

- Review of HiWay service was completed in September 2012. Bid for funding to develop an outcome measure for the service was successful. Work on outcome tool commenced in January 2013

  Review indicated that the change to Mind Monmouthshire Services was a positive change in line with national and local strategies.
- The Forensic Service was created in 2012 and is now hosted from Newport, pathways for referral and transferring casework are now in place. Service Users with a need for forensic support will now receive more co-ordinated and coherent service.

- Implementation of the Mental Health Measure is still in early stages of development but has seen:
- Deployment of Multi-disciplinary Staff have into the primary care mental health service in Monmouthshire across two bases – Maindiff Court, Abergavenny and Hywel Dda, Chepstow. Currently we don't have social workers in this service but have a social care assessor within the Memory assessment service. This service is an all age service.

  Service users are being seen sooner and are offered an earlier diagnosis. And offered support/signposting at an earlier stage enabling people to manage their illness and retain independence.

  Over 400 people have been assessed by the Memory service – this has resulted in 16 referrals to the Social work service. Only 7 of these people were provided with services. The others were signposted to alternatives support systems as necessary e.g. singing for the brain, tea dances, drop-in services, memory café.
- Service users are clear about the services they are receiving, who their care co-ordinator is and how and where to seek support
- 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. The re warranting process is now complete in Monmouthshire

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

- To assess the need for a social care worker within the other parts of the primary care team.
- Completed but processes need to be kept in place to ensure future compliance care and treatment plans

- AMHPS to be re-warranted every 5 years
- Continue with plans in order to get an integrated manager by summer 2013
- AMHP fit for future and practice / independence and risks around being an AMHP/
- Monitor changes in practices – policy development SS Health Ambulance Police Magistrates 135 (1)

Protection of Vulnerable Adults/Safeguarding

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

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 remain a feature of Adult Protection work, we continue to see 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 Safeguarding Board 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

- 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.

What did we do?

- Monmouthshire have been involved in a pilot with SSIA (In full) to look at outcomes for service users who have been in the POAV process. This project has involved workers from four areas of Monmouthshire working with service users with capacity using a 'guided interview' approach to gain feedback regarding POVA process. Social workers and District nurses from Monmouth team road tested the guided interviews.

  The Pilot has provided limited opportunity for useful feedback .Evaluation is expected at the end of March 2012. A positive outcome is that staff have developed competence and confidence in using different tools and can take the learning forward.
- Training has been offered to health staff this year, with a good take up of the opportunities offered. Health staff have been offered both level 3 workshops and attending the Designated Lead managers workshops POVA. Integrated teams mean that Health and Social care staff work closely together and are able to share information about POVA concerns and learn together.

  This is evidenced by greater involvement of Health staff in POVA process.
  Source of Referral – Information reported to Welsh Government by Monmouthshire highlights that 30.2% of referrals in 2011/12 were raised by Health or hospital professionals, as opposed to 20% of referrals in 2010/11.
  This indicates greater awareness by Health staff about the need for POVA referrals.
  In 2011/12 7 POVA investigations were completed by Hospital staff, 5 by Health staff.
- GWASB sets Strategic Direction for Adult Protection the POVA coordinator attends the GWSAB which has been in progress for 12 months now with a sub group structure. Action plans are in place for each sub group.
- Further awareness raising and training session with GAVO in July 2012 which informed wider agencies about All Wales Policies and Procedures.
- Making links to other agencies with responsibility for community safety/public protection has been active this year. Developed links with the chair of community safety partnership to look at what other agencies do in terms of public protection e.g. hate crime and links established with domestic abuse coordinator on how we feed into MARRAC process to ensure there is a cross over between POVA and Domestic Violence.

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- POVA administrator is in the process of visiting all Designated Lead Managers to collect all POVA data to ensure reporting is accurate.

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

- Continue to develop Designated Lead Manager workshops to include wider people e.g. personnel.
- Training and on-going development for DLM's, Health and Front Line Duty staff to be further developed, potential for collaboration across region to be explored.
- POVA coordinator to contribute to Hate Crime group.
- On-going work with police regarding inappropriate adult in need forms, and ensure people are safeguarded.
- Identifying with commissioners services areas where the referral rates are low and work to raise awareness and monitor referral levels.

References

[1] National Performance Framework Item SCA/007
[2] University of Worcester Report - www.aliveactivities.org/images/library/files/PDFs/iPad_Draft_Report_2011_FINAL.pdf
[3] The number of people aged 85 and over in Monmouthshire is projected to increase by 39% by 2020 and 121% by 2030, (Source: DaffodilCymru)
[4] Derived from PM2, Table 2b, row 38