

## **Adult Services Overview – Annual Report to Council 2009**

### **Overall Statement**

During 2008/9, a number of strategic actions have proven to be effective in improving service delivery to adults who require social care support. The development of Joint Commissioning Strategies, with Outcome Based Action Plans, for key client groups and service areas has ensured a joined up approach to the prioritisation of investment in health and social care responses. This has also been evident in the multi-agency approach adopted to secure additional resources from WAG to meet NHS Continuing Health Care needs and the shared responsibility for reducing Delayed Transfers of Care (DTOC) at Chief Executive Level. The re-design of the joint strategic planning framework, under the Health, Social Care & Well-being Strategic Board will ensure effective decision making within a clear governance framework, where service users and carers will help shape future service design. The re-design of health, social care and well-being services in North Torfaen has enabled a multi-agency approach to meeting the needs of a distinct locality, which supports WAG policy for joined up public sector responses to create efficiency and break down professional and organisational barriers. We have developed effective partnership working with CSSIW to ensure that our common aim to protect vulnerable people and improve service provision, overrides any organisational tensions.

### **Supporting Transition from Children to Adult Services**

There are named link workers within Adult Services teams to ensure that planning for needs commences as soon as practicable, with the aim to start planning from the age of 14. The educational support that children with complex needs receive very often includes services that are not available within Adult Services and school provides effective respite for parents and other carers. There is a need to ensure that young people are supported to become independent, whilst acknowledging that parents and other carers will be concerned that risks are being appropriately managed. An all Gwent model for a Transition Pathway is currently being developed across Health, Social Care and Education and other statutory partners so that resources are effectively targeted to improve outcomes for young people. A new Transition Team has been recruited, hosted by Monmouthshire County Council, so that agencies can work effectively to meet needs of children in transition and new service models can be developed.

### **Judgement**

Evidence from young people suggests that there is frustration of having to repeat their story to many agencies and the transition policy should reduce this impact. The expectations that young people, their carers and parents have when the child reaches adulthood cannot always be met within available resources but the potential to utilise Direct Payments will enable families to have more control and choice in meeting their support needs.

## **Action**

- Ensure a named Link Worker for each child aged 14 and above, to attend annual reviews and plan to meet future needs
- To implement the Gwent Transition Policy and utilise the learning from newly recruited transition workers to develop new service models
- Maximise the potential for Direct Payments so that young adults can make choices about how their future needs will be met
- Support more young adults to secure local tenancies with appropriate support, to maximise their independence and well-being and retain their local connections.

## **Older People**

The service direction for older people is to maximise well-being and maintain independence in line with the National Service Framework. For most people, this means providing packages of care and support to enable them to remain in their own homes for as long as possible. Some older people may be at risk of abuse due to their vulnerability and safeguards are in place to protect from harm and take action to manage risks. Services are delivered to older people in line with the Council's eligibility criteria, but this is waived where there is a need for protection. Older people are the largest group supported by Social Care and Housing Services and new service models are being developed to meet future needs, with demographic pressures creating more demand for care and support. For example, the first Extracare facility opened during 2008, as well as four Intermediate Care beds in Sheltered Housing and expansion of community based Intermediate Care services, including a Falls Prevention and Support service.

An independent Service Efficiency Review carried out in 2007 provided recommendations for improving performance and these are being taken forward. For example, the majority of personal care is now being delivered via block contracts and the in-house personal care team has been re-designed into an Intake Team, with a focus on re-ablement and specialist support for complex needs. We have block booked a number of transitional beds, to enable people to leave hospital, whilst awaiting their care home of choice and this has given an added benefit of providing stability to local providers.

We have developed a robust Telecare service, to ensure that technological solutions are considered at assessment stage, to further promote independence and provide assurance for families and carers. Service users have the opportunity to test out equipment in specially adapted accommodation, so that solutions can be found within their own homes.

## **Judgement**

Performance on numbers of people helped to live at home is improving, in line with the service direction but there are delays in carrying out timely reviews, mainly due to the large numbers of older people being provided with support and the increase in new referrals, which have increased from an average of 60 per month in 2006, to nearer 90 per month at the end of 2008. \*\*\*

We have made significant improvements in the numbers of people delayed in hospital for social care reasons, moving from 26.74 per 1000 in 2007/8 to 15.38 per 1000 by 3<sup>rd</sup> Quarter 2008/9 (SCA/001) and this level being sustained.

In an effort to create staffing savings during 2008, to ensure we produce an underspend to meet known financial pressures in 2009/10, we have been operating without a Team Manager in the Older Person's Care Management Team for more than six months and this has impacted on capacity to complete assessments and reviews within expected timescales.

## **Actions**

- We need to work with care home sector providers to ensure fee levels help to deliver sustainable local businesses, so that individuals have choice and quality provision to meet their long term care needs
- We need to develop further capacity to meet the needs of frail elderly people and are working across greater Gwent to develop health and social care pathways for this client group, which will aim to reduce reliance on institutional care
- Pilot direct social work response from Customer Care Centre, to signpost appropriate people to alternative routes to meet their needs, e.g., voluntary sector, telecare, equipment loans, Citizen's Advice Bureau, to enable speedier responses and avoid waiting for assessment processes within social care
- Improve performance rates for assessment and care plan reviews, through a re-design of the Referral and Assessment and Care Management Teams.
- Increase capacity in Intermediate Care services, respite services and night time support, to meet future demand and maintain people in their own homes.
- Manage the risk to agreed local plans from the re-organisation of the NHS into a new Gwent Local Health Board.

## **Disabled People's Service**

The creation of a fully integrated service to meet the needs of disabled people was agreed in 2007, and led to three professional groups (Social Workers, Occupational Therapists and Disabled Facilities Grant [DFG] Surveyors) combining their resources and expertise to create a more citizen focused

service. There are specialists within the team who are able to assess and meet complex sensory impairment and mobility needs. During 2008, the new team has been reviewing their operational practices and developing new ways of working to deliver more streamlined services.

## **Judgement**

The new team is still bedding down and is testing out alternative working strategies, as a pilot for the rest of Community Care division. There are performance issues that are impacting on the response times for people to receive equipment and/or adaptations to their properties.

For example, waiting lists continue to rise for OT Assessments– 265 in April 08 to 345 in December 08. The delay in OT assessment is causing a further delay in the utilisation of DFG capital grants, resulting in reduced funding for 2009/10.

There is a lack of suitable respite options to meet needs and a lack of services for meeting needs of people with complex multi-faceted needs. Some care packages are very expensive and will be difficult to sustain on an ongoing basis, as resources are stretched to deliver services to increasing numbers of older people. There is a good uptake for Direct Payments and this avenue may provide the best option for meeting individual complex needs, where the council has limited resources to provide for personal choice, when less expensive options are available to meet needs.

## **Actions**

- The team is currently re-designing its accommodation and purchasing new IT and office equipment to facilitate better working practices in a modern environment. This action is being supported by the Corporate Service Improvement Team
- Individual OT under performance is being addressed
- Business processes are being improved, to ensure DFG grant is maximised
- Discussions are ongoing with providers to develop new services
- Care Plans need to be more outcome focused.

## **Mental health**

During 2007/8, there were significant issues with older people with mental health needs who were delayed in hospital awaiting transfer to a care home (DTCO). At the end of 2007, we piloted the block purchase of a number of EMI transitional beds to enable earlier discharge from hospital. We sustained this investment during 2008 and this has had a significant effect. The co-location of the CMHT with the NHS Trust in 2007 is now showing improved collaborative working, e.g. NHS Trust staff now carry out the Ccare co-ordinator role and the extended hours rota is shared across teams.

## **Judgement**

Further investment in community based services, like Assertive Outreach, First Access and psychological therapies has resulted in fewer hospital admissions. The implementation of the Mental Health Act 2007 amendment has been well co-ordinated across Gwent with local practitioners attending and delivering training programmes to ensure effective implementation.

The number of (DTC) delays due to 'no appropriate placement available code 2.7' has reduced from 9 in October 2008 to 0 in January 2009 '

Gwent Healthcare NHS Trust statistics re: hospital admission rates and trends currently indicating reduced/lower than average admissions in Torfaen.

## **Action**

- Ensure effective implementation of Deprivation of Liberty Standards (DoLS) across all service users not just Mental Health
- Co-location of teams needs to move towards an integrated service, with a shared budget, integrated IT and case file systems and no single line management. The re-organisation of the NHS may delay full implementation of plans
- Care Plans need to be more "Outcome focused"
- Some voluntary sector services need to be re-designed or de-commissioned to meet new priorities.
- New services need to be developed to enable people placed out of county to return home or nearer their home.

## **Learning Disabilities**

The co-location of the Learning Disabilities team with the NHS Trust team took place in March 2009. This has been planned for several years but was not achievable due to other priorities for limited accommodation funds. There have been improvements to the range of Day Activities available and a number of clients in group homes have been supported in their own tenancies.

## **Judgement**

The legacy of expensive service models developed when a local long stay hospital was closed needs to be re-designed, through collaborative working with providers, clients and their families and neighbouring local authorities.

The budget for Learning Disability clients has been significantly overspent for several years, requiring a review of assessment, care management and provider services. An independent review in 2007 provided several recommendations that are being taken forward. For example, a few clients have been supported to become independent tenants, moving from more expensive group home facilities, which did not maximise their independence.

## **Action**

- We will need to ensure that co-location of operational teams moves quickly into full integration to deliver seamless services to clients that maximise their independence and well-being. We need to ensure that lessons are learned from the co-location of Disabled Persons' Team and Mental Health Teams.
- Care Plans need to be more "outcome focused"
- We need to use new models for costing support packages more effectively and this will be done in collaboration with other local authorities
- Develop an effective Strategy to meet the needs of people with Autistic Spectrum Disorder (ASD)
- We are working with others to secure economies of scale through collaborative commissioning, via a Gwent Learning Disability Commissioning Advisory Group
- Review long standing care plans to ensure clients' independence is being maximised and that support is cost effective to meet needs, utilising Direct Payments when possible.

## **Protection of Vulnerable Adults**

Torfaen is part of the south east Wales Adult Protection collaborative, which establishes policy and procedures for all agencies in the area. This ensures that we are robust in our identification of people at risk and in finding strategies to reduce risk and monitor the impact of our interventions. There is significant effort from all operational teams to ensure that strategy meetings and case conferences are well attended and effective in protecting vulnerable adults. There is some difficulty in securing attendance from

## **Judgement**

Torfaen has relatively high numbers of POVA cases but it is not clear whether this means local practitioners are more inclined to refer an individual, as significant effort has been put into training and awareness raising across the health and social care sector, including provider staff. All POVA referrals are investigated and appropriate action taken to reduce risk

## **Action**

- Our aim is to develop an integrated safeguarding team across Children's and Adult Services, although the responsibility for each client group will still remain with the relevant Head of Services. The aim of this integration is to share best practice and create efficiencies through pooling resources
- Continue to provide effective training for practitioners and managers in POVA best practice

- Use evidence from effective interventions to develop new service models or ways of working
- Review and improve working practices and documentation to ensure best use of professional and administrative resources.

### **Support to Carers**

It is recognised that carers are an essential part of the health and social care workforce and sufficient support must be in place, to help carers' sustain their caring role. The unique position of carers to understand service users' needs and preferences provides key information to achieve better outcomes for carers. Torfaen Carers' Centre, in Pontypool, is recognised as best practice in providing constructive support to carers in a safe environment, whilst their loved ones are supported elsewhere. Torfaen CBC was short-listed for an Excellence Wales award for its innovative carer support services, including "Health and Well Being", "Moving on from Caring" courses and "Bargain Holidays" with major holiday companies.

### **Judgement**

The designated Carers' Social Worker has reduced a significant backlog of carer assessments during 2008, compared to the previous year, completing 362 carer's assessments during 2008.

The development of a Carers' Support Worker has proved effective in providing additional capacity.

Carers Centre signposting 250 carers to carers support services and supporting 500 carers during 2008.

17 carers went on a 4 day respite break to Southern England.

10% of direct payments in Torfaen are taken up by carers – one of the best take up by carers in Wales

A number of courses have been developed, to support carers - 68% of new carers identified attending one of the courses during the year totalling 100 carers during 2008.

Approximately 6,000 hours of respite is provided throughout the borough to carers per year.

### **Action**

- We will increase capacity by employing a further Carers' Support Worker
- We will continue to look for innovative solutions to support carers
- We will ensure carers continue to receive assessments in their own right.

- We will continue to identify new carers and ensure they know what support is available to them.