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Cyngor Bwrdeistref Sirol
Blaenau Gwent
County Borough Council

THIS IS A MEETING WHICH THE PUBLIC ARE ENTITLED TO ATTEND

6th February 2020

Dear Sir/Madam

SOCIAL SERVICES SCRUTINY COMMITTEE

A meeting of the Social Services Scrutiny Committee will be held in Council Chamber, Civic Centre on Thursday, 13th February, 2020 at 10.00 am.

Please note that a pre and post meeting will be held 30 minutes prior to the start and following the conclusion of the meeting for members of the committee.

Yours faithfully

Michelle Morris
Managing Director

AGENDA **Pages**

1. SIMULTANEOUS TRANSLATION

You are welcome to use Welsh at the meeting, a minimum notice period of 3 working days is required should you wish to do so. A simultaneous translation will be provided if requested.

2. APOLOGIES

To receive.

3. DECLARATIONS OF INTERESTS AND DISPENSATION

To consider any declarations of interests and dispensations made.

4. SOCIAL SERVICES SCRUTINY COMMITTEE 5 - 14

To receive the Minutes of the Social Services Scrutiny Committee held on 13th January, 2020.

(Please note the Minutes are submitted for points of accuracy only)

5. ACTION SHEET 15 - 16

To receive the action sheet.

6. LIVING INDEPENDENTLY IN THE 21ST CENTURY STRATEGY - ANNUAL PROGRESS UPDATE 2019/20 17 - 54

To consider the report of the Head of Adult Services.

7. UPDATE ON PROGRESS OF THE MY SUPPORT TEAM 55 - 60

To consider the report of the Head of Children's Services.

8. FORWARD WORK PROGRAMME - 2ND APRIL 2020 61 - 64

To receive the report.

To: Councillor S. Thomas (Chair)
Councillor K. Rowson (Vice-Chair)
Councillor D. Bevan
Councillor G. A. Davies
Councillor M. Day
Councillor P. Edwards
Councillor L. Elias
Councillor K. Hayden
Councillor J. Holt
Councillor J. Millard

Councillor M. Moore
Councillor J. P. Morgan
Councillor G. Paulsen
Councillor T. Sharrem
Councillor T. Smith

All other Members (for information)
Manager Director
Chief Officers

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COUNTY BOROUGH OF BLAENAU GWENT

REPORT TO: **THE CHAIR AND MEMBERS OF THE SOCIAL SERVICES SCRUTINY COMMITTEE**

SUBJECT: **SOCIAL SERVICES SCRUTINY COMMITTEE – 13TH JANUARY, 2020**

REPORT OF: **DEMOCRATIC SUPPORT OFFICER**

PRESENT: COUNCILLOR S.C. THOMAS (CHAIR)

Councillors: K. Rowson
D. Bevan
G.A. Davies
M. Day
P. Edwards
L. Elias
K. Hayden
J. Holt
J. Millard
J.P. Morgan
G. Paulsen
T. Sharrem
T. Smith

AND: Corporate Director of Social Services
Head of Adult Services
Service Manager, Provider Services
Service Manager, Children's Services
Mary Welsh, Manager Community Options
Scrutiny & Democratic Officer / Advisor

ITEM	SUBJECT	ACTION
No. 1	**SIMULTANEOUS TRANSLATION** It was noted that no requests had been received for the simultaneous translation service.	

No. 2	**APOLOGIES** Apologies for absence were received from Councillor M. Moore.	
No. 3	**DECLARATIONS OF INTEREST AND DISPENSATIONS** There were no declarations of interest or dispensations reported.	
No. 4	**SOCIAL SERVICES SCRUTINY COMMITTEE** The Minutes of the Social Services Scrutiny Committee Meeting held on 28th November, 2019 were submitted, whereupon:- **Item 6 – Annual Report of the Director of Social Services 2019/20 (Quarter 1 & 2)** Adult Services - a Member proposed an amendment to the second paragraph:- 'The Member commented that the only respite beds available for adults with physical disabilities had been in Cardiff and enquired regarding the number of respite beds available in Blaenau Gwent for adults with physical disabilities who had elderly parents caring for them. The Head of Adult Services said that in Blaenau Gwent there were no respite beds for adults with physical disabilities. In these cases respite beds would be commissioned in other Authorities on a case by case basis to meet specialist needs'. The Committee AGREED, subject to the foregoing, that the Minutes be accepted as a true record of proceedings.	
No. 5	**EXECUTIVE DECISION SHEET FOR THE SOCIAL SERVICES SCRUTINY COMMITTEE** Consideration was given to the Executive Decision Sheet. The Committee AGREED that the Executive Decision Sheet be noted.	

No. 6	**PROGRESS REPORT – SOCIAL SERVICES ASSISTED TRANSPORT PROVISION** Consideration was given to the report of the Head of Adult Services which was presented to provide an update on the outcome of assessments undertaken during 2019, for eligibility to Assisted Transport. The Head of Adult Services spoke to the report and highlighted the main points contained therein. Of the 149 assessments undertaken the Chair commented that one person had ceased accessing the Community Options Service and potentially there could be others. The Head of Adult Services reassured Members that through ongoing communication no other citizens had indicated a wish to cease accessing the Community Options provision. A Member referred to taxi fares from Trefil and pointed out that mobility vehicles could be withdrawn at any time. The Head of Adult Services said that taxi fares from Trefil were being looked at. With regard to mobility vehicles if an individual's circumstances change then the exceptional circumstances element of the policy would be invoked and the citizens circumstances reviewed. A Member enquired regarding the operating hours of the vehicles and whether alternative uses could be found when not in operation. The Service Manager, Provider Services said the vehicle operating hours were 8.00 am to 10.30 am and then started again at 3.00 pm and confirmed that vehicles were parked up in between these hours. Alternative uses had been looked at but would have cost implications due to increased drivers contracted hours. The current Community Options budget was not sufficient to cover an increase in drivers contracted hours. The Chair commented that the Authority did not have a Corporate Transport Policy, an Executive decision had been made to keep home to school transport and felt that a two tier transport policy was operating with vulnerable people being penalised. The Head of Adult Services said that the Service had positive feedback regarding the flexible approach to citizens	

accessing Community Options using own transport and not being reliant on the Local Authority transport runs. They also confirmed that the relevant equality policies had been considered to ensure people were being treated fairly.

Another Member also raised concerns that the Authority was running a two tier transport policy with regard to home to school transport and commented that the Authority was now in an improved financial position and these transport services should be provided for vulnerable people in the community.

Another Member enquired regarding cost implications for assisted transport. The Head of Adult Services said the costs of providing assisted transport was approximately £321,000 currently. She also highlighted the potential inequalities that could happen if the Council decided not to charge for provision for those continuing to use the Local Authority transport when those who had already opted to make own arrangements for transport via taxi's were paying to attend following their social care review.

A Member pointed out that not many taxi's could accommodate wheelchair users.

In response to a Member's question regarding development of a Corporate Policy for reviewing the leasing costs of vehicles, the Head of Adult Services said that existing vehicle leases within Social Services had recently been renegotiated and savings made. The Head of Service reminded Members that the report presented to them outlined the new model for the service with anticipated reduction in fleet and staffing from 8 to 4 vehicles. This would result in further savings being made.

A Member said it was important to sustain this provision so that vulnerable people had access to assisted transport to enable them to attend day centres and felt that a balance needed to be maintained.

A Member enquired if mental health views had been captured in the report and further enquired regarding the low number of wheelchair adapted taxis. The Head of Adult Services confirmed that the views of people who experienced mental health issues had been captured in the

report and agreed there were not enough wheelchair adapted taxis in Blaenau Gwent.

With regard to the 6 objections received to date regarding the outcome of assessments, the Head of Adult Services said that some of the reasons for objection had included that family members may be using the mobility vehicle to travel to work or the cost of alternative transport for example taxis. She added that for some of these citizens they had been considered under the exceptional circumstances policy and would be eligible to continue to use the assisted transport provision to attend Community Options, however, dependent on the outcome of the proposals being presented they may be charged.

A third option was proposed and seconded by Members that the status quo be maintained prior to the implementation of the Assisted Transport Policy and that all citizens accessing Community Options who are assessed as requiring transport, are offered Local Authority Community Options Transport, free at the point of contact.

Upon a vote being taken, the following votes were recorded:-

Option 1 (3 votes)

Members note the progress made in assessing the needs of citizens in line with the Assisted Transport Policy including the outcomes of the assessments. **Plus**, Members recommend that only those citizens who remain eligible for assisted transport continue to receive support **free of charge**. And that those citizens who are deemed **ineligible** but have **exceptional circumstance** continue to receive support but at a charge based on a full cost recovery model. The full cost recovery charges will be based on the configuration of transport required to deliver the future model of Community Options services.

Option 2 (4 votes)

Members note the progress made in assessing the needs of citizens in line with the Assisted Transport Policy including the outcomes of the assessments. **Plus,** Members recommend that only those citizens who remain eligible for

	assisted transport continue to receive support **free of charge.** And that those citizens who are deemed **ineligible** but have **exceptional circumstance** continue to receive support but at a charge based on similar costs illustrated earlier in the report reflecting public transport rates. The charges will be based on the future configuration of transport required to deliver the future model of Community Options services. **Option 3 (6 votes)** Community Options revert back to the previous situation (i.e. the status quo prior to the implementation of the Assisted Transport Policy in January 2019) and that all citizens accessing Community Options who are assessed as requiring transport, are offered Local Authority Community Options Transport, free at the point of contact. The Committee AGREED, subject to the foregoing, that the report be accepted and to recommend Option 3 Community Options revert back to the previous situation (i.e. the status quo prior to the implementation of the Assisted Transport Policy in January 2019) and that all citizens accessing Community Options who are assessed as requiring transport, are offered Local Authority Community Options Transport, free at the point of contact.	
No. 7	**CORPORATE PARENTING PROGRESS REPORT** Consideration was given to the report of the Head of Children's Services and Service Manager, Children's Services which was presented to inform Members of the progress made by Blaenau Gwent Corporate Parenting Board (CPB) throughout 2019 to improve outcomes and services for our Children Looked After (CLA). The Service Manager, Children's Services spoke to the report and highlighted the main points contained therein. In response to a Member's question regarding the use of unregistered care facilities, the Director of Social Services said that the Authority only used unregistered care facilities on a temporary basis until a suitable registered facility could be found.	

	A Member requested an update on capacity within the 14+ team. The Service Manager, Children's Services confirmed that the Safeguarding Manager was now in place and the team were at full capacity and were able to progress outstanding issues. A Member enquired regarding the 10 young people in the Blaenau Gwent Corporate Traineeship Programme established in 2017, the Service Manager said that 2 young people were engaged, 1 in Housing Solutions and 1 in Tai Calon and the other 8 had either moved on to paid employment or undertaken further training. The Service Manager would provide Members with further details on their current status. A Member enquired regarding mental health and well-being support for young people. The Service Manager said that recruitment of a Psychologist in the Placement Team had been unsuccessful as applicants were reluctant to accept a short term contract, however, other options for access to psychology were being explored. The Task and Finish Group which included key partners such as the Aspire programme were still looking at this area of work even though no psychologist was in place. With regard to the Looked After Children (LAC) reference no longer used, a Member requested that the reference Children Looked After (CLA) be used consistently in future reports. The Committee AGREED to recommend, subject to the foregoing, that the report be accepted and endorse Option 1, namely that Members acknowledge progress made throughout 2019 and feel confident that the Local Authority and its partners are doing well to improve outcomes for our looked after children as part of our corporate parenting responsibilities. Councillor Jonathan Millard left the meeting at this juncture.	Service Manager Children's Services
No. 8	**<u>REGIONAL PARTNERSHIP UPDATE</u>** Consideration was given to the report of the Corporate Director of Social Services which was presented to update Members on the work and decisions taken over the last 6	

	months by the Regional Partnership Board, developed under statutory guidance Part 9 of the Social Services and Well-being (Wales) Act 2014 (SSWB Act). The Director of Social Services spoke to the report and highlighted the main points contained therein. A Member raised serious concerns that home assessments to safely discharge people from hospital were being carried out after a patient was discharged. The Director said that an individual would have been declared medically fit before being discharged from hospital and a planned model of discharge to return home would need to be prepared. The Head of Adult Services commented that sometimes patients agreed to be discharged from hospital before the Home Service was made aware of the discharge and this could lead to delays in home assessments. A Member enquired regarding mental well-being for children and young people. The Director said he recognised the Member's concerns as often young people visited their GP and then the next step would be they were referred to specialist intervention provided by CAMHS. The Authority were looking to develop something in between to work in Blaenau Gwent and across Gwent. The Committee AGREED to recommend that the report be accepted and endorse Option 1, namely to scrutinise the report and to support the decisions of the Regional Partnership Board.	
No. 9	**<u>SOCIAL SERVICES WORKFORCE SICKNESS ABSENCE PERFORMANCE</u>** Consideration was given to the report of the Head of Organisational Development and Director of Social Services which was presented to provide Members of specific scrutiny committees the opportunity to scrutinise and challenge relevant Directorate sickness absence performance and the proposed actions for improvements. The Director of Social Services spoke to the report and highlighted the main points contained therein.	

Members welcomed the report but raised concerns regarding high sickness levels in the Directorate and refresher training for managers on the iTrent system. The Director explained that reducing sickness absence levels remained a priority for the Council and CLT were working towards developing an action plan to reduce sickness levels. The Directorate had a duty of care towards staff and protecting vulnerable people who used their services. Provider Services would always have a higher than average sickness absence level than the general Council due to the nature of the services they provide, i.e. staff with flu would need to be absent for a period of 48 hours before visiting service users to prevent the spread of infections.

A Member raised concerns with the number of staff on sick leave due to mental health issues. The Director responded that over the last 5-10 years the numbers of staff on sick leave due to stress and anxiety had increased, but it was important to note that staff formed relationships with service users and may be affected by bereavements. Well-being courses were being piloted to make staff and managers more resilient.

A Member enquired if the Council provided mental health care for employees. The Director explained that staff with stress and anxiety would be referred to Occupational Health to try to intervene early to prevent sickness absence occurring.

Another Member raised concerns that only 45% return to work interviews were being carried out and recorded. The Director stressed that return to work interviews were important to establish the reasons why staff were on sick leave. However, there were some difficulties due to employees shift patterns, whereby some staff did not see their line manager for up to 2 days. The Council had a Corporate Sickness Absence Policy which worked well for staff who work 9-5 and office based, however, there were some anomalies i.e. provider staff who work shift patterns.

The Committee AGREED to recommend that the report be accepted and endorse Option 2; namely that the report and proposed arrangements to support the improvement in attendance be approved.

No. 10	**FORWARD WORK PROGRAMME – 13TH FEBRUARY, 2020** Consideration was given to the report of the Chair of the Social Services Scrutiny Committee. The Committee AGREED that the report be accepted and endorse Option 2; namely that the Social Services Scrutiny Committee Forward Work Programme for the meeting on 13th February, 2020 be approved.	

Blaenau Gwent County Borough Council

Action Sheet

Social Services Scrutiny Committee – Monday 13th January 2020

Item	Action to be Taken	By Whom	Action Taken
7	**Corporate Parenting Progress Report** A Member referred to page 44 of the report, Key Priority 3, and the Corporate Traineeship programme and enquired what the 8 young people who had left the programme were doing now. Officer to provide a breakdown.	Ceri Bird, Service Manager	Verbal update to be provided.

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Executive Committee and Council only

Date signed off by the Monitoring Officer: N/A

Date signed off by the Section 151 Officer: N/A

Committee:	**Social Services Scrutiny Committee**
Date of meeting:	**13th February 2020**
Report Subject:	**Living Independently in the 21st Century Strategy – Annual progress update 2019/20**
Portfolio Holder:	**Cllr John Mason, Executive Member Social Services**
Report Submitted by:	**Alyson Hoskins – Head of Adult Services (Social Services)**

Reporting Pathway								
Directorate Management Team	**Corporate Leadership Team**	**Portfolio Holder / Chair**	**Audit Committee**	**Democratic Services Committee**	**Scrutiny Committee**	**Executive Committee**	**Council**	**Other (please state)**
23/01/20	28/01/20	03.02.20			13.02.20	11.03.20		

1. Purpose of the Report

1.1 This report provides an overview for Members on the 'Living Independently in Blaenau Gwent in the 21st Century' Strategy. It aims to consider the progress against the 8 priorities of the Strategy over the previous 12 months, including how the strategy has been aligned to the Social Services and Well-being (Wales) Act 2014 since its implementation in April 2016.

It also highlights how the department has utilised available external funding to support development of the priorities including challenges and barriers we have faced during the year to date.

2. Scope and Background

2.1 Previous annual reports have identified the history of the 'Living Independently in Blaenau Gwent in the 21st Century' strategy since it was agreed by Council back in November 2006.

2.2 Members are aware that it was developed with an emphasis on ensuring as a Local Authority we were in a position to address the increasing demands for services to older people over the next 15 years due to people living longer, with different aspirations and often complex illness. The strategy was developed with a strong emphasis on supporting citizens of Blaenau Gwent to live safely in their own home for as long as possible.

2.3 The 'Living Independently in Blaenau Gwent in the 21st Century' Strategy was revised in 2012 in anticipation of the Social Services and Well-being (Wales) Act 2014 and a further revision is due in 2020/21 at the end of the 15 year lifespan.

2.4 The Strategy identifies 8 priorities as part of the overarching approach to service development which are outlined below:

- **Priority 1 Long term care:** jointly with Health and other partners, make arrangements to meet the nursing, residential and dementia care needs of the older persons' population

- **Priority 2 Reablement/Enabling services:** further develop this approach and recognise the contribution of other organisations, in progressing this service

- **Priority 3 Day Opportunities/Community Options:** continuing development of everyday activities and opportunities to learn new skills or re-acquire skills through confidence building and tuition measures

- **Priority 4 Assistive Technology:** promote and expand assistive technology supported by a rapid response service, capable of containing situations where no family carers are available

- **Priority 5 Direct Payments:** promote and expand direct payments and empowering people to take responsibility for arranging their own care and support requirements

- **Priority 6 Accommodation:** recognising the key role that appropriate housing plays on the well-being of older people. Work closely with partners to develop a range of suitable housing in Blaenau

- **Priority 7 Carers:** providing accessible and timely support services responsive to individual need

Priority 8 Domiciliary Care: Ensuring provision of appropriate, reliable, quality services.

3. **Options for Recommendation**

3.1 Members are asked to scrutinise the report and how in future they would wish to receive, through a reporting mechanism, progress of this strategy.

3.2 **Option 1**- Endorse the report and the evidence provided to support progress in the 8 priority areas, and for us to continue to provide progress updates on an annual basis to the scrutiny committee as outlined in this report.

3.3 **Option 2** – Members to recommend any additional information and/or an alternative methodology for reporting progress, challenges and opportunities during 2019/20.

4. **Evidence of how does this topic supports the achievement of the Corporate Plan / Statutory Responsibilities / Blaenau Gwent Well-being Plan**

4.1 **Corporate Plan – 2018 to 2022.** The Living Independently in the 21st Century Strategy links to the key themes of the Corporate Plan and in is promotion of resilient communities.

4.2 **Blaenau Gwent Well-being plan –** ***Priority area - enabling older people to feel valued and empowered to maximise their independence and lead healthy and engaged lives -*** this strategy is key in delivering this Wellbeing outcome including:

- **Thinking in the Long Term -** The strategy provides effective cooperation and partnership working between all agencies and organisations, including health, and is a key element of meeting the needs of older people living in Blaenau Gwent.

- **Taking an integrated approach –** The strategy promotes an integrated approach across Health, Social Care and the Third Sector.

- **Taking a preventative approach –** The strategy promotes preventative services including reablement and assistive technology as a model that promotes personal independence and management of a person's own wellbeing. The strategy delivers a preventative and early intervention approach to minimise the escalation of need and dependency on statutory services.

- **Collaborating -** The Strategy is clear that implementation is not only the responsibility of Social Services department but the whole Council and also of its partners including Heath and Housing.

- **Involvement -** A key aspect of the strategy is ensuring people have a voice and control over their care and support to achieve the outcomes that are important to them.

5. **Implications Against Each Option**

5.1 **Option 1 –** this will result in a report for 2020/21 being developed using a similar approach and methodology to that used for 2019/20. However, it is important to note that the overarching Strategy is due for a full review during 2020 and therefore it is anticipated that the report presented to Scrutiny in January 2021 will include a revised Living Independently in the 21st Century Strategy outlining priorities for future years.

During 2020/21 updates will continue to be provided using information contained in the tier 1 and 2 business plans, team briefings, progress reports and data from our Corporate Performance Team and feedback from any relevant regulatory reviews.

5.2 **Option 2 –** the format and reporting mechanism for future reports will be amended to reflect additional information as requested by members.

5.3 **Legal –** there are no legal implications associated with this report. This strategy supports the delivery of the Social Services and Well-being (Wales) Act 2014.

5.4 **Human Resources –** there are no OD implications associated with this report. However, it is important to note that as previously reported to scrutiny we have a number of the posts funded using external funding (Integrated Care Fund/ Pace Setters funding / Transformation Funding) and we continue to have uncertainty from Welsh Government as to the availability of ongoing funding for these posts after March 2021.

6. Supporting Evidence

Some examples of progress and evidence in relation to the 8 priority themes are listed below:

6.1 Priority 1 Long term care:

During 2019/20 the Adult Services department has continued to review and develop services that support the key areas of Long term care. As previously reported we have a Service Manager for Wellbeing and Long-term Care. The post holder has specific responsibilities for:

- Community Care Teams (West and East)
- Disability Team including Children with Disabilities and Adults with Learning Disabilities
- Adult Mental Health Service

6.2 In addition, the post holder has responsibilities for managing the allocation of resources to support Care Home placements, hospital discharge and developments to support and promote long term wellbeing and coordination of long term support to assist citizens to remain in their own homes.

6.3 The department has continued to hold weekly placement panels during 2019/20. The panels chaired by the Service Manager, are attended jointly with colleagues from the Health Board (ABUHB) including the lead nurse with responsibility for Continuing Health Care (CHC) and they consider appropriateness of applications for placement by social workers for citizens who have been assessed as being unable to remain in their own homes due to increased care and support needs.

6.4 The numbers of citizens living in a care home or supported living setting remain relatively consistent, currently (Dec 19) 276 citizens are supported compared to 267 (31st March 19), 280 (31st March 18) and 296 (31st March 17)

6.5 **Table 1: Current placement details to end of quarter 3 report (2019/20):**

Category	***Mar 2018***	***June 2018***	***Mar 2019***	***June 2019***	***Sept 2019***	***Dec 2019***
Nursing Over 65	64	63	50	59	61	59
Nursing under 65	7	7	8	5	5	6
Residential Over 65	120	130	118	119	116	113
Residential Under 65	26	28	28	28	27	27
Supported Living Over 65	5	5	3	3	4	5
Supported Living Under 65	58	60	60	56	63	66
Total	***280***	***293***	***267***	***270***	***276***	***276***

6.6 As a department we are responsible for the monitoring of the Care Home market across Blaenau Gwent including the monitoring of care home quality, areas for improvement, identification of best practice, staff and development opportunities and financial viability. We continue to have a number of vacancies in our commissioned Care Homes. The numbers of vacancies do fluctuate over a 12 month period but as of 21st January 2020 we had:

- 24 vacant beds in care homes who support general residential / nursing needs,
- 7 vacant beds in dementia nursing care homes
- 9 vacant beds in dementia residential care homes

6.7 During 2019 / 20 we have continued to develop the support we give to patients in both our Community and Acute hospital settings though the development of an outreach team who are working within Nevill Hall Hospital 'in reaching' into patients on floor 4 of the hospital. The outcomes of this project are due to be analysed during Spring 2020 with a view to extending the model across other areas of the hospital. The project has been further enhanced during the Winter months (December 19 to Feb 20) due to the Local Authority securing additional funding from Welsh Government to support the Winter pressures. This has enabled us to increase our capacity to undertake assessments at the local hospitals through additional weekend working.

6.8 The Home First Gwent discharge scheme has been in operation since November 2018 and has been invaluable in ensuring that we are able to support patients at the 'front door' of our acute hospitals but who do not need ongoing medical support or admission, and who can return home the same day with social care support. This can often mean the provision of information, advice and assistance (IAA) only or a follow up call once they are home. This service has been particularly important during the exceptional pressures within the NHS over the winter period and Christmas break.

6.9 As an illustration of the demand the service has supported, during the recent busy period faced at both Nevill Hall and Royal Gwent Hospitals, the Local Authority Home First Service supported the following discharges, avoiding unnecessary and often lengthy admissions to hospital:

6.10 **Table 2: Home First Discharges from Acute hospitals example**

Week ending date :	**Number of discharges home from A&E / assessment units etc that week**
8th December 2019	36 discharges
15th December 2019	32 discharges
22nd December 2019	31 discharges
29th December 2019	20 discharges
5th January 2020	28 discharges
12th January 2020	42 discharges

6.11 **Table 3: Home First Case study:**

Case study – Tom and Vera
Referral/presenting issues: **Home First Team** at Nevill Hall received a call from A&E relating to **Tom** and **Vera**, married couple both in 90's. Both brought to hospital earlier in the day following an accident at home which resulted in them both falling. Neither needed to be admitted, although Tom had fractured his shoulder and had a cuff sling for support. They lived together in their own home. Both independently mobile, however Vera had experienced regular falls and already had a care package at home to help with personal care. Tom did the cooking and they had their medication in a dossett box delivered by local chemist. They had a son who was supportive and he did the weekly shopping and visited frequently. Tom had a pendant alarm but Vera didn't. They had been married to each other for over 60 years and had a structured routine which meant they could support each other. Vera did advise that she had been falling a fair bit, hence the injury to Tom's arm as she loses her balance and he had tried to catch her. Both were very keen to get back home as soon as possible.

Issues: Vera was at risk of further falls so the Home First Team referred her to the community Physiotherapist in our CRT for a falls assessment in her own home environment. She was also given a pendant alarm on her return. Tom had a fractured shoulder which will affect his ability to manage some of his and his wife's daily activities. Home First worker arranged a temporary care package to assist him with his personal care in the morning and evening.

Outcome:
Home First were able to arrange a restart to Vera's care package that evening and also start a temporary care package for Tom for the same evening. This enabled them to go home together from A&E. Their son was able to collect them from hospital that afternoon with reassurance that his parent's needs would be met and professional were going to follow them up the next day. This resulted in 2 beds being 'unblocked' at the emergency department and avoided the need for social admission to hospital.

6.12 **Priority 2 Reablement / Enabling services:**

Our Information, Advice and Assistance (IAA) team based at the Vitcc Tredegar continues to focus on enabling citizens to access appropriate support including access to reablement provision that aims to promote independence and reduce dependency on traditional models of care and support. During 2019/20 we launched an integrated (Health, Social Care and Third sector) approach to IAA and we have appointed a Team Manager for IAA. She is successfully leading on developing our 'front door' services to meet the current and importantly future wellbeing needs of our communities.

Through our partnership working with ABUHB, we have been a pilot area for Compassionate Communities since April 2019. In November 2019, elected members attended a members briefing session on how we are supporting the development of alternative roles within GP practices to support the pressures faced by Primary Care in Blaenau Gwent. We have been supporting through offering social care workers in the form of Community Connectors as link workers within the GP surgery and have been participating in conversations with patients attending the surgery, post hospital discharge follows up telephone calls and weekly multidisciplinary meetings to discuss complex patients.

Our Community Resource Team (CRT) continues to be the main driver for ensuring that citizens have access to relevant and appropriate rehabilitative opportunities including therapist based interventions. Our team has this year developed a 'Better Care Project' with the main aim of supporting citizens to enhance their own strengths to manage their care for as long as possible with a particular emphasis on using the latest and most modern 'moving and handling' equipment to support them at home, reducing dependency on them needing domiciliary care staff to support them with personal care tasks and mobility transfers. Further details on the Better Care project will be presented to members as the project develops.

We continue to access revenue and capital Integrated Care Funds (ICF) to enhance the support we can offer citizens. A copy of the full allocation of ICF for Blaenau Gwent was presented to Scrutiny in October 2019. Our most recent allocation of integrated care funding (ICF) dementia funding has been an allocation of £81k annually until March 21 to further enhance our Reablement teams to support citizens and their carers living with dementia.

6.13 **Priority 3 Day Opportunities/Community Options:**

Our Community Options Service continues to provide a wide range of day activities to citizens across the ages from 18 to 90 years of age. During 2019/20 we completed the remodelling of our Lake View facility in Nantyglo resulting in the closure of our Quiet Minds provision with some citizens being supported in Lake Viewand a number of citizens transferring to Ash Parc – where we provide support for citizens living with Dementia, and others successfully accessing community or third sector networks.

Our partnership with Growing Space (third sector Mental Health group) was strengthened further in July 2019 resulting in an increase in community based learning opportunities for those attending our Community Options Green Shoots project.

Growing Space are providing opportunities for citizens to gain experience in retail by working in the furniture recycling shop in Brynmawr, building confidence in meeting new people through assisting customers when purchasing items, checking stock and re-stocking items for sale. Citizens are also participating in the furniture upcycling workshop, and maintaining and developing the gardens in Tredegar House, Newport. The participants have grown in confidence and become motivated in delivering the Growing Space programme.

6.14 **Table 4: Case Study community options - Owain**

Case study – Owain
Owain has accessed the Green Shoots Horticultural Project for the last 6 years assisting with the gardening contracts and hanging basket orders. During the last 12 months he had become less interested in daily activities and often displayed inappropriate behaviours towards his peers and staff, displaying a lack of motivation and a reluctance to engage in activities. However, during recent months and though our extended links with Growing Space, Owain has been supported to work at a project which provides support to vulnerable families though the recycling used furniture and paint. In addition, through support provided as a result of the implementation of the Assisted Transport policy, Owain expressed a wish to have independent travel training so that he could access his work placement via public transport. His travel training went well and provided him with greater flexibility to access the Green Shoots service

independently. During the past 6 months Owain has grown in confidence, is fully engaged with his new work placement and has become a key member of the Growing Space Team.

6.15 **Priority 4 Assistive Technology:**

A member briefing on progress across our assistive technology agenda was well received during 2019/20. We have progressed the assistive technology flats in extra care – see section below relating to accommodation. We continue to promote the use of technology as part of our community packages including the use of sensors and alarms including pendant alarms, falls detectors, bed/door sensors as well as bespoke solutions to meet individual health and social care needs. We have a number of monitoring tools to provide support and reassurance for carers as well as providing invaluable information to inform the assessment process and keep people safe at home. These include My Homehelper, Canary monitoring systems, Mindme alarm and Mindme locate.

Teams are actively promoting the use of our dementia therapy - dolls, cats and dogs alongside every day technologies such as use of the 'amazon echo' and 'google home' hubs. Finally, we are working with our partners in Worcester Telecare to access further funding to expand the provision we have to include the promotion of virtual reality and artificial intelligence units as part of our assessment process.

6.16 **Priority 5 Direct Payments:**

The Social Services and Wellbeing (Wales) Act 2014 promotes the use of direct payments for individuals and since April 2016, our Local Authority has been responsible for undertaking and funding Criminal Record Bureau Checks on behalf of the employing individual. In line with the Act we continue to offer Direct Payments to individuals as part of our care and support assessments as this is an option for providing support to meet eligible needs. The number of adults with a direct payment has remained fairly consistent over the last few years.

- At the end of March 2019 there were 121 adult's recipients of a direct payment in Blaenau Gwent compared to 121 at the end of March 18, 124 at the end of March 2017

- As at the end of quarter 3 (31st December 19) there are 123 Adults receiving a direct payment and 41 Children receiving a direct payment in Blaenau Gwent.

6.17 **Table 5: Direct Payment case study**

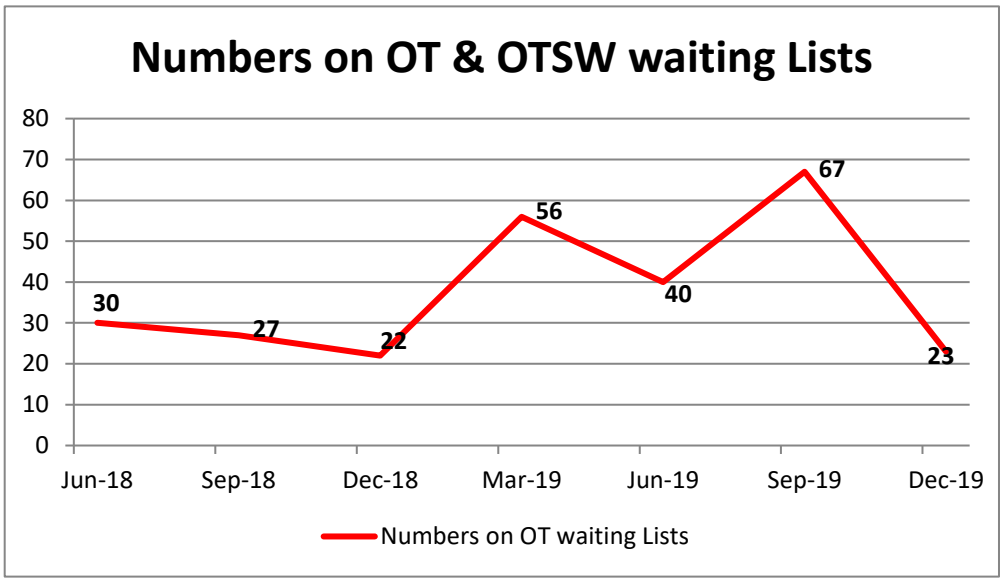
Examples of how a Direct Payment are used to support a family:
Elin is a 55-year-old woman who has been diagnosed with early onset dementia and epilepsy. She lives with her husband (Aled), daughter (Betsi) and much loved pets. She has difficulties undertaking daily tasks such as dressing, personal care, taking medication correctly and going out along and finds it difficult to accept support from Betsi as she feels that she should care for her daughter, not the other way around. Her main support is her husband and she becomes very anxious when he is not at home. Her condition is progressively getting worse and it is no longer safe for her to be left alone. Elin wants to live with her family and pets and also wants support to remain independent and enjoy the things she used to do before becoming ill, she likes going out shopping and walking, and she takes pride in her appearance which is important to her. Aled wants his wife to be happy, safe and hopes she can stay at home for as long as possible. He also wants to be able to continue to work full time. Following an assessment by a social worker in Blaenau Gwent, they decided that a direct payment was the best option for them to meet Elin's care and support needs and is flexible so it meets Aled's working pattern. They have employed 3 personal assistants who get together with Aled on a weekly basis to agree a rota which fits into his shift pattern and decide how best to support Elin during that week. Elin is happy that she is able to meet her outcomes and she remains as independent as possible in her own home. Aled is happy that his wife is supported, she's safe and remains with him and their daughter, and pets in the family home and he is able to remain in work which also gives him a break from his caring role.

6.18 **Priority 6 Accommodation:**

During 2019/20 we have continued to have good partnership and working arrangements between our RSL partners including Tai Calon, colleagues in Housing Strategy, the Supporting People Team and the Community Resource Team (CRT) ensuring that key partners are involved when allocating properties to citizens who have complex needs and mobility issues. We have made a decision to continue our secondment of an Occupational Therapy Support Worker within Tai Calon as feedback continues to demonstrate that she continues to support timely identification of suitable properties to meet specific health needs. Our frontline IAA (information, advice and assistance) staff have received training to enable them to become trusted assessors in the identification of low level equipment and this has enabled the department

to focus on addressing any waiting lists. We have had significant pressures in the Occupational Therapy Team (part of the Community Resource Team) during 2019/20 due to recruitment pressures and availability of suitably qualified Occupational Therapists across (Wales and not unique to Blaenau Gwent) but despite particular pressures during the Spring and Summer 2019 our OT waiting lists have now returned to a manageable level as a result of the alternative ways of working we have adopted and is credit to the CRT manager in how referrals are prioritised ensuring our most vulnerable citizens with complex health needs are supported.

6.19 **Table 6 – Waiting lists for OT assessments (June 18 to Dec 19)**



During the Summer 2019 we officially opened our assistive technology demonstration flats at both our Extra Care Schemes. These flats provide our care management staff, our citizens and their families an opportunity to see first-hand what technologies are available that promote independence and enable people with the most complex needs to live as independently as possible. During Autumn 2019 we were notified that we had secured an additional £63k to further develop assistive technology in Blaenau Gwent and staff from Adult Services are working with Worcester Telecare to develop phase 2 of the programme.

6.20 **Priority 7 Carers:**

The Carers Strategic Partnership Board (Chaired by Corporate Director of Social Service in Blaenau Gwent) and Operational Group (Chaired by Blaenau Gwent's Head of Adult Services) continues to meet on a quarterly basis and has developed a work plan for the future development of Carers Services in Gwent.

Support for Carers continue to be a key priority both locally in Blaenau Gwent and also on a national level with Welsh Government recently publishing its plans to develop a National Strategy for Carers.

Within Blaenau Gwent we had a visit from our regulator Care Inspectorate Wales (CIW) in July 2019 where they met with a number of our carers as part of Carers Day Activities. Our staff continue to access support for unpaid carers from the Gwent - Carers Small Grant Scheme and Age Cymru. There has been a significant additional investment made by the Gwent Regional Partnership Board (RPB) to the Gwent Small Carers Scheme and this has enabled the scheme to support many more carers including young carers with one off grant payments (up to £500) for items such as holidays, washing machines, driving lessons etc.

Our Carers Engagement Project workers continue to support carers and have maintained a robust partnership approach in all of the GP surgeries. They have a regular presence within each practice which enables the surgery staff to refer Carers directly to the Carer Engagement Officers and into the service. Recently each surgery has identified a member of staff as a Carers Champion and this staff link is proving very positive with Carers Champions referring into the service. Raising awareness through publicity materials and engaging with patients within the surgery waiting areas has also allowed our Engagement Officers to identify and interact with individuals who may not yet have recognised their role as a Carer. This ensures that individuals are given the appropriate information regarding what their rights are as a Carer as well as information on what services are available to assist and support them in their caring role. As the service is progressing, it is evident that there are real benefits being provided to Carers from offering emotional support and offering the opportunity for Carers voices and stories to be heard. Some Carers have commented that “it helps to have a good chat to somebody who understands” and “I feel better for talking to you”. Many Carers have described what their caring role entails and the pressures that this sometimes brings and, although they do not always want further support at that particular point, they often say that being able to speak to somebody about how they feel has been really helpful. These Carers are given the information and contact details for the service should they need advice or support in the future.

6.21 **Table 8: Carers Feedback:**

Feedback from Carers during quarter 3 – Carers Engagement Project
• *My life has changed since you supported me to claim all the benefits I was entitled to, I can now afford taxis to visit my husband in hospital rather than catch buses, thank you so much.* • *"I feel so much better now I have spent time talking to you, thank you for lending me your listening ear and not judging me".* • *"Thank you so much for informing me that as a carer I have rights".* • *Thank you for arranging for me to attend a training course it was very useful and also provided me with some time to myself to do the things that are important to me."* • *"Very useful to know that you are there for the future"* • *"Thank you for organising and inviting me to your Carers Rights Day event it was very informative and gave me the chance to meet other carers".* • *"Thank you for arranging for me to receive a grant so I could have a short break with my husband it gave us some quality time together in a different surroundings I was able to recharge my batteries".*

However, despite pockets of good practice as an authority we remain concerned that we still have a low take up of carers assessments and we continually are reviewing our data collected from our Quality Assurance process alongside feedback from our Carers Citizen questionnaires to identify trends and potential solutions to increase carer engagement and participation.

6.22 **Priority 8 Domiciliary Care:**

The sustainability of the national domiciliary care market remains a concern for all Local Authorities The monitoring of commissioned domiciliary care services continue to be undertaken and our Contracts and Commissioning Team review the call monitoring reports which includes attendance of calls; call times and call lengths. The team continues to contribute to the Gwent wide commissioning group on potential areas where concern over the sustainability of the domiciliary care market can be addressed. Regionally, events have been held with Domiciliary Care providers to enhance awareness

of the benefits of working within this field and our staffs have supported a number of job fayres and development sessions.

The authority maintains good working relationships with all commissioned domiciliary care providers so that commissioning and service provision is open and transparent. Our domiciliary care agencies have worked closely with the Commissioning Team to identify market pressures and support recent requirements for registration of the domiciliary care work force from April 2020. We continue to have regular provider meetings where best practice and development issues are shared.

During 2019/20, Blaenau Gwent and Caerphilly CBC collaborated on a joint tender to establish a framework with a list of accredited and approved Service Providers to deliver the Support at Home service for both Adults and Children. This was in respect of 'new' business only meaning that people with a care package could keep their existing Provider and Care Workers ensuring continuity of care for those Individuals. A project team was established with Commissioning and Procurement Officers from both LAs and from June 2018 through to August 2019, work which included a Provider Engagement Event, development of the contract, terms and conditions; service specification and tender documents incorporating the Ethical Care Charter and meeting the requirements of the Social Services Well-Being (Wales) Act 2014 and Well-being of Future Generations (Wales) Act 2015, was undertaken. The tender was concluded and contract awarded at the end of August 2019 and as a result, the number of Domiciliary Care Providers on the Blaenau Gwent framework has increased from 5 to 10.

The contract is for a period of 5 years with an option to extend for a further 5 years, with the aim of: -

- Continuity of care for Individuals
- Securing stability within the local market
- Increased choice for the citizens of Blaenau Gwent
- Strengthen capacity within a pressured market
- Support independent living and patient flow through hospital
- Movement from payment on planned hours of care delivery to payment on actual hours
- Commissioning from an increased number of Providers to support the spread of risk to the Council (as at 1st October on commencement of the new contract, BG commissioned 5,750 hours per week for care deliver to 406 people, from the existing 5 Providers)
- Community benefits such as local employment (E.G. 269 carers currently employed within the local market by the initial 5 Providers) and use of local suppliers/sustainable procurement

Joint meetings with Providers and information sessions with all Care Management Teams took place on various dates during September and meetings with Providers on an individual basis have continued to take place on a regular basis to progress commissioning under the new contract. New Providers have experienced some problems with recruitment in the area

although progression has been made with establishing bases and management structure for the Blaenau Gwent branch and it is expected that commissioning will commence from January/February 2020.

Within Blaenau Gwent the numbers of packages of commissioned care have gradually reduced since March 2019 and can be attributed to the impact of our preventative approaches, however this does not identify the rising complexity of care delivered to citizens in their home often with two or more carers required at one time.

6.23 **Table 9: Numbers of citizens receiving a domiciliary care package**

Category	***Mar 2018***	***June 2018***	***Mar 2019***	***June 2019***	***Sept 2019***	***Dec 2019***
Sitting Service Over 65	33	29	30	26	27	23
Sitting Service under 65	2	2	2	2	3	2
Home Care Over 65	411	415	383	367	372	365
Home Care Under 65	86	81	79	74	73	74
Total	***532***	***527***	***532***	***469***	***475***	***464***

7. Expected Outcomes for the public

7.1 This strategy focusses on the development of services that promote Wellbeing and independence in their own homes which may or may not include a Care Home. It utilised the key principles of the Social Services and Wellbeing (Wales) Act 2014 including:

a. **Voice and control –** putting the individual and their needs, at the centre of their care, and giving them a voice in, and control over reaching the outcomes that help them achieve well-being.
b. **Prevention and early intervention** – increasing preventative services within the community to minimise the escalation of critical need.
c. **Well-being** – supporting people to achieve their own well-being and measuring the success of care and support.
d. **Co-production** – encouraging individuals to become more involved in the design and delivery of services.

8. Monitoring Arrangements

8.1 An annual report to Scrutiny/ Executive is submitted. Progress is also monitored via the Adult Service Business Plans (tier 1 and 2) and Integrated Partnership Board Action plan.

Background Documents /Electronic Links

- Appendix 1 – Copy of the Living Independently in the 21st Century Strategy (updated 2014)

Cyngor Bwrdeisdref Sirol
Blaenau Gwent
County Borough Council

Living Independently in Blaenau Gwent in the 21st Century

Commissioning Strategy for Older People 2008 – 2021

Developed - 2006

Initially reviewed - 2008

Revised - November 2012

Revised – December 2014

SOCIAL SERVICES DIRECTORATE

Version number:	2	**Date Written:**	October 2006
		Date Approved:	October 2006
Status:	**Approved**	**Date of Issue:**	October 2006
		Initially reviewed	October 2008
	For consideration and approval	**Date of current review**	November 2012
Approved by:	Senior Management Team		
Author:	Paul Price - Development Officer		
Supporting documents:	"Needs Assessment 2012"		
Equality Impact Assessment	**Approved by:**		
	Date:		
Change history	**Dates reviewed:**	**Outcome of review:**	
	October 2008 November 2012 December 2014 (statistics update)		

1. INTRODUCTION

1.1 This paper gives an overview of the progress made, the actions taken to date, and the priorities planned for the future, as Social Services continues to focus its efforts in meeting the changing expectations and needs of 'older people'.

The focus to date has been one, which builds upon service quality whilst modernising and improving services, by ensuring that:

- An assessment is person centred and services are packaged to meet individual need
- Individuals live well and receive the support and any treatment they need if their health fails or they become frail and vulnerable
- Individuals feel that the services and support they receive, albeit possibly from different sources, are "joined up", or integrated, and delivered as a package which is purposeful and avoids omissions or duplications.
- Individuals recognise that services are delivered, whether by individual agencies, or in partnerships, in ways which enable individual needs to be met in a flexible and co-ordinated way

The strategy initially developed continues to be of huge relevance and it is clear that great strides have been made in 'modernising' the services available to 'older people'. Examples of the successes to date are included in section 4 and also in the appendices.

There is now a need to decide which services need to be targeted for change, why, and what the potential return might be if we are successful in adjusting the way in which any service is delivered

1.2 The 'Living Independently in Blaenau Gwent in the 21st Century' is a vision for the future, and from the outset, it set out to "modernise" the way in which it approaches its duties, and, in so doing, it has reflected on, and taken full account of, all emerging national

policies and strategies determined by the Wales Government, and, at the same time, determined how it is to meet the growing level of demand for service, and or, support from the 'older people's' population.

1.3 The initial fifteen year commissioning strategy developed in 2006 was formulated to cover a period of fifteen years to 2021 and set out to achieve a number of goals:

a) to respond to the express wishes of older people and their carers, meeting their changing needs and expectations
b) to satisfy national standards and give full implementation to the National Service Framework for Older People and the WAG 10 year strategy for social care ('Fulfilled Lives, Supportive Communities'), in partnership with the National Health Service
c) to enable older people to live as independently as possible, as full and equal citizens of Blaenau Gwent and their local communities

1.4 The title of the strategy and the planned future actions sought to encapsulate Social Services vision for the future and was named **'Living Independently in Blaenau Gwent in the 21st Century'.**

1.5 The strategy acknowledged that close collaboration between all Directorates would be required, as there were and continue to be wider Corporate implications, to enable more 'older people' to remain and be supported in their own homes.

1.6 This document both reflects on the achievements to date and highlights the future intentions as Social Services incrementally changes and delivers services to 2021.

2. BACKGROUND

2.1 The 'Living Independently in Blaenau Gwent in the 21st Century' project commenced in June 2005, with a period of consultation, and then set out to:

- Develop a strategy for meeting the needs of vulnerable older people in Blaenau Gwent in the 21st century.
- Assess the level of need for vulnerable older people in Blaenau Gwent now and in the future.
- Research the range of options available to meet the assessed need.
- Consult extensively on the range of options.
- Achieve value for money and affordability.
- Confirm the future model of service.
- Where necessary to reconfigure existing services, including the Council's direct provision of residential care.

2.2 The analysis and research undertaken as part of the strategy constructed a clear vision for future service delivery that embraced the standards outlined in the above section.

In supporting these standards Blaenau Gwent has continually aimed to improve the quality of life for older people by enabling them to participate as active citizens in the community; life of Blaenau Gwent; and, when necessary to receive the right care, in the right place, at the right time, provided in the right way, by the right people.

2.3 The over-arching principle of this strategy is based on the concept that actions should be taken to "help older people to find solutions that work for them".

2.4 As a direct result of the 'Living Independently in Blaenau Gwent in the 21st Century' strategy, a 'Commissioning' strategy was also developed to underpin the actions specified in the 'Living Independently in Blaenau Gwent in the 21st Century'. The established 'Commissioning' strategy recognised that a coherent range of services could only be established through a combination of joint and collaborative approaches that change the status quo.

In carrying through the overall programme of change, outlined in this report, both strategies placed an emphasis on caring 'with' people instead of caring 'for' people with social care provision being seen much more as an exercise in partnership, more fully utilising the resources of individuals themselves, their families and local communities as well as those of all the other care and mainstream services.

3. PURPOSE FOR REVIEWING THE STRATEGY

3.1 This review provides an opportunity for the Authority to consider the actions taken in the past 6 years, since the initial 'Living Independently in Blaenau Gwent in the 21st Century' and 'Commissioning' strategies were completed, and to help the Authority understand the range of changes that have been made, whether these changes have had a positive impact on the lives of people aged 65+, and, whether the plans and priorities set out in the 'Living Independently in Blaenau Gwent in the 21st Century' and 'Commissioning' strategies are believed to be appropriate and remain relevant to the needs of the 'older' population.

3.2 The assessment, completed within this review, will also enable the Authority to consider what other measures should be taken in re-positioning or re-providing services for the 65+ age group.

3.3 It is important to recognise that when considering future provision, the 'review' can only reflect on, and, factor into any deliberations, information that is readily available at the time the assessment is updated.

3.4 In collating current information it will help determine demographic changes and accordingly help plan to meet the perceived and projected needs of people aged 65+. The assessment reflects on and takes proper account of information available at the time it was produced – (**see appendix 1 "Needs Assessment").**

4. ACHIEVEMENTS MADE TO DATE IN SUPPORT OF THE 'LIVING INDEPENDENTLY IN BLAENAU GWENT IN THE 21ST CENTURY' STRATEGY, TOGETHER WITH THOSE OUTLINED AND SUPPORTED THROUGH THE 'COMMISSIONING' STRATEGY.

4.1 The vision, contained in the 'Living Independently in Blaenau Gwent in the 21st Century', and 'Commissioning' strategies set out a number of **"key over-arching"** themes that were to be focused on, and these were:

<table>
<tr><th>The initial "key" elements to be considered and focused on included:</th><th>Outcome of the actions taken against those initial "key" elements</th></tr>
<tr><td>1. Fewer older people placed into 'institutional' long term care, especially 'standard' residential care, with the development of more specialist Elderly Mentally Infirm (EMI) care.</td><td>The closure of 4 of the Council owned properties resulted in a reduction of some 130 places and private providers have been encouraged and subsequently acted to transfer provision to EMI. The bed situation is as follows:
<table>
<tr><th>September 2008</th><th>November 2012</th></tr>
<tr><td>221 Residential</td><td>113 Residential</td></tr>
<tr><td>254 Nursing</td><td>178 Nursing</td></tr>
<tr><td>46 EMI</td><td>91 EMI</td></tr>
<tr><td>90 EMI Nursing</td><td>101 EMI Nursing</td></tr>
</table></td></tr>
<tr><td>2. Developing services that help older people overcome the barriers that prevent them from getting on with their lives</td><td>Through the (Services for Older People – SfOP 50+ network), measures are being taken to promote positive images of older people with an emphasis on counteracting age discrimination by actively focusing on initiatives that create greater understanding and respect between the generations. Initiatives have been and are continually being considered through the 50+ network to provide learning opportunities and improve access to those opportunities for formal/ informal and non-accredited learning</td></tr>
<tr><td>3. A 24-hour care at home service, 365 days per year service and strengthen 'out of hours' home care to support more people at home.</td><td>There has been a major programme of service modernisation for domiciliary care services, including both in-house and commissioned services. Domiciliary care services currently operate over a 52 week period, between 7.00 – 23.00 hours (includes the twilight service) The need for a night service was not justifiable when considering the associated costs involved. Limited need was identified for a night service and "spot" contracting arrangements exist for a night sitting service.</td></tr>
<tr><td>4. Extra care housing to prevent avoidable admissions to institutional care (in particular residential care), to increase choice and flexibility and to create a more enabling person centred service</td><td>2 extraCare developments made with:
41 units at Llys Glyncoed, Ebbw Vale (opened inn 2010); and,
44 units at Llys Nant-y-Mynydd, Nantyglo (opened in 2011)
Bid for Social Housing Grant made to the Welsh Government for a 3rd scheme</td></tr>
</table>

5. A combination of borough-wide specialist services, combined with local services that reflect the 4 main communities of Blaenau Gwent - Abertillery, Brynmawr, Ebbw Vale and Tredegar.	Created through the development of 4 "zones" within the Community Care team and the re-modelling of specialist sensory impairment services. Each team has access to specialist CRT teams as required. Internal and external Home Care have been developed to run conterminously on the 4 zone basis.
6. A 'whole-system' approach with a range services for a range of needs and excellent links with healthcare providers, transport, housing and leisure services to ensure the best quality of life possible	'Specialist services exist and joint working with Health continues through joint team collaborations. These include the Gwent Frailty Programme. Collaborative approaches have been established between Social Services and Lifelong learning and Leisure with the specific remit of developing practices that enable a more integrated "working together" ethos to evolve.
7. Complementary provision with Health, combining social care commissioning intentions	Complementary provision exists with Health enabling the same service providers to support users and ensure care consistency. Examples include the Gwent Wide Integrated Community Equipment Stores (GWICES), and the Gwent Frailty Programme (GFP). Work is also progressing to extend the joint commissioning of services at an individual level.
8. An investment to improve intermediate care services to better help people recover from illness and injury and to prevent avoidable admissions to institutional care.	Facility developed at Llys-y-Capel, Blaina but under-used and not fully supported. Has now been replaced through the introduction of the CRT (Frailty Programme). The CRT has been established to focus specifically on this and is jointly managed with Social Services.
9. Increased availability of personal aids and adaptations in people's own homes	Local Authority consortia created through the 'GWICES' service agreement which was established to improve access to aids and adaptations Increased year on year investment into Care and Repair for minor adaptations with joint working arrangements in place to deliver the 'Disabled facilities Grant'.
10. Increased support for unpaid/family carers	Much work has been done to better identify and assist carers. The following elements have been included and are being focused on as a direct result of the strategy: • Carers Strategy • Carers Forum • Information/advice/guidance

	• Learning & development to understand key aspects of caring • Social care workforce to better understand carer needs and assessment practices • Development of carer networks • Befriending services • Providers working collaboratively
11. Working with a range of partners from the planning stage	Increased links with the voluntary sector have evolved to develop low-level support, such as 'choices'; 'Hospital Discharge Scheme'; 'ECSH'; and, 'Supporting People Floating Support' all of which enable older people to access those services they need to maintain their independence and well being.
12. A modern flexible and responsive service that enables older people to maximise their independence and live with appropriate support in their communities.	The proposed service model (see **appendix 2**) is designed to reflect this with the emphasis on mobilising the support of community based organisations, agencies and groups operating in a defined area to create stronger communities to meet the needs of vulnerable people.

5. THE VISION FOR FUTURE SERVICE DELIVERY

5.1 In reviewing the strategy, 'Living Independently in Blaenau Gwent in the 21st Century', Social Services have worked towards achieving the aims and objectives that are consistent with, and support, the overarching strategic aims, namely to:

- Maximise Independence
- Minimise Dependence
- Intervene Where Appropriate

By:

- Promoting independence
- Preventing dependence
- Protecting children and vulnerable adults
- Understanding what people want and need
- Managing our affairs
- Valuing our staff
- Promoting partnership
- Being clear about roles and responsibilities

5.2 The strategy initially developed continues to be of huge relevance and it is clear that great strides have been made in 'modernising' the services available to 'older people', in accordance with the above 'philosophy and principles'.

5.3 Central to the philosophy of all developments in Health, is the “key” aim, “to develop innovative proposals for improving the integration and seamlessness of Health & Social Care provision”. Actions proposed are based on the following principles:

- The recognition to invest in the future health and wellbeing of the people of Blaenau Gwent, through reducing the incidence of preventable disease and empowering people to take responsibility for their own health and wellbeing;
- The need to transform the existing health and social care services and workforce to provide integrated services, which focus on maximising independence and where all care interventions are based on assessed needs, with all goals identified and subsequent outcomes continually evaluated;
- The need to involve staff at all levels to address cultural differences between staff groups, to ensure ownership and deliverability through effective communication and full collaboration.
- There have been some significant improvements associated with the ‘integration’ approach, namely:
  - ‘Frailty’ programme
  - Neighbourhood Care Networks and the creation of an integrated approach and service
  - Integration of Mental Health and Learning Disability Services

5.4 With the changes in demography, the emerging strategies from Wales Government that all impact of the delivery of service and the changing expectations of older people, there is now a need to re-assert, or, re-prioritise our plans and priorities to ensure they continue to have a major influence on the development of social care provision. Importantly, the manner in which these priorities are integrated with health care provision and, those of organisations that have a community presence, will enable greater collaboration to evolve so that each can draw on the expertise of one another. A ‘working together’ approach as outlined below is viewed as being critical to the success of the strategy, together with all community based developments.

Future Service model (proposed)

The model is intended to help create greater clarity about what it is that the Department is trying to promote or prevent in support of its community citizens.

The model will help staff to understand why changes are being promoted and what the potential return might be as a result of a different approach.

The service model creates 4 distinct groups of people and is intended to create more diverse, focused and integrated pathway of service delivery.

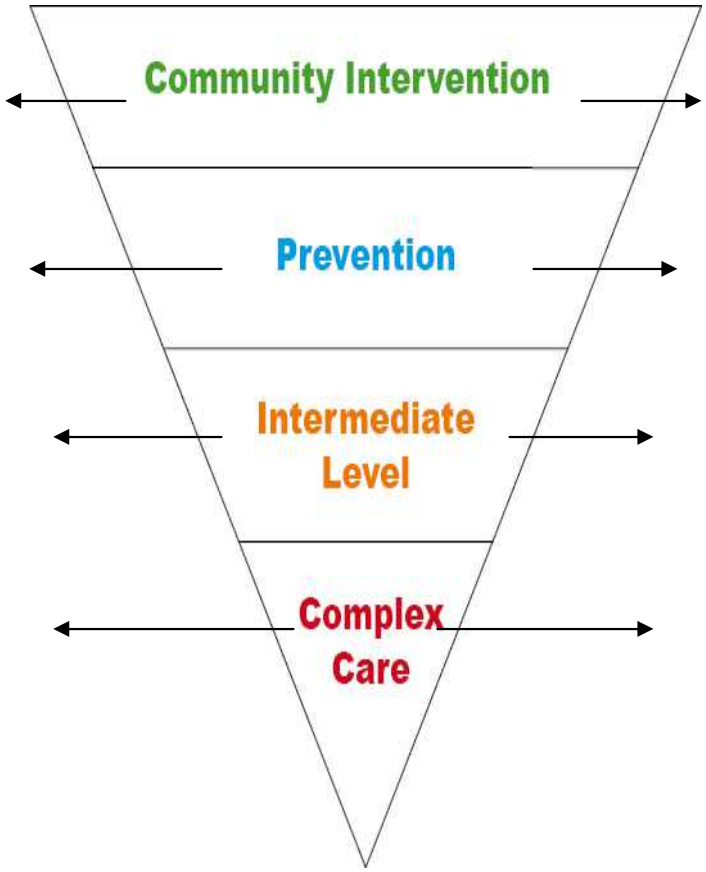
Focus

Community Support
Working with community based organisations to develop an enabling, early intervention approach.

Prevention
Low level care targeted towards enhancing independence and diverting individuals away from direct service provision.

Intermediate Level
Reablement process, helping individual's regain confidence/skills and keeping people out of social care provision with outcome focused interventions.

Complex Care
Provision where there is little opportunity for people to gain good health and or skills to regain independence.



Challenges

Divert demand – early identification
Mobilise organisations and groups operating in a defined area to create stronger communities to meet the needs of vulnerable people.

Reduce demand – identify what are the key `trigger' points along that pathway that lead to the inability/capacity of the individual to care for themselves; what interventions may change or divert that outcome.

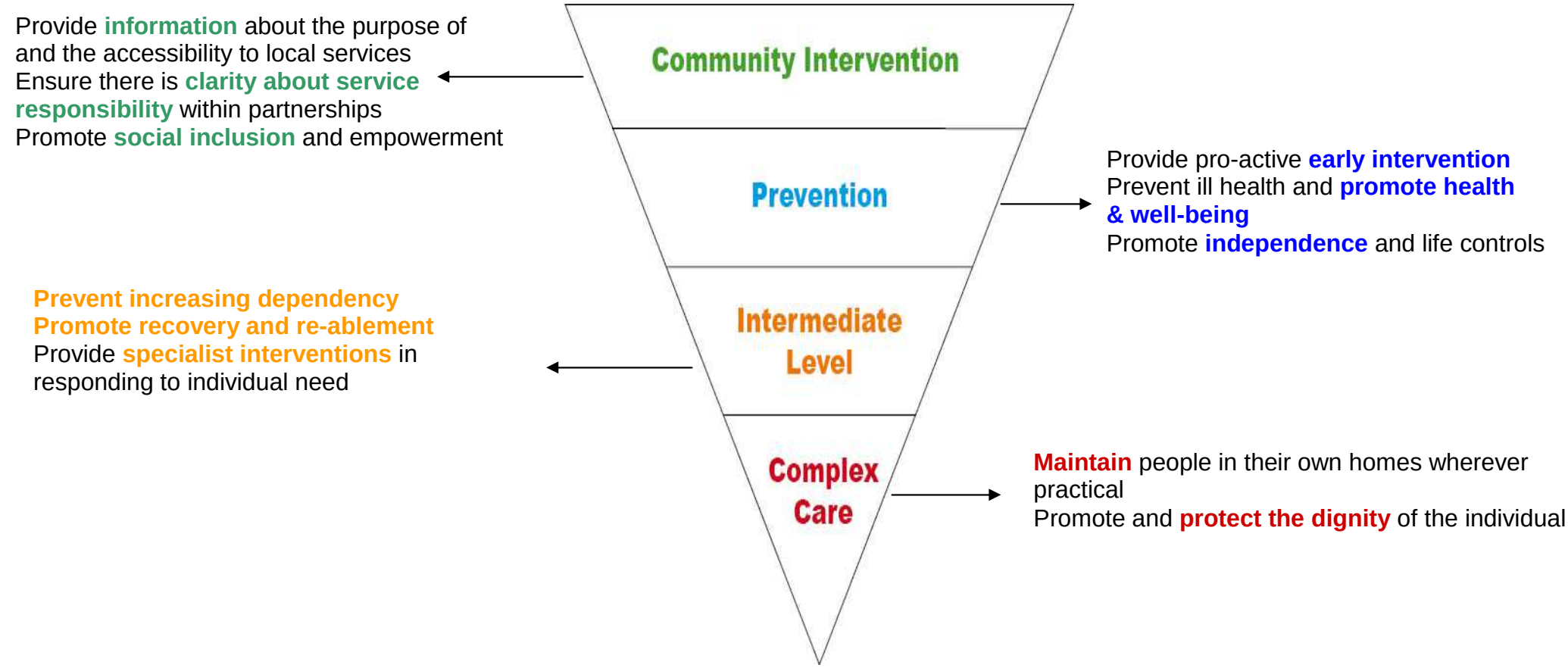
Promote independence – determine whether services provided actually promote independence or create dependency and what alternatives might be available.

Manage the demand that remains better and more efficiently - identify success through outcomes achieved. Current incentives are perverse, i.e., the provider benefits from people's needs increasing rather than diminishing. How can providers be encouraged not by the volume of provision but by the outcomes they have achieved.

Common challenges which straddle all four of the above categories include:

- **Understand demand and supply** - understand the key drivers behind demand and how can these be managed, lessoned or deferred.
- **Stimulate the development of a more diverse market** – outcome-based specifications for all contracts with perhaps a reduction of block contracts through the promotion of direct payments.
- **Generate efficiencies through more effective partnership working** – the identification of multi-disciplined organisations capable of tackling a broader range of health and social care issues
- **Capacity/resources** – to be delivered by workers with the relevant skills and knowledge.

The 'core' principles required to help fulfil the service model include:



5.5 This model reinforces the 'Wales Government challenge' of the next 10 years which is to:

- "create a Wales where full participation is within the reach of all older people and their contribution is recognised and valued. Developing communities that are age-friendly while ensuring older people have the resources they need to live, will improve participation and individual wellbeing";
- "ensure that future generations of older people are well equipped for later life by encouraging recognition of the changes and demands that may be faced and taking action early in preparation. Population ageing is a permanent feature of our modern society. There is a need to work collectively and embrace this reality for the opportunities and challenges it brings".

6. THE NATIONAL VISION IN PROGRESSING SERVICES TO OLDER/DISABLED PEOPLE

6.1 Local authorities are at the forefront of dealing with the implications of an ageing population. The need to re-define our role and place within their local communities is becoming increasingly more important in the current economic climate and through times of austerity.

6.2 If Social Services is to cope with the many demands expected of it then there needs to be a fundamental change in attitude towards old age, moving away from the negative stereotypes of dependence and loss, to a more positive appreciation of the knowledge, coping skills and experience, possessed by older people. These attributes equip older people to make a significant contribution to the well-being of their local communities.

6.3 While good physical and mental health is an important contributor to individual wellbeing, the presence of chronic or disabling health conditions need not stand in the way of life satisfaction or personal well-being. Services that support individuals and address the disabling effects of health conditions can play a major role in enabling a good quality of life.

6.4 Social Services will undoubtedly need to reduce demand on its services and if it is to achieve this it needs to identify what the key `trigger' points are for older people along a pathway that leads to the inability/incapacity of the individual to care for themselves and what interventions may change or divert that outcome. As a consequence there is a growing emphasis to move to a more health and well-being focus as opposed to the traditional 'welfare' approach. This focus has to gain prominence in the way in which Social Services is organised and responds in the future.

6.5 The expectation outlined in ***'Sustainable Social Services- A Framework for Action:'***

states that "Social Services need to take better account of individual requirements and to achieve this they must act in ways that:

- strengthen the voice of older/disabled people;
- allow older/disabled people to have maximum control over their lives;
- build on the strengths of older/disabled people;
- sustain and strengthen older/disabled people and enable them to make a full contribution to the community and importantly to draw on it for support".

6.6 This in effect means that in setting out plans for improvement the following 'themes' are identified as being critical:

- **Getting Help (Access to Services and Quality of Services provided)**
  - Offer, with health, a rapid, community based assessment and response service
  - Provide mechanisms to ensure prompt access to specialist diagnostic and/or emergency services when required.

- **The Effect on People's Lives**
  - Respond to individuals' changing social and clinical needs.
  - Protecting vulnerable people,
  - Promoting independence and social inclusion

- **Shaping Services**
  - Planning and Partnerships, Commissioning and Contracting Resources
  - Making optimum use of available diagnostic and therapeutic technologies.

- **Delivering Social Services (Workforce; Performance Management)**
  - Ensuring staff are appropriately trained in preparation for the 'culture' change as it emerges.
  - Ensuring the appropriate balance of staff is achieved to support the priority service activities

- **Providing Direction (Leadership and Culture; Corporate and Political Support and Scrutiny**)
  - Preparing the political and corporate agenda to meet the challenges identified within national policy
  - Developing a shared understanding of need and commitment to future developments and changes in service delivery.

6.7 The Local Authority has a leading role in responding to these challenges and also in promoting economic, social and environmental well-being within the context of a strategic community partnership involving a broad range of statutory, voluntary and private sector organisations.

6.8 Our work, to date, reinforces this approach and the need to create standards within the communities of Blaenau Gwent where older people (**taken from the Community Plan**):

- Are valued citizens
- Do not suffer from health inequalities
- Contribute to, and share in, the prosperity and resources of the community
- Live safely and feel safe at home and outside
- Are financially secure
- Learn, achieve and share their skills, experience and knowledge with others
- Live as independently as possible, with choice and control over their lives
- Live well and receive the support and any treatment they need if their health fails or they become frail and vulnerable

6.9 Using these principles, the work of Social Services has to now, be more focused on maximising the abilities and potential of older people and, to only provide "care" related

services to those individuals who are unable to benefit from rehabilitation/reablement services.
In maximising the abilities and potential of older people and in promoting and enabling people to live as independently as possible, a broader approach is needed and it is believed the following aims must now come into focus as we lead the work of Social Services:

- Services to promote social inclusion
- Services to support individuals at times of difficulty and protect them from harm.
- Services to assist individuals to recover independence where this has been threatened;
- Services to promote and protect the dignity of the individual.

(refer to the proposed service mode - above)

7. DRIVERS FOR CHANGE

7.1 Over recent years there have been a number of developments both locally and nationally that have required a review of existing service provision, these include:

- The key strategic aims and core themes of the Council, including the aim for individuals to live as independently as possible with access to services that are local, high quality, efficient, safe, timely and delivered in modern facilities.
- Key national strategies all emphasise the need to promote health and social care policies which enable older people to live at home with appropriate support as long as is possible. These strategies include:

    - 'Social Services (Wales) Bill';
    - the Community Plan;
    - the Health Social Care and Well Being Strategy;
    - 'Fulfilled Lives, Supportive Communities'
    - "Making the Connections"
    - 'Sustainable Social Services: A Framework for Action;,
    - Evolving joint commissioning strategies with Health partners e.g. CHC Domiciliary Commissioning.
    - 'The 'Strategy for Older People in Wales';
    - 'The 'National Service Framework for Older People'; and,

The common 'theme' across all national strategies is to:

- provide services, opportunities and activities in a timely and appropriate way;
- promote and ensure health and well–being; and,
- enables people to maximise their independence, potential and participation as valued members in society".

7.2 With the changes in demography, the emerging strategies from Wales Government that all impact of the delivery of service and the changing expectations of older people, there is now a need to re-assert, or, re-prioritise our plans and priorities to ensure they continue to have a major influence on the development of social care provision. Importantly, the manner in which these priorities are integrated with health care provision and, those of organisations that have a community presence, will enable greater collaboration to evolve so that each can draw on the expertise of one another

7.3 The need to review and adjust service provision to meet the changing expectations of older people, in the future, is paramount. The commissioning strategy needs to respond to the above whilst recognising that a coherent range of services will only be established through a combination of joint and collaborative approaches that change the status quo.

7.4 In carrying through the programme of change, outlined in this report, Social Services will place an emphasis on facilitating responses to people who are vulnerable or "at risk", in partnership, fully utilising the resources of individuals themselves, their families and local communities as well as those of all the other 'mainstream' services, and will only make longer-term social care provision available, after all rehabilitation programmes have been exhausted.

7.5 By taking forward this work the aim of the strategy is to bring about radical change that fundamentally shifts the way we all think about, talk about and respond to the needs and aspirations of older people.

8. PROFILE OF BLAENAU GWENT'S OLDER CITIZENS

8.1 The strategy for future service development has to take full account of the projected demographic changes in the future. A 'needs analysis' has been undertaken to try and assess likely levels of future demand (**see appendix 1**).

8.2 The number of people aged over 80 in Blaenau Gwent, is reported to have consistently increased, year on year, since 1991. In 2014 the number of people aged 80+ in the Borough is 1,470 and is projected to increase by 230 in 6 years and by 1,070 in 16 years.

Table 1:
Population projections

	2014	**2015**	**2016**	**2017**	**2020**	**2025**	**2030**
Age 65+	11,840	11,960	12,100	12,180	12,350	12,870	13,620
Age 80+	1,470	1,500	1,500	1,540	1,700	2,260	2,550

Source: http//www.daffodilcymru.org.uk;

8.3 Proportion of older people with limiting long-term illness.
In the 2001 Census 11,566 people in Blaenau Gwent declared their health to be 'not good' with some 19, 838 stated they had a long-term illness, health problem or disability which limited daily activities or work.
More recent indications using the "Daffodil" projection of care services in Wales system are that in 2014 there were 4,646 people, aged 65 and over, with 'limiting long-term illness'**.** This compares to the Wales position where in 2014 there are 217,242 people with 'limiting long-term illness' aged 65 and over.

Table 2:
Population with limiting long-term illness

	2014	2015	2016	2017	2020	2025	2030
People aged 65-74 (Blaenau Gwent)	2,101	2,119	2,137	2,124	2,076	2,022	2,232
Figures for Wales population aged 65-74	92,803	94,773	96,406	97,346	98,218	96,644	105,095
People aged 75+ (Blaenau Gwent)	2,545	2,579	2,617	2,688	2,911	3,382	3,598
Figures for Wales population aged 75+	124,439	126,558	128,626	131,561	143,740	171,662	189,351

Source: http//www.daffodilcymru.org.uk;

While medical advances and improved standards of living are continuing to increase life expectancy, those same factors are combining to increase the period of time that people live in a state of ill-health, requiring higher levels of health and social care. This trend is evident from the national statistics for the last 20 years:

8.4 The Welsh Index of Multiple Deprivation study of 2008 a number of electoral wards in Blaenau Gwent, have been awarded Communities First status on the basis that these wards face significant economic and social deprivation. Some statistics in addition to those already reported include: -

- Lowest average property values in the United Kingdom.
- High proportion of persons providing unpaid care to disabled family members;
- High unemployment levels in comparison to the rest of Wales;
- Low gross weekly earnings in comparison to the rest of Wales;
-

The Welsh Index of Multiple Deprivation (2005) comparisons show that people in Blaenau Gwent have a greater degree of disadvantage than in other areas of Wales and the UK. The impact of income and wealth on health is liable to mean that despite the decrease in heavy industry the older population of Blaenau Gwent will still have poorer than average health.

Table 3:
Life expectancy at Birth in Blaenau Gwent

	Between 2001-03	Between 2008-09	2022/23
Males	73.6	75.6	79.0
Females	78.4	78.2	81.0

Source: Population census

A growing proportion of this ill-health in old age is attributable to dementia. Based on national estimates that 20% of people over 80 live with dementia, it can be estimated that there are over 1,000 Blaenau Gwent residents living with this condition now.

Table 4:
People aged 65 and over predicted to have dementia, by age and gender, projected to 2030

	2014	2015	2020	2025	2030
People aged 65-79	284	295	319	332	324
People aged 80+	547	554	617	732	888

Source: http//www.daffodilcymru.org.uk;

8.5 As of March 2006, there were, in Blaenau Gwent, 3,091 care packages open to adults; 2,228 service users were aged 65 plus, 673 of this total, related to people aged over 80 years and there were 863 packages to people under 65 years of age.

As of September 2014, there were 2,741 care packages open to adults; 1,587 service users were aged 65 plus, with 494 of this total related to people aged over 80 years and 1,154 packages to people under 65 years of age.
The table below reflects the fact that services have been targeted on those with the most significant needs, and although there is a fluctuating situation over the period 2008 to 2014, overall there has been a reduction in actual numbers receiving community care packages, although there is evidence to indicate that the total packages of care are starting to rise (up by 36 cases) in the period 2012 to 2014.
Interestingly, the complexity of their care needs throughout the period March 2006 to September 2014 has increased.

Table 5
Service users supported through community care packages

Service user numbers	March 2006	March 2012	September 2012	September 2014
Total number of users supported	3,091	2,792	2,723	2,741
Service users 85+	673	544	501	494
Service users aged between 65 - 84	1,555	1,227	1,221	1,093
Service users aged 18 -64	863	1,021	1,001	1,154

Source for the above information in table 5:
Business Management Team, Social Services

9. FUTURE SERVICE PRIORITIES AND COMMISSIONING INTENTIONS

9.1 The strategy acknowledges that in the face of severe financial restraints now, and, particularly in the future, new sets of challenges are likely to emerge and one of those challenges relates to the level and type of services the Authority is able to deliver. Different options for services, in this era of growing scale and complexity of need, will be required with some of the services gaining in prominence at the expense of others, purely and simply because of affordability, due to the ever changing demands as the population ages.

9.2 The needs analysis has identified the likely demographic pressures that have to be faced in the future, analysed current service provision, and identified a 'service model' that will need to be established if Social Services is to combat and divert demand.

9.3 In an attempt to overcome many of the concerns for the future, Social Services is proposing to change some of its current focus and concentrate time and effort in the early identification of vulnerable, or, potentially vulnerable people so that staff can intervene early in an attempt to remedy concerns at an early stage and delay or prevent the individual's circumstances or personal health from deteriorating to the extent that the only option is intensive support through a 'care' package.

9.4 The 'service model' proposed is based on a broader definition of help and facilitation with the services and support individuals receive, albeit possibly from different sources, being "joined up", or integrated, and delivered as a package which is purposeful to the individual, avoids omissions and focuses specifically on outcomes that will benefit the individual.

9.5 The challenge is to ensure that sufficient resources are made available to meet our statutory responsibilities and create sufficient capacity to focus on diverting demand. Integral to the success of this challenge is the action of mobilising organisations and groups operating in a defined area, to work collaboratively with Social Services, to create a more 'joined-up' approach in generating stronger communities that will better meet the needs of vulnerable people.

9.6 The framework established in the "Living Independently in Blaenau Gwent in the 21st Century Strategy for Older People aged 65+" clearly outlines developments proposed over a fifteen year period 2006–2021 and this document, in the earlier section, outlines the achievements to date.

9.7 The intention is to continue the work that has brought significant change and success to the citizens of Blaenau Gwent, albeit by strengthening our work with partner and 'like-minded' organisations which will "add value" to the work of the Department.
The service model proposed continues to be based on already stated and evolving health, social care, accommodation, transport and voluntary sector developments.

9.8 In addition to these wider 'social service developments', the following 'service provision' will be targeted as priority, all of which are part of the overarching "Living Independently in Blaenau Gwent in the 21st Century Strategy for Older People".

- **Priority 1. Long term care:** jointly with Health and other partners, make arrangements to meet the nursing, residential and dementia care needs of the older persons population
- **Priority 2. Reablement/Enabling services:** further develop this approach and recognise the contribution of other organisations, in progressing this service

- **Priority 3. Day Opportunities/Community Options:** continuing development of everyday activities and opportunities to learn new skills or re-acquire skills through confidence building and tuition measures
- **Priority 4. Assistive Technology:** promote and expand assistive technology supported by a rapid response service, capable of containing situations where no family carers are available.
- **Priority 5. Direct Payments:** promote and expand direct payments and empowering people to take responsibility for arranging their own care and support requirements
- **Priority 6. Accommodation:** recognising the key role that appropriate housing plays on the well-being of older people. Work closely with partners to develop a range of suitable housing in Blaenau
- **Priority 7. Carers:** providing accessible and timely support services responsive to individual need
- **Priority 8. Domiciliary Care:** Ensuring provision of appropriate, reliable, quality services.

9.9 Taking forward the above priorities is considered critical, and these priorities need to be reconciled with the integration agenda with Caerphilly County Borough Council, so that the respective Authorities:

- Develop more appropriate care and support arrangements
- Enable people to live independently for as long as possible

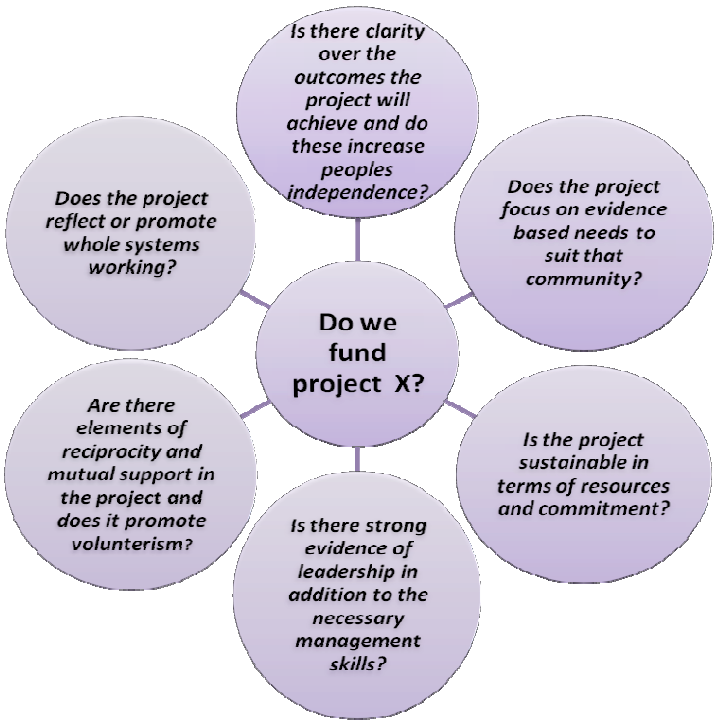
To achieve this there is a need to

- Ensure consistent outcome focused assessment & care management arrangements exist
- An early identification and intervention service exists with appropriate

10. Commissioning for future services

10.1 The key issue is, what services are we to invest in, that will maximise better outcomes for service users, provide efficiency and value for money, minimise risks to users and limit pressures on budgets. There is a need to remove the often perverse nature of commissioning services, so that providers are paid on outcomes achieved, as opposed to the amount of ‘care’ provided. In working to this approach it reinforces the practice principle of ‘enabling’ people to become more independent through programmes that help people recover self-help skills.

10.2 In order to assess and determine the services we will invest in, and those we need to de-commission. The following criteria is recommended **(taken from framework of services to older people):**



10.3 In working with partners, including service providers, there will be a need to develop a shared understanding, a commitment to change and in the way services are delivered. This is particularly important because in moving to this proposed model there will in many instances need to be a cross departmental/multi agency undertaking and or agreement. In addition the Council will need to consider how services are delivered, working closely with a range of partners, including the voluntary and independent sector to secure the most effective methods to deliver services. The proposed social services integration programme with Caerphilly Council will require that future commissioning intentions converge and complement each other.

10.4 In considering the developmental service aspirations, it should be noted that there will be a limit to what can be achieved at any one time, therefore immediate priorities have been established. Listed below are details of the work priorities:

Range of "Core" Community and Borough-wide services:

- Integrated social care and Health services
- Assessment & Care Management/Community Care Team
- Primary and secondary mental health services
- Domiciliary care services
- Joint Frailty Community Resource Team (including Occupational Therapy and Re-ablement services) that support people to regain skills and confidence
- Accommodation options to support people with high dependency needs e.g. people with dementia / extra care)
- Supporting People Floating Support Services that help people to keep their our accommodation
- Community Options (Day Care provision)
- Carer Support
- Long-term care
- Respite care

The specific actions that are required to underpin and support the development and or, re-positioning of services are set out below:

- **Long term care:**
  - Fewer older people being placed into institutional care, including standard residential care;
  - Increased availability of specialist residential (high dependency), dual nursing and dementia care.
  - Projections on the need for future long-term care provision, based on population and dementia trends, reveals the following (red type indicates pressure points):

Calendar Year	Residential Care	EMI Residential Care	Dual Residential/ Nursing Care	Nursing Care	EMI Nursing Care
2012	113	91	New category	178	101
Beds available at the end of 2014	84	90	**75**	**113**	54
2015	70	92	79	94	54
2016	68	102	79	90	61
2020	72	109	84	96	
2025	78	117	89	104	71
2030	86	135	102	116	81

- **Accommodation**:
  - Development of Extra Care Sheltered Housing, a bid has already been submitted for Tredegar, in addition to the 2 existing schemes
  - Housing – appropriate housing choices
  - Housing and repairs – long-term maintenance of private dwellings; energy schemes; handyman services

- **Domiciliary Care**: with'
  - Personalised enabling domiciliary service that maximises independence;
  - Increased specialism for those who are elderly mentally infirm;

- Increased **support for carers**;
  - Carer assessments appropriately reflect carer needs and properly signpost
  - Flexible respite care to include 'sitting service';
  - Sustaining the caring role over a longer period without direct help and support.
  - Mobile response services as an increased support for carers

- **Facilitation and promotion of Low-level (preventative) support**, addressing issues of social inclusion such as shopping, low-level maintenance:
  - Good quality information to the public - crucial to helping individuals and families make informed decisions. Older people can benefit hugely from having help to 'navigate' around the system

- Practical help with things like shopping, gardening, minor repairs and adaptations in the home etc
- Advocacy/Floating support – helping people to navigate through any issues and concerns
- Social connections/social networks/befriending – avoiding isolation and re-establishing or building contacts
- Welfare advice
- Healthy living advice and support – e.g. exercise classes, diet advice, risky lifestyle, issues awareness etc
- Community safety – fire safety, antisocial behaviour, victim support, crime prevention etc

- **Increased usage of assistive technology;**
  - Increased use of Telecare to enable older and vulnerable people to remain independent in their own homes
  - Formal assessments as part of assessment & care management – use of demonstration/assessment facility
  - Falls prevention that help minimise risk
  - Digital inclusion to promote social inclusion

- **Increased availability of personal aids and adaptations in people's own homes;**
  - Continue to work with Care & Repair, GWICES and other providers to ensure needs are met

- **Universal day opportunities for older people; need to**
  - Find more financially sustainable models for delivering services, thus allowing us to spend our resources on those in most need.
  - Continue to look for value for money by working in partnership and sharing resources.
  - Design specialist services to meet the growing demand.
  - Consider options for developing some of our existing projects through the social firm or social enterprise route.
  - Develop pathways to progression beyond the service

- **Increased rehabilitative services**
  - Outcome focused rehabilitation/reablement delivery
  - Community care packages – with an emphasis on getting people to do as much as they can for themselves

- **Extended links with voluntary sector support;**
  - Undertake an audit of the work of the voluntary sector and determine commissioning opportunities
  - Explore how the voluntary sector are able to assist 'older people' to have meaningful contacts with and be active in the community
  - Identify how the sector can deliver low-level practical services

References:

1. Framework of Services for Older People: Wales Government 2012
2. The Strategy for Older People in Wales, 2008-2013 - **("Living longer, living better")**

3. Sustainable Social Services for Wales: A Framework for Action
4. Fulfilled Lives, Supportive Communities'
5. The Community Plan;
6. Improving Social Care in Wales - SSIA
7. "Basics of efficiency in Adult Care" – John Bolton
8. Together for Health: A Five Year Vision for the NHS in Wales

Executive Committee and Council only

Date signed off by the Monitoring Officer: N/A

Date signed off by the Section 151 Officer: N/A

Committee:	**Social Services Scrutiny Committee**
Date of meeting:	**13th February 2020**
Report Subject:	**Update on Progress of the My Support Team**
Portfolio Holder:	**Cllr John Mason, Executive Member Social Services**
Report Submitted by:	**Tanya Evans, Head of Children's Services**

Reporting Pathway								
Directorate Management Team	**Corporate Leadership Team**	**Portfolio Holder / Chair**	**Audit Committee**	**Democratic Services Committee**	**Scrutiny Committee**	**Executive Committee**	**Council**	**Other (please state)**
23.1.20	28.1.20	03.02.20			13.2.20	Info item 11.03.20		

1. Purpose of the Report

The purpose of this report is to provide an update on the work of the My Support Team since it become operational in May 2019.

2. Scope and Background

2.1 A report was presented to Social Services Scrutiny Committee in September 2018 recommending the establishment of a joint My Support Team (MyST) between Blaenau Gwent and Monmouthshire. Scrutiny supported this proposal as did Executive.

2.2 To remind members the MyST provides a multi-disciplinary intensive **therapeutic fostering service** for Children Looked After. The Team work intensively with children currently in residential care with the aim of bringing them back to live closer to Blaenau Gwent and be placed with foster carers or family members. The Team also works with those children in care who present with complex needs and are at risk of going into residential care, to prevent this from happening.

2.3 In the summer of 2018 a bid was made via the Children and Families Partnership Board for Integrated Care Fund (ICF) grant money to develop a Gwent wide approach in developing a joint multi-disciplinary intensive **therapeutic fostering service** for Children Looked After. As Torfaen and Caerphilly already had a MyST in place the Partnership Board agreed Blaenau Gwent and Monmouthshire should be the next authorities to develop this service. It was already well evidenced by Torfaen and Caerphilly how MyST had improved outcomes for children looked after with complex needs and how it had made savings and cost avoidance for the local authorities.

3. **Options for Recommendation**

3.1 **Option 1**
For scrutiny members to acknowledge the positive work MyST have undertaken in demonstrating good outcomes for our children looked after and the positive impact the work of the team has had on the Children's Services budget.

Option 2
For scrutiny members to acknowledge the positive work MyST have undertaken in demonstrating good outcomes for our children looked after and the positive impact the work of the team has had on the Children's Services budget and advise of any points for clarification

4. **Evidence of how this topic supports the achievement of the Corporate Plan / Statutory Responsibilities / Blaenau Gwent Well-being Plan**

The work of the MyST supports the achievement of the following priorities for Social Services under the Corporate Plan:

- To intervene early to prevent problems from becoming greater
- To work with our partners including Aneurin Bevan University Health Board and neighbouring authorities to deliver integrated responsive care and support
- To promote and facilitate new ways of delivering health and social care involving key partners and our communities

The My Support Team is also a key part of the Safe Reduction of Children Looked after Strategy 2017- 2020.

5. **Implications Against Each Option**

6. ***Impact on Budget (short and long term impact)***

6.1 Since being established the MyST successfully moved 3 children from residential care into foster care

6.2 The costs relating to both children are as follows:

Figure 1

	weekly residential costs	Current foster care costs
Child 1	£5250	£450
Child 2	£4400	£450
Child 3	£5000	£0

6.3 Figure 1 demonstrates the savings made due to the change of placement for the 3 children who have moved from residential care to foster care and back to family.

6.4 This has had a positive impact on the Children's Services budget which was showing an under spend of £154,813 at the end of Quarter 2 for 19/20. A note of

caution must be made as this situation could change if other children are admitted to residential care during the remainder of the financial year.

7. ***Risk including Mitigating Actions***

7.1 **Risk 1**
Increase in the numbers of children being placed in high cost residential placements which doesn't always achieve good outcomes for the children

7.2 **Mitigation**

- The continued work of MyST to reduce the numbers of children currently in residential care and continue to prevent children entering residential care will help to mitigate against this risk.

8.0 ***Legal***

8.1 N/A

9. ***Human Resources***

9.1 As Monmouthshire are hosting the MyST, there will be no implications for Blaenau Gwent Organisational Development department.

10. **Supporting Evidence**

10.1 ***Performance Information and Data***

10.2 As previously mentioned the MyST become operational from May 2019. In May Blaenau Gwent had 18 children in residential care. In December 2019 we have 15 children in residential care and 1 in secure accommodation. The plan is for the child in secure accommodation to move into residential care early February 2020. MyST have been supporting this transition.

10.3 The following information outlines three key areas of work undertaken by MyST from May – December 2019.

1. Numbers of Blaenau Gwent children the team have supported to move out of residential care.
2. The numbers of Blaenau Gwent children the team have supported to prevent children going into residential care
3. The number of Blaenau Gwent practice consultations undertaken

10.4 **Numbers of Blaenau Gwent children the team have supported out of residential care.**

Since May 2019 MyST has successfully worked with 3 children to move them out of residential care into foster placements or home. At the heart of this work is the relationship the MyST workers build with the children and their support networks. The small numbers that MyST work with at any one time allows their work to be very intensive, providing 24/7 support to the child and their carers. It is this

intensive support that has enabled 2 children to move successfully in a planned way into foster care and 1 child to be rehabilitated back to their parent's care.

The MyST are also working with 1 other child who is currently in residential care who has a plan to move back into the care of an extended family member. This plan will take some time to realise but good progress is being made.

In addition, we have identified 2 other children in residential care who, once the right foster placement has been identified MyST can start to work with them to support their move out of residential care.

10.5 **The numbers of Blaenau Gwent children the team have supported to prevent children going into residential care**

Since May 2019 MyST have worked intensively with 4 children whose foster placement was at high risk of breaking down. If the foster placement had broken down the only placements for these children would have been residential care. Providing hands on intensive 24/7 support to the child and foster carers has enabled these placements to remain stable, enabling the child to remain local and continue in the same schools and maintain contact with their family and friendship groups.

10.6 **The number of Blaenau Gwent practice consultations undertaken**

MyST provide practice consultations to Social Workers and Foster Carers when they are struggling to understand and support a child whose needs are starting to become complex. These consultations provide advice and guidance in managing emerging complex needs by trying new approaches when managing various risks/behaviours. To date MyST have provided 10 practice consultations to staff and foster carers. The feedback has been very positive

The views and feedback from the children and young people, foster carers and professionals experiencing the service is critical to evidence the improved outcomes for our children looked after. Examples of the comments received are below

10.7 • **BG Young Person** – "I like having someone there, just for me, and I like being a part of MyST. It has been helpful (and very difficult) to talk about my feelings. I'd prefer to see my worker out of school so that we have more time together"

10.8 • **BG foster carer** "working alongside MyST and being in weekly contact with the team has allowed me to share my knowledge and ideas and I feel like a valued person within the child's support network. I feel listened to and that my skill set as a foster carer is appreciated

10.9 • **BG parent** - "thank you for last night, I truly appreciate it, having someone to speak to really helps" following evening on call support

10.10 • **BG Social Worker** “To have them on board to be able to offer such flexibility with supporting the placement is really such a valuable resource. We have been able to get over some real tricky obstacles which without MyST being involved I am almost certain may have ended with further disruption to the placement. I was particularly struck by how D and E embraced this as an opportunity to really see and understand the dynamics between the boys and the way that they deal with stressful situations; whereas others may have become overwhelmed by the chaos”

11. ***Expected outcome for the public***

11.1 The work of the MyST work to achieve the following outcomes for children

- Children placed closer to home which will enable sustained relationships with their families and friends
- Increased placement stability
- Improved school attendance
- Improved emotional wellbeing

11.2 ***Involvement (consultation, engagement, participation)***
As part of the ongoing monitoring there will be consultation with the children and young people, foster carers and staff receiving a service from MyST

11.3 ***Thinking for the Long term (forward planning)***
The development of the service outlined in this report is aimed at enhancing and improving services for children looked after and young people in the longer term. Bringing children closer to home will enable them to form local support networks and communities which will no doubt benefit them into the future.

11.4 ***Preventative focus***
MyST aims to improve outcomes for children who have experienced multiple Adverse Childhood Experiences (ACE) and who have the most complex and challenging needs. If successful MyST interventions will reduce the use of expensive and sometimes ineffective out of area placements. MyST works in close alignment with the Gwent-wide attachment service, to achieve psychologically-informed environments, including an ACEs-informed workforce.

11.5 ***Collaboration / partnership working***
MyST is an excellent example of how the Children and Families Partnership is working together to improve outcomes for children and young people who present with complex needs.

11.6 ***Integration (across service areas)***
MyST engages with the whole support network around the child. This includes school, youth workers and any community activities/clubs. The work undertaken to date by MyST has evidenced very close working relationships with schools both inside and outside of Blaenau Gwent. MyST have also presented a workshop to members in December 2019.

12. **Monitoring Arrangements**

12.1 The following will monitor the MyST arrangements:

- The Children and Families Partnership Board
- The Regional Partnership Board
- The Regional MyST Steering Group
- The Project is included as part of the action plan in the Blaenau Gwent Children Looked After reduction strategy which will be monitored on a quarterly basis

Executive Committee and Council only

Date signed off by the Monitoring Officer: N/A

Date signed off by the Section 151 Officer: N/A

Committee:	**Social Services Scrutiny Committee**
Date of meeting:	**13th February 2020**
Report Subject:	**Forward Work Programme – 13th February 2020**
Portfolio Holder:	**Cllr John Mason, Executive Member Social Services**
Report Submitted by:	**Cllr Steve Thomas, Chair of the Social Services Scrutiny Committee**

Reporting Pathway								
Directorate Management Team	**Corporate Leadership Team**	**Portfolio Holder / Chair**	**Audit Committee**	**Democratic Services Committee**	**Scrutiny Committee**	**Executive Committee**	**Council**	**Other (please state)**
x	x	03.02.20			13.02.20			

1. **Purpose of the Report**

1.1 To present to Members the Social Services Scrutiny Committee Forward Work Programme for the Meeting on 2nd April 2020 for discussion and to update the Committee on any changes.

2. **Scope and Background**

2.1 The Scrutiny Work Programmes are key aspects of the Council's planning and governance arrangements and support the requirements of the Constitution.

2.2 The topics set out in the Forward Work Programmes link to the strategic work of the Council as identified by the Council's Corporate Plan, corporate documents and supporting business plans. Effective work programmes are essential to ensure that the work of scrutiny make a positive impact upon the Council's delivery of services.

2.3 The Committee's Forward Work Programme was agreed in July 2019, recognising the fluidity of the document to enable the Committee to respond to urgent and emerging issues, and included timescales when reports will be considered by the Committee. The work programme is managed and implemented by the Scrutiny and Democratic Officer under the direction of the Chair and Committee.

2.4 The forward work programme for the forthcoming meeting will be presented to Committee on a 6 weekly cycle in order that Members can consider the programme of work; request information is included within the reports, as appropriate and / or make amendments to the work programme.

3. **Options for Recommendation**

3.1 **Option 1:** The Scrutiny Committee consider the Forward Work Programme for the meeting on 2nd April 2020, and:

- Make any amendments to the topics scheduled for the meetings;

- Suggest any additional invitees that the committee requires to fully consider the reports; and
- Request any additional information to be included with regards to the topics to be discussed.

3.2 **Option 2:** The Scrutiny Committee agree the Forward Programme for the meeting on 2nd April 2020, as presented.

Background Documents /Electronic Links

- Appendix 1 – Forward Work Programme - Meeting on 2nd April 2020

Social Services Scrutiny Committee
Forward Work Programme

Scrutiny Meeting Date: Thursday 2nd April 2020
Scrutiny Deadline to receive reports: Wednesday 18th March 2020

Report Title	Lead Officer	Purpose of Report	Method/ Expert Witness/Exec Member	CLT Sign Off	Executive Meeting Date	Council Meeting Date
Assistive Technology	Alyson Hoskins	**Service Delivery** To report findings of review to Members.	Agenda Item	17.03.20	22.04.20	N/A
Children Looked After Update	Tanya Evans	**Monitoring** To update Members on the current situation in relation to the numbers of children who are looked after and the progress made in relation to the implementation of the Safe Reduction of Looked After Children Strategy.	Agenda Item	17.03.20	22.04.20	N/A
Regional Partnership Board - Quarterly	Damien McCann	**Monitoring** To provide Members with quarterly updates from the work of the Regional Partnership Board developed as part of the Social Services and Well-being Act, Part 9, integration and partnership.	Agenda Item	17.03.20	22.04.20	N/A
Preventative Model of Service to meet future social care demand	Alyson Hoskins	**Policy Development** Development of a Preventative Strategy for Adult Services.	Agenda Item	17.03.20	22.04.20	N/A
INFORMATION ITEMS						
Annual Independent Reviewing Officer report	Tanya Evans	**Information** Statutory responsibility.	Information Item	17.03.20	Info Item - 22.04.20	N/A

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