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**

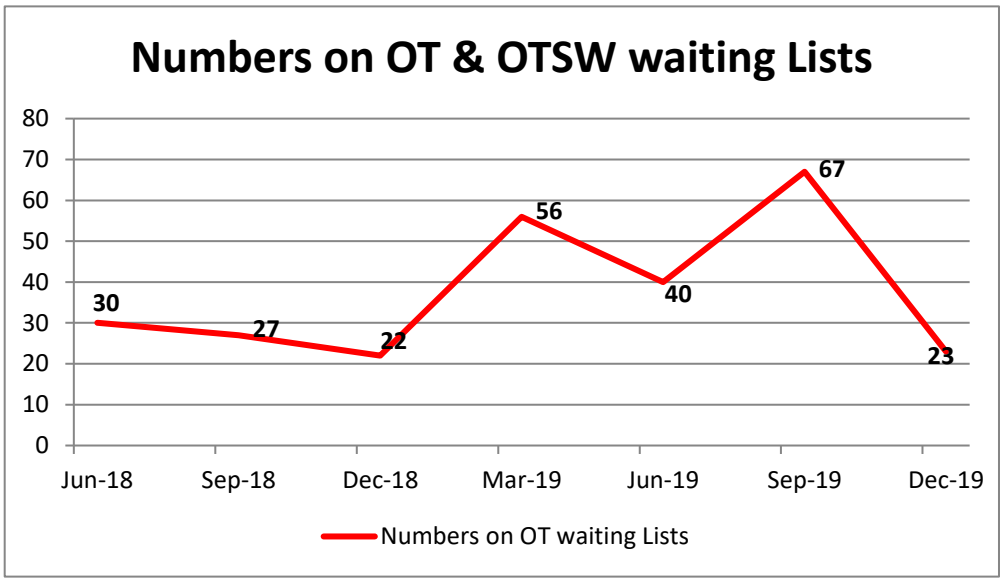
Examples of how a Direct Payment are used to support a family:
Elin is a 55-year-old woman who has been diagnosed with early onset dementia and epilepsy. She lives with her husband (Aled), daughter (Betsi) and much loved pets. She has difficulties undertaking daily tasks such as dressing, personal care, 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)