



Arolygiaeth Gofal a Gwasanaethau Cymdeithasol Cymru  
Care and Social Services Inspectorate Wales

## Review of Social Services in Blaenau Gwent County Borough Council

Inspection: March 2012



Review of Social Services in Blaenau Gwent County Borough  
Council – March 2012.

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# Review of Social Services in Blaenau Gwent County Borough Council – March 2012.

## **Role of CSSIW**

CSSIW reviews social care services at a local and national level so that it may inform the public whether services are up to standard; suggest ways of improving services and help safeguard the interest of children and adults who use services and also their families/carers.

This report is intended to be of interest to the general public, and in particular those people who use services in Blaenau Gwent. It will assist the council and other agencies in working together to improve the lives of vulnerable people, children and their families through the provision of appropriate locally provided services to meet their needs.

## **The profile of Blaenau Gwent**

Blaenau Gwent is a County Borough rich in history with a successful industrial past. This past has left a legacy of poor health, high levels of unemployment and poverty, and the need to raise aspirations by creating opportunity. It covers an area of 10,900 hectares and is the third smallest unitary authority in Wales. Its main towns are Abertillery, Brynmawr, Ebbw Vale and Tredegar. The County Borough's population is approximately 68,368 and is generally described as deprived. Demands for Social Services are consistently high and increasing and almost 6% of the population receive support from Social Services at some point.

Information that impacts on social services includes:

- High proportion of benefit claimants amongst people of working age
- 32% of the population with long term limiting illness
- Blaenau Gwent has 21% of its local areas in the 10% most deprived in

Wales

- High proportion of children living in overcrowded housing
- 12,584 people aged 65 years and over, of whom 545 are aged ninety or over.

## **Scope of this Review**

The inspection of services for children and adults took place in March 2012 and draws together a number of different strands and work activities. Together they inform our analysis and assessment of Blaenau Gwent's performance in key areas of adult and children's services.

CSSIW designed the inspection in order to focus on identified areas for improvement in both services, including Blaenau Gwent's approach to modernising services. We drew on information from the Director of Social Services' Annual Report and our own Annual Council Reporting Framework (ACRF) evaluation report for 2010-2011.

The inspection in children's services focused on transition planning and co-ordination for young people with a disability and / or a complex need, aged between 14 and 20 and living in the Borough. It considered the outcomes where young people received additional support through the transition project (described in detail later in the report). It also considered the capacity in adult services to support young adults to reach their potential. From a policy perspective it links with the transition key actions set out in the National Services Framework for Children, Young People and Maternity services (2005) where it not only highlights the importance of ensuring safe and effective transition throughout children's services but also dedicates a standard to growing up into adulthood.

In adult services the main remit of the inspection was to examine the way support through domiciliary care services is commissioned for older adults, a key area in the authority's modernisation programme. This was linked to CSSIW's national

objective to review commissioning in local authority social services. The Welsh Government has published guidance on commissioning which sets out its expectations. It should drive the promotion of independence, choice and personal development, enabling people to take control of their lives within the wider context of promoting social inclusion, sustainability and delivering value. At the same time, the guidance expects local commissioning plans to be in place, based on the needs of the local population, as well as using assessment and care planning information to increase its understanding of those people already using services.

Drawing on these different, though complementary strands of investigation and analysis means that this report is not solely about commissioning or transition services and their development, but also about the wider management and practice environment. The report sets out separately the key findings and areas for improvement or further development from adult and children's services. However, there are areas that apply to both services and the report draws these findings together.

## **Findings that apply across Social Services**

There are a number of findings which apply to both adult and children's services. These are drawn together here.

### **Integration with Caerphilly County Borough Council Social Services**

In summer 2011 following a period of initial discussions agreement was reached between Blaenau Gwent and Caerphilly County Borough Councils to proceed with an innovative merger of the two social services departments. The proposal recommended a staged approach to collaboration between the two departments over a three year period.

This decision was based on a history of close working relationships between them as well as some existing partnerships. It is in line with the principles of the

government initiative “Sustainable Social Services for Wales - A framework for Action” which sought to address:

- the sustainability of small local authorities within a fragile economy
- more collaborative working with neighbouring authorities
- increase in demand as well as higher expectations of service users.

During the inspection, discussions with senior managers and staff at all levels in social services indicated an open minded approach to integration. Managers and staff recognised the value they will bring to the further development of joint services as well as the opportunity to benefit from fresh approaches. Blaenau Gwent has a stable workforce with staff who have had the opportunity to progress within social services. The integration with Caerphilly will offer them the opportunity to widen their perspectives further. Staff welcomed the information on progress they have received from managers and some staff have met with counterparts in Caerphilly to begin mapping specific areas of joint work. We found staff are working to deliver services “here and now” while continuing to review the effectiveness of service delivery and looking for early opportunities to maximise best practice from both organisations. An example of this is the integrated workforce development team which became operational from April 2012.

### **Partnerships**

In addition to the integration programme the directorate has worked towards partnership arrangements with health, education and housing as well as the third sector to meet the needs of local people and deliver best value. The partnership with colleagues in the Aneurin Bevan Health Board has been particularly close, with shared premises and some co-located teams. Social services has numerous collaborative partnerships which increase choice and encourage independence for people who use services and their families. This is demonstrated well in both adult and children’s services.

## **Corporate and Political Support**

Social services functions have continued to receive corporate and political support. The Director of Social Services sits on the corporate management team. It was evident during two interviews undertaken with the Executive Member for Social Services that arranging and providing safe, good quality services in both children and adult services is given high priority. He works proactively to promote understanding of social services issues and welcomes the challenges provided by Scrutiny members. Senior social services officers also offer training and awareness raising opportunities to members.

The authority holds quarterly meetings with regulators (representatives from Estyn, Wales Audit Office as well as CSSIW inspectors) which are chaired by the leader of the Council and attended by the most senior officers within the authority including the acting Chief Executive. These meetings provide the opportunity to discuss the key priorities and issues facing the council as well as considering progress updates on the delivery of services.

Implementation of the Living Independently in Blaenau Gwent in the 21<sup>st</sup> Century Strategy has had all-party support over a sustained period. (This strategy provides a framework for modernising social services for older people that has also impacted on a number of other directorates.) The Corporate Improvement Plan sets out the priorities for the Council's business and contains strategic outcomes that impact on the delivery of social services, including the requirement for all children and young people to be safe, healthy and receive good quality education to help them reach their full potential.

Senior officers and their staff have worked across directorates to ensure that universal services are accessible to all, while working to ensure that people receive specific support from social services when needed. Both of the themes examined in the inspection offered examples of co-operative work between directorates.

Social services in Blaenau Gwent has benefited from the regeneration agenda and accessed funding for developments across both service areas.

### **Planning and Commissioning**

Blaenau Gwent County Borough Council and its partners have produced plans and work to the frameworks required by the Welsh Government. There is a Community Plan with high level priorities, the Children and Young People's Plan, the Health, Social Care and Well-Being Plan and the Community Safety Plan. All reflect the challenging economic and demographic characteristics of the area and determination to overcome disadvantage to build on the strength of its communities.

Senior managers in social services reported increasing pressure in managing the volume and complexity of the work within an environment of continuing financial constraint. In order to manage this effectively commissioning decisions have been made to achieve best value for money whilst improving the outcomes for people who need support through high quality services. In adult services this has included the decision to move to block contracts for domiciliary care services, and to re-focus the in-house Home Care service. In children's services a commissioning strategy has been developed. Most commissioning work is based on partnership arrangements and service delivery models developed with a small number of key stakeholders which are often jointly provided with the third sector. This year a revised contract with the third sector has been re negotiated in order to ensure services are more outcome focussed and person centred.

### **Leadership and Vision**

The senior management team have worked together for some years, with some adjustment when the Head of Adult Services was promoted to the post of Director of Social Services in 2010, after the previous post-holder's retirement. Staff praised their visibility, accessibility and approachability. The planned move to bring more staff together under one roof should enhance this further, although the

same positive comments were made by staff who are not currently co-located alongside their senior managers.

Social services recognises the need to communicate effectively with the public and last year set out its achievements and challenges in a newsletter called “Connect”. This is a supplement to the Annual Directors’ report designed to inform the public about the role of social services. It makes clear connections between its functions and improvements to people’s lives.

### **Performance Management and Quality Assurance**

The director presents a quarterly comprehensive monitoring report linked to the council’s corporate and departmental priorities which ensures that members and senior staff are kept updated on key issues and challenges within the department. The senior management team has also made progress in aligning performance management processes to the Annual Council Reporting Framework (ACRF). This provides an auditable trail of the progress made. Whilst this is a good starting point the authority will want to continue to implement robust procedures as well as providing quality work within a busy working environment.

The small size of the local authority lends itself to good joint working across adult and children’s services. The transitions work has demonstrated how well services can work together. Although we found a good example of a young carer and her parent being well supported by both adult and children’s services, there is no formal route for sharing good practice outside of the transitions framework. The principles of co-operative working across teams in adult and children’s services are essential to ensuring effective person centred planning with individuals and their families.

## **Direct Payments**

Direct payments<sup>1</sup> are cash payments made by local authorities directly to individuals who have been assessed as having community care needs and are eligible for certain services (including to people who care for others). The payments must be spent on support to meet an individual's social needs and to maintain or improve independence. Parents of children with a disability are also able to use direct payments to purchase services. Regulations introduced in Wales have extended direct payments to groups which were previously excluded due to a lack of capacity to consent to them. This includes some people with dementia and children with a disability moving into adulthood (who would previously have lost their direct payment). Young adults with learning disabilities now continue to be eligible for direct payments when they reach 18 years of age.

Blaenau Gwent provides a dedicated staff member to support people to set up the systems necessary to allow them to employ a personal assistant or an agency. At set intervals, the local authority monitors whether the money is being spent as intended. In all other respects, the individual is free to make their own arrangements.

Inspectors found that both adult and children's service have made good use of direct payments. In eighteen months they have increased the number of people using them from 39 in July, 2010 to 94 in March 2012. (That is 14 in children's services, 80 in adult services.) Individuals contacted as part of the inspection described how the direct payments had helped them. For some people, direct payments purchase all the services they need to retain independence, for others they may be supplementary, for example, to improve access to leisure facilities. More detailed observations later in the report give examples of how this works in both adult and children's services.

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<sup>1</sup> For more detail on Direct payments, see the current Welsh Government Guidance 2011, published April 2011

More can be done to take this good work further. Social workers or community occupational therapists need to explore direct payments routinely with service users as part of their assessments. To do this, all need to be clear about what this option can offer.

## **Findings from each theme.**

### **Children's Services**

#### Context - What is Transition?

Transition into adulthood is exciting and challenging for all young people. For young people with a disability or special needs, this is the time when they move from the protection and support of children's services and school to adulthood and further education or other opportunities. Parents in particular want to see seamlessness in the planning education and social services undertake, as well as that within social services. Young people and their parents want to be part of the reassessment that takes place to see what support they will need in order to maximise their potential and promote independence.

In response to parents, professionals, researchers and the Special Educational Needs (SEN) Transition review, Welsh Government funded 5 pilot projects to develop Transition Key Working in Wales. One of these projects included the Blaenau Gwent area and 14 young people from the area took part.

The "Your Life Your Choices Transition Project" was set up in February 2009 and followed two phases. In the initial phase the framework for implementation was developed, setting out principles for good engagement and problem solving for all the partners. The Project worked with a pilot group of 36 young people aged 14-25 living in Monmouthshire, Torfaen and Blaenau Gwent, between April 2009 and March 2011. The second phase improved transition planning and coordination for

young people with disabilities and/or complex needs by direct input from transitions co-ordinators. Caerphilly became a partner in the project at this stage.

Overall the Transition Project has five aims which can be summarised as:

- To develop a person centred approach to transition planning
- To develop better information about transition planning
- To develop the role of Transition Coordinator
- To develop a multi-agency transition process
- To model best practice with other professionals.

### **Breakdown of relevant transition data 2010-2011**

**46 young people aged 14-20 known to social services were eligible for transition support, of whom**

**7 aged 14 to 16**

**17 aged 16-18**

**22 aged 18-20**

**14 young people receive direct payments**

### **Specific Findings**

In both children and adult services there are eligibility criteria that support access to services. In adult services efforts were made to ensure that the eligibility threshold did not become a barrier to receiving support as young people moved through transition. (There is further detail on the eligibility threshold on page 22 of this report.) There was evidence that the needs of service users were paramount and carried the most weight in making decisions. This ensured that the service responded appropriately and positively to individual needs and was based on the fundamentals of person centred planning. This helped to provide a seamless transfer into adult services.

The inspection examined the circumstances of a total of eight children and young people, incorporating a sample that spanned an age range from 14 to 20 years. It looked at young people who were not part of the pilot project as well as those who were, to see if the outcomes for each were different. All of the young people were receiving a service and known to social services.

As part of the inspection we considered the following questions;

- Is there a person centred approach to transition planning?
- What is the impact of the multi agency referral process for transition support?
- What has the outcome of change been for individuals and their family or carers?
- How far has the Council already evaluated this?

In response to these questions, we found that transition in Blaenau Gwent is implemented in a way which considers the best interest of the young person. Adopting a multi agency approach to strategy, services planning and implementation requires a willingness to work in partnership with all stakeholders. We found that this occurred consistently. Outcomes were positive for all eight of the young people whose files we examined. This success could not be linked solely to additional support provided by the workers within the transition pilot as three young people were not part of the pilot. All benefitted from the partnership framework now in place across all participating organisations. Additionally, the team for children with disability work in an inclusive person centred way that supports good outcomes.

Social services' own evaluation continues as part of their annual review process as well as through the pilot project itself. We were pleased to note, for example, that the Community Learning Disability Team (CLDT) in adult services had instigated an internal review of families who had been through the transition. However, the outcome of the review suggests that families had mixed views of their experience.

The big challenge for the Council will be whether the young people feel they have continued to be supported long term in adult services.

Planning for moving on from school was triggered by Education Services in an appropriate and timely way when children reached 14. There was evidence on some files of active adult services involvement at this stage in the process, but it was certainly apparent when a young person reached 16 years old. All of the files examined had a transition plan in place which was drafted by the most appropriate professional and included a mixture of input from school, college, social worker or transition project worker. There is a system whereby the allocated adult worker is notified immediately the young person is referred to the transition panel.

Involvement in planning from an adult services' worker included attending statutory Children in Need reviews.

Through discussion with families, service users and the care management teams we saw that transition work within the council was underpinned by clear interagency planning, user and family engagement and a professional approach. Staff reported that the case transfer process between teams was good and evidence indicated that planning the move on between teams was well managed particularly between the leaving care team and the CLDT. Most (80%) of the referrals for transition are made to this adult services team. This joint work shows commendable practice.

### **Service Users' Experiences**

As part of the inspection we met with six families to talk about their experiences. This included young people who were not part of the pilot that was established in 2009 as well as young people who were directly supported through the pilot project. Overall those we spoke to thought that the services and support provided made positive differences to the outcomes for the young people involved particularly over the last two years.

Example 1 of good practice

X (who was not part of the pilot) experienced a number of different foster placements before being placed permanently at the age of 10. The young person currently attends residential school but returns home at weekends. She is hoping to attend college locally later this year and will then return to live full time with her foster parents. This placement has been so successful that agreement has been reached with her and her foster carers that she will continue to live with the family on a Supported Lodgings basis until she completes her education in 2013.

Having a transition plan in place at an early stage in this instance has helped professionals ensure that all the young person's complex needs are appropriately met. The plan in place clearly reflected her wishes and feelings and empowered her to make informed decisions about her future. The case has been transferred to the CLDT where work is ongoing and support will be provided to move on to independent living when the time comes.

Example 2 of good practice

Y (who was part of the pilot) has been known to children's services for some time and received support and guidance from the Transitions coordinator at what was a potentially anxious time for the whole family. Y had been receiving a service from Barnardo's and with the help of direct payments was able to access a Personal Assistant and is now able to pursue social and leisure activities. The case was transferred to the CLDT last year.

The use of direct payments in this instance has encouraged this young person to become more independent and has helped develop her confidence as well as promoting life skills. An allocated social worker was identified by the Transitions panel for Y at 16 which meant that the transfer to adult services was a smooth

process for all the family. The parents were happy that they had received help in assisting their daughter achieve her own personal goals.

Parents expressed satisfaction with the current arrangements for support from social services and a number of parents said they had become more confident in the service they received particularly over the past few years. This was not necessarily as a result of the transitions project in itself but it was linked to the use of an inclusive social work model approach which is evident throughout children's services in Blaenau Gwent. Parents and young people spoke about their involvement in the planning for the future which involved all key stakeholders. It was important to them that progress was made at the young person's pace. Where they had experienced challenges these had eventually been resolved and were mainly around transport issues and educational placements. Two sets of parents told us that they had wanted their child to experience mainstream education throughout their school careers. In practice these parents found their children's needs were only met adequately within special educational provision.

A sample of comments and feedback from parents;

"We feel well supported at present"

"There is a feeling that everyone who is involved with X work well together for her benefit"

"The transition process was brilliant"

"Getting transport sorted was a nightmare"

## **Moving into Adulthood**

It is widely acknowledged that as young people move between services and on to adult services they often experience significant differences in the delivery, style and culture of services at the same time as their own care needs are evolving. Managers and staff in both adult and children's services are acutely aware that families face this tension. For example, some young people in transition who are vulnerable rather than disabled may not meet the eligibility threshold to receive a service on reaching adulthood. Others who meet the criteria find that resources in adult services are stretched and the level of support they have been used to may not be available. This is a dilemma facing most authorities in Wales.

The CLDT has recently completed a project to examine outcomes for young people who have already been through the transition process. Parents gave a variety of views about the levels of support received in adult services. In some instances parents thought high quality support had been provided, in others less so. Underlining this, two of the families we spoke to whose children had recently moved into adult services felt they received a different level of support from the new team. It was unfortunate that two families from the small sample that we looked at had been allocated to workers who were subsequently not available through sickness. As a result they did not have the level of support they were used to. Whilst they were not complaining, they missed the level of contact previously experienced. Although they found the team manager very approachable, they did not want to bother her and tried to resolve issues themselves. While these experiences are unlikely to be typical, it demonstrates the difficulties in maintaining services when resources are scarce.

The team manager readily acknowledged the need to have consistent social work input particularly where there are young adults who have complex needs. While the team members have the skills and knowledge to offer their support they struggle to find the capacity to do so. During the course of the inspection the head of adult services secured funding for an additional temporary member of staff

which will help address the issues of capacity in the short term. However, in the long term the department will need to consider issues of sustainability in relation to support to individual adults who have transferred from children's services. This will become particularly relevant when they come to the end of their college experience, when further plans for the future need to be made.

Social services in consultation with health colleagues has begun to undertake a mapping exercise around identifying children at 16 years old for whom it may be more appropriate to be signposted to universal services. It is also mindful of the potential increase in demand due to greater awareness and diagnosis around Autistic Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD).

### **Working Together**

The transition project is led by an overall manager for the local authorities currently involved in the project - Blaenau Gwent, Torfaen and Caerphilly. There is a dedicated co-ordinator linked to Blaenau Gwent. In the manager's view the council has made good steps forward and is in a position to continue to develop the transition work. A protocol has been agreed by all five Gwent local authority social services and education directorates, which sits alongside the Aneurin Bevan Health Board Continuing Health Care protocol. Other stakeholders such as Careers Wales are also well linked in. In each area there is a multi-agency Transitions Group. In Blaenau Gwent this group meets quarterly and is chaired by a Service Manager from Adult Services which ensures that there is an overview on progress and a forum for necessary problem solving. The project team report that the systems and triggers for transfers between children and adults are good and a lot of work has been undertaken on transition pathways. This is positive.

One of the challenges identified is around information held by the three key partners (Health, Social Services and Education) who each have their own transition list. This can result in confusion and duplication and the need for an

information protocol to address this has been recognised. Doing so will not only provide a more joined up approach but will free up resources that can be used more effectively elsewhere.

Pen y Cwm special school was the initial school to link with the pilot and its role is well established. The school takes the lead on developing a number of plans which are used as the basis for review meetings from year nine onwards. Reviews involve the young people themselves. The aim is now to roll this approach out to other schools and colleges in the area.

The responsibility for drawing up each child's transition plan in year nine lies with the school head teacher as part of the statement review process. Historically the transition process has often included a number of separate assessments and a lack of communication and co-ordination between the different agencies concerned. Education colleagues described the existing working relationship with social services as strong, particularly since the pilot project was introduced, and there is a willingness by all parties to move the transition agenda forward.

Plans are in place for the transition manager to undertake training with schools commencing with Special Educational Needs Co-ordinators (SENCOS) who are teachers affiliated to schools and are responsible for coordinating provision for children who have special educational needs. It is hoped to extend this training to Learning Support Assistants in the classroom who have the closest relationship with the child while in education. Information packs including a Guide for Parents and a Young Person's Guide have recently been drafted and will be available in a number of formats.

There is recognition in children's services that the ever changing needs of children and young people require continuous review of how services are delivered as well as developing new models of service. Barnardo's is a third sector partner who has historically provided a range of services to disabled children including support with

leisure, long term carer support and play schemes. Discussions took place between children's services and Barnardo's last year regarding reconfiguration of some services, particularly play schemes, into more targeted and cost effective support. Since April 2012 play schemes have been incorporated as part of universal services provided by the council's own Leisure services with additional ring fenced funding from the Families First programme. For a small number of children with particular complexities there will be a specialist service provided by Pen y Cwm school.

Managers at Barnardo's also recognised the need to reconfigure some services and to move towards more outcome focussed service delivery. Money saved from the play schemes has been re invested in services which deliver more outcome based learning. These changes aim to deliver more needs-led services for individual children and young people and their families. It is also a creative way of exploring different avenues to provide quality services within increasingly pressurised financial constraints.

### **The contribution of Assessment, Care Management and Review to effective support**

Staff involved in the transitions appeared to understand individual service users needs well and know the difficulties they were facing. They reported that transition was now much better than it had been previously and there was a clear process to follow. They welcomed the new forms which are more suited to young people. Transition plans are embedded on DRAIG, the social services electronic information system, and it is hoped that soon education colleagues will be able to input onto the same system in those cases where children are known to both services.

Social Services staff commented:

“There has been phenomenal progress over the last 2-3 years. The transition project has brought structure and clarity” Care Manager

“Transitions provide a more strategic perspective” Head of Service

The Children with Disability Team (CwDT) say they are confident they will be able to promote and further develop the work on transitions when the pilot finishes at the end of this year. They are now involved more in working directly with the young people so taking over the coordination of the transition process fits well with this. Based on the information and discussions we held with key case holders and families we could not differentiate between those young people who were part of the pilot and those who were not. Consequently we feel that the transition process is well embedded in teams, partnership arrangements are strong and in future young people in Blaenau Gwent will continue to be well served by the teams involved in their futures.

## **Adult Services**

People who get the right amount of support at the right time can overcome substantial difficulties and live independently at home in their own communities. The main theme for the inspection of adult services was the impact and effectiveness of the revised arrangements to procure domiciliary care for older adults and younger people with complex needs. We considered whether the changes have achieved social services' stated objectives and whether there was clear application of commissioning and procurement principles.

During the review, we asked three key questions:

- What has the outcome of change been for individuals and their family carers?
- How far has Blaenau Gwent already evaluated this?
- How effectively has strategic planning achieved the required changes to service provision arrangements?

These questions were designed to establish how domiciliary care was arranged before the changes, what needed to be different and how far the changes achieved the required objectives.

Recognising that service users and their families were directly affected by these changes and the importance of service users' experience, we gave significant weight to the views of service users receiving domiciliary care. This included people whose service provider changed or where direct payments have been made. Rather than engage in global consultation, social services made the decision to contact and inform only those people where change was anticipated, which avoided unnecessary worry for others who would not be affected by the proposed changes. We found this to be an effective way of avoiding alarm, particularly as the overall direction of change had been well publicised previously.

## **Context:**

### **Performance Information**

National Performance Indicators 2010/11

2759 Older People, aged 65 years and over were supported in the community (86% of people of that age supported)

451 older people were supported in residential/nursing care (14% of people of that age supported)

1368 people aged between 18 – 65 years were supported in the community (97% of people that age supported)

884 reviews of adults of all ages receiving a service completed on time (72%)

Blaenau Gwent has set the threshold at which people with eligible needs receive services at critical and substantial<sup>2</sup>. All local authorities decide where they set their thresholds so as to determine when people can receive services. This is part of a national eligibility framework which identifies 4 factors (autonomy, health and safety, managing daily routines and involvement) vital to maintaining individual independence.

The modernisation of services to older people has been a long-standing priority for the Council with their strategy “Living Independently in Blaenau Gwent in the 21<sup>st</sup> Century” published in October 2006 and reviewed regularly thereafter. It prioritised the needs of people aged 65 years upwards, recognising the need to shift the balance further towards people being effectively supported in their own homes in the community for as long as possible. Priority 2 of the strategy related to domiciliary care services, requiring that:

- the in-house home care service be concentrated on more complex and specialist provision
- Direct Payments should be more available
- brokerage arrangements should be introduced
- the independent sector domiciliary care provision should be refocused to include longer term maintenance support; block contracts; a wider range of providers to facilitate increased choice, flexibility and value for money.

Initially, attention was given to planning additional community based services including housing-based extra care developments as alternatives to residential care beds provided by the Council. This has now largely been achieved. From 2009 modernising domiciliary care became another development, starting with an Elected Members’ working group which considered the way forward. For any

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Substantial risks to independence include significant physical or mental health problems, significant loss of choice or control over the immediate environment, inability to carry out the majority of personal self care, domestic or other routines.

service user not receiving in-house home care service, domiciliary care had been purchased through spot contracts with nine agencies from a preferred provider list. Companies with spot contracts then worked wherever the service users lived in Blaenau Gwent. They each charged different hourly rates and service quality levels varied from agency to agency. Providers themselves recognised that there was a need to strengthen the contracting arrangements and improve consistency.

As part of the next stage of implementing the “Living Independently in Blaenau Gwent” strategy the Council took forward the proposals to review domiciliary care procurement and move to block contracts. They pursued a formal tendering process and awarded block contracts to three domiciliary care providers in June 2010. The process of transferring packages of care to the successful provider took place over a number of months with time taken to solve initial difficulties. In December 2010, the Director of Social Services reported to the Social Care and Inclusion Scrutiny Committee that all arrangements were in place.

### **Specific Findings**

#### The scale of change

580 service users had been receiving domiciliary care services; of whom 25% received the in-house service and 75% the independent sector service.

Around 313 (54%) service users were faced with change, while 124 (21%) already received care from the successful agency in their area. 27 (just over 4%) service users with very complex needs were also exempted from change, based on their requirement for continuity of care.

Overall, the strategic organisational objectives for awarding block contracts through tendering have been achieved:

- Block contracts were awarded to the companies who fulfilled the tendering requirements
- An effective Brokerage system is in place

- Systematic quality assurance is in place and working effectively
- Financial savings were made in 2010/11 although there has been a significant overspend at the end of 2011/12
- All service users affected were provided with a review of service and supported through the change

The development of the in-house home care service continues, with further plans to transfer additional complex packages of care to that service, while also developing its input to short term reablement through the Community Resource Team within the Gwent Frailty services.

### **Impact on existing Service Users**

We spoke directly to a sample of 18 people and their families; six in face to face interviews and 12 people over the telephone. (More were contacted but did not wish to be interviewed.) Their age ranges and ethnic origins reflected the priorities of the strategy and the demography of the area. Most were aged 65 years or older, including people well into their nineties.

More than 12 months have elapsed since the new arrangements were introduced for most people. The feedback given by service users and their families indicates that the changes to their service provider have been achieved more smoothly than they anticipated when first given information. This was particularly noticeable where individual domiciliary care staff were able to continue to work with individuals, even though their employer changed. Most people were supported through any difficulties that arose. Service users are now generally content with the service they are receiving and the way problems are resolved. Effective brokerage and contract monitoring has enabled concerns to be identified and raised with the providers at an early stage.

Whoever provides the care, service users said that they wanted to be supported by a small group of competent and skilled staff that they get to know well, who know

what needs to be done, with a caring friendly attitude. They prefer to specify the gender of the people who care for them where possible and dislike constantly changing staff.

A sample of comments and feedback

A daughter contacted said “My mother receives an excellent service with a consistent team of carers.”

Many individual care staff were praised for their caring approach and patience. One service user said “I am happy with what is being provided and couldn’t do without the help”

One carer acknowledged that her husband was only able to continue living at home with the care package in place, as she also had health problems.

Another elderly service user had a more mixed experience. When asked “Are your needs being met?” her family member said “now they are, previous experience of xx and xx (block contract providers) and their inconsistent delivery of services led (relative) to move to extra care housing”

For a small number of service users despite the efforts made to avoid problems, vital care arrangements did falter at the point of change where newly appointed block contract providers took on more work so needed more staff and better systems.

We also found some examples where social services could have been more flexible in the way they applied the changes. The council understood that the anticipation of change would raise considerable anxieties for many. Additional

staff were made available to assist in managing the process and social workers were asked to identify circumstances where change would be detrimental to an individual's well-being. The Project Board then considered each case. On the one hand this meant that they considered every circumstance on its merit, but on the other that it was hard to contest their decisions. This approach also potentially undermined social workers' judgements, and staff raised this with us. An exemptions policy with clear criteria would have provided a clear audit trail on how decisions were reached.

Our conclusions from reading case files and speaking to people were that while 27 exceptions were made, the Board could have operated more flexibly in a number of cases.

An example where more flexibility was needed

One very elderly lady wanted to stay with the carers she knew well. Her family made strong representation to senior managers asking that no change be made. This was rejected. She then asked for a direct payment so she could stay with her existing provider. This was agreed, but she was not allowed to stay with them while the direct payment was put in place. Because of a number of delays, this meant that for nearly four months she had an unnecessary change of carers. Once the direct payment was in place she changed back to the providers she preferred, and is now content.

Direct payments were the main way in which people were able to exercise choice. In all, eight additional service users and their families took up the offer of direct payments which allowed them to choose how and by whom they would be supported.

The Council routinely commissions independent advocacy for those over 50 years of age through Age Concern and information was provided to service users about independent advocacy. In the event no-one requested assistance from this

service. Representatives from Age Concern acknowledged that their advocacy services are better known to people in residential care homes, where advocates visit regularly.

Social services recognised the need to check the outcomes for individuals after the changes were consolidated. They have conducted at least one service review with all relevant service users and their families since changes were made. They continue to carry out Community Care questionnaire surveys. They also carried out their own telephone survey of 22 people which included questions about the information provided, and how well the arrangements for change worked. Some of their results were similar to our own and a similar range of initial concerns was raised by service users. At the end of the process 18 people (82%) were either satisfied or very satisfied with the service now received. Eleven (50%) people thought the transfer went well, while seven (32%) people thought that it could have been done better.

### **The contribution of Assessment, Care Management and Review to effective support**

The service users we contacted generally valued the involvement of social workers and support workers, although half did not know if they had an allocated social worker. Even where services users do not see a social worker regularly or had only seen them to review the services they received, most knew where help could be obtained. Uncertainty about who was providing social work support may have arisen because the extra temporary social work staff employed to support the changes undertook a large number of the reviews or re-assessments. Senior managers in adult services recognised the need to improve consistency and initiated a Systems Thinking review of care management processes, involving frontline staff. This ultimately established the Community Care Team. The new frameworks were established by September 2011, and are in part designed to support greater continuity of relationship between service users and the workers responding to their needs

In order to appreciate how decisions had been reached, we examined a sample of 16 case records setting out assessments, care plans and reviews for the period prior to change and after change. This examination showed some variation in the clarity of what was recorded about people's circumstances, wishes and aspirations. Improved processes had been introduced to the service users' information system as part of the Systems Review, with the small "pilot" team designing helpful new templates. Their development involved staff across assessment and care management services.

Where the new documents had been used successfully, it was much easier to see what had been decided and what had been achieved. However, they were used inconsistently, with individual workers bringing different levels of skill to applying the processes. Where done well, it was possible to see outcomes that followed on from assessments and care plans, with reviews that took account of the whole of the individual's circumstances. The new template for recording care plans has a very useful section which explicitly asks for details of risks and contingencies to meet possible complications. This is still being developed but once embedded should help social services to respond more effectively.

Our detailed analysis showed that most (86%) of the 16 assessments sampled had a clear focus on helping people to keep their independence, remain in their own homes and supported social inclusion. Much (86%) of the time the care plan was appropriately informed by the needs assessment and used the required objectives and outcomes to inform the planning of service delivery. We found evidence that the service users' feelings, wishes, aspirations and preferences were clearly documented in 64% of care plans.

We also found a minority of recording that did not reach these standards, with assessments that failed to convey key information. Discussion revealed that some workers knew more about the service users' circumstances but did not record

these fully within the assessment. In one case, information only came to light when another professional visited the home at the request of the family and learned significantly more about the individual's life.

There is a requirement for all adults receiving care services through social services to have their circumstances reviewed at least once every twelve months to make sure that the care is effective and promotes good outcomes. It is also a requirement to review arrangements before changes are made to services arranged. All service users whose files were examined or who were directly contacted were involved in a recent review of their circumstances through face to face contact with a social worker or support worker. Unless people had very complex needs, once the services had been put in place, many were designated "open/closed to review". (Both terms were used.) This is used as a way of managing workloads in the face of considerable increases in demand through rising referrals.

Service users were not always clear when a visit was a formal review, or just part of social work support and fine tuning to ensure that their care was effective. Similarly we found that in reviews for over 30 individuals, it was unclear for half of them whether this was intended to be the main formal review for the 12 month period, or a review of domiciliary care services alone. Effective formal reviews looked at the outcomes for all services received, for example day opportunities or respite care services alongside any changes in circumstances. For people who are closed to review, and only receive the minimum 12 monthly review, some exploration of wider circumstances of their life is essential. We talked to a service user who had received a service review which accurately recorded satisfaction with the domiciliary care service, but took no account of other difficult circumstances. As no active social work involvement had been triggered by the review, no help was being offered to assist with these wider concerns.

The positive findings are a credit to the thoughtful and thorough approach social workers and support workers bring to their work. However, the less positive findings suggest that more can be done in supervision to improve the quality and clarity of recording by some staff. It also speaks of frontline workers with busy caseloads and choices to make about where time is best spent. Senior practitioners are expected to set the standards for other frontline workers while also managing their own busy workloads, including adult protection work. Leading by example is a very powerful way of establishing good practice, but senior practitioners also need space to supervise and set standards for the staff in their respective areas.

Social services has already looked at how and when reviews are carried out. Senior managers have acknowledged our findings and are working to gain improvements. They also accepted that assessment and care management teams require further training to develop skills, improve the consistency of recording and focus on outcomes. This work must be a priority, if people are to receive the right help and outcomes are to be evaluated effectively.

Through their contact with individual service users, social workers and support workers have a valuable part to play in identifying unmet need to inform future commissioning plans. The assessment template asks for this information but it was not found on the files sampled even where examples of unmet need were highlighted in discussion. This means that information from existing service users cannot be drawn together to inform commissioning plans. This is an area for improvement.

### **Brokerage and Quality Assurance**

We received very positive feedback from service providers, social workers, and contract monitoring staff about brokerage. This system has improved the process of turning care plans into tasks, with required times for service delivery that the providers with block contracts are asked to apply for. It has improved the process

of allocating new or revised care packages through a consistent decision making process. It has freed care managers from a number of administrative functions thus releasing more capacity to work directly with service users and their families. There was agreement that the brokerage system enabled providers to be clear what they are taking on and contract monitoring staff to be clear when tasks are achieved effectively. However, there can be tension in balancing the brokerage-led focus on the tasks required, while supporting care plans with outcome based approaches which ask for flexibility.

The new contracts have required the providers to implement electronic call monitoring, linking it to the more formalised contract monitoring process. It allows missed calls to be highlighted quickly allowing providers to make contingency arrangements.

Information from Adult Protection processes has been linked more closely with contract monitoring to ensure that it is shared appropriately. However, outcomes from reviews are not routinely shared with contract monitoring staff. This aspect could be considered alongside of the work in progress already referred to. More can be done to routinely capture feedback from service users and social work staff about the quality of services and the outcomes achieved. At the moment complaints are more often raised while compliments or improved outcomes may not be.

### **Continued Engagement with Service Providers**

We met with domiciliary care providers awarded block contracts. We also sent a survey to all agencies on the Approved Provider list which included agencies that had formerly held spot contracts. Only one response was received. This may indicate that the agencies that did not gain block contracts have now disengaged from the Council. This is an aspect of managing the future market that social services needs to keep under consideration.

The quarterly Domiciliary Care Forum was set up as a result of the new block contract arrangements and is chaired by Social Services. Members include representatives of the three agencies fulfilling the block contracts and the in-house Home Care Service (known as the Tier 1 providers). The social care workforce development partnership has been in place for some time before the tendering process and has a wider membership. Both groups are encouraged to work together in partnership to share information, look at practice development and to establish an outcome focus to their work with individuals.

The three companies who provide the block contracts told us that the transfer of staff from one company to another happened less than anticipated. A few other providers did not co-operate with Transfer of Undertaking (Protection of Employment) (TUPE)<sup>3</sup> employment rights. This had an impact on some service users and their carers, This has been reported in similar inspections in other authorities where new contracts have been awarded.

The group also highlighted the challenges to offering quality services and meeting individual needs. There is concern that flexibility may be lost through an over-reliance on the electronic call monitoring system. Examples were given of the difficulties in responding to services users' wishes day by day, while at the same time delivering the expected tasks on time, within the time allocated. They were concerned that the proposed move to minute by minute billing would make this worse. Social services is keen that it is implemented, not least because of the benefits to service users from more accurate charging.

There will continue to be decisions where the commissioners' and service providers' interests may not coincide. There is no service user reference group in place, although such a group could usefully inform decision making. Social

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<sup>3</sup> The purpose of TUPE is to protect employees if the business in which they are employed changes hands. Its effect is to move employees and any liabilities associated with them from the old employer to the new employer by operation of law.

services may wish to consider this option, when seeking to develop service user engagement.

### **Service Modernisation and Commissioning**

Social services is effectively modernising services to older people through implementing the key strategic plan which has recently been fine tuned. This has been achieved through well developed partnership working. Managers now ready to embark on phase 2 of modernising in-house domiciliary care. Taking forward the modernisation agenda has involved considerable effort from staff and managers at all levels. This has been achieved through effective project management and attention to detail.

Social services has prioritised commissioning and the commissioning team has been central to achieving the procurement of block contracts through an effective tendering process. Senior managers have reflected on the progress made so far and accept the need to further develop service user engagement to inform service changes.

Nevertheless, we found a few examples where the focus on achieving complex tasks has taken precedence over maintaining a person centred approach to service users. This will need to be taken into account when planning future change.

### **Overall Conclusions**

The two themes selected for this inspection illustrate the effort that managers and staff put into achieving better outcomes for people and their families, whether they work in children's or adult services. The transition work demonstrates that both services can work effectively together. These person centred principles could be used more widely across the whole directorate to support good practice and integrated working wherever it is required.

The inspection has also highlighted areas where workers in adult services are hard pressed with little spare capacity to meet rising demand. This makes delivering better outcomes increasingly challenging, no matter how committed managers and staff are.

Blaenau Gwent has been active in seeking change and has come a long way in modernising services. The council is not complacent and recognises there are still a number of areas to develop. It is keen to support citizens' independence but also recognises the constraints small social services directorates face.

Social services is now ready to move to the next phase which involves integration with Caerphilly. It will be important to ensure that strengths are maintained while it makes progress with identified areas for development.

## **Appendix 1 Methodology**

### **Children's Services**

The framework, inspection programme and tools used by CSSIW for this bespoke inspection were developed following discussions with the Head of Children's services and CSSIW colleagues involved in the inspection.

#### **Who we contacted**

- Face to face interviews with six families who had experienced transition
- Interviews with social workers responsible for those files examined in depth
- Meetings with a range of key staff and managers at all levels in the Council including service manager, team managers, senior practitioners, social workers and social care assistants
- Meeting with Transition Project Manager
- Meeting with Third Sector provider
- The Director of Social Services
- Head of Children's Services
- The elected member sitting in the Cabinet with the portfolio for Children's Services
- Education services

#### **Supporting evidence and background information included:**

Policies, procedures, structures and plans relating to Children's services

Relevant information, protocol, meeting notes relating to Transition Services

Relevant Minutes and notes relating to senior management meetings, service and team manager meetings

Performance information on Children's services and third sector provision

## **Adult Services**

The framework, inspection programme and tools developed by CSSIW for their national inspections on commissioning were used in the examination of Adult Services. We used surveys with service users and their families and domiciliary care providers. The case file analysis tool was used on 16 case files, applying consistent standards to each file. A structured programme of interviews was carried out putting service users and their carers at the centre.

### **Who we contacted**

Six service users and their family representatives face to face

12 services users or their family representative on the telephone

A range of key staff and managers at all levels in the Council including social workers and support workers

Team managers, service managers, commissioning specialists

The Director of Social Services

Head of Adult Services

The elected member sitting in the Cabinet with the portfolio for Adult Services

Managers of domiciliary care services

### **Supporting evidence and background information included:**

An overview report from Adult Services, detailing context, progress and achievements

Progress briefings:

Briefings to staff

Director's briefings to elected members

Samples of information and correspondence sent to individual service users

Information on:

Pre-tender and tendering process

Implementation of contract

Contract Monitoring and Brokerage

Relevant minutes of domiciliary care tender meetings