Review and Options Appraisal

Day Time Activities for Older People including Day Centres

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1 INTRODUCTION AND BACKGROUND

1.1 In November 2014 a Project Plan was approved via the Integrated Care Pathway for Older People (ICPOP) to *'disinvestment from the direct delivery of Older People Day Centres and work in partnership with the third sector and Community Councils to find alternative delivery mechanisms.'*

1.2 The primary aim was to find 3rd sector providers to take over existing Powys County Council Day Centres, i.e. to transfer an 'as is' service to another provider with a view to reducing delivery costs.

1.3 The methodology was as follows:-

1. Work with stakeholders in the [relevant] communities, local County Councillors, and Town and Community Councils and the third sector to identify alternative service delivery arrangements for these day centres.
2. Assist these stakeholders to understand the options available and develop a detailed and costed business plan for the delivery of cost effective day services in these communities which include new models of business.
3. Facilitate co-operation and where possible co-production between the day centres to explore in the establishment overarching service delivery solution (e.g. group structures etc.)
4. Identify external funding opportunities to support the delivery of this project and the sustainability of the day centre provision.

1.4 In the 2014 Medium Term Financial Plan, which was approved by Council on March 5th 2014, it was proposed to reconfigure Day Time Opportunities for Older People. The proposal was to spread the savings over a three year period:-

2014-15 - £250,000
2015-16 - £300,000
2016-17 - £450,000
2017-18 - £490,000[1]

1.5 The approved proposal stated that there would be a disinvestment from PCC directly delivering Day Centres for Older People, whilst retaining £500k for re-investment in a different form of service. For example consideration was given to seek out community groups / voluntary organisations who might wish to run their local centres but it was emphasised that '*it would have to be at lower cost than PCC direct delivery, and engage volunteers to assist in service delivery*'. Within this option Community Asset transfer to community groups was possible and was part of the Council's overall approach to Community Delivery.

1.6 In addition it was proposed that customers with eligible needs (critical and substantial) would receive a direct payment to enable them to purchase a place at the community run provision should they wish and that disinvestment would be done on a rolling programme:-

- In 14/15, in order to save £250k, PCC planned to disinvest in the direct management of 3 day centres.
- In 15/16 PCC would need to disinvest in a further 2 day centres
- In 2016/17 PCC would need to disinvest in the final 2 day centres.

The PCC Day Centres were named as:-

- Ystradgynlais
- Brecon (Arosfa)
- Crickhowell

[1] This figure of £490,000 was added to the savings profile at a later date as part of the rolling programme of savings identified in the Medium Term Financial Plan.

- Llandrindod (Arlais)
- Llanidloes (Maes y Wennol)
- Newtown (Park)
- Welshpool (Westwood)

1.7 During the eighteen months following approval of the budget savings officers worked with community organisations, volunteer organisations, PAVO, Social Firms Wales, Royal Voluntary Service and Town and Community Councils to explore options for delivery in each of the current areas. The work focused on Welshpool, Newtown and Crickhowell.

1.8 In Newtown a community steering group was formed to develop a business plan and explore the viability of running the centre as a social enterprise. Considerable work was undertaken by an enthusiastic group of community members, supported by PAVO and Social Firms Wales, however the only proposal formerly received was from Abercare, which when assessed, was not a 'like for like service', or sustainable in the longer term without further significant financial investment.

1.9 In Welshpool, Members, stakeholders and Officers worked together to design a model suitable for the needs of the community. Following a report to Cabinet on 25th March 2015 the operation of the Day Centre (along with the building) was transferred to the Town Council on 1st July 2015, supported by a start-up grant of £25k and revenue funding for delivery and transport. This was also explained in an updated Cabinet Report on 10th November 2015. Although the longer term savings were not as sizeable as originally anticipated it was down to the ability of the Town Council to take a strong leadership role together with their existing incorporated status that meant the transfer could take place relatively swiftly. However, due to a changing financial position the funding arrangements could not and cannot be replicated for other areas of the county.

1.10 In respect of Crickhowell, Officers worked with the Volunteer Bureau to explore options and although discussions looked promising no formal arrangements could be agreed.

1.11 Officers then worked with Royal Voluntary Service (RVS) for a period of six months to actively explore the organisation's ability to run the day centres. Again, initial discussions proved promising, however following a national restructure at RVS, the organisation indicated that it was not in a position to pursue these developments any further.

1.12 The process of seeking alternative operators for the day centres was time consuming and made more difficult due to staff changes within the service and a lack of dedicated project support. Despite hard work from councillors and officers, it was not possible to reach a successful long term conclusion for the remodelling of the service.

1.13 As part of the ongoing developmental process a complimentary model did emerge for Crickhowell[2] and it was agreed to pilot (using Intermediate Care Funding – ICF) a new way of working with the Befriending Service.

1.14 In November 2015 a Cabinet Report proposed a revised approach to the Review of Day Time Activities. The proposal suggested a number of options should be explored as part of the revised process, these being:-

a. Develop an alternative service, which may be provided by other organisations, to take the place of the existing day-centre service. This might include a befriending service to help individuals access activities at a time that is convenient to them, and will support a greater number of older people to access what is happening in their community.
b. Allocate financial support by way of direct payments for clients to buy the type of service, and at the times, that they need.
c. Seek alternative organisations to run day centres.

[2] Further information can be found in the Evaluation of the Crickhowell Pilot in Appendix 4

d. Change the way we run the day centre service, for example by offering different services, opening times or locations.
e. Maintain the day centre service the way we do now *(NB the consultation material will state this is less likely to be a realistic option)*

1.15 The report also recommended the need to consult on a more formal basis.

1.16 In addition the report highlighted that further budget changes meant that the allocation to day time activities was further reduced changing the total savings to £940,000 leaving a total of £304k operational budget to re-invest. However commitments made to Welshpool Town Council (for a 7 year period) results in the total left for re-investment being £157k.

1.17 In order to ensure a comprehensive assessment of all day time activities for the elderly, and give full consideration to issues of parity of provision, it was proposed that the grant aided and contracted areas would be brought within the scope of the review and consultation. As Welshpool Town Council contract had only just been approved, and an appropriate period needed to elapse before this arrangement could be reviewed, it was recommended that the Welshpool service did not form part of the consultation.

1.18 Due to the growing complexity and the sensitive nature of this review (shortening timescales in which projected savings had to be made, the needs of the client group and the status that these facilities have in the community), Powys County Council commissioned the Consultation Institute[3] to advise officers and the Cabinet Lead on how to progress to ensure that the process was fair, met with best practice and minimised the opportunities for future legal challenge.

1.19 The advice included the importance of the pre-consultation process and enabling key stakeholders including users of the service to have their voice heard before the options design stage, giving them the opportunity to share their concerns, ideas and views in shaping the future. The timetable outlined in the November 2015 Cabinet report would not allow sufficient time to complete the pre-consultation and then the formal consultation, and due to the lack of capacity and resource to support such a process, it was agreed that three substantive project areas would have a combined pre-consultation approach, these were:-

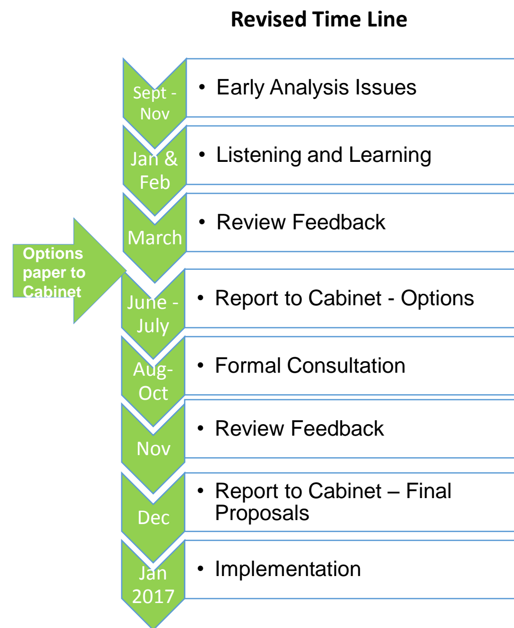
- Day Time Activities
- Residential Care
- Fair and Affordable Funding

1.20 The timetable was therefore revised as illustrated below and whilst the timescales have slipped slightly due to more work on a possible future model, and in line with advice from the Consultation Institute, it will not make a significant difference to the outcome.

[3] The Consultation Institute is nationally recognised not for profit organisation who supports and advises those carrying out public or stakeholder consultation to ensure they meet best practice to improve value to decision-making process.

1.21

Revised Time Line



1.22 This paper outlines the conclusions and the methodology for making choices

2 VISION AND OUTCOMES

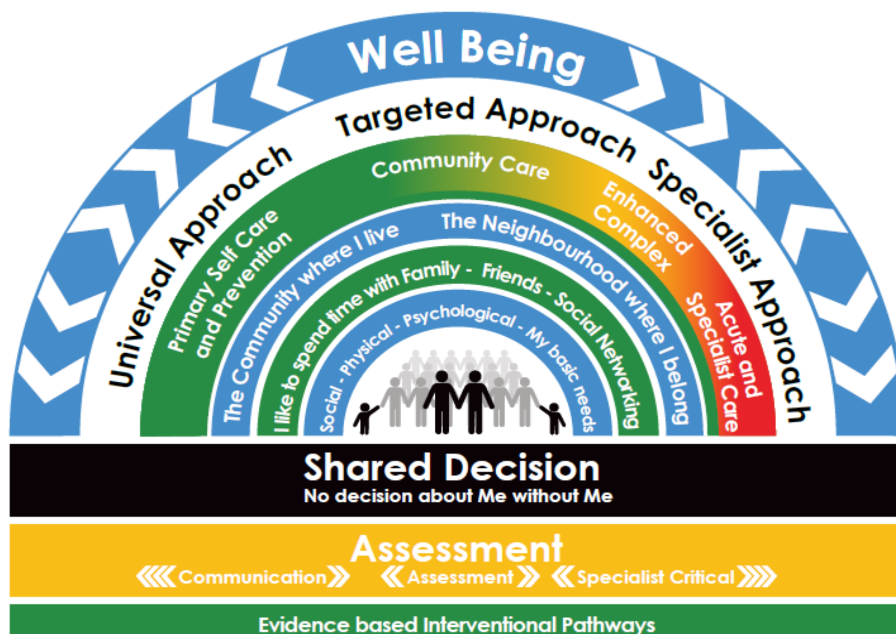
2.1 Our Vision outlined in the Joint Commissioning Strategy for Older People states that we will work together with our public, patients, people who use our services and their families to make sure older people in Powys:

- Have the opportunity to take part in social activities and be included in the community, to maintain their well-being;
- Feel safe in their own homes and keep their independence for as long as possible by using home-based services;
- Are given relevant information, so that they have an increased choice and control over what matters to them;
- Have greater access to health and social care which is close to home and can meet their needs;
- Can quickly access appropriate hospital and specialist health care when needed and are discharged home safely once they are fit enough;
- Experience a good quality of life; and are safe from abuse and neglect.

2.2 **<u>The Care Continuum</u>**

2.3 In addition Adult Social Care and Health have adopted the 'Continuum of Need' which outlines the overarching approach within which all services will be delivered to ensure we achieve our vision.

2.4 The framework will empower people to maintain and improve their own health and wellbeing, and build active and supportive networks among people within communities. It will also enable individuals, families and communities to meet a range of challenges which they may experience in their lives, leaving specialist social care services to concentrate on those with higher level support needs. This is illustrated in the diagram below.



2.5 At a local level, services will be developed through the integration agenda to achieve a seamless and coordinated system for older people. The new service model will promote independence through active management of risk and has three core elements:

a) Universal approach: Primary self-care and prevention. Services will be focused on developing and maintaining individuals' independence through supporting the development of a strong community network and services at home.

b) Targeted approach: Community care and enhanced complex care. More care will be provided through community services. This will enable more people to be cared for and treated at home and will reduce unnecessary admissions to secondary care and facilitate timely discharge from services outside of Powys.

c) Specialist approach: Acute and specialist care. Specialist care will continue to be available for people with complex. Where it is not appropriate to provide these services locally within the home or community they will mainly be delivered in an acute hospital, residential/nursing home or hospice setting.

2.6 Through this review process we will therefore be looking to re-align and pool resources to providing an integrated and co-ordinated community based wellbeing and support service that takes a whole system approach to meeting people's needs within a universal and preventative service framework.

2.7 Early Intervention and Prevention – A Strategic Intent

2.8 The current model of service provision is not sustainable (both in terms of expectation or financially), and in most cases, it promotes dependence and requires the client to fit in with what we can offer rather than address 'what matters' to them at the right time, in the right place and in a way they would prefer.

2.9 Supporting individuals to maintain their independence and preventing acute needs developing, where possible, is of benefit to all. In addition, if we can address system or failure demand by swift intervention, capacity and resilience can be extended both for the service user in terms of the reduced negative impact of anxiety and the notion of giving in and up, and the provider in terms reducing repeat calls, the danger of growing complications, and the likely result of dependence.

2.10 Thus people retain their independence for longer and receive the kind of care and assistance they actually want ('what matters') at a time they want it. The two key aspects of prevention and early intervention are seen as: -

- Services which prevent/ delay/ reduce the need for more costly intensive support services
- Approaches which promote quality engagement with the community to promote community cohesion through effective support help and assistance.

2.11 As outlined in the Care Continuum above we want to shift the emphasis, as far as is practicably possible to the universal approach, primary and self-care and the prevention end of the continuum. The purpose of this approach will be to help people live as independently as possible by

- providing people to be or extend their independence or support to enable them to live in their own homes, hostels, sheltered housing or other specialist housing
- preventing problems in the first place or providing help as early as possible in order to reduce demand on other services such as health and social services
- providing help to complement the personal or medical care that some people may need

- providing opportunities for social, leisure and cultural activities and or helping people take an active and valued role in their own community including learning, education and employment.

2.12 The Review of Day Time Activities cannot be seen in isolation of a longer term strategy to change our model of delivery. Whilst it is clear that the current services, particularly 'Day Centres, are valued by current users, the provision is not equitable across the county and addresses the needs of a relatively small number of the target population. Nor does it promote independence, and is limited in the way it supports self-directed and personalised opportunities. It is also expensive and has insufficient budget to keep existing services going let alone grow to meet rising numbers of older people.

2.13 Powys has been developing early intervention services for some time and we need to further develop our approach to service delivery and will look to progress an Early Intervention Project to establish a new integrated and co-ordinated community based wellbeing and support service that takes a whole system approach to meeting people's (all age) needs within a universal and preventative service framework. It will need to be designed to meet Part 2 of the Social Services and Wellbeing Act and in particular the elements around:-

- Information, advice and assistance
- Prevention
- Social enterprise and working with the third sector.

2.14 By 2020 we will need to ensure that we have achieved the following:-

- A shared understanding and definition of early intervention and prevention with the public of Powys.
- A single strategic approach to building community capacity (community development)
- A well trained, multi-agency/disciplinary workforce (paid and unpaid0
- Early Identification and assessment of need – 'everybody's business'
- Clear and useable systems and processes which help us map and track people through the system including a step up or down from statutory services
- Locality management and co-ordination that holds the baton on delivery and services needed.
- A graduated response to meeting needs and a clear care pathway that everyone is clear about
- Evidence based approaches to meeting generic and additional needs (with in a universal targeted framework)
- No wrong door for people to gain access and support
- Strong resilient communities who care and support their own
- The building of personal capacity is approached as the norm
- Resources are available close to the front line to enable a quick and flexible response.

2.15 More detail about our Strategic Intent can be found in **Appendix 1** and a more specific description of the type of service that needs to be developed can be found in Section 7 of this report.

3 STRATEGIC CONTEXT AND RATIONALE

3.1 Notwithstanding our vision and outcomes, the financial pressures, and the demographics there are some other key drivers for change. These include:-

- The Social Services and Wellbeing Act
- One Powys Plan
- The Councils 2020 Plan
- The current planned direction of travel for Adult Social Care in line with the Joint Commissioning Strategy for Older people
- The Strategic Needs Assessment
- Emerging research and good practice around prevention and community focused services.

3.2 The consistent theme and golden thread through out is a move towards a preventative model of service delivery. This is borne out by research and changing practice nationally, particularly in a response to austerity measures.

3.3 Social Service and Wellbeing Act

3.4 The new Social Services and Wellbeing (Wales) Act introduces major reforms to the legal framework for Health and Social Care, to the funding system and to the duties of local authorities and key partners such as Health. The Act introduces the concept of wellbeing and enhances the rights of those in need of social care and gives additional rights to carers to access support too. There is no clear definition of early intervention and prevention within the Act although it is seen as underpinning the Wellbeing components of the Act.

> ”Promoting people’s well-being **must** include a focus on delaying and preventing the need for care and support to stop people’s needs from escalating….”

3.5 The Act also states Preventative services can be:

a) universally provided to help people avoid developing needs for care and support;
b) targeted at individuals who have an increased risk of developing care and support needs; and
c) aimed at minimising the effect of an existing care and support need on a service user.

3.6 Within the new legislation users must be fully engaged in identifying what preventative measures could assist them to achieve their well-being and in planning their delivery. These can be from within their own and their communities’ resources. The requirements of the Act around Information, Advice and Assistance Service will play a key role in this engagement process.

3.7 Wellbeing has been defined in the Act as having the following component.

- Securing rights and entitlements and Control over day to-day life
- Physical and mental health and emotional well-being
- Protection from abuse and neglect
- Education, training and recreation
- Domestic family and personal relationships
- Contributions made to society
- Economic and social wellbeing and participation in Work
- Suitability of living accommodation

3.8 We as an Authority, together with our partners, therefore not only have a moral and fiscal obligation but a legal obligation to change our modes operandi to a preventative approach.

3.9 One Powys Plan

3.10 The One Powys Plan provides the strategic context within which all partnership work takes place. The priorities for improvement laid down in the One Powys Plan 2014-17 are:

- Integrated health and adult social care.
- Children and young people.
- Transforming learning and skills.
- Stronger, safer and economically viable communities.
- Financially balanced and fit for purpose public services.

3.11 The work outlined here emanates from the Integrated health and adult social care priority and supports the outcome commitment of:-

- Older people will be supported to lead fulfilled lives within their communities

3.12 The One Powys Plan also made a commitment to early intervention and prevention by stating:-

- *We will address issues through prevention and early intervention rather than reaction.*
- *The aim is to address problems at the earliest opportunity before they escalate.*

3.13 Council 2020 Plan

3.14 Powys County Council has set out it's strategic vision in a document called Powys 2020. It states that:-
""Strong communities in the green heart of Wales" is our vision and sets the ambition for 2020. Our vision will guide us in our response to the challenges and opportunities ahead."

3.15 The Councils priorities are:

- Services delivered for less - remodelling council services to respond to reduced funding
- Supporting people in the community to live fulfilled lives
- Developing the economy
- Learning - improving learner outcomes for all, minimising disadvantage

3.16 The key theme is the changes in the way public services will be delivered and the responsibility communities will need to take in not just shaping but supporting and managing the delivery of services.

3.17 This will require a cultural shift both for the council and for our communities, town councils and other community groups and organisations will have to step in where the council can no longer afford or needs to operate. This will be particularly important at the universal and preventative end of service delivery, leaving the council to focus its efforts on the higher, specialist and statutory end of need.

3.18 This step change is seen as one of the biggest challenges the Council and Powys communities will have to make. Difficult and painful decisions will need to be made in order *'to help communities make the transition to this new world of public service where personal responsibility plays a big part. Our role will be to support people to take an active part in their communities.'*

3.19 Any new models of delivery will need to address this growing theme and ensure that there is a facilitative and supportive component to draw in and engage the community to build capacity and ensure it meet its own needs, particularly that of the elderly and those who with a little additional support will be able to lead independent and fulfilled lives.

3.20 All these changes are set to a back drop of substantial efficiency savings for the whole Council and a budget reduction in real terms for Adult Social Care.

3.21 In 2014 the Cabinet adopted a set of Budget Principles which provide a greater link between the Council's Vision, the strategic plan (One Powys Plan) and the use of resource. The budget principles are key in order to deliver our priorities and achieve our efficiency targets by shaping our decisions to allocate resources. The budget principles are as follows:

- Valued Services- in future services must support the Council's outcomes. Those that don't will have to be provided by others
- Supporting the Vulnerable - Scarce resources mean we must focus on the truly vulnerable not those who have historically received support and services
- Local Delivery – Services delivered within communities by communities are more responsive and efficient
- Personal Responsibility – Nationally we must move from the entitlement culture; our population and our employees will be encouraged to take more control of their lives and take on greater responsibility
- Value for Money – the council must look for value for money in everything it does
- Improving Productivity – once the preserve of private enterprise productivity and performance now matters in the public sector.

These principles underpin and shape the Councils budget, ensuring that it will deliver the Powys 2020 vision.

3.22 Direction of Travel for Adult Social

3.23 The blue print for the future of Adult Social Care builds on the 'continuum of need', focusing on more early intervention and prevention supported by investment in workforce, culture and skills. This is echoed in the vision and strategic objectives agreed by all stakeholders including Health and the 3rd sector in the Joint Commissioning Strategy for Older People which is looking to help manage increasing demand by aiming to deliver services in a more creative way in the future.

3.24 The service has already made a start on developing and delivering services that focus on early intervention and prevention. For example the following have been commissioned to align with the future model including:-

- Powys People Direct
- Reablement
- Carers
- Substance misuse
- Domestic Abuse
- Other Children and Young People's Partnership work
- Supporting People (Housing)

3.25 Further work needs to be done to consolidate practice, align other areas of work and provide better community based co-ordination and to help communities build and release their capacity to support their own, thus helping to reduce down demand on higher cost more intense services.

3.26 Strategic Needs Assessment

3.27 As part of the process of assessing current and future need a comprehensive needs assessment has been completed (Please see Appendices 2 and 8). The aim of the needs assessment is to inform and guide the commissioning arrangements and underpin the strategy for moving forward

and in particular accurately assess the needs of the local population in order to plan for the improvement of the wellbeing outcomes. It must be emphasised that it cannot be seen in isolation of all other contributing factors, such as the legislative framework and the financial pressures outlined above.

3.28 Current Models of Provision and Cost Profile

3.29 Powys County Council currently run 6 Day Centres as in house provision as follows:-

Provision	Cost	Number of Register (31.03.16)	Unit Cost
Arosfa – Brecon	£197,290	53	£3772
Canolfan - Ystradgynlais	£171,520	41	£4183
Maesyffynon - Crickhowell	£122,240	29	£4215
Maesywennol – Llanidloes	£180,990	68	£2661
Park – Newtown	£237,690	71	£3347
Arlais –Llandrindod	£175,960	44	£3999
Average Unit Costs	£1,085,690.00	**306**	**£3548**

3.30 In addition, a number of 3rd sector and one Town Council are funded to provide a variety of types of Day Time Activities including two Day Centre (East Radnor and Westwood) as follows:-

Provision	Cost	Number of Register (31.03.16)	Unit Cost
Welshpool[4]	£146,640	46	£3187
East Radnor - Presteigne	£122,480	37	£3310
Tanat Valley[5]	£11,900	7	£1700
Machynlleth	£75,000	24	£3125
Bethshan[6] – Newtown	£55,680	10	£5568
	£411,700.00	124	£3320

3.31 Overall the total cost for all current provision is **£1,497,390** providing a total of 430 places at an average unit cost of £3482.

3.32 Nine of the providers are available Monday to Friday for clients from approximately 9.30am to 4.00pm. Tenat Valley operate one day a week (Wednesday). Bethshan provides a service for 2 days a week for clients with dementia only.

3.33 All clients pay for their own lunches and these will be provided in a number of ways, some Day Centres bring in meals whilst others provide the meals from their own kitchens – the full salary cost of providing this service is £79,320 (as of Feb 2016) additionally there will be overhead and utility costs on top but because they are so integrated in the Centres overheads it would be difficult to separate them out.

3.34 Transport costs are included in the above overall costs, but separated out costs for the elements managed by Powys County Council are as follows:-

[4] Welshpool is core funded for 15 places @ a total cost of £115k (including transport) – the unit cost for these places is £7666 the additional places (31) identified above are spot purchased at a cost of approximately £1021. Efforts are being made to reduce the number of spot purchased places.

[5] Tanat Valley did up until recently have 12 attendees which would make their unit cost £991

[6] Bethshan provide day care / respite for people with dementia only.

Centre	Transport Cost
AROSFA DAY CENTRE, BRECON	£44,940.00
CANOLFAN DAY CENTRE, YSTRAD	£10,730.00
MAESYFYNNON DAY CENTRE, CRICK.	£25,820.00
MAES-Y-WENNOL DAY CENTRE,LLANY	£35,290.00
THE PARK DAY CENTRE, NEWTOWN	£51,140.00
ARLAIS DAY CENTRE, LLANDRINDOD	£30,520.00
WESTWOOD DAY CENTRE, WELSHPOOL[7]	£46,300.00[8]
Total	£244,740.00

3.35 PCC owned (or leased) Day Centres tend to be in Mid or South Powys, whilst externally provided sites dominate in the North of the county. Three localities have no Day Centre Provision (Builth and Llanwrtyd, Hay and Talgarth and Llanfair Caereinion). These areas tended to score highly for percentage of residents that participate in local community events and activities however there is a variation in how well localities score in terms of data from the residents survey, for example:-

- On average 28% of residents feel satisfied with the care for older people / the elderly
- The highest score in relation to this view was Llanidloes at 34% and the lowest was Llanfair Caereinion at 17% probably due to the fact that there is no Day Centre or other commissioned day time activity services in that area.

3.36 In terms of the Council provision there are a variety of ownership and lease arrangements which in some cases may lead to additional costs being incurred. Arrangements are as follows:

Building	**Ownership / lease Arrangements**	**Possible Additional Costs if Vacated**
Arosfa – Brecon	Freehold – Council Ownership	-
Canolfan - Ystradgynlais	Freehold – Council Ownership	
Maesyffynon - Crickhowell	Freehold – Council Ownership however leased to Wales and West for Sheltered Housing, with a part lease back to the Council to provide accommodation for the Day Centre provision.	Wales and West have indicated that the cost of the accommodation that the Day Centre occupies if vacated will transfer to the residents at an additional £10 per apartment per week.
Maesywennol - Llanidloes	Freehold – Council Ownership however leased to Care First Partnerships Limited and Bupa Finance for the provision of Residential Care, with a part lease back to the Council to provide accommodation for the Day Centre provision.	Discussions are ongoing.
Park – Newtown	Freehold – Council Ownership	-
Arlais –Llandridnod	Freehold – Council Ownership with some covenants	-

3.37 East Radnor lease a Council owned building for a peppercorn rent and Westwood was transferred as a freehold asset to Welshpool Town Council ownership with a covenant stating the building should be for community usage.

[7] Westwood receive a separate allocation in their grant to cover the cost of transport.

[8] The Transport agreement is for a total of £40,300 the additional £6,000 is associated with spot purchased places.

3.38 User Profile

3.39 There is an in depth statistical needs assessment that can be found in Appendices 2 and 8 of which some high level data and observations have been drawn out here. The data has been extracted from a variety of sources and reconciled where anomalies have been identified.

3.40 Work is required on ensuring that the information available is as up to date as possible and this is planned for via the new Community Care Information System (CCIS) which will be introduced in Powys at the end of this calendar year.

3.41 95% of users are aged 65 or over; 41% of all clients are aged between 65 and 85 and 54% are over 85. Those over 85 using a Day Centre represent **3.5%** of the over 85 population of Powys. Generally the user profile is similar across both PCC and the commissioned services. The average age of users is 83 years old however we are aware that there are about 5% of users who are younger disabled people (under 65) across the authority who make use of PCC Day Centre provision. This is because they no longer want or feel able to attend the Day Centre provision for Learning Disabled and no other alternatives have been found. One person in this category attended the Listen and Learn session and clearly enjoyed their time at the Centre – whilst the majority of the other clients were much older they were in the company of the staff who were closer in age and it was this fact that made the experience enjoyable for them.

3.42 Two thirds (64%) of clients use Day Centre provided transport whilst 21% of clients use their own transport (which is likely to be family or carer rather than self drive) and 15% use transport provided by the Voluntary Sector and is also likely to be paid for by the service for the majority of users.

3.43 Clients attending Day Centres visit an average of 6 times every 4 weeks. The highest frequency of visits is 20 per month. We also know that from some bespoke analysis that potentially up to 50 clients are attending for respite purposes which indicates that attending the Centre supports the needs of Carers too. This is also reflects the views of Carers we spoke to as part of the Listen and Learn pre consultation process see Section 3.59 for more details.

3.44 A good percentage of clients have a high level of dependency and will have assessed needs that will need to be met irrespective of whether the Day Centres or other day time activities exist or not for example:-

- On average 54% of Clients have mobility issues – for PCC centres, this varies from the highest for Canolfan clients (63%) to the lowest for Park (11%)
- 15.5% of Clients are Wheelchair users (for PCC centres, this varies from the highest in Canolfan and Park (both 15%) to the lowest for Arosfa clients (9%)
- Just over half (53.5%) of Clients live alone (for PCC centres this varies from the highest proportion for Maesyffynon clients (72%) to the lowest for Maesywennol clients (9%)
- Up to 28.6% of clients have memory loss or diagnosed dementia.[9]

3.45 Population Profile

3.46 Powys covers a quarter of Wales and is the most sparsely populated county in England and Wales. It has a Population 132,952. Overall, the population has decreased by 119 since 2011 (0.01%). A large proportion (58.7%) live in villages, hamlets and isolated dwellings (Wales, 17.1%) Due to the lack of transport options in our rural communities, most households own at least one car.

3.47 It is estimated that there were 58,345 households in Powys in the 2011 census, this is an increase of 8.3% since 2001 (Wales, 7.4%). The average household size has reduced, it fell from 2.32

[9] These figures have been provided by the services themselves and will be verified in more detail as part of the re-assessment of every client as part of the formal consultation process.

people per household in 2001 to 2.25 in 2011. This can be attributed to longer life expectancy and more elderly people living alone.

3.48 The proportion of the 60 and over age groups is increasing, which has particular relevance to the provision of older people services, as demand for these services will increase year on year. At the same time, the 30-39 age group and those aged between 0-14 years has reduced over the past decade. As the ratio between retired and the working-age groups increases, there is an increased pressure on the economically active part of the population to maintain the welfare of the economically dependent.

3.49 The over 65 plus population of Powys is projected to increase by 14.3% over the next 5 (from 33,592 to 38,405) years and by 47% by 2036 (to 49,515). Within this, the number of people over 85 is expected to rise by 25% in five years and by 158% by 2036. Localities with the highest proportion of over 65% in the populations are Crickhowell, Llandrindod and Knighton & Presteigne a further indication that we have to find a way of supporting more people with less money or alternatively making a charge for certain levels f service.

3.50 In Powys there are 6,500 residents employed in the Caring/Leisure/Service sector[*3]. This represents 10% of the working population of Powys. This figure is highest in Ystradgynlais (13%) and lowest in Crickhowell (9%).

3.51 However, over recent years, the net flow of individuals into and out of Powys has fluctuated. The outflow of individuals was slightly higher than inflow in 2013 (Mid-Year 2012 to Mid-Year 2013) with a net flow of 80 out of the county. However, for some groups the outflow was pronounced. For example there was a net outflow of 570 15-19 year olds, 80 25-29 year olds and 30 30-34 year olds. This will have a major impact on the numbers of working age people available in the care industry and or family carers available to support their own family members.

3.52 In 2012 Gross Disposable House Income (GDHI) per head in Powys stood at £15,299 and was the seventh highest amongst the 22 Welsh local authorities, above the Welsh average. However this is mis-leading in terms of the working age population who have some of the lowest average weekly income.[10] We can deduce from this that the high levels of over 65's (retired and inward migrated) are the ones with the higher disposable income. Whilst we recognise there will be a percentage of older people who will have low incomes a good majority should be able to afford to pay for some of the services they may need.

3.53 Access to Services varies between Powys Localities. Regarding travel times to GP and Dental Surgeries, access is good for the Llandrindod & Rhayader, Newtown, Welshpool and Montgomery and Ystradgynlais localities and poorer for Machynlleth and Llanfyllin.

3.54 83.9% of residents aged over 65 feel satisfied that Powys is a place where people look out for and support each other—the figure is higher than for other age groups (aged 45 - 64 = 81.6%; under 45's = 80.2%)

3.56 As at September 2015 11, 037 hours per week of domiciliary care to 823 Powys residents. Localities with the highest provision of domiciliary care tend to be in the **North** and **Mid** Powys (Llanfyllin, Knighton & Presteigne, Llandrindod and Rhayader, Llanfair Caereinion, Builth and Llanwrtyd, Machynlleth) and lower in the South (Brecon, Ystradgynlais, Hay & Talgarth). Any future work must look to reduce down or delay expenditure in this area of provision.

3.57 Dementia

3.58 There are about 800,000 people in the United Kingdom (UK) with dementia and this figure is

[10] Powys citizens have, on average, earned consistently less than those in most other Welsh local authorities (£487 average weekly earnings, 2013), ranking third lowest in Wales.

predicted to rise along with the growth in the numbers of older people in our communities.

3.59 Dementia is a theme that any future service model will need to address in terms of providing low level and or target support for people with dementia and their carers to ensure that carers are able to support people with dementia for as long as possible without becoming overwhelmed. In addition, at a higher end of need, statutory services, in particular residential care providers can expect the majority of people needing their services to have a high level of dependency, particularly in relation to dementia.

3.60 Isolation and Loneliness

3.61 When Powys Residents were asked which services are missing from their local community, the sixth most common answer was “places to go during the daytime for older people”. In addition, the overarching issue that came out during the Listen and Learn process was the companionship that people valued most in terms of attending the Day Centre.

3.62 There are estimated to be 14,741 people over 50 living alone in Powys (24% of the over 50 population). Isolation and loneliness will be critical factors going forward and there is much research too suggest that a key focus of any future work will need to take this key issue in to account.

3.63 For example (IRISS March 2014) reviewed all the research into the impact of isolation and loneliness and well as investigate what works. They found that

- Loneliness and isolation are common problems amongst older people
- Tackling loneliness and isolation is inherently preventative in terms of delaying or avoiding the need for more intensive support.
- Age UK (2010) states that research shows the figure of those often or always lonely is between 6 and 13%.
    - 6% in Powys would equate to approximately 1697 people suffering from loneliness and isolation.
    - 13% would equate to 4261 (this is a more realistic figure in a rural county)
- The effects of social and emotional loneliness on physical and mental health and wellbeing are extensive.

3.64 The effects of loneliness and isolation includes:-

- Adverse effects include increased blood pressure, abnormal stress response, heart disease and poor sleep, and its associated health problems
- Additionally, several studies indicate a strong association with depression
- Older people who are lonely or isolated also have substantially increased chances of developing dementia and, specifically, Alzheimer’s disease, compared to better connected individuals.
- Older people who have unsatisfactory or limited social relationships have a significantly greater risk of mortality than people with stronger social networks.
- Those with good connections had a 50% greater chance of survival.
- The authors highlighted that this is comparable to the impact of smoking fifteen cigarettes each day and has a greater effect on mortality than current public health priorities such as obesity, drinking alcohol or being sedentary.

3.65 Selected Conditions (observed in people aged 65 years and over, 2008-10) in Powys indicated the following:-

	Powys	Wales
Currently treated for:		
High Blood Pressure	50%	51%

Heart Condition	25%	29%
Respiratory condition	17%	22%
COPD*	5%	7%
Mental illness	10%	8%
Arthritis	27%	33%
Diabetes	14%	15%

3.66 Listen and Learn

3.67 Due to the growing complexity and the sensitive nature of this review (shortening timescales in which projected savings had to be made, the needs of the client group and the status that these facilities have in the community), Powys County Council commissioned the Consultation Institute[11] to advise officers and the Cabinet Lead on how to progress to ensure that the process was fair, met with best practice and minimised the opportunities for future legal challenge.

3.68 The advice included the importance of the pre-consultation process and enabling key stakeholders including users of the service to have their voice heard before the options design stage, giving them the opportunity to share their concerns, ideas and views in shaping the future. due to short timescales and the lack of capacity and resource to support such a process, it was agreed that three substantive project areas would have a combined pre-consultation approach, these were:-

- Day Time Activities
- Residential Care
- Fair and Affordable Funding

3.69 Powys County Council embarked on this engagement work during the first quarter of 2016. Daytime opportunities generating the most feedback during the engagement and while there were low numbers of responses to some of the questionnaire surveys, the feedback generated raised some valuable issues. A copy of the full Listen and Learn report can be found in Appendix 3.

3.70 The process was supported by the Councils Communication Team and a team of council staff met with and or invited a wide range of stakeholders including:

- Day centre service users and their carers in Brecon and Llanidloes;
- Residents of residential homes in Welshpool and Hay on Wye;
- Day centre staff, managers and union reps;
- Representatives of Powys Teaching Health Board and other partners;
- The county's Older People's Forum and the Wales Pensioners (Llandrindod branch);
- County councillors
- Assembly Members or their representatives
- Representatives of third sector day-care providers;
- Colleagues in the council's library service;
- Advocates for carers;
- Care home and domiciliary care provider forums.

3.71 In addition, a survey was produced (mainly paper but also made available online) to allow extra feedback.

3.72 The top three themes emerging from the Listen and Learn process were:-

[11] The Consultation Institute is nationally recognised not for profit organisation who supports and advises those carrying out public or stakeholder consultation to ensure they meet best practice to improve value to decision-making process.

- Social inclusion – the companionship and friendships that going to a Day Centre provides.
- Respite – carers rely on the fact that the people they care for attend a Day Centre and they either use the time to recharge their batteries, or for some, continue to work and or look after other family members.
- Vulnerable client and particularly those with Dementia – a good percentage of users have memory loss and or dementia and the Centre provides a consistent place that they can be cared for and supported by good quality caring staff. They felt that regular changes to the venue may cause confusion and anxiety

3.73 Other significant issues raised included:-

- Widespread support from service users for the day centre staff and concerns about the loss of jobs should any centres close.
- There was also concern that, should a day centre close, that this could cause a great deal of anxiety, particularly for the more vulnerable. Having a model of day service provision – with different venues on different days – could prove confusing for these service users
- Widespread frustration that there appears to have been little progress in this area in recent years, and particular concern that arrangements for community groups to take on some day centres had not progressed.

3.74 There was little difference in the top three issues highlighted from the survey in relation to what was most important for having a good sense of wellbeing. Over 65's answered Physical Health first and the 50 to 65 age group answered Mental Health.

3.75 This feedback, like all of the other information gathered, will be tested by the formal public consultation process should the council proceed to formal consultation.

3.76 Models of Good Practice

3.77 As part of this review process a range of different service models were researched and or visited to ensure that any future direction of travel was in line with current thinking.

3.78 **The Shropshire Model – People 2 People**

3.79 People2People provides social work and occupational therapy services across Shropshire for older people and adults who have disabilities. They are a 'not for profit' organisation that has been in existence since January 2012. The service aims is to put social work back into the community and to be accountable to local people, reducing bureaucracy and increasing common sense.
They work to enable people to live as independently as possible and for as long as possible as part of their communities, leading active and fulfilled lives. Key elements of interest are:-

- People2People recruits and supports a volunteer and befriending workforce to work along-side social workers and help to facilitate the 'Let's Talk Sessions'.
- ''Let's Talk' sessions are a combination of group discussion and individual appointments if required – the key aim is to ascertain the level of need, network and link people to services and opportunities or each other. This would include access to commissioned preventative services. If the need appears to be greater, then a full Assessment takes place. The underlying principle is to empower people to meet their own needs.
- Single Point of Contact intrinsic to model (ascertains the level of need, provision of low level information, advice and guidance but more importantly appointments are given for the local 'Let's Talk Local' hub session.

3.80 **Solva Care Project**

3.81 Although still in the early stages of a two year pilot project funded by the Sustainable Development Fund (SDF) administered by Pembrokeshire Coast National Park Authority, the project seeks to support older people in the community through the project which is free at the point of delivery.

3.82 The Project aims to improve the health and well-being of the aging population and provide care packages at a variety of levels according to need. Solva Care also aims to provide respite cover. A person centred service which will respond to the individual needs of older people in the community, and is supported by a paid and volunteer workforce, examples include:-

- Pop in visits
- Phone calls
- Shopping and picking up prescriptions
- Help with correspondence and form filling
- Conversation and reading
- Transport (if normal transport is unavailable)
- Walks
- Trips out
- Minor repairs and maintenance
- Small domestic and garden chores
- Dog walking
- Help with electrical devices and internet
- Sign posting to other services

3.83 **Gloucester Village and Essex Community Agents Model**

3.84 The village agent model has been adopted by a number of English authorities and is supporting their drive around early intervention and prevention and managing the front door to social and health care. Most are jointly funded by the local authority and health but sit in the 3rd sector.

3.85 The Gloucester model is run by Gloucester Rural Community Council and although supported by the County Council is still relatively arms-length from key business processes. However they train a number of agents to support people with particular needs such as those with cancer and palliative support needs. Its key defining features include:-

- Promoting health and independence
- Reducing social isolation
- Finding practical solutions to daily living
- Providing confidential trusted Information
- Informing choice and reducing confusion
- Increasing individual and community resilience

3.86 The Essex model started life in much the same way as the Gloucester model but the scheme has shifted considerably from its original brief and is now being delivered by an innovative consortium arrangement which includes four partners (Rural Community Council of Essex, British Red Cross, Age UK and Neighbourhood Watch. Essex County Council have fully funded the model for 3 years, funding will be reduced in years four and five and the service will be expected to produce a sustainable funding strategy, identifying other long term funding sources including charitable donations, grant-giving philanthropic organisations and potential social investment.

3.87 Community Agents Essex scheme are managing demand on social care and health services targeting those older people and their carers most likely to require support in the near future – identified through referral by Social Care Direct (equivalent of our Powys People Direct), GPs and the community – and delay or divert their need by helping individuals to identify and implement solutions to the issues they face, with the support of their local networks and communities

3.88 The scheme aims to manage increasing demand on health and social care. It links within the broader landscape of strengthening community resilience and mobilising communities across Essex, increasing independence and enabling residents to help and support themselves within their community. It is based on analysis of data that shows a significant number of older people contacting Social Care Direct could have been supported earlier in the community.

3.89 The Community Agents Essex scheme enables timely and effective resolution of issues, which achieves better outcomes for people in Essex and at the same time avoids escalation of need and crisis, and the associated social care costs. A Community Agent will visit a person at home to discuss and help with:

- Mobility issues
  - where equipment, adaptations, or technology could support independence, or where, travel, social interaction and physical activity could sustain and improve wellbeing
- Practical living skills
  - after a significant life event, such as bereavement or hospital stay, supporting people to gain or regain practical skills such as paying bills, taking medication or getting to appointments
- Social inclusion
  - connecting people into one-to-one and group interactions or activities; or supporting the use of technology-based interaction and social media
- Healthy living
  - enabling or supporting people to prepare meals or linking individuals into community activities such as lunch clubs
- Caring for someone
  - for people new to caring or for people who have been caring for some time and struggling to cope in their changing role. Helping them to access practical support, information, advice and peer support
- Individual resilience
  - by providing advice and support that ensures correct entitlement to benefits and pension and increases personal safety and security

3.90 **Powys Befriending**

3.91 PAVO have developed and managed a Befriending programme that was funded for three years by the Big Lottery initially the service was designed to provide lower level befriending with the use of volunteers, supporting people who were socially isolated and lonely to engage in other services and or be sign posted to other relevant or appropriate services. The service is targeted at people aged over 50 who live in Powys are lonely and or at risk of losing independence. The service has helped and supported many clients to improve their quality of life and has had measurable benefits on their independence and confidence. Powys Befrienders is also the first service in Wales to receive the Befriending Quality Mark which evaluates the following areas:-

- client referrals, assessments and waiting lists
- volunteer recruitment, assessment and selection
- volunteer training
- matching
- reviews and ongoing support for clients and befrienders
- endings
- risk management and safety
- project resources
- monitoring & evaluation, and implementing change

3.92 Funded by the 2015-16 Intermediate Care Fund, PAVO, through Powys Befrienders and the Powys Befrienders delivery partner Crickhowell Volunteer Bureau (CVB), was tasked with delivering a pilot project for a total of 35 registered clients, both current Day Care Centre (DCC) clients from the DCC in Crickhowell and new clients over the age of 60 in the surrounding areas, working alongside the services that they already receive to provide added benefit to their lives.

3.93 The pilot sought to establish a safe and consistent service model that would demonstrate an increase in the health, well-being and independence of the registered clients, as well as a decrease in feelings of loneliness and isolation, whilst also providing demonstrable benefits for carers and the local community. The project used a three tiered approach in response to the clients' needs:-

- *Lower level befriending:* The service will use volunteers who will develop a less focused relationship with the day centre clients in their own home; this will just be a chat and a cup of tea with increased wellbeing as an outcome but will include signposting to other organisations if necessary.
- *Focused support:* A prevention Service, which will be delivered by staff members to support and work with clients who need higher support and clients with mental health issues, this will utilize the *outcome star* methodology to identify client goals to work towards.
- *Continue Group activities:* Through clients' identified needs, activity/social groups will be set up in community settings. The groups will be client centred and will encourage becoming self-sustaining and any support required will be provided by PAVO

3.94 Most of the targets for these improvements were met and, where they were not, this was because not all of the registered clients were able, mainly for health reasons, to participate in the planned activities and could not, therefore, derive any benefit from them. 100% of those who did participate evidenced improvement. The full results of the pilot are contained in the evaluation report can be found in Appendix 4.

3.95 Linked to the research on isolation and loneliness and the outcomes of the Crickhowell pilot project this scheme must play a critical part in any model going forward. PAVO are currently preparing a feasibility and business plan for the continuation of Befriending and at its core will be how it integrates with existing community activities.

3.96 **Meeting Dems and Dementia Friendly Communities**

3.97 The Association for Dementia Studies at Worcester University has been awarded a EU research grant in order to carry out potentially vital work in helping people and families living with dementia. The project, known as MEETINGDEM is supported through the EU Joint Programme - Neurodegenerative Disease Research (JPND), and aims to implement and evaluate the Meeting Centres Support Programme which has achieved great success in the Netherlands. There are currently two formal schemes – one in Droitwich and the other in Leominster. There is also a growing body of people in Hay and Brecon who have ambitions to do the same in Powys as well as find ways of co-ordinating and sharing good and innovative practice across the County. These developments compliment the work of Powys's Dementia Champion, the Council's dementia pledge and the networking forums.

3.98 The Meeting Centres Support Programme (MSCP) provides an innovative way of supporting people with mild to moderate dementia and their families through an evidence-based, person-centred approach. Providing regular community based and facilitated group activity – two or three times a week. It also encourages peer to peer support both between those with dementia and carer to carer.

3.99 There is a close alignment between this programme and the drive to establish Dementia Friendly Communities (DFC). DFC's are defined by the Alzheimer's Society as: "A city, town or village where people with dementia are understood, respected and supported, and confident they can contribute to community life. In a dementia friendly community people will be aware of and understand dementia, and people with dementia will feel included and involved, and have choice and control over their day-to-day lives"

3.100 Continuing the Dementia Friendly Community scheme across Powys and also promoting / developing the MeetingDEM model as part of our wider strategy would both help prolong independence and provide community based support for people with dementia and their carers.

3.101 **Rhayader Home Support**

3.102 The aim of the service is to improve the support available to the older people in the Rhayader area, enabling them to continue to live at home with greater practical assistance and to maintain links with the community.

3.103 Rhayader Home Support began in 1998 following the closure of a local nursing home the service also provides the warden service, it operates within a 7 mile radius of Rhayader and the majority of those registered with the service are patients of Rhayader GP practice with a few being patients of either Llandrindod Wells or Llanidloes GPs. The service is free at delivery.

3.104

- 180 service users are registered with the service (service user can register their details with the service but not all want current daily/weekly involvement but are known to the service who maintain their details and can support if needed) service users can self-refer and referrals also come from family, GPs, health workers and social care staff.
- 62 people are currently active members of the service receiving regular contact with the service ranging from 1 contact per week to daily contact.
- Service user visit/call via telephone up to 49 per day Monday to Friday with a limited number also receiving a telephone call on Saturday and Sunday if required
- In addition to monitoring the service user health and wellbeing staff also support service user by:
    - Essential shopping; collection and delivery of medication; helping to manage recycling/waste collection; help with correspondence and form filling: fitting and testing Careline alarms, arranging and reminding of appointments
    - Staff do not form part of a domiciliary care service but can provide domiciliary care in the case of an emergency/or while a care package is sourced/or to return home from hospital /carer illness – this is normally time limited to not more than six weeks.
    - The service acts as a key holder and rapid response service for 92 individuals with a Careline alarm.

3.105 Staffing consists 1 Senior Support worker (30 hours)and 4x support staff 80 hours (110 hours per week), and the hours of operation 8.30am to 5.30pm Monday to Friday and an out of hours service from 5.30pm to 8.30am and on Saturday and Sunday. One of the key aspects of the service is that they work closely with:-

- **Health:** Rhayader GP surgery, District Nurses, Llandrindod Hospital, Health OT's Physiotherapist, dementia nurse, Psychiatry Specialist and Diabetic nurse. The service plays an active part in the weekly virtual ward meeting.
- **Powys County Council**: Care managers and CSOs, Reablement, OTs, Careline and Housing
- **Third Sector**: Community support, Befrienders, Community Transport, Hospital Transport Age, PAVO, Age Cymru, Luncheon Club.
- **Others:** Fire Service, Police.

3.106 The service was evaluated[12] the Institute of Rural Health in 2013 and the report demonstrated significant financial savings stating that:-

'… indicative costings suggest that the provision of high quality, low level care has the potential to deliver better outcomes for people and cost benefits for all stakeholders, particularly the NHS. The following critical success factors are identified as enabling the Rhayader 'model' to succeed where others may fail:-

- *Timely*
- *Responsive*

[12] Jarrett, C., Williams, F., Lewis, L. (2013) The Provision of Integrated Care in a Rural Community – an Evaluation of Rhayader Home Support Scheme. Institute of Rural Health. Cardiff.

- *Tailored*
- *Flexible*
- *Cost-effective*

3.107 In addition, as part of this review some simple drill down and cost benefit analysis have illustrated potential savings and impact. Further details can be found in Appendix 5.

3.108 **Critical Features of Best Practice**

3.109 In the Cabinet Report of November 2015 there was a synopsis of some Age Concern research which did a review of research evidence in to the Effectiveness of Day Services (2011), the following were the key elements that older people valued and wanted from the services that they used:-

- Participants wanted and valued different things in their lives, but all expressed common human needs for social, psychological and physical well-being
- People valued their close emotional relationships, though some expressed concerns about 'imposing' on family and friends. Many had made new friends as a result of their increasing support needs.
- Control over their lives was important but meant different things to different people. Adjusting well to change was also central to psychological well-being, and this might require support
- Participants valued getting out and about, keeping mentally and physically active and having contact with nature
- Care, support and other people's time were key factors that enabled or prevented people doing things that mattered to them.
- Participants faced various challenges and difficulties, some a result of illness, disability and ageing but many because of lack of access to information, money, technology, equipment and transport

3.110 Professor John Bolton (IPC) in his paper *Predicting and Managing Demand in Social Care Discussion Paper* (April 2016) identified the following local factors that are significant in influencing the demand for state funded services in adult social care, in addition to pure demographic changes some of the most pertinent reflect our emerging approach around early intervention and prevention in particular:

- The relative wealth in the population (or the opposite in relation to areas of high deprivation).
- The behaviours of key players in the NHS, the performance of intermediate care and the availability of therapists and nurses in the community.
- **The effectiveness of the council front door in finding solutions for people and their problems - The effectiveness of short-term help and the approach to preventive help.**
- **The way in which the needs of people with lower care needs are met including the use of assisted technology.**
- The practice and supervision of assessment and care management staff.
- **The approaches taken to progression towards greater independence for those with long-term conditions**.
- **The way in which people with long-term conditions are helped to self-manage their conditions including dementia care.**
- **The approaches taken to the assets of the person being assessed and the involvement of family and community in a person's solutions.**
- **The way in which providers deliver outcomes including the availability and vibrancy of the voluntary sector.**
- The availability and the nature of supported housing services including Extra-Care Housing for Older People.

- **The partnership with carers and carer organisations.**

3.111 A number of the most pertinent to this review have been highlighted but the links and dependencies with other strategies such as supported housing, partnerships with the NHS and the culture change requirements around care management practice will also play their part.

3.112 Building capacity both within individuals and the community is also highlighted in a range of recent research and literature for example *Aging well an asset Approach* states that *'viewing older people through a lens of deficits, problems and needs'* will only result in us seeing an:-

> *'…increasing demographic challenges and pressures on state services, such as health and social care, at a time when resources are shrinking. However, there is a more positive way of looking at this. By valuing the contribution that older people make to their communities, it is possible to see the increasingly ageing population as an opportunity.'*

3.113 SITRA in their reflective report on *Asset Backed Community Development (ABCD) for Older people* [13] stated

> *'The first premise of ABCD is that providing individuals with maximum choice and control over the public services they require and tailoring support to meet individuals' strengths, skills and aspirations is one of the key principles of all asset-based approaches. In services such as housing support, adult social care and health, individual assets are often identified through person-centred planning…. Identifying individuals' assets, along with their expectations and aspirations, and coproducing local solutions is the key to achieving outcomes that are relevant, meaningful and valuable for people who live in that community.'*

3.114 The following have been gleaned from a wide variety of research and bench marking and are identified as broad factors of success for any future model, in particular one that takes and early intervention and prevention approach:-

- Neighbourhood or community based
    - Building on existing activities / facilities
    - Variety (social, cultural, leisure including sport)
    - Group activities
- Developed with the involvement of people / community in co-production and as key assets both in the planning and delivery
    - Outcome focused
    - Personalised
    - Greater control and choice
- Accessible, flexible and responsive (right place right time)
    - Simple
    - Quick
    - Trusted
    - Known – local / key worker / lead practitioner / lead professional
    - Transport (not necessarily free but available)

3.115 However there has to be a supportive and facilitative infrastructure, one that could be described as a 'Commissioning Council' and the following identify the types of infrastructure requirements that will enable the above to happen:-

- Whole system approach – delivering joined up co-ordinated services
- Funding for early intervention and low level services
- A clear framework for a conversation / assessment starting at the lowest level
- Information sharing (systems and practice)

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[13] Burcu Borysik, - SITRA (November 2014)

        - One record
        - Minimum repeat conversations
        - Use of technology
- Clear care pathways (step up and step down) – the continuum
- Shared responsibility - statutory sector as community leader / facilitator (all valued irrespective of role)
- Third sector centric
    - Range of models including Social Enterprise, Community Interest Companies, Charities, Co-ops, Trusts
- Evidence / theoretical based
- Innovative use of resources – letting go / prepared to take risks
- Workforce Development
    - Shared narrative & language
    - Shared leadership and team development
    - Shared behaviours
    - Motivational interviewing / inquisitive research

4 ALIGNMENT AND INTEGRATION OPPORTUNITIES

4.1 Aligning and integrating a range of strategies and delivery programmes will be essential to get the best value and ensure a single process that is easily identifiable and accessible for clients and those who support and care for them.

4.2 It is also clear that there will be economies of scale by pooling and aligning resources, financial, community and human asset (skills, time buildings etc.). The following illustrates very briefly why and how the alignment would and could take place to ensure any shared outcomes could be met.

4.3 For some areas such as Families First, Carers, Domestic Violence, and Substance Mis-use there has been a phased progression towards an 'Everybody's Business' model which works within the care continuum, supports early intervention and prevention and will, once the core elements are in place clearly link with any community focused wellbeing and preventive arrangements we put in place supporting the whole population and not just older people. We have outlined examples below to illustrate our direction of travel

4.4 For others, such as the Community Delivery Project the connections are becoming more critical as community services such as libraries, culture, sports and leisure services are beginning to diminish due to financial austerity in the public sector. These services have historically, provided opportunities for people to stay healthy, socialise and participate in learning and culture, all the things that help maintain connectivity, independence and significantly contributes to peoples sense of wellbeing.

4.5 **<u>Powys People Direct (PPD)</u>**

4.6 Managing the front door has been highlighted in much of the research cited above. PPD currently provide the single point of contact for social care and continue to develop their Information, Advice and Assistance service.

4.7 PPD cannot and should not be seen in isolation of any early intervention of prevention model of delivery, its role is to provide an initial response, provide advice, information and or sign posting but then, if the person is not highlighting a safeguarding issue, or a high level crisis, then they need the ability to pass on for a level of assistance that can only be provided at community level should this be required.

4.8 Likewise, the current 3rd Sector Brokers play a much more significant role at community level by not only networking people but by helping to develop services to meet identified gaps as the service develops. They would help to co-ordinate the local service but also provide a community

development function to support the recruitment and management of volunteers and build capacity in the wider community.

4.9 **Supporting People**

4.10 The Supporting People Programme provides the framework by which housing related support services are commissioned and funded within Wales.

4.11 By achieving the outcomes that matter to the people it supports, housing related support makes a significant contribution to the strategic objectives of the Council and its statutory partners in relation to:

- reducing the incidence of homelessness and repeat homelessness
- reducing the risk of offending and improving community safety
- increasing the skills and employability of people
- reducing the incidence of break-up of families
- reducing risks to the health, safety and well-being of vulnerable people
- reducing pressure on the NHS and Social Services
- reducing the incidence of poverty, unsustainable debt and bankruptcy.

4.12 If the new model addresses the notion of 'what matters' to people and their community then the opportunities for alignment of systems, processes and resources to support a whole system approach is substantial.

4.13 **Children and Young People's Partnership (CYPP)**

4.14 The CYPP, as a partnership is seeking to review its collective delivery of service for children, young people and families and develop a new, locality based model which more closely integrates Health, Social Care and Education and builds a sound Early Intervention and Prevention Model – it seeks to align / integrate with the whole system and has already identified some core components that will be critical to success:-

- A Locality Delivery Model (4, 5 or 6 locality areas?)
- To push core resources 'upstream' to create a sustainable Early Intervention and Prevention Model
- Community level hubs as an outreach of PPD but also a place for co-location of services
- Community Champions/Co-ordinators in locality areas
- Integrated teams with Matrix management – both locality management and professional/specialist supervision
- A Shared Database/intelligence system - CCIS
- Integrated and proportionate assessments – build across the continuum of need
- Team around the Family approach adopted at all levels
- Pooled Budgets/resources
- A Single Governance Structure
- Integrated performance framework with shared outcomes
- Integrated Workforce Development strategies and plans
- Joint Commissioning Methodology

4.15 **Substance Misuse**

The Newly recommissioned service includes a stronger focus on recovery and ensuring service users are supported to gain access to the key ingredients which are more likely to support sustained recovery from substance misuse. This will include the development of community level social and support networks and diversionary activities alongside opportunies to build a healthier lifestyle.

4.16 **Dementia Plan**

4.17 It will be essential that there is an alignment of any new model with the Powys Multi-agency Dementia Plan (2016 – 2019), and it's 7 high level outcomes which have emerged from the Ministerial priorities for dementia; they are:

- more people with dementia living a good quality life at home for longer;
- dementia-friendly and dementia-supportive local communities, that contribute to greater awareness of dementia and reduce stigma;
- timely, accurate diagnosis of dementia;
- better post-diagnostic support for people with dementia and their families;
- better promotion of rights in all settings, together with improved compliance with the legal requirements in respect of treatment;
- people with dementia in hospitals or other institutional settings always being treated with dignity and respect;
- more people with dementia and their families and carers being involved as equal partners in care throughout the journey of the illness;

4.18 **Carers**

4.19 The Powys Carers Commissioning Strategy provides a clear commitment to improving the quality of life of carers through planning and commissioning services that meet their assessed needs. The strategic approach will be around developing and implementing a multi-agency 'everybody's business' model for identifying, assessing and meeting the needs of carers.

4.20 Whilst there is a recognition that the needs and requirements of all Carers (both young and adult) are individual and distinct, many of the issues affecting them are common concerns shared by all carers. Developing an integrated strategy across all age groups will help agencies address these issues in the round, so that carers can benefit from joined-up services and support, particularly at community level.

4.21 Under priority 1 of the strategy the links to an merging new model have already been made with a commitment to implementing the following:-

- Develop and implement a multi-agency 'everybody's business' model for identifying, assessing and meeting the needs of carers.
- Develop and deliver a multi-agency workforce development programme that will support a range of practitioners to:
  - Identify carers and understand the impact of their caring role;
  - Assess the needs of carers holistically;
  - Understand and follow integrated service/intervention pathways.
- Develop and implement a multi-agency commissioning strategy that:
  - has a focus on early intervention and prevention;
  - will ensure a range of support services are available and accessible for carers across the spectrum of need.
- Embed new governance supporting the development of a Carers' champion in every GP surgery and Secondary School as a point of contact and to help carers (including young carers) get advice and support.
- Consultation and engagement framework.
  - Structures to improve the involvement and control carers have in all key developments that affect them in their own lives, in shaping the services they use and in service design and delivery.

- Work with carers and local communities to develop local community enterprises to support improved access to community based services.has a focus on early intervention and prevention;

4.22 In particular we are seeking to transform our processes and services in relation to:
- Raising awareness of Carers important roles in the community and the additional support needs they may have;
- Developing Carers Assessments – an early 'wellbeing' assessment and statutory assessment for 'support';
- Providing Early Intervention and Preventive support for Carers;
- Developing social enterprises and community delivery models to support carers and provider opportunities for work, training and socialisation.

4.23 **Domestic Abuse**

4.24 The newly developed Domestic Abuse Commissioning Strategy has been developed through meaningful engagement with key partner agencies, service providers and service users. While it has recognised the need for specialist Domestic Abuse services to support survivors it has also recognised the need for community level support, information and advice to help them firstly disclose and seek to escape their abuse earlier and secondly rebuild their lives and achieve independence once they have escaped the abuse.

4.25 The resulting service design includes a close connection and working arrangement, based on a 'Team around the person' approach between specialist providers and community level/locality services. In this model a lead practitioner will help a survivor to 'pull in' and access a bespoke package if support to meet their needs and those of their family.

4.26 Under the strategy Powys has also committed to engaging in a new pilot scheme to look at developing 'safe disclosure points' within local communities. Community staff and members will be trained to know how to respond should someone disclose to them that they are a victim of domestic abuse. This will include members of the community such as hairdressers and members of the WI who could provide a safe and non-stigmatised environment for victims to come forward and seek help.

4.27 **Community Delivery Project**

4.28 The Powys One Plan under the theme Stronger Communities developed a Community Delivery Project summarised as follows:-

> *'Development and implementation of good practice models to improve delivery of all services through joined up working at a local level, involving community in that process to better address issues and sustain solutions.'*

4.29 The project to date has had some significant successes however it has also taken significant effort. In a recent Reframing Document shared at the project board, and a subsequent workshop, it was felt that rationalisation would be essential to continue to build capacity and enable communities to build sustainable platforms on which they could then develop and or take over services.

4.30 We need to keep focused on the broader remit of community delivery that encourages a more holistic approach to enabling communities to do more for themselves and that may require engagement with other stakeholders within the County Council. Social Care and in particular the development and or provision of preventative services could be a key element of any future vision

for Community Delivery and the new proposed model would align to ensure coherence and effective use of resources.

4.31 **Assistive Technology**

4.32 The vision for Assistive Technology in Powys is that we work together with our public, patients, people who use our services and their families to take hold of and develop the range of opportunities advances in technology can provide to make sure that people in Powys:

- Are supported to maintain their health and wellbeing;
- Are given relevant information, so that they have an increased choice and control over what matters to them;
- Have greater access to health and social care which is close to home, and can meet their needs;
- Experience a good quality of life; and can live independently in their own homes for as long as possible;
- Are supported to move back to their own home and communities following hospital discharges as fast as safety allows;
- Have the choice and opportunity to take part in social activities and be included in the community, to maintain their well-being.

4.33 By bringing together health and social care through shared processes, information systems and co-location, we will help maximise opportunities for individuals to be supported at home[14]. In doing so, we are determined that where ever possible, our older people, people with disabilities, people with mental health problems and other vulnerable people are able to live independently with in their own homes. Technology will play an increasing role in delivering this vision.

4.34 Assistive technology is critical to supporting early intervention and prevention – a community based model can support the promotion of assistive technology as well as respond such as working with Care Line to provide a fast response.

4.35 **Residential Care**

4.36 During 2014/15 there were 907 people placed in the 32 care homes in the county, which are all managed by the private sector. In addition, 161 people were placed in homes outside of Powys. We also provided sheltered housing to 1,626 people over the age of 60.

4.37 Currently care homes only serve a proportion of the elderly people in Powys there is also local evidence of falling demand for standard residential care in comparison with the rising need for residential care for people with complex needs such as dementia. Evidence also shows us that the more independent people are - and if they are well connected with their local communities and the services in their community - the greater their health and wellbeing is.

4.38 The council is therefore considering alternative ways to support older people in their community that would not reduce the quality of care provided. The review of residential care, and the development of alternative accommodation such as 'extra care' and the development of any new community based support and wellbeing service is inextricably linked. Any new model of service must enable people to live a supported fulfilled life in their own home, and their own home has to be fit for purpose.

4.39 **Welfare Reform**

[14] PCC/PtHB Statement of Intent, 2015

4.40 The introduction of Welfare Reform and Universal Credit is likely to have wide ranging impact on the residents of Powys and it will be important to ensure that residents in the county have access to all the necessary support and assistance they need. A new model of delivery needs to ensure that there is swift and easy access to support for people for whom this will have an impact now, and in the future.

4.41 A community focused service can ensure a clearly co-ordinated approach to addressing these needs and ensuring that people get access to the benefits they are eligible to claim.

5.00 METHODOLOGY FOR MAKING CHOICES

5.1 The options outlined below consider the financial impact and the viability of each. However, it is essential that potential risks are also understood.

5.2 Without ensuring that appropriate services are in place there are significant risks, which include:

- Older people may feel more isolated and will not have the same social interaction as they currently have;
- Informal carers may find the reduction in respite support detrimental to their wellbeing;
- Older people may not have the care they currently receive at day centres;
- Older people may require care at home in place of attendance at the day centre, which may be difficult to provide;
- Providing care at home may mean additional pressure on the domiciliary care budget.

5.3 Each of these risks were raised as concerns from the individuals who participated in the Listen and Learn exercise (See Appendix 3).

5.4 It should be noted that whichever option is chosen there will be a financial deficit to be managed. The timescales for de-commissioning will make it impossible to make all the savings aligned to this financial year brought forward from 2015/16 of £253k and 2016-17 of £450k, but all savings for the following financial year £490k for 2017/18 could be achieved depending which option is identified for implementation following the public consultation . The reasons for this year’s shortfalls are because:-

- We are legally bound to go out for a 3 month public consultation.
- The earliest Cabinet could make their final decision would be November 22nd 2016. No formal action can be taken until this decision is made.

5.5 However our confidence to deliver from this point on has a sound foundation. This is because:-

- There is a vision for the medium and longer term and the potential for the pooling of resources is being explored to develop a new preventative community based model.
- There is a new Head of Service for Transformation
- The Programme Lead for Early Intervention and Prevention has returned and is also now leading on this review.
- The service manager has returned to manage the service and is supporting the review process and will support the implementation of any options approved.
- A comprehensive needs assessment now exists, so all best and worse-case scenarios are clear and transparent.

5.6 The work done to date leads us to present only three options however it should be noted that there are a number of different permutations, all with their own financial implications. The detailed Full Options Appraisal document provides the underpinning theory and evidence for both the residual options and the longer term vision.

5.7 It must be emphasised that work continues to try and find alternative ways to secure the future of the Day Centres and this will remain the case up until any final decisions are made, this includes

meetings with private care providers operating in the County, but will be on the basis that any subsidy will be small if not none existent.

5.8 In addition, Officers have recently met with Welshpool Town Council to discuss options in relation to their current contract and whether they would be interested in exploring, as part of any future developments, to aligning their current work to the new model. This was received very positively and would therefore ensure an equitable approach across the whole of the County would be achieved. It has been agreed with the Town Clerk that during the formal consultation period further work would help firm up a developmental road map to realise this approach.

6 OPTIONS

6.1 OPTION 1

To not close any of the existing services and to continue as is.

6.2 Viability

6.3 The viability of this option would rely on an ongoing budget of £1.497 million which is not available to Adult Social Care. Further details can be seen within the Full Options Appraisal, (the operational budget allocation 2016-17 is £794,390 and 2017-18 is £304,390). Some savings could be made by providing lunch time food by buying in ready-made lunches - the current costs are:-

- Annual Salary Costs = £79,320 (as of Feb 2016)
- One off Redundancy Costs = £16,531 (as of Feb 2016)

Clients pay for their own lunch so this would be cost neutral going forward and alternative providers have informally been sourced.

6.4 Analysis of transport has revealed that unless there is a whole system approach to addressing community transport the savings on transport are likely to be minimal because a) the lack of mobility of the clients and b) the lack of private taxi hire or community transport in many parts of the county. The Lead officer is now sitting on a new project board (under the Place directorate) looking at the provision of transport including public and community.

6.5 In addition, many of the buildings will need some capital investment because the age of building stock is such that they have been allowed to deteriorate, some do not have double glazing and as with all assets there will be ongoing maintenance costs.

6.7 OPTION 2

6.8 To close all day centres including 3rd sector provision with effect from March 2017 (but excluding Westwood in Welshpool), and to ensure any clients who have assessed need will be found / offered alternative provision such as other existing services available to adult social care such as domiciliary care.

6.9 Viability

6.10 Work will need to be undertaken to review the care needs of all existing service users (a desk top review has started and it is planned that every client will be visited to have their care and support plan reviewed as part of the formal consultation process). Hypothetically, if the current day centre attendees required an additional two hours of domiciliary care every week following the closure of day centres this would cost approximately (430 people x 2 hours care at £18 per hour x 52 weeks) £804,960. It must be emphasised that this is an estimate only. This money is not currently available to Adult Social Care and it would place additional pressures upon the Domiciliary Care Services

which may have difficulty accommodating the additional need. In addition the individuals would not benefit from essential social interaction, other than with the domiciliary carers.

6.11 If respite is required we may have a spot purchase cost of approximately £30 per day we believe there could be as many as 60 people across all services who may require respite. Calculated at 1 additional day per week each this would equate to £93,600.

6.13 At the commencement of 2017/18 the centres would be closed and £1.013m savings would be achieved. The outstanding savings from 2016/17 of £365k and an additional target of £490k for 2017/18 would be fully achieved. This leaves a remaining budget of £157k, plus Westwood £147k, in total £304,390k to fund this service provision.

6.14 If this option was chosen the savings target for 2016/17 of £703k would remain unachieved and a cost pressure. At the commencement of 2017/18 the centres would be closed and £1.350m savings would be achieved. The outstanding savings from 2016/17 of £703k and an additional target of £490k for 2017/18 would be fully achieved. This leaves a remaining budget of £157k, plus Westwood £147k, in total £304k to fund this service provision.

6.15 There would be a remaining £157k budget (excluding the Westwood allocation) and one suggestion is that the service could pay back an annual sum to clear the debt created by not making the savings but it would important to leave some allocation to cover the needs of clients who have been displaced by the Centre closures. The redundancy costs would go up by nearly 3% to a total of £510k.

6.7 Therefore the costs to be incurred will be:-

- Unachieved savings for 2016-17 £703k (one off)
- Additional annual costs in meeting assessed needs approximately £896,560 (ongoing)
- £510k redundancy costs

6.8 The cost beyond the current financial envelope would be of this model will be:

	2016-17	**2017-18**	**Ongoing (to meet assessed needs)[15]**
Cost	£1,213,000	£896,560	£896,560

6.6 The full SWAT Analysis can be found at the end of this chapter under section 6.37

6.17 OPTION 3

6.18 To take a phased approach to decommissioning all existing provision (except for Westwood in Welshpool). All existing services will be closed by March 2019 but the realisation of the savings will be met by March 2018.

This would require a reducing budget to be maintained to cover the costs of the ongoing running costs of the Day Centres during a phased closure.

Viability

This option would allow us to have more time to build on our existing early intervention and prevention work and to develop an improved future model of delivery that provides better community co-ordination, helps build and release capacity at community level and can draw in

[15] This figure is approximate and that we would envisage that as the current population changes and the impact of the improved future model kicks in we would anticipate that these costs should reduce.

resource to support identified service gaps to support people to be more independent and live in their own homes.

The costs of this option, excluding any costs for the improved future model, will be:-

	2016-17	2017-18	2018-19
Budget	£1,497,000	£1,497,000	
Efficiency requirement	-£703,000	£1,193,000	
Deficit	-£599,626	-£524,616	
Redundancy Costs	£283,433	£297,281	
Cost to cover assessed need		£597,706	
Total Cost	**£1,677,449**	**£1,723993**	**£298,853** [16]

Looking to the Future

It is our aim to pool and align a whole range of resources to help further deliver our proposed early intervention and prevention model. However there are some specifics that we hope to establish as part of the model that are designed to meet the needs of the older population and these would include:-

- **Home and housing support** – a service that provides older people with bespoke personal support and assistance to enable them to stay in, or get back to their own homes and provides a crisis response when needed, including a warden type scheme – based on the Rhayader Home Support Scheme.
- **Befriending / good neighbours / Day Sitting Respite Service** – offering low level individual or group befriending as required, with an emphasis on reducing social isolation and loneliness as well as support with everyday tasks. Loosely based on the Befriending Pilot in Crickhowell and RVS Good Neighbour Scheme. In addition we would seek to slightly expand the model to provide a Day Sitting / Respite Service designed to give care givers a break.
- **Dementia Service** – support for families and people affected by dementia including a range of therapeutic, social and informative activities, based on, but not necessarily exclusively on the MeetDem Centre Model and the embedding of the Dementia Friendly Community programme.

The core of the service would provide clear co-ordination as well as a community development / engagement function which should link to other universal and specialist target services such as Substance Misuse. Domestic Abuse and Carers. It would also support the step up and down requirements from statutory services such as reablement and hospital discharge.

As stated above the model will have to supplement any identified allocations with extensive voluntary in-put and community development capacity and this will have to be at the heart of the improved future model and will take time – hence the funding profile is projected up to 2020.

A financial profile and proposed timetable for roll out which links options 3 to the development of the early intervention and prevention model can be found in Annex 1 Review and Options Paper **-** Appendix 7. However it is important to note that the timetable can be changed (although not outside the outlined total timescale envelope), and a number of tests have been run using different dates for different services, and although it does change the projected costs overall they are not significant.

Whilst good progress has been made there is a need to further consolidate and strengthen the model if we are to realise the efficiencies and added value that can be gained through an early

[16] This is an approximate cost and may well go up the following year until the future model delivers on anticipated outcomes.

intervention and prevention approach. To fund the next stage of development will be a challenge and will require some very difficult decisions to be made about a range of funding from grants to contracted work. The implications to recipients of grant funding may mean they will not get grants they may have been receiving for many years, and for contracted providers they will either have to flex significantly to meet / align to any new requirements or be decommissioned.

There will also be a significant challenge in the timing of any decommissioning work and aligning it to a developmental timetable, particularly where, a whole county service and structure will need to be revised to enable a community focus.

We will not be developing anything for which there is no identified resource and all work will have to take place within any available budget envelope. However we will also have to look externally to specific Welsh Government Grants and work with colleagues in Health and the third sector to attract alternative sources of funding to realise the vision.

Some work has started on identifying sources of funding we currently have at our disposal for pooling and re-aligning to the model and to help us get to the next stage these are:-

- Any surplus baseline budget that remains after the review of Day Time Activities is completed and implemented. (approximately £100k)
- Supporting People Grant (approximately £1.3 million)
- Innovation Fund (PCC) (approximately £100k)
- ASC Grant funding (approximately £100k)
- Existing services that could be aligned to the improved future model including Rhayader Home Support. (approximately £88k)
- Intermediate Care Fund (approximately £100k plus)
- The decommissioning of other ASC contracts that are no longer fit for purpose. (approximately £40k)

Total £1,828,000

In addition, we are working closely with the Place directorate to release more potential and added value in relation to the Community Delivery project.

It should be noted that a number of the funding streams mentioned above include significant grant funding from Welsh Government, in changing times, and potentially higher levels of public savings to be made none of these amounts are fully guaranteed year on year. In addition it is important to emphasise that a significant percentage of the identified funding outlined above could not be used to invest in existing provision such as Day Centres.

The diagram below illustrates the phased approach to decommissioning the existing services that are within the scope of this review and the developmental phase of further developing the early intervention and prevention model.

2015-16	2016-17	2017-18	2018-19	2019-20
Current Model Cost of Service £1,497,390 Average Unit Cost £3,482 Total Clients on Register = 420	Cost of Service £1,394,016	Cost of Service £829,006	Cost of Service £180,426	Review / Extend or Re-Commission
	Commission £156,825	£635,202	£1,517,427	Community Based Wellbeing and Prevention Service £1,803,504 Average Unit Cost £1678
Other Costs	£283,433	£297,281	£266,771	£139,502
Total Spend	£1,834263	£1,761,489	£1,964,624	Total £1,943,006
Budget	£1,497,390	£1,497,390	£1,497,390	Benefits = • Total Annual Places Available 1075 • Reduced Unit Cost • Potential savings to be made in other / statutory services
Efficiency	-£703,000	- £1,193,000	-£1,193,000	
Overspend (not including new service or costs associated with assessed need)	- £599,626	-£524,616	£324,427	

De-Commission

6.37

Option	Strengths	Challenges	Opportunities	Threats / Risks
Option 1				
To not close any of the existing day time activity services including Day Centres and to continue as is.	• All existing clients and their carers would continue to receive a valued service. • We would not have to find alternative services for clients where there is an assessed need. • The least politically sensitive.	• Not in line with current service provision thinking and good practice. • An operational budget (exclusive of central recharges) would be required. • Further capital investment in the buildings would be needed.	• We could still seek community take over but with a more realistic budget allocation in line with that given to Welshpool. • We could sell the facilities to be run as a private concern.	• Limited numbers would have their needs met and the gap between the haves and have nots would continue to grow. • The Medium Term Financial Plan commitments in terms of financial savings would not be delivered. • Some buildings have a relatively short life span and may not meet health and safety requirements in the future. • We will not have met the Social Services and Wellbeing Act requirements in relation to Part 2 and in particular prevention.
Option 2				
To close all day centres including 3rd sector provision (but excluding Westwood in Welshpool), and to ensure any clients who have assessed need will be found /	• We will deal with all the changes as a single decommissioning process. • It brings to an end a long protracted process for staff and clients so that both can come to terms with the change and move on.	• This Option does not allow other alternative models of service delivery to emerge – not enough time to source alternative funding and or commission a new service. • Following the final decision there will need	• There would still be opportunities to explore take over arrangements if expressions of interest are submitted right up until any decisions are made. • All surplus buildings may provide opportunities for	• Timescales – the longer the process takes the more the budget overspends. • Politically sensitive and is likely to generate high levels of emotion, anxiety and publicity. • Sufficient notice will need to be provided for third

offered alternative provision such as other existing services available to adult social care such as domiciliary care.	• Minimises the impact of instability of staff teams because the turn-around would be quicker than other options such as a phased approach • Support service capacity to help facilitate the process will be more manageable with a less complicated option – which compared to Option 3 this Option is. • Shortens the political impact. • Financially certainty could be achieved albeit with a short term deficit. • To date ASC have not yet closed / finished any services and this proposal will bring them in line with other Council departments.	to be at least 4 months before implementation can start to allow for requirements under consultation guidance and employment law to be implemented. • All clients who have assessed need will have to be found alternative services – this will cost other areas of ASC (cost shunt), but will still be less than current Day Centre budget. • Capacity to plan and or implement anything else would be limited because all effort would be focused on closure plans. • All client would need to be re-assed during the formal consultation process to ensure every person had an opportunity to discuss their needs.	other services and organisations to use. • Surplus buildings and land may provide capital receipts for the Council if they are sold for development. • Once completed there would be a clean slate for any new initiative to be developed and there will be more capacity to manage and develop this in the long term. • There may be opportunities to commission respite as part of Integrated Commissioning of Older People's Residential and Nursing Care Homes.	sector service providers (of which there are currently 6), the minimum notice is 3 months and if not met there may be contractual liabilities. • We may have difficulty finding satisfactory services to accommodate all assessed clients in a preferred service. • Costings for accommodating clients in alternative services may put additional / unmanageable strain on the social care system. • Those Carers receiving respite for elderly family members under the SS&WB Act may have needs that will not be met. • By closing day Centres there is likely to be a short term impact on other services such as Health and Hospital Admissions due to anxiety and change for the existing clients losing the service.
Option 3				
To take a phased approach to decommissioning all existing provision	• This approach would ensure a smoother transition from one model to the next.	• This option will need investment which until a decision is made on the way forward cannot be fully verified. This money would	• This Option would enable Day Centre staff to potentially transfer to the new model.	• The new service is a complete re-design to delay or prevent dependence and would not necessarily meet

(except for Westwood in Welshpool) whilst developing a new home support and befriending model using different funding streams so that closure and the phasing in of the new model align up to March 2019	• Would give us more time to manage the decommissioning process without extensive up front management resource.
	• Would provide some clients with re-assurance that there would be an alternative model if appropriate for meeting their needs.
	• Would provide us time to develop the positive narrative around the new service.
	• More time to re-assess the needs of clients and find alternatives where the new model would not meet their needs.
	• New model will meet the requirements under Part 2 of the Social Services and Wellbeing Act in particular prevention and use of the third sector and social enterprise.
		need to be found from existing sources and grant funding.
		• Questions may be raised about new investment whilst closing Day Centres (new investment will have different criteria and is designed to support the implementation of new requirements in the Social Services and Wellbeing Act - Part 2)
		• The new model would **not** support or be relevant to people living in extra care/residential/nursing homes, however at an extra cost to the client they could gain access to some social aspects of the service.
		• A phased approach may create instability if the remaining Centres if they knew they would be being decommissioned.
			• The new model will be designed to build on and co-ordinate much needed capacity around the individual with a view to reducing down the impact on services designed to meet higher levels of need.
			• The new model would support the delivery of people living in their own home and sheltered housing and would therefore support the delivery of the Integrated Commissioning Strategy of Older People's Residential and Nursing Care Homes.
			• Some programmes have already been commissioned to deliver as part of the model such as:-
			  ○ Carers
			  ○ Substance Misuse
			  ○ Domestic Abuse
			• Links to the Community Delivery Project (led by Place Directorate) would provide opportunities to align resources and build and release capacity in the
				many of the existing Day Centre clients' more complex needs.
				• The new proposed model does not include the provision of respite and this could result in cost shunting
				• There are implications for some commissioned and grant funded providers who may lose their grant funding to help pay for and deliver the new model.
				• Preliminary research shows some saving benefits to be generated from the new model and national research supports the management of the 'front door' but further work needs to be done to measure impact.
				• Managing the timeline for decommissioning a service and recommissioning a service may mean that alignment would not always be possible – therefore there may be a gap between the closure of one service and the opening of the new

			community for example alternative uses of Leisure Centres and Libraries. • The new model would mean contact with the number of individual older people would go up significantly.	community based model. • By closing day Centres there is likely to be a short term impact on other services such as Health and Hospital Admissions due to anxiety and change for the existing clients losing the service.

6.39 **Next Steps**

9.2 It will be important to seek the public's view on all three options in order to help Cabinet identify which option should be taken forward for implementation.

9.3 It is recognised that there are unresolved financial issues with all 3 options, due to the costs associated with each. However it is important to gather views and information about a proposed course of action before the final decision is taken, rather than asking the public for a preference as to which option they would choose.

9.4 It is also important that the Council shares with the public a proposed way forward which seeks to embed an early intervention and prevent approach in order to delay and or prevent the flow of services users into higher more costly interventions. Whilst we cannot prove at this stage that the improved future model will release resources in real cash terms it will, through its design, build, mobilise, and free up capacity where it is needed, by improved co-ordination and a linked up approach to commissioning any future service, and not just within Adult Social Care. As referenced earlier in this report this will not be done outside any resource envelope at our disposal but is a requirement in order for us to meet our statutory responsibilities for Part 2 of the Social Services and Wellbeing Act.

7 A WAY FORWARD - DESIGN PROPOSAL FOR AN IMPROVED FUTURE SERVICE

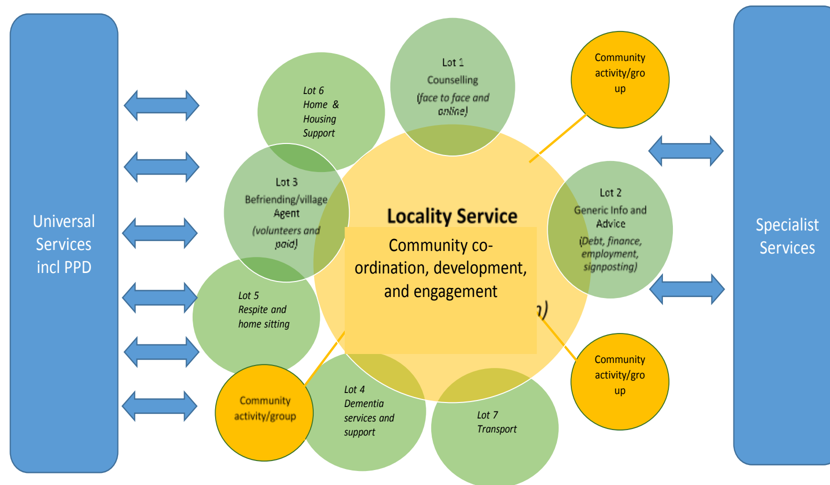
7.1 The improved FUTURE service will adopt as many of the principles and approaches that have been identified from the research and good practice models. Whilst the whole model will be for all age, the elements that will most likely meet the key requirements of older people will include the following:-

- **Home and housing support** – a service that provides older people with bespoke personal support and assistance to enable them to stay in, or get back to their own homes and provides a crisis response when needed, including a warden type scheme – based on the Rhayader Home Support Scheme.
- **Befriending / good neighbours / Day Sitting Respite Service** – offering low level individual or group befriending as required, with an emphasis on reducing social isolation and loneliness as well as support with everyday tasks. Loosely based on the Befriending Pilot in Crickhowell and RVS Good Neighbour Scheme. In addition we would seek to slightly expand the model to provide a Day Sitting / Respite Service designed to give care givers a break.
- **Dementia Service** – support for families and people affected by dementia including a range of therapeutic, social and informative activities, based on, but not necessarily exclusively on the MeetDem Centre Model and the embedding of the Dementia Friendly Community programme.

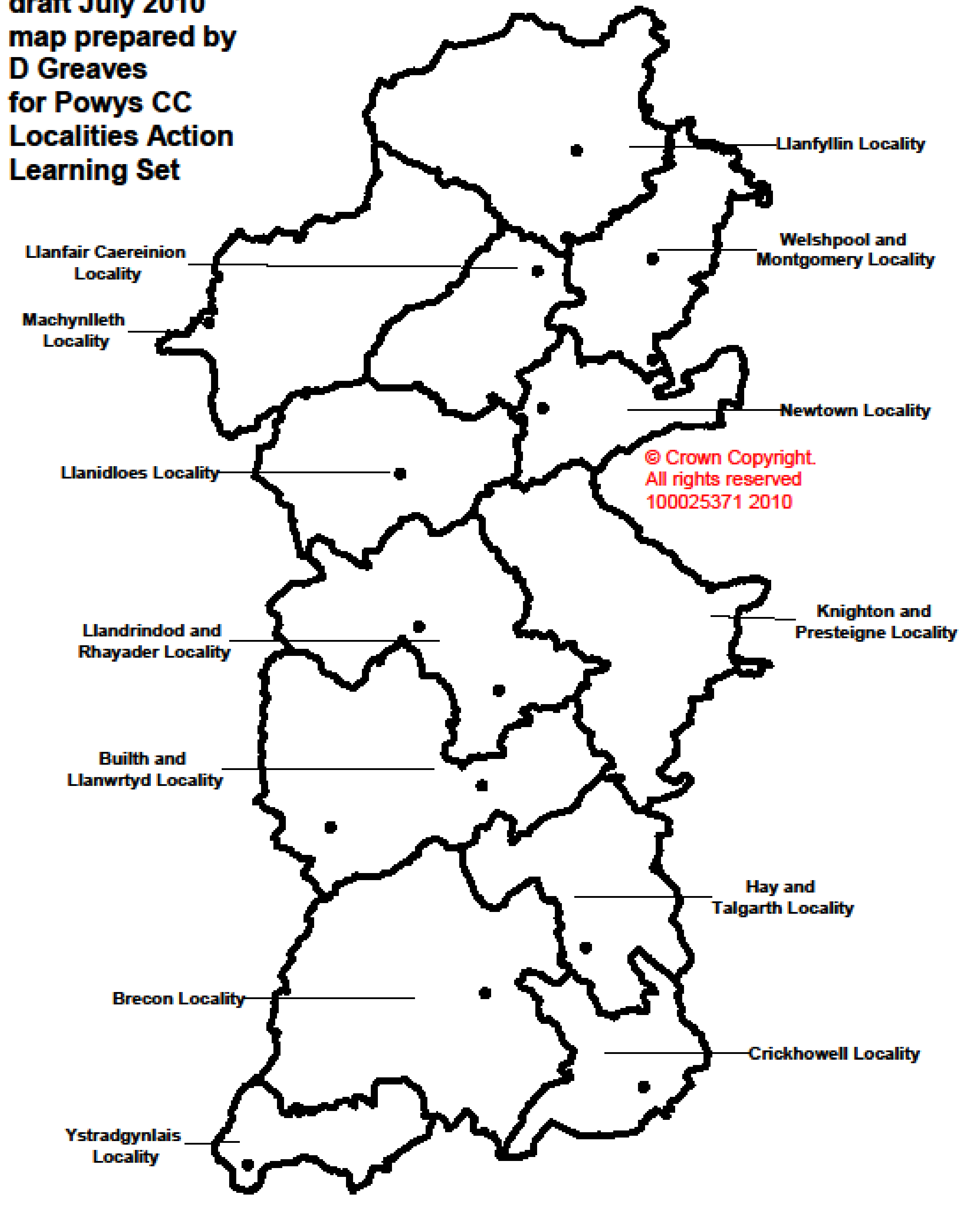
7.2 The core of the service will provide clear co-ordination as well as a community development / engagement function which should link to other universal and specialist target services such as Substance misuse. Domestic Abuse and Carers. It would also support the step up and down requirements from statutory services such as reablement and hospital discharge.

7.3 The diagram below provides a visualisation of the strategy and how different commissioning strategies will connect and overlap with, and link to, service delivery.

Locality Generic/Community Support Service Model (examples)



7.4 Although the communities are net yet defined we would be seeking to ensure all areas of the county are covered and that the service will operate at the lowest level that can be afforded ensuring that it draws on and develops local capacity and intelligence. For example it may operate in or around the 13 areas defined on the following map and used to map out the needs assessment:-



7.5 Following some low level informal consultation the new service has been referenced as the 'What Matters' service which has received a positive response – what matters could be a question or a statement and has been coined from the approach taken by the Supporting People Strategy. Whatever we call the service the branding will be important to ensure it is identifiable, easily accessible and seen as quality, independent and trustworthy. For the purpose of the service descriptor below we will continue to describe it as 'What Matters'.

7.6 Service Descriptor

7.7 What is the Service?

The 'What Matters' service would be a community based wellbeing and support service for anyone who has an additional need or a short term crisis that they need assistance to overcome. The main people we aim to help are:-

- The elderly frail or older people
- People with mental health conditions or learning disabilities

7.8 The service has been discussed positively at the Integrated Care Pathways for Older People group, along with other integrated planning groups.

7.9 In addition, the service will also provide non specialist assistance to help those who have found themselves in difficult circumstances such as having high levels of debt, being at risk of homelessness, problems with substance misuse, unemployment or domestic violence. It will endeavour never to turn people away and if no one has the skills or experience to help the service will work to find those that have.

7.10 How Could the Service Help?

The core staff team and other service providers will work with the person and or family to address 'what matters' to them, but the main aim is to help people help themselves or their own family, with the right kind of support, provided quickly at the right time and in the right place will help build capacity and independence and to not have to call on or rely on statutory services unless absolutely necessary.

7.11 We know from other models and the research that if people are helped early enough before things get out of hand and become difficult and a complex crisis, their quality of life, confidence and ability to cope are increased and they can in most cases become partly or fully self-sufficient.

7.12 What Kind of Things Could the Service Do?

It is difficult to list everything that the service will do because everyone is an individual and has different needs. The service will try to respond to any issue that presents, recognising that people often have more than one problem. Getting to know the person or family will help to identify the full range of issues but perhaps also the things they don't initially recognise. Here is a flavour of the types of things the service would aim to do for older people:-

- Advice and information about other local services
- Assistance in identifying benefit entitlements and help with the process of application
- Provide peace of mind and arrange regular visits and telephone contact to ensure people are alright.
- Provide short term emergency support if people are struggling at home with an illness, this might include small shopping items or getting a prescription and liaising with a GP
- If longer term support is required the service will help navigate the process.
- Provide help to someone after a stay in hospital and organise things for a return home and provide ongoing support until the person fully back on their feet. Alternatively providing support for going in to hospital.
- Provide short term personal care particularly if the person is waiting for a care package from social services.
- Respond to a fall and if the person is not injured to get them back on to their feet.
- Provide a 24/7 emergency response through the Careline Service and or telephone call out service.
- Help you get out and about by facilitating access to transport.

- Support for main carers to identify the help they need in order to ensure they can continue to care such as Day Sitting / Respite.
- Regular sessions for those with onset dementia and memory loss to support them and their family and carers
- Helping people stay in touch with their friends and or make new ones through a befriending scheme and the organisation of community involvement activities.
- Supporting access to food / lunches and nutrition.

Additional areas for the service to provide might include:-

- Pop in visits
- Help with correspondence and form filling
- Conversation and reading
- Walks
- Trips out
- Minor repairs and maintenance
- Small domestic and garden chores
- Dog walking
- Help with electrical devices and internet

7.13 **<u>How Could the Service Work?</u>**

- All our staff will be well trained and qualified to work with people with lower level, short term needs
- They will implement a proportionate assessment to identify main concerns – 'what matters'.
- Volunteers will be well supported and valued and also receive training to enhance their skills and qualifications.
- The service will co-ordinate the support of other services such as Care and Repair, Housing, Assistive Technology, Counselling Services, Domestic Violence support, Education or any service that might help improve a persons or family's wellbeing. This process will be called the Team Around the Person (TAP) or Team Around the Family (TAF)

7.13 In addition to the above the service will also support the development of new services, activities and opportunities where gaps have been identified. It will not just address 'what matters' to individuals but aim to help the community to help its self by encouraging communities to provide opportunities for social, leisure and cultural activities and or helping people take an active and valued role in their own community including volunteering, learning, education and employment.

7.14 **<u>Where Could the New Service Operate From?</u>**

The Service could operate from anywhere – it would not necessarily need to have a dedicated building and could be co-located with other services. Activities might take place in a variety of spaces within a community.

7.15 However one option is that it works alongside any developments to establish a community hub or co-location of other community services such as libraries, hospitals, community centres, church facilities, sheltered housing and extra care housing complexes etc. It is envisaged that it would be different for every community.

8 FORMAL CONSULTATION PLAN

8.1 The Review will go to Powys County Councils Cabinet following which a three month formal consultation will take place.

8.2 Powys County Council's Corporate Communications Team will be leading on the formal consultation and have prepared a formal consultation plan for the next stage of the process, please see Appendix 6

8.3 Depending on what the initial options that Cabinet want to take out for consultation preparation will start on a commissioning and or decommissioning strategy relating to the preferred model/s.

8.4 Following the formal consultation process a report will be taken back to Cabinet who will then make a decision about the next stage of the process after which implementation will start. This is predicted to be late in the Autumn 2016.

Appendices

Appendix 1 – Strategic Intent – Early Intervention and Prevention

Appendix 2 - Needs Assessment – Day Centre Business Intelligence Insight – Powys Overview

Appendix 3 - Listen and Learn Report

Appendix 4 – Crickhowell Befriending Pilot Evaluation

Appendix 5 – Over View Report – Rhayader Home Support

Appendix 6 – Formal Consultation Plan

Appendix 7 – Financial Profile for Phased Approach

Day Centre Business Intelligence Insights are available on request:

- Brecon
- Builth and Llanwrtyd
- Crickhowell
- Hay and Talgarth
- Knighton and Presteigne
- Llandrindod and Rhayader
- Llanfair Caereinion
- Llanfyllin
- Llanidloes
- Machynlleth
- Newtown
- Welshpool and Montgomery
- Ystradgynlais