

# Bridging the Gap

Addressing the challenge to fully utilise the third sector contribution in the management of complex care.

May 2011

## Document Information

<b>Title</b>	<b>Bridging the Gap</b>
<b>Date</b>	May 2011
<b>Purpose</b>	This document has been developed by the Continuing NHS Healthcare National Programme. It demonstrates the range of third sector services and schemes in place across Wales that complement and support statutory services in maximising all opportunities for independent living.
<b>Attention</b>	For the attention of Local Health Boards, local authorities, and third sector organisations across Wales.
<b>Action</b>	All organisations are asked to consider this report and the related action plan as part of their planning and service delivery arrangements.
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## Foreword

This report focuses on third sector services and schemes that support people with complex care needs, and also on work to support independent living; prevent avoidable decline; and re-able people as much as possible. You will all know about some of your local third sector services, and some of the national organisations – but this report aims to ‘bridge the gap’ in working collaboratively across the full range the third sector can offer and, in doing so, to provide high quality, sustainable services that meet needs in our communities across each LHB area.

The predicted population changes over the coming decade, with an increasing number of older people, coupled with a reduction in the birth rate, provide many challenges for public sector organisations. The implications of the changing demographic profile are significant, and the NHS and local government will find it increasingly challenging to manage the demands placed upon it, unless new approaches and service models are developed that exploit opportunities for collaborative approaches, including those that the third sector can provide.

National policy outlines and reinforces the need to protect and support independence, and to maximise all opportunities for independent living.

The third sector already plays an important role in working with statutory organisations to improve outcomes for service users. The services provided are very broad, and range on a continuum of social to medical care. Most often the third sector care and support is holistic and includes ‘small things’ that can make a community based package of care sustainable - assistance with paying bills, or with household maintenance, for example.

This report is one of the ‘deliverables’ of the Continuing NHS Healthcare (CHC) National Programme. The work of the CHC Programme is based on two main strands of development work – effective and high quality service models for those people who have complex needs and are eligible for CHC, and the upstream actions needed to support independent living and prevent avoidable dependency. Early in the life of the Programme, it became clear that the third sector has an essential role to play in both of these areas.

**Bridging the Gap** shows how the third sector provides services to support people through illness, injury, or longer term chronic ill health. Importantly, the report also shows the third sector’s valuable contribution in the identification of local service models and solutions, as well as those service responses that can be delivered nationally where that is appropriate.

There are good examples in most areas but, to offer sustainable service provision, we need to address the gaps.

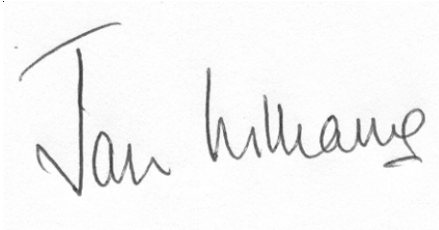
**Bridging the Gap** includes examples provided by third sector organisations across Wales. They are examples - they are not intended to provide a comprehensive list of third sector services, but, collectively, they demonstrate the range of creative service solutions, often with partners that support people to live more independent lifestyles across Wales. They should stimulate ideas and approaches for collaborative working and the development of service solutions.

The current economic climate makes it even more essential that agencies work in partnership to deliver truly seamless, integrated and sustainable responses to meet need.

This report identifies the third sector as a partner in meeting these demands, and the action plan included in the report proposes a way forward.

We ask you therefore;

- to bridge the gaps in your service provision for complex care, by exploring further how the third sector can support improved flexibility, responsiveness, and integration locally and
- to commit to implementing the report's action plan.



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# 1. Introduction

## 1.1. Scope of this Report

This Report has been developed as part of the ongoing work of the Continuing NHS Health Care National Programme. Its intention is to identify the role and contribution of the third sector both in supporting independence, and in managing complex and ongoing care.

The Continuing NHS Health Care National Programme (The Programme) is one of the 12 National Programmes that support delivery of the Five Year Service, Workforce and Financial Strategic Framework. This Framework sets out the strategic direction, approach and actions for NHS Wales over the next five years, and reflects the need for NHS Wales to work with its partners to deliver efficient, effective and responsive person centred services that meet need.

The Programme Board has broad and diverse membership that reflects the main areas of work being taken forward. In addition to supporting Local Health Boards in developing and implementing effective, efficient and flexible service models for those assessed as eligible for Continuing NHS Health Care (CHC), the Programme is also undertaking work further “upstream”, and within the context of Setting the Direction, seeking to support and maximise all opportunities to maintain independent living, support people with longer term and more complex needs to remain within their usual place of residence/care setting wherever possible, and prevent avoidable dependency on higher levels of care.

The third sector has a key and specific role to play in all of these areas, working in partnership with NHS organisations and local government to provide comprehensive, flexible, person centred care options. Evidence demonstrates their added value, and the ability to respond flexibly can be invaluable in keeping people within their usual residence/care setting. This Report aims to set out the diverse range of support provided by third sector organisations, identify opportunities for Health Boards and local government to consider as part of their overall service planning, and provide - at Appendix 1 - a number of example services and schemes that demonstrate the benefits both to individuals and to statutory services.

## 1.2. The Context

Population projections across Wales identify some significant changes over the coming 20 years, with a 75% increase in the numbers of people aged 75+ as a proportion of the general population by 2031. This increase is predicted in most local authority areas. During the same period, there is a reduction in the number of people of working age. The converging pressures of this demographic change, leading to increasing demand, and reducing public expenditure requires a new approach to public services, placing far greater emphasis on prevention and early intervention, and developing more community-based support to reduce the need for more costly services.

National policy and local service planning reflect these pressures, with *Setting the Direction* and *Fulfilled Lives, Supportive Communities* both setting out the need to develop integrated person centred service planning with the aim of keeping people within their usual residence/care setting wherever possible, and moving towards a more primary and community led NHS.

The third sector already provides public services across health and social care, but there is scope for public bodies to work much more imaginatively with the sector to develop services that are closer to citizens and more responsive to their needs, and which add real value by drawing on community resources.

The third sector brings:

- A citizen-dimension and expertise in service design to commissioning and procurement of public services.
- A tradition of 'co-design and co-delivery' – an approach in which service providers work with service users and carers in the provision of services – a working partnership that draws on the resources of the individual and potentially the community, as well as those of the provider.
- More flexible service delivery options (including through charities, social enterprise, mutual or co-operative provision) that are closer to and more directly involve citizens.
- Experience of supporting people to manage their own services and maintain independent living.
- Experience of prevention and early intervention, reducing future needs for more expensive provision, including supporting carers who provide 95% of care in the home.

With both public spending and the commercial market under pressure, the third sector – the organisations created by people and communities to meet the needs that they identify – has a critical role to play. It can develop responses and services that are closer to, and led by, people and communities, sometimes complementing those offered by the state and by the market, and sometimes improving on and replacing these. It has the flexibility to respond quickly to the fast changing landscape we are in. We need all three partners to play their part in meeting the challenges to get the best deal and best value for society.

### **1.3. The Continuum of Care**

The work of the CHC National Programme reflects national policy and sets out the continuum of care – this ranges from supporting and maximising the potential for independence and independent living, through self management models that enhance person centred approaches to chronic conditions, to the more complex and longer term requirements of people with complex care needs including, but not limited to, those who are eligible for CHC.

The continuum of care is not confined to adults. Children will also experience illness, injury and disability that may require support on a longer term basis. Such services tend to be provided on a partnership basis across all agencies and are not

considered within this Report. The need for a carefully planned transition into adult services for those children who are likely to have longer term needs that extend into adulthood is essential. Planning needs to begin from the age of 14 years to ensure a properly planned transition takes place.

A range of national reports on Delayed Transfers of Care undertaken by Wales Audit Office (WAO) during 2007/08 identified the risks to independence when a vulnerable person is moved from their usual care setting. Their work identified that admission to hospital can threaten independence very quickly, and that any delay in moving vulnerable people out of hospital can mean the end of independent living. They concluded that there are a number of key actions that need to be undertaken to ensure statutory services do not disable people when this is avoidable. These actions included:

- Further development of primary and community based service responses, including Intermediate Care type services, which support people within their usual residence/care setting, and deliver care/therapeutic inputs without the need to admit to hospital, where this can be avoided. In order to have the best effect, such services should be developed on a partnership basis and be available 24/7.
- If a person requires admission to hospital, discharge planning should be an active process that commences on admission, in order to avoid any delays that may threaten the potential to return home.
- In addition to the complex care that statutory organisations provide, there needs to be recognition of the added value of low level support in keeping people independent and within their own homes.

In addition to the 2007 Wales Audit Office reports, the National Assembly for Wales commissioned an Independent Review of Delayed Transfers of Care. This review was undertaken by the Welsh Institute for Health and Social Care and reported in 2008. Its conclusions mirror those of the previous WAO reports, and its recommendations were considered by the National Assembly for Wales Audit Committee in 2008. The Audit Committee produced its findings and proposed a series of recommended actions for policy makers to consider and include within future policy development.

More recently, the CHC National Programme has developed and issued *10 High Impact Changes for Complex Care*. This guide reflects the findings of both the WAO and the Independent Review, and sets out a series of recommended actions that, if adopted, will support improved management of those with complex care needs and support independent living.

#### **1.4. Range of the Third Sector**

The Third sector is very broad and diverse, and in being so can seem confusing and even daunting to partners as to how to approach working with it; and it can also be the case that partners are only aware of those organisations they traditionally work with and may therefore be missing additional opportunities. The third sector itself is aware of the difficulties its size and number of organisations and groups can pose for collaborative working and works to offer organised access to the sector, as well

as developing new approaches to better enable joint working both with and within the sector in order to make best use of resources and efficiencies (See Section 3 – Third Sector Delivery Infrastructure and Co-production.)

However the third sector and many of our partners would state that this is the third sector's very strength and value: this sheer scale and spread coming from its community basis which is shown in its reach and engagement with so many communities and client groups.

In Wales there are over 30,000 organisations and groups involving 1.1 million people as volunteers, taking their own action to benefit their own communities. The majority of these are small, local groups that receive no public funding (20,000 groups have an income of less than £10,000)<sup>1</sup>. They are run by volunteers who not only provide real benefits for people and local communities, but who also develop their own skills and abilities through their volunteering. Other organisations provide important services to the public, and employ an estimated 51,000 people in Wales. The sector promotes social justice, fosters social enterprise and community action, contributes to community and economic regeneration, and helps to create employment and raise skill levels.

The third sector encompasses community associations, self-help groups, voluntary organisations, charities, faith-based organisations, social enterprises, community businesses, housing associations, co-operatives and mutual organisations. They display a range of institutional forms, including registered charities, companies limited by guarantee (which may also be registered charities), Community Interest Companies, Industrial and Provident Societies and unincorporated associations. Each organisation has its own aims but all share the following common characteristics making them part of the third sector:

- Independent, non-governmental bodies.
- Established voluntarily by citizens who choose to organise.
- Value driven and motivated by the desire to further social, cultural or environmental objectives, rather than simply to make a profit.
- Committed to reinvesting their surpluses to further their social, cultural or environmental objectives.<sup>2</sup>

The profile<sup>3</sup> of the third sector active in health and social care in Wales is:

- 120,000 people involved in providing services: the majority of these are volunteers, but there are over 30,000 employees and over 5,000 trainees.
- Major service areas are general health and well being activities; older people; services for people with specific health conditions; carers (300,000 providers of unpaid care in Wales, Census 2001); people with physical, sensory or learning disabilities; people with mental health problems; and children and families.

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<sup>1</sup> WCVA Almanac 2009

<sup>2</sup> The Third Dimension: A Strategic Plan for the Voluntary Sector Scheme. Welsh Assembly Government January 2008

<sup>3</sup> Health Social Care and Wellbeing Services Provided by Voluntary Organisations in Wales: a Report for the Welsh Assembly Government, Bryan Collis WCVA, 2007

- The nature of the service provided varies greatly, with major activities including advice and advocacy provision, social support and support for people to live independently.
- Services can be delivered over different areas: a telephone help line might be local or national, whilst a drop-in will be local. Services for specific health conditions tend to cover a larger area than more generic services.

The Welsh Assembly Government has very clearly identified, in *Designed to Add Value* - a strategic direction for the voluntary and community sector in supporting health and social care 2008, the important contribution that the third sector can make to the shift in balance of NHS provision towards services that are closer to home, in communities and outside of the hospital environment. *Designed to Add Value's* stated vision is 'A dynamic, innovative, responsive and sustainable voluntary sector working in partnership with health communities ensuring the improvement of health, well being and independence for people and communities in Wales.'

The Independent Commission on Social Services in Wales report *From Vision to Action*, (November 2010) recommends a mixed economy of care and states, 'Opportunities to shape the market to innovate and achieve efficiencies are being missed. We recommend that private and voluntary sector providers should be more constructively engaged in the planning, design and commissioning of services. We also recommend that micro-providers and user-led organisations should be encouraged to contribute to self directed support arrangements.'

In terms of quality assurance and safety, third sector organisations that are funded by the NHS as partners in the delivery of health care, are required to use the Welsh Assembly Government's *Doing well, doing better – Standards for Health Services*. These standards are in place to enable all NHS organisations to look across the range of their services in an integrated way to ensure that all that they do is of the highest quality. With a focus on improving health and wellbeing as well as providing high quality and safe healthcare, the standards provide a framework for third sector organisations to consider all aspects of their service provision, acting as a mechanism to drive forward safety and quality improvements where needed.

To assist third sector organisations to use the Standards for Health Services a guidance document and support programme for the third sector is currently being introduced in partnership by the Welsh Assembly Government, WCVA and the County Voluntary Councils.

## **1.5. The Third Sector and Funding**

Many third sector organisations neither seek nor receive public funding as they are small groups and self finance their own activities. Public sector funding is however of major importance to many other third sector organisations and the people and communities they work with, as this funding provides the platform for a wide range of activities and services that are an essential component of the wider public services on which people and communities depend.

Analysis of 2008/09 funding for third sector services in Wales demonstrates that local government spends only 3% of its total budget on the third sector. This is within the context of 21% of local government expenditure allocated to social services and social care. A similar picture is demonstrated when examining NHS funding over the same period. Funding to third sector organisations has not kept pace with inflation; with only 0.3% of total health spend in Wales invested in the third sector<sup>4</sup>.

The most significant aspect of central government funding is its “strategic long term funding commitment” to the core funding of organisations, networks or partnerships with Wales-wide coverage. Local government is a significant core funder of local organisations, with the trend showing an increase in service level agreements and contracts rather than in grants.

Uniquely, the third sector almost always adds direct cash value to any funding it receives from the public sector, drawing in funding from additional sources as well as adding direct value in kind through volunteer effort. Research carried out by WCVA on behalf of the Welsh Assembly Government mapped the health, social care and well being services provided by third sector organisations in Wales. This found that the sector provided an estimated total service budget of £292 million; of this, just less than 50% was provided by the Welsh Assembly Government, local authorities and the NHS. For every £1, the third sector secured over an extra £1 from other sources.

Care & Repair Cymru has identified that each £1 it spends on its Rapid Response Adaptations programme saves public services around £7.50 by speeding up hospital discharge and reducing bed blocking, preventing hospital admissions, and avoiding the costs of residential care and more expensive support.

The Matrix research into housing-related support, commissioned by the Assembly Government, showed that for every £1 spent, £1.68 was saved across other policy areas such as health. Housing-related support in Wales is provided primarily by third sector organisations. One organisation that provides accommodation for seven adults who require an intensive level of support saved the local authority £0.5m in its first year by bringing clients who were based out of county back to their home area.

Research in England into the Partnerships for Older People Projects (POPP) pilot programme demonstrates that prevention can be both effective and deliver value for money: for every £1 spent on preventive services, there was an average £1.73 benefit to the health and social care economy, even in the short term. POPP has increased the evidence base on the benefits of prevention, early intervention and integration by promoting joint approaches to independence in place of hospital or long-term institutional care. Key messages from the research are that meeting people’s needs with a preventative approach can create efficiencies; these efficiencies are available across the health and social care system; quality of life can be improved through preventative approaches; and preventative services can be sustained (as they often win the argument by demonstrating their cost-benefit).

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<sup>4</sup> Third Sector Statistical Resource 2011 WCVA

For the past three years, initially Brecknock & Radnor Crossroads and then Crossroads Mid & West Wales, has been delivering a pilot project in Powys, aimed at supporting people living with cancer and their carers. It is a well-established fact that the stresses under which carers are placed, as a result of their caring role, has a hugely negative impact on their own health and well-being, which almost invariably results in consequential costs on health and social care services when carers themselves are no longer able to maintain their caring role. In palliative care situations, this effect is even greater, as the mortality rate for female cancer sufferers is approximately 44% and for men 57% (Cancer Recovery Foundation data 1976-2005). The choice of where to die and to be able to die with dignity is of high importance and the impact of the pilot project has been considerable in this regard. During the period of the project to 31 August 2010, 119 patients and their carers have benefited; 59 patients had a terminal diagnosis and 47 (80%) were able to die at home. The estimated savings to the NHS during this period exceeds £250,000, generated by a service that costs £50,000 per annum.

Third sector organisations are responding to the current public expenditure situation and seeking efficiencies. A number of organisations have entered into mergers and other forms of joint working. However, the sector would be concerned about funding being used to introduce inappropriate rationalisation. Different organisations exist to serve the needs and interests of their client or citizen base having established local roots and developed their specialist services, through their ability to engage and involve their local communities. These are qualities that should not be lost.

There are however, circumstances where mergers and joint working make sense, which could lead to the provision of better and more secure services for citizens. This could also help with cost saving, although the focus should be more about consolidating and extending services and adding value rather than solely being concerned with cost reduction. For example:

- Community Housing Cymru and Care & Repair Cymru have created a group structure, under a single Group Chief Executive, that shares back office services, as well as pooling policy and other expertise to create additional efficiencies.
- Age Concern Cymru and Help the Aged in Wales have merged to create Age Cymru.
- St David's Foundation Hospice Care and Usk House Day Hospice have merged and will be able to enhance their services across a wider geographical area.
- The Crossroads schemes in Ceredigion, Pembrokeshire and Powys have formed a single organisation, Crossroads Mid and West Wales, unifying their administrations and operational management, and creating a more sustainable entity that would provide a vehicle for more cost-effective and efficient administrative support systems; facilitate access to larger funding opportunities and contracts; increase the volume of service provision; and allow wider partnership working with the public sector. This was done with no interruption to service provision, no compulsory redundancies and no reduction of employee terms and conditions.

There is also scope for increasing collaborative working with statutory partners, for example:

- As part of admission avoidance/supported early discharge services.
- As part of integrated service models that provide complex care to people within their own homes/community settings.
- As partners in developing specialist service responses, including housing, for people with specific and complex needs.
- As key partners in schemes and services that help to promote healthy lifestyles and independent living.

If it is accepted that the third sector service providers are an appropriate way to enabling significant contributions to be made to supporting complex care, it follows that the third sector and partners should work to both:

- understand more fully the social return on investment that the third sector represents.
- work together to maximize the full potential the sector can make to services within communities.

## 1.6. The Value of Volunteering

### Case Study

#### The Role of the Voluntary Sector in Delayed Transfers of Care (DToC) Hospital Discharge and Prevention of Readmission

June 2010 Bangor University, Welsh Assembly Government, WCVA

This published research demonstrates the value of organised volunteering in reducing delayed transfers of care and avoiding unnecessary admission to hospital. British Red Cross operating out of Ysbyty Gwynedd provide via volunteers managed by paid staff a home from hospital service for two counties made up of transport and escort; care and support in the home; and equipment loans.

The research 2008-9 detailed the cost of providing the service within the context of hospital bed-days saved, by either preventing an admission or by assisting a discharge and preventing a delayed transfer of care consequently freeing up a bed. A conservative assumption was that each referral saved only one bed night. The home from hospital service has taken 344 referrals, so the conservative estimate of the impact of this service is that 344 bed days were created through the prevention of a delay

136 wheelchair loans and 15 commode loans were made in the year 2008-2009, allowing many people to be discharged without a delay

The service is citizen-centred, the aim being to reduce or preventing a stay in hospital, enabling an improved quality of life, and the maintenance of independent living.

This holistic, person centred approach also offers an important befriending role, providing emotional support and relevant information about other sources of help. The service has the advantage that it is not restricted by geographical or organisational boundaries. This means that it can respond promptly, easily establish communication between different sectors, and is effective in encouraging people to take up services that can help prevent readmission to hospital.

Volunteering is freely undertaken and not for financial gain; it involves the commitment of time and energy for the benefit of society and the community.

Volunteering plays an essential role in the economic and social fabric of Wales. It is estimated that some 1.1 million people volunteer within an organisation each year, contributing around £1.6bn to the Welsh economy (WCVA Statistical Resource 2010). Volunteering helps build social capital and community cohesion and plays an important role in the delivery of key public services.

The profile of volunteering in health, social care and wellbeing services in Wales is 85,000 volunteers providing the equivalent of nearly 30,000 full time posts<sup>5</sup>.

Volunteering is also good for the volunteer: it helps improve health and wellbeing and provides opportunities for individuals to acquire skills and knowledge that can enhance career development or employment prospects. Volunteering has a key role to play in addressing the Welsh Assembly Government's workforce strategy for the social care sector by providing the necessary work focused experience required for students undertaking academic courses linked to health and social care or the social work degree course. Volunteers also have the opportunity to demonstrate the attributes as well as the skills necessary for a career in social care such as sound values promoting dignity, respect and choice.

There are therefore very real economic and social opportunities for our communities in Wales through voluntary activity and the time, skills and commitment given by volunteers in terms of complex care services.

These findings complement those from other reports<sup>6</sup> on delayed transfers of care and the need for holistic and joined up services. In addition, they highlight the positive impact of services provided by the third sector and volunteers, and the contribution made by these services to the Welsh Assembly Government's strategies *Designed to Add Value*, *Designed for Life* and *Fulfilled Lives Supportive Communities*, and the Framework for Services for Older People.

It is important to reiterate the following principles for volunteering: WCVA has jointly developed with the TUC, a Charter for Strengthening Relations Between Paid Staff and Volunteers,

This Charter stands between WCVA and Wales TUC as a statement of principles and good practice. It is commended for use by individual unions, volunteers involving organisations in public, third and private sectors and other bodies, to stimulate discussion and good practice regarding the appropriate, harmonious and mutually rewarding involvement of volunteers. Charter Principles:

- Volunteering is undertaken by choice and individuals have the right to volunteer, or indeed not to volunteer.

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<sup>5</sup> Health Social Care and Wellbeing Services Provided by Voluntary Organisations in Wales: a Report for the Welsh Assembly Government, Bryan Collis WCVA, 2007

<sup>6</sup>Wales Audit Office (May 2009) Delayed transfers of care follow-through; National Assembly for Wales, Health, Wellbeing and Local Government Committee (May 2010) Report on Inquiry into Wheelchair Services in Wales

- While volunteers should not normally receive or expect financial rewards or incentives, they should be reimbursed for reasonable out of pocket expenses.
- The contribution of volunteers and paid staff should complement one another. Volunteers should not be used to replace paid staff or to undercut their pay and conditions of service. Volunteers should enhance the quality of an organisation's activities.
- Where there is a contract for service delivery, volunteering should be expressly included in the contract. Volunteer involvement should not, however, be solely used as a means of reducing staffing costs.
- It should be clearly established how the individual meets the criteria for 'worker', 'volunteer' or voluntary worker' as outlined in the National Minimum Wage Regulations. This should equally apply where the individual is undertaking a role in an internship capacity.
- Effective mechanisms should be in place to support and develop volunteers; these should be considered and costed when volunteering projects are being planned.
- Volunteers and paid staff should be given opportunities to contribute to the development of volunteering policies and procedures.
- Volunteers and paid staff should be able to carry out their duties in safe, secure and healthy environments that are free from harassment, intimidation, bullying, violence and discrimination. All should be treated sensitively with regard to their preferred language.
- Volunteers and paid staff both should have access to appropriate opportunities for learning and development.
- There should be a recognised process for the resolution of problems, for both staff and volunteers.
- Volunteers should not be used to undertake the work of paid staff in the case of industrial disputes.

In terms of public services, this is a transitional period for Wales with public service model development recognising that old models of delivery may be overtaken by new ones in seeking to transform services to become more citizen-centred.

Potentially volunteers have a major contribution to make to services that support and develop wellbeing and independence. Good practice examples highlight the importance of exploration and negotiation being enabled between the statutory (paid) sector and the organised volunteers.

This is vital in developing new service models that bring multiple benefits and value gains in both economic and social terms, resulting importantly in a better quality of life for all in that community.

## 1.7. The Range of Third Sector Inputs - 'soft' and core inputs

The third sector can contribute significantly towards:

- More services to support people in their communities, by working on the ground with our client groups and communities to meet local and individual need.
- Personalised and improved public services.
- Reductions in geographical health inequalities, by developing third sector services that we are best placed to deliver.
- Strategic, effective national and local planning as a sector, using our existing infrastructure and networks to contribute to service delivery with our partners, and the efficient use of resources.

As stated at the beginning of this report, because the third sector is large and diverse, partners and even other third sector organisations may only have experience of some types of service delivery and activity. This has in some cases led to the sector's contribution not been understood fully in the round, and a false distinction being made between the commissioned (contracted or service level agreement) service that sits alongside and makes up statutory provision, and additional activity, usually at the local and neighbourhood level, that can be seen as 'softer', 'fringe' and by implication of less value.

Public services may be just about keeping pace with current demand, but there are pressure points. There are also serious issues about people's quality of life. We may have been successful in helping to keep people in the community, but we have had much less success in helping people to become part of their community. More support does not necessarily mean a better life or more independence, and issues of loneliness and belonging are often more critical than the quality of personal care. People are very vulnerable to changes in their community; shops, transport, neighbours, local groups; and the less stable these are, the more people rely on professional agencies for belonging.

This report has already stated that the value of the third sector contribution is that the sector can develop responses and services that are closer to and led by people and communities (Section 2 goes on to explain this service model in greater detail). We would argue that our services are often uniquely holistic, and that this is achieved by working with other colleagues within the sector to get the menu of skills and expertise required. Also that with the growing self-directed services, under the personalisation agenda, that being able to deliver this mix of core and softer, more personal services will be an increasing strength.

## 1.8. Current Context and Common Aims

The NHS, local government, independent and third sector organisations are all experiencing the impacts of the current challenging economic environment. Whilst this is without doubt a difficult period, there are opportunities to consider alternative and innovative approaches that operate in an integrated fashion to deliver shared service responses that are person centred.

Population projections, combined with the increasing demands from an increasingly ageing population, present us with a unique opportunity to refocus service planning and develop alternative approaches that seek to keep people as well as possible and as independent as possible for as long as possible.

Medical and therapeutic advances have led to people with catastrophic illness and/or injury now surviving, but with complex needs. This is, without doubt, something to celebrate, but it does mean that statutory and voluntary organisations will need to consider how to redesign current service models to meet these needs, within settings that are appropriate and reflect personal choice.

The overall shift in position outlined in *Setting the Direction* towards a primary and community led NHS in Wales will also mean that, over time, more people will receive care within their current place of residence/care setting, and that admission to hospital will not be the care option of choice if this is avoidable.

If, as partners, we are to meet these challenges then we need to identify and capture opportunities to further develop integrated service planning and delivery that are flexible, responsive, cost effective, and are able to meet needs across the continuum of care.

## 2. Co-design and Co-delivery Service Model

### 2.1. What is it and why is it Important?

The ideas of co-design and co-delivery are not new and are part of the tradition of mutuality and community. It has been restated as strong service model for our times, in answer to very specific needs because it can deliver services that are:

- Citizen-centred and therefore of better quality and with better outcomes for the service user.
- Efficient and sustainable in making best use of all the resources in a community.
- Empowering and energising for everyone involved.
- Progressing the personalisation agenda in a form applicable for Wales that is community based.

There are ways of developing future public services which create a bigger resource 'cake' and which deploy, not just public sector staff and budgets, but also users, families, neighbours, local third sector organisations and the wider community in a 'total service' which goes beyond traditional service provision and releases new resources, skills and energies. It means commissioned services and self-organised support complementing each other rather than operating in isolation. This needs a new equation that measures the total value of a service and benefits for the citizen (taking account of all resources deployed – employed staff time, user input, volunteer time, community support groups) against the public sector investment. The prize is to use our public funding in ways that lever in additional resources – to achieve better value for the citizen.

This can mean a new approach based on co-design and co-delivery of public services, where activities and services are designed and delivered by a wide range of actors – bringing together the independent third sector and the public sector with the citizen and the community at the centre. It means investing in community capacity and initiative in order to provide mutual support that complements, and reduces demands on, other services. The approach can involve:

- Citizen-directed support
- Service user led services
- Community led services
- Mixed volunteer and staffed services
- Integrated services

These types of services are already happening across Wales (see Section 2.2 below for more information) and there is the need to systematically embed the approach in commissioning practice if we want significantly more. WCVA is supporting the third sector to achieve this through the development programme for

*Fulfilled Lives, Supportive Communities Commissioning Framework Guidance and Good Practice*, which includes Value Wales' Procurement Route Planner.

Innovative partnerships between commissioners, service users and providers can focus on mutuality and co-production in service design, bringing service users greater choice and control, and charged with achieving strategic coherence between service level outcomes and wider social, economic and environmental sustainability.

We need to encourage more radical approaches to reviewing and designing service delivery. A "whole system" approach to commissioning should be able to re-think what services are required to meet the needs expressed by citizens and service users. It would take account of all services that citizens' use, which may not be only those formally, provided or procured by the public sector. Many services that citizens use and depend on are provided outside statutory provision.

Co-design means that commissioners and service providers work with service users and citizens to design services. The challenges for commissioners are varied. They include how to ensure an effective representation of the local service user population and utilising different approaches to engagement and co-production that go beyond traditional consultation meetings.

The process of how to engage is as vital as the methods used to engage. Effective service user engagement requires a culture in which a commitment to understanding the complex needs of service-users is paramount in commissioning and delivery of services. This demands those who commission and plan services to think and behave differently to the existing way of doing things.

The Welsh Assembly Government is supporting Participation Cymru to extend its work with public services, and to provide a central information and advice resource for those responsible for public engagement. It is already working with a number of LSB's and LHBs in their work on Citizen and Community Engagement. The strength of partnership working in engagement work pays dividends. The overall view from service users and the public in general is that they do not want to increase the amount that they are consulted but rather improve the experience of the engagement itself.

The commissioning and procurement procedures need to build in and assess co-production.

Service specifications can be broadened to include activity that will improve people's well-being and quality of life, and sustain independent living. For example, whilst an individual may have an immediate health or social care need, their longer term independence and quality of life could be enhanced by:

- Making new friends if wanted
- Exploring different experiences
- Sharing skills
- Help with accessing internet-based services
- Experiencing stimulating social, creative or physical activities

- Helping to form groups of people who share the same interests
- Developing friendship and support from groups
- Exploring options and opportunities
- Seeking solutions to problems and barriers

We need to commission services from providers that are equipped to address these, for example through:

- Advice, Information and Advocacy: signposting to or provision of information, advice or advocacy on services that can meet an individual's needs and that support independent living. This could include where appropriate support to individuals to help them maximise their income through benefits advice and assistance with form completion.
- Developing networks of support: identifying and working appropriately with a service user's own network of support.
- Building community links: one-to-one support to enable a person to re-engage with their community of interest to address social isolation. This can range from a locality based social diary outlining activities, to personal introductions into local groups, signposting to befriending services, support to use the internet, or confidence building to leave the home and /or use public transport.

Procedures should require providers to express the ways in which they would involve service users and draw in additional support. Prospective providers should be required to answer specific questions on service user involvement, and how they can assist people to access a wide range of services from statutory, third and private sector providers in accordance with the individual's needs.

Service providers should be assessed against:

- How their service identifies and mobilises service users' strengths?
- How their service assists people to participate in community life and benefit from community networks and support?
- How their service supports people in finding ways to help and support others, including fellow service users, family, neighbours and the local community?
- Where appropriate, how their service creates additional benefits through the contribution and development of volunteers?
- How activities and approaches meet both service level and community level objectives and outcomes?

## **2.2. Overview of Current Examples**

Examples already happening in Wales, delivering enhanced services at reduced cost, include:

- Out-of-hours transport from hospital and support for older people who are clinically able to return to home, helping to avoid re-admissions. The saving on the cost of re-admissions more than covered the cost of the service in 2009.
- Involving volunteers in longer term support and relationships with young people leaving care and, in turn, care leavers volunteering themselves through Millennium Volunteers.
- Integrating statutory and third sector services into a seamless Intermediate Care Service.
- Direct payment schemes which increase user satisfaction, independence and control, and also produce both savings and an enhanced service.
- Community alliances bringing together people needing care and support with local groups to build formal and informal networks and structures to meet their needs.

## 2.3. The Challenge for the NHS

The Delivering a Five-Year Service, Workforce and Financial Strategic Framework for NHS Wales: Project Summary and Recommendations sets out the key aims for the NHS in Wales and its partners as to secure:

- Improvements in quality of service that reduce variation, waste and harm
- Patient-centred care
- A cohesive, motivated and professional workforce
- Better value for money
- Affordable world class health and social care services for the citizens of Wales

The Framework sets out the need for transformational change in the way services are developed and delivered, and identifies four key areas of focus in making this happen:

- **Improving performance, quality and financial stability by reducing harm, waste and variation:** building on the solid foundations of the 1000 Lives Campaign and intelligent targets to promote adoption of best practices on an “adopt or justify” basis that will deliver the best possible care.
- **Capturing the opportunity of integration:** balancing health improvement and health care, creating integrated care, and aligning all the support systems, with a stronger focus on the role of the patient, carer, and citizen as co-producers/directors of their own health and care packages.
- **Empowering the front line:** providing clinical and non-clinical staff with the tools they need to lead change and deliver highly quality care.

- **Supporting services to deliver through good government and strong partnerships:** ensuring that the combined role of Chief Executive of NHS Wales and Director General of Health and Social Services within the Welsh Assembly Government is used to the full to drive joined-up working between NHS Wales and government, and a much wider partnership working agenda across government and public service to improve quality of life and well-being.

The Framework also sets out the context, the challenge and the evidence available that identifies why we need to move towards a more integrated approach to service delivery. Some examples provided are:

- Health outcomes are poorer in Wales than for our peers
- Age standardised death rates are higher than in England
- Cancer mortality in Wales is declining but significantly lags behind international rates
- The chronic disease burden is severe, with one-third of all Welsh adults (~800,00) have at least 1 chronic condition
- 57% of adults are overweight or obese
- The most deprived segment of the population is 50% more likely to have a limiting long term illness
- An aging population is stretching resources - the number of people aged 75+ will increase by 75% by 2031
- System performance leaves room for improvement
- Hospital capacity is strained by suboptimal use
- A 999 call is 30% more likely to lead to a hospital admission than in the best English regions
- Financially, the current system is unaffordable

The challenge is to ensure continued support for, and growth and development with, relevant third sector organisations whose work:

- Focuses on prevention or early intervention, avoiding or reducing much greater public expense over a relatively short period of time
- Draws in additional resources (financial and human) to provide more value for people and communities
- Builds capacity in communities to take their own action and enable people to support each other and promote mental well-being
- Is indispensable in that no other agency or group of agencies could credibly provide the service offered
- Provides more efficient and effective ways of meeting objectives

### 3. Third Sector Delivery Infrastructure and Coproduction

This section explains how the third sector is organised to work with LHBs and Local Authorities – the key role of County Voluntary Councils and Local Compacts; national umbrella organisations; and national networks.

As stated earlier the third sector in Wales includes over 30,000 organisations, of which 1,200 are all-Wales organisations; 1,200 regional organisations; and at least 27,000 local organisations and groups. The third sector is organised and has an infrastructure to enable it to work at community, local authority level, regional and national levels: this is continues to evolve and be developed to best meet beneficial partnership working.

The Wales Council for Voluntary Action (WCVA), the County Voluntary Councils (CVCs) and the Volunteer Centres are in formal Partnership Agreement with the Welsh Assembly Government recognising the generic support role these give to the third sector and their national, regional and local responsibilities.

WCVA is the national umbrella body for the third sector in Wales. WCVA represents campaigns for, supports and develops voluntary organisations, community action, and volunteering in Wales. It represents the sector at a UK, and national level, and together with a range of national specialist agencies, county voluntary councils, volunteer centres, and other development agencies, it provides a support structure for the third sector in Wales. It has over 2,500 members, and is in touch with many more organisations through a wide range of national and local networks. WCVA's continuing specific work with the sector on health, social care and well being, includes facilitating the:

- Health, Social Care and Well Being Network
- NHS Third Sector Reference Group
- Local Health and Social Care Facilitator Network
- Biannual third sector meetings with the Welsh Assembly Government Minister for Health and Social Services, and the Deputy Minister for Social Services
- Third sector representation on key national working groups.

Health and social care national third sector organisations are organised around supporting addressing particular medical conditions and/or client groups and have developed specialist knowledge and expertise. A well recognised example of a national umbrella body is Children in Wales. Some national organisations are UK wide, for example The Alzheimer's Society and The British Lung Foundation. Others are organised to have a structure in Wales, for instance The British Red Cross in Wales, Cross Roads Care Wales. Some are specific to Wales, for instance Age Cymru. The majority have local groups or branches, or federations both delivering services and fundraising very much embedded in communities. The national bodies bring essential efficiencies and economies of scale in working; alongside ensuring standardised training and quality assurance; and lobbying and campaigning.

County voluntary councils (CVCs) work to support and facilitate dialogue between the third sector in their areas, and local authorities and local health boards. A number of local authorities are entering into discussions with the sector in their area about the funding situation, not only to keep organisations informed, but also to discuss options for service delivery and new ways of working together.

The CVCs each have a Health and Social Care Facilitator post, established by the Welsh Assembly Government's initiative Building Stronger Bridges to develop strong partnership working with the NHS and local authorities. These posts continue to deliver a pivotal local role in enabling third sector engagement and participation in the health and social care agenda in a facilitated and organised way.

CVCs work with the local third sector, and now with the LHBs coming into being also in these new regional areas with the other relevant CVCs to ensure that the third sector is able to engage meaningfully and work strategically. The role of the CVC's is critical to the new engagement structures: across Wales there are 19 CVC's with the aim 'to support, promote and develop the third sector and have a role in co-ordinating local networking'

For instance the Abertawe Bro Morgannwg University (ABMU) LHB area brings together the CVCs for Bridgend, Neath Port Talbot and Swansea with over 4,000 local third sector organisations in total. The CVCs in ABMU have worked to replace the ad-hoc and historic with an organised and structured third sector so that it is in a position to work with the LHB in a strategic way and to give a clear message that "we are organised and in a position to discuss how we can develop and deliver services with, and for, the Health Board".

The local Health and Social Care Facilitators employed by each CVC have a key role in this organised local third sector working. In the ABMU area the three Facilitators are engaged in and enable:

- The Local Compact between ABMU LHB and the local third sector
- a new regional Health and Social Care and Wellbeing Network meeting quarterly in each of the localities on a rotational basis with the Facilitators encouraging local involvement
- Monthly ABMU wide meetings held with the LHB Third Sector Non Officer member and the Planning Officer for ABMU LHB
- Joint regional events including a Designed to Add Value workshop which gave the third sector the opportunity to input into the Five Year Plan, with a further event planned to enable the sector to highlight what it can provide to support the delivery of the Health Board's objectives
- The recruitment of third sector representatives to the Stakeholder Reference Group (SRG), with the Facilitators regularly meeting with these representatives to ensure support and communication to and from the sector
- Both the CVC Directors and the Facilitators are part of the working group overseeing the Review of Third Sector Service Level Agreements, with each Facilitator being the third sector member of the Community Network Zones

- The Facilitators also work together as a team: for instance mapping all health and wellbeing related third sector activity across the ABMU area in conjunction with ABMU's Partnership Manager; the CHC locality meetings; and using a rota system to attend regional groups such as the South Wales Neurological Alliance

In ABMU, as in all other areas across Wales, the CVCs therefore have a structure that offers organised access to the third sector, and over the coming months they will be building on the relationships with the Health Boards in developing new approaches to make best use of resources and providing efficient, effective and responsive person-centred services that meet local need

There is similar joint working within health. For example, Hywel Dda Health Board is working collaboratively with the county voluntary councils in its area to "co-design" what the third sector role can become as part of the whole health, social care and wellbeing system. They are exploring how to maximise the third sector's role and that of carers and volunteers. They are also exploring a procurement portal across the Hywel Dda area in partnership with Local Authorities and the CVCs in order to generate more appropriate service specifications which can be met by collaborative tenders from a cohort of third sector organisations from the large national charities to the small local groups.

Hywel Dda believes this co-design, if it is to be done well and really deliver better services within the reducing financial envelope, will need twelve to eighteen months and therefore will aim to roll forward existing contracts into next financial year to allow this development work to be done, prevent service gaps and if necessary enable organisations to have sufficient time for a planned exit strategy.

Working relations between the third sector and both the local authorities and the LHBs are formalised through Local Compacts, these are agreed codes of practice including funding, partnership working, and scrutiny. The Local Compacts are developed by the CVCs, with WCVA carrying out annual monitoring to support this. The CVCs are also beginning to develop Memorandum of Understanding with the Community Health Councils in order to best utilise the third sector's networks and client groups in engagement and consultation.

### **3.1. Current Good Practice: the consortia model; brokerage; linking national and local third sector service providers**

The small scale of most third sector providers and social enterprises may be problematic in terms of commissioning and procurement, but it may be precisely what citizens need in terms of personal, local, holistic, flexible and participatory service delivery.

County Voluntary Councils in their generic support role to the local third sector have been leading developing mechanisms to address this.

**The Consortia Model:** A consortia offers a potential solution through collaborative service delivery by partnerships of both third sector organisations and statutory partners. Planners have a single point for the procurement of service packages for

specific population groups on a regional and local basis. A consortia can be a fluid alliance that charges and reshapes itself according to need with service packages that are both dynamic and responsive.

The Welsh Assembly Government funded a pilot led by the Health and Social Care Facilitator for Conwy CVC to develop a consortia linking intermediate care seamlessly with local third sector services, called the CICS project. The third sector services were able to address the identified gap where clients had returned to a level of physical health and no longer required the services of the Intermediate Care Team but still needed support to return to independence. This pilot has been successful and the aim is to mainstream it and roll out this approach to other service provision. The consortia are made up of:

- British Red Cross, the host organisation for the service coordinator post and volunteers
- Crossroads Care North Wales, host for the carer respite service
- Conwy Community Directory Partnership
- Conwy Intermediate Care Service

**Brokerage:** The CVC for Pembrokeshire introduced two broker posts in October 2010. Their role is to utilise knowledge of the local third sector in Pembrokeshire, in order to support the work of the Community Resource Teams by brokering the services the third sector can provide.

People dealing with poor health are often dealing with a range of other issues, such as low income, social isolation and unsuitable housing, and in these situations additional support can make the difference between staying at home and having to be admitted to hospital or a care home.

While the NHS and Social Services have a clear role in assisting people, the third sector comes into its own in providing services that are not available through these agencies, and providing them in a flexible way. The third sector already has some established core service provision such as hospice care, support for carers and meals on wheels. The sector also provides a large range of other important services from cancer support, to toe nail cutting, to welfare benefits advice. Many of these services are provided free or at low cost and can be delivered in a way that suits the client's needs.

The Community Resource Teams have been set up to help people with health problems to avoid unnecessary stays in hospital or care settings. The first team began operating early in 2010 in North Pembrokeshire: there are now four teams covering the whole county, the brokers support two teams each. Teams meet weekly and the meetings include district nurses, social workers, occupational therapists, physiotherapists and community psychiatric workers. Feedback from the Teams to the Brokers suggests their input to the work of the Community Resource Teams is valued. To date the Brokers have been involved with at least two hundred cases, giving advice, researching options or making referrals.

**Linking National and Local Third Sector Providers:** In Powys, the Health and Social Care Facilitator with the CVC is leading an action leaning project on

encouraging more national and local third sector service providers in health and social care to work collaboratively in the county. Managed by WCVA and funded by the Welsh Assembly Government this work seeks to address a specific aspect of improving access to services in rural areas through developing integrated and efficient service models, under the Rural Health Plan. The Powys CVC project is:

- Identifying barriers to national and local third sector organisations working collaboratively in an LHB area
- Developing the CVC brokerage role to address these barriers
- Contributing to evaluation of activity to produce learning and good practice for other CVCs and the third sector to implement.

## 4. Making It Happen: Enabling the Full Third Sector Contribution Pan-Wales

### 4.1. Identified Barriers and Solutions

Firstly, people need access to properly funded, and more citizen centred public services when they need them, delivered by those organisations best placed to meet their needs. In many cases this can be delivered by organisations in the third sector or through citizens directing their own care.

Secondly, people want far better integration between both formal public services and other community support for those who are vulnerable, and need additional help to maintain their independence and well-being. There are examples of this in some areas between the third sector, health and social care, and these approaches need to be far more widely replicated.

Co-design and co-delivery in public services is needed to bring enhanced value and support for citizens:

- The balance of existing provision, including relative take-up and relative costs, and the fit between different services
- The required balance between meeting short-term needs, and developing longer term strategies for prevention and self-reliance
- The value of services that could be provided, taking account of additional/non-public resources available

As a result commissioners could determine:

- The right pattern and mix of service delivery for current and future needs
- How individual services complemented and reinforced other provision
- The balance between provided services and self-managed services through personalised budgets, and support required to facilitate personalisation
- What services need to be funded and how (through grants, through competitive tendering, as appropriate)
- Priorities for development

Based on this, commissioning would open up the potential to deliver any services to all interested providers. All providers would then be then tested against their ability to deliver the best results in terms of both cost and citizen benefits. How do we get there – proposed action plan.

**Third Sector Board Members will have a specific role with this action plan, to champion its implementation and engagement across all LHB partners and to monitor progress and attainments.**

## 4.2. Recommendations, key actions and suggested outcome indicators

<b>Recommendations, key actions and suggested outcome indicators</b>	<b>lead &amp; timescale</b>
<p data-bbox="237 347 1536 443"><b>1. Standardising third sector provision across Wales wherever possible and appropriate.</b></p> <p data-bbox="237 518 432 550"><b>Key Actions:</b></p> <ol data-bbox="331 595 1680 774" style="list-style-type: none"><li><b>a. Establish a baseline - capture information on all third sector services delivered within each Health Board area.</b></li><li><b>b. Ensure Third sector to be linked to the development of local Communication Hubs.</b></li><li><b>c. Based upon benchmarking exercise, identify evidence based services that would provide benefits if delivered across Wales.</b></li></ol> <p data-bbox="237 817 383 849"><b>Enablers:</b></p> <ul data-bbox="331 892 1559 1040" style="list-style-type: none"><li>• Health and Social Care Facilitator posts and local Health and Social Care Networks</li><li>• Development of local Communication Hubs</li><li>• Development of third sector Compacts</li><li>• Third sector Board members</li></ul> <p data-bbox="237 1083 719 1115"><b>Suggested Outcome indicators:</b></p> <ul data-bbox="331 1158 1644 1382" style="list-style-type: none"><li>• Compacts to be in place in every health board area, as outlined in 5 year plans.</li><li>• Evidence base developed of services that should be provided across Wales</li><li>• Percentage areas where the third sector is formally involved in the development of a local Communications Hub</li><li>• Percentage of third sector organisations registered on NHS Direct and/ or the local Communications Hub compared to initial stock take</li></ul>	<p data-bbox="1727 347 2051 443"><b>Third Sector Board members</b></p> <p data-bbox="1727 496 2051 539"><b>September 2011</b></p>

## Recommendations, key actions and suggested outcome indicators

## lead & timescale

### 2. Exploit all opportunities to enable the third sector to contribute to transformational change.

Third Sector Board members

#### Key actions:

- a. Identify third sector inputs within the Innovation and Efficiency Board reports, the Levering Service Change Compendium and the Bridging the Gap report, and disseminate and promote evidence based good practice within each HB area.
- b. Consideration of the added value of third sector inputs within all new or revised service models developed in each Health Board area.

WCVA  
Innovation and Efficiency Board members

April 2012

#### Enablers:

- Health Board five year plans
- National Policy direction towards integrated services
- Improved efficiency, reducing waste and duplication
- Health and Social Care Facilitator posts and local Health and Social Care Networks
- Health, Social Care and Wellbeing Strategies

#### Suggested Outcome Indicator:

- Percentage of services with third sector inputs included compared to % at initial stock take

**Recommendations, key actions and suggested outcome indicators****lead & timescale****3. Third sector services must be able to actively contribute to formal assessment and care planning process.****Third Sector Board members****Key actions:****WAG Policy Lead on UA**

- a. Third sector to be formally linked into Unified Assessment Health Board processes in those circumstances where third sector organisations are providing part of the service response, or acting in an advocacy role for either or both a service user and/or carer.
- b. Health Board approach to UA will reflect this requirement and ensure processes are in place to formally link third sector partners into the assessment and care planning process.

**Health Board Workforce and OD team****Enablers:****April 2012**

- Access to Health Board training and support
- Health Board UA process and incorporation in IM&T tools
- WAG review of UA in 2011/12

**Outcome Indicators:**

- Percentage of third sector staff providing inputs into a care package that are formally linked in to UA process

**4. Commissioning strategies must proactively embrace third sector****Third Sector  
Board members****Key actions:**

- a. **Third Sector to be included within appropriate service planning processes to ensure appropriate consideration of inputs is available at an early stage.**
- b. **Social clauses to be recognised in SLAs where appropriate and contracts/grants to reflect outcomes.**
- c. **Where appropriate establish a third sector Key Fund with the CVCs to enable small local interventions that have high impact in complex care**
- d. **Local Compact Code of Practice for Funding the Third Sector principles reflected in local commissioning and procurement processes**
- e. **A Register be established of current third sector providers with grant agreements/ contracts**

**Health Board  
Director of  
Planning****April 2012****Enablers:**

- Revised LA Commissioning Guidance recently issued by WAG Fulfilled Lives Supportive Communities Commissioning Framework Guidance and Good Practice 2010
- Third Sector Board members and HB five year development plans
- Health and Social Care Facilitators and Health and Social Care Networks
- Code of Practice for Funding the Third Sector 2009, local third sector compacts and local funding and commissioning codes of practice

**Outcome indicator:**

- Percentage of Third sector included within service planning processes.
- Percentage of SLAs with social clauses
- Percentage of new/increased third sector services commissioned
- Percentage of areas with a key fund
- Percentage of areas with a funding/ commissioning code of practice that explicitly subscribe to the Code of Practice for Funding the Third Sector 2009 principles

## Recommendations, key actions and suggested outcome indicators

## lead & timescale

### 5. Thirds sector providers are members of the multidisciplinary team

Third Sector  
Board members

#### Key actions:

- a. Third Sector representation to be included as part of the care planning process when it is determined they will contribute towards the overall care package, and to support service user and carer voice and choice
- b. CHC Programme MDT development work to include Third Sector representative as part of the Task & Finish Group.
- c. MDT development work to include reference to third sector roles as part of an MDT where appropriate.
- d. Utilisation of local Communications Hub directory of services in order to sign-post patients to third sector services

MDT co-ordinator

April 2012

#### Enablers:

- CHC Programme MDT development training and support work
- HB Board members
- Health and Social Care Facilitators and Health and Social Care Networks
- Health Board MDT training
- Health, Social Care and Wellbeing Strategies

#### Outcome Indicators:

- Percentage of MDTs with third sector representation when care plan requires third sector inputs.
- Number of referrals to third sector services per LHB area

## Recommendations, key actions and suggested outcome indicators

## lead & timescale

### 6. Third sector must work together to demonstrate the quality of services using the Standards for Healthcare in Wales.

Third Sector Board members

#### Key action:

- a. Third Sector Board members to develop and implement a pan-Wales Support Programme to enable third sector organisations to use the Standards for Health Services through the 'How to Guide' with joint learning and support resources for both the third sector and Health Board staff

#### Enablers:

- 'How to Guide' Project team (WCVAWAG)
- CVCs
- Health and Social Care Facilitators and Health and Social Care Networks

#### Outcome Indicators:

- Percentage increase of third sector organisations who use Standards for Health Services with completed self-assessment portfolio.

## Recommendations, key actions and suggested outcome indicators

## lead & timescale

### 7. Better utilise new and existing opportunities to improve knowledge and skills within the third sector and about the third sector.

Third Sector Board members

#### Key Actions:

- a. Third sector included in appropriate training and development opportunities provided by Health Boards. These opportunities are in addition to core training available via CVCs.
- b. Health Boards to facilitate training for their staff on the role of the third sector.

Health Board Workforce and OD Directors

CVC's

#### Enablers:

- Workforce & OD training programmes.
- Third sector Board member
- CVC opportunities
- Health and Social Care Facilitators and Health and Social Care Networks

April 2012

#### Outcome Indicators:

- Percentage of third sector staff accessing joint training opportunities
- Percentage of HB staff receiving training on the role of the third sector

**8. Actively increase and improve support for Carers.****Key Actions:**

- a. With reference to the Carers Strategy Measure and work under Sustainable Social Services: A Framework for Action, contribute to and support the development of the Communications Hubs using the community resources model of primary care delivery, and build on the approach of existing carers centres in Wales in order to provide access to information; training for the unpaid carer such as manual handling and infection control; and emotional support
- b. Work to agree and establish universal access for carers to these comprehensive services in Wales
- c. Work to support the involvement of carers in Unified Assessments and Multidisciplinary Teams

**Enablers:**

- The Carers Strategy Measure
- Sustainable Social Services for Wales: A Framework for Action
- Third Sector Board members
- Carers Forums
- Health and Social Care Facilitators and Health and Social Care Networks
- Health, Social Care and Wellbeing Strategies

**Outcome Indicators:**

- Agreed universal service standard
- Percentage of Wales with access to this standard
- Percentage of MDTs, UAs and discharge processes involving carers

**Third sector  
Board members****Carers leads in  
each Health  
Board**

## Recommendations, key actions and suggested outcome indicators

## lead & timescale

### 9. Understand and improve the use of the third sector in the care of people with specialist conditions.

Third sector  
Board member

#### Key Actions:

- a. Where appropriate, each HB to undertake a gap analysis to determine how HBs use third sector organisations when planning and providing services for people with specialist conditions.
- b. Identify third sector inputs in supporting people with specialist needs during the transition process from children & young people to adult services.

Practitioners  
involved in  
transition  
planning

#### Enablers:

- Specialist service expertise within HBs
- Third sector Board member
- Service planning for specialist services within HBs
- Health and Social Care Facilitators and Health and Social Care Networks

April 2012

#### Outcome indicators:

- Communications Hubs providing clear map of third sector inputs into specialist conditions care planning
- Gaps in service provision identified
- Support to Transition planning identified.

## Recommendations, key actions and suggested outcome indicators

## lead & timescale

### 10. Improved access and proactive discharge planning.

**Workforce & OD  
within HBs**

#### Key Issues:

- a. Third sector to link in to discharge planning training and development within HBs as route to inform operational practitioners of third sector roles in effective timely discharge plans.
- b. Each HB to have a strategy in place re access to third sector services that are available within their HB area

**Third sector  
Board member**

**April 2012**

#### Enablers:

- Links to Action 1, 3 and 5
- Third sector Board member
- HB training and development plans
- Health and Social Care Facilitators and Health and Social Care Networks

#### Outcome indicators:

- Percentage of discharges that have third sector input as part of the ongoing care plan
- Percentage of Health Boards that have collated evidence and information on third sector services that support timely discharge, linking to 5d) above

## Recommendations, key actions and suggested outcome indicators

## lead & timescale

### 11. People and families have greater knowledge and awareness of third sector services and how to access them.

Third Sector Board member

#### Key Actions:

HB primary care development staff

- a. HBs to work with Health and Social Care Facilitators to collate information held on third sector inputs and ensure the information is easily accessible
- b. HBs to explore ways in which third sector inputs can be highlighted with primary care practitioners to support community based access to third sector inputs via the Communications Hubs
- c. Communication Hubs information to be reviewed to ensure it remains up to date and provides access details.

April 2012

#### Enablers:

- Third sector Board member
- Patient information officers
- Primary care development officers within HBs
- NHS Direct development team
- Health and Social Care Facilitators and Health and Social Care Networks

#### Outcome indicators:

- Percentage of third sector organisations on NHS Direct and/ or Communications Hubs (see number 1 above)

## Recommendations, key actions and suggested outcome indicators

## lead & timescale

### 12. Incorporate this action plan into organisational performance, planning and development processes.

Third sector  
Board members

#### Key actions:

April 2012

- a. Each HB to link the actions recommended in this action plan to the work undertaken as part of the COMPACTS development process.
- b. Quarterly updates on progress to be provided to each HB and the third sector through dissemination by WCVA
- c. Review progress in April 2012 with WCVA and WAG
- d. As part of review develop longer term indicators for the LHB Annual Operative Plans

#### Enablers:

- Five year service workforce and financial planning mechanism
- NHS Annual Quality Plan 2011

#### Outcome Indicators:

- Total value commissioned third sector healthcare services for people across Wales
- Total number of people with complex needs receiving commissioned third sector services

## 5. Appendix Service Examples

The purpose of the service examples provided in this Annex is to demonstrate the range of services, schemes, and functions supported by Third Sector organisations in Wales.

The services and schemes that follow are not intended to be a comprehensive list of all services provided by the Third Sector in Wales – they are examples of the many schemes and services that exist to assist people to maintain as independent a lifestyle as possible, and provide support on a daily basis.

The examples provided range from mainly volunteer type services, seeking to support people in their own homes by providing assistance with general support, to the direct delivery of complex care, working in partnership with statutory services to help people who require high levels of care and support. Schemes 1 to 15 demonstrate those services provided on a mixed volunteer/paid basis, whilst schemes 16 to 30 demonstrate services provided by paid staff.

The overarching aim of these services is to maximise opportunities for independence, and to allow people to maintain as independent a lifestyle as possible, within community settings.

Each example provides contact details – further information can be obtained directly from the contact point provided.

### List of Schemes Section1: Mixed volunteer and paid schemes

- 5.1 TARAGGAN Community Allotment Scheme
- 5.2 Gwelfor WRVS Luncheon Club
- 5.3 Luncheon Club Development Project, Wrexham
- 5.4 WRVS Meals on Wheels Carmarthenshire
- 5.5 Eat, Chat and Shop Scheme
- 5.6 Dewis Centre for Independent Living
- 5.7 Developing equitable Third Sector support in Powys
- 5.8 Community Choice and Inclusion, Pembrokeshire
- 5.9 Community Voluntary Health Guardian Pilot Project
- 5.10 Carmarthenshire Twilight Service
- 5.11 Age Concern Gwent Rapid Response Hospital Discharge
- 5.12 Conwy Community CIC Start

5.13 Touch Trust

5.14 British Red Cross Services provided across Wales

5.15 Tenovus Cancer Support Team

## **List of Schemes Section 2: Formal Schemes**

5.16 Age Concern Gwent Prevention of Admission Service

5.17 Age Concern Gwent Respite Care Service

5.18 Crossroads Care

5.19 Carers Assessment Powys

5.20 Powys Urgent Response Service at Home

5.21 Age Concern Gwent Hospital Discharge Services

5.22 Robense House

5.23 Continuing Care Carmarthenshire

5.24 Newport Kaleidoscope

5.25 Person Centred Planning Service

5.26 Health Checks Video Clips (MENCAP)

5.27 Getting it Right Campaign

5.28 Carer Well Being Scheme (Intermediate Care Service)

5.29 Transition Key Worker

5.30 Monnow Vale Day Services Remodelling

## 5.1. TARAGGAN Community Allotment, Bargoed.

**Contact Details:**     **Mark Ellis**  
**Mentro Allan, 8 Under Cardiff Road, Bargoed. CF81 8NZ**  
**☎ 01443 878958**  
**✉ Mark.Ellis@gavowales.org.uk**

### Link to 10 High Impact Changes:

The project most closely supports Change 1: Avoid disruption to the usual care setting. As stated in the 10 High Impact Changes - independence is maintained by “utilising all opportunities for promoting independent living.” Importantly, these opportunities often arise prior to any diagnosed illness, and the TARRAGAN community allotment intersects with the high-impact changes programme at this point. By providing information on nutrition, and the opportunity to engage in exercise outdoors, service users are able to make “informed choices and decisions about their future lifestyle and wellbeing”.

In the longer term, such a programme is likely to improve the health of service users by promoting balanced nutrition. Moreover, the method by which this is achieved, through a *community* allotment upon which large numbers of persons from all walks of life work, is likely to reduce “fear of losing independence” as a strong network of friends and colleagues is developed.

The project also overlaps with Change 9 in that the service has emphasised collaborative working among various third sector and statutory organisations (although not specifically with Health).

**Collaborative Working:** The close cooperation between a number of voluntary organisations and local government has been at the core of the TARAGGAN project and responsible for much of its success. Mark Ellis of the Mentro Allan project to promote outdoor activity came together with a colleague, Ron, in 2007 to produce a business plan to develop the site. Over the following months and years the community task force, *Groundwork*, have provided volunteers, and in 2009 *Cleaner, Greener Communities* provided funding, allowing fencing to be put up and topsoil brought in. At this point interest in the project grew quickly and the allotment opened doors to the whole community. After arriving on the open day and recognising the good work, Lindsay Whittle of Caerphilly Borough Council provided assistance in the paving of disabled access. Now, the local county council holds the TARAGGAN allotment up as a model for other allotment projects in order to emulate Bargoed’s successes across the county. It is only through this collaboration between different organisations that TARAGGAN project has grown so quickly and been so successful.

### Brief background to the Project:

The TARAGGAN Community Allotment is the result of collaboration between *Mentro Allan*, *Cleaner, Greener Communities*, and local residents. Sporting twenty plots and three raised beds, the allotment allows school groups, voluntary organisations, and residents to plant organic vegetables and grow a variety of plants, including a new rose garden.

In the months the allotment has been open the first crop of herbs and vegetables has been successfully harvested, and the project has involved groups and individuals in gardening and conservation, promoting healthier lifestyles through outdoor activity and a balanced diet. Moreover, the project has begun to function as a hub for local community activities at their education centre by hosting fund-raising events such as a Strawberry & Cream day and a local market to sell fruit and vegetables.

### **Aims and objectives of the project:**

Through the TARRAGAN project, promote and work with the community to enhance a better and healthier environment for the people of the Gilfach Estate and surrounding areas. This will be achieved through the following objectives:

- To provide community events.
- To develop a healthy living initiative through recreational and social activities.
- To promote cross-generational working and community spirit.

### **Measurable outcomes of the project:**

The TARRAGAN allotments are new, having only just finished their first growing season. Nonetheless, the project can boast several successes, principally in regards to improving personal outcomes and boosting cohesion within the community and amongst otherwise isolated persons groups.

By fostering an interaction with food all the way from the soil to the dinner plate, the TARAGGAN project educates residents - particularly school children - on the importance of nutrition that will likely yield long-term health and social care results.

The TARAGGAN group seeks to promote cross-generational working and community spirit, and manage to achieve that both by creating a space where a plurality of persons come together and through particular programs. *Pathways to Education*, for example, allowed a number of fifteen-year-old children to participate in the allotment, and these persons subsequently prepared plots for the toddlers. This interaction fell under the supervision of a number of the TARAGGAN staff, many of who are at retirement age, which provides the opportunity for intergenerational cooperation.

Persons working on the TARAGGAN allotment of twenty plots and three flat beds have successfully grown a variety of plants and vegetables, and in doing so proven that all members of society can participate and garden. The positive outcomes are not, however limited to the amount of food produced. A sizable number of elderly persons are active on the allotment and therefore gain exercise and invigoration they would otherwise lack. Moreover, as the allotment is a community area, the project has *reduced barriers to social integration for otherwise isolated individuals*. The TARAGGAN group now offers trips for those involved, recently to Cardiff for St. Patrick's Day, which for paid and unpaid staff, volunteers, and those working allotments is a greatly appreciated opportunity to make friends and establish connections. Moreover, the allotments provide opportunities for persons with learning disabilities. As a green space that allows individuals to involve themselves, service users with conditions such as Autism make regular visits and gain satisfaction in giving a meaningful contribution to the allotment. They also enjoy the benefits of social interaction, spending time with other allotment users on their visits.

### **What evidence is there to support success?**

Having established itself as a local landmark, the TARAGGAN project has received commendations from Caerphilly Borough Council including the mayor's *Civic Award*, and was also the recipient of the *2009 Environmental Award* from the voluntary sector awards in Caerphilly. TARAGGAN now seeks to further its role as a point of strong intergenerational interaction and local pride, and is competing for the *Queen's MBE Award* for services to the community.

The TARRAGAN allotment is now being used by Caerphilly Borough a model for other allotment projects in order to emulate Bargoed's successes across the county.

The success of the project is evident when interviewing those involved in the project. The TARRAGAN project is a WCVA HSCWB example of Good Practice and includes quotations from service users that express the success of the project in improving personal outcomes by reducing isolation and improving knowledge of nutrition.

### **Costs:**

None provided.

### **Is the project formal or informal? (ie paid or voluntary or a mix)**

The project is mixed; there are three paid staff and ten volunteers. Money to pay for staff comes from both external sources and from fund-raising, and the project adheres to the values of co-design; co-delivery, and consequently several of the volunteers are also service users.

### **Additional supporting information:**

Please see the WCVA HSCWB Good Practice Portfolio.

## 5.2. Gwelfor WRVS Luncheon Club

**Contact Details:** Gwelfor Community Centre  
Ffordd Tudor, Holyhead, Anglesey, LL65 2DH  
☎ 01407 763559

### Links to the 10 High Impact Changes:

- Integrated services and effective partnerships'-working in partnership with Anglesey County Council, Social services and working towards a befriending and information service in the area.
- Responsive long term care –Helping people remain independent in their own homes for longer.
- Workforce designed to serve complex needs – we work with partner organisations to develop services and processes to support service users in their neighbourhood.

### Brief background to the Project:

The Club started in June 2004 and meets every Monday apart from Bank Holidays. A team of volunteers arrive early in the morning to prepare the room for the service users. Two WRVS employed staff a cook and assistant cook, prepare the meals each Monday from fresh locally sourced foods. The service users choose from a menu the week before, all dietary needs are catered for ensuring that all the service users receive a hot nutritious three course meal. Anglesey Social services provide transport to and from the club ensuring that everyone who wants to go is able to. Some service users arrive by public transport others live near enough to walk. There are in the region of forty service users sitting down to eat each week.

### Aims and objectives of the project:

- To provide a nutritious meal to older people within the region
- Offer the opportunity for social interaction
- To improve the well being of both the service users and the volunteers
- Offer care and entertainment within a community setting
- Recognise changes in health and behaviour at an early stage.

### Measurable outcomes of the project:

Although we do not specifically measure outcomes from this project it is clear to see that there is a need for the service in this area, it attracts large numbers of regular service users; for some this may be their only weekly outing and opportunity for interaction within their community.

### What evidence is there to support success?

The club has been running since June 2004 and continues to be busy and well used by the local older people. Most of the volunteers that started the club are still volunteering and continue to do so until their health doesn't allow. The club has a 'happy' feeling about it, all

the service users appreciate their meal and the socialising with other people. They have raffles, and some stay to play bingo after the meal. Many of the service users do not go to any other social events during the week.

Volunteers play a vital role in this project and their dedication and support is shown through the longevity of their service.

N.B. we will shortly be recording 'regional activity' on a monthly basis to ensure our services meet the requirements of the older people in our region; and provide us with the evidence to expand our services to suit the needs of the service users.

### **Costs:**

The cost for the service user is £5

The charge covers their meal and transport to and from the club if they use it. The raffle provides a little extra funding to help with the cost of providing the service.

### **Is the project formal or informal? (ie paid, voluntary or a mix)**

Two paid staff – Cook & Assistant Cook

WRVS volunteers prepare the room, serve the food, clear the room and provide the opportunity for conversation/ discussion, raising any concerns problems; identifying personal changes e.g. weight loss, confusion, changes in personality etc.

### **Additional supporting Information:**

Gwelfor Community Centre has a website and a quarterly newsletter which both feature the WRVS Luncheon Club

[www.gwelforcommunitycentre.com](http://www.gwelforcommunitycentre.com)

### 5.3. Lunch Club Development Project

**Contact Details:** Elaine Blease  
Wrexham County Borough Council, Adult Social Care  
Crown Buildings 31 Chester Street Wrexham LL13 8BG  
☎ 01978 298619  
Fax: 01978 298029  
✉ [Elaine.Bleas@Wrexham.gov.uk](mailto:Elaine.Bleas@Wrexham.gov.uk)

Christine Brownridge  
Lunch Club / Surefeet Development Officer  
Age Concern North East Wales  
Suite 2, Daniel Owen Precinct  
Mold, Flintshire CH7 1AP  
☎ 08450 549969  
✉ [CBrownridge@acnew.org.uk](mailto:CBrownridge@acnew.org.uk)

#### Link to the 10 High Impact Changes:

Not provided.

#### Brief background to the Project:

It is proposed that a total grant pot of up to £50k is identified for a Luncheon Club development scheme in the current year, whilst officers work with Age Concern North East Wales and the Planning & Development Officer for the Strategy for Older people to determine the best approach to increasing the number of clubs in operation.

The Proposal is to offer small grants or up to £5k to organisations who will set up new lunch clubs, as a first priority, and as a second priority to those that will develop activities within their existing clubs that support the health and well-being agenda.

#### Aims and objectives of the project:

To increase in the number of Lunch Clubs within the Borough by:

- start up grants from the Adult Social Care Department
- the development of Lunch Clubs in pubs and restaurants
- the integration of Lunch Clubs previously operating independently into the advice and support network

A part time lunch club development worker was appointed through Age Concern North East Wales (ACNEW) to support the establishment of Lunch Clubs in poorly served areas, explore less traditional models of service delivery, and to support volunteer recruitment.

#### Measurable outcomes of the project:

- To increase the start-up and development of Lunch Clubs through grant aided and non grant-aided support
- To increase consultation and engagement.
- To extend advice and guidance on good practice and sustainability.

- To provide support through outreach, communication and networking.
- To extend access to Lunch Clubs to a greater number of older people, who will benefit from a nutritious hot meal, activity and companionship.

### **What evidence is there to support success?**

The number of Lunch Clubs across the County Borough has increased from 18 in March 2009 to 28 in March 2010, meeting the target of 10 additional Lunch Clubs in the financial year. The number of lunch club places has increased from 541 in March 2009 to 783 in March 2010, providing an additional 242 places.

Four clubs operating independently were brought into the support network providing places for 67 people, and two of them have been awarded development grants. A further two new lunch clubs have been established in restaurants without any grant funding, providing places for 60 people. Volunteer coordinators for these lunch clubs were recruited and inducted by ACNEW.

Lunch Clubs are under development in three localities. When open these clubs could provide places for approximately 65 people. Community Councils in every locality have been approached by the development worker to encourage start-up. A further 15 localities are being targeted and approached for future development.

### **Costs:**

A budget of £75k was allocated for Lunch Club development in 2009-10. The total spend for the year was approximately £26,735, which supported and developed a service covering 783 people (an average spend of £34.14 per person).

The amount of funding awarded for start up grants in 2009-10 was £5,309 which supported the development of four new Lunch Clubs, providing places for 115 people. The cost of generating these new lunch club places was £46.16 per person.

Nine existing lunch clubs were supported with single grants totalling £6,592.79 to develop their services in 2009-10.

### **Is the project formal or informal? (ie paid or voluntary or a mix)**

A part time lunch club development worker was appointed through Age Concern North East Wales (ACNEW) to support the establishment of Lunch Clubs in poorly served areas, explore less traditional models of service delivery, and to support volunteer recruitment.

### **Additional supporting information:**

<http://www.acnew.org.uk/>

<http://www.wrexham.gov.uk/>

Lunch club newsletter/ Age Concern Lunch club leaflets

## 5.4. Carmarthenshire Meals on Wheels

**Contact Details:** WRVS, Crosshands Day Centre, Memorial Hall, Carmarthen Road, Crosshands, Llanelli, Carmarthenshire, SA14 6SU  
☎ 01269 843819  
✉ [carmarthenshirems@wrvs.org.uk](mailto:carmarthenshirems@wrvs.org.uk)

### Links to 10 High Impact Changes:

The Meals on Wheels service meets the following:  
High Impact Changes – 1, 3, 4, 6, 7, 8, and 9

### Brief background to the Project

WRVS have been successfully providing Meals on Wheels services for over 70 years. Our experience is based on person centred approach using professional people who provide a caring, professional service to vulnerable people within their own communities.

### Aims and objectives of the project:

We believe that the main considerations in any community meals service are:

- Quality service and products.
- Hot, nutritious and appetising meals being supplied.
- Trained and caring employees and volunteers who regularly visit service users.
- The meal being delivered at the correct time and temperature.
- Effective communication with everyone being kept informed and up to date - the service user, the local authority and our employees and volunteers.
- Clear information and help always being available for service users without patronising them.
- Providing a person centred approach, listening to the service user, taking into account their individual needs and requirements and caring enough to do that little bit extra like posting letters, pouring a glass of water, plating/cutting up food and other non-personal, low-level help.

### Measurable outcomes of the project:

Our contract is based on the individual requirements of the local authority and service users, all Key Performance Indicator's have been agreed prior to contract commencement. The service we offer requires constant evaluation to ensure standards are maintained.

### What evidence is there to support success?

For over 20 years, we have successfully delivered over 90,000 meals a year in Carmarthenshire. We can evidence that every effort has been made to ensure every round has been delivered regardless of weather conditions, road-closures and power failures and we believe that the contingency plans we have in place enable us to provide a continued service regardless of circumstance.

## **Costs**

Annual budget agreed with local Authority.

### **Is the project formal or informal? (ie paid or voluntary or a mix)**

The project is a mix of paid and voluntary.

### **Additional supporting information:**

A flyer is available that demonstrates the key areas of the scheme.

[www.wrvs.org.uk](http://www.wrvs.org.uk)

[www.carmarthenshire.gov.uk](http://www.carmarthenshire.gov.uk)

## 5.5. Eat, Chat and Shop scheme

**Contact Details:**     **Dial-a-Ride**  
**Unit 8, Milland Road, NEATH, West Glamorgan SA11 1EL**  
**☎ 01639 646608**  
**✉ townrider@live.co.uk**

### Links to 10 High Impact Changes:

Not identified.

### Brief background to the Project:

The members of the Eat, Chat and shop scheme were previously members of a Taxi card scheme which ended on the 30<sup>th</sup> June 2010. Neath Port Talbot Community Transport with the support of Neath Port Talbot CVS established the Dial-a-Ride scheme which then went on to form the Eat, Chat and Shop scheme.

The scheme was started to fill the gap for individuals who were unable to access public transport to enable them to be as independent as possible also to try and alleviate any further social isolation becoming an issue.

Whilst in talks it was thought that the new scheme could incorporate a number of issues which existed within the lives of some of the socially isolated individuals by starting a scheme which would run on a Monday and Thursday of each week, would pick individuals up from their homes, take them for lunch together and to the local supermarket where they could shop independently or with support with the added benefit of them being assisted home to their front doors.

### Aims and objectives of the project:

The aim of the project is to ensure individuals who are unable to access public transport can live as independently as possible. The objectives of the project are:

- Live independently – ensuring individuals are fully integrated in society.
- Social interaction – enabling individuals to interact and enjoy the company of others, reducing isolation.
- Practical solution to shopping
- Access to appropriate transport

### Measurable outcomes of the project:

The Co-ordinator of the scheme would ring participants of the project each session to see if they were interested in attending each week's session, the names and addresses would be collated from each interested individual and then the organiser would ring each individual back with a time for them to be picked up at their homes.

As the scheme progresses it has been found that individuals are ringing themselves and booking on to the scheme ensuring they have a place and gathering their own information in regards to time for them to be picked up. This shows that the individuals are enjoying

and finding the scheme useful. Also the comments from the participants are that they feel this is a worthwhile scheme allowing them to co-ordinate their own lives instead of having to rely on others and thus feeling empowered.

### **What evidence is there to support success?**

The evidence of the success of the scheme can be seen by the sustainability and growth of the project and also the feedback which is gained from the participants which is very positive.

### **Costs:**

There is no cost to the individuals using the Dial-a-Ride scheme as individuals use their bus pass as a means of admission (as they would if using public transport), if the passenger doesn't have a bus pass they are charged a standard rate.

### **Is the project formal or informal? (ie paid or voluntary or a mix)**

The driver is a paid member of staff who gets paid through the scheme.

### **Additional supporting information:**

The scheme was supported through Neath Port Talbot CVS and the attached flyer was used to initially advertise the scheme.

Further Marketing material is being drafted for the scheme and will be available in the near future.

## 5.6. Dewis Centre for Independent Living

**Contact Details:**     **Unit 6, Maritime Offices, Woodland Terrace, Maesycod, Pontypridd CF37 1DZ**  
   **☎ 01443 408418**  
   **✉ info@dewiscil.org.uk**

### Links to 10 High Impact Changes:

Integrated services and effective partnerships, **and** effective multidisciplinary working

### Brief background to the Project:

Dewis was established in 1996 as a charitable trust and non profit-making Company Limited by Guarantee. It was designed to act as a 3rd party organisation run by disabled people who used its services. Its specific aim was to enable a small number of disabled people to have choice (“dewis”) and control over the support they needed to live independently, e.g. choosing who they wished to have as their care workers/personal assistants, who Dewis employed. When Direct Payments were introduced in Rhondda Cynon Taf in 2001, the organisation undertook the role of providing a third party ‘support service’. Dewis has subsequently developed an independent advocacy service and provides a wide range of training opportunities, including personal assistant and volunteer training.

Dewis currently works in partnership with the Social Services Departments in Rhondda Cynon Taf, Powys, Vale of Glamorgan, Newport & Merthyr Tydfil.

From its inception, the Centre for Independent Living has had a management committee composed of disabled people who use its services and non-disabled people who are supporters of its ethos and values. The Management Committee oversees the work of the staff and helps to develop future policies. The project continues to seek innovative ways of supporting disabled people to live independently.

### Aims and objectives of the project:

Dewis CIL’s primary goal is to enable disabled people to live independently. Its aims and objectives are:

- To provide a range of services to disabled people who wish to take greater control over their community care needs, to enhance ‘choice’ and ‘control’ in their lives and promote independence, and which respond to disabled people’s needs and take into account their opinions of these services.
- To provide disabled people, their families, their advocates and their supporters with useful, practical and accessible information on independent living.
- To supply disabled people, their families, their advocates and their supporters with a comprehensive support scheme which will enable the employment of personal assistants
- To create greater opportunities for disabled people to develop their own independence and to benefit from wider social inclusion.
- To recruit, develop and train volunteers and others in furtherance of these aims.
- To continue to develop its services for and with the co-operation and views of disabled people in accordance with Dewis CIL’s beliefs.

**Measurable outcomes of the project:**

Dewis CIL's Annual Report 2009/10 details the organisation's current activity in providing direct payment support across four local authorities and makes a comparison with the previous year. Figures show an average 17.5% increase in the number of service users taking up a Direct Payment in those areas in which it works.

**What evidence is there to support success?**

Dewis CIL's services have gradually expanded over the past 15 years and the organisation is now growing rapidly. In 1996 Dewis had one part time worker for two days per week with no office base. In 2001 one full time worker was employed and an office was opened. In 2006 the organisation grew to eleven full time staff and moved to new offices. Dewis currently employs 24 staff, has extended its offices and has six local authority contracts.

**Costs:**

Dewis CIL's total income in 2009-10 was £591,368. Its expenses were £579,693.

**Is the project formal or informal? (ie paid or voluntary or a mix)**

The project is run mainly by paid staff with some volunteer opportunities being provided. Several staff members are disabled.

**Additional supporting information:**

Dewis CIL's website is [www.dewiscil.org.uk](http://www.dewiscil.org.uk)

The organisation's annual report for 2009-19 and its current newsletter will be forwarded separately.

## 5.7. Developing Equitable Third Sector Tier 1 (wellbeing) Support in Powys

**Contact Details:** PAVO  
Marlow, South Crescent  
Llandrindod Wells, Powys, LD1 5DH  
☎ 01597 822191  
[hscf@pavo.org.uk](mailto:hscf@pavo.org.uk)  
[siobhan.luikham@pavo.org.uk](mailto:siobhan.luikham@pavo.org.uk)

### Links to 10 High Impact Changes:

The project focuses on Change 1. The projects funded under the Continuing Health Care Third Sector scheme intend to reduce the necessity and risk of admission to hospital, by providing appropriate support to those with long-term needs and their carers in the home or community setting.

These projects also make a contribution to several more of the 10 High Impact Changes for Complex Care. These are Change 2, 3, 5, and 9.

### Brief background to the project

PAVO as the intermediary organisation for the third sector is working closely with third sector organisations, including service providers and community groups, and with statutory partners to develop a progressive realignment of third sector support so it dovetails more closely with models of care. In Powys, an enormous range of third sector groups contribute to the health and wellbeing of people in communities. They provide support to older, frail and vulnerable people and their carers and help them to live more independent lives in their own homes.

Groups active in Powys include national and international organisations as well as small local groups providing support in specific communities. Activities include local good neighbour schemes, befriending; transport to health and leisure facilities; provision of luncheon clubs; shopping and prescription collecting as well as more technical services such as the provision of information and advice; aids and adaptations; advocacy services and the provision of respite care.

The presence of small, local groups allows for services tailored to the specific needs of the individuals in their community. These services build on local knowledge and relationships. Local groups also provide a mechanism by which a community is able to identify local issues and develop local solutions to local problems: a key element in developing community cohesion and in building bridging social capital. The flipside of local provision is that the pattern of service provision can sometimes be patchy, resulting in a lack of equity across Powys and difficulty in integrating the third Sector element of support into care pathways.

For the last 12 months, PAVO has been working with third sector organisations to develop and implement five pilot projects funded under the Continuing Health Care award scheme to support people to remain in their own homes; to support prompt discharge from hospital; and to prevent avoidable admissions.

Three local projects use volunteers to provide bespoke support in three communities. These projects are delivered by Crickhowell Volunteer Bureau, Llandrindod Wells and District Volunteer Bureau, and Ystradgynlais and District Volunteer Centre

Two further projects have been funded under this scheme:

- The extension of the Rapid Response Adaptation Programme (RRAP) delivered by Care and Repair that has enabled Care and Repair to increase its activity in Powys.
- Powys Urgent Response Service at Home (PURSH) which provides personal care service at home.

PAVO is also undertaking work under the Rural Health Plan to develop community cohesion in three pilot areas as part of service redesign. A further piece of work is the development of an alliance of information and advice providers, including Care and Repair MWW; Age Concern Powys; Powys Carers Service and Disability Powys.

Learning lessons from these various strands of work, PAVO is working with statutory partners and third sector organisations to facilitate the development of a more strategic, coherent and coordinated third sector with a clear interface at different geographical levels to statutory health and social care partners. This is in line with the Common Vision for Health and Social Care in Powys as well as the key national strategic initiatives in Wales (Rural Health Plan, Setting the Direction, and Chronic Conditions Management). Funding has been sourced from the Continuing Healthcare Schemes and the Rural Health Innovation Fund to take forward these activities.

### **Aims and objectives of the project:**

- To identify core (tier 1) services necessary to support independent living in small rural communities.
- To build on the success of the CHC pilot schemes in supporting people to live independently in own homes and to develop and deliver equitable and safe tier 1 services.
- To work with the third sector and statutory agencies to develop stronger working relationship at critical points in the patient journey and care pathway and to maximise third sector contributions in supporting people with complex care needs.
- To build community cohesion and engagement aligned to the Rural Health Plan.

### **Measurable outcomes of the project:**

- Prevention of avoidable admissions
- Support for prompt discharge from hospital
- Support to remain independent in own home
- Equitable tier 1 service across Powys based on people's needs
- Demonstrating social return on investment

### **What evidence is there to support success?**

The Continuing Healthcare Third Sector Award Scheme has been running for just over 9 months. Work is now focused on fine-tuning these tier 1 pilot projects.

**Is the project formal or informal? (ie paid or voluntary or a mix)**

A mix of paid and voluntary

**Additional supporting information:**

- Quarterly monitoring reports provide further information on each aspect of the projects.
- Zinovieff, F. and Robinson, C.A. (2010) The Role of the Voluntary Sector in Delayed Transfer of Care (DToC)/Hospital Discharge and Prevention of Readmission. Bangor: Bangor University. ISBN: 978-1-84220-123-7.

## 5.8. Community Choice and Inclusion (Social Enterprise)

**Contact Details:** Awelfa  
Maenclochog, Pembrokeshire, SA66 7LD  
☎ 01437/532715 AND 07970864818  
✉ luke@communitychoice.org.uk

### Links to 10 High Impact Changes:

No 3,4,5,7 and 9

### Brief background to the Project:

Set up in May 2010 as a not for profit Community Enterprise, supporting people with complex needs and their families to make person centred plans for the future.

### Aims and objectives of the project:

To enable people with complex health care needs to develop lifelong sustainable networks of support that will empower them to lead fulfilling lives with choice and control:

- Measurable outcomes of the project
- Support to explore, set up and maintain Networks of Support
- Significant reduction in costs of complex care packages as a result of joint and open working between all agencies
- Person centred plans to effect control over how support is provided
- Achieving key identified action plans
- Development of Micro enterprises around the future employment needs
- Access to further education
- Reduced stress amongst Family Carers, able to pursue most community activities.

### What evidence is there to support success?

- Development of 12 Networks of support around young people (aged 14-22) in Ynys Mon, a Transitional project set up in partnership with Ynys Mon CC (Transitional Support Team).
- Development of 4 Networks of Support in Pembrokeshire.

### Costs:

£350 per day

### Is the project formal or informal? (ie paid or voluntary or a mix)

A mix of paid and voluntary work

### Additional supporting information:

Detailed additional information is available from the contact details above. In addition a website is also under construction: [Communitychoice.org.uk](http://Communitychoice.org.uk)

## 5.9. Community Voluntary Health Guardian Pilot Project (South Gwynedd)

**Contact Details:** Mantell Gwynedd  
23-25 Y Bont Bridd, Caernarfon, Gwynedd LL55 1AB  
Yr Hen Orsaf Heddlu  
Y Lawnt, Dolgellau Gwynedd LL40 1SB  
☎ 01286 672626  
☎ 01341422575  
✉ [sioned@mantellgwynedd.com](mailto:sioned@mantellgwynedd.com)  
✉ [ellenapdafydd@mantellgwynedd.com](mailto:ellenapdafydd@mantellgwynedd.com)

### Links to 10 High Impact Changes:

The main links are with Changes 1, 4, 5, 7, 9, and 10.

### Brief background to the Project:

In April 2009 Mantell Gwynedd produced a report, commissioned by WAG, on current befriending and listening schemes provided within Gwynedd and beyond. It became apparent from this work that this kind of support was inconsistent across the region. It also became clear that addressing the needs of people living with chronic conditions remains a challenge and that the needs of those people living in rural areas are perceived as being greater. A number of key recommendations arose from the work which included identifying a suitable pilot area within Gwynedd and developing a pilot scheme. South Gwynedd was identified as a possible pilot area due to its rural geography and demographic nature.

In addition, equity of services in some parts of the county remains questionable, particularly in the South of the county where access to services are more problematic and the instances of social exclusion are far greater e.g. it includes Communities First areas and Convergence recipient areas. Pilot project commenced with Co-ordinator in post – December 2009 and will run as a pilot until March 2011

### Aims and objectives of the project:

The Community Health Guardian Project forms part of Chronic Condition Demonstrator site (Gwynedd) aimed at supporting individuals to manage their own chronic health conditions. The main aim of this Community Health Guardian Project is to develop a befriending, listening and signposting scheme in South Gwynedd with the view for this initiative to be replicated in other parts of Wales. To work with Third Sector organisations who are actively involved in chronic condition management to develop a robust framework for this pilot scheme.

The co-ordinator will identify and implement appropriate operating protocols and procedures for the scheme, and also identify and map out voluntary organisations who are involved with current befriending/listening and signposting schemes across South Gwynedd and identify chronic condition voluntary support groups with a view to develop a co-ordinated and integrated approach. The co-ordinator is also expected to liaise with voluntary organisations, other community groups as well as health and social care professionals/GPs via the integrated health and social care locality based teams.

With other colleagues the project will also organise specific sessions to raise awareness of services provided by the third sector. These sessions are aimed specifically at health and social care workers (Meirionnydd integrated locality teams) including volunteers from the befriending scheme and other community leaders (i.e. influential and pro-active individuals within their communities). These individuals will then be able to signpost individuals on to further support and information.

### **Measurable outcomes of the project:**

Evaluation Reports have been produced on this project and can be accessed on:

<http://www.nliah.com/portal/microsites/Uploads/Resources/rdnCwRPIL.pdf>

In addition, the proposed outcomes are:

- Create Framework & infrastructure to implement appropriate protocols
- Trained and better skilled Volunteers across organisations to support CCM
- Improved quality of life for service users and their carers = less dependency on other statutory services with a better understanding and awareness of voluntary sector services available to attempt self-manage their condition effectively.
- Better and more effective use of services and empower individuals and communities.
- Better informed GPs, other health & social care professionals re services provided by third sector organisations.

### **What evidence is there to support success?**

NLIAH evaluation reports - Sheila's Story – contact name

[MarkRhys.Kingston@wales.nhs.uk](mailto:MarkRhys.Kingston@wales.nhs.uk) (01443 233517) or [lhjones@glam.ac.uk](mailto:lhjones@glam.ac.uk) or Janet Ellis (North Wales CCM Project Manager) [JanetEllis2@wales.nhs.uk](mailto:JanetEllis2@wales.nhs.uk) (01286 674247) or CCM

Demonstrator's Website – evaluation and learning papers

<http://www.ccmdemonstrators.com/NorthWales.aspx>

### **Costs**

Co-ordinator Post & admin support (both part time basis).

Training and travel costs etc for volunteers; events costs – room hire & refreshment etc

### **Is the project formal or informal? (ie paid or voluntary or a mix)**

Formal & informal with volunteers volunteering their time as befrienders

### **Additional supporting information:**

<http://www.ccmdemonstrators.com/NorthWales.aspx>

<http://www.nliah.com/portal/microsites/Uploads/Resources/rdnCwRPIL.pdf>

Volunteer Community Health Guardian Report April 2009

Progress and Achievements – Year 2: CCM Demonstrators – November 2010 (Dr Roger Richards – National CCM Demonstrator Programme Manager

[roger.richards2@wales.nhs.uk](mailto:roger.richards2@wales.nhs.uk) (Tel 01443 233505)

## 5.10. Carmarthenshire Twilight Service

**Contact Details:** 11-15 Coalbrook Road  
Pontyberem, Llanelli, Carmarthenshire SA15 2DS  
☎ 01269 871600  
✉ [janet@mentercwmgwendraeth.org.uk](mailto:janet@mentercwmgwendraeth.org.uk)

### Link to the ten high impact changes:

This service example links to High Impact Changes 3, 4, 5 & 9

### Brief background to the Project:

The goal of this project is to promote and develop support networks for older people within their communities to ensure maintenance of independence within their own homes and prevent hospital admission and hence functional decline. Accident and Emergency is an accessible interface between the community and acute hospital care particularly outside of GP surgery hours. Older people are frequent attendees to these departments as a result of higher frequency of accidents and unfortunately much result in hospital admissions. Older people who are admitted to hospital are at risk of extended stay; malnutrition; exposure to hospital acquired infection; reduced independence; functional decline and increased mortality (Age Concern 2007).

The then Hywel Dda NHS Trust indicated that a number of older people are admitted unnecessarily to hospital via A and E and via the Clinical Decision Units. These admissions are largely due to a lack of social support ensuring safe discharge home. In 2007 the Carmarthenshire Health Social Care and Well-being Partnership established the 'Twilight Service'. The service operates between 2pm and 10pm for 5 days a week, at an annual cost of £105,000.

### Aims and objectives of the project:

- To reduce avoidable demand on the acute sector, by assisting in the transport of patients back to their residence following safe medical discharge.
- To promote independence and ensure safe discharge to usual residence, by undertaking risk assessment and linking/signposting to other groups and agencies.
- To ensure all staff are appropriately trained.
- To identify cost savings based upon an assessment of avoidable admissions.

### Measurable outcomes of the project:

- A 'Twilight Service' Steering Group meet on a bi-monthly basis to monitor progress and performance against the agreed plans, and audit compliance with the scheme.
- A 'Community Multi Agency Group' meets bi-monthly to ensure that community support post discharge is harnessed.
- Menter Cwm Gwendraeth uses feedback questionnaires, one to one discussions and other involvement and evaluation techniques to ensure that quality and cost effectiveness is maintained. A formal analysis of the cost benefits has been commissioned via Bangor University.

### **What evidence is there to support success?**

- Identified savings to the NHS is £300 per person per night times an estimated 420 patients per year (based on 5 days a week) = £126,000.

### **Costs:**

Annual and costs around £105,000 pa for 2008/09. The LHB in collaboration with the Council have agreed to continue to part fund the service for the remainder of this financial year, with a further contribution being sought from the Hywel Dda NHS Trust to make up the difference.

### **Is the project formal or informal? (i.e. paid or voluntary or a mix)**

Mainly formal with 3 recently appointed Volunteers

### **Additional supporting information:**

- Website -Mentercwmgwendraeth .
- Welsh Health Care Awards winner 2008
- WCVA commissioned Bangor University as part on the “Building Strong Bridges “initiative .Report now available (2010)

Additional information on the service, including activity and outcomes information is also available from Menter Gwendraith.

**Note:** an additional 6 month pilot project providing a week day service from 10.00am – 2.00pm is underway. Further information is available from the contact details above.

## 5.11. Age Concern Gwent Hospital Discharge Services

**Contact Details:** HDS Caerphilly  
Beaumont House, Bloomfield Rd, Blackwood  
☎ 01495 227039

HDS Newport, St Woolos Hospital 131 Stow Hill Newport  
☎ 01633 2383101

HDS Monmouthshire, Neville Hall Hospital, Abergavenny  
☎ 01873 850619

HDS Blaenau Gwent, Neville Hall Hospital, Abergavenny  
☎ 01495 718548

### Link to the 10 High Impact Changes:

The services apply to some elements of all the Impact Changes.

### Brief background to the Project

Our core services of HDS in all areas provide temporary extra help and support for older people from all ethnic backgrounds, suffering from physical and mental health problems on their return from hospital. This applies to anyone aged over 50yrs of age and living in the Gwent area.

In Caerphilly we also have a weekend service that offers short term health and social care, which also covers bank holidays.

In Newport to supplement the HDS we have a support worker designated to serve the ethnic population. There is also a personal care service which generally delivers a package of care for a 6 week period including weekends following discharge from hospital. This package of care is agreed with the local authority Social Services Dept.

### Aims and objectives of the project:

- Provide a quality service to patients on discharge from hospital.
- Maintain and improve independence
- Maximise the income of individuals
- Ensure personal safety within the home setting

### Measurable outcomes of the project:

- Improved mental, physical and financial wellbeing of the clients.
- Prevention of admission to hospital
- Enabling clients to regain their confidence
- Maintain and improve their standard of living

### **What evidence is there to support success?**

- Evidence is obtained via reports from the CSSIW particularly in relation to the personal care service.
- Monitoring reports from the commissioners / Funders
- Regular feedback from the clients on the benefits they report by having had our services

### **Costs**

Funding for the projects are through the Local Authority and Aneurin Bevan Health Board.

### **Is the project formal or informal? (ie paid or voluntary or a mix)**

All core Hospital Discharge Scheme services are staffed with paid workers. However some services have more volunteers than others. The volunteers full fill various roles depending on their commitment. This can range from volunteering for admin duties or going into the community to give extra support to clients where and when needed

### **Additional supporting information:**

None provided.

## 5.12. Conwy Community CIC Start

**Contact Details:**     **Colette Neal**  
                                  **Project Manager, Conwy Voluntary Services Council**  
                                  **8 Rivières Avenue, Colwyn Bay LL29 7PU**  
                                  ☎ **01492 523850**  
                                  ✉ [coletteneal@cvsc.org.uk](mailto:coletteneal@cvsc.org.uk)

### Link to the 10 High Impact Changes:

The main link is to impact 9: Integrated and effective partnerships, but the service can also be mapped to impacts no 1 no 4 and no 7

### Brief background to the Project:

The scheme involves the development of a collaborative service delivery model based upon consortia of a number of organisations working as partnerships. Collaboration within and across these sectors is likely to bring a number of benefits.

The Conwy Intermediate Care Service (CICS) is a multi-disciplinary statutory sector team which includes professionals from both Health and Social Care, who are co-located and managed as a single entity that reports to both statutory bodies on its activities. The CIC Start Pilot aims to link the services delivered in the community by Third Sector organisations seamlessly with the team. The members of the consortium each retain their own contractual relationships with their funding agencies, but have developed shared processes and paperwork to support the service delivery. The relationship between the organisations is supported by a Joint Working Agreement where the distinct roles and responsibilities of each partner are made explicit.

This project has been divided into two distinct phases with phase one based around gaining local buy in and strategic support, designing the service and securing funding. Phase two was the development and implementation of a one year pilot service to test the model of consortia style working.

### Aims and objectives of the project

- For WAG: the “testing out” of a model of partnership working with the voluntary sector, the learning from which can be used elsewhere to achieve the aspirations around jointly funded, collaborative, citizen-centred service delivery, outlined in recent strategic documents such as Making the Connections; the Beecham Review and Designed for Life.
- For the local health community in Conwy: Maximum use of the total resource available to deliver intermediate care in Conwy through enhanced collaboration with the voluntary sector as a means of extending access to a range of services for the patient.
- For the voluntary sector: a framework for engaging as equal partners with the statutory sector in service planning and delivery which is fully flexible and responsive.

- For all: a framework for the procurement of services that is workable with any number of funding agencies and any number of voluntary organisations, and any combination of both.

### **Measurable outcomes of the project**

- Patients independence and autonomy will be maintained
- Reduction in unscheduled hospital admissions as patients are receiving enabling support in the community
- Prevention of social isolation and empowerment of the individual towards independence and self management
- Increased uptake of self management initiatives
- A framework for engaging as equal partners with the statutory sector in service planning and delivery which is fully flexible and responsive
- Reduction in re-referrals to CICs Team as the patient/service user is receiving an enhanced level of enabling support from a wider section of core community services
- Reduction in admissions to long term nursing and residential care which will release resources and benefit the patient and continuing health care
- Possible reduction in social services costs as a result of better utilisation of the voluntary sector services in relation to chronic disease management
- A model for consortium working

### **What evidence is there to support success?**

Early monitoring data, service user feedback and case studies indicating success of service is available. The Pilot service is in the process of being evaluated externally by the Health Services Management Unit at the University of Birmingham. Report will be forthcoming in 2011.

### **Costs:**

Total cost for 1 year pilot project was £68K

### **Is the project formal or informal? (ie paid or voluntary or a mix)**

Mixture of paid staff and volunteers

### **Additional supporting information:**

Detailed supporting information including information on the planning, the 2 phases of the scheme, and outcomes is available directly from the Conwy CIC Team.

## 5.13. Touch Trust

**Contact Details:**     **Touch Trust Ltd**  
**Wales Millennium Centre**  
**Bute Place**  
**Cardiff CF10 5AL**  
**☎ 02920 635660**  
**✉ [nfor@touchtrust.co.uk](mailto:nfor@touchtrust.co.uk)**

### Links to 10 High Impact Changes:

The main link is to high impact change 1, but can also be linked to changes 2, 7, 9, and 10.

### Brief background to the Project:

The Touch Trust, based from a purpose built suite within the Wales Millennium Centre in Cardiff provides creative, touch-based movement, education and dance programmes for the benefit of individuals with autism, profound and multiple disabilities and challenging behaviour. Within the Touch Trust's beautiful purpose built sensory rooms they offer group and individual sessions developing relaxation, confidence, communication, self esteem and social skills in a holistic and happy environment. This intensive interaction, benefits participants both in physical and mental health, involving sensory integration and praise which enhance the quality of life and enjoyment for their guests, their carers and families.

Their programmes support babies and their families, people with dementia and brain damage as well as adults and children with profound and multiple disabilities including autism and challenging behaviour. Their ethos is that no one is turned away. The Touch Trust also provide outreach services across Wales within educational and community settings, offering staff training, monitoring and awareness sessions. They also provide group sessions for schools, community houses and day centres. 'Touch Trust rooms' with staff especially trained are now set up in several locations across Wales.

The Touch Trust aims to help create more inclusive communities, advocating for disability equality work and the break down social and physical barriers that exist within communities. Whilst already working within community arts/dance organisations, they are now looking to extend their reach and work with those professionals who are likely to come into contact with individuals who have autism, profound and multiple disabilities and challenging behaviour within their workplaces.

### Aims and objectives of the project:

The Touch Trust mission statement is to:

- Advocate for the development of an inclusive community through the provision of creative movement opportunities for those often denied access to the arts and other social activities.
- Developing and promoting life-long learning, education and self-development within a creative and nurturing environment

- Training, development, research and outreach activity in adapted creative movement programmes for individuals with autism, profound and multiple disabilities and challenging behaviour.

### **Measurable outcomes of the project:**

The Touch Trust has a range of accounts demonstrating the impact their work has had which are available on request. Below are a few extracts from one individual's experiences.

*'The first time I went to a Touch Trust session with my sister, I was shocked by the effusive greeting we received, having become accustomed to horrified gaping at her disinhibited behaviours, and the distance this set between us and the rest of humanity. Dilys and Charlotte [Touch Trust staff] seemed to accept these things as aspects of her personality, just as if she were shy or aloof. On reflection, it speaks volumes about how isolated we had become in terms of social interaction, that the fact of this attitude could elicit such a response....*

Since that day, some years ago now, Naomi has benefitted substantially from the unique approach of Touch Trust. This means that, as a consequence, my family and I have benefitted, not only personally from accompanying Naomi to her sessions, but also from the positive effects of attendance on her psychological state and behaviour... It is not overstating the case to say that Touch Trust is essential, to people like my little sister and me and my family. Touch Trust speaks Naomi's language, which is music and other noise, and the Trust allows her space to find a way to make that noise a tool to express herself in a meaningful way. She has learnt how to tolerate invasions of her personal space which had previously elicited violent tantrums, and how to be quiet for others to have their say (sometimes!).

### **What evidence is there to support success?**

The Touch Trust monitor closely the progress individuals make through sessions keeping written accounts as well as carrying out larger scale reviews every few months. It has received much recognition from the Welsh Inspectorate, head teachers at special schools and managers of day centres. For example Matthew Gough, the Community Director of Rhondda Cynon Taff is an enthusiastic advocate, setting up three centres and is planning more. Another advocate is Mike Kerr, Professor of Learning Disability Psychiatry at Cardiff University School of Medicine. He believes the Touch Trust makes a real difference in the field of disability. More information is available on request.

### **Costs:**

- £16 Group Session, £30 one to one session (no one is turned away, bursaries can be made available)
- £650 Training session for leaders, £variable Training Day workshops
- The Touch Trust receives a £150,000 grant from the Arts Council, some smaller Cardiff Council grant funding and also undertakes fundraising activities.

### **Is the project formal or informal? (i.e. paid, voluntary or a mix)**

Predominantly formal, paid. The Touch Trust also work in partnership with Welsh National Opera and Royal Welsh College of Music and Drama who provide skilled volunteer musicians; UWIC also runs student volunteering placements.

**Additional supporting information:**

Website: [www.touchtrust.co.uk](http://www.touchtrust.co.uk)

## 5.14. British Red Cross services provided across Wales

**Contact Details:**     **Jeff Collins, Director Wales**  
**British Red Cross**  
**Ynys Bridge Court**  
**Gwaelod Y Garth**  
**Cardiff CF15 9SS**  
**☎ 02920 815680**  
**✉ [jcollins@redcross.org.uk](mailto:jcollins@redcross.org.uk)**

### Link to 10 High Impact Changes:

The main link is to High Impact Change 1, but services also link to changes 2, 4, 5, 7, 9, and 10. An additional grid is available that sets out in detail how different services link to the 10 High Impact Changes.

### Brief background to the Project:

The British Red Cross has a comprehensive programme of health and social care delivery in Wales ranging from very complex service activities registered with the Care and Social Services Inspectorate Wales through to the more generic support in the home schemes. As well as delivering regional and local service provision to meet the individual need of local communities within Wales the Red Cross also provide a range of core services delivered throughout Wales. These include:

- **Care in the Home.** Staff and volunteers provide short-term care and support in the home for people after an accident or illness, giving them the confidence to continue their daily lives. This enables people to maintain their independence, help prevent hospital admission and managed hospital discharges effectively by providing personal care, practical support, emotional support and assisting with medication. In addition those with more complex needs, particularly palliative care patients can be supported to remain at home by providing personal care and assisting with medication
- **Medical Loan.** Short term (6-8 weeks) loans of medical equipment for people with disability or illness. Items include wheelchairs, commodes, bath-aids, bed-aids, toilet aids and smaller daily living aids.
- **Practical Aids to Daily Living (PAL).** The service sells a wide range of medical and daily living aids equipment, helping older people and individuals recovering from illness to undertake daily tasks.
- **Patient Transport Service.** The transport service offers freedom and independence for people who cannot get about easily or use public transport. It helps people to get to medical appointments and to do everyday essentials like shopping, or even just getting out of the house to socialise. This service is particularly useful for disabled people and those living in rural areas where access to transport can be limited.
- **Therapeutic care.** Trained volunteers offer gentle therapeutic massage and emotional support to people at times of personal crisis to reduce stress and promote a sense of well-being.
- **Skin camouflage.** Red Cross practitioners teach people with disfiguring skin conditions and scars how to use prescribable cover creams, helping them regain

confidence and independence. Individuals are usually referred by GP or other health professionals but can also be self referred.

### **Aims and objectives of the project:**

Working with partners across Wales the Red Cross aims to deliver services providing crisis care and rapid response to people in their homes, helping people to remain safe and independent through a health crisis.

### **Measurable outcomes of the project:**

The British Red Cross in the delivery of these activities undertakes to measure the difference made to the individual, by the use of a range of both internal and external outcome tools appropriate to the service and agreed with partners and Commissioners

### **What evidence is there to support success?**

In 2009:

- The Care in the Home service provided care to 4,865 people
- The Medical Loan service provided support for 9,038 individuals
- Therapeutic care was provided to 3,466 people

### **Costs:**

Unknown

### **Is the project formal or informal? (ie paid, voluntary or a mix)**

A mix of paid and voluntary staff

### **Additional supporting information:**

[www.redcross.org.uk](http://www.redcross.org.uk)

*'Saving Lives, Change Lives...Introducing the British Red Cross in Wales'* British Red Cross, 2010.

*Note: In addition to this template British Red Cross have developed a grid that sets out how all their schemes and services map against the 10 High Impact Changes. This grid is available directly from British Red Cross.*

## 5.15. Tenovus Cancer Support Team

**Contact Details:** 9<sup>th</sup> Floor, Gleider House,  
Ty Glas Road,  
Llanishen,  
Cardiff, CF14 5BD  
☎ 02920 768850  
✉ [post@tenovus.org.uk](mailto:post@tenovus.org.uk)

### Link to the 10 High Impact Changes:

Although Tenovus has no statutory duties and is not an emergency service, it is able to meet some of the high impact changes. The main change would be High Impact 9 which advocates partnership working and integrated services. Tenovus, in working with individuals and groups, regularly encourages a shared response from services irrespective of organisational boundaries, working together for the good of the patient. Other high impact changes that Tenovus can meet, working alongside statutory services are:

- Identifying complex needs
- Effective multi disciplinary working
- Proactive discharge planning
- Being part of a workforce designed to serve complex needs.

### Brief background to the Project:

Since 2008, (having been a cancer support charity for over 65 years) we have focused our charitable activity, in line with the NICE manual and Welsh Assembly Government policies, on providing a truly holistic support system designed around the complex needs of patients, their families and carers, delivered at the heart of the community. Consequently, we have expanded our Cancer Support Team (CST) of cancer specific counsellors (including bereavement counsellors), welfare advisors and social workers. Following a successful lottery bid, we will now be offering our welfare rights service in each of the local health boards within Wales. To support this, we have a dedicated Freephone Cancer Support Line managed by a Senior Development Nurse, Cancer Support Advisor and Health Advisor. They are supported by trained volunteers who have received accredited benefits training.

The majority of cancer patients need cancer specific welfare and social care support following their cancer diagnosis. Often there is insufficient professional capacity to meet these complex cases, which can add to the pressure on nurses, who are called upon to deal with this demand. Provision to meet this need is often dependent on the resources available in certain geographical areas which we are endeavoring to meet. In rural areas and those of high deprivation, access to services is often a significant issue for people.

In February 2009 we launched the world's first Mobile Cancer Support Unit, which is equipped to deliver advice, treatment (including chemotherapy), and information into the heart of vulnerable communities. The demand we have experienced over the past year through operating the Unit has been significant. A total of 4,048 people have visited it since it was launched on February 2<sup>nd</sup> 2009. Between then and the end of March 2010 the bus has been open for 214 days in 33 locations in Wales and England. During the same

period 736 treatments have been provided with up to 25 patients receiving treatment on each day of chemotherapy delivery.

### **Aims and objectives of the project:**

Our ten key messages are follows:

- At Tenovus, we are there for you – from diagnosis, right through treatment and beyond.
- We help you understand more about your treatment, possible side effects and future care plans through our specialist oncologist nurses.
- We offer you and your family the support you need, when you need it, through our team of highly trained professional social workers and counsellors.
- We bring cancer care, treatment and support right to the heart of the community through our Mobile Cancer Support Unit.
- We provide a Freephone Cancer Support Line to help answer any questions or concerns that you may have.
- We ease financial pressures by helping you claim the benefit money that you are entitled to.
- We fund and conduct vital, varied scientific and social research to help prevent, treat and find a cure cancer.
- We help you come to terms with your illness and all the life changing issues that may affect you.
- We raise money to help you with all aspects of your cancer care.
- We help raise awareness of cancer by providing health checks and education services.

### **Measurable outcomes of the project:**

Tenovus uses two data base systems to record, monitor and track its relationship with individuals and their progress, namely:

- MegaNexus for all referrals received in respect of people affected by cancer
- Raiser's Edge for all other contact relationships.

All contracts undertaken by Tenovus are managed on a day to day basis by the department of the charity involved. The Director of Cancer Support is a member of the charity's Senior Management Team, answerable to the Chief Executive and the Board of Trustees.

Details of all referrals for cancer support received by Tenovus are recorded on our Cancer Support Team's Meganexus database and details of all volunteers recruited and trained by the charity are recorded on our general data base. From this database it will be possible to extrapolate detailed information about cancer patients, their families and carers who want to or return to the workforce. The database (which has been bought specifically to help improve our analysis of the service we deliver) has the facility to provide daily, weekly, monthly, quarterly and annual management reports.

### **What evidence is there to support success?**

The reports obtained from the database enables us to measure and track the service delivered by the project to cancer patients and enables us to measure the progress made against the outcomes set.

The Cancer Support Team works closely with the Research Team at Tenovus, ensuring that any developments in our services are evidence-based and we are reacting to needs and/or gaps in service provision.

**Costs:**

- The annual cost to operate the Cancer Support Team is approximately £578,000
- The annual cost of the mobile unit is in the region of £348,000

**Is the project formal or informal? (ie paid, voluntary or a mix)**

The Cancer Support Team is a multidisciplinary team made up of welfare rights officers, oncology nurses, health advisors, social workers, counsellors and trained volunteers. Tenovus has a dedicated Volunteer Development Manager to oversee the support and development of volunteers within the Cancer Support Team.

**Additional supporting information:**

Please visit our website [www.tenovus.org.uk](http://www.tenovus.org.uk) for all up-to-date information on our services.

## 5.16. Age Concern Gwent Prevention of Admission Service

**Contact Details:** Age Concern Gwent, St Woolos Hospital Newport  
☎ 01633 238313  
✉ [david.liles@wales.nhs.uk](mailto:david.liles@wales.nhs.uk)

### Link to the 10 High Impact Changes:

The service applies to some elements of all the high impact changes

### Brief background to the Project:

The service provides temporary help and support for older people who are ill, to prevent admission to hospital. Referrals are received from General Practitioners and Medical/Nursing Staff of the Accident and Emergency Department the Medical Assessment Unit and designated wards of the Royal Gwent Hospital. Service Users are visited within two hours of the referral being received. The service is available 8.00am-8.00pm seven days a week including Bank Holidays. Anyone over the age of 50 and living in the County Borough of Newport can receive the service free of charge for 7 days.

### Aims and objectives of the project:

- To reduce the number of inappropriate hospital admissions of older people
- To provide fast response, time limited care service to support the Service Users in their own home and prevent admission to hospital.

### Measurable outcomes of the project:

- Prevent Admission to Hospital
- Increase/Return quality of life
- Increase/Return Independence
- Increase sense of wellbeing
- Return to Independent Living

### What evidence is there to support success?

- Report from CSSIW
- Monitoring Reports From commissioners /funders
- Regular feedback from the service users

### Costs:

Funding from Local Authority and ABHB

### Is the project formal or informal? (ie paid or voluntary or a mix)

The service is staffed with paid workers

### Additional supporting information:

No additional information provided.

## 5.17. Rapid Response Hospital Discharge Service

**Contact Details:** Age Concern Gwent  
Rapid Response Hospital Discharge Service  
☎ 01633 234699  
✉ [david.liles@wales.nhs.uk](mailto:david.liles@wales.nhs.uk)

### Link to the 10 High Impact Changes:

The service applies to some elements of all impact changes.

### Brief background to the Project:

The Rapid Response Hospital Discharge Service is a short term service delivering Reablement in personal care, to people over 50years of age living in the Newport area who are being discharged from hospital. The care package offered to the service user is a short term package for 14 days, a visits are made daily during the first week, reducing care during the second week to every other day.

### Aims and objectives of the project:

- To provide fast response to enable patients be discharged from hospital and be cared for in their own home.
- To reduce the amount of time patients wait to be discharged.

### Measurable outcomes of the project:

- Reduce Hospital stay
- Increase/Return quality of life
- Increase/Return of Independence
- Increase sense of wellbeing
- Return of Independent daily living
- Prevent readmission to hospital

### What evidence is there to support success?

- Report from CSSIW
- Monitoring reports from commissioners/Funders
- Regular feedback from service users

### Costs:

Funding from Local Authority

### Is the project formal or informal? (ie paid or voluntary or a mix)

The service is staffed by paid workers

### Additional supporting information:

None provided

## 5.18. Age Concern Gwent Respite Care Service

**Contact Details:** St Woolos Hospital, Stow Hill, Newport NP20 4SZ  
☎ 01633 240195  
✉ [respite@ageconcernqwent.org](mailto:respite@ageconcernqwent.org)

### Link to the 10 High Impact Changes:

The service applies to some elements of the changes

### Brief background to the Project:

The aim of the service is to provide respite within the cared-for person's home to enable their carer to have a break from their caring role. Care is provided to people over 50 years of age suffering from a chronic or mental health illness living in Newport and Monmouthshire. Periods of care range from four to twelve hours and are provided on a regular basis.

### Aims and objectives of the project:

The aim of the service is to promote independence and to provide support in order that the Carer can continue in their caring role, enabling the cared-for person to remain in their own home. Regular visits are agreed at the Carer's convenience and we also provide support when medical appointments etc are required. We try to provide a certain amount of flexibility should a Carer require to change or extra placement but this is subject to Care Worker availability. The Care Worker can provide tasks such as personal care, washing, dressing toileting etc, help with meal preparation and feeding along with general stimulation and companionship as required.

### Measurable outcomes of the project:

On initial assessment we carry out an evaluation of service users desired outcomes by asking the following questions to ascertain why they require respite:-

Able to have time to themselves, able to have a social life/leisure interests, able to have a holiday, able to spend time with their family, able to do something that is important to them, able to continue working/education, able to have a good nights sleep, emotional support, Other reason. On review we then ask if these have been achieved and whether the outcomes have changed.

### What evidence is there to support the success?

Feedback on the service is gained on Client Evaluation Forms and within the CSSIW Annual Report. We have been supporting a number of clients for many years, allowing them to remain at home. We have a good demand for the service with referrals awaiting support. Monitoring reports received from Commissioners/Funders.

### Costs:

Funding is received from Local Authorities and a Local Health Board

**Is the project formal or informal? (ie paid or voluntary or a mix)**

All staff are paid either on Contracted or Bank Hours

**Additional supporting information:**

None provided.

## 5.19. Crossroads Care

**Contact Details:**     **Andi Lyden**  
                                  **Development Manager**  
                                  **Crossroads Care Wales**

### **Links to the 10 High Impacts Changes:**

There are demonstrable links to all of the 10 High Impact changes.

### **Brief Background to the Project:**

Crossroads Wales provide a range of services and schemes across Wales in partnership with both local government and the NHS. These schemes include working with GP out of hours services to prevent avoidable admissions to hospital, assisting and supporting carers, and specialist emergency response schemes.

Services are able to respond flexibly to manage changes in need, adopting a person centred approach to assessment, and are able to manage complex needs and requirements, by linking in with other statutory and voluntary agencies to ensure a co-ordinated approach.

Cross roads care are involved with specific regional programmes which could be expanded to other areas. These include the CIC's project in Conwy – a consortia led project involving Conwy LHB, Conwy Social Services, Intermediate Care Team, British Red Cross and Crossroads Care North Wales. The project is a twelve week involvement to prevent hospital readmissions.

### **Aims and objectives:**

Crossroads care provides a wide range of schemes and services, each of which will have their own aims and objectives.

### **Measureable outcomes of the project:**

Crossroads care work closely with other agencies to ensure outcomes are identified and captured for their schemes and services.

### **What evidence is there to support success?**

Outcome based findings are available for services provided. In addition management systems ensure data is available to ensure an accurate match with all systems.

Crossroads Care schemes in Wales have a structure that can work at a national level in long term planning and with the Health Boards to address regional and locality specific needs.

**Costs:**

The costs of the schemes vary, depending upon their purpose and requirements

**Is the project formal or informal? (ie paid or voluntary or a mix)**

Formal via a skilled workforce

**Additional supporting information:**

Crossroads care have provided detailed supporting information and have mapped their services against the *10 High Impact Changes for Complex Care* guide, setting out their contribution to meeting the requirements of each of the high impact changes.

Further information, including the mapping exercise, can be obtained directly from Crossroads.

## 5.20. Carers Assessments Powys

**Contact Details:** Powys Carers Centre  
Coniston House, Temple Street  
Llandrindod Wells, Powys, LD15HG  
☎ 01597 823800

### Link to the 10 High Impact Changes:

Early intervention model for the generic nature of carers

### Brief background to the Project

Under the Equal Opportunities (Carers) Act 2004, local authorities have a duty to offer and undertake a Carers Assessment with identified carers.

This duty has normally been carried out by a member of a social services team which inevitably has a long waiting period and/or places a low priority on carrying them out.

### Aims and objectives of the project:

- To conduct earlier assessments and thereby earlier identification of need that may be met by non statutory services, referring onto statutory services if a need is identified and best met by statutory service provision.

### What evidence is there to support the success?

The project has been running for 3 months and is planned to be evaluated at the end of one year. To date 18 carers have been assessed by a designated Powys Carers Service Outreach Worker. The Outreach worker is able to offer rapid assessment, a support plan and a source of information, advice and emotional support. An initial evaluation will be carried out by March 2011 but, to date, all Carers have found the assessment useful and a small number have been referred on for the rapid provision of statutory services. Early intervention has enabled carers to reflect on their role, the future and to identify additional means of support. This early intervention is leading to a reduction in the deterioration in their health and well being.

*One couple's referral to Rethink (a mental health charity) has been "the best thing that ever happened".*

*A carer told us that the PCS intervention "has really helped her clarify my thinking and pointed out a way forward".*

*Another said, "You have managed to articulate precisely everything I was worrying about but could not put in to words. It has been so so helpful to discuss everything with you. I can now see a way forward for myself and it is really positive one. I feel a great weight has literally been lifted from me".*

In a recent survey by PCS over 70% of respondents said that they agreed or strongly agreed that PCS helped them carry on caring, enabled them to have more control over their life and improved their health and wellbeing.

**Costs:**

£17,000 per annum (1 pt worker)

**Is the project formal or informal? (ie paid or voluntary or a mix)**

- The project is a formal arrangement (a six month pilot) between Powys Carers Service and Powys social services.
- Powys Carers Service provides information advice and advocacy through a network of community based outreach workers.
- Powys County Council Adult services is funding one part time PCS Outreach Worker to carry out Carers Assessments in mid Powys. If the pilot is successful it is intended that the service will be expanded across the whole of Powys.

**Additional supporting information:**

Results based Accountability reporting and the following data is available:

- Number of Carers Assessments completed
- Number of PCS Support plans completed in relation to Carers Assessments.
- Carers Assessments passed onto Social Services.
- Review towards in the first 6 months of project and end of project of all Carers Assessments taken place Statistics on interventions & outcomes.
- Carer's Quality of Life questionnaire pre & end of project.
- Stakeholder's questionnaire Re: process, communication, benefits, strengths & weaknesses.
- Case Studies
- Carers Assessments that have started but not completed and reasons will also be recorded.

## 5.21. Powys Urgent Response Service at Home

**Contact Details:** Crossroads Care Mid and West Wales  
2 Wheat Street, Brecon, LD37DG  
☎ 01874 610900  
✉ [mid.west@crossroads.org.uk](mailto:mid.west@crossroads.org.uk)

### Link to the 10 High Impact Changes:

Meeting the generic needs of carers across the ten areas and preventing hospital admissions.

### Brief background to the Project:

Avoidable admissions to hospital were taking place when the GPs out of hours service had no other option to admit someone when further continual medical observation of the patient were required.

Through contracting a registered provider of such a service, then considerable savings and efficiency in bed stays, ambulance costs, emotional upheaval and more immediate service provision could be achieved.

The project is a partnership arrangement between the Powys Teaching Health Board, Powys Association of Voluntary Organisation and Crossroads Care.

### Aims and objectives of the project:

- To provide short term support and care within peoples' own homes, in emergency situations when hospital admission is deemed inappropriate.
- To provide support to carers to enable them to sustain their caring role and personal wellbeing.
- To contribute to a coordinated approach between medical, social and third sector services to enable the individual to remain at home, to support return to previous level of independence.
- To enable individuals to overcome an episode which involves deterioration in their health and wellbeing
- To contribute to the provision of information to the care team which will inform the planning of future services.

### Measurable outcomes of the project:

The costs of admitting someone in these circumstances to hospital range between £800 and £2000 per day as opposed to contracting a short term domiciliary service with an overnight unit cost of no more than £350.

Each referral and non admission will be set against these savings

### What evidence is there to support success?

The service started in early October and has had 10 referrals so far with the rate increasing. The early indications have been so encouraging that the service is shortly to commence in Mid Powys as well.

**Costs:**

£80K contract per annum for the registered provider

**Is the project formal or informal? (ie paid or voluntary or a mix)**

Formal contracting arrangements are in place

**Additional supporting information:**

PAVO has provided a detailed service specification to support this template. This is available from PAVO and sets out in detail the general and specialist tasks that are included within the service.

## 5.22. Robense House (Family WISH Project)

**Contact Details:** Robense House  
12 Uplands Terrace, Uplands, Swansea  
☎ 01792 450040  
✉ [Mark.Hopkins@fha-wales.com](mailto:Mark.Hopkins@fha-wales.com)

### Link to the 10 high impact changes:

- **High Impact Change 1** – By maximising service users capacity for independent living and supporting people within their own homes .
- **High Impact Change 2** – By involving all parties e.g. service users, ourselves as care and support providers, family members and health and social care professionals involved in the care of the person in planning to meet complex needs.
- **High Impact Change 3** – by ensuring that a person centred approach is in place with service users care and support individually tailored to meet their needs in a way that maximises their capacity to live as independently as possible.
- **High Impact Change 4** – By adopting a MDT approach and working closely and cohesively with health and social care professionals in order to best meet the needs of service users.
- **High Impact Change 5** – By working with service users before they are discharged from hospital (pre-tenancy work) and by being involved in the discharge process from the outset.
- **High Impact Change 6** – By developing contingency plans and joint working arrangements with health and social care professionals, clinical psychology, community mental health teams, occupational therapy and crisis intervention teams, that ensure staff have access to expert advice and resources and to make clear the processes for dealing with escalation. These include risk management plans and procedures that complement the Unified Assessment.
- **High Impact Change 7** – By working in partnership with health and social care professionals to jointly deliver care and support to service users in their own home.
- **High Impact Change 8** – By developing a bespoke data collation system for service users inputs and outcomes in this project in conjunction with clinical psychology that enable managers conduct a robust evaluation of the service using evidence based information to inform service improvements.
- **High Impact Change 9** – the commissioning of this project was a joint enterprise between Health and the Local Authority with a focus on improving quality and cost effectiveness. The outcomes demonstrated at the initial service evaluation evidence the fact that this project is certainly delivering on this aim. Examples of effective partnership working include joint assessments, sharing of information, access to training, staff having specialist support from health professionals eg psychology and occupational therapy, to enable them to be better able to deliver care and support to service users.
- **High Impact Change 10** – by supporting the shift towards a community setting and by health making available resources such as specialist training and support to project staff.

### Brief background to the Project:

The project provides an alternative to long stay hospital and high cost private residential care. It is phase 5 of the then Swansea Health Trusts's repatriation programme. It was commissioned as a joint venture between Health and Supporting People with the aim of providing a supported housing setting for people with complex mental health issues who are eligible for continuing healthcare funding. Service Users have their own tenancies as opposed to living in a residential care setting and receive relatively intensive high relational support focussed at maximising the capacity to live independently in the community.

The project was commissioned in the summer of 2009 and opened on the 11<sup>th</sup> January 2010.

### **Aims and objectives of the project:**

Detailed information on the aims and objectives are available.

### **Measurable outcomes of the project:**

Detailed information on outcomes is available in a separate evaluation report.

### **What evidence is there to support success?**

Reports are available from independent consultants. Testimonials are also available. A separate evaluation report has been prepared.

### **Costs:**

The projects costs are £482,937 per annum or £80, 500 per unit per annum. This compares to benchmark private residential care costs of £98,000 per annum or the cost of long term hospital inpatients of £109, 500 per annum (£300 per day Source: Prof M. Aylward: Supporting People Review 2010). As such the project works out as 18% and 26% cheaper respectively.

### **Is the project formal or informal? (ie paid or voluntary or a mix)**

Formal – paid staff.

### **Additional supporting information:**

Detailed additional reporting information, including testimonials, nominations for awards, and outcomes is available directly from Robense House.

## **5.23. Continuing Care Carmarthenshire**

(Supporting Independence in the Home Programme)

**Contact Details:** C/O PAI  
3 Heol Rhosyn Dafen Park, Dafen, SA14 8QG  
☎ 01554 7570896  
✉ [BRCSSP-Llanelli@redcross.org.uk](mailto:BRCSSP-Llanelli@redcross.org.uk)

### **Link to the 10 High Impacts:**

In partnership the Carmarthenshire Continuing Care service has mapped their work against the high impact changes and can identify links to the following: Change 1, 2, 3, 4, 5, 6, 9, and 10.

### **Brief background to the Project:**

In November, 2006 the British Red Cross in Carmarthen began partnership working with the Acute Response Team (ART). The British Red Cross, with 3 part time support workers, worked alongside the ART Team to provide the social care support to patients who require nursing intervention that can be carried out in their own homes. The aim of the service is to prevent inappropriate admissions to hospital and facilitate an earlier discharge.

During our partnership work with ART the Red Cross were asked to assist the District Nurses and the ART team in supporting continuing care, end of life patients. The Red Cross provided the social care support and with CSSIW registration were able to provide the personal care required to enable the patients to remain at home with loved ones.

In 2008, the British Red Cross working in partnership with Marie Curie provides end of life care to patients wishing to die in a place of their choosing. The British Red Cross operates the service 7 days a week, 8 am – 5pm, conducting multi visits to patients, providing practical and emotional support to patients and their families.

Current activity – 69 patients and their families supported to date in 2010.

Providing 210 Hours a week, with 7 x full time Senior Health Care Support Workers (SHCSW), 1 x part time (SHCSW) operationally managed with a Team Leader and a Care in the Home Manager ( Registered Manager CSSIW). The SHCSW's and Marie Curie Senior Health Care Assistance cover a 24/7 rota to provide a seamless continuity of care to the patients.

### **Aims and objectives of the project:**

- To provide practical and emotional support to patients and their families in their own homes to enable them to die in a place of their choosing with dignity and respect.

### **Measurable outcomes of the project:**

In 2006/07 the rates of patients dying at home was 21.6%, with partnership working across sectors our aim is to increase that percentage

**What evidence is there to support success?**

A WHISC Report and a CSSIW 2010 Report are available, and demonstrate the outcomes of the scheme.

**Costs:**

Current funding streams = £158K

**Is the project formal or informal? (ie paid or voluntary or a mix)**

The project is formal, and delivered with paid Senior Health Care Support Workers with NVQ level 3 in Care and End of Life Training.

**Additional supporting information:**

Detailed additional reports and outcome information are available directly from the point of contact.

## 5.24. Newport Kaleidoscope

**Contact Details:**      **Old School Building**  
**Powell's Place, Newport, NP20 1LU**  
**☎ 01633 245890**  
**✉ [sian.chicken@kaleidoscopeproject.org.uk](mailto:sian.chicken@kaleidoscopeproject.org.uk)**

### Links to 10 High Impact Changes:

The project can be mapped against the 10 impact changes. The main links are:

- effective multidisciplinary team working
- Integrated services and effective partnerships

The project also meets the other 8 changes.

### Brief background to the Project:

Newport Kaleidoscope's mission is to contribute towards safe and fulfilling lives, free from the constraints of substance misuse – for our service users, their children, their significant others and the wider community. Within this contract we are commissioned to provide the following services:

Substitute Prescribing	BBV Services
Harm Reduction Services	Health Promotion
Single Point of Contact	Bibliotherapy
Duty-care System	Outreach work
Joint Allocation Meetings	Preparation Programme
Comprehensive Assessment & Care Coordination	Day Care
Structured Care Planned Counselling	Diversionary Activities
Community Detoxification Support	Aftercare

Services are delivered from the purpose designed building in Powell's Place.

### Aims and objectives of the project:

Kaleidoscope's core business in England and Wales is the provision of substitute medication prescribing services. The aims of the service are:

- To engage substance misusers in a continuum of service provision in order to reduce substance related harm and improve access to more rewarding and fulfilling lives.
- To stabilise and detoxify service users on appropriate substitute medication to alleviate withdrawal and cravings to reduce the use of illicit or non-prescribed drugs until he/she can achieve a drug free life.

The objectives of the service are:

- To provide a single point of access and triage assessment
- To target high risk and local priority groups
- To engage substance misusers in an appropriate level of treatment

- To reduce substance related harm
- To improve and support a client's motivation
- To promote and reward service user compliance
- To appropriately assess clients to allow individualised care pathways to be developed with clients
- To use recognised model approaches that support reintegration
- To help clients rebuild social networks outside their drug using community
- To ensure all clients are contacted if they disengage with the service from commencement of service delivery
- Development of service user involvement
- Documented and operational care pathways in place by developing working protocols
- Documented and operational care pathways in place with other appropriate Tier 2, 3 and 4 services

### **Measurable outcomes of the project:**

Kaleidoscope provides detailed information to commissioners on a quarterly basis. The complete set of reported outcomes is available from Kaleidoscope. This information is both qualitative and quantitative in nature. Kaleidoscope are also measured against Key Performance Indicators set by the Welsh Assembly Government.

### **What evidence is there to support success?**

Kaleidoscope has continuously met all the listed KPI's. We are able to offer our clients a fully comprehensive service.

### **Costs**

£635,000

### **Is the project formal or informal? (i.e. paid or voluntary or a mix)**

The Project is formal, with paid carers.

### **Additional supporting information:**

Additional detailed information on the services provided, aims, objectives and outcomes are available.

[www.kaleidoscopeproject.org.uk](http://www.kaleidoscopeproject.org.uk)

Please contact Kaleidoscope if you require an annual report.

## 5.25. Person Centred Planning Service

(Provided by Reach – Commissioned by Aneurin Bevan Health Board)

**Contact Details:**    **Person Centred Planning Service**  
**Alders House, Llanfrecha Grange Hospital,**  
**Cwmbran. NP44 8YN**  
**☎ 07837033305**  
**✉ [sarah.beckingham@reach-support.co.uk](mailto:sarah.beckingham@reach-support.co.uk)**

### Links to 10 High Impact Changes:

The Person Centred Planning Service for people with complex needs/ labelled as having behaviours that may challenge maps against several high impact changes. The main link is to No1, Avoid disruption to the main care setting. The Person Centred Planning process concentrates on ensuring that the person's choices and personal views are taken into consideration and maintaining their current living arrangement (rather than going into a hospital setting) is often an important aspect despite what may be going on for the person at the time. Maintaining the person's independence and presence in the community can be key to reducing the disruption to their lives whilst ensuring that they are happy, healthy and safe. Other High Impact changes that the project can be mapped to are:

- No 3 – Agreed Triggers and timely assessment
- No 4 – Effective multidisciplinary working
- No 5 – Proactive discharge planning
- No 8 – Focus on the data for complex care
- No 9 – Integrated services and effective partnerships
- No 10 – A workforce designed to serve complex needs

### Brief background to the Project:

In April 2008, commissioning proposals to develop services for people with a learning disability who engage in behaviours that challenge and / or have mental health problems were approved by the Aneurin Bevan Health Board. This involved the establishment of an Intensive Community Intervention Service (ICIS), an Intensive Support Packages service as well as further resources for the Assessment and Treatment Unit. A key objective of these services was to ensure that services are person centred and responsive to people's needs. To enable this objective to be met, a Person Centred Planning Service was required. Aneurin Bevan Health Board tendered out this service and reach were successful in winning the contract. The Person Centred Planning Service is a 2 year project that started in April 2010.

### Aims and objectives of the project:

- To fully involve the person, their family, carers and Multi Disciplinary Teams (MDT's) in planning
- To facilitate plans with people with complex needs across the range of services (ICIS, ISP and A&T) provided by Aneurin Bevan Health Board. These plans will give a voice to people with complex needs and their families.

- To complete Individual Service Designs where appropriate that detail bespoke service requirements for the person.
- To provide training to staff across these services both breadth and in depth training.
- To identify, train and mentor members of staff from Aneurin Bevan Health Board as Person Centred Planning (PCP) Facilitators in order to develop internal capacity to plan.
- To establish a Person Centred Planning reference group for people to share their experiences and to shape the Person Centred Planning Service.

### **Measurable outcomes of the project:**

- Number of plans (agreed number is 25 over two years)
- Number of training days – breadth and depth
- Number of outcomes identified for individual people in their plans
- Number of outcomes achieved for individual people
- Number of trained Person Centred Planning Facilitators

### **What evidence is there to support success?**

Successful outcomes and anecdotal support from families about the difference it has made. Mr X was referred for a Person Centred Plan from the Assessment and Treatment Unit. He had been on the Unit for some time and plans for him to move needed to be made. The Person Centred Planning Facilitator worked with the person, his family and friends, carers and MDT to put together an Essential Lifestyle Plan and an Individual Service Design which helped to map out the right service for him and the right support staff to match his needs and his hobbies and Interests. Mr X has moved into his new home which matches what was detailed in his Individual Service Design. All the adaptations that were identified have been made to ensure he is safe but can maintain his independence in his own home. His staff team have also been recruited in line with the characteristics identified to suit him.

### **Costs**

£30,000.00 per annum

### **Is the project formal or informal? (ie paid or voluntary or a mix)**

Formal

### **Additional supporting information:**

None provided.

## 5.26. Health Checks Video Clips

**Contact Details:** Mencap Cymru  
31 Lambourne Crescent  
Cardiff Business Park, Llanishen, Cardiff, CF14 5GF  
☎ 02920 747588  
✉ [helpline.wales@mencap.org.uk](mailto:helpline.wales@mencap.org.uk)

### Links to 10 High Impact Changes:

The rolling out of the video-clips could be easily pegged to making a contribution to High Impact Change 3, specifically addressing concerns around “timely assessment”. The principles around comprehensive, people centred approaches to assessing care mirror those behind the production of the video clips.

The Outcome Indicators, specifically care plans that define outcomes and goals and decrease in hospital stays, are targets that Mencap would hope to contribute to with the video clips.

The emphasis of promoting independence, in HIC 1, also reflects the purpose of the video clips. The video clips are intended to give people with a learning disability a stake in their healthcare. The clips let them know not only about their right to a health check, but also the processes leading up to and following on from it.

### Brief background to the Project:

Mencap Cymru talked to more than 1000 people to get an idea of what health services were like for people with a learning disability. We found that people with a learning disability were more likely to have experienced inequality in their access to healthcare.

As a direct result of our campaign and the wider Mencap campaign across the UK, the then Disability Rights Commission and Health Inspectorate Wales both launched investigations into health services for people with a learning disability.

These investigations confirmed that there was a deficit in the level of health care people with a learning disability were experiencing in Wales and in the rest of the UK.

Following the success of Mencap Cymru's Treat Me Right campaign, the Welsh Assembly Government introduced free annual health checks for people with a learning disability who are known to social services.

### Aims and objectives of the project:

Four years on health checks are making a big difference to the lives of people with a learning disability. There are still lots of people however who do not know about the health checks, or if they do, are not taking them up. In 2009, the Welsh Assembly Government commissioned Mencap Cymru and All Wales People First to produce a series of videos to promote the benefits of having a health check.

The main objective of the project was to create an accessible resource for people with a learning disability. It is hoped that this will make people not only aware of the annual health checks, but also to allay their potential fears over what the process involved.

Measurable outcomes of the project:

The obvious outcome of the project will be a marked increase in not only the knowledge, but also the take up of, the free annual health checks. It is hoped that the clips will make the health check part of the general dialogue when people with a learning disability are talking about their health.

It is also hoped that the clips will go some way towards letting people know what it is they are entitled to as part of the health check. Work is currently underway to monitor the quality, not simply the quantity, of health checks being carried out in Wales. This study will work hand-in-hand with the video clips.

### **What evidence is there to support success?**

- An increase in the number of people with a learning disability taking up the offer of a free annual health check
- The study into the quality of the checks giving a high standard to the current method of delivery.

### **Costs**

£10,000 was given to source, produce, edit and host the video clips. They are hosted on the Mencap website (see below) and can be linked to other sites.

### **Is the project formal or informal? (ie paid or voluntary or a mix)**

N/A

### **Additional supporting information:**

[www.mencap.org.uk/waleshealthchecks](http://www.mencap.org.uk/waleshealthchecks)

## 5.27. Getting it Right Campaign

**Contact Details:** Mencap Cymru  
31 Lambourne Crescent  
Cardiff Business Park, Llanishen, Cardiff, CF14 5GF  
☎ 02920 747588  
✉ [helpline.wales@mencap.org.uk](mailto:helpline.wales@mencap.org.uk)

### Links to 10 High Impact Changes:

The principles of comprehensively trained staff, person centred approaches, involvement of relevant parties and recognition of potential difference are ingrained in both the High Impact Changes and the Getting it Right campaign.

HIC 10 has principles that concerns adequately trained staff and support services for staff (liaisons on learning disability).

Ensuring that all parties involved have access to timely and comprehensive information is one of the most vital aspects of the campaign, and to see these written into so many of the HICs is to be welcomed.

### Brief background to the Project:

People with a learning disability have historically had a vastly unequal access to healthcare services, in spite of the fact that they are far more likely to have medical conditions and illnesses in addition to their impairment.

Mencap has historically worked in the fields of health campaigning for the closure of long-stay hospitals in Wales, providing training on learning disability to frontline primary care staff and being the catalyst for the introduction of free annual health checks for people with a learning disability in Wales.

The Ombudsmen's report highlighted the experiences of six people with learning disabilities who had been failed by health services. The *Getting it Right* campaign was established to address such inequalities in secondary health settings

### Aims and objectives of the project:

The *Getting it Right* campaigns aims to have all Local Health Boards and NHS Trusts in Wales signed up to, and practicing, the principles set out in the *Getting it Right* charter. The nine principles are:

1. make sure that hospital passports are available and used
2. make sure that all our staff understand and apply the principles of mental capacity laws
3. appoint a learning disability liaison nurse in our hospital(s)
4. make sure every eligible person with a learning disability can have an annual health check
5. provide ongoing learning disability awareness training for all staff
6. listen to, respect and involve families and carers

7. provide practical support and information to families and carers
8. provide information that is accessible for people with a learning disability
9. display the Getting it right principles for everyone to see

### **Measurable outcomes of the project:**

Measurable outcomes of the project would cover principles 1, 2, 5, 6 and 7.

The introduction of a method of communicating all of the vital information about a person, who may often times lack the ability to do so themselves, is vital to good quality service delivery.

The variation in the level of training that is given to hospital staff in the areas of mental capacity and learning disability awareness would be a measurable outcome of the campaign.

A final measurable outcome of the project would be to monitor the processes in place to provide practical support and information to parents and carers of people with a learning disability.

### **What evidence is there to support success?**

Success could be determined by achieving positive results in the above. Effective, sustainable implementation of these processes would be a great stride towards equality.

### **Costs:**

The project is being run by Mencap Cymru's campaigns team, and is this core funded as it meets the core objectives of the campaigns team's business plan.

### **Is the project formal or informal? (ie paid or voluntary or a mix)**

Run by paid members of staff

### **Additional supporting information:**

[www.mencap.org.uk/gettingitright](http://www.mencap.org.uk/gettingitright)

## 5.28. Carer Well Being Scheme (Intermediate Care Service)

**Contact Details:**     **Wrexham Carers Service**  
**AVOW 21 Egerton Street, Wrexham LL11 1ND**  
**☎ 01978 318812**  
**✉ [marie.gibson@avow.org](mailto:marie.gibson@avow.org)**

### **Link to 10 High Impact Changes:**

The intermediate Care Project can be mapped to all high impact changes. The Carers Well Being Scheme links to High Impact Changes 4, 1, 3, and 5.

### **Brief background to the Project:**

The Carer Well Being Scheme is attached to the Intermediate Care Service, operating within the County of Wrexham.

The Intermediate Care Service is a collaboration of services/agencies; including Local Authority, Local Health Board and Third Sector, and has two main aims - to facilitate timely and safe discharge, and to avoid admissions of patients through Accident & Emergency or via community referrals.

The Carer Well Being Scheme is attached to the Intermediate Care service and offers timely and appropriate support to any individuals caring for those patients accepted. The scheme relies on all professionals involved to take responsibility in helping to identify carers and encourage them to recognise themselves as carers. All carers are offered the opportunity of a Carers Needs Assessment and a referral into the scheme. The assessment would identify positive outcomes to work towards.

The Assessment is carried out by a Community Care Worker (employed through the Local Authority), who then refers onto a Carer Well Being Worker (employed by AVOW, a third sector organisation) to deliver the outcomes identified.

During the assessment process the Community Care Worker also has the opportunity to apply for a small, one off payment, which may assist the carer in their role. This could range from a practical solution to the opportunity for relaxation.

The Carer Well Being Worker has a 6 week period (flexible dependent on need) to work closely with the carer to address any identified needs. This support is tailor-made to each individual and is delivered to suit their wishes. The support offered includes access to all generic service offered by Wrexham Carers Service. The worker will ensure all avenues of support are considered, including referrals and signposting to a wide range of third sector organisations, e.g. Stroke Association, Alzheimers Society, MS Society, Parkinsons Society, Age Concern etc.

The importance of the carer having somebody to turn to, separate from the patient, is vital for the overall success of the Intermediate Care Service. The carer can feel at ease when discussing the impact their caring role has on them, without fear of judgement or consequence. Maintaining patients at home is more likely to succeed if the carers are supported too.

## **Aims and Objectives of the Project:**

The main aims are to work towards positive outcomes for the benefit of the carer:

- Maintaining/improving physical, mental, emotional, and social well-being.
- Experience 'a life of my own' alongside caring responsibilities.
- A positive relationship with the person cared-for.
- Freedom from discrimination including financial hardship caused from carrying out caring role.
- Equality of opportunity for all carers in Wrexham.
- Having access to a range of quality services that are flexible and responsive to the changing needs of carers.
- More people recognise themselves as carers and experience increased confidence to take up their rights.
- Carers have choices in caring; including the limits of caring.
- Satisfaction in caring.
- Caring alongside services/a sense of shared responsibility.

## **Measurable outcomes of the project:**

The Carer Well Being Scheme is closely monitored and we submit monthly qualitative and quantitative information. Examples of this are available.

## **What evidence is there to support success?**

The Intermediate Care Project had had academic involvement from Glyndwr University and has been evaluated as a whole. Copies of the Pilot Project Final Reports are available.

## **Costs**

The total cost is £56,250.

These costs are shared across Local Authority and Third Sector.

## **Is the project formal or informal? (ie paid or voluntary or a mix)**

Formal, 1 full time Community Care Worker and 1 part time Carer Well Being Worker

## **Additional support information:**

Additional information, including outcomes and an information sheet is available via the point of contact.

## 5.29. Transition Key Working

**Contact Details:** CCNUK Wales  
Community Enterprise Centre  
Well Street, Cefn Mawr, Wrexham, LL14 3AL  
☎ 01978 821324  
✉ [sally.rees@ccnuk.org.uk](mailto:sally.rees@ccnuk.org.uk)

### Links to 10 High Impact Changes:

The Transition Key Worker model approach should encompass and respond to the ten high impact changes. Further detailed demonstration of the link to the 10 High Impact Changes is available.

### Brief background to the Project:

Key working across the age range, including at transition, can be defined as a service provision in which two or more services (both statutory and Third Sector) which provides a co-ordinated system to support disabled children and young people and their families. A key worker service initiates a collaborative approach both strategically and at a practice level, and ensures where eligible (a child, young person and family who is accessing two or more specialist services above and beyond those provided universally to all) has access to a named Key Worker. Parents have identified the Key Worker as the “scaffold” (case studies, CCNUK website) which provides a “positive, purposeful relationship between professionals and (the) family”, and that the Key Worker from the parent perspective “has been my key support”.

The role of the Transition Key Worker is varied and their primary function(s) is to be:

- The co-ordinator
- provide support and advocate when appropriate,
- connect professionals and services,
- arrange appointments to ensure that they are convenient and timely,
- acts as a hub for information provision,
- ensures that assessment of need is undertaken and review as appropriate, and
- can support the young person to make the right choices through responding to their needs, wishes and aspirations for the future

A Transition Key Worker (as well as across the age range 0-25) can either provide a designated role (single nominated function and solely key works with a number of young people) or one that is non-designated (those who key work with a small number of families as part of their professional role i.e. a social worker, teacher, health professional and have protected time to do so).

### Aims and objectives of the project:

- to support the development of a model way of working to improve the transitional experience for disabled young people age 14-25 years of age

- to develop a transition key worker framework
- to design and deliver Transition Key Worker training

Detailed criteria are available for the pilot/ESF funded sites.

### **Measurable outcomes of the project:**

- Increased numbers of young people have access to a named Transition Key Worker.
- Increased numbers of young people have an active holistic person centred transition plan which is regularly reviewed at least annually or when circumstances change.
- A trained person centred Transition Key Worker workforce whom are informed and knowledgeable.
- Numbers of professionals and parents undertaking the Transition Key Worker training.
- Improved transitional experience for young disabled people and their parents/carers.
- Holistic co-ordinated multi-agency delivery with transition key working as the central hub.

### **What evidence is there to support success?**

Further detail and research are available that set out the evidence based benefits.

### **Costs:**

Each project is receiving differing amounts of funding from a 'pot' of £3m (Welsh Assembly Government/ European Social Fund)

### **Is the project formal or informal? (ie paid or voluntary or a mix)**

It is a formal organised project funded by the Welsh Assembly Government and matched funding from the European Social Fund Reaching the Heights: First Footholds programme. The Transition Key Worker posts (designated) are paid staff. In projects where the Transition Key Worker is providing a non designated function they are taking on this role in addition to their substantive post.

### **Additional supporting information:**

Additional information is available via the contact details, and also via the following website: [www.ccnu.org.uk](http://www.ccnu.org.uk)

## 5.30. Monnow Vale Day Services Remodelling Project

**Contact Details:** Monnow Vale  
Drybridge Park, Monmouth, NP15 5BL  
☎ 1600 773113

### Links to 10 High Impact Changes:

This project contributes to high impact change 9 in particular and also changes 2, 3, 4 & 5.

### Brief background to the Project:

A review of existing day activities concluded that there was a need for integrated health & social care services that would target people with intensive needs who would benefit from active and time limited Reablement, including older people with mental health needs. A multi agency group was established to oversee the remodelling work our aim was to develop an inclusive approach that recognised that people's social, environmental, physical and mental health needs were entwined. The vision was as follows:

- Staff will work with individuals to agree what they are hoping to achieve and to assist them towards this end.
- Activities are funded and provided by the most appropriate organisation. This may be the Council, the Health Service or voluntary or private providers.
- To work in partnership where appropriate to provide integrated services and avoid duplication or gaps.
- Resources are directed towards those people with the greatest needs and services are available when they're really needed, especially at times of crisis or change.

### Aims and objectives of the project:

To develop the following:

- A treatment and rehabilitation programme to enable people to remain as independent.
- A range of day activities accessible to older people
- A local network of social facilities where older people can meet in their own local communities.

The following basic principles were agreed:

- The starting point is always the needs of the individual and their carer.
- When people attend a service they do so for a specific reason and, when appropriate, move on to other activities within their community.
- All services will encourage people to be as independent as possible, promote social integration and help them play a full part in their own communities.

### Measurable outcomes of the project:

- Number of people supported to access community services
- Number of people introduced to Grass Routes community transport scheme

- Number of people able to remain in their own homes due to the provision of day activities either at the day hospital or in a community setting.

### **What evidence is there to support success?**

These are just a few examples of how the revised service provision has improved the life of service users:

A lady had been attending the Mental Health Day Hospital for 2 years, following a Review, and with encouragement from her family, she has moved on to join a computer class for beginners run by the local community education service. The cost is £16.50 per year, less than £0.50 per week.

A lack of escorted transport was identified as a major barrier to people accessing community services. The multi agency steering group supported a local community centre in developing an escorted transport service that now enables patients and others to get into Monmouth and make use of the community services available in the town.

### **Costs:**

This was a remodelling project intended to improve service provision within existing resources.

### **Is the project formal or informal? (ie paid or voluntary or a mix)**

This project demonstrates a multi agency approach to the provision of care.

### **Additional supporting information:**

A leaflet explaining the service is available directly from Monnow Vale.