Cyngor Bwrdeisdref Sirol
Blaenau Gwent
County Borough Council

Living Independently in Blaenau Gwent in the 21st Century

Commissioning Strategy for Older People 2008 – 2021

Developed - 2006

Initially reviewed - 2008

Revised - November 2012

Revised – December 2014

SOCIAL SERVICES DIRECTORATE

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	Date:		
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	October 2008 November 2012 December 2014 (statistics update)		

1. INTRODUCTION

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

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

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

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

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

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

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

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

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

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

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

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

2. BACKGROUND

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

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

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

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

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

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

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

3. PURPOSE FOR REVIEWING THE STRATEGY

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

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

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

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

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

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

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

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

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

5. THE VISION FOR FUTURE SERVICE DELIVERY

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

- Maximise Independence
- Minimise Dependence
- Intervene Where Appropriate

By:

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

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

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

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

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

Future Service model (proposed)

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

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

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

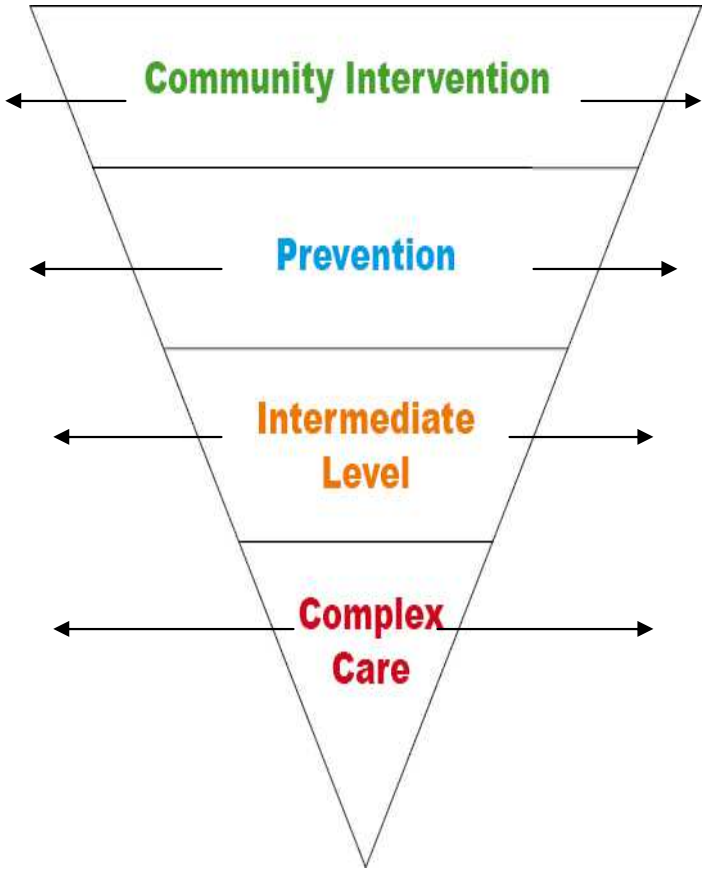
Focus

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

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

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

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



Challenges

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

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

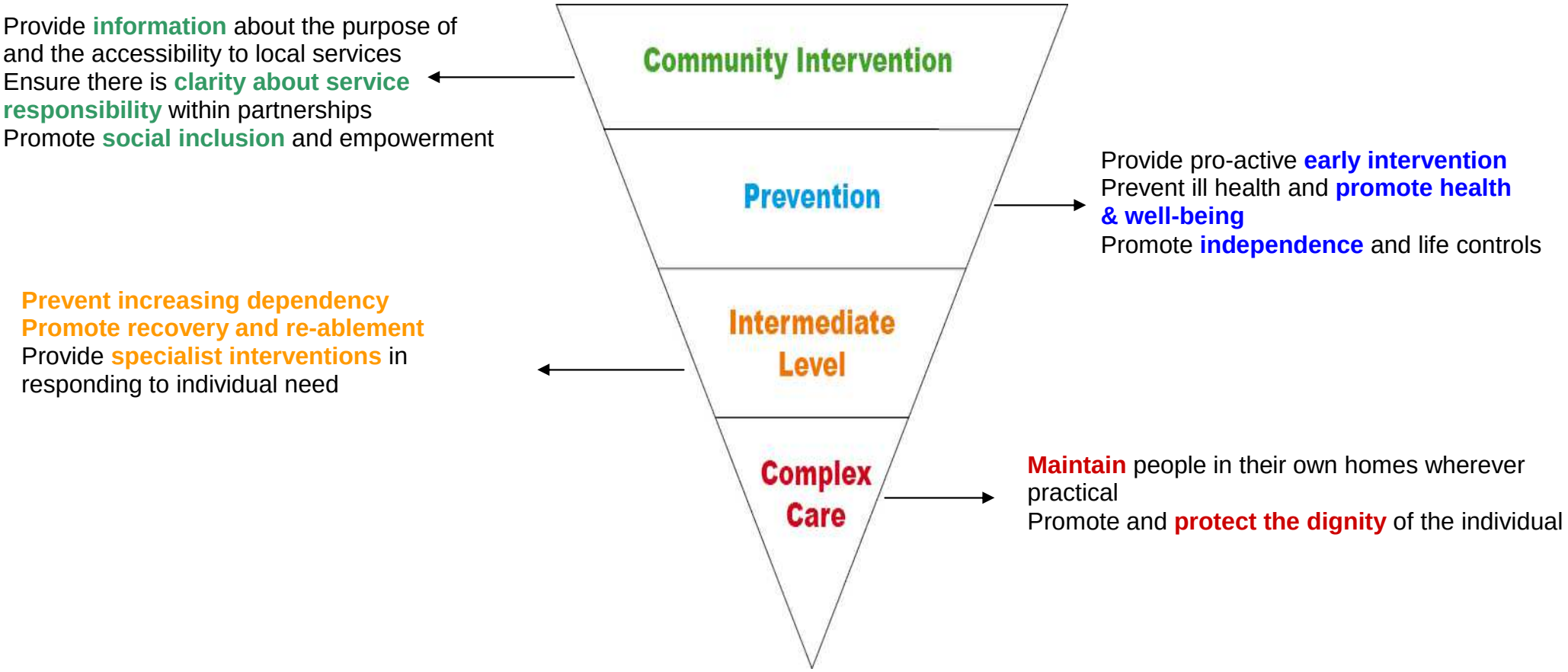
Promote independence – determine whether services provided actually promote independence or create dependency and what alternatives might be available.

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(refer to the proposed service mode - above)

7. DRIVERS FOR CHANGE

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

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

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

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

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

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

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

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

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

8. PROFILE OF BLAENAU GWENT'S OLDER CITIZENS

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

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

Table 1:
Population projections

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

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

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

Table 2:
Population with limiting long-term illness

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

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

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

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

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

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

Table 3:
Life expectancy at Birth in Blaenau Gwent

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

Source: Population census

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

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

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

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

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

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

Table 5
Service users supported through community care packages

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

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

9. FUTURE SERVICE PRIORITIES AND COMMISSIONING INTENTIONS

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

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

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

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

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

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

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

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

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

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

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

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

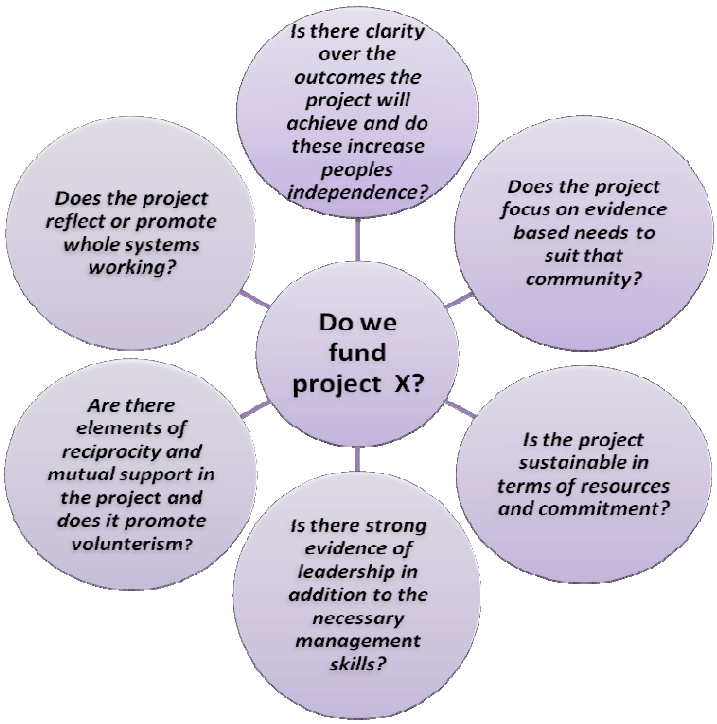
To achieve this there is a need to

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

10. Commissioning for future services

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

References:

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

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