
# VALE OF GLAMORGAN COUNCIL

# SOCIAL SERVICES COMMISSIONING STRATEGY FOR OLDER PEOPLE'S SERVICES

## 2011-2018

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# Foreword

This commissioning strategy identifies how the social care needs of older people will be met within the resources available to the Council during the period 2011 to 2018. It should be read in conjunction with the Social Services Commissioning Plan 2011.

Producing the strategy has been used as an opportunity to further the Council's overall programme for improving and modernising the social care services it provides for older people and their families. In particular, the Vale of Glamorgan Council is concerned to help older people in need of social care services to maintain a good quality of life and to promote their ability to be as independent as possible.

# Section 1 Introduction

## What is Social Care Commissioning?[1]

1. Commissioning involves making decisions about the type, range and quality of services that will be made available, where and in what settings, on what scale and with what capacity, at what cost and by which provider.

'*Social care commissioning is a set of activities by which local authorities and partners ensure that services are planned and organised to best meet the social care outcomes required by their citizens. It involves understanding the population need, best practice and local resources to plan, implement and review changes in services. It requires a whole system perspective and applies to services provided by local authorities, as well as public, private and third sector services*.'

Source: Welsh Assembly Government *Fulfilled Lives Supportive Communities Commissioning Framework Guidance and Good Practice*

'*Commissioning is the means of securing the best value for local citizens. It is the process of translating aspirations and need, by specifying and procuring services for the local population, into services for users which:*

- *deliver the best possible health and wellbeing outcomes, including promoting equality;*
- *provide the best possible health and social care provision;*
- *achieve this with the best use of available resources.*'

Source: Department of Health, 2007 *Commissioning Framework for Health & Well-Being*

[1] It is essential that the current document is read alongside the overall Social Services Commissioning Framework 2011 which sets out the generic approach taken by the Council in this area of work. Please provide link, when available.

**What are the benefits of effective commissioning?**

2. Effective commissioning helps to ensure that:
    - there is a consistent focus on the needs of citizens;
    - the independent and voluntary sectors have a clear understanding of the intentions of the local authority and so range, quality and cost effectiveness of services can be adjusted to meet the needs specified;
    - constructive dialogue with all stakeholders is encouraged;
    - a framework for utilising resources is developed to achieve objectives through making best use of all sectors;
    - providers have more certainty, which gives them the opportunity to plan ahead;
    - bridges are built between service and financial planning.

**Why do we need a specific commissioning strategy for older people?**

3. In the Vale of Glamorgan, information about demographic trends indicates that there will be a considerable increase in the size of the population aged 65 and over in the next 10 years. This is shown in the table below.

| Age range | % increase by 2020 |
|---|---|
| 55-64 | 7 |
| 65-69 | 12 |
| 70-74 | 39 |
| 75-79 | 36 |
| 80-84 | 25 |
| 85+ | 34 |

4. Inevitably, demand for social care and health services will increase at an unprecedented rate over this period. As a responsible authority, we need to ensure that there are services in place to meet such demands and that older people can access good quality social care when they need it, underpinned by policies which promote healthy living, wellbeing and community participation.

5. Commissioning for the health and wellbeing of a local population includes:
    - understanding and anticipating future need;
    - promoting health and inclusion and supporting independence; and
    - delivering the best and safest possible quality of care.

## What is the purpose of this strategy?

### a) Strategic Intent

6. The strategy outlines how the Council will commission services designed to achieve the best possible outcomes for older people within the Vale of Glamorgan in the next seven years. It describes our strategic intentions as well as the changes we hope to make in the pattern of services as an effective broker.

7. A key aim of the strategy is to explain how we intend to help older people in the Vale of Glamorgan:
    - have real control over the services they receive;
    - experience better outcomes when they require advice, information or support;
    - make meaningful choices about the type of help available and when they can get access to these services;
    - look after themselves, stay healthy and remain independent; and
    - be able to participate fully as active members of their community.

### b) Model of Service Provision

8. Effective service commissioning requires that partners across social care (including users and carers, other directorates within the Council, the NHS, the third sector and the independent sector) cooperate in developing a shared model of service provision and in ensuring that the local market in social care delivers the range of services required. This strategy sets out in Section 6 the model of social care provision for older people on which the Council has been working and for which there appears to be a broad degree of consensus across key stakeholders. The model is underpinned by the concepts which service users and others believe are necessary to underpin a dignified life in old age – independence, choice and control, wellbeing, health, social inclusion, appropriate levels of care. It demonstrates how we want to shift the balance of care from traditional

models of intervention which emphasise ‘caring for adults’ to preventative approaches which emphasise ‘supporting and assisting adults’ in their own community.

9. The model is intended to:
    - encourage dialogue and get consensus about overall direction;
    - provide a way of establishing priorities;
    - act as a precursor for decisions about investment of resources and commissioning;
    - be the touchstone for assessment/care management decisions;
    - provide clarity/sense of direction for staff, partners and service users/carers;
    - assist service planning; and
    - establish a benchmark for measuring success.

10. Adult social care for older people includes preventative services, assessment and care management, nursing and residential care homes, respite care, community services (home care, day care, meals), reablement to prevent hospital admission or enable continued independence, intermediate care (after a spell in hospital), supported and other accommodation (including adult placement and extra care), direct payments to service users, safeguarding, and the provision of equipment and related areas (including telecare).

11. Traditionally, the commissioning process has regarded individuals as recipients of services from a limited range of options. The strategy set out here sees individuals as people with the right to make choices about what services best meet their needs and achieve the outcomes they want for themselves and their families. This involves providing a range of services, some of which are accessible to all and some of which are specialist, subject to eligibility criteria and cater for those with the most complex needs.

## c) Shaping services through engagement with the social care market

12. A key aim for the strategy is to help shape the market in social care services within the Vale of Glamorgan - that is the way in which financial and other systems work to determine what services are made available by independent providers, third sector providers and the Council. This will be achieved by:

- making best use of the resources available;
- better matching of needs and services;
- better engagement with the independent sector and the third sector;
- better links between planning and partnerships, commissioning and contracting and resources management;
- ensuring that services run directly by the Council operate efficiently and in a business-like way; and
- effective use of early intervention and/or prevention services.[2].

[2] "Use of Resources in Adult Social Care" (Department of Health) advises local authorities to be aware if a high percentage of their spending is on residential care and they have no plans to reduce this. Spending more than 40% of the budget on residential care means that they have less room to deliver efficiencies; have less opportunity to decommission or change the shape of their services; and are likely to face uncertain prospects about their financial stability over the medium term. Increasing fee levels in the Vale, especially the need for a substantial rise in 2011/2012, risk placing the Council in this position.

# Section 2 The Context for Commissioning

13. The priorities within this strategy are derived from a number of imperatives, only some of which are external.

**Local imperatives**

a) The Vale of Glamorgan Community Strategy 2011 – 2021
http://www.valeofglamorgan.gov.uk/living/local_service_board/community_strategy_2011-21.aspx

14. The Community Strategy incorporates the Health, Social Care and Wellbeing Strategy and the Older People's Strategy. Among the ten priority outcomes in the strategy are:
    - Priority Outcome 5: Older people are supported to remain independent, healthy and active and receive the necessary services to meet their diverse and changing needs.
    - Priority Outcome 10: Health inequalities are reduced and residents are able to access the necessary services, information and advice to improve their wellbeing and quality of life.

b) The Vale of Glamorgan Corporate Plan 2010 – 2014.

A key objective within the Corporate Plan is: "to work with partners to meet the diverse needs of our residents in ways that will safeguard and support those who are most vulnerable and in greatest need; help people to keep fit and healthy; and increase social cohesion and equality of opportunity for all".

c) The Social Services Change Plan 2011 – 2014
http://www.valeofglamorgan.gov.uk/living/social_care/change_plan.aspx

15. Through the Social Services Change Plan 2011-14, a corporate approach is being taken across all Council directorates to the task of modernising social services in the Vale of Glamorgan. The document sets out the key strategic work streams where action is required if social services are to meet the challenges of increasing demand, reducing public sector finances and the need to support people to remain as independent as possible.

16. The Change Plan objectives include the following.
    - The Council converts plans into commissioning intentions so that services are provided by the most appropriate provider and deliver best value.
    - Information is available to enable appropriate linking of need/demand and service options (analysis of markets, resources, risks).
    - Commissioning strategies match needs and facilitate re-shaping of services where required needed to deliver improved outcomes or sustain appropriate levels of service delivery.
    - The Council manages the social care market well, having developed effective relationships with service providers across the different sectors.

**National Imperatives**

17. Key national documents that set the direction for Social Services in Wales and for commissioning practice include:
    - 'Sustainable Social Services for Wales - A Framework for Action' – Welsh Government
      http://wales.gov.uk/topics/health/publications/socialcare/guidance1/services/?lang=en
    - 'Fulfilled Lives, Supportive Communities – Commissioning Guidance & Good Practice – Welsh Government

http://wales.gov.uk/topics/health/publications/socialcare/circular/commissioningguidance/?lang=en

- "Better Support at Lower Cost – Improving Efficiency and Effectiveness in Services for Older People in Wales" – Social Services Improvement Agency
  http://www.ssiacymru.org.uk/index.cfm?articleid=6595

18. These documents have many similar themes.
    - Current levels of services cannot be maintained.
    - Individuals should have a greater say in the services they receive.
    - An integrated approach to services across health and social care is required.
    - There is a need to promote independence.
    - There is a need to develop preventative, rehabilitative, community-based services.
    - We must ensure that services are of a high quality.
    - There is a need for services such as Intermediate Care that reduce inappropriate admission to hospital.
    - There must be a greater focus on prevention, on promoting well-being and on delivering services in settings that are more convenient to the people that use them.

**Efficiency Savings**

19. In the current financial context, all public services in Wales are required to reduce costs. The Social Services Directorate is required to make annual efficiency savings of approximately 4% from 2011/2012 to 2013/2014, to meet efficiency targets and to fund growing departmental budget pressures. This follows a period when the Directorate has successfully met the efficiency savings required by the Council, which were to reduce spending by £5m over four years.

20. As a local authority service, we act within a statutory framework and we are accountable for the implementation of national policy and performance targets. Social services and social care are facing real and unsustainable increases in demand. There is a rising number of older people with complex care needs who can benefit from support and whose support needs are extensive. The financial outlook is difficult and so it is not possible to buy a way forward. The new national strategic plan for social

services, "Sustainable Social Services for Wales - A Framework for Action" concludes that the choice is either retrenchment or renewal. Retrenchment would see fewer people receiving services, greater expectations that people find their own solutions, increased burdens on informal carers and a growing number of disputes between services such as the NHS and social care about who is responsible for services. Renewal means focusing more clearly on delivery (including preventative services), continuing to innovate and creating sustainable services.

21. It is essential that the commissioning strategy for older people's services establishes a financially affordable model of assistance and support.

**The Social Care Market**

22. The social care market has some very distinctive characteristics which must be taken into account if commissioning is to be effective.
    i) There is a wide range of purchasing arrangements. On the one hand, local authorities still use large block contracts or provide services themselves, to secure bulk provision. On the other hand, increasingly services are purchased individually by self-funders, through direct payments or spot contracts.
    ii) Government exercises considerable control over the market, with extensive regulation, prices set by the biggest purchaser (individual local authorities) and with a strong influence from the fact that the relationship between providers and public sector consumers is filtered through the local authority.
    iii) There is a wide range of providers operating under different rules of engagement. The market is characterised by providers with different backgrounds (including voluntary, private and public services) and different business models..

## Joint Commissioning

23. There has been a renewed emphasis on the need to make greater progress with joint commissioning where expertise and capacity are shared across organisations. The Vale has been in the forefront of pioneering initiatives for joint commissioning - with the NHS in commissioning substance misuse services and with nine other local authorities in commissioning independent sector placements for looked after children. As described more fully in Section 5 of the strategy, the Council has helped to establish important mechanisms for taking forward this work more systematically through the South East Wales Improvement Collaborative and the Cardiff and Vale Integrating Health and Social Care Services Programme Board.

# Section 3 Social Care Commissioning

### The Commissioning Process

24. Commissioning involves the activities described in the diagram below.


Source: Institute of Public Care Commissioning Framework, October 2006

25. In summary the stages are:

**(a) Analysis** - understanding the values and purpose of the agencies involved, the needs they must address, and the environment in which they operate. This element of the commissioning cycle involves activities such as:

- clarifying the priorities through reviewing legislation, national guidance and local strategies and policy statements;
- undertaking a population needs assessment;

- mapping and reviewing existing and potential services across agencies to understand provider strengths and weaknesses, and identify opportunities for improvement or change in providers; and
- identifying resources needed and risks involved in implementing change and/or continuing with the status quo.

**(b) Plan** - identifying the gaps between what is needed and what is available, and planning how these gaps will be addressed. This element of the commissioning cycle involves activities such as:

- undertaking a gap analysis to review the whole system and identify what is needed in the future;
- designing services to meet needs; and
- writing a commissioning strategy which identifies clear service development priorities and specific targets for their achievement.

**(c) Secure Services** - ensuring that the services needed are delivered as planned, in ways which efficiently and effectively deliver the priorities and targets set out in the commissioning strategy. This element of the commissioning cycle involves activities such as:

- supply management and capacity building to ensure a good mix of service providers, offering service users an element of choice in how their needs are met;
- developing good communications and effective relationships with existing and potential providers; and
- purchasing and contracting services and de-commissioning services that do not meet the needs of the population group.

**(d) Review** - monitoring the impact of services and analysing the extent to which they have achieved the purpose intended. This element of the commissioning cycle involves activities such as:

- pulling together information from individual contracts or service level agreements;
- developing systems to bring together relevant data on finance, activity and outcomes; and

- analysing any changes in population need and reviewing the overall impact on services to identify revisions needed to the strategic priorities and targets.

# Section 4 Needs Assessment

26. A detailed assessment of the future health and social care needs of older people in the Vale of Glamorgan and Cardiff for the period 2010-2030', on the basis of trends in demography and morbidities, is attached at Appendix 1. It was carried out by the Cardiff & Vale Public Health Team.

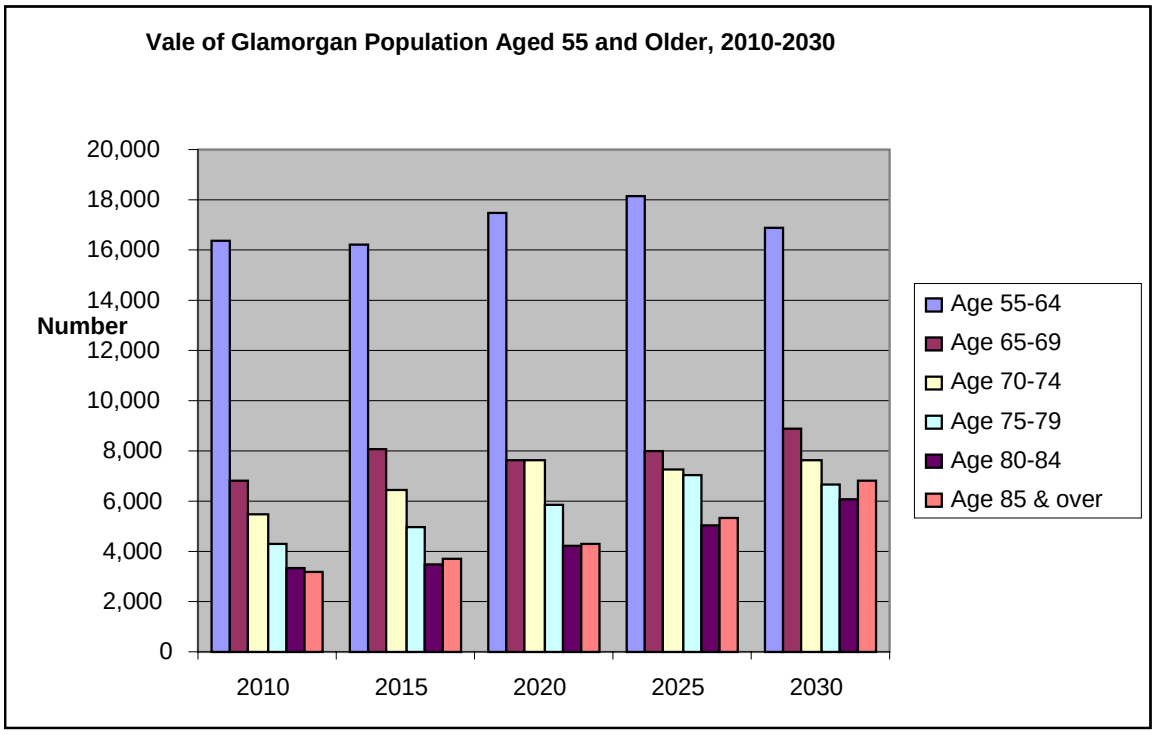
**The impact of expected population changes**

27. In the last 25 years, the percentage of the population aged 65 and over increased from 15% in 1984 to 16% in 2009, an increase of 1.7 million people. This trend is projected to continue, so that by 2034, 23% of the population is likely to be aged 65 plus.

28. The fastest population increase has been in the number of those aged 85 and over. In 1984, there were around 660,000 people in the UK aged 85 and over. Since then the numbers have more than doubled, reaching 1.4 million in 2009. By 2034, the number of people aged 85 and over is projected to be 2.5 times greater than in 2009, reaching 3.5 million and accounting for 5% of the total population. The impact on demand for services is likely to be considerable as this section of the population has the highest dependency needs.

**Demographic Projections**

29. The graph below shows the projections for the population of the Vale of Glamorgan, in 5-year bands, to 2030 and it clearly reflects a rise in the number of older people over time. The projections are based on the Welsh Assembly Government 2008 local authority population projections for Wales.




Source - IPC Daffodil Projections

30. A recent study commissioned by the Department of Health in England from the Personal Social Services Research Unit (PSSRU) indicated that current trends show on average a 1.9% demographic pressure per annum. The Vale of Glamorgan will face higher pressures, as shown below.

| Vale of Glamorgan | 2010 No. | 2015 No. | % | 2020 No. | % | 2025 No. | % | 2030 No. | % |
|---|---|---|---|---|---|---|---|---|---|
| **Age 55-64** | 16,340 | 16,190 | -1 | 17,500 | 7 | 18,130 | 11 | 16,860 | 3 |
| **Age 65-69** | 6,790 | 8,060 | 19 | 7,610 | 12 | 7,980 | 18 | 8,910 | 31 |
| **Age 70-74** | 5,490 | 6,410 | 17 | 7,650 | 39 | 7,260 | 32 | 7,630 | 39 |
| **Age 75-79** | 4,280 | 4,940 | 15 | 5,830 | 36 | 7,010 | 64 | 6,690 | 56 |
| **Age 80-84** | 3,340 | 3,500 | 5 | 4,190 | 25 | 5,020 | 50 | 6,080 | 82 |
| **Age 85 & over** | 3,220 | 3,700 | 15 | 4,300 | 34 | 5,360 | 66 | 6,800 | 111 |

31. The table above shows the projected increase in numbers of older people in the Vale of Glamorgan from age 55 and the percentage increase from the baseline number in 2010. All age groups except those aged 55-64 increase significantly to 2030, particularly those aged 80-84 and aged 85 and over. Those aged 80-84 increase by more than 75% in the Vale. Those aged 85 and over more than double, highlighting the expected rising demand for services over the next 20 years.

## Residents Living Alone

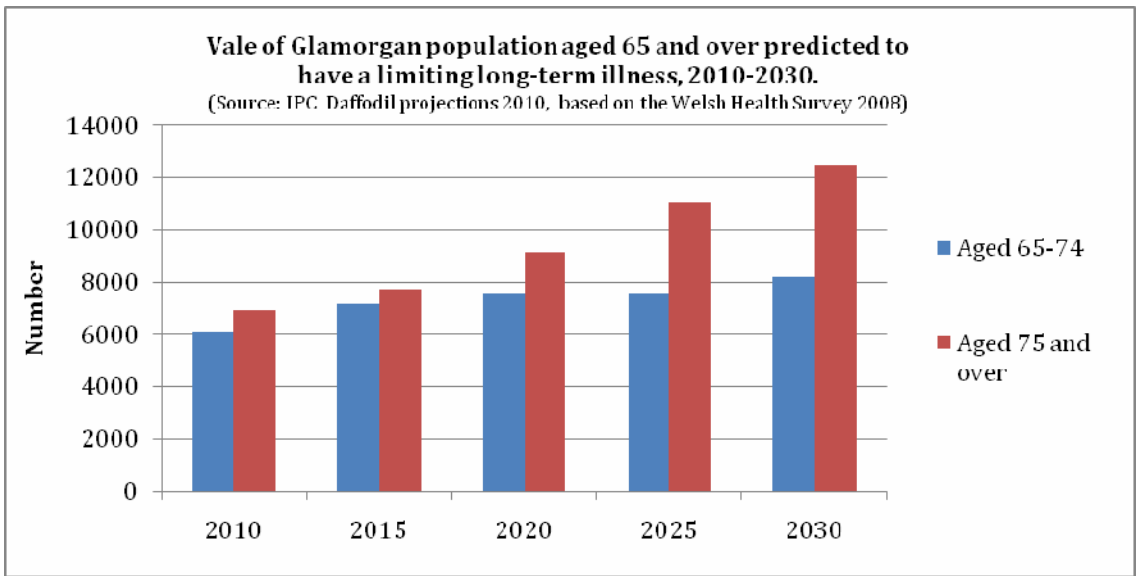
32. Living alone has been identified as a major determinant in whether an individual will require care services in older age. The details are in the table below:

| Vale of Glamorgan | 2010 No. | 2015 No. | % | 2020 No. | % | 2025 No. | % | 2030 No. | % |
|---|---|---|---|---|---|---|---|---|---|
| Age 65+ | 10,522 | 12,062 | 15 | 13,392 | 27 | 14,786 | 41 | 16,397 | 56 |

33. The population information shows a significant increase, with 56% of the older residents within the Vale of Glamorgan living alone by 2030. This will increase the likelihood of residents being dependant on the local authority to meet their social care needs. The rise in numbers of older people living alone with no co-residential informal carers clearly has implications for the provision of domiciliary and residential care services in the future.

## Limiting Long-term Illness

34. The graph below shows the population aged 65 and over predicted to have a limiting long-term illness.

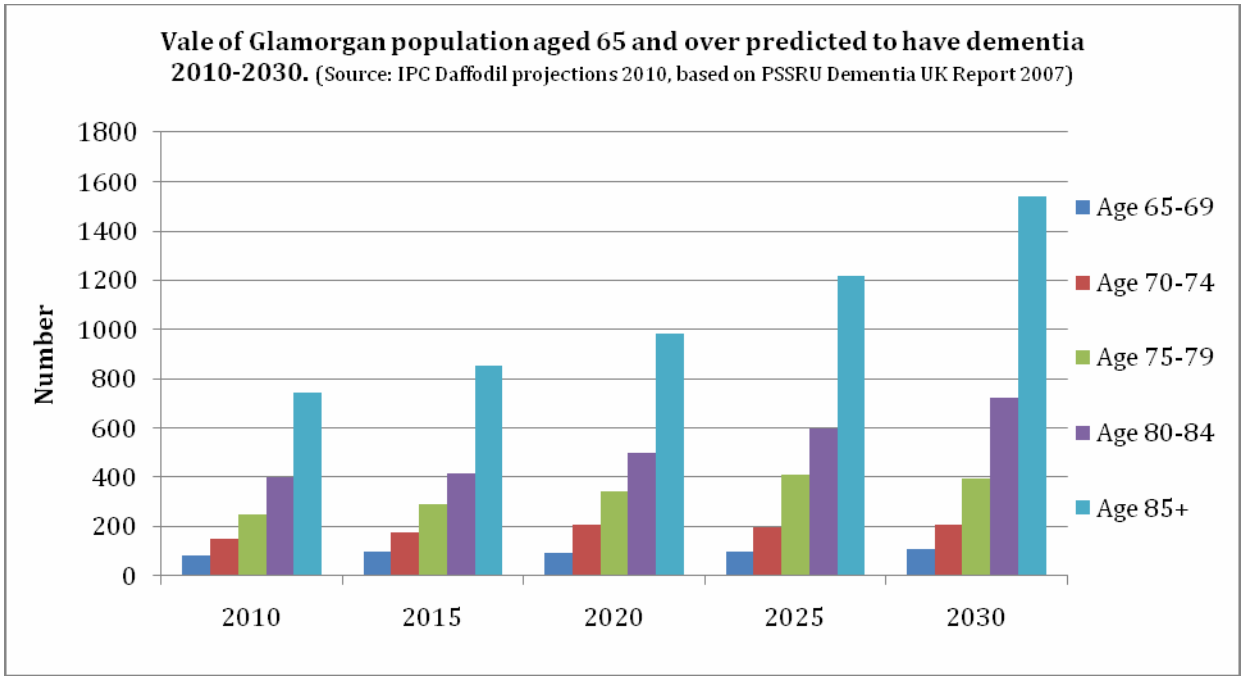



35. The graph above shows the predicted increase in the numbers of people aged 65-74 and 75 and over with a limiting long-term illness in the Vale of Glamorgan. In the age group 65-74, the numbers are predicted to rise by just under a quarter from 6,070 in 2010 to 7,540 in 2020, and by a third to 8,170 in 2030. Limiting long-term illness is widely used as a measure of

health status and has been shown to be an accurate predictor of early mortality, psychological health and hospital utilisation. The projections above are based on responses to the Welsh Health Survey question which asks respondents if they have 'any long-term illness, health problem or disability which limits their daily activities or the work they can do.'

**Dementia**

36. Dementia can affect people of any age but it is most common in older people. As shown in the graph below, in the Vale of Glamorgan, the number of those aged 80-84 with dementia is predicted to rise by a quarter from 400 in 2010 to 500 in 2020 and by over three-quarters to 720 in 2030. The number of those aged 85 and over with dementia is predicted to rise by nearly a third in 2020 (from 750 in 2010 to 980) and to more than double in 2030 (to 1,540).

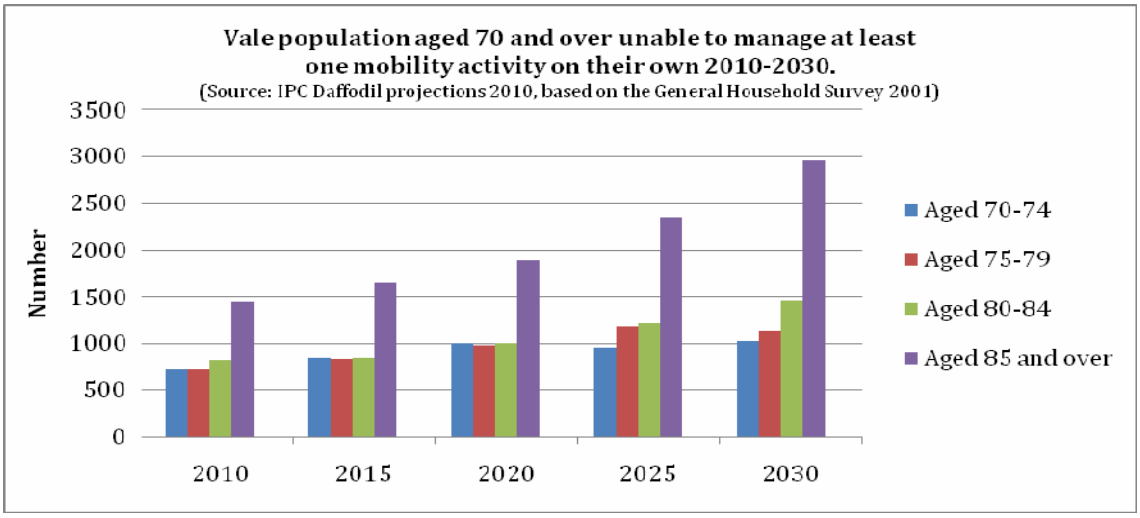



37. These predicted increases mean it is imperative that, as a local authority, we manage both the independent care home sector and community services sector to ensure that there is a supply of services available to support this expected increase in demand for EMI services.

**Mobility**

38. The projections for mobility are taken from General Household Survey (GHS) data relating to:
    - going out of doors and walking down the road;
    - getting up and down stairs;
    - getting in and out of bed.

39. The largest proportion of the population who are unable to manage at least one mobility activity on their own is in the age group 85 and over. As demonstrated in the graph below, in the Vale of Glamorgan, the numbers are predicted to rise by nearly one third from 1,440 in 2010 to 1,890 in 2020 and to more than double to 2,960 in 2030.



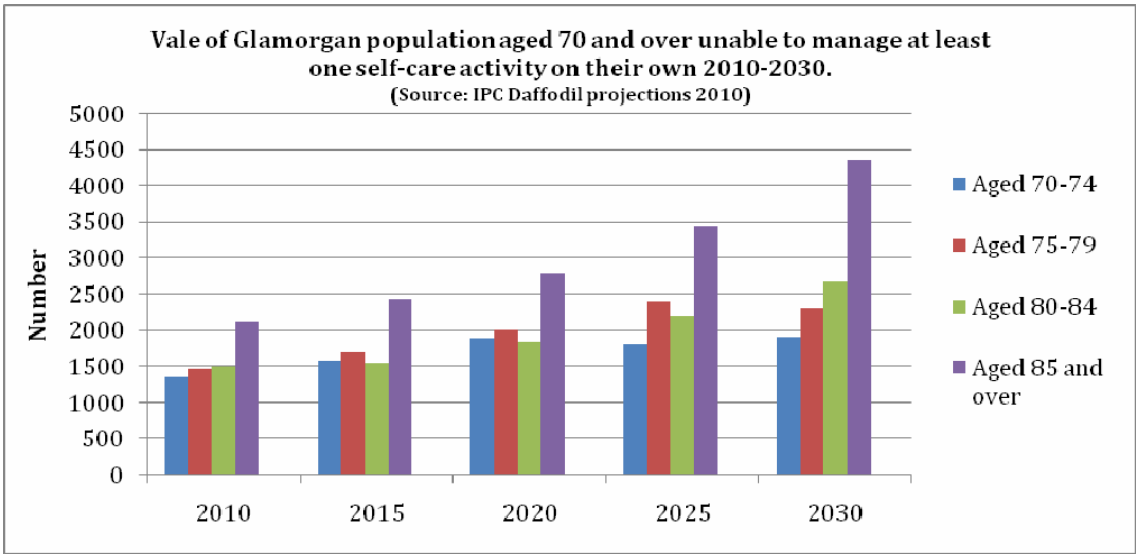

40. Meeting the demand for services which help to maintain an individual's mobility is likely to have a significant impact on domiciliary care services provided by the local authority unless preventative measures are put in place to stop demand from escalating.

**Self Care**

41. Self-care projections are based on data from the General Household Survey (GHS) relating to respondents' ability to perform the following activities:
    - bathing, showering, washing all over;
    - dressing and undressing;

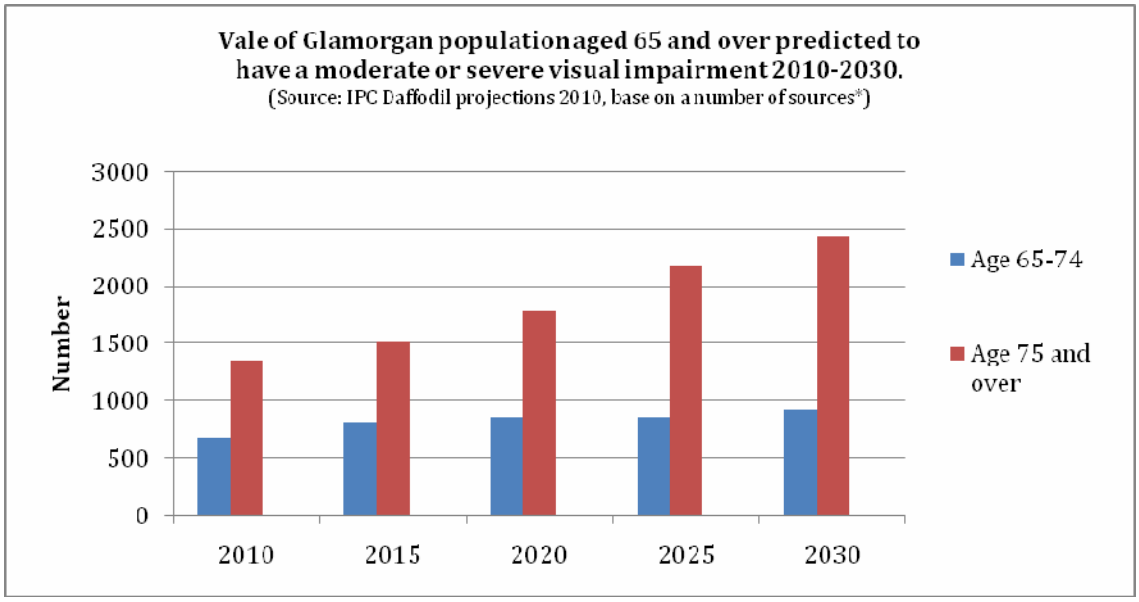
- cutting toenails;
- taking medicines.

42. Figures in the graph below show that in the Vale of Glamorgan the number of people aged 85 and over (that is, those who are least able to manage self-care activities) will increase. The number of people aged 85 and over unable to manage at least one self-care activity on their own is projected to increase by nearly one third from 2,130 in 2010 to 2,790 in 2020 and to more than double to 4,360 in 2030. As with mobility, this demographic increase is likely to put considerable strain upon domiciliary care provision unless preventative measures are put in place to enable people to take care of themselves.




**Visual Impairment**

43. In the Vale of Glamorgan, the number of people with a moderate or severe visual impairment is predicted to rise by nearly one third from 1,350 in 2010 to 1,790 in 2020 and by over three quarters to 2,470 in 2030.


Vale of Glamorgan population aged 65 and over predicted to have a moderate or severe visual impairment 2010-2030.
(Source: IPC Daffodil projections 2010, base on a number of sources*)
Number
3000
2500
2000
1500
1000
500
0
2010
2015
2020
2025
2030
Age 65-74
Age 75 and over

# Section 5 The Council's Overall Approach

## Managing Change

44. On the basis of the Director's Annual Report 2009-2010 on the delivery of social services in the Vale of Glamorgan and on our plans for improvement, the Council agreed a three-year strategic Change Plan. This set a clear direction for social services in the Vale and provided a blueprint for sustained improvement and service redesign.

45. There are seven priority areas in the plan.
    i. Using different ways to improve access to information and services.
    ii. Joining up health and social care services in cooperation with the Cardiff and Vale University Health Board and Cardiff Council.
    iii. Joining up services in the community for children and young people.
    iv. Improving how we shape and commission social care services.
    v. Providing a stable, skilled workforce and reducing the amount of bureaucracy and paper chasing our staff have to do so that they can spend more time in direct contact with service users and carers.
    vi. Making sure that the Council uses the money and assets it provides for social care services as effectively as possible.
    vii. Increasing the amount of social care that can be described as *citizen directed support*, which means people being in control of the support they need to live their life as they choose[3].

46. The Council anticipates that delivering the actions set out in the plan will realise the following benefits.
    - Provide sustainable, flexible and innovative services (which can adjust to new circumstances and needs).
    - Increase user and carer satisfaction with the range of services (which emphasise recovery, restoration and reablement).
    - Provide services users and carers with a strong voice and real control over their services.

[3] In the Change Plan, this is called *co-production*.

- Make best use of the fact that social services is an integral part of local government (able to call upon all the resources available within the local authority to meet statutory obligations including the community leadership role, the expertise available in other parts of the council, performance management and improvement frameworks, etc.).
- Develop even further a competent and confident workforce (which is skilled, responsive and professional, able to operate with a reduced volume of prescriptive government guidance about processes).
- Work together more collaboratively, especially with the NHS (to deliver better service integration).
- Secure better value in the use of scarce resources (through efficient and effective delivery of services, promoting independence and reducing demand for intensive support services through a focus on prevention.

47. The Vale Change Plan anticipates many of the themes contained in the strategic plan produced by the Welsh Government for putting social services nationally and locally on a better footing, 'Sustainable Social Services for Wales – A Framework for Action'.

**Collaborating with other local authorities and integrating services with the NHS**

48. For example, we are already giving considerable priority to planning with the NHS and other partners how to provide more joined up services in service areas such as and reablement for older people. The work of the Integrating Health and Social Care Services Programme Board places the Vale Council in a good position for responding positively to increased emphasis on implementing new service models.

49. The programme board has senior representatives from the Vale Council and Cardiff Council and from the Cardiff and Vale University Health Board. Under the auspices of a formal collaborative agreement, it co-ordinates agreed projects, defines the outcomes expected and provides the overarching leadership required to manage and take forward significant change, promoting partnership approaches across both public and third

sector bodies. The board has allocated a senior responsible officer to and oversees a number of delivery programmes, including one for Older People's Services which is to be regarded as the key workstream for the statutory agencies involved.

50. Creation of a unified health board has increased the opportunities for partnership working. An appointment to the joint post of Head of Adult Services and Locality Manager for the Cardiff and Vale UHB was made in 2010 and the successful candidate took up post in January 2011. This is a very significant development in supporting our aim to promote joint working between the Council and University Health Board. Further joint management posts with Cardiff Council in adult services have now been established.

51. The Vale has already embarked on a considerable programme of change to increase the scale of partnership working by social services across local authority boundaries through the South East Wales Improvement Collaborative (SEWIC).

52. With the support of Leaders and Chief Executives in each local authority as part of "Connecting South East Wales", ten Directors of Social Services in South East Wales (Vale of Glamorgan, Bridgend, Cardiff, RCT, Merthyr Tydfil, Blaenau Gwent, Caerphilly, Torfaen, Newport and Monmouthshire) have formed the South East Wales Improvement Collaborative (SEWIC). We are working together to improve the provision and commissioning of social services in the region.

53. The ten Directors have produced a feasibility study, to identify other potential areas of collaboration across and within the SEWIC region - between local authorities and with wider key stakeholders such as NHS partners, Housing and the Third Sector. As a result, the SEWIC Board has agreed to take forward six projects, including collaborative extension of Shared Lives/Adult Placements schemes; realising current investment plans for supported and extra care housing and development of additional capacity; and implementing Assistive Technology (including Telecare) and the regional commissioning of such technology. These projects are at early

stages of development with Project Managers having been appointed for some of the work streams. The benefits of the schemes will be seen during the life time of this Strategy.

54. The overall programme will help to provide the local authorities with an additional means of delivering service modernisation and cost effectiveness. The projects are at different stages of development but already there is strong evidence of purposeful and effective collaboration.

55. Alongside these individual projects, there have been considerable efforts made to improve the overall framework for partnership working by social services. We have been actively engaged in taking forward the work of the five strategic multi-agency partnerships in the Vale, which operate under the leadership of the Local Services Board. This is especially the case with the Health, Social Care and Wellbeing Partnership, which has recently produced the five-year plan required by the Welsh Government.

**Managing our resources**

56. There are formidable challenges facing us, most obviously in finding ways to bridge the gap between the resources available and the year on year rises in social care demand and costs. We know that, in many areas of work, demand is increasing while our capacity at best remains the same and sometimes has been reduced.

57. We have to deal with a growing volume of referrals and greater complexity in cases where social services are already involved while at the same time trying to improve standards of care and provide more responsive services. 'Sustainable Social Services for Wales – A Framework for Action' also poses a whole range of new challenges. These will have to be met at a time of severe financial constraints for local government and social services. Social services must respond to increasing demand and greater expectations; however, they have to do so within the resources available. The amount of money available for social care services is decided primarily by central government (Parliament in London and the Welsh Assembly in Cardiff). The Council has sought to alleviate the impact of pressures on the

budget for social services but the outcome remains that the Directorate will be required to achieve 4% efficiency savings each year for the next three years. This follows considerable savings in every year since 2007/2008.

58. There is good evidence that local government is already the most efficient part of the public sector and, as shown above, social services in the Vale has been in the forefront of steps to reduce spending. We welcome the additional funding for social services provided by the Welsh Government in the three-year revenue settlement announced in January 2011, in order to provide a degree of protection from the impact of an adverse settlement overall. Across Wales, there is evidence of a net over spend for 2010/2011 of £18.5 million across Wales in respect of social services. The cost of delivering social care continues to experience significant price inflation. Additional unfunded pressures are becoming evident.

59. Care home fee inflation continues to be a major concern. Across Wales, spending in this area has risen more than 50 per cent over the last decade. We have to reconcile the need for securing high quality local provision with the financial consequences for the Council. We anticipate too that the financial impact of the introduction of the national £50 weekly cap on non-residential care charges will be more substantial than anticipated by the Welsh Government. The concern relates primarily to the numbers of people who currently pay privately for home care who will now seek support from the Council to meet these costs. The Vale of Glamorgan is likely to be affected disproportionately by any trend of this kind. In reviewing services for individuals, decisions will have to be made regarding the most appropriate service to meet the assessed need.

60. Moreover, 'Sustainable Social Services for Wales – A Framework for Action' is predicated on an assertion that there is a choice between retrenchment and renewal but there is no economic or business case to demonstrate that this premise to be true. There is strong evidence that the current financial basis for the provision of social care is fundamentally broken, especially given the failure to deal with issues around paying for care. Increasingly, local authority social services are experiencing the impact of a depressed economy which generates increasing demand for

services (in addition to demographic trends) and simultaneously reduces the resources available.

61. In response to this crisis, the Vale of Glamorgan is in the forefront to efforts to reshape the range of services available, based upon agreed principles:
    - an emphasis on promoting preventative services which divert people from inappropriate and higher cost provision or manage demand at lower levels of intensity/intrusiveness and which can be accessed without complex assessments;
    - clear tiers of services, with known thresholds; and
    - service models which are underpinned by the concepts which service users and others believe are necessary to underpin a dignified life – independence, choice and control, wellbeing, social inclusion.

62. The three-year change plan for social services will help us to tackle the overall strategic agenda required, especially in developing the tools needed for reshaping services, with better links between planning and partnerships, commissioning and contracting and resources management. Recent work undertaken with the Social Services Improvement Agency to emphasise reablement and restoration has encouraged a whole systems approach to problem solving, lessening the grip of traditional organisational silos and helping us to develop integrated models of health and social care for Older People.

63. We are building on acknowledged strengths but the only way to deal effectively with a context where the need for social care is growing rapidly and resources are not keeping pace is a combination of reshaping services to divert demand, retrenchment and reducing costs. Additionally, efforts to modernise services face many obstacles. Our budget management is at times undermined by new Welsh Government initiatives that are ill-conceived and not costed properly.

64. For example, the final guidance notes relating to the Social Care Charges (Wales) Measure 2010 were received by local authorities in July 2011, although the changes had to be implemented in April 2011. The measure does not place a duty on local authorities to impose charges but does

detail those services for which charges can be made and provides guidance regarding the setting of a reasonable charge for such services. The legislation gives local authorities discretion to impose their own charging policy. However, these must comply with the requirements set out in the legislation and guidance.

65. The Vale of Glamorgan has had a charging policy in place since 1993. The key change to the policy is that there is now a maximum weekly charge that can be levied by the Council. This is set by the Welsh Government at £50 per week in 2011/2012. This is a significant change for the Vale of Glamorgan as no maximum charge was in place in the previous policy. The Measure is also more prescriptive about how people can be asked to undertake a financial assessment. We anticipate that the impact of the change in guidance is that the vale has lost approximately £1m of income in the current financial year over and above the finance received in compensation from the Welsh Government.

**Promoting independence**

66. Given the financial context and increasing demands for services, the only sustainable answer is to change the pattern of services, based upon an understanding that we need to promote independence and focus services away from institutional settings and into people's homes.

67. We have been working with the UHB and Cardiff Council to develop the approach set out in the SSIA report *Better Support at Lower Cost,* ensuring that reablement becomes even more embedded in older people's services. Reablement is about supporting people to regain, following illness or injury, the skills needed for day-to-day living such as dressing, cooking and eating. The service is often targeted at people who have just left hospital and involves a short period of intensive support. We are pressing on with our efforts to increase the use made of direct payments and telecare. Products like falls detectors, bed occupancy sensors and gas detectors have the potential to reduce the incidence of problems associated with elderly and disabled people living at home.

Modernising day services is one of our specific aims, along with the need to support more people with physical disabilities to adapt their homes and receive equipment to help sustain their independence.

68. As part of plans for remodelling services, we have increased the speed of plans for joining up or integrating services, increasingly through formal agreements with our partners (including voluntary organisations). For example, there are emerging plans for moving towards single access points for health and social services. The overall task is reducing the number of people dependent on social services or reducing the costs of care for those most in need of support through services such as reablement, intermediate care, community equipment, support related housing, assistive technology, crisis response and help towards independence. We will look at the best methods for delivering these services. We must promote prevention and ensure that low-level services do not lead to increasing dependency. The approach will build upon developments to date and help us to move towards preventative and coordinated care in the community, with a particular emphasis on high-risk groups and those with increasing frailty and vulnerability.

69. Other parts of the Council also have a key role to play in this agenda, including Housing, Transport and Leisure. Through the Community Strategy and the Health, Social Care and Wellbeing Strategy, these links need to be strengthened.

70. Inevitably, some of this work meets with opposition. Changes in the pattern of services and to individual service settings such as day centres arouse considerable anxiety among those who depend upon them to keep safe and have a better quality of life. Through consultation and advocacy, we have tried to engage with service users and carers in helping us to plan these changes to services. We recognise that they often know best what works for them and also whether proposals for change properly reflect their hopes and wishes. We also consult extensively with providers of services and partner agencies. There is still more to be done to ensure consistent involvement across all service user groups.

71. Getting full commitment to the programme of change that we must undertake (to manage the challenges posed by increasing demand for services, rising expectations and reducing resources) requires us to increase the amount of social care that can be described as *citizen directed support*[4]. We believe that the first question we should be asking is *what is the best way of helping this individual and family, one which preserves their dignity and independence either when they are in crisis or when they need assistance in their lives*? From here emerges the next question *how can we do this in close collaboration with others such as the different departments within the Council, the NHS, the Third or voluntary sector and independent social care providers?* Finally*, can we use all the resources at our disposal in ways that are cost effective; value the range of contributions from all organisations, do not involve duplication or over provision; and do not create dependency?* We are working hard to devise service models for the Vale of Glamorgan that will help to answer these questions and it is one of the key priorities in the social services Change Plan.

[4]C*itizen directed support* means people being in control of the support they need to live their life as they choose.

## Section 6 The Current Service Model

72. In preparing this Commissioning Strategy, an analysis has been undertaken that sets out a broad overview of current social care provision in the Vale of Glamorgan in order identify gaps and decide on the commissioning intentions needed to address shortfalls.

73. Spending on Older People Services in 2010-2011 was £14.6m, that is 33% of the overall social services budget. There are different patterns of spending on services for older people among Welsh councils. The pattern in the Vale is mainly historical but there has been a move to changing this pattern in recent years through strategic commissioning.

74. The main categories of spend are shown in the table below.

| Service Area | Spend £'000 |
|---|---|
| Domiciliary Care – including home care and day care | 3,355 |
| Reablement | 1,302 |
| Residential Care – council provision | 1,092 |
| Residential Care – external provision | 1,043 |
| Residential Care EMI – Council provision | 509 |
| Residential Care EMI – External provision | 1,792 |
| Nursing Care – Frail Elderly | 1,476 |
| Nursing Care – EMI<br>Direct Payments | 1,400 |
| Direct Payments | 169 |
| Other costs (including assessment and care management) | 2,400 |

75. The pattern of social care provision for older people in the Vale of Glamorgan is largely traditional, with the following services being provided as at 31st March 2011.

| Service Area | Number of Service Users |
|---|---|
| Domiciliary Care – including home care and day care | 584 |
| Reablement | 443 |
| Residential Care – council provision | 46 |
| Residential Care – external provision | 99 |
| Residential Care EMI – Council provision | 6 |
| Residential Care EMI – External provision | 55 |
| Nursing Care | 198 |
| Direct Payments | 65 |

NB Total number of clients does not equal the sum of numbers of clients receiving the different services as some clients may receive more than one service.

76. In 2010/2011 303 clients were supported by the Reablement Team who mainly provide services for people aged 65 and over. Through this service, 213 individuals were able to regain their independence completely. 197 referrals were made by the Community equipment store for people aged 65 or over. Over 7,000 hours per week of domiciliary support was provided to older people by the independent and third sector at 31st March 2011.

77. Informal carers are the main providers of support to older people in the Vale of Glamorgan. Carers provide informal, unpaid care to individuals who have a chronic illness or disability. Supporting carers reduces reliance on statutory services by the people for whom they care, which tends to result in significant cost savings. Respite services are a crucial element of that support and provide an invaluable break for carers. During the year, £100,000 was spent on respite services for older people. The Vale of Glamorgan Social Services has a demonstrable track record in

terms of funding support for carers – the provision of a separate budget for carers is some recognition of the value that the Council places on their contribution. Generally, the cost of respite services is met from either the former carers grant, the budget for carers' services or from individual service budgets.

78. In recent years, assistive technology options have been developed to support people to remain in their own homes whilst providing reassurance that help is available if required. This service is available for all older people within the Vale of Glamorgan. At present, there are 300 Telecare packages in place. In addition, bespoke Telecare packages are available which provide additional support to meet individual needs. This has been a recent development within the Vale and currently 20 such packages have been made available.

79. The Council acknowledges that more work needs to be done on analysing not just costs and numbers but also the way in which these services are provided across the different sectors – public, independent and third sector – as well as the extent of unmet need, service quality and the outcomes for services users. The Cardiff & Vale Public Health Team has started a further needs assessment exercise to provide some of the information needed for this purpose.

# Section 7 Future Service Model

80. “It is increasingly recognised that the twin goals of improving efficiency and delivering better outcomes for service users are not necessarily in conflict with each other. Some local authorities recognise that the kinds of service transformation they are now contemplating would make sense in terms of service improvement even if current financial constraints were not present. The old system has merits but it risks creating a paternalistic and protective set of services based on institutions and building unhelpful degrees of dependency both from service users and staff. There needs to be further culture shift towards a service which offers real opportunity to help people become more independent, both in the way they live their lives and how flexibly they can use services.” SSIA Report *Better Support at Lower Cost: Improving efficiency and effectiveness in services for older people in Wales.*

81. Our Commissioning Strategy has been designed to make best use of the resources available to social services by encouraging a reablement approach to care and reducing the pressure to accommodate growing numbers of older people in traditional residential settings. This will involve developing further the use of assistive technology and reconfiguring services through the decommissioning of traditional, high cost services in favour of more preventative models. There will be a focus on partnership with other local authorities, the NHS, the third and private sectors in order to achieve these aims through maximising efficiency and ensuring that people are supported proportionately and in a way that maintains independence as long as possible.

**What is our Vision?**

82. Service users and carers consistently tell us what they want is to:

- have access to a good range of services that are available at the right time and meet their most pressing needs;

- use services that solve practical problems while also attending to their emotional wellbeing; and
- to be seen by staff who have the right attitudes and enough time, who will respond to them as a whole person within their family and community, making sure that they get the right service.

83. The Council's new model of social care provision for older people is underpinned by the concepts which service users and others believe are necessary to underpin a dignified life in old age – independence, choice and control, wellbeing, health, social inclusion, appropriate levels of care. It demonstrates how we want to shift the balance of care from traditional models of intervention which emphasise 'caring for adults' to preventative approaches which emphasise 'supporting and assisting adults' in their own community.

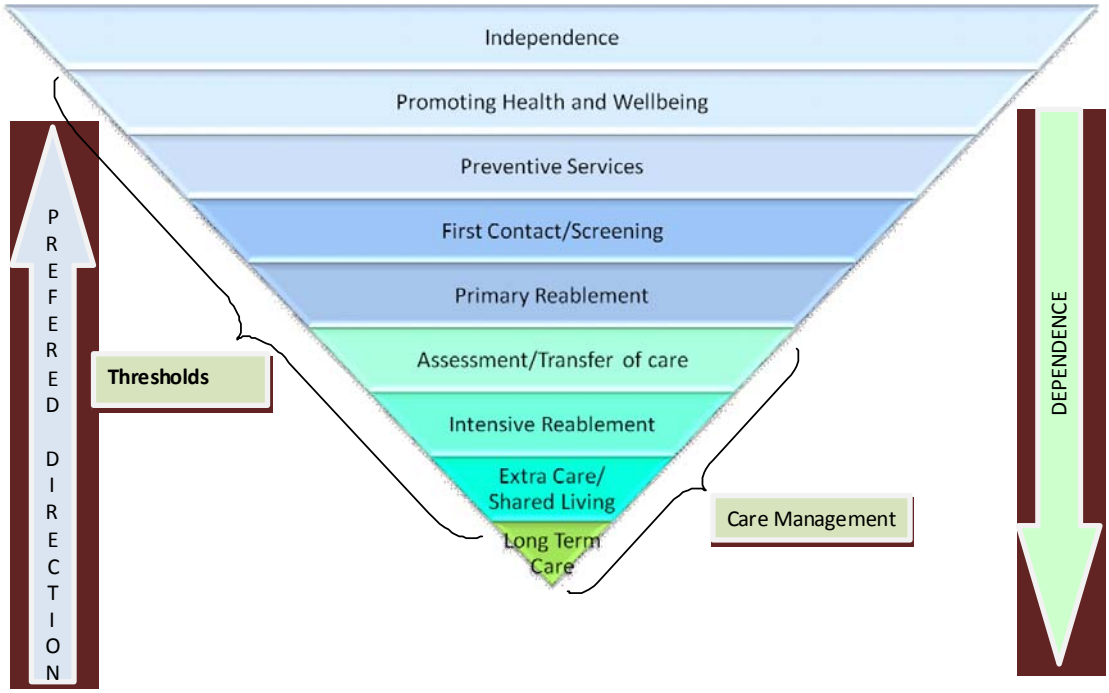
84. The model is intended to:

- encourage dialogue and get consensus about overall direction;
- provide a way of establishing priorities;
- act as a precursor for decisions about investment of resources and commissioning;
- be the touchstone for assessment/care management decisions;
- provide clarity/sense of direction for staff, partners and service users/ carers;
- assist service planning; and
- establish a benchmark for measuring success.

85. Traditionally, the commissioning process has regarded individuals as recipients of services from a limited range of options. This strategy sees individuals as people with the right to make choices about what services best meet their needs and achieve the outcomes they want for themselves and their families. This involves providing a range of services, some of

which are accessible to all and some of which are specialist, subject to eligibility criteria and cater for those with the most complex needs.

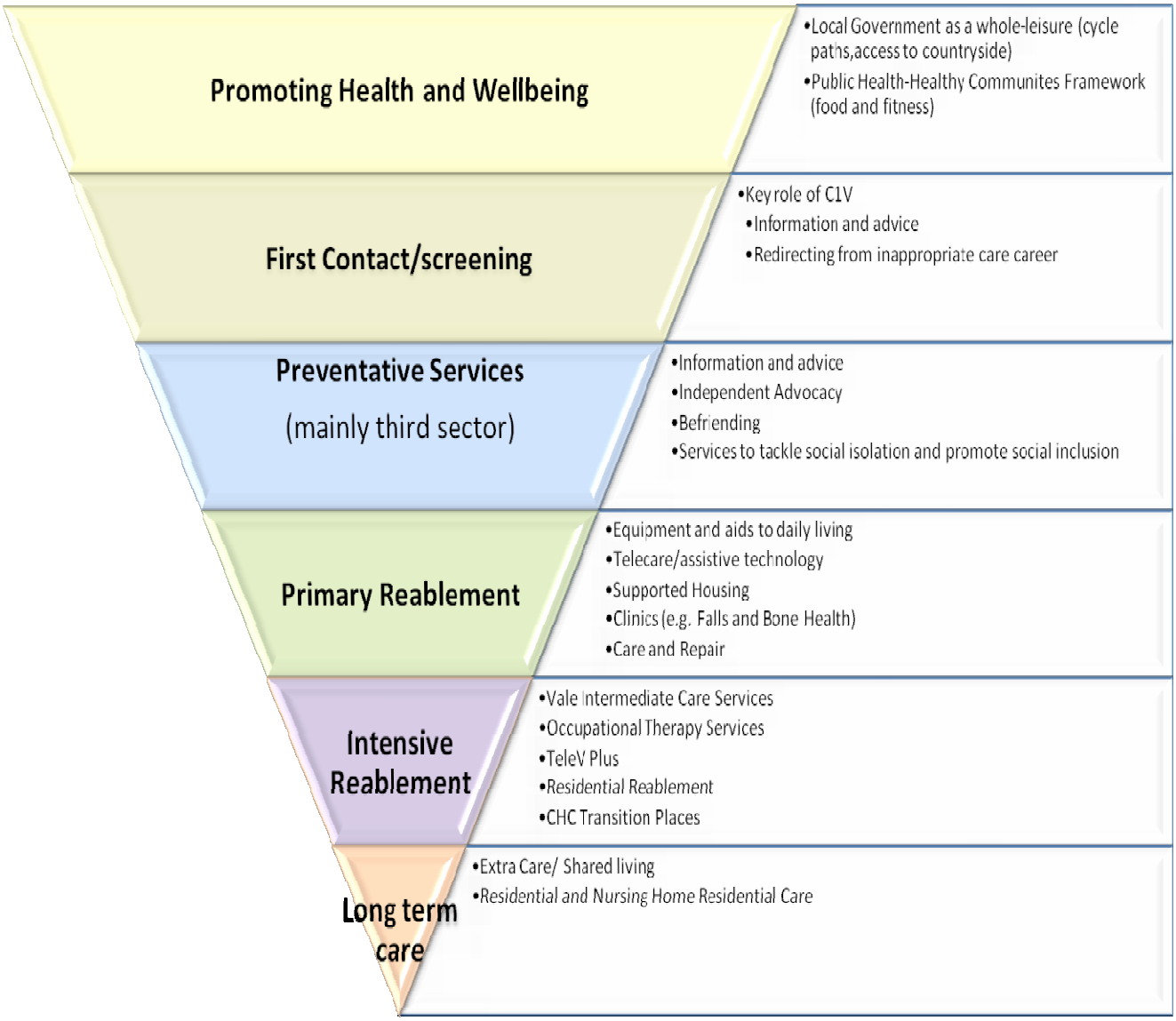
**MODEL SUPPORT SYSTEM FOR OLDER PEOPLE'S SERVICES**




86. The model describes a whole system, tiered approach, reflecting the provision of services at all levels of dependency (as indicated by the green arrow). There is a preferred direction of travel (as indicated by the blue arrow). Clear thresholds and gate keeping between each tier are essential, to reduce demand for the most intensive and intrusive services. The model demonstrates how we want to shift the balance of care from traditional support services which emphasise 'caring for adults' to preventative approaches which emphasise 'supporting and assisting adults' in their own community.

87. The model starts with a focus on universal services, enabling people to remain outside the formal social care system. This involves providing appropriate information and advice and other services that promote and sustain healthy, independent lifestyles in the community (including health care, benefits information and wellbeing services such as exercise

programmes). In the next phase, which also occurs before entry to the formal social care system, people are provided with primary reablement services such as housing adaptations, equipment and assisted technology. Finally, the third tranche of services involve formal social care packages, which includes assessment of eligibility for state funded care. This menu of services is described in the diagram below.




88. Revised models of service delivery will be agreed which place prevention and independence as our top priority. This is in line with people's expectations and important if we are to prevent people entering into services which do not meet their aspirations and are more costly to provide.

89. It is important that, in using this framework, we must look to:

- manage expectations and ensure effective engagement;
- help people regain or attain independence, outside of social care services, wherever this is possible;
- find alternative ways of meeting need;
- both commission and decommission local authority and NHS services;
- promote the need for individuals to take more responsibility for their own welfare;
- deliver quality services at the lowest possible cost;
- assist people to use their own financial resources wherever this is feasible, including assistance to access welfare benefits they may be entitled to; and
- maximise income collection

90. To deliver better outcomes, we will develop new services but this task of reshaping often involves building upon and adapting an effective range of existing resources. The overall tasks are to reduce the number of people dependent on social services or to reduce the costs of care for those most in need of support through services such as reablement, intermediate care, community equipment, support related housing, assistive technology, crisis response. The system will be based on strongly integrated community services, preventing illness where possible and supporting independent living and wellbeing. To be successful improved working with other services will be essential. This will include services such as Housing, Transport, Leisure, Lifelong Learning and Public Health which will support people to maintain their wellbeing. and reduce the likelihood of them having to rely upon more intensive forms of social care services.

91. The potential gains are significant for social care and health agencies as well as service users themselves. There is evidence that good

intermediate care services can reduce acute admissions of frail elderly people by 30% and reduce use of community hospital beds. We know that there are health interventions (e.g. incontinence services, stroke services, falls prevention, podiatry and dentistry) that reduce the need for social care services among older people and maintain valued independence for longer. Single assessments can promote greater clarity and understanding for those assessed, but also avoid duplication of effort and waste of staff resources. We are especially keen on working with colleagues in the NHS and other parts of the Council to produce a strategy for encouraging healthy communities in the Vale.

# Section 8 Commissioning Intentions

92. Within the resources available, the outcomes we want to achieve based on our vision can be summarised as follows.

- People will be enabled to live as independently as possible in their own homes and to have control of their lives.
- People will experience citizen centred services which are responsive to their needs and circumstances.
- Carers will be able to access support carers more effectively.
- People will lead longer, healthier and active lives.
- People will be safeguarded against abuse and mistreatment.
- People will avoid inappropriate admission to hospital or care homes.
- People will be discharged home from hospital as soon as possible.
- People will receive seamless and co-ordinated services that are delivered promptly when they need them and when they are most effective.
- The Council will work effectively with local communities through improving third sector provision.
- There is an increased range of service providers, including social enterprises and cooperatives.

**Universal Services**

- We will build a care and support system that focuses on keeping older people out of residential care and using reablement models of care; both to achieve better outcomes for individuals but also to reduce the predicted rise in demand for services.
- We aim to increase the amount of support that can be described as “citizen directed”. This will ensure that people are in control of the support they need to live their life as they choose.
- We want to meet service users’ rising expectations about greater choice, increased control and more support to live as independently as possible.
- We aim to change the balance of service provisions between residential care and community based solutions through the creative use of resources, especially promoting prevention and ensuring that low-level services do not

lead to increasing dependency. This approach will build upon our achievements to date in changing from reactive, crisis management to preventative, proactive, coordinated care in the community, with a particular emphasis on high-risk groups and those with increasing frailty and vulnerability.

- We want to make greater progress with joint commissioning where expertise and capacity are shared across organisations.
- When commissioning services, we aim to ensure that there are adequate mechanisms in place which mean that all the safeguarding needs of service users are met by the service provider.

**Preventative**

- We aim to increase the range of options for self-support and assistance in a person's own home or community setting that enables them to utilise and build on their strengths and needs to improve or maintain their quality of life.
- We want to provide appropriate and timely information to allow people to:
    - manage their finances to support their long term care needs without reliance upon state funding;
    - make informed decisions regarding how they are supported to remain in their own communities;
- We propose to review our information systems to ensure that we can offer timely problem-solving advice and help about the range of older people's facilities and services. The service will target those people who have historically funded their own care, often with little advice, support or input from social care.
- We will work with the third sector to promote the range of services available for older people living in their own home that prevent social isolation and to ensure that people are able to access them.

**Targeted Intervention**

- We aim to reduce the number of people dependent on social services and to reduce the costs of care for those most in need of support through services such as:
    - reablement;
    - intermediate care;

    - community equipment;
    - housing related support;
    - assistive technology;
    - crisis response.
- We aim to make Telecare an integral option for all community-based packages of care and support. Self-care plays a key role in supporting people to prevent or manage long-term conditions. We will work with Cardiff and Vale UHB to look at further development of the Telecare service to support people in their own homes.
- We will develop short-term, home-based respite cover to provide support in crisis or emergency situations.
- We will develop daytime provision that offers flexible, individually tailored services for people within their communities, moving away from the traditional centre-based model.
- We will review our assessment processes to ensure that they identify clearly the outcomes people will experience as a result of any intervention that is provided.
- We will develop an accommodation strategy for older people during 2011/2012, reviewing current provision and helping to ensure that appropriate housing is available for older people in the Vale of Glamorgan.
- We aim to complete our first Extra Care housing provision with our preferred partner Hafod Care Association.
- We will work with other providers of supported accommodation, to offer a range of alternative accommodation options for older people.
- We will work with independent domiciliary care providers to support increasing numbers of people in the community and to ensure that people receive improved quality of care through person centred planning.

**Long-term Care**

- Alongside partners, we aim to influence the market for residential/nursing homes. Current demand and supply information is showing a lack of capacity relating to EMI provision and this shortfall is likely to increase. This is coupled with an over supply of general residential beds for ‘frail elderly’. We hope to work with the sector to reallocate resources to ensure that options are available to meet these EMI needs and offer appropriate choice to service

users and their families. This coupled with the development of Extra Care facilities will provide enhanced services for older people with mental health issues.

| Universal Services | Targeted Interventions | Care and Support |
|---|---|---|
| What citizens should expect is:<br>• to be seen or dealt with as quickly as possible<br>• to have access to the appropriate person with the right expertise<br>• to be treated with dignity and respect<br>• to be provided with the appropriate information, guidance and advice<br>• to be signposted to information, support and other services wherever possible | What citizens should expect is:<br>• a focus on maintaining and regaining independence<br>• to be encouraged to manage their own lives for themselves<br>• services delivered in their own home and community where possible<br>• time-limited services based on their needs<br>• access to a range of expertise<br>• to receive safe and appropriate care<br>• to be involved in decision-making about their care<br>• If admission to hospital is necessary, to stay for the minimum amount of time their condition requires and then to be supported to recover at home whenever possible | What citizens should expect is:<br>• a focus on maximising independence<br>• ongoing care in their own home for as long as possible<br>• support for the carer of the person receiving services<br>• an active approach to supporting those with long-term conditions and frailty<br>• access to a range of expertise, co-ordinated by one named person<br>• tailored support drawn from a wide range of local services<br>• some services may require a financial contribution |

**Monitoring**

- We will routinely gather and collate information from a range of relevant sources. We will closely monitor responses and systems of support delivered by providers in terms of outcomes for service users, best value and best practice. The approach will involve:

- engaging with service users and carers, to inform the review of key priorities in the strategy and to demonstrate that they are clearly linked to the outcomes specified by people in their care plans);
- evaluating progress achieved against specific priorities using local and national performance indicators and benchmarking our performance against other local authorities;
- continually reviewing our responses against the current and projected need within strategic and performance management frameworks to ensure there is sufficient capacity to meet any shifts in service user demand;
- adjusting our approach to build on existing good practice to accelerate the implementation of good ideas which strengthen the key elements of our vision; and
- ensuring that the commissioning strategy is reviewed on a three-year cycle in collaboration with key stakeholders, in order to align priorities with the Health Social Care and Wellbeing Strategy.

## Section 9 Next Steps

93. This commissioning strategy has set out clear priorities for older people's care and support services. Implementation should have significant and measurable benefits. In order to achieve our ambition, we recognise the need to incorporate actions from the strategy into the service plan for the Adult Services Division and then to ensure that key decisions within the commissioning process are in accord with expressed intentions. To succeed in delivering this strategy, it is essential to combine a clear vision with a robust approach to project management, ensuring that milestones are reached and reviewing progress in order to refocus where things are not working.

94. It is not a strategy that can be delivered by social services working in isolation. The Community Strategy will be an important vehicle for taking forward the overall agenda in terms of supporting people older people to remain independent, healthy and active. The Council in partnership with the Vale Older People's Strategy Forum will lead on coordinating and monitoring the actions required. A corporate approach by the Council is needed also to create an environment which supports the aims of independence, prevention and community-based services. Similarly, our key partners in integration and collaborative commissioning across local authority boundaries will play a key role and there is a partnership framework in place to make sure that change is delivered.

95. Crucially, this commissioning strategy provides an opportunity to recast the Council's relationship with the providers of social care from the independent and third sectors. From the responses received to the draft strategy, it is reassuring to note considerable areas of agreement. However, there remain significant issues where further dialogue is required. For example, more work needs to be done in looking together at the scale on which residential and nursing home care will be required, in response to demographic pressures and changing expectations of services users. Some homes are responding quickly to the need to cater for people with dementia-related illnesses and we need to learn from their experiences in caring for residents who once would have needed to move elsewhere. Their role in re-ablement could be developed further. Other

service providers also need to have opportunities to explore matters they regard as especially important.

96. A number of the actions contained within this strategy are already underway. The remaining actions will be allocated within the Service Planning process for 2012/2013. An action plan to support this strategy will be developed to ensure progress in relation to the issues can be monitored and reported.