SCRUTINY : SOCIAL SERVICES MEETING

3.00 PM TUESDAY, 10TH MARCH, 2020

BACKGROUND PAPERS

Please note that this supplement only contains background papers that have been provided by the responsible departments.

Anyone requiring information should contact the Democratic Services Department on (01685) 725203 or democratic@merthyr.gov.uk

5. Adult Services Accommodation Strategy for Older People and Adults with a Learning Disability

   To consider report of the Chief Officer Social Services **3 - 40**

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MERTHYR TYDFIL COUNTY BOROUGH COUNCIL

INTEGRATED ADULT SERVICES DIRECTORATE

A HOME FOR LIFE STRATEGY FOR THE OLDER PEOPLE OF MERTHYR TYDFIL (SERVICES AND QUALITY OF LIFE)

2006 – 2020

Updated July 2011

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Context

Social care services for our older people in Merthyr Tydfil continue to provide for the needs of our community, achieving the County Borough's vision and strategic aims for the future. The needs of the population continue to change and social care services need to continue to modernize in order to deliver the vision for Merthyr Tydfil County Borough, the Government's modernising agenda and the wishes of our customers within the context of finite resources. Our focus for the next ten years is to continue to provide services that maximise independence and self determination.

Population figures suggest that the local older population will increase by 2,646 or 29% by 2020. Within this figure, it is predicted that the number of older people aged 85 and over will increase by 55%. To meet future demand for services in community based social care, provision would have to increase by at least 29% if all other factors remained the same.

Within the overall older population there are vulnerable groups including the very old, those who live alone, those who are dependent on a carer, those with mental frailty including dementia and those who live in unfit and/or unsuitable accommodation. It is not possible to accurately predict numbers based on these groups, as some people will fall into two or more categories, which could lead to double counting. However, there is sufficient information available to give an indication of the proportion of particularly vulnerable older people.

High on the priority list for all adults is the right to exercise choice over their living and care arrangements and maintain their independence. This is entirely consistent with the directorate's approach to service responses based on maximising independence and self-determination. National research suggests older people want to be able to live in their own home and access a range of appropriate and integrated services as required. If alternative accommodation is necessary, then a range of housing options should be available, but importantly they should be able to offer a home for life. Residential/nursing care homes are the least favoured option because of a perceived loss of independence and concerns about the quality and standards of the care provided.

Merthyr Tydfil County Borough Council's vision is:

"By 2010 Merthyr Tydfil will be a safe, healthy and exciting place to live and visit. Our ambition is to become a sustainable, confident County Borough which recognises and promotes equality of opportunity where ***people want to achieve in all aspects of life through work, leisure and learning.*** *Our vision is to be recognised as a vibrant, thriving regional centre for the valleys."*

Vision for Community Services

We want to help people in Merthyr Tydfil to be fulfilled, free from poverty, independent and healthy, and to live in supportive and resilient communities. We will do this through social care and social regeneration services which are responsive and well co-ordinated in protecting and supporting the population as a whole and vulnerable people in particular.

We will ensure that all services, whether delivered by the council, private or voluntary organisations, offer more choice and control to their users, and achieve the highest possible standards of quality and cost effectiveness.

BACKGROUND

In January 2005, the Older People's Steering Group commissioned the Institute of Public Care (IPC) to assist with the development of a long term Older People's Accommodation Strategy. This was to encompass community services, people remaining in their own home for life and their quality of life. The project was completed in September 2005 and was updated in April 2008.

The document focuses on the specialist accommodation provided by the County Borough, the Health Service, Registered Social Landlords, the Voluntary sector and the independent sector. It explores the range of health, housing and social care provision that maintains older people within the community along with identifying the current and potential service users/tenants from amongst the wider population of older people both now and in the future.

The premise upon which this strategy has been developed includes:

- Current service configuration is not necessarily affordable, desirable or consistent with Government thinking and most importantly delivering the Authority's vision.
- Existing studies and local experience clearly shows that most older people wish to remain in their own home.
- The need to develop an approach which offers older people a home for life, where people may not need to move on from one form of provision to another.
- Providing services that maximise independence and self-determination.

The Homes for Life, (Services and Quality of Life) Strategy (HSQL) has been developed from the work commissioned by the Older Persons Steering Group and will be the key driver for delivering our vision for the future development of social care services for people in Merthyr Tydfil.

The HSQL Strategy defines an overall direction of travel for the County Borough Council and its health and social care partners with regard to the provision of accommodation and support services for older people. Our vision for the future is to see world class services provided locally to the people of Merthyr Tydfil with the continued emphasis on supporting people to remain in their own homes, to be as independent as possible, for as long as possible.

This strategy will enable us to deliver and commission locally based excellent quality services including:

- Specialist accommodation for people with dementia which will enable the customer and their carer to remain in that accommodation for life.
- Specialist home support services for people with mental health, dementia, hearing and visual impairment, learning and physical disabilities.
- An enhanced multi-agency re-ablement service that will enable people to remain in their own homes and prevent hospitalisation.
- Integrate service responses with other community partner agencies using common IT solutions and e-technology.
- Assistive technology developed with specialist providers focussing on developing needs based equipment.

- It will also enable us to plan our future work, budgets, commissioning and de-commissioning arrangements so we can help develop regional working with partners to deliver this vision.
- Care homes where necessary with facilities that will be above and beyond the minimum care standards.

A number of shared outcomes have emerged from the existing housing and health and social care strategic documents.

- To make provision for a wide range of housing development set within an attractive, clean, safe environment, supported by a high quality transport system (the County Borough's Housing Strategy 2004/09).
- To improve the health, social care and well-being of Merthyr Tydfil (Strategic Housing Partnership theme as cited in the County Borough's Housing Strategy 2004/09).
- To help older people find the housing and support services they need in the most efficient way and remain in their own homes for as long as is practical (Welsh Assembly Government objective as cited in the County Borough's Housing Strategy 2004/09).
- To develop a whole system approach so that health and social care services are integrated and delivered in the community (Merthyr Tydfil Health, Social Care and Well-being Strategy 2005/08).
- To increase access to community based health and social care services for vulnerable groups and those most at need to enable individuals with specific support needs to live an independent life within their own communities (Merthyr Tydfil County Borough Community Strategy 2020).

What is clear from the above is that our priority remains the further enhancement of community based service provision.

STRATEGIC AND LEGISLATIVE CONTEXT

Community Strategy

The Community Strategy is the single, over-arching borough-wide strategy that the supporting strategies of the key partners involved in the County Borough will follow.

Health Social Care and Well Being Strategy 2011-14

The Health Social Care & Wellbeing (HSCWB) Strategy is a statutory plan written by Merthyr Tydfil Local Authority and Cwm Taf Local Health Board. The purpose of the Strategy is to ensure that Merthyr County Borough Council and Cwm Taf Local Health Board work together alongside partners including the Third Sector, Private Sector and Public Health Wales to improve the Health, Social Care & Wellbeing of our communities. It is closely linked to the Community Plan, Children & Young People's Plan, Local Development Plan and the Community Safety Strategy.

The strategies vision is as follows:

BY WORKING TOGETHER MERTHYR TYDFIL WILL BECOME A PLACE WHERE

- All people in Merthyr Tydfil live longer, healthier and happier lives with fairer outcomes for all.
- All people in Merthyr Tydfil live their lives to the full and are enabled to maintain their independence for as long as possible.
- All people in Merthyr Tydfil who become ill, frail or vulnerable receive the care and support they need at the right time and in the right place.
- All individuals and communities in Merthyr Tydfil recognise the need to take more responsibility for their own health and wellbeing and are supported to do this.

After reviewing the previous strategy the themes below were agreed:

Theme 1: Promoting healthy lifestyles and preventing ill health.
Theme 2: Promoting independence and protecting the vulnerable.
Theme 3: Improving services and joint working

Priorities were identified under each theme and were as follows:

Theme 1:

Reduce the levels of smoking
Improving people's emotional wellbeing
Employability and Well-being at Work
Increasing participation rates in physical activity
Reducing unhealthy eating

Alcohol and Drugs
Reducing Teenage Pregnancies and Improving Sexual health
Reducing Accidents and Injuries
Immunisation
Reducing Health Inequities

Theme 2:

Older frail people.
People with long term conditions.
People with a mental health problem.
People with a learning disability.
People with a physical disability and/or sensory impairment.
People with a substance misuse problem.
Carers.
Children (see CYPP).

Theme 3:

Develop an integrated model of health and social care built around the needs of our citizens.
Provide the right services at the right time, in the right place and by the right staff.
Address the underlying causes and rebalance care with a more local provision.
Avoid crisis and escalation.
Ensure partnership synergy.
Beat cycles of dependency.
Ensure that information is shared and used to provide the most effective service.

Strategy for Older People in Wales

In January 2003 the Welsh Assembly Government launched the Strategy for Older People in Wales that builds upon the findings contained within the report 'When I'm 64…..and more'. The strategy aims to provide a structured framework within which the Welsh Assembly Government, local authorities and other statutory agencies can develop polices and plans, which reflect the needs of older people and recognise the changing demography and social circumstances.

County Borough's Housing Strategy 2004/2009

The Housing Strategy 2004/2009 aims set out the general direction of housing policy in Merthyr Tydfil to achieve the corporate vision agreed by the Council.

Areas of priority relating to this document are:

- Housing and support services for people with mental health and substance misuse problems.
- Housing and support services for ex-offenders.
- The development of extra care-housing within existing sheltered housing schemes.

Fulfilled Lives, Supportive Communities - Improving Social Services in Wales

The Vision

The Welsh Assembly Government's vision for the next ten years is to ensure that we modernise social services in order to provide more accessible, personalised care for people. We want to ensure that people are supported earlier and helped to retain their independence for longer.

The document notes that there will be a number of significant challenges ahead both now and in the future. These relate to greater public expectations, increasing demands and pressure on front-line services.

By 2016 they expect to see:

- Less need for universal services.
- Increased demand for services and support for people with high care needs and over a longer period of time.
- An increase in people aged 50 – 60 who provide informal care.
- An increase in lone living particularly older men.
- High demand for services from those aged 85 and over.

Carer's Strategy for Wales – Action Plan 2007

Research shows that unpaid carers provide around 70% of all the care in the community. This is compelling evidence that carers should be regarded as part of the solution to addressing people's care needs. However, forecast demographic changes suggest that the pool of potential carers relative to the numbers of people needing care is likely to decrease over the medium term, which would have a consequential increase in demand for health and social services.

There is also the concern over the risks of carers being expected to continue their caring roles for much longer as a consequence of an increasing life expectancy.

Carer's Strategy (Draft) 2011

The current Carer's Strategy is in draft form. It is scheduled to go out for consultation on XXXX

Creating a Unified and Fair System for Assessing and Managing Care Guidance

Under Section 7 of the Local Government Act 1970, the Welsh Assembly Government has placed responsibility on local authorities and health bodies to ensure that effective multi-agency working takes place in order to secure compliance with the guidance. The purpose of the guidance is to ensure that agencies take a holistic approach to assessing and managing care and work together so that a number of objectives are achieved including; assessment and care planning is person-centred and proportionate to

need, services are coordinated and integrated at all levels and duplication of information, assessments and paperwork is minimised.

Care Standards Act 2000

The Care Home Regulations (Wales) 2002 and the Domiciliary Care Regulations (Wales) 2004 are secondary legislation and applicable to all care homes and home care providers within Wales. In addition to these regulations, the Welsh Assembly Government has issued National Minimum Standards for both areas. The standards set out the standards of practice that are necessary to comply with these requirements.

Mental Capacity Act

The MCA has five key principles which emphasise the fundamental concepts and core values.

The five principles are:

1. Every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise. This means that you cannot assume that someone cannot make a decision for themselves just because they have a particular medical condition or disability.

2. People must be supported as much as possible to make their own decisions before anyone concludes that they cannot make their own decisions. This means that you should make every effort to encourage and support the person to make the decision for himself/herself. If a lack of capacity is established, it is still important that you involve the person as far as possible in making decisions.

3. People have the right to make what others might regard as unwise or eccentric decisions. Everyone has their own values, beliefs and preferences which may not be the same as those of other people. You cannot treat them as lacking capacity for that reason.

4. Anything done for or on behalf of a person who lacks mental capacity must be done in their best interests.

5. Anything done for, or on behalf of, people without capacity should be the least restrictive of their basic rights and freedoms. This means that when you do anything to or for a person who lacks capacity you must choose the option that is in their best interests and interferes the least with their rights and freedom of action.

CURRENT POSITION: THE NEED FOR CHANGE

In setting out the need for change we have based the following on local knowledge and the work undertaken by the Institute of Public Care in partnership and consultation with both internal and external partners.

The data within the strategy presents a number of implications for this Authority in meeting customer needs from the current period till 2020 and the projected increase of the older population in Merthyr Tydfil presents a challenge to the authority. More people will require enabling and effective community care services to ensure they remain within their communities in line with the authority's overall vision for the County Borough and its citizens.

Current customer base

There are 23,145 households in the county borough of which 5,508 or 24% are pensioner households. The total number of people aged 65+ is 9050 and only 295 are currently living in communal establishments.

A number of factors increase the likelihood of an older person being admitted into institutional care. These include people aged 75 and older, living alone and being female. At the time of the census in 2001, Merthyr Tydfil had 1505 older females in this category. Living alone also increases the likelihood of an older person requiring community care services.

There are 3587 or 40% of the older population living alone in the county borough but with predominately more females than males.

Care Management update from Tina pending

The table 1 shows the number of enquiries and referrals that IAS has received over the last three years. The number of enquires has risen from 2,862 in 2005/06 to 4,693 in 2007/2008 a rise of 1,831. The actual number of referrals that then required a full Unified/community care assessment rose by 790 during this period, increasing the pressure on the social work teams and their ability to complete these assessments/reviews on time.

Table 1

Financial Year Contact Received	No' of Enquiries	Enquiries progressed to Referral	No' of Referrals still open	No' of Closed Referrals
2008/09	4,642	2,468	398	2,070
2009/10	4,284	2,299	510	1,789
2010/11	4,195	2,436	895	1,541
2011/12	1,124	634	503	131

The social work and COT teams also have responsibility to complete an annual review of each person who receives a commissioned service through IAS. Table 2 shows the number of reviews that have been completed against the % of reviews that should be completed.

Table 2

Financial Year	The number of Clients with a care plan at 31st March who had their care plan reviewed as required during the year	The number of Client with a care plan at 31st March	PI Figure SCA/007
2005/06	1,363	2,269	60.07

2006/07	1,568	2,327	67.38
2007/08	1,650	2,340	70.51%
2008/09	1,304	1,560	83.60%
2009/10	969	1,161	83.50%
2010/11	1,140	1,272	89.60%

With the increase in assessments and people receiving a service, we will not be in a position to achieve a 100% review rate with the current numbers of staff within the socialwork teams.

Integrated Adult Services currently provide or commission the following community based services to support older people:

Residential Care – Local Authority.

The council owned and maintained 4 residential care homes for Older People and have a duty meet the required regulatory standards for this provision.

National Minimum Standards for Care Homes for Older People identified that single bedrooms occupied by service users should be a minimum of 9.3sq m.

Of the original 127 beds within the four homes, only 45 met the minimum size requirements. As a result of this, it was determined that existing residents would continue to reside in below size rooms but once these rooms were no longer in use, they would be decommissioned and not offered to new service users. An additional action would be that when a larger above size room became available, this would be offered to a service user occupying a below size room in the first instance, and not offered to new admissions until current service users had recorded a choice to continue in their current below sized room.

It was identified that the needs of the community placed a greater emphasis on the need for additional residential accommodation for older persons with a dementia. As a result, it was agreed that two new care homes would be built. In order to facilitate this on the site of two existing homes, service users and staff from Bargoed House and Gurnos House were transferred to Sandbrook House and Victoria House respectively. This was only undertaken following a consultation process with service users, carers and staff and the involvement of Age Concern who acted in an advocacy capacity throughout the process.

To date, Sandbrook House is registered to accommodate 16 service users and Victoria House registered to accommodate 26 service users. However, Sandbrook House has since had 2 below sized rooms become vacant and Victoria House 1 below size room become vacant. These have not been offered to new service users until a variation of conditions of registration has been agreed by CSSIW allowing the Authority to re-register some below size rooms on a temporary basis until the new care homes are ready to be occupied. This is with the intention of increasing service user choice within the locality and meet the increasing demand for specialised residential dementia care.

The overall occupancy levels for these two remaining care homes for older people is therefore currently at 89%.

Table 3 below shows the number of local authority residential and nursing home beds available in each of the four homes as at July 2011.

Table 3

Figures	Sandbrook	Victoria	Total
Total number of beds	28	38	66
Beds no longer allocated – due to size regulations	14	14	28
Number of beds meeting care standards	14	24	38
Number of residents	12	22	34
Occupancy %	43%	58%	51%

Residential/ Nursing Care – Private / Independent

In 2005/06 the Authority spent £2.4 million on commissioning independent residential and nursing care beds, both from within and outside of the County Borough.

In 2007/2008 the Authority spent £3 million on commissioning independent residential and nursing care beds, both from within and outside of the County Borough although this includes £64,561 for respite and temporary placements.

Within the **Independent Sector** the total number of older persons' bed spaces that the local authority commissions is 165 as at 5th July 2011. These placements are spread over 10 providers within Merthyr Tydfil and 33 homes outside the County Borough.

At this time we commission 45 older persons beds outside of the Local Authority at a cost of approximately £783,000. This includes 4 Nursing EMI commissioned beds at a cost of £68,000 and £174,000 for 13 EMI Residential.

Table 4 gives the current older persons residential and nursing figures as at 5th July 2011

Table 4

Placements	Number
Local Authority residential (elderly frail)	30
Local Authority Elderly Mentally Infirm	4
Independent residential within Merthyr Tydfil	15
Independent residential within Merthyr Tydfil (EMI)	50

Out of County residential	8
Out of County residential (EMI)	12
Elderly Frail Nursing in Merthyr Tydfil	43
Elderly Frail Nursing – Out of County	19
EMI Nursing in Merthyr Tydfil	10
EMI Nursing – Out of County	6
Total	197

As the table above indicates there are 197 older people currently placed in residential or nursing care. Out of the 197 there are 119 people living within the county borough and 45 customers now residing outside the county borough. This is largely due to the lack of EMI residential and nursing beds within the county borough and people wishing to remain close to their relatives.

62 of all placements are EMI Residential with 4 EMI placements within the local authority homes and 50 people accommodated in other EMI residential care within Merthyr Tydfil. There are currently 12 people placed in EMI residential care out of county.

With regards to EMI nursing there are currently 16 placements in all with 10 people living within Merthyr Tydfil and 6 people placed outside of the county borough.

The issues within this area include:

- These figures suggest that residential care home capacity exceeded demand despite the reduction in local authority places.
- The continuing loss of local authority beds up until the present time has not affected waiting lists for residential care home placements. It has meant that we have placed more people in independent sector homes than in-house homes.
- In 2005/06, the usual daily cost of local authority home provision was reported to be £88, while placements in independent sector homes cost £35 per day. However, the unit cost of local authority care has increased, as the number of actual residents in each home has decreased.
- In 2007/08, the usual daily cost of local authority home provision was reported to be £91, while placements in independent sector homes cost £46 per day based on a provision of elderly residential care.

Support in the Home Services

Home support services provide 3675 hours of service to 415 people per week on average.

This is provided by both the in-house service (2,206 hours per week) and services commissioned from the independent sector (1469 based on average deployment of hours across the 3 providers available).

The key issues for home support services include:

- The current local authority service is unlikely to meet all the projected demand from customers in the future.

- There is no maximum with regard to the number of home care hours someone can receive and recipients can have up to 4 visits a day.
- There is currently no specialist home care provision for older people with dementia or other cognitive impairments and for visual/hearing impairment. A pilot scheme for Dementia will be available in 2009/10 with £80,000 of funding available via WAG grant funding. Agreement has been reached with Cwm Taff Trust to supplement the team with an Occupational Therapist to undertake functional assessments and develop support plans and strategies that promote independence and enable customers to maintain self care skills for as long as possible.

The County Borough has an effective Initial Response Service, which offers time limited (up to 6 weeks) personal care services to individuals in the community and to individuals following a period of hospitalisation where customers are receiving personal care services for the first time. For those discharged from hospital the service is in effect providing a step down provision to those customers who are receiving services for the first time following a period in hospital and it is likely that this provision will be linked to the future development of an intermediate community health care service, which will also have a step up provision. Again this service is County Borough wide and in 2005/06 they were able to provide care for 174 people per week and this has now risen to 257 people for 2007/008.

This service enhances the initial needs assessment with staff working with customers in a way that focuses on re-ablement. It has proven to be very successful in reducing long term support needs by maximising independence and self-determination.

The high demand for community services is evident in the data above. Not only will the authority need to increase the home care capacity to meet future demand, but it will also need to develop/commission specialist services.

The transfer of service hours from in house provision to the independent sector has continued commensurate with the reduction of staff resources within directly provided services through natural transition.

The average number of hours deployed in the independent sector during 2010-11 was 1,700 per week compared to 1,400 per week in the directly provided services. The independent domiciliary care contracts were re-tendered in 2011 and two new providers have been allocated block contracts of 600 hours per week each with the provision to spot purchase additional hours at the same rate or lower dependent on the number of hours.
As part of the tender process the service specification included the Directorates intention to move to outcome based service plans and the service providers have now provided an all encompassing hourly rate which will enable service users to transfer hours to different days and times to meet need without having varying financial implications.

The pilot project for the specialist dementia domiciliary care service was successful in maintaining service users with complex needs in the community. The Well Being and Independence Grant that originally funded this service ceased in March 2011 but the cost of the service has been met by the LA and Cwm Taf health Board

Community Occupational Therapy (COT) Service no update

With regard to the provision of equipment and adaptations from Social Services, some minor items of equipment are supplied within 1 or 2 days through the duty desk. However, for other items it may take longer to complete the assessment and the average time from assessment to delivery is ten days.

Table 5 below highlights that this service in 2007/08 is already dealing with more referrals than was anticipated from IPC and issued 2,110 items of equipment to 1,140 people at a cost of £183,961. (This does not include equipment provided through Care and Repair, Telecare or through Disabled Facility Grants)

Table 5

Year	Projected % increase	Projected Additional Referrals	Total People issued Equipment	Total People provided with an Adaptation
2005	-	-	807	
2010	6%	48	855	
2007 /08			1,140	441
2008/09			888	541
2009/10			958	462
2010/11				

Again the data presents a picture of service demand out-growing capacity and resources. The projected number of referrals for 2015 was 974 but we have already reached 1,140 for 2007/08. The COT service is an integral component in maintaining people in their own homes in the County Borough and the need for continued investment and enhancement is well evidenced.

Housing provision

The figures in the IPC report showed that the County Borough has a total of 447 sheltered housing units with 194 or 43% being provided by the local authority and 253 or 57% being provided by 4 housing associations. There are high occupancy levels of 97% in housing association sheltered housing and 91% in LA sheltered housing.

Some sheltered housing is not able to offer a home for life and there is no Extra Care housing or specialist housing provision for older people with mental health needs available in the County Borough at the present time.

Sheltered Housing units are equipped with alarms in order that tenants can call assistance from wardens who are employed on a full time basis. When wardens are not on duty, tenants can use their alarms to summon assistance from control centres. Assistance may be in the form of advice or contacting the emergency services if required. Sheltered housing schemes also offer regular opportunities for peer socialisation and planned leisure activities. Tenants may also access community social services and health care services as required.

One of the key questions to ask of sheltered housing provision is whether or not it is or can be a home for life for its tenants. In the IPC report sheltered housing was not able to offer a home for life for 9 tenants out of 50 or 18%. The reason cited most often as to why people had to move was around mental health needs and associated risk.

Mobility problems as a result of strokes were also cited as a reason for why people could not continue to live in their sheltered accommodation. This included the unsuitability of the environment, eg, bathrooms, kitchens and access issues.

Best practice suggests Extra Care housing works most effectively on a ratio of a third of tenants being older people who otherwise would need to be in residential care, with the others having lower needs.

Older Carers

In many older couples one person is caring for the other, even though they may not be in good health themselves. When the carer is no longer able to care for whatever reason, the cared for person is particularly vulnerable to being admitted to a care home. There are 358 carers aged over 65 who are providing care when the carer is not in good health. The most worrying aspect of this is that 203 carers are providing over 50 hours or more of care every week.

From the cared for's perspective there is a need to ensure that their carers are supported to carry on this caring role by providing support in the community rather than having the cared for being admitted into residential accommodation.

The appropriateness of carers' services and the level of support available is highly important when considering the number of older carers in the County Borough, who report providing substantial amounts of care and the fact that carer breakdown was often cited as a reason for care home admission in the Delayed Transfer of Care panel paperwork.

EMI Dementia

The Welsh Health Survey 1998, which is a self-completion postal questionnaire based on a random sample of adults (18+), reports that Merthyr Tydfil has the highest proportion of self reported mental illness in Wales, with 20.7% of adults in the County Borough reporting being treated by a doctor for anxiety or depression, compared with 12.7% of adults in Wales.

The onset of dementia in older people is often associated with a need for alternative accommodation and/or care arrangements. The Alzheimer's Society website highlights that there is an estimated 41,800 people in Wales who have some form of dementia. The society also suggests the following prevalence rates of the disease by age across the UK; people 65-70 - 1 in 50, people 70-80 - 1 in 20 and people over 80 - 1 in 5.

Based on the 2001 population census data there may be a total of 697 older people with some form of dementia residing in the County Borough. Most will continue to live in the community with the support of spouses and other family members, but many will be vulnerable to needing alternative care and support as their dementia progresses, especially if living alone.

There is a greater percentage increase in people over 85, amongst whom the proportion of those with dementia is higher. This suggests there will be 976 older people with dementia by 2020, about 8% of the total older population. The reviewed literature suggests that a specialist home care service is required to meet more complex needs such as dementia, as will be the expectations of the Domiciliary Care Standards.

WHERE WILL WE NEED TO BE BY 2020?

In accordance with the authority's vision and strategic aims, the key driver for change is to maximise opportunities for individual independence and self determination and providing, when necessary, high quality support services to people within this context. It is acknowledged by all partners that within the context of high local need and limited resources, the focus needs to be on developing better learning opportunities and maximising the populations' potential for greater independence and reducing the level of dependence.

Where social care support is needed, this will be provided in a way that supports this approach and avoids creating an environment that promotes dependency.

On a Welsh national level it is reported that over the next 20 years the overall population is projected to grow by just 3% (less than 100,000 people), but the number of people of current retirement ages will increase by 11% to 650,000. The number of 85+ in Wales is projected to increase by over a third to 82,000. These demographic changes will significantly alter the balance of the population.

3587 or 40% of the older population live alone which increases their vulnerability in terms of requiring accommodation and other support services and the older a person is, the more likely they are to need services.

This table shows population figures from 2005 and the projected population for the year 2020 broken down by age and gender if net out-migration continues.

Table 6: Population projection for 2020 and percentage increase

	2006			2020			
Age Range	**Males**	**Females**	**All Older People**	**Males**	**Females**	**All Older People**	**Percentage increase**
65-74	2,400	2,500	5,000	2,921	3,211	6,132	23%
75-84	1,300	1,900	3,100	1,770	2,283	4,053	31%
85+	300	800	1,000	444	1,073	1,517	52%
Total	4,000	5,200	9,100	5,135	6,567	11,702	29%

Source: Institute Public Care - HSQL Review 2005

The total projected figure of 11,702 older people for 2020 shows a potential increase of 2,602 or 29% from the 2006 mid-population estimate of 9,100. The biggest numerical increase is to be found in the age range 65-74 at 1,132 or 23%. For the age range 75-84 the increase will be 953 or 31% and for 85+ the increase will be 517 or 52%. The increase in the numbers of older people aged 85 and over is particularly significant as vulnerability and the need for health and social care services clearly increases with age.

The projected population increase for 2020 was applied to current take up of social care, housing and health services to estimate what increases in services would be required if all other factors remained the same. However, evidence shows that there will have to be significant increases in services by 2010 and again by 2015 to meet the needs of an increasing older population of 6% and 19% respectively. Of particular significance is the fact that the over 85 population will have increased by 7% by 2010 and by 24% by 2015.

This projected population increase can be applied against current take up of social care, housing and health services to estimate what increases in services would be required if all other factors remained the same.

The projected population increase of 29% by 2020 will require extra investment in the current main social care provision in order to meet the future predicted demand. The table below indicates the level of increase in provision by 2020 that would be necessary to meet future demand if we continue to provide the current service provision as it stands today.

Table 7

Level Increase	Service Increase	Estimated Revenue Cost
29%	Extra Residential beds	£61,000 per annum up to 2020
29%	New Nursing Beds	£24,000 per annum up to 2020
29%	New hours of home support p/w	£600,000 per annum
29%	Extra Day Care places	£300,000
		Total: £2m.320,000

N/B: This does not include any capital build costs.

In order to reconfigure existing services to meet the increased customer demand shown in the table above, the local authority's intention is to implement step by step changes based on a 3-year implementation cycle. This will enable the authority to review the implementation progress at the end of each reconfiguration cycle and its effectiveness in delivering the objectives and also to re-evaluate the next implementation stage cycle to take account of changes in demography, legislative or government drivers and local priorities.

HOW DO WE INTEND TO GET THERE BY 2020?

Reconfiguration: A Local Response

In determining options for the future, the following criteria have been applied:

- Viability and sustainability – not least in terms of cost in the context of the authority's three year financial planning framework.
- Increasing customer need projections – ensuring support is available for our most vulnerable client groupings, whilst at the same time allowing us to address some of the root causes.
- Re-configuring services to maximise independence and self determination - our key customer focus.
- National guidance and regulatory requirements e.g. Care Standards Act requirements and National Service Frameworks.
- Delivering the authority's overall vision for its community as a whole - improved community/own home focus for support provision.

Stage 2: Implementation Cycle 2006-2009

Key Developments:

Development of more specialist home support

The Council currently supports in excess of 400 people to remain in their own homes through the provision of home support services. These services assist people to manage their every day needs including washing, dressing, eating, social inclusion, cleaning, sitting and managing their household and personal responsibilities. Existing in house services are currently provided in a generic way by a staff team who provide services to a variety of customers including older people, people with dementia, sensory impaired people, people with a learning disability and people with mental health problems.

In order to meet both the increased projected demand in customer numbers and to improve the quality of services to certain customer groups, the Council has identified the need to develop certain specialist home support teams/services which will deliver specific tailored services to meet the needs of particular customer groups. The four key groups of customers which have been identified as needing these services are:

- Older people with dementia
- People with sensory impairment
- People with mental health problems
- Physical disability

The development of these specialist home support services will extend and enhance the current provision and enable resources to be targeted in appropriate and effective ways in order to maximise the outcomes for customers in maintaining their independence and quality of life. The need for the development of more specialist home support services is further underpinned by the Domiciliary Care Regulations and National Minimum Standards, which re-enforce the need to have specially trained staff groups to work with customers with dementia and other specific health related needs.

Development of Assistive Technology (Telecare) Services

Assistive Technology forms the basis of Merthyr Tydfil County Borough Council's Telecare Strategy. Telecare means the provision of support and reassurance from a distance, provided with the help of technology through a range of alarms and passive sensors which raise an alert at a call centre in the event of a potential problem or accident. Telecare can help vulnerable people manage risks of living in their own homes, while still remaining as independent as possible.

The benefits of Telecare are:

- Increases quality of life.
- Promotes independence.
- It provides reassurance and peace of mind to the service users and relatives.
- Provides support to carers.
- Provides rapid response in the case of emergencies.
- Reduces hospital admissions.
- Facilitates hospital discharge.
- Increases safety and security.

Merthyr Tydfil County Borough Council received a grant from the Welsh Assembly Government (WAG) to provide our service users with telecare assistive technology equipment over a two year period. The grant ended in April 2008 and we have now applied for Continuing Health Care (CHC) funding to continue to fund this service and develop the Telehealth care service with our health colleagues.

The existing grant enabled people with EMI/dementia to have a sensor installed in their homes. In 2009 any person identified with this condition will be offered a basic package of sensors as part of their annual review which will include the following:

- CO detector
- Flood detector
- Smoke detector
- Gas detector.

A Telecare demonstration house is also being built as part of the Integrated Demonstration and Equipment Store in Cefn Coed and this will be operational from April 2009.

This service should be seen as a core service in enabling people to remain at home and it is seen as a priority when releasing revenue funding from our traditional services back into new community based services.

Residential Care

The Council owns and maintains four residential homes for older people and has a duty to meet the required regulatory standards for this provision. As stated in previous reports and QBR presentations a critical issue for the local authority is that the current bed sizes do not meet these requirements. The current situation means that only bedrooms that meet the minimum space requirements can be filled either by existing residents moving from smaller rooms or by new admissions. To date 45 beds have been taken out of use and de-registered with another 18 beds waiting to be de-registered. Out of the 127 beds that were previously available for use in the four homes, only 64 are now available.

Since the HfL report in March 2007, there have been a number of significant developments which need to be considered in taking forward any refurbishment programme.

- In 2007 the report showed an overall occupancy level of 51% in the four homes; this has now dropped to just 37%.
- The proposed Extra Care facility has now been agreed.
- Greenhill Manor has opened with 111 beds.
- No capital has been made available to enable any refurbishment to start.

As a result we will undertake a further review of the current in house residential provision and develop a number of options for consideration. It is clear from the evidence available that long-term residential care will still be required in the future but this will be more specialist residential care, catering for the needs of older people who are elderly and mentally infirm.

Specialist Extra Care Housing Development

This strategy document highlights the need to maintain the progress made in developing a local Extra Care Housing (ECH) scheme to compliment improved community based dementia services (to support people in their own homes) and enhanced residential EMI provision. ECH schemes are an enhanced form of sheltered housing with accommodation that is specially adapted to meet the needs of tenants who are elderly and may be quite frail. In addition to the building design, a feature of ECH is the availability of a dedicated domiciliary care staff group who can respond to changing needs and provide care as required. The application submitted to WAG in October 2007 for £5.5 million capital to develop a 60 unit Extra Care Housing (ECH) Scheme for older people has been successful and funding will be accessible in 2010/2011. We will need to identify the revenue funding to support this critical service development.

Extra Care offers a new way of supporting people to live independently for as long as they possibly can. It provides security and privacy of a home of their own, a range of facilities on the premises, with 24hr care services available.

Key principles of extra care housing include:

- Living at home, not in a home.
- The provision of culturally sensitive services delivered within a familiar locality.
- Flexible care delivery based on individual need that can be easily adapted as circumstances change.
- The opportunity to maintain or improve independent living skills.
- The provision of accessible buildings with smart technology that makes independent living possible for people with physical or cognitive disabilities including dementia.
- Building a real community including mixed tenures and mixed abilities.
- The inclusion of facilities and services, which are also used to support people living in the local community.

Extra care is a major contributor to the authority's preventative strategy, enabling the people of Merthyr Tydfil to have a wider choice of services to help to maintain high levels of independence.

Expansion of the Initial Response Service

The Initial Response Service is a specialist home support service which supports individuals in their home following discharge from hospital for a time limited period of 6 weeks. The service works with individuals and other agencies to maximise their independence and to identify the longer term support needs of customers. The service began in May 2003 and has been very successful in supporting people to maximise their independence. Every year over 70% of people have not required home support services following the first 6 weeks of the Initial Response Services' intervention, as people have been able to attain sufficient skills to remain independent.

The intention is to expand the service so that all people who require a home support service for the first time will have this service provided by the Initial Response Service (IRS) and not just those being discharged from hospital.

The referral criteria of the Initial Response Team were amended in 2007 This affected the extension of the Initial Response Team to accept all community requests for domiciliary care services whereas they had previously only supported hospital discharges. The Initial Response Service now operates as an intake model for all personal care domiciliary care provision and does not operates a screening process at the commencement of service.
The outcome of this alteration to referral source has meant that there has been a decrease in the number of service users who end service.

The number of referrals has risen year on year and in 2010-2011 the service supported 287 service users.

Development of the Merthyr Tydfil Integrated Demonstration and Equipment Centre (MIDEC)

The purpose of integrating equipment services is that agencies work together to provide a more effective and efficient service. In line with Merthyr Tydfil County Borough Council's principles, the facility will offer modern and sustainable services.

The integrated demonstration and equipment store is an initiative being developed by Merthyr Tydfil County Borough Council in partnership with Rhondda Cynon Taff County Borough Council, the respective Local Health Boards and Cwm Taf NHS Trust and will provide a resource for health and social work occupational therapy staff, as well as providing essential storage for home care and community alarms equipment.

The development of this facility will ensure that local people are able to access aids and adaptations which will help them to live independently at home.

In order to achieve these objectives we aim to:

- Ensure the joint equipment store is able to respond to an increasing demand for equipment, based on plans to support Vulnerable and older people in their homes as well as families and Carers.
- To maximise efficiency in delivery of aids and equipment to physically disabled and older people. This is in operation and working well.
- The establishment of the joint store will allow occupational therapy staff to focus on assessment of need only. They are now looking holistically at services and will refer to other services such as teleacare etc if need be.
- Provide a facility which is multi-purpose and flexible to accommodate shared use across the wide range of health, social care, statutory, and the voluntary sector organisations. This facility is well used, by a range of professionals for training purposes, visits, assessments information, and advice so on.
- Training has been delivered at the facility using the Re-hab, room, assessment rooms and the Demonstration house facility for District Nurses, Occupational Therapists, Telecare, and Manual Handling for Care Staff. - a range of training has been delivered in 2009/10 and in 20011 we have had an increase in demand to use this resource from our health colleagues, District nurses have now scheduled this in for 2011. – For community nursing.
- Telecare training has been completed at the Centre for all Adult Social Workers and a training programme for this is ongoing.
- Sandbrook day service is now using the centre to deliver opportunities to service users enabling them to carry out life skills to, develop, learn and maximise independence.
- SMT conduct and arrange visits for the Police in relation to all the safety and security equipment that is on displayed, a range of people have visite dteh centre to see what is available and SMT have been fortunate to secure funding for their security projects from this.
- We have a well equipped Sensory room which people who have sensory needs can have/request an assessment and test out the appliances suitable for their needs.
- We have had a very successful open day in 2010 and are in the process of planning another for September 2011.
- To date we have had over 400 visitors to the centre.
- We have and have had a range of volunteers, and jobs match people to assist in some of the admin work.

Meals on Wheels

The Meals on Wheels service is based in Cefn Coed and employs fifteen members of staff. There are five delivery rounds operating in Merthyr Tydfil, delivering to 279 customers. Frozen meals are purchased from Appetito and Flow Foods, warmed and placed in hot locks which allow the food to stay warm for up to three hours. The hot locks store approximately 40 meals or 80 desserts, with each van having capacity for 3-4 hot locks.

There are currently no defined eligibility criteria for access to the service and there is insufficient detail available on the level of assessed need for Meals on Wheels.

Proposed Customer Consultation

A review of the service will involve a customer consultation exercise, the purpose of which will be to identify current levels of satisfaction with the service, identify any potential gaps and assess what aspects of the service need improving.

The proposed customer consultation will be carried out in January 2009 with an analysis of findings, including proposed options for the future delivery of the service, being undertaken in February 2009. These proposed options will be assessed in terms of their impact and associated risks and this will inform the production of a final report on the findings of the Meals on Wheels review by February/March 2009.

The review of Meals on Wheels was undertaken in 2009, the outcome of the review being that the staff resources within the team have been revised to affect a more efficient service. This has been achieved through the removal of the delivery assistant posts. Analysis of the rounds has demonstrated that the meals can be delivered within the same time allocation therefore not affecting service delivery to customers.

Mentro Allan

Mentro Allan is a collection of 15 projects in Wales supported by the Big Lottery Fund and a National Partnership. Each project has a defined geographical area and target group. The programme targets specific groups that are generally less active than the wider population. The projects are funded for four years (2007-11) and aims to increase the physical activity levels of its target groups by making best use of the local natural outdoor environment close to where people live. The programme will collect evidence on the effectiveness of specific interventions designed to increase people's levels of health-benefiting physical activity.

The project has a value of £497,000 over four years. Approval from the Big Lottery Fund was granted in April 2007 and the project will be expected to reach completion by March 2011, supported by an exit strategy for sustainability.

Institute of Public Care review (2010)

Mentro Allan Venture Out

In March 2007, MTCBC and Blaenau Gwent CBC won Big Lottery funding (BLF) to deliver this cross boundary action research-type project until February 2011. The current coordinator is the sole paid member of staff (i.e. paid by BLF). Although he reports through Adult Social Care, the project is virtually an outsourced service, making its own service level agreements with a range of provider services. As such, it has a lean staff profile, the coordinator now being supported by two volunteers sourced through Employment Routes and Jobs Fund, all working out of a single office located in a neighbourhood learning centre. This location provides some useful overlaps with adult learning facilities, while the majority of activities take place at external locations. We would encourage the use of volunteers in a service, built in as a route for service user development, and we hope the practice continues at Mentro Allan and is incorporated into their service specifications with providers. Mentro Allan addresses issues of access for clients by providing pick-up transport where needed, and builds this facility into its specifications. The two volunteers track attendance registers on a daily basis and chase absentees. It was clear that much had been achieved in a relatively short space of time, with value added by the Co-ordinator through the targeted development of linkages with other community initiatives and focused joint funding applications for community health and employment projects.

There is a considerable body of evidence supporting the impact of physical activity out of doors for people with mental health issues, and many successful schemes have been developed that offer a palette of slightly different approaches. Mentro Allan provides services for people over the age of 16, including: a menu of ecotherapy interventions delivered jointly with health services (linked to changing themes of earth, air, water, fire); a range of outdoor activities (such as sailing) and excursions designed by service users and picked from a summer and winter menu of options; green gyms for inpatients at St Tydfil's Hospital and Thomastown House and a number of other venues, plus allotments and greenhouses in the north and south of the county; a new programme All Round Employment in partnership with Working Links (an independent employment agency and part of New Deal contracts for South Wales); a special programme for 16-20 year olds; and Art for Dementia for the 50+ age group.

Although the Mentro Allan approach is not for everyone, Table 3 below shows that demand for the service is strong and increasing, with over 400 clients (combined figures for Merthyr Tydfil and Blaenau Gwent) over the three years to 2010-11, compared with a projected target of 300. Enrolments for the current year are already 70 per cent above target.

Table 3: All client enrolments at Mentro Allan *(Source: MTCBC, November 2010) NB: Figures are for Merthyr Tydfil and Blaenau Gwent clients.*

Financial Year	2008 -09	2009 -10	2010 -11
Total number of service users engaged	131	100	170
Projected Target	100	100	100

Under BLF funding, Mentro Allan has not been restricted by the Directorate's decision to fund only substantial and critical need. Its services therefore range
from 'Tier 1' (universal services) to 'Tier 3' (where provision addresses specialist

or complex need that stops short of residential care). All clients must be referred through an organisation, although this can and does include – for example - the GP Exercise Referral Programme, interventions for Adref (a hostel) and Merthyr Housing, peer mentoring for Drug Aid, and diversionary activity for the WAG funded Communities First initiative. Links are stronger with secondary care services, such as St Tydfil's Hospital, Thomastown House, the Community Mental Health Team, and Assertive Outreach). We understood the current balance of activity is approximately 60 per cent secondary care clients and 40 per cent primary. The range of interventions fits well with good practice and addresses all six of the strategic outcomes we have set out in this report.

Management of the service demonstrates good commissioning practice in terms of: researching models of good practice and evidence based approaches, linkage of its activities with MTCBC's corporate objectives and with the National Service Framework for Mental Health; consistent performance reporting to a range of stakeholders, including service users, referral agencies, the Lottery Fund and MTCBC corporate managers; use of outcomes-based specifications with targets for a range of commissioned services, along with monitoring and review. Clients receive personalised care programmes, using WAG physical activity templates. The service recently commissioned training from Glamorgan around CPA and Risk Management, which was open also to its own providers. A new internal system puts clients onto time-limited programmes which will be assessed for achievement of outcomes and reviewed after 12 weeks. The service demonstrates the real power of service user involvement, and has been recognised as an exemplar of best practice in this field. It has a marketing plan that is regularly reviewed, updated and reported, with objectives aimed at a range of stakeholders, including links with target groups and agencies. Given continued funding, the service could continue to evolve in an iterative way, addressing these potential new needs. For example, Mentro Allan may wish to consider how it could evolve to add services for clients with physical disabilities.

Summary

The project offers excellent value for money and has won external recognition and support - owing not a little to the drive of the current Co-ordinator, who has built on a good base. However, funding ceases in February 2011, when without additional support it is probable that only the green gym at St Tydfil's (because the capital element for the land is covered and staff are shared with health) will escape closure. MTCBC's Medium Term Financial Plan for 2011-12 indicates that £92,540 would enable the project to continue to provide the current level of service for Merthyr.

Recommendation

Ensure the continuation of Mentro Allan by transferring £92,540 saved from disbanding the Community Mental Health Day Services team and redirecting its remaining clients as above. Whereas a Fair Charging policy applies to in-house social services, we think this would be inappropriate for a virtually outsourced service such as Mentro Allan[1], and believe such a policy applied to this project would dramatically reduce referrals and jeopardise the impact it can have on the long-term unemployed in Merthyr and all those on a low income. We also strongly recommend continuation of the current client mix, which includes mild to moderate need, and this will imply departure from the Directorate's current policy of addressing solely substantial and critical need. It is important for MTCBC to address the preventative agenda, where there is mounting evidence across social and healthcare that relatively low-

cost interventions made early on prevent escalation of need into a critical phase later on that requires the authority to provide more expensive solutions. Mentro Allan is a unique, successful and well-regarded initiative that has already achieved good outcomes for the client group and has excellent potential to evolve further.

NB: With a shift in funding source from BLF to local authority, the service will need to consider whether it raises its age threshold to 18-plus.

Future Developments include:

- MTCBC have allocated £50,000 to continue the program
- Continue to use the Recovery Model as the underpinning ethos
- The program currently operates a 2 day / week service for service users with primary and secondary mental health conditions aged 18+
- Hope – Providing service users a non medical provision that promotes physical and metal wellbeing
- Opportunity – Service users are offered opportunities to progress into community learning and training
- Control - Service users design the activity program
- From April 2011 to date there are 52 service users accessing the provision which has already exceeded the target set in the MTCBC operational plan
- Operate a 12 week cycle with service users offered additional programmes at the end of the 12 weeks

Service user wellbeing measured using the Warwick and Edinburgh university wellbeing scale

Future Commissioning Plan Overview

Current provision	**2006/07**	**2007/08**	**2008/09**	**2009/10**	**2010/11**	**2011/12**	**2012/13**	**2013/14**	**2014/15**
Support in the home	130 staff. Review Independent contract.	New contract awarded. Start in September 2007. Completed.				3 year contract for Dom care starts in Oct 2011			
Initial response	current staff level of 7, Increased the capacity of the service to meet current demand in 2007/08 Completed.	14 staff now transferred or employed. Completed.	Continue to monitor the capacity of the service to ensure it continues to meet current demand.	Review whether this service should relocate. Ongoing work with health on the out of hospital community care model.		Integrate d health and social care commun ity teams?			
Meals on Wheels			Commenced review of the MOW service.	Complete review and strategy for services and future commission ing / delivery arrangement s.					
Specialist	4 staff now		6 Dementia	Establish	Commissi				

Current provision	**2006/07**	**2007/08**	**2008/09**	**2009/10**	**2010/11**	**2011/12**	**2012/13**	**2013/14**	**2014/15**
Continuing Social Care support	based in mental health. Completed.		workers introduced utilising WAG grant.	pilot specialist dementia domiciliary care team. Submit a bid for CHC to pilot a service for Brain Injury service users. Submit a bid for CHC funding to pilot a service for Autistic service users. Conduct service needs mapping / feasibility on need for Sensory Impairment. Explore	on specialist service for Dementia. Implement the 1 year pilot project. Implement the 1 year pilot project Commission sensory Impairment service if required Commission on independent sector for specialist LD				

Current provision	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
				requirement for commissioning of a specialist LD domiciliary care service. Develop strategy and action plan for future of directly provided domiciliary care	domiciliary care.				
Intermediate Care team	Re-modelling work with the 2 Trusts.	Team linked with Initial response and Long Term Illness team Ongoing with the Trust.	Ongoing work with health. Now Cwm Taf.	Continue to participate in the joint planning groups for Out of Hospital services and chronic conditions management and determine the participation of the LA in		Integrated health and social care community teams?			

Current provision	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
				these programmes					

Current provision	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Telecare/Telehealth medicine/ Life - Line	Upgrade life - line system. Provider to be agreed. Strategy to be developed. Identify available building for demonstration facilities.	Telecare sensors available with priority on Dementia and Falls. Completed.	Telecare demonstration house available. .April 2009. Telehealth/ medicine to be used as part of LTI team and Falls service. Submit bid for CHC funding for Telehealth and purchase equipment.	Telecare equipment purchased through grant funding. Falls service to be developed in line with Out of Hospital services model. Integrate Telehealth into community based services following pilot in RCT.	Telecare part of core funding. 24/7 response service developed.				
Aids/ Adaptations (Vision Products)	Joint commissioning plan with RCT. MTIB	Joint Equipment Stores and Demonstr	MIDEC open in April 2009.			Move to HWB centre.			

	identified as potential building. Work with Estates on commissioning the building.	ation Facilities building work being commissioned.							
COTS	6 staff.	Increase to 8 Second 1 onto the COT degree programme. Completed.							
Specialist workers mental health	4 staff transferred in to CMHT as part of Sainsbury.	Completed							

Current provision	**2006/07**	**2007/08**	**2008/09**	**2009/10**	**2010/11**	**2011/12**	**2012/13**	**2013/14**	**2014/15**
Mental Health	Crisis resolution team in place.	Assertive Outreach team in place. Primary Care	Ty Gwyn reviewed and new service developed following	Sainsbury review of mental health accommodation.		Move to Health Park.			

		liaison in place. CMHT fully integrated with Health. Completed. Mentro Allan project starts with Blaenau Gwent. Completed.	consultation with service users and partners. Completed. HSCWB priority.						
Mental Health Older People	EMI Team in place. Completed.	Fully Integrate team with Health. Completed.	Move into health accommodation Completed.	Review team capacity against predicted rising customer base.	Increase SW resource as necessary.	Move to Health Park.			
Social work teams			Strengthen Case file audit process. Implement quality assurance processes.	Review case load impact following population increase for assessments. Introduce Outcome	CCWs to change to qualified staff. Introduce costed	Increase SW resource to meet increasing community need.			

			New SWIFT system introduce in Jan 2009.	Focused Care Planning. Feasibility study on Home Working. Specialist Visual Impairment worker to be core funded.	care packages.				
Current provision	**2006/07**	**2007/08**	**2008/09**	**2009/10**	**2010/11**	**2011/12**	**2012/13**	**2013/14**	**2014/15**
Carers	1 staff.	Linkage with DWP.							
Adult protection	1.5 staff.	Growth bid for an extra member of staff. Still awaiting funding.	Feasibility study looking into integration of a protection team.	Review team capacity against predicted rising customer base. Secure funding for a manager.					
Direct payments	18 clients.	50 clients Complete d.	Review Service Completed.	Target 100 customers. Review of resource implications in relation to	Target 150 customers.				

				homes for life strategy.					
Local Authority residential Homes	4 homes in place.	Refurbish highest priority. Not started.	Review remaining homes and consult on future accommodation needs.		2 home closed				
Extra Care/ Sheltered accommodation	Initial outline plan to be developed. Available land to be identified.	Extra Care Housing development. Not going ahead Extra care Housing bid with Housing made to WAG using Social Housing Grant. On track.	Provider commissioned and land has been bought.		Extra Care Dementia Care scheme in place. Extra care Housing project in place.				

Current provision	**2006/07**	**2007/08**	**2008/09**	**2009/10**	**2010/11**	**2011/12**	**2012/13**	**2013/14**	**2014/15**
Nursing/EMI		Joint commissioning review							

		with LHB. Hallmark Home opens. Completed.							
Respite	Adult placement scheme viability study.	Take to Network. No decision yet.	Mental Health Carers grant in RSG.						
Day Services Older people and learning disability		Review existing provision. Completed.	Develop proposals for service improvement. Completed.	EMI day service and Day hospital provision reviewed as part of the Health Park proposals.		Specialist unit for people with severe and complex learning disabilities as part of the Health Park.			