Powys Home Support

Annual Report

April 1st 2018 – March 31st 2019

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Project & Contract Officer

Contents

Version Control

The Home Support Annual Report is an update and is to replace the Home Support Interim Evaluation Report (April – December 2018) published in January 2019.

This report provides a full year's data for the period from April 2018 to March 31st 2019 and is the final version.

Acknowledgements

With thanks to the senior support workers in each of the Home Support localities, their teams and operational manager's, members of the Home Support Steering Group and wider stakeholders for their support and contributions.

Section 1: Executive Summary

The UK population as a whole is ageing, there are currently 9.3 million households headed by a person over retirement age. This is expected to reach 13 million by 2033.

In Powys, there are 34,158 people aged 65 and over (26% of population), with 3% aged over 85 and 15,571 people aged 50+ are predicted to be living alone. The 65 plus population is projected to increase by 38% by 2036 and the 85 plus population is expected to increase by 159% by 2036.[1] Although, it is not expected there will be such significant increases for people with a disability or mental health problem (excluding dementia) population projections show a small increase of 2% and 3% respectively.[2]

As life expectancy increases, support and care needs will likely increase. The Social Services and Wellbeing Act (2014), local needs assessments and surveys all advocate for early intervention and prevention and support at home that allows people to remain in their own home and community, helping to retain their independence and be close to their family and friends.

The Home Support project has sought to address this - to develop a consistent approach to supporting people to live at home whilst being both responsive and adaptable and taking account of the profile and needs of local communities and individuals and the often variable services and resources provided within each. This has meant that whilst the Home Support service in each of the project areas has evolved and developed differently they have retained a clear reference to the revised and pan Powys service specification. This has also presented with differing workforce arrangements, service, resource challenges, and opportunities, which highlighted within this report.

This report covers the first year of the project and includes additional data to the interim evaluation report published earlier this year, continuing and reinforcing very promising outcomes.

This report demonstrates that Home Support is a responsive and adaptable service that ensures that the nature and frequency of support is reflective of each individual's needs and abilities, ultimately enabling them to live at home by providing very practical assistance and support, as and when needed and without requiring potentially more intrusive and costlier support and services.

The findings also indicate opportunities to develop the service further to address current and projected need:

- Better consistency across the four areas in terms of provision, recording and data collection and asking individuals about their views and experiences
- Health and wellbeing promotion, improvement and intervention
- Proactive approaches to tackling loneliness and social isolation
- Partnership and integration with similar health and social care services
- Co-production with service users and carers to develop and review services
- Diversion from more intensive service interventions, in particular, emergency service escalations
- Return on investment particularly in terms of cost avoidance of health services
- Application of an established service model, practice and systems to other areas
- Analysis and learning from comparator services

This report further shows that services provided across the project areas are highly regarded as a much valued, innovative and unique, proactive and preventative service. It is anticipated that the findings, conclusions and recommendations of this report will support the case for continuation and further development to help address the future needs of and service responses to people living as dependently as they can in Powys.[3]

[1] file:///Z:/Wellbeing%20&%20Population%20Assessment/Market_Position_Statement_Older_Peoples_Accommodation%20(2017).pdf

[2] file:///Z:/Wellbeing%20&%20Population%20Assessment/Domiciliary_Care_Market_Position_Statement%20(2017).pdf

[3] At the time of publication: Awaiting Welsh Government ICF (Integrated Care Fund) approval for project extension from April 1st 2019 – March 31st 2021.

Section 2: Summary of Recommendations

1	**Extend and expand the Home Support project in the four service areas as detailed below to March 31st 2021**
Strategic	
2	Refocus the role of the Steering Group to future proofing and sustainability of Home Support beyond April 2021 – including working with related HS services in PCC, PHTB and community services to consider pooled budgets, commissioning opportunities and future intentions
3	Continue the project reporting and evaluation (6-monthly) to inform a business case going forward that is based upon research , the revised and implemented service specification, practices and documentation and data recording systems established in 2018 and with key stakeholders
4	Review service eligibility criteria particularly in terms of age and service user group
5	Evaluation to provide a clear picture regarding the added value of Home Support return on investment, including cost avoidance, cost saving and income generation
6	Evaluation to include analysis and learning from comparator/related services and research/evidenced base practice
Operational	
7a	Review service resourcing to ensure right sizing and right pricing for all service areas including pay and non-pay commitments
7b	Confirm capacity for project support, service reviewing/evaluating services and admin support across all service areas
7c	Review and optimise both in-house and commissioned Home Support workforce capacity and allocation to ensure parity and proportionality across the service areas
8	Establish full Home Support services in Llandrindod Wells. Ring-fence a dedicated workforce and separate recording, documentation and Data Management System from Rhayader Home Support
9	Progress the establishment of Llanidloes Home Support ensuring there is a distinction from Bodlondeb service and workforce. Ensure the service has access to Manga Elk equipment and that transferred Bodlondeb cases are reviewed. Consider alignment of service area with Health boundaries for Llanidloes
10	Continue the East Radnor service with reference to Recommendations 3 (including day time capacity), 7, 8 and 9
11	Continue the Rhayader service with particular reference to Recommendations 3, 7, 8 and 9
12	Review case work activity across all areas to optimise resources and consistency whilst also taking account of services/stakeholders/need in each locality (Inc. shopping and prescription collection, healthy lifestyles)
13	Early review and ratification of the current eligibility criteria
14	Clarify if CIW registration is a requirement for this service
15	Develop Home Support services (working with key partners) in response to the needs identified in the personal profiles/snap shot questionnaires) so interventions include proactive healthy lifestyles interventions (mental/physical health/wellbeing/isolation & loneliness/Technology Enabled Care)
16	100% completion of personal profiles/snap shot questionnaires/referral activity forms, one focus group questionnaire per annum and completion of the Data Management System across all service areas
17	Improved recording at the point of/during Home Support interventions regarding the involvement of other services to help determine whether Home support services were additional to people's support or used as an alternative.
18	Update the Data Management System and amalgamate all data recording/reporting requirements where possible to minimise duplication (including in-house operational reporting)
19	Refine revised Home Support documentation for continued application across all service areas
20	Promote and support specific and service focused workforce development through staff training and service meetings
21	Review and implement a Home Support marketing approach to optimise awareness, uptake and partnership/joint/integrated working practices

Section 3: Introduction

The aim of this annual report is to review and evaluate and the progress of the Home Support services (both substantive service and pilots) in Powys, with a view to drawing some conclusions and recommendations in terms of what and how to go forward. This involves consideration of some key questions:

- **Has the service has been successful in achieving its objectives and outcomes?**
- **Does the service deliver?**
    - Promoting independence by providing early intervention and prevention.
    - Providing support to improve and/or maintain health and wellbeing including life skills, healthy lifestyles, learning and occupational opportunities and links with family, friends and local communities.
    - Helping to prevent or delay the deterioration of health and wellbeing resulting from ageing, illness or disability.
    - Do people stay at home longer?
- **What is the impact of the Service?**
    - Does the service help prevent and/or delay the use of other services?
    - Are the service user outcomes positive? For example, improved health and wellbeing and personal and relevant support at home.
    - Have there been any unexpected outcomes?
- **Is the service cost-effective and sustainable?**
    - Does the service help reduce the need for costlier and intensive services?
    - Is there a return on investment?
    - Are there cost savings and/or cost avoidances and opportunities for income generation?
    - Are the services right sized and right priced?
    - What is the added value of the service?
    - Is this way of working worth it?
- **What have been the key achievements, challenges and opportunities?**
- **Has there been any variance between the project/service areas? If so what and why?**
- **What risks have there been to the project?**
- **What references, learning and applications can be made from practice in other areas?**
- **Is there good enough information to inform conclusions and recommendations?**
- **Is there a need for the service, or even a need for further development and expansion?**

To help reflect and address these questions this report is structured as follows:

- **Sections 3 and 4** provide the aims and outcomes of the annual report, and the review and evaluation methodology.
- **Section 5** provides an overview of the project and its development, highlighting its aims, objectives and outcomes.
- **Section 6** provides outlines the four project areas, highlighting differences and variances in starting point and implementation.
- **Section 7** provides and reviews the data and information pertaining to service and project activity.
- **Section 8** aims to draw conclusions and highlight the impact of the service in terms of service user, service and system outcomes and by answering those questions posed above.
- **Section 9** provides a summary of recommendations (which are highlighted throughout the report).
- **Section 10** contains the Appendix including references and further information.

Section 4: Review and Evaluation Methodology

Measuring a discrete service within adult social care across four localities within a rural area that is both internally provided and externally commissioned is complex. This is not least because the small-scale populations and discrete/unique community and workplace settings often challenge the application of generic references (service specification, co-produced outcomes and indicators, data management tools, and recording and documentation). A key issue for the design of the evaluation of the project and this interim report has been concerned with accommodating these challenges whilst also ensuring that the report is methodologically robust.

This report has amalgamated two data management systems. The first (implemented in December 2017 at Rhayader and in April for East Radnor and Llanidloes) recorded unscheduled activity and very limited data on scheduled activity only. The second and current system (Data Management Record (DMR)) was developed in April 2018 and implemented in full from September 2018 to reflect the revised and implemented service specification and practice documentation recording all activity, service user, carer, service and systems outcomes. This was done in the absence of a suitable existing database that was fit for purpose and useable by both PCC and external service providers. The DMR was refined in May 2019 following staff feedback and consequent amendments/adjustments.

The methodological approach used for this report and the DMR incorporates the following outcomes and data records:

1. Service Activity (based on/recorded scheduled and unscheduled (callouts/referrals) activity/incident reports).
2. Service User/Carer Outcomes & Feedback (based/recorded on pre/post support questionnaires/ case studies/compliments/complaints).
3. Service User/Carer Profiles (based/recorded on personal profiles).
4. Workforce Activity (based/recorded on workforce reports).
5. Service and Systems Outcomes (based/recorded on workforce report/partner case studies & feedback/value and cost analysis).
6. Locality Profiles (based/recorded on workforce report/PCC intelligence)
7. Project Activity (based/recorded on minutes/PCC CIP/RPB Reports/project documentation).

Data Collection

The DMR forms the basis for this report and aims to capture both quantitative and qualitative data to help demonstrate the impact and outcomes of the service and the project as a whole.

Data (excluding PCC intelligence) is recorded for domains 1-6 outlined above on the corresponding work sheet of the DMR (comprising of 5 discrete data sheets) and supporting practice documentation. The DMR is submitted by the respective Senior Support Worker in each area on a monthly basis to the Project Officer.

The service activity data (domain 5) is recorded on the DMR generally by the respective Senior Support Worker in LHS and ERHS following each home support intervention. In RHS, all support staff input this data on a daily basis.

Data relating to domain 7 above is recorded on respective PCC documentation by the project officer, providing monthly CIP reports, quarterly RPB/DPB Reports and promotional bulletins/materials as and when required.

Consent

Data collected and collated for this report has been provided through the consent of individuals using the services and approval and consent from Powys County Council.

References

References providing guidance and evidence (although limited) includes:

- **Solva Care in Pembrokeshire**[4] is a not for profit social initiative, which has been set up in 2015 by Solva Community Council to offer friendly, local support and help to those who need it in Solva and the surrounding area. The support is delivered via volunteers and has similarities to Home Support but within differing contextual frameworks and constraints. Solva Care aims to maintain and improve health and wellbeing by enabling residents to stay in their own homes and remain part of the community, offering a way to counteract loneliness, isolation and social disadvantage and through providing extra support for those who are caring for relatives.

- **Tunstall Televida tele assistance service in Spain** supports more than 250,000 people across Spain with telecare and associated services. Its eight monitoring centres manage more than 16 million calls each year. The service aims to provide continued contact and support to older and vulnerable people in the community, helping them to remain independent for as long as possible and delay or avoid the need for more complex interventions.

  The service combines telecare monitoring and response, coordinates social care and third party services and delivers proactive outbound contact from monitoring centres. Including prevention in the delivery model has been a key contributor to the success of the tele assistance service.

  The service has significantly reduced the number of emergency service escalations, improved the wellbeing of users and made effective use of public services. It also provides significant potential in terms of linking with public health and healthy lifestyles.[5]

[4] https://solvacare.co.uk/

[5] Tele assistance in Spain: adding value with a preventative approach http://tunstall.com/media/1237/tunstall-televida-case-study.pdf

Section 5: Service/Project Overview

Aims

Home Support aims to provide the support and practical assistance an individual may need in their day-to-day life to stay living at home, safely and independently.

The purpose of the project is to pilot a home support service to citizens (50+) that provides an early intervention service (including 24/7 cover for emergencies through community alarms) to assist members and their families to remain at home, maintaining and maximising their independence, health and wellbeing; retaining their links with the community; and to contribute towards preventing and/or delaying the development of needs for care and support and reducing isolation and loneliness.

The Home Support project is based on an existing service operating in Rhayader (since 1998), called Rhayader Home Support. The Project was established to improve and build upon current practice and so:

- Develop current practice within Rhayader (RHS)
- Extend Rhayader Home Support to provide 24/7 cover for emergencies for those living in sheltered housing/receiving warden based services into Llandrindod Wells (LWHS)
- Pilot a full Home Support Service in Llanidloes (LHS)
- Pilot a full Home Support Service in Knighton and Presteigne area (ERHS)

Each service area works from a single pan Powys service specification that was developed at the beginning of the project over a series of workshops/months with project staff and management. The aim was to develop a consistent approach to support people to live at home whilst enabling a responsive and unique delivery in each area - taking account of the profile and needs of local communities and individuals and the often variable services and resources provided within each.

Through working alongside existing community and service provision, Home Support flexes to provide localised relevant services and doing what matters to an individual in how and when they receive help and what works best for them. The service is free and some of the things Home Support can help with include:

- Welfare visits and telephone support
- Essential Shopping
- Emotional Support
- Assistance with prescriptions
- Support with appointments
- Assist carers with their role
- Support in emergency situations
- Staying fit and healthy
- Signposting and help to access other services
- Accessing local community groups and supportive networks

Service Objectives

The service and project aligns with the Powys County Council (PCC) Adult Services Improvement Plan (Vision 2025) which sits within a wider strategic framework, evidence and research, and seeks to draw a golden thread across all key strategic and planning arrangements. The objectives of Home Support are to provide person-centred local services that:

- Promote independence by providing early intervention and prevention;
- Provide support to improve and/or maintain health and wellbeing including life skills, healthy lifestyles, learning and occupational opportunities and links with family, friends and local communities;
- Help prevent or delay the deterioration of health and wellbeing resulting from ageing, illness or disability;
- Help reduce the need for costlier and intensive services;
- Enables/assist hospital discharge and look to prevent re-admission and reduce residential placements;
- Provide short term support to help continuity of care with changing needs/circumstances/support agencies;
- Is a point of contact for members;
- Provide a 24/7 rapid response service via an emergency care line;;
- Provide support for carers and families;
- Is registered Service with CIW (Care Inspectorate Wales).

Impact and Outcomes[6]

Improved health and wellbeing

- Improved quality of life
- Improved health and wellbeing

Personal and relevant support at home

- Improved experience of support and care
- People feel more empowered and in control
- People have better access to information, advice, assistance and advocacy
- People receive relevant, local and personal support
- Quality support and care

Value and sustainability

- Quality leadership and workforce
- Evidenced-based practices
- Joined-up, co-ordinated and collaborative practices
- Effective and efficient information management
- Cost-effective and prudent service model
- Sustainable fit between needs and resources

[6] For a full List of the Home Support Outcomes in the Home Support Service Specification - Appendix Two

Section 6: Project Scope

Powys County Context

"Powys covers a quarter of the area of Wales and is one of the most sparsely populated county in England and Wales, with 26 people per square kilometre. Powys has an estimated population of 132,705, which is a predominantly rural population, with numerous villages and hamlets around the main 15 market towns.

The population of Powys is also older than the average for authorities in Wales with the mean average age being 44.8 in mid-2012 as compared to Wales at 41.3. The 65+ population (currently 34,638) is projected to increase by 11% over the next 5 years (38,405 by 2020) and by 43% by 2036 (49,515). The 85+ population is expected to increase by 19% over the next 5 years from 4,660 to 5,551 and 146% by 2036 (11,456). In contrast, the proportion of young working aged people (20–39) is substantially lower than that of Wales. This has implications for the health and social care workforce and for service delivery. Whilst the male older population is expected to increase at a higher rate than that of females, it is projected that there will continue to be older aged women than men."[7]

Whilst there is a general consistency to community service provision across Powys, how is it used has often been dependent on the demand and supply within in each area.

As mentioned above, the aim of the Home Support project has been to establish a shared and consistent approach to Home Support across Powys whilst taking account of and being responsive to the profile and needs of local communities and individuals and the often variable services provided within each and accessible resources. This has meant that each service area has evolved and developed differently in response to the revised service specification and indeed often presented with differing workforce and service challenges as highlighted in the locality and service profiles below.

[7] Care & Support Pop Assessment for Powys. file:///Z:/Wellbeing%20&%20Population%20Assessment/Powys_Population_Assessment_Summary_-_Final_V1.pdf

Project Locality/Service Profiles

Rhayader

The Rhayader Home Support (RHS) scheme was established in 1998 in response to the closure of a local nursing home and the need for the provision of a warden service for 30 council warden properties. RHS serves a population of approximately 3,350[8] individuals living within a 7-mile radius of Rhayader town and has a current membership of 225 (at March 31st 2019).

The base for this service is in Rhayader and is staffed by six part-time workers (1 senior support worker (SSW) and 5 support workers) and 3 relief workers, totalling 129 hours, 11 of which are currently assigned to LWHS.

RHS is PCC provided and funding is substantive. Backfill funding for 30 hours' SSW is ICF (Integrated Care Fund) funded from April 2018 - March 31st 2019. This includes service development, day work, and standby and call outs backfill for both RHS and LWHS. This has been divided according to staff reported time allocated to each area: 19 hours for RHS or RHS and 11 hours for LWHS.

Local statistics:

- Lone person households 65+ - 1,488 equates to 31% of households
- 4% population decrease by 2036 (19,505 to 18,688)
- 72% population increase by 2036 (3,332 to 5,734)
- 83% increase by 2036 people of with dementia (389 to 712)
- 38% increase by 2036 in the 65+ population (5,528 – 7,689)
- 139% increase by 2038 in the 85+ population (784 – 1,876)
- 3484 Welsh speakers (25%)[9]
- Key local services: Rhayader Community Support/Pharmacy/Virtual Ward/Community Connectors

Drawing on the experience, knowledge and local expertise of a very well established team and service has served as both an asset and a challenge.

The former being through the continuation of the existing service and supporting the review and implementation of the service specification, practice documentation, promotional materials and data management; providing time and commitment (particularly from the SSW) to support colleagues with the development of their respective pilots and of the project as a whole.

The challenges being to manage the changes across a team of 9, and balance the demands relating to the implementation of the documentation and recording practices as part of the project, alongside CIW governance and ongoing PCC practice requirements. This has been compounded by the protracted nature of the completion of the revised data management system and promotional materials for implementation.

Notwithstanding, the team have steadily adopted and embedded change, particularly, in relation to the revised documentation and the DMR. This is evident in the next section of this report; providing an emerging individual profile of service users in Rhayader and comprehensive service profile of RHS, which alongside previously reported data/information, contributes a significant insight into the activity and outcomes and benefits of the home support service.

[8] The Provision of Integrated Care in a Rural Community - an Evaluation of Rhayader Home Support Scheme 2013. Institute of Rural Health.

[9] Accommodation for an ageing population Powys County Council. Market Position Statement March 2017 covering Llandrindod, Rhayader, Builth and Llanwrtyd

Llandrindod Wells

The LWHS was established as part of the pilot project to develop home support services across Powys. The service provides one aspect of Home Support only which is 24/7 cover for emergencies for those living in sheltered housing/receiving warden based services in Llandrindod Wells and has a membership recorded at the time of this report of 13 of a potential 81 properties.

The base for LWHS is in Rhayader and is staffed by RHS part-time support staff totalling 11 hours funded by ICF as outlined above.

Local statistics:

- Lone person households 65+ - 1,488 equates to 31% of households
- 4% population decrease by 2036 (19,505 to 18,688)
- 72% population increase by 2036 (3,332 to 5,734)
- 83% increase by 2036 of people with dementia (389 to 712)
- 38% increase by 2036 in the 65+ population (5,528 – 7,689)
- 139% increase by 2038 in the 85+ population (784 – 1,876)
- 3484 Welsh speakers (25%)[10]
- Llandrindod Wells Town population: 5333; 65+ population: 1374 people (26.4%); 2484 Welsh speakers (25%)[11]
- Key local services: Wardening Services/Pharmacy/Red Cross/Positive Steps/Community Connectors

Utilising RHS staff to establish the LWHS pilot has brought both benefits and challenges. Bringing the experience from an established service has provided a depth of knowledge and understanding of the service, which has been a particular asset. Key challenges have included:

- Ring-fencing adequate time from the RHS service alongside implementing changes within RHS
- Establishing the out of hours' emergency an emergency care line (Delta Wellbeing) support within an existing warden support environment
- Knowledge of the local community and resources
- Base proximity to service delivery

Consequently, the pilot has taken longer to establish and has not been as fully implemented as anticipated, with a current reach of 16% of the targeted population.

Further, data is currently recorded and included as part of the RHS service so it is therefore difficult to extrapolate any meaningful data to inform an adequate representation of either an individual or service profile including uptake, activity and outcomes for Llandrindod Wells.

[10] Accommodation for an ageing population Powys County Council. Market Position Statement March 2017 covering Llandrindod and Rhayader, Builth & Llanwrtyd

[11] Local Area Profiles based on 2012 Census Data. https://customer.powys.gov.uk/article/5963/Local-Area-Profiles

Llanidloes

The LHS was established in April 2018 as part of the pilot project and has developed upon existing community based services and non-PCC residents at Bodlondeb. LHS serves a population of approximately 2889[12] individuals living within Llanidloes Town and has a current membership of 36, 13 of whom live within Bodlondeb. The base for LWHS is in Bodlondeb, Llanidloes and is staffed by the senior support worker and/or Bodlondeb support worker on behalf of senior support worker (37 hours). The backfill time covers the establishment of LHS as well time to continue managing Bodlondeb services.

Bodlondeb is a property owned by Mid-Wales Housing Association.[13] The property houses bedsits for up to 26 tenants and has communal facilities for all residents with PCC providing 24/7 support and care. Approximately half of the residents are funded and supported by social care packages and PCC staff based at Bodlondeb. Thirteen of the residents are self-funded and whilst also supported by the PCC staff have been 'transferred' to the Home Support service. Once reviewed, it is intended they will be supported akin to any home support member living in the community rather than as a supported living tenant.

LHS is PCC provided and backfill for 37 hours' SSW work backfill is ICF funded from April 2018 - March 31st 2019 and includes service development, day work, sleep-ins, standby and call outs.

Local statistics:

- Lone person households 65+ - 1,841 equates to 31% of households
- 8% population decrease by 2036 (29,758 to 27,469)
- 38% increase in the 65+ population by 2036 (6, 856 – 9,410)
- 139% increase in the 85+ population by 2036 (872 to 2,086)
- 82% increase by 2036 of people with dementia (450 to 818)
- 5,029 Welsh speakers (17%)[14]
- Key local services: Day Centre/Day Hospital/Pharmacy/GP Practices/Community Connectors

With extensive experience and local knowledge and indeed genuine endeavours from the SSW (including supporting the review and development of the service specification, practice documentation, promotional materials and data management), the establishment and implementation of the pilot in Llanidloes has proven challenging. A key factor has been because the service is based at and draws from staff allocated to the Bodlondeb service. Although, there has been staff backfill provided to establish the service in Llanidloes, the application of this has proven to be impracticable in that the role has required the continuation of management responsibilities (as a priority) for Bodlondeb.

Further, the implementation of the documentation and recording practices as part of the project, alongside CIW governance and ongoing PCC practice requirements relating to the Bodlondeb service have been a source of challenge.

It is also worth noting, that the transfer of half of the Bodlondeb service users to the new Home Support service will require the review and change of long and established support and practices for those individuals and staff which continues to include three daily welfare visits/calls and general access to support staff that is not cognisant of the home support service and would not be available in the wider community.

Consequently, the service (and use of documentation) is not as fully established or implemented as anticipated. With new caseload of thirty-one at the time of this publication (not including the transferred Bodlondeb cases), and minimal data reported on the DMR, this report is unable to show any meaningful individual or service profile (including uptake, activity and outcomes) for Llanidloes at this time.

[12] Local Area Profiles based on 2012 Census Data. https://customer.powys.gov.uk/article/5963/Local-Area-Profiles

[13] Mid-Wales Housing Association was established in 1975 and has over 1600 properties throughout Powys and Ceredigion as well as a few properties in Shropshire.

[14] Accommodation for an ageing population Powys County Council. Market Position Statement March 2017 (Newtown, Llanfair Caereinion and Llanidloes)

Presteigne and Knighton (East Radnor)

The ERHS was established as part of the pilot project to develop home support services across Powys. It serves a population of around 6,916[15] individuals living in Presteigne, Knighton and the wider communities and surrounding villages within a 10-mile radius of Presteigne. ERHS has a current membership of 174.

The base for the service is in Presteigne at the East Radnor Day Centre with general management from the Day Centre Manager, one dedicated full-time SSW and 3 relief staff supporting the out of hours' work.

The service is PCC commissioned, East Radnor Day Centre (ERDC) provided and ICF funded from Nov 2017 - March 31st 2019.

Local statistics:

- Lone person households 65+ - 712 equates to 28% of households
- 4% population decrease by 2036 (9,784 to 9,348)
- 65+ age group will have a 36% increase (2036) (2,900 to 3,941)
- 85+ age group will have a 139% increase (2036) (333 to 797)
- 77% increase (2036) people with dementia (185 to 328)
- 835 Welsh speakers (8.53%)[16]
- Key local services: GP Practices/Re-ablement/Community Connectors

The initial months of the contract involved the recruitment of the SSW, establishing office space and equipment, and supporting the development of the service specification.

The newly appointed SSW worked alongside the SSW's from Rhayader and Llanidloes with the finalisation of the service specification and development of the practice documentation, promotional materials, recording practices and DMS – all of which formed part of the contractual requirements (albeit completed after the contract start). Irrespective of this, service preparations included substantial promotional work across the locality including an official launch at the ERDC AGM, with service delivery commencing in March 2018.

The experience and knowledge of the SWW has proven to be an asset to the planning, development and delivery of the pilot service.

As with RHS, there have been challenges relating to the protracted nature of the completion of the revised data management system for implementation which has caused some duplication in work but not incurring any delay in service delivery. In addition, it is anticipated that extra staffing in the daytime will be needed particularly given the numbers of service users and need to provide cover and contingencies for service continuation in the absence of the SWW.

The service specification, practice documentation and recording in relation to the DMR have been fully adopted and delivered against. This is evident in the next section of this report, which provides a comprehensive individual profile of service users and service picture in the Presteigne and Knighton area. This provides a significant insight into the activity and outcomes and benefits of the home support service both locally and alongside RHS in particular.

[15] Local Area Profiles based on 2012 Census Data. https://customer.powys.gov.uk/article/5963/Local-Area-Profiles covering Llangunllo, Presteigne, Knighton and Old Radnor

[16] Accommodation for an ageing population Powys County Council. Market Position Statement March 2017 covering the areas for Presteigne and Knighton

Section 7: Data Review

Service Activity

Table 1: Home Support Membership (April 1st 2018 - March 31st 2019)

Locality	Rhayader				Llandrindod Wells				Lanidloes				East Radnor				Four Localities			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Total Membership	180	173	189	225	0	13	13	13	0	23	24	36	76	108	148	174	256	317	374	448
Active		62	89	90	0	13	13	13		23	24	36	33	17	84	84		115	210	223
Non-Active		111	100	135	0					0	0	0	43	91	64	90		202	164	225
Number of carers supported in their own right by Home Support services		1		19	0					0	0		11	6	6	2	11	7	6	21

Table 1 shows Home Support membership in the first three quarters of 2018 across the four service areas. At March 31st 2019, there is membership of 448, 49.5% active and 50.5% inactive (that is people/members using Homes Support as a point of contact only - via an emergency care line (Delta Wellbeing or similar company). Membership has steadily increased over the year by 57%, with active membership increasing from 36% in quarter 1 to 56% in quarter 2, and levelling off to around half the total membership in quarter 4. N.B. The blocked out sections highlighted red denote no returns.

Scheduled Activity

Table 2: Scheduled Support (April 1st 2018 - March 31st 2019)

Locality	Rhayader & Llandrindod Wells					Llanidloes					East Radnor					Four Localities				
Activity Overview	Q1	Q2	Q3	Q4	Total	Q1	Q2	Q3	Q4	Total	Q1	Q2	Q3	Q4	Total	Q1	Q2	Q3	Q4	Total
Number of independent living support/interventions	961	1208	1694	1635	5498	230	528	1798	2462	5018	186	97	94	152	529	1377	1833	3586	4249	11,045
Number of care alarms/pendants fitted	10	23	16	13	62	0	3	2	1	6	12	17	15	14	58	22	43	33	28	126
Number of temporary personal and/or domestic care interventions	10	15	0	94	119		14	0	0	14	19	3	2	7	31	29	32	2	101	164
Number of healthy lifestyles and wellbeing interventions		0	16	205	221			0	0	0	0	14	90	151	255	0	14	106	356	476
Number of advocacy interventions		0	10	21	31			0	0	0	0	15	33	13	61	0	15	43	34	92
Number of information, advice and assistance interventions	21	5	39	40	105			0	14	14	0	50	73	85	208	21	55	112	139	327
Number of phonecall interventions	989	1061	1109	1346	4505			0	6	6	83	45	110	46	284	1072	1106	1219	1398	4,795
Number of Referral/Support planning/Review Visits	99	106	27	34	266	0	0	2	19	21	91	28	46	30	195	190	134	75	83	482

Table 2 shows the total and make-up of the scheduled support provided. Scheduled support may include up to three types of support which are all recorded: of the total recorded (17,507), 63% of scheduled activity involves independent living interventions (home visits), 27% tele-support only, with 3% of support involving the healthy lifestyles and wellbeing interventions and 126 care alarms fitted across the areas. NB: The figures for Llanidloes high in comparison to membership numbers, as they are reflective of practice that continues to include three daily welfare visits/calls to 13 of the 36 service users as part of the established Bodlondeb service that would not usually be available in the wider community.

Scheduled Support Breakdown

Table 3: Independent Living Support/Interventions (April 1st 2018 - March 31st 2019)

Locality	Rhayader & Llandrindod Wells					Llanidloes					East Radnor					Four Localities				
Independent living support/interventions	**Q1**	**Q2**	**Q3**	**Q4**	**Total**	**Q1**	**Q2**	**Q3**	**Q4**	**Total**	**Q1**	**Q2**	**Q3**	**Q4**	**Total**	**Q1**	**Q2**	**Q3**	**Q4**	**Total**
Encourage self-care	0	0	57	8	65	0	0	0	0	0	53	0	7	10	70	53	0	64	18	135
Welfare visits and tele-support	646	1056	921	1020	3643	230	526	1795	2197	4748	24	72	23	6	125	900	1654	2739	3223	8516
Essential Shopping	55	53	152	141	401		1	3	3	7	0	0	17	29	46	55	54	172	173	454
Emotional Support	0	0	85	57	142		0	0	0	0	0	0	2	27	29	0	0	87	84	171
Household and practical assistance	0	0	61	90	151		0	0	182	182	0	16	7	8	31	0	16	68	280	364
Access to assistive technology and install and manage community alarms			10	7	17			0	0	0	7	0	16	40	63	7	0	26	47	80
Ordering and collecting medication	250	96	298	243	887		1	0	78	79	0	1	14	18	33	250	98	312	339	999
Support with appointments	0	0	19	26	45		0	0	1	1	0	0	4	11	15	0	0	23	38	61
Assistance to access to community transport	0	0	16	5	21		0	0	0	0	0	1	3	3	7	0	1	19	8	28
Assist carers with their role	0	0	24	26	50		0	0	0	0	19	0	0	0	19	19	0	24	26	69
Temporary personal and/or domestic care	10	3	46	3	62		0	0	0	0	0	3	0	0	3	10	6	46	3	65
Other	0	0	5	9	14		0	0	1	1	83	4	1	0	88	83	4	6	10	103
Total	961	1208	1694	1635	5498	230	528	1798	2462	5018	186	97	94	152	529	1377	1833	3586	4249	11045

Independent living support includes (but is not exclusive to) eleven broad areas.

Table 3 shows that around three quarters (77%) of the support involves welfare visits and tele-support and a not insignificant focus is on encouraging self-care in R&LWHS and ERHS.

It is notable that whilst 9% of support includes ordering and prescription collections and 4% essential shopping, the majority of this type of support is provided by RHS which is proportionally high, especially in comparison to ERHS. This may be a reflection of the 'custom and practice' within the service that originated and evolved from warden services, and that the rationale provides opportunities for welfare support (which if the case would be reported anyway). On enquiry, the local pharmacy in Rhayader does not provide home delivery of prescription services unlike Knighton.

Current Home Support services are registered with CIW[17] so enabling responsive temporary personal/domestic care as a bridge (only) to more appropriate services. It would appear timely to determine whether CIW registration is required to provide effectively 'good neighbour' support and indeed clarify this intervention in relation to other services providing personal and domestic care and support as a core function.

The reporting of activity across the spectrum of independent living support provides an emerging picture, and is dependent on the staff confidence and competence both in terms of undertaking their roles and fully embracing the data management system.

[17] At the time of publication, ERHS has applied for and is awaiting CIW registration.

The category 'other' is to record activity that falls outside of the eleven areas. The high numbers recorded by ERHS in Q1 is likely to be reflective of early reporting methods/changes in the data management record. Further scrutiny is required to determine the detail and subsequent action.

NB: The figures for Llanidloes are high in comparison to membership numbers as they are reflective of practice that continues to include three daily welfare visits/calls to 13 of the 26 service users (as part of the established Bodlondeb service) and would not usually be available in the wider community.

Table 4: Healthy Lifestyles and Wellbeing Support/Interventions (April 1st 2018 - March 31st 2019)

Locality	Rhayader & Llandrindod Wells					Llanidloes					East Radnor					Four Localities				
Healthy lifestyles and wellbeing interventions	**Q1**	**Q2**	**Q3**	**Q4**	**Total**	**Q1**	**Q2**	**Q3**	**Q4**	**Total**	**Q1**	**Q2**	**Q3**	**Q4**	**Total**	**Q1**	**Q2**	**Q3**	**Q4**	**Total**
Learning and occupational opportunities			0	3	3			0	0	0		0	0	0	0	0	0	0	3	3
Advice, information and referral in relation to home safety, extreme weather conditions, fire safety and assistive & digital technology			10	19	29			0	0	0		1	7	4	12	0	1	17	23	41
Support that promotes healthy living (Inc. 'big 4' interventions/falls prevention)			4	21	25			0	0	0		3	2	7	12	0	3	6	28	37
Support that helps to develop and/or maintain life skills			1	10	11			0	0	0		1	1	4	6	0	1	2	14	17
Proactive safe and well contact (visits/calls)			1	11	12			0	0	0		6	77	131	214	0	6	78	142	226
Support and referral to social groups and supportive networks			0	7	7			0	0	0		2	3	7	12	0	2	3	14	19
Newsletter			0	132	132			0	0	0		1	0	0	1	0	1	0	132	133
Total			16	203	219			0	0	0		14	90	153	257	0	14	106	356	476

The data returns on this table show an emerging picture of healthy lifestyles interventions. This is in part due to the revised service remit, definitions and reporting methods calling for proactive health interventions in relation to local strategic aims and ambitions, rather than a reflection of practices. Especially so in relation to RHS which has been delivering interventions along these lines for some years in the form of newsletters, safe and well checks, particularly in extreme weather conditions as well as via the social club that was established for home support members and is now run by them independently and on a regular basis.

The self-reported health and wellbeing data shown in the Personal Profiles below strongly indicates the need for proactive healthy lifestyle inventions, particularly in relation to exercise, falls prevention, diet and mental health. Further, the population data (indicated in the previous section) for all services areas shows around a third of the over 65's population are lone households with figures projected to rise with the increase in ageing population – calling for innovative interventions to address social isolation and loneliness.

Table 5: Information, Advice and Assistance Support/Interventions (April 1st 2018 - March 31st 2019)

Locality	Rhayader & Llandrindod Wells					Llanidloes					East Radnor					Four Localities				
Information, advice and assistance interventio	Q1	Q2	Q3	Q4	Total	Q1	Q2	Q3	Q4	Total	Q1	Q2	Q3	Q4	Total	Q1	Q2	Q3	Q4	Total
About local services, activities and groups	21	4	4	0	29			0	3	3		30	18	22	70	21	34	22	25	102
Signposting and referral to local services, activities and groups	0	5	27	24	56			0	11	11		5	23	23	51	0	10	50	58	118
Assistance to access local services, activities and groups	0	0	8	16	24			0	0	0		2	42	41	85	0	2	50	57	109
Total	21	9	39	40	109			0	14	14		37	83	86	206	21	46	122	140	329

As with the previous table, Table 5 shows an emerging picture of information, advice and assistance interventions. It is arguably difficult to extrapolate this type of intervention as standalone as it is often inherent in all interventions. However, the data indicates that 31% of the support involves informing individuals about local services, 36% involves signposting and referral to local services and 33% includes assistance to access those services.

Unscheduled Support

Table 6: Total Emergency Call-outs (April 1st 2018 - March 31st 2019)

Locality	Rhayader & Llandrindod Wells					Llanidloes					East Radnor					Four Localities				
Total Emergency Callouts	Q1	Q2	Q3	Q4	Total	Q1	Q2	Q3	Q4	Total	Q1	Q2	Q3	Q4	Total	Q1	Q2	Q3	Q4	Total
Emergency call outs (not careline)	0	0	28	41	69		1	0	62	63	0	1	5	18	24	0	2	33	121	156
Emergency call outs (careline)	45	105	76	60	286		1	0	0	1	19	16	40	27	102	64	122	116	87	389
Emergency call outs (Bodlondeb)						48		176	141	365						48	0	176	141	365

Table 6 shows the number of emergency call-outs Home Support services responded to in one year. A call-out is defined as any emergency request for support that is over and above any planned/arranged support, in or out of office hours. Of the 545 call-outs, 71% were through the main Powys emergency care line company (Delta Wellbeing) where Home Support services are first responders, and 29% were with different emergency care-line companies or via the Home Support line during office hours.

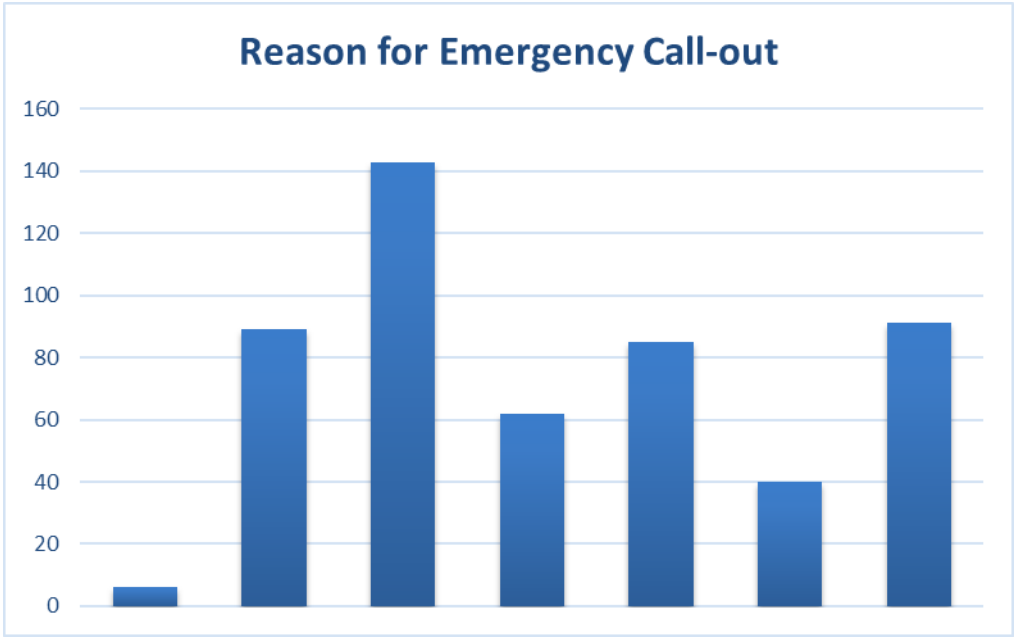
For the purposes of this report, the call-outs for Bodlondeb (365) are not included as they are specific to that service only. Data for RHS prior to this period is recorded in a different format and are available on request.

N.B. The blocked out sections highlighted yellow denote no returns.

Table 7: Reasons for Emergency Call-outs (April 1st 2018 - March 31st 2019)

Locality	Rhayader & Llandrindod Wells					Llanidloes					East Radnor					Four Localities				
Reason for emergency callout	Q1	Q2	Q3	Q4	Total	Q1	Q2	Q3	Q4	Total	Q1	Q2	Q3	Q4	Total	Q1	Q2	Q3	Q4	Total
Carer Absent	0	0	1	5	6	0		0	0	0	0	0	0	0	0	0	0	1	5	6
Fall	10	19	15	20	64	0		2	3	5	4	1	5	10	20	14	20	22	33	89
Practical Assistance	11	52	30	18	111	0		0	31	31	1	0	0	0	1	12	52	30	49	143
Health Need	7	14	10	13	44	0		0	5	5	6	0	1	6	13	13	14	11	24	62
Task Help	8	14	17	27	66	0		5	6	11	0	0	6	2	8	8	14	28	35	85
Unable to Contact	7	3	6	11	27	0		0	0	0	0	1	1	11	13	7	4	7	22	40
Other	2	4	4	3	13	48		0	22	70	8	0	0	0	8	58	4	4	25	91
Total	45	106	83	97	331	48	0	7	67	122	19	2	13	29	63	112	108	103	193	516

Chart 1: Reasons for Emergency Call-out (April 1st 2018 - March 31st 2019)



Nearly half (44%) of the emergency call-outs were to provide practical assistance/task help to an individual with 17% requiring assistance with a fall, 12% with support with a health need and staff were unable to contact the individual in 8% of call-outs.

NB. The reference to other is predominantly a response from Llanidloes, which is reflective of the nature of the call-outs for individuals living within Bodlondeb, so should be disregarded.

Table 8: Outcome if Service User Has Fallen (April 1st 2018 - March 31st 2019)

Locality	Rhayader & Llandrindod Wells					Llanidloes					East Radnor					Four Localities				
Outcome if service user has fallen	Q1	Q2	Q3	Q4	Total	Q1	Q2	Q3	Q4	Total	Q1	Q2	Q3	Q4	Total	Q1	Q2	Q3	Q4	Total
Used Manga Elk			16	19	35			0	2	2		0	13	6	19	0	0	29	27	56
Used Manga Camel			1	0	1			0	0	0		0	0	0	0	0	0	1	0	1
Ambulance called			1	5	6			2	1	3		1	3	1	5	0	1	6	7	14
Other			1	1	2			0	2	2		1	0	0	1	0	1	1	3	5
Total	0	0	19	25	44	0	0	2	5	7	0	2	16	7	25	0	2	37	37	76

Data reported is emerging due to its recent introduction as part of the revised DMR. However, the use of the Manga Elk/Camel to assist with a fall is evident in 75% of the call-outs, arguably inferring a diversion from emergency service escalations because of the home support services being called out and an appropriate referral to ambulance services (18%) when required.

NB: The assessment by the home support worker in response to a fall is based upon the Welsh Ambulance Services NHS Trust 'I Stumble' Practice Tool.

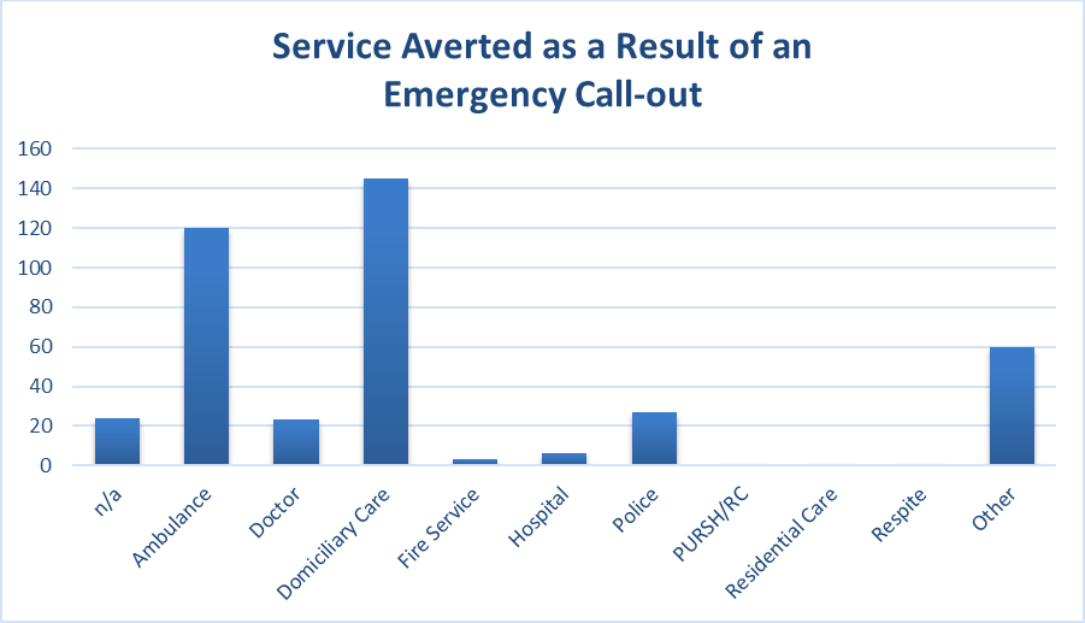
Table 9: Services Averted as a Result of an Emergency Call-out (April 1st 2018 - March 31st 2019)

Locality	Rhayader & Llandrindod Wells					Llanidloes					East Radnor					Four Localities				
Service averted as a result of an emergency call-out	Q1	Q2	Q3	Q4	Total	Q1	Q2	Q3	Q4	Total	Q1	Q2	Q3	Q4	Total	Q1	Q2	Q3	Q4	Total
n/a	8	7	0	1	16			2	2	2	0	1	0	3	4	8	8	2	6	24
Ambulance	8	21	17	22	68			1	5	1	4	0	20	22	46	12	21	38	49	120
Doctor	5	5	2	3	15			0	0	0	6	0	0	2	8	11	5	2	5	23
Domiciliary Care	6	62	30	41	139			4	0	4	0	0	2	0	2	6	62	36	41	145
Fire Service	1	1	0	1	3			0	0	0	0	0	0	0	0	1	1	0	1	3
Hospital	0	0	4	2	6			0	0	0	0	0	0	0	0	0	0	4	2	6
Police	4	5	5	12	26			0	0	0	0	0	1	0	1	4	5	6	12	27
PURSH/RC	0	0	0	0	0			0	0	0	0	0	0	1	1	0	0	0	1	1
Residential Care	0	0	0	0	0			0	0	0	0	0	0	0	0	0	0	0	0	0
Respite	0	0	0	0	0			0	0	0	0	0	0	0	0	0	0	0	0	0
Other	11	5	22	3	41			0	0	0	9	0	7	3	19	20	5	29	6	60
Total	43	106	80	85	314	0	0	0	7	7	19	1	30	31	81	62	107	63	123	355

Table 9 and Chart 2 below show the number and type of services averted because of an emergency call-out from home support services. The total number of reported aversions was 355 of the 516 total emergency call-outs from April to December 2018. These include 41% aversions from domiciliary care, 34% from the ambulance services, 8% from police services and 7% from the GP.

The 'aversions' recorded are reflective of and dependent on staff's understanding and their assessment of the most likely service averted.

Chart 2: Services Averted as a Result of an Emergency Call-out (April 1st 2018 - March 31st 2019)



The data shown in relation to unscheduled care shows some interesting outcome, but does reinforce the need for reporting to be supported by clear service definitions, consistent recording practices alongside some specific case studies providing practice examples.

Unit costs for each of the services (including home support) have been identified for the purposes of this report.[18] Whilst not in a position to provide a true financial cost, (and so cost avoidance/savings) and consequent return on investment by the aversion of services, the data does appear to support emerging indications of not insubstantial returns as shown in Table 10 below. It is also of note that this information concurs with the 2013 RHS Evaluation (Institute of Rural Health) which was based on four detailed case analyses.[19]

Table 10: Indicative Cost Avoidances

Service	HS Call-outs/ Interventions	Cost	Cost Avoidance	Income Generation
Home Support		**TBC**		
Ambulance	120	£238 per call out	28,560	0
Doctor	23	£242 (Q) HRLY Rate. AV Call-out = 1HR	£5,566	0
Domiciliary Care	145	£15.52 AV HRLY rate for independant Sector. AV Call-out 2hrs = 290 HRS	£4,500.80	0
Hospital	3		Unknown	0
Fire Service	6	AV £300 per engine and 23 min call-out	£1,800	0
Police	27	More detail required (101/999 response required?)	Unknown	0
Prescription Delivery	999	Pharmacy Charges: £1 per delivery	£999	0
PURSH/RC	1		Unknown	0
Residential	0	0	0	0
Careline Install	126	£25/£30	0	£3,150/£3,780
Careline Rental	126	£198.32/£238 PA	0	£24,988.32/£29,988

[18] See Appendix Five

[19] The Provision of Integrated Care in a Rural Community - an Evaluation of Rhayader Home Support Scheme. Final Draft Report 2013. Carol Jarrett, Fiona Williams and Leo Lewis. Institute of Rural Health. Commissioned Rural Health Plan Innovation Project: Report for the Welsh Government.

Table 11: Service Administration Overview (April 1st 2018 - March 31st 2019)

Service Overview	Rhayader & Llanddrindod Wells	Llanidloes	East Radnor
Assessments	29		174
New Referrals	17	36	174
Referral Data Reported	28		85
Home Support Plans	18		174
Personal Profiles	24	3	149
Service User/Carer Questionnaires	24	2	57
Reviews	9		17
Case Closures	8		15
Complaints	0	1	0
Compliments	2	2	13
Incidents	0		0
Adult Protection Referral	2		0
Carers Assessment Referral	2		15
Newsletters	4 P/A		1P/A
Case File Review	1	2	2
Case Studies	10	0	8

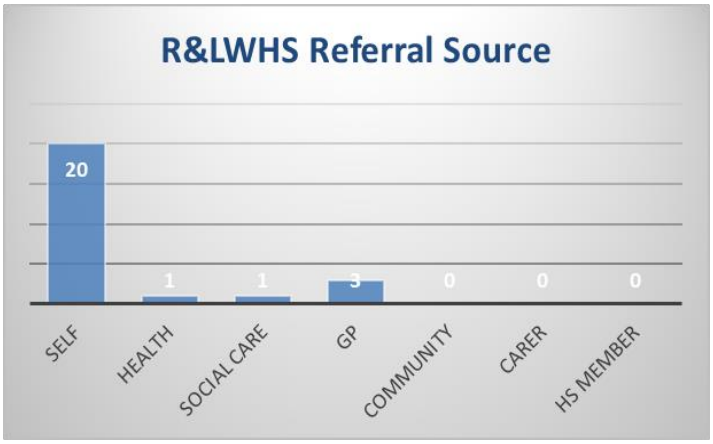
Table 10 shows a broad overview of casework and service administration.

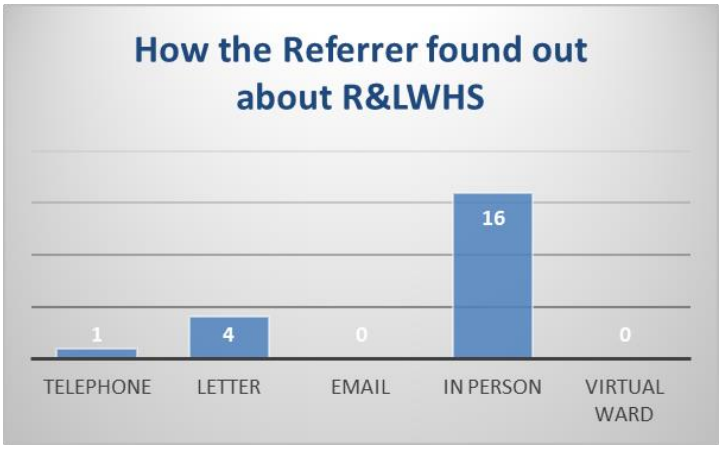
As highlighted on page 43 below, the project has also included the revision of the service specification and service recording and documentation. This has involved the workforce learning and implementing the updated/new processes and documentation across all the service areas affecting time allocation and management. This has been compounded within the PCC service areas as the teams have also been required to implement revised CIW practices which have yet to be fully integrated with the revised Home Support processes meaning there is duplication regarding reporting, governance, and recording outcomes.

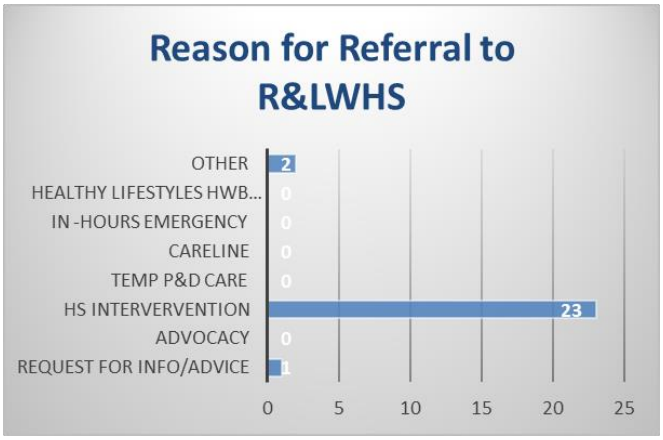
Referral Activity (April 1st 2018 - March 31st 2019)

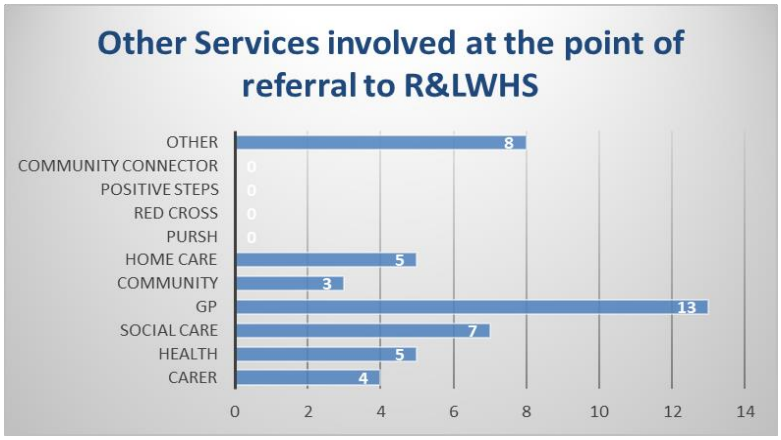
Charts 3-10: Rhayader and Llandrindod Wells Home Support

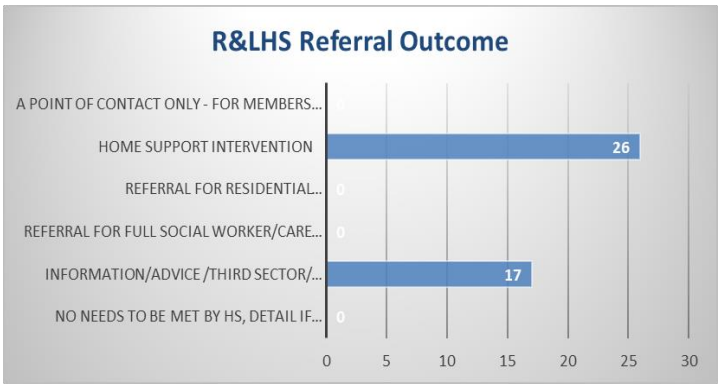
Referral Activity Reported	**28 (13%)**
Total Membership	**225**

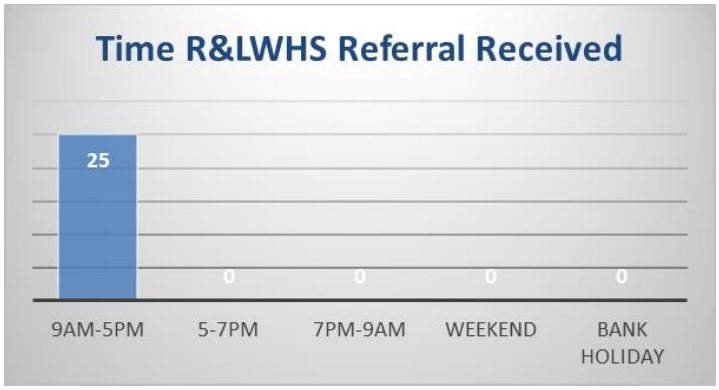










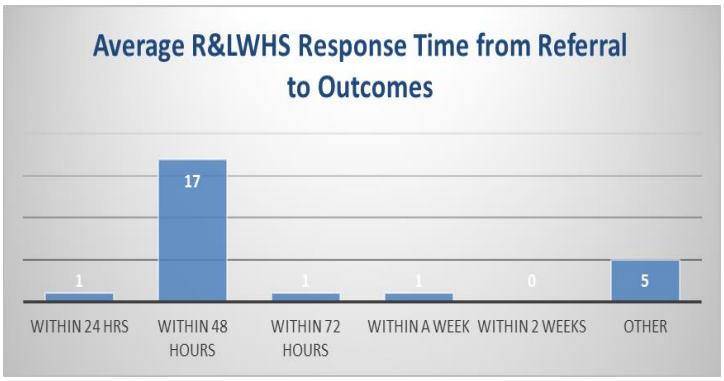


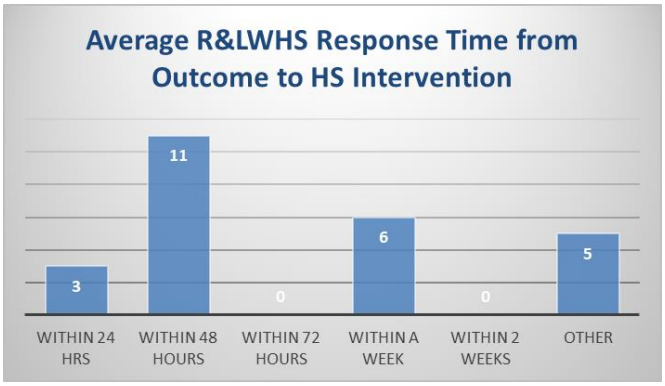
Referral information is based on 13% of RHS and LWHS membership. The caseload of RHS was established prior to April 2018, so only new referrals have been reported. This would suggest that the 28 referrals predominantly relate to LWHS – although this is unclear.

Charts 4 and 5 above show that most people self-referred and heard about the service via word of mouth/in-person, requesting and receiving a home support intervention as an outcome. Half of the referrers also received information and advice about other services.

Chart 6 shows the involvement of other services involved with individuals being referred to home support across health and social care and less so informal carers or community support.

Charts 8-10 show that all referrals were received within usual office hours (9am – 5pm). 72% of referrals were responded to within 48 hours with 56% receiving a service within the same time period and 24% within a week.

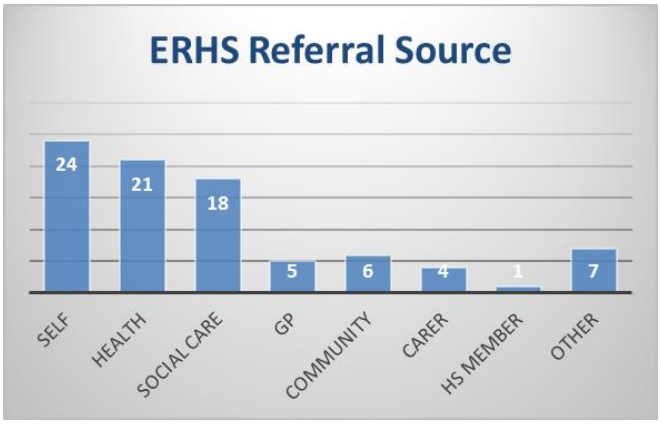


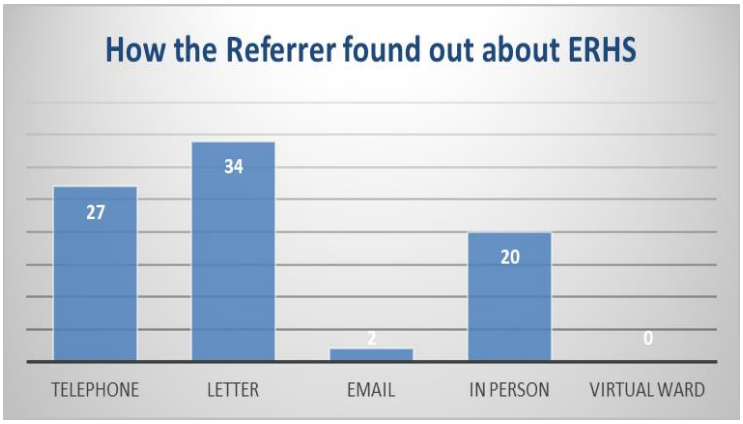


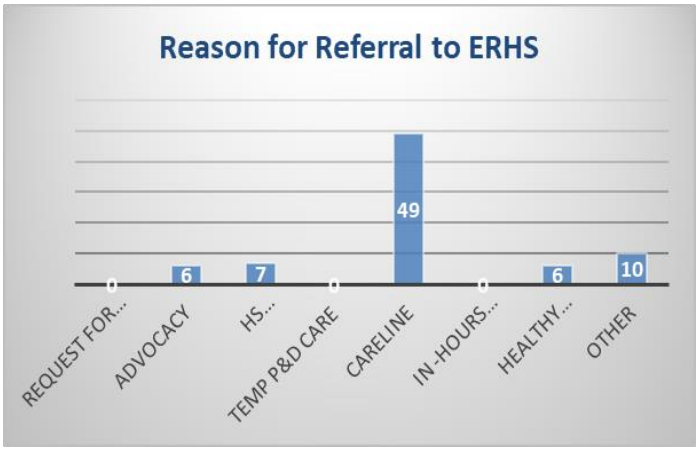
Further analysis (and revised recording options) is required to understand the reason why a quarter of response times were recorded as 'other' and not within the timeframes provided.

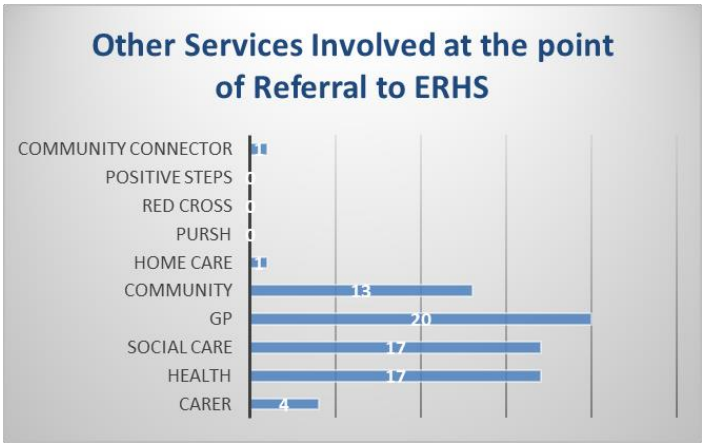
Charts 11-19 East Radnor Home Support

Referral Activity Returns		**85 (49%)**
Total Membership		**174**







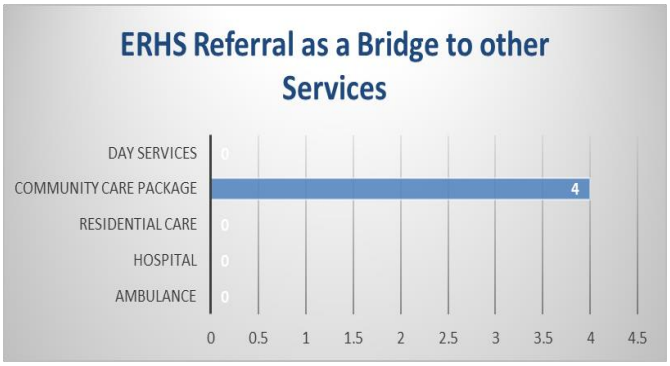


Referral information is based on 49% of the ERHS membership. As the service commenced in Feb/April 2018, it is unclear why there is not a full return on data. However, the returns do indicate an emerging picture of referral activity.

Chart 11 shows that referrals to ERHS were from three main sources including self (28%), social care (21%), health (25%), with GP and community referrals at 6% and 7% respectively. In addition, chart 12 shows that 41% of all referrers found out about ERHS via letter, with third via telephone and a fifth in person.

Chart 13 shows that 63% of referrals were made regarding care alarms, with 10% for a home support intervention and 8% relating to the need for advocacy. The numbers of enquiries regarding care alarms is just under the actual numbers of emergency care lines fitted (49 initial enquiries to 58 fitted. See Table 2 above), indicating that TEC information and advice was given and acted upon following the initial referral. Four referrals were made for support as bridge to community care packages.

Chart 14 shows the involvement of other services involved with individuals referred to home support across general practices, health and social care and informal carers and community support. It is not genuinely possible to show that individuals' independence and ability to stay at home is a direct and singular result of home support services. Improved recording at the point of intervention regarding the involvement of other services would be desirable. This would to help determine whether Home support services were additional to people's support or used as an alternative.



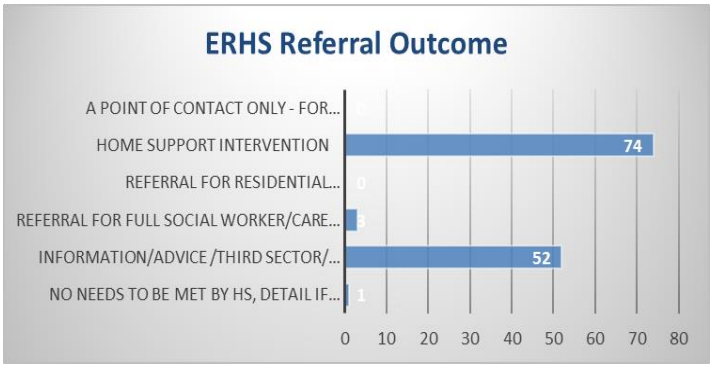
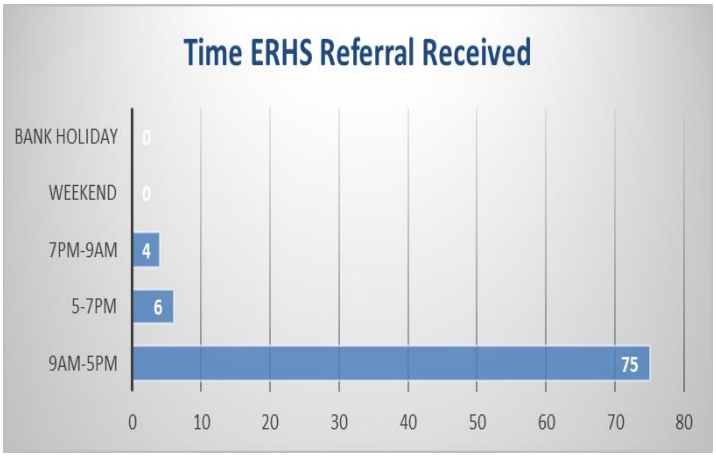


Chart 16 above shows that 87% of individuals received a home support intervention as an outcome and 61% received information and advice about other services.



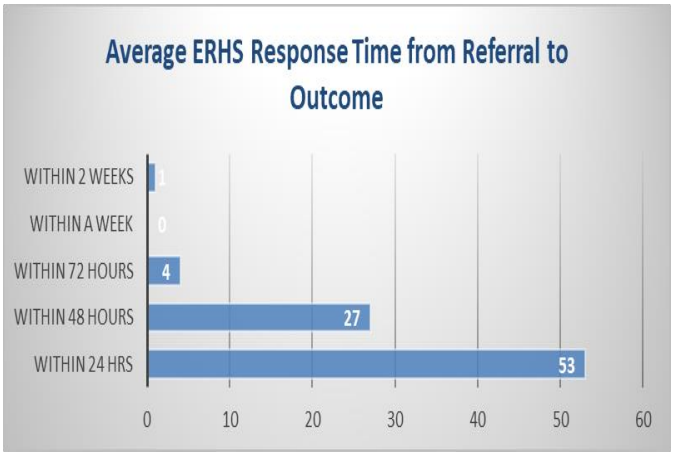
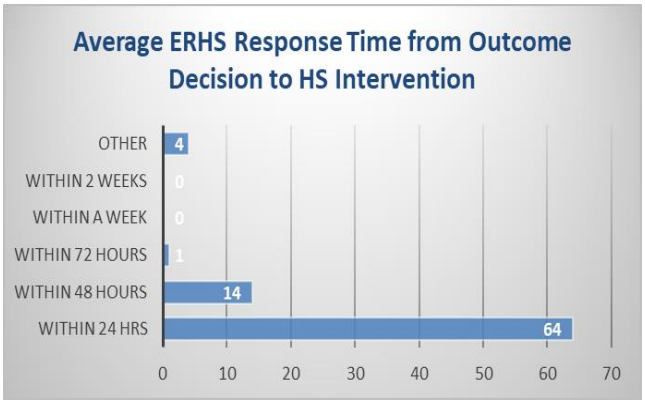


Chart 17 shows that the majority of referrals were received within usual office hours (9am – 5pm), and Chart 18 shows that of the 85 referrals, 94% of referrals were responded to within 48 hours with 62% of those within 24 hours.



Charts 19 shows that 82 % of individuals received a service within 48 hours, 74% of those within 24hrs.

Service User Profiles (April 1st 2018 - March 31st 2019)

The personal profiles were developed to support consistent data collection requirements with the Social Services and Wellbeing Act core data set, and more crucially to support robust and specific data collection relating to home support and consequently help deliver and develop core service objectives and outcomes relating to promoting independence, health and wellbeing (including healthy lifestyles), and helping to reduce isolation and loneliness.

Personal profiles can be completed with the service users at any point in their membership, but are invariably completed and are of particular significance at the point of assessment and/or review or change in individuals' circumstances.

The profiles are pertinent on an individual and service basis in terms of support planning and service development respectively. And, when presented alongside other service areas, the data does indicate some common/recurring themes across the project and grounds for action.

Charts 20-35: Rhayader and Llandrindod Wells Home Support Service User Profiles

Personal Profile Returns	**24 (11%)**
Total Membership	**225**

Data for this report is based on 24 completed profiles that is around 11% of the total R&LWHS membership. This is a small data sample, and likely based on the referrals to LWHS as a new service rather than RHS, which would be better qualified by returns relating to RHS specifically and including all RHS members.

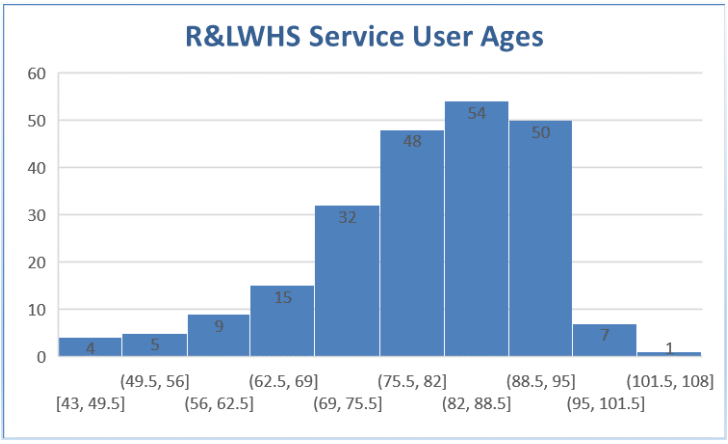
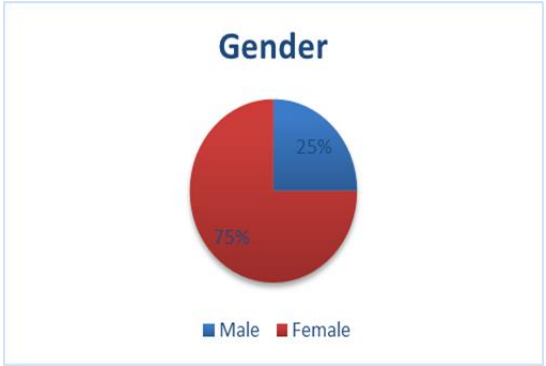
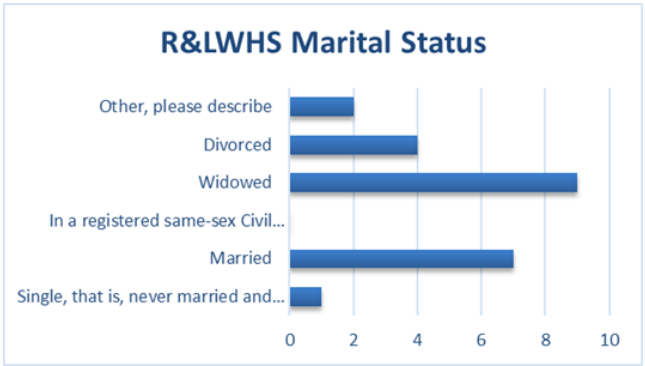


Chart 20 is based on the whole membership of 225, and shows the age and age range of service users with (89%) being 65+, of which 40% are 85+. The age of individuals is their rounded down age on 31/03/2019.

Chart 21 and subsequent Charts are based on the personal profile returns that are approximately 11% of the total membership. Three quarters of the recorded membership are female; 58% are widowed, divorced or single.





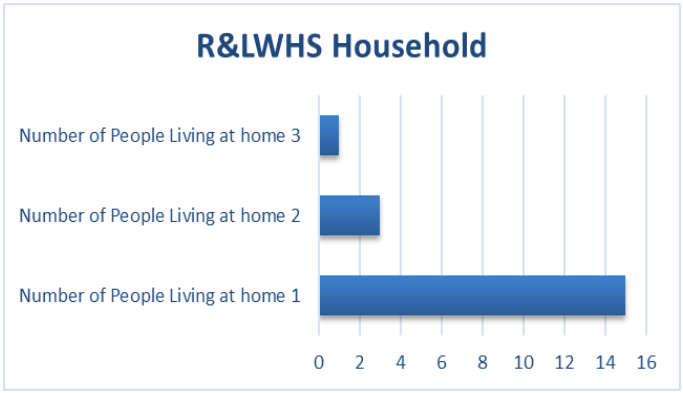
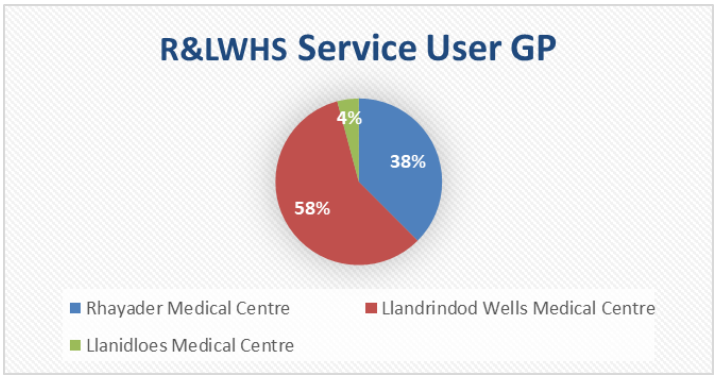


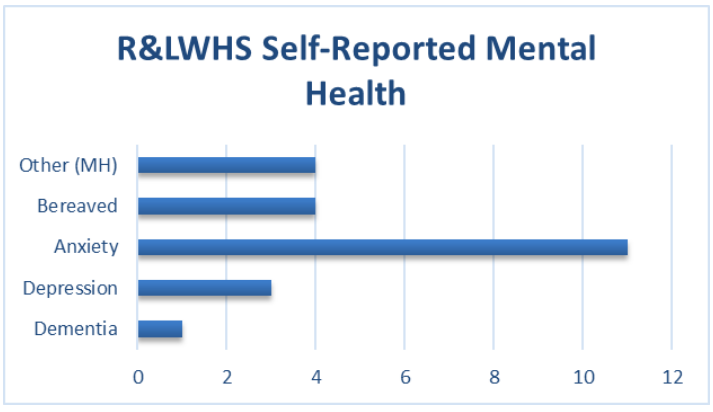
Chart 23 shows that 58% of individuals recorded live alone.

Chart 24 below, shows that nearly two thirds of the service users are registered with the Llandrindod Wells Medical Practice. This indicates the likelihood that the data returns are based on referrals to the pilot there.



The profiles also show that 100% of service users were reported as English, white and English speaking and heterosexual, with 54% recorded as Christian (all denominations), and 13% of no religion.

Charts 25 – 34 below show self-reported information relating to the physical and mental health and wellbeing of service users. Individuals were able to report up to three conditions in relation to their physical and mental health. Chart 25 shows that anxiety is the highest reported mental health condition, with depression and bereavement reported in a third of service users. Based on the numbers of 'other' returns, it would be pertinent to extend the options and so help provide more information (and consequential response) on the mental health of service users. N.B. A review of the full membership recorded 8 individuals reported as having dementia and 9 recorded as experiencing memory problems.



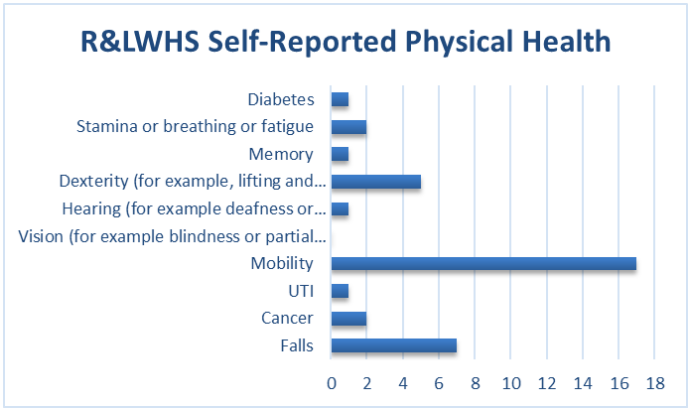
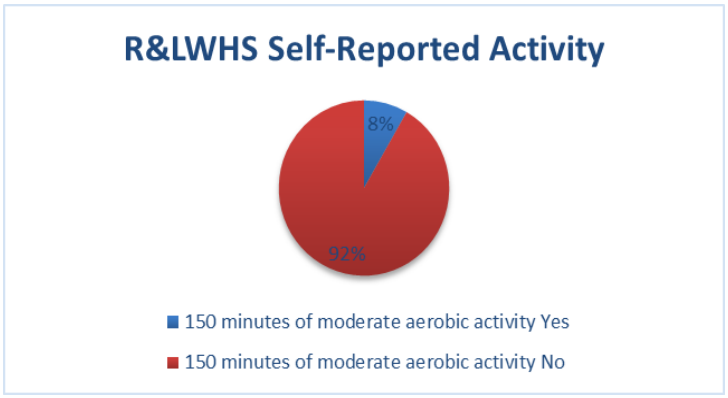
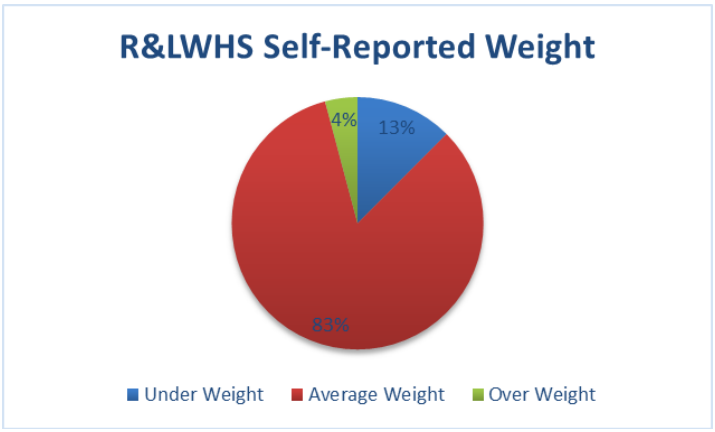


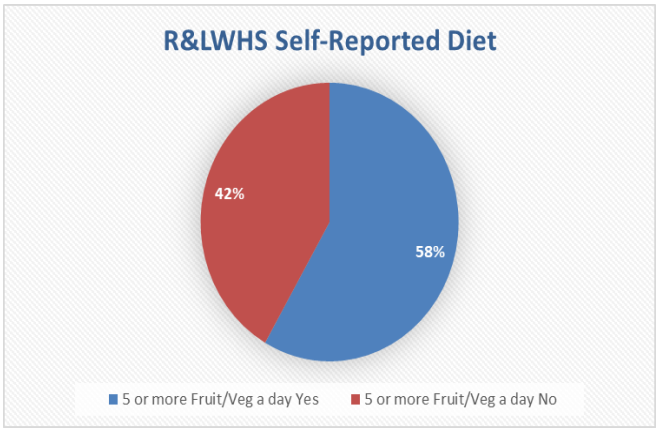
Chart 26 above, indicates that mobility is a key health issue for individuals (71%) with nearly a third expressing concern regarding falls. It is interesting to note whether this has any correlation to the self-reported activity in

Charts 27 and 28 below, where 92% of individuals said they did not do the recommended 150 minutes of moderate aerobic activity per week, and all said they did not do strength exercises on two or more days a week.

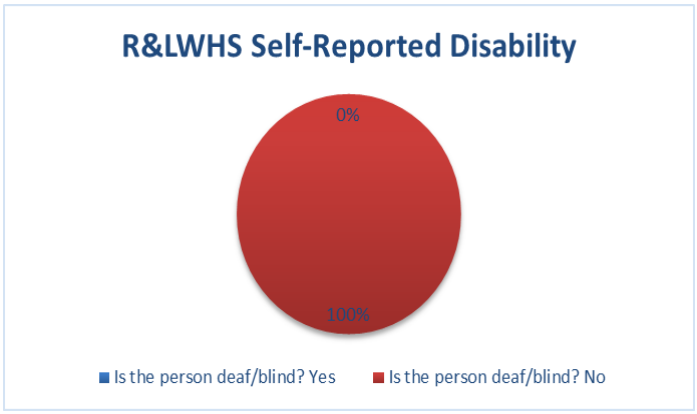


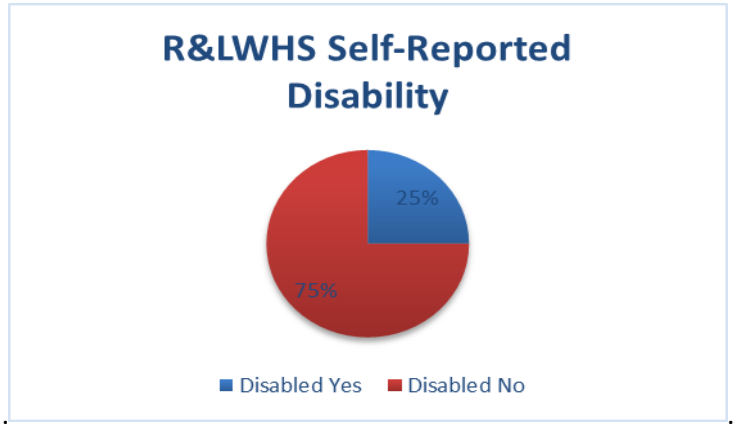
Charts 29 and 30 below show that 83% of individuals report to being of average weight with 58% stating they eat the recommended five or more fruit and vegetables a day.





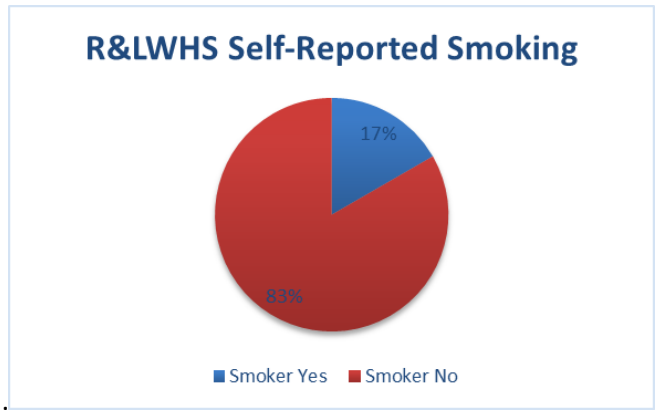
Charts 31 and 32 below shows that 75% of service users reported as being disabled which may relate to individuals' responses regarding mobility and exercise above. No services users reported being deaf or blind, although a hearing impairment was reported on an earlier question.





....

All service users reported that they drank within the recommended 14 units of alcohol a week, and 17% of individuals reported that they were smokers.



Information drawn from both the personal profiles above, and in respect of the nature of the emergency call-outs relating to falls and use of the Manga Elks/Camels shown in the previous section, has indicated opportunities for further exploration and consideration in both in terms of the type and nature of home support interventions - particularly regarding mental health, physical activity, fall prevention and healthy lifestyles promotion and interventions.

Charts 35-50: East Radnor Home Support Service User Profiles

Personal Profile Returns	**149 (86%)**
Total Membership	**174**

Data for this report is based on a high return of personal profiles. This provides a significant insight into the specific profiles and views, and potential needs and support of/required by individuals using the home support service both in the Presteigne and Knighton and within Powys when compared alongside the R&LWHS profiles in particular.

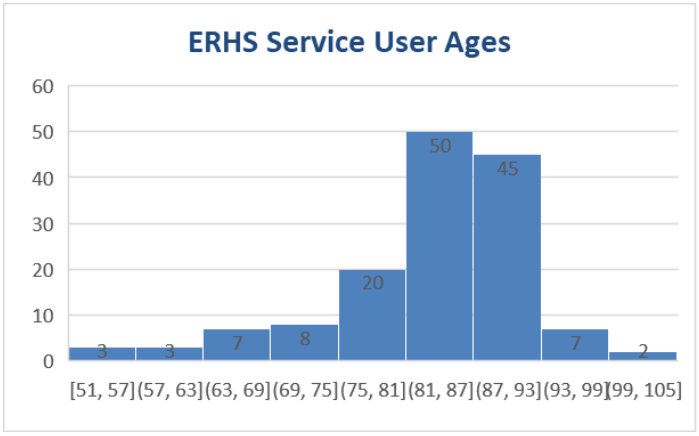
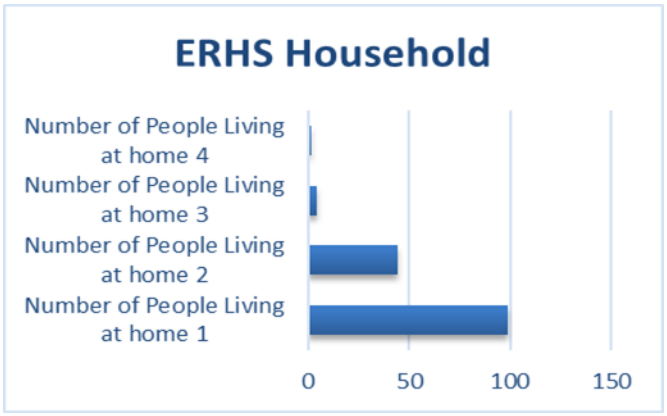
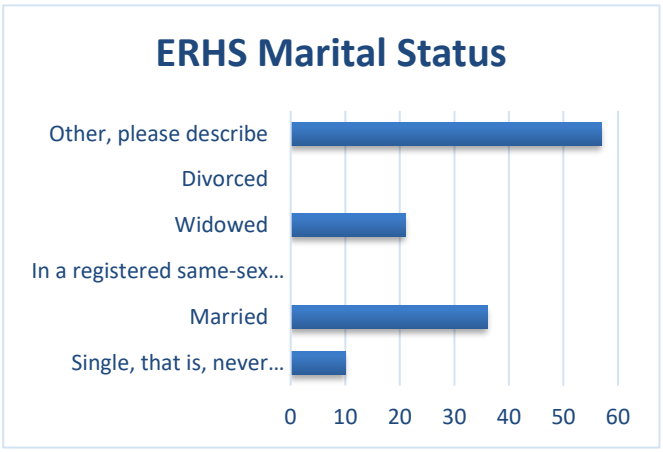


Chart 35 shows the age and age range of service users with 138 being 65+ (93%) and 73 (46%) being 85+. The age of individuals is their rounded down age on 31/03/2019.



Charts 36–38 show that around two thirds of ERHS service users are female; 15% are widowed or single with 66% of service users living alone and 30% living in a two-person household.



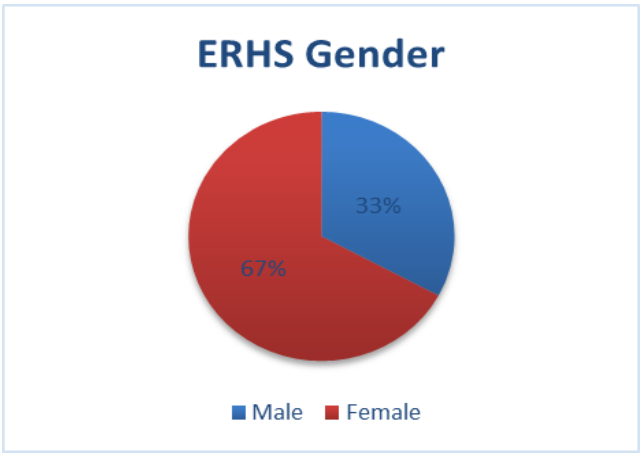
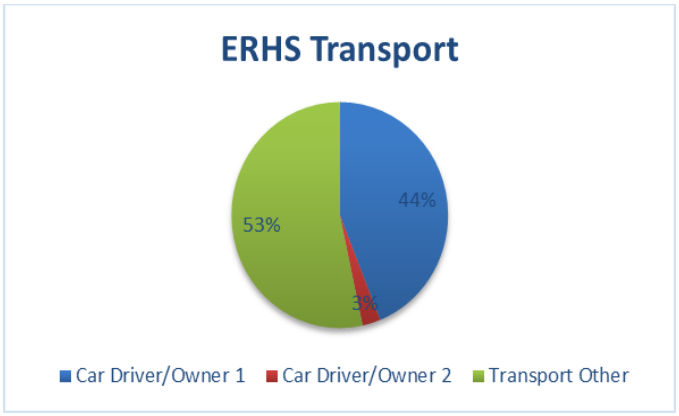
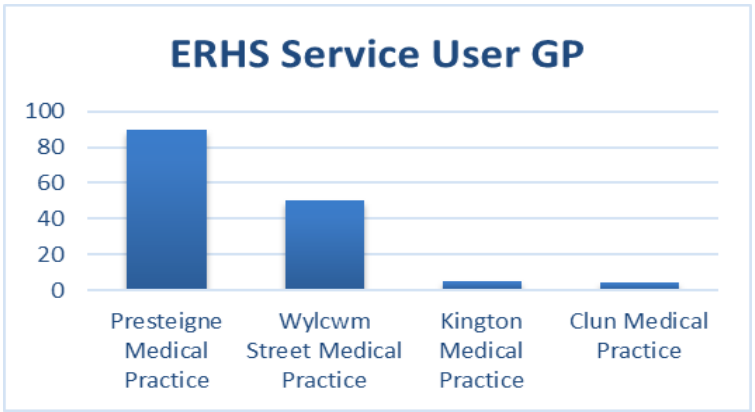


Chart 39 below indicates further detail is indicated with reference to transport, although 44% of service users report that they own a car and they can drive.

Chart 40 shows that of the total ERHS membership, 60% of the service users are registered with the Presteigne Medical Practice and 34% with Wylcwm Street Medical Practice.



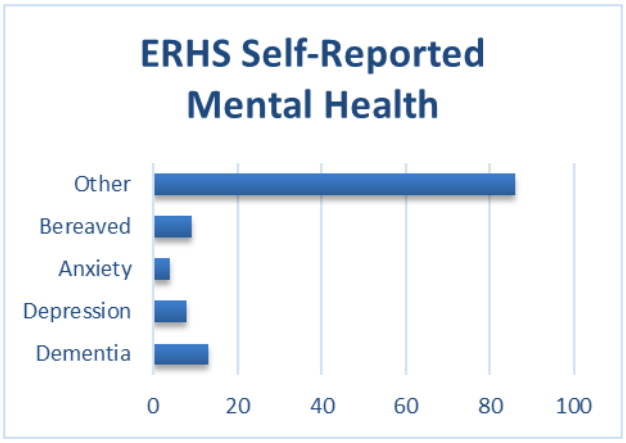


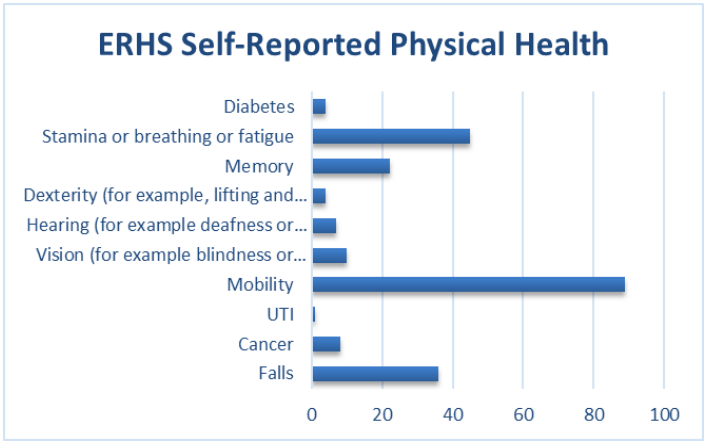
The profiles have also shown that 100% of service users are reported as English, white and English speaking, 97% heterosexual and with 75% recorded as Christian (all denominations), and 22% of no religion.

The following ten charts show self-reported information relating to the physical and mental health and wellbeing of service users. Individuals were able to report up to three conditions in relation to their physical and mental health.

Chart 41 shows reference to depression and anxiety (8%) and bereavement (6%) and dementia (9%) relating to around 23% of service users. However, based on the numbers of 'other' returns, it would be pertinent to extend the options and so help provide more information (and consequential response) on the mental health of service users. N.B. A review of the full membership recorded 13 individuals reported as having dementia and 20 recorded as experiencing memory problems.

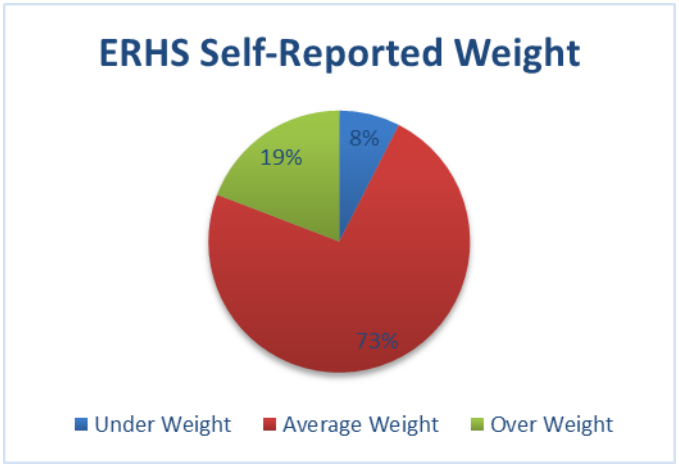
Chart 42 indicates that mobility is a key health issue for individuals (60%) with about a quarter expressing concern regarding falls, 30% reported issues relating to stamina, breathing and/or fatigue with 15% highlighting problems with memory.

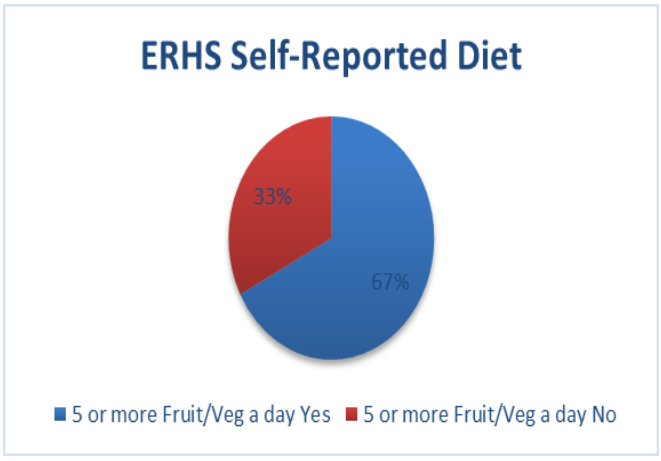




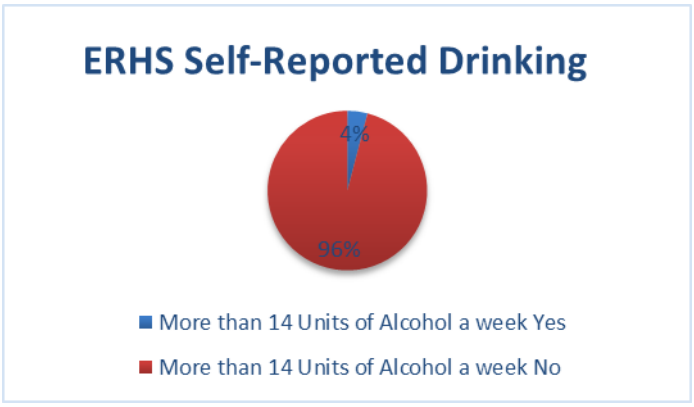
As with R&LWHS, it is interesting to note whether the self-reported physical health has any correlation to the self-reported activity in Charts 43 and 44 below. Here 93% of individuals said they did not do the recommended 150 minutes of moderate aerobic activity per week, and as with R&LWHS, all said they did not do strength exercises on two or more days a week.

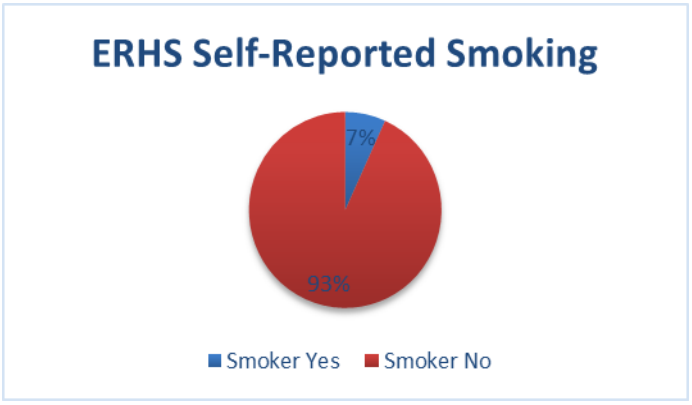
Charts 45 and 46 below show that 73% of individuals report to being of average weight and 19% being overweight, with 67% stating they eat the recommended five or more fruit and vegetables a day.



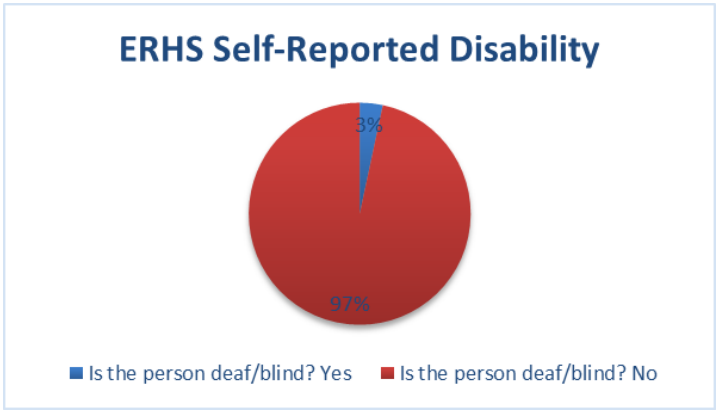


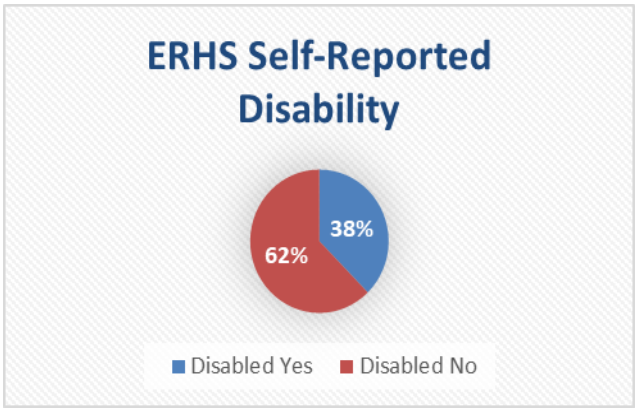
Data on Charts 47 and 48 shows that 96% of service users reported that they drank within the recommended 14 units of alcohol a week, and 7% of individuals reported that they were smokers.





Charts 49 and 50 show that 3% of services users reported being deaf or blind, and that 62% of service users reported as being disabled which may be correlated to their responses relating to mobility and exercise above.





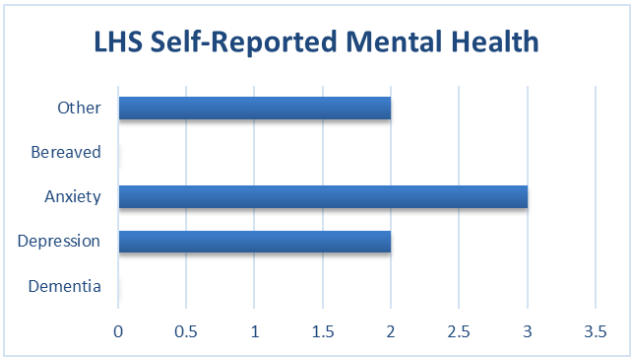
As with R&LWHS, information drawn from the personal profiles above and in respect of the nature of the emergency call-outs relating to falls and use of the Manga Elks/Camels shown in the previous section, has indicated some clear opportunities for further exploration and consideration in both in terms of the type and nature of home support interventions - particularly regarding mental health, physical activity, fall prevention and healthy lifestyles promotion and interventions.

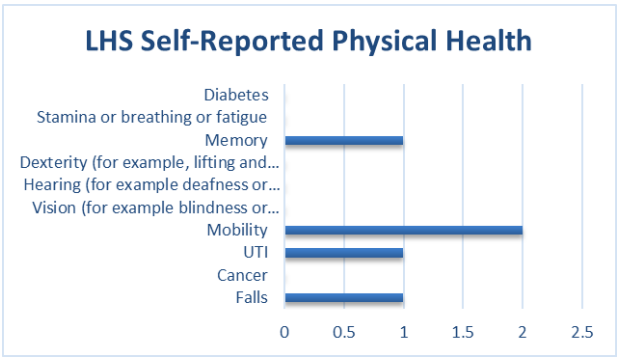
Charts 51-58: Llanidloes Home Support Service User Profiles

Personal Profile Returns	**3 (8%)**
Total Membership	**36**

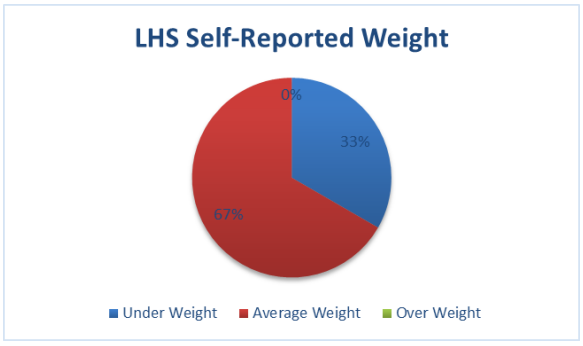
Returns from LHS are too small a data sample for meaningful local use or comparison across the service areas and are reflective of the service challenges highlighted in Section 6 above. The data can/does, however, have individual resonance outside of this report in terms of personalised care and support planning.

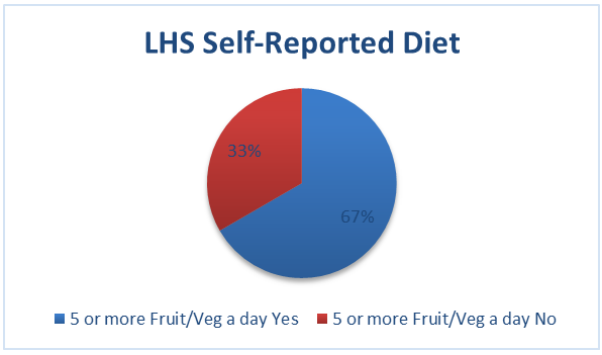
Chart 51 indicates all service users self-reported anxiety and with two of the three respondents stating depression as a mental health concern. Notably, mobility and falls feature in the self-reported physical health data, including reference to memory concerns (1).



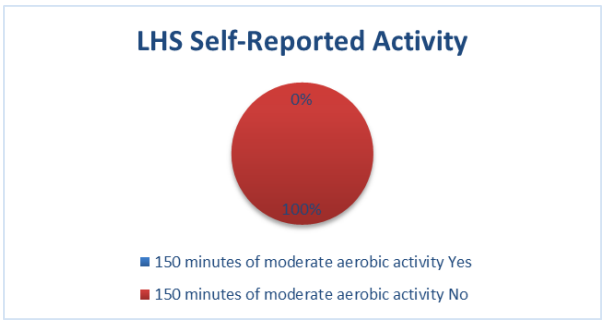


Charts 53 and 54 show that two of the three individuals report to being of average weight and stating they eat the recommended five or more fruit and vegetables a day, and a one of the three reporting that they were under-weight.

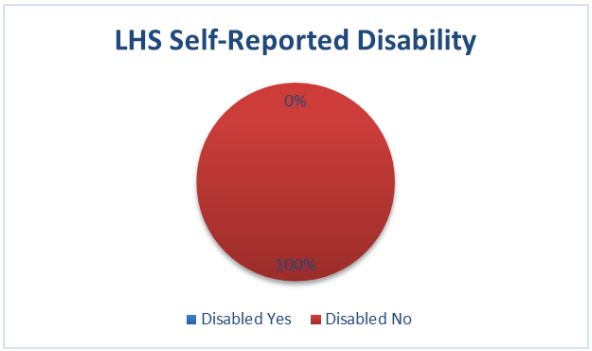


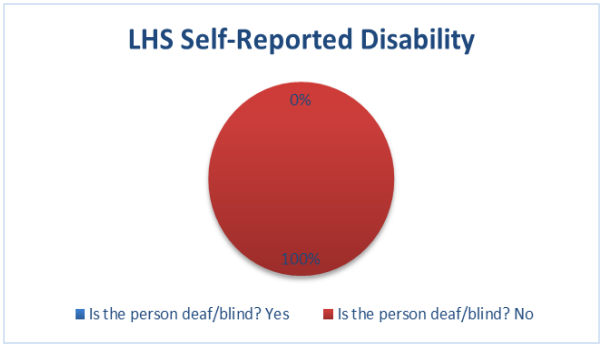


Charts 55 and 56 show that all of individuals said they did not do the recommended 150 minutes of moderate aerobic activity per week, and as with R&LWHS, nor did they do strength exercises on two or more days a week.

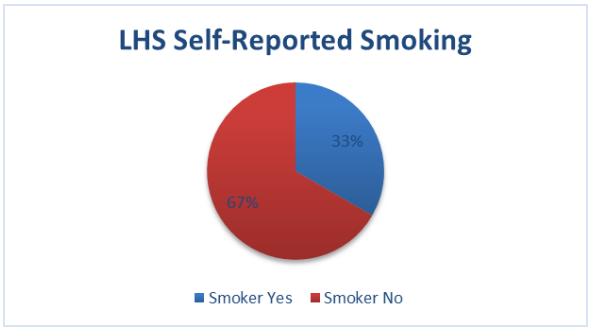


Charts 57 and 58 shows that all of service users reported as not being disabled or being blind or deaf.





Data in Chart 59 and 60 shows that all of the service users reported that they drank within the recommended 14 units of alcohol a week, and one of the three individuals reported that they smoked.



English/White	2
Welsh/White	1
English Speaking	2
Welsh Speaking	1
Living Alone	3
Car Driver/Owner	1
Other Religion	3
GP Practice	3@ Llanidloes Medical Practice
Age	(68/74/97)
Single	1
Widowed	1

If/when the service challenges are addressed (as highlighted in the recommendations), it would be anticipated that full data reporting and collation would provide an individual and service profile appropriate to Llanidloes.

Service User Outcomes and Feedback (April 1st 2018 - March 31st 2019)

Snap Shop Questionnaires

The snap shot questionnaire was developed alongside the revision of the Home Support service specification and development of outcomes. The aim of the questionnaire is to show the impact of the service and the effect and benefits it has on people's lives, and to help understand what matters to individuals and ensure transparency around expectations and experiences.

The questionnaire was designed to be completed with the service users (there are also specific ones for carers) at any point in their membership. The questionnaire was initially developed as a pre and post intervention tool to ask people to say what, if any, impact their support has had on various aspects of their life. Having said this, they have been mostly completed and are of particular significance at the point of assessment and at case review or with a change in individuals' circumstances.

Each question aligns closely with the strategic framework including the domains of wellbeing set out in the Social Service and Wellbeing Act (Wales) (2014). Respondents are asked to rate the impact of their support, saying for each area of life that we ask about, whether they: Strongly Agree, Agree, Neutral, Disagree, Strongly Disagree.

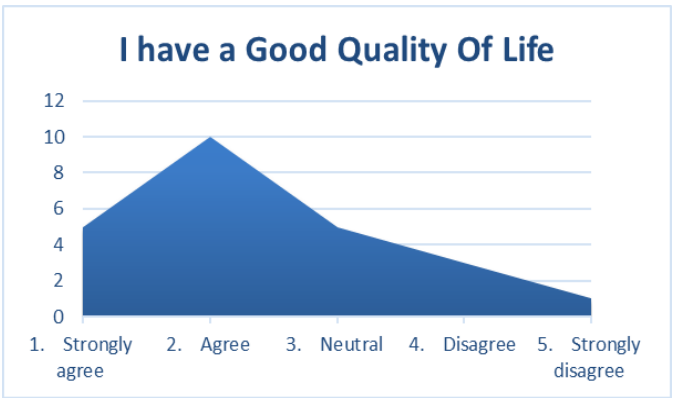
A focus group questionnaire has also been produced with a view to collecting feedback from a group of individuals. This is a more detailed questionnaire reflective of all the Home Support service user and carer outcomes intended for annual completion.

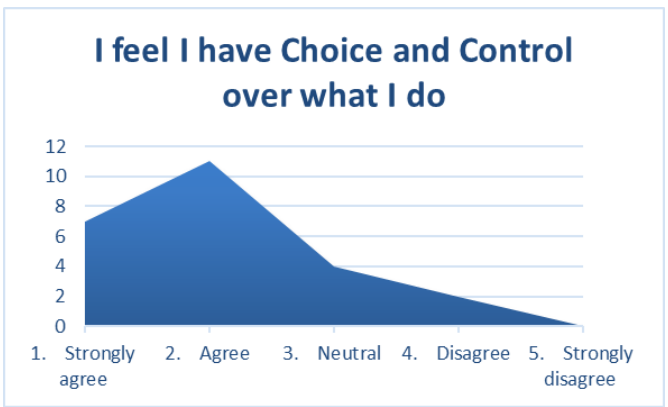
The questionnaire is pertinent on an individual and service basis in terms of support planning and local service development respectively. And, when presented alongside key service areas, the data does indicate some common/recurring themes across the project and grounds for action.

Charts 61-66: Rhayader and Llandrindod Wells Home Support Service User Outcomes

Snap Shot Questionnaire Returns	**24 (11%)**
Total Membership	**225**

The questionnaires completed were for individuals newly referred to Home Support. Chart 61 shows that most (63%) individuals felt they have a good quality of life. Three quarters said that they felt they had choice and control over what they do (Chart 62). It is anticipated that those reporting a neutral to strong disagreement will prompt opportunities for conversation about why they may disagree and what if anything could be done to change their experience positively.





Charts 63 and 64 indicates that most of the respondents felt involved in addressing what mattered to them and have access to information, advice and assistance when they needed it, with two saying they disagreed with both of these statements.

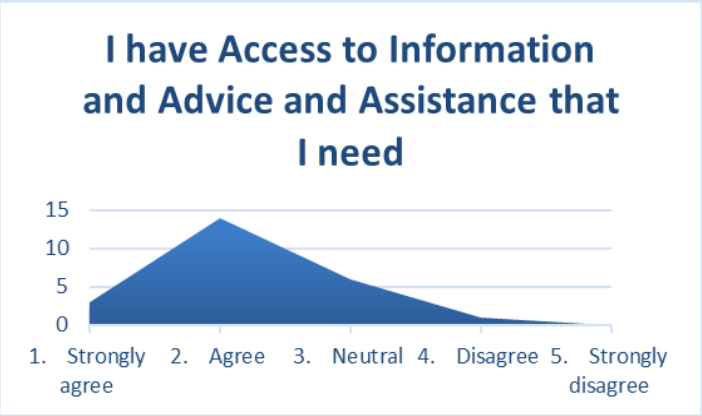
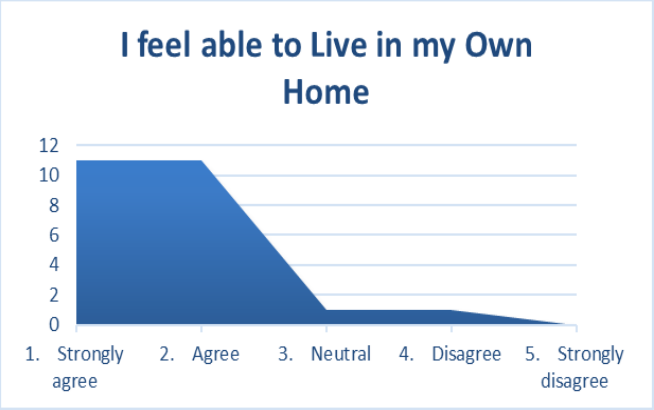
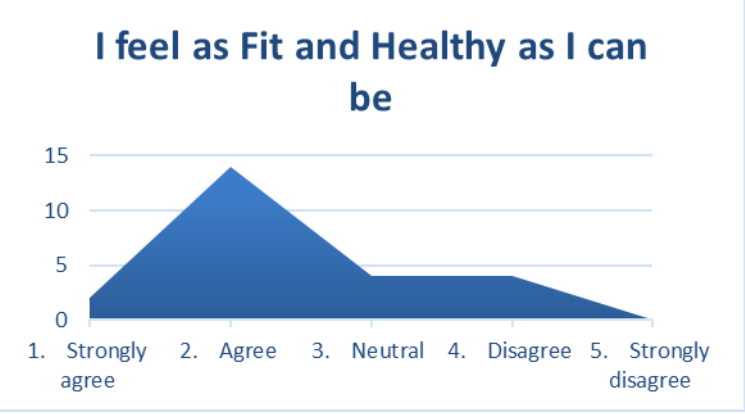


Chart 65 shows that 2 of the 24 individuals felt neutral or disagreed about being able to live in their own home. Chart 66 shows that a third of the respondents felt the same in relation to feeling as fit and healthy as they could be. Both responses give opportunities in terms of home support interventions and signposting to other services, particularly in relation to individual's health and fitness.





It would appear that questionnaires have not been completed with service users at review, which would have highlighted their views and experiences more specifically about and a reflection of home support services.

As a recommendation from the interim evaluation report, the questionnaire has been revised. Therefore, with effect from April 1st 2019, there is one questionnaire only, which can be completed at any point during an individual's membership of the service, and, routinely within review.

Rhayader and Llandrindod Wells Home Support Service User Feedback

Alongside the questionnaires, the following feedback is a sample of the some of the views of service users and carers highlighting the strength of feeling and value placed upon the Rhayader service. Feedback has been obtained from compliments, comments and case studies.

"Thank you all so much for all that you did to support (my husband and I) through the challenges for his last 12 months. We are so lucky to have home support in Rhayader, you're very prompt, cheerful and professional help at times when we were in great need and exhausted was priceless. You are such a friendly and enormously competent team with extensive local knowledge and a magic touch. Thank you."
(Service User)

"Thank you so much for all your care & rapid reposes with grateful thanks."
(Service User)

"Just taking a moment to thank you ALL so much for EVERTTHING you did. You made a difficult period so much more bearable."
(Service User)

I would like to say a huge thank you to Rhayader support team for the help we received yesterday and peace of mind in knowing that I couldn't get to my mother quick enough. You went out of your way beyond your duties and I am sincerely grateful. Rhayader has an amazing support team and nobody knows how important you are to our community unless they needed your assistance, how lucky Rhayader is to have you! Thank you so much from the bottom of my heart and reassuring my very frightened Mother.
(Carer)

We cannot thank you enough for the support you have provided for my father it has made a great difference to his quality of life. Thank you.
(Carer)

Thank you all so much for your kind support and for such a special and valuable service. We are so lucky to have you. (Service User)

We couldn't have got through this last year without your never ending support Thank you.
(Service User)

Charts 67-72: East Radnor Home Support Service User Outcomes

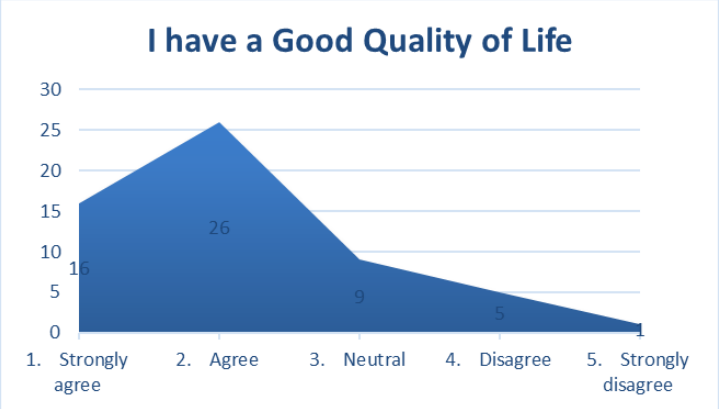
Snap Shot Questionnaire Returns	**57 (33%)**
Total Membership	**174**

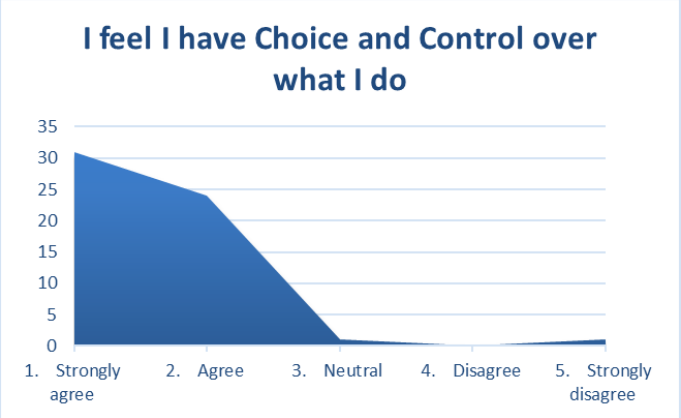
The questionnaires completed in the Presteigne and Knighton area were from relatively newly referred individuals. And, in doing so has prompted opportunities in terms of reflecting further with those individuals about what matters and what they feel would help to change their circumstances and how/if home support interventions and signposting to other services could contribute, rather than feedback about the Home Support service they were receiving.

Further, as there is a 33% return on questionnaires, the information obtained is pertinent on service wide basis in terms of a local response and development.

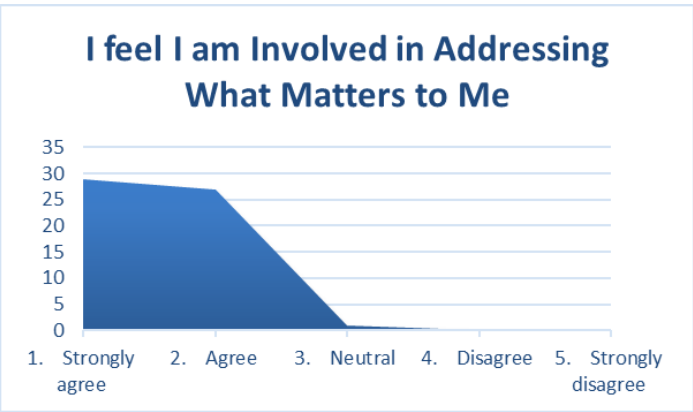
Chart 67 shows that 74% of individuals said that they agreed/strongly agreed to having a good quality of life. The remainder of respondents prompting opportunities to reflect further with those individuals about what matters and how they feel they could improve their quality of life.

As with RLWHS, most individuals (97%) said that they felt they had choice and control over what they do, and an opportunity for the one individual who strongly disagreed with this statement, for conversation about why they disagreed and what if anything could be done to change their experience positively.





Charts 69 and 70 show that most (98%) of the respondents felt involved in addressing what mattered to them and (95%) have access to information, advice and assistance when they needed it, with two saying that they disagreed with having access to information, advice and assistance providing a clear opportunity to address this issue.



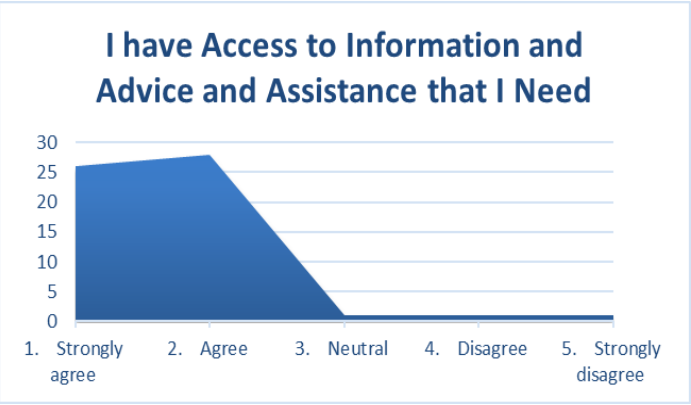
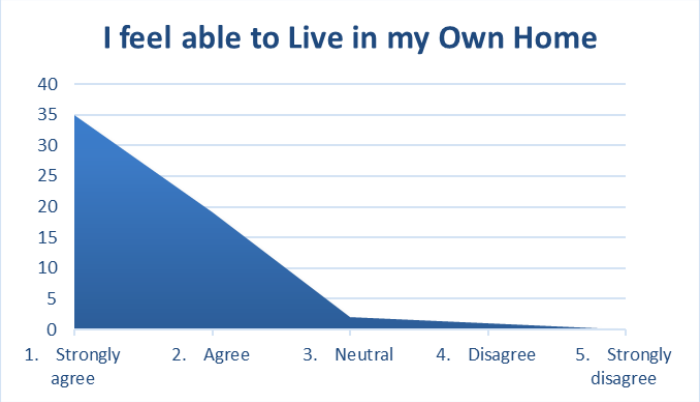
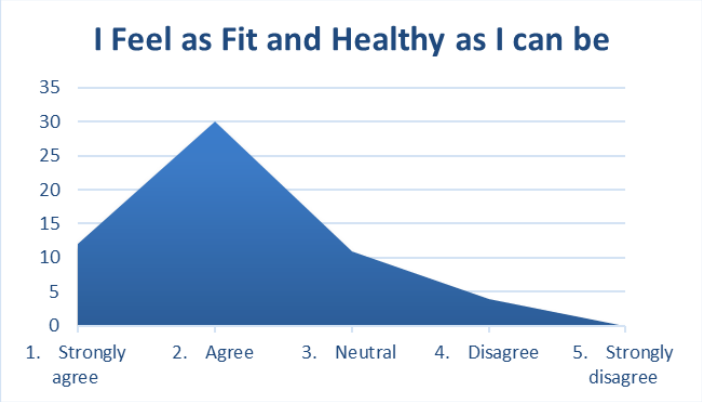


Chart 71 shows that three of the 57 individuals felt neutral or disagreed with feeling able to live in their own home, and as with the last comment, providing a clear opportunity to discuss the matter further.

Chart 72 shows that 74% of the respondents felt as fit and healthy as they could be. However, about a fifth gave a neutral response and 4 individuals disagreed with the statement, providing opportunities in terms discussing the matter further and how the individuals may wish to address the matter (particularly if their responses to self-reported health and activity in the personal profiles above were of resonance).





As with RLWHS, questionnaires have not been completed with service users at review, which, if they had would have highlighted their views and experiences of and about home support services more specifically. As mentioned above, the questionnaire has been revised. Therefore, with effect from April 1st 2019, there is one questionnaire only, which can be completed at any point during an individual's membership of the service, and, routinely within review.

East Radnor Home Support Service User Feedback

The following feedback is a sample of the some of the views of service users and carers highlighting the strength of feeling and value placed upon the East Radnor service.

"I feel very supported since we signed up to home support. It feels like a comfort blanket to me knowing the girls who come are so lovely and helpful and I feel confident with them helping my husband up" (Carer)

"It's so nice someone can check up on us as we don't see many people at all. It's nice someone talks to us and gives us useful advice. We are very grateful for the service she provides and to know that someone is there for us" (Service User)

"I worked closely with East Radnor Home support for several months. They were able to build a strong relationship with one lady who had advanced dementia and no other living family. Without their support she would have not been able to continue living at home and would have required an EMI residential placement. They go above and beyond to provide an excellent service and build relationships with service users. From speaking with members of the community in Knighton and Presteigne they are very grateful to have such a wonderful service." (Reviewing Officer)

"Your service it's extremely important to our service users. As a falls nurse I feel happier knowing my clients have you. I can't express enough how important it is for this service to continue."
(Falls Prevention Nurse)

Project Development and Activity

Steering Group

The Powys Home Support Project Steering Group was established in December 2017 to support the development and implementation, monitoring, review and evaluation of the Home Support Project. The group comprises of operational and commissioning personnel across social, health and community based care. The group initially met on a monthly basis essentially to support the implementation of the pilot and key operational work. It is anticipated that going forward (April 2019), the steering groups will meet on a bi-monthly basis, with wider/more strategic focus including developing partnerships with key stakeholders and determining/realising the future of the service and sustainable ways forward. The progress of the project has been and will continue to be documented within the Home Support Action Plan, which is overseen by the Steering Group. See Appendix 3 for current terms of reference and membership.

Governance

The Home Support Steering Group has until recently reported to the Regional Partnership Board (RPB) on a quarterly basis. From December 2018, the steering group sponsor reports to the Disability Partnership Board, which has delegated reporting responsibilities from the RPB. Therefore, in terms of the Home Support Project, key reports/recommendations from the steering group will go to the DPB that will in turn be fed into the RPB for approval etc.

The project officer will continue to provide quarterly 'statistical' reports to the RPB as well as monthly reports (to PCC Senior Management Team (SMT)) as part of the Corporate Improvement Plan (CIP) Assurance Reports.

Service Specification

The Home Support service specification was developed at the beginning of the project in November 2017 over a series of workshops/couple of months with project staff and operational/commissioning management. As with the project as a whole, the specification was based upon the RHS service, Care Inspectorate Wales (CIW) requirements, new legislation and local strategy, demographic/need projections and where possible research and best practice across the UK. The latter has proved particularly challenging, as the service is unique in that it is wholly funded through social care and joint funding resources and is a free service.

The aim of developing a new specification was to develop a consistent pan Powys approach that both provides clear and quantifiable interventions that support people to live at home, and enables a responsive and unique delivery in each area - taking account of the profile and needs of local communities and individuals and the often variable services and resources provided within each. The specification was finalised in February 2018 and is currently being implemented across all four project areas and forms the basis of the monitoring, review and evaluation of the service and project as well as the contract for the commissioned services provided in East Radnor.[20]

Recording and Documentation

In response to the CIW practice requirements and the revised service specification, practice recording and documentation has been reviewed and revised and is compliant with CIW regulations. These include:

- 13 Practice Documents (across all key work areas including referral/assessment/support planning/review/closure)
- 5 Practice Checklists (to support staff to adopt shared and consistent practices)
- 9 Outcomes Documents (including service user/carer questionnaires/case study templates/focus group questionnaires)

The documentation will be reviewed within the second year of the project (provided the project is extended).

[20] Powys Home Support Service Specification - Helping individuals to live life their way (May 2018). Appendix Two.

Data Management

The Home Support data management record (DMR) was developed following the revision of the RHS service profile and production of a pan Powys Home Support service specification to serve all 4 project areas. The DMR is the basis for this report and aims to capture both quantitative and qualitative data to help demonstrate the impact and outcomes of the service and the project as a whole. Following review, the DMR has been revised and updated for use with effect from April 1st 2019.

Marketing and Promotions

To support the marketing and communication of the services and project work and help access to and awareness and understanding of the Home Support through the provision of clear and consistent messages the following promotional materials have been developed:

- PCC Home Support Logo use on all project/practice documentation and promotional materials
- 1500 Home Support A5 flyers (English) for the PCC provided services
- 750 Home Support A5 flyers (Welsh) for the PCC provided services
- 50 Home Support Posters (A3) for PCC provided services
- 200 Home Support tri-fold flyers for ERHS services
- Promotional film (RHS and one due for ERHS)
- Home Support internet presence (Regional Partnership Board)
- Home Support Launch Bulletin (internal and external partners)
- Home Support Project Promotional Poster (A3)

Service Interdependencies

The Powys Home Support Multi-Agency Pathways Group was established in March 2018 and has met three times to date (including individual stakeholder meetings). The Group was set up in response to and with the aim of exploring and addressing issues to support responsive joined up home support related services so that individuals using them would have one 'touch point' and have/continue to have their needs/what matters to them met first time, thus minimising duplication and optimising resources across all services. Key services identified including Home Support, Red Cross/Positive Steps/PURSH/Re-ablement/Domiciliary Care/Supporting People/GP Practices/Virtual Wards/Ambulance services. Key issues raised:

- Need for improved and shared understanding and clarity of key services including Home Support/Red Cross/Positive Steps/PURSH/Re-ablement;
- Need to support equitable geographical service cover in Powys (Knighton area a key challenge)
- Insufficient care personnel to meet need (domiciliary care in particular);
- Service users/carers waiting times for care packages impacting on lower level services;
- Emerging potential service duplication;
- Ensuring good experiences and outcomes for service users/carer across all services;
- Risks and sustainability of Individual services;
- Clarity for future service commissioning/provision by health and social care;
- Managing winter pressures/DTOC etc. across services;
- Ensuring good communications across key services.

Work to date has included the development of a comparator data base to help clarify and identify service remits, distinctions, commonalities and overlap; supporting a PHTB initiative for the installation of lifting equipment with training across key health and social care sites (ERHS and RHS already have this in place); and some practice suggestions yet to be realised.

Project Support

The project has been supported (and will continue, if the project is extended) through the appointment of temporary project officer.

Training and Development

The revised Home Support Service Specification highlights essential and desirable training requirements to support staff to feel confident and be competent within their roles. In addition, the following is available to specifically to support staff development within their home support roles:

- **Making Every Contact Counts:** Two half-day sessions provided by Public Health Wales to all Home Support and PCC Day Centre Staff in June 2018.
- **Motivational Interviewing: PHTB** recommendation that is already part of PURSH/Red Cross training programme.
- **Sage and Thyme:** PAVO recommendation provided via the University of Manchester to support a 'strengths based' approach to work.
- **Person Centre Training: PCC pilot** training through pilot Cmryd-Rhan as part of the supporting people services. Future availability to be confirmed.
- **What Matters Conversations:** PCC training/support opportunities concerning "What Matters Conversations".
- **Investing your Health:** PHTB recommendation: public health workshops via Apple a Day/Activate.
- **Dementia Matters:** Training covering all aspects of dementia provided by Dementia Matters.
- **I Stumble:** Training to support use of Manga Elk/Camel to support falls management and help reduce ambulance all-outs.
- **DMR Support:** On-going support and training to staff to use/populate the project Data Management Record.
- **Home Support Documentation:** On-going support and training to staff to record/populate service documentation.

Investment in staff development and training specific to Home Support will be essential to supporting a consistent approach across the service areas and ensuring staff feel confident and are competent to undertake their work.

Home Support Service Meetings

Established as a follow on from the initial workshops held January and February 2018 to support the senior support workers (and management) regarding:

- Share experiences
- Support each other with the work you are doing
- Learning and training opportunities
- Raise and deal with any issues/challenges
- Sort out any practicalities
- Share good news you have
- Highlight work in relation to the home support action plan
- Update on what's hot and what's not in the world of home support
- Feedback/work from steering group/multi-agency pathways meetings
- Project monitoring and evaluation

To date there have been seven service meetings chaired by the project officer revising and developing the project and supporting the service implementation. It is anticipated that these will continue as part and for the duration of the project.

Project Learning and Applications

The extensive preparatory work and ongoing development has incurred some delays in relation to the implementation, documentation and recording. However, this report has shown the value and impact of this work and that the application and effectiveness of a pan Powys service specification, practice and recording documentation and system, and approach across PCC provided and commissioned services is possible and works, and which would be applicable as a developed and established 'package' to other areas in Powys.

Section 8: Impact and Conclusions

Has the project/service has been successful in achieving its objectives and outcomes?

Yes. This report demonstrates that Home Support is a responsive and adaptable service that ensures that the nature and frequency of support is reflective of each individual's needs and abilities, ultimately enabling them to live at home by providing very practical assistance and support, as and when needed and without requiring potentially more intrusive and costlier support and services.

This report has shown that the project has made significant achievements particularly within two of the four localities (East Radnor and Rhayader), with foundations and early indications for progression (taking into account specific recommendations) in Llandrindod Wells and Llanidloes.

The outcomes were developed as an integral part of the service specification and are essentially the quality benchmark from which to determine the impact and success of this project. This has been demonstrated across all three of the outcome areas (service user and carer, service and system outcomes).

This report has also shown clear opportunities to develop the service further that address current and projected need particularly in terms of:

- Better consistency across the four areas in terms of provision, recording and data collection and asking individuals about their views and experiences
- Health and wellbeing promotion, improvement and intervention
- Proactive approaches to tackling loneliness and social isolation
- Partnership and integration with similar health and social care services
- Co-production with service users and carers to develop and review services
- Diversion from more intensive service interventions, in particular, emergency service escalations
- Return on investment particularly in terms of cost avoidance of health services
- Application of an established service model, practice and systems to other areas

Does the service deliver?

Yes, through:

- **Promoting independence by providing early intervention and prevention.**

  This has been demonstrated in Section 7 - particularly in relation to scheduled independent living support activity. Whilst the reporting of activity across the spectrum of independent living support is an emerging one (in part due to recording practices with the implementation of the data management system and partly due to revised practice definitions giving recognition to areas of work not previously explicitly acknowledged/recorded), this report has shown a wide range of support and interventions in response to a wide range of individual needs and indeed abilities.

  There are particular noteworthy practices that have informed the recommendations of this report both in terms of promoting consistency across the areas and responding to identified issues (Inc. essential shopping and prescription collection, tele-care and healthy lifestyles).

- **Providing support to improve and/or maintain health and wellbeing including life skills, healthy lifestyles, learning and occupational opportunities and links with family, friends and local communities.**

  This report has shown an emerging picture of in terms of healthy lifestyles interventions. This is in part due to the revised service remit, definitions and reporting methods calling for proactive health interventions in relation to local strategic aims and ambitions, rather than a reflection of current practices (e.g. RHS

newsletters, safe and well checks, and Home Support social club). However, this report has shown that there are clear opportunities for service development with regard to health and wellbeing promotion, improvement and intervention.

The self-reported health and wellbeing data highlighted in the Personal Profiles strongly indicates the need for proactive healthy lifestyle inventions, particularly in relation to exercise, falls prevention, diet and mental health. Further, the population data (Section 6) for all services areas shows around a third of the over 65's population are lone households with figures projected to rise with the increase in ageing population – calling for innovative interventions to address social isolation and loneliness of which Home Support does and can respond to.

The use of personal profiles and questionnaires to ascertain the views and experiences of service users and carers helping to inform the development and review of services.

- **Helping to prevent or delay the deterioration of health and wellbeing resulting from ageing, illness or disability.**
  This report has demonstrated that home support provides a range of responsive interventions enabling people to live in their own homes. And, there are strong indications to develop service provision in relation to preventative support so there is a stronger presence and provision of proactive healthy lifestyle interventions. By recording this via the newly implemented data management system, it is anticipated that the outcomes relating to prevention and/or delay of health and wellbeing will be better demonstrated.

- **Do people stay at home longer?**
  As in much of the developed world, increased wealth, health and standards of living mean that people can now enjoy a far longer retirement than that of even relatively recent generations. And, as in common with other developed economies, successive Welsh Governments have followed a policy of enabling older people to maintain their independence and stay in their own home for as long as possible. Home Support is one of many initiatives established to do this. It is not genuinely possible to show that individuals' independence and ability to stay at home is a direct and singular result of home support services. Improved recording at the point of intervention regarding the involvement of other services would be desirable. This would to help determine whether Home support services were additional to people's support or used as an alternative.

  On a micro level, feedback from service users and carers does show that most feel able to stay at home and where home support has been a contributing factor to this, it is highly commended and valued.

What is the impact of the Service?

- **Does the service help prevent and/or delay the use of other services?**
  Yes. The unscheduled support activity highlighted in Section 7 shows the reason and nature of responses to emergency call-outs by home support and the number and type of services averted because of those call-outs. This is reinforced by data collected (pre 2018) by RHS. This report has shown that 91% of the total call-outs in the reported period were aversions from domiciliary care, ambulance services, police/fire services and GP services.

- **Are the service user outcomes positive? For example, improved health and wellbeing and personal and relevant support at home.**
  Whilst the responses to the snap shot questionnaires generally indicate pre or early views relating to home support interventions, the outcomes views and experience of service users are positive. It is anticipated that if the project is extended, and the questionnaire is used routinely within review, there will be better information highlighting individual's views and experiences of and about home support services.

In the absence of this, this report has highlighted a sample of the consistent and regular feedback from service users, carers and other professionals (comments, compliments and case studies) that shows that services provided across the project areas are highly regarded as a much valued, innovative and unique, proactive and preventative service.

- **Have there been any unexpected outcomes?**
  - Services provided across the project areas are consistently highly regarded as a much valued, innovative and unique, proactive and preventative service.
  - The use of personal profiles and questionnaires to ascertain the views and experiences, and outcomes of service users and carers helping to inform the development and review of services.
  - Staff across all the service areas bringing a wealth of knowledge and experience to the project and showing commitment, belief and professional tenacity for progress.
  - The application and effectiveness of a pan Powys service specification, practice and recording documentation and system, and approach across PCC provided and commissioned services is possible and works which would be applicable as a developed and established 'package' to other areas in Powys.

Is the service cost-effective and sustainable?

- **Does the service help reduce the need for costlier and intensive services?**

  Yes. This report has shown that 91% of the total call-outs in the reported period were aversions primarily from domiciliary care, ambulance services, police services and GP services, which would indicate the reduction in need for costlier services. Further analysis of the indicative costs of these and home support services would help demonstrate the actual cost comparison and consequent avoidance or savings.

- **Are there cost savings and a return on investment?**

  Yes, it would appear so. The data in Table 10 in Section 7 above, does appear to support emerging indications of not insubstantial returns with service costs avoidances from ambulance, domiciliary care, GP and police and fire services. Further, income generation is indicated through the promotion, sign-up and installation of emergency carelines. It is recommended that there is further analysis based on full indicative costs highlighted in Appendix 5 alongside the Section 7 unscheduled support activity (with supporting findings from on 2013 RHS Evaluation).

- **Are the services right sized and right priced?**

  No. There is limited parity and proportionality of resourcing across all project areas which has likely impacted on the delivery of the pilot in Llandrindod Wells and Llanidloes in particular and hence the recommendations regarding the need for an urgent review of service resourcing to ensure right sizing and right pricing for all service areas including pay and non-pay commitments and that there is capacity for project support, service reviewing/evaluating services and admin support across all service areas.

- **What is the added value of the service?**

  This report has clearly shown the added value of Home support:

  I. It is a person-centred local service that is flexible and response to individual's needs and what matters to them whilst also taking into account strengths, preferences and desires.

  II. It promotes independence by providing early intervention and prevention to improve and/or maintain health and wellbeing including life skills, healthy lifestyles, learning and occupational opportunities and links with family, friends and local communities.

  III. It promotes independence and integration of people within the community, providing support based on outcomes rather than institutional lifestyles.

IV. It works with and alongside existing community and service provision.

V. Once individuals become a member of Home Support they can dip in and out of the service according to their needs without having to be re-referred as is often the case with services.

VI. The Service is free.

VII. The eligibility criteria are not means tested or dependant on FACS criteria.

VIII. Emergency careline installation charges (with Delta Wellbeing) were initially waived for individuals who become members of the home support service. This has been as a result of a local partnership agreement which involves Home Support staff installing the personal alarm on behalf of Delta Wellbeing. The company now charge a small installation fee (with effect from April 1st 2019) to the individual. This is across all four localities.

IX. Staff across all the service areas bringing a wealth of knowledge and experience to the project and showing commitment, belief and professional tenacity for progress.

X. The use of personal profiles and questionnaires to ascertain the views and experiences of service users and carers helping to inform the development and review of services

XI. A pan Powys service specification, practice and recording documentation and system and approach that provides clear and quantifiable interventions that support people to live at home, and enables a responsive and unique delivery in each area - taking account of the profile and needs of local communities and individuals and the often variable services and resources provided within each.

- **Is this way of working worth it?**
  Yes. The outcomes demonstrated in terms of service activity and service user/care feedback and as highlighted in this conclusion clearly show the effectiveness and impact of home support, and that this way of working is worth it in terms of personal, systemic and financial value.

What have been the key achievements, challenges and opportunities?

- **Achievements:** This project has delivered in terms of its aims, objectives and outcomes particularly in Rhayader and East Radnor. This report has shown the impact the service has made, its value and added value when implemented in full.
- **Challenges:** There have been challenges from the start of the project in respect of parity of resourcing and approach across the four service areas, inconsistent in-service planning and preparation and subsequent implementation as highlighted in the Section 6 above relating to each of the service area profiles**.** The challenges could arguably have been expected because of the nature/make-up of what could be perceived as unique area/service area profiles within a rural county. Having said this, and despite the fact that the individual area challenges have also been compounded by the protracted nature of the completion of the revised data management system and promotional materials for implementation, the challenges have been addressed as an on-going part of the project. They have also informed the recommendations going forward, with staff across all the service areas showing commitment, belief and professional tenacity for progress.

  Opportunities: This report has also shown clear opportunities to develop the service further that address current and projected need particularly in terms of:

  - Better consistency across the four areas in terms of provision, recording and data collection and asking individuals about their views and experiences
  - Health and wellbeing promotion, improvement and intervention

- Proactive approaches to tackling loneliness and social isolation
- Partnership and integration with similar health and social care services
- Co-production with service users and carers to develop and review services
- Diversion from more intensive service interventions, in particular, emergency service escalations
- Return on investment particularly in terms of cost avoidance of health services
- Application of an established service model, practice and systems to other areas

Has there been any variance between the project/service areas? If so what and why?

Yes. There have been challenges from the start of the project (as highlighted above), in respect of parity of resourcing and approach across the four service areas, including inconsistent in-service planning and preparation and subsequent implementation as documented in the Section 6 above relating to each of the service area profiles.

It is anticipated that the recommendations regarding consistency across the four areas will help shape the service going forward and acknowledge and allow scope for local flexibility as needed and appropriate.

What risks have there been to the project?

Key risks have been highlighted throughout the report and addressed as an on-going concern basis the steering group and/or in practice, including:

- Workforce challenges (particularly in respect of Llanidloes and Llandrindod Wells)
- Adequate and timely resourcing
- Data management system and practice support
- Administrative support

What references, learning and applications can be made from practice in other areas?

Comparative analysis and learning from Tunstall Televida tele assistance service in Spain needs to be seriously considered in terms of ongoing development, application and sustainability in Powys….

"By looking at prevention at scale – would the Barcelona model work here? As indicated when you're doing something differently at scale, it becomes a game changer. It's not messing around at the edges. Clearly we don't want to place people into a care home setting if that can be prevented because that is invariably not what people want and as part of a 'promoting independence' philosophy there's something really preventive by thinking at scale."[21]

Is there good enough information to inform conclusions and recommendations?

Yes. See above and report recommendations.

Is there a need for the service, or even a need for further development and expansion?

Yes. This report has also shown clear opportunities to develop the service further that address current and projected need:

- Better consistency across the four areas in terms of provision, recording and data collection and asking individuals about their views and experiences which in turn will help shape the service going forward
- Health and wellbeing promotion, improvement and intervention
- Proactive approaches to tackling loneliness and social isolation

[21] Tele assistance in Spain: adding value with a preventative approach http://tunstall.com/media/1237/tunstall-televida-case-study.pdf

- Partnership and integration with similar health and social care services
- Co-production with service users and carers to develop and review services
- Diversion from more intensive service interventions, in particular, emergency service escalations
- Return on investment particularly in terms of cost avoidance of health services
- Application of an established service model, practice and systems to other areas
- Analysis and learning from comparator services

Section 9: Recommendations

1	**Extend and expand the Home Support project in the four service areas as detailed below to March 31st 2021**
Strategic	
2	Refocus the role of the Steering Group to future proofing and sustainability of Home Support beyond April 2021 – including working with related HS services in PCC, PHTB and community services to consider pooled budgets, commissioning opportunities and future intentions
3	Continue the project reporting and evaluation (6-monthly) to inform a business case going forward that is based upon research , the revised and implemented service specification, practices and documentation and data recording systems established in 2018 and with key stakeholders
4	Review service eligibility criteria particularly in terms of age and service user group
5	Evaluation to provide a clear picture regarding the added value of Home Support return on investment, including cost avoidance, cost saving and income generation
6	Evaluation to include analysis and learning from comparator/related services and research/evidenced base practice
Operational	
7a	Review service resourcing to ensure right sizing and right pricing for all service areas including pay and non-pay commitments
7b	Confirm capacity for project support, service reviewing/evaluating services and admin support across all service areas
7c	Review and optimise both in-house and commissioned Home Support workforce capacity and allocation to ensure parity and proportionality across the service areas
8	Establish full Home Support services in Llandrindod Wells. Ring-fence a dedicated workforce and separate recording, documentation and Data Management System from Rhayader Home Support
9	Progress the establishment of Llanidloes Home Support ensuring there is a distinction from Bodlondeb service and workforce. Ensure the service has access to Manga Elk equipment and that transferred Bodlondeb cases are reviewed. Consider alignment of service area with Health boundaries for Llanidloes
10	Continue the East Radnor service with reference to Recommendations 3 (including day time capacity), 7, 8 and 9
11	Continue the Rhayader service with particular reference to Recommendations 3, 7, 8 and 9
12	Review case work activity across all areas to optimise resources and consistency whilst also taking account of services/stakeholders/need in each locality (Inc. shopping and prescription collection, healthy lifestyles)
13	Early review and ratification of the current eligibility criteria
14	Clarify if CIW registration is a requirement for this service
15	Develop Home Support services (working with key partners) in response to the needs identified in the personal profiles/snap shot questionnaires) so interventions include proactive healthy lifestyles interventions (mental/physical health/wellbeing/isolation & loneliness/Technology Enabled Care)
16	100% completion of personal profiles/snap shot questionnaires/referral activity forms, one focus group questionnaire per annum and completion of the Data Management System across all service areas
17	Improved recording at the point of/during Home Support interventions regarding the involvement of other services to help determine whether Home support services were additional to people's support or used as an alternative.
18	Update the Data Management System and amalgamate all data recording/reporting requirements where possible to minimise duplication (including in-house operational reporting)
19	Refine revised Home Support documentation for continued application across all service areas
20	Promote and support specific and service focused workforce development through staff training and service meetings
21	Review and implement a Home Support marketing approach to optimise awareness, uptake and partnership/joint/integrated working practices

Section 10: Appendices

Appendix One: Abbreviations

Abbreviation	Reference
CIP	Corporate Improvement Plan
CIW	Care Inspectorate Wales
DMR	Data Management Record
DMS	Data Management System
DPB	Disability Partnership Board
ERHS	East Radnor Home Support
ICF	Integrated Care Fund
LHS	Llanidloes Home Support
OOH	Out of Hours
P/T	Part Time
PCC	Powys County Council
PHTB	Powys Health Teaching Board
R&LWHS	Rhayader and Llandrindod Wells Home Support
RHS	Rhayader Home Support
RPB	Regional Partnership Board
SSWB Act	Social Services and Wellbeing Act – Wales (2014)
SWW	Senior Support Worker
WTE	Whole Time Equivalent

Appendix Two: Home Support Service Specification

Home Support
Service Specification

Appendix Three: Powys Home Support Steering Group Terms of Reference

PHS Steering Group
TOR SH V5 (29.06.18

Appendix Four: Project Finances

Project and service costs to be confirmed and authorised prior to publication.

Appendix Five: Indicative Return on Investments

Unit Costs to support cost analysis (to be competed):

Role/Service	Unit costs available 2016/2017 (costs including qualifications given in brackets)	Source
Home Support Worker	TBC: Grade 5: WTE: 19,554-20,344/HRLY: 10.1354-10.5488. On-costs = approx. £17 HRLY rate/OOH? + £12.05 per call-out	Pay Scales for NJC Employees – 01/04/19/PCC
Social Worker	£43 (£59) per hour; £59 (£82) per hour of client-related work.	https://www.pssru.ac.uk/project-pages/unit-costs/ unit-costs-2017/#sections
Home Care Worker	Based on the price multipliers for **independent sector home care** provided for social services: £22 per weekday hour (£22 per day-time weekend, £22 per night-time weekday, £22 per night-time weekend); **Face-to-face**: £26 per hour weekday (£27 per day-time weekend, £27 per night-time weekday, £27 per night-time weekend). The average standard hourly rate is £25.62 for services provided in-house, compared to £15.52 for provision by external providers.	
LA own-provision day care for older people	£63 per client attendance; £14 per client hour; £48 per client session lasting 3.5 hours.	
Private sector residential care for older people (age 65+)	£659 establishment cost per permanent resident week; £708 establishment cost plus personal living expenses and external services per permanent resident week.	
Private Sector Nursing Homes	£806 establishment cost per permanent resident week; £831 establishment cost plus personal living expenses per permanent resident week; £115 establishment cost per permanent resident day; £119 establishment cost plus personal living expenses per permanent resident day.	
GP (HV/TC)	Per hour of patient contact: £242/£205 (Q/UQ); prescription costs per consultation (net ingredient cost) £29.203;	
District Nurse	Depending on AFC Band (5-7): £36/ £44/£53	
Ambulance Callout	Every emergency ambulance mobilised costs the Welsh Ambulance Service an average of £238.	www.healthcosts.wales.nhs.uk/news/35294
A&E Assessment	TBC	
Community Hospital Adm	TBC	
Day Hospital (per day)	TBC	
Community Hospital per night	TBC	
Pharmacy Prescription Delivery	Cost of worker TBC; Charge to individual - £1 per delivery	Current Powys Practice
Police	TBC More detail required (101/999 response required?)	
Fire Service	On average, crews are tied up for 23 minutes, costing up to £300 per engine.	https://www.bbc.co.uk/news/uk-wales-43726836
Re-ablement	£23 per hour; £45 per hour of contact; £2,187 average cost per service user.	PCC
PURSH	TBC	PHTB
Red Cross	TBC	PHTB
PCC Project Support Officer	TBC	PCC
Project Admin	TBC	PCC
Project Evaluator	TBC	PCC

Delta Wellbeing	**Careline installation and programming charge**: £48.00 (Inc. VAT)/£40.00; **Home installation** (alarm can be pre-programmed and sent in the post for individual/HS service to connect at home) recorded postal charge included: £30.00 (Inc. VAT)/£25.00; **Rental and Monitoring charge per quarter**: £59.50 (Inc. VAT)/£49.58; **Rental and Monitoring Monthly Charge**: £19.84(Inc. VAT)/£16.53; **Weekly cost**: £4.58(Inc. VAT)/£3.82	Delta Wellbeing 2019/20 Charge Sheet

Appendix Six: References

I. A Profile of Rural Health in Wales (Centre for Health March 2007) file:///Z:/EB%20Research/RuralProfile%20Wlaes.pdf
II. Prevention services, social care and older people: much discussed but little researched?
III. What role can local and national supportive services play in supporting independent and healthy living in individuals 65 and over? Future of an ageing population: evidence review. Foresight, Government Office for Science file:///Z:/EB%20Research/gs-15-24-future-ageing-supportive-services-role-er14.pdf
IV. Accommodation for an ageing population Powys County Council. Market Position Statement March 2017. file:///Z:/Wellbeing%20&%20Population%20Assessment/Market_Position_Statement_Older_Peoples_Accommodation%20(2017).pdf
V. Care and Support Population Assessment for Powys. file:///Z:/Wellbeing%20&%20Population%20Assessment/Powys_Population_Assessment_Summary_-_Final_V1.pdf
VI. Joint Commissioning Strategy and Plan for older people in Powys 2016 to 2021. http://pstatic.powys.gov.uk/fileadmin/Docs/Comms/Older_People_strat_and_plan_2016_en.pdf
VII. Local Area Profiles based on 2012 Census Data. https://customer.powys.gov.uk/article/5963/Local-Area-Profiles
VIII. The Provision of Integrated Care in a Rural Community - an Evaluation of Rhayader Home Support Scheme. Final Draft Report 2013. Carol Jarrett, Fiona Williams and Leo Lewis. Institute of Rural Health. Commissioned Rural Health Plan Innovation Project: Report for the Welsh Government.
IX. https://solvacare.co.uk/
X. Tele assistance in Spain: adding value with a preventative approach http://tunstall.com/media/1237/tunstall-televida-case-study.pdf