Our Place: Wye

A community and needs-led response
to service provision in rural Kent

March 2015

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Business Plan 2015 - 2018

Translating our aspirations into better outcomes on the ground.

Our aims are to nurture a more inclusive, integrated community, which is more resilient and responsive to individual needs, age and social profile, and stimulates a healthy, caring and sustainable community in Wye and the surrounding areas.

March 2015
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Executive Summary

The Our Place: Wye project (OP:W) has its origins in planning and consultation activity which has been under way in the village since 2011 for the Neighbourhood Plan, and continues to be very clearly community and Parish Council led, through local working and reference groups. This consultation has identified that there is clearly a need for a greater community focus where proactive activity takes place to develop more community cohesion, especially across the different generations and between settled residents and newcomers.

It is widely recognised that if our village is to continue to function as a community of place, then ‘Our Place’ needs to be created, and it needs to look and feel good to maintain the commitment we have created in developing our plan this far.

Community consultation has identified a series of outcomes to help shape an improved future, and these we have described as the ‘top-twenty by 2020’, and these are described in our Logic Model, shown at Attachment Eleven. These aspects form the framework for this plan, and act as an important reference point for the engagement programme with the community over the coming months and years.

This business plan serves a number of purposes, firstly as a working reference document for the Wye Parish Council (WPC), the community and stakeholder partners to outline what it is to be achieved, why, and by when; and secondly, to report to the Central Locality Team, who are working on behalf of the Department of Communities & Local Government [DCLG] on progress with the planning.

The overall aims and objectives of the OP:W strategy are to nurture a more inclusive, integrated community, which is more resilient and responsive to individual needs, age and social profile, and stimulates a healthy, caring and sustainable community in Wye and the surrounding areas.

To achieve this a programme consisting of up to nine projects, comprising three priority projects, a further five ‘stepping stone’ projects, and an over-arching independent monitoring and review project will need to be planned and delivered. This will be undertaken over a three-year timeframe, delivering value as they go along.

A wide range of cumulative benefits are expected to be available by 2020, subject to the right levels of investment and resources, good governance and the continued commitment of the community, stakeholder partners and the Parish Council.

The initial costs and benefit profile for Year One is encouraging; there is an estimated cost in year one of nearly £90,000 and a potential savings target of £439,000 pa. This is described in more detail in Table One shown in the Value for Money section of this report. The working assumptions behind the cost/benefit analysis are shown at Attachment Thirteen.

The principles behind The World Health Organisation (WHO) model for Age Friendly communities will also be embedded into our specific project for Intergenerational Learning. Those principles will be carried forward into other project areas, so that over the lifespan of...
the overall programme, it will be demonstrating a commitment to having our community recognised as one of the first villages in the UK to receive WHO accreditation, which is seen as a planned programme outcome and a key performance indicator.

The OP:W programme and project activity is expected to be in three major phases, with some individual project activity at times running in parallel. The delivery of individual projects can also add value, knowledge and experience to others in the programme, and collectively will create a sound infrastructure of services, managed and resourced as locally as practically possible.

The overall programme will continue to be sponsored by the Parish Council (PC) and will be overseen by a new Programme Management Group¹ and undertaken in partnership with our stakeholders, including Kent County Council (KCC), the local GP Surgery, Ashford NHS Clinical Commissioning Group etc.

The first phase consists of provisionally funded activity and includes:

- Planning for a new organisation to create the strategic environment for the establishment of community managed services through a ‘community cooperative’ or similar². This could take place by Autumn 2015³.

- Two of the series of ‘stepping stone’ projects, with the immediate priorities in 2015 given to setting up the Community Connector Service and developing new ways of working for the commissioning of publicly funded social care by KCC.

The second phase is to follow up with the balance of the remaining projects, subject to the success and lessons learnt from the earlier work, the identification of achievable benefits and the appropriate levels of new funding.

The third phase will cover an independent monitoring and review project, which will be linked to community engagement, monitoring the achievement of the main benefit areas described later in this plan, and meeting the WHO criteria for Age Friendly Villages.

All of this project activity⁴ will require funding in some form or other. KCC is willing to input in kind officer time, funded from their own budgets; balances of the existing OP:W budget can also be utilised to support initial project planning and getting professional advice on the shape and legal structure of the community cooperative etc.

The PC is also willing to fund some of the early infrastructure required, but new funding streams will be required for Phase Two activity and this will require imagination and input on the part of the community to achieve.

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1. Please see the draft terms of reference for this group at Attachment One
2. We have used this general term to describe the formal structure that may be required; no decisions have yet been taken on its final constitutional ‘shape’ or function.
3. A briefing note on the options and choices for this is shown at Attachment Two
4. A summary of the projects are shown in Attachment Three
Approach to Our Place

The Wye Neighbourhood Plan was a major initiative in 2011 to seek the views of the community in terms of what they wanted the village to look like over the next decade. What also emerged quite clearly during the extensive consultation that took place, was the aspiration of villagers for a more age-friendly place in which to live.

This was in part because there are an increasing number of people in Wye and its more immediate communities that are facing health and care challenges now, and an anecdotal view that the existing services were not providing enough person-centric care.

A more detailed follow up ‘household survey’ in 2012-13 also found that the existing system of publicly-funded ageing services was seen as fragmented, uncoordinated and isolated from existing community social resources. Many people also believed this contributed to inefficiencies and substantial unmet needs, particularly among older adults living, or being cared for, in the village.

These surveys and related community consultation activity provided a strong reference point for developing the initial thinking behind what was to become the Our Place initiative. Subsequent research was also undertaken and for example, the World Health Organization’s studies on creating Age Friendly societies reinforced the commitment by the Parish Council to create a developmental plan for identifying ways to improve on what exists, and to find new and innovative ways to move forward. This is, in essence, the Our Place:Wye programme.

This broad range of community consultation and engagement routes will continue throughout 2015, including a new dedicated website for OP:W, a monthly update in the Parish Council newsletter, regular workshops and meetings to assess that the reflecting the prevailing views of the community are acknowledged and embedded in plans.

A more formal Programme Management Group is now being established to take the lead on delivering this business plan in partnership with the Parish Council and other stakeholders. The PC will continue to act as the sponsoring/accountable body for the Business Plan until the completion of the funding for OP:W, or the setting up of the community cooperative is achieved.

Context and background

It is well recognised that the structure of society is changing; rather than accept the negative perceptions of an ageing population, the Wye community seeks to embrace and celebrate living longer, as well as trying to find ways to encourage the rest of the community to contribute to and participate in a ‘whole systems model’ of care. To achieve this, a new relationship between the local community and the “state” needs to be developed to create an innovative, inclusive, user-led, localised service.

5. Rather than develop the initiative from an organisational-based service delivery approach, individuals will be at the centre, and have services based around their needs and priorities.
However, that means giving some careful and imaginative thought as to how to amend attitudes and social infrastructure. This will entail not only considering new ways for communities to support, care and enable people to remain as independent in their own homes as possible, but also to ensure individuals are in control of their lives and valued for their contributions within the community.

Wye\textsuperscript{6} will also need to respond to significant change, due in part to housing developments under way which could potentially increase the population of the village and surrounding areas by about 25%, and which will inevitably influence the socio-demographic make up of the community. Additionally, the high-speed railway is also attracting more commuters to live in this part of the country.

A brief summary of the geographic profile and key community indices are shown at Appendix Eight; key features include:

- The parish has a population density of one person per hectare, but its shops and facilities serve about 8,000 residents from Wye and several neighbouring rural parishes. These cover about 100 square miles of the North Kent Downs Area of Outstanding Natural Beauty. The parish contains the village of Wye and the hamlet of Hinxhill and has a combined population of 2,300 in around 1200 households.

- A third of the parish population of 2,300 is aged over 60, and over 16% are aged over 75 years (2011 National Census).

- The two Lower Super Output Areas in Wye show extremes of both affluent and deprived households; and the two populations are diverging.

As the local population expands (and new age groups are lower than hitherto) through consultation exercises many people refer to increasing problems with a lack of coordination and fragmentation of activities. Moreover, there is for newer residents a disappointing shortage of facilities that they might have reasonably expected to be in place. This could potentially be exacerbated by a sense of disengagement by new residents and commuters who live within, but are perhaps not yet fully part of, the village community.

The village has proudly functioned as a community of place in the past and enjoyed a strong sense of place; but residents will need to work together to retain and shape an identity that is fit for our future. This plan will form a blueprint to help achieve this.

There are a significant number of residents who have lived in the village for many years, a lot of whom were born in Wye, and have a strong identity with the village and its history. There are some 65 clubs and societies in Wye, and the same group of people who have run the activities and events for years, are now considerably older. There is already concern that fewer younger people are coming forward to organise these activities, which may mean a ‘virtual decline’ of some of the well-established social fabric in our villages, which would be unfortunate.

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\textsuperscript{6} The programme covers the Wye & Hinxhill Parish, and elements of the surrounding villages that the local GP Surgery covers, but for the purposes of this submission, and ease of reference, ‘Wye’ and ‘village’ will be used to represent the whole community, irrespective of geography.
There is therefore clearly a need for a greater community focus, where proactive activity takes place to develop more community cohesion, especially across the different generations and between settled residents and newcomers. It is now recognised that if the village is to continue to function as a community of place, then ‘Our Place’ needs to be created, and it needs to look and feel good to maintain the commitment that has been created in developing this plan, this far.

**Vision for Our Place: Wye**

The aim is to promote wellbeing, a sustainable good quality of life, and an inclusive supportive and caring community, and have this managed more locally through a community cooperative, linking individuals with services more in tune with their needs. This will obviously take time and effort and may take up to three years to fully achieve.

A sound core needs to be created, which is seen as Phase One activity, and this will include a new joint ‘social-care organisation’ model, working with public sector partners, which KCC and the NHS fully support and are engaged with. Specialist advice to help develop the shape and legal structure and governance of this is now being commissioned and proposals will be considered over the next three months.

Complementary to this, ideas around funding need to get under way on the other project initiatives. These form the basis of Phase Two of our overall business plan for 2015-2018, as described below.

**Phase One**

**Turning the vision into reality**

**Setting up a village/community cooperative to eventually manage a ‘whole system’ of care for the local community**

The development of the community cooperative will require a significant level of strategic thinking and development of options and choices. This is because the ideas generated so far go further than just the initial ideas around new ways of working for social care services, for example,

- They cover a much wider range of the community.
- It will also have to synchronise with our partners’ business objectives.
- It will potentially have a higher degree of complexity and inherent financial risk, particularly in relation to the strategic commissioning intentions of public sector partners in terms of the Care Act 2014.

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7. Please see Attachment Four – what does good care feel like?
8. Some of which are seen as perhaps being ‘vulnerable’ in the care services sense
Beyond this, it is anticipated that there will be a significant number of benefits:

- An improved range of quality of life indicators – including reduced loneliness/isolation, increased confidence, resilience and ability to cope.
- Reduction in the numbers of people entering the care system.
- Reduced hospitals admissions.
- Reduced residential care admissions.
- Reduced visits to GPs.

During 2013 volunteers co-ordinated by the Parish Council identified a range of weaknesses in service provision and related issues for the over 60s which need to be addressed; to help resolve these the local community has expressed its aspiration for there to be a locally driven, locally "owned" and holistic framework for service delivery: hence the intention to create a multi-stakeholder health and social care cooperative.

This will be the vehicle by which, over time, most of the operational elements of this business plan and project programme will be overseen and governed. The expectation is that any trading surpluses will be retained by the co-operative and re-circulated for local benefit.

The ethos is to combine within the cooperative, local activity neighbourliness and volunteering with high quality trained and supported staff. This interconnectivity aims to be empowering and enabling within the community, continuously reviewing and being proactive to the needs and interests of members of the community.

Quite clearly this will be a major undertaking for the village, and a wide range of professional advice will need to be sought in advance of any significant decisions as to what sort of formal structure will be required, how this might work, how it might be taken forward, what the management board will look like, where its funding will come from, what activity will be managed etc.

Complementary to this, community research has also highlighted the wide range of existing networks of support, neighbourhood watch, the outreach home visiting and new neighbour welcoming services provided by the parish church, the 54 Neighbourhood Plan ‘patch’ workers, and the general level of “neighbourliness”.

With a modest amount of effort, a higher level of coordination of this could be achieved bringing increased community ‘value’ and, once established, this task will feature as one of the first priorities of the community cooperative. It will do this by organising a ‘time-banking’ service that volunteers can register involvement in, this resource can then be matched to some of the needs that the Community Connector Service has identified.

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9. Time banking builds social networks of people who give and receive support from each other, enabling people from different backgrounds, who may not otherwise meet, to come together and form connections and friendships. Generating social capital in this way can be an important determinant of health, wellbeing and resilience, all of which can prevent needs arising; examples include ensuring older people receive nutritional food and have regular personal contact.
Managing this community willingness to contribute to improving wellbeing and care for others blends in well with the first ‘stepping stone’ project, a **Community Connector Service**.

This will be modelled around the successful Gloucestershire Village Agent community services\(^{10}\) although it will have some differences. This is reflected in the draft job description\(^{11}\), which is being developed with KCC and the community.

What this will provide, in a local community setting, is a trusted point of contact to assist better navigation of the various existing publicly funded support services, which could have an impact in reducing, for example, the need for acute admissions and calls upon GP time for non-urgent and non-medical issues. In addition the ‘community connector’ will assist, enable and connect people within and across the range of current, active but fragmented, independent networks. For example, Wye already has some 65 Volunteer Community Services groups and activities, 54 patch workers and about 30 Neighbourhood Watch members.

This approach accords very closely with Kent County Council's commissioning intentions to reduce demand for adult social care by intentionally working to support individuals, families and communities to stay strong, thereby diverting people from formal services wherever possible, through sustainable, local, flexible, individual and community-level solutions.

**New ways of working for delivering publicly funded care services (Doing things Differently in Neighbourhoods)**

The biggest demand pressure facing local government is from ageing populations, increased longevity, and rising expectations. Unfortunately this has coincided with dramatic public-sector budget reductions. Publicly funded social care budgets are largely allocated to funding home care packages or care home placements, which in many cases are provided by large-scale private sector providers.

Kent County Council shares with Wye the concern that this combination of factors is not really delivering long-term value for users, and is also not socially and economically sustainable\(^{12}\).

The council is very keen to work with the newly established community cooperative to explore co-production techniques, which could support people to remain active, stay well, and remain connected to their communities. Collectively, they form two shared objectives:

- Finding better ways to encourage the self-management of care, thus enabling people to find more personalised services and support solutions; ideally, they can also prevent or delay the need for statutory assessment and services.

- To explore viable alternatives to traditional social care provision, which is more locally accountable to the communities, and give increased choice and control to individuals and their families.

\(^{10}\) Please see Attachment Five – The Gloucestershire model for community services
\(^{11}\) Please see Attachment Six – Job description for the OP:W Community Connector Service
\(^{12}\) Please see Attachment Fourteen – KCC Building Community Capacity

**OUR PLACE : WYE BUSINESS PLAN 2015 – 2018**
In terms of locally funded public services, currently there are around 28 people who receive an on-going support package. The total annualised average spend on this by KCC is over £358,000. In addition to this there will be many people who fund their own care, for example, KCC funds around 4% of the village’s 760 elderly residents, and many residents are over sixty-five, with 54 people aged ninety or over.

Over time, it is quite feasible, subject to the right governance arrangements, that some of this funding could be made available to the community cooperative to manage and coordinate care services. To help achieve this, KCC will work with OP:W to develop the business case to support this initiative.

The current arrangements for care and support is via a range of different contracted and grant funded providers. The residents in receipt of support have a range of needs. Most are older people but some are people with physical, sensory and learning difficulties and people with mental health needs.

Collectively, Wye and KCC believe that it could be possible to provide a more tailored support to match what people want, more cheaply, through transferring the managing of existing care services to the community cooperative model. Research shows that this approach allows the flexibility and freedom to innovate in order to meet local people’s needs, as well as increasing the efficiency of service delivery through greater employee engagement.

**Phase Two**

**Activity**

A Community Cafe (food – eating & socialising)

As highlighted by the informal study undertaken last year, there are no opportunities for people to gain access to nutritious, value for money lunches aimed at “older people”.

There have been a range of initiatives in the past in the village, including voluntary lunch clubs, meals delivered akin to “meals on wheels” from the local primary school, even concessionary meals for seniors provided by local public houses. Each of these has now ceased to operate.

It is firmly believed that opportunity for eating in a social context, access to nutritious, value for money meals is a crucial element of the programme. It helps reduce social isolation, encourages social inclusion, and provides a focus, and is in essence, another social space, but with a clear purpose. Many people living alone often do not go to the trouble of cooking proper meals. The report also indicated the number of people without access to cars; and frailty does not make it easy to shop by public transport. We have reviewed existing arrangements and intend to research different models and opportunities, which are realistic and cost effective.

There is strong local support for this area of activity; many people recall that Imperial College (currently closed and disused) allowed the local community access to its dining rooms. The emerging vision of this venture is to establish a ‘community cafe’ (emphatically not an older people’s lunch club); to strive to create a vibrant ‘age inclusive’ space that people wish to be part of and visit, as the heart of village life.
NHS colleagues also take the view that the healthcare cost of managing malnourished patients was more than twice that of managing non-malnourished patients, due to increased use of healthcare resources\(^\text{13}\). After adjusting for age and comorbidity, malnutrition remained an independent predictor of mortality. Malnourished people saw their GP twice as often, had three times the number of hospital admissions and stayed in hospital more than three days longer than those who were well nourished.

**A Community Hub (Information and Information technology)**

Currently the branch library provides some aspects but is severely constrained by space. The library has been a keen partner to examine what might be possible; this is closely aligned with its own future development. The emerging vision is to explore how to draw together the existing programmes of support, and re-shape the current facilities to promote more digital inclusion amongst older people\(^\text{14}\).

**Extending the Community Connector ‘networks of support’**

Once the connector service has been established and bedded down, this would be taken further through a second stage of development, by building upon the existing base of community support, and to also explore how to develop more strategic, inclusive, and better-coordinated information advice and advocacy services, which in turn will lead to creating a more integrated and forward looking ‘care & wellbeing support’ system.

**Enhancing care services in the community; designing new models of care planning and delivery**

One clear feature of an age-friendly society would be the consistent involvement of older people in the governance and co-production of services, initiatives and activities, and the OP:W approach to improved health and wellbeing has this at its centre.

Creating the community cooperative will be an essential infrastructure step towards this, but over time, it is intended to go further than just arranging a new way to manage what exists today, particularly for those individuals who fund their own care, and to provide better levels of support for the unpaid carers in our community.

**Intergenerational opportunities**

Formal organisational and institutional structures tend to create and encourage generations being apart. This project aims to explore different ways to organise public service and related community activity and be proactive in creating intergenerational opportunities and ways of doing things, including providing services or short-term programmes to promote understanding across generations and build a more cohesive community. Developing the approach to the WHO Age Friendly Village is a key part of this.

Other suggestions so far include running arts focussed courses, creating a Dementia Friendly village, an open air exercise park for the elderly, running a regular cinema, taking part in the Shared Lives\(^\text{15}\) initiatives etc.

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\(^{13}\) http://www.malnutritiontaskforce.org.uk/resources/malnutrition-factsheet/

\(^{14}\) Please see Attachment Seven – the new information age, and old-age

Phase Three Activity

Measuring outcomes

The Programme Management Group will also agree what will be monitored in the Programme and how this will be undertaken, for example, how regular reporting on progress with the planning and delivery of key elements of the overall programme will be achieved. This will include finalising a benefits realisation programme. The primary costs and socio-demographic data that will provide the basis for this will be agreed with stakeholder partners at an early opportunity.\(^{16}\)

The Centre for Health Services Studies at the University of Kent will be engaged to develop a framework for the evaluation of the programme aims and objectives in this plan.

It’s crucial that measures of success significantly reflect:

- The involvement of local people (especially the users of services) to help define the plans and projects that will be delivered.
- That the benefits identified in the programme are measurable and achievable.
- Measuring how much of the ‘what good looks like’ has been achieved.
- Assessing how far we have got in meeting the WHO criteria for Age-friendly Villages\(^{17}\).

In addition to this, the advice and involvement of Health Watch Kent will also be sought. This is a new, independent consumer champion for health and social care in Kent. It is an independent organisation that is commissioned by the KCC Consultation & Engagement Division.

Stakeholder Engagement\(^{18}\)

Securing buy-in

From the community

The Our Place: Wye project was launched at a public meeting in May 2014, with some 200 residents present. Since then the Library has been the focal point for information, which has hosted three “drop-in” sessions. The Parish Council e-newsletter and Parish Magazine also include regular articles providing the background to the project and progress with developing the plan.

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16. Please see Attachment Eight – Base Line Data and http://www.pssru.ac.uk/project-pages/unit-costs/2014
17. Please see Attachment Nine – WHO standards for Age Friendly villages
18. See Attachment Ten for member details
There is now also an OP:W specific website with opportunities for feedback and comment on the programme: http://www.ourplacewye.org.uk.

There have also been four three-hour drop-in sessions at the village Farmers Market. The Kentish Express newspaper and the Parish Council’s website also publicised the Our Place: Wye events. As a result of the publicity and word getting about, there are around seventy-five local individuals who have registered their interest in helping shape the project; this has led to the setting up of an informal steering group, and a thematic advisory group. Over one hundred villagers have now also attended the working lunchtime meetings in May, November, January and February.

Volunteer members for the Programme Management Group to take the overall business plan forward are now being sought to formalise strategic direction, without losing momentum from the activities mentioned above.

From Partners

The ambition is to develop a new relationship between the local community, the voluntary agencies and the ‘state’ (i.e. the Local Authority’s services to individuals and communities, and the NHS – commissioning support and GPs). Good partnership work with the main agencies providing care to the community is essential to achieving this. There is also a very active community volunteer services network in Kent, and the local branch in Ashford will also take part in the programme, alongside other volunteer groups and organisations, for example, Social Enterprise Kent and the Kent Association of Rural Communities.

From the Local Authorities/Authority Perspective

The ‘new ways of working’ described earlier is an approach that fits very closely with Kent County Council’s commissioning intentions and community capacity building, to reduce demand for adult social care by intentionally working to support individuals, carers, families and communities. In their view, keeping local engagement strong diverts people from formal services wherever possible, through sustainable, flexible, individual and community-level solutions.

They have been fully engaged so far, and their continued organisational buy-in is crucial to the financial viability of the proposals in the implementation plan, as well as helping shape the plan, identifying its associated risks, and increasing understanding as to how OP:W ambitions might be convergent with their commissioning intentions.

From the NHS Perspective

The NHS Ashford Clinical Commissioning Group Strategic Commissioning Plan 2014 – 2019 has also recently been published and this recognises that compared to the rest of England, Ashford has a higher than average population between the ages of 5-14, 40-49 and 60-69. Alongside the importance of health promotion and prevention for the younger generation, ACCG must also plan for a 16% rise in 65+ age groups.

19. Please see Attachment Fourteen – Community Capacity Building briefing note
Ashford’s population is ageing due to lower birth rates and higher life expectancy over the past few decades. The most immediate implications for health services are the increasing need for health and social care for elderly people at home or in care homes, which require more staff and more funding.

Some of the key elements of the Our Place:Wye fit quite closely with the strategic commissioning changes needed to help the NHS manage these increases in demand for services.

For example, the NHS recognises, like OP:W that improving services for older people requires a ‘whole system’ thinking approach across the public sector to consider each component of care, since many older people in particular use multiple services, and the quality, capacity and responsiveness of any one component will affect others.

Working with NHS partners, there are some key success criteria for healthy, active ageing and supported independence to which OP:W may be able to contribute within the project delivery activity, including:

- Living well with simple or stable long-term conditions.
- Living well with complex co-morbidities, dementia and frailty.
- Rapid support close to home in times of crisis.
- Good acute hospital care when needed.
- Good discharge planning and post-discharge support.
- Good rehabilitation and reablement after acute illness or injury.
- Planning for high-quality nursing and residential care for those who need it.
- More choice, control and support towards the end of life.
- A coordinated approach to integration to provide person-centred care.

It is collectively recognised that transforming services for older people requires a fundamental shift towards care that is coordinated around the full range of an individual’s needs (rather than care based around single diseases) and which genuinely prioritises prevention and support for maintaining independence. This aspect is a major feature in the CCG business plans 2014-2019.

**Governance**

As the accountable body and sponsor for OP:W, the Parish Council, through a management sub-committee, continues to have responsibility for the programme until new or alternative local funding arrangements for projects has been achieved, or the community cooperative is established.

A broad based Programme Management Group (PMG) will now have oversight and ownership of the business plan, and its terms of reference are shown at Attachment One.

The stakeholder members of the PMG will also have their own internal accountability procedures and processes to guide them. For example, KCC has internal management and political processes, as well as ensuring existing service users are informed and enabled to voice their views about changes proposed. Similarly, the NHS (and Wye Surgery) have their own protocols for informing and seeking views upon any proposed changes both internally and with patients and service users.
In terms of project management, as and when each of the projects are individually commissioned, a PMG member will take lead responsibility for it, and a project manager would be identified to take responsibility for delivering the project objectives, supported by a project plan covering resources, timelines, risks and dependencies, reporting arrangements etc.

Over time, as project delivery gets under way, these arrangements will need to be reviewed to make sure that they remain fit for purpose. It is anticipated that once the community cooperative has become well established, it takes over responsibility from the PMG for the overall programme, absorbing individual projects as and when appropriate, and ‘inheriting’ management experience through membership arrangements.

Outline implementation plan

The outline programme plan has a series of major components, or projects: the overall programme delivery strategy is operating within an April 2015 – March 2018 timeframe and is shown on the following page.

The delivery strategy is highly dependent upon progress made with key public sector partners in, for example, negotiating new style commissioning budget arrangements and with developing complementary approaches to inward investment, which could be from a wide range of new sources.

The intention is that for each of the project areas a project lead from the PMG will be identified, a lead project manager appointed, who could be supported by a community advisory team of volunteers if appropriate, and a detailed project plan would be developed.

This would follow industry standard project management best practice guidelines, but tailored to suit our local circumstances, so that it would be easy to follow what's happening, rather than being ‘top-heavy’ with process and paperwork.

The project manager and sponsor will work together to create a realistic plan, and identify: what it is trying to achieve; by when; who is responsible for what; what is needed to achieve this; how it is going to be done; and how we will know what is going on.

This will be briefly described in a plan under the following main headings:

- Its scope and objectives.
- The timeline of operation, showing a clear start and finish.
- Resources: required and allocated.
- A budget, with financial control processes identified.
- The stages and phases of the project where appropriate, with review points.
- Risks and dependencies.
- The governance arrangements, describing responsibilities and accountabilities.
- The way it would regularly report on progress and achievements.
- Project closure arrangements.

The plan does not need to be over-long or complex, but should provide transparency from the outset, so that it can be easily monitored.
**Project implementation timeline**

![Timeline Diagram](image-url)

**Project Area**

- **Community Connector Service**
  - Plan
  - Implement
- **Social enterprise**
  - Plan
  - Implement
- **New ways of working - publicly funded care services**
  - Plan
  - Implement
- **Community Café/food hub**
  - Plan
  - Implement
- **Community IT Hub/Training**
  - Plan
  - Implement
- **Extending the community Connector Service**
  - Plan
  - Implement
- **New models of care planning and delivery**
  - Plan
  - Implement
- **Intergenerational Activity in the community**
  - Plan
  - Implement
- **Evaluating Projct Outcomes**
  - Plan
  - Implement

**Bold=provisionally funded and priority activity**
**Value for money**

Being able to demonstrate value for money will be a consistent theme running across, and through, the project areas and this will occur in three dimensions: individually at the project level, collectively as they create synergy throughout the programme and more formally through Phase Three, the external monitoring and audit programme.

Nevertheless, OP:W is committed to finding ways to develop a consistent, and recognisable value for money approach and the Programme Management Group will work closely with the independent monitoring agency to describe this prior to each project start-up, and over the life-cycle of each project.

Cost & Benefit Analysis for Phase One Projects

**Table One - Costs & Benefits**

<table>
<thead>
<tr>
<th>Project Area</th>
<th>Funded from</th>
<th>Costs</th>
<th>Possible Full Year Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Connector</td>
<td>WPC</td>
<td>£18,000</td>
<td>£49,600</td>
</tr>
<tr>
<td></td>
<td>KCC</td>
<td>£14,000</td>
<td>280,000*</td>
</tr>
<tr>
<td>Community Cooperative</td>
<td>OP:W</td>
<td>£6,800</td>
<td>£85,000</td>
</tr>
<tr>
<td></td>
<td>KCC/NHS</td>
<td>£22,500</td>
<td></td>
</tr>
<tr>
<td>New ways of commissioning public services</td>
<td>KCC</td>
<td>£22,500</td>
<td>£25,000</td>
</tr>
<tr>
<td></td>
<td>OP:W</td>
<td>£4,800</td>
<td></td>
</tr>
<tr>
<td>Overall</td>
<td></td>
<td>£88,600</td>
<td>£439,600</td>
</tr>
</tbody>
</table>

Notes: WPC = Wye Parish Council; KCC = Kent County Council; OP:W = Balances from the originally funded Our Place Wye budget allocation.

*Some of these benefits are also attributable to the NHS.

More details on the costs and benefits are available at Attachment Thirteen.

Provisional Costs: Year One

For the priority Phase One projects, these costs will be met from existing OP:W, Parish Council or in-kind, through KCC budgets. These figures are all provisional; the balances in the OP:W budget can fund project management and professional advice for setting up the community cooperative; WPC can also potentially fund the community Connector Services staff and office support costs. The KCC costs are predominantly in-kind officer time for the community warden pilot, asset-mapping activity and assigned strategic management/commissioning resources.

Outline Benefits

In terms of potential benefits, these have been identified for the projects in Phase One in two areas, firstly, that of public service value, and secondly, the potential cost savings to the NHS and Local Authority Social Care services. These are described below for reach project area and in more detail in Attachment Thirteen.
Community Connector Service

The value for money assumptions are based on the Gloucestershire experience, whereby the overall benefits model suggests for elderly customers of the service, a spend:gain ratio of £1:£3.10 is achievable in terms of public service value. For OP:W that would be an overall equivalent target of nearly £100,000 pa, subject to further evaluation of key elements. A 50% risk factor has been built into the estimates shown above to take account of the OP:W start-up process.

The Gloucestershire Service overall NHS and Local Authority benefit for the community agent per individual engaged with these services is estimated to be up to £7,365 pa, depending on circumstances. These relate mainly to the range of public services involvement reducing or even being avoided, and increases in state benefits, or increased access to reducing fuel poverty measures for individuals.

However, Gloucestershire is a well-established service, but modest gains for the OP:W community and public sector partners could be established quite quickly, and then build up over time to something more substantive. The main benefit areas that would be targeted are seen initially in:

[i] Finding ways to achieve a 20% increase in falls prevention, thus reducing hospital admissions/A&E treatment, and the likely need for discharging into residential care for recovery.

[ii] Reducing loneliness and social isolation, which affects the health and wellbeing of individuals and reduce the risks associated around:

- High blood pressure.
- The onset of disability.
- Cognitive decline – one study concluded that lonely people have a 64% increased chance of developing clinical dementia.
- Being more prone to depression.
- Making more GP visits, reducing a higher use of medication.
- Earlier entry into residential or nursing care.

Using the socio-demographic data at Attachment Eight, combined with the Gloucestershire experiences, it would seem reasonable to assume improved circumstances for up to 10% of the elderly population, which equates to helping around seventy-six individuals per year, which is less than two per week.

This tends to suggest that with a potential saving of around £7,365 per individual, an overall full year benefit target of around £50,000 is possible; applying a 50% risk factor to this to take account of the OP:W start-up process still means there is a substantial incentive of around a £280,000 pa benefit target to get the service under way.

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20. An extract from the Gloucestershire CBA is shown at Attachment Five – Village Agents
21. This equates to 40 individuals aged 60, and a further 36 individuals aged over 75.
Setting up the village/community cooperative

The community wants to become more engaged and empowered to identify priorities for improving care and wellbeing services, and it wants to get more involved in the design and delivery of new and existing care services. It wants to do this by:

- Involving people directly in decisions about the future of health and care services in the community.
- Encouraging community volunteering through new volunteer programmes and better support for volunteering.
- Encouraging community endeavour through local projects and support programmes.

The setting up of the village cooperative will be fundamental to achieving this; once established, one of the first initiatives it wants to get under way is to create a ‘time-bank’ for individuals to volunteer their time to support others. The administrative support allocated for the Community Connector office will initially fund and coordinate this. The ASHE/ONS data from Volunteering England\(^\text{22}\) estimates that volunteering for OP:W would have a public service value of £14.80 ph.

The estimates for the first year of Time Banking suggest that fifty volunteers would offer up to five hours per week to support improvements in care and wellbeing in the village. This equates to a value of around £170,000. A 50% risk factor has been applied to this estimate to take account of the OP:W start-up process.

New Ways of Commissioning Public Services

KCC take the view that by moving their commissioning strategies towards co-production, and developing the options for transferring responsibility for currently managed services to the community cooperative, service costs could be reduced within the range of 10-12%, potentially giving a savings profile of around £50,000 pa for their client base in the community, which incidentally, is bound to increase over time as more individuals probably become eligible for state funded care. A 50% risk factor has been applied to this estimate to take account of the OP:W start-up process.

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\(^{22}\) www.volunteering.org and www.rgtb.org.uk/index.html give more detail on this
Major cost areas for the Phase Two projects

**Capital costs**

One off investments, such as new or refurbished buildings and facilities are now being actively considered. This initially has most bearing upon the Community cafe/Community IT Hub aspects. Research will be needed to review all opportunities available and over different timescales. Already some buildings and possible options have been proposed and the new plans for the Village Hall potentially offers exciting opportunities in a wide range of areas.

However there would be a need to undertake surveys and commission professional estimates for bringing any sites up to legal standards. The key to the way forward is to build upon what is currently available, but could be ‘re-aligned’. To help achieve this, KCC have offered in-kind officer time to create an asset map of the village, and this work will be undertaken in the near future.

**Revenue costs**

As each of the key projects/initiatives in Phase Two gets under way, it will be necessary to assess the costs and funding required to get them to completion by developing a ‘mini’ business plan or short proposal for evaluation by the PMG. This would describe the feasibility, management arrangements, outline costs, outcomes, etc. Occasionally, they may require further work to get them to the full approval stage, which the PMG may also agree to fund, subject to prioritisation of resources etc.

**Summary & Conclusions**

This plan has documented a great deal of individual requirements identified through extensive consultation undertaken in the village over recent years and particularly in recent months. To reflect these feedback sessions, the Logic Model\(^{23}\), which has been widely accepted within the community as a good ‘shorthand’ blueprint and point of reference, where it identifies ‘what does good look like’ has been updated.

This business plan clearly identifies the way forward through a phased project management approach for the community to achieve its vision, but acknowledges that in Phase Two, more detailed work will be required in terms of developing the cost benefit analysis for project areas identified in the plan.

The exception to this will be the projects centered on Phase One which covers the creation of the community cooperative style organisation, the community connector service, and the new ways of working to deliver a new style of publicly funded health & wellbeing services for the village.

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\(^{23}\) See Attachment Eleven – the OP:W Logic Model.
Discussions are currently underway with key stakeholders to help them re-align their strategic commissioning intentions, linked to their local implementation of the Care Act, to get these projects under way.

As the cost benefit analysis showed earlier, even with modest gains being targeted, there is a real opportunity to provide community benefit from getting project activity under way as soon as practicably possible, and there is a commitment from stakeholders to provide in-kind resources to support this.

Getting the project work under way and keeping it on track will require good governance, as well as sound financial management, and well managed resources. The setting up of the Programme Management Group made up of key stakeholders presents a significant opportunity to take the work forward, ready for launch in April 2015.
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Main Purpose of Group

The purpose of the group is to oversee the development and implementation of the Our Place Wye Programme, as described in more detail in the OP:W Business Plan. The main aim of this plan is to improve the health and wellbeing of an age-inclusive community that is both sustainable and value for money.

This improvement will be achieved through the planning and delivery of a series of projects listed below and described in more detail in the Business Plan. The group will co-ordinate and commission the individual, but linked projects through a programme management approach and by working in partnership with key stakeholders.

The group will identify a person for each project to take lead responsibility for it and they will report on progress with the project activity to the overall group.

Main Tasks of the Group

To act as the primary point of contact for OP:W through engagement and communications with the community and stakeholders to keep them informed of progress.

To provide leadership for the development and delivery of improvements in the health and wellbeing of the community.

To provide an appropriate forum for the community to work with stakeholder partners on the delivery of care services and other initiatives that will enhance the health and wellbeing of the community.

To agree the Business Plan for OP:W and take overall responsibility for it, including delegating a member for coordinating its content.

To consider what investment and funding arrangements might be required for supporting the business plan, and developing strategies to achieve the plan.

To have oversight of the projects within the business plan (please see below).

To identify and appoint lead members of the group to take the lead on projects agreed for delivery within the business plan.

To encourage volunteers to participate in project activity or provide specialist advice for specific project activity.
To help identify synergies between projects within the plan and with developments and organisations both outside and within the community.

To offer advice when appropriate on the direction of individual projects and agree any additional or new priorities for the business plan.

To appoint a Programme Manager if needed, to deliver the full range of projects within the business plan.

To appoint project managers for individual projects where appropriate.

**Membership of the Group**

Membership is open to all residents in the community and key stakeholders, e.g. KCC, Ashford North CCG, Wye Surgery, Parish Council etc. Expressions of interest for joining the group will be invited at the earliest opportunity.

A membership of 10-12 is proposed to represent the range of stakeholders, a wide body of opinion, the diverse make up of the community, and to provide a pool of expertise for sponsoring project activity.

The Group will elect a Chair.

Other specialist members for specific advice, or project area expertise and input are expected to be invited to join the group where appropriate, and by agreement of the Chair.

**Working Arrangements**

To take account of the interests of all represented parties in the group,

- The group will meet on a regular basis to review progress with the delivery of the Business Plan and to oversee progress with project activity.
- The group will meet on a regular basis with the respective project leads members, who in consultation with appropriate project managers, will produce regular reports for consideration.

The Parish Council remains the accountable body for OP:W until April 2015, or a new organisational body is created, and will provide support and general advice to the group, for example.

- Agreement of the agenda with the Programme Group Chair.
- Organising meetings.
- The proper and timely preparation and circulation of papers.
- Keeping a proper record of the meetings and all decisions and actions to be taken forward.
- Advising the Group and its Chair on matters of best practice, for example on Programme Management etc.
- Financial and book keeping administration, where appropriate.
- Acting as the employing and accountable body, until the arrangements for a different organisational structure is established.

The Group will be considered quorate with the Chair and at least three other members present, one of which must be a stakeholder representative. All members are expected to attend 75% of meetings.
The group will be run on consensual lines, but ultimate decision-making responsibility will rest with the Chair, supported by at least two other members and a stakeholder representative, if appropriate.

**Initial Priorities for OP:W**

The following areas are seen as Phase One of the programme and have provisional funding.

- Implementation of the Community Connector Service in partnership with KCC.
- Working with the community and stakeholder partners to develop the strategy and implementation plan for the Village/Community Co-operative.
- Developing new ways of working for delivering publicly funded care services.

**Note**

There is also an over-arching task for the group to evaluate what funding opportunities may be available for delivering the business plan and associated projects, and securing the funding for specific project resources where appropriate.
Attachment Two

Briefing Paper On Social Cooperatives

This briefing note is a discussion document for the community and Parish Council describing some of the options open to OP:W on the setting up of a new style organisation to oversee and manage the proposals for innovative services in the 2015-2018 Operational Plan.

The basis on which the community wants to have an organisation like this established is:

- To create improvements in community health and well-being, and this includes providing ‘fair-care’ services.
- To operate independent businesses which need to be individually self-sufficient in the medium-longer term to survive.
- To have the trading of these enterprises underpinned by values, which are fundamental to the community.
- To set up a member-based organisation to give members, customers, staff and suppliers a real say in the running and ownership of the organisation.

The debate about comparisons of different legal forms, such as Community Interest Company, Community Benefit Society, mutual, co-operative, and employee-ownership can be confusing. The essence of the matter is (a) whether an organisation is intended to exist for a private purpose or a public/social purpose, and (b) what sort of ownership and governance arrangements are in place, and how appropriately they underpin and protect private or public assets and resources.

What is clear is that whatever we chose to do, we need to establish sound constitutional arrangements within a clear legal structure; this will ensure that we are legally and constitutionally committed to carrying on the business of the ‘social enterprise’ for the benefit of the community, which we are serving, and not for private benefit.

However, it is important to recognise that legal and constitutional arrangements are a means to an end, not an end in themselves. They exist to provide a framework for the holding and operation of a business or service, and need to be designed to enable that business or service to succeed in its vision, and its strategic objectives.

Examples of different Legal structures for ‘social enterprises’

**Community Interest Company (CIC)**

This is a relatively new legal structure created by legislation in 2004, with its own regulatory body, which provides legal assurance that the business is being carried on in the interest of the community, rather than for private benefit. What is this assurance?

First, before a community interest company can be registered, the Regulator must be satisfied on the basis of the Community Interest Test that their activities are being carried on for the benefit of the community.
This must be re-confirmed annually by the directors by means of a community interest report. The Regulator has a range of enforcement powers in the event, for example, of failure to continue to satisfy the community interest test.

Once registered, there are restrictions in the constitution prohibiting the distribution of assets (ordinary limited companies are not so restricted, and can therefore operate for private interest).

Subject to certain exceptions, a so-called “asset lock” prohibits any distribution of assets including on a solvent winding-up, and puts a limit on any dividend payable to shareholders.

Whilst in practice this allows distribution of profits, express commitments have to be in the constitution to retain profits for the benefit of the community. Furthermore, no member or shareholder can hold more than one share, making it impossible for any one shareholder to control the organisation.

Community Benefit Society (CBS)

A community benefit society can only be established if the Registrar is satisfied that the business is to be conducted for the benefit of the community.

In order to be registered, the constitution must prohibit any benefit going to members, either by way of dividend out of trading surplus, or by way of capital distribution on a solvent winding-up. As with the community interest company, there is an asset lock to protect accumulated reserves, ensuring that all surplus is retained and applied for the benefit of the community, and not for the private benefit of members.

There are two major types of CBS

[i] Industrial and Provident Societies, which provide services to people, other than its own members. The organisation must be run primarily for the benefit of the community at large, rather than for the members of the society. Profits must also be ploughed back into the organisation, rather than being distributed to members, and the business must demonstrate that there are ‘special reasons’ why it should be registered as an IPS rather than a company under the Companies Act.

[ii] Cooperatives, which are run by and for the benefit of its members, with the majority of surplus profits being retained within the enterprise in order to maintain it and provide social value.

The main objective of a co-operative is not to make money, but to finance its own growth in order to benefit its members as a direct result of their participation in the business.

Membership

Membership of the social enterprise would be open to all residents of Wye, their carers and families. Membership could also be open to employees of the businesses that the social enterprise may wish to create and run, key ‘suppliers’ of services, public sector organisations that are funding some of these services and key partners. It hasn’t been decided yet, but it is traditional that every member holds a £1 share, and nobody may hold more than one share.
Ownership and Governance

The choice of legal structure provides a base-line for understanding the nature of the organisation (i.e. community interest company, community benefit society), but it is the ownership and governance arrangements which establish the day-to-day basis on which it is run.

The members are the owners in the sense that nobody else owns the organisation – neither the state, nor investors, nor any other organisation and they exist as members on behalf of the wider community.

The members derive no financial benefit from being a member. This is not “John Lewis public services”, where the annual profits are shared out amongst the staff at the end of the year. It is a form of ownership in which the members are custodians for the time being of this organisation – making sure it delivers what it is supposed to do.

Only the members can agree to any changes to the constitution; they also recruit non-executive directors and appoint service managers to run things on their behalf, who are in turn accountable to the members for the running of the organisation.

Being independently owned, but committed to a public purpose, the ‘social enterprise’ can be thus clearly be regarded as neutral – an “honest broker” – and not unduly influenced by health service commissioners, local authority managers or others.

All of the organisational ‘shapes’ mentioned above (CIC, CBS etc) have a similar basic framework, namely members, who elect the majority if not all those who serve on a representative body; this body in turn, appoints a separate board of directors comprising a majority of non-executives, and a balance of lead managers, who ‘run the business’ of the social enterprise.

This more modern approach keeps the representative function outside the boardroom, but specifically enables the interests of members to be expressed and to carry influence via the representative body. The board of directors is then comprised solely of those who fulfil criteria for skills and experience, either as appointed (employed) executives, or as independent non-executives.

It represents a significant development from more traditional membership led models, where it was common for the board of directors to include members, acting as representatives and stakeholders. Without a clear separation of roles and responsibilities, these stakeholder boards can be problematic with conflict of interest issues, and an inability for the stakeholders properly to promote the viewpoint of each and all of those they represent, particularly given their additional duties as service managers and directors.

Roles & responsibilities

The structure and role and responsibilities of the representative body is expected to evolve over time as the start-up model is designed to accompany a change in culture and organisational practice from the public sector, towards a more collaborative and engaging approach with the community, as well as to develop community based services and introduce innovating new ideas and services.
It seeks to bring the key constituencies of interest of that community inside the organisation and its governance, enabling them to work together to optimise the resources and opportunities available, in the pursuit of the organisation's ultimate aims.

The number of elected members to this new body could initially be around six-eight representatives, but it could potentially grow in time to perhaps no more than twelve, subject to the range and scope of activities and services it might ultimately cover.

The key role of the representative body is to influence the direction and strategy of the organisation as a whole, bringing into the formal governance arrangements the viewpoint of key constituencies of interest. In this way, it links those carrying ultimate responsibility for running the business to those actually delivering the services on the ground and those receiving the services.

The specific roles of the representative body therefore include: recruiting non-executive directors, appointing and working with the board of directors in developing strategy and future plans, overseeing membership strategy, appointing and removing non-executive directors, and working in other ways to support the board of directors. The representative body receives regular reports on the progress of the business, and with the wider membership it provides the mechanism by which the board of directors is held to account.

The board of directors would typically consist of around six – eight individuals, depending on the scope and range of services being provided by the enterprise, and could evolve over time in terms of numbers. A non-executive director usually acts as chair of the board, alongside perhaps up to another three-four non-executive directors, but enough to establish a majority position. Lead service managers of services would act as the other board directors. Some serious consideration would also need to be given as to how legal, finance and personnel issues etc. would be managed effectively.
### Phase One

**Project Areas**

<table>
<thead>
<tr>
<th>Scope &amp; Objectives</th>
<th>Timetable</th>
<th>Resources</th>
<th>Estimated Costs</th>
<th>Funded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developing the community cooperative</td>
<td>2015</td>
<td>Project management, Professional advice</td>
<td>£ 4,800 £22,500</td>
<td>OP:W KCC officer time</td>
</tr>
<tr>
<td>Establishing the community connector service</td>
<td>2015</td>
<td>‘Community Connector’, Support services and facilities</td>
<td>£18,000 £14,000</td>
<td>WPC Funded by KCC officer time</td>
</tr>
</tbody>
</table>

**New ways of working for publicly funded services**

<table>
<thead>
<tr>
<th>Scope &amp; Objectives</th>
<th>Timetable</th>
<th>Resources</th>
<th>Estimated Costs</th>
<th>Funded</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2015-2016</td>
<td>Project management</td>
<td>£4,800 £22,500</td>
<td>OP:W Funded by KCC officer time</td>
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### Phase Two

**Project Area**

<table>
<thead>
<tr>
<th>Scope &amp; Objectives</th>
<th>Scope &amp; Objectives</th>
<th>Resources</th>
<th>Estimated Costs</th>
<th>New funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establishing a community technology and IT training hub</td>
<td>2015</td>
<td>Project management, Support services and Facilities</td>
<td>£4,800 £10,000</td>
<td>New funding needed Tudor Trust grant?</td>
</tr>
<tr>
<td>Establishing the community café/foodhub</td>
<td>2015</td>
<td>Project management, Support services and Facilities</td>
<td>4,800 £10,000</td>
<td>New funding needed Awards for All grant?</td>
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<tr>
<td>Extending the community connector network: Developing more inclusive, and better-coordinated services</td>
<td>2016-2017</td>
<td>Project management and existing Community Connector services</td>
<td>£4,800 £4,800</td>
<td>KCC officer time Funding required</td>
</tr>
<tr>
<td>Designing new models of care planning and improving existing services for ‘self funder’</td>
<td>2015-2018</td>
<td>Project management</td>
<td>£4,800 £4,800</td>
<td>KCC officer time Funding required</td>
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### Phase Two

<table>
<thead>
<tr>
<th>Project Areas</th>
<th>Scope &amp; Objectives</th>
<th>Timetable</th>
<th>Resources</th>
<th>Estimated Costs</th>
<th>Funded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Creating the Intergenerational Activity in the community</td>
<td>To evaluate how age-independent activity can reinforce community cohesions</td>
<td>2016-2017</td>
<td>A more detailed statement of requirements will be developed in mid 2015</td>
<td>A more detailed statement of requirements will be developed in mid 2015</td>
<td>New Funding required</td>
</tr>
</tbody>
</table>

### Phase Three

<table>
<thead>
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<th>Project</th>
<th>Scope &amp; Objectives</th>
<th>Timetable</th>
<th>Resources</th>
<th>Estimated Costs</th>
<th>Funded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measuring Outcomes</td>
<td>Designing continuous improvement programme [CIP] for measuring success of projects</td>
<td>2015-2018</td>
<td>Independent advice requires to be commissioned</td>
<td>£1,000</td>
<td>Built into new project budgets</td>
</tr>
</tbody>
</table>
Attachment Four

What should good, person centred care, feel like?

We asked our community about this, and this is what they told us\textsuperscript{24}

“I have the information and support I need in order to remain as independent as possible and manage my own conditions.”

“I am not left alone to make sense of information. I have help to make informed choices if I need and want it.”

“I have access to easy-to-understand information about care and support, which is consistent, accurate, and accessible, up to date.”

“I am supported to use it to make decisions & choices about my care & support.”

“I can speak to people who know something about care and support and can make things happen. I am told about the other services that are available to someone in my circumstances, including support organisations.”

“I know where to get information about what is going on in my community.”

“I feel valued for the contribution that I can make to my community.”

“I tell my story once. I have one first point of contact. They understand both me & my condition(s). I can go to them with a question at any time.”

“Information is given to me at the right times. It is appropriate to my condition & circumstances. And is provided in a way that I understand.”

“I know the amount of money available to me for care and support needs, and I can determine how this is used (whether it’s my own money, direct payment, or a ‘personal budget’ from the council or NHS).”

“I have access to a pool of people, advice on how to employ them and the opportunity to get advice from my peers.”

When I use a new service, my care plan is known in advance & respected.

“I can decide the kind of support I need and when, where and how to receive it.”

“I have good information and advice on the range of options for choosing my support staff.”

\textsuperscript{24}. Extract from recent KCC Strategic Commissioning Consultation exercise
“I feel safe, I can live the life want and I am supported to manage any risks. I know what is in my care & support plan and I know what to do if things change or go wrong.”

“I feel that my community is a safe place to live and local people look out for me and each other.”

“I have as much control of planning my care & support as I want.”

“I have considerate support delivered by competent people. They help me to make links in my local community.”

“I am in control of planning my care and support. I can decide the kind of support I need & how to receive it.”

“I have a clear line of communication, action and follow up. When something is planned, it happens.”

“I have care and support that is directed by me, I am as involved with discussions & decisions about my care support & treatment, and it is responsive to my needs.”

“I have help to make informed choices if I need & want it; my family or carer is also involved in these decisions as much as I want them to be.”

“I have opportunities to train, study, work or engage in activities that match my interests, skills, abilities.”

“All my needs as a person are assessed & taken into account; I am listened to about what works for me, in my life.”

“I am supported to understand my choices & to set & achieve my goals.”

“I have regular reviews of my care and treatment including comprehensive reviews of my medicines, and of my care and support plan.”

“I can plan ahead and have systems in place to keep control in an emergency or crisis.”

“My carer/family have their needs recognised & are given support to care for me.”

“I always know who is coordinating my care.”
Attachment Five

Village Agents – Gloucestershire

Gloucestershire Village and Community Agents
Cost/Benefit Analysis

This attachment covers the Executive Summary and Table Twenty Four from a major report published by Gloucestershire Rural Community Council, November 2014, in partnership with Gloucestershire County Council and Gloucestershire Clinical Commissioning Group.

The report, which is provided as a separate document to this plan, is an analysis of the benefits, including financial benefits, accruing to clients and to Health and Social Care services, as a result of the work of Gloucestershire Village and Community Agents between 2012 and 2014. These page extracts and the main report is acknowledged, and reproduced with thanks to Gloucestershire Rural Community Council.

Copies of the full document are available from:
Kate Darch, Gloucestershire Village and City Agents Manager, GRCC.
Tel: 01452 528491   Email: kated@grcc.org.uk
Executive Summary

This is an excellent scheme and a valuable addition to supporting the local populace and their many and various needs which Village Agents with their special skills and approach can often help where we and others cannot.

GP in Stroud

GRCC has managed the Gloucestershire Village and Community Agents since the launch of the scheme in 2006. The Agents provide information and support to people aged 50 and over, raising awareness of preventative measures, services and assistance which can help them remain independent in their own homes. Specialist Cancer Agents provide support to people aged 18 and over who have been affected by cancer.

Overall Return on Investment

Between 2012 and 2014, the Agents’ activities resulted in savings to Gloucestershire Health and Social Care services totalling £1,290,107.42, and financial benefits to individual clients totalling £16,207.24. The cost of the scheme over the same time period was £680,000.

For every £1 that the scheme cost, the return on investment is calculated to be £3.10. This breaks down further as:

- £1.90 savings to Gloucestershire Health and Social Care services;
- £1.20 financial benefits to clients

12,961 records (known as ‘gateways’) were analysed against a series of themes where savings to services resulting from the Agents’ activities could be identified:

- Falls Prevention
- Income Maximisation
- Retaining Independence
- Loneliness and Social Isolation
- Fuel Poverty
- Specialist Cancer Agents

A literature review was conducted to identify relevant economic evidence and statistical indicators to use for the calculations. Reports were sourced from Government departments, local authorities, university studies, charitable organisations, and peer-reviewed journal articles. Toolkits developed by or on behalf of Government departments were also used.

Calculations and supporting literature are referenced throughout the full report.

Activities and economic calculations by theme

Each theme was further broken down into sub-categories which result in savings to Health and/or Social Care services, and benefits to clients. While elements of some themes overlap, care was taken to avoid duplication of activities in the analysis. For the full summary of savings to Health and Social Care services and benefits to clients, see table overleaf.

Copies of the full analysis are available from:
Kate Darch, Gloucestershire Village and Community Agents Manager, GRCC
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**Village & Community Agents’ Activities**

<table>
<thead>
<tr>
<th>Interventions</th>
<th>Savings to Services</th>
<th>Financial Benefit to Clients</th>
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</thead>
<tbody>
<tr>
<td><strong>Health</strong></td>
<td><strong>Social Care</strong></td>
<td><strong>Joint Health &amp; Social Care</strong></td>
</tr>
<tr>
<td><em>Falls Prevention</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grab rails</td>
<td>£3,119.92</td>
<td>£11,204.08</td>
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<tr>
<td>Mobility aids</td>
<td>£3,119.92</td>
<td>£2,168.08</td>
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<tr>
<td>Small repairs</td>
<td>£6,239.04</td>
<td>£11,834.16</td>
</tr>
<tr>
<td>Wet rooms</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Stairlifts</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Sub total</td>
<td>£12,479.68</td>
<td>£25,206.32</td>
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<tr>
<td><strong>Income Maximisation</strong></td>
<td></td>
<td></td>
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<tr>
<td>Lower rate Attendance Allowance</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Higher rate Attendance Allowance</td>
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<td>-</td>
</tr>
<tr>
<td>Carer’s Allowance</td>
<td>-</td>
<td>-</td>
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<tr>
<td>Pension Credit</td>
<td>-</td>
<td>-</td>
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<tr>
<td>General benefit checks</td>
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<tr>
<td>Sub total</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Retaining Independence</strong></td>
<td></td>
<td></td>
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<tr>
<td>Gloucestershire Telecare</td>
<td>£52,570</td>
<td>£118,725</td>
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<td>Community Alarms</td>
<td>£11,988</td>
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<td>OT assessments</td>
<td>£8,579</td>
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<td>Social Care assessments</td>
<td>£6,670</td>
<td>£17,940</td>
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<tr>
<td>Carer’s Needs assessments</td>
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<td>Reablement</td>
<td>-</td>
<td>£43,772</td>
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<tr>
<td>Support in the homes</td>
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<tr>
<td>Home Safety Checks</td>
<td>-</td>
<td>£6,637.34</td>
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<tr>
<td>Sub total</td>
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<td>£208,748</td>
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<tr>
<td><strong>Loneliness and Social Isolation</strong></td>
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<td></td>
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<tr>
<td>Befriending services</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Social Groups and Activities</td>
<td>-</td>
<td>£29,066.24</td>
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<tr>
<td>Transport</td>
<td>-</td>
<td>£27,950</td>
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<tr>
<td>Volunteering</td>
<td>-</td>
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<td>Sub total</td>
<td>-</td>
<td>£84,556.24</td>
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<tr>
<td>Fuel Poverty</td>
<td>-</td>
<td>£4,393</td>
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<tr>
<td>Specialist Cancer Agents</td>
<td>-</td>
<td>£51,660</td>
</tr>
</tbody>
</table>

**Totals**

| -                                 | £91,886.68          | £213,085.32                  | £306,971.92 | £818,207.24 |
Attachment Six

Job description - Community Connector

Role & Purpose

The main purpose is to provide support to individuals and groups to help reduce social isolation and exclusion, particularly amongst older people, and to increase their involvement and participation in the community.

This would include being prepared to provide information and advice on a wide range of topics, working locally with existing networks and creating new ones where appropriate. This will help connect, assist, and empower people so that improvements in their care and well being is achievable.

Main Responsibilities

The main purpose of the job and responsibility is to:

- Be the lead person for the Connector Service scheme in the community.
- Work within the designated Parish and community of Wye & Hinxhill, in both a reactive and proactive way.
- Respond holistically and appropriately to the issues and needs identified, and be able to provide accurate, high quality information.
- Create referrals of appropriate urgency to relevant agencies and service providers.
- Engage with people in a friendly, courteous, prompt and appropriate manner, using excellent communication skills and ensuring delivery of high quality customer service at all times.
- To be aware of the particular needs of the whole range of individuals including those unable to access services directly and to refer these clients onto other services effectively.
- Develop effective working relationships with all partners and stakeholders including the parish council etc.
- Work as part of a team, contributing to meetings, attending relevant training, cascading information and providing ongoing support and information to enable the smooth running of the service.
- Access and accurately maintain electronic/hard copy client records, calls and referrals ensuring compliance with the Data Protection Act, maintaining management information to assist in workload/demand profiling and to inform continuous improvements to the services provided.
- Use the IT equipment provided, appropriately and effectively.
- Use allocated budgets to effectively promote the Village and Community Connector service and engage older people in the most appropriate way.
- Contribute to the maintaining of a robust and sustainable database of community information and assets clients.
Other responsibilities

- To take responsibility for your own time management and administration.
- Report regularly to the Connector service scheme manager.
- Attend relevant village agent progress meetings and training.
- Make necessary links to local services and stakeholders.

Essential Personal skills

- Excellent communication skills by telephone and face to face with patience and understanding.
- Use of initiative/self-motivated.
- Self-awareness.
- Non-judgemental.
- Thorough, and attentive to detail.
- Positive outlook.
- Problem solver, pragmatic and resilient.
- Flexible and adaptable.
- Able to maintain confidentiality.
- Willingness to participate in training and acquire new skills.
- The ability to work in a team and network with partners.
- The ability to work confidently alone.
- The ability to manage your own workload and identify priorities.
- The initiative to develop the role.

Essential Values

- Commitment to the needs of older people living in rural areas.
- Desire to help people.

Essential professional Skills

- Computer literacy, including familiarity with multi-media.
- Excellent written, verbal and administration skills.
- Effective record keeping of visits and budgets.
- Full current driving licence.

Terms & Conditions

Currently under review with Kent County Council and the Parish Council.
The New Information Age and Old-Age

Article: Does she use the Internet?
Published by: Vicky Sargent 2014

The radio programme ‘Does he take sugar?’ highlighted a tendency to treat disabled people as generally incapable. The same syndrome affects older people and the Internet.

At a conference last year on social care and digital, one of the speakers spoke of research with care home residents that showed a mismatch between their digital aspirations and those of their families.

While the older people told researchers they had been hoping to receive tablets and smartphones for Christmas, family and friends had actually produced chocolates, perfume and other items considered suitable for Grandmas (Grandads presumably getting socks and jumpers).

Statistics do tell us that older people are less likely to use the Internet. ONS data says that of 6.7m UK adults (13.1%) who are not online, almost three quarters of this group are 65 or older, and in the 75+ age bracket, more than 60% of people are not online. There are many reasons for this. Research studies highlight the cost of devices and connection, lack of digital skills (older cohorts may never have used computers at work), security concerns, lack of interest and even fear and resentment at the age of ‘digital everything’.

The cost issues are fast diminishing now that free Wi-Fi is widespread (although important to remember not everywhere) and connection through hotspots is increasingly an option. The price of tablets and smartphones is also tumbling. At the same time there is increasing evidence of the benefits of being online, ranging from access to lower cost goods and services, to opportunities for connecting with existing friends and family, as well as finding new interests and new social networks online.

The digital skills charity Digital Unite says the latter is particularly important, with depression affecting 20% of older people living in the community and 40% living in care homes for older people, compared with 10% of the population at large.

Digital Unite research has shown that, of those over 55s who are using the internet, four out of five (86%) said it had improved their lives. 72% said that being online had helped reduce their feelings of isolation and 81% said it makes them feel part of modern society.

The same research also says that rates of digital exclusion in social care are higher than in the general population.

So, with 1.6 million people providing adult social care services in England, and 6 million unpaid carers (many of whom suffer equally from loneliness and isolation), it is important to work with both carers and those who are cared for to ensure both parties are digitally capable and confident.

One lever that can be used to overcome the perception by some older non-liners that ‘there is nothing on the Internet for me’ is their health. There is plenty of information and advice online to help and support people with disabilities and long-term conditions, and this can be used as an incentive to get people started.
This is part of the thinking behind NHS England’s Widening Digital Participation programme, which is run by the Tinder Foundation (which also runs UK Online centres) to get large numbers of people, particularly older people, to improve their digital health literacy.

Up to March 2014, the programme had engaged with 100,000 people, and actively trained nearly 60,000. In 2014-15, the respective targets are 121,500 and 81,000, and the programme has further ambitions to get GPs and health practitioners involved, with training taking place in GP surgeries.

According to Bob Gann, NHS England’s Director for the Widening Digital Participation programme, it is having a really positive effect on people’s lives. ‘Reducing isolation and loneliness is just one way technology can help,’ he says, ‘and when a lot of evidence suggests that this is as great a risk to the health and wellbeing to the elderly population as obesity, it shows how important the work is.’

In addition to this programme, UK Online Centres have 43 specialist centres, specifically set up to help older people learn about computers and the Internet within their local communities. They can cite plenty of examples of people who have come to the Internet at a late age and found it transformative.

Two examples, featured as part of last week’s ‘Get online week’, are Stella Cruse, 80, and Doreen Milner, 78, who met at ‘Get Online’, a computing course for ‘absolute beginners’ at Devizes Library, run by local UK online centre The Learning Curve.

According to Stella, ‘there’s no denying that when you know practically nothing about computers the first few sessions are quite hard work (but) now Doreen and I can do all sorts of things online that we’d never even imagined.’ Her friend continues ‘It’s a great way to keep the grey matter going, a great way to follow your hobbies, and a great way to meet people. Computers and the internet aren’t going away and using them really can be enjoyable. Stella and I are living proof – we’re having a great time!’

Another story told by UK Online is that of 78 year-old Norah Hanley, who lost her husband of 55 years following a period of caring for him full time. After attending computer classes and then buying her own computer, Norah was inspired to take up a diet plan supported by an online community for sharing tips, recipes and dieters’ stories.

Having never been successful with dieting before, she lost four stone, which has had a significant impact on her health generally, including her diabetes and arthritis. According to Norah “the more I learn about the Internet and use it, the more it changes my life. And as my dad used to say ‘if you’re lucky enough to be born in to this world, the only sure thing is death. But between the two there’s a lot of living to do!’”

So, if you were thinking of giving your Nan a box of chocs and a nice scarf this Christmas, think again. Why not investigate the launch by Argos, as part of Get Online Week, of a tablet, training on how to use it, and a year’s free broadband from TalkTalk, all for £20.

Vicky Sargent attended the Digital Care Surgery - Innovating for Change event in Birmingham organised by DISCOVER. The project aims to familiarise carers with digital technologies and embed them in their day-to-day lives.
Health & Well-being: headline figures

A third of the parish/ward population of Wye of around 2,300 is aged over 60, and over 16% are aged over 75 years.

Parts of the parish/ward are in the 11-20% most income deprived nationally.

Over 10% of the population are widowed.

A further 7% are either separated or divorced.

The district average of elderly on state support is 2.5%. Wye is around 13.5%.

The area has a higher percentage of people providing unpaid care (12%) compared to the average in England (10%), with 3.7% providing over 20 hours of unpaid care a week.

Although 81% report themselves to be in good or very good health, 5.5% say they are in bad to very bad health.

Just over 9% of the population report that their day-to-day activities are limited a lot.

Fewer than 20% of the population have a long term illness or disability which they report as limiting their day to day activities a little to a lot.

Estimating current expenditure

Detailed discussions with colleague in the public sector are underway to developing expenditure models. Its also recognised that there is little real evidence as to the publicly available estimates on expenditure by families with private and third sector care, although OP:W expects to undertake any qualitative research locally on this.

In addition to this OP:W will work with NHS colleagues to extrapolate the current costs of Hospital admissions and other health and social care data which can be drawn from amongst others, the Kings Fund research, which has identified that:

- The costs of an Ambulance journey = £344.
- The costs of a Hospital Admission/overnight stay = £250.
- The costs of an A&E visit = £111.
- The costs of a GP Visit = £36.
Ashford CCG have confirmed that the 2014/15 national allocations for them locally is an overall figure = £1,283 pp, which is broken down as follows:

- For hospital, community and mental health services = £1,048 pp.
- To Area teams for primary care = £199 pp.
- To local authorities for public health = £36 pp.

KCC Adult Social Care [ASC]: scale and scope of local services is currently as follows

- At the end of March 2014, there were 89 clients receiving community-based services in Wye. Some additionally took direct payments and others also had personal budgets.

- Of the 89 clients, 28 were matched with a funded care package. The total weekly spend for these clients was £4,645.63, creating an annual cost of £241,573. An overall spend of around £358,000 when these other factors are taken into account.

- There is also evidence from research from 2010, that social work initial contact work would be costed at around £65 per hour, and more complex work would be around £265 per hour.

More work will be undertaken in March with the NHS CCG and KCC to develop a costs and benefits profile for the ‘whole systems’ models of care that OP:W is planning to deliver over the next three years.
Extract

The past decade has seen dramatic increases internationally in efforts to assist individuals to age in place. This focus on aging in place reflects two main things that have changed radically over recent times: firstly, more people are living longer, and seek more fulfilling lives; and secondly, they are more vocal about how these lives could be led. One clear example of this is that older adults’ have an expressed desire to continue to live in familiar homes and neighbourhoods, and want a ‘rebalancing’ of financing and service-delivery systems, to promote community-based care.

Formal efforts to promote aging in place typically involve traditional aging network services formal service providers, including local government, not-for-profit organizations, or private for-profit companies. These community-wide planning efforts face a number of challenges, including inconsistent and really timely planning information, lack of community structures to facilitate translation from strategic intentions to ground-level actions, a focus on major system changes that typically occur very slowly, and inadequate inclusion of older consumers in planning and implementation processes. In essence, top-down, ‘done-to’ initiatives.

Although well-intentioned, these earlier age-friendly community efforts are only now beginning to acknowledge the potential benefits of actively engaging community social organizations, including membership associations, neighborhood groups, and organizational collaborations, thus creating a done-with, done-by climate of managing change.

By engaging existing community social organisations, age-friendly initiatives can draw upon available social capital within existing communities of common interest, facilitate older adults’ engagement in the change process, and ensure that interventions are targeted most effectively to the needs and preferences of specific community sectors.

Community social organizations are now being recognised to be of increasing importance in the context of increasing population diversity and the declining roles of families, religious institutions, and governments in the postmodern state.

One of the most prominent emerging social initiatives is the Village model. Villages are membership associations developed and operated by older community members for the primary purpose of enhancing their quality of life and ability to age in place. In exchange for membership dues, participants gain access to an array of social, educational, and recreational activities; assistance with driving, housekeeping, and other support services; a dedicated source of information and assistance; and referrals to community service providers, often at a reduced

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25. This initiative identified eight domains contributing to health, participation, and security as people age, based on prior conceptual and empirical findings of the AdvantAge Initiative and the AARP Livable Communities initiative (WHO, 2007).
26. (e.g., nutrition, transportation, case management, in-home care)
rate. A unique characteristic of the Village model is the extent to which it promotes consumer engagement and social support, typically by involving older adults in governance roles and as direct providers of supportive services in so doing.

Villages provide an organisational framework through which older adults might together enhance their own well-being and facilitate access to existing services, while also fostering infrastructure changes that enhance age friendliness for members as well as other community residents. By involving members in these activities, Villages may serve as a potential mechanism for promoting the empowerment of older adults.

The main domains include:

1. Social participation – engagement in recreation, socialization, cultural, educational, and spiritual activities.
2. Civic participation and employment – opportunities for civic engagement, unpaid work, and paid work.
3. Respect and social inclusion – attitudes of the community as a whole toward older people.
4. Supportive services include community support and health services - access to social services as well as a range of health services that are not strictly medical.
5. Communication and information – access to information and technologies that enable elders to stay connected and obtain needed information.
6. Transportation – the ability to get to places when needed.
7. Housing – the opportunity and ability to age comfortably and safely within one's chosen community.
8. Outdoor spaces and buildings – environments that promote inclusiveness, safety and accessibility.
### Stakeholder Organisations

<table>
<thead>
<tr>
<th>Partner name</th>
<th>Role in partnership</th>
<th>Level of commitment</th>
<th>Resources contributed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kent County Council Strategic Commissioning Community Support Libraries</td>
<td>Key Partner, (“Our Place Champion” within KCC.) Branch library local community resource</td>
<td>Very high: models to “roll out” across county and influence future commissioning strategy High</td>
<td>Member of the KCC Commissioning team identified to work alongside the Programme Library as focal point</td>
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<tr>
<td>Kent County Council Strategic Commissioning Community Support Community Engagement</td>
<td>Important partner, brokering contact with elected members/other agencies</td>
<td>High</td>
<td>Outreach assistance. Equality and Diversity expertise</td>
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<tr>
<td>Ashford NHS Clinical Commissioning Group</td>
<td>Key Partner</td>
<td>High: (interest aligned to future arrangements for “Hub”)</td>
<td></td>
</tr>
<tr>
<td>Wye Surgery</td>
<td>Local Partner</td>
<td>Promoting health and well being, reduction of calls upon GPs for non medical issues</td>
<td></td>
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<tr>
<td>Wye Patients Participation Group</td>
<td>Local Partner</td>
<td>High</td>
<td>Two PPG members on Reference Group</td>
</tr>
<tr>
<td>Action with Communities in Rural Kent</td>
<td>Voluntary sector strategic partner</td>
<td>High: interest in County-wide “roll-out” of model, particularly the “Village-Agent” aspect</td>
<td></td>
</tr>
<tr>
<td>Wye Free School</td>
<td>Local partner.</td>
<td>Good – keen for integration of new secondary school within the local community</td>
<td></td>
</tr>
<tr>
<td>Ashford Community Volunteer Service</td>
<td>Local partner</td>
<td>High: part of 2015 business plan</td>
<td>Senior Manager</td>
</tr>
<tr>
<td>Social Enterprise Kent</td>
<td>Local partner</td>
<td>High: part of 2015 business plan</td>
<td>Senior Manager</td>
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</table>
Local Policy context: What influences change to occur?

**Conditions: Local Context**

**District Population: Wye Parish lies within the Ashford North NHS District**

“Compared to the rest of England, Ashford has a higher than average population between the ages of 5-14, 40-49 and 60-69. Alongside the importance of health promotion and prevention for the younger generation ACCG must also plan for a 16% rise in 65+ age groups.

Ashford’s population is ageing due to lower birth rates and higher life expectancy over the past few decades. This is a universal problem that many developed countries currently face. The implications for health services are: increasing need for health and social care for elderly people at home or in care homes, requiring more staff and more funding.

The distribution of the Ashford CCG population means that there are lower numbers of young people and larger numbers in the age ranges between 40 and 69. This type of age structure is often referred to as the “ageing population time bomb”. The shift in age structure towards older people with a simultaneous reduction in working-aged adults has implications on future pensions, provision of health and social care and economic growth.”

**Wye Demographics [2011 census]**

Over a third of the Wye Parish population is aged over 60, 787 people (over 16% are aged over 75 years – 373 people).

The area has a higher percentage of people providing unpaid care (12.1%) compared to the average in England (10.3%), with 3.7% providing over 20 hours of unpaid care a week.

Although 81% report themselves to be in good or very good health, 5.5% (125 people) say they are in bad to very bad health. Some 9.2% of the population (210 people) report that their day to day activities are limited a lot.

Just under 20% of the population (420 people) have a long term illness or disability which they report as limiting their day to day activities a little (233 people) to a lot (188 people).

Lone pensioner and all pensioner one family households without a car or van 188 (47%).

**National Policy Context (The Care Act 2014)**

The Care Act places an emphasis on preventing, postponing and minimising people’s need for care and support. Key provisions in the Act for Local Authorities and their partners, which can directly affect our community, include:

- A requirement to arrange for the provision of preventative services, i.e. services which will reduce, prevent or delay the development of need for care and support.
- Duties to promote the wellbeing of individuals and promote integration between health and social care services.
- A requirement for local authorities to manage and develop the market for care in their area. Part of that development may be directly generated by authorities themselves, which will be able to delegate many of their social care functions to organisations from any sector: this could create new market opportunities for providers.
- A ‘well-being principle’ as an overarching approach that local authorities should take when exercising their responsibilities under the Act.
- Ensuring that well-being covers a range of outcomes such as physical and mental and emotional well-being. It also covers participation in work, education and training and social and economic well-being.
- Placing a new duty on local authorities to provide or arrange for services, facilities or resources, which will prevent or delay the development of, or reduce the needs for care and support of, adults.
- A duty to provide information, advice and guidance on care services to improve access and eligibility.

**Intended impacts**

- Lower local hospital admission rates.
- Increased local volunteering rate.
- Higher %age of people who say they feel connected to their neighbours.
- Higher “satisfaction and view of quality of life”.
- Greater individual ownership of the solutions to developing needs.
- People gain in choice and independence, helping the community to become stronger and self-sustaining.

**Intended Outcomes – What Does Good**

**Look Like Our Top Twenty by 2020**

[not in priority order]

1. Reducing incidence of loneliness & isolation.
2. Supporting more people to live as independently as possible.
3. More effective communication in the community, about the community
4. Increased support for family carers.
5. Increasing the access to IT, and training and support.
6. Promoting the use of IT, particularly social media.
7. Improving health & well being (nutrition, exercise, purposeful activity).
8. Improving community cohesion (across the ages).
10. Ownership and involvement in service design.
11. Reducing avoidable episodes of hospital admission/care services.
12. Helping people to cope with long term illness at home.
13. Reducing the incidences of calls upon GPs time for non medical issues.
14. Lower levels of non-attendance for NHS services.
15. Increasing inward investment of capacity building in employable skills.
16. Providing very responsive locality based services.
17. Increasing inward investment to create community assets.
18. Increasing community capacity to help each other.
19. Develop an innovative user-led, localised service responsive to the needs of our community.
20. Development of a community-scale model that can be replicated in Kent.
There is extensive evidence that connected and empowered communities are healthy communities. Communities that are involved in decision-making about their area and the services within it, that are well networked and supportive and where neighbours look out for each other, all have a positive impact on people's health and wellbeing.

In a period of economic restraint, it is vital that local government and the NHS obtain economic and social value from the services they commission and deliver. Traditional ways of looking at value have tended to ignore what people and communities can bring to services. It makes sense that building on the assets within communities will lead to a more equitable and sustainable use of resources.

Of course, community involvement and volunteering are not free. Training, volunteer coordination, project management and set-up costs, meeting out-of-pocket expenses and ongoing support are all legitimate costs.

Evidence on the cost-effectiveness of community engagement interventions is limited, although some reviews have reported cost benefits in some circumstances. The recent review on community and engagement and inequalities concluded that there was not enough evidence to draw firm conclusions, with only 21 economic evaluations of mixed quality. Evaluations may fail to capture the full span of resources used and the wider benefits of involvement and unanticipated outcomes.

27. A guide to community-centred approaches for health and wellbeing; Public Health England; February 2015
For example, many volunteer and peer health programmes will see a proportion of volunteers gain employment, which generates savings to the public purse but may not be picked up in an evaluation about health behaviour’s. Using 2011 figures, the Cabinet Office calculated the monetary value of volunteering to the wellbeing of the volunteers as £13,500 per person per year. 

Currently there is considerable interest in developing practical methods to estimate the return on investment of community and volunteer programmes. The London School of Economics undertook an economic analysis of community capacity building using three interventions: time banking, community navigators and befriending. All three were found to deliver a net economic benefit when costs and value were calculated. For example, time banking had an estimated net value of £667 per person per year, extending to £1312 if improvements in quality of life were included in the analysis.

Using social return on investment (SROI) methodology, a specific methodology for assessing value, an analysis of community development in local authorities reported a return of £2.16 for each pound invested, and the value of volunteers running activities was almost £6 to a pound invested to employ a community development worker.

York Economics consortium carried out an SROI on individual case studies from ‘Altogether Better’ health champion projects and found that overall, and based a number of assumptions, there was a positive return on investment but with large variability from £0.78 to £111 per pound invested.

Similar results about the positive return on investment have been found in other volunteer prevention programmes. In summary, despite an incomplete picture, community-centred approaches, including community capacity building and volunteering, potentially offer a significant return on investment. Variability in the economic value may be due to multiple factors, but poor volunteer retention, high turnover and low levels of community ownership and low uptake are likely to push costs up. Hidden costs should not be borne by the community, and consideration should be given to whether financial incentives to support engagement are needed.

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Introduction & Background

A key feature of population ageing in the UK is the projected unprecedented rise in need for long-term care in the next two decades. There is, however, still considerable uncertainty over the future supply of public investment in care and well-being services. This is also compounded by the gap that is emerging in the provision of unpaid care for older people, which might have been expected to be available from their adult children. Research\textsuperscript{31} is showing that demand for unpaid care will begin to exceed supply by 2017, and the unpaid ‘care gap’ will grow rapidly from then onwards.

The Our Place:Wye programme aims to try and provide solutions to help manage this rise in demand and the shortfall in supply through two primary routes:

Firstly, the community wants to become more engaged and empowered to identify priorities for improving care and well-being services; and it wants to get more involved in the design and delivery of new and existing care services. It wants to do this by:

- Involving people directly in decisions about the future of health and care services in their community.
- Finding new ways to support carers, particularly unpaid family members.
- Encouraging community volunteering through new programmes and to provide better support for volunteering, like organising ‘time-banks’.
- Encouraging community enterprise through local projects and support programmes.
- Developing stronger partnerships with the public and voluntary sector so that working together more effective ‘reach’ is achieved, including people who are currently excluded, or on the margins of their community.

Secondly, to put people more in control of their own care; it wants to do this by:

- The provision of personal budgets where appropriate, for publicly funded health and care services.
- Been treated as genuine partners with the NHS, Local Authorities and with voluntary organisations to more effectively integrate care, which may mean pooling health and social care budgets with the Social Cooperative being considered by OP:W.
- Providing comprehensive and accessible information and advice to enable people to understand how the system works, what services are available locally and how to access/purchase them, particularly for those who are paying directly for this care.

\textsuperscript{31} http://www.pssru.ac.uk/publication-details.php?id=4901
Encouraging a more localised ‘market’ for care services, to provide greater choice of high-quality, responsive and personalised services.

Investing local time and money in promoting either self-management of services or by providing local support for individuals to feel more engaged in choices that affect them and their families directly.

Actively promoting the centrality of people’s role in determining wellbeing and independence so that patients, their families and carers, are recognised as ‘experts by experience’.

The OP:W programme will provide solutions to help support these two routes and in doing so will also produce benefits to the wider community. Inevitably, putting these solutions in place also has a cost; there are three priority projects needed to get the programme underway and the outline costs and benefits associated with these are described as follows:

**Table One: Phase One – Project Summary**

<table>
<thead>
<tr>
<th>Project Area</th>
<th>Funded from</th>
<th>Costs</th>
<th>Possible Full Year Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Connector</td>
<td>WPC</td>
<td>£18,000</td>
<td>49,600</td>
</tr>
<tr>
<td></td>
<td>KCC</td>
<td>£14,000</td>
<td>£280,000*</td>
</tr>
<tr>
<td>Community cooperative</td>
<td>OP:W</td>
<td>£6,800</td>
<td>£85,000</td>
</tr>
<tr>
<td></td>
<td>KCC</td>
<td>£22,500</td>
<td></td>
</tr>
<tr>
<td>New ways of commissioning public services</td>
<td>KCC</td>
<td>£22,500</td>
<td>£25,000**</td>
</tr>
<tr>
<td></td>
<td>OP:W</td>
<td>£4,800</td>
<td></td>
</tr>
<tr>
<td>Overall</td>
<td></td>
<td>£88,600</td>
<td>£439,600</td>
</tr>
</tbody>
</table>

Notes: WPC=Wye Parish Council; KCC=Kent County Council; OP:W=Balances from the originally funded Our Place Wye budget allocation.

* Some of these benefits are also attributable to the NHS.

**KCC manages care contracts in Kent. Bidding for the annual commissioning cycle opens each June, so this core project area is not scheduled to start to operate until Q3 2016.

**Unit Costs metrics**

In terms of unit costs the research material from the Personal Social Service Research Unit based in Kent is mainly being used to provide benchmark figures, supplemented by the Kings Fund and Think Local Act Personal material.

The majority of the costs identified in the above table are associated with staff time, and in the case of KCC, this is an in-kind contribution, funded from existing staff budgets.

Hourly rates for staff time for KCC are estimated as £81ph for practitioners; £29 ph for team staff and £21 ph for other support staff. Each staff member is assumed to be working for up to 2 days per week for 23 weeks on the projects.
Hourly rates for the WPC funded staff is based on £12.50 and £10.50 ph for Community Connector and administrative support, plus a small amount of travel expenses, covering between them a five day week, for 36 and 46 weeks per year respectively. Office systems costs are estimated at £1,200 and premises costs of around £3,800.

For the OP:W funded activity project management rates are assumed as £200 pd including expenses, for two days per week for twelve weeks per project. For the Community Cooperative area, £2,000 has been provisionally allocated for professional advice for providing information on the options and choices for the new organisational body.

Benefits Strategy

Outline Benefits

In terms of potential benefits, these have been identified for the projects in Phase One in two areas, firstly, that of public service value, and secondly the potential cost savings to the NHS and Local Authority Social Care services. These are described in more detail for each major project area as follows.

Community Connector Service

We have based the benefit assumptions on the Gloucestershire experiences. These fall into two main areas.

Firstly, their overall benefits model suggests for elderly customers of the service, a spend:gain ratio of £1:£3.10 is achievable in terms of public service value.

For OP:W that would be an overall equivalent target of nearly £100,000 pa, subject to further evaluation of key elements. A 50% risk factor has been applied to this to reflect the start-up position of the service, giving an initial benefit target profile of £49,600.

Secondly, there is an overall NHS and Local Authority benefit per individual engaged with these services, which are estimated, to be up to £7,365 pa, depending on circumstances. These relate mainly to public services involvement reducing or even being avoided, and increases in state benefits, or increased access to reducing fuel poverty measures for individuals.

However, it is recognised that Gloucestershire is a well-established service, but significant gains for the OP:W public sector partners could be established quite quickly, and then build up over time to something more substantive. The main benefit areas that would be targeted are seen initially in:

[a] Finding ways to reduce falls by, thus reducing hospital admissions/A&E treatment, and the likely need for discharging into residential care for recovery.

32. An extract from the Gloucestershire CBA is shown at Attachment Five – Village Agents
Reducing loneliness and social isolation, which affects the health and wellbeing of individuals and reduce the risks associated around:

- High blood pressure.
- The onset of disability.
- Cognitive decline – one study concluded that lonely people have a 64% increased chance of developing clinical dementia.
- Being more prone to depression.
- Making more GP visits, reducing a higher use of medication.
- Earlier entry into residential or nursing care.

Using the socio-demographic data at Attachment Eight, combined with the Gloucestershire experiences, it would seem reasonable to assume that OP:W could deliver improved circumstances for up to 10% of the elderly population, which equates to helping around seventy-six individuals per year, which is less than two per week33.

This tends to suggest that with a potential saving of around £7,365 per individual, an overall full year benefit target of around £560,000 is possible; applying a 50% risk factor to this still means there is a substantial incentive of around a £280,000 pa benefit target to get the service under way.

To stress test these assumptions, and to improve confidence levels on achieving results, two further studies relating to similar Community Connector type services have been analysed.

Firstly, Ashford North CCG has been undertaking local pilot work with Age Concern in the Faversham area34, and they have just recently extended the pilot, having found a high degree of value, directly to the community group [of over 330 individuals] engaged in the pilot, and to NHS services.

The most recent findings have indicated the following improvements in outcomes:

**Table Two – Initial Finding from Age Concern Faversham Pilot**

<table>
<thead>
<tr>
<th>Key outcome</th>
<th>Result from pilot</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improvement to emotional wellbeing</td>
<td>80% reported that the service had a positive impact</td>
</tr>
<tr>
<td>Improvement to social isolation</td>
<td>30% reported improvement</td>
</tr>
<tr>
<td>Improvement to physical wellbeing</td>
<td>30% reported improvement to physical health</td>
</tr>
<tr>
<td>Increased awareness of health and social care provision</td>
<td>20% reported increased awareness of local services</td>
</tr>
<tr>
<td>Reduction in urgent care activity</td>
<td>20% of all referrals reduced need for intervention</td>
</tr>
<tr>
<td>Prevention of readmission</td>
<td>10% of all referrals avoided the need for readmission</td>
</tr>
<tr>
<td>Reduced reliance upon primary care &amp; social services</td>
<td>27% of all referrals avoided need for intervention</td>
</tr>
<tr>
<td>Early discharge supported</td>
<td>8% of referrals supported early discharge</td>
</tr>
</tbody>
</table>

33. This equates to 40 individuals aged 60, and a further 36 individuals aged over 75.
34. Please see http://www.ageuk.org.uk/faversham/our-services/care-navigator/
Following discussion with colleagues at NHS Ashford North CCG, it is clear that there is synergy possible between the Faversham pilot and OP:W, and there will now be opportunities for the potential for the CCG funding a second complementary pilot in Wye in mid-late 2015.

Secondly, Age UK Kensington and Chelsea\(^{35}\) have also been piloting ‘Primary Care Navigator’ models and this integrated approach has produced a second comparator site showing how support services can reduce the number of people needing healthcare on a local level. Their latest survey results clearly indicate that the service is working well in their area, and OP:W will be exploring with them in the near future how they might be able to be used as a control site, to improve the local metrics needed for OP:W to measure its effectiveness.

**Table Three – Reducing demand for health services in Kensington & Chelsea: Six Months pilot, per-individual results**

<table>
<thead>
<tr>
<th>Service type</th>
<th>Average Cost per contact</th>
<th>Pre-intervention Contact Average</th>
<th>Post Intervention Contact Average</th>
<th>£ Savings per patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP</td>
<td>£25</td>
<td>8.6</td>
<td>4.6</td>
<td>£99</td>
</tr>
<tr>
<td>Inpatient</td>
<td>£1,825</td>
<td>0.4</td>
<td>0.08</td>
<td>£584</td>
</tr>
<tr>
<td>Outpatient</td>
<td>£160</td>
<td>2.9</td>
<td>2.3</td>
<td>£96</td>
</tr>
<tr>
<td>Out-of-Hours</td>
<td>£45</td>
<td>2.3</td>
<td>1.2</td>
<td>£54</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>£152</td>
<td>1.4</td>
<td>0.6</td>
<td>£116</td>
</tr>
<tr>
<td>Overall savings</td>
<td></td>
<td></td>
<td></td>
<td>£947</td>
</tr>
</tbody>
</table>

**Setting up the village/community cooperative**

The community wants to become more engaged and empowered to identify priorities for improving care and wellbeing services, and it wants to get more involved in the design and delivery of new and existing care services. It wants to do this by:

- Involving people directly in decisions about the future of health and care services in the community.
- Encouraging community volunteering through new volunteer programmes and better support for volunteering.
- Encouraging community endeavour through local projects and support programmes.

The setting up of the village cooperative will be fundamental to achieving this; once established, one of the first initiatives it wants to get under way is to create a ‘time-bank’ for individuals to volunteer their time to support others.

The administrative support allocated for the Community Connector office will initially fund and coordinate this. The ASHE/ONS data from Volunteering England\(^{36}\) estimates that volunteering for OP:W would have a public service value of £14.80 ph. The estimates for the first year of Time Banking suggest that fifty volunteers would offer up to five hours per week to support improvements in care and wellbeing in the village. This equates to a value of around £170,000 and applying a 50% risk factor this suggests that a benefit of around £85,000 pa would be a reasonable target to consider.

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\(^{35}\) [http://www.ageuk.org.uk/kensingtonandchelsea/](http://www.ageuk.org.uk/kensingtonandchelsea/)

\(^{36}\) [www.volunteering.org](http://www.volunteering.org) and [www.rgtb.org.uk/index.html](http://www.rgtb.org.uk/index.html) give more detail on this

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New Ways of Commissioning Public Services

KCC take the view that traditional models of public service delivery cannot solve complex social problems, but by moving their commissioning strategies towards co-production, and developing the options for transferring responsibility for currently managed services to the community cooperative, service costs (described below) could be reduced within the range of 10-12%.

This could potentially giving a savings profile of around £50,000 pa out of the £358,000 spend on their client base in the community, primarily in two areas, firstly by a reduction in the numbers of people entering the care system and secondly reducing the time they stay in the ‘system’, which incidentally, is bound to increase over time as more individuals probably become more eligible for more state funded care. Applying a 50% risk factor to this gives a £25,000 benefit target. The overall spend by KCC in the Ashford Borough area is over £11.5m, so the successful outcomes of the ‘Doing things Differently’ in OP:W is therefore highly significant to them.

The detailed data and improvement in outcomes supporting how this will be achieved, particularly the potential savings in KCC management and practitioner time, is still being developed. It will be based upon the unit costs described in Appendix One of the National Programme – ‘Think Local Act Personal’37 with local unit cost variations factored in to help create a robust business case for the council to consider as part of its strategic planning for commissioning services more locally.

Table Four – Current spend by KCC on Wye clients 2014-15

<table>
<thead>
<tr>
<th>Number of Clients</th>
<th>Female</th>
<th>Male</th>
<th>Service Type</th>
<th>Weekly Spend</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>2</td>
<td>1</td>
<td>Adult Residential</td>
<td>£811.24</td>
</tr>
<tr>
<td>3</td>
<td>2</td>
<td>1</td>
<td>Day Care</td>
<td>£714.22</td>
</tr>
<tr>
<td>6</td>
<td>2</td>
<td>4</td>
<td>Direct Payment</td>
<td>£3,489.05</td>
</tr>
<tr>
<td>42</td>
<td>29</td>
<td>13</td>
<td>Domiciliary</td>
<td>£1854.97</td>
</tr>
<tr>
<td>29</td>
<td>23</td>
<td>6</td>
<td>Equipment/Adaptation</td>
<td>£0.00</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>0</td>
<td>Independent Living Scheme (Hourly)</td>
<td>£15.38</td>
</tr>
<tr>
<td>4</td>
<td>0</td>
<td>4</td>
<td>Social Work Only</td>
<td>£0.00</td>
</tr>
<tr>
<td>1</td>
<td>0</td>
<td>1</td>
<td>Telecare</td>
<td>£0.87</td>
</tr>
<tr>
<td><strong>89</strong></td>
<td><strong>59</strong></td>
<td><strong>30</strong></td>
<td><strong>Total</strong></td>
<td><strong>£6,885.73</strong></td>
</tr>
</tbody>
</table>

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OUR PLACE: WYE BUSINESS PLAN 2015 – 2018
Developing local metrics

Quite clearly there is a range of benefits that could be achieved by the OP:W programme; the newly established Programme Management Group will oversee how this will be achieved, and provide sound governance for the project planning and delivery behind this. External advisors will be providing an overall benefits realisation strategy and monitoring framework to support them in this, as well as working with key stakeholders to identify agree sound metrics to measure improvements in outcomes for the community that NHS and KCC colleagues provide services for.

For example, the CCG have confirmed that nationally that 6.1% of the elderly population are likely to have experienced falls per year, which would suggest that for the community cohort of 766 elderly residents, around 46 could be affected by falls over the year, and if the OP:W activity can positively influence avoiding this, ten individuals would benefit; the unit costs savings for the NHS for this could be in the order of £12,000 pa just in terms of hospital admissions.

The intention is that over the next month, more extensive work will be undertaken to work with colleagues in the NHS and KCC to develop a wider range of metrics to reflect the benefit areas for each project, in terms of improved outcomes and opportunity-cost areas. To help achieve this, a series of unit costs and associated activity targets monitoring forms and client questionnaires will be created, in part based on national standards, but customised to meet local requirements.

Attachment Fourteen

Community Capacity Building

Please note this is an abridged version of internal KCC document for sharing with stakeholders published 6th March 2014.

Programme Lead: Emma Hanson, Head of Strategic Commissioning, Community Support.

Senior Responsible Owner: Mark Lobban, Director of Strategic Commissioning.

This Programme Brief was developed for the Adult Social Care Transformation Board to gain agreement to a new approach to commissioning community-based services being planned by Strategic Commissioning Community Support Unit. The objective of the programme is to build community capacity in order to support the transformation of adult social care.

1. Background

In May 2012 Kent County Council set a Blueprint for the Transformation of Adult Social Care, in doing so we established the key foundations for transformation:

- A determined focus on prevention and targeted intervention, ensure that services respond rapidly and are more effective.
- To encourage and empower individuals to do more for themselves and ensure greater support is available to carers.
- And importantly to this programme brief that we would develop a new deal with both voluntary and independent providers; one that is based upon trust and incentivisation.

This is a transformation programme that will deliver savings, not a savings programme that will deliver transformation.

Through transformation our goal is straightforward:

That people are at the heart of all adult social care activities, receiving integrated services that are easy to access, of good quality and that maximise their ability to live independently and safely in their community.

2. Purpose of Document

Through the Community Capacity Building Programme we will explore and better understand the role that community support plays in preventing or delaying the need for statutory services. This will lead us to develop a commissioning approach for building community capacity including a core offer or menu of services to support wellbeing, social inclusion and independence across the county.

Our core offer will consist of a range of services developed through co-production principles and built on an understanding of what people need to remain active, well and connected to their communities. All services will be designed to support self-management, enabling people to find their own care and support solutions and prevent or delay the need for statutory assessment and services. For those who do require statutory services, the core offer will offer cost effective alternatives to traditional social care provision, providing increased choice and control.
The current arrangements are based on how services have developed locally without a considered and planned strategic direction. Developing a core offer will mean that there is no postcode lottery about what type of support is available in the community. New services will be designed to maximise inclusion in the wider community, prevent social isolation, promote access to mainstream activities and support people to make informed choices about care early enough to support and maximise independence.

A precedent for this approach has been established, as a core offer for Carers Assessment and Support is already in place. Developing and commissioning the carers core offer involved ending a history of grant funding, 37 grants with 13 organisations including MIND, MENCAP and Age UK/Concern. An outcome based service specification was developed and contracts awarded to 4 providers who meet regularly with commissioners to ensure the contract is fully mobilised. This approach has rationalised the market, reducing the resources needed to monitor services and has established a culture of performance management. In addition, this contract was jointly commissioned with all Kent CCGs via a section 265 agreement underpinning an integrated commissioning approach which directly benefits recipients of the service.

Community based core offers could/should include services such as:

- Information, advice and guidance (including benefit maximisation).
- Social inclusion opportunities – connecting people with their communities.
- Employment support.
- Befriending.
- Caring for Carers.
- Advocacy.
- Co-production and Engagement Forums.
- Tele-technology.

Key principles:

- Easily accessible – no wrong door.
- Tailored to individuals needs.
- Generic services where possible – specialised only where proven essential.
- Proactive and designed to support self-management.
- Jointly commissioned wherever possible.

To ensure that:

- People are able to make informed choices about when, how and where to get their support.
- People using services have as much choice and control as possible when building their support package.
- People are able to access services at the right time and place.

This programme brief will need to be shared and discussed with all Kent’s Clinical Commissioning Groups (CCGs). Kent’s Integration Pioneer Programme contains work streams of Self Care and Personalisation which will be directly impacted by this programme; we believe this is a key area for joint commissioning considerations with both CCGs and Public Health. We will use Integrated Commissioning Groups as a means of sharing and gaining ‘buy in’ to the programme ensuring more effective use of resource and better demand management. For Mental Health the service improvement groups and performance oversight groups with the CCG’s will be central to decisions going forward.
This is a programme to ensure the right community based services and support are available across Kent to promote independence and wellbeing, delaying or preventing the need for statutory services. Most of these services are currently provided by the voluntary sector and predominantly through grant funding so inevitably the programme will involve moving a range of services from grants into longer term contracts, requiring a transformation in the way we work with, and fund the voluntary sector.

3. Outline Vision Statement

In repeated consultations with people who use our services and those who choose not to, we been told that... *people want a life not a service*. However, our current case management model has developed over years to be primarily about supporting people to access care package services. This programme of community capacity development is central and crucial to transformation in two key ways:

- By providing a range of community based services that support independence and wellbeing, diverting people away from formal social care systems (cost avoidance).
- By providing a range of quality, value for money services that provide an alternative to, or supplement traditional care packages (cost savings).

The commissioning of these services supports both the Pathway and Optimisation work streams of transformation by ensuring that individuals who are supported through enablement are supported post enablement to maintain their levels of independence and that the right services are in place to support people in their communities, preventing the need to provide ‘dollops of care’.

The programme will move adult social care from a position of inequitable service provision through annually awarded grants to a consistent core offer of services that support independence and wellbeing on longer term funding arrangements, with the majority of support secured via competitive contracts, which can be effectively performance managed.

The programme will seek to assess and understand the impact of investment in community capacity and be able to demonstrate return on investment in two ways:

1. As direct substitute for other forms of support, (cost savings) e.g. enablement or home care, and,
2. In preventing or delaying the need for on-going support (cost avoidance).

Evidence demonstrating the return on investment for preventative or voluntary sector services is minimal, although the evidence that does exist suggests that services delivered by voluntary sector organisations can result in care packages being reduced and positive outcomes. Given the work undertaken by Newton Europe to understand the true cost of care provision within KCC, cost savings will be measurable as services are commissioned with performance monitoring systems in place and regular monitoring. However, cost avoidance is harder to demonstrate and work will need to be undertaken with providers to ensure that performance measures allow for the collection of information that will capture this.

It will be essential to work with optimisation and care pathways work streams to ensure that gaps in service provision are identified, that commissioned services complement and enhance existing services on an individual’s pathway through social care and that processes are in place to promote referrals to these services as with any other commissioned service.

**OUR PLACE: WYE BUSINESS PLAN 2015 – 2018**
The programme will determine the work of the community support unit within strategic commissioning over the next 1 – 3 years and will shape the service provision for future generations of vulnerable adults.

Due to the current nature of grant funding, this programme will, by default re-shape Adult Social Care’s relationship with the voluntary sector market and consideration must be given to the management of that process.

This programme will support the transformation of adult social care by aligning with on-going work programmes within Community Support, such as Home Care and Accommodation Strategies. It will look at ways to breakdown silos between differing types of provision and support the move towards prime integration partners and local networks of supply.

Core offers will be built upon the needs and requirements of the people of Kent. Central to this programme’s development will be the engagement of people who use our services, their families and carers but also members of the general public who do not use services.

This programme cannot be developed or delivered in isolation and wherever possible we will look to jointly commission with public health and Kent’s CCGs. Joint/Integrated Commissioning opportunities will be fully explored as the programme develops; including opportunities for KCC to lead commissioning in this area through either section 75 or 256 agreements.

4. Outline Description of the Benefits

We face some fundamental choices to ensure that we have a sustainable model of social care fit for the future and are able to continue to meet the needs of the most vulnerable in our communities. A different approach is needed if we are to succeed in a context of increasing demand, rising public expectations and less funding. This means adopting an asset based approach which empowers individuals, families/carers and communities to meet their own needs outside of a social care model of support.

Newton Europe our efficiency partner completed a mini diagnostic assessment focused on current provision with the voluntary sector. The diagnostic showed that there was scope for greater use of the voluntary sector as our care pathways are redesigned to direct people to find different solutions in the community. However, the current proposal is to reconfigure services within existing budgets. Monitoring of services will give clear indication of the levels of demand and we will work with providers to understand the impact on their capacity. By understanding the return on investment this approach produces it will be possible to make recommendations regarding future levels of investment or disinvestment in these types of services.

This programme offers a unique opportunity to understand and design methods to evidence impact of investment and explore means of understanding and assessing the wider social return on investment (SROI).

The core offer will enable us to deliver this new model with the following benefits:

- Effective demand management through increase promotion of independence.
- Standardised access to community based services for vulnerable people across Kent.
- It will enable us to reinvigorate our approach to personalisation and Think Local, Act Personal (TLAP) initiative ‘Making it real’.
- People accessing services at the right time and in the right place.
o Increase the take up of direct payments - a more attractive and realistic prospect for a wide range of people.
o Review and reduce some service provision, reducing duplication and inefficiencies and commission cost effective services that are fit for purpose.
o Supporting new relationships/federations and consortiums within voluntary sector to create fewer points of management for the local authority.

**Required Outcomes**

o Reduction in the numbers of people entering care system including the secondary mental health care system.
o Reduced residential care admissions.
o Reduce average stay in care homes.
o Reduction in domiciliary care hours.
o Reduced hospitals admissions.
o Number of visits to GP (reduction in frequent visits).
o Range of quality of life indicators – including reduced loneliness/isolation, increased confidence and ability to cope.

**Issues for consideration – dis-benefits**

o Some voluntary sector organisations may be unsustainable without LA funding.
o Changes to voluntary sector can be extremely sensitive and attract press interest.
o This programme will require Member agreement to proceed and Members will need regular and substantial briefings as the programme develops.

5. **Resources**

The programme will be funded via decommissioning historic grants and moving to outcome focussed contracts. We aim to fund the programme within the current envelope but will also be looking to secure through robust business plans joint investment with public health and CCGs.

Timeframes are projected and are subject to variation based on approach, governance and capacity issues. If the programme is accepted a detailed project plan will be developed outlining commissioning options and timescales once the core offer for older people, physical disability and dementia services has been identified.

Core offer is being considered for all client groups. However, prioritisation is recommendation for the following:

o Mental Health services core offer. Mental Health grants are already aligned into a core offer with performance measures and therefore are well placed to move to a contracted core offer.

o Older People’s core offer. Greatest demand for services is within this client group. Ensuring that older people have access to community services is essential to the success of Transformation programme. We need to ensure we have capacity in local communities to support people coming out through enablement, or who are self-funders or those vulnerable people on the cusp but not quite ready for formal social care.
Services for older people will need to include the needs of older people with dementia, sensory issues and/or with learning disabilities in service specifications and providers will need to demonstrate they can meet these needs.

Consideration will also be given to whether support is commissioned on client group basis or whether there are some services, for example, advocacy which could be commissioned as a generic service across all client groups.

These considerations will be explored through the co-design of services and a range of options presented to Transformation Board as the programme is implemented.

Governance of the programme will be through a Programme Board. This board will link to the Integration Pioneer work streams of self-care and personalisation and report directly to Transformation Board.

It is proposed that Emma Hanson, Head of Service for Strategic Commissioning for Community Support will chair the board. Other members of the board will include representatives from:

- Older People/Physical Disability (Assistant Director(s)).
- Learning Disability/Mental Health (Assistant Director(s)).
- Strategic Commissioning.
- Public Health.
- CCG Representatives.
- Other operational colleagues as required.
- Category Manager Procurement.
- Policy.
- Performance.
- Key partners/providers from the sector.

A stakeholder co-production panel will be established to ensure real people’s voices are key in influencing future service redesign.
**Phase 1**
November to September 2014
- Gain political support for programme.
- Begin to commission Mental Health Core offer – in conjunction with Public Health & CCGs.
- Equality Impact assessment for MH Core offer.
- Undertake co production of core offer for Older people.
- Review of day services for older people, people with a physical disability and people living with dementia.
- Develop IAG solution to ensure appropriate signposting.
- Begin Voluntary Sector Market Development activity, including networking and information events.
- Commissioning of Market Development and Training Support Service with CCGs.

**Phase 2**
September 2014 to March 2015
- Complete commissioning of Mental Health core offer.
- Determine options for commissioning of core offer for older people.
- Complete governance processes for core offer for older people to gain permission to end grants and commission new services.
- Equality Impact Assessment for older people's core offer.
- Once agreed, work with Procurement support write new service specifications and terms and conditions based on co produced core offer.

**Phase 3**
April to September 2015
- Issue 6 months notice on existing grants.
- Commissioned core offer for Mental Health Services in place.
- Begin procurement process for older people's core offer.
- Begin to consider future provision of Carers Services.
Attachment Fifteen
Map of Wye Surgery

Patient catchment area, coterminous with the Our Place: Wye target area of benefit