SOCIAL CARE AND HEALTH DIRECTORATE
REPORT ON THE REVIEW OF MARDY PARK RESOURCE CENTRE
8th July 2015

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MONMOUTHSHIRE COUNTY COUNCIL

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1. FOREWORD

1.1. The report is intended as an open document to be shared as a whole with all the stakeholders of Mardy Park Resource; be it the local community, those that work there, visit or live at the centre

1.2. The report has brought together a number of streams of work and reports. Thank you to all the members of the mardy park development team. Thank you to the staff at the centre and those who use the services and support for their assistance, honesty and patience.

2. INTRODUCTION

2.1. Mardy Park Resource Centre [MPRC] is situated on the Hereford Road approximately one mile from Abergavenny Town centre. It is one of the three integrated health and social care hubs

2.2. The review of Mardy Park was commissioned by the SCH senior management team to critically evaluate the current service model and more importantly to assess the role that MPRC should play moving forward. Overall, the emphasis of this review is on the future. In the context of the different agendas set out below, what does the community of Abergavenny need from the centre and its resource.

2.3. The centre is a great place, with so many positives. Most notably the staff teams based there have maintained high quality service levels over the last few years since the last review despite the anxiety that has inevitably been present during this time. In essence, the review looks at the centre from a foundation of strength.

2.4. Currently, though, its purpose is not clear and this has meant high levels of uncertainty for all those that live there, make use of its services and for those that work there. It is not a service that has stood still but there is an absence of clear strategic direction in sync with the needs of the community and mindful of the financial and legislative drivers.

2.5. The review at MPRC is part of the Council's 'Your County Your Way' strategy, and the commitment to review services to makes sure they are:

> "… efficient, effective and sustainable. We start by asking the people who use services what matters to them and then try and redesign the service from that perspective. Staff are empowered to do what matters and encouraged to challenge processes that they believe get in the way of purpose."

2.6. The review works to a definition that integration is not just about health and social care services working together; it is working with whoever the person at the centre needs us to. In the context of supporting people, integration is about partnerships and working together with families, the local community, the 3rd sector and all other stakeholders. This may require co-location or it may not. Boundaries whether they are to do with access to information, communication, availability or venue should be removed wherever possible to support this approach.

3. BACKGROUND

3.1. Mardy Park was opened in 1997 providing residential services, respite and day services. A number of reviews have seen incremental changes to the services and purpose of the centre:

3.1.1. Opening of rehabilitation unit to support early discharge and prevent admission in 2000.

3.1.2. Closure of one residential wing to support the integration agenda.

3.1.3. Review of services and reduction of respite places and decision to not offer new long term residential placements at the centre. The review report [2010] headlined:

"Mardy Park will be a community hub for health and social care services, primarily focused on older people, in north Monmouthshire for the next 10 – 15 years. There will be a range of services in place that provide outcome focused, help to people when they need to keep them living independently and which are capable of acting rapidly to prevent hospital admissions."

4. CONTEXT OF THE REVIEW

4.1. The development of Mardy Park cannot sit in isolation. In reading this report, the context of the review is critical; both in terms of the sustainability of its recommendations and also ensuring the development supports other key priorities.

4.2. **Financial:** the review must be mindful of the current financial climate within which it exists. As a publically funded body the centre must be able to clearly demonstrate that each pound is targeted and thoughtfully spent. Despite its clear strengths and good reputation it must sit comfortably alongside other services in terms of outcomes in relation to spend.

4.3. **Sustainability:** the outcomes of the review must support a long-term plan that gives clarity to the local population and the people that work, visit and call the centre home. This clarity must extend long-term to ensure confidence and an environment which promotes innovation.

4.4. **Supporting and in line with the Adult Services agenda:** the recommendations and future shape of service must actively support the various agendas in development across adult social care and health. Principally:

4.4.1. Strengths based assessment focussed on what matters to the individual and their personal outcomes.

4.4.2. The development of community co-ordination and the support required to help people find their own solutions.

4.4.3. The Aneurin Bevan Health Boards hub development programme running in partnership and in parallel.

4.4.4. The development of new models of care and support and the absolute that all involvement starts with a relationship.

4.4.5. Workforce and Leadership development programmes with an emphasis on authority to act at the frontline and leadership focussing on support; not control.

4.5. **Corporate Priorities:** Extracts below of key areas:

4.5.1. People are Confident, Capable and Involved: we want Monmouthshire to feel safe and people to be confident. We want to create a place where people want to be involved; they are confident in themselves and their abilities and what they contribute to their own community

4.5.2. We will work to help people live their own lives by building flexible and responsive services. Our focus will be on safeguarding people, further developing our approach to integrated services and implementing community coordination in the pilot areas.

4.5.3. Nobody is Left Behind: we want to be a place of cohesive communities where everybody is treated with dignity and respect and has the same opportunity to achieve what they wish.

4.6. **Legislative: -** building on the Fulfilled lives, Supportive Communities: 'A strategy for Social Services in Wales over the next decade' [2007], the Social Services and Well Being Act [Wales [2014]] is the key piece of legislation directing the shape of services over the next few years. Of key importance to the review of Mardy Park are the following requirements placed on us by the Act:

4.6.1. People receive services that prevent their care needs from becoming more serious, or delay the impact of their needs.

4.6.2. Individuals can get the information and advice they need to make good decisions about care and support.

4.6.3. Individuals have a range of providers offering a choice of high quality, appropriate services.

4.6.4. That local authorities must provide or arrange services that help prevent people developing needs for care and support or delay people deteriorating such that they would need ongoing care and support.

4.6.5. That local authorities will work with their communities and provide or arrange services that help to keep people well and independent. This should include identifying the local support and resources already available, and helping people to access them.

4.6.6. Local authorities should also provide or arrange a range of services which are aimed at reducing needs and helping people regain skills, for instance after a spell in hospital. They should work with other partners, like the NHS, to think about what types of service local people may need now and in the future.

5. METHODOLOGY

5.1. Early on in the review we established a framework for development building on the conclusions that Mardy Park should remain an integrated services hub for the next 10 years. As stated integration in the context of supporting people should broaden to include partnerships with all. The framework is built on a simple health and well-being pathway set out below.

DEVELOPMENT FRAMEWORK – HEALTH AND WELL-BEING PATHWAY
The role that Mardy Park has to play to support the community to support itself to stay well through facilitation of groups, hosting events, improved access and information
The development of enhanced intermediate care services that support people in the short term.
The enhancement and development of longer term support services aiming at best practice in the provision of health and social care services.
The development of an enhanced and consistent end of life care pathway.

5.2. In addition a number of principals for development were established by the project team to guide the review throughout the phases and to ensure that outcomes were developed consistently.

DEVELOPMENT PRINCIPALS
Everyone's contribution (working, visiting, living at…) is welcomed, listened to & valued.
The site, building, services & activities are owned by everyone in the local community.
Mardy Park is a place people want to come and they make a 'positive' choice to be there.
Mardy Park provides opportunities for all irrespective of age, condition, background…

Mardy Park is a nice place to work.
We will support a philosophy of testing new ways of working to inform the change process
Support will focus on enablement and be proportionate
Support is only provided on the basis of a relationship & having had a 'what matters' conversation.
Co-location of staff will be on the basis that it supports the individual.
The Hub will grow and develop in response to the local community**.**
Permission to act is derived from the relationship and proximity to the issue at hand

5.3. The report is laid out against outcomes for each of the five work streams that were established following consultation with the community, staff at the centre and other stakeholders. The outcomes provide the platform from which to ask the questions: where are services currently placed and what are the gaps and the areas for development. Each section of the report highlights recommendations. Collectively these represent the roadmap for future service shape and highlight the future strategic direction.

6. COMMUNITY & PARTNER ENGAGEMENT

6.1. The overarching purpose for Adult Services is 'helping people live their own lives.' This is underpinned by the outcome "that people are engaged in and supported by the communities and not dependent purely on statutory services" both of which are aligned with the council's priority of "support for vulnerable people."

6.2. What role does Mardy Park need to play to support the community to support itself. Mardy Park itself, sits in a wider context of supporting communities within Monmouthshire to decrease reliance on statutory services. These approaches aim to:

6.2.1. Help people to pursue their vision for a good life

6.2.2. Strengthen the capacity of communities to welcome and include people

6.2.3. Develop small local enterprises to deliver more personal, flexible and accountable services

6.2.4. Co-produce community opportunities and support

OUTCOME: To encourage stakeholders, service users and members of the public to contribute towards the development of MPRC at large and to develop the relationship that the centre has with the community.

6.3. As part of the review the development team held two large community events in July and November 2014 with in excess of 600 people attending over the two days.

6.4. Since opening the affection with which the centre is held is apparent when talking to members of the local community. Concerns since the commencement of the review has to a greater or lesser extent been focussed on the preservation of services. An explicit aim of the review has been to meaningfully engage with the community. This can only be meaningful if those consulted have an understanding of what actually happens at the centre and are equally aware of what is achievable and needed in the

context of what is currently available. A critical part of the first consultation day was to showcase the services supported from the centre to overcome these perceptions of services being diminished in favour of office space. An emotional response to service change is completely understandable but critically we must maintain an objective view for any proposals to be sustainable.

6.5. The first consultation day adopted the theme of Learn/ Discover / Contribute. The day invited groups and individuals alike to talk about what they were doing, what was missing from their lives and their community.

> **DISCOVER** what is happening in your community, **LEARN** about the various health social care and health services being co-ordinated by the teams based there and to **CONTRIBUTE** to developing Mardy so that it becomes a resource for the entire community

6.6. Overall, the main benefit of these consultation days was to start a conversation and to invite the community in. Whilst many ideas were generated and the voices of the community have genuinely influenced the course of the review it was the simple act of coming together for two days that was the greatest success of these events.

RECOMMENDATION: regular community events should be planned each year to maintain this conversation and support on-going community involvement in the centre and its development.

OUTCOME: To scope and respond to the requirements of the community and those who access our services.

6.7. During the consultation days there was overwhelming support for the idea of Mardy Park being a place for people to come together; whether as a group or just friends meeting for coffee. There was concern however about the potential for duplication with many other community centres in Abergavenny and we need to ensure that support & services at MP are uniquely best placed there. Going forward we must maintain contact with and support other community centres to create a network across Abergavenny.

6.8. An emerging idea throughout this period of consultation was to establish the Abergavenny wing as the 'public facing' part of the building. Creating shared spaces is, in part, about a visible face of statutory services. If we can create the right spaces it creates a more natural environment for people who need our help, support or advice to engage with their keyworkers, social workers and other front facing members of the integrated services.

6.9. A cornerstone of the developments has been the idea to establish a small café at the centre and again, this has almost universally been welcomed by the community and all other stakeholders at MP. Ultimately it's less about coffee and more about providing somewhere for members of the public to come together for whatever reason.

'For some individuals, community cafes helped reduce social isolation, promote positive health and help them to acquire new skills and opportunities' *('Report on research into community cafes in Scotland'; Community food and health Scotland, March 2011)*

6.10. For the café to be fully embraced by the community; it needs to be centred around the community. From the design to the groups and events it will hold, to the food that's served the public has to be at the heart of the concept. For much of the past year, the MPRC Development team have carefully planned each element with the community in mind. The food and drink served will be non-

profit, making it much more financially accessible than local alternatives. The food will also be healthy and freshly produced on site with the intention of using fruit and vegetables grown on the grounds.

6.11. The function of the community café will extend beyond food and drink. One of the ideas that has come out of the development team meetings is to use the café as a venue and foundation for special projects. One idea was to create a permanent exhibition of portraits of older people accompanied by statements about sustaining wellbeing in later years. The focus of this project is to promote positive images of older people. It is funded in part by the Joseph Rowntree Foundation who for a year have run the 'Better Life Programme' looking at what matters to the older individuals in our communities. The community coordinator has been working with a local support and older person's advocacy group, Abergavenny Action Fifty Plus.

'Thinking positively about getting older can extend one's life by years… *(Rebecca Levy, assistant professor, Department of Epidemiology and Public Health, Yale University).*

OUTCOME: To support community and individual wellbeing through a place based approach.

6.12. An approach that supports one place where the statutory, health and 3rd sectors and other groups are sharing a space. Place based approaches are designed to *"develop creative ways of working, which overcome departmental or agency silos in order to make best use of the resources available within the area in question"*[1]

6.13. In essence, this is the next stage of integration; more than co-location of health and social services. Our vision is for Mardy Park to become the location where we begin this work and where we learn further about place based approaches to wellbeing and to build on the assets and strengths of individuals and communities.

6.14. Through providing an environment where partners on the front line can meet, share resources, information, knowledge and skills we can work together to maximize existing and create new opportunities for people to get involved, to contribute to and receive support.

6.15. As part of the consultation and the on-going work of community co-ordinator and others the centre has already begun to host and work in partnership with a number of organisations:

Partner organisation	Purpose of partnership
Stroke Association Gwent	To form a weekly stroke support group in Mardy Park Resource Centre.
The Green Valley CiC The Woodland Trust	To co-manage and maintain the orchard at MPRC
Assertive Outreach Team, CMHT, Maindiff Court.	To develop growing spaces in the grounds of MPRC. To fulfil outreach community therapy outcomes for the individuals receiving support from the AOT. To work with the community coordinator and the staff at the day centre to provide small therapy workshops for daycentre attendees.
Macmillan Cancer Support, Gwent Abergavenny Library	To provide a space for weekly shared reading therapy sessions.
Men Heal	To provide space for a support group that serves men with mental health issues who live in the Mardy community. The men will meet on a weekly basis at MPRC.

[1] Ageing Well – a whole system approach - a guide to place based working
Local Government Association

Community Connections, Bridges Community Centre, Monmouth.	To support recruitment and provide ongoing consultation and support with future volunteer coordinator based at MPRC.
MCC Youth Service King Henry VIII School, Abergavenny	To work together with the community coordinator to develop a 'drop in' ICT beginners skills course at MPRC. The workshops will be facilitated by support staff and officers from the youth service and students from King Henry VII School who are working towards their Welsh Bac or DOE Award.
Men's Sheds Cymru	To co-develop a wall of 'Men's Sheds' in the grounds of MPRC. These sheds will be used by socially isolated men.

'Mardy Park has given us hope, happiness and a great feeling of belonging. I don't know what we would have done without it' (Assistive Outreach Team attendee, March 2015)

6.16. **OUTSIDE AT MARDY PARK** - An additional part of the consultation with the community has been the invitation to get involved with and make use of the wonderful grounds there. This invitation has been a catalyst for a number of groups to become involved such as the Men's Sheds, Woodland Trust and the Assistive Outreach Team (AOT) highlighted above. The development of the grounds is an extension of the work inside Mardy Park. Key initiatives are detailed below to illustrate the work already underway and the potential moving forward:

6.16.1. **Wildflower Orchard, Growing Spaces and Community Garden.** One of the key areas of the grounds development is establishing a wildflower orchard. This area sits at the bottom of grounds and benefits from 9 mature apple trees. In autumn 2015; the community coordinator plans to work with the Youth Service to host an 'apple pressing' event where members of the public will be able to come to Mardy Park, pick their own fruits and make their own juices. This event will aim to engage people of all ages including local environmental and woodland groups.

6.16.2. **Shared reading Group.** Since working with Macmillan Cancer support and staff at Abergavenny Library on a shared reading group at Mardy Park, the community coordinator has expressed an interest in creating an outdoor reading element to the orchard. It has been proposed that we purchase wooden benches and situate them among the apple trees. This would not only offer the existing shared reading group an alternative to meeting indoors, but could offer a therapeutic outdoor resource to the day centre and resident service users.

'Children, like people of all ages benefit from the therapeutic effects of reading outdoors. The changing nature of the outdoor environment also gives a very rich context for exploration and developing vocabulary' *(Taking it outdoors: communication, language and literacy, www.essex.gov)*

6.16.3. **Growing Spaces.** Increasingly, communities are putting their green spaces to better use. These green spaces are valuable assets with the value lying in their potential to bring people together and provide space for therapeutic recreation. Work has already began on the grounds at MPRC. AOT have situated a poly-tunnel at the lowest part of the grounds and are growing crops to transplant into the growing space in the summer.

6.16.4. **Community Sensory Garden.** A project set over 2015/2016, the MPRC Community sensory garden will be the highlight of the grounds development programme. It will utilise volunteers and community groups to bring together a space that's accessible by all and focusses on the therapy only outdoor spaces can bring. The vision is to have a space that loosely wraps around the south easterly corner of the building. It will run from the car park to the community growing space; just above the orchard. The garden will be considered and will feature a diverse display

of plants, grasses and shrubbery. It will also feature light displays and sound instruments. It will have a few seating areas throughout and will provide a therapeutic experience for those that wish to use it.

'Sensory gardens can benefit older adults by encouraging them to spend more time outside. Their design and layout aim to provide a stimulating journey through the senses, heightening a person's awareness of what's around them' (Dementia Activities, www.nhs.uk)

6.16.5. **The 'Men's Sheds Wall'.** Following the response from the *Men's Shed* group the community coordinator developed with the Abergavenny Community Centre, the MPRC Development group decided that It would be beneficial to provide a similar resource from members of the Mardy community. We have proposed the situation of four small wooden sheds against a south facing wall on the grounds of MPRC. These sheds will all function differently but will all share a common outcome; to provide a space for the socially isolated older men of the Mardy Community to come and partake in relaxed activates that centre around DIY. The Men's Shed concept, born in Western Australia became popular as a way to engage men with each other and to stay busy, purposeful and well.

'It gives me a reason to get up in the morning and for two days a week I feel I'm gainfully employed. I really feel good working with and helping chaps who often feel isolated in the community. I would need a very good reason not to come' (Brian, www.menssheds.org.uk)

6.17. **Investment in Grounds Development.** We need to invest to create the infrastructure and a basis for moving forward. Key developments set out below:

Grounds Development projected costs	
Item	**Cost**
Wildflower Orchard	£250
Community Sensory Garden	£4500
Men's Sheds Wall	£1510.44
Total	**£6,260.44**

RECOMMENDATION: As part of the developments at Mardy Park funding is agreed to support community engagement projects / initiatives and an on-going budget agreed to support this approach in the long-term.

6.18. In addition to community groups and individuals it is critical that MPRC supports MCC partner organisations so that we contribute effectively to a more seamless approach to supporting people. The opportunity for partners to share space, improve networks and avoid duplication.

'I work all over Gwent, so when I'm in Abergavenny, I usually do my paperwork in the car. It will be lovely to come to Mardy Park's community café instead. I could even meet clients there for a cup of tea and chat' (Louisa Stokes, Stroke UK)

Good coffee, superfast Wi-Fi – I'll definitely be back – Louise George [GAVO]

6.19. Future planning of the centre must incorporate the support for the development of community facing groups such as local enterprises and co-operatives to underpin Mardy as a community hub that belongs to the community and not a local authority building with 'add-ons'.

6.20. Partnerships need to extend to increasing the levels on integration and co-location with Aneurin Bevan University Health Board.

6.20.1. The newly formed Mardy Park Integrated Services Model group has been established to support the development of a consistent hub model across Monmouthshire and will report to the Monmouthshire Integrated Services Partnership group. This work will build on the planned

health based clinics that will transfer from Neville Hall Hospital supporting the principal of services being as local as possible and accessible.

6.20.2. Discussions have been ongoing with Older Adults Mental Health Services [OAMHS] to assess the potential to re-site some clinics and the 'Memory Assessment Services' [MAS] at MPRC to adopt a similar model to that seen at Monnow Vale. Key advantages include that the environment is suitable, will promote integrated services and place based working will improve access to support and 3rd sector groups. There is now support from all stakeholders to move forward on this basis but accommodation requirements are high and will include:

6.20.2.1. Two rooms to support pre-testing.

6.20.2.2. One room for family consultation and briefing

6.20.2.3. One room for Consultant run clinics

6.20.2.4. Waiting area close to or adjacent to these rooms.

6.20.3. It is not anticipated at this stage to move OAMHS Day Hospital due to insufficient available space and the nature of the support that some people attending require.

6.20.4. As part of earlier consultation the Community Nursing Team identified the need for a nurse run clinic which will support four different clinics from Mardy Park. These will re-sited from NHH. The clinic has already been created but will not open until the car park and other infrastructure is in place.

RECOMMENDATION - As part of the on-going development of MPRC set aside agile working space for place based team partners.

RECOMMENDATION - As part of the on-going development of MPRC space to be set aside to accommodate OAMHS clinics and the MAS.

To explore models of personal voluntary contribution through providing working opportunities such as the community café and the community growing spaces.

6.21. Volunteers will be critical in helping the community spaces come alive. We have commenced partnership work with Community Connectors; a volunteer befriending service based in Monmouth. We have secured £25,000 via the Intermediate Care Fund to recruit two part time volunteer co-ordinators to support MCC's two community coordinators; one in Caldicot and the other in Abergavenny. In the north, we see the coordinator primarily recruiting volunteers to act as support staff for the community café; to work on the various grounds projects and to lend support in one of the many groups and events held at Mardy Park. In the past six months, we have seen 3 volunteers come forward to support groups at MPRC. One facilitates the shared reading group on a Wednesday morning; a group that currently has between 6-10 weekly attendees. The other two support the stroke support group held every Tuesday. The co-ordinator will also support the existing volunteer team that provide such invaluable support to the centre.

6.22. More and more we are understanding the core importance contribution plays in keeping us well throughout our life. From the volunteers pouring coffee and slicing cake at the stroke group to the ones volunteering to have their photograph taken for the 'Better Life' wall. Contribution in older age is represented well all over MPRC, and this is why working with volunteers and members of the community is vital.

6.23. Following the appointment of a volunteer coordinator in summer 2015, Mardy Park will be a hub of voluntary activity. Working in partnership with local volunteers will be crucial for the success of the community café, but will also provide opportunities for older members of the public to contribute to their community. The café will be chiefly run by MPRC kitchen staff and they will be supported by volunteer's assistants.

6.24. There is strong evidence to support the claim that social contribution in older age keeps people feeling well. This notion is the very cornerstone of much of the work at Mardy Park, and the community café, through providing voluntary opportunities such as kitchen assistance, activity organising and befriending will significantly help in reducing the isolation felt by many members of the community.

'Since I started volunteering at my local coffee shop, I have felt happier and fitter than I have in years. I now have something to do with my time and I've made new friends' *(Pensioner from Weymouth; Volunteer experiences, www.ageuk.org.uk)*

7. DAY SERVICES

7.1. Day Services at Mardy Park are provided seven days per week with four days for older people with dementia and three days for older frail people.

7.2. The service has undergone a number of reviews and changes over the last few years but there is a need to give the service as a whole and the staff team clearer leadership and strategic guidance to inform the further development of the service and to ensure that changes are effective in the long term.

7.3. The development of the day services initially will need to focus on creating a foundation for effective service provision. This will centre on the individualisation of services, staffing, activities, processes and information.

7.4. On first working with the day services team 12 months ago I was concerned about the service provision on a number of fronts:

7.4.1. The team were demoralised and there was an absence or perceived absence of leadership and support.

7.4.2. The numbers attending the day service had dwindled and there were days with as few as 3 or 4 people attending.

7.4.3. The service was flat and there was a little activity, noise or atmosphere emanating from the centre.

7.4.4. Referrals were not often made and there was a clear sense of a service in decline.

7.4.5. Critical through the review and the development of the day service has been the establishment of a day services staff development group which meets at least monthly. Through discussion with the team and others we highlighted the key issues and developed the outcomes for the service.

OUTCOME: A relationship based approach to supporting people and their carers is adopted throughout the service. Services are provided on the basis of effective listening and having agreed personal outcomes for each person attending.

7.5. The practice and approach of the team is focussed in part on personalisation and throughout the past four years they have maintained high quality services. A number of the team have attended dementia care matter's courses and adopted some of the principles but these approaches have not been consistently adopted throughout the team.

RECOMMENDATION: All team members to attend dementia care training as part of the direct care development programme.

7.6. The team acknowledge that individual plans for those attending were / are not being kept up to date and the current paperwork does not support an individualised approach. There is a large degree of duplication and over complication of the service delivery framework.

RECOMMENDATION: In sync with the development of other service delivery frameworks, the day services process and paperwork should be reviewed and rewritten so that they are simple, proportionate and focussed on individual outcomes.

7.7. The current approach to receiving referrals does not promote the development of relationships from the point of referral and staff were not directly involved in the meeting people from the point of referral, although this has now been changed

RECOMMENDATION: A new workflow should be developed to support the involvement of staff in establishing relationships before people attend the centre.

OUTCOME: Centre based services look, sound and feel focussed on the individual; inviting, lively, active and stimulating. This will include the matching of days to specific need including the context of where someone is in their journey with dementia.

7.8. Over the last twelve months there have been significant improvements in the day service from a position of it being quiet, potentially unstimulating and a service focussed in on itself (insular). Whilst there is still more distance to travel, the team are starting to embrace opportunities via community co-ordination, other groups and the development of new activities.

7.9. All staff have attended outcomes training; however, the current organisation of the staff rota does not support the development of individual outcomes. There are three staff on duty most days three to support a maximum of 12 people. As a ratio this is not low, but given all other responsibilities around transport, refreshments, supporting the wings, personal care etc… there is insufficient time to spend with people to a) develop individual profiles and b) support them individually.

RECOMMENDATION A new post of Day Services Team Lead to be created which is focussed on hands on support to the people attending but has a clearly distinct role to support planning and promote the individualisation of services.

RECOMMENDATION - the current rota should be re-organised within current resources so that time as a resource is focused on the times that people attend the service and to ensure sufficient flexibility to support a broader range of activity both in the centre and more widely in the community.

7.10. **Matching –** ahead of the review and as a result of some of the team attending Dementia Care matters training a decision was taken to adopt a matching approach to a 'Thursday'. Simply, this is support people on the same day who are at a similar point in their journey with dementia. Most people attending on a Thursday need a sensory approach based on touch and the other senses. The team are to be congratulated for taking this step.

7.11. **Spaces –** the layout of the centre twelve months ago saw most activity focussed on a large lounge area which was open to the corridor and use of the main dining room. These spaces were OK for group work but there was no space for individual activity. Considerable work has been undertaken to develop the layout with the lounge area closed off, spilt into a lounge and craft /activity area. The dining area has been divided into a small lounge area and dining area. Both areas have been refurbished. The team will also make use of the café area and are excited to work with the wider team on the development of a wider programme of centre based services which will see greater movement across the centre as a whole. In addition a confidential and quiet space needs to be identified for one to work of a personal nature.

RECOMMENDATION – As part of the accommodation review a room is set aside for this purpose. This would support the day service, 3rd sector, family support, therapies and alternate spaces for care management reviews.

7.12. Despite initial concerns the team have worked with other organisations to develop shared spaces and the above spaces now support:

7.12.1. Shaw's Day Support for people with dementia one day per week.

7.12.2. The local reading group once a week.

7.12.3. The Stroke Association support group

Activities at the centre will be stimulating, varied, and promote access to and interaction with the local community.

7.13. As outlined above the current organisation of staffing does not support an individualised approach and there is insufficient time for planning and as a result, there is a 'hand to mouth' approach to service delivery where activities are not based on a clear understanding of what matters but rather a default to group activities based on what the team know to work. As said, there is a drive to develop activities but there is also insufficient support and leadership present within the centre to drive this. The 2010 review removed the Team Leader post from the day service and transferred responsibility to the officer team. Whilst there was capacity, the responsibility is generic to the role of officer and there is no clear lead. In essence, the day service is an 'add-on' and the team feel this strongly in that they do not feel valued or a part of the centre as a whole.

RECOMMENDATION - A new post of Day Services Team Lead to be created which is focussed on hands on support to the people attending but has a clearly distinct role to support planning and promote the individualisation of services.

7.14. Work is already underway to try to develop links with the community with the removal of the assumption that day services referrals should lead to attendance at the centre. Currently, each member of staff is undertaking a home visit with the community co-ordinator to look at having a different conversation. Adopting similar approaches as those currently in place in the south of the county which have seen the establishment of smaller groups coming together through shared interests will require a different approach to the staffing model

The service will run at capacity being mindful of the need to have flexibility to deliver a variety of services which should also involve spontaneity. Staffing will be proportionate.

7.15. Current occupancy is at around 60% and numbers are steadily growing. In comparison with day services in South and Central Monmouthshire, this is very low. However, as relationships with Abergavenny Integrated Services Team and others has developed the number of referrals has increased significantly.

7.16. Not all people currently attending would meet eligibility criteria if re-set in terms of need and other opportunities. Anecdotally some people attend on particular days due to involvements elsewhere on each of the other days.

7.17. The current referral process that supports people to attend is slow and some referrals are not being processed in a timely manner.

7.18. As a small day service, there are clear limitations placed on the service by transport issues. There is only one bus and the areas are very rural, but the main issue is that there is an expectation that transport will be provided to all, irrespective of whether they can make their own way in. A review of the transport policy is currently underway in Monmouthshire.

RECOMMENDATION: Review eligibility criteria for attendance at the day service.
RECOMMENDATION – undertake a focussed review of all people attending with a view to cessation of service / alternative provision to support closure of one day.
RECOMMENDATION – Following the review of people attending consideration should be given to reducing the days to 6 or to 5 days per week. This would support a more flexible staffing model as detailed above.

8. REVIEW OF CEFN

8.1. Mardy Park' Cefn wing now supports 1 permanent resident and 6 respite beds. There is a need to ensure that 24 hour services are only provided from the centre on the basis (of a council run service) that these are best placed, support the redesign principles under the health & well-being pathway and are not available elsewhere across the sector. Moreover, services should be flexible, outcome focussed, relationship based and linked to other services and agencies run / based at the centre. As part of the review a focussed audit of current provision was undertaken by a member of the Abergavenny Integrated Services Team to inform the development of a model that that balances affordability with the outcomes required from the residential services model. This piece of work included meetings and direct consultation with people receiving our services, carers and the staff team currently supporting services on Cefn.

8.2. At the same time as the review of services on Cefn was underway, other uses of the wing were explored. These included the potential to provide residential respite services for people with dementia and also to support people with high needs currently placed outside of the county due to the unavailability of places in MCC. Having met with senior managers concerned these options were ruled out on the basis of cost and that the need for respite was primarily in nurse led services.

8.3. The services provided by Cefn were reviewed in 2010 and below is an extract of the original report:

> *'Respite beds play a key role in maintaining independence. Nonetheless, despite providing high quality care, they are not sufficiently aligned with the principles for Mardy Park in that they: are not part of an integrated approach with health; are not sufficiently outcome focused; are not sustainable and do not offer value for money.*
>
> *The remaining beds on Cefn should be converted to respite use as current residents pass away to maintain unit costs. Once, at a future undetermined date, the ratio moves from 5:2 to 7:0 a decision should be taken on the most appropriate use of that wing taking into account the vision and principles. In the medium term the shifting ration should be used to accommodate some of the increasing demand for respite caused by demographic trends'.*

8.4. Having reviewed the 2010 report, the principals of development are largely in line with the outcomes set out below but the information below and recommendations whilst mindful of the original review are based on current findings within the context of new service models and the development of other service areas.

8.5. From individual feedback from carers and service users, the main expectation of respite is:

8.5.1. To feel safe.
8.5.2.To be looked after at
8.5.3.To be somewhere familiar,
8.5.4.To have a private clean room,

8.5.5. To be somewhere in the community where family can visit them and

8.5.6. To have some company from staff and other users of the service.

8.5.7. To overcome feelings of loneliness and isolation when family and carers are away from the home. The locality of MP is very important to support visits from families and friends and clearly highlighted as a corporate priority that services are as a local as possible.

OUTCOME: Services should be targeted at those people with high needs that can be uniquely met at MP and we should retain an 'umbrella' role; that they can still respond to ad-hoc emergencies. We should not create un-met need through changes made.

8.6. Respite is accessed via assessment for suitability. Eligibility is insufficiently defined. Criteria includes:

8.6.1. People will typically be aged over 65.

8.6.2. May be in receipt of a domiciliary support package

8.6.3. Have needs that require night time support or monitoring.

8.7. All referrals for respite are supported by social work input. An application must be completed stipulating the reason for respite. A copy of supporting background information proportionate to the persons needs must also be submitted. Examination of files revealed a very mixed picture in terms of detail and a focus on outcomes for the individuals.

8.8. There is insufficient integration between direct care staff and members of the AIS.

8.9. The table below shows a breakdown of referrals for the 12 months from 1.4.14 – 31.3.15. Data was gathered from an individual analysis of each person and is available on request.

	Total	**%**
Unplanned / Emergency	25	33
Planned	50	66
Regular	30	40
One-Off	45	60
Carer break/Carer hospitalisation	51	68
SU break	24	32
Night care required	36	48
Existing Care plans	42	56
POVA / Immediate welfare need	13	17
Respite aged 65-79	19	25
Respite aged 80 and over	56	75

8.10. **Summary of findings of reasons for accessing services (AIS Caseload 14/15)**:

8.10.1. Main reasons for accessing respite:

8.10.1.1. Carer/ cared for breakdown of support at home

8.10.1.2. When the carer needs a holiday

8.10.1.3. Assessment periods to help determine needs.

8.10.1.4. To offer regular carer breaks to minimise carer/cared for breakdown

8.10.1.5. Emergency support as required when welfare concerns are immediate

8.10.2. 75 people have accessed residential respite services during this 12 month period.

8.10.3. Only 48% of people had night time needs.

8.10.4. Less than half the people supported had an existing domiciliary care package.

8.10.5. 60% of those people were considered to be receiving support on the basis of a 'one-off' period of support.

8.10.6. Only 40% of people are in regular receipt of respite at Mardy Park.

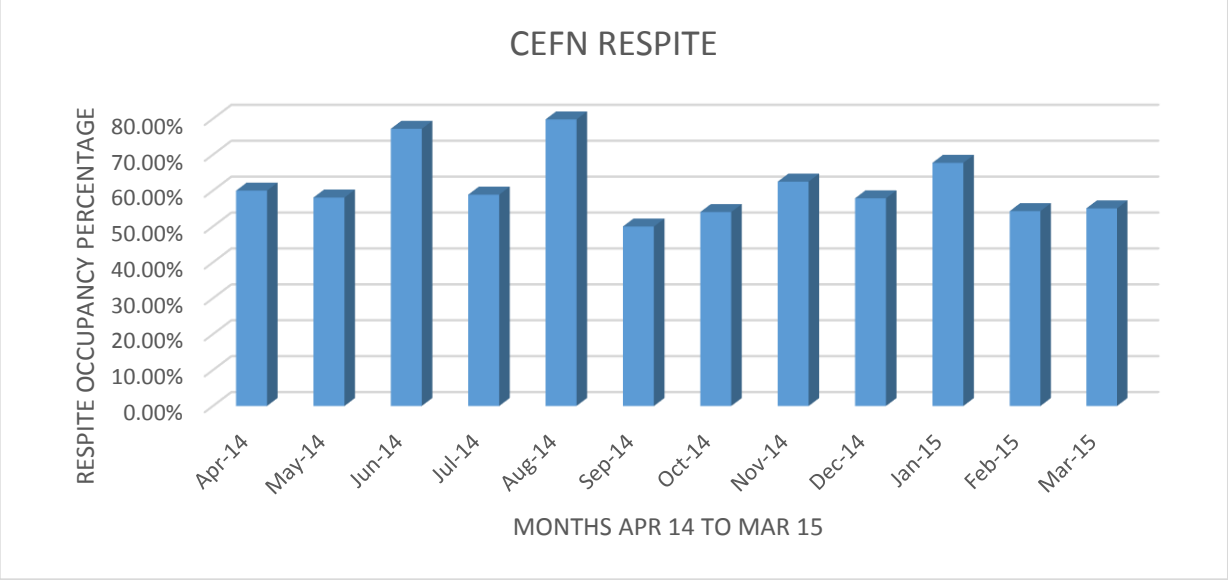
8.10.7. 17% of people required immediate support due to welfare issues or concerns raised via the Protection of Vulnerable Adults procedures.

8.10.8. The majority of referrals are received from the Abergavenny Integrated Services Team due probably to co-location of services and the fact that the centre is not registered with CSSIW to support people with dementia.

8.10.8.1. **RISK -** Any proposals must maintain an element of provision to support immediate access to 24 hour support.

8.11. Occupancy. As stated Cefn has the capacity to support 6 people on respite. On average there are 180 nights available per month.

8.11.1. A total of 1,443 nights support were provided in the 12 months from the 1.4.2014.



8.12. Whilst the recommendations from the 2010 review recommended 2 rooms be made available for respite there was a supplementary recommendation that as permanent beds became available due to the death of long term residents these should be made into short term beds on the basis that a future review would establish the long term use of these beds. It is clear that the demand for residential respite has grown in direct correlation to the capacity created. It is not possible to determine the exact basis for this but it is likely that there has been a drive to maintain reasonable occupancy levels.

8.13. Below is a table detailing occupancy for the first 6 months of both 2013/2014 and 2014/2015 to illustrate the issue of service creep. The percentage occupancy has been maintained at approximately 60%. Critical is that in each of the 6 months in 13/14 there was capacity to accommodate higher demand. The conclusion is that the demand did not exist and the increase in occupancy is directly related to the drive to maintain reasonable occupancy levels.

1st 6 months 13/14	Apr 13	May 13	Jun 13	Jul 13	Aug 13	Sep 13	Total
Nights Available (4 beds)	120	124	120	124	124	120	732
Occupancy	73	62	74	73	99	60	441
Percentage Occupancy							60%
1st 6 months 14/15	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	
Nights Available (6 beds)	180	186	180	186	186	180	1,098
Occupancy	108	108	139	108	134	105	702
Percentage Occupancy							64%

RECOMMENDATION – reduce bed availability to 2 respite beds – in sync with levels 18 months ago

RECOMMENDATION: retain 1 bed in combination with Deri that is earmarked for emergencies

OUTCOME: Services should be integrated within the health and social care framework with a focus on promoting independence and active rather than passive approach to service support should be adopted.

8.14. From discussions with several users of the respite service the need to be cared for has been the highest priority. However some service users have found little engaging support on offer to stimulate and promote their level of wellbeing. On further discussions with some service users/carers, the need for involvement in worthwhile or productive activities has been superseded by the need to be looked after. This leaves some individuals using respite support at Mardy Park as simply a mechanism to manage this fundamental need. Service expectations have been found to be low and the level of involvement appears to be accordingly low. There is some clear interplay between both low expectation and low service engagement.

8.15. There is an understandable disconnect between those commissioning and those providing services. This is leads to a passive approach to respite and opportunities to support, review and re-able are not taken.

8.16. As discussed later in the report the staffing levels are proportionate currently in terms of meeting basic support needs. There is currently little activity and occupation. This extends to involvement with other services and opportunities at MP and in the local community. The current emphasis is on safety and following set care & support plans. The alternate being to use care and support plans as a flexible framework within which to provide support with a refocus on social and emotional well-being

8.16.1. **RECOMMENDATION**: care & support framework redesigned and workflow developed to support a greater level of integration & focus on social and emotional well-being.

OUTCOME: Full consideration is given to alternate models of delivery such as respite through shared lives.

8.17. Mardy Park, as a council run service, operates within the context of a diverse market with a wide range of services available within the private and 3rd sectors. In undertaking the review at MP it was critical that we understood what else was available and who potential partners may be. Of importance is the need to consider respite as being something other than functional and service design should focus on experience, enjoyment and even adventure.

8.18. **The 'Shared Lives' scheme** offers placements for people within the homes of 'Shared Lives' carers. It may provide an alternative for long term, short term and emergency respite support. The settings available vary and can support individuals with complex needs. The focus of 'Shared Lives' is to provide a 'home from home' environment within a family setting. The individual's own outcomes shape the support and experience they want from the service. Individual needs are assessed by the care manager prior to using shared lives support and depending upon the level of needs they are banded as shown in table below. A setting is then 'matched' with the individual according to their outcomes.

SEWAPS /Shared Lives Weekly Fee Levels/Banding 2014-15

Band	Level of Care and Support Needs	Weekly Fee
A	Person has minimal care and support needs; able to go out independently.	**£308**
B	Person requires moderate levels care and support, needs to be accompanied at all times when outside of the house, and needs occasional support with personal care. There may be some behaviour that requires additional support.	**£361**
C	Person requires moderate levels of care and support, needs to be accompanied at all times when outside of the house, and has regular personal care needs. There may be some behaviour that requires additional support.	**£412**
D	Person requires a high level of care and support, needs to be accompanied at all times when outside of the house, and has as high level of personal care needs. May have some mobility problems, and some home adaptations may be necessary. May occasionally present behaviour that challenges the service.	**£516**

NB Sessional support can be offered at £6.40 per hour, plus agreed mileage allowance at 45p per mile- this support is currently used for regular day care breaks.

8.18.1. The uptake of the scheme with the Abergavenny Integrated service has been low -1% in the last financial year with only 1 service user on current AIS SW caseloads.

8.19. **Bed &Breakfast**

8.19.1. This type of accommodation can provide alternative respite support within varying settings. Rooms would typically need to be booked but some B&B's could offer emergency accommodation depending upon room availability.

8.19.2. For the purpose of the review a B&B in Abergavenny has been looked at to provide an overview of the support that can potentially be commissioned. The proprietors are very keen to work alongside the LA and offer a service to individuals specifically over the age of 65. It is a well-established business and already offers accommodation to both the general public and emergency support cases from other local authorities. They are keen to support a holiday style approach to support with a homely family orientated environment.

8.19.3. At the point of the review a charge of £45 per night was given as indicative.

8.19.4. This type of support would not be able offer accommodation to people with any behaviours that could be seen as challenging.

8.20. **Respite Opportunities Service –**

8.20.1. Sited in the Caldicot, South Monmouthshire, it is a small respite facility that is typically been used by individuals with learning disabilities aged 18-64. Service users from the whole of the county can access respite here but it's predominantly used by those in the South. Budden Crescent has 4 registered beds but is currently being operated as a 2 bed facility due to current staffing levels. Information gathered for the purpose of this review indicate the setting has potential to be used for further exploration into developing respite services. No figures have been provided for uptake of this service.

8.20.2. Even if no partnerships were explored the model of service is a great illustration of a flexible respite model that is delivering an experience, enjoyment and even adventure.

8.21. **Severn View**

8.21.1. Based in Chepstow the care home has 32 rooms and is registered for use by individuals with dementia/older adults. Most referrals come from SW teams in the South. The facility has

residential and respite availability, and on the most comparable wing (to Mardy Park) for Apr 2014-Mar 2015 a **76%** respite occupancy level was achieved; although this was unusually low in fact, compared to previous years.

8.21.2. Whilst this is an option worth exploring the are a number of competing developments at Severn View to address lower occupancy levels / reduction in demand and placement there could not be considered local.

8.22. **Planned Holiday breaks**

8.22.1. Used more widely by younger individuals with disabilities this support tailors a holiday package to an individual's needs and outcomes. There are specialist providers for all age ranges and PA's/carers even attend planned holidays with the person-these packages can vary in price and can cater for individuals to have a break in the UK or abroad. There are many providers including SAGA that can create a bespoke package for either the individual or the carer.

8.23. **Non-residential respite**: We need a better understanding of the reasons that people access residential respite services away from the home. A number of options are available and again these are found to be under-utilised.

8.23.1. Capacity within existing day services

8.23.2. Day Support on the wings at MP with additional community support.

8.23.3. Using sessional support via Shared Lives

8.23.4. Use of homecare services.

8.23.5. Discussion on night staffing

RECOMMENDATION: A further piece of work should be undertaken to explore in detail the potential of the options outlined in the report for sessional and residential respite.

9. DERI REVIEW

9.1. Deri Rehabilitation Unit has been open since December 2000, and is an 8 bedded therapy-led step-up/step-down facility within a residential care home setting. 7 of the rooms have an en-suite toilet facility, and 4 of the rooms have shared access to an adjoining kitchen. There is also a shared lounge/ dining room, an assisted bathroom, a level access shower, and a laundry room. Currently there is one dedicated member of care support staff with support from an additional member of staff working across Deri and Cefn. In addition there is dedicated input from occupational therapy and physiotherapy. Deri is a joint funded unit with 53 / 47% split between Monmouthshire County Council and the Aneurin Bevan Health Board.

9.2. Referral to the unit is on the basis of being over 18, in need of rehab / assessment, able to engage in the process, registered with either of the three Abergavenny practices.

9.3. A focussed review was undertaken by the Lead Occupational Therapist to inform this report and the development of a model that balances affordability with the outcomes required from the residential services model. This piece of work included meetings and direct consultation with people receiving our services, members of the AIS, carers and the staff team currently supporting services on Deri. As with all sections of this report the findings are set against a number of outcomes for the review with a focus on whether best placed and whether needed.

Bill Thomas (83) has been at Mardy Park for three weeks, after having a lower leg removed due to poor circulation. He said: "They look after you really well – 10/10. If you need anything, they come to help you. I have been doing exercises and building up my strength. It helps to get confidence and independence back. It's been wonderful, you couldn't ask for more. It's handy here too. People can visit, as I live in Abergavenny."

OUTCOME: The need for services are evidence based and we preserve those residential services that are uniquely and best placed at Mardy Park. We do not create areas of unmet need through changes made.

9.4. The primary role of the unit over and above community reablement is as follows:

9.4.1. 24 hour assessment that cannot realistically be provided in either a ward or person's home environment.

9.4.2. Provide an opportunity for people to do more functionally rather than stay in a patient's role for longer.

9.4.3. To practice and gain confidence with night time independence.

9.4.4. To increase confidence after a prolonged hospital stay

9.5. The profile of individuals using the service has changed over the years in line with the development of the Gwent Frailty project and the community Reablement team /START. The number of people supported via community reablement has grown from 173 in 2009 to 266 in 2014. Moreover, whilst the majority of admissions to Deri have come from hospital settings the number of community referrals falling.

9.6. Individuals with a more straightforward presentation who would previously have been admitted to the rehab unit are now usually able to receive their support and rehabilitation within their own home, unless there is an environmental or social reason to prevent this. Evidence of this is those people supported via Deri following orthopaedic surgery:

- 03/09/09 = 5 out of 7 people
- 14/10/13 = 2 out of 8 people
- 12/05/15 = 2 out of 6 people

9.7. The average occupancy for 12 months from April 2014 to March 2015 was 87%

9.8. Those admitted now with increasingly complex needs usually require a period of assessment as well as a rehabilitation programme. This does not necessarily increase length of stay as the community Reablement team can continue the rehabilitation at home if needed. Also, the assessment process would help to identify whether long term support or a residential placement might be the most appropriate option, and these arrangements can be started in a timely manner.

9.9. As part of the review of Mardy Park a number of censuses have been undertaken to get a picture in time of who we are supporting and why. The original census was carried out on 14/10/13 and as part of the current review; this was repeated on 12/05/15.

9.9.1. The following table provides a comparison of some of the results:

Descriptor	Census 14/10/13	Census 12/05/15
Rooms occupied	8	6
Sex	7 female / 1 male	4 female / 2 male
Admitted from Neville Hall Hospital	4	5
Transferred from a peripheral hospital	1	0
Admission from home	3	1
Needing a 24 hour approach to assessment and support	5	5

9.10. In addition we have an undertaken a 3 month study of all individuals receiving assessment and rehabilitation on Deri 1.0.15 to 31.03.15

Occupancy:

Month	January 2015	February 2015	March 2015
Bed nights available	248	224	248
Bed nights occupied	199	224	195
% occupancy	80.24% [6.42 beds]	100% [8 beds]	78.6% [6.3 beds]
NB: No delayed admissions due to lack of available beds during this time.			

Analysis of the 23 people admitted to Deri – January 2015 to March 2015 – Average Stay 26 nights					
Admission from		**Night time needs**		**Discharge destination**	
Neville Hall Hospital	18	Assistance with toileting	11	Home independent	3
RGH – 2	2	Reassurance	5	Home with reablement	9
Other hospital	1	Low mood	2	Home with LTC	5
Home	2	No support needs	5	Residential Care	1
				Neville Hall Hospital	4
				Not yet discharged*	1

***delay due to flooding at persons home**

Range of personal outcomes identified during admission and progress made:

Personal Outcomes categories (based on Talking Points)	Number of times identified	Achieved at time of discharge	Not achieved at time of discharge
Living where and how I want to	20	16	4
Having meaningful things to do	2	-	2
Feeling safe	1	1	-
Improved skills	9	8	1
Stable or improved health and well-being	1	1	-
Community connections	8	1	7
Staying as well as I can	2	1	1

9.10.1. At each data point collection approximately 20% of people staying have no night needs. Therefore is it safe to say that with an average of 80%occupancy [6.4 beds] a reduction of 20% could be achieved without reducing our capacity to support people with night time needs. This would leave a figure of 5.12 beds.

9.10.2. It is worth noting that there has been a recent addition of 1 or 2 additional step down beds in South Monmouthshire at Severn View.

9.11. Support and services are well thought of by all that use it and there is a seemingly high levels of satisfaction from people using the services. Similar to Cefn there may be a low sense of expectation and we need to develop a much better evaluation framework.

RECOMMENDATION – Build on the current development of outcome based service planning to incorporate a clear evaluation framework based on outcomes.

9.12. The most recent revisions to the eligibility criteria for admission to Deri Unit were made in July 2014, and highlight the provision of assessment as well as rehabilitation, and also clarification around admission of individuals experiencing cognitive impairment.

RISK - The current registration does not support admission to Deri Unit for individuals with a confirmed diagnosis of dementia. The SCIE Guide 49, May 2013, advocates that individuals with a dementia "should be assessed on the basis of their needs and strengths …. their potential to be 're-abled' ".

9.13. Only residents with an Abergavenny GP are eligible for admission and this has been challenged in the past to no avail by senior managers within ABHB, but proved not to be cost-effective due to medical governance and prescribing issues.

RISK - Urgent cases may fall outside these parameters or the team are forced to work outside of this criteria.

April 2015)

***Beryl Curran** (aged 90) has been at Mardy Park for three weeks receiving therapy support, having fractured her hip following a fall. She has been encouraged to increase her mobility and she praised the support: "I have been doing exercises and practicing walking up the steps. It's nice here and there is plenty going on. They are doing a really good job."*

***Jill Davis** (aged 86) has now returned home following a hip replacement operation and a short period of rehabilitation at Mardy Park. Jill explained: "I was transferred to Mardy Park following the operation, as I couldn't come home straight away. I was given exercises to help me and the support was excellent. There was a great, lively group of people there and we all had good camaraderie. In one word, it was excellent."*

9.14. It is clear from the detailed analysis of the 23 people staying on Deri our support is focussed on returning people home and improving ability and the team have delivered consistently well against these outcomes. In contrast the need to feel connected with the local community was highlighted on 9 occasions but only met once. It is only in the last 6 months that personal outcomes have begun to be captured properly so no data exists prior to January 2015 but it is probably safe to assume that the outcomes based on returning home and physical ability have been the focus of the team.

RECOMMENDATIONS:

- Changes should be made to handover so that they are focused on outcomes within an integrated care planning framework.
- Reduce the number of beds from eight to five.

RISKS:

- The reduction of beds may impact our ability to respond to seasonal variations.
- The unit may experience increased demand if referrals for people with living with dementia increase.

9.15. **Comparison with Gwent Authorities.** All 5 boroughs have some form of intermediate care beds, but there is a need to clarify how they are differentiating between the terms "step up", "step down", "assessment" and "rehab" before comparison of provision can be accurately made. The following gives a summary:

Borough	Location	Purpose	No. of beds	Occupancy rates
Torfaen	Meadow View	Step down	3	Not available
	Panteg	Step up/step down	2	Not available
	Leadon Court	Step up/step down	2	Not available
	Plas-y-Garn	Rehab	3	90%
Monmouthshire	Mardy Park	Assessment & Rehab	8	80%

	Severn View	Step up step down	1	Not available
Newport	Hillside	Step down	6	Not available
Blaenau Gwent	Red Rose Care Home Llys Nant Y Mynydd Llys Glyncoed	Assess, step up/down Assess, step up/down Assess, step up/down	2 1 1	90% 62.50% 62.30%
Caerphilly	Ty Clyd Ty Iscoed Rhymney Integrated Health & social care	Assessment Assessment Assess, step up/down	7 3 6 (flex = 11)	100% 100% 100%

OUTCOME: We ensure models of residential rehabilitation services are targeted and broaden to make the best use of available resources and support a flexible approach to supporting the person's personal outcomes.

9.16. As detailed above there is a clear need for night time services. An initial estimation is that services would be largely unaffected if 6 beds remained although full occupancy of 8 beds was required only as recently as February 2015.

9.17. To achieve a safer reduction of beds, we must consider both our ability to reduce average length of stay and a broader range of services.

9.18. **Broader Range of Services**

9.18.1. **Day Assessment & Rehabilitation.** Anecdotally discussed for some time, has been the benefit of retaining all the benefits of the rehabilitation service without the need for residing. Mardy park is uniquely placed to support this crossover between residential and community services and evidence from the Falls clinics and Day therapy sessions that have been periodically run from the centre support this approach. As part of the review therapists were asked to consider cases as to their suitability with two case examples given below for illustration.

Mrs X lives with her husband in a very small house. She has a diagnosis of progressive supranuclear palsy, but with just the support of her husband has been leading as independent a life as possible. Mrs X had a fall and fractured her wrist which was then put in plaster. She requested temporary help with personal care due to loss of independence from the injury. A morning call by reablement was put in place.

Mrs X was reviewed by an occupational therapist (OT), who was concerned about the deterioration in her balance, and the risk of further falls. It was noted that the home environment was extremely small and there was not sufficient space to fully assess Mrs X. The OT highlighted the suitability of day assessment on Deri Unit as an alternative Mrs X was agreeable to this approach.

Mrs Y lives alone in a 2 storey house with a stair lift in situ. She has a history of depression and is regularly reviewed by the mental health team. Physically she is limited by arthritis and the related pain. She has a long term support package provided through a care agency. The mental health consultant contacted Mrs Y's care manager, an Occupational Therapist (OT) in the integrated services team, to request that she attend day centre at Mardy Park.

The OT went to assess Mrs Y at home, and found that she was spending all of her days upstairs, mainly lying on her bed. She was not eating or drinking very well, and her mobility was quite poor. Mrs Y said that she would like to attend day centre as she missed socialising

with people. It was agreed that in preparation the therapy technician would visit for a few days so she could assist her to go downstairs, where Mrs Y would stay for 2 hours until her next carer came.

However, Mrs Y did not always feel like going downstairs, so this was achieved only 2 out of 5 attempts, and she was still spending a lot of time on her bed. She was still saying she wished to attend day centre, but we remained concerned that it would be too much for her to attend straight away. It was then suggested that she come for day assessment on Deri Unit, as this would give her a purpose to come downstairs and she could be collected mid-morning and just stay for a short while which could then be increased on a few subsequent occasions.

9.18.2. In addition, day assessment and therapy has the potential to enable earlier discharge from Deri Unit, particularly in conjunction with an enhanced model of community enablement support to include nights (as outlined below) and the use of Careline/Telecare.

9.19. **On-call community waking night support**

9.19.1. From the information gathered from Deri Unit from 01.01.15 to 31.03.15, the following supports further exploration of the potential for on-call night provision within the community:

9.19.1.1. 5 people required no assessment or support at night at all during their stay

9.19.1.2. 13 people were either assessed as independent or night support stopped during stay

9.19.1.3. 5 people required night support during the whole of their stay

9.19.2. Currently the only night cover that can be commissioned for the community is a whole night in a person's home (either waking or sleeping) carried out by an agency carer. It is possible to fund up to 3 waking nights from the Frailty budget, which tends to be used for community emergencies, transition home from hospital and occasionally from Deri Unit. March to May 2015, we have commissioned 21 night sits (8 service-users). Based on Allied's rate for a waking night, this is £140.30 per night, so a total of £2,946.30. Applying this to 12 months we would spend £11,785.20. It is not always easy to get timely feedback from the agency, and many people find it intrusive, and sometimes even stressful, to have a carer in their house overnight.

9.19.3. Previously there was a trial of on-call at night using the in-house home care team, which was linked to individuals who had a Careline /Telecare installed but had no family or friends to respond in an emergency. The uptake of this was very low initially but numbers grow to over 70 in the 18 months that the project ran. Due to shortages in funding the trial was ended. Individuals without a responder can now only be linked directly to calling out the emergency services. At the time, this trial was viewed largely as supporting the use of Careline/Telecare and the wider possibilities for use in individual care & support plans were not considered.

9.19.4. One proposal is that on-call night support could be one of the key elements available to care managers who are putting together short term Reablement packages to enable individuals to regain their independence whilst remaining at home, preventing some admissions to either hospital or Deri Unit, and also facilitating earlier discharge home from either location.

9.19.5. Currently there is on-call night provision for residents of Lavender Gardens who do not have a responder, and it is suggested that the funding for this be incorporated into this proposal to cover both Lavender Gardens and the wider community.

9.19.6. Of the recent 5 [12.5.15] that needed overnight support during their stay:

9.19.6.1. 2 could have potentially gone home sooner had there been on-call night support

9.19.6.2. 1 could have potentially gone home had there been a combination of on-call night support and day assessment

9.19.6.3. 1 could have potentially gone sooner with on-call night support but had a flood in her house so couldn't have gone even if it was available

9.19.6.4. 1 could have potentially gone sooner with on-call night support but was waiting for tenancy to be sorted with Lavender Gardens as she was moving there.

9.19.6.5. The person who didn't need a 24 hour approach did have very severe confidence issues which could not be met with Reablement calls initially, but with day assessment available we might have been able to support her straight home.

9.20. **Key factors to support pace in discharge.** Set out in summary below are the key steps to increasing pace for discharge and allowing a safer reduction of the number of beds:

9.20.1. **Staff Development & Integration:**

9.20.1.1. Develop a new role profile and competency framework for direct care staff to ensure clearer focus on rehabilitative work.

9.20.1.2. Develop a generic role profile to support staff working across Mardy and community

9.20.1.3. Ensure all staff receive 6 day dementia care training programme.

9.20.1.4. All senior staff to have completed Occupational Therapy level 3 training

9.20.1.5. Ensure that the Deri Unit has a Band 7 therapy lead.

9.20.1.6. Increased levels of integration across all involved agencies.

9.20.1.7. In-reach of community enablement staff on to Deri and day assessment unit.

9.20.2. **Re-focus of Deri – function.**

9.20.2.1. Update Deri eligibility criteria

9.20.2.2. Create statement of purpose to clarify role and function of Deri. Share with all stakeholders including primary and secondary care.

9.20.2.3. Implement mechanisms to support greater integration and closer working between Mardy and community staff. To include urgent review process to prevent blocking of beds

9.20.2.4. Implement new data capture framework based on outcomes.

9.20.3. **Care and Support Planning**

9.20.3.1. Develop and implement integrated care and support framework.

9.20.3.2. In partnership improve the flow from NHH and back to home through:

9.20.3.3. More creative planning and use of resources.

9.20.3.4. Stepped return home.

9.20.3.5. Supported access to community resources whilst on Deri etc.

9.20.3.6. Ensure all processes support outcome based working as part of an individual's plan.

9.20.4. **Implementation of day assessment provision**

9.20.4.1. To prevent admission to Deri when night assessment or support not required

9.20.4.2. To support earlier discharge home from Deri.

9.20.4.3. To provide assessment where home environment prevents this.

9.20.4.4. To provide a stepping stone to day services.

9.20.4.5. To provide an intensity of physical rehab not possible in home environment

9.20.4.6. To provide short periods of rehab for individuals in community to maintain health & well-being.

9.20.5. **Consideration of on-call waking night provision**

9.20.5.1. To prevent some admissions to Deri.

9.20.5.2. To allow people to go home earlier from Deri.

9.20.5.3. To be used as a trial run for discharge.

9.20.5.4. To replace some of the frailty night sits (which could help to fund).

9.20.5.5. To replace Lavender gardens on call (could help to fund)

RECOMMENDATIONS:

- Management arrangements should be changed so that Deri becomes a therapy led unit.
- Implementation of new day assessment unit to provide more targeted support.

OUTCOME: We will support a truly integrated approach based on a joint approach with shared understanding of personal outcomes and the role of each member of the team. Staff structures develop the fluidity to support the person across service areas to promote consistency and relational approaches to support.

9.21. The current staffing structure has members of the AIS working on Deri alongside direct care staff who are managed by the officer team at Mardy Park. Feedback outlines some critical issues:

9.21.1.1. Officers feel in part excluded from the work of the AIS, referral process and care planning process.

9.21.1.2. A disjointed feel to care planning and support is evident.

9.21.1.3. Therapists feel that there is inconsistency in following therapy plans and goals could be achieved sooner.

9.21.1.4. Staff are not clear as to the respective roles of each person

9.21.1.5. Minimum staffing levels leave direct care staff focussing on physical care to the detriment of social welfare.

9.21.1.6. Staff recognise the need to be involved in home visits and hospital visits to engage in the assessment process. Time limits and a feeling of having 'too much to do' prevent this

9.21.1.7. The need to network and broaden their understanding of the respective roles of healthcare professionals

9.21.1.8. There is some feedback from staff that at times they are unsure as to the purpose of people staying there and a sense that people shouldn't be there.

9.21.2. Recommendations to address these issues are cited elsewhere within the report; principally in staffing. With the integration of services and planning, clarity of leadership, new role profiles and the implementation of new models of service delivery we should go some way to overcoming these issues. Adoption of enhanced models of reablement

OUTCOME: Staff support, training and development supports their role within the integrated services team and they feel empowered to inform the on-going assessment process

9.22. Critical is that leadership should be practice led and based on working alongside the team. In addition creating clarity of purpose and a secure future staff will work within an environment that supports mutual support and creativity.

9.22.1. Night staff are involved in planning and training, and it is hoped that a review of the documentation will further support their contribution to promoting a 24 hour enabling approach.

9.22.2. Monmouthshire's Dementia Care training, which focusses on relationship based care & support, will be delivered to all staff

9.22.3. Most staff have attended training in personal outcomes

9.22.4. Working parties have been set up to look at the environment and the provision of activities

9.22.5. A twice weekly multi-disciplinary meeting has been set up so that the whole team can focus on the individual's personal outcomes and progress towards these through their rehabilitation programme. This both supports and empowers the care & support workers to fulfil their role in delivering rehabilitation programmes

9.22.6. Domestic staff have been encouraged to attend the multi-disciplinary meeting, and also have been supported to record their contribution with breakfast preparation

9.22.7. Staff are being encouraged to work more flexibly across the whole service at Mardy Park to enhance person centred and relationship based approaches to care & support

9.23. Staff feedback has been mixed, as whilst they are generally in support of the new developments and approach, they are concerned about how the current staffing levels and rotas will support them to spend enough time with individuals whilst still carrying out essential duties such as the medication round; booking medication in and out on admission and discharge, etc. Key themes include:

9.23.1. ***Is there a way we could have supported individuals to return home sooner?*** Ideas discussed around graded return home – supporting people to spend time at home during the day initially; bed at Mardy being held open for them for 1 or 2 nights after discharge; provision of night support at home; carrying out more work in the community with people whilst on the unit.

9.23.2. ***Did everyone in the study really need to come into the unit?*** Discussed one lady in particular who had been transferred from an out of county hospital so we had not assessed her first, and agreed that it is likely we would have recommended she go straight home with reablement.

9.23.3. ***Could we do more to support people to start working on community connections whilst on rehab unit?*** Discussed being able to work in the community with individuals on the unit, and staffing levels was raised – general feeling that this put constraints on what was possible outside the building.

9.23.4. ***Could we do more to encourage people to engage in activities whilst on the unit?*** Discussed need to identify and prioritise time for activities; need to build up some resources and ideas; could get some ideas from people who have recently stayed on the unit; could attend activities on day centre.

9.23.5. ***What makes some people need 24 hour assessment or rehabilitation?*** Ideas were poor mobility and transfers; difficulty toileting at night; home environment unsuitable; high falls risk; anxiety and loss of confidence; poor safety awareness; will not accept support into own home; incomplete assessment whilst in hospital; recent cognitive decline; fluctuating physical health.

10. STAFFING

10.1. OVERVIEW

10.1.1. Mardy Park currently supports approximately 108 staff across integrated services.

Abergavenny Integrated Services Team	26
Abergavenny Community Nursing Team	22
Centre based direct care teams	47
Community based direct care teams	6
St David's Nursing Team	2
Protection of Vulnerable Adults Team	5
Total	108

The focus of the staffing review is on centre based direct care teams, although the accommodation requirements of all staff form part of the recommendations of the report.

TEAM	Posts	Hours
Day Services Team	6	150
Care Support Teams	15	353
Night Care Support Team	4	126
Domestic & Laundry Team	6	129
Kitchen Team	4	93
Officer Team	3	111
Handyman	1	30
Bank Staff	2	
Therapist [Band 7]	1	37
Therapist [Band 5]	1	37
Reablement Technician	2	50
Admin	2	
Total		

Taken from staff establishment list – not up to date but indicative of budget

10.1.2. There are current members of AIS sitting within the MP staff establishment list.

10.1.3. It is important to stress that only the care team can considered as direct care base and the kitchen, admin and domestic teams are there to support all services within the building not just the function of direct care.

10.1.4. Following section is some additional general observations and findings in relation to the staffing at Mardy Park

OUTCOME: To be listened to, valued, contribution recognised, supported with strong and empowering leadership.

10.2. The last review which reported in 2010 has had a significant impact on the staff team and the feelings are still raw and apparent 5 years on. The current review and the time taken has helped on the one hand in that something is actually happening but on the other has re-surfaced feelings of anxiety regarding job security, the impact of changes on people receiving surfaces.

10.3. The review team have met with the staff team on a regular basis including 1 to 1s with most of the centre based team. There is a contrast between those willing to be involved and those choosing to sit on the side lines. Individually all staff are engaged but as a group this dichotomy exists. Over time the numbers of people actively involved has increased. The commitment to Mardy Park and the people at the centre has maintained throughout but there has been a disconnect for some between supporting the future of Mardy Park and being involved. In essence there is view that the developments are going around them and are not connected to their day to day work; that MP and its current service model, for some, can continue in isolation. Whether the review team has failed to engage, or the person is fearful or in some cases that there is apathy I am unsure. This observation does not dilute the commitment of the team to the people using our services and as said an increasing number are actively working to move the service forward

10.4. In the 1:1s with staff, they are supportive of change and had many ideas to take the service forward. Critical issues raised by staff revolved around poor communication, being unsure as to what is going on. Unfortunately a strong theme emerged of a less than engaged relationship with some members of the senior team at centre. Issues of control, lack of trust and feelings of not being valued were strongly felt by some; but not all. Simple things like access to stores and a sense of having to ask permission to re-stock has a disproportionate effect on the team in that there is an implicit distrust.

10.5. Support mechanisms are not consistently in place and there is no regularity of staff meetings and other forums for communication. Supervision is sporadic and inconsistent. Conversely, daily handovers were disproportionately long with one hour set aside each day for all care staff. This has now changed to twice weekly and includes the domestic team who have an invaluable role to play in the support of people staying.

10.6. The staff team as a whole recognise the need for integration and are asking for closer relationships to exist. Some staff even suggesting socials with GPs, nurses and others as a way of developing broader relationships outside of the AIS.

RECOMMENDATION - A leadership model is developed which focuses on support for the staff, rather than management and control.

RECOMMENDATION A staff forum is created which allows staff to contribute to and seek explanation of…

RECOMMENDATION – The supervision and appraisal framework is reviewed in line with changes elsewhere in direct care to ensure that it is focussed on support and development.

A staffing structure is developed which is proportionate to service provision and is sustainable in the long-term.

Staffing structures incorporate sufficient fluidity to support the person across service areas to promote consistency and relational approaches to support.

10.7. Some of the **recommendations** are cited elsewhere in the report but for ease, those affecting staffing are all given below.

10.8. **DAY SERVICES**

10.8.1. Changes to the staffing below are dependent on the reduction of the service from 7 to 6 days per week. As outlined the current staffing structure does not support the staff to:

10.8.1.1. Provide a flexible activity programme which combines groups with activities for individuals and time to spend develop a relationship based approach to support.

10.8.1.2. Plan and develop the service in advance of people attending so that the content of days is not supporting people according to their personal outcomes and specifically what a good day looks like.

10.8.1.3. To develop and maintain community based support and activities.

10.8.1.4. To work flexibly across the week so that staff presence is focussed on need on a particular day.

10.8.1.5. Receive the support and input from a dedicated senior member of the team.

10.8.1.6. Maintain a range of transport options for people attending. Transportation is via the centre bus only but if staff were available then the lease vehicle could be used and also a member of staff would be present for people attending via their own transport.

RECOMMENDATION: In consultation with the staff team re-organise staff rota (within existing resources) to maximise staff presence during the times that people are present in the centre. Typically this will be staff working either an early or late shift of 9am – 3pm or 10.30am to 2.30pm.

RECOMMENDATION: Create a new post of day services lead who is predominantly hands on but has specific duties to support the team and co-ordinate the planning of services and ensure a prompt and relationship centred approach to new referrals.

RECOMMENDATION: review current role profile and develop to support a relationship based approach to support.

10.9. RESIDENTIAL CARE SUPPORT

10.9.1. Given the recommendation to reduce the number of rehabilitation beds to five places and the number of respite beds to two, a staffing structure needs to be developed that does balance the needs of the service but is comparable with other services and sustainable.

10.9.2. The current structure of 1.5 care staff per wing, does, in part, lead to a focus on physical well-being with insufficient time to focus on the social and emotional needs of the people staying at MP.

10.9.3. The evidence from the review illustrates the increasing complexity and higher level of support needs people may have.

10.9.4. An integrated model and a more proactive approach to therapy and assessment requires more time set aside to input into therapy programmes.

10.9.5. The introduction of a day assessment unit will require additional staff resources.

10.9.6. If services are to support the person from hospital, residential and community a staffing model is required that supports this fluidity. This will reduce service 'hand-offs' and improve relationships and consistency.

10.9.7. Currently there are two waking night staff to support a maximum of 15 people. If the number of beds are reduced to 8 then two waking nights represents a disproportionate cost and staffing ratio. During the 3 month intensive review there was one person who sometimes needed assistance from two people for transfers but this varied. At night however, he was largely independently.

RECOMMENDATION: Combine the role of staff working on Deri and Cefn and reduce dedicated staff compliment from three people to two members of care staff.

RECOMMENDATION: Develop new combined role profile for all care staff so that cross boundary working is implicit.

RECOMMENDATION: create new rota which incorporates floating support hours (x5) for each day to:

- Support the new day assessment unit.

- Create flexibility in the fixed rota to support staff to work across Deri, day assessment, day service, hospital based and community settings.
- Ensure sufficient capacity to support care staff's active involvement in rehabilitation programmes.
- Ensure sufficient flexibility to meet all of the person's needs.
- Ensure the involvement of front line staff in the initial assessment processes.

RECOMMENDATION: Reduce night staffing to one, with a second person sleeping in to support in the event of emergencies.

RISK: reducing the night staffing will mean a change to eligibility criteria so that people who require the support of two during the night will not be able to access the service.

RISK: CSSIW may have a view that the presence of one member of waking nights is not sufficient.

MITIGATION: spot purchase waking nights from the independent sector as and when needed.

10.10. **DOMESTIC & LAUNDRY TEAM**

10.10.1. There are currently 105 hours of domestic and 24 hours of laundry support; roughly equivalent to 2.85 and 0.65 FTE respectively. The team comprises 4 x 18.75 hour posts, 1 x 30 hour post and 1 x 24 hour laundry post.

10.10.2. The team have dedicated areas of responsibility and the current cleaning regime appears manageable within existing resources although the team state 'the building is not as clean as it once was'.

10.10.3. The following feedback was received from the team in group meetings and in 1:1s:

10.10.3.1. That there is too much separation between respective job roles and that some members of the wider MP staff team will not attend to immediate matters if they do not consider it part of their job.

10.10.3.2. The team can at time feel under-valued and not trusted at times

10.10.3.3. The team are keen to play a more active role in the development of services at MP. This included a real enthusiasm for the role of centre to support small local enterprises and wish for all the team to have more direct contact with people needing our support.

10.10.4. The team have responsibility for supporting people with the preparation of breakfast on the wings. They also recognise the value of promoting involvement and independence with domestic tasks. However, they have received no training in enabling approaches and are not sufficiently involved in the care and support planning process.

10.10.5. During the last review the team was significantly cut. It is not recommended that any further changes be made to the domestic team. This is in consideration of the size of the building, the diverse range of duties, the need for greater involvement in enablement and the potential additional responsibilities that the development will create.

10.10.6. The domestic team are currently paid at Band B which is not in line with other similar posts within the county.

10.10.7. The post of laundress at the centre is valued but similar reviews elsewhere have seen this role removed and duties transferred to members of the night team. The recommendation of this report is that this post <u>be retained</u> for the following reasons:

10.10.7.1. The above proposed changes to night staffing mean that a transfer of duties would not be possible.

10.10.7.2. The laundry fulfils an important function not only for the building but also in undertaking community laundry. The development of the community laundry needs to be

moved forward. In addition there is a real potential for the development of a small local enterprise that would include laundry and seamstress services.

10.10.7.3. To support the above laundry needs to be available 365 days of the year which would not be possible with current arrangements/.

10.10.7.4. We need to retain flexibility to support additional pressures on the kitchen team and the domestic team.

RECOMMENDATION: re-write role profiles for all domestic and laundry staff to support a flexible approach and to ensure that participation in rehabilitation programmes is implicit. This will include making the role of domestic and laundry assistants combined.

RECOMMENDATION: submit role profiles for evaluation to ensure consistency of grading across the county. Budgets prepared on the basis that all staff will be paid at Band C.

RECOMMENDATION: Make enablement and dementia care training available to all domestic staff.

RECOMMENDATION: explore the development of a small local enterprise for laundry and seamstress services based from the centre.

RECOMMENDATION: introduce the role of senior domestic assistant to support the team and undertake all ordering, planning etc…

RECOMMENDATION: Change staff contracts so that all staff work equally across all areas within the building and to take account of increased pressures due to café areas and increased traffic. Initially, this is proposed as 6 x 24 hour contracted posts.

10.11. **HANDYPERSON.** Currently employed for 30 hours per week, the role is somewhat confused and from discussion this person is pulled in a number of different directions. The role requires this person to support the day service, support collections as well as undertake a number of jobs around the building. Some areas of the centre are in disrepair and there is a need for this role to focus here.

RECOMMENDATION: Create and annual maintenance schedule

RECOMMENDATION: Review Handyperson's role to ensure clear focus on priority areas.

10.12. **KITCHEN TEAM**

10.12.1. The team is currently staffed with 1 x 30 hour & 1 21 hour cook posts and 2 x 21 hour kitchen domestic posts

10.12.2. The hours that the cooks work are different and I am not clear as to why this is.

10.12.3. The standard of food is viewed as very high and the choices / menus are balanced and well planned.

10.12.4. There is huge potential within the kitchen team but the team dynamic makes progress difficult.

10.12.5. During development meetings some very honest conversations have taken place about the need to embrace change in the context that their role must broaden if the team is to be sustainable in its current form.

10.12.6. The manager of Monmouthshire Meals is currently working with the team to develop systems so that additional responsibilities as a result of the community café can be incorporated within existing resources.

10.12.7. Consideration needs to be given in terms of a professional lead for the kitchen team to ensure a focus on team and skills development

RECOMMENDATION: Assess staffing following systems review and consideration of a new kitchen lead post.

10.13. **ADMIN TEAM -** With the forthcoming admin review across the directorate, the admin arrangements have not formed a full part of the review. However, in the context of the review the following issues are highlighted for consideration:

10.13.1. Currently there are 2.40 FTE admin posts within direct care services (at Mardy Park) that provide support to homecare, residential and day services. There is a crossover of roles between services but an approximate 1 X FTE is dedicated to the residential and day services with additional responsibilities to cover reception 5 days per week.

10.13.2. A proportion of work is to receive visitors, enquiries and phone calls on behalf of the AIS and Abergavenny Community Nursing teams.

10.13.3. Currently the reception is covered until 4pm Wed – Friday.

RECOMMENDATION: consideration during the forthcoming countywide admin review of creating a centre based admin team to support all functions of the centre.

RECOMMENDATION: Support for reception cover is provided in part from the AIS and Community Nursing Team. In addition reception cover may also be available via the OAMHS team as part of the co-location of services at the centre.

RECOMMENDATION: changes to reception cover rota to ensure cover until 5pm, five days per week.

10.14. **THERAPEUTIC INPUT**

10.14.1. Therapeutic input is provided to Deri by 0.5 FTE physiotherapist (approx.) and 1 x FTE Band 5 Occupational therapist. In addition a Band 7 Lead OT (funded via ICF) is supporting the enhanced enablement model of community support and overseeing the development of Deri Unit in partnership with others.

10.14.2. As highlighted there is a separation between members of AIS and the direct care team in terms of integration and a shared approach to rehabilitation. There are a number of opinions in terms of why this is but going forward it is clear that a role is needed to bridge this divide which will:

10.14.2.1. Take responsibility for the professional supervision of staff; their training, development and day to day work planning and guidance.

10.14.2.2. To take overall responsibility for Deri; including capacity management, medication, risk management, referrals etc…

10.14.2.3. To take overall responsibility for the day assessment unit.

10.14.2.4. To roll-out the learning from the enhanced enablement model of support to all services.

10.14.2.5. To develop, promote and support an active approach to respite services.

10.14.2.6. To provide direct therapeutic input and to cover in the absence of other therapists.

10.14.2.7. To work alongside the Band 7 Community OT to ensure cover in each other's absence and to provide a seamless approach to therapeutic input.

10.14.3. To support and actively promote cross boundary working.

RECOMMENDATION: Current therapeutic input is ring-fenced to Deri and the Day Assessment Unit

RECOMMENDATION: Create new Band 7 Lead OT role dedicated to active respite, the Deri unit and Day Assessment

10.15. **MANAGEMENT:**

10.15.1. Primarily the management team and philosophy must support the staffing structure outlined above. The approach should be one of leadership with the emphasis on support and not control.

10.15.2. The posts of Head of Care and Assistant Head of Care are in the above context disproportionate to the needs of the service. In effect a 3 x FTE super-numery team to support a wing with 8 people is not sustainable or merited.

10.15.3. The leadership team must focus on support and working alongside the care team and others to promote the highest quality of services.

10.15.4. If the recommendations to reduce residential provision are approved then we will need to be mindful of requirements to CSSIW and partners in commissioning.

RECOMMENDATION: The current management model should be replaced by the following:

- One of the two staff dedicated to Deri should be in a senior role and should sleep over. This role will need to be defined but will be at least 75% hands on with additional responsibilities around medication, etc…
- Operational responsibility for the line management of the four senior care staff and senior day care will fall to the Lead Manager for Residential and Day Services who works across Severn View and Mardy Park.
- Professional supervision will be provided by the Lead OT for residential and day [assessment] services.

Staff configuration:

- The current policy for placing staff at risk outlines the following criteria. Clearly the significant changes above will mean that there will be a smaller staffing contingent required to support services at MPRC.
- It is critical that we balance three things when re-sizing services:
  - That early retirement or redundancy may be a favourable option for some staff.
  - That staff can demonstrate their reliability (and attendance) to support the consistency that is required if the service is to develop and we can meet people's personal outcomes
  - Above all, that they are able to demonstrate that their identity and beliefs are in keeping with a proactive, relationship based approach to supporting people.

11. ACCOMODATION & INFRASTRUCTURE

11.1. The centre is laid out broadly on four wings; Abergavenny wing forming the entrance and main public areas, day services, kitchen, laundry and the base for community direct care services. The Skirrid wing is the base for Abergavenny Integrated Services Team and Community Nursing Team. Cefn wing supports long term and short term residential services and lastly Deri is the rehabilitation wing providing residential support on discharge from Neville Hall Hospital and to prevent admission

Infrastructure, services and systems will support and be proportionate to the demands of a multi-agency community resource centre.

11.2. The reality is that the current accommodation and infrastructure is suitable for a residential home. Designed and built to support 20+ residents and a day services; all supported by a staff team of 50. The centre is still home to residential and day services but the number of staff who call Mardy their base has risen to 108. The lack of car parking has become a focal point in terms of evidencing inadequacy but the poor infrastructure extends to include for example; an overburdened electricity supply, lack of space, poor IT and systems infrastructure and inadequate facilities. Simply, the movement of various teams to be based at Mardy has not been sufficiently supported with the corresponding changes and improvements so a centre has emerged that is struggling to cope. There is clearly a negative impact in terms of health and safety but there is also an impact in terms of effectiveness and the well-being of all those that visit and are based at the centre.

11.3. Whilst some of these issues have started to be addressed over the last twelve months there is still a considerable distance to travel to ensure that the above outcome is met. Moreover, the demands placed by the development agenda set out will place an even greater burden on the centre and the need to improve infrastructure is essential to support the services moving forward. Simply, the centre will not be able to develop. For example, due to delays in construction of the car park I have prevented the opening of café and any health based clinics until such time that this is in place due to the clear health and safety implications.

11.4. Funding from the Intermediate Care fund secured in April 2014 has enabled us to progress some improvements. These have clearly been made in advance of the review concluding but have been in part directed by feedback and consultation received as part of the consultation days and from discussions with staff and others.

Day Service Spaces	As outlined in the day services section significant changes have been made to the day service areas to improve furniture, layout, privacy etc...
Communal Spaces	We have undertaken some structural changes and the entrance is now an open plan communal space including agile working and the community café. From chairs to computer desks; the café furniture has been carefully selected to address the varying needs of the community. Occupational therapists and reablement officers were consulted over the design of each piece of furniture
Clinical Spaces & Equipment	We have created one clinical area in response to requests made by the Community Nursing Team and the development of these areas is discussed below
IT and telephony	Telephone systems and the IT infrastructure to support co-location of partner agencies and colleagues in health services has been upgraded. This has included significant improvements to the line speed so that internet access will support multi-media, increased use and extend to external areas in the Abergavenny wing. We were also very keen to respond to the increasing pressures on our aging community to be digitally inclusive and therefore felt it was important to incorporate web and digital accessibility into the design of the café. We will introduce a PC and iMac into the café on opening and will encourage users of all age to use them to learn, create and communicate with others
Car Parking	Plans were developed last year but due to unfortunate delays, these plans were not considered until March this year. The planning approval was deferred to consider alternate proposals. Alternate designs in consultation with local residents have been submitted and will be considered at the July planning committee.
External access and spaces	We have given limited access to the outside areas for some groups and this will increase once safe access can be provided. In addition we have created an additional patio area and provided direct access from the café area.
Main Kitchen	To support the developments across the centre we have been able to upgrade some of the kitchen equipment. We have also created and fitted out a servery for café in the main reception area.
Furniture	In addition to the above, we have been able to purchase some additional furniture that will support developments going forward.

OUTCOME: Mardy Park is a great place to work that supports well-being and the different needs of individual staff members

11.5. The co-location of teams and services has overall been a huge success but it has to be implicit that well-being and outcomes of the people we support is directly linked to the well-being of the staff responsible for supporting them. At MPRC teams are not just co-located; there is clear evidence of integration but the teams migrate to specific areas which prevents the further levels of integration. This is best evidenced by the development of place based working. If this is to positively impact the

outcomes for people it cannot simply be co-location. We must create an environment that promotes inter-agency relationships and the informal benefits that derive. This must see team members working alongside a diverse range of stakeholders, not just their colleagues.

11.6. The welfare of staff will be further supported if we provide environments that support their individual style of working and also accommodates the nature of the work that they are undertaking. By undertaking simple personality tests we know that broadly people will fall loosely into two categories; introverts and extroverts. As with all things, these are not two distinct groups and people will fall somewhere on a scale between the two. However, we know that introverts will thrive in certain environments and extroverts in a different environment. Current accommodation is largely shared spaces with up to 15 people working from one office. Additionally, this working environment does not take account of the different environments required to support a diverse range of duties. Specifically, report writing, confidential conversations, meetings etc…

RECOMMENDATION: To achieve the required balance to support different styles and different duties a comprehensive accommodation review should be undertaken, in consultation with all teams, using specialist advice to support the design.

11.7. Based on work to date an estimate of current accommodation requirements is given in the next section.

The centre and its facilities will support new services, partnerships, co-location and place based approaches to service delivery and signposting.

11.8. To support the development of the health and well-being pathway it is critical that key services are based and available at Mardy Park. However, managing a diverse range of services within a hub alongside wider community access has its challenges and there is a need to balance community access with security and confidentiality. The demands on space within the centre are high and set out below are the key commitments that need to be accommodated as part of the overall developments. <u>All room allocation must be on the basis that they are multi-functional and shared spaces.</u>

11.8.1. The potential to co-locate with elements of Older Adults Mental Health services has been discussed for a number of years. The model to wrap support around the person is a central tenant of the development of the community hub and to remove wherever possible hand-offs between different components that form part of the same support pathway. Locating key memory assessment services and consultant led clinics will place this key element alongside rehabilitation, assessment, specialist provider and third sector support. Moreover, it will support people at difficult times to remain part of their community. A number of rooms for clinics, pre-assessment testing and family support need to be made available.

11.8.2. In partnership with others we need to facilitate and support family training, guidance and support for families and carers of people with dementia at the time of diagnosis and longer-term.

11.8.3. To support a more diverse range of rehabilitation services as outlined earlier in the report space needs to be set aside for a day therapy unit within the centre.

11.8.4. To support the development of placed based working, additional shared office accommodation needs to be made available within the site to promote agile working from the centre from a broad range of representatives from 3rd sector organisations.

11.9. To mitigate the current lack of space on Skirrid wing and to support flexible solutions to the current working environments additional space be made available elsewhere within the building. This needs to include a permanent base for the five members of the Protection of Vulnerable Adults team.

11.10. To support a variety of activities and personalisation within day services, additional space needs to be created.

11.11. Mardy Park must support a diverse range of information and access to support to services. It is critical that there is sufficient space to multi-media displays as well as a broad range of written literature.

RECOMMENDATIONS:

- The Abergavenny wing is set aside primarily for 'front facing services' and homecare offices are re-located within the centre as part of the accommodation review.
- The rooms marked 1 – 4 on the attached layout schedule are ear-marked for memory assessment services, family support, interview rooms and areas for private conversations. These rooms are in addition to the health clinic already designated – marked '5' on the layout.
- All residential services, whether long term, short-term or rehabilitative should be based on Deri wing. **NB** Please note that this is the ideal proposal but the long-term resident will be given the choice to move wings or remain in her current room.
- The residential and day services offices are combined and relocated to room '6' on the layout.
- The room marked '7' on the layout is proposed as the new location for the sleeping-in room.
- The room marked '8' on the attached layout should be set aside for the day assessment unit.
- All remaining office spaces on Skirrid and vacant rooms on Cefn should be set aside as part of the detailed accommodation review.
- Additional off-site meeting and agile spaces at Maindiff Court should be negotiated with the Aneurin Bevan University Health Board as part of the discussions to site health based services at MPRC.
- A budget is set aside to support the accommodation review and the necessary alterations needed to change use.

12. FINANCES

The financial framework within which the resource centre operates is proportionate and comparable with other funded services in terms of spend and outcomes.

12.1. The current combined staffing budget for services at Mardy Park stands at £975,259. This supports all services and ancillary support at the centre. In analysing the current budgets there are a number of anomalies in the staff establishment list. Specifically, posts not listed, posts wrongly coded to the budget and hours.

12.2. ABUHB contribute approximately £147K funding. The S33 agreement would need to be re-written to detail change and broadening of rehabilitative services as well as the introduction of numerous health led services to the centre.

12.3. The current and future breakdown of staffing costs is given in detail in Appendix 1 but in summary below:

Current Staffing Arrangements				Proposed Staffing Arrangements		
Current roles	**Budget hours**	**Actual hours**	**Costs**	**Revised roles**	**Hours**	**New costs**
Management Team	111	111	123,321	Therapy Lead	37	50,192
Night staff team	126	126	123,479	Night staffing	63	61,739
RSO Cefn	165	165	123,510	RSO Senior Care**	101.5	95,278
RSO Deri	150	150	116,238	RSO Care**	128	98,506
Day Services	150	150	110,835	DSO Senior	30	27,711
				DSO Care	120	86,244
Tech & Therapy***	87	74	87,661	Tech & Therapy***	74	79,117
Admin	37	15	24,711	Admin	15	9,930
Bank Hours	38.5	0	26,224			
Sleep Over	n/a	n/a	15,607	n/a	n/a	15,607
Domestic & Laundry Team	105	129	60,673	Senior Domestic	24	17,217
				Domestic Team	120	75,393
Kitchen Team	93	93	65,129	Kitchen Team	93	65,129
Handyman	30	30	21,894	Handyman	30	21,894
Sub total		**1,043**	**899,283**	Sub Total	**835.5**	**704,008**
Cover / balancing*			75,976	Cover / Balance		59,841
Total			**975,259**	Total		**763,849**
				Savings		**211,410**

***** Balancing figure – cover at 12% but not applicable to all posts so a balancing figure of 8.449% is used.

** Includes support to day assessment unit.

******* Band 7 therapist post in wrong budget – Band 5 in post so hours correct but grading incorrect. Tech time is community based. Therefore total therapist cost is c£28K

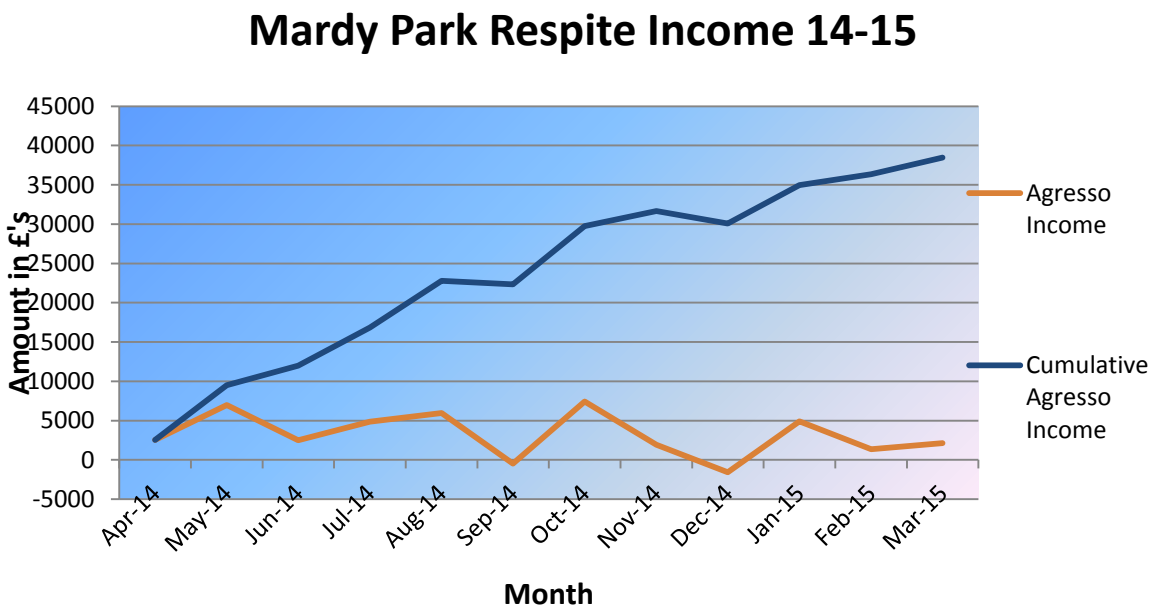
12.4. As outlined, staff would be offered the opportunity to express an interest in voluntary redundancy. Costs schedules are given in the attached for all staff. The number of redundancies would be limited and would fall only in officers and RSO roles. Exact calculations will be supplied following consultation with the teams.

12.5. Adjustments to current budgets in terms of supplies, services etc...need to be considered. Current budgets are reasonably balanced but once the centre is fully functioning, there may be a need to revisit supplies, services and infrastructure costs.

12.6. There is a need to do further remedial work on the upkeep of the centre. Maintenance and all budgets currently sits with Property Services. As with all SCH establishments we have no way of knowing whether any maintenance work is scheduled.

RECOMMENDATION: Review of current arrangements with Property Services and a whether a distinct budget is set aside to support a maintenance schedule.

12.7. Current income levels stand at £118K budget with a shortfall of £73K forecast for this year. Income budgets were historically set and based on a number of long term residents. With a reduction in respite there will be a cumulative impact on the income budgets for MPRC and accordingly the budget as a whole. The table below illustrates current income levels current for respite. Based on 60% occupancy this will potentially drop by approximately 60%.



12.8. There is a shortfall in funding for the car park. Despite the compromise design being smaller the costs have risen by £50K. There was a shortfall in funding anyway of £10K so total shortfall is £60k. This is due to site costs previously being a part of the wider capital works programme. Therefore we are paying site infrastructure twice. Additionally industry rates have risen dramatically in the last 6 months. We will not know the exact costs until tendered.

12.9. The remodelling of the centre will require investment – estimates given in Appendix 2 and as set out earlier in the report.

12.9.1. £6,260 to fund external projects, with an annual budget of £2,500.

12.9.2. Change of room use is estimated at £3,000 per room. Details of financing will not be available until the accommodation review has completed but would estimate between 8 and 12 rooms requiring alteration.

12.10. There may be replacement costs for some service re-design. Again, details will be provided during the implementation phase but an estimate of £24,000 is given for shared lives as a replacement for respite services.

12.11. Total investment costs as estimated at £100k.

12.12. Savings as part of Mandate 34 are not due until the financial year 17/18 so savings on 16/17 could be utilised to fund the shortfall.