Community Coordination and Small Local Enterprises

an Evaluation

monmouthshire
sir fynwy

An Evaluation of Community Coordination

Background

Public services are encountering huge pressures brought about by demographic changes coupled with more complex needs and increased expectations set against a backdrop of declining local authority budgets. In 2012 Monmouthshire County Council estimated that it would require an additional £9 million a year by 2025 to deliver like-for-like services. The council began to look at transforming the way it meets needs to try and improve outcomes within its available resources.

Community coordination is an approach that originated in Western Australia and has been implemented in parts of England and Scotland[1]. The model is based on establishing local coordinators within communities to work with people who may otherwise require social services. By engaging early on, building on strengths and helping people to build local connections they help people find their own lasting solutions.

The development of small local enterprises facilitates the promotion of community enterprises whose aim, in general, is to improve the wellbeing of those involved as well as the wider impact of improving community integration.

Cabinet agreed to fund a two-year learning pilot. The pilot has taken forward community coordination in two areas, Abergavenny and Caldicot and the development of small local enterprise across the whole county. The first community coordinator began on 1 April 2014. The second community coordinator and small local enterprise coordinator took up their posts two months later.

The learning pilots took place within a programme of transformational change across the whole of adult social care and health. This whole system approach to helping people live their own lives is changing the nature and shape of all existing practice and provision and as such the impact of the pilots cannot be seen in isolation from the wider work.

During the life of the learning pilot Welsh Government has been preparing to implement two major pieces of legislation:

The Well-being of Future Generations Act which makes clear the need for public bodies to consider the long-term impact of their decision making, work better with people, communities and each other, look to prevent problems and take a more joined-up approach. This new law introduces, for the first time, a duty upon public bodies to ensure what they do is sustainable. It has defined the principles of sustainability as long-term; integrated; collaborative; preventative and involvement.

The Social Services and Wellbeing (Wales) Act which makes clear the need to provide services that enhance wellbeing, with a new definition of people in need and a focus on families and communities. It highlights the role of public services in building on individual and family strengths, helping people to have a stronger voice, choice and more control and supporting meaningful and valued contribution to local community life.

Methodology of the Evaluation

The initial business case identified the use of a Learning and Evaluation Framework. This identified a number of metrics including measurement of personal outcomes, estimates of financial impact and reflective practice from coordinators employed to implement the approaches. These were to be overseen by a leadership group.

The business case recognised that this type of culture change would take a long time to realise its full potential. The short-term impact would be limited to a small number of individuals with the greatest gains taking many years to materialise as the resilience of individuals and communities is developed. The modelling of impact was initially projected up until 2030.

The original intention had been to use a distance travelled tool to assess the progress individuals made against self-defined personal outcomes. Early in the learning pilot coordinators identified that this method of evaluation was creating a potential barrier whilst they were attempting to establish informal relationships with people and a decision was taken to replace the tool with self-assessment questionnaires[2].

One limitation of the questionnaires is that the responses were gathered by the coordinators themselves which can impact on the veracity of the findings. Nonetheless they are consistent with unsolicited feedback provided by individuals, their families and other agency partners.

In the absence of personal outcomes data the effectiveness of the approach is mapped against the original high level business case outcomes. Monmouthshire was also a site for the national outcomes pilot across Wales and so these are also linked to national outcomes which have subsequently been established as part of the Social Services and Well-being Act (Wales) 2014.

The development of a new social services system to support transformation is in progress. More work is needed to ensure data from the old system is migrated to accurately evidence changes in the number of people requiring long term care.

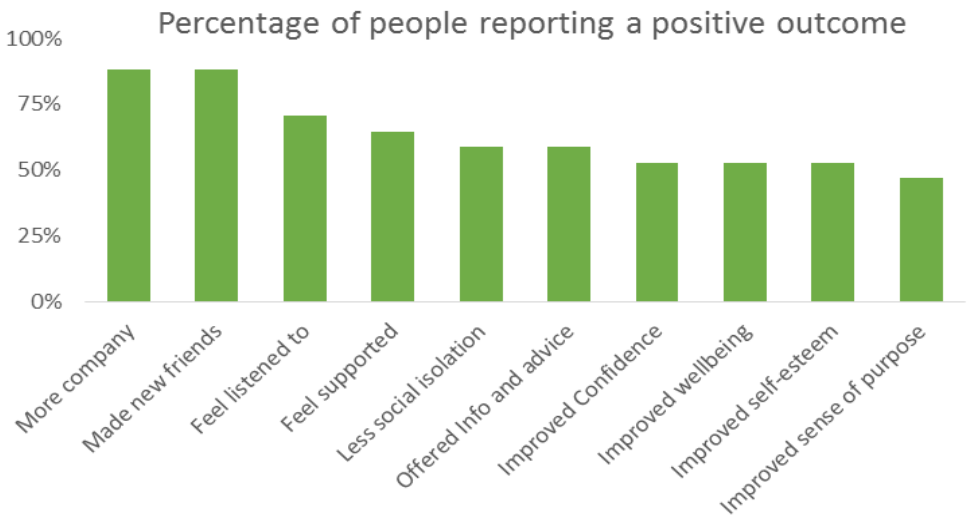
Findings

The project employed two community coordinators. One in Abergavenny and one in Caldicot. These are communities with very different health, social and demographic characteristics. By selecting these areas, a comparison of the approach in different settings was enabled. This is explored in the second-half of this section

Outcomes for Individuals and Families

It is recognised that there are difficulties in measuring the results of this type of work where there may not always be tangible outcomes, since a positive result may be stopping a future event from occurring. There is a strong-reliance on feedback and self-assessed outcomes and since the evaluation is being completed after a relatively short pilot the longevity of any impact cannot be assessed.

All of those who responded to the community coordination evaluation questionnaire reported at least one positive outcome. Several questions came back with the same percentage response although not necessarily from the same respondent with people reporting a variety of outcomes.



The prevalence of different outcomes the learning pilot engendered is shown in the chart above and then explored in more detail over the following pages. These are set out to show how the outcomes relate to those outlined in the original business case alongside national outcomes that were subsequently established as part of the Social Services and Well-being (Wales) Act 2014.

1. People are well informed about resources in their community

53% of people who responded to the evaluation questionnaire said they had been offered information and advice by a coordinator. This situation seems to be broadly similar in Caldicot and Abergavenny.

92% of professionals and partners across the county said the coordinator had signposted them to information or services. This is articulated by a social worker who described how the coordinator:

> *"…provides me with an instant link to what is out there, what is being developed and what needs to be developed to serve the community. [The Role] provides practitioners with an opportunity to have support to find ways to meet needs that are outside of traditional services and targets needs that are often hard to reach such as emotional and psychological needs and enabling people to feel joined up to their community."*

Coordinators made themselves known in the community in a variety of ways from community engagement events to newspaper articles, Facebook accounts and market place consultation. The reach of the coordinators has been beyond health and social care with a local shop-keeper and member of the *Town Team* reporting it as *"a vital role in our community."*

When mapping the availability of local groups and resources, coordinators identified a wealth of well-being provision, both formal and informal, but found this to be fragmented and not always well-communicated.

National Outcomes:

- I know and understand what care, support and opportunities are available and use these to help me achieve my well-being
- I can access the right information, when I need it, in the way I want it and use this to manage and improve my well-being

2. People have a greater sense of well being

53% of people the coordinators worked with reported improved well-being while 79% of partners stated that the coordinator has helped them to support others in the community.

One attendee of the Stroke Support Group, established through the coordinator, commented "*Coming here makes me feel better and I wouldn't miss it for the world*."

Another said:

> "*It has been the best thing that has happened to me since having the stroke, the welcome friends made and the purpose has given me a reason for getting up in the morning and something to look forward to*."

In a further example a person had been in regular contact with the integrated team telephoning twelve times in a six month period. Despite being provided with lots of information and advice about opportunities, it seems none were able to meet the person's outcomes. The practitioner subsequently described how this person appeared to be heading towards a traditional care package which would have had a financial cost to the authority and could have led to further dependency.

Through the community coordinator, a role was developed which enabled this individual to begin to feel well through helping others. Since the role was created there has been no further contact with the integrated team – a care package seems to have been avoided.

Cooking up an Opportunity

M is in his 60s and lives alone in his own home. He has one son who lives in London, and is his main carer. M's son was worried that he lacked motivation and was spending too much time alone. M is a retired chef and catering lecturer who enjoys food and cooking. He was very willing to share his skills with others.

M visited the lunch club run by a local church. He now volunteers there each Thursday morning peeling and slicing carrots and potatoes, returning to the hall at the end of the lunch to polish glasses and cutlery. He cooked and carved turkey for 80 people for the Christmas lunch at the lunch club.

M has agreed to provide cookery lessons to the staff at a local homecare agency. The staff are required to prepare meals in a very short time, and often they only have a microwave and a toaster to cook with. This can be quite difficult, and the agency manager was looking for someone to provide training. M also plans to create a photographic cook book from his menu so that staff can receive this as part of a training manual during their induction process.

M has also agreed to assist the Macmillan coordinator with the set-up of a men's group in the local library.

Through Community Coordination M has been supported to become involved in his local community again. He is using his valuable skills to help others, and is becoming more active and less isolated through volunteering. The link with the homecare agency is particularly exciting as members of the community will benefit greatly from M's extensive knowledge and expertise in cookery. M's son is also very pleased that he is getting out and becoming more active. He feels better knowing that there is someone local who can help his dad stay active and well.

National Outcomes:

- I am happy and do the things that make me happy
- I am healthy and active and do things to keep myself healthy

3. People are empowered to find their own solutions

65% of people said they felt supported by the coordinator.

A newcomer to the area described how the community coordinator had helped him establish a clear sense of purpose and social belonging. He reported improved self-esteem, a reduction in social isolation and making new friends after the coordinator involved him in the development of the *Men's Shed* project. He stated how positive this had been:

> *"(Through) Information dissemination, therefore giving grounding – as my role became apparent in the community; to a sense of purpose and social belonging."*

This was consistent with feedback from a family member:

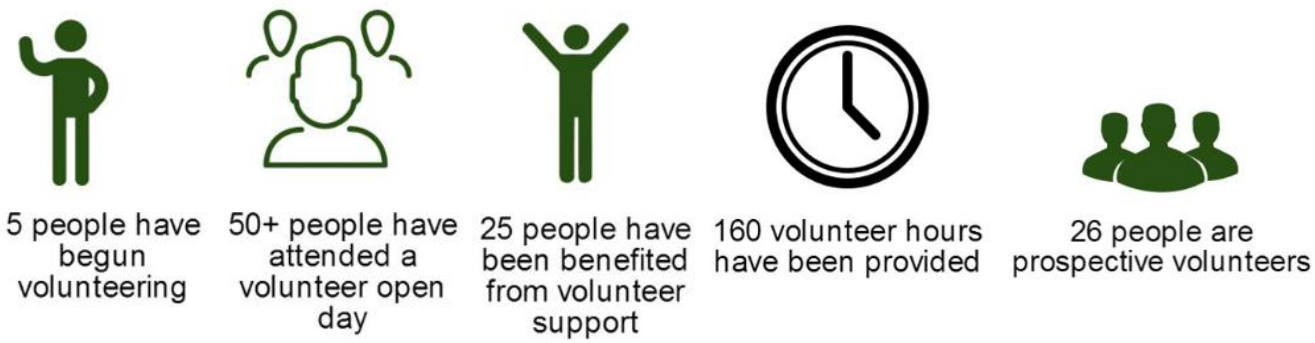
> *"Our community coordinator has supported my father to access local activities which has really helped him to be more motivated, confident to meet new people and empowered him to continue with these activities enriching his life."*

Partners have also responded positively, a Police Community Support Officer writing:

> *"Whenever [the coordinator] and I met we would talk about gaps in the provision for isolated people. [They] have implemented so many projects that make a difference to the quality of life of people in the community."*

People want to be active participants not passive recipients

At the mid-point of the pilot it was clear that success was greatest when people were provided with opportunities to contribute. To develop this potential, more formal support for individual contribution through volunteering was introduced. In partnership with Bridges Community Centre a volunteer coordinator was appointed, funded through a successful bid to the Intermediate Care Fund.



This local experience and learning is supported by a wealth of national evidence that contribution through volunteering is a key element of helping people to stay well:

> *"Through years of successful work, we know by investing in people through the power of volunteering the service can make a tangible difference; improving health and well-being, building stronger more cohesive communities and achieving lasting results. Those working in adult social care believe that everyone can play a role in their community and should have a chance to participate." Volunteering Matters (formerly Community Service Volunteers)*[3]

National Outcomes:

- I do the things that matter to me
- I engage and make a contribution to my community
- I feel valued in society
- I contribute to my social life and can be with the people I choose

4. People are supported to identify, use and develop their social capital

47% of people reported an improved sense of purpose after working with a coordinator. There are no specific questions in the methodology that measure social capital.

One of the key ways in which social capital has been unlocked is through the small local enterprise coordinator. The coordinator works with people who have ideas to develop small enterprises in their community that would benefit others, to help bring concepts to life and sustain them through advice and or opportunities to connect with others who can offer support, guidance or resources.

Through the Rogiet Community Café story (see below) it is shown how social capital that lay dormant was brought to life and grew. The support of the coordinator was integral to releasing this latent energy as summarised by the one of the founders of the café:

> *"I don't know what she does but I talk to her and she sows seeds in my head and they grow in my sleep…She believes in us, she believes that we can do more than we think we can and then we believe it too."*

Rogiet Community Café

Two residents of Rogiet were sad about what they felt was the decline of their community which had once been a vibrant place with local shops a pub and a heart. The small post office was closing and due to be replaced with a bi-weekly van service.

The friends began talking to the small local enterprise coordinator who describes her role as to "listen, challenge, mentor and ask: *is there a market? how do you know? do you have the skills? what do you need to make this work?"* The coordinator's objective was to promote natural connections, using the community as a resource and being a resource to the community.

A steering group was formed who began to explore the idea of a community shop and set about researching the idea. They sent questionnaires out to assess the market and had around 200 responses. People were concerned about the closure of the post-office and about the lack of places where people could get together.

Lack of suitable venues was a potential barrier. An opportunity arose to use the community church hall. Monmouthshire Housing Associated awarded a small grant, the local authority gifted a food hygiene course, the group created an on-line presence and logo and Roget Community Café was born. Posters were printed and the café officially opened in October 2015.

Since opening: the local nursery group have begun using it; local craft people have stalls there; Police and Community Support Officers are on hand with monthly surgeries, a national supermarket has offered time and supplies and the co-op is also donating milk. The team of volunteers has grown from four to ten people.

The community café shows just how much the community wants to help when it is asked; that a prudent person centred approach can be a more effective and cheaper way of working and that it can grow the community's social capital.

National Outcomes:

- I engage and make a contribution to my community
- I feel valued in society

5. People are supported to develop non-traditional, person centred support

The small local enterprise coordinator is in touch with 42 enterprises across the county. She has worked closely with 27 of these either in creating the enterprise or helping it towards sustainability. People involved with these organisations have all either had contact with social care and health services at some point or are providing support to people with physical and/or mental health needs. There are a further 14 enterprises at the development stage.

People will volunteer to build better communities

Community coordinators are also working with existing organisations to deliver non-traditional support as evidenced from this quote from Macmillan Cancer Support:

> *"I have benefitted from (the coordinator's) experience of working with the community, (the coordinator) has helped me to share information with other organisations. We are working together to support someone…to improve a difficult situation and reduce social isolation. We are working together to deliver a winter wellness event offering advice, guidance and workshops around well-being."*

National Outcomes:
- I get the right care and support as early as possible - My individual circumstances are considered

6. People live the life of their choosing within their local community

59% of people reported less social isolation, 53% reported improved self-esteem and 88% reported they have more company and met new friends

One of the people attending the Shared Reading Group wrote

"It is stimulating and starts me thinking of new ideas. I enjoy the contact with different people whom I would not otherwise meet".

People make people happy

Comments from the group are incredibly positive as to the benefits people are receiving. Others attending the group indicated that without it they would have been at home or had nothing to do.

These are pre-cursors of social isolation that has the potential to lead people towards day centres and other traditional social care models run by the local authority. However there are also individuals attending groups who indicate that they would still have a very full-life without the groups suggesting a diversity of attendance.

Musical Connections

D met the community coordinator during summer 2015. She is a lady in her mid-nineties who lives locally to the resource centre. D doesn't receive any support from social services and has quite a supportive family, but was beginning to feel as though she needed something to occupy her time. After meeting with her, the coordinator learned that over the years she had enjoyed volunteering; specifically playing the piano for a range of audiences including people with dementia:

"There is nothing like music to evoke memories from the past and if I can help people remember the past, that's what I will do."

Through the support of the coordinator D began to volunteer at the resource centre to play piano for the people attending on Wednesdays. This began in November and over time, D who would have previously been at home by herself, become a member of the resource centre family.

In December, she and the community coordinator performed together at the local Action Fifty Plus Christmas Party. This was D's first public performance in years and after a series of rehearsals, D felt comfortable enough to play in front of the group. Following this, D and the coordinator performed at the day centre Christmas celebrations also. In December, BBC Wales filmed D. The focus of the broadcast was to share positive stories of contribution in older age. Through this and the weekly volunteer sessions at the centre, she has not only become a symbol of wellness-through-contribution but also contributes towards local culture change; inspiring older people, irrespective of age or ability to give back to their community and feel well. During 2016, D plans to alternate days at the centre in order for a wider range of attendees to hear her play.

Six months ago, D was relatively well, but beginning to feel the pressures of loneliness at home. Now after investing in the wellbeing of others, D shares how she feels better and happy that she is able to contribute to her local community.

National Outcomes:

- I speak for myself and contribute to the decisions that affect my life, or have someone who can do it for me

7. People are in control of their lives

71% of people feel listened to

People can only be in control of their lives if a number of things are in place. They must be empowered, well-informed and able to live the life of their choosing. This outcome then is an amalgam of those that have gone before.

National Outcomes:

- I speak for myself and contribute to the decisions that affect my life, or have someone who can do it for me
- Less social isolation

Differences between localities

As the learning pilot progressed and coordinators established many positive relationships with communities, links to existing and new well-being opportunities were created. Examples include introducing people to the older persons' youth group, knit and natter, shared reading and the creation of a Men's Shed, Women Starting Over group and Stroke Support.

In many of the individual stories it was apparent that new and existing community groups were a vital part of the support network. The ability of the coordinator to connect people to groups seemed to make the real difference and led to a more sustainable longer term relationship developing.

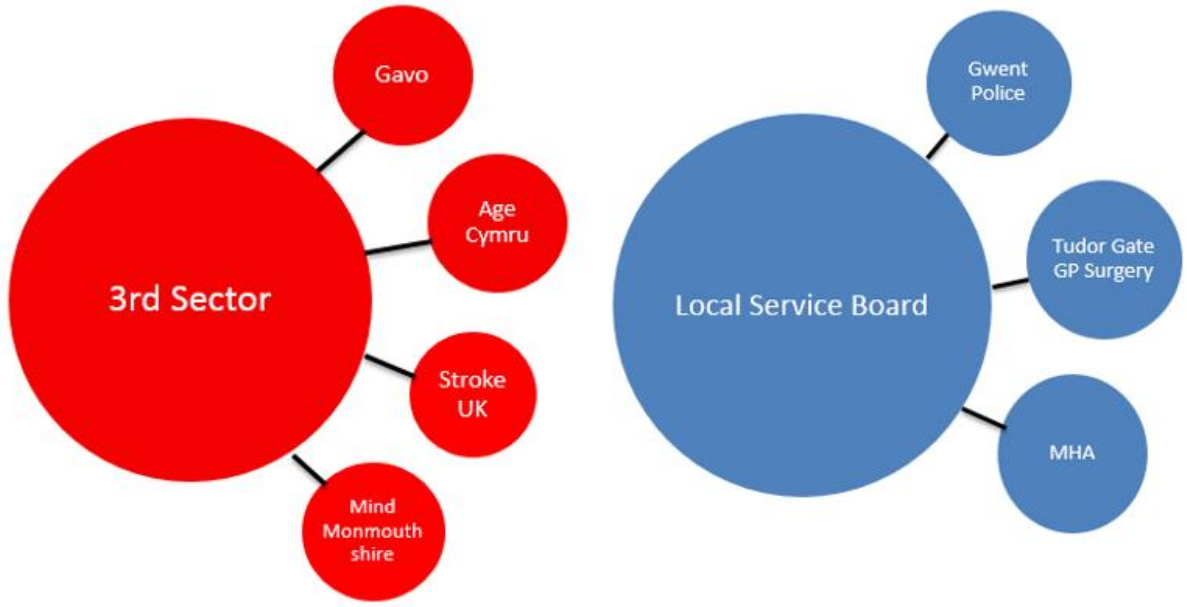
These groups are far more prevalent in Abergavenny with a greater success in that area and this appears to have been a factor in helping people connect with others. That is not to say the pilot in Caldicot was without successes – with around one in every five people the coordinator worked with connecting up to groups such as U3A.

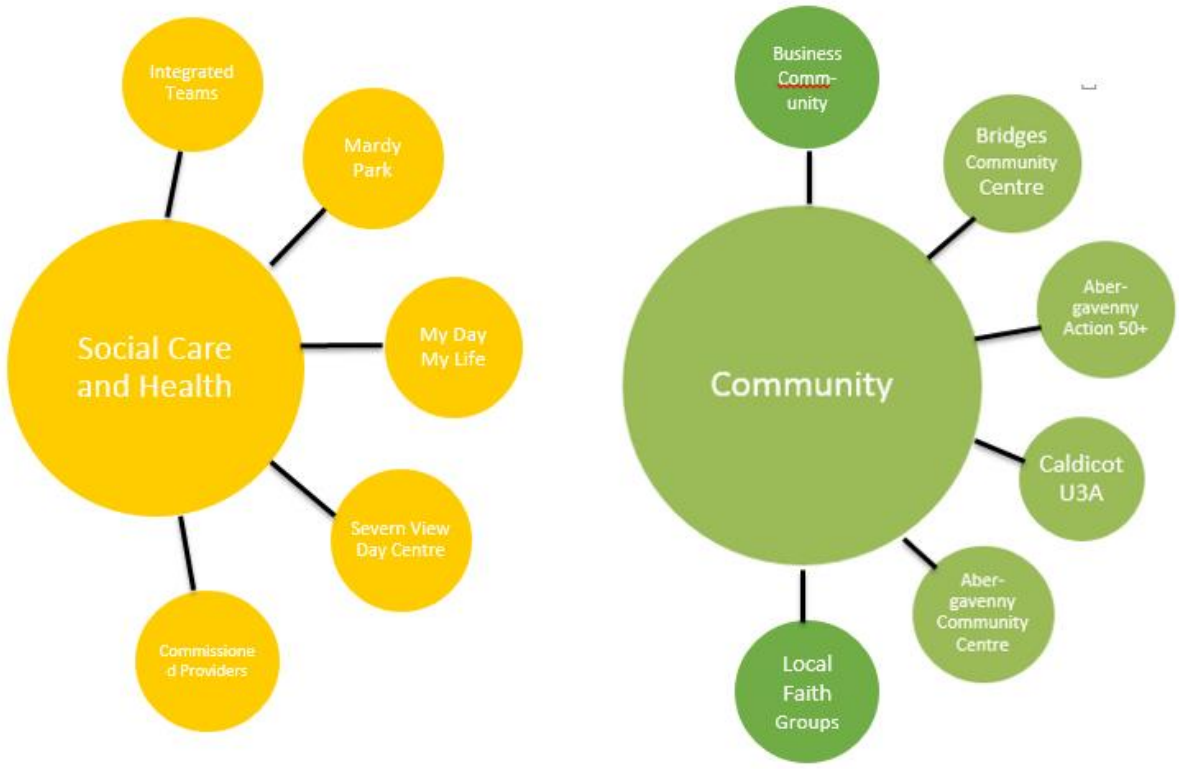
Shared community space was sparse in Caldicot when compared with some of the other larger communities in Monmouthshire, also highlighted in the Rogiet case study. Opportunities in Caldicot are less well-developed although they are emerging, for example through the creation of the Town Team. The experience of the learning pilot has been that the social capital in this part of the county is evolving rather than established when compared with Abergavenny.

An associated factor is that each coordinator brought different skills, knowledge and experience to the role. This in turn would have had a bearing on the impact of the role within localities although this cannot easily be measured.

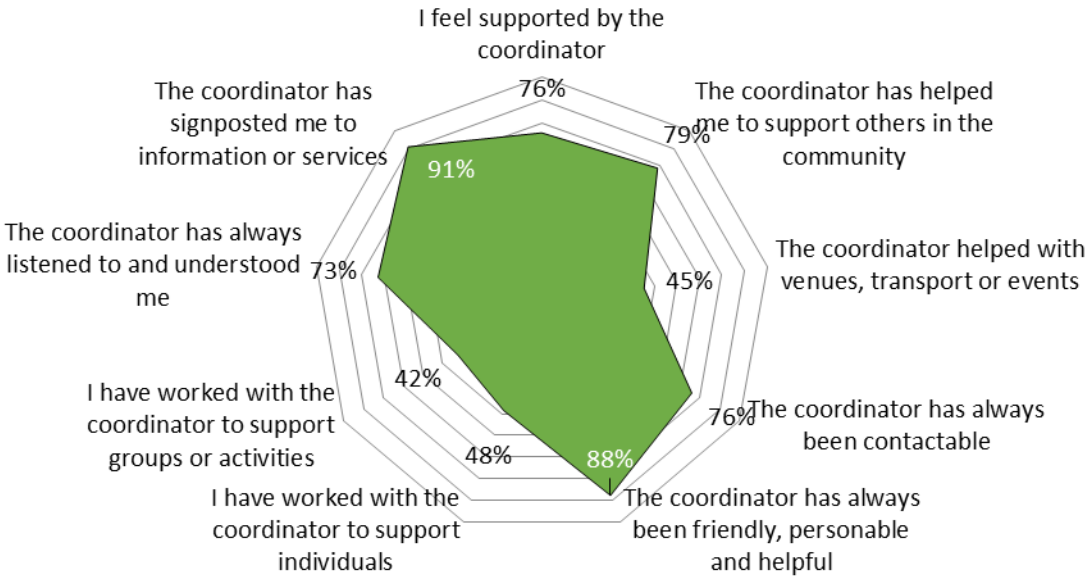
Response from Partners and other professionals

Engaging with a range of partners allowed coordinators to identify need, provide information and advice, map and make use of local resources, support individuals and groups and develop events and other opportunities at a community level. Some of these partnerships and connections are shown in the diagram below:





Qualitative feedback from partners has been incorporated into the analysis above. The following chart summarises quantitative evidence to illustrate where partners judged the approaches to have had greatest impact. More positive responses are signified by a shaded area closer to the edge of the diagram.



Learning

We have learned that working alongside individuals can be a fragile and nuanced process requiring not only the traditional interpersonal skills of reflective and active listening, but those that enable us to arrive at bespoke solutions based upon **interdependency and friendship**.

We recognise that natural associations and connections provide a structure of support for people to live enjoyable and fulfilled lives. Our experience has been that in bringing people together via shared interests/circumstances they begin to support one another independently of external support or interventions. In other words **people make people happy**.

We have learned that the need to be occupied, attached and included are fundamental to an individual's well-being. We understand **that people want to be active participants not passive recipients** as it is through contribution and involvement that people achieve a greater sense purpose and identity.

We have learned that **people will volunteer to build better communities**. When we have the right conversations with the right people it is possible to recalibrate relationships, craft new opportunities and develop new responses.

One size does not fit all

We have learned that the wider community is already part of the solution but that **one size does not fit all**, people are different, and communities are different so our solutions will have to be different.

Demand Management

It was initially envisaged, by the end of the learning pilot, coordinators would be supporting around 40 people per year to develop community connections in place of traditional social care services. It was expected that through these new methodologies, the authority would be able to help individuals identify and achieve personal outcomes, the progress towards which we could measure through the use of a shared agreement.

In reality people who were *"just coping"* or *"could go either way"* as identified in the original business case have been difficult to engage. Contact with established local entities such as businesses, libraries, GP's and U3A resulted in very few connections. When people were identified they generally said they were doing okay, were already engaged in the community through existing groups/activities, or were not interested in engaging.

As a result the main source of referrals for more intensive one-to-one support, originated from integrated teams and consisted largely of individuals already receipt of services or at risk of becoming dependent on services. Working with this group it became apparent that the opportunities to support people in different ways was impeded by a number of internal and external influences rather than lack of opportunity.

This can perhaps better be described in terms of an 'anatomy of dependence' or a combination of key elements which impacted on a person's intrinsic motivation to accept alternatives to the traditional services provided. Some of the elements we identified are shown below, a full overview can be found in the appendices[4].

These factors help to explain why, despite providing a range of information and support, people who have been supported historically via a traditional care management/ commissioned service approach do not or indeed cannot reintegrate into the community. It should be remembered that user satisfaction with traditional services is very high in Monmouthshire – consistently over 90% of people report they are happy with their services[5]. Once in receipt of a traditional service people are very reluctant to see it taken away.

The impact of historic and traditional practice and provision has been recognised and a range of approaches across assessment, care management and direct care developed in line with the "anatomy of resilience" model.[6] The impact that the specific methodologies of community coordination and small local enterprise can have on building that resilience should continue to be considered when shaping the future of social care provision across the county.

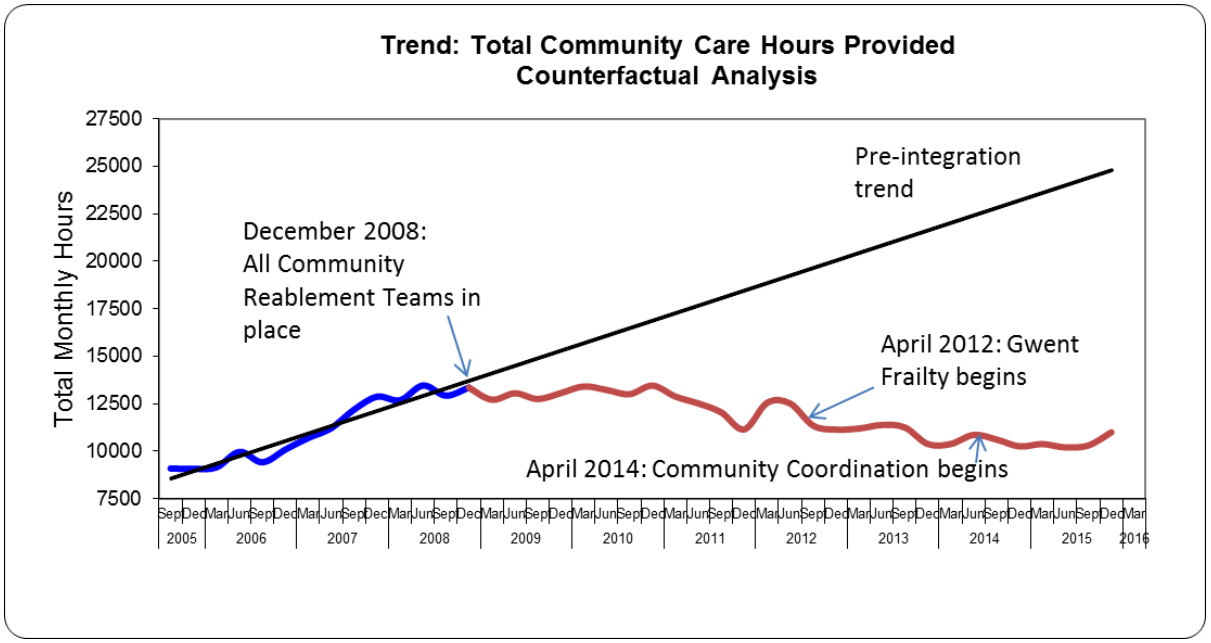
Financial Benefits

The initial business case was based on estimates of how the approaches would reduce the pressures forecasted to fall on to community care budgets in future. The business case recognised that it would not be possible to separate out the impact of community coordination and the development of small local enterprise from other elements of the transformation programme happening concurrently.

Reserve budget allocation over the two year learning pilot totalled £391,908. This together with further sources of external funding (notably a successful bid to the Intermediate Care Fund) has given rise to a predicted 2015/16 year end underspend of £57,000. A request has been made to carry this underspend into 2016/17 to mitigate the costs associated with delays in coordinator recruitment. The costs were scheduled to be off-set by the impact of the project in reducing future demand and avoiding the cost pressures associated with this.

During the course of the learning pilot, the directorate began the development of a new database for both adult and children's services. Differences in recording practice mean it has not been possible to produce a reliable figure for cost avoidance from April 2015 onwards. The last available figure was £211,789 which was in-line with the targets set of £123,000 – £246,000.

Overall there has been an increase of 2.3% reduction in the number of care hours purchased weekly over the period from 2013 (when the business case was agreed) to 10,999 hours in December 2015. This cannot solely be attributed to community coordination and small local enterprise. As has been reported to date, the relative financial benefit of these approaches cannot be isolated from those achieved by other transformation work streams across adult services. It should also be borne in mind that these figures have historically shown month to month fluctuations in the short-term and readers should be wary of attaching too much significance to short term trends.



It is important to highlight that lack of market capacity and above inflation cost increases for commissioned care mean this does not translate proportionately into cost-avoidance. What is important to note is that adult social care has delivered services on-budget and have not needed to make a case for budget increases which could be expected when aligned to the projected rise in demand caused by an ageing population and increased complexity of need.

Conclusions and Recommendations

The purpose of adult social care and health is to "help people live their own lives." Key to this is the ability to intervene at the earliest opportunity and support people to build networks and connections and to find their own solutions to the issues they face.

The intention set out in the original business case was for people to be supported by coordinators in three ways: through the provision of information and signposting, through the provision of information, advocacy, and advice and in the community as an alternative to medium or long term care and support.

As an alternative to care and support for those already in receipt of services the experience and learning of the pilot demonstrated that the pure Local Area Coordination methodology of coordinators holding caseloads was not feasible. Consequently the numbers of people receiving medium to long term care packages did not decline as modelled in the original business case.

The implementation of the approaches as a learning pilot, together with ongoing review, meant the team were able to evolve the way they were working to areas where it was felt they could have the

greatest impact. The original business case was to scale up the project after two years. The learning suggests that it should not be scaled up in its current form.

There is evidence of positive impact on the well-being of individuals and this evaluation includes instances where people have been diverted from a path that would have taken them towards costly statutory services.

There have been a number of successes with new enterprises coming into existence. In some instances, such as the FreeWheelers club, these were successful but short-lived. The benefits in terms of individual personal outcomes cannot be measured through hard-evidence. Case studies, feedback from partners and anecdotal evidence however suggests that there has been a positive impact at community level which in turn led to improvements in individual well-being.

What does appear to have worked well has been to engage people through contribution. People clearly have a need to be involved and to shape the future for themselves and their community rather than be passive recipients of services. The team has worked hard and learned much to inform the wider programme of transformational change developing thinking as to what needs to be in place going forwards to support people to live a life they value, with purpose and meaning.

Preventative approaches comprise a range of elements which, when deployed, developed and adapted to suit a specific community, have the capacity and flexibility to support people at individual and community levels.

These have been effective when rolled out as part of a whole system of service transformation at strategic, operational and individual levels and cannot be considered in isolation either from other approaches or from the communities in which they exist.

Act as a place not an organisation

Increased resilience and the sustainability of preventative approaches may be gained if Monmouthshire **acts as a place not an organisation** by developing place based wellbeing teams 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."*[7]

The learning pilot has offered enough positive evidence that further work should be considered to maximise people's individual contribution and to develop community spaces where people can come together to develop friendships and to share experiences and support; with the understanding that, over time well-being at an individual and community level will continue to improve.

It is recommended that the findings from this report are used to develop a model of place-based support which reflects the requirements of the Social Services and Well-being Act and is underpinned by the sustainable development principles of the Well-being of Future Generations (Wales) Act: long-term, integrated, collaborative, preventative and above all one that involves people in co-creating their own solutions.

Appendix 1 – Factors which contribute to a person's "*Anatomy of Dependence*"	
Cycle of dependency	The person remains in a constant cycle of dependency, (crisis ➔ intervention ➔ fix) because the focus is not preventative nor supports the person to anticipate and manage another decline/crisis we constantly perpetuate the cycle and maintain/increase dependency
Service creep	Insidious increase in service provision over time, due to lack of focus on personal outcomes and active measurement
Loss	The persons experience is of wider scale loss - role, identity, familiarity, support, finance
Learned behaviour	The person has been conditioned to think, expect and respond in a service led way. Changing the way that people think, and go about their life requires a significant shift in behaviour. Breaking the pattern of dependence requires a set of attractive alternatives
Unwilling to participate	The person is too entrenched in the current service model, they cannot see or don't want to consider any alternatives. They have their "package for life" it is difficult sometimes impossible to introduce change. The reasons are complex and the result of many issues. At this point it is difficult to introduce the concept and make change. People have become conditioned to receive a package of care.
Lack of motivation	A lack of desire and/or energy (frail) to be interested and committed to consider alternatives. The person does not want to make the effort to change their current life
Confidence	The feeling or belief that the person cannot succeed in doing something for themselves, or rely on someone else to do something for them
Family anxiety	Concerns of the family that the person could lose the services and support they currently receive
Provider collusion	Obvious collusion between the person and the provider in maintaining the current service. Concerns about zero hours contracts, and employment insecurity, creation of co-dependency
Poor models of care	Transactional care provision which does not place the person at the centre. Characterised by inconsistency, unreliability and poor communication leading to stress/distress for the person and their carer
Relationship dynamics	Service provision impacts negatively upon the relationships between family members. Caring becomes an identity for carers not a role. Care commodified by policy agenda
Instability	The health and wellbeing of the person is likely to fail should no preventative work be done
Safeguarding	The person is in a vulnerable position due to living in a high risk situation
Financial advocacy	The person has a lack of access and control of their finance, either physically or mentally
Loneliness	A mismatch of the relationships the person has and those they want.
Rural isolation	The feeling of disconnection experienced by a person as a consequence of living in a rural area

References

[1] In Australia this is called Local Area Coordination, in Monmouthshire we decided to use the name Community Coordination as the acronym LAC was already in common use to describe Looked After Children
[2] Self-Assessment Questionnaire context
[3] http://volunteeringmatters.org.uk/app/uploads/2015/11/Vol-Social-Action-Health-and-Care-web-version.pdf
[4] See appendix 1 for full complete overview of factors
[5] Monmouthshire County Council, Community Care Questionnaire
[6] "The anatomy of resilience: helps and hindrances as we age A review of the literature" By Imogen Blood, Ian Copeman & Jenny Pannell October 2015
[7] Ageing Well – a whole system approach - a guide to place based working Local Government Association