Rainbow Centre

Charity No 1100479

Rainbow Pathway Project Feasibility Study Final Report

December 2020

CADWYN Clwyd
Asiantaeth Datblygu Gwledig
Rural Development Agency

Cronfa Amaethyddol Ewrop ar gyfer Datblygu Gwledig: Ewrop yn Buddsoddi mewn Ardaloedd Gwledig
European Agricultural Fund for Rural Development: Europe Investing in Rural Areas
LEADER
Llywodraeth Cymru
Welsh Government

CONTENTS

1.Background to the study.....2
Context.....2
Purpose of the study.....3
Deliverables.....4
2.The case for change 5
The vision:.....5
Issues for concern.....10
3.Requirements for success 22
4. Regulatory environment 28
5. Site and facility requirements 30
6. Statutory consultation 31
7. Financial feasibility 34
8. Legal requirements 40
9. Potential funders 41
10. Indicative timetable 43
11. Risks.....44
12.Current situation and options 47
13.Conclusion and actions 49
Appendix 1: Visioning workshop.....51
Appendix 2: RC- Vision and mission.....53
Appendix 3: the design brief 55
Appendix 4 57
Financial and Operating Assumptions.....57
Appendix 5 61
Notes on indicative timetable.....61
Appendix 6 62
Who we consulted with:.....62

1. Background to the Study

Context

Rural Development Agency Cadwyn Clwyd Cyfyngedig (hereafter Cadwyn Clwyd), agreed to fund the Rainbow Centre to undertake a feasibility study into the establishment of a step up step down transitional facility to connect to the Rainbow Centre's hub, based within Penley, Wrexham.

The Rainbow Centre has been operating since 1994. It is a registered charity and serves the communities of Wrexham and North Shropshire borders. Many of the services are delivered from the community hub at Penley Rainbow Centre, which is located on the same site as Penley Polish Hospital. Services include Day Opportunities (sometimes referred to as day care) Social Prescribing sessions (including a carers group, art group and gardening group) Community Transport and, our innovative 'Community Wellbeing Service' which incorporates Community Agents, Social Prescribers and Befriending Buddies working to support residents across Wrexham to improve their health and wellbeing, via outreach within the community and across all GP Surgeries within Wrexham.

The aim of the Rainbow Centre is to improve the health and well-being of our communities; providing support, services and facilities that can empower people of all ages to retain as much independence as possible and enable them to access services in their locality.

The Rainbow Centre's vision is for older people to be recognised to their full potential and to lead healthy fulfilling lives as engaged citizens; with rights of access to quality services in their locality and according to their need.

Established in 1994, the Rainbow Centre originally ran services from an unused ward of the original Polish Hospital. Today's Centre opened in 2010 and shares the site with the newer polish hospital which opened in 2002.

The polish hospital has its origins in a military field facility that accompanied the Polish Army across Europe, the Middle East and North Africa before settling in the abandoned US army base in Penley, North Wales. Churchill signed an accord at the conclusion of World War II, promising to maintain services for the Polish veterans for as long as they were needed. Around 2,000 patients and staff were at the hospital when it first settled in Penley, but over the years the number of patients has been steadily falling as the veterans moved on to settle into their local communities, and have now deceased. The current Penley Hospital was rebuilt as a 9 bed unit and currently houses no polish veterans.

Adjacent to the hospital, the Rainbow Centre is currently operating at capacity and does not have the floor space to accommodate a step up step down and respite facility within the existing building. However, there is potential for the wider site to accommodate one.

The proposed step up step down facility would add to the current service offer for the betterment of the local community; helping to alleviate delayed discharges from local hospitals whilst also responding to a demand for care services to be delivered close to home.

Purpose of the Study

To address the issues identified a feasibility is sought to assist in establishing the viability of redeveloping the Rainbow Centre site to encompass as step up step down facility, linked to their newly emerging domiciliary care service and wider health and wellbeing activites.

The key aims and objectives of the study were identified as:

- liaison with stakeholders to establish the level of support and demand for the proposition, including consulting with Betsi Cadalwadyr University Health Board (hereafter BCUHB), Wrexham Council Borough Council (hereafter WCBC), potential service users and their carers.
- consider development options, including:
    a. a complete new build
    b. bringing the existing polish hospital building into the scheme supported by a smaller build
- background research into setting up and operating the facility, including regulatory, building and planning requirements and operating assumptions, providing a rational for why the facility is needed, and likely sources of revenue
- leaseholder and facilities management issues in relation to extending the Rainbow Centre on land owned by BCUHB
- overview of potential funders who could assist with reconfiguration of the site and associated capital build and fit out costs
- clear recommendations on the likely viability of the project and next steps.

Deliverables

The key deliverables from the work is a business plan that contains the following:

- a comprehensive written appraisal of the issues outlining the benefits and threats of the proposal
- financial costings, including a three-year forward cash flow projection and predicted revenue
- three-year forward business plan, and
- a detailed risk analysis

The following feasibility report describes the proposal for delivering the preferred option, which provides a framework for service delivery, an emphasis upon a rehabilitative and therapeutic model of support and demonstrates sustainability for the future.

2. The case for change

The Vision:

We will be a Centre for excellence in delivering an outstanding and outcome focused step up step down and respite care facility which will link to our home care service and award winning wellbeing hub. Our cohesive multi-partnership model will embrace residents and families, local communities with health and social care professionals and local educational establishments, to provide care and rehabilitation closer to home for our local elderly population.

- Person centred
- Holistic
- Caring and compassion
- Outcome focused
- Preventative screening
- Rehabilitative and therapeutic
- Take positive risks to promote independence
- Formal health promotion
- Dementia friendly
- Carers support
- Integrated with the community





Step Up - The intended project will work with the NHS community health teams to identify a person(s) who may be at risk of needing hospitalisation because of the unsuitability of their home or because they have been assessed as having care needs. There may be no medical need but because they are at risk from continuing to live in their home, being in hospital may be the only alternative. Through Step Up, the proposed service will accommodate people in Independent Living whilst their home is made suitable or another home identified, or for a care package to be arranged.

Step Down - The Rainbow Project would look to support elderly people moving back into the community after a stay in hospital. Our step down service would provide people with ongoing therapies and support in a suitable environment with trained staff, to help them get back on their feet in an appropriate setting with the focus on enabling people to return to their own homes safely. This is a way to ensure that people receive the right care at the right time and in the right place. The step down service will be in people's local community and will aim to support individuals to maximise their potential and to remain as independent as possible through rehabilitation. The service will help to avoid prolonged stays in hospitals.

Respite Care – This service would also be available for people in the local community to enable carers to gain respite whilst enabling their family member to remain living within their local community. It would also enable clients from the day opportunities service to receive more continuity of care.

Associated 'Home Care' service - The step up step down facility will be linked to our 'care at home' service which will enable clients to resettle into their surrounding after a period of staying away from their home or when they are at risk of hospital admission.

The Rainbow Project proposes to bring together on the one site, all of these services and to deliver a quality driven provision, which will showcase best practice and successfully meet the care needs of older people within their local community.

Details of the Visioning Workshop which informed this vision can be found in appendix 1.

Who are we?

'Age doesn't stop you wanting to do things...
Rainbows has been a lifeline!'

The Rainbow Centre operates a community hub in Penley, South Wrexham and this year took over the management of Marchwiel Village Hall to develop a second hub. The Rainbow Centre has been effectively tackling loneliness and isolation whilst promoting good health and wellbeing for the past 25 years.

We are on the ground, listening to what people want and need, and developing services based on these needs in line with their strategic approach, set out in Appendix 2. We are often the first point of contact for older people in our community when they are trying to access services or deal with change.

At our core is our day opportunities service which supports people to remain living independently within their community, for many we are the first point of contact when they need extra support to stay living in their local area. All our staff are dementia trained and our services are dementia friendly from our teacups to how we design our therapeutic activities such as a Hensioners Project.

We know our client group well. Within the day opportunities service:

- 83% of our clients are the old elderly (over 75's)
- 26% of which are aged over 90 years old
- 55% of our clients have dementia
- 44% are affected by frailty and mobility issues

These statistics inform how we develop interventions, services and staff training, to ensure we effectively promote independence and wellbeing for all.

We have lots of social prescribing opportunities running from the centre which are open to clients carers and families and the wider community, including our carers support group, community garden, hensioners (chicken) project, knit and natter, pilates, craft sessions, the rainbow singers community choir and much more.

We have 2 mini buses to support people to get to and from the centre and a committed team of volunteers working across all our areas of service delivery.

Our newly established Community Wellbeing Service is building stronger communities by placing Social Prescribers in all GP Surgeries across Wrexham, supported by a team of Community Agents working across 12 community council areas, and a team of volunteer Befriending Buddies_ all of whom work with individuals to promote good health and reduce loneliness and isolation.

In the last 2 years, we have supported over 2,000 people either here at the Centre or within the community.

And in response to demand for services during the coronavirus pandemic we have launched 3 new services:

- Domiciliary Care Service
- Meals to You
- Welfare telephone calls.

What makes the Rainbow Centre special?
As a small charity it's our distinctive approach

- We 'listen' and put individuals needs first
- We Never turn people away
- We are Embedded in our community
- We Reach early and stay longer…
- And Provide spaces where people feel safe, respected and useful

We are changing peoples lives for the better. In Audreys' words:

"After my fall I had a nervous breakdown. I'd always suffered with my nerves but this time I got very depressed, I was so lonely in the house. I don't know what would have happened if not for Rainbows." "Living on your own is quite isolating. Night times are lonely, I can't go out and the silence is so hard." "Rainbows has helped with my grief. There are people here who understand and I can talk, laugh and reminisce with them." "Age doesn't stop you wanting to do things. Rainbows has been a lifeline."

Recent awards:

- Shortlisted finalist, GSK Impact Awards, Kings Funds (award due to be announced in 2021)
- Winner, Social Care Wales Accolade 'working with and listening to people with dementia' (2020)
- Second place (second), Small Charities Big Impact Awards (2019)
- PQASSO Quality Mark (2019) awarded for effective governance and management processes.

Photo: members of the Day Opportunities staff team

Issues for concern

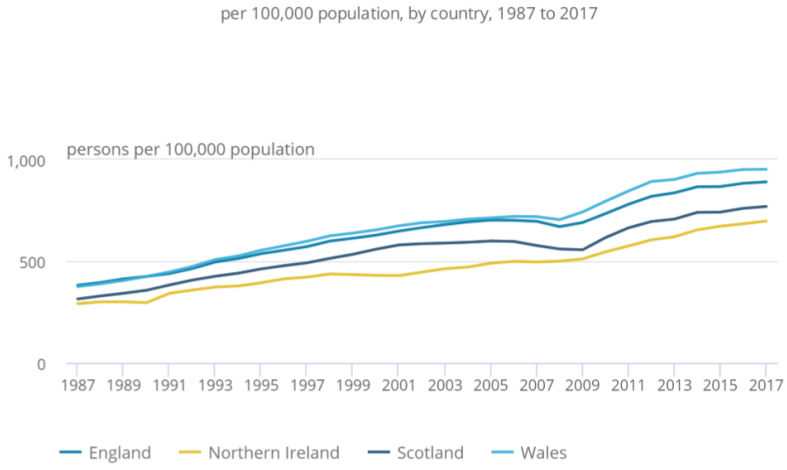
An aging population

Over the past fifteen years the NHS has dramatically improved. Cancer survival is its highest ever. Early deaths from heart disease are down by over 40%. Avoidable deaths overall are down by 20%. However, there are several issues of concern in relation to the care of frail older people in the local community that appear to be connected and require an approach for change.

Context:

- People aged 85 years and over are the fastest growing segment of the UK population and this group is projected to more than double by 2039 and is associated with increasing incidence of dementia.
- The number of centenarians is projected to rise by nearly 6-fold increase in the next 25 years. In 2017 there were 579,776 people in the UK aged 90 and over living in the UK including 14,430 centenarians.
- Wales has a significantly aging population, in 2008, 18% of the population was over 65; by 2033 this is expected to rise to 26% (Baxter and Boyce – The aging population of Wales)
- Wales has the highest proportion of residents aged 90 years and over, and the highest proportion of centenarians. (OFNS)

Figure 1: Number of people aged 90 years and over



Source: Office for National Statistics, National Records of Scotland, Northern Ireland Statistics and Research Agency

- The same pattern is seen for centenarians, with Wales having the highest proportion at 26 per 100,000.

- People over the age of 80 years who are likely to require 24-hour care is projected to increase by 82% with a demand for 630,000 care home places across the UK by 2030. Most frail older people with complex needs requiring 24-hour care are cared for in care homes although this may not be the best provision for them.

Hospital admissions and delayed transfer of care

Hospital inpatients are increasingly old. Many are living with frailty and most have a degree of functional impairment – either in mobility or other activities of daily living. Many such patients leave hospital less mobile and independent than when they were admitted – making rehabilitation after acute illness and injury a core business not just for hospitals but also for their partners in 'step-down' intermediate care services. These services also have the potential to provide 'step-up' (admission prevention) care, for early supported discharge from the hospital front door or wards. The impact of long covid will further exasperate demands for supported discharge.

A 'delayed transfer of care'; when a patient is ready to leave a hospital or similar care provider but is still occupying a bed, can occur when patients are being discharged home or to a supported care facility, such as a residential or nursing home, or are awaiting transfer to a community hospital or hospice.

Delayed transfers – often described as 'bed-blocking' – can cause considerable distress and unnecessarily long stays in hospital for patients. They also affect waiting times for NHS care, as delayed transfers reduce the number of beds available for other patients.

There are limitations to the national data on delayed transfers of care. It is not clear whether all providers are using the definition of delayed transfers of care or reasons for delay in the same way; small differences in interpretations could lead to large changes in reported numbers.

National data may also understate the number of patients who could be cared for safely and effectively out of hospital. This is because the 'clock' for measuring delayed transfers only begins when a full multidisciplinary team has assessed the patient's needs – for example, to determine if a patient needs further therapy or social care input – before deciding when the patient can be discharged. Patients in hospital who have been assessed by a consultant or other clinician as being 'medically fit for discharge' will not be counted as a delayed transfer before this fuller assessment takes place.

However, it is apparent that the proportion of delayed transfers due to social care has risen steeply since 2014, but the majority of delays (58 per cent in 2016/17) are still attributed to the NHS. However, it is too simplistic to view delayed transfers as either a 'social care' or 'NHS' problem. Delayed transfers

can be the result of delayed processes within the NHS, social care, or across both sectors, and can occur for a number of reasons.

Patients can often be delayed waiting for onwards care. For example, intermediate care services occupy an important middle ground between primary and hospital care for patients leaving hospital. These services include bed-based care, rehabilitation and reablement services, which often provide a much-needed 'step-down' service for people moving between more intensive hospital care and independent living or social care. However, recent reports suggest there is insufficient capacity to meet the demand for intermediate care, resulting in increased waiting times and delays in accessing this much-needed care. (Kings fund)

Research shows that initiatives to moderate demand for hospital care often struggle to succeed. Progress depends on having sufficient capacity to provide appropriate care outside hospital, yet evidence suggests that intermediate care capacity is currently only enough to meet around half of demand.

The timing of discharging patients from hospital is important. Sending a patient directly home from hospital prematurely, before their medical care is completed, can lead to poor patient experience and readmission to hospital. Nationally, readmission within 28 days of leaving hospital runs at around 15 per cent for people over 65 and the overall numbers are rising. This is where a step down service could more appropriately meet a client's needs. But delayed transfers of care are currently a significant concern to patients and staff in the health and care system. Longer stays in hospital are associated with increased risk of infection, low mood and reduced motivation, which can affect a patient's health after they've been discharged and increase their chances of readmission to hospital. The *National audit of intermediate care* argues that, for older patients, a delay of more than two days negates the additional benefit of intermediate care, and seven days is associated with a 10 per cent decline in muscle strength due to long periods of immobility in a hospital bed.

Improving support for older people in respite/ step up/ step down services – either to prevent hospital admission (or readmission) or to facilitate discharge when they are ready to leave hospital – is key to patient flow.

It is a stressful environment for clinicians and operational managers, who are under constant pressure to prevent hospital admissions, discharge patients sooner and get them home when capacity and responsiveness in primary and community health services is lacking. Social care has also suffered cuts in revenue since 2010, and with many people receiving no statutory care despite their needs being classed as 'substantial'. In addition, few carers for older people get formal support.

Hospital inpatients are increasingly old. Many are living with frailty and most have a degree of functional impairment – either in mobility or other activities of daily living. Many such patients leave

hospital less mobile and independent than when they were admitted – making rehabilitation after acute illness and injury a core business not just for hospitals but also for their partners in 'step-down' intermediate care services. These services also have the potential to provide 'step-up' (admission prevention) care, for early supported discharge from the hospital front door or wards.

The National Intermediate Care Audit has shown insufficient capacity or responsiveness in these step-up/step-down services, though they work well for people who use them who often report good person-centred outcomes.

Wales: The Strategic Context

As a result of all these issues and a need for change, providers and commissioners across the UK are now adopting strategic changes to the way in which services are delivered with the growth of more healthcare out of acute hospitals and closer to home, with the aim of providing better care for patients, cutting the number of unplanned bed days in hospitals and reducing net costs.

Successive Welsh governments have followed a policy of enabling older people to maintain their independence and stay in their own home as long as possible, this is known as Aging in Place. To support this policy there is increased expectation around the quality and flexibility of services in Wales. With the increase of an older generation in Wales and the increase of dementia, the need for specialist services at the interface of social care is growing. Acute hospitals in Wales are under pressure to respond to these service needs. Even though we have a rapidly ageing population and an increasing number of people living with complex long-term conditions, frailty or dementia, we have continued to lose hospital beds over the past three decades.

In November 2014, the Older People's Commissioner (hereafter OPCW) for Wales published "A Place to Call Home? A Review into the Quality of Life and Care of Older People living in care homes". The review considered the quality of life and care of older people in care homes. The report highlights: "Older people want to maintain their physical and mental health for as long as possible. However, formal health promotion is absent from many care homes. Too many older people are not being offered preventative screening or interventions, such as falls prevention, mental health support, speech and language therapy, occupational therapy, physiotherapy and wider reablement, which would enable them to sustain or regain their independence, mobility and overall quality of life. This is a particular issue when older people move into care homes after periods of ill health or following hospital admissions."

In June 2018 the Welsh Government published a long term future vision of a whole system approach to health and social care, in "A Healthier Wales: our plan for Health and Social Care". The plan is the Welsh Government's response to the 'Parliamentary Review into the Long Term Future of Health and

Social Care in Wales', which was published in February 2018 and builds on the ambitions set out in recent legislation including the Social Services and Well-being (Wales) Act 2014 and the Well-being of Future Generations (Wales) Act 2015.

New models of seamless care_ delivering care closer to home

By building on the philosophy of prudent healthcare, and on close and effective partnership working in Wales, the Welsh Government aim to make a positive impact on health and wellbeing throughout life. This will be achieved through a greater emphasis on illness prevention, on supporting people to manage their own health and wellbeing. People will be enables to live independently for as long as they can, supported by new technology and integrated health and social care services which are delivered closer to home.

The achievement of this future vision is dependent upon the development of new models of seamless local health and social care, which will scale from local to national level. The Parliamentary Review into the Long Term Future of Health and Social Care in Wales called for four goals for the health and social care system in Wales, which it referred to as the Quadruple Aim, namely:

1. Improved population health and wellbeing
2. Better quality and more accessible health and social care services
3. Higher value health and social care
4. A motivated and sustainable health and social care workforce

They also set out what delivering the Vision would entail, which included:

- Achieving longer, healthier and happier lives through people taking more responsibility for their own health and wellbeing, and for their family and those they care for

- A whole system approach to health and social care which is not just about services but a 'wellness' system which supports and anticipates health needs to prevent illness and reduce the impact of poor health

- An equitable system which achieves equal health outcomes for all

- Services which are seamless and delivered as close to home as possible, with integration at local and regional level and multi-disciplinary services focused on prevention and early intervention within localities, involve other partners beyond the NHS and local authorities, such as the third sector.

Measuring the needs of the local community

In Wrexham alone, we know that there is a need to provide holistic person centred care closer to home for frail older people to assist them to retain their independence

- People aged over 85 are the fastest growing segment of the population in Wales
- In Wrexham, 3,000 elderly people were aged over 85 years old in 2010. It is anticipated that this figure will reach 6,000 by 2030
- 25% of people ages over 85 will be frail (based on NHS clinical frailty scores)
- Rural Wrexham has a dispersed ageing population which is higher than in the local urban areas, urban bias leaves rural communities at a disadvantage.
- Villages in South Wrexham in the 10% most deprived in Wales for access to services.

Wrexham Maelor Hospital is seeing an increased demand on their services by the elderly and a growth in delayed discharge due to frail elderly having no access to care closer to home.

Dr Cameron Abbot, Care of the Elderly Department, Wrexham Maelor Hospital states that immobility that occurs in hospital is a huge problem for patients as it leads to deconditioning. Some headline statistics he notes about deconditioning are as follows:

- 10 days of bed rest is equivalent to ageing 10 years in the muscles of patients over 80 years old
- Hospitalised patients spend 83% of their time in bed
- 60% of immobile older patients have no medical reason for bed rest

(figures from the National Audit of Intermediate Care)

The Community Resource Team (CRT) within BCUHB works across Wrexham to provide a service to the elderly community, offering them home visits to support them with issues like urinary tract infections and falls. During these visits the team conduct trusted assessor screenings which include assessing if a patient needs step up care in their locality, with the aim of keeping patients out of hospital unless it is completely necessary.

The team have identified a shortage of specialist step up step down provision and the need for care closer to home to support discharges earlier across South Wrexham. Delayed discharges are occurring across Wrexham due to:

- a major lack of domiciliary care,
- a lack of providers able to offer double handed care,
- a lack of specialist step down care and,
- fewer care agencies taking on clients in rural areas due to the travel time between calls.

Demand for domiciliary care is growing and the impact of long covid will only add to the demand for services.

WCBC Social Services report (2019-2020) reported that:

- 49% of Wrexham carers are not provided with adequate support from social services
- domiciliary care assessed as high risk problem for the LA
    - shortage of care providers
    - social services can't always provide people with the right care in a timely way
    - extra strain on informal carers
    - delayed hospital discharges, reducing the availability of 'reablement', as the Councils in-house service becomes blocked
    - harder for people to stay independent, puts extra pressure on our communities.

Current step up/step down provision

In recent contract award notices published by WCBC in 2017, 2018 and 2019. The requests were for service provision to meet the following objectives;

- to provide timely access to short-stay beds
- to work with the Intermediate Care Service to ensure individuals placed are enabled to regain / maintain their independence in all aspects of daily living, in order to ensure a safe transfer back to their own home.
- to support the implementation of 'assess to admit' and 'discharge to assess' pathways in Wrexham.
- to provide high quality, outcomes-focused and dignified care to individuals placed within the beds
- to maintain accurate records and produce regular monitoring information in line with the monitoring requirements of the Integrated Care Team and project funders.

Following discussions with WCBC commissioners and members of the health board, most clients requiring step up/ step down or respite services, are being placed in care homes, because of the lack of provision for these specialist services in the local area. This is reinforced by clients who access the current Rainbow day opportunities services who report a lack in these provisions close to their homes and the detrimental effects this can have on their health and well being. This is especially the case following hospital admissions in the area, where clients have reported either, staying in hospital for prolonged periods of time or being sent home prematurely and struggling to regain independence without the relevant support.

There are several care homes in Wrexham offering respite care to clients. In discussion with some of these care homes they state that they provide care to clients who require respite care, but do not have facilities for clients to cook their own meals or to engage in activities which promote independent living.

This is consistent with the care homes who are providing step up step down beds across Wrexham under the current contract who have confirmed that facilities do not include spaces for cooking or to engage with independent living skills.

Rainbow Pathway Project to provide respite, step up and step down care, has been highlighted to the Rainbow Centre as a definite need in the local community over the last few years. And the demand for this provision is growing. The evidence for which comes from numerous clients and members of the local community who have struggled for support. Real examples include:

- a frail lady, aged 89 who was admitted into Wrexham Maelor hospital after a minor fall only to remain there for 11 months, despite having no medical needs. This was due to a lack of local step down and/or home care provision in South Wrexham.
- a frail gentleman with advanced dementia, aged 87 years old went into respite care outside of the South Wrexham area whilst his wife who was his principal carer (aged 86) received treatment for cancer. Due to a lack of agency support, the family felt forced into employing a personal assistant privately to be paid for via direct payments, so that he could return home and to the day opportunities service at the centre. This experience added to their already stressful situation, they didn't feel they had the skills to manage the personal assistant, or deal with direct payments which caused them additional anxiety during challenging times.
- an elderly lady, aged 90, who lives by herself, she is mobile and mentally fit. After a fall at home which broke her wrist, she went into Wrexham Maelor Hospital, she was then moved to Chirk community hospital, before being moved to Penley Hospital when no care package could be sourced. This lady could have come home over a month ago if she had had a care package in place. Her new care package is for 6 visits which include 2 night time calls. Due to her need for night time calls no care agency has taken on the package which leaves her remaining in hospital despite being ready for supported discharge.

When the first two clients returned to the Rainbow Centre they had increased frailty, reduced mobility and a reduced ability to self-care, this is also likely to be the case for the third client.

Recent stakeholder consultation with clients and their carers

The Rainbow Centre's day opportunity clients and carers have raised a consistent need for local, quality respite care facilities, close to home, especially for clients living with dementia who find it disorientating to go to new surroundings when accessing respite care.

A recent consultation, in the form of interviews was conducted with 24 clients and their families agreeing to take part.

Respite Care
Out of 24 people interviewed 9 had previously used respite care and a further 8 said although they have not needed it as yet, they would use the service if it was offered by the Rainbow Centre.

The people who hadn't used respite care, explained they had family support around them currently so didn't feel the need to, but in future if circumstance changed, they would prefer to use a service connected to the Rainbow Centre to ensure they had a consistent quality of care which remained local to them.

The main reason for accessing to respite was to:

- help carers have a break from the full time care they were offering or
- deal with their own medical needs, treatments and care.

The length of stay varied, but was normally:

- between 1 - 2 weeks
- a maximum of 4 and half months due to a client's wife having to have an operation.

Selection of the homes
Care homes had previously been selected by social services, clients, and their families. Some respondents felt disappointed they were 'just given a list to select from' and felt that they did not have a choice on which home they could choose due to social service funding limits.

Paying for their stay, was met as follows:

- 5 families had social services support
- 2 were part funded by social services, with the client paying the shortfall,
- 2 privately funded.

Quality of care

When questioned about the experience of respite care over 50% of respondents stated that they had experienced poor care, although it should be stated that our sample was very small so may not be representative of respite care across Wrexham.

Reasons care was reported as poor included:

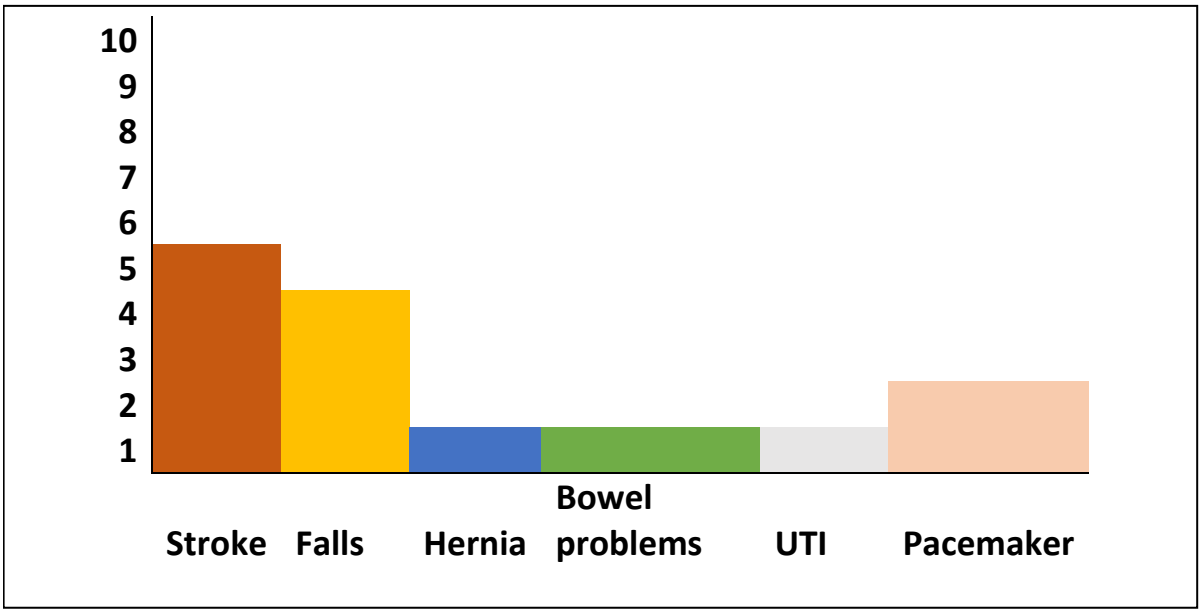
- the family member not being happy during their stay and coming back with a different mood
- room was too small
- limited facilities
- little to no monitoring the persons health and no medical intervention resulted to infections
- staff did not have the correct training to support or care for a person with dementia

As a result of these issues 2 families said they would not use respite care again but when questioned if the Rainbow Centre offered it they agreed they felt the care and support within the Day Opportunities service was 'excellent so yes we would be happy to leave their family member', and 'all staff are dementia trained which is so important'.

Hospital admissions and discharge support

58% (14 out of 24 of the Rainbow Centre's clients interviewed) had been admitted to hospital in the last 2 years, due to a range of causes.

Figure 2: Bar chart showing reasons for hospital admission at Wrexham Maelor Hospital



Length of admission varied significantly:

- 1 discharged then readmitted twice over a period of 3 weeks
- 3 delayed discharges (23 days – 4 months)

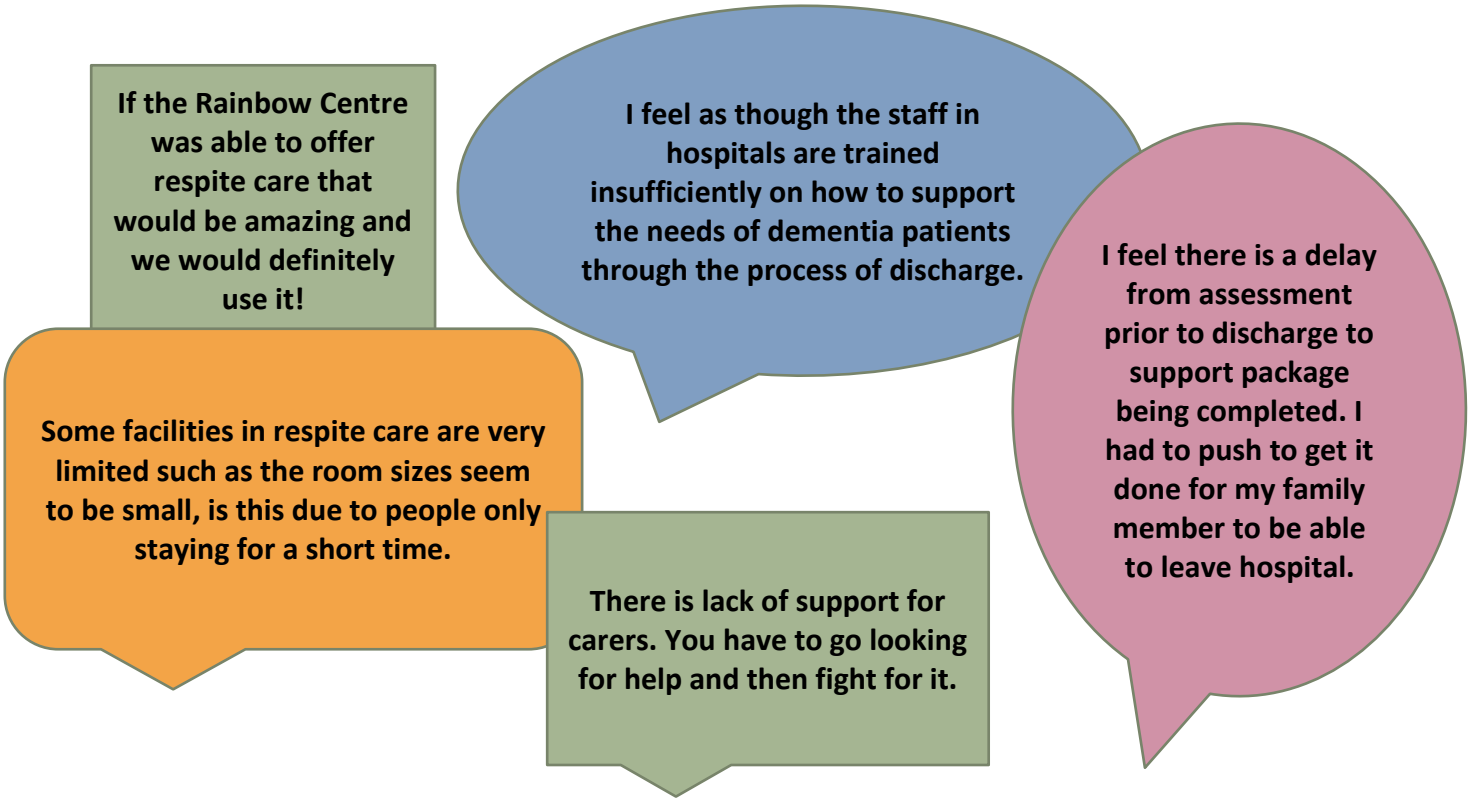
- 5 had 3-7 days admission before going home
- 3 were discharged promptly and no care or support package was required
- 2 were discharged promptly due to families taking control of after care
- 1 supported at the hospital with rehabilitation (4 months)

Qualitative comments

Client's and carer's comments were consistent and showed a clear need for speclialist care closer to home for our client group and their families. One carer explained that she felt that 'hospitals and homes are ill-equipped in-patient care.' 'Due to mum being very quiet, she didn't get checked regularly. This resulted his her having bed sores at point of discharge'.

Another gentleman who had a 1 week extra stay in hospital after having a stroke noted:
'my discharge was delayed due to a care package being unavailable. Once in place I was only offered 3 weeks of support.'

A clients' daughter reported a delayed discharge of 4 months for her mum who has dementia and frailty, due to being unable to get assessed and have a package set up due to COVID-19. She said 'I couldn't go in to visit mum so watched through the window outside, I saw her crying in the corner of the ward. It was heartbreaking, there was nothing I could do'. 'There was no dementia support and was unable to do anything due to being outside the building which was heartbreaking'.



In our small sample of 14 clients who had stayed in hospital during the last 2 years, over 20% experienced a delayed discharge and could not access care close to home.

In the last month, we have seen 2 clients enter Wrexham Maelor hospital:

- 1 client is experiencing a delayed discharge (waiting for a care package to become available) and,
- 1 client was admitted due to a urinary tract infection (UTI) and was then being assessed for Alzheimer's when she contracted coronavirus on the ward. As of this week, she was still in hospital receiving care and, we have yet to be updated from the family on her condition.

We are aware of former clients who experienced delayed discharges during the last 2 years, they have now deceased, so we chose not to interview their families for this survey due to the distress it may have caused them.

Our findings show there is a need for care closer to home, and that any care provided needs to recognise skills in the workforce to ensure the right care is being provided. Some families have stated they had to fight for care, pay privately and /or experience long delays.

In the recent Healthcare Inspectorate Wales Inspection of Older Adults services – WCBC. The reports states in relation to prevention and early intervention that:

- the priorities for improvement are for the 'local authority and local health board to develop a joint approach to the review and provision of third and independent sector early intervention and prevention services (including community agents)
- to improve the range and coordination of services that reduce isolation and support people to remain independent.
- local authority and local health board make better use of the Population Needs Assessment process.
- continue to work with statutory and voluntary sector partners to identify local need and gaps in preventative services, transform individual projects into sustainable services that promote independence and prevent hospital admission for a reason other than clinical need'.

Our intentions are timely, if we are to collaborate with partners to bring care closer to home. Step up step down provision allows elderly people to avoid hospitalization for prolonged periods where there is no medical reason for bed rest, allows care to be delivered closer to home, ensures delayed discharges from hospital are avoided for BCUHB, and ensures Community Resource Teams can access the right support for patients in need within their locality and provide better continuity of care.

3.Requirements for success

Therapeutic model

The intention for the Rainbow pathway project is to remain focused on social inclusion, daily living skills, improving mobility and reversing frailty, and continuing work that remains an obstacle to eventual discharge into the community. The approach will be recovery led, focusing on the skills and abilities that patients have and assisting them in developing these further aiding improvements in self-esteem and confidence. The support staff will draw from the many skills of the multi-disciplinary team including psychological support and therapy, physiotherapy, and other specialist professionals when needed, working within a common framework. The team realise how vital structure, education and activity are in maintaining mental and physical health well-being, providing opportunity onsite and within local areas.

The Rainbow Centre

A most vital aspect of the therapeutic model that we propose, is the link to the current Rainbow Centre. The Rainbow Centre is a registered charity and serves the communities of Wrexham and North Shropshire. Many of the services are delivered from the community hub at Penley Rainbow Centre, which is located on the same site as Penley Polish Hospital. Services include day opportunities (sometimes referred to as day care) peer support group sessions, community agents service, social prescribing, volunteering, and community transport. The aim of the Rainbow Centre is to improve the health and well-being of our communities; providing support, services and facilities that can empower people of all ages to retain as much independence as possible and enable them to access services in their locality.

The Rainbow Centre's vision is for older people to be recognised to their full potential and to lead healthy fulfilling lives as engaged citizens; with rights of access to quality services in their locality and according to their need.

We have been delivering Day Opportunities (day care) services for 24 years and have an excellent reputation for this service across Wrexham. We receive referrals from Overton and Hanmer Surgery, as well as from Chirk Community Hospital, Wrexham Maelor Hospital and across Wrexham.

In 2020 the Centre won the Social Care Wales accolade for 'working with and listening to people with dementia'. We maintain a strong reputation for supporting our clients directly but also for supporting their carers to better care for themselves and to access wider support to cope with their caring responsibilities.

The model would enable people receiving respite/step up/ step down care to access the centre and all aspects of its service, with shared links, staff, physical proximity and the combined approach to care we feel this is an essential element to the therapeutic model we propose.

To support the model, the intention is to have a 24 hour staff team, 7 days a week who will be trained in:

- care and
- therapeutic support
- motivational interviewing/coaching
- dementia
- can do attitude
- culture of taking safe risks for the benefit of patients
- actively progress patients from double to single handed care
- frailty assessments, followed up with stability strength exercise such as LiFT
- income assessments including accessing social security benefits including Attendance Allowance

We would welcome colocation of health and social care services which would add to the service offer and provide greater opportunities for interdisciplinary services to realise individual personal outcomes.

We would maintain our person centred approach to practice established through the formation and fostering of healthful relationships between all care providers, clients, their families, and others significant to them in their lives. We are looking to be underpinned by values of respect for persons, individual right to self-determination, mutual respect and understanding.

The step up step down and respite facility will be linked to our 'care at home' service which will enable clients to visit their homes during their step up step down stay and also support them to resettle into their surrounding after a period of staying away from their home or when they are at risk of hospital admission.

The Physical Environment.

One aspect of this project that sets it aside from other local provisions of this kind will be the physical environment to support the therapeutic model of support. The intention is to provide a purpose built and carefully designed service that specifically meets the needs of people needing step up down or respite care in a homely environment.

The setting is intended to be like home, where families and friends can visit any time. A quiet environment to aid rest and recovery whilst also linking residents to the Day Opportunities service where health and wellbeing is at the forefront of service delivery.

Workforce

The Centre management structure incorporates a mix of current health and social care management and innovative models of management from the charity sector. The Rainbow Centre will be a demonstration site for integration between all sectors. Lead roles at the Centre will be undertaken by those best qualified for the job. Management will remain to be seen 'on the floor'. Overall management, leadership, care and enablement will be undertaken collectively ensuring staff take responsibility for developing a high-quality care culture.

Staffing levels

Research shows that 12-hr shifts in care home environments are not cost effective. They lead to increases in sickness/absence, use of agency staff and are detrimental to the quality of care being provided.

Our staffing ratios will exceed levels for well-reviewed respite care homes and will be above the current CIW recommendations, which are 1:6 during the day and 1:12 at night. Our ratios will replicate those adopted within our current day opportunities service which operates at a minimum 1:4 ratio during the day, equating to a minimum of 2:12 a night.

This ratio will be complemented by additional staff and volunteers including students on placements and volunteers in the day-to-day routine. The Centre will have the following shift patterns but with some flexibility to meet individual staff needs: two 7.5-hr day shifts (07.30 - 15.00 and 14.30 - 22.00) one 10.5-hr night shift (21.30 - 08.00).

These staffing levels will allow us to adequately offer targeted therapy and support and ensure we can offer double handed care.

Volunteers

Volunteers enhance the quality of life of frail older people and their families. Volunteering will be for all ages. We will maintain and strengthen opportunities for students and children from local schools and the pre school as well as those people who have retired from full-time work to be involved. Volunteers are trained to work in the Centre and there will be many and varied opportunities for volunteers to support the Centre and its clients. Centre volunteers are regarded as an 'enhancement' – they do not replace Centre staff.

Research and quality improvement initiatives

The Health and Social Care Benchmarking Network carried out an appreciative inquiry into the outcomes of step up and step down services during December 2015, and found that 70% of clients returned home following a step up/down intervention, and remained at home 12 weeks after discharge.

In certain areas, personal outcomes are collected within service provision to support service change and improvement and these feed into national frameworks including a Community of Practice Website – Community Hospitals and Intermediate Care Networks. Outcomes from step up step down services which support the model of delivery service are illustrated below, by some real client experiences in Stirling, Scotland:

Service User Experience.	**Outcomes**
Mr C was admitted to step up/down services following a number of falls at home. Personal outcomes of improving mobility, while being assessed on ability to manage daily living tasks were identified. Mr C was visually impaired, meaning that he had additional risks when carrying out some tasks, especially managing his medicines.	While Mr C worked at improving his balance and physical strength, the team worked with him to identify simple, low tech solutions to managing his medicines effectively. Mr C was reluctant to accept home carers as part of his discharge plan so it was found that through a simple method of colour coding his medicines, which his family could maintain, he could manage these independently. The service was able to seek solutions which were meaningful to Mr C, with him at the centre of decision making. This avoided overly complex or costly packages of care to return home, while supporting him to maximise his independence.
Mrs D was admitted to step up/down services following assessment of risks identified by her Reablement Carers. This avoided an admission to the Acute Hospital and allowed Mrs D to be assessed in a more homely environment. Mrs D had a diagnosis of Alzheimer's and had had a number of falls at home.	Following assessment and rehabilitation of her physical strength and mobility, Mrs D was identified as someone who would benefit from a range of technology enabled care solutions to support her to live at home. This included:- • A wrist worn fall detector • A light sensor connected to a bed exit monitor

She was also having difficulty in managing her own meal preparation, sometimes forgetting to eat at regular intervals. Mrs D had also activated the fire alarm within the housing complex where she lived, due to burning food that she was trying to prepare.	• An extreme temperature sensor • A dementia clock Links were made with a Third Sector organisation who were able to offer a befriending service to D and support her with both her shopping and social networks. This gave Mrs D the confidence to be able to return to a historical society she attended locally as well as her library, enabling her to live well with her condition at home.

These outcomes mirror work taking place at Rainbow Centre currently in supporting our clients and families to manage their health better and remain living at home, not just through our day opportunities service where we promote social interactions, movement, nutrition, and build confidence, but also through the work of our social prescribers, community agents, carers group, and volunteer befrienders.

Our Strategic Plan for the Rainbow Pathway Project identifies a core set of outcomes for the people we propose to support. These outcomes are:

- **Self-Management**

Individuals are enabled to manage their own health, care and wellbeing;

- **Community Focused Support**

Supports are in place, accessible and enable people, where possible, to live well for longer at home or in homely settings within their community;

- **Safety**

Support systems help to keep people safe and live well for longer;

- **Decision Making**

Individuals, their carers and families are involved in and are supported to manage decisions about their care and wellbeing;

- **Experience**

Individuals will have a fair and positive experience of respite care/step up/step down.

The desired scope for this service model is a continuum of care from prevention through to short term therapeutic intervention and thus long term continuing care.

Quality improvement methodology offers opportunities for the Centre to identify and monitor their progress against important national or local standards and identify individual solutions to improve practice and maintain quality in care. Use of such methodologies will require ongoing support and training for all our staff. This is something the Rainbow project are committed to providing.

4. Regulatory environment

The new step up /step down facility will be regulated by Care Inspectorate Wales (CIW) who are the independent regulator of social care in Wales for both care homes and domiciliary care.

The work of inspection is guided by the following principles.

- Being people-focused – inspectors put people who use regulated services at the centre of their work, and assess services in terms of outcomes for people's safety, well-being and rights.

- Supporting improvement – inspectors make judgements about services. We commend good practice, identify poor practice and promote improvement in care and support services.

- Being transparent – inspectors are open about the information they have used to inform their inspections, reports are clear and inform people about what we can expect from services.

- Being fair and impartial – inspectors base their inspections on evidence; this includes observations, speaking to people and information we read. We provide prompt feedback to the service provider about what we have found including areas of strength and where improvements are required. We give them the opportunity to address any concerns, provide further information and question any matters that are not correct.

- Being robust – inspectors take firm and timely action when services provide poor care or place people at risk.

- Being proportionate – inspectors focus on matters that directly affect people's safety, well-being and rights. We apply our enforcement powers when we see that care services are failing in these areas.

- Being consistent – inspectors apply the same principles and undertake the same approach to all services and providers that we inspect.

The focus of the inspection is based on 4 themes:

Assessment Theme	**Evaluation**
Well-being: the well-being of individuals receiving care and support.	Inspectors evaluate the extent to which outcomes are being achieved.
Care and support: the quality of care and support staff provide.	Inspectors evaluate the degree to which people receive a high-quality service which reflects best practice, is provided by staff who have the appropriate knowledge and skills and supports people to achieve the best possible outcomes.
Environment: the physical setting in which care and support is provided. This theme does not apply to regulated service types that do not provide accommodation.	Inspectors evaluate the degree to which outcomes for people are supported by surroundings that are safe, clean, accessible, comfortable, welcoming, well-maintained, stimulating, and suitably equipped and furnished.
Leadership and management: organisational arrangements for the provision of care and support.	Inspectors evaluate the degree to which organisational arrangements provide assurance for the delivery of high quality services, by motivated staff in a well led and managed service.

Registering the Rainbow Centre with CIW

The Rainbow Centre is in the process of registering with Care Inspectorate Wales. The impact of the coronavirus pandemic during 2020 resulted in the Rainbow Centre bringing forward plans to deliver domiciliary care sooner than initially planned. This was due to their being a distinct lack of home care available for our geographically dispersed clients across South Wrexham when our day opportunities service closed temporarily during the first lockdown.

As a result of this:

- the Rainbow Centre are commencing the registration process with the CIW.
- we intend to provide all of our services under the same legal entity, and as such can apply to register all of these under a single application.
- we aim to be registered by September 2021 for our domiciliary care service. With the step up step down facility being added to our registration during 2022.

5. Site and facility requirements

Environment is key, our new building will mirror a comfortable home environment. The new build will be innovative but fit for purpose and 'dementia friendly', both outside and inside and will consist of:

- 24 accessible apartments with their own kitchen pods and en-suite bathrooms
- operate as 2 households of 12
- shared laundry areas
- aids and adaptations that enable people to be as independent as possible and the use of personalised technology to enhance care and support
- internet and telephone access in every room
- fully accessible garden for exercise and relaxation, sensory area, vegetable patch, a greenhouse, small orchard area, bird boxes, resident chickens, childrens play area.
- café including private dining areas for those who don't want to eat publicly due to advanced dementia or confidence issues which will be open to the community
- shared living room for each household with access to books, jigsaws, mindfulness exercises, and a DVD library
- consultation room for visiting services

Linking to our existing community hub, which provides;

- day opportunities for people with and without dementia including a programme of daily exercise, and mental and social stimulation with links to the wider community
- social interest groups
- carers support groups
- daily exercise classes
- domiciliary care service
- community agents – outreach support to clients and families
- volunteer befrienders service
- meals on wheels
- community garden
- childrens outdoor play space
- hall for private hire and events
- large accessible bathroom
- treatment room
- visiting services, including:
    - Hairdresser, Chiropodist, Beautician, Post office, Vicar, Library

Refer to Appendix 3 for more information on the initial design brief.

6. Statutory consultation

A change of use to the existing Polish Hospital may require statutory consultation with both existing BCUHB staff and the wider public if it is deemed to be a significant change to services, BCUHB are requested to advise on this in March, if plans going forward involve the hospital.

Staff consultation

If it is agreed by BCUHB that Penley Hospital will be utilized for the proposed step up step down facility staff consultation will may need to be undertaken as the service change will impact on staff and their immediate workplace. This form of staff consultation will be led by the Human Resources Directorate of BCUHB and staff should seek advice when necessary.

As we understand it from initial discussions with BCUHB, any closure of the polish hospital would result in staff being requested to relocate to another site ran by BCUHB. A full consultation would need to take place adhering to employment law to take employees through the options of relocation.

Length of consultation

There's no time limit for how long the period of consultation should be, but the minimum is:

- Less that 20 – no minimum (30 days is good practice)
- 20 to 99 redundancies - the consultation must start at least 30 days before any dismissals take effect

Public Consultation

If the polish hospital forms part of the plans for the proposed step up/step down facility in Penley a formal consultation may need to be undertaken in line with the Welsh Government Guidance on engagement and consultation The Guidance for Engagement and Consultation on Changes to Health Services EH/ML/0161/11.

A brief overview of public consultations:

- run for 12 weeks
- the overall aim of the public consultation is to deliver a public consultation in line with best practice that complied with legal requirements and duties and maximised opportunities for stakeholders and local people to get involved and give their views
- involve all stakeholder including staff, patients and wider community

Planning consultation

Planning consultation forms part of the formal Planning Process and as such, will need to be undertaken by all partners supported by the design team, and could involve either:

- application for Change of Use from a Hospital, to a step up step down facility attached to the existing Community Hub with associated building works
- application to build a 24 bed facility attached to the community hub

The formal consultation period will normally last 21 days, and should engage with a number of different groups, including neighbouring residents and local community stakeholders.

If proposals include bringing the hospital building into the scheme there is opportunity for both the consultations to be conducted together.

There are a wide range of methods of consultation when promoting a planning application. The list below provides an indication of some of the consultation tools available, which can be pooled together as part of a larger consultation:

Printed media

Setting out information for proposals in a written format, ranging from an invitation to an event to publications presenting information about a scheme. The distribution area needs to be carefully considered to ensure enough residents are contacted about the proposals.

Meetings

With local residents or interest groups provides an opportunity to explain a scheme on a large-scale basis to a wide audience. However, sometimes larger meetings do not provide an opportunity for all residents to voice their concerns as there is limited time and often a small number of vocal residents or interested parties can cause the meeting to focus on limited issues.

Smaller-scale meetings are a good method of consulting with specific organisations or traditionally excluded groups who may find larger meetings challenging.

Exhibitions

Exhibitions provide an opportunity to engage directly with the public and explain the scheme on a one-to-one basis with interested residents. The extent of an exhibition will need to relate to

the scale of development, but it would be more effective to run an exhibition for several days utilising the hall within the Rainbow Centre to share the vision for the development with visual plans of what it could look like.

At the heart of our proposition is the ethos that new and extended services will be developed to help to maintain people at home, support their independence and wellbeing, and provide a locally accessible and high quality service.

The need for this project has so far been driven by a demand from our local community for high quality care and rehabilitation closer to home which is connected to the Rainbow Centres award winning hub in Penley. As such, the Rainbow Centre are keen to actively support BCUHB, the wider communities and all concerned locally in having a voice in the future plans, as we see this as a positive development which is directly responding to the needs of our local community via the range of services on offer.

The consultation will also need to take into account any negative impact the development will have on residents living close by and would be an opportunity to set out how these will be minimised whilst promoting local benefits which could include:

- awareness initiatives with local schools
- opportunities for local work placements.

7. Financial feasibility

The contents of this chapter of the report have been modelled around the preferred components of care, extrapolating information from other care providers that have included 'not for profit' care organisations delivering similar innovative service models across the United Kingdom. The financial feasibility will be driven by the operating assumptions which depend on an agreed way forward which may or may not include making changes to the existing Polish hospital.

Capital costs

Developing the Polish hospital site: at present this is unknown until further discussions have taken place and other available locations considered and their acquisition cost understood.

- Preferred vision: for the project being part of the whole Rainbow Centre rather than a traditional stand-alone care home. The project would be at the heart of Penley village surrounded by community facilities.
- Developing the existing Polish hospital site will be required to achieve the project's aims. The vision is not to provide a traditional corridor care home model but to provide apartment type settings. Some care and respite home organisations are finding it difficult to survive the current financial climate of intense care – many of which have not diversified to take on 'sheltered housing' or apartments within a care village design. It is very difficult, to compare a traditional respite care home and an apartment care model, as the self-contained apartments with kitchenettes are an integral part of this innovative model. Data from recent 'care village' builds that we have been given, (including land, financing costs and professional fees) is at around £1,936/m2.
- We have costed the scheme to allow for 24 apartments. For a scheme to be financially viable best practice suggests it needs to be designed based on a minimum of 24. Any smaller would not be financially sustainable and larger schemes are at risk of not delivering on the vision of a homely environment.
- Costing for the build for this project to be on the Polish hospital site has been based upon 2 options, with the preferred option to be finalised once the project has been agreed. The costs range from £2,785,000 to £3,848,648 depending upon which option of development best suits the project. Initial discussions around funding options for the build are underway.

Estimated Capital Costs

Capital Costs	**Option 1 –** 24 bed unit utilising the hospital	**Option 2 –** 24 bed unit without hospital
Financing, planning, initial design, and professional fees	£243,000	£388,800
Construction incl. external works	£2,130,000	£3,002,000
Fit out (assuming vacant possession of existing buildings)	£240,000	£240,000
Contingency 6%	£171,360	£217,848
Total	**£2,784,360**	**£3,848,648**

NB – costs are estimates to be revised once a final model is determined.

Operating costs

Operating costs as based on the following assumptions:

- The project wants to attract and retain staff because, we envisage it to be is a Centre of Excellence.
- Salaries therefore are based on those from the independent and health sector and applied to a 24 bed setting.
- On-costs of 20% have been added for all frontline care staff and accounts for full sick pay (not statutory), pension contributions at 6%, and 5 weeks' paid annual leave with variation based on length of service.
- The operating costs include additional estimated running costs.

Operating costs

ESTIMATED EXPENDITURE	FTE'S	SALARY PER P	ANNUAL COST	TOTAL ANNUAL COST	NOTES
CORE STAFF					
STEP UP /STEP DOWN MANAGER (FULL TIME) X 1	**1**	**32000**	**39200**	**39200**	**Include on costs for pension, full sick pay and annual leave cover, HR, payroll and office space**
FRONT OF HOUSE	**1**	**20000**	**22250**	**22250**	
SENIOR CARE COORDINATORS	**1**	**27000**	**30075**	**30075**	
SENIOR HCA'S (7.5HR SHIFTS)	**5**	**23000**	**28175**	**140,867**	
HCA'S (7.5HR SHIFTS)	**7**	**21800**	**26705**	**186935**	
SENIOR HCA NIGHTS (10 HR SHIFT)	**1.5**	**32000**	**39200**	**58800**	
HCA NIGHT TIME STAFF (10 HR SHIFT)	**5**	**30000**	**36750**	**183750**	
ACTIVITY COORDINATOR	**0.5**	**14000**	**7350**	**7350**	
PHYSIO	**0.5**	**15000**	**9188**	**9188**	
NURSE	**0.75**	**26700**	**26700**	**40940**	
ADDITIONAL CAFÉ STAFF	**2.5**	**19000**	**23275**	**58188**	
HOUSEKEEPERS	**2**	**19500**	**23888**	**47775**	
HANDYPERSON / CARETAKER	**0.5**	**5000**		**5250**	**Include on costs of NI, Pension and**
FINANCE OFFICER	**0.5**	**11250**		**12000**	

FINANCE DIRECTOR	**0.4**	**12000**	**13460**	**13460**	**5% on costs for HR, payroll and office space**	
SOCIAL PRESCRIBER	**1**	**25000**	**29090**	**29090**		
VOLUNTEER COORDINATOR	**0.5**	**13000**	**15158**	**15158**		
MARKETING OFFICER	**0.5**	**13000**	**15158**	**15158**		
OPERATIONS MANAGER, DEP DIR	**0.4**	**19200**	**22919**	**22919**		
DIRECTOR	**0.4**	**24000**	**29400**	**29400**		
TOTAL STAFF COSTS				**967,753**		
ADDITIONAL RUNNING COSTS						
MANAGEMENT SOFTWARE				**3000**		
TELEPHONE AND COMPUTER				**8000**		
INSURANCES				**2000**		
UTILITIES AND MAINTENANCE				**30000**		
FOOD AND SUPPLIES				**28000**		
STAFF TRAINING				**14000**		
OTHER EXPENSES INCL OFFICE SUPPLIES				**5000**		
TOTAL				**90000**		
TOTAL EXPENDITURE				**1,057,753**		

*FTEs have been worked out using: Seven Day Ward Staffing Formula. Time-and a-half has been given for equivalent night-duty hours. Costs are estimates to be revised once the final model is determined

More details on costs can be found within Appendix 4

Operating Revenue

Income from admission of clients:

Income	
No of Beds	**24**
Local Authority funded (%)	**50%**
Self-Funded (%)	**50%**
Average Weekly Council Fee	**£950**
Average Weekly Self Funder Fee	**£1000**
Average Vacancies (%)	**10%**
Calculated Weekly Fees (Base)	**£23,400**
Calculated Weekly Vacancies (Base)	**£2,340**
Net Weekly Fees	**£21,060**
Annual Turnover	**£1,095,120**

N.B. these figures are for guidance at this stage.

Operating revenue is based on the following assumptions:

- 50/50 split in how clients are funded client (social services self funded) which replicates the split we see within our current day opportunities service.
- set the Council fee at £950 and the private fee at £1000 per week.

It should be noted that, current weekly fees for respite care across Wrexham range from £586 to £950. Providers offer care against a staff ratio of approximately 1:12 for night shifts and 1:6 for day shifts, this is in line with CIW regulations, but best practice would suggest that this ratio is too low for a step up step down facility. Out staffing levels are higher as staff will be involved with targeted therapeutic work.

Operating surplus and opportunity for on-going growth:

Detailed statements for income and expenditure, together with means of identifying any operating surpluses and opportunities for on-going growth, will be produced once initial assurances have been obtained for the projects direction in March 2021.

Income and expenditure statements for the next four years:

Indicative income and expenditure for the next 4 years (2021- 2025):

Estimated expenditure	Year 1 – fundraising, design and consultation	Year 2 – build period	Year 3 - operational	Year 4 – fully operational
Income	1. £2,784,360 2. £3,848,648	Secured the previous year	£600,000	1,200,000
Expenditure (for Option 1 and 2)	1. £243,000 2. £388,000	1. £2,541,360 2. £3,460,648	£550,000	1,100,000
Profit and loss	None	Possible contingency of £171 – 271k available	Any profit is likely to be used to support any shortfall left from the previous year.	

N.B. Detailed income and expenditure statements would need be produced once initial assurance has been given for the preferred way forward and to reflect the delivery timescale. In addition to this, soft market testing is needed to understand the exact costs of the design and build and operational costs and income will need to be reviewed to ensure they reflect the market.

8. Legal requirements

The legal requirements to take the proposition forward are yet unknown.

At this stage, The Rainbow Centre envisage continuing the positive partnership they have with BCUHB.

Currently:

- BCUHB own the land in Penley, where both the hospital and Rainbow Centre reside
- BCUHB own the Hospital building
- Rainbow Centre lease the land
- Rainbow Centre own the Rainbow Centre building.

Options to consider:

- BCUHB extending the lease to the Rainbow Centre to encompass the whole site,
- Potential to include an asset transfer of the current polish hospital once vacant possession is secured.

Options are open to discussion with BCUHB and work will need to take place to understand the legal requirements for any change in ownership of premises or use of the site.

9.Potential funders

A range of potential funding sources to support the initial capital funding for a step up/step down provision in Penley were identified.

Steve Morgan Foundation
The Steve Morgan Foundation was founded in 2001 by Steve Morgan CBE, to support projects that help children and families, people with physical or learning disabilities, the elderly, or those that are socially disadvantaged in North Wales, Merseyside and Cheshire.
"The focus is to gain maximum impact on the quality of life, to ensure the Foundation is making a difference." Steve Morgan

The Foundations have awards capital grants of up to £5million. The Foundation are currently reviewing their strategic approach to funding including their approach to funding large capital projects. They have been a supporter of the Rainbow Centre in the past. A project brief for a new build facility been submitted to them to assist them with their strategic review.

National Lottery - People and Places: large grants
People and Places: Large grants offers funding from £100,001 to £500,000 for projects where people and communities are working together and using their strengths to make positive impacts on the things that matter to them the most.

Currently in response the COVID-19 the Lottery had stated that all the funding decisions they make for the next six months will prioritise addressing the current crisis, they will prioritise applications that are COVID-19 related.

This means we will prioritise applications from organisations:

- supporting people who are at high risk from COVID-19
- supporting communities most likely to face increased demand and challenges as a direct result of measures to prevent the result of COVID-19
- with high potential to support communities with the direct and indirect impact of COVID-19

Initial conversations with Lottery Funding Advisers indicate that they are positive about the project, and they would welcome an application for funding.

Garfield Weston Foundation
The Foundation accepts applications from charities working in the areas of Welfare, Youth, Community, Arts, Faith, Environment, Education, Health and Museums & Heritage.

Capital Grants are available to cover the capital costs of a new build project for up to 10% of the total project costs. In order to proceed with requesting a grant we would need to establish the lease arrangement and have planning permissions in place if required for the project.

Welsh Government
There are two funding streams that may be available to the project.

- **Community Facilities Programme**

The Community Facilities Programme is a capital grant scheme operated by the Welsh Government. Grants are available at two levels; small grants of under £25,000 and larger grants of up to £250,000.

- **Integrated Care Fund (ICF)**

Since its establishment in 2014-15, the ICF has evolved into the large scale programme it is today. From a discrete fund aimed at keeping older people independent and out of hospital or residential care, it now provides much needed integrated support for a wider range of citizens with care and support needs including those with a learning disability, autism and other neurodiversities, children with complex needs, carers and more recently children in care or at risk of coming into care. Across all the regions of Wales, the ICF funds projects and services that are delivering seamless health and social care to people, focusing on prevention and early intervention and helping people to live their lives their own way. Importantly, the fund is making a significant contribution to helping deliver on commitments set out in 'A Healthier Wales', which is a key delivery mechanism for the transformational Social Services and Well-being (Wales) Act 2014.

The ICF has been used to support a wide range of new and innovative ways of working which have the potential to influence future patterns of care and support and in some instances accommodation, for the better. There are now numerous multi-disciplinary teams of health, social care, housing and third sector professionals working together to develop tailored interventions to help individuals meet their well-being goals and improve their quality of life. Several of the new models of delivery developed and tested through the ICF have proved so successful that they have formed the foundation of larger scale transformation programmes funded through the new Transformation Fund. The fund is allocated to and administered by each of the seven regional partnership boards that have been established across Wales to ensure a collaborative approach is taken.

Further work would need to be undertaken with a range of partners including BCUHB and WCBC to establish how potential funding could be accessed once the project approach is approved.

10. Indicative timetable

There are too many variables at this stage to produce a precise timetable.

Funding is a key issue that will need to be explored further. Consideration will also need to be given for the procurement route, whether it is design and build or a traditional procurement route, all of which will directly impact on the resources required to lead the project and achieve the desired vision.

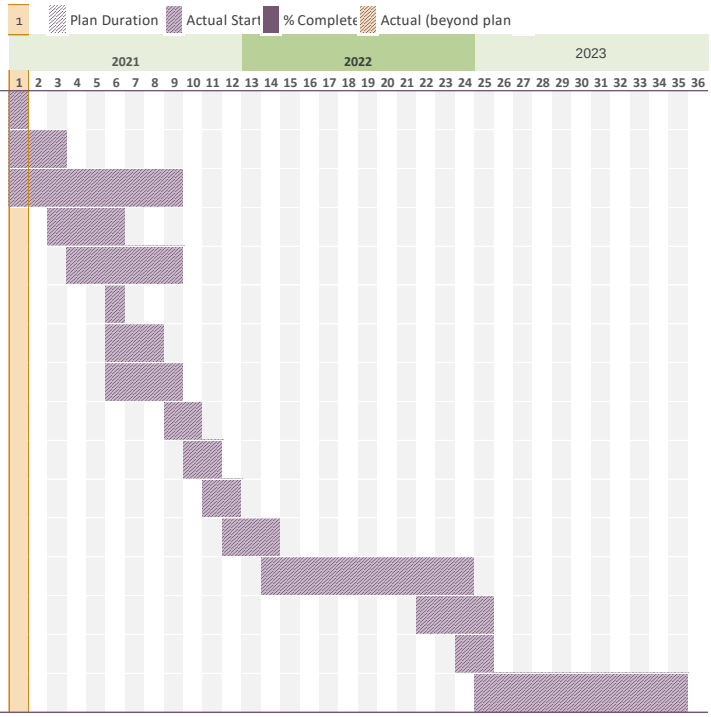
Given the disruption the build will cause to existing services, it may also be worthwhile considering moving the Day Opportunities Service to the Rainbow Centre's secondary hub at Marchwiel Village Hall during a phase of the construction period to minimize any access, disruption, and noise issues.

Rainbow Pathway Project Planner

Select a period to highlight at right. A legend describing the charting follows.

1 Plan Duration Actual Start % Complete Actual (beyond plan

ACTIVITY	PLAN START	PLAN DURATION	ACTUAL START	ACTUAL DURATION
feasibility signed off by RC	1	1	1	1
submit to BCUHB for review	1	3	1	3
register RC with CIW	1	9	1	9
agree joint project board	3	4	3	4
secure funding	4	6	4	6
constult with staff on site	6	1	6	1
appoint architect & develop proposals	6	3	6	3
community consultation	6	4	6	4
planning application submitted & approved	9	2	9	2
technical design	10	2	10	2
tender period	11	2	11	2
mobilisation	12	3	12	3
build	14	11	14	11
recruitment and training of new staff	22	4	22	4
practical completion	24	2	24	2
open new services	25	11	25	11



*Notes on likely periods for each stage are further set out in Appendix 5

11. Risks

Risk Management is an integral and essential part of project management. It involves developing an understanding of uncertainties that could cause problems for the project and planning a response to mitigate the risks should they occur. There are 4 core elements of Risk Management: Identification, Assessment, Action and Review.

Key risks, which have been informed by our initial SWOT analysis, are identified at this stage as:

1. **Unable to secure capital funding to achieve the vision**
   Risk rating: High
   Mitigating action: Engage with BCUHB and WCBC regarding funding options. Our vision is strongly aligned with Welsh Government and ICF priorities so there is potential for us to access financial resources to support the project. As a charity we will investigate match funding from charitable foundations.

2. **Loss of momentum between the vision and the build**
   Risk rating: Medium
   Mitigating action: Look to ensure resources for project management are set aside to keep the project on track. Follow Prince2 project management processes to plan and deliver the project.

3. **Failure to achieve cohesion in vision with all partners**
   Risk rating: Low
   Mitigating action: Engage with key partners from the outset, gain early buy in and build momentum around the innovative model proposed capturing shared benefits of all partners. Full business case to reflect benefit to partners after further consultation. Establish a project board with representation from key stakeholders.

4. **Community opposed to the development**
   Risk rating: Low
   Mitigating action: Involve the community early on, with a clear rationale for project and benefits it will bring, including reopening of the community café and employment opportunities. Deliver Polish Heritage Project, project includes village walking tour, and a small garden of remembrance with a sculpture at the Rainbow Centre to remember Penley's polish history.

5. **Capital build runs over time and cost**
   Risk rating: medium
   Mitigating actions: Establish project board with risks, issues and finances, tolerances - all being managed by qualified project manager reporting to a project board.
   Soft market testing to ensure budget for the build is realistic.
   Ensure design brief and tender documents are comprehensive to allow for true costs.
   Ensure contract includes penalty clauses for going over cost and time.
   Have a contingency for limited overspend.

6. **Failure to maintain the centres sustainability**
   Risk rating: Medium
   Mitigating actions: Larger development will benefit from economies of scale, and link to wider services delivered via the Rainbow Centre already. Ensure charging model is reasonable, does not put a strain on limited WCBC budgets but equally covers costs
   Carry no debt with the scheme to ensure it is financially viable, look to secure appropriate level of funds to build the project. No loans. Evidence cost savings of model to funders and outcomes achieved – clear evaluation of services in place from the outset.

7. **Failure to secure excellent report following CIW registration**
   Risk rating: Low
   Mitigating actions: Ensure resource for management to lead on registration. Purchase additional support to assist us with the registration. Strong monitoring and management procedures in place to ensure services are delivered to quality standards.

8. **Failure to achieve therapeutic outcomes**
   Risk rating: Low
   Mitigating actions: Evidence suggests that therapeutic outcomes should be achieved based on model. We will embed therapeutic assessments and outcomes from the outset.
   Commitment to staff training and ongoing learning. Effective leadership to ensure innovation and learning are embedded in the culture.

9. **Rural location makes it difficult for carers and families to visit**
   Risk rating: Low
   Mitigating actions: Utilise community transport provision and volunteer support to enable people to visit when public transport is not running or if it is not accessible.

Utilise community transport to enable people to visit their homes, to build their confidence as part of their phased return home.

10. **Struggle to recruit and retain staff in social care, exasperated by our rural location**
    Risk rating: Low
    Mitigating actions: We will ensure we remain an attractive employer through a range of support including no zero hours contracts, sick pay beyond statutory sick pay, living wage employer. Maintain a management team that treats our amazing staff with respect, rewards them, learns from mistakes, and invests in their future.

A full risk register is available for the Pathway Project and will be regularly reviewed and updated by the project board.

12.Current situation and options

SWOT Analysis

Service Options

In the current circumstances the Rainbow Centre has the following options:

(1 Do Nothing
(2 Extend our provision for Centre users only
(3 Extend provision a part of a wider pathway project

The Pros and Cons of each of these options are considered in the table below:

OPTIONS	FOR	AGAINST
1. DO NOTHING	No actions to undertake No additional costs	Needs of individuals and the organisation remain unmet
2. EXTEND PROVISION FOR CENTRE USERS ONLY	Focuses provision on the needs of centre users only Limits impact on management	Needs of wider community unmet Not financially viable Limited opportunities to spread overhead costs across wider provision
3. AS ABOVE BUT FOR ALL COMMUNITY	Service will meet unmet needs of local community Provides opportunities to develop innovate model of care, which respond to community needs.	Will take more resources and funding Requires pump priming, initial investment to develop the vision

Evaluation of the service options

Of the service options considered:

- Option 1: Do Nothing is discounted as it does nothing to meet the Rainbow Centres aims
- Option 2: As above, is discounted as demand will not be met over time and the model is deemed financially unviable due to its size.
- Option 3: Extend provision is the preferred option that best meets the aims of the Rainbow Centre.

13.Conclusion and actions

The proposition set out in this feasibility study is aligned to the Rainbow Centres Vision and Mission.

There is clear demand for the step up step down facility in the local community, which would add to the current service offer for the betterment of the local community; helping to alleviate delayed discharges from local hospitals whilst also responding to a demand for care services to be delivered close to home. Once built, the scheme is financially viable and, will bring cost savings to BCUHB by preventing hospital admissions and reducing delayed discharges whilst also improving patient satisfaction.

Recommended next steps
Based on the findings of this study, the next steps are outlined below:

Immediate (Dec,20-March,21):

- submit Report to BCUHB for approval to proceed with one of the 2 build options presented
- continue to develop the new domiciliary care service, including:
    - commencing registration with CIW
    - ensuring staff are confident with 2 handed care, frailty tests and achieving health targets.

Short term:

- meet to discuss Preferred Option to take forward in partnership with BCUHB (scheduled for March 2021)
- review the business case in light of the above and impact of long covid on service needs
- seek capital funding required to take the scheme forward
- firm up planning, and procurement requirements
- agree project plan for the development with all partners
- continue to develop domiciliary care team with appointment of a new manager and extension of scope of services to support 2 handed care and overnight home care.

Longer term:

The Rainbow Centre will need to continue to develop its business and services to ensure it is ready to take on the additional responsibilities brought on by the scheme.

- develop transport scheme
- gain Investors in Volunteering kite mark
- complete CIW registration
- engage with and bring on board stakeholders and partners involved in the project
- business ready_ including staff resourcing and training, governance, and management processes, insurances.

Appendix 1: Visioning workshop

Step Up / Step Down facility

VISION

The Step up/Step down facility is a short-term, residential service that provides support and access to treatment in a 24 hour staffed, open home-like environment, that is enabling and supportive with a therapeutic and positive risk taking culture to encourage independence and self care.

Ethos…

Adopt the same model as that used within the Day Opportunities Service at Rainbow now

- Not risk adverse_ active management of risk to ensure people keep their independence
- Encourage clients to be active and manage their own health
- Goal setting care plans
- Open to the family and friends _ home from home_ not an institution
- Access to Rainbow Centre's services, incl. day opportunities, café and garden, to ensure contact with the Community is maintained – don't want people sat around unstimulated

Maintaining our positive Culture:

Open / Caring / supportive – of clients and each other / go the extra mile / Don't turn people away / listen to peoples needs / take positive risk / learn from mistakes together / aspire to be the best!

Appreciate our staff / invest in staff / reward staff / integrity and fairness

Support our staff, reflective with paid sick pay(beyond statutory), pension, living wage employer, fixed hour contracts / no zero hours, Employment Assistance Programme / Mental health first aider, quality support and supervision embedded

What makes it home like…

Welcoming to all!
Surroundings - decor
Garden
Own kitchen space / bathroom / living room space
Small family homes concept
Open to visitors always
Work with family to ensure clients keep doing tasks they will be required to do when they return home
Responsibility for chores that you are required to do when you return home

What makes it enabling and supportive…

Access to varying level of support dependant on need
Therapeutic element
Care plan which ensures direction of movement for patients is positive
Care package based on need
Above the care package_opportunity to socialize an engage with activity
Nutrition and hydration
Holistic assessment of needs and support

Resources required…
24/7 Staff trained in:

- care and
- therapeutic support
- motivational interviewing/coaching
- dementia
- can do attitude
- culture of taking safe risks for the benefit of patients

Associated 'Home Care' service

The step up / step down facility will be linked to our 'care at home' service which will enable clients to resettle into their surrounding after a period of stay away from their home. We will also explore home care support for our day opportunities client and the wider community

Appendix 2: The Rainbow Centres Vision, Mission and Strategic Approach

Our Vision is for older people to be recognised to their full potential, and to lead healthy fulfilling lives as engaged citizens, with rights of access to quality services both in their locality and according to their need.

Our Mission is to help older people to regain their sense of worth and discover their full potential, by supporting them in making changes to bring this potential into the world and ensuring their voice is heard.

All Our Work is guided by 4 Values:

- Respect
- Dignity
- Opportunity
- Empowerment

Our Strategic Approach to developing services and support consists of delivering:

1. **Foundation services**

– identify and make contact with lonely people, seek to gain a deeper understanding of the issues and help them to access existing resources

2. Direct interventions

– focus on enhancing and developing relationships, and building self-confidence (includes our day opportunities service and domiciliary care)

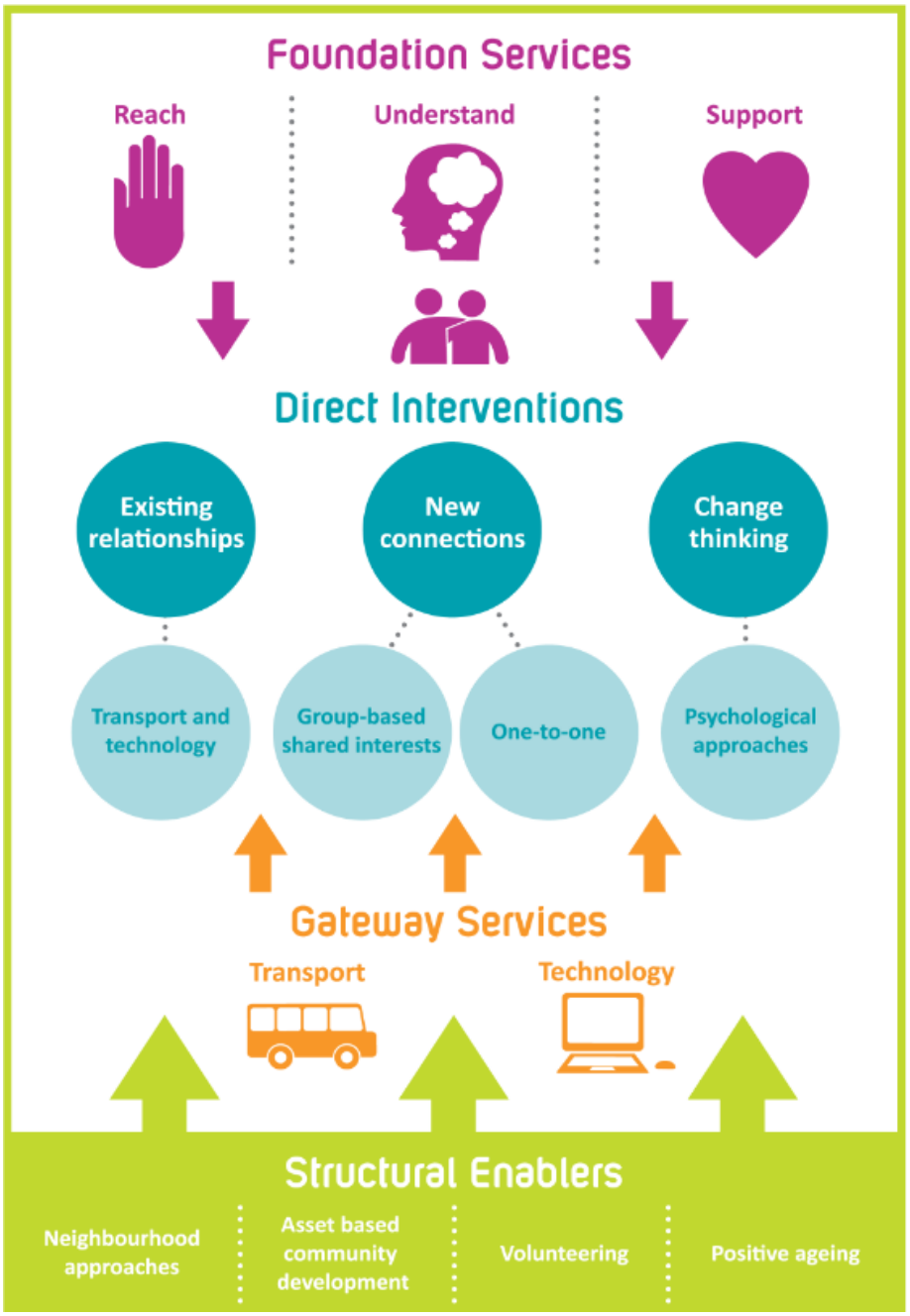
3. Gateway interventions

– transport and technology are key areas that can transform lonely people's lives

4. Structural enablers

– focus on neighbourhoods, take an asset based approach, encourage volunteering/peer support and advocate for positive ageing/tackling negative stereotypes.

The Rainbow Centres Strategic Approach,



*follows the approach developed by the Campaign to End Loneliness and Age UK

Appendix 3: the design brief

The Design Brief

The initial design brief has been informed by our own experience of delivering care in a home from home environment and 'Building better care homes guidance' Care Inspectorate.com

Small scale group living to replicate the supportive and homely environment.

The advantages of small-scale group living include:

• people living there are not overloaded with stimuli of noise, activity and too many other people

• the design can be domestic, homely and so, more familiar

• it may be easier for people to participate in domestic activities

• it is easier for staff to get to know individual people and understand what matters to them

• the small-group living model will enhance team development, knowledge and expertise that

produces high-quality care, particularly for people with dementia

• people often experience less stress in smaller units

• staff develop a greater sense of ownership and pride in their unit.

Layout

The building and its external areas such as garden and outbuildings will support the aims and objectives of the service. For example:

• small-group living, provided with their own en-suite bedrooms and a communal bathroom, lounge and dining facility just for their own group can promote a homely, domestic environment

• provision of communal spaces such as sitting rooms, activity rooms, multipurpose room, reminiscence room, café, quiet lounge areas

• provision of services like a hairdresser, library, café

• appropriate siting of support service areas such as domestic service rooms, dirty utility areas, medication storage, laundry, kitchen and accessible pantry areas for use by residents and visitors

• provision of suitable kitchen equipment, crockery, cutlery and utensils, and adequate facilities for the preparation and storage of food by people living in the service and visiting

• sufficient storage space should be an integral part of the design in bedrooms

• bedroom space should also take into account enough space for the potential need for hoists, wheelchairs or other equipment

• garden areas for everyone who uses or visits the service to enjoy

Design to promote physical activity and movement and support people to live well.

Interior Design

Must be homely.

Ensure that any design complies with other legislation, regulations or standards

such as building standards, food hygiene, health and safety, infection prevention and control and

waste. Some people will be living with complex needs or dementia but these needs should not be

considered in isolation

Bedroom, ensuite and kitchen pod

All designed to space standards, allowing for double handed care

With:

• enough space for care equipment such as walking aids, wheelchair, and commode

• space to have visitors in the room.

Throughout the building:

Clear signage though our the building – inside and outside with clear access routes to the garden, café and shared areas.

Fit out of rooms to the use of everyday crockery: following recommendations University of Stirling, dementia research - contrasting colours, encouraging nutrition, movement and independence.

Appendix 4

Financial and Operating Assumptions

We have not costed for the acquisison of land as we are hopeful that BCUHB will support us to extend our services in Penley on the existing site we share with the hospital.

Start up costs

We will need to include an element of design and build, plus additional funds for the refurbishment of any existing buildings, as well as a budget for the fit out and a level of start up fees for insurances and management and office systems.

Starting a respite care unit is not a lean start-up model. The main cost is obviously the premises. And for a care home to be profitable, best practice suggested that you will need to be able to provide for a minimum of 25 clients.

However, it should be noted that most care homes are privately owned and operate with a level of debt repayment which is decucted from annual income and accounts from around at approx 13% of overall expenditure. Also, if we are applying CIW staff to client ratios, going up in blocks of 12 / 24 would prove more optimum given that approx.

It is widely understood that 58% of costs are spent on staffing once the facility is open.

Initially, the main cost is for the premises. But fit out and equipment is also expensive.

A purpose-built home is the best choice. Data from a recent 'care village' build that we have been given, (including land, financing costs and professional fees) is at around £1,936/m2 . Build costs have been based on 24 small apartments with and without utilising the community hospital.

Our rural location is against us in terms of attracting staff as they won't want to travel too many miles to work, as it does not pay them to travel too far. With this in mind we will continue to ensure that we offer attractive rates of pay and care for our staff by offering effective support, management and access to training whilst they are with us, we will ensure we are a living wage employer.

Relatives of the people residing in the home might be elderly themselves so they may need to use accessible transport or they may only like to travel a short distance to visit, our model is about care closer to home and we acknowledge that our developing community transport scheme and network of volunteers may need to be utilised to ensure families can visit their loved ones whilst they are staying in Penley.

Fit out of the premises

For equipment, we obtained an estimate of the typical capital expenditure spend in a residential and nursing home, on a per resident basis. A large provider told us that equipment, fixtures and fittings for a new home costed in the range of £8,000 - £15,000 per bed. For both datasets, we then multiplied the number of residents by the estimated spend on equipment, by using the mid-point of this range.

Care home insurance

The care home sector has its own specific risks. We will need to ensure our exisitng policies are reviewed to ensure they provide adequate cover in the event of a crisis or calamity.

Our current insurance policies protect the Rainbow Centre against the following:

- **Public liability –** this will cover you in the event that a member of the public is injured whilst on your business premises. It is not a legal requirement but certainly a good idea. Current limit of Indemnity is £5m.
- **Employers liability –** this is legally required even if you only have one employee and will cover you in the event one of your employees is injured or becomes ill whilst working for you. You must have at least £5m worth of cover. Curent limit of Indemnity is £10m.
- **Building –** this will cover the cost of repairing damage or rebuilding your main building or any outbuildings.
- **Contents –** a care home insurance policy can protect the equipment and items belonging to your business from theft or damage. Residents' and employees' belongings can also be covered on this policy though very high value items may have to be insured separately
- **Business interruption –** this will cover you for any loss of income suffered if disaster prevents or changes the normal running of your business
- **Medical malpractice –**as your residents will rely on medication and other treatments, this will cover you if your staff do anything wrong such as administer the wrong dosage

Our existing policies include public liability cover of £5m and employers liability of £10m, this will need to be reviewed if we are to proceed with plans to develop the site and assocaited services.

Staffing levels

Most neglect in care homes comes from being understaffed so inline with our Day Opportunties Service we are assuming a higher staffing ratio than that set out by the CIW (1:6), this is to ensure we have enough staff to attend to the needs of every resident adequately and also to allow time for targeted interventions and theraputic support.

During 2019, it was announced that the National Institute for Health Research (NIHR) was funding a study into optimal staffing level for care home quality. Set to be published in 2020, the study will explore the relationship between the impact of the ratio of nurses to care staff and how this affects the quality of care in nursing homes.

A high turnover of staff isn't conducive to maintaining a consistent service for residents, who will also benefit from being looked after by familiar, friendly faces. The Rainbow Centre has excellent retention of staff, we will aim to retain this through the continued use of fair pay, strong management, our supportive environment and team culture.

Care home management software

There are a number of businesses that offer comprehensive care home management software to help you keep track of the provision of care, we have costed for a solution outside of the scope of this project - that will suit both our domiciality care service and the new step up step down facility - and will be purchasing this at the start of 2021 to support our new domicialiary care service.

Utilities and maintenance

Catering for older people means an increase in heating costs as older people feel the cold more due to decreased mobility and poorer circulation. This is certainly the case for our day opporunities service, and these operating cost has been used as a base for us to calculate likely costs of heating any new build.

Operating income and reaslistic forcasting

We have developed our charging model conservatively as the rates WCBC are currently paying for step up step down care a relatively low compared to other Councils, and range from £550 – 950 per week. In neighbouring Chester similar care can exceed £1300 per week. But we are mindful of financial pressures and do not want to price private clients away from their local community.

We have forcast our income based on 90% occupancy, which seems to be a conservative appraoch across the sector.

Financial sustainability

Across the UK, most care homes are privately owned and have an element of cost associated with rent and debt (approx. 13%), if we can attract capital grant funding as a charity and minimise costs associated with rent, we have a financially viable model and strong business case for extending our site in Penley.

Value added of supporting the Rainbow Centre as a charity is that this 13% can go back directly into maintaining outstanding services, and there is no expectation or drive for profits.

Stakeholders have commented on the relative stability of the industry in terms of the capacity, and our understanding is that the need for capacity is likely to grow or remain stable over time. Also, our financial analysis indicates that industry revenue and operating profit margins have been relatively stable, without significant volatility.

The difference between profit (private provider) vs surplus for a Rainbow Centre managed service

Some of the key differences in cost structure between charities versus private providers are that charities don't pay corporation tax. This means our costs may be lower versus a private company so potentially, we offer better value for money than a private operator.

We also don't have to make profits to pay to shareholders, so whatever profit is made can be reinvested in the enterprise. This means that they are services can be designed for sustainability as opposed to profit.

Appendix 5

Notes on indicative timetable

Minimum period for each stages:

Stage	Activity	Indicative start date	Period	completion
Feasibility report to Trustees and BCUHB	To be signed off before proceeding	Dec, 2020		March 2021
Staff consultation	With BCUHB staff (if hospital within scheme)	When funding is confirmed	30 days	
Initial design	Appoint architect and scope initial design – pre planning application	Tbc	12 weeks	
Statutory Community Consultation	Engagement and consultation	Tbc	12 weeks	
Planning consultation		Tbc	21 days	
Soft market testing		July	1 month	31st August
Agree final requirements/ prepare tender documents	Full planning approved at the end of this stage	July	3 months	September
Commence open Procurement Process (subject to funding)	Out to tender for a design and build contract Evaluate/select and appoint	Oct, 21	60 days	Mid November
Build lead in		Dec, 2022	1 month	
Construction period		Jan, 22	40 weeks	Oct 2022
Close Rainbow for	Utilising Marchwiel Village Hall to deliver services to clients	May,22	16 weeks	August,22
Handover facility		Tbc		
Financial close		Tbc		
Business ready	Marketing, pricing, staff	tbc		
Phased opening of new facility		Nov, 22		

Appendix 6

Who we consulted with:

Rob Smith	East Area Director, overseeing the healthcare needs of those living in Flintshire and Wrexham.
Amanda Lonsdale	Assistant Director of Community Services (East), BCUHB_currently on secondment
Karen Evans	Assistant Direcotr of Commuity Services (East), BCUHB
Jayne Sankey	Assistant Director of Nursing, East Area, Community, BCUHB
Dr Gareth Bowdler	East Area Medical Director, BCUHB GP, Overton Medical Practice
Dr Alison Hughes	Southern Cluster Lead, BCUHB GP, Llangollen Medical Practice
Helen Bainbridge	Head of Service Older People, WCBC
Roger Barnett	Strategic Procurement Lead, WCBC
Delyth Pridding	Commissioning Officer, Older People, WCBC
Rob Loudon	Commissioning Officer, Older People, WCBC
Nigel Adams	Funding Offcer, AVOW
Potential Funders	National Lottery, Steve Morgan Foundation, Garfield Weston Foundation
	Care Inspectoate Wales

Acknowledgements: we are extremely grateful to our clients, carers, and staff for giving their time to share their unique experiences through the questionnaires and interviews that were conducted.

The feasibility study was supported by a grant from Cadwyn Clwyd.