Item 6a

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**West Wales Care Partnership**

**Intermediate Care Programme 2016-17**

**Quarter 4 Report: West Wales**

**Overview**

The West Wales Intermediate Care Programme for 2016-17 comprises 3 components, or themes, which reflect shared principles underpinning our approach to Intermediate Care: **Prevention in the Community**; **Reablement at the Core**; and **Reducing Admissions, De-escalation and Accelerating Discharge**. This year they apply across frail older people, people with learning disability and children with complex needs. Additional funding this year has enabled us to roll forward existing successful projects alongside a number of new initiatives.

Workstreams focus mainly on implementing innovative service models, but also include the development of integrated, regional commissioning arrangements for a range of services.

Projects included in the programme have been developed in partnership between health, social care and the third sector and agreed by local integrated services boards before being endorsed by the Regional Partnership Board. Arrangements are in place at regional level for ongoing dissemination of learning and outcomes from local projects and encouraging wider adoption of proven approaches.

A robust governance structure is in place to support the programme. Detailed Project Initiation and Reporting Templates have been produced for all projects setting out key objectives, expected outcomes, financial profiles and key milestones. A Memorandum of Understanding has been signed by all partners and sets out expectations and accountabilities of the various stakeholders in delivering and monitoring the programme. The Regional Collaboration Unit within Carmarthenshire County Council and Hywel Dda University Health Board will share responsibility for financial and programme management and quarterly reporting on progress to the Regional Partnership Board and Welsh Government. Our governance arrangements are currently under review with a view to improving collaboration in the development of future bids.

Underpinned by the Welsh Government’s commitment to a revenue allocation for the remainder of the current term of office, confirmation of the capital grant for three years and consistency in the ICF themes, learning from 16/17 implementation and evaluation has had considerable influence on the refinement of processes for delivery and monitoring of the 17/18 programme.

**Delivery in Quarter 4**

**Outcomes from the Programme**

As expected, delivery of measurable outcomes accelerated during quarter 4, as a result of successful recruitment into vacant posts and increasing capacity as processes were tested and refined.

Programmes such as Transfer of Care Advice and Liaison Services (TOCALS) in Carmarthenshire; Accessing Alternatives to Admission (AAA) in Ceredigion and Multi Agency Advice Team (MAST) in Pembrokeshire are demonstrating significant progress in referring to affective community provision at the front door of acute services, thereby reducing the numbers admitted. Along with others identified during the quarterly reporting process, these programmes demonstrate similar outcomes in all three counties in the region, offering the opportunity to develop a more regional approach to the pooling of budgets and project management during 17/18.

The Frailty Support service currently offered in Carmarthenshire is demonstrating significant improvement in nutritional outcomes and as such, has influenced a more regional approach being considered for the 17/18 programme, along with a regional approach to podiatry services being developed as a result of successes in local delivery.

Third sector engagement in the programme is also delivering positive outcomes. Case studies from projects such as Community Connectors in Pembrokeshire, Community Resilience Co-ordinators in Carmarthenshire and 3rd Sector Integration Facilitators in Ceredigion demonstrate the extent to which they are impacting on acute services and are appreciated by those who have benefitted from their activities. Following on from some initial pilot projects agreed for 17/18, a regional approach to co-producing services will be included in quarterly project meetings also.

As each quarter’s returns were monitored and evaluated, it has become increasingly apparent that a number of similar projects in each of the counties have the potential to be managed regionally, albeit retaining delivery in-line with local need. A small number of regional projects will be piloted during 17/18, with a process to co-produce a number of others being developed over the course of the next year.

**‘Post-election’ funding**

Our programme has been expanded following confirmation by Welsh Government of the ‘post-election’ revenue allocation which has brought an additional £1.5 million to the region.

A significant number of the post-election projects found it difficult to demonstrate measurable outcomes in the short timescales available for development and implementation, particularly those requiring recruitment of new staff. However, in the majority of cases, it is expected that developments undertaken during quarters 3 and 4 will begin to deliver outcomes from quarter 1 of 17/18.

A proportion of the new funding supported delivery of strategic priorities identified by the Regional Partnership Board, namely:

* **Strategic commissioning** (focusing on older people’s services). Funding has supported the development of a shared service model, streamlining commissioning arrangements and redesigning existing pathways through the system.
* **Information, Advice and Assistance and prevention**. Significant developments in the way effective signposting services across the region have been achieved as a result of ICF. In Carmarthenshire the service has been relocated and expanded, Porth Gofal has been developed in Ceredigion and in Pembrokeshire, the Corporate Contact Centre has been remodelled to include IAA. In many cases, local IAA services are delivered in partnership with local third sector organisations, who are also developing opportunities to grow community-led wellbeing services to help keep people out of long-term care.
* **Remodelling Mental Health and Learning Disability Services**. Although the implementation of new, community-based models of service that promote independence and provide care closer to home has been slower than anticipated in some counties, learning from pilot projects delivered during 16/17 will influence implementation of the 17/18 programme.

The Board also identified the **implementation of WCCIS** as a strategic priority and used the final element of ICF funding to support a regional delivery programme, building on the implementation process already underway in Ceredigion. A programme lead is now in place and significant outcomes have been achieved in the short time they have been in post.

The remainder of the new funding has supported further service enhancements at a local level, under our agreed programme themes.

Section 1: Frail and Older People

Total region allocation

£4,064,920 (Net, after deductions for regional programme coordination and Carmarthenshire area coordination)

| **2016-17 funding allocation – ICF Guidance refers** | **Identified services to support delivery of ICF objectives – ICF Guidance paragraph 2.2 refers** | **End of year projected Outcome(s) for each service (col 2)** | **Actual Outcome(s) to date** |  | **Expenditure to date** | **Additional Information** |
| --- | --- | --- | --- | --- | --- | --- |
| £100,000 | Third sector led community prevention model (Carmarthenshire) | * Reduced demand for urgent hospital care * Reduced number of readmissions * Increased social impact * Better self-management * Reduction of social isolation and loneliness * Effective engagement of vulnerable groups | Q4:   * All recruitment complete * CUSP model agreed by identified partners * Specific dementia preventative model established and put into place. * Outcome measures agreed and measurement tool implemented. * Professional launch 05/2017 | Q4 | £110,000.00 | Project was £10,000 over spent due to the agreement to pay British red cross to develop an outcome measurement tool. Overspend agreed by Project Board & minutes to support decision available. |
| £56,919 | Vascular and diabetic foot pathway (Carmarthenshire) | * Improving health and wellbeing and reducing preventable heart attacks, strokes and leg amputations. * Reducing demand on health and social care * Improving quality of life for patients | Q4: All staff recruitment achieved. We have employed 3 x band 6 and 1x band 7in post. Staff training underway.  Two day training and pathway conference organised bringing together Podiatrists, Vascular Surgeons , nursing staff from HB and ABMU HB to develop the  Above. Protocols being developed and evidence based practice rolled out. Specific diagnostic clinics set up and prevention programme in development. Project on target and, ongoing and recurring. | Q4 | £27,844.19 | Project was £29,075 under spend as at end of year due to recruitment issued. This underspend was re-allocated within the revenue programme. |
| £100,391 | Community Resilience Coordinators  (Carmarthenshire) | * Improved wellbeing of people in Carmarthenshire in need of care and support, through: * Enhanced understanding of local community assets and resources, identification of gaps and development of third sector and community provision * Greater community resilience with enhanced preventative services providing early intervention | Q4:   * Carmarthenshire is Kind event delivered with 350 participants to deliver an asset based approach to resilience – report and film attached. | Q4 | £64,166.16 | Project was £36,225 under spend – this is due to the inability to recruit the third post despite two attempts at advertising. The post is currently going through the Trac process and it is hoped the third post will be in place by early part of 2017/18. |
| £20,132 | Health and Social Care Worker project  (Carmarthenshire) | * Numbers of staff receiving training * Reduction in demand on the district nursing service/ number of patients being supported through a generic worker | Q4:  Non Complex Wound Care Update:  Llys Y Bryn to date:   * 8 staff have completed training * 5 Staff working towards and awaiting District Nurse Assessment   Awel Tywi   * 8 Staff trained * 7 completed (workbooks sent for IV) * 1 working towards (has been on long term sick)   I have asked Sharon to send a case study by Weds this week  Y Plas   * 7 Staff trained and awaiting District Nurse assessment, dates TBC   **Home Enteral Tube Feeding via Gastrostomy:**  See attached PID for Gold and Silver training package. Completed phase 1 of the project which was to train staff I quality assured, competency based training around HETF which was delivered to staff working within the Learning Disability team at Tir Einon respite centre. To date, 4 staff have already completed their units and are awaiting their certificates from Agored Cymru. Of the additional 9 learners, the majority are near completion and two candidates will be asked to attend Tir Einon as they no longer have a client with a feeding tube and will need to be observed in practice where there are regular clients with feeding tubes. The external verification visit went very well and any changes suggested by the EV will be embedded on the next course, for example the workbook layout needs to be extended to allow room for candidates to write full answers and one of the questions needs to be reviewed to provide some clarity to the learners.  Next stage which will take place during 2017/18 will be to continue to phase 2 of the project which is to consider a model of delivery that would enable this work to be rolled out to other care settings across HDDA UHB in a cost effective, prudent and sustainable way – this is to develop a Gold and Silver level package of training as outlined in the attached PID document. | Q4 | £12,991.51 | Project is £7,141 under spent due to the slow progress of the roll out of the Non Complex Wound care workstream. This was due to the inability to access the Agored Cymru assessor training in a timely manner. Project is back on track now and progressing well. |
| £13,147 | Out of hours social standby cover for older people and adults with physical disabilities  (Carmarthenshire) | * Enhanced out of hours service for older people and adults with physical disabilities * Reduced night admissions to hospital * Appropriate training delivered to all out of hours social work staff | Q2: Project terminated due to recruiting difficulties. | Q2 | £0 | Process underway to re-allocate spend and has considered the following:   * £5,000 to purchase additional Dietetics support for the Frailty Support Workers (this will be offset by current slippage in the project due to delays in recruitment) * £8,147 for TOCALS for uplift of the current 0.8 fte Band 6 DLN to full time (offset by current slippage in the project due to delays in recruitment) * £250,000 – Continuing Care Team & Convalescence Beds (Through remaining slippage in the TOCALS Team and Community Proactive Care Team to support winter pressures) |
| £18,550 | Healthy Activity Coordinator for older adults  (Carmarthenshire) | * Increased number of NERS (National Exercise Referral Scheme) referrals | Q3: Coordinator appointed to post in November 2016, networking, planning and gathering knowledge on building a sustainable service for Frailer Older Adults in Carmarthenshire. | Q3 | £0 |  |
|  |  |  | Q4: No expenditure in 16/17 due to the late appointment of the post holder and the HB core grant that supplements ICF funding covering all salary costs.  Postholder is now in place and full outcomes will be reported in 17/18. | Q4: | £0 |  |
| £56,920 | Additional OT reablement capacity  (Carmarthenshire) | * People receiving service are functionally more independent and less dependent on statutory services | Q4: All 3 OT’s are now in post and have started attending weekly pathway meetings and taking on Reablement referrals. Outcomes will be reported in Q1 17/18. | Q4 | £0 |  |
| £40,000 | Cartref Cynnes Assessment Beds  (Carmarthenshire) | * Number of people supported within Cartref Cynnes * Number of avoided hospital admission | Q3: Due to licensing issues between the Health Board and Family Housing Association who run Cartref Cynnes, we have been unable to place any individuals within the facility during Q1&Q2. These issues have now been resolved and we anticipate being able to place individuals from mid-October. | Q3 | £0 |  |
|  |  |  | Q4: Due to ongoing licensing issues between the Health Board and Family Housing Association who run and manage the landlord function at Cartref Cynnes, placements have been unable to take place. Spend for 2016/17 has only been in relation to rental costs of the 2 apartments. | Q4: | £20,009.00 | £19,991 underspend due to the inability to place individuals within the assessment units as explained within the update.  The contract issues are almost resolved and we are expecting to place individuals within the units during Q1 17/18 |
| £238,690 | Community Care Proactive Care Review Team  (Carmarthenshire) | * Reviews conducted according to statutory requirements and individual need * Reduced number of reviews outstanding * Reduced commissioned care hours * Reduced requirement for CHC funded care * Reduced number of residential placement * Reduced length of stay in residential reablement (median) | Q4:   * Length of stay in residential reablement is currently 6 weeks. * Whilst the numbers of reviews outstanding remain high, there has been a steady decrease in those outstanding. 406 reviews outstanding in Q4, compared with 601 in Q3 and 644 in Q2 demonstrating the Proactive Care Team is having a positive impact. * The number of service users requiring domiciliary care is falling. 981 service users in March 2017 compared with 1142 service users 2 years ago. The number of commissioned hours of care is also steadily reducing, 1368 hours less per week which equates to a 11% reduction. | Q4 | £147,988.58 | Full Physio complement in place from Q3. Full OT complement in place from Q4. Nursing have recruited and the post holders commenced I post at the end of March 17. Social Work have had some difficulty recruiting for this team. 2 Social workers were recruited and commenced in post during March, however, one went on long term sick not long after appointment. Recruitment is being undertaken for the third vacancy at the moment.  Project under spent by £90,701 – this is largely due to delays in recruitment. Particularly within OT, Nursing and Social Work. Recruitment has almost been completed and we are almost at full complement of staff. Outcomes will continue to be reported, including those missing, during 2017/18. |
| £500,000 | Rapid Response Domiciliary Care Service  (Carmarthenshire) | * Number of people receiving an intervention from the RR service * Number of avoided hospital admissions by RR * Number of safe hospital discharges achieved by RR * Numbers of people responded to by RR due to Telecare Alarm alerts (To be discussed following outcome of Reablement Review) | Q4:   * 204 people receiving an intervention from the RR service * 94 escalations of care, including hospitals admissions avoided * 3 people supported early hospital discharges * 83 responses from the Telecare alarms | Q4 | £500,000.07 | Project achieved full spend – original figure is incorrect. Original allocation was £500,000, not £527,000. |
| £636,305 | Transfer of Care Advice and Liaison Service  (TOCALS)  (Carmarthenshire) | * Reduction in the number of admissions and re-admissions into acute care * Decreased length of stay on admission | Q4:  Number of TOCALS assessments completed:  PPH –237  Number of patients discharged within 24 hours:  PPH – 46  GGH -  Number of patients discharged at the ‘front door’ :  PPH - 68  GGH | Q4 | £574,567.24 | PPH – Locum PT recruited for March, Full time PT recruited and due to commence in post May. Second DLN commenced in January. |
| £77,760 | Increased OT and physiotherapy capacity (Carmarthenshire) | * Reduced length of stay on medical wards * Integrated assessment completed within 72 hours of ‘medically fit’ judgement * Increased satisfaction of users and carers | Q4: *Update to follow* | Q4: | £207,127.71 |  |
| £141,140 | Frailty Support Workers (Progressive Care)  (Carmarthenshire) | * Reduced Length of Stay * Decreased requirement for commissioned care * Number of patients transferred to rehabilitation * Patient body weight during admission * Additional calories provided * Additional protein provided * Patient and relative feedback | Q4: WARD 1: Overall LOS for the year has reduced on the ward by 0.5 days equating to a saving of £90,000. This data is for the whole ward, and therefore the reduction is despite the ward (of 24) only having an average of 10 patients on the frailty programme at any one time.  Improved communication with local care homes with reduced need of managers to re-review patients may equate to a saving of approximately £45,000 if all care homes are included (currently LA care facilities and Hafan y Coed).  Nutritional data to follow from dietetics team.  Median frailty scores improved by 1 point from admission to discharge.  WARD 3: LOS data unavailable at present as too early but nutritional data to follow.  Patient feedback particularly strong with patients referencing the nutritional rounds and visible improvements in both weight and mobility.  Several thank-you letters and one thank-you letter in local press. | Q4 | £138,715.71 |  |
| £200,000 | Continuing Care Team (CCT) (Carmarthenshire) | This additional resource will support our existing teams to focus on 1:1 support for patient with complex long term healthcare needs | Q4: Through strengthening the current in house continuing Care team this has allowed for role redesign e.g. development of generic workers, efficient transfers of care for acute to the community to support the patients and their carers within the locality.  This has facilitated early discharge and avoided longer tem placements resulting in increasing the patients choice, respecting individuals wishes to die in their own home. This funding has decreed additional care hours to support the delivery of the above. Case study is available to demonstrate the impact of this service. | Q4: | £200,000.00 | Slippage scheme. |
| £5,000 | Carer Demonstrator Project Evaluation (Carmarthenshire) | Effective evaluation of the existing ICF investment made to the Carer Demonstrator Project – this project was originally funded through ICF 2 | Q4:   * 19 referrals received during the life of the project, of these 19, 11 individuals reported positive outcomes * Evaluation conducted and report attached which suggests the level of referrals is so low as to call into question the need for the project and suggests if another pilot was to be set up, the project would need to be re-engineered to be successful | Q4 | £4,500.00 | Slippage scheme |
| £19,500 | Care to Move (Domiciliary Care) (Carmarthenshire) | * Training delivered to staff group * Increase the number of people completing short term reablement interventions. * -Increase the numbers of people leaving reablement without ongoing services. * -Reduce the length of time spent within a reablement service. * -Reduce level of support needed following reablement intervention. | Q4:   * 66 Domiciliary Staff have undergone the Care to Move Key Trainer Training delivered by Later Life training. * 2 Key Supervisors are leading on supporting the Senior Support Workers with cascading the programme to all Domiciliary Staff focussing initially on Reablement, Rapid Response and Extra Care. * 126  Domiciliary Support Workers  will be trained in the coming 9 months. * This training  will continue for the duration of 2017/18 with measures to evaluate following staff attendance – back in the workplace.   Tested outcomes following training to include:   * Reduced level of support needed following Short term services / Reablement working to the Care to Move principles * Reducing the length of time spent within the Reablement Service.   Longer term outcomes for Reablement:   * Increase the numbers of people leaving reablement without the need of Ongoing Services * Increase the number of people completing short term Reablement interventions. | Q4 | £8,036.35 | Slippage project |
| £25,000 | Information , Advice & assistance (IAA) (Carmarthenshire | To provide additional support to allow existing Careline staff overtime hours to train in IAA | Q4:   * A total of 34 staff have been trained within the IAA service on the requirements of the act and other basic aspects * 24 staff have received detailed training on how to undertake a proportional assessment and handle IAA calls. * Each IAA member of staff has received the equivalent of 112hrs of training to deliver the new service * In excess of 3000 proportional assessments have been undertaken by the team since mid-November. * The team now handle all adult social care enquiries and will shortly move to phase 2 in order to integrate another division 4: | Q4 | £27,349.84 | Slippage scheme |
| £131,555 | Caring Communities Innovation Fund (Ceredigion) | * Establishment of a Third Sector Targeted Intervention Service Framework which will allow the statutory providers to determine patient / client needs and ‘spot purchase’ services to meet those needs. * Third Sector Providers have sustainable practices which meet the needs of changing and evolving needs of patients / clients in Ceredigion. | Q4: Call for project ideas and Panel convened to assess applications. Initiatives supported include evening support provision for service users, rural transport provision and trusted assessor training.  3rd Sector Core Community Resource Team indicators;   * Number of clients - 107 * Number of interventions initiated - 471 * Time spent to date - 50.2 hours   Links created with AA2A as key referral route.  Joint working processes established between team partners. | Q4 | £131,555.00 |  |
| £42,732 | Third Sector Integration Facilitators  (Ceredigion) | * Promote awareness of the 3rd sector provision available in the County; * Identify gaps in provision; * Inform commissioning; * Support groups in relation to the Social Care and Wellbeing Act and subsequent impact on commissioning services. | Q4: Work from previous quarters continues.  Number of contacts: 742 | Q4 | £42,732.00 |  |
| £339,671 | Accessing Alternatives to Admission (AAA)  (Ceredigion) | * Reduction in admission for patients into an acute bed * Care plans which support the patient across acute and community services * Reduction in re-admissions * Reduced lengths of stay. * Positive experience for patients, carers and staff involved | Q4: Number of complex discharges supported:   * Ceredigion = 81 * Powys = 38 * Gwynedd =27   Totalling 146  Number of patients who were not discharged on the date they were medically fit:   * Ceredigion = 54 * Powys = 30 * Gwynedd =21 * Totalling 105   Number of patients who were not discharged within two days of the date they were medically fit:   * Ceredigion = 41 * Powys = 20 * Gwynedd =13 * Totalling 74   Number of patients who were not discharged within five days of the date they were medically fit:   * Ceredigion = 34 * Powys = 11 * Gwynedd =11 * Totalling 56 | Q4 | £346,870.40 |  |
| £38,042 | Community Falls Clinics  (Ceredigion) | * Reducing the numbers of residences who are admitted with a fractured neck of femur * Residents in Ceredigion aging well without a fear of falling. | Q4: Q4: Service Specification for Safe & Steady (Falls) Clinics finalised and approved  Venues organised  Clinic launched  Clinic in Aberystwyth running alongside Bone Health screening with DEXA scanning service  Exploring options for reciprocal arrangement with Aberystwyth University to host clinic  Falls risk screening tool has commenced roll out to facilitate appropriate referral to clinic  Multi-factorial Falls Risk Assessment tool finalised  Contribution to Falls Prevention education of Care Home staff in South Ceredigion on-going  Physiotherapy brief intervention falls “care bundles” developed for use within Physiotherapy service as adjunct to SAS clinic  Referrals received to end March North = 2  Referrals received South = 1  Patients seen and managed within clinic = 1 | Q4 | £38,042.00 |  |
| £241,430 | Interim Placement Scheme  (Ceredigion) | * Improved patient flow for Ceredigion residents who have been admitted into acute hospital. * Admission avoidance for Ceredigion residents who use the scheme and remain closer to home. * Appropriate timely assessment reducing the admission to nursing / residential care on discharge from hospital / the scheme. | Q4: Number of new admissions: 14   * Hospital avoidance: 9 * Timely discharge: 5   Number discharged: 15   * Nursing care: 6 * DGH: 3 * RIP: 2   Home: 4 | Q4 | £264,250.72 |  |
| £139,260 | Review of high cost packages (Pembrokeshire) | * People are supported with maximum care that meets their individual needs and maximises independence | Q4: Employment of a full time project OT enables a dedicated project assessment and review process and drives cultural change to support project progress  Cultural change is being supported at every level. Well-established and attended Project Enablers Group meets every month to support system redesign.  14 clients have had care packages reduced to single handed care as a direct result of the RTTC programme of work, including 8 reductions and 6 avoidances. Please see attached case study for an example of outcomes of the impact on clients. 83 clients have been identified in total. These are a mixture of referrals and clients identified through other OTs who have been able to support single handed care in these cases as well as cases taken on board by RTTC OT. This is supporting the efficient use of staff time and of care providers’ time, supporting clients’ progression, and supporting the overall project goal of releasing care hours.  A training programme has been developed and delivered for assessment staff and providers:  - Eight two day training courses were developed and delivered for professionals and providers of care. Initial feedback from training indicates high initial levels of confidence andsignificant gains in staff confidence levels. The last element is of particular interest, as although the overall confidence levels with single handed care techniques are lower than confidence levels with moving and handling / associated equipment, it is the area with the most significant gains, indicating that the training has achieved its intended outcome:   |  |  |  |  | | --- | --- | --- | --- | | Average confidence levels (out of 10): | Before course | After course | % change | | With moving and handling skills | 7 | 8.4 | 20.0% | | With equipment to support moving & handling | 6.8 | 8.2 | 20.6% | | With single handed care techniques | 6 | 7.9 | 31.7% |   - Further training on specific items of equipment has been provided with high uptake levels  - Training packs have been developed to enable care agencies to cascade training internally  Providers are engaging with the project. A questionnaire was carried out with the pilot care provider for the Releasing Time to Care project. See attached analysis for detailed information.  New documentation has been developed to support the project, including a shared Moving & Handling risk assessment  Equipment to support single handed care provision for individual use and for training purposes has been purchased. | Q4 | £40,420.80 |  |
| £234,836 | PIVOT, Care and Repair and Community Support Workers  (Pembrokeshire) | * Inappropriate admissions avoided * Timely and effective discharges * Improved opportunities for independent living in the community * Improved quality of life for service recipients * Improved integrated working with the 3rd sector * Reduction in social isolation for individuals | Q4: 1300 bed days saved  130 admissions avoided  100% of recipients said that the service has made things better  196 individuals supported by Community Connectors to meet identified wellbeing goals | Q4 | £240,520.00 |  |
| £30,000 | Community innovation and resilience grants  (Pembrokeshire) | * Increased community capacity to support independent living | Q4: Q4: A total of 6 grants panels have been held, and a total of 22 grants have been awarded.  14 grants were awarded to projects and organisations working with older people, to a total of £24,640  6 grants were awarded to projects and groups working with people with Learning disabilities, to a total of £16,166  Q4: The increased assessment capacity has facilitated a more person centred approach, which has delivered better value for money. For further updates on this programme please see the Learning Disabilities project further below. | Q4 | £27,040.00 | Projects awarded with funding will report their outcomes by the end of April 2017 whereupon a full report on the outcomes and achievements of the CCIG will be made available. |
| £87,300 | Increased targeted Assessment capacity (Pembrokeshire) |  | Q4 The increased assessment capacity has facilitated a more person centred approach, which has delivered better value for money. For further updates on this programme please see the Learning Disabilities project further below. | Q4 | £87,917.71 | This funding has contributed to this programme of work and for further updates on this programme please see the Learning Disabilities project further below. |
| £189,315 | Additional step up/ step down beds Hillside and Bro Preseli  (Pembrokeshire) | * People regain their independence closer to home in a supportive environment that helps build their confidence. * People are supported to improve or learn new skills to support their independence with the support of trained professionals * Integrated service provision utilising shared resources | Q4: Number accessing beds from hospital 13  Number accessing beds from home 1  Those leaving this service with not long term care 2  Those leaving this service with reduced care 0  Those transferring from this service to reablement at home 3 | Q4 | £154,174.70 |  |
| £174,598 | Extension of reablement contract  (Pembrokeshire) | * Minimisation of DTOC for patients requiring reablement support in the community * Saved bed days through timely discharges * Positive impact on quality of life of those who have received the service | Q4: 66% of people receiving reablement in this quarter have no need for ongoing domiciliary care  14% of people receiving reablement in this quarter have reduced need for ongoing domiciliary care  Set target of 66% average for percentage of people who have no need for ongoing care.  DTOC figures  National Measure: Rate of delayed transfers of care per 1,000 population aged 75+ [StatsWales is source] Wales 15/16 average is 4.90 and Wales 15/16 top quartile is 2.4.  Q1 = 0.52 [7]  Q2 = 1.55 [21]  Q3 = 2.07 [28]  Q4 = 2.96 [40] | Q4 | £275,264.06  THIS INCLUDED POST ELECTION ALLOCATION | The average length of a reablement intervention has decreased from 6 weeks in 15/16 to 4 weeks in 16/17. The average for March 2017 is 3 weeks which suggests further improvement in theAmmanford16 management of flow through the service. This should be viewed in conjunction with the positive outcomes with 66% of service users leaving with no long term domiciliary care at the end of 16/17.  We report on reablement on a monthly basis to our health colleagues by way of a reablement dashboard |
| £30,553 | Push/ pull post for reablement/ hospital interface  (Pembrokeshire) | * Individuals enabled to regain/ maintain optimum independence * Control, choice and dignity in care * LA care resources used effectively * Reduction in care provision for individuals * Efficient use of staff knowledge, skills and capacity * Reduced risks with moving and handling * HB resources shifted towards community from acute provision * Released resources and capacity | Q4: Review workers are in place, also supplemented by PCC funded worker  66 people receiving service during last day of period  4 weeks is average length of reablement intervention  66% of people complete the service with no ongoing care needs.  Review workers continue to support flow through the service and timely discharge to domiciliary care providers when needed which maximises availability of the service, which in turn supports the delayed transfer of care / patient flow agenda from hospitals. | Q4 | £30,247.46 | The average length of a reablement intervention has decreased from 6 weeks in 15/16 to 4 weeks in 16/17. The average for March 2017 is 3 weeks which suggests further improvement in the management of flow through the service. This should be viewed in conjunction with the positive outcomes with 66% of service users leaving with no long term domiciliary care at the end of 16/17. |
| £254,000 | Multi Agency Support Team (MAST)  (Pembrokeshire) | * Reduction in hospital admissions * Improved personal and functional outcomes for people using the service | Q4: 240 assessments undertaken by MAST  59 assessments undertaken at weekends or bank holidays.  61 % (142) of those assessed not admitted to acute care.  58 people received rapid response assistance at home  58 urgent community OT referrals received and 100% responded to within 2 working days  30 Rapid Responds community physiotherapy referrals received and (76.7)% responded to within 2 working days  Bed days saved estimated to have resulted in £ 362,100 cost avoidance. | Q4 | £271,091.60 | “Thank you for coming so quickly, we have been reassured by your assessment and advice, dad was much happier once back home” |
|  | Social Enterprise  (Pembrokeshire) |  | Q4: | Q4 | £16,092.00 | Regional slippage |
| £205,024 | Care at Home Team  (Pembrokeshire) | * Development of the In house Team * Match capacity with demand of End of Life and complex packages * Contain commissioning budget within resource, with 1% savings identified in Quarter 4. | Q4: The Care at Home Team have provided End of Life Care to 33 patients in Quarter 4. All patients are referred through a single point of access. The patients are assessed from category 3 to 1 to prioritise the urgency of need.  Category 3:  Patient entering a terminal phase  Category 2:  Less than 7 days life expectancy  Category 1:  Less than 48-72 hours life expectancy.  To date referrals have been received from community District Nursing Teams and Acute wards in Glangwili General Hospital and Withybush General Hospital.  Duration of care provision has varied from 1 day to 44 days.  The service is provided between the hours of 08.00-22.00, 7 days a week 365 days a year.  The team comprises of 10 WTE Health Care Support workers and the Team Leader who is a Nursing Sister.  The Team currently work as two HCSW on each 12 hour shift which has improved continuity of care and cost efficiency.  To ensure the success of the service it essential that we work collaboratively with District Nursing Teams, Social Services, Paul Sartori Foundation, Acute Response Team, Palliative Care Specialist Nurses, Advanced Chronic Conditions Nurse Practitioners, Long Term Care Team, Continuing Health Care Specialist Nurses, Marie Curie, Out of Hours Service, Day time GP service, , Allied Health Professionals, and Community Connectors.  Patient information leaflet attached and two case studies. | Q4 | £205,024.00 |  |
|  |  |  | **Total:** |  | **£4,214,538.81** |  |

**Section 2:** **Learning Disability and Complex Needs**

**Total region allocation**

**£487,558 (Net, after deductions for regional programme coordination)**

| 2016-17 funding allocation | | Identified services to support delivery of ICF objectives | | End of year projected Outcome(s) for each service (col 2) | | To date – actual Outcome(s) | |  | Expenditure to date | **Additional Information** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| £107,466 | | Behavioural Intervention Service  (Whole region) | | * Reduction in expenditure on commissioned services * Increased no. of children receiving appropriate behavioural support * Improved family experience of accessing support * Reduced waiting times for specialist behavioural intervention | | Q3: Service is currently being scoped. The Clinical Psychologist has been appointed. | | Q3 | £0 |  |
|  | |  | |  | | Q4: Successful recruitment to Senior Clinical Psychologist post, start date 10.4.17.  Next stage of recruitment for additional posts underway following consultation with other Children’s Services. | | Q4: | | £7005.88 | **Expenditure includes cost of staff providing skeletal interim service for children with Learning Disabilities (LD) and Challenging Behaviour from Adult LD Service; Head of Service time for recruitment process; additional resources/test materials for assessment of children.** |
| £33,458 | | Sensory Integration Pathway Project (Carmarthenshire) | | * Increase engagement and co-production, * Allow individuals to make choices and express themselves * Promote individuals understanding of the world and allow them to communicate in a way which we do not find challenging * Promote fair and equal access to services and the community by reducing barriers, * Allow individuals to develop skills and abilities * Build individuals confidence * Provide the right environment within the person’s community of origin decreasing the need for out of county specialist placements. * Promote the longevity of family living decreasing the need for residential placements and subsequent hospital admissions. * Ensure local community provision is robust enough to support a community based step down package by providing skilled and confident staff with the right resources in the right place. * Ensure the least restrictive option of support is available, focused on individual’s strengths | | Q3: Delays in recruitment have meant the project has not commenced delivery. | | Q3 | £0 |  |
|  | |  | |  | | Q4: Recruitment has commenced for the OT position to lead this project. The Advert will be going out week commencing 24th April and the post holder will commence delivery as soon as possible. The outcomes stated will continue and feature in a new Proposal document for 17/18. The project is expected to make steady progress in 17/18 from Q2. | | Q4: | | £0 |  |
| £38,902 | | Regional Planning and Commissioning for children and young people with complex needs  (Carmarthenshire) | | * Prevent the reliance upon out of county specialist provision; reduce the costs to LAs/HB’s * Children and young people with complex needs remain within their local communities * Children and young people with complex needs access a wide range of services that support them to live as independently as possible * Local provision meets the needs of young people * A robust planning and commissioning process is established to oversee current and future demand and provision | | Q4: IPC were commissioned to undertake a feasibility study of the most effective and efficient way of developing a regional panel for children with complex needs. This report has been completed in draft form and recommends that a regional commissioning framework for children with complex needs is developed across the Health Board footprint to encourage consistency of practice and reduce inequity of service. | | Q4: | £19,989.00 |  |
| £101,297 | | Assessment and Respite Service for Adults with LD and Complex Health and Social Care Needs  (Carmarthenshire) | | * Reduction in high cost residential placements out of County * Number of individuals with complex needs accessing the service * Reduction in delayed transfers of care * Qualitative data on improved outcomes for individuals and carers | | Q4:   * Project was unable to progress due to interdependent capital scheme that was unable to progress. * Funding was re-allocated to support high cost out of county placements that were made across H&SC. | | Q4 | £0 |  |
| 241,662.00 | | Challenging Behaviour Placement Costs  (Carmarthenshire) | |  | | Q4:   * Supported 7 individuals who were required to be placed in a residential placement due to challenging behaviour. | | Q4 | | £241,662.00 | **Slippage scheme.**  **Case Study:**   * A lady in her early forties who has had a history of placement breakdown, resulting on more than one occasion in her needing to be readmitted to hospital. The additional support has enabled her to maintain her present placement avoiding the requirement for an emergency readmission whilst intensive behavioural work is in progress. |
| £75,567 | | Therapeutic Service for LD and Complex Needs  (Ceredigion) | | * Sustainable model for delivering therapeutic services for clients who have LD which operates across Ceredigion building self and community resilience | | Q4: Call for project ideas and Panel convened to assess applications. Initiatives supported include evening support provision for service users, rural transport provision and trusted assessor training. | | Q4 | | £75,567.00 |  |
| £130,869 | | Learning Disability Service remodelling  (Pembrokeshire) | | * People with learning disability are able to live more independent lives * People with learning disability have greater choice and control in how their needs are met * People with learning disability have a greater voice and say in services | | Q4: LD Website and Assistive Technology - ‘Accessible Pembrokeshire’ - Four people with LD have been creating and uploading pages for the LD website. Three have been paid and 1 young person is still in school. The site will be launched at the “Big Access Talk” on 18th May 2017. IT resources purchased to enable people with LD to access website – includes physical resources and software solutions.  The Accommodation and Efficiency project - specialised in assessing over 40 complex clients during 2016/17. By doing so, the project achieved the following outcomes:  Client assessments were brought up to date. Packages of care in supported living and residential placements within the Learning Disabilities Team were ‘right sized’ to ensure that they are sustainable and meet customers’ needs.  Packages of care were reviewed to ensure that they:   1. promote independence with clear outcomes, and are focussed on an asset-based progression model; 2. are centred around, and co-produced with, the individual, and 3. are in accordance with the principles of the Social Services and Well-being Act (Wales) 2014   Commissioned services being delivered were scrutinised to ensure that they are of good quality, are being delivered efficiently and are offering value for money.  The project supported the development of a consistent, systematic and clear approach to reviewing care plans, fees and contracts, both internally and for partners and providers.  Alternative Models, 3rd Sector Support and Developmental Projects -  We planned to:   * Develop a provider standard for day opportunity services * Develop an outcome based specification for services * Commission a framework of providers.   We have achieved:   * In consultation with service providers, a provider standard which considers organisational governance, financial and service sustainability, staff recruitment, training and supervision, health and safety, safeguarding and other policy requirements has been agreed and implemented. Providers are currently working through the standard. The standard is already driving up the standards across the sector. * An outcome based specification has been provided to service providers for review and broadly agreed.   Way forward:  Commission a framework of providers – carried over from this year as the market was not ready for a tendered process. | | Q4 | | £88,014.23 | **FOR CONSISTENCY OF REPORTING UIPDATES RELATING TO SOME CAPITAL SPEND HAVE BEEN INCLUDED IN THIS SECTION.** |
|  | |  | |  | | Total Q4: | |  | | £432,238.11 |  |

Section 3: Other (Revenue)

Total region allocation

£80,786

| 2016-17 funding allocation | | Identified services to support delivery of ICF objectives – ICF Guidance paragraph 2.2 refers | | End of year projected Outcome(s) for each service (col 2) | | To date – actual Outcome(s) | |  | Expenditure to date | Additional Information |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| £75,000 | | Financial and programme coordination and evaluation  (Whole region) | | * Effective coordination of programme and evaluation of impact | | Q3:   * Post allocation process facilitated. * Regional Q3 Report produced * Monthly finance reports produced | | Q3 |  |  |
|  | |  | |  | | Q4:   * End of year process facilitated. Report produced * Monthly finance reports produced | | Q4 | £68,774.67 |  |
| £27,193 | | Programme Coordination (Carmarthenshire) | | * Effective coordination of Carmarthenshire programme | | Q2: PIDs developed for all post-election projects  Report produced | | Q2 |  |  |
|  | |  | |  | | Q3: Report produced | | Q3 |  |  |
|  | |  | |  | | Q4:   * Project Manager has been developing 17/18 ICF governance mechanisms in conjunction with the regional team. * Collation of the Q4 WG ICF report * Supporting the development of new Project proposal forms for 17/18 | | Q4 | | £27,562.55 |  |
|  | |  | |  | | Total Q4: | |  | | £96,337.22 |  |

Section 4: Capital

Total region allocation

£1,301,00

| 2016-17 funding allocation – | Identified housing-related developments to support delivery of ICF objectives | End of year projected Outcome(s) | To date – actual Outcome(s) | End of year projected expenditure  £ | Expenditure to date  £ | Additional Information |
| --- | --- | --- | --- | --- | --- | --- |
| £20,000 | Behavioural Intervention Service  (Whole region) | * Reduction in expenditure on commissioned services * Increased no. of children receiving appropriate behavioural support * Improved family experience of accessing support * Reduced waiting times for specialist behavioural intervention | Q3: No reported progress to date. | £20,000 | Q3: £0 |  |
|  |  |  | Q4: funding reallocated to other ICF programmes within WW region. | Q4:20,000 | £0 | Funding re-allocated due to late start. |
| £200,000 | Integrated Community Equipment Service  (Carmarthenshire) | * Citizens are safe in their own homes as a result of equipment being provided by Carmarthenshire Integrated Community Equipment Stores (CICES) * Citizens stay at home during an incident or illness, rather than entering a hospital, as a result of equipment provided by CICES. * More patients have a swifter discharge from hospital back into their home environment, as a result of equipment provided by CICES prior to discharge. * Citizens can remain in their home for as long as possible before transfer to a residential home setting, using equipment provided by CICES. | Q4: Smaller items such as bathing and toileting equipment purchased this quarter has allowed patients recovering from an operation return home at the earliest opportunity. This equipment also allows patients to stay safe in their own home. | £200,000 | Q4 £338,523.00 | Hundreds of individual items were purchased as part of this project with dozens of different equipment types purchased. In particular, community profiling beds, dynamic mattresses and hoists allow patients either to remain at home or leave a hospital setting at a much earlier date. Each time a dynamic mattress is delivered for someone leaving hospital, this must allow the patient to leave at least three days earlier than they otherwise would. For the 30 beds and 30 mattresses purchased as part of this project that have been used at least twice so far this equates to a saving of £36,000 to the Health Board alone (based on a patient costing £200 a day to look after in hospital and each bed and mattress used at least twice to facilitate a swifter return home) |
| £25,000 | Sensory Integration Pathway Project (Carmarthenshire) | * Increase engagement and co-production, * Allow individuals to make choices and express themselves * Promote individuals understanding of the world and allow them to communicate in a way which we do not find challenging * Promote fair and equal access to services and the community by reducing barriers. * Allow individuals to develop skills and abilities * Build individuals confidence * Provide the right environment within the person’s community of origin decreasing the need for out of county specialist placements. * Promote the longevity of family living decreasing the need for residential placements and subsequent hospital admissions. * Ensure local community provision is robust enough to support a community based step down package by providing skilled and confident staff with the right resources in the right place. * Ensure the least restrictive option of support is available, which is focused on individual’s strengths. | Q4: Equipment has been purchased for 3 facilities (one on Carmarthen, one in Llanelli and one in Ammanford). The current rooms have been enhanced by the additional equipment and will offer more opportunities for individuals to develop skills and make choices. People who do not currently access services have made enquiries about accessing the new rooms.  The advert for the OT is currently out. Baseline information will be taken for each person accessing the facilities with development recorded. | £25,000 | Q4: £20,246.20 | Timescales have not been possible to achieve due to recruitment requirements and support to ensure correct equipment is purchased.  Although the rooms and equipment will be able to be used as of now, their full use and recording of plans and progress will not be achievable until the OT is in position |
| £123,923 | Transfer of Care Advice and Liaison Service  (TOCALS)  (Carmarthenshire) | * Reduction in the number of admissions and re-admissions into acute care * Decreased length of stay on admission | Q1: Project initiation on hold pending WG approval of Capital bids | £123,923 | Q1: £0 | Project not approved. |
| £120,000 | Carmarthenshire Independent Living Centre (CILC)  (Carmarthenshire) | * Citizens are aware of C.I.L.C and what it can do for them. * Citizens have a greater choice of options to help them with their daily living. * Professionals have a centre that they can use to demonstrate large equipment and re-assure families who have to have significant support in their lives. * Support services are relied on less, as different types of equipment and assistive technology in particular, are used by individuals which can reduce dependency on formal and informal carers. * The centre becomes self-funding – it should also be recognised that the centre should make “savings” in other teams as less formal intervention is required by individuals. | Q4: All works completed by the end of March 2017 with contractors visiting after the project end to liaise with the Project Manager to ensure sign off. The work has been completed in accordance with the project plan and to a high standard. The completed project has seen the creation of a large demonstration / display room that can be used by prescribers and the general public to see how community and Telecare equipment can enhance peoples’ lives and will showcase what is available to the public through the Health Board, Social care and what can be purchased in the market place. A new training room has been created so that prescribers and members of the public can see and trial equipment and methods of use. The room also acts as a classroom for local groups and prescribers. A large meeting room adds another use to the centre, bringing in an income to the service. On the ground floor a "hub” has been created. The hub will act as an information / display area for public walking in off the street. Anyone will be able to call in to ask about community and telecare equipment as well as other services offered by the Health Board and Social care, and they will be given information and advice as well as helped to access any relevant help that they require. | £120,000 | Q4: £98,264.08 | Alternative proposal for TOCALS.  CILC has started taking meeting room booking for 2017 and has had many pieces of equipment donated for use in the demonstration rooms. Visual and hearing impairment equipment will also be displayed at the centre. A publicity campaign will take place in mid-May which will promote the centre and its use throughout the County. |
| £100,000 | Co-location of integrated Community Team  (Carmarthenshire) | TBC | Q4:   * The Careline team has re-located from Llandeilo to Eastgate at the end of October 2016 * The IAA service began operation utilising the Careline staff from mid November. * An integrated multi-disciplinary team has been set up within the room to facilitate the training of staff and proportional assessment of enquiries coming in. * The service is now fully integrated and operational for adult services. | £100,000 | Q4: £95,970.44 |  |
| £80,000 | Assessment and Respite Service for Adults with LD and Complex Health and Social Care Needs  (Carmarthenshire) | * Reduction in high cost residential placements out of County * Number of individuals with complex needs accessing the service * Reduction in delayed transfers of care * Qualitative data on improved outcomes for individuals and carers | Q4:   * Physical work to the building where the Assessment & respite service was going to be located did not progress in time. This meant that the contractor was unable to complete the work by the end of March 17. * This scheme will continue into 17/18 but will be slightly re-worked and a new project proposal submitted. | £80,000 | Q4: £41,996.00 | £38,000 under spend largely due to the fact that the physical work to the building where the respite service was going to be located was unable to progress due to timescales. |
| £100,000 | Supported Living provision for individuals with a learning disability  (Carmarthenshire) | * People with a Learning disability receive support that is person centred and meets their assessed needs. * Improved service user and carer experience and satisfaction * Improved level of social inclusion * Increased level of independence and self-actualisation * Reduced use of residential care and in particular ‘out of county’ residential care. | Q4: Project is not proceeding in this financial year due to largescale delays in identifying a suitable property for this scheme. The outcomes will be carried forward into 17/18. | £100,000 | Q4: £0 |  |
| £50,000 | Equipment Releasing time to care (Carmarthenshire) |  | Q4   * As a result of this project, the number of individuals receiving double handed calls steadily continues to reduce – from 328 (Oct 15) to 282 in March 17 * This equates to a cost saving of £xxx | £50,000 | Q4 £50,000.00 | Slippage scheme |
| £189,748 | Maintaining independence through provision of accommodation based solutions  (Formerly Keeping the elderly safe, warm and secure in their homes)  (Ceredigion) | * Development of a sustainable home safety service * 100 Home Safety Assessments across Ceredigion * 100 follow up works * 25 emergency repair assistance grants processed. * 5 convalescence type beds | Q4: (end of year totals included in figures below, totals of Q1-4):   * Handyperson commenced work in February. * Home safety assessments have been carried out and delivered from the existing service provided by Care and Repair and as a result of referrals received as part of the 3rd sector Community Resource Team (ICF funded). * 38 Home Safety assessments carried out. * 20 Handyperson adaptations completed * 31 Emergency Repair Assistance grants have been delivered * Works to refurbish 5 convalescence beds within the north of the county completed | £189,748 | Q4: £252,254.00 |  |
| £62,506 | Residential Assessment bed Scheme  (Formerly Information technology to support ICF projects)  (Ceredigion) | * Improve patient flow for residents admitted into acute hospital * Build capacity within residential homes to safely discharge resident back to their own homes * Avoid admittance to hospital for Ceredigion residence and provide solutions closer to home * Monitor, review and report | Q4: Work has now been completed with all beds open and accepting step downs from BGH and Step Up from within the community. Weekly MDT meeting are a key element of this project, and relationships have down developed across Social Care and Health. The next step will be to review and set up processes to evaluate the project and learn for the next phase in the South of the County and further linking to Glangwili and Whithybush | £62,506 | Q4: £0 | Substitute proposal. |
| £30,000 | PIVOT, Care and Repair and Community Support Workers  (Pembrokeshire) | * Timely and effective discharges * Improved opportunities for independent living in the community * Improved quality of life for service recipients * Improved integrated working with the 3rd sector * Reduction in social isolation for individuals | Q3: Referrals for the capital spend are made through the PIVOT project as normal.  Spend is then allocated for rapid response, out of hours, minor adaptations to allow an individual to be supported at home safely rather than in a hospital setting. | £30,000 |  | The following are the numbers of adaptations provided through this scheme this year  Key safe – 90  Grab rails – 62  Stair rails – 14  External rail – 11  Fire safety check – 15  Shower seat – 6  Lever taps – 1  Steps – 1  Electrical work - 1 |
|  |  |  | Q4 A total of 108 referrals have been responded to during the year either through the PIVOT Caseworkers or from Home Safety Checks provided within PIVOT. |  |  |  |
| £30,000 | Community innovation and resilience grants  (Pembrokeshire) | * Increased community capacity to support independent living | Q3: 3 panel meetings have been held so far and grants totalling £18,310.56 have been awarded | £30,000 |  |  |
|  |  |  | Q4: A total of four panel meetings were held throughout the year and capital funding totalling £30,000 was allocated across 12 different projects |  |  | Projects awarded with funding will report their outcomes by the end of April 2017.  A full report on the outcomes and achievements will be made available. |
| £84,000 | Community Equipment  (Pembrokeshire) | * More people supported to live at home * Increased independence and quality of life for individuals | Q4: 25 clients supplied with bath hoists or bathing cushions provided a quick, effective response to meet needs and are also a cost effective alternative to adaptations.  18 clients provided with specialist beds and seating and 30 ‘Sara Steadys’ and 10 profiling beds and air mattresses were supplied to support living at home and increase independence. | £104,000 | Q4: £90,000.41 | Increase in projected expenditure as a result of projects not being approved. |
| £90,000 | Housing Adaptations  (Pembrokeshire) | * People are supported in the community through reablement, on discharge from hospital and avoiding unnecessary admissions; to maintain independence. * People are supported to live independently as part of a transition pathway * To reconfigure existing in house residential provision to enable people to transition into adult services in a supportive way, which allows people to develop skills and confidence which will enable them to live more independently. | Q4: 14 adaptations completed. All customers satisfied on completion with the work undertaken and foresee positive outcomes going forwards. Outcomes will be reviewed with customers after adaptations have been in place for 6 months. Primary anticipated outcomes will be avoiding unnecessary admissions through falls, etc and improving independence of individuals with less reliance on family/dom carers. | £90,000 | Q4: £94,981.48 |  |
| £20,000 | Predictive software for GPs and IT enhancement to support agile working for health staff (Pembs) | * More responsive and timely services | Q4: | £20,000 | Q4 £0 | No progress reported. |
| £125,822 | Learning Disability Service remodelling  (Pembrokeshire) | * People with learning disability are better equipped to lead independent lives and are supported by their local communities through employment, skills development, training and volunteering opportunities | Q4: The upgrade and remodelling works commenced at the start of February 2017 and the respite unit opened towards the end of March 2017.  Modifications will support a broader client base incorporating assistive technologies to enable children and young people to become more independent.  The refurbishment of the kitchen and bathroom areas will facilitate the development of life skills and will support service users to overcome everyday challenges.  Assistive technology purchased has been matched with the specific needs of the cohort of the respite facility and will also support a broader client base.  Training on the use of the technology has commenced. Further training is scheduled. Training and use of equipment/technology will be incorporated into visits at Holly House to promote technology in a positive way.  Opportunities to maximise the use of the facilities/equipment are already being explored to support multiple service users to remain independent for as long as they can.  Open day provisionally scheduled on 10.06.17 for parents/carers to be able to fully view the changes/technologies and understand the benefits they offer to children during their stay at Holly House and the potential for use in their home environment.  Assistive Technology update is included with community equipment above. | £125,822 | Q4: 129,212.00 |  |
| £20,000 | Time to care Equipment (Pembrokeshire) |  | Q4: Range of equipment to support training and assessment for single handed care purchased for 3x locations in health. |  | Q4: £67,452.00 |  |
|  | LD Accessible Website Software  (Pembrokeshire) |  |  |  | Q4 £9,629.05 |  |
| Capital Q4: | | | | £695,000 | £1,228,528.66 |  |

**Section 5: Post Election**

**Total region allocation**

**£1,577,592.65**

| **2016-17 funding allocation** – | **Identified housing-related developments to support delivery of ICF objectives** | **End of year projected Outcome(s)** | **To date – actual Outcome(s)** | **Period** | **Expenditure to date**  **£** | **Additional Information** |
| --- | --- | --- | --- | --- | --- | --- |
| £12,000 | Carers support officer  (Carmarthenshire) | •Improved response for carers seeking assessment.  •Improved performance in relation to carers assessments in line with the SS WB Act | Q4: Job Profile has been written and is currently being evaluated to ensure the grade is accurate for the level of responsibility of the post. Advert will be out during February, with anticipated start date of April 2017. | Q4: | £0 | Full underspend is anticipated on this scheme |
| £22,000 | Resource allocation System (Carmarthenshire) | * The support is controlled by the individual/family * The level of support is agreed in a way which is fair, open and flexible * More sophisticated commissioning/delivery of services * Reduction in costs of delivering services | Q4: A detailed audit has been undertaken of cases open to the Children’s Disability team and Transition between January 2016 and December 2016.  Workers have completed a resource allocation tool to give an objective measure of complexity.  The audit has also compared the level of expenditure on services for those cases during the audit period.  Stakeholder sessions have been held with families to ‘test’ the application of a Resource Allocation Tool.  A final report is awaited from IPC to detail the analysis. This will provide us with a Resource Allocation System tool and methodology to implement within the service. | Q4: | £21,757.19 |  |
| £128,000 | Central review Teams (Adults) (Carmarthenshire) | * Those who use our services contribute to the review of their support and services enabling choice and control. * Independence maximized and enhanced self-determination of individuals accessing services * To realise cost savings by right sizing packages and placements. | Q4: Due to delays In recruitment, the post holders have only recently commenced in post. The Nursing and Social Work elements are now in place and will begin to deliver outcomes as stipulated. We are also currently in the process of appointing 4 reviewing officers who will support the social workers and nurses to develop this scheme further. | Q4: | £0 | £128,000 under spent. £35,000 of this funding was re-allocated to the slippage scheme to employ two right sizers to look at high cost packages of care and realise cost savings where possible. The remainder of the funding was re-allocated within the revenue programme. |
| £90,000 | Additional step-up/step down beds  (Carmarthenshire/HDUHB) | * Maintenance of wellbeing and independence * Decreased requirement for formal social care and admission avoidance | Q4: During the period of use, 5th December 2016 – 31st March 17, a total of 33 individuals accessed the beds to facilitate hospital discharge. Average length of stay of these individuals is 23.1 days (range 3 – 42 days).  The evaluation of the project resulted in decommissioning with one care home and re-commissioning 10 beds with the other care home, with revised eligibility criteria, for a further 10 weeks. A further evaluation will be carried out at the end of May. | Q4: | £101,639.76 | Project over spent by £11,640 – over spend agreed through project board. |
| £10,000 | Physical Activity Pathway for health and wellbeing (LD/ complex needs) (Carmarthenshire/HDUHB) | TBC | Q4: Equipment has been purchased with support from Physiotherapist. The room is currently being prepared. Individual programmes are yet to be developed. Baseline information will be recorded for all individuals who will be accessing the facility. This information will be available for evaluation 20017/18. | Q4 | £7,040.00 | Further work will be needed to the grounds surrounding the building. This will support access for people who have more profound disabilities. The possibility of creating additional bathroom facilities for that part of the building is also being explored. |
| £35,000 | Enhanced home to hospital service - seven day provision (Carmarthenshire/Red Cross) | * Reduction in length of stay * Reduced requirement for formal social care | Q4: | Q4: | £18,500.00 |  |
| £15,000 | Nursing post for IAA MDT (Carmarthenshire HDUHB) | • Early identification of ‘sudden functional decline’ secondary to physiological compromise  • Maintenance of wellbeing and independence  • Decreased requirement for formal social care and admission avoidance | Q4: Post holder has been confirmed and due to commence in post during early April . Outcomes will be reported in 17/18 as recurring post. | Q4: | £0 | Full underspend due to recruitment issues. |
| £15,000 | Care to Move - Community Hospitals (Carmarthenshire HDUHB) | * To reduce length of stay for this group of vulnerable adults by 10% annually. * To reduce unnecessary readmissions for this group of vulnerable older adults. * To improve patient self-management and maximise independence | Q4:   * 12 individuals trained in Care to Move principles. * An evaluation report is in the process of being drafted and can be available as evidence of this scheme once received. | Q4: | £1,549.00 | £13,451 under spent due to inability to recruit the number of individuals onto the training as initially expected. This under spend was re-allocated into the wider revenue programme. |
| £22,133 | Generic tech posts to support therapeutic intervention (Amman Valley/ Llandovery) (Carmarthenshire HDUHB) | * Reduced Length of Stay * Decreased requirement for commissioned care | Q4: Llandovery posts currently in the process of recruiting adverts out waiting for interview dates  AVH – recruitment completed staff commencement early May | Q4: | £0 | £22,133 under spend. No spend in 2016/17 due to delays in recruitment of the posts |
| £200,000 | Convalesence beds (Carmarthenshire HDUHB) | * Increase the number of people completing short term residential convalescence/reablement interventions. * Reduce the length of stay within the residential convalescence/reablement service. * Increase the numbers of people leaving residential convalescence/reablement without ongoing services. * Reduce level of support needed following residential convalescence/reablement intervention. | Q4: Provided 4,786 nights of residential convalescence through the two local authority care homes within the County. | Q4 | £306,056.00 | £106,056 over spent to allocation. This is due to the numbers of individuals placed within the beds over the course of 1 year and across 2 residential care homes.  In terms of cost benefit, the cost of a night in residential convalescence is £83.71.The cost of an acute inpatient bed day equates to £478.84. This translates to a cost saving of £395.13 per day/night and therefore, over the course of a year, would mean a cost saving of £1.89 million to the NHS. |
| £96,000 | Additional nursing bed capacity (spot purchase - admissions avoidance) (Carmarthenshire HDUHB) | • Maintenance of wellbeing and independence  • Decreased requirement for formal social care and admission avoidance | Q4: Realisation of flow through the system from acute to community. The integrated assessment nurses are now in reaching into the acute areas to facilitate the spot purchase of these beds. During 2016/17 20 beds were spot purchased in Nursing homes in Carmarthenshire to support individuals to be assessed in an appropriate environment. 3 of these were deceased before the MDT 5 of these were deemed to have needs that could be met by CHC and 12 met the eligibility for FNC. A report of outcomes achieved is available | Q4: | £96,000.00 |  |
| £26,250 | Enhanced Acute Response Team (Carmarthenshire HDUHB) | * Avoidance of admission which promotes independence * Decreased requirement for formal social care | Q4: Recruitment complete & appointments have been made and commenced in post during March. Outcomes will begin to be evidenced in Q1 17/18. | Q4: | £5,962.59 | £20,287 under spent due to inability to recruit majority of posts during financial year. |
| £35,000 | Positive Behaviour service - rightsizing capacity (LD / complex needs) (Carmarthenshire HDUHB) |  | Q4:   * Two post have been appointed to look at rightsizing care packages to ensure they are fit for purpose for the individual and to also look at realising cost efficiencies. * Cost efficiencies of £700,000 have been achieved since December 16 (£450k LA & £250k HB) | Q4 | £35,543.77 | **Case Study: A young lady in her early 20s, was placed in a residential setting in a crisis scenario and unfortunately remained there for 2 years. With the support of the team she is now being stepped down to a supported living arrangement with 3 other transition clients of a similar age, with all the opportunities and benefits this less restrictive option offers. In addition this has been achieved with a significant financial saving to the commissioning authority.** |
|  | ARCH Consultant - Ian Lancaster Watts  (Carmarthenshire) |  | Q4: | Q4 | £10,475.00 | Slippage scheme. |
|  | Rehabilitation Ward 9 (Slippage)  (Carmarthenshire) | * Functional outcomes via Goal Attainment Scale * Length of Stay * Admission and Discharge modified Rankin score * Patient experience Qualitative & Quantitative questionnaire * Patient Stories | Q4: | Q4 | £14,195.00 | Slippage scheme. |
| £10,000 | Pathway planning analysis - Amman Valley/Llandovery (Carmarthenshire HDUHB) |  |  |  | £0 | **This is now being led regionally and no longer funded on a County basis.** |
| £20,000 | Third sector community resource team (CAVO) | * Establish a Third Sector Community Resource Team which will allow the statutory providers to determine patient / client needs and ‘spot purchase’ services to meet those needs. * Develop sustainable practices for Third Sector Providers which meet the needs of changing and evolving needs of patients / clients in Ceredigion. | Q4: : 3rd Sector Core Community Resource Team indicators;   * Number of clients - 107 * Number of interventions initiated - 471 * Time spent to date - 50.2 hours   Links created with AA2A as key referral route.  Joint working processes established between team partners. | Q4 | £20,000.00 |  |
| £8,980 | Rally Round (CAVO) | * Integrate Rally Round as a tool for use by the Third Sector Community Resource Team to provide an improved package of support to those currently in receipt of health and social care services. | Q4: Rally Round purchased and implementation proposal devised | Q4 | £8,980.00 |  |
| £23,519 | Preventative interventions pilot-social prescribing (CAVO) | Develop and implement an integrated Social Prescribing tool developed for use by the Third Sector Community Resource Team, to provide an improved package of support to those currently in receipt of health and social care services. | Q4: Work continued to further develop a potential model for implementation in Ceredigion. Analysis completed of other regional approaches. | Q4 | £23,519.00 |  |
| £6,500 | Telecare service review and options appraisal (Ceredigion) | * Improve and increase use of technologies to make them an integral part of service delivery. * Improve prevention and re ablement services, making them more personalised, efficient, affordable and responsive to people’s needs, aspirations and circumstances. * Establish a new model that enables people to live more independently in their accommodation and will support more effective assessment and increase move through from inpatient and intermediate care settings. | Q4: This project has managed to set the scene, by consulting with a wide ranging of professionals across Health, Social Care, Independent and 3rd Sector. Consultation events have been held across the County.  The report has been written and fed back to the key Stakeholders. The next step will be to develop an implementation plan. | Q4 | £6,500.00 |  |
| £22,569 | Community Falls Clinic (podiatry) (Ceredigion/HDUHB) | * Reducing the numbers of residences who are admitted with a fractured neck of femur. * Increasing numbers of residents in Ceredigion aging well without a fear of falling | Q4: As the commencement of the Falls Clinic was late in the quarter, the podiatry figures are being presented separately.  During the quarter, podiatry service saw (on average) 274 patients each month with issues relating to falls. | Q4 | £9,490.80 |  |
| £119,909 | Cylch Caron pilot beds (Ceredigon/HDUHB) | * Improved assessment experience for the patient, enabling appropriate decisions to be made whilst giving the patient time to recuperate after an episode and fully participate in the long term plan. * Improved assessment timeline and reporting outcomes for statutory bodies. * Improved engagement between residential home and community services (Joint, Health board and Social Services teams) which will in turn support their sustainability by enabling differing models of care. * Testing the Cylch Caron model of care | Q4: During this quarter six beds have been commissioned.  11 patients have used / are using the scheme  2 were admitted in order to avoid hospital admission  9 were to enable timely discharge  BGH, GP, Community Hospital and Community have all referred into the scheme  8 patients have been discharged  2 into intermediate residential care  1 into sheltered housing  5 returning home | Q4 | £79,951.71 |  |
| £33,523 | Interim placement scheme - spot purchase of EMI beds (Ceredigion/HDUHB) | * Target of 9 additional patients accessing these spot purchase beds * A target of a minimum of 25% of patients using the scheme to be discharged to their own home. * A target of no more than 5% of patients using the scheme to be discharged into DGH. | Q4: Total for IPS scheme  Number of new admissions: 14   * Hospital avoidance: 9 * Timely discharge: 5   Number discharged: 15   * Nursing care: 6 * DGH: 3 * RIP: 2   Home: 4 | Q4 | £56,538.00 | It proved unfeasible to spot purchase EMI residential beds in the timeframe allotted to this spend, as only one home in Ceredigion offers this service and the beds were already occupied. The allocation was used to support the Winter Planning and purchase addition nursing interim placements. |
| £25,000 | Long term pathway improvement plan (Ceredigion/HDUHB) | * Reduce admission for patients into an acute bed * Improve Care plans which support the patient across acute and community services * Reduce in re-admissions * Reduce lengths of stay. * Improve experience for patients, carers and staff involved | Q4: Review of the use of the Complex Discharge Pathways has been undertaken; learning from the review has identified a need for ongoing cultural change associated with the evolving delivery of AA2A and Discharge Liason Services.  The learning will be taken forward for further developments associated with bridging the gaps between traditional acute care and appropriate access to community services and will inform further development of the AA2A and Discharge Liaison Services. | Q4 | £25,000.00 |  |
| £20,000 | Community Frailty Service (Pembrokeshire/HDUHB) |  | Q4:   1. Frailty services extended across South Pembrokeshire. 2. Commenced service in North Pembrokeshire in September 2016 working closely with GP partners, social care and health multidisciplinary team to ensure equity of access County wide. 3. A&E Frailty audit undertaken to review patients suitable for frailty assessments. 4. Ongoing development of service to NHS. commissioned beds, care homes and Hillside Intermediate beds. 5. Appointment of an additional Band 7 Frailty Nurse Practitioner post. 6. Full review of service embedded with Case study. | Q4 | £20,000.00 |  |
| £20,000 | Discharge liaison nurse/ coordination of assessment beds (Pembrokeshire/HDUHB) |  | Q4:   1. Additional capacity of 1 WTE Band 6 Community Hospital Discharge Liaison Nurse to complement the Acute Hospital Team. 2. DLN team now integrated across acute/community providing coordination between acute and community and support of complex cases. 3. Additional capacity is facilitating a current DLN Service Review, with a view to development of a DLN Service Improvement Plan.   Weekly 'Community Pull' meetings initiated as a means of identifying complex patients requiring additional review by Joint Discharge Team and onward escalation. | Q4 | £20,000.00 |  |
| £25,000 | Pembrokeshire time bank (Pembrokeshire) |  | * Q4:Scoping project carried out during Q4, focussing on 2 communities in Pembrokeshire – Fishguard/Goodwick and Milford Haven. * A multi-agency project steering/advisory group has been set-up, which met monthly during the scoping period. * 3 community events were held to gauge community interest in a Timebanking scheme engaging a number of interested individuals * Visits, meetings and conversations were had with a range of Timebanking schemes across England and Wales to explore models * Timebanking Broker training was undertaken with Timebanking UK to understand how person-person timebanks operate   Scoping report drafted and awaiting formal sign off | Q4 | £12,000 |  |
| £14,000 | Facilitator role CRT - integrated working (Pembrokeshire) |  | Q4: This workstream has been re-prioritised and the ICF Project Group agreed to re-profile funding to allocate an additional £7k each to Reablement and MAST projects to further support the excellent outcomes being achieved. | Q4 | £0 | **REALLOCATED AS PER UPDATE** |
| £4,000 | Effective referral training (Pembrokeshire) |  | Q4: Effective referral conversations 2 day training for 30 places across health, social care and third sector commissioned incl. venue hire. | Q4 | £3,937.85 |  |
| £160,000 | Community assessment beds (Pembrokeshire) |  | Q4:  •The coordination of patient flow through these beds was undertaken by a Band 7 Senior Nurse.  •The acute and community team worked with people who accessed the beds to accommodate their illness or condition(s).  •The placements did not usually exceed six weeks with the trend being for shorter placements.  •Eligibility criteria was applied.  In Summary:  The use of interim care beds funded via ICF monies was introduced in January 2017 and has now been operational for about 12 weeks, 5 beds are currently opened in Ashdale Care Home and 1 bed remains opened in Parc Y Llyn Care Home. A total of 47 patients have accessed the scheme for a variety of reasons including waiting on:  •Packages of care / reablement  •Rehousing  •Decisions of eligibility panels  •Prevention of admission  •Undergoing recuperation prior to active rehab  Calculated inpatient bed days saved = 486 days  Average number of days spent in the beds varies between health (17.5 days) and social (8 days).  Cost of ICF beds in care homes during project period = £97 / bed / day  Cost of Hospital based acute bed during project period estimated at £500 / bed / day  Cost of ICF beds during project period = £45,299.00p (excluding transport cost)  Cost of inpatient support for same number of patients = £233,500.00p  Potential financial saving = £188,201.00p during project period  Some Outcomes Include:  •Increased bed occupancy in acute setting  •Shorter length of stay  •People moving out of hospital in timely fashion  •Effective rolling program  •Excellent feedback from users of the services. Some have described how they have really enjoyed their time in Ashdale, has provided them with recuperation time away from hospital to gain increased strength to return home / increased confidence / staff described as ‘lovely’ and ‘can’t do enough for you’. One lady has described how she was showing other care home residents how to flower arrange so there has been a positive impact of having more able patients in the care home.  •Some relatives have reported how supportive they have found the Ashdale staff in helping them to prepare for discharge in a less ‘rushed’ environment.  •Ashdale staff described as very ‘proactive’.  The strengths and weaknesses of the scheme have been well documented in this report as highlighted by the professionals involved in its implementation but overall the scheme has saved 486 inpatient bed days, a significant cost saving over the 12 week period, significantly contributing to a reduction in bed pressures in the acute and community setting.  Those involved in the scheme would suggest ongoing investment with a ‘spend to save’ motivation with possible expansion and support of the scheme to ensure most importantly ongoing therapy and SW support of the project. A possible view of this would be to help to secure more timely transfer from the acute setting, for the reasons previously mentioned. Most importantly with significant increased support, assessment could occur in the care home rather than in the hospital setting resulting in more timely transfer. But a change in ethos with regard to patient / families /professionals expectations remains a significant barrier and challenge to overcome. | Q4 | £160,000.00 |  |
| £14,000 | Quality Assurance/ broker (Pembrokeshire) |  | Q4: The brokerage function has developed to include brokerage for respite in addition to that for domiciliary care. Additional resources have also supported two major tenders for Supported Living Services and Domiciliary Care Framework. | Q4 | £13,784.37 | The retender of support of those living independently and utilising support services at home, such as domiciliary care will improve the access to and quality of care, across health and social care. |
| £27,555 | Additional commissioning capacity for children's services (Pembrokeshire) |  | Q4: This has facilitated an alignment of commissioning processes across education and children’s social services. There is now a more robust contractual framework and compliance with the SSWBA. | Q4 | £27,000.00 |  |
| £12,000 | Programme Co-ordination (Pembrokeshire) |  | Q4: Supported management of the project and capacity to meet reporting and evidence requirements. | Q4 | £11,651.00 |  |
| £53,000 | Development of assistive technologies (Pembrokeshire/HDUHB) |  | Q4: Fifty-five people were given a community alarm and home safety package of sensors for a 12 week period following hospital discharge.  All but 3 people have decided to continue with the system after the initial 12 week period. .  One person was given a telecare system on discharge to assist carers monitor and manage night time wandering.  Eighteen palliative care patients were given a community alarm to facilitate a fast track return home.  Fourteen palliative care patients were given tailor-made packages of telecare systems which ranged from a simple call button linked to a pager for the carer / partner / family member, to more complex systems which connected the pager to bed and chair sensors, falls detectors etc.  Overall 88 people and their families were given equipment to improve the discharge process, reduce risk and alleviate anxiety and concerns. The installation of the equipment allowed risk to be managed and well-being improved. This also gave palliative care patients the choice to spend their remaining time at home instead of on a hospital ward or in a hospice setting.  There were 124 activations of the community alarm equipment recorded. 11 people have fallen and used their equipment to raise the alarm for assistance and ambulances have been called 5 times. | Q4 | £19,096 | Case study  Mrs N was given a fast track palliative care diagnosis with liver cancer. Her only family was a daughter living in South Africa.  A telecare pendant/pager system with an easy press adapter was delivered to the property on the day the daughter arrived from South Africa to facilitate Mrs N returning home for her final weeks.  Mrs N was able to stay at home until she passed away 5 weeks later with the assurance she could call her daughter immediately should she need assistance or was in distress.  Mrs N’s daughter was able to spend quality time with her mother and was able to leave her alone in her room when she needed quiet or rest but was able to respond straight away if needed.  The equipment allowed Mrs N to maintain dignity and peace of mind in such a distressing time. |
| £17,000 | Trusted Assessor and Referral Training (Pembrokeshire/HDUHB) |  | Q4: 2 day trusted assessor training delivered to staff across health and social care. Feedback from participants extremely positive. Participants now able to safely prescribe range of daily living equipment without person requiring additional OT assessment, improving timely response, reducing risk and duplication of assessment. | Q4 | £0 |  |
| £40,400 | MAST - nurse/ social worker at front door of acute hospital (Pembrokeshire/HDUHB) |  | 1. Q4: Additional District Nursing Band 6 1 WTE has facilitated District Nursing presence on all weekends and Bank Holidays in Q4. 2. The Additional District Nursing capacity has facilitated greater liaison with the hospital Discharge Liaison Nurse Team, Joint Discharge Team and Complex Care Team in terms of in-reach to acute wards for patients assessed at A&E / ACDU. 232 assessments were completed in A&E/ACDU by MAST, with 142 patients (61%) of those assessed not requiring admission to an acute hospital bed. A further 211 patients received post-discharge support by the MAST team. 3. 59 assessments were completed on weekends / Bank Holidays. 4. All 232 had District Nurse input according to identified need. | Q4 | £29,885.99 | Comments received:  “Couldn’t thank you enough – didn’t expect such good service on a Sunday!”  “Impressed by the team who were able to assess what I needed so that I could go home”.  “A good thorough service. Surprised dad came home on a Saturday but he is much better. Lovely to receive the follow-up call, thank you”. |
| £185,000 | WCCIS |  | Q4:   * The WCCIS Regional Implementation Manager commenced on 6th March * A WCCIS Regional Implementation Board has been established and the first meeting scheduled for 12th May * A Regional Options Appraisal has been developed, in order to assist the identification of the most appropriate target Go-live date to maximise the benefits for the region, and for all stakeholder organisations. * Local, regional and national linkages have been made, in order to establish and strengthen the West Wales position within a national context. | Q4 | £189,459.00 |  |
| £95,000 | Integrated commissioning (Pembrokeshire) |  | Q4: Foundational activity in relation to standardisation of contracts, terms and conditions and associated processes as a basis for regional roll-out to support the RPB’s Integrated Commissioning priority | Q4 | £103,641.00 |  |
|  | Vascular & Diabetic foot Pathway  (Pembrokeshire) |  | Q4:  1 Band 6 Podiatrist appointed to provide service to Pembrokeshire.  2.Outcomes  being monitored.  3. Reprofiling of training with vascular podiatrist and future mentoring with the Vascular team.  4. ABMU and Hywel Dda staff Training Programme on Lower limb vascular assessment held for staff on 3rd and 4th April 2017. | Q4 | £882.00 |  |
|  | Acute Response Team (ART)  (Pembrokeshire) |  | Q4:  ICF investment has facilitated the recruitment of an additional 1.88 WTE Band 5 Nurse, 1.4 WTE Band 3 Nurse and 0.53 WTE Band 3 Admin & Clerical support, which represents a 17.8 % increase in ART’s staff capacity.   1. Additional staff capacity has resulted in increased ART patient activity over the past few months. In January 2017 the service responded to a record 187 referrals, the typical average for October 2017-March 2018 being 150, ranging between 125 and 187 per month. 2. The additional staff resource has facilitated development of a ‘Coordinator’ role within the service which is now pivotal in supporting ART’s effective liaison with acute ward areas, GP’s, community teams, the hospital Joint Discharge Team / Discharge Liaison Team etc. This effective liaison now sees ART directly involved in proactively identifying patients suitable for referral to ART and overseeing the coordination of timely acute hospital discharge / uptake to the service from the community. 3. Additional staff resource has increased ART’s capacity to accept referrals for patients requiring social care / awaiting Reablement upon discharge. In Q4 53 patients were supported for an average of 6 days, representing approximately 318 acute bed days saved, compared to previous quarter where 25 patients were supported for an average of 5.4 days, representing approximately 136 acute bed days saved.   Additional staff resource has enabled ART to now routinely accept referrals for patients requiring Miami Collar care following # cervical vertebrae / odontoid #, which previously required acute hospitalisation for approximately 12 weeks. In Q4 ART has cared for 4 such patients for between 8 and 12 weeks, representing | Q4 | £54,057.75 | **Comments received:**  “You have played such a major part in my recovery and rehabilitation over the last 11 weeks and for that I am truly grateful”.  “Thanks for your kindness and concern over the past 6 weeks – without your service I would probably still in hospital in Cardiff instead of the comfort of my own home”.  “Your service meant I could leave hospital earlier and be with my young family”.  “Thanks, your service prevented my elderly mother from needing to be admitted”.  “This service makes total sense, right care in the right place!” |
| £95,000 | IAA community prevention (Pembrokeshire) |  | Q4: | Q4 | £90,162.00 |  |
|  | Remodelling Mental Health and Learning Disability Services |  | Q4: | Q4 | £43,500.00 |  |
| Post election total Q4: | | | |  | £1,647,754.78 |  |
| Grand Total: | | | |  | £7,679,397.58 |  |