Integrated Care Fund 2018/19
Project Brief

Project Title	Releasing Time to Care
Is this a new project or continuation?	Continuation
What alternative delivery concept is being tested?	
In which financial year will the project complete testing of concept?	2019/20
Which ICF theme does it align with?	Older people with complex needs/learning disabilities
Regional Project Lead/Link Representative	
Local Authority Project Lead/Leads and/or Link Representative/ Representatives	Jason Bennett
HDUHB Project Lead/ Link Representative	Sonia Hay
Third Sector Project Lead/ Link Representative	

1. **Background/Rationale:** *(No more than 300 words, including how your proposal (1)* ***tests alternative delivery concepts*** *(2) l****inks with local strategies and plans such as Transforming Clinical Services; Integrated Medium Term Plan; Well Being Plans etc.*** *(3)* ***contributes to regional priorities*** *and (4)* ***supports delivery of objectives within the West Wales Area Plan.****)*

The Releasing Time to Care (RTTC) project supports the SSWBA (2014) prevention and early intervention priorities. These are cross-cutting themes that have been taken into account in our Ageing Well Strategy and Learning Disabilities Strategy.

An occupational therapist working with health and social care professionals will facilitate integration of support provided across health and social services and seamless transfer between services.

RTTC also supports recommendations identified in the population needs assessment such as:

GENERIC RECOMMENDATIONS
5.2. Prevention and early intervention
3. Build on the considerable foundations in place across the service areas covered in this assessment to ensure appropriate services are available to prevent or delay the need for ongoing care and support and that the prevention ethos underpins all levels and types of care.

Specifically, opportunities should be taken to develop consistent preventative frameworks across services, which build on existing good practice, facilitate transition between children and adult's services and demonstrably reduce the need for ongoing care and support.

5.5. Cooperation, partnership and integration
11. Develop consistent delivery models across service areas and the region, based on a shared strategic vision and the principles within the Act; ensuring common standards to all residents in West Wales.

HEALTH AND PHYSICAL DISABILITIES RECOMMENDATIONS
To improve the mental health and wellbeing of our local population through improved promotion, prevention and timely access to appropriate interventions. Including greater flexibility to deliver step up and down provision to respond to changing needs and a greater focus on mental health provision.

2. **Purpose: What will you do and how will you do it?** *The proposal should support at least one of the aims identified within the Welsh Government* Guidance *for use of the ICF. Please outline how your service would meet a particular Aim (or Aims).*

ICF Aim	Description of how your proposal will meet the Aim(s)
ICF General Principles: 18 – ii. Establish a more proactive approach, seeking to identify those people at risk of becoming 'stuck' within secondary care with a resulting impact upon their ability to return to independent living	The RTTC occupational therapist works with people who have experienced a decline in functional abilities, which result in a request for significant formal care provision. They are routinely assessed and reviewed by occupational therapy to ensure their abilities are optimised and equipment & techniques are utilised appropriately. This ensures that the capacity of care providers is utilised efficiently, releasing capacity to meet the needs of the population, supporting avoidance of unnecessary admission to acute and residential care and facilitate timely discharge home.
ICF General Principles: 18 – v. Encourage innovation and develop new models of delivering sustainable integrated services	Through working with health and social care professionals it affords an opportunity to influence a cultural change within health and social care practitioners and providers to sustain enduring change to statutory care provision.
ICF General Principles: 18 – vi. Promote and maximise independent living opportunities, including provision of timely home adaptations	**Individuals** Enabled to regain/maintain optimum independence Control, choice and dignity in care – reducing the number of care staff &/or care visits in/out of a person's home. This is supported with the provision of assistive technology and minor adaptations.

ICF Aim	Description of how your proposal will meet the Aim(s)
ICF General Principles: 18 – vii. Help develop collaboration in needs assessment and service planning, organisation and delivery at primary care cluster level;	This project spreads the good practice from a number of local authorities and builds on the successful outcomes of the Releasing Time to Care project in Carmarthenshire. • **Local Authority** ➢ Care provision/resource utilised effectively ➢ Reduction in care provision for individuals ➢ Releasing capacity to meet needs of more people with resources • **Care providers** ➢ Efficient use of their staff ➢ Improve knowledge and skills of workforce ➢ Support retention of staff ➢ Reduced risks with moving & handling • **Health Board** ➢ Care resources released to support avoidance of admission and discharge from acute and community beds, with potential of positive impact on length of stay ➢ Reduction in care provision for individuals funded by Health Board ➢ Releasing capacity to meet needs of more people with resources

3. **Outcomes:** *Please list which of the outcomes from the regional outcomes framework attached will your proposal contribute towards and how it will do so (minimum of 1, maximum of 3.)*

Regional Outcome(s)	Description of how your proposal will meet the Outcomes(s)
Theme 2: Promoting independence – "step up my care"; preventing admissions to hospital & discharge at front door	Service users are supported to regain/maintain optimum independence, offered control, choice and dignity in care as a result, there will be a reduction in the number of care staff &/or care visits in/out of a person's home. This is supported with the provision of assistive technology and minor adaptations.
Theme 3: Promoting independence – efficient discharge from hospital & continue to care for me	The RTTC occupational therapist works with people who have experienced a decline in functional abilities, which result in a request for significant formal care provision. They are routinely assessed and reviewed by occupational therapy to ensure their abilities are optimised and equipment & techniques are utilised appropriately. This ensures that the capacity of care providers is utilised efficiently, releasing capacity to meet the needs of the population, supporting avoidance of unnecessary admission to acute and residential care and facilitate timely discharge home.

4. **Implementation Timescales –** *please indicate the following:*

When will project development commence?	On-going
When will initial expenditure commence?	1st April, 2018
When will staff recruitment commence (if required)?	Staff in post
When will project delivery commence?	1st April, 2018
Expected date of completion of project concept testing.	31st March 2020
Expected date of project review/embedding learning into mainstream practice or termination.	31st March 2020

5. **Amount Requested** (*include detailed breakdown of costs and if revenue or capital*)

Revenue

1.00 WTE Band 7 Occupational Therapist = £44,892 P/A
Travel costs = £2,000 P/A

Revenue SUB TOTAL = £46,892 P/A

6. **Proposed Performance Indicators:** *(What will it enable you to achieve in addition to what you are doing now. i.e. how many additional participants/outcomes? Please refer to ICF 17/18 C)*

Performance Indicators	
How much will you do? (Quantity)	**How well will you do it? (Quality)**
• *Number/percentage of admissions and re-submissions in and out of hours by GP practices by cluster* • *Number/percentage of people supported by short term assessment and acute response.* • *Number/percentage of people supported by short term assessments and acute response* • *Number/percentage of commissioned hours of domiciliary care*	• *An increase in the percentage of people whose care and support has helped them have a better quality of life;* • *An increase in the percentage of people who rate the people that provided their help, care and support as excellent or good;* • *An increase in the percentage of people who feel they have been treated with respect.*

• *Number/percentage of people receiving domiciliary care at home*	• *Number/percentage of people supported by short term assessment and acute response.*
How will people be better off as a result? (Quality and Quantity of effect)	
Service will be better off as a result of this service that can: • *Assess, treat and support people at home or in the community* • *Help avoid hospital admission* • *Ensure prudent use of resources on discharge* • *Manage demand and capacity, recognise budget constraints (efficient use of finite long term social or nursing care resource; both domiciliary and residential.*	

7. **Sustainability:** *After testing and review, how will successful concepts be incorporated into either mainstream delivery, IMTP, TCS, Area Plan or Well-Being developments and what is the exit strategy? (no more than 100 words*)

It is anticipated that the outcomes of this project will result in cost savings as a result of more prudent use of resources and ensuring that the capacity of care providers is utilised efficiently, releasing capacity to meet the needs of the population. We would seek to reinvest these savings into the service to support sustainability.

9. **What are the implications if this business case isn't supported?**

There would be an inability to support the transformational programme of work needed to provide older/frail people with services that are different to the status quo. An increase in the capacity challenges that hinder pro-active attempts to adequately plan for future demand on services and continued reliance on hospital/residential types of care. The rural nature of Pembrokeshire has resulted in a post code lottery of services as other areas have already developed in this area.

10. **Please provide supporting evidence of engagement with key stakeholders, in the development *or* delivery of the project, particularly 3rd sector and community partners when alternative delivery concepts are being tested.**

Proposal developed and supported by Pembrokeshire ICF board, incorporating health board, local authority and third sector representation.

11. **Please ensure a completed 12 month budget profile is attached.**