WEST WALES INTEGRATED CARE FUND (ICF) REVENUE INVESTMENT PLAN 2018-19

wwcp
Partneriaeth Gofal Gorllewin Cymru
West Wales Care Partnership

PRIORITY AREA FOR INTEGRATION: OLDER PEOPLE WITH COMPLEX NEEDS AND LONG TERM CONDITIONS, INCLUDING DEMENTIA

PROJECT/SCHEME DESCRIPTION	PLANNED BUDGET (£)	LINK TO ICF PRINCIPLES eg Prevention and Alternative Delivery Models, Supporting Independence	Link to National Outcomes Framework	ANTICIPATED IMPACT	KEY DELIVERY MILESTONES	Additional resources if applicable
REGIONAL						
Coordination Staff costs	**£75,428.00**	Facilitating development and monitoring of the regional programme	**Citizens get the right care and support as early as possible.**			
RPB Strategic priorities programme management & delivery	**£266,626.00**	Supporting development and implementation of regional alternative delivery models	**Citizens get the right care and support as early as possible.**			
OTs Integrated Community Equipment Stores These posts will ensure improved patient outcomes and flow through targeted prescribing of equipment according to need, to reduce demand and dependency on equipment stores.	**£54,747.00**	**Supporting Independence**	**Citizens get the help they need to be independent**	•People will be supported to continue to live independently in their homes and communities •Increased number of individuals provided with equipment relevant to their needs	•Recruitment of OTs •Commencement of assessment and prescribing	
CARMARTHENSHIRE						
1.**Intermediate Care Pathway –** encompassing TOCALS, Proactive Care team, Rapid Response Dom Care , Reablement OT's, Acute Response Team (ART) & Demand and	£2,322,303	**Integration & Prevention –** Improving outcomes for older people is dependent on an effective Intermediate Care pathway that avoid admission and support efficient discharge.	**Citizens get the right care and support as early as possible** – an effective Intermediate Care Pathway will provide a timely response for Older Adults with acute and sub-acute	•Eliminate Occupational Therapy Waiting list •Reduced number of individuals requiring domiciliary care •Reduced number of individuals in	•Review the current DLN & Unscheduled Care Co-ordinator roles within TOCALS •Strengthen ART & Proactive Care Nurse role in Community	

Capacity to provide an integrated, responsive service to reduce or avoid admission and support safe rapid discharge.			presentation and efficient discharge from hospital	community waiting for assessments of care & support •Increased number of individuals discharged at the 'front door' of the hospital within 72 hours	•Review short term domiciliary resource & develop a Joint Intermediate Care Provider service Commissioning framework •Absorb TOCALS into CRT and operate a duty rota for 'front door' of hospitals •Implement Community Geriatrician role following successful TOCALS + pilot •Integrate with relevant cluster & pacesetter funded initiatives •Map potential duplication with Dementia ICF criteria	
2. Therapeutic Intervention: Frailty Workers in Community Hospitals - This initiative enhances current resources to provide timely and efficient review of frail older adults to ensure the care provision meets their needs while maximising their opportunity for independence	£97,632	**Integration** - These posts will ensure improved outcomes at individual level but will also contribute to improved performance at organisational level in terms of reduced length of stay, improved patient flow and reduced demand and dependency on commissioned social and health care. This initiative enhances current resources	**Citizens live in a home that best supports them to achieve their well-being** - This will be achieved by improving patient self-management, so as to ensure less reliance on health and social care support. To provide care closer to home that is flexible and supportive.	•To improve patient mobility. •To improve patient self-management, so as to ensure less reliance on health and social care support.	•This is a continuation of the previous PID and ensures enhancement of service delivery focused outcomes.	

		to provide timely and efficient review of frail older adults to ensure the care provision meets their needs while maximising their opportunity for independence.	**Citizens get the right care and support, as early as possible -** These roles will enhance the patients input from therapies as these will continue therapy intervention over a 24 hour period outside of the Therapists involvement. Individuals supported to achieve maximum independence for longer in the community.			
3. Complex care review Team - This initiative enhances current resource to provide timely and efficient review of frail older adults in receipt of care to ensure the care provision meets their needs while maximising their opportunity for independence.	£226,327	**Integration & Prevention -** Ensure reviews of care provision are undertaken according to statutory duties and in accordance with individual needs in order to ensure that the wellbeing and independence of the individual is optimised	**Citizens get the right care and support as early as possible** - The additional resource will ensure timely review of care and support plan. **Citizens contribute towards their social life and can be with the people that they choose** - Reviews will adopt an outcome focus that reflects 'what matters' to the individual and considers social inclusion **Citizens get the help they need to continue to be independent** - Reviews will ensure that the care and support an individual receives is asset focused and proportionate to their	•Individuals are able to maintain their independence •Individuals are ensured to be receiving the correct care •Regular reviews ensure that individuals' needs are met, avoiding deterioration in health and well-being or "crisis".	•Scheme is already in place and fully staffed. Milestones are around maintaining reviews to ensure that individuals are receiving the correct levels of care and support	

			needs in order to support them to be able to manage their activities of daily living as far as possible.			
4. Prevention, Early Intervention & Independent Living (PEIPL) - This proposal aims to demonstrate how community based provision in Carmarthenshire can help to make the shift from health and social care being a being reactive model and embeds a way to work collaboratively, moving away from a culture of ongoing crisis management that focuses on a small number of people with the greatest needs, to one that addresses the whole population, with a wide range of preventative support at all levels.	£200,000	**Prevention** - The purpose of this proposal is to outline a specific approach to community preventative activity which will have maximum impact on improving wellbeing. This new approach must work from the premise that previous models of service have not had the desired impact; in some cases, despite major investment. Care and support resources have traditionally been found in families and communities, not in services or state budgets. Now more than ever we need to see growing 'social productivity' as the core business of health and social care, where interventions align and support people's 'real' relationships and ensure investment in social capital.	**Staying well & independent in the community** - identified projects will provide individuals with information and make appropriate referrals/connections to community-based activities, volunteering/time banking opportunities and local community services that people can access to manage and improve their well-being. Supporting social connections that help people stay well and live independently for longer in their communities. **Promoting Independence 'Step up my care'** - CUSP/Enhanced Home from Hospital service provides individuals with low-level support to prevent the need for admission to hospital, or to enable them to return home from hospital rather than being admitted. The collaborative approach means that individuals are	•People will be supported to continue to live independently in their homes and communities •People will not need to call on statutory social care services and/or visit the GP as frequently •People will feel valued and part of the community in which they live •Individual and community well-being will be improved •People will actively participate in the co-design and delivery of services in their local area •People will not spend more time than is absolutely necessary in hospital, thus reducing costs and improving individual resilience and well-being		

			supported to access the services they need, including commissioned services in the third sector to support independent living, with the majority of referrals made to the service preventing admission to hospital or escalation into statutory care.	•People will be able to access information and support when they need it •There will be an increase in the range of third sector services available to support people in their local communities		
5. Health Activity for Older People & Specialist Populations (HACOA) – This is an evidence based community exercise programme to develop and maintain strength and fitness for older people.	£23,776	**Prevention**	**Citizens get the right care & support as early as possible** - physiotherapy and the rapid access frailty service to ensure that referrals for frail individuals access the service as soon as possible. **Citizens get the help they need to be independent** - to reduce injurious falls in older adults to improve independence and reduce the need for formal commissioned care and risk of hospital admission	•Reduced pressure on unscheduled care from reduced number of falls in frail adults •Reduced demand on physiotherapy through the provision of an early exit route from the physio service which is in high demand	The transfer of funding will further expand the service and will ensure that it is embedded within the range of intermediate multidisciplinary care services available in the county and will contribute to a reduction in admissions to hospital.	
6. Clinical Psychology Service – To deliver early intervention for people with conditions to prevent further deterioration of depression and anxiety which are impacting	£70,928	**Innovation; Transformation; Additionality; Integration; Prevention & Delay.** **New way of working** addressing psychological risk in long term conditions;	**Citizens get the right care and support as early as possible -**	•Patient access to psychological support relating to their long term condition •Improved wellbeing •Improved self-management •Improved depression	Continued scheme from 17/18.	

upon their ability to self-manage & cope with their chronic condition. To up-skill health and social care staff working with older people with long term health conditions in delivery of low intensity psychosocial intervention		Integrating psychology into intermediate care & social care services. Prevent, Reduce and Delay impact of depression and anxiety in people with long term conditions. Enhance wellbeing & resilience to live fulfilled lives with chronic conditions		•Improved anxiety •Enhanced engagement with meaningful activity •Health& Social Care staff will have additional psychological skills & access to specialist training & ongoing consultation		
CEREDIGION						
Accessing Alternatives to admission in reach team Collaborative working across Health and Social Care Services offering an in-reach service into Bronglais General Hospital to reduce admissions, support safe and timely discharge and reduce reliance on statutory services.	£347,438	**Integration & Prevention** – Improving outcomes for older people is dependent on an effective Intermediate Care pathway that avoid admission and support efficient discharge.	**Citizens get the right care and support, as early as possible**	•Reduction in admissions and Length of Stay in BGH •Clear and communicated care plans which are delivered in a timely fashion close to home. •Patient stories demonstrating integrated working	Scheme revised and continuing from 17/18	
Safe and Steady falls clinic Multi factorial falls clinic based in the community to determine a personalised plan which may include referral to National Exercise on Referral Postural	£109,356	**Integration & Prevention**	**Citizens get the right care and support, as early as possible.** **Citizens understand what care, support and opportunities are available and use these to help them achieve their well-being.**	•Number of people seen in clinic •Fear of falling (quantified via the FES-International tool)	Scheme continuing from 17/18	

Stability Instruction; signposting into 3rd Sector groups (including Care & Repair for home safety assessment).						
Integrated training – Each of the training sessions will be open to all three sectors; enabling a shared approach to service delivery and a greater understanding of roles, responsibilities and boundaries, to enable prudent care planning.	£20,000	**Integration & Prevention; Alternative Delivery Methods -** The multidisciplinary approach enables the appropriate joint decisions are made in a timely fashion. By sharing training and development opportunities the MDTs will working more efficiently and effectively **a**cross all ICF population groups	**Citizens understand what care, support and opportunities are available and use these to help them achieve their well-being**. **Citizens get the right care and support, as early as possible.**	•Clear and communicated care plans which are delivered in a timely fashion close to home. •Patient stories demonstrating integrated working	•Evaluation of the scheme will take place in order to identify if the needs have been met and if there are any additional needs; as well as the benefits to the integrated working framework. •Priority areas will be identified by the Ceredigion Health and Social Care Wellbeing Exec and the County Steering Group, with progress being reported to both.	
Interim placement scheme – Spot purchase of interim nursing / residential beds on a needs basis to enable timely assessment of patient needs in the appropriate setting, to reduce length of stay and improve repatriation to the community.	£95,783	**Integration** **Partnership working and co-operation;** **Alternative Delivery Methods;** **Prevention**	**Citizens understand what care, support and opportunities are available and use these to help them achieve their well-being;** **Citizen's voices are heard and listened to;** **Citizens live in a home that best supports them to achieve well-being**	•Ensuring safety – each patient referred to the scheme has a care plan developed to ensure the home can meet needs (this may include additional support); •Joint planning – reducing duplication and clarity for all those involved;	Scheme continuing from 1718. Monthly updates are received by the Ceredigion County Steering Group which has representation from HDUHB Community & Primary Care, Ceredigion County Council Ceredigion HSCWB Exec and CAVO	

				•Timely assessment – having a set period of time to assess a patient's long term needs ensures that decisions are made appropriately and safely.		
Third sector Core community resource team – A collaborative working partnership between key Third Sector partners in Ceredigion which provides blended, timely and appropriate community support to address the causes of issues faced by those who are frail and elderly.	£268,292	**Partnership working and co-operation.** **Alternative Delivery Models**. Citizens Advice Ceredigion and Ceredigion Age Cymru deliver advice, information, support and representation on a wide range of issues including maximising income, reducing debt, as well as heating and energy costs. Care & Repair undertake home assessment and address any repairs or adaptations identified.	**Citizens understand what care, support and opportunities are available and use these to help them achieve their well-being.** **Citizens get the right care and support, as early as possible.**	•People feel involved in decisions about their care and support •People report that they are able to do things that matter to them	Further evaluation will be completed in March/April 2018, to inform the development of the Ceredigion Target Operating Model which includes Porth y Gymuned and the re-commissioning of preventative and third sector services. Findings will be shared across the region through the work of the Integrated Commissioning and Preventions Programme Board.	
Porth y Gymuned management and 3rd sector integration facilitators – To manage three Community Connectors posts who will be recruited as part of the	£109,965	**Partnership working and co-operation.** **Alternative Delivery Models.**	**Citizens understand what care, support and opportunities are available and use these to help them achieve their well-being.** **Citizens get the right care and support, as early as possible.**	•Indirectly, by raising the profile of the 3rd Sector the number of people who volunteer in the area will increase.	The four differing pillars of Porth y Gymuned will be evaluated to determine which elements prove the best value for money and sustainable over the next five years; subsequently	

Social Services Transformation process. To empower professionals and community champions to utilise the 3rd and community sectors as well as inform commissioning.				•Patient stories demonstrating integrated working •Individuals will report that their wellbeing outcomes have improved and they are better informed of community and third sector provision.	which elements will be prioritised for funding	
Caring communities innovation fund – The Caring Communities Innovation Fund will act as a financial instrument to enable community organisations to pilot innovative new approaches to improve service delivery.	£43,200	**Partnership working and co-operation.** **Alternative Delivery Models.** The Grant Scheme Panel consists of representatives from Ceredigion County Council and Hywel Dda University Health Board.	**Citizens understand what care, support and opportunities are available and use these to help them achieve their well-being.** **Citizens get the right care and support, as early as possible.**	•Impact of individual initiatives will be gathered through project end monitoring reports.	Monthly reports on progress are also presented to the Ceredigion County Steering Group and learning shared with colleagues across the Region and the wider Third Sector.	
PEMBROKESHIRE						
PAVS Preventions incl PIVOT The third sector-led preventions programme is managed by **PAVS Third Sector Health & Well-being Facilitator**, who also provides a strategic lead for third sector involvement in the preventions agenda. It brings the following activities together in an	£248,997	**Preventions** **Alternative Delivery Models**	**Staying well and independent in the community** **Promoting independence – 'Step up my care'** **Preventing admission to hospital & discharge at 'front door'** **Promoting independence – Efficient discharge from**	• No of people receiving information, advice and assistance to help them to manage their own health and well-being • No of referrals made to enable people to manage their own health and well-being by		

integrated delivery framework: **(1) Community Connectors** - a key element of the *Active and Connected Communities* programme, this 2-year project is piloting a third sector, community and citizen-centred approach to improving health and wellbeing in Pembrokeshire. **(2) Pembrokeshire Integrated Voluntary Organisations Team (PIVOT**) - a PAVS-led consortium of third sector organisations, namely British Red Cross, Care & Repair, RVS and PACTO (Pembrokeshire Association of Community Transport Organisations). **(3) Caring Communities Innovation Grants** - a small grants scheme administered by PAVS on behalf of Pembrokeshire County Council and			**hospital and 'continue to care for me'**	accessing other services in the community • Number of people volunteering in their communities • Number of user-led activities and services established in community • No CICs and social enterprises developed • No of third sector organisations and services uploaded onto **info**engine • Number of hits on **info**engine website, from Pembrokeshire • No of people provided with domiciliary-based intermediate care services following a hospital stay or community referral • No of supported discharges at the front door of acute services		

Hywel Dda University Health Board. The scheme supports community-based projects that aim to **(4) Pembrokeshire Time Bank Network –** PAVS is running a 2-year pilot working directly with communities to establish volunteer-led and sustainable time banks. Time banking is an asset-based model and are, by nature, co-operative entities that encourage active citizenship and participation.				• No of hospital admissions prevented		
Developing integrated community teams-programme manager- This bid is for a project development / project lead post to continue to take this agenda forward over the next 15 months. Leading on engagement and establishing a working model of co-located multidisciplinary teams, this again has a strong evidence base and is in	£49,544	**Integration** **Alternative delivery models**	**Promoting independence – "step up my care"; preventing admissions to hospital & discharge at front door** **Promoting independence – efficient discharge from hospital & continue to care for me** **Citizens get the right care and support, as early as possible.**	• Number/percentage of residents admitted due to lack of community resources • Number/percentage of admissions and re-admissions in and out of hours by GP practices by cluster • Number/percentage of ED attendance converted to		

place in many areas of Wales e.g. Gwent Frailty Programme, Carmarthenshire, Neath Port Talbot etc.			**Citizens live in a home that best supports them to achieve their well-being**	admission by age group (over 65/76/85) • Percentage of people whose care and support has helped them have a better quality of life • Percentage of people reporting that they are able do the things that matter to them • Percentage of people who rate the people that provided their help, care and support as excellent or good		
Acute Response Team- The Acute Response Team (ART) provides 24hour county-wide coverage and is an integral unscheduled care rapid response service delivering acute interventions and care that otherwise require admission to hospital	£100,000	**Integration** **Alternative delivery models**	**Promoting independence – "step up my care"; preventing admissions to hospital & discharge at front door** **Promoting independence – efficient discharge from hospital & continue to care for me**	• Ensure patients are in receipt of support and care that is better integrated, more coordinated and matched to their individual need; • Develop ART's capacity and capability to prevent unnecessary hospital admissions, reduce length of		

				stay and associated risks of hospitalisation and more proactively support and facilitate early and safe discharge. • Extend and enhance ART's capacity to provide care and support for more patients to remain independent and well for longer within their home environment and community support network; • Enhance ART's capacity to increasingly tailor and individualise care and support for older patients with a focus on patient decision making and choice; improve dignity and quality of life for patients.		
Community resource-Care at home team- The Care at Home Team is a service that is providing county-wide	£200,000	**Alternative delivery models**	**Promoting independence – "step up my care"; preventing admissions to hospital & discharge at front door**	• The focus on Care Closer to Home will provide complex and end of life care packages to enable		

coverage to enable complex care to be provided in the patient's own home by support staff working across Pembrokeshire.			**Promoting independence – efficient discharge from hospital & continue to care for me**	patients to remain within their home environment; • More tailored and individualised care and support for patients with a focus on patient decision making and choice; • Improved dignity and quality of life for patients. • Availability of 'in-house' care provision will provide a consistent approach and prevent delay of discharge.		
Frailty nurse practitioner- An extension of the existing 'Community Services for Frail Older Adults' to a more collaborative, integrated and multi-disciplinary service for frail older people living in Pembrokeshire	£50,000	**Integration** **Alternative delivery models**	**Promoting independence – "step up my care"; preventing admissions to hospital & discharge at front door** **Promoting independence – efficient discharge from hospital & continue to care for me**	• We will support people to remain independent and well for longer • We will support people to remain at home or within their place of choice • We will work to prevent patients being admitted hospital unnecessarily		

				• We will work to maximise patients' quality of life • We will give people the opportunity to discuss advance care plans, giving them control and decisions of their future health needs		
Multi-disciplinary assessment & support team (MAST)- Building on the multi-disciplinary approach (MAST) at the front door of Withybush General Hospital, in 2018/19 the team plans to extend inter-professional working to improve efficiency and utilise capacity to test alternative, innovative concepts.	£322,709	**Prevention** **Integration** **Alternative delivery models**	**Promoting independence – "Step up my Care" Preventing admission to hospital and efficient management of acute episodes**	• Number of assessments undertaken in A&E/ACDU. • Number of people supported in community intermediate beds • Number of responses to people who have fallen at home • Number/percentage of people assessed not admitted to acute hospital care (admission avoided) • Number/percentage of people who have fallen, responded to by MAST and not conveyed to hospital (timely		

				response & admission avoided*)*		
Releasing time to care- 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 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.	£42,896	**Alternative delivery models**	**Promoting independence – "step up my care"; preventing admissions to hospital & discharge at front door** **Promoting independence – efficient discharge from hospital & continue to care for me**	• 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.)		
Technology enabled care Home monitoring of behaviour routines in conjunction with reminders and orientation	£7,500	**Alternative delivery models**	**Staying well & independent in the community** -	• Percentage of people helped to remain at home • Percentage of people reporting that they feel safe • Percentage of people supported to remain at home by being offered tried and effective		

				equipment prior to purchase		
Assistive Technology The project aims to increase well-being and safety and maximise independence by using assistive technology. The project will be targeted specifically for services users discharged from hospital or are fast tracked palliative care	£2,500	**Alternative delivery models**	**Staying well & independent in the community** -	• Percentage of People supported by replacing and updating equipment		
Reablement- This service is part funded by ICF to support integrated working and to maintain links with other intermediate care services. This is evidenced by the capacity available to support referrals from health professionals.	£241,639	**Prevention** **Integration**	**Citizens get the right care and support, as early as possible.**	• Percentage of people whose care and support has helped them have a better quality of life. • The % of people who leave Reablement with no long term domiciliary care needs. • The % of people who leave Reablement with reduced long term domiciliary care needs.		
Step up step down beds Provision of step up / step down to prevent	£170,000	**Prevention** **Integration**	**Citizens get the right care and support, as early as possible.**	• Percentage of people whose care and support has		

service users avoiding admission to hospital or facilitates safe discharge and eventual return to living independently. This project funds 7 beds in Hillside Care Home.				helped them have a better quality of life. • The % of people who leave the service with no long term domiciliary care needs. • The % of people who leave the service with reduced long term domiciliary care needs.		
REGIONAL TOTAL	£5,857,586.00					

PRIORITY AREA FOR INTEGRATION: PEOPLE WITH LEARNING DISABILITIES AND CHILDREN WITH COMPLEX NEEDS, CARERS

PROJECT/SCHEME DESCRIPTION	PLANNED BUDGET (£)	LINK TO ICF PRINCIPLES eg Prevention and Alternative Delivery Models, Supporting Independence	Link to National Outcomes Framework	ANTICIPATED IMPACT	KEY DELIVERY MILESTONES	Additional resources if applicable
REGIONAL						
Regional Behavioural Intervention Service	**£257,199.00**					
CARMARTHENSHIRE						
Positive Behaviour Service - Additional support given to staff teams (both LA and external providers) to prevent people from needing services that are out of the area and to	£126,204	**Prevention & Additionality -** This service will facilitate early discharge from hospital and avoid admission. It will also be a realistic alternative to specialist placement and be able to respond to family breakdown and crisis	**Citizens get the right care and support as early as possible**. - Improve access to services for individuals with complex needs and their carers. Pro-active interventions to prevent escalation of	•People will be closer to their family/friends – wellbeing •Prevention of escalation and placement breakdown	PBS Scheme Manager is already in post so key milestones are to complete recruitment of the PBS Outreach workers & commence the service.	

support them being repatriated. This is in addition to the existing PBIS team.		situations. This facility will respond to the prevention and well-being agenda and will contribute to the prudent healthcare objectives, i.e. Care for those with the greatest need first. The service will provide additional support for adults with a learning disability and who also exhibit behaviours that challenge.	challenging behaviour and placement breakdown. **Citizen's individual circumstances are considered**. - Person centred behaviour management will prevent admission into secondary care or specialist placement and will improve individual outcomes.		Regular reporting will be made to the LD Programme Board	
2. Information & Assessment Officer (Carers) - a service to promote and support better recognition and practice around unpaid carers. Based within the 3rd sector and employed by CCC the post is designed to help all social services care management teams to become better at supporting unpaid carers in line with legislation and best practice. The role will provide information and signposting to practitioners who are engaged in supporting unpaid carers	£42,451	**Integration -** Carers are a priority group within ICF guidelines. The post will impact directly on better support for carers by facilitating knowledge and expertise to front line staff who are supporting carers. Informing and signposting is critical in supporting carers, many of whom don't ask for anything more than information. Whilst we have several carer information services commissioned from the third sector our monitoring of these services demonstrates that referral rates from social care teams are poor. The service will address this gap.	**Citizens get the right care and support as early as possible.** **Citizen's individual circumstances are considered.**	•Carers will be better recognised and supported to maintain caring and have a life of their own •Team practitioners will be supported to facilitate better outcomes for carers •Relevant Third sector orgs will feel more included and valued and ensure take up of their services •The culture within social services will change – Carers,	Continuation – Post holder already in place.	

				respected and have their rights upheld •Carers will be more willing to sustain their caring role for longer		
3. Sensory Integration Occupational Therapist - To embed Sensory Integration practice and Therapy into the community provision promoting mental wellbeing and resilience for all whilst ensuring individuals maximise their potential. We aim to provide an assessment service in which we develop a sensory diet for an individual consisting of various activities and interventions some of which can then be delivered outside of the day service environment and within the persons own home some independently, some facilitated by staff and some consisting of environmental changes/additions**.**	£46,400	**Prevention** - **Contribution to de-escalation and normalisation** - This project will provide an environment where we can understand how individuals prefer to communicate and provide them with individualised packages so that they are able to make sense of the world they live in and play an active role in their lives and their communities. This will in turn mean that individuals find situations less challenging and will reduce the amount and type of restrictive and specialist interventions. This approach could also support those who are being repatriated into their community of origin form more specialised or secure care and prevent escalation into specialist residential accommodation.	**Citizens get the right care and support as early as possible**. - Individuals will have access to a sensory integration assessment. Pro-active interventions to prevent escalation of challenging behaviour and placement breakdown. **Citizen's individual circumstances are considered**. - Person centred support will prevent admission into secondary care or specialist placement and will improve individual outcomes.	• Increased 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	•Recruitment of post holder •Establishment of a Sensory Integration Pathway	

Partnership & Governance Manager	£55,686			To support, lead & manage the successful delivery of the ICF programme for 2018/19 and make the necessary links across the region & PSB's.		
CEREDIGION						
Carers Resilience and Well-being	£50,896	**Integration** **Partnership working and co-operation;** **Prevention;** **Alternative Delivery Methods**	**Citizens understand what care, support and opportunities are available and use these to help them achieve their well-being.** **Citizens access the right information, when it's needed, in the way they want it and use this to manage and improve their well-being.** **Citizens contribute towards their social life and can be with the people that they choose.**	•Participants can self-assess and report their improved awareness of personal resilience to evaluate the impact of the core components and their place on the resilience pathway, reporting more voice and control over daily life.		
PEMBROKESHIRE						
LD partnership board-supported employment model The LD partnership board wants to ensure that employment of people with LD is central to the achievement of its	£100,000	**Prevention** **Integration** **Alternative delivery models**	**Citizens get the help they need to grow up and be independent.** **Citizens contribute towards their social life and can be with the people that they choose.**	• Support up to 20 people with LD to engage with paid work • Provide events calendar in accessible		

actions. The supported employment partnership would provide learning and paid work opportunities for people with LD by establishing a supported employment partnership working on projects			**Citizens engage and make a contribution to their community.**	format for people with LD • Recruit 6 LD champions to engage with the wider community. • Develop 1 social enterprise to improve social engagement		
Support and Accommodation Progression Project (formerly known as the Accommodation & Efficiency Project) The team works in collaboration with Health colleagues within Learning Disabilities and elsewhere and uses new commissioning frameworks to hold service providers to account and ensure that services being commissioned are delivered. This includes work on supporting service users to move to appropriate local accommodation solutions.	£88,000	**Integration** **Alternative delivery models**	**Citizen's individual circumstances are considered** **Citizens live in a home that best supports them to achieve well-being**	• The number of services users supported through progression into accommodation that best meets their needs. • % reporting the care and support they received was excellent or good • % of people whose care and support has helped them have a better quality of life.		

Complex needs accommodation project- Strategic development of appropriate accommodation options for service users allows enhanced opportunities for service users to access suitable accommodation and related support.	£14,534	**Integration**	**Citizens live in a home that best supports them to achieve well-being** **Citizens get the right care and support, as early as possible**	• Number of clients matched with properties • Number / percentage of voids will • decrease, with associated void costs • Percentage of successful placements • Feedback from stakeholders on satisfaction with new processes and systems • Percentage of people reporting that their accommodation is suitable for their needs • Percentage of people whose care and support has helped them have a better quality of life		

TOTAL	£781,370.00					

PRIORITY AREA FOR INTEGRATION: INTEGRATED AUTISM SERVICE

PROJECT/SCHEME DESCRIPTION	PLANNED BUDGET(£)	LINK TO ICF PRINCIPLES eg Prevention and Alternative Delivery Models, Supporting Independence	Link to National Outcomes Framework	ANTICIPATED IMPACT	KEY DELIVERY MILESTONES	Additional resources if applicable
As Regional IAS proposal	£398,000.00	TBC	TBC	TBC	TBC	
TOTAL	£398,000.00					

PRIORITY AREA FOR INTEGRATION: WALES COMMUNITY CARE INFORMATION SYSTEM (WCCIS)

PROJECT/SCHEME DESCRIPTION	PLANNED BUDGET(£)	LINK TO ICF PRINCIPLES eg Prevention and Alternative Delivery Models, Supporting Independence	Link to National Outcomes Framework	ANTICIPATED IMPACT	KEY DELIVERY MILESTONES	Additional resources if applicable
TBC	**£184,000.00**	**TBC**	**TBC**	**TBC**	**TBC**	
TOTAL	**£184,000.00**					