Integrated Care Fund Project Proposal Form - Revenue

**Llywodraeth Cymru
Welsh Government**

Project Overview

Region: West Wales - Pembrokeshire	**ICF Project name:** Clinical Falls Coordinator

Project start date: April 19 (subject to recruitment)	**WG ref:**	**Project completion date:**

Is this project linked to an ICF capital project?   N

Is this project linked to the Dementia Action Plan funding?   Y/N *delete as appropriate*

What is the primary focus (1) and secondary (2) focus of the project are you proposing? * *please mark 1 and 2 as appropriate*

Children's/young carers projects		Adults/Carers projects		Regional Capacity building/Infrastructure	
Information/Advice/Awareness raising		Information/Advice/Awareness raising		Regional Partnership Board Development	
Access to Services/single point of access/transport		Access to Services/single point of access	1	Regional Workforce development/training	
Assessment and diagnosis		Assessment and diagnosis	2	Regional Programme management and evaluation	
Social Prescribing		Social Prescribing		Regional/Integrated planning and commissioning	
Early Help and Prevention		Early Help and Prevention		Regional Support for Social Value Sector Engagement	
Emotional Health and Wellbeing		Emotional Health and Wellbeing/loneliness and isolation		Regional support for Citizen/carers engagement	
Edge of Care support		Stay at home/return home		Other – (please specify below)	
Family Group Conferencing approach		Integrated Community Teams			
Family re-unification		Step up/down from hospital			
Therapeutic intervention		Intermediate Care/ pathway			
New accommodation/ residential solutions		New accommodation/ Residential solutions			
Other (please Specify below)		Other (please Specify below)			

ICF Project Description (*brief description using theory of change model*):

*1 - **What is the problem you are trying to solve?*** Despite the presence of a range of falls support service across key stakeholders, the current gap in falls management coordination has resulted in no clear pathway for patients who have or who are at risk of falling to access the appropriate support in the timeliest manner to meet their needs.

*2 - **What long-term outcome/change are you hoping to achieve?*** A robust, integrated falls pathway that helps identify, risk stratify and manage people at risk of falls or who have fallen, reduce hospital admissions and readmissions, providing a rapid response in people's homes to maintain independence and support earlier identification of physical and mental health needs, including symptoms of dementia.

*3 - **Who is your key audience?*** "Older people with complex needs and long term conditions" - It is highly likely that the majority of people requiring support will be over 65: currently at risk of falls, demonstrating symptoms of frailty, have poor mobility, presenting with multiple conditions and those patients requiring medication review.

*4 - **How will you reach them?*** Recent engagement events have shown that the development of a falls pathway is one of the top three priorities identified by stakeholders to better support the population of Pembrokeshire. GP Clusters, WAST, Local Authority, Fire Services, Acute, Community and Primary Care Services all agreed that there is a clear demand for a Falls Pathway which once established and operational would be fully utilised by all services and staff supporting older people in the community.

5 – What resources are available to support? In Pembrokeshire, there are already specialist teams who will be able to provide easy access to information and data for potential patients. In addition, there are geriatric consultants who will be able to provide clinical supervision, existing GP falls registers in the county and a therapy falls task force who can contribute to the development of the pathway.

6 - What activities will bring about the change?

- Recruitment of: 1.0 WTE Falls Co-Ordinator Band 4

    2.0 WTE Falls Clinical Assessors (Therapist or Nurse) Band 7

    1.0 WTE Falls Health Care Support Worker Band 3
- Scoping and mapping of existing services
- Agreement of how to address gaps identified
- Setting up a falls steering group

How does your project address your population needs assessment and area plan? Across Wales, it is accepted that services for older people need to change to match the predicted future demand. The WWCP population needs assessment highlights that this population increase will result in significant and increasing pressure on acute services as the risk of being admitted to hospital increases with age; a problem exacerbated by the rural nature of Pembrokeshire with often frail older people living in isolated communities with minimal support.

The recruitment of a Clinical Frailty Coordinator will provide the capacity to join up existing services into an integrated falls pathway. This meets the following WCCP Area Plan overarching theme eight:

*"**OR8** We need an integrated approach to commissioning and delivery of services and should look to pool resources where possible to ensure we make best use of available budgets and join services up at the point of delivery"*

What level of 'prevention/Intervention' (continuum) best describes your project? *please tick as appropriate*

Self Help, Information and Advice	Early Help and support	Intensive Support	Specialist Intervention
✓	✓		✓

Project Costs

YEAR ONE	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total Cost
Direct delivery costs -					
Staffing	£37,500	£37,500	£37,500	£37,500	**£150,000**
Overheads (heat, light, rent etc)	**£1,500**	**£1,500**	**£1,500**	**£1,500**	**£6,000**
Resources/activity costs					
Equipment/IT					
YEAR TWO	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total Cost
Direct delivery costs -					
Staffing	£37,500	£37,500	£37,500	£37,500	**£150,000**
Overheads (heat, light, rent etc)	**£1,500**	**£1,500**	**£1,500**	**£1,500**	**£6,000**
Resources/activity costs					
Equipment/IT					

Project Delivery

Delivery partners	
Local Authority	
Health Board	✓
Third Sector/Social Value sector	
Private/Independent sector	
Housing Association/RSL	
Other (pls specify below)	

Project budget holder	
Local Authority	
Health Board	✓
Third Sector/Social Value sector	
Private/Independent sector	
Housing Association/RSL	
Other (pls specify below)	

Project geographical footprint	
Regional	
Sub-regional	
Multiple regions	
Local Authority	✓
Local community	

Project Beneficiaries (*pls check boxes as appropriate*):

Primary beneficiaries	
Older people	✓
People with learning disabilities	
Children with complex needs	
Children at risk of becoming looked after	
Care experienced children including adopted children	
Carers	
Young Carers	
People with dementia	

Secondary beneficiaries	
Older people	
People with learning disabilities	
Children with complex needs	
Children at risk of becoming looked after	
Care experienced children including adopted children	
Carers	✓
Young Carers	
People with dementia	

Other beneficiaries	
Older people	
People with learning disabilities	
Children with complex needs	
Children at risk of becoming looked after	
Care experienced children including adopted children	
Carers	
Young Carers	
People with dementia	

Project Design Principles (*pls check boxes as appropriate*):

Which of the 'A Healthier Wales' Quadruple aim/s does this project **primarily** address?

Improved health and wellbeing	
Better quality and more accessible health and social care service	✓
Higher value health and social care	
A motivated and sustainable health and social care workforce	

Which of the 'ten national design principles' from A Healthier Wales will the project address?

Prevention & Early Intervention	✓
Safety	
Independence	
Voice	
Personalised	
Seamless	✓
Higher Value	
Evidence Driven	
Scalable	
Transformative	

With voice and co-production as key principles, tell us who you have engaged with in the design of your projects

Service users (adults)	
Service users (Children/young people)	
Carers	
Young carers	
Workforce	
Social Value/third sector	
Community members	
Other:	

Project outcomes and impacts

What Population level indicators/measures is your project seeking to address? * *please select from national outcome/performance management framework*

- Citizens understand what care, support and opportunities are available and use these to help them achieve their well-being
- Citizen's individual circumstances are considered
- Citizens get the right care and support, as early as possible

Tell us how you will measure/understand the impacts of your project?

How Much? (outputs)	How Well? (quality)
Theme 2: - Number/percentage of supported turnaround at the front door of acute hospitals -	- We will use case studies and the Most Significant Change (MSC) technique for gather stories to details the experiences of service users and staff.

Difference made? *(impact)*

- Citizens understand what care, support and opportunities are available and use these to help them achieve their well-being
- Citizen's individual circumstances are considered
- Citizens get the right care and support, as early as possible

Tell us how you intend to evaluate the following aspects of your project (*please refer to ICF guidance*)

Impact Evaluation *(How will you measure/understand the outcomes that have been achieved by your project?)*	
Process Evaluation *(How will you evaluate the system & process changes delivered by your project e.g. integration, co-production, social value?)*	The initial mapping and scoping exercise will provide a baseline to measure future progress against.

Economic Evaluation *(How will you evaluate the cost benefits/cost avoidance delivered by your project?)*	Admission avoidance rates due to the successful implementation of the falls pathway will provide data that can be calculated to develop cost benefits of the project.
Qualitative Evaluation *(How will you capture the experiences of service users/staff/communities?)*	We will use case studies and the Most Significant Change (MSC) technique for gather stories to details the experiences of service users and staff.

Exit Strategy

Tell us about your exit strategy for the project (post 2021):

This project is for a fixed term coordinator to develop and implement a clear falls pathway joining up existing services in the community. Once the pathway is established, it will link with the Transforming Clinical Services ambition for providing more support in the community whilst also becoming a core part of the intermediate care response in the county.

Project contact details

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