Integrated Care Fund Project Proposal Form - Revenue

Llywodraeth Cymru
Welsh Government

Project Overview

Region: West Wales (Carms)	**ICF Project name: Workstream 3 – 3.1 Crisis Response (Int Care)**	
Project start date: April 1st 2019	WG ref:	**Project completion date: March 31st 2021**

Is this project linked to an ICF capital project? N
Is this project linked to the Dementia Action Plan funding? Y

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

Information/Advice/Awareness raising	
Access to Services/single point of access/transport	
Assessment and diagnosis	
Social Prescribing	
Early Help and Prevention	
Emotional Health and Wellbeing	
Edge of Care support	
Family Group Conferencing approach	
Family re-unification	
Therapeutic intervention	
New accommodation/ residential solutions	
Other (please Specify below)	

Adults/Carers projects

Information/Advice/Awareness raising	
Access to Services/single point of access	
Assessment and diagnosis	
Social Prescribing	
Early Help and Prevention	
Emotional Health and Wellbeing/loneliness and isolation	
Stay at home/return home	1
Integrated Community Teams	
Step up/down from hospital	2
Intermediate Care/ pathway	3
New accommodation/ Residential solutions	
Other (please Specify below)	

Regional Capacity building/Infrastructure

Regional Partnership Board Development	
Regional Workforce development/training	
Regional Programme management and evaluation	
Regional/Integrated planning and commissioning	
Regional Support for Social Value Sector Engagement	
Regional support for Citizen/carers engagement	
Other – (please specify below)	

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

1 - What is the problem you are trying to solve? Develop a Clinically led, Crisis Response to extend and enhance the current range of intermediate care services for Carmarthenshire patients (with a focus on frailty, aged 75+ years) to avoid hospital admission and support timely discharge back to the community.

2 - What long term outcome/change are you hoping to achieve? Aiming to treat at home, 25% of the patients currently admitted to hospital for unscheduled care will be treated at home instead.

3 - Who is your key audience? Frail Older People aged 75+

4 - How will you reach them? Receive referrals from Primary Care, Community Nursing & WAST through a single point of access & clinical triage within

5 – What resources are available to support? Funding from ICF if approved, Cluster funding, Transformation Funding (applied for) Core Funding from both Health & Social Care, ICF Dementia funding & Health Board Annual Plan key actions funding to support clinical strategy.

6 - What activities will bring about the change? Develop a new Geriatrician/GP-led Crisis Response service, providing intensive multi-disciplinary assessment, diagnostics and treatment at home for between 48 hours and 7 days, to avoid a hospital admission.

How does your project address your population needs assessment and area plan? PA: The WW Population Assessment demonstrates a significant rise in the over 65 demographic over the next 20 years. With this increase comes more people with chronic conditions, frailty & dementia with multi-pathology. We know that older people who are admitted to hospital de-condition immediately and their independence declines rapidly.

AP : OR2 – Maintain independence through provision of targeted support the prevents the need for people to be admitted to hospital or long term res care or, supports timely discharge

What level of 'prevention/Intervention' (continuum) best describes your project? **please tick as appropriate (all apply but this is the primary focus)*

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

Project Costs (not including ICF Dementia funded posts)

YEAR ONE	***Quarter 1***	***Quarter 2***	***Quarter 3***	***Quarter 4***	***Total Cost***
Direct delivery costs -					
Staffing	***154,985***	***154,985***	***154,985***	***154,985***	***619,940***
Overheads (heat, light, rent etc)					
Resources/activity costs	***45,864***	***45,864***	***45,864***	***45,864***	***190,000***
Equipment/IT					
YEAR TWO	***Quarter 1***	***Quarter 2***	***Quarter 3***	***Quarter 4***	***Total Cost***
Direct delivery costs -					
Staffing	***156,485***	***156,485***	***156,485***	***156,485***	***625,940***
Overheads (heat, light, rent etc)					
Resources/activity costs	***45,864***	***45,864***	***45,864***	***45,864***	***190,000***
Equipment/IT					

Project Delivery

Delivery partners

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

Project budget holder

Local Authority	x
Health Board	x
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	x
Local community	

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

Primary beneficiaries

Older people	x
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	x

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	x
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	X
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	x
Voice	
Personalised	
Seamless	x
Higher Value	
Evidence Driven	x
Scalable	x
Transformative	x

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

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

1. ***Timely intervention to prevent crisis***

- Rapid response to an episode or crisis; assessing, treating and or supporting people at home wherever possible, working closely with partners (standard for response is 2-4 hours)
- Enabling people to be as independent as possible through providing services and support that are proportionate to need

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

How Much? *(outputs)*	***How Well?*** *(quality)*
• No of hospital admissions avoided (Avoiding hospital admission for up to 1500 patients aged 75+ per annum) • Reduce average LOS for patients aged 75+ supported by the service compared to similar patients who remain in the hospital • Number of discharges supported within 72 hours • Reduction of 15,000 bed days in PPH and GGH • Reduction in A&E conversion rate for emergency admissions for people aged	• % of re-admissions avoided • Improve the patient experience, especially those with a cognitive impairment whose well-being can be negatively impacted by a hospital stay. • Improve Mortality rates of Service Users • Improve care needs of service users on discharge – eg reduce care package following right sizing process through Bridging Service • Patient/Carer Experience

Difference made? *(impact)*

- Support people age 75+ to maintain their independence at home and reduce their care needs on discharge from the service.

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?)*	• Number of hospital admissions avoided • Number of discharges supported within 72 hours • Number of emergency bed days (reduction) • Length of stay of service users treated at home/ time spent at home
Process Evaluation *(How will you evaluate the system & process changes delivered by your project e.g. integration, co-production, social value?)*	• Conversion rate from A&E attendances to emergency admissions for over 75s • Readmissions of service users
Economic Evaluation *(How will you evaluate the cost benefits/cost avoidance delivered by your project?)*	Using a number of methods including: • Planned closure of two wards in acute hospital sites (£1,488,000 per annum full year costs)
Qualitative Evaluation *(How will you capture the experiences of service users/staff/communities?)*	Developing: • Patient and carer experience / satisfaction • Care needs of service users on discharge • Mortality rates of service users • Case studies

Exit Strategy

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

The implementation of this model is a key feature of the HB's TCS strategy, the planned closure of the acute wards are completed and funds transferred into Community to maintain service in line with TCS.

Project contact details

Project key contact (name):	Debra Llewellyn
Email address:	dllewellyn@carmarthenshire.gov.uk
Telephone:	01267 234567