Integrated Care Fund Project Proposal Form - Revenue

Llywodraeth Cymru
Welsh Government

Project Overview

Region: West Wales (Carms)	**ICF Project name: Workstream 3 – 3.3 Non-Crisis Intermediate 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	3
Integrated Community Teams	
Step up/down from hospital	2
Intermediate Care/ pathway	1
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 Home Based intermediate care to extend and enhance the current range of intermediate care services (including Reablement) to avoid hospital admission and support timely discharge back to the community, and to avoid admission to a care home.

2 - What long term outcome/change are you hoping to achieve? Better outcomes and levels of independence for older people requiring non-specialist rehabilitation for the following types of conditions: Cardiac; Pulmonary; Cancer; Stroke; Neuro; Lymphoedema; Musculoskeletal; Weight management.

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

4 - How will you reach them? Receive referrals from hospital wards, GPs, Community Nursing, Domiciliary care providers, family and self-referrals.

5 – What resources are available to support? Funding from ICF if approved and Core Funding from both Health & Social Care.

6 - What activities will bring about the change? Re-configure existing and additional resources to develop a new multi-disciplinary Home Based intermediate care service, providing multi-disciplinary assessment, symptom management through therapies input and monitoring at home for 6 - 12 weeks, complementing existing Reablement service.

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

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	***199,309***	***199,309***	***199,309***	***199,309***	***797,235***
Overheads (heat, light, rent etc)					
Resources/activity costs					
Equipment/IT					
YEAR TWO	***Quarter 1***	***Quarter 2***	***Quarter 3***	***Quarter 4***	***Total Cost***
Direct delivery costs -					
Staffing	***201,302***	***201,302***	***201,302***	***201,302***	***805,208***
Overheads (heat, light, rent etc)					
Resources/activity costs					
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	x
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	
Higher value health and social care	x
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	x
Seamless	x
Higher Value	x
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

Maximising people's time spent in their home of choice

1. To devise an individual plan for short term support to meet agreed outcomes (what is important to them).
2. To make arrangements to deliver the individual plan.
3. To monitor the service user's progress against the agreed outcomes and revise the plan if required.
4. To discharge the service user from the home-based service and record their outcomes.

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

How Much? *(outputs)*	***How Well?*** *(quality)*
• No. of care home placements reduced • Reduce average LOS for patients aged 75+ • Support people age 75+ to maintain their independence at home and reduce their care needs on discharge from the service. • No. of patients requiring specialist rehab reduced • Patient and carer satisfaction	• Improve the patient experience, especially those with a cognitive impairment whose well-being can be negatively impacted by a hospital stay.

Difference made? *(impact)*

- Support people age 75+ to maintain their independence at home and reduce their long term 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?)*	• Better management of patients' symptoms resulting in reduction in caseload for specialist rehab and step-down of patients to community based services to maintain their level of function
Process Evaluation *(How will you evaluate the system & process changes delivered by your project e.g. integration, co-production, social value?)*	• Integrated, multi-disciplinary working for a wide range of conditions on an individual and group basis
Economic Evaluation *(How will you evaluate the cost benefits/cost avoidance delivered by your project?)*	• Reduction in hospital admissions for chronic conditions
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 • Improved Therapy Outcome Measures (TOM) of service users • Case studies

Exit Strategy

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

The implementation of this model is in line with national guidance on intermediate care services and the benefits to the target population should be demonstrated to be consistent with the HB's TCS strategy of "growing the green" in the community.

Project contact details

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