Integrated Care Fund Project Proposal Form - Revenue

Llywodraeth Cymru
Welsh Government

Project Overview

Region: West Wales	**ICF Project name:** Safe and Steady Clinic	
Project start date: 1st April 2019	WG ref:	**Project completion date:** 31st March 2021

Is this project linked to an ICF capital project? N

Is this project linked to the Dementia Action Plan funding? N

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	3
Access to Services/single point of access	
Assessment and diagnosis	2
Social Prescribing	4
Early Help and Prevention	1
Emotional Health and Wellbeing/loneliness and isolation	
Stay at home/return home	
Integrated Community Teams	
Step up/down from hospital	
Intermediate Care/ pathway	
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? *To reduce the risk and rate of harm from falls in the adult population of Ceredigion. To proactively promote holistic wellness in adults by intervening early through the use of predictive markers to limit and where possible prevent the advance of frailty. To enable and foster a culture of meaningful holistic rehabilitation throughout the county based on prudent healthcare principles and meeting the challenge of spread (Health Foundation, 2018). Supporting the move towards a more social model of care in Wales.*

2 - What long term outcome/change are you hoping to achieve? *Reduction in number of hip and other fragility fractures in the adult population; Reduction in use of secondary care services; Increase in social engagement in the adult population at risk of falls; Development of predictive tools to identify older people in frailty transition in order to most effectively intervene early, in a coordinated, joined-up way.*

3 - Who is your key audience? *Older adult population, particularly those living with frailty or advancing along frailty spectrum.*

4 - How will you reach them? *By collaboration with partners across health, social care and third sector such as hospital services, Red Cross, WAST, GPs, other health and social care professionals, community groups, support groups, Town Councils and information providers such as DEWIS, 111 and Info Engine etc. to facilitate access to the service. Promoting an inclusive service with the use of simple and standardised case identification and referral tools.*

5 – What resources are available to support? *DEWIS, 111 and Info Engine.*

6 - What activities will bring about the change? *The Advanced Practitioner (AP) falls Physiotherapist role brings a unique set of skills including sensemaking which allows identification of rehabilitation potential in older people at risk of falls. The AP can recognise and care for patients who require the medical model of care, with support networks existing with the local Consultant Ortho-geriatrician. Also uniquely, the falls AP Physiotherapist can identify the need for an asset-driven approach, facilitating community connectivity and the "shift-left". In this way the AP can turnaround people who don't need a medical model of care, making prudent use of community resources.*

Specifically:

Using predictive markers to analyse causes of falls; identification of prognostic markers to guide prudent care planning; development of useable tools for coordinated early identification of risk factors for falls; first point-of-contact Advanced Clinical Practitioner clinics to plan holistic and meaningful wrap-around care centred on patient and based on need. Delegation of work across the health and social care system. The service will also provide medicines review and de-prescribing of medicines where possible and appropriate.

How does your project address your population needs assessment and area plan?

The proportion of older people in West Wales is higher than the Wales average. The service is proactive, aiming to identify those adults in transition on the frailty spectrum and intervening now via advanced clinical assessment and practice to reduce the risk of falls and frailty-related problems in the future, The project aims to first identify and then intervene to meet people's needs before they reach crisis point in common with the WWCP's Area Plan theme of Prevention.

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 -	***£26,412***	***£26,412***	***£26,412***	***£26,412***	***£105,648***
Staffing	***£26,412***	***£26,412***	***£26,412***	***£26,412***	***£105,648***
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 -	***£26,412***	***£26,412***	***£26,412***	***£26,412***	***£105,648***
Staffing	***£26,412***	***£26,412***	***£26,412***	***£26,412***	***£105,648***
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	x
Private/Independent sector	x
Housing Association/RSL	x
Other (pls specify below)	

Project budget holder

Local Authority	
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	
Local community	x

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	
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	x
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	x
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	x
Young carers	
Workforce	x
Social Value/third sector	x
Community members	x
Other:	

Project outcomes and impacts

What Population level indicators/measures is your project seeking to address?

Number of people seen in Safe and Steady Clinic

Number of onward referrals made to provider partners across health, social care and third sector

Number of patients with reduced fear of falling on follow-up review

Number of patients with hip fractures (NHFD)

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

How Much? *(outputs)*	***How Well?*** *(quality)*
• Number of people seen in clinic • Number of onward referrals made to provider partners • % of patients seen using secondary care services in following 6 months • Number of patients referred to NERs PSI • Number of patients attending the NERs PSI programme	• *% people with reduction in fear of falling on follow-up review* • *% people reporting the service as good or excellent on experience measurement*
Difference made? *(impact)* • Citizens remain well at home or in their community for longer reducing dependencies. • Citizens use secondary care emergency and crisis services less. • Citizen's individual circumstances are considered encompassing what maters to you conversations. • Citizens understand what care, support and opportunities are available and use these to help them achieve their well-being. Supporting an empowering culture within our communities.	

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?)*	• ***Database analysis of quantitative data (i.e. fear of falling, balance, gait and mobility measures, falls, secondary care service usage)*** • ***Benchmarking against Regional and National data*** • ***To explore a financially viable means of measuring quality-adjusted life years (QALY) through patient-reported outcome measurement***
Process Evaluation *(How will you evaluate the system & process changes delivered by your project e.g. integration, co-production, social value?)*	• ***Project steered by Ceredigion Strategic falls group and County steering group*** • ***Review of service specification*** • ***Mentorship with Consultant Ortho-geriatrician***
Economic Evaluation *(How will you evaluate the cost benefits/cost avoidance delivered by your project?)*	• ***Analysing available local /regional and national data including secondary care service usage*** • ***Reviewing impact on other services as a result of project*** • ***To explore a viable means of monitoring cost-per-QALY via patient-reported outcome measurement***
Qualitative Evaluation *(How will you capture the experiences of service users/staff/communities?)*	• ***Patient-reported experience measure*** • ***Video patient stories and case studies***

Exit Strategy

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

The service aims to be sustainable through transformation of staffing profiles and skill mix review in the Physiotherapy / podiatry service; specifically, developments in primary care, greater emphasis on preventative care and public health and joint working; Funds will be shifted to sustain the service through transformation of core staffing structures. This work will be considered core in the values based clinical lead workstreams.

Project contact details

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