



Integrated Care Fund 2018/19

Project Brief

Project Title	Community Prevention in Carmarthenshire <i>(PEIPL) Prevention – Early Intervention – Supporting Independent Living</i>
Is this a new project or continuation?	Continuation
Which ICF theme does it align with?	Preventions/Alternative Delivery Models
Regional Project Lead/Link Representative	Joanna Jones
Local Authority Project Lead/Leads and/or Link Representative/ Representatives	Julia Wilkinson
HUHB Project Lead/ Link Representative	Julia Wilkinson
Third Sector Project Lead/ Link Representative	Jackie Dornan / Annie Fazackerly

- 1. Background/Rationale:** *(No more than 300 words, including how your proposal (1) tests alternative delivery concepts (2) links with local strategies and plans such as Transforming Clinical Services; Integrated Medium Term Plan; Well Being Plans etc. (3) contributes to regional priorities and (4) supports delivery of objectives within the West Wales Area Plan.)*

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.

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.

This project ensures that the third sector remains integral to the strategic planning and delivery of the overall aim to co-produce preventative services, support independent living, strengthen community resilience and reduce the need for statutory interventions as developing preventative services has been identified as a key priority of the **West Wales Care Partnership** and supports delivery of the West Wales Area Plan.

The West Wales Population Assessment 2017 highlights the need to develop preventative measures so that individuals can take care of themselves, access information and low level support when needed, and remain independent for as long as they choose to be. Activities delivered will encourage volunteering, increase participation, signpost to information and assistance, and enhance community-based support to prevent social isolation and promote independence. The aim is to provide the opportunity for voluntary and community groups to test out new community-based care and support models. This will contribute to developing a greater diversity of public services, identified as a key aim in the West Wales Population Assessment.

The **PEIPIL** programme brings a clear strategic framework around community based preventions and links preventative activities to the tiers of offer as outlined in Carmarthenshire's Vision for Sustainable services.

These are:

1) Prevention: To provide help to help yourself

These are activities aimed at individuals who have no current particular health or care needs, though they obviously may use them. These are largely universal activities and are fundamental to overall success of the other two types of prevention.

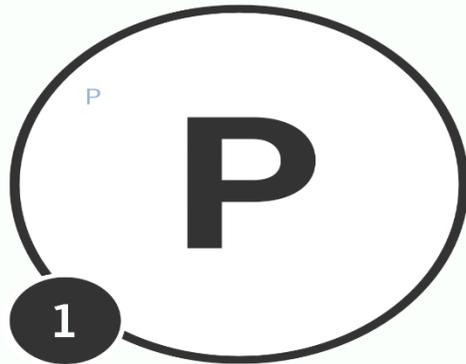
2) Early Intervention: To provide help when you need it which may reduce the impact of illness or disability. These are more targeted interventions aimed at individuals who have an increased risk of developing needs, where support may prevent needs from developing or help slow down deterioration.

3) Promoting Independent Living: To provide ongoing specialist help to effectively delay dependency

This is aimed at minimising the effect of disability or deterioration for people with established health conditions, complex care and support needs. The aim is to minimise the impact of disability and to reduce deterioration.

The work streams are also aligned to the 3 tiers of prevention as identified by public health which are; prevent, reduce and delay which ensures that the work is congruent across different sectors and with all stakeholders.

3 Ways of Working



Prevention, for help to help yourself.



This work focuses promoting well-being, for anyone who wants to be as well as they can be and aims to prevent ill health and disability, as well as supporting all other levels of prevention.



Early Intervention, for help when you need it.



This work looks at activities that support people at risk because of particular issues, where this help aims to reduce the impact of disability and ill health, prevent needs from developing further, to slow down deterioration and regain independence.



Promoting Independent Living, for ongoing specialist help.



This work aims to ensure that wellbeing and independence is maximised, managing the effect of disability or deterioration for people with established health conditions and/or complex care and support needs, to delay dependency for as long as possible.

Tier 1: Prevention aims to:

- Encourage and support kindness & connection through addressing loneliness and isolation
- Promote community and individual strengths and assets
- Ensure that communities are age, disability and dementia friendly
- Encourage active community engagement

We will do this by:

Carmarthenshire is Kind

This is a programme of work based on an information session that raises awareness about the importance and benefits of kindness. It shares 5 key messages and gives evidence about the positive effects of kindness for health and wellbeing. We are recruiting Carmarthenshire Friends as part of this initiative who will be champions of kindness and connectivity in their communities.

Dementia and age friendly communities

We support and recruit dementia friends as well as work with communities and third sector to promote DFC. We promote the 8 domains that promote age friendly communities and link this work with dementia friendly communities and the Ageing Well Plan.

Community Resilience Co-ordinators

We have designated workers in Carmarthenshire that directly support community connection; ensuring that there is a good mix of provision to give people opportunities to join in and contribute, to deliver practical support to maximise community networks.

Dewis

The online information portal about well-being with information about local organisations and services that can help.

Connected Communities Funding

A small grants scheme of up to £500 which supports community-based projects that aim to develop locally-led innovative projects which improve the resilience of local communities and individuals to build and stimulate social capital. It offers small grants to voluntary and

community groups and social enterprises, but not individuals or private sector businesses. It provides an opportunity to invest in developing community-based preventative services that strengthen community resilience, and improve individual and community well-being.

SPICE Time Banking

Time Credits work very simply: for every hour that an individual contributes to their community or service, they earn one Time Credit. This Time Credit can be spent accessing an hour of activity provided by corporate and community partners, or gifted to others.

Tier 2: Early Intervention aims to:

- Work with the voluntary sector and communities to offer the right advice and support to remain independent for as long as possible.
- Deliver the right type of support to encourage independence; personal and community resilience.
- Use the voices of the people we support to improve the way we commission and deliver services

We will do this by:

CUSP Carmarthenshire's United Support Project

Carmarthenshire United Support Project (CUSP) is a collaborative based commissioning project in the third sector. It aims to provide support to people who are 'on the cusp' of needing statutory care and provide a co-ordinated community response to keep people well and independent. It refers into statutory care at the 'right time – to ensure that the right support is delivered at the right time.

Home from Hospital

The home from hospital discharge scheme helps patients leave hospital when their medical and nursing needs have been met. It provides them with emotional and practical support immediately after discharge to ease the transition from hospital to home. It also can refer to CUSP to ensure the right community and third sector engagement for ongoing practical support.

Third Sector Funding Scheme

A grant scheme that supports intelligent commissioning of community-based third sector projects that aim to:

- Deliver or enhance locally-led projects based on need identified through CUSP

- Improve care coordination between social services, health, housing, third and independent sectors
- Focus on preventative care and to avoid unnecessary hospital admission or entry into statutory services.

Social Prescription: Living well no matter what

Spice is working with GP Clusters on an innovative Time Credits social prescribing programme. Social Prescribers are active across the seven GP practices in the Llanelli area and will be extended to the 3Ts, working with patients to improve patient health and well-being through spending and earning Time Credits. The programme has been designed to work with a specific patient demographic that includes older people, regular attendees, patients living with chronic pain conditions and people with low level anxiety and depression.

Tier 3 prevention – no specific funding is requested for tier 3 services but resources identified from the previous tiers will be utilised to ensure that this level is effective.

2. Outcomes: Please list which of the outcomes from the regional outcomes framework attached will your proposal contribute towards and how it will do so (minimum of 1, maximum of 3.)

Regional Outcome(s)	Description of how your proposal will meet the Outcomes(s)
Staying well and independent in the community	<p>The 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.</p> <p>Individuals supported within these projects are provided with comprehensive information so that they are aware of what care and support opportunities are available.</p> <p>Within the programme, projects all work to support the development and population of DEWIS.</p>
Promoting independence – ‘Step up my care’ Preventing admission to hospital & discharge at ‘front door’	<p>The 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 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.</p>
Promoting independence – Efficient discharge from hospital and ‘continue to care for me’	<p>The Home from Hospital service also provides individuals with low-level support to help them return home from hospital, in a planned way, sooner than would otherwise be possible.</p>

3. Implementation Timescales – please indicate the following:

When will project development commence?	The projects are all fully developed
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When will initial expenditure commence?	1 st April 2018
When will staff recruitment commence (if required)?	Staff are in post – no staff recruitment required
When will project delivery commence?	All of the projects are currently being delivered and this will continue throughout 2018/19 subject to funding
Expected date of completion of project concept testing	
Expected date of project review/embedding learning into mainstream practice or termination	It is anticipated that decisions will be taken during the year on how the activities can be embedded in mainstream practice, based on the Integrated Intermediate Care Strategy , which is currently in development

4. Amount Requested (*include detailed breakdown of costs and if revenue or capital*)

£3,000	Carmarthenshire is Kind
£66,028	Community Resilience Co-ordinators x 2
£87,000	Enhanced Home from Hospital
£82,000	CUSP
£40,000	Caring Communities Innovation Grant
£20,000	Dewis
Total:	£298,028

5. Proposed Performance Indicators: *(What will it enable you to achieve in addition to what you are doing now. i.e. how many additional participants/outcomes? Please refer to ICF 17/18 C)*

Performance Indicators	
How much will you do? (Quantity)	How well will you do it? (Quality)
<ul style="list-style-type: none"> • 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 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 Dewis • Number of hits on Dewis website, from Carmarthenshire • No of people provided with community based intermediate care services following a hospital stay or community referral • No of supported discharges at the front door of acute services 	<ul style="list-style-type: none"> • % of people who rate the service as excellent or good • % of people reporting that they are able to do the things that matter to them • % people reporting satisfaction with Dewis • % of people reporting that they are able to do the things that matter to them • % of people who feel that they belong to their local area • % of people reporting a reduction in overall emotional and social loneliness • % of people reporting the things they do in life are worthwhile • % of people who volunteer/part of time bank

How will people be better off as a result? (Quality and Quantity of effect)

- 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
- 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

6. Sustainability: *After testing and review, how will successful concepts be incorporated into either mainstream delivery, IMTP, TCS, Area Plan or Well-Being developments and what is the exit strategy? (no more than 100 words)*

The PEIPIL programme is vital to ensuring that communities are fully engaged in the strategic planning, co-design and delivery of preventative services that impact positively on individual and community well-being. The programme helps statutory partners deliver their statutory duties under the Act and to meet their stated strategic aims to build resourceful communities and reduce the need for statutory interventions.

It is anticipated that the work will contribute to outcomes identified in the IPOP framework and evidence value and as such become embedded as mainstream and funded accordingly from health and social care budgets.

What are the implications if this business case is not supported?

If the business case is not supported, then all the services currently delivered within the PEIPIIL programme will either be withdrawn or significantly reduced. This will have a significant negative impact on our ability to contribute to the further development of preventative services, and the broader health, social care and well-being policy agenda at both local and regional level.

The PEIPEL work has attracted other funding sources such as £30k public health primary care funding and the effectiveness of this work will be compromised.

Failure to support this business case will also mean that the third sector/communities will not be involved in the ICF investment plan in Caramrthenshire. This goes completely against the wish of Welsh Government to see the third sector receiving a greater share of ICF funding in relation to developing new service delivery models and promoting social enterprise.

If the business plan is not supported, it should be noted that transition funding will be needed to manage the 3-month notice period that will be required to close down the CUSP and Hone from Hospital service.

Please provide supporting evidence of engagement with key stakeholders, in the development or delivery of the project, particularly 3rd sector and community partners when alternative delivery concepts are being tested.

CAVS co-ordinates delivery of the CUSP programme, holding regular project management meetings with key stakeholders.

Reports on service delivery are made to appropriate partnerships including the local ICF management group.

Referrals are made to a wide range of third sector organisations. Feedback from service users is collated and reviewed in order to continuously improve service delivery.

