West Wales Care Partnership
Partneriaeth Gofal Gorllewin Cymru

Integrated Care Fund 2018/19
Project Brief

Project Title	Home from Hospital (HFH) Carmarthenshire –Enhanced Seven Day Service
Is this a new project or continuation?	ICF funding will ensure the continuation of an enhanced BRC home from hospital service that is able to provide support over the weekends in addition to the core and contracted five day service. During commencement Feb 17 – Dec 17, 147 individuals received support during the weekend which otherwise may of needed to remain in hospital. During this period 336 weekend visits were made. Through this enhanced service provision the service will be able to ensure the safe and timely discharge from hospital of individuals who require a daily support package in order to safely return to their own home setting.
What alternative delivery concept is being tested?	Provision of weekend support for individuals is already being delivered and incorporated into our existing 5 day service. The model is to deliver a more responsive service that can support the continuing demands of the national health service.
In which financial year will the project complete testing of concept?	If continuation funding is unsuccessful then the 7 day element of the service will cease end of March 18.
Which ICF theme does it align with?	Older People
Regional Project Lead/Link Representative	
Local Authority Project Lead/Leads and/or Link Representative/ Representatives	Joanne Jones
HDUHB Project Lead/ Link Representative	Julia Wilkinson
Third Sector Project Lead/ Link Representative	British Red Cross – Annie Fazackarley – Independent Living Operations Manager

1. **Background/Rationale:** *(No more than 300 words, including how your proposal (1)* ***tests alternative delivery concepts*** *(2) l****inks with local strategies and plans such as regional priorities*** *and (4)* ***supports delivery of objectives within the West Wales Area Plan.****)*

Our proposal will enable the continuation of an enhanced home from hospital service that will be able to provide support (including personal care support) over the weekends for individuals whose safe discharge from hospital is conditional on them being able to receive a daily care package.

In doing so the proposal is aligned to and supports many of the priorities and recommendations that are outlined in the West Wales Population Assessment. These include the following:

- The provision of appropriate and efficient intermediate care services including rapid response care and support… and supported discharge schemes in which the third sector can play a major role
- Help when people need it including rapid access to domiciliary care provision
- Care and support designed to support people to regain their previous level of independence after an illness or injury, including reablement & rehabilitation at home
- Improving the availability of rapid response services for older people who have a short term need

The proposal also supports the overarching prevention theme by enabling people to return to a state of independence following a stay in hospital and empowering them to sustain that independence (and in doing so reduce their risk of readmission) through signposting/referral to more long term community based support solutions.

The proposal equally supports many of the priorities outlined in the West Wales Care Partnership Regional Outcomes Framework. These include:

- The need for citizens to get the right care and support, as early as possible
- The importance of citizens understanding what care, support and opportunities are available to help them maintain their well-being
- Ensuring that citizens are safe and protected from abuse and neglect

Commitment to citizens being able to speak for themselves and contribute to the decisions that affect their life.

2. **Purpose: What will you do and how will you do it?** *The proposal should support at least one of the aims identified within the Welsh Government* Guidance *for use of the ICF. Please outline how your service would meet a particular Aim (or Aims).*

ICF Aim	Description of how your proposal will meet the Aim(s)
This proposal for funding to enable the seven day provision of the BRC Home from Hospital service to continue is in line with the following general principles and aims of ICF: i. Focus resources and increase capacity of care coordination or rapid response schemes (such as community resource teams) and the pace at which they are developed, to better meet demand and improve equity of access to services; ii. establish a more proactive approach, seeking to identify those people at risk of becoming 'stuck' within secondary care with a resulting impact upon their ability to return to independent living; iii. establish preventative intervention to help avoid unnecessary hospital admissions or inappropriate admission to residential care as well as preventing delayed discharges from hospital; iv. increase the capacity of reablement and rapid response services to better meet demand (including night time and weekend services);	Our proposal, which will see the BRC home from hospital service able to provide support seven days a week, will meet the ICF aims in the following way: > Provision of a seven day support service will increase care co-ordination capacity and enable discharge liaison teams to ensure a safe and timely discharge for individuals who require support at weekends. It will also improve equity by enabling individuals who require post discharge support every day of the week for a time limited period to have access and receive the same service as those who require support over 5 or less days. > Provision of a seven day service will help to improve patient flow and avoid individuals becoming stuck at the secondary care level. It will do this by reducing the number of individuals who have their discharge delayed due to an inability to meet their care needs over the weekend. > It will help to increase current capacity at the weekends and in doing so provide a solution to help meet demand for services over the weekend period. > Ensuring that individuals who require seven day support to be safely discharged from hospital receive that support will have an important preventative impact. It will do this by ensuring that people receive the level of support in line with their needs, thus reducing their risk of readmission.

3. **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)

Citizen's get the right care and support, as early as possible	The provision of a seven day home from hospital service will ensure that, individuals who require a support at home package of care seven days a week in order to be safely discharged from hospital, receive that support as soon as they are clinically fit. In doing so it will reduce the number of individuals whose discharge from hospital is delayed due to lack of an appropriate social care support package to enable them to safely return home. The proposal also supports this particular regional outcome by offering a service model that will support the timely recuperation at home and regaining of independence for the service users assisted.
Citizens speak for themselves and contribute to the decisions that affect their life, or have someone who can do it for them.	The provision of a seven day home from hospital service will ensure that, individuals who require a support at home package of care seven days a week in order to be safely discharged from hospital, receive that support as soon as they are clinically fit. In doing so it will reduce the number of individuals whose discharge from hospital is delayed due to lack of an appropriate social care support package to enable them to safely return home. The proposal also supports this particular regional outcome by offering a service model that will support the timely recuperation at home and regaining of independence for the service users assisted.
Citizens understand what care, support and opportunities are available and use these to help them achieve their well-being.	Whilst the primary aim of this proposal is to facilitate the safe and timely discharge of individuals who require seven day support equally important is the BRC aim of reducing the readmission of those individuals. BRC is committed to ensuring that the recovery and recuperation of service users in their own home setting is sustained once BRC support ceases. This is achieved by looking at what personal resilience the service user has and then working with them to build on that resilience. Through the BRC service, users are made aware of what support is available within their local community that can help them to maintain their independence and continue to live safely at home. Through this provision of information and helping to signpost and refer service users to community support available service users are empowered and able to access services that will help them to maintain their well-being.

4. **Implementation Timescales –** *please indicate the following:*

When will project development commence?	1st April, 18
When will initial expenditure commence?	1st April 18

When will staff recruitment commence (if required)?	1st April 18- 1st July 18 Once notified of funding a 30 day consultation phase can commence with existing staff in order to change Terms of conditions of their employment and vacancy post the consultation will then be advertised. (staff recruitment and induction can take 2 months) in the interim agency staff will be deployed to reduce any delays in recruitment.
When will project delivery commence?	1st April, 18
Expected date of completion of project concept testing.	The concept has already been tested.
Expected date of project review/embedding learning into mainstream practice or termination.	Expectation of it being embedded into mainstream practice by end of the 12 month funding period.

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

Cost Type	Set Up Costs	2018-19
Recruitment Staff		1000
Staff Costs		128,868
Staff training		2250
Staff Travel		15050
Staff Workwear		1503
Fleet Costs		13183
Property Costs		9000
IT/Telecoms/Postage	980	3082
Office Equipment		2200
Stationary		300
PPE equipment		500
Irrecoverable VAT	196	2611
Overhead contribution		17955
Total Costs	**£1,176**	**£197,501**

Please see figures are for the entire home from hospital service – current funding received for the 5 day amounts to £110.213. Therefore an additional £87, 288 would be required to deliver the 7 day enhanced service. The additional costs are for the recruitment of additional staffing, mileage and general operational and set up costs

6. **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)**

• Provision of a HfH service over the weekends from will continue from April 2018 to March 2019 • 10 to 12 individuals a month receiving weekend (7 day) support equating to 144 more users accessing the HFH service over the period April 2018 to March 2019 • A minimum of 1000 weekend support visits undertaken with service users over the period April 2018 to March 2019	• The service will provide a fully trained and competent staff team over weekends to enable support to be provided to service users. This team will be supported at all times by an 'on call' duty manager • Support will be tailored to the needs of the individual and service users will receive from one to three visits a day over the weekend dependent on their support needs. Support needs will be reviewed on an ongoing basis with the user and will be tailored if support needs change • The duration of support visits will be tailored to the needs of the individual but on average will be for a minimum of one hour
How will people be better off as a result? (Quality and Quantity of effect)	
• 144 service users will receive the right care at the right time to enable them to be safely discharged from hospital and return to their own home setting • 144 service users will not have their discharge delayed for social rather than clinical reasons • 144 individuals will have the opportunity to safely recuperate in their own home setting and receive a support package that has been tailored to their individual care needs and wishes • 144 individuals will be empowered to maintain their independence once BRC support ceases through signposting/referral onto other support services available within their local community • 144 individuals will have their risk of being readmitted in hospital reduced. This will be achieved through service users (where needed) being supported to put other more long term strategies in place to ensure they are able to remain living safely in their own home setting once BRC support ceases.	

7. **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*)

Sustainability beyond 2019/20 will be a challenge and the only effective solution to ensure service continuity will be to amend the existing health board and Carmarthenshire County Council Social Care contract for the five day home from hospital service and build into the contract seven day service provision. This will have funding implications but cost efficiency savings could be achieved if a more regional approach was undertaken in terms of the delivery of hospital prevention/hospital discharge service support models.

8. **What are the implications if this business case isn't supported?**

Detailed below are the implications if this business case is not supported:

- The current and contracted Home from Hospital service will revert from the delivery of support over seven days to the delivery of support over five days from the 1st April onwards.
- Personal impact on individuals whose discharge from hospital will be delayed due to their discharge being conditional on them being able to receive support within their own home setting seven days a week
  or
- Personal impact on individuals who will be discharged and will be put at risk because they require support over seven days to return safely to their own home setting following a stay in hospital but will only receive support over five days
- Detrimental impact on patient flow as a result of patients having their discharge delayed
  or

Detrimental impact on patient flow due to risk of readmission increasing for those patients who are discharged and require support seven days a week but only able to access support five days

9. **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.**

Through 2017/18 ICF funding the BRC home from hospital service was able to extend its service provision to include weekend coverage. In rolling out this enhanced support model BRC worked very closely with the Integrated Community Care Co-ordinator Aysha Taylor and the Integrated Community Care team with referrals to the Red Cross service coming through this team.

Below is a statement provided by Aysha which demonstrates the impact that seven day provision has made to both patients and the NHS.

'I would like to highlight that the Red Cross Home From Hospital service is an extremely valuable resource for the NHS. Since being able to cover the 7 day service the service has been utilised fully and has prevented prolonged hospital stays for patients. It has allowed patients to be discharged prior to the weekend where previously they would have had to remain in hospital until the Monday. The short input is beneficial for patients who do not require a service via Social service and have low level needs. Patients who we have spoken to have been complimentary of the service and have stated it eased their transition from hospital to home.

We have excellent communication channels between the hospital and Red Cross team and have even managed to utilize their services at short notice to prevent hospital admissions. It is essential that this service continues for our patients in order to reduce length of stay and improve the patient experience of the NHS.'

10. Please ensure a completed 12 month budget profile is attached.

Please Attach

Cost Type	Set Up Costs	2018-19
Recruitment Staff		1000
Staff Costs		128,868
Staff training		2250
Staff Travel		15050
Staff Workwear		1503
Fleet Costs		13183
Property Costs		9000
IT/Telecoms/Postage	980	3082
Office Equipment		2200
Stationary		300
PPE equipment		500
Irrecoverable VAT	196	2611
Overhead contribution		17955
Total Costs	**£1,176**	**£197,501**

Please see figures are for the entire home from hospital service – current funding received for the 5 day amounts to £110.213. Therefore an additional £87, 288 would be required to deliver the 7 day enhanced service. The additional costs are for the recruitment of additional staffing, mileage and general operational and set up costs