CYDWEITHREDFA GWELLA GWASANAETHAU
GOFAL A LLESIANT **GOGLEDD CYMRU**

NORTH WALES SOCIAL CARE AND WELL-BEING
SERVICES IMPROVEMENT COLLABORATIVE

Integrated Care Fund - Revenue Investment Plan 2018-19

Scheme	Allocation
Frail and Older People	7,061,774
LDIS, Complex and Carers	3,378,226
Integrated Autism Service	652,000
Wales Community Care Information System	343,000
Regional	160,000
TOTAL	**11,595,000**

PRIORITY AREA FOR INTEGRATION: OLDER PEOPLE WITH COMPLEX NEEDS AND LONG TERM CONDITIONS, INCLUDING DEMENTIA

THEME	REF. NO.	PROJECT NAME	PROJECT DESCRIPTION	Total Expenditure	LINK TO ICF PRINCIPLES (e.g. Prevention and Alternative Delivery Models, Supporting Independence)	LINK TO NATIONAL OUTCOMES FRAMEWORK	Population Needs Assessment - link to Action Priorities	ANTICIPATED IMPACT	KEY DELIVERY MILESTONES (including key dates)	Additional resources if applicable
Alternative Models of Service	AM1.1	**Minor Injury Unit Extension Hours**	An extension to four Minor Injury Unit hours across Gwynedd and Mon will be piloted in the following four community hospitals: • Alltwen MIU (from 20:00 until 22:00) 7/7 • Bryn Beryl MIU (from 18:00 until 22:00) 7/7 all year round • Penrhos Stanley MIU (from 20:00 until 22:00) 7/7 • Dolgellau MIU (from 08:00 to 20:00hrs) to 10:00 to 22:00hrs 7/7 in line with the other units The aim is to provide minor treatment for people in the most appropriate location closer to home where this is possible. By extending MIU hours and also by changing (extending) MIU referral criteria with WAST to increase what can be seen safely locally, the pilot hopes to ensure that more patients will receive minor injury / minor illness care at an appropriate level in the community. This should have a positive impact on ED and result in a reduced number of unnecessary ED attendances particularly in the evenings, as well as avoiding unnecessary WAST conveyances to YG meaning emergency vehicles remain in their communities and better able to respond.	207,682	• To avoid unnecessary ED attendances / hospital admissions • To provide appropriate care as locally as possible	1.1, 1.2, 2.3	• Perspective and needs of older people around delivery of health, health-care and well being services • Promoting healthier lifestyles and reducing health inequalities • Review specialised services and provide care closer to home	• No. of patients seen within extra MIU opening hours • % of patients waited less than 1 hour to be treated • No. patients treated and discharged home • No. of patients sent on to ED	• Recruitment of additional required nursing staff • Engage with MIU staff on each site • Commence new extended opening hours and achieve consistency across all 4 sites (until 10pm 7/7) • Focus on achieving consistency of MIU staff skills / competences to raise to minimum core competency level across Area (including minor illness) • Promote / raise awareness of service with public • Monitor service activity and outcomes • Promote / raise awareness of service with public • Monitor service activity and outcomes	
	AM1.2	**Pontio'r Cenedlaethau (Bridging the Generations)**	A Bridging Generations Co-ordinator will be responsible for implementing the pilot scheme of two series of activities "Bridging the Generations" in Bangor and Nefyn during the Summer Term of 2018. The "Bridging Generations" scheme means bringing a cluster of children from Year 1 of Garnedd Primary School in Bangor to visit the extra care home Cae Garnedd, Bangor once a week for a number of weeks. The same programme will happen between Plas Hafan Care home and Nefyn Primary School. The Bridging Generations Coordinator will be responsible for facilitating these two programmes with the support of Bangor University Research student on Masters level that will evaluate both programmes (dependent on the authorisation from KESS2 panel in Bangor University by the end of January 2018).	17,232	- Proactive approach to care and support - preventative intervention - encouraging innovation - promoting and maximising independent living	1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 2.1, 2.2, 2.3, 3.1, 3.2, 3.3, 5.1, 5.2, 6.1, 6.2, 7.1, 7.4, 8.1	• Perspective and needs of older people around delivery of health, health-care and well being services • Review specialised services and provide care closer to home	# of people supported % reporting a positive difference in their wellbeing	The Bridging Generations Coordinator will facilitate activities between the generations in Gwynedd through: 1. Running a series of weekly sessions between Year 1 pupils and older people that are in a care setting, in two different areas of Gwynedd. 2. This will mean careful organisation between the two schools and two care settings to bring the children and residents together on a weekly basis over a few weeks. 3. Create a handbook of suitable activities to be undertaken during the sessions through using different art forms (e.g. music, photography), and activities (e.g. cooking, game playing) and anything that will promote building a positive and supportive relationship between children and older people. 4. Work closely with relevant staff from schools and care settings to plan and prepare the children and older people that choose to take part. 5. Consult with Gwawr Wyn Roberts (Art), Nia Davies Williams (Music) ac Edwin Humphreys (Memory Problems) as well as the expertise of Dr Catrin Hedd Jones from Social Science College, Bangor University, when creating the booklet of activities that can be transferred to other locations to run "Bridging the Generations" programme in the future. 6. Co-ordinate Bridging the Generations activities through sharing current information across sectors e.g. health settings, nursery schools, 3rd sector organisation, so that everyone learns from each other and do not duplicate in this field. 7. Be a point of contact for schools and care settings that show interest in "Bridging the Generations" through sharing good practice and contacts with them. Be ready to visit care settings, schools, nursery schools and nurseries to promote and advise on how to include generations in their activities as a way of building a resilient community. 8. Make contact with Secondary Schools and 6th form colleges to look at how they can contribute and influence older pupils to undertake voluntary work with older people in the context of Welsh BAC qualification. In addition, to encourage young people to undertake work experience in the care sector as a way of considering a career in the care setting. Work with Education, Care and further education sectors to promote recruiting more young people to work and train in the care sector. 9. Arrange workshops between January and March 2019, for various stakeholders, underlining what has been learned, through promoting sharing good practice within the field. 10. Prepare a report at the end of the year reflecting on the programme and underlining how the work can continue. The hope is that schools and care settings throughout Gwynedd would continue with the work in the future, following establishing a foundation of practical materials and a good practice guide.	half year funding - remainder will be funded from core funding
	AM1.3	**Home Care Transformation**	One of the barriers identified by our Community Resource Teams was the availability and the nature of the domiciliary care services, which meant it, was difficult to achieve the service purpose. For example, achieving what matters' to Gwynedd Citizens proved to be difficult due to the rigidity of the domiciliary care service contract. The findings of the CRT project has given Gwynedd Council the confidence to conclude that the only option is to redesign Domiciliary Care Service in Gwynedd as the current model: • Considers Social Services and Health wewed as the only solutions • Offers solutions that do not address the root cause • Focuses on paying for specific tasks within a specific time • Overemphasis the need for reviews and completing paper work • Overemphasis processes rather than individual Therefore this project will work with all of our Domiciliary Care Service providers to adopt the Vanguard Systems thinking Methodology as means of developing a new approach to providing domiciliary care, this will include: • Having a 'what matters' conversation with individual service users. Review and identify what are the driving factors behind domiciliary care working arrangements and systems at present. • Establish a purpose and measures for domiciliary care service, map current processes and cases alongside the current domiciliary care working arrangements and systems • Developing a holistic approach to providing domiciliary care service, which focuses on what matters to individuals and is underpinned by the service's purpose. • Review the caseload and establish a sample of individuals deemed suitable to become part of the pilot. • Establish what matters to individual service users and unpaid carers or families • Develop a service that allows service users to meet their personal outcomes and achieve their full potential • Establish what matters to paid carers working in the domiciliary care service. • Understand what promotes paid carers job satisfaction, development and retention • Identifying, developing and sharing good practice in the delivery of domiciliary care service. • Support and promote a culture of change amongst service users and workforce. • Making the best use of workforce capacity To support the development and enable new learning and development of a different approach to delivering domiciliary care, the ICF will fund two full time carer's posts for a period of 12 months in each pilot area (4 in total). 7 to enable new learning and development. The domiciliary care provider in each area will support the post holders to: • Trial different approaches to supporting service users meet their outcomes • Be involved in meetings to discuss and develop knowledge and learning. It is expected that 10-15% of the additional hours should be allocated to discuss progress at the operational and leadership meetings.	151,124	- focus resources and increase capacity and meet demand - proactive approach to care and support - Preventative intervention (incl. delaying and reducing the need for care and support and enabling people to live their lives as independently as possible - encouraging innovation - promoting and maximising independent living	1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 2.1, 2.2, 2.3, 3.1, 3.2 ,3.3, 4.1, 4.2, 5.1, 5.2,6.1, 6.2, 7.4,8.1	• Improve joint working between services. • Reducing loneliness and isolation. • Promote independent living; people's choice and control over their own lives • Care and support at home (domiciliary care) • Provide support for people with chronic conditions	The Agreed Measures that will be reported on a quarterly basis are: • No. of people supported • % who have achieved what matters	Quarter 1 • All 4 pilots at implementation stage • Monitor progress and collate data for agreed measures above as well as case studies Quarter 2 • Monitor progress and collate data for agreed measures above as well as case studies Quarter 3 • Midpoint Evaluation for the pilots • Monitor progress and collate data for agreed measures above as well as case studies Quarter 4 • Pilot Evaluation • Detailed work programme in place to realise a new joint-commissioning model with the Health Board for 2019/20 onwards • Monitor progress and collate data for agreed measures above as well as case studies	
	AM1.4	**Improving Access to Home Care**	The Domiciliary Care Transition and Monitoring Manager will manage the transition of the domiciliary care contract and will monitor the contract in line with the services specification and contract. Will also work in partnership with current and new domiciliary providers on behalf of the commissioners (Ynys Môn Social Services & Betsi Cadwaladr University Health Board).	44,448	• Focus resources and increase capacity. • Preventing or delaying the development of people`s needs for care and support and unnecessary admission to residential care. • Promoting independent living.	1.1,1.2,1.3,1.4, 1.5,1.6,2.1,2.2,2.3, 3.1,3.3,5.1,6.1,,8.1	• Improve joint working between services. • Reducing loneliness and isolation. • Promote independent living; people's choice and control over their own lives • Care and support at home (domiciliary care) • Provide support for people with chronic conditions	• 100 Individuals will experience a seamless transition from the current domiciliary care provider to a new domiciliary care provider (if necessary) by developing a robust Transition Plan to include a contingency plan for market failure. • Individuals' well-being outcomes will be maintained throughout the transition process. • A 10% reduction in cases of Delayed Transfer of Care (DToC).	June Award contract Sept onwards Co-ordinate and work with domiciliary care providers through the transition process to support the direct impact on services users' well-being. Maintain service users' care and welfare within the transition process by working with domiciliary care providers and health and social care professionals. Develop an outcome based monitoring framework in order to monitoring individual's outcomes and report on these outcomes with domiciliar care providers and services managers.	
	AM1.5	**Mon Enhanced Care**	The project is to add 1.0 WTE band 7 APP to the MEC team, to increase service capacity and develop the APP role within the team. The APP's experience of working previously in ambulance settings will enhance MEC's role in supporting acutely ill patients in their own home and will accelerate the introduction of WAST referrals directly to the MEC team.	56,485	• Focus resources and increase capacity of rapid response services. • Encourage innovation and develop new models of integrated services. • Proactive approach to care and support. • Preventative interventions (incl) delaying and reducing the need for care and support and enabling people to live their lives as independently as possible. • Promoting independent living.	1.1,1.2,1.3,2.3,8.1	• Integration of services for older people with complex needs and long term conditions, including dementia • Promote independent living; people's choice and control over their own lives • Review specialised services and provide care closer to home • Develop primary care and community resources to provide quicker access and more holistic services.	• Number of patients referred to MEC. • Number of hospital admissions avoided , ambulance conveyance reduction in Mon. • Bed days saved. • % of people reporting improved wellbeing outcomes.	NEED TO IDENTIFY	
	AM1.6	**Hospice Unit**	Establishment of a 4 bed satellite hospice unit within Ysbyty Penrhos Stanley to provide a combination of end of life care, symptom control and respite care. This will address the inequality in end of life care across North West Wales where Anglesey has no hospice beds at present. Provide a social worker service to aid discharge and resilience.	132,352	• Proactive approach to care and support. • Focus resources and increase capacity. • Preventative intervention to help avoid unnecessary hospital and/or care home admission.	1.1,1.3,1.4,1.5,1.6, 2.3,3.1,8.1	• Promote independent living; people's choice and control over their own lives • Perspective and needs of older people around delivery of health, health-care and well being services • Developing greater support for good end of life care	Prevent at least 75 inappropriate admissions to acute hospital annually 2. Save 1460 bed days in hospital or care homes according to patient's needs. Estimated that 50% of this is related to acute bed days. 3. 100% of patients will be offered an advance care planning discussion. 80% of the patients offered a discussion will die in their preferred place of care. Preferred place of care may vary between home and hospice bed according to individual circumstances.	April Adapt and refurbish the current clinical area at YPS to receive patients October Staff will be recruited and trained between April and October 2018	
	AM1.7	**Care Homes Support**	The programme of work has been developed collaboratively with unscheduled care and community health colleagues with the aim of creating a stable, safe and sustainable Care Home Sector in Conwy, improving experience for our residents and avoiding inappropriate A&E attendance and/or hospital admissions. In 18/19 the aim is to focus on access to expertise and continue to provide a timely response to patients in Care Homes, collaborating with the Bevan Exemplar project. The scheme aims to ensure safe, effective evidence based care is provided for our patients residing in care homes. This team will provide multidisciplinary support, advice, and education clinical skills to care homes in the Conwy area. This aims to build working relationships between care providers and health colleagues and maximise the benefits of the Community Resource Teams for those in resident ial and nursing care homes. The key aims are to: · Manage conditions within the care homes to prevent unnecessary hospital admissions, delayed transfers of care and GP/Out of Hours call outs. · improve patient experience, quality and safety, · increase competencies and clinical skills of staff The Team consists of Advanced Nurse Practitioner, Physiotherapy, Occupational therapy, Speech and Language therapy, Podiatry, Dietician, Pharmacist with input from Community Psychiatric Nursing and a Practice Development Nurse. The team aims to: · make the service safer by providing an MDT approach to patient reviews, undertake quality audits and providing clinical support and leadership. · make it sound by providing equitable access to health care services and providing support and leadership to the care home sector, help to prevent home closures, escalating concerns and loss of beds. · make it happen by providing targeted support, advice education and training. Identifying clinical concerns and quality issues earlier and identifying and implementing solutions in a timelier manner. · make it sustainable by providing continuing professional development, clinical skills education and training in house to staff. By reducing demands on Primary Care and acute services.	182,000	Focus resources and increase capacity Proactive approach to care and support Increase capacity to meet demand Promoting and maximising independent living Develop partnership working and collaboration	1.1, 1.3, 1.4, 1.5, 1.6, 2.3, 3.3, 7.4, 8.1	To bring together services for older people with complex needs including dementia. To support organisations who provide care. To work together more.	Designated care homes better able to support their residents through training and information about service provision. Services are wrapped around the resident and enable people to optimise their independence. People are treated with fairness, dignity and respect. · Reduction in emergency calls to GPs and GP Out of Hours Service · Reduction in admissions to hospital from Care Homes supported by the team · Reduced number of homes in escalating concerns · Improved relationships with Care Homes, supporting the recruitment and retention of staff		
Care Home Support	CHS1.1	**Additional practical and financial support to the care home sector.**	Working with care homes to implement a programme of funding and support options to improve sustainability. Examples of interventions for 2018/19 to include: Progress for Providers Quality Assurance Scheme implementation and roll out in year to nursing homes and domicilliary care providers. Provision of six steps training to support advanced care planning.	500,000	1, 8	1 2 3 4.2 5.1,5.2 6.1 7.5 8.1	To support organisations who provide care. To work together more	Number of care homes operating in the county at end of the year = 26 (no reduction to baseline) Number of beds in use or available for use in the county at end of year = 809 no reduction in baseline) Number of care packages handed back to the local authority in the year = 50 (no increase on baseline) Number of independent providers in escalating concerns over the year = 5 (no increase on baseline) Add any re progress for providers or six steps?	Further roll out of the Progress for Providers quality assurance scheme to nursing homes and domiciliary care providers by March 2019.	
Community Support & Integration	CSI1.1	**Community Resource Team (Part 1)**	A multi disciplinary team of workers to provide support to patients with clinical needs that can be managed in the community as an alternative to hospital admission or prolonged stays. Funded elements include extension of Intermediate Care Service to 10pm and contribution to overnight District Nurse Service	368,636	1,2,3,4,6,8,	1.3, 1.5 2.3	To work together more To bring together services for older people with complex needs including dementia	Number of people supported to remain at home = 50, 70,100, 90 by quarter(case load, not all "NEW") Estimated number of hospital bed days saved = over 3000 % of people who have achieved what matters to them =100 %		

THEME	REF. NO.	PROJECT NAME	PROJECT DESCRIPTION	Total Expenditure	LINK TO ICF PRINCIPLES (e.g. Prevention and Alternative Delivery Models, Supporting Independence)	LINK TO NATIONAL OUTCOMES FRAMEWORK	Population Needs Assessment - link to Action Priorities	ANTICIPATED IMPACT	KEY DELIVERY MILESTONES (including key dates)	Additional resources if applicable
	CSI1.2	**Community Resource Team (CRT)**	A multi disciplinary team of workers to provide support to patients with clinical needs that can be managed in the community as an alternative to hospital admission or prolonged stays.	696,357	Focus resources & increase capacity Proactive approach to care & support Preventative interventions Increase capacity to meet demand Promoting & maximising independent living Develop partnership working & collaboration	1.1 1.2 1.3 1.4 1.5 1.6 2.1 2.2 2.3	To work together more To bring together services for older people with complex needs including dementia	No of people supported to remain at home: TARGET 98 per quarter Estimated bed days saved: TARGET 3,127 per quarter %of people achieving What Matters outcomes: Target 80%	None: scheme fully operational	The budget does not meet the cost of the CRT. Additional resources are provided by BCUHB to ensure delivery of the service
	CSI1.3	**Navigation**	Nurse Navigators support the effective and efficient throughput of cases; pulling people through the acute setting. These link workers are based within the Emergency Department (ED) and the Medical Assessment Unit (MAU). The Nurse Navigator is responsible for screening all cases which pass through MAU and ED, regardless of age and county of residence. Onward referrals are made to the Community Resource Team, where appropriate. Crucially, the Nurse Navigator is able to access and expedite a full range of clinical interventions opinions.	159,574	Focus resources & increase capacity Proactive approach to care & support Preventative interventions Increase capacity to meet demand Promoting & maximising independent living Develop partnership working & collaboration	1.1 1.2 1.3 1.4 1.5 1.6 2.1 2.2 2.3	To work together more To bring together services for older people with complex needs including dementia To support organisations who provide care good services working together to support carers	No of people supported to remain at home: TARGET 71 per quarter Estimated bed days saved: TARGET 246 per quarter % of people achieving What Matters Outcomes: TARGET 80%	None: scheme fully operational	
	CSI1.4	**Night Owls**	The Night Owls service enables Social Care workers to support people who have been assessed as requiring care needs during the night from 10pm to 8am, 7 nights a week. The service involves visits to people's home for planned care or to respond to crisis situations. The project will focus on developing falls protocols with WAST	72,000	• Focus resources and increase capacity • Proactive approach to care and support. • Preventative interventions incl delaying need for care and support. • Increase capacity to meet demand. • Promote and maximise independent living.	1.1,1.2,1.3,3.1,3.3, 5.1,5.2,8.1	• Reduce loneliness and isolation in our communities. • Promote independent living, people's choice and control over their own lives. • Promoting healthier lifestyles and reducing health inequalities. • Care and support at home (domiciliary care)	• Number of people supported to remain at home • Estimated number of hospital bed days saved. • % of people that have achieved what matters.	April Re-visit terms of reference for the steering group Revise engagement plan Develop falls protocols with WAST	
	CSI1.5	**Community Resource Teams**	This project is a continuation of further developing Community Resource teams within 5 local areas of Gwynedd. These teams will initially include Social Service staff as well as community Nursing with the final phase including therapies within the teams as well. The project will also continue to develop the community connectors within the CRT teams to further map out what is available for individuals of Gwynedd in the local community, identify unmet needs in the local area as well as work with low-level need individuals. This project will also trial out Health and Social Care Workers in the local Community in South Meirionnydd area. A Health and Social Care worker will undertake health and social care tasks prescribed and appropriately delegated by professional staff, thereby contributing to supporting the individual to live as independently as possible through the delivery of a holistic and person centred approach to care. The aim is to provide an integrated service. The aims and objectives of the role are: • Early identification of the need for further assessment by a health and social professional. • Sign posting and health promotion • Enablement • Social care including personal care • Implementing planned care to meet identified health and social care support needs in the context of outcome based person centred care. • improved communication between one worker and members of the community resource team with will lead to timely identification and co-ordinated response to changes in need which will result in improved long term outcomes for the individual.	303,229	- Focus resources and increase capacity - proactive approach to care and support - preventative intervention (incl. delaying and reducing the need for care and support and enabling people to live their lives as independently as possible - encouraging innovation - promoting and maximising independent living - helping collaboration - promoting social enterprises, co-operatives, user-led service and the third sector	1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 2.1, 2.2, 2.3, 3.1, 3.2, 3.3, 4.1, 4.2, 5.1, 5.2, 6.1, 6.2, 7.1, 7.2, 7.3, 7.4, 8.1	• Reduce loneliness and isolation in our communities. • Promote independent living; people's choice and control over their own lives • Promoting healthier lifestyles and reducing health inequalities • Develop social prescribing – strengthen the links between healthcare providers and community, voluntary and local authority services.	Agreed measures: • # of what matters conversations undertaken • % of individuals who have achieved what matters The Health and Social Care workers effectiveness will also be Measured through: • Service user Questionnaire • Staff Questionnaire • MDT satisfaction questionnaire • Case Studies • # individuals supported • % who have avoided hospital admission • % who have returned home from hospital with support • % saved GP contacts Agreed Outcomes: • # of what matters conversations undertaken • % of individuals who have achieved what matters	Quarter 1 • Induction of generic workers • Training for GW • Update some competencies • Start supporting service users, with the competencies that have been completed • Waiting list for care reducing • Sign off of Section 33 Agreement • Find an appropriate location for Caernarfon CRT • Supporting Bangor and Caernarfon CRT team in turn to • Further develop the IAA service • Understand the demand and agree on the most appropriate way of dealing with it • Ensure that purpose and operational principles steer the work of the teams • Identify and remove blockages • Further develop the community connectors in providing low level needs for individuals within their community and identifying unmet needs in the local area to feed into the population needs assessment. Quarter 2 • Continue with the training / competencies • Develop the numbers of individuals that are being seen • Monitor the success of the pilot • Develop more efficient systems within both organisations • Supporting Eifionydd/North Meirionnydd and South Meirionnydd CRT team in turn to • Further develop the IAA service • Understand the demand and agree on the most appropriate way of dealing with it • Ensure that purpose and operational principles steer the work of the teams • Identify and remove blockages Quarter 3 Continue with the training / competencies Increase the numbers of individuals that are being seen Monitor the success of the pilot Quarter 4 • Appoint support workers in each team to facilitate integrated working between agencies and release professionals time. • Training of staff. • Extending working day for therapy staff. • Identifying new roles. • Information Governance Framework.	
	CSI1.6	**Community Resource Teams**	Community Resource Teams (CRT) is a flagship programme for health and well-being in Conwy and Denbighshire devised to build new integrated models of working to benefit communities across the Area. This project will build on what is already in operation which will entail new pathways, changes to organisation development enabling meaningful co-location where possible through accommodation, technology and more agile working. The project encompasses the development of integrated working for a range of professionals including Community Nursing, Primary Care, Adult Social Services and Third sector providers to offer a seamless service to citizens in a community. The long term vision is for a service provision for the whole adult community based on demographic boundaries. This will enable teams to adopt a holistic approach to individuals and their carers offering a wraparound service as and when needed. This project will provide a multi-disciplinary workforce who will be able to respond by providing advice, rapid access and support for individuals, carers and care homes to keep people out of hospital and enable faster discharge for others ensuring all physical, mental, medical and social needs are met to designated populations. This will be done by having skilled professionals from across a range of disciplines working together to service the population within the community. Integral to developing a sustainable model of care is a change in culture to focus on resilience, independence, self-care and community support for people, families and communities. These themes are underlined in both the Social Services and Well-being (Wales) Act 2014, the Well-being of Future Generations (Wales) Act 2016 and the Parliamentary Review of Health and Social Care in Wales[1]. The publication "Primary & Community Services Strategic Delivery Programme" (Dr C D V Jones CBE, February 2010)[2] encourages providers to ensure primary care and community healthcare services work together with social care and third sector partners to provide an integrated service to those living in GP population areas. This work has influenced the development of scope of this programme.	493,827	Focus resources and increase capacity Proactive approach to care and support Preventative interventions Increase capacity to meet demand Encourage innovation Promoting and maximising independent living Develop partnership working and collaboration	1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 2.1, 2.2, 3.1, 3.2, 3.3, 6.2, 7.1, 7.4,7.5, 8.1	To bring together services for older people with complex needs including dementia. To support organisations who provide care. To work together more.	• Agreed model for Community Service provision is determined, and appropriate project plans and work programmes drafted. Once this project has extended beyond the research and planning phase, the following measures will come into being: Increased integration of community staff, measured by: • % of assessments undertaken using shared processes and documentation. • Number of integrated care and community support plans. • Number of "shared" posts, where post holders undertake work for more than one professional group / agency. • Number of shared bases available for partner liaison and coordinated approach to care. For patients/citizens ma naged within an integrated team: • Number / % of patients receiving "Enhanced Care". • Number / % of admissions to hospital for basket of chronic conditions. • Estimated no of hospital bed days saved. • Number / % requirement for care home placements. • Number of people supported to remain at home. Qualitative – to be measured through surveys / case studies: • Level of staff satisfaction with working within integrated teams. • Interventions based on "What Matters" conversations. • Increased communication and improved working relationships between community and local authority staff and GP Practices. •Evidence of reduced duplication for the individual (via case studies and process mapping identification of steps).	• Appoint support workers in each team to facilitate integrated working between agencies and release professionals time. • Training of staff. • Extending working day for therapy staff. • Identifying new roles. • Information Governance Framework.	Core funding from existing teams will fully utilised in delivering an integrated service via community Resource teams.
	CSI1.7	**Community Resource Teams**	Community Resource Teams (CRT) is a flagship programme for health and well-being in Conwy and Denbighshire devised to build new integrated models of working to benefit communities across the Area. This project will build on what is already in operation which will entail new pathways, changes to organisation development enabling meaningful co-location where possible through accommodation, technology and more agile working. The project encompasses the development of integrated working for a range of professionals including Community Nursing, Primary Care, Adult Social Services and Third sector providers to offer a seamless service to citizens in a community. Integral to developing a sustainable model of care is a change in culture to focus on resilience, independence, self-care and community support for people, families and communities. These themes are underlined in both the Social Services and Well-being (Wales) Act 2014, the Well-being of Future Generations (Wales) Act 2016 and the Parliamentary Review of Health and Social Care in Wales[1]. The publication "Primary & Community Services Strategic Delivery Programme" (Dr C D V Jones CBE, February 2010)[2] encourages providers to ensure primary care and community healthcare services work together with social care and third sector partners to provide an integrated service to those living in GP population areas. This work has influenced the development of scope of this programme.	336,365	Focus resources and increase capacity. Proactive approach to care and support. Preventative interventions. Increase capacity to meet demand. Encourage innovation. Promoting and maximising independent living. Develop partnership working and collaboration.	1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 2.1, 2.2, 3.1, 3.2, 3.3, 6.2, 7.1, 7.4,7.5, 8.1	To bring together services for older people with complex needs including dementia. To support organisations who provide care. To work together more.	• Agreed model for Community Service provision is determined, and appropriate project plans and work programmes drafted. Once this project has extended beyond the research and planning phase, the following measures will come into being: Increased integration of community staff, measured by: • % of assessments undertaken using shared processes and documentation. • Number of integrated care and community support plans. • Number of "shared" posts, where post holders undertake work for more than one professional group / agency. • Number of shared bases available for partner liaison and coordinated approach to care. For patients/citizens ma naged within an integrated team: • Number / % of patients receiving "Enhanced Care". • Number / % of admissions to hospital for basket of chronic conditions. • Estimated no of hospital bed days saved. • Number / % requirement for care home placements. • Number of people supported to remain at home. Qualitative – to be measured through surveys / case studies: • Level of staff satisfaction with working within integrated teams. • Interventions based on "What Matters" conversations. • Increased communication and improved working relationships between community and local authority staff and GP Practices. •Evidence of reduced duplication for the individual (via case studies and process mapping identification of steps).	• Appoint support workers in each team to facilitate integrated working between agencies and release professionals time. • Training of staff. • Extending working day for therapy staff. • Identifying new roles. • Information Governance Framework.	Core funding from existing teams will fully utilised in delivering an integrated service via community Resource teams.
Dementia Support	DS1.1	**Dementia Go –**	Dementia Go is a physical activity class for people living with dementia and their caregivers. It is a weekly rolling programme of physical movements which include cardio-vascular aerobic activity; strength, balance and coordination and games. The class is purposeful, adaptable, and enjoyable and has a compelling social aspect. Each session cost £2.00 per person. The programme currently consists of 14 classes currently running in Leisure Centres, local community centres and residential homes throughout Gwynedd. Recent new development is the 'Moving Moment' project to support staff in Residential homes to empower people living with dementia to move more in order to enhance quality of life. 11 Gwynedd Council Residential homes are on board and staff are being given the opportunity to learn about the importance of keeping active/ movement and creating challenges for the residents. The Instructors delivering the DementiaGo class are Advanced Level 4 Instructors and have qualifications in, amongst others, Exercise Referral, Falls Prevention and Cardiac rehabilitation. They have attended Later Life Training Dementia 1st Steps CPD Training. In 2014, 190 Leisure Centre staff also received Dementia Awareness Training by Gwynedd Council's Social Services training team, with a further 30 becoming Dementia Friends. Other community instructors who specialise in classes for older people have also had the opportunity to attend the 1st Steps in Dementia CPD training in order to ensure that classes in the community are inclusive for people living with dementia. Referrals for the DementiaGo classes are received from clinical professionals and through self- referral. Links have been made with BCUHB, Health & Social Care and Third Sector agencies to make certain they are aware of the classes and are able to pass the information on. As part of the DementiaGo project, Instructors working on the programme have an induction to become Dementia Friends Champions – an Alzheimer's Society initiative to help raise awareness of Dementia. They run Dementia Friends information sessions and have initiated over 400 new friends in the community to date. The programme also supports working towards creating Dementia Friendly Communities and Porthmadog became the first town in Gwynedd to gain the status. Recent new development is the 'Moving Moment' project to support staff in Residential homes to empower people living with dementia to move more in order to enhance quality of life. 11 Gwynedd Council Residential homes are on board and staff are being given the opportunity to learn about the importance of keeping active/movement and creating challenges for the residents.	54,825	• Supporting life alongside caring • Identifying and recognising carers – • Providing information, advice and assistance of delivering sustainable services • Enabling people to live their lives as independently as possible.	1.1,1.2, 1.3, 1.4, 1.5, 1.6, 2.1, 2.2, 2.3, 4.1, 4.2, 6.1, 6.2, 7.1, 7.5	-Develop additional servbices that meet the individual's needs, particularly for younger people with Dementia and through the medium of welsh - Provide more information and support after diagnosis	Agreed outcomes measured on a quarterly basis: • How many attend • How many assessed* • % of improvements • Satisfaction Questionnaire • Case studies and service user's feedback *Assessments are carried out on each new participant prior to them starting the DementiaGo Classes where appropriate. The assessments are founded on the evidence based on the Wales National Exercise Referral Scheme protocols and include a Pre Exercise Questionnaire (PARQ); physical assessments (Sit to Stand; Timed Up and Go; Dynamometer wrist strength); Quality of Life Questionnaire (EQ5D5L). The assessments are re-done at around 16 Weeks and all findings recorded. Case studies of the impact the classes have had in the past on particular participants are available.	Quarter 1. • Continue to develop opportunities in the community for people living with Dementia and their carers through promotion and creating and maintaining strong partnerships. • Support residential care home staff to assist residents to move more by delivering a 'Moving Moments' Workshop training day and creating a working party consisting of care home staff to discuss and plan physical challenges and a special event. • Work in partnership with Bangor University, Dementia Services Development Research Centre team to undertake research work on the effect of the care to move on staff, residents and their families. Ensure that the KESS 2 application is successful so that the research can begin as the 'Moving Moments' project gets underway. • Liaise with the local community of Porthmadog to encourage as many shops, businesses and individuals to take part in the Dementia Friends information sessions and to complete relevant actions in order to gain 'working towards being dementia friendly status. Create an event to celebrate the successes and to raise awareness of dementia friendly communities. • Deliver at least 4 Dementia Friends information sessions throughout the county. Quarter 2 • Continue to develop opportunities in the community for people living with Dementia and their carers through promotion and creating and maintaining strong partnerships. For National Dementia Action Week 21-27th May, work with local partners, Council, BCUHB and Third Party organisations to present 3 x drop in Open Sessions in areas where classes need to be promoted i.e. Tywyn, Bala and Caernarfon • Support residential care home staff to assist residents to move more by creating a specific week of activities 'Go for Gold Sports Week' to encourage competition between homes, interaction with staff, families and friends and connection to the community. • Quarterly meeting with Moving Moments Working group • Deliver at least 4 Dementia Friends information sessions throughout the county. Quarter 3 • Work in partnership with Bangor University, Dementia Services Development Research Centre team to start research work. Produce a 'Social Returns on Investment' report on the DementiaGo Community classes by working closely with the Data and Research section for the Bwrn iach department. • Liaise with the local community of Porthmadog to encourage as many shops, businesses and individuals to take part in the Dementia Friends information sessions and to complete relevant actions in order to gain 'working towards being dementia friendly status. • Quarterly meeting with Moving Moments Working group • Deliver at least 4 Dementia Friends information sessions throughout the county. Quarter 4 • Provide a Boccia Competition in central location to bring people that take part in DementiaGo classes throughout the county together to do physical activity. • Work in liaison with Ffestiniog Railway in Porthmadog to run a dementia friendly trip and picnic on the steam train. • Support Residential Care Home Staff to assist resident to move through developing the DementiaGo ' Moving Moments' Project in Local Authority owned Residential homes.	50% funding from core funding. This will help transition the scheme to full funding from core funding in 2019-2020

THEME	REF. NO.	PROJECT NAME	PROJECT DESCRIPTION	Total Expenditure	LINK TO ICF PRINCIPLES (e.g. Prevention and Alternative Delivery Models, Supporting Independence)	LINK TO NATIONAL OUTCOMES FRAMEWORK	Population Needs Assessment - link to Action Priorities	ANTICIPATED IMPACT	KEY DELIVERY MILESTONES (including key dates)	Additional resources if applicable
	DS1.2	**Garreglwyd**	The Strategy for Older People places emphasis on promoting independence and supporting people to live at home for as long as possible. The development of more robust/accessible community based services means people will live in their own homes for longer thus providing improved outcomes for individuals. When an individuals' care needs go beyond the support that is able to be provided at home then they have easy and timely access to integrated services.	207,074	• Encourage innovation and develop new models of delivering sustainable integrated services. • Support accommodation solutions for individuals with complex care needs to receive care and support closer to home. • Collaboration in needs assessment and service planning. • Preventative interventions to avoid hospital admissions as well as preventing delayed discharge from hospital.	1.1,1.3,2.3,3.1,8.1	• Innovation in dementia services. • Tackling the lack of mental health nursing beds on Anglesey. • Improve joint working between services.	• Number of people supported. • % of people receiving the service within their own community • Number of people with improved physical health.	April Complete refurbishment work Service model in place Quarterly reporting Evaluation of service model.	
	DS1.3	**Residential Care Dementia Development**	Development of Dementia Beds in three residential care homes within Gwynedd • Plas Hafan, Nefyn • Plas Hedd, Bangor • Bryn Blodau, Llan Ffestiniog The three residential homes will undertake building works to develop a further 8 beds in each home. The Local authority and BCUHB will work together to develop further support within each home from health staff to ensure residents can remain in the home when their condition deteriorates or will able to admit those with higher dementia needs that require additional support than the average residential home can provide through onsite support from CPN's and DN's. This will ensure people can remain in their community without having to look out of local area or even out of county for the care that they require.	101,312	• Focus resources and increase capacity • Proactive approach to care and support • Helping collaboration	1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 2.1, 2.2, 2.3, 3.1, 3.2, 3.3, 5.1, 5.2, 8.1	• Innovation in dementia services. • Tackling the lack of mental health nursing beds on Gwynedd. • Improve joint working between services.	# of additional EMI beds # of new people supported in an EMI bed within the new beds % of those remaining in their own community % of avoidance of nursing bed admittance or hospital admittance	Quarter 1 Building works ongoing for Plas Hafan and Plas Hedd Finalise plans at Bryn Blodau Tendering process for Bryn Blodau works Commence Building works at Bryn Blodau Discussions with Mental Health, Nursing and Social Services Prepare section 33 agreement Agree on resources for each location Any additional resources that need to be recruited – advertise posts Agree measures Assess clients of need - Prepare waiting list for new beds Quarter 2 Complete building works in Plas Hafan and Plas Hedd Kit out new units with equipment and furniture Necessary safety checks and regulations Assess clients - prepare waiting list for new beds at Bryn Blodau Quarter 3 Complete work at Bryn Blodau Kit out new unit with equipment and furniture Recruit necessary staffing for each unit. Quarter 4 Register all new beds	
FALLS	F1.1	**Falls**	Funded service staffed with 2 x 0.5 WTE Technical Instructors Band 4, supported by an experienced Physiotherapist (Band 7), to undertake Multifactorial Risk Assessments for older people living within the community in line with the evidence based North Wales Falls Prevention Service model.The TIs also provide appropriate advice and signposting to services and interventions in order to further reduce the risk of falls.	44,299	Preventative Interventions Promoting & maximising independent living	1.1 1.2 1.3 1.4 1.5 1.6 2.1 2.2 2.3 8.1	To work together more To bring together services for older people with complex needs including dementia To support organisations who provide care good services working together to support carers	No of MRA's completed TARGET 100 per quarter	None: scheme fully operational	
	F1.2	**Gwynedd Falls Team**	In partnership with NERS, to roll out Falls Prevention Classes throughout Gwynedd. The deliveries of the classes are based on evidence based practice under a Postural Stability model. The delivery will be undertaken by appropriately trained unregistered practitioners trained as Postural Stability Instructors. The governance and supervision element will be held by local Physiotherapy leads and ultimately Lead Officers for the project	160,538	- focus resources and increase capacity - promoting independent living preventative interventions (incl. delaying and reducing the need for care and support and enabling people to live their lives as independentenly as possible	1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 2.1, 2.2, 2.3, 8.1	• Reduce loneliness and isolation in our communities • Promote independent living, people`s choice and control over their lives • Promoting healthier lifestyles and reducing health inequalities	• No. of FRAT referrals • No of MRA assessments completed • % of people who feel more confident • % of people who have achieved their personal outcomes • % of people who feel less isolated in their community	Awaiting response from team to ascertain milestones	
	F1.3	**Falls Prevention**	A falls prevention service, delivered collaboratively between health, social care and Third Sector colleagues, to ensure that the risk of falls for older people in Conwy is reduced. • Developing the Falls Prevention and Management Service in Conwy – ensuring that the FRAT in the community is extended to all services, including citizens and that Health and Local Authority are trained in the use of the MRA and falls prevention to make it a sustainable service. In addition, emphasis will be placed on setting up a training programme, processes, looking at data collection tools, documentation, and establishing links with the acute sector and raising awareness. • Educating the care homes in falls prevention and management, including supporting them with the implementation of MRA and monitoring their progress in this area so that there is a reduction in the number of falls in the care home settings and A&E attendances. • To implement the Conwy falls pathway in a coordinated and systematic process. • To deliver multi-factorial risk assessments that filter service users into the appropriate intervention for them. • To connect with Community Wellbeing Team, and 3rd sector partners to promote the healthy ageing agenda in community venues in the 5 Conwy locality areas of Llanrwst, Llanfairfechan, Llandudno, Colwyn Bay, Abergele. • To give service users information and advice to increase their resilience and maintain their independence, thereby preventing over time accumulating falls risk factors, e.g. poor strength and balance.	115,000	Focus resources and increase capacity Proactive approach to care and support Preventative interventions Encourage innovation Promoting and maximising independent living Develop partnership working and collaboration	1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 2.1, 2.2, 2.3, 3.1,3.3, 4.2, 6.1, 7.5, 8.1	To bring together services for older people with complex needs including dementia. To support organisations who provide care. To work together more.	• Number of referral received. • Referral source. • Number of Multi-factorial Risk Assessments (MRA) completed. • Number of professionals that Falls Prevention training was delivered to. • Number of Postural Stability Instructor (PSI) led classes provided. • Number of participants attending PSI classes.	• Education and awareness for health, social and 3rd sector services programme development. • Development of training for care home staff with the Falls Prevention Care Home Tool. • Increase number of PSI classes in the community. • Full staffing matrix of Community Falls Team achieved.	
	F1.4	**Falls Prevention**	This project provides a Falls prevention service. A stream-lining of sign posting into the relevant existing services as well as developing a PSI provision, provides an asset based, all systems approach to providing an evidence based service in a cost neutral environment. The aim of the service is to support those over the age of 65 by identifying, assessing and providing timely and evidence based interventions to reduce falls and subsequent hip fractures in Denbighshire. By adhering to the Falls Prevention Service Models in the three areas of community, acute and care home settings we will reduce the number of unnecessary hospital admissions.	115,000	Focus resources and increase capacity. Proactive approach to care and support. Preventative interventions. Encourage innovation. Promoting and maximising independent living. Develop partnership working and collaboration.	1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 2.1, 2.2, 2.3, 3.1,3.3, 4.2, 6.1, 7.5, 8.1	To bring together services for older people with complex needs including dementia. To support organisations who provide care. To work together more.	• Number of referral received. • Referral source. • Number of Multi-factorial Risk Assessments (MRA) completed. • Number of professionals that Falls Prevention training was delivered to. • Number of Postural Stability Instructor (PSI) led classes provided. • Number of participants attending PSI classes.	• Education and awareness for health, social and 3rd sector services programme development. • Development of training for care home staff with the Falls Prevention Care Home Tool. • Increase number of PSI classes in the community. • Full staffing matrix of Community Falls Team achieved.	
PROJECT MGT & SUPPORT	PM1.1	**Programe Management**	Programme Management Support for the Flintshire	7,179						
	PM1.2	**Area ICF Co-Ordination**	Central co-ordination of regional and national returns and monthly R-A-G status reports to Area Integrated services Board (AtSB) for the Central Area. Named link person for the coordination of the Central Area report to feed into the Regional Report. Role of the AtSB Programme Lead, which would include being the main point of contact to liaise with local authority and other Health project leads to collate the Central Area ICF report.	22,000	Focus resources and increase capacity Develop partnership working and collaboration	N/A	N/A	-Concise update reports from all Locality Forum meetings to ISB on timely basis -Focused financial reports including forecasts on quarterly basis -Highlight reports with RAG status on quarterly basis -Comprehensive change control notices raised when needed for movement of finds between schemes -Timely issue of agenda and papers for AtSB including coordination of forward work plan -Development of integrated partnership working	Above milestones in place with immediate effect – roll-over Agreement of plan for 2018/19 in April.	
	PM1.3	**Area ICF Co-Ordination**	Central co-ordination of regional and national returns and monthly R-A-G status reports to Area Integrated services Board (AtSB) for the Central Area. Named link person for the coordination of the Central Area report to feed into the Regional Report. Role of the AtSB Programme Lead, which would include being the main point of contact to liaise with local authority and other Health project leads to collate the Central Area ICF report.	22,000	Focus resources and increase capacity Develop partnership working and collaboration	N/A	N/A	-Concise update reports from all Locality Forum meetings to ISB on timely basis -Focused financial reports including forecasts on quarterly basis -Highlight reports with RAG status on quarterly basis -Comprehensive change control notices raised when needed for movement of finds between schemes -Timely issue of agenda and papers for AtSB including coordination of forward work plan -Development of integrated partnership working	Above milestones in place with immediate effect – roll-over Agreement of plan for 2018/19 in April.	
SPOA	SPOA1.1	**SPoA**	Third sector link worker working within the Wrexham Initial Response team (IRT) to ensure that information on third sector provision is readily accessible to relevant professionals and to broker service provision for service users/carers in response to identified need, who are referred by the IRT and others.	191,255	Preventative Interventions Encourage Innovation Promoting & maximising independent living Promoting social enterprise, co-operatives, user-led services and the 3rd sector Develop partnership working & collaboration	1.1 1.2 1.3 1.4 1.5 1.6 2.1 2.2 2.3 4.1 4.2 5.1 5.2 6.1 6.2	good joined up services for people with learning disabilities to bring together services for older people with complex needs including dementia to support organisations who provide care to work together more good services working together to support carers	No of contact enquiries TARGET 30 per quarter No of referrals made TARGET 29 per quarter No of referrals to statutory TARGET 1 perquarter No of referrals non-statutory TARGET 28 per quarter	None: scheme fully operational	
	SPOA1.2	**Community Link**	Linc Cymunedol Môn is an Anglesey-based Single Point of Access based in Medrwn Môn, the County Voluntary Council (CVC) and has strong working links with its partner organisations throughout the Region. Linc Cymunedol Môn aims to provide a dedicated phone line that provides information to the people of Anglesey organisations that.	36,000	• Promoting independent living • Promoting healthier lifestyles and reducing health inequalities • Encouraging innovation. • Focus on resources and increased capacity.	1.1,1.2,1.3,4.1,4.2, 5.2,6.2,8.1	• Reduce loneliness and isolation in our communities • Promote independent living, people`s choice and control over their lives • Promoting healthier lifestyles and reducing health inequalities	• Number of contact enquiries • Number of referrals • Number of referrals – statutory • Number of referrals – non statutory	The budget is part of a pooled funding arrangement to drive forward the social prescribing model on Anglesey. Agree Partnership Agreement Continue to map services/opportunities Service model in place and quarterly reporting Conduct SROI evaluation	

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	SPOA1.3	**Single Point of Access (SPOA)**	SPOA is a streamlined way for adults and professionals across Conwy to gain direct access to information, advice assistance and coordinated community Health & Social Care Services by contacting one central, integrated team.	293,923	Focus resources and increase capacity Proactive approach to care and support Preventative interventions Increase capacity to meet demand Encourage innovation Promoting and maximising independent living Promoting social enterprise, co-operatives, user-led services and the 3rd sector Develop partnership working and collaboration	1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 2.3, 4.2, 5.1, 6.1, 6.2, 7.1, 7.5, 8.1	To bring together services for older people with complex needs including dementia To support organisations who provide care To work together more.	* Continue to use established regional SPoA data set, and any other local performance measures as appropriate. * New measures will be introduced (where supported by the teams which provide the data) to provide evidence relating to the following non-call handling function, which will include: • How many referrals resulted in MDT/care coordinated decision? • How many referrals did we divert away from hospital? • Was PDD reduced? • Sample of 5 case studies – patients and professionals • Return call rate to SPoA. These new measures will require the support of and will be coordinated via the SPoA operational group, whose membership includes Service Manager Wellbeing, Service Manager Older People, Conwy Matron, GP Cluster Lead, SPoA Team Leader and others.	Quarter 1 • Undertake recruitment of operating staff to ensure enhanced core opening hours. • Return to continuous approach and ongoing contact with all Conwy GP practices, with a view to visiting to discuss SPoA in future quarters. • Establish pilot in Colwyn Bay CRT for localised working. • Operational Group held monthly or as required. Quarter 2 • Extra operating staff are recruited and have undergone initial training. • Interim review of Colwyn Bay pilot. • Operational Group held monthly or as required. Quarter 3 • Review Colwyn Bay pilot. • Staff all trained and able to work independently across the roles and functions. • Operational Group held monthly or as required. Quarter 4 • Staff able to deliver role in any locality. • Operational Group held monthly or as required.	This scheme will be supplemented by the following additional resources, not requiring ICF funding: 1 x GO6 Team Leader 3.5 x GO4 SPoA Operators 1 x Band 3 BCUHB Admin Support 1 x CAB Project Worker (2 days per week) 1 x Care and Repair Support Worker (4 days per week)
	SPOA1.4	**Single Point of Access**	SPOA is a streamlined way for adults and professionals across Denbighshire to gain direct access to information, advice assistance and coordinated community Health & Social Care Services by contacting one central, integrated team.	503,142	Focus resources and increase capacity. Proactive approach to care and support. Preventative interventions. Increase capacity to meet demand. Encourage innovation. Promoting and maximising independent living. Promoting social enterprise, co-operatives, user-led services and the 3rd sector. Develop partnership working and collaboration.	1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 2.3, 4.2, 5.1, 6.1, 6.2, 7.1, 7.5, 8.1	To bring together services for older people with complex needs including dementia. To support organisations who provide care. To work together more.	Continue to use established regional SPoA data set, and any other local performance measures as appropriate. New measures will be introduced (where supported by the teams which provide the data) to provide evidence relating to the following non-call handling function, which will include: • How many referrals resulted in MDT/care coordinated decision? • How many referrals did we divert away from hospital? • Was PDD reduced? • Return call rate to SPoA. These new measures will require the support of and will be coordinated via the SPoA operational group, whose membership includes Service Manager Wellbeing, Service Manager Older People, Conwy Matron, GP Cluster Lead, SPoA Team Leader and others. • Sample of 5 case studies – patients and professionals	1. Establish and implement a robust quality assurance framework. One key measure of success will be a skilled, knowledgeable and confident SPOA team delivering an excellent IAA service. 2. Improve interface working with hospital and community based health and social care services. 3. Review and redefine the roles and skill mix in SPOA. 4. Make SPOA more accessible to support GP practices and promote public health messages. 5. SPOA to support the development of Talking Points and the Community Navigator Service. 6. Adapt and evolve the SPOA model of delivery to fit with plans for Community Resource Teams.	A large proportion of the cost of SPOA is funded by the Integrated Care Fund with the remainder being an equal commitment met by contributions from the NHS and the Council.
STEP UP STEP DOWN	SUSD1.1	**Step Up Step Down Service**	Purchase of beds within a care home for the provision of either step up or step down care. Through provision of bed based care, the intent is to reduce the risk of hospital or long term bed admission or reduce the time spent within an acute or community hospital bed. Residents are also supported by a Social Worker and/or Occupational Therapist as necessary	380,521	2,3,6,8	1.1 1.4 1.5 8.1	To support organisations who provide care To work together more	The following measures will be reported. # of admissions of which, # that were Step Up of which, # that were Step Down # of nights people were supported in a bed % of discharges in quarter, where individual: - returned home/went to live with a relative - admitted to hospital - went into long term care - discharged for furtehr assessment # of people who died whilst being supported in the bed Targets not applicable. However if there is a 50/50 split in package sacross residential and nursing homes, and the average length of stay is 4 weeks, we would support 112 packages of care.	Not applicable - continuation of service delivery.	
	SUSD1.2	**Step up / Down**	Funding 8 (out of 23) enablement/recovery beds within 10 council run residential homes in Gwynedd. The facilities are to assist recovery with professionals available to support the individual. It is anticipated that this will enable older people who are uncertain as to whether or not they need a bed in a residential home to take time to recover before making any life changing decisions from their hospital bed. For some older people, discharging them home from hospital may be unsafe or impossible, as they will need more time to improve their health and recover, although, it is possible that they will not need health intervention or monitoring, they will be able to stay within the home for short periods of time to aid recovery and speed the discharge from hospital. Individuals can also be admitted to the beds from home when they are going through a period of feeling unwell e.g. chest infection again avoiding hospital admissions. The project will also fund a discharge co-ordinator that will be based at Ysbyty Gwynedd who will, this post will be funded from ICF across Gwynedd and Anglesey The development of short term care facility within Extra Care Housing facility in Bangor, the unit would be a one bedroomed unit on the ground floor of the Extra Care Housing facility. The unit will be dual purpose [social care and health] and therefore used flexibility to optimise usage, providing accommodation and care for older people as follows. Social Care – providing respite care for Service users who are usually cared for at home and whose main carer requires a break, or to provide short-term care for services users in the event of a crisis. Health Care – providing care for Service users who have been assessed as being able to benefit from short period of intervention and support which may prevent hospital admission or the need for nursing/residential home care and help to maintain independence. Anglesey Project: - To provide community based Intermediate Care services – both residential and domiciliary in order to support individuals to remain at home and avoid inappropriate admissions to care homes/hospital and to facilitate fast track hospital discharges. There will be a more focussed approach to support people living with dementia.	338,335	• Promoting independent living • Promoting healthier lifestyles and reducing health inequalities • Encouraging innovation. • Focus on resources and increased capacity.	1.1,1.2,1.3,2.1,3.1, 3.2,5.1,5.2,7.1,8.1	• Reduce loneliness and isolation in our communities • Promote independent living, people´s choice and control over their lives • Promoting healthier lifestyles and reducing health inequalities	- Number of people supported - % of admissions from step up - % of admissions from step down - Number of Days avoided in Hospital - % returned home - % went to hospital - % went to long term care setting - % needed further assessment - % passed away	• Develop one short term care flat within extra care housing (replicate what is currently in Bala area) • Need to agree what costs that need to be covered i.e. Cleaning Service, laundry, Maintenance of flat, • Agree Exit Strategy i.e. – which partner will fund what going forward • What specialist equipment is needed • link to sec33 arrangement – opportunity to consider CHC funding if appropriate? • Set up local short term bed meetings – local leaders to lead going forward • Evaluate the scheme for future funding • Monitor and report progress quarterly	
	SUSD1.3	**Step Up / Step Down**	The scheme offers a short term stay for social care or health care needs in extra care housing where domiciliary care and support is available 24 hours a day, dependant on the assessed need of the individual. The service can also be offered in short term residential or nursing care homes for limited periods. This service is monitored and reviewed by the District Nursing Service. The funding also enables step up/down into nursing care to support early hospital discharge. Step up bed spot or block purchasing in the independent sector would avoid admissions and step down beds would facilitate the discharge to assess process. This is a continuation of the existing scheme to prevent admissions and facilitate early discharge / discharge to assess. There is a strong focus on using a reablement approach with individuals with the aim of ensuring their skills are maintained and enhanced and a return to optimal health. The project would provide intensive support for clients over short periods of time within extra care housing to avoid residential placement for respite or in crisis situations and to allow a person to recover from an acute episode of illness with additional health resource support from district nursing, physiotherapy and occupational therapy care programmes. It will increase integration and support across health, social care and housing to provide a viable, responsive and safe alternative to an acute admission or facilitating appropriate discharge and promoting or sustaining an individual's independence.	112,000	Focus resources and increase capacity. Proactive approach to care and support. Preventative interventions. Increase capacity to meet demand. Encourage innovation. Focus resources and increase capacity. Proactive approach to care and support. Preventative interventions. Increase capacity to meet demand. Encourage innovation. Promoting and maximising independent living.	1.3, 1.5, 2.3, 8.1	to bring together services for older people with complex needs including dementia to support organisations who provide care to work together more.	• A Reduced Length of Stay for Older People: Facilitates discharge from hospital. • A Reduction in Emergency Hospital Admissions (including re-admissions) for Older People: if used by enhanced care district nursing team. • A Reduction in the Number of Older People in Receipt of Statutory Long-term Social Care Services (Domiciliary Care, Residential Care): Reablement focus reduces care packages, OT assessment regarding home facilities. • Enhanced Quality of Life for People with Care & Support Needs: Maintains independence, social interaction a service user remains part of the community. • Maximised Cost and Service Efficiencies: ECH saves £100 per week versus residential care for step down and over £1000 per week compared to a Community Hospital stay. • Improved Service User/ Patient Experience of Integrated Services: Seamless service by the community support staff and district nurses. • To provide carers respite to enable carers to continue with their role and avoid permanent placement of the cared for in residential care.	To review and strengthen the Discharge to Assess process. To establish the spot purchase process.	Service users from health are not charged for their care and support which comes from Social Services core funding.
WELLBEING SUPPORT	WS1.1	**Community Agents**	Community Agents work with the over 50s in Wrexham. Based in community council areas, providing easy access to a wide range of information that will enable them to make informed choices about their present and future needs. Agents aim to enable older people to feel more independent, secure, and cared for, and to have a better quality of life. They support people living in areas of Wrexham, bridging the gap between the local community and the statutory or voluntary organisations and are able to offer help and support.	142,294	Preventative Interventions Encourage Innovation Promoting & maximising independent living Promoting social enterprise, co-operatives, user-led services and the 3rd sector Develop partnership working & collaboration	1.1 1.2 1.3 1.4 1.5 1.6 2.1 2.2 2.3 4.1 4.2 5.1 5.2 6.1 6.2	to bring together services for older people with complex needs including dementia to support organisations who provide care to work together more good services working together to support carers	No of new people supported TARGET 77 new people each quarter % of people feeling less isolated TARGET 75% % of people who reported a positive difference TARGET 75%	None: scheme fully operational	

THEME	REF. NO.	PROJECT NAME	PROJECT DESCRIPTION	Total Expenditure	LINK TO ICF PRINCIPLES (e.g. Prevention and Alternative Delivery Models, Supporting Independence)	LINK TO NATIONAL OUTCOMES FRAMEWORK	Population Needs Assessment - link to Action Priorities	ANTICIPATED IMPACT	KEY DELIVERY MILESTONES (including key dates)	Additional resources if applicable
	WS1.2	**Good Neighbour Programme (RVS)**	Following funding provision which began in 2nd quarter 2017, this project has been delivering a valued and well used service. The evidence for the success of this service can be found by looking at the number of citizens referred for help. The service is available throughout Gwynedd and managed by one staff member located in the regional Hub office located at Bangor. Community Good Neighbours will continue to deliver practical support to help reduce the isolation so many older people experience and help them stay connected and engaged with their community. We believe one impact will be to support older people to access the community services provided to allow them to both benefit from existing community services, engage with groups and clubs to combat isolation and the interminable isolation that can be so destructive in later life. We will also continue to ensure those referred stay safe, well and happy to remain at home. Volunteers will continue to support those already accessing the service to achieve their personal goal(s). Volunteers will continue to support individuals to regain confidence, to access social activities and to, where possible, re-engage with communities following admission to the NHS. For those with little or no family and friends to help them, this bespoke service will encourage new community bonds. The support provided by the volunteers is flexible, tailored to each citizens needs and aspirations and will continue to include the following: • Support to develop, or re-connect with, social networks in the community, for example support to access faith groups, day centres, to regain confidence after a fall, to work with someone with anxiety issues to encourage them back to everyday life, to join a group for hobbies or interests. • Utilise our existing transport service to facilitate attendance at medical appointments. E.g. GP, hospital dental and opticians. Statistics (one in three older people have trouble getting to places they need to go to) are still showing transport is a major factor for all older people, and can be a barrier preventing them attending appointments. • Following discharge or prior to admission to the NHS, we will continue to work to support people to be reassured all will be well. • Volunteers will help with pets, finding appropriate care facilities for animals should their owners need someone to step in at short notice. I know from helping several older people, they worry dreadfully about the care provision for their animals if they need NHS admission. • Continue to make sure the environment is safe, warm and well. Working with individuals to access help and advice if financial reviews are needed. • To keep people informed of community events, and to encourage discussions around local news topics. Many volunteers speak Welsh as their first language, as does our staff team and we welcome and encourage diversity. • Assisting with shopping, working with citizens to ensure they have a robust shopping plan in place which, will continue to work for their needs. • Volunteers often run errands, posting letters, buying cards, picking up and dropping off all sorts of items. • With the support of the staff team, we will continue to work with each citizen to ensure any additional help or support is provided. E.g. signposting to other third sector partners for additional information or advice.	27,943	- promoting social enterprises, co-operative, user-;ed services and the third sector - focus resources and increase capacity - proactive approach to care and support - promoting independent living - helping collaboration	1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 2.1,2.2,2.3, 3.1, 3.2, 3.3, 4.1, 4.2, 5.1, 5.2, 6.1, 6.2, 7.4, 8.1	• Reduce loneliness and isolation in our communities. • Promote independent living; people's choice and control over their own lives • Promoting healthier lifestyles and reducing health inequalities • Develop social prescribing – strengthen the links between healthcare providers and community, voluntary and local authority services.	• The number of service users supported • The number of service users signposted to other services • The number of advisory group meeting arranged We will collate volunteer and service user impact sheets to demonstrate the difference. We will set goals and collate outcomes completed and measure difference made. Therefore: % of individuals feeling a positive change has been made % of individuals reporting being healthier and Safer % of individuals staying connected and feeling less isolated	Review those initially referred to the service and decide if outcomes have been met • Continue to support those initially referred to the service if necessary • Support 125 vulnerable older people • Support 50 volunteers and continue to promote volunteering offering support into employment for some • To deliver 3,000 volunteer hours per annum • Continue to support out luncheon clubs 3 in total • Organise 3 (1 each quarter) advisory groups to gather the needs and expectations of our service users and volunteers • Measure the impact made by gathering evidence through the use of our service user and volunteer impact sheets • Collate evidence through case studies to further demonstrate the difference made through volunteering and the positive impact that it has on our community	
	WS1.3	**Reducing Loneliness and Community Transport Link (O Ddrws I Ddrws)**	O Ddrws I Ddrws organises community transport, taking people to medical appointments, to day care centre, to visit, to shop, the majority of people are older people or are disabled or with development problems following a period of ill health. We have develops a service – Coastal Bus Llyn – A bus that transport walkers to walk along the Llyn coast. This project 'reducing loneliness' would aim to bridge the two services together along with extending it out to new partners. We will arrange for current O Ddrws I Ddrws client as well as other to be invited to take part in activities. The activities will be a combination of activities that have already been organised (e.g. Neuadd Dwyfor, Llyn Produce Market) and arranging visits, new activities and walking trips. People will receive encouragement and a way of travelling from Door to door. Some would also need carer support especially at the start. The service will develop close working partnerships with statutory and voluntary organisations as well as care and health services and community activities. Their will also be a second part to their funding which is Community Transport Link between Rhydbach Surgery and Abersoch. Rhydbach Surgery closed its branch in Abersoch in late 2017. The impact upon elderly patients is potentially more significant and due to the irregular, or inconvenient bus routes/timetable between both Abersoch and Botwnnog some patients have resorted to using a taxi service which is believed to cost in the region of £25-30 due to the 'waiting time'. The purpose of the scheme is to assist those patients with restricted mobility or those with limited access to convenient transport from Abersoch, and communities immediately near Abersoch to the surgery in Botwnnog.	11,180	-promoting social enterprises, co-operatives, user-led services and the third sector - promting independent living - helping collaboration	1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 2.1, 2.2, 2.3, 6.1, 6.2, 8.1	• Reduce loneliness and isolation in our communities. • Promote independent living; people's choice and control over their own lives • Promoting healthier lifestyles and reducing health inequalities • Develop social prescribing – strengthen the links between healthcare providers and community, voluntary and local authority services.	Agreed Outcomes: # people supported % of individuals feeling a positive change has been made % of individuals reporting being healthier and Safer % of individuals staying connected and feeling less isolated	Reducing Loneliness • Discuss and work with partners to develop the project • Offer a variety of social activities • Raise awareness and promote people to join the project • Monitor and evaluate the project and create case studies Community Transport Link • Content of leaflets to be agreed and printed (bilingually) and shared with relevant parties for distribution as agreed • Practice Manager to agree process with GP Partners • Practice Manager to share with reception team this process to ensure patients can be accommodated, and where possible keeping appointments as close together as possible to avoid long waiting times for the bus driver and paients who had an earlier appointment. • Project group to reconvene at a date close to the end of the trial to discuss the success of the scheme and decide on the continuation plans if appropriate. We agreed that the service must be well used and supported during the trial; if it is not utilised or seen as beneficial, we will not continue.	
	WS1.4	**Local Asset Co-ordinator**	Local Asset Coordination (LAC) is a new model of working with communities and has been developed on Ynys Mon over the past two years. It is a community based approach encouraging adults and their families to take the lead in developing their own support systems whilst focusing on their strengths and abilities	74,936	• Proactive approach to care and support. • Promoting independent living • Preventing or delaying the development of people`s needs for care and support. • Encourage innovation and develop new models of delivering sustainable integrated services. • Promote social enterprises, co-operatives, user-led services and the third sector.	1.1,1.2,1.3,1.4,2.3, 3.1,4.1,4.2,5.1,5.2, 6.1,6.2,7.1,8.1	• Reduce loneliness and isolation in our communities. • Promote independent living; people's choice and control over their own lives • Promoting healthier lifestyles and reducing health inequalities • Develop social prescribing – strengthen the links between healthcare providers and community, voluntary and local authority services.	• 120 people supported. • % of people who feel less isolated. • % of people who reported a positive difference.	April Agree Partnership Agreement with BCUHB – quarterly reports June Quarterly reports September Conduct SROI evaluation	
	WS1.5	**Community Wellbeing**	The ongoing development of a programme of wellbeing will continue to support the older people in Conwy through provision of healthy activities, social opportunities, mental stimulation, the opportunity to develop friendships and a support network, providing a purpose to the day, and preventing or delaying the need for formal support. The project will be delivered across the 5 locality zones in Conwy of Llanrwst, Llanfairfechan, Llandudno, Colwyn Bay and Abergele. During this funding year, the emphasis will be on developing deeper into these localities, to include more rural areas. In addition, planned partnership work alongside colleagues from Denbighshire County Council will provide the opportunity to collaborate on mapping activity and delivery on border areas of Cerrigydrudion, Llansannan and Kinmel Bay in particular.	177,000	Focus resources and increase capacity Proactive approach to care and support Preventative interventions Encourage innovation Promoting and maximising independent living Develop partnership working and collaboration Increase capacity to meet demand	1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 2.1, 2.2, 2.3, 3.1, 3.2, 3.3, 4.1, 4.2, 5.1, 5.2, 6.1, 6.2, 7.1, 7.4.	To bring together services for older people with complex needs including dementia. To support organisations who provide care. To work together more.	Work has already begun on collaborating with Public Health Wales in order to better evidence the impact of this preventative activity and connection-building on people's health and wellbeing – particularly those suffering from one of the 'basket of 8' conditions. This work will develop during 2018-19 with a focus on those projects already trialled in collaboration with BCUHB partners during 2017-18 such as 'Take Notice' (Mental Health) 'Well Now' (Obesity) and 'Sophrology' (Chronic pain) for example.	Quarter 1 • Implement 6 monthly programme of activities which will incorporate wider locality areas that have been mapped in previous quarter. • Meet with current and new providers to discuss expectations/requirements of delivering services; update and implement new Service Level Agreement. • Establish a Community Wellbeing Group with representatives from Social Care, BCUHB, Third Sector, Public Health and Leisure to agree wellbeing model and strategy for Conwy including key objectives and delivery model link to the population needs assessment. • Implement monthly highlight reports and scatter diagrams that can be shared with statutory partners and across MDT's to encourage referrals. • Continue work in new areas of focus identified during mapping in Q4. Quarter 2 • Update evaluation tools. • Final preparation for CWB team to go live on the Paris database. • Planning for delivery of sessions for Conwy Rural Health and Wellbeing Hub. • Focus work on the 'basket of 8' health conditions. • Develop/enhance the social prescribing models in collaboration with the Third Sector. • Plan / Develop model based on DCC talking points in local libraries. • Alternative Delivery Model agreed and ready for Implementation in Q3. Quarter 3 • Implement new agreed delivery model. • Work with Dementia Friendly groups to plan an event to bring the Mobile Virtual Dementia Tour Bus to Conwy. • Creat a map of county to identify activity levels (red/amber green) and new areas of focus. • Revaluate and implement our new marketing strategy. • Work with our DCC Community Development Team to underake collaborative working along border areas such as Cerrig / Corwen. • Plan awareness raising sessions with Reablement teams to make better links, with the aim of trying to reduce their frequent flyers. Quarter 4 • Draft Wellbeing plan and link in to corporate strategy. • Finalise the protol for communication, joint working and signposting. • Investigate options for sustainable implementation plan beyond grant funding. • Focus work on care homes to include delivery of taster sessions in homes that residents can access in the community. • Plan and deliver showcase event in the Central Area. • Implement referral pathwats with NWFRS, CAT team and NW Police.	
	WS1.6	**Community Navigation – Social Prescribing Service for Denbighshire**	Community Navigators connect citizens with sources of support and opportunities within the community. They are at the heart of their communities building knowledge and support. Focus is on increasing independence and empowerment of citizens.	103,500	Focus resources and increase capacity. Proactive approach to care and support. Preventative interventions. Encourage innovation. Promoting and maximising independent living. Develop partnership working and collaboration. Increase capacity to meet demand.	1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 2.1, 2.2, 2.3, 3.1, 3.2, 3.3, 4.1, 4.2, 5.1, 5.2, 6.1, 6.2, 7.1, 7.4.	To bring together services for older people with complex needs including dementia. To support organisations who provide care. To work together more.	• Citizens will have a voice in their local community. • Citizens will be able to access information from a variety of sources to meet their health and well-being needs. • Citizens becoming more independent and able to access social prescribing activities with less intensive support. • Citizens becoming better at managing their long term conditions themselves. • Citizens and carers feeling less socially isolated and enjoying more social interaction. • Citizens will be better able to avoid or cope with crises and other situations which cause stress or anxiety because they have local community support or are actively engaged within their community. • Citizens will be able to engage with and benefit from the services they need as independently as possible.	Increased number of Well Being Information Points within GP surgeries. Action Plan developed in line with new and existing developments. Establish monitoring and reporting requirements.	The Community Navigators are very much an integral part of the Community Resource Team model and therefore indirectly supplemented by core funding and some cluster funds.

PRIORITY AREA FOR INTEGRATION: PEOPLE WITH LEARNING DISABILITIES AND CHILDREN WITH COMPLEX NEEDS, CARERS

THEME	REF. NO.	PROJECT NAME	PROJECT DESCRIPTION	Total Expenditure	LINK TO ICF PRINCIPLES (e.g. Prevention and Alternative Delivery Models, Supporting Independence) See definitions tab	LINK TO NATIONAL OUTCOMES FRAMEWORK See definitions tab	Population Needs Assessment - link to Action Priorities (Easy Read Version)	ANTICIPATED IMPACT - outcomes achieved in 17/18 to be used as baseline targets unless specified otherwise	KEY DELIVERY MILESTONES (including key dates)	Additional resources if applicable
Alternative Models of Service	AMS1.1	Diana Service	The project provides additional nursing and HCSW hours to children with complex / life limiting medical conditions to keep them at home in their own communities in response to fluctuating needs	16,500	1,2,4,	1.3,1.5,2.3	to improve health and social care support for children with complex needs	# of children in receipt of service as a result of this additional funding = 21 # of bed nights saved = 70 # of hospital bed days saved = 99 # of DTOC = 0	Not applicable - continuation	
	AMS1.2	Acute Liaison Nurse	The nurse and specialist nursery nurse will support parents / carers and acute staff enabling the specific needs of this group of children and young people to be met whilst receiving acute hospital admissions and when a child or young person with disabilities requires health based medical assessments. To ensure the health needs of children with disabilities are appropriately met if admitted to hospital and thus enhance recovery and facilitate discharge home the service will offer and enable : • Timely holistic assessment for child and carer • Preventative and targeted Intervention based on assessment • In-reach support to hospital staff to enhance care and support parents / carers when their child is in hospital and optimise timely and planned discharge home. • Out-reach support to children, young people and parents/carers when medical based invasive or investigative examinations are required. • access to opportunities available to all children	78,874	-preventative interventions (incl. promoting family upbrining, minimising the effect of disability, reducing the need for care proceedings and enabling independence.) . - proactive approach to care and support - promoting independent living	2.3, 3.1, 3.2, 3.3, 5.1, 5.2, 8.1	• Improving emotional health, mental well-being and resilience of children and families • Promote healthier lifestyles and reducing health inequalities • Support young people with care and support needs with transition to adult services	• The number of children the service can support to facilitate discharge home • The number of children and young people with a hospital passport • The number of children and young people supported to attend outpatient appointments	To ensure that each child admitted onto an acute ward (planned) has a Hospital Passport. • Children awaiting invasive tests receive support and intervention for them to be able to have these tests for example: desensitisation work. • Home based visits will enable collaboration between the agencies involved in service delivery to ensure effective seamless care. • Children, young people and parents/carers are provided with information about treatments and appointments in a format that is understandable and practical. • Children and young people and their families will report a positive experience of accessing acute services • Deliver education and training to acute staff in all areas where children and young people are seen to enable an understanding of the acute liaison nurse role in support this group of children and young people to enable equal access to health provision. • Reasonable adjustments for this group of children and young people will be identified and facilitated by this team through the co-ordination of care.	
	AMS1.3	Blaenau Project Facilitator	This bid is for a Facilitator to support the current clinical team in setting up the new service, co-ordinating the patient journey through the pathway, optimising communication between various professionals, gathering outcome data and being present during clinics to meet and greet patients and their carers.	22,285	• Preventative interventions (incl. Delaying and reducing the need for care and support and enabling people to live their lives as independently as possible). • Proactive approach to care and support. • Focus resources and a more rapid response to better meet demand and improve access to service. • Encourages joined up working between Local Authority and Health Board, development of new models of delivering sustainable integrated services. • Delivering a service closer to home.	1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 2.3, 4.1, 4.2, 5.1, 5.2, 2.1, 2.2, 3.1, 3.3, 6.1, 6.2, 7.1, 7.2, 7.3, 7.4, 8.1	• Develop more access in the community to support people with a learning disability, including work and friendships. • Support older carers and older people with learning disabilities • Promote good health of older people with learning disabilities and support people with learning disabilities	• Patient feedback (mixed quantitative and qualitative form) • Clinical audit cycle before and after service development (quantitative) • Annual number of new out of area placements	• Open Day of the Blaenau Ffestiniog Health Facility • Clinics commence • Clinic process reviewed and refined (direct impact on clinic model) – letters, clinical processes, data gathering processes, patient identification, communication, information sheets, information governance, record keeping, storage of records, IT system to track clinic outcomes • Broader refinement of service (indirect impact on clinic model) – Need for LD register, need for system to flag up patients requiring screening, LD register kept up to date • Develop links with 3rd sector partners • Initiation and planning of preventative/early intervention group sessions • Implementation of preventative/early intervention groups • Refinement of preventative/early intervention groups • Ongoing assessment, feedback and refinement of the clinic model • Sign off from Clinical Governance of clinical model of care (including pathways)	
	AMS1.4	Transition	Project Aims • Individual: To support adults with learning disabilities and / or Autism to learn new skills and to be more independent and to develop confidence in their ability to be more independent. • Community: To improve community participation and reduce social isolation. Encouraging support staff to explore with the person opportunities in the community. • Carer: To reduce reliance on the family carer, to raise expectations and confidence in the cared for's ability to develop skills and take calculated risks. • Statutory Services: To reduce long term reliance on statutory services, by embedding an approach that focuses on progression and the achievement of agreed outcomes. • Provider: To embed a different culture and approach to enablement. • Support Workers: To increase confidence in working innovatively, seeking opportunities in the community and seeing their role differently. • Integration: To embed an enhanced enablement staff resource to work within the Disability Service Early Intervention & Prevention Team (Conwy) / Complex Disabilities Team (Denbighshire), Occupational Therapist, Nurses and Providers. • Local Authority: To promote cross boundary working and the sharing of skills and assets Objectives • To prepare and equip people with the skills they will need for independent living or if/when they move on to a model of housing that provides a lower level of support, by focusing on the development of specific skills for each individual within an agreed time scale. • To reduce reliance on paid support and on family carers. • To encourage people to be active members of their local community and to participate in local activities by supporting people to engage in local activities with a planned phasing out of that support. • To facilitate peer support and friendships by identifying compatible individuals who have similar interests and then dovetailing their support with a planned phasing out of that shared support. • To support and enable individuals to travel independently wherever possible. • To encourage family carers and others to adopt a positive approach to risk taking. • To change attitudes and thinking towards short term interventions. • To develop skills in thinking about outcomes rather than hours of support. • To encourage and support people to adopt an active and healthy lifestyle.	46,054	Focus resources and increase capacity Proactive approach to care and support Preventative interventions Increase capacity to meet demand Encourage innovation Promoting and maximising independent living Develop partnership working and collaboration	1.1, 1.2, 1.3, 1.5, 2.3, 3.1, 4.1, 4.2, 5.1, 5.2, 7.4,8.1	Good, joined up services for people with learning disabilities	· Individuals able to take responsibility for managing their own lives. · Increased sense of well-being. · Families understand how their young person will be supported as they transition to adult life. · To increase independence and use of own resources and those within communities in line with the SSWBA 2014. · To promote self-confidence. · Reduced likelihood of recurrent family crises. · Improved joint working practices at transition. · Families more informed and linked in to appropriate services. · Reduced reliance on carers and statutory services. · Increased community integration. · Reduction in risks. · Promotion of proportionate responses to individual's outcomes. · Promotion of voice and control using advocacy if appropriate	Identification of potential project beneficiaries Identify key partners in education and health and establish process. Establishment of a pro-active assessment process with a focus on prevention Joint assessments completed	
Carers	C1.1	Carers Support (Carers Outreach)	Full time Carer's Support Officer in Ysbyty Gwynedd that will be dealing with patient's carers on clinical ward and those wards that do not refer at the moment including Hergest. The extra officer will go around wards to identify carers and give information and advice when necessary. The purpose of the post will be to support carers during the difficult time, this is often when carers realise they are a carer or realise they will be a carer when their loved one returns home. Majority of carers do not know what is available to them. We explain the discharge process, what is to be expected when they go home, guide them and and put things in place like, help with the bins etc. and support the carer emotionally. When the patient is home, the carer then receives support from our contact officers and officers in the community. We offer support with benefits and grants as necessary.	33,000	• Supporting life alongside caring - All carers must have reasonable breaks from their caring role to enable them to maintain their capacity to care and to have a life beyond caring; • Identifying and recognising carers - Fundamental to the success of delivering improved outcomes for carers is the need to improve carer's recognition of their role and to ensure they can access the necessary support; and • Providing information, advice and assistance - It is important that carers receive the appropriate information and advice where and when they need it	1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 2.1, 2.2, 2.3, 4.1, 4.2, 5.1, 5.2, 6.2, 7.1, 7.2, 7.3, 7.4, 7.5	Early Identifiaction and support for carers Support carers in employment Young Carers	• No. of carers supported • No. of individuals that return home that or on hospital delay list. • % of carers who feel they have more information to continue to be a carer. • % of carers who note an improvement in their wellbeing	• Support 100 carers a quarter • Identify unknown carers • Support on benefits being offered to carers • Working with organisation in the community and signpost • Emotional support and ongoing support offered to all • Ensure the patient is discharged safely from the hospital a carer's confidence is raised • Work with Health and Social Services • Raise awareness with Staff and students/nurses under training	one officer employed through funding from BCU and Gwynedd Council funding
Community Support & Integration	CSI1.1	Community Resource Team (Part 2)		131,364	Reported under OP tab to avoid duplication	Reported under OP tab to avoid duplication	Reported under OP tab to avoid duplication	Reported under OP tab to avoid duplication		
Dementia	D1.1	Developing Dementia Friendly Communities and Cafes	Expanding Dementia Care and Support in the Community through the development/ sustainability of Community Initiatives such as Dementia Friendly Communities and Memory Cafes and other inclusive opportunities for all living with dementia.	27,024	2,6,7,8	1,6,	to bring together services for older people with complex needs including dementia	2 additional Dementia Friendly Communities in year 4 Towns to have accredited business as dementia friendly in year Memory Cafe/ Inclusive Activities Theatr to Clwyd to deliver and be accredited as Dementia Friendly in year Leisure Services Aura to deliver and be accredited as Dementia Friendly in year	Connahs Quay to achieve DF status by September 2018 and Holywell by March 2019 Buckley to accredit businesses by March 2019 , Mold by June 2018, Flint by Sept 2018, Saltney by Dec 2018 Memory Cafe/ Inclusive Activities Theatr to Clwyd to deliver and be accredited as Dementia Friendly Leisure Services Aura to deliver and be accredited as Dementia Friendly	
Early Intervention & Prevetion	EIP1.1	Targetted intervention for children with complex needs	Additional targetted social worker capacity to support children and young people with complex needs and their families.	45,227	1, 4,	2,7.4	Improve health & social care support for children with complex needs better support for children's mental health better family support services good services working together to support carers	# of new referrals per quarter - NEW Total # on caseload at end of quarter - Approx 20 per quarter % of children who achieve what matters to them - NEW	Not applicable - continuation	
	EIP1.2	Repatriation & Prevention (RAP)	3 service elements to support children and young people with complex needs (and their families) closer to home. A third sector provider is contracted to provide: 1.Rehabilitation and therapeutic support 2.Provision of solutions to prevent family breakdown and/or escalation of need leading in risk of out of county placement The third element is led by FCC to increase fostering capacity fo RAP children to provide respite for families (often foster carers themselves)	250,000	Preventative Interventions Develop partnership working & collaboration	2.3 3.1/3.2 4.1 5.2 7.4	Improve health & social care support for children with complex needs better support for children's mental health better family support services good services working together to support carers	No of people supported TARGET X new people per quarter AWAITING DETAIL % of people who reported a positive difference TARGET		

THEME	REF. NO.	PROJECT NAME	PROJECT DESCRIPTION	Total Expenditure	LINK TO ICF PRINCIPLES (e.g. Prevention and Alternative Delivery Models, Supporting Independence) See definitions tab	LINK TO NATIONAL OUTCOMES FRAMEWORK See definitions tab	Population Needs Assessment - link to Action Priorities (Easy Read Version)	ANTICIPATED IMPACT - outcomes achieved in 17/18 to be used as baseline targets unless specified otherwise	KEY DELIVERY MILESTONES (including key dates)	Additional resources if applicable
	EIP1.3	Repatriation & Prevention (RAP)	The provider will work within a multi-agency context, and through the medium of therapeutic work, to provide an early intervention and preventative therapy service for children, young people, their carers and education. The interventions will aim to reduce the risk of family or placement breakdown. This represents a shift from ongoing provision towards early intervention and preventions, integrated across health and social care across a two authority footprint.	106,440	Preventative Interventions Develop partnership working & collaboration	2.3 3.1 3.2 4.1 5.2 7.4	Improve health & social care support for children with complex needs better support for children's mental health better family support services good services working together to support carers	No of people supported TARGET 28 new people per quarter % of people who reported a positive difference TARGET 81%	None: scheme fully operational	
	EIP1.4	IM-PACT Team, offering Preschool Autism Communication Therapy (enhanced by Interactive Music for more severely affected children)	Preschool Autism Communication Therapy (PACT) and Interactive Music (IM, or Musical Interaction Therapy, detailed below) are evidence-based therapies, both designed to improve the core "symptoms" of autism by trying to restore the natural processes of development. Parent and therapist work together as partners using video feedback to interpret the child's often puzzling communication patterns, and find ways to respond that will help the child to engage in interaction and develop clearer communication. PACT firmly places parents at the heart of helping their child, aiming to reskill them with an understanding of their child's communication, to empower them in how to respond, and improve their morale and confidence. Parents are empowered to better understand their child and how to support their development. Promoting positive parent-child interaction experiences is likely to reduce parental distress and challenging behaviour of the child. Working with parents also enables and beneficial changes in interaction to be carried into the child's everyday life, the context in which early social skills are usually learned.	200,076	Focus resources and increase capacity • Proactive approach to care and support. • Establish preventative interventions.	1.3, 1.5, 2.1, 2.2, 2.3, 3.1, 3.2, 5.1, 5.2, 8.1	• Improving emotional health, mental well-being and resilience of children and families • Promote healthier lifestyles and reducing health inequalities • Support young people with care and support needs with transition to adult services	- No. of people supported - % of people who reported a positive difference	This project will build on the work done to date to develop a comprehensive PACT service which spans different services and disciplines. It will be offered whenever it is seen as appropriate and proportionate to the need. The project will actively contribute to establishing a more coherent and consistent approach to early intervention for social communication disorders in Gwynedd and Anglesey. Specifically: A. To build on existing work to develop a sustainable, multidisciplinary, multiagency, early intervention service to address the core features of autism and social communication disability. B. To empower parents to better understand their child's communication and build their confidence in how to respond to their child. C. To reduce the adverse childhood experiences of the child by ameliorating parental distress, and preventing escalation of behaviour that challenges due to adult-child communication difficulties. D. To raise the understanding and intervention skill level of universal and third sector providers in relation to the unique needs of children with social communication disability. E. To actively contribute to establishing a coherent and consistent approach to early years intervention for autism and social communication disorder in Gwynedd and Anglesey.	
	EIP1.5	Support and Intervention for ADHD	The provision of a band 6 nurse and band 4 assistant psychologist will enhance the current service for children and young people who have received a diagnosis of ADHD, which is being developed by an advanced nurse specialist and is currently lead by consultant psychiatry and clinical psychology who provide assessment and medication prescribing and monitoring currently. Additional 7.5 hours a week from a clinical psychologist will provide supervision to this team regarding intervention and prevention strategies. Currently specific interventions for this group of children and young people and families are extremely limited. This proposed team will work as part of the neurodevelopmental service in the West in collaboration with children's integrated disability teams, CAMHs and education.	100,495	Focus resources and increase capacity • Proactive approach to care and support. • Establish preventative interventions.	2.1, 2.2, 2.3, 5.1, 5.2, 8.1	• Improving emotional health, mental well-being and resilience of children and families • Promote healthier lifestyles and reducing health inequalities • Support young people with care and support needs with transition to adult services	• No. of people supported • % of people who reported a positive difference	All parents with a newly diagnosed child/young person will be offered 'newly diagnosed' workshop • Incredible years Parenting programme will provide parents with knowledge and tools to manage challenging behaviours at home • Families will receive support with challenging sleep problems • Families will be able to have access to support and advice from a skill mix team • Families will benefit from the development of a positive behaviour support plan	
	EIP1.6	Short Breaks	The project will build on and improve current Short Break services and increase and develop the range of options available to meet the needs of disabled children, young people and their families following multi-agency assessments. The developments will operate across Gwynedd and Mon	145,079	Focus resources and increase capacity • Proactive approach to care and support. • Establish preventative interventions. • Encourage innovation. • Promote and maximise independent living. • Support local accommodation solutions	5.1, 5.2, 2.1, 2.2, 2.3	• Improving emotional health, mental well-being and resilience of children and families • Promote healthier lifestyles and reducing health inequalities • Support young people with care and support needs with transition to adult services	Disabled children and young people have a wider range of activities and opportunities to take part in safe and supportive environments • Families, parents and carers have increased resilience and enhanced emotional well being • Relationships within the family are more stable • Money spent on high cost placements can be reinvested into positive, preventative services Agreed Outcomes • No. of people supported • % of people who reported a positive difference	Agreed Vision for service with all stakeholders • Development of Service Plan in line with existing budgets available • Pro-active recruitment of volunteers, formal and informal short break carers, Direct Payment personal assistants • Service is operational	75% of Short breaks manager post funded from Gwynedd core funding
	EIP1.7	Child Development Centres (CDC)	The project aims to integrate services for Children who have complex disabilities aged 0-5 and ensure there is consistency with regard to eligibility. Both centres provide a base for families to utilise when they require support from a range of disciplines. Integration with colleagues from the Local Authority including Education and Social Services supports the delivery of holistic assessment and intervention. The implementation of the project has enabled more families to utilise the centres and benefit from the support we can provide. We have provided tiered intervention ensuring that we can deliver intervention and support in a timely manner. We have reduced waiting times from 18 months to 6 month which supports early assessment and intervention. Person centred planning is key and we involve Parents/ carers with every aspect of care delivery thus promoting confidence and independence in supporting their child. We have been able to deliver groups based on behaviour management and play and for children who have complex behavioural needs we have delivered home based intensive intervention as times when families require this, this has proved very successful and avoided family breakdown. We have been able to provide early intervention into Nurseries and schools and behavioural support as required.	283,098 155,338 (CCBC) 127,760 (DCC)	Focus resources and increase capacity. Proactive approach to care and support. Preventative interventions. Increase capacity to meet demand. Encourage innovation. Promoting and maximising independent living. Develop partnership working and collaboration.	1.1, 1.2, 1.3, 1.5, 2.3, 3.1, 4.1, 4.2, 5.1, 5.2, 7.4,8.1	• to improve health and social care support for children with complex needs • better support for children's mental health • all children to be safe and healthy from pregnancy to two years old • to prevent childhood obesity • better family support services.	-Families report improved wellbeing following intervention- carer evaluation. -Reduced waiting times for assessment and intervention. -Reduced DNA appointments as families can access those involved with the child at the centre and they do not have to travel to multiple appointments. -Reduction in re- referral to services by supporting enablement and independence (although it must be recognised that some children with very complex needs may require ongoing support). -Reduction in families requesting additional support at times of crisis for example foster placement, respite placement. -Increased acceptance of referrals to the centres as a result if tiered intervention and eligibility criteria.	This is a recurring project for 2018/19 we have appointed and trained the majority of staff and continue to review the impact on service delivery.	
	EIP1.8	Child & Adolescent Learning Disability Service	The Service provides support to children and young people aged 5-18 and their families within the counties of Conwy and Denbighshire. With additional staffing resources we have been able to provide support to families and prevent escalation of crisis and family breakdown. The project promotes the enablement and independence of families to support their child/YP within the family home, accessing support throughout the weekend and evenings. We have also supported children and YP with severe challenging behaviour to access community services throughout holiday periods and participate in workshops at the centres, developing daily living skills.	392,974 215,628 (CCBC) 177,346 (DCC) Llys Gogarth / Challenging Behaviour / Holiday Scheme – 86,315 (CCBC Only)	Focus resources and increase capacity. Proactive approach to care and support. Preventative interventions. Increase capacity to meet demand. Encourage innovation. Promoting and maximising independent living.	1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 2.1, 2.2, 2.3, 3.1,3.3, 4.2, 6.1, 7.5, 8.1	• to improve health and social care support for children with complex needs • better support for children's mental health • all children to be safe and healthy from pregnancy to two years old • to prevent childhood obesity • better family support services. • good, joined up services for people with learning disabilities	· Families report improved wellbeing following intervention- carer evaluation. · Reduced waiting times for assessment and intervention. · Improved family stability / reduced likelihood of recurrent family crisis reduction in re- referrals. · Measurement of time between request for intervention and delivery. · Review of how many families are supported out of hours. · Measurement of length of intervention. · Reduction in the use of formal respite services. · Evidence of group or dovetailed activities which can be sustained beyond the period of intervention. · Evidence of new skills – related to activities of daily living. · Evidence of reduction in escalation of need. · Carer confirmation and feedback that they feel more comfortable and confident to follow care plans and interventions as advised and modelled by the team. · Formal evaluation to include baseline qualitative information of how the family feel prior and following intervention. · Regular review of family care plans ensuring that carers are involved in the design and delivery of services. · Evaluation from the child/YP and siblings prior and following workshops. · Evaluation of staff responses, measurement of confidence in the approach. · Evidence showing cases which have gradually ended, where the individual would have been supported indefinitely under traditional services. · Review of expenditure on admissions to respite and residential placements	This is a recurring project for 2018/19 we have appointed and trained the majority of staff and continue to review the impact on service delivery.	
Falls	F1.1	Multifactoral Risk Assessment for the management and prevention of falls.	Funded service for 2 x 0.5 WTE Technical Instructors Band 4, supported by an experienced Physiotherapist (funded at one hour per week, Band 7), to undertake Multifactorial Risk Assessments for older people living within the community in line with the evidence based North Wales Falls Prevention Service model.	28,622	3,6	2	to bring together services for older people with complex needs including dementia good services working together to support carers, including young carers.	# of multifactoral risk assessments completed = 363	Not applicable - continuation	
Progression	PR1.1	Progression Service for adults with a disability.	A team of multi disciplinary professionals to support people with disabilities in their own homes to learn new skills and become more independent so they rely less of staff support	50,288	2,6	1,2.1,2.2,8.1	Good, joined up services for people with learning disabilities	NEW for 18/19 # of individuals who have been supported through the service within the quarter to achieve outcomes agreed on an individual basis. ANTICIPATED IMPACT= 6 minimum as intensive support offered OF WHICH % of individuals who have a reduced funded care package in place (from benchmark at start of service) ANTICIPATED IMPACT = 75% of individuals within the service % of reduced funded care package hours ANTICIPATED IMPACT = 25% %of individuals who have achieved what matters to them ANTICIPATED IMPACT = 90%	Milestones are bespoke to each service user being supported: Address 1 (anonymised) Monitor figures/hours from benchmarking skills form quarterly to identify impact of work on care packages Address 2 - Needs of individuals mean that progress cannot be measured in reduction of care package; instead an increase in individual development Address 3 - Work with independent provider to be creative in the support hours allocated and use of telecare to encourage positive risk taking. Address 4 - one named individual will have reduced support on day not in day opportunity service over the year Address 5 - Culture change achieved and development of outreach work in community	Whist this is a broad approach undertaken by Disabilities Service as a whole, ICF have funded 1 Social Worker post (and part time physio and OT) to achieve specific change in LD supported living service, as specified in work plan. They have been allocated specific houses/individuals to achieve specific outcomes and reduce support hours provided.

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	PR1.2	Progression	A team of multi disciplinary professionals to support people with disabilities in their own homes to learn new skills and become more independent so they rely less of staff support	73,856	Proactive approach to care & support Promoting & maximising independent living	4.1 4.2	Good, joined up services for people with learning disabilities	No of new people supported TARGET 3 per quarter No of new staff teams engaged with TARGET 3 per quarter No of staff teams reporting positive change TARGET 2 per quarter % of people who reported a positive difference TARGET 100%	None: scheme fully operational	
	PR1.3	Active Support	The focus of this intervention will be to roll out the use of the established approach of the Active Support model support for individuals residing in community-based services with learning disabilities and the potential to display behaviour that challenges. A training package for service providers will be developed in order to establish a philosophy of Positive Behaviour Support and Active Support within their organisations. A culture of improving quality of life and reducing behaviour that challenges will be established through increasing participation and active engagement in valued and meaningful activity. This approach will be underpinned by person centred planning and enhanced primary prevention raising the standard of care provision, and shaping up the expectations regarding commissioning of services.	262,110	• Proactive approach to support and exploring opportunities. • Focus resources and increase capacity. • Promoting and maximising independent living. • Preventative interventions (including minimising the effect of disability, reducing the need for support and enabling people to live their lives as independently as possible. • The use of adaptations, making a significant contribution to help people to remain living safely and independently. • Contribute towards preventing people from suffering abuse and neglect. • Deliver improved outcomes. • Promote social enterprises, co-operatives, user led services and the third sector. • Develop more effective partnership working and collaboration across health, housing and social care. Jointly undertake an assessment of care and support needs. • Assist transformation and change, as to test and develop new models of how we deliver support. • Identify local accommodation solutions for people who are accommodated out of area. • Build on existing new practices. • To share examples of innovation and good practices.	1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 2.1, 2.2, 2.3, 3.1, 4.1, 4.2, 5.1, 5.2, 6.1, 6.2, 7.1, 7.2, 7.3, 7.4, 8.1	- Addressing the need to work with providers to develop the vision and plan the way forward. not working in this could mean a lack of opportunities for individuals with complex needs and over servicing people. - lack of comprehensive training programme in terms of active support principles and progression for all service providers.	1]Number of individuals supported 2] Number of individuals who have a PBSP/ Active support plan or progression plan in place. 3] % of individuals who have achieved their personal outcomes.	Quarter 1 1. Identifying candidates for champions - Apr 2018 2 Training of project staff (to gather baseline data and facilitate training (classroom and interactive) - Apr 2018 3 Agree baseline recording tools (including but not limited to): • Training sessions undertaken • Participant details • MAS • QABF • Measure of meaningful engagement • Mansell AS Measure • Quality of Life indicator (BILD) • Staff satisfaction surveys • AS SPOA referral level Quarter 2 and 3 1 Implement training of provider staff (dates/venues/names/numbers TBA) May – Dec 2018 2 Identify needs and develop training programme for champions May 2018 3 Training and mentorship of champions Dec 2018 4 Regular progress meetings/update with provider management and champions Monthly (as appropriate) 5 Provision of information for ICF Quarterly Review As required 6 CoP (presentation to CB CoP partway through and at completion of project) At agreed CB CoP meetings Quarter 4 1 Establishment of CoP for ASM (linking in with Ed/Kathy for advice) 2 Monitoring outcomes completed with provider 3 Produce ICF bid for continued roll-out	
	PR1.4	Progression / Prevention	To support adults with learning disabilities to be as independent as possible within their own communities in line with the principles of the Social Services & Wellbeing (Wales) Act 2014. Progression – Day Services: This will be achieved by developing the work already completed with regard to progression plans during 2017. We will undertake detailed data analysis of this work and produce a "what we want" report which we will share within the department and with 3rd sector and private suppliers. We will create a points based system which will allow us to : 1. Analyse whether the resources allocated to day centres gives us the best value 2. Look at where services need to be developed to address unmet needs for those people with significant disabilities that are currently being overlooked. 3. Look at expanding the provider base to facilitate volunteering opportunities and activities within the community with an emphasis on non-specialised services and integration. 4. Review how we currently provide 1:1 support within day services with a view to ensuring that individuals gain the maximum benefit and maximum independence and ensure protocols are compliant across the 3rd and private sectors. 5. Undertake a survey of accessible buildings and toileting facilities across the island to support the increase in individuals undertaking volunteering and activities in the communities.	115,196	• Encourage innovation and develop new models of delivering sustainable integrated services. • Collaboration in needs assessment and service planning. • Preventative interventions to avoid care home admissions. • Promoting independent living • Proactive approach to care and support.	1.1,1.2,1.3,1.4,1.5,2.1,2.3, 3.1,3.3,4.1,4.2,5.1,5.2,6.1, 6.2,7.1,7.3,8.1	• Develop more access in the community to support people with a learning disability, including work and friendships. • Support older carers and older people with learning disabilities • Promote good health of older people with learning disabilities and support people with learning disabilities who have dementia	Progression (Day Services): • Number of external organisations who are given access to the "What we want" report • Number of participants engaged in community activities • Number of new opportunities developed in the community • Number of progression plans developed • Number of people who have been given a "points based" disability score Progression (Llawr y Dref Move on): • % of targets achieved by each individual • Number "moved on" from Llawr y Dref (when assessed as ready for move on) Progression (Day Services): • Number of external organisations who are given access to the "What we want" report • Number of participants engaged in community activities • Number of new opportunities developed in the community • Number of progression plans developed • Number of people who have been given a "points based" disability score Progression (Llawr y Dref Move on): • % of targets achieved by each individual • Number "moved on" from Llawr y Dref (when assessed as ready for move on) Agreed Measures.- • Number of people being supported – 90 in day services + 3 in Llawr y Dref • % people who report a positive difference	Progression (Day Services): End of Qtr 1: produce the "What we want" report End of Qtr 2: complete the points based rating End of Qtr 3: increase the number of community based volunteering opportunities and activities End of Qtr 4: review number of personal outcomes that have been achieved End of Qtr 4: complete the survey of accessible buildings and toileting facilities across the island. Progression (Llawr y Dref Move on): End of Qtr 1: agree the support service model End of Qtr 1: the pathways in and out of Llawr y Dref (who is eligible for the unit and what are the move on options following assessment) End of Qtr 1: agree the short term tenancy and housing benefit arrangements End of Qtr 2: First individuals moving into assessment unit End of Qtr 3:	
Project Support	PS1.1	Programme Support	To provide programme management leadership and support for the Wrexham ICF programme as well as the wider transformation agenda of partners	64,686	Applies to all	Applies to all	Applies to all	All projects delivering Reporting mechanisms in place and reports presented on time Improve partnership working	None: scheme fully operational	
	PS1.2	Progression	Project Aims • Individual: To support adults with learning disabilities and / or Autism to learn new skills and to be more independent and to develop confidence in their ability to be more independent. • Community: To improve community participation and reduce social isolation. Encouraging support staff to explore with the person opportunities in the community. • Carer: To reduce reliance on the family carer, to raise expectations and confidence in the cared for's ability to develop skills and take calculated risks. • Statutory Services: To reduce long term reliance on statutory services, by embedding an approach that focuses on progression and the achievement of agreed outcomes. • Provider: To embed a different culture and approach to enablement. • Support Workers: To increase confidence in working innovatively, seeking opportunities in the community and seeing their role differently. • Integration: To embed an enhanced enablement staff resource to work within the Disability Service Early Intervention & Prevention Team (Conwy) / Complex Disabilities Team (Denbighshire), Occupational Therapist, Nurses and Providers. • Local Authority: To promote cross boundary working and the sharing of skills and assets Objectives • To prepare and equip people with the skills they will need for independent living or if/when they move on to a model of housing that provides a lower level of support, by focusing on the development of specific skills for each individual within an agreed time scale. • To reduce reliance on paid support and on family carers. • To encourage people to be active members of their local community and to participate in local activities by supporting people to engage in local activities with a planned phasing out of that support. • To facilitate peer support and friendships by identifying compatible individuals who have similar interests and then dovetailing their support with a planned phasing out of that shared support. • To support and enable individuals to travel independently wherever possible. • To encourage family carers and others to adopt a positive approach to risk taking. • To develop skills in thinking about outcomes rather than hours of support. • To change attitudes and thinking towards short term interventions. • To encourage and support people to adopt an active and healthy lifestyle.	223,130 102,730 (CCBC) 120,400 (DCC)	Focus resources and increase capacity Proactive approach to care and support Preventative interventions Increase capacity to meet demand Encourage innovation Promoting and maximising independent living Develop partnership working and collaboration	1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 2.1, 2.2, 2.3, 3.1, 3.2, 3.3, 4.1, 4.2, 5.1, 5.2, 6.1, 6.2, 7.1, 7.4, 8.1	Good, joined up services for people with learning disabilities	Output · Direct support being provided. · Number of people being supported by this project. Outcomes Service Users will… · Have learnt new skills · Be less reliant on their family carers · Have made new friends · Be better prepared for community living · Be more confident about accessing community based activities Outcome Carers will… · Feel better supported · Feel more confident about the person they care for being more independent · Have more time to themselves Outcome for Health and Social Care… · Reduced long term reliance on traditional services by individuals · Increased staff confidence in short term interventions which focus on outcomes · Improved joint working practices · Support workers will think differently about their roles	April 2018 – renew posts and contracts so as to retain the staff team previously appointed. May 2018 - review findings from 2017/18 and update lesson learned - adjust processes and pathways in light of findings. July 2018 – Quarter 1 Review to monitor the achievement of outcomes for individuals. October 2018 – Quarter 2 Review to monitor the achievement of outcomes for individuals. January 2019 – Quarter 3 Review to monitor the achievement of outcomes for individuals. April 2019 – Quarter 4 Review to monitor the achievement of outcomes for individuals.	
SPOA	SP1.1	Third Sector SPOA Coordinator	Provision of information, signposting and referrals to support available in the third sector and community; with the aim of maintaining independence and improving wellbeing.	28,036	3,6,7,8	1,2,1,2.2,4.2,7.1	to work together more.	# of NEW CASES = 301 # of individuals who have achieved what matters to them TO BE DEFINED	Not applicable - continuation	
Step Up Step Down	SUSD1.1	Step Up/Step Down	Purchase of beds within a care home for the provision of either step up or step down care. Through provision of bed based care, the intent is to reduce the risk of hospital or long term bed admission or reduce the time spent within an acute or community hospital bed. Residents are also supported by a Social Worker and/or Occupational Therapist as necessary	338,414	Proactive approach to care & support Preventative interventions Promoting & maximising independent living Develop partnership working and collaboration	1.1 1.4 1.5 8.1	To support organisations who provide care To work together more	No of admissions to a bed TARGET 23 per quarter % of admissions from step-up TARGET 50% % of admissions from step-down TARGET 50% No of nights people supported in a bed TARGET 987 per quarter % who return home TARGET 15% % admitted to hospital TARGET 19% % into long term care TARGET 29% % passed away TARGET 6% % further assessment TARGET 32%	Q1- April Secure provision of 5 SU/SD beds from alternative care home provider	

THEME	REF. NO.	PROJECT NAME	PROJECT DESCRIPTION	Total Expenditure	LINK TO ICF PRINCIPLES (e.g. Prevention and Alternative Delivery Models, Supporting Independence) See definitions tab	LINK TO NATIONAL OUTCOMES FRAMEWORK See definitions tab	Population Needs Assessment - link to Action Priorities (Easy Read Version)	ANTICIPATED IMPACT - outcomes achieved in 17/18 to be used as baseline targets unless specified otherwise	KEY DELIVERY MILESTONES (including key dates)	Additional resources if applicable
	SUSD1.2	Step Up / Step Down	Set up an Enhanced support Service for Looked After Children (Step-up Step-down Model) The experience of ACE's, prior to being Looked After, has a significant impact on a child or young person's development, requiring specialist care and support to minimise interventions and placement breakdowns. The "Enhanced support service for Looked After Children" is designed to provide safe and nurturing care to a child or young person in a more structured environment than the 'typical' foster placement, or family placement and it provides better outcomes is cost-effective alternative to residential care which is always a 'last resort' option. The Enhanced support Service for Looked After Children will: a) Provide support for children to remain in their placements with an enhanced support service avoiding escalation to Residential care due to care needs (Step up) b) Support children to step down from Residential placements into foster carers placements or rehabilitated home to family with enhanced support (Step down) The program will provide enhanced support to existing in–house foster carers; placement with parents, connected persons and significant others who are caring for children with complex needs. A therapeutic supportive approach ensures placements remain stable and that children's carers feel supported in their local communities thus encouraging confidence and independence. The therapeutic approach is supported with practical and regular respite arrangements including overnight. This enhanced service will provide a consistent approach around settings such as education, home and in the community and will help carers feel more resilient and supported to care for a child with complex needs. This is a radical approach to maintaining and supporting children with complex needs in local foster care placements with wraparound multi-disciplinary support services - reducing the need to commission independent residential and independent fostering placements. This is a timely project to move forward the transformation of services in Conwy due to rising costs of care, limited local availability and questionable quality of placements for children in the and young people with complex needs in the independent sector.	130,277	Focus resources and increase capacity Proactive approach to care and support Preventative interventions Increase capacity to meet demand Encourage innovation Promoting and maximising independent living Develop partnership working and collaboration	1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 2.1, 2.2, 2.3, 3.1, 3.2, 3.3, 4.1, 4.2, 5.1, 5.2, 6.1, 6.2, 7.1, 7.4, 8.1	• to improve health and social care support for children with complex needs • better support for children's mental health • all children to be safe and healthy from pregnancy to two years old • to prevent childhood obesity • better family support services.	· Childs progression including: · Child accessing education · Child accessing community clubs No. of commission placements: · Step down to foster care from residential placements · Step down to community living from residential placements · Maintaining current foster placements · Maintaining current supported living · Maintaining current kinship/ Connected persons placements · Placements maintained and children not escalating to Residential care · Transfers to adult services · Children not accessing tier 4 CAMHS services · Training programme feedback · Cost savings from avoidance of commissioning high cost independent residential placements.	Develop a referral pathway • Employment of psychologist and support staff • Recruitment process to posts • Staff appointed • Training commissioned for the multi-disciplinary team • Deliver training • Commence service delivery • Record case study's as we go • Agree how we evidence distance travelled for carers or child e.g. strengths and difficulties questionnaires etc. • Establish processes for working with the edge of care team • Set up of team • Final Evaluation	We are going to approach CAMHS to provide clinical supervision to the Psychologist within their existing service model
Wellbeing Support	WS1.1	Hoarding Service	Intensive practical and emotional support to adults with hoarding tendencies or behaviours resulting from chaotic lifestyles and/or mental health. Creating safer homes, improving wellbeing and diminishing impact on local services including NHS.	30,603	2,8,9	1.3,1.4,1.5,1.6,8		# of people supported in the year as an active case = 20 % of people who achieve what matters to them = 100%	End of Q1 Arrange a Knowledge Sharing/Network event on hoarding End of Q2 Engage and train volunteers within the service to increase support for the service and to reduce the waiting list Set up peer support group for hoarders in Flintshire in conjunction with Hoarding UK Development of training and awareness sessions for Flintshire health, housing and social case colleagues End Q3 Secure additional funding from other sources to ensure (expand capacity of project)	
	WS1.2	Anturio Mlaen - Antur Waunfawr	Developing the Antur Waunfawr Wellbeing project to establish and mainstream Health and physical wellbeing opportunities adults with Learning Disabilities, through planning and organising new, purposeful and different activities to transform exercises and opportunities for individuals. The project will offer a wide variety of options and will encourage individuals to test out new wellbeing and fitness activities, to take part in more. This will enable the adult with Learning Disability, including older people, to increase their fitness, wellbeing, Mental Health, reduce or ease the effects of ageing like dementia, travel and keeping safe independently. Consulting with other, the social and physical elements is important to create satisfaction and happiness – to reduce Health problems in the long term. Through this, we will meet the objectives of the Social Services and Wellbeing Act Wales 2014 and the Antur Waunfawr Wellbeing statement.	50,000	-focus resources and increase capacity of care coordination -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 -establish preventative intervention to help avoid unnecessary hospital admissions or inappropriate admission to residential care as well as preventing delayed discharges from hospital; -encourage innovation and develop new models of delivering sustainable integrated services - promote and maximise independent living opportunities,	1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 2.1, 2.2, 2.3, 3.1, 3.2, 3.3, 4.1, 4.2,5.1, 5.2, 6.1, 6.2, 7.1, 7.2, 7.3, 7.4, 8.1	Need to enure all service providers are commissioned to provide a service that implements the progression, activities support and positive behavioural support principles.	• Number of people supported • % of people who report a positive difference	• Measure the participation and increase in participation amongst 65 service users in relation to choosing from 37 activities, over a period of 12 months. Data collected by ICF Project Co-ordinator. • Compare measures of participation across all Antur Waunfawr sites per quarter, namely 30 June, 30 September, 31 December 2018, and March31 2019. • Present quarterly updates to the Antur Waunfawr Board and ICF Team. • Utilise Wiki pages to deliver outcomes. • Monitor and measure baseline scores as outlined. • Collaborate with Active Support Team from Gwynedd Council. • Monitor individuals' feedback and wellbeing through project questionnaires, including changes in health, satisfaction, happiness, the desire to participate socially. Feed into personal plans.	
	WS1.3	Community Navigators	Community Navigators connect citizens with sources of support and opportunities within the community. They are at the heart of their communities building knowledge and support. Focus is on increasing independence and empowerment of citizens.	34,500	Focus resources and increase capacity Proactive approach to care and support Preventative interventions Increase capacity to meet demand Encourage innovation Promoting and maximising independent living Develop partnership working and collaboration	1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 2.1, 2.2, 2.3, 3.1, 3.2, 3.3, 4.1, 4.2, 5.1, 5.2, 6.1, 6.2, 7.1, 7.4.	• to improve health and social care support for children with complex needs • better support for children's mental health • all children to be safe and healthy from pregnancy to two years old • to prevent childhood obesity • better family support services.			

PRIORITY AREA FOR INTEGRATION: INTEGRATED AUTISM SERVICE									
THEME	PROJECT NAME	PROJECT DESCRIPTION	Total Expenditure	LINK TO ICF PRINCIPLES (e.g. Prevention and Alternative Delivery Models, Supporting Independence)	LINK TO NATIONAL OUTCOMES FRAMEWORK	Population Needs Assessment - link to Action Priorities	Population Needs Assessment - link to Action Priorities	KEY DELIVERY MILESTONES (including key dates)	Additional resources if applicable
Integrated Autism Service	Implementation of national framework to deliver the Integrated Autism Service.	Establishing and delivering the Integrated Autism Service as set out by the Welsh Government while also responding to local needs	652,000	Prevention and Early intervention as well as focus resources and increase capacity	1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 2.1, 2.2, 2.3, 3.1, 3.2, 3.3, 4.1, 4.2, 5.1, 5.2, 6.1, 6.2, 7.1, 7.2, 7.3, 7.4, 7.5, 8.1	Filling service gap; raising profile of available services and support across the region; Awareness raising; Training to improve understanding	Agreed outcomes and measures to be confirmed by Welsh Government	Dates to be confirmed, but key delivery milestones for 2018/19 include a fully staffed operational service running in line with national guidelines and agreed outcomes by Welsh Government.	N/A

PRIORITY AREA FOR INTEGRATION: WELSH COMMUNITY CARE INFORMATION SYSTEM

THEME	PROJECT NAME	PROJECT DESCRIPTION	Total Expenditure	LINK TO ICF PRINCIPLES (e.g. Prevention and Alternative Delivery Models, Supporting Independence)	LINK TO NATIONAL OUTCOMES FRAMEWORK	Population Needs Assessment - link to Action Priorities	KEY DELIVERY MILESTONES (including key dates)	Additional resources if applicable
WCCIS	North Wales WCCIS	Funding of regional resources to provide the required technical and business change support staff to prepare, implement and enhance the use of the WCCIS throughout the region.	343,000	Focus resources and increase capacity; Proactive approach to care and support; Preventative interventions Encouraging innovation	• 1.1, 1.2, 1.3, 1.4, 1.5, 1.6 • 2.1, 2.2, 2.3 • 3.1, 3.2, 3.3 • 4.2 • 5.1 • 6.1, 6.2 • 7.1, 7.3, 7.4, 7.5 • 8.1	Making optimal use of community assets Improving access to information and advice Focus on prevention and independent living	Delivery of a system configuration and associated information governance requirements to support integrated ways of working with BCUHB and sites that have implemented the WCCIS Delivery of enhanced system functionality to maximise the use of the WCCIS system to support end user engagement with the solution Delivery of a Business Case for those sites in the region that currently don't have a deployment order to implement the WCCIS Continued engagement with the National Programme to support the delivery of the WCCIS through the medium of Welsh Continued engagement with the National Programme to support the delivery of identified system enhancements	

CYDWEITHREDFA GWELLA GWASANAETHAU GOFAL A LLESIANT **GOGLEDD CYMRU**

NORTH WALES SOCIAL CARE AND WELL-BEING SERVICES IMPROVEMENT COLLABORATIVE

Ariennir gan **Lywodraeth Cymru**
Funded by **Welsh Government**

Integrated Care Fund Revenue Investment Plan - Approvals

Group	Comments	Date Endorsed
ICF Programme Team	Final Plan circulated to Programme Team for review and forward any comments to SH by 18th April 2018	19th April 2018
Regional Leadership Group	Request to endorse the revenue investment plan at 27th April 2018 meeting.	27th April 2018
Regional Partnership Board	For Information	18th May 2018
Submit to Welsh government	Approved plan submitted to WG	31st May 2018
Website	Approved plan published on NWSSIS website, links from all partners websites to this plan	1st June 2018