CWM TAF REGIONAL SOCIAL SERVICES & WELL-BEING PARTNERSHIP

INTEGRATED CARE FUND
REVENUE INVESTMENT PLAN 2018/19

INTRODUCTION & BACKGROUND

Welsh Government has published Guidance on the Integrated Care Fund (ICF) effective from 1st April 2018 The Guidance sets out the objectives; conditions; governance requirements; and reporting arrangements to Welsh Government for ICF in 2018/19.

ICF REVENUE ALLOCATIONS IN 2018/2019

The ICF Guidance confirms that the ICF is to continue at the level of £50m across Wales in 2018/19. Within this, Cwm Taf Region is to receive the following ICF revenue allocations:

	Frail & Older People	Prevention	Integrated Autism Service	WCCIS	Total
Cwm Taf	£2,910,000.00	£1,580,056.45	£367,000.00	£158,005.65	**£5,015,062.10**

Cwm Taf Region is also to receive an additional allocation of c £480,000.00 in support of the Dementia Action Plan in 2018/2019. Further guidance is due from WG which will assist Regions in finalising their detailed proposals. This Investment Plan therefore contains an outline of the Region's intentions in relation to dementia.

STRATEGIC APPROACH

This Investment Plan sets out the Cwm Taf Region's priorities against the c. £5m of revenue funding in 2018/19. To inform this, the Partnership has considered the following:

- Requirements set out under the Social Services & Well-Being (Wales) Act 2014
- The quarterly evaluation and annual review of Regional ICF schemes funded in 2017/18;
- Needs identified within the Cwm Taf Population Needs Assessment (published in April 2017);
- Feedback received from people (including service users and their carers) during any local stakeholder engagement activities; and
- Alignment to the partners' and partnership strategic plans, including:
    - The Cwm Taf Regional Plan 2018-23 (ie the Area Plan published in April 2018)
    - The Cwm Taf Joint Commissioning Statement for Older People's Services 2015-25;

- The Cwm Taf Carers' Strategy 2016-19
- The Cwm Taf Joint Statement of Intent for People with Learning Disabilities and their Families;
- The emerging Cwm Taf Regional Shared Strategy for Children, Young People & Families (due to be finalised and approved in July 2018)
- The UHB's Integrated Medium Term Plan (IMTP) 2018-21.

CWM TAF ICF REVENUE SCHEMES

The Cwm Taf Region intends to build upon the good practice and progress achieved via the ICF in 2014/15, 2015/16, 2016/17 and 2017/18. Consequently, a range of schemes are to be progressed with the objectives of:

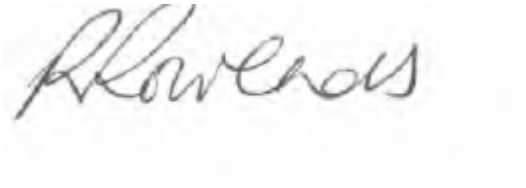
- Improving care co-ordination between health, social care, third sector and housing;
- Promoting/maximising independent living opportunities;
- Avoiding unnecessary admission or delayed discharge;
- Supporting recovery by increasing reablement provision;
- Establishing more proactive approaches;
- Facilitating integration; and
- Improving outcomes.

GOVERNANCE

Full details can be found in the Cwm Taf Region's ICF Written Agreement 2017-20, as agreed by the Cwm Taf Regional Social Services & Well-Being Partnership Board.

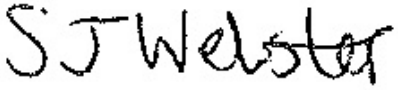
CONCLUSION

The Cwm Taf Health & Social Care Region is proud of the positive progress which was made through the utilisation of ICF monies in 2014/15, 2015/16, 2016/17 and 2017/18. This has laid strong foundations for the integration of health, social care and third sector services for older people in Cwm Taf, and more latterly for people with learning disabilities, children with complex needs and carers. All schemes have the intention of promoting independence & well-being, reducing crises and improving outcomes. We believe the opportunity presented by the continued allocation in 2018/19 will further enable the Cwm Taf Region to deliver transformational change across the priority areas and client groups specified in this Investment Plan.



Rachel Rowlands, Chair of the Cwm Taf Regional Partnership Board date: 31ST May 2018

Allison Williams, Chief Executive, Cwm Taf University Health Board date: 6th June 2018



Steve Webster, Director of Finance, Cwm Taf University Health Board date: 31st May 2018

The following tables outline the Investment Plan for the Cwm Taf Region, in line with the requirements of the ICF Guidance 2018/19. All schemes are confirmed as being deliverable within 2018/19.

OLDER PEOPLE WITH COMPLEX NEEDS AND LONG TERM CONDITIONS, INCLUDING DEMENTIA **£3,468,268**						
LINKS TO THE CWM TAF POPULATION ASSESSMENT: The schemes below have been assessed as addressing the care and support needs of older people in Cwm Taf: • Supporting people to live at home/ in the community • Ensuring that as people get older they continue to enjoy their lives and do not have so many care and support needs • Providing more tailored care and support for people with a higher level of need (e.g. the frail elderly) at, or as close to home as possible • Helping people to regain their independence following a setback (e.g. illness or bereavement) • Tackling loneliness and isolation • Reducing reliance on long-term care						
ICF Scheme Description	**Planned budget**	**Link to ICF principles (see Appendix 1)**	**Link to National Outcomes Framework (See Appendix 2)**	**Anticipated Impact** **(Detailed activity and targets/benchmarks to be included in quarterly monitoring returns)**	**Key Delivery Milestones**	**Additional Resources (if applicable)**
OP1 Stay Well @Home Service Service preventing hospital admission and facilitating discharge by integration of health and social care services at the critical interface during presentation at	£1,830,268	ifocus resources and increase capacity of care coordination or rapid response schemes iii. preventative interventions to help avoid unnecessary hospital admissions by assessing people in A&E and commissioning/ providing rapid health, social care and third sector community	1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 2.1, 3.1, 3.3, 4.2, 7.2, 7.4, 8.1	As this is a large and complex new service, robust sets of PIs have been developed for all components of the service. Overarching measures below are reported to WG quarterly:	Q1– Service model in place (continuing from 2017/18) Building on inhouse 6 month and 12 month reviews, external evaluation has been commissioned, to be carried out by the	£150k reprovided by Cwm Taf UHB from 2017/18 as agreed with WG

A&E. The multi-disciplinary team operates 365 days a year from 8am to 8pm based in both RGH and PCH.		support to facilitate patients' timely return home. iv. increase the capacity of reablement and rapid response services to better meet demand (including night time and weekend services); v. encourage innovation and develop new models of delivering sustainable integrated services; vi. promote and maximise independent living opportunities, including provision of timely home adaptations;		Increase in the % of 61+year old turned around at the hospital front door Increase in the % of 0 LOS of 61+year old Reduction in the % of 61+ years old staying 5+ days Reduction in ALOS of those 61+ year old staying 5+days 50 % reduction in the number of patients identified per month for transfer to a community hospital site	University of South Wales in q1 June 2018 - Quarterly activity reporting timescales, processes and RBA templates agreed Q1 and q2 – Business case for phase 2 to be developed Q3 - Annual review of scheme to inform 2019/20 plans	
OP 2 - Community Co-ordinators Working with individuals, groups and communities to reduce loneliness and isolation by providing information, advice, support and signposting to activities and services in local communities.	£248,500	**iii** preventative interventions to delay/reduce the need for care and support which may also help avoid unnecessary hospital admission as well as prevent delayed discharge. **v** encourage innovation and develop new models of delivering sustainable integrated services through the promotion and development of Third sector and community led services **vi** Encouragement of independent living/helping people to maintain their independence	1.1, 1.2, 2.1, 2.2, 4.2, 5.1, 5.2, 6.1, 6.2, 7.1, 7.2, 7.3, 7.4	• Increased No. of referrals received • Increased No. of new initiatives supported/ promoted • Increased No. of new groups/ activities identified • Increased No. of signposts/ referrals made to other 3rd Sector or statutory agencies • Increased No. attending screening awareness/ myth busting sessions • Increased No. of new beneficiaries • Increased Total no. of beneficiaries	April 2017 – Service model in place (continuing from 2017/18) June 2017 - Quarterly activity reporting timescales, processes and RBA templates agreed Q3 - Annual review of scheme to inform 2019/20 plans	

				• Increased No of new volunteers recruited • Total hours of volunteering • Use of Wellbeing toolkit to measure impact for individuals – seeking improvement in terms of good relationships; meaning and purpose; good feelings		
OP 3 - 5 Ways to Well-Being Provides volunteering opportunities to people wanting to volunteer or work in the care sector. The volunteers work in sheltered housing schemes to provide wellbeing and enablement support.	£40,000	**iii** Prevention – the outcomes generated through the project to date indicate that older persons health, wellbeing, loneliness and isolation is significantly improved, thus resulting in sustained health, happiness and wellbeing at home with less dependency on hospitals and or residential care provision. **v** encourage innovation and develop new models of delivering sustainable integrated services working with the RSL sector	1.1, 1.2, 2.1, 2.2, 4.2, 5.1, 5.2, 6.1, 6.2, 7.1, 7.2, 7.3, 7.4	Measures as above - for reporting, scheme is amalgamated with community coordinators OP1	April 2018 – Service model in place (continuing from 2017/18) with review being undertaken of arrangements with RSLs for future sustainability June 2018 - Quarterly activity reporting timescales, processes and RBA templates agreed Q2 - Recommendations from review of scheme to inform funding for second half of 2018/19	Discussions with RSLs
OP 4 Additional Social Workers Meeting the additional demand for assessment and care management in complex cases.	£223,333	**i** Focuses resources and increases capacity of care coordination or rapid response schemes (such as community resource teams) and the pace at which they are developed, to better meet demand and improve equity of access to services. **ii** Establish a more proactive approach, seeking to identify those people at risk of	1.2, 1.3, 1.4, 1.5, 2.3, 3.1, 8.1	• No. of requests for assessment • Outcomes including --- care home placements; - return to community; - independent with no ongoing services	April 2018 – Service model in place (continuing from 2017/18) June 2018 - Quarterly activity reporting timescales, processes	

		becoming 'stuck' within secondary care with a result impact upon their ability to return to independent living.			and RBA templates agreed Q3 - Annual review of scheme to inform 2019/20 plans	
OP5 Health & Social Care Discharge Co-ordinators Improvement of communication and information sharing between health and social care, and facilitate timely discharge, particularly for complex cases,	£97,014	**ii** Establish a more proactive approach, seeking to identify those people at risk of becoming 'stuck' within secondary care with a resulting impact upon their ability to return to independent living. **iii** Establish preventative intervention to help avoid unnecessary hospital admissions or inappropriate admission to residential care as well as preventing delayed discharges from hospital. **v** Encourage innovation and develop new models of delivering sustainable integrated services.	1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 2.1, 2.2, 2.3, 3.1, 3.2, 3.3	• No. of referrals received • Reduction in No. of referrals requiring further information	Q1 – New Service model in place (changes agreed to 2017/18 model to work more effectively with Stay Well@Home) June 2017 - Quarterly activity reporting timescales, processes and RBA templates agreed Q3 - Annual review of scheme to inform 2019/20 plans	
OP6 Care Home Support Team Prevent hospital admission and provide support to residents with more complex needs. Care home staff have rapid access to advice, assessments, enhanced treatment service, skills training to better manage residents' needs and	£181,901	**i** increasing capacity of care coordination and rapid response - enhanced input into all care homes and residential homes **iii** Preventative interventions - Patients in residential care are supported through periods of being unwell, lessening the likelihood of them from requiring earlier transfer to nursing care placements or admission to hospital. Service also takes referrals from secondary care enabling earlier discharges back into care/residential homes with support.	1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 2.1, 3.1, 3.3, 7.2, 7.4, 8.1	• No. of new referrals • No. of follow up face to face contacts • No. of follow up non face to face follow ups • Avoided hospital admissions • Bed days saved	April 2018 – Service model in place (continuing from 2017/18) June 2018 - Quarterly activity reporting timescales, processes and RBA templates agreed Q3 - Annual review of scheme to inform 2019/20 plans	

provide a more holistic and quality service.						
OP7 Increased Capacity within Intermediate Care, Reablement and Initial Response Services Short term multi agency intervention and reablement to support hospital discharge and avoid admission, promoting independence.	£598,250	**i** Increasing the capacity of care coordination or rapid response schemes, including support for people with dementia **iii** Preventative interventions to avoid unnecessary admissions to hospital or unnecessary admissions to residential care. Improve discharge process from hospitals. **iv** Greater capacity of reablement team and improvement of rapid response service to meet needs. Vi. promote and maximise independent living opportunities	1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 2.1, 3.1, 3.3, 4.2, 7.2, 7.4, 8.1	• Hours of support provided • % of service users enabled to live independently • % service users requiring no further support from statutory services • % of service users who felt they had achieved their goals • No. of referrals made to the memory project • Hours of support provided • No. of bed days saved	April 2018 – Service model in place (continuing from 2017/18) June 2018 - Quarterly activity reporting timescales, processes and RBA templates agreed Q3 - Annual review of scheme to inform 2019/20 plans	
OP8 Early Supported Stroke Discharge Service Multi-disciplinary team providing improved rehabilitation at home and earlier hospital discharge for stroke patients.	£249,002	**i** focus resources and increase capacity of care coordination or rapid response schemes -supports efficient flow from hospital to community based services. **ii** establish a more proactive approach, seeking to identify those people at risk of becoming 'stuck' within secondary care with a resulting impact upon their ability to return to independent living; **iii** Preventative interventions - facilitates bespoke community responses and promotes return to independent living	1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 2.3, 3.1, 3.2, 3.3, 7.1, 7.2, 7.4, 8.1	• % of total stroke patients within the UHB accepted into the service • Average hospital length of stay for patients accepted by the service (days) compared with benchmark length of stay for all stroke patients (11 days)	April 2018 – Service model in place (continuing from 2017/18) June 2018 - Quarterly activity reporting timescales, processes and RBA templates agreed Q3 - Annual review of scheme to inform 2019/20 plans	
Total	**£3,468,268**					

PEOPLE WITH LEARNING DISABILITIES, CHILDREN WITH COMPLEX NEEDS AND CARERS
£1,021,788.45

LINKS TO THE CWM TAF POPULATION ASSESSMENT:

The schemes below have been assessed as addressing the care and support needs of people in Cwm Taf:

Learning Disabilities

- Helping people with learning disabilities to be more independent of public services.
- Providing specialist support to people with complex/ enduring needs
- Helping people to live the lives they want to - to have more independence, to be in control of their own lives and needs and to be a part of their community.

Children with Complex Needs

- Providing early intervention and support
- Providing support with self esteem, positive relationships and life skills
- Reducing Adverse Childhood Experiences (ACEs)
- Supporting children and young people to take control of their own lives and well-being, helping them to live their best possible lives
- Providing services which work with children in all parts of their lives, including their homes, families, schools and communities
- Providing support and assistance with meeting the challenges of parenting

Carers (of all ages)

- Recognising that "one size does not fit all" for carers
- Improving how we identify carers so we are better able to meet their needs
- Providing the right information, advice and assistance, together with a range of services to help people carry out their caring role
- Helping carers to have a 'balanced' life, where their own well-being is not affected negatively by their caring responsibilities and to help them to continue to connect with a life alongside their caring responsibilities
- "What good looks like for carers is when we get it right for the person they are caring for."

ICF Schemes	Planned budget	Link to ICF principles	Link to National Outcomes Framework	Anticipated Impact	Key Delivery Milestones	Additional Resources (if applicable)
CLD 1 Community Capacity Grant (CCG) 3rd sector projects for prevention to improve health and wellbeing.	£60,000	**iii** Application criteria is designed to attract a wide range of preventative schemes which may help avoid unnecessary hospital admission as well as prevent delayed discharge. **v** The community Capacity Grant Scheme is purposely set up to encourage	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, 7.2, 7.4, 8.1	Each of the successful projects for 2018/19 listed below will impact on specific groups of service users and carers .Detailed activity and outcome data will be included in quarterly returns, including use of Cwm Taf's Well-being tool which	April and May 2018 – Outcomes of bidding process approved by TLG and RPB	Transitional Funding for Carers grant

		innovative approaches to the set criteria, and to be a test bed for pilot projects which demonstrate new approaches to service delivery. **vi** Encouragement of independent living/helping people to maintain their independence has been a key criteria of the Grant Scheme since its inception. viii All applicants to the Grant Scheme are asked to identify match funding that will be of benefit to the Cwm Taf Health and social care economy, should they receive a grant award. For example, in 2015-16 the total grant allocation was £64,485 and further £68,765 was achieved in match funding. (any update))		measures impact on good relationships, meaning and purpose and good feelings. **CLD1A** New Pathways - Cwm Taf Family Support Service for Children, Young People and Families affected by sexual abuse **CLD 1B** RCT People First - developing approach to co-production in service design and evaluation for people with learning disability **CLD1C** Safer Merthyr Tydfil – supportive mentoring programme for people over 50 **CLD 1D** Shine Cymru – work with service users and carers for people with spina bifida and/or hydrocephalus **CLD1E** Volunteering Matters Befriending scheme in Merthyr Tydfil	June 2018 - Quarterly activity reporting data, timescales, processes and RBA templates agreed June – Projects operational Q3 - Annual review of scheme to inform 2019/20 plans	
CLD 2 Learning Disability Joint Packages of Care Creation of a pooled budget for LD joint packages of care to provide more proactive case	£961,788.45	**i** focus resources and ensure integrated approach to case management v –innovative approach to providing care packages with joint agency responsibility ix – identify local accommodation solutions for people accommodated out of area	1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 2.1, 2.2, 2.3, 3.1, 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	• No. of joint packages of care supported through pooled agreement • No of joint reviews undertaken • Following review, number who become single agency funded (and move out of pooled arrangement)	April 2018 – Pooled fund in place (continuing from 2017/18) June 2018 - Quarterly activity reporting timescales,	Additional core funding from RCT and Merthyr Tydfil CBCs and the UHB

management and move on arrangements ensuring individuals' needs are met in the right place at the right time.				• Following review, number in inappropriate placement and time taken to provide alternative appropriate placement • Outcomes for individuals will be bespoke based on their needs	processes and RBA templates agreed Q3 - Annual review of scheme to inform 2019/20 plans	
Total	**£1,021,788.45**					

INTEGRATED AUTISM SERVICE **£367,000**						
LINKS TO THE CWM TAF POPULATION ASSESSMENT: The schemes below have been assessed as addressing the care and support needs of people with Autism (of all ages) in Cwm Taf: • Improving access to care and support • Helping people to fell more in control of their lives • Providing integrated/ holistic care and support						
ICF Schemes	**Planned budget**	**Link to ICF principles**	**Link to National Outcomes Framework**	**Anticipated Impact**	**Key Delivery Milestones**	**Additional Resources (if applicable)**
Integrated Autism Service (IAS)	£367,000	**i, iii, v** More effective partnership, multi agency working, integration and engagement to meet the needs of individuals with autism and their families / carers.	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, 7.3, 7.4,7.5, 8.1	The service will be delivered in line with Welsh Government Guidance and reflecting local flexibility, impacting on children, young people and adult service users and their families, parents and carers by improving integrated assessment, diagnosis, support and brief intervention. The service will provide information, advice, support and training. eg in relation to	April 2018 – Service operational and embedded June 2018 - Quarterly activity reporting timescales, processes and RBA templates agreed	

				• emotional, anxiety and behavioural issues and aim to reduce social isolation • ASD specific issues and life skills • Support to access to social, leisure and employment opportunities • Transition • Developing understanding within generic and community services. Detailed impact will be captured through WG quarterly monitoring returns which require information on national service standards, activity data and outcome data in relation to quality of life, anxiety and depression	Q3 - Annual review of scheme to inform 2019/20 plans	
Total	**£367,000**					

WELSH COMMUNITY CARE INFORMATICS SYSTEM (WCCIS) **£158,005.65**						
ICF Schemes	**Planned budget**	**Link to ICF principles**	**Link to National Outcomes Framework**	**Anticipated Impact**	**Key Delivery Milestones**	**Additional Resources (if applicable)**
A range of Regional proposals have been developed to support implementation and roll out of WCCIS (confirmation of proposals to follow)	£158,005.65	Ensuring the Region has the capacity, skills and equipment in place to successfully implement and roll out WCCIS		• Support service delivery • Ensure continuity and delivery of performance reports • Provide a robust approach to end user training • Ensure successful data migration • Regional Delivery Plan	Q1 - Agree proposals to support implementation Merthyr CBC live July 2017 – RCT planned live May 2018	

					June 2018 – Quarterly reporting timescales, processes and RBA templates agreed Q3 - Annual review of scheme to inform 2019/20 plans	
Total	**£158,005.65**					

DEMENTIA - Addendum ICF guidance is due from WG in relation to this funding. Schemes listed below (developed by a multi agency group including service users and carers) are therefore in outline only. Detailed proposals will be submitted to WG for consideration prior to release of funds.
C £480,000

Building on work such as the Valley LIFE project with our local communities and stakeholders, we want to make sure people living with dementia, their carers and families receive timely support and benefit from a clear care pathway to improve their wellbeing and quality of life, with services flexible to meet differing needs at different stages of living with dementia.
Ysbyty George Thomas has been remodelled as a Health and Wellbeing Centre in Treorchy for people with cognitive and memory problems. An Extra Care facility is also being considered for development on the site by 2020. Subject to funding, we plan to build a new Health and Well-being Centre for people with cognitive and memory problems as part of a dementia friendly village resource on the Keir Hardie Health Park site in Merthyr Tydfil.

ICF Schemes	Planned budget	Link to ICF principles	Link to National Outcomes Framework	Anticipated Impact	Key Delivery Milestones	Additional Resources (if applicable)
Development of dementia friendly cafes/hubs in appropriate welcoming environments in RCT and Merthyr Tydfil. Possible locations are currently being	Up to £350k Full year effect	All schemes proposed will **i** focus resources and increase capacity of care coordination and rapid response with a specialist team around the individual approach	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, 7.3, 7.5,, 8.1	Links to Dementia Action plan for Wales: Dementia friendly café and specialist integrated teams operating from a "core and cluster" model with an outreach team around the individual approach will support	Addendum guidance issued by WG in quarter 1, following which detailed proposals and costings will be submitted to WG asap.	Some schemes will be dependent on ICF Capital. Bids being developed for submission to

explored, including the health and wellbeing centre at YGT. Sustainable funding model being developed through third sector social enterprise and income generation delivery model. Training, work experience, volunteering and employment opportunities will support the development of dementia friendly communities. **Development of specialist teams around the individual approach focussing on early intervention and young onset dementia** Multi disciplinary teams would be established in RCT and Merthyr Tydfil. Based in the health and wellbeing centre/café hub and outreaching into local communities to work primarily within the "preventative and first	Up to £625k full year effect	iii preventative interventions to provide timely support in the community and in their own homes for people with developing symptoms of dementia v innovative and new models of delivering integrated more proactive services eg specialist team for young onset dementia (people under the age of 65); outreach to specific vulnerable groups; and a social enterprise delivery model for a dementia café linked to local health and wellbeing hubs and/or local community. Vi increase opportunities for independent living, including developing community understanding of dementia and the role local people, including volunteers, can play in supporting people, their carers and families to live well at home		• **Risk reduction and delaying onset**: more individuals will understand the steps they can take to reduce their risk or delay the onset of dementia eg by the team and café promoting and assisting with the 6 simple steps to lifestyle changes (from the Dementia Action plan) • **Raising awareness and understanding** : the wider population will better understand the challenges faced by people living with dementia and the actions they can take to support them • **Recognition and identification**: people will be more aware of the early signs of dementia, the importance of an early diagnosis and know where they can go to get help • **Assessment and diagnosis**: given the teams' focus on early onset of dementia, young onset dementia, and specific vulnerable groups, more people will be diagnosed earlier, enabling them to plan for the future and access early support and care if needed, remaining as independent as possible throughout their pathway		WG - additional guidance on ICF capital and application process due from WG in quarter 1

onset" stage of dementia and cognitive decline **Work with Dementia Care Matters to adopt the DCM model in two residential homes and day services in Merthyr Tydfil**	£35k			The detailed scheme proposals will include activity and outcome measures to be reported quarterly to WG, in line with the requirements of the addendum guidance when issued.		
Total	**£1,010,000**					

APPENDIX 1

INTEGRATED CARE FUND GUIDANCE APRIL 2018

ICF should assist Partnership Boards to achieve the principles and requirements of the SSWB Act including integration, partnership working and co-operation, prevention and early intervention and the development of alternative delivery models. It also provides an opportunity to:

i. focus resources and increase capacity of care coordination or rapid response schemes (such as community resource team and multidisciplinary teams) and the pace at which they are developed, to better meet demand and improve equity of access to services;

ii. establish a more proactive approach, seeking to identify those people at risk of becoming 'stuck' within secondary care with a resulting impact upon their ability to return to independent living;

iii. establish preventative intervention to help avoid unnecessary hospital admissions or inappropriate admission to residential care as well as preventing delayed discharges from hospital;

iv. increase the capacity of reablement and rapid response services to better meet demand (including night time and weekend services);

v. encourage innovation and develop new models of delivering sustainable integrated services;

vi. promote and maximise independent living opportunities, including provision of timely home adaptations;

vii. help develop collaboration in needs assessment and service planning, organisation and delivery at primary care cluster level;

viii. utilise, though not substitute, other sources of funding, such as the primary care fund, to maximise opportunities; and

ix. identify local accommodation solutions for people who are accommodated out of area, individuals with complex needs and people with learning disabilities

Appendix 2

The National Outcomes Framework for People who need Care and Support, and Carers who need support

(http://gov.wales/topics/health/socialcare/well-being/?lang=en)

What well-being means	National well-being outcomes	
1. Securing rights and entitlements. Also for adults: control over day-to-day life.	1.1	I know and understand what care, support and opportunities are available and use these to help me achieve my well-being
	1.2	I can assess the right information, when I need it, in the way I want it and use this to manage and improve my well-being
	1.3	I am treated with dignity and respect and treat others the same
	1.4	My voice is heard and listened to
	1.5	My individual circumstances are considered
	1.6	I speak for myself and contribute to the decisions that affect my life, or have someone who can do it for me.
2. Physical and mental health and emotional well-being. Also for children: physical, intellectual, emotional, social and behavioural development.	2.1	I am healthy and active and do things to keep myself healthy
	2.2	I am happy and do the things that make me happy
	2.3	I get the right care and support, as early as possible.
3. Protection from abuse and neglect.	3.1	I am safe and protected from abuse and neglect
	3.2	I am supported to protect the people that matter to me from abuse and neglect
	3.3	I am informed about how to make my concerns known.
4. Education, training and recreation.	4.1	I can learn and develop to my full potential
	4.2	I do the right things that matter to me.
5. Domestic, family and personal relationships.	5.1	I belong
	5.2	I contribute to and enjoy safe and healthy relationships.
6. Contribution made to society.	6.1	I engage and make a contribution to my community
	6.2	I feel valued in society.
7. Social and economic well-being.	7.1	I contribute towards my social life and can be with the people that I choose

Also for adults: participation in work.	7.2 7.3 7.4 7.5	I do not live in poverty I am supported to work I get the help I need to grow up and be independent I get care and support through the Welsh language if I want it.
8. Suitability of living accommodation.	8.1	I live in a home that best supports me to achieve my well-being.