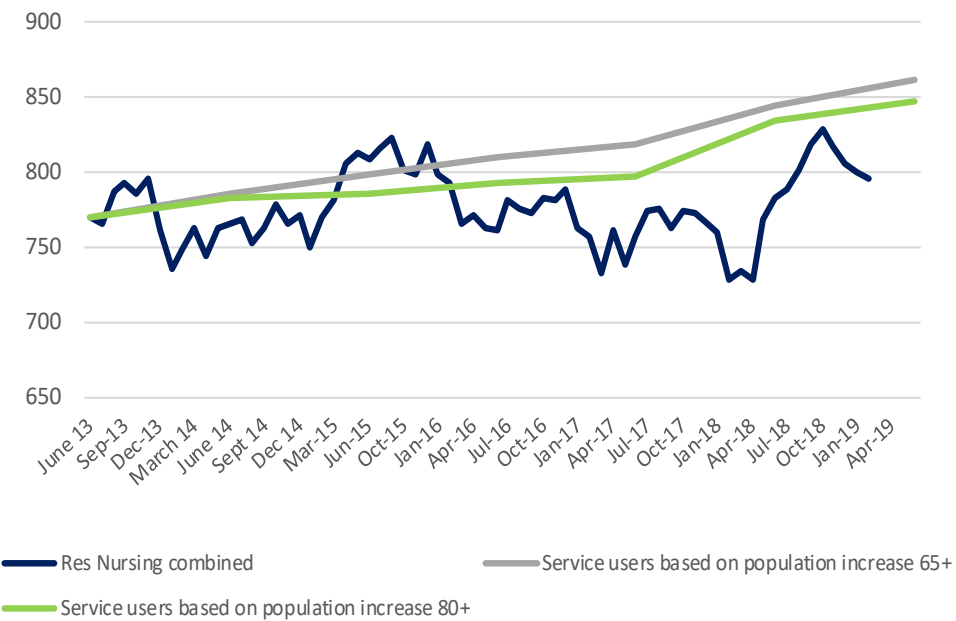




Improving Outcomes for Adults

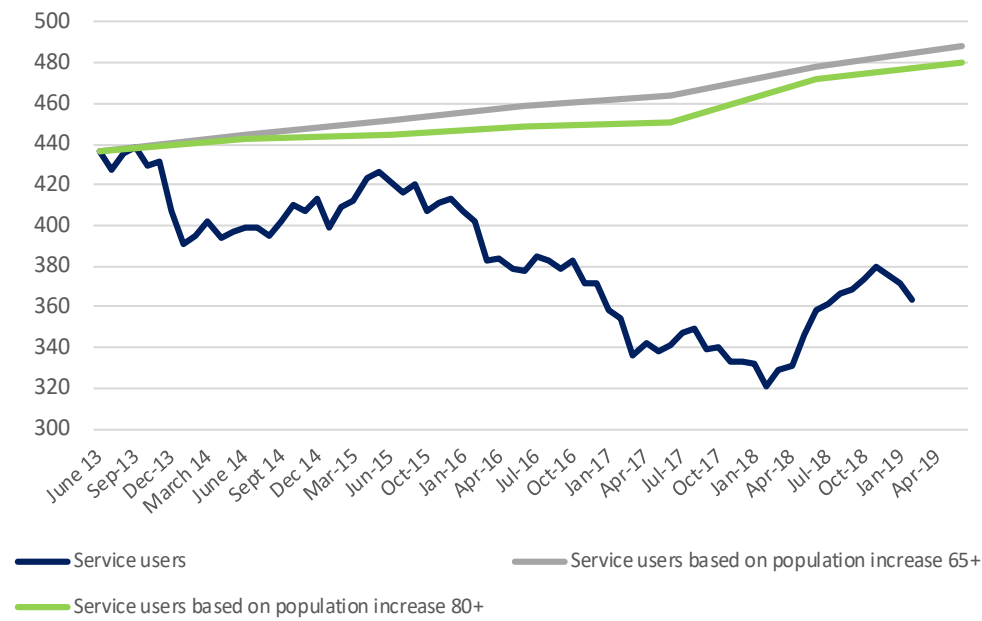
Population Outcomes

Residential & Nursing placements OP PD MHSOP 65+



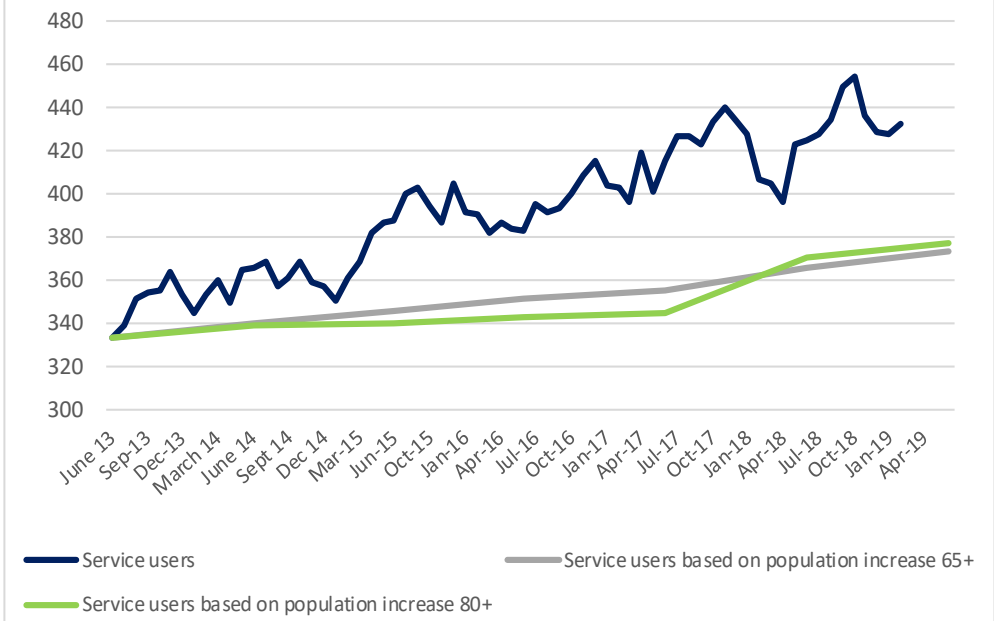
At the end of February 2019, 796 people were in Residential& Nursing Care placements, an increase from 728 in February 2018 and 757 in February 2017.

Residential Care OP PD MHSOP 65+



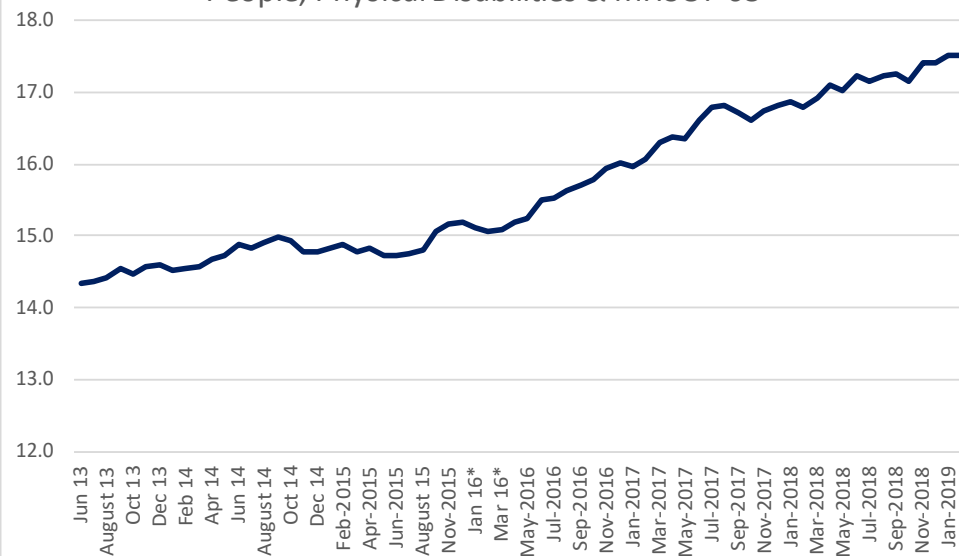
At the end of February 2019, 363 people were in Residential Care placements, an increase from 321 in February 2018.

Nursing Care OP PD MHSOP 65+



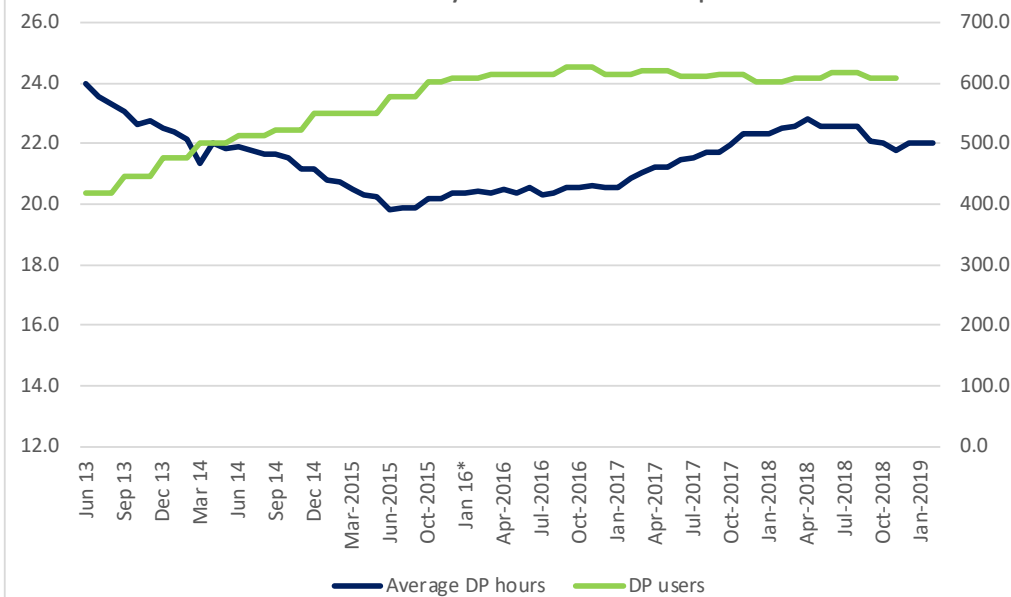
At the end of February 2019, 433 service users were in Nursing Care placements, a slight increase from 407 in February 2018.

Domiciliary Care & Direct Payments Average Hours Older People, Physical Disabilities & MHSOP 65+



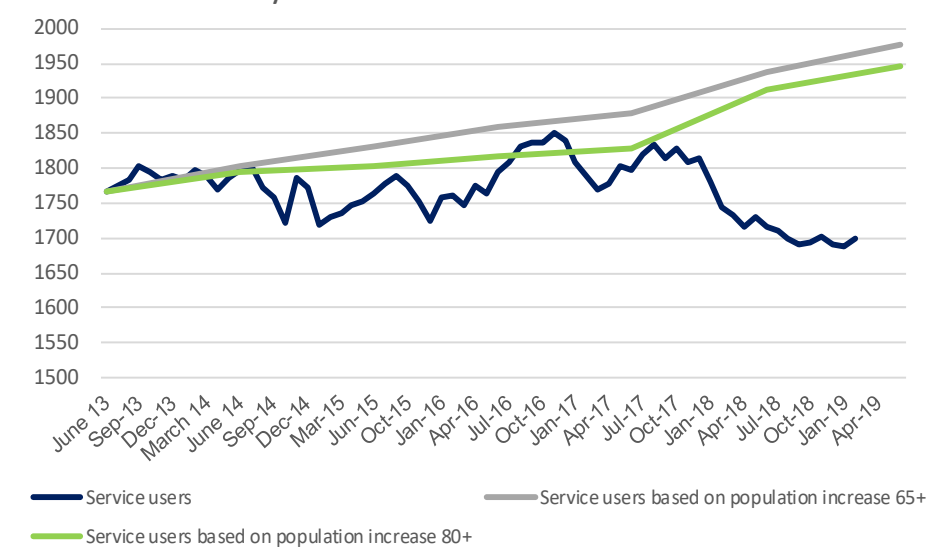
At the end of February 2019, the combined average hours were 17.5, an increase from 16.8 in February 2018 and 16.1 in February 2017.

Direct Payments Older People



At the end of February 2019, the average hours were 22, a decrease from 22.5 in February 2018 and up from 20.8.1 in February 2017.

Domiciliary Care & Direct Payments Older People, Physical Disabilities & MHSOP 65+



At the end of February 2019 there were 1,698 service users accessing 29,788.50 hours of care. This is a small increase in service users and increase in hours from December 2018 when 1,692 service users (0.35% increase) received 29,427 hours of care (1.23% increase) on the number of services users, based on the increasing over 65 population, this would have been 1,964 in February 2019. This indicates a 13.5% reduction in the people over 65 receiving care (266 less people) than expected.



Improving Outcomes for Adults

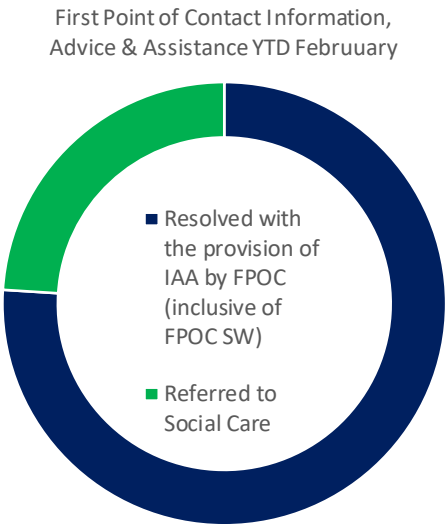
Get Me Home

● **Project Executive:** Carolyne Palmer

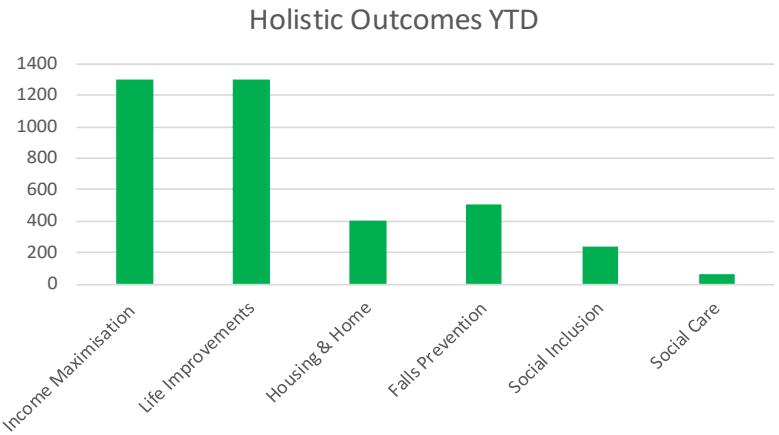
● **Project Manager:** Becky Duggan

● **Data Lead:** Gavin Howells

Prevention



- During February 259 Wellbeing assessments completed
- 76% of assessments dealt with by FPOC with no onward referral to Social Care



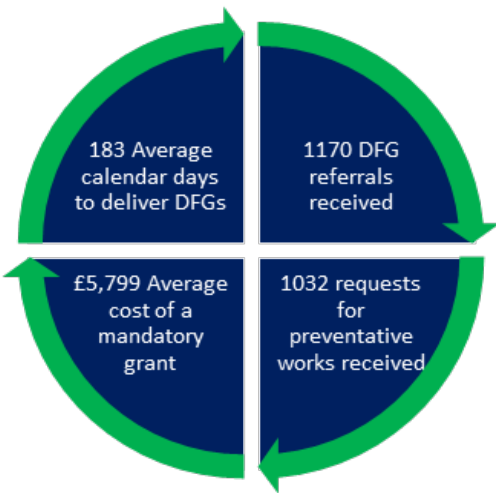
- 389 visits in February inc Holistic, Disabled Facilities Grants, Domiciliary, Residential, Nursing & Respite
- Income Maximisation YTD: £3,385,342

Equipment and Adaptations

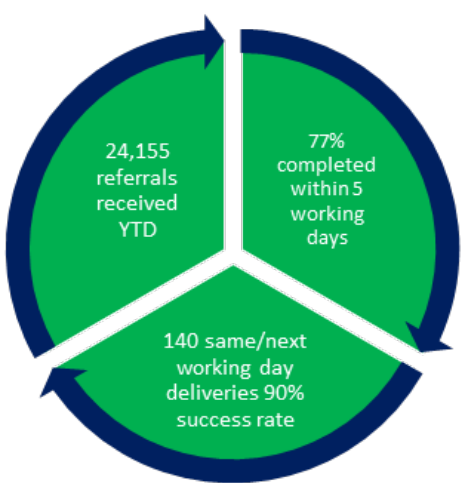
Occupational Therapy YTD



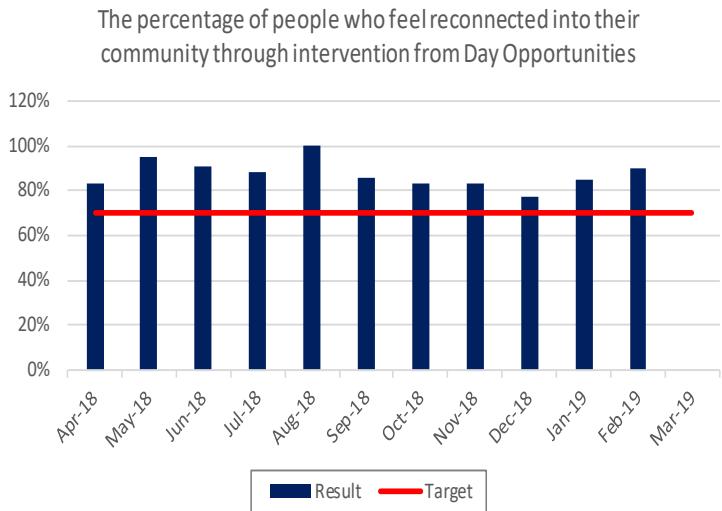
Disabled Facilities Grant YTD



Joint Equipment Services YTD



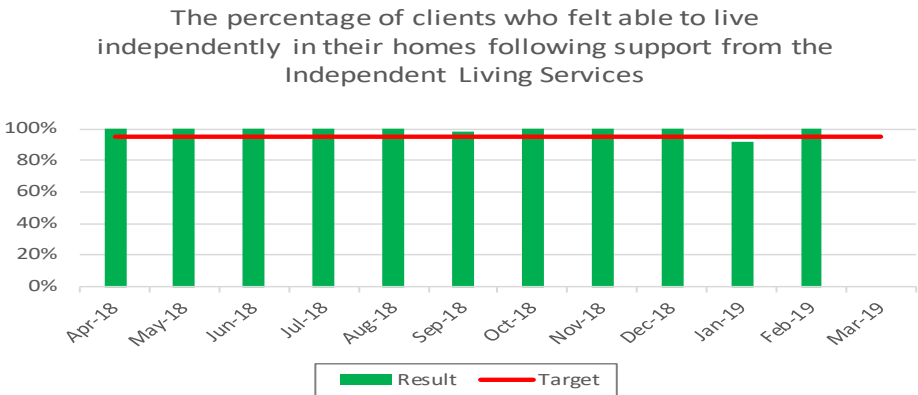
Hospital and Community



Assisted Discharges YTD



Customer Satisfaction



- “Personally I feel that this service is beyond a measure, a life line”
- “I think that all retired people who are on state pension and need pension credit should be automatically referred to the service, even if not needed at the time they would know about it if things got difficult”
- “Rhian was Knowledgeable and keen to help”
- “The service you gave me is greatly appreciated. Thank you very much”



● **Project Executive:** Carolyn Palmer

● **Project Manager:** Becky Duggan

● **Data Lead:** Gavin Howells

Decisions Required at Board

- None at this time

Key Project Successes

- Launch of Get Me Home Pilot on A4 and C7 at UHW
- Refresh of accommodation and office arrangements to create Council Hub at UHW
- Recruitment for full team complete
- Get Me Home team have been assisting a third ward by extending the service out to C7 at UHW. We have also been providing information and Advice to hospital teams for patients on non pilot wards.

Project Milestones

- Create high level to-be process map for discharge of patients – 4th October (by next GMH Project board) - **COMPLETED**
- Recruitment of pilot Get Me Home team - **COMPLETED**
- Training of new posts mid-September 2018 - **Underway, Completion 23.11.2018**
- Implement pilot GMH solution at Wards C6 & A1 at UHW, November 2018 - **Go Live 26th November, confirmed Wards C6 & A4**
- Implement full robust FPOC GMH service – End April 2019
- Transition planning workshop aranged for the 1st of April
- Second Pilot Feedback Review Session 22.01.19
- Third Feedback Review Session took place 19.02.19

Risks and Issues

- RS0103_RSK_07 - Implementing pilot solution may cause duplication of effort and working relationship issues with third sector provider, Age Connects, whose Discharge Support Officers carry out a similar function to the proposed FPOC Get Me Home Officer.
- RS0103_RSK_09 - Adequate Social Work team resources are needed to support the Get Me Home team principles. The pilot will potentially not be successful if the Get Me Home team is not able to pull on this resource swiftly when required.
- RS0103_RSK_10 There will be disparity in patient experiences on pilot wards in comparison to other wards at UHW during the pilot period until the new model is rolled out across the rest of the hospital. As the none pilot wards will be working within the current process, however this enables us to evaluate the impact of GMH as a comparison



● **Project Executive:** Lisa Wood

● **Project Manager:** Mike Maguire

● **Data Lead:** Shelly Lyle

As is:

CRT is comprised of Social Services, Homecare staff and Health staff, usually therapists. The system has been in place for over a decade and has over five different sources of funding. There is a need to review the structure and purpose of the service and to consider future opportunities for development. Staff from both health and social care will work together with an independent resource to consider the current structure and purpose of CRT and to plan to strengthen and develop the service.

Update:

Target group are in patients in wards A4 and C6, UHW.

The aim is to discharge an individual as soon as that person is declared medically fit by the clinicians. The best place to carry out an assessment for care is in a persons own home. We take people home as soon as is safe for them, provide a wrap around of care calls on a 24/7 basis. People want to go home as soon as they can. Long stays in hospital cause muscle wastage, can increase confusion and people are at risk of hospital acquired infections.

Core Community Resource Team Services

All CRT Assessments Undertaken following a referral								
Outcome of the Assessment/Home Visit Form	Aug	Sep	Oct	Nov	Dec	Jan	Feb	YTD
Appropriate for CRT	114	105	128	111	113	145	137	1,344
Admitted to hospital	1	1	2	2	4	8	3	35
Deceased								0
Declined further services	4	3	3	2	4	8	5	47
Discharge cancelled by hospital	2	1	1	1	3	1	3	17
Left the area								0
Discharged to Ty Llandaff								0
Not appropriate for CRT	3	1	2	1	2	7	2	33
Telecare only								0
Therapy only	21	28	16	31	28	23	23	244
Total	145	139	152	148	154	192	173	1,720

Outcomes

All Discharge from Home Care CRT Service								
Outcome of the Service	Aug	Sep	Oct	Nov	Dec	Jan	Feb	YTD
Aim Achieved	61	65	78	52	58	54	50	678
Arrangements made for alternative care	21	15	30	26	16	52	26	275
Admitted to hospital	22	21	23	29	23	23	20	252
Deceased	1	2	1		1	3	2	19
Declined to continue with CRT service			3	1	3	9	2	34
Declined further services - ongoing needs	3		2	2	1	2	2	14
Residential/Nursing Care	2	2		1	1		1	16
Moved out of Area				1		1		7
Total Closures	110	105	137	112	103	144	103	1,295

Customer Satisfaction

- 78% of Home care assessments found to be appropriate for CRT
- 75% of cases completed a period of CRT reablement
- 22% of CRT home care resulted in ongoing long term care
- 70% of cases that were completed in a period of reablement were 'Aim Achieved'
- 30% 'Aim achieved' from Bridging
- 70% 'Aim Achieved' from CRT



● **Project Executive:** Lisa Wood

● **Project Manager:** Mike Maguire

● **Data Lead:** Shelly Lyle

Points for Consideration

- Current cost: we have funded cost that is predicated on the use of the night service. Staff have been recruited on that basis (10 FTE carers) There has been no use of this service
- Staff time: the process on the wards has required two full days from a Homecare Manager and an Occupational Therapist. This has impacted on an already challenging aspect of our service, i.e. capacity to assess
- The overall capacity at discharge has increased to 32 via CRT. This can only be maintained with sufficient funding

Discharge Offers

- Total Discharge offers: 42
- GMH+ Discharges: 25
- Full Team Discharges: 16
- Lost Capacity: 1
- Night Calls: 0

Key Project Successes

- The Programme Board has agreed to map development land available, ownership and any proposed plans for the land.
- Alongside the plans of the local authorities and RSLs, it has been agreed that the Board needs to understand the sustainability plans of health and GPS in particular to identify and opportunities for co-location in any new redevelopment.
- In addition, it was agreed that all partners would provide any specifications/policies they have regarding development e.g. all ground floor accommodation to be developed as 1 bedroom accessible homes.
- The Programme Board has agreed that there should also be a focus on refurbishment and re-modelling of existing accommodation (rather than new build) as potentially this may be more economical. Case studies of learning (both good and bad) such as Extra Care should also be shared to inform future developments.
- Citizens have been assessed in their own homes. Outcomes have been good for individuals and we have been flexible when people have been re-admitted, picking them up quickly to take them home again.
- Two members of CRT, a Homecare Manager and an Occupational Therapist visit the wards and actively work with ward staff to pull people out of hospital
- Links with wards have been improved and CRT is better understood
- Contact with the GMH officers has increased staff knowledge within CRT

Project Milestones

- Mapping of Development opportunities - by January 2019
- Partners to circulate specifications/policies regarding development - January 2019
- Case Studies to be shared by partners

Risks and Issues

- No use of night service although that was cited by health colleagues as a key gap in services
- There have been several discharges cancelled because family members have been resistant to the citizen returning home. Families appear to view the discharges as being too soon
- Difficulties in finding candidates as scope is limited to 2 wards. This has been widened to offer the service to other wards and Clinical Boards
- There have been logistical issues with discharge timings, pharmacy and other practical matters



Improving Outcomes for Adults

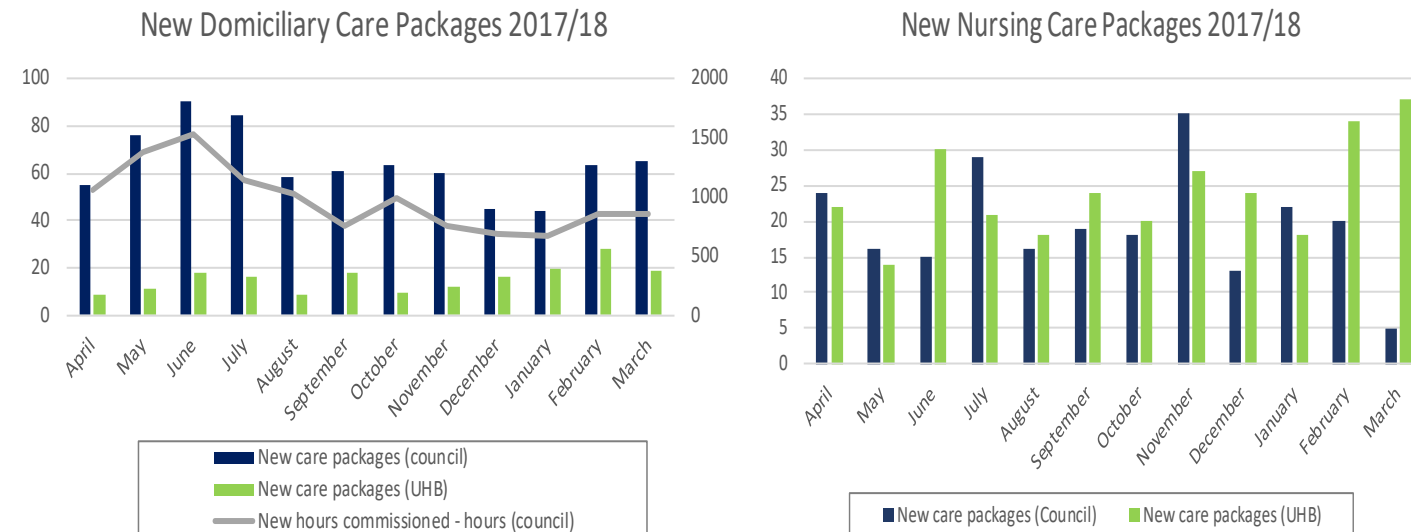
● **Project Executive:** Rachel Jones

● **Project Manager:**

Care & Housing

● **Data Lead:** Rebecca Archer

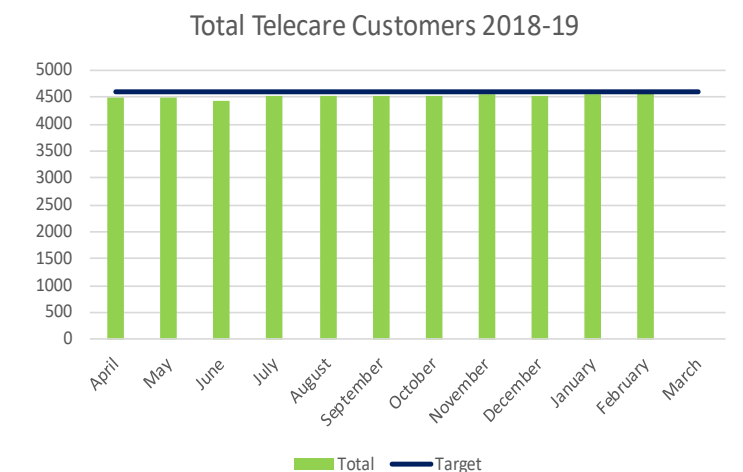
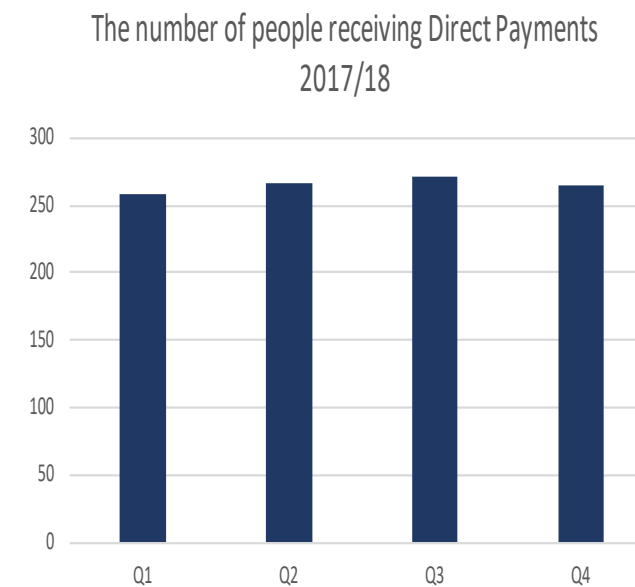
Route into Accessing Services



During 2017-18 Cardiff council took an average of 8 days to begin the service provision from start date.

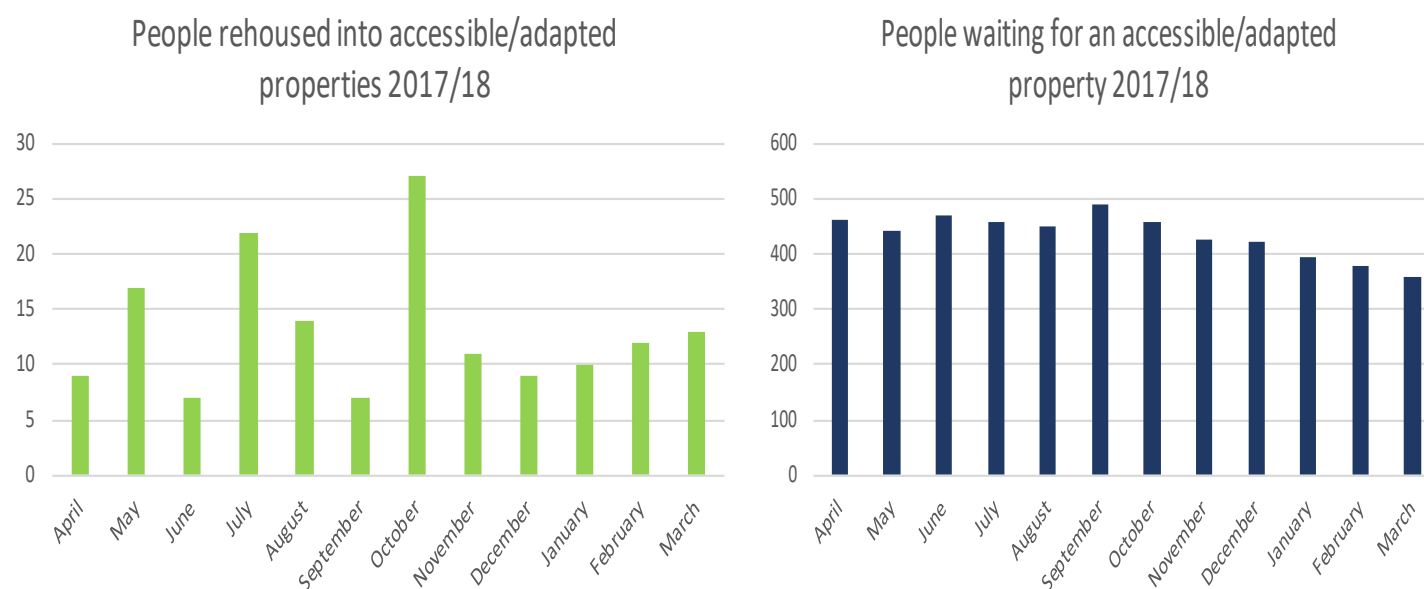
During 2017-18 Cardiff council commissioned 123 new packages of Residential care.

Care & Housing Services

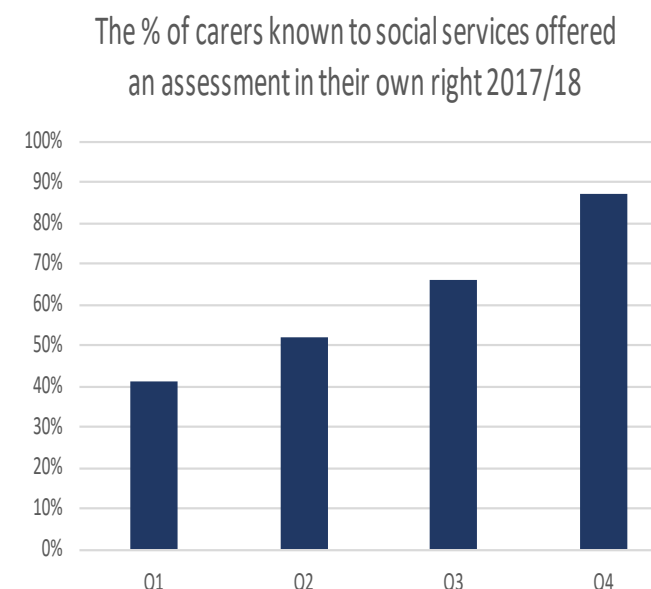


6% of telecare calls have resulted in an ambulance being called out so far this year (April-February 2019)

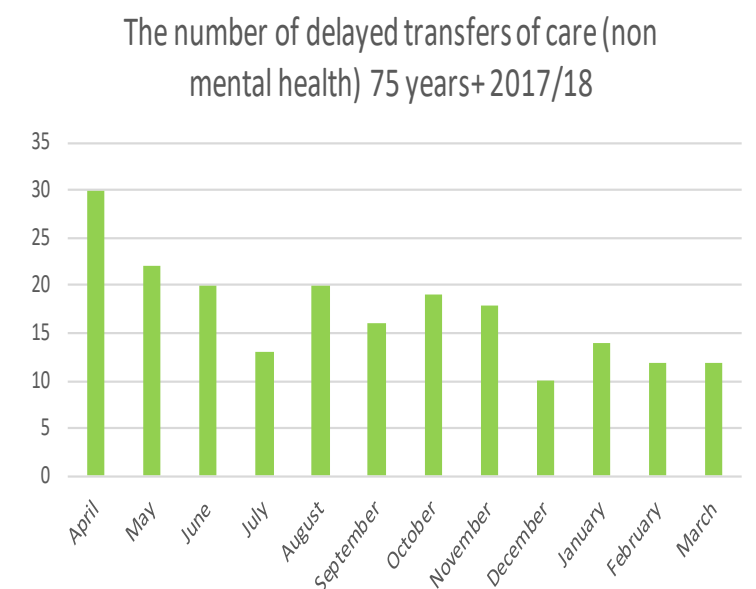
Outcomes



Customer Satisfaction



An average of 61% through the year



A total of 4.7% in the year, per 100,000 HB population



● **Project Executive:** Claire Marchant

● **Project Manager:** Nicola Pitman

● **Data Lead:**

Event Updates:

Alzheimer’s Society Cymru Conference - The conference will be taking place in City Hall in March and Cardiff has been identified as an example of a City that exemplifies best practice and ambition and will be presenting at the conference.

Progress on Key Work Strands

Item	Progress	Points for the Board to consider
Dementia Friends E-Module Training	Work has continued with Alzheimer’s Society Partnership Programmes to develop the digital Dementia Friends training. The relevant videos are currently with Bilingual Cardiff for translation. It is anticipated that translation will take in excess of 2 weeks.The housekeeping arrangements require concluding including distribution of the Dementia Friends badges to staff – likely to be located in Council key buildings including Community Hubs. We are looking at potentially launching the training by Dementia Action week in May which will also achieve maximum exposure and advocacy for Dementia Friendly City.	None
Dementia Information Packs	These remain in development – draft graphics have been created and information is being collated which will include Alzheimer’s Soc content, local dementia friendly events, health and carer information as well as information regarding relevant Council services. The packs require input from Health, but links have now been made including confirmation of Health representatives on the Steering group.	None
Dementia Drop in	The first dementia support drop in session will take place on the 2nd April at Butetown Pavilion Hub. Professional dementia support workers will be available to answer questions to those living with dementia, families and carers. The sessions will provide information or referral to other agencies if required. Comms plan has been put together for the first session including internal and external promotion including PSB comms. Further sessions will be delivered within the Hubs and will move around the City.	None
Reading Well - Dementia	Promotion has continued to take place with Health professionals. 479 books have issued since launch (July). Welsh translation of the titles is continuing. E-Books and E-Audio Books have been sourced and have just been made available to download.Through the work of the Library Strategy team an agreement has been secured with Boots to prescribe and promote the books to their customers. This is a national arrangement resulting in 104 Boots outlets across Wales throwing their weight behind the scheme that aims to support people living with Dementia and their families. Reading Well – Mental Health (Books on Prescription) will provide further support for carers wellbeing. The national launch of this scheme will take place in Cardiff Central Library Hub on the 26th June.	None



● **Project Executive:** Claire Marchant

● **Project Manager:** Nicola Pitman

● **Data Lead:**

Next Steps

- Secure agreement to launch Dementia Website consultation
- Progress Dementia information points within Community Hubs
- Organise Quarterly DFC Event
- Launch E-module through the Academy

Dementia Focused Authority Led Website

Initial discussions have taken place with the Web team within the Authority and preliminary research has been taking place looking at the accessible elements of the website

Nic Pitman and Claire Marchant briefed Councillor Elsmore on the consultation plans for the website, which will include:-

- Consultation Survey to those affected by dementia (directly and carers)
- Consultation Survey to stakeholders and partners (including internal service areas)
- Consultation Survey to Business

Councillor Elsmore has requested a briefing to take place to Cabinet before consultation commences. The date of which is to be confirmed.

A mock up of the website was also presented and positively received.

Bilingual Cardiff have indicated that they are happy to assist in promoting the consultation with Welsh language groups.

Points for Board to consider

- Give any feedback in relation to the initial consultation planning
- Give any recommendations regarding encouraging buy in from Council service areas to support the provision of quality website content e.g. presentation at senior level etc.

Dementia Friendly City Governance

The first re-launched steering group will take place at the end of January. There is a requirement for an action plan to be drafted by the group detailing our immediate actions. Plans will also be discussed relating to the Quarterly Committee meeting which will need to take place prior to the end of Quarter 4.

Dementia Friends training has continued to take place with sessions in Hubs, Libraries, Independent Living, Rentsmart Wales, Adult Services, Bereavement & Registration Services and Projects Design and Development. A session has also been delivered to the Bright Start Trainees who have become Dementia Friends.

The Community Wellbeing Hub restructure has been completed and work has already been initiated to develop further supportive dementia environments within local communities. Talks are underway with Alzheimers Society to develop dementia information points in all Hubs to include key information for those directly affected and their carers including referral advice.

In addition to this, the Alzheimer’s Society are scoping health partners in order to deliver dementia support sessions within the Community Hubs. This will provide informal opportunities for carers and those with dementia to receive help and enable individuals to live well with dementia within their local community. Potential partners are Admiral nurses.