

## HSC&WB Strategy 2008 - 2011

### THEME : MAINTAINING INDEPENDENCE

#### Action Plan 2010 - 2011

#### Priority goal 1 PREVENTION AND SELF CARE

**Outcome :** *More people are supported and empowered to take responsibility for their own health and independence*

Actions	Timescales	Lead Partner	Funding Implications	Links to other Themes/Strategies/Partnerships	Performance Indicators
1. To develop a self care strategic action plan for Cwm Taf with the purpose of improving outcomes for people who are at risk of developing or have a diagnosis of a chronic condition.	By end of October 2010	Public Health Wales Cwm Taf LHB, RCT & M T LA , Interlink and VAMT	Nil for development of strategy, however funding may be needed to address some of the actions that may be identified.	WAG Integrated Framework for Chronic Conditions CCM Service Improvement Plan CCM Maturity Matrix CCM Local Action Plan	Production of Action Plan
2. Continue to roll out the Expert Patient Programme,	By March 2011	LHB and Interlink	Funding for 2010-11 to be agreed by LHB.	LHB Chronic Conditions Strategy WAG Integrated Framework for Chronic Conditions	Delivery of 9 Expert Patient Programmes (at

increasing the number of courses delivered (both generic and LAM) and the number of participants completing courses.				CCM Service Improvement Plan CCM Maturity Matrix CCM Local Action Plan Carers' Strategy	least 2 of which should be LAM courses).  Increase participant numbers by 20%.
3. Increase the number of credit based learning programmes delivered in primary care.	By March 2011	LHB GP Practices	LHB staffing resources to support Practices where possible.	LHB Chronic Conditions Strategy WAG Integrated Framework for Chronic Conditions CCM Service Improvement Plan CCM Maturity Matrix CCM Local Action Plan	Number of courses delivered in primary care. Patient feedback
4.To continue to develop assistive technologies that support independence and self management –  a) Continue to roll out COPD Health Forecasting Service across RCT	By March 2011	LHB GP Practices MET Office	Funding secured via LHB.	LHB Chronic Conditions Strategy WAG Integrated Framework for Chronic Conditions CCM Service Improvement Plan CCM Maturity Matrix CCM Local Action Plan Respiratory Service Development and Commissioning Directives	Increase the number of patients in receipt of the service by 250.  Recruit an additional 2 Practices to the service.

Continue to pilot telehealth technology	By December 2010	LHB GP Practices Tunstall	Funding secured from CCM Transitional Funding budget	LHB Chronic Conditions Strategy WAG Integrated Framework for Chronic Conditions CCM Service Improvement Plan CCM Maturity Matrix CCM Local Action Plan	No of GP Practices involved in the pilot.  No of patients receiving telehealth support. Impact on patients condition and quality of life.
b) Telecare – to continue to promote telecare as a service to support independence	Ongoing	LA		Fulfilled Loves Supportive Communities Older People's Strategy NSF for Older People Supporting People Operational Plan Older People's Mental Health Strategy	No of people accessing service Tier 1 Tier 2 Tier 3
5. Ensure National Exercise on Referral Scheme establishes effective links with rehabilitation/support services provided by health professionals in RCT.	Ongoing – 2010/2011	LHB Local Authority Cwm Taf Trust	Funding provided by WAG, LA and tLHB.	LHB Chronic Conditions Strategy WAG Integrated Framework for Chronic Conditions Management CCM Service Improvement Plan CCM Maturity Matrix CCM Local Action Plan Community Collaboration and Prevention theme	Integration of services at the interface between health/local authority.  No of participants completing courses.
6. Re introduce Home Care Medication Administration scheme	March 2011	HMAS Project Board	Funding secured by LHB.	Fulfilled Lives Supportive Communities Older Person's Strategy NSF for Older people Older People's Mental Health Strategy Setting the Direction	Sign up to rolling out the scheme across Cwm Taf  Implementation of Action Plan No of participants on scheme

## Priority goal 2: OUT OF HOSPITAL CARE

*Outcome: In partnership, more services and care are managed outside hospital when appropriate to do so, as close to home as possible*

Actions	Timescales	Lead Partner	Funding Implications	Links to other Themes/Strategies/Partnerships	Performance Indicators
<p>1. Determine and implement local plans to establish the new model for integrated community health and social care</p> <p>Key actions will include establishment of</p> <p>Communications Hub</p> <p>Integrated Transport Services (see Transport and Access Action Plan)</p> <p>Locality Networks</p> <p>Community Resource team</p>	Ongoing 2010/11	<p>Local Service Board</p> <p>HSCWB Strategy Group</p> <p>Fframwaith</p> <p>Chronic Conditions Workstream</p> <p>LHB Primary care working group</p>	<p>Expectation of resource neutral or disinvestment to reinvest or shift of resource from secondary to community care</p> <p>Staffing implications not yet quantified however expectation that majority of workforce already in place</p> <p>Transitional funding available from WAG to pump prime service developments</p>	<p>Setting the Direction Designed for Life Fulfilled Lives Supportive Communities RCT and MT Strategic Outline Plan ( Building Healthy Communities)</p>	<p>Improved management of chronic conditions in the community</p> <p>Reduce hospital admissions, readmissions and average length of stay</p> <p>Qualitative feedback Service user information</p> <p>More integrated service delivery</p> <p>Access closer to people's homes</p>
2. Implement Community Pulmonary	Service to commence May	LHB LA (NERS)	Funding secured by LHB from CCM	LHB Chronic Conditions Strategy WAG Integrated Framework for	Improvements to functional health

Rehabilitation service across Cwm Taf.	2010.  Full implementation by March 2011		Transitional Funding budget	Chronic Conditions CCM Service Improvement Plan CCM Maturity Matrix CCM Local Action Plan Respiratory Service Development and Commissioning Directives	status for patients.  No of patients completing programmes.  No of patients continuing on to NERS programme.
3. Commence transition of specialist nursing services in to community (linked to development of Community Resource Teams).	March 2011	LHB	N/A	LHB Chronic Conditions Strategy WAG Integrated Framework for Chronic Conditions Setting the Direction	No of clinics provided in the community.  Reduction in referrals to secondary care.  Reduction in hospital admissions.
4. Pilot Community Diabetes Team model in Rhondda locality.	Pilot to be completed by Feb 2011	LHB	Funding secured from LHB.	LHB Chronic Conditions Strategy WAG Integrated Framework for Chronic Conditions CCM Service Improvement Plan CCM Maturity Matrix CCM Local Action Plan Diabetes NSF	No of joint clinics undertaken in the community.  Reduction in referrals to secondary care.  Improvements in skills and knowledge of primary care staff.
5. Redesign the current day hospital and day care facilities and resources, with a view to improving their role in supporting delivery of the out of hospital model.	October 2010	Day services project team	Redesign within existing services	Designed for Life	Impact on reducing delayed transfers of care and readmission rates

6. Based on the findings of an audit of hospital and care home admissions, develop an action plan for targeted interventions to help prevent admissions including the need for training and education	October 2010	Cwm Taf LHB, LA and Independent sector			Improved healthcare support to care homes  Reduction in inappropriate hospital admissions from care homes
7. Develop the use of the Intermediate care/ Reablement service through	Ongoing	LA	The JWSG and Independence grant will cease in April 2011 This has considerable implications for the existing service as a significant proportion of the funding comes from these two grants	Fulfilled Lives Supportive Communities Older Person's Strategy NSF for Older people LHB Chronic Conditions Strategy, WAG Integrated Framework for Chronic Conditions Management, Setting the Direction	Number of people accessing Intermediate Care service baseline XXX
Increasing the numbers of people accessing the service by 5%	March 2011	LA			% of referrals to Intermediate Care Service (ICS) which require no ongoing homecare support following completion of ICS programme baseline XXX target (possibly lower because of move to considering all new cases)
Sharing modelling of the service with LHB colleagues	May 2010	LA			
Taking forward business case for a section 33 agreement	March 2011	LHB/LA			
Increasing direct referral from Hospitals	March 2011	LHB/LA			

**Priority goal 3: WORKING TOGETHER**

***Outcome : Working together across organisations to deliver easier access to services which are better coordinated and integrated where appropriate***

Actions	Timescales	Lead Partner	Funding Implications	Links to other Themes/Strategies/ Partnerships	Performance Indicators
1. Continue project to review issues relating to hybrid/generic health and social care workers eg employment, professional and training issues	Audit to be complete	LHB/LA/University of Glamorgan	Project funded by Local Health Board	Project part of Local Service Board plan	<ul style="list-style-type: none"> <li>• To agree the patient group/service area the project will initially focus on.</li> <li>• To undertake an audit to identify whether there is any duplication in the tasks delivered by health and social care services in respect of the services delivered to the above patient groups.</li> <li>• To agree whether a new role is required or whether there are alternative options to deliver the stated aim above.</li> <li>• If a Generic Worker role is required agreement will be sought on the tasks that this person could reasonably undertake.</li> </ul> <p>Further detailed PIs within project initiation document.</p>
2. Agree and implement a local 2010/11 NSF for Older People and Older People Strategy implementation plans	May 2010	LA, LHB	Within existing resources	Older Persons Strategy NSF for older people	<p>SAAT scoring</p> <p>Joint HIW/CSIW review findings</p>

3. Monitor implementation of the new Joint Carers Strategy and associated Action Plans	March 2011	Carers Strategy Steering group	Within existing resources	RCT Young Carers Strategy	Included in Action plan of carers strategy
4..Development of the Integrated Community Equipment service (ICES) Deliver and collect equipment within agreed timescales Phase 3 – Explore other areas to link to pooled budget Seating, communication aids, District Nursing equipment Review section 33 agreement	March 2011	ICES project Board	Section 33 agreement signed Financial modelling will be revised in light of operational delivery of service	Fulfilled Lives Supportive Communities Older Peoples Strategy NSF for Older People Older Peoples Mental health Strategy	Proportion of aids to daily living delivered within 7 days (target 80%) Proportion of collections made within 14 days (target 100%)
5.To support the implementation of the ASD action plan as appropriate	Ongoing	HSCWB Fframwaith	To be determined in plan	The Autistic Spectrum Disorder Strategy Action Plan for Wales	To be developed in plan
6. To support the implementation of the recommendations highlighted in the review of community based health services for adults with learning disabilities.	March 2011	Learning Disability Services Partnership group	To be determined	Review of Specialist Learning Disability Services for Young People and Adults - HIW Equal Treatment: Closing the Gap	Improved user experience

<p>7. To identify funding to establish a nursing team that will work in partnership with existing social care staff in the development and provision of integrated models of community day services for individuals with a learning disability who have complex health and social care needs.</p>	<p>March 2011</p>	<p>LHB/Learning Disability Services Partnership Group</p>	<p>To be determined</p>	<p>Commissioning and Development Strategy for “Support to Families Services” for adults with a Learning Disability in RCT</p> <p>RCT Skills for Independence Strategy</p> <p>Statement of Policy and Practice for Adults with a Learning Disability (WAG)</p>	<p>Type and range of specialist health interventions provided/number of individuals (staff) involved</p> <p>Number of</p> <ul style="list-style-type: none"> <li>- individuals with complex health needs accessing mainstream services</li> <li>- new individuals accessing the new service eg via transition</li> <li>- health care plans completed through the project</li> <li>- staff trained in specialist techniques eg peg feeding</li> </ul>
---	-------------------	---	-------------------------	---	--