Regional Integration Fund - Two-page profile

Ambition 2 (PR017)

This profile shows the high-level details relates to the annual proposal, monitoring and evaluation, including indicators, performance measures, expenditure and the impact for service users.

Overview/summary of the programme

BCBC in partnership with CTM UHB and BAVO aims to enhance community services for adults through integrated and joint models. This comprehensive programme extends beyond the RIF and embodies a whole-system approach, integrating core funded work to enhance services alongside District Nursing, Social Work, and third sector provision. Key objectives:

Integrated community networks team: Develop a multidisciplinary workforce linked with cluster networks to focus on anticipatory and contingency planning, preventing unnecessary hospital admissions and long-term care placements.

SPoA for district nurse triage: Provide seven-day access from 8 a.m. to 8 p.m. for district nursing referrals and advice, ensuring timely and proactive responses.

MDT Approach: Create MDTs with diverse professionals, including therapists, pharmacists, mental health practitioners etc to deliver comprehensive assessments and services.

Primary care and GP integration: Collaborate with primary care and GP practices to facilitate early intervention and engagement through MDT meetings. GP Clusters have funded additional posts enhancing he integrated operating model.

Focus on older people and dementia care: Support older adults, including those with dementia, and their carers through an integrated community service model. Identify unpaid carers and conduct care assessments to address support needs and reduce carer strain.

RIF deliverables:

Primary model of care:

Prevention & Community Co-ordination

Priority population group/s:

Older people

Enablers:

Integrated planning and commissioning

Workforce development and integration

Technology and digital solutions

Regional approach:

The programme is delivered by CTM UHB, BCBC and third sector partners and is currently operating in Bridgend only.

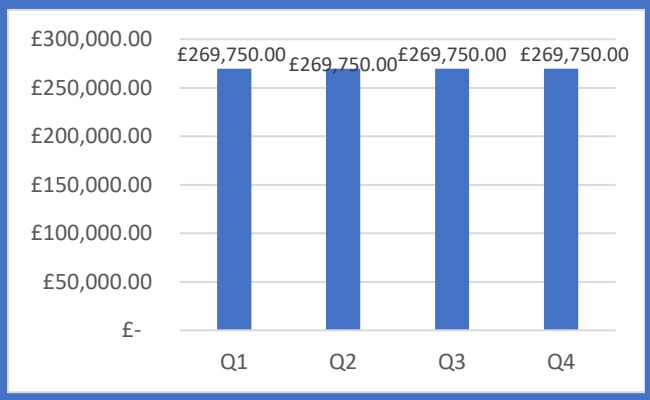
Priority (Linked to Area Plan)

Older people and people with dementia will enjoy good health and wellbeing and supported to live independently for longer.

Older people and people with dementia will receive the support they need to remain in their home for as long as possible, or to move back home as quick as possible following a hospital admission.

People with dementia and their families will have access to the information, advice and guidance that they need.

Project expenditure – £1,079,000 (2023/24 FY)



Projects/partners supporting delivery:

CTM UHB
BCBC
BAVO
GPs
PHW
Voluntary sector

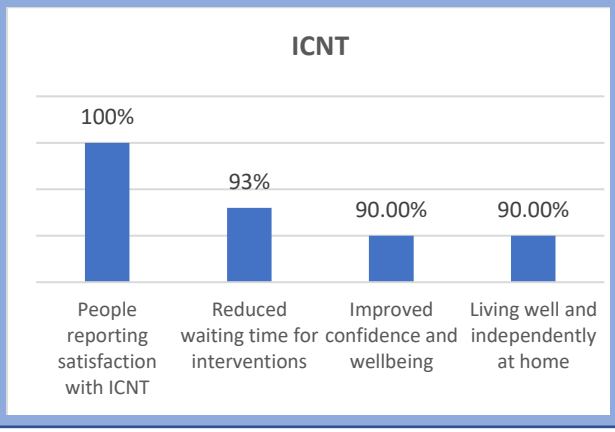
Summary of expenditure:

The funding received from RIF is a contribution towards the delivery of a larger range rehabilitation support services operating across the whole region. The funding provided during 2023/24 was fully utilised during the year.

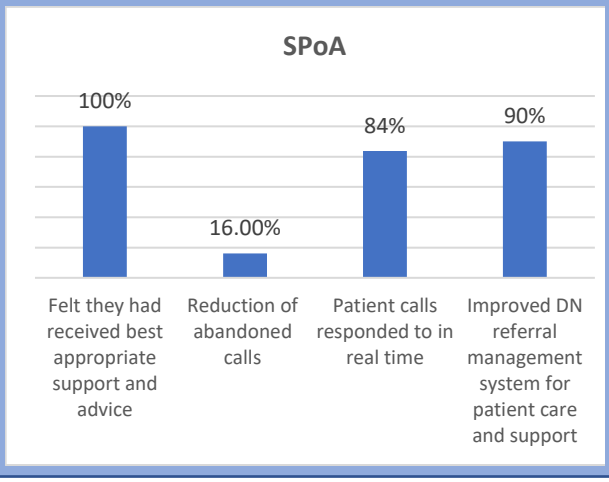
Programme outputs (annual figures):
(includes additional outcome measures)

Referrals into Integrated Cluster Network Teams (ICNT)	2317
ICNT referrals to district nursing	200
People discussed at MDM	592
Social work referrals	592
GP referrals to MDT	630
Therapy requests/referrals	1550
Pharmacy technician referrals	300
No of overall calls into SPoA	28307
No of abandoned calls	6572
Referrals over extended days/hrs	361

Programme outcomes: (primary measures)
(Numbers)



Programme outcomes: (primary measures)



Performance overview: (summary)

The performance data highlights positive operational and patient outcomes. Referrals to the ICNT demonstrate robust engagement with 2,317 referrals, facilitating coordinated care across various disciplines. Notably, 100% satisfaction evidences effective service delivery, with 93% reduced waiting times indicating improved efficiency. The high % for improved confidence, wellbeing, and independence at home (90% each) reflect impactful support provided by ICNT.
In parallel, SPoA managed 28,307 calls, with a notable 84% responded to in real time and a 16% reduction in abandoned calls, indicating effective triaging and patient management. The SPoA also saw 361 referrals during extended hours, enhancing accessibility and timely response. A commendable 100% felt they received appropriate support and advice from SPoA, aligning with a 90% improvement in district nurse referral management, promoting seamless transitions and reducing hospital readmissions. Overall, these outcomes demonstrate the programmes commitment to integrated care models and achieving positive health outcomes through efficient service delivery and patient-centred approaches.

Impact of the programme (qualitative):

The qualitative impact highlights significant strengths in patient-centred care and multidisciplinary collaboration. Feedback consistently shows high levels of satisfaction with services provided, indicating effective communication and support tailored to individual needs. The emphasis on multi-disciplinary meetings and GP involvement enhances care planning and decision-making, fostering comprehensive treatment approaches.

Key outcomes include improved patient confidence, well-being, and independence at home, supported by proactive referrals to therapy and pharmacy technician services. The programme's approach to post-hospital discharge care through the ICNT and SPoA demonstrates a commitment to reducing readmissions and improving care coordination, despite challenges like high call abandonment rates. efforts to enhance SPoA's responsiveness have resulted in significant improvements, with a notable reduction in abandoned calls.

Overall, the programme's qualitative impact evidence its success in delivering integrated health and social care solutions that prioritise patient satisfaction, collaborative care models, and proactive management of health care needs across Bridgend.

Recommendations:

Continue funding for the Programme.
The programme has evidenced positive outcomes for the people it supports and their carers/family's but has shown a reduction in outcomes over the past few years.
The whole programme is a key element of RIF and will form part of future plans around the delivery of the 2 new pathways. It will be an integral part for supporting people to remain independent, safe at home and home from hospital following an admission.

Additional considerations:
Long-term funding strategy: Consider stable, long-term funding arrangements to support strategic planning and service expansion.
Investment in ICT infrastructure: Allocate resources towards improving ICT systems like WCCIS and SPoA to streamline operations further.
Promotion of regional integrated care models: Encourage broader adoption of integrated care models by collaborating with regional partners and stakeholders.