REPORT TO HEALTHIER COMMUNITIES COMMITTEE
17 November 2016

VANGUARD – PROGRESS MADE IN IMPLEMENTING THE NEW WAY OF WORKING IN THE NORTH TORFAEN WELLBEING TEAM (NTWBT)

Report Submitted by: Gill Pratlett Head of Adult Services
Report Written by: Joanne Newman, Group Manager, Adult Services
Sam Jones, Team Leader NTWBT

Area Affected
Whole of the County Borough.

Suggested Scrutiny Activity
Committee’s role – Members are invited to consider the information contained in the report to assess whether the new way of working is making a positive difference in the delivery of support to people in north Torfaen, what lessons have been learnt and how these lessons will be incorporated into service development going forward.

In doing this, Members are invited to make clear comments or recommendations to the relevant Executive Members and / or Chief Officers regarding implementation of the approach, any insights for the service area whilst developing services on a locality basis, and whether sufficient progress has been made in respect of positive outcomes for service users.

Background
Deteriorating health is one of the key challenges that people face as they age and become more susceptible to a wide range of conditions. Some of the most common health issues experienced are frailty, mobility and dementia, with an estimated 42,000 people in Wales currently living with dementia, whilst the provision of services and accommodation to meet these needs is limited.

The need for greater collaboration between services is essential to ensuring an holistic approach to meeting the needs of older people and Health, Social Care and Housing services must all work together to find suitable solutions.

Key Points Made in the Report
Social Care has responded to this challenge by undertaking a programme of transformation including invest to save projects, promoting independence, social inclusion and positive risk taking, rightsizing packages of care, smarter commissioning, raising eligibility thresholds so that we now only meet the needs of the most vulnerable, together with partnership working and collaboration across sectors where it adds value.

Key Areas for Investigation
Is the new way of working making a positive difference in the delivery of support to people in North Torfaen? What lessons have been learned?

The SSWBA sees a return to Social Work intervention being a skill and an asset; to work with people to have the right conversations with people at the right time and the right place about what matters to them and how they might use their own strengths and abilities alongside those of their family networks and community to achieve their goals. Thus moving away from the deficit model of previous legislation and the care management role.
REPORT TO HEALTHIER OVERVIEW AND SCRUTINY COMMITTEE
17 November 2016

VANGUARD – PROGRESS MADE IN IMPLEMENTING THE NEW WAY OF WORKING IN THE NORTH TORFAEN WELLBEING TEAM (NTWBT)

Report Submitted by: Gill Pratlett Head of Adult Services
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Sam Jones, Team Leader NTWBT

1. **Area Affected**
   1. Adult Services Division. North Torfaen

2. **Purpose of Report**
   2.1 To update Scrutiny on progress and lessons learnt from North Torfaen Wellbeing pilot project exploring if the new way of working making a positive difference in the delivery of support to people in North Torfaen and advise on planned next steps.

3. **Suggested Scrutiny Activity**
   3.1 Members are invited to consider the information contained in the report to assess whether the new way of working is making a positive difference in the delivery of support to people in north Torfaen, what lessons have been learnt and how these lessons will be incorporated into service development going forward.

   In doing this, Members are invited to make clear comments or recommendations to the relevant Executive Members and / or Chief Officers regarding implementation of the approach, any insights for the service area whilst developing services on a locality basis, and whether sufficient progress has been made in respect of positive outcomes for service users.

4. **Background**
   4.1 Torfaen has an ageing population (16,477 residents currently over the age of 65), which is projected to increase significantly by 2020 (19,661). This estimated growth will present a range of strategic and operational challenges for Torfaen

   4.2 An older population is more likely to experience health problems including frailty, mobility issues, dementia and other age related illness, which will have a huge impact on their needs and will put increased pressure on the NHS and other service providers.

   4.3 The ability of older people to access services can become more problematic as they age, with mobility and independence often becoming curtailed. Therefore the location of residents relative to the location of community support and services becomes more important to promoting independence, social inclusion, resilience and positive risk taking all of which slow demand for intervention by statutory services
4.4 Torfaen provides a wide range of services to support independent living, but knowledge of these services can vary. In Torfaen 1227 adults aged 65+ are currently receiving a community based service which allows them to remain in their own home. This is compared to 326 adults aged 65+ being in a care home. This shows the service direction is to support people to remain in their community in their own home wherever possible.

4.5 Packages of care are increasing to support people’s needs which are becoming increasingly complex, with the average number of hours of domiciliary care being provided increasing from 9.6 hours per week in 2010 to 11.2 hours per week in 2016.

4.6 Where needs become too complex the only option is for the service user to be supported in a care home.

4.7 Deteriorating health is one of the key challenges that people face as they age and become more susceptible to a wide range of conditions. Some of the most common health issues experienced are frailty, mobility and dementia, with an estimated 42,000 people in Wales currently living with dementia, whilst the provision of services and accommodation to meet these needs is limited.

4.8 Bed Blocking or delayed transfers of care (DTOC) and Hospital discharge is a major pressure on the health and housing services with patients who enter hospital being unable to return to their current accommodation due to mobility / access issues which must be addressed before discharge.

4.9 The need for greater collaboration between services is essential to ensuring an holistic approach to meeting the needs of older people and Health, Social Care and Housing services must all work together to find suitable solutions.

4.10 For the past 5 years we have experienced significant and far reaching austerity measures that have year on year seen a reduction in the resources available to meet the social care needs of vulnerable citizens in Torfaen.

4.11 Social Care has responded to this challenge by undertaking a programme of transformation including invest to save projects, promoting independence, social inclusion and positive risk taking, rightsizing packages of care, smarter commissioning, raising eligibility thresholds so that we now only meet the needs of the most vulnerable, together with partnership working and collaboration across sectors where it adds value.

4.12 In October 2015 having carefully considered the indicative budget, required savings and cost pressures, senior managers in the adult services division recognised that we will only now be able to meet the needs of the population and balance the budget through a radical redesign of Adult Services.

4.13 At the same time the senior managers in Adult services acknowledged that the Social Services and Wellbeing Act 2014 (SSWBA) was coming in to enactment in April 2016 and any redesign needed to support the division to meet its duties under this Act in addition to the requirements of the Future Generations Act as well as being mindful of the philosophies of Prudent Health Care.
The SSWBA sees a return to Social Work intervention being a skill and an asset; to work with people to have the right conversations with people at the right time and the right place about what matters to them and how they might use their own strengths and abilities alongside those of their family networks and community to achieve their goals. Thus moving away from the deficit model of previous legislation and the care management role.

The new model of care that the SSWBA engenders is that the person themselves has a voice, has control and can make decisions about their own life. The role of support is more about support to keep well emotionally as well as physically and enabling people to live the life they choose as part of their own communities for longer.

Collaboration with Health, as previously highlighted, is essential if we as an adult services division are to meet our statutory requirements under this Act and serve the vulnerable members of our community in a holistic and enabling way. Therefore any redesign that we embarked on also needed to begin to dovetail in partnership with the clinical futures model for Aneurin Bevan University Health Board (ABUHB) i.e. Care Closer to Home linked to the development of the Specialist and Critical Care Centre and the Neighbourhood Care Networks (NCN)

The Clinical Futures and NCN model uses the Kings Fund evidence as its evidence base for re-designing its services.

The Kings Fund identifies the key components as:

- Healthy, active ageing and supporting independence
- Living well with simple or stable long-term conditions
- Living well with complex co-morbidities, dementia and frailty
- Rapid support close to home in times of crisis
- Good acute hospital care when needed
- Good discharge planning and post-discharge support
- Good rehabilitation and re-ablement after acute illness or injury
- High quality nursing and residential care for those who need it
- Choice, control and support towards the end of life
- Integration to provide person-centred co-ordinated care

Some of the methods by which the clinical futures and NCN model seek to do this is by

- Developing a pro-active culture to ‘own’ the local population at NCN and hub level, with admission to secondary care facilities being a last resort, developing an in-reach model of care
- Providing urgent, co-ordinated health and social care to stabilise the situation and assembling care plans that avoid clinically unnecessary admission to hospital. This will include a revised assessment model at local level, and the potential for rapid access clinics.
- Reducing excessive length of stay in hospital beds to maximise potential for the patient’s return to pre-admission health status
- Reducing or ceasing services which are over-provided for the population need or do not deliver evidence based care.
5. **Issues and findings**

5.1 Key Facts

5.2 In December 2015 the Adult Services Division, with the support of the NCN’s, commissioned Vanguard Consultancy Group to undertake a 6 day training session. This was funded from an initial investment of £40,000 off set by contributions from the Primary Care Fund and Intermediate Care Funds. This was attended by a group of adult services staff and community nursing staff to start the process of closer collaboration between operation health and social care staff for the benefit of the vulnerable adults of Torfaen.

5.3 The Vanguard Method is used by service organisations to change from a command and control approach to organisational culture to a systems approach to the design and management of work. The method was invented by the occupational psychologist and former Professor John Seddon who began his career researching the reasons for failures of major change programmes. Based on what he learned he developed this method for change, which he describes as "a combination of systems thinking - how the work works - and intervention theory - how to change it".

5.4 The six day training saw the group “digging up” our current systems of support, (the way we doing things around here) by process flow mapping all our team’s processes and interventions., The group looked at current cases to see how many processes they had been part of and how many professional “hand offs” ie referrals and assessments between professionals there had been before the person actually achieved what they wanted to achieve or if they had achieved anything at all. The group also visited some of our current service users in their own homes to ask what it was they wanted, what a good day looked like for them, and what their strengths and attributes were.

5.5 The expectations of our community were low and not different from what we all might say if we were asked the question:

- “I want to be of value”
- “I want to contribute to society”
- “the relationships with my family and friends are important”
- “enough money to make choices”
- “a place to call my own”
- “security”
- “support when I need it - but only tell the story once”
- “see me as an individual – I am the expert on my life”
- “listen to me”

5.6 This ground work enabled the group to challenge our assumptions of:

- Everybody wants care
- People understand what we do as professionals and the systems we work in
- If I, as a social worker, don’t give them something I have failed
- Your self-worth as a social worker is based on the number of assessments you do, the paperwork you fill in and the performance indicator boxes you tick
• We know what it is that is “safe” for a person to do.

Once the group’s thinking based on the fieldwork started to change they were able to explore “what different would look like” and how they would know “they were doing a good job” what doing a good job would mean”

This resulted in a local “leap of faith” based on the national evidence


and the establishment of a pilot project based in the north of Torfaen covering the geographical area of Blaenavon through to Abersychan and related areas for all newly presented cases The clientele being all people 18+ with the exception of those with acute mental health issues and those with a learning disability. The Adult Mental Health Team and Learning Disabilities team are working with Vanguard on testing out different models pan Gwent for their service user groups.

This area was chosen as it had purpose built accommodation in the form of the Blaenavon Resource Centre which already housed our community nursing colleagues and GPs who welcomed the expansion of care to include social care support and community development.

From the training a team ethos of “Enable me to live the life I choose, the way I choose to live it” was developed as a purpose everyone could work to.

The following value steps were adopted to test the new way of working against:

• Listen to and understand what matters
• Build on strengths, networks and community
• Design against predictable demand
• Expertise upfront
• Pull in don’t hand off
• Only do the value work
• Proportionate, purposeful, person centered practice and recording
• Only measure what matters.

Using social work as an intervention itself the team aim to build a hierarchy of support with the individual they are working with that consists of the following:

1. The person’s own strengths, abilities and gifts, their current and past networks
2. The community network and support available to them from within the locality
3. Then and only when the above cannot help commission services to support.
4. When commissioning services these should be proportionate, skill building and enabling and for as short a time as is necessary to meet the outcome of “what matters to the individual

A Team Lead was recruited and through expressions of interest we recruited to the
following team members:-

- Team Leader
- Social workers 1.81 FTE
- Nurse 0.72 FTE
- Occupational Therapist
- Community Care Workers 1.81 FTE
- Re-ablement Assistant
- District Nurse (Seconded from Health)
- In House (intake) domiciliary care service

The staff group have been supported by Vanguard consultancy, the Group Manager as Project Lead and an enabling group across Health and Social Care to help with the removal of any “blockages” or hurdles in the current system or processes. This will assist to facilitate a new way of working that keeps the service user at the heart of all decision making and minimising handoffs and concentrating on what matters to the service users.

6 Assessment of current position and analysis of what we have learnt

6.1 The team became operational in March 2016 and it was important to invest time to learn the Vanguard method, embed the principles in practice, and learn a highly reflective approach supported by fishbowl working to develop a hierarchy of support in which commissioned services are the last resort.

6.2 Time was also needed to build and develop normative experiences for colleagues and partners who are critical of the ongoing success of the pilot. A quick snapshot of current cases open to adult services (apart from learning disability and specialist mental health) confirms that at present the NTWBT are working with 13.5% of our open cases.

6.3 The current allocation of staff to the team is less than 13.5% of current staffing and there are some variations across disciplines for example there are two social workers and three band 5s’ which is not the usual registered/unregistered staff ratio. As we are now moving to Stage two and extending the remit to not only just new cases but rolling in all open cases known to that geographical area, we will be extending the team to cover the increase in demand and anticipate this taking place by the end of November 2016.

6.4 In practice we are learning that we don’t always ask the right questions. The issue the person presents with is not necessarily the issue in its purest sense i.e. “My mother wants to go into residential care” is really “I can’t see any other way of coping and although my mother doesn’t want to go into residential care – what other options do we have” or “My mother cannot be left while I go on holiday and I need respite care” becomes “I feel guilty about leaving my mother to have a break I have a difference of opinion about what she can and can’t do for herself and would never forgive myself if something happened to her”. We have learnt that it takes longer for these conversations to happen and to build up relationships and trust with clients and carers’s.

6.5 We need to work as a multi-disciplinary team using each others strengths, experience and gifts to problem solve. We need tools such as the fishbowl where
in-depth conversations and reflection can take place in a supportive team room environment.

6.6 We need to work with providers of care differently so that they too become part of our multi-disciplinary team ensuring they are skilled to enable, motivate and encourage individuals to do ‘with’ people rather than do ‘for’ people. This may mean changing our model of commissioning from a time and task model to an outcome achievement model. We are currently researching best practice models and evidence to determine whether this maybe easier to deliver on a patch base rather than a whole Torfaen commissioning framework.

6.7 We need to stop being process driven, we need to act on the system and system conditions to create a perfect flow that releases capacity to spend time with individuals and the community to build networks, make connections and create cultural and behavioral changes.

6.8 A clear purpose, a good methodology with autonomy and trusted professional judgment enables us to develop as professionals. This is a recipe for us to feel that we as professionals can be the best we can be in getting things right enabling us to feel empowered. In turn this empowerment, positivity, self-esteem and energy is passed on to individuals to enable them to make positive changes, take positive risks and experience positive social inclusion.

7.0 **Challenges and Barriers**

7.1 Developing this new model of working has been a culture change not only for us in social care but for our colleagues in health and other significant stakeholders. Culture change involves the undoing of learnt behavior and the management of change both of which are not easy concepts, are not without challenge, and take time to achieve.

7.2 The NTWBT model is based upon a social model of intervention, care and support which true to the SSWBA gives the power and control to the citizen shifting the balance of care and responsibilities away from professionals and towards individuals. This cultural shift is a challenge as culturally society has learned to defer to professional opinions.

7.3 The medical model which works with diagnosis, treatment and discharge in a linear fashion where power lies with “those who know best” the professionals. This requires not only a cultural but a behavioral change which needs to start with some common ground i.e. that hospital is not the best place for a “well” person to be. Achieving the what, why, how methodology in the discharge process to enable a measured risk assessment to facilitate the person to live the life they choose the way they choose to live it will take a lot more concentrated work and normative experiences for those involved.

7.4 To transfer workers from our current system to allow the pilot to begin with a reduced work load has resulted in increased pressures in our existing care management system. As we have fewer resources and are in effect ‘double running’ in terms of social workers and practice methods we have had to accept a dip in performance against national and prescribes performance indicators. It has not been easy to juggle the two methodologies but has been necessary in order to gain improved outcomes, improved performance and budget efficiency in the long
To support the learning, an “enabling” group has been set up which includes the team leader from the NTWBT, the Team Manager of the Community Nursing Teams, the Team Manager of the Community Resource Team, Senior Nursing and Divisional Managers from the County Hospital Site as well as Group Managers and project leads from Social Care. This enables multi agency problem solving and solution finding to the challenges and blockages identified by the team.

8.0 Monitoring and Evaluation

8.1 What our performance measures are telling us:

The vanguard methodology has taught us that system targets can be dysfunctional. If a target is too high then the people operating the system can rush and cut corners to accomplish it. If the target is too low then peer pressure can operate as an artificial barrier to limit productivity. Sometimes our actions are geared to heavily to what we can measure and we lose sight of the outcome for the person or community we set out to serve in the first instance.

8.2 A more helpful way of measuring is based on the work of W.E. Demming in the 1950’s. He suggested “you cannot inspect quality in but rather the system itself needs to change” The shift needs to be to understanding problems and their resolution by looking at their interconnectedness in whole or in part to the relationship to the system within which they operate.

8.3 Therefore the NTWBT have been asked to ask what matters to the individual, and set up measures that give an indication of how much they did (demand), how well are they dealing with demand (capacity), is it making a difference (outcomes).

8.4 The following measures are the team measures:

- Date into team to first contact
- Volume in/volume out
- Outcomes for people, stories/quotes
- Budget/ spend
- Staff morale

8.5 In terms of qualitative outcomes the general themes are:

- Increased independence via an enabling approach
- Increased social interaction, using the persons own networks and history - connections made with the local community as opposed to traditional services
- Living in suitable, accessible housing
- Remaining at home
- Being out of pain
- Feeling well again
- Being able to cook again
- Maintaining independence at home
8.6 Case studies that evidence this can be seen in appendix 1 a, b, c

Service User Quotes include:

- The empathy you showed my wife was second to none
- What you are doing up there is outstanding and I can’t thank you enough
- You’re doing a fantastic job
- Please thank your team they are doing a fantastic job
- I must say that you have been efficient beyond my expectations, not only efficient and helpful but in a kindly way. I would give you 10 out of 10.
- You don’t realise just how much you have helped us and how grateful we are.
- I can’t ask for more I am being treated with respect. I like seeing one person, we’ve got to know each other and I know I can trust you.
- Thanks you my sweetheart you’ve been a darling
- He speaks very fondly of you, thank you so much for your support

8.7 One of our National Performance Indicators that we recognise we need to improve is DTOC. Since the implementation of the team in March 2016 there has been only 4 DTOC’s that applied to this geographical area compared to 60 for Torfaen as a whole (01 April – 01 August). Time has been invested in establishing stronger links with the wards so they refer to the team rather than the Hospital Social Work team, hospital OT’s and Physios. This means the same person would follow a service user into hospital and back out with the knowledge of that person’s routines and risk management skills

8.8 All cases have benefited from a face to face response within 48 hours. The key learning from these initial discussions has been the presenting issue was seldom the one which needed to be addressed or supported. Much of the work has been supporting carers and Health professionals to understand and support positive risk taking and the rights of people with capacity to make unwise decisions i.e. living alone despite risks of falls and burns from cooking. For those without capacity they have supported the least restrictive course of action based on known wishes and feelings of the service user.

8.9 The role of interventionist as opposed to care manager has used different skills to promote or retain self-reliance rather than buying in commissioned services, this has resulted in only 16 of 130 service users (12%) requiring either short-term or ongoing commissioned support.

8.10 At this stage we are unable to benchmark that against the work of care managers not engaged in this pilot and this is compounded by the implementation of SS&WB Act 2014 with different expectations of all staff.

8.11 To estimate the likely cost savings the first 43 cases were reviewed in detail to determine what the most likely service response would have been through the “old” way of working compared to the new approach. This showed that under the old system we would have expected to commission £107,040 of services for these 43 cases over a 6 month period, (savings could be over a longer period of time) whereas we actually commissioned £26,067 giving a notional saving of £80,973 in the 6 month period. If these savings were replicated for the remaining 2/3rds of the cases this would equate to £242,919 for 6 months. It is not reliable to forecast any further than this period of time due the changing needs of vulnerable adults. (see
This demonstrates that this way of working delivers savings on the money spent on commissioned services and is already evidenced in the current budget forecasts.

It is difficult to calculate a definitive figure since all assessments are based on the needs of varied individuals and the length of time that the saving applies per individual will vary significantly.

9.0 **Next Steps for NTWB**

9.1 The intention is to increase the geographical area to cover 25% of the population in the North of the Borough (to include Pontnewyndd, Pen–y-garn and Trevethin) and, through expressions of interest, increase the staffing establishment accordingly from existing staff. This will require engagement with GP’s and District Nursing staff covering the expanded area. As part of this process we will be reviewing the transfer of resources from the Hospital Team, in particular those staff that support Nevill Hall and County Hospital to carry the same function but on a patch base.

9.2 Further work is planned with hospital ward based staff and the Community Resource Team staff to deliver training from Vanguard to help dovetail thinking and remove blockages to patient flow.

9.3 We also plan to engage with Staff from Bron Afon and Melin to improve community support and involvement.

9.4 Once the NTWT has imbedded we plan to roll out the Vanguard methodology and patch based working across the whole of the Borough. It is envisaged that this will take the form of two teams in the North of the Borough and three covering the South of the Borough. Again engagements with South NCN, GPS, and District nurses will be crucial to the roll out.

9.5 It is important to note that the culture and approach of the 2 NCN areas is very different and we will factor that into our planning.

10.0. **Staff and Partner Engagement**

10.1 We are currently following a process of expressions of interest with our staff to identify their preferences to work in the North or South of the Borough. Wherever possible we will aim to meet staff preferences however we do need to take into consideration the size and skill mix needed in the team. We are engaging with HR colleague and Union representatives during this exercise. We do not anticipate material changes in roles or job descriptions at this stage, but as the learning develops or posts become vacant we plan to revisit all options.

10.2 There will be ongoing need for training and support for staff from both those experienced practitioners and Vanguard which will be critical to the successful development of teams 2, 3, 4 and 5.

10.3 We recognize that this new way of working requires additional staff time and
wherever possible or appropriate we will seek opportunities to secure grant or other identified funding streams using business cases to increase the staffing establishment where the need can be proven.

11. **Risks**

11.1 During the initial six day training facilitated through Vanguard it became evident that to continue with our current practice was not sustainable. If we were to do so we would be unable to meet the demands of our population in terms of public expectation and Welsh Government expectations (SS&WB Act) alongside not be able to respond to demand or manage the financial pressures. To do nothing we would be at risk of not delivering at all levels.

11.2 Financial Implications - As shown in 8.12 above we are delivering material savings in the third party budget whilst delivering improved outcomes for service user and carers. The total impact of this is yet to be seen and will increase as we roll in other parts of the Borough to this way of working. Savings proposals have been revisited with a recommendation that all savings are found from the third party budget rather than reduce the number of staff in the division. The initial outlay of £40,000 off set by contributions from the Primary Care Fund and Intermediate Care Funds. to fund the training has proved a worthwhile investment.

12. **Actions to be taken following consideration by the scrutiny committee**

12.1 This scrutiny activity is designed to strengthen the understanding of our vision, goals and priorities and to provide an endorsement for us to move forward. Consequently any recommendations resulting from the scrutiny activity will be considered by the division and addressed accordingly in consultation with Senior Management Team and Executive Member – Social Care & Housing.

13. **Conclusion**

13.1 Adult Services through the NTWBT pilot, the pilot expansion and joint working with health colleagues and other significant stakeholders are committed to focusing its interventions on “what matters” to the vulnerable people of Torfaen in an outcome focused, enabling fashion.

14. **Suggested scrutiny activity**

14.1 Members are invited to consider the information contained in the report to assess whether the new way of working is making a positive difference in the delivery of support to people in north Torfaen, what lessons have been learnt and how these lessons will be incorporated into service development going forward.

14.2 In doing this, Members are invited to make clear comments or recommendations to the relevant Executive Members and / or Chief Officers regarding implementation of the approach, any insights for the service area whilst developing services on a locality basis, and whether sufficient progress has been made in respect of positive outcomes for service users.
Appendices

Appendix 1 Case Studies (a,b,c)

Appendix 2 Torfaen Wellbeing Team vital statistics August 2016
Appendix 1

Case Study A

Background
P had fallen at home, sustaining a fractured right neck of femur. She had surgery. At the point of us first meeting she had transferred from Nevill Hall to Rowan Ward, County Hospital.

What would have happened before?
P would have been seen by a hospital social worker. She is likely to have been referred To Community Resource Team. When P was deemed medically fit & therapy complete she would have been visited on the ward to discuss discharge. She would have been discussed in Multi-Disciplinary Team meetings until she was deemed fit. Care would have been brokered as necessary.

What did we do this time?
Social Worker met with P several times on the ward, before she was considered medically fit. I also met her family members during visiting times. P was provided with my contact number so her family could contact at any time. During these visits I gained an understanding of what mattered to P and considered her strengths. P was very clear she wished to return home, being supported by her “beautiful family” and regaining a little independence. P has strong community links, including band and chapel. She also has wide ranging interests including painting, cooking, crafts, flower arranging and rugby. It was clear P would not wish to make decisions without family discussion.

P described limited Physiotherapy input on the ward. She was advised she should not walk without supervision and was not encouraged to do so. P has steep steps to her home & internal stairs. She agreed that we should arrange a home access visit with our OT and P’s her daughter. We were able to see that P would require stairs practice in hospital and also handrails were planned around the home. Physiotherapy were urged to undertake stairs practice. P had to consider bending precautions post operatively. Due to this she considered whether to accept temporary home care support or just family support. P wished to discuss these options with her family.

Whilst I was on annual leave the Discharge Liaison Nurse contacted our OT to arrange immediate discharge, stating this could be managed from hospital, with care arranged 3 x daily. P declined this input, on the basis plans were in progress, & the person arranging discharge did not know her or her home situation.

We planned together for P to return home with short term home care support morning and night. Her daughter transported her home. Our OT and Re-ablement assessor met P on arrival home. A temporary key safe was fitted. Her hospital bed was requested to be retained until she had safely accessed her home. P returned home 9th June 2016.

P was visited over the next few weeks. She also received input from our team nurse for dressings and advice. On occasion we were able to joint visit which P thoroughly enjoyed. P cancelled her night calls 27th June & her morning calls 5th July.
Case study B

**Presenting issues**

R was referred to the North Torfaen Wellbeing team via Nevill Hall hospital following admission for Pneumonia. The hospital made a referral for a social work assessment for a package of care with the possibility of reablement input. R was discharged from hospital with her daughter’s support and doctor deeming R as medically fit.

**What matters?**

A visit took place the day following R discharge, R was very withdrawn and tired following discharge. R lost her husband the day before being admitted to hospital and hasn’t had time to grieve and come to terms with her loss. R was feeling a little overwhelmed with returning home and dealing with the emptiness of her home. R is currently being supported by her daughter C for all aspects of her daily needs, C wants to continue to support her mum as she also cared for her dad up until his passing, and C felt that it was important to her to continue supporting mam.

R felt what was important was to regain her strength and mobility which she felt would get better following discharge. R felt it was important that she attend her husband’s funeral, to manage transfers in the house safely and tend to her hearing difficulties. R does not feel strong enough to attend her husband’s funeral but feels with support from her family she will be able to manage on the day, R is hard of hearing and would like a home visit to assess for hearing aids. R also feels that she struggles to transfer on and off the toilet, in and out of bed and from the settee.

**Strengths and Networks**

R has an excellent support network and is cared for by her daughter and son in law. R is currently in the process of moving in with her daughter and they both feel that this will be a positive move. R has grandchildren and she enjoys their company. R is mindful of her strengths and is aware of aspects of her daily living where she requires some support.

**Actual Issues**

R was very aware of the issues she has and wants to address, R explained that she wants to have a hearing test as she believes she will require hearing aids. R is hard of hearing and feels this will help. R has struggled with her mobility following hospital discharge and wants to regain her strength, R is aware of her limitations however eager to mobilise around the home to improve her strength. R is having minor difficulties transferring off the toilet, settee and bed. R would like some additional support to remain independent and reduce risk.

R had very little time to grieve for her husband due to being admitted to hospital the day after his passing. R feels she needs time to come to terms with her husband’s passing. R also expressed that she wishes to go on holidays with her daughter however hasn’t got holiday oxygen, R is unsure how to manage this.
Outcomes

R is very clear of her personal outcomes and what she wants to achieve, which are outlined below

- To go home from hospital.
- To attend her husband’s funeral.
- To transfer safely within her home.
- To go on holidays with suitable oxygen supply.
- To move in with her daughter.
- To regain strength and improve mobility.
- To have a home visit hearing test.

Home visit 02.06.2016

R seems more herself today and feels she has had more time to come to terms with her husband’s passing. R feels her mobility has improved a little and informed me the equipment that I had ordered is being delivered on the 3rd June. R has extra oxygen and is due a visit from the COPD nurse next week to discuss holiday oxygen to allow her to go on holidays with her family. R attended her husband’s funeral and felt it went very well, R explained that he had a ‘good send-off’ and she was pleased that she felt well enough to go. Telephone numbers were passed onto R and her daughter to arrange a hearing test at home, R also explained that her house went on the market and hopefully the move will take place in a few weeks’ time.
Case study C

A underwent surgery to amputate his lower left leg following a growth that had formed from an ingrowing hair and had become cancerous. A underwent surgery in Moriston hospital and was later transferred to Rowan ward at Panteg hospital which was nearer his home town.

A was eager to return home however received information from the occupational therapist at Moriston hospital that his home was unsuitable for him to return too. A loves living in Blaenavon and love the home which they live in, they have many friends that live close by and visit regularly and there is a good support network around them. A was faced with the dilemma of giving up their home and felt unsure which way to turn. Due to the property being a Bron Afon owned home, A contacted Bron Afon to request their services.

A was assessed and issued a self-propelled wheelchair whilst in hospital, unfortunately A’s wheelchair was too wide to fit through the current doorways within his home. Bron Avon were unable to widen the door ways or provided temporary ramping to gain entry into his home and a stair lift was also not an option as the home was deemed unsuitable. A was advised to sign up to the home seekers website and start bidding on suitable properties. A remained in hospital for the duration and was unsure which way to turn. A explained their situation as ‘going around in circles’

A was referred to the North Torfaen Wellbeing Team following two weeks on Rowan ward. A had been discharged from physio and was fit for discharge however there were still problems surrounding housing issues and this was preventing A from returning home. Prior to contact being made with A, a telephone call was received from a specialist at Moriston hospital explaining that A was feeling angry and frustrated as he was ‘going around in circles’. A felt he was on a ‘geriatric ward’ and his mental wellbeing was being effected. A felt he may discharge himself.

A joint visit from our Care Management Nurse and OT benefited A due to the mixed skill base and the presenting issues. When meeting A he explained that what was important to him was to get home, A explained that he did not want to move, neither does his wife and that he would do anything to get home as soon as possible. A misses his dog and wants to return to normality. A explained and demonstrated his ability to transfer; he explained that he is self-caring and that all he needs to return home is a Zimmer frame and a ramp. A informed us that he can hop on one leg along with a frame however he had been advised by physio that ‘hopping’ following an amputation goes against the guidelines.

A explained that he will eventually be fitted for a prosthesis and that he expects to use his wheelchair short term. A is a very positive person with determination to not let his amputation effect his quality of life. I would describe A as a ‘glass half full’ kind of guy. A was aware of the risks involved in returning home and was happy to go ahead. Equipment was put in place where possible to reduce risk and advice given where appropriate. A was advised to bring a bed down stairs, offered a commode however declined (A wishes to use a urine bottle) was supplied with a smaller wheelchair to fit through doorways within the home and two ramps issued to enter the property.

A got to remain in the home he was very fond of.
A was reunited with his dog.

A was given the opportunity to discuss any risks involved in returning home and work through problems that may occur. This empowered A and allowed him to take control and decide what was best for himself.
North Torfaen Wellbeing Team Vital Statistics  August 2016

- Number of service users = **130**
- Average number of referrals per month = **27**
- Profile of Referrals

<table>
<thead>
<tr>
<th></th>
<th>March</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>August up to 6/8/16</th>
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<tbody>
<tr>
<td>Case</td>
<td>7</td>
<td>10</td>
<td>23</td>
<td>30</td>
<td>33</td>
<td>19</td>
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</tbody>
</table>

**Case Status**

Active = 91 = **70%**
Closed = 39 = **30%**

Responsiveness = number of days from referral to “what matters conversation = **48Hrs**
Number of cases using commissioned services = 16/130 as at 16/8/16 = **12%**

Using the first 43 or 1/3 of cases managed by the team thus far the next page shows a table of the intervention outcomes and possible cost saving conclusion. NB any savings forecast are from date of intervention/discharge to the week of 15/8/16 – not 52 week snap shot. No income from client contribution is assumed.
The assumptions on costings are as follows:

- Residential Placement: £518 per week
- Nursing Placement: £562 per week
- EMI Residential Placement: £602 per week
- EMI Nursing Placement: £585 per week
- Day Activities: £45 per day
- Sitting Service: 6hrs at £14.50 per hour
- Domiciliary Care: £14.50 an hour*

**Note**
With the exception of 2 cases intake team have been providing services and where it states in the narrative the team, intake team are integral part of the NTWBT make up.

<table>
<thead>
<tr>
<th>Case Number</th>
<th>Case Description</th>
<th>Referrer requested outcome</th>
<th>Cost</th>
<th>Actual Outcome</th>
<th>Cost</th>
<th>Cost Benefit</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Community Referral</td>
<td>Residential Care</td>
<td>8288</td>
<td>POCx2 visits of ½ hr 24/4/16 to date = 16 weeks</td>
<td>1624</td>
<td>6664</td>
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<td>2</td>
<td>Community Referral</td>
<td>Residential Care</td>
<td>2590</td>
<td>POCx1 visit of 1hour twice a week from 7/3/16 – 4/4/16 = 5 weeks</td>
<td>145</td>
<td>2445</td>
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<td>3</td>
<td>Community Referral</td>
<td>Day Activity from 7/3/16 – to 16/8/16 1 session At £45 per week = 23 weeks</td>
<td>1035</td>
<td>Ground Force cleared garden now has patio and is back gardening in pots</td>
<td>0</td>
<td>1035</td>
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<tr>
<td>4</td>
<td>Community Referral</td>
<td>POC x4 per day ½ hr per visit from 10/3/16 to 16/8/16 = 23 weeks</td>
<td>4669</td>
<td>POC x1 per day ½ visit from 10/3/16 – 17/3/16 Pain management and equipment</td>
<td>102</td>
<td>4567</td>
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<td>Case Number</td>
<td>Case Description</td>
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<tr>
<td>5</td>
<td>Community Referral</td>
<td>4 weeks respite per year (residential)</td>
<td>2072</td>
<td>Intensive team intervention regarding “whose risk is it” and accepting risk – no support needed</td>
<td>0</td>
<td>2072</td>
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<tr>
<td>6</td>
<td>Community Referral</td>
<td>EMI Residential Placement = 23 weeks</td>
<td>13846</td>
<td>Telecare and intensive intervention ongoing from the team regarding dementia “whose risk is it” and accepting risk – no support needed</td>
<td>0</td>
<td>13846</td>
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<tr>
<td>7</td>
<td>Community Referral</td>
<td>Day Activities from 7/3/16 – to 16/8/16 1 session At £45 per week = 23 weeks</td>
<td>1035</td>
<td>Handrails Walking practice with RA to build confidence following a fall. Nurse intervention re wound care</td>
<td>0</td>
<td>1035</td>
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<tr>
<td>8</td>
<td>Hospital Discharge (NH) Patient new amputee</td>
<td>Nursing Care from 16/6/16 to date = 9 weeks</td>
<td>5058</td>
<td>Step up/step down residential care plan is to discharge to adapted property</td>
<td>4662</td>
<td>396</td>
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<tr>
<td>9</td>
<td>Hospital Discharge (County)</td>
<td>POC x4 (7 days) visits 3/4hr + X3 1/2hr duration and day activities from 7/7/16 to date = 7 weeks</td>
<td>1932</td>
<td>POC x4 (5 days) x3 (2 days) ½ duration, chapel and lunch-club</td>
<td>1323</td>
<td>609</td>
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<td>Case Number</td>
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<td>10</td>
<td>Hospital Discharge (NH)</td>
<td>Residential Placement from 24/4/16 to date = 16 weeks</td>
<td>8288</td>
<td>POC x3 visits a day, 7 days a week, ½ hr duration, intensive team work with hospital, family and service user about “whose risk is it” and risk minimisation solutions</td>
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<td>5852</td>
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<td>11</td>
<td>Hospital Discharge. Patient had TIA</td>
<td>POC x2 visits a day, 7 days a week, ½ hr duration from 24/4/16 to date = 16 weeks</td>
<td>1624</td>
<td>Lifeline, Family support and intensive work from the team to deal with fears re TIA's and confidence building – no commissioned care</td>
<td>0</td>
<td>1624</td>
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<tr>
<td>12</td>
<td>Hospital Discharge (NH) query need for lower leg amputation in future</td>
<td>POC x3 visits per day, 7 days a weeks, ½ hr duration from 20/4/16 – 12/7/16 = 13 weeks</td>
<td>1979</td>
<td>Same</td>
<td>1979</td>
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<td>Case Number</td>
<td>Case Description</td>
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<tr>
<td>13</td>
<td>Hospital Discharge</td>
<td>POC x2 visits per week, 7 days a week from 13/4/16 to date = 17 weeks</td>
<td>1725</td>
<td>Equipment Ramping and POC x1 visits per week from 13/4/16 – 9/5/16 = 5 weeks and work from RA</td>
<td>507</td>
<td>1218</td>
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<tr>
<td>14</td>
<td>Hospital Discharge (county)</td>
<td>EMI Nursing Placement from 22/7/16 = 4 weeks</td>
<td>2340</td>
<td>POC x5x2 carers visits per day, 7 days a week, 1/2hr duration of calls and intensive work about “whose risk is it” with hospital staff</td>
<td>4060</td>
<td>+1720</td>
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<td>15</td>
<td>Hospital Discharge (YAB)</td>
<td>Prior to admission x4callsx2 carers x 7 days a weeks, ½ duration of calls living with family providing 24hr support 22/7/16 = 4 weeks</td>
<td>1624</td>
<td>POC x4 calls, x1 carer (improved equipment choice), x7 days a week, OT, RA, Physio continue to work to maximise potential and ease family carer intervention</td>
<td>812</td>
<td>812</td>
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<tr>
<td>16</td>
<td>Hospital Discharge (County)</td>
<td>POC x2 visits, x7 days with ½ hour duration from 22/7/16</td>
<td>406</td>
<td>Equipment</td>
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<td>Case Number</td>
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<td>Actual Outcome</td>
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<td>17</td>
<td>Hospital Discharge (RGH)</td>
<td>POC x2 visits, x7 days with ½ hour duration from 22/7/16</td>
<td>406</td>
<td>Died – catastrophic bleed but plan was no services</td>
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<tr>
<td>18</td>
<td>Hospital Discharge (County)</td>
<td>Residential care from 21/6/16 to date = 8 weeks</td>
<td>4144</td>
<td>POC x3 visits, 7 days a week with 1/2hr duration plus RA and risk with family and the ward</td>
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<td>19</td>
<td>Community Referral</td>
<td>Patient Terminally III – Hospice, Hospital or Nursing Home 1 week</td>
<td>562</td>
<td>Died at home – St Davids, Nurse and Social Worker from team – counselling, pre bereavement work</td>
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<td>20</td>
<td>Community Referral</td>
<td>Sitting Service and Day Activity from 3/5/16 = 15 weeks</td>
<td>1980</td>
<td>Ongoing social work intervention re risk management - no commissioned services</td>
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<td>21</td>
<td>Hospital Discharge</td>
<td>--------</td>
<td>0</td>
<td>Equipment and wound care</td>
<td>0</td>
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<tr>
<td>Case Number</td>
<td>Case Description</td>
<td>Referrer requested outcome</td>
<td>Cost</td>
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<tr>
<td>22</td>
<td>GP Referral</td>
<td>Adult Protection, Pain management</td>
<td>0</td>
<td>Adult Protection, Pain Management</td>
<td>0</td>
<td>0</td>
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<tr>
<td>23</td>
<td>Community Referral</td>
<td>4 weeks respite per year</td>
<td>2072</td>
<td>Activities in complex, neighbour support, Housing Officer intervention, MOW's and Luncheon Club</td>
<td>0</td>
<td>2072</td>
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<tr>
<td>24</td>
<td>Hospital Discharge</td>
<td>Nursing Home from 20/6/16 to date = 8 weeks</td>
<td>4496</td>
<td>Restart POC 4 calls with 2 carers x7 days, Adaptations, catheter care, skin bundle, ongoing OT and RA re wheelchair practice and move to single handle carer</td>
<td>3248</td>
<td>1248</td>
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<td>25</td>
<td>Hospital Discharge</td>
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<tr>
<td>26</td>
<td>Community Referral</td>
<td>POC x2 call of 1 hour x7 days from 12/5/16 = 14 weeks</td>
<td>2842</td>
<td>Bariatric Equipment and RA support</td>
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<td>2842</td>
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<tr>
<td>27</td>
<td>Community Referral</td>
<td>POC x2 calls of ½ hr x7 from 12/5/16 = 14 weeks</td>
<td>1421</td>
<td>Equipment, rails and RA support</td>
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<td>1421</td>
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<td>Case Number</td>
<td>Case Description</td>
<td>Referrer requested outcome</td>
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<tr>
<td>28</td>
<td>GP referral, self-neglect and diabetic leg pain</td>
<td>Adult Protection, POC x4 calls a day of ½ hour duration x7 from 11/5/16 = 14 weeks</td>
<td>2842</td>
<td>Adult Protection, Telecare, lifeline, medication dispenser. On-going team intervention</td>
<td>0</td>
<td>2842</td>
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<tr>
<td>29</td>
<td>Hospital Discharge (County)</td>
<td>Residential Care from 26/6/16 =12 weeks</td>
<td>6216</td>
<td>Early Dementia, frightened of falling. Could have gone home with a POC x2 per day x7 days but pressure from family, service user and hospital too great therefore placed self-funding in residential care</td>
<td>1363</td>
<td>4853</td>
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<tr>
<td>30</td>
<td>Hospital Discharge (YAB)</td>
<td>POC x1 for 7 days a week for a duration of 1/2hr from 26/6/16 = 12 weeks</td>
<td>606</td>
<td>POC x1 for 7 days a week for a duration of 1/2hr for 1 month. RA support and luncheon club</td>
<td>203</td>
<td>403</td>
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<tr>
<td>31</td>
<td>Hospital Discharge (County)</td>
<td>POC x4 for 7 days a week duration of 1/2hr per visit from 9/6/16 = 11 weeks</td>
<td>2233</td>
<td>POC x2 for 7 days of ½ hour duration from 9/6/16 to 5/7/16 = 6 weeks when care was cancelled, pain relief, nursing and RA support</td>
<td>609</td>
<td>1624</td>
</tr>
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<td>Case Number</td>
<td>Case Description</td>
<td>Referrer requested outcome</td>
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<tr>
<td>32</td>
<td>Hospital Discharge (YAB) Patient has early dementia, daughter and main carer has mental health diagnosis of anxiety and depression</td>
<td>EMI Residential Placement from 8/6/16 = 11 weeks</td>
<td>6622</td>
<td>Discharged with NTWBT home on 26/5/16 plan was home visit assessment and stay however daughter had such high expressed emotion and negative feelings that patient returned to ward. Continued intervention with daughter pulled in RMN from OPS regarding dementia and risk, wishes and feelings of patient. Discharge home successful 8/6/16 POC x1 call per day x7 of ½ duration with contingency of step up step down bed in AJ – yet to be used. Continued telephone support from team</td>
<td>558</td>
<td>6064</td>
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<tr>
<td>33</td>
<td>GP Referral Anxiety and pain management self-neglect</td>
<td>POC x1 for 7 days duration of visit ½ hour from 10/6/16 = 10 weeks</td>
<td>507</td>
<td>RA support – no commissioned services</td>
<td>0</td>
<td>507</td>
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<tr>
<td>34</td>
<td>Hospital Discharge</td>
<td>Deceased</td>
<td>0</td>
<td></td>
<td>0</td>
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<tr>
<td>35</td>
<td>Hospital Discharge (NH) patient moving in with daughter</td>
<td>POC x4 for 7 days a weeks for duration of ½ hr per call from 19/5/16 = 14 weeks</td>
<td>2842</td>
<td>Bereavement Support, COPD symptom support, Hearing support from SW, Nurse and RA ongoing - no commissioned care</td>
<td>0</td>
<td>2842</td>
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<td>Case Number</td>
<td>Case Description</td>
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<tr>
<td>36</td>
<td>GP referral, Low mood and pain management, self-neglect</td>
<td>POC x2 calls for 7 days a week for ½ duration from 25/5/16 = 13 weeks</td>
<td>660</td>
<td>Mind support service, link to Bronafon tenancy support and home seekers for move to a more suitable property</td>
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<tr>
<td>37</td>
<td>Community referral</td>
<td>POC x2 calls for 7 days a week for ½ duration from 25/5/16 = 13 weeks</td>
<td>660</td>
<td>Equipment and adaptations</td>
<td>0</td>
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<tr>
<td>38</td>
<td>GP referral Patient has ABI, COPD and Epilepsy</td>
<td>Sitting services and day activity, residential respite from 3/6/16 = 11 weeks</td>
<td>3524</td>
<td>Work with the team, telecare, no commissioned service as yet but may look to direct payments in the future</td>
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<td>3524</td>
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<tr>
<td>39</td>
<td>Hospital Discharge (YAB)</td>
<td>POC x3 for 7 days a week with calls of ½ hr duration and management of warfarin and insulin from 2/8/16 = 3 weeks</td>
<td>196</td>
<td>Nursing support, telecare, equipment, - no commissioned services</td>
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<tr>
<td>40</td>
<td>Hospital Discharge</td>
<td>POC x2 calls for 7 days a week for ½ duration from 1/7/16 = 12 weeks</td>
<td>1218</td>
<td>POC x2 calls for 7 days a week for ½ duration from 1/7/16 = 12 weeks and adaptations – ongoing monitoring as service user has pulmonary fibrosis and is deteriorating</td>
<td>1218</td>
<td>0</td>
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<tr>
<td>Case Number</td>
<td>Case Description</td>
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<tr>
<td>41</td>
<td>Referral from tenancy support – disrepair cleanliness of property</td>
<td>POC x2 calls for 7 days a week for ½ duration from 1/7/16 = 12 weeks</td>
<td>1218</td>
<td>Nursing intervention for wound care and RA declining all other offers of support - on going monitoring</td>
<td>0</td>
<td>1218</td>
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<tr>
<td>42</td>
<td>Referral from Residential Home. DNR in place patient end stage organ failure</td>
<td>Upgrade to nursing care from 11/8/16</td>
<td>44</td>
<td>St David's Nursing intervention, review manual handling – will end life in current placement</td>
<td>0</td>
<td>44</td>
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<tr>
<td>43</td>
<td>Community Referral</td>
<td>POC x2 calls for 7 days a week for ½ duration from 1/7/16 = 12 weeks and adaptations</td>
<td>1218</td>
<td>Equipment and support to move to a more suitable property through Bron-Afon and home seekers</td>
<td>0</td>
<td>1218</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cost Assumption Old System</th>
<th>Cost NTWT system</th>
<th>Cost Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTALS</td>
<td>107,040</td>
<td>26,067</td>
</tr>
</tbody>
</table>

Assumption: if 1/3 of caseload = £80,973 then total caseload for 6 months could give a potential saving of = £242,919
If the same assumption is carried forward over 12 months then potential saving could be = £485,838
Glossary of terms

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>POC</td>
<td>Package of Care</td>
</tr>
<tr>
<td>RA</td>
<td>Reablement Assessor</td>
</tr>
<tr>
<td>COPD</td>
<td>Chronic Obstructive Pulmonary Disease</td>
</tr>
<tr>
<td>RMN</td>
<td>Registered Mental Health Nurse</td>
</tr>
<tr>
<td>OPS</td>
<td>Older Persons Service</td>
</tr>
<tr>
<td>MOW</td>
<td>Meals on Wheels</td>
</tr>
<tr>
<td>TIAs</td>
<td>Trans ischaemic attacks – mini strokes</td>
</tr>
<tr>
<td>DNR</td>
<td>Do Not Resuscitate</td>
</tr>
</tbody>
</table>