HEALTHIER COMMUNITIES OVERVIEW AND SCRUTINY COMMITTEE
22 NOVEMBER 2018

SUPPORTING VULNERABLE PEOPLE – HOME FIRST

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Report Summary

Home First is one of a suite of initiatives sponsored by the Gwent Regional Partnership Board to support the continued development of a '*seamless system'* of care, support and wellbeing in Gwent in response to the Welsh Government's new long term plan for health and social care 'A Healthier Wales'.

This paper sets out to explain what Home First is, why it was created, what it aims to deliver and how its effectiveness will be measured and monitored.

The paper will also detail activity and outcomes to date since the launch in October 2018 at Nevill Hall Hospital. A verbal update will be given in committee regarding the activity in the Royal Gwent Hospital as this part of the pilot is not due to be launched till 1st November 2018

1. Introduction and Scrutiny Activity

1.1 The pressures, challenges and demands in adult social care have been well documented both locally and nationally. The demand for social care services are growing in the context of significant demographic changes and the growing incidence and large prevalence of complex, long term conditions. The ageing population means over a quarter of the population in Wales is aged 50 plus. Those aged over 65 are expected to increase from around 600,000 in 2013 to 900,000 in 2037 and the number of over 85s is growing at an even faster rate (Age Cymru, 2015). Wales also has a higher proportion of people aged 85 plus compared to the rest of the UK (Stats Wales, 2012). The Population needs assessment for the Gwent region has highlighted some key points

- There are significant increases projected for the over 65 years of age population when an estimated 1 in 4 people (26%) will be aged 65 or older – which is broadly similar to Wales.

- By 2036, it is estimated that the number of people aged 85 and over will increase by 147%

1.2 As expected, the challenges experienced in adult social care are mirrored in the health service. Changes in how people live their lives and the success of the NHS in keeping people alive for longer means demand for care is rapidly rising. Wales currently has the highest rates of long-term limiting illness in the UK. All these factors affect people's health and increases demand on health and care services.

1.3 The impact, whilst all year round, is exacerbated in the winter months. The ageing population, accompanied by increasing co-morbidity, medicalisation, frailty and social isolation, is a long term driver of unscheduled care demand in the hospitals. As people live longer but have fewer children, there is an increased proportion of the population who are dependent on care. On average, older people have lower baseline functions,

greater frailty and lower resilience. This leads to greater need for support for the activities of daily living, tipping over into acute ill health at a lower threshold, and slower recovery from illness, which places increased demand on health and social care services.

1.4 While attendance at Emergency Departments (**EDs**) remains generally static, the complexity of patient need and other influencing factors have resulted in performance not improving despite numerous initiatives focussed on ED's efficiency. The complexity and severity of conditions of those admitted places a huge strain across ED. The most significant issue is not the numbers of people presenting at ED but the ability to provide alternatives to admission alongside the ability to transfer patients safely and quickly from hospital to their place of residence and to prevent readmission.

1.5 Winter planning is high on the agenda for Welsh Government to ensure there is an effective flow for patients. In essence, the previous service at the front door EDs could not cope with the rapid presentations with limited exit routes. This resulted in

- Delays due to social care assessments
- Longer stays on short term wards
- Patients being admitted into the hospital system unnecessary
- Increased dependency of clients
- Ambulance back ups

1.6 To avoid the repeat of the previous problems, the five Local Authorities have worked in collaboration to provide an alternative response to these patients. In line with the philosophy of Social Services and Wellbeing Act the response promotes the maximisation of independence utilising strength based assessments hence the name **Home First** not hospital admission by default.

1.7 **Scrutiny Activity**

1.8 Members are invited to consider the information contained in the report to:

- assess whether the proposed local arrangements and collaboration will be effective and make a positive difference in supporting early discharge from the Emergency Departments;
- review the early data and outcomes achieved;
- provide comments to the Executive Members and / or Chief Officers regarding the effectiveness of the Home First Model in respect of reducing delayed transfers of care for service users and make recommendations on any proposed areas for improvement/ development

2. Information/Results

2.1 The winter of 2017/18 saw high levels of escalation at all hospital sites due to pressure across the urgent care system in Gwent with the highest volume of attendances at RGH and NHH emergency departments for 9 years' experienced in June and July. Alongside this, GP referrals to secondary care assessment continue to rise.

2.2 In March 2017, ABuHB commissioned an external organisation (My Care my Home, MCMH) to provide a rapid assessment and emergency domiciliary care response to the EDs in Neville Hall facilitating 10 discharges a week. The intervention of a private organisation in the hospital discharge processes generated some concerns and challenges to the five Gwent Local Authorities which were shared with ABuHB.

Towards the end of the pilot in May 2018 there were a number of lessons learnt for all partners.

- Rapid assessment from **one** team on site has positive benefits
- An extended service 7 days a week keeps the flow going
- The introduction of a private company to a systems response creates a 'stand-alone' procedure that does not flow or tap into any of the existing support systems
- Assessments by MCMH resulted in an over provision of care on discharge which was difficult to reduce when expectations had already been set thus increasing dependency and calling upon an increasing use of a scarce domiciliary care resource inappropriately.

2.3 In response to Winter Pressures ABuHB expressed a wish to secure a support service for EDs that would :

- Develop a standardised definition for Home First Model.
- Provide a single point of access for the clinical teams in order to expedite discharge assessment
- Provide accelerated discharge times
- Provide a home first pathway for patients as a viable option to short term admission into hospital, through short term care options-Front door turnaround.
- Provide a Gwentwide Local Authority discharge process, with Local Authorities working in partnership for the Home First model.
- Enhance the current step up/down pathway as an alternative community pathway from acute hospitals i.e. use of intermediate care beds in the community to avoid hospital admission (step-up) of facilitate hospital discharge to an interim bed to receive further rehab before returning home (Step-down)
- Provide information, advice and assistance empowering patients to meet their own needs using their networks and resources.
- Provide an opportunity to think in a whole system way and support cultural change.
- Prevent unnecessary moves from district general hospital setting into community beds in order to increase patient flow-avoiding missed opportunities to discharge.
- Develop a pathway to discharge people directly to Community Frailty service especially reablement to promote independence and reduce reliance on traditional services.
- Provide necessary equipment and minor adaptations in order to expedite discharge.
- Provide bridging packages of care and support until long term provider is in place to reduce length of stay for people.
- Provide assessment at home/assessment beds daily using Local Authority experienced care staff to reduce and or cease care packages/support as soon as possible to ensure capacity and flow.
- Provide a pull model for wards across district general hospitals. i.e. patch social workers follow clients into the hospital (as they know the clients best) and 'pull' them out of hospital by proactively arranging the discharge rather than waiting for the hospital staff to highlight they are ready for discharge planning.
- Provide this service alongside Third sector organisations which support the Home First model.
- Provide services between 8am-8pm, weekend and Bank Holidays.
- Provide an opportunity to grow our own "Home First" champions across the

Gwent Health and Social Care community.

- Provide a bridging service (package of care) of 14 days along with assessment within persons home during the period, over-night stays (night sits) when required to support earlier discharge
- Support 10 discharges a week from Nevill Hall Hospital and/or Ysbyty Aneurin Bevan Hospital
- Support 15 discharges a week from Royal Gwent Hospital and/or Ysbyty Ystrad Fawr and /or County Hospital

2.4 As an alternative to commissioning a private provider the five Local Authorities put together a collaborative 'offer' to the health board that would meet the targets and requirements by introducing the following model:

- Local Authorities will use their knowledge of local services and support across all sectors to facilitate discharge rather than default to formal care provisions. This will speed up discharge and release capacity within the care system
- This will be seen as one of the pathways for discharge, not a replacement for good discharge planning for people with complex needs
- Local Authorities will manage the process thus making it simple for the wards rather than them having to determine which pathway and referral route to follow, linking current project together to ensure there is no duplication of effort.
- Assessment capacity, Local Authorities will primarily operate a pull model, learning from current project that has approximately 50% of inappropriate referrals. This will ensure there is capacity to respond. Referrals will be taken and discharges facilitated on bank holidays and weekends to maximise efficiency and reduce cost this will be done on a partnership basis with staff working across Local Authorities assessing on behalf of each other.
- Discharge, each Local Authorities will provide early supported discharge via a bridging service of domiciliary care where required by bolstering either Emergency Care @ Home (EC@H) and/or in house domiciliary service thus maximising the capacity in the sector. EC@H is a rapid response home care service (part of the Community Resource Team) that provides personal care normally for up to 10 days. They take referrals 7 days a week direct from practitioners, GPs and short stay hospital wards.
- Focus will be on turning people around at the front doors preventing admissions to wards. Operating a discharge to assess model people will primarily go home with no support or with their existing care packages and be followed up at home with access to services should they be required
- Assessors will aim to see this cohort of people and commence an assessment within 1 hour after the patient is deemed medically fit, and aim for discharge within 4 hours
- Assessors will liaise with family/carers to ensure informal support mechanisms are in place where appropriate to support discharge
- Assessors will use data system available to us, such as the national social care data base, Welsh Community Care Information System (WCCIS), access to all 5 data bases will be available to staff on weekends and bank holidays to establish what support (both formal and informal) is already in place to avoid duplication and speed up the flow and discharge
- Any necessary equipment and minor adaptations will be provided
- Rapid Assessors will arrange taxi transport to facilitate discharge where this has been assessed to be a blockage to discharge.
- Assessors will work to the Social Services and Well-being Act providing Information Advice and Assistance to enable people to be independent and meet

their own needs

- The service will operate between the hours of 7am -7pm, (discussions ongoing whether this will be 8am – 8pm) Monday to Friday and 9am – 5pm Saturday and Sunday
- Local Authorities will work collaboratively to provide a response to new people at the front doors. We will assess for each other and all have access to domiciliary care within each LA area.
- The additional EC@H capacity will also be used to facilitate discharge from the general wards when a care package has been brokered to support the client on discharge but is unable to start immediately. EC@H will fill the gap until the permanent package starts, known as bridging.
- In cases where a care provider cannot be identified in a timely manner this capacity will be used to facilitate discharge whilst the appropriate Local Authority brokerage source a care provider
- Communication will be maintained with ward staff of those being discharged to improve flow and bed management
- Local Authority core staff will continue to attend ward rounds/flow meetings etc. as now to ensure we are planning appropriately for discharge for people with complex needs.

Post discharge

- Compliance with the new Regulation Inspection Social Care Act (RISCA)
- People will be subject to continuous assessment in their own homes/assessment beds for a maximum of 14 days using our experienced care staff to reduce and or cease care packages/support as soon as possible to ensure capacity and flow. Some clients will only need support for a few days post discharge
- Communicate with each LA via WCCIS whenever possible and FLO system for Monmouth. (Local Authority information data bases)
- Where required GP's will be provided with a service discharge summary

Each Local Authority has increased the capacity of their rapid response home care services or in some cases introduced a new service. In Torfaen this has meant a proposed increase of six 24 hour Emergency Care @ Home posts. Management and assessment capacity has also been extended through the recruitment of a Home First Service Manager and six rapid assessment staff working to the five Local Authorities and hosted by Newport City Council.

2.5 Following endorsement by the Regional Partnership Board the proposal was incorporated into the Regional Transformation Offer to Welsh Government in order to secure funding from the Transformational Grant.

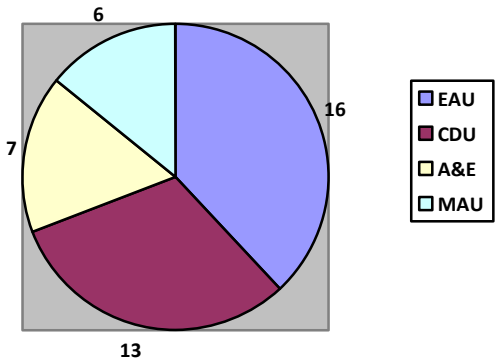
2.6 A flow chart (Appendix 1) has been agreed across all partners.

2.7 The following KPIs have also been agreed

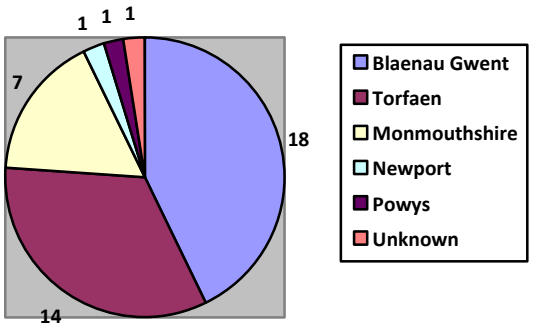
- Number of people discharged using this route per week against the target , can split North and South and by LA
- Number /Percentage of people who didn't require transport
- Number and description of items of equipment provided
- Number and description of minor works of adaptations undertaken
- Number of people who were not discharged as planned and reasons for this

- Compliance with target time of assessment to commence within 1 hour
- Compliance with target time of discharge 4 hours but no more than 24 hours
- Number of people referred directly to reablement and/ or assessment beds
- Volume of people being discharged using the route
- Feedback from people and their carers/families on the service
- Rate of Delayed transfers of care for social care reasons aged 75+ per 1,000

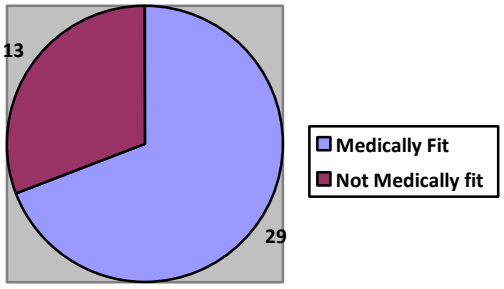
2.8 A pilot was started in Nevill Hall hospital on 5th October pulling upon existing resources whilst recruitment to the 2 year fixed term posts was in progress. During the first 23 days of operation in Nevill Hall hospital (5th – 28th October), 42 referrals were made to Home First. Detail is contained in Appendix 2. As the pilot is not fully up and running the data is limited.



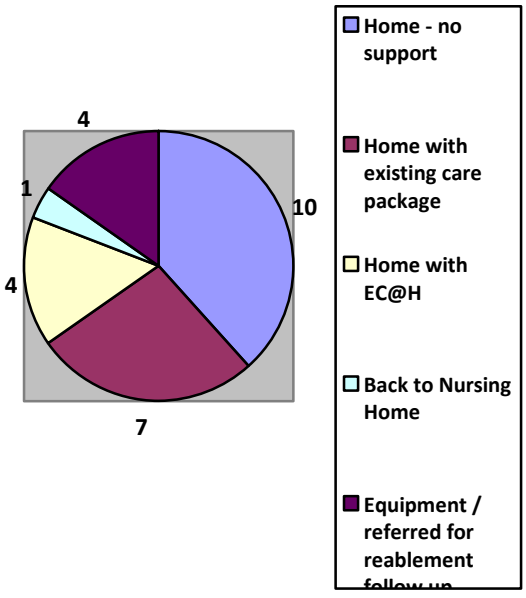
SOURCE OF REFERRAL (WARD)*



ORIGIN OF PATIENT



% MEDICALLY FIT



OUTCOME OF ASSESSMENT

*EAU - Emergency Assessment Unit
MAU – Medical Assessment Unit

A&E – Accident and Emergency Department
CDU – Clinical Decision Unit

2.9
- **Total Referrals at Nevill Hall Hospital 42**
  - Blaenau Gwent had 43%* (18) of the Referrals, followed by Torfaen with 33% (14) and Monmouth with 17% (7). The remaining 7% (3) originated from Powys (1), Newport (1) 1 referral did not have the borough of origin recorded. * N.B %s are to nearest whole figure

- **Percentage Deemed Fit for Discharge (29/42) 69%**
  - Blaenau Gwent had 48% (14) of the Referrals, followed by Torfaen with 31% (9), Monmouth with 17% (5) and Newport with 3% (1). * % add to 99% as rounded to nearest whole figure.

- **Percentage Actually Discharged (26/42) 62%**
  - Blaenau Gwent had 46% (12) of the Referrals, followed by Torfaen with 31% (8), Monmouth with 19% (5) and Newport 4% (1).

- Only 3 of those deemed fit for discharge, were not discharged. 2 due to paperwork not being signed off by Doctor and 1 due to the Care Home Provider requesting a re-assessment.
- Most referrals, 31% were made on a Saturday, followed by 26% on a Friday and 17% on a Sunday.

Referral Day	Count of Referral No.	%
Saturday	13	31%
Friday	11	26%
Sunday	7	17%
Wednesday	4	10%
Thursday	3	7%
Tuesday	2	5%
Monday	2	5%
Grand Total	**42**	**100%**

- The busiest day was Saturday 13th October when 8 referrals were made, 6 of which were discharged. The most common days on which we have had **no** referrals are Mondays and Thursdays however there has been 1 Saturday and 1 Sunday where no referrals were made.

- Of those discharged 39% (10) were discharged with No Support, followed by 27% (7) discharged with an Existing Package and 15% (4) with an Emergency Care Support. The remaining 19% (5) were discharged with Information, Advice & Assistance (2), referral to single point of access / equipment (1), returned to nursing home (1) and follow up with reablement (1)

- The majority of referrals (38%) came from EAU followed by CDU (31%). However of those actually discharged the majority were those from CDU followed by EAU.

2.10 During the development of 'the offer' the Local Authorities have researched Discharge to Assess models across Wales and the UK to identify best practice. To date we have not identified another scheme where five Local Authorities have collaborated and agreed to jointly commit to resources and shared assessments however there are elements of the service currently operating in Carmarthenshire. Early discussions have

taken place with the NHS Delivery Unit to share experiences and learning as the pilot progresses

3.0 Discussion

It is difficult to draw conclusions from only 28 days' worth of data however there are a few observations that can be made at this early stage. My observations have also drawn upon the content of weekly conference calls and daily emails with senior managers, hospital and pilot staff.

- Weekend referrals have been very positive with 48% of the referrals made on the weekend.
- The service has been well received by hospital staff and managers however further communication and publicity is needed as not all staff were aware of the initiative
- Maintaining continuity and consistency is difficult when the service relies on a temporary staff rota operating 7 days a week
- The need for new care support arrangements has been significantly lower than anticipated
- 38% of patients did not require any support however hospital staff would not have made the decision to discharge all the patients without the input of home first
- Additional discussions are needed to understand the reasons for the two discharges blocked due to Drs not completing documentation
- All areas need to engage the external provider sector to ensure they are aware of the 24 / 7 flow and availability of services
- There have been some days where no referrals have been made by the EDs. Whilst we recognise it is early days into the project, it is important to scope out other areas of pressure within the hospital that the resource could be redirected to.
- Expectations from the hospitals will need to be managed and the remit of the team clearly communicated (early indications are that some staff want the Home First Assessors to have the ability to respond to referrals from all the wards
- Further work is needed with the ward staff to identify patients that are medically fit (some patients are being referred before medically fit and others not being referred when they could be discharged)
- IT connections have been challenging in order for staff to access the data bases. A number of solutions are being explored
- The service so far has been in Nevill Hall hospital (NHH) and therefore highly concentrated on Torfaen, Blaenau Gwent and Monmouthshire patients. The expansion to the Royal Gwent Hospital (RGH) will continue to benefit Torfaen residents as well as Newport and Caerphilly.
- The operational models in the RGH and NHH differ significantly. Different responses may have to be developed in order to achieve maximum outcomes.

4. Implications

4.1 There are some implications, deemed to be positive, in progressing with the current pilot.

Client experience - All the research indicates that turning patients around at the front door when medically fit produces better outcomes for the patient.
Local Authority experience – combining resources to provide a rapid assessment in EDs is cost effective. As stated above, appropriate timely discharge produces positive

outcomes. An elongated stay may result in loss of independence and increased risk of acquiring hospital based infections.

Health Board experience – any intervention that aids the flow at the front door will benefit the whole system. The benefits are two fold, i.e. stopping unnecessary admissions thus freeing up beds on the main wards and aiding offloads from ambulances at the front door.

4.2 **Policy**

There are no policy implications

4.3 **Well Being and Future Generations Act**

In considering the Well Being and Future Generations Act, the ongoing focus on prevention and early intervention at the front door of the hospital lends itself to a longer term approach that impacts on future generations, whilst aiming to prevent problems occurring or getting worse and requiring the input from statutory service. The collaborative approach based on strengths based assessment is consistent with the five ways of working.

4.4 **Social Inclusion and Equalities**

The collaborative will ensure that all patients presenting to the EDs in the Gwent area will receive the same timely response and service irrespective of their Borough of origin.

4.5 **Financial**

The service is funded by the Welsh Government as part of the Implementing a seamless system of health, care and wellbeing: A Gwent response to 'A Healthier Wales' Transformation Grant bid. The allocation is £1.86m to all partners up to March 2020. (Appendix 3)

4.6 **Human Resources**

There are no HR implications, additional assessment staff will be employed by Newport City Council. The additional EC@H staff will be employed by TCBC and managed through the Community Resource team

4.7 **Strategic Risks**

The Transformation Grant is allocated until March 2020. There is a risk that the Grant will be withdrawn at this stage leaving six part time care staff unfunded. The risk to the Council is minimal due to the high turnover and vacancy rates for care staff.

5. Conclusions

5.1 The Home First pilot has only been in operation for a few weeks therefor it is difficult to assess its full impact however early indications are favourable. Seven day working is proving positive and outcomes for clients beneficial. Full data at month three will give a more robust picture of the successes and challenges.

6. Scrutiny activity

6.1 Members are invited to consider the information contained in the report to:

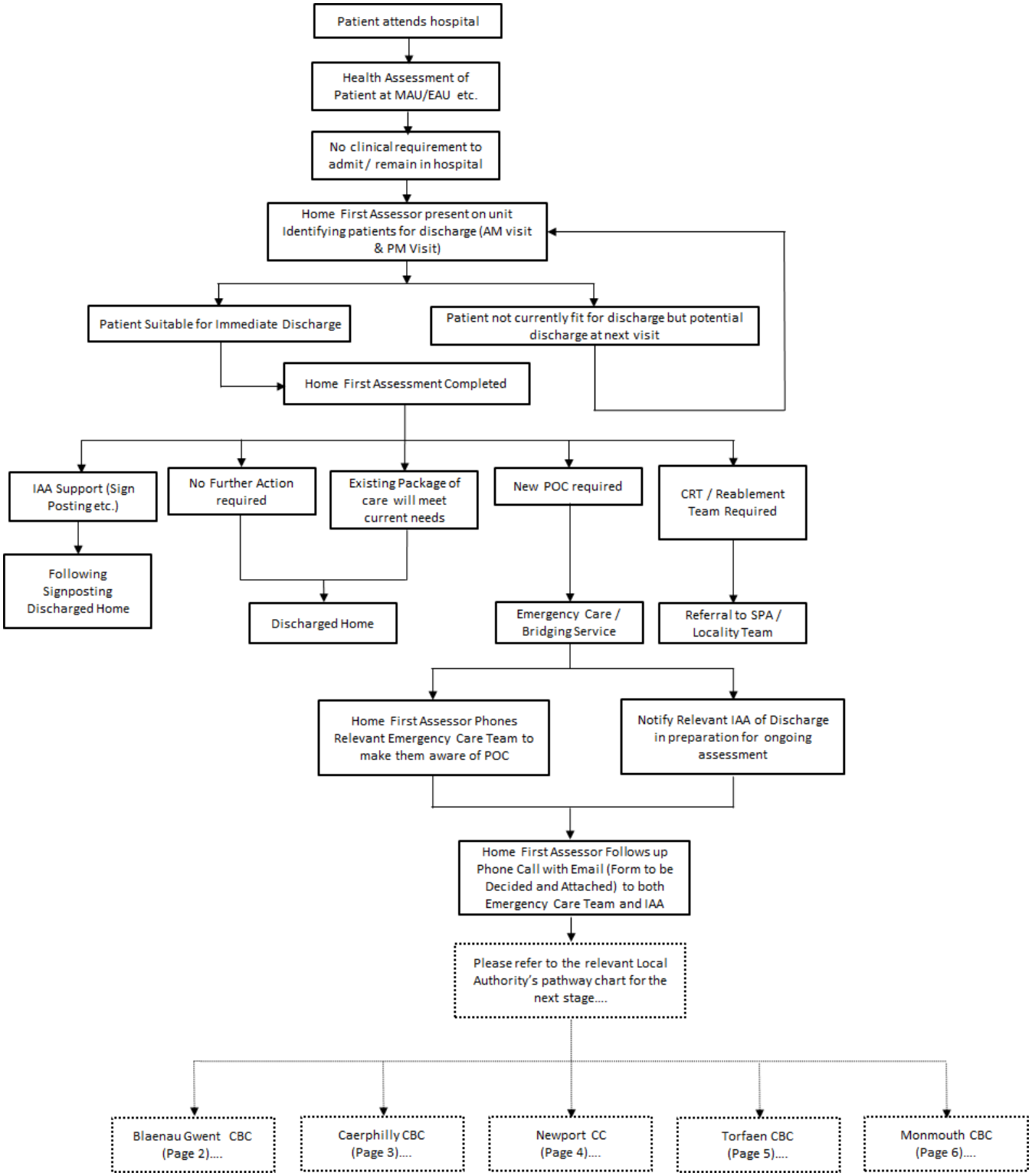
- assess whether the proposed local arrangements and collaboration will be effective and make a positive difference in supporting early discharge from the Emergency Departments;
- review the early data and outcomes achieved;
- provide comments to the Executive Members and / or Chief Officers regarding the effectiveness of the Home First Model in respect of reducing delayed transfers of care for service users and make recommendations on any proposed areas for improvement/ development

Appendices	Appendix 1 Flow Chart Appendix 2 Data for 5th – 28th October Appendix 3 Grant submission (costings)

Background Papers	**Note: Members of the public are entitled, under the Local Government Act 1972, to inspect background papers to reports. The following is a list of the background papers used in the production of this report.** N/A

For a copy of the background papers or for further information about this report, please telephone:
Gill Pratlett Head of Adult Services
01495 742611

Appendix 1 Flow Chart



Appendix 2

Home First Overall Statistics

Reporting Period: Friday 5th October to Sunday 28th October 2018

General Statistics

Total Number of Referrals	**42**

Of which, number Fit Discharge	**29**

Of those Fit for Discharge, number discharged	**26**

Number of Times Taxi Used	**2**

Number of Times Admission Could Have Been Avoided	**2**

Reasons Admission Could Have Been Avoided	**Count of Referral No.**
If Dr had deemed patient as medically fit for discharge she may have benefited from care at home to minimise confusion if there was no medical concern to cause confusion.	1
X ray at A&E rather that admission to EAU.	1
Grand Total	**2**

Breakdown by Local Authority

Count Of Referrals By Local Authority	
Blaenau Gwent CBC	18
Monmouth CBC	7
Powys CBC	1
Torfaen CBC	14
Newport CC	1
Unknown	1
Grand Total	**42**

Count Of Referrals By Local Authority																	
Date Of Referral	**05/10/2018**	**06/10/2018**	**08/10/2018**	**09/10/2018**	**11/10/2018**	**12/10/2018**	**13/10/2018**	**14/10/2018**	**16/10/2018**	**17/10/2018**	**19/10/2018**	**21/10/2018**	**25/10/2018**	**26/10/2018**	**27/10/2018**	**28/10/2018**	**Grand Total**
Blaenau Gwent CBC	1	3	1		1	1	2			2	2	3		1	1		18
Monmouth CBC		1				2	2			1						1	7
Powys CBC								1									1
Torfaen CBC			1			2	4	1	1	1	2		2				14
Unknown				1													1
Newport CC																1	1
Grand Total	**1**	**4**	**2**	**1**	**1**	**5**	**8**	**2**	**1**	**4**	**4**	**3**	**2**	**1**	**1**	**2**	**42**

Breakdown by Ward

Count Of Referrals By Ward	
EAU	16
CDU	13
A&E	7
MAU	6
Grand Total	**42**

Count Of Referrals By Ward																	
Date Of Referral	**05/10/2018**	**06/10/2018**	**08/10/2018**	**09/10/2018**	**11/10/2018**	**12/10/2018**	**13/10/2018**	**14/10/2018**	**16/10/2018**	**17/10/2018**	**19/10/2018**	**21/10/2018**	**25/10/2018**	**26/10/2018**	**27/10/2018**	**28/10/2018**	**Grand Total**
EAU				1	1	3	1		1	4	4				1		16
CDU		2				1	2					3	2	1		2	13
A&E		2	2			1		2									7
MAU	1						5										6
Grand Total	**1**	**4**	**2**	**1**	**1**	**5**	**8**	**2**	**1**	**4**	**4**	**3**	**2**	**1**	**1**	**2**	**42**

Breakdown by Discharge

Fit for Discharge?	Count of Referral No.
Yes	29
No	13
Grand Total	**42**

If Fit for Discharge, Were they Discharged?	Blaenau Gwent CBC	Torfaen CBC	Monmouth CBC	Newport CC	Grand Total
Yes	12	8	5	1	26
No	2	1			3
Grand Total	**14**	**9**	**5**	**1**	**29**

Reason Not Discharged.	Blaenau Gwent CBC	Torfaen CBC	Grand Total
Care Home Provider Requesting Reassessment		1	1
Discharge not signed off by Doctor	2		2
Grand Total	**2**	**1**	**3**

Breakdown by Exit Route

Exit Route	05/10/2018	06/10/2018	12/10/2018	13/10/2018	14/10/2018	16/10/2018	17/10/2018	19/10/2018	21/10/2018	25/10/2018	26/10/2018	27/10/2018	28/10/2018	Grand Total
Home with No Support			2	2				1	1	2			2	10
Home with Existing Package of Care	1	1		2		1	1				1			7
Home with Emergency Care at Home					1				2			1		4
Home with IAA Support				1				1						2
Home to Residential / Nursing Care				1										1
Home with Referral to Spa & Equipment		1												1
Home with Reablement Support		1												1
Grand Total	**1**	**3**	**2**	**6**	**1**	**1**	**1**	**2**	**3**	**2**	**1**	**1**	**2**	**26**

Exit Route	Blaenau Gwent CBC	Torfaen CBC	Monmouth CBC	Newport CC	Grand Total
Home with No Support	3	3	3	1	10
Home with Existing Package of Care	4	2	1		7
Home with Emergency Care at Home	3	1			4
Home with IAA Support	1	1			2
Home to Residential / Nursing Care		1			1
Home with Referral to Spa & Equipment	1				1
Home with Reablement Support			1		1
Grand Total	**12**	**8**	**5**	**1**	**26**

Exit Route	CDU	EAU	MAU	A&E	Grand Total
Home with No Support	6	2	2		10
Home with Existing Package of Care	2	3	1	1	7
Home with Emergency Care at Home	2	1		1	4
Home with IAA Support	1	1			2
Home to Residential / Nursing Care			1		1
Home with Referral to Spa & Equipment				1	1
Home with Reablement Support	1				1
Grand Total	**12**	**7**	**4**	**3**	**26**

Appendix 3

Home First Model	2018/19 Sept-Apr 7 mths	2019/20 12 mths	Total 19 mths
Assessment Costs			
3 full time equivalent Occupational Therapist Grade 10	£86,625	£148,500	£235,125
1 full time equivalent Occupational Therapy Assistant Grade 7	£20,708	£35,500	£56,208
1 Occupational Therapist Grade 10 at Royal Gwent (Saturday and Sunday only)	£11,550	£19,800	£31,350
1 Occupational Therapist Grade 10 at Neville Hall (Saturday and Sunday only)	£11,550	£19,800	£31,350
Total Assessment Costs (Including Mileage)	**£130,433**	**£223,600**	**£354,033**
Care Package Costs			
Blaenau Gwent 8 carers at 14 hours per week (plus cover)	£49,554	£84,950	£134,504
Caerphilly 14 carers at 14 hours per week (plus cover)	£104,207	£178,640	£282,847
Monmouthshire 5 carers at 35 hours per week (plus cover)	£92,464	£158,510	£250,974
Newport 8 carers at 24 hours per week (plus cover)	£91,373	£156,640	£248,013
Torfaen 6 carers at 24 hours per week (plus cover)	£65,975	£113,100	£179,075
Total Care Package Costs	**£403,573**	**£691,840**	**£1,095,413**
Programme Manager Post (1wte Agenda for Change 8a)	**£35,760**	£61,302	£97,062
Evaluation Post (1wte Agenda for Change 8a)	**£35,760**	£61,302	£97,062
TOTAL PAY COSTS	**£605,526**	**£1,038,044**	**£1,643,570**
Additional Non Pay Costs			
Set up costs (mobile phones, portable key safes, lap tops, uniforms etc)	£27,500	£0	£27,500
Set up costs - Transport contingency 3rd Sector	£30,000	£0	£30,000
Non-pay costs (phones/medication safes/minor adaptations e.g. furniture moves)	£22,167	£38,000	£60,167
Transport	£35,583	£61,000	£96,583
TOTAL NON-PAY COSTS	**£115,250**	**£99,000**	**£214,250**
TOTAL COST PAY & NON-PAY	**£720,776**	**£1,137,044**	**£1,857,820**