NEATH PORT TALBOT COUNTY BOROUGH COUNCIL

SOCIAL CARE, HEALTH & HOUSING CABINET BOARD

5 OCTOBER 2017

REPORT OF THE DIRECTOR OF SOCIAL SERVICES – N. JARMAN

Matter for Monitoring

Wards Affected:

All Wards

Community Resource Team (CRT) ANNUAL REPORT 2016/17

PURPOSE

1. The purpose of this report is to provide Members with an annual update on the progress of delivering the integrated CRT model.

BACKGROUND

2.1 In September 2013 the Western Bay Health and Social Care Programme set out a joint commitment to work together to integrate and improve the planning and delivery of community services for older people, *Delivering Improved Community Services.*

The commitment was a whole systems approach to addressing the challenges of the issues presented by an ageing population. It stated clearly the first phase of integration would focus on intermediate care services which in turn would act as a catalyst for change across the rest of the system.

A detailed business case, *'Delivering Improved Community Services – Business Case for Intermediate Tier Services'* was developed and approved by the Social Services Health and Housing Cabinet Board in May 2014.

2.2 As a result of the business case, investment was made into the delivery of an optimal intermediate care service model, comprising of the following elements:

Key Feature of Optimal Model
Multi-disciplinary triage in common access point
Mental Health provision within common access point
Third Sector Brokerage in common access point
Acute Clinical Team
Therapy led reablement service
Intake & review reablement
Therapy led residential reablement
Access for people with dementia
Step up / down intermediate care (residential or community)

2.3 In October 2015, the Council approved a formal pooled fund arrangement for the delivery of the Intermediate Care Services between NPT CBC and ABMU HB in accordance with Section 33 of the National Health Service (Wales) Act 2006. In doing so the Council requires regular updates on the financial position and performance of the service.

2.4. Schedule 1 (7) of the Section 33 Agreement, sets out the key performance measures as follows:

- To reduce unscheduled hospital admission through enhanced rapid response and more focus on reablement
- To reduce occupancy of hospital beds by residents of the locality utilised for post acute recuperation or step up
- To reduce the number of placements in residential and nursing homes

- To reduce the need for ongoing domiciliary care packages through increased reablement and right-sizing of care
- To have reduced the hours of support provided at commencement of enabling intervention when leaving service.

2.5. This paper presents the annual end of year approved financial report (Appendix 1) and the end of year performance report for 2016/17 (Appendix 2).

2.4 In summary –

2.4.1 Hospital Admissions

The total numbers of unscheduled care admissions into hospital are 1.6% lower than in 2014/15, however, the length of stay for a NPT resident admitted to hospital increased by 9.6%.

The CRT facilitated 539 hospital discharges within 2016/17 an increase of 24% compared to 2015/15 data.

Avoiding £1,304,710.00 hospital bed day costs

2.4.2. Care Home Admissions

New permanent residential care home placements for those aged 65 years and over, decreased by 52% compared to 2014/15 (baseline) data, indicating that people are remaining independent and supported in their homes for longer.

2.4.3. Domiciliary Care

CRT reduced the need for 3,447.32 hours of domiciliary care.

Avoiding a weekly cost of £59,209.80 of domiciliary care hours, or £3,032,226.6 per annum

APPENDICES

3.1 Appendix one – End of year finance report
Appendix Two – End of year Performance report

LIST OF BACKGROUND PAPERS

4.1. None

OFFICER CONTACT

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Appendix 1

POOLED FUND MANAGER

FINANCE REPORT

April 2016 - March 2017

The Intermediate care pooled fund has a **budget for 2016/17 of £4.9m**, this is funded by contributions from each partner, **AMBU £2.3m** and **NPT CBC £2.6m**

Full Year S33 Budget Monitoring to March 2017

	Annual Budget £'000	Budget to date £'000	Actual to date £'000	Variance to Date £'000
ABMU	**2,306**	**2,306**	**2,318**	**12**
NPT CBC	**2,600**	**2,600**	**2,676**	**76**
Total	**4,906**	**4,906**	**4,517**	**88**

At the end of the financial year, the service has **overspent by £88k**

ABMU

Since the last report ABMU posts that were part of the CRT team but had previously not been included in the S33 contribution were causing the HB to show an overspent position. The S33 funding has now been corrected to reflect this and for 17/18 the S33 contribution has been agreed, is fully funded and no overspend is forecast.

NPTCBC

The main reason for the overspend for the LA is due to an increase in the cost of assistive technology (AT). After the budget was set, Carmarthenshire CC gave notice that the charge for their lifeline service was to increase significantly. This has resulted in an annual cost pressure of circa £90k for the AT budget.

The Council accepted that this is a pressure and have identified funds that cannot be (as per the Section 33) be part of the pool to pay for the increase in costs. Most of the funds will come from AT income which has arisen due to better collection rates and an increase in fees; the AT income budget sits outside of the pooled fund.

The pool fund budget for the Council has been amended for 2017/18 and the current services as outlined in the s33 agreement will continue to be fully funded by both partners.

The positions above include the relevant adjustment for any agreed cross charging between funding areas as part of the integrated management across Organisations.

Appendix 2

JPB Intermediate Care Performance April 2016 - March 2017
Community Resource Team– *Neath Port Talbot Local Authority and AMBU HB* Area

Intermediate Care Business Case:

The Intermediate Tier Business Case was developed in conjunction with Whole System Partnership (WSP), in order to achieve sustainable health and social care services for frail or older people. Following approval of the business case in April/ May 2014, considerable work has been undertaken to develop an effective intermediate tier of service, in order to provide a boundary between wellbeing and the need for managed care, with the potential to enable more people to maintain their independence.

The following table outlines our progression towards the optimal model of intermediate services including the baseline status.

Key Feature of Optimal Model	Baseline	Established	Optimised
Multi-disciplinary triage in common access point	Y	Y	Y
Mental Health provision within common access point	N	Y	Y
Third Sector Brokerage in common access point	N	Y	Y
Therapy led reablement service	Y	Y	Y
Intake & review reablement	N	Y	D
Therapy led residential reablement	N	Y	Y
Access for people with dementia	N	Y	Y
Step up / down intermediate care (residential or community)	N	Y	D
Key; *Y(yes) N(no) D (in development)*			

Programme Outcomes:

- Reducing new homecare packages via signposting by a common access point and increased levels of intake intermediate care
- Reducing escalation in existing homecare packages via increased levels of review intermediate care
- Reducing new permanent care home placements via increased levels of review intermediate care
- Reducing unscheduled admissions to hospital and (therefore bed days) via increased diversion to rapid response services
- Reducing post– acute hospital stays for unscheduled, scheduled and surgical patients via increased step down intermediate care
- More older people are supported to live independently with the support of technology
- More frail and older people are supported to remain independent and keep well, as well as to have improved quality of life
- More frail and older people to become cared for at home rather than in institutional care, i.e. in hospitals / care homes.

Performance Measure: Hospital Admissions between April 2014— March 2017

Emergency Unscheduled Hospital Admissions 65+ and 75 + For NPT Month by Month comparison between 2015—2017.

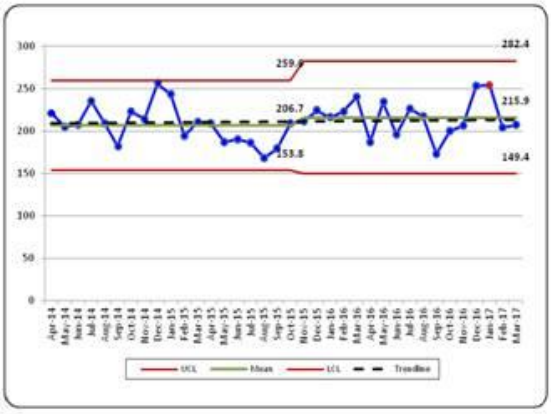
Year	65 Yrs and over		75 Yrs and over	
	March	Variance +/-	March	Variance +/-
2015	261	Baseline	231	BL
2016	278	+6.1%	194	-16%
2017	295	+11.5%	201	+3.5%

Variance data represents yearly comparison with the baseline data

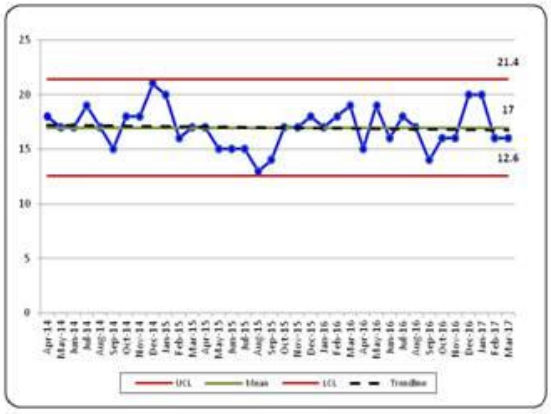
Emergency Unscheduled Hospital Admissions 75 + For NPT Quarter by Quarter comparison between 2015—2017.

Year	Qtr1	Qtr2	Qtr3	Qtr 4	Total	+/-
2014/ 15	633	626	693	647	2599	BL
2015/ 16	586	533	644	676	2439	-6.2%
2016/ 17	619	616	658	665	2558	-1.6%

Emergency Unscheduled Hospital Admissions (>75) made by NPT Resident Patients between April 14—March 17



Hospital Admissions Rates (>75) Per 1000 Population NPT Locality between April 14—March 17



Unscheduled care admissions for those aged 75 and over, in year, remain lower than the baseline (-1.6%) for the second year running, despite showing an in month increase (+3.5%).

The data also shows a step change(statistically significant change) in November 2016, which increased the upper and lower control limits as the average flow fluctuated. This also indicative of changes made to the reablement and Intermediate Care beds – whereby the intake model moved from selective to a catch all model and the introduction of the Assessment bed unit in Plas Bryn Rhosyn.

Despite the step change in actual admissions, the rate of admissions for those aged 75 and over remains within the control limits and operating as expected.

Data source: ABM UHB

Performance Measure: Hospital Admissions between April 2014— March 2017

Total Bed Days for 65 + For NPT Quarter by Quarter comparison between 2015—2017.

Year	Qtr1	Qtr2	Qtr3	Qtr 4	Total	+/-
2014/ 15	17155	17704	18889	18430	72188	BL
2015/ 16	17581	17559	18326	19445	72911	+1%
2016/ 17	19228	19302	20048	21274	79852	+9.6%

Variance data represents yearly comparison with the baseline data

Total Bed Days Consumed (Age 65+) originally admitted as an unscheduled care medical admission April 2014—February 2017

28 Day Readmission Rates for 65 + For NPT Quarter by Quarter comparison between 2015—2017.

Year	Qtr1	Qtr2	Qtr3	Qtr 4	Total
2014/ 15	14.10%	14.80%	13.70%	12.60%	13.80%
2015/ 16	13.10%	13.60%	13.40%	14.20%	13.20%
2016/ 17	12.60%	13.40%	14.70%	9.8%*	-

*Data only available for February 2017, as one month in arrears

The total number of bed days consumed for those aged 65 and over has increased by 9.6% as compared to the baseline. (Total bed days consumed for those aged 75 and over is not routinely collected for the reporting purposes of this report)

January 2016 saw an increased step change to the control limits for the total number of bed days consumed, indicating that people are staying longer in hospital and that this is an ongoing trend. Without a detailed sample of the reasons behind the increased length of stay it is not possible to identify the cause of this increase.

Conversely, the rates of readmission back to unscheduled care within a 28 day period remain lower than the baseline and previous years data. Indicating that once discharged from hospital, less people are being readmitted within the month.

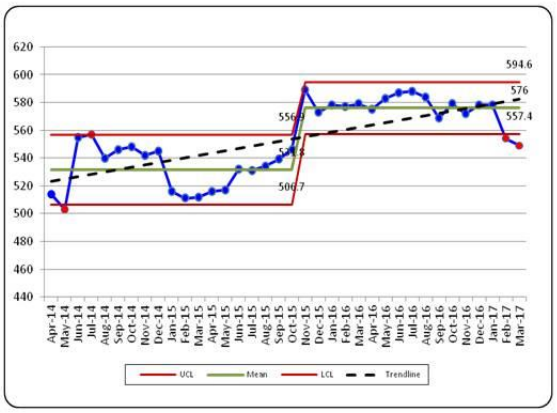
Data source: ABM UHB

Performance Measure: Care Home Admissions April 2014 – March 2017

Total Number of People Support In a Care Home Aged 65 + in Neath Port Talbot between 2015—2017.

	March 2015 (Baseline)	March 2016	March 2017 (Actual)
Total No. of People Supported	512	579	549

The data reported does not include those people supported in nursing placements, respite or short stay placements.



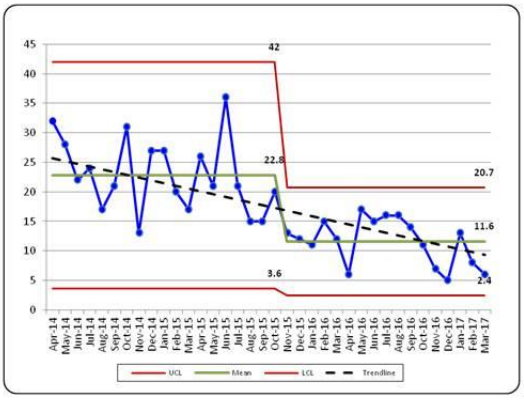
Total Number of Care Home Admissions on a quarter by quarter basis between 2014—2017

Year	Qtr1	Qtr2	Qtr3	Qtr 4	Total	+/-
2014/ 15	82	62	71	64	279	BL
2015/ 16	83	51	45(81)*	37	209	-16.7%
2016/ 17	38	46**	23	27	134	-52%

*Nov 2015 saw the closure of 2 home; residents re-located to new homes were recorded as a new care home admission, skewing the data for quarter 3. The red figure takes into consideration this variance.

** September 2016 data initially included residential, nursing and respite data which skewed the original data. The data presented in the above table represents the true number, following a data cleanse.

Care Home Admissions aged 65> within NPT between April 2014 and March 2017



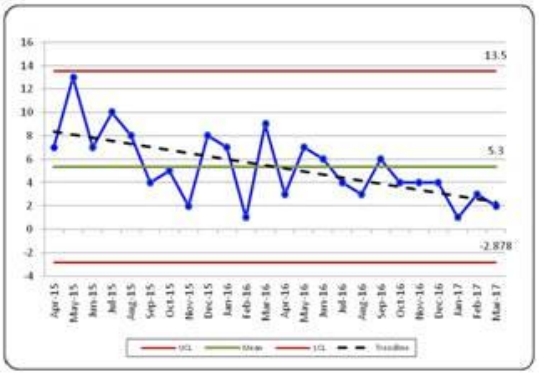
New admissions into residential care continue to decrease (-52%) in comparison with the baseline. In contrast the number of people being supported in a care home, on a month by month comparison for March remains higher (+7.2%). It is not possible to say why the numbers of people being supported remain comparatively high to the number of new starters. Further analysis of this is needed to understand this fully.

The data shows a significant downward step change in the control limits from November 2016, which is inline with the changes made to the reablement service and the introduction of the assessment bed unit.

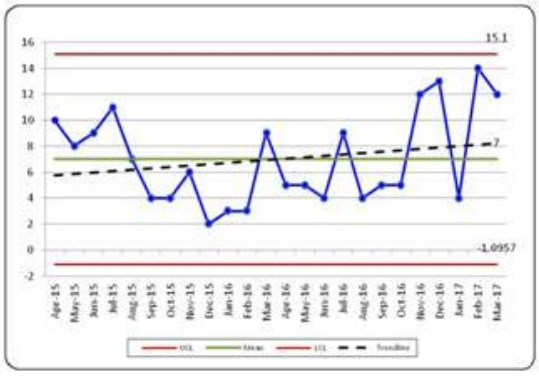
Data source: Local Authority

Performance Measure: FNC and CHC Admissions April 2014 – March 2017

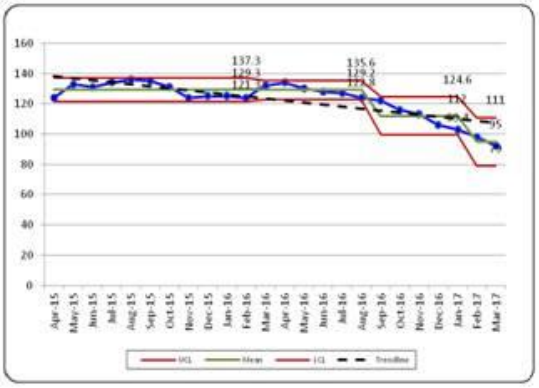
Total Number of CHC Admissions
April 2015 - March 2017



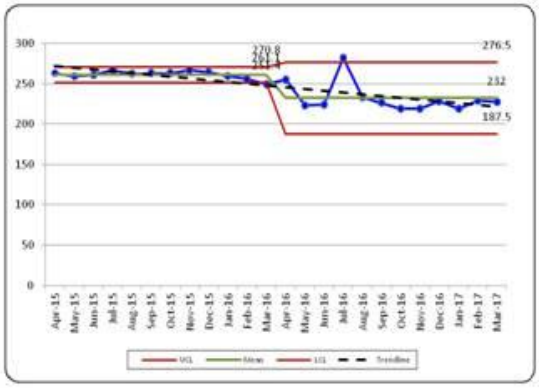
Total Number of FNC new starter
April 2015 — March 2017



Total Number of people supported By CHC
April 2015 — March 2017



Total Number of people supported by FNC
April 2015 – March 2017



CHC admissions remain on a downward trajectory, but remains within normal control limits. The data also shows that the total number of people supported by CHC is on a downward trajectory, with three step changes in March 16, Sept 16 and Feb 17.

The number of new FNC starters remains within variance, with gradual increasing trend. The total number of people supported by FNC saw a widening of the control limits in March 2016 with the continuation of a steady downward trend.

Data source: ABM UHB

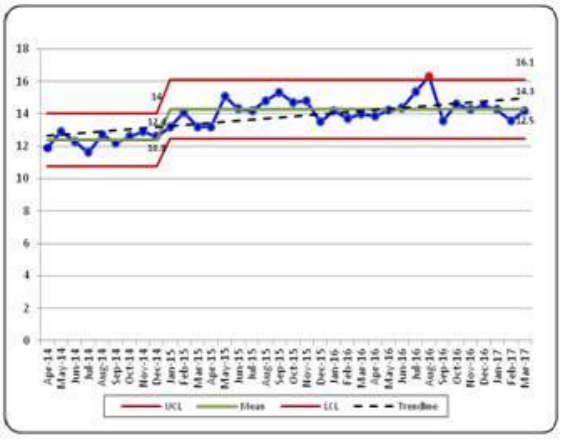
Performance Measure: Domiciliary Care Starts April 2014 – March 2017

Total Number of New Domiciliary Care Starts within Neath Port Talbot aged 18+,
Quarter by Quarter comparison 2014—2017

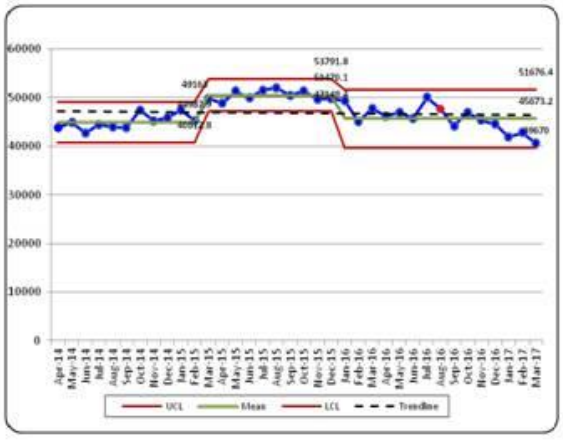
Year	Qtr1	Qtr2	Qtr3	Qtr 4	Total	+/-
2014/15	106	100	87	125	418	BL
2015/16	84	100	69	84	337	-20.7%
2016/17	63	81	51	57	252	-39.7%

Data includes those aged 18 and over, who have not previously had a domiciliary care package.

Average Domiciliary Care Hours per Client Per Week
between April 2014—March 2017



Total Number of Domiciliary Care hours provided (>65)
between April 2014 and March 2017



The number of new domiciliary care starters continues to reduce, with a 39.7% reduction when compared to the baseline figure. There have been a number of issues within the domiciliary care market within the borough over the passed year that are currently being addressed and monitored by the Local Authority.

Intake reablement, which work with individuals who have not previously had a care package and those who require an increase over 3.5hrs, requested a quarter of all care, with the remainder coming direct from social workers (increases of care up to 3.5 hrs) and the hospital.

Data source: Local Authority

The Community Resource Team contributed to the outcomes in the following way:

Rapid Response Service (ACT)

ACT	2014/ 2015	2015/ 2016	March 2017	Qtr 1 16/17	Qtr 2 16/17	Qtr 3 16/17	Qtr 4 16/17	Total
No. New Starters	959	1321	94	248	388	336	295	1267
No. Admissions avoided (stayed at home)	-	932	81	175	248	292	291	954
No. Hospital bed days avoided	6891	10499	810	1750	2480	2920	2390	9540
Bed day costs avoided	£758,010	£1,154,890	£89,100	£192,500	£272,800	£321,200	£262,900	£1,049,400

ACT 's primary focus this year has been on preventing admissions into hospital, through the provision of step up nursing beds placed within a local nursing home. As such admissions avoided data shows a 2.3% increase, when compared to the previous year.

ACT experienced a high level of demand into the service in the 2nd and 3rd qtr of the year, with the team reporting the second highest month (November) new starters this year (n= 139).

High level of demand and complexity of cases coming into ACT and staff sickness has impacted on the service's ability (at times) to take on new referrals. Nevertheless, the service continues to provide a high standard of care,

Intake Reablement

Intake Reablement	2014/ 2015	2015/ 2016	March 2017	Qtr 1 16/17	Qtr 2 16/17	Qtr 3 16/17	Qtr 4 16/17	Total
No. New Starters	-	646	54	187	204	165	197	753
No. Hospital Discharges Facilitated	-	298	25	93	112	67	65	337
No. Hospital bed days avoided	-	894	75	279	336	201	279	1011
Bed day costs avoided	-	£98,340	£8250	£30,690	£36,960	£22,110	£29,700	£119,460
No. Domiciliary care hrs avoided	-	3087.29	292.29	791.37	851.55	902.43	1342.12	3887.47
Weekly Domiciliary care costs avoided	-	£42,789.84	£4384.35	£11,870.55	£12,773.25	£13,536.45	£20,131.80	£58,312.05
Annual Domiciliary Care Costs Avoided should everyone remain on the same level of care for 1 year.								£3,032226.6

Intake Reablement has increased its performance across all key target areas in comparison with 2015/16.

The number of hospital discharges facilitated has increased by 12%, and the number of domiciliary care hours has increase by 20.6%, meaning more people are remaining in independent in their own homes for longer.

The annual costs avoided, should everyone remain on the same level of care for a year is just over £3 million.

The Community Resource Team contributed to the outcomes in the following way:

Intermediate Beds

Intermediate Beds	2014/ 2015	2015/ 2016	March 2017	Qtr 1 16/17	Qtr 2 16/17	Qtr 3 16/17	Qtr 4 16/17	Total
No. New Starters	-	103	10	32	50	22	37	152
No. Hospital Discharges Facilitated	-	61	8	28	42	18	33	131
No. Discharged to own Home	-	54	12	20	30	12	26	90
No. Discharged to Long Term Placement	-	12	6	7	15	8	10	43

In November 2015 the number of intermediate care beds increased with the introduction of the Assessment unit and an additional 2 beds in the Reablement unit. As such, there has been a increase in performance against all key targets. Most significant, is the rise (40%) in the number of people who retumed home, indicating that people are remaining independent within their own homes for longer.

Common Point of Access - Gateway

Gateway	2014/ 2015	2015/ 2016	March 2017	Qtr 1 16/17	Qtr 2 16/17	Qtr 3 16/17	Qtr 4 16/17	Total
No. calls responded to and closed by contact officers	-		21	3276	3108	1953	105	8103
Total no. people referred to Gateway MDT	-		783	2313	2773	2372	2209	9740
No. people responded to and closed by MDT	-	2920	273	867	957	1016	777	3617
No. People referred to CRT	-	-	856	2783	2932	2182	2394	10291
No. People responded to and closed by 3rd sector broker	709	655	29	140	107	74	91	409

There has been a 19.3% increase in the number of people who are referred to and closed by the MDT. The number of referrals made to the third sector broker has decreased by 36%.

The Community Resource Team contributed to the outcomes in the following way:

Assistive Technology

Assistive Technology	2014/ 2015	2015/ 2016	March 2017	Qtr 1 16/17	Qtr 2 16/17	Qtr 3 16/17	Qtr 4 16/17	Total
Total No. People Supported*	-	-	2505			2478	2505*	-
No. New Referrals	-	-	83	171	218	196	238	823
No. New Installations Completed	-	-	54	147	165	176	161	649

This is the first year of data recording for Assistive Technology. A business strategy for 2017/18 is currently being developed, which aims to see the take up of

100 mobile phone life lines have been purchased to be used with all clients who receive reablement support

Medicine Management

Medicine Management	2014/ 2015	2015/ 2016	March 2017	Qtr 1 16/17	Qtr 2 16/17	Qtr 3 16/17	Qtr 4 16/17	Total
No. New Starters	-	-	70	115	165	117		362
No. Discharges Facilitated from Hospital	-	-	4	2	4	4	7	17
No. Hospital Bed Days Avoided	-	-	12	6	12	12	21	8
Hospital Bed Costs Avoided			£1320	£660	£1320	£1320	£2310	£5610
No. Domiciliary s Avoided	-	-	11.7	14.9	16.3	7.5	21.1	59.85
Weekly Domiciliary Care Costs Avoided	-	-	£175.50	£223.50	£244.50	£113.25	£3316.50	£897.75
Weekly Medicines Costs Avoided	-	-	£42.79	£81.19	£443.10	£283.28	£134.31	£941.88

This is the first year of data reporting for the Medicines Management service.

The data shows that the service has contributed to the facilitation of hospital discharges and avoided hospital bed costs of £5610 . Domiciliary care hours have also been reduced due to the intervention of the service at a weekly cost avoidance of £891.75.

The Community Resource Team contributed to the outcomes in the following way:

Rapid Response Home Care Team

Rapid Response HC	2014/ 2015	2015/ 2016	March 2017	Qtr 1 16/17	Qtr 2 16/17	Qtr 3 16/17	Qtr 4 16/17	Total
No. New Starters	-	-	34	-	75	44	118	237
No. Discharges Facilitated From Hospital	-	-	16	-	18	16	64	98
No. Hospital Bed Days Avoided	-	-	48	-	54	48	192	294
Bed Day Costs Avoided	-	-	£5280	-	£5,940	£5,280	£21,120	£32,340
No. Admissions Avoided (Stayed At Home)	-	-	7	-	42	9	38	89
No. Hospital Bed Days Avoided	-	-	70	-	420	90	380	8900
Bed Day Costs Avoided	-	-	£7,700	-	£46,200	£9,900	£41,800	£97,900
Average Length of Time on Service (days)	-	-	16	-	14	15	14	11

The Rapid Response Home Care Team was established in July 2016. Since its implementation it has facilitated 98 hospital discharges , avoiding £32,340 of bed costs and prevented 89 hospital admissions, avoiding £97,900 bed costs.

In December 2016, the capacity of the team was increased enabling more people to be safely discharged home from hospital and to remain independent in their homes for longer.

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	TOTAL
Acute Clinical Team													
New Starters	84	58	106	113	111	164	106	139	91	105	96	94	1267
Number from Community	73	53	83	101	96	153	103	130	88	101	87	90	1158
Number from Secondary Care	9	5	6	12	11	10	3	9	3	5	9	4	86
Discharges	97	55	43	94	71	149	120	133	81	104	91	96	1134
Number of Early discharges facilitated	8	5	6	12	11	5	3	0	0	3	9	4	66
Number of Hospital Admissions prevented	81	60	34	75	44	129	109	118	65	82	76	81	954
Bed Days Saved	810	600	340	750	440	1290	1090	1180	650	820	760	810	9540
Costs Avoided	£89,100	£66,000	£37,400.	£82,500.	£48,400	£141,900	£119,900.	£129,800	£71,500.	£90,200.	£83,600	£89,1000	£1,049,400.
Common Point of Access - Gateway													
Total Number of Enquires Dealt with by Contact Officers	1133	1106	1037	924	1049	1135	859	637	97	68	37	21	8103
Total Number of referrals (people)	766	872	983	719	948	871	840	843	689	697	729	783	9740
Number of referals to CRT from Common Access Point	811	868	1104	842	1116	974	908	521	753	761	777	856	10291
Total Number of people dealt with by the Gateway Team	252	244	371	254	405	298	424	286	306	256	248	273	3617
Total Number of people screened to Voluntary Sector	36	51	50	30	40	37	24	27	23	38	24	29	409
Intake - Reablement													
Total Number referred to Reablement	186	204	234	198	135	210	190	211	186	196	126	91	2167
Caseload Reablement (Snapshot Friday)	128	97	117	105	97	106	115	120	108	104	115	107	
Number of Double Staffed Clients (Snapshot Friday)	9	9	12	6	9	9	9	6	9	13	5	6	
New Starters	64	57	66	72	71	61	58	51	56	44	153	54	807
Number from Hospital (Earlier Discharge)	23	33	37	43	38	31	26	19	22	15	50	25	362
Number from Community	17	18	25	27	32	24	25	28	22	18	69	23	328
Number from ERS (Rapids)	4	6	4	2	1	6	10	4	12	11	34	6	100
Discharges	54	57	66	61	57	62	53	43	76	55	160	47	791
Reduction in hours from admission to leaving service	219.63	300.14	271.6	281.18	297.54	272.83	305.95	243.87	352.61	286.55	763.28	292.29	3887.47
Financial savings	£3,294.45	£4,502.10	£4,074.00	£4,217.70	£4,463.10	£4,092.45	£4,589.25	£3,658.05	£5,289.15	£4,298.25	£11,449.20	£4,384.35	£58,312.05
Total Number in Hospital Discharge Ready (Snapshot Friday)	15	20	10	13	7	7	13	14	5	10	8	16	
Number Awaiting Reablement from Community (Snapshot Friday)	40	64	48	58	39	35	28	33	45	39	63	70	
Number Hospital Not Discharge Ready (Snapshot Friday)	49	54	50	58	31	19	28	22	32	31	55	44	
Number waiting transfer to alternative service (Snapshot Friday)	27	27	18	18	24	41	35	38	30	25	30	42	
Average length of time supported by Reablement (Days)	43.76	43.44	39.1	35.17	37.11	32.69	31.11	34.32	35.19	30.35	35.7	39.94	
Number of people who did not complete programme	12	7	10	14	9	9	9	8	2				51
Intermediate Residential Beds													
Bed Occupancy(Snapshot last Friday of month)	18	19	17	21	20	21	21	19	19				
Total new admissions	13	13	6	22	9	19	14	8	11	18	9	10	152
Number of admissions from Hospital	10	12	6	18	8	16	10	8	10	16	9	8	131
Total Number of Discharges	12	13	7	19	13	19	16	7	13	15	9	12	155
Number discharged to own home	10	7	3	10	9	11	10	2	6	10	6	6	90
Number discharge to long term placement	0	4	3	6	2	7	5	3	3	3	4	3	43
Brokerage													
Total number of POC requests received	76	30	87	65			274	286		221	676	356	2071
Number of requests from CRT	41	18	50	31			114	129		86	277	179	925
Number of requests from all other services	21	12	37	32			160	157		135	399	177	1130
Number requests from hospital	5	1	4	8			20	25		33	92	34	222
Total number of POC unallocated	10	4	4	1			14	13		11	12	20	
Number of CRT requests unallocated	10	4	4	1			12	12		10	25	19	
Total number of POC arranged	57	17	45	45			79	90		86	249	74	333
Total number of POC pending	26	3	19	9			32	13		6	2	5	
Assistive Technology													
Total Number of supprted with AT	2076	2127	2168	2209	2258	2317	2378	2445	2478	2506	2479	2505	
Total Number of New Referrals Received	50	53	68	61	84	73	67	70	59	80	75	83	823
Total Number of New installations completed	42	60	45	56	51	58	61	62	53	58	49	54	649
Number of Lifelink	42	51	38	50	43	53	54	56	42	43	41	46	559
Number Lifelink Plus	3	5	3	3	2	2	5	3	1	10	3	8	48
Number Lifelink Extra	3	4	4	3	6	3	2	3	10	5	5	0	48
Meds Management													
Total Number of new referrals received		38	77	74	44	47	41	41	35	55	47	70	569
Number of Hospital Admissions prevented		0	2	2	0	2	0	2	2	3	0	4	17
Number of Hospital discharges facilitated		0	1	0	2	1	1	2	0	6	4	0	17
Total number of hrs domiciliary care prevented per week		3.4	11.5	4.6	2.5	9.2	2.3	3.5	1.75	4.6	4.8	11.7	59.85
Financial savings - domiciliary care		£51.00	£172.50	£69.00	£37.50	£138.00	£34.50	£52.50	£26.25	£69.00	£72.00	£175.50	£897.75
Financial savings - reduction in medication use		£75.27	£5.92	£324.87	£58.99	£59.24	£59.24	£112.76	£111.28	£37.50	£54.02	£42.79	£941.88