Meeting Date	29th November 2018	**Agenda Item**	**2iii.**
Report Title	**Transformation Fund Proposals**		
Report Author	Joanne Abbott-Davies Assistant Director of Strategy & Partnerships Hilary Dover, Primary and Community Services Delivery Unit Director		
Report Sponsor	Siân Harrop-Griffiths, Director of Strategy Chris White, Chief Operating Officer/Director of Primary & Community Services		
Presented by	Siân Harrop-Griffiths, Director of Strategy		
Freedom of Information	Open		
Purpose of the Report	To provide the Health Board with information about the submission of two complementary proposals for the Welsh Government Transformation Fund: • "New Western Bay" Regional Offer – Our Neighbourhood Approach • Cwmtawe Whole System Approach.		
Key Issues	The need to ensure that the "New Western Bay" Regional Offer and the Cwmtawe Whole System Approach 'dovetail'. Agreement has been reached with the Western Bay Regional Partnership Board to support both these proposals, as well as a further proposal for the Neath Cluster Whole System Approach (to match the Regional Offer which covers both areas. In addition further consideration is being given to other proposals which may be submitted against the Transformation Fund, including a joint proposal across Local Authorities and ABMU Health Board for the roll out of the Welsh Community Care Information System and Mobilisation and a joint proposal for transforming Learning Disabilities services.		
Specific Action Required ***(please ✓one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
	√			
Recommendations	The Board is asked to: • Note the "New Western Bay" Regional Offer – Our Neighbourhood Approach • Note the whole system model for Cwmtawe • Support the development of the proposal for the whole system model for Neath • Support the development of the proposal for the Regional Partnership Board to submit to Welsh Government for a roll out of this model across all 8 clusters. • Note the intention to consider the development of additional proposals for submission against the Welsh Government Transformation Fund.		

Transformation Fund Proposals

1.0 Introduction

This paper provides the Health Board with information about the submission of two complementary proposals for the Welsh Government Transformation Fund:

- "New Western Bay" Regional Offer – Our Neighbourhood Approach
- Cwmtawe Whole System Approach.

2.0 Background

Welsh Government has made £100 million available across Wales over 2 years for its Transformation Fund and asked for submissions by each Regional Partnership Board against this, aimed at achieving the implementation of "A Healthier Wales" with pace. The Cabinet Secretary for Health and Social Services and the Minister for Older People, Children and Social Care have held a series of meeting with members of the Western Bay Regional Partnership Board to discuss and refine the proposals which should be made against the Transformation Fund. This has led to the development of the "New Western Bay" Regional Offer – Our Neighbourhood Approach, which is attached as **Appendix A**.

In parallel discussions were taking place between the Primary Care and Community Services Delivery Unit and Welsh Government about a new approach to the development of GP Cluster working which led to the development of the Cwmtawe Whole System Approach, which is attached as **Appendix B**.

3.0 Assessment

Through the work on both the above proposals, the need to ensure that the "New Western Bay" Regional Offer and the Cwmtawe Whole System Approach 'dovetail' with each other has been the subject of discussions between all partners in the Western Bay Regional Partnership Board. Agreement has been reached with the Western Bay Regional Partnership Board to support both these proposals, as well as a further proposal for the Neath Cluster Whole System Approach (to match the Regional Offer which covers both areas.

Welsh Government has requested for the Regional Partnership Board to submit a further proposal scaled up to cover all 8 clusters within Swansea and Neath Port Talbot, but the RPB has only agreed to support the Neath additional one at this stage until a response of the New Western Bay offer has been received. (This is expected imminently).

It is anticipated that proposals for the remaining 6 clusters can then be submitted.
In addition further consideration is being given to other proposals which may be submitted against the Transformation Fund, including a joint proposal across Local Authorities and ABMU Health Board for the roll out of the Welsh Community Care Information System and Mobilisation and a joint proposal for transforming Learning Disabilities services.

In addition, for information attached as **Appendix C** is the Bridgend Transformation proposal which has been made to Welsh Government (Bridgend were asked to work with Cwm Taf in submitting their proposal, but because of timings, Bridgend's submission was made separately).

4.0 Recommendations

The Board is asked to:

- Note the "New Western Bay" Regional Offer – Our Neighbourhood Approach
- Note the whole system model for Cwmtawe
- Support the development of the proposal for the whole system model for Neath
- Support the development of the proposal for the Regional Partnership Board to submit to Welsh Government for a roll out of this model across all 8 clusters.

- Note the intention to consider the development of additional proposals for submission against the Welsh Government Transformation Fund.

Governance and Assurance							
Link to corporate objectives ***(please ✓)***	Promoting and enabling healthier communities	Delivering excellent patient outcomes, experience and access	Demonstrating value and sustainability	Securing a fully engaged skilled workforce	Embedding effective governance and partnerships		
	√	√	√	√	√		
Link to Health and Care Standards ***(please ✓)***	Staying Healthy	Safe Care	Effective Care	Dignified Care	Timely Care	Individual Care	Staff and Resources
	√	√	√	√	√	√	√
Quality, Safety and Patient Experience							
Care delivered closer to home improving patient experience							
Financial Implications							
£1.7m proposal for whole system model for Cwmtawe supported by Welsh Government. £5.9m proposal submitted to Welsh Government for approval.							
Legal Implications (including equality and diversity assessment)							
None							
Staffing Implications							
There will be a need to recruit staff and change existing roles.							
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)							
The proposal is in line with A Healthier Wales, Social Services and Wellbeing (Wales) Act 2014 and the Wellbeing of Future Generations (Wales) Act 2015							
Report History	Proposals submitted to and agreed by Western Bay Regional Partnership Board						
Appendices	Appendix A – "New Western Bay" Regional Offer - Our Neighbourhood Approach Appendix B – Cwmtawe Whole System Approach Appendix C – Bridgend Transformation Proposal						

Appendix A

"NEW WESTERN BAY" REGIONAL OFFER

OUR NEIGHBOURHOOD APPROACH

PURPOSE

Following meetings between representatives of the ABMU Health Board, Neath Port Talbot CBC and Swansea Council, this paper sets out our combined regional offer to the Cabinet Secretary and Minister for Children and Social Care on our intent to radically transform our care system into one that is integrated to respond to issues that matter to the people we serve and care for, and our priorities to achieve this.

In a **Healthier Wales: our Plan for Health and Social Care** Welsh Government wants everyone to have long, healthy, happy lives. For this to happen we need to help people look after themselves well, and we need to make sure we have the right health and social care services to help people stay well, to get better when they are ill, or to live the best life possible when they have problems that won't get better.

The five main ways in which health and social care need to change are:

In each part of Wales **the health and social care system will work together** so that people using them won't notice when they are provided by different organisations. New ways of joined-up working will start locally and scale up to the whole of Wales. We will make sure local services learn from each other and share what they do, because we want everyone in Wales to have the same high quality services. We also want services to use a single digital record so that they can give the most appropriate support and treatment based on a complete picture of a person's needs.

We want to **shift services out of hospital to communities**, and we want more services which stop people getting ill by detecting things earlier, or preventing them altogether. This will include helping people manage their own health, and manage long term illnesses. We also want to make it easier for people to remain active and independent in their homes and communities.

We will **get better at measuring what really matters** to people, so we can use that to work out which services and treatments work well, and which ones need to be improved. We will identify and support the best new models of health and social care so they scale up more quickly to the whole of Wales.

We will **make Wales a great place to work in health and social care**, and we will do more to support carers and volunteers. We will invest in new **technology** which will make a real difference to keeping people well, and help our staff to work better. By making health and social care a good career choice, investing in training and skills, and supporting health and wellbeing at work, we will be able to get and keep the talented people we need to work in Wales. We will look to introduce digital advances that help staff work more effectively.

To make our services work **as a single system, we need everyone to work together** and pull in the same direction. We think we can do this in a small country like Wales, especially if we as a government provide stronger national leadership, and make sure we keep talking – and listening – to the people who deliver and use our health and social care services.

This is our proposal for how we can start making this aspiration a reality in the Neath Port Talbot and Swansea areas.

OUR VISION

Our vision is to:

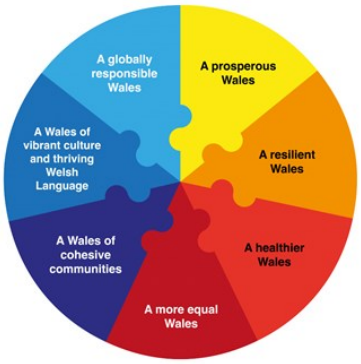
- Enable individuals to live longer, happier lives and take more control of their own health and wellbeing, including supporting others in their local areas by developing partnerships with a wide range of organisations and people from the public, private, third sector and communities to deliver support to people in local areas.
- Provide health and care for people that need it from people that act as one team and work for organisations that behave as one system.

We will achieve this by:

- Joining forces across organisations to integrate services and to invest in ways to prevent illness and keep people out of hospital.
- Ensuring decisions are made at the most appropriate level, and empowering local leaders to plan around the long-term needs of the people we serve.
- Providing more care in the community and home-based settings, including in partnership with voluntary and community sectors.
- Ensuring communities can work with us to take collective responsibility for how best to use resources to improve health outcomes and quality of care.
- Implementing an organisational programme for relevant staff across all participating organisations and sectors to ensure they are supported to change practices and approaches so that they can act as one team and behave as one system.

CONTEXT

The Wellbeing of Future Generations Act outlined that all public bodies in Wales needed to work towards the 7 goals.



The intentions laid out in this paper show how the new ABMU Health Board, Swansea Council and Neath Port Talbot County Borough Council aim to work collectively, with other partner organisations, stakeholders and local communities to transform its services, at pace to achieve these goals. In doing this we will ensure the five ways of working identified in the Act are embedded in all that we do and how we do it.

BACKGROUND

ABMU Health Board, Neath Port Talbot CBC and Swansea Council have been working together within the Western Bay Partnership (with Bridgend CBC) since 2012, developing a range of joint approaches and integrated services for the people we serve. Making the transition to delivering the requirements of the Social Services and Wellbeing (Wales) Act and establishing the associated Western Bay Regional Partnership Board was therefore in line with this previous work and enabled this to be based on solid foundations immediately. Our Western Bay Population Assessment and subsequent Area Plan have been developed on an inclusive basis with the resulting priorities being incorporated into individual organisation's operational plans.

The Health Board and individual Local Authorities have also worked together since the inception of the Wellbeing of Future Generations (Wales) Act on developing Public Services Boards on an even more inclusive basis, and developed the associated Wellbeing Plans effectively. However through this, the overlap between these various areas of work, and potential for duplication and lack of clarity over accountabilities has become clearer.

The Western Bay Partnership has also been committed to embedding co-production into its principles and ways of working, with the establishment two years ago of a Citizen's Panel who consider the Regional Partnership Board's work. Increasingly the Citizen's Panel is involved in the full range of the Partnership's work, as evidenced by the co-produced Western Bay Mental Health Strategic Framework for Adults. The Regional Partnership Board has two service user and two Carers representatives from the Citizen's Panel on it, and a report on issues raised by the Panel is discussed at each RPB meeting. Whilst this is a good start, the Health Board and Local Authorities recognise that more needs to be done to develop co-production as part of everything it does.

Western Bay since 2012 has concentrated on implementing the **"What Matters to Me Model"** in particular with improving the Intermediate Care Tier and Specialist Care with regards to Reviewing Individuals with Complex Need, which this year was presented with two All Wales Continuous Improvement Awards for its work in Collaboration and as the best Local Government Initiative.

The Intermediate Care tier identified and supported the implementation of the "Optimal Model" via the Integrated Care Fund. Each locality had differing services and the region agreed that once approach to services would be adopted and implemented to ensure that all citizen from the region received the same services whatever their postcode.

Western Bay has always identified that this tier is only part of the model of care and that the prevention tier would need concentration in order to avert individuals entering the health and social care systems. What we will ensure is that the same components part of the "Neighbourhood Approach" are scaled and delivered using the same methodology and governance approach as used in the delivery of the Intermediate Care Optimal Model.

ACHIEVED OUTCOMES AND CASE STUDIES

Across Western Bay we have been utilising ICF Funding in order to deliver a whole systems approach for intermediate care. In 2017/18 the below outcomes were achieved:

Description of Scheme	Projected Outcomes and outputs	Totals
<u>Intermediate Care Services (underpinned by S33 agreement) Whole Systems Approach)</u> Acute Clinical Response	Admissions avoided	2919
	Number of bed days saved	29190
	Cost of bed days saved	£3,669,600
Common Access Point	Number of people referred to Community Resource Team	7,424
Reablement - Discharges facilitate	Discharges facilitated	957
	Number of bed days saved	2817
	Cost avoided	£363,960
Reviewing Individuals with Complex Needs	Number of placements assessed	275
	Total saving including costs avoided	£4,953,291

Please see below examples of how we've already transformed services / approaches across Western Bay

CASE STUDY – LOCAL AREA COORDINATION

Emma Jones is the Neath Port Talbot Local Area Coordinator for the Skewen, Longford and Neath Abbey areas. Her role includes supporting people to build and develop their vision for a good life by getting to know the person, their family and neighbourhood and helping individuals gain confidence and feel connected with their local community. Here, she tells us about her journey with 19 year old Zoe, who is making great progress

ZOE'S STORY…

Zoe is 19 and has learning disabilities. She was referred to Local Area Coordination by her doctor after being prescribed medication to treat depression. Zoe spent a great deal of time sleeping and had lost motivation to participate in any social activities.

After the referral was received, I arranged to meet Zoe at home and spent a few hours chatting with her and her mother about LAC and its key principles. Zoe was initially nervous and reluctant to chat, but she soon relaxed and started to open up. Zoe said she felt low and that her mood rapidly changed throughout the day: "One minute I feel ok, the next very down".

She explained that although she was bored, she couldn't be bothered to do anything and had lost confidence.

During the discussion, I asked Zoe what she was interested in and what she felt would improve her life. After giving it some thought, Zoe started to identify activities she would like to try. These included working with and helping animals, making her own art and taking some exercise.

What happened next?

Over the next few months, I met with Zoe on a regular basis and was able to build a positive, trusting relationship which allowed her to talk about her problems, address some issues, break down barriers and plan what her vision for a better life would look like. Together, we were able to look at creative opportunities where she was able to focus on her interests and pursue her goals. I supported Zoe with introductions and spent time alongside her with all activities until she felt confident enough to undertake them independently. I also helped connect Zoe with other local young people with similar interests.

A new lease of life

I think it's fair to say that Zoe's life has started to be transformed. She is undertaking a number of activities which are helping to increase her confidence and motivation.

These days, a typical week for Zoe will include:

Volunteering at Llys Nini Animal Rescue Centre.

Volunteering at the 'Dognasium', where her role includes walking, feeding and training dogs, as well as taking advantage of the organisation's training opportunities.

Participating in a new weekly community 'walk and talk' group set up by Local Area Coordination in partnership with the 'Go Green for Health' project.

Creating her own artwork as part of the Dragon Arts and Learning 'Upcycling' initiative.

Zoe has come such a long way and it's been wonderful to see.

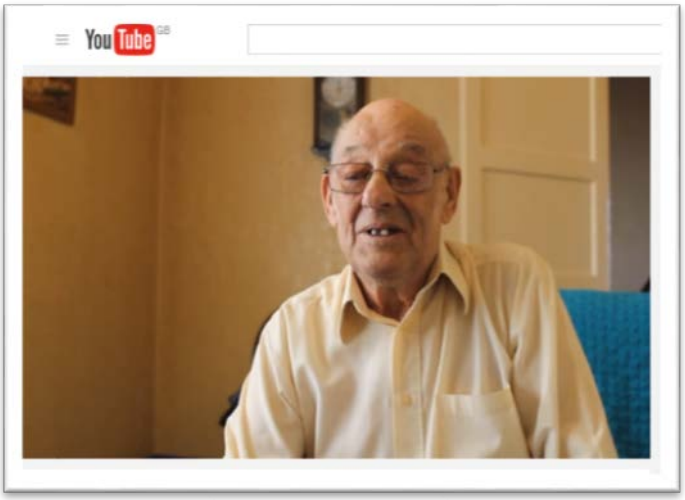
She's recently expressed an interest in taking up rugby, so our next plan is to find a local women's rugby team for her to give it a go.

There's no stopping her now!

CASE STUDY: BOB'S STORY

We're pleased to bring you 'Bob's story', which gives a flavour of the good work being carried out by Swansea's Acute Clinical Response (ACR) service.

Thanks to this service (funded by the Welsh Government's Intermediate Care Fund), 76 year old Bob was able to be discharged from hospital early and is delighted to be back in the comfort of his own home.



Click on the following link to view Bob's story on 'Western Bay TV':

https://vimeo.com/282806450

AIM

Our collective aim is, through these proposals to address the following:

- Managed care services running at maximum capacity and still not keeping pace with demand
- Finding a different way to reduce pressure on managed care services
- How to downstream activities
- Enabling people and communities to take control of their circumstances
- Provide alternatives to hospital beds
- Provide true alternatives to current services
- Focus on vulnerability of people, irrespective of their needs
- Scaling up and widening social prescribing
- Maximise independence of citizens across the region

AMBITION

Our collective ambition is to:

- Work together to improve health and care for the populations we serve
- Plan and deliver care which reflects outcomes that matter to the people we serve and care for – we will check this through measures which reflect individual experiences and system wide impacts
- Seamlessly integrate care through a place/locality based approach - we will do this through pooling budgets and resource (staff/assets) on a locality basis
- Collaborate to manage the common resources available to us rather than adopting a "fortress mentality" in which each organisation acts to secure its own future regardless of the impact on others
- Have a single and simple governance structure – we will do this by integrating and streamlining Public Service Boards, the Regional Partnership Board and sub-structures for the region

QUADRUPLE AIM

The Parliamentary Review highlighted that Health and Social Care need to address issues across the sector:

- Workforce Shortages – Including staff capacity, staff training

- Speed of Transformation – the outcomes for Wales are not improving as fast as the government and citizens require
- Service Delivery Inconsistent – Different services available in different communities and not all at the same level
- Risk Averse Culture – limiting efficient and effective decision making
- Funding Pressures – Spending is out pacing country's wealth and investment. Health and Social Care funding is sometimes allocated at the expense of other services such as Education and Housing
- Implementation of Key Legislation - Wellbeing of Future Generations Act, Social Services and Wellbeing Act, new National Strategy "Prosperity for all" , "Once for Wales"

The offer from the "New Western Bay" to address the Quadruple Aims are:

Aim 1 - Improve the population health and wellbeing through a focus on prevention

- Increase the scale and pace of preventative programmes across the region for example "Wellbeing from Birth – First 1000 days"
- Increase and improve the collaboration and integration with partners such as 3rd Sector, Council for Voluntary Services, Providers, Education, Leisure, Housing
- Ensure clear communication across the region with all stakeholders

Aim 2 – Improve the experience and quality of care for individuals and families

- Further develop compassionate communities or neighbourhood's
- Increase the scale and pace of collaboration efforts through; the use of WCCIS, Effective Pooled Budgets, Multi-Agency and Disciplinary Teams
- Reduce harm by focusing services more effective to address key issues / problems within communities / neighbourhoods (e.g. substance misuse)
- By changing the questions and conversations with Citizens to "What Matters to You"

Aim 3 – Enrich the wellbeing, capability and engagement of the health and social care workforce

- Support the workforce within the community to look after themselves and ensure they feel valued
- Ensure timely and inclusive decision making and reduce conflict
- Allow the workforce time to work with citizens and explore opportunities

Aim 4 – Increase the value achieved from funding of health and social care through improvement, innovation, use of best practice and eliminating waste

- Review, develop and continually support the assets we already have in our community
- Invest in people – they are key to community based assets
- Review "Best Practise" within and outside of the "New Western Bay" to develop new ideas and opportunities
- Improve and develop the digital community

SWOT ANALYSIS

As a region we have a number of strengths, weaknesses, opportunities and threats:

STRENGTHS	OPPORTUNITIES
- Cohesive communities - Some well-developed integrated community services for older people - Examples of co-production – e.g. mental health strategic framework - Well established multi-agency Early Years focus – e.g. Early Years approach in Network Clusters, Jig-So project - Local Area Coordinators established - Good working relationships - Small number of partners (3) - Collective commitment and ambition for transformation - Good relationship with Swansea University and University of Wales Trinity Saint David to build on - Strong Third Sector Relationships - Links to the Cwmtawe and Neath Cluster Whole System Approach "A Healthier Wales" bid for Primary Care Transformation - Established ARCH Programme - Collaborative City Deal - 11 established cluster networks bringing together multi-agency/ multi-disciplinary partners to agree and implement create three year plans to support improved health and wellbeing and new innovative ways of delivering care. - World Health Organisation Healthy City Designation and membership of European and UK network which provides a strong understanding of action needed to reduce health inequalities - Information/ signposting systems DEWIS/ 111/ Family Information Service	- Build on links with Housing Associations - Building blocks of our different services need to be aligned to simplify system - Opportunity to align the CMHTs with Integrated CRTs - Rationalise governance arrangements for PSBs/RPB - A new identity for "Western Bay" - Addressing more innovative / transformational service change
WEAKNESSES	**THREATS**
- Focus on narrow not wider part of system - Complex Western Bay governance - Duplication between Western Bay and Public Services Boards - Upscaling to business as usual and consequences across system - Lost innovative/transformation focus - 3rd sector capacity to deal with demand	- Governance structures – too many lines of reporting and too many meetings - Bridgend – outcome of consultation and potential subsequent timing - Differential tendering processes

WHAT WE ARE TRYING TO ACHIEVE

Our intention is to:

- Empower people and communities to co-design our services to meet their needs better and support them to be resilient and self-supporting;
- Ensure that all staff from across all agencies, including Trade Unions, are engaged in shaping the approach and changes we decide to make;

- Focus on building on and developing assets within communities. This will empower people to provide support to members of their own community based on what matters to them. This will enable people to support each other rather than rely on statutory services;
- Adopt the Digital Inclusion Charter to develop Digital Champions for the area from within key organisations and community groups to ensure people can make the most of information available to them digitally, and to develop digital solutions to provide required support;
- Organise our services to respond to the holistic needs of families, focusing on doing this once based on total needs, rather than responding to different needs with separate and distinct care services;
- Focus on developing our staff to provide services in different ways, co-productively, based around individual and family needs, focusing on this rather than the traditional way services have been organised;
- Reduce demand and long-term pressures on our managed care services;
- Enable all of our acute / managed care services to care for people within available capacity;
- Manage our resources to deliver best outcomes for people within the resources available, enabling our care system to be financial viable;
- Develop volunteering from our communities to support the changes we make and deliver services and support as required.

HOW WILL WE DO THIS/OUR OFFER

To ensure our priorities are based on best practice we have utilised the Kings Fund report "Place based systems of care", the Canterbury paper and Wigan Deal to inform our proposal. We believe that the learning from Asset Based Community Development and Compassionate Communities should be applied in all that we do to reform our services. This will ensure that people in their own communities can do as much as possible to support each other by focusing on:

- Identifying and making visible the health-enhancing assets in our communities;
- Seeing citizens and communities as the co-producers of health and wellbeing, rather than recipients of services;
- Promoting community networks, relationships and friendships that can provide caring, mutual help and empowerment;
- Identifying what has the potential to improve health and wellbeing;
- Supporting individuals' health and wellbeing through self-esteem, coping strategies, resilience skills, relationships, friendships, knowledge and personal resources;
- Empowering communities to control their futures and create tangible resources such as services, funds and buildings.

To deliver this we will need to focus all our efforts and those of our staff to:

- Focusing on people's and communities assets not needs;
- Building a dynamic picture of personal and community assets;
- Connect people to each other and to wider community assets;
- Grow and mobilise community assets;
- Monitor the impacts and learn from evidence.

We believe this focus on an asset based approach will also help reduce health inequalities by:

- Targeting appropriate community to work with;
- Using local assets to empower people and communities;

- Valuing resilience;
- Strengthening community networks;
- Building trust between service providers and communities.

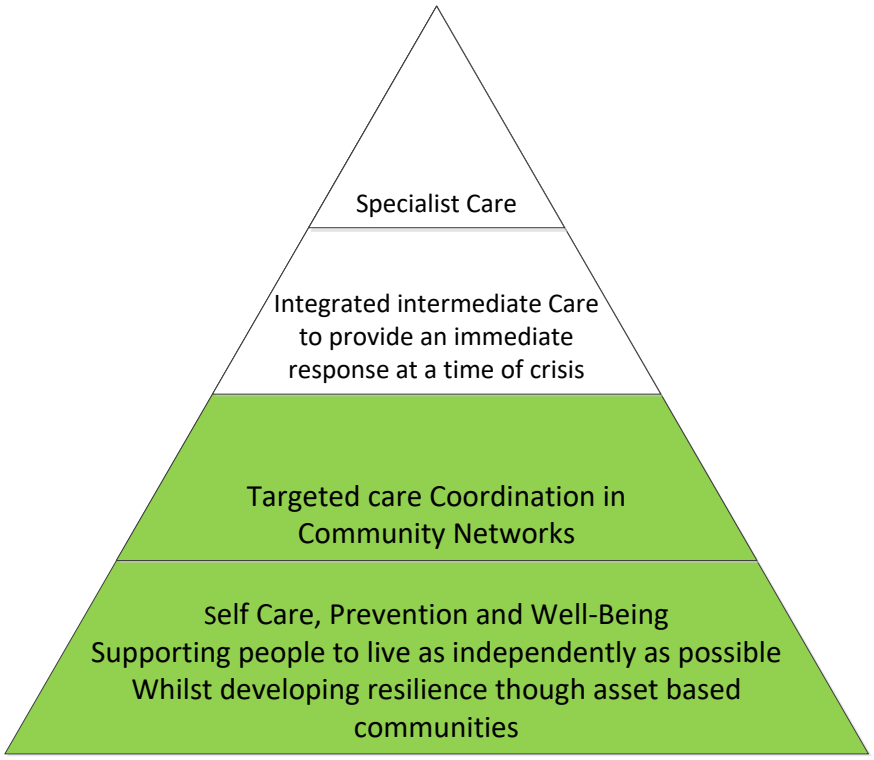
The New Western Bay's Model

As previously described Western Bay has been concentrating on delivering the "What Matters to Me" Model of Care for our citizens. Our plan is to develop the tiers of Targeted Care Coordination and Self Care, Prevention and Wellbeing in two geographical areas Swansea North Hub and Neath Cluster. Please see Appendix A for a full description of the areas identified.

We have various levels of support within the two defined areas, where one is described and co-located and not integrated in ways of working, the other has having very disparate services where Health and Social Care staff are not co-located or have any joint working services. The intention is to bring a standard model where Health and Social Care staff are coterminous, in a "neighbourhood" or cluster area to provide seamless health and social care services to the citizens.

In alliance with other stakeholders and utilising processes already used for supporting delivery of projects through the use of Integrated Care Funds, Carers Funding and Changing for the Better Funding we will endeavour to commission services to deliver on the key themes as identified in specific geographical locations, by working in this way we will ensure that there is no duplication of services across the neighbourhoods. An example of previously used process for approving projects across Western Bay can be reviewed in Appendix B.

Our plan is to test out various approaches over the next 2 years within these defined geographical areas. We will be continuously monitoring the developments and as each are proven we intend to scale up and implement across the whole of the New Western Bay area.



In order to deliver the whole system approach we will build on our existing infrastructure and provide the social care wrap around service to the Primary Care Clusters. The wrap around service will support the Cwmtawe and Neath Primary Care Cluster Model by supporting the local communities to develop on the assets are found in the community and to support individuals and community groups to come

together to realise and develop their strengths. Both "Our Neighbourhood Approach" and the "Cwmtawe and Neath Whole System Approach for Primary Care" are intrinsically linked and one programme could work without the other, but this is not the intention of the Western Bay Regional Partnership Board.

We will:

- Develop a **shared vision and objectives** based on One system, One budget, which ensures financial and clinical sustainability of local services as well as developing new care models that cut across current organisational and service boundaries
- Agree **two carefully defined population groups**, with different challenges and demographics to test and learn from, prior to scaling up across the region
- Ensure that all our services are **coterminous** with these two defined areas, using network clusters as the building blocks
- Ensure that **home is the centre** of the health and social care system and managed care facilities on the outside
- Focus on a **family/lifetime approach** to communities, rather than specific age/client/condition groups so that we take responsibility for all people and all their needs within the defined population
- Take a **whole person approach** to addressing physical health, mental health and social needs
- Build on work done to understand the needs of the defined populations, by involving local people in identifying their needs and **working co-productively** with us to agree objectives and priorities for action
- Ensure that **improving population health and wellbeing** underpins all our actions and services
- Focus on **developing community resilience** through **integrating services** across health and social care and other services – e.g. third sector, fire, police
- Ensure support and advice can be **accessed at an earlier stage** so as to prevent problems escalating
- Have a **single point of contact** within the locality for people to access support and to respond to people's questions and needs
- Using **digital opportunities** wherever possible, and taking the opportunity to reduce digital exclusion as part of our work with communities
- Develop an appropriate, inclusive **governance structure** to reflect existing accountabilities while also creating a basis for collective action, and clearly identifies how conflicts will be resolved
- Create a **dedicated team** to lead the implementation of this new approach, ensuring the right system leadership to enable substantial change to happen, with clear involvement of frontline clinical and operational teams
- Develop a **sustainable financing model**, working together to pool budgets and commission services jointly and in different ways to incentivise action behind our objectives
- Establish **information sharing protocols** across all relevant agencies to ensure that this is not a barrier to progress and changing services to meet our population's needs
- Develop a new approach to **contracting on an alliance basis** which supports multiple and different types of providers working together to provide integrated care and support. We will be involving a range of partners as outlined in our Communications Plan in Appendix E including partners from the Cwmtawe and Neath Whole System Approach for Primary Care Offer.
- Ensure **development of all staff** underpins all that we do
- Agree on a **single set of measures** to underpin our shared objectives and assess the overall performance of the system, including the improvements the public want to see

We envisage that the successful implementation of the "Our Neighbourhood Approach" though enabling citizens to self-care, self-responsibility and prevention will reduce the cost of admissions to hospital, primary care and resident placements, which can then be used to offset the roll-out of the model across the region. It is widely reported that the Froom Model showed a reduction of costs by 21% across 4 years after implementation.

In addition, the Canterbury model has proven that as a result of implementing a model such as "Our Neighbourhood Approach" has enabled more care to be provided in the community, has improved and brought about closer links to primary and secondary care, that spending on diagnostic services has fallen, pressure on acute hospitals has reduced and that admissions has reduced by 13% and demand for long term residential placements has reduced from 16% to 12%.

We also envisage that once staff have moved to the new model for delivering the place based approach that this will be mainstreamed though the realigned services. Additional staff appointed during the transition will be employed on a fixed term basis to support the development and implementation of the new model.

The ambition has been shared with partner organisations and conversations will continue with our current partners and new partners as the programme develops. We will also be speaking with other Regions as we develop our programme and we already have establish the sharing of best practice of ICF Projects with West Wales and will continue to develop this relationship.

STAKEHOLDER DEVELOPMENT

Specifically to transform the way people expect to be supported in future and how our services respond to this, there are some key areas we will focus on:

- **Leadership** to develop and implement the vision of asset-based approaches, including representation from voluntary and community sectors at strategic and governance levels, ensuring local figureheads and councillors are intrinsic to this;
- **Co-production and partnerships** to develop services, plans and strategies with local people, recognising that this takes time and focused resources to make this a reality;
- **Training and development** to enable frontline staff and residents to work together and focus on the assets available within communities and individuals in this;
- **Devolution of power** to neighbourhoods so that community groups can offer places to meet or provide community development support;
- Investment in the **voluntary, community and social enterprise sectors**;
- **Inclusive commissioning** that draws on the expertise of communities to prioritise outcomes that are important to them
- **Participatory budgeting** to give local people a say on priority-setting and spending

WHAT AREAS WILL WE TARGET?

Initially we intend to focus on two identified areas:

- North Hub area in Swansea covering the Cwmtawe and Llwchwr cluster areas
- Briton Ferry and Melin area within Neath Port Talbot covering the Neath cluster areas

Review **Appendix A** for more details about these areas

with the clear intention to evaluate these approaches with external support from Swansea University and roll out the learning from these with pace and focus to the next phase, which will focus on the:

- Central Hub area in Swansea covering City Health Network & Penderi Clusters
- Cwmllynfell, Rhiwfawr, Gwaun-Cae-Gurwen, Tairgwaith and Lower Brynamman in Neath Port Talbot covering the Upper Valleys Network clusters

We aim to build on some of the transformation work already underway through for example the Cwmtawe and Neath Whole System Approach for Primary Care and provide the wrap around service so as to maximise the use of existing and additional resources available to us to ensure neighbourhoods can benefit from these changes as quickly as possible and shape with us how change should happen going forward.

WHAT WILL BE DIFFERENT?

We will develop with our neighbourhoods an integrated, co-productive way of building safe and resilient communities, with clear levels of decision making and delegation of power to these neighbourhoods which will require all the statutory organisations involved to act on what neighbourhoods highlight needs to happen within their areas to provide greater resilience and enable communities to support each other better. Key to this will be a network of integrated, multiagency services and support arrangements, responsive to what people and families in the neighbourhoods require to remain strong and resilient. These networks will incorporate local organisations, groups, communities, primary and community services, children and family services, housing organisations, landlords, schools, youth clubs, mental health services, voluntary organisations, PCSOs, local fire officers and any other groups / organisations in the neighbourhood identified through mapping of the neighbourhood. A key part of our approach will be linking up the existing individual and organisations in the area who are providing support and contributing to the neighbourhood becoming safe and resilient. Local Area Coordinators, building on the current model already in place across Swansea and Neath Port Talbot, will be a key component of making these links, but these will be supplemented by integrating with a network of community connectors – people from local communities, community groups and voluntary organisations who can work together to ensure the best outcomes are delivered for the local population.

We will build on the existing network of network clusters, developing a single point of access for all issues, so reducing the need for people to navigate their ways through complex systems in order to get advice and support. We will ensure that all statutory services are provided on the basis of the neighbourhoods defined in this offer. We will also work to provide more specialist services in a more integrated way which will deliver integrated secondary health and other specialist care closer to our neighbourhoods.]

We plan to repurpose existing teams to support the “Whole System Approach” for example existing social work teams may be reorganised to provide support to the communities identified, by creating new integrated “place based” teams who support these communities from birth to end of life. In order to achieve this, we will require additional capacity while the changes to the culture of the organisations takes place.

Individuals will be supported by one worker who will ensure that all aspects of support they require are identified, followed through by the same person. This will support citizens in only having to tell their story once and only have a single point of contact throughout the assessment and support process. The worker will act as the problem solver for the citizen.

We will support local and grass root community organisations in order that they are sustainable and are actively supported by partner organisations, increasing and raising awareness of our assets in the community.

HOW WILL WE KNOW IF IT WORKS?

We will measure the impact on an individual and system wide basis for each of our two defined neighbourhood areas initially, using a single set of measures, agreed with our staff and the local populations. We have outlined some of the key measures we are likely to use to monitor changes as **Appendix C** but recognise that these will need to be further developed with communities to ensure they reflect the issues which matter to them.

We will also collect this data for the other areas within Swansea and Neath Port Talbot to compare and contrast benefits. To achieve this we will work with Swansea University to establish a baseline of key indicators from the outset, and where possible using already available data, such as from SAIL. We have close working relationships with Swansea University and would look to develop these in order to ensure we can maximise the impacts we are delivering and revise our input accordingly.

We will measure change and impact at 3/6 months; 1 year; 2 years etc., and report this openly to the public and the neighbourhoods so that we can jointly evaluate at Regional Partnership Board Level the effectiveness of changes made quickly and review where necessary.

The monitoring timetable is identified in the High Level Project Plan in **Appendix D.**

FUNDING & HIGH LEVEL PROJECT PLAN

We have outlined in **Appendix D** the costs to deliver the programme by quarter and a high level project plan which we believe we will need to make this proposal a reality.

These requirements will need refining as we implement in co-production with our neighbourhoods and will use this flexibly to respond to the asset development identified as part of this approach.

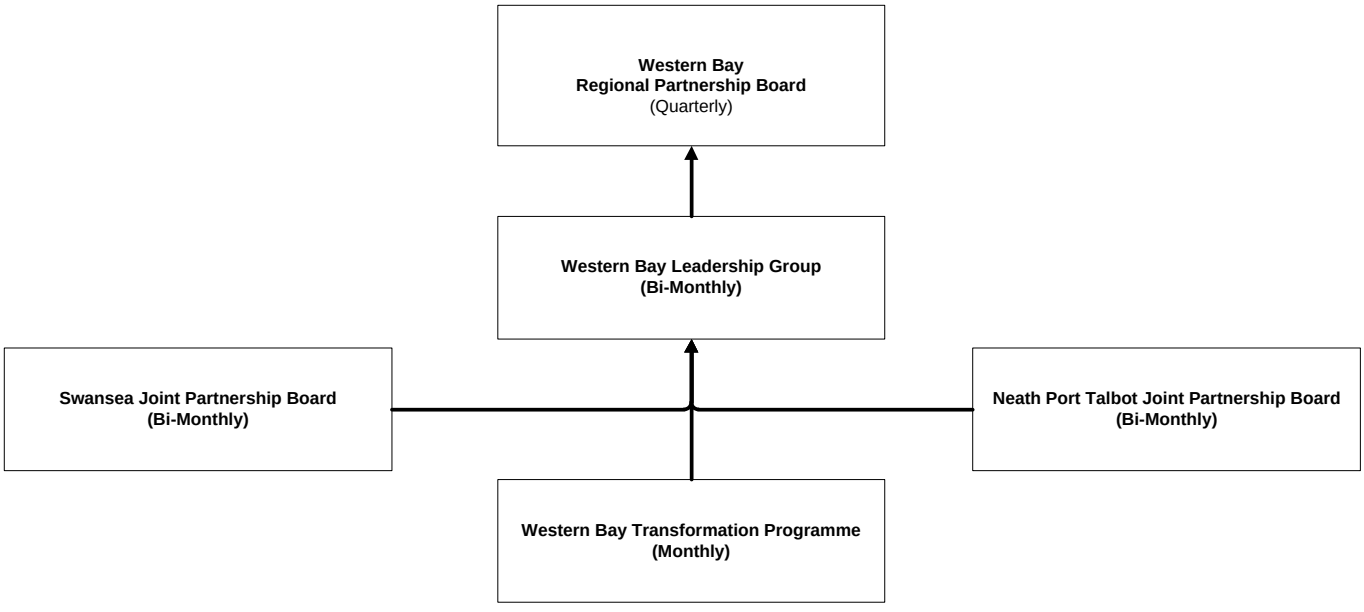
We will also want to work with Welsh Government and wider partners about how we can best ensure we use the resources identified to take forward the substantial culture change, capacity and skills building for individuals, workers and communities and coproduction which will be critical if we are to achieve such transformational change.

We have included funding for a dedicated team to lead this programme across the two areas identified, plus teams of workers (including those from the neighbourhoods) who will focus on transforming how we can support people and communities going forward.

Also included is funding for evaluation of the programme and running costs to enable staff to develop new services and ways of working which will be set up alongside existing services for a transition period, which in the longer term will allow existing services to be dismantled and funding freed up to transfer learning to new additional areas within Neath Port Talbot and Swansea.

GOVERNANCE

The New Western Bay "Our Neighbourhood Approach" will be governed though the existing Western Bay Arrangements. The programme will be managed with a Programme Lead and Project Implementation Managers who will report to the Regional Partnership Board.



The delivery of the Transformation Programme will be monitored and managed through the governance arrangements as described above. The Programme will also be controlled using usual project management tools and techniques for example Risk and Issue Logs, along with Quarterly Highlight reports to the Regional Partnership Board.

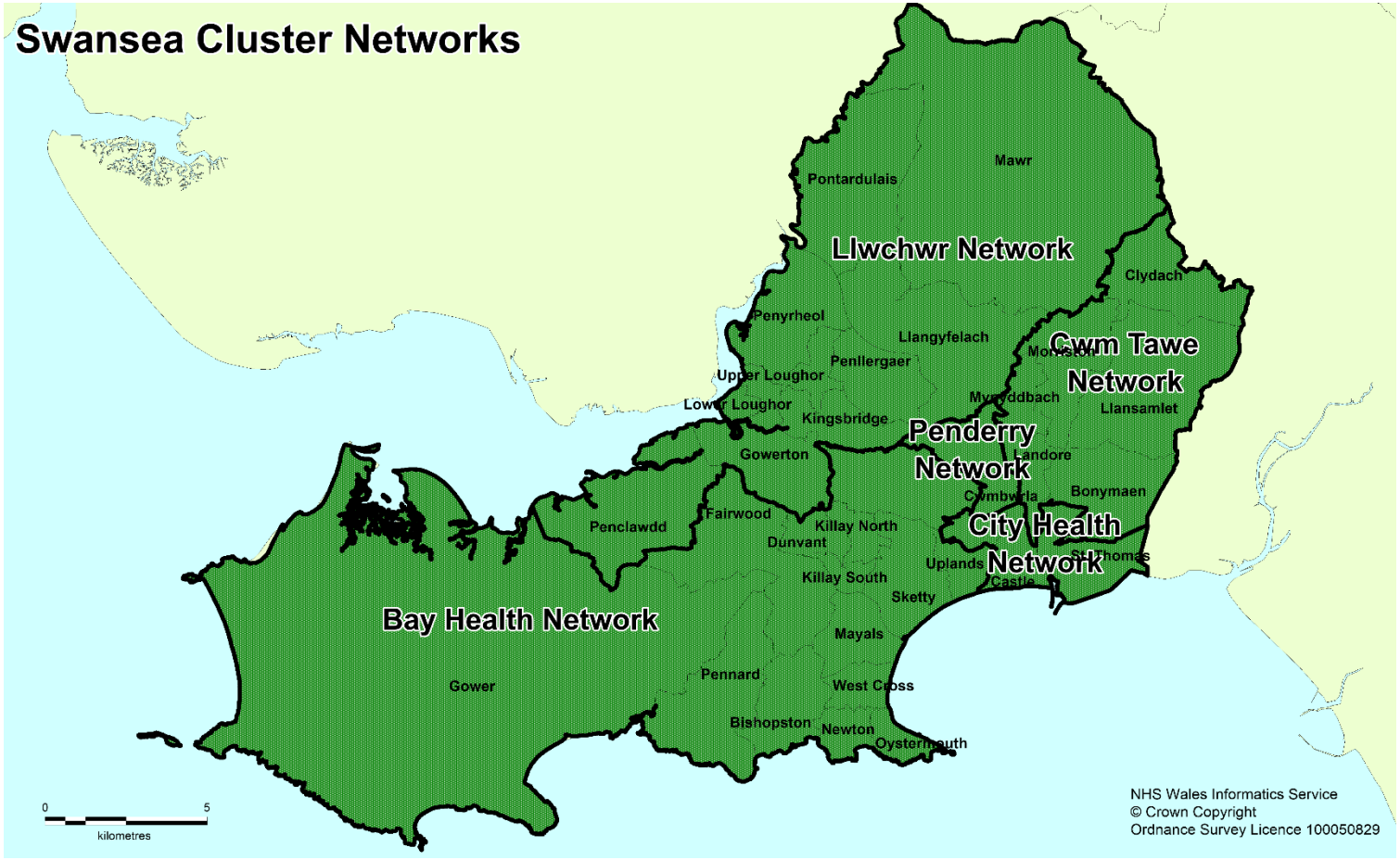
COMMUNICATIONS

A high level communications strategy has been developed and is outlined in **Appendix E.**

General Data Protection Regulation

Western Bay has been a successful partnership between Health, Social Care and the Third Sector for over 6 years and had been safely sharing information. We will ensure that any new information sharing as a result of "Our Neighbourhood Approach" is considered and an Information Sharing Protocol is developed to safeguard the data for all staff and citizens. We will ensure that the all information sharing complies with GDPR and the Data Protection Act 2018. Work is already underway to review our Wales Accord on the Sharing of Personal Information (WASPI) Agreements.

APPENDIX A –MAP AND DEMOGRAPHICS OF THE AREA'S TO BE TRANSFORMED



SWANSEA LOCALITY

The **Swansea Council North Hub** covers the areas of Cwmtawe Network and Llwchwr Network

The older people's mental health team are based in Garngoch and cover the whole of Swansea

CMHT areas 3 and 4 cover most of the Llwchwr and Cwmtawe Network:

Network	Population January 2017
Llwchwr Cluster Network	47,900
Cwmtawe Cluster Network	42,865
Total Registered Population	**91,865**

Llwchwr Cluster

The Llwchwr Cluster is one of five community network areas in the City and County of Swansea, covering the Llwchwr geographical area of the of the City incorporating Pontarddulais, Gorseinon, Gowerton and Penclawdd areas

The Llwchwr Cluster has a total of 47, 500 listed patients across 5 general practices, with individual practice list sizes ranging from between 4914 to 14089. The Cluster is formed of partners of GP practices, Community Health and Social Care Services, the Voluntary sector, Public Health Wales, and other primary and community services.

The Cluster has 7 dental practices, 13 pharmacies, 3 Opticians, 6 nursing homes and 23 schools.

The Cluster has particular strengths in engaging with patients in the development of health and social care services, through its Patient and Carer Participation Panel.

Llwchwr Network has:

- High numbers of Elderly population (10, 266 patients aged 65+ and a further 4698 patients aged 75+)
- High proportion of patients with asthma
- High numbers of Care Home patients
- Low student population
- Low ethnic minority patient numbers
- Low asylum seekers numbers
- The smallest percentage of patients in the 'most deprived' category of all Swansea clusters , and the third highest percentage of patients in the 'least deprived' category
- The highest percentage of patients living in areas classified as rural
- The second lowest rate of people who smoke in Swansea networks and is significantly lower than the health board average. The estimated

Cwmtawe Cluster Network

The Cwmtawe network based in Swansea is made up of three general practices working together with partners from social services, the voluntary sector, and the ABMU health board. Cwmtawe covers the area of Bonymaen, Clydach, Landore, Llansamlet, Morriston and Mynyddbach.

The Cluster currently has a total of 42865 listed patients, an increase of 141 on last year's figures. Individual practice list sizes range from between 6735 to 10807. Within its network area Cwmtawe has, 8 Dental Practices, 10 Pharmacies, 6 Nursing Homes, 4 opticians, 26 schools.

The cluster has a strong background in collaborative working and innovative thinking coupled with the ability to implement, review, evaluate and adapt. Some components of a transformed model are already in place. These include:

- There is a history of strong partnership working with the third sector leading to projects on falls prevention, and outreach by third sector organisations. The Council for Voluntary Services is a member of the cluster.
- The cluster is in discussion with the Local Authority on the development of a Clydach Community Hub, from which it is intended that local people will be able to access all Swansea Council services from October 2018 and will be a "digital gateway" for service users with low-level digital skills. There is also the possibility to access other partner organisations' services too, either digitally, or via volunteers. One aim of this is to improve community resilience.
- A range of cluster-based staff are in place namely a Cluster Pharmacist, Nurse and a Social Prescribing Link worker (employed through third sector). This work aligns to the Swansea PSB Wellbeing plans Cross Cutting Action – To work towards an integrated public services sector in Swansea by sharing resources, assets and expertise. The cluster commissions Children and Young People counselling services and are

number of smokers is 9,940 = 18.1% of the cluster population.

- There is a significant overlap of registered patients who live in adjacent geographical areas of Carmarthen

Below is an extract of the Disease Register relating to the cluster highlighting areas of significant variance or change (2017)

2017 Disease Register Totals					
Area		**Cancer**	**COPD**	**Dementia**	**Mental Health**
Health Board	**ABMU**	15,040 (2.7%)	12,212 (1.8%)	3,925 (0.7%)	5,955 (1.1%)
Local Authority Area	**Swansea**	6,620 (2.6%)	4,886 (1.9%)	1,734 (0.7%)	2,704 (1.1%)
Llwchwr Cluster	**Llwchwr**	1,404 (3%)	844 (2.2%)	352 (0.7%)	429 (1.1%)

- Relatively low (in ABMU) numbers of Emergency Dept. attendances and GP Out of Hours attendances
- Influenza vaccination uptake is high for 2-3 year olds (3rd highest in ABMU at 50.6%) but amongst the lowest for those under 65 years in clinical risk groups (41.5%) and for those aged 65+ (64.4%)
- The Cluster has strong performance (ranked first) comparatively in ABMU for uptake of childhood vaccinations until age 4 (e.g. 98.1% for 5 in 1, aged 1) however uptake rates decrease thereafter.
- Bowel Screening – 56.3% of those eligible were screened in 2016/17 (ABMU average of 53.2%), a slight decrease on 2015/16
- Breast Screening – 73.2% of those eligible were screened in 2016/17 (ABMU average of 73.5%)
- Cervical Screening – 79.6% of those eligible in 2016/17 (5 yr. rate/ABMU in the process appointing an Early Years worker.
- An integrated health and social care team serving the Cwmtawe cluster is based in Gorseinon Hospital and Clydach Primary Care Centre.
- All GP practices undertake clinical triage for same day requests for GP appointments.
- All GP practices have the same IM&T platform namely Vision and have invested in Vision 360. This facilitates the ability, with the patient's consent, through secure, remote access to view and edit clinical data away from the registered practice - and allows appointments to be booked by any clinicians or receptionist working in any of the cluster practices or venues.
- A cluster based INR service has been established.
- All community pharmacies deliver the minor ailments scheme.
- New models have been developed: The Cwmtawe Medical Group formed by the merger of three separate GP practices, has a wide range of professionals working within the practice.
- The cluster also recognises the importance of evaluation and review and contributing to the evidence base. Currently evaluation is being undertaken on the social prescribing model in conjunction with Community Action in Research and Policy (CARP collaborations), on the early years worker in conjunction with 1000 lives service improvement team and Swansea University, and a review of children and young people's mental health counselling has been completed to inform future service provision.
- Is planning for transformations within Primary Care e.g. Cwmtawe Cluster Whole System Approach "A Healthier Wales" bid.

Cwmtawe Network has:

- 8625 patients aged 65+ and a further 3831 patients aged 75+.
- Low student population

average of 76.1%)

- AAA Screening – 82.1 % of those eligible were screened in 2016/17 (81.9% ABMU average), an increase on 2015/16 and above the national target
- 2.99% percent of people over 65 are registered with their GP practice as having dementia
- The Cluster has the largest number of patients of with Dementia prescribed anti-psychotic medication (4.08%)
-

- Low ethnic minority patient numbers
- Low asylum seekers numbers
- Deprivation greater than Welsh Average and variable across the area. (Cwmtawe has 23% of patients living in the most deprived fifth of areas in Wales, compared to the Wales average of 20% using Welsh Index of Multiple Deprivation 2017)

The population of Cwmtawe exhibits a wide range of health and well-being issues:

- Swansea has 25.9% of 4-5 year olds that are overweight or obese. There are 56% of adults (aged 16+) who are also classed as overweight or obese.
- Below is an extract of the Disease Register relating to the cluster highlighting areas of significant variance or change (2017)

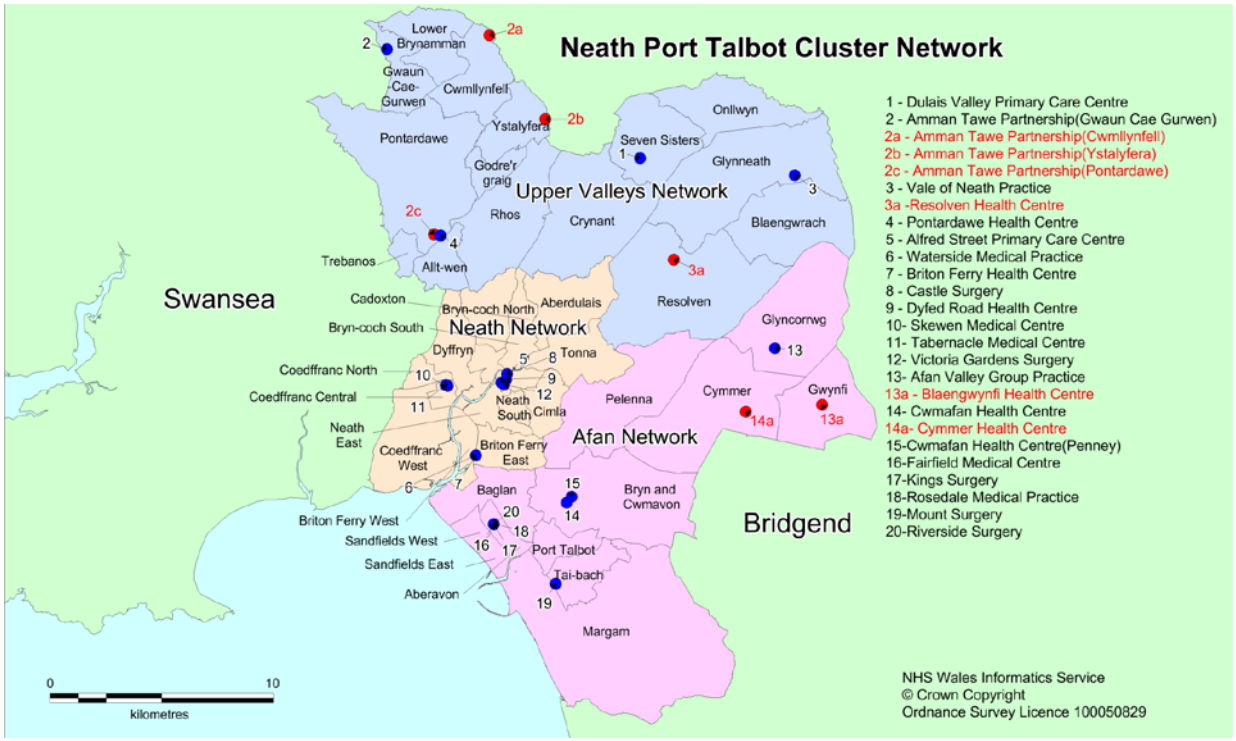
Disease Register	Cwmtawe Register Total 2017 (%)	Swansea %	ABMU %
Atrial Fibrillation	933(2.2%)	2.2%	2.3%
Cancer	1121(2.6%)	6620 (2.7%)	15040 (2.9%)
Dementia (2nd lowest numbers in Swansea)	266 (0.6%)	1734 (0.7%)	3925 (0.7%)
Mental Health	397 (0.9%)	2704 (1.1%)	5955 (1.1%)
Obesity (3rd highest % in ABMU, highest # in ABMU	5034 (11.7%)	21608 (9.0%)	54284 (10.09%)
Diabetes	2676 (6.2%)	14181 (5.6%)	33851 (6.2%)
Hypertension (2nd highest % in Swansea)	6326 (14.81%)	34593 (13.1%)	84010 (15.3%)
Heart Failure	499 (1.2%)	2559 (1.0%)	5812 (1.1%)
COPD (lowest number/cluster in	817 (1.9%)	4886 (1.9%)	12212 (2.2%)

Swansea)			
Chronic Kidney Disease	1551 (3.6%)	7459 (3.0%)	21487 (3.9%)

- Smoking remains the biggest cause of premature death and the Welsh Government has also set a target to reduce the prevalence of smoking to 16% by 2020, with an interim 2016 target of 20%. Cwmtawe has;
  - An estimated number of smokers of 7,390 = 18.1% of the cluster population
  - The number of smokers who accessed Stop Smoking Wales from the cluster was 207
  - The number of smokers who accessed the Level 3 pharmacy service from the cluster was 76
- Bowel Screening – 54% of those eligible were screened in 2016/17 (ABMU average of 53.2%), a slight decrease on 2015/16
- Breast screening- 73.5% uptake of those eligible were screened in 2016/17 (ABMU average of 73.5%)
- AAA screening – 81.4% uptake of those eligible were screened in 2016/17 (81.9% ABMU average), an increase on 2015/16 and above the national target
- Cervical screening- 78.1% uptake (5 yr. rate/ABMU rate of 76.1%)

- Flu Immunisation 11th April 2017
  - At-risk under 65s: 37.4% - Lowest uptake out of Swansea Clusters. The target is 55%.
  - Over 65s: 61% - the lowest uptake out of Swansea Clusters. The target is 55%.
  - For 2-3 year olds the take-up was 42.2%, whilst above the Swansea figures, it is still well below 75%
- The Cluster has the joint second largest number of patients of with Dementia prescribed anti-psychotic medication (3.64%)
  - 2.68% percent of people over 65 are registered with their GP practice as having dementia

NEATH PORT TALBOT LOCALITY



Network	Population January 2017
Neath Cluster	56,126
Total Registered Population	**56,126**

Briton Ferry East, West & Neath East

Number cases open to adult services	Number of cases open to children's services
473	464

This is a densely populated urban area served by five Ward Councillors. The area has high levels of poverty, deprivation and unemployment. Key presenting issues across these localities are; substance misuse and associated litter, accommodation and private landlords, community safety, community transport. There is fragmentation of key community groups based around competition rather than collaboration. However, there are also resources to work with in the forms of individuals, buildings and voluntary organisations. If supported effectively these represent a longer term opportunity of place based information, assistance and support to citizens in a sustainable and co-productive manner.

Neath Cluster consists of the following GP practices:

GP Practice	Practice Registers Population July 2018
Alfred Street PCC	2494
Waterside Med Centre	5507
Briton Ferry Health Centre	6189
Castle Surgery	10139
Dyfed Road Health Centre	9371
Skewen Medical Centre	8723
Tabernacle Medical Centre	5110
Victoria Gardens Surgery	8592
Total Registered Population	**56,126**

Demography

- Between 2017 and 2018 the overall cluster list size has **decreased by 0.7%.** However, this can be attributed to out of area patients from one practice being transferred to local surgeries. Some practices have seen a small variation in list sizes due to movement of patients within the cluster.
- A few practice have also seen an increased patient base due to new local housing developments.
- The cluster has an increasing elderly population with 22.2% of the registered population 65+ and 10.1% over 75 (both demographics are over the ABMU average of 19.7% and 8.9% respectively)
- There are high levels of deprivation found in the Neath Cluster, which is mainly an urban population with high levels of low income and unemployment.

Needs Profile The Cluster:

- Neath Cluster has a high proportion of smokers 21.2% (2016/17 data and needs to increase referrals to smoking cessation services. Since April 2018, **Community Help Me Quit Services have treated 76 individuals** and **44 individuals have subsequently quit smoking.**
- During the 2017 Flu Season vaccination uptake for those 65+ in the Neath Cluster was **66.5%,** and under 65 in clinical risk groups **47%** as at April 2018. The Cluster are developing a project to address this poor uptake in 2018.
- In Neath Cluster only **89.9% of children** have received their 4 in 1 pre-school booster (Hib/Men C booster and second MMR) by 4 years of age with only, **95.4%** of children aged 2 having had an MMR vaccine based **on July 2107 – June 2018 data**.
- Neath Cluster has a high prevalence of obesity, **62% of adults and 26.8% of under 5s in NPT,** coupled with low levels of physical activity and poor rates of referrals, and patient uptake of the National Exercise Referrals Scheme (NERS).
- Neath Cluster has more patients with mental health issues (including young people) with depression or anxiety than the ABMU average.
- The cluster has poor uptake of cervical screening **77% (April 2017)**, though a good uptake of AAA and breast screening, with Bowel Screening uptake levels at **74.5%.** (November 2017 data)

Access Arrangements

- **6 out of the 8** Cluster practices are offering a full telephone first model, with same day appointments for all patients who need to see a GP. 2 practices offer a mixed approach to telephone first and pre-bookable appointments.
- The Cluster will continue to develop the Neath Primary Care Hub of shared services and professionals including Physiotherapists, Mental Health Support Worker, Pharmacist and Audiologists to support the management of patient demand.

Service Provision

- Cluster practices continue to provide enhanced services to patients and continue to participate in the pre-diabetes screening project. The cluster will develop clear protocols and pathways for referrals
- Practices also have identified the need to work more closely with the Third Sector to signpost patients appropriately including the joint development of a shared referral platform to launch during 2018.

- The cluster will engage more closely with patients as well as other primary care, social services etc. to meet the needs of the community through a series of engagement events in association with third sector partners. The first event held in central Neath in November 2017.

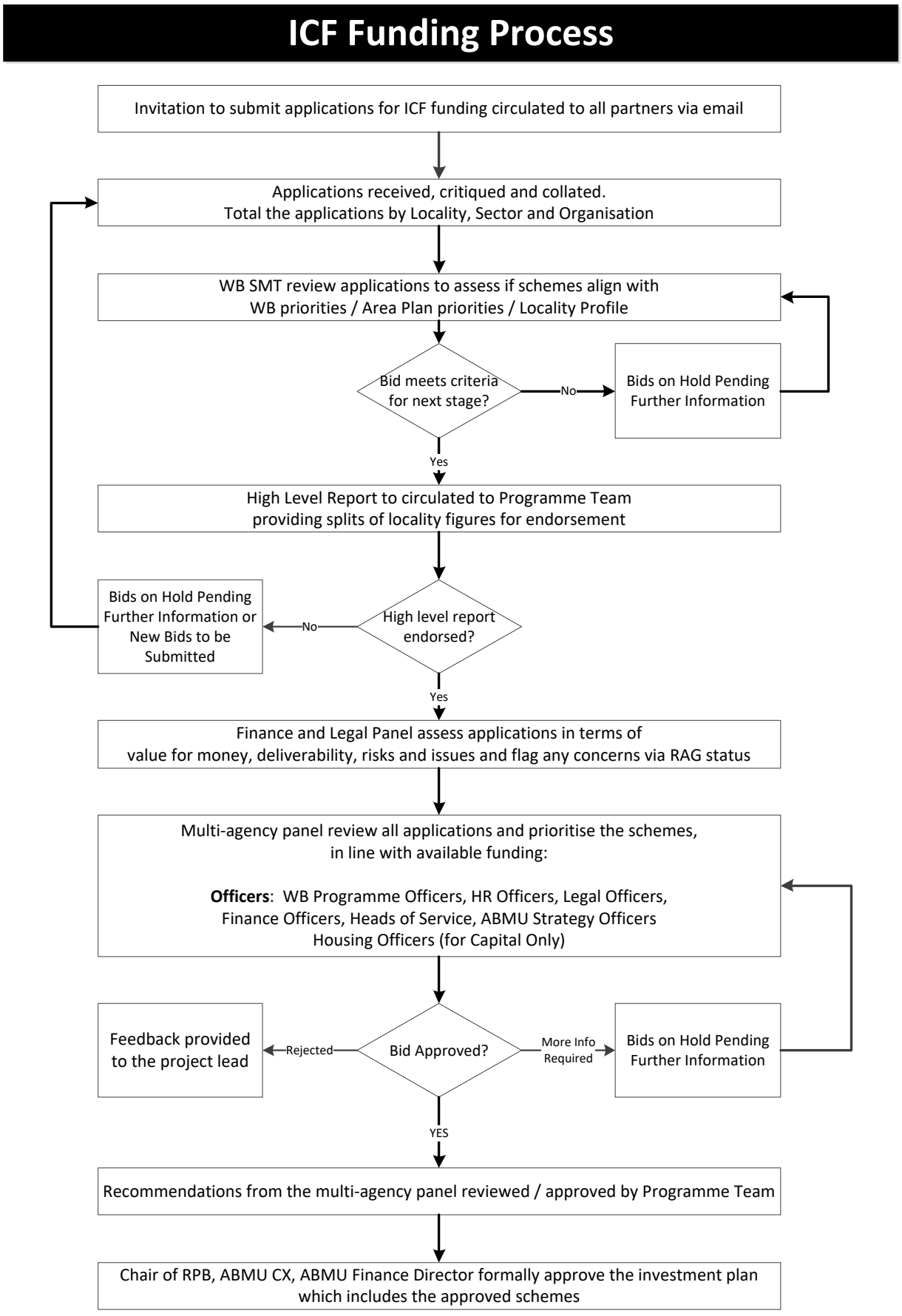
Education & Training

- A Cluster skills and needs analysis of the Cluster HCSW was undertaken and a programme of training has been delivered to upskill identified staff.

Workforce

- Sustainability: Recruitment of GP's, retirement, retention of staff, the ability to attract locums remains an issue. The cluster has assessed the workforce skill mix and the development of multidisciplinary teams to meet the needs of patients and support primary care services is progressing as part of the Transformational Model of Primary Care.
- The Cluster is engaged in the GP Fellowship Scheme to support the recruitment of GP's to the area.

APPENDIX B – Example of the Process to Approve Commissioned Projects across Western Bay



APPENDIX C - KEY OUTCOME MEASURES TO MONITOR PROGRESS

All comparators below should be broken down by Network Clusters across the "New Western Bay"

1. Current population numbers for people residing within each cluster across Swansea and Neath Port Talbot

2. Reduced number of new admissions of looked after children.

Baseline Comparators:

a. Number of new admissions for looked after children broken down by the clusters since 2015

b. Length of stay for looked after children broken down by the clusters since 2015

Measures after Implementation

a. Number of new admissions for looked after children broken down by the clusters monthly from April 2019

b. Length of stay for looked after children broken down by the clusters monthly from April 2019

3. Reduced number of younger adults with a learning difficulty entering supported accommodation or residential care.

Baseline Comparators:

a. Number of new admissions for younger adults with a learning difficulty entering supported accommodation or residential care broken down by the clusters annually since 2015

b. Length of stay for younger adults with a learning difficulty entering supported accommodation or residential care broken down by the clusters annually since 2015

Measures after Implementation

a. Number of new admissions for younger adults with a learning difficulty entering supported accommodation or residential care broken down by the clusters monthly from April 2019

b. Length of stay for younger adults with a learning difficulty entering supported accommodation or residential care broken down by the clusters monthly from April 2019

4. Reduced number of adults across all cohorts requiring new packages of domiciliary care.

Baseline Comparators:

a. Number of individuals requiring new packages of domiciliary care broken down by the clusters annually since 2015

b. Length of time individuals have received packages of domiciliary care broken down by the clusters annually since 2015

c. Total number of hours of domiciliary care provided broken down by the clusters annually since 2015

Measures after Implementation

a. Number of individuals requiring new packages of domiciliary care broken down by the clusters from April 2019

b. Length of time individuals have received packages of domiciliary care broken down by the clusters monthly from April 2019

c. Total number of hours of domiciliary care provided broken down by the clusters monthly from April 2019.

5. Reduced number of older people being admitted to residential or nursing care.

Baseline Comparators:

a. Number of older people being admitted to residential or nursing care entering supported accommodation or residential care broken down by the clusters annually since 2015

b. Length of stay for older people being admitted to residential or nursing care entering supported accommodation or residential broken down by the clusters annually since 2015

Measures after Implementation

a. Number of older people being admitted to residential or nursing care entering supported accommodation or residential care broken down by the clusters monthly from April 2019

b. Length of stay for older people being admitted to residential or nursing care entering supported accommodation or residential broken down by the clusters monthly from April 2019

6. Increased Service Uptake for example; Screening, Immunisation

7. Decrease in Smoking

8. Lower levels of Obesity

9. Number of Recipients of Services

10. Number of Agencies involved in partnership "Place Based Approach"

11. Increase in the Number of Community Champions identified

12. Increase in the Number of Community Services

13. Increase in Citizen Engagement

14. Reduced DTOC

15. Reduced A&E Admissions

16. Reduced Hospital Admissions

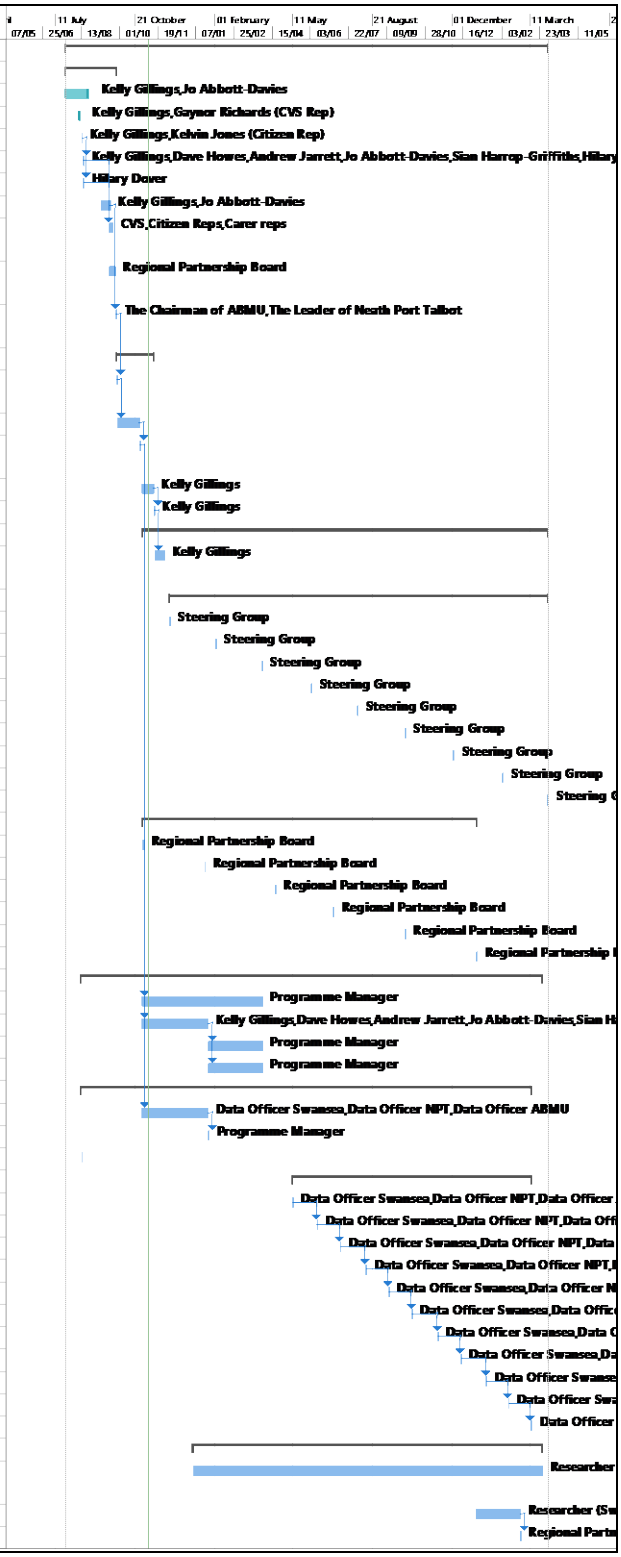
17. Reduced dependencies on GP's

18. Reduced demand on Prescription Medications

APPENDIX D – FUNDING ALLOCATIONS & HIGH LEVEL PROJECT PLAN

Financial Years and Quarters		2018/2019			2019/2020					
		Q3	Q4	Total 18/19	Q1	Q2	Q3	Q4	Total 19/20	Total Spend
Community Asset Building	**£1,800,000**									
Building resilience in communities through enhanced family and individual support and investing in early intervention and prevention.	£1,800,000		£200,000	£200,000	£300,000	£300,000	£500,000	£500,000	£1,600,000	**£1,800,000**
Project Management	**£282,000**	£47,000	£47,000	£94,000	£47,000	£47,000	£47,000	£47,000	£188,000	**£282,000**
Training, Backfill for Statutory Workers	**£2,998,000**									
Social Workers	£1,200,000	£200,000	£200,000	£400,000	£200,000	£200,000	£200,000	£200,000	£800,000	**£1,200,000**
Mental Health Workers	£468,000	£78,000	£78,000	£156,000	£78,000	£78,000	£78,000	£78,000	£312,000	**£468,000**
Community Services	£1,000,000	£165,000	£165,000	£330,000	£167,500	£167,500	£167,500	£167,500	£670,000	**£1,000,000**
Substance Misuse Workers	£330,000	£55,000	£55,000	£110,000	£55,000	£55,000	£55,000	£55,000	£220,000	**£330,000**
Innovation, Technology and Infrastructure	**£240,840**			£0	£100,000	£100,000	£40,840		£240,840	**£240,840**
Communications, Engagement and Coproduction	**£100,000**			£0	£25,000	£25,000	£25,000	£25,000	£100,000	**£100,000**
Facilities Development	**£500,000**			£0	£125,000	£125,000	£125,000	£125,000	£500,000	**£500,000**
Total	**£5,920,840**	£592,000	£792,000	£1,384,000	£1,144,500	£1,144,500	£1,285,340	£1,244,500	£4,818,840	**£5,920,840**
			£1,384,000					£4,818,840		

ID	Task Name	Start	Finish
1	**Transformation Fund 2018-2020**	**24 July 2018**	**01 April 2020**
2	**Project Initiation**	**24 July 2018**	**26 September 2018**
3	Develop Expression of Interest	24 July 2018	20 August 2018
4	Review with CVS Rep	10 August 2018	10 August 2018
5	Review with Citizen Panel Rep	13 August 2018	13 August 2018
6	Review with Steering Group	15 August 2018	15 August 2018
7	Review with Area Clinical Director	15 August 2018	15 August 2018
8	Final Document Completion	07 September 2018	18 September 2018
9	Share Document with CVS and Citizens Panel for Comment	17 September 2018	21 September 2018
10	Share Document with Members of RPB for Final Review and Sign Off	17 September 2018	24 September 2018
11	Regional Partnership Board Sign Off	26 September 2018	26 September 2018
12	**Funding Approval**	**27 September 2018**	**13 November 2018**
13	Expression of Interest Forwarded to WG	27 September 2018	27 September 2018
14	WG Transformation Board to Review	28 September 2018	25 October 2018
15	Formal Confirmation Received from WG for Bid Approval	26 October 2018	26 October 2018
16	Update Funding Bid with Additional Information	29 October 2018	12 November 2018
17	Formal Confirmation Received from WG for Bid Approval	13 November 2018	13 November 2018
18	**Governance**	**30 October 2018**	**01 April 2020**
19	Ensure Programme built into the "New Western Bay" Governance to RPB	14 November 2018	27 November 2018
20	**Steering Group Meetings**	**03 December 2018**	**01 April 2020**
21	December	03 December 2018	03 December 2018
22	February	01 February 2019	01 February 2019
23	April	01 April 2019	01 April 2019
24	June	03 June 2019	03 June 2019
25	August	01 August 2019	01 August 2019
26	October	01 October 2019	01 October 2019
27	December	02 December 2019	02 December 2019
28	February	03 February 2020	03 February 2020
29	April 2020	01 April 2020	01 April 2020
30	**Report to RPB**	**30 October 2018**	**01 January 2020**
31	October	30 October 2018	30 October 2018
32	January	17 January 2019	17 January 2019
33	April	18 April 2019	18 April 2019
34	July	01 July 2019	01 July 2019
35	October	01 October 2019	01 October 2019
36	January 2020	01 January 2020	01 January 2020
37	**Development of Project**	**13 August 2018**	**25 March 2020**
38	Recruitment of Posts	29 October 2018	01 April 2019
39	Accommodation Selection	29 October 2018	21 January 2019
40	Accommodation Refurbishment	22 January 2019	01 April 2019
41	Purchase of Equipment	22 January 2019	01 April 2019
42	**Key Outcome Measures**	**13 August 2018**	**11 March 2020**
43	Baseline Measures - Data Collected	29 October 2018	21 January 2019
44	Develop Measure Working Group	22 January 2019	22 January 2019
45	Working Group to agree Outcome Measure Targets	13 August 2018	13 August 2018
46	**Collect Monthly Measures**	**10 May 2019**	**11 March 2020**
47	Collect Monthly Measure Data - April	10 May 2019	10 May 2019
48	Collect Monthly Measure Data - May	10 June 2019	10 June 2019
49	Collect Monthly Measure Data - June	10 July 2019	10 July 2019
50	Collect Monthly Measure Data - July	12 August 2019	12 August 2019
51	Collect Monthly Measure Data - August	10 September 2019	10 September 2019
52	Collect Monthly Measure Data - September	10 October 2019	10 October 2019
53	Collect Monthly Measure Data - October	12 November 2019	12 November 2019
54	Collect Monthly Measure Data - November	12 December 2019	12 December 2019
55	Collect Monthly Measure Data - December	13 January 2020	13 January 2020
56	Collect Monthly Measure Data - January	11 February 2020	11 February 2020
57	Collect Monthly Measure Data - February	11 March 2020	11 March 2020
58	**Evaluation of Programme**	**03 January 2019**	**25 March 2020**
59	Ongoing Evaluation of the Measures and Effectiveness of the Programme	03 January 2019	25 March 2020
60	Evaluation of Programme - Final Report	01 January 2020	25 February 2020
61	Decision to Repeat the Programme for 2nd Wave	26 February 2020	26 February 2020



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PENDIX E – High Level

Communications Strategy

"New Western Bay" Regional Offer

Draft Communications Strategy

Background and Context:

Since 2012, Abertawe Bro Morgannwg University (ABMU) Health Board, Bridgend County Borough Council, Neath Port Talbot County Borough Council and Swansea Council have been working collaboratively under the auspices of the Western Bay Health and Social Care Programme. The Programme seeks to drive the strategic change that is needed to realise the Social Services and Well-being (Wales) Act's vision of productive partnership working and greater 'voice and control' for those accessing health and social care services.

This is a time of significant change for Western Bay. The Health Board boundary change affecting the Bridgend area will be enacted in April 2019. The region will undergo a geographical change, as well as a radical culture shift in terms of how services are delivered across the "New Western Bay" footprint.

The focus going forward will be on seamless integration of health and social care services using innovative approaches designed to empower people and communities to take control of their circumstances (in line with the 'national design principles' highlighted in the Welsh Government's 'A Healthier Wales – Our Plan for Health and Social Care').

We are moving towards new models of prevention-focused, asset-based care that will build resilience and strengthen community connections. This will include supporting people to manage their own health and personal well-being, thus minimising the reliance on traditional hospital services.

The intention in the first instance is to concentrate on two specific areas - the North Hub which includes both the Llwchwr and Cwmtawe cluster areas within Swansea, and the Briton Ferry area within Neath Port Talbot. We will work with our partners at Swansea University to develop robust indicators to measure the initiative's impact, and the evaluation's findings will inform subsequent phases of implementation as the approach is scaled up across the region.

Stakeholders:

The stakeholder scope is both varied and broad, therefore a thorough and targeted approach to communications is vital.

The following groups have been identified as key audiences:

- Citizens
- Service providers (General Practitioners, Social Services staff, Health Board staff, Local Area Coordinators, Dentists, Pharmacists, Audiologists, Ophthalmologists, Hospital Based Staff, Out of Hours Services)
- Third sector organisations
- Service users and prospective service users
- Families and carers of service users
- Those involved in the governance of the initiative (Regional Partnership Board, Public Service Board)
- Community groups and organisations
- Housing organisations and landlords
- Schools and colleges
- Youth Groups
- Other public-facing organisations (e.g. Fire Service, South Wales Police, Royal Mail employees)
- Welsh Government
- Private Sectors
- Public Health
- Local Businesses
- Councillors and Assembly Members
- Transport Providers
- Media Organisations

This list will grow and evolve as the project progresses. The phased approach to implementation will allow us to revise the list over time and ensure the stakeholder reach is as wide and inclusive as possible.

Communications Objectives:

Communications objectives for the proposed initiative include:

- To utilise a variety of communications methods to ensure stakeholders understand the ethos of the new model, and the benefits of this transformative approach
- To ensure those responsible for delivering services are aware of asset-based, community-focused solutions and are supported to embed/apply them to their working practices
- To ensure messages relating to funding are communicated on an open, transparent and collaborative basis.

Key Messages:

Key messages will include:

- We are trialling a new model of care that aims to bring people and communities closer together
- Services will become more joined-up and 'person-centred'. When someone is in need of help, services will work with them and their loved ones to determine 'what matters' to them and what needs to happen to ensure they get the right support
- More care and support services will be delivered outside of a traditional hospital setting. This will help reduce the pressure on services and allow people to be treated in their homes, or in the community
- Co-production will be a key element of this new approach. All stakeholders will have a valuable role to play in identifying and maximising assets
- Strengthening community networks will create sustainable support systems and help build trust between service providers, communities and individuals
- We will seamlessly integrate care and support by pooling budgets and resources (staff, assets) on a locality basis.

A more detailed timetable will be devised to ensure communications activities are as relevant and timely as possible.

Methods of Communication:

The current suite of communications channels includes:

- Western Bay Programme newsletter - circulated on a quarterly basis
- Bilingual Western Bay Programme website - www.westernbay.org.uk
- Western Bay TV – You Tube channel.
- Western Bay constituent partner organisations' websites (internal and external pages)
- Social media accounts of Western Bay constituent partner organisations
- Newsletters and bulletins compiled and published by Western Bay constituent partner organisations (aimed at internal and external audiences)
- Local media outlets (Media Wales publications, etc.).
- Face to Face Presentations
- Briefings
- Public Meetings
- Drop in Meetings

Communications Action Plan:

Further detail to be included in due course.

Activity	Description	Lead	Timescale

Stakeholder mapping exercise	More detailed analysis of stakeholders affected by/involved in the initiative	TBC	TBC
Plan for co-productive approach to communications	Input required from citizens and other stakeholders to ensure communications activities are meaningful and effective	TBC	TBC

If you require any further information, please contact the Western Bay Programme Office via email at western.bay@swansea.gov.uk or telephone 01792 633805.

www.westernbay.org.uk

Appendix B

CWMTAWE CLUSTER
WHOLE SYSTEM APPROACH

‘A HEALTHIER WALES’

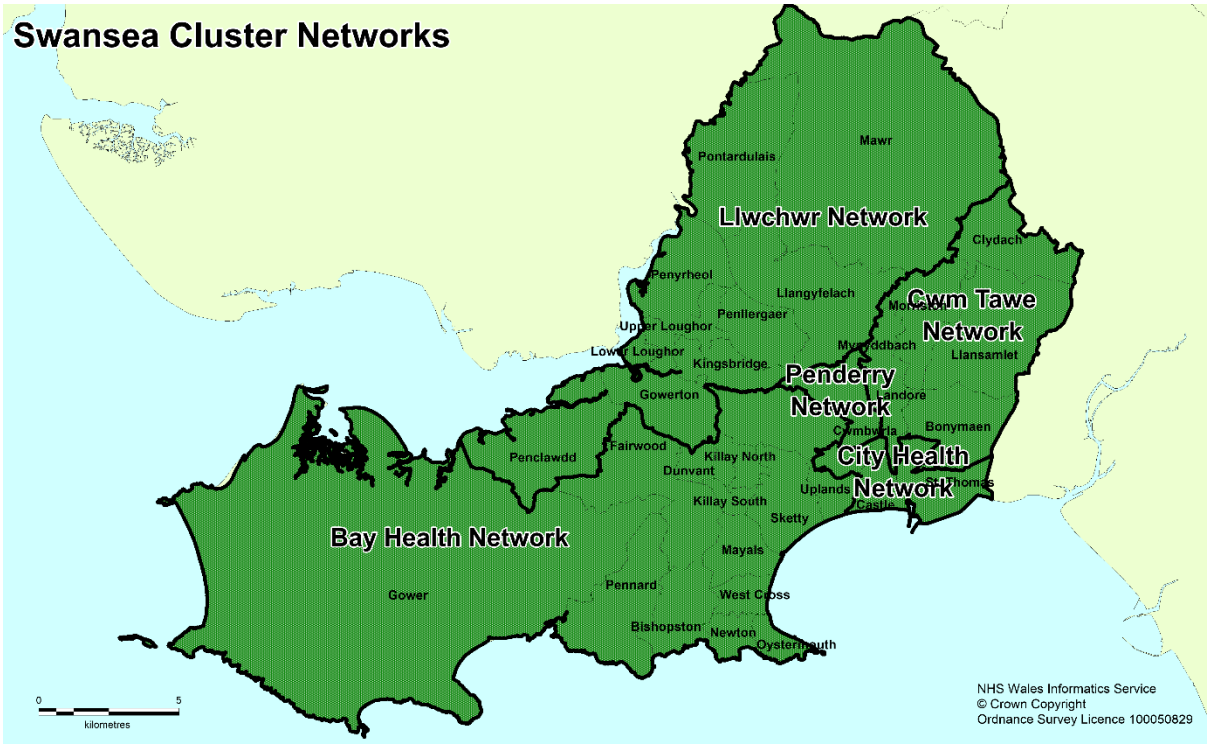
CWMTAWE CLUSTER WHOLE SYSTEM APPROACH

INTRODUCTION

In light of the publication of 'A Healthier Wales' the Welsh Government plan for health and social care, it is proposed Cwmtawe cluster network could provide an ideal test ground for a transformed model of a cluster led, integrated health and social care system, to meet the needs of the cluster population of circa 44,000 patients.

BACKGROUND

Cwmtawe cluster covers the geographical area of Clydach, Morriston, and Llansamlet. The cluster network is made up of representatives from Swansea Council for Voluntary Services, GP practices, integrated health & social care team managers. The cluster meets regularly, has terms of reference in place, and in common with other clusters in Wales has developed a three-year plan setting out the aims to improve health and well- being. The cluster has investment funds allocated by Welsh Government (via the Health Board) of £130k and an additional £42k was provided through the Health Board Prescribing Management Plus scheme. Building upon collaborative cluster working, three of the five GP practices within the cluster have now formally merged.



CURRENT SERVICE PROVISION

The cluster has a strong background in collaborative working and innovative thinking coupled with the ability to implement, review, evaluate and adapt. Some components of a transformed model are already in place. These include:

- There is a history of strong partnership working with the third sector leading to projects on falls prevention, and outreach by third sector organisations. The Council for Voluntary Services is a member of the cluster.
- The cluster, in discussion with the Local Authority, has been involved in the development of a Clydach Community Hub, from which it is intended that local people will be able to access all Swansea Council services. The Hub was launched in November 2018 and will be a "digital gateway" for service users with low-level digital skills. There is also the possibility to access other partner organisations' services too, either digitally, or via volunteers. One aim of this is to improve community resilience.
- A range of cluster-based staff are in place namely a Cluster Pharmacist, Nurse and a Social Prescribing Link worker (employed through third sector). This work aligns to the Swansea PSB Wellbeing plans Cross Cutting Action – To work towards an integrated public services sector in Swansea by sharing resources, assets and expertise. The cluster commissions Children and Young People counselling services and are in the process appointing an Early Years worker.
- An integrated health and social care team serving the Cwmtawe cluster is based in Gorseinon Hospital and Clydach Primary Care Centre.
- All GP practices undertake clinical triage for same day requests for GP appointments.
- All GP practices have the same IM&T platform namely Vision and have invested in Vision 360. This facilitates the ability, with the patient's consent, through secure, remote access to view and edit clinical data away from the registered practice - and allows appointments to be booked by any clinicians or receptionist working in any of the cluster practices or venues.
- A cluster based INR service has been established.
- All community pharmacies deliver the minor ailments scheme.

The Cwmtawe cluster has a strong background of focussing on the social determinants of health. Citizen Advice Bureau is already outreaching to work with the population to meet the needs of patients. A survey undertaken by the cluster with patients (167 respondents) explored what would be most helpful to assist in improving health and well-being. As a result, the cluster have appointed a social prescribing link worker and are in the process of establishing a social enterprise for well-being. This has attracted positive comments from service users (captured below) and over 70,000 Facebook hits. This focus on the social determinants of health supports community resilience.

GP Surgeries ar
prescribing gardening

- ✓ New models have been developed: The Cwmtawe Medical Group formed by the planned merger of three separate GP practices, has a wide range of professionals working within the practice. This includes access to 11 doctors, 2 nurse practitioners, 10 nurses, a mental health liaison worker, a paramedic, physiotherapist, audiologist, and practice pharmacists. The Cwmtawe Medical Group covers approximately 27,000 patients (60% population cluster) and is now the largest practice in Wales.

Practices merger brings extra services t

- ✓ The cluster also recognises the importance of evaluation and review and contributing to the evidence base. Currently evaluation is being undertaken on the social prescribing model in conjunction with Community Action in Research and Policy (CARP collaborations), on the early years worker in conjunction with 1000 lives service improvement team and Swansea University, and a review of children and young people's mental health counselling is underway to inform future service provision.

INTEGRATED WHOLE SYSTEM WORKING – FUTURE VISION

The vision is to **'achieve a transformed model of a cluster led integrated health and social care system for the cluster population'**. This aligns well with the Regional Partnership Board action plan. It also aligns with key objectives within the Swansea Public Services Board Wellbeing Plan.

The **overall strategic aims** would be to:

- **Improve wellbeing across the age spectrum.** There would be a key focus on facilitating self -care and building community resilience. There would also be a key focus on the **earliest years** and **young carers and mental well being.**

  Swansea Wellbeing plan objective:
  - To ensure children have the best start in life to be the best that they can be.

- **Co-ordinate services to maximise wellbeing, independence and care closer to home.** This would include Cwmtawe Cluster Network having control to design, co-ordinate and implement services in partnership with the community that effectively meet patient and carer need. There would be a particular focus on **older people** in relation to integrated services trying out new models of care closer to home and reducing unscheduled admissions.

  Swansea Wellbeing plan objective:
  - Live well, age well, to make Swansea a great place to live and age well.

- **Test out the vision and aims within the ten-year plan** and to implement components of the overall model proving proof of concept, and an ability to evaluate and redesign.

Preliminary discussions have identified the following priority areas for the cluster to move closer towards the transformed model. These take into account **the quadruple aim** and the **ten design principles:-**

Quadruple Aim/ Transformed model of care components	Priority Area
Improved population health and well-being	Establish social enterprise for wellbeing and social prescribing which can attract resources Establish a evidence based model of community involvement drawing on experience in Frome/ Wigan Pro- active communication campaign on new model for patients, carers and workforce Design of interactive co –design, engagement and feedback mechanisms for cluster population (focus on digital) Establish Local Area Coordination Increase support for young carers Enhanced nursing provision to increase vaccination and immunisations and an enhanced preventative approach and to enhance cluster led chronic conditions management.
Better Quality And More Accessible health and social care services Strong, stable primary care / cluster based working / care closer to home	Further expand the MDT based on (Cwmtawe Medical Group) to cover all practices within the cluster to facilitate more sustainable GP workforce and care closer to home Strengthening the ability for prompt assessment of mental health problems and enhancing the ability to provide speedy low intensity interventions in line with MATRICS Include additional clinical capacity/ sessions to facilitate a rebalanced clinical model across the whole cluster from traditional GP partnership model to a specialist generalist approach (RoundHouse model) with senior experienced GPs leading the expanded MDT, including complex case management, clinical mentorship and ensuring robust clinical governance. Establishment community phlebotomy service Establish cluster based Outpatient clinics to deliver care closer to home (initially Rheumatology and Physiotherapy) Acute clinical outreach and response team becoming part of the cluster workforce serving the cluster population to provide a key focus on reducing unscheduled care Enhanced eye check service post stroke

	Increased Speech and Language Therapy - piloting talking clinics working collaboratively with education to ensure best start in life
Higher Value health and social care	Dedicated clinical leadership capacity for pathway and service redesign Evaluation and continual review Enhanced eye check service post stroke Model of enhanced Diabetic Care at cluster level based on Tower Hamlet approach Enhanced cluster based oral health project focusing on older people and other groups.
A motivated and sustainable health and social care workforce	Clinical Leadership Workforce development /Training – workforce optimisation Repeat Prescribing Ordering Hub Equipment

The areas identified through preliminary discussion are covered in more detail in the attached Appendices. To ensure successful implementation, additional clinical leadership and clinical capacity for service transformation would be needed.

Appendix One shows **the indicative costs** between 18/19 and 19/20
Appendix Two shows **the fit with the transformed model of primary care** (along with services already in place)
Appendix Three shows an initial mapping against the **ten design principles**
Appendix Four shows the **expected benefits and outcome measurements.**

In addition, the cluster will explore with partners areas to **strengthen social care capacity** (within the existing integrated team), **end of life care** and **services for those with dementia.** The vision for cluster based end of life care is an enhanced fully co-ordinated service for end of life which incorporates a holistic model of care by specialist GPs, Pharmacist, Nurses, with access to the latest equipment and telehealth facilities - facilitating more patients to die in the place of their choosing.

To further improve community resilience, the cluster will also explore greater links between health and housing, the use of assistive technology and closer working with housing associations in the area.

CLINICAL LEADERSHIP - TRANSFORMATIONAL CAPACITY

The transformation would consist of several interrelated projects of service change that would be formally managed. **A Cluster Clinical Leadership team** would be established with membership comprising of a patient and a carer member, the Cluster Lead, Area Clinical Director, GPs, Dental, Pharmaceutical and Ophthalmic professionals, the Head of Primary Care, Nursing, Adult and Children's Social Services with appropriate financial and IM&T input. It would also be intended to work closely in partnership with the Community Health Council. The current cluster network with expanded membership of dental, pharmaceutical and ophthalmic professions would act as the Clinical Reference Group and provide a forum for pathway redesign, service remodelling, review and continuous improvement. A dedicated business/ project manager would be appointed. Clinical Governance would be addressed through the Primary and Community Services Unit Quality Assurance Framework and report through to the Quality and Safety Board.

Reporting would be through respective organisational lines with oversight by the Joint Partnership Board in Swansea (Jointly chaired by the Director of Social Services, City and County of Swansea and the Director Primary and Community Services, ABMU Health Board) to ensure collective oversight by the Health Board and Local Authority and to respective corporate mechanisms, i.e. Executive Team/ABMU Board and Cabinet/Council Swansea Local Authority and the Regional Partnership Board.

SUSTAINABILITY/SCALABILITY

The priority projects have been identified with long-term sustainability as the key objective and the ability to "scale up" in mind. This is addressed through several methods:-

- Transformational time limited work to facilitate the new model and add to the evidence base.
- Robust evaluation to inform benefits realisation
- Establishment of a social enterprise to attract inward investment from external sources
- Onward funding through independent contractors with revised business/ partnership model as demonstrated by Cwmtawe Medical Group
- Redesign of Health Board core services: Business case preparation for Regional Partnership Board, and Health Board IMTP when impact analysis and success has been proven and savings achieved.

The proposal has been based on the intent for this model to become self-sustaining through the improvement in health and wellbeing, co-production and use of social prescribing as an alternative to more traditional models of health and social care including a shift of resources where appropriate from secondary to primary care. This principle would be tested through evaluation of the Cwmtawe model as outlined in Appendix 4 through monitoring of the outcome measures and adapting the model as required.

CONCLUSION

Cwmtawe cluster has a strong base and could provide an excellent geographical area to further test out and

accelerate a transformed model of care as envisaged in '**Our Healthier Wales'** in order to improve health and well-being, reduce inequalities and increase independence, with a particular focus on older people, carers, the early years. The model also introduces a social model of health across the social gradient proportionate to need.

This proposal has the support of the Chair, Vice Chair, CEO and Executive team in line with the strategic direction of travel for the Health Board. The proposal has also received support from the Regional Partnership Board Chair.

Appendix 1

Quadruple Aim/ Transformed model of care components	Priority Area	Indicative Cost 2018-2019	Indicative Cost 2019-2020	Anticipated source of funding post 2020
Improved population health and well-being	Establish social enterprise for wellbeing and social prescribing	10k	10k	Social Enterprise
	Feasibility study to review evidence based and recommend best model of community involvement (year 2 implement co designed model)	10k	35k	Social Enterprise
	Pro- active communication campaign on new model for patients, carers and workforce	25k	25k	Time limited for transformation period
	Design of interactive engagement / feedback mechanisms for cluster population in conjunction with community	10k	10k	Social Enterprise
	Establish Local Area Co-ordination in cluster area	10k	42k	IMTP HB (1)
	Increase awareness of /and support to young carers	5k	5k	Social Enterprise
	Total	**70k**	**127k**	
Better Quality And More Accessible Health and Social cares services Strong, stable primary care / cluster based working / care closer to home	Further expand the MDT to cover all practices within the cluster			
	Physiotherapist	20k	48k	Core GP practice remodelled service
	Advanced Nurse Practitioners	35k	83k	Core GP practice remodelled service
	Practice Based Pharmacist	35k	85k	Core GP practice remodelled service
	Clinical resource		267k	Core GP practice remodelled service
	Paramedic	23k	54k	Core GP practice remodelled service
	Audiology	34k	82k	Redesign of core HB services
	Total	**147k**	**619k**	
	Establishment of Community Phlebotomy Service	17k	41k	
	Better space utilisation to allow care closer to home – storage of medical records scan and store	18k	8k	GP practices
	Establish Outpatient clinics		100k	Redesign of core HB services
	Acute clinical outreach and response team becoming part of the cluster workforce serving the cluster population	14k	14k	Redesign of core HB services
	Total	**49k**	**163k**	
	Total	**196k**	**782k**	
Higher Value health and social care	**Cluster leadership team**			
	Cluster Leadership - Business/ Project Manager	24k	49k	Time limited for transformation period (2)
	Evaluation of model/service changes	20k	30k	Time limited for transformation period (2)
	Enhanced eye check scheme post stroke	4k	4k	Redesign of core HB services
	Diabetics introduce Tower Hamlet model	20k	35k	Redesign of core HB services (agreed in principle)
	Enhanced community dental service improving and delivery of oral health and hygiene in patients living in a care home	23k	55k	Redesign of core HB services
	Total	**91k**	**173k**	
A motivated and sustainable health and social care workforce	**Cluster leadership team**			
	Workforce optimisation training and support for cluster (non-medical staff to process medical	9k	8k	Time limited/GP practices
	Repeat prescribing hub establishment	50k	50k	Redesign of core HB services (3)
	GP time (cluster lead/ deputy cluster lead and practice representatives)	30k	39k	Time limited for transformation period
	Clinical management	20k	49k	Redesign of core HB services
	Other professions clinical time (dental/ophthalmic)	3k	7k	IMTP HB
	Workforce development and qualifications	20k	20k	IMTP HB/GP practices
	Equipment (audiology and physiotherapy)	35k	10k	Redesign of core HB services
	Total	**167k**	**183k**	
	Overall Total	**524k**	**1265k**	
	Enhanced Health Visiting service to undertake targeted vaccs and immunisation work	11k	45k	Redesign of core HB services
	Enhanced Cluster led chronic conditions management	14k	55k	Redesign of core HB services
	Cluster Speech & Language Therapist - to meet the demands of the early years population and provide SLT -lead speech sound intervention prior to full-time school entry	9k	35k	Redesign of core HB services
	Strengthening Mental Health assessment and low intensity intervention (MATRICS)	17k	81k	Redesign of core HB services
	Training pilot Silver Cloud CBT		5k	
	Revised Total	**575k**	**1486k**	
	Footnote			
	(1) "Core HB funding which will be sourced through annual budet allocation process"/"redirection of funding from existing Health Board services from cost reductions/cost avoidance resulting from programme". IMTP HB and Redesign of core services will be dependent on successful evaluation.			
	(2) Dependant if further phases in year 3 or beyond			
	(3) Anticipated medicines savings			

Neath Port Talbot Castell-nedd Port Talbot County Borough Council Cyngor Bwrdeistref Sirol

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Abertawe Bro Morgannwg University Health Board

Cyngor Abertawe Swansea Council

Appendix Two

CWMTAWE WHOLE SYSTEM APPROACH

Empowered Citizens
Patient survey
Interactive feedback mechanisms/Patient Carer Forum/Citizens' Panel

Informed Public
Social media, websites, newsletters
Proactive media communication plan

Stable Primary Care
Workflow, optimisation scan/store
3 stable practices
Population, GPs/practice staff

Motivated Professionals
New professional roles

Promotion of Healthy Living
Falls prevention,
Smoking cessation
Flu immunisation
Weight management scheme
National exercise referral scheme

Integrated, whole systems approach
Cluster Based Acute clinical outreach team/Acute clinical response team
Cluster based -Integrated health & social care team

Increased citizen wellbeing

Sustainable Community Resource

Integrated, whole systems approach

Improved access to quality care

Accessible Resources
Modern fit for purpose buildings/infrastructure

Support for Self Care
Screening services
Social prescribing
Explore models of digital enabled self-care

New Cluster Models
Super practice
Cluster based services
(see range of community resources below)

Complex & Specialised Care in Community
Diabetes model
Outpatient clinics –cluster based
INR monitoring

Wide Range of Community Resources
Citizen Advice Bureau
Audiology
Cluster Pharmacist
Cluster Nurse
Minor ailments scheme – community pharmacy
IM&T Vision 360
Early Years worker
Carers Help desks
Children and Young People Counselling

Increased Community Resilience
Social enterprise for well being

Reduced preventable & avoidable ED/hospital admissions
(See integrated whole systems approach)

**Italics denotes new model*

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Cyngor Abertawe Swansea Council

Appendix 3

The ten national design principles to drive change and transformation – and examples of

Project	Prevention & early intervention	Safety	Independence	Voice	Personalised	Seamless	H
Population and well-being							
Social enterprise	✓		✓		✓	✓	✓
Community involvement	✓		✓	✓	✓	✓	✓
Communication campaign	✓	✓	✓			✓	✓
Design & implement interactive engagement & feedback mechanism	✓		✓	✓	✓	✓	✓
Local area coordinator	✓	✓	✓	✓	✓	✓	✓
Young carers	✓	✓	✓	✓	✓	✓	✓
Quality and Accessibility							
Extended Multidisciplinary Team	✓	✓	✓		✓	✓	✓
Community phlebotomy service		✓			✓	✓	✓
Outpatients clinics cluster based	✓	✓	✓		✓	✓	✓
Acute clinical outreach/response	✓	✓	✓	✓	✓	✓	✓
Higher Value							
Clinical leadership team	✓	✓	✓	✓	✓	✓	✓
Evaluation	✓	✓	✓	✓	✓	✓	✓
Eye service	✓	✓	✓		✓	✓	✓
Enhanced cluster based Diabetic care	✓	✓	✓		✓	✓	✓
Oral health and hygiene	✓	✓	✓		✓		✓
Workforce							
Repeat prescribing hub	✓	✓	✓		✓		✓
Workforce development		✓					✓

Appendix 4

Project	Expected benefits	Outcome Measurements
Population and well-being		
Social enterprise	Investment	Sustainable income
	Co-ordination of Third sector/well-being activates	Number of patients/citizens accessing social prescribing activites
Community involvement	Prevention/early intervention	Number of patients/public involved
	Better designed services	Self organised/sustaining community involvement
	Personalised	
Communication campaign	Better informed, patients/carers, staff/workforce	Number of social media 'hits'
		Number of press articles/radio/newspaper
	More prudent use of services	
Design & implement interactive engagement & feedback mechanism	Testing of digital solutions to support self-care and patient engagement	Number of MHOL/Pocket Medic active users Resulting project with Swansea University
Local area coordination	Reduced social isolation for members of the community	Number of contacts/people on case management
	Improving independence	Reduction in hospital admissions/long term care placements
	Reduced reliance & health social services	Reduction in number of GP contacts
Young carers	Improve well-being of carers	Number of training packs issued/sessions carried out
	Increase support and awareness	
	Reduce social isolation	
Quality and Accessibility		
Extended Multidisciplinary Team for whole cluster population	Increase accessibility for patients	Number of clinical appointments undertaken by MDT
	More sustainability primary care	Improved sustainability 'core' GP practices
	Development of professional roles	
	Prudent use of MDT workforce	
Community phlebotomy service	More prudent use of community nursing resource	Reduction in District Nursing blood contacts
	More convenient /accessible service for patients	Domiciliary POCT for INR established
Outpatients clinics	Care closer to home	Number of clinical sessions
	Multidisciplinary working	Number of educational sessions
	Skilling up workforce	
Acute clinical outreach/response	Better coordination of services to achieve care closer to home	Reduction in hospital admissions for over 75
	Reduction in unscheduled care demand	
Higher Value		
Clinical leadership team	Capacity to transform model	Clinical leadership formed
	Better cross agency disciplinary working	Number of projects completed
	New service/pathway model	
Evaluation	Add to evidence base	Evaluation is completed
	More effective design of components	Number of outlets for shared learning
Enhanced Eye service post stroke	Early detection and prevention of eye problems	Reduced number of falls in post stroke patients
	Increased independence	
Enhanced cluster based Diabetic care	Improved outcomes for Diabetics	Improved BP/HBAIC control, discharge from O/P clinic, reduced ambulations, less hypoglycemic admissions
	Reduced hospital admissions	
Enhanced Oral health & hygiene	To improve quality of life/nutrition and oral health to patients in care homes	Number of care homes visited Number of educational sessions carried out
Workforce		
Repeat prescribing hub	More convenient and accessible service for patients	Number of GP practices participating/continuing with scheme
	More prudent use of medicines management resource	Savings to medicine management budget
	Prudent use of workforce	
Workforce development	Benefits of prudent use of workforce	Number of courses/educational sessions undertaken/or qualifications obtained
	More sustainable Primary Care	
Enhanced Health Visiting Service	Increased uptake of vaccination and immunisation	Improvement in uptake of immunisations
Cluster based Nursing	Preventative Approach - Improved Chronic Conditions Management	Number of people benefitting from preventative service
Speech and Language Therapy	Better early years outcomes	Number of additional children receiving speech and language therapy
		Successful testing of talking clinics
Mental Health	Improved mental health well being	Increase in number of brief interventions
		Successful pilot of Silvercloud
		Number of staff trained.

Appendix C

Bridgend County Borough Council / Abertawe Bro Morgannwg UHB

Integrated Community Services

Acceleration the Pace of Change for Our Integrated Services

BACKGROUND

Bridgend Local Authority and ABM University Health Board in partnership with the third sector, have developed integrated and joint models and approaches for community services for adults, based on pre-emptive early interventions, to ensure that people receive timely responses that are proportionate to their needs and risks, and that promote through co-produced approaches to people's independence, voice and choice.

The traditional models of service have been through a process of transformation that have evolved into the current approaches, which are consistent with the aspirations of the Social Services and Wellbeing Act and with the shift expected within Welsh Government's *A Healthier Wales, Our Plan for Health and Social Care* are based on the following:

- Wellbeing And Prevention: Information advice and assistance, including local area coordination
- Early Intervention: reablement, progression and recovery approaches in the community
- Managed Care and Support: outcome based approaches to complex and long term care, as well as anticipatory coproduce contingency planning with people and their families.

The focus of our integrated services is on keeping people independent and able and resilient, to enable them to continue to live independently within their communities. Our approach to the integration of our services was highlighted as an exemplar and described as being amongst those considered to be most aligned with the principles outlined in recommendation 3, "Bold New Models of Seamless Care - national principles, local delivery", in the final report of the *Parliamentary Review of Health and Social Care in Wales, A Revolution from Within: Transforming Health and Social Care in Wales* (2017). Essentially we believe that our success and progress is predicated on taking a whole system approach to changing our services, wrapping services around individuals, particularly for those affected by frailty and disability. In doing so we have reduced duplication in our system, maximised the use of resources, improved our communication and collaboration across

social and health and third sector services and delivered tangible improved outcomes for people using community services in Bridgend County Borough.

Improvements in outcomes that we have evidenced to date:

- Person centred, outcome focused, proportionate plans of reablement, recovery and progression, putting 'Mrs Jones' at the heart of all we do.
- Reduction in number of placement days commissioned despite the increasing older adult population and demand for placements
- Reduction in length of stay for people over 75
- 8.9% less of adults 65+ in core service than five years ago
- High levels of people made fully independent by reablement services
- 9% (LD Register comparison aged 16+: 523 at 31/03/2015 and 475 at 31/03/2017) reduction in the numbers of people in core learning disability services
- 973 people managed by prevention and early intervention services in the community.
- We have developed a repository of digital stories from individuals who have used our integrated services and feel they have benefited from our person centred, strength based approach to intervention

However our progress has been delivered mainly through the reconfiguration of existing resources and the support of the Integrated Care Fund. The ability to consolidate proven success to date, and deliver a seamless whole system of care, building on the learning we have gained from the last three and half years of integrating our services, has been thwarted by access to resources to accelerate our integrated working at pace and scale, and in this context we welcome the opportunity afforded through the Transformation Fund to change at pace, existing approaches in a sustainable way.

WHERE ARE WE NOW

We have a fully integrated approach to accessing community health and social care services, particularly for older and disabled people, and our Community Cluster Network Teams and our CRT have fully integrated management arrangements. Our approach to integrated community services was highlighted in a case study, in *Working for a Shared Common Purpose Experiences of Health and Social Care Integration in Wales*, commissioned by Unison and completed by WHISC in 2018; and demonstrated that by having a fully integrated approach, this has enabled us to wrap services around 'Mrs Jones' ensuring that she gets the right person to respond to her needs and proportionate and pre-emptive approach to intervention and support.

The integrated services are now well established include the following:

- Common Access Point for all adult services and community services for frail, older and disabled people

- Community Resource Team Services, Including Acute Clinical Team, Reablement Telecare and Mobile Response; this is a regional approach to intermediate care and subject to a Section 33 arrangement
- Integrated Community Cluster Network Teams Comprising Social Work, District Nursing and Therapies
- Underpinned by integrated community equipment services and the extensive rollout of Telecare and 24 hour mobile response services

In addition we have many co-located and collaborative services in mental health, learning disabilities, substance misuse, and in our multiagency safeguarding hub; in addition we have a section 33 for integrated community equipment and for assisted recovery in the community supporting people with their mental health and well-being.

OUR AMBITION TO ACCELERATE THE PACE OF CHANGE

The configurations of our community health and social care services are based on traditional models of service access and delivery, whereby the public and professionals can access services from Monday to Friday mainly between 9 AM and 5 PM. We are aware that this creates pressure within the system particularly at the beginning and the end of the working week; for example people wait over the weekend for senior reviews on Mondays in hospitals, people are referred health, social and integrated services on Mondays where there has been a personal or family crisis over the weekend with an expectation of support and resolution of their issues immediately. The real activity of the week commences following a rapid and intense period of assessment and planning on Tuesdays; and by Fridays community services are fully committed and usually at capacity; this inevitably means that some people have to either wait until the following week, or will remain in hospital unnecessarily, or will need temporary avoidable care arrangements to be put in place until their issues can be resolved the following week.

Building on our strong track record of partnership working and integration, our ambition is to have fully operational accessible services over seven days, over an extended day, as well as providing care and support at night. We want to lead in Wales, developing and delivering a coordinated integrated approach to service where *'Every Day Is Tuesday'*; where the flow of people in and out of our services is continuous and accessible, particularly to out of hours and secondary care, and WAST services colleagues. We feel this approach will provide higher value, and be scalable regionally and potentially nationally, offering a transformative approach to the delivery of community services; in that context we would welcome the opportunity to collaborate in any research and evaluation of this approach. To realise our ambition of delivering *coordinated health and social care services seamlessly, wrapped around the needs and preferences of individuals;* and deliver where practical and safe to do so, home-based and community models of integrated care and support; we have four ambitions which will transform our community services.

OUR FOUR AMBITIONS ARE AS FOLLOWS:

Ambition 1: Seven Day, 24 hour Community Health and Social Care Services – "Every Day is Tuesday"

Building on our existing Common Access Point, we want our services to be accessible over seven days with extended hours, so that at the most challenging times for core services, if things go wrong, support will be available. Our proposal therefore is to develop a fully operational Common Access point to community services that will operate from 8 AM to 8 PM over seven days.

This will be delivered in partnership with the CVC providing third sector brokerage, who alongside access to core services, would support and enable individuals to navigate the range of potential support organisations or mechanisms to meet their individual needs, utilising effectively Dewis and Infoengine. The brokerage would provide a single information access point, offering choice and control, that would enable appropriate signposting to third sector and community based services and support, aiming to improve the individual's overall health and wellbeing and empowering them to remain independent for as long as possible in their home.

In our non-selective enabling and re-enabling, and bridging (Better @ Home) services we would like to extend access to these services from five days to seven days; to enable continuous flow from secondary care, to care at home, and prevent unnecessary admission to hospital or long-term care, ensuring that the place of care is nearest to home. In addition this would enable a fully regional approach to *bridging and stay well at home services* across the new Cwm Taf and Bridgend County Borough regional partnership. In addition we would like to provide care at night, working collaboratively with other services such as out of hours district nursing and home care services to ensure that our care is personalised to individuals needs and wrapped round the choices and preferences of people for their place of care, where it is safe and prudent to do so. To deliver on this we intend to extend the range of functions for our Acute Clinical Team from community based interventions, to enable them to pull people from the emergency admissions unit, whose interventions and care can be safely managed at home, with the appropriate clinical and care support services.

We want to expand our intermediate care beds from 6 to 10, and recommission the unit as a flexible and responsive step up and step down facility, to deliver recovery, reablement and reabling respite. We envisage this will support the timely discharge of people recovering from periods of acute illness in order to support their recovery in a more appropriate setting than hospital; it will also be used to prevent inappropriate admissions to hospital for people who need support day and night during transient periods of ill health. The unit will be underpinned by an intermediate care approach to recovery and reablement to maximise people's potential for their return to their own homes; as well as supporting carers in providing flexible and reabling short breaks, which will allow for continuous assessment and

intervention, in order to ensure that people return home as enabled as they possibly can be, in order to prevent respite breaks inadvertently causing further dependency or disability.

Ambition 2: Primary and Community Care interagency Multidisciplinary Primary and Community Cluster Network Team

For people living with chronic ill-health and disability we want to develop the ability to deliver a multidisciplinary team around people. The multidisciplinary team will comprise primary care professionals, and an expanded community cluster network team to include additional therapies to support, and timely and responsive assessments around individuals receiving care and support at home. This will ensure that the short term services based within the CRT can focus on people who have not been in services before, as well as expediting discharge from hospital. This will enable the core services to deliver prudent care coordination to support individuals, their carers and families at home, with timely interventions and responses as there illness and/or disability progresses. It will also facilitates anticipatory and contingency planning with people and their families, their care providers and the community and primary care teams.

It is recognised that this offer should be considered in the context that our network clusters will also be extending the primary care clinical teams; and that the cluster network teams should complement and collaborate with the wider primary care team to deliver a transformational approach to the delivery of home-based care, ensuring that the right professionals are wrapped around individuals receiving care and support to deliver appropriate and timely interventions to prevent inappropriate admissions to hospital on long-term care. We envisage in time further bids for Transformation Fund support, to expand the primary care clinical team, to maximise the seamless multidisciplinary approach to care and intervention.

In addition we want to create a long-term and sustainable approach to Resilient Community Coordination. Without comprehensive, accessible and well promoted information many people struggle to find out what is happening/available in their area. People are unable to access support independently and professionals often struggle to signpost people on to different or appropriate services. We know that good information and services are essential to making ‘every contact count’, and in promoting wellbeing and resilience; good connections between local services and accessibility of support are essential.

We are aware that we have a number of funding streams supporting discreet areas of work such as, dementia and carer support workers, as well as local community connectors; to maximise and coordinate all these resources prudently, we would like to appoint a project manager to actually scope all the people and services, whether professionals or citizens, engaged in community connection, and develop a coordinated approach to resilient community connection and compassionate communities, based on the footprints of the

community cluster networks. This will enable us to maximise this resource and prevent duplication as well as support citizens and staff working in this area more effectively.

In addition we would like to develop a 'Bridgend Link-line' team to help people living in the Bridgend County area to cope with the challenges they face in terms of their personal health or wellbeing and reduce the impact on higher tier services, such as GPs or hospital admittance, by connecting them to community support at a much earlier preventative stage. Based in the community network clusters, would envisage this team being managed by the CVC to ensure a coordinated and responsive multi-agency community support service; the team and volunteers would be trained in life coaching skills so that they can safely and adequately provide help and assistance on an individual basis.

Another challenge for core community services is assessing for and meeting the needs of people who need long-term nursing care. We are aware that people often wait for protracted times in hospital while their needs are assessed in terms of placements in nursing care services, to ensure suitable placements can be found. We would like to move to appropriately resourced out of hospital assessment for nursing care needs and to do this we would like to commission a facility with our independent sector partners, with four nursing care assessment beds, two specifically for people with dementia. This was enable us to deliver timely 48/60 hour multidisciplinary assessments of people's needs in a more appropriate care setting and move people to the appropriate place of care in a more timely way. This would enable the long-term care team from the University Health Board to undertake comprehensive assessments of individuals in a more timely and evidence-based way, working collaboratively with the care provider.

In addition we want to stem the flow of inappropriate admission from nursing homes to hospital particularly when care becomes complex or end of life, and wish to appoint to specialist nurses to support the nursing home care sector with information, advice and skills where appropriate. This will ensure people can remain in familiar and comfortable surroundings with the support of people they know well, with clinically safe support and interventions. In addition the provision of expert support may prevent unnecessary escalating concerns, if care providers can be supported in a more constructive way.

Ambition 3: Maesteg Hospital Community a Clinical Resource Centre for primary and community services

Our Community Hospital in Maesteg is an asset we would like to reconfigure to meet the needs of our new home-based model of care, in order to deliver a Community Clinical Resource Centre for Primary and Community Care and Dementia support. We would envisage a remodelled facility offering a number of inpatient beds for clinical interventions and investigations; as well as day facilities to provide multidisciplinary clinical assessment and review, interventions, and community clinics such as for example bloods, blocked catheters, assessment and review with access to diagnostics and therapies

Ambition 4: To Mobilise the Workforce

Our ambition is to mobilise our workforce into a paperless approach coproducing the management of records with the people using our services. To deliver this we would like to move to a single integrated record using the infrastructure of WCCIS; and would like to share the single records across all primary and community services including GP practices and the Princess of Wales hospital. We would like to scan all paper-based records to make them accessible and safe, whilst removing the ongoing responsibility to physically store and maintain them. We would like to implement new technology such as Voice to type, write to type technology, secure mobile scanning, and safe share photo, skype to support mobilisation.

Miscellaneous

We recognise we are extremely ambitious in wanting to deliver 24/7 integrated community services and feel we could need additional capacity in the short term, of a transformation manager and a project manager in order to deliver on our ambition at scale and pace. We would want the support of these professionals for a period of two years

The following table explains our ambition to deliver a whole system transformation of our community services, working over seven days and nights, delivering on home based care and self-management. Following the table is a spreadsheet with the draft projected cost to deliver on our plans.

Our Ambition to Accelerate the Pace of Change

Quadruple Aim	A Healthier Wales Theme	CURRENT PROVISION	OUR VISION FOR TRANSFORMATION
Improved population health and well-being - better prevention and self-management better quality and more accessible health and social care services – supported by engagement and enabled by digital solutions high value health and social care – rapid improvement and innovation enabled by data		**Ambition 1: Seven Day 24 hour Community Health and Social Care Services – "Every Day is Tuesday"**	
	Health Well-Being And Prevention Home-Based Care And Self-Management	Common Access Point open Monday to Friday 8.30 to 5 PM for access to social services and intermediate care	**Common Access Point Open 7 Days a Week 8 PM to 8 PM, for access to coordinated Community Health and Social Care and Third Sector Services -** strengthening links to primary care and the pull from hospital, and the sharing of pre-emptive and contingency information and arrangements with OOHs, and WAST. In addition a third sector brokerage services enable individuals to navigate the range of potential support organisations or mechanisms Healthier Wales Design Principles: prevention and early intervention, safety, independence, voice, personalised, seamless, higher value, scalable, transformative
	Home-Based Care And Self-Management Local Health And Social Care Services	Non-selective reablement/enablement services accessible Monday to Friday with service provision over seven days	**Non-selective reablement/enablement services accessible over seven days.** Current short-term services operate over seven days but Access to current services is only available Monday to Friday. This will enable access over seven days promoting seamless flow over seven days of people in and out of these short-term services, preventing the bottlenecking of services on Mondays and Tuesdays and full capacity by Fridays Healthier Wales Design Principles: prevention and early intervention, safety, independence, voice, personalised, seamless, higher value, evidence driven, scalable, transformative
	Home-Based Care And Self-Management	Better at home bridging service accessible Monday to Friday to support the discharge	**Better At Home bridging service:** learning from the work Cwm Taf's Region has delivered in their *Stay Well At Home Project,* increase capacity to enable an MDT approach accessible over 7 days to prevent admission to hospital where people can be clinically managed at home or as a result of needing urgent care and support at

Quadruple Aim	A Healthier Wales Theme	CURRENT PROVISION	OUR VISION FOR TRANSFORMATION
focused on outcomes motivated and sustainable health and social care workforce leading to improved well-being	Local Health And Social Care Services	of people from hospital	home and to expedite discharge from hospital operational between 8 AM and 8 PM Healthier Wales Design Principles: safety, personalised, seamless, higher value, evidence driven, scalable, transformative
	Home-Based Care And Self-Management Local Health And Social Care Services	Acute Clinical Team working with people in the community over seven days	**Acute Clinical Team supporting admission avoidance** as well as people in the community, with additional care services in order to make the place of care home based additional capacity and additional care from B@H Healthier Wales Design Principles: prevention and early intervention, safety, independence, voice, personalised, seamless, higher value, evidence driven, scalable, transformative
	Local Health And Social Care Services	Bridge link mobile response services, regulated response to Telecare alerts particularly for people who have fallen	**Mobile response and care at night:** Increase the capacity of the bridge link regulated mobile response service to enhance and support the district nursing service to provide care at night to support people and their carers to avoid unnecessary admission to hospital or residential settings Healthier Wales Design Principles: prevention and early intervention, safety, independence, voice, personalised, seamless, higher value, evidence driven, scalable, transformative
	Home-Based Care And Self-Management Local Health And Social Care Services	Six reablement beds in an existing residential BCBC home	**10 flexible step up and step down beds for intermediate care, recovery and reabling respite assessment, to prevent residential placements.** to deliver flexibility and responsiveness in the service prevention unnecessary admissions to long term care, and the opportunity for recovery and to build resilience Healthier Wales Design Principles: prevention and early intervention, safety, independence, voice, personalised, seamless, higher value, scalable, transformative
		Ambition 2: Primary and Community Care Multidisciplinary Primary and Community Cluster Network Team	

Quadruple Aim	A Healthier Wales Theme	CURRENT PROVISION	OUR VISION FOR TRANSFORMATION
	Home-Based Care And Self-Management Local Health And Social Care Services	Integrated Community Network Teams comprising social work and district nursing	**Integrated Community Networks Team comprising a primary care multidisciplinary workforce linked strongly to the Cluster Networks** focusing on people in core services and anticipatory/contingency planning to prevent unnecessary admission to hospital or long-term care comprising of a multidisciplinary workforce of social work, district nursing, occupational therapy physiotherapy, speech and language therapy, dietetics, pharmacy, phlebotomy, the third sector and community connectors Healthier Wales Design Principles: prevention and early intervention, safety, independence, voice, personalised, seamless, higher value, evidence driven, scalable, transformative
	Health Well-Being And Prevention Home-Based Care And Self-Management	Local community connectors x 3 1.2 FTE dementia support worker 3 x carer support workers (temporary funding)	**Resilient Communities Coordination** **Co-ordinated asset-based, prevention and early intervention services based on 'compassionate communities' methodology** focusing on primary care support for people need access to local community coordination, information and advice through a 'link-line', carer support, and daily life support/coaching e.g. for people with memory problems and early dementia. Coordinated by third sector core and supported by the core services Healthier Wales Design Principles: prevention and early intervention, safety, independence, voice, personalised, seamless, higher value, evidence driven, scalable, transformative
	Local Health And Social Care Services	No Out of hospital Nursing Assessment	**4 blocked booked beds for out of hospital nursing assessment,** to enable intensive 48/60 assessment under supervision of long term care team, Nurse assessor led with social work, OT and physio support Healthier Wales Design Principles: safety, voice, seamless, higher value, evidence driven, scalable, transformative

Quadruple Aim	A Healthier Wales Theme	CURRENT PROVISION	OUR VISION FOR TRANSFORMATION
	Local Health And Social Care Services	Support for the nursing home care sector	**2 x clinical nurse specialists/assessors to support the independent nursing home sector** with health care interventions, training and assessment of individuals Healthier Wales Design Principles: prevention and early intervention, safety, personalised, seamless, higher value, evidence driven, scalable, transformative
		Ambition 3: Maesteg Hospital Community Clinical Resource Centre	
	Home-Based Care And Self-Management Local Health And Social Care Services	Maesteg Hospital 20 beds for mainly for people waiting for placement	**Maesteg Hospital Community Clinical Resource Centre for Primary and Community Care and Dementia support:** for multidisciplinary clinical assessment and review, including in patient stay for intervention, investigations, day interventions and community clinics e.g. bloods, blocked catheters, MDT assessments Healthier Wales Design Principles: prevention and early intervention, safety, independence, voice, personalised, seamless, higher value, evidence driven, scalable, transformative
		Ambition 4: Mobilise The Workforce	
	Local Health And Social Care Services	Mixture of existing ICT systems and hardware supporting community health and social care professionals. Not as yet enabled to record real time assessment and intervention	**Our ambition is to mobilise our workforce into a paperless approach coproducing the management of records with the people using our services.** To deliver this we would like to move to a single integrated record using the infrastructure of WCCIS. We would like to share the single records across all primary and community services including GP practices and the Princess of Wales hospital. We would like to scan all paper-based records to make them accessible and safe, whilst removing the ongoing responsibility to store and maintain them. We would like to implement new technology such as Voice to type, write to type technology, secure mobile scanning, and safe share photo, skype to support mobilisation
		Miscellaneous	

Quadruple Aim	A Healthier Wales Theme	CURRENT PROVISION	OUR VISION FOR TRANSFORMATION
			To deliver on our ambitions we would like to appoint a transformation manager and a project manager in order to transform our services at scale and pace

Please see projected costs to deliver on the transformation of our services

Financial Summary

AMBITION	2018/19	2019/20
Ambition 1 Total	**£ 1,031,479.58**	**£ 1,836,968.45**
Ambition 2 Total	**£672,872.30**	**£1,177,257.37**
Ambition 3 Total	**£426,026.42**	**£745,375.82**
Ambition 4 Total	**£368,841.08**	**£645,324.36**
Total Bid	**£ 2,499,219.37**	**£ 4,404,926.00**

Conclusion

We are ambitious to deliver on expanding and accelerating the scale of our integrated community health and social care and third sector services.

Full business plans for each individual project will be developed if the offer for each transformational project is accepted. Plans will include consultation with key stakeholders, a delivery timeline, proposed audit and evaluation and the learning from implementation, in order that elements that work prudently and effectively, can be shared in order to be scalable.

Bridgend Integrated Community Services Structure

Microsoft Word Document

Contact Officer:

Carmel Donovan

Integrated Community Services Manager

On behalf of the Bridgend County Borough Area Integration Board

31.08.18