Appendix A

Submission of Evidence to Scrutiny - Transformation Programme
Author Transformation Programme Lead, Gwent Regional Partnership
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Transformation Programme Background and Context

'A Healthier Wales', published in June 2018 is the Welsh Government's long term plan for Health and Social Care and their direct response to the recommendations of the Parliamentary Review (January 2018). The plan sets out the expectation of:

- Improved collaboration between health and social care
- An increased emphasis on improving wellbeing through early intervention and prevention
- An expectation of greater integration in the planning and commissioning of services
- A demonstration of developing services to meet population need now and for future generations.

A national £100 million fund was established to support the delivery at pace of 'new models' of care across health and social services, with all regional partnership boards asked to develop a 'transformation offer'

The Gwent Transformation Offer

Recognising the complexity of the Gwent Landscape with six sovereign bodies, a transformation leadership group was established and met weekly, to agree a set of shared priority areas of equal benefit and impact to both local government and health. Whilst the additional funding secured is welcome, it is a pump primer to facilitate greater collaboration in areas of shared priority, ensuring that funding is directed at front line pressures for Council where possible.

The funding is provided for 2019/20 and 2020/21 and totals £13 million across a two year period, it is split across two themes, in four programmes. Each programme is either underway, or planned to commence in Newport.

It is recognised that the transformation funding is a one of 'pump prime funding grant', therefore those programmes funded, are currently the subject of 'sustainability' reviews to determine either a plan to mainstream or exit planning, and a report detailing this will be available in late Autumn.

The offer focuses on two elements:

- Alignment of the 'out of hospital system' to ensure that people are able to receive more care closer to home, benefit from greater access to information, advice and assistance and benefit from an acceleration in citizen centred 'multi-disciplinary working'
- Service Redesign in areas of significant demand and pressure on both local authorities and the health board.

The agreed and funded programmes are:

1. Develop a new model of prevention and wellbeing services (Integrated Wellbeing Networks) in partnership with Public Service Boards.
2. Develop 'place based care' by developing a Gwent Compassionate Communities model, providing more 'care closer to home'
3. Reform child and adolescent mental health services to provide a more integrated approach across health, education and social care (The ICEBERG Model)
4. Development of a regional Home First Admission Avoidance Service

Impact and Benefits to Newport

Each of the four programmes are either underway in Newport or are planned for delivery in 2020/21. The remainder of this paper provides an overview of the activity and benefit to families in Newport for the Integrated Wellbeing Network and Place Based Care programme.

Delivering Place Based Care in Newport (Integrated Wellbeing Networks & Compassionate Communities)

The transformation offer emphasised the importance of developing improved early intervention and prevention services, in tandem with the reform of primary and community care, to deliver more care closer to home.
The concept of the Newport Integrated Wellbeing Network (IWN), is to better align existing resources to improve wellbeing, and reduce duplication by working closely with third sector providers and partner agencies such as health, housing and social care and this will be done in tandem with the expansion of primary and community care, around 'wellbeing' hubs in places such as Ringland.

The intention is better collaboration between health and social care resources, which keep people independent for longer within their communities. Working with the Newport NCNs, Health Board, Local Authority and third sector this will support the delivery of more 'care closer to home' in Newport, by providing an enhanced primary, community and social care offer, including multi-disciplinary teams (MDT) able to work together across organisational boundaries to treat patients in a more seamless way, changing culture, behaviour and harnessing a new integrated way of patient centred working.

Recognising that improving wellbeing is a core aim of the Newport Public Services Board (PSB), this programme is the first pilot in Wales to be delivered jointly between the PSB and the Regional Partnership Board (RPB), with the GSWAG officer coordination group a key member of the Integrated Wellbeing Network steering group.

The programme will ensure that services are developed and constructed to provide a menu of wellbeing services across Newport on a place based approach. The Newport Integrated Partnership Board will have a key role in supporting delivery of the programme and is sighted on the programme.

To date the programme has:

1. **Establish place-based co-ordination and development of well-being resources**

- Proposal with Welsh Government to deliver Compassionate Communities across Newport
- A 'Healthy Community Checklist' has developed to support process. In terms of what a well-functioning place based well-being approach looks like
- A 'Wellbeing Offer' is in draft for Ringland – based on assessed need – this will be reviewed and developed further following community engagement
- Mapping of programmes has been completed for Ringland and is underway for Pillgwenlly. Mapping is based on domains of wellbeing and focuses on general population activities and those for more vulnerable/at risk groups/individuals.
- The Service Lead is working with key agencies and LA hub managers to negotiate delivery existing programmes on a place basis if not doing so already.
- A Community Health Profile has been developed for Ringland and work has commenced on a profile for Pillgwenlly.

2. **Identify ways that hubs can be centres for well-being resources in the community**

- LA hubs are to open late September 2019. Discussions are taking place with new hub managers in Ringland and Pillgwenlly with regard to developing the wellbeing offer.
- 'Mapping' of community organisations, schools GP practices and other community assets completed for Ringland and underway for Pillgwenlly.
- Meetings have taken place with range of partners and programmes to discuss involvement in IWN including DWP, CAB, MIND, Platform, Newport Live, Newport City Homes, Age Cymru, Supporting People, Multi Sport, Children's Services, Community Connectors, Living Well Living Longer, Exercise on Referral, GAVO, NCNs
- A range of satellite and ultimately connected wellbeing centres are being identified in target communities as part of the wellbeing network.

3. **Develop the well-being 'workforce' (people delivering services and support)**

- Mapping of connecting and linking roles has been completed across a range of agencies, including workforce in a 'support' or assessment role. Core competencies for wellbeing are in draft.

4. **Ensure easy access to well-being information and support**

- Work has been completed to review existing 'champion' roles.
- A review of ASKSARA is continuing across Gwent.
- A Social Prescribing Discussion Paper has been developed in relation to strengthening and supporting referrals from GPs and other health and social care professionals.
- Discussions with regard to digital technology support for wellbeing are taking place.
- Discussions are taking place with DEWIS with regard to local requirements.

Reform child and adolescent mental health services to provide a more integrated approach across health, education and social care (The ICEBERG Model)

Recognising that early and accessible support for families with children experiencing emotional and mental health issues, is a shared priority for Newport Council and Aneurin Bevan University Health Board. Improved access can support enhanced placement stability for children in the looked after system, and can provide much needed early and non-stigmatised support to families. This programme works with community resources such as psychology and local schools through a 'whole schools' approach, to provide one front door for access, and better coordinated support across the four tiers of the system, reducing long waiting lists, escalation and crisis.

To date the programme has delivered:

- A Single Point of Access for Newport launched in March 19 and was an expansion of existing multi-agency referral point
- Family Intervention Team- Due to start in Newport from October 2019
- Parent and Infant mental Health service PIMHS operational since the start of April 2019
- 1 ½ days a week of a Psychotherapist specifically to work into Newport, initially as a scoping exercise and then in developing support, consultation to staff, specific interventions and training to staff.
- Development of academic training with University South Wales
- Development of specialist interventions – PND Wellbeing group, Watch, wait and wonder group (Beginning Aug – Oct 2019)Development and rolling out of Parent Infant MH training for staff (beginning Sept 2019)
- Working with FS managers and generic HV services to enhance service delivery
- Liaison with local services and groups – NCN, SPACE wellbeing, Baby & Me, NCC partnership community
- Liaison and link to UK wide organisations – PIP-UK
- Days of multi-agency staff have been allocated to also work in Newport and these temporary roles will upskill the practitioners and promote wider roll out of skills to parents and infants in Newport.

Home First – Admission Avoidance Service

The Home First service has been fully operational within the 2 District General Hospital sites in Gwent: Royal Gwent Hospital and Neville Hall Hospital since November 2018. The service is an admission avoidance service delivered at the hospital front door by the 5 Gwent Local Authorities. One of the many transformational elements to this service delivery provision is an opportunity for local authorities to work across organisational boundaries for the first time providing accelerated assessment and short-term care packages for citizens irrespective of their normal place of residence. The service is developed to complement existing step up/down facilities with clear pathways back "home". Admission avoidance is underpinned by the Welsh

Government's Delivery Unit (DU) four discharge pathways for patients, two of which form part of the Guidance for winter planning 2019/20.

The service also provides a bridging service to enable people to be discharged earlier than planned from the hospital admission units, for example where a care provider has been identified but cannot start for several days Home First will provide the care until the identified long-term care provider is in place. This aims to reduce length of stay and provide better outcomes for people and their carers. The Home First model provides clear alignment with community frailty services.

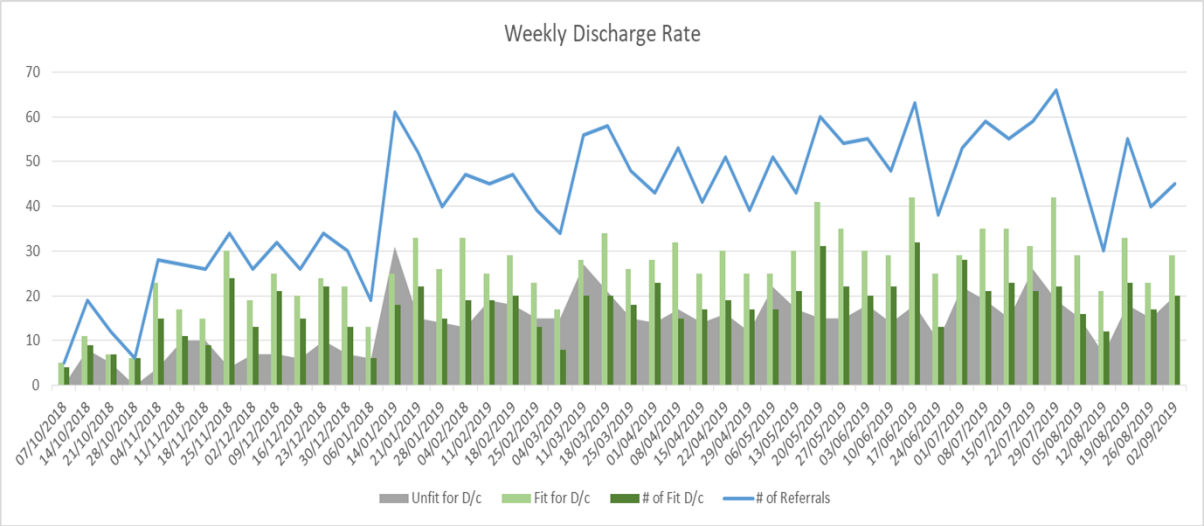
The service is acknowledged as an enabler for organisational and cultural change with the ability to change the discharge narrative across health, social care & third sector, with this in mind a workshop was delivered in July 2019, to ask what the next steps would be in order to truly support an integrated patient discharge. The workshop had representation from each Local Authority social care team, general practitioners, consultant medical staff, nursing staff, therapists and senior management. The workshop highlighted several areas where change would support and improve process and patient experience:

- Strengths based assessment process in hospital- What Matters to You?
- 4 questions for discharge- What is the matter with me? What will happen to me today? What is needed to get me home? When will I go home? Which provides a coproduced discussion between clinician and patient
- In-reach and trusted assessor service for social care, this will reduce the over referral to social care from wards and provide support for clinical teams. Over referral is estimated at between 32-40%
- Review all patient and carer literature on admission, this has been completed and supported by the Community Health Council (CHC)
- Revisit existing roles within the discharge process and realign those with the Home First ethos. Providing an opportunity for those individuals to work across organisational boundaries and a greater understanding of community services. The roles will also become part of the Home First service.
- The opportunity for rotation within the Home First service from within the hospital service to increase capacity and develop a stepped cultural change within the hospital setting.
- Reduce duplication within the discharge process.
- Stop thinking front door/back door in discharge and start thinking whole system, 70% of patients who are admitted into hospital are known to the community teams.
- The important role which pharmacy plays within the patient discharge
- Realign the third sector Service Level Agreements to reflect service change, there is currently over £730,000 spent on commissioned third sector discharge services across Health and Social Care.

In order to further maximise the impact of the service four time limited task and finish groups have been developed:

- Revisit existing roles within patient discharge
- The role of Trusted Assessor
- The optimum In Reach service model for Gwent
- Complex Discharge

The diagram below illustrates the outcomes achieved by the service-referral rates into the service since its inception, the number of discharges the service facilitated and clearly outlines those patients who were medically unfit therefore unable to be discharged.



The information below illustrates the number of discharges broken down by Local Authority area, the information also aims to explain the service provided to individuals in order to facilitate the discharge from hospital.