



A Healthier Wales:

our Plan for Health and Social Care

Transformation Fund

Here is a summary of the models that have been approved so far through the Transformation Fund.

The aim of the fund is to improve health and social care services by scaling up models that are successful, and replacing less successful or outdated ones.

As a result people should see an improvement in their local services.

Summary of the projects

1. The Cwmtawe Cluster Whole System Approach

West Glamorgan Regional Partnership Board

The *Cwmtawe cluster whole system approach* sets out a transformed model of a cluster led integrated health and social care system for their area. The cluster network is made up of Swansea Council for Voluntary Services, GP practices and integrated health & social care team managers and covers Clydach, Morriston, and Llansamlet.

The cluster has developed a three-year plan to improve health and well-being. Three of the five GP practices within the cluster have now formally merged.

The project aims to:

- Improve the wellbeing of people of all ages. There is a focus on facilitating self-care and building community resilience. There will also be a focus on the earliest years, young carers and mental wellbeing.
- Co-ordinate services to maximise wellbeing, independence and care closer to home. This would include Cluster Networks having control to design, co-ordinate and implement services in partnership with the community that meet patient and carer needs. There will be a focus on older people to integrate services, try out new models of care closer to home, and reducing unscheduled admissions to hospital.

2. Seven cluster roll-out of the Whole System Approach

West Glamorgan Regional Partnership Board

Building on the work in Cwmtawe, The *whole system approach* rolls out to the remaining seven area clusters. The project sets out an ambition to significantly increase the scale and pace at which clusters become the vehicle to achieve a much greater focus on self-care and prevention, the integration of health and social care systems at the local level, and the delivery of care closer to home - within a managed programme environment.

This will accelerate learning on facilitating community resilience, strengthening self-care and the utilisation of existing community assets. It will accelerate cross organisational multi agency working. There will also be a positive effect on the overall clinical service pathways for a range of chronic conditions such as diabetes, heart failure, COPD, and a new approach to the way in which services are accessed and delivered, wherever possible at a local community level.

The project aims to:

- Improve wellbeing across the age spectrum. There will be a key focus on facilitating self-care and building community resilience. There will also be a focus on targeted population groups dependent on the cluster demographics.
- Co-ordinate services to maximise wellbeing, independence and care closer to home. This will include the clusters having control to design, co-ordinate and implement services in partnership with the community that effectively meet patient and carer need. There will 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.

3. Our Neighbourhood Approach

West Glamorgan Regional Partnership Board

The third project in West Glamorgan, *Our Neighbourhood Approach* will focus on making services work as a single system, by ensuring that staff from across all agencies are engaged in shaping and implementing changes. There will be a focus on building assets within communities and empower people to provide support to members of their own community rather than rely on statutory services alone.

The project aims to:

- Enable individuals to live longer, happier lives and take more control of their own health and wellbeing. This will include 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.

- Provide health and care through people that act as one team and work for organisations operating as one team.

4. Me, My Home, My Community

Cardiff and Vale of Glamorgan Regional Partnership Board

Me, My Home, My Community aims for seamless working in Cardiff and the Vale of Glamorgan. This project is a progressive approach to improving population health through a joined up system of community, third and independent sector partners, primary and community services. All partners will work together to support individual, family and community resilience. This should improve people's health and well-being, by reducing the need for secondary services and combatting the health consequences of loneliness, isolation and disconnection.

The project aims to;

- Change the way organisations work together in hospitals. For example local authorities will work with the NHS to provide increased daily contact on the wards. *Get Me Home Plus* will see people being assessed in their own home after being discharged from hospital, rather than being assessed before being discharged. This will give a better understanding of the support and adaptations needed in their home, and it will allow people to return home more quickly after a stay in hospital. Wrap-around care at home will be provided by healthcare professionals, social services carers, and social workers.
- Develop a well-being website to link services across the community and allow health and social care professionals to securely share information about patients.
- Develop and recommend community based care – for example community gardening projects, walking groups 'men's sheds', and 'talking cafés'.
- Develop a well-being workforce. In addition to social prescribers and existing well-being officers, reception staff will be trained to provide information and connect people to volunteer carers in the community.
- Identify people who are at risk and actively support them to remain as independent as possible. This involves creating better connections between hospitals, GPs, and pharmacists to ensure everyone is informed of individual patients' needs when they are discharged from hospital, and patients have one point of contact.
- Implement multi disciplinary teams, led by a GP, to develop and review services.

5. Implementing a Seamless System of Health Care & Wellbeing

Gwent Regional Partnership Board

Gwent's *Implementing a Seamless System of Health Care & Wellbeing* has two parts: the first is an early intervention, prevention and improved population wellbeing system with new integrated services. This is specifically around Integrated Wellbeing Networks, and Primary Care Transformation. The second, creating integrated models of health and social care, focusing on the service redesign of existing service models, in Children and Adult Mental Health Services and hospital discharge.

The project aims to:

- Establish a 24/7 hospital discharge scheme, which will mean that people are able to get home faster, with the right package of care in place.
- Redraw the landscape across Child and Adolescent Mental Health Services to deliver improved access to better services, closer to home.
- Implement a place based model of care in Caerphilly as an initial pilot, which will mean that people can access a range of new services within their community rather than being reliant on GP services alone.

6. Together for Mental Health in North Wales

North Wales Regional Partnership Board

The first of four approved projects in North Wales, *Together for Mental Health in North Wales* aims to promote the mental wellbeing of people in the area and to ensure that those with mental health problems and mental illness get the support they need when they need it.

The project aims to:

- Have an effective framework in each county for identifying people who are most vulnerable and take a multi-agency approach to prevent crisis occurring.
- Develop a multi-agency crisis care pathway that will provide prudent (right time, right response, right place) care and support that meets the needs of the person.
- Underpin the multi-agency approach to crisis care by training front line staff from all organisations on roles and responsibilities to improve practice and the experience for people in crisis, as well as to avoid escalation.
- Integral to the recovery pathway for people, the project will align with plans for developing supported housing in North Wales and key services which are currently not available.

7. Seamless Services for People with Learning Disabilities

North Wales Regional Partnership Board

The *seamless services for people with learning disabilities* model aims to help people with learning disabilities live more independently and get the care they need closer to home through better integrating health, social care and the third sector.

The project aims to:

- Develop better integration of health and social services with less duplication of record systems so people only have to 'say it once'.
- Develop the workforce to create better awareness of disability issues among the wider public sector workforce. This approach should reduce the demand for specialist learning disability services in future.
- Use assistive technology to help people with learning disabilities become more independent.
- Implement community and culture change by increasing the number of people with learning disabilities employed in paid work, access to training, and volunteering opportunities, with more effective regional approaches for social prescribing.

8. Integrated Early Intervention and Intensive Support for Children and Young People

North Wales Regional Partnership Board

This project sees opportunities in further developing its services to provide integrated seamless approaches to early help, and more timely and responsive assessment and support to bring about better outcomes to children and young people.

Through a whole system approach that focuses on the family, this project will transform integrated early intervention and support, in an integrated manner, to provide the right support and approach to build family resilience.

The project aims to:

- Help prevent problems from escalating through timely integrated support - including new approaches to early help and accessing therapeutic support.
- Establish multi-functional 'assessment and support' teams that provide responsive and intensive support that seeks to build individual and family resilience and facilitate effective de-escalation of complex/escalating/crisis situations,

- Achieve better outcomes for children and young people whilst reducing the need for costly, long term statutory intervention.

9. Community Services Transformation

North Wales Regional Partnership Board

The vision for the Community Services Transformation is that its community-based services will enable early help and support for people to be provided within their own home. Through this approach the outcomes for individuals will be improved and demand for hospital admissions and care provision will reduce over time. The project expects that over the next few years it will have reduced the need for hospital based care, and treatment will have shifted to health, wellbeing and prevention.

The project aims to provide:

- Well co-ordinated services designed around 'what matters', ensuring equality of access and services provided in the language people choose
- Help to navigate the health and social care system, as well as accessing a range of other services that would improve their well-being.
- Access to a range of preventative services, community support, advice and information.
- Access to a range of community support, care and therapeutic interventions.
- Assistance in dealing with crisis, end of life and on-going health conditions.

10. A Healthier West Wales

West Wales Regional Partnership Board

The West Wales Care Partnership brings together partners from local government, the NHS, third and independent sectors with users and carers. The aim is to transform care and support services by encouraging integration, innovation and service change.

To project aims to:

- Develop a wellness approach for people and staff, working across the whole health and care system, to improve people's health, working together to focus on well-being.
- Put safety and quality first, and ensure as a minimum that services do no harm, so that people can live safely within their communities. Any changes to hospital services and the way care and treatment is delivered to the

population will be carefully managed in a phased way, which prioritises safety and quality.

- Support people to live independently, where they can manage their health and well-being, focused around their own homes and localities. This includes speeding up recovery after treatment and care, and supporting self-management of long-term conditions. Working with key partners and staff to help build resilience and support people to live well within their own communities.
- Continuously engage to personalise and tailor health and care services to the needs and preferences of both people and localities, with a focus on supporting people to manage their own care and outcomes.
- Work with partners and staff across the whole health and care system to develop integrated services, where social, primary and secondary care are not seen in isolation but work together to provide services. They will be seamless and improve the experience for people by providing less complex, better coordinated care.
- Invest in staff and explore innovative workforce solutions to recruit, train and retain the best workforce for mid and west Wales.

11. Delivering a Healthy, Caring Powys

Powys Regional Partnership Board

Delivering a healthy, caring Powys will support the scale up of new models of seamless health and social care in North Powys.

The project will deliver a significant change in the way services are provided and promotes wellbeing, early help and support, utilising social and green prescribing opportunities and encouraging people to take greater responsibility for their wellbeing and plan for their future health needs.

The project aims to:

- Enable citizens, staff and partners to be actively involved in the delivery of the new integrated model and support a new approach to delivery in North Powys.
- Achieve wider connectivity across Mid Wales to improve equity of service to a rural population through integrated health and care pathways across counties.
- Multi-agency wrap around services with focus on prevention and risk stratification tools to reduce emergency admissions.
- Increase uptake of prevention services to reduce smoking, achieve greater participation in physical activities, undertake targeted risk assessments for

people with cardiovascular disease and minimise the impact of clinical risk factors (improving adherence to medicines).

- Enable more people to live independently and remain at home safely through technology enabled independence and care; and more integrated working to prevent needs from escalating and immediate intervention at time of crisis.

12. Cwm Taf – Stay Well in Your Community (part 1) Cwm Taf Morgannwg Regional Partnership Board

Cwm Taf Morgannwg Regional Partnership Board is developing a whole system population health and social care model which responds to the voice of the individual through three layers:

- Wellbeing;
- Integrated community care, closer to home; and
- Acute health and social care and tertiary health services

It will focus on scaling up and linking pilots which have already delivered proven benefits across Cwm Taf. These are:

- Risk stratification and segmentation – the current pilot links and analyses primary and secondary care data to segment the cluster population into distinct groups based on their collective characteristics.
- Cluster focused multi-disciplinary teams – a ‘virtual ward’ approach has been piloted in Cynon Cluster. A multi-disciplinary approach is to providing support to reduce demand on general practice both in and out of hours and in Emergency Departments.
- Stay Well@Home – in response to growing pressures in Emergency Departments and the challenge of patient flow, integrated multidisciplinary teams have been introduced in Prince Charles and Royal Glamorgan Emergency Departments, Acute Medical Unit and Clinical Decision Unit departments.
- Detecting cancer early – in line with the Health Board’s Early Cancer Diagnosis Programme, a Rapid Diagnostic Clinic has been piloted across Cwm Taf since July 2017.

As the model continues to develop and test at scale a new system of seamless services, formal evaluation and dissemination will allow projects to be implemented at pace across other regions. This will empower staff at Cluster and Locality level to transform the way they work and the services they provide.

Bridgend – Accelerating the Pace of Change for Our Integrated Services *(part 2)*

Cwm Taf Morgannwg Regional Partnership Board

Bridgend County Borough Council and Abertawe Bro Morgannwg University Health Board (now part of Cwm Taf Morgannwg Health Board) in partnership with Bridgend Association of Voluntary Services has developed integrated and joint models and approaches for community services for adults. This is based on pre-emptive early interventions, to ensure that people receive timely responses that are proportionate to their needs, and that promote people's independence, voice and choice.

The project aims to:

- Have seven day access to community health and social care services – “Every day is Tuesday”, delivering extended alternative service options to hospital and long term care.
- Have a primary and community care multidisciplinary team approach, delivering a one team approach around people, coordinating primary care and community services cluster responses.
- Develop and deliver resilient coordinated communities; with key organisations, their partners and the communities that they serve developing benefits, by working collaboratively to apply preventative approaches that enhance the wellbeing of the population of Bridgend.

End

