Appendix 2

Proposal Title:	**Gwent Transformation Programme 'Delivering a seamless system of care for Gwent'**
Reporting Quarter:	Quarter 2 - 1 Apr 2019 to 30 Jun 2019
Reporting Date:	July 2019
Contact:	Dr Emily Warren

A brief summary of progress within the project from beginning to the current quarter

Main Achievements between 1 April – 30 June 2019:

Headline Achievements

- Compassionate Communities engagement with all 20 GP surgeries has been successfully completed with small steering groups now set up and running and mentoring has commenced in 7 GP practices
- Talks underway to extend capacity by utilising existing resources (community connectors) in Caerphilly and Blaenau Gwent.
- Cohort one of both the nursing and pharmacy academy are approaching 6 months in role –the pharmacy arm are already started to see indicative benefits of having pre-registration pharmacists in practice – and two nurses have taken up permanent roles in practice. Nursing cohort 2 begins in October
- Delivery plan agreed for 'whole school approach to emotional wellbeing' as part of the ICEBERG model
- SPACE successfully implemented with referral data due to be shortly available but positive outcomes collected from families and a 'promotional 'video is currently under commission

In the period between 1.01.19 – 30.06.19 the Home First Teams across the two sites have:

- Seen 930 patients and across this cohort have visited to assess/support 1245 times.
- From this cohort 477 were discharged on 501 occasions (19 had more than one instance of discharge in 6 months)
- 42% of the overall total patients seen were not deemed medically fit for discharge
- 89% of patients deemed medically fit were discharged.
- Admission Avoidance - 30+ patients have been identified as not requiring attendance.

Strategic Programme Delivery

- All four programmes continue to progress at pace, with Q1/Q2 delivery largely on track. The Regional Partnership Board and the Leadership group continue to receive substantive updates on the programme, enable scrutiny and effective collaborative leadership to guide the programme. Governance is robust with an effective framework established with a Programme Leads Operational Group (PLOG) reporting into an Executive led 'Transformation Steering Group' which meets on a three weekly cycle to ensure pace and progress are maintained. Initial milestones across all four programmes have been achieved, but delays to recruitment have caused ongoing effects on some aspects of the programme which has led to some underspend. Programme leads have developed mitigation plans for these and which are currently being scrutinised by the RPB Leadership Group. These are most prominent in the ICEBERG programme and Place Based Care. We are confident that the revised plans will ensure that these risks are mitigated.

Delivery continues to be the primary focus, but as we draw to the close of Q2 the following area areas of ongoing priority**:**

- **Measuring, capturing and disseminating Impact:** All programmes have analytical capacity and are collective quantitative and qualitative data to demonstrate programme impact. Critically significant emphasis has been placed on capturing patient stories and service user experience, to shape continued model development throughout the remainder of the programme.
- **Sustainability:** Challenge and Support sessions have been held for Directors to take an 'early temperature check' on progress and to inform the development of a process to determine if the programmes are deemed to be delivering the intended outcome, how they can then be upscaled at pace post the end of the transformation funding. An initial sustainability report is due to be received by Leadership Group in September.
- **Evaluation:** Significant work has gone into developing an evaluation framework, which complements national requirements and is fit for purpose to inform the RPB in their decision making role, regarding the outcome of the transformation programmes. A tender is now live on Sell2Wales, and follows a successful market engagement event in July. A contract award will be made in September, with four reports required at specified intervals to align with WG requirements and the Gwent RPB meeting cycle in 2020, alongside the final follow up report in 2021**.**

- **Engagement**

Ensuring that the staff working across the projects are informed, and engaged as co-producers is critical, as is engaging our public as those who will be using and testing the utility of the new services. We have placed considerable emphasis on engagement and communication, and programmes are in the process of securing communications and engagement dedicated capacity, as we complete Q2. There are now significant changes and outcomes to communicate, and engagement will be critical with staff and the public to help programme leads to determine, what works well.

We have:

- Held a regional engagement event for each programme during July, where early outcomes for each programme were articulated and a series of questions posed in group work format to help inform future planning.
- Ensured that the Transformation Programme has had a profile at a range of regional events and relevant working groups including internal committees of the Health Board.
- Established a formal meeting mechanism with GSWAG to ensure alignment between the PSB priorities across Gwent and the transformation programme. Specific links have been made with the Integrated Wellbeing Network programme and the Place based care Programme. Through links with the Early Action on ACE Board the ICEBERG programme is also well linked.
- Presented at National Conferences including the WCVA Annual Conference
- Presented to each of the RPB Strategic Boards, which includes Carers, Adults, LD and Mental Health and Housing.

Change Achieved

- **ICEBERG:** The introduction of the SPA is slowly embedding a different referral pathway and a change in culture for GPs particularly. Feedback from the LMC is positive but highlighted that the implementation of such significant change at such pace, did not facilitate effective consultation. This reflection is key, and requires considerable careful thought in the pace at which change is being made.
- **HOMEFIRST:** The culture change required is slowly embedding, with the ‘trusted assessors’ becoming more known and understood. Significant analytical evidence is available to demonstrate the extent of hospital admission avoidance, and the improved discharge time. Initial workshops have been held to consider how to widen and develop the model to spread change management across the entire model, rather than just the prevention of avoidable admissions.
- **IWN:** Significant engagement work has been undertaken to galvanise community resources, in the mapping, networking and analysis of capacity. It is recognised that the PSB have a key role to play and link officers have been identified. Much progress is around ‘traction’ of the concept and an understanding that how community resources are planned and delivered to support seamless care and improved wellbeing is critical to success. All five locality leads are now in the process of developing implementation plans.
- **Place Based Care:** There is real buy in and traction across Gwent, led by the local authorities and Health Board, the Compassionate Communities Model is finding its 'Gwent Feet’ as a set of principles to guide the planning and re modelling of services. As critical partners GPs have engaged with this programme, with mentoring and development support already underway, and discussions around upscaling already being considered. This work in particular is timely in that it will inform the first iteration of NCN IMTP in September.

INTEGRATED WELL BEING NETWORKS Milestones for delivery during Q2 (April to June 2019)

Description of the Target	Date by when it should be achieved	Action taken / outputs
Programme objective 1: Establish place-based co-ordination and development of well-being resources ○ 1.1 Map existing programmes aimed at promoting well-being or co-ordinating use of resources on a place basis and take action to ensure alignment with IWNs ○ 1.2 Place Based Well-being Networks: Phase1 – verify the well-being assets of the area and engage participation in the place based collaborative Well-being Networks / forum ○ 1.3 Identify key engagement networks & contacts in each locality ○ 1.4 Develop a plan of opportunities and appropriate methods for collaborating with the community in each LA area to develop well-being information, advice and assistance, including under-represented groups	30th June 2019	○ Key programmes have been mapped in all areas and links have been made with PSBs and Integrated (health & social care) Partnerships. Work to align key programmes to IWNs has begun and will continue. ○ Initial geographical 'places' have been identified for establishing well-being networks and assessing the potential to deliver existing programmes on a place basis. In Torfaen, Blaenavon and Llanyrafon have been agreed; Newport around the East and West of the city linked to 4 developing hubs; Caerphilly in Rhymney, Bargoed and Lansbury Park; in Blaenau Gwent places are being agreed. ○ The programme team have utilised the mapping already undertaken as part of the initial baseline review as a starting point for identifying and engaging community well-being assets, and have been verifying this information and making further contacts. This will be an ongoing activity and partners will continually be engaged and invited to join the well-being networks. ○ Plans are progressing in all areas for establishing initial well-being network meetings in the next quarter, involving identified partners. A place-based collaborative is beginning to develop in Blaenavon in

		the form of a 'Healthy Blaenavon Steering Group' which will hold an initial workshop in July. ○ The Community Development and Engagement Practitioner has identified and made links with PSB Engagement Groups and officers involved in public engagement and community development across various organisations in order to establish how these functions can support Integrated Well-being Networks, and what techniques are already being used ○ Profiles for each area are in development, including key demographic groups and appropriate methods for engagement, in order to inform the work of place based well-being networks as they are established ○ Work to re-develop the Community Health Champions programme alongside GAVO has been accelerated, and a review of the existing programme and new delivery model are being developed. This will align with Compassionate Communities
Programme objective 2: Identify ways that hubs can be centres for well-being resources in the community ○ 2.1 Verify well-being 'offer' within hubs in the place and engage them in the place based Well-being Network	30th June 2019	○ A summary of hubs, what they offer and whether they are engaged and networked with each other is being developed in each area, utilising the existing baseline review mapping. ○ There has been engagement with a range of hubs in each area to align with IWNs at an early stage and identify ways to develop a network of hubs. This will continue in quarter 3. For example, in Caerphilly there are plans for creative mapping exercises to generate community owned well-being maps for Rhymney. In Torfaen the Service Development Lead will work closely with Bron Afon on the launch and implementation of their Pontypool hub in order to links IWNs at the earliest stage of development. In Newport where hubs are newly developing, liaison will take

		place with hub managers when they are appointed, and background work is being undertaken on an 'ideal' hub offer, linked to community profiles and other intelligence.
Programme objective 3: Develop the well-being 'workforce' (people delivering services and support) ○ 3.1 Verify Linking Roles in the locality and engage them in the Place based Well-being Network	30th June 2019	○ Verification and updating of linking role mapping is being undertaken in all areas. In Torfaen, this has been linked to work being undertaken by the NCNs and overseen by the Integrated Partnership. ○ In North Caerphilly and Blaenau Gwent, this work has been aligned to the development of Compassionate Communities, to ensure best use is made of the resource already in place

PLANNED MILESTONES FOR THE NEXT QUARTER – Q3. JULY 2019 TO SEPTEMBER 2019

1. Establish place-based co-ordination and development of well-being resources
1.3 Establish place based collaborative Well-being Networks (by 30th September 2019)
***Phase 2*:** Establish network / forum – aim to determine:

- Collective understanding of what a well-functioning place based well-being approach looks like,
- What it means for individuals
- A common set of values
- What is currently preventing this from working well and opportunities for improvement?
- How community engagement and co-production will be embedded in the place based Well-being approach

2. Identify ways that hubs can be centres for well-being
2.2 Develop and implement a plan (by 30th September 2019) to:
○ develop the well-being offer in public sector hubs
○ Increase connectivity between hubs to enable place based collaborative working
(N.B. This may align with Place based Well-being Network priorities and improvement projects)

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

3.2 Facilitate a local workshop(s) to:

- Develop a collective understanding of what a well-functioning place based well-being approach looks like
- Map current referral pathways for 'linking roles'
- Identify what is working well
- Identify opportunities for improvement
- Identify how Compassionate Communities will complement this (N Caerphilly & Blaenau Gwent)

3.4 Facilitate mapping of the well-being workforce in each Place-based Well-being Network, and co-production of a training plan aligned to agreed vision and values

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

4.1 Facilitate Mapping existing approaches to communicating WB information in each Place-based Well-being Network, and co-production of a communications plan

2. PLACE BASED CARE

Description of the Target	Date by when it should be achieved	Evidence required
Workforce stabilisation phase one – All posts with practice agreement to fund post transformation have been given go ahead	End Q2	Recruitment update from each HOS Five posts are appointed too, the remainder are still to be appointed too MH division are currently working up their offer to support the initiative to ensure that the existing service is not destabilised
Workforce stabilisation phase one –for all posts without practice agreement to fund post transformation are still to be fully agreed, options appraisal is currently under review with divisional leadership team	End Q3 End July	Financial/Workforce risk has been quantified SLT are currently deciding on how to proceed with the wider organisation
Compassionate Communities – Engagement with all 20 GP surgeries through bi-monthly steering groups and coaching/mentoring	End Q2	Steering groups are now set up and running separate from NCN meetings, coaching/mentoring has commenced in 7 practices

Compassionate Communities – Identification of practice based community connector resource	End Q2	BG have committed resource from connectors available, An agreement with Caerphilly to appoint additional connectors has been reached
Compassionate Communities – Commencement of MDT sessions and GP fellows to be recruited as backfill	End Q2	MDTs have now taken place across 4 practices and 3 GP fellow post are out to advert
Compassionate Communities – Recruitment of IT post and implementation of common IT platform	End Q2	IT post appointed too and connector forms have developed and sent to Vision for implementation
Dental contract reform phase one – Introduced and complete by April 2019	End Q1	11 practices signed up and working to revised UDA rate
Dental oral health improvement – Practitioner appointed and programme underway	End Q1	Programme monitoring on monthly basis, outcome measures developed
Dental early years access – Team appointed and programme underway	End Q1	Programme monitoring on monthly basis, outcome measures developed
Training academy – Pharmacy cohort one	End Q1	Cohort one appointed and currently on rotation with agreed training practices – outcome measures developed

Training academy – Nursing cohort one	End Q1	Cohort one appointed and currently on placement with agreed training practices – outcome measures developed
IAA: Increased capacity of IAA service (support worker capacity)	End Q2	Capacity in place. Aligns support of current social care support to Compassionate Communities/IWN

QUARTER 3 MILESTONES: **PLACE BASED CARE**

Proposed milestone	**Date by when it should be achieved**	**Notes**
Workforce stabilisation phase one – staff to be inducted and in post	End Q3	Outcomes measurements to be developed and agreed
Workforce stabilisation phase two – opportunity to be extended to remaining practices that have been identified to have sustainability challenges Staff to be appointed to by end September	End Q3	Practices to be identified and approached with offer of 6 months funding to test new extended roles

Compassionate Communities – Introduction of discharge liaison model across community hospitals in first instance and secondly complex patients in acute hospitals	End Q3	DLN staff calling practices to report discharges on same day. Work ongoing to introduce phases one and two, phase three; calling practices for all noncomplex patients is being process mapped ahead of agreeing how to implement
Compassionate Communities – Recruitment of education post in partnership with third sector	End Q3	GAVO have provided initial offer – to be reviewed and agreed by divisional leadership
Dental contract reform phase two – offer will be given once again to all practices in Gwent	End Q3	Expressions of interest for phase two required by end of August for October start date
Training academy – Therapies cohort one	End Q3	Meeting to discuss options for September cohort scheduled for July
Training academy – Nursing cohort two	End Q3	Second cohort have been appointed to and commence 17th October
KPIs and robust evaluation process to be agreed and shared with all practices for all work streams	End Q3	All KPIs to be agreed and in place
Communication Strategy to be developed and agreed	End Q3	TBC
Accommodation Strategy to be developed and agreed	End Q3	TBC

Outcome measures across each programme work stream	End Q3	To be developed and monitored in line with individual work stream aims and objectives

3. THE ICEBERG MODEL / CAMHS TRANSFORMATION

Description of the Target	Date by when it should be achieved	Evidence required
Development of logic models for the overall programme and each individual component	June 19	Target achieved - logic models using the WG theory of change template have been developed for each programme workstream together with an overarching programme logic model.
Commence implementation of Peer Support	June 19	Target achieved - Peer Support implementation (Gofal 4YP) has commenced. Waiting list issues left by previous peer support provider have been successfully resolved
Commence implementation of Community Family Intervention	June 19	Target not achieved – as a result of significant delays in the procurement process and recruitment challenges, full operational implementation of this service will commence in September 2019. Full value from the contract (tender was awarded to Action for Children) will be ensured by (1) increasing the geographical coverage of the service in the 19/20 period (the service will cover the LA areas of Newport and Torfaen, significantly over 1/3 of the Gwent region); (2) increasing staffing levels to ensure sufficient provision to these areas; (3) undertaking preparedness work that will enable delivery to the Blaenau Gwent and Monmouthshire LA areas from April 20.

		Start date for Blaenau Gwent / Monmouthshire may be moved forward (to January 20) using programme slippage.
Develop programme plan with focus on initial implementation for Community Psychology	June 19	Target achieved – workstream delivery plan has been developed for implementation in Q3. Implementation plan is staggered as a result of delayed start dates for Community Psychology staff commencing in some LA areas. Plan is being presented to CAMHS Transformation Steering Board in July 2019.
Develop programme plan with focus on initial implementation for Parent-Infant mental Health	June 19	Target achieved – workstream delivery plan has been developed for implementation in Q3. Plan includes provision of training, supervision and consultation; access to psychotherapy; integration of parent-infant mental health focus in early years developments including 'early responsiveness team'.
Finalise plan and undertake recruitment for whole-school approach to emotional wellbeing	June 19	Target not achieved. Recruitment for ABUHB post has been completed but recruitment for Education-hosted posts has had to go through SLA (which has been developed). Aim is that posts will be interviewed for in July and August 2019. Workstream plan has been developed but not all objectives have been met within planned timescale as a result of recruitment delays and limited capacity across partners to progress the work. Meeting with Senior Leaders is being scheduled for August to review and revise workstream plan.

QUARTER 3 MILESTONES: ICEBERG

Programme	**Proposed Milestones**
CAMHS transformation / Iceberg Model	• Complete procurement for programme evaluation • SPACE-Wellbeing: initial evaluation / early learning with recommendations • Whole-school approach: complete recruitment, commence consultation to support development of Regional approach, review and revise workstream plan • Community Psychology: commence implementation • School nursing: commence implementation of training plan, commence service delivery • Develop stakeholder and public engagement strategy and commence implementation • MyST commence operational delivery in Blaenau Gwent and Monmouthshire

4. **HOMEFIRST**

Description of the Target	**Date by when it should be achieved?**	**Evidence required**
Undertake a gap analysis across Gwent in order to determine current availability of third sector service	**By Sept 2019**	A Gap Analysis has started to be completed across third sector agencies. Aligned to this is the review of ICF provision across the

and securing a Gwent wide approach.		third sector and WAG funded projects for example Red Cross (Pastoral Care in the RGH) and Care & Repair
Procure Service and provide contract for the successful service provider	**By April 2020**	This will commence following outcome of the analysis.
Third Sector organisation appointment for discharge support in the community – providing a pathway from statutory services.	**By April 2020**	This will commence following outcome of the analysis.
Learn Lessons from the first 6 months of service delivery to ensure that the service is proactive and supports core service delivery.	**By June 2019 and ongoing review.**	- Identification of key stakeholders to support implementation, delivery and review. This is ongoing and forms part of the communication strategy. - Recruitment of Home First staff on both sites is now complete. A dedicated team in place prior to launch would have been a preferred option to support consistency, engagement and identity.

		- IT requirements on both sites are now in place and have improved the operational requirements. IT requirements and infrastructure prior to launch would have been a preferred option. - Identified base to locate the Home First Team on both sites prior to launch would have been a preferred option. There have been challenges with finding suitable space to operate from which has impacted on visibility, engagement and development of the service. There is an agreement that Home First will have desk space within the Hub on NHH site when it moves location which is expected to have a significant impact on coproduction between health and the service. - Understanding of demand as the project has developed and embedded into practice. Demand patterns will support the review of the service and operational requirements going forward and options for sustainability. - Understanding and recognition of the different identities, cultures and operational processes of each site was and remains a key requirement in the future provision and sustainability of the service.
The Home First service will develop a communication strategy that supports delivery of the service. The strategy will be both inward and external facing and will be undertaken in a number of ways to ensure the widest spread possible	**Ongoing**	There have been a number of key developments which include - Home First video which is on social media, ABUHB website etc - Information about the service has been published in ABUHB newsletters. - Information about the service has been published in the local area of one of the main sites. - A leaflet is currently being developed for wards/patients/families etc

i.e social media, patient literature and face to face engagement exercises.		- Key links between Home First and the Local Authorities are continuing to be developed to disseminate information about the service. - There is ongoing work to enhance and improve communication with key stakeholders to ensue Home First is at the forefront of discharge planning on the identified wards.
The data collated illustrated a number of key findings about current admission system and a greater level of analysis is required to: - Understand admission of patients who could be cared for within their own home, the length of stay for these patients and the access to packages of care – whether the time of the assessment has an impact on the availability of POC's. - Ensure that discharge forms are signed off as quickly as possible - Potential to spread Home First discharge ethos across existing discharge processes. Develop	**Ongoing monthly reporting**	There is now a dedicated part time resource attached to Home First to support a more in-depth data analysis. Ongoing recruitment for the remainder of the resource available is being undertaken. There will be an ongoing review of the data collected to ensure accurate definition and consistency when recording. This is critical to ensure the analysis and identified outcomes are a true representation which may influence and identified changes in for example, culture/working practices/processes. In the period between 1.01.19 – 30.06.19 the Home First Teams across the two sites have: - seen 930 patients and across this cohort have visited to assess/support 1245 times.. - From this cohort 477 were discharged on 501 occasions (19 had more than one instance of discharge in 6 months) - 42% of the overall total patients seen were not deemed medically fit for discharge

a scoping exercise to understand how these processes can be aligned using the Home First approach and brand.		- 89% of patients deemed meeically fit were discharged. An immediate overview of data also includes - Admission Avoidance - 30+ patients have been identified as not requiring attendance. Further information is being collated around what could have been done in the community to prevent this. The information collated is an opportunity to link in with key stakeholders including third sector/primary care etc. Ongoing work is being undertaken to determine between each Local Authority the discharge pathways to support any potential future alignment. There is now a clear increase in the number of referrals to Home First which is reflected in the increased number of weekly discharges.

SUMMARY OF Q3 PROPOSED MILESTONES: HOMEFIRST

Programme	Proposed Milestones
HomeFirst	Map IAA across the Authorities to support discharge Pathways. Review the interface for Home First and consider how Home First as an ethos supports an integrated discharge pathway across the hospitals.
	Identify Funding Streams for existing Third Sector Agencies to support any review and alignment for future hospital discharge/community support services.
	Ongoing review of Communication Strategy to include: - Engaging key stakeholders - Interface with Third Sector providers - Ongoing interface with operational staff to support a review and further development/design/requirements of Home First

	The data will be produced in line with the agreed PI's on a monthly basis and reported through agreed channels to support evaluation/analysis and outcomes for change.
	Home First to track cases that are not discharged and are admitted into hospital. The information obtained from the patient journey will support ongoing work and interface in relation to Home First as a service and brand.
	Review of the demand and requirements to inform the ongoing operational delivery.