Health & Social Care
Regional Integration Fund

Gwent Regional Partnership Board
Strategic Outline Plan 2022-23

DRAFT

Bwrdd Partneriaeth Rhanbarthol Gwent
Gwent Regional Partnership Board

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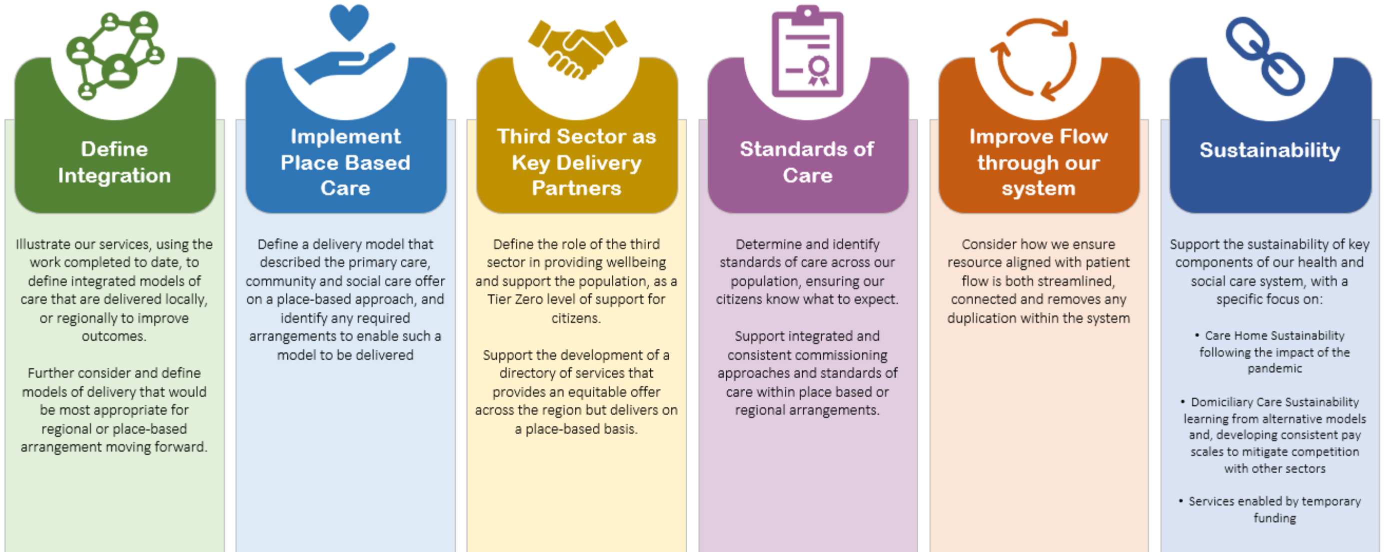
Development Approach

The transition period afforded provided by Welsh Government during the 2021-22 financial year allowed for thorough consideration of an established portfolio of work delivered within our regional partnership. To demonstrate our intent and commitment to the consideration and strategic development of a new programme, regional strategic priorities were established by the Regional Partnership Board.

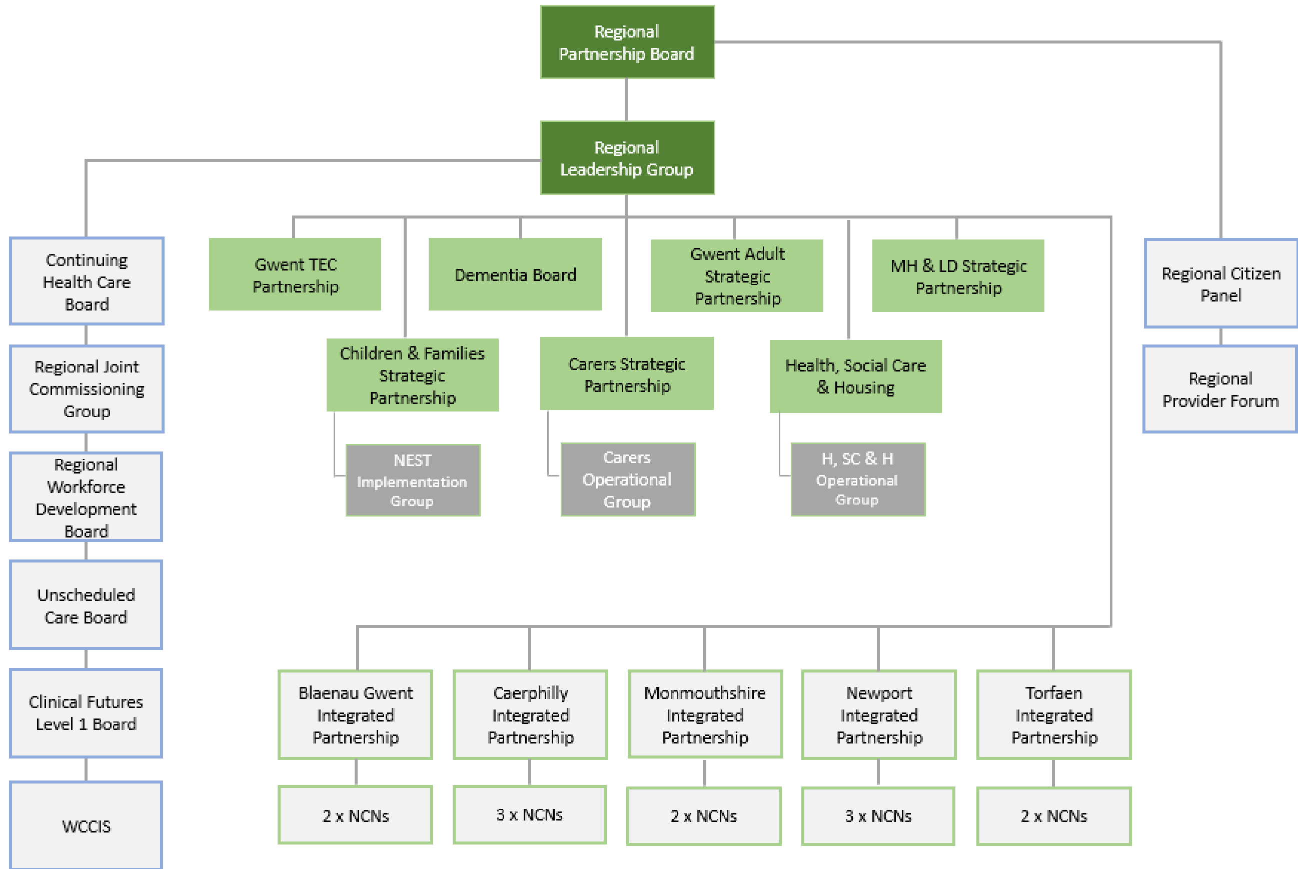


Recognising the level and range of services enabled by partnership funding, thorough assessments were undertaken to demonstrate the learning and potential risk within the system should services need to cease due to funding availability. The evaluation and assessment approaches focussed on supporting sustainability planning, to identify areas of good practice and learning able to be shared, to introduce or strengthen regional models of delivery. The outcomes and impact of the projects, along with weighted prioritisation scoring and workforce implications were all included during this process. This allowed for refreshed strategic priorities to be developed to enter into a new 5 year programme for Gwent Regional Partnership Board, as part of the overall development approach illustrated below.

A refreshed programme infrastructure supported by our strategic partnerships has established the transformation ambition described within this strategic plan. This detail will continue to be developed over the coming weeks and months to ensure we have a rigorous programme of transformation. More detailed aspirations will be established for models of care reflective of our regional programme developments. We will ensure clear benefits realisation plans and timeframes are developed to support the continued implementation of the new Regional Integration Funding model. The ongoing development activities will be reflected within a live version of this strategic plan and shared across the partnership, and with Welsh Government, at regular intervals.

Regional Infrastructure

As one of the largest Regional Partnership Boards in Wales, our partnership infrastructure is wide reaching to support collaboration across all priority areas for integration as established within the Social Services and Wellbeing Act (Wales) 2014, and the requirements of the Part 9 statutory guidance and Partnership Arrangements Regulations.



The supporting resource to enable this infrastructure and collaboration is provided via regional resource configured within two distinct areas; a Portfolio Management Office, and a Partnership Team.

Dedicated capacity for the implementation and management of partnership programmes, including governance and evaluation, is provided within our Partnership & Integration Portfolio Management Office. The PMO also has responsibility for partnership funding utilisation and financial governance as an enabler to the integration and transformation agenda.

The Regional Partnership Team provides dedicated capacity to the partnership infrastructure, and leads on the Part 9 requirements for the Regional Partnership Board to support the membership and governance of our Regional Partnership Board, and undertaking of our Population Needs Assessments and Market Stability Reports.

In the context of refreshed membership of the Regional Partnership Board, and the development of a new strategic transformation programme emerging, a scoping exercise is currently underway to determine the total regional resource requirements, and the change management capacity required within programmes to support our place-based approaches to transformation and integration within operational services.

This section will be updated to confirm the total utilisation of the £750,000 regional resource funding from the Regional Integration Fund, along with the resource match from the Regional Partnership Board in due course.

Regional Continuous Engagement Approach

Our aim is to be open and progressive in our continuous engagement efforts. Our partnership infrastructure supports continuous engagement across all sectors, and our engagement forums will be strengthened to respond to feedback. The Regional Partnership Board will provide a transparent and connected network of partners, services and social value organisations enabling the delivery of our strategic priorities and transformation programmes.

As outlined within the Social Services and Wellbeing Act (2014) coproduction will be an integral part to the development of our RPB 5 year plan. The Population Needs Assessment demonstrated a clear commitment to collaborative and co-productive working. In 2022/23, we will continue to build on the work undertaken to develop a Regional Communication and Engagement Strategy.

Coproduction will be a golden thread within our continuous engagement approach; we will continue to use a variety of methods tailored to a wide range of stakeholders, ranging from formal committees and boards, partnership and provider networks, to more direct public facing communications. Engagement with citizens and communities will be a continuous driver to empower them to give feedback to ensure services meet their needs and improve their individual outcomes.

Each regional strategic programme will have a communication and engagement strategy and accompanying plan, to illustrate how coproduction will be achieved within each area.

Population Needs Assessments

The findings of the population needs assessment have been included within each strategic programme development session and reflected within the strategic outline investment plans herein.

The thematic structure of our strategic partnerships aligns with the population cohorts identified within the population needs assessment, supporting Gwent RPB to deliver against the needs identified. The RIF Strategic Outline Plan describes our regional programmes that will address the needs identified, summarised below.

Children & Young People

- Improve outcomes for children and young people with complex needs through earlier intervention, community-based support, and placements closer to home
- Ensure good mental health and emotional well-being for children and young people through effective partnership working, especially mitigating long-term impact of Covid-19 pandemic.
- Strengthen a single front door approach to reduce hand offs and establish a sequenced approach to multiple intervention needs
- Implement principles of NEST/NYTH as a whole system approach
- Eliminate profit in residential care for children looked after

Older People

- Improve emotional wellbeing for older people by reducing loneliness and social isolation with earlier intervention and community resilience
- Improve outcomes for people living with dementia and their carers
- To support older people to live, or return following a period of hospitalisation, to their own homes and communities through early intervention, integrated care models and a whole system approach
- To mitigate the long term impact of Covid-19 pandemic through reducing waiting lists and times to access support, appointments and medical procedures

People with Disabilities

- Support disabled people, including sensory impairment, through an all-age approach to live independently in appropriate accommodation and access community-based services
- Ensure people are support through access to accurate information, assistance and 'rehabilitation' where required
- Improve transition across all age groups and support services
- RPB to ensure all frontline workers receive up to date training and awareness raising
- Recruitment across health and social care needs to increase including specific roles such as rehabilitation officers for visual impairment

People with Learning Disabilities

- To support people with learning disabilities to live independently with access to early intervention services in the community
- Greater public awareness and understanding of the needs of people with learning disabilities
- Increase the number of bespoke and individual support packages for people with a learning disability which will involve more one to one support in the community
- Recruitment to a greater number of volunteers

Awareness of Mental Health

- Increase understanding and awareness of mental health amongst the public to reduce stigma and help people to seek support earlier
- Improve emotional wellbeing and mental health for adults and children through early intervention and community support

Unpaid Carers, including Young Carers

- Support unpaid carers through flexible respite, access to accurate information, peer to peer support, effective care planning and increased public understanding
- Improve wellbeing of young carers and young adult carers, and mitigate against the long-term impact of Covid-19 pandemic
- Increase awareness of the needs of unpaid carers and the ability for frontline staff to recognise those with caring responsibilities and signpost for information
- Increase support through third sector and community partners to increase befriending opportunities and community groups

Housing

- Ensure appropriate housing and accommodation for older people and vulnerable citizens via a multi-agency partnership approach
- Effective use of Disabled Facilities Grants and appropriate partnership support from available resources
- Collaborative response to homeless from public services and partners, especially the use of unregulated placements for young people, through prevention and early intervention

Investment Appraisal

The total allocation of the Regional Integration Fund for Gwent Regional Partnership Board is £26,858,840. Whilst the funding is provided at the outset of the financial year (to be allocated as determined by the Regional Partnership Board in line with RIF guidance), part of the financial allocation is ringfenced for specific use, or for specific priority groups where minimum investment levels are identified.

The ring-fenced elements of the Regional Integration Fund relate to the Dementia Action Plan (£1.611m), Memory Assessment Services (£0.565m), the Integrated Autism Service (£0.458m) and ring-fenced carers funding (£0.191m).

This section of the Strategic Outline Plan describes the utilisation of the funding, and adherence to the funding model within Year 1. The percentages shown within this information relate to the total allocation of funding (£26.8million).

Further detailed work will be undertaken to understand the benefits realisation of each regional programme and clear medium term financial plans to reflect the funding model identified within the RIF guidance.

Match Resources

Match resources are a key principle of the Regional Integration Fund (RIF) and are intended to assist with levering sustainable change across our health and social care system. Match resources can be made up of two key elements, monetary and wider resources; monetary match funding consists of direct financial contributions from core funds or other non-Welsh Government grant sources, the wider resource contribution consists of staff time, volunteer time, and use of premises and / or facilities.

The match resources brought alongside the RIF investment reflect the total scope of the regional programmes that will support the delivery of the national models of integrated care. Within each programme the resource matching is clearly identified. It is noted that a consistent position across all partnership organisations identifies no monetary match available in Year 1 (2022-23). Our development work will identify the budget tapering realisation across our plan, and the budgetary match contributions from partners, that will be included in a more detailed medium term RIF plan.

The requirement to provide resource match between 10% and 30% of the budget has been achieved. The calculation across the total portfolio identified an average 31% resource match. The summary overview below provides the resource match identification within each model of care.

	2022/23	**2022/23**	**2022/23**
Models Of Care	**Provisional Budget**	**Resource Match**	**% Resource match**
Community Based Care - Prevention & Community Coordination	£5,306,245	£886,429	17%
Community Based Care - Complex Care Closer To Home	£9,001,418	£2,917,406	32%
Promoting Good Emotional Health & Wellbeing	£1,677,683	£231,244	14%
Families Staying Together & Therapeutic Support For CEC	£3,299,271	£2,090,413	63%
Home From Hospital	£4,070,009	£1,127,273	28%
Accommodation Based Solutions	£0	£0	
TOTAL	**£23,354,626**	**£7,252,764**	31%

Social Value

The target of 20% investment in the third sector has not been reached at the outset of the programme with 11% of the RIF directly provided to third sector organisations. This is due to the previous requirement of the 20% only being applicable to the Integrated Care Fund (20% of £16million). With growth in funding level that the investment target

is now applicable to, and the majority of the funding already utilised to sustain existing activity, additional focus will be needed to work towards this target in the development of additional projects and services.

	2022/23	2022/23	2022/23
Models Of Care	**Provisional Budget**	**Third Sector Budget**	**Third Sector %**
Community Based Care - Prevention & Community Coordination	£5,306,245	£1,192,217	22.47%
Community Based Care - Complex Care Closer To Home	£9,001,418	£337,751	3.75%
Promoting Good Emotional Health & Wellbeing	£1,677,683	£757,139	45.13%
Families Staying Together & Therapeutic Support For CEC	£3,299,271	£200,000	6.06%
Home From Hospital	£4,070,009	£476,702	11.71%
Accommodation Based Solutions	£0	£0	
TOTAL (INCLUDING OTHER)	**£23,891,803**	**£2,963,809**	**11.03%**

Minimum Investment Levels

The 5% minimum investment level established for carers has been met with 5.22% investment already provided to this vulnerable population group.

	2022/23	2022/23	2022/23
Models Of Care	**Provisional Budget**	**Carers Budget**	**Carers %**
Community Based Care - Prevention & Community Coordination	£5,306,245	£1,402,798	26.44%
Community Based Care - Complex Care Closer To Home	£9,001,418	£0	0.00%
Promoting Good Emotional Health & Wellbeing	£1,677,683	£0	0.00%
Families Staying Together & Therapeutic Support For CEC	£3,299,271	£0	0.00%
Home From Hospital	£4,070,009	£0	0.00%
Accommodation Based Solutions	£0	£0	
TOTAL (INCLUDING OTHER)	**£23,891,803**	**£1,402,798**	**5.22%**

Likewise, the 14% minimum investment level for children with complex needs has been met, with 17.75% of funding allocated.

	2022/23	2022/23	2022/23
Models Of Care	**Provisional Budget**	**CwCN Budget**	**CwCN %**
Community Based Care - Prevention & Community Coordination	£5,306,245	£0	0.00%
Community Based Care - Complex Care Closer To Home	£9,001,418	£444,003	4.93%
Promoting Good Emotional Health & Wellbeing	£1,677,683	£1,024,433	61.06%
Families Staying Together & Therapeutic Support For CEC	£3,299,271	£3,299,271	100.00%
Home From Hospital	£4,070,009	£0	0.00%
Accommodation Based Solutions	£0	£0	
TOTAL (INCLUDING OTHER)	**£23,891,803**	**£4,767,707**	**17.75%**

Proportionate Investment: Accelerate v Embedding

RIF guidance identified a 30:70 split between accelerate and embedding funding respectively. The analysis of our regional fund utilisation identifies a 46% accelerate allocation, and a 30% embedding allocation. Notably, the total utilisation is therefore reflecting 76% of funding, this is due to both unallocated funding, along with ringfenced and third sector allocations not applicable for tapering.

Model Alignment	Allocation	Regional Position	Model Requirement
Accelerate	£12,325,131	46%	30%
Embed	£8,138,191	30%	70%

Consideration will be needed for a national mechanism that can reflect/deduct funding applicable for tapering within regional and national allocations to support ongoing reporting of adherence to the funding model.

Funding Utilisation by Strategic Programme

This strategic outline plan describes all regional programmes currently in receipt of Regional Integration Funding, their respective allocations shown below as provisional budgets pending formal approval of the plan by the Regional Partnership Board.

The table below also identified the resource matching and funding model alignment within each programme. We would wholly expect that if the transformation is undertaken effectively, our programmes would consist

Programme Reference	Programme Name	2022/23 Provisional Budget	2022/23 Resource Match	2022/23 % Resource match	Funding Model Alignment
SP01-UC	Support for Unpaid Carers	£1,402,798	£252,641	18%	Embed
SP02-EIS	Early Intervention & Support: Edge of Care	£2,803,381	£2,090,413	75%	Embed
SP03-CEC	Supporting Care Experienced Children	£495,890	£0	0%	Embed
SP04-CwDN	Supporting Children development needs/ND	£444,003	£0	0%	Embed
SP05-EHW	Good emotional health & wellbeing	£823,562	£231,244	28%	Accelerate
SP06/ACC	Safe Accommodation	£0	£0		N/A
SP07-ChWD	Workforce development/professional support	£200,871	£0	0%	Accelerate
SP08/DAP/R&I	Dementia: Recognition & Identification	£0	£0		N/A
SP09-DAP-A&D	Dementia: Assessment & Diagnosis	£826,328	£0	0%	N/A
SP10-DAP-LwD	Dementia: Living with Dementia	£1,406,976	£149,018	11%	N/A
SP11-COMM	Connected Communities	£2,345,386	£624,866	27%	Embed
SP12-PBGC	Place Based Graduated Care	£6,394,640	£2,479,857	39%	Accelerate
SP13-FLOW	Improving System Flow	£4,070,009	£1,127,273	28%	Accelerate
SP14-LD	LD Independence & Wellbeing	£496,333	£8,922	2%	Embed
SP15-FTIER	Enhanced Foundation Tier	£195,250	£0	0%	Accelerate
SP16-TRAN	Transition	£366,904	£142,567	39%	Accelerate
SP17-AT	Assistive Technology	£273,895	£145,964	53%	Accelerate
SP18/DATA	Integrated Data	£0	£0		N/A

Unallocated Funding

Of the funding allocation, we currently have a commitment of £23,891,803, therefore circa £3million unallocated. To ensure funding is targeted at the areas of greatest impact, simultaneous developments are underway to support plan development:

- Firstly, a review of our regional integrated winter plan 2021-22 to identify areas of success, and areas of learning for inclusion within early winter planning activities for 2022-23. Regional Integration Funding, both unallocated, and in-year slippage, will be identified to support a regional winter plan should specific winter funds not be identified.

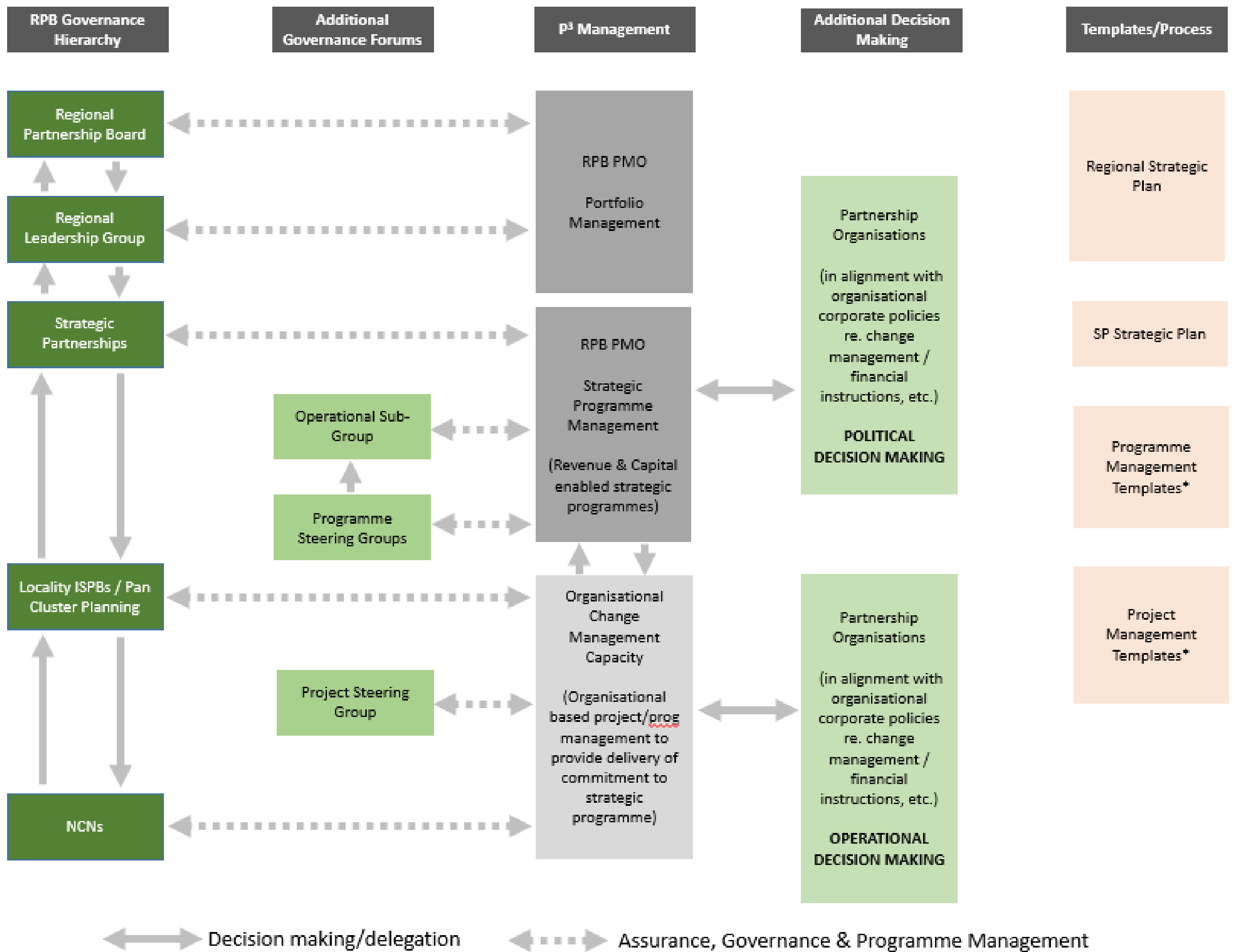
- Secondly, to support ongoing assessment and consideration of areas of greatest impact, a regional prioritisation framework is being developed to ensure a robust and consistent approach across our partnership in the consideration of business cases.

Gwent RPB will ensure full utilisation of the regional allocation of the Regional Integration Fund.

Governance

Governance of the Regional Integration Fund will be a key aspect of the development activities in early 2022-23. The illustration provided below highlights the governance considerations currently underway to develop governance mechanisms under the Regional Partnership Board applicable to all partner organisations.

These considerations will ensure transparency, oversight and accountability is placed correctly across the system, reflected within regional documentation as a clear audit trail of decision making, programme delivery and impact.



Whilst wider governance developments are undertaken, a Memorandum of Understanding specifically for the Regional Integration Fund will be established. Due to significant changes in membership, Gwent Regional Partnership Board will reconvene in July 2022, and it is proposed the memorandum of understanding will be discussed at the Regional Partnership Board meeting of September 2022.

Model of Care Investment Proposal
COMMUNITY BASED CARE – PREVENTION & COMMUNITY CO-ORDINATION

Strategic Vision

A Healthier Wales aptly describes the aspirations for community based prevention and co-ordination, introducing a 'wellness' system, which aims to support and anticipate health needs, to prevent illness, and to reduce the impact of poor health. Our regional programmes will support the prevention and early intervention approaches needed to enable and encourage good health and wellbeing throughout life. Encouraging and supporting people to manage their own health and wellbeing, be resilient and independent for longer, will mean individuals can remain in their own homes and localities.

To do so, our programmes will empower people with the information and support they need to understand and to manage their health and wellbeing, to make decisions about care and treatment based on 'what matters' to them, and to contribute to improving our whole system approach to health and care. Information, advice and assistance will be provided to our citizens and vulnerable population groups appropriate to age and level of understanding.

Dementia Action Plan (DAP) Summary

Across all local authority areas in the Gwent region, an increase in the number of people living with dementia is predicted. The increases range from 62.1% in Blaenau Gwent to 97.1% in Monmouthshire over the period 2013 to 2035. The RPB are working to support more timely diagnosis and are developing a consistent clearly understood diagnostic, care and support pathway which incorporates standards of care and outcome measures. Living with dementia can have a big emotional, social, and psychological impact on a person, their families, and carers. This can affect the relationships a person has with their environment and the support that they receive. It is important to people living with dementia that people develop awareness and an understanding of the condition so they can be supported to maintain quality of life. As an RPB we provide development and learning opportunities jointly with our key partners to the workforce and communities to raise awareness, understanding and highlight risk factors and preventative measures. We also work with partners and continue to develop and build on the strengths of our Dementia Friendly Communities, working in collaboration of Age Friendly Community groups.

Case for Change

Loneliness is an issue across all local authority areas and highlighted in the previous population needs assessment, this will have been exacerbated recently through the Covid-19 pandemic where a number of vulnerable people will have been shielding. The data varies across the region, but is generally high and between 15%-20% (1 in 5 people) which is a considerable number of people susceptible to poor emotional and mental health and deterioration in physical help. Loneliness may be perceived as an older person's issue – recognised by Older People's Commissioner for Wales – but given that the percentage is approximately 20% it is likely that younger people will be affected too, especially given virtual working arrangements. Solutions are generally low cost/no cost and it is important for the RPB to promote networks, access to information and local groups.

Older people need good, timely and accurate information to be able to understand what support is available to them, and this can be important to maintaining independence.
Information is now often provided digitally and so access to online information for people is dependent on skills and resources. Greater consideration will be given to supporting people to develop the necessary skills and confidence to access information online.

Remaining at home is at the heart of many peoples view of being independent. People have told us they would like help and support to move around and maintain their own home, go out as they please and not have to

depend too much on others. We also know that many older people with long term health conditions are caring for a family member, friend or neighbour and need to be supported to continue to do so. These unpaid carers contribute significantly to the Gwent economy and potential health and social care costs.

People living with disabilities have been disproportionately impacted by the Covid 19 pandemic. They have had potentially higher risk of catching the virus due to underlying health conditions and have had difficulty in engaging in preventative measures and have experienced disruptions to health services they usually rely on. People with sensory loss have found it extremely challenging as their communication needs have not been met leaving them increasingly isolated. Although health and social care have worked hard across Gwent to reach out and support people during this time, we need more specific actions going forward, to recognise the impact there has been for people with health, physical and sensory disabilities.

Key Enablers	
Integrated Planning and Commissioning Ensuring community support services, delivered by all agencies, are co-ordinated and aligned within an integrated system. Supporting a no wrong door approach in providing information, advice and assistance	✓
Technology enabled care Assistive Technology is an enabler to independence; working closely with the assistive technology programme we will continue to test and develop new methods of supporting independence and wellbeing in a persons own home.	✓
Promoting the social value sector The third sector are well placed within the early intervention and prevention part of our system and will a key partner in the holistic approach to this model of care. Our provider network and third sector forum will support the system connectivity needed, aligning the significant range of third sector services not commissioned by health or social care.	✓
Integrated Community Hubs Alignment of existing community hubs and spokes will be central to the development of this model of care, identifying gaps or opportunities in provision where the Integration and Capital Rebalancing Fund can support enhanced/strengthened community provision.	✓
Workforce development and integration Work with our workforce across all sector to support a no wrong door approach, ensuring individuals are connected to their communities and receive information, advice and assistance appropriate to their needs. A strengths based approach is fundamental to supporting individuals to manage their own health and wellbeing needs.	✓

Priority Population Groups	Primary Beneficiary	Secondary Beneficiary	DAP
Older people including people with dementia Older People with Complex Needs, including those living with Dementia, will be supported to connect with their communities, and receive information, advice and assistance appropriate to their needs. Improving and/or maintaining independence and wellbeing	✓		✓
Children and young people with complex needs			

People with learning disabilities and neurodevelopment conditions, including autism			
People with learning disabilities will be supported to connect with their communities, and receive information, advice and assistance appropriate to their needs. Peer support and networking opportunities will be providing to promote improved and/or maintained independence and wellbeing.	✓		
Unpaid carers			
Unpaid Carers will be supported to connect with their communities, and receive information, advice and assistance appropriate to their needs. Improving and/or maintaining independence and wellbeing	✓		
People with emotional and mental health wellbeing needs			
People with emotional and mental health wellbeing needs, will be supported to connect with their communities, and receive information, advice and assistance appropriate to their needs. Improving and/or maintaining independence and wellbeing		✓	
Other beneficiaries			
N/A			

Total programme cost and match funding					
Total cost of programme	Welsh Government contribution	Partner monetary match	Partner resource match	% support for unpaid carers	% for social value sector delivery
£6,192,674	£5,306,245	£0	£886,429	26.44%	22.47%

Programme management resource to be confirmed.

Strategic Outline Plan (Gwent refer as Programme, WG refer as Project)
SP01: Support for Unpaid Carers

Model of Care Alignment					
Community based care – prevention and community coordination	Community base care – complex care closer to home	Promoting good emotional health and wellbeing	Supporting families to stay together safely and therapeutic support for care experienced children	Home from hospital	Accommodation based solutions
✓		✓			

Programme Summary
The Unpaid Carers Programme consists of two workstreams – Carers Support and Co-ordination and the Regional Hub and Spoke Model. The work of these programmes aligns with the four key priorities for unpaid cares outlined in the Welsh Government Strategy for Unpaid Carers 2021. Unpaid carers will be actively encouraged to recognise themselves as unpaid carers, in order to feel valued and supported in their caring role, and will be empowering along with those they care for to live healthy and fulfilled lives, achieving personal wellbeing goals and living a life alongside caring. For all unpaid carers living and supporting others in the Gwent Region to be recognised and valued for their caring role; empowering them to live well and fulfil their own well-being outcomes To embed and develop the support in the Gwent Region for unpaid carers, to improve the identification of carers and ensure they feel valued and supported both in their caring role and in their own well-being outcomes. A seamless, connected system of support across Social Care, Third Sector and Health will be developed for unpaid carers, at a regional and local level. This system will support unpaid carers in their caring role, and empower unpaid carers to live a life alongside caring and meet their personal well being goals.

Intended Outcomes	
Person Centred Outcomes	▪ Unpaid carers will be actively encouraged to recognise themselves as unpaid carers, in order to feel valued and supported in their caring role ▪ Empowering unpaid carers and those they care for to live healthy and fulfilled lives, achieving personal wellbeing goals and living a life alongside caring ▪ Through connected services preventing duplication for unpaid carers, who may be time limited to access support, for example reducing the need for multiple assessments
System Outcomes/Benefits	▪ Through early identification and support the risk of carer crisis/breakdown will be reduced and associated demand on statutory services

	▪ Preventing duplication maximising time for services to support unpaid carers

Baseline Position
An unpaid carer is someone who provides unpaid care to an adult or a disabled child. This can range from one hour a week to full time care. Under the Social Services and Well-being (Wales) Act 2014 unpaid carers have an equal right to an assessment and support as those that they care for. Local Authorities have a duty to consider the support needs of an unpaid carer who is looking after someone who usually lives within its area (including a disabled child) and provide unpaid carers with information and advice relating to their caring role and support needs (in Welsh if the unpaid carer wishes). Unpaid carers also have a right to a Carers Assessment to be undertaken by the Local Authorities. The Strategy for Unpaid Carers in Wales (2021) outlines four key priority areas which the Unpaid Carers programmes will align to. There are currently a range of initiatives in place to support unpaid carers in the Gwent region – dedicated carers support services (including Young Carers and Young Adult Carers), carers co-ordination (sitting withing Community Connector teams) and the hub and spoke model (a single point of access for carers, co-producing services for carers alongside existing provision including all partners in Local Authority, Health and the Third Sector). During the year 2021-2022 16017 carers have been engaged with, either virtually or face to face. Dedicated support and activities for Unpaid Carers has been provided with 430 Drop-in sessions for unpaid carers to attend when convenient for them, 403 dedicated unpaid carers events and activities and 698 unpaid carers have attended support groups. 11087 Unpaid Carers have received Information Advice and Assistance. 370 Unpaid carers have been provided with crisis support and 528 carers assessments have been undertaken. In order to identify Unpaid Carers it is important that any agencies they may contact are able to signpost to appropriate support. 464 partner organisations have been engaged with by services within this programme. Carer's reported that events, activities and drop in sessions have made a positive difference to their lives, and well-being scores and have made a positive difference to the cared for or carers family. Outcomes have been collected on the difference made to Unpaid Carers by the programme April 2021-March 2022. From information provided Unpaid Carers have reported increased confidence (1703 Unpaid Carers), Increased Independence (1660 Unpaid Carers), and reduced feelings of isolation (2086 Unpaid Carers). For Unpaid Carers who have attended events/activities or drop ins 4618 Unpaid Carers have reported that these made a positive difference to their lives/wellbeing scores, and 4079 reported that they made a positive difference to those cared for or their families. Dedicated support has been provided to Young Carers and Young Adult Carers. During the year 2021-2022 53 schools have engaged in the Young Carers in Schools Programme, and 339 Young Carers have been identified and supported in schools. The unpaid carers programmes will build on these services, enhancing support for unpaid carers to recognise themselves as unpaid carers, to increase the identification of unpaid carers by Social Care, Health and the Third Sector and to ensure equitable support and person-centred outcomes across the region.

Key Enablers	
Workforce Development & Integration	Defining an integrated system, including workforce required to support a seamless service for unpaid carers that embodies the principle of No Wrong Door and provides equitable person-centred outcomes for unpaid carers throughout the region. Widen the reach of the Carer Friendly training to support unpaid carers in the workplace.

	Undertake and embed a development plan for dedicated psychological support for unpaid carers across the region.
Integrated Planning & Commissioning	Ensuring all carers support and co-ordination services, including SLA's between areas, are part of a whole system approach that provides equity of support and outcomes across the region.
Technology & Digital Solutions	Linking with the Assistive Technology programme exploring how Assistive Technology can maximise independence for those cared for, and support unpaid carers in their caring role. Implementing a communications and engagement strategy embedding the use of digital solutions to support connectivity and access for unpaid carers.
Capital Infrastructure	The Carers programme links with the Connected Communities Programme, and the use of Integrated Wellbeing Centres as potential spokes in the Hub and spoke model.
Social Value Sector	The Third Sector will be key partners in developing and supporting the Unpaid Carers Programmes to achieve optimal person-centred outcomes, enabling unpaid carers to access support close to home in the community

Priority Population Groups		
	Primary Beneficiary	**Secondary Beneficiary**
Older people with complex needs		✓
People with Dementia		✓
Unpaid Carers, inc. Young Carers	✓	
Children with Complex Needs		✓
People with emotional and mental health wellbeing needs		✓
People with Learning Disability and Neurodevelopmental conditions		✓

Development Approach

Priority 1: Identifying and Valuing Unpaid Carers

Aligned to Priority 1 the Carers Support and Co-ordination Services and Regional Hub and Spoke model currently will be embedded and strengthened. These services aim to increase the number of carers identified and supported. Further work will be undertaken to develop training to support identification of carers, particularly working with professionals to increase awareness. There are currently a suite of resources available such as Carer Friendly training and Young Carers in Schools Accreditation, through mapping and expanding it will be ensured that the reach of this training is maximised throughout the region.

A focus on supporting unpaid carers around hospital discharge will be developed, sharing current good practice to both ensure identification of unpaid carers during discharge planning, including individuals new to caring, and to support unpaid carers through the discharge process.

An engagement programme will be developed to build on the current networks utilised to raise awareness and celebrate unpaid carers, as well as direct engagement with unpaid carers. Part of this strategy will be to include

targeted/themed engagement for different cohorts of unpaid carers, for example young carers, young adult carers, older age carers, working age carers, carers of people with dementia. Through this it is hoped to support carers from all areas of life to identify as an unpaid carer as early as possible in their carer journey, as well as ensuring information is accessible and relevant/informative. Engagement and support will be accessible and bilingual (English and Welsh).

Priority 2: Information, Advice and Assistance
Aligned to priority 2 the carers co-ordinators services which sit alongside the Community Connectors in Local Authorities, will be embedded in order to ensure unpaid carers have access to the right information and advice at the right time and in an appropriate format.

As part of the engagement strategy in priority 1, awareness will be raised of ways to access Information, Advice and Assistance. It is also acknowledged that there are some unpaid carers who are not digitally connected (the digital divide) and so work will be undertaken to engage with these groups of unpaid carers via different formats.

The provision of Information, Advice and Assistance will be supported by the Regional Hub and Spoke model. A mapping of current spokes will be undertaken, allowing gaps to be identified and the establishment of new spokes where needed. This will be interlinked with the Connected Communities programme of work, with a potential for Integrated Wellbeing Centres to be aligned with the model.

P3: Supporting life alongside caring
Unpaid carers will be supported to take breaks from their caring role to enable them to maintain their own health and well-being and have a life alongside caring. This priority underpins the Carers Support services and Regional Hub and Spoke model.

Through the Unpaid Carers Programmes the offer of respite across the region will be refined and redesigned. Research will be undertaken to identify and define respite opportunities (ranging from hourly activities to residential care, with or without the person cared for). The approach to respite will be person focused, based on What Matters to You conversations, considering provision of bespoke respite services e.g. short breaks, or support in own home. In order to support a person-centred approach co-production will be essential to ensure the respite offer is fit for purpose. Consideration will be given on how to support unpaid carers to choose what to do with their personal protected time, alongside offers of specific opportunities.

To support a life alongside caring Priority 3 outlines that access to psychological support for unpaid carers must be extended. As part of the Unpaid Carers programmes scoping and implementing dedicated psychological support will be established, for example through recruiting counsellors, or establishing dedicated support from psychological wellbeing practitioners in GP surgeries.

P4: Supporting unpaid carers in education and the workplace
The Unpaid Carers programmes will further develop work to support unpaid carers to work and learn.

It is acknowledged that Young Carers and Young Adult Carers may face specific challenges and difficulties to live their own life and undertake a caring role and through the carers support programme development of specific Young Carers and Young Adult Carers support will be undertaken.

The current Young Carers in School Accreditation Programme which supports the identification of Young Carers in Primary and Secondary schools will be mapped and expanded to ensure equitable cover throughout the region.

To support unpaid carers in the workplace the Carer Friendly training will be expanded, enabling unpaid carers to be identified and organisations empowered to support unpaid carers to continue to work.

Engagement will also be undertaken with unpaid carers who are NEET (not in education, employment or training) to ensure that all unpaid carers in the region have the opportunity to be valued and supported to access work or training. This links to the Children and Families NEST framework for young adult carers and the Young Person's Guarantee (to provide everyone under 25 an offer of a place in education or training, or support to get into work or self-employment).

Alongside supporting unpaid carers with training or entering the workplace/maintaining work financial resilience will be promoted. Promotion of welfare benefits and financial support will be undertaken through unpaid carers support services and engagement, and consideration of how to link with other services such as the Citizen's Advice Bureau will be undertaken.

Interdependencies

The work of the Workforce Development Board and Assistive Technology Programme will be key enablers in supporting the Unpaid Carers Programmes.

The Unpaid Carers Programmes will interlink with the Improving System Flow and Place Based Graduated Care Programmes to identify and support unpaid carers during discharge planning. The Unpaid Carers Programme will also link with the Community Connectors Programme to support the potential of unpaid carers spokes via the Integrated Wellbeing Hubs.

Through support for young carers and young adult carers the unpaid carers programme will interlink with the NEST implementation group and the Young Person's Guarantee (to provide everyone under 25 an offer of a place in education or training, or support to get into work or self-employment).

Interim Financial Model (Year 1 Only)

Total cost of programme	RIF Contribution	Partner match monetary	Partner match resource	% support for unpaid carers	% support for social value sector
£1,655,439	£1,402,798	£0	£252,641	100%	43.23%

Regional Investment Model

Select the funding element which the project will be set against. Repeat the table and rationale for each project

Element	
Element 1 – Acceleration funding year 1	
N/A	
Element 1 – Acceleration funding year 2	
N/A	
Element 2 – Embedding funding year 1	
The regional programme supporting unpaid carers was established under the Integrated Care Fund. The Covid-19 pandemic has increased the need for unpaid carer support. We have a regional model of support that will continue to be embedded to continue to deliver the positive outcomes achieved, and the support needs identified for unpaid carers.	✓
Element 2 – Embedding funding year 2	
N/A	
Element 2 – Embedding funding year 3	
N/A	
Element 3 – Legacy fund	
N/A	

Element 4 – National priorities (Dementia and Memory Assessment Services/Diagnostic support)	
N/A	

Strategic Outline Plan (Gwent refer as Programme, WG refer as Project)
SP09: DAP Assessment & Diagnosis

Model of Care Alignment					
Community based care – prevention and community coordination	Community base care – complex care closer to home	Promoting good emotional health and wellbeing	Supporting families to stay together safely and therapeutic support for care experienced children	Home from hospital	Accommodation based solutions
✓		✓			✓

Programme Summary
Early recognition and diagnosis of Dementia is essential to ensuring people access holistic support and treatment early in their Dementia journey, enabling people with Dementia to live well for longer. Early access to practical and emotional support can have a significant impact on how patients manage their condition and continue to live independently, including co-morbidities such as Hearing Loss. The Assessment and Diagnosis programme, has a specific focus on strengthening Memory Assessment Services by providing additional consultant capacity, advanced nurse practitioners, and to introduce audiology and memory Rehabilitation as part of the MDT approach. It will also focus on reviewing and standardising the role of dementia support workers to minimise handoffs and ensure people with dementia and those that care for them understand how to access diagnosis and support. It supports the ethos of developing 'teams around the individual' to provide additional support for people with dementia and their families/carers, and a focus on the roll out of the 'Good work – Dementia Learning and Development Framework' to enable people who work with those living with dementia to have the skills to recognise symptoms earlier and help them feel confident and competent in caring for and supporting those living with dementia.

Intended Outcomes	
Person Centred Outcomes	• Individuals will understand the steps they can take to reduce their risk, or delay the onset, of dementia. • The wider population understands the challenges faced by people living with dementia and are aware of the actions they can take to support them. • People are aware of the early signs of dementia; the importance of a timely diagnosis; and know where to go to get help. • More people are diagnosed earlier, enabling them to plan for the future and access early support and care if needed. • Those diagnosed with dementia and their carers and families are able to receive person-centred care and support which is flexible. • Research is supported to help us better understand the causes and management of dementia and enables people living with dementia, including families and carers, to be co-researchers.

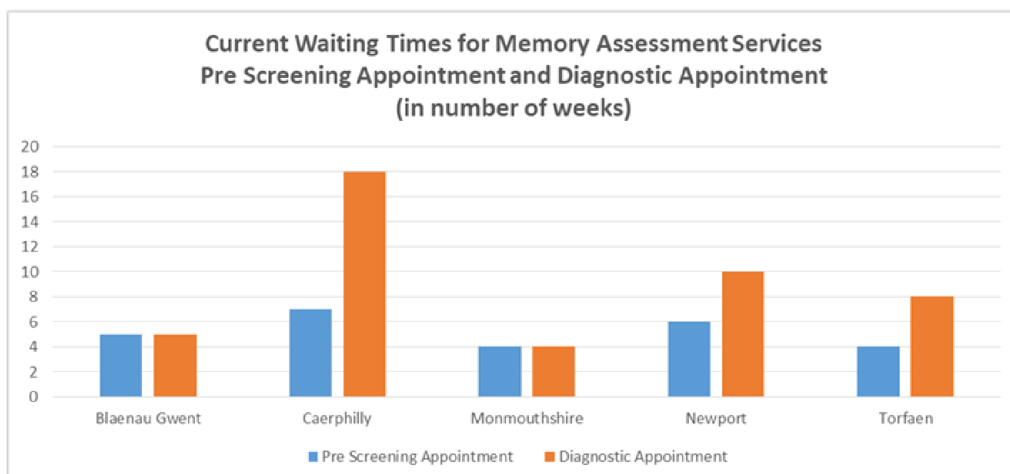
	• Staff have the skills to help them identify people with dementia and to feel confident and competent in supporting individual's needs post diagnosis (DAP)
System Outcomes/Benefits	• Developing 'teams around the individual' to provide additional support for people with dementia and their families/carers. • Reviewing and standardising the role of dementia support workers – increasing their numbers as required. • Increasing the rate and timeliness of dementia diagnosis. • Strengthening collaborative working between social care and housing to enable people to stay in their homes longer. • The roll out of the 'Good work – Dementia Learning and Development Framework' to enable people who work with those living with dementia to have the skills to recognise symptoms earlier and help them feel confident and competent in caring for and supporting those living with dementia. • Introducing the principles of 'John's Campaign' across the system

Baseline Position

Generally there has been an increase in referrals to Memory Assessment Services since the initial first wave of Covid. Although this is still not up to the levels of referrals we were receiving pre Covid, it is evident that the referrals coming through to services are often not at the early stage of memory issues as we have seen in the past, and progression and deterioration is further advanced, hence needing additional input from MAS Services.

In line with Dementia Standard 6 of the All Wales Dementia Care Pathway of Standards people should receive a range of interventions to support diagnosis within 12 weeks of referral. It is important to note that this is the maximum acceptable waiting time, but the service strives to see, diagnose, and provide intervention as soon as possible after referral.

There is a MAS in each of the five localities in the Gwent region. Waiting times vary across the region, impacted by factors such as medical availability, geographical variation, social demographics and population numbers. Waiting times for MAS services for each locality as at July 2021 are shown in the Graph below, with the Caerphilly locality showing the longest wait:



MAS Services were stepped down for four to five months during the first wave, and only urgent referrals were seen routinely. Whilst all efforts were made to carry out initial assessments on routine new referrals virtually, what the teams have found across all Boroughs was that people were happy to wait to be seen in person rather than have a virtual appointment. This was probably around 80% for routine new referrals. Similar could be said for routine follow up appointments.

This step down of services caused a backlog and delay in patients having their initial appointment, and their diagnostic appointment.

Waiting List Clinics have proved very difficult to achieve, as this requires staff to work additional hours on weekends to provide additional clinics. Staff in MAS Services during the pandemic have been working flexibly and at times working within other areas, such as CMHT and Inpatient Units. Across all Boroughs staffing levels have been affected by Covid and additional sickness levels throughout the pandemic. Previously, when the directorate have implemented WLIs there has been a huge uptake from Medical, Nursing and Admin staff to work these additional hours. On speaking to staff there has been a very small appetite recently to complete additional hours due to the pressures in their current roles in their working weeks, ie covering covid sickness, vacancies etc.
WLIs have taken place in Newport (4 Saturday Clinics), Torfaen (4 Saturday Clinics) and Monmouthshire (3 Saturday Clinics) since October 2021. More are planned up until June 2022 in all Boroughs.

That being said, all MAS teams have been working extremely hard to see additional patients whether it be virtually, face to face or at home to lessen delays for patients coming through MAS services.

Current Waiting List Data
(WG MAS Waiting Times targets are 4 weeks for Pre Screening and 12 weeks for Diagnostic Appointment)

BOROUGH	PRE SCREENING	DIAGNOSTIC APPOINTMENT	PRE SCREENING	DIAGNOSTIC APPOINTMENT
BLAENAU GWENT	8 weeks	12 weeks	5-6 weeks	12 weeks
CAERPHILLY	6 weeks	15 weeks	12 weeks	18 weeks
MONMOUTHSHIRE	4 weeks	10 weeks	5 weeks	12 weeks
NEWPORT	12 weeks	16 weeks	10 weeks	12 weeks
TORFAEN	4 weeks	10 weeks	6 weeks	12 weeks

Monmouthshire and Torfaen have clearly benefitted from the additional clinics. Blaenau Gwent pre-screening has deteriorated this is due to a number of vacancies at present in the MAS team. Newport also has a high number of vacancies in both nursing and admin currently, and this is the main reason for their increased appointment times. Newport team have planned additional clinics booked in for February and March.

Caerphilly has markedly improved. They have been unable to undertake additional Saturday Clinics due to admin staffing shortages, but they have been maximising all opportunities with using the additional medical staff they have at present (Consultant post 28 week pregnancy working from home to complete additional new assessment clinics virtually and an additional SpR) to work specifically on the MAS waiting list.

Key Enablers	
Workforce Development & Integration	A resilient, skilled and integrated health and social care workforce is critical to the successful delivery of the national models of care. Through a revision of the current resource capacity across the dementia model and alignment across health and social care services, local authorities

	and third sector will improve retention of staff to ensure the workforce is appropriately trained and upskilled to provide truly seamless, integrated services for the people across the region, aligning to the Strategic Regional Learning and Development Plan. To provide a straightforward framework that will guide our regional agencies and stakeholders together so they can all feed into and benefit from broad perspectives associated with learning and training for dementia. Redefined support worker role to ensure all individuals with dementia living in the community have a dedicated support worker.
Integrated Planning & Commissioning	To successfully develop and then mainstream the national models of integrated care, DAP and Dementia standards effective whole system planning and/or commissioning across health, social care, housing and wider delivery partners will be critical. By linking in with divisions/organisations a review of all current SLA's will be undertaken including core funded, partnership funded, WG funded SLA's. An added regional approach will ensure equitable service provision across the region.
Technology & Digital Solutions	Explore Assistive Technology to maintain independence for as long as possible for individuals living in their own homes and technology enabled care solutions for those that require more complex care within the community or an acute setting. A key population group as a beneficiary of the Assistive Technology programme is people living with dementia, their families and carers, focusing on three key areas: ▪ Supporting independence in their own home ▪ Providing therapeutic technologies ▪ Technology enabled care for more complex care when needed
Capital Infrastructure	Diagnosis advancements and Independent living solutions for people living with dementia to support delivery of: ▪ Independent living solutions enabled by RIF capital programmes working with a range of partners for example, RSL's etc. ▪ Development of integrated hubs that are dementia specific or dementia friendly ▪ Providing intermediate care capacity that will support reablement of people living with dementia or alternative respite facilities.
Social Value Sector	The third sector are key partners in the delivery of the programme to delivery against the priorities of the Dementia Action Plan and Dementia Standards, support a range of priority areas including: ▪ Community based early intervention activity ▪ Support for those with more complex needs ▪ Pre bereavement and bereavement support

Priority Population Groups		
	Primary Beneficiary	**Secondary Beneficiary**
Older people with complex needs		✓
People with Dementia	✓	
Unpaid Carers, inc. Young Carers		✓
Children with Complex Needs		
People with emotional and mental health wellbeing needs		✓
People with Learning Disability and Neurodevelopmental conditions	✓	

Development Approach

MAS - Advanced Nurse Practitioners

One of the limiting factors in expanding the MAS service across the region in line with predicted demand is that currently a Consultant Psychiatrist is required to undertake the diagnostic interventions.

To free up the capacity of the Consultant Psychiatrists a change in way of working was identified as essential for sustainability of the service. Funding was awarded for the recruitment of 4 Advanced Nurse practitioners to undertake prescribing and Diagnostician roles to allow the service to expand and free up clinical time for patients. This would also ensure all patients, regardless of complexity receive a diagnosis within 12 weeks. In addition, recruitment of a Band 7 practice facilitator to develop educational programmes relating to dementia for staff within the MAS system and wider care home, GP forums.

The Advanced Nurse Practitioners will also undertake a programme of engagement with third sector parties and referrers to improve awareness. In line with providing care closer to home, expansion of the team will allow for negotiation of clinical spaces outside of the MAS locations, using hubs and surgeries where able, to ensure inclusion and accessibility for as many individuals as possible. They will also hold post-diagnostic responsibilities for Young Onset PLWD to ensure robust management and support for unique needs in this patient cohort

MAS - Additional Consultant Capacity

The Torfaen Borough was identified as having the lowest Older Adult Consultant Psychiatrist WTE rate per 10k population out of the 5 Boroughs in ABUHB. This insufficient Consultant Medical Capacity within Torfaen was impacting on the ability to provide expertise and support to the memory assessment services within the locality.

In order to stabilise the service in Torfaen and ensure equity of Senior Clinical Cover as well as supporting the expansion of the MAS in line with growing demand funding was approved for the appointment of a second Consultant Psychiatrist. Thus providing a sustainable service to meet the existing and predicted medium term future demand within the speciality.

Recruitment of a Consultant Psychiatrist in Torfaen will also improve MAS cover in the Caerphilly area, which currently has the longest waiting times. This is because the Electroconvulsive Therapy Service responsibility is currently held by the Caerphilly Borough Consultant team. With increased Consultant cover in Torfaen this will allow the transfer of responsibility to Torfaen, freeing up dedicated Consultant Psychiatrist time in Caerphilly for the MAS service

MAS - Home Based Memory Rehabilitation (OT)
An audit of ABUHB Occupational Therapy (OT) provision to memory services in 2020 identified a significant gap. Too few people are accessing recommended early interventions, such as planned OT interventions in ABUHB at the point of diagnosis, except for the offer of memory enhancing medication and the offering of Cognitive Stimulation Therapy programmes in some Boroughs. This falls far short of the recommendations and standards.

In order to address these Gaps as identified funding was awarded for the implementation of an early intervention OT service. The service will consist of a team lead occupational therapist (1 x WTE Band 7) with a team of OT staff (4 x WTE Band 6s) to deliver an equitable service to all memory services across Gwent. The intention is for this to be the starting point for an AHP/MDT specialist early intervention service in-order to holistically meet the needs of those diagnosed with dementia and their carers.

The focus will be on offering input within 12 weeks following a diagnosis and with people who are either willing or able to identify their own goals (with support from OT) i.e therapy will not be done 'to' them based on other's concerns. The need and want will come from the person.

Two Highly Specialist OTs are undertaking the pilot and evaluation of an early intervention service (in two Boroughs), starting. The plan is to finetune Service Pathways in April, following which suitable participants (Service Users) will be recruited.

Information has been developed for all stakeholders, and exact 'assessment' and evaluation tools and methods have been developed. The pilot OTs have completed the 'Master Class's training in Home based Memory Intervention' in March.

MAS - Hearing Assessments (Audiology)
Alongside timely access to diagnosis a holistic approach to Dementia assessment and management is required to ensure that patients have the best opportunity to engage effectively with memory assessment services, in particular by incorporating hearing assessments into the diagnostic process.

Funding was approved for the recruitment of specialist band 7, band 5 and band 4 audiologists to ensure a seamless service between audiology and memory services is established. This will allow all patients who are referred to the MAS to access a hearing assessment prior to the memory assessment, in Primary Care or Community Settings where possible.

The service will also provide educational support for carers and family on impact of hearing loss and management of hearing aids through local carer education and support services.

Development work is being undertaken collaboratively across Audiology and Memory Assessment Services to embed this approach within the diagnostic pathway.

After an analysis of likely referrals and funded staffing Torfaen, Newport and North Caerphilly will be covered and will provide a test of concept for roll out to other boroughs. The audiology pathway has been written and agreed with the dementia team, with processes identified for when staffing is in place. Links have been made with BCU to collect similar data to build an evidence base.

Interim Financial Model (Year 1 Only)					
Total cost of programme	RIF Contribution	Partner match monetary	Partner match resource	% support for unpaid carers	% support for social value sector

£826,328	£826,328	N/A	N/A	0%	0%

Regional Investment Model *Select the funding element which the project will be set against. Repeat the table and rationale for each project*	
Element 1 – Acceleration funding year 1	
Element 1 – Acceleration funding year 2	
Element 2 – Embedding funding year 1	
Element 2 – Embedding funding year 2	
Element 2 – Embedding funding year 3	
Element 3 – Legacy fund	
Element 4 – National priorities (Dementia and Memory Assessment Services/Diagnostic support)	
As a reflection of the service development enabled by Memory Assessment Services funding, both the MAS funding and an element of Dementia ringfenced funding supports the delivery of this programme	✓

Strategic Outline Plan (Gwent refer as Programme, WG refer as Project)
SP11: Connected Communities

Model of Care Alignment					
Community based care – prevention and community coordination	Community base care – complex care closer to home	Promoting good emotional health and wellbeing	Supporting families to stay together safely and therapeutic support for care experienced children	Home from hospital	Accommodation based solutions
✓					

Programme Summary

The Connected Communities Programme provides a whole system approach to community support, early intervention and prevention using a triad of support, building on the established links within our communities via community connectors, IAA teams and Integrated Wellbeing Networks.

The programme will ensure wellbeing of people is maintained or improved, and social isolation and loneliness, avoided or reduced. It intends to reduce the impact of loneliness and isolation by fostering community wellbeing spaces and approaches, establish locality links and networks and create community-based solutions that will:

- Support people to stay well through taking part in activities they enjoy.
- Support people to stay well through information, advice, and assistance.
- Support people to make their contribution, including exploring and supporting the development of small local enterprises as a route to wellbeing.
- Reduce social isolation.
- Promote independence.
- Develop partnership working with primary care, other Local Authority services, Registered Social Landlords' and the third sector.

The programme will support a range of adults with varying levels of need, ranging from isolated individuals to improve their confidence and access services in their local community, to individuals with more complex support needs.

Intended Outcomes	
Person Centred Outcomes	▪ People remain active and independent in their own homes

	▪ People maintain good health and wellbeing for as long as possible
System Outcomes/Benefits	▪ Development of a consistent approach to community wellbeing and prevention across Gwent ▪ Timely access to wellbeing support for people in the community ▪ Enhanced community wellbeing, reducing demand on packages of care ▪ A skilled workforce who are able to link people to wellbeing support local to them

Baseline Position

OPwCN Connected Communities Programme Performance Outcomes April 2021 – March 2022	
Number of individuals accessing connected communities service	**13,360**
Number of community events or groups supported	**223**
Number of new volunteers recruited	**316**
Number of people socially connected	**231**
Number of people supported to remain independent	**21**
People signposted and given IAA	**6553**
Number of individuals attended groups or events	**945**
Number of supporting home visits completed	**1691**
Number of new individual Support / Stay Well Plans developed	**169**
Number of passenger journeys have been provided	**2362**
Number of GP Surgery & Volunteer sessions delivered	**684**

Across all services **13,360** individuals have accessed the programme and helped **231** people become socially connected with **316** volunteers recruited to support individuals and **21** people have been supported to remain independent.

223 events and groups have been supported with **945** people attending.

6553 people were signposted and given information, advice & assistance. **1691** home visits were carried out, and from these people were supported with income maximisation, housing enquiries, digital inclusion, and COVID-19 related enquiries.

169 stay well plans were developed with **2362** passenger journeys provided.

The service carried out **684** GP and volunteer sessions.

From a sample of individuals accessing services: **40%** maintained or improved independence

52% maintained or improved wellbeing, **61%** maintained or improved confidence **52%** individuals avoided social services intervention, and **64%** individuals achieved outcomes.

Key Enablers	
Workforce Development & Integration	Work with our workforce across all sector to support a no wrong door approach, ensuring individuals are connected to their communities and receive information, advice and assistance appropriate to their needs. A strengths based approach is fundamental to supporting individuals to manage their own health and wellbeing needs.
Integrated Planning & Commissioning	Ensuring community support services, delivered by all agencies, are co-ordinated and aligned within an integrated system. Supporting a no wrong door approach in providing information, advice and assistance.
Technology & Digital Solutions	Assistive Technology is an enabler to independence; working closely with the assistive technology programme we will continue to test and develop

	new methods of supporting independence and wellbeing in a persons own home.
Capital Infrastructure	Alignment of existing community hubs and spokes will be central to the development of this model of care, identifying gaps or opportunities in provision where the Integration and Capital Rebalancing Fund can support enhanced/strengthened community provision.
Social Value Sector	The third sector are well placed within the early intervention and prevention part of our system and will a key partner in the holistic approach to this model of care. Our provider network and third sector forum will support the system connectivity needed, aligning the significant range of third sector services not commissioned by health or social care.

Priority Population Groups		
	Primary Beneficiary	**Secondary Beneficiary**
Older people with complex needs	✓	
People with Dementia		✓
Unpaid Carers, inc. Young Carers		✓
Children with Complex Needs		✓
People with emotional and mental health wellbeing needs		✓
People with Learning Disability and Neurodevelopmental conditions		✓

Development Approach

The pandemic has changed communities dramatically since March 2020 and the services have had to adapt their roles considerably since the outbreak. The approach and programme have never been more important however with the impact of shielding and social isolation and increased risks of frailty, lack of confidence, isolation, and loneliness. The following adaptations to the model of delivery have been proposed by the project to encompass "new normal":

- Virtual Meeting Places
- Addressing the Digital Divide
- Moving Groups Online
- Development of Outdoor Spaces
- Reintroducing Physical Meeting Spaces
- Partnership and Collaboration

Key learning highlights the need for a flexible approach to respond to the needs of individuals within a changeable landscape. Developments to date have highlighted the organic nature in the way community assets and connections develop, with an organic approach support evolution of the offer. Working with communities to ensure a coproduced and collaborative approach is essential to supporting ongoing engagement.

Learning shows that services have evolved over several years, the School of Social Care Research in Swansea University have written and supported development of the collaborative approach to wellbeing and prevention of

which this project is a key element. In partnership with Pembrokeshire, the service leads also undertook a research project using Most Significant Change and Community of Enquiry techniques by using exploratory talk, narrative, and stories we were able to evaluate the impact of individual elements on individuals and communities along with the experience of colleagues involved in the developing approach, examples of such are available locally.

In line with the vision set out in the 'National Primary Care strategy', but there will be a heavy emphasis on maximising the role of third sector providers, particularly in providing information, advice and assistance, and helping to develop a 'wellbeing workforce' where social prescribers, care navigators and other multi-disciplinary professionals are seen as part of the core offer, and shifting the emphasis away from the GP as the gatekeeper of health and wellbeing services.

Our capital strategic needs assessment will support an understanding of the opportunities and gaps within the network of hubs and spokes already provided within our communities. A common language needs to be established to aid both citizen and professional awareness and understanding of the offer enabled by hubs and spokes. Consideration will be given to a differentiated skill mix, with specific OD and workforce development programmes implemented where needed.

Interdependencies

This programme will work closely with all other programmes aligned to the Community Care: Prevention and Early Intervention Model of Care to ensure learning and good practice shared, and embedded.

Interim Financial Model (Year 1 Only)

Total cost of programme	RIF Contribution	Partner match monetary	Partner match resource	% support for unpaid carers	% support for social value sector
£2,970,252	£2,345,386	£0	£624,866	0%	9.44%

Regional Investment Model

Select the funding element which the project will be set against. Repeat the table and rationale for each project

Element	
Element 1 – Acceleration funding year 1	
Element 1 – Acceleration funding year 2	
Element 2 – Embedding funding year 1 This programme brings together the developments enabled through the Integrated Care Fund and Transformation Fund, providing a whole system approach to community resilience and wellbeing. Embedding the existing capacity and new ways of working is critical to the prevention and early intervention required for longer term system wide impact.	✓
Element 2 – Embedding funding year 2	
Element 2 – Embedding funding year 3	
Element 3 – Legacy fund	
Element 4 – National priorities (Dementia and Memory Assessment Services/Diagnostic support)	

Strategic Outline Plan (Gwent refer as Programme, WG refer as Project)
SP14: LD Independence & Wellbeing

Model of Care Alignment					
Community based care – prevention and community coordination	Community base care – complex care closer to home	Promoting good emotional health and wellbeing	Supporting families to stay together safely and therapeutic support for care experienced children	Home from hospital	Accommodation based solutions
✓		✓			✓

Programme Summary
This programme intends to ensure all individuals with a Learning Disability have access to equitable opportunities and 'joined up' services. Individuals their families and carers feel supported and fully informed when accessing services and services are driven by what matters to them, and will be supported to live as independently as possible within their community. The programme also includes a specific focus on reducing health inequalities for people with a learning disability working with primary care GP practices. All individuals with a Learning Disability have access to equitable opportunities and 'joined up' services. By establishing an integrated system that supports people with a learning disability, their transition across the system will be seamless, they will live as independently as possible within their community and only tell their story once. Establish integrated working and data sharing across the health & social care system. Reducing health inequalities through reasonable adjustments to mainstream services and access to specialist services when needed. Improving community integration, including increasing housing options closer to home. Further develop and transform innovative flexible services for people with a learning disability across the Gwent region to construct an integrated, fair, equitable and safe service, in line with the Equalities Act (2010); that's shaped by the Learning Disability Improving Lives programme (2018.)

Intended Outcomes	
Person Centred Outcomes	▪ Reduce health inequality for people with a learning disability ▪ Individuals their families and carers feel supported and fully informed when accessing services and services are driven by what matters to them ▪ Individuals have access to equitable services and adequate specialist support. ▪ Individuals' health and social care needs are fully met, with no-one 'falling through the gaps' ▪ Building independence for people with a learning disability
System Outcomes/Benefits	▪ Preventing further escalation, reducing duplication and the need for complex health services

	▪ Prevention of pressures of statutory services ▪ Improved joint-working pathways through systems ▪ improve planning and funding systems ▪ Improved community support structures ▪ The system demonstrates quality and synergy of the learning disabilities services

Baseline Position

It has been previously highlighted that the transition from child and adult services for people with a learning disability transitioning through the system can be complex and hard to navigate. This is restricting the opportunities for complementary working across services and the prospects to provide a whole integrated flexible system that will empower individuals and let them have their say on how the system works.

Joining up and integrating services is a challenge, for example, when people leave school or college, support may vanish. Data on people with a learning disability and the impact lack or disjointed services have on them, and their families and carers is detrimental to them living a full and healthy life. When services are not available, and a person's needs are not met this can result in escalation of the original presenting issues forcing them to access primary/emergency services. The programme of services for people with learning disability is built in to help prevent and relieve pressures on primary services and make sure they are offered the same options as everyone else within their communities/closer to home across the Gwent region.

Gaps across the region; where a service is offered in one area and is producing successful outcomes for people with a learning disability, their families, and carers, it is not offered in other local authorities causing disparity, creating an unequitable service, which goes against the Equalities Act (2010) and A Healthier Wales (2018), Learning Disabilities Improving Lives (2018). For a fair and equitable service where outcomes are person centred, we need to build on the successful piloted innovations to be delivered and expand across the Gwent region.

Through our population needs assessment, we have identified a total of 673 people with learning disabilities known to ABUHB with average life expectancy increasing over the last few decades. However, the pandemic has had a negative impact on people with a learning disability, where they have felt isolated at being separated from family and friends and daily routines disrupted. People have said that stress, anxiety, feeling isolated and changes to their normal routine has had a negative impact on mental health. Also, some people felt their health had deteriorated as they were not as active and had put on weight due to not going out and about.

Key Enablers	
Workforce Development & Integration	▪ Upskilling staff to enable better retention. ▪ Embed appropriate training with workforces in strategic/ operational levels. ▪ Revision and agreement of current resource with exploration into alignment across services, from health to social care. ▪ Established connectivity between Health, social care housing & education workforces to ensure a coordinated response for families.
Integrated Planning & Commissioning	▪ Implement an integrated approach across services and organisations to ensure individuals, their families and carers are given the right equitable support. ▪ Working with organisations to commission and implement the suite of services agreed to take forward.

	▪ Revision of current SLA's - By linking in with divisions/organisations a review of all current SLA's will be undertaken including core funded, partnership funded, WG funded SLA'.
Technology & Digital Solutions	▪ Expand opportunities of assistive technology that may benefit people with a learning disability, their families, and carers to help promote independence and make sure there are equitable options for individuals. For example, a focus on the assistive technology arena that can help alleviate the problem of an individual having to repeatedly tell their story. Use of integrated data system such as WCCIS.
Capital Infrastructure	▪ Supporting independence via a range of living solutions
Social Value Sector	▪ To work with third sector to build resilience for people with a learning disability, their family, and carers; and enhance community-based provision. Making sure their voices are heard and needs are acted upon and are met.

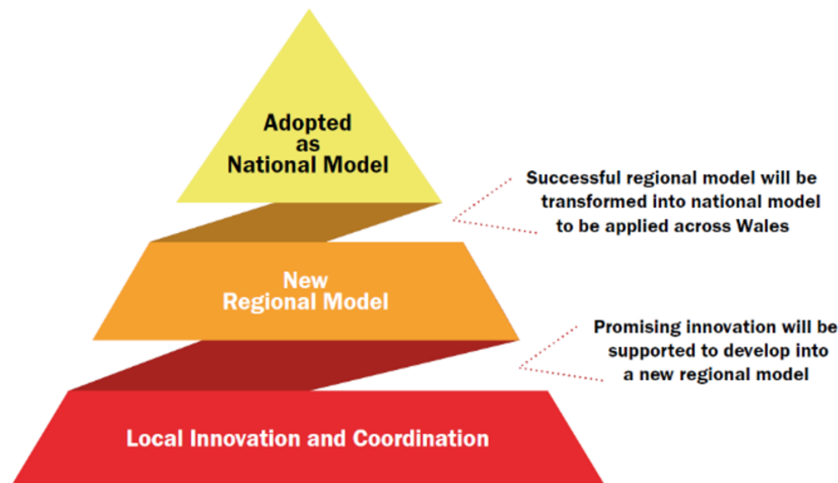
Priority Population Groups		
	Primary Beneficiary	**Secondary Beneficiary**
Older people with complex needs		
People with Dementia		✓
Unpaid Carers, inc. Young Carers		✓
Children with Complex Needs		
People with emotional and mental health wellbeing needs		
People with Learning Disability and Neurodevelopmental conditions	✓	

Development Approach

The future vision as set out in A Healthier Wales (2018) focuses on a 'Whole System Approach' to health and social care' focused on health and wellbeing and preventing illness. The ambition in line with A Healthier Wales (2018) & Learning Disability Improving Lives (2018), is to strengthen services across all sectors for individuals with a learning disability, their families, and carers, by increasing community integration and improving planning and funding systems, to reduce preventable health inequalities making sure they have access to equitable opportunities and can take more responsibility for their own health and wellbeing.

Through engagement with professionals and individuals, there will be a strategic and sequenced approach, to embed the learning disabilities suite of services as highlighted for continuation into the future 5-year plan. In line with this piece of work there will be opportunity to develop the expansion of the services highlighted as exceptional, delivering positive outcomes across the Gwent region. This will work towards a prosperous environment where resources will be used efficiently and proportionately as stated in one of the seven well-being goals from the Well-Being of Future Generations Act (2015); developing a skilled and well-educated population, to create consistency and creating a healthier society where wellbeing is maximised, to reduce the negative impacts experienced by individuals with a learning disability to get it right.

Areas highlighted for growth / expansion started as local innovation pilots, which falls into the bottom red section of the pyramid in the A Healthier Wales 2018 (Diagram Below). These services have demonstrated and evidenced the positive impact, they have been able to make in the lives of individuals with a learning disability, their families, and carers. The expansion is to move these services into a new regional model which will require a whole system approach for successful integration.



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Under the policy drivers within the A Healthier Wales (2018); people with a learning disability will be supported to stay well. The programme will offer a suite of services, working seamlessly together, that will help tackle inequalities people with a learning disability, their families and carers come up against when accessing services, help or support.

To drive this forward, a whole system approach across health and social care will need to take place, working in collaboration, using a person-centred approach and bringing support into the community, working towards creating a single system.

Interdependencies

Aligns with the Transition, Children with complex needs, Emotional Health and Wellbeing, Edge of Care, Complex Care, and Complex Needs Panels.
Children & Adolescents with Learning Disabilities Service
Adult Learning Disability Services
Child & Adolescents with Mental Health
Adult Mental Health Service.

Interim Financial Model (Year 1 Only)

Total cost of programme	RIF Contribution	Partner match monetary	Partner match resource	% support for unpaid carers	% support for social value sector
£505,255	£496,333	£0	£8,922	0%	26.01%

Regional Investment Model

Select the funding element which the project will be set against. Repeat the table and rationale for each project

Element 1 – Acceleration funding year 1	

Element 1 – Acceleration funding year 2	
Element 2 – Embedding funding year 1	✓
This programme brings together the developments enabled through the Integrated Care Fund providing a regional programme of peer support and wellbeing activity. Embedding the existing capacity and new ways of working is critical to the prevention and early intervention required for longer term system wide impact.	
Element 2 – Embedding funding year 2	
Element 2 – Embedding funding year 3	
Element 3 – Legacy fund	
Element 4 – National priorities (Dementia and Memory Assessment Services/Diagnostic support)	

Model of Care Investment Proposal
COMMUNITY BASED CARE – COMPLEX CARE CLOSE TO HOME

Strategic Vision
To establish a robust and sustainable community infrastructure that support individuals with care needs to be cared for within their own homes, or as close to home as possible. Embodying the principles established within the six goals for Urgent Care policy handbook, this model of care will provide a right sizing approach to the community capacity needed to provide care close to home, and facilitate the discharge to recover and assess pathways. To have nationally overcoming the challenges associated with community capacity across multiple professions (ranging from allied health professionals to domiciliary care), including workforce recruitment, retention and pay scales.

Dementia Action Plan (DAP) Summary
We are aware of the impact of the pandemic on people living with dementia and professionals within health and social care have been working hard to support people through assistive technology, online support and telephone calls where face to face visits could not be provided. We have also been supporting people living with dementia, their family and carers through the Get There Together National project, working with partners to create a series of films aimed to reduce concerns and reassure anyone who is anxious about getting beyond the front door as well as dealing with the stresses of Covid-19.

Case for Change
Healthy life expectancy is increasing over time, which is positive, however when the time comes where the oldest population develop care and support needs, those needs are more intensive and expensive as people live longer. People over the age of 65 are more likely to need extra support to remain independent in their own homes and across all local authorities in Gwent it is predicted there will be an increase in people unable to manage at least one domestic task on their own. Predicted number of people aged 65 or over that will be unable to manage at least one domestic task on their own (household shopping, wash and dry dishes, clean windows inside, jobs involving climbing, use a vacuum cleaner, wash clothing by hand, open screw tops, deal with personal affairs, do practical activities). Figures are taken from *Living in Britain; Results from the 2001 General Household Survey, Supplementary report: People aged 65 and over, table 37, ONS*. The predicted increases range is from 44.9% in Blaenau Gwent to 71.6% in Monmouthshire. As an RPB we have a range of multi-disciplinary reablement and care services in place to provide long and short-term support to help people live independently in their own homes. The number of older people with unmet care and support needs is increasing substantially due to challenges in the health and care system. Effective solutions are needed to address these needs including addressing delayed discharges in hospitals that can lead to worsening health outcomes and complications around care and support needs. It is clear that most people desire to cope with their illnesses and remain independent at home and care models need to reflect the needs of the person as part of their care and support.

Key Enablers	
Integrated Planning and Commissioning	
Planning and Commissioning will be integral to the establishment of right sized community capacity. Consideration is needed to the mechanisms that will enable integrated approaches to	

commissioning; the capacity and commissioning requirements will be identified within ongoing work.	
Technology enabled care	
The use of assistive technology to support independence at home will be explored in conjunction with the Assistive Technology Programme, which will in turn support admission avoidance or early discharge. Shared information between services will support the goal of integrated working, and seamless care for the individual.	✓
Promoting the social value sector	
Working with our provider network and third sector forum to identify intermediate care capacity within the system, supporting resilience and community care closer to home.	✓
Integrated Community Hubs	
Connectivity to hubs that provide assessment (step up/down) beds and reablement facilities will enable a seamless model and implementation of the D2RA pathways. The capital strategic needs assessment and evaluation of recently implemented older persons integrated hubs will support the continued development of this infrastructure.	✓
Workforce development and integration	
The success of this model of care is entirely dependent on the ability to right size community capacity and overcome the current and ongoing workforce capacity constraints. Both regional and national activity is required to overcome this issue.	✓

Priority Population Groups			
	Primary Beneficiary	Secondary Beneficiary	DAP
Older people including people with dementia			
Enabling care to be provided in a persons own home will maximise outcomes achievable for each individual, and mitigate avoidable physical deconditioning.	✓		
Children and young people with complex needs			
N/A			
People with learning disabilities and neurodevelopment conditions, including autism			
N/A			
Unpaid carers			
Working with unpaid carers to ensure they are supported, and considered alongside care plans.		✓	
People with emotional and mental health wellbeing needs			
N/A			
Other beneficiaries			
N/A			

Total programme cost and match funding					
Total cost of programme	Welsh Government contribution	Partner monetary match	Partner resource match	% support for unpaid carers	% for social value sector delivery
£11,918,824	£9,001,418	£0	£2,917,406	0%	3.75%

Programme management resource to be confirmed.

Strategic Outline Plan (Gwent refer as Programme, WG refer as Project)
SP04: Supporting Children with Development Needs

Model of Care Alignment					
Community based care – prevention and community coordination	Community base care – complex care closer to home	Promoting good emotional health and wellbeing	Supporting families to stay together safely and therapeutic support for care experienced children	Home from hospital	Accommodation based solutions
	✓	✓	✓		

Programme Summary

This programme of work supports children with development needs and aims to improve access to specialist by improving strategic and operational planning and access to services. It has a focus on improving community integration, including increasing placement options closer to home to reduce the number of out of county placements.

The model of support provided via 'Helping Hands' ensures parents and families receive timely guidance and support to preventing any further avoidable escalation.

Establishing an integrated system that supports children with complex needs and their families, providing appropriate support so that they can meet their potential.
They will have access to a suite of initiatives, using prevention and early intervention techniques and reducing adverse childhood experiences

- Improve access to specialist services offering fairness & equity across the system to build resilience
- Improved strategic and operational planning and access to services
- Improving community integration, including increasing placement options closer to home to reduce the number of 'out of county placements.

Creating a whole system approach for wellness flexible enough to meet the needs of children with complex needs, and their families, ensuring they receive the same level of care regardless of where they live, putting the children and family at the centre of the system/NEST.

Intended Outcomes	
Person Centred Outcomes	• Reduce health inequality for children with complex needs • People feel supported and fully informed when accessing services and services are driven by what matters to them • Access to equitable services with adequate specialist support • Health and social care needs are fully met, with no-one 'falling through the gaps'

System Outcomes/Benefits	- Preventing further escalation, reducing duplication and the need for complex health services - Further improve joint-working pathways through systems - Improve planning and funding systems - Further improve community support structures

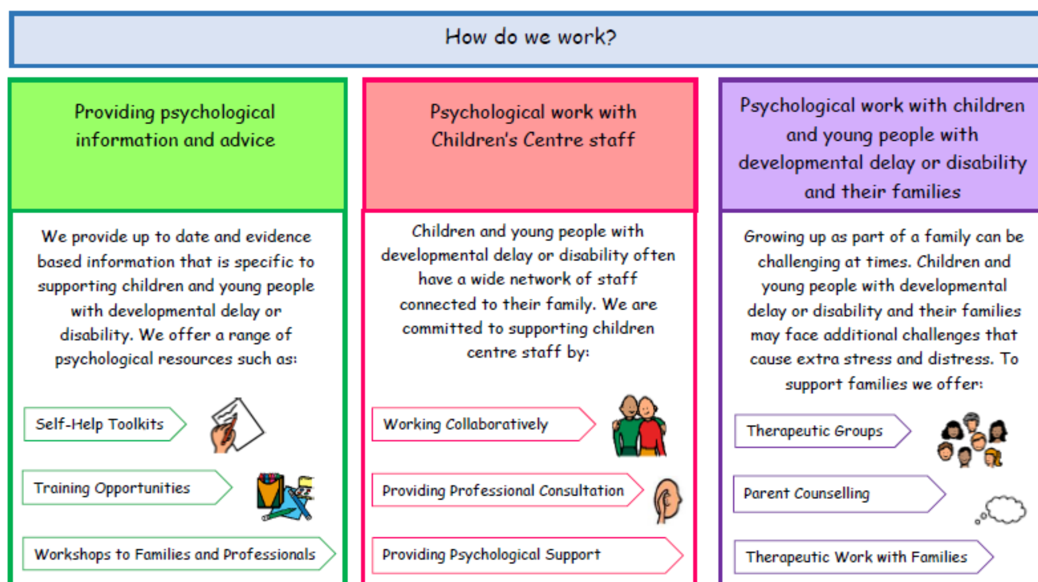
Baseline Position

Following changes made to the statutory guidance in relation to Part 9 of the Social Services & Well-Being Act (2014); the definition of children with complex needs now comprises:

- children with disabilities and/or illness
- children who are care experienced
- children who in need of care and support
- children who are on the edge of care/at risk of becoming looked after
- children with emotional and behavioural needs

The children with complex needs programme comprise of services that use a whole family approach and support the improvement of emotional health and wellbeing. Whereas some services focus on direct work with the child and their families, siblings and carers, other services support a family's ability to navigate the complex system of support a child might have when numerous professional agencies are involved in that child's care and treatment. Other services align with the *Workforce* principles, the mechanism for change is in providing professionals across health, social care, and education; training on attachment and developmental trauma, with the addition of follow-up sessions for the workforce to ensure frontline teams are supported in contributing to wider cultural change in their approach with families.

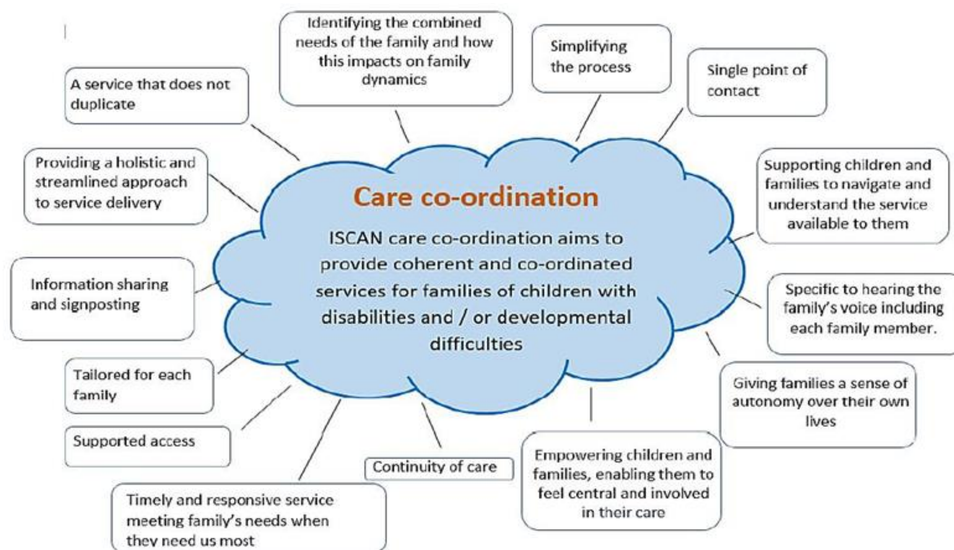
Helping Hands - The system promotes psychological wellbeing and offers earlier and targeted intervention that is equitable across the Gwent region. Working directly with those in need through early intervention. To improve family understanding, relationships, and stability. A whole family approach to emotional wellbeing is adopted, so we can achieve a decrease in reported parental stress, an increased level of care closer to home and long-term benefits such as a reduced burden of economic care in adulthood. The inclusion of community-based support and placement closer to home to reduce the number of children with complex needs escalating through the support system. Below is a diagram of how this part of the system works:



Between April to September 2020, a total of 33 children were supported . When referring to the information and advice provision, A total of 252 informal professional contacts had been made. Four workshops were delivered of which a total of 50 delegates attended, comprising of 44 parents and 6 professionals. From a sample of delegates that attended the workshops, 100% found the content helpful or very helpful and 100% were likely or very likely to recommend the session to another parent. Currently, in addition to the one-off workshops, an Early Positive approach to Support (E-PatS) parenting programme is delivered over a 9-week period for 6 families.

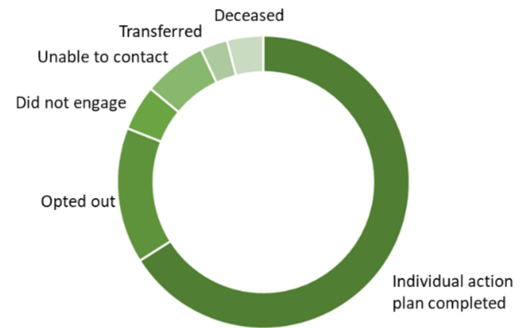
A total of 19 calls from concerned parents have been received by the team, averaging 46 minutes per call where bespoke information and advice has been provided on the challenges experienced by the parent. From the 19 calls received, 3 safeguarding concerns were raised by professionals, which if the service was unavailable could have potentially not been identified. In addition to parent calls, a total of 6 calls were received from associated professionals requiring support and service signposting information, however due to the nature of the calls, the professional calls averaged 12 minutes in duration which is significantly lower than parental contact.

Integrated Assessment & Planning (IAP/ISCAN) - Providing care co-ordination to families who are struggling to cope with the multitude of professionals / agencies involved in their child's care which supports and guides them through the maze of services, empowering the families to take ownership of their child's care. The service facilitates a multi-agency integrated assessment and plan for those children with the most complex needs, to improve the emotional wellbeing, which achieves a decrease in reported parental stress, an increased level of care closer to home and long-term benefits such as a reduced burden of economic care in adulthood. Below shows a representation of how this part of the service functions:



Between October 2018 to December 2019, 183 children were accepted by the Integrated Services for Children with Additional Needs care-coordination team, 86% (157 children) were for developmental support, whilst the remaining 14% (26 children) requires non-developmental support coordination. The majority required care or complex care coordination (49% and 46% respectively) whereby only a small percentage required integrated assessment and planning (5%). However, of the referrals accepted, 38% were referred to the Family Liaison Officers, latterly referred to as Family Support Worker. The outcomes of the pilot project in 2016 stipulated that waiting times were reduced for 100% of the cases accepted, furthermore, 90% of the cases had their waiting time reduced in the region of 12 to 13 weeks.

Children supported through the Care Coordination team whereby closed cases were identified. *Graph 2* identifies the reason for case closure for the 74 cases during the reporting period. As depicted by *graph 1*, the majority of the cases (66%) were closed due to the children successfully completing their individual action plan, demonstrating the success of the intervention. 15% of the accepted referrals opted out of receiving support as they felt they had their children's behaviours under control following advice and guidance from various services.



Graph 1. Reason for case closure 2018-2019

Now more than ever, supporting people's emotional health and well-being is vital to keeping society healthy and preventing the escalation of health and social care needs. With the impacts of COVID-19, this is further realised with an increasing number of people of all ages, including children and young people, being identified as having emotional health and wellbeing support needs

Joining up and integrating services is a challenge, for example, when people leave school or college, support may vanish. When services are not available, and a person's needs are not being met this can result in escalation of the original presenting issues forcing them to access primary/emergency services. The programme of services for children with complex needs is built in to help prevent and relieve pressures on primary services and make sure that the services offered are consistent and equitable for all, across the Gwent Region.

Gaps across the region; where a service is offered in one area and is producing good outcomes is not necessarily offered in other local authorities is causing disparity, creating an unequitable service, which goes against the Equalities Act (2010) and A Healthier Wales (2018), Learning Disabilities Improving Lives (2018). For a fair and equitable service where outcomes are person centred, we need to build on the successful piloted innovations for delivery and expansion across the Gwent region.

Key Enablers	
Workforce Development & Integration	▪ Upskilling staff to enable better retention. ▪ Ensure training with workforces in strategic/ operational levels around the NEST framework and their contribution to the whole system. ▪ Revision and agreement of current resource with exploration into alignment across services, from health to social care ▪ Established connectivity between Health, social care & education workforces to ensure a coordinated response for families.
Integrated Planning & Commissioning	▪ Implement an integrated approach across services and organisations to ensure individuals, their families and carers are given the right equitable support. ▪ Working with organisations to commission and implement the suite of services agreed to take forward ▪ Revision of current SLA's - By linking in with divisions/organisations a review of all current SLA's will be undertaken including core funded, partnership funded, WG funded SLA'
Technology & Digital Solutions	▪ NEST framework digital tool to create a platform that enables professionals to demonstrate good practice.

	▪ Expand opportunities of assistive technology that may benefit care experienced children & young people to help promote independence and make sure there are equitable options for individuals. For example, a focus on the assistive technology arena that can help alleviate the problem of an individual having to repeatedly tell their story constantly. Use of integrated data system such as WCCIS.
Capital Infrastructure	▪ Feasibility study for children's centre in the north of Gwent Region ▪ Identify any areas that could benefit from Capital funding and identify opportunities to align capital and revenue resources
Social Value Sector	▪ Working with third sector & local authority to create an integrated system of provision/access, that builds resilience for care experienced children & young people and enhance community provision. Making sure their voices are heard and needs are met. ▪ Ensuring accessible services within the community where they live

Priority Population Groups		
	Primary Beneficiary	**Secondary Beneficiary**
Older people with complex needs		
People with Dementia		
Unpaid Carers, inc. Young Carers		✓
Children with Complex Needs	✓	
People with emotional and mental health wellbeing needs		✓
People with Learning Disability and Neurodevelopmental conditions		✓

Development Approach

The future vision as set out in A Healthier Wales (2018) focuses on a 'Whole System Approach' to health and social care' focused on health and wellbeing and preventing illness. The ambition in line with A Healthier Wales (2018) & Learning Disability Improving Lives (2018), is to strengthen services across all sectors for children with complex needs, their families and carers, by increasing community integration and improving planning and funding systems, to reduce preventable health inequalities making sure they have access to equitable opportunities and can take more responsibility for their own health and wellbeing.

The children with complex needs system currently have services embedded within, that cover many aspects of the whole system, taking on a 'whole system approach'. From direct clinical work with the children, young people their families, siblings, and carers, to support to those who need help navigating the complex system and workforce training & development. There is a need to further progress the suite of services highlighted for continuation into the future 5-year plan and to align them more appropriately.

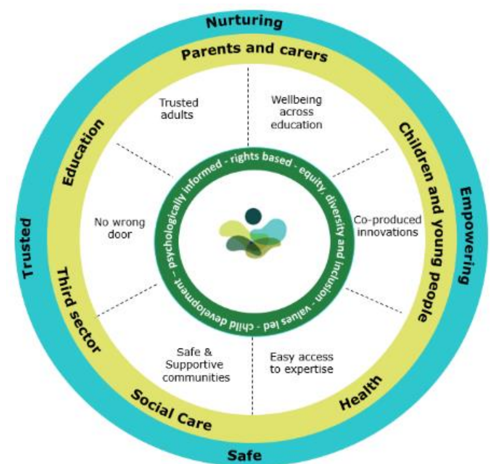
To do this we will need a planned out and sequenced course of action to engage with professionals and individuals across the whole system to gain better insight into how we can expand, embed, and improve integration between each system process and function. In line with this piece of work there will be opportunity to explore the expansion of the service areas highlighted as exceptional, delivering successful outcomes across the Gwent region. This will

work towards a prosperous environment where resources will be used efficiently and proportionately as stated in one of the seven well-being goals from the Well-Being of Future Generations Act (2015); developing a skilled and well-educated population, to create consistency and creating a healthier society where wellbeing is maximised, to reduce the negative impacts experienced by children with complex needs to get it right.

Areas highlighted for growth / expansion started as local innovation pilots, which falls into the bottom red section of the pyramid in the A Healthier Wales 2018 (Diagram Below). These services have demonstrated and evidenced the positive impact, they have been able to make in the lives of children with complex needs, their families, and carers. The expansion is to move these services into a new regional model which will require a whole system approach working this way will allow us to improve integration across the system.

Under the policy drivers within the A Healthier Wales (2018); children with complex needs, their families, and carers, along with the workforce, will be supported to improve knowledge of the services within the system, be given a clearer understanding of the pathways and how to navigate them, a more informed and upskilled workforce and to help them to stay well. The programme will offer a suite of services, working seamlessly together, that will help tackle inequalities that children with complex needs come up against when accessing services, help or support.

To drive this forward, using the NEST approach: a whole system approach across health and social care will need to take place, to develop mental health, well-being and support services for babies, children, young people, parents, carers and their wider families across Wales: working in collaboration, using a person-centred approach and bringing support into the community, working towards creating a single system with 'no wrong door' approach so that families get the right help at the right time and in a way that is right for them.



In Children's and Families Services, we are working towards a NEST framework that embodies the principles of offering children Nurturing, Empowering, Safe and Trusted environments (NEST). The framework is intended to support the working together of services so that babies, children, young people, parents and carers have the support of their own 'NEST'. The shared value base this framework provides helps to focus services on the same priorities that are person led and person centred. The 'no wrong door' approach has supported the development of a single point of access, that has enabled children, young people and families to get the right support and the right time, and a 'no bounce principle' when entering into complex system.

It's not for our children, young people, and families to navigate our complex system, we need to make this as accessible as possible to meet needs and prevent escalation. We know that points of transition and change can be anxiety provoking, so ensuring we support these points are crucial especially when children's services are starting to align in this way. The continuity of experience and sequencing of interventions we provide need to be joined up, so the system doesn't make things worse for people in the long term.

By using feedback from key stakeholders and expanding the opportunity to utilise new assistive technology through coproduction; will enable us to embed value-based healthcare to measure what matters most to people, ensuring that improvement activity is focussed on outcomes.

Through sustainable growth and developing community-based models of care that will provide early intervention and prevent the escalation of poor emotional and mental health and wellbeing for children with complex needs, as set out in the Well-Being of Future Generations Act (2015), we can bring about a more equal, cohesive, healthier, resilient, and prosperous society where children with complex needs, families and carers have the same rights and opportunities available to them locally.

Interdependencies
Aligns with the Transition, Emotional Health and Wellbeing. Children & Adolescents with Learning Disabilities Service, Adult Learning Disabilities, Child & Adolescents with Mental Health & Adult Mental Health Service There is a need to establish formal links with the Complex Care and Complex Needs Panels.

Interim Financial Model (Year 1 Only)

Total cost of programme	RIF Contribution	Partner match monetary	Partner match resource	% support for unpaid carers	% support for social value sector
£444,003	£444,003	£0	£0	0%	0%

Regional Investment Model
Select the funding element which the project will be set against. Repeat the table and rationale for each project

Element	
Element 1 – Acceleration funding year 1	
Element 1 – Acceleration funding year 2	
Element 2 – Embedding funding year 1 The developments enabled through the Integrated Care Fund established the integrated approaches to care co-ordination, and early support for parent carers of neurodiverse children with challenging behaviours. The programme is identified to be embedding to support the new ways of working and support available to be mainstreamed.	✓
Element 2 – Embedding funding year 2	
Element 2 – Embedding funding year 3	
Element 3 – Legacy fund	
Element 4 – National priorities (Dementia and Memory Assessment Services/Diagnostic support)	

Strategic Outline Plan (Gwent refer as Programme, WG refer as Project)
SP10: DAP – Living with Dementia

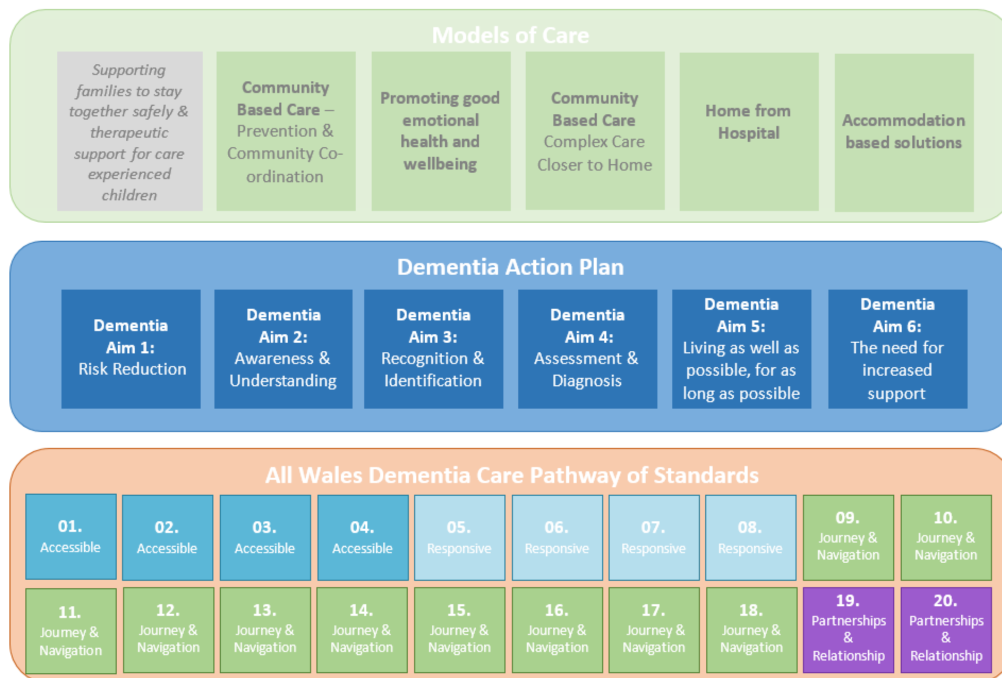
Model of Care Alignment					
Community based care – prevention and community coordination	Community base care – complex care closer to home	Promoting good emotional health and wellbeing	Supporting families to stay together safely and therapeutic support for care experienced children	Home from hospital	Accommodation based solutions
	✓	✓		✓	✓

Programme Summary
This programme will support the continued implementation of the Dementia Action Plan for Wales, and the Regional Dementia Blueprint. Establishing an integrated and connected system of support around the person living with dementia, their families and carers is the key driver within this programme. Working with dementia services across the region to strengthen and where needed redesigned, to establish a model in line with Dementia Care Standards. The programme supports the specific Dementia Action Plan aim for people to live well with Dementia; to increase support through a seamless system for people with dementia to live as well as possible, for as long as possible. This will be enabled by connected services for early intervention and supportive interventions to live well by maximising their independence and ability to participate in the community. The programme has an extended focus on the following: ▪ Dementia services have a regional taskforce approach as a commitment to redesign services aligned to an all Wales vision so they are more 'dementia supportive', including the establishment of 'connector' roles to be navigators and points of contact, offering support, advice and signposting throughout their journey from diagnosis to end of life (Dementia Standards, S12). Taskforce across the system will have increased opportunity of education and training for in person centred learning and development for all staff working on a care plan for people living with dementia, focusing on front door emergency service development for capacity assessment at the outset and enhancing Clinical Work Station awareness of diagnosis coding. ▪ Establishment of a framework and structure for Dementia Care Mapping (DCM) to be adopted as routine practice by organisations and care settings providing intensive dementia care (Dementia Standards, S16). Services will have accurate data of the individual and communication appropriately transferred between settings, improving the success of the person and their carer adapting and adjusting to change in their circumstances (Dementia Standards, S19). Carers will be supported and offered stage appropriate learning, education and skills training to address front door emergency service development and prevention of hospital admissions (Dementia Standards, S10). ▪ The system will provide seamless transition and strengthened partnership working through the Communities of Practice to ensure that all care partners communicate and jointly work with each other to foster smooth transitions of care (Dementia Standards, S19).

Intended Outcomes	
Person Centred Outcomes	People living with dementia, their families and carers will have equitable access to individualised and person-centred care. People living with dementia, and their carers, will feel supported by the system, and understand where to access support at times of need People living with dementia, and their carers, will develop anticipatory care plans to ensure their wishes are known early in the dementia journey
System Outcomes/Benefits	Reduction in hand-offs and duplication across the system Delayed need for formal care

Baseline Position

The Dementia Programme underpins the key themes and aims of the, the six models of care of, Dementia Action Plan and the All Wales Dementia Pathway of Standards:



There are a wide number of service level agreements (SLA) that we are reviewing the mapping exercise for both funded and community support activities across the region to refresh due to the learning from the pandemic and some community groups and services closing or services adapted to meet the needs of the community.

We work with our third sector partners to ensure that they are an integral and equal partner in the delivery of the dementia blueprint, where currently it is acknowledged that there remains a level of activity that is not identified or engaged to provide a seamless system. Welsh Government document of 'Dementia Action Plan: strengthening provision in response to COVID-19' considers a number of recovery priorities that support the vision of the Dementia Action Plan (DAP) and aligned to the four themes: accessible, responsive, journey, partnership and relationships consisting of the 20 standards wrapped around the person, setting out alignment to the aims of the programme below:

Dementia Aim 5 – 'Living as well as possible, for as long as possible with dementia' aligns to:

- 3. Protecting rights / person centred approach
  - 3.1 Post diagnostic therapeutic interventions/rehabilitation
  - 3.3 Improved hospital care
  - 3.4 Palliative care
- 4. Responding to changes in care
  - 4.3 Mental health support

Dementia Aim 6 – 'The need for increased support' aligns to:

- 3. Protecting rights / person centred approach
  - 3.1 Post diagnostic therapeutic interventions/rehabilitation
  - 3.2 Support for care homes
  - 3.3 Improved hospital care
- 4. Responding to changes in care
  - 4.2 Support for unpaid carers
  - 4.3 Mental health support

Key Enablers	
Workforce Development & Integration	A resilient, skilled and integrated health and social care workforce is critical to the successful delivery of the national models of care. Through a revision of the current resource capacity across the dementia model and alignment across health and social care services, local authorities and third sector will improve retention of staff to ensure the workforce is appropriately trained and upskilled to provide truly seamless, integrated services for the people across the region, aligning to the Strategic Regional Learning and Development Plan. To provide a straightforward framework that will guide our regional agencies and stakeholders together so they can all feed into and benefit from broad perspectives associated with learning and training for dementia. Development of 'connector' roles to be navigators and points of contact as identified in standard 12 of the All Wales Dementia Care Pathway of Standards.
Integrated Planning & Commissioning	To successfully develop and then mainstream the national models of integrated care, DAP and Dementia standards effective whole system planning and/or commissioning across health, social care, housing and wider delivery partners will be critical. By linking in with divisions/organisations a review of all current SLA's will be undertaken including core funded, partnership funded, WG funded SLA's. A more regional approach will ensure equitable service provision across the region.
Technology & Digital Solutions	Explore assistive technology to maintain independence for as long as possible for individuals living in their own homes and technology enabled care solutions for those that do require more complex care within the community or an acute setting.

	A key population group as a beneficiary of the assistive technology programme is people living with dementia, their families and carers, focusing on three key areas: • Supporting independence in their own home • Providing therapeutic technologies • Technology enabled care for more complex care when needed
Capital Infrastructure	Independent living solutions for people living with dementia to support delivery of • Independent living solutions enabled by RIF capital programmes working with a range of partners for example, RSL's etc. • Development of integrated hubs that are dementia specific or dementia friendly • Providing intermediate care capacity that will support reablement of people living with dementia or alternative respite facilities.
Social Value Sector	The third sector are key partners in the delivery of the programme to delivery against the priorities of the Dementia Action Plan and Dementia Standards, support a range of priority areas including: • Community based early intervention activity • Support for those with more complex needs • Pre bereavement and bereavement support

Priority Population Groups		
	Primary Beneficiary	**Secondary Beneficiary**
Older people with complex needs		✓
People with Dementia	✓	
Unpaid Carers, inc. Young Carers		✓
Children with Complex Needs		
People with emotional and mental health wellbeing needs		✓
People with Learning Disability and Neurodevelopmental conditions		✓

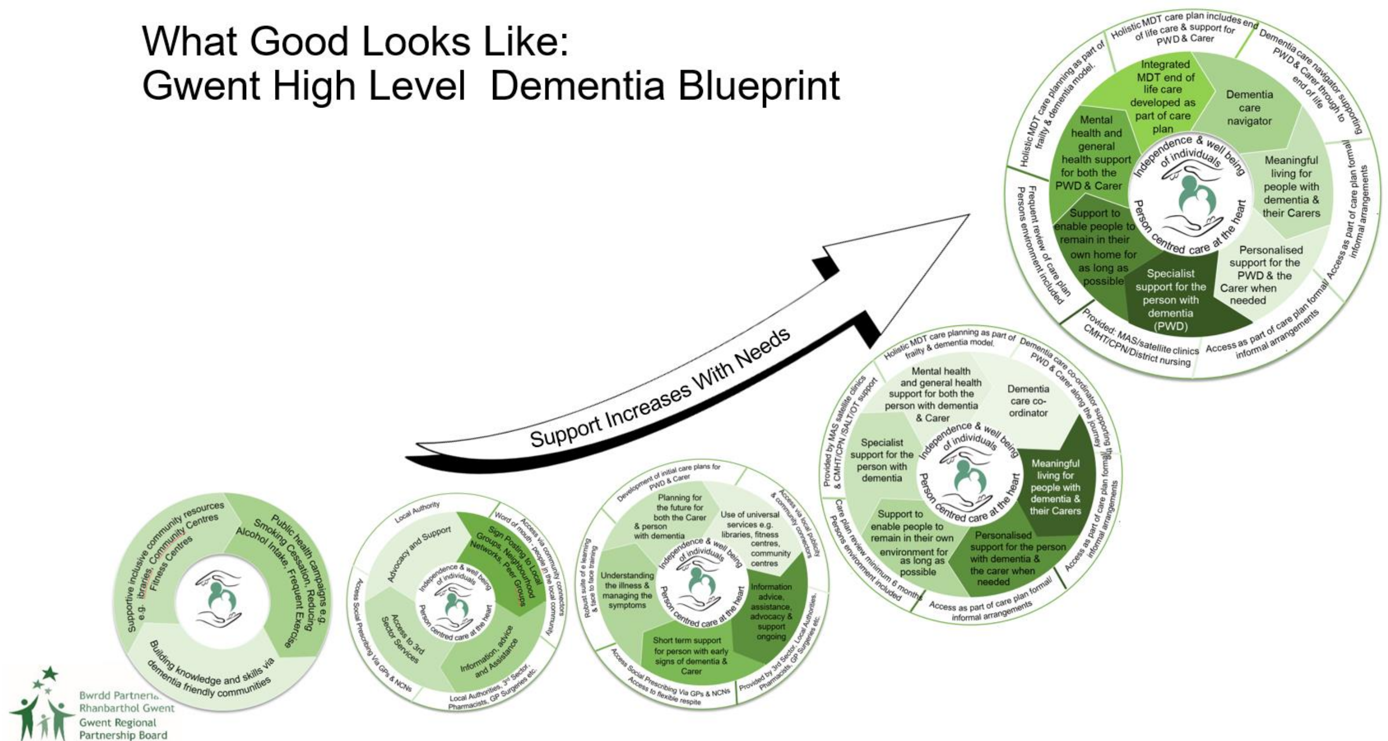
Development Approach

A Healthier Wales highlights the improvement of 'better co-ordination of research, innovation and improvement, in pursuit of higher quality and value, and will provide a pipeline of local opportunities which can be further developed into new models of seamless care'.

The Regional Integrated Fund (RIF) as an enabler of the programme provides 100% intervention rate (no tapering applicable) to support ongoing delivery of the Dementia Action Plan, to redesign activity through sequencing and transformation of the whole system. Welsh Government have shown a commitment to developing cross-cutting themes to consider a number of recovery priorities that support the vision of the Dementia Action Plan (DAP) and aligned to the four themes: accessible, responsive, journey, partnership and relationships consisting of the 20 standards wrapped around the person.

The 'What Good Looks Like' model below illustrates the services and support required as in accordance to the need. Channelling resources to support new models of care will be consistent with the national design principles that will focus on increased investment in prevention and early intervention as outlined in Healthier Wales.

The model has been developed regionally, however due to the pandemic the implementation has stalled. The development approach will focus on the implementation of the model within the work streams that have been established under the dementia standards.



The development of the dementia programme will identify current service alignment of the Dementia Action Plan, providing assessment of service gaps and improvement aligned to the dementia standards, strengthening the system of support to increase support and capacity throughout the whole system. Consideration of RIF revenue and capital as enablers to transformation, alongside core resources. Cross-cutting programmes will provide related support to all strategic programmes where needed formal reporting mechanism into the relevant Strategic Partnership on a regular basis, as described within a governance framework.

The current programme will maintain the existing activity and investment areas whilst the work around the dementia care standards commences and redefining existing activity over the few months as part of the Regional Partnership Board development programme, giving specific consideration to the following:

<u>Living as well as possible, for as long as possible with dementia</u>

- Developing individual advanced care plans
- Maximising physical well-being for example advice and support to keep active, eat well or prevent falls.
- Communication support, such as speech and language therapy.
- Counselling support.
- Introduction to palliative care interventions. These will include the management of pain and other symptoms with a goal of achieving the best quality of life.
- Supporting people in the early stages of dementia to ensure they have the information and opportunity to make decisions about their own future care and support. This should consider lasting powers of attorney12 and advanced decisions.

- Enabling access to cognitive stimulation programmes, such as teaching and practising memory strategies, which can improve both cognitive function and quality of life.
- Ensuring access to allied health professionals (such as physiotherapists and occupational therapists) and reablement / rehabilitation services to delay loss of skills and maintenance of life roles for longer.
- Enabling access to assistive technology and / or equipment and making adaptations to the environment to maintain or improve a person's independence, safety and wellbeing.
- Provision of flexible, enabling and personalised respite support.
- Ensuring access to advocacy support.
- Work with social care, health services and housing providers and involve people with dementia, their families and carers to strengthen collaboration on a strategic approach to housing to enable people to stay in their homes.
- Enable housing staff to access to training to assist them to support people with dementia.

The need for increased support

- Have specialist intensive support for a limited period of time, for example from social services, learning disability teams and/or community mental health teams with training and experience in crisis resolution support and meeting complex needs.
- All carers will have reasonable breaks from their caring role to enable them to maintain their capacity to care, and to have a life beyond caring
- Support for the carer can help to prevent crisis and help maintain their own physical and mental well-being as well as that of the person they are caring for.
- Accommodate the needs of a person with dementia when they are in hospital, with flexibility to allow family members to support a person whilst in hospital if they wish.
- When admitted to any hospital, individuals with dementia should have access to effective non-instructed advocacy or an Independent Mental Capacity Advocate (IMCA) and Independent Mental Health Advocate (IMHA) in the most appropriate manner depending on individual circumstances.
- Ensure that the recommendations from the Royal College of Psychiatrists' National audit of dementia in general hospitals are implemented, including instructing health boards and trusts to adopt the principles of 'John's Campaign'.
- Expand the use of Dementia Care Mapping™ as an established approach to achieving and embedding person-centred care for people with dementia and ensure health boards implement 'Driver Diagram – Mental Health Inpatient Environments for people with dementia'.
- Ensure older person mental health units have agreed care pathways for accessing regular physical healthcare.
- Ensure that access to advocacy services and support is available to enable individuals to engage and participate when local authorities are exercising their statutory duties under the Social Services and Well-being (Wales) Act 2014.
- Ensure the 'teams around the individual' discuss the importance of making advance decisions and ensure an agreed palliative care pathway is in place.
- Identify professionals who would benefit from training in initiating serious illness conversations, and provide such training.

Interdependencies
This programme aligns with the connected communities programme, unpaid carers programme and core resource within Older Adult Mental Health Services, Community Resource Teams, and wider general hospital services.

Interim Financial Model (Year 1 Only)					
Total cost of programme	RIF Contribution	Partner match monetary	Partner match resource	% support for unpaid carers	% support for social value sector

£1,555,994	£1,406,976	£0	£149,018	0%	16.83%

Regional Investment Model *Select the funding element which the project will be set against. Repeat the table and rationale for each project*	
Element 1 – Acceleration funding year 1	✓
A small element of this funding is supporting care homes; due to ongoing recruitment and retention challenges a new model will be developed to provide support to care homes caring for those living with Dementia.	
Element 1 – Acceleration funding year 2	
Element 2 – Embedding funding year 1	
Element 2 – Embedding funding year 2	
Element 2 – Embedding funding year 3	
Element 3 – Legacy fund	
Element 4 – National priorities (Dementia and Memory Assessment Services/Diagnostic support)	✓
The majority of this programme is funded via the Dementia ringfenced funding.	

Strategic Outline Plan (Gwent refer as Programme, WG refer as Project)
SP12: Place Based Graduated Care

Model of Care Alignment					
Community based care – prevention and community coordination	Community base care – complex care closer to home	Promoting good emotional health and wellbeing	Supporting families to stay together safely and therapeutic support for care experienced children	Home from hospital	Accommodation based solutions
	✓			✓	✓

Programme Summary
This programme focusses on providing right sized community services supporting people to maintain independence with seamless care delivered closer to home, allowing individuals to achieve their personal goals. Provided through two interlinked workstreams: Bed based intermediate care is provided in each of the Local Authorities through a series of Step Up / Step Downs services. These are supported through Community Intermediate Care schemes that focus on maintaining independence and improving the quality of life of those returning home following a period of care. Supporting the implementation of the D2RA Framework, the capacity enabled through this programme is intended to ensure people will only be in hospital if acutely unwell, maximising hospital capacity for people who require acute care and assessment, and will aid efficient flow through hospital and community services, with capacity being utilised for the right person at the right time. This programme directly supports the Improving System Flow programme. 'Right sized' community services supporting people to maintain independence with seamless care delivered closer to home, allowing individuals to achieve their personal goals and a true quality of life. The model will be fit for the future, flexible to adapt to changing/growing demand. Community support services will be right sized (with the aim to discharge within 48 hours of being medically optimised, in line with the D2RA measures). Where possible people will be supported to recover in their usual place of residence, accessing community-based care if needed. Community and discharge support services will be strengthened and redesigned to establish a model throughout the region that provides consistent person-centred outcomes, in line with the principles of A Healthier Wales and the Discharge to Recover then Assess model.

Intended Outcomes	
Person Centred Outcomes	▪ People will not be unnecessarily referred to long term care due to deconditioning/delayed intervention ▪ People's experience will be optimised, being fully informed and supported in achieving their personal goals ▪ People will not experience harm associated with deconditioning during avoidable time in a hospital bed

	▪ Through early transfer to reablement pathways the outcomes of recovery and reablement will be maximised, with people being supported to be as independent as possible
System Outcomes/Benefits	▪ Reduced statutory services demand due to a reduction in avoidable deconditioning/deterioration ▪ Reduction in people referred for long term care due to early intervention maximising capacity for people who require long term care ▪ People will only be in hospital if acutely unwell, maximising hospital capacity for people who require acute care and assessment ▪ There will be efficient flow through hospital and community services, with capacity being utilised for the right person at the right time

Baseline Position

Intermediate care is currently provided through two interlinked modalities. Bed based intermediate care is provided in each of the Local Authorities through a series of Step Up / Step Downs services. These are supported through Community Reablement schemes that focus on maintaining independence and improving the quality of life of those returning home following a period of care.

The Place Based Graduated Care Programme is underpinned by the D2RA (Discharge to Recover then Assess) Model which provides a framework for integrated planning and delivery of community and hospital services. There are 5 pathways aligned to community-based care supporting admission avoidance and early discharge, as outlined in Figure 1 below:

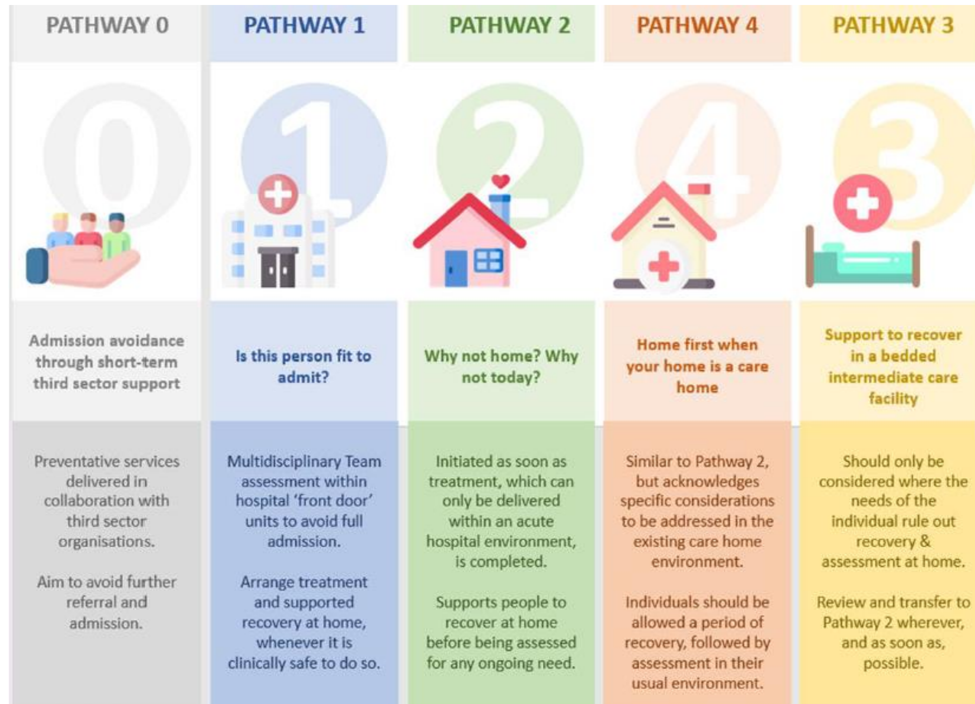


Figure 1: Home First: The Discharge to Recover then Assess model (Wales) – 2021

Quarterly reports are currently submitted for five key D2RA measures. Summary data for January 2021 – December 2021 is outlined below. In order to collect accurate information integrated data systems are required, which aligns with the Integrated Data Development Programme.

Measure 1: Number of People transferred on to each D2RA Pathway

Pathway 0	Pathway 1	Pathway 2	Pathway 3	Pathway 4	Total
2163	2125	3262	194	143	7887

Measure 2: % of those transfers that took place within 48 hours of the decision being made (that they were ready for transfer from hospital to this pathway for supported recovery and assessment)
We are currently unable to provide this information by pathway. Figures are provided from complex list discharges (all pathways including D2RA), indicating 76% of patients are discharged from hospital within 48 hours of being 'medically fit' between January 2021 and December 2021, as shown in the table below:

Number of individuals discharged within 48 hours of being medically fit	Total number of discharges	Percentage of individuals discharged within 48 hours
17245	22780	76

Measure 3: % people transferred to a D2RA Pathway with a co-produced recovery plan in place
A mechanism to capture this information is to be developed as part of ongoing work

Measure 4: % people transferred out of the D2RA Pathway to their usual place of residence

Pathway 0	Pathway 1	Pathway 2	Pathway 3	Pathway 4
tbc	65%	54%	59%*	tbc

*Data currently does not include community hospital beds

Measure 5: % people readmitted to hospital within 28 days

Pathway 0	Pathway 1	Pathway 2	Pathway 3	Pathway 4
tbc	tbc	5%	6%	13%

Key Enablers	
Workforce Development & Integration	Linking with the workforce development programme a recruitment, retention and training plan will be developed to support a resilient and right sourced workforce for Place Based Graduated Care supporting, reviewing skills needed for example Occupational Therapy capacity.
Integrated Planning & Commissioning	An overview of SLA's will be undertaken as part of the Improving System Flow programme to identify third sector services supporting discharge.
Technology & Digital Solutions	The use of assistive technology to support independence at home will be explored in conjunction with the Assistive Technology Programme, which will in turn support admission avoidance or early discharge. Shared information between services will support the goal of integrated working, and seamless care for the individual.
Capital Infrastructure	Accommodation based solutions such as rapid home adaptations to aid discharge, independent living facilities with integrated wrap around care and purpose-built intermediate care facilities will be considered.
Social Value Sector	The Third Sector will be key partners supporting the Place Based Graduated Care Programme to achieve optimal person-centred outcomes. Through SLA's Third sector services currently support hospital avoidance and patient discharge, including providing some intermediate

	care services, which will be reviewed and expanded upon as part of the programme.

Priority Population Groups		
	Primary Beneficiary	**Secondary Beneficiary**
Older people with complex needs	✓	
People with Dementia	✓	
Unpaid Carers, inc. Young Carers		✓
Children with Complex Needs		
People with emotional and mental health wellbeing needs		
People with Learning Disability and Neurodevelopmental conditions		

Development Approach

The Place Based Graduated Care Programme aligns with the Home from Hospital model of care, the six goals for urgent and emergency and urgent care (Goal 6 - Home First Approach and reduce the risk of readmission) and the Home First: Discharge to Recover then Assess (D2RA) model. The programme focuses on the community infrastructure to support patients to be discharged from hospital once acute medical treatment has finished and to recover in the community, prior to any long-term decisions about care being undertaken.

The Place Based Graduated Care programme is closely interlinked with the Improving system Flow Programme as part of a Whole System Approach supporting the Home from Hospital model of care. The Improving System Flow programme supports pathways 0 and 1, along with discharge co-ordination.

The programme supports the four key principles of the D2RA model:

1. Think 'Home First' and keep the individual at the centre of all discharge considerations.
2. Balance risk and agree co-produced, clearly documented plans.
3. Have the community services infrastructure in place
4. Communicate.

A phased approach will be taken for the Place Based Graduated Care programme. During the first year the capacity for community services and infrastructure to support discharge will be co-produced and redesigned. Areas of work that are providing good outcomes for individuals will be embedded, and a new model for graduated discharge support throughout the region will be developed. A benefits realisation plan will be developed to ensure that the programme is providing good person-centred outcomes for individuals based on What Matters to You conversations. During the following years of the programme the new model for discharge support will be implemented and evaluated to ensure the programme is working optimally to support person-centred outcomes for people in the Gwent region.

The programme will work to support pathway 2 (recovery at home) by mapping capacity in community services, that support hospital discharge and admission avoidance, including current SLA's and those that are not directly commissioned by health and social care (in line with the Improving System Flow Programme). This will allow good practice to be identified and shared across the region, as well as any gaps in the system to ensure equity across the region. This work will also consider capacity for pathway 4 (in reach recovery support to a patient's current care home). Interlinking with the Assistive Technology and Capital programmes consideration will be given to how

assistive technology and rapid home adaptations can help people recover and remain/regain independence once discharged from hospital.

The programme will also refine and redesign the model for pathway 3 (bedded intermediate care services). Step up/Step Down beds are currently available in each locality, however a review will be undertaken to identify any gaps or areas of good practice. Working in conjunction with the Capital programme a review of the development of further intermediate care facilities will be considered. Transfer to the pathways will be based around What Matters to Me conversations. Where bedded intermediate care is required there will be a continued focus on people being transferred and supported to recover at home as soon as possible.

Working in line with the rolling engagement strategy to be undertaken as part of the Improving System Flow programme of work it is the intention to raise awareness of staff of the community options available for individuals, supporting conversations with individuals and their families and ensuring a patient's pathway is seamless as they move to different areas for support.

The Place Based Graduated Care programme will work and interlink with other core workstreams that are being undertaken such as the COTE/Frailty pathway review, and the Direct Admission pathway

Interdependencies

The Place Based Graduated Care programme is closely linked to the Improving System Flow Programme as part of a Whole System Approach supporting the Home from Hospital model of care. It also links with the Unpaid Carers Programme, supporting Unpaid Carers and those cared for through hospital discharge.

The work of the Integrated Data Development Programme, Workforce Programme and Assistive Technology Programmes will be key enablers in supporting this Programme.

The Place Based Graduated Care Programme also links with core workstreams that are being undertaken such as the COTE/Frailty Pathway review and the Direct Admission Pathway.

Interim Financial Model (Year 1 Only)

Total cost of programme	RIF Contribution	Partner match monetary	Partner match resource	% support for unpaid carers	% support for social value sector
£8,874,497	£6,394,640	£0	£2,479,857	0%	0%

Regional Investment Model

Select the funding element which the project will be set against. Repeat the table and rationale for each project

Element	
Element 1 – Acceleration funding year 1	
This refreshed programme will introduce streamlined and seamless pathway of care, enabling care closer to home. A model of graduated care will be established across the region, providing consistency and shared understanding of the community care available. Mechanisms to understand capacity across the system, and support effective care planning will closely align with the redevelopment of the Improving System Flow programme.	✓
Element 1 – Acceleration funding year 2	
N/A	
Element 2 – Embedding funding year 1	
N/A	

Element 2 – Embedding funding year 2	
N/A	
Element 2 – Embedding funding year 3	
N/A	
Element 3 – Legacy fund	
N/A	
Element 4 – National priorities (Dementia and Memory Assessment Services/Diagnostic support)	
N/A	

Strategic Outline Plan (Gwent refer as Programme, WG refer as Project)
SP16: Transition

Model of Care Alignment					
Community based care – prevention and community coordination	Community base care – complex care closer to home	Promoting good emotional health and wellbeing	Supporting families to stay together safely and therapeutic support for care experienced children	Home from hospital	Accommodation based solutions
	✓	✓	✓		

Programme Summary
The programme will focus on the development a regional transition strategy to ensure a whole system approach to the planning and support provided to children and their families experiencing transition. Whole system mapping will be undertaken to ensure opportunities and bottlenecks are address, and learning responded to across the system. The ethos of the programme is to foster independency over dependency; ensure the system works well enough so different needs of the individuals across adult and child services are met.

Intended Outcomes	
Person Centred Outcomes	▪ People will feel supported and fully informed when transitioning between services ▪ Individuals have access to equitable services and adequate specialist support. ▪ Develop a clear pathway of support through transition. ▪ Individuals care and treatment continues, with no unintended deterioration in their personal health or wellbeing ▪ People's health and social care needs are fully met, with no-one 'falling through the gaps'
System Outcomes/Benefits	▪ Staff will be upskilled and fully aware of pathways/processes for transition and are empowered to support people on their journey ▪ Through ensuring individuals transition smoothly and care is ongoing there will be no 'unexpected' future demand due to deterioration of conditions. ▪ The system demonstrates quality and synergy of transition services ▪ Transition to be viewed as a priority throughout the system and not just an afterthought.

Baseline Position
Becoming an adult isn't just an event, it's a process full of decisions and lots of changes. For young people getting support from healthcare services, the move from child services to adult services is part of this process. (Transition

Handover & Guidance WG 2020); Young people are all different, they all grow up in different ways. So, the best time for a person to move to adult services could be different to someone else. It's not just about age, it's about being able to show that a person:

- Understands their care needs
- Understand what needs to happen
- Can give consent

Joining up and integrating services is a challenge, for example, when people leave school or college, support may vanish. When services are not available, and a person's needs are not being met, this can result in escalation of the original presenting issues forcing them to access primary/emergency services. The transition programme will be further developed to help prevent and relieve pressures on primary services and make sure that the services offered are joined up, consistent and equitable for all, across the Gwent Region.

From extensive early scoping work in the development of this programmes a number of barriers to streamlined transition arrangements have been identified.

It is perceived that there is currently a level of duplication within transition, the main egress that arises is the duplication or repeated assessments an individual must complete whilst navigating the transition service, resulting in 'Assessment Fatigue'. Complex cases also don't neatly align with one single pathway, which impacts the number of processes currently undertaken; this is an example of one of many areas of variation within current transition arrangements across statutory agencies within Gwent.

Organisations in Gwent have a varying degree of dedicated process and capacity for transition; some areas having a more generalist approach where transition is part of wider working, or other areas where dedicated staff and/or small teams support this specific cohort of individuals.

Key Enablers	
Workforce Development & Integration	▪ An understanding of current transition resource and requirements for additional staff to support transition will be developed as part of the mapping and planning phases. ▪ Upskilling staff to enable better retention. ▪ Embed appropriate training with workforces in strategic/ operational levels. ▪ Revision and agreement of current resource with exploration into alignment across services, throughout health, social care, education & housing ▪ Established connectivity between health, social care, housing & education workforces to ensure a coordinated response for families.
Integrated Planning & Commissioning	▪ Delivering on the developed strategies to undertake transformation of the transition services. ▪ To work on the ground at grass roots with services to help them develop and implement any changes laid out in the strategies. ▪ Implement an integrated approach across services and organisations to ensure individuals, their families and carers are given the right equitable support throughout transition. ▪ Working with organisations to commission and implement the suite of services agreed to take forward.

	▪ Revision of current SLA's - By linking in with divisions/organisations a review of all current SLA's will be undertaken including core funded, partnership funded, WG funded SLA'.
Technology & Digital Solutions	▪ Explore integrated data systems that would assist shared transition planning across agencies. ▪ Expand and exploring opportunities of assistive technology that may benefit transition and may help promote independence for individuals in the transition service.
Capital Infrastructure	▪ Regional facilities providing support during transition, to develop independent living skills, training flats, etc.
Social Value Sector	▪ The Social Value Sector will be a key consideration of available and future transition support. Where an integrated MDT approach to transition will be developed through the course of the programme.

Priority Population Groups		
	Primary Beneficiary	**Secondary Beneficiary**
Older people with complex needs		
People with Dementia		
Unpaid Carers, inc. Young Carers		✓
Children with Complex Needs		✓
People with emotional and mental health wellbeing needs		✓
People with Learning Disability and Neurodevelopmental conditions	✓	

Development Approach

The future vision as set out in A Healthier Wales (2018) focuses on a 'Whole System Approach' to health and social care' focused on health and wellbeing and preventing illness. The ambition in line with A Healthier Wales (2018) & Learning Disability Improving Lives (2018), is to strengthen services across all sectors for individuals their families, and carers, navigating the transition services by increasing community integration and improving planning and funding systems, to reduce preventable health inequalities making sure they have access to equitable opportunities and can take more responsibility for their own health and wellbeing, through the 'whole system approach'.

We know that points of transition and change can be anxiety provoking, so ensuring we support these points are crucial especially when children's services are starting to align in this way. The continuity of experience and sequencing of interventions we provide need to be joined up, so the system doesn't make things worse for people in the long term.

In transition we are trying to foster independency over dependency but in order to do this we need to ensure the system works well enough so that all the different needs of the individuals across adult and child services are still met.

Using the 5 principles set out in the 'Moving from children's to adult's services handover guidance (2020)', we will work with all services engaged with young people expiring transition so that processes are consistent and seamless. Through mapping current services and developing the strategies to implement effective change throughout the transition system. we will improve collaboration efforts with other organisation and enhance our information sharing which will help ensure that the needs of the people are identified early, and the right support is put in place to produce positive outcomes. (Additional Learning Needs [ALN] Act 2018).

1. Listen to young people and put your needs and wishes first.
2. Focus on early and easy access to care and support, especially for young people in crisis, with a disability or disadvantage.
3. Work with other services to meet young people's needs.
4. Give young people all the information they need to make decisions.
5. Give young people feedback and confidence by showing strong planning, monitoring and leadership.

The programme will be developed and implemented within three phases:

Phase 1 – focussing on system mapping, benchmarking, and research, which will be undertaken to map out current transition resource available within the system. Evidence will be captured as to how the system for transition is configured within each service area, where the gaps in services occur and identify where bottlenecks may exist as barriers to seamless transition.

Evidence gathered will be collated and reviewed and the findings will be written up and shared with relevant key stakeholders. Current standard operating procedures (SOPs), policies and procedures will be gathered and reviewed from each organisation as each area has their own policies to follow which makes transition across services difficult to navigate. It is the plan to create an overarching strategy for transition where there are streamlined SOPs, policies and procedures dedicated to transition.

Phase 2 – Will focus on areas for improvement, which will then feed into the development of the proposed strategies for; transition between children and adults service and for vulnerable adults who fall between services as they don't meet the relevant criteria for a particular service. This will outline and shape how the changes will be taken forward and create the vision of how transition will work in the improved model.

The strategies will be coproduced with key stakeholders and all areas and aspects highlighted for change or realignment will need to be agreed and signed off by all involved before moving on to the next phase.

Consultation will take place with individuals once the strategies have been developed for agreement and sign off. Agreement across services and from all stakeholders is paramount to the success of creating a seamless transition service so that individuals feel empowered and involved in the changes that will take place.

Within this phase we will explore the opportunities of utilising any new technology and assistive technology that can support the transition process and future independence.

Phase 3 - Implement the changes needed to ensure a seamless transition strategy is adopted across the region and any necessary reengineering of the transition system is undertaken.

A nominated service area will be identified so that a Deming cycle can be implemented so change and realignment can be carried out on a smaller scale so that the proposed changes can be documented to measure the impact of the changes and the reengineering of the services. By doing this we can review the outcomes of the small scale changes and reengineering and make any necessary adaptations to the process of change prior to wider implementation.

An implementation plan will be developed to ensure sequential adoption of change across all transition services.

A communication tool will be produced for signposting and to raise awareness of services. Throughout the process there will be review gates allocated for analysis and to sense check all findings and documentation and progress.

Within transition there will be an awareness of the children and families' services and how they work under the nest framework. The shared value base this framework provides helps to focus services on the same priorities that are person led and person centred.

Interdependencies
NEST implementation plan Children services across health and social care Assistive technology programme LD wellbeing programme Emotional and mental health wellbeing programme

Interim Financial Model (Year 1 Only)

Total cost of programme	RIF Contribution	Partner match monetary	Partner match resource	% support for unpaid carers	% support for social value sector
£509,471	£366,904	£0	£142,567	0%	0%

Regional Investment Model
Select the funding element which the project will be set against. Repeat the table and rationale for each project

Element	Selected
Element 1 – Acceleration funding year 1 Capacity was initially enabled via the Integrated Care Fund to introduce dedicated transition works in parts of the region. This programme has a new focus to develop a regional transition strategy, and an agreement programme of transformation to align/re-engineer the system to implement seamless transition pathways.	✓
Element 1 – Acceleration funding year 2 N/A	
Element 2 – Embedding funding year 1 N/A	
Element 2 – Embedding funding year 2 N/A	
Element 2 – Embedding funding year 3 N/A	
Element 3 – Legacy fund N/A	
Element 4 – National priorities (Dementia and Memory Assessment Services/Diagnostic support) N/A	

Strategic Outline Plan (Gwent refer as Programme, WG refer as Project)
SP17: Assistive Technology

Model of Care Alignment					
Community based care – prevention and community coordination	Community base care – complex care closer to home	Promoting good emotional health and wellbeing	Supporting families to stay together safely and therapeutic support for care experienced children	Home from hospital	Accommodation based solutions
✓	✓	✓	✓	✓	✓

Programme Summary
The Assistive Technology Programme seeks to maximise the use and impact of Technology Enabled Care solutions to improve health and wellbeing outcomes, maintain independence for as long as possible, and support transformation of models of care. The programme will facilitate development and sharing of learning across the partnership, supported by an evaluation framework to ensure future investments and expansion of Technology Enabled Care solutions are made in the right areas with impact and learning maximised. The programme provides the space and capacity to capture, promote and deliver evidence-based AT products consistently across Gwent and explore, with all sectors, how technology can transform and support the delivery of technology-enabled care which based around the person. Maximise the use and impact of Technology Enabled Care solutions to improve health and wellbeing outcomes, maintain independence for as long as possible, and support transformation of models of care. Develop and share learning in partnership, supported by an evaluation framework to ensure future investments and expansion of Technology Enabled Care solutions are made in the right areas with impact and learning maximised. Provide the space and capacity to capture, promote and deliver evidence-based AT products consistently across Gwent and explore, with all sectors, how technology can transform and support the delivery of technology-enabled care which based around the person.

Intended Outcomes	
Person Centred Outcomes	▪ People will have various AT products available depending on their needs ▪ People will be supported to remain independent and at home where possible ▪ AT considered as part of individual care plans ▪ Supporting people early to ease condition development and improve familiarisation with AT products

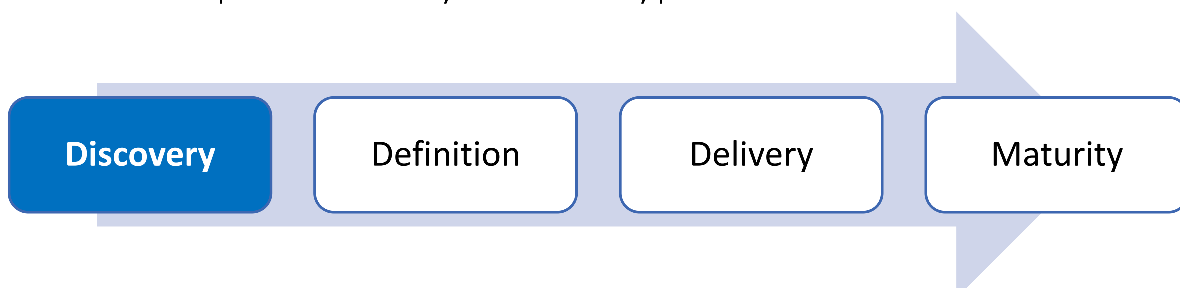
	▪ Improving access to assistive technology and/or equipment and making adaptations to the environment to maintain or improve a person's independence, safety and wellbeing
System Outcomes/Benefits	▪ Awareness of AT products for specific conditions and prevention ▪ Evaluation Framework ▪ Local, regional and national AT collaboration ▪ Central Resource including AT product database ▪ Shared knowledge and good practice ▪ Development of digital skills, inclusion and confidence ▪ Re-imaging the delivery of care using AT ▪ Awareness of new AT products and developments ▪ Improved digital skills and confidence of staff ▪ Shared vision of AT delivery across Gwent ▪ Pathway development and consideration of AT within care planning ▪ Awareness of ethical/duty of care considerations and the new LPS (Liberty Protection Protocols) ▪ Equity of funding considerations ▪ Good practice sharing and events ▪ Lessons learned ▪ Expanding AT awareness to existing and new networks ▪ Mapping of touchpoints where AT products are prescribed ▪ Consistent documentation to support safe deployment of AT products ▪ Support AT delivery for each county to deliver devices and upskilling staff ▪ Regional showcase events

Baseline Position

Technology continues to play an increasing role within the daily lives of most people. The pandemic further increased the speed of adoption as many people relied on technology to keep in touch, order supplies and access appointments. Technology also plays an expanding role within the provision of care, which has the potential to both improve the quality of life and the delivery of care. While AT is not new it is advancing and evolving quickly with significant opportunities to transform how support and care are provided.

It is crucial that knowledge and learning are shared, that new ideas are embraced and evaluated to ensure that the people of Gwent are aware, supported and able to use technology that has the potential to significantly transform lives and the provision of care.

Locally, organisations across Gwent continue to innovate and use AT products in ways that are making a positive difference. Over the last four years of AT development within the ICF programme the understanding and potential impact of AT products has grown and the mostly anecdotal impact, encouraging. In the lifecycle of the programme the baseline position is currently in the Discovery phase:



Discovery – Mapping Current Activity / Identifying Stakeholders / Capturing Existing Capacity Definition – Co-producing Programme Definition / Establishing Communication Structures / Defining and Agreeing on Strategy Delivery – Delivering Strategy / Monitoring Progress / Capturing and Sharing Learning / Providing Platform for Delivery Maturity – Platform Used to Continue Delivery and Development / Continued Sharing of Learning / Collaboration across Regions

Key Enablers	
Workforce Development & Integration	AT products are being used across all sectors in Gwent and through existing networks key stakeholders are learning from each other, however, there is not currently a mechanism for integrated planning and commissioning. When considering telehealth, for example, the provision is not currently consistent across all five of the local authority areas.
Integrated Planning & Commissioning	The programme is built on the provision of technology and digital solutions as an enabler to delivery and success.
Technology & Digital Solutions	The social value sector plays a crucial role within the AT space. Housing associations, charities and other organisations all use AT in various ways and are an integral part of the programme. When considering a whole system and person-centred approach they will continue to be an important cog in the wheel of AT delivery and success in Gwent.
Capital Infrastructure	Capital is required to facilitate the testing of AT products and provide the funding required to implement innovative and non-innovative AT solutions. Non-innovative solutions are those available from shops online and offline such as Google, Amazon, Apple and associated connected products that are considered smart.
Social Value Sector	Assistive Technology can only be deployed successfully if there are several components: • Workforce digital skills and confidence of the people using them • Awareness of AT products and their use • Quality internet connection where required • Time to integrate AT into the service provided The programme will support the awareness of AT, promote digital skills and confidence while providing guidance and support wherever possible.

Priority Population Groups		
	Primary Beneficiary	**Secondary Beneficiary**
Older people with complex needs	✓	
People with Dementia	✓	
Unpaid Carers, inc. Young Carers	✓	
Children with Complex Needs	✓	
People with emotional and mental health wellbeing needs	✓	
People with Learning Disability and Neurodevelopmental conditions	✓	

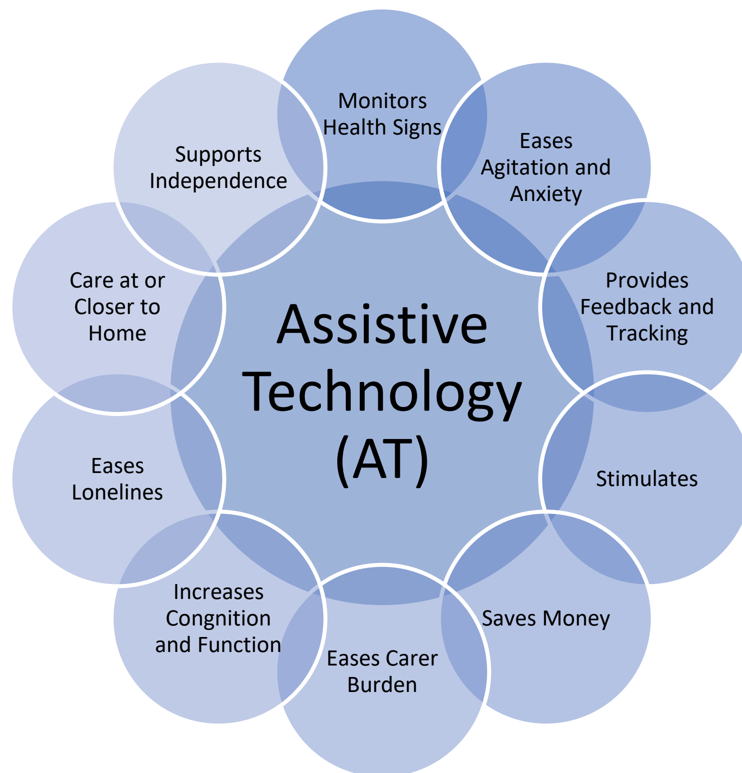
Where applicable, provide details on any additional population groups this programme will support:

Assistive Technology can be specifically designed for a condition, or it can be universal. This programme will look to support and tackle some other population groups in line with the biggest health challenges within Gwent including Dementia, mental health, diabetes and heart disease. The programme will also work with all other regional strategic programmes.

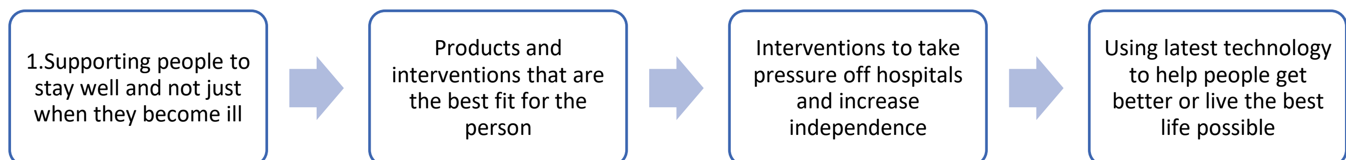
Development Approach

The transformation ambition is to create an AT centre of excellence within Gwent that collates AT information for partners both within the region and outside and inspires AT use. The centre will drive AT innovation, share good practices, and create a testbed to evaluate new products and developments.

At the heart of the programme is the ambition to use technology safely and appropriately to improve health outcomes, ease carer burden and maintain or improve independence. AT can help prevent and support many conditions and health aims, including but not limited to those shown in this diagram:



Assistive Technology supports A Healthier Wales future ambitions for health and social care through the Quadruple Aim:



"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.

Gov.wales. 2019. A Health Wales: our Plan for Health and Social Care. [online]
Available at: <https://gov.wales/sites/default/files/publications/2019-10/a-healthier-wales-action-plan.pdf>
[Accessed 16 March 2022]

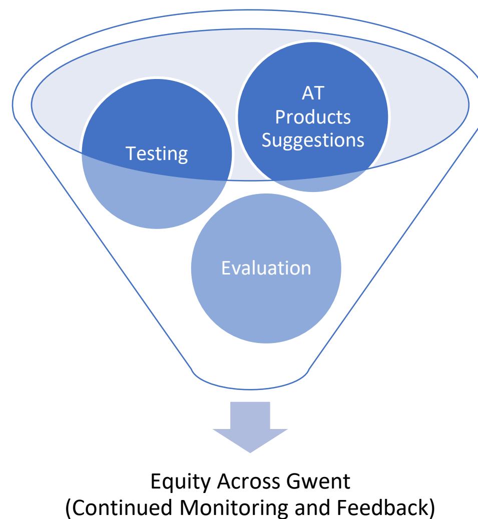
Learning from the use and rollout of AT products previously it is crucial that moving forward, testing, evaluation and development is built into the delivery of the AT programme. The programme will develop a relationship with a research partner, potentially TEC Cymru, to support evaluation.

Value-based health care is a transformation approach to designing and delivering care solutions that offer the greatest value to a person receiving them at the lowest possible cost to health and social care systems.

Life Science Hub Website Accessed 14/03/2022

The value-based healthcare approach will be used when developing and evaluating products to ensure prudent use of any funds available. The programme will

The AT development approach will include key components:



Equity Across Gwent
(Continued Monitoring and Feedback)

Data-driven

The development approach will be built on data collated from partners across all sectors and what is available in each of the five counties. Mapping of availability and use across Gwent will provide the necessary data to drive decision making and funding of AT products. Where possible, opportunities will be taken to procure jointly.

Measuring Outcomes

Measuring and evaluating outcomes is a key missing cog in the wheel. While there are many AT products available (currently a locally developed database of over 250) not many have been evaluated locally. This has led to a variation in the availability of AT products across Gwent. The programme will measure outcomes of chosen AT products and use this as a basis to roll out to ensure equity of access in all five counties.

Co-production

The Social Services Wellbeing (Wales) Act 2014 and Wellbeing of Future Generations Act 2015 require an emphasis on co-production and the promotion of personal wellbeing.

The sheer volume of AT products available makes it difficult for one organisation to know everything. TEC Cymru, Life Science Hub Wales, Health Education and Improvement Wales are all active within this space and keen to collaborate. Working together will benefit all stakeholders and build a strong AT and Technology Enables Care partnership.

Regional, local and national co-production will be embedded within the development and delivery of the programme. This will be achieved through a Gwent AT Steering Group which currently meets to share existing projects and communicate through appropriate channels including the RPB website and social media and through wider AT networks or groups.

This model of co-production will be used to facilitate conversation and delivery:

The AT programme will work with all programmes and co-produce a plan for each to discover how AT can support delivery.

Interdependencies

Interim Financial Model (Year 1 Only)

Total cost of programme	RIF Contribution	Partner match monetary	Partner match resource	% support for unpaid carers	% support for social value sector
£419,859	£273,895	£0	£145,964	0%	0%

Regional Investment Model

Select the funding element which the project will be set against. Repeat the table and rationale for each project

Element 1 – Acceleration funding year 1	
A pilot project enabled by the Integrated Care Fund to explore the implementation of single handed equipment, along with use of capital funding to test and implement assistive technologies, this new regional programme provides the structure and evaluation mechanisms necessary to foster	

Technology Enabled Care as solutions to maintaining and/or improving independence and and wellbeing. Working closely with the Life Sciences Hub, this programme will support shared learning wider than Gwent.	
Element 1 – Acceleration funding year 2	
Element 2 – Embedding funding year 1	
Element 2 – Embedding funding year 2	
Element 2 – Embedding funding year 3	
Element 3 – Legacy fund	
Element 4 – National priorities (Dementia and Memory Assessment Services/Diagnostic support)	

Model of Care Investment Proposal
EMOTIONAL HEALTH & WELLBEING

Strategic Vision

To empower individuals to manage their own emotional health and wellbeing, and understand where they can access support and materials, to prevent the escalation of poor emotional and mental health wellbeing.

To have successfully embedded the 8 pillars of the NEST framework across children's services, and to consider it's application or similar frameworks across wider service areas; recognising the importance of an individuals informal and formal system of support, to be identified and connected.

Case for Change

Mental health affects everyone as it includes emotional, psychological, and social well-being. It affects how we think, feel, and act. It helps determine how we handle stress, relate to others, and make life choices. Mental health is important at every stage of life, from childhood and adolescence through to adulthood. A quarter of people will experience mental health issues or illness at some point during their lifetime, often facing discrimination and stigma and affecting the people around them.

Research was completed in 2020/2021 by a range of partners from ABUHB, Swansea and Cardiff University, *'The influence of the COVID-19 pandemic on mental wellbeing and psychological distress: A comparison across time'*. This research highlighted the impact the pandemic has likely had on psychological wellbeing and the mental health of many people. It was found that there was an increase in clinically significant levels of psychological distress in Wales, particularly in younger adults, women, and those from areas of greater deprivation.

Key Enablers

Enabler	
Integrated Planning and Commissioning N/A	
Technology enabled care Ensuring digital platforms are maximised to support wider accessibility to self-help materials, resources, and awareness of the network of support available.	✓
Promoting the social value sector Ensuring third sector partners are an integral part of our system so we maximise community accessibility as part of the prevention agenda	✓
Integrated Community Hubs As described within the Connected Communities programme	✓
Workforce development and integration ▪ Ensure training with workforces in strategic/ operational levels around the NEST framework and their contribution to the whole system. ▪ Adopting the Connect 5 Foundation Tier training programme across all sectors, supporting recipients of training to identify their own wellbeing needs, and support peers. ▪ Collaborating to establish ways we can collectively promote good Emotional Health and Wellbeing.	✓

Priority Population Groups	Primary Beneficiary	Secondary Beneficiary	DAP
Older people including people with dementia N/A			
Children and young people with complex needs Children will understand the support available to them, and their support networks will embody the principles of the NEST framework ensuring a holistic approach to a young person's care needs, and support available to both the child and their trusted adult when needed.	✓		
People with learning disabilities and neurodevelopment conditions, including autism N/A			
Unpaid carers N/A			
People with emotional and mental health wellbeing needs All individuals, including the vulnerable cohorts identified within guidance, will be empowered to manage their own emotional and mental health wellbeing needs via a range of resources and materials.	✓		
Other beneficiaries N/A			

Total programme cost and match funding

Total cost of programme	Welsh Government contribution	Partner monetary match	Partner resource match	% support for unpaid carers	% for social value sector delivery
£1,908,927	£1,677,683	£0	£231,244	0%	45.13%

Programme management resources to be confirmed.

Strategic Outline Plan (Gwent refer as Programme, WG refer as Project)
SP05: Children's Emotional Health & Wellbeing

Model of Care Alignment					
Community based care – prevention and community coordination	Community base care – complex care closer to home	Promoting good emotional health and wellbeing	Supporting families to stay together safely and therapeutic support for care experienced children	Home from hospital	Accommodation based solutions
✓		✓			

Programme Summary
Building on the success of the Iceberg Programme, this refreshed programme focusses on reviewing local innovation and scaling up good practice to a regional level. It will improve alignment of current services to ensure sequencing of intervention that's driven by need and enhance our Single Point of Access system to embed our 'no wrong door' principle across the whole system. Addressing the above will ensure early and right support will help our children/young people fulfil their life potential and become resilient adults. A seamless and more 'joined up' mental health and emotional wellbeing system that has a focus on early intervention, therapeutic support and prevention. Reviewing local innovation and scaling up good practice to a regional level. - Improve alignment of current services to ensure sequencing of intervention that's driven by need. -Enhance our Single Point of Access system to embed our 'no wrong door' principle across the whole system. To move beyond our current 'known' setup of health, social care and third sector working in partnership towards a wellness system that isn't just about service delivery, but reflects what matters, with enough flexibility to meet the needs of people moving through it.

Intended Outcomes	
Person Centred Outcomes	Early and right support will help our children/young people fulfil their life potential and become resilient adults.
System Outcomes/Benefits	Establish a whole system response that prevents duplication and escalation.

Baseline Position
The original purpose of the 'Iceberg' programme was to redraft the landscape of multi-agency provision to support the mental health and emotional wellbeing of children, young people and their families across the greater Gwent region. In line with the principles set out in *A Healthier Wales*, the programme aimed to introduce a transformative, high-value, evidence-driven and seamless system of community-based care and support with

multi-agency collaboration at its heart. The model aspired to deliver a whole-systems approach from early intervention and prevention through to highly specialist provision.

The programme was based on the 'Iceberg model', a conceptual framework grounded in key principles:

- Culture change: the recognition that all services and front line staff have a significant part to play in prevention and intervention (at all levels, from early help to highly specialist intervention) with our most vulnerable children and families.
- Moving from a 'refer on' to a 'support in' culture: supporting the existing relationships in a child's life, as these can make the biggest difference, by making specialist clinical expertise more accessible to the adults best-placed to support children and effect change.
- Ensuring that support for children is grounded in psychological understanding, with emphasis on the importance of relationships and ACEs.
- Partnership working: planning service developments in partnership and moving at a 'casework' level from 'silo', single-agency responses to co-ordinated, multi-agency approaches.

Regarding key resources and activities, the Transformation Grant resource was used to implement a number of inter-connected workstreams, which complemented other core- and grant-funded initiatives:

- Platfform 4YP, a peer support service;
- the Family Intervention Team (FIT), providing brief, psychological formulation-based interventions;
- Gwent Community Psychology (GCP), supporting culture change and improving access to specialist 'support in' for frontline staff;
- the provision of 'drop-in' support clinics by School Nurses;
- Gwent Parent-Infant Mental Health Service (G-PIMHS), providing support and training to early years staff as well as direct therapeutic provision;
- the whole-schools approach team (WSA), supporting whole-school approached to improved mental health and wellbeing;
- regional leadership roles for My Support Team (MyST), a mental health service for children looked after in Gwent; and
- Capacity to support the Gwent Single Point of Access for Children's Emotional wellbeing (SPACE-Wellbeing) model.

The following provisions have now been developed sufficiently that they are now core funded by Health and/or Social Care, including;

- Gwent Community Psychology (GCP), supporting culture change and improving access to specialist 'support in' for frontline staff;
- the provision of 'drop-in' support clinics by School Nurses;
- Gwent Parent-Infant Mental Health Service (G-PIMHS), providing support and training to early years staff as well as direct therapeutic provision;
- the whole-schools approach team (WSA), supporting whole-school approached to improved mental health and wellbeing;

Core capacity to support the Gwent Single Point of Access for Children's Emotional wellbeing (SPACE-Wellbeing) model (although due to the spike in referrals because of the COVID 19 pandemic, referrals have increased significantly leading to a need for additional capacity.

PNA feedback on what we can do to improve wellbeing in Gwent in the future highlighted schools as a tool that can be utilised by local communities for groups to meet and more community classes to be held. Schools are very much seen as a positive way to engage with our local residents too. It was also suggested more youth activities will help improve mental wellbeing of teenagers.

The PNA identified children and young people in contact with the youth justice system may have more health and wellbeing needs than other children of their age. They have often missed out on early attention to these needs. The frequently face a range of other, often entrenched difficulties, including school exclusion, fragmented family relationships, bereavement, unstable living conditions, and poor or harmful parenting that might be linked to parental poverty, substance misuse and mental health problems.

For vulnerable children and young people, wellbeing is about strengthening the protective factors in their life and improving their resilience to the risk factors and setbacks that feature so largely and are likely to have a continuing adverse impact on their long term development.

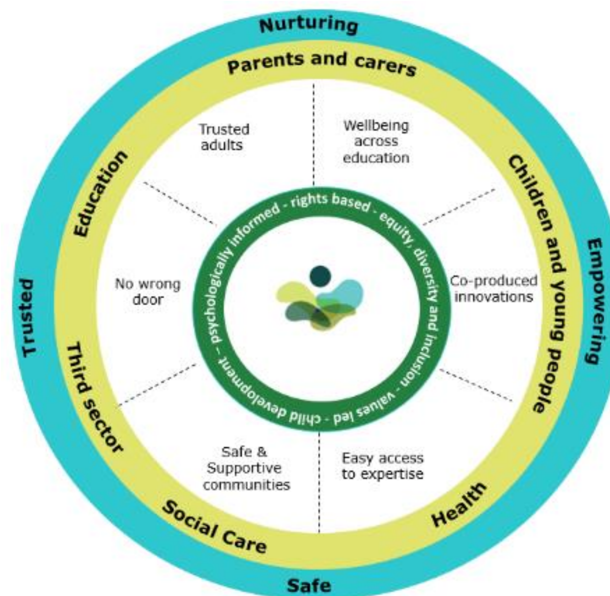
Key Enablers	
Workforce Development & Integration	Ensure training with workforces in strategic/ operational levels around the NEST framework and their contribution to the whole system. Collaborating to establish ways we can collectively promote good Emotional Health and Wellbeing.
Integrated Planning & Commissioning	Revision of current SLA's to ensure consistency and alignment of KPI's with our whole system strategic approach.
Technology & Digital Solutions	NEST tool to create a platform that enables professionals to demonstrate and share good practice.
Capital Infrastructure	Aligns with the work within 21st Century schools around making environments that flex to the needs of our children and young people. We need to ensure a consistent response to Emotional Health and Wellbeing across Education, Health and Social Care so the principles of our NEST/NYTH framework are reinforced across all environments.
Social Value Sector	Ensuring third sector partners are an integral part of our system so we maximise community accessibility as part of the prevention agenda. As outlined in the NEST/NYTH agenda, safe and supportive communities are an integral pillar to the framework, and our third sector agencies offer those community based services that extend our offer and meet a range of needs.

Priority Population Groups	Primary Beneficiary	Secondary Beneficiary
Older people with complex needs		
People with Dementia		
Unpaid Carers, inc. Young Carers		
Children with Complex Needs		✓
People with emotional and mental health wellbeing needs	✓	
People with Learning Disability and Neurodevelopmental conditions		✓

Development Approach

The Transformation programme enabled us to make significant changes into our Mental Health/Emotional Wellbeing landscape, and has created the foundations for us to build on with the National NEST/NYTH framework. Our 'Iceberg' programme is already aligned with some of the pillars in the framework, and we are committed to building on this and developing a new iteration of this workstream. We know that due to the pandemic, the demand on Mental Health services has risen, and will continue to rise, so our offer in this area needs to be sufficiently flexible to meet the ever changing landscape of need.

To drive this forward using the NEST/NYTH framework, we will be further developing our whole system approach to Mental Health and Emotional Wellbeing.



We have elements of innovative practice such as our 'no wrong door' approach through our Single Point of Access wellbeing panel (SPACE) and our Whole School Approach workstream, but we are now primed for the next stage of development that includes the following elements;

<u>SPACE Wellbeing 'No Wrong Door'</u>

- Using our Transformation Iceberg Evaluation and emerging evidence from our Population Needs Assessment to further develop the 'network' behind the SPACE wellbeing panel door to ensure there are enough options to meet the needs of our population.
- Ensuring an alignment and connectivity with services that are providing support across the wider system such as transition and services for children with complex needs to prevent people falling through gaps.
- Continuing to streamline processes across the region, and sharing good practice within our Regional SPACE steering board quarterly meetings.

<u>Safe and Supported Communities</u>

- Increase the amount of universal and community provision to promote and support individuals taking care of their own Emotional Health and Wellbeing as a preventative approach.
- Establish and embed integration opportunities with community provisions and wider public services.
- Through coproduction develop an understanding of what 'safe and supported' means to our young people and families and implement changes accordingly.

<u>Easy Access to Expertise</u>

- Analysing our local innovative to explore opportunities for services to be further adapted and up scaled regionally, ensuring we align with existing provisions and build in integration from the start.
- Scanning our current landscape to identify areas of improvement and addressing any gaps or sticking points in the system.
- Developing further links between Health, Social Care and Education to ensure equity of access to specialist support when needed.
- Continue to adapt and embed our system to meet the needs of our population, aligning with but not replacing acute Mental Health Services such as CAMHS.

<u>Wellbeing across education</u>

- Aligning services within the wider 'Whole School Approach' agenda to ensure connectivity and clarity around access to support in order to support Educational staff.
- Establish alignment with the 'Health and Well-being' elements of the new curriculum to promote and encourage good Emotional Health and Wellbeing.
- Build confidence and resilience in School staff by ensuring adequate access to support when needed.

<u>Co-produced innovations</u>

- Coproducing with young people new ideas of promoting good Emotional Health and Wellbeing and creating positive feedback loops.
- Work with families and young people to understand any barriers or challenges that might emerge in accessing our services.
- Coproduce solutions around Mental Health stigmatisation and develop innovative practice that really gets to the heart of 'what matters' to our children, young people and families.
- Ensuring learning is developed and shared at a micro, meso and macro level in line with NEST/NYTH principles.

<u>Trusted Adults</u>

- Embedding the principles of NEST/NYTH into our delivery models across the Mental Health Landscape through regular engagement events, building in opportunities to share good practice and finding a way to formally capture our principles in action. By doing this, we are able to build on the culture change we have started through the Transformation Iceberg Programme around how we view Emotional Health and Wellbeing needs.
- Empowering adults around the children and young people in our system by offering support, advice, guidance and training when they need it and in a way that suits their needs.

The COVID 19 pandemic has resulted in an inevitable increase in demand for Emotional Health and Wellbeing Services, now more than ever, we need to be working collaboratively to ensure we meet children and young people's needs in a timely manner to prevent any escalation that may result in more acute service needs.

As reflected above, how we promote Children and Young people taking care of their own Emotional Health and Wellbeing needs is an area that could be strengthened and developed as a form of earlier intervention to support resilience for their future.

Interdependencies

Aligns with the Transition, Children with complex needs, care experienced children, complex care and complex needs panels.
Children & Adolescents with Learning Disabilities Service
Adult Learning Disabilities
Child & Adolescents with Mental Health
Adult Mental Health Service.

Interim Financial Model (Year 1 Only)					
Total cost of programme	RIF Contribution	Partner match monetary	Partner match resource	% support for unpaid carers	% support for social value sector
£1,054,806	£823,562	£0	£231,244	0%	86.47%

Regional Investment Model *Select the funding element which the project will be set against. Repeat the table and rationale for each project*	
Element 1 – Acceleration funding year 1	✓
This refreshed programme will support the continued development of a regional system of support for children with complex needs, and the implementation of the NYTH/NEST framework. A regional model of care will be described, and identified on the national NEST digital tool.	
Element 1 – Acceleration funding year 2	
Element 2 – Embedding funding year 1	
Element 2 – Embedding funding year 2	
Element 2 – Embedding funding year 3	
Element 3 – Legacy fund	
Element 4 – National priorities (Dementia and Memory Assessment Services/Diagnostic support)	

Strategic Outline Plan (Gwent refer as Programme, WG refer as Project)
SP07: Children's Workforce Development & Professional Support

Model of Care Alignment					
Community based care – prevention and community coordination	Community base care – complex care closer to home	Promoting good emotional health and wellbeing	Supporting families to stay together safely and therapeutic support for care experienced children	Home from hospital	Accommodation based solutions
	✓	✓	✓		

Programme Summary

This programme will act as a catalyst for change to effectively improve the experience and wellbeing of children and in how professionals work with children and young people affected by attachment difficulties and developmental trauma. The mechanism for change will be in providing professionals across Health, Social Care and Education with training on Attachment and Developmental Trauma, providing follow-up sessions to ensure frontline teams are supported in contributing to wider cultural change in their approach with families.

In addition, workforce engagement and development will be undertaken to ensure the principles of the NEST framework are embedded within our ways of working, generating a consistent language and approach in the support and opportunities for children and their networks.

Gwent Attachment Service – Delivers attachment-informed training; a dedicated service to support highly vulnerable children who have experienced complex developmental trauma and disrupted attachment histories. In a move from traditional models of delivery, the service has been developed to offer an indirect model of intervention rather than work directly with the children and their families. It acts as a catalyst for change to effectively improve the experience and wellbeing of children and in how professionals work with children and young people affected by attachment difficulties and developmental trauma.

The service is fundamental to supporting vulnerable children with developmental trauma in line with Iceberg transformation model, creating cultural change to mitigate specialist referrals. The service has been integral in supporting social care and education with children with developmental trauma.
The model of training is attachment-informed, experiential, and skills-driven with emphasis on self-care and staff wellbeing. The model reflects this with efforts taken to ensure that initial training is co-produced with the teams to tailor the programme to their current level of skill and understanding.

The initial training covers five themes over the course of two days, with the aim of addressing the barriers to working effectively with children who have experienced trauma and improving confidence in evidence-based skills. Themes covered are:

Table 1: Schedule of Initial Training

Day 1	1. What is attachment? 2. Impact of developmental trauma and disrupted attachment 3. Implications of attachment difficulties and developmental trauma
Day 2	4. Promoting Change

	5. The importance of looking after yourself

Table 2: Schedule of Skills Development

Session	Prominent themes and exercises
1	Recap of the concepts and case formulation
2	Exploring the use of PACE in practice and case formulation
3	PACE responses to difficult statements
4	Shield of shame and case formulation
5	Case formulation and outcome measures

The training is followed up with a series of six, two-hour Skills Development Sessions (SDSs), scheduled approximately one month apart. Based on previous case consultation models, the sessions were developed with the aim of improving knowledge and confidence and reducing worries about working in an attachment and trauma informed way. The sessions are tailored to the team's capacity, wellbeing and existing skills, with different approaches and exercises used to illustrate the key points.

Intended Outcomes	
Person Centred Outcomes	A smaller cohort of staff able to support a child's needs where appropriate
System Outcomes/Benefits	Reduction in onward referrals Avoidance of additional waiting lists Professionals feel supported and have increased confidence in managing complex needs

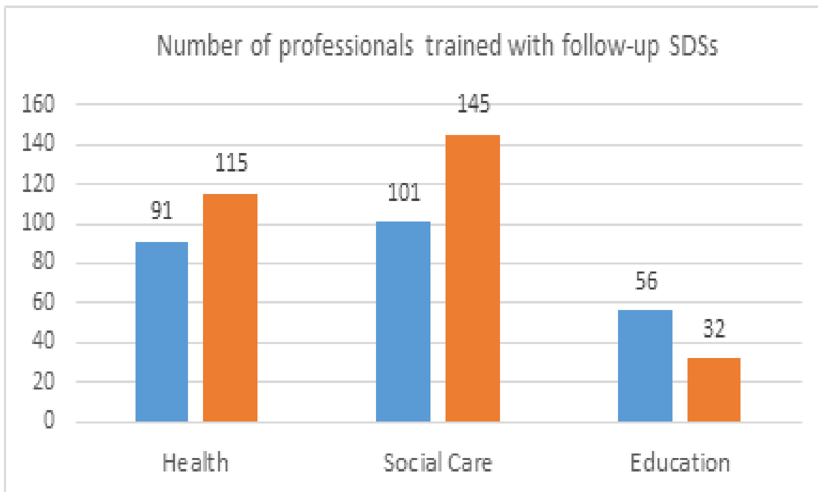
Baseline Position

GAS Performance Outcomes April 2021 – March 2022	**Total**
Teams accessing training materials	**96**
Training sessions provided (Hrs)	**537**
Direct therapeutic work (Hrs)	**179.5**

Training sessions provided covered subjects such as attachment & trauma informed leadership, co-producing train the trainer models for foster care groups and connected care groups, attachment informed supervision triad, and research, with a redesign of the education training process.

The following is a sample taken from 2018 - 2020: the Gwent Attachment Service have undertaken a total **of 47 training sessions**. Of these, **30** were for the initial two-day attachment-informed training and **13** were Skills Development Sessions. The remaining **4** were for bespoke training sessions provided to Guardians, to the Attachment Champion Forum and to Welsh Assembly members.

Graph 1. Professionals Trained across all sectors



Training was extended to **40 teams** across Health, Social Care and Education from across all five boroughs of Gwent. In total, this equates to **540 professionals trained** with follow-up Skills Development Sessions. *Graph 1* shows the number of professionals trained and which partnership area they work in.

Gaps in the information provided by the teams was limited however for the **200** professionals who provided details of their case numbers, it is estimated that over **2837 children would directly benefit** from being cared for in an attachment-informed way

A total of **282 participants** provided **feedback**, the responses were collated into themes, which are; Knowledge and Understanding, Relevance of Training, Training Structure and Delivery, Impact and Benefits to Working Practice, Professional Experience and SDS Structure and Delivery.

98% of all respondents felt that the session provided them with new ideas, or a more helpful way of thinking about the situations they face. **100%** of responses agreed that the experience gained through the training sessions would be useful in their work, with almost all participants **(99%)** stating that their working practices would change following the sessions, and that this would result in positive changes in the child and carer relationship.

All respondents agreed that they had a decreased feeling of anxiety and increased confidence in the skills that they had developed. Almost all attendees (92%) stated that they had quite a lot, or a great deal more understanding of the child and of their behaviour in a way that would make them more confident at approaching complex cases.

Key Enablers	
Workforce Development & Integration	Ensure training with workforces in strategic/ operational levels around the NEST framework and their contribution to the whole system. Collaborating to establish ways we can collectively promote good Emotional Health and Wellbeing.
Integrated Planning & Commissioning	Workforce development will extend to commissioned or third sector delivered services
Technology & Digital Solutions	NEST tool to create a platform that enables professionals to demonstrate and share good practice.
Capital Infrastructure	Principles of our NEST/NYTH framework are reinforced across all environments.
Social Value Sector	As outlined in the NEST/NYTH agenda, safe and supportive communities are an integral pillar to the framework, and our third sector agencies offer community-based services that extend our offer and meet a range of needs.

Priority Population Groups		
	Primary Beneficiary	**Secondary Beneficiary**
Older people with complex needs		
People with Dementia		
Unpaid Carers, inc. Young Carers		✓
Children with Complex Needs	✓	
People with emotional and mental health wellbeing needs		
People with Learning Disability and Neurodevelopmental conditions		

Development Approach

Working with all statutory partners, we will identify a system wide understanding of professional support needs and the support already available.

The programme will seek to address gaps in provision, and also provide a programme of engagement and organisational development to support both an understanding and implementation of the NYTH/NEST framework and it's 8 supporting pillars. Professionals will be provided with tools and techniques to assess current provision against the NYTH/NEST framework, informing areas where further workforce development may be needed.

Interdependencies

Aligns with all children's services, and regional children's transformation programmes

Interim Financial Model (Year 1 Only)					
Total cost of programme	RIF Contribution	Partner match monetary	Partner match resource	% support for unpaid carers	% support for social value sector
£200,871	£200,871	£0	£0	0%	0%

Regional Investment Model *Select the funding element which the project will be set against. Repeat the table and rationale for each project*	
Element 1 – Acceleration funding year 1	✓
The learning and success obtained through the Gwent Attachment, has provided an approach that will be built on in this children's services specific workforce development programme. The programme will explore and develop an enhanced model of professional support across health, social care and education, and the provision of dedicated interventions for very complex cases.	
Element 1 – Acceleration funding year 2	
Element 2 – Embedding funding year 1	
Element 2 – Embedding funding year 2	

Element 2 – Embedding funding year 3	
Element 3 – Legacy fund	
Element 4 – National priorities (Dementia and Memory Assessment Services/Diagnostic support)	

Strategic Outline Plan (Gwent refer as Programme, WG refer as Project)
SP15: Enhanced Foundation Tier

Model of Care Alignment					
Community based care – prevention and community coordination	Community base care – complex care closer to home	Promoting good emotional health and wellbeing	Supporting families to stay together safely and therapeutic support for care experienced children	Home from hospital	Accommodation based solutions
✓					

Programme Summary
Identified as a key regional priority, this relatively new programme will have a refreshed focus on the following areas: ▪ Further develop digital and non-digital self-help provision, to be promoted through the Melo brand, focusing on evidence-based, accessible and appropriate resources which target groups of the population at greatest risk of poor emotional and mental wellbeing. ▪ Rapidly expanding and continuing the quality improvement of the Gwent Connect 5 workforce training programme, to provide our local workforce with the knowledge and skills to improve their own emotional and mental wellbeing, as well as equipping them with the confidence and motivation to have mental health conversations with the communities they serve. ▪ Ensuring that a proportionate universalism approach is achieved when incorporating key components of the Foundation Tier programme into existing care pathways to maximise their impact on emotional and mental ▪ Wellbeing of the population. Deliver transformational change across the whole system to improve population mental wellbeing, and reduce levels of suicide and self-harm, focusing on groups of the population at greatest risk including those disproportionately impacted by C-19. Identify needs, map and develop assets to provide an enhanced foundation tier of early intervention and prevention, ensuring all local strategic programmes and services maximise their impact on mental wellbeing by incorporating components of the Foundation Tier programme. Developing accessible and appropriate self-directed resources for different groups of the population at greatest risk of poor mental health & wellbeing Coproduce a culture, set of principles and common approaches to mental wellbeing across all parts of the system .

Intended Outcomes	
Person Centred Outcomes	We will empower and motivate the population of Gwent, particularly those communities at greatest risk of poor emotional and mental

	wellbeing, to practice self-care which will improve and protect their mental health.
System Outcomes/Benefits	We will achieve whole system change by supporting and encouraging our partner organisations to adopt and embed initiatives, developed by the programme, which positively enhance the emotional and mental wellbeing of their workforce and the communities they serve

Baseline Position

Two thirds of people in Wales have said the pandemic has had a negative impact on their wellbeing. People have gone through adverse experiences such as losing their jobs, falling into debt, worrying about their health, and been isolated from friends and families.

Many people feel worse emotionally since the pandemic however it is worth noting that some people in Gwent also said they feel more relaxed in some ways; as life has slowed down for them and they don't have to go out of the house to access some services.

Key Enablers	
Workforce Development & Integration	Continued workforce development using the Connect 5 model
Integrated Planning & Commissioning	N/A
Technology & Digital Solutions	Making use of digital platforms to provide accessible resources to empower individuals to management their emotional and mental health wellbeing needs
Capital Infrastructure	Linked to the connected communities programme, hubs and wellbeing centres will be key capital infrastructure to support individuals
Social Value Sector	Continue to develop the relationship with the third sector providing early intervention and prevention services, via the provider network and third sector forum as described in the connected communities programme.

Priority Population Groups	Primary Beneficiary	Secondary Beneficiary
Older people with complex needs		✓
People with Dementia		
Unpaid Carers, inc. Young Carers		
Children with Complex Needs		✓
People with emotional and mental health wellbeing needs	✓	
People with Learning Disability and Neurodevelopmental conditions		

Development Approach

1. Advocate for 'Whole Systems Change' to ensure an integrated approach to promoting emotional and mental wellbeing by collaborating with the local community and partners to maximise the impact of programme.

2. Achieve long-term sustainable improvements in emotional and mental wellbeing by involving community members and partners in understanding and identifying local needs to inform the development of a 5 year strategy.

3. Improve the accessibility, availability and appropriateness of self-help resources and messaging to provide greater opportunity and motivation for individuals to improve their own emotional and mental wellbeing.

4. Provide our frontline workforce with the knowledge, skills, confidence and motivation to improve their own emotional and mental wellbeing as well as supporting the communities they serve.

5. Prioritise reducing inequalities when planning and delivering prevention initiatives using behavioural science to inform actions.

We will do this by:

- Developing local strategies which guide the co-production of action plans with local partners to prioritise improving emotional and mental wellbeing.

- Undertaking ongoing assessment of local needs, including mapping of existing assets, to identify priorities/opportunities to increase the access to, and appropriateness of, initiatives which improve the emotional and mental wellbeing of our population.

- Further develop digital and non-digital self-help provision, to be promoted through the Melo brand, focusing on evidence-based, accessible and appropriate resources which target groups of the population at greatest risk of poor emotional and mental wellbeing.

- Rapidly expanding and continuing the quality improvement of the Gwent Connect 5 workforce training programme, to provide our local workforce with the knowledge and skills to improve their own emotional and mental wellbeing, as well as equipping them with the confidence and motivation to have mental health conversations with the communities they serve.

- Ensuring that a proportionate universalism approach is achieved when incorporating key components of the Foundation Tier programme into existing care pathways to maximise their impact on emotional and mental wellbeing of the population.

Interim Financial Model (Year 1 Only)					
Total cost of programme	RIF Contribution	Partner match monetary	Partner match resource	% support for unpaid carers	% support for social value sector
£195,250	£195,250	£0	£0	0%	0%

Regional Investment Model *Select the funding element which the project will be set against. Repeat the table and rationale for each project*	
Element 1 – Acceleration funding year 1	
This programme is in it's early days of development with progress made in Year 1 (2021-22). Whilst the testing and development is still underway, it is reflected as accelerating until a regional model of support is defined.	

Element 1 – Acceleration funding year 2	
Element 2 – Embedding funding year 1	
Element 2 – Embedding funding year 2	
Element 2 – Embedding funding year 3	
Element 3 – Legacy fund	
Element 4 – National priorities (Dementia and Memory Assessment Services/Diagnostic support)	

Model of Care Investment Proposal
FAMILIES STAYING TOGETHER & THERAPEUTIC SUPPORT FOR CARE EXPERIENCED CHILDREN

Strategic Vision *Provide a short, precise summary of the strategic vision for successfully achieving the regional aspirations for [Model of Care]. This should contribute to the wider delivery of 'A Healthier Wales'*
To have a sustainable offer of early intervention and prevention services in collaboration with health, social care and third sector services, that can have a longer term impact on the number of children becoming known to statutory services. In addition, for those children where entering care system is the best option, they will be supported as they transition from the care system as young adults, able to lead independent and fulfilling lives.

Case for Change
As the cohorts of children are distinctly different, the baseline position for both programme reflects the case for change supporting this model of care.

Key Enablers *Select which of the key enablers will maximise the delivery of the programme, using the free text box to describe how this will be achieved*	
Integrated Planning and Commissioning Implement an integrated approach across services and organisations to ensure individuals, their families and carers are given the right equitable support.	✓
Technology enabled care Use of the WCCIS programme to provide safe, effective, local, integrated care across social services and community health through a single system and a shared electronic record across Local Authorities and Health Boards in Wales.	✓
Promoting the social value sector Working with our third sector partners to increase community provision/access for families and support our coproduction journey. Ensuring our current third sector partners in the EIS stream are closely aligning with the strategic context and direction driven by Social Care and Health Services.	✓
Integrated Community Hubs The capital strategic needs assessment will consider the hub developments specific to children with complex needs, that may differ from the wider developments within the Connected Communities programme.	✓
Workforce development and integration Establish a connectivity between the workforces in Social Care, Health and Education to ensure a coordinated response for children & families.	✓

Priority Population Groups	Primary Beneficiary	Secondary Beneficiary	DAP
Older people including people with dementia N/A			
Children and young people with complex needs Children and their networks will received appropriate support as prevention, early intervention or a transition to independence, to help them realise their potential and lead fulfilling lives.	✓		
People with learning disabilities and neurodevelopment conditions, including autism N/A			
Unpaid carers N/A			
People with emotional and mental health wellbeing needs N/A			
Other beneficiaries N/A			

Total programme cost and match funding

Total cost of programme	Welsh Government contribution	Partner monetary match	Partner resource match	% support for unpaid carers	% for social value sector delivery
£5,389,684	£3,299,271	£0	£2,090,413	0%	6.06%

Programme management resource to be confirmed.

Strategic Outline Plan (Gwent refer as Programme, WG refer as Project)
SP02: Early Intervention & Support

Model of Care Alignment					
Community based care – prevention and community coordination	Community base care – complex care closer to home	Promoting good emotional health and wellbeing	Supporting families to stay together safely and therapeutic support for care experienced children	Home from hospital	Accommodation based solutions
		✓	✓		✓

Programme Summary
This programme was developed to reduce and prevent the number of children coming into the care system by creating a whole system cooperative response for families (this includes Health, Social Care, Education and Housing) that is able to be locally flexible to meet needs but has regional consistency to ensure the same level of access and support. The programme has a focus on ensuring Children and Young People on the edge of care are supported to enjoy the same life chances as others. Families are supported to stay together safely and to improve wellbeing outcomes for children and young people. Establish an integrated system that works with families to support them staying together safely, and therefore preventing the need for children to become looked after To provide integrated health, social care, and education support for children and their families at the edge of care that meets their needs and feels 'joined up'. Identify areas of local innovation to upscale good practice regionally that helps families stay safely together. Reduce and prevent the number of children coming into the care system by creating a whole system cooperative response for families (this includes Health, Social Care, Education and Housing) that is able to be locally flexible to meet needs, but has regional consistency to ensure the same level of access and support.

Intended Outcomes	
Person Centred Outcomes	▪ Ensure Children and Young People on the edge of care are supported to enjoy the same life chances as others. ▪ Support families to stay together safely and therefore improve wellbeing outcomes for children and young people.
System Outcomes/Benefits	▪ Prevent the rise in number of children needing to come into the care system. ▪ Reduce duplication in the system by coordinating multi-agency support.

Baseline Position

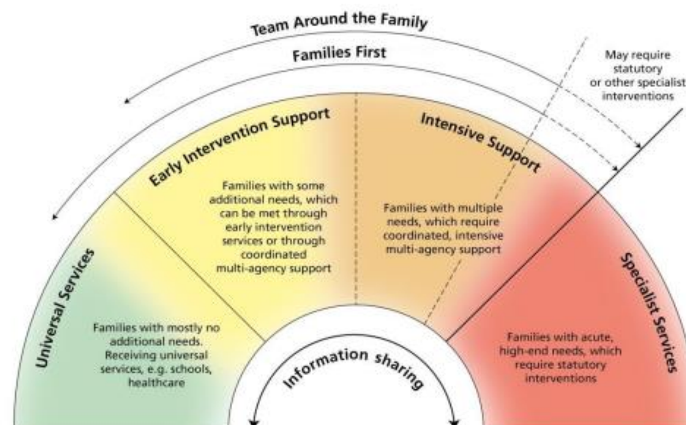
The Early Intervention Service (EIS) funding stream was introduced in the 2019-20 to support children and their families at the edge of care. The projects within this programme aimed to: reduce the number of children entering the care system, reduce the number of those becoming "Looked After", and help families stay together where possible.

A regional programme emerged that comprised of a series of projects with a shared objective of "*Supporting Children & Families known to Social Services to mitigate, where possible, children entering care and to support family reunification"*

The programme is delivered to all five Local Authorities of the Gwent area, and includes the following delivery elements;

- Enhanced Edge of Care
- Family Group Conferences
- Mediation
- Special Guardianship Order

Diagram 1 – Families First and the continuum of support



It was identified across the regional programme that if adequate prevention services were not available, there would be an increase in Children and Young People who would become 'Looked After'. Children and Young people coming into care results in an increase of involvement with children's statutory services and often a need for a complex care package, therefore putting pressure on our Health and Social Care Services and more importantly, impacting the resilience factors and outcomes for our Children and Young people. We know through the research of the ACE agenda, that Adverse Childhood Experiences have a significant impact on people as they grow, following them into adulthood.

As illustrated in the Families First continuum above, there are differing levels of support available depending on the needs of the family. Providing sufficient support in the earlier stages prevents escalation and therefore prevents families moving across this continuum and needing more statutory intervention. Although the theory of this appears straightforward, the complexity of the system and the differing needs of families means this isn't simple. Families at the edge of care have often had a myriad of different prevention services that haven't been sufficient to make the sustained second order change that is needed to keep the family together safely. This is exactly why a specialist

Early Intervention stream is needed to work with families in a focused way. Further, a whole system approach to this continuum is vital to ensure gaps don't emerge between services and therefore needs of the Child, Young Person and/or family are not met.

Below demonstrates the data across the EIS workstream so far, and highlights we are heading in the right direction in terms of prevention, however, we need to ensure our system is well coordinated and equipped to meet the needs of our families.

Key Enablers	
Workforce Development & Integration	▪ Establish a connectivity between the workforces in Social Care, Health and Education to ensure a coordinated response for children & families. ▪ Upskilling staff to enable better retention. ▪ Ensure training with workforces in strategic/ operational levels around the NEST framework and their contribution to the whole system. ▪ Revision and agreement of current resource with exploration into alignment across services, from health to social care
Integrated Planning & Commissioning	▪ Implement an integrated approach across services and organisations to ensure individuals, their families and carers are given the right equitable support. ▪ Working with organisations to commission and further embed the children at the edge of care programme. ▪ Revision of current SLA's to ensure consistency across delivery partners.
Technology & Digital Solutions	▪ NEST tool to create a platform that enables professionals to demonstrate and share good practice nationally. ▪ Use of the WCCIS programme to provide safe, effective, local, integrated care across social services and community health through a single system and a shared electronic record across Local Authorities and Health Boards in Wales.
Capital Infrastructure	▪ Independency with access to community hubs to give families a single point of access for community-based support. ▪ Identify any areas that could benefit from Capital funding and identify opportunities to align capital and revenue resources
Social Value Sector	▪ Working with our third sector partners to increase community provision/access for families and support our coproduction journey. ▪ Ensuring our current third sector partners in the EIS stream are closely aligning with the strategic context and direction driven by Social Care and Health Services.

Priority Population Groups		
	Primary Beneficiary	**Secondary Beneficiary**

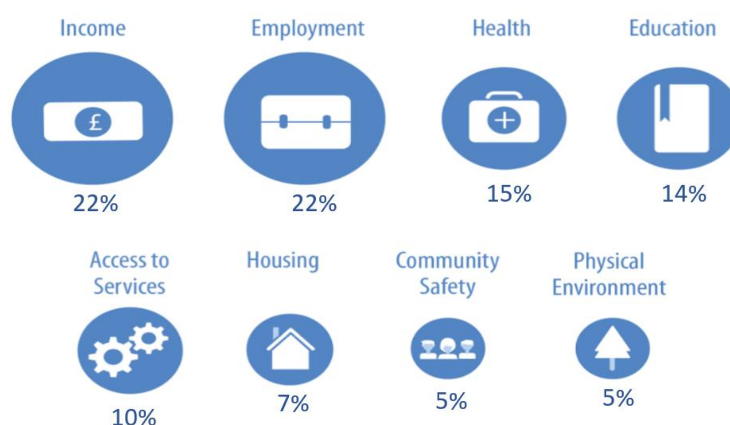
Older people with complex needs		
People with Dementia		
Unpaid Carers, inc. Young Carers		
Children with Complex Needs	✓	
People with emotional and mental health wellbeing needs		✓
People with Learning Disability and Neurodevelopmental conditions		✓

Development Approach

The Social Services and Well-being Act (2014) highlights the importance of providing the right support to people, at the right time, to enable access to an intervention that is the least invasive. Our Early Intervention Service programme has developed local innovative practice that has not only worked in a positive way to support families, but has safely kept families together as underpinned by the principles of a 'Healthier Wales'. As highlighted above, we are now at the next stage of our development that involves further embedding the EIS agenda that will prevent escalation and reduce the number of children coming into care. It's paramount that we take into account the emerging evidence from our previous outcomes and the recent population needs assessment, whilst holding in mind the impact (and ongoing impact) of the COVID 19 pandemic when entering into the new phase of development.

Firstly, we want to establish and understand consistency in our delivery across the region and identify further opportunities to capture how we are able to prevent escalation. We have some evolving good practice locally, and time to share and explore how this works in more detail will not only support us to understand how this translates to a regional footprint, but also supports us to identify where areas of the system might need to be strengthened to achieve our goal of a fully integrated system. Improving the system will ensure that the work aligns with other models of care for example when children have complex health, emotional or care needs, resulting in us being able to provide a seamless and well sequenced approach to families and their needs.

As highlighted above, we know the impact that Adverse Childhood Experiences have on people as they grow, following them into adulthood; this is particularly poignant when we consider the families at the edge of care and the intergenerational trauma factors that will be at play. In Wales there are large differences in healthy life expectancy, across society. We know that poorer communities suffer from higher mental health issues and trauma, where ACEs tend to be more prevalent. The Welsh index of multiple deprivation (2019) cover 8 domains of deprivation as shown in the diagram below.



A whole system approach will look at tackling the wider influences and the social gradient to create a more equitable community provision so that everyone has the same life chances and health outcomes. Reducing this deprivation across society will support the reduction in ACEs experienced by children at the edge of care. Again, aligning with the principles within the 'A Healthier Wales', we understand the importance of children at the edge of care being supported to stay within their family circle where possible to improve their resilience factors, however, we also need to ensure the family environment is sufficiently supported and have to access to appropriate and timely intervention.

We will use the NEST/NYTH framework as our guide to develop this robust whole system approach that responds to the mental health, wellbeing and support service needs for babies, children, young people, parents, carers and their wider family members. The person centred approach will help us to develop a system around all members of the family that are at the edge of care and improve the likelihood of families staying safely together.

By reviewing and further developing the successful practice found throughout the Edge of Care services and aligning these services with the NEST framework; that is designed to fit around the individual and family and not the other way round; we will create and expand a system that is fair equitable, fully integrated, and focuses on what matters, through a joined up, whole system approach. This will benefit strengthening our workforce to be able to support families to stay together and safely reduce the need for children to be looked after by managing risk confidently and effectively.

Interdependencies

Aligns with the Transition, Children with complex needs, Emotional Health and Wellbeing, Complex Care and Complex Needs Panels, and associated core services.

Interim Financial Model (Year 1 Only)

Total cost of programme	RIF Contribution	Partner match monetary	Partner match resource	% support for unpaid carers	% support for social value sector
£4,893,794	£2,803,381	£0	£2,090,413	0%	0%

Regional Investment Model

Select the funding element which the project will be set against. Repeat the table and rationale for each project

Element	
Element 1 – Acceleration funding year 1	
Element 1 – Acceleration funding year 2	
Element 2 – Embedding funding year 1 This programme continues the focus on Early Intervention and Support enabled through the Integrated Care Fund, providing a regional focus on reducing the number of children entering the looked after children system. Embedding the additional capacity and enhanced ways of working is critical to the prevention and early intervention required for longer term system wide impact.	✓
Element 2 – Embedding funding year 2	
Element 2 – Embedding funding year 3	

Element 3 – Legacy fund	
Element 4 – National priorities (Dementia and Memory Assessment Services/Diagnostic support)	

Strategic Outline Plan (Gwent refer as Programme, WG refer as Project)
SP03: Supporting Care Experienced Children

Model of Care Alignment					
Community based care – prevention and community coordination	Community base care – complex care closer to home	Promoting good emotional health and wellbeing	Supporting families to stay together safely and therapeutic support for care experienced children	Home from hospital	Accommodation based solutions
		✓	✓		✓

Programme Summary
Recognising the risk taking behaviours displayed by young people who have experienced trauma, this programme has a specific focus on therapeutic support for care leavers with complex needs, supporting them to fulfil their potential. The model is implemented using trauma informed approaches to provide therapeutic interventions to minimise risk taking behaviours and ensure care experienced Children and Young People are supported to enjoy the same life chances as others. Create a seamless therapeutic support and emotional wellbeing system that is able to coordinate around the needs of Children & Young people to support them to fulfil their potential.

Intended Outcomes	
Person Centred Outcomes	▪ Ensuring care experienced Children and Young People are supported to enjoy the same life chances as others. ▪ People feel supported and fully informed when accessing services and services are driven by what matters to them. ▪ Access to equitable services with adequate specialist support. ▪ Health and social care needs are fully met, with no-one 'falling through the gaps'.
System Outcomes/Benefits	▪ Preventing further escalation, reducing duplication and the need for complex health services. ▪ Improved joint-working pathways through systems. ▪ improve planning and funding systems. ▪ Improved community-based support structures . ▪ The system demonstrates quality and synergy of the children with complex needs services.

Baseline Position

A Survey completed by Barnardo's with care leavers found that 46% were identified as having mental health needs, with 65% of them not receiving any form of statutory support (The Care Leavers' Association, 2017; Social Market Foundation, 2018) and are between four and five times more likely than their peers to attempt suicide (NYAS, 2019).

We know that the perpetuation of trauma and the failure to support healing where children are already experiencing poverty and inequality is reflected in poor outcomes for many who have experience of the care system (Care Review, 2020a).

Proactive and preventative mental health support is as important when leaving care as much as during, more so when CAMHS or adult mental health services are not always available. Professionals noted (NSPCC, 2015) the limitations in the support they can offer and the time they have to build relationships with care leavers, which can't adequately deal with issues such as abandonment, trauma from the care system, transitioning into independence at a premature age, and manifestations of childhood trauma in adulthood.

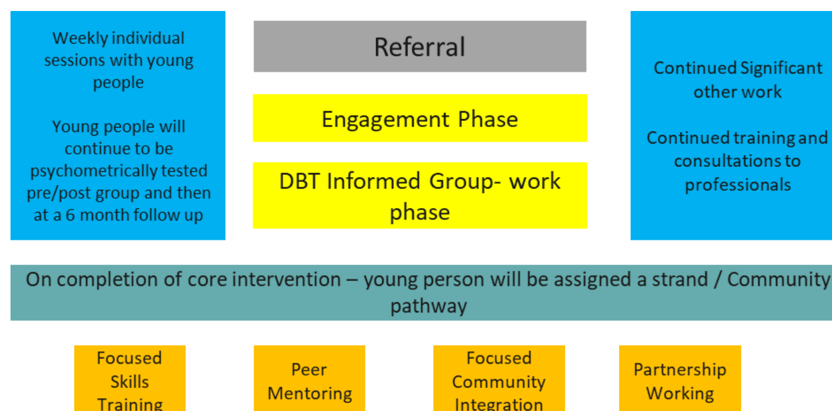
Now more than ever, supporting people's emotional health and well-being is essential to keeping society healthy and preventing the escalation of health and social care needs. With the impacts of COVID-19, this is further realised with an increasing number of people of all ages, including children and young people, being identified as having emotional health and wellbeing support needs.

The programme for children who are care experienced is comprised of services that improve the emotional wellbeing of young people leaving care across the Gwent region. The model was designed to meet the shared priorities of health, social care and educational partners involved in the care of looked after children through coproduction. The service further supports the workforce within these sectors, providing training to develop and upskill the workforce so that they can support care leavers in a consistent manner. The success of the service relies on the integration of these organisations successful outcomes to support the delivery of a consistent and equitably high-quality service to care leavers across Gwent.

Joining up and integrating services is a challenge, for example, when people leave school or college, support may vanish. When services are not available, and a person's needs are not being met, this can result in escalation of the original presenting issues forcing them to access primary/emergency services. The programme of services for care experienced children and young people will be built in to help prevent and relieve pressures on primary services and make sure that the services offered are consistent and equitable for all across the Gwent Region.

The service is offered to young people who were in the care system on their 16th birthday, especially targeting those who have experienced significant emotional distress and have developed self-destructive behaviours. The process is laid out in *figure 1* below.

Figure 1. Process of the *Skills for Living Project*



Care experienced children and young people often describe care as something that is done to them, not with them, feeling they have no control over their lives. Being subject to decisions out of their control or perceived abuses of trust can make them wary of engaging with health and care professionals, which in turn can leave issues untreated until a crisis develops.

Referrals to the team are accepted from all Local Authorities and via SPACE wellbeing, as well as young people and their carers. Individuals who are accepted, receive weekly one to one Dialectical Behaviour Therapy (DBT) focused therapy sessions, each lasting up to 1.5 hours. Followed by a 14-week DBT group where they learn the skills with their peers. The groups are a powerful mechanism for the young people to gain support from their peers and realise that they are not alone in feeling intense emotions.

Usually, support is offered for approximately 9-12 months and on completion of the intervention, young people are assigned to a pathway to allow for continued support; this can include peer mentoring or working with partners to provide access to further skills training or employment opportunities.

Between 2018-2019 a total of 115 young people have been referred to the care experienced service for children and young people from all five local authorities. Of these, 98 (85.2%) were accepted by the service and, following the engagement phase had proceeded to attend the group therapy sessions. Where the referral could not be accepted, individuals were signposted to other services that would better meet their needs.
The service has offered a total of 1046 clinical sessions to young people; attendance rates are noted to be continually high with an average contact rate of 78% throughout the lifespan.

The service has engaged with and provided support to carers and families through 33 care leavers support networks. A total of 56 clinical consultations have taken place with additional training provided to a total of 124 health and social care professionals. These continue to be well received by those attending, with personal advisors noting that they felt better in moving forward with the complex cases discussed.

Outcomes following intervention are assessed using the CORE-OM tool; the tool consists of 34 statements where the individual needs to select one of the following: ‘Not at all’, ‘Only Occasionally’, ‘Sometimes’, ‘Often’ or ‘Most of the time’ to score how they have been over the last week. A mean average is taken from responses within each domain, with the overall score being of a possible 4 (the higher score denoting a higher level of distress). On average, pre-intervention, young people referred to the project report an overall wellbeing score of 1.85, meaning that they have a high level of distress.

As outlined in the *table 1* below, the average pre-intervention scores indicate that most young people referred to the service show this level of distress across all domains. Following intervention, a significant improvement was seen in the wellbeing, problems, and functioning domains, with the average scores being more representative of the distress seen within the general population and of their peer group.
The exception to this is within the risk domain. On review it is noted that questions within this domain skewed the data slightly, with respondents being asked to rate the frequency in which they thought of self-harm rather than actually harming themselves. The nature of the therapy is such that whilst thoughts of harming are still present, the frequency of doing is reduced and therefore the improvement may not be evident with the score.

Table 1. Average pre-intervention scores

	Wellbeing	Problems	Functioning	Risk	Total	Total (excl. Risk)
Clinical Significant level* (male / female)	1.37 / 1.77	1.44 / 1.62	1.29 / 1.3	0.43 / 0.31	1.19 / 1.29	1.36 / 1.5
Pre-intervention	2.08	2.1	1.64	0.56	1.7	1.85
Post- intervention	1.27	0.7	0.74	0.27	0.9	1.6

(*Responses scoring below the level outlined signifies a clinically significant level of distress relating to that domain

In practice they should be experts in their own experiences, with a right to contribute to their own mental health care and service developments. NSPCC Wales (2019) state that care experienced children and young people must be involved in the planning and development of services that meets their needs and supports their engagement. So that we are enabling children to express their wishes. Giving them regular opportunities to feed back on the quality of care and support and to help co-design services.

Over 90% of young people reported an improvement in mood, functioning and problem solving, with the 85% of young people reporting a reduction in the risk to themselves or others. This provides assurance that the interventions over a 9–12-month period have been successful in teaching young people to manage their distress in a healthier way, resulting in a positive impact to their emotional wellbeing and ability to cope.

This is a small service area with a wide reach. There is no alternative for children looked after and care leaving young people. The service is a mental health service in which statutory services look to, to provide a specialist mental health assistance to their young people. The service also provides support to the professionals working with young people.

Key Enablers	
Workforce Development & Integration	▪ Upskilling staff to enable better retention. ▪ Ensure training with workforces in strategic/ operational levels around the NEST framework and their contribution to the whole system. ▪ Revision and agreement of current resource with exploration into alignment across services, from health to social care. ▪ Established connectivity between Health, social care & education workforces to ensure a coordinated response for families.
Integrated Planning & Commissioning	▪ Implement an integrated approach across services and organisations to ensure individuals, their families and carers are given the right equitable support. ▪ Working with organisations to commission and implement the suite of services agreed to take forward. ▪ Revision of current SLA's - By linking in with divisions/organisations a review of all current SLA's will be undertaken including core funded, partnership funded, WG funded SLA'.
Technology & Digital Solutions	▪ NEST framework digital tool to create a platform that enables professionals to demonstrate good practice. ▪ Expand opportunities of assistive technology that may benefit care experienced children & young people to help promote independence and make sure there are equitable options for individuals. For example, a focus on the assistive technology arena that can help alleviate the problem of an individual having to repeatedly tell their story constantly. Use of integrated data system such as WCCIS.
Capital Infrastructure	▪ Residential homes- Windmill Farm, Bridgeview. ▪ Identify any areas that could benefit from Capital funding and identify opportunities to align capital and revenue resources.

Social Value Sector	▪ Working with third sector & local authority to create an integrated system of provision/access, that builds resilience for care experienced children & young people and enhance community provision. Making sure their voices are heard and needs are met.

Priority Population Groups		
	Primary Beneficiary	**Secondary Beneficiary**
Older people with complex needs		
People with Dementia		
Unpaid Carers, inc. Young Carers		✓
Children with Complex Needs		✓
People with emotional and mental health wellbeing needs	✓	
People with Learning Disability and Neurodevelopmental conditions		✓

Development Approach

The landscape of support services for care experienced young people can be a challenge to pull together and standardise due to the fact young people might experience multiple moves from foster homes to care- settings, with some of these moves and placements taking them away from the area they know, their school, friends, and extended family. All of this can have a negative impact on the development of attachment and the experience of trauma and loss, can cause or worsen feelings of anxiety, fear, and instability, and make continuity of mental health services difficult.

As outlined within the NEST/NYTH framework, we will be strengthening our 'Whole System Approach' for care experienced young people by aligning our Health, Social Care, Education and Third Sector systems to create a wellness cooperative that works together and has sufficiently flexibility to meet the needs of our care experienced population.

Through engagement with professionals and individuals, there will be a planned out and sequenced course of action, to embed the services for care experienced children & young people as highlighted for continuation into the future 5-year plan. In line with this piece of work there will be opportunity to develop the expansion of the services highlighted as exceptional, delivering positive outcomes across the Gwent region. This will work towards a prosperous environment where resources will be used efficiently and proportionately as stated in one of the seven well-being goals from the Well-Being of Future Generations Act (2015); developing a skilled and well-educated population, to create consistency and creating a healthier society where wellbeing is maximised, to reduce the negative impacts experienced by care experienced children & young people to get it right.

The good practice within the service will be further reviewed for growth/expansion and embedding across the Gwent region. These services currently fall into the bottom red section of the pyramid in the A Healthier Wales 2018 (Diagram Below). These services have demonstrated and evidenced the successful outcomes and positive impact they have been able to make in the lives care experienced children & young people. The expansion is to move these services into a new regional model which will require a whole system approach for successful integration.

Under the policy drivers within the A Healthier Wales (2018); care experienced children & young people will be supported to stay well. The programme will offer a suite of services, working seamlessly together, that will help tackle inequalities that care experienced children & young people come up against when accessing services, help or support.

To drive this forward, using the NEST approach: a whole system approach across health and social care will need to take place, to develop mental health, well-being and support services for babies, children, young people, parents, carers and their wider families across Wales: working in collaboration, using a person-centred approach and bringing support into the community, working towards creating a single system with 'no wrong door' approach so that families get the right help at the right time and in a way that is right for them.

It's not for our children, young people and families to navigate the complex system, this needs to be as accessible as possible to meet needs and prevent escalation. We know that points of transition and change can be anxiety provoking, so ensuring we support these points are crucial especially when children's services are starting to align in this way. The continuity of experience and sequencing of interventions we provide need to be joined up so the system doesn't make things worse for people in the long term.

By using feedback from key stakeholders and expanding the opportunity to utilise new assistive technology through coproduction; will enable us to embed value based healthcare to measure what matters most to people, ensuring that improvement activity is focussed on outcomes.

Some approaches aim to encourage positive mental health and wellbeing and improve the social and emotional skills of the young person. Others offer treatment for those diagnosed with a mental health disorder such as depression or anxiety. Others might offer support and training to foster carers and residential carers. Some programmes look to change how medical professionals or social workers work with children and young people, such as development of a trauma-informed approach among social work teams.

Through sustainable growth and developing community-based models of care that will provide early intervention and prevent the escalation of poor emotional and mental health and wellbeing for children with complex needs, as set out in the Well-Being of Future Generations Act (2015), we can bring about a more equal, cohesive, healthier, resilient, and prosperous society where children with complex needs, families and carers have the same rights and opportunities available to them locally.

Interdependencies

Aligns with the Transition programme, Emotional Health/Wellbeing, Edge of Care, Children with complex needs, Young Carers.

Interim Financial Model (Year 1 Only)

Total cost of programme	RIF Contribution	Partner match monetary	Partner match resource	% support for unpaid carers	% support for social value sector
£495,890	£495,890	£0	£0	0%	40.33%

Regional Investment Model

Select the funding element which the project will be set against. Repeat the table and rationale for each project

Element 1 – Acceleration funding year 1	

Element 1 – Acceleration funding year 2	
Element 2 – Embedding funding year 1	✓
This programme continues the dedicated support for care experienced children, enabled through the Integrated Care Fund and Transformation Fund, providing a dedicated approach to reducing challenges/risk taking behaviours. Embedding the additional capacity and enhanced ways of working is critical to the prevention and early intervention required for longer term system wide impact.	
Element 2 – Embedding funding year 2	
Element 2 – Embedding funding year 3	
Element 3 – Legacy fund	
Element 4 – National priorities (Dementia and Memory Assessment Services/Diagnostic support)	

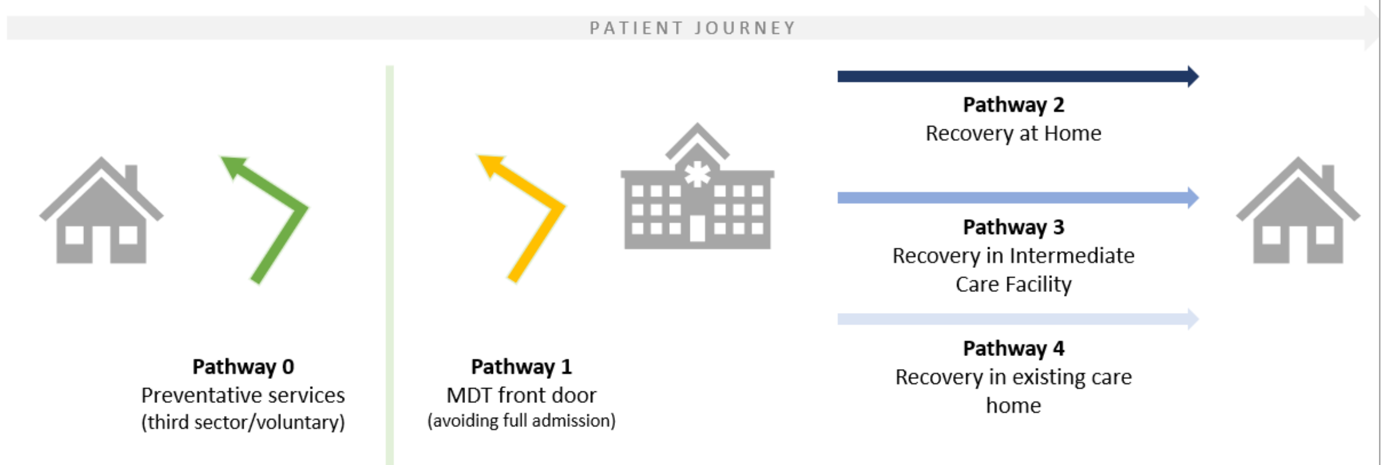
Model of Care Investment Proposal
HOME FROM HOSPITAL

Strategic Vision

To have established seamless discharge pathways from district and community hospitals; having consistent resources and processes facilitating discharge planning and co-ordination across the system, and a pull mechanism established from the community.

Case for Change

Whilst the Place Based Graduated Care programme places emphasis on the capacity needs to improve flow through the health and social care system, the ability to efficiently support patients through a period of hospitalised intervention to return home, consistency of pathways, processes and resource will support the embedding of the Discharge to Recover and Assess pathways.



Covid-19 has highlighted the fragility of the system, and the significant number of personnel involved in a person's care planning whilst in hospital.

To support improving system flow, dedicated capacity needs to be correctly placed within the system to be as effective as possible, and have an awareness of the capacity enabled via the Place Based Graduated Care programme that supports care closer to home.

Having this capacity at both the 'front door' and 'back door' of the hospital, will not only support effective discharge planning and ownership of the process, but also ensure patients are only admitted when absolutely necessary. Where at all possible and appropriate, patients will be redirected to alternative care settings where urgent acute care is not required.

The Urgent Goals national policy handbook will significantly influence the ongoing development of this programme, particularly Goal 5: optimal hospital care and discharge practice from the point of admission. The programme will endeavour to ensure people admitted to hospital are treated consistently and reliably in line with the expectations of health, social care, third and independent sector partners in Wales, as described in Welsh Government Hospital Discharge Requirements guidance.

Key Enablers *Select which of the key enablers will maximise the delivery of the programme, using the free text box to describe how this will be achieved*	
Integrated Planning and Commissioning The integrated approaches described within the Place Based Graduated Care programme will support the community capacity required to improve system flow.	✓
Technology enabled care Development of Robust digital solutions to support whole system performance metrics.	✓
Promoting the social value sector The Third Sector will be key partners supporting System Flow to achieve optimal person-centred outcomes, with the development of an optimal model for system flow in collaboration with the Third Sector. Through SLA's Third sector services currently support hospital avoidance and patient discharge, including providing some intermediate care services, which will be mapped and expanded upon as part of the programme.	✓
Integrated Community Hubs As reflected within the Place Based Graduated Care Programme	✓
Workforce development and integration A workforce development programme will be undertaken to redesign the current roles supporting discharge in the system ensuring clarity and equity throughout the region. Linking with the workforce development programme a recruitment, retention and training plan will be developed to support a resilient workforce for system flow alongside a rolling staff engagement strategy to support the Home First approach.	✓

Priority Population Groups *Select both the primary and secondary beneficiaries of the programme by priority population group, using the free text box to describe the particular impacts this will have. Please also indicate if the beneficiaries are supported using DAP funding*	Primary Beneficiary	Secondary Beneficiary	DAP
Older people including people with dementia With older people requiring the greatest support with complex discharge planning, individuals will be supported to return home as soon as medically able, allowing them to recover in the own home, or as close to home as possible, preventing any avoidable deterioration in physical conditioning.	✓		
Children and young people with complex needs Further consideration is needed on the system flow for children who are admitting to hospital, where complex discharge planning is required. This will be identified within our continued programme development activities and included within an updated RIF plan.		✓	
People with learning disabilities and neurodevelopment conditions, including autism N/A			

Unpaid carers With the ringfenced funding moving to support unpaid carers in the discharge process; developments will be undertaken to ensure clear communication with the unpaid carer, and the carers needs considered as part of this programme.		✓	
People with emotional and mental health wellbeing needs N/A			
Other beneficiaries N/A			

Total programme cost and match funding					
Total cost of programme	Welsh Government contribution	Partner monetary match	Partner resource match	% support for unpaid carers	% for social value sector delivery
£5,106,764	£3,979,491	£0	£1,127,273	0%	11.98%

Programme management resource to be confirmed.

Strategic Outline Plan (Gwent refer as Programme, WG refer as Project)
SP13: Improving System Flow

Model of Care Alignment					
Community based care – prevention and community coordination	Community base care – complex care closer to home	Promoting good emotional health and wellbeing	Supporting families to stay together safely and therapeutic support for care experienced children	Home from hospital	Accommodation based solutions
	✓			✓	

Programme Summary
The improving system flow programme has two workstreams. The first, delivered by the Home First model, provides turnaround services at the front door of the hospital, preventing admission to hospital where appropriate. Where admission is required, the second workstream will provide streamlined discharge liaison capacity to support people to be discharged to recover at home as quickly and safely as possible, transferring seamlessly between pathways Provide turnaround services at the front door of the hospital, preventing admission to hospital where appropriate. Where admission is required, people will be discharged to recover at home as quickly and safely as possible, transferring seamlessly between pathways. The overarching objective for the Improving System Flow programme is that community admission prevention and discharge support services will be strengthened and redesigned to ensure that they are right sized to meet a persons need Through the redesign of services outcomes for individuals will be improved through the avoidance of unnecessary days in a hospital bed and subsequent deconditioning. The model will be fit for the future, and flexible to adapt to changing or growing demand.

Intended Outcomes	
Person Centred Outcomes	• People will not experience harm associated with deconditioning during an avoidable stay in hospital • People will not be overprescribed long term care • People will be supported to remain independent and in their usual place of residence where possible • People's experience will be optimised, being fully informed and supported in achieving their personal goals • Through early transfer to reablement pathways the outcomes of recovery and reablement will be maximised

System Outcomes/Benefits	• Individuals will only be in hospital if acutely unwell, maximising hospital capacity for people who require acute care and assessment • Staff will be fully informed and empowered to support individuals to avoid hospital admission, or discharged once they are clinically optimised • There will be efficient flow through hospital and community services, with capacity being utilised for the right patient and the right time • There will be a reduction in avoidable demand for long term care/frailty support for people

Baseline Position

Admission avoidance services are currently in place through the third sector and Community Resource teams, mapping will be taken of the Gwent region to ensure there is equity across the five localities. Front door turnaround is provided by Home First, which will be redesigned and expanded to ensure cover is aligned with need across all hospital sites in the Gwent region.

There are currently a variety of roles in place to support Hospital Discharge including Patient Flow Co-ordinators, (DISCOs Discharge Co-ordinators), DLN's (Discharge Liaison Nurses), HAD's (Hospital Discharge Assistants), Social Workers and Occupational Therapists. Due to the number of different roles there can be a lack of clarity of the responsibilities for each role, and a difference of service provision across the region.

System Flow and Hospital Discharge are underpinned by the D2RA (Discharge to Recover then Assess Model) which provides a framework for integrated planning and delivery of community and hospital services. There are 5 pathways aligned to community-based care supporting admission avoidance and early discharge, as outlined in the table below:

PATHWAY 0	PATHWAY 1	PATHWAY 2	PATHWAY 4	PATHWAY 3
Admission avoidance through short-term third sector support	Is this person fit to admit?	Why not home? Why not today?	Home first when your home is a care home	Support to recover in a bedded intermediate care facility
Preventative services delivered in collaboration with third sector organisations. Aim to avoid further referral and admission.	Multidisciplinary Team assessment within hospital 'front door' units to avoid full admission. Arrange treatment and supported recovery at home, whenever it is clinically safe to do so.	Initiated as soon as treatment, which can only be delivered within an acute hospital environment, is completed. Supports people to recover at home before being assessed for any ongoing need.	Similar to Pathway 2, but acknowledges specific considerations to be addressed in the existing care home environment. Individuals should be allowed a period of recovery, followed by assessment in their usual environment.	Should only be considered where the needs of the individual rule out recovery & assessment at home. Review and transfer to Pathway 2 wherever, and as soon as, possible.

Figure 1: Home First: The Discharge to Recover then Assess model (Wales) – 2021

Quarterly reports are currently submitted for five key D2RA measures. Summary data for January 2021 – December 2021 is outlined below. In order to collect accurate information integrated data systems are required, which aligns with the Integrated Data Development Programme.

Measure 1: Number of People transferred on to each D2RA Pathway

Pathway 0	Pathway 1	Pathway 2	Pathway 3	Pathway 4	Total
2163	2125	3262	194	143	7887

Measure 2: % of those transfers that took place within 48 hours of the decision being made (that they were ready for transfer from hospital to this pathway for supported recovery and assessment)
We are currently unable to provide this information by pathway. Figures are provided from complex list discharges (all pathways including D2RA), indicating 76% of patients are discharged from hospital within 48 hours of being 'medically fit' between January 2021 and December 2021, as shown in the table below:

Number of individuals discharged within 48 hours of being medically fit	Total number of discharges	Percentage of individuals discharged within 48 hours
17245	22780	76

Measure 3: % people transferred to a D2RA Pathway with a co-produced recovery plan in place
A mechanism to capture this information is to be developed as part of ongoing work

Measure 4: % people transferred out of the D2RA Pathway to their usual place of residence

Pathway 0	Pathway 1	Pathway 2	Pathway 3	Pathway 4
tbc	65%	54%	59%*	tbc

*Data currently does not include community hospital beds

Measure 5: % people readmitted to hospital within 28 days

Pathway 0	Pathway 1	Pathway 2	Pathway 3	Pathway 4
tbc	tbc	5%	6%	13%

Key Enablers	
Workforce Development & Integration	A workforce development programme will be undertaken to redesign the current roles supporting discharge in the system ensuring clarity and equity throughout the region. Linking with the workforce development programme a recruitment, retention and training plan will be developed to support a resilient workforce for system flow alongside a rolling staff engagement strategy to support the Home First approach.
Integrated Planning & Commissioning	A mapping of the SLA's in the community supporting admission avoidance and hospital discharge will be undertaken, ensuring an equitable and integrated approach across services and organisations throughout the region. It is acknowledged that different solutions may be required in different areas, to achieve equal outcomes for individuals.
Technology & Digital Solutions	The use of assistive technology to support independence at home, which will in turn support hospital avoidance or early discharge.

	Shared data systems between services will support the goal of integrated working, and seamless care for the individual, providing a whole person view regardless of who is providing care and support. Data systems will need to align with national data requirements to ensure consistency and minimise duplication.
Capital Infrastructure	Linking with the Place Based Graduated Care Programme and Capital Programmes accommodation based solutions such as rapid home adaptations to aid discharge, independent living facilities with integrated wrap around care and purpose-built intermediate care facilities will be considered.
Social Value Sector	The Third Sector will be key partners supporting System Flow to achieve optimal person-centred outcomes, with the development of an optimal model for system flow in collaboration with the Third Sector. Through SLA's Third sector services currently support hospital avoidance and patient discharge, including providing some intermediate care services, which will be mapped and expanded upon as part of the programme.

Priority Population Groups		
	Primary Beneficiary	**Secondary Beneficiary**
Older people with complex needs	✓	
People with Dementia		✓
Unpaid Carers, inc. Young Carers		✓
Children with Complex Needs		
People with emotional and mental health wellbeing needs		✓
People with Learning Disability and Neurodevelopmental conditions		

Development Approach

The improving system flow programme aligns with the Home from Hospital model of care, the six goals for urgent and emergency and urgent care (Goal 6 - Home First Approach and reduce the risk of readmission) and the Home First: Discharge to Recover then Assess (D2RA) model. Improving System Flow crosses all pathways (0-5) of the D2RA model, and is closely interlinked with the Place Based Graduated Care Programme as part of a Whole System Approach supporting the Home from Hospital model of care. The Place Based Graduated Care Programme supports the community infrastructure enabling early discharge (pathways 2, 3 and 4).

The programme supports the four key principles of the D2RA model:

1. Think 'Home First' and keep the individual at the centre of all discharge considerations.
2. Balance risk and agree co-produced, clearly documented plans.
3. Have the community services infrastructure in place
4. Communicate.

A phased approach will be taken for the Improving System Flow programme. During the first year the system for supporting seamless flow between hospital to community care will be co-produced. Areas of work that are providing good outcomes for individuals will be embedded. The model for system flow including capacity, processes, use of technology and information sharing that support admission avoidance and discharge will be

redesigned to establish a simplified admission avoidance and discharge model for the region. A benefits realisation plan will be developed to ensure that the programme is providing good person-centred outcomes for individuals based on What Matters to You conversations. During the following years of the programme the new system will be implemented and evaluated, to ensure the system is working to provide good person-centred outcomes for people in the Gwent region.

The programme will work to support pathway 0 (preventative services through third sector/voluntary services) by mapping SLA's held with community services, including those that support hospital discharge and admission avoidance that are not directly commissioned by health and social care. This will allow good practice to be identified to be shared across the region, as well as identifying any gaps in the system to ensure equity across the region.

The programme will also work to support pathway 1 (front door services) through the Home First team. The model will be redesigned and reconfigured to strengthen medical alignment to the model, ensuring that individuals who access hospital services do not receive conflicting information and are directed to the most appropriate service for them, with community services being a key consideration in this process. The reconfiguration will ensure cover at all LGH's in order to support pathway 1 at these sites. It will also consider whether the right skill mix is currently available to support person centred decisions, focusing on potential skills needed for example dementia skilled staff, or the ability to challenge medical teams where appropriate, and whether the team have the required level of permission and support to enable discharge.

This programme will redesign the discharge co-ordination capacity in place, with the aim of reconfiguring and streamlining roles providing a consistency to the discharge roles and responsibilities. These roles support patients to be discharged as soon as possible once medically optimised, through pathways 2, 3 and 4 where appropriate. It is essential these roles support appropriate discussions with individuals and family members, as part of seamless care so that people and their families have clear information throughout their journey through the system, and to enable person centred decisions to be made. This programme of work will align closely with the workforce programme, considering recruitment, retention and training. The redesign will consider how to ensure discharge to community care is place based, for example aligning discharge roles to boroughs.

A rolling engagement strategy will be established for staff in hospital and community settings, including referrers e.g. GP's. The intention of this is that all staff understand the Home First principle and the balance of risks when considering admission or discharge, that communication for patients and their families is consistent and that there is an awareness of all services available so that individuals can be supported and signposted as appropriate. This will be a rolling programme due to regular changes of personnel e.g. rotations for junior doctors. This work will be underpinned by the mapping of community services, to ensure staff are aware of what community options are available.

The Improving System Flow programme is closely linked to the Place Based Graduated Care Programme. Seamless system flow can only be achieved when community capacity is right sized.

Interdependencies

The Improving System Flow programme is closely linked to the Place Based Graduated Care Programme as part of a Whole System Approach supporting the Home from Hospital model of care. It also links with the Unpaid Carers Programme, supporting Unpaid Carers and those cared for through hospital discharge.

The work of the Integrated Data Development Programme, Workforce Programme and Assistive Technology Programmes will be key enablers in supporting the Improving System Flow Programme.

The Improving System Flow Programme also links with core workstreams that are being undertaken such as the COTE/Frailty Pathway review and the Direct Admission Pathway.

Interim Financial Model (Year 1 Only)					
Total cost of programme	RIF Contribution	Partner match monetary	Partner match resource	% support for unpaid carers	% support for social value sector
£5,106,764	£3,979,491	£0	£1,127,273	0%	11.98%

Regional Investment Model *Select the funding element which the project will be set against. Repeat the table and rationale for each project*	
Element 1 – Acceleration funding year 1 This refreshed programme will support realignment and reconfiguration of capacity within the system, to test a new approach to patient redirection and discharge planning.	✓
Element 1 – Acceleration funding year 2	
Element 2 – Embedding funding year 1	
Element 2 – Embedding funding year 2	
Element 2 – Embedding funding year 3	
Element 3 – Legacy fund	
Element 4 – National priorities (Dementia and Memory Assessment Services/Diagnostic support)	

Appendix 1: Gwent Strategic Programmes - RIF Alignment

Strategic Programmes (subject to refinement through development period) | Alignment to National Models of Care

NEW Ref.	NEW Programme Name	Primary Population Cohort	Community Based Care - Prevention & Comm Co-ord	Community Based Care - Complex Care Closer to Home	Emotional Health and Wellbeing	Families Staying Together & Therapeutic Support for CEC	Home From Hospital	Accommodation Based Solutions
SP01/UC	Support for Unpaid Carers	Unpaid Carers	**✓**		✓			
SP02/EIS	Early Intervention & Support: Edge of Care	Children with complex needs			✓	**✓**		✓
SP03/CEC	Supporting Care Experienced Children	Children with complex needs			✓	**✓**		✓
SP04/CwDN	Supporting Children development needs/ND	Children with complex needs		**✓**	✓			
SP05/EHW	Good emotional health & wellbeing	Children with complex needs	✓		**✓**			
SP06/ACC	Safe Accommodation	Children with complex needs						**✓**
SP07/ChWD	Workforce development/professional support	Children with complex needs			**✓**			
SP08/DAP/R&I	Dementia: Recognition & Identification	People with Dementia	**✓**		✓			
SP09/DAP/A&D	Dementia: Assessment & Diagnosis	People with Dementia	**✓**		✓			
SP10/DAP/LwD	Dementia: Living with Dementia	People with Dementia	✓	**✓**	✓	✓	✓	✓
SP11/COMM	Connected Communities	Older People with Complex Needs	**✓**		✓			
SP12/PBGC	Place Based Graduated Care	Older People with Complex Needs		**✓**			✓	✓
SP13/FLOW	Improving System Flow	Older People with Complex Needs		✓			**✓**	
SP14/LD	LD Independence & Wellbeing	People with Learning Disabilities	**✓**		✓			
SP15/FTIER	Enhanced Foundation Tier	People with Emotional Health & Wellbeing Needs	✓		**✓**			
SP16/TRAN	Transition	People with Learning Disabilities / Children with Complex Needs		**✓**	✓	✓		
SP17/AT	Assistive Technology	All population groups	✓	**✓**	✓	✓	✓	✓
SP18/DATA	Integrated Data	All population groups	✓	**✓**			✓	

✓	Priority alignment to model of care
✓	Additional learning to be shared within model of care/community of practice