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A Healthier Wales:
our Plan for Health and Social Care

Llywodraeth Cymru
Welsh Government

Transformation Fund

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

The aim of the fund is to improve health and social care services by scaling up models that are successful, and replacing less successful or outdated ones. As a result people should see an improvement in their local services.

Due to the COVID 19 pandemic each region has completed a rapid review of the projects delivered within their area. This has meant a shift of resource within projects to meet the demand. The flexibility within each of the regions has been invaluable to support the pandemic response.

Regional projects

1. The Cwmtawe Cluster Whole System Approach
West Glamorgan Regional Partnership Board

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

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

The project aims to:

- Improve the wellbeing of people of all ages. There is a focus on facilitating self -care and building community resilience. There will also be a focus on the earliest years, young carers and mental wellbeing.

- Co-ordinate services to maximise wellbeing, independence and care closer to home. This would include Cluster Networks having control to design, co-ordinate and implement services in partnership with the community that meet patient and carer needs. There will be a focus on older people to

integrate services, try out new models of care closer to home, and reducing unscheduled admissions to hospital.

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

West Glamorgan Regional Partnership Board

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

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

The project aims to:

- Improve wellbeing across the age spectrum. There will be a key focus on facilitating self-care and building community resilience. There will also be a focus on targeted population groups dependent on the cluster demographics.

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

3. Our Neighbourhood Approach

West Glamorgan Regional Partnership Board

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

The project aims to:

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

areas by developing partnerships with a wide range of organisations and people from the public, private, third sector and communities to deliver support to people.

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

4. Me, My Home, My Community

Cardiff and Vale of Glamorgan Regional Partnership Board

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

The project aims:

- To change the way organisations work together in hospitals. For example local authorities will work with the NHS to provide increased daily contact on the wards. *Get Me Home Plus* will see people being assessed in their own home after being discharged from hospital, rather than being assessed before being discharged. This will give a better understanding of the support and adaptations needed in their home, and it will allow people to return home more quickly after a stay in hospital. Wrap-around care at home will be provided by healthcare professionals, social services carers, and social workers.

- To develop and recommend community based care – for example community gardening projects, walking groups 'men's sheds', and 'talking cafés'.

- To develop a well-being workforce. In addition to social prescribers and existing well-being officers, reception staff will be trained to provide information and connect people to volunteer carers in the community.

- To identify people who are at risk and actively support them to remain as independent as possible. This involves creating better connections between hospitals, GPs, and pharmacists to ensure everyone is informed of individual patients' needs when they are discharged from hospital, and patients have one point of contact.

- To implement multi-disciplinary teams, led by a GP, to develop and review services.

5. Implementing a Seamless System of Health Care & Wellbeing
Gwent Regional Partnership Board

The Gwent programme aims to create an integrated framework of seamless care around a place based model of transformation, recognising the value of multi-agency collaboration between health, social care, third sector, education and housing partners. Each programme has been adapted to respond to new community needs as a result of the COVID-19 pandemic. In some cases there is evidence of an acceleration in partnership working to assist with both the safe management of COVID-19 and in supporting reconstruction and stabilisation work going forward. Delivery has been impacted by COVID and a future year of funding would be valuable in enabling clear evidence to inform the scaling up of programmes.

- Integrated Wellbeing Networks- Designed to network community wellbeing capacity to support early intervention and prevention, the team have supported those shielding and isolating, by utilising the networks reach and scale across Gwent.

- Place Based Care- Whilst our Compassionate Communities pilot work has been paused, the principle of multi-disciplinary working around a practice remains a critical asset in managing COVID-19.

- HomeFirst- Designed to test an integrated model for hospital discharge, this programme has been at the forefront of safely supporting admission avoidance during the height of the pandemic, and this experience and evidence will shape a future preferred regional model.

- ICEBERG- With children and young people vastly impacted by lockdown and school closures, the ICEBERG programme continues to be at the forefront of developing new and integrated ways of supporting children, young people and their families to access mental and emotional health services and support. Virtual platforms have been implemented, and the Whole Schools Approach programme is likely to play a leading role in supporting the transition back to school.

6. Together for Mental Health in North Wales
North Wales Regional Partnership Board

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

The project aims to:

- Have an effective framework in each county for identifying people who are most vulnerable and take a multi-agency approach to prevent crisis occurring.

- Develop a multi-agency crisis care pathway that will provide prudent (right time, right response, right place) care and support that meets the needs of the person.

- Underpin the multi-agency approach to crisis care by training front line staff from all organisations on roles and responsibilities to improve practice and the experience for people in crisis, as well as to avoid escalation.

- Integral to the recovery pathway for people, the project will align with plans for developing supported housing in North Wales and key services which are currently not available.

7. Seamless Services for People with Learning Disabilities

North Wales Regional Partnership Board

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

The project aims to:

- Develop better integration of health and social services.

- Develop the workforce to create better awareness of disability issues among the wider public sector workforce. This approach should reduce the demand for specialist learning disability services in future.

- Use assistive technology to help people with learning disabilities become more independent.

- Implement community and culture change by increasing the number of people with learning disabilities employed in paid work, access to training, and volunteering opportunities, with more effective regional approaches for social prescribing.

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

North Wales Regional Partnership Board

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

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

The project aims to:

- Help prevent problems from escalating through timely integrated support - including new approaches to early help and accessing therapeutic support.

- Establish multi-functional ‘assessment and support’ teams that provide responsive and intensive support that seeks to build individual and family resilience and facilitate effective de-escalation of complex/escalating/crisis situations,

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

9. Community Services Transformation

North Wales Regional Partnership Board

The Community Services Transformation programme seeks to develop a place-based model of health and social care, through the provision of integrated seamless services, delivered at the local level. Through this approach, outcomes for individuals will be improved. Demand on statutory services will be better managed through the development of a robust and joined up approach, which focuses on early intervention. Well-being and prevention will be delivered within strong and resilient communities.

The project aims to provide:

- Well-co-ordinated care and support designed around ‘what matters’ to the people of North Wales, ensuring equality and equity of provision in the language people choose

- Help to enable people to navigate the health and social care system, and access a range of care and support that will improve their health, well-being and emotional resilience.

- Support and assistance to improve digital inclusion amongst people with health and social care needs

- Access to a range of community support, care and therapeutic interventions

- Assistance in dealing with crisis, end of life and ongoing health conditions.

10. A Healthier West Wales

West Wales Regional Partnership Board

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

To project aims to:

- Develop a wellness approach for people and staff, working together across the whole health and care system, to improve people's health and well-being.

- Put safety and quality first, so that people can live safely within their communities. Any changes to hospital services and the way care and treatment is delivered to the population will be carefully managed in a phased way, which prioritises safety and quality and ensures as a minimum that service changes do no harm.

- Support people to live independently, where they can manage their health and well-being, focused around their own homes and localities. This includes speeding up recovery after treatment and care and supporting self-management of long-term conditions. Working with key partners and staff to help build resilience and to support people to live well within their own communities.

- Continuously engage with communities and individuals to personalise and tailor health and care services to the needs and preferences of both people and localities, with a focus on enabling and supporting people to manage their own care and outcomes.

- Work with partners and staff across the whole health and care system to develop integrated services, where social, primary and secondary care are not seen in isolation but work together to provide services. They will be seamless and improve the experience for people by providing less complex, better coordinated care.

- Invest in staff and explore innovative workforce solutions to recruit, train and retain the best workforce for mid and west Wales.

11. Delivering a Healthy, Caring Powys

Powys Regional Partnership Board

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

The North Powys Wellbeing Programme will deliver a significant change in the way health and care services are provided by promoting wellbeing, early help and support, and utilising social and green prescribing opportunities. The programme aims to encourage people to take greater responsibility for their health and wellbeing, and actively plan for their future health needs.

The project aims to:

- Enable citizens, staff and partners to be actively involved in the design and delivery of a new integrated model of health and care in north Powys.

- Improve equity of service to a rural population through integrated health and care pathways, including commissioned services from neighbouring counties.

- Multi-agency wrap around services with a strong focus on early help and prevention, improved risk stratification tools to reduce emergency admissions.

- Increase uptake of prevention services to reduce smoking, achieve greater participation in physical activities, undertake targeted risk assessments for people with cardiovascular disease and minimise the impact of clinical risk factors (improving adherence to medicines).

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

- Ensure joined up care involving neighbourhood teams and communities working together so that citizens have a more seamless service when they need it.

12. Cwm Taf – Stay Well in Your Community *(part 1)*

Cwm Taf Morgannwg Regional Partnership Board

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

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

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

- Risk stratification and segmentation – the current pilot links and analyses primary and secondary care data to segment the cluster population into distinct groups based on their collective characteristics.

- Cluster focused multi-disciplinary teams – a ‘virtual ward’ approach has been piloted in Cynon Cluster. A multi-disciplinary approach is to providing support to reduce demand on general practice both in and out of hours and in Emergency Departments.

- Stay Well@Home – in response to growing pressures in Emergency Departments and the challenge of patient flow, integrated multidisciplinary teams have been introduced in Prince Charles and Royal Glamorgan Emergency Departments, Acute Medical Unit and Clinical Decision Unit departments.

- Detecting cancer early – in line with the Health Board's Early Cancer Diagnosis Programme, a Rapid Diagnostic Clinic has been piloted across Cwm Taf since July 2017.

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

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

Cwm Taf Morgannwg Regional Partnership Board

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

The project aims to:

- Have seven day access to community health and social care services – "Every day is Tuesday", delivering extended alternative service options to hospital and long term care.

- Have a primary and community care multidisciplinary team approach, delivering a one team approach around people, coordinating primary care and community services cluster responses.

- Develop and deliver resilient coordinated communities; with key organisations, their partners and the communities that they serve developing benefits, by working collaboratively to apply preventative approaches that enhance the wellbeing of the population of Bridgend.

National Projects

1. Collaborative Kidney Care for A Healthier Wales

Delivery Organisation: Welsh Renal Clinical Network

Renal services across Wales are coordinated and commissioned by the Welsh Renal Clinical Network (WRCN), who have been bold in their collaborative vision for change. The Network has created the mechanism to deliver nationally through a regional delivery model. Its vision is to bring about value-transformation by digitising the service through a single platform.

Digital transformation for all of Wales provides a real opportunity to deliver on the promise of A Healthier Wales. The model offers both a digitally enabled renal patient group and workforce to recognise, prevent and manage kidney disease across Wales. Digitising the operations of the renal centres will:

- Enable early intervention
- Deliver safer care
- Support independence
- Give people a voice
- Offer personalised expert care
- Make fragmented service seamless
- Achieve much better value
- Capture data at the point of care to create the evidence

The *Collaborative Kidney Care for A Healthier Wales* model aims to improve the quality of care, to enable people to take care of themselves, to identify and prevent chronic kidney disease (CKD) progression in the population, and to make renal services sustainable for the long-term.

2. Home Haemodialysis Programme

Delivery Organisation: Swansea Bay University Health Board.

The Home Haemodialysis programme empowers chronic kidney disease (CKD) patients to have self-care through co-production. Developed with patients, for patients, this programme puts them back in control by managing their treatment at home which promotes independence, improves patient accessibility to treatment, allows patients to re-engage in society and possibly return to work.

A multi-disciplinary task group will develop and expand a nocturnal programme focusing on patient-centred care. The group will establish an exemplary multi-disciplinary team, streamlining home therapy training, and so allow other units to implement. The intention is to publicise the developing expertise to motivate other

dialysis units to follow suit and for the programme to become scalable to national level. The aims are to:

- Establish an innovative, transferable training programme to communicate the benefits of nocturnal haemodialysis to the CKD population.
- Deliver service quality improvement that directly translates into improved patient outcomes for this group with a chronic health condition and significant cost reductions.
- Expand the home haemodialysis population and reduce the burden on hospital and satellite units as dialysis providers, mitigating the need for expansion and provision of costly new dialysis units.
- Reduce patient travel by removing the need for multiple journeys to and from dialysis facilities.

3. Cluster Based Optometry Services

Delivery Organisation: Health Education and Improvement Wales

The *cluster based optometry services* model funds education places and placements in secondary care for optometrists to provide patient care closer to home. This is a unique approach to training placements for qualifications where optometrists work in hospital glaucoma and acute services with an NHS contract. By ensuring that qualifications are offered to optometrists working in every cluster in Wales thereby achieving national coverage, targeting a reduction in demand for secondary care across Wales. The overall aims of the model are:

- For patients to be managed closer to home
- To improve patient experience and satisfaction
- To improve services in eye hospital for patients by:
    - Releasing capacity in secondary care in wet Age-related Macular Degeneration (AMD) services
    - Releasing capacity in secondary care in glaucoma outpatients
    - Releasing capacity in secondary care in eye casualty.
- To improve utilisation, career pathways, recruitment and retention of optometrists
- To extend capacity in hospital eye care outpatient clinics when optometrists are on placement in these clinics.

End