ipc institute of public care

Driving improvement and innovation in care

Welsh Government

Transformation Fund Regional Evaluation Update Report Cwm Taf Morgannwg Regional Partnership Board

Report

May 2021

scie social care institute for excellence

Llywodraeth Cymru
Welsh Government

OB3 Ymchwil Research

OXFORD BROOKES UNIVERSITY

http://ipc.brookes.ac.uk

Welsh Government

Transformation Fund Regional Evaluation Update Report Cwm Taf Morgannwg Regional Partnership Board

Report

Contents

1 Introduction 44
2 Background 44
3 Methodology 66
4 Structure of Report 66
5 Project Update – Assistive Technology 66
5.1 Overview 66
5.2 Model of working 88
5.3 Pace of Change 1616
5.4 Engagement 1717
5.5 Governance 1919
5.6 Cost benefit 2020
5.7 Outcomes and Impacts 2323
6 StayWell@Home2 2727
6.1 Overview 2727
6.2 Models of working 2828
6.3 Pace of change 3434
6.4 Engagement 3535
6.5 Governance 3636
6.6 Cost Benefit 3737
6.7 Outcomes and Impacts 3939
7 Community Health and Wellbeing Teams 4444
7.1 Overview 4444
7.2 Model of working 4444
7.3 Pace of change 5050
7.4 Engagement 5252
7.5 Governance 5454
7.6 Cost benefit 5555

7.7 Outcomes and Impacts 5656
8 Population Segmentation and Risk Stratification 6060
8.1 Overview 6060
8.2 Models of working 6161
8.3 Pace of change 6363
8.4 Engagement 6464
8.5 Governance 6464
8.6 Cost Benefit 6565
8.7 Outcomes and Impacts 6666
9 Bridgend Ambition 1-7 Day access to health and social care services "Everyday is Tuesday" 6767
9.1 Overview 6767
9.2 Models of working 6969
9.3 Pace of change 7070
9.4 Engagement 7171
9.5 Governance 7171
9.6 Cost benefit 7171
9.7 Outcomes and Impacts 7373
10 Bridgend Ambition 2 – 'One Team Approach Around People' 7676
10.1 Overview 7676
10.2 Models of working 7878
10.3 Pace of change 8383
10.4 Engagement 8585
10.5 Governance 8686
10.6 Cost benefit 8686
10.7 Outcomes and Impacts 8787
11 Bridgend Ambition 3 – Building Resilient and Co-Ordinated Communities 9292
11.1 Overview 9292
11.2 Models of Working 9393
11.3 Pace of change 9898
11.4 Engagement 9898
11.5 Governance 100100
11.6 Cost Benefit 101101
11.7 Outcomes and Impacts 102102
12 Conclusions and Recommendations 105105
12.1 Project level conclusions and recommendations 105105
12.1.1 RCTCBC, MTCBC, CTUHB Project Overviews 105105
12.1.2 Bridgend Project Observations 107107

12.2 Regional/strategic conclusions and recommendations ..... 110~~110~~

1 Introduction

This is the Regional Evaluation update for the Cwm Taf Morgannwg (CTM) Regional Transformation programme, prepared by IPC, the programme's Evaluation Partner. The programme covers three local authority areas, Rhondda Cynon Taf, (RCT) Merthyr Tydfil and Bridgend.

The Cwm Taf Morgannwg Regional Partnership Board transformation programme comprises two components which originally began independently:

- Accelerating the Pace of Change in Integrated Services *in Bridgend*
- Stay Well in Your Community *in RCT and Merthyr*

In 2018, two proposals separately covering the Bridgend and Cwm Taf areas were made to the Welsh Government having been approved through the appropriate governance structures prior to the creation of the Cwm Taf Morgannwg region. These were subsequently approved and funding of £22.7m was awarded to the Cwm Taf Morgannwg Regional Partnership Board by the Welsh Government in June 2019.

Since then, work has been underway to align and deliver these two components as a single Transformation Programme.

2 Background

The CTM Transformation Programme is made up of eight projects being delivered across the Regional Partnership Board footprint that covers Bridgend, RCT and Merthyr Tydfil. Three of the projects are located in Bridgend and five are located in RCT and Merthyr, although they share common approaches and common aims.

All eight projects are focused upon improving the performance and effectiveness of community services in order to both improve the experience, wellbeing and health of the local population and to reduce the reliance upon acute and in-patient health services to meet the needs that people have.

In Bridgend, BCBC in partnership with Bridgend Association of Voluntary Services (BAVO), have sought to build on their previous record of partnership working and integration. The overall ambition is to have fully operational accessible community services over seven days and over an extended day, as well as providing care and support at night. This, they believe, will help them towards achieving *'coordinated health and social care services seamlessly wrapped around the needs and preferences of individuals'*.

To support this they have three deliverable ambitions that they intend will transform their community services:

Ambition 1 - 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.

Ambition 2 - A Primary and Community Care Multidisciplinary Team approach, delivering a one team approach around people, coordinating Primary Care and Community Services Cluster responses.

Ambition 3 - Developing and Delivering 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.

In Merthyr Tydfil and RCT the two councils and CTUHB are pursuing similar aims with their workstreams that were designed to build upon and 'scale up' work done previously. Their five workstreams are:

Workstream 1 – Risk Stratification and Segmentation; Risk Stratification will be used to calculate individual patient risk scores using a range of modifiable and non-modifiable factors. These scores can be used at a GP practice, GP cluster and Health Board level to identify individuals or groups of patients within the highest risk groups and to enable the management and reduction of risk through targeted and anticipatory care.

Workstream 2 – Assistive Technology; expands upon existing services to provide a new 24 hour/365-day mobile response service that responds within 1 hour to non-medical requests. Also, a proof of concept piece around wellbeing assessments linked to proactive out-bound telephone calls at regular intervals to prevent escalation or crisis following a preventative intervention.

Workstream 3 – Community Health and Wellbeing Teams; Enhanced Community Cluster Teams that are made up of a range of professionals from health and social care, they take on a strategic role and to directly plan, organise and manage services for their local populations and deliver Anticipatory Care - Using the information from the population segmentation and risk stratification workstream.

Workstream 4 –– Stay Well@Home2 has enabled the Local Authorities to extend the opening hours of their Adult Social Care Single Points of Access (SPA) from 5 days to 7 days a week, 8:30am – 8pm which provides community health and social care professionals access to rapid assessment and response services to support individuals to remain safely living at home and avoid any unnecessary conveyancing to hospitals.

Workstream 5 – Urgent Primary Care Out of Hours[1]**;** Strengthening the MDT team triaging through the 111 clinical services and maximising the opportunities from the application of artificial intelligence to sign post patients to self-care and appropriate alternative services.

All of the projects that make up the programme have been impacted upon in some way by the pandemic. In some cases, it has accelerated their development and in others it has clearly held them back, primarily because programme staff were necessarily re-deployed into Covid-related activity.

[1] This report does not include an update from this project as it is no longer required to update on progress

With the exception of the Risk Stratification and Segmentation workstream all have services up-and-running.

Both the Bridgend and Cwm Taf sub-programmes are intended to both shift activity from the acute sector into the community and to provide people with a more preventative and effective service. In both localities the range of services being developed are meant to be mutually reinforcing and to contribute to the wider and overall health and well-being of the population.

The Institute of Public Care (IPC), Oxford Brookes University is the Evaluation Partner for the Programme and has been involved in working with the Programme since its inception. However, formal evaluation activity has been very limited by the impact of Covid-19. Work is now in progress to ensure that there is effective evaluation activity over the next 12 months. The intention is for this to encompass measures and judgments that relate not only to the individual projects but also to the wider impact of the programme as a whole.

3 Methodology

Opportunity to undertake detailed evaluation activity has been severely curtailed by the impact of the Covid-19 Pandemic, but IPC has worked with the programme in compiling a number of reports for the Welsh Government and in developing the necessary framework for a full evaluation including the development of an overall Theory of Change and the compilation of evaluation datasets for each of the projects.

For this Evaluation report we have drawn upon that work and also upon work undertaken to produce previous reports and up-dates for the Welsh Government. In addition, we have met with programme and project staff and drawn upon knowledge, information, materials and experiences provided by those staff.

4 Structure of Report

This report follows the format set out by the Welsh Government template and it provides an up-date for each funded project within which it seeks to address the research questions posed by the Government. Not all of the research questions are equally relevant for each project and this is reflected in the variable lengths of the answers provided. Whilst the projects have a common focus and there are some strong common themes that emerge we have sought to report on the basis of each workstream not each research question, so there is a chapter for each workstream. However, we have added a short overview section at the beginning of and a summary section at the end.

5 Project Update – Assistive Technology

5.1 Overview

This report draws on an in-house review of the Assistive Technology model in RCT and first 12 months of operational performance information. It includes both qualitative and quantitative information through performance data, case studies and user surveys, and takes account of the region's approach to drawing together the Social Services and

Wellbeing Act (Wales) 2014, A Healthier Wales and the Well Being of Future Generations Act through the Cwm Taf Stay Well in Your Community Programme.

As with other elements of the CTM programme, the Assistive Technology workstream reflects the stated desire of the region to improve the experience of individuals in accessing support and to 'future proof' services to meet demands placed upon the health and social care economy. Through strengthening services in the community and promoting a culture of prevention this strategy looks to increase hospital avoidance.

The Assistive Technology model offers both preventative and responsive models of support to individuals who are in receipt of alarm monitored telecare equipment. Based upon the innovative 'Teleassistance' approach in the Spanish region of Catalonia, the model often described as the 'Barcelona model' offers an enhanced assistive technology offer through:

- Well-being assessments linked to proactive calling which enable individuals who have been in receipt of other preventative services, such as reablement, the opportunity to discuss their wellbeing and have this captured in an assessment. Regular contact is then made with the individual over the telephone based upon the contents of the assessment. This enables the team to continue to provide support and monitor the individual to observe trends and put in place an intervention that prevents a crisis response.
- A Mobile Responder Service that responds to triggered telecare alarms; this service forms part of the RCT Domiciliary Care service and is registered with Care Inspectorate Wales. Staff are experienced domiciliary care workers who are individually registered with Social Care Wales. In addition to their domiciliary care training, which includes the Reablement Calderdale competencies, they have also been trained by the Welsh Ambulance Service (WAST) and provide support to individuals who:
  - have fallen, but no injury has been reported;
  - require a welfare check, due to alarms being triggered and no response being gained by the alarm monitoring centre;
  - experience personal care emergencies.

The Assistive Technology model should also be considered in the broader context of the regional strategy and the links to other workstreams; for example the referral pathway into the SW@H2 service for individuals who require either a health or social care intervention as a result of a proactive call or a Responder visit. The strength of this pathway reinforces the focus upon keeping a person well at home with an assessment and access to a range of rapid and appropriate services that prevent a conveyance and admission to hospital.

In addition to its contribution to the regional strategy, the Assistive Technology model has had unanticipated spin off benefits across the health and community care model which are captured within the responses to the research questions below.

Whilst a Mobile Responder service is a feature in a number of Assistive Technology models across the UK, the range of response takes a variety of forms with many sitting outside of the scope of the social care system and providing a falls response only. The White Paper 'The transformation potential of telecare' provides recent independent

research into models of operation for Assistive Technology in addressing emerging needs. In addition to reducing the emergency demand upon health services the research found:

- with a responsive model of telecare in place a cost of £4,500 per service user per annum was avoided in wider social care costs[2];
- where the offer was extended to include a personalised and proactive approach, there were delays to individuals requiring a residential care placement when compared to individuals who were not in receipt of the offer. On the research cohort this saving was calculated at £5,900 per person and also had a positive impact on residential capacity[3].

The research studies within this White Paper describe well established models of support and it is important to note that comparable achievements may take a number of years to become evident within RCT community care.

The section below follows the revised 'A Healthier Wales' Transformation Fund Research Questions template.

5.2 Model of working

RQ1. ***What changes have been made to the projects during the Programme, particularly in response to Covid-19?***
There are no changes to the overall model described above which was developed based on a review of the Assistive Technology offer in RCT and research into national and international best practice models; the preferred operating model replicates the 'Barcelona' model of reactive/responsive services, underpinned by a personalized and proactive approach.

At the core of the model is a reactive and responsive offer through the provision of a Mobile Responder service that operates 24 hours a day, 365 days a year that can respond in a timely manner to alarm triggers to the Lifeline Monitoring Centre. This service element has been placed with the registered domiciliary care service in order to provide a broad offer that includes responding to emergency personal care needs as well as supporting with non-injury falls. In order to benefit from the Responder service, individuals are fitted with telecare services which include the installation of a keysafe in order for rapid access to be gained to a property.

The model extends the offer and promotes the preventative agenda by offering a personalised and proactive response to individuals through the undertaking of wellbeing assessments and proactive calling which is designed to avoid or reduce a crisis response. Case Study 1 below demonstrates the proactive offer of this extended service:

[2] YHEC research for Tunstall investigating the impacts on social care costs of reactive telecare with Lancashire County Council, referenced on page 7 of 'The transformational potential of telecare' White Paper 2020.
[3] Ignetica research for Tunstall investigating the benefits realised through proactive and personalised telecare in Spain, referenced on page 9 of 'The transformational potential of telecare' White Paper 2020.

Case Study 1

Miss D is 39 years old and suffers with MS.

Miss D had been in receipt of 5 x morning calls to support with showering. Miss D is independent with tasks and has benefited from Reablement input. However, for safety reasons Miss D requires someone to be in the property whilst the task is being completed and she undertakes this task when her family visit – Miss D reports that she is 'proud she can undertake the task by herself.

The Reablement Therapist completed a Wellbeing Assessment with Miss D and collectively they agreed that Miss D would benefit from a fortnightly phone call to check in with her; with the contingency that should Miss D experience a dip in how she is managing or her family are no longer able to support then a referral will be made back through to the Single Point of Access who can undertake the 'What Matters conversation'.

Initially the proactive element will focus on a 'proof of concept'; Across RCT, individuals who have benefitted from a preventative service such as Reablement, do not require further input from social care but would benefit from regular contact to monitor they do not experience any deterioration that would require more formal services or crisis intervention. As individuals complete their reablement programme a wellbeing assessment is completed and highlights key risk factors that would signal a further intervention is required. This assessment forms the risk stratification for the individual and is the basis for conversation of the regular proactive telephone calls.

Staff undertaking the telephone calls have received appropriate social care training and have support from the whole system approach to recognise when a further intervention is required.

Both the Mobile Responders and the personalised proactive approach ensure that changes are identified early to ensure that time limited interventions or responses can be put in place that negate the need for dependency on long term support services and support hospital avoidance.

The Mobile Responder element of the service became fully operational in January 2020 and continued to successfully operate during the pandemic, including lockdowns and provided a level of resilience to the surge capacity demands on the domiciliary market during this period.

Whilst the initial 'lockdown' caused some delays to the implementation of the wellbeing assessment and proactive calling, as staff were utilised to support Covid pressures for individuals who were shielding or required to isolate, the service continued to successfully operate throughout the pandemic and provided a level of resilience to the surge capacity demands on the domiciliary market during this period; staff were accustomed to supporting individuals through proactive calling, and the experience gained during this period has been valuable to the rollout of the wellbeing assessments and proactive calling since July 2020.

RQ2. What impact have any changes made to projects during the programme had upon projects ability to transform the service?

There have been no changes made to the model which remains transformative and with the same anticipated outcomes. The only noted change has been the ability of the service to consistently deliver the full range of services (namely the proactive calling) during unplanned key pandemic events. The service is currently fully operational, and it is anticipated that this will be sustained in the future.

RQ3. What were the critical success factors in enabling transformation, particularly in response to Covid-19 challenges?

Prior to investment from the Transformation Fund, RCT already had a well-established Assistive Technology offer through an installation service and alarmed monitoring centre, all provided by the Local Authority. In addition to the Assistive Technology element, Adult Social Care has a sizeable in-house domiciliary care service that provides enabling and reablement along with a long-term domiciliary care function and is supported by a robust management team. This significant local authority investment in its core services was able to support the additional transformational element with sound knowledge/experience and day-to-day oversight of the functions when they became operational.

In addition to the above, further critical success factors in enabling the transformation include:

- Local and regional experience, knowledge and key partnership relationships; for example, relationships with the Welsh Ambulance Service.
- Appropriate level of investment into the project to ensure that there were sufficient resources to make the changes required for the workstream to be transformational.
- Regional commitment made to dedicated Programme Management.
- Programme Manager and Programme Group representatives with operational knowledge and experience, who were able to move at a pace to ensure implementation in a timely manner.
- Local commitment to recruiting permanent staff to work in the service, rather than seeking to make temporary appointments or secondments.
- Local flexibility and adaptability of the service and the staff to accommodate the different circumstances and challenges that have prevailed since the pandemic began.
- Local ability to adapt to the change in community needs for people who were shielding.

Another key factor in the scaling up and transformation achieved is in the interconnectivity between the Assistive Technology model and other workstreams which are part of the Stay Well in Your Community programme; the interdependence between the Mobile Responder and the Stay Well at Home 2 services illustrate this well. Promotion of the Assistive Technology service is also a key offer of the Community Health and Wellbeing Team social worker function in maintaining independence.

RQ4. ***To what extent have the Transformation Projects addressed the AHW Design Principles? And the Well-being for Future Generations 5 ways of working (long term, integration, involvement, collaboration, prevention)?***

The Assistive Technology programme aligns with the design principles set out in 'A Healthier Wales', in particular prevention and early intervention. The project addresses a gap in service provision for an alternative to conveyance and admission to hospital through providing a response for individuals who require a support following a fall at home.

The programme particularly meets those elements associated with better quality and experience in health and social care enabled by digital technology, supported by engagement, along with higher value and rapid improvement and innovation, enabled by data, focused on outcomes.

Along with the Responder Service, the provision of telecare equipment linked to the monitoring centre allows the collection of individual datasets for people who have benefitted from both the provision of equipment and the Mobile Responder service; this translates into the assessment and care and support planning process in order to achieve a personalized approach to their needs. For example;

Case Study 2

Mr W had recently been discharged from hospital following a stroke and also suffers with muscular dystrophy and epilepsy. He was supported by a large package of domiciliary care and provided with an epilepsy sensor and falls detector linked to the monitoring centres and Mobile Responders.

Within four weeks of discharge, Mr W had called upon the Responder service on 50 occasions and Welsh Ambulance service were also in attendance on 40 of the visits. A report was compiled from case records of visits and a multi-disciplinary meeting arranged.

Through knowledge gained from the Mobile Responders and the Lifeline Monitoring centre it was evident that the epilepsy sensor provided was not suitable for Mr W's form of epilepsy; the Assistive Technology Officer took the lead with equipment developers and quickly sourced an appropriate sensor with advice provided from the Epilepsy clinic on Mr W's epilepsy. The new equipment was produced and installed within one week, leading to a significant reduction in demand upon both the Mobile Responder service and WAST. Using the most appropriate equipment is essential in meetings individual needs.

This case study demonstrates the strength of response when using the most appropriate equipment to meet an individual's needs.

The introduction of wellbeing assessments and proactive calling ensures that individuals experiencing a 'dip in health' or their support needs will have a timely response as a result of the evidence from the proactive calling.

The project builds upon the principles, including *safety* and *independence* and delivery of a *seamless service* along with the *integration* of health and social care services. Specifically, the project addresses the Welsh Government Design Principles in the following ways:

- Being part of a whole system transformation, the Cwm Taf Region Stay Well in Your Community programme and linking with the Assistive Technology and Community Health and Well Being teams workstreams to provide an improved community response supports the moved towards *seamless* services. Also, in the longer term, the aim is to explore the option of sharing datasets from the Risk Stratification and Segmentation and Assistive Technology workstreams. The expected outcomes of this are:
  - development of falls prevention programme;
  - identification of those who most at risk in the community are targeted with Assistive Technology offer which includes the provision of equipment, wellbeing assessment and proactive calling, and Mobile Responder service;
  - closer working with partners, such as the Community Health and Wellbeing teams, @home nursing.
- Supporting the hospital avoidance agenda by reducing the need to convey to hospital and to maintain individuals' *safety* at home.

The project employs the philosophy of Prudent Healthcare through:

- providing an assessment of a person's situation and providing an appropriate response as alternative to a 999 call;
- better use of resources;
- better outcomes for the individual;
- better outcomes for professionals.

The programme relates to all aspects of the Well-being for Future Generations 5 ways of working, in particular *collaboration and prevention*, as the focus is upon supporting people to keep them in the community and to avoid admission to hospital:

- *Long term improvement in individuals' wellbeing* – longer term improvement of service provision closer to home.
- *Integration* – closer working with other community professionals and services providing individuals with a more joined up approach; for example, engaging with colleagues in WAST to promote the service and work with WAST and Social Work teams around frequent flyers.
- *Collaboration* – with individuals, communities and professionals; for example, engagement with Corporate Colleagues within RCT to promote the service and with Care Managers to inform assessment and reviews.
- *Involvement* – of communities, individuals, professionals and services; for example, training the frontline workforce of Support@Home and engagement with Welsh Government who are developing an Assistive Technology strategy for Wales.
- *Prevention* – forms a key part of preventative services using enabling approach; for example, the development of the wellbeing assessment and supporting responses.

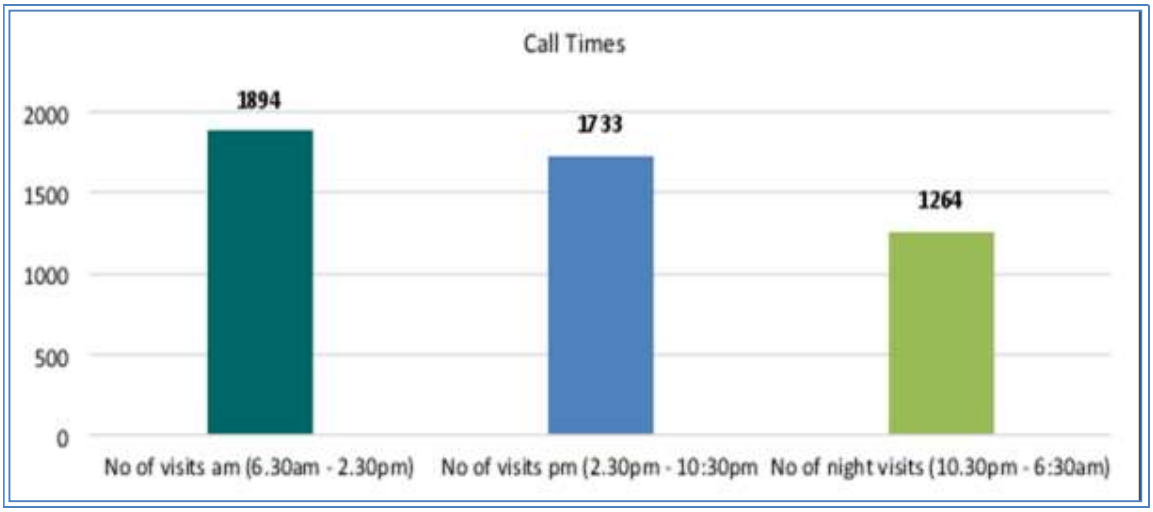
RQ 5. To what extent can the Transformation Projects demonstrate a sustained shift to preventative services?

Prevention has been a key driver in the Assistive Technology programme through the introduction of the Mobile Responder service that has addressed the gap in provision for non-injury falls, welfare calls and provision of emergency personal care. Both the Mobile Responders and the personalised proactive approach ensure that changes are identified early to ensure that time limited interventions or responses can be put in place that negate the need for dependency on long term support services and support hospital avoidance.

Mobile Responders are requested for a variety of reasons. Evidence from the first twelve months demonstrated that the largest referral reason was due to 'falls' or to undertake a welfare check following an alarm being triggered but no response being achieved. Prior to the introduction of the Mobile Responders the majority of these types of calls would have resulted in a paramedic being called to attend which due to the business of the ambulance service and the time delay form the fall to the ambulance crew attending would in most cases have resulted in a conveyance to hospital.

The responders also respond where an ambulance has been requested by the Lifeline Monitoring Centre due to an injury being reported. This is in case of delays from paramedics and to provide reassurance and where possible make the individual comfortable to reduce any other complications. For example, with a fall where an injury is reported, the responders are able to undertake tasks such as placing a blanket over them to keep them warm and reassuring them to prevent shock.

Of particular note is the number of night-time visits made by the service. These are the ones most likely to have resulted in a call to the emergency services had the Mobile Responder not been funded by the Transformation Grant. A breakdown of call times is provided in the graph below: (all figures provided are as a result of direct funding from the Transformation Grant).



Over the past 12 months, Responders have been proactive in identifying where a person needs further support and using the correct channels to ensure that the individuals needs are met appropriately; this includes onward referrals to the co-located Single Point of Access and the GP out of hours service, which is also based in the same building.

The Mobile Responder service has also provided a platform for the development of an intake domiciliary care model in RCT. The purpose of the intake is to ensure that individuals receive domiciliary care support in a timely manner as part of an ongoing assessment to 'right size' packages of support. The intake service will work with other professionals in Community Care in order to tailor packages of support according to needs – ensuring that the right equipment is in situ and the correct level of domiciliary care support is in place before the commissioning of a long term package with an external provider. In stabilising packages before long term commissioning and providing a lead time for external providers to hand over, this will support with the demands on the domiciliary care market in the region.

Case study 3

A prisoner was resettled in Rhondda Cynon Taf area during the height of the first lockdown; information received by the Social Worker from the prison was that the individual required intensive support and hoisting. In order to facilitate the package in a timely manner the Mobile Responders were tasked with the care provision for four times a day double handling. Through working with Occupational Therapists and the daily feedback from the Responders, after a six-week intervention the individual required no long-term services commissioned.

RQ6. ***To what extent can the Transformation Projects demonstrate scale-up, particularly in response to Covid-19 challenges?***

Evidence from a review undertaken by PA Consulting in 2018 into the Assistive Technology offer in RCT demonstrated that, whilst the service was robust, a new model that reduced the demand on domiciliary care services should be considered. The outcome of the review coincided with emerging research into the 'Barcelona' teleassistance offer which provided a more holistic response to an individual's needs through a multi-faceted approach that had been developed around a core offer a simple lifeline unit and pendant.

The Barcelona approach aligned with the ethos of the assistive technology strategy RCT, which recognised that whilst there is a place for utilising innovative equipment, the greatest value could be placed upon services that wrap around an individual to keep them safe in their own home.

The enhanced elements of the Assistive Technology funded from the Transformation Grant were embedded within well-established services. This brought credibility to the approach and provided a robust offer for individuals who are in receipt of the service due to the operational knowledge and experience of the support structures.

The Mobile Responder service, which is demonstrating a continued impact, was implemented before the Covid-19 restrictions hit and provided an additional resilience to the adult social care offer during this period.

RQ7. *What were the critical success factors in enabling scaling, particularly in response to Covid-19 impacts on services?*

A critical success factor has been the dedicated Programme Management with operational knowledge and experience. Crucially, the Programme Managers have been able to:

- retain oversight of the project;
- provide a key link to the Cwm Taf Region Stay Well in Your Community whole system model;
- ensure that tweaks to process and practice following implementation have been made in a timely manner so that outcomes are achieved.

A further critical success factor for the Mobile Responder service is in the location of the management with the registered Support@Home service; Responders are experienced and registered domiciliary care workers who benefit from the knowledge and expertise of the management team.

Time taken establishing strong links with other elements of the service has also been important. For example, the Responders are co-located at base with other elements of the Short-Term Intervention service[4] of community care in RCT. When they need to discuss a case with a supervisor or another professional this can be carried out in a timely manner.

Integrated working across health and social care has been critical to ensure a whole system response to the Covid 19 pandemic especially during periods of increased demand and during the lockdowns. As the following case study demonstrates, whole system community services working to support hospital discharges and hospital avoidance have been essential to relieve some of the pressures on acute hospital services as a result of the pandemic:

Case Study 4

Mr and Mrs J, both mid-70s, were referred to the Single Point of Access (SPA) by a neighbor at 14:00. Mr J was extremely unwell with symptoms of Covid-19 and required an urgent hospital admission. Mr J was main carer for his wife who had been diagnosed with dementia several years earlier, however they had been managing successfully at home without the intervention of any services from Social Care. Mr J was reluctant to be admitted to hospital as he did not want to leave his wife who as well as being diagnosed with dementia, also suffered from epilepsy which was triggered in times of stress.

The SPA ensured that an urgent duty visit was undertaken whilst the paramedics were en-route to the property. The Social Worker was concerned that Mrs J would not be able to stay in the property alone due to risk of seizures; however due to the

[4] The Short Term Intervention Service in Rhondda Cynon Taf CBC Community Care consists of the Single Point of Access (SPA, which includes Stay Well at Home 2), Support@Home (which includes Reablement, Intermediate Care, Mobile Responders and long term domiciliary care provision), Short Term Care Management (Social Worker team), Community Occupational Therapy Team, Sensory Team and the Stay Well@Home hospital based team.

restrictions around care home admissions and the need for Mrs J to isolate after being in contact with her Covid positive husband it was unlikely an urgent placement would be achieved. The Social Worker considered the option of a social admission to hospital in order to keep Mrs J safe. As the Social Worker liaised with the SPA the option of telecare and lifeline linked to the alarm centre and responders was explored; alongside the commissioning of a 4 x daily and night domiciliary care package from the internal domiciliary care function. The SPA was able to arrange for an epilepsy sensor and lifeline to be fitted immediately and the care package to start that afternoon.

It is anticipated that there will be an increase in demand on preventative services, such as Reablement, as people come forward for support in the following circumstances:

- Have been avoiding contact with those from outside of their own household (both the service user and carer) and as such did not previously seek the support they required.
- Have paused their care and support.
- Have delayed seeking medical advice.
- Have paused their medical diagnostics or treatment.
- Are now managing long Covid 19 symptoms.

5.3 Pace of Change

RQ8. How has pace of change varied as a result of responding to the Covid-19 challenge?

The pace of change in establishing the Mobile Responder element was rapid; the period from the appointment of a Programme Manager to implementation was less than seven months. During this time the Programme Group, led by the Programme Lead and Programme Manager undertook the following:

- Developed a management of change process.
- Created new job roles/descriptions.
- Advertised and recruited to the roles.
- Developed processes from the Lifeline Monitoring Centre to the Mobile Responders and other services.
- Inducted new staff and provided training for Mobile Responders, which included training delivered by the Welsh Ambulance Service.

Whilst staff were recruited to the Wellbeing Assessment and proactive calling element in line with the 20th January 2020 start date, the processes were still being developed, and as the demands of the Covid19 pandemic unfolded the resources were diverted to support surge capacity in social care or redeployed to support the corporate effort to support individuals who were vulnerable and shielding. Upon the easing of restrictions after the first lockdown in July 2020, the process for wellbeing assessments and proactive calling was implemented.

During the first 12 months of operation, the Mobile Responder met its target of responding to callouts within 1 hour on 96.6% of occasions (total of 4,891 visits recorded between January 2020 and January 2021). This response time is critical for

fallers in ensuring that other associated complications of being left on the floor for prolonged periods doesn't occur and therefore require a paramedic to attend.

RQ9. ***What barriers have you faced in your attempts to achieve transformation change? How could these have been mitigated?***
The onset of the Covid-19 pandemic delayed the implementation of the wellbeing assessments and proactive element of the transformed service as the staff employed in this area were deployed to support the immediate pressures. This element was then implemented upon the easing of the first lockdown in Wales.

Another impact of the Covid19 pandemic was a delay in the installation of the Tunstall ICT system that will underpin the processes. However, processes have been put in place to operate the model without this system and, as a result, tweaks to processes have been able to be made in a timely manner and will better inform the requirements of the system when implemented.

The extension of the Transformation Fund provides the opportunity to evaluate the project over a longer period of time which will go some way to mitigate the impact of the pandemic on the evaluation for 2020/21.

5.4 Engagement

RQ10. To what extent has the workforce and citizens contributed to the ongoing development of TF projects?
As part of the promotion of the programme, roadshows were undertaken with frontline staff in the Support@Home service to outline how the model would operate. This was quickly followed by a full Management of Change exercise with staff. Information on the model was also published on the internal webpage of RCTCBC for all social care staff to familiarise themselves with the developments.

Key partners were included in developing the operational processes and procedures. Partners also provided support to deliver multi-agency training to support staff in their new roles. Training provided to Mobile Responder service from the Welsh Ambulance service included:

- I-stumble model
- Mangar training (lifting equipment)
- Defibrillator training

Internal teams were engaged in the process developments to ensure appropriate pathways to and from the model. In particular the community care service in RCT was encouraged to consider the use of the Mobile Responders as a rapid response service that would help meet an urgent social care need in the community. This is evident from the wider requests to the Mobile Responder service as a trusted resource to undertake welfare checks, deliver food parcels and provide initial feedback on situations in order to inform assessments and decision making.

In ensuring the model was placed in context of the wider Stay Well in Your Community regional model, a concerted effort was made to develop processes between the programmes in the region; the most natural alignment was formed between the Stay

Well @Home 2 model and the Mobile Responders who benefit from co-location and a shared management structure.

The following comments have been received from surveys:

- *'Single Point of Access have utilised the addition of the mobile response service to complete welfare checks to ensure the safety of multiple individuals and has negated the need for additional resources in some circumstances, but informed us of the need for services in others and streamlined the type of service required. Always a timely response and the staff are exceptionally helpful, always provide accurate feedback'*
- *'Carers have felt safer knowing that the persons cared for has this service in place. In some instances, the service has been critical to the welfare and safeguarding of service users. Responders not only responded to incidents but have also passed on vital information that has potential safeguarding implications. It has allowed for further integrated working in multi-agency context that in all, protects and safeguards individuals'.*
- *'I think that this service can sometimes give reassurance to family members as well as individuals in regard to safety within the home.'*
- *'Lifeline is needed for 90% of my caseload and provides reassurance to me as a worker that the person's risks are minimised by accessing lifeline services'.*
- *'Excellent Service – especially now there is a responder team attached which will prevent more admissions into 24-hour care and maintain people at home longer'.*

An information sharing and consultation exercise was undertaken with the existing users of the established telecare model in September 2019. During this process, over 3,500 people were provided with an information leaflet on how the model would operate and an audit exercise was undertaken of equipment in the community; as part of the exercise users were invited to either provide details of an existing keysafe or offered the installation of a free keysafe to ensure that Mobile Responders were able to enter a person's property once an alarm had been triggered.

The engagement exercise had a 98% response rate with a positive response from users with a large uptake of the keysafe offer and comments upon booking the keysafe installation including 'this is a great idea' and 'as a carer I feel reassured that this extra support is being put in place'. As a result of this exercise, nearly 1,000 new keysafes were fitted over a three-month period in the lead up to the January 2020 start date.

RQ11*. What behaviour changes within staff/citizens have occurred as a result of these projects?*

The successful implementation of the model has engendered confidence amongst partners and internal stakeholders in the service's ability to contribute to maintaining individuals in their own home and diverting individuals away from crisis interventions.

Engagement from the Welsh Ambulance Service in the development and training of the model provided reassurance to professionals on the knowledge base of the Mobile Responder service in being a viable alternative to a 999 call for non-injured falls. In addition, the robust management of the Mobile Responders and the placement with a long established and respected domiciliary care service has provided credibility to the service.

Colleagues across the wider Adult Social Care service are now supported with urgent community cases through the provision of assistive technology and the offer of the Responder service in maintaining an individual at home; this is particularly prevalent where there is a risk to the commissioned service provision being maintained as a result of the Covid pandemic. The service was recognized at the early stage of the pandemic as providing resilience in contingency care and support plans and is now a key feature of the offer.

The extension of the Transformational grant will allow more time for the service to demonstrate to professionals, partners and the individual citizen the difference an innovative whole model approach will have on the preventative agenda.

5.5 Governance

RQ12. How have governance arrangements been adapted to respond to Covid-19?

The Assistive Technology programme is overseen by an Operational Group, chaired by the Programme Manager and attended by representatives from all partner agencies and services involved in the model. The group met monthly through implementation and operationalizing the model, until the pandemic. At this point, attendance for some services became difficult due to the demand and group met less frequently as a result. However, monthly meetings are now being re-established.

To ensure Covid-19 guidelines are adhered to all professional meetings, updates and marketing of the service is now undertaken online via “teams” meetings.

A “safe” Covid-19 friendly office space is available for operational staff who cannot undertake duties at home. Operationally, electronic systems are used for assessments and any resulting referrals, and to provide information for reporting and evaluation. For visits, the Mobile Responders comply with enhanced PPE requirements, following the donning and doffing process for PPE when entering a property. To ensure the safety of the Mobile Responders, an exercise was undertaken by managers to reconcile information provided by Cwm Taf Morgannwg UHB on users of NIVs/CPAP, with the PNC system (alarm monitoring system) to ensure that an alert is flagged upon a call out. This is due to a NIV/CPAP being an aerosol generating procedure (AGP) and requires a different type of mask (FFP3) to be worn for these visits. The Responders completed FIT testing sessions with the District Nursing service to ensure compliance for FFP3 mask wearing.

The installation element of the Assistive Technology model is managed by Vision Products which is part of RCTCBC and employs a large cohort of staff who have disabilities/health conditions. This meant that during the first lockdown there were a number of individuals who were required to shield. In recognizing the importance of a timely installation of equipment to safeguard vulnerable individuals training was provided to a wide range of staff within Short Term Intervention services in order to maintain installs. During the first lockdown staff were called upon on numerous occasions to support with installs due to shielding and isolation periods of the traditional installers.

As part of the Adult Social Care Assessment and Care and Support planning process all Care and Support plans were reviewed for their level of resilience to support individuals in their own homes should service provision be affected by the Covid levels in the community.

All Care and Support plans were given a Red, Amber and Green (RAG) status based upon their level of risk, due to the additionality of the Mobile Responder service the offer of a Lifeline along with other telecare equipment was added as an alternative to service provision in the event of impact upon core service provision.

The installation element of the Assistive Technology model is managed by Vision Products which is part of RCTCBC and employs a large cohort of staff who have disabilities/health conditions. This meant that during the first lockdown there were a number of individuals who were required to shield. In recognizing the importance of a timely installation of equipment to safeguard vulnerable individuals training was provided to a wide range of staff within Short Term Intervention services in order to maintain installs. During the first lockdown staff were called upon on numerous occasions to support with installs due to shielding and isolation periods of the traditional installers.

Whilst the option of Assistive Technology would have existed without the Mobile Responder service, the alarm centre would have been required to divert requests to other emergency services such as the Welsh Ambulance Service which would have placed social care demands on an already stretched provision who were responding to the pandemic.

RQ13. What impact have any changes to governance processes and procedures had on the delivery of outcomes?
Despite the Operational group not meeting regularly during lockdown periods, the Programme Manager has maintained regular contact with partners on all developments. Budgets and any slippage requests have been monitored and resources used to best effect, by consulting with partners as and when necessary. The Programme Manager has also maintained regular contact with the Stay Well in Your Community Programme Group.

As a result, the delivery of the project outcomes remains unchanged with the full service operational and anticipated to continue.

5.6 Cost benefit

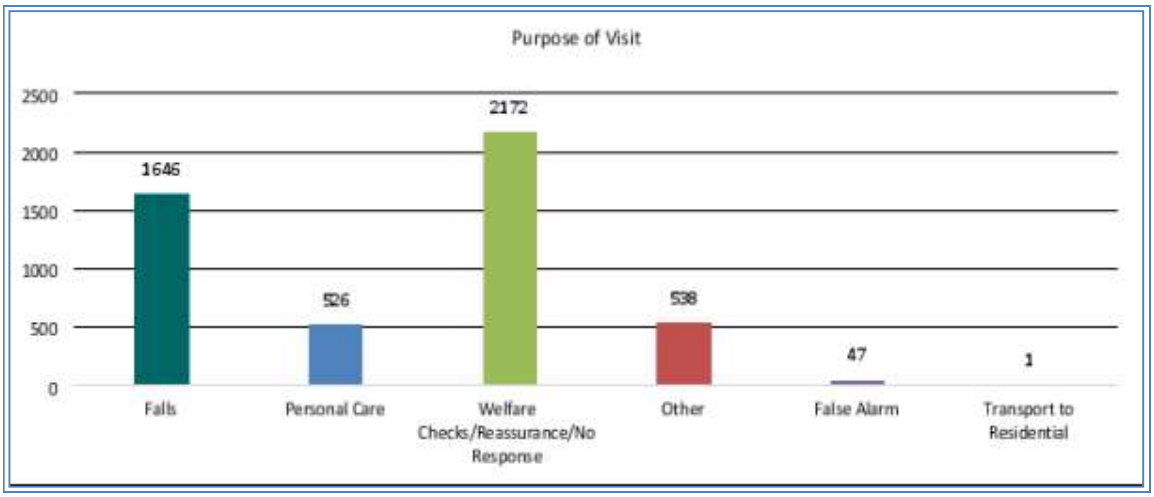
RQ14. Has the TF resulted in any return on investment / financial savings / improved citizen outcomes?
In terms of return on investment, there are major savings being made through cost avoidance as a result of the Mobile Responder interventions which divert from the call-out of ambulance, conveyance to hospital and in-patient stays; during the first two quarters of reporting to Welsh Government (Qtr 2 and 3 20/21) 1,734 conveyances to hospital were avoided because of the intervention of the Mobile Responders. Assuming that these people would have been conveyed to hospital via ambulance, using costing provided by the Welsh Ambulance Service, that itself amounts to a cost avoidance of £393,075.

Where an individual is taken to hospital, Cwm Taf Morgannwg UHB estimates that for someone who attends an A&E department and receives the lowest level of investigation and treatment the average cost is around £95.72. Therefore, with 1,734 admissions avoided during Q2 and 3 of 20/21 the minimum cost avoidance from the service is estimated to be £165,978.

It is also important to consider that during this time period hospitals were facing unprecedented pressure with the emerging Covid pandemic and the impact of a potential reduction in demand on the Welsh Ambulance Service and A&E departments facilitated by the Assistive Technology model was unlikely to have been immediately evident to these services. However, in evaluating the impact of the Assistive Technology model recognition must be given to how these 1,734 avoidance cases would have been a significant additional pressure during Q2 and Q3 of 20/21.

Responder Data

In addition to the data reported for Q2 and Q3 for the purposes of the RBA, operational data from the first 12 months of operation shows that the Mobile Responders undertook 4,930 visits. There are several key reasons why a responder is requested to visit, with a breakdown given below:



Purpose of Visit	% of all Calls
Falls	33.4%
Personal Care	10.6%
Welfare Check/No Response	43.1%
Other (Reposition/test equipment/care calls/NHS shielding)	11%
False Alarm	0.9%
Transport to Care Home	0.02%

The latest feedback gathered from the user surveys in Quarter 3 20/21 indicates improved outcomes for citizens:

- 100 % of carers felt supported in their caring role by receiving services.

- 100 % of service users rated the service received as 'Good' or 'Excellent'.
- 100 % carers rated the service received as 'Good' or 'Excellent'.
- 100% of service users service felt treated with dignity and respect.

The information gathered by the Mobile Responders when they undertake their visits is recorded on the WCCIS system and a record of visits is available for Care Managers to utilize when undertaking assessments to inform the care and support planning process.

Managers of the Mobile Responder service have also coordinated multi-disciplinary team meetings and produced reports on individuals who are 'frequent flyers' to the Mobile Responder Service; as the following case study demonstrates, this has resulted in the managers working with Care Managers to achieve better outcomes for individuals:

Case Study 5

Mrs C was frequently triggering her alarm during the early hours which resulted in either paramedic attendance or a call out to the Mobile Responders. Mrs C had previously suffered a stroke and had limited communication in order to advise the monitoring centre on the need for the alarm trigger. Mrs C was in receipt of a large package of domiciliary care and on the face value of the number of call outs, the assessment from Care Management was recommending a residential home admission as 24-hour care was required. Through utilizing the feedback from the Mobile Responders, managers within the service were able to suggest alternative considerations including:

- Review of pain medication by GP to ensure a slow pain relied medication was considered to support Mrs C from her last evening call until the morning.
- Mrs C enjoyed the TV and radio during the daytime; when awake in the evening she did not have access to these. As a result, the Social Worker arranged for Mrs C's family to install a TV in the bedroom.
- Night mobile call commissioned to support Mrs C with her toileting need during the evening.
- Closed questions given to the Lifeline Monitoring Centre to help establish Mrs C's needs better at the point the alarm was triggered, as Mrs C could answer 'yes' or 'no'.
- Mrs C was missing family visits due to the Covid pandemic and therefore a referral was made to the Community Resilience support provided by the Local Authority in order to provide socialization during the lockdown period.

As a result of this intervention Mrs C was able to stay in her sheltered accommodation and a residential admission was not required. Call outs to the Welsh Ambulance Service, estimated at a cost of £6,000 for the month of January 2020, and to the Mobile Responder reduced by 75%.

RQ15. How has the utilisation of TF funding alongside other resources e.g. ICF, core budget, Covid-19 emergency funding resulted in better outcomes?
Much of this question is covered in responses to previous questions above. The foundation for the transformation was already in place because of significant local authority investment in its core services. The development of the Assistive Technology model is a positive move towards integrating health and social care, and in considering its effectiveness within the context of preventative services and hospital avoidance.

The extension of the Transformational grant for an additional year has provided the opportunity to provide a longer period of evaluation in which to evidence the true impact of transformational change, during what will hopefully be a more stable period for the whole of the health and social care services.

The key element in ensuring the ongoing positive impact of the model is the continuation of the Mobile Responder service. What sets its impact apart from most other Responder Services in other regions is:

- the alignment with the in-house domiciliary care function;
- the knowledge and experience within the management of this service;
- the range of services that the Responder service can access in a timely manner;
- the variation in the role to respond to other social care emergencies, where individuals do not have a lifeline but are reported to social care

5.7 Outcomes and Impacts

RQ16. What evidence do you have of changes to the baseline/original position of the funded projects?
Due to the nature of this development and the introduction of new components of service, there is clear evidence of the impact of the introduction of the Mobile Responder service and the impact upon hospital conveyance.

Due to the delays in the Wellbeing assessments and proactive calling being introduced, the evidence base is limited. However, there are positive results produced in Q3 with nearly a quarter of calls managed within the system being 'proactive'.

See also response to question18 below.

RQ17. What are the key outcomes achieved by the TF funded projects?
The Assistive Technology model adopted offers an opportunity to work with partner agencies to support the health and social care model in the region to ensure that support can be provided in an individual's home in a timely manner, through ensuring robust processes and teams providing a trusted alternative to ambulance attendance and conveyance to A&E.

In addition to the robust response, the model seeks to 'future proof' demand on resources through the proactive approach of wellbeing assessments and proactive calling, developed processes with established health and social care models of practice that support the preventative agenda through monitoring wellbeing calls that maintain regular contact with individuals that can trigger an intervention before a person hits the requirements for a crisis intervention.

The main outcomes the project seeks to achieve are:

- More people will receive care or support in their own homes and fewer admitted to hospital
- Emergency departments more able to meet demand in a timely manner
- WAST callouts will be avoided and able to meet other continuing demands upon their service supported to not convey people to hospital
- Individuals will benefit from a holistic response, when required, following an intervention of the Mobile Responders
- More people will have a positive experience of using services and feel they have been supported and treated with dignity and respect.
- Carers feel supported in their caring role
- More people will maintain independence for longer and be able to live safely at home
- People with be provide with technology equipment suited to their individual needs
- People will be provided with a key safe to allow easy swift access to property
- People will be provided with a wellbeing assessment
- People will be provided with proactive outbound telephone contact on a regular basis to prevent crisis intervention
- Increase in individual provided with a rightsized care and support package

In addition to the data captured in the RBA reporting, the case study below illustrates the outcomes that have been achieved within the first 12 months of the service becoming operational. Collecting further evidence of the impact in terms of outcomes will be a key focus in our evaluation efforts over this next period:

Case Study 6

Age: *80+ years,* ***Living Arrangement:*** *Lives alone,* ***Time of call:*** *weekend at 8:23am*

Responders attended property after alarm being triggered with no response. Upon arrival, responders found Mrs A, who is blind, had fallen and was on the bedroom floor.

Responder staff carried out the I-stumble risk assessment and established that Mrs A had not sustained any injuries, they proceeded to help Mrs A from the floor using the specialist equipment and ensured she was safe and well. Following their observations and discussions with Mrs A's sister, felt that due to being so unsteady on her feet and the risk of further falls, more regular, ongoing help was required to assist Mrs A with performing daily tasks.

Mobile Responders made a referral directly to the StayWell@Home2 Out of Hours Single Point of Access (SPA), as the call was completed on a Saturday, who in turn proceeded with completing a 'What Matters' conversation with Mrs A over the telephone, within 1hr of the responders visit. The outcome agreed was for Mrs A to commence with an Intermediate Care and Rehabilitation programme to help her

perform the essential tasks during her morning routine, such as washing, dressing and preparing breakfast.

Following this intervention an ongoing service was commissioned for Mrs A as it became apparent that she had not been managing for a long period of time, if this had not been addressed by the Responders with an onward referral Mrs A may have hit crisis which could have potentially resulted in an admission and a more costly social care intervention.

RQ18. What evidence do you have of the difference made/impacts achieved by the TF funded project?

The RBA card completed for the programme which covers Q2 and Q3 of 2020/21 demonstrates that the Mobile Responder element of the service has had an immediate and significant impact upon ambulance avoidance and hospital conveyance, with 1,883 calls to emergency services and 1,734 conveyances to hospital avoided during this period.

The RBA report card will be developed further in Q4 to take account of the wider service model and its contribution to the success of the enhanced elements.

Also, the impact of this service contributes to the wider Stay Well in Your Community strategic aims and objectives. Notably the rapid response provided and the ability to meet emerging demands, for example more recently the night Responder team has been called upon by the Out of Hours GP service to help facilitate video consultation process for mutually known individuals. We understand that there are further discussions to be undertake before any further developments can progress in this area.

RQ19. How can outcomes, impacts and financial sustainability be achieved post March 2022?

The programme would not have been able to progress at this pace and scale without the Transformation Fund. The core elements of the model focus upon the avoidance of crisis intervention and demonstrate evidence of successful interventions which prevents hospital admissions.

The Assistive Technology model in RCT has seen an existing approach (pendants and lifeline monitoring centre) developed to include further proactive and reactive approaches. The existing approach is primarily funded from core budgets and income generated from a £2.85 a week flat rate charge which is allowed under the Social Services and Well-being Act Wales (2014).

The investment of the Transformation Fund has allowed the Mobile Responder Service, Well-being Assessments and Proactive calling to be developed and introduced without users of the service incurring increased weekly charges.

Whilst RCT recognises that increasing the flat rate charge that can be applied to preventative services can generate income to sustain the level of service offered, the Local Authority has responsibility to ensure the affordability of any preventative service it offers – Social Services and Well-being Act Wales (2014), Part 2 Code of Practice (General Functions) – Page 45:

> *'A local authority **must** consider both the level of the flat rate charge it proposes to make, and its potential financial effect on the person required to pay. Local authorities should avoid a situation where the flat rate charge they set discourages take up of the preventative services and therefore inhibits the local authority's ability to achieve the purposes of section 15 of the Act as set out in paragraph 148.'*[5]

Should the Local Authority seek to cover the costs of the Transformation Funded elements through increasing the weekly costs, the weekly flat rate would need to increase by 426% to cover the costs of the service – this increase is clearly not in the spirit of Social Services and Wellbeing Act 2014 and is likely to have an adverse effect on service take up.

Any changes to the charging strategy for Assistive Technology will also be subject to local Political decision making via the Cabinet process and will be subject to an Equality Impact Assessment and Public Consultation.

Due to the Covid 19 pandemic the opportunity to deliver the programme over a longer period of time will provide a period of further evaluation. As further evidence becomes available upon the impact of the model partner organizations will need to consider how this project can be sustained beyond 2022. For the service to continue in its current form after March 2022 will require significant funding to be allocated to it from within the regions health and social care economy.

RQ20. What are the key lessons learned for future transformation programmes?
Where improvements are being made, focusing resources on developing and implementing quickly does pay dividends in terms of moving forward and making best use of the opportunity afforded by funding such as the Transformation Fund.

It is important to ensure that the system is easy to navigate for both professionals and citizens. The suite of projects in the Stay Well in your Community programme present transformational offers; the key challenge is to ensure that the programmes are not pursued in silos in order to offer true sustained transformational change to the health and community care model in the region.

Emerging research as we move into the 'new normal' recognises that considerable pressure will be placed on hospital waiting lists and services due to the delays caused by the pandemic response. To allow these services to regroup and return to a sense of normality; programmes that have been developed and supported as part of the Transformation Fund and have evidenced a sustainable shift to reducing demand on conveyance and admission will be critical to providing the breathing space for this to happen.

During the daily Covid-19 briefing held on the 22nd March 2021, the Health Minister acknowledged that the recovery from the pandemic *"will take a full Welsh Parliament term*[6]*"* and recognised *"we know that the waiting list is likely to expand further before*

[5] Social Services and Well-being Act Wales (2014), Part 2 Code of Practice (General Functions) – page 45
[6] Vaughan Gething, Health Minister, MS – Welsh Government Daily Covid briefing

we're out of the pandemic - that's because as I've set out in this statement, and in others that I've made, we know that our NHS can't operate at full capacity."[7]

Evidence gathered from the programme demonstrates the positive benefits of co-location with other core services in providing a response in a timely manner. Co-location of additional services could be considered as a future service development.

6 StayWell@Home2

6.1 Overview

Single Point of Access (SPA) arrangements now exist in a range of services across the UK. Whilst they do take a variety of forms and provide a 'front door' to different combinations of services, there is wide acceptance of their value in developing integrated community services. In an online resource for referrals and single points of access[8] NHS Innovation state that:

"The best access processes are:

- easy to use for members of the public, staff and partner organisations;
- responsive so that people's needs are met in a timely way;
- efficient so that they make the most of providers' resources.

These aims are best achieved through the use of a single point of access (SPA).."

They recommend that providers:

- *"Implement a single point of access across all services they are accountable for, in preparation for a future where this is implemented across providers. We suggest implementation is phased, eg. starting with urgent response and reablement services.*
- *Implement and maintain an electronic directory of services..'*

Ensuring a rapid response through a SPA can have a significant impact on hospital admissions. For example, the Sussex Community Trust Rapid Response Service[9] helped reduce by more than half the number of people who went to A&E after a fall in which they had hurt themselves but had not suffered a fracture. Also, they were able to successfully manage at home 74% of people referred, who otherwise would have been taken to hospital.

Similarly, a key characteristic of the Enhanced Rapid Response Service: Kent Community Health NHS Foundation Trust[10] was to have a Single Point of Access.

[7] Vaughan Gething, Health Minister, MS – Welsh Government Daily Covid briefing
[8] 'Referrals and single point of access', NHS Innovation, https://improvement.nhs.uk/resources/referrals-and-single-points-access/
[9] Reported in '*Avoiding A&E through Rapid Response teams and See and Treat Models - A rapid review of existing evidence',* Woodward, M., Proctor, N, 2016. October 2016, https://www.healthylondon.org/wp-content/uploads/2017/11/Rapid-review-Rapid-response-teams-and-see-and-treat-models.pdf
[10] ibid

Whilst the configuration of the services accessed was somewhat different to those in the single points of access in the Cwm Taf region (they included a consultant geriatrician, the Cwm Taf model consultant geriatrician can only be accessed the next working day) the principle of early access to services via a SPA remains key. The rapid review cited includes a number of other examples of services that incorporate a SPA operating outside of normal office hours (generally seen as a key characteristic) and have a significant effect on hospital attendance and admission.

This report draws on information obtained from an in-house review of the first 12 months performance of Stay Well@home phase 2 (SW@H2). The project builds upon previous work done in the Cwm Taf region, especially the initial Stay Well @Home project (phase 1) which focused on effective hospital discharge, and it is a further move towards integrating community health and social care services.

SW@H2 has expanded the single points of access (SPA) in Rhondda Cynon Taf (RCT) (operational 20.01.20) and Merthyr Tydfil (MT) (operational 20.07.20) and enabled the development and enhancement of a suite of response services including occupational therapy, @Home Nursing, enabling domiciliary care and provision of community equipment response, among others. SW@H2 offers an enhanced SPA with social care and health services operational 7 days a week, from 8.30 am to 8.00 pm. It also looks to provide a more transformational element that includes providing services to community health and social care professionals such as WAST, GP out of hours, Community Nursing, among others, providing them with a robust and practical alternative response to conveying people to a hospital setting.

SW@H2 aims to establish the most appropriate service within 4 hours of referral; a nursing response, enabling domiciliary care response, occupational therapy intervention, provision of community equipment as required or more frequently a combination of services. The SPA, the key conduit to accessing SW@H2 service, is part of the well-established Information, Advice and Assistance service for Adult Social Care. This means referrals also benefit from broader support and access to services which include a range of support from the third sector.

The previous gap for community out of hour's preventative services on the care pathway, highlighted by SW@H1 (a hospital based multidisciplinary teams at A & E), is now being addressed specifically during evening and weekends through the additional resources provided by Transformation Grant.

In addition to the existing teams established Performance Reports, a new reporting form has been developed in WCCIS to allow for greater and clearer analysis of the data, including service response times. This will allow for more effective monitoring of the impact of the extension of the service to cover out of hours.

6.2 Models of working

RQ1. What changes have been made to the projects during the Programme, particularly in response to Covid-19?

Stay Well@Home 2 followed on from the first phase of the initial Stay Well@Home project (which saw multidisciplinary teams being established at the local district general hospital to avoid admission). The aim of Phase 2 has been to develop access to rapid

response community services to support community professionals to avoid hospital conveyance and admission.

The planning for this project was well-advanced before the onset of the pandemic and the RCT element of the service, launched on 20.1.20, was fully operationalised by the time the pandemic had taken hold. However, the introduction of extended hours in the RCT service had to be paused twice during the last year, and implementation of the MT service was delayed, both due to the Covid-19 pandemic.

No significant changes have been made to the project model which was developed from the Phase 1 SW@H evidence base. There have, however, been a number of pauses in the full rollout of operational hours due to demand created by Covid-19.

While all services have continued to be operational throughout the pandemic there has been an impact on staffing levels. A decrease in staffing levels resulted in a pause for some of the out of hours service at two significant points during the pandemic, namely the first full lockdown April – June 20, then the introduction of track and trace leading into the second lockdown and increase in infection rates from Nov 20 – Feb 21.

The requirement for staff shielding and self-isolation, along with a change in demand for services, has at times resulted in 2020/21 seeing a refocusing of the staffing resource to meet core demand for services including supporting the corporate response to Covid-19.

Whilst the RCT service has continued throughout the pandemic, it experienced a significant change in the pattern of demand initially due to the requirement to refocus resources to meet the demand of a substantial increase in hospital discharges; as all hospitals worked to increase their capacity to focus on Covid-19 patients the demand for the RCT service shifted to hospital avoidance and support for a new cohort of people who were previously self-managing in the 'shielded' category. Accordingly, the access hours of the SPA reverted back to office-hours only (April to June) and resources were concentrated to meet demand within those periods of time. The extended hours were paused again from November to February due to the second wave of the pandemic, causing similar issues, coupled with the impact of the infection and track and trace implications on staff.

This increased pressure is not evidenced in the SW@H2 data as the route of referrals was not in line with the project outline. Rather SW@H2 resources were used to best effect for the health and social care system.

At the time of reporting, the model of SW@H2 remains unchanged and staffing levels have recovered. The extended hours have been reintroduced as staffing levels improved in RCT. MT have been able to sustain their full hours since becoming operational in July 2020 with the support of sufficient temporary staff.

The service is currently fully operational. It is anticipated this will be sustained for the future and will provide an opportunity to support further evaluation.

RQ2. What impact have any changes made to projects during the programme had upon projects ability to transform the service?

There are no changes to the model. The model and service developed remains transformative with the same expected outcomes. As described above, the only noted change has been in the ability of the service to consistently deliver the full range of operating hours during unplanned key pandemic events.

Despite the challenges presented by Covid-19, data collected in the first 6 months of operations, between January and June 2020, shows that community health professionals contacted the SPA to request support to help someone stay safe in their own home on over 200 occasions; this would have been critical in helping to address the number of people attending hospital during the first wave of the pandemic.

Initial evidence, identified through case studies and results of professional and user surveys, suggests SW@H2 is supporting people in need of a rapid response, in addition to supporting the wider health and care system, immediately and in the medium and long-term.

RQ3. What were the critical success factors in enabling transformation, particularly in response to Covid-19 challenges?

The foundation for the transformation was already in place by the time of the pandemic, with significant local authority investment into its core services and the Trusted Assessor role already established within the SPA. The Transformation Grant provided the opportunity for a further culture change in social care to 7 day working and the further developments described in the introduction above.

The following have been critical success factors in enabling successful transformation:

- Local and regional experience, knowledge and key partnership relationships gained from the phase 1 Stay Well @Home project.
- Appropriate level of investment into the project to ensure there were sufficient resources to make the changes required for the workstream to be transformational.
- Regional commitment made to dedicated programme management.
- Local commitment to recruiting permanent staff (RCT only), rather than seeking to make temporary appointments or secondments.
- Local flexibility and adaptability of the service and staff to accommodate the different circumstances and challenges that have prevailed since the pandemic began.
- Local ability to adapt to the change in community needs for people who were shielding.

Also critical to success is the timeliness and range of response services which provide an alternative to conveyance to hospital and address the preventative agenda to support people who become unwell to remain safely within their own home; the essential moving and handling issues requiring an Occupational Therapy response needs to be addressed within hours; the fitting of key safes to allow access to properties, assistive technology equipment and moving household furniture where an individual's mobility is compromised, have been essential in reducing conveyance and admissions to hospital settings.

Following a referral to the SPA, the target for assessing the situation, agreeing a response with the referrer and accessing suitable services is 4 hours. There is currently 96% compliance against this target.

***RQ4. To what extent have the Transformation Projects addressed,* the AHW Design Principles and the Well-being for Future Generations 5 ways of working (long term, integration, involvement, collaboration, prevention)?**

The StayWell@Home2 project aligns with all of the design principles set out in a 'Healthier Wales'; it particularly relates to *prevention and early intervention* by seeking to avoid hospital admissions through activity in the community and to *independence* by working to keep people in their own homes and communities.

It achieves this with some innovative service solutions; for example, Vision Products (The equipment provider) being able to also move furniture in a person's home to facilitate the provision of enabling service delivery e.g. if a person cannot get the enabling equipment (perching stools, return aids etc.) into their home, due to their furniture being a barrier, then they would not be able to receive a service. SW@H2 offers a holistic approach to enabling good outcomes for individuals while supporting the health and care system through hospital avoidance.

The project builds upon the principles, including *safety* and *independence* and delivery of a *seamless service* along with the *integration* of health and social care services. Specifically, the project addresses the Welsh Government Design Principles in the following ways:

- Being part of a whole system transformation, the Cwm Taf Region Stay Well in Your Community programme and linking with the Assistive Technology and Community Health and Well Being teams workstreams to provide an improved community response supports the moved towards *seamless* services.
- Supporting the hospital avoidance agenda by reducing the need to convey to hospital and to maintain individuals' *safety* at home.

The project employs the philosophy of Prudent Healthcare by:

- providing an assessment of a person's situation before they are conveyed to hospital to see if community services can provide a more appropriate response;
- better use of resources;
- better outcomes for the individual;
- better outcomes for professionals.

The project addresses the Well-being for Future Generations 'five ways of working' in the following ways:

- Long term improvement in individuals' wellbeing – longer term improvement of service provision closer to home.
- Integration – closer working with other community professionals and services providing individuals with a more joined up approach.

- Collaboration – with individuals, communities and professionals; providing a point of access for professionals to draw on a whole range of support services at short notice and in a timely fashion.
- Involvement – of communities, individuals, professionals and services; the communication plan for the project involved meeting with all referrer groups to ensure good engagement, clear pathways and a whole system approach.
- Prevention – forms a key part of preventative services using enabling approach; the focus is upon supporting people to keep them in the community and to avoid admission to hospital.

The new model also demonstrates a shift to preventative services through:

- earlier access to enabling and preventative services including OT assessment and Reablement programmes of support
- provision of equipment necessary for a person to remain safely at home
- access to assistive technology
- medication reviews – to look at alternatives to achieve the outcome of gaining independence to administer medication.

RQ 5. To what extent can the Transformation Projects demonstrate a sustained shift to preventative services?

The SW@H2 development, as part of the Cwm Taf Region Stay Well in Your Community whole system model, firmly places the service as the main preventative response for community health and social care professionals to support people to stay at home out of hours. It signifies a major shift of emphasis out of hours into preventative community health and social care services.

Phase 1 of the Stay Well @Home model is made up of integrated multidisciplinary teams, working at A & E to prevent any unnecessary admissions along with a "discharge to assess" model to identify people earlier in their hospital journey who could be better supported at home. Phase 2 extends this provision to those people who have not yet been conveyed to hospital from the community. It provides a SPA response to referrals from community health and social care professionals 365 days a year from 8.30am to 8.00pm.

The service ensures that people in the community get the right response when they need it, without the need for multiple assessments, and in a timely way. Prior to the implementation of phase 2, social care was only available to community professionals from Mon-Fri 8:30am-5pm (not including bank holidays). Outside of these hours, if individuals had social care needs, they were frequently taken unnecessarily to hospital.

The initial assessment is supported by a range of enabling, preventative and rapid response services including:

- CTMUHB @Home Nursing Team for community nurse response (consultant geriatrician in hours).
- RCT/MT Reablement and enabling domiciliary care and care and support services.
- Occupational Therapy – assessment, moving and handling assessment and plan, the provision of small equipment.

- Vision Products - provision of larger piece of equipment both in and out of hours, moving of furniture, fitting of a key safe etc.
- Access to 3 step-up beds in a residential care home (RCT only).
- Mobile Responders (Assistive Technology programme RCT only).
- Your Medicines @Home Team for a review of medication leading to medication management plans (in hours).

RQ6. To what extent can the Transformation Projects demonstrate scale-up, particularly in response to Covid-19 challenges?

Evidence from phase 1 of the Stay Well @Home project identified the need for a community response 7 days a week, including outside of core hours, to provide an alternative to conveyance to hospital. Phase 2 represents the scale up and development of this service from evidence gathered during phase 1 to ensure people receive the timely support they need to help them avoid unnecessary conveyance and hospital admissions.

Also, the service was implemented in two phases, the RCT service going live in January 2020, with the MT service following in July 2020 following delays caused by recruitment problems and Covid-19.

Whilst the service continued operational delivery during Covid-19, the change in the pattern of demand for the services was significant at the outset of the pandemic. Because of this there was a reduction in the number of referrals from health professionals as people sought to avoid contact with those from outside of their own household. However, there did emerge a need to support a new cohort of people who were in the 'shielded' category, who normally might not have needed support, resulting in resources being concentrated to meet this demand. This was replicated during the second wave of the virus.

As the need for Covid-related services has reduced, more normal patterns of demand are re-emerging, but with an anticipated high volume of referrals as people (and carers) who have sought to 'manage' during the pandemic period now approach services, frequently presenting as in "crisis". Both RCT and MT services are now fully operational, both within core and out of office hours.

RQ7.What were the critical success factors in enabling scaling, particularly in response to Covid-19 impacts on services?

Overall, Covid-19 had a delaying effect upon the workstream and altered the patterns of both demand and referrals as people sought to limit the numbers of people (including professionals) entering their home. A number of critical success factors have enabled the scaling up of this service during these challenging times:

- Having dedicated programme staff to retain project oversight, even during lockdown' periods of the pandemic, and provide the critical link with the Cwm Taf Region Stay Well in Your Community whole system model.
- Integrated working across health and social care has been critical to ensuring a whole system response to the pandemic, especially during periods of increased demand and during the lockdowns.

- Whole system community services working to support hospital discharges and hospital avoidance have been essential to relieve some of the pressures on acute hospital services as a result of the pandemic.
- SW@H 2 successfully responded to the reduced staffing levels and refocused, as described earlier in the report, to ensure the preventative agenda remained a viable option for individuals.

It is anticipated that there will be an increase in demand on preventative services, such as Reablement, as people come forward for support in the following circumstances:

- Have been avoiding contact with those from outside of their own household (both the service user and carer) and as such did not previously seek the support they required.
- Have paused their care and support.
- Have delayed seeking medical advice.
- Have paused their medical diagnostics or treatment.
- Are now managing long Covid 19 symptoms.

More recent data from work undertaken at WG Delivery Unit indicates that individuals and carers who have had their treatment paused, delayed accessing support, who have been shielding or are now managing long Covid will be placing greater demand on services as we move out of the pandemic.[11]

6.3 Pace of change

RQ8. How has pace of change varied as a result of responding to the Covid-19 challenge?

The pace of change in establishing the service was rapid, especially in RCT where the service was operational only 7 months after the funding was approved. However, there were then suspensions and delays caused by Covid-19 as described previously.

The service is fully operational with the full model available.

The target set for the response time for service provision of 4 hours has not changed as a timely response is critical to the success of keeping people at home. Current performance against this target is excellent with 96% of referrals being responded to within 4 hours.

RQ9. What barriers have you faced in your attempts to achieve transformation change? How could these have been mitigated?

Clearly the onset of the pandemic impacted upon the roll-out of the new services. The full operation of the RCT service was suspended during the first wave of Covid-19 and the implementation of the MT service was delayed by 3 months. Staffing levels were also reduced at times due to shielding, track and trace and pandemic infection rates. Out of hours working for some of the 1st year of operations was adjusted as described earlier in the report and therefore there is less data than anticipated for the first-year evaluation.

[11] Rehabilitation needs of people affected by the impact of Covid-19, Welsh Government, 17th June 2020

However, experience of the first two waves of Covid, particularly in relation to pressure on hospitals and shielding, have led to a number of measures being taken and guidelines introduced that will equip us well should we need to respond to a 3rd wave:

- All staff have now had the opportunity to have two doses of the vaccination.
- Lateral flow tests are undertaken by response services such as enabling domicillary care and OT.
- All professional meetings, updates and marketing of the service are now undertaken online via “teams” meetings.
- A “safe” Covid 19 friendly office space is available for operational staff who cannot undertake duties at home.
- Operationally, electronic systems are used for assessments and any resulting referrals, and to provide information for reporting and evaluation.

The extension of the Transformation Grant funding will provide the opportunity to evaluate the project over a longer period of time which will go some way to mitigate the impact of the pandemic on evaluation.

6.4 Engagement

RQ10. To what extent has the workforce and citizens contributed to the ongoing development of TF projects?

The need for this service was established following the citizen consultation carried out during Stay Well@Home phase 1, and as part of the wider consultation for the Older People’s Statement of Intent and Joint Commissioning Statement for Older People’s Services 2015-25. It was always intended that the Stay Well@Home model would have a phased approach to being rolled out, and the need for this was confirmed by the consultation.

Referring professionals and staff working in the response services were regularly communicated with both during the implementation phase and after the model went live, via the Operational Project Board and scheduled review meetings.

Involvement with the third sector was initially limited by the impact of Covid-19, although there was contact with representatives from Interlink in RCT and VAMT in Merthyr Tydfil prior to full implementation.

Third sector and partner agencies such as the Community Co-ordinator had already established referral pathways with SPA prior to the SW@H2 model.

All partner agencies, via their referral professionals, are invited to undertake a survey to provide feedback on their experience; this includes the opportunity to comment on any proposed service developments or changes. All surveys are scrutinised and form part of the overall evaluation process. This process remains ongoing.

Surveys are also provided to service users and their carers to ensure they can feedback immediately on their experience.

It is the intention to formally survey staff annually. This will be taking place during March 2021 and will provide feedback on how staff feel about the services that they work in and the change in their working patterns.

RQ11. What behaviour changes within staff/citizens have occurred as a result of these projects?

The successful implementation of the model has resulted in a growing confidence from professionals in the delivery of the service, and its place in the Cwm Taf Region Stay Well in Your Community whole system model. This has been evident through surveys and anecdotally.

It is anticipated that, as more service users are supported to remain at home with the appropriate support, their confidence to self-manage will grow. Feedback gained so far from professionals who have referred, as evidenced in the comments above, illustrates that services are well received.

Colleagues across the wider adult social care service are now more supported when working at the end of the day in situations that take them outside of their core working hours, as there is now support available and access to rapid response services via the extended opening hours of the SPA.

RCT made a commitment to employing staff with permanent contracts to ensure the success of the cultural change that the SW@H2 programme seeks to bring about. This involved a 'Management of Change' process with existing staff to enable a change to their contracts to reflect the move to working across 7 days. Whilst everyone agreed with the ethos of the model, the change to traditional working patterns was a concern to some initially, but through consultation both in groups and 1:1, staff reported that they understood the need for the service to benefit the individuals they work with and appreciated the investment in services to build extra capacity. This resulted in all staff signing their new contracts without any delay to the target date for the programme to start.

The staff survey taking place during March 2021 will provide feedback on how staff feel about the services that they work in and the change in their working patterns.

6.5 Governance

The SW@H2 project is overseen by an Operational Group, chaired by the Programme Manager and attended by representatives from all partner agencies and services involved in the model. The group met monthly through implementation and operationalizing the model, until the pandemic. At this point, attendance for some services became difficult due to the demand and group met less frequently as a result. However, monthly meetings are now being re-established. A WASPI and memorandums of understanding are in place with partner agencies.

To ensure Covid-19 guidelines are adhered to, all professional meetings, updates and marketing of the service are now undertaken online via "teams" meetings.

A "safe" Covid 19 friendly office space is available for operational staff who cannot undertake duties at home. Operationally, electronic systems are used for assessments and any resulting referrals, and to provide information for reporting and evaluation.

The @Home Nursing service redeployed staff to meet demand in other areas such as Community Nursing and community Outreach for the Care of the Elderly Team who were not able to see their patients in a hospital outpatients clinic setting. However, they still maintained a response element available to SPA throughout.

Vision Products, which employs a large cohort of staff with disabilities/health conditions who were unable to attend work, undertook significant planning to implement new systems of work and to be able to carry on providing an equipment service. They also had to pause their out of hours response during the first lockdown and were able to recommence this at the beginning of August 2020.

All front-line social care response services continue to be functional in the community during the pandemic, undertaking home visits, delivering equipment etc. in line with Welsh Government Covid 19 guidelines.

RQ13. I'm What impact have any changes to governance processes and procedures had on the delivery of outcomes?
Despite the Operational group not meeting regularly during lockdown periods, budgets and any slippage have still been monitored and resources used to best effect, by consulting with partners as and when necessary. As a result, the delivery of the project outcomes remains unchanged with the full service operational and anticipated to continue.

6.6 Cost Benefit

RQ14. Has the TF resulted in any return on investment / financial savings / improved citizen outcomes?
In terms of return on investment, there are major savings being made through prevention; avoiding the call-out of ambulance, conveyance to hospital and in-patient stays.

For example, the programme has reported that during the first two quarters (Qtr 2 and Q3, 20/21) 230 conveyances to hospital were avoided because of the Stay Well@home2 service. Assuming that these people would have been conveyed to hospital via ambulance, using costing provided by the Kings Fund[12] that itself amounts to a saving of £57,960 ambulance costs alone.

Where people are taken to hospital, the King's Fund[13] estimates that the average cost for someone who attends an urgent care centre and receives the lowest level of investigation and treatment is around £45. For an individual at a major A&E department who receives more complex investigation and treatment, the average cost is estimated at around £400. Therefore, with 230 admissions avoided so far, the minimum saving from the service is estimated to be £10,350 (Urgent Care costs) and up to £92,000 (A & E costs). It is reasonable to expect that these figures can perhaps be doubled in a full year.

[12] 'Facts and Figures about the NHS' Kings Fund, 2019, https://www.kingsfund.org.uk/audio-video/key-facts-figures-nhs
[13] 'Facts and Figures about the NHS' Kings Fund, 2019, https://www.kingsfund.org.uk/audio-video/key-facts-figures-nhs

The cost avoidance (or reductions in pressure, monetised) in this restricted six-month period could be anything up to £149,960 (£299,920 for a full year). This excludes the costs of any in-patient bed-days saved (at a cost of £158 per day). These are of course speculative figures based on limited data, and further analysis after a period of full delivery is really needed to establish impact of the service.

It is also important to consider that, during this time period, hospitals were facing unprecedented pressure with the emerging impact of the Covid pandemic, and so the impact of a potential reduction in attendance facilitated by the SW@H2 model was unlikely to have been immediately evident to hospital services. However, in evaluating, recognition should be given to how these 230 avoidance cases would have been a significant additional pressure.

The latest feedback gathered from the user surveys in Quarter 3 20/21 indicates improved outcomes for citizens:

- 86 % of carers felt supported in their caring role by receiving services.
- 91% of people felt that services had helped them manage their situation at the time of referral.
- 86% carers rated the service received as 'Good' or 'Excellent'.
- 96% of service users service felt treated with dignity and respect.

RQ15. How has the utilisation of TF funding alongside other resources e.g. ICF, core budget, Covid-19 emergency funding resulted in better outcomes?
As discussed above, the foundation for the transformation via this programme was already in place as a result of significant local authority investment in its core services, via core budgets and ICF, which were able to support the additional transformational element.

Despite the challenges presented by Covid-19, data collected in the first two quarters shows that community health professionals contacted the SPA to request support which helped 230 people to remain safe in their own homes and avoid conveyances to hospital.

This transformation has resulted in better outcomes for both professionals and citizen's using its services, as evidenced by quantitative and qualitative data available through surveys described in question 10 and case studies in question 17.

The following are examples of comments taken from a range of professional and citizen surveys:

- **District nurse** *"Massive help to DN's who are not always office based - great that you can just ring and provide contact details over phone, no paperwork - huge help and time saver."*
- **WAST** *"The service was excellent and stopped us having to take the patient to hospital via ambulance."*
- **GP** *"The new service makes such a difference. My patient had clear needs and the service stopped the hospital admission. There is a clear need for this service, and it makes sense it has been established. It's wonderful."*

- **Service user** *"I couldn't believe that the GP was here at half past six, and the carers were here by eight o'clock. The service was fantastic, and I felt well looked after. It was service with a smile and the OT was amazing."*
- **Service user** *"Without your help I would have definitely had to go into hospital. The carers are marvellous".*
- **Carer** *"The care was very efficient and very quick. He should have gone in with the ambulance but wanted to stay home. The care made sure he was safe."*
- **Carer** *"We both felt that it was a very helpful service. He has dementia but they still treated him respectfully and made him feel valued."*

The latest feedback gathered from the user surveys in Quarter 3 20/21 indicates that:

- 86 % of carers felt supported in their caring role by receiving services;
- 91% of people felt that services had helped them manage their situation at the time of referral;
- 86% carers rated the service received as 'Good' or 'Excellent';
- 96% of service users service felt treated with dignity and respect.

It is anticipated that, as more service users are supported to remain at home with the appropriate support, their confidence to self-manage will grow. Feedback gained so far from professionals who have referred, as evidenced in the comments above, illustrates that services are well received.

6.7 Outcomes and Impacts

RQ16. What evidence do you have of changes to the baseline/original position of the funded projects?
Due to the nature of this development, there is the factual evidence of extended operating hours of service which is providing access for community professionals and a cohort of people who would otherwise have been conveyed to a hospital setting. Information that could be used here is perhaps more directly relevant to question 18 and so we would refer you there.

RQ17. What are the key outcomes achieved by the TF funded projects?
Heath, social care and partner agencies working together effectively, with efficient processes are all underpinning principles to this transformational approach. As are respecting other professionals, listening to people themselves, building on their strengths and assets and responding quickly, getting it right first time which is considered better for people and services.
The main outcomes the project has sought to achieve are listed below:

- More people will receive care or support in their own homes and fewer admitted to hospital.
- More people will have access to enabling services when they need it.
- More Community Professionals will have rapid access to quality community support for individual.
- More people will have a positive experience of using services and feel they have been supported and treated with dignity and respect.

- Carers feel supported in their caring role, and the burden of caring will be shared due to appropriate services being provided.
- More people will feel supported to live the lives they choose/achieve what matters most to them?
- More people will feel confident about taking steps to maintain and improve their own health & wellbeing.
- More people will maintain independence for longer and be able to live safely at home.

Data provided via the RBA card and the case studies included below illustrate the impact of the workstream on outcomes; collecting further evidence in relation to the outcomes listed above will be a key focus in our evaluation efforts over this next 12 months:

Case study 7

The SPA received a telephone call one afternoon from the Welsh Ambulance Service (WAST) which had responded to a 999 call from a 94-year-old who lived alone with no formal care services, walks with the aid of a Zimmer frame, and who was feeling very weak, nauseous and was experiencing some issues with their chest. The paramedic from WAST suspected a chest infection and was waiting for the GP to arrive, who subsequently confirmed that it was a chest infection and that the person also had other health conditions and had not been taking their medication. The GP prescribed antibiotics and anti-nausea medication which the patient's family would make sure was taken as needed. However, they were not able to help with any care and at that point the person was very weak, not eating well and struggling to move about the house. The GP relayed to SPA that under normal circumstances he would admit this person to hospital but was reluctant to do that due to the risk of the person contracting COVID and they would be at high risk from the infection. Within three hours of the beginning of the initial phone call with WAST, the following had been implemented:

- SPA conducted the necessary assessments with WAST, GP and the person's family
- An OT visited the house, provided sofa raisers to aid the person's transfers and a mobile commode to help them avoid struggling to get to the bathroom.
- A package of care and support four times a day was requested and began that evening.
- A keysafe to allow access to the property was ordered.
- Installation of the Lifeline system was ordered. This would then mean that the person could summon help such as the RCT Mobile Responder service if required.

The outcome was the person avoided going into hospital and recovered enough from the chest infection to leave services independently seven weeks later, after receiving an enabling package of support from intermediate care, following the initial two-week recovery period.

Case study 8

The SPA received a telephone call late in the afternoon from a GP requesting a package of support for a 78-year-old who had a urinary tract infection. The person was very unwell and not able to get up and move about by themselves and the GP was considering admitting the person to hospital. There was already an existing privately arranged care provider involved for the purpose of medication administration. The GP prescribed antibiotics which it was agreed that the care provider would also make sure the person would take as required. Within two and half hours of the beginning of the initial phone call with the GP:

- *SPA conducted the necessary assessments with GP and family involvement*
- *An OT visited the house and provided equipment to aid the care package to support the person to transfer and also a mobile commode.*
- *A package of care and support was arranged for four times a day as requested – this began the same evening.*
- *Vision Products visited the house that evening to bring the person's bed downstairs*

The outcome was the person avoided going into hospital and at the two-week review they were able to move around with only the use of a stick and the care package was reduced.

The short-term impact of the SPA is likely to be seen in the continued timeliness of the response to referrals, the 'flattening out' of demand across the week and the ability to respond quickly to identified needs. This should relieve pressure in other parts of the system. At the same time, should there be a further surge in Covid-19 cases the SPA will continue to have systems and processes in place to provide a flexible response tailored to the immediate needs of the public and the health and social care system.

RQ18. What evidence do you have of the difference made/impacts achieved by the TF funded projects?

Evidence for the difference made and impacts achieved by SW@H2 can be seen in the case study examples in Question 17, the RBA report, which will be further developed in Qtr 4, and the responses to the survey reports in Questions 10 and 14. Collecting further evidence in relation to the outcomes listed above will be a key focus in our evaluation efforts over this next 12 months.

In addition to the quantifiable measures and the case studies available, our evaluation will also need to take full account of the impact of the project in achieving wider strategic aims and objectives, notably its contribution to achieving wider culture change within the agencies, meeting the long-term aspirations of legislation and transforming the ways health and social care services are delivered.

In addition to the figures reported for SW@H2 which only reflect community health and professional referrals, there also needs to be recognition that SPA is, as previously mentioned, the IAA service for Adult Social Care and is therefore the access point for all community referrals from the public (Mon-Fri 8:30am – 5pm). As such, it should be noted that provision of further services via SPA also contribute to hospital avoidances

since Trusted Assessors can access the same services which are provided to health and social care referrals in response to urgent requests. To reflect this wider context the overall SPA referrals will be included in the RBA ongoing from Quarter 4 onwards. Shown below are the total number of assessments undertaken by SPA (from all referral sources including health and social care professionals) during the same period as RBA reporting for SW@H2 so far.

Qtr 2 20/21	Qtr 3 20/21
1909	1,712

Again, it is important to see this project in the context of the wider whole system approach that the Cwm Taf Stay Well in Your Community programme has taken in addressing the preventative agenda, and the impact as a result of the links built between the projects. The interdependence between SW@H2 and the Mobile Responder service established as part of the Assistive Technology programme illustrates this well.

The Mobile Responder service is a referrer into and a response element of SW@H2. Mobile responders can assess someone who has fallen using the training they have had from WAST in the "i-stumble" model which frequently avoids the need to call an ambulance. They then assess if the person needs further support and if so will refer to SPA to access services via the SW@H2 model. In addition to this SPA can call on the Mobile Responder service to help avoid a conveyance to hospital but providing support such as transporting a person to a step-up bed, undertake welfare checks and deliver small pieces of equipment or an emergency food parcel.

The following case study illustrates this:

Case Study 9

Mobile Responders were alerted, one Sunday afternoon, via the lifeline system, to call to a 95 year old person, living alone, who was having severe mobility issues and was very upset as they couldn't get into bed. The Mobile Responders identified that the person was at high risk of falling and with the person's consent, contacted SPA to request support to manage the risks identified.

The SPA Advisor had a' what matters conversation' with the person in order to understand the current situation, and agree the outcomes the person wanted to achieve. Within two hours of the initial referral from the Mobile Responders, SPA had sourced a package of enabling domiciliary care which started that evening. If the SW@H2 or Mobile Responder services (as part of the AT programme) had not been developed then this person would have had to contact community health professionals (WAST and/or Out of Hours GP) which may have resulted in a conveyance to hospital in the absence of access to community services on the weekend.

The multidisciplinary nature of the SW@H2 has fostered a practical, 'can do' approach and a sense of shared responsibility for ensuring better outcomes for individuals.

RQ19. How can outcomes, impacts and financial sustainability be achieved post March 2022?

This project would not have been possible without the Transformation grant. Its role in effective prevention and early intervention means that there are rapid response services in place along the care pathway and across the whole prevention spectrum.

SW@H2 plays a specific role in this respect by intervening at a stage where people are entering the system in a "crisis" environment i.e. an assessment and services are required to support the person to avoid conveyance and admission to hospital. It therefore clearly contributes to the prevention of unnecessary hospital admissions, but its overall contribution to the prevention agenda needs to be considered more widely and measured alongside other interventions on the care pathway.

Though many services similar in nature to SW@H2 frequently acquire funding or support looking to produce potential cost savings, some research evidence suggests that once evaluated, cost savings were visible. This was evident in the Gwent Frailty project, the Southwark and Lambeth Integrated Care Service, and the projects evaluated by the Nuffield Trust and Kings Fund. SW@H2 faces the same significant challenges as other integrated care projects that while trying to measure costs savings may be necessary, it may be that integrated care programmes cannot produce tangible cost savings however the project development provides the best outcome for the individual and the professionals involved and leads to an important culture change.

Due to the Covid-19 pandemic the opportunity to deliver the project over a longer period of time will provide a period of further evaluation. As information becomes available partner organisations will need to consider how this project can be sustained beyond 2022. This will need to be through the re-direction of funds from elsewhere.

RQ20. What are the key lessons learned for future transformation programmes?

Continuing development is needed in respect of education and learning for all staff and partners to enable a sustained culture shift that ensures all community service options are considered in the first instance to avoid people being inappropriately conveyed or admitted to hospital.

As demand for services continues to grow, and the move to more community based preventive services continue, there is a need to ensure services, including nursing, pharmacy, Reablement and domiciliary care services, are sufficiently robust and sustainable to respond to inevitable pressures caused by the shift to hospital avoidance.

At present, older adults/adults with disabilities are the target citizen user group. In the future there could be consideration as to how the transformational community-based model can be applied across more specialist adult user groups e.g. Learning Disabilities.

Developing a holistic, and possibly longitudinal, means of evaluating the success and impact of SW@H 2 and other preventative services which include, for example,

measuring changes in organisational culture, well-being outcomes and enhancements in people's ability to exercise voice and control over their care.

7 Community Health and Wellbeing Teams

7.1 Overview

Growing evidence shows increasing demand in Wales on GP practices, both in and out of hours, on A&E and the Welsh Ambulance Service Trust (WAST). This is compounded by an increasing elderly population and the complexity of delivering efficient, sustainable services whilst managing people of all ages with acute and chronic multi-morbid conditions.

There is recognition that Cwm Taf needs to move from a system of reactive interventions to one of anticipatory care which proactively manages escalation of need through more seamless working. Understanding patient populations, groups or clusters by characteristics related to their need and use of health care resources can help Primary Care Clusters, GP Practices and the Local Authority to decide how best to use limited time and resources to deliver anticipatory and pre-emptive care for patients.

Through greater understanding about the most dependent groups of patients, the necessary interventions can be implemented through a holistic approach, pulling on the expertise of a team of multi professionals.

With this in mind, the focus of Community Health and Well-Being teams (CHWBTs) is to provide a service built around the individual's aims, supporting them to maintain independence, improve long-term health outcomes and giving them a better experience of care.

This development of Cluster focused multi-disciplinary teams is building upon the successful development of a 'Virtual Ward' approach that has been piloted in North Cynon Cluster. In that virtual ward a multi-disciplinary, anticipatory Primary Care, WAST and Third Sector approach has been taken to providing support to the top 3% of service users in a GP practice, reducing demand on general practice both in and out of hours and on A&E.

7.2 Model of working

RQ1. What changes have been made to the projects during the Programme, particularly in response to Covid-19?
Since the beginning of the programme, several factors have led to delays in the implementation of this workstream, not least the delay in the recruitment of the Programme Manager until September, at which point the service models had not yet been fully agreed. Significant preparatory work and planning was undertaken before the service could be implemented across the clusters such as workshops, recruitment, sourcing bases for the teams, laptops and equipment, procedures and policies, GDPR/data sharing agreements and more.

The above notwithstanding, the plan was to roll out all teams on a cluster-by-cluster basis between March and April 2020. However, the introduction of Covid-19 restrictions

and subsequent impact on resources led to further significant delay; in line with a directive from the Welsh Government and the requirement for all enhanced services in primary care to be suspended, the roll-out of the new teams was delayed and staff were re-deployed to work elsewhere to meet the needs created by Covid-19. (It is worth noting that, even if the services had already been up and running at this point, suspension of operations and temporary re-deployment would still have been the required response). Some staff were temporarily deployed into the Community Respiratory Hub and a Multi-Disciplinary team was set up within the Urgent Primary Care Out of hour's service to assist with the increasing new demand during the pandemic.

The roll out of services re-commenced across all clusters in RCT and Merthyr during w/c 13th July 2020.

The initial MDT model was reliant on the Population Segmentation and Risk Stratification (PSRS) workstream data which would provide targeted information around patients that fall within the top 3% at risk of poor health category. The initial aim was to fully deliver anticipatory care to this group of the population. However, the COVID 19 pandemic placed significant delays on the PSRS workstream which had a knock-on effect on the CHWBT. In response to this, the teams proactively adopted an alternative model of delivery in the interim until the segmentation workstream re-commenced. This saw a change in the way that teams would have to identify the most appropriate patients for the service, rather than being provided with the information from the offset. A key requirement whilst adopting this new model was to communicate with each GP practice and provide training and information sessions to trainee GPs so they had a greater understanding about appropriate complex patients for our service and ways to access.

We established early on that the change required provided the teams with an opportunity to deliver on the five ways of working in line with the 'The well-being of Future Generations (Wales) Act 2015 by embracing collaboration, integration, the importance of prevention and involvement.

Covid-19 placed substantial pressure on Primary Care, affecting staff accommodation and the ability to conduct team meetings face-to-face. However, the use of MS Teams and digital technology has been invaluable to maintaining regular discussions and providing community-based clinics. All CHWBT staff were provided with the electronic equipment that allowed them to continue to operate and deliver the services to patients throughout the Covid-19 period. The teams continued to conduct face-to-face home visits with patients through robust risk assessment prior to any visit, ensuring both staff and patients remained safe and limited exposure to risk. The teams were some of the only staff members to continue to provide face-to-face visits throughout the Covid-19 period.

Additionally, there has been a requirement to redeploy staff for a range of Covid-19 related activities such as vaccinations and testing.

Since then, the local CHWBTs have continued to operate and mature throughout the Covid-19 period and subsequent lockdown. At the same time, the impact of Covid-19 has been felt across the footprint through backfilling of staff shortages in community and secondary care services, in addition to absences and restricted duties for a number of

MDT staff, which has placed increasing pressure to maintain the services where demand is growing.

Even with the staffing capacity per quarter having been reduced and the cumulative staffing capacity approximation for the financial year running at 70%, the teams were able to maintain vital service delivery during this difficult period; between quarters 2 and 4 there was an increase of 69% in the total number of people accessing the CHWBT service and direct access to the professional team (total of 2,614 patients) and an increase of almost 35% in patients accessed by the MDT (total of 711 patients).

RQ2. What impact have any changes made to projects during the programme had upon the project's ability to transform the service?
Whilst Covid-19 has slowed down the implementation of this workstream and influenced the type of services needed, overall, the aims and objectives remain unchanged. This can be seen by the numbers accessing the service (total of 2,614 patients). It is still expected that there will be a transformation of the community services in each cluster, and it clear that that transformation continues to take place as the service evolves and matures.

However, it is accepted that delays experienced by another transformation workstream as a result of the pandemic will have a negative knock-on impact on the progress of the CHWB workstream; the PSRS workstream, which intends to provide details of those patients who fall within top 3% at risk of poor health. CHWBs are reliant on this information in order to fully deliver anticipatory care. How the link between these two workstreams is operationalised and made effective will be an important area for evaluation over the next 12 months and there are plans to test this in quarter 2 of 2021.

Although numbers through the service have been lower than were planned (as a result of the negative impact of the pandemic) the service was still able to deliver on The Quadruple Aim and have an impact on transformation. The team continued to collect information to evidence improved population health and well-being and access to health social care services through outcome measures for those patients being referred. Each patient undergoes two assessments to holistically review their health and social needs, once at initial contact and again at discharge. Evidence of overall improvement across all areas is illustrated in the table below. The reduction in scores shows positive impact:

			Q2	Q3	Q4	Cumulative
Professional Perspective (PCAMs)	Average difference in patient outcomes scores - **Health and Wellbeing**	**PCAMs scores -** a negative number demonstrates an overall improvement in this area	-3.18	-3.04	-2.36	-8.58
	Average difference in patient outcomes scores - **Social Environment**		-2.00	-1.42	-1.37	-4.79
	Average difference in		-0.18	-1.02	-0.03	-1.23

			Q2	Q3	Q4	Cumulative
	patient outcomes scores - **Health Literacy**					
	Average difference in patient outcomes scores - **Service Coordination**		-2.24	-1.80	-1.19	-5.23
Service User perspective (EQ5D5L / VAS)	Improved self-reported **QoL** scores	**EQ5D5L** - a negative number demonstrates a positive outcome	-1.27	-1.4	-3.21	-5.88
	Improved self-reported **health** score	**Visual Analogue Scale** - a positive number demonstrates a positive outcome	13.64%	10.70%	7.66%	32.00%

RQ3. What were the critical success factors in enabling transformation, particularly in response to Covid-19 challenges?
The critical success factors to enable transformation include:

Patient centred care
The shared vision that the patient needs should be at the heart of the service has continued to remain important to the CHWBT and any interventions should only be made in the best interests of the patient. The assessments and interventions need to be timely, flexible, responsive and 'suitable' for the patient and take into account the patient's and respective carer's perspective and experience. The intervention also should be easy for patients to navigate by having a single care co-ordinator.

Shared goals
A clear understanding of the individual roles and responsibilities and but also a shared appreciation of the overall goals and objective of the CHWBT team and the wider Stay Well in Your Community programme. Despite the Covid 19 pandemic the overall goals and objectives remain the same.

A culture of collaboration
The CHWBT need to continue to put the interests of the patient before the long-standing cultural norms or professional bias, and each team member must be prepared to work differently. This will also require other services across Cwm Taf Morgannwg Health Board and the two Local Authorities to put aside long established 'them and us' cultures and professional protectionism in order to put the patient in the middle. Collaborative team working will be key. All team members need to be accountable for the patient well-being and delivery of care and it will not rest solely with the GP as has been the long-standing perception.

The CHWBT have been able to forge links with other services such as the @Home Services and have worked together in a mutually supportive capacity in order to avoid

duplication but to work prudently to ensure that each does only what they are able to do to support the patient. Discussions are taking place with regard to how this can be further strengthened to support frailty.

Shared information
Robust information sharing and, ultimately, systems of sharing will aid communication for the CHWBT. All members have access to GP clinical systems to ensure they have timely and up to date shared record and information. Vision Anywhere has been commissioned to assist with this.

New technology
Covid-19 pandemic has led to an opening up and acceptance of different ways of working. No longer do contacts by the CHWBT need to be face-to-face, but they can be done via telephone, e.g. clinical and non-clinical triage and remote assessments via video consultations (National Video Remote Consultation platform). Access to Consultant Connect has been rolled out in CTM and with the @Home, Care of the Elderly service and other specialties and has made more specialist advice more easily accessible. Patients can be assessed quickly and safely limiting the risk of infection to all.

Implementation of the Risk Stratification
The top 3% of the population was the intended focus for the CHWBT. Scaling up the PSRS pilot to tailor interventions to specific populations and to support targeted and anticipatory care is key going into 2021/22.

Flexibility & Agility
Whilst the full impact of the pandemic longer-term is not known, what we do know is that there will be:

- a continuing need to support Covid-19 patients (including preparedness for any future spike in the number of cases);
- a further change in patterns of demand (volume and nature);
- contribution to the recovery and rehabilitation plans.

The CHWBT will need to remain flexible and agile in order to support the changing needs.

RQ4. To what extent have the Transformation Projects addressed:
- **The AHW Design Principles?**
- **The Well-being for Future Generations 5 ways of working (long term, integration, involvement, collaboration, prevention) (WBFG)?**

The stated aims of this workstream and alignment with the AHW Design Principles and the WBFG 5 ways of working was clearly articulated in the initial business case and subsequent business plan submitted to Welsh Government:

- It aims to improve longer term improved access to responsive and timely primary care services;
- It supports prevention and wellbeing and a decrease in the levels of avoidable unscheduled care; and will be evidenced by A collaborative approach between

health, local authorities and third sector to the design of services and the delivery of care, reduction in acute outpatient appointments; reduction in out of hours services reduction in ambulance hospital conveyances and the length of stay of acute care of admissions;

- Delivering multi-agency, multi-disciplinary working at cluster level.
- Delivering care closer to home by facilitating access to services within the cluster.
- Improved links with third sector and community well-being services.
- Accelerated cluster development and operationalised cluster governance.
- Improved GMS sustainability.
- Better use of skills and resources across the whole system.
- Shared information systems across seamless system to enable seamless care.
- Development of a range of new extended roles- adding skills competencies and experience to the Enhanced Community Cluster Teams.

RQ5. To what extent can the Transformation Projects demonstrate a sustained shift to preventative services?

The CHWBT can demonstrate a shift to preventative services and is continuing to support patients' lives independently within their own homes. This can be seen in the reduction of contact with unscheduled care activities; by Quarter 4, 1,004 patients had an ambulance conveyance and associated hospital admission avoided and the estimated reduction in bed days equated to 7,737; 2,242 patients did not need to contact a GP (in hours or out of hours) as a direct result of contact and intervention by the CHWBT.

An example of GP feedback from the Taff Ely Cluster is given below - this scenario is being replicated across all Clusters on a weekly basis:

"Just a little email to tell you that we had a direct OT referral from a GP at Old School Surgery last week. I contacted the patient's family the same afternoon as the situation seemed pretty difficult. The daughter of the patient was very surprised we responded so quickly after speaking to the GP only a few hours earlier asking for social care support and equipment as her dad was struggling to support her mother with dementia. The following morning after speaking to the receptionist at the GP's another GP called me to answer my query about the patient. Dr. White expressed that the patient had glowingly mentioned in passing how quickly we had sorted out the issue and they were very impressed with our timely response and support. If the above intervention had not been made it may have resulted in a deterioration of the patient's condition and an admission to hospital which was unnecessary."

The RBA performance report, submitted to Welsh Government showed that:

- 22.5% of patients accessing the MDT service were signposted to the community wellbeing coordinator instead of more traditional routes such as hospital or a GP.
- 40.5% of patients were directed to Care and Repair support and services and their issue resolved.

RQ6. To what extent can the Transformation Projects demonstrate scale-up, particularly in response to Covid-19 challenges?

The CHWB teams have been developed across the footprint in response to the successful pilot carried out in Cynon cluster as described above. The teams receive referrals not just from GP's but also from larger numbers of sources e.g. A&E, Wellbeing, OT, District Nurse's etc.

The CHWBT has not been scaled up since the pandemic, but instead the resource has been sustained. The CHWBTs have actively looked for opportunities to pull patients into the MDT where appropriate. Additional pathways have been agreed and developed with other services and partners to ensure all the services are responsive, appropriate and are all mutually supportive of one another. For example, the CHWBT Operations Managers and GP leads are attending 'Frequent Flyers' meetings within secondary care to identify patients who may be more suitable for the CHWBT's. A pathway has also been agreed with WAST to pick up frequent flyers from ambulance crews. Links with the newly established Frailty Nurses within the Taff Ely cluster has taken place. If the Frailty Nurses identify that the CHWBT could intervene with the patient relevant reviews will take place. It is anticipated that house bound patients will likely commence shortly. These pathways were not originally identified at the start of the design or implementation stage.

Regular dialogue is taking place with the cluster practices to identify ways in which the CHWBT can further support patients in the response to the challenges from the Covid-19 pandemic. It is sometimes difficult to differentiate between patients who require support as a result of Covid-19 or because of other health factors. The important issue is that patients receive a responsive service which is appropriate and preventative.

As described above, despite the pressure placed on Primary Care by Covid-19, the use of digital platforms such as MS Teams and Consultant Connect and video consulting has been invaluable in maintaining regular discussions and providing community-based clinics. All CHWBT staff were provided with the electronic equipment that allowed them to continue to operate and deliver the services to patients throughout the Covid-19 period. The teams continued to conduct face-to-face home visits with patients through robust risk assessment prior to any visit, ensuring both staff and patients remained safe and limited exposure to risk. The teams were some of the only staff members to continue to provide face-to-face visits throughout the Covid-19 period.

7.3 Pace of change

RQ7. What were the critical success factors in enabling scaling, particularly in response to Covid-19 impacts on services?
The critical success factors are:

- **Continued collaboration** with the other community services, whether that be health, social care or third sector. The ability of the CHWBT to emerging needs in conjunction with community services.
- **Transfer of the management and integration of the CHWBT into each of the 'Integrated Locality Groups' (ILG).** The ILGs hold the management and budgetary responsibility for the delivery of all acute and community services across their respective locality areas. There are 3 ILGs covering 3 localities, Merthyr Tydfil/Cynon, Rhondda/Taff Ely and Bridgend. They have the responsibility to provide co-ordinated responsive care to their patients who reside in the respective localities and they hold the budget and autonomy to make changes to service

priorities and delivery and it is in their gift to move resources that have traditionally been placed in secondary care or community into further scale up or enhancement of the CHWBTs. They are also best placed to make further modifications to support integration with teams.

- **The retention of the new ways of working,** e.g. video consultation which have proved to be a benefit to patients and staff delivering services.
- To take advantage of the **opportunity not to replicate what was done prior to pre Covid times** and to avoiding returning to old pathways or service delivery which were not effective.

RQ8. How has pace of change varied as a result of responding to the Covid-19 challenge?

Responding to the Covid-19 challenge caused an initial delay to the implementation of the new arrangements and significant preparatory work and planning was required before the service could be implemented across the clusters such as workshops, recruitment, sourcing bases for the teams, laptops and equipment, procedures and policies, GDPR/data sharing agreements and service models agreed. The planned rollout date on a Cluster basis was March and April 2020. However, the introduction of Covid-19 restrictions and subsequent impact on resources led to further significant delay; in line with a directive from the Welsh Government and the requirement for all enhanced services in Primary Care to be suspended, the roll-out of the new teams was delayed and staff were re-deployed to work elsewhere to meet the needs created by Covid-19. Staff were temporarily deployed into the Community Respiratory Hub and a Multi-Disciplinary team was set up within the Urgent Primary Care Out of Hour's service to assist with the increasing demand during the pandemic.

In July 2020, roll out of the programme was recommenced and through engagement with Clusters has seen the number of patients supported by this workstream increase to the expected levels had population segmentation and risk stratification data been available. The number of patients who have deconditioned due to the impact of lockdown and also the effect of service closures such as day centres and community hubs has also added to the volume of patients being supported through this work stream.

Between quarters 2 and 4 there was an increase of 69% in the total number of people accessing the CHWBT service and direct access to the professional team (total of 2,614 patients) and an increase of almost 35% in patients accessed by the MDT (total of 711 patients).

RQ9. What barriers have you faced in your attempts to achieve transformation change? How could these have been mitigated?

As with other workstreams, the major barrier to change has been the Covid-19 pandemic which caused an initial delay in the implementation of this workstream and continues to impact on implementation of the Population Segmentation and Risk Stratification workstream on which CHWBT teams rely for information. Until that flow of information is established between the two workstreams, the CHWBTs will not be in a position to fully adopt an anticipatory care approach.

Covid-19 led to both programme and operational staff being re-deployed to other duties. Even after the first wave of the pandemic had subsided and the new services rolled-out, it continued to distort the demands that would normally be made on community services

and diminish the focus and energy needed across primary and community services to take forward the work to deliver on the transformed services.

Covid-19 has placed substantial pressure on primary care, affecting staff accommodation and ability to meet face-to-face for the team and clusters. However, the use of MS Teams and digital technology has been invaluable to maintaining regular discussions and providing community-based clinics. Additionally, there has been a requirement to redeploy staff for a range of Covid-19 related activities such as vaccinations and testing, backfilling of staff shortages in community and secondary care services, in addition to absences and restricted duties for a number of MDT staff, which has placed increasing pressure to maintain the services where demand is growing.

Over and above the impact of the Covid-19 pandemic, a barrier to change has been a scepticism from some GPs in clusters to engage fully and to take responsibility for the direction of travel. This does appear to be a short-term barrier and as time is progressing the GPs are realising the value of the team and the contribution it makes to delivery more timely care.

7.4 Engagement

RQ10. To what extent has the workforce and citizens contributed to the ongoing development of TF projects?
Following the redeployment of the CHWBT during the Covid-19 peak, there was a re-launch and team induction in each cluster, and several meetings and presentations to wider stakeholders as a reminder of the transformation programme.

As part of the planning process, 'welcome days' were arranged for all the staff in order to give clarity on processes, team roles, bases, as well an opportunity to meet new colleagues in their cluster. Posters, leaflets, lanyards and marketing were designed with the new name and logo, to promote the team and to give to patients once they have been referred.

The teams have established good relationships with clusters and are aligning work to local priorities, for example by:

- providing regular performance and activity figures at cluster meetings;
- encouraging regular communication, feedback and comments;
- developing a communications plan in collaboration with the strategic lead;
- sending out a digital questionnaire to GP practices to receive feedback from clusters on services.

Clusters are continually being asked for their feedback and being informed that it is in the 'gift' of them to influence and direct the teams as to the best place for them to have an impact. This is undertaken at cluster leads and other meetings and via discussions with LMC.

RQ11. What behaviour changes within staff/citizens have occurred as a result of these projects?
Training between CHWBT members has improved skill sets across the team. An example of this is around the approach and knowledge and skills gained around

Advanced Care Planning (ACP). Appropriate and timely ACP was a key factor identified at the beginning of the Covid-19 pandemic. The training delivered by the ACP team was critical and the CHWBT professionals who received the relevant training now have the knowledge and skills to be able to identify when a patient may benefit from advice and supportive literature etc. This not only has a positive impact on staff but also on patients and carers. The table below illustrates the number of patients identified requiring ACP intervention / support and the other activities undertaken to provide a meaningful discussion and outcome. Without the CHWBT intervention these conversations and ACP may never have been put in place:

ACP Activity Q4

General	Taff Ely	Rhondda	Merthyr	Cynon N	Cynon S	Total
Triggers Identified for ACP from CHWBT Triage	26	45	2	5	5	**83**
Leaflets given	19	33	1	1	1	**55**
Advice Given	19	33	1	5	3	**61**
Patient/Family Visits	14	26	3	9	8	**60**
Drafts ACP/RBID	11	22	0	0	0	**33**
Completed ACP/RBID	8	19	1	1	1	**30**
DNACPR	4	9	2	2	2	**19**

Feedback from the team members has been sought and has been positive throughout. They have stated that the MDT approach has not just provided them with the opportunity to deliver their patient services, but also widened their knowledge around the workings of other professionals within the team.

The CHWBT has also led to a breakdown of professional protectionism and there is now a greater mutual respect between team members with regard to the roles that everyone has to play. There is a culture that the main focus is to do the 'right thing' for the patient.

An example of feedback from a social worker about another member of the Taff Ely CHWBT:

"I'm the social worker allocated to the CHWBT in Taff Ely and went out today on a joint visit with OT/Physio Tec for the team. I just wanted to pass on how incredible the OT was today during our visit and how I couldn't have managed without her! We went out to see an individual, the patient, referred at MDT and upon arriving, it was evident he was not medically well and required a hospital admission. Whilst I sorted out liaising with the GP and Ambulance, the OT was upstairs with the patient providing him with care and support. The patient is suspected to have a chronic UTI and was displaying signs of septic shock. As a result, he was urinating constantly over the floors, walls and himself. The OT supported him to wash and change repeatedly whilst maintaining his dignity

throughout. She managed to distract him from what would have been an exceptionally distressing situation and allowed him to feel comfortable with having such intimate support. She was fantastic and I felt so lucky to have been out on this visit with her. The level of compassion and care she demonstrated was above and beyond and I hope this can be passed on as a reminder of how excellent she is at her job!"

It has been identified that further work is required in influencing behavioural change and educating patients in respect of accepting anticipatory care. Patients appear to be content to wait for a crisis to happen before accepting help. This will be a focus of the behavioural change going forward in 2021.

Patient and carers feedback demonstrate that they were not aware of the various Third Sector services which are available to help support them and their relatives. For example, the Care and Repair team have made interventions to support people with home equipment and adaptations to enable them to remain in their homes. Community Health and Wellbeing Coordinators have also helped individuals secure increases to income and benefits through specialist advice and support. These interventions will mean that not only will individuals access future support in the right way (not through the GP or hospital because the help was sought too late) but they will also be in a position to transfer the learning to other members of the family and friends in the community.

It is also clear from patient feedback over Quarters 3 and 4 that patients are becoming better informed about the range and availability of other health and social care professionals (not just GPs and hospital consultants) who are better placed to support them.

7.5 Governance

RQ12. How have governance arrangements been adapted to respond to Covid-19?

Process governance – significant review of procedures/policies were updated as the response to Covid-19 to ensure compliance with IPC and social distancing measures (e.g. appropriate Personal Protective Equipment, to F2F meetings, to leave etc). Reporting of any issues was directed up through the Primary Care Directorate and on to usual governance reporting structure but also through Covid 19 Bronze and Silver meetings.

As an aside, regular retrospective mortality reviews relating to patients who have passed away during the Covid 19 pandemic has been taking place and the results and learning have been pulled into a central reporting process.

Robust information governance processes were already put in place at the implementation stage, e.g. data sharing agreements. This facilitated the implementation of remote platforms of working (video consultation, telephone triage etc.) necessary as part of the pandemic response.

RQ13. What impact have any changes to governance processes and procedures had on the delivery of outcomes?

There has been limited impact on delivery of outcomes as the teams were supplied with digital equipment to ensure they were able to continue to work. Also, the teams

continued to provide face-to-face appointments for patients where the need was identified but the relevant risk assessments were undertaken.

7.6 Cost benefit

RQ14. Has the TF resulted in any return on investment / financial savings / improved citizen outcomes?
Regular reports are produced to evidence the impact of financial savings and improved outcomes.

The estimated cost avoidance / cost savings as a result of the intervention made by the CHWBT is detailed below. This is based on the assumptions from the original calculations from the Virtual Ward and which formed the basis of the original bid into Welsh Government. For example:

- **A&E visit**: £95.72 per visit avoided (A&E cost per visit = £191.43, this is the full cost (Variable and Fixed)). Because the fixed costs cannot be split out we cannot easily identify the marginal cost. Finance advises an assumption of 50:50 for variable and fixed costs, so £95.72 per visit to A&E.
- **WAST Ambulance conveyance**: In the data extrapolation for Virtual Ward, the cost for this cohort of patients was estimated to be £364 per call out. Stay Well@Home modelled an Emergency Ambulance per hour would be £150 with a typical job cycle lasting 90 minutes (getting to call, dealing with the issue then conveying) so that would be £225 per incident.
- **Bed days:** In the data extrapolation for Virtual Ward, the lowest hospital stay for a patient was 7 days and the cost for this cohort of patients was estimated to be £310/24hrs in hospital. Stay Well@Home Project 1 indicated the average length of stay was 7.7 days for admissions. An approx. cost per bed day is around £114 per bed day.

- **In hours** = £48/appointment
- **Out of hours** = £120/call out

		Q2	Q3	Q4	Cumulative
Estimated cost avoidance / cost savings as a result of reduction in contact with other services (MDT patients only)	NA		£1,899,104	£1,056,243	£2,955,347
Estimated medicines management cost savings based on available WTE to support clusters	NA		£63,250	£34,512	£97,762

Value of home adaptations and benefits claims undertaken by Care and Repair	NA	£7,277	£39,694	£284,267	£331,238

RQ 15. How has the utilisation of TF funding alongside other resources e.g. ICF, core budget, Covid-19 emergency funding resulted in better outcomes?
It was never intended that the Transformation Fund would support the development of standalone services. The objective was that the funding would provide additional capacity and capability to enable existing community primary care teams allowing them to respond more proactively in supporting patients in need. In addition to this it would support the shift of other health and social care professionals out into the communities to would assist in the creation of the Primary Care Model for Wales.

It would also facilitate a more integrated and collaborative approach to supporting patients to live independently and this would be achieved through the breaking down of traditional ways of working, services working in silos and organisational boundaries with Local Authorities and with third sector. This has largely been achieved, although there is room for the service to mature. The services funded by the different workstream are all mutually supportive and avoid duplication. Clear pathways have been developed between the different services.

The Covid-19 emergency fund has helped to support additional resource for the Community Respiratory Team. This team for example works closely with the @Home team and in turn they all work collaboratively with the CHWBT to avoid duplication but to deliver the best outcome for the patients. The CHWBT is able to refer on to the most appropriate specialist service whether this be the Respiratory Team or the @Home for access to the Care of the Elderly expertise. In turn if it is simple advice and sign posting the CHWBT will direct the patient to the Covid Hub.

7.7 Outcomes and Impacts

RQ16. What evidence do you have of changes to the baseline/original position of the funded projects?
There has been little change to the baseline/original position for the CHWBT. A small number of posts have not been appointed into, but these are not significant.

An RBA report card has been produced for quarters 3 and quarter 4. Some of this data is based on the St. Johns virtual ward.

RQ17. What are the key outcomes achieved by the TF funded projects?
The key outcomes identified in the original transformation business case have been achieved. These include:

- Improvement to the wellbeing of individuals who have accessed the CHWBT. This is evidenced through the improvement in scores recorded by professionals and patients and detailed in question 2 above. Patients are reporting improved wellbeing following intervention for the CHWBT.

- In addition to this there is the reduction in access to unscheduled care routes, such as conveyance to hospital, transport via WAST, reduction in GP in hour and out of hours contacts. This has been detailed in Q18 below.

RQ18. What evidence do you have of the difference made/impacts achieved by the TF funded projects?

The table below provides evidence of the various interventions made by the CHWBT and the impact for these contacts. As can been seen the highest percentage of interventions has been for Occupational Therapists at 76.27%, 61.92% review and intervention by a Pharmacist, and Physiotherapists at 57.75%. Direct access to Health and Wellbeing Coordinators and also Care and Repair are also meaningful interventions that may otherwise not have been made.

		How much?				
			Q2	Q3	Q4	Total/average % per month
	Total number of people accessing the CHWBT service Inc. direct access to professional groups	NA	**630**	**919**	**1,065**	**2,614**
	No of patients accessing the multi-disciplinary team	NA	**186**	**274**	**251**	**711**
MDT activity	% of people who have received OT as part of MDT interventions	NA	Not yet available	61.31%	91.24%	76.27%
	% of people who have received Physiotherapy as part of MDT interventions	NA	54.84%	72.99%	45.42%	57.75%
	% of people identified as needing ACP input	NA	Not yet available	44.93%	33.07%	39.00%
	% of people identified with MH needs	NA	Not yet available	46.38%	15.14%	30.76%

		How much?				
			Q2	Q3	Q4	Total/average % per month
	% of people who received support and interventions from social care	Taff Ely / Rhondda data only	Not yet available	24.82%	45.54%	35.18%
	% of people who have received Wellbeing Coordinator support	Taff Ely / Rhondda & Cynon data only	15.05%	19.27%	25.86%	22.56%
	% of people who have received Care and Repair support	Taff Ely / Rhondda & Cynon data only	4.30%	26.15%	54.98%	40.56%
	% of people reviewed by pharmacist and needing intervention (all patients initially reviewed) - excludes GP clinics & specialist	NA	Not yet available	48.55%	75.30%	61.92%
Other activity	No. of people who had direct access to Occupational Therapy (excludes MDT activity)	NA	91	94	130	315
	No. of people who had direct access to Specialist Pain Management Pharmacy support (excludes MDT activity)	NA	-	44	57	101
	No. of people who had direct access to Care and Repair Services (excludes MDT activity)	NA	61	83	105	249
	(no. of interventions / works)		521 & 3	328 & 33	225 & 91	849

		How much?				
			Q2	Q3	Q4	Total/average % per month
	No. of people who had direct access to MH Practitioners (excludes MDT activity)	Taff Ely / Rhondda data only	0	76	214	290
	No. of people who had direct access to Wellbeing Coordinators (excludes MDT activity)	Taff Ely /Rhondda & Cynon data only	292	348	308	948
	No. of times people have been signposted to third sector (WBCs)	NA	1,175	1,005	835	3,015
	estimated hours of service user support		5,875	5,025	4,175	1,5075

The above table of measures demonstrates the qualitative aspects of the outcomes but there are softer quantitative outcomes being achieved and captured. The quote below has come from a patient when she returned her feedback questionnaire following an intervention from Merthyr Tydfil CHWBT.

"there is nothing that can be improved with the service. It is lovely to know that there is a team out there completing visits and look after people. Thank you for the toilet frame and the ideas on how to improve my life and functions within my home".

RQ19. How can outcomes, impacts and financial sustainability be achieved post March 2022?

The impact on reduction on secondary care services demonstrated from the data provides evidence to support a request for ILG's to contribute to sustaining services post March 2022. Sustainable funding must come from the impact on demand in other parts of the system such as secondary care.

Further work is being undertaken to inform sustainability planning. The Optimal Model for Integrated Community Services arrangements are being reviewed in Bridgend with a view to developing a business case for the sustainability of an optimal model and dynamic service, financial and performance framework. Within RCT and Merthyr Tydfil there is a similar piece of work progressing looking to develop a business case for the sustainability of community services including review of effectiveness of existing community services arrangements and their appropriateness across the Merthyr Cynon and Rhondda Taf ILGs and the local authority areas.

RQ20. What are the key lessons learned for future transformation programmes?
The CHWBTs have been flexible and versatile in the face of the challenges presented over the last year. Not only have they adapted to the different ways of working, which has been a necessity, they have also explored new ways in which suitable patients for the MDT can be identified and be pulled through the system to prevent an adverse unscheduled care contact.

At the start of the programme the assumption made was that the composition of each CHWBT in each Cluster should be the same i.e. number of physiotherapists, mental health practitioners, pharmacists etc. However, it has become clear that the populations across the CTM footprint is not the same and therefore the needs of those patients in one Locality, for example North Bridgend, is very different to those needs of patients in central Bridgend. The levels of deprivation and the social determinants of health are very different. The composition of the CHWBT needs to reflect the needs of each area. This will be addressed over the forthcoming year.

Co-location of the MDT alongside the wider primary care team in primary care premises is key to facilitate collaborative working.

8 Population Segmentation and Risk Stratification

8.1 Overview

This workstream covers the whole of the regional footprint. It is based around the development and introduction of a process that utilises both Population Segmentation and Risk Stratification (PSRS) to identify individuals, or groups of patients, within the highest risk groups, and to enable the management and reduction of risk through targeted and anticipatory care.

Population Segmentation supports population-based service planning and refers to the use of 'big data' to divide populations into distinct groups based on their collective characteristics, for which intervention programmes can be designed. The tailoring of interventions to specific segments is considered the best way of ensuring the most effective use of healthcare resources.

Risk Stratification will be used to calculate individual patient risk scores using a range of modifiable and non-modifiable factors. Example risk models which will be applied to the 'big data' are:

- Probability Emergency Hospitalisation
- Probability Inpatient Hospitalisation
- Predicted Relative Cost Weight
- Predicted Relative Pharmacy Cost Weight
- Mortality Risk Score

These scores can be used at GP practice, GP cluster and Health Board level.

The evidence base to demonstrate the impact of Population Segmentation and Risk Stratification (PSRS) is not well developed. Nevertheless, there is a clear rationale to target resources at those who need them most and to prevent their requirement for more intensive forms of care and support. Some research has shown that cost efficiencies can be achieved if effective preventive services can be implemented and where these services are known to be more cost effective.

Consultation with stakeholders has demonstrated a keen appetite for the implementation of this approach. The Programme offers potential benefits in terms of individual outcomes and also in the quality and accuracy of strategic public health planning and in organisational learning generally.

Implementation of the Programme was delayed by the need for key staff to prioritise the Public Health response to the Covid-19 crisis. However, since July 2020, capacity has been allocated and work is being progressed to complete information governance, identify pilot GP practices and implement the approach. It had been anticipated that routine provision of information would be available to all GP Practices by March 2021. However, following the delays it is now anticipated that information will be available from May 2021 for LPHT data and June 2021 for GP data, with quarterly roll-out from 2021 onwards.

However, further work is needed to liaise with GP practices and other services to ensure that the available information is being accessed and used by them.

8.2 Models of working

RQ1. What changes have been made to the projects during the Programme, particularly in response to Covid-19?
The workstream remains fundamentally the same despite the Covid-19 pandemic. Implementation of the PSRS programme has been delayed because of internal and external programme staff being diverted to deal with the Covid-19 crisis. None the less, more recently there has been extensive work with the CTMUHB Programme Team and the four suppliers/users - SAIL, NWIS, the Sollis Partnership and the GPs - to formulate the complex data flow and appropriate information governance arrangements required. There are detailed data specifications and contracts as well as a joint Data Disclosure Agreement and a joint Data Protection Impact Assessment which are coming to completion in March 2021.

Covid-19 has changed health care utilisation; for example, in part suspension of outpatient activity and lower GP consultations. To account for this, a sensitivity analysis has been added to test the predictive ability of segmentation during the first wave of Covid-19. Specifically, the data extraction for the predictive ability work was delayed to incorporate sufficient data to cover the first wave.

RQ2. What impact have any changes made to projects during the programme had upon projects ability to transform the service?
Apart from the delays identified above, none. Effective use PSRS continues to have a potentially transformative effect on services, particularly with regard to facilitating anticipatory care.

RQ3. What were the critical success factors in enabling transformation, particularly in response to Covid-19 challenges?
Whilst transformation has not yet taken place, the critical success factors to achieving it will be in overcoming the data protection issues, developing and validating the segmentation model chosen and ensuring that clinical staff are committed to using the data provided.

Also critical will be efficient linkage with other TF workstreams and key providers to maximise the impact and use of PSRS; in particular the workstream links to the MDT workstream where PSRS will be used in future as a referral tool by GP Practices to refer to the MDTs; this will allow monitoring of the impact of the use of the data given that in their first year of operation the GPs and MDTs did not have access to the data. Also, GPs and MDTs can use the data to refer to the Assistive Technology workstream/service.

RQ4. To what extent have the Transformation Projects addressed: the AHW Design Principles and the Well-being for Future Generations 5 ways of working (long term, integration, involvement, collaboration, prevention)?
The focus of the project is on developing anticipatory care and ensuring that GP practices are provided with information on the segmentation and risk stratification of individual patients in a format that allows that information to be easily linked to patient records.

By providing an accurate and effective stratification of risk, the process being developed will be very much preventative in nature. The objectives of the process are to:

- enable improved identification of patients with greatest need;
- provide evidence-base for predictive ability of segmentation;
- enable policies or integrated interventions targeting segments.

RQ5. To what extent can the Transformation Projects demonstrate a sustained shift to preventative services?
See above – the implementation of the project will facilitate accurate and effective anticipatory care by GP practices and those working with them. By understanding the needs of population groups, evidence-based interventions can be piloted to improve health outcomes. These interventions will include addressing the risk factors of chronic disease to prevent/delay disease onset.

Evaluations of integrated care services have consistently shown that case finding individuals with complex conditions for targeted work helps to avoid hospital admissions[14]. The PSRS workstream aims to provide a mechanism where those at greatest risk of deterioration can be identified and resources focussed most effectively towards them.

RQ6. To what extent can the Transformation Projects demonstrate scale-up, particularly in response to Covid-19 challenges?
Substantial planning is currently underway to scale up the work to support wider population health management across CTMUHB, including plans for additional

[14] Purdy, S (2010) Avoiding hospital admissions What does the research evidence say?

resources for the next 5 years. The Local Public Health Team (LPHT) will be ideally placed to support CTMUHB in using the data from TF to create new models of care, addressing current and future population health needs and to transition from a healthcare-providing organisation to a population health management organisation.

This includes:

(i) technical support;
(ii) short- to medium-term engagement support to partners; and
(iii) long-term developmental support to partners.

This can be done through supporting individual General Practitioner (GP) practices as well as at a more strategic level by supporting Integrated Locality Groups (ILGs) and Systems Groups. The areas considered include potential planning activities relating to waiting lists due to Covid.

RQ7. What were the critical success factors in enabling scaling, particularly in response to Covid-19 impacts on services?
The programme is yet to be implemented due to delays listed above. Communication and engagement at an early stage is going to be critical to ensure the development of segmentation and the application of PSRS is as broad and as flexible as possible. Insight obtained via the aggregated data sets will be developed and shared via a number of fora across the Health Board. This will include the Executive Team, System Groups, Integrated Locally Groups (ILGs) and clusters. Engagement surrounding the practical implementation of the data by clusters and practices will be undertaken via attendance at cluster meetings and MDT operational meetings.

8.3 Pace of change

RQ8. How has pace of change varied as a result of responding to the Covid-19 challenge?
The project has been significantly delayed by the impact of Covid-19 which saw the re-deployment of programme staff and also placed operational pressures on GPs and others that has limited the opportunities to liaise and engage with them. Ensuring GP buy-in is essential to the workstream.

RQ9. What barriers have you faced in your attempts to achieve transformation change? How could these have been mitigated?
The workstream represented the introduction of a new approach to working and one that can seem complex to those not familiar with it or the concepts that underpin it. Accordingly, engagement and education are essential elements of the process of implementation. It is envisaged that the data for the LPHT will arrive in May 2021. In preparation, CTM data analysts will be trained, and support roles will be assigned to work with the key stakeholders – the Executive Board, System Groups, ILGs and cluster groups. The data for the GP's is due June 2021 and programme team members and the cluster supports will be ready to work with GPs and MDTs as the data access is rolled out in two phases over 3 to 4 months.

Also, of prime importance, but which has proved difficult, is ensuring that all data protection requirements are being kept and that stakeholders are assured about this.

There has been extensive work with the CTMUHB Programme Team and the four suppliers/users - SAIL, NWIS, the Sollis Partnership and the GPs – to formulate the complex data flow and appropriate information governance arrangements required. There are detailed data specifications and contracts as well as a joint Data Disclosure Agreement and a joint Data Protection Impact Assessment, which are coming to completion in March 2021.

8.4 Engagement

RQ10. To what extent has the workforce and citizens contributed to the ongoing development of TF projects?

The workstream has identified key stakeholders who have been interviewed to assess their understanding of, and expectations for the PSRS Programme:

The following themes and illustrative quotes were identified:

- "We're really excited about this work – it will help us to inform our strategic plans and focus our interventions"
- It promotes a close match with Healthier Wales objectives
- "This work will help us to target our resources and our collaborative efforts"
- Use of data will drive transformational change to intervene earlier in disease management
- "There is an appetite with GPs but it relies on developing a multi-agency response"
- The emphasis in CRTs may need to change from a response service to something which emphasises proactivity.
- There is strong buy-in: "We're really quite excited about this."
- "We need a more sophisticated radar"
- (Risk Stratification) "...helps the health board to shift its focus away from secondary care towards primary proactive prevention"
- Simple, non-costly tests can identify patients most at risk and, for example in the case of heart failure treatment, reduce the "journey to diagnosis from 1 year to 4 months"

8.5 Governance

RQ12. How have governance arrangements been adapted to respond to Covid-19?

There have been no governance changes in response to Covid-19 other than suspensions to accommodate programme staff and supplier/user diversions.

RQ13. What impact have any changes to governance processes and procedures had on the delivery of outcomes

There have been no governance changes in response to Covid-19 other than suspensions to accommodate programme staff and supplier/user diversions to that work.

8.6 Cost Benefit

RQ14. Has the TF resulted in any return on investment / financial savings / improved citizen outcomes?
The project has yet to be implemented.

RQ15. How has the utilisation of TF funding alongside other resources e.g. ICF, core budget, Covid-19 emergency funding resulted in better outcomes?
The project has yet to be implemented.

8.7 Outcomes and Impacts

RQ16. What evidence do you have of changes to the baseline/original position of the funded projects?
Progress has been made in further refining the segmentation methodology to ensure the data is applicable for practice use with the Health Board. This has been achieved through the progress of a separate research project set up which continues to run.

RQ17. What are the key outcomes achieved by the TF funded projects?
The project has yet to be implemented in the community.

RQ18. What evidence do you have of the difference made/impacts achieved by the TF funded projects?
The project has yet to be implemented in the community.

RQ19. How can outcomes, impacts and financial sustainability be achieved post March 2022?
As mentioned above, planning is currently underway to scale up the work to support wider population health management across CTMUHB based on PSRS developed for TF. This includes plans for additional resources over the next 5 years and can be done through supporting individual General Practitioner (GP) practices, as well as at a more strategic level by supporting Integrated Locality Groups (ILGs) and Systems Groups.

Examples of this support include helping our health and care system to:

(i) build integrated data systems reflecting need and demand across full pathways of care;
(ii) understand the current and future needs of our populations;
(iii) identify which segments of the population to target to achieve their local priorities and health system goals;
(iv) understand the health and care priorities of individuals in different segments of our population;
(v) combine local information with priorities for action in order to interrogate the evidence base and identify the most appropriate and effective interventions;
(vi) identify achievable outcomes and indicators of success;
(vii) evaluate the impact of any PHM interventions;
(viii) share learning about the needs of different segments of our population; and prepare funding bids based on local needs.

RQ20. What are the key lessons learned for future transformation programmes?
Use of the SAIL database provides both opportunities and barriers/limitations with regards to the source of data utilised in the programme. Future transformation programmes could consider some of the limitations in this approach (e.g. access to linked social care data) but should benefit from the precedents set regarding information governance and relationship building during this programme development.

9 Bridgend Ambition 1-7 Day access to health and social care services "Everyday is Tuesday"

9.1 Overview

The Bridgend Community Resource Team model works within a person centred, proactive case management model, with an emphasis on the benefits of working as a multi-disciplinary service within a multi-agency framework. This ensures that care is assessed professionally and delivered appropriately.

The CRT service model components are:

- Common Access Point (CAP)
- Better at Home Bridging Team
- Bridgelink (Telecare) & Mobile Response
- Acute Clinical Team (ACT - Team of multi-professionals, led by Clinical Practitioners and supported by: Consultant Physicians, Nurses, Physiotherapists, Occupational Therapists and Social Workers.)
- Reablement Team & Reablement Unit
- Bridgestart Team (Focuses on patients who require care to remain at home or to be discharged safely from hospital and there are goals to improve the person's independence.)
- Sensory Team
- Community Dementia Team (CDT)
- Mobile Response Team

The model is built upon the early service integration set by the Reablement Team that provided the framework to develop current high levels of service integration in Bridgend that promote improved and closer collaboration between agencies and multi-disciplinary working.

This workstream seeks to expand and consolidate key components of the CRT model to improve its effectiveness. The CRT is based on traditional models of service access and delivery, Monday to Friday mainly between 9 am and 5 pm. This creates pressure within the system particularly at the beginning and the end of the working week. ***The real activity of the week commences following a rapid and intense period of assessment and planning on Tuesdays;*** and by Fridays community services are fully committed and usually at capacity. This often means that some people have to either wait until the following week, or will remain in hospital unnecessarily, or will need temporary avoidable care arrangements to be put in place.

The intention is to have fully operational accessible services over seven days and over an extended day where "Every Day is Tuesday". In summary the intention has been to deliver:

- **Common access point** – recruiting 9 new posts (9 wte) to enable access to coordinated community health and social care and third sector support seven days a week 8 AM to 8 PM

- **Non-selective reablement** – 23 new posts (18.86 wte) enabling services accessible over an extended day/seven days,
- **Better at Home** bridging service – 10 new posts (4.6 wte) to increase service capacity
- **Mobile Response Team** – 15 new posts (8.8 wte) to increase capacity and improve response times
- **Acute Clinical Team -** 2 new posts (1.8 wte) to support admission avoidance from the community

Unfortunately, the impact of the health board boundary change at the point of bid approval and early in the implementation meant that the service had to recommence consultation on the Bridgend Transformation ambitions with a new health board to enable recruitment to commence. Covid-19 and recruitment difficulties, along with changing expectations and requirements with regard to consultation and to the role of therapy staff mean that only limited progress has been made towards 7-day working since the mid-term report. Also, the uncertainty over the amount of funding available for 2021/22 has added further doubt about sustainability and reduced the ability of the workstream to appoint new staff to remaining vacancies.

For example, additional staff have been recruited into 2-year temporary posts for reablement therapy services but following changes in the regional configuration of health services agreement has not been finalised on the deployment and professional oversight of those staff as part of the extended hours service.

The planned expansion of the Better@Home service has not taken place because of difficulties in the recruitment of social care caused by the current state of the social care labour market in and around Bridgend. However, it has been possible to recruit to the Acute Clinical Team, although this was a relatively small number of posts.

Additional requirements around the need to consult with staff around the extension of the Common Access Point were further exacerbated by the impact of Covid-19, that has prevented effective consultation being possible with those staff affected by a change to an extended day. Also, there have been difficulties in recruitment and retention to this service also.

One area where progress has been possible is the Mobile Response Team (MRT) where Transformation Funding has supported the expansion of the existing Mobile Response Service. Fourteen additional mobile response workers (14 x 0.62WTE) have been employed to deliver a second mobile response team across the Bridgend locality.

The second team will improve response times and decrease the amount of calls that cannot be responded to thereby reducing ambulance call outs/conveyances to hospital. A Physiotherapist and Therapy Technician have been funded to deliver a proactive falls prevention service that will work alongside the Mobile Response service to reduce falls amongst our MRT frequent fallers. The second MRT went live in May 2020.

Performance to the end of Q3 shows:

- Estimated Cost Avoidance of Mobile Response Team Callouts of £537,075.00 against the previous full year total of £759,262.00

- No of people receiving telecare service was 2,638, against the previous full year total of 2,659
- No. of Mobile Response Team Callouts- Ambulance avoided 2,387 against the previous full year total of 3,375
- No. of Mobile Response Team Callouts- Ambulance was called and the person conveyed 137 against the previous full year total of 186

Covid-19 has added to the uncertainty, not only by impacting upon the recruitment and consultation processes, but also through its effects upon patterns of need and demand. During the first wave people were very reluctant to access services such as the short-term assessment services because of fears of contracting the disease. However, reluctance to referrals are no longer a problem, the experience now is that people referred are experiencing fatigue, low resilience and/or long-Covid. Amongst other things this has increased the need for a more intensive therapeutic input.

With progress made in terms of recruitment, HR and consultation it could be possible to have services in place and operating by June '21. However, there remains uncertainty over available funding and unless funding can be secured beyond April 2022 it would be difficult to recruit either temporary or permanent staff for just 8 months or so.

9.2 Models of working

RQ1. What changes have been made to the projects during the Programme, particularly in response to Covid-19?
No changes have been made to the programme because of Covid-19, but there have been delays and difficulties in recruitment and consultation that have been exacerbated by the pandemic. There are emerging patterns of demand that are evolving and changing both as a result of the pandemic and of its coming to an end, but as yet the impact of these remain unclear.

RQ2. What impact have any changes made to projects during the programme had upon projects ability to transform the service?
The ability of the project to transform services has been affected by a number of different factors, some linked to the pandemic, some not. Whilst the late start of the CTM programme has not helped, it seems clear that projects that depend upon recruitment and/or the re-deployment of staff can take some time to bring to fruition and that adherence to professional boundaries may also create some difficulties.

RQ3. What were the critical success factors in enabling transformation, particularly in response to Covid-19 challenges?
Progress in terms of transformation has been slow and limited so far. The only area where real progress has been achieved has been with the mobile responder service. The critical factors here were that as the service is hosted by the local authority the requirement to consult on the ambition with a new health board partner was not a delaying issue and recruitment could be started much earlier, with recruitment processes unchanged.

RQ4. To what extent have the Transformation Projects addressed the AHW Design Principles? the Well-being for Future Generations 5 ways of working (long term, integration, involvement, collaboration, prevention)?
The community services in Bridgend are being built around the Design Principles in 'A Healthier Wales' and the 5 ways of working and this is evident from the developments being pursued through this workstream.

Prevention and early intervention, safety, and personalised services, for example are built into both the wider community model in Bridgend and into the proposals that make up this workstream.

The Bridgend workstreams are labelled as Ambitions to convey the scope and longevity that they are intended to have. Although there remain difficulties to be ironed out (for example around the therapists intended to work in the reablement service) the workstream also emphasises integration and collaboration across health and social care services and professions.

RQ5. To what extent can the Transformation Projects demonstrate a sustained shift to preventative services?
The increased capacity in the Mobile Response Service is a clear shift towards more preventative services, ensuring people receive an effective response in their home that limits the need for them to attend or stay in hospital or other forms of care not based in their home.

Other aspects of the workstream also clearly have a preventative element as does the overarching aim of the workstream to provide an effective community service for extended days across the whole seven days of the week.

RQ6. To what extent can the Transformation Projects demonstrate scale-up, particularly in response to Covid-19 challenges?
Apart from the expansion of the mobile response service, there has been no discernible scaling up of services so far.

RQ7. What were the critical success factors in enabling scaling, particularly in response to Covid-19 impacts on services?
In terms of the Mobile Response service the critical factors in scaling-up were having a second team that factored in the business continuity plan for the service, ensuring a consistent level of service availability.

9.3 Pace of change

RQ8. How has pace of change varied as a result of responding to the Covid-19 challenge?
Overall, the impact of Covid-19, combined with other factors such as new health board adoption of the Bridgend ambitions and new health board processes to adopt has been to slow up the developments proposed under this workstream. However, this has less to do with Covid interrupting the required processes to consult with existing staff and recruit new staff than it has been to do with responding to the impact of Covid-19 on services.

RQ9. What barriers have you faced in your attempts to achieve transformation change? How could these have been mitigated?
There have been a number of barriers to overcome in achieving transformation, as referred to above.

Clearly, as described in the previous question Covid-19 has had an impact, slowing up both recruitment and consultation with staff. Changes in terms and conditions of existing staff, for example, have to be the subject of consultation with those staff. Both the impact of the pandemic and the unexpectedly long duration of it have affected the ability of employers to carry out those necessary consultations in a way that meet Covid restrictions and satisfies employers requirements.

However, there have been further problems that have impacted upon those processes. One is the current state of the social care labour market in Bridgend (which itself may have been affected by Covid-19).

Another has been the difficulties over deploying therapy staff into the reablement services as planned. In part this reflects changes in governance that have taken place in Bridgend more generally, but it also reflects the difficulties inherent in working in multi-disciplinary teams whilst retaining an appropriate level of professional supervision and oversight.

9.4 Engagement

RQ10. To what extent has the workforce and citizens contributed to the ongoing development of TF projects?
This has been very limited for the reasons outlined above.

RQ11. What behaviour changes within staff/citizens have occurred as a result of these projects?
Covid has had a greater impact.

9.5 Governance

RQ12. How have governance arrangements been adapted to respond to Covid-19?
Governance arrangements have not been altered in response to Covid-19

RQ13. What impact have any changes to governance processes and procedures had on the delivery of outcomes?
Not applicable

9.6 Cost benefit

RQ14. Has the TF resulted in any return on investment / financial savings / improved citizen outcomes?
Although capacity of the Acute Clinical Team has been reduced to an average of 62% unto November 2020 and further reduced over the Christmas period. The approach being adopted by this team is leading to improvements in citizen outcomes as evidenced by example case studies. For example:

Case Study 10

48-year old woman with complex medical history, otherwise independently living at home with her husband, manages her own feeds etc. 6 different episodes between 2018 and 2019. Initially referred by Consultants at UHW and later by her own GPs.

Medical diagnoses:

- Recurrent pelvic abscess second to pelvic inflammatory disease and previous surgeries.
- Panenteric GI dysmotility (very slow gut) requiring IV feeding at home (Total parenteral Nutrition – TPN)
- Type 1 diabetes
- Loop ileostomy (stoma)

Referred to ACT who accept referrals from both UHW and the GPs. Irrespective of referral source, the ACT were able to obtain, organise and administer IV antibiotics therapies at home. Clinical observations (NEWS) and blood tests were monitored and she was clinically reviewed by the ACT. Treatments were stopped either as per hospital Consultant instructions or were concluded by the ACT based on clinical resolution (in some cases avoiding further GP or outpatient appointments).

Outcome

- Avoided 6 inpatient stays in hospital avoiding nosocomial infection risk in a very clinically vulnerable patient (with associate avoidance of hospital beds).
- Other hospital-acquired complications avoided.
- Patient was happy to remain home where she was able to meet all her daily needs herself.
- She was emotionally much happier at home rather than in hospital.

Clinically recovered on each occasion.

It appears that the recruitment within the Mobile Response Team has had a positive impact on citizen outcomes and changes to the baseline/original position. Please see MRT figures below for the period 01/04/2019 to 31/12/2020

RQ15. How has the utilisation of TF funding alongside other resources e.g. ICF, core budget, Covid-19 emergency funding resulted in better outcomes?

ICF and core budgets form the main sources of funding for the home base teams of the ambitions. Those funding streams have facilitated well established multi-agency teams that provide intermediate care and admission avoidance functions over a working week form. The transformation aims to enhance these further to provide additional capacity to spread over extended days and 7 days.

Transformation funding has also enabled to fund two posts to focus on falls prevention, working closely with the Mobile Response Team it is planned that these posts will target frequent fallers, aiming to understand the reasons why falls are occurring and initiating patient pathways to mitigate these risks.

9.7 Outcomes and Impacts

RQ16. What evidence do you have of changes to the baseline/original position of the funded projects?

Mobile Response data

Mobile Response Call Outs

Call outs	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2019/20	315	284	265	348	294	285	319	280	268	257	305	302
2020/21	255	265	296	355	365	349	451	387	424	TBC	TBC	TBC

Mobile Response Call Outs by Ambulance Information

Ambulance Information		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2019/20	Ambulance called and conveyed	20	19	12	12	14	10	13	12	12	10	13	17
	Ambulance called but not conveyed	11	9	19	11	11	9	9	7	6	4	7	9
	Avoided ambulance call	270	247	230	320	259	235	261	238	231	228	270	263
	No information provided within form	14	9	4	5	10	31	36	23	19	15	15	13
2020/21	Ambulance called and conveyed	14	15	16	15	22	15	27	13	18	TBC	TBC	TBC
	Ambulance called but not conveyed	9	6	1	4	11	8	7	12	12	TBC	TBC	TBC
	Avoided ambulance call	225	237	264	307	307	312	398	340	374	TBC	TBC	TBC
	No information provided within form	7	7	15	29	25	14	19	22	20	TBC	TBC	TBC

Mobile Response Call Outs by Response Time

Response Time		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2019/20	Over 30 minutes	27	22	32	46	36	28	31	34	26	26	38	42
	Within 30 minutes	263	237	212	279	236	232	261	222	219	210	249	241
	No response time recorded	25	25	21	23	22	25	27	24	23	21	18	19
2020/21	Over 30 minutes	21	11	15	22	27	26	26	28	45	TBC	TBC	TBC
	Within 30 minutes	213	229	259	306	312	294	390	338	359	TBC	TBC	TBC
	No response time recorded	21	25	22	27	26	29	35	21	20	TBC	TBC	TBC

The data shows increased response activity and improved response times. This increase in activity serves to improve the outcomes for people who have activated their telecare alarms by ensuring a more timely response, avoiding any “long lays” in those who have fallen, more timely reassurance and onward referral/ treatment, etc,

In relation to other transformation areas, the figures are not showing the same impact as MRT. It is likely that Covid has impacted most on these areas, as the intake for these services is from the hospital and community. CRT referrals for 2020/21 are showing a decrease in comparison to 2019/20, this is line with the overall drop in referrals to Adult Social Care in 2020/21 to date. Staff sickness has increased on last year. This year for the period 01/04/2020 to 31/12/2020 there have been 13.93 Day Lost per FTE as compared to last year (01/04/2019 to 31/03/2020) there were 12.75 Day Lost per FTE. These figures do not include those required to self-isolate.

RQ17. What are the key outcomes achieved by the TF funded projects?
As the projects have not been fully recruited to or consultations successfully concluded the main outcomes achieved to date is that where additional staff have been recruited then they have supported the increased service capacity in order to meet demand.

The additional team within Mobile Response have supported improved service availability to meet alarm activations, ensuring provision of support and reassurance to those who have fallen, or who activated their alarm due an event.

The provision of a small resource for falls prevention has provided falls prevention training, developed falls prevention literature. The small team has also developed a falls passport, which ensures every professional in contact with a person who has fallen has a full picture of falls and interventions to date, ensuring that the individuals management plan is well informed.

Additional resource to ACT has supported the delivery of intra venous therapies in the community, ensuring people have avoided having to be admitted for this course of treatment.

RQ18. What evidence do you have of the difference made/impacts achieved by the TF funded projects?

ACT

Est. cost avoidance from hospital bed days avoided	£285,000.00
Estimated Cost Avoidance of Mobile Response Team Callouts	£537,075.00

REABLEMENT

Estimated Cost Avoidance from Hospital bed days avoided (£114 per bed day)	£537,075.00

CAP Case Study

Mr C is a 54 year old gentleman who was referred to CAP by the Integrated Autism Service. Mr C lived alone prior to lockdown and received support from his family.

BEFORE CAP - Due to Covid-19 lockdown restrictions Mr C moved into his parent's residence to receive the ongoing support they had provided, however, Mr C advised his autism had been heightened and that he was arguing a lot with his father due to losing his independence. Mr C also noted how he felt nervous with regards to re-engaging in the community and living on his own again once the restriction have been lifted. Mr C attended general group activities within his local community, however, these we 'general groups' and not tailored to his learning style or needs. As such, Mr C was asked to not attend certain groups due to his behaviour to other individuals. Mr C's family noted they are struggling to cope with his growing demands and mood swings. Mr C lost his confidence in living alone – he advised he was worried what would happen when he moved back to his residence after restrictions have been lifted.

Due to the increase in CAP staffing Mr C was able to receive telephone support, advice, and information for ASD support groups, where he could attend coffee mornings or cooking classes, activity classes, and ICT support that understood his individual needs.

With extra staff in CAP, it allowed more time building rapport with Mr C. This has allowed us to discuss each concern at a pace he felt most comfortable with and time ensuring he understood what was being said. By having this additional time spent with Mr C CAP were able to better understand what it is he expected from the service, what mattered to Mr C and his concerns. Due to Mr C's communication needs he required more time in order to promote his understanding and have time to process the information. The additional staffing provided time to be able to reach out to other organisations, such as, BAVO, Community Navigators, and Care & Repair to source the required support from the local community along with Social Services. Although the above is all positive, CAP may have been able to better support Mr C if we were 7 day working as we receive emails of concerns for Mr C over the weekend from other organisations he had reach out to as he was unable to contact CAP.

ACTIONS COMPLETED:

- Provided Mr C with Silver Line's free phone number
- Referral to BAVO to help promote independence
- Carer Assessment offered to both his parents

RQ19. How can outcomes, impacts and financial sustainability be achieved post March 2022?

Whilst the difficulties and barriers to progress have meant that only part of the programme has been implemented the underlying approach appears to be sound in concept and consistent with the national approach and requirements. However, it is clear that this is an approach that built upon the extension and/or expansion of services and the achievement of that through the recruitment and (to a lesser extent) redeployment of staff (including some staff working in multidisciplinary settings where they have not done so previously).

To achieve outcomes and impact post March 2022 there needs to be further funding secured for those new posts to be filled and maintained, including funding in 2021/22 if progress is to be made with appointments. There may also need to be some changes in the social care labour market in Bridgend or some re-thinking about how the required functions can be delivered through the creation of more appealing jobs (but without escalating costs).

It will be also important to work through the issues pertaining to the out of hours governance for multi-disciplinary working, especially in services managed within social care where the intention has been to deploy health-based therapists.

RQ20. What are the key lessons learned for future transformation programmes?

The ability to deliver on a transformation project within a set timeframe can be impacted upon by a range of different factors. Some of these may be completely unforeseeable (such as the pandemic) whilst others may have been apparent in some form (e.g. such as the recruitment problems experienced here).

Also, changes in organisational context can also have an impact, requiring original plans to be re-considered and possibly stopping progress from being made.

10 Bridgend Ambition 2 – 'One Team Approach Around People'

10.1 Overview

This is a new coordinated, at scale approach in Bridgend, based upon best practice in Torbay and elsewhere. The principals are pre-emptive and pro-active, flexible and effective integrated community services. The first element of the project has been to deliver seven-day access to referral and advice for people needing district nursing input, through a Single Point of Access (SPoA). This involves extending the operational day from 8 a.m. until 8 p.m. over the full seven days, providing a professional nurse-led service, enabling timely and pre-emptive responses for professional referral and four people, and their families, who are using or in need of district nursing services.

The second element is to deliver multidisciplinary teams within the existing integrated cluster networks which formally comprised social work and district nursing, adding greatly to the capability and capacity of those networks. The multidisciplinary teams are comprised primary and community service professionals, and an expanded integrated cluster network team to include number of allied health professionals. Staff in the teams include: Occupational Therapy, Physiotherapy, Pharmacy Technicians, Speech and Language, Dietetics, and mental health practitioners (CPN) . They sit alongside other team members that include district nursing and for social work. In addition, they work with and alongside other professionals who operate within the primary care cluster services, including GPs as well as broader third sector services.

The third element, facilitated by the MDTs is to develop pre-emptive co-produced anticipatory/contingency care plans (ACCP) with people who are at risk of avoidable admission to hospital or long-term care, or in situations where there is significant risk of carer breakdown. The idea is for plans to be co-produced with people and their families, in order to ensure choice, 'voice and control', enabling the person to live well and independently at home for longer. The anticipatory/contingency care plan will support the management of risk or situation/circumstance change to prevent an delay admission to hospital, residential care where possible; as well as sharing that intervention across primary and community services.

There are three cluster networks in the Bridgend County Borough area made up of rural, urban and coastal areas. All clusters have pockets of deprivation, with the North having areas of severe deprivation.

Up until January 2020 progress with implementation was going well, but it was then hit by the need to respond to the Covid-19 pandemic. Whilst the SPoA expansion has been put in place, this has been with some temporary arrangements to accommodate the impact of Covid-19 on the demands on the service. The Cisco Jabber system has been provided to those staff shielding at home to enable them to continue to work as part of the SPoA, responding to calls and triaging the DN referrals for the extended hours; utilising staff skills and experience in a different way who may have been excluded from contributing to the response to the pandemic in other circumstances.

Recruitment to the MDTs and their deployment has been delayed in part but has now been completed. The implementation of the ACCP process was initially delayed but is now relaunching and MDT's are being held weekly in each cluster network.

The SPoA has provided an effective response during the pandemic period, improving the access to the District Nursing service for other professionals and also improving operational co-ordination of the service. The impact of the other developments is only just beginning to be felt, the SPoA is up and running and has had an effect, but the rest of the developments in this project for example the Anticipatory Care, have not as yet. Planning is progressing around the developing of the MDT modelling, but because of the collaborative nature of this work, there is a need to engage quickly and effectively with other parts of the system (e.g. GPs and Primary Care services) that may be distracted by the ongoing impact of Covid-19 and the demands created by any further spike in Covid-19 cases.

The developments within this workstream were always seen as having a more long-term impact especially from the anticipatory/contingency care planning and MDT

elements. However, all aspects have strong support from both the national policy agenda 'Healthier Wales' and evidence of success from elsewhere.

10.2 Models of working

RQ1. What changes have been made to the projects during the Programme, particularly in response to Covid-19?

Delay in implementation has been the major impact of Covid-19 upon this workstream as both the new services themselves and those services they work with were disrupted by the pandemic. Up until January 2020 implementation was progressing smoothly, but it was then hit by the need for the whole system to respond to the pandemic.

Whilst the SPoA expansion took place, this was with some temporary arrangements in place which initially were about resolving the ability existing SPoA staff working from home; and thereafter other experienced professional nursing staff who were shielding. Throughout the peaks of the pandemic a Band 7 District Nurse was supporting the service as circumstances and demands were changing daily particularly through the first wave.

The recruitment to the MDTs and their deployment was delayed with some newly recruited staff temporarily re-deployed to support the in-patient response to the pandemic. CPN's were redeployed to wards and to the field hospital but because staff were and have been fully operational within the emergent MDT approach.

The development of Anticipatory Care Planning process was also delayed because of Covid-19. The Care Navigators, who coordinate the MDT's and ensure quality assurance, were appointed but was not possible to release them to carry out their role fully to develop A/ACCP, as they were covering their recent admin roles due to delays in recruitment to substantive posts.

The Care Navigators are now taking forward the A/ACCP developments.

The SPoA provided an effective response during the pandemic period, providing more timely response to GP's and people and their families requiring advice, reassurance, support during end-of-life care and equipment failure and requirements are responded to in an immediate way. This prevents situations for people and their families escalating, preventing pressure in primary care and/or admission to hospital, in addition this intervention minimises the risk of pressure damage and infection through inappropriate or equipment failure by prompt and timely responses. Improving the access to the District Nursing service for other professionals and also improving operational co-ordination of the service has been vital in the robust triaging of DN referrals, ensuring appropriate and timely responses to people, especially those requiring same-day responses by ensuring they are given an appropriate priority.

Development of the other elements of the workstream had to be taken more slowly because of the collaborative nature of the work and the need to engage quickly and effectively with other parts of the system (e.g. GPs and Primary Care services) that were distracted by the ongoing impact of Covid-19 and the demands created by the further spike in Covid-19 cases.

Whilst it has disrupted and delayed the implementation of the workstream the onset of Covid-19 has not changed the overall long-term intentions that they behind it.

This is in part because the specific circumstances of the pandemic and also because the developments within this workstream were always seen as having a more long-term impact upon population health and the demand for services. However, all aspects have strong support from both the national policy agenda and evidence of success from elsewhere.

By providing better multi-disciplinary collaboration, improved services and better planning for individuals these elements should have a strong longer-term impact upon both the wellbeing of the population and the demands and pressures on other services.

However, evaluation activity over the next year need to focus particularly upon the impact that the CCP and the MDTs will have particularly for individuals and their families and in the longer term on the hospital and care sector.

RQ2. What impact have any changes made to projects during the programme had upon projects ability to transform the service?

Because staff had been recruited by the start of the pandemic and because this is a workstream that is expected to have a significant transformational effect over a longer period of time, the delays experienced by the workstream will have minimal impact upon its ability to transform the service. Once the workstream can solely focus on this rather than responding to the issues of Covid and long-Covid progress can be made towards delivering the wider changes.

Engagement workshops with Primary Care and GP's and other stakeholders, in the usual sense did not happen due to limitations imposed by national restrictions and the refocusing of GP priorities during the pandemic. Consultation and engagement was delayed, however virtual sessions and set up of the Implementation group has enabled GP representation, Therapy and Mental Health leads in the development of the service.

RQ3. What were the critical success factors in enabling transformation, particularly in response to Covid-19 challenges?

The critical success factors in enabling transformation have been the soundness of the concepts that underlie the approach being taken, the careful planning and preparation that has taken place and the early recruitment of staff. In terms of concept Bridgend had been involved in some anticipatory care modelling with the former UHB, before the boundary change. As a result, professional staff were already positive about the potential outcomes of intervening collaboratively and in a coordinated way. This is enabled staff to continue to be committed to this approach even with all the distractions of the pandemic. In addition the coordination of the district nursing response for the pandemic through the single point of access, and the use of mobile working, have been enablers in delivering a resilient, flexible and what has proved to be reliable responses in the most challenging of situations.

Access to multi-professionals during the pandemic has really been an advantage and the ability to flex their roles and responsibilities during the implementation phase and focus on more on the response of the pandemic has enabled additional capacity within the community and potentially avoided admissions to hospital and long-term care.

It remains the case that full transformation implementation has not yet taken place. The extension to the hours of the District Nursing service is now having an impact and there is a growing body of evidence of calls managed outside the former core hours and pre-emptive intervention to support the service. The MDTs are also now beginning to have an impact with GP's engaging in the meetings to discuss their concerns regarding patients and be involved in the co-production of contingency care plans; this is enabled a multi-professional response in a coordinated way focusing on 'what matters' to individuals and developing plans of care and support that develop contingencies for 'worst-case scenarios' preventing personal and family crisis in a co-produced way. The Contingency/ Anticipatory Care Planning approach in particular will take some time to become fully embedded and even then, as a preventative measure it is likely that it will take a longer period of time before the full impact can be evaluated and benefits realised.

RQ4. To what extent have the Transformation Projects addressed the AHW Design Principles? the Well-being for Future Generations 5 ways of working (long term, integration, involvement, collaboration, prevention)?

The underlying principles of the workstream and their application in practice continue to be very much in line with the Design principles set out in 'A Healthier Wales'. The Workstream has a preventative pre-emptive approach with the health and social care system working together around individuals as a single system, and in a way that people are unaware that they are having support services provided by different organizations. Focusing on what matters to people, coordinating services around individuals with an emphasis on supporting people to manage their own health and well-being and keeping people at home and some for as long as possible.

Prevention and early intervention, Safety and Independence, for example are all well-reflected in the three different elements of the workstream. The expansion of the SPoA for the District Nursing service gives rapid access to help when it is most needed at an early stage and helps keep people safe and independent; and provides a clear audit trail of referrals triage and action. The Contingency/ Anticipatory Care planning approach is fundamentally preventative in nature and also focuses upon supporting people to make best use of their own assets and remain independent (As well as providing people with a clear 'voice' in the shaping and delivery of their own health and care).

The development of the MDTs reflect the move towards seamless services with locally based networks bringing together a range of professionals across primary and community services.

In terms of the Well-being for Future Generations 5 ways of working, again this workstream very much reflects those ways of working, with a focus upon longer-term transformation, integration and collaboration, particularly around the development of the MDTs but also with the A/ACCP system.

Long Term: the hypothesis of the anticipatory/contingency planning approach is that it will enable people to remain independent in their own home, exercising choice and control for as long as possible. To a degree this is a long-term approach, and the benefits to people and their families, would have to be measured over a number of years to ascertain whether there well-being outcomes had been delivered through this co-produced approach

Prevention: implicit in the anticipatory/contingency planning approach is the focus on pre-emptive planning around predictable potential personal and/or family crisis for individuals and their families. This is equally true of people with long-term complex adverse conditions around determining what matters to them most and having a co-produced approach to managing risk with people

Integration: the MDT modelling is fundamentally based on prudent healthcare approaches to intervention ensuring that the right responder at the right time is in place seamlessly around 'the Jones'' to deliver a proportionate and pre-emptive co-produced anticipatory care plan. This approach is the delivery of integration across primary community and the third sector to work with individuals and their families on supporting them to meet their well-being outcomes

Collaboration: this transformational pre-emptive and preventative approach is delivered through the collaboration with people and their families across organisations in a coordinated way. It is not just primary and community services involved, many agencies become involved in the delivery of anticipatory/contingency care plans including for example, out of hours doctors, the Welsh ambulance service, the emergency department at the hospital. This is about collaboration across organisations to support and meet people's well-being outcomes

Involvement: the key to success in delivering an anticipatory /contingency care planning approach is the involvement of people their families and carers in planning and delivery of plans of care and support that enable them to stay well and at home for longer. The success of plans is predicated on what works for people and their families; and these are often unique to that person or their families set of circumstances. Engagement of key professionals in supporting this work is also vital to the success of implementing these plans

There is good evidence from elsewhere of the effectiveness of this approach in delivering both the design principles and the 5 ways of working from developments elsewhere and emerging evidence of it in Bridgend. However, the further evaluation activity over the next 12 months will need to focus upon those areas of development that are less-readily-substantiated by the availability of data-driven approaches.

RQ5. To what extent can the Transformation Projects demonstrate a sustained shift to preventative services?

Whilst there are elements of a shift to prevention in terms of the extension of the District SPoA and the development of the MDTs the major shift to prevention will come when the ACCP process is fully up-and-running and operational. The relaunch of the ACCP through the MDT meeting is now in process and whilst this is still emerging there is clearly a demand for this approach and as the MDT and ACCP develop there will be a requirement to review capacity. The MDT and MDT meeting are operational but has yet to promote this work with primary care and GPs, however the additionality is almost at full capacity due to workload already. Also, if ACCP's are seen as an effective preventive method to avoid admission to hospital, residential or nursing care this will increase the demand of the care navigator role.

Again, the expectation within the workstream is that the full impact of this development will only become apparent in the longer-term. However, we will be working with the

programme over the next 12 months to ensure that we can evaluate the progress being made in this area and the impact of that system as it is rolled out.

RQ6. To what extent can the Transformation Projects demonstrate scale-up, particularly in response to Covid-19 challenges?

The major area of scale-up for this workstream has been in the development of the MDTs which has seen the recruitment and deployment of 40 staff into new posts across of range of professions.

The new therapy staff, community psychiatric nurses (CPN) and dietician in the Integrated Cluster Networks went 'Live' in September 2020. To date these services have not been promoted or communicated as a referral pathway to GP's or primary care yet they have seen an incrementally increasing and sustained demand for intervention. Internal Cluster Network referrals have been received from District Nursing and Social workers (see Q16 below).

In other parts of the UK there has been a targeted focus in anticipatory/contingency planning on certain vulnerable groups such as people over 75 with comorbidities with more than two hospital admissions in 12 months; in order to pre-emptively intervene to reduce unnecessary reliance on hospital admission and admission to regulated care settings. The MDT approach in Bridgend is in the first instance is focusing on a unless restricted access criteria, concerned with people whose independence might be at risk, about whom we wouldn't be surprised if they or their carer ended up in hospital or long-term care in the next six months without a coordinated anticipatory/contingency plan of support. As this approach becomes most mainstreamed into day-to-day practice it is envisaged that all adults in managed health and social care services will have contingency/anticipatory care plans as part of the work focusing on what matters to them.

As indicated above, there was a delay in the deployment of some staff because of the impact of Covid-19. Similarly, the scaling-up of the ACCP has been delayed by Covid-19 and, for example, the restrictions upon visiting people in their homes unless absolutely necessary.

In terms of the SPoA, it now triages all DN calls. The workstream reports that piloting this approach initially has enabled a safe and prudent approach to the management of requests for district nursing services; in addition, it has provided safe systems of referral management and an audit trail of all requests for support from the district nursing in the community. The implementation of this way of working has freed the capacity of the senior nursing workforce to focus on patient care and quality assurance in the community. The SPoA has eased access to real-time advice and support for people receiving district nursing services.

Previously senior and experienced DNs could spend hours of their time answering messages and responding to them, whereas now SPoA triage all calls in a timely manner and DNs are able to commit to clinical practice in the community, hence proving to be time saving and more efficient.

We will look to confirm these findings as we undertake further evaluation activity. However, the opportunity to introduce an SPoA into other District Nurse teams not operating such a system does seem likely to be both possible and desirable.

RQ7. What were the critical success factors in enabling scaling, particularly in response to Covid-19 impacts on services?
A key factor on this regard has been the willingness to commit to the workstream and for the large majority of the MDT, staff to have been recruited on permanent contracts even though future funding for the service is subject to the development of a revised financial sustainability plan.

This meant that despite the immediate impact of Covid-19, staff have been recruited and are now in place.

Also, the model adopted, which has an emphasis upon developing a team across each cluster rather than establishing wholly separate teams has meant that the new service has been established in a much less-disruptive way than a wholesale structural change would have done. However, the longer-term effectiveness of this approach does need to be evaluated and will be looked at over the next 12 months.

10.3 Pace of change

RQ8. How has pace of change varied as a result of responding to the Covid-19 challenge?
The main impact of Covid-19 has slowed down the implementation as both operational and workstream staff were diverted by the need to address immediate Covid-related issues. However, programme activity has been renewed and progress is again now being made.

Having the Single Point of Access has meant that the District Nursing service can respond more quickly and effectively to requests for services, whether from community or in-patient sources and this will continue in the short-term and on into the future.

Also, as part of this workstream there is work to move Health Community professionals to WCCIS (Social Care system) to deliver an integrated record and eradicate paper based records and develop a wholly electronic records system. There has also been implementation of a new District nursing scheduling system (‘Malinko’) to complement the work of the SPoA. This auto scheduling system works in real time for DN visits, scheduling against available skills and capacity.

The setup, infrastructure associated with ICT and accommodation for the new staff was slow initially during the pandemic. A revised project plan was produced to focus on any outstanding work with timelines and the work is almost at completion.

Separately, an ICF grant was submitted by the programme manager and approved by Welsh Government to add another element of integration to the Cluster networks.

The Community Independence and Wellbeing Team a team working with people with long-term complex adverse conditions, would be based on the same site at Glanrhyd hospital as an additionality to the cluster networks, providing an even more robust MDT approach. Accommodation reconfiguration through ICF and Transformation will support this additional development.

Finalising ICT infrastructure in respect of referrals particularly from primary care, has been delayed because ICT have been understandably prioritising enabling the workforce to continue working often from home during the pandemic. This has been complicated further by the fact that much of the ICT infrastructure in Bridgend is still provided by the neighbouring health board who Bridgend was formally apart prior to the recent boundary change.

RQ9. What barriers have you faced in your attempts to achieve transformation change? How could these have been mitigated?

Clearly, the onset of Covid-19 has been the main barrier, impeding both the deployment of staff and the progress of associated developments around accommodation and communications technology.

It remains the case, however, that the continuing impact of the pandemic may further delay some important elements, notably collaboration and engagement with GPs and others. However, virtual GP cluster meetings are back in place, and engagement is ongoing to further develop aspects of the MDT/ACPs, maximising the opportunities in advancements made for virtual meetings as a way of progressing participation in MDTs.

We now know that significantly different patterns of demand occurred during the pandemic period. As well as there being an upsurge in Covid-19 cases that need to be responded to, there is also a reduction in the number of other types of cases as people sought to meet the requirements of the lockdown, avoid contacts and with those outside of their immediate household/circle.

In response to the pandemic extending the hours and access to the single point of access have been accelerated in order to meet the new demands faced by the district nursing service as a result of Covid 19. This has included adjusting the original modelling, and using alternative ICT, to enable some staff, who were shielding, to work remotely on the SPoA from home; the extended hours and seven-day working are fully operational as intended.

A further aspect of this has also been the fact that staff in existing services, with whom effective collaboration is essential, have similarly diverted by the pandemic, perhaps to an even greater extent. This is because significant delays in having a coordinated multi-professional response around people because it is limited access to the full MDT.

However, virtual MDTs have been created, operating in a much more flexible way than previously and (where possible) making fuller use of technology to engage patients and professionals in care planning and to undertake virtual consultations in the community between district nursing and GP's.

The workstream report that there is already evidence, though, of the presence of the new staff having an impact upon the thinking of existing staff, and helping to build up the Anticipatory/Contingency Care model.

10.4 Engagement

RQ10. To what extent has the workforce and citizens contributed to the ongoing development of TF projects?

Engagement with the workforce has been a key element of the development so far. Engagement with the local population has so far been limited and whilst it is recognised as being needed, it is unclear as to how it might be accomplished in the post-lockdown period/foreseeable future.

Citizen surveys are in development and will be used in the near future to provide feedback and inform the further development on the service. As part of the RPB website development there will be a Transformation Fund section on the website which will contribute to citizen and staff engagement.

RQ11. What behaviour changes within staff/citizens have occurred as a result of these projects?

As yet, it is difficult to determine what changes have taken place. As an integrated cluster network, varying professionals have had the opportunity to learn about each other's roles and responsibilities. The networks have shared visions and priorities and because staff work and a single integrated management and are co-located, building relationships and sharing practice, understanding role accountability and constraints within service areas has progressed that pace.

<table>
<tr><th colspan="2">Case Study</th></tr>
<tr><td>SITUATION- What was the situation?

A patient (GG) was brought to the Multi-Disciplinary Team (MDT) meeting by a social worker. Two pharmacy colleagues had already been out to assess and deemed independent/safe with medication. Initially, the referral came from Community Occupational Therapy (COT), however through triaging it was decided that the Integrated cluster network team (ICNT) take the referral.

Now GG came under the Networks, the social worker wanted to put in care calls to help administer medication, and put GG's medication into a blister pack. From the social worker's assessment "Medication is a concern, and although tried alternative for prompts, has difficulty particularly in the morning."</td><td>TASK-What tasks were involved in the situation?

■ Medication management assessment was conducted.
■ Medication optimisation.
■ Medication regime was simplified.
■ New medication reminder chart was issued.
■ Prevented blister packs.
■ Prevented intervention from carers.
■ Money saving on unused equipment (OT perching stool).
■ Provided dosset box.
■ Aim to achieve safe independence with medication.</td></tr>
<tr><td>ACTION -What actions were taken?

A re-referral was taken from the social worker from the MDT and a joint second home visit was undertaken.</td><td>RESULTS -What were the results of those actions?

We re-visited the following week, GG's son present, to discover GG had taken his medication correctly all week.</td></tr>
</table>

Case Study	
GG's son had bought him an alarm prompt to take his medication. GG's son was filling the dosset box using the MRC left by pharmacy colleagues from the previous visit.	He had even walked to his GP surgery twice that week, and this was a big achievement as he hadn't managed that amount of exercise in months. His son believes this was a result of him taking his medication correctly all week. GG deemed safe and independent with medication at present. Living more independently and has improved wellbeing as able to go out and have some exercise.

10.5 Governance

RQ12. How have governance arrangements been adapted to respond to Covid-19?

The strategic direction for integrated community services, is currently subject to a joint review across group and the adjourned integrated locality group of the UHB and the social services and wellbeing directorate of the council. Former arrangements have consisted joint partnership board and a local integration group, as well as reporting to the regional partnership board and the various relevant governance arrangements in the UHB and the council. The re-energised and refocused integrated strategic direction should be in place by September 2021. Meetings through the pandemic have continued virtually through Teams and Skype etc.

RQ13. What impact have any changes to governance processes and procedures had on the delivery of outcomes?

None that have impacted in a negative way.

10.6 Cost benefit

RQ14. Has the TF resulted in any return on investment / financial savings / improved citizen outcomes?

Piloting the SPoA approach has delivered a safe and prudent approach to the management of requests for district nursing services; in addition, it has provided safe systems of referral management and an audit trail of all requests for support from the district nursing in the community. The implementation of this way of working has freed capacity of the workforce to focus on patient care. This has eased access for people receiving district nursing services to real time professional advice and support. An example of real time saving is the ordering of pressure relieving equipment whereby timescales have improved (less than 5 days) since the SPoA has been operational. Calls into the SPOA are broken down into Palliative/Bloods/ Equipment/Generic/Staff. Moving forward baselines will be formalised and a scale score questionnaire will be implemented for patient/professional satisfaction feedback. Which will enable improved reporting of citizen outcomes.

RQ15. How has the utilisation of TF funding alongside other resources e.g. ICF, core budget, Covid-19 emergency funding resulted in better outcomes?

In conjunction with Transformation funding, ICF and capital funding is being utilised to reconfigure an old ward within the hospital to create a meeting room/conference suite to enable actual and virtual participation in MDTs when this is once again allowed. In addition, this will provide accommodation for additional staff (Community Independence Wellbeing Team- CIWT) which will provide additionality to the Integrated Cluster Networks and more seamless approach across community services.

Bringing this area of the Estate back into use would in the longer term be beneficial for the ILG and estate as a whole (CTMUHB) as there would be additional capacity for shared space, conference and meeting rooms with refreshment facilities.

The improvements in the ICT infrastructure during the Covid 19 pandemic have enhanced the offer from community services, in that it has provided a suite of options for contacting people and their families as well as professionals across the health social care and third sector system.

10.7 Outcomes and Impacts

RQ16. What evidence do you have of changes to the baseline/original position of the funded projects?

Within Bridgend there has been an integrated approach to health and social care and community services for a number of years. Social workers and District nurses have been realigned into integrated teams under single integrated service managers, based in health and local authority (LA) buildings; the integrated managers within the community services are funded jointly by the health board and local authority.

To further develop this approach and meet the ever-growing population in Bridgend a number of professionals have been recruited with the aim to support people to stay well and independent in their homes longer.

The new therapy staff, community psychiatric nurses (CPN) and dietician in the Integrated Cluster Networks went 'Live' in September 2020. To date these services have not been promoted or communicated as a referral pathway to GP's or primary care. Internal Cluster Network referrals have been received from District Nursing and Social workers. Between September and November 2002 there were 157 therapy referrals received and 178 CPN referrals.

- The MDTs are currently taking referrals from Social Work and District Nursing with the aim to implement the WCCG platform for intake of GP referrals moving forward. This will formalise the GP referral pathway whereas currently the referrals are coming ad hoc through discussion with MDT professionals. Measures will be implemented moving forward to measure impact on reduction of GP visits from people who attend primary surgeries.
- For Q3 there have been 237 referrals across the cluster networks, 170 that have required a Multi- Disciplinary Team (MDT) response with 81 people discussed at a multi-disciplinary meeting (MDM).
- This joined up approach has enabled the teams to bring information on cases for discussion, to share experience and knowledge to achieve the best outcomes for the individuals concerned. Co-produced plans are agreed and put into place.

- In this quarter MD meetings (22) have continued but with a focus on resuming development of the anticipatory/ contingency care plan modelling which is coordinated by the Care Navigators in line with individual's, their families, carers, 3rd sector and professionals. Moving forward there will be an expectation to report on completed /ACCP's and actions agreed from the MD meetings and measure the difference made.

The newly recruited Pharmacy technicians have provided 10 Education sessions with network teams during December to support cost savings on medical waste reduction.

(£30 million is spent on medication in Primary Care per year in Bridgend with roughly 10% wasted. With the support of the new pharmacy techs providing education to all of the Integrated Cluster Network staff and other colleagues there could be a potential saving of £3 million).

Case Study

Mrs S lives at home on her own, she has a Package of Care 4 x daily calls. She takes a large amount of medication throughout the day. Due to her severe rheumatoid arthritis and poor dexterity she cannot dispense her own medication, therefore her niece dispenses them into little labelled pots so she can take them over the course of the day.

During the start of 2021 there was an occasion where her niece had to isolate due to Covid-19 and there was no one to dispense Mrs S's medication. The situation became so severe that an ambulance was called and Mrs S nearly had to be admitted to hospital, however the paramedics were able to administer the medication.

This was picked up by Social Work Assistant (SWA) Sherie from the Transformation and Review team and it was suggested that Mrs S be bought to Multi-Disciplinary Meeting (MDM).

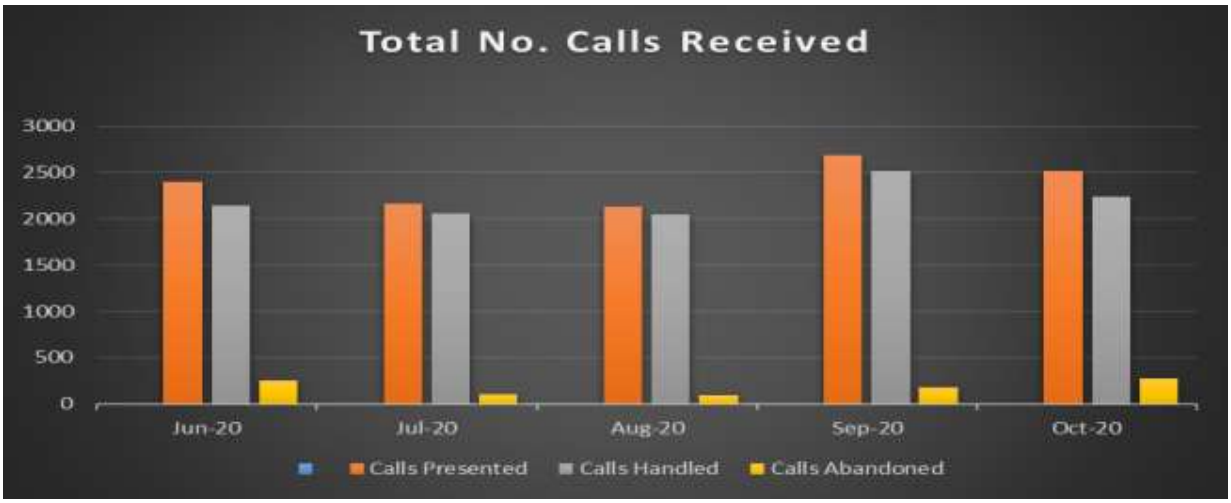
Pharmacy Tech Sara went out and visited Mrs S and her niece, it is a very unique case as Mrs S is fully aware of her drug regime, but she is unable to dispense her medication herself. Sara had a joint meeting with her care provider and SWA Sherie. It has been agreed that Mrs S will now have her medication dispensed into blister packs by the pharmacy, which the care staff can transfer into pots so Mrs S can take her medication independently. A care plan has been written stating that Mrs S will take full responsibility for taking her medication.

This means that Mrs S will be able to remain home safely and her family no longer need to worry about what will happen of they are unable to dispense her medications for any reason.

As part of the workstream a Single Point of Access was established to triage all DN calls. Piloting this approach initially has enabled a safe and prudent approach to the management of requests for district nursing services; in addition, it has provided safe systems of referral management and an audit trail of all requests for support from the

district nursing in the community. The implementation of this way of working has freed capacity of the senior workforce to focus on patient care in the community. This has eased access for people receiving district nursing services to real time professional advice and support.

Ordering pressure relieving equipment and timescales have improved (**less than 5 days**) since the SPoA has been operational. Calls into the SPOA are broken down into Palliative/Bloods/Equipment/Generic. A dashboard supports calls waiting, responded to and abandoned. There were **11,984** calls presented between June and October 2020.



Since moving to out of hours in Sept 20, **509 emails for DN referrals have been responded to in real time**. Prior to extended hours and days these emails would be followed up the next working day delaying the referral.

There were **8,947** District Nurse referrals on caseload between March and August 2020. **5023** referrals came through the SPoA triaging. Malinko reports will be available moving forward for DN referral data.

The introduction of SPOA has dramatically improved all aspects of the District Nursing service. Having a standardised procedure for all calls with access to historical data has been invaluable. Phone referrals are triaged by qualified nurses ensuring that urgent DN attendance is arranged immediately, and any non-essential requests are placed on a designated referral template for each network.

A number of referrals dealt with by the nurses during triage often indicate a DN call is not warranted and they are signposted avoiding unnecessary visits which is cost saving.

There has been a significant reduction in the number of complaints received in respect to missed messages and lack of communication. The SPOA has received compliments from the public and professional services.

Case Study

Mr B lives in his friend's annexe on their property, they also act as his carers, providing him with meals and doing his washing etc. Mr B has a diagnosis of

dementia, and also has diabetes. His friends/carers were concerned about a deterioration in his health so contacted Common Access Point (CAP). A social worker visited Mr B then brought the case to the Multi-Disciplinary Meeting (MDM).

Following the visit, the social worker had concerns regarding Mr B's skin integrity, his mobility, speech and eating habits. Mr B did not appear to want interventions but indicated that he had a lot of respect for Doctors and Nurses. It was decided at the MDM that the District Nurse (DN) team would visit first to introduce themselves and check his skin, and then use this visit to encourage further interventions. The DN team met Mr B, reassured his carers that his skin was intact but ordered pressure relieving equipment to prevent any breakdowns.

Following this visit an Occupational Therapist (OT) assessment was undertaken, Mr B was provided with steps for his shower, a referral was made into care and repair for grab rails. The OT visited to check these and Mr B's carer said she was very pleased with the work. The Speech and Language Therapist (SaLT) is due to go out 28th April to discuss Mr B's communication, and offer information for eating and drinking with dementia.

Mr B is now able to stay living independently at home for longer, and his carers feel supported in looking after him. A good example of joint working, sharing information and good practice.

RQ17. What are the key outcomes achieved by the TF funded projects?
Much of this question is covered in answers given to questions above.

The requirements of the pandemic have delayed and restricted the impact made to date by this workstream, particularly slowing the development of the MDT modelling. However, good progress has been made in terms of making the necessary changes required to deliver on the desired outcomes – staff have been recruited, accommodation and technology put in place and engagement carried out with key stakeholders.

The single point of access for district nursing is fully operational and is already demonstrating a step change in delivering professional community nursing; particularly in terms of positive outcomes for people receiving this service and quality improvement and prudent healthcare approaches to responding to requests for this service.

RQ18. What evidence do you have of the difference made/impacts achieved by the TF funded projects?
The new arrangements with regard to extended hours are in place and the MDTs are in operation.

Whilst there is not yet sustained evidence of improved outcomes as a result of this workstream there are case studies that give a clear indication that the potential is there for improved outcomes to be achieved.

However, collecting further evidence of the impact in terms of outcomes will be a key focus in our evaluation efforts over this next period. All three elements of the workstream – the district nursing SPoA, the MDTs and the ACP system should be able

to provide clear evidence of improved outcomes for patients/people using services and their carers.

Case study for Network patient:

80+ year old patient

Lives alone with Dementia and rapidly declining cognitive function and capacity. Family live outside of Wales, however has supportive friends close by. When Covid-19 brought the first lockdown the patient was isolated in her house, they began to lose weight away from the normally supportive network of their family and friends.

This lady was initially referred into the Dietetic clinic when the family realised this patient was no longer able to prepare meals for themselves and they visibly had lost weight. In an emergency move by the Social Worker, 1 call a day was added in at lunch time to provide a hot meal and provide snacks left for them to have in the evening.

One call a day meant the patient was sleeping in until 12pm and getting up when the carers attended at lunch time, missing one vital meal of the day especially for someone already at risk of further malnutrition. The patient was commenced on ONS, however it was unknown whether they were having these.

Shopping had been arranged by the family to arrive at the time of the lunch time call, but due to the unavoidable variable times in both sectors, occasionally these shopping deliveries were being missed. The family also put in place “Meals on Wheels” which were delivered daily to the patient and the delivery driver was able to access the property without the carers being there to provide the meals to the patient if necessary.

The clinic appointments proved difficult with Dietitians seeking out the best people to get information on this patient’s current nutritional status.

With meetings now virtual it was possible for the Dietitians to attend the Social Workers meetings and bring up this patient’s care plan, fortunately this led to the partnership working for the Dietitian and the Social Worker to move forward in the best interest for the patient.

It was asked that their calls be increased to include a morning call which would allow for breakfast to be offered, working towards the recommended 3 meals a day and helping to meet the nutritional requirements to help prevent further malnutrition occurring. The carers were also involved in the process and asked that they kept records of what they were eating and drinking daily and if they were accepting the ONS drinks prescribed to continue to justify the need for these.

Further Plan:

To provide the Social Worker with justification to continue to have the care plan in place, in line with what is felt to the best interest for this patient.

This has been valuable partnership working for the Dietetic Team, when otherwise we may not be able to access information relating to individuals like this. The meeting provided an accessible way to speak with the Social workers "face to face" and to discuss plans for patients quickly and clearly.

RQ19. How can outcomes, impacts and financial sustainability be achieved post March 2022?
In order to ensure the impact of the workstream is maintained after March 2022 it will be necessary to fully establish the MDTs and the ACP system as core elements of the cluster-based services and secure additional funding from other sources to maintain the extended hours of the SPoA services and cluster-based services and systems.

RQ20. What are the key lessons learned for future transformation programmes?
Management of risk is always a part of effective programme management. However, it is clear that an event such as the recent pandemic falls outside of the parameters of most risk management approaches. However, the possibility of a repeat or similar occurrence may need to be factored into the planning of major programmes.

Part of delivering on this ambition is focused on the rebalancing of care, from secondary care and regulated care settings to community-based, collaboratively produced plans of coordinated support around people to maintain their resilience and independence at home. To deliver such a step change it is a clear that more time is required to meaningfully evaluate dynamic pre-emptive approaches such as ACCP.

It is important to have the right balance between developing services for which there is already a sound evidence base whilst recognising the need to try out new and innovative approaches that may yield a positive return.

Also, whilst it does mean that there needs to be funding made available from elsewhere in order to sustain the service, the commitment to recruit staff on a permanent basis greatly facilitates putting the service in place.

11 Bridgend Ambition 3 – Building Resilient and Co-Ordinated Communities

11.1 Overview

The Building Resilient and Co-Ordinated Communities Ambition aims to develop cross sector working and to invest into the development of the third sector to support people in their communities. We recognise that the third sector has significant potential to help people to remain independent and to have good standards of physical and mental wellbeing within local communities.

This project has a number of distinct areas of focus:

- Recruitment, training and deployment of volunteers to build third sector resilience.
- Ensuring there is early support for vulnerable people to prevent needs escalating via community navigators and co-ordinators.

- Developing cross sector working where the third sector is connected to the Common Access Point.
- Developing prevention and wellbeing networks that engage a range of stakeholders.
- Where gaps in support are identified investing in third sector development of programmes and services.

The programme is utilising transformation investment but aligning it effectively to a series of other complementary investments.

Key areas provided for by the Transformation Grant include:

- salary costs for co-ordination and community development.
- the interface with common access point in the local authority.
- Salary contributions and project cost for engaging volunteers, building community networks and social prescribing investments.

Covid-19 has presented the third sector with a unique set of challenges and opportunities going forward. Some groups have strengthened and energised, whist others have been challenged and withered. In the short and medium term there is a strong case for continued support to these groups as they adjust to “the new normal”. In the longer term, the opportunity is there for the Resilient Communities Programme to consolidate and embed still further into local health and social care systems to achieve ever strengthening impact.

The transformation investment is focused on building longer term sustainable approaches that can support health and social care, particularly in relation to ensuring support is available in communities and preventative approaches reduce the escalation of needs.

11.2 Models of Working

RQ1. What changes have been made to the projects during the Programme, particularly in response to Covid-19?

During year 2, there has needed to be a responsive approach to the pandemic with high public demands from vulnerable groups and statutory partners. The levels of community support harnessed has been significant during quarters 1 and 2. The project has been fully mobilised and community networks have been developing even though restrictions have been in place. The project is now best aligning its resources recognising that it was later than planned in being able to commence in relation to funding approvals and that there has been an eight-month period of needing to refocus wholly on Covid 19 support. A performance framework has been established and is being tested and refined in regard to prevention and wellbeing.

The Building Resilient Communities programme has had to respond to high volumes of community demand during the first two quarters as part of a joint approach with health and social care and a steady demand for support across the County can be seen during quarter 3.The reductions in demand are indicative of the approach taken which is to sustainably support people , to offer choice and enable them to create their own solutions as opposed to delivering services other than in emergency situations.

- The transformation resources have been supportive of such an approach. To date there have been.
- 3707 beneficiaries including the responsive phase.
- (695 shopping,2265 prescriptions,553 foodbank support,275 telephone befriending and 1136 shielding/ welfare support and visits).
- WCVA identified Bridgend as having the third highest rate of volunteering step up and these volunteers were integral to the above performance. This included the emergence of mutual aid groups within communities and ensuring safe and supportive approaches have been in place.

Covid-19 has left the third sector with a unique set of challenges and opportunities going forward. In the short and medium term there is a strong case for continued support to the third sector as it adjusts to "the new normal". In the longer term, the opportunity is there for the Resilient Communities Programme to consolidate and embed still further into local health and social care systems to achieve ever strengthening impact. The growing recognition for the need to reduce more formal support, enabling people to be independent and connected within their communities and to rebuild physical, mental and social wellbeing is an underlying opportunity for this Ambition.

RQ2. What impact have any changes made to projects during the programme had upon projects ability to transform the service?

The Covid-19 pandemic has had a very significant impact upon this workstream although that impact has not been straightforward and the ramifications of it are still being worked through.

During year 2, there has needed to be a responsive approach to the pandemic with high demands from the general public, vulnerable groups and statutory partners. The levels of community support harnessed has been significant during quarters 1 and 2. The project has been fully mobilised and community networks have been developing even though restrictions have been in place.

Over this period, the workstream arrangements have been used to mobilise volunteers and the voluntary sector and to ensure effective liaison between the local authority and those third sector organisations providing hyperlocal support to vulnerable people / people in need and communities of interest.

In some ways the pandemic has helped further the aims of the workstream by encouraging a high volume of community activity in response to the needs being identified in the prevailing circumstances. At the same time, a great deal of community activity has been curtailed by the need to respond to the pandemic and the lockdown restrictions imposed at various times.

So, whilst the workstream has been supporting high volumes of demand and a growing network of partners this activity has been focused upon responding to the pandemic, not building up the longer-term strength and sustainability of the sector which had been the original aspiration. In reality, these two themes can align to each other in terms of reaching and supporting the more vulnerable and there has been more contact with people whose needs could escalate which is helpful for future development. The

pandemic has encouraged more cross-sector collaboration and development of understanding of the complementary roles and positioning of the partners.

Resources are currently being reviewed in order to plan for sustainability-based approaches whilst recognising that Covid recovery in local communities will require responsive support also in the coming months. The ambition remains to build resilience in people and communities, but there is a continuing need to meet existing high levels of Covid and post-Covid demand.

The continuing restrictions on people engaging in community activity or attending venues continues to impact on public confidence or concerns for their safety and this will potentially impact on engagement and participation in the coming months. There are clear risks to the rebuilding and sustainability of community led facilities and related services during the next phases of the pandemic and the need for restoration approaches across the third sector.

In summary what has been noted is:

- the flexibility and agility of the third sector to respond to the most challenging of circumstances has been tested during Covid-19 pandemic and with positive results.
- The willingness of people to provide volunteer effort or mutual aid has highlighted the potential for future developments.
- The pandemic has created a compelling case for community led responses and this energy would benefit from being harnessed and owned by communities.
- The cross sector working, particularly between BAVO and Bridgend Social Care and Wellbeing Services has been extensive and notable.
- Third sector organisations have increased awareness of health and social care pressures and priorities and begun to offer solutions via project proposals.
- A collaborative approach between third sector organisations to sharing resources and working with others has commenced as opposed to competitive funding.
- The investment into smaller and local organisations promotes a legacy of investment whilst smaller investments where successful can be scaled up.
- There are early signs that local people and organisations are keen to work collectively as networks on common themes and priorities.
- In a short period, the progress made to capture qualitative and quantitative information relating to prevention has been positive.

RQ3. What were the critical success factors in enabling transformation, particularly in response to Covid-19 challenges?

As with any community-based project the critical success factor has been the willingness and commitment of communities and organisations to come together to meet clearly identified needs. However, at the same time there has been a massive benefit from having in place the workstream infrastructure and the resources provided by the Transformation Fund.

Two new roles have helped create additional support and community opportunities. These roles are part of the original model that was developed and interface with community navigators and local community coordinator roles as part of a cohesive system. There is a growing focus on social prescribing across Cwm Taf Morgannwg

health board and this work is providing early examples of what might be attainable with longer term commitment:

- Connector/Activator role (Awen). – Focussing on social prescribing and developing cultural wellbeing programmes. Awen are a large charity operating library, cultural venues and some community centres.
- Community Network Builder (BCBC) – Supporting partners to expand the range of physical wellbeing community opportunities available. The individual recruited is an occupational therapist and experienced in working within the third sector and supporting additional needs, disabilities etc.

Additionally, there are:

- 5 x Community Navigators based with BAVO- Connecting with the above and funded by ICF revenue.

All aspects of the workstream developments were up and running by mid-March 2020, putting the whole area of community-based activities into a much stronger position to respond effectively to emergencies such as Covid-19.

RQ4. To what extent have the Transformation Projects addressed the AHW Design Principles? the Well-being for Future Generations 5 ways of working (long term, integration, involvement, collaboration, prevention)?

Ambition 3 was built upon an approach very intended to reflect the design principles set out in 'A Healthier Wales'. Specifically, there is a focus on prevention and early intervention, working with communities to help people build up and maintain their own health, wellbeing and independence through active lifestyles and positive contributions to the community. Also, encouraging good neighbourliness and community spirit to ensure that people round about are protected from harm. This has very much been in evidence in the mobilisation of local communities to support vulnerable people through the pandemic.

Working with local communities and through that, providing people with a voice, has also been a key component. Also, a key feature of the response to the pandemic has been the close working relationships established between the statutory and voluntary sectors that has led to the further development of a seamless approach.

Community approaches continue to be scalable – thriving communities both provide effective responses and provide a strong foundation for further development. As set out above, the impact of the pandemic upon local community activity in Bridgend and upon this workstream has been significant but complex, both generating new types and levels of activity but doing so in specific and unusual circumstances. Building upon the gains made, therefore, will require a continued focused and concerted effort.

This workstream also reflects all aspects of the Well-being for Future Generations 5 ways of working, with the emphasis upon communities, well-being and sustainability of a vibrant and thriving third sector.

RQ5. To what extent can the Transformation Projects demonstrate a sustained shift to preventative services?

Almost by definition community-based activities are preventative in nature, supporting people in their local communities not only to maintain their own health and wellbeing, but encouraging communities to support people in ways that de-escalate needs, offer choice and independence and relieve the demand for statutory services.

This has been very apparent during the pandemic, where through this workstream local communities and volunteers have supported vulnerable people to be able to remain in their own homes rather than either moving elsewhere or having recourse to statutory services. There has also been a focus on maintaining wellbeing during the "stay at home" phases linked to national restrictions. A range of approaches including befriending, home based activities, digital activities and telephone mentoring have been taken forward and some of the learning and insight could create longer term benefits.

As already identified above, the impact of the pandemic on this workstream has been complex, both generating high volumes of activity, but not necessarily in ways that are or need to be sustainable.

RQ6. To what extent can the Transformation Projects demonstrate scale-up, particularly in response to Covid-19 challenges?

See Question 1, above. Also, the workstream has had to support high volumes of community demand during the first two quarters and a steady demand for support across the County during Quarter 3. There has been a reduction in demand, indicative of the approach to sustainably support people and enable them to create their own solutions as opposed to delivering services other than in emergency situations.

- The transformation resources have been supportive of such an approach. To date there have been.
- 3707 beneficiaries including the responsive phase.
- (695 shopping,2265 prescriptions,553 foodbank support,275 telephone befriending and 1136 welfare visits/ shielding support.).
- WCVA identified Bridgend as having the third highest rate of volunteering step up and these volunteers were integral to the above performance.

BAVO have managed the training and deployment aspects including the signposting to community groups. There have been 185 individuals supported via common access point route and over 100 vulnerable individuals supported per quarter by local community co-ordinators and navigator support on a 'case work' basis. This represents those most likely to have been diverted away from other services.

Within communities mutual aid groups that emerged as generic pandemic support for day to day needs are moving into new areas which provides potential for a strong legacy of the pandemic. Examples would include the creation of a cross county network to enhance digital skills and connections, creative and cultural online communities linked to the "Stronger Together Programme", the expansion of the Super Agers network to encourage physical activity and combat loneliness and isolation and the development of a new Bridgend Inclusive Network Group (BING) working with parent carers of young people with additional needs.

RQ7. What were the critical success factors in enabling scaling, particularly in response to Covid-19 impacts on services?

The major factors in being able to scale up the response were the willingness of local communities, organisations and people to support each other in a time of obvious need. At the same, Transformation Funding had both made available dedicated staff to enable a greater level of flexibility and responsiveness from BAVO to organise, co-ordinate and/or connect to community effort. Although cross sector working had already commenced to create the Transformation Ambition, the practical aspects of cross sector working went forward at greater pace and with far more agility than might have been expected within traditional project management approaches that would have been applied pre-pandemic.

11.3 Pace of change

RQ8. How has pace of change varied as a result of responding to the Covid-19 challenge?

The pace of change required accelerated greatly during the main periods of the pandemic and had declined somewhat more recently. However as indicated above, the response to the pandemic required and necessitated a re-orientation of activity in order to meet the immediate needs arising from the pandemic. At the same, non-Covid-related activity underwent a sharp downturn with the effects of the various lockdowns. The national restrictions had curtailed many of the originally anticipated activities that would have involved gathering and group activity and even the availability of community venues other than for identified essential public activity. These restrictions will have eased during quarter 3 but re-emerged as the next phase of level 4 lockdown has been applied. The use of digital approaches to support people and communities will have gone forward at significant pace but also emphasised that the gap has been exacerbated for the most digitally excluded.

RQ9. What barriers have you faced in your attempts to achieve transformation change? How could these have been mitigated?

The main barrier has been the need to re-focus activity to respond to the immediate needs created by Covid-19 and then also the restrictions placed upon non-Covid related activity by the lockdowns. In the circumstances these could not have been mitigated. It is pertinent also that during the early stages of the programme the changes to the health board boundary has taken place and new ways of working and establishment of governance across the new footprint being taken forward has taken time. This is relevant in relation to this Ambition as the approach being taken with the third sector generally within Bridgend may differ to what was understood in relation to how the third sector had historically operated within the former Cwm Taf footprint. The third sector will respond to its local circumstances which requires flexibility to meet local needs rather than consistency in approach. There has been positive work throughout sharing the Resilient Communities philosophy of approach in regional partnership meetings.

11.4 Engagement

RQ10. To what extent has the workforce and citizens contributed to the ongoing development of TF projects?

This is a co-produced and cross sector programme with leadership provided by BCBC and BAVO. There have been some changes in approach since Covid-19 restrictions were applied to ensure that staff remain engaged and informed and partners are aware of progress being made:

- BAVO have operated a weekly team meeting where navigators and other roles connected to Ambition3 can exchange information and coordinate their work.
- On a fortnightly basis the local community coordination staff and other roles of relevance have joined the meeting to broaden the discussion and identify areas for further collaboration. There has been increased shared input into casework dependant on levels of complexity and sharing of information on community support resources. Improving processes and making support more seamless across sectors has been an aspiration of this Ambition.
- There is now a strong focus on use of digital resources to maintain communication but also a realisation that some important anchor points in communities may benefit from enhancing their digital capacity.
- Prior to lockdown there had been three network events planned to look at how partnership working could be further developed in the north, east and west clusters. This had to be paused but there was interest from public and third sectors and this will be progressed when restrictions are lifted.

There has been a large increase in the number of people volunteering to help in their local community and many of those people have been processed, trained and deployed, carrying out tasks such as delivering prescriptions, shopping and generally providing people with some moral support and a point of contact with the outside world. These activities are felt to have considerably reduced the pressure on statutory health and social care services.

There has been an opportunity to develop further online activities focused on helping people retain their well-being at home including programmes such as “Active at Home” and “Stronger Together Bridgend”. Work has progressed with AWEN trust, Wales Co-Operative Centre and Digital Communities Wales to engage carers in becoming more digitally included, targeting and establishing new groups such as a carers digital co-operative or enhancing skills in existing groups.

Some individuals and groups have become “dormant” and disconnected, particularly where their community venue base has closed and this energy needs to be resuscitated. The support from Transformation Third Sector Development Officers has been mobilised and work with groups on safe reopening has recommenced; this momentum needs to be capitalised upon.

Rising to the demands of the Covid-19 pandemic has provided a real test for the new infrastructure and the relationships that underpin it and whilst lessons have been learned, overall, the outcomes have been very positive and the model has proved itself to be very robust. Data collected by the programme team illustrates the activities undertaken during the first three quarters of 2020-21 from April to December.

RQ11. What behaviour changes within staff/citizens have occurred as a result of these projects?

There have been three major behaviour changes that have emerged as a result of this workstream. The first has been from the local authority and its staff and their greater recognition of the value that the third sector can bring and also a greater willingness to utilise the resources available in the voluntary sector to support vulnerable people.

The second area of change has been in the increased numbers of people within local communities actively volunteering, particularly to support those who have been vulnerable to Covid-19 and shielding at home. The challenge for the workstream is to retain the interest and commitment of those people into community activities as the pandemic recedes. Volunteers have been asked if they cannot commit to regular volunteering whether they will consider become part of an ad hoc emergency volunteer response 'team' retained by BAVO.

The third area of change will have been the workforce in general being prepared to work flexibly and beyond role descriptions to support communities often needing to respond within short timescales and limited precedent on how to deliver the best and most appropriate approaches. This has required greater agility in relation to decision making and use of creativity in problem solving.

11.5 Governance

RQ12. How have governance arrangements been adapted to respond to Covid-19?

Following the establishment of the new regional programme board the transformation programmes have been given clear routes to provide performance reporting in partnership with project managers. This ambition had included the development of a performance scorecard that had been useful in trying to capture population level outcomes. This had proven achievable during the first phase of the programme but will have been difficult during the lockdown periods.

There has been the development of an Integrated Locality Group (ILG) and the transformation programmes and progress are shared there on a scheduled basis. The reports are jointly developed and agreed between BCBC and BAVO reflecting the works that have jointly been taken forward. The recent introduction of the Results Based Accountability framework has been applied to the project and is helping to support the evaluation process of impact.

RQ13 What impact have any changes to governance processes and procedures had on the delivery of outcomes?

The connection of the Transformation ambitions to the ILG meetings has encouraged sharing of information and progress more broadly between those attending and has for this ambition helped to illustrate the potential for investing in community based preventative opportunities that support independence. This approach has also helped the individual projects to identify opportunities for greater collaboration on key issues as learning and insight is further developed e.g., falls prevention, support for sensory impairments. Ambition 3 had in the first phase developed a performance scorecard based on a balanced scorecard approach that has been able to be applied to the new Results Based Accountability (RBA) requirements of Welsh Government. As this Ambition is focused on prevention the project has needed to maintain discipline in not chasing high volume support where it is not required and to do only what is necessary to build resilience. Some of the qualitative data has been difficult to collate as originally intended due to face to face restrictions but alternative approaches have been attempted. The ILG approach encourages a cross sector response to performance reporting and review with BAVO and BCBC attending the meetings.

11.6 Cost Benefit

RQ14. Has the TF resulted in any return on investment / financial savings / improved citizen outcomes?

There is earlier evidence (including that from the study of an area that at the time included Bridgend) that enhanced community activity can generate a considerable and real return on investment, especially if a broader perspective is taken on wellbeing. Whilst this will be an area we wish to focus upon for the final evaluation the last 12 months has seen the voluntary sector in Bridgend working well to support individuals and relieve the pressure on statutory services.

The approaches being taken forward have been based on the national models of local area coordination that present a range of evidence based cost savings that can be made based on reductions of visits to GP surgeries, visits to A&E etc although this ambition is prevention based and focused on cost avoidance and demand management in the main. The original study on this approach in Bridgend conducted by Swansea University had suggested a social return rate of 4:1

RQ15. How has the utilisation of TF funding alongside other resources e.g. ICF, core budget, Covid-19 emergency funding resulted in better outcomes?

The building resilient communities programme was designed from the outset to align a broader range of resources that could support a range of complementary roles that could respond to needs and also to develop or enhance the support that might be available and appropriate within communities.

ICF CONNECTED COMMUNITIES PROGRAMME

This has funded the community navigator roles that have been integral to being able to meet the increased demands arising from the pandemic, providing information and assistance in relation to escalating needs and connecting people to partners that can provide ongoing support. The investment has also supported enhancement of community opportunities.

LEGACY FUNDING - LOCAL COMMUNITY COORDINATORS

This funding has supported 3 local community coordinators in the north of the county borough to work collaboratively with navigator roles and to provide support for more complex needs, often linked to open social work cases. There have been a broad range of needs emerging and this has escalated through quarter 3. Individuals who have previously been supported to be resilient have in a number of cases lapsed and needed further in-depth support particularly relating to mental health.

LEGACY FUNDING - VOLUNTEER DEVELOPMENT

This has part supported a role and related workstreams within BAVO to manage the high volumes of volunteers that expressed an interest in supporting their communities and matching people to relevant activities. There has also been a need to support mutual aid groups emerging to have safe operating systems and safeguarding arrangements for their new activities and approaches.

HEALTHY AND ACTIVE FUNDING - SUPER AGERS PROGRAMME

This programme has supported a community activator role within BCBC and a super agers development role within BAVO to support physical and mental wellbeing. During this period there has been a range of structured group activities where permitted but

also home support programmes and telephone mentoring approaches. This work has been identified as a Bevan Exemplar project. It has been able to support some of the more vulnerable at home and created learning for future approaches.

OTHER ICF - DEMENTIA, CARERS
BCBC has ensured that other relevant ICF investments have had a connection to the Building Resilient Communities programmes in relation to carers and people living with dementia/cognitive impairments and their carers. There has been partnership working with Wales Co-operative centre and Digital Communities Wales recognising the challenges that digital exclusion has brought for the more vulnerable and a focus on developing carers co-operatives based on themes of interest to support wellbeing. Additionally, through cultural and Creative work with Awen cultural trust, we have been building our approach to community social prescribing activities.

Beyond these sources the model has enabled BAVO to be in a strong position to mobilise a range of other investments relating to food poverty and security, money management, equipment and resources to support community venues and programmes. Whilst such an approach may exist across Wales there has been great progress made in relation to the cross sector working and positioning of the partners to make best use of resources and maximise the potential of collaborative working

11.7 Outcomes and Impacts

RQ16. What evidence do you have of changes to the baseline/original position of the funded projects?
In regard to work conducted the volume of support that was anticipated within baseline target setting has been significantly exceeded although potentially not in the manner that had been originally planned. This is evidenced within the RBA scorecard with performance targets being achieved by the end of quarter 3 in most instances. The focus of this workstream has been upon the third sector and on communities, that we know are more difficult to measure in terms of provision and impact than statutory services. Add to that the effects of the pandemic and it is clearly not possible to compare the current position with the baseline that existed before the pandemic. Many community-based activities and their outcomes do not lend themselves to easy measurement. Add to that the changing pattern of community activity necessitated by the pandemic and measurement becomes even more difficult. However, as the impact of the pandemic recedes there will be an opportunity to begin capturing more face to face qualitative data.

RQ17. What are the key outcomes achieved by the TF funded projects?
In advance of Covid-19 the following key milestones had been achieved:

- The identified workforce within the transformation plan had been recruited and the project had been mobilised.
- A performance framework based on the “balanced scorecard model” was adopted, identifying the evaluation commitments contained within the related funding applications. This includes performance indicators that consider financial, process, customer and learning/growth aspects of the programme.
- The grant investment scheme to support third sector engagement and development was established with investment at 3 levels (small, medium and larger). This has

now been superseded based on a network-based approach to encourage greater collaboration across sectors and within sectors.

'Building Resilient Co-ordinated Communities' has brought community organisations and partners together. There are 22 themed areas of support that have been identified and over 60 partner organisations supporting this resilience-based approach.

Also, the course of the programme so far there has been a new approach to develop collaborative work across the third sector and the development of themed networks which sets the direction for aligning future resources. There is a need to reduce the competition for investment and rather to invest in building capacity within partner organisations.

Quarter 3 of this year has seen a growth in wellbeing issues emerging, manifested in both new referrals and people previously supported to be independent needing more support. To date the programme has been able to support all forthcoming requests through the strong partnerships developed with no identified complaints or dissatisfaction.

Again, the need to meet the strong prevailing level of need has to some extent drawn workstream resources away from the longer-term work of building effective, sustainable communities.

The Building Resilient Communities programme has supported high volumes of community demand during the first two quarters of 20202/21 and a steady demand for support across the County during quarter 3. The reductions in demand are indicative of the approach to sustainably support people and enable them to create their own solutions as opposed to delivering services other than in emergency situations.

The transformation resources have been supportive of such an approach. To date there have been:

- 3,707 beneficiaries including the responsive phase.
- (695 shopping,2,265 prescriptions, 553 foodbank support and deliveries, 275 telephone befriending and 1,136 welfare visits/shielding support.).
- WCVA identified Bridgend as having the third highest rate of volunteering step up and these volunteers were integral to the above performance.

RQ18. What evidence do you have of the difference made/impacts achieved by the TF funded projects?

Building Resilient Communities has brought community organisations and partners together. There are 22 themed areas of support that have been identified and over 60 partner organisations supporting this resilience-based approach.

Quarter 3 has seen a growth in wellbeing issues emerge manifested in both new referrals and people previously supported to be independent needing more support. There are indicators on the scorecard that would benefit from a sample review in Quarter 4 particularly whether people have felt better connected to their communities. To date the programme has been able to support all forthcoming requests through the strong partnerships developed with no identified complaints or dissatisfaction.

During Quarter 3 there has been 37 hours per week of out of hours calls support and an average of 8 calls per day being supported (631 calls in total). Issues raised have included loneliness, anxiety, alcohol, mental health, money worries, carer support, housing and tenancy support, befriending, bereavement, vision and mobility deterioration, medical appointments and domestic violence. A range of new community opportunities have been developing including digital approaches, community networks, food poverty collective approaches and physical and mental wellbeing opportunities.

The RBA indicators submitted to the Welsh Government show a startling response to meeting the needs created by Covid-19 during 2020.

	Annual baseline target	Q2	Q3	Q4	Cumulative
Indicator 1-individuals engaged in community prevention opportunities.	300	3,484	223	n/a	3,707
Indicator 2-number of community prevention opportunities established	10	5	11	n/a	16
Indicator 3-individuals receiving training including volunteers	50	60	15	n/a	75

In terms of impact the RBA reporting shows that this is significant also.

	Is anyone better off?				
	Annual baseline target	Q2	Q3	Q4	Cumulative
Indicator 1-Individuals diverted from mainstream services	120	269	125	n/a	394
Indicator 2-People able to access the facilities and services they need	65%	100%	100%	n/a	100%
Indicator 3-People express improvements to their health and wellbeing	40%	n/a	61%	n/a	n/a

RQ19. How can outcomes, impacts and financial sustainability be achieved post March 2022?

In addressing this question there is a need to refer back to the impact of Covid-19 on this workstream. That impact has been both significant and complex. The resources made available through the Transformation Fund were used to organise and co-ordinate a massive response from the voluntary sector to meet the needs of those people affected by the pandemic, especially those vulnerable people who were shielding from

it. At the same time, a great deal of community activity ceased because of the lockdown and much of the broader transformation activity stopped.

Hence, whilst the Transformation funding has had a major impact in terms of the overall response to Covid-19 much of the original work planned for this workstream has not yet taken place and the longer-term effectiveness of the third sector has not yet been secured.

In order to achieve the sustained change envisaged at the outset of the programme further funding and resources need to be allocated for the current year (2021/22) to continue the Transformation work.

Subsequent to that (i.e. post March 2022) there will continue to be a need for local resources in order to support the Transformed Sector and to maintain the infrastructure required to both focus and support that activity.

RQ20. What are the key lessons learned for future transformation programmes?
The major lesson learned is the need to ensure that any future transformation needs to include the Third sector as key partners in the process and as a major focus for the Transformation activity. As statutory services continue to experience increased demands and pressures, communities and the third sector are vital resources to be used on both reducing and responding to demand.

The capacity and responsiveness of the Third sector has been demonstrated by the response to Covid-19. However, it is important to be aware of the difference between a short-term response to an emergency and building the longer-term resilience of the Sector (Not least because the ability of the sector to be able to respond to any future emergency depends upon that long-term resilience being there).

Also, whilst the pandemic has generated a great deal of involvement and activity from individuals and communities it has also curtailed many activities and organisations and time and energy will be needed to provide support to them to enable an effective re-set as the pandemic/lockdown comes to an end.

One of the unique features of this ambition has been the development of a model that has used Transformation investment but aligned it alongside other resources including Integrated Care Funding (ICF), Welsh Government Legacy Funding, Healthy and Active Funding and core budgets to look to make best use of all available resources.

12 Conclusions and Recommendations

12.1 Project level conclusions and recommendations

12.1.1 RCTCBC, MTCBC, CTUHB Project Overviews

Response time targets set for both the **Mobile Responder** and **SW@Home2** services have been excellent - 96.6% and 90% of referrals respectively. A timely response is critical to the success of keeping people at home. Positive survey feedback and case studies illustrate outcomes are being achieved **by Assistive Technology** and **SW@Home2**. Both projects have already had a significant impact by diverting from the

call-out of ambulances, conveyance to hospital and in-patient stays. For example, it is estimated that 1,964 conveyances to hospital have been avoided across both workstreams.

As a result of these two interventions, savings are being made through cost avoidance. For example, the programmes have reported that during the first two quarters (Qtr 2 and Q3, 20/21), assuming that 1,964 people would otherwise have been conveyed to hospital via ambulance, and using costing provided by the Kings Fund,[15] that itself amounts to a saving of £451,035 ambulance costs. If these 1,964 people had been taken to hospital, it is estimated that, based on the average cost for someone who attends an urgent care centre or A&E department and receives the lowest level of investigation and treatment, the minimum total saving from these services is £268,328.

Similarly, by Quarter 4, there was a significant reduction in contact with unscheduled care activities as a direct result of contact and intervention by **CHWBT**; for example, it is estimated that 1,004 patients avoided an ambulance conveyance and associated hospital admission and 2,242 patients avoided having to contact a GP (in hours or OOH). The programme has reported savings made through cost avoidance as a result of this reduction in contact with other services (MDT patients only) of £2,955,347.

The impact of Covid-19

Whilst Covid has not resulted in any changes being made to the Assistive Technology, SW@Home2, PSRS and CHWB models (all remain transformative and with the same anticipated outcomes), there has been an impact on the roll-out of the new services due to resources being diverted. Specifically:

- **Assistive technology** had to delay the implementation of the wellbeing assessments and proactive calling element of the service.
- **SW@Home2** had to pause its delivery of the full range of operating hours.
- **PSRS** have experienced significant delays and as such have not yet been able to implement the programme. (Capacity has been allocated and work is now being progressed).
- **CHWBT** staff had to adapt the way they identified the most appropriate patients for the service, rather than being provided with the information from the offset as a result of the delay experienced by the PSRS workstream.

Notwithstanding this**, Assistive Technology** and **SW@Home 2** have provided a level of resilience to the surge capacity demands on the adult social care offer during the pandemic. Both services continued to be operational throughout the Covid pandemic and are currently fully operational. It is anticipated this will be sustained into the future. There has been no impact on governance arrangements and the anticipated project outcomes remain unchanged.

Experience of the first two waves of Covid, particularly in relation to pressure on hospitals and shielding, have led to a number of measures being taken and guidelines introduced that will equip workstream staff and managers well should they need to respond to a 3rd wave.

[15]'Facts and Figures about the NHS' Kings Fund, 2019, https://www.kingsfund.org.uk/audio-video/key-facts-figures-nhs

Considerations
Having an understanding of, and building on, the interconnectivity that exists between each of the individual workstreams is critical to the scaling up and transformation they can achieve. It is therefore important to continue to make sure individual workstreams are not pursued in silos in the future – rather to keep in mind the whole system regional approach - Stay Well in Your Community – and how each service contributes to the overarching strategic aims and objectives. There are already a number of links established, including:

- The Mobile Responder element of the Assistive Technology workstream has a referral pathway into SW@Home2 for individuals who require either a health or social care intervention as a result of a proactive call or a Responder visit.
- A longer-term aim is to explore the sharing of datasets from the PSRS and Assistive Technology workstreams.
- Promotion of the Assistive Technology service is a key offer of the Community Health and Wellbeing Team social worker function in maintaining independence.

Continuing development is needed in respect of education and learning for all staff and partners to enable a sustained culture shift that ensures all community service options are considered in the first instance to avoid people being inappropriately conveyed or admitted to hospital.

Finally, as stated in our **SW@H2** report, as demand for services continues to grow, and the move to more community-based preventive services continue, consideration should be given to ensuring the sufficient sustainability of key services such as pharmacy, reablement and domiciliary care services; it is vital these services are able to continue to respond to the inevitable pressures caused by the shift to admissions avoidance.

12.1.2 Bridgend Project Observations

Some services have performed well despite Covid, particularly where early recruitment to expand teams was successful. For example:

Ambition 1- Seven Day Access to Community Health and Social Care Services – "Every Day Is Tuesday"

During the first wave people were very reluctant to access services such as the short-term assessment services because of fears of contracting the disease. However, reluctance to referrals are no longer a problem, the experience now is that people referred are experiencing fatigue, low resilience and/or long-Covid. Amongst other things this has increased the need for a more intensive therapeutic input.

One area where progress has been possible is the Mobile Response Team (MRT) where Transformation Funding has supported the expansion of the existing Mobile Response Service. Fourteen additional mobile response workers (14 x 0.62WTE) have been employed to deliver a second mobile response team across the Bridgend locality. The second MRT went live in May 2020.

Performance to the end of Q3 shows:

- Estimated Cost Avoidance of Mobile Response Team Callouts of £537,075 against the previous full year total of £759,262
- No of people receiving telecare service was 2,638, against the previous full year total of 2,659
- No. of Mobile Response Team Callouts- Ambulance avoided 2,387 against the previous full year total of 3,375
- No. of Mobile Response Team Callouts- Ambulance was called and the person conveyed 137 against the previous full year total of 186

Ambition 2 - A Primary and Community Care Multidisciplinary Team 'One Team Approach Around People'

Whilst it has disrupted and delayed the implementation of the workstream the onset of Covid-19 has not changed the overall long-term intentions that they behind it.

This is in part because the specific circumstances of the pandemic and also because the developments within this workstream were always seen as having a more long-term impact upon population health and the demand for services. However, all aspects have strong support from both the national policy agenda and evidence of success from elsewhere.

By providing better multi-disciplinary collaboration, improved services and better planning for individuals these elements should have a strong longer-term impact upon both the wellbeing of the population and the demands and pressures on other services.

The **SPoA** provided an effective response during the pandemic period, providing more timely response to GP's and people and their families requiring advice, reassurance, support during end-of-life care and equipment failure and requirements are responded to in an immediate way.

Ambition 3 - **Developing and Delivering Resilient Coordinated Communities**

Covid-19 has presented the third sector with a unique set of challenges and opportunities going forward. Some groups have strengthened and energised, whilst others have been challenged and needed to pause former activity with the future less certain for some organisations.

There has needed to be a responsive approach to the pandemic with high demands from the general public, vulnerable groups and statutory partners fortunately, the **Building Resilient Communities** programme has had to respond to these high volumes of community demand during the first two quarters as part of a joint approach with health and social care.

The project has been fully mobilised and community networks have been developing even though restrictions have been in place and we can see levels of community support harnessed has been significant during quarters 1 and 2 and a steady demand for support across the County can be seen during quarter 3.

The impact of Covid-19

There are a number of factors, aside from where Covid-19 has had a negative impact on staff recruitment (particularly there remains uncertainty over available funding and unless funding can be secured beyond April 2022 it would be difficult to recruit either temporary or permanent staff for just 8 months or so) and consultation to enable changes to service delivery arrangements to take place, For example:

Ambition 1 - Seven Day Access to Community Health and Social Care Services "Every Day Is Tuesday", 'One Team Approach Around People'

Unfortunately, the impact of the Health Board boundary change at the point of bid approval and early in the implementation meant that the service had to recommence consultation on the Bridgend Transformation ambitions with a new Health Board to enable recruitment to commence. Covid-19 and recruitment difficulties, along with changing expectations and requirements with regard to consultation and to the role of therapy staff mean that only limited progress has been made towards 7-day working since the mid-term report. Also, the uncertainty over the amount of funding available for 2021/22 has added further doubt about sustainability and reduced the ability of the workstream to appoint new staff to remaining vacancies.

For example, additional staff have been recruited into 2-year temporary posts for reablement therapy services but following changes in the regional configuration of health services agreement has not been finalised on the deployment and professional oversight of those staff as part of the extended hours service.

The planned expansion of the **Better@Home** service has not taken place because of difficulties in the recruitment of social care caused by the current state of the social care labour market in and around Bridgend. However, it has been possible to recruit to the Acute Clinical Team, although this was a relatively small number of posts.

Additional requirements around the need to consult with staff around the extension of the Common Access Point were further exacerbated by the impact of Covid-19, that has prevented effective consultation being possible with those staff affected by a change to an extended day. Also, there have been difficulties in recruitment and retention to this service also.

Ambition 2 - A Primary and Community Care Multidisciplinary Team 'One Team Approach Around People'

Delay in implementation has been the major impact of Covid-19 upon this workstream as both the new services themselves and those services they work with were disrupted by the pandemic. Up until January 2020 implementation was progressing smoothly, but it was then hit by the need for the whole system to respond to the pandemic.

Whilst the **SPoA** expansion took place, this was with some temporary arrangements in place which initially were about resolving the ability existing SPoA staff working from home; and thereafter other experienced professional nursing staff who were shielding.

The recruitment to the MDTs and their deployment was delayed with some newly recruited staff temporarily re-deployed to support the in-patient response to the pandemic. CPN's were redeployed to wards and to the field hospital but because staff were and have been fully operational within the emergent MDT approach.

The development of **Anticipatory Care Planning** process was also delayed because of Covid-19. The Care Navigators, who coordinate the MDT's and ensure quality assurance, were appointed but was not possible to release them to carry out their role fully to develop A/ACCP, as they were covering their recent admin roles due to delays in recruitment to substantive posts.

Considerations

Ambition 1 - Seven Day Access to Community Health and Social Care Services "Every Day Is Tuesday",

The key to maintaining the momentum created to date, assuming that further funding from 2021/22, is not only to focus on the recruitment to the roles but, to ensure that the roles are more appealing.

Furthermore, specific attention to multi-agency working arrangements during out of hours is required.

Ambition 2 - A Primary and Community Care Multidisciplinary Team 'One Team Approach Around People'

As we state in the report above, there is some evidence from the case studies that there is good potential for improved outcomes to delivered. Maintain the pace of development and delivery to fully establish the ACCP system and MDTs (alongside confirming funding for maintaining the SPoA arrangements) will be crucial going forward. The ability to recruit staff on a permanent basis will be crucial.

Ambition 3

Whilst the workstream has been supporting high volumes of demand and a growing network of partners this activity has been focused upon responding to the pandemic, not building up the longer-term strength and sustainability of the sector which had been the original aspiration.

In the short and medium term there is a strong case for continued support to community networks and groups as they adjust to "the new normal". In the longer term, the opportunity is there for the **Resilient Communities Programme** to consolidate and embed still further into local health and social care systems to achieve ever strengthening impact.

12.2 Regional/strategic conclusions and recommendations

The CTM Transformation Programme Workstreams were designed originally to help ensure that partners were able to develop services in line with the A Healthier Wales agenda. As a result of the Covid-19 pandemic response, all of the 7 Workstreams implementation plans have to varying degrees been affected, resulting in delays to their implementation of initiatives and on-going development, and more significantly, experienced real operating difficulties due to their ability to recruit staff or re-position staff to priority Covid-19 responses. However, since our last report in the Summer of 2020, the majority of projects have made progress, the evidence of which is beginning

to emerge as most robust data and qualitative evidence is routinely gathered and analysed.

With reference to our previous reporting of the regional projects funded by the Transformation Fund[16], we see:

- All of the workstreams continue to focus on improving the capacity of services in the community to support their local health, care and wellbeing needs. The design of the interventions in each workstream continues to fit well with national policy and Government guidance, evidence and emerging best practice.
- In the Summer of 2020, we reported that none of the projects had, at that time (mainly due to the pandemic), been able to show that they had successfully been fully implemented as planned or that the full evaluation of activity, performance and impact had been completed. However, as can be seen by the individual reports, and as a whole system, the projects provide real evidence of the improvement of individuals' outcomes, professionals' stating their experience and impact of new arrangements, and emerging data of positive cost avoidance activities.
- As stated in our previous report, given the level of investment that has already been made in these projects, the potential that they have for improving care and reducing costs elsewhere in the system, and their fit with national policy and evidence from elsewhere, there should be an on-going confidence that they will continue to achieve both positive individual and system outcomes. This of course, is assuming that each project can continue to maintain a robust regime of data collection in 2021/22.
- While 2021/2022 will continue to put energy into building robust data collections for the final evaluation report in 2022, it is noted that additional work is currently being undertaken across the region to inform sustainability planning. In Bridgend, the Optimal Model for Integrated Community Services arrangements is being reviewed with a view to developing a business case for the sustainability of an optimal model and dynamic service, financial and performance framework. A similar exercise in RCT and Merthyr Tydfil is looking to develop a business case for the sustainability of community services including review of effectiveness of existing community services arrangements and their appropriateness across the Merthyr Cynon and Rhondda Taf ILGs and the local authority areas. The result of these initiatives is that similar collection of evidence, albeit for different purposes is being collected simultaneously, therefore the region and individual projects will require a clear understanding of the requirements of both reports.
- We reiterate our previous statement that when assessing the impact for the final evaluation report in March 2022, there is a need to recognise the challenges in judging how any cost avoidance can be attributed to the activities of workstreams. We have seen that a number of the individual projects have provided this assessment – Community Health and Wellbeing Team and the Bridgend Community Resource Team (Bridgend Ambition 1) specifically records hospital bed days avoided as an outcome from their intervention. However, other projects currently do not make this financial link. Once again therefore, we reiterate that the final evaluations will have to be careful to evaluate cost/benefit for each workstream in a way that doesn't disadvantage those that are less clinical in nature.

[16] IPC (July 2020) Cwm Taf Morgannwg Regional Partnership Board Transformation Fund Deep Dive Review Overview Report

In addition to the points we have built upon from our earlier report, we would like to suggest that as all the projects enter their final year, the task of reflecting on their impact as a collection of inter-related or integrated services is increasingly important. Therefore, the region will need to explore how the performance of one project impacts on others. One suggestion is to ensure that the evaluation plans for each of the projects are in part 'co-produced' by as many of the projects as possible. Not only can this support a better understanding of the individual initiatives but also explore and agree how, in particular qualitative evidence from services users and professionals, be collated effectively and cross-referenced.

Finally, the region should consider how best to encourage and support on-going development in respect of improved understanding through education and learning for all staff and partners to enable the required and sustainable culture shift that ensures all community service options are considered in the first instance to avoid people being inappropriately conveyed or admitted to hospital.

Institute of Public Care
April 2021