Report of the Cabinet Member for Care, Health & Ageing Well

Adult Services Scrutiny Performance Panel – 17 February 2020

WEST GLAMORGAN PARTNERSHIP

Purpose	To provide an update as required by the board in relation to: • West Glamorgan Transformation Programme
Content	This report includes an update on the Key Workstreams of the three Transformation Board. Case studies from across the programme
Councillors are asked for their views on	The work of the programme since April 2019
Lead Councillor(s)	Cllr Mark Child, Cabinet Member for Care, Health and Ageing Well
Lead Officer(s)	Dave Howes, Director of Social Services
Report Author	Kelly Gillings; West Glamorgan Regional Director of Transformation

1. Background

1.1 Vision and Aim of the West Glamorgan Partnership

1.1.1 We will drive transformational improvements in wellbeing, health and care for the populations we serve through better practice, better services, better technologies and better use of resources.

1.1.2 We will change the way that we work with citizens away from paternalistic care to shared responsibility and co-production.

1.1.3 We will secure the delivery of seamless care which will meet the outcomes that matter to the people we serve and support through integration, earlier intervention and prevention

1.1.4 We will manage our common resources collaboratively and pool resources wherever we can.

1.1.5 We will have a single and simple governance structure covering Public Service Boards, the Regional Partnership Board and sub-structures for the region (Appendix 1)

1.2 The Regional Programme exists to:

1.2.1 Drive continuous improvement in wellbeing, health and care in partnership.

1.2.2 Work in co-production with partners from the third sector, voluntary sector, private sector and our citizens to secure more seamless care in communities.

1.2.3 Cross service boundaries to develop better, more seamless care.

1.2.4 Promote a healthier region through asset-based communities.

1.2.5 Make sure our agencies put people at the heart of wellbeing, health and care transformation, integration and prevention.

1.2.6 Help to make sure that people live healthier and happier lives

1.2.7 Deliver the Regional Transformational Strategy and Plan

The aims and vision of West Glamorgan Partnership can be summed up in the following simple strapline, which we can use in all promotional material.

Promote West Glamorgan's real wealth through better wellbeing, health and care

2. Regional Priorities

2.1 The regional priorities for West Glamorgan as documented in the Area Plan for 2018-2023. There are key themes, which align with the Population Assessment priorities and where regional working has been identified as adding the most value:

- Older People (OP)
- Children and Young People (CYP)
- Mental Health (MH)
- Learning Disability and Autism (LD)
- Carers (cross-cutting theme) (CA)

2.2 To this end, the following priorities were agreed by the Regional Partnership Board:

OP.P1: Develop and maintain a sustainable range of services that meet demand, enabling individuals to remain at home while maintaining their independence for as long as possible receiving appropriate support at times of need.

OP.P2: Develop and provide a range of future accommodation options to meet demand and enable people to remain independent for as long as possible.

OP.P3: Develop community resilience and cohesion to tackle social isolation in areas where older people live

OP.P4: Develop an optimum model for older people's mental health services (including relevant components of the Welsh Government All Wales **Dementia** Strategy/Plan)

CYP.P1: Develop a better range of services for all children with emotional difficulties and well-being or mental health issues, including transition and single point of access to services

CYP.P2: Develop robust multi-agency arrangements for children with complex needs

CYP.P3 Safe Reduction of Looked After Children

MH.P1: Commence implementation of the agreed optimum model for Adult Mental Health services, as outlined in the West Glamorgan Strategic Framework for Adults with Mental Health problems

MH.P2: Ensure placements for people with complex needs are effective, outcome-based and appropriate

LD.P1. Develop age blind person centred models of care to ensure prevention and early intervention through multi-disciplinary services, by remodelling services away from establishment-based care into community-based services.

CA.P1: Ensure work continues to promote early recognition of all Carers so that they are signposted to information and support in a timely manner

CA.P2: Develop and continue to provide information, advice, assistance and support to all Carers enabling them to make informed choices and maintain their own health and well-being

CA.P3: Co-produce with all Carers on an individual and strategic basis so that their contribution is acknowledged and their voices are heard.

3. Workstream Information

The workstream background and information can be viewed in Appendix 2

4. Case Studies

The case studies as requested at the last meeting:

- **Appendix 3** - 3 Case Studies for the Commissioning for Complex Needs Programme
- **Appendix 4** - 2 Case Studies from the Working Together Programme
- **Appendix 5** – 2 Case Studies from Multi Agency Placement Support Service

5. Workstreams and Progress Update

Key Workstreams	Progress - High Level Milestones	RAG
Adults Transformation Board		
Review of the Optimum Model, What Matters to Me, for Intermediate Care Services	**April to June 2019** • ICF funding proposal agreed for 19/20 • Implementation Group established • Programme Plan and Programme Initiation Document approved **July to September 2019** • Workshop held to identify differences/similarities between service provision in Neath Port Talbot and Swansea • Developed a spreadsheet outlining service delivery in each locality mapping element of the optimal model including funding streams and staffing • Working with H2H work stream to gain clarity on patient flow, checking data and working out performance measures around reablement **October to December 2019** • Contribution to the HB strategic Winter Plans and development of the RPB winter pressures plan. **Upcoming Milestones** • In depth review of the remaining elements of the Optimal model that are not part of H2H or separate Health Board review of ACT	**Reason** Resource has currently been focussed on implementation on H2H. Adults Transformation Manager post vacant until 24th January 2020 **Mitigation** Work to commence in January to review the remaining optimum model elements, alongside the new H2H service to support what is required. Adults Transformation Manager post filled from January 24th 2020

Key Workstreams	Progress - High Level Milestones	RAG
Regional Hospital to Home (Recovery) Service	**April to June 2019** • Transformation bid submitted to Welsh Government to develop a Hospital to Home reablement service • ICF funding proposal agreed for 19/20 • Implementation Group established • Programme Plan and Programme Initiation Document approved • Options Appraisal in progress **July to September 2019** • Workshop held in July with staff to begin to map the different components and delivery process and explain Prof John Bolton's Model. • Amended Transformation funding application submitted to Welsh Government with reduced funding request, acknowledging any reduction in funding will impact on delivery. • Workshop with Professor John Bolton to map West Glam data against the Model • Continue to work on ensuring we have the correct baseline data to inform current capacity and what is required going forward • Separate work streams identified to work through current capacity and to consider feedback form each workshop **October to December 2019** • Develop and Refine standard operating procedures for each element of the H2H model	**Reason** Risk around the lack of capacity in domiciliary care market to support H2H service Programme Manager post vacant **Mitigation** Number of winter pressures funding initiatives to increase dom care capacity Programme Manager post recruited to – await start date

Key Workstreams	Progress - High Level Milestones	RAG
	• Staff engagement sessions to ensure all operational staff understand the rationale for change and have the opportunity to ask questions • Recruitment of therapist to support the model (Health Board) • First phase, soft launch implemented in December • Performance measures agreed and baseline data captured • Data collection systems currently under development, including electronic SIGNAL system • H2H navigator competency training completed • Communications material produced • Service launched on 10th December • Outward Flow for Reablement Services was considered and option agreed • Service operating procedures brought together as one regional document and reflects local delivery • Same level of ICF funding approved for 20/21 • Winter pressures funding allocated and approved for H2H (£850k) **Upcoming Milestones** • Rollout of H2H service to remaining wards • Start of new programme manager • Final baseline figures to be collated • SIGNAL system for data collection to be completed and rolled out	

Key Workstreams	Progress - High Level Milestones	RAG
	• Develop a regional reporting score card and finalise formal reporting process • Trouble shoot any issues as they arise • Sign off final regional pathway	
Strategic Framework and Plan for Dementia	**April to June 2019** • ICF funding proposal agreed for 19/20 • Programme Plan and Programme Initiation Document approved **July to September 2019** • Commissioned Swansea University (Centre for Innovative Ageing) to complete research-led mapping exercise that will support the development of the strategic framework and strategic plan – outlining available services across the region and associated barriers to access (those living with dementia and their carers). • Institute of Public Care workshop to support the development of key strategic documents - engagement with key stakeholders across the region to inform work. • Formation of themed Task Groups underpinned by DAP and governed by over-arching Dementia Strategy Group. **October to December 2019** • Engagement with Welsh Government and Opinion Research Services to improve strategic drive across region for dementia services. • Draft Evaluation Framework to ensure outcomes are measurable and reflect principles of '*what matters to me*.'	

Key Workstreams	Progress - High Level Milestones	RAG
	• Engagement with clinical expertise to bolster service pathways and link with Improvement Cymru. • Structure integration of co-production across strategy groups **Upcoming Milestones** • Allocate dementia ICF funding for 2020/21 • Refine/focus the priorities outlined in the Strategic Framework document • Receive updates from Swansea University research team with regards to stage 1 and 2 progress. • Plan focus for remaining IPC day allocation – Evaluation Framework/Training • Formalise Task Groups and Identify key priorities • Develop timeline for delivery	
Commissioning for Complex Needs Project	**April to June 2019** • ICF funding proposal agreed for 19/20 • Programme Plan and Programme Initiation Document approved • £74,321 annual saving achieved • 38 outcome focused assessments carried out **July to September 2019** • £109,383 annual savings achieved with an additional £174,000 awaiting finance sign off • 9 outcome focused assessments carried out	**Reason** Savings not on target due to delays in recruitment of Outcome Focused Assessors **Mitigation** Assessor posts currently out to advert

Key Workstreams	Progress - High Level Milestones	RAG
	ICF Capital Grant approved for complex needs accommodation in Swansea Continued development of Joint Funding Matrix **October to December 2019** £326,633 annual savings achieved with an additional £27,215 awaiting finance sign off 16 outcome focused assessments carried out Process to begin the purchase of land in Penyrheol, Swansea for the new ICF Capital funded supported living scheme Business case for 20/21 approved at Adults Transformation Board **Upcoming Milestones** Review the regional brokerage service Continue with work to review funding of packages of care for individuals with complex needs Individual environmental briefs to be written and building specification for new build supported living property Business case to be written by December 2020 showing future options and exit strategy	
Transforming Adults Mental Health Services	**April to June 2019** ICF funding proposal agreed for 19/20 and 20/21 Confirmation of 7 key projects within the programme with allocated lead for each All project teams have been established, with meeting dates scheduled for the next 12 months	

Key Workstreams	Progress - High Level Milestones	RAG
	July to September 2019 • Programme Plan and Programme Initiation Document signed off by West Glamorgan Adults Transformation Board • ICF Funding Re-profile submitted • Invest to save proposal for expansion of CHC team was not considered by IBG in September. Held over to October Meeting **October to December 2019** • Final agreement of service specification for the Sanctuary Service following provider and service user and carer market engagement events • Successful recruitment of 2 X fte project manager and 1 X fte project support officer posts to support delivery across all projects • Review and feedback on the initial draft of the Strategic Outline Case for the Adult Acute Assessment Reprovision **Upcoming Milestones** • Revise all projects to establish any interdependencies and cross cutting themes. Project governance will be revised as required • Completion of procurement exercise and contract award for Sanctuary Service • Establishment of a Single Point of Access Hub in Swansea for CMHTs & Cluster Based Services	

Key Workstreams	Progress - High Level Milestones	RAG
Children and Young People Transformation Board:		
Regional Strategy	**April to June 2019** • Regional working group set up **July to September 2019** • Draft regional strategy and plan on a page circulated **October to December 2019** • Revise strategy to cover all children and young people within the region **Upcoming Milestones** • Hold workshop for all sectors	
Multi Agency Placement Support Service	**April to June 2019** • ICF funding proposal agreed for 19/20 • Programme Plan and Programme Initiation Document approved • Steering group established • Induction training carried out for new staff • Draft performance management framework developed **July to September 2019** • Performance management framework established • Business support post appointed – service fully staffed **October to December 2019** • Mapping exercise	**Reason** Two therapy posts have become vacant **Mitigation** New staffing structure to be implemented and recruited for based on agreed business case

Key Workstreams	Progress - High Level Milestones	RAG
	• Feedback survey from children, carers, social workers and schools • Business Case for 2020/21 agreed at CYP Board Meeting **Upcoming Milestones** • Management of change to be implemented • A business case will be developed for December 2020 demonstrating the impact of gaining funding for 20/21 to mainstream the delivery model through core funding from April 2021, which could include an option for a pooled fund.	
Children and Young People's Emotional and Mental Health Planning Group	**April to June 2019** • ICF funding proposal agreed for 19/20 • Programme Plan and Programme Initiation Document approved • Delivery plan agreed for 19/20 • Set of activity measures developed **July to September 2019** • Strategic vision for CAMHS – Task and Finish group meetings held with staff, and conclusions presented to CYP Planning Group in September • Suitable accommodation for CYP identified for all services including centralisation of NDD. Plan agreed for final completion June 2020. • Presentation to planning group to highlight CAMHS liaison role, and outcomes by presenting case studies	**Reason** CAMHS were compliant against 3 out of 4 Welsh Government targets at the end of October. P-CAMHS were non-compliant against the assessment target at the end of October, however the trend in the graph below highlights a significant improvement during this financial year. **Mitigation** Work is progressing to implement the strategic vision for CAMHS including a single point of access and an integrated service.

Key Workstreams	Progress - High Level Milestones	RAG
	• CAMHS and NDD Performance – improving position with some stabilisation of NDD, still some Welsh Government targets where compliance remains under target, hence amber rating **October to December 2019** • Business case for CAMHS Liaison workers presented at CYP Transformation Board and agreed • Key recommendations in relation to accommodation and the service model for CAMHS were approved by CYP Emotional & Mental Health Planning Group in relation to CAMHS service model and accommodations plans • WLI clinics to maintain good performance for S-CAMHS, expansion of P-CAMHS team to improve 28 assessment target • Specification agreed for the CYP website • Training secured for local authority staff (Youth Mental Health) **Upcoming Milestones** • Meeting of the CAMHS Prevention & Wellbeing Sub-Group to discuss progress with training and the development of the website for CYP • A meeting will be scheduled with the single point of access teams to discuss the CAMHS liaison business case, and agree a work programme for implementation • Work will continue on phase 2 of the accommodation plans for CAMHS including staff consultation, and development of the Kingsway property for children & young people living in Swansea • Exit strategy for 2021/22 for the liaison service offered by CAMHS will be expanded to include these roles as part of the	

Key Workstreams	Progress - High Level Milestones	RAG
	CAMHS core service, enabling this service to be mainstreamed via Health Board core funding.	
Working Together Project	**April to June 2019** • ICF funding proposal agreed for 19/20 • Associated ICF capital funding proposal agreed for 19/20 • Programme Plan and Programme Initiation Document approved • Recruitment processes underway **July to September 2019** • Capital funding for Edge of Care property has been agreed and property has been identified • Appropriate level of governance has been agreed • Begin to establish keyworker teams **October to December 2019** • Regional paper covering service written, which describes the regional approach • Staff have come into post and training implemented • Developed IFSS (Integrated Family Support for Substance Misuse) model to focus on neglect • Finalising outcomes and development of overarching performance monitoring **Upcoming Milestones**	

Key Workstreams	Progress - High Level Milestones	RAG
	• Accurate timeline for the development of the respite home (Swansea). • Development of regional training programme • Sharing the learning regional and showcasing the model event • Business case showing future options for exit strategy to be written by December 2020	
Western Bay Adoption Therapeutic Service	**April to June 2019** • ICF funding proposal agreed for 19/20 • Recruitment of team in progress **July to September 2019** • Recruitment to the therapy posts completed • Further advertisement of the Psychologist post **October to December 2019** • Recruitment of therapists has been completed – they are starting in post from now until 4th January 2020. • Psychologist has now been successfully recruited • Development of Performance Framework • Agreement that Western Bay Management Board will operate as the steering group for the service **Upcoming Milestones** • New staff starting – training and induction to be carried out • The therapists will begin their interventions with families. Weekly team referral/consultations will take place to consider the cases open within the adoption support team.	

Key Workstreams	Progress - High Level Milestones	RAG
	• The team will attend the monthly linking meetings to support effective matching processes. • The team will provide upskilling support to social workers and family finding social workers. • Move to Tregelles Court planned for January 2020 • Business case showing future options for exit strategy to be completed by December 2020	
Integrated Transformation Board:		
Welsh Community Care Information System (WCCIS)	**April to June 2019** • Development of refreshed Project Initiation Document and revised governance structure to take into account a regional approach to digital transformation • Continued to support Swansea Council's local implementation, identifying opportunities for service improvement and streamlining processes • Supported Swansea Bay University Health Board's review of the Community Nursing Proposal, which would allow early adoption of the system for recognised teams **July to September 2019** • Inaugural meeting of Digital Transformation & WCCIS Implementation Group in August 2019; Terms of Reference agreed • Governance agreed and groups established/arranged • Programme Initiation Document updated and approved • ICF confirmed for 19/20 & 20/21 (including uplift in 20/21)	

Key Workstreams	Progress - High Level Milestones	RAG
	October to December 2019 • Sub-Groups established and Terms of Reference agreed • Task and finish group to develop regional Benefits Register established • Programme Plan updated in collaboration with partners • Interviews arranged for Regional WCCIS Project Support Assistant early in the new year • Meeting with CVS Directors to determine appropriate engagement with WCCIS programme **Upcoming Milestones** • Programme Plan to be finalised • Recruitment of Regional WCCIS Project Support Assistant • Regional Benefits Register drafted • Strengthen links with 3rd Sector and establish data sharing opportunities • The implementation of WCCIS in Swansea Council, which also incorporates a considerable volume of Swansea Bay UHB staff who sit in integrated teams and regional substance misuse teams, is due to conclude with system Go-Live in June 2020.	
Digital Transformation	**April to June 2019** • Development of Project Initiation Document and governance structure to align Digital Transformation ambitions with those of the WCCIS work-stream	

Key Workstreams	Progress - High Level Milestones	RAG
	July to September 2019 • Inaugural meeting of Digital Transformation & WCCIS Implementation Group in August 2019; Terms of Reference agreed • Introductory meetings held between Programme Lead, Regional Team and Digital/Service Leads across the partner organisations • Governance agreed and groups established • Programme Initiation Document updated and approved **October to December 2019** • Sub-Groups established and Terms of Reference agreed • Task and finish group to develop regional Data Sharing Protocol established • Facilitated discussions to agree how devices are managed for SBUHB staff using Swansea Council kit in the short term. **Upcoming Milestones** • Regional Digital Strategy drafted • Regional Data Sharing Protocol drafted • Longer term approach to device management across the region, particularly within integrated teams.	
Our Neighbourhood Approach, Transformation Fund Programme	**April to June 2019** • Funding proposal approved by Welsh Government. • Governance arrangements agreed.	

Key Workstreams	Progress - High Level Milestones	RAG
	• Evaluation for transformation tender process underway. • Collation of baseline performance measures in progress. • Recruitment for posts under-way. • Development of Community grant pots under-way. **July to September 2019** • Governance arrangements for both Swansea and Neath Port Talbot programmes are in place. • Recruitment of key posts for delivery of pilots in Swansea (some posts are in progress) including Our Neighbourhood Development Officers. • Launch of grant pot to support Voluntary Community groups/social enterprises for the Briton Ferry/Melin area in Neath Port Talbot. • Appointment of a third party to conduct the programme evaluation (across programmes in Swansea and Neath Port Talbot). **October to December 2019** • 'A Healthier Wales – Transforming health and care in Wales' regional event in Swansea. • Completion of Mid-Point evaluation review and production of a Mid-Point Report, for RPB endorsement by and submission to Welsh Government. • Completion of consultation for Early Help Hubs with staff and stakeholders.	

Key Workstreams	Progress - High Level Milestones	RAG
	• High-level action plan covering the work under Building Safe and Resilient Communities (BSRC) is live and being updated regularly. • A number of public-facing engagement events have been held including public meetings with local communities, third sector and council representatives. **Upcoming Milestones** • Completion of mapping of short- and medium-term measures across Transformation Funded programmes, aligned with outcomes and performance measurements. • Completion of outstanding recruitment activities in Swansea including Local Area Co-ordinators and Social Workers. • Establishment of Neighbourhood Forums in communities in Neath Port Talbot areas. • Planning for sustainability of new models and services beyond end of Transformation Funds.	
Clusters Whole System Approach, Transformation Fund Programme	**April to June 2019** • Funding proposal for remaining rollout to all 8 clusters approved by Welsh Government • Evaluation for transformation tender process underway • Collation of baseline performance measures in progress Cwmtawe: • The establishment of an extended primary care audiology service across the whole cluster	

Key Workstreams	Progress - High Level Milestones	RAG
	• The introduction of Local Area Co-ordination • Commencement of a young carers project working closely with GP practices • The introduction of community based glaucoma clinics. • The establishment of a Community Interest Company providing a sustainable focus on improving health and well being Neath: • Scoping and progression of the Social Enterprise with a Community Interest Group decided upon, learning from Cwmtawe is being shared. • Roll out and recruitment for the oral health programme in care homes. • Development of a cluster based patient group to take forward community involvement and interactive feedback mechanisms. • Remodelling of the Neath Hub Wellbeing service to develop a Social Prescribing Link Worker • Developing an innovative business case for a digital hub within care homes. **July to September 2019** • All four planned cluster elements have commenced, with Cwmtawe moving at pace into implementation for many of the projects • Active learning is being used to support rollout across clusters, based on success of Cwmtawe implementation **October to December 2019**	

Key Workstreams	Progress - High Level Milestones	RAG

	• Establishment of a Programme Board to ensure effective oversight and scrutiny.
	• Successful workshop delivered at The National Primary Care Conference on the Cwmtawe Approach.
	• Cwmtawe Cluster is in full implementation phase, recent developments include launch of 'Ask my GP' digital consultation option.
	• The remaining roll out clusters continue to progress well with activities including:
	  ○ Ongoing testing of the extended Multidisciplinary Team (MDT) at primary care level;
	  ○ Roll out of "Walk in Talk in" Clinics;
	  ○ Additional Audiology provision;
	  ○ Development of a community-based "Upper Valleys Suite" completed collaboratively using a place-based approach;
	  ○ Development of service proposals to moved care closer to home e.g. Ultra Sound Guided injections and sleep apnoea clinics;
	  ○ Exploration of care navigation models and integrated wellbeing approaches;
	  ○ Increasing the scope of Local Area Co-ordination across the region;
	  ○ Commissioning of feasibility studies for social enterprise models commenced.
	Upcoming Milestones	

Key Workstreams	Progress - High Level Milestones	RAG
	• Launch of the four remaining clusters in January 2020, • Commissioning of a feasibility study for Social Enterprises in Neath Port Talbot. • Development of a Programme Visual articulating the Transformation Funded programme for external audiences. • Planning for sustainability of new models and services beyond end of Transformation Funds.	
Development of Regional Strategic Framework for Housing, Health and Social Care	**April to June 2019** • Initial allocation of ICF capital funding allocated to range of regional priorities supporting the West Glamorgan programmes and projects • First Social Care, Health and Housing Group held on 14th May. TOR agreed. • Work underway by Opinion Research Services (ORS) to undertake a local housing market needs assessment across the Region • Second allocation of capital schemes prioritised by Housing Group members and submitted to Welsh Government **July to September 2019** • Scheduling of consultancy support from the Institute of Public Care (IPC) to facilitate development of Regional Housing Strategy • Meeting of Social Care, Health and Housing Group in August to review links to the work of the Citicial Incident Group.	**Reason** Until a Regional Strategic Framework is in place, allocation and commitment of future capital investment is unclear. **Mitigation** 'Outline' document created to inform allocation of Capital Funding for 2020/21 and co-production of the Regional Strategic Framework. Future allocations will be informed by the framework for future years of capital investment.

Key Workstreams	Progress - High Level Milestones	RAG
	• Development of proposal for Welsh Government on use of revenue funding for support of people with complex needs, particularly the homeless/vulnerably housed. **October to December 2019** • Completion of planning workshops (supported by IPC) and research to inform Regional Housing Strategy. • Draft 'Outline' document created to inform a co-productive approach to developing a regional strategic framework. • Priorities for allocation of ICF Capital Funding in 2020/21 – delivered in parallel to design of the framework – agreed through Integrated Transformation Board. **Upcoming Milestones** • Completion of prioritisation and allocation of ICF Capital Funding for 2020/21. • Submission of Project Initiation Document and Project Plan for the development of the Regional Housing Strategy. • Co-production of a draft Regional Strategic Framework, supported by representatives from Social Care, Health and Housing Group and their stakeholders/ • s.	
Development of Regional Carers Strategy	**April to June 2019** • Carers Partnership Board meeting took place on 25th June. • TOR reviewed and agreed	

Key Workstreams	Progress - High Level Milestones	RAG
	New Chair / Lead Gaynor Richards, Director for Neath Port Talbot Council for Voluntary Service for Carers Partnership Board appointed in July 19. **July to September 2019** Approval of Regional Carers Strategy Project Initiation Document and Project Plan. Planning has commenced on the development of the strategy vision and principles following a number of workshop sessions. **October to December 2019** Initial input into the Regional Carers Strategy including carers-focused sessions in Swansea and Neath Port Talbot. Completion and submission of an 'outline' strategy document which establishes the vision, principles and key aims of the strategy. Priorities for allocation of Carers Funding in 2020/21 – delivered in parallel to design of the strategy – agreed through Integrated Transformation Board. Following the resignation of the previous post hold, recruitment to the West Glamorgan Carers Development Officer post has commenced. The Post will support the development of the Regional Strategy. **Upcoming Milestones** Completion of co-production activities to inform the development of the Regional Carers Strategy including engagement with carers groups, networks and representatives. Completion of prioritisation and allocation of Carers Funding for 2020/21.	

Key Workstreams	Progress - High Level Milestones	RAG
	• Recruitment to West Glamorgan Carers Development Officer post.	
Social Value Forum	**April to June 2019** • Integrated Care Fund Proposal for Co-production approved at Integrated Board • Recruitment of Social Value Development Officer completed in Swansea CVS and recruitment underway in NPTCVS. • Links have been established with the North Wales Social Value Forum and we have attended a presentation about an approach to using SROI to demonstrate social value. • Training dates for Forum members are being booked with a full Forum regrading launch intended for October. • Worked with a partnership of local organisations who are submitting a Regional bid to the Foundational Economy WG grant scheme. The intention is to link the RPB Social Value Forum work into wider work around procurement should the bid be successful. **July to September 2019** • Approval of Project Initiation Document and Project Plan by Integrated Transformation Board on 19th September 2019 • Set-up of revised Social Value Forum with focus on ensuring the right people are invited. **October to December 2019**	

Key Workstreams	Progress - High Level Milestones	RAG
	• Relaunch of Social Value Forum was held on 9th October 2019 with good feedback and interaction from various organisations and sectors. • Completed delivery of training to support attendees in the application of Social Return on Investment (SROI) within the Social Value Forum. • First meeting of Social Value Forum Steering Group held on 11th December 2019. **Upcoming Milestones** • Next Social Value Forum event to be held in Spring 2020, to present a Social Value Charter for organisations to sign up to at the event. • Finalise work plan and communications plan for continuation of support for Social Value Forum. • Planning for making the Social Value Forum an ongoing, sustainable function.	
Co-production	**April to June 2019** • Integrated Care Fund Proposal for Co-production approved at Integrated Board • A member of staff has been recruited to undertake the work in SCVS, with recruitment underway in Neath Port Talbot CVS. The recruitment process has been co-produced with citizens/carers. The post holders will be expected to coordinate recruitment of citizen/carer representatives (in partnership with WGlam Coproduction Group).	

Key Workstreams	Progress - High Level Milestones	RAG
	• A meeting has been scheduled for August 2019, this will agree the recruitment process for representatives as well as consider the development of a co-production strategy and expenses procedure for representatives. **July to September 2019** • Co-production Group meeting on 20 August 2019 to review the Terms of Reference and associated processes for establishing co-production. • Establishment of a Task & Finish Group for the development of the Project Initiation Document and Project Plan for delivery of the Regional Co-production Strategy. • Recruitment of part-time Co-production Development Officers who will support co-production service design and implementation. **October to December 2019** • Co-production Group met to review progress and agreed next steps. • Task & Finish Group met to plan the delivery of key pieces of work related to co-production, but agreed that the approach to embedding co-production would not follow traditional project management processes. • Representative recruitment process has been co-produced and the campaign is scheduled to begin with promotion from partners and supporters. • Launch of the Co-production Group Facebook page and private group, accompanied by a dedicated logo and strapline. **Upcoming Milestones**	

Key Workstreams	Progress - High Level Milestones	RAG
	• Commencing a co-productive approach to defining and embedding the principles of co-production with partner organisations and West Glamorgan programmes of transformation. • Begin developing co-production and representative processes and work to support our regional ambition for co-production. • Complete recruitment, induction and training of additional citizen and carers representatives across various boards and sub-groups.	
Social Enterprise	**April to June 2019** • Ongoing work to support development and sustainability of Social Enterprises. **July to September 2019** • Social Enterprise development officers continue to engage with and support organisations across the region through advice, information and assistance. • Some successes in this engagement include Paul Popham Fund, Swansea Community Farm, Magnolias Cancer Charity and Bulldogs Boxing and Community Activity. **October to December 2019** • Submission of Business Case to Integrated Transformation Programme for continuation of funding for Social Enterprise Support Officer roles in SCVS and NPTCVS. **Upcoming Milestones** • Continuation of support provided to organisations across the region.	

Key Workstreams	Progress - High Level Milestones	RAG
	Commence planning for ongoing sustainability of the service provided beyond current funding allocation.	

6. Financial Implications

There were no financial implications for core funding in this programme. All programmes and projects are either funded via ICF funding or transformation funding.

7. Workforce Impact

Not applicable.

8. Equality and Engagement Implications

All individual programmes and projects will consider the equality and engagement implications.

9. Legal Implications

There are no legal implications associated with this report

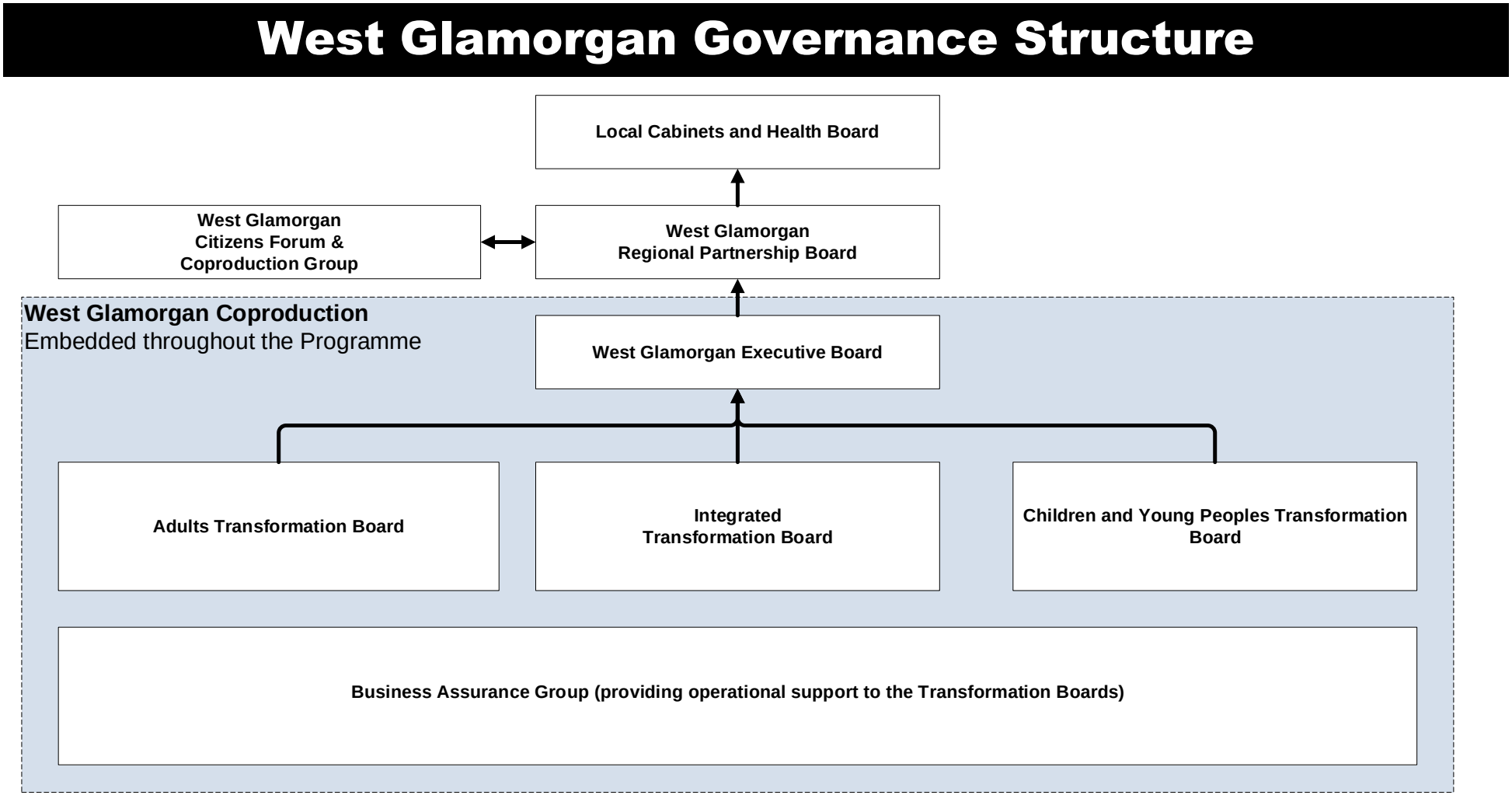
10. Risk Management

All individual programmes and projects utilise a risk management strategy.

11. Background Papers:

West Glamorgan Adult Services Scrutiny Performance Panel – West Glamorgan Partnership 30th July 2019

Appendix 1 – West Glamorgan Partnership Governance Structure



Appendix 2 - Workstream Background Information

Adults' Transformation Board

The Adults' Transformation Board oversees the transformation of Health and Social Care services for adults, ensuring partners work together to improve outcomes for citizens across the West Glamorgan region.

The Board comprises the following workstreams:

Optimal Model Review of Intermediate Care Services

Since 2014, the organisations that make up the West Glamorgan Regional Partnership have been working together to improve services for frail older people aged 65 and over. The key aim of this workstream is to help older people who become unwell to remain in the comfort of their own home, avoiding a hospital stay unless it is absolutely necessary. If an older person does need to go into hospital, the service supports them to return home as soon as they are well enough to be discharged. People are also given support to live independently in their own homes for as long as possible.

When the service was created, its intention was to change the nature of conversations with people by asking 'what matters to you?', rather than 'what's the matter with you?'. By shifting the focus, those delivering services could work towards what people identified as being important to them, rather than assuming what they needed.

The optimal model comprises a number of elements that have been implemented across the region, and involves a number of different professions, including doctors, nurses, social workers, occupational therapists, physiotherapists and health care support workers.

An independent evaluation of the approach described above was undertaken in 2017. This found that many elements were working well, and a recommendation was made to carry out a review to ensure services continue to develop and improve. This review will look at each part of the service put in place in 2014 and determine if everything is still working efficiently and delivering the best possible outcomes for people.

The reablement pathway following a hospital admission element of the optimal model is being reviewed as part of the 'Hospital 2 Home' Recovery Service outlined below.

'Hospital 2 Home' Recovery Service

The 'Hospital 2 Home' Recovery Service focuses on ensuring patients leaving hospital receive the right level of reablement care and support. The service aims to improve outcomes for older people following an unscheduled admission to hospital.

Earlier discharge from hospital will be facilitated through development of a more streamlined pathway, with a view to reduce demand and long-term pressures on managed care services. The intention is to create a system that is financially viable, while making the best use of resources and most importantly, delivering the best outcomes for those leaving hospital.

The service will ensure care packages are appropriate before being put in place, which will prevent over-prescribing of Social Care over long periods of time. Coproduction and decisions based on 'what matters' to the individual will be central to every case, in keeping with the service's ethos of empowerment and person-centred care.

How will this be achieved?

Staff will initially assess people in hospital to ensure they are suitable for the service, then a more in depth assessment will take place with the individual in their own home, identifying what services are required and ensuring they are offered the opportunity to reach their full potential in terms of reablement and independence. Staff responsible for delivering the service work across Health, Social Care and the Third Sector, and have an in-depth knowledge the kinds of support available.

Development of a Strategic Framework to support those living with Dementia and their Carers

Dementia is a major public health issue in Wales. Approximately 42,000 people have dementia, and it is most common among older people. As life expectancy increases, so will the prevalence of dementia, posing a significant challenge to Health and Social Care services. We also acknowledge care and support for those with early onset dementia. As with late onset dementia, the consensus is that prevalence increases exponentially with increasing age, roughly doubling every five years.

Over the years many organisations, including of Health and Social Care, have developed services and projects aimed at supporting people living with dementia, their families and carers. The development of services has not always been 'joined-up' with different organisations not always understanding what each can offer.

The plan for this work stream is to look at all the services offered and take a more strategic, integrated approach to ensure people receive the best possible support and care. The Welsh Government's Dementia Action Plan for Wales (2018-2022) provides a basis for this agenda in West Glamorgan.

It includes seven key themes:

1. Risk reduction and delaying onset
2. Raising awareness and understanding
3. Recognition and identification
4. Assessment and diagnosis
5. Living as well as possible for as long as possible with dementia
6. The need for increased support
7. The implementation of actions to support the plan.

These themes provide a solid foundation upon which to build a strategic framework and clear plan. However, before we start planning for the future we need to understand our current position. An integral part of this is a research-led *mapping exercise,* governed by the Centre for Innovative Ageing at Swansea University. This will capture what support is already available, identify what might be missing and help formulate an approach to support existing services and develop provision for service shortfalls.

The mapping exercise will include all statutory and non-statutory Health and Social Care services that people living with dementia and their carers can access. This will help provide a better understanding of the processes and experiences of dementia care, offering an insight into how care is delivered and identifying any barriers.

The work will run alongside, and inform, the development of a strategic framework and clear plan. The framework will highlight the key areas which need to be developed and identify examples of good practice that could be rolled out across the region.

Commissioning for Complex Needs Project

The Commissioning for Complex Needs Programme is transforming the lives of people receiving care services, while also delivering significant financial benefits. Its main aim is to address any irregularities in the quality of commissioned care across the region. This involves fostering positive, co-productive relationships with care providers, with the ultimate aim of increasing the independence of service users, and supporting them to achieve their personal well-being goals.

The ethos is one of true collaboration that puts the person at the centre of service planning and delivery. Care providers work closely with representatives from health and social services to create bespoke, outcome-focussed packages of care for each individual.

This methodology empowers people to support themselves, become less reliant on services in the longer term, meaning cashable savings are also realised.

The main aims of the Commissioning for Complex Needs Programme are:

- To effect a sustainable and efficient 'practice to commissioning' methodology across West Glamorgan which commissions high quality health and social care services which are proportionate to need and are cost effective.
- To enable sharing and coordination of information, intelligence and planning together in the service areas of common interest
- To help partners shift front line practice towards the requirement of the Social Services and Well-being (Wales) Act 2014
- To provide opportunities for people with learning disabilities to live fulfilled lives within their local community, being closer to family, friends, specialist services and support networks.

These will be achieved through implementing an 'Outcome Focused' methodology to assess an individual's needs and identify opportunities where independence can be developed.

Focusing on outcomes creates a pathway to independence, which in turn reduces the need for people to access residential or hospital provision.

A 'step down' model will also be implemented to move individuals from long-term residential and educational facilities into more suitable provision that is closer to home whilst also increasing independence.

Well-being and Mental Health

The Well-being and Mental Health Board was established to oversee the implementation of a new Strategic Framework for Mental Health, as well as the delivery of the Welsh Government's 'Together for Mental Health Strategy'. It reports directly into the West Glamorgan Adults' Transformation Board.

Implementing the Adult Mental Health Strategic Framework

The policy agenda for Mental Health and Learning Disability services is aligned to the principles of the Social Services and Well-being (Wales) Act 2014 and the Well-being of Future Generations (Wales) Act 2015; that we cannot continue to do things in the same way if we are to meet future challenges and increasing demand.

The Strategic Framework for Adult Mental Health (created in 2018) covers the whole spectrum of need; from building resilience at a community level, to improving the range of specialist services available to people with the most complex needs. It incorporates the findings of a report commissioned by the previous Western Bay Regional Partnership Board on unmet Mental Health needs in our area.

Developed co-productively with stakeholders and service users, this framework provides a clear direction of travel for enhancing the availability of services across Health and Social Care. The framework lays the foundation for the development of a new model which will deliver a range of services available to everyone experiencing Mental Health problems (irrespective of the severity), with a clear focus on prevention and earlier intervention.

Children and Young People's Transformation Board

The Children and Young People's Transformation Board's main aim is to oversee the development and delivery of the regional transformation of Children's Services.

We want all children, young people and families to live safe, healthy and fulfilled lives and to reach their full potential. Our services will work together to help families and communities to be resilient and independent. When they need extra care or support, we will listen carefully to what they say, and work hard to provide the right help at the right time.

The Children and Young People Programme will focus on:

- ensuring children and young people get a great start in life
- preventing problems arising and promoting resilience
- working as equal partners (organisations/agencies, professionals and citizens)
- offering safe, proven and cost-effective seamless services
- helping people quickly when they need it so that problems don't get out of hand, and we can reduce the demand for complex or substitute care
- working across professional and agency boundaries whenever it is in the interest of children, young people and families.

The Board comprises the following workstreams:

Regional Strategy

- To develop or enhance integrated approaches to the delivery of health & social care to support children and young people with complex needs to remain living safe and well in their families and communities within the region
- To invest in effective and joined up models of targeted and integrated prevention services across the continuum of need
- To invest in effective, integrated models of specialist support for the most vulnerable children and young people, particularly those with complex health and social care needs to enable those children to have the best chance to remain (or to return to) living safe and well within families and communities within the region
- Where children and young people with complex health and social care needs cannot be supported to live safe and well within families and communities in the region, to ensure effective and timely arrangements are in place to secure joint commissioning

of specialist care and support that reflects the holistic needs of those children and young people

Multi Agency Placement Support Service (MAPSS)

MAPSS is a regional multi-disciplinary team, fully operational since last August 2018. It aims to help children who are currently in foster care or residential care and are at risk of emotional and behavioral difficulties. The team goes in and provides specialist support and provides a particular focus on children with complex needs who have experienced placement instability and educational disruption.

The Service will support children to ensure practice across the West Glamorgan Region is preventative, pro-active, planned and promotes permanence.

The creation of the service was driven by the need to develop an effective pathway to improve the mental health and emotional wellbeing of looked after children with particularly complex needs. Often looked after children fall outside of universal mental health services as they require interventions that not only consider their attachment, early trauma but require an approach which promotes the development of resilient carers to provide them with a stable base from which to start to understand their story and start to develop positive relationships with their care givers.

The proposal for 2020/21 is to invest in a new development phase of the project. There is evidence from the existing performance management data that MAPSS has been successful in supporting the step down of children from residential care to fostering/return to family, and in achieving a cost avoidance of children escalating to high cost placement provision. A business case will be developed for December 2020 demonstrating the impact of gaining funding for 20/21 to mainstream the delivery model through core funding from April 2021, which could include an option for a pooled fund.

Children and Young People's Emotional and Mental Health Planning Group

There are a number of streams under this work supporting the regional programme for children and young people. They include:

1. Access to Child & Adolescent Mental Health Services (CAMHS)
2. Neurodevelopmental Disorders
3. CAMHS Liaison (ICF) – Early intervention available through Social Services and Education - placed in social work team and links to schools (e.g. counselling services in school)

The CAMHS liaison work is the establishment of an integrated, multi-agency approach to support children and young people, with professionals getting the right support at the right time. The main objectives of the CAMHS liaison work is as follows:

- Consider and facilitate the options available to children, young people & adolescents on an individual case basis
- Provide additional support to schools, social services and health professionals
- Reduce the number of inappropriate referrals to CAMHS, and reduce the demand for a part 1 assessments

- Provide an equitable service and better access to existing support across the West Glamorgan area.

For 2021/22 the liaison service offered by CAMHS will be expanded to include these roles as part of the CAMHS core service.

Western Bay Adoption Therapeutic Service

The aim of the Post Adoption Support service is to provide targeted and specialist psychological support and services for children and young people with a plan for adoption, and who have been adopted. It will provide support that is underpinned by the following guiding principles:

- Meeting need early – providing timely access to support and intervening early so families do not have to reach a crisis point before meeting the threshold for support
- Access to psychological services throughout the journey of adoption – providing support throughout the various stages of the adoption process
- A multi-layered approach – working with professionals and with adoptive parents, and facilitating access to specialist therapeutic support for families where it is needed

A business case will be developed by December 2020 demonstrating the impact of the project and the options to mainstream the service from April 2021 which may include a pooled fund.

Working Together Project

The Working Together Project is a regional service covering the West Glamorgan footprint, working with children, young people and their families in their home environment.

The ultimate aim of the Service is to support more children and young people to grow up in conditions that are safe, that do not impact negatively on their wellbeing and allow them to develop to their potential (Article 6 of the UNCRC).

Child and Family Services recognise that, for most children and young people, this is most likely to be achieved by supporting children and young people to remain in the care of their families. The Service shall assist families (Article 18 of the UNCRC) by providing interventions which increase resilience and enable safe, sustainable changes. The consequence of which being that more children and young people are able to remain living with their family.

The service will adopt a systemic approach to its work with families. Systemic approaches are a way of working which emphasises people's relationships as key to understanding their experiences. Understanding the complex relationships within a family can help people to change patterns of thinking, and enhance interactions, lending itself to increased tolerance, resilience and more positive family functioning.

A business case will be developed by December 2020 demonstrating the impact of the project and the options to mainstream the service from April 2021 which may include a pooled fund.

Integrated Transformation Board

The Integrated Board was established to oversee any programme or project which was cross cutting across both Adults and Children. There are a variety of workstreams operating under the West Glamorgan Integrated Transformation Board.

The Integrated Transformation Board comprises the following workstreams:

‘Our Neighbourhood Approach’ Transformation Funded Programme

‘Our Neighbourhood Approach’ focuses on the seamless integration of Health and Social Care services using an asset-based approach and pioneering initiatives designed to empower people and communities to manage their own health and personal well-being. This new and innovative approach will transform the way in which people are supported in terms of their health and social care. It focuses on maximising the assets available in communities and centring provision around the ‘whole person’ and the ‘whole family’. It is focussed on 2 areas, the North Hub location in Swansea, which covers Cwmtawe and Llwychr and the Briton Ferry and Melin area in the Neath Cluster. A more joined-up way of working will lead to better communication between service providers and the introduction of a single point of contact for health and social care will prevent individuals from having to repeat their story time and time again.

Although elements of the initiative focus on care and support for older people, ‘Our Neighbourhood Approach’ also aims to:

- improve the mental well-being of all citizens
- promote the independence of individuals with a learning disability, and
- support families and communities to maintain the safe care of children.

It is expected that success will come in the form of a heightened awareness of self-care, self-responsibility and prevention among citizens. This in turn would lead to a reduction in the cost of admissions to hospital, primary care and residential placements.

‘Our Neighbourhood Approach’ represents a significant culture shift for both citizens and staff within organisations delivering services. The ethos is one of true collaboration as services will work co-productively with local people to build resilient, inclusive communities.

‘Whole Systems Approach for Primary Care Clusters’ Transformation Funded Programme

The ‘Cluster Whole Systems Approach’ aims to achieve a transformed model of a cluster-led integrated Health and Social Care system for the cluster populations. Initiated and informed by the Cwmtawe Transformation Programme, this programme is systematically implementing a range of projects locally including a phased roll-out in the seven remaining Health Board clusters, which included Cwmtawe commencing November 2019 , Neath cluster starting in April 2019 and both Llwcwhr and Upper Valleys starting in July 2019. The remaining four clusters commenced delivery in January 2020.

This programme dovetails with ‘Our Neighbourhood Approach’ in the 3 clusters: Cwmtawe, Llwcwhr and Neath.

The overall strategic aims are to:

- Improve wellbeing across the age spectrum. There would be a key focus on facilitating self -care and building community resilience. There would also be a key focus on the earliest years, and young carers and mental well-being.
- Co-ordinate services to maximise well-being, independence and care closer to home. This would include Cluster Networks having control to design, co-ordinate and implement services in partnership with the community that effectively meet patient and carer need. There would be a particular focus on older people in relation to integrated services trying out new models of care closer to home and reducing unscheduled admissions.

The proposal was based on the intent for this model to become self-sustaining through the improvement in health and wellbeing, co-production and use of social prescribing as an alternative to more traditional models of Health and Social Care, including a shift of resources where appropriate from secondary to primary care.

Development of Regional Strategic Framework for Housing, Health & Social Care

In 2018, the former Western Bay Regional Partnership Board agreed that Housing required a more strategic focus within the Transformation Programme.

The 'Your Housing, Your Health' symposium was held in October 2018, which enabled all key partners to come together to identify key issues and agree next steps. As a result, the Regional Partnership Board agreed that the current Health and Housing Group be reformed as the new West Glamorgan Social Care, Health and Housing (SCH&H) Group and this Group would play a central role in the development of a five-year capital programme for the expenditure of Integrated Care Fund capital.

The main aim of the SCH&H Group is to devise a regional strategic framework for housing, health and social care transformation. The key priorities will be funded by the Integrated Care Fund Capital Programme and will align with the workstreams and projects within the West Glamorgan Transformation Programme.

Co-production

The new West Glamorgan structure ensures that co-production is embedded across all areas of work. One of the key principles for West Glamorgan is, "We will change the way that we work with citizens away from paternalistic care to shared responsibility and co-production".

Citizens with a vested interest in West Glamorgan Regional Partnership Board's five themed priorities are being recruited to sit on the Transformation Boards and Implementation Groups across the programme. This represents a more inclusive role for both citizens and carers in the planning and delivery of transformative projects and workstreams. Neath Port Talbot CVS and Swansea CVS are supporting for the overall co-ordination of co-production for West Glamorgan and oversee the recruitment of citizen and carer representatives. They are experienced at engaging with individuals who are harder to reach, and will use their existing networks and contacts to engage with citizens and carers.

West Glamorgan Co-production Group

The West Glamorgan Co-production Group (formerly 'Western Bay'), was established in April 2018 as a smaller sub-group of the broader Citizens' Panel. Its purpose is to identify specific tasks suitable for co-production (e.g. communications activities, opportunities for wider engagement). The group will continue to meet and deliver against a work plan comprising specific actions.

Social Value Forum

Part 2, Section 16 of the Social Services and Well-Being (Wales) Act 2014 places a duty upon Welsh Local Authorities, along with Health Board partners, to: "establish regional forums to support social value based providers to develop a shared understanding of the common agenda, and to share and develop good practice. The aim of the forum is to encourage a flourishing social value sector which is able and willing to fulfil service delivery opportunities".

September 2018 saw the launch of our region's Social Value Forum, with over 80 members of the community, statutory sector partners and community organisations coming together to pledge their support. Further forum meetings to be organised. The Social Value Forum has a broad remit and is open to anyone with an interest in enhancing the health and well-being of citizens and building stronger, more resilient communities.

The project will also ensure that there are links with the co-production work, in particular around Measuring the Mountain and Most Significant Change. Members of the co-production network will link with the Social Value Forum in order to ensure that the work of the Forum is delivering organisational and service changes that do work for citizens. Training will be made available to Forum members, with more in depth Social Return on Investment training for key staff within Regional Partnership Board partner organisations. This will mean that there is a cross sector understanding of the approach, those attending training could then be tasked with sharing the learning within their own organisations and being 'ambassadors' for social value, reporting back to the Forum on individual action plans to implement the social value approach within their own organisation. Alongside the Social Return on Investment, Measuring the Mountain and Most Significant Change work, regional procurement colleagues would have access to Social Value Academy training so that those procuring services are also adopting a consistent approach to delivering social value across the region.

Social Enterprise

The aim of the project has been to deliver development support and capacity building to third sector organisations to assist them to become sustainable, to develop additional and diverse local services within the sector to meet the health and wellbeing needs of citizens. The social enterprise development support offered links to the Act and the need to transform and develop new models of service delivery. The support service is offering ongoing support to projects at various stages of development, if the support service was lost there would be a risk to reaching the full potential of some of the developments in progress, this includes work with startup groups referred by social services where exploratory work is ongoing.

Development of Regional Carers Strategy

A Multi-Agency Board, now titled the West Glamorgan Carers Partnership Board has been active for the last seven years, producing and overseeing an annual regional action plan with the overall aim of improving the lives of unpaid carers across the region.

The main aim of the West Glamorgan Carers Partnership Board in 19/20 will be to develop a regional strategy for carers. This will include the development of a vision for the region, including review of priorities, co-produced by carers. Review of the current governance structure will take place to simplify and align with new West Glamorgan structure.

Digital Transformation and the Welsh Community Care Information System (WCCIS)

One of the common and key impediments to integrated working between Health and Social Care services nationally and within the West Glamorgan region has been the inability of services to share information effectively.

To meet the necessary functional requirements of a solution to support the required integrated working, Local Authorities and NHS Wales organisations jointly procured the Welsh Community Care Information System (WCCIS) ensuring that the business and technical design is person centred and allows professionals to access and share information.

The implementation of WCCIS within the region goes hand in hand with digital transformation and enabling professionals to easily access and utilise information remotely within the community. In the latter half of 2018, the regional WCCIS board acknowledged that it is not going to reach the desired outcome of ICT supporting integrated working in the region, by implementing WCCIS alone. It was agreed that the regional WCCIS board needed to broaden its scope to include other digital opportunities and deliver benefits to service delivery.

The objective of this programme is to deliver the ambitions set out within the Welsh Government plan 'A Healthier Wales' to "[use] technology to support high quality, sustainable services" and meet the needs of the citizens within the region through the provision of an innovative digital strategy. This will be supported by the implementation of the WCCIS and the technologies that will enable mobilisation of the workforce, in order to deliver "new models of seamless local health and social care" and achieve the best possible outcomes for citizens across the region.

Swansea Council are well-into their implementation plan having signed their Deployment Order with the supplier CareWorks in October 2018, who continue to work closely with the Authority to ensure progress is monitored. Swansea Bay University Health Board's WCCIS project team presented an outline business case to the Investment and Benefits Group in November 2018, who approved the project moving into stage 2, to produce a full business case and draft a Deployment Order by December 2019. Neath Port Talbot Council have recently reaffirmed their commitment to adopting WCCIS, and are engaging with the regional WCCIS team to draft a business case to be presented to Cabinet later this year.

Appendix 3 – Case Studies – Commissioning for Complex Needs

OUTCOME FOCUSSED ASSESSMENTS

Rhys's story *(Please be advised that this individual's name has been changed as they do not have sufficient capacity to consent to their personal information being shared).*

Rhys is in his early twenties and has severe learning difficulties, epilepsy, osteoporosis and challenging behaviours. He previously resided at a residential educational establishment, but the placement ended when he reached adulthood. Rhys received transitional support to take up a permanent tenancy in supported living accommodation. He has a good rapport with staff and has settled into his new environment well.

Managing Rhys's personal hygiene (especially bathing) can be extremely challenging for staff, who require specific strategies and systems to support him. Rhys is described as a happy and sociable individual. His weekly planner is often packed with activities involving his family, and he loves spending time watching buses and trains go by.

An 'Outcome-Focused Assessment' was undertaken in August 2018, which identified some personal and well-being goals for Rhys...

- Rhys loves all things Disney and was very keen to attend a performance of Disney on Ice.
- Rhys enjoys interacting with others and having a busy weekly schedule. The management at his supported living scheme agreed to carry out a brainstorming session with Rhys, his mother and the key worker to share ideas for activities Rhys might like to try.
- Staff will continue to follow a set bathing routine for Rhys, enabling him to enjoy it more than he was able to previously.

What happened next?

Rhys attended a performance of Disney on Ice in Cardiff and thoroughly enjoyed himself. Staff are now looking into more Disney related experiences, with the ultimate goal being a trip to Disneyland Paris.

Rhys now has a membership to Folly Farm as he loves to visit the animals. He continues to spend time at different train stations watching the trains and having picnics on the platform, as well as traveling on the trains.

Rhys is now able to bathe every day as staff have devised an approach that works well for him. He recognises key words associated with bathing, and while he is in the tub staff use toys and other methods of distraction to help manage his behaviour and allow him to relax and enjoy the experience.

The manager at Rhys's supported living scheme said:

"*Rhys has been enjoying going out a lot more, and he especially likes a train ride through the countryside as he usually sees many animals along the way".*

Savings

Before the assessment, Rhys was receiving 156 hours of support.
This has been reduced to 138.5 hours and includes 2-1 and 1-1 support.
The times of these support hours have been changed to reflect his waking hours and bed time, reducing the amount of time staff spend waiting for Rhys to wake up or after he has gone to bed.

This is reduction of 17.5 hours per week.

Brenda's story *(Please be advised that this individual's name has been changed as they do not have sufficient capacity to consent to their personal information being shared.)*

Brenda is in her early 60s and has a diagnosis of Cerebral Palsy and a severe Learning Disability. She is a wheelchair user and is also sensitive to sunlight. Brenda lived at home until her mother's death in 2013. Following a short assessment placement, she moved to a supported living scheme where she still resides today.

Brenda has no verbal communication but instead indicates her needs and wants via facial expressions and body language. Despite being non-verbal, she is a sociable character who enjoys the company of others. Brenda attends a local church group on a weekly basis with staff support. The congregation are always welcoming and regard Brenda as part of their church community. She particularly enjoys the hymns and joins in by moving in time with the music.

An 'Outcome-Focused Assessment' was undertaken in December 2018, which found that Brenda has a keen interest in live theatre and wishes to attend performances on a regular basis. Self-care is also important to her, and she would like to make more time for pamper sessions at home.

What happened next?

Since the assessment, Brenda has attended four theatre productions and has thoroughly enjoyed each one. She's particularly fond of musical theatre and moves her head and arms in time with the musical numbers. In terms of self-care, a professional masseuse now attends the house twice a month, and Brenda gets a great deal of stress-relief and relaxation out of these sessions.

Due to her sensitivity to sunlight, Brenda is unable to sit outside and enjoy the garden on a sunny day, which is something she finds frustrating. However, since the assessment, the scheme managers have erected a summerhouse located in a shaded part of the garden. Its décor is designed to capture the feel of the outdoors (with scented plants, etc.), providing Brenda with a perfect alternative to the garden. She enjoys spending time in the summerhouse with her fellow tenants, as well as using it for some occasional quiet time away from the hustle and bustle of the main house.

Savings

Before the assessment, the scheme comprised 399 hours of support per week, including two wakeful members of staff at night. The assessment has led to a reduction to 321.5 hours of support and one wakeful staff member at night time.

This has resulted in a saving of 77.5 hours per week, representing an annual saving of £55,453.32.

Gwyn's story

Gwyn is in his 50s. He has a diagnosis of Cerebral Palsy, a Learning Disability and requires a walking frame to get around (using a wheelchair for longer distances). During his childhood, Gwyn attended boarding school, after which he returned to his family home in Swansea. He then left his family home to seek a more independent lifestyle and moved into Maes Glas residential home where he resided for two years.

In 2013, Gwyn took up a permanent placement in Glan Yr Afon (a supported living scheme), which provides him with longer-term stable accommodation.

Gwyn has a good sense of humour; he enjoys going out and meeting people and spending time in the community. He attends the Vale Day Centre and the Friends of the Young Disabled group twice a week. Gwyn's main interests are TV and radio, keeping up to date with sports, listening to Pink Floyd, and supporting his beloved Swansea City Football Club.

Gwyn's mobility car is his pride and joy. He visited several garages to test out different models to assess their suitability for his needs. He is delighted with his choice, especially as he was also able to choose the colour - a lovely bright red.

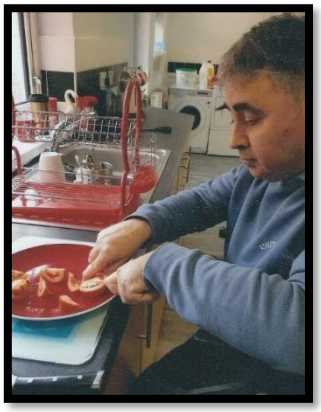
An 'Outcome-Focused Assessment' was undertaken in January 2019, which identified the following personal and well-being goals for Gwyn...

- Gwyn indicated that he would like assistance to create a visual board featuring images of activities he would like to try. This would help enable him to plan activities to include in his weekly schedule.
- He enjoys walking and taking part in Bikeability sessions. These will be included in his weekly planner to help maintain/improve Gwyn's strength and mobility.
- Gwyn expressed that he would like to be able to cook a simple meal.

Since the assessment, Gwyn has created a visual board and filled it with activities to include in his planner. He refers to this on a daily basis and even includes alternative options for plans that are 'weather permitting'.

Gwyn now looks forward to shopping for groceries and preparing a meal. His skills and knowledge are improving all the time; completing many of the tasks independently as he grows in confidence.

Gwyn said, “My favourite meal to cook is Spaghetti Bolognese - the more you do it, the easier it gets!”



His next challenge is to book a holiday as independently as possible.

Savings

Before the assessment, Gwyn was receiving 93.5 hours of support. This has been reduced to 84 hours, including 26 hours of 1-1 provision per week, enabling Gwyn to access the community using his new car.

This represents a saving of 9.5hrs per week.

Appendix 4 – Case Studies – Working Together

Edge of Care

The Working Together project in Swansea, also known as Edge of Care (EOC) has developed holistic packages of support to families who are experiencing acute stress, which is impacting on their ability to parent their children safely, or manage the behaviour of the young person. These families are at the point where the risk of local authority accommodation is likely/imminent.

Family A

Family composition and presenting issues:

A referral was received relating to a14 years old male. He had been living with his sister who was 23 years old, for the past 6 years. Also living with them was his sister’s child who was 6 years old. The young person came to live with his sister after experiencing many years of parental neglect. He had not attended school consistently, was often seen walking the streets late at night. He hadn’t attended medical appointments and had no regular routines or boundaries. The sister, who was already living alone aged 16 and had just had a baby of her own, took her brother in to live with her as a family arrangement.

There were few referrals to Social Services from the sister asking for support, but the family hit crisis point in May 2019 and his sister was requesting he be accommodated elsewhere. A referral was made to the FAST (Family Action Support Team, offering benefit and financial advice/support), to work intensively with the family to prevent a breakdown.

What did we offer, and how did we do it?

This family had input from our FAST intensive support team, an adolescent link worker and internal EOC therapists.

The FAST duty worker attended the family home with the Social Worker to discuss support options and agree an immediate start to the intervention. The FAST worker met with the sister and brother separately and together, exploring the issues, what things they felt needed to change, and how a plan could be developed to achieve this. The sessions took place 3 times a week at a time that suited the family, which was often later in the evening.

The core models used were of Signs of Safety, Solution Focused Therapy and motivational interviewing.

During the first few weeks of relationship building and getting to know the family, the complexities became evident and at this point a consultation was arranged with the Edge of Care therapists. The consultation provided guidance and direction around type of support the family needed, with agreement that the sister could access one-to-one therapy sessions. On-going sessions with FAST focussed on what her brother needed from her in terms of meeting his needs, structure and routine to his life, boundaries and expectations, exploring what's normal teenage behaviour, and risky behaviour that she felt worried about. Safety plans and crisis plans were drawn up by the family and used to manage challenging situations.

The therapist supported the sister to look at her childhood experiences and trauma, and how this was impacting on her ability to cope with caring for her brother. It was also identified how worried she was that her own child would be taken into care as she couldn't manage to care for her brother.

These sessions were primarily person-centred, taking the lead from the sister on what she needed to talk about, but incorporating other models of therapy, which helped her explore her past, think of the impact on the present and consider what she wanted for the future.

The strain on the family was ongoing and made further challenging by the young person's refusal to attend school, as well as his increasing criminal activity within the local community. The sister found this extremely challenging and left her feel like she was failing to care for him. As a result she requested he be accommodated again. Two short episodes of emergency accommodation were needed when the family were at crisis points, but this didn't work out for the family, and he ended up going home after a few days.

At this point, the adolescent link workers were asked to work specifically with the young person, with the primary aim of engaging and building a relationship to help understand his refusal to attend school. The young person was difficult to engage, and would often run out the back door when staff attended the home. Exploration around who already had a relationship with the young person helped staff 'piggyback' into building a relationship with the young person. At times this felt like a slow process, but determination and consistency of staff turning up helped build trust and encouraged the young person to start engaging. At this point he was refusing to attend activities, and by chance a peer of his had also been referred to the service. The opportunity was seen to engage them as a pair, which they were more agreeable to. Links were made with YOS (Youth Offending Service) preventative services, and a shared offer of activities at the centre, where adolescent link staff supported them to attend. They slowly began building up practical skills such as making wooden decorations and wood burning.

During these sessions, staff work with the pair to address risky behaviour, consequences of their actions, and building their interests in positive activities. The aim is for this to continue with further exploration around reintegration into education, and any further plans will include areas of support needed.

To date the young person and his peer are engaging twice a week with the link workers, with plans of getting back into school. The intervention with the FAST team has finished and entered a reviewing phase, where for 3 months, goals set by the family will be evaluated, with the offer of booster sessions if needed. The sister also continues fortnightly therapy sessions, with the aim of being able to bring the brother and sister together for sessions in the future.

The family are also being offered the opportunity for a residential family stay in a newly developed facility in Rhossili. This will allow the family to spend quality time together with structured activities and relationship building tasks. This residential stay will be co-worked with the FAST intensive workers, activity workers, and therapists who already have established relationships with the family and have been working with them over the last year.

Case Study (completed by Andrew Watkins, Consultant Social Worker)

Following a referral and consultation, a family begun engaging with the Working Together Service (WTS) on the 19th if November 2019. The referral was in relation to poor home conditions that were identified in the Care and Support Plan.

Family composition

The primary carer (Father) is a single male with 3 children aged 8, 6 and 3. Father is a victim of domestic abuse, with the perpetrator being the children's birth mother. The birth mother does not reside at the family home, and it is believed that there are concerns relating to her alcohol use and the nature of her current relationship (she is reported to be the victim of domestic abuse). Father also has issues with his mental health and suffers with depression.

The family (Father and children) have been known to NPT Social Services for a number of years, this includes a period of registration for neglect due to poor home conditions, which is also the nature of the current referral.

Intervention

The WTS initially began to support Father in addressing the outcome/s of the Care and Support Plan by assisting him to de-clutter and by cleaning the living room. The family at the time of referral were at 'Red', however with the support of the WTS the family progressed to 'Amber' following approximately two weeks of intensive support. Unfortunately due to the Christmas period, the intensive intervention was suspended (due to staff annual leave) which resulted in a setback to progress made. This has served as an identified learning need for the WTS and will be explored further.

On 6th January 2020, the WTS and a Social Worker visited the family home and were of the opinion that the family were at 'Red' given the deterioration of the living conditions. As a consequence the WTS spent several hours assisting Father with de-cluttering and tidying the living room.

Prior to Christmas 2019, the WTS had contacted the environmental pest control officer due to rats being seen in the garden. Unfortunately, the pest control officer was not able to attend before Christmas as originally planned and attended the property the on same day (6th January 2020). The pest control officer advised that the rats were also inside the property and took steps to resolve the situation.

The WTS returned to the family home the following day, and concluded that the family remained at 'Red'. Due to continued concerns, the WTS contacted the Children's Community Team. It was advised from the duty Social Worker that action be undertaken in order for the children to remain at the home. The WTS provided intensive support for Father, which included:

- purchasing new bedding for the children

- taking a large quantity of clothing to the laundrette
- cleaning the kitchen.

This intensive intervention took the family from ‘Red’ to ‘Amber’ and consequently the children were able to remain at the family home.

The WTS returned to the family home on the 8th January where the WTS was advised by Father that one of the children was unwell. Following support / advice from the WTS, Father took the child to see the GP.

Additionally, the front door of the property wasn’t secure and following his return from the GP, Father was able to rectify the situation supported by the WTS. The family remained at ‘Amber’ but progressing to ‘Green’.

On Friday 10th January, a referral was made to FAST (benefit and financial advice / support) by the WTS as a consequence of the property’s landlord advising that Father was in rent arears. This was deemed necessary so as not to have a negative impact on his mental health.

In addition, the WTS explored with Father his wider support network where he was able to identify his sister as a potential source of support. As a consequence of this and the intervention of the WTS, Father and the children moved in with her (sleeping there overnight and returning to the family home in the day).

With the aforementioned support from FAST and the WTS, Father has since been allocated a new property and it is anticipated that the family will move in approximately two weeks (it is understood that he has now signed for the property).

The WTS continue to support the family and are helping to take the children to school even when they are residing with Father’s sister. In addition, the WTS will be working with Father in order to prepare for and assist with the move. The WTS has also encouraged Father to contact his GP regarding his mental health and as a consequence has been prescribed anti-depressants.

The WTS has also supported Father to attend hospital appointments, etc. by providing child care as the extended family are not in a position to help. The WTS has also referred Father to receive support in relation to the previous domestic abuse from the children’s mother and has been allocated a male worker to address past traumatic experiences.

Given that Father has been in crisis, it has been agreed that he will continue to receive support from the WTS. This will include support in preparation to move and if required, assistance to move.

Once Father has moved to the new accommodation, the WTS will reinitiate the intensive phase of the intervention, in effect starting afresh. It may be viewed that during this period Father, will be in a better position emotionally and mentally to make and maintain positive changes to address the concerns of NPT Social Services. This period will also allow the WTS to gain the voice of the child through evidenced based interventions.

Appendix 5 – Case Studies – Multi Agency Placement Support Service

Dyadic Therapeutic Play (DTP)
Training Evaluation

Venue: Primary School **Date:** 07/10/19
Attendees: Teachers & Teaching Assistants **Number of Attendees:** 17
Provided by: Jenny Harding & Leighanne Palmer – Family Support Workers

Reason for Training:

- Providing support for school staff to help a child engaging with MAPSS, along with other looked after children within the school.
- Helping a child/children to regulate their emotions.

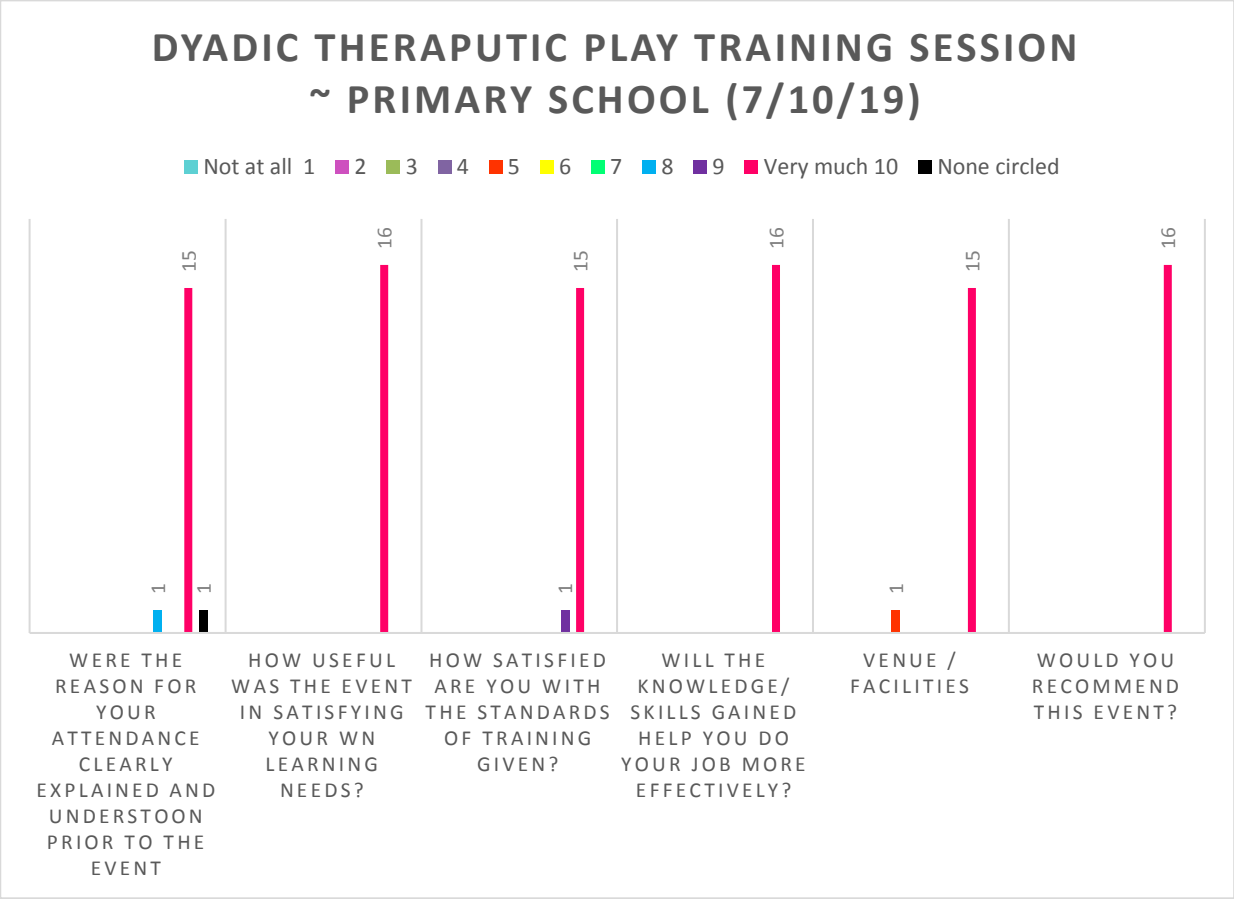
Objectives of Training:

- Training staff to understand how to use Dyadic Therapeutic Play.
- To re-establish and emphasise the importance of building a trusting relationship through a play based resource.
- Helping staff understand how DTP fills in developmental gaps on how to regulate emotions with a trusting relationship.
- Using DTP as a tool to build a relationships and gain a better understanding of a child's need, likes and dislikes.
- Building a trusted relationship that allows a child to explore emotions through play and learn the ability to co-regulate their emotions through a playful, safe resource.
- Encouraging staff to use a more PACE (Playfulness, Acceptance, Curiosity and Empathy) approach with children, helping them regulate their emotions and process their trauma.
- Helping staff understand the difference between empathy and sympathy and how children need more empathy.
- Demonstration and participation of DTP games.

Outcomes of Training provided:

- Each class to have their own DTP box of resources for staff to use as de-escalation activities and session times.
- Class teacher for MAPSS child will be timetabling DTP time into each day.
- Each box of resources includes Lego character emotions cards, DTP game idea cards and a games leaflet to enable quick and easy access.
- Suggestion made by school to use DTP with their buddying system for peer mentoring programme.

Feedback
Overall:



Duration:

- ✓ Just enough
- ✓ Perfect length
- ✓ Quick and informative
- ✓ Very useful
- ✓ Fun and compact
- ✓ Suitable
- ✓ Good pace and length
- ✓ Appropriate
- ✓ Very good, timed well
- ✓ Very quick, filled with knowledge
- ✓ Perfect, concise and full of content
- ✓ Moved at a good pace.

Useful parts:

- ✓ Games and effects
- ✓ Physical activity
- ✓ Playing
- ✓ Games and why
- ✓ Practical demonstrations
- ✓ All of it

- ✓ Practical trying the games
- ✓ Games showed interaction of child
- ✓ Practical element
- ✓ Games simple and effective
- ✓ Activities to use with children

Not so useful:

⇨ PowerPoint

⇨ None

General feedback:

- ➢ Well delivered and interactive
- ➢ Very well explained and examples
- ➢ Very good session
- ➢ Excellent trainers and knowledgeable
- ➢ Very informative.

CASE STUDY - TRAINING

Delivered by Ellen Wheller (Consultant Social Worker)

Background

I had been working with two sets of Foster Carers who had siblings in each placement. Child (F) was the oldest of the group of four siblings (aged 14) and was placed in a single placement. I had undertaken family therapy with him and his carers (C and G), and had developed a good working alliance. The outcome of the family therapy was positive and enabled the young person to share his emotions.

The second set of Foster Carers (B and N) had the three other children from the group of 4 siblings placed with them. This set of Foster Carers were struggling in managing the 10 year old child (H) and understanding his attachment style, and were difficult to engage in placement support.

I understood that both sets of Foster Carers knew each other and therefore made arrangements for them to participate in attachment training together (which I delivered). This was with the view of enabling Foster Carers (B and N) to engage with me in placement support sessions as well as providing therapeutic intervention to the young person.

What type of training was offered?

Attachment, Trauma and Dyadic Developmental Practice (DDP) training with the two sets of in house Foster Carers in Bridgend, who together cared for a group of four siblings.

Purpose of the training:

For Foster Carers to understand the children's attachment style, to aid communication between the two sets of carers, and to stabilise both placements.
Fosters Carers (B and N) developed a relationship with me and it enabled them to accept placement support and a better triangulation of support with the school.

Feedback:
Foster Carer 1:
“Thank you for all your help and support - our foster child has done so well and been able to express (their) emotions”
“I am very happy with the MAPSS service and the work you have done for me and the child in placement.”

Foster Carer 2:
“The young person blamed (themselves) for being in care and was totally closed down in terms of (their) emotions. ---- Since the training I have more understanding and I am able to support them more.”

Impact:
We were able to stabilise both placements and the Foster Carers were able to work together more closely. They were also able to use DDP skills with the children and support co-regulation.