Cwm Taf Morgannwg Regional Partnership Board Transformation Fund Deep Dive Review Overview Report

1 Introduction

This document has been prepared by the Institute of Public Care at Oxford Brookes University (IPC) for Anthony Hughes, Senior Officer leading the Cwm Taf Morgannwg (CTM) Transformation Programme. The purpose is to summarise the position of the 8 Workstreams which make up the CTM Transformation Programme and offer an analysis of their future potential to inform future service, investment and business planning by partners on the Regional Partnership Board.

The report has been produced based on latest available data from the respective Workstreams and a series of interviews with Workstream Leads and other key stakeholders between 1 July and 31 July 2020, reviews of evidence from elsewhere about the potential benefits of the service models involved and an earlier interim report prepared by IPC in June 2020.

The report draws on the more extensive and detailed reports completed during this time for each of the workstreams and submitted at the same time.

2 Summary of Workstreams

The programme as a whole comprises 8 Workstreams supported by a Welsh Government grant under the national Transformation Programme to support the implementation of the A Healthier Wales plan. The Workstreams are focused upon building up community-based services in order to both improve patient/service user/carer outcomes and to create greater efficiency within the health and social care system as a whole, reducing the reliance and pressure on in-patient services.

In Bridgend 3 Workstreams are concerned with accelerating the pace of change for its integrated services by:

- Ambition 1: Providing 7-day access to community health and social care services – "*Every Day Is Tuesday*", delivering extended alternative service options to hospital and long-term care
- Ambition 2: Having a primary & community care MDT approach, delivering a one team approach around people, coordinating primary care and community services cluster responses.
- Ambition 3: Developing and delivering resilient coordinated communities; with key organisations, their partners and the communities they serve developing benefits, by working collaboratively to apply preventative approaches that enhance the wellbeing of the population of Bridgend.

In Cwm Taff there are 5 Workstreams building on and scaling up existing services to improve support for people at risk in communities and to reduce pressures on acute services by:

- Scaling up the Population Segmentation & Risk Stratification pilot to tailor interventions to specific populations and to support targeted and anticipatory care.
- Building on the Assistive Technology service to include a mobile responder service that will operate 24 hours a day, 365 days a year responding to triggered alarms and establishing/deploying the most appropriate response.
- Scaling up cluster focused MDTs with a 'virtual ward' approach to reduce demand on general practice both in and out of hours and on A&E.
- Extending the SW@H hospital model to give community professionals an alternative to hospital care and support, providing access to social care, community equipment and @home nursing services 7 days a week, 8.30a.m. to 8.00p.m.
- Developing a service to deliver urgent primary care out-of-hours, with new roles and an MDT approach.

Prior to the lockdown in response to the Covid-19 pandemic, the 'go live' dates for each workstream were as follows:

Project	**Planned go-live date in 2020**
Bridgend Ambition 1 – 'Every day is a Tuesday' (BCBC)	▪ 31st March
Bridgend Ambition 2 – 'One Team Approach around People' (CTMUHB)	▪ SPoA April ▪ MDT end of June
Bridgend Ambition 3 – 'Resilient co-ordinated Communities' (3rd Sector)	▪ 31st March
Risk Stratification And segmentation (All CTM Footprint)	▪ Mid-June
Assistive Technology (RCTCBC)	▪ 20th Jan
Community Health and Wellbeing Teams (ECT,RCTCBC, Merthyr LA, CTMUHB, 3rd Sector)	▪ 24th Feb – Rhondda ▪ 16th Mar – Taff Ely ▪ 6th April – Merthyr ▪ 6th April – Cynon South (north already Live)
SW@H2 (RCTCBC, Merthyr LA)	▪ 20th January – RCT ▪ 6th April - Merthyr
Urgent Primary Care Services OOH	▪ TBC

3 Context: Welsh Government policy, evidence-base and funding

Whilst it continues to be difficult to identify conclusive evidence to support the approaches being developed by the programme overall[1], there has for some time been an emerging consensus that they represent the only effective way to address the increasing needs of the population. For example, as far back as 2014 the Kings Fund[2] identified that there was an emerging consensus and longstanding ambition to *'shift more health care from hospitals to settings closer to people's homes, and from reactive care to prevention and proactive models based on early intervention.'* (Kings Fund, Page 2). This consensus is strong enough in both England and Wales to underpin the plans for Health and Social Care. The Healthier Wales Action Plan[3] identifies the following Whole System Values:

- Co-ordinating health and social care services seamlessly
- Measuring (and using) the health and wellbeing outcomes which matter to people
- Proactively supporting people throughout the whole of their lives, …making an extra effort to reach those most in need to help reduce the health and wellbeing inequalities that exist.
- Driving transformative change through strong leadership and clear decision making,
- Promoting the distinctive values and culture of the Welsh whole system approach with pride… (Healthier Wales Action Plan, page 5)

It talks of …*' a shift from Hospitals to Communities and communities to homes' and 'Primary and community care will offer a wide range of professional-led services and support,' 'hospital only when essential'* and *'Using technology'.*

Professor John Bolton argues the main reason why delayed discharges from acute hospitals have dominated the health and care political landscape across the United Kingdom for the past three decades is because of the failure to design and procure the right services to support older people after a period in an acute hospital.[4] This work highlighted that about a third of people leaving hospital should need some care and support, and most of those (around 85%) can be helped at home. In a further discussion paper in March 2020,[5] Professor Bolton identifies the behaviours that should underpin integrated strategic demand management thinking. Most notably,

[1] '*The effects of integrated care: a systematic review of UK and international evidence'*, Baxter, S et al, BMC Health Services Research 18, Article number: 350 (2018), https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-018-3161-3
[2]' Community services - How they can transform care' Edwards, N Kings Fund 2014, https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/community-services-nigel-edwards-feb14.pdf
[3] 'Healthier Wales Action Plan', Welsh Government, 2018, https://gov.wales/sites/default/files/publications/2019-10/a-healthier-wales-action-plan.pdf

[4] 'Reducing delays in hospital transfers of care for older people - Key messages in planning and commissioning' Bolton, J, IPC, 2018, https://ipc.brookes.ac.uk/publications/Reducing-delays-in-hospital-transfers-of-care-for-older-people.html
[5] '*Commissioning Out of Hospital Care Services to Reduce Delays', Bolton, J, IPC 2020, https://ipc.brookes.ac.uk/publications/Out_of_hospital_care_to_reduce_delays.html*

that services should be based in the person's own home as this is the place where they are most likely to recover quickest; in their own familiar surroundings.

He also says that "discharge to support recovery and then assess" is a much more pertinent way of describing what should happen to an older person leaving hospital. If either more voluntary sector services are used or shorter-term help is offered there is likely to be more capacity available for the next set of people needing support.

There is also a need to be mindful of over prescribing care and support post discharge and to ensure there are mechanisms in place to reduce or stop care and support when it is no longer required. He concludes that in most hospitals it has been found that significant numbers of older people are moved on to a permanent residential care or nursing care bed unnecessarily.

Even more recently (May 2020)[6] the NHS Wales Delivery Unit review of discharge practices in Wales identified the important role played by right-sizing community services to facilitate timely discharge. They estimate that about a third of people leaving hospital should need some care and support, and most of those (around 85%) can be helped at home. The numbers ending up in residential or nursing care as a new admission on a permanent basis following a hospital episode should be very low. Whilst three local authority areas met or exceeded the reasonable proportion of patients discharged with this type of support (20% of admissions), the data submitted indicates that there is significant opportunity to utilise this option more effectively, and to potentially avoid over-referral to intermediate care 'to be on the safe side'. Those who received support in the community, including domiciliary care reablement, were more likely to experience a positive recovery. In other words, community/home-based intermediate care services in Wales appear to be generally effective, where people have prompt access to them. The question is whether such services are available in sufficient capacity to support such recovery for everyone who could benefit from it, in a timely manner.

From an NHS perspective there has been a conscious move towards rebalancing provision of primary and community led healthcare service. This makes it even more essential that services exist to ensure people can access care in the most appropriate location when they no longer require acute care and treatment; and where further rehabilitation is required prior to a long term solution being agreed and implemented. In some areas however, acute hospital teams continue to over-refer to intermediate care or direct to long-term care pathways, when short-term, 'low-level' support could be a safe and sufficient option.

Previously, a joint report by the SSIA, NHS Wales and Welsh Government[7] sought the views and opinions of frontline health and social care practitioners and clinicians on these issues. Capacity in community services was identified as the major factor impacting upon effective flow and contributing to Delayed Transfers of Care. Whilst the range of services covered by the CTM Workstreams goes beyond what is

[6] *'Right Sizing Community Services to support discharges from hospital'*, NHS Wales Delivery Unit, May 2020, Awaiting publication.

[7] *'Delayed transfers of care: informal review to identify good practice'* , SSIA/NHS Wales/Welsh Government, 2016, https://socialcare.wales/cms_assets/file-uploads/6a-DTOC-INFORMAL-REVIEW-TO-IDENTIFY-GOOD-PRACTICE-REPORT-Final-ENG_170313_140210.pdf

normally associated with 'Intermediate Care' it is worth noting the evidence-based best practice elements drawn from the NICE guidelines on Intermediate Care (NICE 2017)[8]. NICE describes Intermediate Care as covering a range of integrated services that aim to

- promote faster recovery from illness;
- prevent unnecessary acute hospital admissions and premature admissions to long- term care;
- support timely discharge from hospital; and
- maximise independent living.

In the last few months The Welsh Govt published guidance to local partners intended to help them plan rehabilitation services following the coronavirus pandemic in May 2020[9]. The Framework is essentially an overview of the value of rehabilitation in the context of the coronavirus particularly as it applies to 4 population groups: people recovering from COVID-19, people whose planned care is paused, people who are at risk having avoided services in the lockdown period, and people who were isolated or shielded. It argues that:

'Priority should be given to providing rehabilitation in the environment that will secure the best outcomes for the individual at, or as close to, home as possible. Rehabilitation will need to become "everyone's business" in order to meet the expected increased demand. A workforce-wide culture of empowering people to be equal partners in maximising their own recovery and independence will be essential. In line with A Healthier Wales, promoting self-management and co-production of care will enable people to take more responsibility for their own health and wellbeing. Advances in technology and smarter ways of working must be embedded to support the increased demand and improve access, outcomes and experience.'

It also states that:

'It will be critical that the planning focusses on the individual and demand and capacity rather than location. The 'Discharge to Recover then Assess (D2RA) model' forms the basis of the hospital discharge service requirements: COVID-19. This requires health and social care in Wales to maximise the opportunity for active therapeutic input during the early recovery phase and people on these pathways should have a clear recovery plan, with access to rehabilitation that is appropriate to their needs. It also requires empowering the wider social, health and voluntary care sectors to embed recovery focussed interventions.'

4 Impact of Covid-19

Covid-19 arrived at a crucial point in the progress of the CTM Transformation programme. All of the service-based projects were due to 'go live' between January

[8] *'NICE Guidelines on Intermediate Care',* NICE 2017, https://www.nice.org.uk/guidance/ng74

[9] 'Rehabilitation: a framework for continuity and recovery 2020 to 2021' Welsh Government May 2020, https://gov.wales/rehabilitation-framework-continuity-and-recovery-2020-2021

and April 2020. By the time of the lockdown and associated impacts in mid-March only one service project was fully up and running and one partially so.

Even for these projects Covid-19 has been a disruptive influence, changing the nature and level of the demand experienced and requiring new and different approaches. As well as implementation being delayed by Covid-19 it is clear that it will also be complicated by the ongoing and longer-term impact of the pandemic, and key issues including:

- The continuing need to support Covid-19 patients (including preparedness for any future spike in the number of cases).
- Further changed and changing patterns of demand (volume and nature).
- Re-direction of resources to specialist respiratory services.
- Continuity and recovery plans.

Nevertheless, re-deployed staff are now returning to their substantive posts in the Transformation programme projects, most of which are either already operating or anticipating being able to be staffed and able to 'go-live' in the near future. Each of the workstreams has given consideration to the risk they face in doing so.

5 Conclusions

The CTM Transformation Programme Workstreams were designed originally to help ensure that partners were able to develop services in line with the A Healthier Wales agenda. As a result of the Covid-19 pandemic response, all of the 8 Workstreams implementation plans have been affected, and overall it is clear that by July 2019 the projects had not had sufficient time or capacity to deliver on the models proposed, or to collect sufficient data to show impact and outcomes.

There is continuing uncertainty about whether the national Transformation Programme will be extended to enable the wide range of Transformation projects across Wales to be fully tested and evaluated. This presents a difficult judgement for the Regional Partnership Board and, in particular, its statutory partners about whether and how to continue support for the Workstreams. To help with that judgement we offer the following summary drawn from this review:

- All of the workstreams are focused on improving the capacity of services in the community to support their local health, care and wellbeing needs. The design of the interventions in each workstream fits well with national policy and Government guidance, evidence and emerging best practice. There is no reason why the good practice principles which were used to help design the Transformation Programme Workstreams originally should not still be used as the basis for ongoing and potentially further investment in community services across CTM in the next period.
- It is clear from recent (and impending) guidance from Welsh Government such as the Rehabilitation Framework published in late May and, we understand, an impending revised implementation programme for A Healthier Wales, that national expectations will centre on continuing to promote the principles which underpinned the A Healthier Wales Plan in 2019. Therefore, there would be no

justification for closing any of the 8 Workstreams because of flaw in design or concept.

- The key question is then one of effective implementation and impact. None of the projects have, to date, been able to show that they have successfully been fully implemented as planned or that the full evaluation of activity, performance and impact had been completed. (Although parts of some programmes have been fully completed) In all cases this has been due to the direct or indirect impact of the exceptional circumstances brought on by the Covid-19 pandemic.
- Stay Well @ Home 2 and Assistive Technology workstreams are continuing with their original service plans. Others are currently working on renewed or revised plans, on securing the capacity and resources needed to complete their implementation, and on collecting the data necessary to test their effectiveness. The workstreams have almost all got comprehensive frameworks in place to enable effective evaluation, but it is highly unlikely that convincing performance and impact data will emerge until at least the end of the 2020-21 financial year. This will provide the first major opportunity to adjust intervention design or consider the potential for wider roll-out of the interventions across the region.
- Given the level of investment that has already been made in these projects, the potential that they have for improving care and reducing costs elsewhere in the system, and their fit with national policy and evidence from elsewhere, there appears to us to be a very strong business case for continued investment in all of the projects for at least the period through to March 2022. This would allow for the projects to be judged using data collected up July/August 2021 and for decisions about future funding to be made in September 2021, in time to continue, enhance or close down the workstreams from March 2022.
- This period will also provide the opportunity to explore further questions about the extent to which the interventions can be rolled out more widely across the region (currently just one project has a CTM-wide remit) and how other existing services and pathways can be adjusted to make best use of the Transformation projects. This will need to include consideration of the use of the Integrated Care Fund (ICF) and how projects being supported by the Fund might be developed to link more closely to these workstreams.
- When assessing the impact in due course, the final evaluation will need to recognise the challenges in judging how any cost avoidance can be attributed to the activities of workstreams. Some can evidence this attributability more easily than others. For example, the Bridgend Community Resource Team (Bridgend Ambition 1) specifically records hospital bed days avoided as an outcome from their intervention. The activities of voluntary groups in communities (Bridgend Ambition 3) promotes health and wellbeing and ultimately will avert the need for other forms of care, but the causal link will be harder to demonstrate. The final evaluations will have to be careful to evaluate cost/benefit for each workstream in a way that doesn't disadvantage those that are less clinical in nature.
- Partners will obviously have many other pressing demands on their resources over this period and investment decisions will need to be taken in this context. If Welsh Government extend the Transformation Grants then this will no doubt cover some or all of the resources needed to continue the workstreams as originally planned – but even in this scenario it may be worth considering whether and how additional resources from the region might be allocated in 2021-22 to ensure that the workstreams are able to deliver as wide and deep a range of

services across the region as possible. If there is no further Welsh Government support then we think that for the reasons specified above, there remains a very strong case for continued investment in these workstreams with the intention of saving on other acute and substitute care services in the future.

- The analysis we have been able to complete for each of the 8 Workstreams in the short period between the start and end of July, and captured in the individual reports on each do, we hope, provide good detail on progress to date and advice on how these might develop further if investment continues.

The Institute of Public Care
7 August 2020

6 Appendix: Summary of key findings by workstream

The following sections summarise the detailed findings and conclusions in the reports on each of the 8 Workstreams in the programme. It is important to emphasise that the analyses explore the value of the workstreams' community-based services in the context of the wider health and social care economy, *rather than in relation to each other*. This is particularly important given the varying stages of implementation prior to lockdown; in order to provide a fair representation, and conclusions and recommendations which are not influenced by the extent to which workstreams travelled down the implementation journey, our analysis focuses on the *potential* as well as *actual* impact of services.

6.1 Bridgend Ambition 1: 'Every Day is Tuesday'

This workstream responds clearly both to national and local priorities and delivers early, multi-professional interventions "wrapping around the individual" to prevent unnecessary hospital admissions, speed discharge and reduce demand on home care and care home capacity. Emphasis is placed on the ability to respond promptly and effectively at times of crisis and acute need.

Transformation funding is being used for recruitment to enable the existing Community Resource Team model to enhance its availability beyond standard office hours to provide an 8am-8pm availability, seven days per week. Although a number of new posts have been appointed, full implementation of this extended service has been delayed primarily by the restrictions associated with the Covid-19 pandemic.

In view of this, it is not possible to evidence the impact of extended availability. However, an analysis of information from a range of sources shows clearly that the CRT is effective at improving service user experience and outcomes. A wide range of stakeholders have given powerful testimonies for the value of the Team and number of studies have modelled significant cost savings as a result of diverting demand away from other services.

Progress made in the last few weeks mean that this Programme is now prepared for full implementation. There are a number of risks and issues that must be managed and addressed but the Programme Team are clearly sighted on these. A plan is in place now for the final stages of implementation and once this is completed by the end of November 2020, it is reasonable to expect that the impact and outcomes described above will start to be visible within a short timescale.

6.2 Bridgend Ambition 2: One Team Approach

This workstream is made up of three elements – the extension of the Single Point of Access for District Nursing services to cover longer weekday and the weekends; the development of Multi-disciplinary Teams within the Integrated Community Networks incorporating a range of specialist practitioners and the development of the Anticipatory Care Planning system around those people who cause the greatest concern.

Up until January 2020 progress with implementation was going well, but it was then hit by the need to respond to the pandemic. Whilst the SPoA expansion has been put

in place, this has been with some temporary arrangements. The recruitment to the MDTs and their deployment has been delayed in part as has the development of the ACP system.

The SPoA has provided an effective response during the pandemic period, improving the access to the District Nursing service for other professionals and also improving operational co-ordination of the service. The impact of the other developments is only just beginning to be felt. Planning is in progress to take this forward, but because of the collaborative nature of this work, there is a need to engage quickly and effectively with other parts of the system (e.g. GPs and Primary Care services) that may be distracted by the ongoing impact of Covid-19 and the demands created by any further spike in Covid-19 cases. All aspects have strong support from both the national policy agenda and evidence of success from elsewhere.

The different elements of this workstream (ACPs, MDTs, SPoA) are all based on well-established evidence from elsewhere and seek to build upon and develop what has been learnt, and this development was always seen as one which would have a profound impact upon patterns of care and support, but over a long-term period. It was never envisaged that it would operate as a 'quick-fix' in terms of impacting immediately upon hospital services and in-patient stays. However, a more effective approach to planning to meet developing care needs and having the right services in place to do that will have an impact in the longer-term.

The revised project plan is the first step in this process, but further work is needed to plan and implement the remaining steps towards full implementation and delivery.

6.3 Bridgend Ambition 3: Resilient Communities

The Bridgend Resilient Communities Programme has been fully implemented through the Covid-19 lockdown. A number of posts have been appointed which have been shown to be effective in identifying, developing and consolidating community resources. They are identifying isolated and vulnerable individuals and supporting them to make links with these resources. The support individuals receive has been shown to offer them fundamental and life-changing benefit. Whilst still in the early stages of implementation, this programme has made links with the wider health and social care system, particularly through the presence of a Common Access Point Broker embedded within the Community Resource Teams.

The Covid-19 evidence has shown how community groups and organisations have shown exemplary responsiveness in adjusting quickly to offer practical and emotional support to a large number of individuals. Statutory partners have testified to the invaluable role played by these groups. Case examples have illustrated how a coordinated community response can address complex and challenging needs, making links with other appropriate services where necessary. Whilst the effect on people's health and wellbeing is clear, it remains challenging to demonstrate an attributable impact on the demand for other services. More detailed case sampling as part of the ongoing evaluation of the programme may provide some useful insight. Nevertheless, other studies of similar approaches have demonstrated a benefit/cost ratio ranging from 2:1 to 4:1

The impact of the Programme has been magnified during Covid-19. In the medium term, community resource needs to be actively supported and coordinated and without this intervention, there is a clear risk that the strength and effectiveness of the "community offer" will wither. In the long term, through this Programme, Bridgend has put itself in a unique position to continue to develop the strength and resilience of communities to make a tangible difference to an ever-increasing number of individuals and families.

6.4 Cwm Taf and Bridgend Population Segmentation and Risk Stratification

The implementation of the Population Segmentation and Risk Stratification Programme has been significantly delayed due to a combination of information governance and database issues and more recently, the necessity for key staff, including the Workstream Lead to prioritise the Public Health response to the Covid-19 pandemic. Work has recommenced on the workstream and anticipates that:

- information governance will be completed by October 2020,
- initial provision to select pilot GP practices to be completed by January 2021 and
- routine provision to all GP practices to be completed by March 2021.

The Programme has not yet had the opportunity to produce any impact. Although the evidence base for the impact of this approach is not well developed, the review has suggested that Risk Stratification facilitates national and local policy and supports good, preventative clinical practice and accurate public health planning.

A potential impact on individuals is implicit although again the evidence base to demonstrate this is not yet strong and, in some cases, conflicting. Nevertheless, evidence does exist internationally, nationally and even locally to suggest that identifying populations or individuals at particular risk and focussing co-ordinated resources at these will produce improved outcomes for individuals and efficiencies in the health and care system.

Work is still required to implement this Programme and so there will be some delay before any impact can be seen, particularly on individuals and, latterly in terms of health and social care system efficiencies. Shorter term impacts may be identified in terms of information system development and creating new connections between roles which will go on later to support more focussed targeting of resources.

There are indications that there is significant impact to be achieved through this Programme. The approach supports the evidence-based targeting of resources to prevent clinical deterioration wherever possible. While there are a range of challenges and design issues to address, the workstream offers an opportunity to develop and refine a methodology to do this.

6.5 Cwm Taf Assistive technology

The Workstream has shown, despite the impact of Covid-19 that the use of digital technology to support people at home has been shown to be very effective. The evidence set out in the report indicates that the introduction of the mobile responders

has had a significant impact in the short-term (despite the disruption caused by Covid-19) and that this impact can be sustained and increased in the longer term with new individuals being brought into the service.

There are clear benefits both for people using services and their families and friends, the latter being relieved of the burden of effectively providing the first responder service themselves. There are positive signs of an immediate beneficial impact for the Ambulance Service with some knock-on effects for hospital services and a potential for considerable savings for those services. These impacts are likely to continue through into both the medium and long-term.

Assistive Technology generally, is likely to continue to develop as a model of service with increasing amounts of digital technology impacting positively upon the capability and capacity of the service. The well-being assessment and proactive calling is likely to realise benefits through the medium and long term through a proactive and preventative approach that captures individuals before crisis and prevents dependency on more expensive longer-term services or admissions to secondary care. The impact of the Mobile Responder service upon the Ambulance Service in particular is very clear and it is likely that in at least some cases, that impact runs through to hospital services.

Covid-19 has caused a delay in the implementation of the proactive calling element of the service development and this is only now getting underway. It is less likely to have an immediate impact because of the nature of the development - the people who receive this support will be identified over time and the service will then operate in a pro-active and preventative way to ensure that people's need are being met and to flag up any emerging problems and difficulties before they reach any sort of crisis or emergency point.

In short, the model has demonstrated that resources being put into the 'right place' within the system creates a responsive, tailored service that can meet emerging demand. Whether there is a tailing-off of Covid-19 demand or a renewed surge in the autumn, the Assistive Technology model is well-placed to respond effectively to meet the ever-changing levels and pattern of demand. It is particularly designed to meet the needs of people in the community at the point at which they occur, and in doing so to alleviate the need for ambulance service attendance and conveyance and hospital attendance and stays.

In the longer-term, the case for effective community services to better support people and alleviate the need for hospital services, as set out in a raft of Welsh Government Guidance remains compelling, and, with regard to Assistive Technology, is supported by evidence from elsewhere. Having an Assistive Technology service that makes use of the most advanced systems and processes will be essential to the overall development of the Health and Social Care system. This workstream has been focused entirely within RCT. As the impact of digital technologies increases, a wider programme of transformation across the region could have significant benefits.

6.6 Cwm Taf Community Health and Wellbeing Teams

Despite the interruption of the CHWBT project due to the pandemic and subsequent delay in implementation, the building blocks for roll out are now in place, with a

successful recruitment drive almost complete, supported by robust stakeholder engagement and communications plan. The data from the pilot gives enough evidence to continue to support this project going forward. If run in the right way, benefits can be seen that are financial, improve safety and quality, patient satisfaction, and the working lives of those working within primary care.

For professionals, the evidence shows that the Virtual Ward encourages an understanding of each other roles and remits, particularly across health and social care, that in many areas of the country, have long prevented an integrated approach being delivered.

Whilst the evidence of the more well-known and publicised Virtual Wards does not show huge successes in outcomes, there are lessons that can be learnt from them. More recent evidence around adapted versions of the Virtual Ward, such as the North-West London approach, and other models that have been strengthened to respond to the pandemic should be noted in how to manage the coming months and years of this disease.

The proven successes seen in the pilot strengthens the argument that all CTM citizens with more complex needs, should have equal access to a holistic multi-disciplinary approach to their care. However, the Virtual Ward roll out is dependent on the commitment and ownership from GPs and their teams. Tenacity, commitment, and patience are required to allow a Virtual Ward to evolve and become sustainable. The success of the St Johns' pilot was largely due to strong leadership, with a committed team prepared to try something new. It will be important to recognise that planning and implementing large-scale service changes takes time.

Hospital use and costs are not the only important impact measures. The success of Virtual Wards should be measured through a reduction in hospital admissions, but balanced with a measure of improvements in coordination, informed patient decisions, and care being delivered closer to home will have an impact on the overall health economy.

Other Virtual Wards have shown that the right IT solutions that allow sharing of information are a critical factor in their success. Without this access, it makes multi-disciplinary working across primary, community and secondary care that bit harder and slower, which could affect their sustainability. Whilst IT is not a reason to not start this initiative, transparent IT support plans should be in place. It may be worth exploring the potential of linked data sets, including greater use of GP data to develop cohort-based techniques for tracking the care of individuals with long-term conditions that include analysis of the quality of care, as well as estimated cost and service use.

To demonstrate statistically significant change, size and time are important. The use of the evaluation framework for CHWBT should be implemented at the start of the roll out to capture performance and outcomes, alongside measuring patient and carer experience through case studies, patient stories and satisfaction surveys. A range of connections will also need to be made between the Community co-ordinators, managed within the 3rd Sector (One of who was focused upon Health) The GP

support officers in the Merthyr and Caerphilly areas and the proposed 'Well-Being' co-ordinators.

It may also be of benefit to build strong relationships and communication links with secondary care partners, allowing support of patients on the Virtual Ward that have been admitted to hospital or will be discharged home and could be at risk of re-admission. Coordination of their care will be paramount from all sides.

6.7 Cwm Taf Stay Well@Home 2

The Stay Well@Home 2 services looks to build upon the impact of the original Stay Well@Home service and to extend the concept of rapid out-of-hospital care to include those at risk of admission as well as those who are ready for discharge. It provides a Single Point of Access Response (SPoA) to referrals from community professionals (both health and social care) 365 days a year from 8.30a.m. to 8.00p.m. It utilises 'Trusted Assessors' and aims to provide a service, where needed, within 4 hours. The service commenced in RCT in January and Merthyr Tydfil in July 2020. Operation of the RCT service and implementation of the Merthyr service were both delayed by the pandemic.

The evidence to date suggests that the new Stay Well@Home2 service can have a significant impact in the short and medium-terms. However, it will take some time for the new service in Merthyr Tydfil and the re-started service in RCT to adjust from the effects of dealing with the height of the pandemic, move to more normal ways of working and get fully up to speed. Whether there is a tailing-off of Covid-19 demand or a renewed surge in the Autumn the Stay Well@home 2 service looks well-placed to meet future levels and pattern of demand. It is particularly designed to meet the needs of people in the community at the point at which they occur, and in doing so to alleviate the need for ambulance service attendance, conveyance and hospital attendance and stays, and this can lead to considerable financial savings at all points.

6.8 Cwm Taf Urgent Primary Care Out of Hours

This workstream addresses some of the issues that have been identified around the pressure on the GP out of hours (OOH) service both at local and a national level. It has been identified that Cwm Taf (RCT/Merthyr) OOH service has been almost solely dependent on GPs to undertake clinical phone triage as well as face to face contact both in Primary Care Centres (PCCs) and for Home Visits. This dependency is a major cause of the system vulnerability. The model is now out of step compared to many other parts of Wales and compared to the national Primary Care Model. The workstream focuses on a Multi-Disciplinary Team in OOH services and within 111 to manage demand more appropriately and have a positive impact on patient experience. It includes new roles such as ANPs, District Nurses, Advanced Care Planning Nurses, Paediatric Specialist Nurses, Mental Health, Paramedics and MSK Physios. It is intended that in time (within 18 months) this service will be able to reduce 25 – 30% of the patients from the GPs workload. It is complemented by the exploration of digital solutions including applications and web-based programmes.

The quantitative data available for this review is too limited to reach firm conclusions about the impact of the service so far, and the collection of data has been effected by

the Covid-19 pandemic response. Whilst data from previous quarters is useful as a baseline, more recent data is needed to show how the service works now, and the impact of Covid 19 may make is harder to make direct comparison with previous data. The feedback from the peer review and stakeholders of the service go some way in evaluating the short term outcomes the service set out to achieve, such as strengthening of clinical leadership to help teams with decision making, increased capacity within the system due to the effectiveness of nurse triage (telephone and face to face), and robust and effective multidisciplinary team working to include paramedics, advanced care planning nurses, mental health specialists to improve patient experience.

The service has the potential to provide more streamlined pathways, with a stronger collaboration with social care, mental health services and the voluntary sector, and the use of digital technology for signposting.