‘Happily Independent’

Strategic Outline Case for the Gwent Frailty Programme
Contents

Opening Statement .............................................. Page 3

Executive Summary ............................................. 5

Introduction & Context ........................................ 34

Chapter 1: ‘Where we are now’
Background and journey so far ...................... 35

Chapter 2: ‘Where we want to be’
Vision & Principles ............................................ 42

Chapter 3: Integrated Community Resource Teams
‘What they will look like on the ground’ ........ 49

Chapter 4: ‘What needs to change?’
Modelling Exercise ............................................. 57

Chapter 5: ‘How we are going to get there’
Implementation ............................................... 75

Chapter 6: ‘How will we know we’re achieving what we want to?’
Evaluation & Performance Management ....... 103

Chapter 7: Programme Structure ......................... 106

Photographic images reproduced with the kind permission of Age Concern
© Copyright Age Concern, or from Microsoft Clip Art
The Strategic Outline Case takes ONE part of the overall Programme as a staged approach to implementation of the whole system change.

The Programme considers the whole system to be embodied by the PERSON who will use services or assistance. They are the centre, focus and reason for the work. They have a life with its own story and context. How well the parts of that life work together will affect the individual’s outcomes. We need to focus on that interdependence and not separate out different medical, social, environmental responses.

The present system within health, social care and partner agencies across the public, private and voluntary sector has grown in complexity. It is increasingly process driven through:-

- Organisations
- Specialisms
- Professions
- Initiatives

The separate parts then spend considerable amounts of energy and resources in trying to connect up in order to assist the individual who needs the help.

The Frailty Programme aims to SWITCH the focus and simplify the processes so that agencies work together and locate services to people in their homes and work with them to preserve independence and dignity.

We know that the resource envelope will be under increased pressure as the ageing demographic rise continues and the public purse contracts. Consequently the Programme aims to:-

- **Re shape what happens in primary and community care within locality settings.**
- **Rebalance health and social care away from a secondary setting into peoples’ homes and their communities.**

We need to use the total resource envelope to provide for INTEGRATED SERVICE DELIVERY which is multi professional and multiorganisational and is based on a LOCALITY TEAM approach.

The Programme includes:-

- Prevention initiatives
- Crisis Responses
- Reablement
- Longer Term or programme of care across the acute and primary / community sector
All of which need to align and work as part of the integrated approach that focuses on the individual. For that person or their carer they should expect:-

- One point of contact
- One contact person
- 24/7 availability and timely responses
- Preservation of independence

To achieve the necessary change, we need to adopt a realistic and staged approach to implementation. This SOC is concentrating on Phase 1 which covers the elements of Crisis Response and Reablement as the initial stage.

However, to achieve the system change as outlined, it is essential that these elements do not become another “specialist approach” which add to the complexity and consequently does not achieve effective use of the shared resource.

The next phase needs to include the total community resource which will include amongst others:-

- District Nursing
- Continuing Health Care
- Chronic Conditions Management
- Palliative Care
- Longer term Social Care
- Local authority, housing and voluntary organisation activities that provide both the setting and the prevention potential that maintains independence
- Continued involvement of Primary Care (as exemplified by Dr Chris Jones’ work)

The model is based on realignments and resource flows from secondary into community / locality as well as realignment within the community setting. As the locality approach increases its capacity and reach, there will be staged reductions in the usage of those hospital facilities that are better located within a primary / community setting.

The specific timing, project management and development of the change management and business cases of these next phases require scoping as the next part of the implementation programme but it is essential to locate this SOC within the Strategic Context. It is part of the whole and not an end in itself.

Moya Wilkinson: Director of Social Services, Monmouthshire
Professor Pradeep Khanna: Chief of Staff, Aneurin Bevan Health Board
David Murray: Chief executive, Age Concern, Gwent
Executive Summary

Background & Journey So Far.....

This Strategic Outline Case (SOC) is the culmination of work commenced in October 2007, when Chief Executives from across the local health and social care community established a joint working party to focus on what these organisations could do collectively to improve the quality and sustainability of care for people in Gwent.

At the time it was decided to focus activity on frail older people but as a result of discussions and workshops in the intervening years this has evolved and the Programme now seeks to address the needs of any adult who meets the frailty criteria described below.

The work was initiated under the auspices of the Clinical Futures Programme: Community Based Services and this SOC draws extensively on information gathered by that project as well as more recent workshops and data analysis. It also seeks to address the recommendations made by Dr Christopher Jones in his paper “Gwent Clinical Futures: Pulling it all together”.

‘Frail’ Population in Gwent

The Programme is clear that it aims to support and promote independence for any adult who is experiencing frailty.

It is therefore adapting the concept of frailty, which is traditionally viewed as a syndrome affecting older people. It can be seen however, that the features described below can apply to a much broader group, including many people with chronic conditions for example.

Dependency
- Chronic limitations on Activities for Daily Living (ADLs)
- With one or more functional, cognitive or social impairments

Vulnerability
- Running on empty
- An overall loss of physiological reserves
- Loss of functional stability

Disease State
- People with chronic condition
- Presence of social and physical co-morbidities
That said, it is highly likely that the majority of people requiring support will be over 65, and as a result it is the data available on older people that has informed the calculations below.

It is reiterated however, that the Programme will not exclude anyone on the basis of age.

The prevalence of frailty in a community setting is outlined in the graph below. Using these criteria there are approximately 20,000 people who could be described as frail older people across the health community.

The Current System of Service Delivery

The Human Perspective:
From November 2008 David Murray, Chief Executive of Age Concern Gwent, led a workstream on behalf of the Frailty Programme which sought the experiences of older people in Gwent.

The evidence gathered indicated that the way we currently provide health and social care support:

- Is complex, fragmented and extremely difficult to navigate;
- Pushes people by default towards hospital admission or long-term institutional care;
- Fails to address the person as a whole, within the context of their lives and communities;
- Fails to address the needs of informal carers.

These findings are of course consistent with national studies and reports.

The positive stories provided highlighted that the keys to success are:
Seeing the individual as a whole human being and as a result treating them with due dignity, respect and understanding;
One person taking the responsibility to co-ordinate a timely and appropriate response;
Joined up responses from primary, secondary, social and voluntary care agencies;
Effective communication with the individual, their carers and between professionals/agencies.

The Service Perspective:
The Wales Audit Office Report (2007) ‘Tackling Delayed Transfers of Care across the whole system – Gwent health and social care community’ highlighted that the existing system could be managed more effectively to promote independence for vulnerable people. In particular, it detailed the need for integrated steps across the whole community to develop an effective whole system according to a clear and shared vision of what services should look like (Para 2.48)

We know that people who are frail and have more complex needs are those most likely to have frequent attendances at A&E, are more likely to be admitted to hospital and once there often become ‘stuck in the system’.

For example Bed Census exercises undertaken in 2008/9 in Torfaen, Caerphilly and Newport indicate that approximately 50% of people in Community Hospital Beds need not have been there had sufficient community based services been available.

Drivers for Change
There is a clear strategic direction emanating from the Welsh Assembly Government that aims to provide more efficient, effective and integrated services closer to people’s homes.

The vision is unique but has been developed using the evidence base from the UK (e.g. Croydon, Salford, North Devon and Torbay) and further afield (NB Canada, USA, Australia and Scandinavia).

It is anticipated that implementation will lead to:

- More people remaining independent in their communities for longer;
- Individuals receiving timely, responsive and proportionate services that avert crisis and promote independence;
- Individuals and their informal carers feeling that they are listened to by the people providing support and that they are ‘worked with’ rather than ‘done to’;
- A proactive rather than reactive individual care pathway.
The impact will be manifested as:

- Reduced numbers of acute hospital admissions NB ‘revolving door syndrome’;
- Shorter lengths of stay;
- Reduced delayed transfers of care;
- Improved flow through secondary care;
- Reduced hospital acquired infections and associated costs;
- Reduced duplication and improved efficiency;
- Improved access to community based services, 24 hours, seven days a week;
- More people being helped to live at home;
- Reduced demand for large, complex care packages as a result of the enabling approach;
- Improved outcomes for individuals and communities;
- Greater user and carer satisfaction as we meet people’s aspirations;
- More effective use of public money utilised as a joint health and social care resource;
- In the longer-term reduced demand for Continuing NHS Healthcare as people’s health and well-being is maintained for longer.

Where we want to be……

The underpinning principle of the Gwent Frailty Programme is to provide:

‘Help when you need it to keep you independent’

The mantra for those delivering services is to provide help that is Sustaining independence.

The Frailty Programme will implement the Outcomes Based Approach (see Chapters 5 & 6), which is predicated on understanding the experience of the people we seek to serve.

Engagement events asked older people in Gwent what being ‘happily independent’ meant to them.

The full report ‘Towards Independence for Older People in Gwent: Key Findings from the 2009 Older Peoples Experience Workshops’, is available on the Frailty Programme web site www.gwentfrailty.torfaen.gov.uk
The people consulted stated that if they are happily independent they will:

1. Be able to remain living in their own home with support
2. Receive services in their home
3. Be listened to by people who are responsible for providing services to assist them
4. Have their health and social care problems solved quickly and considered as a whole rather than individually.

- Be safe and secure
- Live in good quality homes
- Be able to cook, wash, clean and go out
- Be able to maintain their standards
- Be financially stable to make independent choices
- Be receiving the benefits available to enable them to live independently
- Not be lonely
- Have a supportive family
- Have good friends and neighbours keeping an eye out for them
- Have company
- Be going out to social activities
- Have planned for old age
- Be accessing peer support
- Be able to keep a pet if they so wish

The shaded box represents the specific deliverables of **Phase 1** of the **Gwent Frailty Programme** and thus its priority focus of activity up to March 2011. This must however, sit within the context of existing and developing work within local authority areas promoting independence in its wider context.

In other words, the full impact of the Programme will only be achieved if Phase 1 is viewed as the first step to the wider vision of the integrated locality approach described in the introduction to this Strategic Outline Case and in the diagram and Table below.
The overarching responses required by each Borough to address the desired outcomes are described in the diagram above and detailed more fully in the table below.
<table>
<thead>
<tr>
<th>Level of Need</th>
<th>Example Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Care</td>
<td>Alternative to admission to hospital, e.g. Urgent Comprehensive Assessment and management in the community, or if clinically necessary admission to hospital</td>
</tr>
<tr>
<td>Intensive Packages</td>
<td>High level complex needs requiring co-ordinated interventions</td>
</tr>
<tr>
<td>Episodic or longer term interventions</td>
<td></td>
</tr>
<tr>
<td>Identified needs</td>
<td>Intermediate Care as described in proposed service models</td>
</tr>
<tr>
<td>warranting integrated approach</td>
<td></td>
</tr>
<tr>
<td>Some identified</td>
<td>Carer assessment and support Overview assessment Telecare Information Care co-ordination and a clear contact person</td>
</tr>
<tr>
<td>health/social care needs</td>
<td></td>
</tr>
<tr>
<td>Preventative Services</td>
<td>Housing Benefits &amp; financial advice Transport Personal safety Activities Interests Sociability Screening Community Needs Shopping assistance Home Safety Checklist Occasional contact with primary care Keeping healthy at home</td>
</tr>
<tr>
<td>Community Context</td>
<td>Area/neighbourhood focus Relationships Universal service Information Available on what’s happening locally Cultural/leisure/sporting/church, activities etc Involvement Wellbeing</td>
</tr>
</tbody>
</table>
Frailty Programme Layers of Activity

In order to support the delivery of those responses, the Frailty Programme will undertake the following activity. They are described as layers rather than Programme Phases as they will be commenced in parallel, though some will take longer than others (NB cultural change) to be demonstrably achieved.

| Integrated Community Resource Teams in each Borough to bounce people away from crisis and the dependency spiral, back to a place where they can be supported to be ‘happily independent’. |
| Seven Implementation Workstreams to support effective implementation of the above |
| Training, Development and Cultural Change Management Programmes with the staff both in the Community Resource Teams and in the wider health and social care community to promote the ethos of sustaining independence |
| Work with Local Service Boards to ensure that other supporting services for sustaining independence are provided e.g. access to adequate housing, benefits, community safety etc. |
| Influencing and aligning with developments in the wider Community Based Services, to ensure that the Frailty Programme is a catalyst for change and not simply a ‘bolt on’ set of services. |

Focus of this Strategic Outline Case

The top two blue layers of the Programme form the focus of this Strategic Outline Case. That is, the development of integrated locality-based Community Resource Teams that prevent people from entering the dependency spiral as a result of a health and social care event or crisis.

It is recognised that all Boroughs currently have some form of intermediate care service, but there is not equitable provision for every Gwent resident and some Boroughs are closer to the proposed model than others.

The locality based integrated intermediate care teams which we will now refer to as Community Resource Teams, will build upon the good practice which already exists within the Gwent health and social care community. They represent the most immediate and tangible outputs of the Frailty Programme, in that having a consistent standard of service and outcomes across the Gwent region is anticipated to produce relatively quick wins in terms of:

- Providing an holistic approach to user and carer needs;
- Improved co-ordination of quality health and social care services;
- Improved outcomes in terms of people’s health and wellbeing;
- Decreased numbers of unnecessary admissions to hospital;
- Shorter lengths of stay for those who do require admission;
More people receiving appropriate and proportionate support in the community;
Less reliance on long-term care;
The ability to ensure that what works well can be spread across the Region;
More effective use of resource.

Integrated Community Resource Teams

The integrated Community Resource Teams are designed to intervene to support an individual to:

- avert pending health or social crisis wherever possible;
- operate a ‘pull system’ to support through the crisis and restore/maintain independence;
- provide a smooth transition with core services or longer-term care where required.

Services will be available to people in their own place of residence, including those who live in care homes.

As emphasised previously, the services provided by the Community Resource Teams will only achieve the desired impact within the context of the wider vision of an integrated locality approach.

The concept of catching people before they hit the downward dependency spiral and working with them and their informal carers to ‘bounce back’ into the degree of independence with which they are happy (hence the phrase ‘happily independent’) is illustrated in the diagram below.

Whilst intervention at the point of crisis will achieve the ‘quick wins’ described in Chapter 2, it can be argued that the greater but more challenging impact will be achieved by pulling those who are currently dependent (in the blue circle) back towards independence (the green circle) and providing longer-term maintenance support to the user and their informal carers.

Hence the repeated assertion in this document that the development of the Community Resource Teams represents Phase 1 of the Gwent Frailty Programme.

The Community Resource Teams will operate as co-located ‘teams without walls’, reporting to one manager and providing:

- Urgent Comprehensive (health and social care) Needs Assessment
- Rapid Response to health and social care needs
- Emergency care at home
- Reablement.

If you are accessing the Community Resource Team you should expect:

- Access via a single point of contact
- 24/7 availability, 365 days a year
- Comprehensive assessment and review of your needs
- A named care co-ordinator
- A tailored package of care that responds to your health and social care needs quickly and as a whole
- An 80:20 generalist/specialist approach to service delivery
They will incorporate existing intermediate care type services and falls services where they exist.

They will work closely with Welsh Ambulance Service Trust (WAST) Specialist Practitioners with the WAST pilot studies for alternative Falls Pathways.

They will interface (during Phase 1) closely with Chronic Conditions Management Teams, Older People’s Mental Health Teams/ Community Mental Health Services, specialist Palliative Care Teams.

Successful alignment with the District Nursing Service and GP practices will be a critical success factor for the Programme, and will need to be explored further in preparation for the local detailed business cases.

Following urgent comprehensive assessment the allocated Care Coordinator will be able to ‘pick and mix’ from the available services (including local voluntary sector support, telecare and housing) to provide a prompt and proportionate response to individual need.
## Common Service Standards

<table>
<thead>
<tr>
<th>ACCESS</th>
<th>Urgent Assessment &amp; Rapid Response Intervention element</th>
<th>Reablement &amp; Independent Living element</th>
</tr>
</thead>
<tbody>
<tr>
<td>Via locality Single Point of Access</td>
<td>Via locality Single Point of Access</td>
<td></td>
</tr>
</tbody>
</table>

| HOURS OF OPERATION | 7 days a week 365 days a year 8am to 10pm | 7 days a week 365 days a year 8am to 10pm |

| RESPONSE TIME | 2-4 hours (for both health and social care components) | To be confirmed |

| ASSESSMENT | Comprehensive Needs Assessment | Agreed shared assessment document |

| SERVICE PROVISION | Urgent Assessment Within 2-4 hours Management/ Hospital @ Home Up to 14 days in response to assessed need and to include: - Rapid Response Intervention for health need - Emergency Home Care package for social care need and carer support No charge to user | Up to 6 weeks rehabilitation and reablement support from a range of therapists, social care and nursing staff. Ongoing review to ensure the individual is getting what they need. Reablement can be for less or more than 6 weeks. No charge to user for first 6 weeks |

| ACCESS TO | ‘Hot Clinics’ for rapid access to specialist and diagnostic support (Monday to Friday) Acute specialists e.g. Mental Health; Palliative Care Falls Pathway Therapists Rapid access to equipment and minor adaptations. | Specialists including psychology, dietetics, pharmacy, speech & language therapy, podiatry, EMI teams. Rapid access to equipment and minor adaptations. |
What needs to change........

The Frailty Programme recognises that each Borough has already worked hard to develop at least some intermediate care provision and that this needs to be considered in the resource envelop for the proposed Community Resource Teams.

After considerable debate and analysis of the Mary Williams Case Scenario and Pathway, the Frailty Programme Board agreed that the following should be considered as existing service provision that can support the model:

- Urgent assessment teams such as the Acute Comprehensive Assessment Team (ACAT) in Torfaen;
- Rapid Response Teams (healthcare);
- Emergency Care at Home Schemes (social care);
- Voluntary sector
  - hospital discharge support teams
  - carer support that focuses on facilitating early discharge/preventing unnecessary hospital admission
  - care & repair type functions that support as above
- Reablement teams (including those operating the ‘Intake Model’)  
- Fall teams  

* **Note:** In calculating the current resource, it has been difficult to disaggregate the proportion of the reablement component of the intake model that would contribute to the provision of Community Resource Team service. This will be resolved at detailed business case stage by for example, using the SSIA Reablement Tool.

Calculating the potential increase in demand as a result of implementing the proposed service model has been challenging. Exploration of other areas’ methodology indicates that there is no single established means of doing so. Most models reviewed utilised the data of existing or approximate services and the methodology focused on what the service was trying to achieve.

A pragmatic approach has been assumed and a combination of information sources collated to give a best estimate of the potential increase in demand, based on individual and population need.

The **sources** used in the calculations were:

- Data gathered on behalf of the Clinical Futures project;
- Caseload information from existing intermediate care services;
- Bed Census data from Torfaen, Newport and Caerphilly;
- Data from the Torfaen Acute Clinical Assessment Team (ACAT);
- Borough –specific business cases where they already exist;
- Welsh Ambulance Service Trust (WAST) data on Category C falls patients.
- The business cases for Ysbyty Aneurin Bevan and Ysbyty Ystrad Fawr.
The **caveats** that need to be considered include:

- **Peaks and troughs in demand.** The calculations are based on average caseloads, but the nature of health and social care is that there will be peaks and troughs in demand. If it is to succeed in achieving its desired impacts that model must be able to respond. The calculations will therefore include a buffer to account for such fluctuations in demand.

- **The accepted safe occupancy rate for hospital beds is around 85%, yet we know that hospitals in Gwent currently operate at an average of 94% occupancy.** Any calculated potential for shift in resource from hospital to community services will therefore need to allow for this rebalancing and for the increase in acuity of in-patients if unnecessary admissions are avoided and early discharge facilitated.

- **WAST were unable to provide information on how many of the Category C patients were clinically assessed as being safe to be managed at home but were conveyed to hospital because of lack of alternative service provision.** For the purpose of the calculations it has been assumed that all the Category C calls for people who have fallen could be managed in a community setting with the support of the Community Resource Team. It is acknowledged that this is likely to be an overestimate but until the alternative Falls Pathway is piloted this represents the ‘best guess’.

The calculation of potential demand for ACAT/Rapid Response type services is based on the ACAT data and scaled up/down for population size, with an additional 30% added to take account of increase required to provide a service from 8am to 10pm, seven days per week.

The calculation of potential demand for Reablement is based on the bed census data for Caerphilly, Newport and Torfaen.

Monmouthshire and Blaenau Gwent have not undertaken the same local Bed Censuses though Blaenau Gwent has reviewed bed requirements as part of the Ysbyty Ystrad Fawr Business Case. For the purposes of the modelling exercise the same methodology has been applied across the five Gwent localities. There is a view amongst some managers in Blaenau Gwent that this may represent an over-estimate for that Borough, and this will be examined further as the detailed business case in developed for each locality between January and March 2010.

As above, the calculations add a further 30% to cover the proposed extended hours of operation, except for Blaenau Gwent which currently has the only team working 7 days a week up to 8pm.
### Potential Demand for CRT Service: Cases per month

<table>
<thead>
<tr>
<th></th>
<th>ACAT/Rapid Response</th>
<th>Reablement</th>
<th>Falls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caerphilly</td>
<td>280</td>
<td>254</td>
<td>52</td>
</tr>
<tr>
<td>Blaenau Gwent</td>
<td>115</td>
<td>113</td>
<td>22</td>
</tr>
<tr>
<td>Monmouthshire</td>
<td>145</td>
<td>111</td>
<td>27</td>
</tr>
<tr>
<td>Newport</td>
<td>231</td>
<td>159</td>
<td>41</td>
</tr>
<tr>
<td>Torfaen</td>
<td>148</td>
<td>133</td>
<td>30</td>
</tr>
<tr>
<td><strong>Gwent Total</strong></td>
<td><strong>919</strong></td>
<td><strong>768</strong></td>
<td><strong>172</strong></td>
</tr>
</tbody>
</table>

The shift in demand is predicted to impact on current secondary care delivery as follows:

**ACAT/Rapid Response:**
- Reduction in medical emergency admissions and lengths of stay;
- Improved patient flow;
- Reduction in delayed transfers of care.

**Reablement:**
- Reduction in the number of community hospital beds required;
- Reduced lengths of stay;
- Decrease in size of care packages required after intervention.

**Falls:**
- Reduction in pressure on A&E/MAU;
- Reduction in emergency admissions for this category specifically.

**Costs of implementation of pan-Gwent Community Resource Teams based on projected demand.**

At this stage it is only possible to give a high level view of the broad resource envelope that may be required to cope with the estimated potential demand on existing Community Resource Team-type services.

For the purpose of the calculation the falls cases have been added to reablement costs, but it is acknowledged that these patients may need access to urgent assessment also. These elements will of course be integrated in the CRTs.

The analysis is based on current experience and skill mix; it does not account for potential efficiencies achieved through working together more flexibly and effectively.

It is proposed that each locality will develop its own implementation plan in response to the agreement on the proposed service model and standards. From these local plans, detailed business plans will be formulated between January and March 2010.
The costs detailed below have been calculated using the common multiplier of £25,420.

<table>
<thead>
<tr>
<th>Costs of New Model</th>
<th>ACAT/Rapid Response</th>
<th>Reablement (incl. falls)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caerphilly</td>
<td>£1,442,288</td>
<td>£7,765,864</td>
</tr>
<tr>
<td>Blaenau Gwent</td>
<td>£593,883</td>
<td>£3,434,266</td>
</tr>
<tr>
<td>Monmouthshire</td>
<td>£746,596</td>
<td>£3,495,274</td>
</tr>
<tr>
<td>Newport</td>
<td>£1,187,766</td>
<td>£5,073,867</td>
</tr>
<tr>
<td>Torfaen</td>
<td>£763,564</td>
<td>£4,133,321</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>£4,734,097</strong></td>
<td><strong>£23,902,592</strong></td>
</tr>
</tbody>
</table>

The total projected costs of the new service therefore are **£28,636,289**.

Across Gwent there is a current investment in the intermediate care services described on Page 1 of this Chapter totalling £11,641,988. Of that total, £1,624,779 is derived from Welsh Assembly Government grant funding that is due to cease in March 2011.

At this stage of development of the business case, it is anticipated that the Frailty Programme will be seeking to access circa £17 million pump-prime ‘Invest to Save’ funding.

**Next Steps**

The Finance Workstream will meet on a weekly basis throughout January to collate the information required for the Invest to Save bid, including the following:

- Future modelling & assumptions need to be confirmed - in particular open cases
- Timescale of the benefits realised from the new service model
- Timescale of the pump priming investment
- Confirm the resourcing of the new model Gwent wide
- Confirm the governance arrangements to support integration - potential use of ‘pooled budgets’

The Frailty Implementation Groups (FIGs) in each locality will develop their own local business cases between January and March 2010.
Options for Roll-out 2010/11

Three options have been identified for the roll-out of the proposed model and these are:

1. The Big Bang Approach: all five localities ‘go live’ on an agreed date in 2010/11 financial year;

2. Pre-determined phased roll-out: one or more localities ‘go live’ at agreed times throughout the 2010/11 financial year;


Board Recommendation
Having debated and considered all three of the above options the Frailty Programme Board proposes that a combination of Options 1 & 3 should be adopted.

That is, it is recommended that all the localities sign up to commence implementation on 1st April 2010, but that each then works to their own implementation plans and timescales.

How we’re going to get there............

Communication and Stakeholder Engagement.

During the planning process a significant amount of time and effort has been focused on gaining the views of staff, patients and the public to ensure that there is local support for the proposals set out in this Strategic Outline Case.

A Communication and PR Group has been a core part of the project structure from the outset, chaired by the Medical Director, Newport Local Health Board and incorporating representatives from the Trust, Community Health Council, Local Authorities and the Voluntary Sector.

The Communication and PR Group has taken forward three specific programmes of work:

- Stakeholder briefings
- Staff Communication
- Public Engagement
The Communication and Stakeholder Engagement Team have developed a stakeholder matrix, which will underpin the Communication Strategy and Communication Plan that will underpin the Frailty Programme.

The matrix highlights the types of information that would be of most interest to each broad category of stakeholder. This will enable the communication plans to be developed specifically to respond to the needs of each stakeholder group.

Priorities for engagement were also developed and are:
- Potential and existing service users
- Power brokers (Politicians and executive teams)
- Service Providers
- Influencers/Experts
- Interested Parties/general public

**Governance and Structures**

The governance framework required to underpin the Frailty Programme is complex. There were 11 organisations all with different accountability structures in place. The six health organisations became the Aneurin Bevan Health Board on 1st October 2009, although it must be recognised that it will take time for the new structures and accountability framework to become embedded.

This section of the Strategic Outline Case:
- Gives an overview of the corporate governance and assurance process in place across the health and social care organisations involved and the regulatory and legislative frameworks, which underpin these.
- Sets out the approach being taken to develop a governance and assurance framework for the Programme.
- Details the work programmes of the sub groups established to progress this.

The Governance and Structures Workstream has representation from Local Health Boards, Local Authorities, Gwent Healthcare NHS Trust, Care and Social Services Inspectorate for Wales, General Practitioners, the Voluntary Sector and National Leadership and Innovations Agency for Health.

The workstream identified all the issues and risks which needed to be considered when developing the framework. This included the use of language by different organisations and the different corporate assurance mechanisms. The issues were analysed by the workstream lead and Programme Manager and arranged in three groups. These being:
- Clinical Accountability
- Operational Issues
- Managerial Issues (to include professional and regulatory issues).
Three sub groups have been established to progress this work, leads and members have been identified. The Groups are in the process of identifying the major risks, key issues and agreeing processes to address these.

Options for the structures needed to demonstrate assurance to the Board of Aneurin Bevan Health Board and Scrutiny Committees of Local Authorities will also be developed. The existing Health, Social Care and Well Being Partnerships could be pivotal to this.

In order to address the complexities of agreeing processes across organisations, the governance arrangements will both influence and reflect the phasing of the implementation of the programme.

**Information Sharing and Single Point of Access**

Information sharing and the development of an effective Single Point of Access logically go hand in hand. The tight timescales for the Programme and the volume of work involved in addressing these two issues is such that for practicalities sake the two elements will need to be undertaken concurrently, and in close conjunction with the Governance and Structures Workstream.

The ultimate aim is to achieve the vision set out by Dr Chris Jones as the ‘Communications Hub’; that is, any professional, service user, carer, member of the public can ring one number with their health/social care/housing query and speak to ‘Mavis’ who will have the tools, skills and knowledge available to co-ordinate resolution.

The pragmatic approach adopted by the Frailty Programme is that it implementation of the Single Point of Access will consist of building blocks that will support our evolving service model and contribute to the Gwent Communications Hub.

**Key Aims for the Workstream**

There are two broad aims proposed which are separated purely by the speed in which they need to be implemented and the resource required for development.

- **Phase 1: Single point of Access**
  - This comprises one phone number to access the service and access to a Directory of Services
  - Delivery by April 2010

- **Phase 2 : Information System required to support the Gwent Frailty Model**
  - Delivery post April 2010
Phase 2 requires close liaison with the Governance Workstream in order to define:

- The specification for the Frailty Register;
- How the system can utilise an Outcome Based Approach. An example of this is SPICE tool written by the NLIAH software developer (Nick Lewis) and reports on activity and service user outcomes;
- An agreed assessment template such as that based on summary Unified Assessment document;
- Who completes the information? This could be achieved with Integration/interfaces. One option is to feed the system through interfaces from PAS or SWIFT or ePEX etc based on criteria/algorithm via data dumps;
- How it is physically accessed (i.e. web service) and also the equipment needed to access it (mobile devices or PC’s etc.);
- System security requirements - Define the levels of user access (read only / delete / edit etc) as well as various levels of access to the layers of information;
- How and when client/carers gain access to the information and to what degree;
- The Consent Model to enable the sharing of information (perhaps based on the IHC IHR model of explicit consent);
- Key responsibilities for the Named Care Co-ordinator;
- Who is responsible for maintaining/updating the assessment?

**Workforce Planning & Development**

The current workforce identified for the project are drawn from three sectors represented by the Trust, 5 local authorities and the voluntary sector primarily Age Concern. Each of the organisations provides elements of the Frailty service requirements within their remits but collectively they have the opportunity to deliver a cohesive and whole service model.

The easier workforce to identify within the current service has been the ‘specialist’ workforce includes Consultants, GPs, Social Workers, Nurses, Occupational Therapists, Physiotherapists, Speech and Language Therapists, Psychologists. Occupational Therapists are employed by both Local Authorities and the Trust though there are some variations in their role.

The strategic vision document “Happily Independent” identified that two teams in particular were important to delivering the Frailty service model these being Urgent Response and Intervention and Reablement. It is proposed that in each Borough these two elements are merged to form a Community Resource Team, managed by a single manager.

The current picture shows that across Gwent such services vary within each Borough in terms of how they are managed, funded and by which sector, which professional groups and how many staff they employ.
From a workforce perspective this raises a number of issues including:

- How the number and variation in registered and unregistered staff groups will be decided
- How the transition will be managed across the sectors
- How staff will be engaged in these processes
- How this service will be line and professionally managed.

The project is also intending to develop and expand upon a Care and Well Being worker who will be able to support a large range of the duties within the care plans developed by registered staff. They will support the person to whom they have been allocated in meeting their physical, practical, social, community, psychological, motivational and other independence needs.

This potentially is a complex and wide range of skills for an unregistered worker and will need some careful differentiation of skill progression development. It should be noted that the Reablement worker takes time to develop to a level of competence that can be signed off in confidence by the registered practitioner. There needs to be some debate around the skills and competencies required within this work force and how they can be built from entry level to ‘higher level’.

This programme needs to be managed with the full engagement of staff and their Trade Union or other representatives. Key to this will be to ensure that there is:

- Regular programmed meetings with Staff Side
- Consultation meetings about the service model at key stages of development
- Consultation with staff who may be affected by change in line with agreed models of service change.

All though each service has their own Management of Change policies and procedures it is complicated where the change may affect staff from different sectors and therefore differing policies. It is proposed that this matter is taken forward with the Trade Unions to agree a best practice model that supports all sector requirements where possible.

Consultation with service users.
Some discussion needs to take place regarding the requirement from WAG to consult on service changes with affected organisations and users over a three month period.
Workforce Risks

<table>
<thead>
<tr>
<th>Risk</th>
<th>High</th>
<th>Medium</th>
<th>Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unable to recruitment staff numbers required</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Service Cost too high</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of staff engagement</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Not meeting phase 1 deadline</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unable to agree change process</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Training costs too high</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Challenge to variations in terms and conditions</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Locality Planning

To date the Locality Planning Workstream has focused on:

- its contribution to the modelling work detailed in Chapter 4;
- highlighting and debating the immediate issues in relation to the implementation of the new service model; and
- exploring how the Outcomes-Based Approach (described in Chapter 8) can be utilised for local planning.

As we move into the ‘Preparation for Implementation Phase’ of the Programme, locality planning will be the main focus of activity, supported by the outputs of the other workstreams.

It is proposed that, subject to approval of this Strategic Outline Case, from January 2010 onwards Locality Frailty Implementation Groups (FIGs) will be formed that will be responsible for operationalising the proposed model.

It is likely that these will be drawn from existing locality groups e.g. Intermediate Care, Older People’s Strategy, Health. Social Care and Wellbeing etc and therefore will be ideally placed to locate the implementation of Phase 1 of the Frailty Programme within the wider community context.

Terms of Reference have been agreed for the FIGs (attached as an Appendix in the main body of the report) and they will be supported by the Locality Planning Workstream lead and the Programme Manager.

Effective knowledge management will be key to ensuring that the advantages of the locality approach are harnessed whilst not losing the consistency and standardisation of the pan-Gwent approach.
The current Locality Planning Workstream will therefore act as a regional Community of Practice, providing the opportunity for:
- sharing innovation;
- joint problem solving;
- working through operational challenges;
- accessing necessary expertise and
- escalating to the Frailty Programme Board where required.

The other workstreams will continue to provide support with a pan-Gwent approach and tangible products, and will be asked to respond to requests from the Locality Planning Workstream.

**Evaluation and Performance Management**

The Gwent Frailty Programme has committed to the adoption of the Outcomes-Based Approach (OBA) to planning and performance management.

Described as a disciplined way of thinking that supports Programmes seeking to ‘get from talk to action’, this approach will ensure that we do not get side-tracked from our ultimate desired outcome.

The outcomes measures were developed around the overarching desired outcome that frail people in Gwent will be ‘happily independent’ and from the experiences highlighted in the local engagement events with older people.

Taking the OBA and working back from these experiences, the workstream has identified a set of outcomes indicators and performance measures for each of the five user experiences highlighted above. These will be developed into a draft Performance Management Framework for further consultation.

Whilst the Programme is delighted to have the opportunity to take such an innovative approach, in reality health and social care providers within the Region will still need to satisfy existing performance management requirements and targets.

Working across geographical, sectoral and professional boundaries, the Programme will need to find a way of satisfying all those demands without imposing a serious bureaucratic burden on the people who’s priority needs to be ‘doing the job’.

The workstream has undertaken an exercise to match across NHS performance targets and Local Authority Key Performance Indicators in order explore how these could be streamlined together.

A similar matching exercise has been undertaken with the outcome measures developed by the workstream, and again there is some overlap and potential for streamlining.
From a qualitative perspective the workstream is examining existing audit tools e.g. to measure compliance with ‘Fundamentals of Care’, that might further inform the evaluation process.

Knowledge Management

It is acknowledged that collecting performance information can become an end in itself and will fail to help us achieve what we want unless the partner agencies act as a single virtual learning organisation. It is proposed that this will be achieved through a series of managed networks and/or Community of Practice methodology (feeding into the national fora).

The Workstream will develop a detailed proposal, in conjunction with the Workforce Planning & Development workstream by the end of January 2010.

Programme Structure & Key Milestones

So far the Programme has:

- Agreed and articulated the Vision
- Made significant progress in completing the groundwork.

The seven Implementation Workstreams have delivered some agreed outputs as described in Chapter 5, and have clear plans to ensure that the pan Gwent standards/support mechanisms are in place before the end of March 2010.

From November 2009 to end of March 2010 there will intensive activity at locality level representing Preparation for Implementation, before we enter the Locality Roll-Out Phase from April 2010.

The Programme Structure will need to be amended to:
- reflect progress;
- support the detailed planning required at locality level;
- address pan Gwent operational issues.

The proposed structure is detailed below.
Gwent Frailty Programme: DRAFT Structure for Phase 3 – Preparation for Implementation

**Reporting & Decision Making**

- Strategic Vision Group: Quality Assurance Function
- Workstream Leads Group: Pull together workstream activity

**Pan Gwent Planning & Support**

- Communications & Stakeholder Engagement
  - User Engagement sub group
- Workforce Planning & Development
- Governance & Structures
  - Operational Issues
  - Managerial & Professional Accountability
  - Clinical Accountability
- Outcomes, Performance & Continuous Improvement
- Information Sharing & Single Point of Access
- Financial Modelling/Building the Business Case

**Local Implementation**

- Locality Planning Community of Practice
  - Blaenau Gwent FIG
  - Caerphilly FIG
  - Newport FIG
  - Monmouthshire FIG
  - Torfaen FIG

**Frailty Programme Manager:** overseeing, co-ordinating & communicating

**Co-ordinated Knowledge Management Framework:** Lessons Learnt & Organisational Memory
<table>
<thead>
<tr>
<th>Year</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 2009</td>
<td>Strategic Vision Document Agreed</td>
</tr>
<tr>
<td>Oct 2009</td>
<td>Implementation Workstreams established and functioning</td>
</tr>
<tr>
<td>Nov 2009</td>
<td>Strategic Outline Case Agreed</td>
</tr>
<tr>
<td>Jan 2010</td>
<td>Locality Frailty Programme Teams established and functioning</td>
</tr>
<tr>
<td>Feb 2010</td>
<td>Knowledge Management Framework established</td>
</tr>
<tr>
<td>March 2010</td>
<td>Detailed locality action plans agreed and implemented</td>
</tr>
<tr>
<td>April 2010</td>
<td>Pan Gwent Workstream outputs delivered</td>
</tr>
<tr>
<td>March 2011</td>
<td>Single Point of Access tested and ready for use</td>
</tr>
<tr>
<td></td>
<td>Roll out commenced</td>
</tr>
<tr>
<td></td>
<td>Phase 1 delivered</td>
</tr>
</tbody>
</table>
‘HAPPLY INDEPENDENT’

Strategic Outline Case for the Gwent Frailty Programme

(Full Version)
The Strategic Outline Case takes ONE part of the overall Programme as a staged approach to implementation of the whole system change.

The Programme considers the whole system to be embodied by the PERSON who will use services or assistance. They are the centre, focus and reason for the work. They have a life with its own story and context. How well the parts of that life work together will effect the individual’s outcomes. We need to focus on that interdependence and not separate out different medical, social, environmental responses.

The present system within health, social care and partner agencies across the public, private and voluntary sector has grown in complexity. It is increasingly process driven through:

- Organisations
- Specialisms
- Professions
- Initiatives

The separate parts then spend considerable amounts of energy and resources in trying to connect up in order to assist the individual who needs the help.

The Frailty Programme aims to SWITCH the focus and simplify the processes so that agencies work together and locate services to people in their homes and work with them to preserve independence and dignity.

We know that the resource envelope will be under increased pressure as the ageing demographic rise continues and the public purse contracts. Consequently the Programme aims to:

- **Re shape what happens in primary and community care within locality settings.**
- **Rebalance health and social care away from a secondary setting into peoples’ homes and their communities.**

We need to use the total resource envelope to provide for INTEGRATED SERVICE DELIVERY which is multi professional and multiorganisational and is based on a LOCALITY TEAM approach. The Programme includes:

- Prevention initiatives
- Crisis Responses
- Reablement
- Longer Term or programme of care across the acute and primary / community sector
All of which need to align and work as part of the integrated approach that focuses on the individual. For that person or their carer they should expect:-

- One point of contact
- One contact person
- 24/7 availability and timely responses
- Preservation of independence

To achieve the necessary change, we need to adopt a realistic and staged approach to implementation. This SOC is concentrating on Phase 1 which covers the elements of Crisis Response and Reablement as the initial stage.

However, to achieve the system change as outlined, it is essential that these elements do not become another “specialist approach” which add to the complexity and consequently does not achieve effective use of the shared resource.

The next phase needs to include the total community resource which will include amongst others:-

- District Nursing
- Continuing Health Care
- Chronic Conditions Management
- Palliative Care
- Longer term Social Care
- Local authority, housing and voluntary organisation activities that provide both the setting and the prevention potential that maintains independence
- Continued involvement of Primary Care (as exemplified by Dr Chris Jones’ work)

The model is based on realignments and resource flows from secondary into community / locality as well as realignment within the community setting. As the locality approach increases its capacity and reach, there will be staged reductions in the usage of those hospital facilities that are better located within a primary / community setting.

The specific timing, project management and development of the change management and business cases of these next phases require scoping as the next part of the implementation programme but it is essential to locate this SOC within the Strategic Context. It is part of the whole and not an end in itself.

Moyna Wilkinson: Director of Social Services, Monmouthshire
Professor Pradeep Khanna: Chief of Staff, Aneurin Bevan Health Board
David Murray: Chief Executive, Age Concern, Gwent
Strategic Outline Case for Phase 1
Of the
Gwent Frailty Programme

Introduction and Context

‘Developing the Bigger Picture’

This Strategic Outline Case focuses on Phase 1 of the Gwent Frailty Programme; that is the development of Community Resource Teams that will provide consistent and equitable outcomes for service users across the five Gwent Boroughs.

The achievement of Phase 1 by the end of March 2011 will:

- End the current postcode lottery and provide equitable access to intermediate care-type services across the Borough;
- Demonstrably improve outcomes for service users and their carers;
- Provide quick wins in relation easing the demand on secondary care and reliance on longer-term care facilities;
- Evidence that the Gwent health and social care community can work together to a common vision, crossing geographical, sectoral and professional boundaries.

The Programme Board recognises the risk however, that Phase 1 will be viewed as the end product, when it is in fact the first step towards a much bolder and innovative vision of the future.

Indeed, if we were to stop at the end of Phase 1 we run the real risk of simply adding another tier of speciality and further fragmenting an already over-complicated system.

Throughout this document we refer to the importance of viewing Phase 1 as a building block towards the wider integrated locality approach which is described in detail in ‘Happily Independent: the Strategic Vision Document for the Gwent Frailty Programme’ and summarised here in Chapter 2.

Turning that ‘big picture’ vision into reality will require sustained commitment from the highest levels of each partner organisation all the way through to our frontline staff.

Only by working consistently together, with the passion for public service that we know exists in Gwent, can we certain that people are properly supported to be *happily independent.*
This Strategic Outline Case (SOC) is the culmination of work commenced in October 2007, when Chief Executives from across the local health and social care community established a joint working party to focus on what these organisations could do collectively to improve the quality and sustainability of care for people in Gwent.

At the time it was decided to focus activity on frail older people but as a result of discussions and workshops in the intervening years this has evolved and the Programme now seeks to address the needs of any adult who meets the frailty criteria described below.

The work was initiated under the auspices of the Clinical Futures Programme: Community Based Services and this SOC draws extensively on information gathered by that project as well as more recent workshops and data analysis. It also seeks to address the recommendations made by Dr Christopher Jones in his paper “Gwent Clinical Futures: Pulling it all together”.

Gwent Geography

The Gwent Region covers an extensive area of South East Wales, and from the perspective of the provision of health and social care, interfaces with Gloucestershire, Cardiff, Rhondda Cynon Taff, Merthyr and Powys.

The Brecon Beacons form a boundary to the north, the Rhymney Valley to the west and the Wye Valley to the east. The City of Newport is located at the mouth of the river Usk in the south.

The geography of the county boroughs is diverse, for example, Newport is an urbanised area with a relatively small catchment area in stark contrast with Monmouth and south Powys which has a much smaller population dispersed over a large rural area in villages and small towns.

The Gwent Frailty Programme recognises that in order to succeed it must respond to local diversity whilst providing common service standards and avoiding the current ‘postcode lottery’.
Gwent Demographics

The most recent Census of 2001 reports that a total of 552,148 people live in the former “Gwent” area amounting to approximately 19% of the total population of Wales. Interim population projections for Wales [Source WAG, “Wales in Figures” 2001] indicate that the population of Gwent will increase by 44,000 only by 2011.

The overall population has remained stable over the past decade increasing by just 0.5% since the Census of 1991. Small increases in Newport and Monmouthshire are balanced by similar decreases in Blaenau Gwent and Caerphilly.

One of the important trends identified over the next ten years is the relative increase of the population aged over 45, compared to a reduction in the population in the under 45 group. The Director of Public Health for the former Gwent Health Authority (Annual Report 2002) noted that this factor coupled with the effects of falling birth and death rates will result in an increasing dependency ratio.

The needs of minority ethnic communities must also be addressed particularly in the urban communities in the south of the area.

The valleys also experience high levels of social deprivation including low incomes, poor housing stock and high unemployment. For example, the percentage of households with gross annual income less than £10,000 in Caerphilly county borough ranged from 21.7% to 43.4% at “ward” level; unemployment in Caerphilly and Blaenau Gwent was 8% in 2001/02 compared to an all Wales level of 6% and 34.7% of households in Blaenau Gwent have a gross annual income of less than £10,000.
It is predicted that although the total population of Gwent will remain stable over the next ten years, this will include an increasing population of older people and a generally higher dependency ratio leading to further increases in demand and pressures for change in the way services are delivered.

The Health Statistics Wales 2006 reports demonstrate that the Unitary Authorities in Gwent have some of the highest numbers of people reporting limiting long-term illness. Blaenau Gwent, Torfaen and Caerphilly all score in the top twenty and those indicating their health is “not good”, ranks them in the top ten districts. The level of permanent sickness and disability in the economically inactive population in Wales is higher than any English region and some of the worst scores are in Blaenau Gwent ranked third and Caerphilly seventh. Torfaen is also in the top twenty.

‘Frail’ Population in Gwent

The Programme is clear that it aims to support and promote independence for any adult who is experiencing frailty.

It is therefore adapting the concept of frailty, which is traditionally viewed as a syndrome affecting older people. It can be seen however, that the features described below can apply to a much broader group, including many people with chronic conditions for example.

Dependency

☑ Chronic limitations on Activities for Daily Living (ADLs)
☑ With one or more functional, cognitive or social impairments

Vulnerability

☑ Running on empty
☑ An overall loss of physiological reserves
☑ Loss of functional stability

Disease State

☑ People with chronic condition
☑ Presence of social and physical co-morbidities

That said, it is highly likely that the majority of people requiring support will be over 65, and as a result it is the data available on older people that has informed the calculations below.
It is reiterated however, that the Programme will not exclude anyone on the basis of age.

The prevalence of frailty in a community setting is outlined in the graph below. Using these criteria there are approximately 20,000 people who could be described as frail older people across the health community.

The graph below uses these criteria to illustrate the numbers of people who could be described frail older people by Unitary Authority of residence and age band.
The Current System of Service Delivery

The Human Perspective:
From November 2008 David Murray, Chief Executive of Age Concern Gwent, led a workstream on behalf of the Frailty Programme which sought the experiences of older people in Gwent.

The evidence gathered indicated that the way we currently provide health and social care support:
- Is complex, fragmented and extremely difficult to navigate;
- Pushes people by default towards hospital admission or long-term institutional care;
- Fails to address the person as a whole, within the context of their lives and communities;
- Fails to address the needs of informal carers.

These findings are of course consistent with national studies and reports.

The positive stories provided highlighted that the keys to success are:
- Seeing the individual as a whole human being and as a result treating them with due dignity, respect and understanding;
- One person taking the responsibility to co-ordinate a timely and appropriate response;
- Joined up responses from primary, secondary, social and voluntary care agencies;
- Effective communication with the individual, their carers and between professionals/agencies.

The Service Perspective:
The Wales Audit Office Report (2007) ‘Tackling Delayed Transfers of Care across the whole system – Gwent health and social care community’ highlighted that the existing system could be managed more effectively to promote independence for vulnerable people. In particular, it detailed the need for integrated steps across the whole community to develop an effective whole system according to a clear and shared vision of what services should look like (Para 2.48)

We know that people who are frail and have more complex needs are those most likely to have frequent attendances at A&E, are more likely to be admitted to hospital and once there often become ‘stuck in the system’.

For example Bed Census exercises undertaken in 2008/9 in Torfaen, Caerphilly and Newport indicate that approximately 50% of people in Community Hospital Beds need not have been there had sufficient community based services been available.
**Drivers for Change**

There is a clear strategic direction emanating from the Welsh Assembly Government that aims to provide more efficient, effective and integrated services closer to people’s homes.

Across Gwent all partners, including patients and the public, aspire to a more primary and community service led NHS, as detailed in the Clinical Futures Programme.

Gwent is recognised as having already developed pockets of excellence in the delivery of Primary and Community Services in Wales. It is also recognised that Gwent has not yet delivered significant shifts in the overall model of care that continues to rely heavily on acute hospital beds and care home beds within social care.

The National Advisory Board through the Primary and Community Service Strategic Delivery Programme has recognised pockets of excellence which have delivered significant benefit to patients who access them but in the absence of a single vision and clear strategic framework for Primary and Community Services have added complexity to the current model of care and inadvertently inequalities as they are not uniformly spread across all communities who could benefit from them.

The Gwent Frailty Programme has been developed in response to the fact that the way we currently deliver services is not sustainable and does not deliver the experience we believe our people should expect.

The vision is unique but has been developed using the evidence base from the UK (e.g. Croydon, Salford, North Devon and Torbay) and further afield (NB Canada, USA, Australia and Scandinavia).

It is anticipated that implementation will lead to:

- More people remaining independent in their communities for longer;
- Individuals receiving timely, responsive and proportionate services that avert crisis and promote independence;
- Individuals and their informal carers feeling that they are listened to by the people providing support and that they are ‘worked with’ rather than ‘done to’;
- A proactive rather than reactive individual care pathway.

The impact will be manifested as:

- Reduced numbers of acute hospital admissions NB ‘revolving door syndrome’;
- Shorter lengths of stay;
- Reduced delayed transfers of care;
- Improved flow through secondary care;
- Reduced hospital acquired infections and associated costs;
 Reduced duplication and improved efficiency;
 Improved access to community based services, 24 hours, seven days a week;
 More people being helped to live at home;
 Reduced demand for large, complex care packages as a result of the enabling approach;
 Improved outcomes for individuals and communities;
 Greater user and carer satisfaction as we meet people’s aspirations;
 More effective use of public money utilised as a joint health and social care resource;
 In the longer-term reduced demand for Continuing NHS Healthcare as people’s health and well-being is maintained for longer.
Chapter 2: The Gwent Frailty Programme

'Where we want to be'

The Vision

Our Principles & Values

The underpinning principle of the Gwent Frailty Programme is to provide:

‘Help when you need it to keep you independent’

The mantra for those delivering services is to provide help that is

Sustaining independence.

- We start with a view that the present system is untenable and that we are not treating people as well as we could or in a way that best uses the available resources and skills.

- We believe that people are made more helpless and lose the vital ingredients of confidence and control by present processes that lead to hospitalisation.

- We believe that people want to and can stay longer and more successfully in their own home environment provided that is of an acceptable standard, e.g. is warm and safe and accesses technology such as Telecare.

- We believe that people should not be in institutional care unless absolutely necessary.

- We firmly believe that people have to be seen as individuals with a life, a history, a future. Consequently, at a time when they can be most fearful then it is more important to respect and listen to what they want and need and provide simple, clear communication ideally through one allocated coordinator.

- We believe that people are the experts in their own life and that we need to tap into that expertise.

- We know that we can do a better job if we work together and that we need each others professional perspectives.
We uphold the necessity of real multi agency work where each profession keeps its own distinctive colour and by sharing our expertise we deliver the sort of service that people deserve.

We see the need for locality work that is integrated at the health and social care delivery end and is based on:

The Person at the centre
  Shared values
  Joint ownership
  Joint outcomes

We consider that the integrity of separate organisations within health and social care can add to the dynamism and productivity of the model.

We believe that a range of community activities and services are key to ensuring that people are supported in maintaining and returning to independent living.

Outcomes

The Frailty Programme will implement the Outcomes Based Approach (see Chapters 5 & 6), which is predicated on understanding the experience of the people who we seek to serve.

Engagement events asked older people in Gwent what being ‘happily independent’ meant to them.

The full report ‘Towards Independence for Older People in Gwent: Key Findings from the 2009 Older Peoples Experience Workshops’, is available from:

David Murray: d.murray@ageconcerngwent.org

Or Lynda Chandler (Gwent Frailty Programme Manager): lynda.chandler@torfaen.gov.uk
The people consulted stated that if they are happily independent they will:

1. Be able to remain living in their own home with support
2. Receive services in their home
3. Be listened to by people who are responsible for providing services to assist them
4. Have their health and social care problems solved quickly and considered as a whole rather than individually.

- Be safe and secure
- Live in good quality homes
- Be able to cook, wash, clean and go out
- Be able to maintain their standards
- Be financially stable to make independent choices
- Be receiving the benefits available to enable them to live independently
- Not be lonely
- Have a supportive family
- Have good friends and neighbours keeping an eye out for them
- Have company
- Be going out to social activities
- Have planned for old age
- Be accessing peer support
- Be able to keep a pet if they so wish

The shaded box represents the specific deliverables of Phase 1 of the Gwent Frailty Programme and thus its priority focus of activity up to March 2011. This must however, sit within the context of existing and developing work within local authority areas promoting independence in its wider context.

In other words, the full impact of the Programme will only be achieved if Phase 1 is viewed as the first step to the wider vision of the integrated locality approach described in the introduction to this Strategic Outline Case and in the diagram and Table below.
Localities: Frailty Programme in Context

The overarching responses required by each Borough to address the desired outcomes are described in the diagram above and detailed more fully in the table below.
<table>
<thead>
<tr>
<th>Level of Need</th>
<th>Example Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Care</td>
<td>Alternative to admission to hospital, e.g. Urgent Comprehensive Assessment and management in the community, or if clinically necessary admission to hospital</td>
</tr>
<tr>
<td>Intensive Packages</td>
<td>High level complex needs requiring co-ordinated interventions</td>
</tr>
<tr>
<td>Identified needs warranting integrated approach</td>
<td>Intermediate Care as described in proposed service models</td>
</tr>
<tr>
<td>Some identified health/social care needs</td>
<td>Carer assessment and support Overview assessment Telecare Information Care co-ordination and a clear contact person</td>
</tr>
<tr>
<td>Preventative Services</td>
<td>Housing Benefits &amp; financial advice Transport Personal safety Activities Interests Sociability Screening Community Needs Shopping assistance Home Safety Checklist Occasional contact with primary care Keeping healthy at home</td>
</tr>
<tr>
<td>Community Context</td>
<td>Area/neighbourhood focus Relationships Universal service Information Available on what’s happening locally Cultural/leisure/sporting/church, activities etc Involvement Wellbeing</td>
</tr>
</tbody>
</table>

Priority Activities for Gwent Frailty Programme (Phase 1)

Parallel Activities to be Identified in Assessment
Frailty Programme Layers of Activity

In order to support the delivery of those responses, the Frailty Programme will undertake the following activity. They are described as layers rather than Programme Phases as they will be commenced in parallel, though some will take longer than others (NB cultural change) to be demonstrably achieved.

| Integrated Community Resource Teams in each Borough to bounce people away from crisis and the dependency spiral, back to a place where they can be supported to be ‘happily independent’. |
| Seven Implementation Workstreams to support effective implementation of the above |
| Training, Development and Cultural Change Management Programmes with the staff both in the Community Resource Teams and in the wider health and social care community to promote the ethos of sustaining independence |
| Work with Local Service Boards to ensure that other supporting services for sustaining independence are provided e.g. access to adequate housing, benefits, community safety etc. |
| Influencing and aligning with developments in the wider Community Based Services, to ensure that the Frailty Programme is a catalyst for change and not simply a ‘bolt on’ set of services. |

Focus of this Strategic Outline Case

The top two blue layers of the Programme form the focus of this Strategic Outline Case. That is, the development of integrated locality-based Community Resource Teams that prevent people from entering the dependency spiral as a result of a health and social care event or crisis.

It is recognised that all Boroughs currently have some form of intermediate care service, but there is not equitable provision for every Gwent resident and some Boroughs are closer to the proposed model than others. The emphasis of the Programme is how we can work differently, with shared values and determination to deliver common outcomes for all our service users.

Note: at this stage of the Frailty Programme we are interpreting ‘locality’ as equating to the current Local Authority Boundaries. We are mindful however, that implementation of the Programme takes place at a time of major reconfiguration of the NHS in Wales and the development of the work by Dr Chris Jones’ Primary and Community Services Implementation Plan.

The six months between the production of this Strategic Outline Case and the development of the detailed business cases at Borough level will provide the opportunity to ensure that all these models are fully aligned.
The locality based integrated intermediate care teams which we will now refer to as Community Resource Teams, will build upon the good practice which already exists within the Gwent health and social care community. They represent the most immediate and tangible outputs of the Frailty Programme, in that having a consistent standard of service and outcomes across the Gwent region is anticipated to produce relatively quick wins in terms of:

- Providing an holistic approach to user and carer needs;
- Improved co-ordination of quality health and social care services;
- Improved outcomes in terms of people’s health and wellbeing;
- Decreased numbers of unnecessary admissions to hospital;
- Shorter lengths of stay for those who do require admission;
- More people receiving appropriate and proportionate support in the community;
- Less reliance on long-term care (e.g. in care homes);
- The ability to ensure that what works well can be spread across the Region;
- More effective use of resource.

This does not however, mean that the other layers are deemed to be less important. The Frailty Programme will not have the impact that it seeks unless those layers are undertaken in parallel.

To reinforce the ethos described in the Opening Statement, in order to avoid the Community Resource Teams becoming merely another specialist ‘bolt on’ service, a longer-term whole systems approach must be achieved.

In many cases the activity is likely to be cost neutral through:

- influencing, adapting and utilising existing training schedules and mentoring systems;
- better co-ordination of existing core service provision;
- collaborative strategic decision making and leadership.

The Programme recognises the need to employ systems thinking and to be mindful that there will inevitably be a ‘knock on’ effect on other service provision, e.g. core social care services provided by the statutory and voluntary sector, demand for alternative accommodation such as extra care supported housing, home safety checks etc). This reinforces the importance of the locality approach and the need to view service provision in the context of people’s lives and communities. The resource implications of this will need be examined in more detail at locality level, and in the light of the closely monitored learning achieved through implementation of the proposed care service model.

Chapter 4 provides a broad view of the current resource envelop that could support implementation of the Programme, makes some high level calculations regarding predicted demand and sets out how far from the proposed model each Borough is at the present time.

Before that, Chapter 3 describes the service model for the integrated Community Resource Teams in detail.
As described previously, the integrated Community Resource Teams are designed to intervene to support an individual to:

- avert pending health or social crisis wherever possible;
- operate a ‘pull system’ to support through the crisis and restore/maintain independence;
- provide a smooth transition with core services or longer-term care where required.

Services will be available to people in their own place of residence, including those who live in care homes.

As emphasised previously, the services provided by the Community Resource Teams will only achieve the desired impact within the context of the wider vision of an integrated locality approach.

The concept of catching people before they hit the downward dependency spiral and working with them and their informal carers to ‘bounce back’ into the degree of independence with which they are happy (hence the phrase ‘happily independent’) is illustrated in the diagram below.

Whilst intervention at the point of crisis will achieve the ‘quick wins’ described in Chapter 2, it can be argued that the greater but more challenging impact will be achieved by pulling those who are currently dependent (in the blue circle) back towards independence (the green circle) and providing longer-term maintenance support to the user and their informal carers.

Hence the repeated assertion in this document that the development of the Community Resource Teams represents Phase 1 of the Gwent Frailty Programme.

The Community Resource Teams will operate as co-located ‘teams without walls’, reporting to one manager and providing:

- Urgent Comprehensive (health and social care) Needs Assessment
- Rapid Response to health and social care needs
- Emergency care at home
- Reablement.

If you are accessing the Community Resource Team you should expect:

- Access via a single point of contact
- 24/7 availability, 365 days a year
- Comprehensive assessment and review of your needs
- A named care co-ordinator
- A tailored package of care that responds to your health and social care needs quickly and as a whole
- An 80:20 generalist/specialist approach to service delivery
They will incorporate existing intermediate care type services and falls services where they exist.

They will work closely with Welsh Ambulance Service Trust (WAST) Specialist Practitioners with the WAST pilot studies for alternative Falls Pathways.

They will interface (during Phase 1) closely with Chronic Conditions Management Teams, Older People’s Mental Health Teams/ Community Mental Health Services, specialist Palliative Care Teams.

Successful alignment with the District Nursing Service and GP practices will be a critical success factor for the Programme, and will need to be explored further in preparation for the local detailed business cases.

**Community Resource Team Manager**

Community Resource Team providing:
- Urgent Comprehensive Needs Assessment
- Rapid Response to health & social care need
- Emergency Care at Home
- Reablement

Flexible health and social care ‘Support & Wellbeing’ workers. Potential to work across teams & move through the system with the individual to provide continuity

Following urgent comprehensive assessment the allocated Care Coordinator will be able to ‘pick and mix’ from the available services (including local voluntary sector support, telecare and housing) to provide a prompt and proportionate response to individual need.
## Common Service Standards

<table>
<thead>
<tr>
<th></th>
<th>Urgent Assessment &amp; Rapid Response Intervention element</th>
<th>Reablement &amp; Independent Living element</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ACCESS</strong></td>
<td>Via locality Single Point of Access</td>
<td>Via locality Single Point of Access</td>
</tr>
<tr>
<td><strong>HOURS OF OPERATION</strong></td>
<td>7 days a week 365 days a year 8am to 10pm</td>
<td>7 days a week 365 days a year 8am to 10pm</td>
</tr>
<tr>
<td><strong>RESPONSE TIME</strong></td>
<td>2-4 hours (for both health and social care components)</td>
<td>To be confirmed</td>
</tr>
<tr>
<td><strong>ASSESSMENT</strong></td>
<td>Comprehensive Needs Assessment</td>
<td>Agreed shared assessment document</td>
</tr>
<tr>
<td><strong>SERVICE PROVISION</strong></td>
<td><strong>Urgent Assessment</strong> Within 2-4 hours Management/ Hospital @ Home  Up to 14 days in response to assessed need and to include:  - Rapid Response Intervention for health need  - Emergency Home Care package for social care need and carer support  No charge to user</td>
<td><strong>Up to 6 weeks rehabilitation and reablement support from a range of therapists, social care and nursing staff.</strong>  Ongoing review to ensure the individual is getting what they need. Reablement can be for less or more than 6 weeks.  No charge to user for first 6 weeks</td>
</tr>
<tr>
<td><strong>ACCESS TO</strong></td>
<td>‘Hot Clinics’ for rapid access to specialist and diagnostic support (Monday to Friday)  Acute specialists e.g. Mental Health; Palliative Care Falls Pathway  Therapists  Rapid access to equipment and minor adaptations.</td>
<td>Specialists including psychology, dietetics, pharmacy, speech &amp; language therapy, podiatry, EMI teams.  Rapid access to equipment and minor adaptations.</td>
</tr>
</tbody>
</table>
Specific Service Standards

The Urgent Assessment and Rapid Response elements of the Community Resource Teams are described as:

“a service providing an emergency response at home, or in an emergency assessment unit setting, for people identified as frail, who are experiencing a crisis in their health, functional ability, social or environmental well-being.”

Everyone referred to the service will receive a comprehensive needs assessment within 2 to 4 hours, in their own home by the Community Resource Team. This comprehensive needs assessment will include:

1. Physical assessment;
2. Assessment of functioning (e.g. activities of daily living, gait and balance);
3. Psychological assessment;
4. Social assessment (social care support needs required to maintain the person in their own home); and
5. Environmental assessment (e.g. home safety, equipment and general housing conditions).

Such assessment addresses the desire voiced by frail people to be viewed ‘as a whole’ and has been shown to:

a) Be a critically important determinant of successful rehabilitation;
b) Reduce readmission to hospital;
c) Improve survival rate; and
d) Improve physical and cognitive functioning.

The Registered Nurses in the team will be skilled in advanced assessment.

Having identified the person’s individual needs through the comprehensive assessment, the team will provide the multidisciplinary intervention for up to 14 days required to support them through their health crisis.

Social care support e.g. help with personal care, cleaning and food preparation can also be provided throughout the period of intervention.

There will be onward referral if further support is needed, as illustrated in the case study below:
Mrs Jones, a 45 year old lady with Multiple Sclerosis, develops urinary symptoms. Her GP visits and treats Mrs Jones for a urinary tract infection. 24 hours later however she is still not coping and is 'off her feet'. The GP refers her, via the Single Point of Access, to the Community Resource Team for urgent assessment and intervention.

They visit within the hour and assess her thoroughly. They exclude other potential diagnoses and assess that Mrs Jones needs support to help her recover. The team’s nurse acts as care co-ordinator and arranges for social care and occupational therapy to help Mrs Jones get back to independence as quickly as possible. A Care & Wellbeing Worker visits 3 times a day to help Mrs Jones with her daily living needs.

After a week, the infection is resolved, but Mrs Jones is still unsteady and lacking in confidence. The Reablement element of the Community Resource Team provides further support. A discharge letter summarising Mrs Jones’ outcomes is sent to her GP.

Not all of the people referred to the team will require healthcare intervention.

We know that when someone’s ability to remain independent is finely balanced, it is often a change in social circumstances, such as bereavement, illness hitting their informal carers or problems with their housing that can tip them into crisis.

As part of the ‘pick and mix approach’ the team will provide up to eight days urgent social care support to support people through such difficult times as illustrated in the example below:

Mrs Jones is 70 years old and is bed ridden. She is cared for by her husband who is normally a physically fit 75 year old.

Mr Jones develops chest pain and is rushed to hospital by ambulance leaving Mrs Jones alone. The ambulance crew recognise her vulnerability and refer to the Community Resource Team via the Single Point of Access.

The social worker from the team responds within two hours, assesses Mrs Jones and sets up an Emergency Care at Home package. She assumes the role of Care Co-ordinator and communicates with other family members, the GP and the hospital. She provides much needed reassurance for Mr Jones (thereby aiding his recovery) and ensures that hospital discharge arrangements take into account Mr Jones’s needs as a carer.
The proposed model is based on a partnership approach that views the individual as a whole rather than ‘bits of need that require services’.

It is proposed that this element of the Community Resource Team will require the following skill mix:

- Administrative support
- A team of Care & Wellbeing Workers
- Registered General Nurses
- Registered Mental Nurses
- Social Workers
- Pharmacist
- Specialty Doctors/General Practitioners
- Consultant Physician

The independent living and reablement element of the of the Community Resource Teams aims to support people to get back to and retain their independence as soon as possible; be that at their previous level or adjusted to respond to new circumstances.

It will provide a person centred, co-ordinated response, delivered at the right level and in partnership with the individual so that they do not feel overwhelmed or that their life has been taken over.

For the purpose of the proposed model, ‘rehabilitation’ is viewed as a specific process, sometimes specialist, which can be part of an approach that is geared towards ‘reablement’, with reablement conveying more of the outcomes to be achieved which will / can involve a number of different processes including:

- Confidence building.
- Consideration of other independence factors such as housing, emotional well being.

In other words, reablement corresponds more to an outcome than a process.

Key components of the proposed service model include:

- Up to 6 weeks but coordinated reviewing and ongoing reablement elements to sustain independence – i.e. based on need can be a few days or could be longer than 6 weeks
- Rapid access to equipment and minor adaptations
- The ability of Care & Wellbeing Workers to interchange between rapid access and longer term approaches
- Reviewing is frequent to ensure right level of care is given
■ Excellent communication to individual, family, primary care, other professions

It is proposed that this element of the Community Resource Team will require the following skill mix:

Occupational Therapists
Physiotherapists
Reablement Nurses
Social Workers
Reablement Assistants
Senior Reablement Assistants

These will not necessarily be new staff; the Programme will bring together and augment existing services in order to achieve maximum impact.

Although the functions of Urgent Response and Intervention and Reablement have been described separately for purposes of clarity in this Chapter, they will in fact be operating as a single integrated team.

The Mary Williams Case scenario can be accessed on the website http://www.gwentfrailty.torfaen.gov.uk and offers another detailed case study illustrating how an individual and their family can expect to benefit from the alternative Frailty Pathway.

As described throughout this SOC, whilst we have made some very high level calculations on the size of these teams in Chapter 4, they are only intended to give a broad brush view and will need to be worked up in detail over the next six months at Borough/locality level in order to respond most effectively to local need.
Chapter Four

Modelling & Resourcing the Proposed Integrated Community Resource Teams
‘What needs to change?’

Current service provision

The Frailty Programme recognises that each Borough has already worked hard to develop at least some intermediate care provision and that this needs to be considered within the resource envelop for the proposed Community Resource Teams.

After considerable debate and analysis of the Mary Williams Case Scenario and Pathway, the Frailty Programme Board agreed that the following should be considered as existing service provision that can support the model:

- Urgent assessment teams such as the Acute Comprehensive Assessment Team (ACAT) in Torfaen;
- Rapid Response Teams (healthcare)
- Emergency Care at Home Schemes (social care)
- Voluntary sector
  - hospital discharge support teams
  - carer support that focuses on facilitating early discharge/preventing unnecessary hospital admission
  - care & repair type functions that support as above
- Reablement teams (including those operating the ‘Intake Model’ *)
- Falls teams

* Note: In calculating the current resource, it has been difficult to disaggregate the proportion of the reablement component of the intake model that would contribute to the provision of Community Resource Team service. This will be resolved at detailed business case stage by for example, using the SSIA Reablement Tool.

An initial mapping exercise was undertaken by drawing on existing data collated for the Clinical Futures Community Based Services project and early workshops held on behalf of the Frailty Programme.

This was triangulated against data held in the various organisations on workforce and finance and perhaps unsurprisingly this did not match.

The Gwent Frailty Programme Manager with the Finance, Workforce and Locality Planning Workstream Leads therefore worked with operational health and social care managers in each Borough to agree and update the information gathered.
The document attached as **Appendix 1** represents the ‘best estimate’ of where we are at this moment in time, with the proviso that it is in the nature of our work that this is constantly changing and will require frequent review.

The document clearly demonstrates the variation in current intermediate care service provision across Gwent.

Caution needs to be exercised in assuming that where services exist the teams are sized to meet local demand. Team managers in almost all the areas inform us that they often struggle to respond to referrals. For example between May and August 2009, there were 25 recorded delays (261 bed days) in discharge from hospital for Caerphilly residents awaiting reablement.

The inability to respond promptly leads to individuals being absorbed into the system (e.g. transferred to Community Hospitals or Care Homes) and decreases the confidence of those referring to the service in relation to its reliability.

In calculating the potential increase in demand for such services under the new model, we will therefore need to build in a buffer to account for current unmet need and demographic changes.

### Potential demand

Calculating the potential increase in demand as a result of implementing the proposed service model has been challenging. Exploration of other areas’ methodology indicates that there is no single established means of doing so. Most models reviewed utilised the data of existing or approximate services and the methodology focused on what the service was trying to achieve.

In one of the English models viewed for example, the modelling was based primarily on the cost savings to be achieved. Whilst the Frailty Programme seeks to use resource more efficiently, its primary aim is to improve the experience of the individual, with the knock on benefits for the whole system highlighted in Chapter One, i.e.

- Reduced numbers of acute hospital admissions NB ‘revolving door syndrome’;
- Shorter lengths of stay;
- Reduced delayed transfers of care;
- Improved flow through secondary care;
- Reduced hospital acquired infections and associated costs;
- Reduced duplication and improved efficiency (more effective use of public money utilised as a joint health and social care resource);
- More people being helped to live at home;
- Reduced demand for large, complex care packages as a result of the enabling approach;
In the longer-term reduced demand for Continuing NHS Healthcare as people’s health and well-being is maintained for longer.

A pragmatic approach has been assumed and a combination of information sources collated to give a best estimate of the potential increase in demand, based on individual and population need.

The sources used in the calculations were:

- Data gathered on behalf of the Clinical Futures project;
- Caseload information from existing intermediate care services;
- Bed Census data from Torfaen, Newport and Caerphilly;
- Data from the Torfaen Acute Clinical Assessment Team (ACAT);
- Borough –specific business cases where they already exist;
- Welsh Ambulance Service Trust (WAST) data on Category C falls patients;
- The business cases for Ysbyty Aneurin Bevan and Ysbyty Ystrad Fawr.

The caveats that need to be considered include:

- Peaks and troughs in demand. The calculations are based on average caseloads, but the nature of health and social care is that there will be peaks and troughs in demand. If it is to succeed in achieving its desired impacts that model must be able to respond. The calculations will therefore include a buffer to account for such fluctuations in demand.

- The accepted safe occupancy rate for hospital beds is around 85%, yet we know that hospitals in Gwent currently operate at an average of 94% occupancy. Any calculated potential for shift in resource from hospital to community services will therefore need to allow for this rebalancing and for the increase in acuity of in-patients if unnecessary admissions are avoided and early discharge facilitated.

- WAST were unable to provide information on how many of the Category C patients were clinically assessed as being safe to be managed at home but were conveyed to hospital because of lack of alternative service provision. For the purpose of the calculations it has been assumed that all the Category C calls for people who have fallen could be managed in a community setting with the support of the Community Resource Team. It is acknowledged that this is likely to be an overestimate but until the alternative Falls Pathway is piloted this represents the ‘best guess’.
The calculation of potential demand for ACAT/Rapid Response type services is based on the ACAT data and scaled up/down for population size, with an additional 30% added to take account of increase required to provide a service from 8am to 10pm, seven days per week.

The calculation of potential demand for Reablement is based on the bed census data for Caerphilly, Newport and Torfaen.

Monmouthshire and Blaenau Gwent have not undertaken the same local Bed Censuses though Blaenau Gwent has reviewed bed requirements as part of the Ysbyty Aneurin Bevan Business Case. For the purposes of the modelling exercise the same methodology has been applied across the five Gwent localities. There is a view amongst some managers in Blaenau Gwent that this may represent an over-estimate for that Borough, and this will be examined further as the detailed business case is developed for each locality between January and March 2010.

As above, the calculations add a further 30% to cover the proposed extended hours of operation, except for Blaenau Gwent which currently has the only team working 7 days a week up to 8pm.

<table>
<thead>
<tr>
<th>Potential Demand for CRT Service: Cases per month</th>
<th>ACAT/Rapid Response</th>
<th>Reablement</th>
<th>Falls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caerphilly</td>
<td>280</td>
<td>254</td>
<td>52</td>
</tr>
<tr>
<td>Blaenau Gwent</td>
<td>115</td>
<td>113</td>
<td>22</td>
</tr>
<tr>
<td>Monmouthshire</td>
<td>145</td>
<td>111</td>
<td>27</td>
</tr>
<tr>
<td>Newport</td>
<td>231</td>
<td>159</td>
<td>41</td>
</tr>
<tr>
<td>Torfaen</td>
<td>148</td>
<td>133</td>
<td>30</td>
</tr>
<tr>
<td>Gwent Total</td>
<td>919</td>
<td>768</td>
<td>172</td>
</tr>
</tbody>
</table>

The shift in demand is predicted to impact on current secondary care delivery as follows:

**ACAT/Rapid Response:**
- Reduction in medical emergency admissions and lengths of stay;
- Improved patient flow;
- Reduction in delayed transfers of care.

**Reablement:**
- Reduction in the number of community hospital beds required;
- Reduced lengths of stay;
- Decrease in size of care packages required after intervention.
Falls:

- Reduction in pressure on A&E/MAU;
- Reduction in emergency admissions for this category specifically.

**Costs of implementation of pan-Gwent Community Resource Teams based on projected demand.**

At this stage it is only possible to give a high level view of the broad resource envelope that may be required to cope with the estimated potential demand on existing Community Resource Team-type services.

For the purpose of the calculation the falls cases have been added to reablement costs, but it is acknowledged that these patients may need access to urgent assessment also. These elements will of course be integrated in the CRTs.

The analysis is based on current experience and skill mix; it does not account for potential efficiencies achieved through working together more flexibly and effectively.

Alternative proposals put forward by workstreams led by Prof. Pradeep Khanna and Moyna Wilkinson are attached as Appendices 3 & 4.

It is proposed that each locality will develop its own implementation plan in response to the agreement on the proposed service model and standards. From these local plans, detailed business plans will be formulated between January and March 2010.

The costs detailed below have been calculated using the common multiplier of £25,420.

<table>
<thead>
<tr>
<th>Costs of New Model</th>
<th>ACAT/Rapid Response</th>
<th>Reablement (incl. falls)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caerphilly</td>
<td>£1,442,288</td>
<td>£7,765,864</td>
</tr>
<tr>
<td>Blaenau Gwent</td>
<td>£593,883</td>
<td>£3,434,266</td>
</tr>
<tr>
<td>Monmouthshire</td>
<td>£746,596</td>
<td>£3,495,274</td>
</tr>
<tr>
<td>Newport</td>
<td>£1,187,766</td>
<td>£5,073,867</td>
</tr>
<tr>
<td>Torfaen</td>
<td>£763,564</td>
<td>£4,133,321</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>£4,734,097</strong></td>
<td><strong>£23,902,592</strong></td>
</tr>
</tbody>
</table>

The total projected costs of the new service therefore are **£28,636,289**.

Across Gwent there is a current investment in the intermediate care services described on Page 1 of this Chapter totalling £11,641,988. Of that total, £1,624,779 is derived from Welsh Assembly Government grant funding that is due to cease in March 2011.
At this stage of development of the business case, it is anticipated that the Frailty Programme will be seeking to access circa £17 million pump-prime ‘Invest to Save’ funding.

**Next Steps**

The Finance Workstream will meet on a weekly basis throughout January 2010 to collate the information required for the Invest to Save bid, including the following:

- Future modelling & assumptions need to be confirmed - in particular open cases
- Timescale of the benefits realised from the new service model
- Timescale of the pump priming investment
- Confirm the resourcing of the new model Gwent wide
- Confirm the governance arrangements to support integration
- Potential use of ‘pooled budgets’

The Frailty Implementation Groups (FIGs) in each locality will develop their own local business cases between January and March 2010.

**Options for Roll-out 2010/11**

Three options have been identified for the roll-out of the proposed model and these are:

4. The Big Bang Approach: all five localities ‘go live’ on an agreed date in 2010/11 financial year;

5. Pre-determined phased roll-out: one or more localities ‘go live’ at agreed times throughout the 2010/11 financial year;


The benefits and risks associated with each approach are described as follows:
1. The ‘Big Bang Approach’

Benefits:
- Equitable access to all Gwent residents at the same time;
- Fairness of opportunity for each locality to access resources; reduces fear that in the current economic environment that the money could run out before full implementation;
- No region feels penalised as a result of previous political or funding decisions;
- Quick wins come quicker;
- Innovation in progress is not perceived to be held back.

Risks:
- Reduces opportunity to test model operationally and share lessons learnt;
- Places most pressure on those localities with the greatest amount of change to manage, including recruitment issues;
- Requires full stakeholder buy-in from the outset and doesn’t allow those who are yet to be convinced to make a judgement on early results.

2. Phased Pre-Determined Roll-Out

Benefits:
- Provides the opportunity for testing and effective knowledge management to share lessons learnt;
- Buys time for those localities with most to do to implement the model;
- Will be perceived as less risky by those stakeholders who are currently more cautious about the model;
- Roll-out can be designed to ensure that some quick wins are demonstrated early enough to satisfy sponsors and funders.

Risks:
- Localities due to ‘go live’ later in the year may perceive themselves as left behind: perpetuates the postcode lottery;
- Localities that have received less funding in previous financial years may feel unjustly penalised i.e. they go live later because they have less of the proposed model currently in place. Buy-in to the model suffers as a result;
- The localities that go last have less access to the limited workforce pool;
- Those who have developments and business cases in progress may feel held back by enforced timescales.
If the phased roll-out option were to be adopted three critical factors have been highlighted as influencing order of roll-out:

1. the employment of the Consultant Physician (viewed as key to local leadership with regard to the urgent assessment and intervention elements of the integrated teams, but can be challenging in recruiting the right people in a timely manner.)
2. links to Clinical Futures (CF) and new hospitals becoming operational. The alignment of the proposed CF, ‘Chris Jones’ and Frailty models provide the ideal opportunity to implement a new whole systems approach.
3. The size of recruitment exercise required to provide the staffing numbers/skill mix required for implementation.

3. Self-Determined Roll-Out

Benefits:

- Reinforces the commitment to the locality approach;
- Allows greater local control by undertaking own gap analysis and formulating realistic local action plan in response;
- Provides continuity with current planning arrangements and doesn’t hold back existing innovation;
- Encourages healthy competition;
- Allows perceived fair access to resource;
- Could still provide the opportunity of sharing what works and lessons learnt.

Risks:

- Competitive element reduces commitment to shared learning;
- The Programme loses momentum if all localities chose to go live in early 2011;
- Could result in localities staying in their comfort zone (‘more of the same’) rather than the desired new ways of working;
- Makes pan-Gwent co-ordination potentially more challenging.

Board Recommendation

Having debated and considered all three of the above options the Frailty Programme Board proposes that a combination of Options 1 & 3 should be adopted.

That is, it is recommended that all the localities sign up to commence implementation on 1st April 2010, but that each then works to their own implementation plans and timescales.
<table>
<thead>
<tr>
<th>Locality</th>
<th>Current Public Sector Intermediate Care Resource</th>
<th>Current Voluntary Sector Resource (Phase 1 type services)</th>
</tr>
</thead>
</table>
| Blaenau Gwent | **Rapid Response**  
  - Band 7 Nurses x2 WTE  
  - Band 6 Nurses x 3 WTE PLUS 2 WTE Band 6 nurses being advertise now  
  - Access to CPN Mon-Fri 9-5 for advice  

**Reablement**  
- OT Team Leader, both Manager and Practitioner x 1 WTE  
- Occupational Therapists x2 WTE  
- Physiotherapists x2 WTE  
- Registered General Nurse x1 WTE  
- Reablement Assistants x9 WTE  
- Admin Support x1 WTE  

Both of the above teams are co-located at Blaina Hospital and are working on a local single point of access.  

Other teams that they have identified as being linked to intermediate care =  
- Falls co-ordinator  
- Palliative care  
- Medicines management  

| Red Cross  
| Care & Repair  
<p>| Crossroads |</p>
<table>
<thead>
<tr>
<th>Locality</th>
<th>Current Public Sector Intermediate Care Resource</th>
<th>Current Voluntary Sector Resource (Phase 1 type services)</th>
</tr>
</thead>
</table>
| Caerphilly | **Frailty Ward** (Nantgarw Community Ward, Caerphilly District Miners’ Hospital):  
  - Consultant Community Physician x 1.00 WTE  
  - Registered Nursing Staff x 10.9 WTE  
  - Unregistered Nursing Staff x 9.5 WTE  
  - Non-clinical Support Staff x 1.80 WTE | ✈️ Age Concern Hospital Discharge Scheme LHB funding for weekend Service for HDS £33,719 (Wanless).  
✈️ Age Concern Mon-Fri Service LHB Funding £71,289 (core funding).  
✈️ Care and Repair (RRAP and Safety at Home) LHB contribution £20,909 (core funding).  
Health Care worker - LHB contribution.  
✈️ Red Cross £4,620 (core funding) Short-term loan of equipment.  
✈️ Caerphilly Care for Carers LHB funding to provide a sitting service to promote health wellbeing of carer, including enabling carer to attend own health appointments etc - LHB contribution £6,763 (Wanless) + £6,001 (core funding).  
✈️ Crossroad LHB funding to provide a sitting service to promote health and wellbeing of carer, including enabling carer to attend own health appointments etc - LHB contribution £6,763 (Wanless) + £3,598 (core funding). |
|            | **Joint Hospital Discharge Team** (based at Ystrad Mynach Hospital):  
  - Manager x 1.00 WTE  
  - Nurse Care Managers x 4.00 WTE  
  - Social Work Case Managers x 3.00 WTE  
  - Administrator x 1.00 WTE |                                                                                                                        |
|            | **EMI Liaison**  
  - CPN x 1.00 WTE |                                                                                                                        |
|            | **Community Advanced Nurse Practitioners:**  
  - Registered Nurses x 6.00 WTE |                                                                                                                        |
|            | **Rapid Response:**  
  - Registered Nurses x 4.8 WTE | Budget based upon 2009/10                                                                                           |
Home Assistance Reablement Team (HART)

- Occupational Therapists x 4.5 WTE
- Physiotherapists x 4.5 WTE
- Case Managers x 4 WTE
- Reablement Support Workers x 26 WTE
- Admin Support x 4 WTE
- Senior Monitoring Officers x 1 WTE
- Senior Programme Arranger x 1 WTE
- Monitoring Officers x 8 WTE
- Programme Arrangers x 8 WTE
- Emergency Care Co-ordinator x 1 WTE
- Home Carers 204 staff with 16 hour contracts
- Emergency Care at Home Staff x 11 with 10-hour contracts, provide 24/7 service reserve stand by payment.

Shared Posts across Home Care & Reablement and Emergency Care at Home.

- Managers x 2 WTE
- IT Officer x 1 WTE
- Training and Development Officer x 1 WTE
- Senior Administrator x 1 WTE
<table>
<thead>
<tr>
<th>Locality</th>
<th>Current Public Sector Intermediate Care Resource</th>
<th>Current Voluntary Sector Resource (Phase 1 type services)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Torfaen</td>
<td>Co-located Integrated Intermediate Care Team with local Single Point of Contact.</td>
<td>🔷 Care &amp; Repair (rapid response adaptations and care &amp; safety at home schemes)</td>
</tr>
<tr>
<td></td>
<td><strong>ACAT</strong></td>
<td>🔷 Red Cross (up to 6 weeks social care support)</td>
</tr>
<tr>
<td></td>
<td>🔷 Senior Nurses Band 7 x 3 WTE</td>
<td>🔷 Crossroads Carer Support</td>
</tr>
<tr>
<td></td>
<td>🔷 Senior Nurses Band 6 x 3 WTE</td>
<td>🔷 Torfaen Medication Administration Service</td>
</tr>
<tr>
<td></td>
<td>🔷 Support Workers Band 4 x 2 WTE</td>
<td>🔷 Age Concern</td>
</tr>
<tr>
<td></td>
<td>🔷 Admin Support Band 4 x 1.6 WTE</td>
<td></td>
</tr>
<tr>
<td></td>
<td>🔷 Consultant Physician x 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Rapid Response</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Provided by the local District Nursing Teams with Band 4 Support Workers x 3 WTE</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Reablement</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>🔷 Manager (Senior Nurse) x 1 WTE</td>
<td></td>
</tr>
<tr>
<td></td>
<td>🔷 Senior Social Worker (39 hrs)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>🔷 Occupational Therapist (38 hrs)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>🔷 Physiotherapists (35 &amp; 38 hrs)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>🔷 Community Psychiatric Nurse (39 hrs)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>🔷 Reablement Assistants (97 hrs)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>🔷 Admin Support (38 hrs)</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Emergency Care at Home</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>🔷 Support Workers x 3.6 WTE</td>
<td></td>
</tr>
<tr>
<td></td>
<td>🔷 Team Manager x 0.6 WTE</td>
<td></td>
</tr>
</tbody>
</table>
Short-term Alzheimer’s Management Service (SAMS)
- Support Workers x 6 WTE
- Manager x 1 WTE

Falls Team
- Co-ordinator x 1 WTE
- Senior Nurse x 1 WTE
- Occupational Therapist x 0.5 WTE
- Physiotherapist x 0.5 WTE
- Social Worker x 0.5 WTE
- Reablement Assistants x 3 WTE
- Admin Support x 1 WTE

Crossroads Carer Support
- Manager (39 hrs)
- Care Manager (39 hrs)
- Care Co-ordinators x 1 WTE (job share)
- Office Manager (39 hrs)
- Carers Health Worker (25 hrs)
- Young Carers Worker (39 hrs)
- Admin Assistant (39 hrs)
- Care Support Workers (variable)

Step up/down facility
6 beds in social services residential home supported by the Reablement Team
<table>
<thead>
<tr>
<th>Locality</th>
<th>Current Public Sector Intermediate Care Resource</th>
<th>Current Voluntary Sector Resource (Phase 1 type services)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monmouthshire</td>
<td><strong>Rapid Response</strong>&lt;br&gt;None at present; Blaenau Gwent Team covers Abergavenny.</td>
<td>✯ Care &amp; Repair (as in Torfaen plus ‘Healthy at Home’ project and installation of Lifeline and telecare)</td>
</tr>
<tr>
<td></td>
<td><strong>Monow Vale</strong>&lt;br&gt;Manager x 1 WTE&lt;br&gt;Occupational Therapist x 1 WTE&lt;br&gt;Physiotherapist (20 hrs)&lt;br&gt;Reablement Technicians (50 hrs)&lt;br&gt;Senior home care workers and assistants x ??&lt;br&gt;Social Worker x 0.5 WTE&lt;br&gt;Admin Support (10 hrs)</td>
<td>✯ Crossroads&lt;br&gt;✯ Age Concern Hospital Discharge Scheme</td>
</tr>
<tr>
<td></td>
<td><strong>Mardy Park</strong>&lt;br&gt;8 Reablement beds supported by the Abergavenny Reablement Team.&lt;br&gt;Occupational Therapist x 1 WTE&lt;br&gt;Rotational OT x 1 WTE&lt;br&gt;Physiotherapist (20 hrs)&lt;br&gt;Senior homecare workers and assistants&lt;br&gt;Admin Support (25 hrs)</td>
<td></td>
</tr>
<tr>
<td>Locality</td>
<td>Current Public Sector Intermediate Care Resource</td>
<td>Current Voluntary Sector Resource (Phase 1 type services)</td>
</tr>
<tr>
<td>-----------</td>
<td>--------------------------------------------------</td>
<td>----------------------------------------------------------</td>
</tr>
<tr>
<td>Chepstow</td>
<td>Short Term Assessment and Reablement Team - Chepstow.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Team Manager x 1 WTE</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Senior S/W Practitioner x 1 WTE (Joint with Long Term Team)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Business Support Administrator 1 x WTE (Joint with Longer Term Team)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Occupational Therapist 0.48 x WTE (LHB)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Occupational Therapist 1 x WTE (Seconded from Trust)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Physiotherapist 1 x WTE (Trust)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Hospital Discharge Liaison Nurse 1 x WTE (Trust)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Social Worker 0.67 WTE (LA)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Social Worker 1 x WTE (LA)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Reablement Assistant 0.67 x WTE (LHB)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Reablement Assistant 0.67 x WTE (LHB)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Administrative Assistant 0.50 x WTE (LA)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Administrative Assistant 0.27 x WTE (LHB)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Hospital OT x 3 WTE (Trust)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Hospital OT Technician 1 x WTE (Trust)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Hospital OT Support Worker 1 x WTE (Trust)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Hospital OT Support Worker 0.50 x WTE (Trust)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Senior Reablement Assistant x 1 (To meet service need)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Reablement Assistant x 3 (To meet service need)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Reablement Assistants x 4 (To meet service need - To be Confirmed)</td>
<td></td>
</tr>
<tr>
<td>Locality</td>
<td>Current Public Sector Intermediate Care Resource</td>
<td>Current Voluntary Sector Resource (Phase 1 type services)</td>
</tr>
<tr>
<td>----------</td>
<td>--------------------------------------------------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td>Newport</td>
<td><strong>Rapid Response</strong>&lt;br&gt;• Intermediate Care Consultant x 1&lt;br&gt;• Registered Nurse Band 7 x 1 WTE (seconded)&lt;br&gt;• Registered Nurse Band 6 x 4 WTE</td>
<td><strong>Age Concern Rapid Response Early Discharge Service</strong> (up to 14 days social care support with Intermediate Care teams)&lt;br&gt;<strong>Age Concern Prevention of Admission to Hospital (PATH) Scheme</strong> (short-term home-based social care).&lt;br&gt;<strong>Age Concern RREDS</strong>&lt;br&gt;• Manager x 1 WTE 37hrs (hours also include the management of PATH already listed)&lt;br&gt;• Team Leader 1 x 0.8 WTE&lt;br&gt;• Senior Support Worker 1 x 0.77 WTE&lt;br&gt;• Support Workers 5 x 0.43 WTE</td>
</tr>
</tbody>
</table>
SIZING THE REHABILITATION ELEMENT – WORK OF TASK & FINISH GROUP LED BY MOYNA WILKINSON MARCH 2009

Based on approximately 90 people at any given time.

**Reablement Assistant**

Model uses clinical futures ratios, i.e.

- **15%** High Need = 3 hours per day reablement assistant time
- **35%** Medium Need = 2 hours per day reablement assistant time
- **50%** Low Need = ½ hour per day reablement assistant time

Total would = 126 hours per day or 882 per week

**Professional Inputs**

Only a proportion available for hands on work with people and reablement assistants on the specific reablement programme.

Other tasks include:

- assessment, reassessment
- review at the end of the reablement period
- handover tasks
- case coordination
- contact with other professionals
- contact with carers, family members, community links
- arrangements of other assistance through voluntary and private agencies
- arrangement for provision of equipment, Telecare, etc.
- housing discussions
- linking to acute care and hospital discharge
- time needed for supervision, training, team meetings and team development, etc.

(N.B. this list is not exclusive and has not been sized)

**Reablement Approach**

<table>
<thead>
<tr>
<th>Role</th>
<th>Time Available</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occupational Therapists</td>
<td>3</td>
<td>(50% hands on reablement)</td>
</tr>
<tr>
<td>Physiotherapists</td>
<td>3</td>
<td>(50% hands on reablement)</td>
</tr>
<tr>
<td>Reablement Nurses</td>
<td>3</td>
<td>(50% hands on reablement)</td>
</tr>
<tr>
<td>Social Workers</td>
<td>3</td>
<td>Mostly other tasks</td>
</tr>
<tr>
<td>Reablement Assistants</td>
<td>20</td>
<td>(75% of their time available for hands on)</td>
</tr>
<tr>
<td>Senior Reablement Assistants</td>
<td>2.5</td>
<td>(to ensure supervision as 1:8 but also to do 50% of their time as hands on)</td>
</tr>
</tbody>
</table>

Would produce 714 available hands on hours.
Appendix 3

Proposals from Work led by Prof. Pradeep Khanna, March 2009

Based on a population of 70k and current demand, each locality Urgent Response and Intervention team would be required to provide service capacity equivalent to around 70 virtual beds, made up of the following components:

- Assessment of 200 new patients per month for acute exacerbations of chronic conditions and associated disorders.
- Follow-up of 200 patients per month.
- 7-day presence in A&E and MAU to assess patients and prevent admissions, pulling them back into the community, as required.
- Hot clinics in each locality (Monday to Friday) for the provision of advice for GPs.
- Formal links with other specialties, including General Medicine, Falls, Trauma and Orthopaedics and Mental Health.
- On-going management of patients at home for up to 14 days.

The following staffing requirements have been calculated in the light of the experience of staff currently delivering services and based on the projected activity detailed above.

This core team is based on a population of 70 -90,000

1 Consultant
3 Staff Grade doctors
14 Registered General Nurses
2 Registered Mental Nurses
25 - 30 health and social care workers (NVQ 3) working shifts and with on-call arrangements.
A coordinator (NVQ 4 or 5)
Communication and Stakeholder Engagement.

What we have done so far ....

During the planning process a significant amount of time and effort has been focused on gaining the views of staff, patients and the public to ensure that there is local support for the proposals set out in this Strategic Outline Case.

A Communication and PR Group has been a core part of the project structure from the outset, chaired by the Medical Director, Newport Local Health Board and incorporating representatives from the Trust, Community Health Council, Local Authorities and the Voluntary Sector.

The Communication and PR Group has taken forward three specific programmes of work:

- Stakeholder briefings
- Staff Communication
- Public Engagement

Stakeholder Briefings

Following the establishment of the Project Board in November 2008 a series of briefings and discussions were held with key partners to bring everyone up to a comprehensive level of knowledge and understanding about the project, generate support for the case for change and discuss service priorities. Examples of the fora addressed so far include:

- Monmouthshire Local Health Board, and Monmouthshire Older Peoples Strategic Partnership Group;
- Torfaen Health, Social Care and Wellbeing Strategic Board; Older Peoples Joint Strategic Implementation Group; Torfaen LHB Board Meeting;
- Gwent Local Medical Committee;
- Caerphilly County Borough Council Scrutiny Committee;
- Gwent Community Health Council Roadshows;
- Aneurin Bevan Local Health Board Locality Workshops

These meetings have been helpful in defining existing issues, testing service model assumptions, identifying user and service priorities, and in advising the project on the best approaches to communication.
Staff Communications

The service modelling work was led by key clinical staff and practitioners from a wide range of services and settings to ensure that it was driven by a commitment to delivering clinical quality and effectiveness for patients.

This has also helped to facilitate communication amongst staff. In addition to this, a number of routine information mechanisms such as a web site and monthly briefings have been used as well as specific staff stakeholder events, including health, social care and voluntary sector staff. These stakeholder events will continue to play a key role in ongoing staff engagement.

Public Engagement

The third element of the communication programme has been an extensive public engagement process led by the Third Sector and supported by the Trust.

This has taken place at key stages over the course of the past year and builds on a five year public engagement process in relation to the Clinical Futures Service Redesign Programme. A core element of which sees the rebalancing of routine care from District General Hospitals and Community Hospitals to Primary and Community Based Services, supported by a network of Local General Hospitals and a single Specialist Critical Care Centre.

In respect to the public engagement work that has been progressed during 2009, this process was used to explain the case for change, seek public views, in particular the views of frail older people and their carers, on the outcomes they want from responsive, integrated, and relevant public and voluntary sector services, where the shared vision is

"Frail people in Gwent will be happily independent"

Through these events participants also clearly described how they would experience being “happily independent”. The outcomes of these events are described in Chapter 2 of this document and form the basis of the proposed Performance Management Framework detailed in Chapter 7.

A wide variety of mechanisms were used to generate, validate and test theses outcomes including the following:

- Briefings to Gwent Community Health Council
- Information packs for Gwent CHC to support public road shows
- Older People’s Experience Workshop
- Pan Gwent Multi-agency Workshop – Determining Service Outcome Indicators for Older People’s Services
- Gwent Healthcare NHS Trust’s Patient Panel
**What we are planning to do...**

Across Gwent all partners, including patients and the public, aspire to a more primary and community service led NHS within the context of the locality model detailed in the wider vision of the Frailty Programme.

Locally there is evidence of innovative practice and new service models, albeit on a piecemeal basis, that inspire confidence and demonstrate that primary and community based services provide superior alternatives to traditional models of care. Notwithstanding this Gwent has yet to delivered significant shifts in the overall model of care and recognises that the absence of a single vision and clear strategic framework for Primary and Community Services has restricted progress in recent years.

This Strategic Outline Case sets out the single vision for locality-based services to meet the needs of frail people in the Gwent area, together with a strategic framework to support the development and implementation of plans that deliver sustainable community-wide changes.

Sustained and continuous engagement with all stakeholders, in particular, service providers and service users, is critical to the success of the Programme. It is recognised that moving from the traditional bed based model to integrated locality services requires a significant cultural shift from:

- Professionals/service providers in relation to their perception of high quality service delivery in community settings and
- Patients/service users, their carers and the public in general to ensure that primary and community based services are embraced as the service of choice.

**Stakeholder Map**

The Communication and Stakeholder Engagement Team have developed a stakeholder matrix, which will underpin the Communication Strategy and Communication Plan that will underpin the Frailty Programme. This matrix is shown as Figure 5a overleaf. The matrix highlights the types of information that would be of most interest to each broad category of stakeholder. This will enable the communication plans to be developed specifically to respond to the needs of each stakeholder group. Details of the range of stakeholders are shown in Appendix 1.

Priorities for engagement were also developed and are:

- Potential and existing service users
- Power brokers (Politicians and executive teams)
- Service Providers
- Influencers/Experts
- Interested Parties/general public
Types of Stakeholder Group

- **Staff**
  - Users, carers & general public
  - Members of the public
  - People who need services

- **NHS**
  - Social Services
  - ‘Masters’
  - Opinion Formers & Influencers

- **Voluntary & Independent Sector Providers**
  - Technical
  - General Interest
  - Impact on Me

- **Politicians**
  - Keep Up to Date
Stakeholder Issues

Consideration has also been given to the range of issues that will be important to each stakeholder group. This has been developed from the engagement activities that have been undertaken to date. These assumptions will need to be tested and validated.

The following tables outline the range of issues by stakeholder group.

---

**Table 5b**  
**Users and Informal Carers**

<table>
<thead>
<tr>
<th>For older people already consulted with:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the Frailty Programme acting on what we said?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>For new users just being engaged:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is it?</td>
</tr>
<tr>
<td>What does ‘happily independent mean’?</td>
</tr>
<tr>
<td>Where is the information and how can I participate?</td>
</tr>
<tr>
<td>What stays the same and what changes?</td>
</tr>
<tr>
<td>When will the changes happen?</td>
</tr>
<tr>
<td>Will I retain choice and independence?</td>
</tr>
<tr>
<td>How will services be based around me?</td>
</tr>
</tbody>
</table>

For the programme: are the people we’re communicating with getting the messages we intend to send out? Are we using the right language? How do we need to adapt or communication strategy? (Iterative process)

---

**Table 5c**  
**Power Brokers**

<table>
<thead>
<tr>
<th>How will this impact on my credibility/significance?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is my influence recognised?</td>
</tr>
<tr>
<td>Can I be sure there are no surprises?  (‘corridor conversations’)</td>
</tr>
<tr>
<td>What priority does the Frailty Programme have in an already crowded agenda?</td>
</tr>
<tr>
<td>How well does it align/have synergy with other key drivers?</td>
</tr>
<tr>
<td>I need the information to be short, sharp and succinct.</td>
</tr>
<tr>
<td>What is the sensitivity risk?</td>
</tr>
<tr>
<td>What will be the impact/legacy of the Frailty Programme?</td>
</tr>
<tr>
<td>Do the tactics and timing fit with other organisational milestones?</td>
</tr>
</tbody>
</table>

---

**Table 5d**  
**Service Providers**  
(Those who face users and those who manage them)

<table>
<thead>
<tr>
<th>Is the Programme going to throw the baby out with the bathwater?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nothing’s going to change....here!</td>
</tr>
<tr>
<td>Does the programme share our personal and professional values?</td>
</tr>
<tr>
<td>Why should I believe anything will change this time? We’ve been here before.</td>
</tr>
<tr>
<td>Will I need to change my job, role, skills, competencies, place of work?</td>
</tr>
<tr>
<td>Does a more generic approach mean that I will lose my professional identity?</td>
</tr>
<tr>
<td>What will the new management arrangements be?</td>
</tr>
<tr>
<td>How can I have some ownership and feel more secure about the Programme?</td>
</tr>
<tr>
<td>What will be the benefits?</td>
</tr>
<tr>
<td>What is the underpinning ethos?</td>
</tr>
</tbody>
</table>
Table 5 e  Influencers and Experts
What are the benefits? What’s in it for me?
How does the Programme align with my area of expertise?
Is there a hidden agenda? Are they really doing this for the right reasons?
Is this an opportunity to controversialise?
What are the technical risks?

Table 5 f  Interest Groups and General Public
How much money is involved? Could it mean more for my project/interest?
So what?
What will this take away from me/us?
Is there a hidden agenda?
Is there an opportunity for me to take part in it?
‘Soap box assessments’
What are the networks/relationships/signposting that will be involved in the Programme?

Communication/Engagement Strategy and Plan

Developing robust Communication/Engagement Strategy and Communication Plans for each element of the engagement programme will form the next steps. This is subject to this Strategic Outline Case being approved, including a consensus that the stakeholder matrix, communication priorities and stakeholder issues identified will form the basis of the communication programme.
Governance and Structures

Introduction:

The governance framework required to underpin the Frailty Programme is complex. There were 11 organisations all with different accountability structures in place. The six health organisations became the Aneurin Bevan Health Board on 1st October 2009, although it must be recognised that the new structures and accountability framework will take time to become fully embedded.

This section of the Strategic Outline Case:
- Gives an overview of the corporate governance and assurance process in place across the health and social care organisations involved and the regulatory and legislative frameworks, which underpin these.
- Sets out the approach being taken to develop a governance and assurance framework for the Programme.
- Details the work programmes of the sub groups established to progress this.

Corporate Governance and Assurance Processes in Place:

The National Health Service has clearly defined systems and processes under the term Clinical Governance. When correctly in place, this ensures that all care delivered by the NHS is evidence based, provided by competent staff who have the appropriate skills and knowledge to meet the needs of patients and their carers.

All NHS organisations have developed clinical governance frameworks which demonstrate accountability, throughout the organisation, from the care delivered to patients to the statutory Board. There are also external regulatory processes, where health care professionals are registered with and accountable to their professional bodies e.g. General Medical Council.

The NHS in Wales has established a set of core standards, which all organisations must implement. These Health Care Standards for Wales are currently being reviewed; the revised standards are due to be published by April 2010. Whilst these relate to the NHS many of the themes and individual standards, such as dignity and respect and nutrition, are relevant to this programme.

NHS organisations are inspected by Health Care Inspectorate for Wales, who conduct thematic reviews in addition to monitoring all organisations implementation of the healthcare Standards.

Local Authorities have Performance Management Frameworks, which are corporate responsibilities. Scrutiny Committees monitor the implementation of these Frameworks.
There is a range of legislation which is relevant to the Frailty Programme and is being considered by this workstream, for example:

- Health and Safety at Work Act
- Mental Health Act
- Mental Capacity Act
- Deprivation of Liberty Safeguards
- Care Standards Act
- Controlled Drugs Act
- Continuing NHS Healthcare
- In Safe Hands (whilst not separate legislation, relates to the Protection of Vulnerable Adults).

Across the organisations developing the Frailty Programme, there already exists a history of collaboration. This is fully demonstrated in the implementation of some of the above legislation, particularly in relation to the Mental Health Act, Protection of Vulnerable Adults and Mental Capacity Act. The experiences and lessons learned from developing these joint systems, for example for the Supervisory Body function to implement Deprivation of Liberty Safeguards, are being incorporated.

**Approach taken to date:**

The Governance and Structures Workstream has representation from Local Health Boards, Local Authorities, Gwent Healthcare NHS Trust, Care and Social Services Inspectorate for Wales, General Practitioners, the Voluntary Sector and National Leadership and Innovations Agency for Health.

The workstream identified all the issues and risks which needed to be considered when developing the framework. This included the use of language by different organisations and the different corporate assurance mechanisms. The issues were analysed by the workstream lead and Programme Manager and arranged in three groups. These being:

- Medical Accountability
- Operational Issues
- Managerial Issues (to include professional and regulatory issues).

Three sub groups have been established to progress this work, leads and members have been identified. The Groups are in the process of identifying the major risks, key issues and agreeing processes to address these.

**1. Medical Accountability:**

From the health perspective this is a major risk if there is not clarity regarding medical responsibility for the people being cared for through this programme. Traditionally, Medical Consultants are medically accountable for patients in Hospital and General Practitioners are
medically accountable for patients being cared for in their own homes or a residential care home setting. This workstream is led by a General Practitioner and has commenced the debate to clarify this and identify some of the risks involved. These relate to continuity of care, prescribing, record keeping, out of hours care, communication, ordering and acting on results of investigations.

Three options have been identified, these being:

- The Community Physician holding medical accountability whilst they are involved in delivering care. This would commence when the person is referred to the Team and would be end when the person is medically stable and no longer needing intensive medical input. This will require excellent communication between the Consultant and the General Practitioner.

- The General Practitioner continuing to hold medical accountability when the person is referred to the Team. In this scenario, the Community Physician would assess the patient and communicate with the General Practitioner regarding any changes in medication or care.

- Some form of shared care, however, all recognised this could be confusing for patients and their families. This also has the potential to lead to 'The Gap', where no one is managing the patients care appropriately.

From the initial discussions around these options, it is recognised that it is essential that there needs to be effective communication systems between General Practitioners, the Team and patient; a consistent approach and consensus agreed by all and clarity for patients and other team members.

The full options appraisal will be presented to the Local Medical Committee and circulated for wider debate with both general practitioners and secondary care clinicians.

**2. Operational Issues:**

There are a multitude of operational issues which need to be addressed. A detailed operational policy will be developed, which will be supported by a range of policies, protocols and procedures to ensure safe, effective, consistent services are developed and delivered.

The issues have been grouped as follows:

- **Referral management:** This will include receiving referrals at a single point of access, managing inappropriate referrals and discharging patients back to core services, all in a timely way.

- **Assessment and Care Planning and Delivery:** This will incorporate Unified Assessment and Care Management, patient capacity issues, audit, evaluation, integrated care plans and be linked to outcomes for both the organisations and people receiving care.
Medicines Management: This will need to clarify the responsibility for assessment of patient’s medication in the community. Training issues, consistency to Medicines Use Reviews, medication administration and medication administration aids will all be addressed.

Transfer back to core services: It is crucial that patients are transferred back to core services as soon as possible (recognising that some patients could be living in care homes). This should be as seamless as possible, so that patients and their families are clear about their care packages and are able to exercise ‘choice’, where possible.

End of Life Care: Links with Specialist Palliative Care services and generic end of life care will be paramount, to ensure that patients receive appropriate care. The need for rapid access to care packages will be worked through.

Access to Aids and Equipment: The Gwent Wide Integrated Community Equipment Service development will be key to the provision of equipment to enable patients to be cared for at home. There will also need to be flexibility for the Team to provide aids for daily living, without any delay.

Record Keeping, Data Sets and Information Technology: The Information Governance requirements are being worked through. This too, is a complex area, which is likely to require a phased approach to the long term requirements. Maintaining confidentiality will require very clear systems and processes in place. The development of a data set, linked to outcomes, will be fundamental, to agree documentation. Ideally, this should be electronic and span both health and social care systems.

Patient and Care Information: It is essential that both patients and carers have clear information about the services they are receiving and the conditions they are receiving them for. These need to be in a variety of formats to meet the needs of all, especially for people with any form of sensory, physical or learning disability, including patients with dementia.

Policies, Protocols and Procedures: A suite of policies and procedures is to be developed, which will clarify the above issues and be agreed by all organisations.

3. Managerial Accountability:

There will be clear management arrangements in place to ensure the Frailty Programme is delivered safely, efficiently and effectively. This will also include the structures that need to be in place to provide assurance to both the NHS Board and Local Authority Scrutiny Committees that the Frailty Programme is underpinned by effective clinical and corporate governance.

Key issues being addressed by the workstream are as follows:
**Human Resource Issues:** This includes workforce development and health and safety issues. Organisational terms and conditions all vary, and the employing arrangements differ. This is a further area, where a phased approach is needed.

**Managing Risk:** Throughout this workstream, the identification and management of risks both to individuals and organisations are being identified and worked through. This includes corporate, clinical, financial and individual risks. The safe management of operational risk will be a key function of this group.

**Workload Management:** Whilst this is linked to workforce development and the appropriate development and use of all staff skills and competency. There is a need to ensure the development of a flexible, adaptable workforce with transferrable skills to maximise the service provision.

**Financial Management:** There will need to be clear accountability and transparency for budgetary management, which is detailed in the Finance Section. There will also be a need to enable the Team have flexibility to commission services for individual patients in a timely manner.

**Management of Incidents and Complaints:** There will need to be a single process for the management of complaints and incidents, which report to all organisations. Any lessons learned will be identified and shared from all investigations.

**Health and Safety Issues:** This will incorporate a range of issues from a central point for the management of alerts to ensuring the safety of staff working within the service.

**Facilities:** Whilst the service will be mainly delivered in patients homes, there will be a need for the staff base. This will include IT systems, multi professional meeting rooms and possibly an equipment store.

**Organisational Development, Leadership, Sharing the Learning:** This is very much linked to the overall philosophy of the service and culture being developed by the staff involved. This is potentially the most innovative and rewarding component for staff development across health and social care, where patients are at the centre of all service delivery.

**Professional Accountability:** This will address the professional and regulatory issues for individuals working within the service. This will include education, training, supervision and mentorship.

**Carer Issues:** The need for rapid access to respite for carers is paramount for the programme to meet its objectives. There must be a system which is simple to access and timely in its delivery.
**Staffing Structures and Reporting Arrangements:** There will need to be clarity regarding all reporting arrangements and accountability, both professionally and managerially.

4. Conclusion and Next Steps:

The above gives a very brief outline of the current work in progress to identify the issues and work taking place to identify potential solutions to minimise the risks for organisations and service delivery.

Options for the structures needed to demonstrate assurance to the Board of Aneurin Bevan Health Board and Scrutiny Committees of Local Authorities will also be developed. The existing Health, Social Care and Well Being Partnerships could be pivotal to this.

In order to address the complexities of agreeing processes across organisations, the governance arrangements will both influence and reflect the phasing of the implementation of the programme.
**Information Sharing and Single Point of Access**

Information sharing and the development of an effective Single Point of Access logically go hand in hand. The tight timescales for the Programme and the volume of work involved in addressing these two issues is such that for practicalities sake the two elements will need to be undertaken concurrently, and in close conjunction with the Governance and Structures Workstream.

The ultimate aim is to achieve the vision set out by Dr Chris Jones as the 'Communications Hub'; that is, any professional, service user, carer, member of the public can ring one number with their health/social care/housing query and speak to 'Mavis' who will have the tools, skills and knowledge available to co-ordinate resolution.

The pragmatic approach adopted by the Frailty Programme is that it implementation of the Single Point of Access will consist of building blocks that will support our evolving service model and contribute to the Gwent Communications Hub.

**Key Aims for the Workstream**

There are two broad aims proposed which are separated purely by the speed in which they need to be implemented and the resource required for development.

- **Phase 1: Single point of Access**
  Delivery by April 2010

- **Phase 2: Information System required to support the Gwent Frailty Model**
  Delivery post April 2010

**Single Point of Access**

This comprises one phone number to access the service and access to a Directory of Services

The Workstream aims to deliver:

- Directory of services
- One phone number

In order to achieve this, the current plan comprises the following:

- Baseline of current service, what contact centres exist, what models are already in place? To be undertaken as a virtual exercise.
- Collate existing project plans for those who have already put in place a contact centre, examples, Newport contact centre, PID for Unscheduled Care, Pandemic Flu Centre
- Map potential call volumes to help size the Call Centre. Statistics from modelling exercise, current caseloads
- Volumes from Torfaen and Monnow Vale integrated teams.
- Identify deliverables and timescale
Expert advice needs to be gained from:
- The Trusts work on OOHS/WAST/NHS Direct
- From Newport/Torfaen Councils/Social Services/One stop shops

It is acknowledged that NHS Direct Wales currently provides 24/7 access to health information and advice, and signposts the public to local service providers. It has also been commissioned to produce a National Directory of Services. There is obvious potential for collaboration, including accessing the resources of the Welsh Ambulance service Regional Contact centre and Single Point of Access.

**Information System to Support the Frailty Model, including the establishment of a frailty register and sharing the comprehensive needs assessments:**

This piece of work requires close liaison with the Governance Workstream in order to define:

- The specification for the Frailty Register;
- How the system can utilise an Outcome Based Approach. An example of this is SPICE tool written by the NLIAH software developer (Nick Lewis) and reports on activity and service user outcomes;
- An agreed assessment template such as that based on summary Unified Assessment document;
- Who completes the information? This could be achieved with Integration/interfaces. One option is to feed the system through interfaces from PAS or SWIFT or ePEX etc based on criteria/algorithm via data dumps;
- How it is physically accessed (i.e. web service) and also the equipment needed to access it (mobile devices or PC’s etc.);
- System security requirements - Define the levels of user access (read only / delete / edit etc) as well as various levels of access to the layers of information;
- How and when client/carers gain access to the information and to what degree;
- The Consent Model to enable the sharing of information (perhaps based on the IHC IHR model of explicit consent);
- Key responsibilities for the Named Care Co-ordinator;
- Who is responsible for maintaining/updating the assessment?

Once the specification is defined the Workstream will be responsible for:

- Delivering the system to the specification. This could be written in-house (NHS software development team and/or Local Authority software development team) or from a national body (e.g. HOWIS) or could be tendered to outside suppliers (Higher cost);
- To supply and support the central infrastructure (and to ensure resilience and support multi agency access - may need to sit on mirrored servers, one in Health and one Local Authority);
- To determine the potential to integrate with existing systems to reduce duplicate data entry and maintain updates;
To enable access by voluntary service/clients/carers etc. this has to be delivered via the internet rather than intranets and maybe a subset of the information required by staff.

**Estimated costings**
It is difficult to produce outline costs for a system that is yet to be specified but based on the above, outline costs are:

### Phase 1
**Capital**

- **Directory of Service software development**
  10 days @ £500 per day for basic system  
  20 days for additional system intelligence (pathways)  
  **Total**: £5000 + £10000 = £15000

- **Single phone number**
  Telephony equipment  
  **Total**: £5000

- **Call management software licences**
  **Total**: £2000

- **2 x Servers for directory (including MSSQL licences)**
  **Total**: £20000

- **1 Networked PC for each locality (@ £1000 each)**
  **Total**: £5000

*Assumes that staff resources to man this are costed elsewhere*
*Training is from current resources*
*Servers will also house the integrated system in future*

**Revenue**

- Telephone system managed service and call costs  
  **Total**: £5000

- Server Maintenance  
  **Total**: £2000

*Assumes that application development is in house and software support is provided FOC from agencies*

### Phase 2
**Capital**

- **Frailty Register and System development**
  Web Services development 10 days @ £500 per day  
  System integration 20 days @ £500 per day  
  Database development 20 days @ £500 per day  
  **Total**: £5000 + £10000 + £20000 = £35000

- **Mobile devices for community workers 100 @£200**  
  **Total**: £2000

- **Networked PC’s for offices 20 @ £1000**  
  **Total**: £20000

*Servers (included in phase 1)*

**Revenue**

- **Mobile devices £25 monthly tariff**  
  **Total**: £30000

*PLUS Hardware refresh on all the above every 5 years*
Workforce Planning & Development

Introduction

The Workforce agenda within the Frailty Programme is ambitious in that it has to be mindful of the individual requirements of 6 organisations, more than 9 professional groups as well as support the shared goals of the coalition in achieving a robust and innovative approach to the provision of care.

Although there are elements of the preferred service model within each Borough, preliminary investigation shows that each element is unique in terms of their size, structure, roles, pay bandings and terms and conditions of service. The complexity of these current arrangements poses considerable obstacles for closer working structures, a risk that grows the more integrated services become.

At the moment there are strong clinical, social and financial arguments being put forward for changes to the current service model. A key accepted principal by all partners is in basing the service around the needs of the person rather than from a profession or existing service need.

This is a significant shift to the culture of service provision from management and clinician perspectives where budgets and professional governance issues have tended to shape local staffing numbers and ‘requirements’. What is clear is that there are currently considerable variations in the numbers, types of professionals and roles working within each Borough’s service.

For the Programme to be effective as a collective Pan Gwent service there will need to be a degree of harmonisation and an increase in financial cost. But where and on whom does the project spend when increasing the total workforce?

From a work force perspective which ever service option goes forward it will present challenges in terms of how the services are structured, roles developed, how people from different agencies are employed and managed as well as how we go from where we are now to where the services want to be. It will also need to be supported by data that demonstrates how it will achieve:

- Service user outcome and satisfaction measures
- Cost effective use of resources
- Effective use of skills within the available workforce
Background

The current workforce identified for the project are drawn from three sectors represented by the Trust, 5 local authorities and the voluntary sector primarily Age Concern. Each of the organisations provides elements of the Frailty service requirements within their remits but collectively they have the opportunity to deliver a cohesive and whole service model.

The easier workforce to identify within the current service has been the ‘specialist’ workforce includes Consultants, GPs, Social Workers, Nurses, Occupational Therapists, Physiotherapists, Speech and Language Therapists, Psychologists. Occupational Therapists are employed by both Local Authorities and the Trust though there are some variations in their role.

The strategic vision document “Happily Independent” identified that two teams in particular were important to delivering the Frailty service model these being Urgent Response and Intervention and Reablement. It is proposed that in each Borough these two elements are merged to form a Community Resource Team, managed by a single manager.

The current picture shows that across Gwent such services vary within each Borough in terms of how they are managed, funded and by which sector, which professional groups and how many staff they employ.

From a workforce perspective this raises a number of issues including:

- How the number and variation in registered and unregistered staff groups will be decided
- How the transition will be managed across the sectors
- How staff will be engaged in these processes
- How this service will be line and professionally managed.

Harmonising the Structure

This variance in these current service structures across Gwent is significant as it illustrates that staff from different sectors have sometimes have similar skills that can be used to support similar service users and need to be engaged on an equal basis in deciding how to meet those needs.

The modelling is also open to further degrees of speculation as there appears to be little detailed information about the actual and volume of activity undertaken by existing staff within all of the current team structures. It is recommended that the service structures would be more strongly evidenced based if the following actions are taken.
A review of current recorded activity by staff groups;
A focused recording of activity of identified services over a period of a month;
The use of focus groups including service users and current staff in post to identify what the needs of the service user are at each stage of the person’s journey through the Frailty Model;
The same focus groups to identify the skills and competencies required in practice to meet those needs and to what level.

To be efficient as well as cost effective the culture within the new services requires a recognition that some skills and competencies are often shared across registered and support staff and service providers working within differing sectors of care.

Some skills and competencies may also not be profession specific. At the registered staff level there is a strong case to be made for skills such as ‘basic and advanced assessment of the needs of the individual’ to be transferable across to skilled professionals trained to undertake that assessment.

This has been developed in some of the Urgent Response and Intervention and Reablement Services within and outside of Gwent. The review of competencies and skills required within a multidisciplinary team would help to clarify trained specialist skills and knowledge, verses trained generalist skills and knowledge, verses trained generic skills and the level required at each level.

There is also a debate to be had as to the degree the teams fall within a medical or social care managed service, or whether there is a new paradigm to be developed within the service.

The project is also intending to develop and expand upon a Support and Well Being worker who will be able to support a large range of the duties within the care plans developed by registered staff. They will support the person to whom they have been allocated in meeting their physical, practical, social, community, psychological, motivational and other independence needs.

This potentially is a complex and wide range of skills for an unregistered worker and will need some careful differentiation of skill progression development. It should be noted that the Reablement worker takes time to develop to a level of competence that can be signed off in confidence by the registered practitioner. There needs to be some debate around the skills and competencies required within this work force and how they can be built from entry level to ‘higher level’.
Managing the Transition

This programme needs to be managed with the full engagement of staff and their Trade Union or other representatives. Key to this will be to ensure that there is:

- Regular programmed meetings with Staff Side
- Consultation meetings about the service model at key stages of development
- Consultation with staff who may be affected by change in line with agreed models of service change.

All though each service has their own Management of Change policies and procedures it is complicated where the change may affect staff from different sectors and therefore differing policies. It is proposed that this matter is taken forward with the Trade Unions to agree a best practice model that supports all sector requirements where possible.

Consultation with service users.
Some discussion needs to take place regarding the requirement from WAG to consult on service changes with affected organisations and users over a three month period.

Managing Multiagency Staff Groups

Careful consideration needs to be given to the practicalities of employing professional / registered staff from different sectors under one manager in a collocated team. There are many examples where managers from different sectors manage a mix of registered and unregistered staff from other sectors both within and external to Gwent.

These need to be supported by a Workforce Service Level Agreements (WSLA) and a template for a WSLA has been devised in Gwent. The SLA outlines in writing the agreements for service management across the sectors. From a work force perspective this will seek to ensure that:

- Staff within a multi disciplinary / agency setting are managed appropriately on a day to day basis and within a level of supervision that is in line with their on-going professional requirements.
- There are clear lines of responsibility and accountability in respect of the clinical and professional requirements of their team and professional roles.
- Staffs have adequate training and development opportunities which satisfy statutory, mandatory and professional training requirements.
Managers are clear as to the delineation of operational and professional line management responsibilities in order to make best use of shared skills and knowledge.

Staff working to different terms and conditions of employment are able to fulfil their contractual duties and enjoy the full benefits of their contractual agreement.

The experience of multiagency services identifies that Line Management of staff presents a problem because of the inherent differences in employment contracts, terms and conditions, employment policies and procedures.

The SLA will seek to outline how these matters are dealt with by the appropriate manager but will not solve the complication of different employment policies. Some work has been tried to harmonise them which could be picked up by the Workforce Group. These issues will need to be discussed in detail within the meetings with Trade Union representatives.

It is recognised that across the sectors, factors such as pay, annual leave and pensions are at variance. Because of the differentiation of roles across Health and Social Care this is unlikely to affect registered professional staff. However this may be more significant in relation to the Care and Well Being Worker.

Currently across each organisation there is variance in the hourly rate of pay and pay progression. The more these roles are developed in partnership and are consistent in their content and development across Gwent the greater the potential for pressure to harmonise. If this was agreed then it would open up the potential for this workforce to come under one employer with same terms and conditions, employment policies and procedures.

The Frailty Programme not only sets out clear service standards for the development of locality based teams across the whole of Gwent but also enables the development of a consistent workforce across the region. This will require careful workforce planning with the opportunity to build on the work of the Social Care Partnership in taking forward the “One sector One workforce” approach to training and development.

We will need to identify the skills needed by staff who will provide key roles in the provision of care – the ‘Mary Williams’ real life case study will assist in this process.

We will also need to identify the skills, qualifications and experience of the current workforce to establish where the gaps are likely to be. The forthcoming workshops facilitated by the Workforce Development work stream will look to define roles and develop person specifications for the roles to be carried out along with the competencies required.
Leadership roles in the new structure will be key in managing the delivery of the service to the person. It will be important to share knowledge and be able to access training across all statutory, voluntary and independent sectors.

Joint training where appropriate will need to be maximised - this will mean working with providers to develop joint training programmes. Engaging with Higher Education and the Care Council will be essential in order to develop relevant professional qualifications for the workforce and assist professional integration within the workplace.

Issues such as who delivers the learning, where, when and how will also need to be considered to ensure access to learning is available to all.

Education and training for carers and people who need to use services will also need to be considered.

**Workforce Risks**

<table>
<thead>
<tr>
<th>Risk</th>
<th>High</th>
<th>Medium</th>
<th>Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unable to recruitment staff numbers required</td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Service Cost too high</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of staff engagement</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not meeting phase 1 deadline</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unable too agree change process</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Training costs too high</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Challenge to variations in terms and conditions</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Frailty Workforce Workstream Timescales:
### Deadline March 2010
### Activity from September 2009

<table>
<thead>
<tr>
<th>Actions</th>
<th>Status</th>
<th>Completion Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identification and validation of current services and staff across the Boroughs</td>
<td>Ongoing</td>
<td>Largely completed</td>
</tr>
<tr>
<td>Identification of variations in basic terms and conditions of employment</td>
<td>Ongoing</td>
<td></td>
</tr>
<tr>
<td>Consultation with current staff and service users to determine the skills and competencies required to meet the needs of service users</td>
<td>Planned</td>
<td>Mid October</td>
</tr>
<tr>
<td>Development of roles within the service based on competencies and skills required at each stage of the service user pathway taking into account locality planning and local variations</td>
<td>Planned to follow consultation</td>
<td>November</td>
</tr>
<tr>
<td>Design and correlation of competency based Job Descriptions and person Specifications in line with the new service delivery</td>
<td>Planned to follow Consultation</td>
<td>November</td>
</tr>
<tr>
<td>Working in partnership with Trade Union and staff engagement ensuring effective communication with key stakeholders</td>
<td>October then monthly</td>
<td>On going</td>
</tr>
<tr>
<td>Benchmark other service providers outside of Gwent</td>
<td>Ongoing</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Ensure HR presence in Locality Planning</td>
<td>Ongoing</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Staff News communication project</td>
<td>To be discussed</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Design and work up Training and development programme to support competencies, qualifications and new career pathways</td>
<td>Ongoing</td>
<td>December</td>
</tr>
<tr>
<td>Design workforce activity chart</td>
<td>To be worked up and agreed</td>
<td>October</td>
</tr>
<tr>
<td>A month of activity data collection of staff within the rapid response and reablement services</td>
<td>To be worked up and implemented November</td>
<td>November</td>
</tr>
<tr>
<td>Review activity collected</td>
<td>To be worked up</td>
<td>December</td>
</tr>
<tr>
<td>Activity data validation with Job Descriptions, structures</td>
<td>To be worked up</td>
<td>December / January</td>
</tr>
</tbody>
</table>
**Frailty Workforce Timescales:**

**Deadline March 2010**  
**Activity from January 2010**

<table>
<thead>
<tr>
<th>Actions</th>
<th>Status</th>
<th>Completion Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation of new job roles, evaluate and agree employing agency, salaries terms and conditions i.e. Agenda for Change</td>
<td></td>
<td>January</td>
</tr>
<tr>
<td>Evaluation of new job roles and harmonise competencies within National Skills and Competency Frameworks</td>
<td>To be worked up start November</td>
<td>January</td>
</tr>
<tr>
<td>Where possible harmonise employment policies and procedures within multi agency working</td>
<td>To be discussed</td>
<td>January</td>
</tr>
<tr>
<td>Support for managing Phase 1 Change management</td>
<td>To be worked up with Trade Unions</td>
<td>January</td>
</tr>
<tr>
<td>Support the Development of Service Level Agreements to ensure effective line and profession management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agree, map out and implement a change process for effective staff across the services and agencies involved and recruitment into the service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support the development of service activity recording to support informed future people management developments</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Locality Planning

To date the Locality Planning Workstream has focused on:

- its contribution to the modelling work detailed in Chapter 4;
- highlighting and debating the immediate issues in relation to the implementation of the new service model; and
- exploring how the Outcomes-Based Approach (described in Chapter 8) can be utilised for local planning.

As we move into the ‘Preparation for Implementation Phase’ of the Programme, described in Chapter 6, locality planning will be the main focus of activity, supported by the outputs of the other workstreams.

It is proposed that, subject to approval of this Strategic Outline Case, from January 2010 onwards Locality Frailty Implementation Groups (FIGs) will be formed that will be responsible for operationalising the proposed model.

It is likely that these will be drawn from existing locality groups e.g. Intermediate Care, Older People’s Strategy, Health. Social Care and Wellbeing etc and therefore will be ideally placed to locate the implementation of Phase 1 of the Frailty Programme within the wider community context.

Locality Frailty Implementation Groups

These teams will be responsible for undertaking the detailed work necessary for implementation.

This will include:

- Using the gap analysis and the Outcomes Based Approach, develop clear action plans to ensure readiness for implementation by each locality roll out date;
- Confirm local resource requirements for implementation and inform the detailed business case;
- Link to existing local planning and reporting systems, identifying any issues and potential barriers;
- Implement the local Frailty Action Plan;
- Report back to the Frailty Programme Board via the Locality Planning Workstream Lead and the Frailty Programme Manager.

It is recognised that this work will need to be properly resourced in order to ensure that:

- The right people are on the teams;
- They are provided with sufficient time and capacity to complete the practical tasks required for implementation;
They have sufficient influence and permissions from their respective organisations to take this forward.

It is recommended therefore that each Locality Frailty Programme Team is jointly headed by the appropriate Aneurin Bevan Local Health Board Locality Manager, and the Director of Social Services.

Proposed Terms of Reference for the Local Project Teams are attached as Appendix 4.

The Locality Frailty Programme Teams will be supported by the Gwent Frailty Programme Manager and the Locality Planning Workstream Lead.

Effective knowledge management will be key to ensuring that the advantages of the locality approach are harnessed whilst not losing the consistency and standardisation of the pan-Gwent approach.

The current Locality Planning Workstream will therefore act as a regional Community of Practice, providing the opportunity for:
- sharing innovation;
- joint-problem solving;
- working through operational challenges;
- accessing necessary expertise and
- escalating to the Frailty Programme Board where required.

The other workstreams will continue to provide support with a pan-Gwent approach and tangible products, and will be asked to respond to requests from the Locality Planning Workstream.
Appendix 4

FRAILTY PROGRAMME:
PREPARATION FOR IMPLEMENTATION

Local Frailty Project Implementation Teams

Proposed Terms of Reference

To date, the Gwent Frailty Programme has focused on articulating the Vision and undertaking some essential groundwork across the region. Details of the Vision and work undertaken to date can be found in the series of documents:

- Towards Independence for Older People in Gwent
- ‘Happily Independent’: Strategic Vision Document for the Gwent Frailty Programme
- ‘Happily Independent’: Strategic Outline Case for the Gwent Frailty Programme

The first two documents can be accessed on the Frailty Programme website: [http://www.gwentfrailty.torfaen.gov.uk](http://www.gwentfrailty.torfaen.gov.uk)
The Strategic Outline case will be available from the end of December 2009.

From January 2010 the focus of activity will shift towards more localised and detailed planning, with ongoing support from the pan-Gwent workstreams in order to ensure consistency.

Using existing Local Authority Borough Boundaries, five Local Frailty Implementation Groups will be charged with taking forward the detailed planning and implementation process, within the Programme Structure.

Constitution

The Local Frailty Project Implementation Teams will reflect the Programme as whole in terms of overt executive sign up and partnership between health, social care, statutory and voluntary sectors.

It is proposed that the core membership should include the following:

Joint Chairs:

- Director of Social Services or Head of Adult Services
- Locality Manager, Aneurin Bevan Health Board

- Named Local Frailty Project Manager: responsible for developing the local plan and for implementation;
- Human Resources representatives from current Workforce Planning workstream for both the Health Board and Local Authority;
- Finance representatives from current Workforce Planning workstream for both the Health Board and Local Authority;
- Current representative(s) on the Locality Planning workstream;
- Intermediate Care Consultant (if in post);
- Intermediate Care services manager (if in post);
- General Practitioner;
- Lead Nurse for the locality
- Voluntary Sector representation

**Co-opted members** could include:
- Therapies Manager(s)
- Mental Health representative;
- Secondary care geriatrician
- Community Pharmacist
- Community Health Council

**Frequency**

It is expected that the first meeting of each Locality Frailty Project Implementation Team shall be held by the end of November 2009, accepting that interim managers will still be in post for the Health Board at this stage.

Thereafter, it is expected that the group will meet at least monthly, though may choose to meet more frequently in order to develop the detailed action plan and financial plans required by March 2010.

**Authority**

The Committee is authorised by the Frailty Board to undertake the duties set out below.

**Duties**

The duties of the Locality Frailty Project Implementation Teams can be categorised as follows:

- **Undertake Gap Analysis:** using the baseline information provided in the Strategic Outline Case (SOC) and local needs analysis, map current service provision against the Frailty Service Model;
- **Develop Local Implementation Plans:** develop clear plans to achieve full implementation of the Frailty Service Model within the timeframes set out in the (SOC);
- **Prepare the Local Business Case:** confirm the local additional resource requirements for implementation and prepare a detailed local business case;
Link to Local Planning and Reporting Systems: ensure that implementation of the Frailty Service model is embedded into local planning priorities;

Implement Local Plans: within the locally agreed timescales and within the framework of the Gwent Frailty Programme as a whole;

Implement the Frailty Programme Communication and Stakeholder Engagement Strategy; utilising the standard Programme communications products wherever possible, to ensure consistency;

Feedback Local Operational Issues & Solutions to the pan Gwent Locality Planning Workstream so that a consistent approach will be maintained across the Region;

Reporting

The Locality Frailty Project Implementation Teams will provide update reports to the monthly Frailty Programme Board Meetings. They will be required to escalate risks in a timely manner, to the Programme Manager in the first instance.

Progress will be monitored by the Programme Board against the implementation plan and key Programme milestones.

Support

The Locality Frailty Programme Teams will be supported by the Gwent Frailty Programme Manager and the Locality Planning Workstream Lead.

Effective knowledge management will be key to ensuring that the advantages of the locality approach are harnessed whilst not losing the consistency and standardisation of the pan-Gwent approach.

The current Locality Planning Workstream will therefore act as a regional Community of Practice, providing the opportunity for:
- sharing innovation;
- joint–problem solving;
- working through operational challenges;
- accessing necessary expertise and
- escalating to the Frailty Programme Board where required.

The other workstreams will continue to provide support with a pan-Gwent approach and tangible products, and will be asked to respond to requests from the Locality Planning Workstream.
The Outcomes Based Accountability

The Gwent Frailty Programme has committed to the adoption of Outcomes-Based Accountability (OBA) in relation to planning and performance management.

Described as a disciplined way of thinking that supports Programmes seeking to ‘get from talk to action’, this approach will ensure that we do not get side-tracked from our ultimate desired outcome. That is to support frail people in Gwent to be happily independent.

An additional advantage to the OBA is that can be more motivating for service deliverers than traditional performance measurement in that it appeals more directly to professional and personal values. That is, most people enter public service because they want to make a difference to individuals’ lives.

Indeed, at the Frailty Programme staff engagement event held on 11th August 2009, delegates themselves raised the issue of using the opportunity to measure success differently; i.e. on the difference we make for our people rather than against what can feel like arbitrary numeric targets.

Using the established methodology, the users consulted with at the outset of the Programme identified that if they were to be ‘happily independent’ they would have the following ‘experiences’:

1. Be able to remain living in their own home with support
2. Receive services in their home
3. Be listened to by people who are responsible for providing services to assist them
4. Have their health and social care problems solved quickly and considered as a whole rather than individually.

The Evidence-base for Developing the Performance Measures

The outcomes measures were developed around the overarching desired outcome that frail people in Gwent will be ‘happily independent’ and from the experiences highlighted in the local engagement events with older people.
The Implementation Workstream cross-referenced these findings with national studies by:

- Help the Aged: Growing older Programme
- Joseph Rowntree Foundation (2007): ‘The support older people want and the services they need’
- Age Concern (2006): ‘What older people want from community and social care services’.

In view of the rurality of some areas in Gwent, the group also reviewed:


In general these larger studies correlated, with the notable exception of ‘have general good health’, which did not appear to have been highlighted in our local Gwent findings. Review of the original information collected indicated that it had been raised but not explicitly reflected in the write up. The workstream therefore have added a fifth user experience:

5. Have general good health.

It should be noted however, that the Frailty Programme does not only relate to older people; it is designed as a model for any adult over 18 years of age who meets the frailty criteria.

Therefore, the workstream has also undertaken an extensive literature search to identify the key indicators of frailty that can be used to objectively measure individual progress and a result of the intervention.

The Programme has welcomed the support and participation of the Wales Audit Office in this exercise. It is anticipated that the Gwent Frailty Programme will act as a pilot for this model with a view to further roll-out if successful.

**Developing the Outcome Indicators and Performance Measures**

Using OBA methodology and working back from these experiences, the workstream has identified a set of outcomes indicators and performance measures for each of the five user experiences highlighted above. These will be developed into a draft Performance Management Framework for further consultation.

Whilst the Programme is delighted to have the opportunity to take such an innovative approach, in reality health and social care providers within the Region will still need to satisfy existing performance management requirements and targets.

Working across geographical, sectoral and professional boundaries, the Programme will need to find a way of satisfying all those demands without imposing a serious bureaucratic burden on the people who’s priority needs to be ‘doing the job’.
The workstream has undertaken an exercise to match across NHS performance targets and Local Authority Key Performance Indicators in order explore how these could be streamlined together.

A similar matching exercise has been undertaken with the outcome measures developed by the workstream, and again there is some overlap and potential for streamlining.

From a qualitative perspective the workstream is examining existing audit tools e.g. to measure compliance with ‘Fundamentals of Care’, that might further inform the evaluation process.

**Knowledge Management**

It is acknowledged that collecting performance information can become an end in itself and will fail to help us achieve what we want unless the partner agencies act as a single virtual learning organisation.

In addition to abiding by the governance requirements across health, social care and the voluntary sector, the Programme is committed to using organisational and professional (registered and unregistered) knowledge to continuously improve service delivery as we move towards the ultimate vision of integrated locality working.

The Programme’s greatest asset will be the frontline practitioners, support staff and managers who will be delivering the service model on the ground.

As detailed in Chapter 5, we will ensure that they have the training, skills and competencies required to operate this new way of working.

In addition however, if we are to be truly effective and responsive we will need harness their tacit knowledge and experience to meet the challenges of turning the vision into sustained operational reality.

It is proposed that this will be achieved through a series of managed networks and/or Community of Practice methodology (feeding into the national fora).

The Workstream will develop a detailed proposal, in conjunction with the Workforce Planning & Development workstream by the end of January 2010.

**Next Steps**

The workstream will firm up the Performance Management Framework using all these measures and to identify the resources that will be required to effectively collect, manage and utilise the data provided.

The workstream is clear that this process will need to be easy to use and both in terms of input and in using the knowledge gained for service improvement.

It will undertake a consultation exercise on the proposed Framework with service users, practitioners and managers to ensure that this is the case.
Chapter 7

Programme Structure

‘The journey from vision to operational reality’

So far the Programme has:

- Agreed and articulated the Vision
- Made significant progress in completing the groundwork.

The seven Implementation Workstreams have delivered, or are in the process of delivering, some agreed outputs as described in Chapter 5 and have clear plans to ensure that the pan Gwent standards/support mechanisms are in place before the end of March 2010.

From January to the end of March 2010 there will intensive activity at locality level representing Preparation for Implementation, before we enter the Locality Roll-Out Phase from April 2010.

The Programme Structure will need to be amended to:

- reflect progress;
- support the detailed planning required at locality level;
- address pan Gwent operational issues.

The proposed structure is detailed below.
Gwent Frailty Programme: Structure for Phase 3 – Preparation for Implementation

**Reporting & Decision Making**
- Frailty Board
- Workstream Leads Group: Pull together workstream activity

**Strategic Vision Group:** Quality Assurance Function

**Pan Gwent Planning & Support**

**Communications & Stakeholder Engagement**
- User Engagement subgroup

**Workforce Planning & Development**

**Governance & Structures**
- Operational Issues
- Managerial & Professional Accountability
- Clinical Accountability
- Outcomes, Performance & Continuous Improvement
- Information Sharing & Single Point of Access
- Financial Modelling/Building the Business Case

**Locality Planning Community of Practice**

**Local Implementation**
- Blaenau Gwent FIG
- Caerphilly FIG
- Newport FIG
- Monmouthshire FIG
- Torfaen FIG

Frailty Programme Manager: overseeing, co-ordinating & communicating

Co-ordinated Knowledge Management Framework: Lessons Learnt & Organisational Memory
Roles, Responsibilities and Reporting Mechanisms: Preparation for Implementation Phase.

**Gwent Frailty Programme Board**

The Programme Board is representative of the five Local Authority Boroughs, the Aneurin Bevan Local Health Board and the Voluntary Sector.

During Phases 1 & 2 of the Programme the Board’s role was to work creatively to produce the innovative and person centred models described in the Strategic Vision Document ‘Happily Independent’.

As the emphasis now moves to ‘Preparation for Implementation’ i.e. how to turn the vision into operational reality, the role of the Board has needed to develop further.

The proposed whole system changes will be taking place in a complex and dynamic environment, including major structural change to the NHS in Wales.

In order to meet that challenge Board members will be responsible for:

- Representing the views of the partner organisations;
- Robustly debating issues arising from the implementation processes;
- Receiving and scrutinising monthly reports from the seven Implementation Workstream Leads;
- Providing clear guidance and direction to the Implementation Workstream Leads and to the Programme Manager, to ensure that what is delivered is both consistent with the Frailty Programme Vision and has Executive sign up;
- Signing off and promoting products from the Implementation Workstreams;
- Taking prompt responsive action to risks escalated by the Workstream Leads and Programme Manager.

All other elements of the Frailty Programme will report directly to the Board via:

- Monthly Implementation Workstream Reports;
- Attendance and verbal presentation at Board Meetings
- Formal reports and recommendations in response to issues and risks arising.

Members of the Board will provide feedback to their respective organisations via their usual reporting mechanisms. The Programme Manager and Communication & Stakeholder Engagement Group will provide communication products to support this activity.
Even the most innovative and creative programmes can lose their way as they enter ‘project management mode’ and become embroiled in the detail necessary for operationalisation.

In recognition of the importance of the underpinning principles and ethos of the Frailty Programme Prof Pradeep Khanna, Moyna Wilkinson and David Murray were asked to form the Strategic Vision Group. The role of this group is to act as a Quality Assurance mechanism which continuously benchmarks implementation activity against the original vision for the Programme.

They will be responsible for:

- Meeting with the Programme Manager on a monthly basis in the week preceding the Board Meeting;
- Receiving updates at those meetings on Workstream activities;
- Constructively challenging any activity/ non-activity which is perceived not to be delivering the vision;
- Providing guidance and advice to Workstream Leads to ensure alignment.

The advice and recommendations of the Strategic Vision Group will be fed back to the Workstream leads via the Programme Manager. Where appropriate, they will also be agenda’d for wider debate at the Programme Board meeting.

The Implementation Workstream Leads are key to turning the vision into reality. The seven identified workstreams each play a vital role in supporting aspects of operationalisation that have the potential to make or break the success of the Programme.

In relation to their specific workstream, the Leads with the support of the Programme Manager will be responsible for:

- Establishing appropriate and representative membership of their Task and Finish Groups;
- Defining their Terms of Reference;
- Developing a work plan to deliver their identified outcomes, with timescales consistent with the Frailty Programme’s key milestones;
- Producing monthly reports using the standard template in readiness for the Board Meeting;
- Escalating any risks which cannot be managed within the workstream itself, via the Programme Manager in the first instance.
**Programme Manager**

The Programme Manager supports and co-ordinates all the activity detailed above. Specific responsibilities include:

- Providing practical support to Workstream Leads;
- Acting as a communication link between the various workstreams and stakeholder groups;
- Co-ordination and minimalising duplication of effort;
- Supporting Leads to problem solve issues arising and to escalate to the Board where necessary;
- Organising Frailty Board Meetings;
- Maintaining project records and communication systems, including the website for example;
- Being the external point of contact for queries from staff and public.

Reporting mechanisms will be directly to the Board as detailed previously and to Alison Ward as line manager and Programme Chair.

**Common Responsibilities**

All of the people identified above will:

- Act as ambassadors for the Frailty Programme;
- Deliver a consistent message using the agreed standard Frailty Programme communication tools;
- Commit to actively participate in stakeholder events;
- Commit to attending and contributing to relevant meetings and workshops;
- Take responsibility for feeding back and acting upon any concerns raised by our stakeholders.
Programme Management

It is recognised that Programmes as ambitious as this can generate a great deal of project management bureaucracy.

The Gwent Frailty Programme seeks to extend its innovative approach to the implementation of the proposed model.

A Programme Manager has been appointed on secondment until March 2011 and she will be working closely with existing managers and frontline staff to oversee the change management process. There is a clear acknowledgement from the Programme Board that there is already a great deal of expertise and experience in the Region and a commitment to harness both formalised and tacit knowledge to achieve the Programme’s aims.

It is also recognised that implementation will be taking place in a complex and dynamic external environment and that the Programme will need to be responsive and flexible in order to meet those challenges and deliver its desired outcomes.

In view of these factors it is argued that standard project management methodology such as Prince 2 may not facilitate the creativity required to adopt the proposed approach.

The Programme will:

- Identify key milestones and deliverables (as detailed in Chapter 5);
- Manage risk and constraints;
- Actively engage with its stakeholders;
- Have clear reporting and decision making mechanisms in place; and
- Have a comprehensive and transparent communication strategy.

The focus of activity will be on dialogue, debate, adaptation and effective knowledge management rather than the production of reams of Gantt charts that no-one ever reads.

The key milestones and timescales are detailed below:
Gwent Frailty Programme: Key Milestones


- Strategic Vision Document Agreed
- Implementation Workstreams established and functioning
- Strategic Outline Case Agreed
- Locality Frailty Programme Teams established and functioning
- Knowledge Management Framework established
- Detailed locality action plans agreed and implemented
- Pan Gwent Workstream outputs delivered
- Single Point of Access tested and ready for use
- Roll out commenced
- Phase 1 delivered