West Wales Regional Partnership Board

Model of Care workshops

18th to 20th July 2023

Facilitator notes
Tables arranged by regional project (if single regional, group them together)
Facilitator desk: Speed dating sheets, bell, timer
On the table: Regional project Purpose & benefits sheet, measures matrix sheets

Agenda

1. What is RIF and a Model of Care?
2. Our Model of Care and how we got here
3. Local, regional and national reporting
4. Future meetings

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What is RIF and a Model of Care?

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These slides come directly from a Welsh Government briefing presentation.

What is the Regional Integration Fund?

Programme of learning

The Regional Integration Fund builds on the progress made under the previous Integrated Care Fund and Transformation Fund, whilst also responding to the recommendations from the respective independent evaluations and Audit Wales reports.

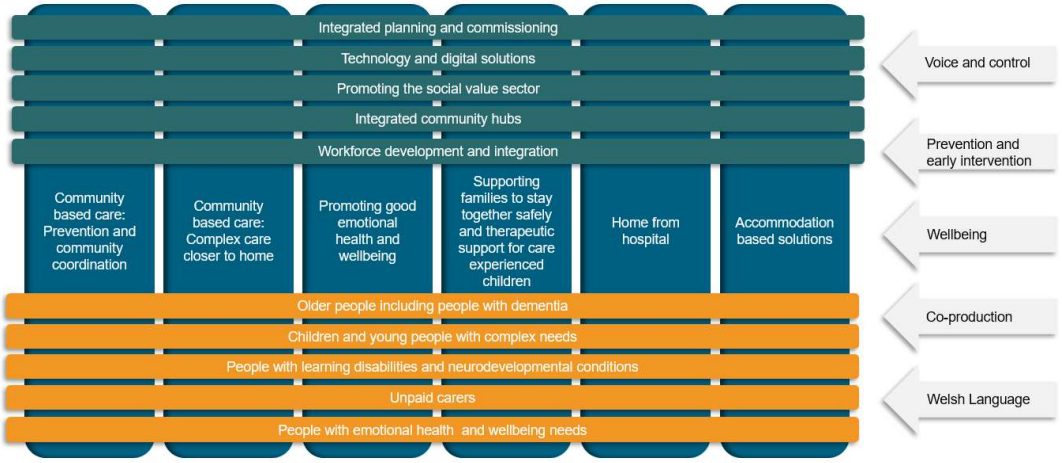
This vital learning has helped us to shape the Fund which includes four key features:

- A greater focus on six national models of integrated care.
- A clear outcomes and measurement framework.
- Opportunities to share learning through communities of practice.
- A longer-term investment horizon, making use of tapering and match funding levers to support mainstreaming and sustainability.

Successor to ICF and TF, with more emphasis on shared learning

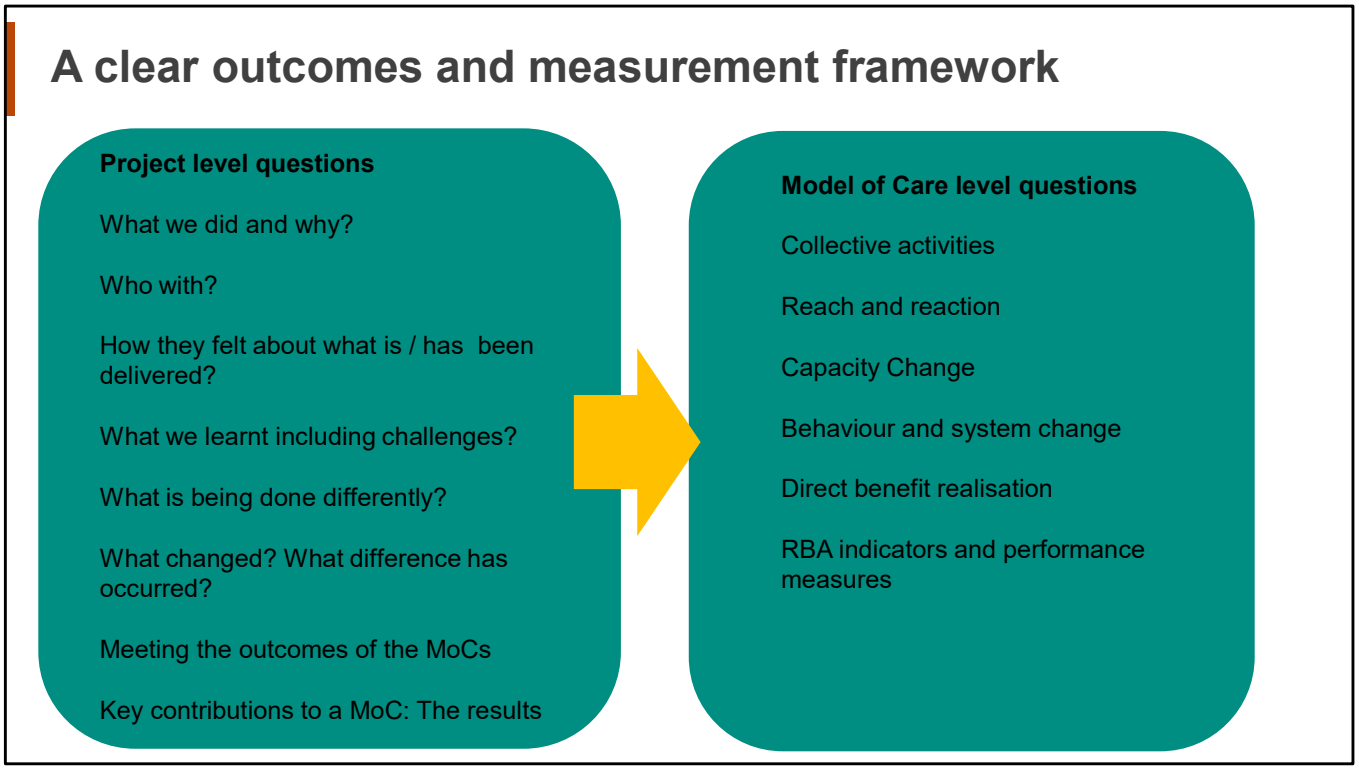
A greater focus on six national models of integrated care

These six models of care have been identified and prioritised for investment based on experiences and learning from the ICF and TF and through extensive engagement and co-design work with RPBs and key partners.



6 blue pillars represent the new Models of Care, developed from the learning from ICF and TF
Green rows are the key enablers to deliver the change
Orange rows are the priority population groups

A clear outcomes and measurement framework



As part of this, in return for the £18m funding being invested into West Wales, there is an expectation to share the learning on how these models are developing, and identifying new ideas that can be applied across Wales.

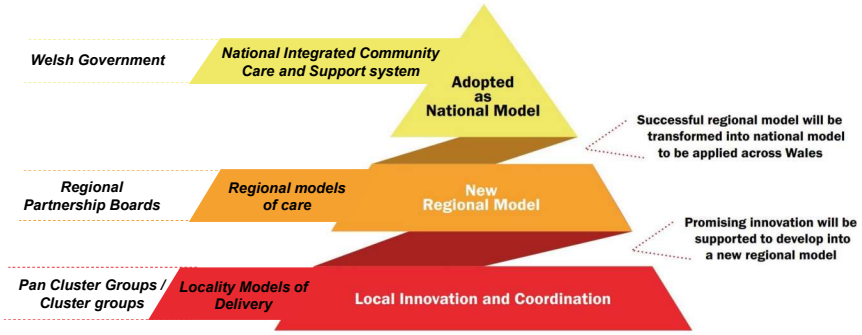
If you've been involved in either of the 2 reporting cycles last year, you'll recognise these questions!

Refining Regional Partnership Board Scope

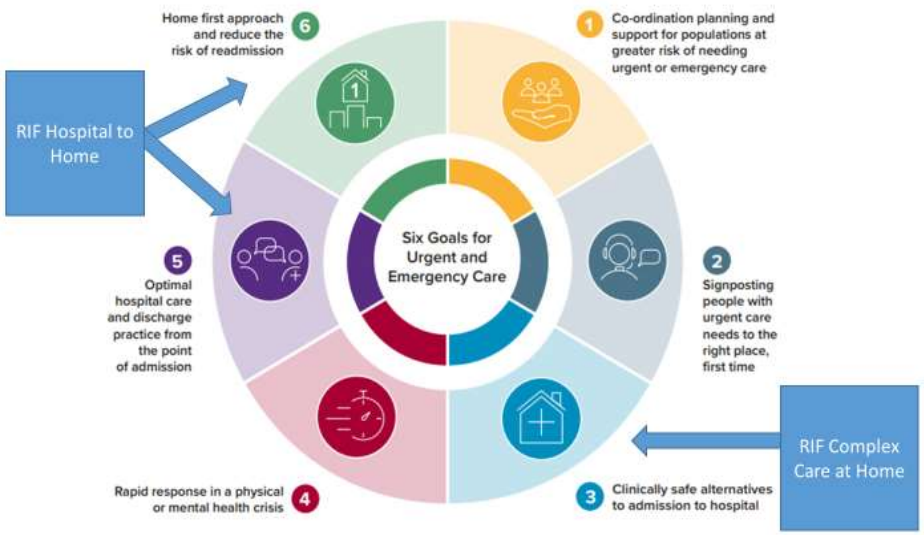
Llywodraeth Cymru
Welsh Government

www.gov.wales

Focussing our efforts to make integration happen for community services – working regionally, locally and at cluster level



Transforming UEC: Frailty Matters



MoC 2 and MoC 5 only

Our Model of Care and how we got here

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Implementation of RIF 22-23

- Integrated Care Fund (ICF) and Transformation Fund (TF) projects
- New county project proposals
- Allocate the available funding
- New concept of Model of Care
- Grouping of projects to an existing purpose or themed regional collection

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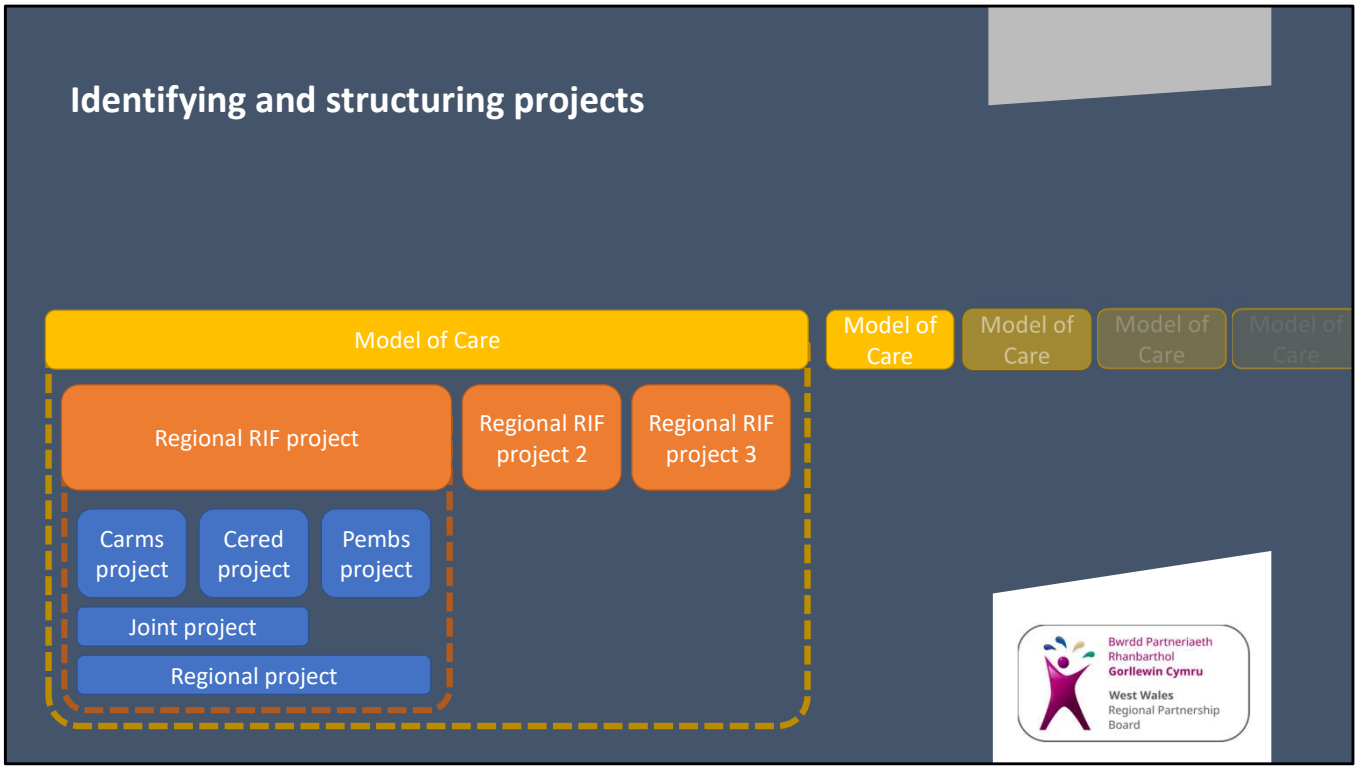
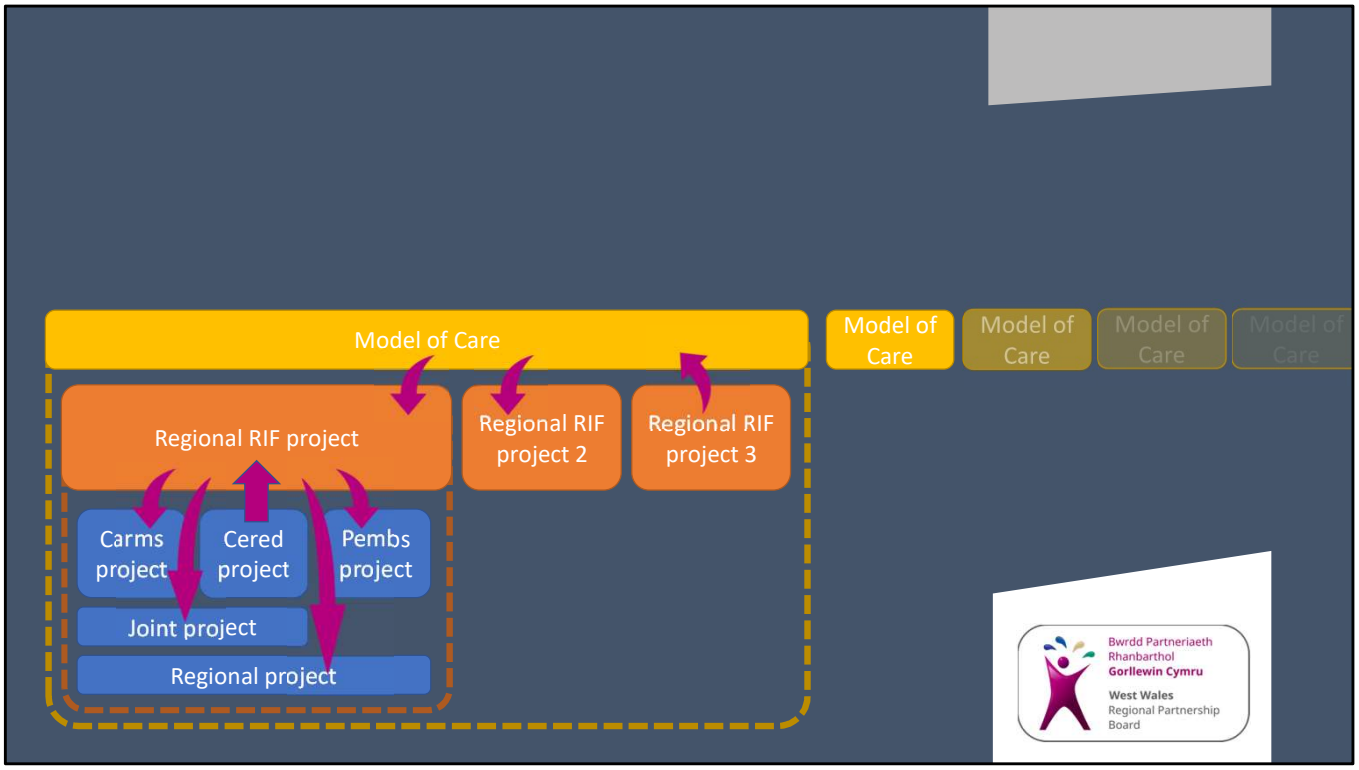
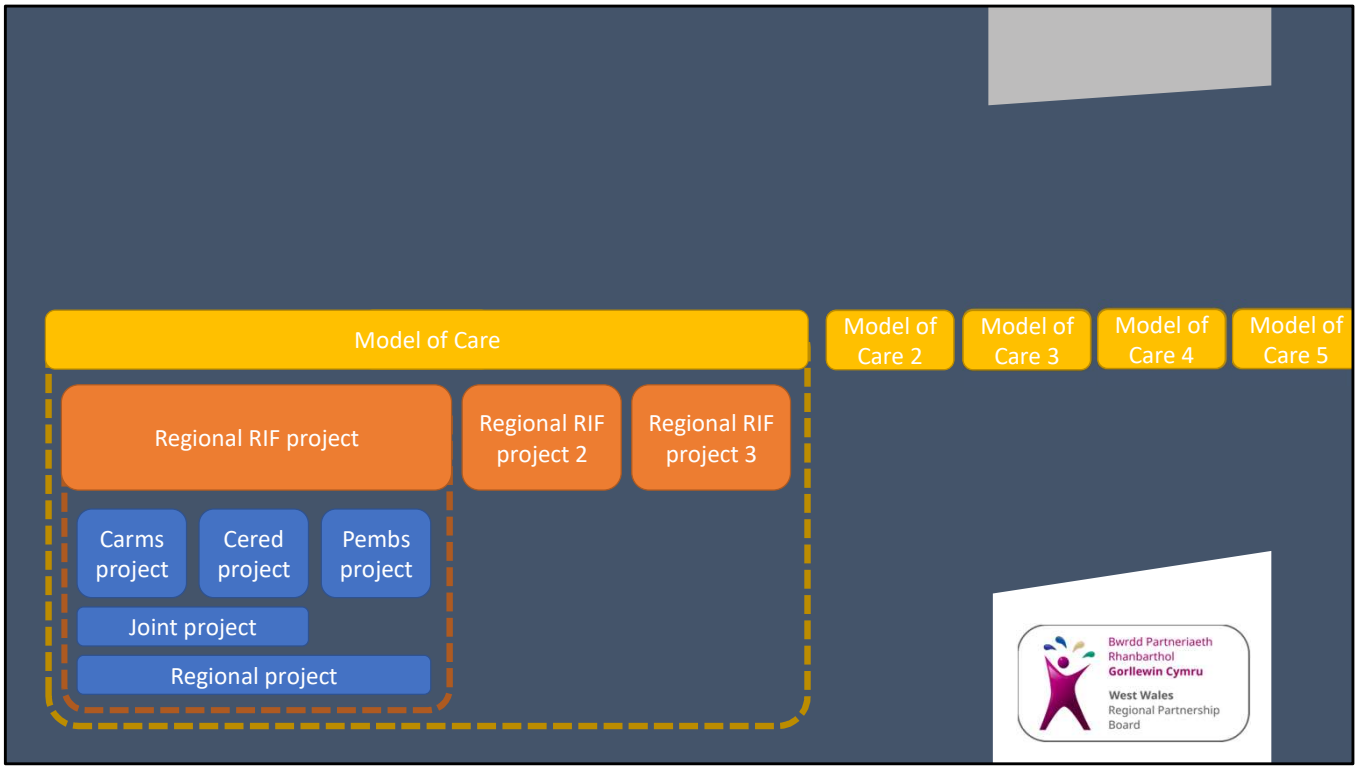
Identifying and structuring projects



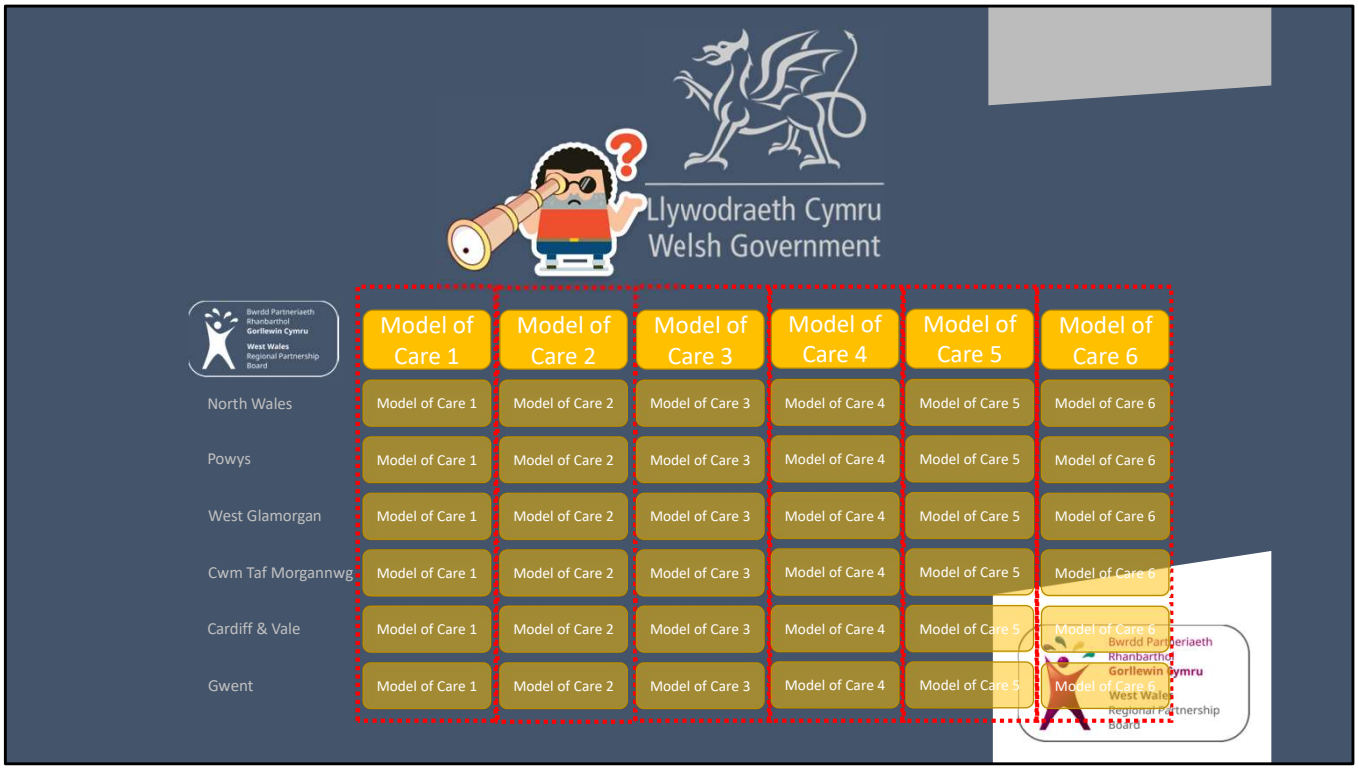
1. Existing projects and new projects across each county were grouped by similar purposes
2. Including some jointly run partnership and full regional projects
3. These were then grouped into a regional project
4. With similar groupings from other projects
5. The regional projects were then aligned to the best fit model from the new Model of Care strategy being developed by Welsh Government
6. And the same process for other projects across the Models of Care.



1. The aim of this structure is to identify good practice and ideas,
2. And share the learning for that project across the region and apply that to the other projects where appropriate
3. Likewise good practice and ideas from the regional projects can be shared across the Model of Care – more on this later!!



1. This gives us a portfolio of 6 models of care
2. Forming the West Wales Regional Integration Fund



1. This structure is replicated across the other 6 regions, though the projects will be different
2. Welsh Government's plan is to learn from each region to develop national models
3. Best practice for a Model of Care will be identified across the regions, and shared through the Communities of Practice
4. This will apply to each Model of Care

< CLICK YOUR MoC BOX TO JUMP TO THE CORRECT SLIDE > (or suffer the consequence of clicking through each!!)

Model of Care 1:
Community Based Care – Prevention and community coordination

Outcomes

1. People's well-being needs are improved through accessing co-ordinated community-based solutions
2. Local prevention and early intervention solutions support people to avoid escalation and crisis interventions

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< CLICK THE ACTIVITY PERSON TO JUMP TO THE ACTIVITY SLIDE OR GRAPH TO JUMP TO RETURN TO THE REPORTING SLIDE > (or suffer the consequence of clicking through each!!)

Model of Care 2:
Community Based Care – Complex care closer to home

Outcomes

1. People are more involved in deciding where they live while receiving care and support
2. Complex care and support packages are better at meeting the needs of people and delivered at home or close to home

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Model of Care 3:
Promoting good emotional health and wellbeing

Outcomes

1. People are better supported to take control over their own lives and well-being
2. People have improved skills, knowledge, and confidence to be independent in recognising their own well-being needs

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Model of Care 4:
Supporting families and therapeutic support for care experienced children

Outcomes

1. Families get better support to help them stay together
2. Therapeutic support improves and enhances the well-being of care experienced children

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Model of Care 5:
Home from hospital

Outcomes

1. People go home from hospital in a more timely manner with the necessary support in place at discharge
2. People have a better understanding of the discharge process and are more involved in pre and post discharge planning

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Model of Care 6:
Accommodation based solutions

Outcomes

1. People are more involved in the design of accommodation to meet their needs
2. People have more choice about where they live and with whom

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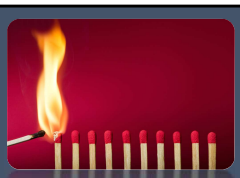
< Arrange the attendees into a circle, initially number them in pairs #1 & #2, but change to 1st and 2nd to speak >

1. (from slide) Exercise brief **< Hand out a dating sheet each >**
2. On the sound of the bell a 30s timer will start, #1 give your name and describe the benefits of your project.
   After 30s the bell will ring, #2's turn to describe their benefits
   After another 30s, stop talking and write any notes about the other project and consider to yourself if the project you've heard about matches yours
3. (from slide) the rules

< LEAVE THIS SLIDE ON THE SCREEN AS A REMINDER >

Changes:
#1 'swipe left' & #2 'swipe right' to another location
One person partner swap with the group opposite
#1 stand up, #2 send them on a blind date to an empty chair
etc.
< Ensure enough rotations to speak with a fair portion of the room. Each 'dater' should be refining their project benefits communication to the available time. Consider if reducing the time may help? >

MoC Speed dating!



- Take a moment to consider which 2 projects best matched the outcomes of your own
- Go and stand with your chosen matches
- **Do you all agree?**

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West Wales regional projects

- Now go and sit on the table for your regional project
- Are you still with the people you identified as a match?
- In 30s, give your project name and describe your project benefits to the rest of your table

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On the tables behind are an envelope. Please turn them over and then go and sit at the table that has your regional project name on it.
If you're not sure stay at the front and ask a facilitator.

Local, regional and national reporting

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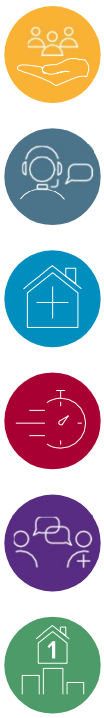
Measure ID	Measure Name	Measure Description
HM1	Number of referrals received	The number of individuals referred to the project.
HM2	Number of new people accessing the service	The number of individuals who access the project for the first time.
HM3	Number of people accessing the serivce (total per quarter)	The total number of individuals who access the project during a quarter.
HM4	Number of contacts (count multiple contacts per individual)	The number of times individuals have contact with the project.
HM5	Number of people receiving IAA (universal)	The number of individuals receiving Information, Advice, and Assistance (IAA) services.
HM6	Number of people receiving Early Help and Support (Targeted)	The number of individuals receiving early help and support services that target specific needs and issues.
HM7	Number of people receiving Intensive Support (Targeted)	The number of individuals receiving intensive support services that are tailored to meet their specific and more complex needs.
HM8	Number of people receiving Specialist Intervention (Specialist)	The number of individuals receiving specialist interventions that require advanced knowledge and expertise to deliver.
HM9	Number of people accessing training	The number of individuals accessing training sessions offered by the project.
HM10	Number of training sessions delivered	The number of training sessions delivered by the project.
HW1	Number of referrals accepted	The number of referrals accepted by the project.
HW2	Number of people satisfied with the information provided	The number of individuals who report being satisfied with the information they received from the project.
HW3	Number of people completing targeted training	The number of individuals who complete the targeted training provided by the project.
HW4	Number of people reporting a good experience with the support they received	The number of individuals who report having a positive experience with the support they received from the project.
DM1	Number of people feeling less isolated	The number of individuals who report feeling less isolated after receiving support from the project.
DM2	Number of people maintaining or improving their emotional health & wellbeing	The number of individuals who report maintaining or improving their emotional health and well-being after receiving support from the project.
DM3	Number of people who feel they have influenced the decisions that affect them	The number of individuals who report feeling that they have influenced the decisions that affect them.
DM4	Number of people with increased knowledge of services/support available to them	The number of individuals who report having increased knowledge of the services and support available to them.
DM5	Number of people starting an Assistive Technology package	The number of individuals who start an assistive technology package provided by the project.
DM6	Number of people receiving aids and adaptions	The number of individuals who receive aids and adaptations that help them remain independent.
DM7	Number of people achieving personal outcomes	The number of individuals who have achieved personal outcomes as a result of the project.

These have been suggested as a common set of measures across all 7 RPBs, though there is still work to do with them to tighten definitions to ensure that everyone is measuring the same thing.

Local measures will be added to monitor the stated project benefits where these measures don’t capture.

Key Performance Indicators / Metrics & Impact



Outcomes Framework for Older People and UEC

'Ends'

- **Patient / Service User feedback Measures:**
  - *'My care is provided in the most appropriate setting to meet my health and care needs'* i.e. What Matters
  - *'How likely are you to recommend our services to your friends or family should they need similar care or treatment'*
- **Population Outcome**
  - Increased number of **healthy days at home** (overarching Outcome for Population)
- **High Level Outcome Indicators**
  - Reducing Conveyanace rates to hospital (and self presentation as balance measure)
  - Reducing Conversion rates to inpatient beds
  - Reducing the number of bed days > 21 – measure of impact on discharge effectiveness / efficiency on the 'back door'
  - Number of 'green days' – (recorded through faculty) – (measure of acute hospital discharge productivity)
  - Reduction in proportion commissioned care hours / placements following in patient stay
  - Reduction in proportion commissioned hours required in the community following intermediate care intervention

PG1 Performance Metrics ('Means')	PG2 Performance Metrics ('Means')	PG3 Performance Metrics ('Means')	PG4 Performance Metrics ('Means')	PG5 Performance Metrics ('Means')	PG6 Performance Metrics ('Means')
• TBC % of population risk stratified as vulnerable and who have stay well plans in place • Number and proportion of vulnerable patients Managed by 'Home First' • Number of service users receiving domiciliary care • Total Number of commissioned domiciliary care hours • Numbers of people waiting for social care	• No. of direct referrals to SDEC • Number of GP referrals streamed through CSH and % directed to SDEC or alternatives • Conveyance Rate (Target 60%) • Ambulance lost hours (Target 0)	• 30% of acute medical take assessed in SDEC. 90% of which go home for >75 year olds, >55 year olds and rest of population • Number Admissions • Number of Occupied Beds • 0-1 day LoS • 0-3 day LoS • Re-admission rates (balance) • Conversion rate (balance) • Number of patients referred to Home First • Number and % patients provided with crisis response	• ED attendances (all) • ED attendances (WAST) • 4 hour wait • >12hr Performance • % of patients with clinical frailty score recorded (pre morbid and on presentation) • TBC re EDQDF	• % of patients have discharge criteria defined by the clinician **and** MDT within 14 hours from 'point of admission' • 10-14 days LoS • Number of patients with LoS > 21 days • Occupied beds rate • Average LOS Admission to Clinically Optimised • Count of Patients with LOS > 100 days, 50 – 99 days and > 21 days	• Average length of time to commission domiciliary care • Average length of time to place into residential and nursing sector • Number of people reported as clinically optimised • Number of domiciliary care hours lost (handed back) due to LOS > 7 days • Number of care hours commissioned following hospital inpatient stay • Number of residential placements requiring increase to general or EMI nursing following hospital stay

MoC 2 and MoC 5 only

Performance reporting – RBA principles

- How much? (Count)
- How well? (%)
- Difference made? (qualitative)

6-monthly for WG, but aim for monthly for regional monitoring

A	Total number of cases or beneficiaries	Number	
B	Number of cases with a specific outcome	Number	
C	% of cases with a specific outcome	Calculation	(B / A) x 100
D	Total number of satisfaction feedback responses	Number	
E	Number of cases who rate their experience as 'Good' or 'Excellent'	Number	
F	% of cases who rate their experience as 'Good' or 'Excellent'	Calculation	(D / C) x 100
e.g.			
RIF_WW_018_A	Number of clients supported with technology		
RIF_WW_018_B	Number of clients logged on to the digital platform in the last month		
RIF_WW_018_C	% of clients using the digital platform		

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Based on Results Based Accounting (RBA) approach

How much?
A count of anything being provided, delivered, requested, achieved etc. relating to the benefits of your project.
Some projects may not have anything to count initially if they rely on setup or recruitment phases or have long term interventions that haven't completed yet.

How well?
These will be a subset of your 'How much?' measures that capture success, completion, satisfaction rates. These are best described as a percentage, so will need a count (how much?) of the subset and a count of the whole set. The whole set may not be the same as your initial 'How much?' e.g. % satisfaction will need to count how many reported as 'good' or 'excellent' as a % of the total number of responses received, not the total service delivery.

Difference made
Qualitative evaluation of the impact of the project. Case studies, evaluations, comparison against baseline data.

Performance reporting – Your project benefits

- How much? (Count)
- How well? (%)

Measures Matrix

Project Name –

What?	Why?	Who is responsible?	Who contributes? E.g. data provision	Where does the data come from?	Where is the data available?	How is it calculated?

Page 1 of 2

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Think about the benefits your project is aiming to achieve. How can you measure them?

Are you already collecting measures about your project? Are they measuring your benefits?

Concentrate for now on the What? and Why? columns. The rest can be developed over the coming weeks.

There is a copy of the proposed national measures set on your table. **Choose at least one from HM5-HM8.**

< After some time to consider, ask for feedback of examples >

Performance reporting – Regional project reporting

- How much? (Count)
- How well? (%)
- Any common measures?
- Any additional measures that can apply to your project too?

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Discuss with the rest of your table. Are there common measures?

Indicate on your sheet which measures can be collected for every project and merged to give a regional result. You may need to adjust your measures to match.

< After some time to consider, ask for feedback of examples >

Performance reporting – MoC reporting

- How much? (Count)
- How well? (%)
- Any common measures?
- Any additional measures that can apply to your project too?
- Do these also capture the MoC outcomes?

Model of Care 1 | Model of Care 2 | Model of Care 3 | Model of Care 4 | Model of Care 5 | Model of Care 6

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Indicate on your sheet which measures capture the outcomes of the Model of Care.

< After some time to consider, ask for feedback of examples >

< The measures matrix is for the project leads to take back to help develop the measures. Team support to take photos of them so that we can see what is being developed. >

Performance reporting – Difference made

- Evaluation template following WG requirements
- Case studies: 2 per 6-month reporting period
  - 1. Service user/patient experience
  - 2. Service delivery/staff experience
- Any time during the half year reporting period
- RPBT can help to develop into a video

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< Click the chicken to play a case study video, approx. 2:30 is likely enough to prove the potential >
https://vimeo.com/849046872

Performance reporting – Timetable

- Jul & Aug: Develop measure definitions and collection processes
- Sep: Live collection of reporting data (and gather historic data?)
- 06/10/23: Measures reported
- 13/10/23: Project evaluations & case studies completed
- 20/10/23: Regional project evaluations completed
- 27/10/23: Model of Care report completed
- 31/10/23: WG submission deadline

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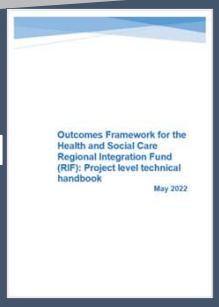
< Slide points first >

October will be a busy period for the performance reporting and evaluation. Case studies can be written before the end of the 6 months, as long as the 'story' is applicable to that period.

Suggest that case studies are written during months 4 & 5 (videography of selected project in month 6) – ahead of the reporting requirements in month 7. The video link can then be added to the report.

Performance reporting – How

- Case studies: Headings and content guidance provided



- Measures reporting through an e-form

- Evaluations through an e-form or Word template (TBC)

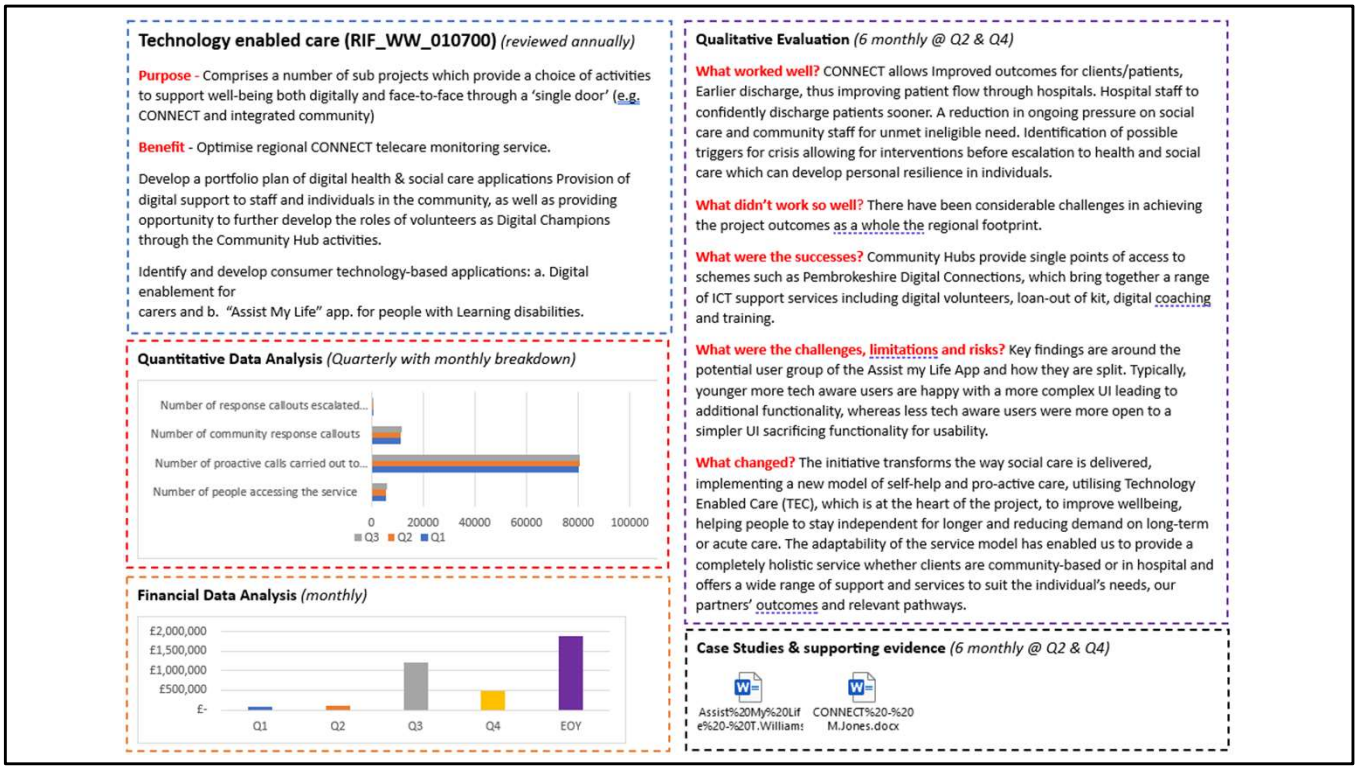
Case studies can be written before the end of the 6 months, as long as the 'story' is applicable to that period.

Suggest that case studies are written during months 4 & 5 (videography of selected project in month 6) – ahead of the reporting requirements in month 7. The video link can then be added to the report.

1. Guidance on the content of the case study is included in the WG Project level technical handbook. A copy will be circulated after this workshop.
2. Measures results will be reported by Snap e-form. Submissions can be saved and completed later.

< Click the eform thumbnail to open in a browser. Use RIF_WW_010700 – Technology Enabled Care Solutions as an example >

3. Qualitative evaluations based on the EOY reporting template will be required. This will only contain the remaining evaluation questions.



This is the sort of dashboard we are working to produce for each project. It will be automatically updated from the submissions through the e-forms. This will be available as a live update for project leads, and any other reporting groups that need access.

Future meetings

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Communities of Practice

Six national CoPs focus on one key area of transformation identified in the national RIF implementation guidance:

- Community-Based Care
- Technology-Enabled Care
- Emotional and Mental Health
- Hospital to Home
- Accommodation-Based Care and Support
- Supporting Families and NEST

Each bi-monthly CoP has 2 key responsibilities:

- To provide a forum where colleagues with enduring interest, experience and responsibility in the subject area from across Wales can meet together, compare learning, and share good practice.
- To support the development and implementation of national models of care and to share learning more widely with colleagues across Wales.

Latest CoP newsletter will be circulated after this workshop, more information and signing up contacts are included.

Communities of Practice – West Wales Regional

- Regional communities of practice for sharing project learning
- Face to face or Teams?
- How often?
  - Reporting cycles support, 6-monthly ahead of WG reporting
  - Quarterly to include sharing learning & case studies
  - More/less often?

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Gauge interest for setting up regular workshops/CoPs

Any remaining questions?

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https://forms.office.com/e/dfynB0Csev