Parliamentary Review of Health and Social Care in Wales

Seamless, community-focused health, social care and well-being for older people in Wales

Key Principles and Features
Seamless, community-focused health, social care and wellbeing for older people in Wales

1 Introduction

This document has been produced as part of the final stage of the Parliamentary Review of Health and Social Care in Wales, and is intended to inform recommendations on how to secure seamless, community-focused health, care and wellbeing services for older people in Wales. It has been developed by the Review Team as an example of what a common set of principles and features might look like if developed 'once for Wales' to inform the development and delivery of local service transformation. The document:

- Focuses on models that are relevant at an operational and locality/hub/cluster level and are concerned with seamless health, wellbeing and social care services supporting and enabling older people to enjoy optimal health, wellbeing and independence.
- Draws on existing good and promising practices in Wales that demonstrate seamless health and social care services and better outcomes for citizens, as well as the evidence from wider research about the factors that are crucial in delivering success.
- Describes the key conditions required for successful delivery, as well as common elements, characteristics or principles of design that enable success.
- Sets out what an older people should expect to experience and expect to see in their locality.
- Is not prescriptive about what a locality or local community is – that is up to agencies to agree. Terms like localities, local areas, hubs and clusters are used in different contexts to describe the kind of boundaries we are thinking of, and indeed there may be arguments that some local communities need not just be geographically based. Certainly however, the emphasis is on local community as opposed, for example, to larger LHB or local authority boundaries.

We have concentrated on seamless locality-based care and support because:

- There is a strong national and international consensus which we noted in our interim report that for people of all ages more effective community-based services, supported by a shift of resources towards early help and support for people in their own home is
achievable, and when well designed and delivered, can improve outcomes and reduce demand for intensive hospital, residential and other substitute care. We want to encourage much greater attention to be paid to delivering on this consensus.

- It is clear from the many exciting case studies we received from different parts of Wales that there are innovative community-based services emerging. However, they are often focused on a single service, profession or condition, and there is frustration that they are not developing fast enough or at sufficient scale. We want to encourage partners to refocus their energies on delivering combined effective services on a health, care and wellbeing perspective – only by doing this will we see the kind of major improvements in quality, efficiency and effectiveness that we need.

We are not proposing that every locality in Wales has an identical range of services or responses to need. This is neither desirable nor achievable – but we do think that by working locally within an overall set of design principles developed ‘once for Wales’. Partners in health, care and wellbeing can deliver care and support for citizens which is evidence-based, and most likely to in achieving better outcomes. We offer here an example for older people’s services, and suggest that there should be related but specific principles for older people, working age adults with disabilities, people with mental health problems and children and young people.

2 A vision for health and social care

2.1 Our vision for local seamless care and support

Our vision is of a revolution in community-based services, supported by a shift of resources towards early help and support for people in their own home. We believe that though this revolution, we can improve outcomes and reduce demand for intensive hospital, residential and other substitute care. There will be different models across Wales recognising the different needs and starting points of different communities, but we would expect them to share some common characteristics. These are described in more detail in the rest of the document, but in summary include:

- Well-run and well-co-ordinated public, private and voluntary services designed around the needs of the local community. Best use of workforce, resources, infrastructure and estate to ensure health, social care and wellbeing support is effective in improving outcomes for the local population.

- Reliable help to navigate the health and social care systems and access welfare, housing, employment and voluntary services to deal with any issue that inhibits maintaining their wellbeing.
- Effective prevention and early help services which ensure that people who may need help are identified, and can get community support, important screening tests, and can access help with medication, domiciliary care and therapies.

- A wide range of professionals working in a multidisciplinary way to support people at home through safe physical and psychological therapeutic interventions in the community.

- Nursing and care homes which provide high quality and flexible respite and long-term care for people who cannot live in their own home.

- Fast and responsive local 24/7 services including intermediate care, ambulance and other rapid response services with the right skills and technology to help where people need urgent care without having to go to hospital, nursing or residential care.

- Easy access to high quality care for patients with complex care needs in the community to take the right action when needed. Specialists in hospitals freed up to advise community colleagues, assess and treat people with specialist needs.

- Best use of technology to improve access to services, reduce the time users have to spend in or dealing with the current system of care, and expand the range of ways in which professionals can spot problems, provide help and share information.

- Best systems and practices of assessment, diagnosis and care planning across agencies to ensure people’s individual needs are understood and met.

- Joined-up training and development for professionals, volunteers and carers promoting generalist skills delivered in the local area.

- Care and support delivered by public, private and voluntary agencies which are so well co-ordinated that citizens experience seamless care.

A key theme of these models is reducing the level of complexity that wastes the time of staff and confuses staff and patients alike. The aim is improved access (including by phone and web) and for those that need it better continuity of care. Teams will develop relationships with hospital specialists that will reduce the requirement for traditional outpatient care and replace this with the ability to get specialist advice and input by phone or video, through e-mail consultation and models in which specialists do teaching sessions to help primary care staff deal with patients with more complex needs. Hospitals and care homes will work more closely with these seamless primary care services and work with them to identify and act to support particular patients or communities. These new arrangements will require rethinking of how acute care is provided and at the same time hospitals will need to consider whether they should be collaborating more between themselves to make the best use of scarce expertise. There is a strong international trend to centralize some specialist services but also to use technology more to spread expertise more widely across networks of hospitals and primary care.

Co-location and close working between health and social care staff will mean that it is possible to mobilise resources much more quickly and easily to respond to crises or get patients out of the hospital and home. Reducing the use of hospital by people who can be cared for
in other ways is usually much better for the individual. This will require changes in working such as the use of single assessment processes, a more proactive approach that anticipates need and uses data to do this and which integrates mental health much more closely into how services are designed and delivered.

A single record will allow people to give access to their data to the professionals that care for them to reduce the gaps and duplications that are too common today and provide a powerful tool to help to predict and prevent problems before they get serious or to respond rapidly if this is not possible. Reducing the hand-offs between professionals will be an added benefit which will improve safety and the patient experience.

2.2 Supporting Policy

To develop this document, we have drawn on key national drivers including Prudent Healthcare, the Social Services and Wellbeing (Wales) Act 2014 and the Wellbeing of Future Generations (Wales) Act 2015 as summarised below.

**Prudent healthcare** describes the distinctive way of shaping the Welsh NHS to ensure it is always adding value, contributes to improved outcomes and is sustainable. Its principles are to:

- Achieve health and well-being with the public, patients and professionals as equal partners through co-production.
- Care for those with the greatest health need first, making the most effective use of all skills and resources.
- Do only what is needed, no more, no less; and do no harm.
- Reduce inappropriate variation using evidence based practices consistently and transparently.

Examples of initiatives include:

- Changing the outpatient model, ensuring it is easier to access specialist advice to support decision-making in primary care.
- Creating person-centred care through meaningful integration with boundaries within and between organisations becoming seamless.
- Development of primary care clusters to better match services to need.

The **Social Services and Well-being (Wales) Act 2014** has the following complementary principles:

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Voice and control – putting the individual and their needs, at the centre of their care, and giving them a voice in, and control over reaching the outcomes that help them achieve well-being.

Prevention and early intervention – increasing preventative services within the community to minimise the escalation of critical need.

Wellbeing – supporting people to achieve their own well-being and measuring the success of care and support.

Co-production – encouraging individuals to become more involved in the design and delivery of services.

The Social Services and Wellbeing Act promotes greater integration between health and social care with requirements for joint working, including for example, developing an understanding of local needs, the extent to which these are being met, and the services required to meet them.

Set around seven wellbeing goals and a sustainable development principle, the Wellbeing of Future Generations (Wales) Act 2015 is about improving the social, economic, environmental and cultural well-being of Wales. It sets out expectations for the listed public bodies to take into account the impact they could have on people living their lives in Wales in the future - bodies must seek to ensure the needs of the present are met without compromising the ability of future generations to meet their needs. In applying the sustainable development principle, public bodies need to demonstrate:

- **Long term**: the importance of balancing short-term needs with the need to safeguard the ability to also meet long-term needs.
- **Prevention**: how acting to prevent problems occurring or getting worse may help public bodies meet their objectives
- **Integration**: considering how the public body's well-being objectives may impact upon each of the wellbeing goals, on their other objectives, or on the objectives of other public bodies.
- **Collaboration**: acting in collaboration with any other person (or different parts of the body itself) that could help the body to meet its wellbeing objectives.
- **Involvement**: the importance of involving people with an interest in achieving the wellbeing goals, and ensuring that those people reflect the diversity of the area which the body serves.
2.3 What older people say they want

We have also considered carefully the views of older people and their families. For example we have drawn on a recent research project which explored what older people felt helped or hindered them as they age recommended a number of themes of relevance here (*Hearing the voices of older people in Wales: what helps and hinders us as we age?* SSIA (2016)):

- Cultural change: how local authorities (Social Services in particular) and other public organisations view and relate to older people – as citizens rather than clients.
- A different form of partnership and collaboration: between and with older people, carers and their families.
- A new social contract: the nature of the relationship between people (older people in this case) and the state.
- Shifting the balance of power: where power does and should reside between older people, local communities and national and local government (and other bodies).
- A more personalised and co-produced approach to adult social services in which the main resources of interest are those held by the individual and the community rather than the state; and
- Redefining roles and responsibilities: between Social Services and other public agencies, voluntary sector organisations, community associations and older people

2.4 Evidence from professionals and leaders

We have also drawn on the evidence we received from a huge range of people in the first part of the Parliamentary Review in early 2017. The interim report of the Panel describes the features of the future shape of care in Wales as including the following:

- Universal primary health services with a proactive approach to preventative care – improving population health.
- Individuals to be supported to self-manage where possible and safe.
- Greater access from care providers to online support, which includes information, consultation, communication, comparisons of quality, appointment bookings, and test results.
- Services provided at home or in the community in the first instance wherever possible. Hospital service restricted to assessment and treatment that only a hospital facility can provide. A more flexible model of home based care and support, which enables the individual to have control over when and for how long they use a service.
- Seamless co-ordination between different types of care; for example, primary and secondary care, health and social care, and mental and physical health.
- A care culture orientated towards the outcomes the citizen wants and can achieve: ‘what matters to me’.
- A relentless focus on quality and efficiency. Services should be more efficiently run and represent good value (quality for the cost).
- Staff should have fulfilled and productive working lives and work towards continuous quality improvement.

2.5 Definitions

Finally, we have gone back to first principles as the basis for defining what we mean by communities, seamlessness, and integration:

**Community** – “a group of people living in the same place or having a particular characteristic in common” (Oxford English Dictionary)

**Seamless from the perspective of an individual** – “I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me” (TLAP/National Voices A Narrative for Person-Centred Co-ordinated Care 2013)

“The essence of integrated care is that individuals received the care services they are in need of when and where they need them. It is care which appears seamless to the service recipients and devoid of overlaps or gaps to service commissioner and providers. It is required when the services of separate agencies and individual professionals do not cover all the demands of the multiple problem service users.” Van Raak, A., Mur-Veeman, I., Hardy, B., Steenbergen, M. and Paulus, A. (eds) (2003) Integrated care in Europe: Description and comparison of integrated care in six EU countries, Elsevier Gezondheidszorg, Maarssen, NL

**Integration** - “Integration is not a matter of following pre-given steps of a particular model of delivery, but often involves finding multiple creative ways of reorganising work in new organisational settings to reduce waste and duplication, deliver more preventative care, target resources more effectively or improve the quality of care.” (Rand Europe, Ernst & Young (2012). National Evaluation of the Department of Health’s Integrated Care Pilots).

3 The document

We hope that this document, as part of the recommendations by the Parliamentary Review will stimulate a leap forward on this agenda across Wales, and that citizens, professionals, leaders and the wider public will take them as a starting point for working together to
secure better outcomes for citizens through seamless, community-focused health, care and wellbeing. The document is based specifically upon work by the Panel between July and November 2017 including:

- An evidence review to understand current good practice (internationally) and from which to develop principles.
- A call for case study examples highlighting current good practice in Wales (Annex 1 refers)
- An expert forum to test and develop the approach
- Wider stakeholder consultation events as part of the Panel’s programme of engagement across the country.

The document proposes an illustrative series of key service features which could be expected within a seamless, community-focused health and social care system, and suggests:

- A summary of the experience older people should be entitled to from a seamless ‘whole system’: “What should I experience”.
- Design principles to guide the development of local services in the next 3-5 years: “What should I expect”
- References to evidence and examples of current good practice and innovation, supported by a final section with submissions from promising examples of emerging seamless services from localities in Wales.
## 4 Seamless and community-focused support and services for older people

### 4.1 Community Based Care and Support

This section describes illustrative key features, design principles, evidence and examples of current good practice, and experience for the older person of services which would be expected within a particular community.

<table>
<thead>
<tr>
<th><strong>What should I experience</strong></th>
<th><strong>What should I expect</strong></th>
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<tbody>
<tr>
<td>I am able to maintain and improve my health and wellbeing with the support of consistent and joined up public health messages and interventions</td>
<td>Health promotion and prevention Consistent and coordinated public health messages and interventions across community and other services</td>
</tr>
</tbody>
</table>
| I am able easily to access information, advice and assistance to enable me to make choices about what matters to me and all aspects of my life, health and wellbeing so I can enjoy life as I get older. I can easily access support to maintain and improve my physical and mental health and wellbeing as my needs change, particularly if I am feeling lonely or isolated. I can contribute to the wellbeing of others in my community and can stay connected to people around me. | Information, advice and support The provision of easily accessible information, advice and assistance that supports people to promote their own wellbeing and manage their own health and care needs  
* A comprehensive multi-platform range of information about local support services for a wide range of support needs including self-referral healthcare services or direct referral through someone involved in my care.  
* Accessible to advice about accessing this information  
* Available in a language of my choice  
Co-ordination of community support Facilitating easy and appropriate access to information and a co-ordinated range of community based support  
* Co-ordinated range of community groups and third sector support  
* Links to Case Finding and Risk Stratification, so community resource can be built around the needs of those whose independence is most at risk  
* Links to health coaching and telehealth vital signs monitoring  
* Focussing on the avoidance of loneliness and isolation |

### Evidence and examples

- Transforming Health Improvement in Wales: Working together to build a happier, healthier future
- West Norfolk – LILY (Living Independently in Later Years) Project
- My Life Website (Suffolk)
- Community Connectors (Parliamentary Review of Health and Social Care in Wales p38)
- Shropshire “People to People” Service
  Predicting and Managing Demand in Social Care, Bolton, J (2016) p12
  https://ipc.brookes.ac.uk/docs/John_Bolton_Predicting_and_managing_demand_in_social_care-IPC_discussion_paper_April_2016.pdf
- Cumbria Partnership NHS Foundation Trust Case Study: “Care Navigators”
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<th>“What should I experience”</th>
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<tr>
<td>Accessible person centred &amp; community focused activities to promote health and wellbeing</td>
<td>Taking asset based approaches, develop a range of accessible befriending, peer support, health coaching and other volunteer/peer support and group opportunities to demonstrate the value of older people’s skills and experiences, supporting older people to avoid social isolation and loneliness, and promote health and wellbeing.</td>
<td><a href="http://www.nhsconfed.org/resources/2016/01/urgent-care-for-older-people-cumbria">http://www.nhsconfed.org/resources/2016/01/urgent-care-for-older-people-cumbria</a></td>
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<tr>
<td>Realising the Value: Making it happen Practical learning and tips from the five Realising the Value local partner sites</td>
<td><a href="http://bristolageingbetter.org.uk/who-we-are/">http://bristolageingbetter.org.uk/who-we-are/</a></td>
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<tr>
<td>Day opportunities</td>
<td>A community resource hub which can be attended by older people for social contact but also to access a range of health and social care support (eg bathing, meals, nail-cutting).</td>
<td><a href="http://www.agewellhwyliogmon.co.uk/index.html">http://www.agewellhwyliogmon.co.uk/index.html</a></td>
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<tr>
<td>A range of social opportunities in community settings</td>
<td>Support to enable people to do what matters to them and continue their social contact in the way they would normally do so including in the language of their choice</td>
<td><a href="https://www.harrow.gov.uk/www2/documents/s109327/Day%20Opp%20App%20TransformationConsultation.pdf">https://www.harrow.gov.uk/www2/documents/s109327/Day%20Opp%20App%20TransformationConsultation.pdf</a></td>
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<tr>
<td>As a carer, I am listened to and feel heard, recognised as an expert about the person(s) I care for.</td>
<td>Carers support</td>
<td><a href="https://www.carersfederation.co.uk/wp-content/uploads/2016/12/Good-Practice-Guidelines-%E2%80%93-Carers-Champions-Dec.-2016.pdf">Central role of Carers’ Centres</a></td>
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<td>I am able to get information, advice and support from local community services when I need it.</td>
<td>A range of services to support carers.</td>
<td><a href="https://www.carersfederation.co.uk/wp-content/uploads/2016/12/Good-Practice-Guidelines-%E2%80%93-Carers-Champions-Dec.-2016.pdf">J Bolton – Managing Demand in Social Care p21</a></td>
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<td>I am able to make an appointment with an appropriate primary health professional in a way that suits my needs.</td>
<td>Accessibility (language, transport options, appointment</td>
<td><a href="https://ipc.brookes.ac.uk/docs/John_Bolton_Predicting_and_managing_demand_in_social_care-IPC_discussion_paper_April_2016.pdf">https://ipc.brookes.ac.uk/docs/John_Bolton_Predicting_and_managing_demand_in_social_care-IPC_discussion_paper_April_2016.pdf</a></td>
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<td>Community and primary health care</td>
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<td><a href="https://ipc.brookes.ac.uk/docs/John_Bolton_Predicting_and_managing_demand_in_social_care-IPC_discussion_paper_April_2016.pdf">https://ipc.brookes.ac.uk/docs/John_Bolton_Predicting_and_managing_demand_in_social_care-IPC_discussion_paper_April_2016.pdf</a></td>
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<td>I will receive support from people with the right expertise and at the right time. I experience support and services as seamless, and am confident that services are working together to support my goals and what matters to me.</td>
<td>- systems, home visits, out of hours services) - Effective triage which directs people to the right professional first time - Continuity of care - Information and choice - Direct access to specialist health professionals without needing to see a GP eg physiotherapists, occupational therapists, audiology, podiatrist, chiropodist, oral health hygienists, advanced nurse practitioners. - Strong communication between primary care clinicians, GPs, geriatricians and secondary care clinicians - Direct access to diagnostic - A multidisciplinary team environment working in a seamless way to support older people.</td>
<td>• RCGP/BGS integrated care for older people with frailty Innovative approaches in practice • <strong>Symphony Programme</strong>: new model of care with an emphasis on person centred, coordinated prevention. Creating team environments where patients will be supported across the team and not simply by registered clinical staff (GPs and nurses). Health coaches and keyworkers are trained to provide relevant and focused support for clinicians and patients. • <strong>Parliamentary Review Call for Evidence</strong>: - Monmouthshire Integrated Services - Healthy Prestatyn / Rhuddlan Iach ( PR website)</td>
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**Digital technology**

A range of digital technologies making access to local primary care (and other) services simpler and quicker. Eg, Online systems for:

• appointments
• repeat prescriptions
• health and wellbeing information
• access to information and guidance

My Health Text System, Caerleon (Parliamentary Review of Health and Social Care in Wales p 49)


**Social prescribing**

Enabling GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services.

• GPs who identify a patient as having non-medical need can refer to a “hub” which can co-ordinate access to a range of resources such as arts; creativity; physical activity; learning new skills; volunteering; mutual aid; befriending; and self-help, as well as support for a wide range of problems including: mental health, employment; benefits; housing; debt; legal advice; and parenting problems.

• Social Prescribing Co-ordinator

Links to “Specialist Information, advice and support” and “Facilitating/co-ordinating community support” (above)

Kings Fund – “What is Social Prescribing”

[https://www.kingsfund.org.uk/publications/social-prescribing](https://www.kingsfund.org.uk/publications/social-prescribing)

Gloucestershire CCG


South Devon and Torbay Social Prescribing


### “What should I experience”
Community Resource/ Multi-Disciplinary Teams
Multidisciplinary groups of health and social care professionals, specialists and generalists, working together to deliver integrated care in the best interests of and in partnership with the individual receiving support
- Integrated, ongoing and proportionate assessment
- Co-located and with organised links to general practice and hospitals
- Multi-disciplinary teams with appropriate specialist input where necessary
- Teams co-ordinate health improvement, care and support with identified sub-population groups based on the health and care needs of the total population and through the involvement of that population in the design of the models and pathways of care.
- General Practice based
- Service user (“Mrs Smith”) as the common focus for service design
- Strong professional relationships, enabled by mechanisms for communication across the primary and secondary care interfaces – collaborative working relationships and ways of working across hospital and community based MDTs

### “What should I expect “
(Design principles for the next 3 – 5 years)

### Evidence and examples
- “Expanded roles for other professional care groups, particularly in the care of people with known chronic or simple conditions”
  (Parliamentary Review of Health and Social Care in Wales p27)
- National Assembly for Wales Health, Social Care and Sport Committee: Inquiry into Primary Care: Clusters October 2017
- LGA/NHS Confederation – All together Now: Making integration happen. p9
  [http://www.nhsconfed.org/~/media/Confederation/Files/Publications/Documents/All_together_now_July2014.pdf](http://www.nhsconfed.org/~/media/Confederation/Files/Publications/Documents/All_together_now_July2014.pdf)
- Parliamentary Review Call for Evidence (see website)
- Monmouthshire Integrated Services
- Gwynedd Integrated Health & Social Care teams
- Bridgend Integrated Care Model (What’s Best for Mrs Jones)
  (Parliamentary Review of Health and Social Care in Wales p37)
- Health Prestatyn Iach
  [http://www.healthyprestatyniach.co.uk/](http://www.healthyprestatyniach.co.uk/)
- Nuka System of Care; Alaska
- Torbay – Integrated Health and Social Care Teams
- Canterbury, New Zealand
| “What should I experience” | “What should I expect “  
(Design principles for the next 3 – 5 years) | Evidence and examples |
|---------------------------|-------------------------------------------------|----------------------|
| Expanded role of community pharmacy services  
Local pharmacy services working with GP Surgeries to provide an expanded range of services including:  
- Common ailments service  
- Medication review  
- Emergency medicine supply  
- Seasonal flu vaccine | “Choose Pharmacy IT application” - Pharmacies providing support and care for people with minor illnesses to free up GP time – Case study: Aberdare.  
http://www.wales.nhs.uk/nwis/page/85219 | |
| My urgent care needs (physical and mental) will be met appropriately so I will feel confident about living independently at home.  
Rapid response  
Services (including out-of-hours) which can respond quickly and appropriately to episodes of health and social care need, and prevent them from escalating to placing an individual’s independence at greater risk  
- 24/7 (or at least extended-hours twilight service)  
- Multi-agency including falls response, community nursing, domiciliary care and provision of community equipment  
- Linked to telecare  
- Working with the ambulance service  
- Intermediate Care responses that are agile and flexibly adapt to changing needs (home based, bed based, reablement and crisis response)  
- Ambulatory Emergency Care – no person with an ambulatory care sensitive condition or at end of life and chosen to die at home, should be admitted to hospital in an unplanned way.  
- Anticipatory care planning – all people on a disease register or with a long term condition that requires active support and management, should have a co-produced (MDT) anticipatory care plan.  
- Advanced care planning – no person with an advanced care plan should be admitted to hospital in an unplanned way. | Kent –Developing an enhanced integrated rapid response service  
Team Bridgend  
Anticipatory Care Planning in Scotland – Health Improvement Scotland | |
| I am able to live in accommodation within my community of choice, and which positively enables me to live independently  
Accommodation  
- A whole system approach to understanding and responding to the supply and demand of accommodation for the local community.  
- A choice of options, all of which are designed to | Planning for the future of older people accommodation in Powys  
Cylch Caron will be a health, social care and extra care resources for Tregaron and the surrounding area. It will consist of a GP surgery, community pharmacy, outpatient | |
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<td>enable independent living, and which sit within local health and social care services.</td>
<td>clinics, community nursing services, long-term care and day care. There are also plans for 34 flats for people who require extra care and support to remain in their own homes and six integrated health and social care places for people who no longer need to stay in hospital, but require more support before they return home, <a href="http://gov.wales/topics/housing-and-regeneration/housing-supply/expert-group-on-housing-ageing-population/?lang=en">http://gov.wales/topics/housing-and-regeneration/housing-supply/expert-group-on-housing-ageing-population/?lang=en</a></td>
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<td><strong>Frailty Service</strong> A system which takes a proactive approach to frailty, proactively seeks it out, making the most of and never missing opportunities to maintain health, wellbeing and independence. Older people should be assessed for the presence of frailty during all encounters with health and social care professionals. A fully integrated, person-centred frailty service based around Locality Hubs, a physical location which will house a multidisciplinary team to provide all assessment and planning, preventive, proactive and reactive care and rehabilitation for an identified cohort of patients; supported by diagnostics, pharmacy and transport services. The use of community and interface geriatrics, urgent co-ordinated social care and the trusted assessor principles to underpin proactive care and support.</td>
<td>• Powys Virtual Ward (Parliamentary Review of Health and Social Care in Wales p37) <a href="https://beta.gov.wales/sites/default/files/publications/2017-07/170714-review-interim-report-en.pdf">https://beta.gov.wales/sites/default/files/publications/2017-07/170714-review-interim-report-en.pdf</a></td>
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<td><strong>Virtual wards</strong> “A virtual ward is a cadre for providing support in the community to people with the most complex of medical and social needs…. (they) use the systems and staffing of a hospital ward but without the physical building…” <a href="https://en.wikipedia.org/wiki/Virtual_wards">https://en.wikipedia.org/wiki/Virtual_wards</a> A GP, district nurse, and social worker meet daily to discuss and assess the patients on the ‘virtual’ ward, with the most appropriate professional attending to them and co-ordinating care with the wider team. The project has led to a 12% drop in emergency admissions to hospitals.</td>
<td>• <a href="https://beta.gov.wales/sites/default/files/publications/2017-07/170714-review-interim-report-en.pdf">West Norfolk Hospital at Home (Virtual Ward) Project</a></td>
</tr>
</tbody>
</table>

I am confident that although I have complex health and social care needs I will continue to receive appropriate and proactive treatment at home.

Virtual wards

"A virtual ward is a cadre for providing support in the community to people with the most complex of medical and social needs…. (they) use the systems and staffing of a hospital ward but without the physical building…”


A GP, district nurse, and social worker meet daily to discuss and assess the patients on the ‘virtual’ ward, with the most appropriate professional attending to them and co-ordinating care with the wider team. The project has led to a 12% drop in emergency admissions to hospitals.

Access to specialist treatments within communities
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<thead>
<tr>
<th>“What should I experience”</th>
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</thead>
<tbody>
<tr>
<td>I am supported to live independently at home through services which monitor my health and wellbeing, and work with me to reduce risk.</td>
<td>Increasing the range of venues at which outpatient consultations/treatments and diagnostics can take place. Improving communication between primary and secondary health professionals Telehealth – “the remote exchange of data between a patient and their clinician(s) to assist in diagnosing and monitoring; typically used to support patients with long term conditions” Telecare – “support and assistance provided at a distance using information and communication technology. It is the continuous automatic and remote monitoring of users by means of sensors to enable them to continue living in their own home while minimising risks such as fall, gas and flood detection and relate to other real-time emergencies and lifestyle changes over time.” (eg Airedale)</td>
<td>consultations and treatments and diagnostics in community settings to reduce pressure in hospitals <a href="http://gov.wales/topics/health/nhswales/about/planned/?lang=en">http://gov.wales/topics/health/nhswales/about/planned/?lang=en</a> • (Parliamentary Review of Health and Social Care in Wales p36) • RCGP Integrated Care for Older People with Frailty – consultant clinics within GP practices: Integrating care for older adults in a remote, rural population – Ullapool, Scottish Highlands • Kings Fund: Co-Ordinated Care for People with Complex Chronic Conditions p5 <a href="https://nhsproviders.org/media/1817/airedale-final-e.pdf">https://nhsproviders.org/media/1817/airedale-final-e.pdf</a> • Parliamentary Review call for evidence – Western Bay Community Services (see website) • New technologies to improve self-management and for remote monitoring (Parliamentary Review of Health and Social Care in Wales p27) <a href="https://beta.gov.wales/sites/default/files/publications/2017-07/170714-review-interim-report-en.pdf">https://beta.gov.wales/sites/default/files/publications/2017-07/170714-review-interim-report-en.pdf</a> • Telehealth at Airedale NHS Foundation Trust <a href="https://nhsproviders.org/media/1817/airedale-final-e.pdf">https://nhsproviders.org/media/1817/airedale-final-e.pdf</a></td>
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<tr>
<td>“What should I experience”</td>
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<td>Evidence and examples</td>
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</table>
| I am confident that I will receive services that focus on maintaining or rebuilding my independence, drawing on appropriate professional skills, and responding flexibly and proactively when I need it to deliver what matters to me. | Intermediate care  
“Intermediate care services are provided to patients, usually older people, after leaving hospital or when they are risk of being sent to hospital. The services offer a link between places such as hospitals and people’s homes, and between different areas of the health and social care system – community services, hospitals, GPs, and social care” (National Audit of Intermediate Care – NAIC)  
- Some intermediate care assessment and interventions need to be carried out while a person still requires a certain amount of personal or health care support. This does not need to be in a hospital but in a person’s home or other suitably commissioned facility, including care homes.  
- People’s ‘ups’ and ‘downs’ are managed flexibly within the community with the use of intermediate care to support core services; ‘stepping up’ care when necessary to support individuals at times of higher need until they return to normal, and preventing deterioration into crisis.  
- During a crisis, the independence of older people will be maintained at home through rapid access (within two hours) to assessment, treatment, care and support. Hospital admission will only happen when clinically needed, not as a result of gap in the care and support available.  
- “Services for people with poor physical or mental health to help them accommodate their illness by learning or re-learning the skills necessary for daily living.”  
- For older people, including those with increasing needs such as frailty and dementia, with appropriate support they will manage better in their own home environment rather than hospital. | NHS England - Integrated Care Pioneer Programme Annual Report 2014 p63  
Built Wells Integrated Health and Social Care Centre – Powys  
National Audit of Intermediate Care (NAIC) NHS Benchmarking Network  
Parliamentary Review Call for Evidence: (see PR website)  
- Ceredigion 3rd Sector Community Resource Team  
- Western Bay Community Services |
| I will receive the same high level of care and support wherever I live. | Enhanced Health Services in Care Homes (EHCH)  
The principles of establishing a successful EHCH care model apply equally to all people living in care homes and those who require support to live independently in the community or who are at risk of losing their independence. The EHCH model aims to ensure the provision of high-quality care within care homes through : | • NHS England “The Framework for Enhanced Health in Care Homes”  
Vanguard Sites eg  
• Connecting Care – Wakefield |
| “What should I experience” | “What should I expect “  
(Design principles for the next 3 – 5 years) | Evidence and examples |
|---------------------------|-------------------------------------------------|--------------------------------------------------|
| I will receive timely help when I want or need it as I near the end of my life, and will be supported to make choices and have control over the care and support I receive, and the setting I receive it in. I will be supported to die at home if that is my choice. | - Putting the needs of the resident or person with care needs at the centre of any changes  
- Working and integrating with local government, the community and the voluntary and care homes sectors to co-design and co-deliver the model of care  
- Acknowledging the value of the care home sector in supporting the NHS and the significant level of healthcare that is delivered in care homes by social care staff  
- Adopting a whole-system approach, breaking down organisational barriers between health, social care and the voluntary sector  
- A focus on quality as the driving factor for change  
- Using clinical evidence to support as well as drive change  
- Strong leadership and a joint shared vision for better care  
- Recognising the cultural differences between organisations and different types of commissioner and provider and focussing on the shared care aims despite differences in language and process. | - https://www.england.nhs.uk/ourwork/new-care-models/vanguards/care-models/care-homes-sites/cc/  
- Newcastle and Gateshead Clinical Commissioning Group  
- Airedale and Partners  

Palliative & End of Life Care  
Principles include:  
The workforce in the community and in hospital settings will be trained to support end of life care.  
Where possible, people in their last year of life will be identified in advance in order to discuss and plan care, including issues such as under what circumstances their treatment should stop.  
A multidisciplinary model of care with good communication between primary and secondary care and with the voluntary sector is essential in end-of-life care to avoid unnecessary admissions and manage discharge from hospital effectively.  

Making our health and care systems fit for an ageing population  
Kings Fund  
Deciding right ‘Deciding right’ is an English north-east regional initiative to help people and professionals work in partnership to make care decisions in advance.  
www.cnne.org.uk/end-of-life-care---the-clinical-network/decidingright |
4.2 Community focused care and support

This section describes illustrative key features, design characteristics, evidence, and experience for the older person of services which would be expected within a seamless, community-focused system but which would not necessarily be located within the community itself. These could be at a local authority, health board, regional or national level but importantly would have a community focus in their design and delivery.

<table>
<thead>
<tr>
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<tr>
<td>I can expect that if something changes I will be able to make a single call to trigger a co-ordinated response from the right person/people to sort out what I need day or night.</td>
<td>Ambulatory Emergency Care (AEC) All patients other than those who are clinically unstable should be considered for AEC as the preferred option. Principles include: • AEC should be available at least 14 hours a day, seven days a week to receive patients directly from the ED and/or primary care. • Selection of patients for AEC should be maximised by: • AEC clinicians undertaking regular board rounds with ED staff to identify patients • There should be immediate access to a senior doctor who is responsible for agreeing the case management plan for each patient.</td>
<td>NHS Improvement : National priorities for acute hospitals 2017 Good practice guide: Focus on improving patient flow July 2017 Hospitals introducing AEC should aim to convert a third of their adult acute medical admissions to ambulatory care episodes.</td>
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<tr>
<td>I know I will be discharged from hospital as soon as is clinically appropriate. I will then be supported to recover in the most appropriate setting with services focused on maximising independence.</td>
<td>The timeframes for initial assessment and medical review in AEC should be similar to those in the main ED. Patients should have access to diagnostics within the same timeframe as other emergency patients.</td>
<td><a href="http://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-discharge-to-access.pdf">http://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-discharge-to-access.pdf</a></td>
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<tr>
<td>I will receive high quality care within an appropriate environment in hospital which supports my recovery and return</td>
<td>Discharge to Recover and Assess pathways (D2RA) and services to support the ‘home first’ principles are the default pathways meaning that all older people will be discharged or transferred when they no longer require medical treatment in an acute hospital. Principles include: Assessment for longer-term care and support needs is then undertaken in the most appropriate setting and at the right time for the person. Daily proactive planning and management will be in place to support a zero tolerance of delays for older people in hospital, eradicating delays that add no value to the patient and their experience. Support to continue recovery will be provided, at home or in an appropriate intermediate care facility to provide the rehabilitation and reablement required to continue recovery, build strength and confidence; and before any decision about longer term support is made. Nobody will be transferred from hospital straight into long-term care (unless this is their usual place of residence, or the placement has been commissioned as a bed based intermediate care solution as a part of the D2RA pathways.</td>
<td>• Kent – Integrated Discharge Team NHS England - Integrated Care Pioneer Programme Annual Report 2014 p64 <a href="https://www.local.gov.uk/sites/default/files/documents/integrated-health-and-care-721.pdf">https://www.local.gov.uk/sites/default/files/documents/integrated-health-and-care-721.pdf</a> • Barnsley Holistic Care Project – Connecting Hospitals to “Integration Hubs” NHS England - Integrated Care Pioneer Programme Annual Report 2014 p12 <a href="https://www.local.gov.uk/sites/default/files/documents/integrated-health-and-care-721.pdf">https://www.local.gov.uk/sites/default/files/documents/integrated-health-and-care-721.pdf</a> • Worcestershire Patient Flow Centre NHS England - Integrated Care Pioneer Programme Annual Report 2014 p149 <a href="https://www.local.gov.uk/sites/default/files/documents/integrated-health-and-care-721.pdf">https://www.local.gov.uk/sites/default/files/documents/integrated-health-and-care-721.pdf</a> • South Warwickshire Discharge to Assess Kings Fund - Acute hospitals and integrated care: From hospitals to health p46 <a href="https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/acute-hospitals-and-integrated-care-march-2015.pdf">https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/acute-hospitals-and-integrated-care-march-2015.pdf</a> • Kings Fund: Co-Ordinated Care for People with Complex Chronic Conditions p5 <a href="https://nhsproviders.org/media/1817/airedale-final-e.pdf">https://nhsproviders.org/media/1817/airedale-final-e.pdf</a></td>
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<td>to the community, and reflects what is important to me.</td>
<td>Strong links with community services and primary health care A culture of reablement within the ward(s) A simple referral system with a single point of access for frail older people. Expert decision makers are available at the front door of the acute hospital from 8am to 8pm, seven days a week. Specialist assessment should be available within 12 hours of admission, seven days a week.</td>
<td>HSJ/Serco Commission on Hospital Care for Frail Older People: Case Studies <a href="https://www.hsj.co.uk/5076859.article">https://www.hsj.co.uk/5076859.article</a></td>
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<tr>
<td>Specialist hospital care “Having a smaller number of larger facilities for some specialised forms of care, which are concentrated together so that expertise and equipment are utilised more effectively, is also a way to improve quality of care. The evidence is strongest for stroke, trauma, and heart attack services, even if this means patients travelling further to receive care. In London, the development of eight hyper-acute stroke units in 2010 led to 168 fewer deaths over a 21-month period.” (Parliamentary Review of Health and Social Care in Wales p32) <a href="https://beta.gov.wales/sites/default/files/publications/2017-07/170714-review-interim-report-en.pdf">https://beta.gov.wales/sites/default/files/publications/2017-07/170714-review-interim-report-en.pdf</a></td>
<td>Kings Fund - Acute hospitals and integrated care: From hospitals to health p21 <a href="https://www.kingsfund.org.uk/sites/default/files/field(field_publication_file/acute-hospitals-and-integrated-care-march-2015.pdf">https://www.kingsfund.org.uk/sites/default/files/field(field_publication_file/acute-hospitals-and-integrated-care-march-2015.pdf</a></td>
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<td>“Age Friendly Hospitals” Hospital systems holistically assess the needs of elderly patients beyond the immediate clinical diagnosis and proactively manage their care to achieve as much recovery and independence as possible within a suitable physical environment and, making links with community services, be discharged appropriately and without delay. “Creating a hospital environment which promotes and preserves independence and dignity for older in-patients.” Key features:</td>
<td>Moving Towards the Age-friendly Hospital: A Paradigm Shift for the Hospital-based Care of the Elderly Allen R. Huang, MDCM, FRCPC, FACP, AGSF, Nadine Larente, MD, FRCP, Jose A. Morais, MD, FRCPC Division of Geriatric Medicine, McGill University Health Centre, Montreal, PQ, Canada DOI:10.5770/cgj.v14i4.8</td>
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<td>“A favourable physical environment Zero tolerance to ageism at all levels of the organisation Integrated processes to identify and manage conditions which threaten independence Assistance with appropriateness decision making Improved links between the acute hospital and community services” (see “Home from Hospital” below)</td>
<td>Examples of this exist for other population groups (Baby Friendly Hospitals and Communities)</td>
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### 5 Enablers of seamless local care and support

This section describes illustrative key features, design characteristics, evidence, and experience for the older person of supporting systems or processes which are crucial to ensuring that a seamless, community focused system works effectively.

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<tr>
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| If/when I am vulnerable due to my health, wellbeing or situation, I am identified at an early stage and suitable support is provided to prevent any risk to my independence from escalating | Targeting inequality of outcomes and prioritising addressing these Early and proportionate assessment and support for people to promote well-being and reduce the need for complex packages of care A system which enables (multi-disciplinary teams of) health and social care professionals to identify and predict which individuals within a given community at highest risk and prioritising the management of their care to promote independence. | • Jönköping County Council, Sweden – using population data to assess health outcomes and plan community (group) based prevention strategies  
• Stockport Targeted Prevention Alliance [https://stockporttpa.co.uk/about-us/](https://stockporttpa.co.uk/about-us/)  
• Birmingham Healthy Villages [https://nhsproviders.org/media/1814/birmingham-final-p.pdf](https://nhsproviders.org/media/1814/birmingham-final-p.pdf)  
• Kings Fund: Co-Ordinated Care for People with Complex Chronic Conditions [https://nhsproviders.org/media/1817/airedale-final-e.pdf](https://nhsproviders.org/media/1817/airedale-final-e.pdf)  
• Nuka System of Care; Alaska [https://www.kingsfund.org.uk/publications/population-health-systems/nuka-system-care-alaska](https://www.kingsfund.org.uk/publications/population-health-systems/nuka-system-care-alaska) |
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| I experience a single “whole system” service which is focussed on my own strengths and needs whether these are physical or mental. | Care co-ordination and planning  
“Care coordination” is a person-centred, assessment-based, interdisciplinary approach to integrating health care and social support services in a cost-effective manner in which an individual’s needs and preferences are assessed, a comprehensive care plan is developed, and services are managed and monitored by an evidence-based process which typically involves a designated lead care coordinator.” (National Coalition on Care Coordination (2011). Implementing Care Coordination in the Patient Protection and Affordable Care Act [online]).  
- Care Co-ordinators/Care Navigators  
- “Team around the person”  
- Integrated teams offering:  
  - Rapid response  
  - Long-term case management/proactive care  
  - Supporting people to self-manage  
  - A health and social care offer to the whole population | • Kings Fund: Co-Ordinated Care for People with Complex Chronic Conditions p5  
[https://nhsproviders.org/media/1817/airedale-final-e.pdf](https://nhsproviders.org/media/1817/airedale-final-e.pdf)  
• Cumbria Partnership NHS Foundation Trust Case Study: “Case Managers”  
• Greenough Co-Ordinated Care – Case Study  
• Islington – Locality model of integrated health and care  
• Joseph Rowntree Foundation: Tackling Social Exclusion at Local Level;  
• Durham “Big Tent” Event – engaging stakeholders to shape priorities for HWB Board  
• Kings Fund – Population Health Systems: Going beyond integration, care and place based systems of care  
[https://www.kingsfund.org.uk/sites/files/kf/field/field_publi](https://www.kingsfund.org.uk/sites/files/kf/field/field_publi) |
| I am supported to achieve the outcomes I identify as important to me. | Having an outcomes focus  
Development of agreed outcomes for individuals working with them.  
Shared language across health and social care services  
Shared outcomes measures which look at impact of seamless and integrated approaches | • Picker/OU Developing measures of people’s self-reported experiences of integrated care |
| My community and I can and are supported to identify issues that are important to us | Community led approaches  
Communities are actively engaged in shaping priorities for local public services which address local needs.  
“Neighbourhood management is a relatively new approach to improving public services. At its simplest, neighbourhood management is a process which brings local community and local service providers together at a neighbourhood level to tackle local problems and improve local services.”  
Conversations take place with the public at every level on the future of health and social care services to raise awareness, |
### What should I experience

#### What should I expect

* (Design principles for the next 3 – 5 years)

#### Evidence and examples

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| My family, community and I are able to influence the design and delivery of the supports and services in my local area, and more widely. | Coproduction
All planners and providers of services take a co-productive approach to the design, monitoring and delivery of services. All contact with patients/public will include opportunity to feedback on their experience. All professionals will receive training on the principles of coproduction, how to use tools to support this, and how to conduct a co-produced consultation | **Powys Fit for Purpose** [http://www.powys.gov.uk/en/adult-social-care/integration-of-health-and-social-care/promoting-independence-fit-for-purpose/](http://www.powys.gov.uk/en/adult-social-care/integration-of-health-and-social-care/promoting-independence-fit-for-purpose/) |
| I am supported to manage my own conditions and so feel more independent. | Self-care and self-management
*People can play a distinct role in protecting their own health, choosing appropriate treatments and managing long-term conditions. Self-management includes all the actions taken by people to recognise, treat and manage their own healthcare independently of or in partnership with the healthcare system. People feel more confident and engaged when they are encouraged to self-manage by professionals, therefore supporting self-management is key to prioritising person-centred care* [https://www.nationalvoices.org.uk/sites/default/files/publications/supporting_self-management.pdf](https://www.nationalvoices.org.uk/sites/default/files/publications/supporting_self-management.pdf) | **New approaches to measurement and management for high integrity health systems** [BMJ 2017;356:j1401](https://doi.org/10.1136/bmj.j1401) (Published 2017 March 30)
**NHS Wales National Discharge Audit Acute Sites September 2016** |
| I experience seamless services and supports which consistently improve my outcomes. | System leadership
*Place-based leadership, drawing on skills from different agencies and sectors based on a common vision and strategy* (p27) [https://www.kingsfund.org.uk/sites/files/kf/field/file/field_publication_file/population-health-systems-kingsfund-feb15.pdf](https://www.kingsfund.org.uk/sites/files/kf/field/file/field_publication_file/population-health-systems-kingsfund-feb15.pdf)
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<td>improve health and social care outcomes</td>
<td>Evidence based health and social care commissioning</td>
<td>• Quality Care for Older People with Urgent and Emergency Care Needs: Silver Book</td>
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<td><a href="http://www.nhsconfed.org/~/media/Confederation/Files/Publications/Documents/All_together_now__July2014.pdf">http://www.nhsconfed.org/~/media/Confederation/Files/Publications/Documents/All_together_now__July2014.pdf</a></td>
<td>Health and social care commissioners and those responsible for commissioning support arrangements must always reflect a joint approach across all disciplines which takes account of the multi-disciplinary nature of care for and working with older people. Commissioners should ensure that all providers of acute or emergency care for older people conduct audit against the standards set out in the Silver Book as well as participating fully in all relevant national audits (e.g. stroke, hip fracture, dementia, fall and bone health, continence) Planning and commissioning of services should be based on a robust understanding of local populations and their health and care needs.</td>
<td>• National Assembly for Wales Health, Social Care and Sport Committee: Inquiry into Primary Care: Clusters October 2017</td>
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<td>Workforce planning and development</td>
<td>Quality Care for Older People with Urgent and Emergency Care Needs: Silver Book</td>
<td>• WHO 2010 Assessing Future Health Workforce Needs – Policy Summary 2</td>
</tr>
<tr>
<td>❧ There is a shared understanding of the workforce needed locally to deliver seamless, placed health and social care.</td>
<td></td>
<td>• WG Shaping a workforce to serve the people of Wales Griffiths &amp; Middlemas</td>
</tr>
<tr>
<td>❧ Service and workforce planners work with clinical leaders to agree who is best placed to provide care at a particular time in a patient’s journey, enabling skill mix changes and integration between professions. This will ensure that individual staff only do what only they can do. Professional demarcations and boundaries will be redefined resulting in less duplication of, improved continuity of care and reduced risk to patients.</td>
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<td>• Jonkoping in Sweden – first year of generic training across professional roles.</td>
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<td>❧ There will be the promotion of rotas across sector boundaries so professionals working in different settings and organisations understand cultural differences and promote integration.</td>
<td></td>
<td>• National Assembly for Wales Health, Social Care and Sport Committee: Inquiry into Primary Care: Clusters October 2017</td>
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<tr>
<td>❧ Improved integration will mean that staff from different disciplines and services are working together more effectively in multi-disciplinary and multi-agency teams. This will mean the skills, competencies and experience of staff are being used in the most effective and efficient way resulting in a more prudent use of the workforce</td>
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<td>❧ There will be an element of shared training within all professionals across organisations, agencies and sectors to</td>
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<td>Creative use of estates  Making more flexible use of existing buildings within a community from which to provide an expanded range of services eg:  • Care homes offering day services  • Care homes/day centres acting as a venue for health/wellbeing activities provided by visiting professionals  • Scoping all estates within an area to assess potential for new/different use to support model of care.</td>
<td></td>
<td>• Kings Fund: Co-Ordinated Care for People with Complex Chronic Conditions p5  <a href="https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/co-ordinated-care-for-people-with-complex-chronic-conditions-kingsfund-oct13.pdf">https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/co-ordinated-care-for-people-with-complex-chronic-conditions-kingsfund-oct13.pdf</a>  • LGA/NHS Confederation – All together Now: Making integration happen. p9  <a href="http://www.nhsconfed.org/~/media/Confederation/Files/Publications/Documents/All_together_now_July2014.pdf">http://www.nhsconfed.org/~/media/Confederation/Files/Publications/Documents/All_together_now_July2014.pdf</a></td>
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<tr>
<td>I do not have to repeat my story to different professionals and am confident information about me is available to the different professionals I come into contact with.</td>
<td>Shared information systems  &quot;Information sharing that supports the delivery of integrated care, especially via the electronic record, decision support systems, systems to identify and target 'at risk' patients at an early stage“  <a href="http://www.nhsconfed.org/~/media/Confederation/Files/Publications/Documents/All_together_now_July2014.pdf">http://www.nhsconfed.org/~/media/Confederation/Files/Publication s/Documents/All_together_now_July2014.pdf</a>  Develop methods for patients/carers to track the co-ordination of their care, and be an active part of care co-ordination.</td>
<td>• LGA/NHS Confederation – All together Now: Making integration happen. p9  <a href="http://www.nhsconfed.org/~/media/Confederation/Files/Publications/Documents/All_together_now_July2014.pdf">http://www.nhsconfed.org/~/media/Confederation/Files/Publications/Documents/All_together_now_July2014.pdf</a></td>
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"What should I experience" | "What should I expect" (Design principles for the next 3 – 5 years) | Evidence and examples
--- | --- | ---
 |  | • WCCIS – Powys, Ceredigion and Bridgend (Parliamentary Review of Health and Social Care p50)
http://www.wales.nhs.uk/nwis/page/66175
• Integrated Digital Care Record & Person Held Record
• Shared Record ‘Health One’ – Canterbury District Health Board, Canterbury, New Zealand.
Annex 1 – Models of Care: Call for Evidence

A ‘call for evidence’ was issued in July 2017 across the health and care sectors in Wales to gather examples of ‘models of care’ to inform the final phase of the Parliamentary Review of Health and Social Care. The submissions received are all available at https://beta.gov.wales/review-health-and-social-care under ‘Call for Evidence’.

We received a broad range of examples on the template provided, many of which demonstrated evidence of some elements of the principles referred to above. However, four in particular were considered by the panel to be most aligned with the principles outlined in recommendation 3 of the final report of the review, “Bold New Models of Seamless Care- national principles, local delivery”.

i) Monmouthshire Integrated Services;  
ii) Western Bay Community Services;  
iii) Bridgend Adult Community Services;  
iv) Healthy Prestatyn Iach.

The full submission of these is included below.
i) Monmouthshire Integrated Services

1. Please provide a description of the model and an indication of the difference from what was done before.

The model is predicated on three hubs providing integrated services to the population of Monmouthshire under single management agreements.

Each hub as one Integrated Services Manager and they are responsible for delivery of services across health and social care. The teams comprise Community Nurses, Chronic Condition Nurses, Occupational Therapists, Physiotherapists, Social Workers, relevant support staff and Direct Care staff (providing services across reablement, dementia care and long term care).

The delivery model varies in each hub depending on previous service developments, for example one hub has rehabilitation beds and one hub has an in-patient ward.

Prior to the development of the model; services were managed separately under different management structures, referrals, service delivery and performance was managed independently and referrals were passed between different service areas each with their own criteria etc.

In this model “a referral” comes into the team and “the team” provides whatever support / intervention is required - there is no requirement for referrals to be made between team members.

2. What is the scale of the project including numbers of citizens and staff involved? How long has it been in place?

The model covers all of Monmouthshire from an adult physical perspective i.e. everyone over the age of 18 years. Population of Monmouthshire is approximately 93,000; number receiving intervention is varied but usually in the region of 2,000 people.

It currently does not include Older Adult Mental Health and Learning Disabilities; mainly because there are alternative partnership arrangements across the organisations.

All other staff from health and social care specific to Monmouthshire are included in the model (as described above).

The model has been developing for over ten years.

In the first instance, Occupational Therapy services were integrated – Occupational Therapists from community hospitals, reablement and long term intervention (traditionally Community OT’s with social Services) were integrated into one team. The outcome being that referrals...
or “hand offs” were not required. Prior to the integration there was significant duplication, people being serially assessed by siloed services and being handed from one team to another.

Following this further integration started approximately six years ago with a single manager structure and included nurses, social workers, physiotherapists and all support staff.

“Direct Care” was included into the integrated hubs at the beginning of 2017.

3. Please outline the specific involvement of primary, social, community, and acute care services including the independent sector.

We have bulleted below some of the involvements that we have across sectors to support the model;

- The ISMs are responsible for the Discharge Liaison Nurses (DLN’s) in the acute hospitals and have the autonomy to progress discharges for residents of Monmouthshire e.g. starting care packages, referring for rehabilitation or community beds. They highlight those that require assessments from specific professions. They have access to and record on the Local Authority system and so are aware of any existing / past involvements. They operate a “pull” model and so have an overview of all Monmouthshire admissions as opposed to waiting for a referral from the wards, this means that they have a pro-active approach and can commence discharge planning as soon as is possible.

- We are currently undertaking a large piece of work with the Independent Care Sector – “Turning the World Upside Down” which is focussed on developing care plans and the delivery of in a person-centred way – with a significant emphasis on the shift from transactional to relationship based care. We have been working closely with the independent sector to look at co-ordinated “cluster” based working to improve service delivery but also to share the hubs as a base for all staff across all organisations

- We work closely with the voluntary sector, in some areas they are based within the hubs. The voluntary sector “hosts” our community connectors (ICF funded and jointly managed). The voluntary sector takes on the role of the recruitment and co-ordination of volunteers both in the hubs / wards and in the community. They are a significant element of the Multi – Disciplinary teams; attending weekly MDT’s to identify people / carers who may benefit from their input.

- We work closely with OAMH – in one hub there are mental health staff based in the hub and managed by the ISM, in two of the hubs memory clinics are carried out there and the value of the co-location is apparent. We are making incremental shifts towards working with OAMH, improving links and making future plans for further collaboration. Memory clinics are based in all three hubs.

- Integrated services do however take referrals and support significant numbers of people who have mild to moderate cognitive problems.

- We work closely with the NCN leads, collaboratively doing the annual plans and are key partners at the meetings, we are an integral part of the management meetings, influencing and contributing to the service needs and developments for Monmouthshire, for example; pulmonary rehabilitation, identification of appropriate “hot” clinics in the hubs, evaluating the medical model provision.
for Monmouthshire with a view to furthering an integrated approach to medical provision across primary / community / rapid response

- Place based cluster work – we are working closely with MHA and the 3rd sector to develop a place based approach to communities with a focus on housing and well being
- We have regular meetings with practice managers from GP services to ensure that practice and developments are supportive of each other.
- We have not included working closely across health and social care as that is the model in which we operate.

4. How have you involved service users in the development/delivery/design/evaluation of your service?

Service users were asked during a significant piece of work approximately five years ago what was important when engaging with “health and social care”. The areas that were predominant were that they wanted it to be easy to access, not be passed from pillar to post (“do you not talk to each other”) and to be listened to as in what was important to them. We designed a set of principles for the service based on the person, staff and service delivery.

Direct Care services consultation – meetings with people (service users and carers), we asked them what they wanted from a service – people’s desires were primarily – competency, consistency and reliability

We have held several consultation and community engagement events across the hubs particularly in Mardy Park, Abergavenny. In Monmouth, we have two active groups; Monnow Vale service Users Focus Group and Friends of Monnow Vale.

We conduct on-going research and consultation across a number of forums but predominantly all service provision is based on the personal outcomes of the person as expressed by them.

5. How have you overcome organisational/structural boundaries?

From a frontline perspective, this has been relatively straightforward, the boundaries become less and even non-existent when people are
focussing on doing the right thing.

Organisational boundaries still remain a significant challenge. Each of the ISM’s has the budgets from across the organisations but the requirements for accountability remain the same. We have to work across two organisational services with regard to HR, finance, policies / procedures etc.

Where we have had the delegated operational line management responsibility this has been very enabling, in some areas this has been delegated in its entirety and enables us to develop services in line with the model e.g. therapies and social work.

In some areas particularly nursing it been very complex to disaggregate the operational management from the central control mechanisms.

Changes in senior management and structures has been a compounding factor, a locality structure from a health perspective was more enabling – success being reliant on developing relationships based on trust and respect whereby in a centralised structure this is more challenging.

Robust governance and operational arrangements are essential to integrated services with clear understanding of responsibilities.

6. How have you overcome workforce barriers?

There have been no significant workforce barriers to be overcome from a frontline perspective. We have teams doing the same job and employed by different organisations with very little problems.

Monmouthshire is unique – integration is key and has been predicated upon the single line management structures which complement each other i.e. operational and professional

Moving from a specialist service across professionals to a generalist service provision has been a culture shift across services, the expectation is that all staff will have competencies in general multi professional skills whilst retaining their own specialism e.g. a social worker doesn’t need to ask a therapist to get involved if someone needs a commode, they are able to do themselves.
All staff assess individuals through a person centred holistic lens as opposed to a linear profession centred lens. Professional lead enables you to support the practice shift and operational enables you to implement.

Introduction of single IT and assessment process that is used by all has supported the integration, collaboration and taken down barriers around differing expectations.

7. What do you measure – what does it tell you?

We collect the measures depicted by respective organisations PI’s e.g. residential beds, care hours,DTOC etc. Measures that we collect specific to Monmouthshire are:

- Predominant measure is “individual’s personal outcomes”. Personal Outcomes are identified by the individual and scored and documented on the system. This indicates if a person has improved and is able to do what is important to them. We have done a lot of work on identifying personal outcomes and moving away from functional outcomes i.e. “I want to walk the dog” as opposed to “Mr M wants to be independent in mobility”.
- We measure “hand offs” to ensure that people are not been moved between services unnecessarily and they are being supported in a consistent way
- We measure a variety of things that evidence the impact that reablement has on individuals e.g. how many people are independent and managing alone after reablement
- We measure staff satisfaction – 1:1’s, appraisals, events activities, breakfast clubs, DIDDIB (doing it different, doing it better – staff events to talk, share, test, reflect) staff surveys – “shoe ‘o’ meter”

- We contact people back who have been “Fished” (described in No. 11) out to make sure they were able to find their own solutions
- We measure the number of people who don’t go onto allocation due to the quality of the conversation in FISH
- Service user satisfaction questionnaires
- Impact of preventative model
The organisations particularly health measure – everything

8. What are the improvements to quality?

- The emphasis on person-centred care, this is predicated on individuals having choice and control, we aim to do “with” and not “to” people, practice is relationship based.
- Other improvements are; consistency, continuity, easy access and where necessary immediate access.
- Staff – increased awareness of the roles of others, individuals having a broader skill base. The teams as a whole have responsibility for managing any issues, this is a collective responsibility.
- Staff are happy, creative, innovative, independent
- Service improvements – small waiting lists (at certain times no waiting lists), good DTOC figures, pull model (we go into the acute hospitals and manage our own discharges), personal outcomes, meeting the requirements of the Act.

9. What are the improvements to outcomes?

Same as above.
What integration has done is enable us to have consistent approach and consistency across service – principles are adopted by all staff

10. How are the developments funded, e.g. new project funding, mainstream, reallocation of resources?

All of the above;
Existing mainstream budgets
Frailty monies
ICF monies

11. How do you assess the impact on the wider system/demonstrate the value – what have you been able to stop doing?

- We introduced a FISH (Finding Individual Solutions Here) five years ago whereby we disconnected from other call centres and
directed everybody through this route. FISH can be accessed by anybody and is “manned” by the integrated team. There is fishbowl in each of the hubs. The model is that people can access a professional directly for advice, signposting, solutions or intervention which may be urgent or otherwise. Previous to this, referrals were taken by a variety of routes contact centre and all were passed to the individual teams and all resulted in assessment, time frame dependent on perceived urgency, duplication. The outcome was unnecessary assessments, delays, increasing dependency on services and judgements on the urgency of requirement based on the quality of the referral as opposed to the actual. This model has reduced the number of assessments by approximately 70%; waiting lists are not non-existent but are usually in their 10’s as opposed to being in their 100’s as was previously the case.
- Pull model
- In take model 72% of people are independent after reablement – reduced or delayed dependency on social care
- Referring between professionals – walk over to a nurse and ask her for help
- Reduced residential placements – able to manage complexity in community
- Direct access to all resources for rapid response

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<th>12. To what extent have the principles underpinning the Social Services and Wellbeing Act and Prudent Healthcare informed the model?</th>
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<td>The principles that we had developed five years ago, very much fitted with the above and so we were then able to use them to underpin our work – we had already started on FISH, personal outcomes, “with and not to” but these have given us significant leverage with staff and organisations to try and support the model.</td>
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<th>13. What lessons have you learned from implementing your model?</th>
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| - It’s very hard swimming against the current
- Organisations are very complex and when you are working differently to others it can be very challenging – we have learnt that sometimes you have to be the square peg in a round hole – you can’t count things in the same way as everyone else! Everyone else counts in silos’
- Integrated single management structure is vital with delegated professional responsibilities
- Co-location is essential to delivering integration
- We have learnt that for the people we are serving and for staff it is so much better and so much easier – they have everything they need in one place. |
14. Is there anything else you would like to add?

I think it is useful to add the barriers or things that impact on continuing the changes / improvements – some of which has already been described in the report;

1) Problems with the care market from an independent sector perspective – particularly in rural areas such as Monmouthshire. We have had significant problems as a result of this which impacts on how long people have to stay in hospital and how many people are delayed in accessing reablement because those receiving reablement who will require longer term support, we have not been able to access
2) Culture shift in other areas e.g. acute hospitals – admitting people who don’t necessarily require hospitalisation
3) Resources – the increase in numbers of people requiring support and also the complexity, capacity is often compromised
4) Continuing Health Care – silo service which isn’t compatible and goes against the ethos of integration

Future Vision - Services need to be configured around a specific population – we need to think about what does that look like from a management / operational perspective??

15. Please provide contact details for someone who could provide further details if required.

Colin Richings
Integrated Service Manager, North Monmouthshire
colinrichings@monmouthshire.gov.uk
Tel: 07786 702753
ii) Western Bay Community Services

2. Please provide a description of the model and an indication of the difference from what was done before.

One of the main, and quantifiable, pressures on current services arises from the growth in the number of people who are frail. People who are frail are also typically, though not exclusively, old and many will therefore have dementia. Identifying the potential impact on services, and resource use, from this group of people, and then focussing our efforts on meeting these needs differently through an enhanced intermediate, integrated health and social care model is therefore vital.

Working together AbertaWe BroMorgannwg University Health board, (ABMU HB) the City and County of Swansea (CCoS), Neath Port Talbot County Borough Council (NPT CBC) and Bridgend County Borough Council (BCBC) have developed integrated community services to tackle these pressures.

The new model of integrated intermediate services provides a number of functions:
The integration of health and social care is making a significant contribution to the wider health and social care community as a result of the joint commitment delivering improved community services enabling:

- Support for people to remain independent and keep well;
- More people to be cared for at home, with shorter stays in hospital if they are unwell;
- A change in the pathway away from institutional care to community care;
- Less people being asked to consider long term residential or nursing home care, particularly in a crisis;
- More people living with the support of technology and appropriate support services;
- Services that are more joined up around the needs of the individual with less duplication and hand-offs between health and social care.
social care agencies;
- More treatment being provided at home, as an alternative to hospital admission;
- Services available on a 7 day basis;
- Earlier diagnosis of dementia and quicker access to specialist support for those who need it.

This means that we are now delivering:
1. Services that support people to remain confident independent and safe in their own homes for as long as possible and in accordance with their dignity and choice.
2. Services that are coordinated to reduce the number of unplanned admissions into hospital and long term care and support timely discharge when a hospital admission is appropriate.

In time this work will result in realignment of capacity, and a shift of resources, into community services to enable more people to receive the right assessment and service in the setting most able to meet their needs.
Two overlapping principles are central to helping us deliver our vision:

*Asking and acting on “What matters to you?”*

2. What is the scale of the project including numbers of citizens and staff involved? How long has it been in place?

ABMU HB, City and Council of Swansea, Bridgend County Borough Council and Neath Port Talbot County Council formed Western Bay Community Services in 2015, taking a whole systems approach to transformation of Health and Social care, and as such is still evolving.

Frail over 65 population, 2012-2016, based on Clegg prevalence estimates, adjusted for projected future changes in the burden of
healthiness and compared to 2012 levels

The projection data produced by Daffodil indicates that in 2020 in Western Bay:
• The projected population of people aged 65 and over will be 111,070
• 45,720 (41.2%) people aged 65 and over will be unable to manage at least one domestic task on their own. Tasks such as cleaning floors using a vacuum cleaner, household shopping, opening screw tops.
• 20,598 (18.5%) people aged 65 and over unable to manage at least one mobility activity on their own. Activities such as: getting in and out of bed, walking up and down stairs and going outdoors and walking down the road.
• 37,378 (33.7%) people aged 65 and over unable to manage at least one self-care activity on their own. Selfcare includes: taking medication, dressing and undressing, able to wash face and hands.

Staffing levels are on target to meet the projections set out in the Business case.

3. Please outline the specific involvement of primary, social, community, and acute care services including the independent sector.

Each part of the pathway is supported by a multi-disciplinary – cross sector team from Health and Social care with the most appropriate professional supporting individuals/families as required.

**Common Access Point**
Access via one contact number, on the basis of that conversation, either they are offered a rapid response, advice and information or signposting, including third sector, where appropriate. Where applicable, a proportionate assessment will be undertaken to access the most suitable response or intervention.

**Rapid Response**
The rapid response service is available through a rapid clinical response (doctor, nurse and/or therapist). The response will be within 4 hours between 8am and 8pm. The main intention of rapid response is avoiding admission where appropriate or expediting discharge.

**Access for people with Dementia**
A rapid response access pathway for a person with dementia that needs support from a mental health professional during a crisis.
**Step-up/Step-down Assessment**
A package of care lasting up to 6 weeks, commonly in an individual’s usual residential setting, which provides care and support to maximise independence. This would normally be offered where support is needed to avoid hospital admission, or when someone needs intensive support upon discharge from hospital.

**Reablement**
Reablement focuses on helping people to regain skills that they may have lost, due to hospital admission or illness. A package of care lasting up to 6 weeks which may include both health and social care interventions to address the client’s individual needs.

**Third Sector Brokerage**
A third sector representative who operates as part of a Common Access Point to provide alternative solutions where statutory support is not needed.

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4. How have you involved service users in the development/delivery/design/evaluation of your service?

The Western Bay Regional Citizens’ Panel was established in 2016 with the aim of providing a strong strategic voice for stakeholders, offering a greater awareness of and involvement in the Western Bay Programme’s activities and a clearer understanding of how organisations can work collaboratively to deliver against the requirements of the Social Services and Wellbeing (Wales) Act 2014.

Panel membership is drawn from the mailing lists of the three Councils for Voluntary Services in Bridgend, Neath Port Talbot and Swansea. Membership is ‘fluid’, ensuring meetings and any engagement activities are open to all interested parties.

This approach was favoured by those who attended the first panel meeting in February 2016, who felt it embodied the spirit of the Social Services and Well-being (Wales) Act’s principles around offering ‘greater voice and control’.
During a workshop session held at the first meeting of members agreed that three sessions per year would be adequate, although additional meetings could be scheduled should the need arise.

The panel is also keen to engage virtually when this is appropriate (e.g. participation in online surveys, consultation activities, etc.)

Meetings generally include a short presentation on a Western Bay’s programme of work, workshop allowing panellists the opportunity to share any comments co-productively with citizens to service users and carers remain at planning and delivery.

Meetings generally particular aspect of and an interactive opportunity to share any comments co-productively with citizens to service users and carers remain at planning and delivery.

The Western Bay Regional sessions are delivered in Health Social Care and Well-being Council for Voluntary Services, and Bridgend Association of

The Western Bay Regional sessions are delivered in Health Social Care and Well-being Council for Voluntary Services, and Bridgend Association of

A service user representative elected by the panel also attends Regional Partnership Board meetings to feed in the views of members. A support representative will also be elected in September 2017.

5. How have you overcome organisational/structural boundaries?

There are a series of sub groups who manage and monitor aspects of the service with representation from across ABMU HB, CCoS, NPT CBC and BCBC. Each group reports to the Community Services Board, Chaired by the Head of Adult Services in CCoS and in turn this
6. How have you overcome workforce barriers?

The individual areas across Western Bay review the staffing requirements working across Health and Social care.

The operational sub group have reviewed work force needs and work with the workforce development group to ensure Community Services are able to review and progress recruitment as required; again there is representation from the Western Bay community services on the workforce planning and development group, ensuring a clear link to service capacity and demand.
A number of staff engagement workshops have taken place to take on board the views of staff and a further workshop to explore issues and also to demonstrate actions, against some areas that were raised in earlier workshops, is due to take place in September.

Different organisations have different terms and conditions and for some staff groups this has been an issue that needed to be addressed; for example, OT and care assistants can be employed by either organisation.

Work to align shift patterns is underway in some areas for care staff; for example, in Swansea, a market supplement has been attached to the Local Authority Occupational Therapy posts so they are now matched to similar Health posts; this was done to support recruitment and retention.

7. What do you measure – what does it tell you?

The key features of the optimal model are tracked from baseline for each area and key performance measures are reported to the performance sub group on a monthly basis and back to the Community service board quarterly

- Emergency Unscheduled Hospital Admissions 65+ and 75+ Month by Month comparison between 2014—2017.
- Hospital Admissions Rates (>75) Per 1000 Population between April 14—April 17
- Emergency Unscheduled Hospital Admissions (>75) Patients between April 14—April 17
- Total Bed Days Consumed (Age 75+) originally admitted as an unscheduled care medical admission April 2014—April 2017
- Emergency Unscheduled Hospital Admissions 65+ and 75 Month by Month comparison between 2014—2017
- Total Number of People Support In a Care Home Aged 65+ between 2015—2017.
- Total Number of New Care Home Admissions Month by Month Comparison between 2014—2017
- Care Home Admissions aged 65> between April 2014 and April 2017
- Total Number of Funded Continuing Healthcare (CHC) new starters April 2015—Month 2017
- Total Number of people supported By CHC April 2015 — Month 2017
- Total Number of Funded Nursing Care (FNC) new starters April 2015 — month 2017
- Total Number of people supported by FNS April 2015—month 2017
- Total Number of New Domiciliary Care Starts aged 65+, Quarter by Quarter comparison 2014—2017
- Average Domiciliary Care Hours per Client Per Month between April 2014—April 2017
- Total Number of Domiciliary Care hours provided between April 2014 and April 201
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## Common point of access:

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### Access for people with dementia (recently added to scorecard)

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<td>Number triaged out (no further investigation)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Number signposted to other services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of referrals that declined an assessment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of open cases</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

As services evolve and become embedded so the scorecard develops to capture key aspects of delivery.

A recent independent evaluation of the service (Cordis Bright 2017) is extremely positive. The analysis suggests that the Western Bay community service is performing effectively in a number of areas; the report further suggests investment in intermediate care services should be continued.
Unscheduled hospital admissions of those aged over 65, Bridgend:

Unscheduled hospital admissions of those aged over 65, Neath Port Talbot:
The report highlights costing savings, of an estimated £4.9m through reductions in use of hospital beds, home care packages and care home placements; also in excess of £769k due to reductions in unscheduled admissions for people 65+. These are all conservative estimates as robust data from Swansea had not been available; this is being addressed and will be forthcoming going forward.

8. What are the improvements to quality?

Bob’s Story:
Bob is 76 and lives in the Clase area of Swansea. Thanks to the work of the Acute Clinical Response (ACR) service, he was able to be discharged from hospital early and continue to receive his treatment in the comfort of his own home.

Click here to view Bob’s story on ‘Western Bay TV’:
www.youtube.com/watch?v=82nyzktUygg

Rena’s Story:
Rena is 93 and lives alone in Llandarcy, Neath Port Talbot. In this clip, her daughter Catherine explains how Neath Port Talbot’s Acute Clinical Team (ACT) helped her mum to avoid an unnecessary hospital admission following a fall in the home.

Click here to view Rena’s story on ‘Western Bay TV’:
https://www.youtube.com/watch?v=hQNzNkKmvM8

Mrs P’s Story:
Bridgend Community Resource Team (CRT)

Mrs P is a 91-year old former Red Crossurse who lives with her son in Bridgend. She was managing well until she suffered a flare up of her arthritis which caused her legs to become swollen.
During this time, she also developed an infection which meant she was in danger of suffering from acute pressure area damage.

When the District Nurses became aware of her situation, Mrs P was referred to the Bridgend CRT. Working together with Mrs P and her son, the Team came up with a comprehensive care plan which allowed Mrs P to be treated in her own home, rather than be admitted into hospital. Arrangements were made for a bed to be brought into the living room and for specialist equipment to be installed in the home to enable Mrs P to get in and out of bed safely. The CRT Nurses, Therapists and Carers all joined forces to support Mrs P through this acute episode, and within 2 weeks she showed real signs of improvement.

To help get Mrs P back on her feet, the CRT’s short term enabling service took over her care and worked with her to improve her mobility and increase her confidence. Specific goals were also agreed, with the help of the CRT Therapist and Support Workers. Mrs P can now move around the ground floor of her home using a walking frame, use the bathroom by herself, and carry out some household tasks that she previously found difficult to manage.

Mrs P was delighted to have avoided a hospital admission and now manages safely in her own home with the help of home care services.
9. What are the improvements to outcomes?

### Summary of evaluation outcomes

*Error! Reference source not found.* outlined evidence of positive outcomes

The table highlights whether data indicates a positive or negative change in an outcome area, and where there is mixed evidence from multiple data sources:

<table>
<thead>
<tr>
<th>Positive change</th>
<th>Negative change</th>
<th>Mixed evidence</th>
<th>No data available</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Evaluation outcome</th>
<th>Positive indicator(s)</th>
<th>Bridgend</th>
<th>NPT</th>
<th>Swansea</th>
</tr>
</thead>
<tbody>
<tr>
<td>More frail and older people are supported to remain independent and keep well, as well as to have improved quality of life</td>
<td>Increased number of Rapid Response clients</td>
<td>✓</td>
<td>✓</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Increased hospital bed days saved by Rapid Response</td>
<td>✓</td>
<td>✓</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Current reablement caseload</td>
<td>✓</td>
<td>✓</td>
<td>•</td>
</tr>
<tr>
<td></td>
<td>Hospital discharges with lower/no homecare packages</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Increased homecare starts</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td></td>
<td>Decreased homecare hours per service user per week</td>
<td>×</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Decreased care home admissions</td>
<td>×</td>
<td>✓</td>
<td>×</td>
</tr>
<tr>
<td></td>
<td>Number of care home admissions avoided</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Increase in the number of older people per 1,000 population supported to live in the community</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Measure</td>
<td>2014-15</td>
<td>2015-16</td>
<td>2016-17</td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>---------</td>
<td>---------</td>
<td>---------</td>
<td></td>
</tr>
<tr>
<td>Self-reported measures through consultation with service users concerning feeling able to live at home independently, feeling safe and well. Impact of services on quality of life</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>More frail and older people to become cared for at home rather than in institutional care, i.e. in hospitals / care homes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increased number of rapid response clients</td>
<td>✓</td>
<td>✓</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Increased hospital bed days saved by rapid response</td>
<td>✓</td>
<td>✓</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Reduction in unscheduled admissions</td>
<td>✓</td>
<td>✓</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Reduction in number of hospital bed days occupied</td>
<td>●</td>
<td>✗</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Reduction in 28 day unplanned care readmission rates</td>
<td>✓</td>
<td>✓</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Increased number of hospital discharges to CRTs</td>
<td>✓</td>
<td>✓</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Increased hospital bed hospital days saved by in-reach</td>
<td>✓</td>
<td>✓</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Increased reablement caseload</td>
<td>✓</td>
<td>✓</td>
<td>●</td>
<td></td>
</tr>
<tr>
<td>Hospital discharges with lower/no homecare packages</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Increased homecare starts</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td></td>
</tr>
<tr>
<td>Decreased homecare hours per service user per week</td>
<td>✗</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Decreased care home admissions</td>
<td>✗</td>
<td>✓</td>
<td>✗</td>
<td></td>
</tr>
<tr>
<td>Increase in number of common access point referrals and assessments (statutory)</td>
<td>✓</td>
<td>✗</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Increase in number of common access point referrals and interventions (Third Sector)</td>
<td>✓</td>
<td>✗</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Number of reablement clients who have gone to bed-based reablement and returned home</td>
<td>✗</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>More older people are being supported to live independently with the support of technology</td>
<td>Increased number of new packages of Assistive Technology</td>
<td>✓</td>
<td>-</td>
<td>✓</td>
</tr>
<tr>
<td>Services users’ individual needs are prioritised in service delivery</td>
<td>Service users and families / carers report that their needs were prioritised</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Project staff are able to articulate how they project prioritises users’ needs</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Service users are supported to receive care in a setting of their choice</td>
<td>Staff and service users report that service users were able to choose where they received care</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Service users are supported to remain independent</td>
<td>Service users and staff report that service users were supported to remain independent</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Service users &amp; families/carers are satisfied with the service</td>
<td>Services have appropriate service user feedback mechanisms and results are positive</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Carers feel supported and satisfied with intermediate care services</td>
<td>Carers reporting they feel more supported and satisfied with the services that the people they care for receive</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Carers reporting that intermediate care services alleviate pressure on them</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Service users are able to access more consistent services across Western Bay</td>
<td>Staff, service users and carers report that services are being delivered in a more consistent manner</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

10. How are the developments funded, e.g. new project funding, mainstream, reallocation of resources?

Integrated services are underpinned by a Section 33 pooled fund agreement between constituent partners, reflecting robust governance arrangements.

Investment in the services is significant on an annual basis from all partners from core funds and is enhanced by Intermediate Care...
Funding which has created an opportunity to accelerate service redesign and develop new ways of working.

11. How do you assess the impact on the wider system/demonstrate the value – what have you been able to stop doing?

The new community service model is delivering positive outcomes, however in terms of transformational change it is still early days.

Given the increasing demographic pressures, and the increasing complexities of need that these pressures create for the system, without investment in the Western Bay community services it is likely that pressures across the system would be much greater.

The original business case outlined how Western Bay partners aimed to achieve both cost avoidance and cash releasing savings through investment in increasing integrated intermediate care services across the region.

Analysis conducted as part of an external independent evaluation, which is likely to be conservative, shows that over the period of the pooled budget (2015 to 2017), intermediate care services in Western Bay may have contributed towards savings of £4,989,691 through reductions in hospital bed usage, home care packages and care home placements. In addition, there may have been in excess of £769,384.00 additional cost savings due to reductions in unscheduled hospital admissions for people aged 65+ in Bridgend and Neath Port Talbot (please note data for Swansea was unavailable).

In terms of a locality analysis the following can be said:

- Bridgend may so far have made £1,962,553 of savings and Neath Port Talbot may have made £4,047,097. However, this does not include potential savings as a result of reductions in acute and post-acute bed use by older people. As a result, actual savings are likely to be greater.

Although investment and savings should be seen as part of a change programme across the whole system, the majority of savings accrue to health in the form of hospital bed days saved. The estimated savings indicate that Western Bay Community Services are playing an important role in managing demand for hospital beds.

(Cordis Bright 2017)
12. To what extent have the principles underpinning the Social Services and Wellbeing Act and Prudent Healthcare informed the model?

Western Bay Community Services through their sovereign bodies deliver their statutory responsibilities determined in the Social Services and Wellbeing Act and reflects the principles of Prudent Healthcare in a number of ways. As outlined previously; these key strategic drivers underpin the integrated way of working, and transformation of services to support individuals; in this case for the frail and elderly.

In terms of the Social Services and Wellbeing Act 2016 Western Bay Community services have transformed services, and continues to do so, across traditional health and social care boundaries; developing integrated services that have made available a range of help within the community to reduce the need for formal, planned support.

- Services are available to provide the right support at the right time
- More information and advice is available
- Assessment is simpler and proportionate – central access point – one point of contact.
- Carers have an equal right to be assessed for support

The principles of Prudent Healthcare are also embedded in the integration of community service working with the public and patients alongside Health and social care professionals and the 3rd sector as equal partners in co-production of services and resources

Community Services actively supports the frail and elderly who are in crisis or need reablement following an episode in hospital; also work with individuals and families to ensure services are enabling and working with rather than people doing to’ embedding the principles of ‘What Matters to me’ Using an integrated approach ensuring staff with the appropriate skillset are working with individuals. Supporting and delivering only what is needed – no more, no less – and doing no harm.

We are working hard to ensure a reduction in inappropriate variation across Western Bay using evidence-based practices consistently and transparently.
13. What lessons have you learned from implementing your model?

One lesson is that transformation of services, and integration across Health and Social services service provision, is not an easy straightforward or quick process. This is not because of a lack of will or enthusiasm; it will take long-term commitment strategically (Nationally and regionally), operationally and financially to realise benefits to patients, carers and statutory services. Once realised the benefits are tremendous as demonstrated by the short selection of case studies attached.

Initially there needs to be strategic ‘buy in’ from Health and Social Care and a willingness to work openly and transparently developing a trusting partnership.

Communication is crucial in any transformation; also an understanding that co-location does not automatically lead to integration; integrating of teams that have historically worked very differently and independently of each other, takes time and effort from all parties.

Agreeing a base line for measurement is vital and understanding the various LA and Health systems and their ability to provide the required data is a consideration.

LA and HBs tend to call different services by different names agreeing definitions very early supports the development of more robust and meaningful measures.

Organisational culture is a significant factor and needs to be factored in as a potential barrier to progress.

14. Is there anything else you would like to add?

15. Please provide contact details for someone who could provide further details if required.
iii) Bridgend Adult Community Services

(NB: this paper is paper 1 of 5. It provides an overview of the services within the Bridgend partnership. Papers 2-5 are available on the Parliamentary Review under ‘Call for Evidence’ (https://beta.gov.wales/review-health-and-social-care)

1. Please provide a description of the model and an indication of the difference from what was done before.

Bridgend Local Authority and ABM University Health Board have developed integrated and joint models and approaches for community services for adults, based on pre-emptive early interventions, to ensure that people receive timely responses that are proportionate to their needs and risks, and that promote through co-produced approaches people’s independence, voice and choice.

In our joint statement of intent in 2014, partners in Bridgend use the following definition, as the basis for understanding what integration actually involves in practice:
‘..an organising principle for care delivery with the aim of achieving improved user and patient care through better coordination of services provided. Integration is the combined set of methods, processes and models that seek to bring about this improved coordination of care’.

The traditional models of service have been through a process of transformation that have evolved into the current approaches, which are consistent with the aspirations of the Social Services and Wellbeing Act and is based on the following:

PREVENTION: Information advice and assistance, including local area coordination

EARLY INTERVENTION: reablement, progression and recovery approaches

MANAGED CARE AND SUPPORT: outcome based approaches to complex and long term care, as well as anticipatory coproduce contingency planning with people and their families.

Throughout Social Services and Wellbeing adult and children services, in partnership with the Abertawe Bro Morgannwg University Health Board, is focused on keeping people as able as possible and resilient to enable them to continue to live independently within their communities and for young people and children to be cared for safety by their families. This approach support the delivery of the Council’s clear vision to deliver “One Council working together to improve lives” and the Primary and Community Services Delivery Unit's

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2 Sara Shaw, Rebecca Rosen and Benedict Rumbold (June 2011), What is integrated care? An overview of integrated care in the NHS Research Report, Nuffield Trust
Directorate Vision: To actively promote independence and choice that will support individuals in achieving their full potential.

This paper will give a high-level introduction to the transformation of adult social care services within Bridgend and the integration with Health Services, and will be accompanied by four papers that will give detailed explanation of the changes that have been made across the service:

- The Common Access Point and Optimum Model for Intermediate Care for Older and Disabled People (Paper 2)
- Integrated Community Networks, and complex long-term and anticipatory care (Paper 3)
- Assisted Recovery in the Community for people living with mental ill-health (Paper 4)
- Bridgend Resource Centre, Joint Learning Disability Services (Paper 5)

Essentially we believe that our success and progress is predicated on taking a whole system approach to changing our services, particularly for those affected by frailty and disability, and in doing so we have reduced duplication in our system, maximised the use of resources, improved our communication and collaboration with social services, health and third sector partners and delivered tangible improved outcomes for people using community health and social care services in Bridgend County Borough.

Our remodelling projects in children’s social care are still developing, we have established a Board which oversees projects including the establishment of a multi-agency safeguarding hub, reducing Looked After children numbers, implementing an early help and permanence strategy, redesigning our residential provision and developing new services for disabled children.

2. What is the scale of the project including numbers of citizens and staff involved? How long has it been in place?

OLDER FRAIL AND PHYSICALLY DISABLED PEOPLE

Following a stakeholder workshop, the Integrating Health and Social Care Programme was established in May 2011 to deliver an integrated approach to the delivery of services for frail and disabled people; a programme of seven projects was established, with an aim of improving outcomes and the quality and timeliness of services, by working across traditional boundaries and in different ways. In scope for this project were all of the traditional local authority services for older and physically disabled people, as well as community nursing staff. From this workshop seven programme projects were agreed, which were as follows:

- The Integrated Referral Management Centre, this is now called the Common Access Point;
- The development of the Community Resource Team;
• Integrated Community Networks Operational Teams, these are now called the integrated community network teams;
• Integrated Long Term Care;
• Integrated Public Health and Prevention Services;
• Locality Networks;
• To review the interface between Secondary and Community based care.

The aim of the programme was to transform services so that citizens (whom we call Mrs Jones) experienced a well-coordinated and planned approach to community health and social care services. The focus of the programme was to develop pathways of care that promoted independence and wellbeing, avoid duplication, unnecessary admission nursing / residential care settings, and /or to hospital, as well as supporting early discharge and independence in the community. The ambition was that these services would aim to support independence, health and wellbeing, and focus on reducing dependency and minimising risk to independence.

The Aims of the Integration Programme:
• To develop an established fully integrated community health and social care services in Bridgend County Borough;
• To keep people (Mrs Jones) independent in their own homes for as long as possible;
• To provide timely responsive and proportionate interventions to prevent avoidable crisis and inappropriate admissions to hospital or long-term care;
• To develop alternative pathways of intervention and support for people affected by frailty or chronic complex long-term conditions, that promote and support their independence;
• To develop interventions that promote independence, and wellbeing
• To offer people a choice and control over their lives, and in the support they receive, and ensure they are treated with dignity and respect and their wishes and preferences are listened to, as are those of their family and carers;
• That the care of people in hospital settings will be for those experiencing acute illness or in need all of medical or other interventions that can only be provided in hospitals;
• To ensure a clear and consistent approach to developing, monitoring and benchmarking of services across the Bridgend health and social care community;
• To ensure resources are utilised efficiently and effectively across organisations.
By January 2013 the following had been established under fully integrated health and social care management: an integrated referral management centre, community resource team serving the whole County Borough, and three integrated community network teams comprising social work, district nursing and occupational therapy, the Network Cluster, and prevention and public health approaches. The Institute of Public Care (IPC) were commissioned by the Bridgend Care Partnership Board in 2013 to carry out a comprehensive review of the strategic directions and key actions for the Partnership to consider in taking forward health and social care integration arrangements over the next three years. This work formed the basis of the completed joint statement of intent on integration required by Welsh Government in January 2014.

In May 2015 the health and social care partnership held a stakeholder workshop to refresh the local and regional joint statements of strategic intent; this was to ensure that developments that had occurred subsequently to the submission of the joint statement intent, would be incorporated into future planning and service development; specifically the requirements of Social Services and Wellbeing (Wales) 2014, and the development of the GP clusters networks.

Integrated community services for frail and disabled people are now well established include the following:

- Common Access Point for all adult social care and community services for frail, older and disabled people
- Community Resource Team Services, including Acute Clinical Team, Reablement, Telecare and Mobile Response; this is a regional approach to intermediate care and subject to a Section 33 with the Health Board (see specific paper on the CRT)
- Integrated Community Network Teams Comprising Social Work, District Nursing and Therapies (see specific paper on the integrated network teams and complex care)
- Underpinned by integrated community equipment services and the extensive rollout of Telecare and 24 hour mobile response services

ASSISTED RECOVERY IN THE COMMUNITY and Mental Health Services

In 2005 the local authority and health board commenced the development of an integrated mental health day opportunities service by amalgamating and reconfiguring previously separate resources provided from the local authority community day services and those at Glanrhyd Hospital. The then new service was called Assisted Recovery in the Community (ARC), to provide integrated Health and Social Care Services for people with more complex mental health needs. Since 2008 the management and development of this service; is subject to a Section 33 arrangement. The services continue to develop and elements of ARC were integrated into the Local Primary Mental Health Service which was established in 2012 with the introduction of the Mental Health Measure for Wales. As a result of these changes between March and October 2013, the Joint Partnership Management group reviewed and updated the Section 33 Agreement to reflect
The assisted recovery in the community service was in response to Welsh Government’s Adult Mental Health Services Strategy along with the National Service Framework (NSF) sets out the direction and standards for Mental Health Services in Wales.

The joint health and social care service ARC (Assisted Recovery in the Community) centre now is a well-established preventative facility for people living with mental ill-health and exist to promote and improve people’s mental well-being. This service supports and empowers people who are experiencing mental health issues to access opportunities in the community. These would include staff support for people to gain employment and education and training. Staff also work with people who have lost daily living skills such as budgeting and the ability to use public transport. The building at ARC is used by many groups as a space to operate support groups. It is used by the Postnatal Response and Management Service (PRAMS) this group provides advice and support for Mums who may be experiencing some ante natal mental health issues; this group is supported by the Genesis project who provide a crèche for this group in the ARC centre. The local Bi-Polar disorder group and the Bridgend Involvement Group (a self-help group to support people with alcohol and substance misuse issues) are two groups among a range of groups that also use the facilities at ARC.

Bridgend County Borough Council takes the lead responsibility for the delivery of the service. The Section 33 agreement is managed by the Partnership Management Group comprised of the Head of Adult Social Care, the Group Manager Mental Health and the General Manager of the Mental Health & Learning Disabilities Directorate of ABMU Health Board. These Officers will report formally to their respective organisations.

The community mental health teams are co-located and have integrated management. The mental health services for older people are also co-located. These teams are specialist secondary services and in the vast number of cases receive their referrals from General Practice. The needs of this client group are complex and generally require a multi-disciplinary team approach.

BRIDGENG RESOURCE CENTRE FOR PEOPLE WITH LEARNING DISABILITIES

Bridgend resource centre (BRC) for people with learning disabilities was established following review of learning disability day services. The core day service at the BRC provides services for people who require intensive support or who have high dependency needs because of their level of disability and/or sensory impairment. The service is delivered through a multidisciplinary team working out of a purpose built facility that has treatment, therapy and activity rooms to support the objective of enhancing the quality of life for users using the core services.
Since 2011, the first floor of the resource centre as being occupied by the joint Community Support Team which consists of a social work and health care team. These teams are made up of qualified and unqualified social workers, therapists, nurses, psychologist and a psychiatrist. The recent reorganisation in ABMU has provided an opportunity to review the joint working arrangements. The centre also provides a base for the Disabled Children’s team and will shortly be hosting a pilot project for a transition Team.

3. Please outline the specific involvement of primary, social, community, and acute care services including the independent sector.

Primary and secondary care services were involved in all elements of the development of the integrated community health and social care services for older and disabled people. When the regional programme of integration and improvement for health and social care was established, the model was enhanced and adopted regionally throughout the ABMU footprint not only in the Bridgend area.

In addition, the new service configuration has supported the development of anticipatory and contingency care planning in coproduction with the community network clusters to benefit individuals.

The mental health and learning disability service are working with Bridgend on local and regional service development plans. These plans involve service users and representatives of the third sector as appropriate.

4. How have you involved service users in the development/delivery/design/evaluation of your service?

People using services and their representatives were involved in the stakeholder events that formulated the development of the integrating health and social care programme for older and disabled people. In the development of the programme there were stakeholder representation on each work stream and there was extensive engagement and communication with the existing planning groups, staff affected by the change, as well as SHOUT, the voice of older people in Bridgend and the Coalition of Disabled People. In developing the regional optimum model for the intermediate tier of the community services programme, there were regional stakeholder and service user consultation and engagement events.

The service modelling, being based locally and mirroring the foot prints of the community network clusters, has enabled closer contact with people living in their locality and improve communication with primary and community services, whether these be statutory and voluntary or universal services.
Service users and carers were involved in the planning for and design of the facilities and services at BRC and ARC and continue to use the facilities for their meetings and activities.

5. How have you overcome organisational/structural boundaries?

There have been a number of approaches to overcoming organisational and structural boundaries these are as follows:

- Senior management commitment and leadership, not to allow organisational structures to impede the integration and delivery of services
- Focusing on our joint vision, ensuring that we had a shared ‘line of sight’, in what we were trying to do and why, for the benefit of the people that we served
- By creating integrated posts from senior management level down
- By setting up Section 33 arrangements where prudent to do so both locally and regionally
- By establishing memorandums of understanding about service specifications and objectives
- By having joint strategic management arrangements
- By having a common understanding that resources are finite and we have an absolute public duty to spend them prudently and wisely.

6. How have you overcome workforce barriers?

In integrating our workforce: we have six fully integrated management roles managing both health and social care staff and the associated resources we did the following:

- We focused on what people did not on what they were paid
- The human resource teams from each agency appointed a lead senior officer
- We developed interagency job descriptions for the integrated management and leadership roles
- In the integration programme for older and disabled people, we developed an integrated approach to teaching leadership and management responsibilities across organisations, developing an integrated leadership programme - which was commissioned after tender from the university of South Wales
- We ensured that the workforce structure was such that people felt professionally confident and safe within the governance arrangements
- In key areas such as human resources, finance and learning and development, ensured that the senior leaders from both
7. What do you measure – what does it tell you?

In core services we measure the following in addition to those measured regionally for the optimum model for intermediate care:

- numbers of people referred
- assessments and reassessments for people and their carers
- respite
- delayed transfers of care

The measurements for our integrated services were agreed jointly as was their interpretation and analysis.

The key features of the optimal model for intermediate care are tracked from baseline and the key performance measures are reported to the performance sub group on a monthly basis and back to the Community service board quarterly for comparison across the Western Bay footprint:

- Emergency Unscheduled Hospital Admissions 65+ and 75+ Month by Month comparison between 2014—2017.
- Hospital Admissions Rates (>75) Per 1000 Population between April 14—April 17
- Emergency Unscheduled Hospital Admissions (>75) Patients between April 14—April 17
- Total Bed Days Consumed (Age 75+) originally admitted as an unscheduled care medical admission April 2014—April 2017
- Emergency Unscheduled Hospital Admissions 65+ and 75 Month by Month comparison between 2014—2017
- Total Number of People Support In a Care Home Aged 65+ between 2015—2017.
- Total Number of New Care Home Admissions Month by Month Comparison between 2014—2017
• Care Home Admissions aged 65+ between April 2014 and April 2017
• Total Number of Funded Continuing Healthcare (CHC) new starters April 2015 - Month 2017
• Total Number of people supported By CHC April 2015 — Month 2017
• Total Number of Funded Nursing Care (FNC) new starters April 2015 — month 2017
• Total Number of people supported by FNS April 2015 – month 2017
• Total Number of New Domiciliary Care Starts aged 65+, Quarter by Quarter comparison 2014—2017
• Average Domiciliary Care Hours per Client Per Month between April 2014—April 2017
• Total Number of Domiciliary Care hours provided between April 2014 and April 2017
• Rapid Response (ACT):

In addition we have developed a regional approach to measuring the impact of anticipatory care planning and have agreed performance data around this initiative across the region. This data and its impact on GP practices in particular is collated and reported at anticipatory care regional steering group.

8. What are the improvements to quality?

• Person centred intervention with proportionate plans of intervention and support, with high levels of people being made fully independent
• Improved access to services and therapies in the community to assist people to achieve what matters to them
• Services that enable people to remain safely in their own homes for as long as possible
• High levels of satisfaction expressed by individuals about the services they receive and low levels of complaints
• Removal of duplication in referral management processes and triaging for proportionate intervention

9. What are the improvements to outcomes?

• Person centred, outcome focused, proportionate plans of reablement, recovery and progression
• Reduction in number of placement days commissioned despite the increasing older adult population and demand for placements
• Reduction in length of stay for people over 75
8.9% less of adults 65+ in core service than five years ago
High levels of people made fully independent by reablement services
9% (LD Register comparison aged 16+: 523 at 31/03/2015 and 475 at 31/03/2017) reduction in the numbers of people in core learning disability services
1153 (167 referrals to Local Community Coordination in 2016/17 and 986 referrals to Assisted Recovery in the Community in 2016/17) people managed by prevention and early intervention services in the community

There are case study examples of quality improvements for individuals in the supplementary papers attached.

10. How are the developments funded e.g. new project funding, mainstream, reallocation of resources?

The transformation of services for frail older and disabled people have been resourced by the realignment of existing budgets and by successful applications to the Integrated Care Fund for the delivery of the optimum model for the intermediate tier across Western Bay

The transformation of services ARC and the BRC have been resourced by the realignment of existing budgets.

11. How do you assess the impact on the wider system/demonstrate the value – what have you been able to stop doing?

We have experienced a change in the composition of people in core services:
- There are less people in the learning disability service and some people now have their personal outcomes met through universal services and social enterprises
- There are less older adults in core services as a result of services that can respond to frailty in older adults
- Increased number of individuals assisted to live at home independently and to have an improved quality of life.
- Reduction in the levels of emergency hospital admissions from community and care homes.
- Reduction in delayed transfers of care from hospital settings.
- Facilitate earlier discharges from hospitals where appropriate.
- Reduction in the need for ongoing and complex packages of care.
- More older people are supported to live independently with the support of technology
- The person, their choice and preferences are at the centre of every intervention, where appropriate.
12. To what extent have the principles underpinning the Social Services and Wellbeing Act and Prudent Healthcare informed the model?

The approach in Bridgend replicates the three pillars of the Social Services and Wellbeing Act: better access to information and advice and universal services, proportionate early intervention, and manage care and support for those who need it. The integration of services has ensured that the principles of prudent Healthcare are applied across community services: an evidence based, co-produced approach with our citizens, ensuring that the right professional at the right skills response at the right time.

13. What lessons have you learned from implementing your model?

- That staff must be empowered to deliver on the shared vision
- That you must be courageous and if you find the direction you have chosen does not produce the benefits you anticipate, you must change the model
- That it is possible to overcome perceived barriers of governance if you have a mutual desire to succeed
- Senior signup and leadership is essential
- The hearts and minds of front-line staff must also be signed up to the model
- There needs to be flexibility in approaches to human resources and finance
- That staff need to feel secure in their professional governance arrangements
- That you need clarity between management roles and responsibilities and professional leadership in matrix models
- For best outcomes, organisations need to put the needs of people we serve first and wrap services around people not fit people into service structures

14. Is there anything else you would like to add?

Throughout the integration journey, ways to improve, work more efficiently and effectively become obvious; the need to be fluid in the delivery of the models is essential to effectiveness and success and sustainability.
Clarity about the place of care is essential to success in delivering fully integrated models of care across primary community and secondary services. Having clarity about where people have certain interventions would enable us to build the appropriate workforce and hypothecated resources to support the delivery of a fully functioning and agreed model.

There are many components of a community services model that we are unable to resource, but we are confident would create further efficiencies and produce better outcomes, as well as alleviating pressure on secondary care services.

15. Please provide contact details for someone who could provide further details if required.

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iv) Healthy Prestatyn Iach

1. Please provide a description of the model and an indication of the difference from what was done before.

BCUHB implemented the Healthy Prestatyn Iach model on the 1st April 2016. Healthy Prestatyn Iach moves away from a traditional GP-delivered model to one which is built around a multi-disciplinary team. Although this is likely to require less GPs per 10,000 patients, the drive was to provide a workforce better suited to delivering the modern day needs of patients using primary care.

In addition to the innovative multidisciplinary team structure, there are a number of other significant departures from the traditional primary care model in force locally:

a. the service is directly run by the Health Board resulting in the entire workforce, including GPs, being salaried.

b. the ethos of the service strongly advocates a ‘social model of care’ with an emphasis upon appropriate non-medicalised interventions and the avoidance of over-medicalisation.

c. an Academy, designed to run alongside, in which to train new professionals able to work at high levels within our primary care MDTs, and with a good understanding of prudent healthcare and the risks of over-medicalisation. Alongside this, the Academy is also providing a focus for patient wellbeing educational opportunities, delivered as part of a social partnership with local providers.

The practice population of approximately 22,000 patients has been split into five ‘teams within a team’ to allow MDTs to be built around approximately 4,500 patients. This has allowed individual multi-disciplinary professionals to be allocated to individual teams, allowing the MDT to develop strong relationships and trust, and allowing continuity of care for patients which could not be delivered if not divided into smaller groupings. We call these teams KeyTeams.

Each KeyTeams MDT includes GPs, Nurse Practitioners, Advanced Nurse Practitioners, Occupational Therapists and Pharmacists, supported by an Admin team consisting of the KeyTeam Coordinator and KeyTeam Assistants, patients are allocated to a particular team.
The KeyTeam Coordinator is a new role to Primary Care in North Wales and one that is proving a huge benefit to the patients and team.

The Key Team Coordinator is a non clinical role with responsibility for

- coordinating the team, and the care of complex patients
- being the first point of contact for patients for complex queries / issues
- streamlining administrative tasks, including some incoming correspondence and laboratory results, to ensure clinicians are able to focus upon activity that only they can do

More information can be found on the patient website www.healthyprestatyniach.co.uk; in addition a professional website http://www.healthyprestatyniach-resources.co.uk containing resources for healthcare professionals interested in our model is currently being created and expected to be available from October 17.

2. What is the scale of the project including numbers of citizens and staff involved? How long has it been in place?

Healthy Prestatyn / Rhuddlan Iach came into effect on the 1st April 2016 (17 months to date (30.8.17).

We serve a combined population of over 22,000 patients and employ over 90 members of staff over 5 sites.

3. Please outline the specific involvement of primary, social, community, and acute care services including the independent sector.

Healthy Prestatyn / Rhuddlan Iach is the largest sole provider of Primary Care services in North Denbighshire and North Wales as a whole. The main surgery is based in Prestatyn and has 4 satellite NHS sites across the catchment area.

The service model aims to reduce the medicalisation of primary care and, where appropriate, focus on the social elements of wellbeing and health. The inclusion of Occupational Therapists in our multi-disciplinary KeyTeams is instrumental in this change. Our Occupational Therapists work within the community and with the community to improve health and wellbeing of our population.

Design of the model was in collaboration with the local authority, town council, and multiple independent sector services operating within the area, and the collaborative approach continues to grow as the service operates.
As many services as possible are delivered off-site in order to reduce the risk of over-medicalisation arising from some service users adopting an illness role when attending NHS sites. To this end, we use Local Authority library and leisure facility sites, and also use the sites of independent sector providers within the area.

We have formed, and coordinate a wellbeing partnership with local Third Sector and community agencies within our catchment area. This now delivers synergistic services and periodic well-being events. Previous events have included a “Health for All’ event, a diabetes event focusing upon lifestyle, social inclusion events, and are about to embark upon delivering flu vaccination services in community settings which allows us to bring patients into contact with a range of community agencies at the same time.

4. How have you involved service users in the development/delivery/ design/evaluation of your service?

Initially we engaged with our stakeholders and patients via public meeting to ensure that the proposals for the model were acceptable. We received excellent support from our local authority colleagues, local town council and community interest groups. We continue to gather feedback via questionnaires and these are in the main very positive.

Going forward we are in the midst of setting up a patient Council along with developing alternative ways to engage with our practice population. The patient Council will have a strong role to play in working with us and our community to help to understand more about individual empowerment, and about how personal responsibility and lifestyle decisions impact upon healthcare service requirements and the difficult decisions that then have to be made when allocating limited resources.

5. How have you overcome organisational/structural boundaries?

We have been able to overcome a number of the organisational and structural boundaries, and the scale of change in a short period of time has been significant. However, there are a number of areas where we are currently having to review initial timescales for delivery due to resources limitations. The challenges generally relate to the formidable, almost impossible, task of undertaking large scale change whilst also having deliver a full service using the same workforce.

The Area Team, Executive and Board have fully supported the development of the model in Prestatyn and continues to do so. However, support at a Board level and implementation at a practical and operational level within a large, complex (Health Board) organisation with multiple competing priorities are considerably different.
Organisationally there is still progress to be made to be able to support the development of our direct provision of primary care – an area which is relatively new to teams used to only having to support the direct provision of secondary care services.

6. How have you overcome workforce barriers?

Workforce issues have restricted our ability to progress, but with progress in some areas. At a national level we acknowledge that there are too few GPs coming into the NHS and Wales in order to deliver a traditionally structured primary care model longer term. Whether there will be sufficient to meet the lower GP requirement arising from a refreshed model of care, such as ours, remains to be seen and is a continued source of debate amongst GPs in North Wales. Responding to this has been distracting at times, as we have tried to reframe the dialogue to respect our belief that a multidisciplinary team approach will better meet the needs of our current communities, rather than being a concession to address a shortfall of GPs.

Unfortunately, the availability of many of the other professionals we require is in short-supply presently. Whilst as a health community we train many extended scope practitioners, including nurse practitioners, the majority have been entirely based within secondary care and experience difficulties in meeting the demands and challenges of working in the less-medicalised, and clinically undifferentiated Primary Care environment. It is imperative that practical training for Primary Care professionals is rooted within Primary Care based training environments.

In response to this we are now developing ‘Advanced Practice’ roles across a number of professional groups to effectively train the professionals we need. This ‘grow your own’ approach is a core component of our Academy. This will still be insufficient if these roles are to be extended across our community in the coming years. If sufficient places can be funded we are well placed and of sufficient size to coordinate the practical training of the next generation of Nurse Practitioners and Pharmacists, OTs and non-clinical coordinators, allowing ourselves and others to progress with speed to new models with confidence.

As a commissioner of primary care services we cannot expect that independent GMS practices are to be solely responsible for creating opportunities for these practitioners as well delivering services to an increasingly demanding population.

Sustainability within Primary Care isn’t just about recruiting GPs today it is about the training and recruitment and retention of a range of clinicians for the future.
7. What do you measure – what does it tell you?

At present we measure
- patient satisfaction,
- QOF indicators,
- secondary care referral and admission rates
- prescribing trends, and
- budgetary spend.

Patient satisfaction is broadly positive, although with some dissatisfaction with waiting times when attending ‘sit and wait’ type appointments if a same day appointment is requested. However all same day requests are accommodated.

Secondary care data has demonstrated no significant change when compared to the data from the previous GMS practices that HPI has since replaced. As we continue to roll out a number of initiatives aimed at addressing areas of known over-medicalisation, we hope to see that the data begins to demonstrate an improved picture compared to the historic data, but these patterns will require a longer-time frame before becoming clear.

Prescribing trends have shown a significant saving in spend compared to the data from previous GMS practices which we attribute to the presence of Pharmacists within our MDTs, and to the higher profile that over-medicalisation has within our service.

Staffing and overall budgetary spend has remained broadly within the envelope consumed by the previous GMS practices.

In addition we have an academic partnership with Bangor University and Public Health Wales helping us to develop a range of outcome measures.

8. What are the improvements to quality?

Patient satisfaction is undoubtedly higher, as judged by feedback from our post-consultation questionnaire, by the small number of formal complaints received, and by feedback of good experience from patients to individual professionals.
Feedback relating to new roles introduced to Primary Care, most notably the roles of Occupational Therapists in Primary Care, and our Key Team Coordinators, has been particularly positive, with multiple patient stories narrating the large impacts that these roles have upon individuals caught within complex NHS treatments, or with previously un-addressed need.

A Healthcare Inspectorate Wales inspection in 2017, just 12 months after starting to operate, was positive identifying evidence to support their conclusions that the service provides consistently safe and dignified care.

9. What are the improvements to outcomes?

In many respects, it is too early to be able to demonstrate some of our expected outcome improvements. For example, the large scale adoption of Advance Care Planning by a dedicated Key Team dedicated to just looking after our particularly frail patients and care home patients will almost certainly result in improved patient experience and outcome; however for many this will take some time to filter through into datasets. Likewise, our approaches to proactively addressing lifestyle factors is expected to lead to outcome improvements further downstream.

Current outcome markers show no deterioration from a change of approach.

10. How are the developments funded e.g. new project funding, mainstream, reallocation of resources?

Healthy Prestatyn / Rhuddlan lach receives the GMS funding awarded to the previous contract holders. In addition, some new Welsh Government Primary Care funding was utilised for Physiotherapy posts and the Medicines Management team.

Some transitional costs received transitional funding in the first year to meet the increased costs incurred as a result of the previous GMS contractors resigning their contracts.

11. How do you assess the impact on the wider system/demonstrate the value – what have you been able to stop doing?

The focus has been upon doing things more efficiently to improve and change patients experience and attitudes to their own health and wellbeing, rather than to stop providing any particular component of Primary Care and so we continue to provide the full range of Primary Care services.
However there are a number of areas that the service model has impacted on.

These include:

- The move from predominantly GP-led primary care episodes to episodes with a range of more suitable clinicians, allowing us to reduce the number of GPs per 10,000 patients.

- De-medicalisation and use of ‘social prescribing’ has led to some early data suggesting that we may require less nursing input to provide our diabetes chronic disease care, whilst improving experience, because of the greater emphasis placed upon lifestyle management.

12. To what extent have the principles underpinning the Social Services and Wellbeing Act and Prudent Healthcare informed the model?

The model advocates placing a social approach to well-being at the very heart of delivering Primary Care, and teaching/training events have focused upon this, and upon the harm created within Primary Care by over-medicalisation.

We strongly advocate non-medicalised approaches and person-centred practice, and collectively this has increased the use of lifestyle interventions to deliver better patient experiences than would previously have been achieved.

The wider team structure has been designed to allow involvement of a range of professionals (including non-clinical professionals), and encourages them to work to the extent of their abilities, with individuals only doing the work that only they can do.

13. What lessons have you learned from implementing your model?

Significant financial investment is required to ensure that there is sufficient capacity within the project / management team to implement the change, ongoing evaluation and roll out of the service model, to understand and share the learning. This is particularly the case when the same team is also having to continue to deliver a full patient service. Transforming a service alongside delivering a service requires significant additional capacity.
We could have envisaged the need to identify additional funding to develop training posts which are supernumerary to the service model workforce requirement at any earlier stage. This would allow us to generate the future workforce, which is currently proving challenging.

Work is needed with all functions within a Health Board to help them recognise that the Health Board now directly provides Primary Care services and that their support, and understanding of the environmental differences in Primary Care compared to Secondary Care is needed.

14. Is there anything else you would like to add?

15. Please provide contact details for someone who could provide further details if required.

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