Specification for Delivering the Perfect Locality

March 2017

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

CARDIFF CAERDYDD

VALE of GLAMORGAN
BRO MORGANNWG

C3SC
Cardiff Third Sector Council
Cyngor Trydydd Sector Caerdydd

GVS
Empowering people. Inspiring excellence. Strengthening communities. unities.
Grymuso pobl. Ysbrydoli rhagoriaeth. Cryfhau cymunedau.

Welcome to the Perfect Locality Specification

Caring for People: Keeping People Well is what we do as a Health Board. We do this in partnership with our two local authorities and third sector organisations.

Cardiff and Vale University Health Board is working with citizens, patients and partners to ensure that: **a person's chance of leading a healthy life is the same wherever they live and whoever they are**. To do this we have produced a specification for a 'Perfect Locality'. This will build on our existing area plans, needs assessments and best practice. This specification is the next step in making **Shaping our Future Wellbeing Strategy** (Published in 2015) a reality.

The principles included within this specification ensure sustainable, prudent, integrated services, that are person centred; our principles were developed in partnership through conversations between people who both use and provide services.

Empower the Person | **Home first** | **Outcomes that matter to People** | **Avoid harm, waste and variation**

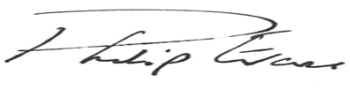
We aim to build a health and social care service which better matches local needs and services, focuses on wellbeing and has a 'Made in Wales' approach, reflecting Welsh needs and aspirations.

We remain committed to working with our communities and partners to improve health outcomes for everyone, **delivering outcomes that matter to people.**

We want to thank everyone who has engaged with us to take the next exciting steps in making change happen. We really appreciate your contribution.

Dr. Sharon Hopkins
Executive Director of Public Health
Cardiff and Vale University Health Board

Paul Orders
Chief Executive
City of Cardiff Council



Philip Evans
Director of Social Services
Vale of Glamorgan Council

Sheila Hendrickson-Brown
Chief Executive Officer
Cardiff Third Sector Council

Rachel Connor
Chief Executive Officer.
Glamorgan Voluntary Service

Contents

This specification has been developed to ensure that a person's chance of leading a healthy life Cardiff and the Vale of Glamorgan is the same, wherever they live and whoever they are. It focuses on:

- **Citizens** – should have free and easy access to wellbeing and self care advice. They should be able to obtain information most appropriate for their needs (including through technology and/ or 1:1 contact for example with someone who can assist and support them).

- **Patients, users of services and carers** – should have easy access to health and social care services. These should be provided either at or close to home. Agencies should work in partnership to ensure all health and social needs are addressed.

- **Staff** – should work across traditional boundaries, sharing of information and ensuring that all the health and social needs of patients are addressed. This will require innovative ways of working and the creation of new roles, to allow integration of health and social services.

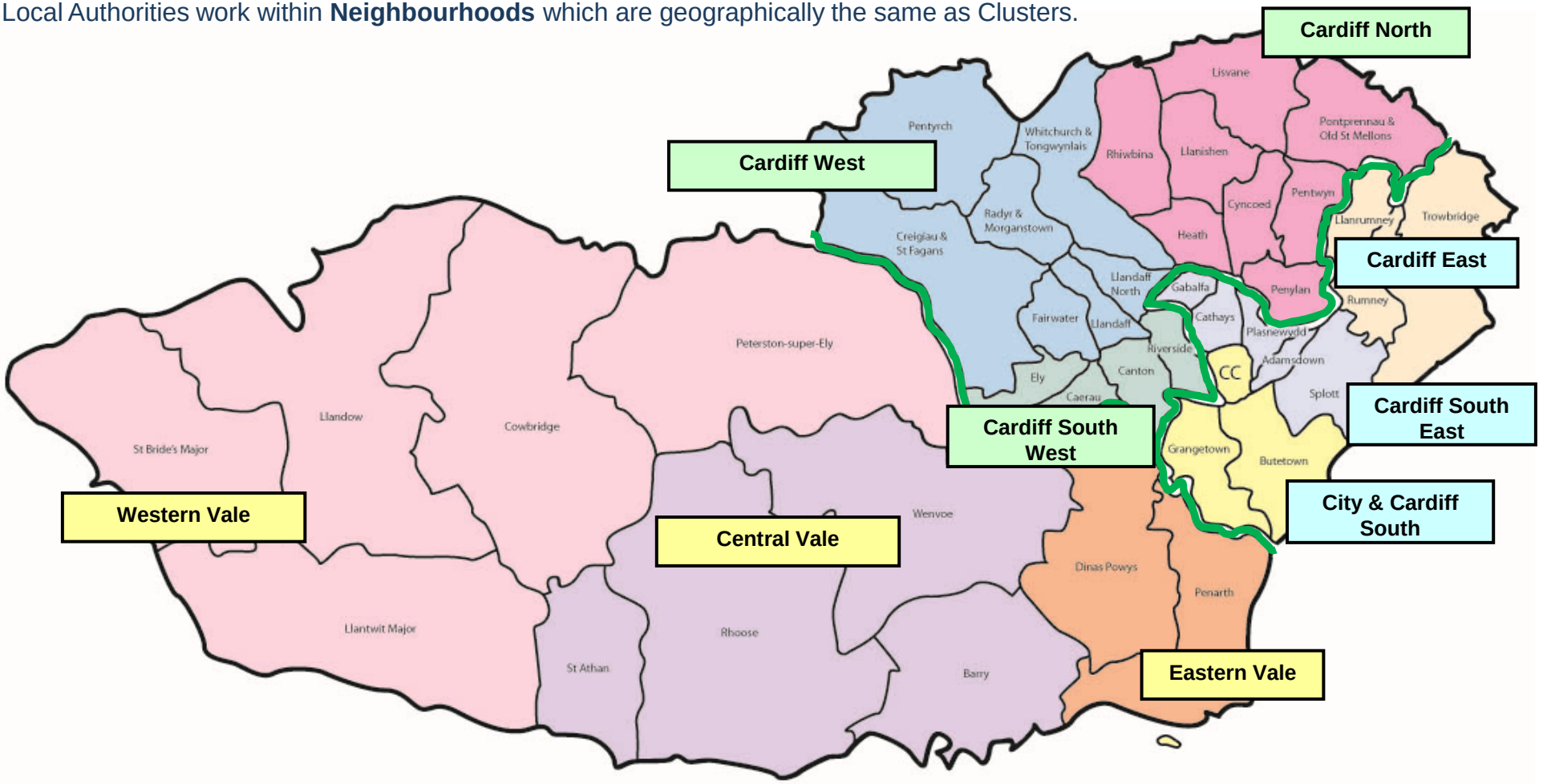
- **Service providers** – should develop technologies to provide clear accessible information to citizens, patients and staff. Services should be delivered in partnership, minimising gaps and duplications and allowing delivery of a comprehensive range of services.

Localities and Clusters

Within Cardiff and Vale of Glamorgan we have three **Localities: Cardiff North and West**, **Cardiff South and East, and the Vale of Glamorgan**.

Each Locality has three Primary Care **Clusters.** These are collaborative Primary Care groupings who support the UHB in planning and delivering services for local communities, responsive to local health and well-being needs.

Local Authorities work within **Neighbourhoods** which are geographically the same as Clusters.



Current Context

Our Population and their Health

Cardiff and Vale of Glamorgan has one of the fastest growing and aging populations in Wales and the UK. Between 2014 - 2034 it is predicted that Cardiff alone will have a population increase of 26% (Cardiff Liveable City report).

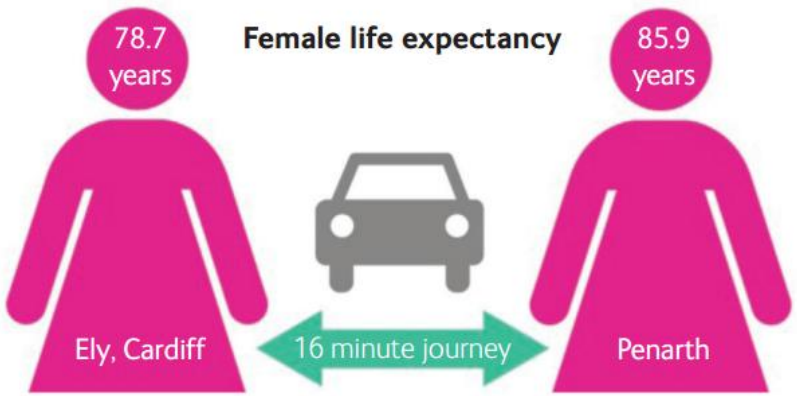
Added to a population that is living longer, with increased complex needs, this is placing a significant challenge on health services across both Cardiff and Vale of Glamorgan. The demographics are changing rapidly too. It is projected that there will be more people aged over 65, more school age children and more working age people between the ages of 30-50.

The city region has a long history of being open and inclusive, with Cardiff being the most ethnically diverse local authority in Wales; 19.7% of its population identify themselves as being from non-white groups (Census 2011).

A combination of health, economic, environmental and social factors means that **Cardiff and Vale has some of the highest health inequalities in Wales.** This gap is caused by significant wider determinants of health such as housing, household income and levels of education, and access to health and healthcare services as well as healthy lifestyle choices. We are committed to reducing health inequalities through a range of health improvement and access to health care initiatives that influence service delivery and individual lifestyle choices.

Over 30,000 people in Cardiff and the Vale of Glamorgan classified themselves in 'bad' or 'very bad' health, a rate of 6.4%. Within local neighbourhoods in Cardiff the proportion of residents reporting bad or very bad health ranged from 1.2% in the Cathays area (LSOA 032C) to 15% in the Rumney area (LSOA 016A). However these are crude percentages only and do not take into account the age structure of the population. The areas with the highest percentages are found in the Rumney and Llanrumney areas of Cardiff. Within the Vale of Glamorgan the areas with the highest proportion of people reporting bad or very bad health are found in the Cadoc and Buttrills areas.

Over the next 10 years the number of over 65s in the region will grow by 22% (from 74,300 to just over 91,000). However, ***the demand driver arising from increased frailty*** differs due to local demographics meaning that this increase is ***31% in the Vale, 25% in Cardiff North & West and 18% in Cardiff South & East***. Similar trajectories are forecast for dementia, and the significant growth in needs for those who are likely to have both dementia and be frail - in the over 85 age group- means that nearly one third of people who have one of these conditions will also have the other, making the case for integration stronger.

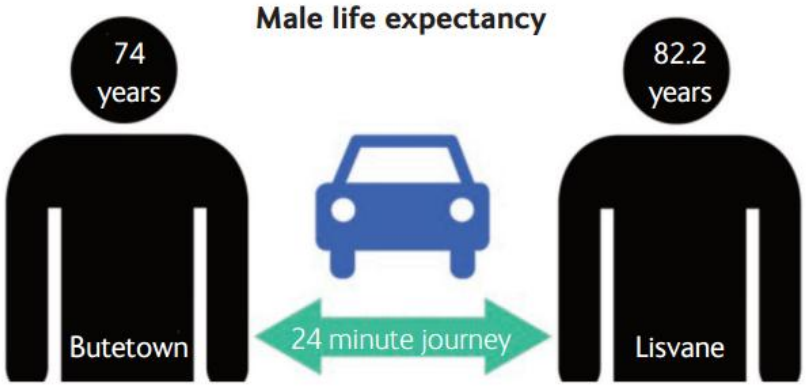


Where we live can influence how long we live.

Life expectancy is not experienced equally across all areas and not everyone experiences the same length of life. If you live in a disadvantaged community, on average your life expectancy will be lower than someone living in an affluent area. Areas in Cardiff and Vale which are just a short drive away can have very different life expectancies. For example, **a woman living in Ely can expect to live 7 less years than a woman living in Penarth.**

Similarly, **a man living in Butetown can expect to live 8 less years than a man living in Lisvane**. Where people live and how they live is important for health outcomes.

When we look at 'Healthy Life Expectancy', the period of life, which can be expected to be lived in good health, the gap is even wider. There is a difference of 23 years for men and 22 years for women and this is continuing to widen across Cardiff & the Vale.

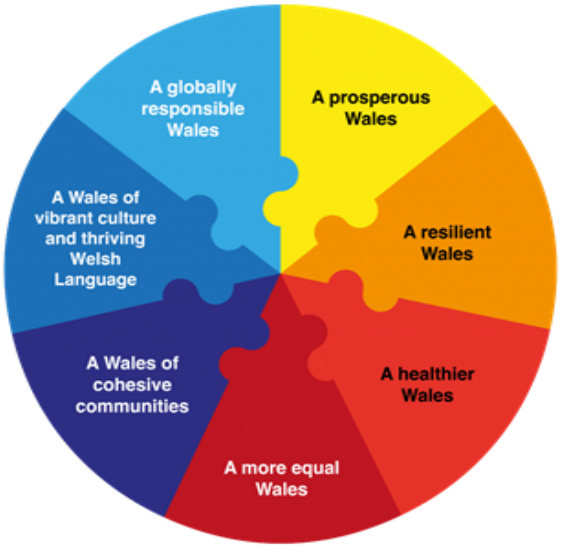


(Figures from Annual Report of the Director of Public Health for Cardiff and Vale of Glamorgan 2015-2016)

Context for the Perfect Locality Programme

National Strategic Context	• Wellbeing of Future Generations (Wales) Act, 2015; - Communities across Wales are safe, cohesive and resilient - To improve equity across Wales • Social Services and Wellbeing (Wales) Act, 2014; - To improve health and wellbeing outcomes - To move towards a social model of health - Greater collaboration and integration across services and organisations • Strengthen primary and community care • Reduce pressure on hospital care and social care • Modernise facilities and systems to support new ways of working
Regional Context	• South Wales Clinical Change • Health Enterprise Alliance for Regional Transformation (HEART) • Cardiff Capital Region City Deal
Local Context	• Regional Partnership Board including the development of Regional Joint Commissioning Framework for older people and pooled budgets • Shaping Our Future Wellbeing Strategy, What Matters Strategy and the Vale Community Strategy, Wellbeing Assessments, Population Needs Assessment • Cardiff and Vale UHB Bold Improvement Goals (BIG) Programme • Cardiff and Vale UHB Estates Asset Management Framework
Health Needs and Equality	• Health inequality in Cardiff and Vale • Population growth and composition • Variation in health needs according to geographical area • Lifestyle choices that increase risk of disease • Patterns of service utilisation

Legislative Enablers



The **Wellbeing of Future Generations (Wales) Act 2015** and **Social Services and Well-being (Wales) Act 2014** both promote the prevention and wellbeing agenda.

- **Wellbeing of Future Generations (Wales) Act**

The seven national well-being goals (shown right) are what we need to achieve for the citizens of Cardiff and the Vale of Glamorgan.

The goals, which all fit together, improve the quality of our environment, our economy, our society, and our culture, to improve the wellbeing of individuals in the local area and in Wales as a whole.

- **Social Services and Well-being (Wales) Act**

Well-being is made up of eight main components:

1. Making sure you have your rights
2. Being physically, mentally and emotionally happy
3. You are protected from abuse, harm and neglect
4. Having education, training, sports and play
5. Positive relationships with family and friends
6. Being part of the community
7. Having a social life and enough money to live a healthy life
8. Having a good home

Working Better Together

The purpose of our Integrated Health and Social Care Partnership ('The Partnership') is to ensure that services and resources are used in the most effective and efficient way to improve outcomes for people in Cardiff and the Vale of Glamorgan.

PARTNERIAETH IECHYD & GOFAL CYMDEITHASOL INTEGREDIG
Caerdydd & Bro Morgannwg

Cardiff and Vale of Glamorgan
INTEGRATED HEALTH & SOCIAL CARE PARTNERSHIP

We aim to achieve this by:

- Encouraging service providers to work better together to develop integrated experiences for citizens;
- Working with communities to develop local solutions to improve the lives of residents;
- Aligning resources (financial and people) to focus on population outcomes which span service and organisational boundaries.

The Partnership is made up of Cardiff and Vale UHB, City of Cardiff Council, Vale of Glamorgan Council, Welsh Ambulance Services NHS Trust, third and independent sectors and carer representatives.

The Wellbeing of Future Generations Act introduced **Public Services Boards** in each local authority area to improve economic, social, environmental and cultural wellbeing through stronger partnership working.

We are working collaboratively with our Public Services Board partners to understand the wider wellbeing needs of our population and to identify innovative and shared solutions to some of the most pressing challenges our communities face. This new way of working, which looks to the long term and centres on involving a diversity of the population in the decisions which affect them, will underpin the approach to develop the Perfect Locality.

Recognising the Third Sector Contribution to Health, Social Care and Wellbeing Services

- The Welsh Government, health boards and local authorities recognise that the third (or voluntary) sector is a key partner in developing and delivering health, social care and wellbeing services.

- The third sector is diverse with approximately 3,000 charities, voluntary organisations and community groups across Cardiff and the Vale of Glamorgan. They provide services for older people, children and young people, people with a learning disability, people experiencing mental health issues and in a whole range of other service areas. The third sector includes housing associations (registered social landlords) who provide social housing and additional support to their tenants and the wider community.

- The Health Board and local authorities have a framework for working with the third sector, ***Working Together For Our Future Wellbeing,*** which sets out the third sector contribution to the delivery of Shaping Our Future Wellbeing and is supported by an action plan which is updated annually.

- The third sector provides services, supports communities to have a voice, facilitates volunteering, is innovative and flexible and able to respond to need at a community level.

- In Cardiff and Vale, the third sector is represented by Cardiff Third Sector Council (C3SC) and Glamorgan Voluntary Services (GVS), along with Cardiff and Vale Action for Mental Health. Both C3SC and GVS support the sector with governance, developing services, funding, working in partnership and ensuring the sector is well informed.

- C3SC and GVS both have Health and Social Care Facilitators who act as a link between third sector organisations and health and social care services.

GVS
Empowering people. Inspiring excellence. Strengthening communities.
Grymuso pobl. Ysbrydoli rhagoriaeth. Cryfhau cymunedau.

C3SC
Cardiff Third Sector Council
Cyngor Trydydd Sector Caerdydd

cavamh
Gweithredu dros Iechyd Meddwl Caerdydd a'r Fro
Cardiff and Vale Action for Mental Health

Adding Value to Communities

The Regional Workforce Partnership

CARDIFF & THE VALE CARE & SUPPORT REGIONAL WORKFORCE PARTNERSHIP

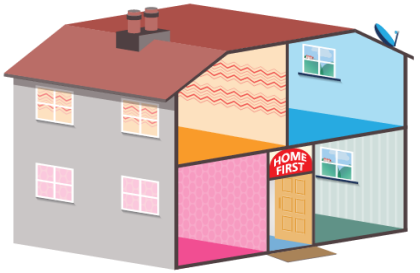
The Regional Workforce Partnership was formed to meet requirements of the social services and Wellbeing (Wales) Act 2014. Its members come from the Health Board, both local authorities, care homes, private providers and the third sector, all of whom have an interest in developing the care and support workforce.

The workforce includes care and/ or support workers, carers and volunteers. The aim is to enable the whole workforce to access training so they can support the independence and choices of the people they care for to be able to achieve their own outcomes.

The partnership is also developing programmes to raise the profile of care and support workers as a career choice. If there is a shortage of workers then this can have a negative impact on the options for people to remain independent in their own homes or communities.

The Contribution of Registered Social Landlords

There has been awareness that housing has a direct impact on health and wellbeing for a very long time. Deprivation has an impact on health as well with those living in deprived communities being less likely to own their own homes and to rely on the rental market.



Social landlords offer some of the highest quality rented accommodation as they have to comply with the Welsh Housing Quality Standard (WHQS). In addition to maintaining the properties, social landlords provide a range of services to their tenants and to the wider community. There are a number of projects where housing associations are involved with promoting wellbeing.

Cardiff and Vale University Health Board

Cardiff and Vale University Health Board (UHB) is one of the largest NHS organisations in the UK. As a Health Board we have a responsibility for the health of 472,400 people living in Cardiff and the Vale of Glamorgan, including the provision of local primary care services (GP practices, dentists, optometrists and community pharmacists) and the running of hospitals, health centres and community health teams. Together, these provide a full range of health services for our local residents and those from further afield in both Wales and England, who use our specialist services, where we are recognised as a centre of excellence.

To deliver these highly diverse and complex services we spend over £1.2 billion every year and employ around 14,000 staff. We are also a teaching Health Board with close links to Cardiff University, which boasts a high profile teaching, research and development role within the UK and abroad. This is alongside other academic links with the University of South Wales and Cardiff Metropolitan University. Together, we are training the next generation of clinical professionals in order that we develop our expertise and advance our clinical outcomes. As a health board funded almost exclusively by the taxpayer, we are acutely aware of our responsibilities in terms both of the stewardship of public money and assets, and also of our responsibility to the communities we serve to provide the best care possible.

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Local Authorities

The City of Cardiff Council

People in Cardiff could be described as being healthier than ever before. Levels of general health are high with life expectancy for men and women continuing to rise, and women in Cardiff projected to live longer than those in the majority of the core cities (The core cities are a group of 10 major cities, including the eight largest city economies in England, not including London, as well as Cardiff and Glasgow). However, these headlines hide substantial variability across the city with different age groups and communities facing wide ranging health problems. There is a significant and growing gap in healthy life expectancy between those living in the least and most deprived areas of the city, which now stands at over 20 years. Similarly, mortality rates from a number of diseases are appreciably higher in more deprived wards. In terms of healthy lifestyles, more than half of the population in Cardiff are overweight, obese or underweight, comparatively few people undertake physical activity.

Furthermore, Cardiff's rapid population growth will be characterised by increases in the number of very young people and an ageing population, both leading to substantial pressures on the city's health and care services.

(Liveable Cities Report, 2017)

The Vale of Glamorgan Council

On average, the Vale of Glamorgan compares favourably with the rest of Wales in terms of population health. For example, both life expectancy and all cause mortality rates improved over the last decade. However this improvement is not experienced equally by all areas and the improvement is less evident in the most deprived areas. Analysis suggests that this gap is growing. Partnership action must therefore work to improve heath and address inequalities.

In the Vale of Glamorgan, a focused approach is being taken through "Vale Healthy Communities" framework, focusing on food and physical activity as well as a partnership approach to tobacco control. The framework has three themes: building capacity and skills for public health; developing healthy environments and; supporting those most in need in disadvantaged areas. Partnership Food and Physical Activity, and Smoke Free action plans have been developed and delivery of the framework is overseen and driven by the Public Health and Wellbeing Board.

Developing the Perfect Locality

Understanding the Vision

For the Perfect Locality vision to become reality, person and community-centred ways of working need to become widely understood and valued as core to the whole health and care system, not just ‘nice to have’. They need to be woven into not just the infrastructure of the system but also the culture of how things are done. Every health and care professional needs to understand their role in this way and every health and care service needs to be designed and delivered this way.

We are aware that the roots of health and wellbeing lie not in our hospitals but in our communities. Although medicine and hospitals make an important contribution to our health and wellbeing, so does a sense of being connected to a thriving community. It is not just our sense of wellbeing that improves as a result - clinical outcomes improve as well.

Success requires working in partnership with people to improve their health and wellbeing – building their emotional strength, skills and knowledge to do so. It means taking account of family, friends and communities and working to reduce wider inequalities. This way of working involves and engages people in ways that enable them to have a voice, to be heard, and to have the opportunity and support to choose how best to live their lives. It means giving people a sense of hope.

It is better for people to be active partners in their care, and it can also reduce inappropriate and unplanned use of health and care services, freeing up valuable resources.

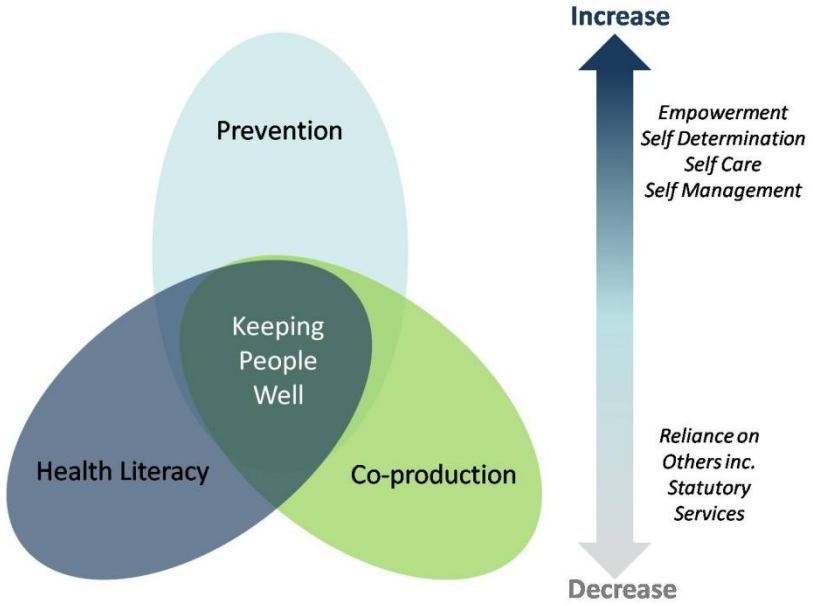
.

Moving Forward to Develop the Perfect Locality

We have outlined the context and current position and now we need to identify how we move forward and ensure that our citizens are equipped and encouraged to make a contribution to the development of services that will contribute to their health and wellbeing and that of their families and their communities.

To produce a perfect locality that matters to citizens and improves outcomes and to keep people well, we need to work together and address **prevention**, use **co-production** approaches, and improve **health literacy**. This will be achieved by creating supportive environments, developing personal skills and strengthening community resilience. Providing support to citizens to navigate third sector and others to provide informal support will lead to a reduction in the need for health and social care services.

To **empower the person** the approach we recommend facilitates self-determination, self-care/ management and ultimately encourages citizens to seize responsibility and make informed decisions around their health and wellbeing.



Promoting Prevention

Prevention activities and services are aimed at individuals who either have no current particular health or care and support needs, or where there is some identified risk that their wellbeing or quality life isn't as good as it could be. Services that promote wellbeing are often provided outside of the scope of traditional health and social care settings and provided in the community through voluntary groups or not-for-profit organisations.

These services are focused towards people who are basically healthy but require some form of support or intervention to maintain their health, to be safe or get the most out of their lives. Delivering and driving improvements in any approach to supporting independence must be seen in the context of this wider preventative agenda. Actions to address healthy lifestyles and the determinants of health through changes in behaviour can result in better health in the longer term, reduction in disease and limiting conditions and an associated **reduction in demand for health and social care services**.

Adopting a universal approach to this type of prevention across all sectors can help to reduce levels of need and the associated pressure that this places upon the health and social care sector as well as improving life experience and chances for people living in Cardiff and the Vale of Glamorgan. However, it is clear that much of the activity to deal with the wider prevention operates over a significant length of time and the outcomes of such interventions are not always clear. For this reason it will be important to also think about an approach in the short term which supports independence within the services that people access.

They are generally universal (i.e. available to all) services, which may include, but are not limited to interventions and advice that:

- Promote uptake of childhood immunisations and flu immunisation amongst at risk groups
- Promote access to good quality information
- Support safer neighbourhoods and safer homes
- Promote independence (e.g. independent living, telecare etc.)
- Promote healthy and active lifestyles (e.g. physical activity, health walks)
- Encourage lifestyle changes (e.g. stop smoking, weight loss, health trainers)
- Reduce social isolation (e.g. befriending schemes)

Provide Health Literacy

The World Health Organisation recognised that becoming a health-literate person is a growing challenge as societies grow more complex and people are increasingly given health information and misinformation and confront complex health care systems. Literacy has been shown to be one of the strongest predictors of health status along with age, income, employment status, education level and race or ethnic group. Weak health literacy competencies have been shown to result in less healthy choices, riskier behaviour, poorer health, reduced self-management and increased hospitalisation.

It is known that:

- High literacy rates in population groups benefits societies
- Limited health literacy (as measured by reading skills) significantly affects health
- Limited health literacy follows a social gradient and can further reinforce existing inequalities
- Building personal health literacy skills and abilities is a lifelong process
- Capacity and competence related to health literacy vary according to context, culture and setting
- Limited health literacy is associated with high health system costs.

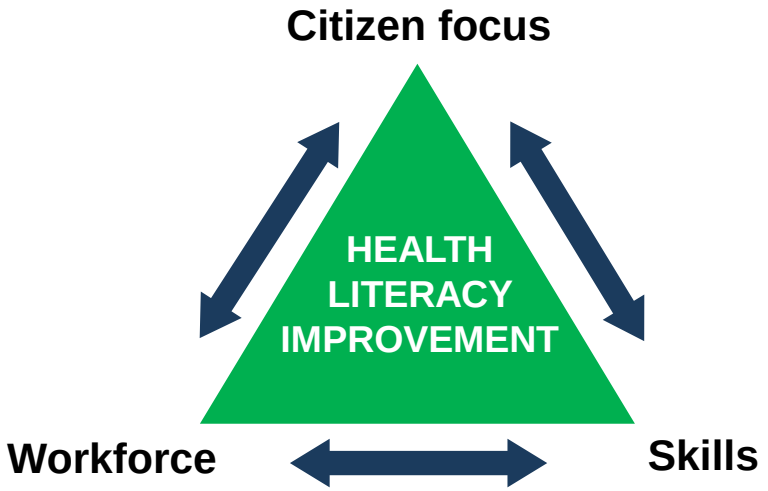
It has been acknowledged that an adequate level of literacy is necessary for people to navigate complex health system, which involves:

- Communicating with health professionals – voicing their own health needs and clarifying information
- Finding, understanding and using the health materials (in a variety of formats) that they need to stay healthy
- Getting the services and support they need
- Applying health-related knowledge to healthcare and decision-making, so that they are able to make healthy choices
- Having more control over the things that make them healthy.

Inaccessible and unduly complicated systems and information can limit a person's health literacy. It is critical to acknowledge that people's health literacy depends on not only individual ability but also on the responsiveness of health and social care systems; it is essential that health and social care providers ensure that services and information are clear and accessible, barriers to access are removed, and people are engaged with and needs understood.

In summary, health literacy is made of:

- Basic health knowledge
- Understanding and evaluating health information
- Prevention, health promotion, and self care behaviours
- Verbal communication with healthcare professionals
- Health decision making
- Navigating the healthcare system
- A two way process between healthcare user and provider



ACCESS, UNDERSTANDING & INFORMATION = IMPROVED HEALTH LITERACY

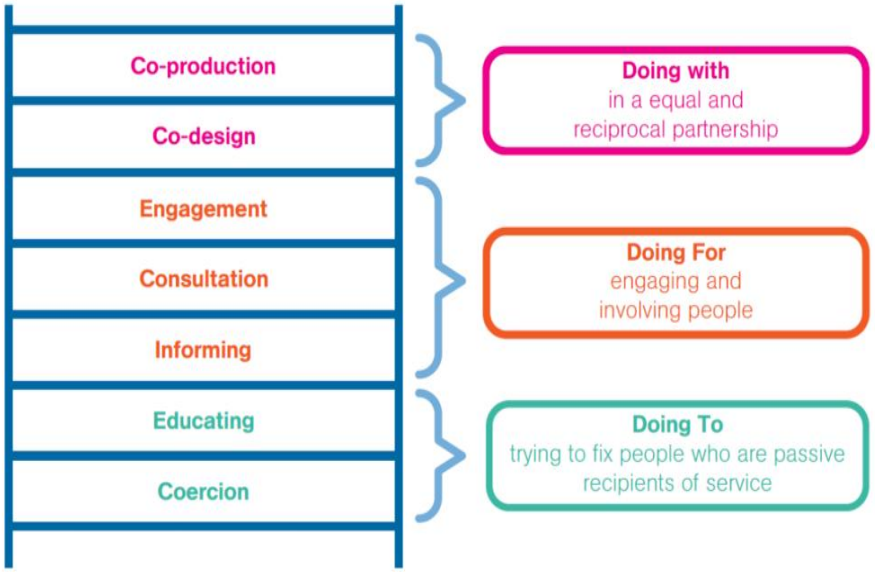
Embedding Co-production

Co-production challenges the usual relationship between professionals and citizen / service users. It requires the latter to be considered experts in their own circumstances and therefore capable of making decisions and having control as responsible citizens. At the same time, co-production implies a change in the role of the professionals from fixers of problems to facilitators who find solutions by working together.

We are living in challenging times, uncertainties on funding and how we respond to need no longer seem clear. Inequality, poverty, reduced funding on public services, and rises in population require us to collaborate both with organisations and citizens, as this is where we can unlock hidden assets and work together to do things differently and more innovatively'

We need to take an assets based approach, which is an integral part of community development and involves facilitating people and communities to come together to achieve positive change using their own knowledge, skills and lived experience of the issues they encounter in their own lives, to achieve the perfect locality.

Co-production, alongside an asset based approach can produce meaningful outcomes and build individual and community resilience. To facilitate this approach professionals/ organisations need to work in partnership, and *doing with rather than* to *doing for* or *doing to* individuals and communities. (See engagement ladder)



(Ruth Dineen and Noreen Blanluet)

Co-production principles are:

Valuing each other

Building on our strengths

Developing peer-support networks

Relationships of trust

Mutuality and reciprocity

Promote Empowerment, Self-Determination, Care and Management

Empowerment

Empowerment can be defined in general as the capacity of individuals, groups and/or communities to gain control of their circumstances and achieve their own goals, thereby being able to work towards helping themselves and others to maximise the quality of their lives. In health and social care empowerment means citizens, carers and others exercising choice and taking control of their lives. Empowerment as action refers both to the process of self-empowerment and to professional support of people, which enables them to overcome their sense of powerlessness and lack of influence, and to recognize and use their resources.

Self-Determination

Self-determination refers to a characteristic of a person that leads them to make choices and decisions based on their own preferences and interests, to monitor and regulate their own actions and to be goal-oriented and self-directing. The abilities of the person and the opportunities presented by the environment contribute to the degree of self-determination that can be expressed.

Self-Care

Self-care is quite a broad concept, but in essence it is about an individual looking after themselves in a healthy way. It can include supporting people to live healthier lives by quitting smoking, drinking sensibly, eating healthily or being more active. The term is also used to cover taking medications and treating minor ailments and knowing when and how to best seek help.

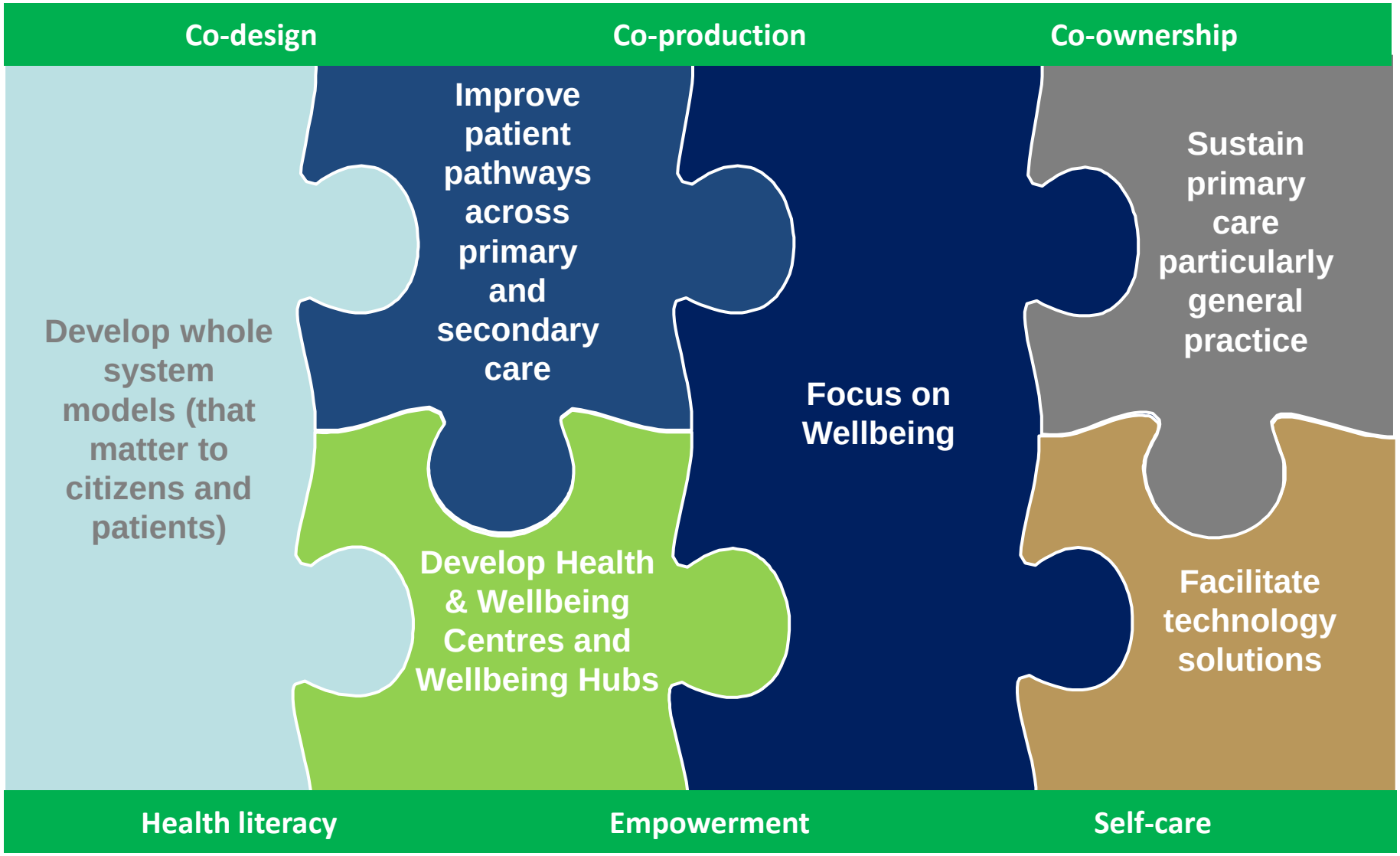
Self-Management

Self-management is about people protecting and managing their own health. The term is most often used in the context of long-term conditions, such as heart disease, diabetes and respiratory problems. When talking about self-care people will often refer to health literacy. This is the degree to which individuals can obtain, process and understand basic health information to make informed decision-making. Supporting those with long term conditions to manage their conditions well and adopt healthy lifestyle choices will help improve health, contribute to prevention and reduce burden on services.

.

Making the Vision a Reality

By working together on all the pieces of the puzzle to ensure that the whole is better than the sum of its parts:



Whole System Models (that matter to citizens)

Develop Whole System Outcomes of the Perfect Locality Programme

People in Cardiff and Vale of Glamorgan are healthy and active and do things to keep themselves healthy

Inequalities that may prevent people in Cardiff and Vale of Glamorgan from leading a healthy life are reduced

Care and support in Cardiff and Vale of Glamorgan is delivered at or as close to home as possible

People in Cardiff and Vale of Glamorgan know and understand what care, support, and opportunities are available and use them to achieve their health and wellbeing

People's voice in Cardiff and Vale of Glamorgan is heard and listened to

Children in Cardiff and Vale of Glamorgan have a healthy start in life

Turning the Citizen Model into a Service Model

In co-producing the *Shaping Our Future Wellbeing Strategy*, the UHB worked alongside over 400 people to describe a vision for health and wellbeing where joined up care is achieved based on 'home first', avoiding harm waste and variation, empowering people and delivering outcomes that matter to them.

This picture of the future, a model of health and care services from the citizen's perspective, became the front cover of the strategy – the first step towards making it a reality.

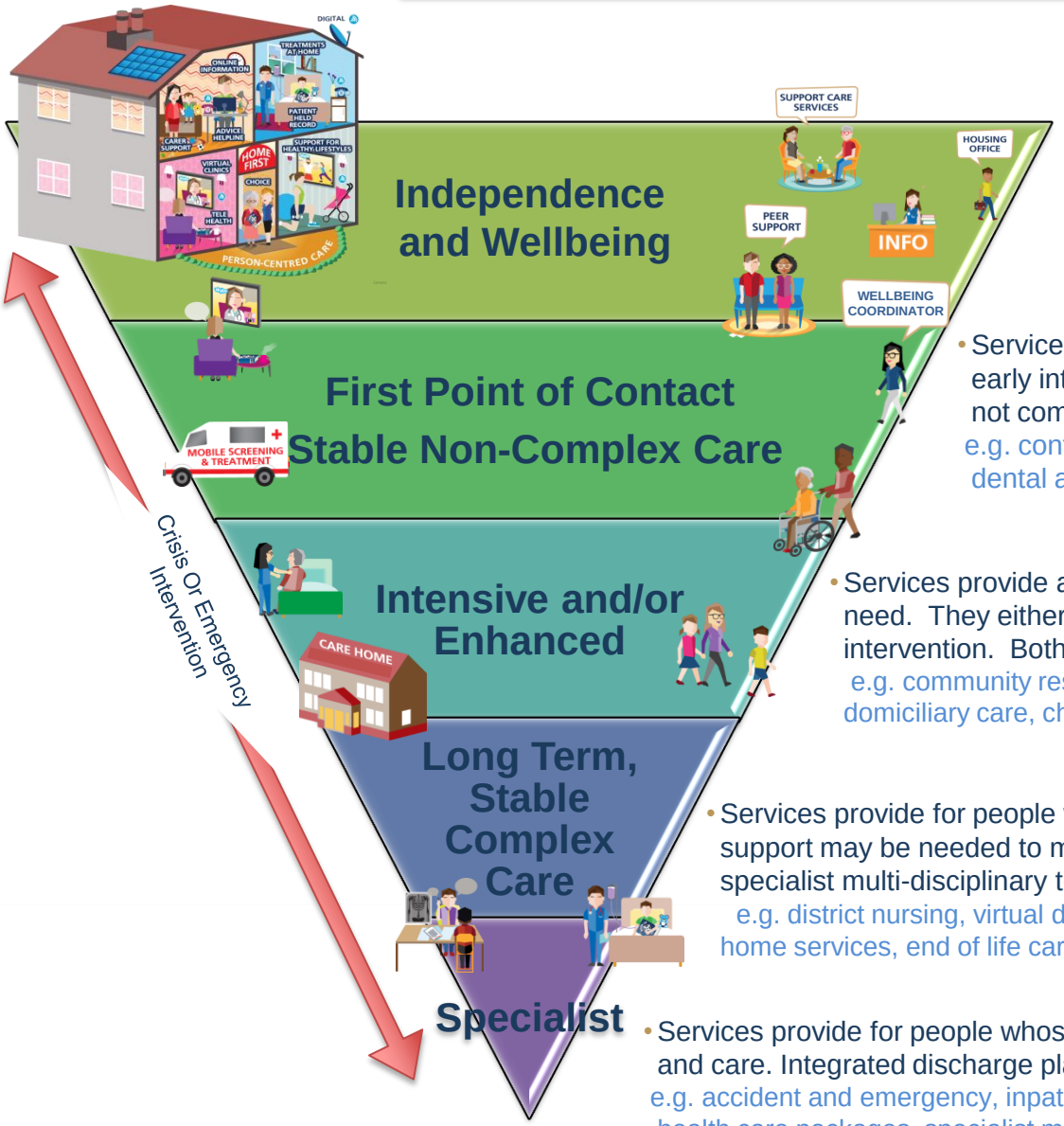
CITIZEN MODEL

To enable the next steps, those that commission and provide services across health and social care need to have a common understanding of how their services fit together; what needs they are seeking to address, how a citizen, patient or service user accesses and moves through the services and where there are gaps in existing services. Taking a whole systems approach, this requires the development of a shared **whole system service model** based on the **citizen model**.

A commonly adopted way to describing services is to take a stepped approach recognising that people move up and down the steps and sometimes jump more than one depending on their needs.

The whole system model described on the next page, starts with those services which are universally available and moves through services which support rising complexity, towards longer term, more specialist care. The model describes the service only, not the location or the workforce/ skill mix. These details will be developed as part of applying the whole system model to population groups or specific long term conditions.

Whole System Service Model



- Services promote prevention, health and wellbeing, independence and empowerment, recognising that a wide range of social and health needs may have an impact on a persons wellbeing.
  e.g. public health promotion, healthy communities, leisure and learning services, self help services, mental health promotion

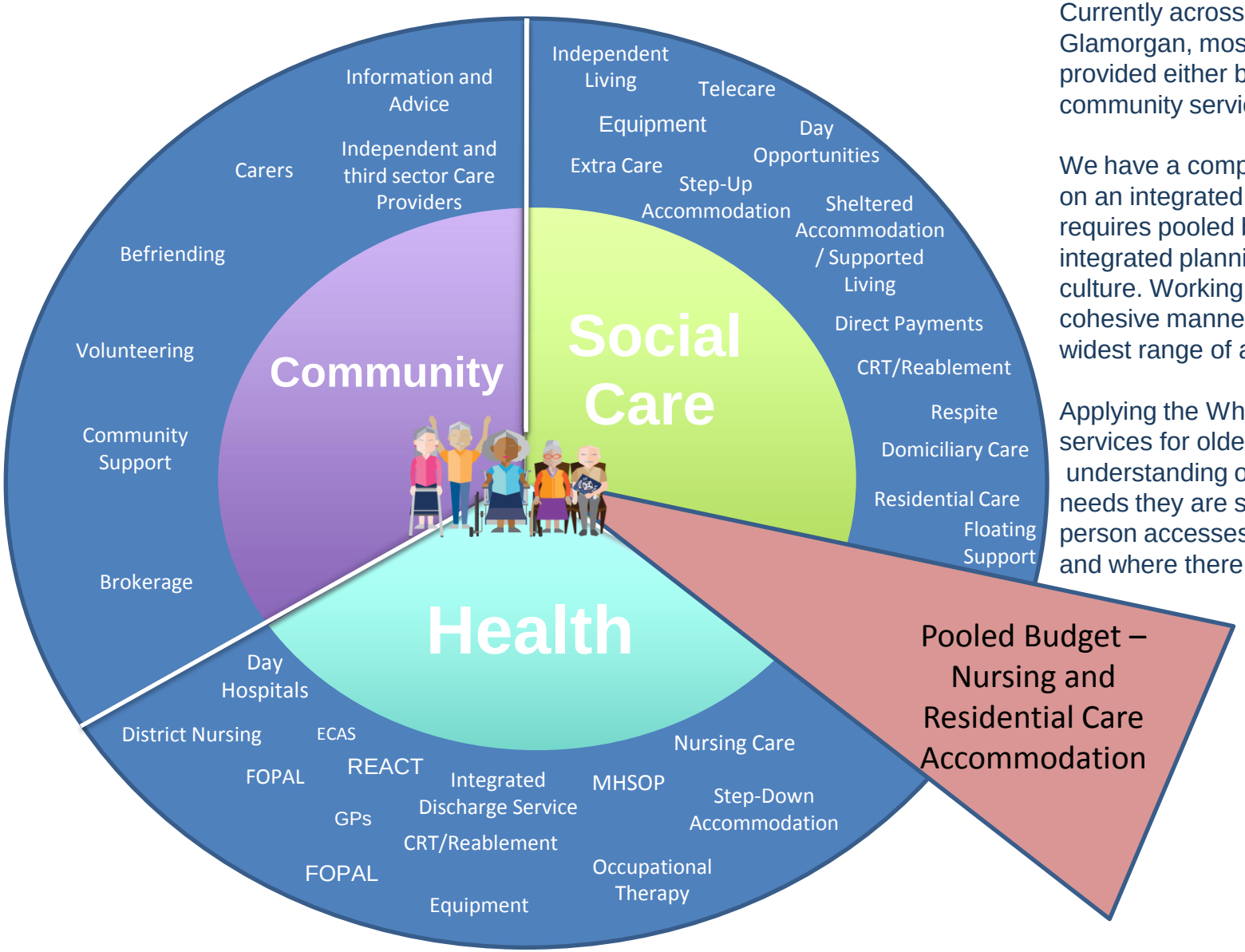
- Services provide a first point of contact, they screen and assess, providing early intervention and sign posting. Where a persons needs are stable and not complex, services provide routine on-going support.
  e.g. contact centres, wellbeing co-ordinators, third sector, general medical, dental and optometry services, community pharmacy, flying start.

- Services provide a flexible and coordinated response to a persons rising unstable need. They either provide, an intensive re-ablement service or an ambulatory care intervention. Both prevent inappropriate long term care and avoid hospital admissions.
  e.g. community resource service/teams, community mental health, acute response team, domiciliary care, children's speech and language assessment, REACT.

- Services provide for people whose needs are not necessarily low but are stable, additional support may be needed to meet daily living needs. Rising complexity can mean care planning by specialist multi-disciplinary teams to avoid unstable acute hospital or care home admission .
  e.g. district nursing, virtual diabetes clinics, community paediatric clinics, residential and nursing home services, end of life care, multi-condition service, community mental health teams.

- Services provide for people whose needs are highly unstable and/or for highly specialist assessment and care. Integrated discharge planning supports timely discharge.
  e.g. accident and emergency, inpatient services, integrated discharge teams, children's centres, continuing health care packages, specialist mental health services, specialist outpatient / diagnostic.

The Whole System Service Model Applied to Older Peoples Services

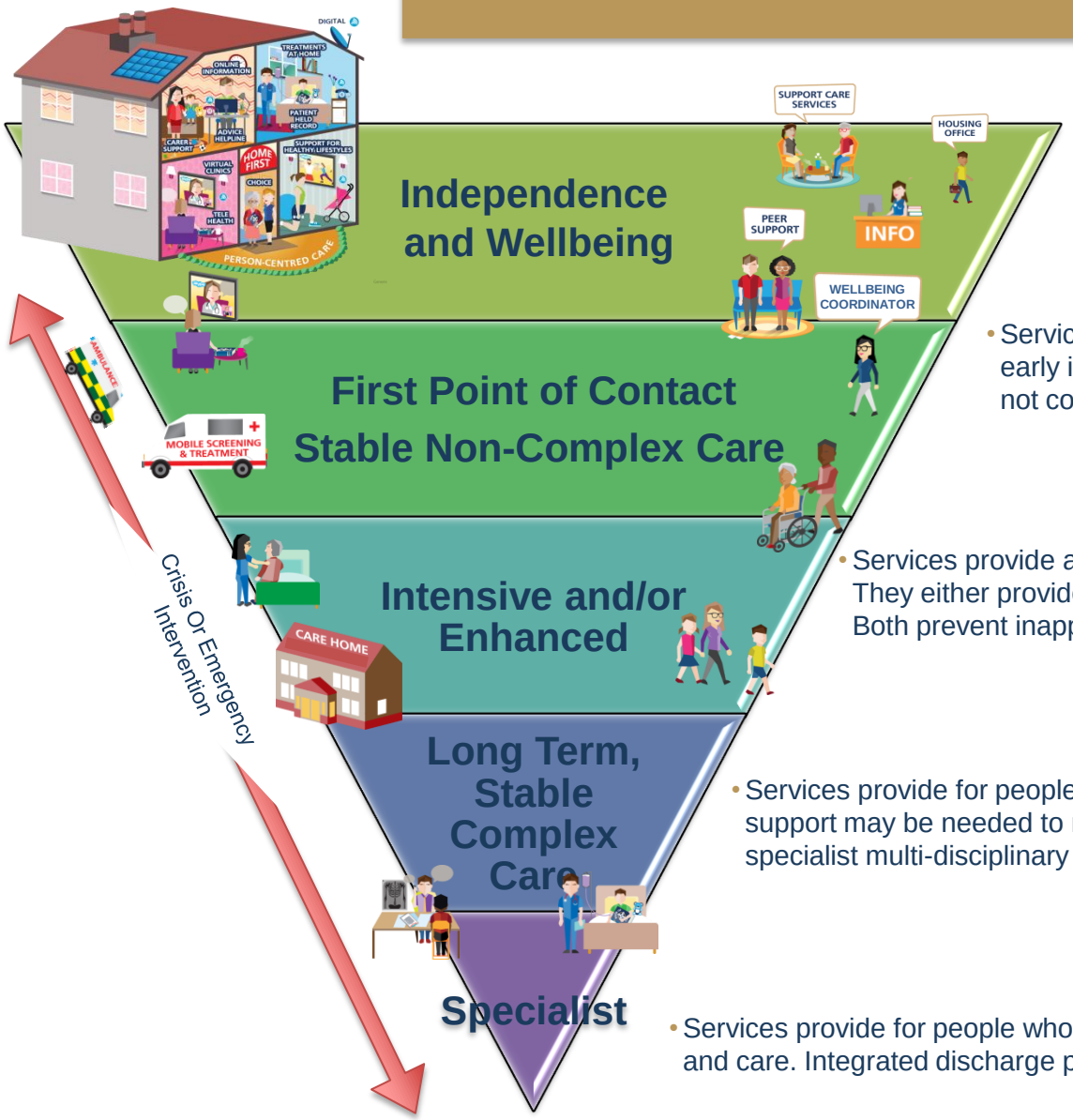


Currently across Cardiff and the Vale of Glamorgan, most services for older people are provided either by health, social care or community services.

We have a complex system and we need to build on an integrated, partnership approach. This requires pooled budgets, joint allocation, integrated planning and a change in geographical culture. Working together to target resources in a cohesive manner to address need, with the widest range of available options.

Applying the Whole System Service Model to services for older people provides a common understanding of how services fit together; what needs they are seeking to address, how an older person accesses and moves through the services and where there are gaps in existing services.

Older Peoples Service Model



- Services promote prevention, health and wellbeing, independence and empowerment, recognising that a wide range of social and health needs may have an impact on a persons wellbeing.
  - Public health/healthy communities
  - Community networks/befriending
  - Leisure and learning activities

- Services provide a first point of contact, they screen and assess, providing early intervention and sign posting. Where a persons needs are stable and not complex, services provide routine on-going support.
  - Contact centres
  - Equipment / aids
  - Third sector
  - Care and Repair
  - GP and dental surgeries
  - Sheltered housing

- Services provide a flexible and coordinated response to a persons rising unstable need. They either provide, an intensive re-ablement service or an ambulatory care intervention. Both prevent inappropriate long term care and avoid hospital admissions.
  - Community resource teams
  - Step up/down accommodation
  - Mental health teams
  - OTs
  - Telecare Plus
  - Domiciliary care

- Services provide for people whose needs are not necessarily low but are stable, additional support may be needed to meet daily living needs. Rising complexity can mean care planning by specialist multi-disciplinary teams to avoid unstable acute hospital admission.
  - Extra care accommodation
  - District nursing
  - End of life Care
  - Residential care homes
  - Nursing care homes

- Services provide for people whose needs are highly unstable and/or for highly specialist assessment and care. Integrated discharge planning supports timely discharge.
  - Specialist assessment
  - Inpatient services
  - Integrated discharge team

Locality Working- Llanishen Project

In line with the aims of the Social Services and Wellbeing Act, Independent Living Services are working with citizens and carers of Cardiff by providing them with a voice and the control to achieve “what matters” to them, to enable them to live independently and improve their wellbeing, with the aim of reducing demand on adult social care and health.

What we are doing:

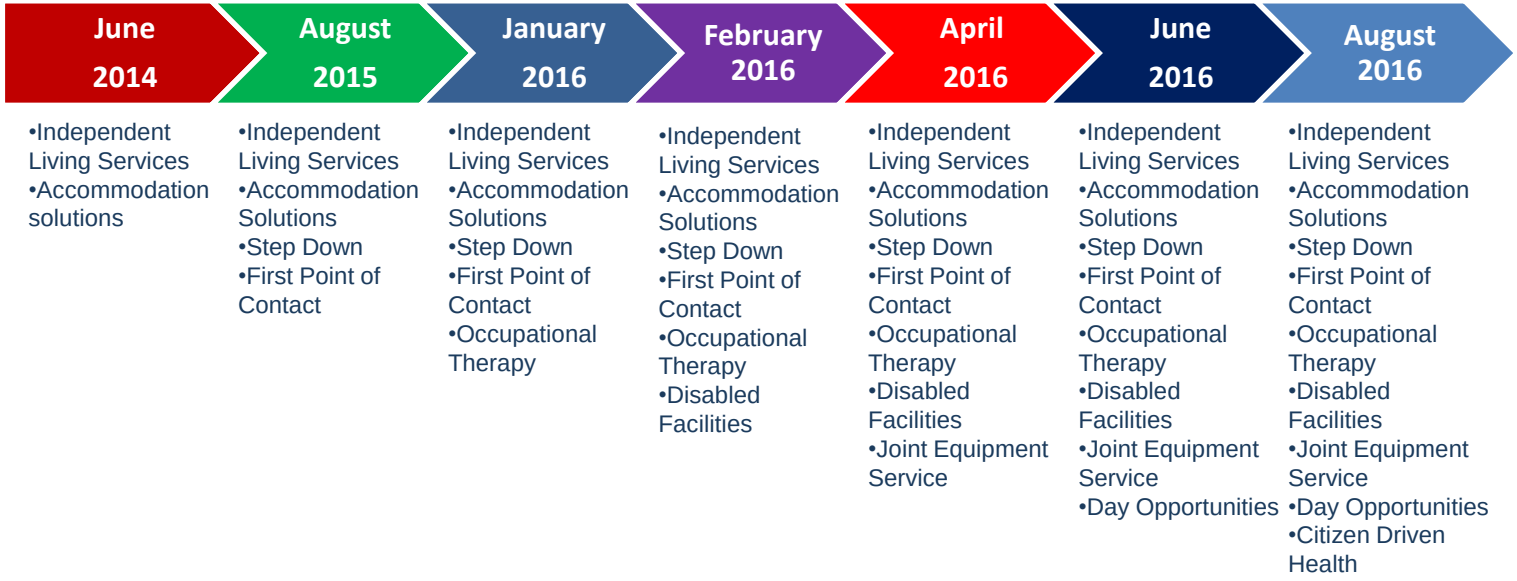
- Through our first point of contact we will provide enhanced triage, via multi-disciplinary teams of contact officers, independent living officers and social workers. By listening to “what matters” to the client we will provide information, advice and assistance, directing citizens to alternative solutions for independent living. Through increased local networks and partnership working with the third sector, health and other council departments, Independent Living Services are taking a whole systems approach to help people stay at home.
- By embedding a preventative agenda and finding out “What Matters” to the client, First Point of Contact have laid the foundations of a cultural shift away from dependency on the social care system towards Independent Living. This is further enhanced through a whole systems approach in partnership with Social Care.

Why we are doing it:

- To keep people at home; to give people the options and tools to make informed decisions; and have control of their life outcomes. As a result we will reduce the demand on social care; prevent unnecessary GP appointments and hospital admissions; and support and sustain discharge.

Part of this process is developing a locality approach, building community resilience with longer term sustainability. To achieve this aim, Locality Based Working commenced delivery in August 2016. The first phase will run through to the end of March 2017, funded by ICF and centred around North Cardiff, mainly focussed on Llanishen ward. The project takes a holistic, community based approach to improving the wellbeing of older people who live locally.

The evolution of the services, bringing together services to meet the preventative agenda



We have **improved community resilience** by enabling and encouraging community participation and volunteering, and keeping older people informed of what is available to them.

We are doing this by:

- Organising a 'Llanishen Gets Together' community event attended by around **40 exhibitors** and **125 local residents**, with 40 of those identifying a new activity to try, reducing their risk of isolation
- Mapping local activities and services and sharing that information with residents
- Working with local third sector organisations to update DEWIS Cymru
- Identifying a potential network of 'Locality Champions'
- Carrying out a gap analysis or missing support services linking into the population needs assessment, working on developing alternative solutions to meet demand, such as volunteers via back to work project for domestic support
- Extensive engagement between day opportunities and local partners in the public, private and third sector has gained an oversight of current day opportunities available to older people in North Cardiff, which led to a series of events to create an information and networking platform for the locality.

This led to a development of the day-opportunities team working with people to re-engage in the community, to give back the confidence for the individual to get out and about:

- Developing a peer-to-peer approach, matching clients with similar interests and goals to provide sustainability to developing relationships within the community.
- We have designed a more **flexible, person-centred model of domiciliary care,** working jointly with social care and taking best practice and learning from other local authorities, to create a Raglan-style model which incorporates reablement and builds on existing joint working with health undertaken by the community resource team (CRT) to ensure the best outcomes for service user independence and wellbeing.

We are working with local health professionals to ensure easier, **more streamlined access to some lower level healthcare** and other statutory services, by:

- Redeveloping Sandown Court to include communal facilities, allowing the complex to become a local facility where older people from the wider community can take part in classes, information sessions, social events and access council services. In 2017, a therapeutic room will be available to healthcare professionals which can be used to deliver flu vaccines, health checks and advice and support for residents and older members of the local community, alongside other key services such as chiropody and confidential social services meetings.
- Creating plans for the redevelopment of the larger complex at Brentwood Court along similar lines, with a larger communal space, and consultation with residents and health professionals to help shape how this space can be best utilised.
- Placed Independent Living Services officers in North Cardiff Medical Centre 2 mornings a week – due to lower than expected referrals, we are reviewing our work to date and will integrate with older persons' nurses in the near future.
- We are fostering **dementia friendly communities** in support of the strategic aim to create a dementia friendly city, with public, third and private sector able to meet the needs of people living with dementia and their families and carers. So far in 2017 we have:
  - Run 2 Dementia Friends talks, creating 29 Dementia Friends in North Cardiff and identifying 2 potential new Champions
  - Planned three more events before the end of March focussed on dementia and volunteering

Suggested Way Forward

Encourage the use of the 'Service Model' for whole system service redesign, focusing first on services for older people.

Our Partnership has agreed an initial focus on developing integrated services for older people and by March 2018 we will:

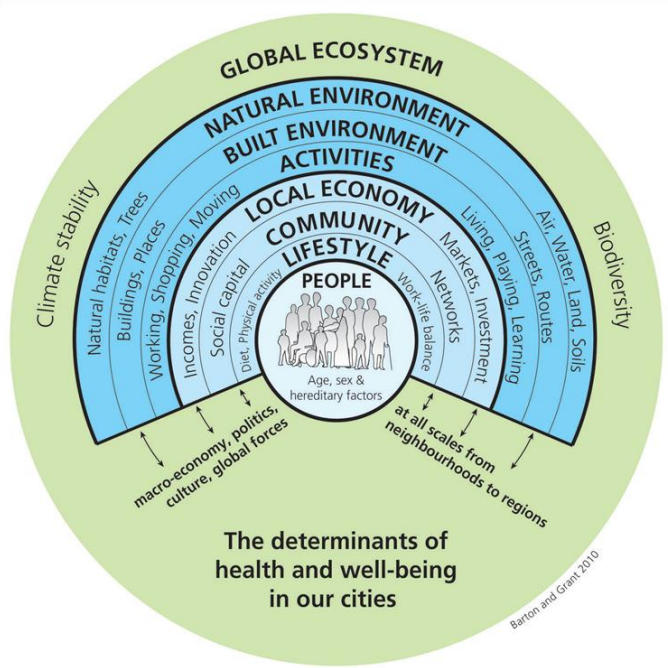
- Produce a population needs assessment and market analysis to include the needs of self funders;
- Develop an appropriate integrated market position statement and commissioning strategy. These will specify the outcomes required of care homes, including the range of services required;
- Develop a new care model across Cardiff and Vale of Glamorgan to reflect changing population needs and home first principles;
- Consider new delivery models for care delivery including third sector and social enterprises and locality approaches;
- Agree the methods of commissioning and procurement;
- Agree a common contract and specification across health and social care;
- Develop an integrated approach to agreeing fees with providers;
- Develop an integrated approach to quality assurance;
- Establish a pooled fund across health and social care for commissioning care home accommodation by 2018.

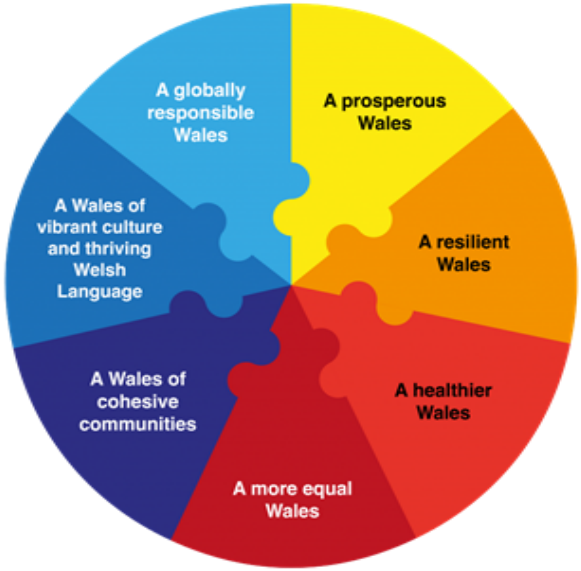
Focus on Wellbeing

Wellbeing

Wellbeing is influenced by our **lifestyle choices**, our **income**, our level of **education**, our **employment**, **where we live**, the **environment** around us as well as **our access to and use of health services**. The health map (right) reminds us of all of these influences.

The Health Map





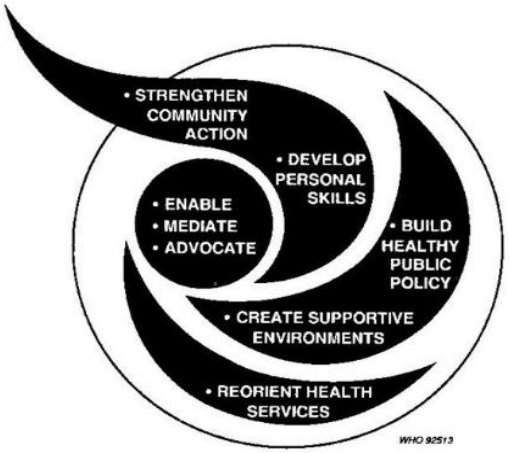
As a Health Board we are committed to **Keeping People Well** as well as Caring for People. Promoting the wellbeing of our citizens is our core business and is a central element of our responsibility within the **Wellbeing of Future Generations (Wales) Act 2015**. The Act has put in place seven well-being goals (shown left) which together promote the **social, economic, environmental and cultural wellbeing** of Wales. This specification will contribute to our achievement of our wellbeing objectives.

Promoting Wellbeing

Wellbeing matters because:

- It adds years to life
- It improves recovery from illness
- It is associated with positive health behaviours
- It is associated with broader positive outcomes
- It influences the wellbeing and mental health of those close to us
- It affects how staff and health care providers work
- It has implications for decisions for citizens care and services
- It has implications for treatment decisions and costs
- It affects decisions about local services
- It may ultimately reduce the healthcare burden

Framework for Promoting Wellbeing



In this document we refer to wellbeing as both physical and mental wellbeing. Our **focus on wellbeing** will ensure that we:

- Promote health and reduce ill-health (what) through the implementation of actions across the areas outlined in the framework illustrated above (how)
- Achieve the following outcomes
  - **Maximise access (balanced with continuity)** to primary and community care services
  - **Reduced activity** across the health system
  - **Sustainability** of primary care services

To promote wellbeing and prevent ill-health, we work with partner organisations across a framework that includes:

Creating supportive environments

Delivering **primary and community care services** from **local appropriate and accessible venues** is a key part of this service specification (Develop Health & Wellbeing Centres and Wellbeing Hubs). A guiding principle across this work as it develops must be to ensure any facilities promote the health of those who access and use any of our buildings and facilities for services or work.

This commitment ensures that our facilities in communities:

- Comply with good building design in terms of promoting health and in meeting our obligations within equality legislation
- Are accessible by public transport, by walking and by cycling
- Implement policies that promote health, for example no smoking on our premises, food prepared and served complies with our catering standards
- Provide green and open spaces
- Work with and complement surrounding buildings, ensuring interconnectivity between services

Strengthening community action

Working with our citizens and communities is at the heart of what we do. This commitment ensures that:

- Community and citizen engagement continues to influence and inform our work
- Community and citizen engagement in developing and delivering primary and community care services will be encouraged
- Community activities that promote well-being are encouraged and promoted

Reorienting our services to focus on prevention

Reorienting health services to promote health and deliver services in the community are core elements of this service specification

This commitment ensures that:

- Promoting health and having a conversations with patients about lifestyle choices will be core elements of all staff roles (MECC – Making Every Contact Count)
- Integration across the health and social care system will continue
- Partnership working between our staff in acute services and primary care will continue
- Appropriate services will be moved from the acute sector to the primary and community care sector

Building healthy public policy across our organisation

We are committed to working in partnership to ensure that all local policies in our own and other organisations promote health and wellbeing. This commitment ensures that:

- Wellbeing remains at the heart of services
- Inequalities in health and in access to services are addressed

Developing personal skills

- We are committed to supporting personal and social development through provision of information, education for health and enhancing life skills. Some examples of initiatives that support the development of skills are outlined below and in the pages that follow.

Social Prescribing

Social prescribing is a way of linking citizens and patients in primary care with sources of support within the community. It provides GPs with a non-medical referral option that can operate alongside existing treatments to improve health and wellbeing. While there is no widely agreed definition of social prescribing, or 'community referrals', reports on social prescribing include an extensive range of prescribed interventions and activities.

Social prescribing is often defined as "a means of enabling primary care services to refer patients with social, emotional or practical needs to a range of local, non-clinical services, often provided by the third and community sector." In practice this means that GPs, nurses or other healthcare practitioners work with patients to identify non-medical opportunities or interventions that will help them adopt healthier lifestyles or improve wider social aspects of their lives.

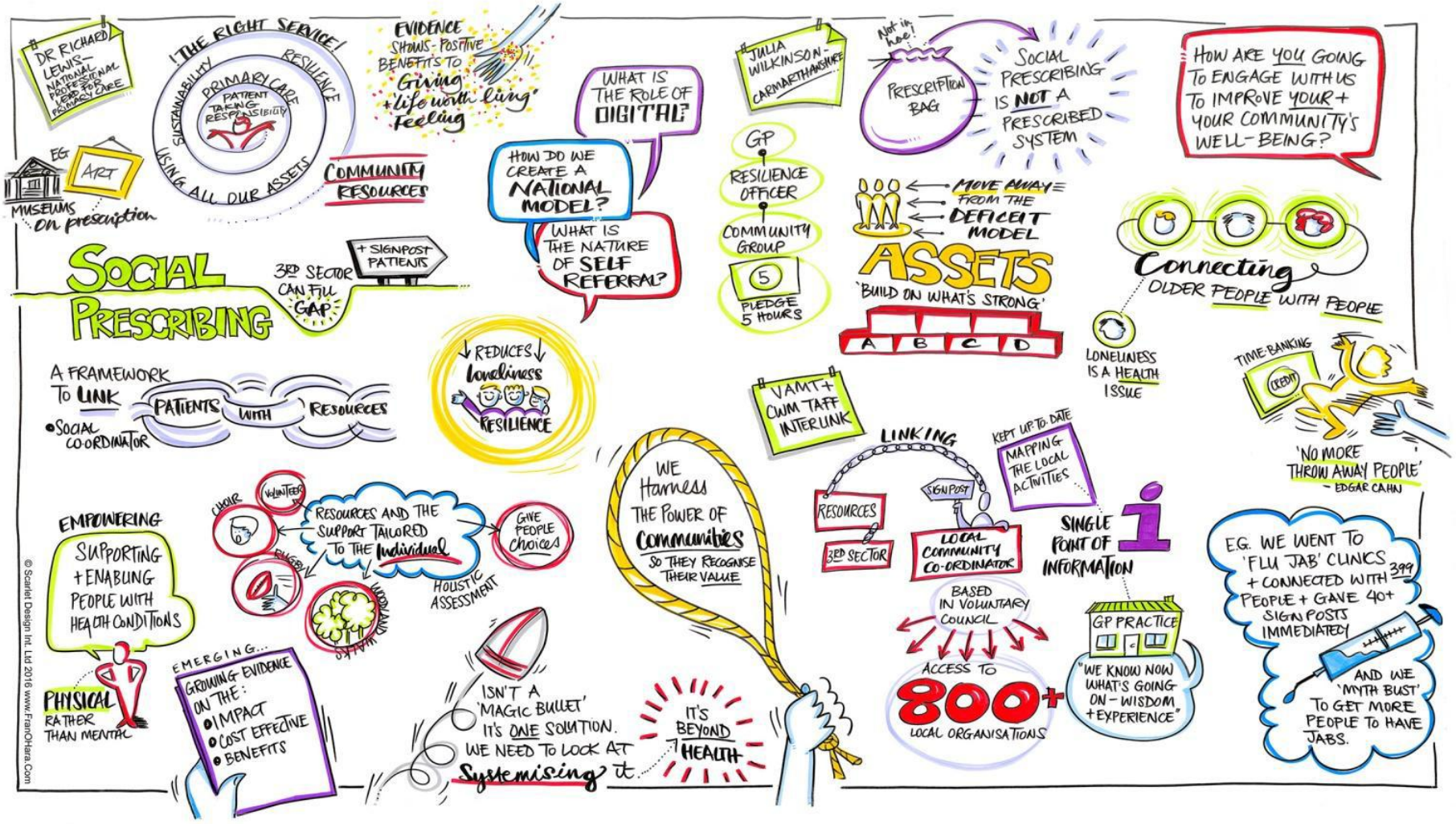
Schemes such as exercise-on-prescription projects have been established or piloted in a number of areas and said to have been 'very successful'. We are promoting access to non-clinical interventions from third sector services and community groups as a way of making general practice more sustainable.

Growing evidence to support that social prescribing:

- Improves health and quality of life
- Increases patient satisfaction
- Results in fewer primary care consultations
- Results in reductions in the number of hospital admissions, visits to Accident and Emergency, and outpatient attendances
- Results in a decrease in the use of wider hospital resources

Examples of social prescribing interventions include:

Community education groups -arts, creativity -learning and exercise on referral -self-help groups - computerised CBT self-help reading - group activities on referral – volunteering - time banks - signposting information and guidance supported education and employment - adult learning - knit and natter clubs - fishing clubs -gym-based activities guided/ health walks - green gym/ gardening clubs - cycling



Developing Personal Skills

Volunteering

Research shows that volunteering makes people feel healthier, happier, lifts their mood and gives them a sense of purpose in life and a new way forward. We will promote volunteering as a way to increase community and personal resilience and strength.

Time Banking

Time credit systems support people in giving their time to strengthen communities and to design and deliver better services. We believe that everybody has something to give that can make a difference in the place they live and they also provide a system for organisations to work together to exchange their skills and resources. Time credits are already being used extensively in Cardiff - across family support services, communities first, neighbourhood partnerships, schools and community groups.

Peer support

Peer support in health and care encompasses a range of approaches through which people with shared experiences, characteristics or circumstances provide mutual support to promote health and wellbeing. Peer support occurs when people provide knowledge, experience, emotional, social or practical help to each other. It commonly refers to an initiative consisting of trained supporters (although it can be provided by peers without training), and can take a number of forms such as peer mentoring, listening, or counselling.

Provide information about Services

We now have a system to assist in providing information:

Dewis Cymru
Have choice and take control

Dewis Cymru
Cael dewis a chymryd rheolaeth

Dewis Cymru is a directory of services which is unlike any other. Dewis Cymru was adopted by the City of Cardiff Council and Vale of Glamorgan Council following the introduction of the Social Services & Well-being Act in April 2015, which places a requirement on all local authorities to provide information, advice and assistance to residents. Dewis Cymru has been growing, with over 1000 resources across Cardiff and the Vale.

Navigators/ Co-ordinators

Providing Wellbeing Navigators or Co-ordinators supports people aged 18 and over with wellbeing, to avoid using services unnecessarily, and assists people with long term health conditions to address social issues that are having a detrimental impact on their lives. It is about helping people to build personal resilience in self-managing health and wellbeing now and to the future by putting in place social action support. This support is there to try and remove the escalation of potentially unnecessary demand on GP/ hospital services due to non-medical reasons.

Build resilience with education

Education programmes for citizens/ patients in Cardiff and the Vale of Glamorgan, provided by Education Programmes for Patients (EPP) Cymru and online, offer a number of self-management courses and workshops for people living with any long-term health condition or have a caring role. These courses provide an opportunity for people to learn new coping skills, enhance confidence to take responsibility for their own care, and encourage them to work in partnership with health and social care professionals.

Suggested Way Forward

We will work with partner organisations across a framework that includes:

- **Creating supportive environments**. We will ensure that our services are delivered from local, appropriate and accessible facilities that comply with good building design, are accessible by public transport, walking and cycling, implement policies that promote health, implement policies that promote health, provide green and open spaces and ensure interconnectivity between services and communities. This links with our commitment to deliver Health and Wellbeing Centre and Wellbeing Hubs.
- **Strengthening community action**. We will work with our communities and citizens to inform our service delivery and will promote community activities that promote health.
- **Reorienting our services to focus on prevention**. We will ensure our services promote health, integrate across the health and social care system, work in partnership and are delivered close to people's homes.
- **Building healthy public policy across our organisation**. We are committed to working in partnership to ensure local policies promote health and wellbeing.
- **Developing personal skills of staff and citizens**. We will support the development of various initiatives including, for example.' Making Every Contact Count' training with staff, social prescribing models in primary care, volunteering, self care courses, time banking.

Sustain Primary Care Particularly General Practice

Sustain Primary Care Particularly General Practice

How big is the problem? What do we know?

- 90% of health care contacts happen in Primary Care
- We have an increasing population who are living longer and have more complex health needs
- Our expectations have increased
- With increasing complexity of care, ideal access to General Practice can be challenging to provide (i.e. rapidly available appointments)
- The more openly accessible General Practice appointments become the less continuity of care we get
- Continuity of care (seeing the same GP/ clinician) results in better patient experience and less admissions to hospital (8-13%)
- Enhanced and improved Primary Care estates (i.e. buildings) need to be an integral part of service improvements
- Information management and technology is relatively well developed within individual GP practices but not between different GP practices, hospitals, mental health services, community care (e.g. district nursing) and social care
- The medical workforce is changing:
  - Age profile (increasing number of GPs >55 years)
  - Generational change with a more fragmented /part time service with other commitments
  - Reduction in the number of GP partners and an increase in salaried GPs and locums
  - Very limited growth over the years in the overall number of GPs
  - Huge problems with recruitment and retention of GPs

- Changes in skill mix e.g. advanced nurse practitioners, nurse practitioners, advanced paramedics, clinical pharmacists, physician's assistants.

Sustain Primary Care Particularly General Practice

Context: Primary Care Plan, Key Messages

Key strategic drivers include:

- Improving health and reducing health inequalities
- Timely, safe, effective investigation, diagnosis & prescribing close to home
- Realising the integrated Local Health Boards' potential
- Move to a "social" model of health, which promotes physical, mental and social wellbeing (rather than absence of ill health)

Statute:

- Social Service and Wellbeing (Wales) Act
- Wellbeing of Future Generations Bill
- Public Health Bill

Key emphasis on workforce – robust approach to workforce planning, wider primary care workforce, stabilising high risk areas

Cluster Service development themes:

- Pharmacy support to undertake polypharmacy reviews on elderly and frail patients
- Dementia enhanced review
- Enhanced heart failure management
- Local improved access dependent on very local issues (deprivation, access) e.g. community pulmonary rehabilitation, community respiratory education sessions
- Improving childhood immunisation uptake
- Co-production including focussed work where languages are a barrier to access

The cluster investment discussion has demonstrated:

- Focus on outcomes to cluster populations
- Whole system thinking

Sustain Primary Care Particularly General Practice

Primary care is about those services which provide the first point of care, day or night for **more than 90% of people's contact** with the NHS in Wales. General practice is a core element of primary care but it is not the only element – Primary care encompasses many more health services, including, pharmacy, dentistry, and optometry. It is also, about coordinating access for people to the wide range of services in the local community to help meet their health and wellbeing needs.

These community services include a wide range of staff, such as community and district nurses, midwives, health visitors, mental health teams, health promotion teams, physiotherapists, occupational therapists, speech and language therapists, podiatrists, phlebotomists, paramedics, social services, other local authority staff and all those people working and volunteering in the wealth of voluntary organisations supporting people in our communities.

Some of the challenges faced within primary care services include:

- Impact of austerity on services and on the population
- Increased demand
- Rising public expectations
- Staff recruitment and retention together with an ageing GP workforce
- Increased number of managed practices in Wales
- Population growth across Cardiff and the Vale and the development of very large housing developments (41,000 homes in Cardiff by 2026) as predicted in the Local Development Plans
- Estate issues where some buildings are not fit for purpose

The Welsh Government Plan 'Our plan for a primary care service for Wales up to March 2018' focuses on moving primary care service delivery to a social model of health.

The overall principles that underpin the Welsh Government Plan include:

- Prevention, early intervention and improving health, not just treatment;
- Co-ordinated care where generalists work with specialists and wider support in the community to prevent ill health, reduce dependency and effectively treat illness;
- Active involvement of the public, patients and their carers in decisions about their care and wellbeing;
- Planning services at a community level of 25,000 – 100,000 people; and
- Prudent healthcare.

Our focus on sustaining primary care takes forward the Welsh Government plan and will ensure that we:

- Deliver local, accessible and equitable primary care services delivered by a skilled multidisciplinary workforce (what);
- Support GP practices, clusters, primary care professionals, local authorities and third sector to plan, establish and evaluate robust models of delivery (how);
- Achieve the following outcomes:
  - **Maximise access (balanced with continuity)** to primary and community care services;
  - **Reduced activity** across the health system;
  - **Ensure sustainability** of primary care services.

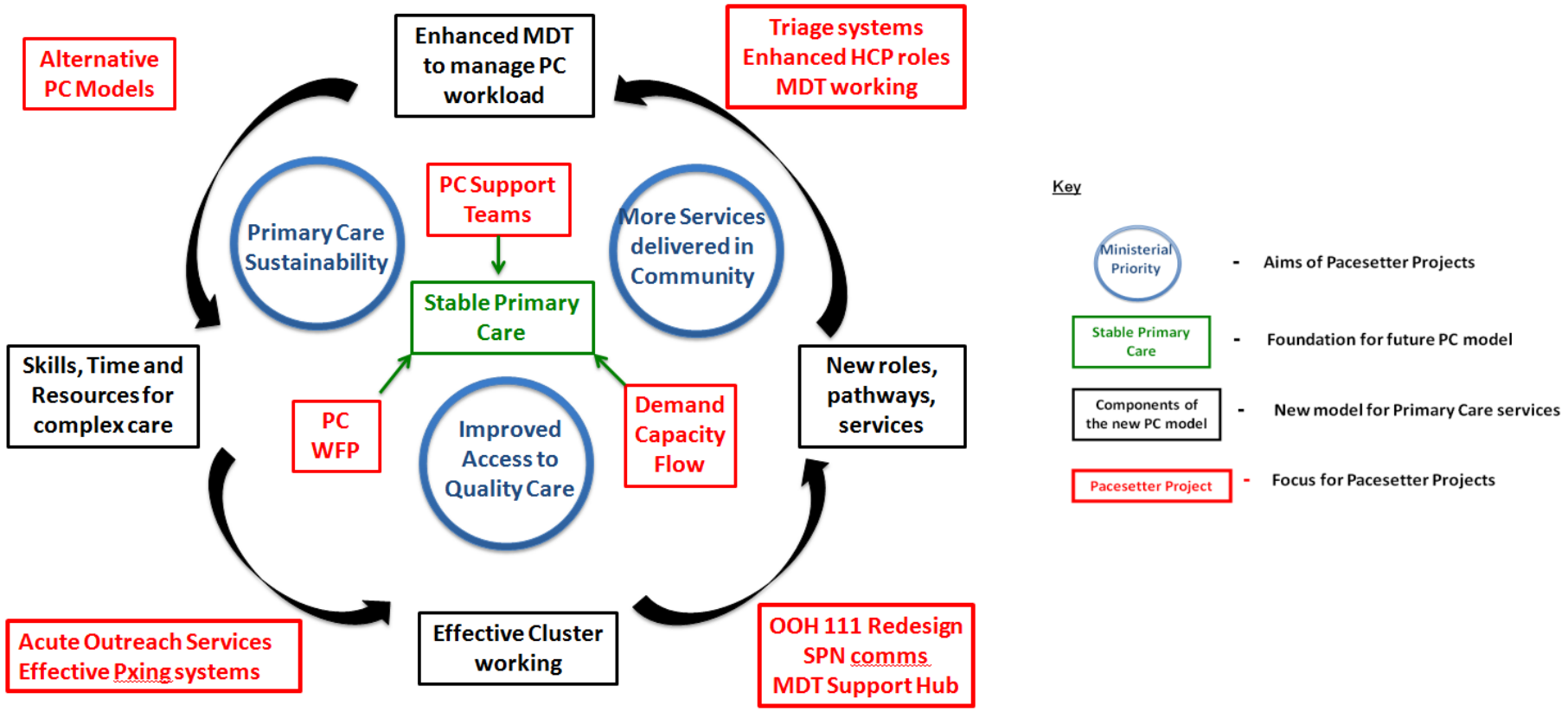
Learning from elsewhere as well as locally, confirms that models of primary care should develop depending on population need, stage of cluster development and needs of the general practice service in the different parts of Cardiff and the Vale. Many models of primary care share a desire to improve and extend primary care services, develop management and leadership capacity and assume a more significant role in the local health system.

Examples of models of primary care across Wales, the UK and from elsewhere include:

- **Wales;** contractual model/ local health board medical services, enhanced care at home, federations, GP social enterprise triage, Locality working: neighbourhood services for older people, multi-morbidity service (provided at Health and Wellbeing Hub level), development of pathways, primary care support teams, secondary care funded and managed services, social model of care, triage and hub.
- **England;** community health organisations, enhanced health in care homes, federations or networks, multi-specialty community providers, primary care home model, primary and acute care systems (PACS) model, regional and national multi-practice organisations, super-partnerships, urgent and emergency care.
- **Alaska;** NUKA System of Care.

Sustain Primary Care Particularly General Practice

The 1000 Lives Pacesetters and Pathfinders Programme has proposed a road map with stable primary care /GMS at the heart of the service



Abbreviations: HCP, Health Care Professionals; MDT, Multidisciplinary Team; OOH, out of hours; PC, Primary Care; SPN, single point number; WFP, work force planning; Pxing, Prescribing.

Additionally, the principle of ‘form follows function’ should underpin consideration of future organisational forms. Based on the context outlined in the Welsh Government Plan, the following functions expected of clusters are:

- **Communication:** providing a route for two way communication between Primary Care/ General Medical Services (GMS) Practices and the rest of the system
- **Sustaining core GMS/ primary care services:** e.g. providing a route for discussion about the emerging evidence for GMS sustainability options
- **Local health needs approach:** receiving cluster based public health information/ local assessment of need and using this to plan & deliver local services
- **Integration of local services**: communication and co-ordination between local agencies, stakeholders and people so that services available locally compliment each other as much as possible
- **Quality improvement**: improving the quality of services delivered locally (e.g. reducing unnecessary variance and waste)
- **Service delivery**: expanded delivery of primary and community services through direct management of resources for the cluster (e.g. cluster staff and budgets)
- **Extended service delivery**: providing a vehicle to consider delivery of extended services through a transfer from “secondary care” (i.e. similar to the move of anticoagulation services) when beneficial to do so
- **Informing the planning/ delivery of secondary care services** so that they are responsive to local needs

Suggested Way Forward

Whole system problems, whole system solutions:

To sustain primary care, especially General Practice we will work at three levels: national, cluster and individual GP Practice

National level we will:

- Influence future developments of the GMS contract to maintain a high quality of care while removing unnecessary bureaucracy
- Influence sustainability programmes at national level to reflect the needs of the population of Cardiff & Vale of Glamorgan

Cluster level we will:

- Work with General Practice to audit workload and support the signposting of patients to the service that best suits their need and so avoids unnecessary delay. As well as seeing the right clinician within GP Practices this may also include, enhanced, more visible 'upstream' Local Authority/ third sector/ wellbeing services at cluster level
- Community services for older people that are responsive to the cluster patients' needs and include, increased provision of admission avoidance services, more integrated pre-hospital physical & Mental Health services
- Maximise collaboration and integration at the Primary/Secondary care interface to avoid duplication of effort, unnecessary steps (or confusion) for patients and unnecessary work for clinicians (thus improving capacity in both parts of the system)
- Develop clinical service, infrastructure, workforce & financial plans for the impact of population increases / the Local Development Plans
- Support further evolution of clusters in order to develop ways for General Practice to collaborate at scale; in whichever organisational form meets the aspiration of the local cluster (e.g. informal clinical network, social enterprise, federation etc)

Individual GP Practice we will:

- Work with individual practices (on a voluntary basis) to put systems into place that prevent destabilisation, sharing resources / best practice including those that relate to clinical services, business processes
- Assist with workforce planning of clinical & none clinical staff, developing the most responsive and efficient skill mix for the Primary Care MDT and addressing HR issues
- Developing the individual practices' bespoke service model that best matches limited capacity to demand and maximally balances acute access with continuity of care
- Support Infrastructure plans
- Assist business planning

Improve Patient Pathways Across Primary and Secondary Care

Primary/ Secondary Care Integration

Working with colleagues to ensure primary and secondary care integration has resulted in a focus on,

1. **Unscheduled Care**: pathway development for ambulatory care sensitive conditions (ACSCs)
2. **Prescribing**: maximising quality and minimising waste in prescribing (e.g. rational antibiotic prescribing / infection reduction)
3. Rational antibiotic prescribing/ infection reduction
4. **Scheduled Care/ Cancer Care**: development of whole system pathways that improve access for the most needy patients; including Gastroenterology, Dermatology and Urology.
5. Development of a model for **GP-Paediatric hubs**, building on the success of the Cardiff & Vale Community diabetes model
6. **Reducing stroke** / ‘Stop a Stroke’ Campaign

1. Unscheduled Care: pathway development for ambulatory care sensitive conditions (ACSCs)

Background:

Ambulatory care sensitive conditions (ACSCs) are conditions where effective community care and case management can help prevent the need for hospital admission.

ACSC's account for 1/6 emergency hospital admissions (England)

- Estimates suggest emergency admissions for ACSCs could be reduced by **8 – 18%,** saving **£6 to £15** million in Wales

Methodology:

A **structured, standardised approach** has been adopted including

- **Development of 8 evidence-based pathways** that support patients more safely and closer to home. Pathways focused on atrial fibrillation, heart failure, Chronic Obstructive Pulmonary Disease (COPD), diabetes, falls related to polypharmacy, dehydration and gastroenteritis in under 5's, uptake of Flu/Pneumovax (at risk groups), and advance care planning.
- **IT templates** were developed (and are being improved in an on-going manner dependant on feedback) alongside the pathways to enable effective use during consultation

Outcomes:

Across Cardiff and the Vale:

- 59 of 66 practices signed up to participate
- Pathways and templates embedded in practice systems and in use since April 2016

2. Prescribing: Maximizing quality & minimizing waste in Primary Care

Background:

With an increasing number, complexity and age of population being treated in primary care there are inevitable pressures on the finite GP prescribing budget. Savings have to be made in order to pay for new drugs and to maintain/ improve the quality of care provided. Historically this has been achieved through switching to generic or less expensive equivalent medicines within the same therapeutic group. Increasingly savings have been more difficult to identify or more complicated and labour intensive to achieve.

Methodology:

A multidisciplinary approach involving primary and secondary care clinicians and pharmacy advisors resulted in achieving the lowest growth in primary care prescribing spend in Cardiff & Vale UHB.

Outcomes:

We now rank 2nd out of 7 Health boards for the lowest growth in spend. We also delivered very significant improvements in performance against the National Prescribing Quality Indicators.

Recruitment of clinical pharmacists working in GP practices has increased the amount of polypharmacy medication reviews taking place. Additionally the prescribing team has piloted working with care homes to provide a medicines reconciliation and review service and to review care home medicines management processes.

Next steps:

- Engagement of community pharmacy with the media and use of the internet to reach patients
- Maintaining and building on cultural change takes time. Continuing with pathway development work with the engagement of secondary care clinicians is needed to ensure that subsequent use of primary care resources are considered when medications are started in secondary care.
- Increasingly, efficiencies cannot be made across the board and a more personalised, patient focused approach needs to enable change, such as more extensive individual patient medication reviews.
- GP practices are also auditing their medicines reconciliation processes – this has the potential to improve safety and reduce waste as well as encouraging consistent quality services

3. Rational Antibiotic Prescribing/ Infection Reduction

Background:

Overuse of antibacterials is associated with antibiotic resistance. There is significant variation in antibacterial prescribing between Health Boards and between practices within those Health Boards.

Reducing unnecessary prescriptions for antibiotics should also release GP appointments through avoiding repeated attendances for viral infections as patients are educated and engage in self care.

Methodology:

A multifaceted approach, working with prescribers, to minimise variation and improve prescribing was undertaken, including;

- Real time review and audit of antibacterial prescribing and group discussion/ peer review comparing with guidelines and evidence with practice, patient awareness campaigns, practice information board kept up to date with current data
- Engagement of cluster pharmacists by prescribing team to ensure consistent messages within cluster; discussion at high prescribing cluster meetings with input from a microbiologist .

Outcomes:

In the year to March 2016, antibacterial usage fell by 6% in Wales. **The largest % decrease was seen in Cardiff & Vale UHB**, with a **8.53%** reduction. Cardiff & Vale is now lower than the English average for this indicator. Co-amoxiclav prescribing reduced by approximately 18% across Wales when measured as items per 1000 patients. Prescribing in Cardiff and Vale **reduced by more than any other health board** at 32%.

Next Steps:

- Maintain and build upon cultural shift by focusing on fluoroquinolone prescribing; and on further reducing volume;
- Ongoing education to support continuous improvement;
- Engaging with patients to further understand the harms of unnecessary antibiotic prescribing
- Continued engagement of community pharmacy with the media, and using the internet to reach patients.

4. Scheduled Care/ Cancer Care: whole system pathways, for example Gastroenterology:

Background:

Outpatient waiting times and endoscopy waiting lists have been identified as problematic. There is a significant time delay between patients being referred from primary care and being seen in secondary care. The problem is exacerbated by reduced thresholds for urgent suspected cancer referrals and a changing demographic. The high volume/ high impact conditions which prompt a referral to secondary care have been identified, and we have started creating care pathways for these. The aim is to ensure an agreed uniform plan of care prior to the point of referral. This is in order to allow the highest risk patients to be seen most quickly. Agreed appropriate management plans will also lead to the earlier diagnosis of sinister conditions and optimal management of common gastroenterological conditions.

Methodology:

Adoption of the Welsh Patient Referral System (electronic referral and 'e-advice') has allowed for a dialogue to be developed between Primary and Secondary care. This has been found to be of great benefit in **signposting patients** (e.g. direct to endoscopy without the need for an additional outpatient appointment) and **earlier clinical case management.**

Outcomes:

- Care pathways have been developed for; iron deficiency anaemia, dyspepsia, and abnormal liver function test results.

- Strong clinical engagement was facilitated between clinicians and GP leads, that included delivery of joint educational events with the GP being viewed as a member of directorate.

Improvement in the management of chronic liver disease has been identified as a national priority. By managing to rule-out alternative diagnoses effectively, the correct diagnosis can be made, and the patient can be more safely managed in primary care.

Other Developments:

- GPs are now able to request faecal calprotectin testing, following liaison with gastroenterology. This test permits a diagnosis of inflammatory bowel disease (IBD) to be confidently ruled-out, with the aim reduce unnecessary referrals to secondary care, and reducing the risk of missed diagnosis of irritable bowel disease.
- For faecal occult blood testing there was a lack of confidence that this was an appropriate investigation to be reintroducing following National Institute for Health and Care Excellence (NICE) guidance. An All Wales statement document has been drawn up, outlining alternative management strategies.

4. Scheduled Care/ Cancer Care: whole system pathways, Urology and Dermatology:

Methodology:

Using a similar approach to Gastroenterology, joint educational events have been developed, and pathways and methodologies for referral and advice have also been agreed for other specialties:

Outcomes:

Urology

•Pathways have included those for prostate cancer and none visible haematuria (blood in the urine), which can be a sign of cancer or kidney disease

Dermatology

•Increased uptake of Teledermatology/ e-referrals now covers approximately 1200-1400 referrals per month with up to 25% being dealt with by advice, this minimising delays for patients

•This also allows direct referrals efficiently to specific consultants and their named clinics accurately after diagnosis as 80% of referrals have photos attached

•In addition, we have recently added provisional diagnosis at the time of accepting referrals which will enable us to plan outpatient clinics more efficiently e.g. rash vs. lesion and diagnoses such as psoriasis, eczema, melanoma, hand eczema, cyst etc can be allocated.

Anecdotal feedback for these initiatives has included:

"Overall, I feel a GP linked in with directorates can only be a good thing. If we don't have a seat at the table, we don't have any influence" **(GP)**

"We now have a named person to link into primary care ... we absolutely want his role to continue" **(Consultant)**

"It is fantastic working with the named GP and has had a really positive impact on the service and in driving things forward. It has also been beneficial in terms of governance issues in helping to understand and provide solutions to scenarios that arise" **(Consultant)**

5. GP Paediatric Hubs

Background:

General Practice and the paediatric outpatient department at Cardiff and Vale UHB face unprecedented demand. Patients needing referrals has increased by nearly 40% in the last 8 years up to 2015. Evidence from across the UK and elsewhere shows that quality of care for children is improved in integrated health systems, when clinicians from different teams work closely together. Children living in countries with this type of system achieve lower mortality rates and earlier detection of serious illnesses such as cancer. Early paediatric integrated care models within the UK are delivering high quality care and reducing the need for the family to travel to hospital clinics on busy sites such as UHW.

Methodology:

- Process-mapping highlighted sources of waste in this system.
- We engaged with all the stakeholders.
- We designed a new integrated system based on the needs of children and families.

The Integrated Care System:

- GPs consult paediatrician using **e-Advice** (robust email system)
- Booking coordinated by primary care team
- **Patients seen in their own or neighbouring practice**
- Paediatrician delivers clinic 1-2 monthly with input from primary care team
- Plan made jointly with paediatrician & GP
- Whole-practice multi-disciplinary team (MDT) meeting with feedback after every clinic
- Plan-Do-Study-Act cycle at every MDT to rapidly evolve model

Next Steps:

- Plans to extend model to further practices in Cardiff South West Cluster.
- 12-18 month programme to define improvement & confirm sustainability.
- Bid for funding submitted to Health Foundation Innovate to Improve .

6. Reducing Stroke

Background:

Atrial Fibrillation (AF) is the most common sustained arrhythmia, affecting at least 2% of the adult population and is the cause of 1 in 5 strokes in Wales. In 2014 National Institute for Health and Care Excellence (NICE) and All Wales Medicines Strategy Group (AWMSG) published guidelines recommending all patients with AF were assessed and offered anticoagulation if found to be at risk, as this has been shown to reduce the risk of stroke by 2/3. These recommendations were endorsed by Welsh Government.

Methodology:

The Stop a Stroke campaign has been led by a multidisciplinary team of a consultant stroke physician, consultant haematologist and specialist anticoagulation pharmacist. This clinical team has been supported by primary care managers, a GP and has had an audit tool provided by Primary Care Quality. The aim has been to develop a model of providing general practice with the knowledge, skills and confidence to review high risk atrial fibrillation patients for suitable anticoagulation to prevent the occurrence of a stroke in line with current NICE guidance.

Outcomes:

The data suggests that in Cardiff &Vale of Glamorgan, 2300 AF patients may not be on anticoagulation. If 920 patients (40%) are anticoagulated, the stroke risk per year will fall from 10% to 3%, which will prevent 65 stroke per year. This would be a potential 10% reduction in all strokes.

The most effective model from our early data is an intervention, which includes a **cluster meeting followed by intensive support (consultant and anticoagulation pharmacist) with e-advice**. This may lead to a **10% reduction in all strokes.**

Next Steps:

We will roll out this model across the UHB area and provide a platform for a national roll out.

Suggested Way Forward

General Practitioners (GPs) have been partnered with various specialties (including Diabetes, Respiratory, Paediatrics, Mental Health, Gastroenterology, Dermatology, Urology) or across services focusing on themes or pathways (for example, Medicines Management, Ambulatory Care Sensitive Conditions and cancer)

This has facilitated quality and cost improvement including:

- Well recognised benefits of the community diabetes model (reduced outpatient department activity)
- Reduced prescribing growth
- Rational antibiotic prescribing / infection reduction
- Further, widespread development/implementation of ambulatory care sensitive condition pathways
- Improved stroke prevention
- Benefits to *Referral To Treatment* in most appropriate pathways (cancer, gastroenterology, dermatology, urology)

To improve Primary /Secondary Care Integration and the further development of patient pathways we will:

- Continue to support innovative multidisciplinary working across the system
- Encourage the use of quality improvement methodology to ensure clarity of need, focus, action, impact and outcomes
- Improve access to data to help benchmark and measure progress and impact
- Ensure robust governance arrangements

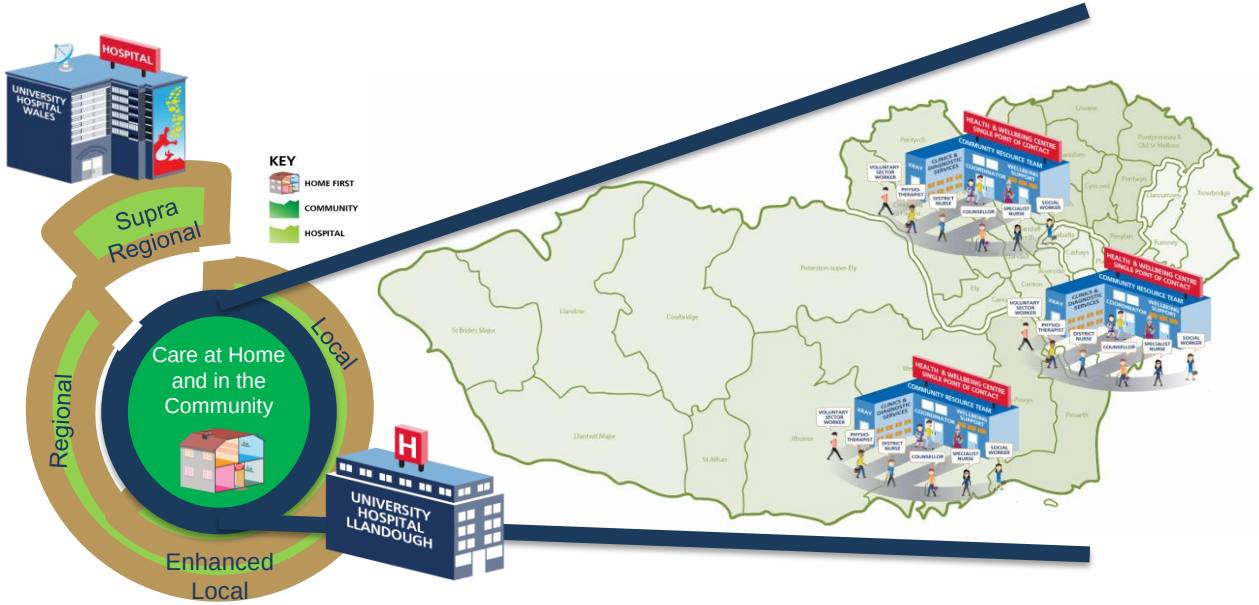
Develop Health and Wellbeing Centres and Wellbeing Hubs

Shaping Our Future Wellbeing:
In Our Community

To provide the major physical infrastructure required to support improved access to community services and assets, to improve health outcomes, set the tone for co-production and ultimately reducing health inequalities.

An options appraisal exercise has been undertaken to assess a preferred way forward in terms of scope, solution, delivery, implementation, funding. As a consequence the preferred scope (before economic appraisal) is:

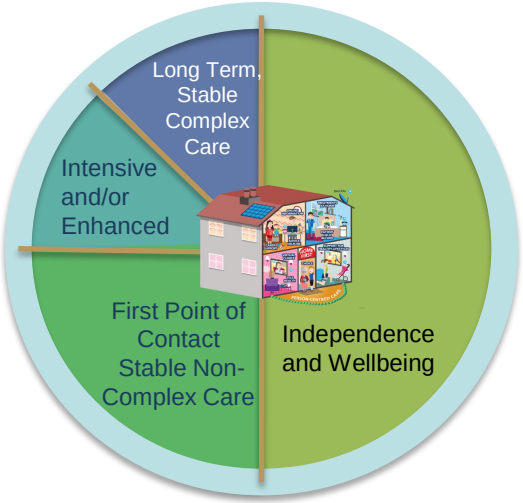
- Existing range of community based services
- Shift of clinics from hospital, both routine services/interventions and transformational innovative services and supporting diagnostics, therapeutic services, IT/health technology.
- Wellbeing services, lifestyle information and education, signposting



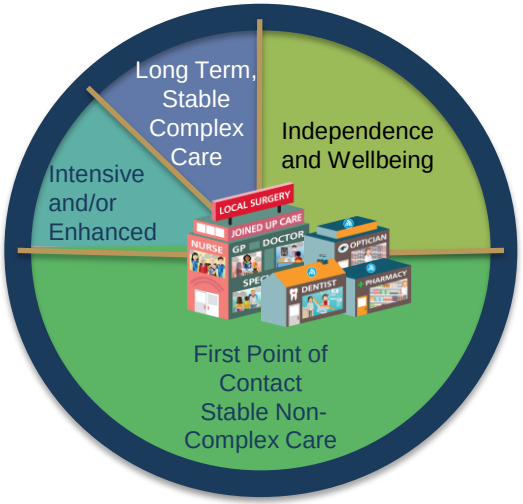
An Integrated Network of Hospital and Community Care and Wellbeing

When we apply the whole systems services model on page 29 to our current services and to those that we want to develop in the future, we can begin to see what the make up of our estates infrastructure could look like in the future.

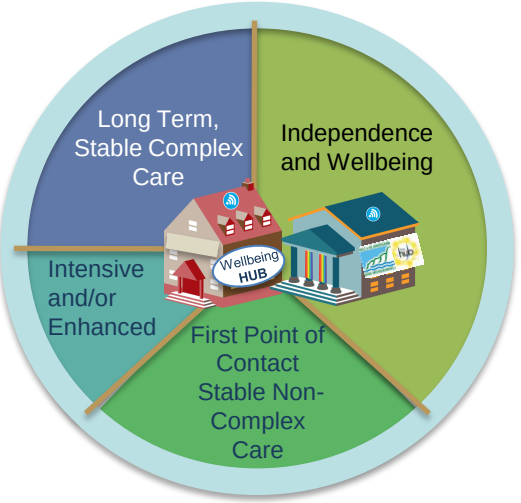
Home



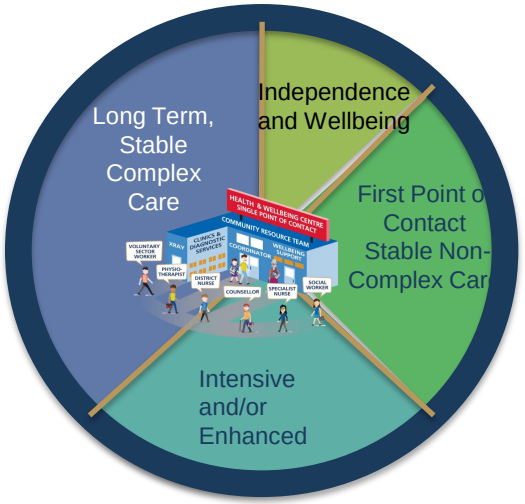
General medical, dental, optician and community pharmacy service



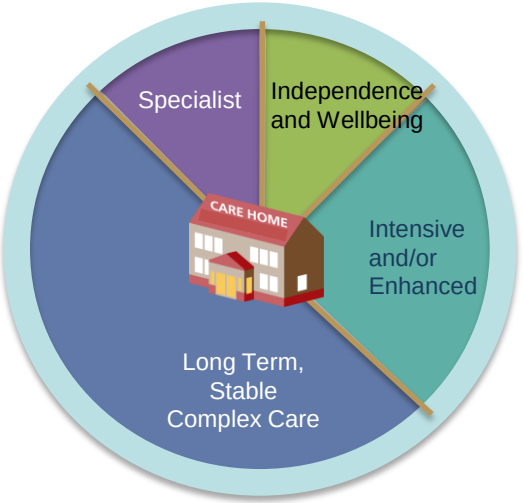
Wellbeing hub



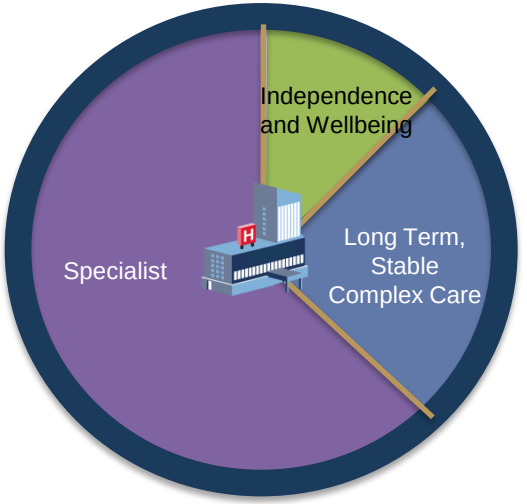
Health and Wellbeing Centre



Nursing home

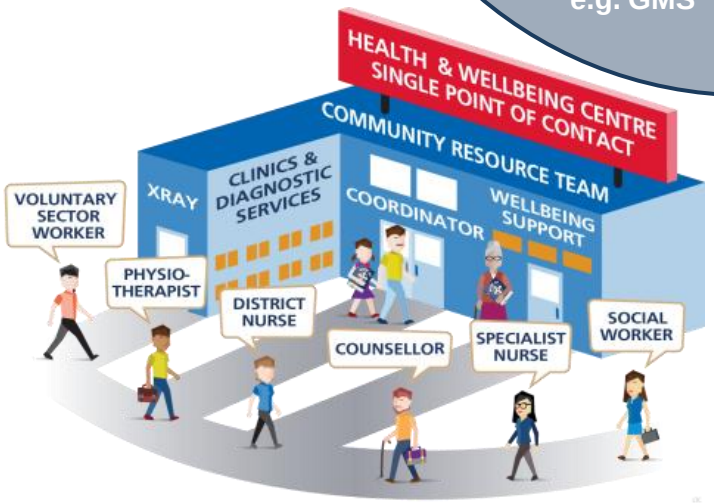


Acute hospital



What's in the Health and Wellbeing Centre?

- Within each of the three Localities we would like to create a **Health and Wellbeing Centre**



Health & Wellbeing Centre

Health Zone
- Diagnostics centre
- Dedicated clinics – dental, podiatry, audiology
- Locality responsive services
- Day / ambulatory treatments
- Pharmacy
- Therapies/ MSK hub
- Community mental health and outpatient clinics
- Multi morbidities service
- Cluster responsive services, e.g. GMS

Community Support Zone
- Targeted local authority services e.g. ARC or Flying Start
- Meeting rooms

Team Zone
- Third sector group bases
- Staff bases e.g. CMHT, district nursing, CRT
- Teaching kitchen

Wellbeing Zone
- Gym
- Information and advice centre – health social, wellbeing
- Library and computers
- Cafe
- Interview/ counselling rooms
- Group education / community rooms
- Independent living services
- Wellbeing Co-ordinators/ social prescribers

What's in the Wellbeing Hub?

- Within each of the clusters we would like to create **Wellbeing Hubs,** building on existing Local Authority infrastructure

Health Zone
- Cluster responsive services e.g. outpatient clinics, pharmacy, multi-cultural resource centre
- Community clinics
- GMS
- Dedicated clinics – dental, podiatry etc

Community Support Zone
- Targeted Local authority services

Wellbeing Hub

Team Zone
- Meeting rooms
- Staff bases eg District nurses, HVs, school nurses etc
- Third sector group bases

Wellbeing Zone
- Group education/ community rooms
- Information and advice centre – health social, wellbeing
- Teaching kitchen
- Interview/ counselling rooms
- Cafe
- Police office
- Wellbeing Co-ordinators / social prescribers
- Independent living services
- Library and computers

Suggested Way Forward

- Improve the way we deliver our universal prevention and population health services to support the empowerment of people to choose healthy behaviours and encourage self management of conditions.
- Improve quality of services by working with our partners to deliver more co-ordinated and collaborative services closer to home.
- Work with partner organisations to provide the appropriate infrastructure to support delivery of local services focused on health and wellbeing need.
- Improve health outcomes, focusing on conditions where prevention will have the greatest impact, as identified in Shaping our Future Wellbeing Strategy.
- Reduce health inequalities through targeted provision of services/ interventions which better meet the health and wellbeing needs of the local population.
- Improve the capacity of services, to meet increasing and changing demand, focusing on clinic utilisation, workforce, facilities, technology.

Facilitate Technology Solutions

Technology in Health and Social Care

Technology can help to transform health and social care and enable people to access information and treatment in a way that meets their needs. Spreading innovation to improve the quality of care while responding to the financial challenge facing the NHS.

Technologies designed to enable the remote monitoring of health status and collect information that can inform treatment plans, and can act as a powerful tool in the co-ordination and delivery of health care. The use of technology can support the management of long term conditions, and provide support for people with chronic disease, and identify those at risk of developing ill health.

Technology has tremendous potential to:

- Enable self care;
- Anticipate need and prompt early intervention;
- Exchange information between organisations;
- Co-ordinate care as patients transition between providers;
- Highlight when citizens are at risk and need help; and
- Enable secure communications between providers and their patients and families.

Technology in Cardiff and Vale of Glamorgan

Telecare Cardiff is a 24-hour telephone link to a community alarm and response service that allows citizens to stay safe and independent in their own homes. Patients receive a lifeline unit and a personal alarm button pendant. When pressed, the Telecare team will speak to the individual immediately and take whatever action is needed.

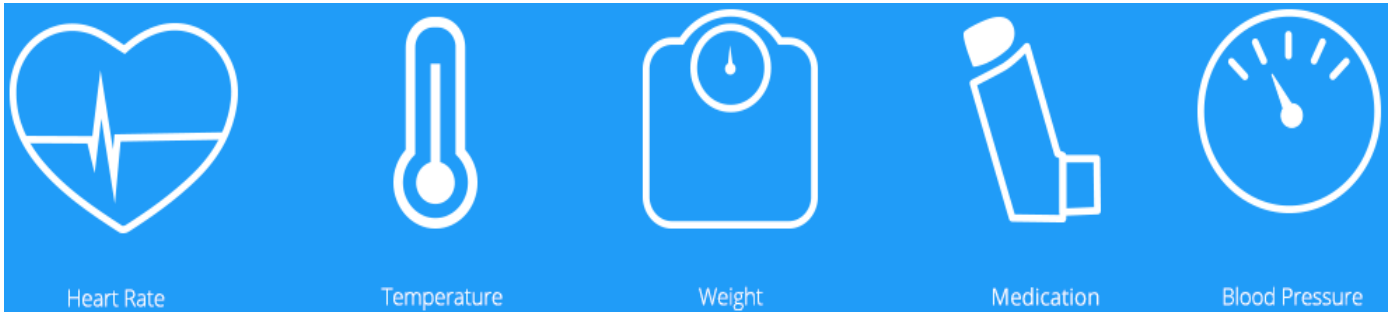
TeleV in the **Vale of Glamorgan** aims to provide any resident of the Vale of Glamorgan with an efficient, responsive and sensitive emergency alarm service 24-hours a day, 365 days a year, as a means of improving personal safety and security and enabling them to remain in their own home.

The TeleV service is available for any member of the community, of any age, who would like to feel safer, more protected or more secure in his or her own home. This may include people with disabilities, those living with serious or chronic illnesses, people leaving hospital following a major or minor surgery and individuals who may wish to use the alarm for added personal security. It offers peace of mind 24-hours a day, 365 days a year.

Florence: customisable for clinicians and patients

Regular, personalised communication encourages behavioural change and gets patients more actively involved in their own healthcare. Florence can be tailored for groups or individual patients with unique healthcare requirements.

Florence is already being used for:



Technology in Primary Care

Technologies such as telephones, email, computers, interactive video, digital imaging and healthcare monitoring devices make it possible for clinicians to monitor, diagnose and treat patients without having to be with them physically. These technologies offer a great opportunity to dramatically increase the efficiency of the healthcare industry, keeping patients out of hospital and allowing care to be facilitated from the home. Technology also provides opportunities for informing and engaging service users and other individuals, giving them the chance to learn about their healthcare and wellbeing through a number of innovative avenues.

- Self-monitoring kiosks in practices for routine assessments.
- Telehealth to assist with self-care and enable triage access to primary care.
- Telehealth for those with complex long term conditions and regular unplanned care events.
- Teleconsultation for those who are hard to reach.
- Telemedicine with specialists to prevent unnecessary outpatient attendance.
- Routine secure text/email communication to avoid unnecessary practice visits.
- Apps for early identification and support of healthy behaviour change.
- Promotion of Telecare / TeleV for carer support, medication management, falls and dementia.
- Apps to improve knowledge of health conditions and treatment options

Suggested Way Forward

- Explore any opportunities for further technology solutions (especially within primary care)
- Promote social networking, Dewis, apps that enhance self determination and wellbeing solutions
- Ensure that citizens are central to any development and are engaged in co-producing any solutions
- Share the Perfect Locality specification with the Health Board and Local Authority departments that will take forward the digital solutions programme.

Communications and Engagement

The Context for Engagement

The context for engaging with stakeholders is the implementation of the Shaping Our Future Wellbeing Strategy. At its heart, the UHB strategy aims to achieve joined up care based on home first, avoiding harm, waste and variation, empowering people and delivering outcomes that matter to them. It focuses on the health and care needs of our local population, the promotion of healthy lifestyles, the planning and delivery of healthcare in people's homes, community facilities and hospitals whilst recognising the need to work more collaboratively with our partners to provide sustainable services, including those which we provide to the wider Welsh population.

The UHB is currently undertaking a number of programmes of work aimed at delivering the strategy. Focusing on establishing suitability, these will transform services through new clinical pathways and service models. There will be a greater focus on a 'social' model of health which promotes physical, mental and social wellbeing through the integration of primary, community and ambulatory care services within the UHB and also in partnership with our stakeholders within the local authorities and the third sector.

Significant stakeholder engagement has already been undertaken, the outcome of which has shaped our plan to transform the way we deliver services within the community. Stakeholders have played a key role in identifying a way forward through a number of engagement exercises:

- Development of the Shaping Our Future Wellbeing Strategy
- Engagement events with citizens
- Partnership planning events
- Population needs and wellbeing assessments (undertaken under the banner of "Lets Talk")
- Focused conversations with clusters, primary care teams and clinical board teams

Why is Engagement Needed?

Communicating and engaging with our citizens, patients, partners, local communities, and the third sector is central to achieving our vision to improve health, wellbeing and health services in Cardiff and the Vale of Glamorgan. It is important that we recognise communication and engagement is a two-way process and work accordingly. To be effective, we need to actively listen to the opinions of the people and groups we communicate and engage with, rather than solely providing information. Issuing a barrage of information is not good practice. Our vision, the way we work and our priorities must be shaped, implemented and finally conveyed through an on-going relationship with all our stakeholders, based on mutual respect and openness.

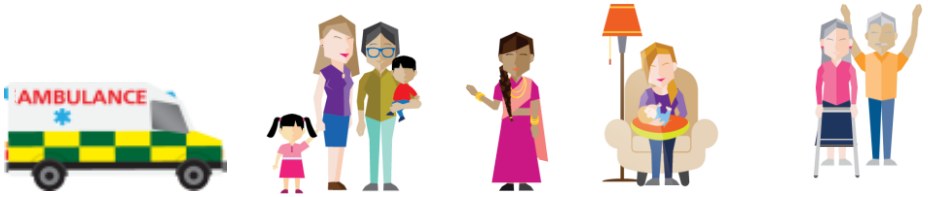
To assist the development of community services designed by those who live and work in the community (clusters/ neighbourhoods) to address the health and wellbeing of its citizens we need to:

- Change culture through meaningful engagement (more than being informed), to develop and deliver solutions and own services.
- Ensure our partnerships are built on trust, sustained, well managed and transparent.

Only then can we improve health and reducing health inequalities and move to a wellbeing model.

We are committed to engaging with:

- Citizens
- Carers
- Community / hospital staff
- Volunteers
- Cardiff Council
- Vale of Glamorgan Council
- Third sector
- Independent sector and providers
- Cardiff and Vale Community Health Council
- Regional Partnership Board
- Welsh Ambulance Service Trust



Communications and Engagement Messages

The Perfect Locality programme will provide a consistent high-level message – We are focussed on **Caring for People: Keeping People Well** and to achieve this we must work in partnership with our two local authorities and third sector organisations.

We are committed to making it a reality that: **a person's chance of leading a healthy life is the same wherever they live and whoever they are**.

Our over-arching key messages are:

- We are working together to improve the health and wellbeing of the citizens of Cardiff and the Vale of Glamorgan.
- We will plan and deliver our services by engaging people who use and work in the services, producing high-quality healthcare services for the people of Cardiff and Vale of Glamorgan to use.
- We will work with our citizens to help them prevent becoming ill and support them to live longer and better quality lives.
- We are committed to working with our partners across the NHS, social care and third sector to improve the health and wellbeing of our citizens.
- We continually work to improve the quality of health and social care services.
- We always encourage feedback from local people and will act on it wherever possible.
- We make our best efforts to use the funding and resources we have to provide prudent, sustainable primary care.

What we have Heard during Engagement?

Let's talk about wellbeing instead of just health or illness

We need more emphasis on prevention, preventing falls, social isolation, illness etc

You should be providing better information to help people access services and promote self-care

We want to feel welcomed in our community/ health settings

We could use developing technology to help people live in their homes for longer and add value to their daily living

I want to stay in my home for as long as possible

The primary care teams are working hard to address need.

We still have more work to do in co-production and engagement with users of services.

I would welcome some expert education

It's hard to keep up with the pace of change

I like knowing what's available in my community

It would be good to have some open space for socialising, spending time and pottering with some gardening

We are interested in social prescribing

I don't really mind who is providing my support/ care (health board, local authority or others) as long as I receive a good service

Suggested Way Forward

- Ensure appropriate, timely information is provided to citizens, patients, staff and partners.
- Engage as many partners as possible to shape community services – ensure a community lens.
- Ask people to provide solutions that impact on the health and wellbeing of themselves, their families and their community/ neighbourhood/ cluster.
- Ensure the principles of health literacy are used in all information.
- Provide further opportunities for co-production.
- Continue to build trusting relationships with the people who use services, staff who provide services and third sector partners.
- It is important that we continue to communicate and engage with stakeholders throughout the planning process to ensure that we deliver services in a way that is meaningful to them, while ensuring that our services are efficient, sustainable and make best use of resources. Making sure we keep people informed and engaged.
- Ensure we recognise peoples expertise to produce creative solutions.
- Listen, listen, feedback and listen- repeat.

Summary

Improvement Plan

We will:

Improve the needs of the citizen by:

- Putting the citizen at the centre of all we do and ensuring they remain central.
- Promoting healthy lifestyles and choices through interventions on preventing ill health and encouraging more activity for general wellbeing throughout life. Utilise digital technologies to help speed up the diagnosis, maintenance treatment and or recovery ill-health.
- Improving the information we provide about services, access and health conditions.

Improve the needs of the community by:

- Valuing the role of people and communities in their health and wellbeing, including through co-production, volunteering and social movements for health.
- Support a thriving and sustainable voluntary, community and social enterprise sector, working alongside people, families, communities and the social care system.
- Work with communities to protect local facilities that bring people together, health provision, libraries, museums, arts centres and leisure centres.
- Enable health and care professionals and the wider workforce to understand and work in person- and community-centred ways.

Improve community services by:

- Invest in a new generation of integrated health and social services centres alongside the transformation of our hospital estate.
- Develop strong and sustained networks as an integral part of implementing and scaling up person- and community-centred approaches.

Improve partnership working by:

- Valuing everyone's contribution to a whole systems approach.
- Designed and delivered with, rather than for people, using shared vision and goals: wellbeing, resilience, autonomy, connection to others.

We expect the Perfect Locality programme will help refocus resources to create the transformational shift that is needed. We recognise this will be challenging, with tough choices to be made. For example, it will be vital to strike the delicate balance between national objectives and local adaptation and co-production with people and communities.

Next Steps

Change the Approach

We expect the Perfect Locality programme will help refocus resources to create the transformational shift that is needed. We can do this by:

- Encouraging the use of the **'Service Model'** for whole system service redesign, focusing first of services for older people.
- Ensure the citizen, as an asset remains central to the development, as it is better for people themselves to be active partners in their care. It can also reduce inappropriate and unplanned use of health and care services, freeing up valuable resources, ensuring **co-production is fundamental.**
- Work in partnership (strengths, not deficits), *We can't do it alone.* Utilise an asset based approach.
- Make services and information accessible
- We need to refocus resources to create the transformational shift that is needed.
- Look for local, minimal cost and non-service solutions, wherever possible this embeds sustainability. **Keep it simple,** local, flexible.
- Relationships are key, **individual, community & professional**.
- It takes time, energy and commitment with a shift of power and control (from professionals to citizens, and organisations to communities).

Recommendations

	Recommendation	Who will take these recommendations forward
Focus on wellbeing	To systemise wellbeing and prevent ill-health, we will work with partner organisations on actions that: •Create supportive environments •Strengthen community action •Reorient our services to focus on prevention •Build healthy public policy across our organisation •Develop personal skills of staff and citizens	Regional Partnership Board / Public Service Boards UHB
Develop whole system models	To develop a new care model and joint commissioning arrangements for older people which enables an increased emphasis on a home first approach, reablement and alternative accommodation options within the community by March 2018.	Regional Partnership Board
Sustain primary care	To sustain primary care we will implement a programme of work to stabilise General Practice working at: •National level •Cluster level, including the identification and functional integration of UHB, Local Authority and Third Sector resources and staff to support patients and the service •Individual Practice level	Primary, Community and Intermediate Care (PCIC) Clinical Board

Recommendations

	Recommendation	Who will take these recommendations forward
Maximising integration/ improving patient pathways across the Primary/ Secondary care interface	To improve Primary /Secondary Care Integration and erode the interface we will continue to support clinical theme and specialty based GP/ consultant 'virtual Directorate' In order to expand the programme and benefits to General Practice, waiting times (RTT and Cancer) and Unscheduled Care we suggest that a needs analysis be done and the further GP leads be appointed, coached and mentored to work across the system with consultant colleagues/MDTs.	Primary, Community and Intermediate Care (PCIC) Clinical Board Working in partnership with other Clinical Boards Executive Team decision
Develop Health and Wellbeing Centres and Wellbeing Hubs	To provide the business cases for major physical infrastructure required to support improved access to community services and assets.	Shaping our Future Wellbeing: in the Community programme
Facilitate technology solutions	To ensure that digital solutions are explored further to promote wellbeing, promoting health and wellbeing and assisting in management of long term conditions.	Digital health strategic programme

Cardiff and Vale University Health Board

Shaping Our Future Wellbeing Strategy

2015 - 2025

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol Caerdydd a'r Fro

Cardiff and Vale University Health Board