Summary Specification for Delivering the Perfect Locality

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.
Grymuso pobl. Ysbrydoli rhagoriaeth. Cryfhau cymunedau.

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

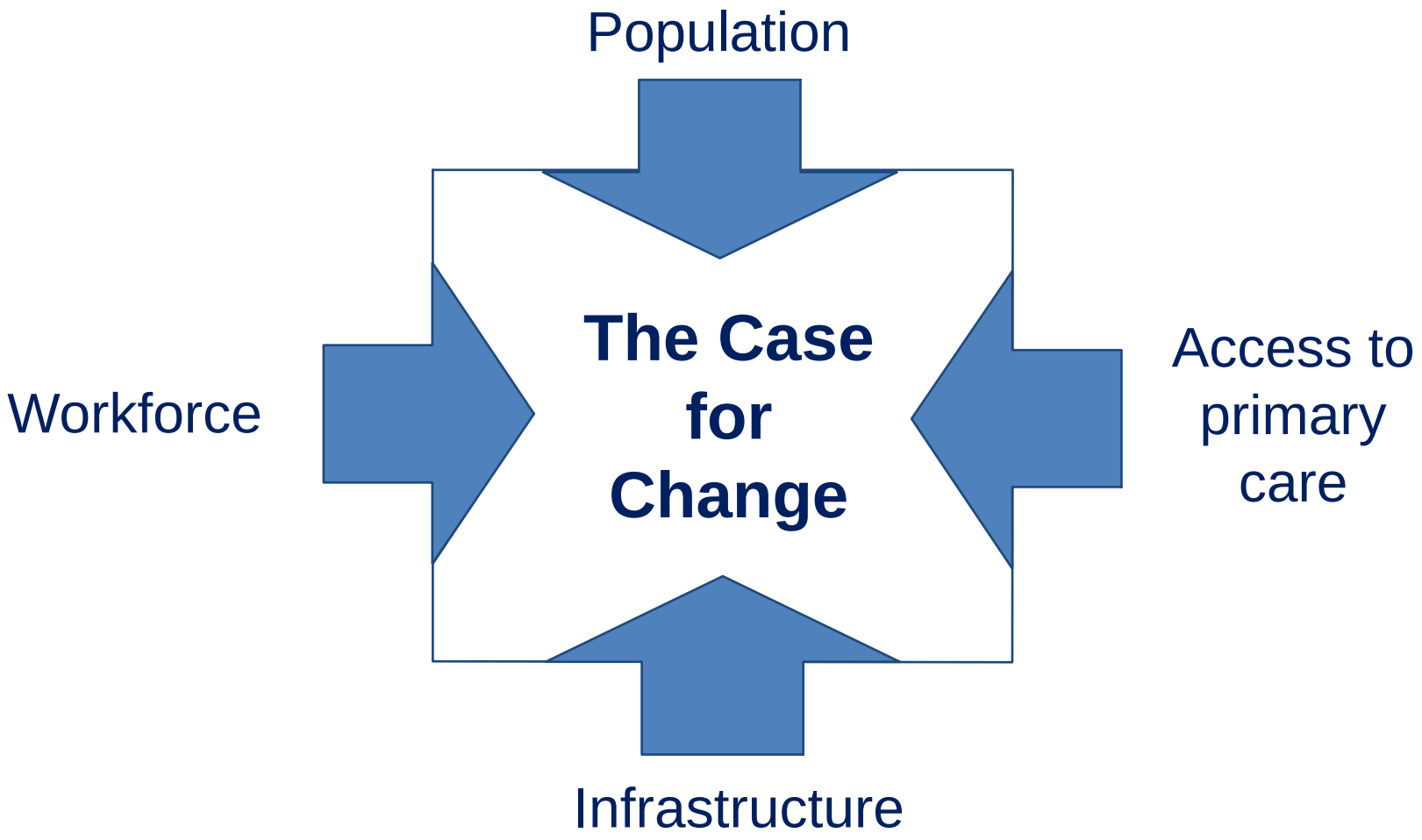
People in Cardiff and Vale of Glamorgan know and understand what care, support, and opportunities are available and use them to maintain their health and wellbeing

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

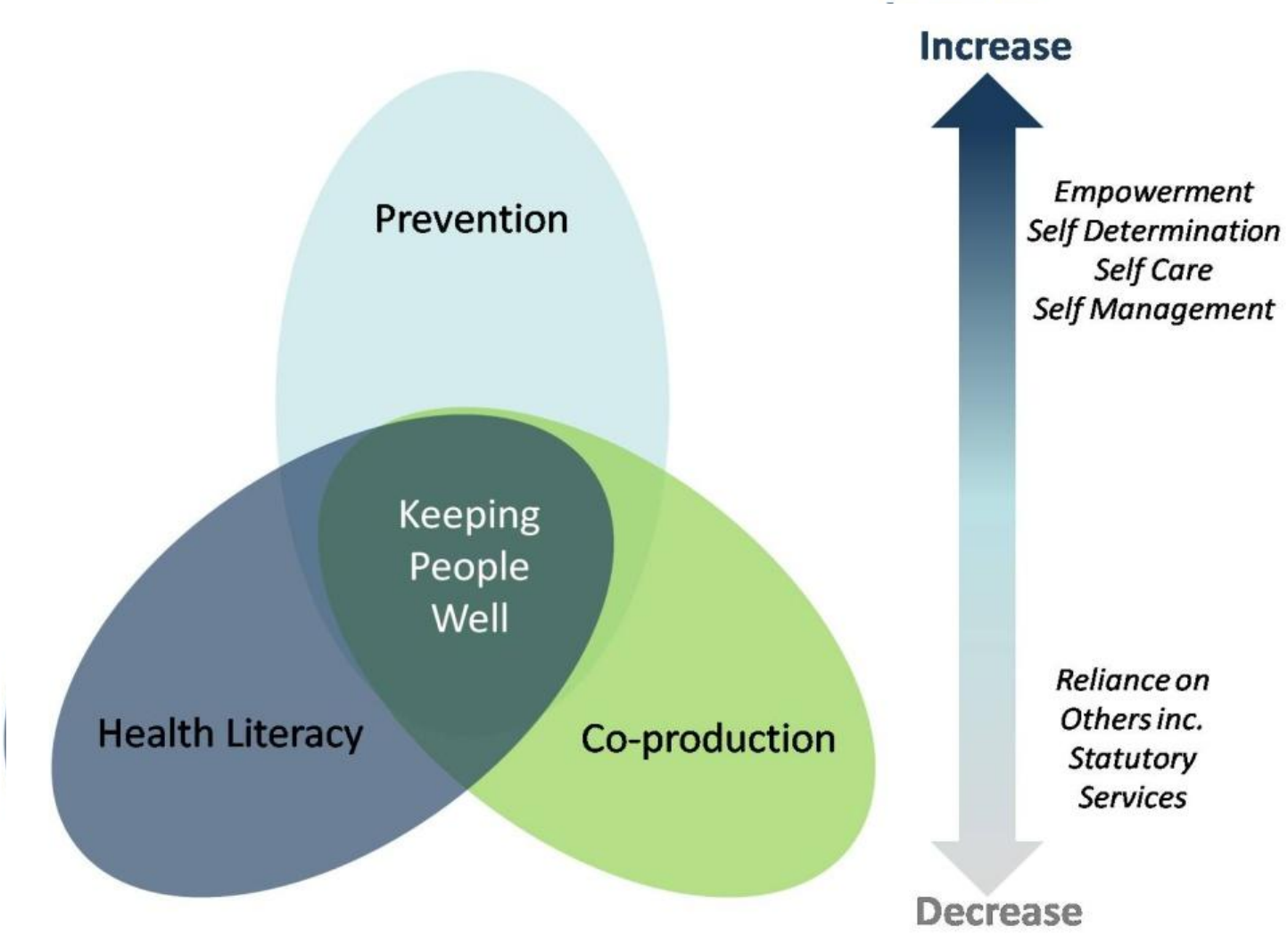
Children in Cardiff and Vale of Glamorgan have a healthy start in life

Locality Working - the Case for Change

There are a number of key drivers for changes to locality working:-

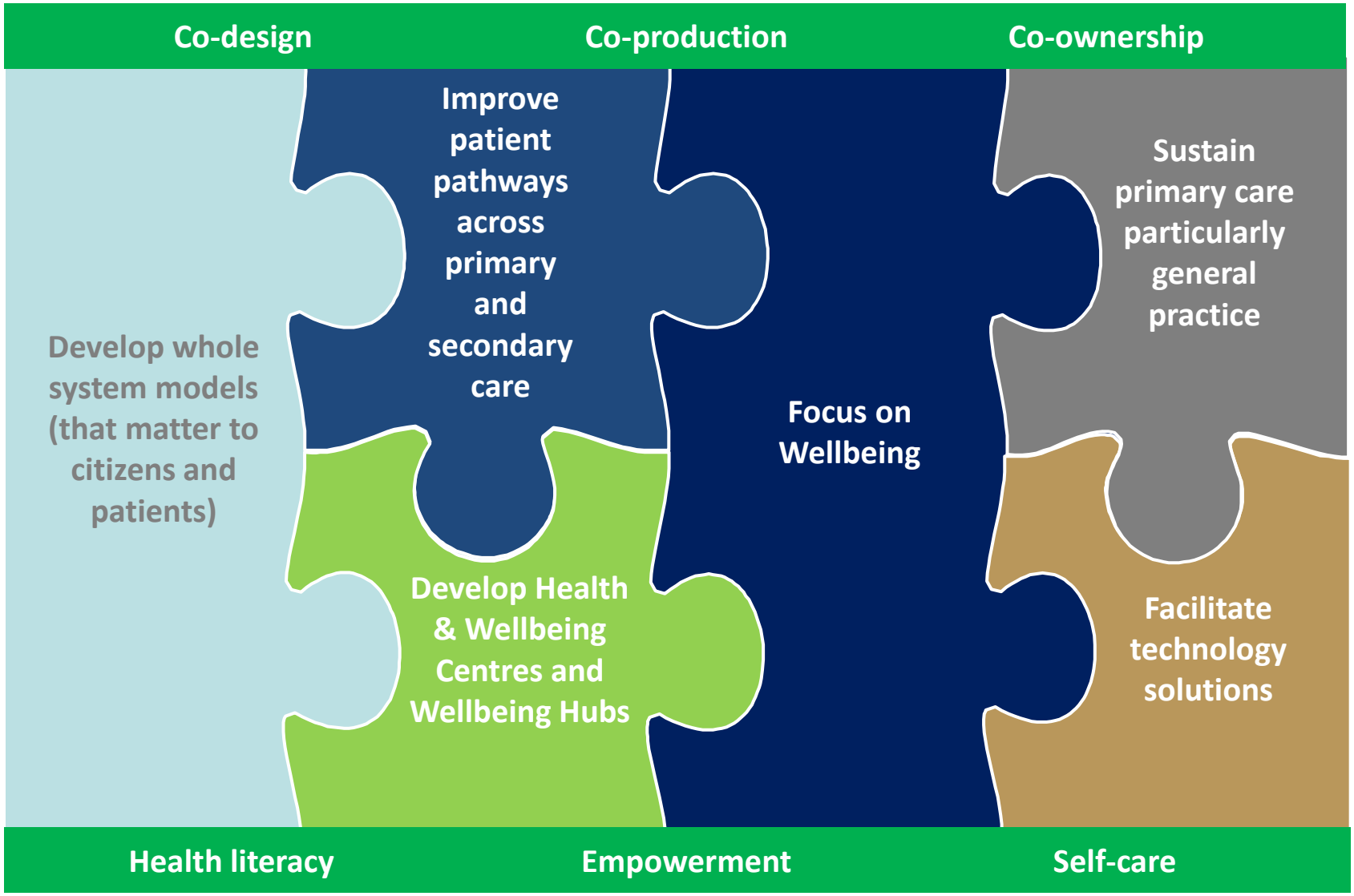


Develop the Perfect Locality



Make 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:



Turn the Citizen Model into a Service Model

In co-producing the *Shaping Our Future Wellbeing Strategy*, the UHB worked alongside over 400 people and organisations to describe a vision for health and wellbeing:

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PARTNERIAETH IECHYD & GOFAL CYMDEITHASOL INTEGREDIG
Caerdydd & Bro Morgannwg
Cardiff and Vale of Glamorgan
INTEGRATED HEALTH & SOCIAL CARE PARTNERSHIP

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

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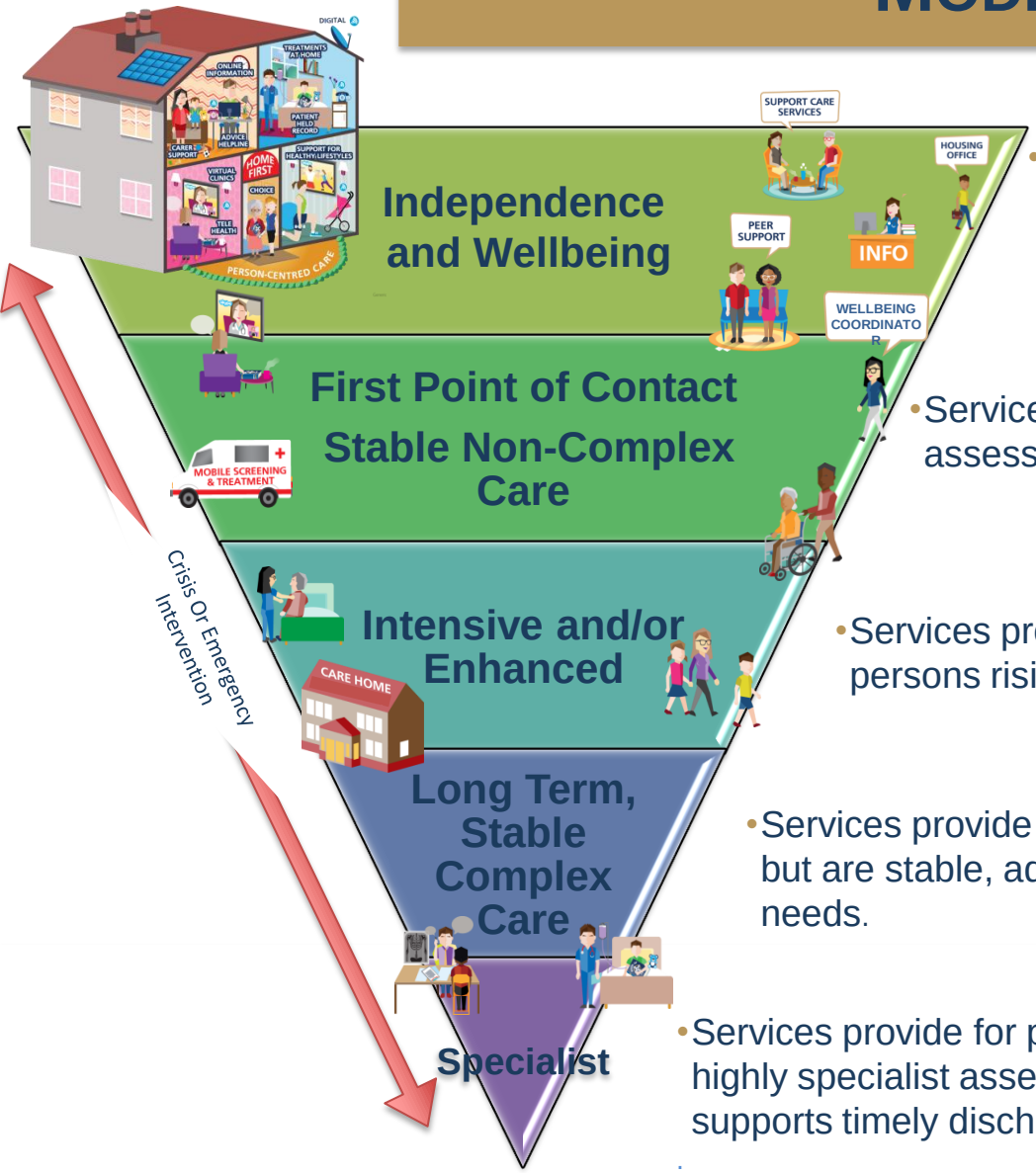
Taking a whole systems approach, this requires the development of a shared **whole system service model** based on the **citizen model**

CITIZEN MODEL

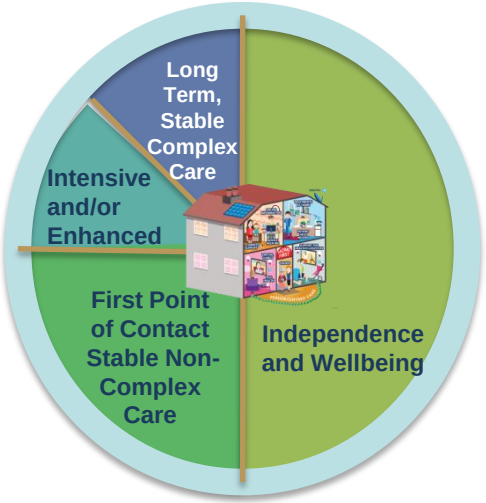
Whole System Service Model



- 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.
- Services provide a first point of contact, they screen and assess, providing early intervention and sign posting.
- Services provide a flexible and co-ordinated response to a persons rising unstable need.
- Services provide for people whose needs are not necessarily low but are stable, additional support may be needed to meet daily living needs.
- Services provide for people whose needs are highly unstable and/or for highly specialist assessment and care. Integrated discharge planning supports timely discharge.

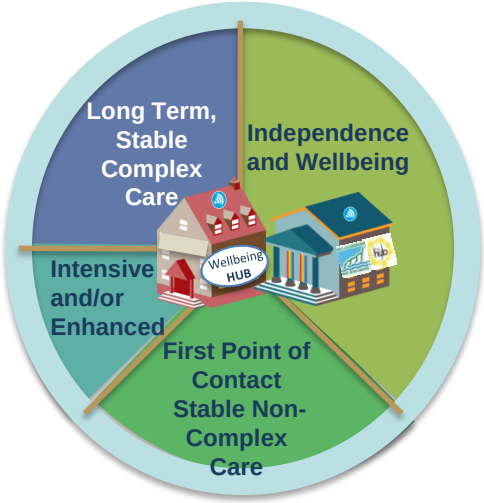
When we apply the whole systems services model to our current services and to those that we want to develop in the future, we can begin to see what the future could look like.

Home

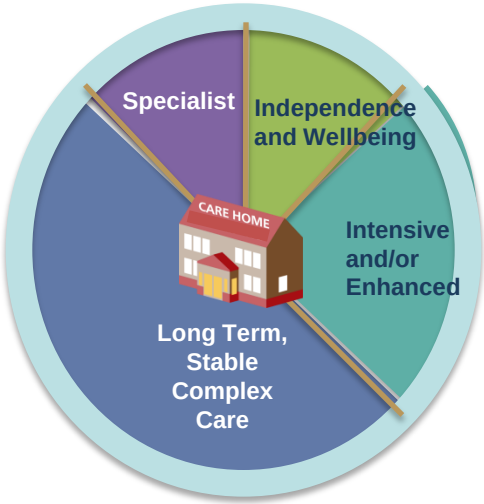


General medical, dental, optician and community pharmacy

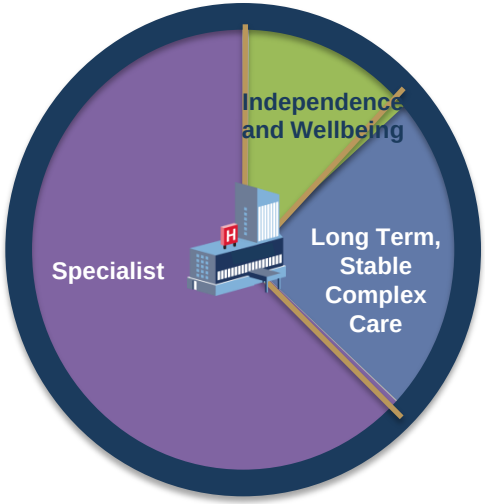
Wellbeing hub



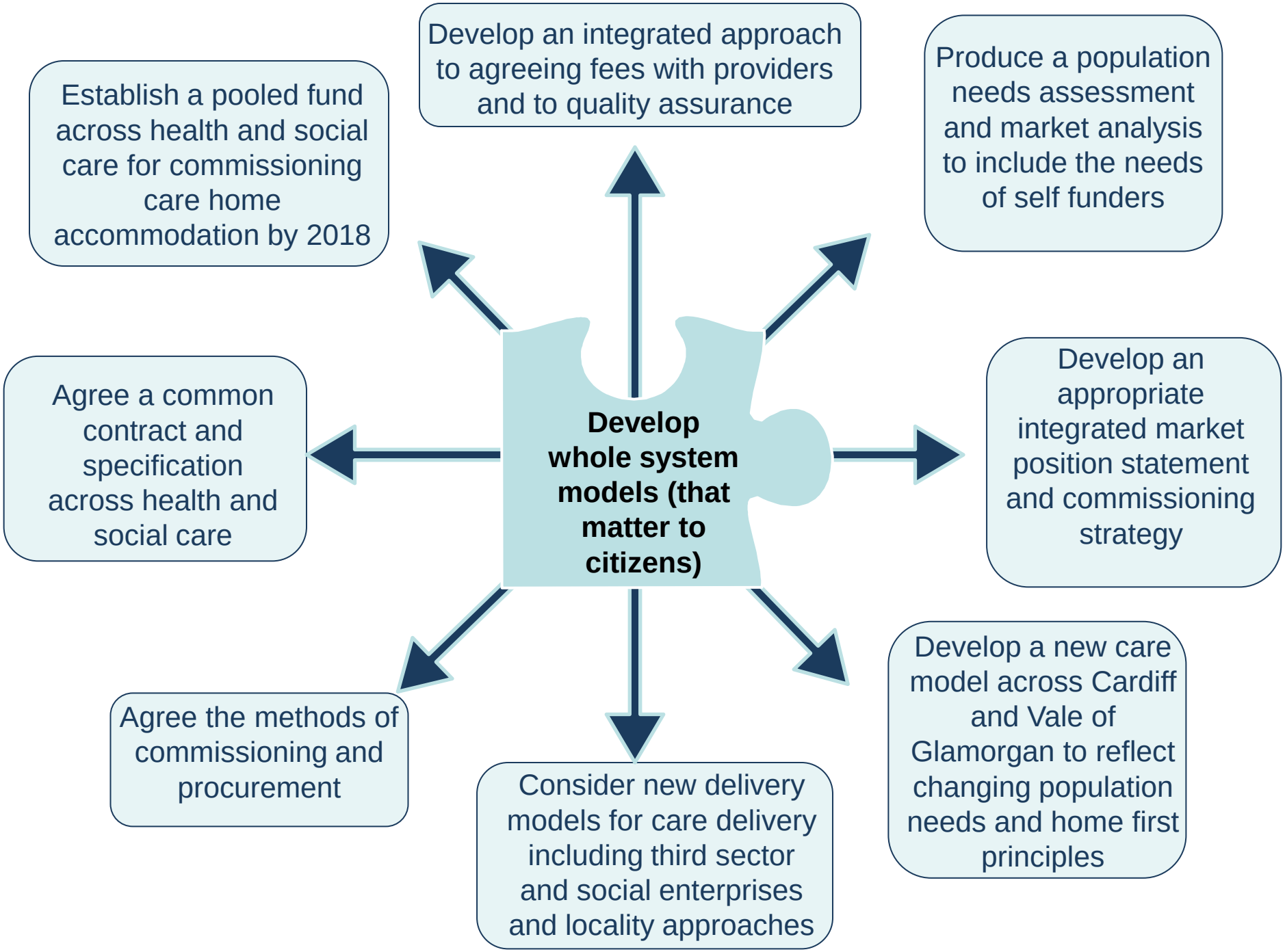
Health and Wellbeing Centre



Nursing home



Acute hospital


Develop an integrated approach to agreeing fees with providers and to quality assurance
Produce a population needs assessment and market analysis to include the needs of self funders
Establish a pooled fund across health and social care for commissioning care home accommodation by 2018
Develop whole system models (that matter to citizens)
Agree a common contract and specification across health and social care
Develop an appropriate integrated market position statement and commissioning strategy
Agree the methods of commissioning and procurement
Consider new delivery models for care delivery including third sector and social enterprises and locality approaches
Develop a new care model across Cardiff and Vale of Glamorgan to reflect changing population needs and home first principles

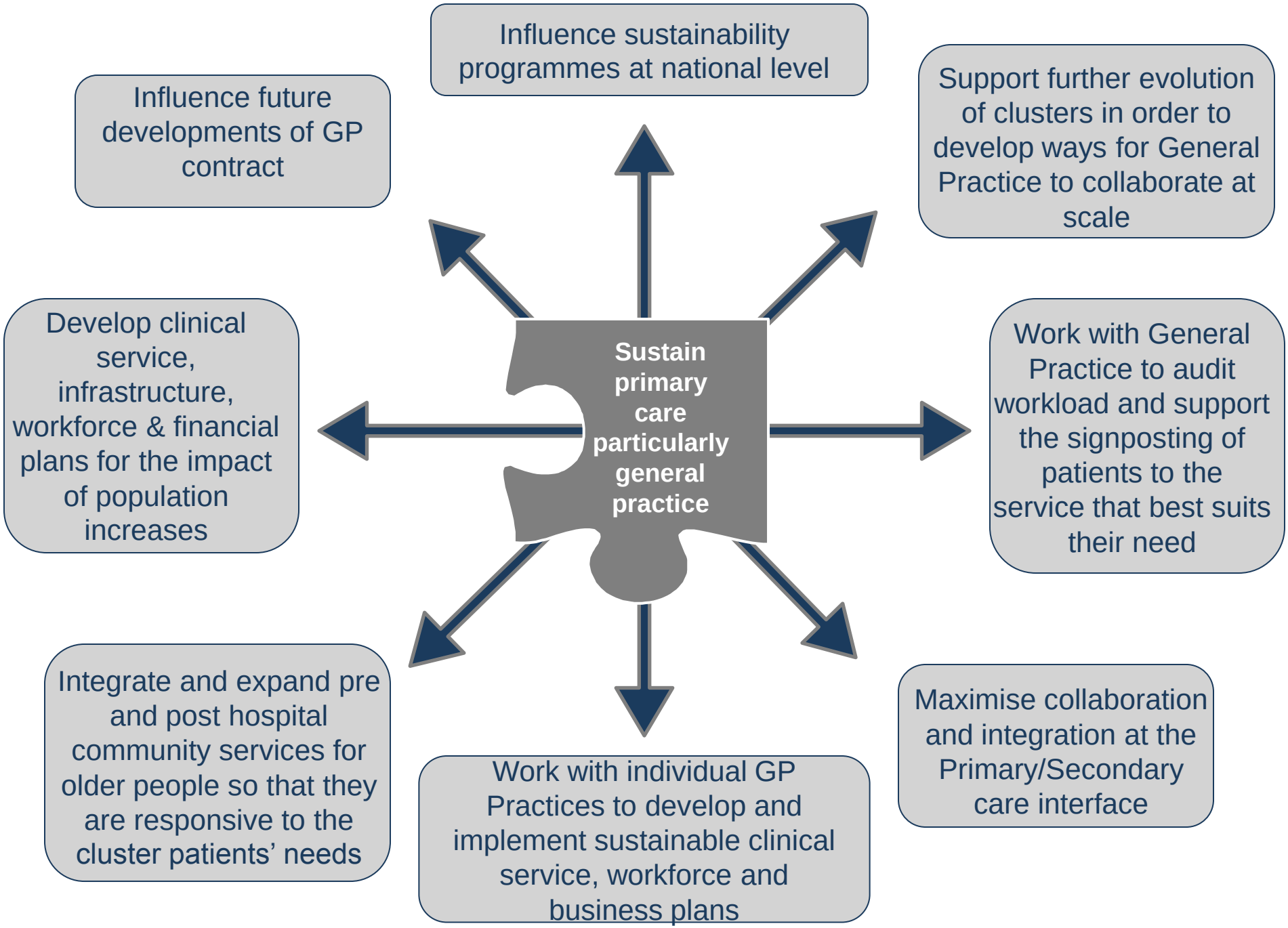
Strengthen community action. We will work with our communities and citizens to inform our service delivery and will promote community activities that promote health.

Create supportive environments and ensure that our services are delivered from local, appropriate and accessible facilities.

Build healthy public policy across our organisation. We are committed to working in partnership to ensure local policies promote health and wellbeing.

Reorient 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.

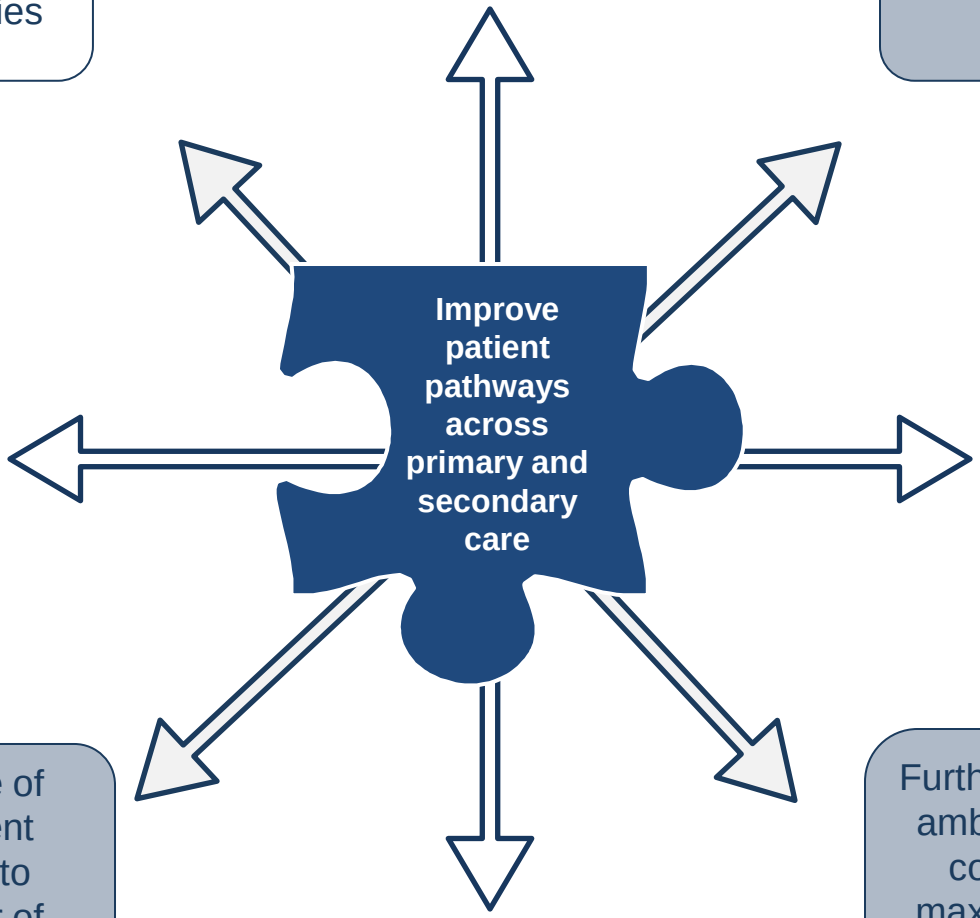
Develop personal skills of staff and citizens.


Influence sustainability programmes at national level
Influence future developments of GP contract
Support further evolution of clusters in order to develop ways for General Practice to collaborate at scale
Develop clinical service, infrastructure, workforce & financial plans for the impact of population increases
Sustain primary care particularly general practice
Work with General Practice to audit workload and support the signposting of patients to the service that best suits their need
Integrate and expand pre and post hospital community services for older people so that they are responsive to the cluster patients' needs
Work with individual GP Practices to develop and implement sustainable clinical service, workforce and business plans
Maximise collaboration and integration at the Primary/Secondary care interface

General Practitioners (GPs) have been partnered with various specialties to…

Maximise the benefits of an integrated organisation

Build on current achievements to maximise high quality, low waste prescribing



Continue to support innovative multidisciplinary working across the system and avoid the need for out-patient attendance e.g. Paediatric hub, Diabetes community model

Build on current work with gastroenterology, dermatology and urology to minimise waiting times and out-patient appointments for patients

Encourage the use of quality improvement methodology e.g. to reduce the number of strokes by 10% per year

Further develop and embed ambulatory care sensitive condition pathways to maximise health and care close to home and reduce admissions

Further develop the cancer care pathway work to ensure that the most needy patients are seen first

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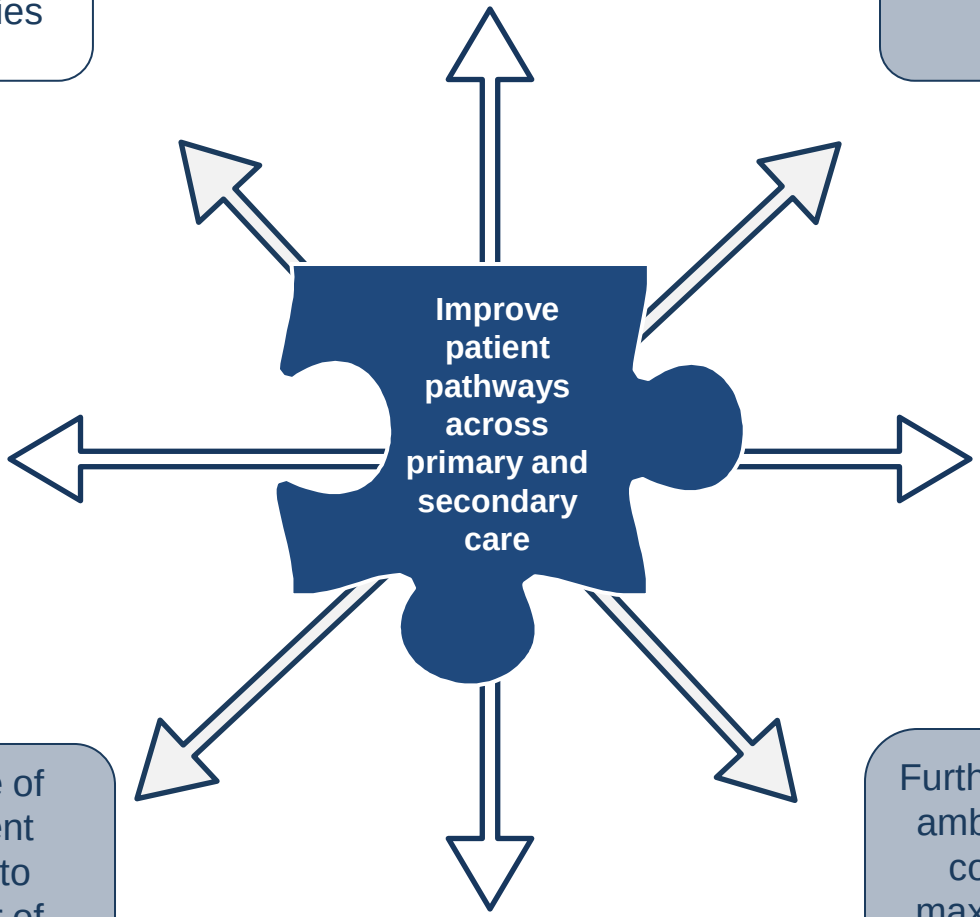

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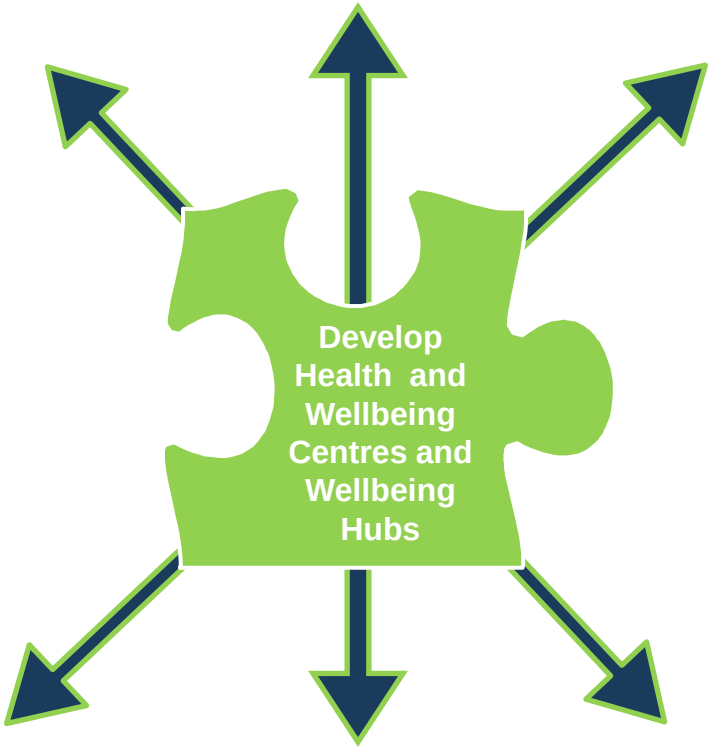
Improve quality of services by working with our partners to deliver more co-ordinated and collaborative services closer to home.

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.

Work with partner organisations to provide the appropriate infrastructure to support delivery of local services focused on health and wellbeing need.



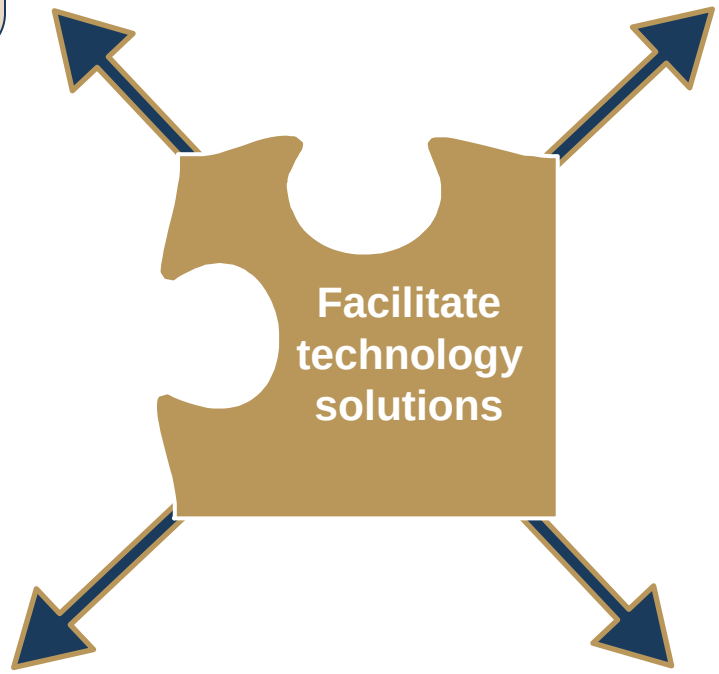
Improve the capacity of services, to meet increasing and changing demand, focusing on clinic utilisation, workforce, facilities, technology.

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

Explore any opportunities for further technology solutions (especially within primary care)

Promote social networking, Dewis Cymru, apps that enhance self determination and wellbeing solutions



Share the Perfect Locality specification with the Health Board and Local Authority departments that will take forward the digital solutions programme.

Ensure that citizens are central to any development and are engaged in co-producing any solutions

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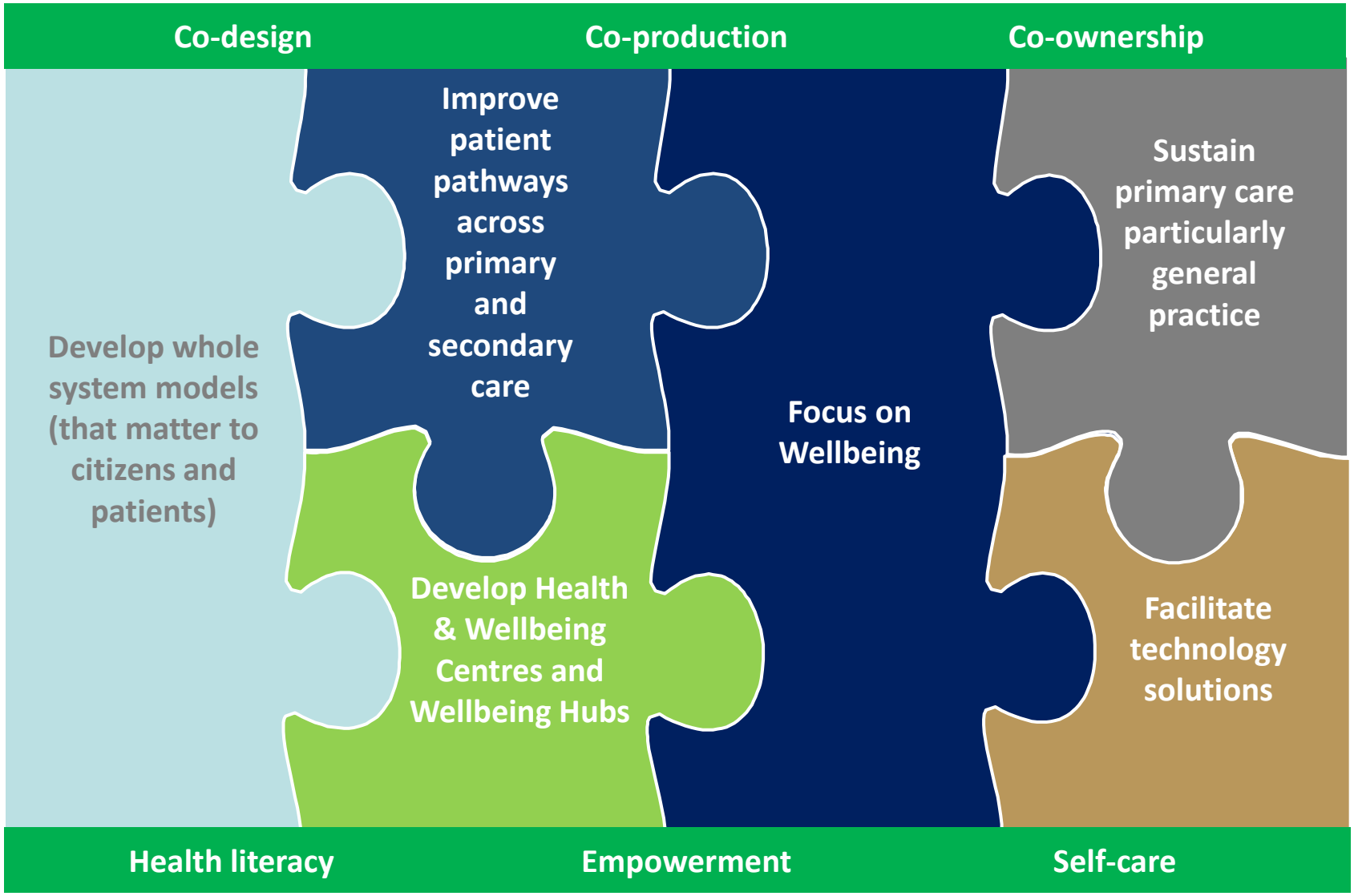

Change the approach

We expect the Perfect Locality programme will help refocus resources to create the transformational shift that is needed *for me, my home, my community* by:

•Encouraging the use of the **'Service Model'** for whole system service redesign, focusing first of services for older people.

•Ensuring 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.**

•Working in partnership (strengths, not deficits), *We can't do it alone.* Utilise an asset based approach.

•Making services and information accessible

•Looking for local, minimal cost and non-service solutions, wherever possible this embeds sustainability. **Keep it simple,** local, flexible.

•Ensuring relationships are key, **individual, community & professional**.

•Taking 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

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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