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National and local policy drivers for the Primary and Community Care Project Team, North Wales

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Evidence to inform the primary and community care project team, North Wales
Rapid review of primary and community care services provided in North Wales: population profile of North Wales

Purpose and Summary of Document: North Wales have a number of projects in progress intended to redesign services across the region. This report summarising the national and local policy drivers was requested to support the community services workstream.

Publication/Distribution:

- Project group
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1 Background

The North Wales Transition Board has identified the need for a work stream to review primary care and community services, which will seek to answer the question:

How do we deliver the model for primary and community services in North Wales?

This work stream is led by Grace Lewis-Parry, Chief Executive of Gwynedd Local Health Board. A project team has been established and National Public Health Service Wales assistance requested.

2 Methodology and scope

The project is being managed via the 90 day methodology adapted by the Institute for Healthcare Improvement. The project team will present their findings to a meeting of key stakeholders every 30 days and feedback, both immediate and from a wider group of stakeholders will be incorporated into the work plan of the next 30 days. The first 30 days comprises the 'scan' cycle. The short timescale of the project means there needs to be a balance between timeliness and rigour and therefore a pragmatic approach will be followed.

The first 30 day cycle will involve:

- Definition and scoping for the evidence review: this will involve clarification of the question being addressed, patient groups included/excluded from the project. Scoping of relevant policy documents to illustrate context of need for changes
- A desktop healthcare needs assessment using existing published material; including demography, trends, projections, burden of disease
- Creating a service profile – using existing local documents to map existing services and proposed developments
- Rapid pragmatic review of literature in relation to shifting care to community settings
- Describing the future model of care in North Wales

This project includes examination of:

- Primary health care services; GP, dental, pharmacy and optometry.
- Generic community services such as district nursing, health visiting, school nursing and therapy.
- Chronic conditions management, from self-management programmes such as the Expert Patient Programme and Xpert Programme for diabetes to case management etc.
- Community hospitals.
- Housing, residential care and extra care housing.
- Joint working across health and social care.
- Voluntary sector.

This project excludes examination of:

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- Children and young person's services
- Mental health including dementia
- Social care

3 The policy context

The drivers for this work are grounded in both national policies and strategies and local service needs outlined in a range of documents.

3.1 Balance of primary and secondary care

*Improving Health in Wales*¹ published in 2001, describes a new vision for primary care in Wales, with primary care as the driver for the development of networks of clinical and care services,

“..given its unique position at the interface of acute healthcare services, social care, and self help”.

A key part of the strategy was the development of primary care resource centres to support existing practice models of primary care. The aim of these centres is to enable the development of new models of primary care practice, providing a base for more specialised services to support primary care in each locality. The centres will develop managerial and clinical services serving a population focus of about 50,000 people, as part of community wide, whole system service development plans, linking primary care to developments in intermediate care and secondary care. However it was acknowledged that the balance between services provided in resource centres and local practices may need to differ in urban and rural settings. It was also noted that in some cases it would not be sensible to provide a range of services from one physical location and it was noted that a network approach can deliver additional services in a way consistent with a resource centre philosophy¹.

3.2 Sustainability

In 2002, a review of capacity in the Welsh health service, *A question of balance*², found that most acute hospitals were working with unsustainable levels of bed occupancy, high numbers of delayed transfers of care leading to cancelled elective admissions due to lack of beds.

*The review of health and social care in Wales*³ in 2003 (Wanless Review), outlined the issues facing the Welsh health service and the excessive reliance on the provision of care in institutional settings. The report stated that the demand for health and social care could overwhelm the systems for provision and the workforce. Wanless stated that the current position at the time was not sustainable; he believed that services needed to be realigned to focus on prevention.

A review of the community hospital service in north east Wales⁴ during 2005 indicated that up to 75% of inpatients could be cared for under alternative models of care if these were available.

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*Designed for life*⁵ distinguished five groups of people within the general population and four levels of care to address the needs of these groups. The document stated that community services were to be greatly strengthened and the primary care team extended, it stated that: “to continue the wholesale transformation of services and their delivery, a new and effective planning system for health and social care is required”.

*Designed for North Wales*⁶ stated that care should be provided in the most appropriate place and that the community should become the focus of care. Barriers between different service providers need to be reduced and there should be a change in usage of hospitals in North Wales. Over 250 individuals and 50 organisations were involved in developing the proposals. The report on the consultation⁷ indicated that while there was some understanding that current systems need to change in response to changing needs, there was a degree of anxiety from primary care staff about the available investment and resource available to do more in community settings. In addition concerns were expressed about travelling times dependent on how services were reconfigured. Finally there was a great deal of anxiety about the future of local community hospitals.

3.3 Quality

The aim of the *Healthcare standards for Wales*⁸ the health minister stated:

“..is about improving the patient experience and placing patients at the centre of the way in which services are planned and delivered.”

In general the healthcare standards indicate that:

- Health services should have appropriate governance arrangements in place and be provided in premises that meet national guidelines and are safe;
- Staff are competent and considerate and provide evidence based care underpinned by national guidance and research;
- Healthcare organisations are expected to work together with local communities to ensure that programmes and services are designed and delivered to promote, protect and improve health and reduce health inequalities.

In relation to those with a chronic condition Standard 7 states:

“Patients and service users including those with long term conditions are encouraged to contribute to their care plan and are provided with opportunities and resources to develop competency in self-care.”

3.4 Serving citizens

*Beyond boundaries: citizen-centred local services for Wales*⁹ also known as the ‘Beecham report’ introduced the citizen model (in contrast to the customer model used in England) to drive service improvement. This model recognizes that citizens have both rights and responsibilities: rights to receive services but also responsibilities to be concerned about the services available to everyone else. The report also promotes an organisational culture that is outward facing and focused on outcomes for citizens. Three main barriers to progress were identified by the report:

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- Culture – difficulties in organisations embracing change and innovation
- Capacity – delivery capacity seen as being extremely stretched across the public sector, in terms of resources, skills and leadership
- Complexity- different boundaries for different agencies, different infrastructures

The health related implementation document for *Making the connections: delivering beyond boundaries*¹⁰ noted that the key elements are:

- Establishment of local service boards
- Develop arrangements so it is easier to bring budgets and resources together across different sectors.
- Formation of all local health boards into 3 regions to commission as consortia
- Internet, e-services, e.g. my health online
- Strengthening active partnership
- Care pathways to replace episodic care
- In collaboration with National Leaderships and Innovation Agency for Healthcare (NLIAH), build organisational development capacity
- Workforce planning

3.5 Older people

The *National service framework (NSF) for older people*¹¹, the Welsh version, outlined the following aims for health and social care:

- People stay safe, healthy and independent for as long as possible;
- Health and social care problems or potential problems are promptly identified and the person's holistic needs are assessed;
- Social care and health needs, including chronic health conditions, are managed effectively within the community - avoiding crises and inappropriate hospital or care home admission;
- Prompt access is available to quality diagnosis and specialist services when required, including acute hospital care;
- Transition from acute services to more appropriate care settings is timely and co-ordinated;
- Long term care provision is co-ordinated and effective;
- Opportunities for return to full or optimum health and independence are maximised, in whatever setting the person is living.

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3.6 Chronic conditions

*Designed to improve health and management of chronic conditions in Wales*¹² aims to: encourage healthy lifestyles; prevention of deterioration of chronic conditions; stratification of practice populations by need for interventions e.g. case management; improve the quality of services closer to patient's homes; reduce inequalities and reduce the impact of chronic conditions on hospitals.

*The Community services framework*¹³ identified the following priorities:

- Keep people fit and healthy
- Help people live independent lives in their own home
- Tackle effectively, and locally wherever possible, problems that may arise

In *Chronic conditions management – a vision for North Wales*¹⁴, the key enablers required to deliver the new model were thought to be:

- Engagement and support of general practitioners
- The engagement and support of local authorities, voluntary sector organisations
- The engagement of the public
- The provision of information management and technology services allowing information to flow between Trust and primary care systems
- The delivery of a workforce development and re-skilling programme to match the new service needs

3.7 Improving social care

*Fulfilled lives, supportive communities*¹⁵, is a strategy for improving social care services in Wales, states that whilst there is much good practice in social care in Wales, there are areas that need modernising or strengthening. The document states that if present trends continue, by 2016 we can expect to see:

- Increased demand for universal services and support for people with high care needs over longer periods of time;
- An increase in people aged 50-60 who provide informal care, but partly offset by more women in the workplace and by people choosing to work more years;
- An increase in lone living, particularly for older men
- High demand for services from those of 85 or over.

3.8 Workforce capacity

Against the background of expected increases in the demands made upon health and social care services we have a decreased proportion of the population of working age. This may have implications in the longer term. In the shorter term Wales still has issues in complying with

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the Working Times Directive for junior doctors¹⁶. There remain potential implications for provision of support services and in-patient services.

3.9 Political agenda

In May 2007 Labour and Plaid Cymru formed a coalition government and produced a joint manifesto document¹⁷. The chapter dealing with health announced that there would be a moratorium on existing proposals for change at community hospital level and that district general hospital service changes would not be implemented until all relevant associated community services were in place. In addition they stated that they would support changes where there was local agreement on the way forward but where there was contention they would proceed on the basis of the best evidence. They also planned to revisit and revise proposals which reconfigure individual services through single site solutions.

The document signalled an end to any remainders of internal market principles and pledged to eliminate the use of private sector hospitals by the NHS by 2011 in Wales. The agreement states that new multi-purpose well-being centres will have pilot investment and they will improve the provision for long term conditions such as stroke and diabetes.

A review of the potential impacts of developments outlined in the *Designed for North Wales* was commissioned¹⁸ during 2008; the resultant report included the following key points and issues;

- The development a vision and strategy to ensure primary and community services are developed together to meet the needs of the Welsh agenda
- A need to build capacity for local ownership and strong local leadership
- Demonstrator sites and service champions should be developed and identified in the North Wales region – allowing living examples to answer the wicked issues.
- We must ensure that patients and carers can have confidence that there will be no ambiguity as to who is responsible for the provision of their care
- How can the NHS in Wales invest more money in community based services if we do not know how much we are currently spending?
- How can we expect the public to understand the case for change and support our proposals or change if we cannot clearly and succinctly explain to them what it will look like and how it will all work together?

3.10 Summary of key policy themes

The range of documents outlined above come from different policy perspectives but focus on a number of common themes for action. These include:

- Improving health, reducing inequalities and maintaining and promoting independence
- Prevention, self care and early treatment of those at risk from chronic conditions to reduce the burden and impact of these conditions
- Moving care closer to homes and out of hospital centres

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- The need for agencies to work better together to improve quality, service capacity and to remove artificial boundaries between services
- The need to plan for and develop the workforce
- Development of services based in the community including local resource centres and networks

Taken as a whole this is a significant change agenda. In as much as anyone owns the NHS in Wales the people of Wales are key. In taking service modernisation work forward both One Wales¹⁷ and the review of the potential impacts of implementing Designed for North Wales highlight the importance of engaging the population with the rationale for change and the design of services.

4 Key themes from LHB community plans

Key themes from the community service framework document or its equivalent have been identified and tabulated in Table 1. Additional information not included in the table can be seen in Appendix A.

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Table 1. Key themes from local health boards' community plans

Anglesey¹⁹	Conwy²⁰	Denbighshire²¹	Flintshire²²	Gwynedd²³	Wrexham²⁴
<ul style="list-style-type: none"> ▪ Ensure that District Acute Hospitals concentrate on providing the specialist services that only they can ▪ Bring, where clinically appropriate and possible, as many services into the community – to be delivered within Community Hospitals, GP surgeries and people's homes ▪ To coordinate services so they support the prevention, delay the onset, and prevent early deterioration of chronic conditions ▪ Review and organise the existing community services. Ensure they are delivered in most clinically appropriate, efficient and cost effective way. This could result in some services being found to be ineffective and require that these cease to exist in their current form. ▪ Ensure a multi-agency reablement approach to service provision 	<ul style="list-style-type: none"> ▪ The prevention and management of chronic disease ▪ Helping people remain independent ▪ Bringing the right services to the community <p>The Estates Strategy helps to deliver these priorities by:</p> <ul style="list-style-type: none"> ▪ Proposing extending the Integrated health and social care centre model currently being piloted in Llanfairfechan to other areas in the county ▪ Building upon the locality model, which is gradually being adopted by both health and social care agencies in the county. (5 identified localities in Conwy) ▪ Integrated health and social care centre in 4 out of 5 localities to supplement current primary care provision and access to a resource centre either at Llandudno or Colwyn Bay Hospitals, which would deliver re-engineered services currently carried 	<ul style="list-style-type: none"> ▪ More people can be supported to remain fit and healthy for longer ▪ More people can be better supported to live independent lives in their own homes and communities ▪ Community based health and social care services are enhanced so that health and social care problems are more easily and effectively addressed locally to people in their own home and local communities ▪ There is reduced reliance on acute hospital admissions or admissions to carer home ▪ Members of the public and local communities are engaged in discussions about what must be done to promote and protect health and how local community services can be developed and commissioned 	<ul style="list-style-type: none"> ▪ Keep people fit and healthy ▪ Help people live independent lives in their own homes ▪ Tackle effectively and locally wherever possible, problems that may arise <p>In the future there will be:</p> <ul style="list-style-type: none"> ▪ An increase in the range of services provided within the primary and community setting ▪ A reduction in the number of buildings these services are provided from ▪ Better coordination of care between services <p>Three localities are to be established:</p> <ul style="list-style-type: none"> ▪ Holywell and Flint ▪ Deeside, Hawarden and Saltney ▪ Mold, Buckley and Caerwrlle 	<ul style="list-style-type: none"> ▪ Priority given to helping people to stay healthy and independent using more proactive assessment ▪ Service users and carers to be told more about their treatment and involved in their own treatment ▪ Staff from different organisations will be able to coordinate their services to address individual's needs thus avoiding duplication and confusion ▪ Local GP and community hospital facilities will be developed and improved to give access to services, which will allow earlier diagnosis and a wider range of treatments in the community ▪ Many more services will be provided in people's homes, avoiding need to travel to hospital, leaving these services more time to spend on the most seriously ill patients ▪ Use of new technology to allow regular monitoring e.g. telehealth and telecare 	<ul style="list-style-type: none"> ▪ Promote fitness and healthier lifestyles ▪ Review organisation of existing community services to ensure they are delivered in the most clinically appropriate, efficient and cost effective way. ▪ Improve management and prevention of chronic conditions within the community via multi-agency teams ▪ Bring as many services into the community, to be delivered within community settings, GP surgeries and people's own homes as is clinically appropriate and cost effective ▪ Reduce demand for unscheduled care through more effective planned care ▪ To reduce the number of unnecessary admissions and re-admissions to acute hospital care ▪ To modernise, and where appropriate re-provide

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<ul style="list-style-type: none"> ▪ Shared information systems to improve and speed up the flow of information and communication. Need for an electronic single assessment, integrated care pathways and access to high risk patient information particularly out of hours ▪ Continue to take advantage of current and emerging technological advances which promote independence Promote independence and self care using: Expert Patient programme, self help groups ▪ To improve prescribing and medicines management, extend role of pharmacists and other professionals in supporting chronic conditions management 	<p>out in the large acute hospitals.</p> <ul style="list-style-type: none"> ▪ Abergele to have 2 new large primary care centres, which together with the current centre will create a network of services available to other localities. 			<ul style="list-style-type: none"> ▪ People will know who to contact first if unwell or concerned about their health ▪ New technology will allow health and social care staff to share information more quickly ▪ Jointly designed health and social care services with the citizen at the heart of the planning process ▪ One point of access ▪ A flexible response to local needs and requirements ▪ Maintenance of professional standards ▪ Implementation of national guidance 	<p>more specialist services within primary and community-based settings</p> <ul style="list-style-type: none"> ▪ To support patients and their carers to live within their own homes as independently as possible ▪ To ensure that acute hospitals concentrate on providing the specialist services that only they can ▪ To make the best use of technology in supporting care delivery, improving the flow of information and communication and to deliver improved care.
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5 The care model

The national and local literature and service documents indicate a direction of travel that moves services into community setting where appropriate, providing services closer to where people live. High level objectives allow scope for local health and social care organisations to adapt strategies to reflect local needs. The key components of this type of model appear to be:

- Care provided closer to home
- Strengthening of community and primary care services with more integrated ways of working
- Secondary care settings used appropriately, providing care that requires that degree of support
- Prevention of unnecessary hospital admissions with an increasing emphasis on proactively managing chronic conditions through identifying at-risk individuals
- Support for self management
- Provision of primary care resource units which provide a range of primary, community and social care under one roof and some services that have traditionally been provided in hospital
- GP surgeries organised in primary care networks
- Identify opportunities for partnership working
- Workforce development
- Information technology solutions in order to collect robust baseline data and risk stratify populations and telecare and telemedicine where appropriate

More detailed components proposed in terms of localities and configuration of future services are not included in the above key points. This detail is included in some but not all of the current local health board plans.

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Appendix A - Local health board community service framework themes

LHB	Strategy	Key relevant information contained in plan
Anglesey	Community services plan	<ul style="list-style-type: none"> ▪ Maximise out of hospital care, and reduce impact on secondary care ▪ Increase self management and promote re-enablement ▪ Promote well-being in the community ▪ Prevent deterioration of chronic conditions ▪ Rebalance resources to reflect best value for money, whilst transferring services closer to the community ▪ Reduce the level of emergency admissions and decrease the length of stay in hospital for patients who no longer require that level of care <p>The CSP aims to:</p> <ul style="list-style-type: none"> ▪ shift care away from acute settings. This includes telemedicine consultations and telecare services involving the support of monitoring ▪ Enhance and promote independence and self care for patients coordinating appropriate engagement with the Expert Patient programme, self help groups etc, within each sub-locality ▪ To improve prescribing and medicines management and extend the role of pharmacists and other professionals in supporting chronic conditions management <p>Model Môn operates across six patches aligned to the joint agency primary care and GP catchment areas. The integrated teams are not the same in each patch. Core team members include input and coordination from district nurses, community psychiatric nurses, physiotherapists, occupational therapists, social workers and care assessors. Other or more specialist professional expertise e.g. chiropodist, specialist social workers, specialist nurses, speech therapist etc has tended to be centrally located being drawn into Model Môn patches as needed.</p> <p>Future</p> <p>Proposed that Anglesey will be managed as one locality and that services will continue to be delivered on a patch basis. In order to place services closer to patient's homes key development will include:</p> <ul style="list-style-type: none"> ▪ To cluster and harness the skills of GPs and clinicians working within the locality

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		<ul style="list-style-type: none"> ▪ Where possible, to drive the c0-location of service teams ▪ To lead the implementation of agreed integrated care pathways ▪ Develop the role of community based consultant physicians <p>Chronic conditions – early developments to improve their management</p> <ul style="list-style-type: none"> ▪ Intermediate care ▪ Integrated care pathways – planned for COPD, stroke, heart failure, diabetes, intermediate care ▪ The GMS contract – proposals for enhanced services in diabetes, osteoporosis and heart failure ▪ Modernisation of community hospital – review suggested establishing dedicated beds/units for management of specific conditions e.g. stroke, intermediate care. Anglesey’s two community hospitals will be developed as described in the public consultation. ▪ Developing integrated patch working – improve care coordination and chronic conditions management preventing inappropriate hospital admissions ▪ Workforce development – the district nursing review has taken place with plans for chronic conditions management in place ▪ Facilities and logistics – hub and spoke model, development of two major Primary Care Resource Centres (Holyhead and Llangefni) and two additional intermediate facilities (Llanfairpwll and Amlwch), Building work is taking place at both community hospitals. Also development of joint integrated equipment store
Gwynedd	Community Services Plan (as at 15/5/2008)	<p>Gwynedd LSB has agreed the first priority of the remodelling of health and social care will be services for adults with chronic conditions:</p> <ul style="list-style-type: none"> ▪ Community services are to be developed in 3 areas across Gwynedd – Arfon, Dwyfor and Meirionnydd <p>Chronic conditions in addition to the above:</p> <ul style="list-style-type: none"> ▪ Develop and enhance services outside the district general hospitals ▪ Give health and care staff greater flexibility in planning, managing and delivering services ▪ Implement the PRISM risk assessment plan by 2010
Conwy	Designed for Conwy Conwy Local Health	<p>Document outlines how CLHB plan to bring community service closer to the communities that they serve. In addition to the main ideas above, the refers to developments in:</p> <ul style="list-style-type: none"> ▪ Chronic conditions

	<p>Board's Community Services Framework</p> <p>April 2008</p>	<ul style="list-style-type: none"> ▪ Intermediate care services ▪ Telehealth and telecare ▪ The community equipment store ▪ The independent sector
Denbighshire	<p>Denbighshire Community Services Framework</p> <p>April 2008</p>	<p>States that one of the core aims of the framework is to ensure a network of community services are developed which is flexible and can meet different levels of need at different times for different groups within the local population.</p> <p>Denbighshire has 4 localities, service may be provided on a locality or county basis. Plans for the localities are:</p> <ul style="list-style-type: none"> ▪ North West – Rhyl area (including Rhuddlan; also allowing for some resource centre based services to be accessible to communities in Prestatyn, Kinnel Bay and Abergele ▪ North East – Prestatyn area – for primary care centre services and some enhanced services to be provided from an augmented care centre, with further resource centre services to be provided from Rhyl ▪ Central – St Asaph and Denbigh and surrounding area ▪ South – Ruthin, Corwen and surrounding areas; certain services for the Llangollen population (with GMS for Llangollen being provided by Wrexham LHB, there is a need for a collaborative approach to development of community services in this area.
Flintshire	<p>Flintshire Community Services Plan – 2008 -2011</p> <p>April 2008</p>	<p>Main aim of the plan is to provide clinically safe and cost effective services which are easily accessible and are delivered as locally as possible on an equitable basis across the county. Working with local service providers they will strengthen primary and community care in order to:</p> <p>The HSCWB strategy details the following priorities (adults only):</p> <ul style="list-style-type: none"> ▪ Health improvement and protection ▪ Social inclusion – people with a disability ▪ Carers ▪ Older people with a mental health problem ▪ Chronic conditions ▪ Access to services

National Public Health Service for Wales	National and local policy drivers for the Primary & Community Care Project Team, North Wales
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		<p>Three localities are to be established:</p> <ul style="list-style-type: none"> ▪ Holywell and Flint ▪ Deeside, Hawarden and Saltney ▪ Mold, Buckley and Caergwrle
Wrexham	<p>Final Draft Community Services Framework for Wrexham County Borough</p> <p>May 2008</p>	<p>Vision – Our vision is ‘to provide a range of multi-agency community services to enable people to remain healthy; live independent lives, and tackle ill-health effectively.’</p> <p>Services will be provided via 3 localities; South Wrexham, Wrexham Town, and North West Wrexham.</p> <ul style="list-style-type: none"> ▪ Co-location of the A&E department, GP and other services on NE Wales NHS trusts existing site (NEW ERA project) ▪ Establishment of locality centre of care within the community ▪ Expansion of skills and capacity of community services ▪ Estates strategy that extends across primary, community and social care. ▪ Multidisciplinary and integrated health teams developed ▪ Full implementation of unified assessment and associated ICT.

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