Healthcare in Ceredigion

Introduction

Ceredigion is one of the largest counties in Wales geographically, covering nearly 1,800sq kilometres. The 76,000 population is concentrated along the coast, with Aberystwyth accommodating around 18-20,000 people. The County is sparsely populated and is defined as a rural area and it has an ageing population. The six main towns (Aberaeron, Aberystwyth, Cardigan, Lampeter, Llandysul and Tregaron) all offer secondary education, employment, housing and retail opportunities.

Hywel Dda University Health Board (HDUHB) is one of the 3 Local Health Boards within Wales that provide health care services to the population of Mid Wales. It is responsible for the provision of healthcare services in Ceredigion, these include primary care services (GPs, Dentists, Optometrists), Bronglais General Hospital (BGH) in Aberystwyth, Community Healthcare services (District Nursing, etc), and Mental Health and Learning Disability services.

Community Services in Ceredigion

Across the county there are 14 GP Practices and core GP services operate 8am to 6.30pm between Monday and Friday, with Out of Hours services operating at all other times. The Community Nursing service operates 7 days per week from 8am to 6pm. The Acute Response community nursing service operates 7 days per week, 24 hours cover.

There are 23 Community Pharmacy outlets and their core hours are from 0900-1800, with services available in the evenings and at weekends in some locations.

Clinical Nurse Specialists / Advanced Nurse and Advanced Therapy Practitioners are employed in numerous roles, supporting chronic condition management across the pathway of care.

Joint initiatives are in operation across each of the localities providing, long term care, palliative care, continuing health care, joint Service Level Agreements (SLAs).

Therapists provide assessment, advice and interventions within all community environments and work across the interface of hospital and home.

Dental, optometry, podiatry and the joint equipment store are available to support the needs of service users in the community.

Telehealth and Telecare developments continue to provide an infrastructure supporting care in the community, together with self-care management and ‘Expert’ service user programmes.

Joint Care Beds are jointly commissioned with the Local Authority and are available across Ceredigion in Local Authority residential homes.
There are community hospitals/resource centres in Tregaron, Aberaeron and Cardigan and in addition there are Community beds across Ceredigion in a range of facilities. Flow from South Ceredigion for acute inpatient care is delivered in Glangwili and Withybush General Hospitals. In addition Ceredigion also works in partnership with the four Local Authorities of Pembrokeshire, Carmarthenshire, Powys and Gwynedd.

The health Board are clear about the need for change in how we deliver services, particularly the need for increased integration in health and social care, placing the individual at the centre with care services becoming increasingly accessible in local areas. To this end, the Community teams core aims are:

- To ensure patients and their families receive community services that are safe and of the highest quality and provide the best experience and outcomes as cost effectively and as locally as possible. As part of prudent healthcare, we want to develop community services which encourage a culture of self-management whilst helping and supporting people to optimise and maintain their own health, well-being and independence.
- To work with our population, our partners and our staff to deliver care that is responsive to local needs and addresses inequalities.
- The overall strategy within the acute setting is to ensure patients’ needs are met in the most efficient and effective way through clinical pathway redesign spanning from Primary Care through the Acute Setting and effective timely discharge.

The intention is to achieve a plan for service transformation which results in a significant shift in the way services are provided across hospitals and the community, with some provision moving from hospitals to the community where safe and effective to do so. Delivering care in this way will support Care Closer to Home for our frail and elderly population, whilst allowing our hospitals to concentrate on what they do best – providing both planned and emergency care when it is needed.

**Primary Care and Community Services**

In planning to deliver Care Closer to Home, the County will need to better manage the significant pressure on healthcare provision due to the increased prevalence of chronic conditions and level of frailty. Care Closer to Home will place Primary Care Teams at the centre of the care provider network. The delivery of community services are increasingly focused through enhanced CRTs and these provide a multidisciplinary approach to the management of patients in the community. CRTs objectives are to prevent unnecessary attendance at hospital through recognition and early identification of acute illness which can be managed in the community avoiding the consequent potential for admission to hospital. Complementary to the CRTs will be the development of enhanced facilitated discharge services, which will similarly provide a team approach to discharge facilitation. The Community Resource Teams and discharge liaison will improve patient flow through the health and social care system.
The north and south Localities of Ceredigion are aligned to the north and south GP Clusters (groups of GP practices). Monthly meetings are held within each Cluster to discuss the development of healthcare services within Ceredigion. Each Cluster has developed the following specific priorities within their Practice population:

**North Ceredigion Cluster Priorities**
- Heart Failure
- Diabetes
- Influenza Vaccinations
- Cancer
- End of Life
- MSK
- Rheumatology
- Leg Ulcers
- Sustainability

**South Ceredigion Cluster Priorities**
- Increase in uptake of flu immunisation
- Improve Access – managing demand
- Recruitment marketing campaign to attract GPs to the area
- Strengthen the role and the use of the Welsh language in primary care as recommended by Welsh Government.
- Complex Care in the Community
- Psychological interventions
- OOH and improvement of hand over of care
- Urgent suspected cancer referrals feedback from secondary care
- National Priority Reviews – Polypharmacy; End of Life Care Retrospective Review; Early Diagnosis of Cancer.

The Cluster populations are as follows:

<table>
<thead>
<tr>
<th>North Locality</th>
<th>South Locality</th>
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</thead>
<tbody>
<tr>
<td>Borth Surgery</td>
<td>Ashleigh Surgery</td>
</tr>
<tr>
<td>Llanilar Surgery</td>
<td>Cardigan Health Centre</td>
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<tr>
<td>Padarn Surgery</td>
<td>Brynmddyg Surgery</td>
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<tr>
<td>Tregaron Surgery</td>
<td>New Quay Surgery</td>
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<tr>
<td>Church Surgery</td>
<td>Meddygfa Emlyn</td>
</tr>
<tr>
<td>Tanyfron Surgery</td>
<td>Lampeter Surgery</td>
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<tr>
<td>Ystwyth Surgery</td>
<td>Lllynfran Surgery</td>
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<td></td>
<td>Meddyfa Teifi</td>
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<tr>
<td><strong>Total: 48,044</strong></td>
<td><strong>Total: 48,246</strong></td>
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The sustainability of GP Practices is an area of concern nationally in Wales and in the UK as a whole, and is reflected within the local context, which is compounded by the rural nature of the county.

Integrated primary care and community health and social care services support acute hospital services by providing as much care locally, preventing unnecessary admission and facilitating early, safe discharge.

**Vision for Future Community Services**

There are two localities North and South of the County which are coterminous with Local Authority boundaries. The Community Resource Team service model provides support to a collection of GP Practices in discrete ‘Neighbourhoods’ within each Cluster. This will enable the allocation of an integrated workforce responsive to clinical demand and providing a single point of access to the multi disciplinary team.

Following the restructuring of Social Care Community Services using the Intermediate Care Fund, the short term team has become operational since October 2014. This will allow for the integration of Health and Social Care teams to develop the Community Resource Teams in the North and South Ceredigion Localities.

A working Group has been established across health and social care to provide the operational detail to implement the Community Resource Teams. This Group will provide specific detail relating to the process of implementation, including the following:
• Referral
• Single point of access
• Allocation
• Care coordination
• Multi-disciplinary Team Meetings
• Assessment process
• Documentation
• Care Plans
• Key performance indicators

The Welsh Government document supporting the introduction of care management and care planning will be implemented: ‘Framework for agreeing care with individuals who have long term conditions’.

Existing community teams across all sectors will work together in order to form the Community Resource Team (CRT). The CRT will provide a method of organising services within Ceredigion aligned to the clusters, North and South. The services will be provided and coordinated across organisations and commissioned when required, allowing the specific needs of the individual to be met.

**Patient Flow**

Investment in community services in Ceredigion will demonstrate a shift of health care from hospitals to settings closer to home and from reactive care to prevention and proactive models based on early intervention.

The main steps identified are to:
• Reduce the complexity of services
• Wrap services around Primary Care
• Establish multi disciplinary teams for those with complex needs including social care, mental health and other services.
• Support from specialist medical input including Consultant services.
• Create services that offer alternatives to hospital.
• Develop capability to engage and create sustainable communities. This approach requires locality based teams that are arranged around Primary Care and natural geographies, providing access to 24/7 services as standard, and complemented by flexible and responsive Health and Social Care.

The following developments are in progress to support the implementation of Community Resource Teams.

**Community Services**
• The Intermediate Care Fund (ICF) has provided an opportunity for social care to restructure domiciliary care providing a “short term care team” which will form the social care input within the CRT. Building on the success of ICF1 further funding will ensure continuation of the Third Sector Facilitators and
additional posts to support patient flow and timely discharge into the Community.

- The decommissioning of inpatient beds in Cardigan has led to the implementation of an enhanced community nursing service within the south locality. An annual review of this service confirms significant increase in activity providing 4,000 home visits, saving 921 inpatient bed days. The activity associated with this team, includes admission prevention, timely discharge, palliative care and support to district nursing activities.

- Interim beds have been commissioned which provide access for six weeks for assessment, treatment, rehabilitation or palliative care. Following a review of this service over a period of one year the evidence confirms that this service flexibly meets the needs of the Community within local facilities as close as possible to the patients’ home. Alternative placements are also provided in Ceredigion Local Authority residential homes with the commissioning of Joint Care beds which are supported by therapists and the Community Nursing teams however a joint review of this service is currently being undertaken.

- Discussions with GP’s in cluster meetings have led to specific pilots for multi disciplinary team development, with Newcastle Emlyn practice commencing in April 2015. A detailed plan is being established to take this forward across both clusters.

- A voluntary sector development to support patients on discharge from hospital is in the process of being implemented.

- There is a continued increase in outpatient activity within the Community for example fibro scanning undertaken by the Blood Bourne Virus CNS, Dermatology Telehealth clinics. It is anticipated with the development of the new resource centres additional activity and new clinics will be provided.

- Resources have been reassigned to provide specialist nurse support within the CRT model e.g. Heart Failure, Minor Injuries Unit.

- Third Sector Brokers contribute to MDT meetings within the hospital and community, raising awareness of 3rd Sector Services instigating referrals, signposting to services, identifying gaps in provision and informing commissioning.

- All Memorandums of Understanding and Service Level agreements are being reviewed. This includes the revenue associated with the re-ablement service. This will allow changes to the way therapy services will be delivered in the Community.

- With the increase in community service delivery, including palliative care, equipment requirements have increased. Currently being developed is the Hywel Dda Palliative care Strategy. The vision in Ceredigion in line with this Strategy will be delivered in Partnership with Severn Hospice in the anticipation that a Hospice at Home service will be re-established in Ceredigion in the near future.

- An estimated 0.1% of the British population suffers with debilitating chronic leg ulcers. The prevalence of leg ulceration increases with age and can be as many as 20 in every 5 people over the age of 80. The cost of leg ulceration is high, both financially and in terms of quality of life for the patient. The cost to the NHS estimated to be £300-£600 million per year. Research has shown that is possible to heal up to 83% of venous leg ulcers.
Two Leg clubs have been developed in Ceredigion. These have been evaluated with reports of high levels of patient satisfaction and an improvement in long standing presentations. Future developments will link with cluster plans and IMTP.

**Cardigan Integrated Care Centre**

Approval has been given by Welsh Government to proceed to Full Business Case on the Cardigan Integrated Care Centre.

Cardigan Integrated Resource Centre will provide the platform for integrated working and will act as a resource and communications hub at the centre of the community. It includes:

- The introduction of a single point of contact for service users;
- Base for the Community Resource Team in South Ceredigion;
- 24/7 services to support Out of Hours (OOH) care;
- The provision of telemedicine systems to provide remote access to specialist advice and diagnostic test results;
- The development of assistive technology to support people in living independently at home;
- The engagement of clients/citizens/patients/carers in the self-management of their care and the planning of services;
- A focus on prevention of ill health and promotion of health and well-being

**Services will include:**

- GP Practice/General Medical Services and GP Out of Hours service;
- Specialist and Nurse led Clinics;
- Base for Community Resource Team in the South Ceredigion area providing services in south Ceredigion, north Pembrokeshire and the Teifi Valley;
- Rehabilitation Day Unit to restore function and improve independence. supported by therapists, nurses and social care within the Community Resource Team;
- Services for dementia sufferers and their carers;
- Minor Injury Service – Nurse-led, walk-in service with telemedicine links to the Emergency Department;
- Radiology and diagnostics – digital x-ray with remote reporting;
- Phlebotomy service and Point of Care Testing;
- Outpatient suite with consulting rooms and clinical treatment facilities for pre-assessment and outpatient consultations by visiting consultants, specialist nurses/therapists and social workers, and opportunities for multi-disciplinary ‘one stop’ clinics;
- Third sector services e.g. voluntary agency service;
- Disease specific services e.g. Heart Failure and Motor Neurone Disease Clinics, COPD Services;
- Telemedicine suite providing access to specialists from across the professions.
Cyllch Caron

Approval has been given by Welsh Government to proceed to Full Business Case on the Cyllch Caron Development.

Cyllch Caron is more than a building, it will deliver an innovative multi agency community resource model responsive to the health, care and housing needs of the community today and for future generations. The model will also work with the community, 3rd sector to develop resilience and wellbeing within the community.

The Mid Wales Healthcare Study (Longley, 2014) reiterates the importance of bringing health, social care and housing services together within Cyllch Caron: “the plans for a shared service in Tregaron demonstrate the potential for holistic and efficient services that shared facilities can support”.

Cyllch Caron will provide a purpose-built centre for the integrated delivery of health and social care services; together with specialist housing for individuals with care needs right at the heart of the deeply rural community of Tregaron. It will provide:

- a hub for supporting changes in lifestyle underpinned by the promotion of community resilience. It is envisaged that this will be an exemplar scheme for
rural integrated working that provides value for money solutions for a unique, cultural and diverse community.

**Key Benefits**

1. Reduction in the number of emergency hospital admissions and readmissions for the basket of 8 chronic conditions (Tier 1 target);

2. More appropriate patient flow resulting in greater resource efficiency including earlier discharge e.g. Increased support in non-hospital settings

3. Number of patients who are cared for and die in their preferred place of care, whether that is at home, in hospital, a hospice or a care home;

4. Housing provide the opportunity for more people to live independently in their own home and community as an alternative to residential care settings

**Mental Health and Learning Disabilities Service**

Mental Health and Learning Disabilities Service delivers a whole system approach to care, working with inpatient, crisis and specialist mental health services to support those in the community with Mental Health difficulties. In Ceredigion the services include the following: Adult and Older Adult Community Mental Health Service, Community Team for Learning Disability (CTLD), Specialist Child and Mental Health Service (S-CAMHS), Crisis Resolution Home Team (CRHT), Local Primary Mental Health Support Service (LPMHSS), Therapeutic Day Service (TDS), Crisis Resolution Home Team (CRHT), Substance Misuse and the Veterans Service.

Offering a service which centres on prevention, integration, and one which is patient focussed is a key factor behind the future development of Mental Health service provision. The following outline recent and proposed developments within Ceredigion:

**Mental Health Project Group**

An opportunity has arisen with the existing mental health services in Ceredigion to consider introducing a more innovative model of enhanced community based services. This will consider the mental health needs of the population across services, age groups and sectors, and address historical barriers and boundaries to service delivery.

The proposed new model presents opportunities for staff to develop additional skills, work in new and extended roles and receive additional training. Training needs will be assessed as part of this process to ensure that all staff have the skills required to deliver these services.

The vision for the service is to have a modern community mental health service that:

- **Is accessible by all 24 hours a day** – The person who needs help, or their supporters, can walk into a mental health centre at any time and establish a safe relationship to discuss their needs and agree immediate support.
- **Has no waiting lists** – The first contact will take place within 24 hours after the request, with planned meetings to follow that agree the support and treatment available taking into account individual choice.

- **Moves away from hospital admission and treatment to hospitality and time out** – The service will provide night hospitality from one night to several weeks to address the crisis during periods when there is higher need for protection and / or to support the needs of the family. The enhanced community service will provide additional support, following a stay in hospital, to help facilitate an earlier return home.

- **Provides time out** – Therapeutic day services will provide the individual with access to the care and support that they need.

The ambition of the Project Group is to work at pace to drive service change in order that it meets the above outlined principles. At present the Mental Health Project group are seeking to engage with a wide range of staff, stakeholders and the public in Ceredigion, on potential service change. The engagement work is planned to continue through until September 2015 and in the event that formal consultation is not required, the financial, workforce, estates and partnership planning will commence and progress through to February 2016. In February 2016 it is anticipated that formal implementation of the agreed service model will commence.

**Tier 2 Drug and Alcohol Service.**

Hywel Dda University Health Board’s Community Drug and Alcohol Team are working closely with new third sector partners Dyfed Drug and Alcohol Service (DDAS) to assist in the implementation of the new Tier 2 drug and alcohol service across Ceredigion. This includes the development of a Single Point of Contact (SPOC) in Ceredigion for people experiencing problematic drug or alcohol use.

**Unscheduled Mental Health Care**

There has been a long standing project within mental health services to consider the introduction of an unscheduled care system. The Crisis Resolution Home Team has recently extended their service to cover 24 hours. Implementation of this has shown the following positive outcomes:

Provided a mental health practitioner to be available for individuals in crisis 24 hours a day.

Supported and supplemented both mental health nursing and psychiatry on call.

Built a more robust working relationship with the A and E department.
Specialist Child Mental Health Services (S-CAMHS)

Has recruited into recent vacancies successfully and provides a robust locality service for children and YP who experience emotional and mental health problems

The new S-CAMHS Crisis and Assessment Team (CATT) is now operational across the HB Footprint - this will enable the service to provide a timely response for any crisis, support Tier 1 professionals to access mental health services and as the team is working extended hours and weekends meet the needs of children and families

Following the announcement by the Minister of the recurrent CAMHS Funding of 7.65 million the service is currently working on a number of key initiatives which will further improve service delivery by increasing psychological therapies and ensuring services are provided at the right time in the right place every time.

Our aim is to minimise variation through the use of prudent healthcare with the provision of high quality evidenced based services for children and young people.

S-CAMHS recently won a significant award in the category “Working with Priority Groups” for their bilingual DVD - Getting the Lowdown - an emotional health resource for primary and secondary schools. The primary mental health team hope to roll this out across Ceredigion and Wales as an initiative to address emotional health, build resilience and reduce stigma and discrimination associated with emotional and mental health problems

Bronglais General Hospital (BGH)

BGH currently provides secondary care health services to a population of approximately 100,000 who live in Ceredigion, North Powys and South Gwynedd. It is based in Aberystwyth, Ceredigion which is over 50 miles from the next nearest town with an equivalent or larger population and an acute hospital. The area it services has a poor road network and public transport system with travel times of over an hour by car and significantly longer by public transport to the next nearest hospital either in Wales or England.

Aberystwyth has a large student population of > 10,000 for which it provides services as well as a large seasonal tourist population that visits all areas within Mid Wales. The hospital is important in its role as a hub which enables the sustainable provision of primary care and community services within the area, finally health care services are one of the major employers in the area and therefore important in the sustainability of the rural economy of Mid Wales and the health and wellbeing of its population.

The biggest challenge facing the future provision of services within Mid Wales is the ageing nursing, medical and other professional workforce both in secondary care.

Current working patterns and training means that as people retire it is not possible to replace them like for like and so a new model is required which embraces the changes in the workforce available and the expectations of that workforce in maintaining their professional standards and having an acceptable work life balance.
The model also needs to take account of the changing professional capabilities of the different professions that make up the workforce and provide education and training opportunities to ensure development of the current workforce and the future workforce.

**Future Model for Bronglais General Hospital**

The future model for the provision of healthcare services in Mid Wales will need to comprise of all of the following elements. They are all interdependent and required to ensure each component is sustainable into the future.

1. Models for disease prevention and self help
2. An integrated Health and Social Care System providing care in the community to people within their own homes.
3. Third sector and independent sector contributions to the community model
4. A federated model for general practice with much closer working between optometrists, community pharmacists, community dentists and general practice.
5. Bronglais General Hospital will become a ‘Rural General Hospital’ or ‘The Mid Wales General Hospital’ and be the hub for the community and primary care services in the area including the continuing development of a community delivered adult mental health service.
6. Removal of the boundaries between GPs and consultants with GPs taking up GP with specialist interest roles
7. Robust pathways will need to be agreed and in place for the onward referral and transfer of the care of patients when required.
8. These services need to be supported by e-health, IT and telemedicine.
9. These services need to be supported by a robust land and air transport network.

Bronglais General Hospital will develop into the Rural General Hospital for Mid Wales. It will deliver services within the hospital setting and as an outreach into Ceredigion, South Gwynedd and Powys to support the primary care and community services.

Bronglais will have a locally based management team consisting of a senior Doctor, Nurse and General Manager, who will ensure BGH runs safely and efficiently on a daily basis. Alongside the management team, a clinically led development group will ensure links into the Collaborative via the innovation group are maintained.

In order to relieve the pressure on other acute hospitals in Wales it is possible to increase the population and geographical area that it serves as demonstrated in the map below. There are opportunities to increase the number of referrals from South Ceredigion and from further north into Gwynedd and east into Powys. By developing outreach services and using technology there are opportunities to improve access to secondary care services and deliver them more locally for the population of Mid Wales.

There will be a network of consultants across the Mid Wales region working across the Health Board boundaries. These professional networks will also link with other larger hospitals. This will improve staff recruitment as standalone posts are no longer attractive and will reduce professional isolation.
Referral Pathways

The map below suggests a proposal for how the services from BGH could be extended to cover a greater area of Mid Wales than they do currently. The current model does not deliver services on a footprint that is consistent across all specialities and the proposal would ensure that there is uniformity of referral pathways and services between specialities.

- Tywyn
- Dolgellau
- Machynlleth
- Newtown
- Llanidloes
- Llandrindod Wells
- Builth Wells
- Tregaron
- Aberaeron
- Cardigan

Main Specialties

Recognising the strategic importance of Bronglais General Hospital it will continue to deliver 24/7 acute and emergency care, out-patient care, day case and short stay
care as well as inpatient care chronic condition management rehabilitation and palliative care in all the following specialties.

- General Medicine
- General Surgery
- Obstetrics and Gynaecology
- Paediatrics
- Anaesthetics
- Trauma and Orthopaedics

The medical model in Bronglais General Hospital should move to a consultant delivered service. The consultants would be mainly generalist with individual areas of special interests where appropriate.

It would be the intention to design services based on the Scottish model of remote and rural care. Examples of medical sub-specialities which should be provided at BGH are:

- Care of the Elderly
- Respiratory
- Cardiology
- Endocrinology
- Stroke services and other neurological conditions
- Cancer and palliative care
- Gastroenterology

The surgical services will be delivered by a team of 5 consultant surgeons supported by doctors in non-consultant grades and specialist nurses. This will allow an emergency surgical rota to be delivered as well as planned surgery for upper and lower bowel surgery, breast and urology.

The more specialist surgical services will be provided either by consultants based in Aberystwyth e.g. ophthalmology or visiting consultants e.g. ENT. There will outpatient clinics, day case and short stay surgery.

Orthopaedic surgery will consist of day case and short stay procedures. Revision surgery and more complex care will be provided in a specialist centre supported by the consultants with colleagues from elsewhere.

Paediatric services would be mainly out-patient, day care and community based however inpatient care should also be available.

A midwifery led maternity unit will be supported by obstetricians providing emergency care. They will also provide emergency and planned day case and inpatient gynaecology services.

A consultant delivered anaesthetic service is already in place and will continue to support the high dependency/intensive care unit and emergency transfers to tertiary centres.

Diagnostic cancer services and oncology and palliative care should also be provided locally; however there would be a continuing need for travel to specialist centres for
complex operative care, radiology and other specialist services. Further work is required to determine what cancer surgery can be performed safely in BGH through a networked model with cancer centres elsewhere.

The hospital will continue to be supported by radiology and pathology services both within BGH and from elsewhere in the HDUHB and across Wales.

The consultants will provide outreach out-patient clinics to the primary care and community facilities within Ceredigion, Gwynedd and Powys supported by the required equipment (eg ECHO, endoscopy) as appropriate to allow local access to a high level of services with high quality and safety of such services. There will be opportunities to develop day case surgery and clinical interventions closer to people’s homes.

Telemedicine and other e-health facilities will be used where clinically appropriate.

The Consultant delivered services will be supported by GPs with special interest, middle grades, nurse and AHP led clinics as appropriate both within the hospital and within the community.

There will need to be sufficient capacity in the system to provide out-reach care to the community it serves. The consultants need regular net-working opportunities as well; an arrangement whereby clinicians can work alongside specialist colleagues to maintain and develop skills.

Care pathways for all conditions will be agreed with specialist centres to support the local delivery of uncomplicated care for scheduled and unscheduled services for all specialities with agreed onward transfer of care to specialist centres within England and Wales for the management of more complex conditions.

Nursing

The specialist and advanced practice nurse roles are already established in Bronglais General Hospital and are designed to work both within the hospital and in the wider community and to support primary care. Examples of where the role is already very successful include osteoporosis, heart failure, diabetes and lymphoedema services. The number of specialist nurses will be expanded as required to ensure that they continue to provide their expert advice to patients and other health care professionals across the whole care pathway.

Therapy

Therapy services include Dietetics, Occupational Therapy, Speech and Language Therapy, Physiotherapy and Podiatry.

Therapy intervention is recognised as a core element of NHS provision to support successful recovery from illness, surgery and injury for people who may not make rapid, spontaneous recovery without therapeutic interventions. In addition therapy services support people to improve or maintain broader health and wellbeing and empower self management.

Where rurality and travel distance pose a challenge, as in North Ceredigion, therapists will be required to work flexibly and frequently deliver services in a variety
of sites e.g. GP practices, health centres, community hospitals, on a sessional basis. Whilst a small number of therapists (dietetics, OT & physio) predominantly work on site, therapists have a significant community focus.

The newly established Community Resource Teams deliver both long and short term care and include occupational therapists and physiotherapists as core members. The CRTs are integrated health and social care teams and are seen to be the cornerstone of integrated community services.

Each of the therapy services is led by a single Head of Service, whose professional leadership role spans all specialties. This provides an opportunity to strengthen partnership working across these specialties. In North Ceredigion therapy practitioners deliver both specialist and more generic services, with therapists working as part of learning disability, mental health, paediatric, diabetes, palliative care and pulmonary rehab teams. Therapists may also deliver stand alone intervention to individual clients and influence the practice of other professions e.g. dietitians work to embed optimal nutritional care into routine practice through education and training.

In addition, a 3 counties approach to providing equitable services ensures that service improvement initiatives are introduced in North Ceredigion to match service change in the other 2 counties e.g. Clinical. Musculoskeletal Assessment and Treatment Service, the MSK weight management service and XPERT diabetes group education programmes.

The therapy professions are progressively exploring the potential use of tele medicine and the use is currently being developed for people with head and neck cancers (linking with SLT in Singleton), pulmonary rehab (education component) and rheumatology (education component)

**Education**

The proposed model would allow the development of undergraduate and post-graduate training opportunities for doctors, nurses and other allied Health Professionals in developing generalist skills appropriate for practising in a rural environment. Joint working with Aberystwyth University of Wales, Trinity Saint David University and other university partners will provide opportunities to develop research and academic posts.

Further work needs to be undertaken to develop Diplomas in Rural Health Care and there is also an opportunity to further develop research excellence in rural health and well-being.

The existing nursing pre- and post-registration programmes through Swansea University will make a significant contribution for nursing and midwifery roles.

We will continue to work closely with the Deanery to ensure future graduates are trained appropriately to provide services in our rural care environment.
Risk

Key risks to the potential model which need to be addressed through the work of the Mid Wales Healthcare Collaborative and the Health Board Operations Director are:

- Support from professional bodies (including Royal Colleges and the Deanery) for rural model of healthcare delivery
- Recruitment and retention of clinical staff, (the recruitment campaign presently underway is aimed at stabilising and developing staff for the future)
- Training time for advanced practitioners
- Training time for rural medical practitioners
- Future Models may not be deliverable within the current financial envelope
- IT infrastructure and capability
- Clinical (and financial) sustainability without redesign of Mid Wales pathways
- Co-operation of and with partners
- Reputational risk of non delivery of expectations
Appendix A

Anaesthetics / ITU

Currently the anaesthetics department in BGH provides:

- Anaesthesia for all elective surgery and nearly all emergency surgery required (most exceptions very young children)
- Pre-assessment clinics (nurse and doctor led)
- Ventilation, invasive monitoring;
- Stabilise and transfer very sick patients including children if not retrieved. In the majority of cases, consultant anaesthetists accompany the patient during transfer, which is different from else where in England and Wales. The transfer distances are usually longer than in other areas.
- Stabilise sick children prior to retrieval; short term care of sick children not needing or offered retrieval

The department does not provide:

- Care for specialist patients – neurology, burns etc

Medicine

Currently the medical department in BGH provides the following specialities which:

- Assess and manage all acutely sick adults presenting via A+E or GP
- Thrombolysis for acute heart attack and stroke
- Non-invasive cardiac investigations
- Invasive investigative and therapeutic endoscopy of GI + biliary tract
- Staging and management of all cancers including chemotherapy with the following exceptions, endocrine, diabetic, lung, neurology provision similar to elsewhere in Hywel Dda

Specialities

- Cardiology
- Diabetes and Endocrinology
- Gastroenterology
- Haematology
- Oncology
- Palliative Medicine
- Respiratory
- Strokes and Care of the Elderly
The department does not do:

- Invasive cardiac interventions
- Medical Thoracoscopy
- Complex ITU and complex neuro
- Cardiac requiring interventional input (acutely and electively)
- Testicular cancer, sarcoma and germ cells cancers should be treated in a Tertiary centre

**General Surgery**

Currently the surgical department in BGH provides the following:

- Straightforward open and laparoscopic gall bladder and biliary surgery
- Palliative surgery for more complex biliary problems
- Emergency lower intestinal surgery
- Transurethral and some open urology
- Breast surgery; most other non-specialist surgery
- All General Surgical emergency and trauma
- General Paediatric Surgery
- Day case general surgery

Currently the surgical department in BGH does not provide the following:

- Colorectal cancer, neurosurgery, cardiac, thoracic or complex vascular surgery

**Orthopaedics**

Currently the orthopaedic department in BGH provides the following:

- All orthopaedic surgery that is done elsewhere in Hywel Dda does plus navigated knee replacements
- Short Stem total hip replacements
- Hand surgery
- Majority of trauma

Currently the orthopaedic department in BGH does not provide the following:

- Revision surgery for Total Hip Replacements
- Elective paediatric surgery
- Cruciate ligament reconstruction
- Arthroscopic shoulder surgery (at present)
- Spinal surgery
- Pelvic fractures, spinal injuries and Os calcis fractures
- Compound Fractures requiring plastic surgical input are not done.
Obstetrics and Gynaecology
Currently the obstetric and gynaecology department in BGH provides the following:

- Elective and emergency obstetrics
- All gynaecology that is done elsewhere in the Health Board

Currently the obstetric and gynaecology department in BGH does not provide the following:

- Complex gynaecology cancer surgery
- Cervical and vulval cancers should be treated in a tertiary centre

Ophthalmology
All ophthalmology operations and procedures that are done on the other sites in the Health Board

Ear, Nose and Throat
Elective minor procedures are done one afternoon every 6 weeks

Paediatrics
Currently the paediatric department in BGH provides the following:

- Assess and manage acutely sick children and adolescents presenting through the A+E or from primary care
- Elective and emergency minor to moderate surgery on children over 6 months (older if premature)
- Stabilise sick newborn
- Provide outpatient service including peripheral clinics

Radiology
The radiology department provides the following investigations:

- Basic X-rays, ultrasound, CT full body, in head and neck out of hours, limited MRI

The radiology department can’t do the following investigations:

- Radio isotope scans, interventional radiology
Pathology, Haematology, Biochemistry, Microbiology

The Pathology Service at Bronglais is provided as part of a formally managed network across Hywel Dda. The Haematology, Biochemistry and Microbiology departments provide 24/7 cover as required for an acute hospital. Microbiology is managed as part of the Public Health Wales Microbiology service.

Non-acute services are provided for primary care and community hospitals in Ceredigion, North Powys and South Gwynedd.

As part of the managed network, some non-acute work is shared out between the four pathology sites, so that, for example some specific tumour marker assays are measured at BGH for the whole of the Health Board; other work is referred to other labs in the network. This model ensures that duplication of work is minimised and expertise maintained.

Genito-Urinary Medicine

Currently the genitor-urinary medicine department in BGH provides the following:

- Assess and diagnose patients with all sexual health problems including HIV infection
- Manage patients with most sexual health problems

Currently the genitor-urinary medicine department in BGH does not provide the following:

- Manage patients with HIV infection or erectile dysfunction
Appendix B

A&E
- Dr Martin Sawyer (locum)

Anaesthetics
- Dr Brian Campbell
- Dr A G Bonsu
- Dr B Collingborn
- Dr R Koju-Shrestha
- Dr Lackmann-Pavenstaedt
- Dr J Zeber
- Dr M Hobrok
- Dr C Nwaefulu (locum)
- Dr M Szappanos (locum)

Haematology
- Dr C Poynton (locum)

Medicine
- Dr G Boswell – Emergency Admissions Unit
- Dr P Jones – Stroke and Care of the Elderly
- Dr C Kotonya – Diabetes and Endocrinology
- Dr D McKeogh – Cardiology
- Dr M Narain – Gastroenterology
- Dr R Canavan – Gastroenterology
- Dr L Pandya – Emergency Admissions Unit and Respiratory
- Dr G Lingesan – Palliative Medicine
- Dr E Jones – Oncology (locum)

Orthopaedics
- Mr M A Omar
- Mr S Sonanis
- Mr M Abdel Salam (locum)
Obs & Gynae
- Mr S A Awad
- Mrs A Nan
- Mrs Angela Hamon
- Mrs Mishra (locum)

Ophthalmology
- Mr Dai Barr
- Mr M Kulshrestha
- Mr S T Shanmugalingham

Paediatrics
- Dr John Williams
- Dr Simon Fountain-Polley
- Dr E Ikapkwu
- Dr K Khan

Radiology
- Dr Liaquat Khan
- Dr Shiblee Hafeez

Surgery
- Mr Taha Lazim
- Mr Samy Mohamed
- Mr Z Sallami (locum)
- Mr B Jameel (locum)

Visiting Consultants
- Rheumatology – Dr Peter Haynes
- ENT – Mr Nicholas Morgan
- Nephrology – Dr Chess
- Paeds Cardio – Dr Peart
- Neurosurgery – Dr Redfern
- Neurology – Dr Hirst and Dr Hinds
- Breast - Mr Holt