

DRAFT

HYWEL DDA HEALTH BOARD

RIGHT

**CARE
PLACE
TIME**

Every time.....

FIVE YEAR PLAN

2010/15

The Hywel Dda Rural Health Implementation Plan

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1. Chairman's and Chief Executive's message

We are pleased to be able to present you with these plans which place service delivery at the heart of your local community. Hywel Dda will be a community led provider with more than 80% of NHS services available locally, delivered by Primary Care, Community and Social Care teams operating from modern, enhanced Community Resource Centres with full access to diagnostics and a range of ambulatory care services.

Hywel Dda will focus more of our resources on services to be delivered as locally as possible by primary, community and social care teams. Of critical importance will be to enhance the support for patients with long term conditions. To support our vision for locally based services we will seek significant investment in fit for purpose primary care resource facilities and also ensure our hospitals are fit for the care of the relatively smaller number of people who require a higher level of care.

Evidence shows that up to 40% of patients currently in hospital are receiving a level of care they don't need. This is often because community services currently can't always provide the right care, at the right time in a local setting. If we get community services right there will be less need for expensive hospital treatment.

This is now very relevant. The Health Minister recently stated that NHS Wales would need to find somewhere between £1.1 and £1.9bn between now and 2014/2015 to balance the books. This will clearly place significant pressure on all our services so we to look at all areas of healthcare and find ways of being more efficient and effective.

There is a major recruitment problem for Doctors across all of Wales as recently stated by the Deanery. This is a particular issue in Hywel Dda. The result is that it is very difficult to maintain many services in the short and medium term. We must therefore work towards long term sustainable services for local people.

Achieving a step change in care will require support from the Hywel Dda population, catchment and stakeholders which will be fundamental in delivering a balanced health system focused on care closer to home. The driver for this is to improve the quality and the safety of the service which fully exploits the potential to bring services to the heart of rural communities.

To enable the Health Board to deliver world class quality care it needs to do things differently and to dispense with the old models and old logic. There will be a requirement for all Partners to be bold and courageous. Being bold means the greater involvement of the third sector, the public, patients and carers and staff in co-designing the future of our health community.



For many years the public and patients have told us that they want high quality services and care delivered closer to or at home. The goals of this plan are consistent with the service redesign principles detailed in this document.

Chris Martin
Chairman

Trevor Purt
Chief Executive

DRAFT FOR DISCUSSION

3. Our Vision

Principles	Personalised, promoting health, equitable, realistic, sustainable, affordable, free at the point of need and promoting independence, interdependence and self care		
			
Vision	Ensure the NHS delivers world class health and the highest quality healthcare for the people of Hywel Dda by operating as a world class health system		
			
Aims	Improve the health and wellbeing for all of the Hywel Dda population	Optimise the delivery of quality health and social care in the most appropriate setting	Be recognised as Wales' leading health system
Objectives	1. Ensure people live longer	4. Delivery quality health and health services efficiently	7. Improve the efficiency of the health service and value for money
	2. Reduce the impact of illness on people's quality of life	5. Identify health and social care needs better and respond creatively	8. Secure the necessary skills and lead by example
	3. Reduce lifestyle related illness	6. Balance collaboration and new ways of working in the delivery of health and social care	9. Work closely with partners to ensure delivery of health, social and community services
			10. Manage our reputation and communicate what we are doing

Right care, right place, right time every time

Hywel Dda Local Health Board is responsible for providing all healthcare services to the citizens of the 3 counties of Carmarthenshire, Ceredigion and Pembrokeshire.

The rural nature of the area presents its own unique challenges but it's our job to make sure everybody gets the highest quality of care they need, when it's needed, from a professional with the right skills.

The Welsh Assembly Government published its "Rural Health Plan" in 2009 following an extensive consultation. This strategy described what a rural health service should look like to meet the needs of our three counties of Carmarthenshire, Ceredigion and Pembrokeshire.

This document is a response to the WAG plan tailored to fit local geography and meet local people's health needs

Why are changes needed?

There are many reasons.

- Too often many people end up in hospital because there is no other service available. And when people are in hospital, many stay longer than they need to for the same reasons.
- The population in West Wales is generally older than in other parts of the country – and as a result there are many people with chronic (long term) conditions who need help and support close to where they live.
- The health needs of people are not the same today as they were 10 or 15 years ago when existing community services were designed.
- The amount of money available to the NHS will be limited in future – so our job must be to make sure every penny we spend gives the best possible results.

We are a new organisation and we have a responsibility to remove all the barriers there are to getting the right care, in the right place at the right time and making it a much easier system for citizens to find their way around.

Our plan is centred on a more effective focus on safety, quality and improved outcomes. Previous consultations with local people have shown us that there was over-whelming support for better community health services and services delivered closer to people's homes. Our plan describes how we will achieve this.

What is the vision and what will success look like?

People in the 3 counties living longer, with a high quality of life and with the right care available to them when it is needed. This means:

- ✓ *The very highest quality care for everyone regardless of where they live*
- ✓ *NHS services available as close to home as possible in modern and enhanced Community Resource Centres with full access to diagnostics, follow up appointments etc*
- ✓ *Community services available 7 days a week for a minimum of 12 hours a day with health and social services working more closely together to support people.*
- ✓ *The local population working with us to use the NHS appropriately and taking responsibility for their own health.*

Right Care

Our Pledge

To make sure the right health teams are available to give local people the care they need

Our plans describe how we intend forming new community teams with different skills to provide the support to care for our population that will enable them to be cared for and treated in the community and to maintain active and independent lives. These same teams will enable discharge from hospital for care at home for those of whom a hospital stay cannot be avoided.

We have already introduced different styles of community teams – the Rapid Response Team in Carmarthen is an example of how community services can give people the right care without the need to go to hospital. We will be taking this further and we describe how there will be multi-skilled teams across the 3-counties to help prevent illness and support people when they return home from hospital.

GPs are a major part of our plan. We describe a new and extended role for local GPs working together to provide more care from surgeries.

Right Place

Our Pledge

To have services available as close to home as possible – including diagnostics, follow up appointments, etc – with only those who need hospital treatment going to hospital

Our challenge is to make sure that people only go to hospital when they need to and only stay in hospital for as long as they need to be there. We can only achieve this if we improve community services and facilities and provide better care and support closer to home.

Our plan describes how we will use existing and new community located facilities as hubs for joined up community services and this will need investment in major refurbishment and redesign programmes for these facilities.

This work has already started with, for instance, plans for new community hospitals in Aberaeron and Cardigan already well advanced.

Right Time

Our Pledge

Community services will be available 7 days a week for 12 hours a day as a minimum

Over 80% of contact with the NHS is outside of hospital (through GPs, District Nurses etc). Currently community services are often only available 9am – 5pm, 5 days a week.

This needs to change and we are looking at support services that are available for a minimum of 12 hours (8am – 8pm) seven days a week.

Our plans include the early introduction of a “One Stop” contact point for people with long term conditions. This centre will make regular contact with patients to check on their condition and provide support to avoid the need for hospital treatment and to work with those individuals where it’s possible for them to manage their own conditions.

..... Every time

Our Pledge

To reduce harm and to provide a better quality of service

Our job is to make sure that everyone gets the best quality care that is safe and makes a positive difference to their quality of life regardless of where they live.

The key to achieving this is to refocus the way we deliver care to ensure it is a “community led” NHS.

When will this happen?

Our Pledge

We will not move any services until new services or facilities are in place and it is safe to do so

We would expect the new rural health plan to be in place within the next 3 years. But we can’t do everything at once. There are many things that will have an impact on when we introduce the changes.

To make the changes happen we will need to invest in both our community facilities and the hospitals

We recognise there are challenges. We will need to look closely at support for carers and families as well as patient transport, emergency services and the skills our staff to deliver improved services.

But doing nothing is not an option. The current structure of the NHS in the 3-counties is inefficient and does not meet the needs of the local population and will not deliver the highest quality of care which must be our aim for the future to make healthcare across the 3 counties of Hywel Dda Health Board as good as it can be.

We will target reforms to:

- Drive quality ↑
- Drive costs ↓
- Drive health outcomes ↑
- Respond to citizens needs ↑

What the document is

This document sets out both the strategic context for our services and the work that will be required to deliver our vision of change and improvement over the five year planning period. It responds specifically to the Rural Health plan; improving integrated service delivery across Wales, outlining our key challenges, why we need to change and the principles underpinning that change. Our ambitious target is to set out a programme of work that will deliver fundamental changes to the way we deliver healthcare, refocusing on a primary, community and social care led NHS over a four rather than five year period. This will be underpinned by a significant capital development programme to ensure all our healthcare estate is sustainable for the long term and meets the needs of our predominantly rural community.

The sections following will set out:

- The profile of Hywel Dda and the Health Needs assessment
- The Challenges and Reasons for Change
- The service strategy
- The engagement

The principles for change are the result of an integrated planning process with social care colleagues and the next stage of detailed planning will be led by clinicians.

3. The Hywel Dda Health Board

Hywel Dda Health Board was formed in October 2009 as a result of the Welsh Assembly Government's reorganisation of the National Health Service. The new Health Board consists of the 6 previous NHS bodies (NHS Trusts and Local Health Boards) and covers the three counties of Carmarthenshire, Ceredigion and Pembrokeshire.

"Our vision is to deliver the highest quality of healthcare for the people in Hywel Dda by operating as a world class health system"

Hywel Dda Health Board is an integrated care organisation, bringing together for the first time secondary, community, primary and social care services.

This enables us to integrate the planning of our services to provide co-ordinated, coherent, accessible services to include rapid response, enablement, rehabilitation, admission avoidance and accelerated discharge.

The Health Board provides services to a resident population of 375,061 taken from the three counties as follows:

Carmarthenshire	Ceredigion	Pembrokeshire
180,657 residents	76,812 residents	117,592 residents

We also provide services for the residents for our neighbouring counties of South Gwynedd, Powys and Swansea.

We aim to:

Improve the health and wellbeing for all the Hywel Dda population

Optimise the delivery of quality healthcare in the most appropriate setting

Be recognised as Wales's leading health system

Acute and community services are provided via our main hospitals as well as a range of community based and residences. We have 4 main hospitals:

- Bronglais General, Aberystwyth
- Prince Philip, Llanelli
- Glangwili, Carmarthenshire
- Withybush General, Pembrokeshire

There are numerous locations and settings across the three counties from which our primary, community and social care services (including mental health) are provided.

Primary care services are provided through:

- **GP Practices:** providing essential services to their registered population and visiting population including those with chronic disease. They can also provide additional services including vaccinations and immunisations, minor surgery procedures and enhanced services (e.g. diabetes and sexual health).

- **Dental practices**
- **Community pharmacies**
- **Optometry premises**

The Headquarters is based in Merlin's Court, Winch Lane, Haverfordwest, Pembrokeshire.

Some Facts

Hywel Dda Health Board covers more than a quarter of the landmass of Wales and is the second most sparsely populated Local Health Board area (after Powys). With a resident population of 375,000 we have roughly 13% of the total population of Wales and cover a landmass of 5874 square kilometres.

A typical day in Hywel Dda

2300 GP consultations
1600 Community Nurse consultation/visits
1500 Outpatient appointments
350 A&E Attendances
100 emergency admissions to hospital
10 Babies are Born
10 patients die in hospital
5 Hips/Knees Replaced

	Sq Km	% of Hywel Dda	Resident Population	% of Hywel Dda
Carmarthenshire	2454	42	181	48
Ceredigion	1806	31	77	21
Pembrokeshire	1614	27	117	31
Total	5874	100	375	100

The majority of our residents live in sparsely populated, rural settings as defined in 'Health in Rural Wales Dec 08'.

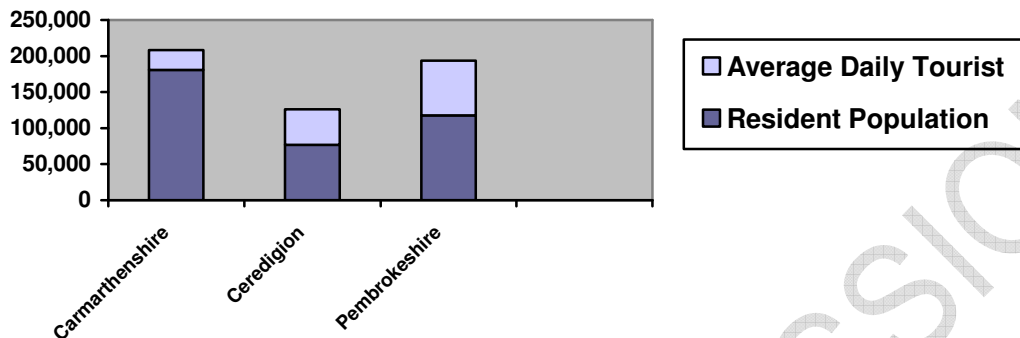
However, there also are a small number of urban conurbations in which approximately one third of our population live

There is a diverse range of people and places across the region by demographics, socioeconomics, culture and lifestyle choice. Most of the region is rural with some very sparsely populated areas such as those in South Ceredigion, North Pembrokeshire and Carmarthenshire with older housing stock and limited public transport.

Urban conurbations (over 10,000 residents) are:

Aberystwyth
Ammanford
Carmarthen
Haverfordwest
Llanelli

There are significant seasonal fluctuations in population (especially in the summer months) due to the large number of tourist visitors. An example of how the influx of tourists impacts on the local population is shown below using August 2008 as a sample period.



Health and Rurality

Whilst people in rural areas tend to live longer than those in urban areas, there are some significant rural healthcare challenges for Hywel Dda including:

- The geography of the Health Board makes travel difficult and journey times longer. Where safe and possible care needs to be delivered closer to people's homes, noting that the costs of delivery will be higher than in urban areas
- We have an older population that is by proportion aging faster than the national average; this means higher than average levels of long term conditions
- Circulatory diseases and cancer are still some of the main causes of death. Smoking, alcohol and obesity rates are high in deprived areas and contribute to the high mortality rates.
- There is significant deprivation and health inequalities, within a number of the localities.
- We need to improve the way we deliver care by focusing on delivering the right 'level of care' in the right care location in line with best practices; reducing the higher than average hospital admissions and lengths of stay; making better use of our community 'assets' – our GPs, our community hospitals (e.g. for step up/step down care) and our health social care and third sector services
- Seasonal fluctuation in the population causes an increase in minor injury type procedures.
- A higher 'end of life' care workload as patients from remote areas may choose to stay in their own homes to die.

Some Travel Times

Carmarthenshire Residents

22% live 20 minutes drive time or less from Glangwili Hospital & 48% from Prince Philip Hospital

Ceredigion Residents

34% live 20 minutes drive time or less from Bronglais Hospital

Pembrokeshire Residents

33% live 20 minutes drive time or less from Withybush Hospital

Challenges for delivering healthcare in a rural setting

- 23% of the population in Wales report having a limiting long term illness compared with 18% in England and 20% in Scotland. (ref McKinsey & Co, Ensuring Financial Stability & Developing a 5 Year Strategic Framework)
 - Chronic diseases i.e. Continuing Health Care, diabetes, Chronic Obstructive Pulmonary Disease (COPD) and asthma are reported in 18% of the Hywel Dda resident population
- Older people occupy 70% of acute hospital beds and are likely to suffer from healthcare acquired infections, lack of dignity in care, delays in discharge and high rates of readmission

Services must be designed to encourage more self care, provide anticipatory care and shift the balance from secondary care to more locally based care

4. The Health Needs of the Hywel Dda Health Community

Some Key Facts

Hywel Dda Health Board covers a quarter of the landmass of Wales and is one of the most sparsely populated health board areas. The Health Board population is predominantly white British with 1.0 per cent of the population coming from a minority ethnic background.

With 13 per cent of Wales' population the area's age profile is similar to that of the Country as a whole. There are, however, notable differences with fewer people aged 25-44 and more people aged 55-79. In rural Pembrokeshire and Ceredigion, there are relatively high numbers of older people.

For babies born today the life expectancy for males is 77 years and for females is 82 years of age. This is slightly higher than the average in Wales

Hywel Dda Health Board – key facts

Area size	5,781 km ²
Total population	375,200
Life expectancy at birth - males	77.1 years
Life expectancy at birth - females	82.0 years
Persons per km ²	64.9
% population from ethnic minority background 2001	1.0%
Total number of births	3,894
Number of deaths	4,186
% lower super output areas (LSOAs) in most deprived 5th of Wales	10%

Looking at semi-urban areas of population there are still some differences in premature death rates from respiratory and circulatory disease.

Overall health is either similar or better than the Welsh average. Ceredigion fares consistently better than Pembrokeshire & Carmarthenshire where there are pockets of poor health in urban areas.

There are significant differences in fertility between the highest and lowest rates across Hywel Dda.

Current projections see a rise in the older population (75 years and over) from 35,000 (10% of the total population) in 2006 to 70,000 (16% of the total population) in 2031. These estimates are based on assumptions about births, deaths and migration. The increase in the number of older people is likely to lead to a rise in chronic conditions such as circulatory and respiratory diseases and cancers. Meeting the needs of these individuals will be a key challenge for the Health Board and its local authority partners.

In the Hywel Dda Local Health Board area, the under 75 age-standardised mortality rate dropped by 22% between 1998 and 2007. This reduction in death rate means that more people are living longer and has remained consistently below the Wales rate.

It is predicted that the increase in the older population with chronic diseases will be the predominant change in health need. These conditions cannot be "cured" and often develop over many years causing increasing disability and ultimately death. However, this prolonged course meant that there are now interventions at every stage to delay deterioration and improve health outcomes, thus achieving the goal of longer, healthier lives.

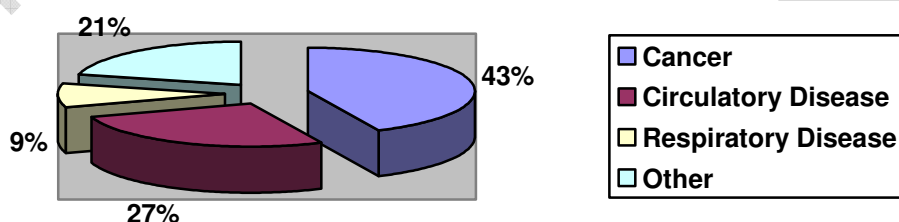
Causes of death

The greatest cause of death in people aged under 75 years among Hywel Dda Local Health Board residents are cancer (43%), circulatory disease (27%) and respiratory disease (9%). It is predicted these causes of death will continue.

Major causes of ill health continue to be:

Diabetes
Dementia
Depression
Musculoskeletal conditions
Accident falls (caused by increasing frailty & multiple medications & made worse by osteoporosis)

Causes of death in the under 75s (per 1,400 deaths during 2007)



Contributors to illness (healthy lifestyles)

People living in the Hywel Dda Health Board have generally healthier lifestyles than is typical across Wales. There are still challenges including obesity, smoking, alcohol consumption, drug misuse etc.

Obesity: there are better than average levels of physical activity and fruit/vegetable intake. However, nearly 6 out of every 10 adults are either overweight or obese.

	Wales	Hywel Dda	Ceredigion	Pembrokeshire	Carmarthenshire
<div style="display: flex; align-items: center;"> <div style="width: 15px; height: 15px; background-color: red; margin-right: 5px;"></div> Statistically significantly worse </div>					
<div style="display: flex; align-items: center;"> <div style="width: 15px; height: 15px; background-color: yellow; margin-right: 5px;"></div> Not statistically significantly </div>					
<div style="display: flex; align-items: center;"> <div style="width: 15px; height: 15px; background-color: green; margin-right: 5px;"></div> Statistically significantly better </div>					
Adults who eat fruit & veg (5-a-day) %	36	40	42	40	38
Adults meeting physical act guidelines %	30	32	32	35	30
Adults who are overweight or obese %	57	58	54	59	60

Alcohol & Substance Misuse: in the Hywel Dda area there were over 6,300 hospital admissions each year are caused by alcohol, despite the rate in every local authority area being lower than the Wales average.

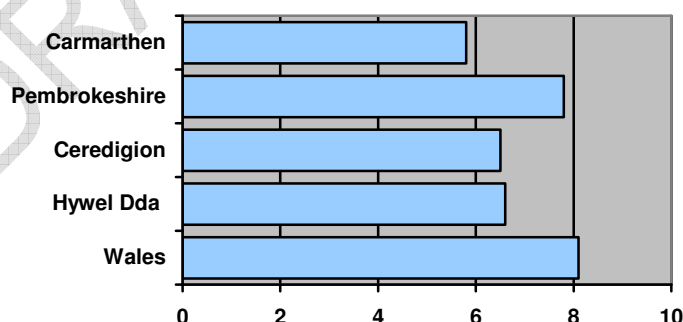
Smoking: around one in five adults smoke, leading to over 700 deaths each year. This equates to an average of 22% of adults who smoke in the Hywel Dda area. Although the rate of such deaths is lower than in Wales as a whole, the effects of smoking present continuing challenges to service providers in the area.

Younger People: *teenage conceptions* are less common in Hywel Dda than in other parts of Wales.

During 2007, there were approximately 140 deaths per 100,000 of the Hywel Dda population which were attributable to alcohol misuse.

There are around 200 patients admitted to hospital each year because of drug misuse.

In Wales, around 24% of people are smokers. Within the Hywel Dda Health Board area, around 22% smoke.



■ Teenage conception rate per 1,000 (under 16s)

Dental health in children is also comparatively good. The average of around two decayed, missing or filled teeth in five year olds however remains a concern.

Immunisations are available against the most common, serious childhood infectious diseases through the National Health Service. High levels of vaccination uptake are important to help provide protection for the entire community:

People with a physical/sensory disability

The numbers of people registered with a physical/sensory disability (as per Register of Physical/Sensory Disability 2001/08) are listed below. Just over half registered live in Carmarthen.

Wales	81,823
Hywel Dda LHB	9,344
Ceredigion	1,443
Pembrokeshire	2,850
Carmarthenshire	5,051

Levels of deprivation

Poor health, whether perceived or diagnosed, is closely linked to socio-economic deprivation. In Hywel Dda Health Board there are areas of deprivation including parts of Llanelli, Pembroke Dock and Cardigan. 22 out of the 230 Lower Super Output Areas (areas which have been shown to have high levels of deprivation) are in the Health Board area. Of these, 10% are among the most deprived fifth in Wales with 11 out of 230 (5%) in the least deprived. However, within less deprived areas there are often pockets of hidden deprivation.

As things stand, there is nothing to suggest that the current areas of deprivation will change or disappear and the serious consequences of the current economic downturn have yet to be modelled to the Hywel Dda population but will clearly have an impact on future health needs. People living in the more deprived areas are more at risk and their life expectancy is less than those in more affluent areas. The health service needs will be greater in these communities and the benefit to the community potentially greater.

5. CHALLENGES AND REASONS FOR CHANGE

This plan has developed over five months of work with a number of different stakeholders.

Ten workshops were held to prepare an internal assessment of our organisation which looked at the strengths, weaknesses, opportunities and threats. Each workshop engaged with a wide range of staff groups (clinical and non-clinical) for the following services/areas:

- Scheduled care
- Women & Children
- Rehabilitation
- Unscheduled care
- Healthy Living
- End of Life
- Mental Health
- Long Term Care
- The Workforce
- Cancer

Some key strengths & opportunities

- Strong, well developed partnerships
- Well qualified, skilled workforce
- Need to target patients to prevent illnesses from developing
- Patient education programmes to empower patients to manage their condition

Some key weaknesses & threats

- Duplication of services
- Need to develop a 24 hour service
- Threats of an ageing population
- Lack of co-ordination of some services

An analysis of our external environment was undertaken which considered the political, economical, social and technological impacts facing our local health services in the future. The analysis was undertaken by local clinicians including Associate Medical Directors, GP Locality Leads and Consultants in Public Health.

Political issues

Competition for public service funding
Equity in providing services in rural setting

Workforce issues such as nationally negotiated contracts and European Working Directive

Economic issues

Demand for services
Wide geographical coverage
Public sector funding under pressure
New technologies on the market

Social issues

Factors affecting demand: unemployment, deprivation, ageing population, healthy lifestyle factors
Fluctuation in population from tourists, students, etc

Technological issues

IT infrastructure issues
Implementation of telemedicine & telehealth
Better technology needed to support those in own community

The outcome of these workshops was used to build on the previous work undertaken for the Clinical Services Strategy and help inform this Five Year Plan.

The Health Board have established 10 'Foundations 4 Change':

1. Be recognised as the local leader of the NHS in Wales
2. Work collaboratively with community partners to plan services that optimise health gains and reductions in health inequalities
3. Proactively seek and build continuous and meaningful engagement with the public and patients, to shape services and improve health
4. Lead continuous and meaningful engagement with clinicians and staff to inform strategy, and drive quality, service design and resource utilisation
5. Manage knowledge and undertake robust and regular needs assessments that establish a full understanding of current and future local health needs and requirements
6. Prioritise investment according to local needs, service requirements and the values of the NHS
7. Deliver continuous improvements in quality and outcomes through clinical innovation and integration
8. Secure procurement skills that ensure robust and viable contracts
9. Effectively manage the local healthcare system to ensure compliance and continuous improvements in quality and outcomes for patients
10. Make sound financial investments to ensure sustainable development and value for money

These are the consequence of an analysis of key change drivers facing health services now and over the coming years and the national health policy initiatives which seek to drive the quality of Welsh healthcare.

Policy Initiatives

- 1000 lives Plus campaign
- Our Healthy Future
- Setting the Direction
- Doing Well, Doing Better: Standards for Health Services in Wales
- Better Outcomes for Tougher Times
- Quality Workforce Service & Financial Framework
- Rural Health Plan

Key Service Challenges:

- The development of primary, community and social care based services: to improve local access to services; ensure appropriate levels of care are provided in the right location and reduce demand on acute hospital services
- Medical staff recruitment: the continuing difficulty in recruiting staff to fulfil essential rotas to ensure safe and sustainable 24 hour 7 day a week services
- The reduction in real terms in health spending due to the present economic circumstances and high rate of "health inflation"
- The ageing population and the increased pressure this will place on the capacity of essential services to deliver high quality care
- Transport and service infrastructure
- Lead time for implementing change
- Availability of capital for the buildings we need to support service improvements
- Short term problems of developing the workforce skills to implement the new service model
- The need to ensure full engagement with and support from key stakeholders for the radical changes proposed
- Increased incidence of chronic disease
- We need to tackle and reduce the high conversion rates to long term continuing care.

'The major causes of chronic disease are known (diet, tobacco use, physical inactivity, obesity). If these risk factors were eliminated at least 80% of all heart disease, stroke and type 2 diabetes would be prevented and over 40% of cancers would be prevented.'
(World Health Organisation)

Predicting future changes in healthcare demand and delivery **Now**

The need to meet European Working Time Directive along with recruitment pressures for a range of health professional including specialist nurses, junior doctors and consultants will continue to challenge service provision. Providing better access to ambulatory and diagnostic services will require more flexible working patterns and workforce.

The ageing workforce and population is starting to create significant service pressures. Chronic diseases are increasing, however, technological improvements are continuing including surgical technology making more daycase and minimally invasive surgery possible. 'Expert' patients could dramatically increase the amount of self care.

The current focus of health spending is on the consequences rather than of the causes of complex problems and needs. Early identification of issues and effective targeting of services is therefore vital. By looking at service provision through the eyes of the service user rather than through the eyes of our individual organisations we have recognised the enormous potential to streamline and make a more relevant and focused impact and hugely influence costs over the long term.

In the past healthcare spend has been focused on treatment and illness, often at the point when patients have reached 'crisis' and thus consume significant resources. It is now widely accepted across developed health economies that as well as treating illness, a sustainable health system must invest in health/wellness in order to limit future demand for costly treatment. It is recognised across the NHS:

Key characteristics of a modern NHS

- Reduction in health inequalities
- Use of new drugs and technologies as they are available
- Improved access to services
- Greater use of care pathways
- Meet the demands of demographic changes
- Ensure quality assurance mechanisms are in place
- Work closely with key partners in health, social and third sector
- Focus on prevention rather than treatment

- That providing responses to illness will outstrip any conceivable increase in rate of funding and in the current economic climate future funding could fall.
- The elderly population is growing at a faster rate than other segments and we are treating patients at latter stages of illness. The rate of preventable and avoidable chronic disease is forecast to rise dramatically over the coming years.

We will target improvements in the following areas:

- Reduced waste and duplication (tests, appointments)
- Reduce harm caused by a lack of specialist skills
- Reduce variations in care
- Ensure sustainable junior doctor and consultant rotas
- Improve emergency care
- Increase clinical team working, peer review and back up arrangements

Risk profiling and disease management is central to increasing the value we derive from health spend as it not only 'adds years to life and life to years' but also reduces the burden of high cost treatment on end stage disease.

How will we know we've made a difference?

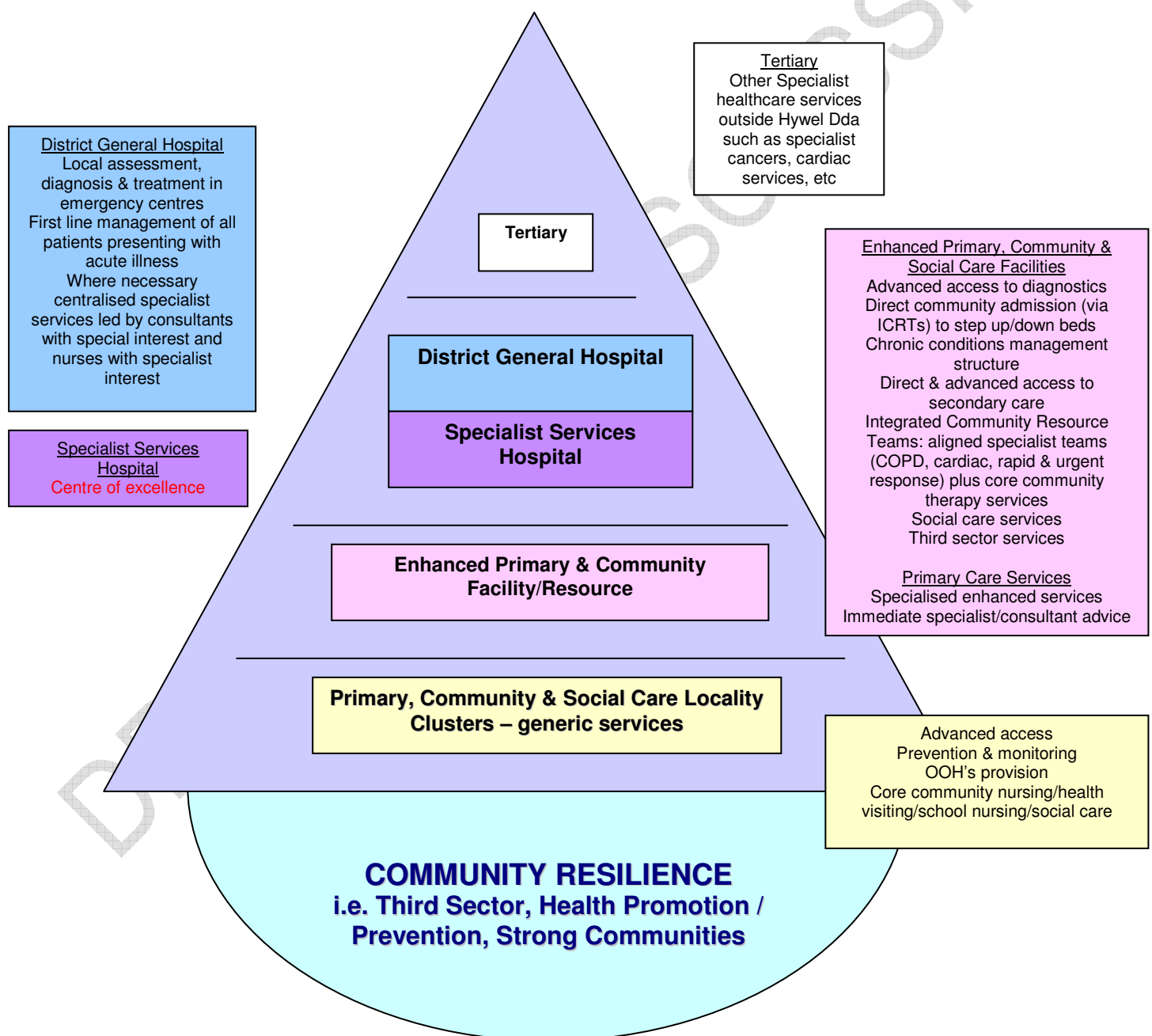
- Reduce deaths from cancer
- Reduce deaths from heart disease and stroke
 - Reduce smoking and deaths from COPD
 - Improve mental health
- Reduce alcohol misuse and alcohol related deaths
 - Reduce under 18 conceptions
 - Reduce the prevalence of obesity
 - Reduce health inequalities
- Improve male and female life expectancy rates
- Improve benchmarked rates of chronic disease
 - Reduce in hospital admissions
 - Increase home based care
- Increase patient and carer feedback

7. Our 5 Year Plan

Service Model Changes

The essence of the plan will see a shift to primary, community and social care services away from secondary care, maximising patient independence, access and satisfaction with services. The 'tiers' of services can be illustrated as follows:

Figure 1: Service Model Changes



The foundation for this is a model for Integrated Community Services. This has been developed through the participation of over 200 people across health, social care and third sector services and will deliver via:

- **Integrated Locality Teams** which will work as one joint team to actively break down barriers between services and drive the greater integration of health and social care in the community.
- **County Teams** to provide additional targeted support to the locally teams across the Three Counties.

This model of community, primary and social care will be based on 7 localities within the three counties of Hywel Dda.

Localities

There will be seven localities in total with a population base ranging between 35,000 and 75,000 providing a range of services designed to meet the population's health and social care needs and support community cohesion and engagement. The proposed County Localities in broad geographic terms are:

Carmarthenshire:

- Amman Gwendraeth Valley
- Llanelli
- Taf, Tywi and Teifi

Pembrokeshire:

- North Pembrokeshire
- South Pembrokeshire

Ceredigion:

- North Ceredigion
- South Ceredigion

The localities will form the core structural building blocks of the new model of community services. It is acknowledged that within these localities smaller patterns of service will exist due to natural geographical boundaries, based on primary care clusters and the transport routes across the community.

The needs of the population are becoming increasingly more complex and the integrated solutions need to be proactive and innovative. This networked approach to delivering services will help to break down 'barriers' and develop closer working relationships amongst teams of staff allowing for less bureaucracy and more responsive access to resources to be targeted at local needs and care delivered as close to home as possible.

Primary Care Practitioners and other co-located staff within the Primary Care setting, will provide the universal core of services for the whole population. Subsequently each Integrated Locality Network will include existing services based within Primary Care together with other health and social care teams who serve the same community.

It will not be possible to plan to meet all our citizens needs at this very local level i.e. specialist targeted care and the provision of urgent services over 24 hours a day

seven days a week. Across the three counties there are already a number of practitioners and teams who fulfil this work and provide support for people across several Localities. These will be developed to provide enhanced services and will be flexible in nature to respond to the changing needs of individuals across the county and allow a coordinated and proactive liaison with secondary care services. This approach will lead to an increased understanding of the immediate needs of the individual frail and vulnerable, the support needed, enable them to maintain their independence and ensure the avoidance of unnecessary admissions to bed based care.

Alongside the active response to local needs these teams will be empowered to identify people accessing secondary services such as an A&E Department or Acute Admissions. These teams in conjunction with the Localities will provide an active in-reach service and proactively pull people through the system and out quickly into appropriately planned, ongoing care closer to home.

Services traditionally delivered across institutional settings and some existing Consultant led secondary care services will also contribute to the range of services available more locally. The composition and ongoing development of these teams will need to be flexible and will be dependant on the emerging population need for health and social care

6.1 Clinical Leadership

Clinical programme groups have been established to ensure that clinical leadership is at the heart of our service modernisation process. There are a number of key components which characterise this approach

- Ensuring the integration of health, social care, the third sector and the citizens agenda through the membership of the groups
- Ensuring the process is clinically led by both primary and secondary care clinicians
- Ensuring that the development of levels of care and pathways of care with primary and secondary care – this will be integral to their success

The clinical programme groups are responsible for shaping their services and ensuring they meet current and future needs. There are eight clinical groups:

- **Scheduled Care**
- **Unscheduled Care**
- **Ambulatory Care and Diagnostics**
- **Women and Children**
- **Mental Health & Learning Disabilities**
- **Primary, Community & Long Term Conditions**
- **End of Life**
- **Healthy Living**
- **Rehabilitation**
- **Cancer & Specialist Services**

The shape of hospital services will respond to the shift in emphasis towards provision in the primary and community setting. Key considerations in deciding where services will be located will be:

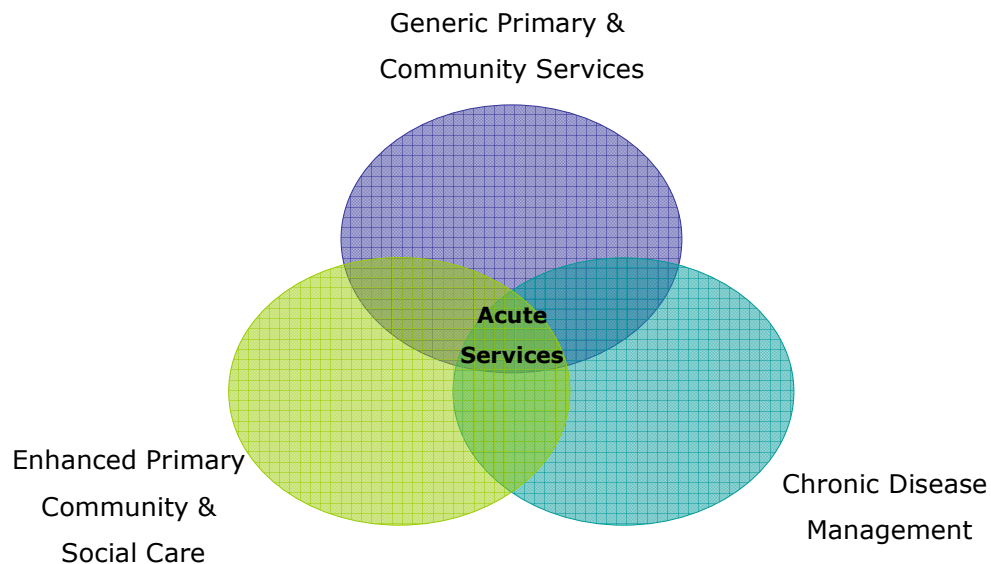
- To meet safe staffing levels as stipulated by the Royal Colleges
- Ensure we only manage cases where there are sufficient numbers to maintain competencies
- Ensure we deliver services which are sustainable and in which we can demonstrate safety and high quality

The provision of greater community and home based care is likely to mean that fewer beds are required in our hospitals. The exact configuration of hospital based services will be proposed by our clinically led workstreams but at this early stage we can say with confidence that certain facilities will definitely be in place:

- Our four hospitals will remain
- A&E departments will remain in each county
- Hospital based medical and surgical services will remain in each county

6.2 Right Care

Local Health and Social Care Services



On any day of the week 4 out of 10 patients in our acute hospital beds really don't need to be there and in truth the majority of those in acute hospital beds don't want to be there! One of the main reasons for this is that our primary, community and social care services have not been supported and structured appropriately to provide a safe alternative to continued acute hospital care.

We will, by rebalancing our resources and focusing on our community services, provide the right level of care at the right time and in the right location. Wherever possible this will be in the patient's home or very close to home, which is where we believe our citizens want to be treated.

Our challenge is to make sure that people only go to hospital when they need to and when people do go to hospital we need to make sure they only stay for as long as they need to. We will provide community support services with a range of skills available to make sure people get the right care at home after hospital treatment.

Right care means taking a patient centred view

- **Appropriateness of care, treatment and services in meeting patients needs and reducing**
 - Under utilisation and over utilisation
 - Inefficient or inappropriate utilisation
- **Effective preventative services and health promotion service programmes**
- **Improved patient outcomes**

Traditionally the need for support for those people who have a need for healthcare or social care over a longer period has been provided in a variety of ways by a variety of providers in a variety of settings. This has sometimes been an inappropriate level of care in the wrong place for the individual and at very high cost.

- **Equal access across our 3 counties**
- **Rehabilitation and reablement to maximise independence**

Changing service delivery also requires a change in culture and working practice with a greater emphasis on the care pathway and case management. The principle supporting this change would be part of the early anticipatory model with focus on improved assessment and decision making, and are key to the whole pathway of the care process. They include:

- Improved use of community beds for rehabilitation and reablement prior to the development of our Community services with clear accountability for the case management and care of patients.
- Greater alignment between decision making and the responsibility for budget management and resources.
- A fundamental focus on improvement, service quality and patient engagement in their care
- The assessment of patients for ongoing care in the appropriate setting
- Services aimed towards prevention and promotion of independence.

Primary care is the centre of healthcare within a community supporting and providing a majority of care locally, including health promotion, self care support, anticipatory care, chronic disease management, primary diagnosis, planned care and minor emergency care. The community will be empowered to support itself through appropriate use of locally available resources.

Current services are organised in a fragmented and re-active way. This can lead to duplication of effort and disjointed care. To sustain future services we will organise them differently. All professional resource within the community will be integrated both in terms of team work and location. The new model will be known as the Community Resource Team and will encompass a partnership approach between agencies and multi-disciplinary teams.

What are the differences of the current model and the new model?

Current and Future	
Primary Care Teams <ul style="list-style-type: none"> • Less fragmentation • Fewer organisational boundaries • Less duplication • Less reactive care • Self care infrequent • Variation in care pathways • Multiple visits to secondary care 	Community Resource Team <ul style="list-style-type: none"> • More integration • More partnership working and seamless care • More efficient care • More anticipatory care • Self care encouragement • Robust negotiated care pathways • Shifting the balance of care of locally based care

Hywel Dda Health Board considers Community Hospitals as a key resource for supporting the needs of local communities. Community Hospitals perform a wide range of roles and it is proposed that through re-design they will become more aligned to the modern care requirements which are particularly important within a rural community. Evidence suggests that investment in local diagnostics allows more patients to be managed within their community and the community hospitals and primary care resource facilities will be central to this.

Commitments

The community hospital capacity will be enhanced to support the implementation of the new service model.

Community hospitals will act as community resource hubs as part of the Community Resource Team and will provide a agreed range of services including enhanced diagnostics.

- Acting as a resource hub to the community, integrating and co-locating services provided by health and other partner organisations;
- A first line emergency service and a minor illness/injury service;
- A range of diagnostic services;
- Undertaking a role in pre-operative assessment;
- A range of outpatient visiting services appropriate to the health needs of the local population;
- An intermediate care service that is accessible by all practitioners;
- A end of life care service.

Long-Term Conditions Management

Evidence shows that of the eleven leading causes of hospital bed use in the UK, eight are due to long term conditions.

Better management of long-term conditions in the community will have beneficial outcomes for individuals and carers and reduce hospital admissions. This is a significant issue in particular for older people, who are at risk of losing their functional independence following admission to hospital.

The range of long term condition management activity will be determined by the skills and competences within the multi-disciplinary team and the resources available for appropriate patient care. This will include routine monitoring of common conditions that do not require specialist input and adjustment of clinical management with the aim of avoiding clinical crisis.

Anticipatory Care

Evidence has shown that the most frequent reasons for admissions of patients to community hospitals are: rehabilitation, as a result of a fall, chronic respiratory conditions and dementia related illness. An analysis undertaken by the NHS Information and Statistics Division (ISD) shows a rise in multiple admissions for over 65 year olds because of a failure of the out of hours care system to provide a preventative and anticipatory care for older people. The Community Resource Team will place more emphasis on the prevention of disease crises, when they arise.

E-Health

The concept of using e-health is a key philosophy and enabler to delivering healthcare in a rural environment. The principles which will underpin a technological approach will be:

- The specialist advice can be provided from a distance by videoconference, telephone or e-mail.
- Travelling to a central point can be obviated by the use of videoconferencing to a Community Hospital, GP Practice or indeed in certain circumstances direct to a patient's home.
- Digital data can be transferred from remote sites to other points, enhancing diagnosis. So, for example, blood tests, Echocardiograms (ECGs), images of all sorts and sounds can be sent to a central point from a peripheral location. Community hospitals could therefore supply a network of community hospitals and/or a Tertiary care could likewise supply scarce intellectual resource to the Community hospital and isolated practitioners.
- Developing the use of Telehealth/Telecare services in the patient home to support Chronic Disease Management through automated monitoring and notification, aimed at reducing direct clinician contact.

These principles support improvement education, clinical care and communication and enhanced patient self-care.

We will review existing premises and ensure any new premises have access to a range of modern communication tools including access, videoconferencing and telemedicine as a minimum.

Levels of care

The principle of 'right care' and which also underpins 'right place' is the definition and consistent application of the level of care required for our individual patients. Figure 2 illustrates the six levels of care which will be the subject of clinical discussion to tailor it to meet the needs of our local services.

Figure 2: Levels of Care

Level of Care	Care Capabilities	Staff	Diagnostics	LOS Range Target LOS
1. Acute care	<ul style="list-style-type: none"> Clinical observation /intervention Medication management Oxygen, IVs, ICU/CCU/HDU 	<ul style="list-style-type: none"> Consultants, SHOs, etc 24/7 Nurses w skilled care every 4 hours Therapists and other AHP 	<ul style="list-style-type: none"> Yes, on-site 24/7 access 	<ul style="list-style-type: none"> Range: 1-7 days Target: 5 days
2. Skilled Medical-Sub-acute Nursing care	<ul style="list-style-type: none"> Clinical observation Med management Oxygen, IVs 	<ul style="list-style-type: none"> GP or Consultant, daily rounds Nurses w skilled care every 6 hours Patient too ill for PT/OT 	<ul style="list-style-type: none"> Yes, either on-site or accessible on demand 24/7 	<ul style="list-style-type: none"> Range: 5-15 days Target: 10 days
3. Sub-acute nursing and therapy care	<ul style="list-style-type: none"> Clinical observation Med monitoring Oxygen, IVs 	<ul style="list-style-type: none"> GP or Consultant, rounds every 48 hours Nurse skilled care every 8 hr P/O/S TH 3d/w/6d/wk 	<ul style="list-style-type: none"> Not available on site Pt or specimen transported to site for diagnostics 	<ul style="list-style-type: none"> Range: 5-30 days Target: 15 days
4. Therapist led rehabilitation care	<ul style="list-style-type: none"> Patient must be motivated and able to participate in aggressive therapy programme 	<ul style="list-style-type: none"> Physiotherapy Occupational Therapy Speech Therapy Low nurse cover 	<ul style="list-style-type: none"> Community/Home based diagnostic support 	<ul style="list-style-type: none"> Range: 4-45 days Target: 20 days
5. Community/Primary/ Social Care	<ul style="list-style-type: none"> Patient must be sufficiently well to be managed and monitored at home 	<ul style="list-style-type: none"> District Nursing Social worker Third Sector Social Networks 	<ul style="list-style-type: none"> Maintenance Home/community diagnostics 	<ul style="list-style-type: none"> Care through primary/community care facilities
6. Primary prevention	GPs Neighbourhood activities Third sector schemes	Day centres Use of leisure services Housing conditions	Keep well this winter Social networks Family and friends	

6.3 Right Place

Localities, ambulatory care, levels of care

Some indicative travel times around isochrone information.

We will reduce some of the significant travel times that our patients currently experience to access outpatient and diagnostic services which are often routine and should be available in each of our localities. We want as many tests and assessments to be done outside of general hospital including:

- Outpatients
- X-ray services
- Blood tests
- Minor treatments
- Minor injuries
- GP led services
- Management of long term conditions

Community Hospitals (Enhanced Primary & Community Care Facility/Resource)

will be established in four key areas within the Hywel Dda Health Board and a further two within neighbouring Health Boards (Tywyn in Betsi Cadwaladr and Machynlleth in Powys). These facilities will blur the boundaries between acute and community and primary care providing the location for outpatients to outreach from secondary care and in-reach to enhanced primary and community care. There will be a range of diagnostics both on site (Pathology hotlab and digital radiology) and the potential for visiting (MR and CT). This will fundamentally change how patients access ambulatory care services in Hywel Dda with much of the elective care pathway and minor injury care pathway available in much more local and convenient locations. The flow of patients into our acute services is not specifically determined by Health Board boundaries e.g. a significant proportion of acute activity delivered in Bronglais Hospital comes from neighbouring Health Boards and any changes to the Ceredigion secondary care service model arising from enhanced primary and community care services and infrastructure in Hywel Dda will also need to be replicated in Powys and Betsi Cadwaladr. Acute outreach from Bronglais into Machynlleth will not only support the Bronglais acute services model but also impact on the current elective work from Powys into England and support the repatriation of work back to Wales.

The role of the Community Hospital is of particular importance in rural and remote communities and will be a key resource for Hywel Dda in supporting the changing needs of its communities. It provides a home for enhanced community services where it makes sense for these to be delivered either on a county wide basis or a geographical footprint that is bigger than a locality so as to maximise flexibility and economies of scale. The services provided from these facilities will vary dependent on the health needs of the local community or particular services where economies

of scale are favourable. The primary and community care teams will be supported by enhanced community resource services which will be made up of multi-disciplinary staff with specific specialist knowledge and skills who can respond quickly to the particular needs of each locality and help to maintain people in their own communities. This additional support will be provided through a number of Teams serving the population at a County level. This is effectively a chronic disease management and frail elderly service that will provide extra support for patients requiring timely health input in order to prevent unplanned or unnecessary admission to the District General Hospital.

The Community Hospital is the Enhanced Community Resource Service for the community. The following are core services which should be provided:

- Chronic Disease Management
 - Identification and risk stratification
 - Communication surveillance and care co-ordination
 - Case management and care navigation
- Blurring the boundaries between acute and primary care
 - Inreach and outreach outpatient services
 - Range of diagnostic services
 - Minor injuries
 - Pre-operative assessment
 - Palliative Care
- Use of Assistive Technologies e.g. Telemedicine and e-Health
- Enhanced primary and community services
 - Access to enhanced primary care services which may be provided by a Primary Care Practitioners

Timely response from Integrated Community Resource Teams (specialist teams for COPD, cardiac, therapy, etc) to provide single case management where the emphasis will be on Community PULL with access to services being needs based not criteria restricted.

6.4 Right Time

A great deal can be done to make services more easily accessible even given the large geographical area of our three counties. There will be investment in the counties infrastructure, both buildings and services. Community and Primary Care services are now available only five days per week 9.00 am to 5.00 pm. We will aim to make them available seven days per week 8.00 am to 9.00 pm.

- Anticipatory care**
- Identification
 - Risk stratification
 - Navigation
 - Primary and secondary prevention

Anticipatory care

We will place more emphasis on the prevention of disease crises and aim to anticipate problems as opposed to merely reacting as they arise. Practitioners, such as community and practice nurses, involved in monitoring patients with long term conditions will be central to this. Systems will be implemented to ensure contact is retained with patients at high risk of emergency admission. Particularly from problems such as falls, nutrition, medication and the appropriate professional will take any action required. Of critical importance is that through integrated planning we can identify high risk patients, ensure early identification of problems and treatment and prevent worsening of health problems into primary or secondary care.

The Development of Communications Hubs

One of the key enablers is the development of a Communications Hub to support service co-ordination and delivery.

The purpose of the Communications Hub is to streamline access to real-time, appropriate service and client information to support effective decision-making and improve service delivery. It is anticipated that the Communications Hub will be accessible by service users, carers and health and social care professionals, acting as a gateway to organising appropriate care and support for people to live as independently as possible.

The proposed core functionality of Communication Hubs include the following 3 strands:

- **Directory of Services / Library**

The Directory of Services would provide a comprehensive live record of all services available within the Local Health Board area to support self-care and for referrals for services across health, social care and the third sector.

- **Call Handling and Scheduling Services**

It would have a single-point-of-access call handling service that would act as the channel for sign-posting and directing members of the public and professionals to

the correct service according to need. It is not anticipated that this would be a clinical triage service.

Specific consideration should be given to:

- Service Scheduling
- GP Out of Hours Services
- Community Nursing Services
- Partial Booking and Non-Emergency Patient Transport Services
- Potential for integration with Local Authority Community Alarm systems/ Care and Repair / Joint Equipment services etc.

The more activity that can be centrally co-ordinated through the Communications Hub via access to scheduling and booking systems, the more effective the functionality will be.

- **Care Co-ordination**

Care Co-ordinators with expert knowledge of local services will be able to schedule care according to individual service-user need; acting as an effective bridge between all sectors and service providers to build care packages that support individuals to live as independently as possible.

7. Workforce

The Health Board employs 9,857 staff and recognises that its workforce is its most important resource in achieving its strategic objectives. There are many longer term workforce challenges within the context of providing quality care to an ageing population in an unprecedented economic climate. The workforce issues will need to be managed effectively, risk assessed and solutions developed to ensure a sustainable workforce.

"Service transformation requires workforce change"

The key issues which must be addressed are:

- Rebalancing the workforce through skill mix review; shifting care to community settings; reviewing and introducing generic workers and extending hours of service for patient care;
- Ensuring an affordable workforce by reviewing the staff cost profile and bandings; reviewing productivity and efficiency to reduce duplication and waste;
- A sustainable workforce is required to maintain safe and appropriate practice and patient care; reviewing supply and demand, labour market analysis and workforce profiles particularly where there is an ageing workforce;
- Promoting the health and well being of our workforce;
- Reducing sickness absence rates;
- Reducing Agency/locum spend to a minimum;
- Continued impact and implications on medical and non-medical workforce of compliance with the European Working Time Directive (EWTB)

"A new culture and different behaviours"

These priorities will be underpinned by the Workforce and Organisational Development team supporting County teams, clinical leaders and corporate departments through the delivery of Workforce & Organisational Development and Leadership Development programmes and by ensuring best practice in the organisation's management of the workforce.

This will be supported by raising data quality and management capability in the utilisation of Workforce Information Systems, the further development of the

"Partnership working and staff engagement"

integration of workforce planning within strategic and operational business processes and through support for the application of improvement techniques, role redesign and change management. The effective engagement of staff and Trade Union partners in all these processes will be critical.

Key Organisational Development Priorities:

- Establish a leadership development framework for the Health Board
- Identify simple, coherent & accessible set of values as a first stage in building a new culture.
- Agree core organisational capabilities to underpin Organisational Development intervention.
- Build levels of trust through employee engagement.
- Embed, spread and sustain expertise in improvement techniques.
- Equip leaders with the skills and knowledge to work in partnership with the workforce & to engage with services users and external partners.
- Support services through the development of individual Organisational Development plans.

Key Workforce Modernisation Activities:

- Increase the proportion of staff in community settings by 10%.
- Ensure an affordable workforce by reviewing the staff cost profile and bandings, reviewing productivity and efficiency to reduce duplication and waste.
- Support the rebalancing the workforce through the identification of new ways of working which address skill mix review, shifting care to community settings, reviewing and introducing generic workers and extending hours of service for patient care.
- Develop a sustainable and affordable workforce which is able to maintain safe and appropriate practice and patient care through reviewing supply and demand, labour market analysis and workforce profile particularly around the ageing workforce in some professional groups.
- Further support the reduction in sickness absence rates.
- Ensure effective utilisation of Workforce information systems through raising data quality, management capability and utilisation.

"Transformational leadership and staff empowered to deliver new models of care"

8. Rural Healthcare and Transport Arrangements

Our rurality based service model is predicated on having an effective medically led transport and retrieval system for fulfilling safe emergency responses along with patient transport. Our geography and road infrastructure dictates that to move to a safe, high quality and financially sustainable model of services requires this to be in place.

Currently, health related transport is provided by a range of different providers/agencies ranging from voluntary drivers to WAST. A strong transport infrastructure which responds to the needs of a large land area with dispersed populations is not the responsibility of one organisation to resolve but needs a co-ordinated approach. Secure and creative transport arrangements will be needed to cover land, air and maritime incidences.

As such, it is proposed a national approach is adopted which responds to and supports the health and social care service changes reflected in the variety of Five Year Framework documents. In particular, on an all Wales basis there should be:

- an Emergency Medical Retrieval Service (EMRS) to support the care of the seriously ill and injured people in remote and rural areas within Wales
- this service would retrieve patients with life threatening injury or illness where advanced medical intervention is appropriate to optimise safe transfer
- this service would use modern technologies ranging from new air ambulances to digital mapping technology & automated vehicle location systems
- the service would be additional to that currently provided and would be deployed if the consultant staff determine that medical intervention is required
- the service would need to link into Major Incident Plans for each County

Our local response to support the EMRS would include modernising or workforce to effectively support an Emergency Retrieval Service e.g. up-skilling rural practitioners, providing them with rapid access to emergency medical advice and the ability to rapidly transfer a consultant with critical care skills to the patient, whatever their location.

9. Community Cohesion and Engagement

Community Cohesion

Community cohesion or community resilience are cumbersome terms to try and describe a community that works well, is tight-knit, is supportive of those who live within it and is self reliant.

Community resilience is something you can feel when it is there but it is difficult to explain and quantify. A community as a whole or individuals within that community can experience the same stresses such as the classic deprivation issues but in a cohesive community it will not affect their physical and mental health and wellbeing to the same extent.

These communities will want to be involved much more in taking control of their own environment, pulling together and doing things to support one another e.g. good neighbour schemes to help support people to do things they would want to do anyway. Many communities have done this for years and help themselves to do what is right for them and in those communities the wellbeing and health of people is better even for those who have long term conditions.

The Audit Commission's report on Older People – Independence and Wellbeing found that for older people they value "inter-dependence" – helping others as well as receiving help themselves. This is the way Hywel Dda will work in communities - to facilitate inter-dependence. We recognise that our service users are not just recipients of our services but have skills, experiences and knowledge that can help others and enhance their community.

Hywel Dda Health Board wants to enter a mature relationship with our diverse communities to jointly plan and design which services are most suitable.

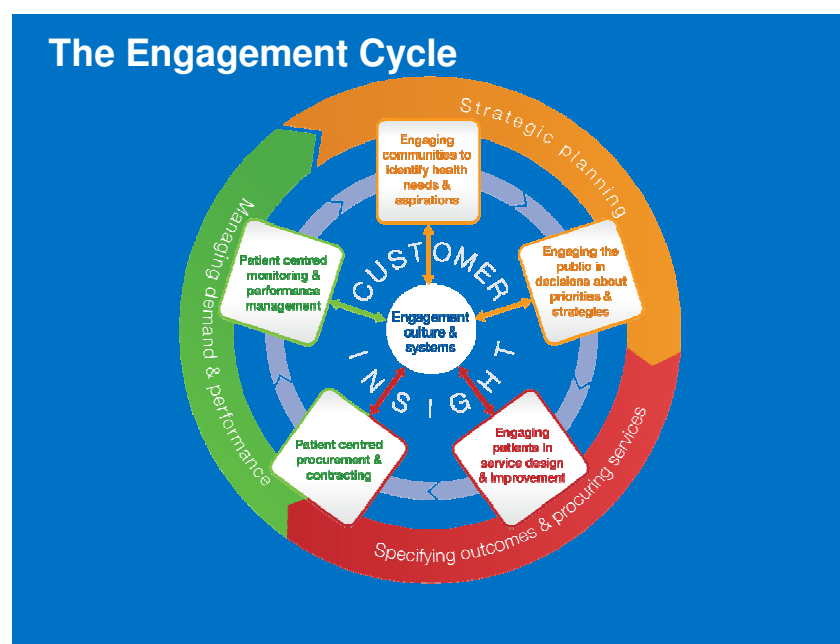
We commit fully to recognising the unique role of tradition, heritage, culture and language. Using the Welsh language and plain language will be key to success when we are designing and delivering our services.

Working through the third sector

This sector is much more adaptable than our large statutory organisations in Health and Social Care and there is a vital role for them in providing informal networks of support, being able to respond to very specific and subtle local differences. This can be provided by charities, voluntary organisations and volunteers, faith groups and the large range of community groups in localities.

We will engage with our third sector partners to co-design where they can most effectively support health and social care services and how those services can be funded. In hospital settings we will ask partners to develop services that support people from the point of admission (e.g. Womens Royal Voluntary Services and Red Cross – supporting during their stay, getting home and helping them be discharged home with extra support)

Where partners support in the community we will develop services to work with our Community Resource Teams and support people to recover, manage their conditions themselves and prevent them being re-admitted. These services would include: Good Neighbour and befriending type schemes, shopping, foot care, community transport, lunch clubs, gardening and cleaning and really growing an army of volunteers, helping one another.



A variety of communications tools and channels will be used and this will include the establishment of a regular information and advice e-letter, using patient experiences to redesign or develop care pathways, user groups and a membership scheme

Welsh Language

We recognise the importance of the Welsh language in rural communities and our Welsh Language Scheme outlines in detail our plans to ensure that patients are given every opportunity for patients in their language of choice.

There are challenges for us in ensuring that our teams of staff have the necessary skills but in establishing these teams and communications hub we will ensure that the requirement for bi-lingualism is incorporated early in the planning stages.